Northamptonshire County Council
Business Intelligence and Performance Improvement

Older People’s Needs Assessment
CONTENTS

Introduction .................................................................................................................. 5
Executive Summary ...................................................................................................... 6
Recommendations ......................................................................................................... 10
Northamptonshire ......................................................................................................... 11
Corby ............................................................................................................................. 13
Daventry ...................................................................................................................... 14
East Northamptonshire ................................................................................................. 15
Kettering ....................................................................................................................... 16
Northampton ............................................................................................................... 17
South Northamptonshire ............................................................................................ 18
Wellingborough .......................................................................................................... 19
Legislative context: the Care Act ................................................................................ 20
General responsibilities .............................................................................................. 20
Who is entitled to care and support? ......................................................................... 20
Older People in Northamptonshire – Demographic .................................................. 21
Population in Numbers ............................................................................................... 21
Gender.......................................................................................................................... 25
Ethnicity ...................................................................................................................... 25
Life Expectancy .......................................................................................................... 26
Risk Factors ................................................................................................................ 30
Smoking ....................................................................................................................... 30
Alcohol and Substance Abuse ..................................................................................... 32
Living Arrangements .................................................................................................. 37
Social Engagement and Loneliness ............................................................................ 41
Deprivation .................................................................................................................. 44
Frailty ........................................................................................................................... 48
Fuel Poverty ............................................................................................................... 50
Excess winter deaths ................................................................................................. 52
Causes of Deaths ........................................................................................................ 53
Cancer ......................................................................................................................... 53
Cardiovascular Diseases ............................................................................................ 56
Respiratory Diseases .................................................................................................. 59
Deaths from ‘Other’ Causes ....................................................................................... 61
Deaths from Liver Disease ................................................................. 62
Deaths from Communicable Disease .................................................. 63
Level of Need and Future Projection .................................................. 64
Support ............................................................................................. 64
Daily Living Tasks ............................................................................ 64
Carers ............................................................................................... 65
Physical Health .................................................................................. 67
Life Limiting Long term Illness .......................................................... 67
Heart Attack ....................................................................................... 70
Stroke ................................................................................................ 72
Bronchitis/Emphysema ................................................................. 74
Incontinence ..................................................................................... 75
Obesity ............................................................................................. 78
Diabetes ............................................................................................ 80
Mental Health .................................................................................... 82
Dementia ........................................................................................... 82
Depression ......................................................................................... 84
Learning Disabilities ......................................................................... 86
Autism .............................................................................................. 89
Mobility ............................................................................................. 90
Falls ................................................................................................... 90
Sensory Impairment ......................................................................... 93
Visual Impairment ............................................................................ 93
Hearing Impairment ......................................................................... 95
Adult Social Care (ASC) ................................................................. 97
Demographic .................................................................................. 97
Adult Social Care Contact With Older People .................................. 101
General Care Needs ........................................................................ 102
Adult Social Care Interventions ....................................................... 103
Placements for Over 65’s ................................................................. 104
Social Care Population Projections ............................................... 106
Social Care Population aged 50-64 ................................................... 106
ASC Spend and the likely level of future resourcing ......................... 108
People who fund their own care (self funders) ................................ 110
INTRODUCTION

People are living longer and the population of the whole of the UK is growing, it is also ageing. In the 2011 census, 9.2 million (16%) residents of England and Wales were aged 65 and over, an increase of almost 1 million from 2001 (8.3 million or 16%). Approximately 13% of this older population is aged 85 or more.

There are many challenges associated with an ageing population, not least for the individuals concerned. Quality of life, susceptibility to illness, keeping active and social isolation are just some of the issues facing the elderly in society. For organisations, the increasing need and the increasing cost of meeting that need is at odds with current budget levels. Keeping people active, independent and engaged at all ages is important, but the advantages for all in promoting and supporting healthy lifestyle choices, social inclusion and prevention strategies for older people are clear.

Northamptonshire is one of the UK’s fastest growing counties and as a result, more of the population of the county will be over 65. Out of all of our geographical neighbours, it is only Milton Keynes that is expected to see faster growth in the numbers of older people. 16.6% of Northamptonshire’s residents are aged 65 and above, 2% more than 5 years ago.

This document takes a snapshot of the current population of older people in Northamptonshire in the second half of 2014, and then projects the growth anticipated in the next 15 years. Wherever possible the data has also been presented at borough and district level.

For the purpose of this JSNA chapter, the term ‘older people’ has been defined as those over the age of 65. In some sections, data relating to a lower group has been included, either by necessity or to inform, as today’s 50-65 year olds are tomorrow’s older people. Also wherever possible the data has been split further by age as the ‘older older’ (depending on the data source this means people aged over 75 or 85), will have more pressing and complex needs than their younger neighbours.

The data used in producing this chapter has been sourced by Northamptonshire County Council’s Business Intelligence and Performance Improvement team (BIPI) unless referenced otherwise. The data used to create the figures in this document has been included in the separate annex. References to figures and the annex have been highlighted in the text for the convenience of the reader.
EXECUTIVE SUMMARY

DEMOGRAPHY

There are 117,400 over 65’s in Northamptonshire, 16.6% of the county’s population.

The highest proportions of older people are in South Northamptonshire, Wellingborough, East Northamptonshire and Daventry.

There has been rapid growth in older populations in the last 5 years.

Numbers of over 80’s have doubled in the last 20 years.

The older population is expected to grow by a further 50% by 2030.

There are expected to be almost twice as many people over 80 in the county by 2030.

There are approximately 10,000 more older females than males.

As Northamptonshire’s population ages, it becomes less ethnically diverse.

LIFE EXPECTANCY

Since 2002, life expectancy from birth for Northamptonshire residents has increased by 2 years for females and 3 years for males.

Life expectancy for both genders is highest in South Northamptonshire and lowest in Corby.

A man in South Northamptonshire can expect to live almost 5 years more than a man in Corby.

Corby has the lowest life expectancy in the county, but it is growing at a faster rate than other areas of Northamptonshire.

Daventry and Northampton have seen a fall in life expectancy in recent years.

RISK FACTORS

Smoking - Despite a lower prevalence of smoking in older age groups compared to younger age groups, men over 60 typically smoked around 15 cigarettes a day, women over 60 smoked 13. The national average for all ages is 12.7, which indicates that older smokers are more likely to smoke more cigarettes per day than other age groups.

Alcohol – Older people tend to drink more than younger generations and research suggests that lowering the recommended alcohol intake guidelines for older people would be beneficial due to the physiological and metabolic changes of the aging process.
Substance abuse – The number of people aged 40 and above in drug treatment programmes is increasing, as is the use of drugs, cannabis in particular, in over 50s. A recommendation from a national organisation is that GPs could screen for late onset drug use.

Around 37% of over 65s in Northamptonshire live alone, nearly 26,000 are over 75. Living alone increases the risks associated with falls, functional impairment, poor diet, smoking and social isolation.

Loneliness and social isolation can have implications for physical health and lead to higher rates of mortality. The numbers of over 65s living alone in Northamptonshire by 2030 are expected to increase by up to 50% in some areas and the increase in over 75’s living alone could almost double.

There is no recognised measure of frailty, however if the number of emergency readmissions to hospital within 30 days of discharge is considered a measure of frailty, residents of Kettering, Corby and Northampton are most likely to be frail.

Excess winter deaths are much higher than national, regional and county averages in Corby, Daventry and Northampton, particularly amongst the over 85 population.

CAUSES OF DEATH

Cancer – Almost two thirds of cancer diagnoses are in over 65s, a third in over 75s. The risk of developing cancer can still be reduced by making lifestyle changes even in later life. Cancer incidence rates and mortality in Northamptonshire are slightly higher than national levels, oesophageal and prostate cancers have the highest incidence rates and mortality in Northamptonshire.

Cardiovascular disease (CVD) – 3 out of every 10 deaths worldwide are caused by CVD. Rates of CVD resulting in death are statistically similar to national averages in Northamptonshire.

Respiratory diseases – Deaths from respiratory disease are much higher in the Corby CCG area than the England average. Prevalence of respiratory disease in the Nene CCG area are also higher than England average, but not to the same margin as Corby CCG.

Liver disease – An inequality between genders exists in Northamptonshire in regard to liver disease. The number of deaths from liver disease is much higher for females than for males in Northamptonshire. This high level of incidence for females pushes the county average for all persons above the average for England.
LEVELS OF NEED AND FUTURE PROJECTIONS

The fastest growth in older populations is anticipated to be in Daventry, South Northamptonshire and East Northamptonshire.

The growth in older populations will generate increases in demand for all services and particularly in the areas of the county noted above. The percentage growths in demand are anticipated to be between 40% and 50%, depending on the condition and the area.

As the level of need increases, so will the number of unpaid carers and the number of hours of care provided by these unpaid carers. Over 80% of unpaid carers said they would like support with their emotional and mental health.

The main body of this document contains projections to 2030 for the following physical conditions – life limiting long term illness, heart attack, stroke, bronchitis/emphysema, incontinence, obesity, diabetes, mobility concerns, falls and sensory impairments (hearing and visual). The pattern of growth across the region is similar for all these conditions.

The document also contains projections for learning disabilities and mental health conditions such as dementia, depression and autism.

SOCIAL CARE

Of the 9,487 Adult Social Care (ASC) clients in 2014/15, 2,957 were aged 65 to 84 and 3,574 were aged 85 and over. 1,162 were aged 50 to 64.

The age of ‘peak demand’ for ASC services is 75. Two thirds of the ASC cohort are female.

In the last 10 years the total number of adults accessing ASC support fell by 43%. Despite this overall fall, demand for dementia support has remained constant.

Projections on the future number of ASC clients show an increase from 7,602 in 2011 to 9,369 in 2021.

South Northamptonshire has the highest proportion of older residents in the county but just 9% of the ASC client base. 27% of the client base live in Northampton.

The age of entry to care is significantly lower amongst residents of Corby and Wellingborough. Life expectancy is lower in Corby as mentioned previously, however in Wellingborough life expectancy is above the county average. This could indicate an issue in Wellingborough around service demand.

The average age of an ASC client over 65 is 83.1 in Corby and 85 in South Northamptonshire.
Half of ASC clients receive support with their personal care. The next most common support reason is memory and cognition at 20%.

Numbers of self-funders in Northamptonshire are estimated at around 5,000. Approximately 3,450 are self-funding residential care.

Delayed transfers of care from hospitals are more common in Northamptonshire than regionally and nationally, although a smaller portion of these can be attributed to ASC in Northamptonshire than these comparators.

Northamptonshire is behind local, national and comparative authority averages in terms of rehabilitation with a smaller number of older people who are still at home 90 days after discharge from hospital.

Northamptonshire is also behind national, regional and statistical neighbour averages for the percentage of older people in reablement services after leaving hospital. The number of older people being admitted to a care home following a hospital discharge is higher than the regional national and statistical neighbour averages.

**ACCOMMODATION**

Northamptonshire currently has 83 care homes and a further 50 care homes with nursing and 304 properties specifically designed for older people, for example sheltered housing complexes.

Northamptonshire has a 70% undersupply of enhanced sheltered housing available to rent or on leasehold and a 46% deficit in extra care housing on the same basis.

In the next 20 years there could be a need for a doubling of the supply of supported accommodation for older people in Northamptonshire if predicted population rises are realised. Nursing care levels in East Northamptonshire are already beyond the predicted numbers for 2020.

Current statistics show shortages in supply in all areas, the most significant in enhanced care and extra care housing. Corby is highlighted as a high priority area to consider development. Significant shortages shown in all sectors with the exception of nursing care make Daventry another high priority area.

Significant shortages in the enhanced sheltered and extra care sectors with demand and supply in the different tenure options (leasehold for enhanced and rented for extra care) indicate that East Northamptonshire is another area for development. Kettering shows deficits in all areas except residential care. Northampton has an oversupply of sheltered housing but a considerable undersupply of enhanced (very sheltered) housing. There are significant shortages in all sectors except nursing care in South Northamptonshire. In Wellingborough there is demand for enhanced sheltered housing but no supply. There is also a 43% deficit in the supply of residential care in this borough.
RECOMMENDATIONS

An ageing population means an increase in demand for support and for services. This is occurring at the same time as budgets are being reduced. Focussing on preventative measures to attempt to stop conditions related to aging from deteriorating to the point that interventions and support are required would be beneficial to both the individual and to the state. Encouraging healthy lifestyle choices such as quitting smoking, improving diet, increasing physical activity would help with this. Also ensuring a safe, comfortable and clean environment, a pleasant place to live and a feeling of community by ensuring levels of crime are low and transport services are adequate, opportunities for social engagement are plentiful and community based schemes are promoted would further assist.

Improve access to health services. There is a discrepancy of over 17,000 between the number of over 65s living in Northamptonshire and the number of over 65s registered with a Northamptonshire GP.

Screen for substance misuse in older people. General practitioners can screen every patient over 65 for substance abuse as part of their routine health check using specific tools. Screening could also include cognitive testing.

Development of age specific smoking cessation interventions. Whilst the focus on smoking prevention or encouraging smokers to quit is rightfully focussed on younger audiences, older people would still see real health benefits if they quit.

Improve access to services to reduce isolation. Locate areas with high concentrations of older people, particularly older people living alone, and locate relevant services in these areas.

Focus on prevention to reduce risk factors associated with cancers. Incidence of cancer in Northamptonshire are higher than national averages.

Encourage the development of a diverse care market and social care offer to reflect the diversity of need within the older population.
Northamptonshire

**Better**
- Sight loss due to macular degeneration or glaucoma
- Deaths related to cardiovascular disease
- Hospital admissions as a result of a fall
- Smoking attributable mortality
- Lung cancer incidence

**Worse**
- Female life expectancy at birth
- Deaths related to oesophageal cancer
- Deaths related to respiratory disease
- Delayed transfer of care from hospital
- Excess winter deaths, people aged 85 and over
- Mortality related to mental illness in older people
- Older people at home 91 days after leaving hospital into reablement
- Mortality related to communicable diseases, particularly amongst older males
- Mortality in females aged 65 and over related to liver disease and 'other' causes
- Deaths related to respiratory disease considered avoidable in females aged 65-75
- Under 75 mortality from cancer and under 75 mortality from cancer considered preventable
- Rates of older people permanently admitted to a residential or care home following discharge from hospital
In 2014, 117,400 people living in Northamptonshire were over 65 years of age. This represents 16.6% of the county’s total population. The proportion of older people in the district populations is higher in the more rural areas of the county, the two lowest proportions of older people in the population are in the urban areas of Corby and Northampton. However, despite only representing 14.2% of the town’s population, the largest number of older people live in Northampton.

The over 65 population of Northamptonshire is 97% White. The gender split is 49.2% male, 50.8% female. The gender split of older people accessing support from Adult Social Care is around 66% female. Life expectancy at birth and at age 65 in Northamptonshire is close to the UK and regional averages, from birth the life expectancy for Northamptonshire is 79.1 for males and 82.7 for females. Peak demand for support from Adult Social Care (ASC) services occurs around age 75.

Northamptonshire is amongst the fastest growing areas in the country and this trend is replicated by the older population of the county. People are enjoying longer lives, but with this increase in life expectancy comes an increase in need amongst an older population who will be becoming more frail, susceptible to diseases and incapacity.

The most populated area of the county is Northampton and it is home to the greatest numbers of older people, however in terms of the proportion of the population, the over 65 population here is lower than the average figures for the county and for the country. The more rural areas of the county have higher proportions of the total population aged 65 or above, areas such as Daventry, South Northamptonshire, East Northamptonshire and Wellingborough have a higher proportion of older people, though actual numbers are lower than Northampton.

As people with disabilities are living longer, the number of older people requiring support from ASC with learning difficulties is increasing. Around half of the 50-64 age group accessing ASC are doing so in relation to learning disabilities. More than half of over 85 year olds providing unpaid care in Northamptonshire are providing in excess of 50 hours care per week.
Levels of deprivation are higher in Corby than the rest of the county. Life expectancy is lower and the needs of older people are greater at an earlier age. Some key points relating to Corby are below. 14% of Corby’s residents are aged 65 and over, around 9,000 people – the lowest proportion in the county. The gender split is 49% male, 51% female. Life expectancy at birth in Corby is 77.3 years for males and 80.2 for females – lowest levels in the county. There is a difference of 4.9 years in life expectancy between a male in Corby, and one in South Northamptonshire, and 4.2 for females in the same localities.
Daventry is expected to see the largest increase in the older people population in the county over the next 15 years. Along with that population increase will come an increased demand for support. Daventry features as the fastest and highest growth area for older people in many measures.

14,700 residents of Daventry are aged 65 and over, making up 18.7% of the district’s population. The gender split in Daventry is 49.9% male, 50.1% female. Life expectancy from birth in the district is 79.5 years for male residents, 83.5 for females.
East Northamptonshire

Better

- Deaths from respiratory disease in people aged 65-84
- Cancer deaths in all persons aged 85 and over
- Deaths from cardiovascular disease
- Smoking attributable mortality
- Households in fuel poverty
- Deaths from lung cancer
- Excess winter deaths

Worse

- Deaths related to prostate cancer
- Cancer deaths in males aged 65-84
- Deaths related to oesophageal cancer
- Hospital admissions as a result of a fall
- Deaths related to respiratory disease in over 85's
- Cardiovascular disease related deaths in females aged 65-84

East Northamptonshire is expected to see one of the highest increases in the population of older people and their needs in the coming 15 years. 16,500, or 18.7%, of East Northamptonshire residents are aged 65 or over. The gender split is 49.5% male, 50.5% female. Life expectancy from birth for a resident of East Northamptonshire is 80 years for a male and 83.1 years for a female.
Numbers of older people, and their need, is increasing across Northamptonshire and Kettering is no exception. The changes in population and demand across the areas looked at in this chapter follow the median for the county. Demand is not expected to be higher in Kettering than in other areas, but nor is it expected to be lower.

Kettering is home to around 16,500 residents aged 65 and over, accounting for 17.2% of the borough’s population. The gender split of older residents in Kettering is 49.2% male, 50.8% female. Life expectancy from birth is 79.2 years for a male, 82.7 for a female.
Northampton is the largest area of population in the county and has the highest absolute numbers of people and the highest absolute numbers in terms of need. It is expected to see growth across all age groups and particularly amongst older people as are other areas of the county. The increase in need for older people in Northampton is consistent with the rest of the county, Northampton is only the most in need in the following cases, all other measures are similar to the average levels across all seven boroughs.

Northampton is home to approximately 30,700 residents aged 65 and over, 14.2% of the total population of the borough. The gender split is 49.3% male, 50.7% female. Life expectancy from birth for a resident of Northampton is 77.4 years for males, 81.8 years for a female.
South Northamptonshire is a mostly rural area and enjoys the lowest levels of deprivation in Northamptonshire. The population of South Northamptonshire is older than in other areas of the county and is anticipated to see higher than average increases in this population. In terms of need, residents of South Northamptonshire tend to have a longer life expectancy which means that the needs associated with older age are higher here. A summary follows below.

The district is home to approximately 16,400 residents aged 65 and over, 18.8% of the total population –highest in the county. The gender split is 49.4% male, 50.6% female. Life expectancy from birth for a male in South Northamptonshire is 82.2 years and 84.4 for a female – the highest levels in the county.
Wellingborough is set to see increases in the numbers of older residents and the associated increases in need in that population, but the increases are less pronounced than in other parts of the county. Although Wellingborough will see lower increases than other areas, the town will still see significant increases in numbers.

Approximately 13,600 people over 65 live in the borough of Wellingborough, 18.7% of the total population. The gender split in this borough is 49.2% male, 50.8% female. Life expectancy from birth in Wellingborough is 80 years for a male, 83.7 for a female.
LEGISLATIVE CONTEXT: THE CARE ACT

The Care Act\(^1\) “represents the most significant reform of care and support in more than 60 years”\(^2\). The Act is particularly relevant to older people, as they constitute the largest proportion of users of social care. The main implications of the Act are outlined below, with a detailed analysis of the main areas of focus in Annex 1.

GENERAL RESPONSIBILITIES

Under the Care Act, local authorities will take on new functions. These are aimed at improving people’s independence and wellbeing. This is to make sure that people who live in their areas:

- receive services that prevent their care needs from becoming more serious, or delay the impact of their needs;
- can get the information and advice they need to make good decisions about care and support;
- have a range of providers offering a choice of high quality, appropriate services.

WHO IS ENTITLED TO CARE AND SUPPORT?

The Act creates a single, consistent route to establishing an entitlement to public care and support for all adults with needs for care and support. It also creates the first ever entitlement to support for carers, on a similar basis.

The Act is also clear about the steps that must be followed to work out this entitlement, to help people understand the process. It follows the person’s ‘journey’ in the care and support system, and includes an assessment of needs, eligibility and financial circumstances.

---

1. Care Act 2014
2. Norman Lamb 2014
Of Northamptonshire’s 706,600 residents, 117,400 (16.6%) are aged 65 and over (Figure 1). This is very similar to the proportion of older people in England relative to the general population, 16.68%. The proportion of older people in the district populations is higher in the more rural areas of the county, as opposed to the urban areas of Corby and Northampton. However, despite only representing 14.2% of the town’s population, the largest number of older people live in Northampton, the largest urban area of the county. Figure 2 shows where in the county the 117,400 over 65’s reside and figures 3 and 4 show the 65 to 84 year old and the over 85 year old populations of the LSOA areas of Northamptonshire as a percentage of the population of each area.

<table>
<thead>
<tr>
<th>Area</th>
<th>Population 65+</th>
<th>% 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northamptonshire</td>
<td>117,400</td>
<td>16.6</td>
</tr>
<tr>
<td>Corby</td>
<td>9,000</td>
<td>14</td>
</tr>
<tr>
<td>Daventry</td>
<td>14,700</td>
<td>18.7</td>
</tr>
<tr>
<td>East Northamptonshire</td>
<td>16,500</td>
<td>18.7</td>
</tr>
<tr>
<td>Kettering</td>
<td>16,500</td>
<td>17.2</td>
</tr>
<tr>
<td>Northampton</td>
<td>30,700</td>
<td>14.2</td>
</tr>
<tr>
<td>South Northamptonshire</td>
<td>16,400</td>
<td>18.8</td>
</tr>
<tr>
<td>Wellingborough</td>
<td>13,600</td>
<td>18.7</td>
</tr>
</tbody>
</table>

---

3 https://www.nomisweb.co.uk/query/construct/summary.asp?mode=construct&version=0&dataset=31
Figure 3: Distribution of Population Aged 65-84 by LSOA, Percentage of Population 2013

Figure 4: Distribution of Population Aged 85 and Over by LSOA, Percentage of Population 2013

http://www.northamptonshireanalysis.co.uk/dataviews/report?reportId=137&viewId=195&geoReportId=5012&geoId=58&geoSubsetId=

http://www.northamptonshireanalysis.co.uk/dataviews/report?reportId=137&viewId=195&geoReportId=5012&geoId=58&geoSubsetId=
The population of Northamptonshire, similarly to the population of the country, is increasing. Since 1992, the proportion of over 65 year olds in the population of Northamptonshire has risen from 14.4% to 16.6%, see Figure 5.

Figure 5: Percentage of Population aged 65 and over

Most of that growth has happened in the last 5 years.

