Improving lives **together**
Norfolk and Waveney Integrated Care System

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Ageing Well Strategic Framework

The ambition

The Norfolk and Waveney Integrated Care System's (ICS) mission is to help the people of Norfolk and Waveney to live longer, healthier, and happier lives. The ICS has published a clinical strategy setting out what we want clinical services across Norfolk and Waveney to deliver over the next 5 years. The ICS has also published a more detailed Joint Forward Plan which includes eight ambitions. One of these is the ambition to transform care in later life.

It is imperative that we support our increasingly ageing population and enable them to experience the best possible quality of life, and to maintain their independence for as long as practicable.

To do this, we have developed a shared mission, vision and strategic framework informed by the evidence base, our local data, and the views of older people who live in Norfolk and Waveney and those who work or volunteer across health and care in our system. We will use this to transform our services and make them fit for our ageing population, to deliver services which are:

- more focussed on the prevention of ill health and promote wellbeing in later life;
- less reactive and more proactive in managing conditions associated with older age,
- and focus on the needs of the whole person including the needs of their families and carers and not on singular conditions or problems.

The context

Norfolk and Waveney have an older population compared to the rest of England. About 1 in 4 of the population is aged 65 and over and about 1 in 30 is aged 85 and over.

Across Norfolk and Waveney life expectancy is slightly longer than the average across England and is currently 80 years for males and 84 years for females. However, there are significant variations in life expectancy between the most deprived and least deprived areas of Norfolk and Waveney which is over 8 years for males and over 6 years for females. Furthermore, the healthy life expectancy across Norfolk is lower than the average for England at about 62.7 years for males and about 62.4 years for females and this figure has decreased over the last few years. This means that the period that older people spend in ill health in Norfolk is getting longer. There are inequalities across Norfolk that mean there is unjust variation across both life expectancy and healthy life expectancy, which is affected by the social and economic environments that people live and work in, for example healthy life expectancy in males varies from 70.5 in the least deprived areas of Norfolk to 52.3 years in the most deprived. A similar pattern follows for females. (Public Health Profiles - OHID).

Older people are already more likely to be living with multiple health conditions. Common conditions that are more prevalent in older age include dementia, heart disease, hypertension (high blood pressure), respiratory disease, mental health conditions such as depression, cerebrovascular disease, joint problems, diabetes, and sensory impairment. These conditions can also interact, meaning that an older person who could have maintained independence and quality of life with any one of these diseases, might struggle to do so with the combination of conditions. That means older people might be expected to attend multiple specialist clinics, be under the care of multiple professionals, and be prescribed multiple medications (polypharmacy).

We must coordinate this care better, and make sure that the person and their family or carers are at the centre of all that we do.

As well as improving the care and support for older people already living with these conditions, we also need to try to prevent or delay them for as long as possible. Long term, that will enable older people to live more of their later life without disability and improve healthy life expectancy.

Becoming an Integrated Care System in 2022 means that the NHS across Norfolk and Waveney is working much more as a partnership with local government, local authorities, voluntary, community and social enterprise (VCSE) organisations. So, we now have the opportunity to work together, to improve the planning, integration, and delivery of services for older people and those who care for them.

Our intention is to review current services across out ICS to identify any gaps and duplication whilst also trying to reduce inconsistencies across Norfolk and Waveney. We will aim to make the best use of our existing services, and look to improve and redesign these services, where required in consultation with older people and those who represent them.

It is imperative that we support our older population to maintain the best possible quality of life and reduce the years of living with disability and ill health to enable older people to retain their independence for as long as is feasible. This work will be led through public health, working closely with wider ICS health and care colleagues, to support people in our community, to prevent or delay ill health for our older population where possible.

We are determined to improve and simplify access to treatment, support and care. It is paramount that the right services are in place to support older people to receive care closer to home, and where possible to prevent the need for a hospital admission. For example, through the virtual ward or hospital at home where people are cared for in their usual residence, with the support of remote monitoring and health interventions from skilled health and care professionals.

