Annex 1
DRAFT REVIEW OF DEMAND
Preamble

Over the next twenty years Britain faces major changes in the balance of its population. Already those aged over 60 outnumber those aged under 16 and by 2040 there will be 5 million more people aged over 65 than there was when the century began. These changes will mean that public services need to adapt to a different population profile and plan ahead if people are to have available the kinds of services and support that they will need and expect.

However, demographic change alone does not enable an accurate prediction of future requirements for services. As the DEMOS report, The New Old[1] states "being literate in the language of demographic change does not by itself improve our clairvoyance about the kind of society that it will help to shape". There are of course many factors that may have a profound influence on the older persons population, for example:

- Changes in wealth with a higher proportion of older people having occupational pensions and equity via their past purchases of property.
- Changes in the ethnicity of the population meaning different types of service may be requested.
- Improved health through drug treatments and new surgical interventions.
- Poorer health due to obesity and stress.
- Changes in the role of local authorities from direct providers to facilitators of provision.

Therefore, whilst the impact that demographic change may have is not entirely predictable it is equally unfeasible for local authorities to simply be reactive to demand when it occurs. Such an approach would only be likely to mean short term, high cost, decision making, a flight of capital from public into private provision and a shortfall of services when most needed as local authorities try to meet rising demand.

This document is a first attempt to address thinking with regard to future provision. It aims to explore the potential needs of the population, demand for and supply of

[1] The New Old: Why baby boomers wont be pensioned off, Huber and Skidomore 2003

services, analyse gaps in provision and look at how those may be addressed over the next ten years.

Needs Analysis

Our understanding of future demand is presented under the four headings:

- Population needs assessment/Population Profiling – An understanding of need based on the assumption that the presence of certain characteristics or conditions is a potential indicator of demand for services.
- Surveys of anticipated future need – This looks at need based on the assumption that people know what they want now and in the future.
- Service user profiling – Assumptions about need are based on the current response to services to meet identifiable demand multiplied by changes in the population.
- Analysis of met, but unsatisfied demand – This more complex aspect of need looks at where services are provided but it does not seem to deliver the outcome required or deliver the benefit the service user anticipated.

1. Population needs assessment/Population Profiling

The 2001 Census reported the total population of York to be 181,053, 34% of which were over the age of 50. 19.4% (35,185) of the population were of pensionable age compared to 13.6% in England and Wales. Map 1 illustrates the demographic breakdown of people of pensionable age by ward.

1: Number of residents in York over the age of 50

Age	Number of residents	% of residents
50-64	**31,475**	**17.4**
65-74	**15,804**	**8.7**
75 and over	**14,756**	**8.1**

Source: NOMIS (Census Tables T05 & T06)

In the above table the 50-64 age group has been included to highlight the post retirement population that will increase over the next twenty years. This is further illustrated by Subnational Population Projections (see table 2), which predicts a growth of 31% by 2020 of the population aged over 65

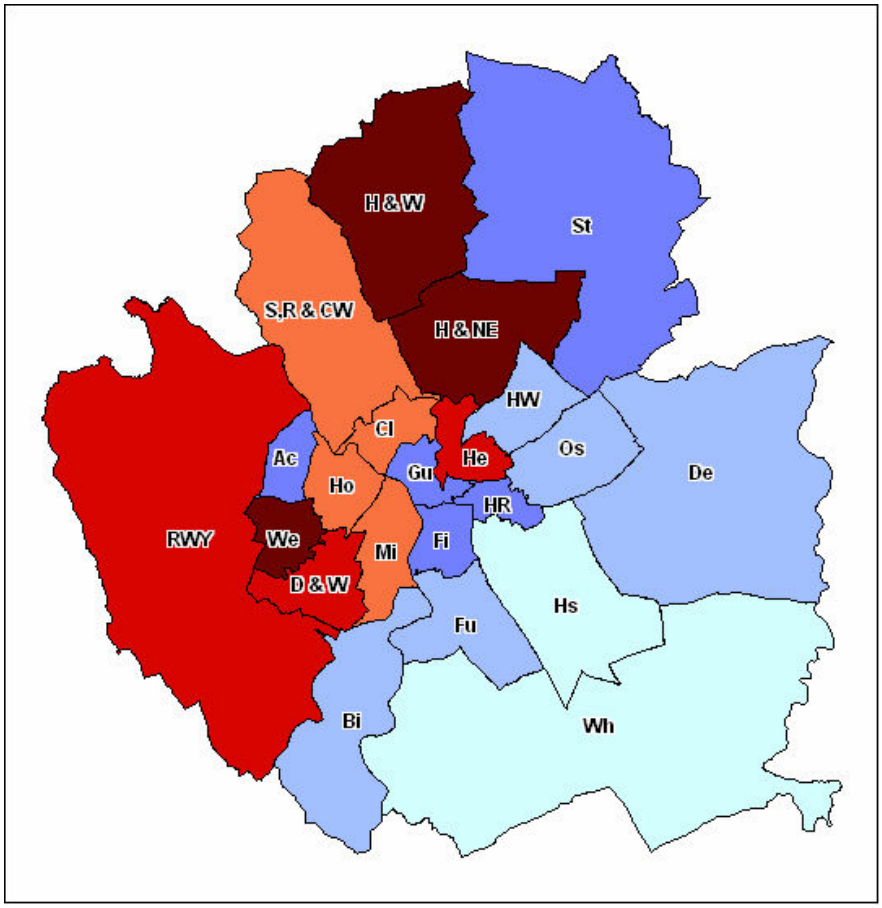
Table 2: Projected number of residents in York, in 000's between 2007 and 2020

AGE GROUP	2007	2010	2015	2020
65-69	8.3	8.8	11.2	10.1
70-74	7.6	7.9	8.3	10.5
75-79	6.5	6.6	7.1	7.5

80-84	5.0	5.1	5.4	5.9
85+	4.3	4.7	5.3	6.0
Totals	31.7	33.1	37.3	40.0

Source: Office of National Statistics

Map 1: Number of people of pensionable age



Wards

Acomb (Ac)
Bishopthorpe (Bi)
Clifton (Cl)
Derwent (De)
Dringhouses & Woodthorpe (D&W)
Fishergate (Fi)
Fulford (Fu)
Guildhall (Gu)
Haxby & Wigginton (H&W)
Heslington (Hs)
Heworth (He)
Heworth Without (HW)
Holgate (Ho)
Hull Road (HR)
Huntington & New Earswick (H&NE)
Micklegate (Mi)
Osbaldwick (Os)
Rural West York (RWY)
Skelton, Rawcliffe & Clifton Without (S,R&CW)
Strensall (St)

Number of people of Pensionable Age (Total per Ward)

2,560 to 3,010 (3)
2,090 to 2,560 (3)
1,620 to 2,090 (4)
1,150 to 1,620 (5)
680 to 1,150 (5)
210 to 680 (2)

In terms of life expectancy women have a greater life expectancy than men (80.5 years compared to 75.9 years). Consequently:

- On average women aged 65 can expect to live to the age of 84, men to the age of 81[2]
- A 75 year old woman can expect to live for another 12 years (to 87) and a 75 year old man can expect to live for another 10 years (to 85) and a.[3]

The 2001 census shows that within the over 65 population 33% (11,688) were identified as living alone. The distribution of older people who are living alone is similar to the overall distribution, with Haxby and Wigginton, Huntington and New Earswick, Westfield Heworth, and Micklegate all having high numbers of lone pensioners

Ethnicity

The ethnic breakdown of York residents over the age of 50 indicates a black and minority ethnic population of 1,756, which equates to 1% of the total population and 2.8% of the population aged over 50.