The over 80 population of the county is increasing proportionally with the increase in the wider population. In 1992, the proportion of residents aged 80-84 was 2%, in 2013 it was 2.1%. The percentage of the county population aged 85 and above has grown more substantially, up from 1.5% in 1992 to 2.1% in 2013. But these proportional figures only tell a part of the story. In terms of numbers of residents aged over 80, the increase is almost double (Figure 6).

Figure 6: Numbers of residents aged 80 and over

Numbers of over 80’s in Northamptonshire

The proportion of older people is anticipated to increase at a faster rate than other age groups. The over 65 population of Northamptonshire is predicted to increase by 51% by 2030, a rate higher than the country and the East Midlands. Figures taken from POPPI (Projecting Older Persons’ Population Information System) predicted the over 65 population of Northamptonshire in 2014 to be 121,700. Figure 7 shows the projected percentage increase. By 2030 POPPI estimates that the population aged 65 and over in Northamptonshire will be 184,000 and of those, 32,400 will be aged over 85.
As Figure 8 shows, the over 80 population is set to grow almost twice as quickly as the over 65 population. Northamptonshire is predicted to have a greater increase in over 65 population than all neighbouring authorities with the exception of Milton Keynes, which is predicted to have a considerably higher increase than anywhere else in the region. The closest of the neighbouring authorities in terms of older people’s population increase is Cambridgeshire.

The complete data, including absolute numbers by country, region, county and district can be found on tab 1 of the accompanying annex 2.
GENDER

Females have a higher life expectancy than males and as a result, there are more elderly female residents than male, by approximately 10,000 (Figure 9).

The split between males and females aged over 65 is approximately 46/54. Absolute numbers and projected growth are shown in annex 2, tab 2. The proportions of the overall population by age band and gender are shown on tab 3.

ETHNICITY

The ethnicity of the older population of the county is less diverse than regionally and nationally. Northampton and Wellingborough display the highest ethnic diversity. Comparison between Figures 10 and 11 demonstrates that ethnicity varies by age with a relatively larger proportion of White people in the older age groups.

Data relating to ethnicity can be found in tab 4 in the accompanying annex 2.

Figure 9: Northamptonshire age/gender distribution 2014

http://www.neighbourhood.statistics.gov.uk/HTMLDocs/dvc183/index.html#0/205/7/null/false/false/na/1
LIFE EXPECTANCY

Life expectancy at birth and at age 65 is increasing across the country and Northamptonshire follows the trend. A female living in 2012 in Northamptonshire can expect to live almost two years longer than was the case in 2002 (life expectancy from birth). For men, the increase in life expectancy over the same period is 3 years. Figures 13 and 14 show life expectancies at birth and at age 65 for male and female residents of Northamptonshire from 2000 to 2012 compared to the regional and national figures.

Across Northamptonshire’s seven districts and boroughs residents can enjoy a longer life, but inequalities still exist. For example a female in Corby would have a life expectancy from birth 4.2 years lower than the 84.4 years a female resident of South Northamptonshire could expect. This discrepancy is replicated in the male population, Corby’s life expectancy for males (at birth) is 77.3, almost five years lower than a resident of South Northamptonshire (Figure 15). Life expectancy at birth projections can be found in annex 2, tab 7.


8 http://www.poppi.org.uk/index.php?pageNo=318&PHPSESSID=9f7ptanfrcrkpqv6dvlen3o4e5&sc=1&loc=8269&np=1
Life expectancy at age 65 is no longer increasing and life expectancy at birth for females is not increasing in Northamptonshire at the same rate as in the East Midlands or nationally.

When looking at life expectancy from the age of 65, it is clear that the rate of increase is higher in the male population than female. The age gap between genders is closing as a result. Once again life expectancy is highest in South Northamptonshire and lowest in Corby, however most recently Corby has been improving at a faster rate than other areas, Daventry and Northampton have seen a decline in life expectancy for both males and females. This data is presented in annex 2, tab 8.

In terms of disability free life expectancy, residents of Northamptonshire have longer disability free life expectancy than others in the East Midlands and England (Figure 12).

Further data relating to life expectancy can be found in the annex, tab 7 (Life Expectancy from Birth) and tab 8 (Life Expectancy at age 65).

Figure 12: Disability free life expectancy in Males and Females 2009-11

---

Figure 13: Male life expectancies (years) at birth and at age 65

Life Expectancy from Birth - Males

Life Expectancy at Age 65 - Males

Figure 14: Female life expectancies (years) at birth and at age 65

Life Expectancy from Birth - Females

Life Expectancy at Age 65 - Females

Figure 15: Life Expectancy at Birth by District

Male life expectancy at birth (years), 2000-2002 to 2010-2012

Female life expectancy at birth (years), 2000-2002 to 2010-2012


RISK FACTORS

SMOKING

Across the UK, 19% of people over 60 years of age are regular smokers. 20% of the male population over 60 and 18% of the female population in 2011 smoked. In the East Midlands, 19% of men over 60 and 20% of women over 60 were smokers; the average for both genders was 19%.

Despite a lower prevalence of smoking in older age groups compared to younger age groups, men over 60 typically smoked around 15 cigarettes a day, women over 60 smoked 13. The national average for all ages is 12.7, which indicates that older smokers are more likely to smoke more cigarettes per day than other age groups. The average number of cigarettes smoked per day has remained fairly constant for older people, despite there being a steady decline in the two age groups below, the 35-49 and 50-59 year olds. Whilst the focus on preventing smoking or encouraging smokers to quit is rightfully aimed at younger people, older people still benefit from quitting the habit and shouldn’t be ignored when planning smoking cessation activities.

It has not been possible to provide a breakdown of smokers by age and by district.

Figure 16 shows the smoking attributable mortality levels for Northamptonshire and boroughs compared to the levels for England and the East Midlands. Corby stands out as the borough with the highest level of smoking attributable mortality in adults.

Figure 16: Smoking Attributable Mortality per 100,000 Population 2011-13

It has not been possible to provide a breakdown of smokers by age and by district.

Figure 16 shows the smoking attributable mortality levels for Northamptonshire and boroughs compared to the levels for England and the East Midlands. Corby stands out as the borough with the highest level of smoking attributable mortality in adults.

Figure 16: Smoking Attributable Mortality per 100,000 Population 2011-13

http://www.tobaccoprofiles.info/profile/tobacco-control/data

---

13 www.ons.gov.uk/ons/dcp171776_302558.pdf

14 http://www.tobaccoprofiles.info/profile/tobacco-control/data
Figure 17 takes selected data from the Local Tobacco Control Profile (http://www.tobaccoprofiles.info/profile/tobacco-control/data) relating to the consequences of smoking, comparing rates of deaths that can be connected to smoking such as lung cancer, chronic obstructive pulmonary disease, heart disease and stroke. As a county, Northamptonshire performs particularly badly in terms of death from lung cancer, four boroughs showing higher rates of death from this than regional and national averages. Corby is once again the standout area; its rates in all four measures are considerably higher than all other localities.

http://www.tobaccoprofiles.info/profile/tobacco-control/data
ALCOHOL AND SUBSTANCE ABUSE

There are many recent reports looking into the increases in the numbers of older people experiencing issues related to consumption of alcohol or misuse of drugs. Whilst the levels of drug interventions for heroin and crack cocaine are reducing amongst the younger population, the number of interventions for these drugs is increasing for over 40’s. Much of the research and data available for drug and alcohol abuse only goes up to the age of 59, so the problems caused by drink and drugs in older people may be hidden.

Older people are at risk of increased alcohol use following major life changes, e.g. retirement and bereavement, and at the same time have lower tolerance to alcohol than younger adults. Furthermore, alcohol can interact with prescription medications. However, an individual drinking at harmful levels may not recognise their drinking as being problematic and may therefore not wish to engage with treatment services.

According to Wadd et al (2011), “evidence suggests that the UK may be on the cusp of an epidemic of alcohol related harm amongst older people.” Those aged 65 and over form a small proportion of those in alcohol treatment – 3% of both men and women. However, an estimated 1.4 million people in this age group nationally currently exceed recommended drinking limits.16

For the period 2002-2010, there was a marked increase in alcohol-related hospital admissions across all age groups, but the increase was greatest for older people: for men aged 65 and over admissions rose by 136%, and for women in this age group by 132%. In 2010, there were almost half a million alcohol-related admissions nationally for those aged 65 and over, meaning that they accounted for 44% of all these admissions, despite comprising just 17% of the population.17 During the last decade, there has been a national 87% increase in alcohol-related death rates in men aged 55-74; for women, this figure is 53%. In 2010, there were 3,651 alcohol-related deaths in men and women aged 55 and over in England.18

The current generation of older people formed their attitudes about alcohol when it was becoming more widely available and socially acceptable. They have drunk more in middle age than previous generations; if they continue with this relatively high level of drinking, it is

18 http://www.ons.gov.uk/ons/dcp171778_254061.pdf
likely that we will see a larger number of older people with alcohol problems as this cohort continue to make the transition into old age across the next two decades.

Current recommended ‘safe limits’ for alcohol consumption are based on research on younger adults. Because of physiological and metabolic changes associated with ageing, these ‘safe limits’ are too high for older people; recent evidence suggests that the upper ‘safe limit’ for older people is 1.5 units per day or 11 units per week.

**Figure 18: Over 65’s in Substance Misuse Treatment in Northamptonshire 2013-14**

<table>
<thead>
<tr>
<th>Substance type</th>
<th>Gender</th>
<th>Northamptonshire 2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Drugs</td>
<td>&lt;5</td>
<td>5</td>
</tr>
<tr>
<td>Alcohol</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>22</td>
</tr>
</tbody>
</table>

4.5% of all persons on alcohol misuse treatment programmes are over 65. The majority of older people on substance misuse programmes live in Northampton. Wellingborough has the next highest occurrence of older people receiving treatment, followed by Kettering and then Daventry.

Males are more likely to have issues with drink or drugs, this is as apparent with the older population as it is with the population in general. But older females are closing the substance misuse gender gap in recent years: currently in Northamptonshire the gender split is around 60/40 in favour of males (Figure 18).

Overall, the number of people in drug treatment is declining, as is the number of people starting treatment for heroin and crack cocaine. However, the number of people aged 40 and over in treatment is rising, as is the number of people in this age group who are ‘new starters’. As Public Health England (PHE) highlights in the most recent drug treatment statistics, an ‘ageing population’ is now becoming “one of the key features of drug treatment in England” (Figure 19).

Overwhelmingly, this ageing population is made up of heroin users; PHE notes that “this older, less healthy population with its persistent problems present a significant challenge for treatment services in the years ahead.”

A recent study examining illicit drug use in those aged 50 and over has concluded that “use of some illicit drugs, particularly cannabis, has increased rapidly in mid- and late-life”, highlighting that prevalence may rise as populations for whom illicit drug use has been more common and acceptable become older. Late-onset substance misuse has different origins and demographic associations, and probably a better prognosis, than early-onset misuse.

Recommendations of best practice from the Royal College of Psychiatry report ‘Our Invisible Addicts’ include the following:

- General practitioners should screen every person over 65 years of age for substance misuse as part of a routine health check, using specific tools such as the Short Michigan Alcoholism Screening Test – Geriatric version (SMAST-G); screening should also incorporate cognitive testing using tools such as the Mini-Mental State Examination (MMSE)
- Re-screening should be carried out if certain physical and/or psychological symptoms are present or if the person is experiencing major life events
- Older people can and do benefit from treatment and in some cases have better outcomes than younger people

---

**Figure 19: Age of all adults in drug treatment 2005-13**


http://ageing.oxfordjournals.org/content/early/2012/03/16/ageing.afs020.full.pdf+html

http://www.rcpsych.ac.uk/files/pdfversion/cr165.pdf
Although applying the standard diagnostic criteria for substance use disorders is useful, it should be noted that sometimes they may not be appropriate for older people. Patients who repeatedly do well in hospital and badly at home, those with unexplained ‘ups & downs’ in health presentation, those with inconsistencies and contradictions in the history and presentation are of particular concern. Association of substance misuse (particularly alcohol) and conditions such as liver disease, hypertension, diabetes, falls, cognitive problems, depression, self-harm, incontinence indicates specific physical investigations. In older people, binge drinking should be defined as >4.5 units in a single session for men and >3 units for women. Local policies regarding older people with substance use problems should be developed: access on the basis of need, elimination of age barriers, easy transfer between services, joint working and decisions regarding who will be the lead service in these circumstances, as well as protocols regarding admission for detoxification.

The recommended actions from the report include defining and communicating safe drinking levels for older people, the removal of age barriers to treatment programmes, training and education for professionals to recognise signs of substance and/or alcohol abuse in older people.

Key messages from the same report are as follows:

- Late-onset substance misuse has different causal and demographic associations, and probably a better prognosis, than early-onset misuse.
- In older people, the relationship between cognitive function and substance (particularly alcohol) use is complex, as is that between functional mental health problems (e.g. anxiety and depression) and substance use. The direction of causality is often unclear.
- Older men are at greater risk of developing alcohol and illicit substance use problems than older women. However, older women have a higher risk of developing problems related to the misuse of prescribed and over-the-counter medications.
- Physical health problems and the long-term prescription of medication (especially hypnotics, anxiolytics and analgesics) are important factors in the development of substance misuse in older people.
- Psychiatric comorbidities of substance misuse are common in older people (including intoxication and delirium, withdrawal syndromes, anxiety, depression and cognitive changes/dementia).
- Among older people, psychosocial factors (including bereavement, retirement, boredom, loneliness, homelessness and depression) are all associated with higher rates of alcohol use.
- Because of physiological changes associated with ageing, older people are at increased risk of adverse physical effects of substance misuse, even at relatively modest levels of intake.
Presentation can be subtle or non-specific and the causal role of substance use in physical conditions is frequently overlooked.

Screening should be user-friendly and take account of sensory, cognitive, environmental and other specific needs (e.g. cultural background and ethnicity).

Questions should be linked to medical conditions or health concerns assessment leading to a diagnosis of dependence.

A report produced by Keele University and University College London resulted in the following findings:

- Older men tend to drink more and to drink more often than women. For both men and women, those in higher income groups and with higher levels of education drink more and drink more frequently.
- Both the amount that older people drink and how often they drink declines over time, though the rate of decline in quantity and frequency varies according to health and partnership status.
- Men who are not in a partnership drink more compared to men with a partner, though there is no difference in the frequency of men’s drinking by partnership status. For women loss of a partner is associated with a faster decline in weekly alcohol consumption and with drinking less often.
- Over time older people with poor health and deteriorating health report a steeper decline in the quantity and frequency of alcohol consumed. This finding suggests that older people moderate their drinking in response to health events.
- Those who stopped drinking at the start of the period of observation and remained in the study were more likely to experience an improvement in health compared to drinkers.

LIVING ARRANGEMENT

People living alone are more likely to report fair or poor health, poor vision, difficulties in instrumental and basic activities of daily living, worse memory and mood, lower physical activity, poorer diet, worsening function, risk of social isolation, hazardous alcohol use, having no emergency carer, and multiple falls in the previous 12 months. After adjustment for age, sex, income, and educational attainment, living alone remained associated with multiple falls, functional impairment, poor diet, smoking, risk of social isolation, and three self-reported chronic conditions: arthritis and/or rheumatism, glaucoma, and cataracts. It is estimated that almost 37% of the over 65’s living in Northamptonshire live alone. That equates to some 43,233 people out of the total over 65 population of 117,400. Of that number, 17,480 are aged between 65 and 74 and the remaining 25,723 are aged 75 or over. Figure 20 shows the numbers of older people estimated to be living alone in Northamptonshire and the seven boroughs or districts of the county.

<table>
<thead>
<tr>
<th>Area</th>
<th>Males 65-74</th>
<th>Males 75+</th>
<th>Females 65-74</th>
<th>Females 75+</th>
<th>Total 65-74</th>
<th>Total 75+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northamptonshire</td>
<td>6,800</td>
<td>7,514</td>
<td>10,690</td>
<td>18,219</td>
<td>17,480</td>
<td>25,753</td>
</tr>
<tr>
<td>Corby</td>
<td>480</td>
<td>578</td>
<td>840</td>
<td>1,342</td>
<td>1,920</td>
<td>1,920</td>
</tr>
<tr>
<td>Deventry</td>
<td>920</td>
<td>952</td>
<td>1,380</td>
<td>2,135</td>
<td>2,309</td>
<td>3,087</td>
</tr>
<tr>
<td>East Northamptonshire</td>
<td>560</td>
<td>1,088</td>
<td>1,500</td>
<td>2,501</td>
<td>2,460</td>
<td>3,389</td>
</tr>
<tr>
<td>Kettering</td>
<td>940</td>
<td>1,020</td>
<td>1,500</td>
<td>2,464</td>
<td>2,440</td>
<td>3,704</td>
</tr>
<tr>
<td>Northampton</td>
<td>1,680</td>
<td>1,972</td>
<td>2,730</td>
<td>5,602</td>
<td>4,410</td>
<td>6,574</td>
</tr>
<tr>
<td>South Northamptonshire</td>
<td>1,000</td>
<td>1,088</td>
<td>1,530</td>
<td>2,440</td>
<td>2,590</td>
<td>3,528</td>
</tr>
<tr>
<td>Wellingborough</td>
<td>780</td>
<td>884</td>
<td>1,260</td>
<td>2,040</td>
<td>2,040</td>
<td>2,950</td>
</tr>
</tbody>
</table>

A quarter of the county’s older people living alone live in Northampton, this being the densest area of population. 28% of older people live alone in the more rural areas of South Northamptonshire and East Northamptonshire, 14% in each. Corby has the lowest proportion of older people living alone in 2014 but the town will see the greatest increase in numbers projected over the next 16 years. Currently there are an estimated 1,320 people aged between 65 and 74 who live alone, this is projected to rise to 1,990 in 2030. The increase in people aged 75 and over is projected to increase further, from 1,920 people in 2014 to 3,182 in 2014.

The biggest increase in the 75 and over living alone population is expected to be in Daventry, where the projection is for the population to almost double from 3,087 to 6,059 in 2030. It’s a similar story in South Northamptonshire, the population there is anticipated to increase by 93%. All areas of the county will see an increase in older single person households higher than the averages for England and for the East Midlands. More data relating to the living arrangements of the older population can be found in annex 2, tab 5.

Older people living at home face a number of potential issues, from loneliness and a lack of social engagement to problems completing everyday tasks alone. The projected numbers of older people aged between 65 and 74 is shown in figure 21.

Figure 21: People aged 65-74 predicted to be living alone

Older People Aged 65-74 Living Alone
Projected to 2030


The rate of increase in Northamptonshire in older people aged between 65 and 74 is in excess of the average rates for England and the East Midlands, with the largest increases expected to be in Corby and

Northampton. The number of 65-74 years olds living alone in Corby is predicted to increase by a half and Northampton is already the largest centre of population in the county and is predicted to have almost 6,000 older people living alone by 2030.

**Figure 22: People aged 75 and over predicted to be living alone**

Older People aged 75 and above living alone, projected to 2030


The numbers of people aged 65-74 will increase by up to 50% across the county, all areas are predicted to grow faster than the national and regional averages in this regard, Corby in particular. However the rate of growth for the 75 and over population who will be living alone is much higher, almost doubling in Daventry over the next 15 years. It is this older group that is more at risk in general, living alone could possibly exacerbate that risk. **Figure 22** shows the same measures as **Figure 21** but for people aged over 75. The chart is presented in the same scale in order to emphasise the considerably higher percentage increase in this ‘older older’ population. Daventry, East Northamptonshire and South Northamptonshire are predicted to see the most dramatic increases, almost doubling in size in Daventry in the next 16 years.

The data used to produce these figures is located in the annex, tab 5.

**Figure 23** shows that as age increases, the proportion of older people who own their own home reduces. Home ownership is higher in the more affluent areas such as South Northamptonshire and the fall as people age is sharp. In Northampton, the largest area of population, the fall is less steep. The proportion of home ownership amongst people aged 85 and over is highest in Northampton.

Home ownership has implications when it comes to determining who will pay for any care needs, as people who own their own home are more likely to self-fund their care. The changes brought about by the Care Act 2012 will mean that more people will be able to retain ownership of their own home when moving into care.

---

More data relating to the ownership of property amongst older people is contained in the accompanying annex 2, tab 6.

**Figure 23: Home ownership amongst older people**

**Percentage of Older People owning their own home**

![Graph showing home ownership amongst older people](http://www.poppi.org.uk/index.php?pageNo=325&loc=&mapOff=1)

It is estimated that in 2014, 3,883 older people were living in care homes in the county. Projections predict an 83% increase by 2030, higher than the 64% increase forecast for England and the 71% increase predicted for the East Midlands. The number of older people living in a care home of some description is predicted to more than double in Daventry and South Northamptonshire, and will increase by 98% East Northamptonshire (Figure 24).

The rising numbers of older people who will be living alone will impact on the market for accommodation with care and support if significant numbers of people choose to move to a different model of housing or other accommodation.

This data is located in annex 2 on tab 9.

---

Loneliness is a complex issue which isn’t as easily defined as having contact with other people. "Loneliness is the difference between your desired contact with people and the contact with people you actually have," says Professor Vanessa Burholt, from the Centre of Innovative Ageing at Swansea University.

Although loneliness and isolation are connected they are separate concepts. Loneliness is a subjective state with a number of forms. For example, ‘social loneliness’ is the absence of a social network or a broad group of friends, neighbours and colleagues. While ‘emotional loneliness’ is the absence of a significant other with whom a close emotional attachment is formed. Loneliness can be a chronic condition which is exacerbated with age or a condition which flares up in later life in response to life changes such as bereavement. It can be difficult to measure. In contrast, social isolation is an objective state, measurable by the number of contacts a person has. Although the terms are often used interchangeably they do remain distinct from each other. Social isolation often contributes to loneliness, but does not guarantee it. Feeling lonely can also lead to feeling anxious and unconnected to society. It is possible to feel lonely when surrounded by people. Loneliness can be


http://www.bbc.co.uk/news/health-18737560


Loneliness has a significant and lasting effect on health. It is associated with higher blood pressure and depression and leads to higher rates of mortality, indeed comparable to those associated with smoking and alcohol consumption. It is also linked to a higher incidence of dementia with one study reporting a doubled risk of Alzheimer’s disease. Lonely people tend to make more use of health and social care services and are more likely to have early admission to residential or nursing care.\(^{36}\)

The English Longitudinal Study of Ageing (ELSA) asked respondents about their feelings regarding social interactions and feeling lonely. The percentage of people feeling lonely “sometimes” or “often” is highest during adolescence when youths enter puberty and are faced with the challenge of establishing their own identity; however, this percentage is also highest during old age when there is increasing frailty and decreased mobility accompanied by the loss of loved ones.\(^{37}\) Referring to figure 25, 25% of respondents between 65 and 69 years of age said they sometimes felt lonely and 9% said they often felt lonely. This figure increases as people age, for example the same question asked to respondents over 80 years of age saw the proportion of people feeling lonely often rise from 9% to 34%.

**Figure 25: Frequency of people aged 60 and over feeling lonely\(^{38}\)**

![Frequency of feeling lonely by age group](http://www.ons.gov.uk/ons/dcp171766_304939.pdf)

Whilst feeling lonely is not the same as being alone, loneliness is most prevalent in those who live alone and have lost a partner either through bereavement or separation. **Figure 26** shows the frequency of feeling

---


\(^{37}\) [http://pps.sagepub.com/content/10/2/250.full.pdf+html](http://pps.sagepub.com/content/10/2/250.full.pdf+html)

\(^{38}\) [http://www.ons.gov.uk/ons/dcp171766_304939.pdf](http://www.ons.gov.uk/ons/dcp171766_304939.pdf)
lonely by various measures but please note that in this case the survey was conducted among people aged 52 and over rather than 65 and over.