When older people do have needs that require a hospital admission, we want to improve their experience of hospital care, and minimise their length of stay to reduce the risk of harm. Older people particularly those are living with frailty, dementia, or cognitive impairment, are at high risk of hospital acquired harms such as infection, deconditioning, delirium and loss of independence. Furthermore, the longer they remain in a bedded environment, the more likely they are to eventually be discharged to residential care rather than return home. We will promote the need for early supported discharge, and the provision of good quality, compassionate, palliative and end of life care where appropriate.

The Norfolk and Waveney ICS's strategic framework and approach will take a holistic approach to ageing well. This will enable us to review and adapt our service delivery to ensure it is designed around, and with, our residents, to support them to age well. We know that NHS health care is a relatively small part of what influences health outcomes for people and we will engage and support our partners to help improve the wider determinants of health.

Approach to strategy development

A blended approach has been adopted in the development of this strategic framework. The ICB hosted an Ageing Well Workshop May 2023 where 85 participants from ICS partner organisations, voluntary organisations, charities and members of the public including older people and their carers attended. This was used to develop the overall aspiration, shared vision and strategy for older people. Seven key areas of focus were identified through this work.

A desk top review of best practice was then undertaken to sense check the outcomes of the workshop – particularly considering the British Geriatric Society (BGS) Joining the Dots report March 23 and subsequently the Chief Medical Officer's Annual Report: Health in an Ageing Society, November 2023.

A steering group reviewed the outcomes of both the workshop and desk top review. The key findings were fed back to multiple stakeholders in one to one interviews to sense check this.

The steering group then combined the outcomes of that sense check to draft the strategic framework. This led to the refinement of the seven initial areas to give a new list of nine strategic goals.

The draft strategic framework and proposed initial priorities were then shared, and ratified, at a follow up workshop December 2023.

The steering group has also tasked the place boards and key providers and stakeholders identified from the initial workshop to begin collating the services already available across the ICS and to start mapping them against the strategic framework to help identify initial work programmes.

Initial Workshop findings

From this workshop and desk top review 7 key areas of focus were initially identified which correlated with the touchpoints highlighted by the British Geriatric Society.

1. **Enabling independence and promoting wellbeing of older people and their carers.**
2. **Population-based, proactive, anticipatory care to prevent ill health in older people.**
3. **Facilitating an integrated urgent community response, re-ablement, rehabilitation and intermediate care for when older people do need urgent support.**
4. **Frailty attuned acute hospital care so that when older people require admission, it is person centred and holistic.**
5. **Reimagining outpatient and ambulatory care so that when older people have long term conditions, they are managed in a coordinated way not in isolation.**
6. **Enhancing health care support for long term care at home and in care homes, so that people living in care homes get the best possible care where they live, and so we reduce the need for emergency admissions from care homes.**
7. **Providing coordinated, compassionate palliative and end of life care.**

There was a clear recommendation that services should be easier to access, and that older people and their carers should be more involved in the planning and delivery of their care. Workshop attendees also felt strongly that there needs to be a shift to empowering older people to make decisions about their care and to be better supported to prevent ill health and frailty wherever possible. Attendees want us to provide services that are designed to deliver:

- **What matters most to the older person themself**
- **To support older people to live happy, healthier lives**
- **To enable older people to live as independently as possible for as long as possible and to "age well".**

As a result, it was recommended that we should consider three stages of ageing when we design and coordinate our services and actions:

a) Preparing for Later Life Phase: focus on preventative activities that promote and extend healthy active life.

