Health and social care in North Lincolnshire: Finding the future together

Consultation on North Lincolnshire’s Joint Strategic Needs Assessment
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Preface

Health and social services in North Lincolnshire will face considerable challenges over the coming years. The needs of our population are changing and expectations are, quite rightly, increasing. If we are to meet these needs and expectations we need to take two initial steps.

Firstly we need to understand the data we have on these changing needs. We have presented some of these data in this document. Inevitably we cannot include everything but if you think there are important gaps please let us know.

Secondly, and just as importantly, we need your views. How are the changes we are anticipating going to affect the way health and social services are provided? Are there new ways of working that will meet these needs better?

Please send your views to:

Email: Angie.Underwood@nlpct.nhs.uk
Post: Dr Andrew Furber
Director of Public Health
North Lincolnshire Primary Care Trust
Health Place
Wrawby Road
Brigg
North Lincolnshire,
DN20 8GS

We are grateful to many people for contributing to this document. In particular we are grateful to Louise Garnett for undertaking much of the work.

Dr Andrew Furber
Director of Public Health
North Lincolnshire PCT
North Lincolnshire Council

Mike Briggs
Head of Service
Adult Social Services
North Lincolnshire Council

Richard Stiff
Deputy Chief Executive
Director of Children’s Services
North Lincolnshire Council
Undertaking a Joint Strategic Needs Assessment is a requirement on local authorities and Primary Care Trusts from April 1st 2008. The Government expects it to provide:

- A joint analysis of current and predicted health and well-being
- An account of what local people want from services
- A view of the future, predicting and anticipating potential new and unmet need

As a first step we have looked at the issues facing older people and people living with long term conditions. Other areas will be covered in future editions.

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There is no legal definition of older people and several terms tend to be used to describe people of different ages in different contexts. In this country the conventional definition is 65+, the state pensionable age for men. Other people use 60 as the cut off. In this report we try and distinguish between different stages of ageing by using the terms: mid years, i.e. people aged 55-64, older people and pensioners, meaning people aged 65+, and people in later life to identify people in their mid 70s and older.

1. What is a Joint Strategic Needs Assessment?

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- A joint analysis of current and predicted health and well-being
- An account of what local people want from services
- A view of the future, predicting and anticipating potential new and unmet need

As a first step we have looked at the issues facing older people and people living with long term conditions. Other areas will be covered in future editions.

2. What do we want to see happen in North Lincolnshire?

It is helpful when going on a journey to know where you want to get to. Similarly with health and social care, it is important to know what we want to achieve. These achievements, or outcomes, are broadly set by Government.

In this paper we have used the outcomes for adult social care described in the Government publication, ‘Our Health, Our Care, Our Say’. However these are very similar to the outcomes set by Government for children’s services (from ‘Every Child Matters’) and for the National Health Service. How they relate to one another is set out in Table 1. Whilst there will inevitably be some overlap between these outcomes, they are variations on a theme and sufficiently similar to have a mutual understanding of where we want to get to.

Table 1: Relationship between Government outcome frameworks

<table>
<thead>
<tr>
<th>Adults</th>
<th>Children</th>
<th>NHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved health and well-being</td>
<td>Be healthy</td>
<td>Promoting health and well-being</td>
</tr>
<tr>
<td>Increased choice and control</td>
<td>Enjoy and achieve</td>
<td>Effective and efficient care</td>
</tr>
<tr>
<td>Making a positive contribution</td>
<td>Make a positive contribution</td>
<td>Promoting health and well-being</td>
</tr>
<tr>
<td>Economic well-being</td>
<td>Achieve economic well-being</td>
<td>Promoting health and well-being</td>
</tr>
<tr>
<td>Maintaining personal dignity and respect</td>
<td>Enjoy and achieve</td>
<td>Responsive and accessible care</td>
</tr>
<tr>
<td>Improved quality of life</td>
<td>Enjoy and achieve</td>
<td>Safe and high quality care</td>
</tr>
<tr>
<td>Freedom from discrimination and harassment</td>
<td>Stay safe</td>
<td>Equitable care</td>
</tr>
</tbody>
</table>

Question: Do these outcomes adequately capture our aspirations for health and social care in North Lincolnshire? Is anything missing which we should look at in the future?

In 2006 North Lincolnshire agreed a Sustainable Community Strategy called ‘Many Faces, One Community’. It describes four shared ambitions:

- an area that is thriving
- communities that are confident and caring
- individuals can see the difference
- everyone works together for the benefit of the area

We believe the outcome frameworks described in Table 1 will help deliver these ambitions. A further tool for delivering these ambitions is the Local Area Agreement. This is an agreement between Government and North Lincolnshire on what our priorities are.
3. What has national Government said about how services should be delivered?

National Government has set a clear direction for health and social services.

That they should be:

- **fair**: equally available to all, taking full account of personal circumstances and diversity;
- **personalised**: tailored to the needs and wants of each individual, especially the most vulnerable and those in greatest need, providing access to services at the time and place of their choice;
- **effective**: focused on delivering outcomes for patients that are among the best in the world;
- **safe**: as safe as it possibly can be, giving patients and the public the confidence they need in the care they receive;
- **locally accountable**: so that staff are empowered to lead change and innovate locally, ensuring that this is based on the best clinical evidence, meets local needs, and is the product of engagement with patients and the public.

Question: Are there any of these aspects that you feel are particularly important for North Lincolnshire?

4. What’s happening in North Lincolnshire now?

4.1 The changing shape of North Lincolnshire

Changing population

North Lincolnshire is a predominantly rural area, covering an area of 85,000 hectares. 159,000 people live in North Lincolnshire (ONS mid year estimate, 2006) although 165,680 people are registered with our General Practitioners (NLPCT, 2007).

Less than half of our resident population, (47%), live in the main urban areas of Scunthorpe and Bottesford. An additional 40% live in the market towns of Barton and Brigg, as well as in medium sized settlements such as Broughton, Crowle, Epworth, Barrow, Barneby, Messingham, Kirton and Winterton. The remaining 13% live in smaller hamlets and settlements across North Lincolnshire.

Our population is already slightly older than the national and regional average, and this trend looks set to continue. The factors behind this include:

- the net outward migration of younger adults
- the recent inward migration of people of retirement age
- improvements in life expectancy

Between 1991 and 2006, the number of people aged 65+ in our local population grew by 17%, compared with an average population growth of 4%. As overall health improves and average life expectancy increases, this age group is likely to account for a significantly larger proportion of our population in years to come, and is projected to increase by an average of 1000 more people aged 65+ per year, between now and 2029.

Whilst this represents a faster rate of growth than nationally, this expansion is unlikely to occur evenly over the next twenty years, with the growing number of 60+s not reaching older age until at least 2015. This means we should not expect to see a significant growth in demand for health and social care services in North Lincolnshire until the middle of the next decade, with the numbers of older people increasing rapidly after the next decade and beyond. The projected change in our population up to 2015 and 2029 is shown graphically in the charts below.

4.2 Projected increases in North Lincolnshire’s resident population by age

<table>
<thead>
<tr>
<th>Age</th>
<th>% increase to 2010</th>
<th>% increase to 2015</th>
<th>% increase to 2029</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;20</td>
<td>-0.9%</td>
<td>-2.0%</td>
<td>-2.5%</td>
</tr>
<tr>
<td>20-39</td>
<td>-2.5%</td>
<td>+0.55%</td>
<td>+1.6%</td>
</tr>
<tr>
<td>40-59</td>
<td>+2.8%</td>
<td>+5.1%</td>
<td>-2.8%</td>
</tr>
<tr>
<td>60-79</td>
<td>+8.8%</td>
<td>+20.3%</td>
<td>+52.1%</td>
</tr>
<tr>
<td>80+</td>
<td>+6.8%</td>
<td>+20.2%</td>
<td>+106.8%</td>
</tr>
</tbody>
</table>

Question: Is there a need to engage people approaching retirement age (people in their late 50s and 60s) in developing new ways of commissioning and providing future older people’s services?

If so how?

Question: Should we be targeting this age group now for prevention to ensure that they enjoy a healthy retirement?
Changing cultural diversity

Over the last fifty years the Scunthorpe steel mills have provided employment opportunities for residents of Scunthorpe and the surrounding area as well as for people migrating from Eastern Europe, Ireland, and more recently from South East Asia. Many of these communities settled and have remained living in the Crosby, Town and Frodingham areas of Scunthorpe.

In 2001, there were an estimated 3,800 residents from Black and Minority Ethnic (BME) communities in North Lincolnshire, representing just 2.5% of the local population, compared with 8% nationally. By 2005, this population was estimated to have grown by more than a third to 5,400, or 3.5% of the local population. The largest BME communities are people of Indian, Pakistani and Bangladeshi heritage. These communities tend to be much younger than the white population, reflecting differences in fertility patterns as well as historic patterns of migration to this country. Currently, we estimate there are no more than 275 people aged 65+ in our BME communities, with little growth in this older BME population expected in North Lincolnshire before 2015.

