Health and Social Care working
together in partnership

SERVICES FOR OLDER PEOPLE - JOINT COMMISSIONING STRATEGY

2009-2014

Putting people at the centre of commissioning for health and well-being

1.0 Contents

3.0 EXECUTIVE SUMMARY

This 5 year commissioning strategy has been developed to achieve a number of goals:

a) To respond to the expressed needs of older people and their carers in terms of their health and social care requirements;

b) To implement more fully the National Service Framework for Older People, and other key Government strategies;

c) To ensure that service developments fit within a comprehensive joint commissioning strategy as required by the Care Quality Commission, World Class Commissioning and the Audit Commission;

d) To enable older people to live as independently as possible, optimising health and wellbeing, maximising quality of life, and promoting good health;

e) To ensure that safeguarding issues underpin all aspects of care and support for older people.

Our population is growing. The number of older people is growing at a faster rate than the population overall. Increases in total life expectancy exceed the increases in healthy life expectancy. There is an urgent need to improve outcomes and target resources by reducing the demand for hospital services and long-term care. This reinforces the need to strengthen services that promote independence.

We are at the start of a considerable change in the profile of Derbyshire's population over the next twenty years, resulting in increased demand for services, with no foreseeable commensurate significant increases in funding. Between 2008 and 2012 we can expect an increase of 12.85% of the total population of Derbyshire aged 65 and over[1]. We can predict an increase of people with late onset dementia of 64.6% from 2005 to 2025[2], estimating that in 2010 there will be almost 10,000 people in Derbyshire with late onset dementia. The number of people in Derbyshire over 65 with social care needs is projected to rise by 59% by 2027 which is above national comparisons[3].

We must therefore act to ensure that prevention and early intervention services are at the forefront or service delivery in Derbyshire across health and social care. It is vital that we are not focussing on treating people only when they are very ill, dependent or in a crisis situation, but that we aim to keep people in good health and living as independently as possible, for as long as is appropriate.

Safeguarding vulnerable people is one of the three key cross cutting partnership priorities agreed by the Derbyshire Partnership Forum and highlighted in the annual Community Strategy. There is a specific theme in this strategy called 'Enhance Dignity and Safety' which sets out how we will make sure that safeguarding issues are addressed and outcomes for individual people are effective and safe.

[1] Office for National Statistics 2007
[2] Alzheimer's Society report 2007, 'Dementia UK'
[3] Planning4care Strategic Needs Assessment: Derbyshire 2007

To achieve the goals expressed in this Executive Summary we will be investing in a number of initiatives relating to our shared service priorities. Detailed Commissioning Intentions can be found in Chapter 6. Some of our key priorities for 2009/10 are:

1. **To increase the range of specialist housing and related support for people with dementia and complex needs**. Two RCCCs are already being built in the county, in Staveley and Swadlincote using money from Derbyshire County Council Capital finances, the first RCCC in Staveley will be open in Spring 2010. We hope to receive PFI monies to build additional centres across the County. We will also work with Providers to develop more Extra Care Sheltered Housing to offer further alternatives to residential care;
2. **To develop specialist services for older people with dementia and complex needs**, this will ensure services are provided in accordance with evidenced growing need. We will develop domiciliary care appropriate for people with dementia, and also expand Memory Assessment Services to ensure that all people with a possible diagnosis of dementia receive appropriate screening and service provision;
3. **To develop a co-ordinated programme of information, advice and advocacy services** across the County, available to all, to maximise the choice and control which older people have in terms of their health, wellbeing and lifestyle;
4. The needs of **Carers** will be addressed through the Carer's Joint Commissioning Strategy, including increasing the number of carers assessments, and increasing the availability of short breaks to allow Carers a break from their caring role. We will also work to improve the health and wellbeing of Carers in conjunction with the needs of the cared for;
5. **To review Intermediate Care services across the county and commission according to need**. As part of this pathway Adult Care will establish Re-ablement teams to provide a short programme of intensive Social Care intervention for all new Service Users, this will focus on enabling individuals to learn how to better care for themselves and therefore reduce reliance on statutory service provision;
6. **To develop high quality, consistent falls prevention services** across Derbyshire, including an increase in the number of older people able to remain at home through the use of Telecare;
7. **To commission high quality, integrated Stroke Services in Derbyshire**, to include the commissioning of a Stroke Support Service which will support individuals throughout the care pathway. In addition Stroke Services in Acute Hospitals and community settings will be reconfigured to maximise the potential for early effective treatment and appropriate rehabilitation;
8. We will work with partners to **reduce health inequalities** and improve life expectancy in specified districts;
9. To maximise choice and control in terms of Adult Care provision, by setting up systems and services to ensure that all new Service Users accessing Social Care services will receive a Personal Budget by April 2010.

