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The University of Manchester
Institute for Collaborative
Research on Ageing

DEVELOPING A STRATEGY FOR AGE-FRIENDLY GREATER MANCHESTER

Chris Phillipson
Professor of Sociology and Social Gerontology
Manchester Institute for Collaborative Research on Ageing (MICRA)
The University of Manchester

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Executive Summary

This report outlines a strategy for Greater Manchester (GM) to help achieve its ambition to be the first 'age-friendly region' in the United Kingdom. The report identifies several policy options designed to assist this objective, building on evidence about demographic, social and economic changes which are likely to affect the region over the next two decades.

The document should be viewed as a contribution to the work of the GM Ageing Hub, established in 2016 to bring together knowledge, resources and expertise with the ambition to develop the city region as an international centre of excellence for ageing.

Key recommendations

1. Ensure the benefits of a regional approach to age-friendly issues are realised through extending the scale of current age-friendly work, widening the scope of age-friendly interventions, and extending activity on behalf of specific populations (e.g. Black and Minority Ethnic Groups (BAME); the LGBT community).

2. Promote age-friendly programmes as a framework for ensuring social inclusion in later life. This can be achieved through the vision of developing GM as a 'social city', organised in ways which ensure connections across different ethnic groups, communities and generations.

3. Re-frame the current policy narrative from that which emphasises the 'ageing' of the GM population to one which addresses the needs of different birth cohorts, these varying in size, resources and attitudes.

4. Recognise neighbourhoods as a crucial resource for improving the lives of older people: policies should focus on removing barriers to mobility, ensuring accessible transportation, and improving security and safety within neighbourhoods.

5. Raising the quality of life for older people from Black and Minority Ethnic Groups will be essential in developing a regional age-friendly approach. Policies should include: extending existing support to networks/ advocacy groups within the BAME community; combatting health inequalities; developing specialist programmes to support carers within the BAME community; and expanding programmes aimed at tackling social isolation.

6. Promoting good quality housing will be central to ensuring age-friendly communities. Work at a regional level provides the opportunity for fresh leadership and initiatives, including registered providers taking on the role of encouraging innovation in areas such as co-housing, intergenerational housing, and home adaptations. This should be supported through a standing conference of GM registered providers, groups representing older people, developers, and local authorities.

7. Securing good quality and age-friendly employment is a GM priority. Reversing the decline in access to training and skill development will be essential to meet this goal. It is recommended that the GM universities and colleges work with Local Enterprise Partnerships to agree a concordat for training and skill development targeted at those 50 and over. This would address issues such as: supporting mid-life reviews, encouraging research on the impact of automation in the workplace, developing new methodologies for running training

courses aimed at older adults, and stimulating new approaches to lifelong learning in the higher and further education sectors.

8. Utilising the benefits of green and blue infrastructure for raising the quality of life of older adults. Policies here should include: widening access to green infrastructure (GI) benefits to those in institutional settings and with limited mobility; ensuring access to GI benefits to those people diagnosed with dementia, depression, and other mental health concerns; and undertaking an audit of GM spaces such as parks and allotments in terms of their viability and usage by older people.

9. Three scenarios for developing an age-friendly GM over the next two decades are outlined in this report:

Incremental change
↓
Age friendly environments

Key features: steady growth of age-friendly model: some expansion in resources to localities, but restricted through continued pressure on funding for health and social care; limited innovation in housing programme; growth in support for carers but lagging behind increase in those caring for people with dementia or older parents caring for adults with learning disabilities.

Decline
↓
Unequal communities

Key features: decline in age-friendly communities: GM evolving as a divided region driven by the impact of gentrification; age segregation within and between communities; failure to resolve high unemployment and the impact on local communities; continuing cuts to health and social care provision undermining neighbourhood activities; carers experiencing limited support but accelerated demands arising from increase in numbers of people diagnosed with dementia, depression, and physical disabilities; and failure to support ageing of black and minority ethnic community.

Transformative
↓
Active caring and learning communities

Key features: Age-friendly model developed and transformed in a variety of ways: services focused on where older people are living; care networks embedded in neighbourhoods across GM, led by older people working with health, housing, and social care agencies; housing innovations in the form of co-housing, shared housing, and the growth of new forms of retirement housing (e.g. for people diagnosed with dementia); reduction in social isolation experienced by older people; growth of naturally occurring retirement communities and 'village' type communities; devolution of care management resources; increase in co-operatives led by and employing older people; development of specialist support (where appropriate) for black and minority ethnic groups; development of community centres facilitating the transition from hospital to home; mainstreaming of community-based services utilising facilities such as leisure centres and art galleries; and expansion of dementia-friendly communities.

Developing a strategy for Age-Friendly Greater Manchester

Introduction

This report outlines a strategy for Greater Manchester (GM) to help achieve its ambition to be the first 'age-friendly region' in the United Kingdom. The report identifies a number of policy options designed to assist this objective, building on evidence about demographic, social and economic changes which are likely to affect the region over the next two decades. The document should be seen as a contribution to the work of the GM Ageing Hub, established in 2016 to bring together knowledge, resources and expertise with the ambition to develop the city region as an international centre of excellence for ageing. The Ageing Hub operates with the following vision for ageing as agreed by the GM Combined Authority and Local Enterprise Partnership:

> "for older residents in Greater Manchester to be able to contribute to and benefit from sustained prosperity and enjoy a good quality of life."

The Ageing Hub has identified three key priorities in developing its programme of work:

- GM will become the first age-friendly region in the UK
- GM will be a global centre of excellence for ageing, pioneering new research, technology and solutions across the whole range of ageing issues
- GM will increase economic participation amongst the over 50s

This document considers the opportunities and challenges associated with implementing the vision of achieving an age-friendly GM. It complements work undertaken by New Economy in their report: The Future of Ageing in Greater Manchester. The analysis which follows contains the following sections:

- Objectives, methodology and outputs
- Developing Greater Manchester as an age-friendly region
- Thematic areas informing age-friendly activities
- Three scenarios for the development of an age-friendly GM region

Objectives, methodology, and outputs

Objectives of project: to develop policy recommendations and priorities for action to assist the development of an age-friendly Greater Manchester.