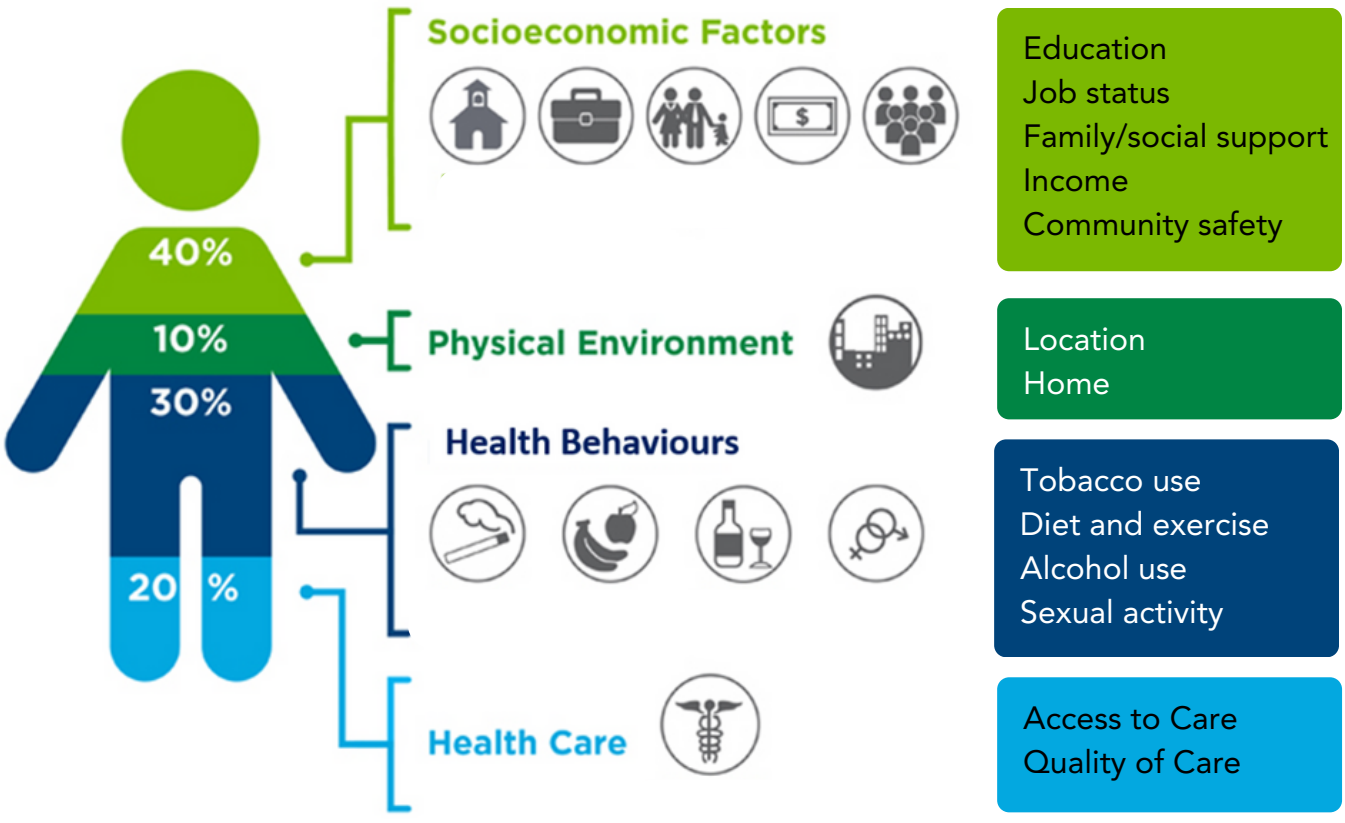
b) Active ageing phase: Time between healthy active life and frailty. Focus upon maximising independence and coordinating care to reduce the impact of long-term conditions on daily life, postponing frailty and other vulnerabilities, preparing and adapting one's environment and personal networks, and compressing the period of time spent in dependency and or frailty, before end of life.

c) Frail and more vulnerable older people phase. Frailty is used to describe a state of health experienced by some people, most often older adults. It describes how some individuals lose their in-built reserves and become increasingly vulnerable to sudden changes in their health, which may be triggered by events such as an infection or change in medication or environment.

Best practice findings and recommendations

The wider determinants of health in later life are influenced by a broad range of factors, and so it is recommended that these are taken into account when planning future service provision, rather than focussing upon those aspects traditionally encompassed within health care services in isolation. In essence, moving from a medical model to biopsychosocial model of care.

The factors that influence a person's health outcomes are shown in the image below.



The British Geriatric Society "Joining the Dots" (2023) report provides 12 recommendations that we will use to underpin our strategic framework.