New Communities

Official population estimates and projections do not take account of the likely impact of more recent migrants to North Lincolnshire as they are not well recorded in official statistics. These include Kurdish refugees as well as economic migrants from the Baltic and the European expansion states, attracted to the area by the availability of work on the farms and food processing plants around North Lincolnshire. Although it is hard to put precise figures on the numbers of recent migrants to North Lincolnshire, one 2005 study put the figure at between 1100-1500 a year, of which two thirds were estimated to be of either Kurdish, Eastern European or Portuguese origin. The vast majority are young single men, although this number also includes a significant number of families with school aged children. It is not known how many of these migrants will stay in the long term, and what impact they have on local services.
Changing child population
In 2006 there were an estimated 30,000 children under 16 living in our area, and just over 8000 16-19 year olds. This represents a decline of 2000, or 5% fewer under 20s, since 1991. Between now and 2015 the under 16 population is projected to fall by a further 1000 and is only projected to return to 2006 levels by 2029.

Although this is a much faster rate of decline than predicted in many other districts in our region, these projections do not take account of the recent increase in live births, both nationally and locally. Following a long period of decline, the number of births in North Lincolnshire now appears to be rising, increasing by an average of just over 3% per year between 2003-7. Factors may include differences in fertility patterns between different ethnic groups, better maternity leave, as well as a better understanding of the problems associated with conceiving later. It is too early to say whether this trend will continue.

Number of live births to North Lincolnshire PCT residents 1996-2007

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<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Births</td>
<td>1702</td>
<td>1677</td>
<td>1662</td>
<td>1521</td>
<td>1629</td>
<td>1563</td>
<td>1570</td>
<td>1606</td>
<td>1680</td>
<td>1759</td>
<td>1819</td>
<td>1836</td>
</tr>
</tbody>
</table>

Due to different fertility patterns, the number of children from BME communities is increasing faster than the white population and is rising fastest amongst younger children. In 2007, 5% of school aged children were from BME communities, with at least half as many more BME children in reception classes as in Year 11.

Official estimates of the child population also fail to reflect the recent arrival of migrant workers, many of whom have dependent children. Between 2005 and 2007 an estimated 400 5-15 year olds from Eastern Europe enrolled at our primary and secondary schools, the majority enrolling with schools in central Scunthorpe, close to areas with relatively affordable, temporary accommodation.

Question: What is the current and likely future impact of these trends on health and social care services? Are the needs of our increasingly diverse population being met? How do services need to be commissioned differently to address anticipated future needs?

Changing complexity of need
Although the child population has declined over the last two decades, children’s services have been presented with growing levels and complexity of need, with recent advances in medical technology meaning that more children with severe disabilities and quite complex health conditions are surviving for longer.

Conservative estimates suggest that 9 new young adults per year will require the support of specialist adult learning disability services in North Lincolnshire over the next 10 years. All of these young people have highly complex needs and are heavy users of health and children’s services. Many have recurrent health problems and are likely to require frequent admissions to hospital as adults as well as significant specialist social care support. Currently, five of these young people are placed in special boarding schools outside of the area, at an annual cost to local services of £620,500.

Our understanding and recognition of children in need (and particularly children at risk of or subject to neglect or abuse) has also improved over the years, meaning that children who come to the attention of statutory services often have quite complex emotional needs which are far more complex than they were 10 or 15 years ago, and which are often significantly more expensive to meet. Vulnerability to mental health problems in childhood tends to be predictive of problems in later life. As some of these emotionally damaged young people get older they are likely to need continuing adult health and social care support.

Changing work and caring responsibilities
Even if the number of live births continued to rise over the next 10 years, this would have little impact on the size of the working age population in North Lincolnshire for some 20 years.

If the current structure of employment remains the same, we can expect increasing dependency on a declining and ageing workforce, many of whom will have increased caring responsibilities. As the number of older people rises, we should expect an increased demand for both paid and unpaid care in North Lincolnshire.

Question: What implications do these changes have for the health and social care workforce?

Question: How will services manage with a smaller proportion of people of working age and a bigger proportion becoming service users?

Currently, an estimated 1 in 7 (4650) female workers and 1 in 9 (4240) male workers in North Lincolnshire are caring for someone with a health problem or disability, the highest rates being amongst men and women aged 45-59 years. Of these, about a quarter spend at least 20 hours a week caring for someone outside work hours.

Over time it seems most of us will need to combine both paid and unpaid work, whatever our circumstances. However, the burden of informal care is likely to fall heaviest on those with the least resources. Those with the heaviest caring responsibilities tend to be clustered in low paid jobs, often in low paid care work. Working age people from Pakistani and Bangladeshi communities are twice as likely to live with someone with a limiting long term illness. They are also more likely to experience poor health themselves. This suggests growing numbers of family carers amongst these BME communities.

Question: What can we do to support the changing needs of working carers and reduce inequalities in the burden of caring?

We should also expect an increase in the amount of care provided by older people, especially spouses. This is because of a projected rise in female employment, a decline in the number of children living with their parents in older age and increasing numbers of childless older people.

It is clear that older people’s care services would collapse were it not for the work of informal carers, many of whom are themselves in their later years. In 2001, an estimated 3,330 people aged 65 years and older provided unpaid care for others in North Lincolnshire. Of these more than a third said they carry out more than 50 hours of unpaid care a week. Older carers are of particular concern as they are more likely to be suffering from ill health themselves.
Changing communities
As in other parts of the country, there has been a steady movement of people out of the town to more suburban and rural settlements. Between 1991 and 2005 the population of Scunthorpe and Bottesford declined by just over 6000 people (8%), whilst the rural population of North Lincolnshire grew by twice this number, (12,000 more people), increasing in size by 16%. Currently, more than half of our resident population lives outside the urban areas of Scunthorpe and Bottesford.

The age profile of our urban and rural populations has also shifted over time, with our rural population ageing faster than our urban communities.

The graph below shows where our 65-74 year olds (the largest group of pensioners in North Lincolnshire), currently live and (all things being equal), where we would expect to see population growth by 2015. Assuming no change in migration patterns amongst our existing 55-64 year olds, (and assuming that premature deaths are evenly distributed across North Lincolnshire) we should expect the number of 65-74 year olds in our rural areas to increase by almost 70% over the next 10 years, compared with a 28% growth in Scunthorpe and Bottesford.

The largest growth is expected in some of our more affluent areas, including Bottesford and the villages to the west and south of Scunthorpe.


Questions: How does the movement of people out of the inner urban areas affect the way health and social care services need to be provided? Will older people choose to live nearer amenities? Are new housing developments in our urban and rural areas going to affect the way services are delivered?

Widening inequalities
Average earnings have been rising steadily in North Lincolnshire, and in 2007 were above the regional average, at £25,979 per annum. This, in part, reflects the high proportion of people employed in shift work in North Lincolnshire, with many people working much longer hours than the national average. It also reflects rising earnings amongst those with the highest incomes.

On average, levels of poverty and low income in North Lincolnshire are not very different to the national picture. Unemployment rates are lower than in many neighbouring authorities and have remained at or below national rates for at least the last decade. Currently, 13% of our working age residents are dependent on out of work benefits, the same as the national average.

The proportion of North Lincolnshire residents who rank amongst the fifth most income deprived in the country is also falling, whilst the number in the richest fifth is increasing fast. This is good news for North Lincolnshire residents and reflects the increasing fortunes of many local people. However, it also suggests a growing income gap between our richest and poorest residents.

As well as national population projections, North Lincolnshire Council has produced household forecasts, based on planned new residential developments. Between now and 2026 the Council anticipates an increase of at least 700 new homes per year, with between 30-40% of these new homes being built on brownfield sites. By 2016 there are likely to be 7500 new homes in North Lincolnshire, including large sites on Doncaster Road, and the Lakeside areas of Scunthorpe, as well as a large site in Crowle on the Isle of Axholme.

In addition it is estimated that the South Humber Bank will provide up to 10,000 jobs, with homes for these workers being built in and around Scunthorpe. North Lincolnshire Council has also recently submitted an expression of interest to the Department of Communities and Local Government to become a ‘Growth Point’. If successful, this could lead to a further 3000-5000 homes over the next 20 years, in an area to the west of Scunthorpe town.

The map below shows the distribution of our most and least income deprived residents. Those areas highlighted in red represent areas where at least 1 in 4 residents are dependent on means tested benefits, placing them amongst the poorest 20% in the country. The white areas, which include places such as Bottesford, Goshill, Messingham, Burton upon Stather, Scawby and Broughton, as well as the Kingsway area of Scunthorpe, rank amongst the 20% least deprived (or most affluent) areas in the country.