Methodology: discussions with policy-makers across GM; focus groups with older people, BAME groups, and health, housing and social care managers in the region with responsibility for developing policies on age-related issues; and analysis of national, regional and local policy documents.

Outputs: final report, conference presentation and feedback to Ageing Hub, policy-makers, and groups representing older people.

Developing Greater Manchester as an Age-Friendly region

The City-Region 'Greater Manchester' is a conurbation of over 2.8 million people in the north-west region of the UK comprising 10 metropolitan districts, each of which has a major town centre and outlying suburbs. The Greater Manchester Combined Authority (GMCA) comprises the 10 Greater Manchester councils and Mayor, who work with other local services, businesses, communities and other partners to improve the city-region.

In recent years, population ageing has been recognised as an important part of the GM Strategy for economic growth and political reform. Work in GM builds on the long-established programme of work on age-friendly issues in Manchester, including activity around dementia-friendly communities (e.g. in Wigan and other local authorities)1.

Developing age-friendly communities has become a significant dimension in debates in public policy2. A variety of factors have stimulated discussion around this topic, including, first, the impact of demographic change affecting many urban areas; second, awareness of the impact of urban change on older people, notably those living in areas experiencing social and economic deprivation; and third, debates about good or optimal places to age, as reflected in debates around lifetime homes and lifetime neighborhoods3.

The issue of developing age-friendly communities arose from a number of policy initiatives launched by the World Health Organization (WHO) during the 1990s and early 2000s. A central theme concerned the importance of encouraging 'active aging', a concept originally developed during the United Nations' Year of Older People in 1999. The notion of 'active' was taken as referring to participation across a range of areas—social, cultural, spiritual, and economic—in addition to those associated with physical activity. Policies and programmes directed at achieving active aging were considered to require a range of interventions, including actions at the level of the social and physical environment.

The approach was taken further in 2006 when the WHO launched the Global Age-Friendly Cities project. In 33 cities around the world, focus groups with older people, caregivers, and service providers were formed to identify those factors that make urban environments age-friendly.

A resulting checklist of action points addressed aspects of service provision (e.g., health services, transportation), the built environment (e.g., housing, outdoor spaces, and buildings), and social aspects (e.g., civic and social participation). Building on this work, in 2010 the WHO launched the Global Network of Age-Friendly Cities and Communities (GNAFCC) in an attempt to encourage implementation of policy recommendations from the 2006 project.

Manchester was the first UK city to join the GNAFCC (in 2010). The network has a membership of around 380 cities and communities across countries in the Global North and South (2017 figures)4.

Theme 1: Developing a regional policy on age-friendly issues

To date, much of the work on age-friendly issues has been carried out within cities or rural communities with limited attention to wider regional issues or initiatives. A key issue for the GM Ageing Hub will concern that of developing an age-friendly policy which is genuinely regional as opposed to an aggregation of local (individual city) policies. Achieving this will require understanding and exploiting the benefits which a regional dimension to AFC work brings. Five aspects to this may be highlighted:

- There is great diversity among different GM local authorities and hence variations in the strategies required to become age-friendly. A regional approach can provide a flexible road map for developing age-friendly initiatives.
- Regional policies offer the potential to extend the scale of age-friendly programmes as well as to provide access to different kinds of infrastructure: social and cultural as well as economic.

- Regional policies offer the potential for intervention programmes which can test the performance of AFCs on indicators such as improving quality of life in older age, widening access to services, and reducing the costs associated with health and social care.
- Regional initiatives can extend the scope of work on behalf of specific populations (e.g. black and minority ethnic groups, the LGBT community, those experiencing mental health issues such as depression and dementia)
- Regional approaches offer the potential for developing new combinations of stakeholders and partnerships working to promote age-friendly issues.

Theme 2: Promoting age-friendly programmes as a framework for social inclusion

Developing age-friendly communities has been linked to the: '…goal of modifying the physical and social environment to improve the health and well-being of older residents and increase elders' social inclusion'5. The concept of social inclusion may be especially helpful to adopt in the GM context, given the challenge of implementing the AFC model in neighbourhoods with high levels of economic deprivation.

Social inclusion has been described primarily as a response to structural barriers that deny individuals and groups the ability to participate fully in society, with particular attention to access to resources, such as goods, services, power and control. Scharlach & Lehning (2013:114) further argue that social inclusion can be understood not simply as a characteristic of individuals, but of the communities within which those individuals live:

'…Physical and social contexts themselves can be 'inclusive' or not – either facilitating or serving as barriers to resource access, social integration and social support' (my emphasis).

A GM policy linking age-friendly work with social inclusion should give particular emphasis to issues relating inequality and poverty. Amongst older people, the level of pensioner poverty was estimated as standing at 50,000 in 2013/14 (women 60 plus/men 65 plus), reflecting experiences of long-term unemployment and chronic ill-health6.

Building age-friendly environments will require a response to the unequal contexts experience by older people in their local environments. This is especially important given the emphasis in Taking charge of our Health and Social Care and The Greater Manchester Population Health Plan 2017-20121, to draw upon community-based support in the delivery of health and social care7.

This goal may be difficult to achieve in localities where older people experience concentrated poverty, the effect of which can weaken networks of support and trust. The Marmot review highlighted that just under a fifth of people (19%) living in the most deprived areas of England have a severe lack of social support and around one quarter have some lack; compared to 12% and 23% in the least deprived areas8.