Figure 26: Frequency of people aged 52+ feeling lonely by marital status, household size, health status and illness or disability

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Some of the time</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married, remarried or in a legal partnership</td>
<td>19</td>
<td>4</td>
</tr>
<tr>
<td>Single, that is never married</td>
<td>30</td>
<td>13</td>
</tr>
<tr>
<td>Separated or divorced</td>
<td>37</td>
<td>14</td>
</tr>
<tr>
<td>Widowed</td>
<td>41</td>
<td>22</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Household size</th>
<th>Some of the time</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>39</td>
<td>20</td>
</tr>
<tr>
<td>2</td>
<td>19</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>26</td>
<td>5</td>
</tr>
<tr>
<td>4 or more</td>
<td>25</td>
<td>8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health status</th>
<th>Some of the time</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>18</td>
<td>3</td>
</tr>
<tr>
<td>Very good</td>
<td>20</td>
<td>4</td>
</tr>
<tr>
<td>Good</td>
<td>25</td>
<td>7</td>
</tr>
<tr>
<td>Fair</td>
<td>33</td>
<td>14</td>
</tr>
<tr>
<td>Poor</td>
<td>36</td>
<td>23</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Limiting long standing illness or disability</th>
<th>Some of the time</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>No long standing illness</td>
<td>22</td>
<td>5</td>
</tr>
<tr>
<td>Long standing illness but no limitations</td>
<td>22</td>
<td>7</td>
</tr>
<tr>
<td>Long standing illness with limitations</td>
<td>31</td>
<td>14</td>
</tr>
</tbody>
</table>

The consequences of feeling lonely or excluded can be difficulty in performing daily tasks and having a lower perception of quality of life and lower states of wellbeing.

According to research by Professor John Cacioppo at the University of Chicago, extreme loneliness can increase an older person's risk of premature death by 14%.

This makes extreme loneliness a risk factor for premature death that is nearly as potent as disadvantaged socioeconomic status. Disadvantaged socioeconomic status is known to cause an increase of 19% in risk of early death.

Loneliness can have profound health consequences for older people. Disrupted sleep, elevated blood pressure, increased levels of the stress hormone cortisol and increased depression are all reported in people experiencing extreme loneliness. This can also cause problems for the body's immune system and generally lower overall feelings of wellbeing.

Professor Cacioppo's work finds that it is not physical isolation itself that causes the health problems associated with loneliness, but the "subjective sense of isolation" experienced by some older people. Cacioppo acknowledges that some aspects of ill health experienced by

---


people as they age - such as loss of hearing or sight - could place people at further risk of becoming isolated and consequently lonely. As loneliness is subjective, it is impossible to succinctly define and measure loneliness. However it is possible to look at what measurable factors can premeditate loneliness. These include:

- Single pensioners
- Widowed
- Retired
- unlikely to meet friends family regularly
- unlikely to interact with neighbours
- Poor health
- Suffering from depression
- Suffering from poor mobility
- Sensual impairment
- Struggling financially

It is unclear whether there are gender differences in loneliness. In recent studies, researchers who examined gender differences in the stability of loneliness produced mixed results. Targeted responses are regarded more likely to achieve results. For example, in general lonely men are best engaged through specific activities related to long-standing interests, such as sport or gardening, and respond less well to loosely-defined social gatherings, which are of more interest to women.

DEPRIVATION

The Atlas of Deprivation 2010 allows the quick identification of individual ranks for each Lower Layer Super Output Area (LSOA) nationally by local authority for seven domains and for an overall Index of Deprivation. The LSOA ranks go from 1 for the most deprived LSOA to 32,482 for the least deprived of the 32,482 LSOAs in England.

The seven domains are:

- Employment
- Income
- Health Deprivation and Disability
- Education, Skills and Training
- Barriers to Housing and Services
- Crime
- Living Environment

Figure 27 below shows maps of the seven boroughs and districts of Northamptonshire showing the index of multiple deprivation at LSOA.

41 http://pps.sagepub.com/content/10/2/250.full.pdf+html

42 http://campaigntoendloneliness.org/toolkit/how/step-2/
level and can be compared with the mapping of the older population on page 13.

Figures 28 and 29 show the 10 most deprived and least deprived areas of Northamptonshire, this time by Middle Layer Super Output Area (MSOA).

It is important to note that not everyone who lives in an area of high deprivation will be deprived and not all deprived people live in areas of deprivation.

Pensioners can fare relatively better than those of working age over a recessionary period, as their incomes remain more stable (as benefit incomes, which represent a substantial proportion of pensioners’ incomes, are more stable). Furthermore, around a million fewer pensioners are living in relative poverty compared to ten years ago. Most of the improvement can be put down to increased pensioner benefits, including Pension Credit, and pensioner incomes have grown faster than average earnings across the economy as a whole since 1998.
Figure 27: Indices of Deprivation mapped by borough/district

### Figure 28: 10 Most Deprived MSOA in Northamptonshire

<table>
<thead>
<tr>
<th>MSOA</th>
<th>District</th>
<th>Wards covered</th>
<th>Deprivation rank</th>
<th>Number of residents 65-84 2013</th>
<th>%</th>
<th>Number of residents 85+ 2013</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>E02005617</td>
<td>Corby</td>
<td>Towerhill, Beanfield, Kingswood</td>
<td>90</td>
<td>1205</td>
<td>11.7</td>
<td>112</td>
<td>1.1</td>
</tr>
<tr>
<td>E02005643</td>
<td>Kettering</td>
<td>Avondale Grange, Brambleside, All Saints</td>
<td>89</td>
<td>894</td>
<td>11</td>
<td>146</td>
<td>1.8</td>
</tr>
<tr>
<td>E02005670</td>
<td>Northampton</td>
<td>Castle</td>
<td>88</td>
<td>490</td>
<td>5.7</td>
<td>87</td>
<td>1</td>
</tr>
<tr>
<td>E02005666</td>
<td>Northampton</td>
<td>Spencer</td>
<td>87</td>
<td>688</td>
<td>8.3</td>
<td>135</td>
<td>1.6</td>
</tr>
<tr>
<td>E02005656</td>
<td>Northampton</td>
<td>Lumbertubs</td>
<td>86</td>
<td>586</td>
<td>9.6</td>
<td>52</td>
<td>0.9</td>
</tr>
<tr>
<td>E02005660</td>
<td>Northampton</td>
<td>Ecton Brook</td>
<td>85</td>
<td>786</td>
<td>13.4</td>
<td>76</td>
<td>1.3</td>
</tr>
<tr>
<td>E02005661</td>
<td>Northampton</td>
<td>Eastfield</td>
<td>84</td>
<td>638</td>
<td>9.4</td>
<td>124</td>
<td>1.8</td>
</tr>
<tr>
<td>E02005693</td>
<td>Wellingborough</td>
<td>Hemmingwell</td>
<td>83</td>
<td>1147</td>
<td>13.6</td>
<td>127</td>
<td>1.5</td>
</tr>
<tr>
<td>E02005675</td>
<td>Northampton</td>
<td>St. James</td>
<td>82</td>
<td>495</td>
<td>8.6</td>
<td>72</td>
<td>1.2</td>
</tr>
<tr>
<td>E02005699</td>
<td>Wellingborough</td>
<td>Croyland</td>
<td>81</td>
<td>910</td>
<td>11.7</td>
<td>122</td>
<td>1.6</td>
</tr>
</tbody>
</table>

### Figure 29: 10 Least Deprived MSOA in Northamptonshire

<table>
<thead>
<tr>
<th>MSOA</th>
<th>District</th>
<th>Wards covered</th>
<th>Deprivation rank</th>
<th>Number of residents 65-84 2013</th>
<th>%</th>
<th>Number of residents 85+ 2013</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>E02005669</td>
<td>Northampton</td>
<td>Weston</td>
<td>1</td>
<td>1074</td>
<td>18.8</td>
<td>205</td>
<td>3.6</td>
</tr>
<tr>
<td>E02005622</td>
<td>Daventry</td>
<td>Brampton</td>
<td>2</td>
<td>1597</td>
<td>18.1</td>
<td>164</td>
<td>1.9</td>
</tr>
<tr>
<td>E02005687</td>
<td>South Northamptonshire</td>
<td>Astwell</td>
<td>3</td>
<td>1013</td>
<td>16.2</td>
<td>123</td>
<td>2</td>
</tr>
<tr>
<td>E02005684</td>
<td>South Northamptonshire</td>
<td>Blakesley and Cote</td>
<td>4</td>
<td>1403</td>
<td>17.1</td>
<td>163</td>
<td>2</td>
</tr>
<tr>
<td>E02005689</td>
<td>South Northamptonshire</td>
<td>Brackley East</td>
<td>5</td>
<td>963</td>
<td>12.4</td>
<td>169</td>
<td>2.2</td>
</tr>
<tr>
<td>E02005619</td>
<td>Daventry</td>
<td>Welford</td>
<td>6</td>
<td>1133</td>
<td>19.2</td>
<td>125</td>
<td>2.1</td>
</tr>
<tr>
<td>E02005680</td>
<td>Northampton</td>
<td>Nene Valley</td>
<td>7</td>
<td>703</td>
<td>8.1</td>
<td>128</td>
<td>1.5</td>
</tr>
<tr>
<td>E02005639</td>
<td>Kettering</td>
<td>Queen Eleanor and Buccleuch, Welland</td>
<td>8</td>
<td>1078</td>
<td>20.5</td>
<td>148</td>
<td>2.8</td>
</tr>
<tr>
<td>E02005682</td>
<td>South Northamptonshire</td>
<td>Brafield and Yardley</td>
<td>9</td>
<td>1345</td>
<td>20.9</td>
<td>139</td>
<td>2.2</td>
</tr>
<tr>
<td>E02005630</td>
<td>East Northamptonshire</td>
<td>Lower Nene, Barnwell</td>
<td>10</td>
<td>1809</td>
<td>18.2</td>
<td>275</td>
<td>2.8</td>
</tr>
</tbody>
</table>
The clinical condition of ‘frailty’ is one of the most-challenging consequences of population ageing (Clegg et al, 2013).

Frailty develops as a consequence of age-related decline in multiple body systems, which results in vulnerability to sudden health status changes triggered by minor stress or events such as an infection or a fall. Between a quarter and a half of people over 85 are estimated to be frail, with overall prevalence in people aged 75 and over approximately 9% (Collard et al, 2012).

People with frailty have a substantially increased risk of falls, disability, long-term care and death. Frailty is a graded abnormal health state which ranges from the majority who are mildly frail and need supported self-management, through those who are moderately frail and would benefit from interventions such as case management, to those who have advanced frailty where anticipatory care planning and end-of-life care may be appropriate interventions. Clinicians should support people living with frailty to maintain their own health and independence for as long as possible.

Frailty decreases resilience, common features include immobility, instability (falls), incontinence and intellectual failure (dementia). Frailty doesn’t spring up unannounced; it develops over five to 10 years. Older people with frailty can be readily identified and are usually known to local professionals. They usually have weak muscles and, often, conditions like arthritis, poor eyesight, deafness and memory problems. They typically walk slowly, get exhausted easily and struggle to get out of a chair or climb stairs. At present, however, we do not formally ‘diagnose’ frailty or identify it with a specific clinical code. This makes systematic case-finding and proactive care difficult. Walking speed is a simple test that could help; taking more than five seconds to walk four metres is highly indicative of frailty.

Falls are another key area of concern for older people. While the causes of falls are complex, frail older people are particularly vulnerable because of medical conditions such as delirium, cardiac issues, problems with poor eyesight or problems with strength and mobility (Patient Safety First, 2009). This complex interplay of individual and environmental factors can be seen in figures showing that the proportion of falls in care among patients over 70 is 2.77%, compared with 1.26% in patients aged 70 or younger (NHS Safety Thermometer, 2013).

It is also now established that frail older people can suffer harm from receiving care in an acute setting when this is not absolutely necessary. There is a combined effect of long-term demographic trends, a failure to embed best practice systematically in caring for frail older patients and

---

44 [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2812%2962167-9/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2812%2962167-9/abstract)

45 [nvi002.nivel.nl/postprint/PPpp5692.pdf](nvi002.nivel.nl/postprint/PPpp5692.pdf)

small stimuli, which has created a vulnerable, fragile system of care with the potential to cause harm (Emeny, 2013). There is also strong evidence that medical assessment following a fall or accident within two hours, followed by specific treatment, supportive care and rehabilitation, is associated with lower mortality, greater independence and reduced need for long-term care.

A disparity in outcomes for older patients can also be seen in the 28-day readmission rate, with standardised rates of 10.1% in the 16-74 age group, compared with 15.3% for the over 75s. The vast majority of older patients are discharged back to ‘usual place of residence’, but there is evidence to suggest that discharge to alternative destinations, such as care homes, is linked to extrinsic factors such as deprivation (Connolly & O’Reilly, 2009) rather than to need. Figure 30 shows the re-admission percentages for Northamptonshire by borough/district compared with the East Midlands.

Delirium characterised by the recent onset of fluctuating inattention and confusion is common in frail older people in hospital and in the care home setting. It contributes to substantial morbidity and mortality, causes considerable distress to patients and families, and it adds an estimated additional £1,275 per patient to the costs of an episode of care (US Department of Health and Human Services, 2004).

Figure 30: Emergency readmissions to hospital within 30 days – 2011/12

Emergency readmissions within 30 days of discharge from hospital 2011/12

---


Fuel poverty in England is measured by the Low Income High Costs definition, which considers a household to be in fuel poverty if:

- they have required fuel costs that are above average (the national median level)
- were they to spend that amount they would be left with a residual income below the official poverty line

The key drivers behind fuel poverty are:

- the energy efficiency of the property (and therefore, the energy required to heat and power the home)
- the cost of energy
- household income

In 2011 Northamptonshire, approximately 11% of households were in fuel poverty (33,997). 7 of 10 of the areas of the county with the highest incidences of fuel poverty are in Northampton. In the highest area (Census name Semilong) over 32% of households are in fuel poverty. 15 of the top 20 areas are in Northampton, the other five being in Kettering and Wellingborough. At the other end of the spectrum, two areas of Northampton have the lowest percentage of homes in fuel poverty with 2.8%. 6 areas in the 10 lowest areas for fuel poverty are in Corby.49

In 2012, 10.6% of households in England and Wales were classified as being in fuel poverty. Corby and South Northamptonshire had the lowest levels of fuel poverty in the county and lower than the national average, see figure 31.

Figure 31: Households in Fuel Poverty50

Households in Fuel Poverty (2012)

http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000041/pat/6/ati/102/page/3/par/E12000004/are/E10000021

Figure 32 shows the spatial distribution of households experiencing fuel poverty in Northamptonshire, being more prevalent in the darker shaded

---

49 http://109.228.12.23/dataviews/tabular?viewId=303&geoid=58&subsetId=

50 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000041/pat/6/ati/102/page/3/par/E12000004/are/E10000021
areas. Figure 33 shows the same data for Northampton as seven of the 10 highest areas for incidences of fuel poverty are in the town.

Figure 32: Percentage of households in Fuel Poverty map

Figure 33: Percentage of Northampton households in Fuel Poverty map

http://www.northamptonshireanalysis.co.uk/dataviews/report?reportId=137&viewId=303&geoReportId=5683&geoid=58&geoSubsetid=

http://www.northamptonshireanalysis.co.uk/dataviews/report?reportId=137&viewId=303&geoReportId=5683&geoid=58&geoSubsetid=
**EXCESS WINTER DEATHS**

The ONS standard method defines the winter period as December to March, and compares the number of deaths that occurred in this winter period with the average number of deaths occurring in the preceding August to November and the following April to July. The Excess Winter Mortality (EWM) index is calculated so that comparisons can be made between sexes, age groups and regions, and is calculated as the number of excess winter deaths divided by the average non-winter deaths: EWM Index = (EWM / average non-winter deaths) x 100.

In 2012/13, 19.6% more people died in England and Wales during the winter months compared with the non-winter months, up from 15.5% in 2011/12. There were an estimated 31,100 excess winter deaths (EWD) in England and Wales in 2012/13 – a 29% increase compared with the previous winter. As in previous years, there were more EWDs in females than in males in 2012/13 (18,000 compared with 13,100) and the majority of deaths occurred among those aged 75 and over. There were 25,600 EWDs in this older age group in 2012/13 compared with 5,500 in people aged below 7553. Using the Office of National Statistics (ONS) definition of Excess Winter Mortality54, all areas of Northamptonshire with the exception of South Northamptonshire and Kettering have higher than regional and national average excess winter deaths (Figure 34). EWM is something that is potentially amenable to preventative interventions.

**Figure 34: Excess Winter Deaths Index**55

---


CAUSES OF DEATHS

The data below is split into Care Commissioning group (CCG) areas. The two CCG’s in Northamptonshire are Corby and Nene, which covers the rest of the county.

This data refers to CCG populations which in addition to the resident population includes non residents who are registered with a Northamptonshire GP. Total residential population for Northamptonshire is 706,600. 117,400 of these are aged 65 and over. The total GP registered population for Northamptonshire is 684,828, 109,650 are 65 years of age or older, a difference of 17,318 older people. 91% of the total population and 92% of the 65 years and older population are registered with NHS Nene CCG.

CANCER

Nearly two thirds of cancer diagnoses occur in the over 65s and one third in people aged 75 and over. By 2020 there will be nearly two million people aged 65 and over alive following a diagnosis of cancer. Therefore we need to critically assess our cancer services to ensure that they are meeting the needs of older people – the very people most likely to need them.

It is important to stress that the needs of all older people are not the same. Type of cancer, socio-economic status, gender and ethnicity all play a role in shaping people’s needs and outcomes. Equally the needs of active older people in otherwise good health will be very different from those of people living with frailty and other health conditions.

The PHE National Cancer Intelligence Network and NHS England Older People and Cancer report brings together information from different sources and studies. It shows a mixed picture. This report – a product of many organisations’ efforts – is an important contribution which sets a


57 http://www.ncin.org.uk/publications/older_people_and_cancer
baseline as we seek to improve cancer outcomes for older people. The evidence in this report suggests that, although we get a lot right, there is substantial scope for improvement.

Causes of cancer and their prevalence in older people:

- Older people could reduce their risk of developing cancer and be fit for more aggressive (but more effective) cancer treatments by changing their lifestyle; it’s never too late for lifestyle change – but the earlier it starts, the better
- More than 4 in 10 of all cancer cases in the UK each year could be prevented by lifestyle changes; key factors are smoking, alcohol (both less common in older people than the adult population overall), overweight and obesity, and physical inactivity (both more common in older people than the adult population overall)

Diagnosing cancer earlier in older people:

- Survival decreases with age, in particular for people over 70. Older people with late stage tumours have substantially lower survival rates
- Older people are more likely to be diagnosed following an emergency presentation, which is associated with poorer outcomes
- More urgent GP referrals for suspected cancer are made for older people and these referrals are more likely to result in a diagnosis of cancer
- More needs to be done to encourage older people to recognise the signs and symptoms of cancer and seek appropriate help.

Older people are 18% more likely than those aged under 65 to be diagnosed with Breast Cancer and 57% more likely than those under 65 to be diagnosed with Lung Cancer.

- Older people are less likely to receive surgery, radiotherapy or chemotherapy treatment than younger people
- Over half of hospital admissions for cancer were for people aged 65 and over, and one quarter for people aged 75 and over
- Unlike for other age groups, inpatient admissions for the 75 and over age group continue to be greater than day cases
Cancer deaths amongst males aged 65 to 84 are proportionally higher in both CCGs than the England average, particularly higher in Corby. The percentage of deaths caused by cancer drops significantly in the 85 and older age group (Figure 35).

Figure 35: Percentage of deaths from Cancer\(^{58}\)


Figure 36 shows that the mortality rate from cancer in Northamptonshire is higher than the rates for England and for the East Midlands. This is principally as a result of the much higher mortality from cancer in males; the rate for females is only slightly higher than these area averages. The mortality rate from cancers considered preventable is also higher and again more so in the case of males under 75.

CARDIOVASCULAR DISEASES

Cardiovascular disease is the most common cause of death throughout the world, responsible for 3 out of every 10 deaths on the planet. Tobacco use is a major cause of many of the world’s top killer diseases.

Cardiovascular diseases (CVDs) are a group of disorders of the heart and blood vessels and they include:

- coronary heart disease – disease of the blood vessels supplying the heart muscle
- cerebrovascular disease (disease of the blood vessels supplying the brain)
- peripheral arterial disease (disease of blood vessels supplying the arms and legs)
- rheumatic heart disease (damage to the heart muscle and heart valves from rheumatic fever, caused by streptococcal bacteria)
- congenital heart disease (malformations of heart structure existing at birth)
- deep vein thrombosis and pulmonary embolism (blood clots in the leg veins, which can dislodge and move to the heart and lungs).

http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049/pat/6/ati/102/page/0/par/E12000004/are/E06000015

http://www.who.int/mediacentre/factsheets/fs310/en/index2.html
Figure 37: Cancer Incidences and Mortality Rates per 100,000 Population

Cancer Incidences and Mortality Rates for Northamptonshire teaching (PCT) compared to National Average

![Bar charts showing cancer incidences and mortality rates for different types of cancer in Nene and National comparison.](http://www.cancerresearchuk.org/cancer-info/cancerstats/local-cancer-statistics/?location-name-1=Northamptonshire%20Teaching%20(PCT)&location-1=SPD)
Heart attacks and strokes are usually acute events and are mainly caused by a blockage that prevents blood from flowing to the heart or brain. 62

There are several risk factors for CVD. The more risk factors present, the higher the risk of developing CVD. And even though people can’t change all their risk factors, there is plenty that can be done to reduce risks and help to protect the heart. 63 Risks include:

- Smoking
- High blood pressure
- High blood cholesterol
- Being physically inactive
- Being overweight or obese
- Diabetes
- Family history of heart disease
- Ethnicity - for example people from a South Asian background have an increased risk of developing coronary heart disease
- Gender - men are more likely to develop CVD at an earlier age than women
- Age - the older you are, the more likely you are to develop CVD.

How you deal with stress, the amount of alcohol you drink, as well as the type of job you do may also influence your risk of developing CVD.

Unlike deaths from cancer, which are more likely amongst the 65-84 population than older people, the situation is reversed for cardiovascular related death; they are more common amongst those over 85. Northamptonshire CCGs tend to show lower percentages of deaths from CVD than England as a whole, but for males aged 65-84 in Corby and females aged 65 to 84 in the Nene CCG, rates are higher (Figure 38).

Figure 38: Percentage of deaths from Cardiovascular Diseases 64

[Graph showing percentage of deaths from cardiovascular diseases by age and gender (2010-12)]


63 https://www.bhf.org.uk/heart-health/conditions/cardiovascular-disease

Compared to neighbouring East Midlands areas, Northamptonshire’s rates of cardiovascular disease resulting in death are statistically similar to England and lower than for the region. In the case of under 75’s, cardiovascular disease ratios are higher in males than females. Compared to England and the East Midlands the rate for females under 75 is worse than these comparators but not statistically significantly so. The rate for males of the same age is slightly lower in Northamptonshire than for England and the East Midlands. Rates for preventable cardiovascular disease are very close to national rates and below the rates for the East Midlands. Please see Figure 39.