This strategy should be seen in the wider context of the strategic development of all services for older people in Derbyshire. It outlines the key drivers for Derbyshire County Council Adult Care, Derbyshire County Primary Care Trust, and Tameside & Glossop Primary Care Trust in terms of the Glossop Dale area in the High Peak, in relation to the development and delivery of services for older people.

5. SERVICE GROUP ISSUES SUMMARY

5.1 NATIONAL

The Government has published a series of integrated strategies, intended to help Local Authorities and Primary Care Trusts to deliver health and social care services which help older people to stay healthy and independent, and enjoy a good quality of life for as long as possible. Derbyshire County Council Adult Care and Derbyshire County PCT will commission services which help to achieve these objectives.

Following the publication of the **Department of Health's Commissioning Framework for Health and Well-being 2007** there is now a stronger focus on developing commissioning processes that are more explicitly driven by health and social need using the Joint Strategic Needs Assessment or JSNA, (rather than by historic patterns of service provision) and that include systems for measuring quality and outcomes. The Framework also promotes:

- Services that are personal, sensitive to individual need, and that maintain independence and dignity
- Strategic re-orientation towards promoting health and wellbeing, investing now to reduce future ill health costs
- Strategic focus on joint commissioning, with a shared goal of promoting inclusion and reducing health inequalities
- Giving a voice to hard to reach groups
- Commissioning focussed on prevention, self care and enablement

The **Department of Health White Paper 'Our Health, Our Care, Our Say' 2006** set out a vision of reforming and improving community services to focus on prevention and on promoting health and well-being. The aim is for care to be delivered in more local settings and for services to be flexible and responsive to peoples' needs and wishes. There are four main goals:

1. Better prevention services and earlier intervention
2. Giving people more choice and a louder voice
3. Doing more on tackling inequalities and improving access to community services
4. Providing more support to people with long term needs.

The White Paper clearly set out the direction of travel for Health and Social Care services over the next five years based on the concept of well being and strongly recommends the notion of 'seven outcomes' for Health and Social Care services as:

1. Enjoying good physical and mental health (including protection from abuse and exploitation);
2. A good quality of life with access to leisure, social activities and life-long learning and to universal, public and commercial services. Feeling comfortable and secure at home, with access to transport and confidence in safety outside the home;
3. Making a positive contribution by maintaining involvement in local activities and being involved in policy development and decision making, with

appropriate advocacy for both individuals and groups. Not being isolated as an older person, but able to participate in intergenerational activities;

4. Having choice and control in daily life through maximum independence and access to information. Being able to choose and control services and helped to manage risk in personal life. Having appropriate preventative independent living services within and outside the home;
5. Being free from discrimination and harassment by having equal access to services. Not being subject to abuse, crime or fear of crime by living in safe neighbourhoods;
6. Enjoying economic well-being by having access to welfare benefits and other income and resources sufficient for a good diet, accommodation leisure activities, and participation in family and community life. Able to meet costs arising from specific individual needs;
7. Maintaining dignity and respect by keeping clean and comfortable. Enjoying a clean and orderly environment. Having appropriate personal care available.

The **Department of Health's 'A New Ambition for Old Age' 2006** follows on from the National Service Framework for Older People. It has three key themes for service development: Dignity in Care, Joined-Up Care and Healthy Ageing. Its ten programme areas for implementation include Dignity in End of Life Care, Stroke Services, Mental Health in Old Age, Falls, and Complex Needs.

The consultative **Department of Health Green Paper, 'Independence, Well-being and Choice' 2005** advocates moving towards a proactive and preventative model of care where users and carers are put at the centre of service planning and delivery. It proposes that users and carers should be involved in the assessment of their own needs given the opportunity to choose the services they wish to receive.

It argues for the better co-ordination and integration of services across health and social care services. It proposes a commissioning model where lower level needs are met though a greater utilisation of universal and community based services, whilst ensuring that people with the highest needs receive the support and protection needed to ensure their own well-being.