Taking a social inclusion approach, the goal of age-friendly work must be to promote GM as a: 'social city', one which is organised in ways which promotes connections across different ethnic groups, communities, and generations9. Accordingly: 'The way we build and organise our cities can help or hinder social connection. At worst, failed approaches can 'build-in' social isolation, with long-term damage to quality of life and physical and mental health.'10

Building on the theme of promoting social inclusion and combatting social inequality, the following points are of particular relevance for building an age-friendly GM:

- Developing partnerships which can tackle long-term poverty within communities, especially those affecting BAME groups, and other minority groups within the older population.

- Addressing the impact of 'de-institutionalisation' on neighbourhoods i.e. loss of core services arising from localised poverty and population decline.
- Developing programmes of co-research with older people and their organisations.
- Supporting innovations in community-based support (e.g. naturally occurring retirement communities (NORCS), 'village' associations)11.

Theme 3: Demographic change and age-friendly environments

The establishment of Greater Manchester (GM) priorities on ageing responds to the significant demographic changes which are forecast in the medium to long term. These have been analysed in detail at ward level and above by the constituent local authorities12.

This report will summarise the key areas of change and summarise the implications for developing age-friendly communities. Tables 1a and 1b summarise 2014-based subnational population projections produced by the Office for National Statistics (ONS), with figures for 2014 and projections for 2021 and 2031 for the age groups 50 plus, 65 plus, and 75 plus, for the 10 local authorities.

The key points from a regional perspective are:

- first, diversity across local authorities (with Manchester and Wigan at contrasting ends of the ageing spectrum);
- second, the overall significance of the 50 plus population for the future social structure of GM: most local authorities are projected to have around 40 per cent of their populations in this age group by 2031;
- third, the growth in numbers of those 75 and over (especially striking in local authorities such as Stockport and Wigan)

The importance of the age-friendly approach is underlined when the composition of the older population is examined in further detail.

Tables 2-7 draw on data from Buckner et al.'s report on demographic change across the North of England (published in 2011)13.

The projections require updating to take account of the 2011 Census but they provide an indication of trends, though must now be regarded as under-estimates. Table 2 indicates the growth across all local authorities in the population 75 and over; Table 3 the projected increases for those living alone. Table 4 highlights the projected increase in the proportion of men 75 plus living alone by 2036 – around one in three across all the local authorities.

The growth in the population of older adults living alone is driven by a combination of health (e.g. improvements in life expectancy) and social factors (e.g. increase in divorce in middle age) – the interaction between these having important implications for the delivery of health and social care at a neighbourhood level14. The study by Buckner et. al. also provides estimates on changes in the number of people unable to manage at least one domestic task and one self-care activity (Tables 5 and 6). The figures confirm the substantial increase in the need for care which will occur over the next decades. In a later commentary on these figures, Buckner et al. suggest that:

'Given the retrenchment of social services, with support being given only to those with substantial or critical needs, the majority of this increase in social care will have to be provided by

unpaid carers particularly for those people with moderate or low levels of impairment. However, if unpaid caring rates continue the number of carers available to provide this care will not meet demand for care due to the changing age profile of the population. In addition, changes in family size and family formation and evidence of generational differences in the willingness to provide care may reduce this further'15.

A regional perspective on demographic change indicates the following:

- The diversity of population change across GM (and within local authorities) raises issues about developing more targeted age-friendly approaches depending upon the age structure and composition of the local population.
- First and second wave baby boomers (those born in the late-1940s/early 1950s and those born in the early-1960s) are now entering middle age and retirement (they show the highest percentage increase of all age groups in GM over the 2001 and 2011 Census years - Figure 1) and will become a key demographic driving raised expectations about future provision for health and social care.
- Focusing on the boomer cohort suggests that it will be important to think about re-framing the narrative which drives age-friendly work. At the present time, planning in housing, health and social care is built around the idea of 'the ageing' of the GM population. But a more helpful (and accurate) perspective would be to attend to the different birth cohorts which comprise ageing populations: these varying in size, resources and attitudes. The 1960s boomers may be especially varied with labour market histories in some cases scarred by industrial decline in GM in the late-1970s and early-1980s. On the other hand, amongst both groups, the impact of higher education, and changing social attitudes more generally, will be reflected in raised expectations about the potential of later life.
- The increase in numbers in the post-war boomer population underlines the importance of public health interventions around middle-age16. However, these will need to address issues around tailoring communications to specific population groups, linking with employers and community groups.
- The growth in numbers of those unable to undertake domestic and self-tasks highlight the need to increase support to carers groups and organisations as a central part of building an age-friendly GM. Initiatives undertaken with the GM Consortium of Carers Trusts Organisations provide an important opportunity in developing a regional approach to supporting carers17.

Theme 4: Developing age-friendly neighbourhoods

Age-friendly neighbourhoods are a crucial resource for improving the lives of older people. At least 80 per cent of the time of those 70 and over is spent in the home and the surrounding area18. Older people are likely to have spent a significant part of their life in their current home and neighbourhood. Supportive communities can be a major asset for improving the quality of daily life.

At the same time they can contribute to the vulnerabilities associated with old age. Cities have to meet the needs of both long-term residents as well as those who are highly mobile (e.g. students, young professionals). The two groups may, however, have different degrees of commitment and contrasting views about how neighbourhoods should develop.

The loss of resources such as banks, post offices and corner shops (or changes in use) may represent a serious problem for many communities. Older residents may be particularly vulnerable to these changes – especially people with limited mobility and those who rely on facilities within easy reach. The fear of being a victim of crime may also be an issue, with people often feeling unsafe about moving around their neighbourhood at particular times of the day or night19.

Focusing on neighbourhoods is central to the age-friendly approach. Despite this, Ball and Lawler make the point that: 'Neighbourhood resources are unfortunately valued as amenities only…viewed as luxuries rather than long-term investments…Public amenities are the first to be cut when budgets tighten'20.