% North Lincolnshire residents in national income groups, 2004 – 7

The large growth in more affluent areas, such as Bottesford and the areas to the west and south of Scunthorpe, has resulted in a larger proportion of our population being in the least deprived groups. This is illustrated in the graph above, which shows the estimated distribution of our 65-74 year old population in 2005 and 2015.

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As the map shows, the most acute problems of unemployment, poverty and low income are concentrated in the urban wards of Crosby and Park, Brumby, Ashby and Frodingham and Town. Some of these areas, most notably Crosby and the Acorns (Brumby and Ashby ward areas) in Scunthorpe, have been the focus of successive regeneration initiatives over the last two decades, and in recent years have been targeted as priority areas for health improvement.

Inequalities in health and well being in these priority areas have been highlighted in recent health and social needs assessments as well as neighbourhood profiles1 and include:

• Lower than average male life expectancy
• Higher than average premature death rates from coronary heart disease and cancer
• Lower rates of educational attainment and employment
• Higher than average teen conception rates
• Higher rates of adult smoking
• Higher risk of crime and disorder
• Higher rates of renting
• Higher levels of long term illness and disability
• Higher rates of mental ill health
• Higher rates of alcohol and substance misuse
• Lower levels of community participation
• Higher rates of people living alone

Although the quality of life of all residents has improved over the last decade, this has improved fastest for those on higher incomes. As a result, the health and well being status of those on the lowest incomes has not kept pace with our better off residents.

If those on higher incomes continue to be drawn to rural North Lincolnshire, we should expect the concentration of poor health in our urban areas to become even more pronounced.

Question: How can health and social care services work more proactively with local communities and partner agencies to address these rising inequalities?

Changing households

Lengthening life expectancy, smaller family size, divorce and separation, have contributed to a rise in one person households. Currently, an estimated 18,400 people live alone in North Lincolnshire, including more than 10,000 people of retirement age, an increase of 12% on the previous decade. Of these lone pensioners, more than a third will have a disability or limiting long term condition.

Problems of isolation amongst older people are likely to become greater with changing family structures and greater mobility in the working age population. By 2025, the number of older people living with a long term condition is expected to grow by more than 60%, the largest growth being amongst those aged 75+. Of these older pensioners, an estimated 45% are forecast to be living alone.

Projected 65-75 year olds and 75+ living alone in North Lincolnshire

<table>
<thead>
<tr>
<th>Year</th>
<th>65-74</th>
<th>75+</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>3,980</td>
<td>6,180</td>
</tr>
<tr>
<td>2010</td>
<td>4,230</td>
<td>6,380</td>
</tr>
<tr>
<td>2015</td>
<td>5,120</td>
<td>7,200</td>
</tr>
<tr>
<td>2020</td>
<td>5,400</td>
<td>8,290</td>
</tr>
<tr>
<td>2025</td>
<td>5,560</td>
<td>10,150</td>
</tr>
</tbody>
</table>

Question: How can we best support an increasing number of older lone pensioners?

Changing expectations

Older people’s expectations are changing and so the aspirations and preferences of people currently in their 60s are likely to be very different from their counterparts 20 years ago. Their attitudes in older age are also more likely to be influenced by their own observations about the adequacy of care for their parents’ generation.

The ‘baby-boomer’ generation who will be in their 70s in the next two decades are already showing signs of change in their approach towards their later lives, demanding greater choice and quality from health and social care services and more control over their own care. They are also more affluent than previous generations of pensioners and are likely to expect much higher standards of care from health and social services. National research already provides evidence that younger people are less satisfied with health services than older generations of health service users.

Those in their mid 50s and 60s are also more likely than previous generations to want to remain living independently in their own homes, and for as long as possible. Perhaps demanding new and potentially more cost effective ways of supporting their needs at home, through initiatives like supporting people, telecare or individualised budgets.

Question: How can health and social care commissioners prepare for these changing expectations?

Question: Health and social care services are not cheap and are likely to become more expensive over time. How can we ensure equitable access to these new types of services?
North Lincolnshire over the last decade and a half, and at a faster rate than nationally, already exceeding national targets for a 40% reduction by 2010 from a 1995-7 baseline.

- Premature deaths from cancer have also declined in North Lincolnshire since 1995-7 and are on course to meet the national target for a 20% reduction by 2010.

However, there is still significant scope for improvement.

- In spite of continuing improvements in health for all social groups, there are significant inequalities in health outcomes between men and women, and between the least well off in North Lincolnshire and the population as a whole.
- We know from national research evidence that there are significant inequalities in health outcomes by ethnicity in North Lincolnshire.

4.2 Improving health and reducing inequalities in health

Given the socio economic profile of North Lincolnshire and its residents as a whole, we would not expect the health status of our population to differ markedly from the rest of the country. On many indicators of health and well being we compare well with the national average, and exceed national trends in some key health improvement areas.

- The proportions of people who report they have a disability or are in poor health are similar to the national average in North Lincolnshire, both for people of working age and older.
- The number of deaths per head of population, a national measure of health improvement and health inequality, has fallen year on year in North Lincolnshire, and at a faster rate than nationally.
- Life expectancy at birth is rising steadily and is currently 76.2 years for males and 81.1 years for females in North Lincolnshire. This is a significant improvement on previous years and means that our rates are now much closer to national figures.
- Most of this improvement is accounted for by a reduction in premature deaths from circulatory diseases, (such as heart disease and stroke). These have fallen steadily in

<table>
<thead>
<tr>
<th>Age at death</th>
<th>Men</th>
<th>Women</th>
</tr>
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<tbody>
<tr>
<td>0-14</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>15-24</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>25-44</td>
<td>30</td>
<td>14</td>
</tr>
<tr>
<td>45-54</td>
<td>91</td>
<td>59</td>
</tr>
<tr>
<td>55-64</td>
<td>166</td>
<td>111</td>
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<tr>
<td>65-74</td>
<td>277</td>
<td>287</td>
</tr>
<tr>
<td>75-84</td>
<td>151</td>
<td>312</td>
</tr>
</tbody>
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As the data show, men are much more likely than women to die prematurely. Currently 44% of deaths amongst men occur prior to their 75th year, compared with 27% of female deaths. This gender difference is reflected in local life expectancy at birth figures, with almost a five year difference in life expectancy between males, (76.2 years) and females (81.1 years).

The most common causes of death amongst men and women of all ages are cancer, coronary heart disease, and stroke.
Amongst men who die under the age of 75, the most common causes of death are coronary heart disease (CHD) which accounts for just under 20% of premature deaths, lung cancer and cancer of the oesophagus, which account for 13%, and lung diseases such as chronic bronchitis and emphysema, (COPD), which account for 7% of early deaths. Amongst women, CHD accounts for 10% of premature deaths, breast cancer 10%, lung cancer 10%, and COPD 4%.

Social inequalities in life expectancy

Whilst the number of premature deaths has fallen in all social groups over the last decade, the gap in life expectancy between our poorest and richest residents, (i.e. those living in the most and least deprived fifth of areas, or quintiles in North Lincolnshire), has widened during this period.

Trends in all age, all cause mortality in North Lincolnshire

As the graphs show, early deaths from coronary heart disease, lung cancer and chronic obstructive lung diseases such as bronchitis and emphysema, (COPD), contribute most to the gap in life expectancy, between our poorest males and the North Lincolnshire average, all of which are smoking related.

The graphs show the contribution that the different causes of death make to life expectancy amongst our most deprived fifth of residents. This is expressed in terms of the number of years gained or lost to their life expectancy, had they the same death rate from each cause as North Lincolnshire residents as a whole.

Smoking

Smoking is the leading cause of preventable ill health and premature mortality in North Lincolnshire and contributes most to inequalities in early deaths, both here and elsewhere in the country. We estimate that about 155 men and 100 women die from smoking related diseases in North Lincolnshire each year, with more than 2000 people being treated in hospital for smoking related illnesses.

We know from national data that people on low incomes are more likely to smoke, to smoke heavily, and to be less successful in their attempts at quitting than other income groups.
There is no equivalent data source for monitoring smoking by income group in North Lincolnshire, although national estimates suggest that smoking rates are likely to be highest in our most deprived areas and amongst men from some of our minority ethnic communities. Local GP practices record data on the smoking status of their patients, and offer advice, and in some cases treatment, to help people stop smoking. In addition, specialist smoking cessation services record smoking outcomes for those who sign up to quit with their services. All of these data sources could potentially help us target our tobacco control measures more effectively and reduce the incidence of smoking related diseases in our community.