Table 3: Breakdown for BME residents of York over the age of 65

Age	Number of residents	Proportion of age group (%)
65-74	371	2.3
75 and over	342	2.3

Source: NOMIS (Census Table T13

There is no one significant community of BME older people within York. The biggest groups are White Irish (301) and White Other (278). The next largest groups are Chinese (40) and then Indian (29).

[2] Office of National Statistics

[3] Ageing, Scientific Aspects (House of Lords, 2005)

Mid year estimates indicate that ethnic minority population is growing within the city, with the biggest changes (numerically) in the White Other, Asian or Asian British Indian and Asian or Asian British Pakistani populations. Over the next 15 years we will need to keep the size and needs of the older BME populations under review.

Tenure

Nationally, over the last fifty years, the proportion of older people who own their home has increased dramatically. City of York has 78% home ownership compared to a 68% national average. This suggests that substantially more older people in York are 'asset rich' compared to their peers in other parts of the country, and potentially have the equity to fund care needs, or to purchase specialist housing.

Table 4: Breakdown of older people's tenure

Percentage of older people living in particular types of housing tenure			
Owned	**Rented from the local authority**	**Other social rented**	**Private rented & living rent free**
78%	12%	6%	4%

Source: NOMIS (Census Table SO17)

The percentages vary across the wards in the city, between 98% owner occupiers in Heworth Without, to 44% in Guildhall. Guildhall, Westfield, Heworth, Clifton and Micklegate wards all have 30% or more of their older population living in social rented accommodation (Council or other Registered Social Landlords), which suggests that the older people living in these wards are likely to be less affluent than those in wards with higher levels of owner occupation

Central heating

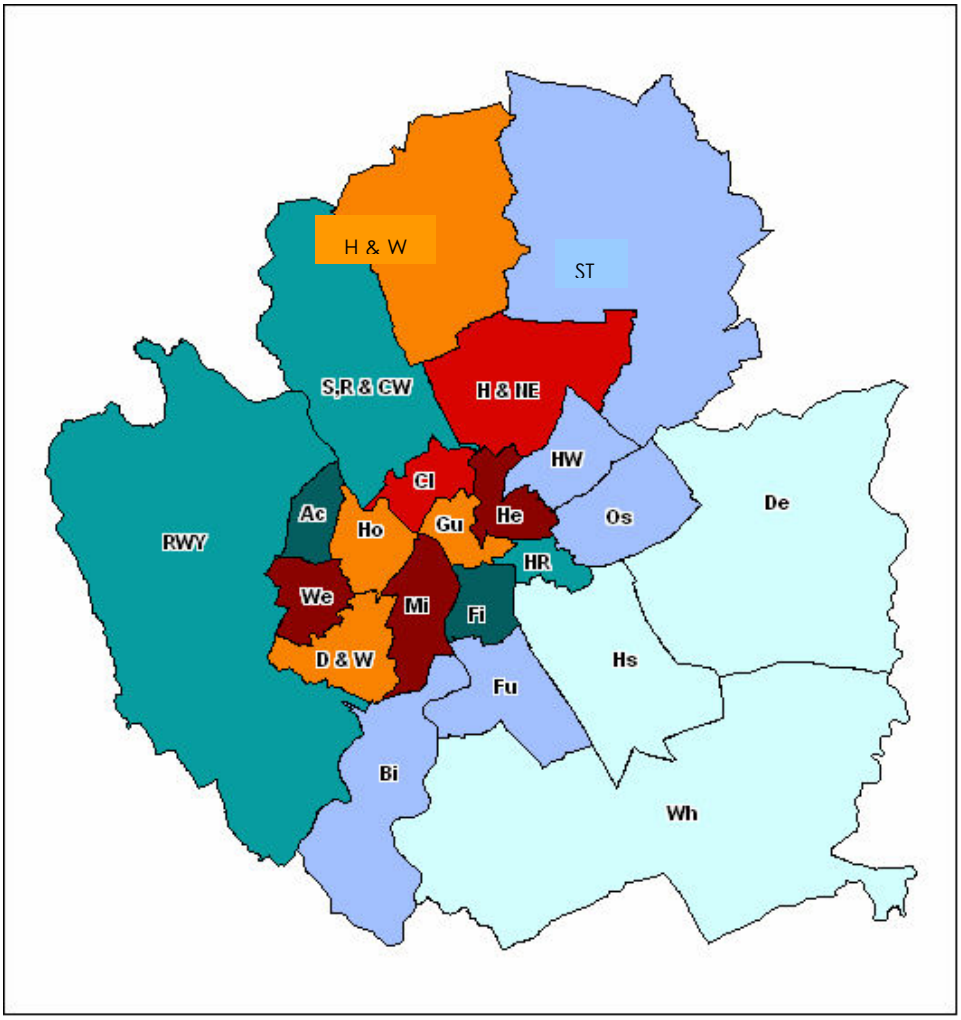
The absence of central heating can be an indicator of poverty, and of increased risk of ill health. 10% of households with people of pensionable age do not have central heating. Proportions tend to increase with age reflected by the fact that 18% of those over 85 live in accommodation without central heating, with the highest concentration being in the wards of Micklegate, Holgate, Clifton and Heworth.

Access to a car

Lack of access to a car is one way that older people can be socially excluded within their communities. Particularly for those with mobility problems, no access to a car will limit access to community facilities and social activities.

Over 50% of pensioner households in Micklegate, Guildhall, Heworth, Clifton and Westfield do not have access to a car. Map 2 shows the actual numbers of households across the city who do not have access to a car.