A regional policy should take account of the neighbourhood dimensions to age-friendly policies through the following actions:

- **There are clear physical and mental health advantages linked to mobility outside the home and being in outdoor spaces in particular.** Neighbourhoods that are designed to make it easy and enjoyable to go outdoors will help people attain recommended levels of physical activity through walking. Access to natural environments and green open spaces are themselves important in promoting health and well-being.

- **Removing barriers to mobility within neighbourhoods is a central issue for those faced with physical or cognitive disabilities.** Key to this will include: minimizing obstructions that might slow down pedestrian traffic or which present a safety hazard; providing road crossings at a greater number on wide or busy junctions; phasing traffic light signals at road crossings to allow pedestrians a longer time to cross; and ensuring that surfaces are non-slip and non-reflective.

- **Transport plays a vital role in maintaining independence and well-being, as well as ensuring that communities are connected**

and services and amenities can be reached. Older adults can become isolated if, for example, the person who acted as their driver has died; or if they are unable to renew their driver's license; or if they have a disability which prevents them from driving. Neighbourhoods flourish where they are integrated with a transportation network offering a variety of options, including community transport and free dial-a-ride schemes. Other interventions are also important, for example, improving the physical accessibility of buses (low-floor buses and minimum door widths); positioning bus stops at key locations with user-friendly seating; and clear, legible and standardized signage at transport intersections.

- **Creating improved security within neighbourhoods is an important part of an age-friendly approach.** In some cases, this will draw on existing resources such as libraries, community centres, colleges and sheltered housing schemes. Work is needed to ensure that groups of older people in areas of high economic deprivation have access to spaces which allow full participation within the community. Outreach activities to those in residential homes, befriending schemes for those who are housebound, and extending access to educational programmes, are crucial areas for expansion within communities.

Building on the above suggestion, the following principles for developing age-friendly neighbourhoods might be identified:

- First, they should provide a mechanism for empowering older people and ensuring social participation in the broader sense21.
- Second, they should seek to preserve social diversity within communities, encouraging a mix of generational groups wherever possible.
- Third, they should promote integration between the physical and social dimensions of the environment.
- Fourth, they should promote collaboration across a broad range of stakeholders, not least older people themselves.

Theme 5: Developing GM as an age-friendly region for Black and Minority Ethnic Groups

A regional policy has the potential to make a major statement about developing an age-friendly agenda which works for all ethnic and cultural groups. The ageing of first and later generation minority ethnic groups will be transformative in terms of re-shaping priorities in the AFC arena.

A regional dimension will allow testing approaches sensitive to the needs of groups who may feel excluded from current AFC initiatives. Migration itself greatly affects how people age and is still poorly understood, both in the ways ethnic diversity creates differential needs and in the contrasting geographical patterns of migration of different age groups and their effects on the demography of age-friendly environments22.

Results from the 2011 Census indicated nearly 12 per cent of the GM region is from mixed race or black minority backgrounds: with a high of 30 per cent (Manchester) and a low of 10 per cent (Stockport). Jivraj, in an analysis of the social geography of GM, concluded that: 'Most ethnic minority groups are evenly spread residentially across Greater Manchester, with evidence for dispersal away from areas where ethnic minority groups are most clustered'23.

However, geographical clustering of the largest ethnic groups remains significant. For example, the Pakistani ethnic group is clustered in wards in parts of Rochdale, Oldham, Manchester and Bolton. In Manchester, more than a third of the population in Longsight ward (36 per cent) and more than a quarter of the population in Cheetham ward (28 per cent) have a Pakistani ethnic identity.

The older population within the different minority ethnic groups is relatively small, but will see substantial growth over the next two decades (Table 7 illustrates projected growth for the BAME population 75 and over based on 2001 Census figures).

Planning for greater diversity in ethnic identities in old age will be a significant issue for realising an age-friendly GM. Developing effective responses to ethnic health inequalities will be of particular importance. Bécares analysed data from the 2011 Census which highlighted the pronounced health inequalities at older ages of those with a Pakistani or Bangladeshi ethnic identity: 56 per cent of all women aged 65 and over reported a limiting long-term illness (LLI), compared with 70 per cent for Pakistani and Bangladeshi women in this age group (similar results were found in respect of men). Older women in the Arab and Indian ethnic groups also reported high percentages of LLI (66 and 68 per cent respectively), whereas Elderly Chinese women reported the lowest limiting long-term illness (47%)24.

Relevant questions in planning for an increase in the BAME population, include:

- Strengthening support networks/ advocacy groups within the BAME community (e.g. the Manchester BME Network/Ethnic Health Forum)25.
- Developing specialist programmes to support carers within the BAME community.
- Improving the quality of housing and providing access to specialist housing where appropriate.

- Expanding programmes which tackle social isolation amongst older people from minority ethnic groups (especially given the projected increase in the numbers of people from BAME communities living alone – Table 4)

Theme 6: Promoting good-quality housing as the key to age-friendly communities

GMCA, together with the individual local authorities, can play an influential role – through the development of its housing strategy and the Spatial Framework – in setting high standards both in plans for new housing development and in the refurbishment of the existing housing stock. Ensuring good quality housing for all older people is central to the policy of 'ageing in place' i.e. helping people to remain in their homes for as long as they wish.

However, support for this goal – which is seen to match both the aspirations of older people and the desire of service providers to limit the cost of institutional care – must also be linked with ensuring the 'places in which people age' can offer appropriate levels of assistance.

The home is where most people – especially those 75 and over – spend the majority of their time. Poorly maintained homes can, however, be a source of danger: Age UK have estimated that the cost of hip fractures (partly associated with falls in the home) could rise to more than £6 billion by 2035, with 140,000 related hospital admissions (almost double the current figure)26.