Inequalities in diet and physical activity

Obesity is the second biggest preventable cause of ill health and death after smoking. It is also increasing in this country. In 1992, the Government produced the ‘Health of our Nation’ White Paper. At that time the target was to reduce levels of obesity, so that by 2005 no more than 6% of adult men and 8% of adult women were classified as obese. Thirteen years later, the national rates are 25% amongst men and 25% amongst women. By 2010, it is predicted that 1 in 3 men, (33%) and more than 1 in 4 women (28%) will be obese in this country and by 2020 nearly 60% of us could be obese. Dealing with this could result in a six-fold increase in NHS costs alone, from £1 billion in 2007, to £6.5 billion.

Currently, levels of obesity and physical inactivity are higher in North Lincolnshire than the national average.

Whilst we have no robust local data on the income distribution of these lifestyle factors in our adult population, national data suggest that rates of obesity and relative inactivity are highest amongst men and women in the lowest income group, with the gap being particularly pronounced for women. With so many chronic diseases being related to excess body weight, we should expect both a rise in obesity related diseases in North Lincolnshire over the next decade and beyond, as well as increasing inequalities in the distribution of these chronic diseases.

The graph below shows the relationship between income and chronic disease found in a national study.

The graph below shows the social gradient in early death rates from coronary heart disease in North Lincolnshire, with rates of premature death rising with increasing levels of income deprivation.

Premature death rates from CHD per 100,000 by income (local income deprivation deciles). 2001-6 pooled data

So, just as poorer people tend to die younger – they are also more likely to enter old age in poorer health, with the prevalence of many long term conditions being more common amongst older adults on low incomes.
In North Lincolnshire there is considerable geographical variation in self reports of long term illness amongst people aged 65+; the difference being as much as 10% higher for those living in Brumby and Crosby and Town wards, than for the same age group living in the more affluent areas of Bottesford, Burton upon Stather and Broughton and Appleby. Because of under reporting of poor health amongst people on lower incomes, the gap in poor health in older age could be even greater than this.

These health inequalities in older age tend to be made worse by other factors such as low income, isolation from family and friends, poor access to facilities, fear of crime, limited access to social networks, poor housing, poor transport, as well as ageism and discrimination.

Older people also make up 75% of those living in poorly insulated homes and are at particular risk of fuel poverty and cold related illnesses and deaths. There is also evidence from national studies that social isolation can directly affect the health of older people. Social networks and social supports have a proven role in reducing cardio-vascular disease, susceptibility to infection and depression amongst older people. The graph below shows the number of contacts per fortnight that older people said they had with 12 different groups of people. This survey was undertaken in North Lincolnshire in 1998 and shows how contact declined with increasing age.

Factors that can trigger social isolation amongst older people include:

- Assuming a caring role
- Low income
- Onset of illness or disability
- Lack of transport

Access to transport within the household is both essential and desirable, especially for older people who live in rural areas. Older people take far less journeys than working age residents, but two thirds of their trips are accounted for by shopping and other essential personal business. According to 2001 Census data, at least half of our over 70s had no private transport, with car ownership being lowest in the rural area of Barton and the Acorns area of Scunthorpe.

Currently, about 1 in 7 pensioners in North Lincolnshire (15%) are dependent on means tested benefits, rising to more than 1 in 3 in some of our most deprived areas. The vast majority of these are older women (aged 80+) living on their own.

4.3 Staying healthy

The NHS is already committing considerable resources in GP and hospital services aimed at reducing premature deaths from the major killer diseases. This includes helping people with high blood pressure, high cholesterol and diabetes to manage their condition effectively and identifying patients who are at high risk of developing heart disease and stroke. Earlier detection of cancer and shorter waiting times for diagnosis and treatment are also helping to reduce premature deaths, as are improvements in medical technology and cancer care.

However, it is estimated that at least half of the reduction in deaths from coronary heart disease and other circulatory diseases over the last decade is due to lifestyle factors, such as improved diet and reduced smoking. Reductions in obesity and smoking, as well as improvements in diet and exercise, are also expected to have an impact on cancer mortality rates in the longer term.

The Director of Public Health’s 2007 Report for North Lincolnshire identified three key priority areas for health improvement over the next three years which are likely to have a major impact on our population’s future health if they are not adequately addressed. They include tackling coronary heart disease, maintaining a healthy bodyweight, and tobacco control. Other important issues include the promotion of mental health and emotional well being amongst our local population and encouraging sensible drinking.

All of these issues are related to each other and are closely linked to income and deprivation. Targeting preventive resources at those at greatest risk of developing poor health is therefore likely to deliver significant savings to health and social services in the longer term.

Question: Deprivation indicator scores alone provide an indicator of where preventive resources could be targeted to reduce inequalities. Are we making best use of this information to commission services and monitor inequalities in health and wellbeing outcomes?

Local agencies are already working hard to address these and other important public health issues in North Lincolnshire. However, none of them are going to be resolved overnight. Many of these health damaging behaviours have been many years in the making and could take just as long to undo. So intervening early, to prevent health problems setting in amongst future generations of adults is clearly important. However, encouraging and supporting people in their late 50s and 60s to take responsibility for their future health will also be critical to delivering health and well being improvements in the next decade and beyond. Research evidence suggests that small changes in lifestyle behaviours can make a big difference to health and well being, whatever our age.

Question: Within finite finances, have we got the balance right between spending resources on treatment as opposed to prevention? Are we targeting our preventive resources effectively?

Healthy weight
Of all age groups, it is people in their mid 50s who are most likely to be overweight or obese, putting them at much greater risk of developing diabetes, heart disease, arthritis, stroke and some cancers in later life. Being overweight or obese can also exacerbate these diseases, making it harder for people to recover from ill health and to manage their condition effectively.

If obesity levels continue to rise, as predicted, at an average 2% per year, we should expect significant health and social care consequences in the years to come. For example, the graph below shows the estimated number of people with Type 1 and 2 diabetes in North Lincolnshire in 2001, and then projects the numbers forward to 2010, holding current levels of obesity constant (in light blue) and then applying predicted increases in obesity (in dark blue).

Estimated no of people with diabetes in North Lincolnshire 2001-2010

For most us, an unhealthy weight is caused by eating or drinking more calories than we use. Remaining active in our middle years and older not only reduces our risk of some chronic diseases, as we reach our 70s and older it can help us to maintain our mobility, reduce the risk of osteoporosis, back pain and osteoarthritis, as well as helping to prevent accidental falls. Yet nationally it is estimated that 40% of our over 50s are sedentary, rising to 65% amongst women aged 85+. 

Smoking
Official estimates of the number of adults who smoke in North Lincolnshire range from 27.1% of all resident adults, to 22.5% of all adult GP patients whose smoking status is recorded. Whichever estimate we use, the number of people at significant risk of smoking related ill health and early death in North Lincolnshire is staggering, with at least 25,000 adult smokers at risk.

Although smoking tends to decline with increasing age (people tend to die younger of smoking related diseases) rates of smoking amongst men over 50 years have not changed since 1998. Because of their age, they are also more likely to have smoked for longer, and more heavily than other younger smokers. Currently, an estimated 19% of people aged 55-64 years of age and 13% of people aged 65 years and older smoke, representing more than 7000 people in North Lincolnshire, or almost 30% of all adult smokers.

This age group are more likely than other smokers to have regular contact with health services, presenting professionals with more opportunities to encourage them to quit. Yet there is some national evidence that health professionals often overlook this older group of smokers for cessation advice and that older people are less aware of smoking support services than other age groups. As a result, older smokers don’t tend to be targeted for cessation support, in spite of evidence that health is improved and mortality reduced by quitting smoking at the age of 65 or older.

Alcohol
There is very little detailed information on the drinking habits of older people in this country. However, as for other people, we know that alcohol consumption has risen amongst this age group over the last two decades – with an estimated 17% of men and 7% women aged 65+ exceeding the government’s recommended daily alcohol limit. (That is, more than 3000 older people in North Lincolnshire). This compares with 48% of adult men and 40% of women of all ages.

Factors which can trigger hazardous drinking in older people are the same as for other groups and include bereavement, mental stress, physical ill health, loneliness, isolation and loss. However, because of the ageing process older people’s tolerance threshold tends to be lower, increasing the risk of falls, incontinence, and exacerbating problems like insomnia and memory loss. They are also at significantly greater risk of hypertension and stroke. Like older smokers, older drinkers are more likely than other age groups to come into regular contact with our health services, presenting professionals with more opportunities to engage them in brief interventions. Yet there is no evidence that this is happening locally.

The benefits of screening in later life
Breast cancer is one of the leading causes of cancer deaths amongst women, both in North Lincolnshire and across the country as a whole. The incidence of breast cancer and the number of deaths from this disease per 100,000 in North Lincolnshire are similar to the national and regional average. It is estimated that breast cancer screening reduces mortality by 35% amongst those who participate.