British Geriatric Society - Joining the Dots - 12 recommendations

Recommendation 1
Demonstrate a strong system leadership that creates a shared vision for healthy ageing and preventing and managing frailty.

Recommendation 2
Appoint a senior officer or non-executive Board member with a specific role to seek ongoing assurance on the quality of health and social care for older people and their carers.

Recommendation 3
Publish baseline, then annual, State of Ageing reports on system-wide outcome indicators related to care for older people including feedback from patients and carers to reflect their experience.

Recommendation 4
Develop a system-wide strategy and costed implementation plan for a population health approach to the prevention and management of frailty, including a specific focus on dementia and falls.

Recommendation 5
Commission or deliver inter-professional education aligned with the Skills for Health Frailty Core Capabilities Framework and which build capacity for Comprehensive Geriatric Assessment, quality improvement and integrated practice in all disciplines across the system.

Recommendation 6
Develop an integrated Workforce Plan to build adequate specialist and generalist multidisciplinary capacity and skill mix to care for older people with complex needs.

Recommendation 7
Protect and preserve the right to rehabilitation for all older people who need it, in line with the principles outlined by the Community Rehabilitation Alliance.

Recommendation 8
Publish an older people equality and diversity impact assessment and action plan.

Recommendation 9
Engage and involve older people, carers and communities as equal partners with health and social care professionals in co-design, delivery and monitoring the impact of these services and support

Recommendation 10
Provide support to enable the lived experience of older people and carers, including those with dementia and mobility, sensory or communications needs, to inform quality improvement and assurance.

Recommendation 11
Work with public health, housing, community and voluntary sector partners to build social capital, mobilise community assets and adopt place-based approaches to create inclusive, compassionate age- and dementia- friendly communities.

Recommendation 12
Make use of existing guidelines and resources and the expertise held within the BGS community.

Further to the BGS Joining the Dots publication, the Chief Medical Officer has also published his annual report which focuses upon Health in an Ageing Society (2023). The recommendations from this report provides the high-level context and direction for our Ageing well strategic framework. This report provides 6 cross-cutting strategic recommendations. The ICS Ageing Well programme board will cross reference, and map, which existing and new ICS strategies (or areas of work) will have responsibility for inputting and/or implementing these. However, the Ageing Well board will maintain an overall overview.

Chief Medical Officer's Annual Report: Health in an Ageing Society, November 2023

Recommendations

A) Older age is becoming increasingly geographically concentrated in England, and services to prevent disease, treat disease and provide infrastructure need to plan on that basis. **Resources should be directed towards areas of greatest need**, which include peripheral, rural and coastal regions of the country. The NHS, social care, central and local government must start planning more systematically on the basis of where the population will age in the future, rather than where demand was 10 years ago.

B) **Primary Prevention**. Making it easy and attractive for people to exercise throughout their lives is one of the most effective ways of maintaining independence into older age. Reducing smoking, air pollution and exposure to environments that promote obesity are other examples where the State has a major role to play in delaying or preventing ill health and disability over a lifetime and into older age.

C) **Delaying disease** to the greatest possible extent, to delay the period of disability in older age, should be the aim of public health and medicine. Science is continuously developing new tools to help do this, but we are often extremely poor at maximising the use of the tools we have. The longer people live with risk factors such as hypertension or high cholesterol the earlier the start of their disabilities will be. Secondary prevention is predominantly the responsibility of the NHS but is currently under-prioritised. Screening programmes help to delay or stop the onset of serious disease and therefore prevent ill health in later life. It is essential that we prioritise secondary prevention and screening services, and to do more to extend these services to groups with reduced access and historically low uptake.

D) The medical profession needs to respond to the inexorable rise of multimorbidity. The single most important way to achieve this is to recommit to maintaining **generalist skills as doctors specialise**. NHS organisations also need to minimise the probability that the same person has to attend multiple clinics for a predictable cluster of diseases.

E) The health and care needs of older adults are often not recognised because the relevant data are not systematically collected or aggregated in one place. For example, epidemiological data on health conditions contributing to disability such as hearing loss and mental health is not routinely available for older adults. To plan appropriately, organisations including the NHS, Office for National Statistics (ONS), and central and local government need **systematically to collect and share data on the health and care needs of older adults**, including by ethnicity, sex and other protected characteristics.