Homes can be supportive of active and healthy living on multiple levels: their physical design and layout can influence healthy living, limit exposure to risks, and assist the maintenance of daily activities. The housing environment can itself provide opportunities for social contact, expand social networks, and enhance feelings of safety and support. The research evidence further suggests that falls can be prevented through modifications to the home (preferably before a crisis situation has occurred), through physical activity, and adoption of assistive technology.

The draft GM Spatial Framework suggests that delivering housing '…designed to meet the needs of older people will be an important priority' over the period to 203527. A strategy for an age-friendly GM needs to identify: what are the key housing priorities to enable 'ageing in place'? What sort of housing options need to be developed? Whose responsibility is it to produce these? What are the best ways of involving older people and the communities in which they live?

The issues raised by these questions will not be easy to resolve: local authorities across GM have substantial stocks of pre-1919 housing in urgent need of repair; there is limited housing wealth in GM in comparison with other (mainly southern) parts of the country (across the North-West 20 per cent of those 65 and over have no housing wealth); tenure profiles are highly diverse across GM (e.g. 79 per cent owner occupiers in Stockport compared with 48 per cent in Manchester)28; and there is evidence of significant housing inequalities affecting minority ethnic groups29.

There is an ongoing debate on the theme of downsizing or re-sizing a way of releasing large properties and helping increase the supply of houses for families/first time buyers30. This policy may be difficult to progress in the case of GM: one-third of those 65 and over already live in one-bedroom properties (a high of 41% in Oldham and a low of 16.8% in Manchester).

Re-sizing is only feasible if there are good quality housing options close to where people have been living, allowing the minimum disruption to existing social networks. And re-sizing does not address the central policy issue of how to expand options for people on low incomes with limited housing wealth – the bulk of owner occupiers and tenants across GM.

Developing a plan to resolve concerns about limited housing options, combined with the risks attached to living in poor quality housing, is an urgent priority for GM to address. Developers and volume builders are unlikely to take the lead in this area, continuing to focus on homes

for first-time-buyers, families, and single professionals (as in central Manchester): an approach which if left on its own will almost certainly intensify age-segregation within GM, a tendency which would go against the benefits associated with mixed age communities.

An alternative approach would be to encourage registered providers/housing associations to encourage innovation in home adaptations, retirement housing, co-housing, inter-generational housing and similar schemes, as well as to encourage local authorities to act as developers for new types of housing for later life. Developing new financial models to support this work will be an important issue to address if new housing options are to be realised31.

The complexity and uncertainty surrounding the housing issue suggests the case for a standing conference of housing providers, groups representing older people, and local authorities. This would complement the work of the existing Greater Manchester Housing Providers' group.

Such a conference would need to consider questions such as: how can the principle of lifetime homes and neighbourhoods be applied across the GM region? How will the need for housing vary within and between different age cohorts? What sort of business models will need to be developed to support innovation in retirement housing? How can the needs of minority groups be embedded in future house planning and development?

This work should also link with the 'Age Well' population health programme which brings together housing, health and social care (although a focus on the second-wave boomer cohort would also be justified in this programme). There is also a major role for the GM universities in the housing area focusing on research in relation to falls, the role of assistive technology, and environmental design.

A future age-friendly housing strategy might also incorporate the following recommendations from Age UK:

- All new mainstream and specialised housing should automatically comply with higher accessibility standards, to reflect lifetime standards.
- Improved design and accessibility should not be restricted to specialised housing, as the vast majority of older people will continue to live in ordinary homes.
- All local authorities and Clinical Commissioning Groups need to implement best practice to speed up the delivery of home adaptation and reduce waiting times to a minimum.
- Funding for home adaptations should be protected, particularly through Disabled Facilities Grant (DFG) allocations.

Theme 7: Developing an age-friendly employment policy

Extending or achieving a fuller working life is now firmly established as a core element of public policy. The framework for this has been set out in Fuller Working Lives: A Partnership Approach (Department for Work and Pensions) which identifies what are viewed as the social and financial benefits of a longer working life32. Increasing employment rates amongst the over-50s is a key target for GM, with the goal of increasing the number of people in work aged 50-64-year-old up to the UK average.

This objective is a particular challenge for GM given the substantial numbers who have had lengthy periods out of the labour market (e.g. in Manchester of those aged 50-64, 17% last worked before 1991 or never worked; 10% in Rochdale; and 9% in Oldham) (Table 8).

The evidence suggests that many first wave boomers hit problems entering or consolidating their position in the labour market in the late-1970s and 1980s, with many failing to gain a secure foothold. The reasons here are likely to have included: health problems affecting people in mid-life which affect their ability to work; loss of manufacturing employment; age-discrimination affecting older workers applying for jobs; lack of skills and qualifications; and responsibilities as working carers.

Minority ethnic groups may also experience discrimination in the labour market. An analysis of Census data for Manchester over the period 2001 to 2011 suggests that employment inequality worsened over this period for the Black African, Black Caribbean and Bangladeshi groups. Employment inequality for the Black African group increased across all districts in GM between 2001 and 201133.

A project led by GM Public Health, Ageing Well in Work: A Call to Action, identified a number of areas for development, including:

- Reducing the flow of older people falling out of work as a result of ill-health.
- Working with individuals, Public Health England, local authorities and employers to reduce early retirements and to identify appropriate community interventions for those who retire on the grounds of ill-health, to help them continue to participate in social or community activities.
- Extension of age-friendly workplaces – working with employers to identify key actions and activities.
- Health promotion and disease – promoting opportunities to help older people manage long-term conditions in order to stay in work and remain independent.34

The Centre for Ageing Better (CfAB), together with GMCA, are testing new approaches to helping adults 50 years and over enter the labour market35. The results from this work will be important in meeting some of the challenges associated with helping adults return to part- or full-time employment. However, employment projects need to be linked to a wider agenda which assists the re-skilling and re-training of adults 50 and over.