Uptake of the breast screening service is good in our area, at more than 75% of those invited to attend. This is above the national average. Nevertheless, this means that a quarter of women who could benefit from the screening programme are not doing so. We know from national research that uptake is generally lower amongst lower income groups, women with physical and learning disabilities and some minority ethnic communities. However we do not know how these rates compare within North Lincolnshire. We need to understand more about the potential barriers to access.

It is estimated that about 1 in 20 of us will develop bowel cancer during our lifetime. It is the third most common cancer in the UK, and the second leading cause of cancer deaths, with an average of 18 people under the age of 75 dying from it each year in North Lincolnshire. Bowel cancer screening aims to detect bowel cancer at an early stage (in people with no symptoms), when treatment is more likely to be effective, and has been shown to reduce the risk of dying from bowel cancer by 16 per cent.

As part of the roll out of the national bowel cancer screening programme North Lincolnshire PCT plans to offer screening to all 60-69 year olds, every two years, beginning in August 2008.

Question: What more can local agencies do to promote these healthy living services and ensure that they are accessible to all?

Housing conditions
As we get older, we tend to spend more of our time indoors. Living in a property which is comfortable, warm, well equipped and can be suitably adapted to our changing needs is likely to make a significant difference to our future quality of life, including our mental health and well being. It might also help prevent a fall. For those of us who are recovering from an operation, or who have a chronic disease or disability, the house that we live in could mean that we are able to remain at home for longer or return home from hospital faster.

Although much of our local housing is in a decent condition and in a reasonably good state of repair, too many of our homes are unsuitable for the needs of an ageing population. A recent housing needs assessment estimated that up to a quarter of our older disabled population are living in unsuitable housing, the largest improvement required being for specific adaptations to the home. Currently, older people account for more than half of all social housing tenants in North Lincolnshire, with an additional 1200 people aged 60+ currently on the housing waiting list.

As our population ages and more care is provided closer to home, the demand for home adaptations, aids and equipment is likely to grow. Any new properties will therefore need to have the potential for assistive technology features, such as stair lifts, and for ground floor bedrooms, shower rooms and bathrooms.

The private sector has already begun to recognize the commercial potential of our older population, with large national retirement home providers, such as McCarthy and Stone and Golden Living, building new retirement complexes in both Scunthorpe and Brigg. A number of other smaller developments are also underway, specifically aimed at the older person’s market, showing that a real niche sector of the housing market is beginning to develop in North Lincolnshire.

There are also some smaller more specialist developments planned in the social housing sector, including a flagship Extra Care housing scheme in Scunthorpe, and a small number of specially adapted bungalow properties under construction in Epworth.

Question: What more can we do to ensure that future housing developments include a sufficient number of properties that can be modified to meet the changing needs of our ageing population?

Telecare is another growth area which potentially offers significant cost savings, enabling older people to remain living safely at home for longer, giving them and their carers peace of mind. Although, most people will have heard of pendant alarms, telecare equipment can go much further than this, from monitoring vital signs, (teledermatic medicine), to preventing accidents in the home, and reducing older people’s sense of isolation and loneliness. Yet older adults of all ages tend to underestimate the type and levels of adaptations they are likely to require as they get older.

Question: Given the preferences of older people to remain in their own home for as long as possible, what more could be done to promote and develop the potential of new aids and adaptations, including telecare?

Opportunities for leisure learning employment and volunteering post retirement have also been shown to be vitally important to maintaining older people’s physical and mental health in later life. In fact many people remain in employment past 60 and 65 years of age, and in the future it is evident that many more of us will have to do so.

Currently an estimated 1 in 4 people aged 65-74 years of age engage in voluntary and community activity in North Lincolnshire, whilst almost 1 in 3 people aged 65-74 volunteer in their spare time.

Are we capitalising on existing opportunities to recruit and train retired people as volunteers within health and social care services?

Is that what our retired population want?

4.4 Living long and living well

Life expectancy in North Lincolnshire has risen by 2.6 years over the last decade and is showing no signs of slowing down, with rates increasing fastest among men. If life expectancy continues to rise each decade at current trends, by 2030 the number of people aged 85 years and older in our population will be nearly twice what it is now.

Projected numbers of older people living in North Lincolnshire (2008-2025)

<table>
<thead>
<tr>
<th>Age</th>
<th>2008</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>60-4</td>
<td>11,200</td>
<td>11,700</td>
<td>11,000</td>
<td>11,900</td>
<td>13,800</td>
</tr>
<tr>
<td>65-9</td>
<td>8,600</td>
<td>9,200</td>
<td>11,500</td>
<td>10,900</td>
<td>11,800</td>
</tr>
<tr>
<td>70-4</td>
<td>7,300</td>
<td>7,600</td>
<td>8,700</td>
<td>10,900</td>
<td>10,300</td>
</tr>
<tr>
<td>75-9</td>
<td>5,700</td>
<td>5,800</td>
<td>6,700</td>
<td>7,700</td>
<td>9,800</td>
</tr>
<tr>
<td>80-4</td>
<td>4,100</td>
<td>4,200</td>
<td>4,700</td>
<td>5,500</td>
<td>6,500</td>
</tr>
<tr>
<td>85+</td>
<td>3,400</td>
<td>3,700</td>
<td>4,200</td>
<td>5,000</td>
<td>6,100</td>
</tr>
</tbody>
</table>

Getting older does not necessarily mean getting sicker. In fact, many people in their eighties and older, are active and independent and regard themselves as in good health, accepting loss of physical function as a natural and inevitable part of the ageing process. However, as people age, the frequency of ill health and disability tends to increase. So, as our population lives longer it is likely that a significant proportion of these additional years will be spent managing a long term condition.
Most people with long term conditions lead active and independent lives, and manage their condition well with the support of primary care professionals and other community based services. A small number have very complex needs and require specialist case management support to help them manage their condition effectively.

Long term conditions (LTCs)

Long term conditions are those that cannot as yet be cured, but can be controlled by medication and other therapies. Nationally, it is estimated that a third of the population live with at least one long term condition.

Common long term conditions include:
- Osteoarthritis
- Coronary Heart Disease & Heart Failure
- Stroke & TIA
- Diabetes
- Dementia
- Chronic Obstructive Pulmonary Disease (COPD)
- Epilepsy
- Cancer
- Chronic kidney disease

A number of these long term conditions (LTCs) have later onset, and so are likely to increase in number as our population ages. Across the country as a whole, it is estimated that more than three quarters of people aged 75 years and older have one or more long term conditions, with more than a quarter having three or more. The graph below shows national estimates of the prevalence of LTCs per 100 residents by age.

Life expectancy and healthy life expectancy at age 65 in North Lincolnshire

![Graph showing life expectancy and healthy life expectancy at age 65 in North Lincolnshire](image)

Proportion of people with LTCs by age

![Graph showing proportion of people with LTCs by age](image)

Nevertheless, people with LTCs are the most intensive users of health services, accounting for an estimated 80% of all GP consultations, and about 37% of hospital bed days nationwide. The table below gives the number of people in North Lincolnshire who are currently known to have a specific long term condition and who are included on GP practice disease registers. (N.B. These data refer to GP patients of all ages in the PCT). Currently, an estimated 670 people in North Lincolnshire are receiving intensive case management support.
As our population ages, it is likely that the number of people living with more than one of these conditions will increase. People with long term conditions are already supported to self care at home, thus avoiding the need for expensive hospital treatment. If the number of people with LTCs increases as predicted, then early detection and self support services are likely to become much more important in the future.

**Table: GP patients with a diagnosed long term condition**

<table>
<thead>
<tr>
<th>Condition</th>
<th>No of NL PCT patients (March 2007)</th>
<th>% of NL PCT patients (March 2007)</th>
<th>% of all English GP registered patients (March 2007)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>24,330</td>
<td>14.8%</td>
<td>12.5%</td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>7,590</td>
<td>4.6%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>6,990</td>
<td>4.2%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Chronic kidney disease</td>
<td>5,950</td>
<td>3.6%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Stroke/TIA</td>
<td>3,000</td>
<td>1.8%</td>
<td>1.6%</td>
</tr>
<tr>
<td>COPD</td>
<td>2,780</td>
<td>1.7%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Cancer</td>
<td>1,530</td>
<td>0.9%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Heart failure</td>
<td>1,430</td>
<td>0.9%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>1,300</td>
<td>0.8%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Severe mental illness</td>
<td>1,120</td>
<td>0.7%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Dementia</td>
<td>664</td>
<td>0.4%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Severe learning disability</td>
<td>410</td>
<td>0.3%</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

As our population ages, it is likely that the number of people living with more than one of these conditions will increase. People with long term conditions are already supported to self care at home, thus avoiding the need for expensive hospital treatment. If the number of people with LTCs increases as predicted, then early detection and self support services are likely to become much more important in the future.