F) **Research** 1) It should be unacceptable to have exclusion criteria based on older age or common comorbidities. 2) Research into multimorbidity, frailty and mental health needs to be accelerated. 3) Social care research needs to be a core component of health research programmes. The lack of inclusion of social care in health research is a significant gap.

Norfolk and Waveney's Strategic Framework

Our framework consists of the following:

- A mission statement which describes the purpose of the ageing well programme,
- A vision statement demonstrates what it will look like when we have delivered against this mission,
- And a strategic framework of 9 goals to cover all of the work that we need to deliver against the 3 different phases of ageing.

Mission: To have health, carer and support services, that are fit for our ageing population - supporting people as they age, to lead longer, happier healthier lives.

Vision: Norfolk and Waveney will be a place where people in later life and their carers:

- **are helped to age well, living happier, healthier lives, living as independently as possible, for as long as possible;**
- **feel heard and respected, and know they will be treated as individuals;**
- **experience services that ask, 'what matters most to you' and proactively act upon their answer.**

How will we do this?

This will require partnership working between NHS organisations, local government, voluntary, community, faith and social enterprise organisations, independent (private) providers and the public. The ICS will facilitate the development of new models of care using this framework, that can be delivered to meet N&W population needs, improve health, care, wellbeing and reduce inequalities.

To deliver better, more personalised and integrated services to our ageing population we propose the following strategic framework. This will form the backbone of all of our operational plans at System, Place and provider level.

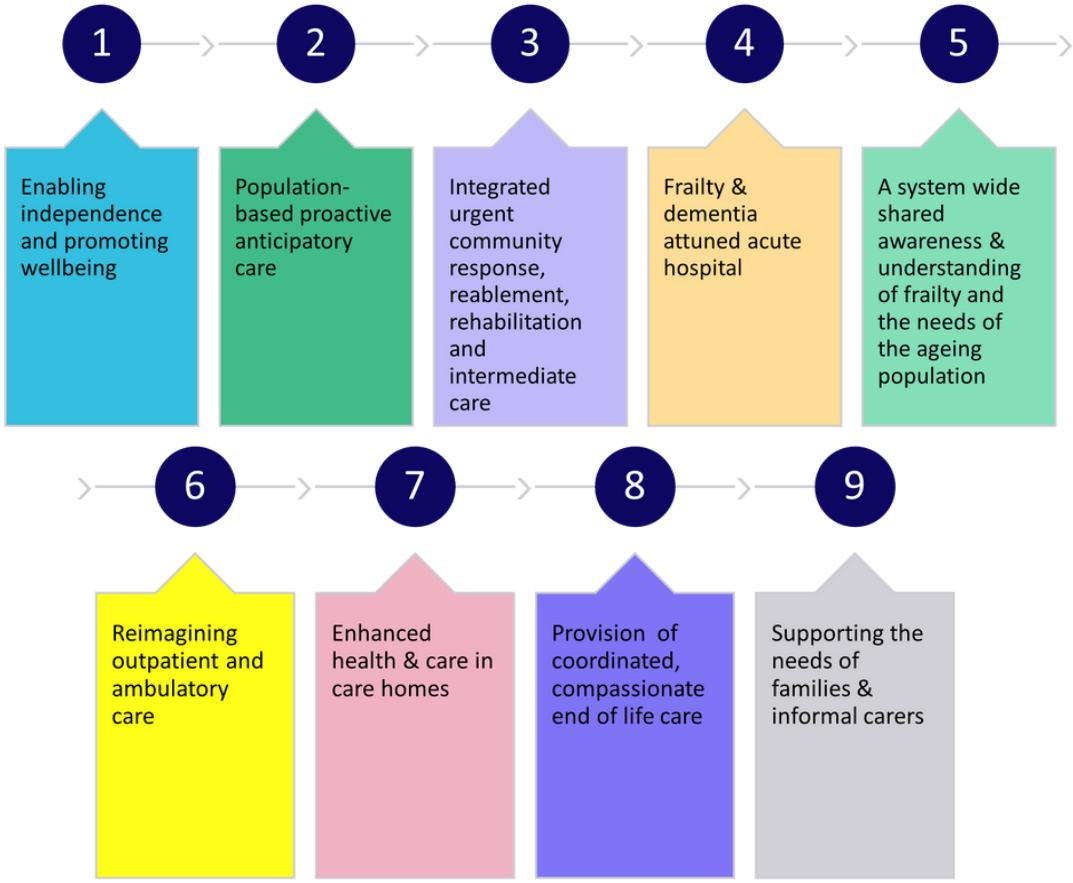
Following feedback and the wider desktop review and national publications, the initial 7 strategic goals have been revised and expanded into 9. This framework should inform ICS partners', thinking, planning, commissioning and delivery of services for people as they age.