**RESPIRATORY DISEASES**

Chronic respiratory diseases are chronic diseases of the airways and other structures of the lung. Some of the most common are:

- asthma
- chronic obstructive pulmonary disease (COPD)
- respiratory allergies
- occupational lung diseases and
- pulmonary hypertension

---

65 [http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049/pat/6/ati/102/page/0/par/E12000004/are/E06000015](http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049/pat/6/ati/102/page/0/par/E12000004/are/E06000015)
The main risk factors associated with respiratory diseases are:
- smoking
- indoor air pollution
- outdoor pollution
- allergens
- occupational risks and vulnerability

Deaths caused by respiratory diseases are most likely in the 85+ population, however respiratory disease is the cause of death for 22.82% of females between 65 and 84 in Corby compared to 17.51% in the neighbouring Nene CCG and 16.38% in England (Figure 40). Apart from this, death rates from respiratory disease are close to the average for England in the 65-84 year old population but worse for the 85 and over population.

As a region, the East Midlands has lower mortality rates for respiratory conditions than England. The rates for Northamptonshire are similar to the rates for the region; however deaths considered preventable from respiratory disease in females are higher than these areas but not statistically significantly different (Figure 41).

---

Deaths from ‘other’ causes relate to deaths for reasons other than cancer, cardio vascular disease and respiratory disease.

Figure 2 shows that rates in Corby are below the national average for all sections of the community apart from females over 85 years of age. For

67 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049/pat/6/ati/102/page/0/par/E12000004/are/E06000015


NHS Nene, the figures are slightly above the national average for all older people.

Figure 42: Percentage of deaths from ‘Other’ causes

% of Deaths from 'Other Reasons' by age and gender (2010-12)


Figure 43 demonstrates that whilst mortality from ‘other’ causes in Northamptonshire is similar to national and regional figures, mortality considered preventable for females is higher here.

Figure 43: Mortality rates from ‘Other’ causes comparison with neighbours

<table>
<thead>
<tr>
<th>Indicator</th>
<th>4.03 - Mortality rate from causes considered preventable (Persons)</th>
<th>4.03 - Mortality rate from causes considered preventable (Persons)</th>
<th>4.03 - Mortality rate from causes considered preventable (Persons)</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>183.9</td>
<td>233.1</td>
<td>138.0</td>
</tr>
<tr>
<td>East Midlands</td>
<td>185.7</td>
<td>235.7</td>
<td>137.7</td>
</tr>
<tr>
<td>Derby</td>
<td>206.8</td>
<td>271.6</td>
<td>147.1</td>
</tr>
<tr>
<td>Derbyshire</td>
<td>181.3</td>
<td>231.4</td>
<td>133.7</td>
</tr>
<tr>
<td>Leicester</td>
<td>222.5</td>
<td>311.4</td>
<td>159.9</td>
</tr>
<tr>
<td>Leicestershire</td>
<td>162.8</td>
<td>206.8</td>
<td>122.3</td>
</tr>
<tr>
<td>Lincolnshire</td>
<td>181.1</td>
<td>231.1</td>
<td>134.1</td>
</tr>
<tr>
<td>Northamptonshire</td>
<td>186.7</td>
<td>233.5</td>
<td>142.0</td>
</tr>
<tr>
<td>Nottingham</td>
<td>242.9</td>
<td>316.3</td>
<td>175.0</td>
</tr>
<tr>
<td>Nottinghamshire</td>
<td>180.7</td>
<td>224.9</td>
<td>139.5</td>
</tr>
<tr>
<td>Rutland</td>
<td>130.5</td>
<td>166.5</td>
<td>93.7</td>
</tr>
</tbody>
</table>

DEATHS FROM LIVER DISEASE

Causes and risk factors of liver disease include the following:

- Alcoholism
- Autoimmune diseases (e.g., autoimmune hepatitis)
- Bile duct disorders (e.g., primary biliary cirrhosis, primary sclerosing cholangitis)
- Exposure to toxins through ingestion, inhalation, or skin absorption (e.g., toxic hepatitis)
- Hereditary conditions (e.g., Wilson’s disease, hemochromatosis, galactosemia, Alagille syndrome, alpha-1 antitrypsin (AAT))
- Obesity
- Severe reactions to certain prescription or over-the-counter (OTC) medications
- Viruses (primarily hepatitis A, B and C)

The risk of developing liver disease varies, depending on the underlying cause and the particular condition.

Being obese or overweight increases the risk for liver disease. Obesity often results in the accumulation of fat cells in the liver.

Deaths from liver disease are close to national figures; however there is a minor inequality between male and female residents. Figure 44 shows that incidences of liver disease in male residents is lower than the

---

70. [http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049/pat/6/ati/102/page/0/par/E12000004/are/E06000015](http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049/pat/6/ati/102/page/0/par/E12000004/are/E06000015)

national average and higher in females, as a result of this inequality the rate for the county is slightly above that of England.

**Figure 44:** Mortality rates from Liver Disease comparison with neighbours

<table>
<thead>
<tr>
<th>Indicator</th>
<th>4.01i Under 75 mortality rate from liver disease (persons)</th>
<th>4.01i Under 75 mortality rate from liver disease (Male)</th>
<th>4.01i Under 75 mortality rate from liver disease (Female)</th>
<th>4.01i Under 75 mortality rate from liver disease considered preventable (Persons)</th>
<th>4.01i Under 75 mortality rate from liver disease considered preventable (Male)</th>
<th>4.01i Under 75 mortality rate from liver disease considered preventable (Female)</th>
<th>Not compared</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>17.9</td>
<td>17.6</td>
<td>12.3</td>
<td>15.7</td>
<td>21.1</td>
<td>16.5</td>
<td>--------------</td>
</tr>
<tr>
<td>East Midlands</td>
<td>17.6</td>
<td>22.9</td>
<td>12.3</td>
<td>13.3</td>
<td>26.7</td>
<td>16.5</td>
<td>--------------</td>
</tr>
<tr>
<td>Derby</td>
<td>12.1</td>
<td>18.4</td>
<td>11.9</td>
<td>14.5</td>
<td>19.6</td>
<td>12.2</td>
<td>--------------</td>
</tr>
<tr>
<td>Derbyshire</td>
<td>15.2</td>
<td>26.5</td>
<td>10.3</td>
<td>11.8</td>
<td>17.7</td>
<td>10.5</td>
<td>--------------</td>
</tr>
<tr>
<td>Leicester</td>
<td>14.4</td>
<td>20.0</td>
<td>10.0</td>
<td>13.0</td>
<td>18.8</td>
<td>9.5</td>
<td>--------------</td>
</tr>
<tr>
<td>Leicesterhire</td>
<td>23.2</td>
<td>30.7</td>
<td>10.3</td>
<td>13.3</td>
<td>19.6</td>
<td>9.5</td>
<td>--------------</td>
</tr>
<tr>
<td>Northamptonshire</td>
<td>19.8</td>
<td>22.3</td>
<td>10.0</td>
<td>13.1</td>
<td>20.0</td>
<td>10.4</td>
<td>--------------</td>
</tr>
<tr>
<td>Nottingham</td>
<td>22.6</td>
<td>24.0</td>
<td>10.0</td>
<td>14.1</td>
<td>21.1</td>
<td>10.5</td>
<td>--------------</td>
</tr>
<tr>
<td>Nottinghamshire</td>
<td>22.4</td>
<td>24.8</td>
<td>10.0</td>
<td>14.8</td>
<td>21.4</td>
<td>10.5</td>
<td>--------------</td>
</tr>
<tr>
<td>Rutland</td>
<td>16.3</td>
<td>22.3</td>
<td>10.0</td>
<td>15.1</td>
<td>20.5</td>
<td>10.4</td>
<td>--------------</td>
</tr>
</tbody>
</table>

Similar findings are found in liver disease considered preventable, the county showing higher than the national average because of higher rates of preventable liver disease in female residents of Northamptonshire.

**DEATHS FROM COMMUNICABLE DISEASE**

Communicable diseases can be transmitted between humans. A list can be found here - https://www.gov.uk/health-protection/infectious-diseases. Mortality from these diseases is similar for both males and females in Northamptonshire compared to national and regional rates (Figure 45).

**Figure 45:** Mortality rates from Communicable Disease comparison with neighbours

<table>
<thead>
<tr>
<th>Indicator</th>
<th>4.01i Mortality from communicable diseases (Persons)</th>
<th>4.01i Mortality from communicable diseases (Male)</th>
<th>4.01i Mortality from communicable diseases (Female)</th>
<th>Not compared</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>62.2</td>
<td>72.1</td>
<td>36.2</td>
<td>--------------</td>
</tr>
<tr>
<td>East Midlands</td>
<td>58.6</td>
<td>66.4</td>
<td>32.4</td>
<td>--------------</td>
</tr>
<tr>
<td>Derby</td>
<td>59.5</td>
<td>71.6</td>
<td>53.1</td>
<td>--------------</td>
</tr>
<tr>
<td>Derbyshire</td>
<td>63.5</td>
<td>69.7</td>
<td>60.0</td>
<td>--------------</td>
</tr>
<tr>
<td>Leicester</td>
<td>62.7</td>
<td>61.1</td>
<td>51.4</td>
<td>--------------</td>
</tr>
<tr>
<td>Leicesterhire</td>
<td>51.1</td>
<td>61.1</td>
<td>45.6</td>
<td>--------------</td>
</tr>
<tr>
<td>Lincolnshire</td>
<td>57.2</td>
<td>60.4</td>
<td>52.5</td>
<td>--------------</td>
</tr>
<tr>
<td>Northamptonshire</td>
<td>62.6</td>
<td>75.1</td>
<td>56.3</td>
<td>--------------</td>
</tr>
<tr>
<td>Nottingham</td>
<td>65.9</td>
<td>68.6</td>
<td>58.3</td>
<td>--------------</td>
</tr>
<tr>
<td>Nottinghamshire</td>
<td>53.9</td>
<td>63.6</td>
<td>48.6</td>
<td>--------------</td>
</tr>
<tr>
<td>Rutland</td>
<td>36.0</td>
<td>43.0</td>
<td>30.9</td>
<td>--------------</td>
</tr>
</tbody>
</table>

72 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049/pat/6/ati/102/page/0/par/E12000004/are/E06000015

73 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049/pat/6/ati/102/page/0/par/E12000004/are/E06000015
LEVEL OF NEED AND FUTURE PROJECTION

SUPPORT

DAILY LIVING TASKS

One of the first signs that an older person is beginning to lose the ability to live independently is whether they can perform domestic tasks such as keeping their home clean and tidy, dressing themselves and preparing meals. It is often a lack of ability to carry out day to day tasks, or a perception of lack of ability to carry out day to day tasks, that prompts contact with social services.

Figure 46 shows the estimated number of older people in Northamptonshire who are unable to complete at least one day to day task unaided.

As expected with the increase in population, the projected proportion of older people who would be unable to complete at least one task is increasing at a higher rate than nationally and regionally, as seen in Figure 47. The highest increases are in the localities that are expected to see the largest increase in the numbers of older people, Daventry, East Northamptonshire and South Northamptonshire. These areas are expected to see increases of around 70% over the next 15 years. The other areas of the county are predicted to see a rise of between 50 and 60%.

Data relating to the projections of older people unable to complete at least one domestic task can be found in annex 2, tab 10.


CARERS

It is estimated that over 17,000 people aged 65 and over provide unpaid care in Northamptonshire. Over 6,000 of these unpaid carers provide in excess of 50 hours a week of care. Across the country it is estimated that 11.8% of the female population and 8.9% of the male population provide unpaid care.

A survey carried out by insurance and investment group Liverpool Victoria in 2009 found that the overall cost of caring for an elderly relative is £132,000 and the cost of 36 hours of unpaid care per month would be £3,873.

Unpaid care has many benefits, as it is often better for the older person receiving care as they will be looked after by someone they know and trust. However, providing unpaid care is often stressful and comes with great sacrifices from the carers. If we wish to continue to promote unpaid care then it is important that the needs of the carer are taken into account and that carers are supported to meet their own outcomes.


1,364 unpaid carers in Northamptonshire are themselves aged 85+. More than half of these are providing more than 50 hours of care. This is undoubtedly a huge burden to the carers at a time of life when their own needs are likely to be significant.

The numbers of unpaid carers over 65 is forecast to increase faster in Northamptonshire than the country and East Midlands region. The biggest increase is predicted to be in Corby where the number will grow by 50%. A random sample of 100 carers’ assessments taken from Northamptonshire Carers assessments in 2013/14 found that the most common needs of our carer population are mental or emotional health, physical health or mobility and social or leisure (Figure 48). This suggests that a high number of our carers are suffering from emotional or mental strain as a result of their caring role. Furthermore, this suggests that a number of our carers are suffering from physical health or mobility problems, where the caring role is impacting on the carer’s physical health. Finally, this suggests that a number of our carers are suffering from inadequate social and leisure opportunities as a result of their caring role. These needs could appear separately or in combination with other needs. A more detailed Carer Assessment analysis, looking at the needs of carers in much more detail, is included in annex 2.

Also, more data relating to self care can be found in annex 2, tab 26 and data relating to unpaid carers in tab 27.
PHYSICAL HEALTH

LIFE LIMITING LONG TERM ILLNESS

It is acknowledged that compared with non-disabled people, disabled people are:

- More likely to live in poverty – the income of disabled people is, on average, less than half of that earned by non-disabled people
- Less likely to have educational qualifications
- More likely to be economically inactive – only one in two disabled people of working age are currently in employment, compared with four out of five non-disabled people
- More likely to experience problems with hate crime or harassment – a quarter of all disabled people say that they have experienced hate crime or harassment, and this number rises to 47% of people with mental health conditions
- More likely to experience problems with transport – the issue quoted most often by disabled people as their biggest challenge
- More likely to experience problems with access to information and guidance relating to their condition and care
- More likely to have difficulties in accessing health and care services.

Also of relevance are the following issues highlighted in the National Service Framework for People with Long-term Conditions (2005):

- There is a wide variety of long-term neurological conditions and people have very different experiences. Conditions may be present at birth (e.g. cerebral palsy) and some of these may be associated with varying degrees of learning disability. Other conditions appear in childhood (e.g. Duchenne’s muscular dystrophy) or develop during adulthood (e.g. Parkinson’s disease)
- Approximately 10 million people in the UK have a neurological condition and 20% of acute hospital admissions are due to this
- Approximately 350,000 people across the UK require support with daily life because of a neurological condition and 850,000 people are carers for people with neurological conditions

The ONS 2011 Census asked the question ‘are day to day activities limited a little or a lot?’ Respondents were asked if they considered themselves to have a limiting long term illness, by that we mean an illness of more than 12 months in duration and the respondent was asked if they considered this illness to restrict their ability to perform day to day tasks a little, a lot or not at all.

This question focuses exclusively on the capture of physical or mental health conditions or illnesses long-lasting in nature (that is, lasting or expected to last for 12 months or more). The focus here is on a long-lasting condition which the person is likely to have for the remainder of their lives and is likely to require some level of supervision and treatment over a long period of time, such as diabetes. The reason for including future judgment is that for most conditions, while symptoms can be controlled with medication and/or other treatment, they are not curable and therefore relevant to the individual for the foreseeable future.

Figure 49 shows the projected increase in people aged 65 and above whose daily activities are limited ‘a little’. All of Northamptonshire’s localities are predicted to grow in this measure at a pace above that of the East Midlands and of England with Daventry and South Northamptonshire again showing the largest projected increases.

---

Figure 50: Over 65’s with activities limited by long term illness a little 2014

<table>
<thead>
<tr>
<th>Area</th>
<th>2014</th>
<th>65-74 - Little limitation</th>
<th>75-84 - Little limitation</th>
<th>85+ - Little limitation</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northamptonshire</td>
<td>2014</td>
<td>15,345</td>
<td>11,108</td>
<td>3,964</td>
<td>30,277</td>
</tr>
<tr>
<td>Corby</td>
<td>65-74 - A lot of limitation</td>
<td>9,509</td>
<td>5,811</td>
<td>6,659</td>
<td>22,977</td>
</tr>
<tr>
<td>Daventry</td>
<td>65-74 - A lot of limitation</td>
<td>1,279</td>
<td>862</td>
<td>220</td>
<td>2,361</td>
</tr>
<tr>
<td>Leicestershire South Northamptonshire</td>
<td>65-74 - A lot of limitation</td>
<td>1,090</td>
<td>1,024</td>
<td>500</td>
<td>2,614</td>
</tr>
<tr>
<td>Northampton</td>
<td>65-74 - A lot of limitation</td>
<td>3,913</td>
<td>3,071</td>
<td>1,125</td>
<td>8,099</td>
</tr>
<tr>
<td>Daventry</td>
<td>65-74 - A lot of limitation</td>
<td>1,381</td>
<td>1,145</td>
<td>438</td>
<td>3,764</td>
</tr>
<tr>
<td>Leicestershire South Northamptonshire</td>
<td>65-74 - A lot of limitation</td>
<td>1,024</td>
<td>3,093</td>
<td>205</td>
<td>2,200</td>
</tr>
<tr>
<td>Northampton</td>
<td>65-74 - A lot of limitation</td>
<td>1,935</td>
<td>1,591</td>
<td>522</td>
<td>4,207</td>
</tr>
<tr>
<td>Daventry</td>
<td>65-74 - A lot of limitation</td>
<td>1,068</td>
<td>1,179</td>
<td>214</td>
<td>2,461</td>
</tr>
<tr>
<td>Leicestershire South Northamptonshire</td>
<td>65-74 - A lot of limitation</td>
<td>1,850</td>
<td>1,405</td>
<td>457</td>
<td>3,722</td>
</tr>
<tr>
<td>Northampton</td>
<td>65-74 - A lot of limitation</td>
<td>1,191</td>
<td>1,132</td>
<td>767</td>
<td>3,090</td>
</tr>
</tbody>
</table>

Figure 51 shows the projections for over 65’s who have a long term illness that restricts their ability to perform daily tasks ‘a lot’. Again Daventry and South Northamptonshire are predicted to see the largest increase in numbers of people affected in this way, but all areas of the county are predicted to see an increase greater than that of the region and of the country over the next 16 years.

Figure 51: Over 65’s activities limited by long term illness a lot

Population aged 65 and over with a limiting long term illness whose day-to-day activities are limited a little projected to 2030


People with a limiting long term illness are likely to need support from medical services to help with the symptoms of their illness and also social care services for more practical support. Clearly those whose day to day activities are restricted a lot are not only more likely to be seeking support from health and social care services, their requirements will be greater.

More detailed data projecting the increase of older people with life limiting long term illnesses can be found in annex 1, tab 11.

HEART ATTACK

Heart attacks are more likely the older people get\textsuperscript{82}. Heart attack treatment is most effective when applied as soon as possible after the beginning of the attack. The increased likelihood of a heart attack in the elderly and the increased chance of living alone makes the risks of a heart attack greater for the elderly and the very old (85+). The British Heart Foundation found that heart attacks are more likely in men than women, estimating that 50,000 males and 32,000 females have heart attacks each year in England\textsuperscript{83}.

---

\textsuperscript{82} https://www.bhf.org.uk/heart-health/conditions/coronary-heart-disease

\textsuperscript{83} http://www.nhs.uk/Conditions/Heart-attack/Pages/Introduction.aspx

---

Figure 52 shows the estimated number of over 65’s who experience longstanding health conditions as a result of a heart attack. This data is also located in the annex, tab 13.

Figure 52: Over 65’s estimated to have longstanding health conditions as a result of a heart attack 2014\textsuperscript{84}

<table>
<thead>
<tr>
<th>Northamptonshire</th>
<th>2014</th>
<th>Kettering</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74</td>
<td>3,135</td>
<td>436</td>
</tr>
<tr>
<td>75+</td>
<td>2,785</td>
<td>395</td>
</tr>
<tr>
<td>Total</td>
<td>5,920</td>
<td>831</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Corby</th>
<th>Northampton</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74</td>
<td>229</td>
</tr>
<tr>
<td>75+</td>
<td>209</td>
</tr>
<tr>
<td>Total</td>
<td>438</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Daventry</th>
<th>South Northampton</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74</td>
<td>419</td>
</tr>
<tr>
<td>75+</td>
<td>338</td>
</tr>
<tr>
<td>Total</td>
<td>757</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>East Northamptonshire</th>
<th>Wellingborough</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74</td>
<td>442</td>
</tr>
<tr>
<td>75+</td>
<td>392</td>
</tr>
<tr>
<td>Total</td>
<td>834</td>
</tr>
</tbody>
</table>

All areas of Northamptonshire are predicted to show increases in the incidences of longstanding health conditions resulting from heart attacks in over 65’s. Wellingborough is the exception in that the number of

---

\textsuperscript{84} http://www.poppi.org.uk/index.php?pageNo=335&areaID=8369&loc=8369
incidences will increase faster than the region and national trend, but is predicted to be roughly similar to these averages on 2030. All other areas of the county are predicted to see an increase considerably over and above that of England and the East Midlands (Figure 53).

Figure 53: Over 65’s estimated to have longstanding health conditions as a result of a heart attack projected to 2030

Population aged 65 and over predicted to have a long standing health condition caused by a heart attack

http://www.poppi.org.uk/index.php?pageNo=335&areaID=8369&loc=8369

85 http://www.poppi.org.uk/index.php?pageNo=335&areaID=8369&loc=8369
A stroke is a serious, life threatening and life changing condition. Around one in four victims of a stroke will die as a result and those who survive will often have life limiting brain injuries. Every year there are approximately 152,000 strokes in the UK. Most people affected are over 65 but anyone can have a stroke, including children and even babies. Rehabilitation involves physiotherapists, psychologists, occupational therapists, speech therapists and specialist nurses and doctors.

The chances of experiencing a stroke can be reduced through healthy diet, exercise, drinking in moderation and not smoking. Lowering blood pressure and cholesterol will also reduce the likelihood of a stroke. Risk of stroke increases with age and certain medical conditions and lifestyle factors can further increase this risk. South Asian and Black people in the UK are also at increased risk of stroke. Although the reasons for this are not completely understood, Black people are twice as likely to have a stroke compared to White people and Black and South Asian people also tend to have strokes at a younger age than White people.

Figure 54 shows the estimated numbers of over 65’s in Northamptonshire experiencing a long term health condition as a result of a stroke in 2014.

Figure 55 shows the projected increase in the numbers of over 65’s with a long term health condition caused by stroke. Northamptonshire is predicted to see these numbers increasing faster than the East Midlands and in England as a whole. Wellingborough is the closest area to these

---

86 [http://www.nhs.uk/conditions/Stroke/Pages/Introduction.aspx](http://www.nhs.uk/conditions/Stroke/Pages/Introduction.aspx)

87 [http://www.stroke.org.uk/about-stroke](http://www.stroke.org.uk/about-stroke)

regional and national averages, all other areas of the county are predicted to increase by over 50% from the current levels.

Data used to create this table can be found in annex 2, tab 14.