Map 2: Pensioner households that do not have access to a car



Households (aged over 65) that do not own a car (total per ward)

798 to 922	(3)
673 to 798	(2)
548 to 673	(4)
423 to 548	(2)
298 to 423	(3)
173 to 298	(5)
48 to 173	(3)

Wards

Acomb (Ac)
Bishopthorpe (Bi)
Clifton (Cl)
Derwent (De)
Dringhouses & Woodthorpe (D&W)
Fishergate (Fi)
Fulford (Fu)
Guildhall (Gu)
Haxby & Wigginton (H&W)
Heslington (Hs)
Heworth (He)
Heworth Without (HW)
Holgate (Ho)
Hull Road (HR)
Huntington & New Earswick (H&NE)
Micklegate (Mi)
Osbaldwick (Os)
Rural West York (RWY)
Skelton, Rawcliffe & Clifton Without (S,R&CW)
Strensall (St)
Westfield (We)

Mental Health: Dementia

The Audit Commission report, *Forget Me Not*, (published in 2002), estimated the prevalence rates for dementia and clinical depression. It stated that for dementia the prevalence rate was 6% for those aged 75-79, 13% for those aged 80-84, 25% for those aged over 85.

Based on these prevalence rates Table 5 provides an estimate of the numbers of people expected to be suffering from dementia for the next 15 years. Map 3 shows the estimated prevalence rates for dementia by ward.

In their report, Dementia North indicated that in 2002 approximately 700 elderly people with dementia were living in the community with daily care needs. Much of this care was provided on an informal basis. The Dementia North report also estimated that 210 dementia sufferers lived alone with 126 of these having no regular access to a carer.

In 2005-06 287 people over 65 who received services from the Housing and Adult Social Services Department were recorded as having primarily mental health needs due to dementia. That is 14% of the estimated total prevalence rate, and 41% of the estimated 700 people with daily care needs.

If referral rates and service provision remained constant at 14% of the total prevalence this would mean that by 2020, with a 31% increase in population we might expect to be providing services for an additional 105 customers, with around 47 needing residential or nursing home care and around 58 needing support in the community. This would mean we would be providing services to a total of 392 customers by 2020.

However, there could potentially be a further 564 people with daily care needs due to dementia, who, using this model to predict future needs, would not be known to us but receiving care on an informal basis. This would be an increase of more than 150 on the 2002 estimates of the Dementia North Report.

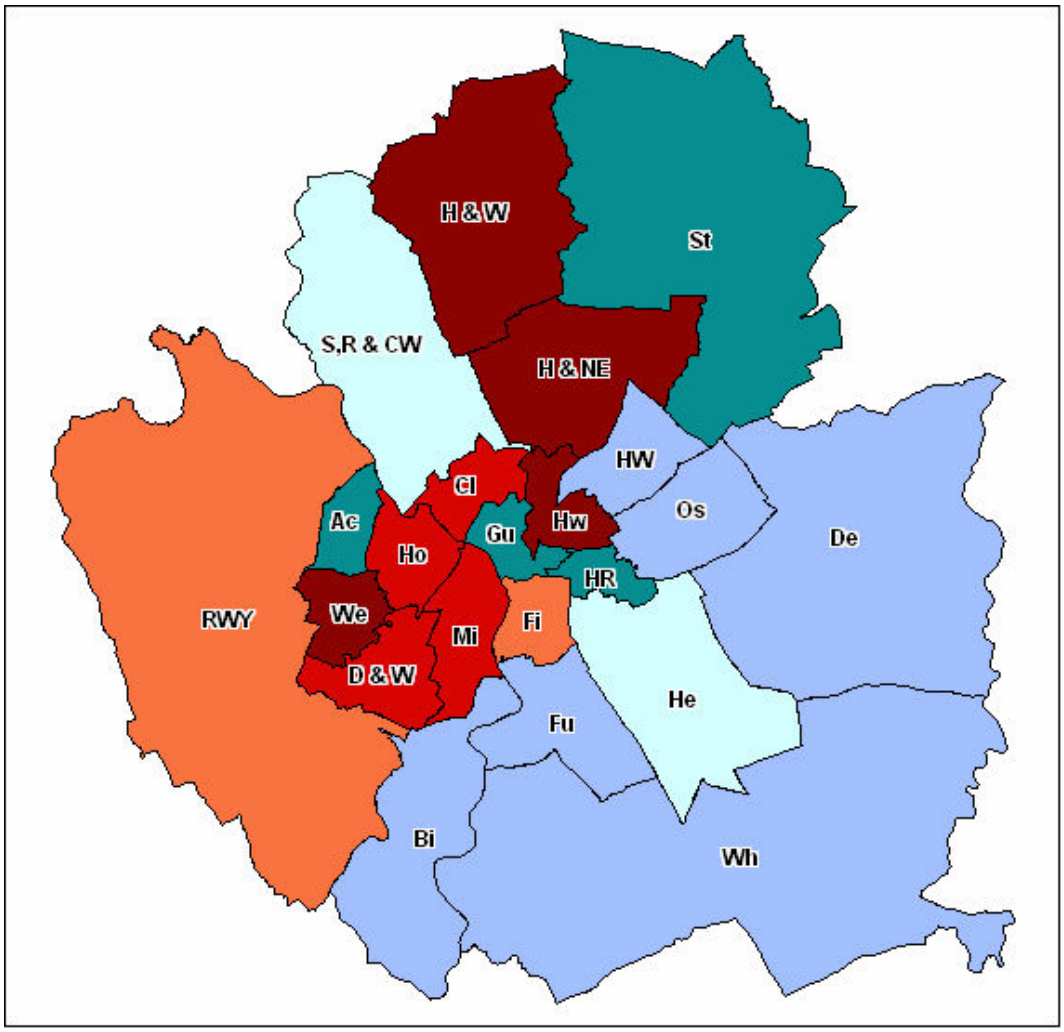
Table 5: Estimated prevalence rates for dementia in York, 2005 – 2020

Age Group	2005	2010	2015	2020
75-79	400	400	400	500
80-84	700	700	700	800

85+	1000	1200	1300	1500

Source: Forget Me Not (Audit Commission)&Subnational Population Projections(Neighbourhood Statistics)

Map 3: Estimated prevalence rate for dementia.



Dementia Prevalance for people aged over 75 (Total personsper Ward)

130 to 158	(4)
100 to 130	(4)
80 to 100	(2)
60 to 80	(4)
30 to 60	(6)
0 to 30	(2)

Wards

Acomb (Ac)
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Westfield (We)

Mental Health: Depression

Forget Me Not also indicated that 10 - 16% for all those aged over 65 would be likely to suffer from clinical depression. Table 6 provides an estimate of the numbers of people expected to be suffering from clinical depression over the next 15 years. The Dementia North report of 2002 estimated a lower number of older people with depression. There estimate was a total of 3,600 with the possibility of in excess of 1,500 of these having severe depression.