**Question:** Given finite monies, have we got the balance right between supporting self-care, and providing specialist services/case management?

At the same time we will need to take action to reduce the prevalence of risk factors in our younger adult population. For example, heart disease, stroke, kidney disease and diabetes all share common risk factors, such as smoking, high blood pressure and lack of physical activity. They also serve as risk factors for each other.

**Questions:** What more can we do to reduce disease risk factors in our local population and promote healthier living amongst adults in their middle years?

What long term conditions affect us as we get older?

It should be remembered that most of us will continue to enjoy good physical and mental health in older age. Becoming ill or disabled should therefore not be regarded as an inevitable consequence of ageing. However, as we approach older age we are more likely to be affected by physical conditions such as arthritis, diabetes, hypertension, stroke and heart disease than younger adults. We may also be affected by mental health conditions such as dementia.

Again many of these conditions share common lifestyle related risk factors, including a fatty diet, smoking, low levels of physical activity and alcohol misuse. Others are caused by a more complex interplay of factors, including our genetic make up, as well as the ageing process itself. Those people on lower incomes, who live in our more deprived areas are much more likely to suffer from LTCs than their wealthier neighbours. They are also less likely to access care that might help them manage these conditions effectively.

Whilst cancer is less common than some of these other conditions, the incidence of some cancers tends to increase as we reach older age, the most common being non-melanoma skin cancer, lung cancer, bowel cancer, breast cancer in women and prostate cancer in men.

More common in older age are difficulties with sight and hearing. Around 80% of people over 60 have a visual impairment, 75% have a hearing impairment, and 22% have both a visual and hearing impairment. All of which can affect our ability to self care in older age. Currently there are an estimated 2,600 people aged 75+ in North Lincolnshire who are blind or partially sighted.

**Diabetes:** Nationally, the number of people diagnosed with the disease has doubled over the last decade, with this expected to increase by more than 2% per year between now and 2010. Type 2 diabetes makes up more than 90% of diabetes prevalence and usually develops after the age of 55.

An estimated 4,000 people aged 65+ in North Lincolnshire, (14%), have either type 1 or type 2 diabetes, including 1 in 5, (20%), of those aged 85+. This is higher than the national average. The prevalence of diagnosed diabetes amongst older nursing and care home residents is estimated to be as high as 1 in 4.

**Coronary Heart Disease:** Prevalence of CHD (angina or heart attack) is estimated to be 6.9% amongst 55-64 year olds, (1,470 people) 15.2% amongst 65-74 year olds (2,230 people) and 23% amongst those aged 75+, (307 people). A total estimated prevalence of 6,770 amongst people aged 55+ in North Lincolnshire. CHD is strongly linked to deprivation, with those on the lowest fifth of incomes being 50% more likely to suffer from CHD than their counterparts in the highest fifth of incomes. The poorest 20% are also least likely to access secondary care.

**Heart failure** is estimated to affect about 3% of the adult population aged 45 years and older (a total of 2,130 people in North Lincolnshire). Most new cases of heart failure tend to be amongst people aged 75 years and older and so prevalence tends to rise sharply in older age, to almost 7% of people aged 75-84 years (700 people) and 14% of those aged 85+ (500). This is significantly more than are currently recorded on GP registers, suggesting that a large number of patients may not be getting access to appropriate diagnostic tests and subsequent treatment.

Prevalence of both CHD and heart failure is expected to increase in the next 20 years as the older population increases and the number surviving heart attacks rises.
Hypertension: Hypertension is a major risk factor for stroke and other cerebrovascular diseases, and for heart disease. Prevalence increases with age in women, but not for men, reaching a peak in those aged 80-4 years. Just under half of adults aged 55-64 are estimated to be hypertensive, (10,500 people), and 59% of women aged 65-69 years, (1180), rising to 71% of those aged 80+, (3380).

Osteoarthritis: By far the most prevalent chronic disease amongst people aged 65 plus, and especially amongst older women, is arthritis. Osteoarthritis is the most common, and is estimated to affect more than two thirds of people over the age of 65 (at least 18,500 people), commonly affecting the hips, knees, feet, fingers and spine. Contributory factors include age, being female, joint injury, previous surgery, obesity, muscle weakness and occupation.

Stroke: An estimated 280 - 350 people are affected by stroke in North Lincolnshire each year, of which three quarters are aged 65+. National data suggest that 1 in 4 people who reach the age of 85 can expect to suffer a stroke during their lifetime. Deaths from stroke have been declining year on year in North Lincolnshire, so we should expect to see an increasing number of older people living with the effects of stroke.

Chronic Obstructive Pulmonary Disease (COPD): COPD is a term used to describe a number of breathing problems where there is permanent damage to the breathing tubes and air sacs within the lung. It encompasses chronic bronchitis and emphysema. The prevalence of spirometry defined COPD is estimated to be as high as 13% amongst people aged 35 years and older, (5.8% with mild COPD, 5.5% with moderate COPD and 1.9% with severe COPD). Applied to local population data this suggests that there may be as many as 13,100 NLPCR registered patients aged 35+ who have the disease, of which about 1900 will have severe or very severe COPD.

Long term exposure to cigarette smoke is the primary cause and so this disease is largely preventable. For many older people with COPD, the initial damage was caused before the health consequences of smoking (and passive smoking) were fully understood. Prevalence of COPD is therefore much higher amongst smokers and ex smokers and tends to increase with age, affecting an estimated 46% of people aged 65+ who smoke.

Dementia: Latest national estimates suggest an estimated 6% of the older population have dementia, (1,900 older people in North Lincolnshire), of which 15% (290), will have the most severe form of dementia. Age is the strongest risk factor associated with dementia, with prevalence increasing sharply after the age of 65, and doubling with every additional five years of life. Even so, less than half of those who reach the age of 95 years will develop the condition. Vascular risk factors such as hypertension, Type 2 diabetes, high cholesterol, dietary fat intake, obesity and stroke are all considered to be important risk factors, not just for vascular dementia, but also for Alzheimers.

Depression: Depression is estimated to affect between 11-15% of our older population, (between 3,000-4,200 older people in North Lincolnshire), with between 3-5% (870-1,400) experiencing depression in its most severe form. Prevalence of depression almost doubles for older people suffering ill health and disability.

Estimated Costs
Long term conditions can be extremely costly, not only in monetary terms to health and social care services, but also in terms of the emotional and financial impact on those who live with the condition. Close family and friends may also be required to provide significant levels of informal care. The following examples give an indication of the size of the costs incurred, and the financial burden carried by health and social care services, as well as informal carers.

Dementia: It is estimated that the average annual costs of dementia per person in the UK, including formal and informal care, are £25,472. Accommodation accounts for 43% of the total costs, informal care 36%, social services costs 15%, and NHS costs 8%. For those people living in care homes, the average costs are estimated at £31,262 per year.

Stroke: Each stroke is estimated to cost the NHS £3000 a year. When the costs to community care services and informal carers are added, the total annual cost comes to more than twice that figure at £7,300.

COPD: The average annual costs to the NHS of caring for someone with severe COPD are estimated at £1307, £1307 for someone with moderate COPD and £149 for someone with mild COPD.

Projected forward
One recent national report projects the following increases in disease prevalence amongst our older population over the next 20 years as follows. This is based on expected trends in age specific prevalence of disease as well as population trends.

- CHD amongst people aged 65+ increased by 42%
- Arthritis amongst 65+ increased by 42%
- Stroke amongst 65+ increased by 46%
- Moderate dementia amongst 65+ increased by 43%.

Other models, based on applying current rather than expected disease prevalence to population forecasts suggest a higher percentage increase between now and 2025. Based on these trends, the table below forecast the number of older people in the population whose day to day activities are likely to be limited by one or more of these conditions.