Figure 55: Over 65 population predicted to have a long term health condition as a result of a stroke projection to 2030

Population aged 65 and over predicted to have a long standing health condition caused by a stroke


BRONCHITIS/EMPHYSEMA

Chronic Obstructive Pulmonary Disease (COPD) is commonly caused by smoking, so it follows that reducing levels of smoking will reduce the frequency and severity of incidences of COPD. COPD impacts on many aspects of life, such as the ability to exercise leading to obesity and associated risks as well as general wellbeing.

The estimated numbers of over 65’s in Northamptonshire with a long term health condition in 2014 as a result of bronchitis and/or emphysema are contained in Figure 56. More data can be found in the annex on tab 15.

Figure 56: Over 65’s estimated to have a long term health condition caused by bronchitis/emphysema 2014

<table>
<thead>
<tr>
<th>Northamptonshire</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74</td>
<td>1,172</td>
</tr>
<tr>
<td>75+</td>
<td>883</td>
</tr>
<tr>
<td>Total</td>
<td>2,055</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Corby</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74</td>
<td>80</td>
</tr>
<tr>
<td>75+</td>
<td>62</td>
</tr>
<tr>
<td>Total</td>
<td>142</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Daventry</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74</td>
<td>156</td>
</tr>
<tr>
<td>75+</td>
<td>106</td>
</tr>
<tr>
<td>Total</td>
<td>262</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>East Northamptonshire</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74</td>
<td>165</td>
</tr>
<tr>
<td>75+</td>
<td>125</td>
</tr>
<tr>
<td>Total</td>
<td>290</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Kettering</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74</td>
<td>163</td>
</tr>
<tr>
<td>75+</td>
<td>125</td>
</tr>
<tr>
<td>Total</td>
<td>288</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Northampton</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74</td>
<td>253</td>
</tr>
<tr>
<td>75+</td>
<td>257</td>
</tr>
<tr>
<td>Total</td>
<td>510</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>South Northamptonshire</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74</td>
<td>171</td>
</tr>
<tr>
<td>75+</td>
<td>123</td>
</tr>
<tr>
<td>Total</td>
<td>294</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Wellingborough</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74</td>
<td>130</td>
</tr>
<tr>
<td>75+</td>
<td>102</td>
</tr>
<tr>
<td>Total</td>
<td>232</td>
</tr>
</tbody>
</table>

Most areas of the county are expected to see a much higher growth than the English and East Midlands predictions in bronchitis and emphysema cases. Wellingborough is the exception as its increase is more likely to be in line with these averages. However the increase up to 2030 is likely to be in excess of 40% (Figure 57). Please see tab 15 in the annex for further data.

**INCONTINENCE**

Loss of bladder or bowel control is more common in women than men. Aside from the expected issues with skin irritation and hygiene, incontinence can have a big impact on an individual’s ability and confidence to conduct a normal life.92

An estimated 6.5 million people in the UK experience some form of incontinence, 2.5 million of those are over the age of 6093. Many don’t talk about these problems or seek any help, either out of embarrassment or because they think nothing can be done. This is not the case and incontinence is not an inevitable part of growing older.


92 [http://www.ageuk.org.uk/health-wellbeing/conditions-illnesses/incontinence/](http://www.ageuk.org.uk/health-wellbeing/conditions-illnesses/incontinence/)

Figure 58: Over 65’s estimated to have a bladder problem 2014

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than once a week ≤ 65-69</td>
<td>1,000</td>
<td>1,212</td>
<td>Less than once a week ≤ 65-69</td>
<td>1,095</td>
<td>1,212</td>
<td>Less than once a week ≤ 65-69</td>
<td>1,141</td>
<td>1,212</td>
</tr>
<tr>
<td>Less than once a week 70-74</td>
<td>636</td>
<td>626</td>
<td>Less than once a week 70-74</td>
<td>666</td>
<td>626</td>
<td>Less than once a week 70-74</td>
<td>714</td>
<td>626</td>
</tr>
<tr>
<td>Less than once a week 75-79</td>
<td>692</td>
<td>636</td>
<td>Less than once a week 75-79</td>
<td>518</td>
<td>518</td>
<td>Less than once a week 75-79</td>
<td>574</td>
<td>518</td>
</tr>
<tr>
<td>Less than once a week 80-84</td>
<td>642</td>
<td>636</td>
<td>Less than once a week 80-84</td>
<td>500</td>
<td>500</td>
<td>Less than once a week 80-84</td>
<td>574</td>
<td>500</td>
</tr>
<tr>
<td>Less than once a week 85+</td>
<td>674</td>
<td>616</td>
<td>Less than once a week 85+</td>
<td>444</td>
<td>444</td>
<td>Less than once a week 85+</td>
<td>574</td>
<td>444</td>
</tr>
<tr>
<td>At least once a week ≤ 65-69</td>
<td>2,500</td>
<td>2,500</td>
<td>At least once a week ≤ 65-69</td>
<td>2,500</td>
<td>2,500</td>
<td>At least once a week ≤ 65-69</td>
<td>2,500</td>
<td>2,500</td>
</tr>
<tr>
<td>At least once a week 70-74</td>
<td>3,758</td>
<td>3,758</td>
<td>At least once a week 70-74</td>
<td>3,758</td>
<td>3,758</td>
<td>At least once a week 70-74</td>
<td>3,758</td>
<td>3,758</td>
</tr>
<tr>
<td>At least once a week 75-79</td>
<td>3,722</td>
<td>3,722</td>
<td>At least once a week 75-79</td>
<td>3,722</td>
<td>3,722</td>
<td>At least once a week 75-79</td>
<td>3,722</td>
<td>3,722</td>
</tr>
<tr>
<td>At least once a week 80-84</td>
<td>2,869</td>
<td>2,869</td>
<td>At least once a week 80-84</td>
<td>2,869</td>
<td>2,869</td>
<td>At least once a week 80-84</td>
<td>2,869</td>
<td>2,869</td>
</tr>
<tr>
<td>At least once a week 85+</td>
<td>3,395</td>
<td>3,395</td>
<td>At least once a week 85+</td>
<td>3,395</td>
<td>3,395</td>
<td>At least once a week 85+</td>
<td>3,395</td>
<td>3,395</td>
</tr>
<tr>
<td>Total ≤ 65-69</td>
<td>19,216</td>
<td>21,400</td>
<td>Total ≤ 65-69</td>
<td>19,216</td>
<td>21,400</td>
<td>Total ≤ 65-69</td>
<td>19,216</td>
<td>21,400</td>
</tr>
</tbody>
</table>

Incontinence can be caused by childbirth, menopause, prostate operations, being overweight, diet, restricted movement, stroke and conditions such as Multiple Sclerosis or Parkinson’s disease.

Figure 58 shows the estimated numbers of Northamptonshire residents to have a bladder problem in 2014.

When projected to 2030, six of Northamptonshire’s boroughs and districts are anticipated to show a greater increase in over 65’s with bladder problems than the region and the country. This is for both people suffering from a bladder problem less than once a week (Figure 59) and those suffering from a bladder problem at least once a week (Figure 60). Wellingborough is expected to see an increase in this population more in line with regional and national rates.

More data relating to incontinence can be found in the annex, tab 17.

---

Figure 59: Over 65 population predicted to experience a bladder problem less than once a week projection to 2030\textsuperscript{95}

Population aged 65 and over predicted to have a bladder problem less than once a week

\textsuperscript{95} http://www.poppi.org.uk/index.php?pageNo=340&arealD=8640&loc=8640
Figure 60: Over 65 population predicted to experience a bladder problem at least once a week projection to 2030\textsuperscript{96}

Population aged 65 and over predicted to have a bladder problem at least once a week


OBESITY

The prevalence of obesity among elderly people in the United Kingdom is higher than among younger people, with almost three quarters of those aged between 65 and 74 years classed as obese or overweight\textsuperscript{97}. Obesity is measured as having a Body Mass Index (BMI) in excess of 30 and people are considered overweight if their BMI is in excess of 25.

Figure 61: Over 65 population estimated have a BMI in excess of 30 in 2014\textsuperscript{98}

\textsuperscript{96} http://www.poppi.org.uk/index.php?pageNo=340&arealD=8640&loc=8640

\textsuperscript{97} http://www.bmj.com/content/341/bmj.c3585

\textsuperscript{98} http://www.poppi.org.uk/index.php?pageNo=343&arealD=8646&loc=8646
The occurrence of obesity is increasing across the country and particularly in older people. As people become less physically active they gain weight. Eating habits may change as we age as we become less able to prepare meals for ourselves and more reliant on precooked meals. Researchers at the University of Glasgow have found higher levels of obesity in younger adults and expect that trend to grow as these obese adults age, in addition to the issues caused by the ageing process.

Levels of obesity in older people are predicted to rise faster in Northamptonshire’s boroughs and districts than in England and the East Midlands. In 2014, 32,123 older residents of the county had a BMI of 30 or more (Figure 61). The prediction is for there to be 46,550 in 2030, an increase of 45%. Corby is expected to see the highest increase at 56%, followed by Daventry and Northampton. The biggest increase in the older population is in South Northamptonshire where the number of over 80 year olds with a BMI of 30 or more is anticipated to more than double. (Figure 62). This data is available in the annex, tab 21.

For information, Figure 63 shows obesity rates in the older population of England.

A consequence of a population living longer, combined with the trend for the weight of the population to increase and their levels of physical activity to decrease is a rise in the incidences of diabetes. Many cases of diabetes could be avoided with a healthy diet, regular exercise and lower BMI.

The management of diabetes is not as simple as reducing fat and sugar content of foods. Irregular eating habits can be a trigger for hypoglycemic attacks, so the importance of eating regularly and healthily is higher for those with diabetes.

Factors that can influence the development of diabetes include inactivity and in older people this may be due to a disability or physical impairment.

Older people can be more susceptible to a hypoglycemic attack through poor food intake, kidney problems, prescription medicines and other illnesses. The signs of a hypoglycemic attack are also less recognisable and with an increasing population living alone, the risks of this can be considerable. Figure 64 shows the estimated numbers of older people with diabetes in Northamptonshire in 2014. The information is presented for the county, as well as the seven boroughs and districts. In addition the numbers are split by age group, the 65-74 year olds and the over 75’s.

**Figure 63: Obesity rates in the older population of England**

<table>
<thead>
<tr>
<th>Age range</th>
<th>% males obese</th>
<th>% males morbidly obese</th>
<th>% females obese</th>
<th>% females morbidly obese</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-69</td>
<td>29</td>
<td>1</td>
<td>30</td>
<td>3</td>
</tr>
<tr>
<td>70-74</td>
<td>27</td>
<td>0</td>
<td>25</td>
<td>1</td>
</tr>
<tr>
<td>75-79</td>
<td>21</td>
<td>0</td>
<td>28</td>
<td>1</td>
</tr>
<tr>
<td>80-84</td>
<td>16</td>
<td>1</td>
<td>23</td>
<td>1</td>
</tr>
<tr>
<td>85+</td>
<td>10</td>
<td>0</td>
<td>15</td>
<td>0</td>
</tr>
</tbody>
</table>

**Figure 64: Over 65’s estimated to have diabetes**

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th></th>
<th>2014</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Northamptonshire</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65-74</td>
<td>9,049</td>
<td></td>
<td>65-74</td>
<td>1,258</td>
</tr>
<tr>
<td>75+</td>
<td>653</td>
<td></td>
<td>75+</td>
<td>882</td>
</tr>
<tr>
<td>Total</td>
<td>9,193</td>
<td></td>
<td>Total</td>
<td>2,140</td>
</tr>
<tr>
<td>Kettering</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65-74</td>
<td>666</td>
<td></td>
<td>65-74</td>
<td>1,265</td>
</tr>
<tr>
<td>75+</td>
<td>463</td>
<td></td>
<td>75+</td>
<td>852</td>
</tr>
<tr>
<td>Total</td>
<td>1,131</td>
<td></td>
<td>Total</td>
<td>2,117</td>
</tr>
<tr>
<td>Corby</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65-74</td>
<td>666</td>
<td></td>
<td>65-74</td>
<td>1,265</td>
</tr>
<tr>
<td>75+</td>
<td>463</td>
<td></td>
<td>75+</td>
<td>852</td>
</tr>
<tr>
<td>Total</td>
<td>1,131</td>
<td></td>
<td>Total</td>
<td>2,117</td>
</tr>
<tr>
<td>Daventry</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65-74</td>
<td>1,261</td>
<td></td>
<td>65-74</td>
<td>1,315</td>
</tr>
<tr>
<td>75+</td>
<td>749</td>
<td></td>
<td>75+</td>
<td>823</td>
</tr>
<tr>
<td>Total</td>
<td>2,010</td>
<td></td>
<td>Total</td>
<td>2,188</td>
</tr>
<tr>
<td>East Northamptonshire</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65-74</td>
<td>1,274</td>
<td></td>
<td>65-74</td>
<td>1,045</td>
</tr>
<tr>
<td>75+</td>
<td>853</td>
<td></td>
<td>75+</td>
<td>711</td>
</tr>
<tr>
<td>Total</td>
<td>2,127</td>
<td></td>
<td>Total</td>
<td>1,760</td>
</tr>
</tbody>
</table>

**Figure 64: Over 65’s estimated to have diabetes**


Figure 65 shows the predicted numbers of diabetes in the older population up to 2030. All areas of the county will see an increase higher than the average for England and for the East Midlands with the exception of Wellingborough, the increase there is anticipated to be more in line with the regional average but still above the national expectations. This data is available in annex 2, tab 22.

Figure 65: People over 65 predicted to have diabetes, projected to 2030

People aged 65 and over predicted to have Type 1 or Type 2 diabetes, by age and gender, projected to 2030


MENTAL HEALTH

DEMENTIA
Dementia is a common condition that affects about 800,000 people in the UK. The risk of developing dementia increases as you get older, and the condition usually occurs in people over the age of 65. Dementia is a syndrome (a group of related symptoms) associated with an ongoing decline of the brain and its abilities. This includes problems with:

- Memory
- Thinking speed
- Mental agility
- Language
- Understanding
- Judgement

Other symptoms can include:

- Increasing difficulties with tasks and activities that require concentration and planning
- Depression
- Changes in personality and mood
- Periods of mental confusion
- Difficulty finding the right words

http://www.nhs.uk/Conditions/dementia-guide/Pages/about-dementia.aspx
Rates of dementia in 65-84 year olds are predicted to increase at a faster rate than England and the East Midlands comparators, particularly in Daventry and South Northamptonshire. Increases in people over the age of 85 are considerably higher than their younger counterparts, more than doubling in South Northamptonshire and Daventry and almost doubling in Corby and Northampton. Northampton is also the largest area of population and is predicted to have 1,821 people over 85 suffering from dementia in some form. The majority of these, 949 people, are expected to be over 90 years of age.

Figure 67: 65-84 population predicted to have dementia projected to 2030

People aged 65 - 74 predicted to have dementia, by age and gender, projected to 2030

The data relating to dementia can be found in the accompanying annex on tab 23.

**Figure 68**: Over 85 population predicted to have dementia projected to 2030

People aged 85 and over predicted to have dementia, by age and gender, projected to 2030


---

**DEPRESSION**

Mental wellness and physical health are closely linked. Depression has been linked to various conditions such as stroke, fibromyalgia, Alzheimer’s and Cancer.

Older people can be more susceptible to depression for a number of factors, including but not limited to illness, medication, loss of loved ones, isolation or anxiety caused by financial pressures or fear of crime for example. Exercise is a great way to combat feelings of depression but this is not always possible with decreased mobility. Loneliness is another factor and as noted previously, this is a risk that increases with age.

**Figure 69** shows the number of older people in Northamptonshire and its districts estimated to suffer from depression in 2014.

---

As the older population increases, so does the risk of depression amongst older people. The projection in Northamptonshire is for numbers of older people with depression to increase faster than the national and regional levels (Figure 70). The number of older people with severe depression is predicted to increase by between 50 and 60% over the next 15 years (Figure 71).

---

**Figure 69:** Over 65’s estimated to suffer from depression and severe depression 2014

<table>
<thead>
<tr>
<th>Region</th>
<th>2014 Depression</th>
<th>2014 Severe Depression</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northamptonshire</td>
<td>5.46%</td>
<td>1.79%</td>
<td>7.25%</td>
</tr>
<tr>
<td>Corby</td>
<td>2.50%</td>
<td>0.58%</td>
<td>3.08%</td>
</tr>
<tr>
<td>Daventry</td>
<td>4.41%</td>
<td>1.13%</td>
<td>5.54%</td>
</tr>
<tr>
<td>Total</td>
<td>12.41%</td>
<td>3.55%</td>
<td>16.04%</td>
</tr>
</tbody>
</table>

**Figure 70:** Over 65’s predicted to suffer from depression

<table>
<thead>
<tr>
<th>Region</th>
<th>2014 Depression</th>
<th>2014 Severe Depression</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northamptonshire</td>
<td>5.37%</td>
<td>1.62%</td>
<td>7.00%</td>
</tr>
<tr>
<td>Corby</td>
<td>2.50%</td>
<td>0.58%</td>
<td>3.08%</td>
</tr>
<tr>
<td>Daventry</td>
<td>4.41%</td>
<td>1.13%</td>
<td>5.54%</td>
</tr>
<tr>
<td>Total</td>
<td>12.41%</td>
<td>3.55%</td>
<td>16.04%</td>
</tr>
</tbody>
</table>


---


LEARNING DISABILITIES

People with learning disabilities are living longer and as a result, the number of older people with a learning disability is increasing. Despite the fact that people with learning disabilities are 58 times more likely to die before the age of 50 than the rest of the population, life expectancy for people with learning disabilities has increased over the last 70 years\(^{114}\). In the 1930’s, life expectancy for people with a learning disability was estimated to be around 20 years of age, by 2002 this had increased to 74, 67 and 58 respectively for people with a mild, moderate or severe learning disability\(^{115}\).

Older people with learning disability need more support to age well, to remain active and healthy for as long as possible. Increased demand in the older age groups is of particular significance since older adults with learning disabilities are significantly more likely than younger adults to rely on public funding for supported accommodation. It is predicted that

\(^{114}\) file:///J:/My%20Documents/downloads/BILD%20Older%20people%20factsheet%202012.pdf

\(^{115}\) http://www.rcn.org.uk/development/practice/social_inclusion/learning_disabilities

Further data can be found in the annex, tab 12.

\(^{113}\) http://www.poppi.org.uk/index.php?pageNo=332&arealD=8646&loc=8646
provision of residential support for older adults with learning disabilities will increase by 20,000 between 2011 and 2021.\textsuperscript{116}

The terms "mild", "moderate" and "severe or profound" learning disabilities appear to suggest distinct categories for learning disability but in reality these do not adequately describe the range of impairments or disabilities this group may have. Someone with autism, for example, who has learning disabilities may have significant social difficulties and appear to have moderate learning difficulties, yet may be able to look after their own personal care and everyday needs quite independently.\textsuperscript{117}

Research by the Disability Rights Commission in 2006 found that people with a learning disability are two and a half times more likely to have health problems than the rest of the community. Further studies by the Commission and Mencap have found that adults with learning disabilities have more unmet needs and receive less effective treatment.

\begin{figure}
\centering
\includegraphics[width=\textwidth]{Figure72.png}
\caption{Over 65’s estimated to have learning disabilities 2014\textsuperscript{118}}
\end{figure}

\textsuperscript{116} http://www.lancaster.ac.uk/cedr/publications/CeDR%202008-1%20People%20with%20Learning%20Disabilities%20in%20England.pdf

\textsuperscript{117} http://www.rcn.org.uk/development/practice/social_inclusion/learning_disabilities\es

\textsuperscript{118} http://www.poppi.org.uk/index.php?pageNo=374&areaID=8646&loc=8646
Figure 73 projects the numbers of older people with learning disabilities to 2030. Corby and Daventry are predicted to see the highest increase, almost 20% higher than the increase in England and in the East Midlands. Wellingborough once again grows at a rate similar to the rest of the East Midlands. This data is available in annex 2, tab 24.

Figure 73: Over 65’s estimated to have learning disabilities projected to 2030

People aged 65 and over predicted to have a learning disability, by age


Figure 74 compares mortality rates in adults under 75 with neighbouring authorities and with the national average. There is no regional data in this case. The rates are higher in Northamptonshire.

Figure 74: Mortality rates in adults under 75 with mental illness, comparison with neighbours 2012/13

<table>
<thead>
<tr>
<th>Indicator</th>
<th>4.09 Excess under 75 mortality rate in adults with serious mental illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Period</td>
<td>2012-13</td>
</tr>
<tr>
<td>England</td>
<td>337.4</td>
</tr>
<tr>
<td>East Midlands</td>
<td>355.1</td>
</tr>
<tr>
<td>Derby</td>
<td>295.0</td>
</tr>
<tr>
<td>Derbyshire</td>
<td>340.0</td>
</tr>
<tr>
<td>Leicester</td>
<td>362.6</td>
</tr>
<tr>
<td>Leicestershire</td>
<td>231.5</td>
</tr>
<tr>
<td>Lincolnshire</td>
<td>366.5</td>
</tr>
<tr>
<td>Northamptonshire</td>
<td>422.2</td>
</tr>
<tr>
<td>Nottingham</td>
<td>337.9</td>
</tr>
<tr>
<td>Rutland</td>
<td>395.6</td>
</tr>
</tbody>
</table>


120 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049/pat/6/ati/102/page/0/par/E12000004/are/E06000015
AUTISM

Autism and Aspergers exaggerate feelings of loneliness and isolation. Many adults with autism are socially isolated and their family is the only form of social contact they may have. As they age, this will only increase as family members age and find it more difficult to meet their own needs.

Autism was identified in the 1940’s and it is only now that the first children to receive a diagnosis of autism of some form are reaching old age. Autism in general has been considered to be a neglected subject in terms of policy and research and particularly so for people approaching old age with autism. Some older adults are receiving a diagnosis of autism in their later years, not every case is identified in childhood. This can bring mixed emotions, the individual can seek to address their condition but on the other hand there can be feelings of regret and disappointment at their missed opportunities in life.121

People with autism may experience and report pain differently to others. Difficulties with understanding feelings, with communication and with insight can make it hard for some people with autism to recognise when they are unwell. This becomes more pressing in older age as ill health increases.

96% of parents of people with autism responding to a survey from the National Autistic Society (2012) said they were concerned about what will happen to their child when they are no longer there to support them122.

Figure 75: Over 65’s estimated to have Autism 2014123

<table>
<thead>
<tr>
<th>Northamptonshire</th>
<th>2014</th>
<th>Kettering</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74</td>
<td>683</td>
<td>65-74</td>
<td>95</td>
</tr>
<tr>
<td>75+</td>
<td>458</td>
<td>75+</td>
<td>63</td>
</tr>
<tr>
<td>Total</td>
<td>1,141</td>
<td>Total</td>
<td>157</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Corby</th>
<th>2014</th>
<th>Northampton</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74</td>
<td>49</td>
<td>65-74</td>
<td>169</td>
</tr>
<tr>
<td>75+</td>
<td>35</td>
<td>75+</td>
<td>121</td>
</tr>
<tr>
<td>Total</td>
<td>84</td>
<td>Total</td>
<td>290</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Daventry</th>
<th>2014</th>
<th>South Northamptonshire</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74</td>
<td>92</td>
<td>65-74</td>
<td>100</td>
</tr>
<tr>
<td>75+</td>
<td>57</td>
<td>75+</td>
<td>66</td>
</tr>
<tr>
<td>Total</td>
<td>149</td>
<td>Total</td>
<td>166</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>East Northamptonshire</th>
<th>2014</th>
<th>Wellingborough</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74</td>
<td>56</td>
<td>65-74</td>
<td>79</td>
</tr>
<tr>
<td>75+</td>
<td>66</td>
<td>75+</td>
<td>54</td>
</tr>
<tr>
<td>Total</td>
<td>162</td>
<td>Total</td>
<td>132</td>
</tr>
</tbody>
</table>

121 http://www.autism.org.uk/gettingon


Figure 75 shows the estimated number of residents aged 65 and over with autism in Northamptonshire and districts.