Table 6: Estimated prevalence rates for clinical depression in York, 2005 – 2020

	2005		2010		2015		2020	
Age Group	Min	Max	Min	Max	Min	Max	Min	Max
65-69	900	1400	900	1400	1100	1800	1000	1600
70-74	800	1200	800	1300	800	1300	1100	1700
75-79	700	1000	700	1100	700	1100	800	1200
80-84	500	800	500	800	500	900	600	900
85+	400	600	500	800	500	800	600	1000

Source: Forget Me Not (Audit Commission)&Subnational Population

Everybody's Business (Dh/CSIP 2005) highlights the inextricable link between physical and mental health for older people. Despite the wide disparity in estimated numbers of older people with depression it is still the most common mental health problem in older age. It is further estimated that 40% of care home residents are depressed. 40% of older adults attending GP surgeries have mental health needs and for 20-25% this is the sole reason for attending. 50% of older people who are hospital inpatients are estimated to have or develop a mental health problem during their admission.

Currently, we do not specifically analyse information about the incidence of depression in our customers and so do not know if we are recognising and dealing with it appropriately. Failure to identify these needs may increase the length of stay in hospital and reduce the likelihood that a patient will return to live independently. If we can improve the way we recognise and respond to depression we will be addressing a key concern in the 'well-being' agenda for older people and potentially reduce the length of stay in hospital and attendance at GP surgeries.

Physical Health

A range of general population data is available about older people's health and well being. For example:

- Most older people die from cancer or circulatory system problems, eg, heart attack, stroke etc. However, cancer diminishes as a cause towards older old age to be replaced by respiratory problems.
- Older people with non age specific conditions such as cancer are often less likely to receive the same sorts of services. Only 8.5% of those age over 85 years dying of cancer die in a hospice compared to 20% of all cancer deaths. Older people are less likely to die at home than younger people although that is their stated preference.[4]
- Since 1980 there has been no change in older people reporting of whether they are in good health or not. 25% saying their health is not good. A third of older people report difficulties with their hearing as compared to 28% reporting difficulties with their sight.[5]
- Just under a third of all women and men aged between 55 and 74 are clinically obese.[6]
- Two-thirds of the population aged over 65 have foot problems of which a quarter of the population over 65 have problems that need professional foot care although they do not receive it.[7]
- Urinary incontinence affects some 24% of older people and between 30-60% of people in institutional care. Faecal incontinence occurs in approximately 1-4% of adults and up to 25% of people institutional care.[8]

The Health Survey of England 2001 provided a level of prevalence for five types of disability, those being:

- Locomotor (walking and using stairs)
- Seeing
- Hearing
- Communication

[4] Dying in old age, Help the Aged, Tom Owen 2005.

[5] People aged 65 and over, General Household Survey, 2001

[6] Health Survey of England 2006

[7] Best Foot Forward, Help the Aged 2005

[8] Report of National Audit of Continence Care, Royal College of Physicians, November 2005

- Personal Care (activities relating to daily living e.g. eating, dressing, toileting)

The same study also shows the differing prevalence rates between those resident in care homes and private household's.

Table 7 Comparison of disability between older people in a care home and those in private households

	Care homes	Private households
Men aged 65-79	77%	35%
Men aged 80 & over	87%	62%
Women aged 65-79	85%	35%
Women aged 80 & over	89%	64%

Consequently, we would expect that today in excess of 12,000 older people living in private households to be suffering from at least one of the five forms of disability, with the most common likely to be locomotor disability. Table 11 shows that in 2005/6 we knew of 4,698 of these (approximately 39%)

Falls

There is limited information on the impact that falls have on the demand for services locally, but the NSF for Older People (Department of Health 2001) makes it clear that falls are a major cause of disability. Even where they do not cause serious injury, falls can lead to a loss of confidence, social isolation and depression, hypothermia, pressure related injury and infection.

Tinetti et al, 1998, indicated that the prevalence of people over the age of 65 falling once was 30% of which 15% would fall more frequently. Based on this calculation Table 8 provides an estimate of the numbers of people in York and the numbers of falls they might have, over the next 15 years.

Table 8: Estimated prevalence rates for falls in York, 2005 – 2020

	2005		2010		2015		2020	
Age	1 Fall	Fall >1	1 Fall	Fall >1	1 Fall	Fall >1	1 Fall	Fall >1
65-69	2600	390	2600	390	3400	510	3000	450
70-74	2300	345	2400	360	2500	375	3200	480
75-79	2000	300	2000	300	2100	315	2300	345
80-84	1500	225	1500	225	1600	240	1800	270
85+	1200	180	1400	210	1600	240	1800	270
Total	**9600**	**1440**	**9900**	**1485**	**11200**	**1680**	**12100**	**1815**

Source: Tinetti et al, 1998 & NOMIS (Census Table T05)

Chronic Disease

Overall York has xxxx people with a limiting long term illness. Assuming all other factors remain equal this population is likely to grow to xxx by 2020. Currently, Haxby and Wigginton, Huntington and New Earswick, Heworth and Westfield also have the highest numbers of pensioners with a limiting long term illness.

This next part of the report provides an indication what is known of the type of conditions and service provision associated with chronic disease, including those conditions which have been identified above as leading to frequent hospital admissions. It is by no means an exhaustive list and we know that we have little information for any of these conditions about the way they impact on the need for services.

Diabetes

The Health Survey for England, 2003 indicated a variation in the prevalence of diabetes in relation to gender and age, this is illustrated in Table 9.

Table 9: Expected prevalence of older York residents suffering from Diabetes

Age	Gender	Number of residents	Proportion of age group (%)
65-74	Male	860	11.9
	Female	720	8.4

75 and over	Male	440	8.1
	Female	590	6.3

Source: Joint Health Surveys Unit (2004) & NOMIS (Census Table T05)

An estimated 4,600 people in the Selby and York PCT area over 60 suffer from type 1 and 2 diabetes (YHPHO). If no action is taken to reduce current and predicted levels of obesity, it is estimated that by 2010 this will have increased to 5,700. Forecasting beyond 2010 is not available at present. To counter this increase local actions have been identified to develop a primary care service model. That builds greater capacity and support to provide ongoing care management in the community. We have little information on the impact of diabetes on the need for services, but people with diabetes have a higher chance of developing certain serious health problems, including heart disease, stroke, high blood pressure, circulation problems, nerve damage, and damage to the kidneys and eyes, any of which will increase the need for help and support.