All of services for older people need to be aligned to one (or more) of these 9 areas. The ICS will work with all the system partners to map the services they provide against this strategic framework to identify gaps, reduce duplication and inform future decision-making. Where a service is not in line with the framework, we will work with the provider, to transform that service.

Where gaps are identified, and we do not currently have services to address an area of the framework, we will aim to address those together, to improve and better integrate health and care for people in Norfolk and Waveney as they age. This means that in time, all 9 strategic goals will be addressed across all of our localities and they will be seen as interdependent with other appropriate ICB/S plans and strategies.

The Ageing Well Programme

Nine strategic goals underpin the Strategic Framework



This framework should inform ICS partner's thinking, planning, commissioning and delivery of services for people as they age. Older people, their carers' and loved one's views are properly represented in decision making, design and evaluation of services.

When reviewing and designing our services we will use the 3 phases of ageing to designate which phase of ageing the service is aiming to address:

1. Preparing for Later Life phase
2. Active Ageing Phase
3. Frail and more vulnerable older people phase

Ageing Well Programme: Strategic Matrix

	9 Goals **Areas of focus for improving quality of life outcomes and the care and support for older people**	**Preparing for later life phase**	**Active Ageing Phase**	**Frailer and more vulnerable older people phase**
1*	Enabling Independence and promoting wellbeing			
2*	Population-based proactive anticipatory care			
3*	Integrated urgent community response, reablement, rehabilitation and intermediate care			
4*	Frailty and dementia attuned acute hospital care			
5	A systemwide shared awareness and understanding of frailty and needs of the ageing population.			
6*	Reimagined outpatient and ambulatory care			
7*	Enhanced health in care homes			
8*	Provision of co-ordinated, compassionate palliative and end of life care.			
9	Supporting the needs of families and informal carers			

Contextualising the Matrix

The N&W Integrated Care System's ambition for ageing well, is to work with all system partners to improve and better integrate health and care for older people in Norfolk and Waveney.

The focus of the strategic framework for people in older age is about improving quality of life rather than longevity. As a system we have agreed there will be a clear focus upon upstream interventions and education to prevent or delay the period of time that people are unable to live independent, happier, healthier lives.

Commissioning services for older people starts with understanding the assets in local communities and the needs of the local population. The matrix is a means of beginning to consider the different levels of complexity helps to target interventions and resources to where they will have most impact (BGS 2023). It is recognised that some of these areas of the 9 goals of the matrix overlap but it is hoped that the manner in which they have been created will allow organisations to identify where they are currently working, where they will be able to support future service development and improvement and any omissions or duplications in current provision.

1 Enabling Independence and promoting wellbeing

Key aim is prevention and health promotion to reduce risks of developing ill health and improving opportunities for healthy ageing. Implementing a combination of age friendly environments and targeted approaches which support and enable people to stay healthy, happy, and independent for as long as possible, Reducing the risk of developing physical and mental health conditions, and encompassing emotional and spiritual wellbeing recognising the wider determinants of health for older people and those living with frailty when promoting healthy lifestyle advice and behaviours including increasing physical activity, improving nutrition, weight management, smoking cessation, alcohol intake reduction, reducing social isolation and improving brain health.
If we delay the point at which people get life-limiting conditions for as long as possible, disease may occur only shortly before their eventual death, or not at all, improving quality of life and reduced years of living with disability.
Enabling independence and promoting wellbeing also includes efforts to improve and/or mitigate the wider determinants of health including good work, housing and adaptations, the built environment such as public spaces, transport and mobility in a whole system approach.
Case example: North Norfolk Health and Wellbeing Partnership has signed up to become an Age Friendly Community.