'Everybody's Business' Integrated Mental Health Services for Older People (Department of Health 2005) states that the mental health of older people should not be marginalised or ignored, but become "everybody's business". Mental ill health in older age should not be a bar to receiving the services people need to maintain their independence and physical health. It also wishes to ensure that high quality specialist mental health services are available to meet the mental health needs of people with more complex needs and more serious mental illness or dementia.

The **National Service Framework** set out a strategy for the management of long term conditions through self care, disease management and self management. **Supporting People with Long-term Conditions (Department of Health 2005)** proposes a case management model of care for those people with complex long term conditions and high intensity needs provided by teams of community matrons.

The increased emphasis on the development of robust health promotion and preventative services is consolidated in the **cross-Government concordat Putting**

People First[4], and the **Derbyshire County PCT Strategic Plan 2008/13** which builds on the East Midlands Darzi review Our NHS Our Future[5]. Putting People First is a cross government commitment (in partnership with local government, the NHS and the social care sector) to the transformation of adult social care, setting out a shared vision of outcomes for the system, which stresses the need for improved information and advocacy, more control and personalisation, and ensuring that prevention becomes the norm.

In March 2000 the **Department of Health and the Home Office** issued **No Secrets** as Guidance under s7 of the Local Authority Social Services Act 1970. One of the main objectives of the No Secrets Guidance was to ensure that all local authorities in England take the lead in developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse. Safeguarding means enabling people to live their lives free from harm, abuse and neglect, and to have their health, wellbeing and human rights protected. All aspects of Health and Social Care commissioned services, and this Strategy in particular, are underpinned by safeguarding principles, which are led on by Derby and Derbyshire Safeguarding Vulnerable Adults Partnership, and specifically the November 2008 Safeguarding Adults Policy and Procedure for Derbyshire. The Partnership uses an Association of Adult Social Services guidance paper 'Safeguarding Adults: A National Framework of Standards for Good Practice and Outcomes in Adult Protection Work' (October 2005) as a reference.

'Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society' published by the Communities and Local Government department in 2008 outlines the Governement's plans for making sure that there is enough appropriate housing available in future to relieve the forecasted unsustainable pressures on homes, health and social care services. It sets out requirements to build all homes to 'Lifetime Homes' standards by 2013 within Lifetime Neighbourhoods. It sets out shorter term actions for older people, including better home adaptations, repairs, advice and information.

In 2008, the Government launched its **'Independent Living Strategy'**, a set of aspirations designed to work across government departments, in order to improve the life chances of disabled people. The broad aim of the Strategy is to remove barriers to disabled individuals exercising choice and control in areas such as housing, transport, health services, education and employment.

Independence and Opportunity: Our Strategy for Supporting People was published by the Department for Communities and Local Government in 2007. The Supporting People programme, created in 2003, provides the means through which the Government ensures that some of society's most vulnerable people receive help and support to live independently, and makes an important contribution to our objective of promoting equality of opportunity and enabling vulnerable people to participate fully in the social and economic life of communities. This strategy is based on four key themes; keeping people that need services at the heart of the programme; enhancing partnership with the Third Sector; delivering in the new Local Government landscape, and; increasing efficiency and reducing bureaucracy. The

[4] Putting People First; A Shared vision and commitment to the transformation of adult social care, 2007
[5] Our NHS Our Future; A Vision for Better Health and Health Care in Derbyshire, June 08

Supporting People programme in Derbyshire funds sheltered housing support and community alarms to support older people.

'**Carers at the Heart of 21st Century Families and Communities: a caring system on your side, a life of your own'** was published by the Department of Health in 2008[6]; a ten year strategy setting out action required to enable carers to be universally recognised and valued as being fundamental to strong families and stable communities. Offering support tailored to meet individual's needs; enabling carers to maintain a balance between their caring responsibilities and a life outside caring, whilst enabling the person they support to be a full and equal citizen.

The **'National Dementia Strategy: Living Well with Dementia'** was published on 3 February 2009 and will transform the quality of dementia care. It sets out initiatives designed to make the lives of people with dementia, their carers and families better and more fulfilled. It is backed by £150 million nationally over the first two years. It will increase awareness of dementia, ensure early diagnosis and intervention and radically improve the quality of care that people with the condition receive.

The **National Stroke Strategy** published by the Department of Health in 2007, is intended to provide a quality framework to secure improvements to stroke services, to provide guidance and support to commissioners and strategic health authorities and social care, and inform the expectations of patients and their families by providing a guide to high quality health/social care services.