COPD

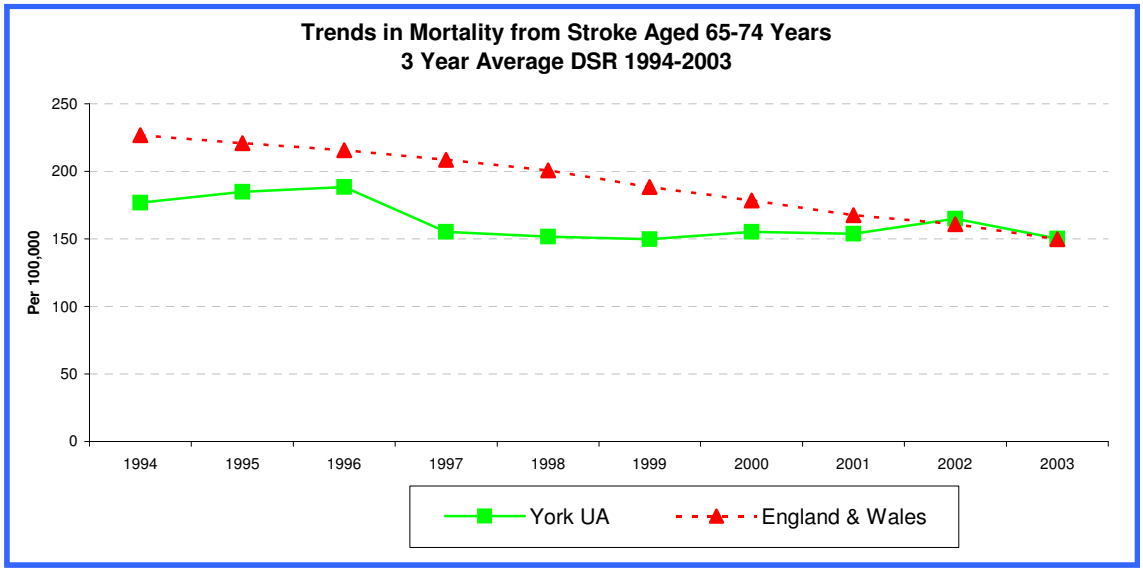
National figures from the Bandolier Journal, 2006, indicate that up to 4% of people over the age of 65 will suffer from COPD. This would equate to 1,100 York residents.

We do not have access to information about the number diagnosed with COPD, or the range of services that they receive. However in 2005/6 there were 417 admissions to the acute hospital, with this diagnosis, resulting in 3,624 bed days

Stroke

Strokes have a major impact on people's lives. 65% of surviving stroke patients can live independently after a year, but 35% are significantly disabled and 5% are admitted to long term care (NSF for Older People). Recovery can continue for several years after a stroke. The Neurological Society, 2003, stated that the expected prevalence rate for stroke was 0.5% of the population. Consequently this indicates that currently approximately 150 of York residents over the age of 65 will have suffered a stroke.

Until 1999 death rates for York residents in the 65-74 year age group due a stroke were well below the national average. However, as can be seen in the graph below, this position has worsened, with York now at the national average level. *(Please note that these are based on 3 year averages and the latest annual figures for 2004 do actually show a marked improvement i.e. 106 per 100,000 for York compared to 136 per 100,000 for England).*



Source: C&HI (ICD10 I60-I69, I69, ICD9 430-438 adjusted)

In summary, the potential increase in number of older people experiencing chronic diseases by 2020 can be predicted as follows, based on a 31% increase in population. Figures for diabetes patients has only been modelled to 2010 to date*:

Table 10: Predicted increase in chronic diseases

Condition	Current numbers	2020 predicted numbers
Diabetes	4,800	*5,700 * forecast for 2010*
Falls (more than 1 a year)	1440	1815
COPD	1,100	1604
Stroke	150	200

2. Surveys of anticipated future need

National studies

The research material below explores the results from a number of studies which look at older peoples needs, attitudes and problems. Whilst this material is not York specific there is no reason to suppose the responses of local people would be any different. Indeed the more limited local studies that have been conducted to date would look to confirm much of this material.

Attitudes to old age and quality of life

- Older people attached importance to three priorities in later life[9]:

    - Staying in their own homes
    - Good health
    - Having sufficient income to be comfortable.

- Those who experienced change in old age through moving, death of a spouse or health generated incapacity were the people most likely to shift their view of what was meant by independence. The report describes some of these key events as transitions and goes on to argue that "Given the difficulty in planning for many of the transitions associated with later life, it is important that services are targeted to meet pensioners needs at key anticipated crisis points, and that these are accessible, easy to navigate, and offer multiple points of contact - where any one agency could jumpstart the facilitation of access to a wider host of relevant services." [10]
- Infrequent social contact with people outside the household correlates with greater chances of a poor quality of life but there is little difference in frequency of contact between owner occupiers and renters.[11]
- A good quality of life for older people was identified as having good friends and neighbours, good health, happy marriage/family, being content with what you've got and having enough money. For people aged 85+ contact with other people was rated as the most important aspect of the quality of their lives.[12]
- Among people aged 65+[13]

    - 14% unable to walk down the road on their own,
    - 10% unable to manage stairs.
    - 5% unable to cook a main meal for themselves.
    - 37% live alone.

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[9] Independent living in later life Dep't Work and pensions Research report 216

[10] Ibid

[11] Inequalities in Quality of Life Among People aged 75 years and over in Great Britain. Breeze, Grundy, Fletcher, Wilkinson, Jones and Bulpitt, March 2002.

[12] Farquhar, Elderly Peoples Definitions of Quality of Life, Social Science and Medicine, 41.10 1995

[13] People aged 65 and over, General Household Survey, 2001

- 79% of older people saw a relative or friend at least once a week.
- The domestic tasks that were most likely to cause older people difficulty were those that involved climbing. Just under a third of older people were unable to perform jobs which involved climbing without help.
- The number of older people receiving help in the home has not significantly changed although there has been a substantial shift from local authority provided help to people funding their own home care. Approximately 14% of older people receive some form of paid for help in the home.[14]
- 7% of older people report that they are often or always lonely. This proportion has not substantially changed over the last 60 years. However the recent study estimates that there is under reporting in this figure.[15]
- Of the coming generation of older people (those born between 1945 and 1965 – The Baby Boomers) only 14% believe that 'in general the people in charge know best' compared to 26% of current over 65's.[16]

Funding and finance

- Over the past two decades pensioner incomes have increased twice as fast as average earnings. [17]
- Whilst older people support equity release schemes in principle older home owners are deeply reluctant to take out loans secured on their property.[18]
- People in their fifties are least supportive of passing on assets rather than enjoying them for themselves (72% -28%). The very old and the relatively young are more supportive of passing on an inheritance. However, even among the over 80's a majority say they will enjoy life rather than worry about inheritance (54%-32%).[19]

Housing Accommodation and Neighbourhoods

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[14] Ibid

[15] Loneliness, Social Isolation and Living Alone in Later Life, Victor, Bowling, Bond and Scrambler ESRC, 2003

[16] MORI Social Values 1999

[17] Opportunity Age, Dept Work and pensions 2005.