A recommendation from the National Autistic Society’s report ‘Getting On?’ was for local authorities to ‘consider volunteer-led models to support older people with autism in developing local commissioning plans, and fund such services to meet need.’

Figure 75

Figure 76 projects the numbers of older people with autism. In this instance, it is Corby that is predicted to have the highest increase, in excess of 60%. This data is contained in the annex, tab 25.

MOBILITY

FALLS

The number of falls amongst the over 65 population in Northamptonshire, and also the number of falls that result in a hospital admission, are lower than the averages across England and the East Midlands. Severity of falls is lower in Northamptonshire than regional and national comparators across all age groups.

The number of falls resulting in a hospital admission is also lower in the county than in the region and country. In 2010/11 in England, 2475.3 people per 10,000 population were admitted to hospital following a fall. In the East Midlands the figure was slightly lower at 2470.6 people per 10,000 population. In Northamptonshire that figure was 2156 per 10,000 population (Figure 77).

In 2012, Northamptonshire’s Crisis Response Team, run by Northamptonshire County Council and the East Midlands Ambulance Service to provide assistance to people who have suffered a fall with the aim of avoiding another, was commended with a national award. The

\[124\] http://www.autism.org.uk/gettingon

service won the Patient Safety in Diagnosis at that year’s National Patient Safety Awards. The Crisis Response Team will attend an emergency call relating to a fall in a specialist ambulance, ensuring that the patient receives appropriate care and freeing up other ambulances to deal with other emergencies. The aim of the team is to avoid unnecessary admissions to hospital as a result of a fall and provide assistance, advice and support to people who have suffered a fall in order to prevent a reoccurrence.

Figure 77: Injuries due to falls in over 65’s per 100,000 population

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2013/14</th>
<th>2013/14</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.241</td>
<td>2.243</td>
<td>2.244</td>
</tr>
<tr>
<td></td>
<td>injuries</td>
<td>injuries</td>
<td>injuries</td>
</tr>
<tr>
<td></td>
<td>due to falls in</td>
<td>due to falls in</td>
<td>due to falls in</td>
</tr>
<tr>
<td></td>
<td>people aged 65</td>
<td>people aged 65-79</td>
<td>people aged 79-80+</td>
</tr>
<tr>
<td>England</td>
<td>2064</td>
<td>989</td>
<td>5182</td>
</tr>
<tr>
<td>East Midlands</td>
<td>1955</td>
<td>913</td>
<td>4976</td>
</tr>
<tr>
<td>Derby</td>
<td>2221</td>
<td>1107</td>
<td>5454</td>
</tr>
<tr>
<td>Derbyshire</td>
<td>2207</td>
<td>1023</td>
<td>5641</td>
</tr>
<tr>
<td>Leicester</td>
<td>1847</td>
<td>1008</td>
<td>4283</td>
</tr>
<tr>
<td>Leicestershire</td>
<td>1667</td>
<td>734</td>
<td>4370</td>
</tr>
<tr>
<td>Lincolnshire</td>
<td>1977</td>
<td>942</td>
<td>4980</td>
</tr>
<tr>
<td>Northamptonshire</td>
<td>1746</td>
<td>836</td>
<td>4386</td>
</tr>
<tr>
<td>Corby</td>
<td>1828</td>
<td>1105</td>
<td>4217</td>
</tr>
<tr>
<td>Daventry</td>
<td>1651</td>
<td>714</td>
<td>4366</td>
</tr>
<tr>
<td>East Northamptonshire</td>
<td>1611</td>
<td>838</td>
<td>3854</td>
</tr>
<tr>
<td>Kettering</td>
<td>1689</td>
<td>813</td>
<td>4228</td>
</tr>
<tr>
<td>Northampton</td>
<td>1846</td>
<td>823</td>
<td>4814</td>
</tr>
<tr>
<td>South Northamptonshire</td>
<td>1802</td>
<td>884</td>
<td>4465</td>
</tr>
<tr>
<td>Wellingborough</td>
<td>1719</td>
<td>874</td>
<td>4172</td>
</tr>
<tr>
<td>Nottingham</td>
<td>2155</td>
<td>1050</td>
<td>5512</td>
</tr>
<tr>
<td>Nottinghamshire</td>
<td>1984</td>
<td>877</td>
<td>5194</td>
</tr>
<tr>
<td>Rutland</td>
<td>1924</td>
<td>880</td>
<td>4952</td>
</tr>
</tbody>
</table>

Figure 78: Over 65’s sustaining injuries due to falls – 2012/13

Figure 79 shows that whilst the percentage of falls that ultimately result in an admission to hospital in Northamptonshire is currently lower than the rates for England and the East Midlands, projections show that it is likely that this will change in the next 10 years and the rate in Northamptonshire is predicted to be more than the rates for England and


the East Midlands. This data can be found in the annex, tab 16. However, this increase will also be dependant on the type of services available.

Figure 79: Projection of falls resulting in an admission to hospital in over 65’s

Northamptonshire currently commissions a specialist Falls Risk Assessment and Risk Reduction Service targeted at those aged 65 and over living in Northamptonshire and/or registered with a Northamptonshire GP who have experienced a fall or are considered at significant/high risk of doing so.

Analysis of Northamptonshire Healthcare Foundation Trust (NHFT) data is hampered by changing datasets year on year since 2010/11. Broad points can be made;

- NHFT saw more people in 2010/11 and 2011/12 in relation to falls and educational and preventative sessions were carried out with key groups in the county.
- 2012/13 saw a 9% increase in referrals and a 3% increase in face-to-face contacts.
- Data for 2013/14 indicate a drop in referral numbers from the previous year of around 22% and an increase in the numbers waiting to be seen (from an average of around 82 to 133).

Data relating to 2014/15 is different in that the new indicator is ‘people seen within six weeks of referral’. Current year end predictions are 68% but the trajectory is positive.

2014/15 has also seen a budget reduction in this area of around 21% which has resulted in the service seeing an anticipated 700 people by the end of the financial year, an estimated 30% of fallers admitted to hospital as a result of their fall and around 2% of all those over the age of 65 years.

Customer feedback from people who have interacted with the falls prevention service has been 90% positive.

**Figure 80: Hip fractures in people aged 65 and over, comparison with neighbours**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2.24ii Injuries due to falls in people aged 65 and over</th>
<th>2.24ii Injuries due to falls in people aged 79</th>
<th>2.24ii Injuries due to falls in people aged 80+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Period</td>
<td>2012/13</td>
<td>2013/14</td>
<td>2013/14</td>
</tr>
<tr>
<td>England</td>
<td>2084</td>
<td>989</td>
<td>5182</td>
</tr>
<tr>
<td>East Midlands</td>
<td>1955</td>
<td>913</td>
<td>4976</td>
</tr>
<tr>
<td>Derby</td>
<td>2221</td>
<td>1107</td>
<td>5454</td>
</tr>
<tr>
<td>Derbyshire</td>
<td>2207</td>
<td>1023</td>
<td>5641</td>
</tr>
<tr>
<td>Leicester</td>
<td>1847</td>
<td>1008</td>
<td>4283</td>
</tr>
<tr>
<td>Leicestershire</td>
<td>1657</td>
<td>714</td>
<td>4170</td>
</tr>
<tr>
<td>Lincolnshire</td>
<td>1577</td>
<td>942</td>
<td>4380</td>
</tr>
<tr>
<td>Northamptonshire</td>
<td>1746</td>
<td>816</td>
<td>4386</td>
</tr>
<tr>
<td>Corby</td>
<td>1828</td>
<td>1105</td>
<td>4217</td>
</tr>
<tr>
<td>Daventry</td>
<td>1651</td>
<td>714</td>
<td>4366</td>
</tr>
<tr>
<td>East Northamptonshire</td>
<td>1611</td>
<td>838</td>
<td>3854</td>
</tr>
<tr>
<td>Kettering</td>
<td>1689</td>
<td>813</td>
<td>4228</td>
</tr>
<tr>
<td>Northampton</td>
<td>1846</td>
<td>823</td>
<td>4814</td>
</tr>
<tr>
<td>South Northamptonshire</td>
<td>1802</td>
<td>884</td>
<td>4465</td>
</tr>
<tr>
<td>Wellingborough</td>
<td>1739</td>
<td>874</td>
<td>4172</td>
</tr>
<tr>
<td>Nottingham</td>
<td>2195</td>
<td>1050</td>
<td>5512</td>
</tr>
<tr>
<td>Nottinghamshire</td>
<td>1984</td>
<td>877</td>
<td>5194</td>
</tr>
<tr>
<td>Rutland</td>
<td>1924</td>
<td>880</td>
<td>4952</td>
</tr>
</tbody>
</table>

To combat the rise in older people experiencing a fall, the Integrated Falls Strategy Development Group has been formed, featuring representatives from Northamptonshire County Council (NCC), NHFT and key partners, building on relationships with Reablement Services (START), Intermediate Care (ICS), Crisis Response Teams (CRT), the Sensory, Equipment And Rehabilitation Team (SERT), the local ambulance service (EMAS).

**Figure 80** shows how hip fractures in the over 65 population of Northamptonshire compares with our neighbours and with England and the East Midlands. Numbers of fractures in Northamptonshire are higher than all of our neighbours with the exception of Rutland in people aged 65 to 79 and third highest in those aged 80 and over.

**SENSORY IMPAIRMENT**

**VISUAL IMPAIRMENT**

In 2014, 13,692 Northamptonshire people aged 65 and over were estimated to have a visual impairment of some description. 10,358 of these could be considered moderate or severe. The majority, 6,460, were aged 75 and over with a moderate to severe visual impairment and 3,334 had a registrable visual impairment. The remainder, 3,898, was aged between 65 and 74 with a moderate to severe impairment (Figure 81).

Figure 81: Over 65 population estimated to have a moderate to severe visual impairment 2014

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northamptonshire</td>
<td></td>
</tr>
<tr>
<td>65-74</td>
<td>3,398</td>
</tr>
<tr>
<td>75+</td>
<td>6,460</td>
</tr>
<tr>
<td>Corby</td>
<td></td>
</tr>
<tr>
<td>65-74</td>
<td>231</td>
</tr>
<tr>
<td>75+</td>
<td>484</td>
</tr>
<tr>
<td>Daventry</td>
<td></td>
</tr>
<tr>
<td>65-74</td>
<td>510</td>
</tr>
<tr>
<td>75+</td>
<td>781</td>
</tr>
<tr>
<td>East Northamptonshire</td>
<td></td>
</tr>
<tr>
<td>65-74</td>
<td>549</td>
</tr>
<tr>
<td>75+</td>
<td>905</td>
</tr>
</tbody>
</table>

Table with visual impairments for different age groups in Northamptonshire.

The rate of increase of older people with visual impairments is once again anticipated to be higher in Northamptonshire than in England and the East Midlands (Figure 82). The largest projected increases are in Daventry, South Northamptonshire and East Northamptonshire, but all seven boroughs and districts are expected to show larger increases than the rest of the region and country on average. In 2020 it is predicted that there will be 16,422 older people with a moderate to severe visual impairment, an increase of 2,730 individuals. By 2030 the increase is projected to be 9,086 people, a total of 22,778 across the county. Data relating to visual impairments can be found in annex 2, tab 18.


Figure 82: Visual impairment in over 65’s projection to 2030

People aged 65 and over predicted to have a moderate or severe visual impairment projected to 2030

Figure 83 shows the prevalence of preventable sight loss in Northamptonshire compared to the England and East Midlands levels. For all measures Northamptonshire’s incidences of sight loss are lower than our neighbours with the exception of Derby. The levels of Age Related Macular Degeneration, glaucoma and the measure for preventable sight loss certifications are considerably lower than the national figures.

Some Black and Minority Ethnic (BME) groups are at higher risk of developing eye conditions, for example African and African Caribbean groups are four times more likely to develop glaucoma and macular degeneration before the age of 60 than other ethnicities, people of South Asian descent are at higher risk of developing cataracts and both the above mentioned groups are at increased risk of developing diabetic eye disease.\textsuperscript{132}

**Figure 83: Preventable sight loss comparison with neighbours 2012-13\textsuperscript{133}**

HEARING IMPAIRMENT

In 2014, 50,465 Northamptonshire residents over 65 years of age have a hearing impairment of some description. 1,312 of these have a profound hearing impairment. Hearing impairments are defined by the quietest sounds a subject can hear. People with mild deafness can hear 25-39 decibels, while its 40-69 decibels for people with moderate deafness, 70-94 decibels for people who are severely deaf and more than 95 decibels for those who are profoundly deaf.\textsuperscript{134}

Hearing impairments were most prevalent in the 75-84 age group and profound hearing difficulties most likely in those over 85. **Figure 84** shows the estimated numbers of Northamptonshire’s older residents with a hearing impairment categorised as moderate, severe or profound.

By 2030, the number of older people with hearing impairments is predicted to increase to 85,014, a 68% increase compared to an increase of 50% in England and 56% in the East Midlands. Profound hearing impairment is estimated to increase to 2,212 cases. All of the boroughs and districts of Northamptonshire are predicted to experience a higher rate of increase in older people with hearing difficulties than the regional and country predictions. Daventry, South Northamptonshire and East

\textsuperscript{132} http://www.boltonshelmhealthmatters.org/content/limiting-long-term-illness-disability-adults-jsna

\textsuperscript{133} http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049/pat/6/ati/102/page/0/par/E12000004/are/E06000015

\textsuperscript{134} http://www.actiononhearingloss.org.uk/your-hearing/about-deafness-and-hearing-loss/deafness-describing-deafness.aspx
Northamptonshire are expected to show the largest increases, 79%, 77% and 75% respectively.

**Figure 84: Over 65 population estimated to have a moderate, severe or profound hearing impairment 2014**

<table>
<thead>
<tr>
<th>Area</th>
<th>Moderate or severe impairment 65+</th>
<th>Moderate or severe impairment 75+</th>
<th>Moderate or severe impairment 85+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northamptonshire</td>
<td>15,306</td>
<td>22,745</td>
<td>33,072</td>
</tr>
<tr>
<td>Kettering</td>
<td>13,857</td>
<td>22,375</td>
<td>32,925</td>
</tr>
<tr>
<td>Daventry</td>
<td>1,565</td>
<td>2,584</td>
<td>3,611</td>
</tr>
<tr>
<td>Northampton</td>
<td>967</td>
<td>1,803</td>
<td>2,602</td>
</tr>
<tr>
<td>Leicestershire</td>
<td>52</td>
<td>82</td>
<td>122</td>
</tr>
<tr>
<td>Derby</td>
<td>1,770</td>
<td>2,930</td>
<td>4,111</td>
</tr>
<tr>
<td>South Northamptonshire</td>
<td>1,441</td>
<td>2,545</td>
<td>3,753</td>
</tr>
<tr>
<td>East Northamptonshire</td>
<td>680</td>
<td>1,090</td>
<td>1,522</td>
</tr>
<tr>
<td>Median age</td>
<td>2014</td>
<td>2014</td>
<td>2014</td>
</tr>
</tbody>
</table>

From the projection in **Figure 85**, three areas are expected to show faster growth in numbers of older people with hearing difficulties than the rest of the county up to 2030. These are Daventry, South Northamptonshire and East Northamptonshire, all of which are predicted to see increases in cases of over 70%. This data is contained in the **annex on tab 19**.

**Figure 85: Over 65’s with a hearing difficulty projection to 2030**

<table>
<thead>
<tr>
<th>Area</th>
<th>Moderate or severe impairment 65+</th>
<th>Moderate or severe impairment 75+</th>
<th>Moderate or severe impairment 85+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northamptonshire</td>
<td>423</td>
<td>756</td>
<td>1,079</td>
</tr>
<tr>
<td>Kettering</td>
<td>395</td>
<td>727</td>
<td>1,050</td>
</tr>
<tr>
<td>Daventry</td>
<td>156</td>
<td>287</td>
<td>402</td>
</tr>
<tr>
<td>Northampton</td>
<td>97</td>
<td>180</td>
<td>262</td>
</tr>
<tr>
<td>Leicestershire</td>
<td>52</td>
<td>82</td>
<td>122</td>
</tr>
<tr>
<td>Derby</td>
<td>1,770</td>
<td>2,930</td>
<td>4,111</td>
</tr>
<tr>
<td>South Northamptonshire</td>
<td>1,441</td>
<td>2,545</td>
<td>3,753</td>
</tr>
<tr>
<td>East Northamptonshire</td>
<td>680</td>
<td>1,090</td>
<td>1,522</td>
</tr>
</tbody>
</table>

**People aged 65 and over predicted to have a moderate or severe, or profound, hearing impairment, projected to 2030**


---


ADULT SOCIAL CARE (ASC)

DEMOGRAPHIC

The current demand for ASC support within Northamptonshire stands at 14,695 intervention cases across 9,487 clients as of August 2014. Of this number, 2,789 were aged 18-64, 2,957 were aged 65 to 84 and 3,574 were aged 85 and over. As a figure generated at a point less than halfway through the care year, this will have increased by the end of March 2015.

Figure 86 shows the age distribution of the total Adult Social Care cohort in Northamptonshire for the year to date.

The profile of this population shows a peak in demand occurring around the age of 75, largely constructed of women. Across the care community the gender split is representative of the general population amongst the 18-64 years cohort, but amongst those aged 65+ female clients account for more than two thirds whereas the gender split amongst the population of older people in Northamptonshire is 46% male, 54% female. This is shown in Figure 87.
Client numbers for Adult Social Care services have been declining since 2005/6 due to decreasing funding and rising contributions\(^{137}\), the total in 2013/14 was only 57% of that in 2005/6. However demand for dementia support has remained consistent. **Figure 88** shows this decline in demand.

**Figure 88: ASC Clients by Age Group from 2005 to 2014**

Northamptonshire Adult Social Care
Clients by age group 2005-2014

Ethnicity of older people receiving support from Northamptonshire’s Adult Social Care teams shows little difference from the profile of the wider population. Almost 93% of the county is of White ethnicity and the proportion of over 65’s receiving support is 92%. However as mentioned on page 29, as the population ages its ethnicity becomes less diverse and this is reflected in the proportions receiving care, shown in **Figure 89**.

**Figure 89: Ethnicity of over 65’s receiving care from Northamptonshire Adult Social Care**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>65+</th>
<th>All</th>
<th>% 65+</th>
<th>% All</th>
<th>% 18+ Pop. [2011]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>105</td>
<td>162</td>
<td>1.60%</td>
<td>1.70%</td>
<td>3.50%</td>
</tr>
<tr>
<td>Black</td>
<td>90</td>
<td>170</td>
<td>1.40%</td>
<td>1.80%</td>
<td>2.20%</td>
</tr>
<tr>
<td>Mixed</td>
<td>15</td>
<td>55</td>
<td>0.20%</td>
<td>0.60%</td>
<td>1.30%</td>
</tr>
<tr>
<td>Other</td>
<td>31</td>
<td>45</td>
<td>0.50%</td>
<td>0.50%</td>
<td>0.40%</td>
</tr>
<tr>
<td>White</td>
<td>6,011</td>
<td>8,538</td>
<td>92.00%</td>
<td>91.50%</td>
<td>92.60%</td>
</tr>
<tr>
<td>No Info</td>
<td>279</td>
<td>350</td>
<td>4.30%</td>
<td>3.80%</td>
<td>-</td>
</tr>
</tbody>
</table>

The highest level of demand is in Northampton, not surprising given that this is the most populated borough in the county. **Figure 90** shows that 27% of over 65 clients are resident in Northampton. The next highest areas of demand are Kettering, East Northamptonshire and Wellingborough.

Corby has the highest proportion of people over 85 accessing services. The highest absolute numbers are in Northampton.

Figure 91 demonstrates that of the over 65 population requiring support services from ASC, more of these are over 85 than between 65 and 84 apart from in Corby, the only area with a higher number of 65-84 year olds but also with the lowest life expectancy in the county. Despite this,
The number of ASC clients within the area can be compared against those of a set of statistical neighbours, as defined by CIPFA\textsuperscript{138}, to provide some indication of the extent of demand within the county. For

\begin{table}[h]
\centering
\begin{tabular}{|l|l|l|}
\hline
 & Current Age & Age of Entry \\
\hline
Northamptonshire & 71.9 & 70.6 \\
Corby & 70.5 & 69.3 \\
Daventry & 72.6 & 71.5 \\
East Northamptonshire & 74.5 & 73.3 \\
Kettering & 72.7 & 71.5 \\
Northampton & 68.5 & 66.8 \\
South Northamptonshire & 74.4 & 72.6 \\
Wellingborough & 68.1 & 66.8 \\
\hline
\end{tabular}
\end{table}

Amongst the 65+ years group, statistical neighbours are identified as Bedford, Warrington, Swindon, Central Bedfordshire and Cambridgeshire. The occurrence of ASC clients per 10,000 population of this age group has reduced in Northamptonshire since 2009/10 by over 300. This trend is replicated across statistical neighbours, some of which have seen a more significant fall in client numbers. Across the group, Northamptonshire has consistently recorded the lowest intervention rate during the period 2009/10–2013/14, Figure 94.

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure92}
\caption{Over 65’s receiving care by district, rate per 1,000 2014/15}
\end{figure}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure93}
\caption{Average age of ASC Clients by borough/district 2014/15}
\end{figure}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure94}
\caption{Over 65’s receiving care from Northamptonshire Adult Social Care - Rate per 1,000 Population}
\end{figure}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure95}
\caption{Northamptonshire, statistical neighbours in ASC are divided into two separate categories, conforming with the division by age between those aged 18-64, defined by CIPFA as ‘Younger Adults’ and those aged 65 and over, defined as ‘Older People’.}
\end{figure}

\textsuperscript{138} CIPFA Statistical Neighbours for ASC data
http://www.cipfastats.net/default_view.asp?content_ref=18004
Access to Adult Social Care is initially made through Northamptonshire County Council’s Customer Service Centre (CSC). Between April 2014 and January 2015, the CSC received 32,585 contacts relating to Adult Social Care. 6,652 have no recorded age details and have been discounted from the totals referred to from this point.

Of the remaining 25,933 contacts, 9,268 (36%) were related to people aged between 65 and 84 and 7,437 (29%) related to people aged 85 and over. 3,393 (13%) contacts were related to people aged 50-64.

The number of contacts to the CSC has been rising over time; Figure 95 shows this increase in addition to the number of contacts that led to an assessment being requested and those that were passed to locality teams. There has been a particularly high number of contacts in January 2015, 14% more compared to January 2014. Whilst data from the CSC’s Customer Records Management system is available going back to 2012, many substantial changes to working practices over this time and the amount of missing data means this data cannot be relied upon and has not been included for this reason.