<table>
<thead>
<tr>
<th>Condition</th>
<th>2008</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>733</td>
<td>772</td>
<td>909</td>
<td>1028</td>
<td>1201</td>
</tr>
<tr>
<td>Heart attack</td>
<td>2028</td>
<td>2140</td>
<td>2523</td>
<td>2799</td>
<td>3129</td>
</tr>
<tr>
<td>Severe Depression</td>
<td>1445</td>
<td>1530</td>
<td>1790</td>
<td>1995</td>
<td>2215</td>
</tr>
<tr>
<td>COPD</td>
<td>640</td>
<td>680</td>
<td>810</td>
<td>890</td>
<td>980</td>
</tr>
<tr>
<td>Registered blind or partially sighted</td>
<td>2640</td>
<td>2760</td>
<td>3120</td>
<td>2640</td>
<td>4480</td>
</tr>
<tr>
<td>Dementia</td>
<td>2050</td>
<td>2163</td>
<td>2480</td>
<td>2848</td>
<td>3377</td>
</tr>
<tr>
<td>Incontinence problem</td>
<td>3220</td>
<td>3380</td>
<td>3880</td>
<td>4300</td>
<td>4740</td>
</tr>
<tr>
<td>Unable to manage at least 1 ADL mobility activity on their own</td>
<td>4474</td>
<td>4656</td>
<td>5360</td>
<td>6104</td>
<td>7128</td>
</tr>
<tr>
<td>Unable to manage at least 1 ADL self care activity on their own</td>
<td>9262</td>
<td>9768</td>
<td>11308</td>
<td>12782</td>
<td>14674</td>
</tr>
</tbody>
</table>

Source: POPPI, CSIP, 2007/8
Adults with a learning disability
At the same time we should expect to see an increasing number of adults with severe learning disabilities surviving into older age. Currently it is estimated that 2.5% of the adult population, (an estimated 3220 adults in North Lincolnshire) has a moderate or severe learning disability, (SLD), with 0.1%, an estimated 130 adults in North Lincolnshire, having very profound and complex needs.

People with learning disabilities tend to have much poorer health than the general population, with higher rates of respiratory problems, diabetes, heart disease, thyroid disorders, and epilepsy, as well as musculoskeletal problems. They are also more likely to have sensory and physical disabilities, as well as mental health problems, which tend to increase in severity as they get older.

The prevalence of dementia is much higher amongst adults with SLD, with adults with Downs Syndrome having an age of onset of dementia that is 20-30 years younger than the general population. According to national estimates at least half of those with Down Syndrome who are aged 60-69 years are affected by dementia, compared with 6% of the general population aged 65+. Those with learning disabilities not due to Downs Syndrome, are 4 times more likely to be affected by dementia in their 60s than the general population.

National projections suggest at least a 1% annual increase in the adult population with SLD over the next 15 years, with most of this increase being accounted for by an increasing number of adults surviving into older age. We should therefore expect to see an increasing number of adults with SLD presenting with early onset dementia, alongside increasingly complex health needs.

Most adults with SLD in North Lincolnshire live in the community, more than 80 in supported tenancies. However relatively few of these adults are in paid employment, and there is a shortage of supported housing for those who wish or need to leave the family home.

Currently, about half of all adults with severe learning disabilities live with their families, often beyond the age of 40. However this could change with the next generation of family carers, as expectations change or as pressures on family life increase. Specialist services know of at least 40 adults with very severe learning disabilities who are still living with family carers who are in their 70s and 80s. It is likely that most of these adults will require alternative accommodation between now and 2012. This suggests that we will need to find an average of 10 new supported living placements a year to accommodate this group of adults alone.

Currently just over 100 adults with SLD who are supported by North Lincolnshire’s specialist services live in specialist residential and/or nursing home care. These adults have significant health and personal care needs, which could be difficult to meet in community settings. At the same time there are an increasing number of children and young people with very complex needs surviving into adulthood, as well as an increasing number of adults surviving into older age, often with complex mental health needs. Both groups are likely to be heavy users of health and social care services in the future.

These demographic changes are likely to have significant implications for health and social care commissioners in the future, as many services are just not geared up to meeting the needs of adults with very complex needs in the community. Currently, those adults with the most profound disabilities are either cared for by their families at home, or in nursing or residential care. With learning disability budgets already under significant pressure, care home placements are unlikely to be an option for many of these adults. Nor is it likely to be their or their families’ placement of choice.

**Question:** What additional services are likely to be needed to support an increasing number of adults with profound disabilities living in the community?
The reasons for these admissions vary. Some are planned and include procedures to remove cataracts, as well as diagnostic procedures and follow up treatments for cancer. Others are unplanned and include falls, heart attacks, urinary infections, strokes as well as respiratory infections. The top 10 causes of emergency and planned admissions for older people are listed in the tables below.

**Planned admissions to hospital of North Lincolnshire patients aged 65+ 2006/7**

<table>
<thead>
<tr>
<th>Primary Diagnosis Description</th>
<th>65-74</th>
<th>75-84</th>
<th>85+</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cataract, unspecified</td>
<td>175</td>
<td>289</td>
<td>91</td>
<td>555</td>
</tr>
<tr>
<td>Follow-up examination after surgery for malignant neoplasm</td>
<td>138</td>
<td>133</td>
<td>35</td>
<td>306</td>
</tr>
<tr>
<td>Senile nuclear cataract</td>
<td>71</td>
<td>149</td>
<td>57</td>
<td>277</td>
</tr>
<tr>
<td>Malignant neoplasm of bladder, unspecified</td>
<td>91</td>
<td>135</td>
<td>12</td>
<td>238</td>
</tr>
<tr>
<td>Anaemia, unspecified</td>
<td>91</td>
<td>105</td>
<td>29</td>
<td>225</td>
</tr>
<tr>
<td>Atherosclerotic heart disease</td>
<td>121</td>
<td>51</td>
<td>3</td>
<td>175</td>
</tr>
<tr>
<td>Myelodysplastic syndrome, unspecified</td>
<td>97</td>
<td>28</td>
<td>32</td>
<td>157</td>
</tr>
<tr>
<td>Hyperplasia of prostate</td>
<td>70</td>
<td>75</td>
<td>11</td>
<td>156</td>
</tr>
<tr>
<td>Other primary gonarthrosis</td>
<td>98</td>
<td>50</td>
<td>4</td>
<td>152</td>
</tr>
<tr>
<td>Haemorrhage of anus and rectum</td>
<td>75</td>
<td>38</td>
<td>14</td>
<td>127</td>
</tr>
<tr>
<td><strong>Total 65+</strong></td>
<td><strong>1027</strong></td>
<td><strong>1053</strong></td>
<td><strong>288</strong></td>
<td><strong>2368</strong></td>
</tr>
</tbody>
</table>

Source: North Lincolnshire PCT, 2007

**4.5 Emergency and planned hospital care**

Most people with long term conditions receive what health care they need in the community, from their GP and other community based health services. However medical conditions related to long term chronic diseases continue to consume a significant amount of hospital based resources. One of the reasons for this may be lack of support to help people self care more effectively in the community. Another might be lack of direct access to diagnostic techniques outside a hospital setting.

Examining data about hospital admissions can help us identify those services which could be more appropriately delivered within community settings, thus reducing unnecessary and costly hospital admissions.

As the graph across shows, with the exception of under 5s, the use of hospital care tends to rise steeply with increasing age, with people aged 85+ accounting for more than half, (51%), of all admissions to hospital beds in North Lincolnshire, (including day cases) and people aged 65+ accounting for more than a third, (35%).
Hospital admissions per 100,000 people aged 65+ in North Lincolnshire, 2006/7, (directly standardised rates)

<table>
<thead>
<tr>
<th>Condition</th>
<th>North Lincolnshire</th>
<th>National</th>
<th>Region</th>
<th>Comparison PCTs</th>
</tr>
</thead>
<tbody>
<tr>
<td>All causes, day cases</td>
<td>23,681</td>
<td>19,126</td>
<td>19,559</td>
<td>20,493</td>
</tr>
<tr>
<td>Elective admissions (excluding day cases)</td>
<td>8,973</td>
<td>8,403</td>
<td>8,519</td>
<td>8,533</td>
</tr>
<tr>
<td>Emergency admissions</td>
<td>20,618</td>
<td>19,833</td>
<td>20,907</td>
<td>21,475</td>
</tr>
<tr>
<td>CHD, day cases</td>
<td>349</td>
<td>460</td>
<td>463</td>
<td>439</td>
</tr>
<tr>
<td>CHD, elective</td>
<td>465</td>
<td>403</td>
<td>368</td>
<td>321</td>
</tr>
<tr>
<td>CHD, emergency</td>
<td>1,247</td>
<td>1,156</td>
<td>1,277</td>
<td>1,388</td>
</tr>
<tr>
<td>COPD, emergency</td>
<td>771</td>
<td>855</td>
<td>1,047</td>
<td>1,293</td>
</tr>
<tr>
<td>Hips, emergency</td>
<td>237</td>
<td>254</td>
<td>251</td>
<td>265</td>
</tr>
<tr>
<td>Hips, elective</td>
<td>441</td>
<td>442</td>
<td>451</td>
<td>436</td>
</tr>
<tr>
<td>Knees, elective</td>
<td>579</td>
<td>538</td>
<td>524</td>
<td>515</td>
</tr>
<tr>
<td>Stroke, emergency</td>
<td>429</td>
<td>621</td>
<td>601</td>
<td>637</td>
</tr>
</tbody>
</table>

We also have substantially shorter waiting times and lengths of stay for some of these planned hospital admissions, with average waiting times 17% lower than the national average and 10% lower than the average for Yorkshire and the Humber as a whole.