[18] Joseph Rowntree Equity release 1998

[19] Attitudes towards inheritance in Britain JRF Findings July 2005

- Older people living in specialist housing schemes regard them as a place to live rather than a place to die in. They did not want to live in a place where everyone was frail.[20]
- Moving down from owner occupation during most of adult life to social sector housing carries significantly greater chance of three out of five poor outcomes. An upward move carries reduced chances of two outcomes compared with staying in the same social sector. [21]
- People in their 50's viewed staying in their own home as generally desirable. Some wanted to stay where they were whatever. Others were prepared to move house or even area, to live in an optimum environment in terms of social networks and housing. People in their 50's strongly disliked the idea of residential care.[22]
- Social exclusion and Older People towards a conceptual framework suggests that the creation of deprived areas and neighbourhoods hits older people harder than other groups, in part because they are more likely to rely on a cash economy (loss of banks and post offices makes accessing fund hard), food and basic goods cost more, general sense of loss when shops and workplaces close. Feeling of isolation, loss and a retreat by communities may be felt even greater by ethnic minority groups who start off from an isolated position.[23]
- Whilst over 60% of people aged under 60 see themselves as staying in their own home when they reach old age over a quarter would see themselves living in some form of sheltered or special accommodation. Only 11% would move to a private care home and 7% a local authority care home.[24]
- Older Home Owners define the advantages and disadvantage of home ownership under three main themes:

    - It offers independence although it also burdens people with responsibilities for repairs and maintenance.
    - It is seen as a capital asset or investment although there is concern again about the cost of repairs, that it means some forms of financial help are not available to them and that they may need to sell their home to pay for care.

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[20] Is enhanced sheltered housing an effective replacement for residential care for older people? Dec 2000 JRF

[21] Inequalities in Quality of Life Among People aged 75 years and over in Great Britain. Breeze, Grundy, Fletcher, Wilkinson, Jones and Bulpitt, March 2002.

[22] Looking Forward to Care In Old Age Levenson, Jeyasingham and Joule, Kings Fund 2005

[23] Social exclusion and Older People towards a conceptual framework: Scharf, Phillipson, Kinston and Smith, Centre for Social gerontology Working Paper, 2000

[24] MORI for CSCI 2005

- Older people who are home owners see their home ownership as an achievement however they can also see themselves as tied down by the property[25].

Surveys of anticipated future need

Local studies

During 2005 a local, multi-agency strategy, '*Never Too Old'*[26], was produced. Its development was based on a 'bottom-up approach' and is effectively a strategy for older people by older people. As a consequence the views of older residents in York were widely canvassed. Their particular priority areas were identified as being:

- Power and control;
- Maintaining independence;
- Staying healthy;
- Planning for future needs.

Specific areas of concerns within these priority areas were identified but there was no further prioritisation within this list:

- Wider partnership working utilising all partners including voluntary and independent sector;
- Assessments done at the speed and convenience of the older person concerned;
- Services being available promptly;
- Avoidance of assumptions about the needs and abilities of the person concerned;
- Avoidance of age discriminatory practice;
- Delivery of an equitable service for both older people and their carers;
- Transparent service provision with an honest assessment of what can be done and what is available;
- Improved communication between those receiving and providing services;
- Timely provision of information to those identified as needing it;
- Informed individuals;

[25] Older owner occupiers perceptions of home ownership JRF Sept 1999

[26] Too Old Older People's Strategy, Selby, York & Easingwold Older People's Partnership, 2005.

- Greater awareness of public health issues and initiatives;
- Proactive and timely service provision with reduced frequency of crises;
- Health of carers maintained and improved and consequently maintaining the support and independence of the 'cared for'.
- Increased emphasis on preventative services;
- Equitable service provision (health, social care, leisure, education & transport);
- Improved communication between those providing services and their elderly recipients;
- Quality of life issues addressed;
- Emphasis of service provision around rehabilitation and enablement;
- Measuring outcomes rather than service volume;
- Genuine consultation with older people.

Another specific piece of consultation with older people took place in the Acomb ward during 2001 as part of a Health Needs Assessment exercise[27]. This work highlighted specific outputs to respond to older people's concerns about being socially isolated. The recommendations that came out of this particular piece of consultation were as follows:

- A Drop In Centre established for the area.
- Improved Toilet Facilities in the area
- Encourage existing coffee shops to offer special rates for seniors and the opportunity to 'sit and linger' at certain times of day.
- Groups/organisations to publicise and promote the service offered.
- Undertake a survey of existing transport available to older people, both public and private, and raise awareness with appropriate publicity.
- Offer information on local services, activities and support available to older people living in York. (ii) Evaluate the 'user friendliness' of 'Out & About' Booklet, (initiated in Acomb as a result of the HNA).

3. Service user and carer profiling

There is not a vast amount of data about service users and carers in York that has been quantified and analysed. However, there are a number of national studies that highlight problems at the care and health interface For example:

[27] Executive Summary of the Survey of Services and Activities for People aged 50+ in Acomb, Age Concern York, 2001

- A study in one local authority estimated that 30% of older people admitted to A&E Departments came in with a dehydrated related illness. Over half of those had come from a care home.[28]
- An American study of continence showed that incontinence increases the likelihood of an older person being admitted to a care home.[29] Despite 80% of services having a written policy that pads should be available on the basis of clinical need, 81% of primary care and 76% of care home services limit the maximum number of daily pads for individuals. 60% of primary and 70% of secondary care patients with bladder or bowel problems receive pads as a way of managing their condition, rather than treating the underlying problem[30].