2 Population-based proactive anticipatory care

Proactive anticipatory care targets people at risk of poor health and social outcomes such as those living with multiple health conditions and frailty, to offer tailored support to stay well and reduce likelihood of developing further progression of frailty resulting in poorer health and wellbeing. Individuals at risk of poor outcomes are identified using validated population level screening tools combined with professional judgement. Those who are identified as presenting with significant or escalating risk of deterioration or poor outcomes are offered a proactive comprehensive assessment of their health and social care needs. In partnership with MDT professionals, older people their families and carers develop a personalised care plan which considers their individual wishes and preferences and goals of care.

3 Integrated urgent community response, reablement, rehabilitation and intermediate care for older people

Integrated urgent community response, reablement, rehabilitation and intermediate care should be delivered by implementing a holistic and coordinated approach with the aim to prevent unnecessary hospital admissions, facilitate timely discharge from hospital and reduce the need for long term care and support by promoting independence and care closer to home. This model recognises the importance of multi-disciplinary team working in delivering short term hospital level care at home or resources that optimise recovery.

- **Urgent community response.** This involves rapid response to people in acute or crisis situations such as acute illness or injury. It may include ambulatory care, assessment and stabilisation of the presenting health and care needs.
- **Reablement.** Reablement focuses on supporting individuals to regain the independence and functional abilities after a period of illness or injury and should not just be confined to physical ill health.
- **Rehabilitation.** Focuses on specialised care and therapy for people with long term conditions or disabilities. It aims to maximise their potential and quality of life through targeted intervention to specific needs.
- **Intermediate care.** Intermediate care provides a bridge between hospital and home to prevent admission or enable discharge by providing care closer to home which can be home based or bed based.

4 Frailty and dementia attuned acute hospital care

Older people living with frailty and /or dementia are especially vulnerable to harms in acute hospital settings such as falls, infections, deconditioning and delirium. There is a need to ensure that people living with frailty and /or dementia are identified, and their holistic needs are assessed in a timely manner across the whole hospital. Many older people living with frailty/ and or dementia who have an emergency admission could return home on the same day if appropriate resources are available to assess, diagnose and treat their acute needs in a timely manner at the front door which reduces the risk of further morbidity and mortality.

5 A systemwide shared awareness and understanding of frailty and needs of the ageing population

There is a need for a systemwide shared understanding and awareness of frailty and the needs of an increasingly ageing population. There is also a need for raising awareness, across society inclusive of those affected, their families and carers which incorporates risk reduction strategies. Moreover, we need a skilled workforce and development opportunities that increase the number of professionals with the appropriate skills, knowledge, and training to meet the needs of those affected across health, social care, voluntary and public sector organisations who are able to understand the multifactorial determinants that can impact on those living with frailty in line with a comprehensive geriatric assessment for example. Consideration should be given to mapping of where skill and resources are currently available and alignment of the workforce whilst considering capacity and resource to meet current and future demand.

6 Reimagined outpatient and ambulatory care

Older people often have multiple conditions and may also be living with frailty which are considered in isolation and are often faced with repeating their story to multiple professionals. These conditions and the treatments offered can interact, there are opportunities to improve outcomes by offering resources that coordinate care by adopting a more person centred as opposed to condition specific approach. This could include one stop outpatient/frailty/ dementia clinics or ambulatory hubs, clinics to avoid multiple appointments and more holistic person-centred care. These approaches may consider the less medical, wider determinants of care and consider a quality of life to be as important as years of life.