All planned hospital admissions per 100,000 people in 2006/7 (DSR)

<table>
<thead>
<tr>
<th>Inpatient Acute Care Planned/Elective</th>
<th>North Lincolnshire 1</th>
<th>National</th>
<th>SHA 1</th>
<th>Comparison PCTs 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting time for admission (overall mean in days )</td>
<td>71.6</td>
<td>85.8</td>
<td>79.8</td>
<td>79.6</td>
</tr>
<tr>
<td>Length of Stay (days)</td>
<td>4.3</td>
<td>6.2</td>
<td>5.7</td>
<td>4.9</td>
</tr>
<tr>
<td>CHD</td>
<td>4.2</td>
<td>4.4</td>
<td>3.9</td>
<td>4.4</td>
</tr>
<tr>
<td>Hips</td>
<td>8.0</td>
<td>8.5</td>
<td>7.5</td>
<td>7.8</td>
</tr>
<tr>
<td>Knees</td>
<td>7.5</td>
<td>7.8</td>
<td>7.1</td>
<td>7.0</td>
</tr>
<tr>
<td>Revascularization</td>
<td>5.3</td>
<td>7.3</td>
<td>4.7</td>
<td>5.3</td>
</tr>
<tr>
<td>Admissions per 100,000 – DSR adjusted</td>
<td>3,599</td>
<td>3,248</td>
<td>3,345</td>
<td>3,380</td>
</tr>
</tbody>
</table>

1 North Lincolnshire data are for 2006/2007
2 SHA data are for the entire Yorkshire and the Humber SHA for 2006/2007
3 Data for the comparison PCTs are the mean values for all PCTs selected for comparison

However, as the number of older people with long term conditions is set to grow in years to come, based on current trends, we should expect the pressure on hospital resources to increase.

Question: Have we got the balance right between investing in prevention, early treatment and emergency care?
Based on current trends, we should expect the demand for both formal and informal care to increase by 2-3% a year, as our population ages. By 2025, assuming constant rates of functional impairment amongst our older population, we should expect at least a 60% increase in the number of older people requiring high levels of support.

In very crude terms, if we apply current estimates of the number of older people living in care and nursing homes in North Lincolnshire to the forecast growth in our older population, we would need to expand the current capacity of the care home sector by at least 60% between now and 2025 to keep pace with this growth.

Projected numbers of older people living in a care home in North Lincolnshire based on current trends

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. aged 65+ living in a care home with or without nursing</td>
<td>1286</td>
<td>1366</td>
<td>1562</td>
<td>1826</td>
<td>2203</td>
</tr>
</tbody>
</table>

When asked, most older people and their carers would prefer not to approach local authority social services for help. When they do, this is typically at the point of crisis, when all other avenues have been exhausted. The most important reasons being:

- Health problems (physical and mental), functional disability, difficulties in performing activities of daily living (ADL), or a need for rehabilitation
- A lack of or breakdown in informal care, or stress on carers
- Poor or inappropriate housing
- Social reasons such as loneliness, fear of crime or abuse

Question: What more could local agencies do to tackle some of these wider issues? Are there other partners with a role to play?

There is some evidence that providing low level support services early on can delay the need for more intensive support, help older people to live for longer in their own homes, and reduce the pressure further down the line on health and social care services.

Examples of activities that older people say they have particular difficulty with include, help with cleaning, odd jobs around the home and garden, chiropody, using public transport, befriending, and help with private finances. Activities that many of us take for granted, but which become more difficult with increasing age and ill health. Many older people already get support with these tasks, often from other family members. Others pay for this sort of support. As our population ages the need for help with these kinds of activities is likely to grow. There are already a number of local programmes and initiatives aimed at filling the gap between informal care provided by relatives and more formal and intensive social care services, including Freshstart, Homelink and Independent Living. However, many of these low level support services are still relatively small scale and are heavily subsidized by public service monies.
highly rated aspects of the service were the Ambulance Service (84% satisfied) and the GP Service (83%). All other services achieved reasonably high satisfaction scores. However, people in North Lincolnshire were more negative about NHS dentist services than across the region as a whole.

Whilst these survey results are useful, they have their limitations. Because they are national, they tend to be questionnaire based, include only a small number of local people in their samples, and are not designed to capture information of local interest. For example, responses to questions about levels of satisfaction do not tell us much about the quality of the patient experience. They also tend to exclude people who do not use services, (although the NHS survey quoted above did not). As a result, a lot of the rich detail about how local people experience local services, including at neighbourhood level, is lost.

What concerns people most?
Other local sources of information include one off public consultation exercises, service evaluations, formal complaints, as well as patient/user/carer groups and advocacy services. Although it is difficult to generalise from some of these sources, some are based on one off or opportunistic studies, whilst others (such as complaints) are based on quite a small numbers of users. However, one of the overriding themes emerging from just a cursory analysis of these data sources suggests that lack of adequate information, and poor communication generally are common causes for concern amongst service users and can prevent people from accessing appropriate support and advice.

The future shape of public involvement?
Many of our older residents, use both health and social care services. They also pay council tax, use public transport, move around in public spaces, and a significant proportion live in social housing. The way that these services interact with each other can make a significant difference to older people’s quality of life.

Yet the Council, social services, housing associations, the local hospital trust, PCT, and police, tend to consult with these same people, at different times and in different ways. This can lead to consultation fatigue amongst our residents. It also makes it harder for agencies to share their results and plan improvements for a group of service users whose best interests they all have in common.

Question: How can we make best use of limited resources for public consultation and involvement across North Lincolnshire and build on existing best practice?
When people get involved in user consultation events, they expect to see some sort of return for their effort. Yet people often complain that they do not get to see or hear what difference their involvement has made. Whilst there are some excellent examples in North Lincolnshire of involving older people in evaluating services, these tend to be the exception rather than the rule. Evidence of how user views are informing joint commissioning and planning is therefore still quite patchy.

At the very least, the public should expect some sort of feedback on how their views have been received and what if anything has happened or is likely to happen as a result. Yet we know that this does not happen as often as it should.

Question: How can we ensure that this happens routinely within health and social care?
The Government is committed to devolving decision making down to smaller areas, giving people a much stronger voice in the delivery of their local services. This is likely to require more engagement with the public at both general practice and neighbourhood level. Some groups, such as neighbourhood actions teams, senior forums and Freshstart management committees, (made up of local people, including services users) already exist within some localities.

Question: How can we ensure that everyone’s voice is heard, including our most vulnerable residents?

Consulting with people who do not make as much use of services as they might, will also be important, and could help us identify barriers to access.

Question: How can we engage better with people who do not use our services?

Extending Choice and Control
The Government is committed to giving patients and social care users more choice and control over how, when and where they receive treatment and care. Over the last couple of years the PCT and the local authority have been responsible for developing these programmes in North Lincolnshire. For example, ‘Choose and Book’ is intended to give NHS patients more choice and control over where they receive hospital care, in much the same way as people who pay for private health care.

Since January 2006, GPs have been able to offer patients a choice from a list of 4 or more providers when booking them in for a specialist outpatient referral, including since April 2007, a choice between NHS and private providers. However, the latest national patient survey, (2007) indicates that less than half of those referred for an outpatient appointment across England were offered a choice. The results were somewhat better in North Lincolnshire placing us in the top third of PCTs nationally on these patient survey results.

Direct Payments go much further than this, and are designed to allow people who are eligible for publicly funded social care, to purchase and manage these care services directly. Direct Payments were introduced in North Lincolnshire in April 2005, and by March 2007 there were 73 social services clients (including carers) in receipt of these payments, of which 19 were aged 65 years or older. This is a massive improvement on the previous year and is a significant achievement in a relatively short space of time. However, because we started from quite a low baseline we still have a lot of catching up to do.

Information and advice
People will only be able to make meaningful choices about their treatment and care if they have access to good quality information and support. As self directed care and individualized budgets are rolled out, older people and their families are likely to need more support, including access to independent advocacy, to help them make choices about their treatment and care.

Ensuring that everyone has equal access to this information and support, including the most vulnerable in our communities will be important to prevent existing inequalities from widening.

Question: How can we ensure access to high quality information and advocacy in every neighbourhood?

Finally, it is worth noting that currently almost half of our electorate are aged 50+. People in their 50s and 60s tend to less politically aligned than previous generations, with poor quality care being cited by them as some of the key issues that might affect their future voting intentions. As our older population grows, local and national politicians will need to ensure that the views of this increasingly vocal population group are taken into account.