The following table shows the number of people aged 65 and over, in York, who received services from social services because of substantial or critical care needs during 2005/6 together with their primary customer group (as detailed in the pf1 return). Note: Some customers may have received both community and residential services, or residential and nursing services during the year

[28] Just add water, Graham Hopkins, Community Care, 13th October 2005

[29] Medically recognised urinary incontinence and risks of hospitalisation, nursing home admission and mortality. Thom, Haan, VanDen Eden, Age and Ageing 1997, Vol 26

[30] Report of National Audit of Continence Care, Royal College of Physicians, November 2005

Table 11: Total number of clients in York aged 65 and over, receiving services during 2005-2006, by primary client type, and service type

Primary client type	Total customers	Community based services	LA residential	Independent residential	Nursing
Physical Disability	4698	4170	230	187	333
Unknown	268	233	9	17	19
Phys dis	2804	2559	85	99	181
Frailty/temp illness	1329	1114	115	61	120
Hearing impaired	95	86	5	2	4
Visual impaired	161	143	12	6	5
Dual sensory loss	41	35	4	2	4
Mental Health	453	265	49	92	104
Dementia	287	162	28	48	87
Vulnerable people	32	28	5	2	1
Learning disability	36	23	5	11	2
Substance misuse	4	3	1	0	0
No record	0	0	0	0	0
TOTAL OF ABOVE	**5223**	**4489**	**290**	**292**	**440**

Selby and York PCT have developed multi-professionals teams (MPT) to provide a proactive and targeted approach to the management of individuals with ongoing health needs. An analysis of the first ten months of service provision was completed in January 2006. This highlights that the majority of patients, 88% (149), were aged 65 and over. It also indicated that 54% (91) were also known to Social Services. It has also confirmed that the vast majority of people with long-term conditions will have more than one medical condition to cope with. The ten month analysis highlighted that 86% had two or more medical conditions, with the most prevalent being:

- COPD (30%)
- Hypertension (25%)
- Osteoarthritis (16%)
- Heart Failure (16%)
- Ischaemic Heart Disease (15%)
- Diabetes (13%)

Work is currently in progress led by North Yorkshire and York PCT, to look in more detail at the needs in relation to falls, strokes, heart failure and COPD, and the impact of these conditions on the demand for unplanned hospital admissions.

Although not a detailed review of service users needs information can also be drawn from the Performance Assessment Framework:

- Our performance on reducing the number of older people admitted on a permanent basis to residential or nursing care is very good (C72)
- Our delivery of equipment and adaptations within targets is very good (D54)
- Our contribution to supporting older people to live at home is good (C32)
- Our ability (with the PCT) to minimise delayed transfer of care is average (D41)
- Our provision of intensive home care to over 65's is acceptable, but possible room for improvement (C28)
- Our support to enabling adults and older people to gain "control" over their provision of care services by providing direct payment is acceptable (with room for improvement (C51)
- Waiting times for assessments is acceptable (with room for improvement) (D55)

Carers

The Audit Commission (2004) found that carers who provide over 50 hours care per week are twice as likely to suffer from poor health as other people. Carers who do not get a break are twice as likely to suffer from mental health problems as those who do. The health of carers is also more likely to deteriorate over time compared with non-carers.

People in their 50's felt that their children would be unlikely to be their main or sole carers although discussing their future care needs with their children would be very difficult.[31]

The general household survey in 1995[32], although ten years old provides a good analysis of national data regarding carers:

i) Prevalence of informal care

- One adult in eight (13%) was providing informal care and one in 6 households (17%) contained a carer.
- Four per cent of adults cared for someone living with them and 8% looked after people living elsewhere. The survey findings indicate that there are about 5.7 million carers overall in Great Britain with about 1.9 million caring for someone in the same household.
- Four per cent of adults in Great Britain (representing about 1.7 million) devoted at least twenty hours per week to caring and 8% (about 3.7 million) carried the main responsibility for looking after someone (that is, they spent more time than anyone else on the dependant).
- Women were more likely to be carers than men but the difference was not very marked, 14% compared with 11%. However, since there are more women than men in the total adult population of Great Britain, it is true that the number of women caring is considerably greater than that of men, 3.3 million compared with 2.4 million.
- The small difference between the proportions of women and men caring was attributable to the higher proportion of women looking after someone outside the household (10% of women and 7% of men). Women were also more likely to carry the main responsibility for caring (9% of women and 6% of men).
- Five per cent of adults looked after parents and 3% cared for friends and neighbours.
- The peak age for caring was 45-64. One fifth of adults in this age group were providing informal care.

[31] Looking Forward to Care In Old Age Levenson, Jeyasingham and Joule, Kings Fund 2005

[32] General Household Survey 1995

- Among men of working age, one in six of the economically inactive were carers compared with one in ten of those in work or unemployed. Among non-married women the proportion caring varied little according to economic status, but among married women, the economically inactive were the group most likely to be caring followed by those working part time.

ii) Who is caring for whom?

In total, 18% of carers were looking after more than one dependant. Nine out of ten carers were looking after someone who was related to them; four out of ten were caring for parents or parents-in-law and two out of ten were looking after a spouse.

Where carers were looking after someone in their own household, just over a half were caring for a spouse; just over a fifth were caring for parents or parents-in-law and a similar proportion were caring for children.

Of carers with dependants in other households, just over a half were looking after parents or parents-in-law; a fifth were caring for relations other than parents or children and just over a fifth were looking after friends or neighbours.

Sixty per cent of carers had dependants with physical disabilities only; a further 15% had dependants with mental and physical disabilities and seven per cent had dependants with mental disabilities only. Almost all remaining carers said that their dependant's disability was the result of ageing.

iii) The nature of care

- A total of 24% of carers had been looking after their dependant for at least 10 years and a further 23% had been caring for between five and nine years. Just under a third of carers who lived with their dependants had been caring for them for at least 10 years.
- Among carers with a dependant in their own household, just under 60% helped with personal care; a similar proportion provided physical help; just under 70% provided practical help and nearly 80% generally kept an eye on them. Carers with dependants in households other than in their own were much less likely to provide personal care.

iv) Time spent on caring activities

- There was a slight preponderance of men among the group of carers spending the least amount of time caring, but apart from this the amounts of time spent by men and women on caring were very similar.
- Over a third of carers with a dependant in another household spent fewer than five hours a week caring while nearly two thirds of those who lived in the same household as their dependant spent at least 20 hours a week caring.

- Of carers devoting at least 20 hours week to caring: over 60% were women; three quarters were aged 45 or over and seven out of ten shared their home with their dependant. Nine out of ten were main carers; nine out of ten were looking after a close relative and a third were caring for dependants with mental disability.

v) Who supports the carers?

- Over a third of all carers reported that no-one else helped them look after their dependants. A further 26% did receive help but spent more time looking after their dependant than anyone else and just under 10% shared the task of caring with another. Women were more likely than men to be caring unaided while men were more likely to be `non-main carers'.
- In total, 59% of all carers had main dependants who did not receive regular visits from health, social or voluntary services.
- Dependants who lived with their carers were much less likely to receive regular visits from service providers than those who lived in another household.

In York the wards of Haxby and Wigginton, Huntington and New Earswick, Heworth, Westfield, Dringhouses and Woodthorpe and Hull Road have the highest numbers of older carers.