National data here confirms that for this age group, the call to extend working life has run alongside a decline in participation in learning generally and work-based training in particular. Only a minority of older workers are likely to have access to regular training and updating of skills: just 11% of those aged 60-69 according to one survey36. Those in low-skilled occupations and working part-time are the least likely to receive training. The danger is that without a major initiative in areas such as training and skill development, older adults may be faced with limited options when attempting to return to employment (especially after a long period of unemployment).

Following the above, one suggestion is for the GM universities and colleges to work with Local Enterprise Partnerships to agree a 'concordat for training and skill development targeted at those 50 and over'. This would address issues such as: developing new approaches to running training courses; supporting people making the transition to self-employment; supporting mid-life career reviews; and undertaking research on the impact of changes in the workplace on older workers (e.g. with technological changes associated with automation). GMCA should also consider implementing some of the recommendations from the Inquiry into the Future of Lifelong Learning, in particular that:

- The 'third age' (50-74) should be viewed as a central period for encouraging enhanced training and education opportunities, based upon more even distribution of work across the life course.
- That there should be 'entitlements to learning' with: (a) a legal entitlement of free access to learning to acquire basic skills; (b) a 'good practice' entitlement to learning leave as an occupational benefit; (c) specific 'transition entitlements', e.g. for people on their 50th birthday, to signal the continuing potential for learning of those moving into the third age37

Theme 8: Promoting an age-friendly environment in Greater Manchester

Securing access to green infrastructure (GI) (diverse spaces such as parks, allotments, and gardens) is an essential part of an age-friendly strategy, and links with the neighbourhood issues in Theme 4. Health benefits are linked to physical activity, and for older people the benefits of regular physical activity in green urban areas are emphasised.

Similarly, available evidence suggests that mental well-being is greater in natural environments. The need for, and access to, GI health and well-being benefits are unequally distributed geographically, socially, culturally or demographically. One study of urban green spaces (both private and publically accessible, though not including domestic gardens) in Greater Manchester showed that people in the 25% richest areas enjoy on average 2.7 times as much green space per head as the 25% most deprived areas.

Research suggests that older people may be one of the groups particularly reliant on urban GI benefits, since they are less likely to travel to surrounding areas with higher GI provision38. However, uptake of urban GI benefits by older people may be limited, especially amongst those with limited physical mobility or experiencing cognitive frailties.

Older people are both vulnerable to environmental pressures but are also a potential source of solutions. Environmental threats may themselves disproportionately comprise the health of the older population, notably through the risks attached to climate change and pollution. On the other hand, older people acting to improve their environment (through volunteering) may be a significant force for change.

Research from the US suggests that environmental volunteering may have particular health benefits for older persons in that it tends to involve physical activity and thus can lead to improvements in health. Some areas for development for an age-friendly environmental policy might include:

- Supporting research on the benefits arising from engagement with green and blue infrastructure.
- Providing access to GI benefits to those in institutional settings and with limited mobility.
- Ensuring access to GI benefits to those diagnosed with dementia, depression, and other mental health concerns.
- Supporting a network of older people working as environmental volunteers across GM.
- Undertaking an audit of GM spaces such as parks and allotments in terms of their viability and usage by older people.
- Developing partnerships with organisations such as the 'Green and Healthy Manchester Partnership'40.

Conclusion: Three Future Scenarios for an Age-Friendly Greater Manchester

This report has identified a number of developments likely to influence the future shape and direction of GM as an age friendly region. The review has highlighted:

Diversity in the extent and type of population ageing across GM; variations between and within cohorts – especially those amongst the first and second wave baby boom generations; the importance of addressing changing needs amongst the black and minority ethnic population for developing an age-friendly region; the increase in demand for care in the home and the impact on carers and their organisations; the central role of the neighbourhood in determining the quality of life in old age; the need to encourage innovation in the field of housing and embedding the principal of lifetime homes and neighbourhoods; developing new approaches in the field of employment, notably around training and skill development; and highlighting the contribution of green infrastructure in contributing to the quality of life for older adults.

Other areas are equally important, notably those relating to culture and the arts and their contribution to age-friendly activities – a major area of work across GM41.

Progress in these areas will be essential if the goal of an age-friendly region is to be realised. At the same time, it is also helpful to think about possible futures for age-friendly work, based on different scenarios about what the future might look like. This approach is used by work undertaken in Foresight programmes undertaken by the Government Office for Science and is adopted here in a simplified form. Swain and Steenmans suggest that: 'Scenarios are contrasting visions of the future, typically produced by imagining the distinctive ways in which the future might look different if one or two significant drivers of change varied.

The resultant stories, the scenarios, can then be used to sense check aspirations, and the actions and events that would drive change'. The authors go on to argue that scenarios do not have to be seen as accurate representations of the future; rather different versions of the future to help engage with different and diverse stakeholder groups42.

Figure 2 offers three possible scenarios for GM as an age-friendly region, taking the period 2017-2030.

They are offered here for discussion and further development and potentially replacement by other options. But the idea of thinking about different outcomes for the region is important and might help influence the direction of travel. The scenarios are:

Incremental change
⬇
Age friendly environments

Key features: steady growth of age-friendly model: some expansion in resources to localities, but likely to be restricted through continued pressure on funding for health and social care; limited innovation in housing programme; some expansion in support to black and minority ethnic groups; growth in support for carers but lagging behind; increase in those caring for people with dementia or older parents caring for adults with learning disabilities.

Decline
⬇
Unequal communities

Key features: decline in age-friendly communities: GM evolving as a divided region driven by the impact of gentrification; age segregation within and between communities; failure to resolve high unemployment and the impact on local communities; continuing cuts to health and social care provision undermining neighbourhood activities; carers experiencing limited support but accelerated demands arising from increase in numbers of people diagnosed with dementia, depression, and physical disabilities; failure to support ageing of black and minority ethnic community; age segregation driven by housing developments

which favour families and first-time-buyers; continued problems of social isolation driven by growth of men and women living alone in disconnected and fragmented communities.