The CSC gave advice and information to 41.2% of contacts between April 2014 and January 2015. Figure 96 shows the outcomes of these calls. The data can be found once again in the annex, tab 29.
Figure 96: Outcomes of ASC Contact with CSC, April 2014 – January 2015 by age group

**Outcome of ASC Assessment by age group - April 2014 - January 2015**

Source: NCC Customer Service Centre CRM

----

**GENERAL CARE NEEDS**

Personal Care Support made up 25.7% of care given to under 65’s but 59.1% of care for over 65’s, indicating a hugely increased need in older people. Support with Memory and Cognition was the next most common provision to older people. Combined with Personal Care Support these account for almost three quarters of the needs of over 65’s. The majority of support (55%) given to adults aged between 18 and 64 was related to learning disabilities, this falls to 2.6% in the older cohort. Figure 97 shows the support needs of the ASC client base, the needs of 18-64 year old clients have been included for reference.

**Figure 97: ASC Client Support Needs 2014/15**

<table>
<thead>
<tr>
<th></th>
<th>18-64</th>
<th>%</th>
<th>65+</th>
<th>%</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access &amp; Mobility Only</td>
<td>85</td>
<td>2.80%</td>
<td>59</td>
<td>0.73%</td>
<td>144</td>
</tr>
<tr>
<td>Learning Disability Support</td>
<td>1619</td>
<td>53.33%</td>
<td>167</td>
<td>2.07%</td>
<td>1786</td>
</tr>
<tr>
<td>Mental Health Support</td>
<td>108</td>
<td>3.56%</td>
<td>399</td>
<td>1.83%</td>
<td>417</td>
</tr>
<tr>
<td>No Relevant Long Term Support Reason</td>
<td>40</td>
<td>1.32%</td>
<td>639</td>
<td>7.92%</td>
<td>679</td>
</tr>
<tr>
<td>Personal Care Support</td>
<td>840</td>
<td>27.68%</td>
<td>4281</td>
<td>53.07%</td>
<td>5121</td>
</tr>
<tr>
<td>Substance Misuse Support</td>
<td>5</td>
<td>0.16%</td>
<td>3</td>
<td>0.03%</td>
<td>8</td>
</tr>
<tr>
<td>Support for Dual Impairment</td>
<td>5</td>
<td>0.16%</td>
<td>16</td>
<td>0.19%</td>
<td>21</td>
</tr>
<tr>
<td>Support for Hearing Impairment</td>
<td>2</td>
<td>0.06%</td>
<td>2</td>
<td>0.02%</td>
<td>4</td>
</tr>
<tr>
<td>Support for Visual Impairment</td>
<td>15</td>
<td>0.49%</td>
<td>24</td>
<td>0.30%</td>
<td>39</td>
</tr>
<tr>
<td>Support for Social Isolation or Other Support</td>
<td>159</td>
<td>5.24%</td>
<td>47</td>
<td>0.58%</td>
<td>206</td>
</tr>
<tr>
<td>Support with Memory &amp; Cognition</td>
<td>56</td>
<td>1.85%</td>
<td>1616</td>
<td>20.03%</td>
<td>1672</td>
</tr>
<tr>
<td>Not Listed</td>
<td>101</td>
<td>3.33%</td>
<td>903</td>
<td>11.29%</td>
<td>1004</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2035</td>
<td></td>
<td>8069</td>
<td></td>
<td>11101</td>
</tr>
</tbody>
</table>

In terms of care needs, of the 10,138 cases active in the 2014-15 year to date at 31st August 2014 almost 60% occurred within one specific category – Personal Care Support. The second most common support demand was Support with Memory and Cognition, whilst a notable number had no definition of care needs allocated to their case, representing almost 17% of the sample, shown in Figure 98.

The distribution of these care needs across the county shows high levels of proportional demand for Personal Care Support in Kettering, Support with Memory and Cognition in Corby and Northampton, and Mental Health Support in Corby and Kettering.
Whilst trends have shown a decline in the number of ASC clients within the 65+ years age group, certain care demands have increased in numbers during this period. Of most significance here has been demand for support with diagnosed mental health problems, specifically the incidence of dementia within Northamptonshire’s 65+ population. The number of recognized Learning Disabilities amongst this group has also increased, although the incidence is relatively low in comparison to other needs, shown in Figure 99. This is due to an ongoing trend in people with disabilities living longer.

ADULT SOCIAL CARE INTERVENTIONS

The spatial percentages of interventions follow a similar pattern to the spatial demographic of the ASC population: fewer interventions in the less deprived areas of the county such as East Northamptonshire, South Northamptonshire and Daventry and more interventions in the urban areas that have more deprivation. Figure 100 shows the spatial distribution of ASC interventions and also how interventions for older people make up the majority of cases.
Within the 65+ years age group as at 31/8/14 a total of 10,138 support placements had been recorded during the year. These consisted of cases which had been both carried forward from the previous year and started within the current year alongside those which were both active at the time the data was downloaded and had been closed during the year-to-date. Of this 10,138, some 4,164 cases active within the year had been closed as at 31/8/14, leaving a total number of 5,974 active placements amongst the 65+ years cohort. Of these active cases the most significant numbers were found in Residential Care and Home Care placements, together representing 54% of those active at the close of August 2014, Figure 101.

Across the high placement number in Home Care and Residential Care, Personal Care Support is the most significant care requirement accounting for 85% and 50% of these respective placements. In addition to these, high demand is evident in Residential Care for Support with Memory & Cognition, Direct Payments for Personal Care Support. (Figure 102).

Within the demand for placements there is variation between the age sub-groups of the 65+ cohort. Whilst the distribution between the 65-84 years and the 85+ years was weighted marginally in favor of the latter sub-group, representing a 47:53 split, a much higher level of demand for Day Care and Direct Payment support was found amongst the 65-84 years sub-group. Within the two most significant placement types, Home Care and Residential Care, Home Care support was close to evenly split
between age sub-groups. For Residential Care however 65% of demand came from the 85+ years group (Figure 103).

Figure 102: Active ASC Placements for over 65’s, August 2014

Of the 1,378 cases of Personal Care Support provided through Home Care, the age sub-group distribution was an almost exact replication of the client distribution within the wider 65+ cohort; 47% were from the 65-84 years group, and the remaining 53% from the 85+ group. In terms of the Residential Care cases placed through Personal Care Support, of 822 only 221 were from the 65-84 years group with the remainder aged 85+, representing a 27:73 split. Amongst the third and fourth highest demand categories – Residential Care Support with Memory & Cognition and Unspecified Specialist Equipment for Support Provision – whilst a number of cases came from both age sub-groups, demand was more prominent and forthcoming from amongst those 85+ years. The fifth highest demand category of Personal Care Support through Direct Payments however indicated higher uptake from those aged 65-84 years.

Figure 103: ASC Placement Distribution over 65’s

Placement patterns show highest level occurring within Northampton, accounting for 30% of active ASC cases. This is the same as the proportion of Northamptonshire’s population living within this borough. A higher proportion can be identified in Wellingborough, whilst lower levels of comparative provision are evident in Daventry and South Northamptonshire.
Demand projection can be calculated by applying the intervention rate for the county (Figure 100) to projected population changes. This calculation predicted an increase in clients of 1,923. 1,767 of these are over the age of 65.

Figure 104: Adult Social Care Clients aged 65+ in Northamptonshire projected to 2021

This method assumes that the proportion of clients accessing Adult Social Care will remain static at around 6.8% and so can be considered a conservative estimate as there are major changes to the funding and eligibility of social care in the next 12 months. However the numbers of adults accessing support through Adult Social Care teams has been decreasing year on year for the last decade. The numbers of 65 and over adults accessing support has been declining by around 7.2% per year since 2005. The projection is shown in Figure 104.

Social Care Population Aged 50-64

Figure 105: Adult Social Care Clients aged 50-64, 2014/15

Figure 105 shows the number of clients of ASC aged between 19 and 64 and how many are currently aged between 50 and 64 years by borough/district. These are the clients that will be having increased needs over the next 15 years.
Figure 106 shows the number of people aged between 50 and 64 in Northamptonshire who have been receiving support of some description from ASC by the length of time they have been receiving this support. Those who have been receiving support for some years are likely to continue to require support as they age.

**Figure 106: Numbers of 50-64 year olds receiving support from ASC by years of support, 2014/15**

<table>
<thead>
<tr>
<th>Years</th>
<th>50-64 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1 Year</td>
<td>130</td>
</tr>
<tr>
<td>1 Year</td>
<td>909</td>
</tr>
<tr>
<td>2 Years</td>
<td>13</td>
</tr>
<tr>
<td>3 Years</td>
<td>30</td>
</tr>
<tr>
<td>4 Years</td>
<td>14</td>
</tr>
<tr>
<td>5 Years</td>
<td>25</td>
</tr>
<tr>
<td>6 Years +</td>
<td>40</td>
</tr>
</tbody>
</table>

Figure 107 shows the care needs of the 18-64 year old ASC population. This figure demonstrates the changing needs of the ASC population as it ages. For example, the numbers of people requiring support for Personal Care Support increases quite significantly as age increases, Memory and Cognition support increases in smaller numbers but proportionally quite dramatically, as does the need for Mental Health Support.

**Figure 107: ASC Client Support Needs 50-64 Years 2014/15**

<table>
<thead>
<tr>
<th>Support Need</th>
<th>50-64</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access &amp; Mobility Only</td>
<td>34</td>
</tr>
<tr>
<td>Learning Disability Support</td>
<td>424</td>
</tr>
<tr>
<td>Mental Health Support</td>
<td>47</td>
</tr>
<tr>
<td>No Relevant Long-term Support Reason</td>
<td>23</td>
</tr>
<tr>
<td>Personal Care Support</td>
<td>469</td>
</tr>
<tr>
<td>Substance Misuse Support</td>
<td>4</td>
</tr>
<tr>
<td>Support for Dual Impairment</td>
<td>3</td>
</tr>
<tr>
<td>Support for Hearing Impairment</td>
<td>0</td>
</tr>
<tr>
<td>Support for Visual Impairment</td>
<td>6</td>
</tr>
<tr>
<td>Support for Social Isolation or Other Support</td>
<td>59</td>
</tr>
<tr>
<td>Support with Memory &amp; Cognition</td>
<td>31</td>
</tr>
<tr>
<td>Unspecified</td>
<td>61</td>
</tr>
</tbody>
</table>

Figure 108 also highlights the change in care requirements as people age, showing the needs of the 18-64 year old ASC cohort from 2005.

The age group 65+ represents the greatest demand on ASC. More specifically within this group are those aged 85 years and over, who account for 55% of service users. An estimated 23% of those aged 85+ are ASC clients, in comparison to a rate of 2.8% amongst the 65-84 years group. This rate of demand is much higher in Corby, East Northamptonshire and Kettering.
During the past decade, demand for support around physical disability has fallen. The need for support around dementia has increased in numbers in spite of the significant decline in ASC clients.

Amongst 18-64 year old clients, highest demand falls within the sub-group aged 50-64 years, whilst lowest demand is amongst those aged 30-49 years. Whilst in volume terms Northampton exhibits the highest numbers, higher proportions of care clients in relation to local populations and county-level proportions can be seen in Kettering, Northampton and Wellingborough amongst those aged 50-64 years.

ASC SPEND AND THE LIKELY LEVEL OF FUTURE RESSOURCING

The Social Care expenditure for 2012/13 and 2013/14 is outlined in the tables beneath. This is the gross current expenditure including Social Services Management and Support Services (SSMSS). ASC spend for older people was £91,167,000 in 2013/14. This is a £2,633,000 decrease from the previous year. The breakdown is shown in Figure 109 below.
The Total ASC spend in terms of gross current expenditure is displayed beneath. In 2013/14 this was £185,483,000. This is a £2,696,000 decrease compared to the 2012/13 gross current expenditure. The gross current expenditure for 2014/15 was £161,073,000, a reduction of £24,410,000 from the previous year (Figure 110). This decrease in total gross current expenditure must be put into context. Local authorities across the country have been subject to financial pressures, with budgets from central government being significantly reduced.

The Council Plan139 2014-19 states that the total budget for all NCC has already been reduced by £177,000,000. A further £126,200,000 will need to be found through savings and efficiencies. Despite continued budgetary pressures and less funding for NCC, ASC is a statutory service which is prioritised due to its importance for residents of Northamptonshire, alongside Children’s Services.

139 Council Plan 2014
PEOPLE WHO FUND THEIR OWN CARE (SELF FUNDERS)

Based on modelling carried out by the County Council we estimate the population of residential (and residential with nursing) self funders to be in the region of 3,450. This is worked out by taking the average number of residential beds occupied and deducting the number of NCC, health or out of county funded placements.

Based on similar modelling exercises the predicted number of domiciliary self funders is 1,626.

This cohort of people may be of particular interest for providers of social care and related services. These people currently fund their own care, and may move to being NCC funded clients as their income/savings change and some meet the £72,000 cap currently proposed by The Care Act. From April 2016, The Care Act will introduce a cap on care costs for people who pay for their own care. This cap is intended to prevent people from catastrophic care costs if they have the most serious needs and it is currently planned to be £72,000.

ADVICE AND INFORMATION SERVICES

All citizens in Northamptonshire can access advice and information about a wide range of topics. This universal service includes information and advice about whether people are eligible for help from the council, advice on paying for care, self funding and financial assessments, safeguarding adults as well as a comprehensive guide for choosing and paying for care, The Care Services Directory on the Care Choices website. This website includes many varied areas like:

- Living independently with care and support: assisted living, care villages and sheltered housing.
- Moving on from hospital.
- Paying for care.
- Self directed support and personal budgets.
- Specialist care: sensory loss, mental health, learning disability, physical disability and Dementia care.
- Care homes.

The Care Act places additional legal demands on local authorities to provide information and advice. This is an area where NCC is developing the existing arrangements to keep our citizens well informed and advised of all the changes the Act introduces.

NCC has recently introduced a new service of this nature. Breeze-e is an online marketplace which allows people to source goods and providers, pay for them and rate their quality in an open forum.

140 http://www.carechoices.co.uk/region/east-midlands/northamptonshire/
PREVENTATIVE SERVICES

NCC strategy prioritises prevention and early intervention. These services can prevent people reaching a crisis point later on, and avoiding this through targeted prevention and early intervention benefits the people by avoiding deterioration to their health and prevents more expensive services being needs later on.

Early help and prevention services cover a wide range of areas for children and families which are outlined in the Early Help and Prevention Offer. These include the following areas:

- Children’s Centre Services (universal and targeted).
- Community connecting support for disabled children.
- Early help for disabled children service.
- Early years entitlement (free childcare and education for 2, 3, and 4 year olds)
- Family Intervention Project.
- Intensive intervention Programme.
- Multi Systemic Therapy Service.
- Short breaks and sleep services for disabled children.
- Social Care support for disabled children.
- Supporting services.
- Targeted Prevention Service.

Targeted NEET (not in education employment or training) support service.

ADVOCACY

The local authority must involve the individual in the key care and support processes of assessment, care and support planning and review, or safeguarding. If the individual has substantial difficulty being involved, and there is no one appropriate to support them, the authority must provide an independent advocate. Independent advocates support and represent individuals to be involved as fully as possible. This widens the use of independent advocacy beyond current Mental Capacity Act considerations, and will apply to people who have ‘capacity’ and to those who are judged to ‘lack capacity’.

VoiceAbility was formed in December 2010 as a merger of Advocacy Partners and Speaking Up. Total Voice Northamptonshire is part of VoiceAbility. Total Voice Northamptonshire: provide independent advocacy for people aged 18+, supporting mental health and adult social care.

Figure 111 below shows the various types of new referrals to the advocacy service during quarter two of 2014 (up till September), the majority of which are professional advocacy. Second most prevalent are independent mental health advocacy (IMHA) and independent mental capacity (IMCA).

141 Making Children Safer 2014
Reablement represents a period where short term intensive support is given to someone who has returned to their home after a period in hospital, who has a physical disability or wants to increase their confidence and live independently in their community. The introduction of the reablement service has led to better outcomes for the people receiving it and prevents much more expensive care being required later on.

Reablement is provided by the Short Term Assessment and Reablement Team (START), the Intermediate Care Team (ICT) or on a short term residential basis, at one of four specialist care centres across the county.

These specialist care centres provide reablement care, by supporting people to return to the level of independence they were enjoying before a period of illness or an accident. The services are aimed at increasing confidence and self-reliance, in a safe and supported environment.

TARGETED AND SPECIALIST SERVICES

The number of carers supported by NCC over the past four years is illustrated in the chart (Figure 112) and table (Figure 113) beneath.

2011 census estimates there are around 70,000 informal carers in the county\(^{142}\). This group represents a significant cohort who could have increasing needs. As the population gets proportionately older, there are going to likely be more informal carers who are themselves in their older years. These carers often have support needs of their own and their health and wellbeing should be considered.

\(^{142}\) Northamptonshire Analysis 2014
Figure 112: NCC supported carers (2010-14): total per 100,000 population

![Bar chart showing the number of carers supported by NCC from 2010/11 to 2013/14.]

Figure 113: NCC supported carers (2010-14)

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Carers</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>3605</td>
</tr>
<tr>
<td>2011/12</td>
<td>2665</td>
</tr>
<tr>
<td>2012/13</td>
<td>2870</td>
</tr>
<tr>
<td>2013/14</td>
<td>2835</td>
</tr>
</tbody>
</table>

HOSPITAL DISCHARGES

Figure 114: Delayed transfer of care 2013-14

Delayed Transfer of Care from Hospital 2013-14
per 100,000 Population

http://ascof.hscic.gov.uk/Outcome/504/2C(1) 
http://ascof.hscic.gov.uk/Outcome/504/2C(2)

Figure 114 shows that there are more delays per 100,000 population in transfer of care from hospital in Northamptonshire than regionally and nationally, 17.8 in Northamptonshire compared to 12.1 in the East Midlands and a national average of 9.6. Late hospital discharges mean

143 http://ascof.hscic.gov.uk/outcome/504/2C(1)
144 http://ascof/hscic.gov.uk/outcome/504/2C(2)
the patient is ready to move out of their hospital bed but there is a delay, for example caused by the NHS or by Social Care Services.

This would indicate that there are more delays in the NHS system in Northamptonshire and the transfer of care to Social Care Services is working better in Northamptonshire than the national average.

Figure 115 shows the standardized percentage of discharged patients over the age of 75 who have been readmitted as an emergency within 28 days of their discharge. Northampton and Kettering stand out as having higher levels of readmission than the region, the country and the rest of the county. The figure also shows the increasing trend in the percentage over the 9 years between 2002/03 and 2011/12.

The Department of Health defines reablement as ‘services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living’.

Figure 116 shows how reablement in Northamptonshire compares regionally, nationally and with comparable authorities. When read along with the other measure of reablement (Older people receiving reablement services after leaving hospital, figure 117) this measure demonstrates the quality of reablement services available. A higher score is better. The measure includes social care-only placements, and excludes people who were only assessed by the NHS.

Figure 115: Emergency Admissions within 28 days, 2002/03 – 2011/12

https://indicators.ic.nhs.uk/webview/

https://indicators.ic.nhs.uk/webview
Northamptonshire falls some way behind the comparators in this measure and is slightly worse in the second reablement measure below, indicating that reablement is not as common or effective here as it is in other areas.

Figure 117 again only includes social care data, excluding those only assessed by NHS.

Reablement focuses on restoring independent function and can help prevent unnecessary admission and re-admission to hospitals and the penalties that these can incur, in addition to saving money by allowing people to adapt to their new circumstances away from a residential care environment and also increase the quality of life for the service user by maintaining their independence.

146 http://ascof.hscic.gov.uk/Outcome/504/2B(1)

147 http://ascof.hscic.gov.uk/Outcome/504/2B(2)
Figure 118: Older people permanently admitted to residential care following discharge from hospital 2013/14

Adults 65 years and over admitted to residential and nursing care homes per 100,000 population

http://ascof.hscic.gov.uk/Outcome/504/2A(2)

Figure 118 demonstrates that more older people in Northamptonshire (750.2 per 100,000) are admitted to a residential care setting following discharge from hospital than regionally (690 per 100,000) and nationally (650.6 per 100,000). This demonstrates that more older people in Northamptonshire are unable to return to their homes following an admission to hospital. This measure does not include people who self-fund their stays in care homes. This could be due to a lack of appropriate services in place to support people who can return to their own homes.

END OF LIFE CARE

People are approaching the end of life when they are likely to die within the next 12 months. This includes people whose death is imminent (expected within a few hours or days) and those with:
- advanced, progressive, incurable conditions
- general frailty and coexisting conditions that mean they are expected to die within 12 months
- existing conditions if they are at risk of dying from a sudden acute crisis in their condition
- life-threatening acute conditions caused by sudden catastrophic events

The underlying causes of death in the older population of Northamptonshire are shown in the tables below, split by CCG and compared to the England average. The tables show that cancer is the largest underlying cause, responsible for a higher percentage of deaths in 65-84 year olds in both CCG’s and particularly in Corby CCG (Figure 119).

Referring to Figure 120, the percentage of deaths caused by cancer falls in people aged 85 and above. In this older age group, it is respiratory

148 http://ascof.hscic.gov.uk/Outcome/504/2A(2)

diseases and ‘other causes’ that account for higher percentages of deaths than the national average.

Figure 119: Underlying cause of death in 65-84 year olds, 2011-13

Underlying Cause of Death by CCG - 65-84 Years 2011-13

65% of East Midlands residents would prefer to die at home. 56% of those aged 65-74 and 45% of respondents aged 75 and over expressed a


preference to dying in their own home. The next most chosen location amongst people in the East Midlands, as well as people in the 65-74 and 75+ age groups, was a hospice. The tables below show the places of death for people aged 65-84 and 85 and over in Northamptonshire in 2010-12, by CCG.

The percentage of over 85’s dying in hospital is lower at 49%, the percentage dying at home is also lower at 18%. The percentage of 85+ people dying in a care home is much higher at 31% than in the younger 65-84 cohort; here the percentage is 10%.

The percentage of people dying in a hospice is higher in the 65-84 age group than in the 85+ age group, 4% and 1% respectively.

Within Northamptonshire, End of Life care (both specialist and generalist) is provided through a wide variety of providers. Services include community nursing teams, three hospices (Cynthia Spencer in Northampton, Cransley in Kettering and Lakelands in Corby), in-patients unit at Danetre Hospital and the two district general acute hospitals (Northampton General Hospital and Kettering General Hospital), Primecare and Continuing Healthcare. However, it is recognised demand and expectation for end of life care is going to grow and as Figures 121 and 122 show, around half of older people in Northamptonshire are dying in hospital at the present time. This causes additional pressures on the hospitals and also prevents a sizeable number of people from dying in their preferred locations.

55% of people aged 65-84 died in hospital, 28% died at home (Figure 121).

Figure 122: Place of death, 85+ years, 2010-12\textsuperscript{154}

Place of Death by CCG - 85+ years
2010-12

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure122.png}
\caption{Place of death, 85+ years, 2010-12.}
\end{figure}

\textsuperscript{154} http://www.endoflifecare-intelligence.org.uk/profiles/CCGs/Place_of_Death/atlas.html
ACCOMMODATION

The following information has been taken from the Social Care Accommodation and Support Strategy for Older People for Northamptonshire.

Nursing Care and Residential Care models

There are currently 133 residential care properties in Northamptonshire: 83 classed as Care Homes and 50 classed as Care Homes with Nursing. These facilities provide Residential Care to older people with substantial/critical levels of personal care needs and nursing care needs and specialist support for older people with dementia. Residents have no tenancy or leasehold rights. Their occupation is by license agreement with the accommodation provider.