Table 12: Provision of 50 hours or more care per week by older people

All people	People aged 75-84	People aged 85+
1,157	448	87

Source: NOMIS (Census Table SO25)

In the year ending March 2006 1,475 carers were identified during care assessments. We do not have details on how many of these were older people. 607 carers were identified as carrying out substantial and regular care. Carers are likely to be vulnerable to health problems of their own, particularly stress related and lifting injuries, and the higher the level of care they provide, the more vulnerable they are likely to be. Table 12 shows the numbers identified from the census who were providing over 50 hours care a week

4. Analysis of met, but unsatisfied demand

Understanding the above is a crucial part of the analysis that needs to be undertaken in developing a commissioning strategy. However, this is not an easy process in York because the information sources required to answer these questions

are limited, and it requires a number of discussions with partners in order to understand the relationships between, and effects upon, a whole range of services. For example; low levels of health service physiotherapy provision may impact on a person's capacity to recover from a stroke which may in turn lead to diminished mobility which may eventually require considerably increased social care provision. Equally, the absence of an early social care intervention may have a consequence for health services that requires hospital admission.

Effective joint commissioning requires a strong evidence base and the capacity to track back through systems to establish cause and effect across organisational boundaries. The commissioning strategy needs to identify, with health and housing, key initial questions and topics to be addressed.

Summary of Current Demand Data

Although there are still gaps in the information we have about needs, primarily around the specific health needs and profiles for the city, we can identify a number of key factors that need to be taken into account in planning service provision:

- We can expect the population of people over 65 in York to grow by 31% over the next 15 years, an additional 9,540 people. Within that growth there will be more men than women although longevity in men is increasing disproportionately. Single women may feel more anxious about living alone in the family home and may feel more vulnerable. Single older women are more likely to suffer social exclusion than their male counterparts.
- Mental health and physical and sensory disability needs will increase as the population grows and ages. Dementia will affect around 700 additional older people within the next 15 years. Given that dementia is likely to consume high level resources the natural growth in this population is concerning. Currently social care provides few services for other mental health conditions in older people.
- Current prevalence figures for clinical depression can be used to project an estimated additional 800 to 1,400 additional older people with clinical depression
- If our current service provision continues at the same level these increases in population and associated needs will mean an additional 163 people could require services because of mental health needs, 105 because of dementia.
- Physical and sensory disabilities can be expected to affect an additional 6,000 people by 2020. If the local authority continues to provide services at the same level reflected in Table 11, this would mean an additional 2,322 service users, with 278 of these potentially needing the equivalent of residential or nursing

home care, and over 2,000 additional older people needing support in the community

- Stroke deaths for older people rose above the national average between 2001-2003 and the prevalence of diabetes is increasing. We predict that approximately 5,700 will be diagnosed with diabetes in 2010, although it is difficult to gauge the exact impact on health and social care needs.
- We can expect an increase of approximately 1,500 older people who will have one fall, and an additional 375 who will experience one or more fall in 2020. While all falls may not cause serious injury they can impact on an older persons feeling of confidence and social isolation caused by restricted mobility.
- There are some areas of the city with much higher numbers of older people than others. Three of the six higher density areas are in the outlying wards and villages: Haxby and Wigginton, Huntington and New Earswick and rural West York. Three are on the outskirts of the city centre: Westfield, Heworth and Dringhouses and Woodthorpe. Linked to these population levels all of these wards also have higher numbers of older people living alone, the number suffering from dementia and the number of older carers, all of which can lead to vulnerability and a need for services.
- We would expect a higher need for publicly funded services to come from those wards where there are a number of factors which would indicate social exclusion or deprivation, such as long term limiting illness, no access to a car, no central heating and living alone. Westfield, Heworth, and Micklegate are the wards that have the highest number of pensioners experiencing some or all of these issues.
- We are able to assume that as there are a significant number of older people who are 'asset rich' due to their home ownership, will potentially have the equity to fund care needs, or to purchase specialist housing.
- Whilst there is no one significant community of BME older people within York we would expect numbers to increase in line with general population increases therefore, we would need to ensure that future services provide flexibility and responsiveness to a variety of needs.

Further Demand Data to be identified and the contribution this will make to the commissioning strategy

One conclusion this needs analysis is an improved understanding of what we know about our population and what we don't know. This has been highlighted by the difficulty in several instances to access the information needed to effectively commission services and understand wider needs. Therefore, we have ended this section by identifying what further work needs to be undertaken to develop our thinking on what and where these information sources need to be. Our current view is that we would like to pursue the following:

- Further thinking needs to be given to how population/patient/service user/ tenant information is captured and analysed across the authority. It is often difficult to compare data about conditions, eg, stroke, cancer, continence, etc with data about outcomes from those conditions, ie aspects of mobility and functionality, with services received, eg, home care day centres. A base line might at least be a shared information depository of data that all three agencies collect at least quarterly.
- Diabetes, stokes and falls are all conditions that could be reduced through good prevention services and where they still occur, the impact of those conditions on peoples lives could be diminished. At present there is not enough information about the relationship between these conditions and their prevalence amongst current service users and the impact this may have on future service provision.
- There is a need to share our knowledge of the health and social care needs of older people within, and external to, the local authority in order to influence developments in infrastructure so that communities support the aspiration, through that infrastructure, for a higher proportion of older people to remain within the community. That may be through planning regulations and controls, through the maintenance of local shops and support services and through design such as in buildings, drop kerbs and other aspects of the urban environment.
- What is known about the relationship between current demand and service provision, eg, which services are under pressure (occupational therapy, day care), is this real or illusory, where is there over supply?
- Is the intensity of services provided sufficient to achieve the outcomes desired, eg, in stroke services do we know what intensity of rehabilitation is required for a particular individual to achieve maximum potential recovery?
- Are there needs being presented where targeted interventions could prevent worse outcomes but where this is not occurring, eg, people coming into care homes where the provision of an alternative, community based service could prevent this happening?
- Are there unintended consequences to current service provision, eg, is the provision of mobility aids actually acerbating immobility?
- Is the point at which intervention occurs the point at which it is most likely to deliver the best outcomes; eg, are eligibility criteria effective rationing devices or do they debar people form provision at a time when it may have the greatest preventative impact?
- In terms of service users and carers there are a number of unanswered issues about provision:

- How can we identify earlier and understand incidence of diabetes, COPD and depression in our clients in order to improve our response and monitoring of outcomes?
- Why do older people and especially those with dementia enter hospital and/or long term care and what does this tell us in order to design better prevention services?
- How many people with dementia access our current services – who are they (age, gender, ethnicity, accommodation status) and what do they access?
- How many people care for people with dementia – who are they and how much care do they give and how would increased services for carers improve the overall contribution to improving support for older people in the community?
- What happens when services are not delivered or are delayed, eg, aids and adaptations?
- What people expect when they ask for a service and whether this is met?
- What might happen if service supply is restricted?