Transformative

↓

Active caring and learning communities

Key features: Age-friendly model developed and transformed in a variety of ways: services focused on where older people are living; care networks embedded in neighbourhoods across GM, led by older people working with health, housing, and social care agencies; housing innovations in the form of co-housing, shared housing, and the growth of new forms of retirement housing(e.g. for people diagnosed with dementia); reduction in social isolation experienced by older people; growth of naturally occurring retirement communities and 'village' type communities; devolution of care management resources; increase in co-operatives led by and employing older people; development of specialist support (where appropriate) for black and minority ethnic groups; development of community centres facilitating the transition from hospital to home; mainstreaming of community-based services utilising facilities such as leisure centres and art galleries; and expansion of dementia-friendly communities.

The above scenarios are offered as three different ways of thinking about the direction of travel over the period to 2030. All three are possible; equally we might think of other ways in which an age-friendly region might or might not develop.

However, the key issue is that we need to think about: the probable direction which AFC might take; the possible; and the one regarded as preferable. Without this type of thinking, an age-friendly GM region could still develop; equally, it might be one considerably removed from the aspirations and ambitions that might reasonably be set.

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ANNEX 1

Table 1A – 2014-based Subnational population projections for local authorities

Local authority name	Age group	Population projections					
		2014	2021	2031			
		Population (in thousands)	%	Population (in thousands)	%	Population (in thousands)	%
Manchester	50+	114.6	22	128.8	23	147.0	25
	65+	49.4	9	53.4	10	67.7	11
	75+	22.8	4	23.3	4	29.8	5
Bolton	50+	96.7	34	107.1	37	114.4	38
	65+	46.8	17	52.0	18	63.0	21
	75+	20.0	7	23.7	8	31.2	10
Bury	50+	67.8	36	75.2	39	80.6	40
	65+	32.8	17	36.6	19	44.8	22
	75+	14.2	8	17.0	9	22.4	11
Oldham	50+	75.5	33	83.5	35	89.8	37
	65+	47.8	21	53.0	22	63.1	26
	75+	15.7	7	18.3	8	24.1	10
Rochdale	50+	72.8	34	79.7	37	85.0	38
	65+	33.8	16	38.0	18	46.3	21
	75+	14.9	7	17.0	8	22.9	10

Table 1B – 2014-based Subnational population projections for local authorities

Local authority name	Age group	Population projections					
		2014	2021	2031			
		Population (in thousands)	%	Population (in thousands)	%	Population (in thousands)	%
Salford	50+	74.6	31	82.6	32	91.9	33
	65+	35.3	15	37.9	15	46.8	17
	75+	16.1	7	17.4	7	21.9	8
Stockport	50+	111.3	39	122.2	41	131.0	42
	65+	55.7	19	61.8	21	74.6	24
	75+	26.2	9	30.1	10	38.6	12
Tameside	50+	79.7	36	88.9	39	95.0	41
	65+	37.8	17	42.1	19	52.4	22
	75+	16.1	7	19.1	8	25.3	11
Trafford	50+	81.9	35	91.4	37	102.0	39
	65+	39.2	17	43.4	18	54.2	21
	75+	19.0	8	21.0	9	27.0	10
Wigan	50+	119.0	37	134.9	41	144.4	42
	65+	58.1	18	65.1	20	79.9	24
	75+	23.3	7	29.5	9	38.9	11

Source: Office for National Statistics (2016)

Table 2 – Greater Manchester local authorities (growth in population 75+)

Local authority name	Population: 75+ ('000s)			
	Change 2011-2036			
	2011	2036	Nos ('000s)	%
Manchester	29.8	51	21.2	71.3
Bolton	24.2	44.7	20.5	84.9
Bury	16.1	28.7	12.6	78.1
Oldham	13	20.1	7.2	55.4
Rochdale	19.6	36.8	17.2	87.7
Salford	19.3	34.3	15	78.1
Stockport	28.4	44.1	15.7	55.2
Tameside	16.9	29.4	12.5	74.3
Trafford	23.5	38.3	14.8	63.1
Wigan	30.5	59	28.5	93.4

Source: Buckner et al. (2011)

Table 3 – Households projections by type by local authority: 2011-2036

Local authority name	People aged 75+ who live alone ('000s)			
	Change 2011-2036			
	2011	2036	Nos ('000s)	%
Manchester	12.4	19.7	7.3	59
Bolton	10.6	18.1	7.5	71
Bury	6.6	11.2	4.5	69
Oldham	5.7	8.5	2.7	48
Rochdale	8.5	15.3	6.8	80
Salford	8.4	14.3	5.9	70
Stockport	13.1	19.7	6.6	51
Tameside	7.5	12.4	4.9	66
Trafford	10.1	15.5	5.4	53
Wigan	14.2	26.7	12.6	89

Source: Buckner et al. (2011)

Table 4 – Households projections by type by local authority (men and BAME): 2011-2036

Local authority name	People aged 75+ who live alone: % men	People aged 75+ who live alone: %BAME		
	2011	2036	2011	2036
Manchester	31	38	5.3	6.9
Bolton	29	36	1.7	2.8
Bury	33	38	0.9	1.5
Oldham	25	31	2.0	3.1
Rochdale	24	28	1.6	2.9
Salford	35	41	0.7	1.2
Stockport	26	27	0.7	1.3
Tameside	28	34	0.8	1.4
Trafford	29	36	2.0	3.1
Wigan	27	29	0.2	0.4

Source: Buckner et al. (2011)

Table 5 – Changes in the number of people predicted to be unable to manage at least one domestic task in the Greater Manchester local authorities: 2011-2036