Housing models

There are a total of 304 properties listed in Northamptonshire that are specifically suited for older people. This number includes sheltered bungalow developments:
- Retirement/Sheltered: 218 properties
- Enhanced Sheltered: 6 properties
- Extra Care Housing: 12 properties
- Age Exclusive (generally small bungalow developments that have Care Call): 68 properties

Generally speaking it is most likely that Adult Social Care will be responsible for funding eligible individuals’ care and support services in extra care and very sheltered housing, than other forms of housing.

In its most developed form, extra care housing and very sheltered housing is seen as an alternative to residential care.

Below there are statistics taken from SHOP@\(^{155}\) for Northamptonshire using national assumptions to demonstrate the current demand and supply and the future predicted demand for older persons accommodation.

\(^{155}\) http://www.housinglin.org.uk/Topics/browse/HousingExtraCare/ExtraCareStrategy/SHOP/SHOPAT/?
CURRENT DEMAND

Figure 123: Current supply and demand for housing 2014 (SHOP@)

An overall small shortage of Residential Care
A very small over supply of Nursing Care

At the present time there is no specific attention in the SHOP@Tool to Residential Care that specialises in supporting older people with dementia or other health difficulties such as learning disabilities or mental health and this is an area that would need further consideration.

The localities in the county have different profiles:
- Northampton has the highest level of volume of accommodation growth needed
- Corby shows the need for steady continued growth
- Daventry, Kettering and Wellingborough and East Northants all show similar patterns of growth between 2015 and 2025 followed by periods of reductions in growth between 2025 and 2035
- South Northamptonshire shows a more inconsistent pattern with the highest demand for growth from 2025 to 2030

Corby
- Current statistics show shortages in supply in all areas with the most significant in enhanced and extra care housing, highlighting Corby as a high priority to consider for development

Northamptonshire
- Some small indications of oversupply in sheltered housing mainly in the rented sector
- A 70% lack of enhanced sheltered in rent and leasehold
- A significant 46% shortage of extra care housing models in rented and leasehold sectors

<table>
<thead>
<tr>
<th>Northamptonshire</th>
<th>Demand</th>
<th>Supply</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sheltered Housing</td>
<td>408</td>
<td>297</td>
<td>-91</td>
</tr>
<tr>
<td>Enhanced Sheltered</td>
<td>70</td>
<td>6</td>
<td>-64</td>
</tr>
<tr>
<td>Extra Care</td>
<td>30</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td>Registered Care</td>
<td>430</td>
<td>505</td>
<td>-75</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Corby</th>
<th>Demand</th>
<th>Supply</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sheltered Housing</td>
<td>781</td>
<td>777</td>
<td>-4</td>
</tr>
<tr>
<td>Enhanced Sheltered</td>
<td>126</td>
<td>110</td>
<td>-16</td>
</tr>
<tr>
<td>Extra Care</td>
<td>158</td>
<td>158</td>
<td>0</td>
</tr>
<tr>
<td>Registered Care</td>
<td>430</td>
<td>505</td>
<td>-75</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>East Northamptonshire</th>
<th>Demand</th>
<th>Supply</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sheltered Housing</td>
<td>512</td>
<td>560</td>
<td>-48</td>
</tr>
<tr>
<td>Enhanced Sheltered</td>
<td>146</td>
<td>206</td>
<td>-60</td>
</tr>
<tr>
<td>Extra Care</td>
<td>183</td>
<td>200</td>
<td>-17</td>
</tr>
<tr>
<td>Registered Care</td>
<td>512</td>
<td>505</td>
<td>-7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Kettering</th>
<th>Demand</th>
<th>Supply</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sheltered Housing</td>
<td>70</td>
<td>6</td>
<td>-64</td>
</tr>
<tr>
<td>Enhanced Sheltered</td>
<td>126</td>
<td>110</td>
<td>-16</td>
</tr>
<tr>
<td>Extra Care</td>
<td>158</td>
<td>158</td>
<td>0</td>
</tr>
<tr>
<td>Registered Care</td>
<td>430</td>
<td>505</td>
<td>-75</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SHOP@</th>
<th>Demand</th>
<th>Supply</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sheltered Housing</td>
<td>512</td>
<td>560</td>
<td>-48</td>
</tr>
<tr>
<td>Enhanced Sheltered</td>
<td>146</td>
<td>206</td>
<td>-60</td>
</tr>
<tr>
<td>Extra Care</td>
<td>183</td>
<td>200</td>
<td>-17</td>
</tr>
<tr>
<td>Registered Care</td>
<td>512</td>
<td>505</td>
<td>-7</td>
</tr>
</tbody>
</table>
Also significant is the lack of demand and supply for leasehold models making any development more dependent on grant subsidy/funding.

**Daventry**
- Significant shortages shown in all sectors with the exception of nursing care making Daventry another high priority area.
- Notably there is demand for enhanced sheltered or extra care in the leasehold sector with no current provision available. This indicates discussions with private sector providers should be arranged.
- Although shortages in the residential sector are shown these could be addressed in additional extra care provision.

**East Northamptonshire**
- Sheltered housing and nursing care sectors are showing over provision.
- Significant shortages in the enhanced sheltered and extra care sectors with demand and supply in the different tenure options eg, leasehold for enhanced and rented for extra care, indicates that East Northamptonshire is another priority area for development. Enhanced sheltered developments for leasehold may be addressed by private sector developers but the extra care developments are most likely to be addressed by registered providers through grant subsidy/funding.

**Kettering**
- Shows deficits in all areas except residential care.
- The highest deficits are shown in enhanced sheltered housing with no local provision at al.
- Extra care in the rented sector shows significant deficit but no demand for leasehold.
- Residential care shows a small surplus and any developments in extra care could impact on this. With figures estimated to double in 20 years additional extra care provision if sufficient in numbers could reduce this demand.
- Nursing care needs development with more than 100% development needed in 20 years.

**Northampton**
- A significant over supply of sheltered housing (90%).
- A 50% shortage of enhanced (very sheltered) housing.
- An oversupply of extra care housing.
- Small shortages in residential and nursing care.
South Northamptonshire

- There are significant shortages shown in all sectors except Nursing Care, making South Northamptonshire another priority area to develop.
- Sheltered Housing is showing almost 50% under provision but this is unlikely to be addressed by registered providers.
- Extra care housing shows a high level of under provision at over 80% and no demand shown for leasehold. This is the area likely to be developed by registered providers.
- Additional extra care housing could divert people away from residential and may affect the market which is already showing a shortage in supply.

Wellingborough

- All sectors are showing a deficit in supply in accordance with the assumptions of the SHOP@ Tool statistics.
- In particular there is demand for enhanced sheltered that has no supply at all.
- Extra care leasehold shows no supply or demand and as per other areas this may relate to the division between home ownership and renting.
- There is a significant deficit of residential care 43% which could be addressed in some way by developing more extra care housing but the likelihood is that more residential and nursing care will be required.

Northamptonshire

- In the next 20 years there could be a need for over 100% increase in the supply of supported accommodation for older people if

**FUTURE PREDICTED DEMAND**

Figure 124 below shows a breakdown of the growth required in each area from 2015 to 2035 in accordance with the SHOP@ Tool basic assumptions.

**Figure 124: Projected estimated housing need to 2035**

Estimated future housing need by district

![Graph showing future housing need by district](image)
Predicted population increases are realised
- The data predicts that all the models listed may need to practically double in numbers to meet demand, although there may be factors that will influence this, for example developments in assistive technology and greater emphasis on adaptations to existing properties that could sustain people in their present homes for longer.
- The Registered Care and Nursing Home statistics do not show any specialism, for example caring for older people with dementia and this would be useful information and may link closer to estimating costs.

In addition to the current statistics on accommodation for older people, both supply and demand, other factors should be taken into consideration.

- Local population trends and prevalence of people over 75
- The affluence of older people locally and the numbers of older home owners
- The growing numbers of older people living alone
- Demand on local Adult Social Care budgets/services to maintain older people in their own homes and in residential care settings

Corby
- Almost all sectors are showing a 100% increase required in the next 20 years with no demand shown for leasehold

Daventry
- The most significant increases are required in the sheltered housing sector and the residential care sectors
- Traditional sheltered housing is generally no longer being developed by registered providers and the tendency for development is in the private sectors. This may be a challenge as most private sector developments are leasehold and the statistics show no demand for leasehold.

East Northamptonshire
- Nursing care levels at current stats are already beyond the predicted numbers for 2020
- Significant increases predicted in the residential care sector will need to be addressed but may need to focus on highest level needs people eg, people with dementia

Kettering
- There are already quite significant numbers of leasehold sheltered housing provided (116) and this could be explored with private sector providers, although it is unlikely that general sheltered housing for rent will be provided in the numbers indicated to meet future demand and other forms of preventative services should be explored to ensure that older
people could remain in their own homes for longer perhaps making a move to extra care housing at an older age

There appears to be growing demand for extra care but not for leasehold in extra care. This would make Kettering another priority area for the development of extra care housing that can possibly also look to reduce residential care which is currently showing an overprovision

Northampton

In accordance with statistics the current supply of general sheltered housing will not need to be developed over the next 20 years. This does not however take any account of the condition of the stock and if it is fit for purpose and any effects on occupancy that new developments in extra care housing might have

Enhanced sheltered housing is showing a 50% deficit and demand set to almost double in the next 20 years

Extra care housing shows an overprovision at current levels and stats show that levels will not be required to increase until 2020-2025 This will be dependent on any specific programmes to address significant increases in diverting older people from residential care to extra care housing services and this should be factored into plans for future service commissioning

Small deficits in residential care and nursing care could also be impacted on by diversions to extra care housing

South Northamptonshire

The deficits in sheltered housing may need to be addressed by looking at other forms of preventative actions such as AT or adaptations to enable older people to stay in their current home for longer

The development of extra care housing is a priority and could prevent the development of residential care models that are currently showing at a deficit

Leasehold demand is higher in enhanced care models and this could be addressed by private sector providers

Wellingborough

The predictions for the development of sheltered housing is very challenging with the current supply being 552 and levels at 2035 being 1425. This is an increase of 873 units over 20 years, averaging 44 units per year = 1 x small scheme per year. It is highly unlikely that this level would be funded in the social rented sector and it does not account for any schemes that may be decommissioned if they become unfit for purpose.

There are no enhanced sheltered units and this could be explored with private sector providers for leasehold and possibly include rented demand in with the development of extra care housing
The demand for extra care leasehold may benefit new mixed
tenure developments where sales can be beneficial to making
new schemes viable.

Shortages in residential care could be considered when planning
extra care schemes and there would appear to be a definite need
for more nursing care.
FUTURE COMMISSIONING PRIORITIES

THE DEVELOPMENT OF MARKETS AND SUPPORT

Adult social care is about supporting individuals to reach improved health and wellbeing outcomes. This is what drives adult social care and any future vision has to be rooted in the experience of people who need or use services. The definition of integrated care by National Voices best describes this key principle underwriting our vision.

“My care is planned with people who work to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes”

There is an emerging consensus about the key features of a future health and social care system. In broad terms these are:

- Integrated health and social care
- Centred around the individual and focused on outcomes
- Pooling budgets and commissioning
- Focus on prevention, co-production and personalisation
- Properly funded baseline
- Localism not centralism

ADASS (The Association of Directors of Adult Social Services) Principles:

- Promoting health and wellbeing.
- Giving people choice and control through person-centred co-ordinated care and support.
- Integrated, joined up approaches between health and social care and other services.
- Ensuring cost effective, high quality services.
- Individuals are safeguarded and their rights are upheld

156 http://www.adass.org.uk/home/
RECOMMENDATIONS

An ageing population means an increase in demand for support and for services. This is occurring at the same time as budgets are being reduced. Focusing on preventative measures to try and stop conditions related to ageing from deteriorating to the point that interventions and support are required is beneficial to individuals and the State. Encouraging healthy lifestyle choices, such as quitting smoking, improved diet, increased activity would help with this. Also ensuring a safe, comfortable and clean environment, a pleasant place to live and a feeling of community by ensuring levels of crime are low, transport services are adequate, opportunities for social engagement are plentiful and community based activities are promoted would also assist.

**Improve access to health services for older people:** There is a discrepancy of over 17,000 between the number of over 65’s living in Northamptonshire and the number of over 65’s registered with Northamptonshire GP’s.

**Screening for substance misuse in older people:** General practitioners should screen every person over 65 years of age for substance misuse as part of a routine health check, using specific tools; screening should also incorporate cognitive testing.

**Development of age specific smoking quit interventions:** Whilst focus on preventing smoking or encouraging smokers to quit is rightfully aimed at younger people, older people still benefit from quitting the habit shouldn’t be ignored if planning smoking cessation activities.

**Improve access to services to reduce isolation:** Locate areas with high concentrations of older people living alone and locate services in these areas.

**Focus on prevention to reduce risk factors associated with cancers:** Incidences of cancers in Northamptonshire are slightly higher than the national average, 399.8 instances per 100,000 population in Northamptonshire compared to 398.1 nationally.

**Encourage the development of a diverse care market and social care offer to reflect the diversity of need within the older population:** The average age of an ASC client amongst the 65+ cohort varies from 83.1 years in Corby to 85 in South Northamptonshire, indicating within certain parts of the county the demand for care emerges at an earlier age than others. A variety of accommodation support should be considered before admission to residential care.
ANNEX 1: THE CARE ACT – DETAILED OVERVIEW

ASSESSMENT AND ELIGIBILITY

After the assessment, the local authority must determine whether the person is eligible for care and support. This is set out in regulations that set the national minimum threshold for eligibility, which will be consistent across England.

Determining eligible needs is important to work out whether the local authority must meet the adult’s needs for care and support. The person will have eligible needs if they meet all of the following:

- They have care and support needs as a result of a physical or mental condition;
- Because of those needs, they cannot achieve two or more of the outcomes specified;
- As a result, there is a significant impact on their wellbeing.

The outcomes are specified in the regulations, and include people’s day-to-day activities such as dressing, maintaining personal relationships and working or going to school. Where the person has eligible needs, and wants the local authority’s help to meet them, then the authority will discuss the person’s care and support plan with them. In all cases, the local authority must give people advice and information about what support is available in the community to help them.

CARE AND SUPPORT PLANNING

The Act sets out when the local authority has a responsibility to meet someone’s care and support needs. It also sets out how it can do so even if it does not have to. The Act also says what must happen next to help the person make decisions about how their needs should be met.

The Act gives local authorities a new legal responsibility to provide a care and support plan (or a support plan in the case of a carer). For the first time, the Act provides people with a legal entitlement to a personal budget, which is an important part of the care and support plan, and a support plan. The personal budget must be included in every plan, unless the person is only receiving intermediate care or reablement support to meet their identified needs.

This adds to a person’s right to ask for a direct payment to meet some or all of their needs. Provided that the direct payment is used to meet the needs identified in the plan, the person should have freedom over how the money is spent. Even when an assessment says that someone does not have needs that the local authority should meet, the local authority must advise people about what needs they do have, and how to meet them or prevent further needs from developing.
The new law for adult care and support sets out a clearer approach to charging and financial assessment. First, a local authority will assess someone and decide whether they have eligible needs. The local authority will then work with the person to consider what types of support might be provided to meet their needs. Not all types of care and support involve a cost for the person. Whilst the Act gives local authorities the power to charge for care and support, they may not charge for services which the regulations say must always be free, for example reablement services or equipment and minor adaptations to the home.

Additionally, from 2016/17, where the individual has reached the cap on care costs, the local authority may not charge towards the cost of meeting their care and support needs.

People pay for their care costs now and will continue to do so in the future.

From April 2016, the Care Act will introduce a cap on care costs and will provide new financial protection for those with modest wealth. The cap on care costs will reassure many people by providing protection from catastrophic care costs if they have the most serious needs. It is intended that the cap will be £72,000 when it is introduced in April 2016. These measures aim to give everyone the peace of mind that they will get the care they need and that they will be protected from unlimited costs if they develop very serious care needs – such as dementia or other conditions that mean they need many hours of care a day.

The Government will also provide new financial help to those with modest wealth. This will ensure that people with the least money get the most support. Currently, only people with less than £23,250 in assets and low incomes receive help from the State with their care and support costs. Care Act changes will mean that people with around £118,000 worth of assets (savings or property), or less, will start to receive financial support if they need to go into a care home. The amount that the Government will pay towards someone’s care and support costs will depend on what assets a person has.

People will be responsible for their care costs as assessed by the local authority, up to the £72,000 cap if they can afford it. They will also be responsible for:

- Any ‘extra’ care costs (for example, if they choose a more expensive care option);
- Any support that is not covered in the care and support package, such as cleaners and gardeners employed by the individual;
- A contribution to general living costs if they are in a care home and if they can afford it. “General living costs” reflect the costs
that people would have to meet if they were living in their own home – such as for food, energy bills and accommodation. This will be set at around £12,000 per year.

The State will be responsible for:

- Any further costs of meeting their eligible needs once a person reaches the cap (based on the costs which the local authority would expect to pay for that type of care).
- Financial help to people with their care and/or general living costs, if they have less than around £17,000 in assets, and if they do not have enough income to cover their care costs.

Safeguarding

Safeguarding is everyone’s business, and it is important that organisations work together to protect people who need help and support. Yet one of the biggest challenges is how to bring together the huge number of teams and organisations involved in keeping people safe.

That’s why the Act requires local authorities to set up a Safeguarding Adults Board (SAB) in their area, giving these boards a clear basis in law for the first time. The Act says that the SAB must:

- include the local authority, the NHS and the police, who should meet regularly to discuss and act upon local safeguarding issues;
- develop shared plans for safeguarding, working with local people to decide how best to protect adults in vulnerable situations;
- publish this safeguarding plan and report to the public annually on its progress, so that different organisations can make sure they are working together in the best way.

CARERS ASSESSMENTS

The Act gives local authorities a responsibility to assess a carer’s needs for support, where the carer appears to have such needs. This replaces the existing law, which says that the carer must be providing “a substantial amount of care on a regular basis” in order to qualify for an assessment.

This will mean more carers are able to have an assessment, comparable to the right of the people they care for. The local authority will assess whether the carer has needs and what those needs may be. This assessment will consider the impact of caring on the carer. It will also consider the things that a carer wants to achieve in their own day-to-day life. It must also consider other important issues, such as whether the carer is able or willing to carry on caring, whether they work or want to work, and whether they want to study or do more socially. If both the carer and the person they care for agree, a combined assessment of both their needs can be undertaken.
CARER ELIGIBILITY

When the assessment is complete, the local authority must decide whether the carer’s needs are ‘eligible’ for support from the local authority. This approach is similar to that used for adults with care and support needs. In the case of carers, eligibility depends on the carer’s situation. The carer will be entitled to support if:

- they are assessed as having needs that meet the eligibility criteria;
- the person they care for lives in the local authority area (which means their established home is in that local authority area)

CONTINUITY OF CARE

The Act describes a process to be followed so that local authorities know when someone wants to move areas, and what must happen to make sure that their needs are met when they arrive in the new area. This applies in a number of circumstances:

- An adult is receiving care and support from one local authority, and wants to move to a new area;
- An adult is receiving care in a type of accommodation (e.g. a care home), which is organised by a different local authority to the one where the accommodation is located. The person wants to leave the care home but stay in the local area; and

From 2016/17, an adult is arranging their own care and support, but has a “care account” because the costs of meeting their eligible needs count towards the cap on care costs.

MANAGING PROVIDER FAILURE LOCALLY

The Act imposes clear legal responsibilities on local authorities where a care provider fails. The Act makes it clear that local authorities have a temporary duty to ensure that the needs of people continue to be met if their care provider becomes unable to carry on proving care because of business failure, no matter what type of care they are receiving. Local authorities will have a responsibility towards all people receiving care. This is regardless of whether they pay for their care themselves, the local authority pays for it, or whether it is funded in any other way. In these circumstances, the local authority must take steps to ensure that the person does not experience a gap in the care they need as a result of the provider failing. For some people, that may only require providing information and advice on the alternative services available locally, to help them make a choice about a new provider. For others, it may require actively arranging the care with a different provider for a period of time, to ensure that there is continuity. The steps will depend both on the circumstances of the provider failure, and what nature of support the person wants from the authority.

This duty applies temporarily, until the local authority is satisfied that the person’s needs will be met by the new provider. At that point, the person...
may again become responsible for arranging their own care. The local authority may make a charge for arranging care and support in these situations, in the same way as it would for ongoing services.

MARKET OVERSIGHT

The Act establishes that the Care Quality Commission (CQC) – the independent regulator for health and care services in England – will take on a new responsibility for assessing the financial sustainability of certain “hard-to-replace” care providers from April 2015. These are care providers who, because of their size, concentration or specialism, would be difficult to replace if they were to fail, and so where the risks posed by failure would be highest for individual local authorities.

To decide which providers it will oversee, regulations include criteria which set out which providers should be captured in the regime. These criteria determine whether a provider would be “hard to replace” – they do not reflect whether or not a provider is likely to fail. There are different criteria for care home providers and for other providers of care and support. Should it be needed, regulations can also specify particular providers to be included in the regime, irrespective of whether they would meet the entry criteria.

To assess financial sustainability, the Act gives the CQC the power to request information from any provider in the regime. Regulations also allow CQC to request information from other companies in the same group, where this is relevant to assessing the finances of the provider itself. The Act allows CQC to request that a provider who they judge to be in financial difficulty develops a sustainability plan and, where needed, arranges an independent business review. This is intended to help the care provider to remain financially sustainable, so that the care it provides to people is not disrupted. CQC’s role is to oversee the provider’s plans to remedy the situation and, if failure cannot be avoided, inform the local authorities affected where it believes a provider is likely to fail, to ensure a smooth, well managed process that provides continuing care to individuals. The CQC’s aim is not to stop providers failing at all costs or to bail out providers in difficulty or to interfere with any commercial discussions surrounding the likely failure.

TRANSITION

The Act says that if a child, young carer or an adult caring for a child (a “child’s carer”) is likely to have needs when they, or the child they care for, turns 18, the local authority must assess them if it considers there is “significant benefit” to the individual in doing so. This is regardless of whether the child or individual currently receives any services. When either a child or a young carer approaches their 18th birthday, they may ask for an assessment. A parent or carer may also ask for an assessment as the child they are caring for approaches 18. As in all assessments, local authorities will need to consider the needs of the person, what needs they are likely to have when they (or the child they care for) turn 18, and the outcomes they want to achieve in life. They should consider what
types of adult care and support might be of benefit at that point, and also consider whether other options beyond formal services might help the individual achieve their desired outcomes.

PRISONERS AND PEOPLE RESIDENT IN APPROVED PREMISES

The Care Act makes clear where the responsibility lies for assessing the care and support needs of prisoners and people in approved premises, and providing care and support where those needs meet eligibility criteria. The Act states that it will be the Local Authority where the prison or approved premises is located which is responsible.

This means assessing whether someone has care and support needs and what those needs may be. After the assessment, the local authority must then determine whether the person is eligible for care and support using the same eligibility framework used for people living in the community. If they are assessed as having needs that meet the eligibility criteria, the Local Authority will meet those needs.
ANNEX 2: DATA

Older Persons JSNA
Annex.xlsx

Careers Assessment:
Analysis.doc