7 Enhanced health in care homes

People living in care homes should expect the same level of support as if they were living in their own home. This can only be achieved through a whole system, collaborative approach, between health, social care, VCSE sector and care home partners. It is recognised that there are varying approaches to implementation. There is a need to ensure that there is appropriate provision available to reflect the care elements set out which are Enhanced primary care support, MDT support including coordinated health and social care, falls preventions , reablement and rehabilitation including strength and balance, high quality palliative and end of life care, mental health and dementia care, joined up commissioning and collaboration, workforce development, data, IT and technology. Further details on sub elements to support matrix development can be found at The Framework for Enhanced Health in Care Homes , NHS England)

Case Example

The Enhanced Health in Care Homes (EHCH) model moves away from traditional reactive models of care delivery towards proactive care that is centred on the needs of individual residents, their families and care home staff.

8 Provision of co-ordinated, compassionate palliative and end of life care

People can die at any age, and palliative and end of life care should be available to support our whole population. However, end of life care for older adults living with multiple health problems and frailty is different from dying with a single disease. The range of trajectories of decline includes sudden death, slow progressive deterioration such as is the case with dementia and frailty, catastrophic events (such as stroke or hip fracture), and periods of prolonged uncertainty associated with fluctuating episodes of acute illness, delirium, or functional decompensation (BGS 2023). The two leading causes of death in England and Wales in 2022 (ONS 2022) were Alzheimer's disease and dementia and Ischaemic heart disease. In 2017 45.6% of deaths occurring in people aged over 75 years old occurred in hospital, 19.7% at home and 39.8% in a care home. Consequently, it is important to understand the level of resource that is available and accessible to older people and reduce inequalities in place of death and access to palliative and end of life care and advance care planning.

9 Supporting the needs of families and informal carers

Family members and other informal carers supporting older people make a substantial contribution to the health and social care economy, but more older people are also becoming carer. It has been suggested that there are over 2m carers aged 65 and over, 417,000 of whom are aged 80 and over across England and Wales. A substantial proportion of older workers already balance work with caring responsibilities, particularly women: almost one in four female workers care, compared with just over one in eight male workers. Family and informal carers can experience detrimental effects to their health, wellbeing and financial stability so need support in their own right and are entitled to a carers assessment, so it is vital that there are mechanisms that support identification of carers. As well as being seen as valuable contributors to care they should also be supported to remain in work or education should that be their preference. There should be local services available that offer accessible information, practical and emotional support, and advice. Services such as befriending, peer support, respite, educational and coping support can build carer resilience.

Case Example: Norfolk and Waveney ICS developed a Carer Passport in 2022 to recognise the value and listen to the voice of unpaid carers, and those members of our community who “look after someone”. To date over 2000 passports have been issued.

Useful resources

- BGS Joining the Dots - A blueprint for preventing and managing frailty in older people.pdf
- Chief Medical Officer's Annual Report 2023 – Health in an Ageing Society (publishing.service.gov.uk)
- Death registration summary statistics, England and Wales - Office for National Statistics
- Death in people aged 75 years and older in England in 2017 - GOV.UK (www.gov.uk)
- https://www.england.nhs.uk/long-read/providing-proactive-care-for-people-living-in-care-homes-enhanced-health-in-care-homes-framework/ Version 3, November 2023
- Public health profiles - OHID (phe.org.uk)

Appendices

Appendix 1
Service Design Self-Assessment Check list (Principles)

Ask what matters,
listen to what matters,
do what matters!

- Focus upon prevention and upstream interventions across end-to-end pathways (avoiding duplication and waste)
- Aligned and informed by the health inequalities and population, health management
- Older people, their carers' and loved one's views are properly represented in decision making, design and evaluation of services
- We will consider the whole person, their carer's and their environment (Healthcare & wider determinants)
- No health without mental health
- Supporting the needs of carers and care homes

Glossary

Older people	Refers to people aged 50 and above
Healthy Life Expectancy	A measure of the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health
Frailty	Refers to a person's mental and physical resilience, or their ability to bounce back and recovery from illness and injury. It is used to describe a particular state of health often experienced by older people but can apply to people of any age
Age-friendly Community	This is a place that enables people to age well and live a good later life. Somewhere that people can stay living in their homes, participate in the activities they value, and contribute to their communities, for as long as possible. There are eight domains for action including outdoor spaces and buildings, social participation, and civic participation and employment