Local authority name	Domestic tasks 65+ ('000s)			
	Change 2011-2036			
	2011	2036	Nos ('000s)	%
Manchester	24.7	41.5	16.8	68
Bolton	20.5	35.3	14.7	72
Bury	13.7	22.6	8.9	65
Oldham	12.4	17.6	5.2	42
Rochdale	16.6	29.8	13.2	80
Salford	16.1	27.3	11.2	70
Stockport	23.7	35.6	11.9	50
Tameside	14.8	24.1	9.3	63
Trafford	18.8	29.5	10.7	57
Wigan	26.3	47.5	21.1	80

Source: Buckner et al. (2011)

Table 6 – Changes in the number of people predicted to be unable to manage at least one self-care activity in the Greater Manchester local authorities: 2011-2036

Local authority name	Self-care activity - 65+ ('000s)			
	Change 2011-2036			
	2011	2036	Nos ('000s)	%
Manchester	20.4	34	13.6	67
Bolton	16.9	28.9	12.0	71
Bury	11.2	18.4	7.2	64
Oldham	10.1	14.3	4.2	42
Rochdale	13.6	24.5	10.9	80
Salford	13.1	22	9.0	68
Stockport	19.4	29.2	9.8	50
Tameside	12.1	19.6	7.5	62
Trafford	15.5	24.2	8.7	56
Wigan	21.7	39.3	17.6	81

Source: Buckner et al. (2011)

Table 7 – Black and Minority Ethnic population projections by local authority

Local authority name	Population: BAME 75+ ('000s)			
	Change 2011-2036			
	2011	2036	Nos ('000s)	%
Manchester	2.265	5.023	2.758	122
Bolton	882	2.770	1.887	214
Bury	244	718	473	194
Oldham	450	1.018	568	126
Rochdale	597	1.871	1.274	214
Salford	214	624	410	192
Stockport	354	930	576	163
Tameside	290	751	460	159
Trafford	689	1.705	1.017	148
Wigan	115	359	244	212

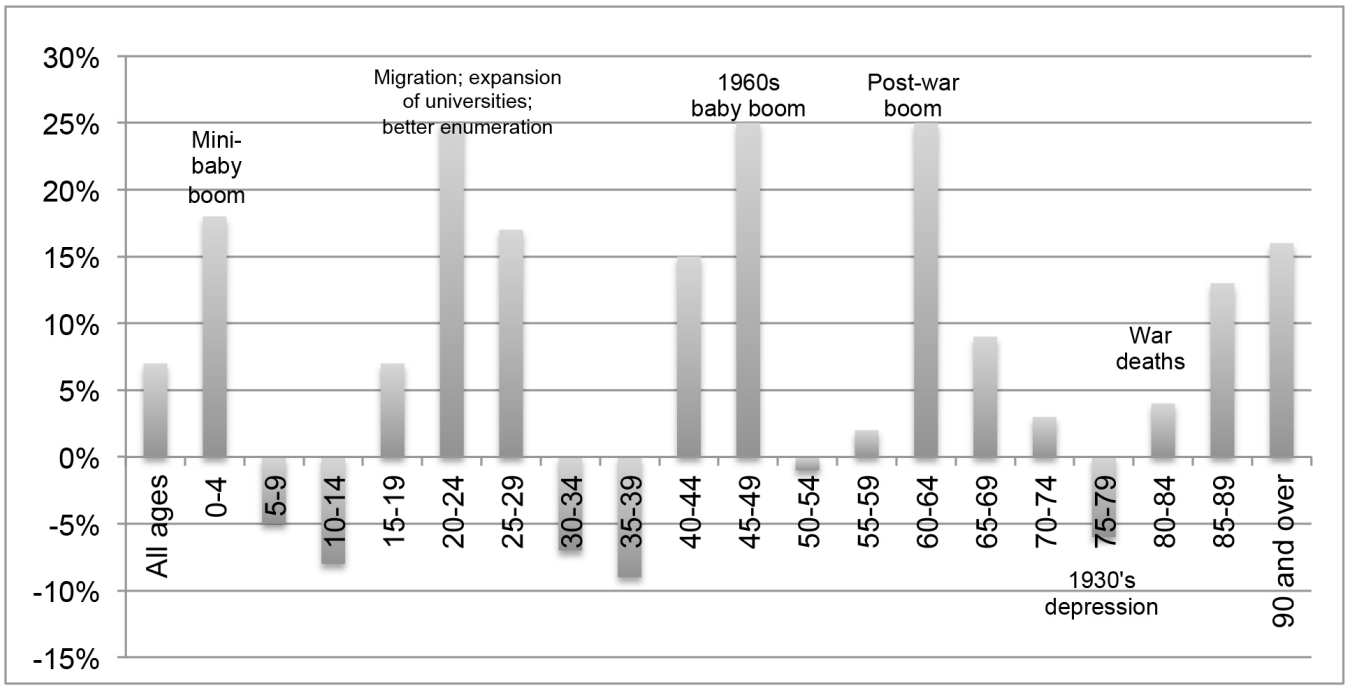
Source: Buckner et al. (2011)

Table 8 – Last year worked by those aged 50-64

Local authority name	In employment (%)	Last worked 2006-2011 (%)	Last worked 2000-2005 (%)	Last worked 1991-1999 (%)	Last work before 1991/never worked (%)
England	67	15	7	5	7
Greater Manchester	63	15	7	6	8
Manchester	56	15	6	6	17
Bolton	63	15	9	6	8
Bury	65	18	5	5	6
Oldham	63	17	6	6	9
Rochdale	61	17	7	6	10
Salford	59	15	9	8	10
Stockport	69	16	7	5	5
Tameside	64	14	7	7	8
Trafford	69	15	7	4	6
Wigan	63	17	7	7	7

Source: Office for National Statistics (2011)

Figure 1 – Percentage change in GM population by age band: mid-2001 to Census 2011



Source: Office for National Statistics (2012)

Figure 2 – Future scenarios for age-friendly communities