Building a Society for all Ages, published in July 2009 by the Department for Work and Pensions, brings forward a series of proposals to help instil a major cultural shift and help Britain prepare for demographic change which is seeing people live longer lives. Key elements of the strategy involve providing support to people to look forward and plan earlier for their longer lives, and making sure that services are suitable when the time comes to use them.

The Department of Health launched a **Prevention Package for Older People** in July 2009. The prevention package raises the focus on prevention as a means of ensuring good health, well-being and independence in later life, by promoting and encouraging uptake of comprehensive health and social care services for older people, and includes:

- bringing together information on existing health 'entitlements' including sight tests, flu vaccination and cancer screening;
- promoting best practice around falls prevention and effective fracture management;
- introducing measures to improve access to affordable footcare services;
- updating national intermediate care guidance;
- summarising existing progress on audiology and telecare.

[6] Carers at the Heart of 21st Century Families and Communities, June 2008

5.2 REGIONAL INITIATIVES

NHS East Midlands

The role of NHS East Midlands is to relay and explain national policy, set direction and support and develop all NHS Trust bodies (Primary Care Trusts and NHS Trusts providing acute, mental health and ambulance services).

They ensure that local health systems operate effectively and efficiently for the population, which includes making certain that national standards and priorities are met so that the population of the East Midlands is cared for in high quality, safe environments and that services are continuously improved and developed. A key priority is improving health and reducing inequalities. NHS East Midlands launched its 10 year vision for healthcare across the region in June 2008 entitled 'From Evidence to Excellence - our clinical vision for patient care ', following months of consultation and engagement with patients, the public and staff. The East Midlands' approach to providing world-class services is in response to the national review - Our NHS, Our Future - led by leading surgeon and Health Minister, Professor Lord Ara Darzi.

The proposals in the vision will save lives, drive up standards and put safety first. Top of the agenda is improving the quality of care, ensuring patients are seen swiftly and conveniently and actively encouraging local people to lead healthy lives.

Changes will include:

- Developing specialist centres for patients suffering heart attacks. This will save more than 40 lives a year and will significantly improve outcomes for many more patients
- Developing specialist hyper-acute and acute stroke treatment centres, to reduce the numbers of premature deaths and support more patients to regain independence
- Establishing within the region, a major (level 1) trauma centre to treat the most seriously injured patients
- Easier access to an NHS dentist; a commitment to year on year improvement in the numbers of patients registereed with an NHS dentist
- Improve cancer screening for breast, bowel and cervical cancer, enabling early diagnosis and better results for cancer patients
- Getting the basics right, ensuring infection rates continue to reduce
- Better access to GP services
- Greater emphasis on health and healthy living
- More care provided closer to home for larger numbers of patients, especially those with long term conditions such as diabetes and asthma
- Greater use of new technology to ensure that patients experience seamless care.

Directorate of Public Health East Midlands

This Directorate brings together the public health teams from the Department of Health's regional presence (based at the Government Office for the East Midlands) and NHS East Midlands under the Regional Director of Public Health. The Directorate of Public Health East Midlands supports the regional health improvement and protection agenda through:

- **Leadership and collaborative working for health** – working closely with other NHS East Midlands Directorates, the Department of Health, Government Office for the East Midlands, the regional Department of Health Care Networks and other regional partners
- **Integrating health improvement activity** in local planning and delivery mechanisms, especially Local Area Agreements
- **Tackling inequalities** through influencing and advising, and carrying out health impact assessments on cross-Government policies in the region and promoting priorities and programmes that help to deliver cross-Government and NHS goals
- **Surveillance and assessment of population health and well-being** – joint working with the East Midlands Public Health Observatory and Health Protection Agency to track trends and report on performance
- Identify regional issues that may need a national policy response, assessing and keeping under surveillance all public health issues and needs
- **Policy and strategy development and implementation** – using public health knowledge and skills to interpret and influence national health and social policy, ensuring implementation through performance management of and by local commissioners and support for health and social care providers
- **Working to improve healthy life expectancy in Derbyshire's Spearhead area of Bolsover**

Department of Health Care Networks

The Care Networks take the lead for the Putting People First team in the Department of Health around integration and whole system reform, housing with care, assistive technology and partnership working. The East Midlands team is also focussing on Dementia, and will be funding a Dementia Service Improvement Post to work between Derby City and Derbyshire County, to ensure joined up working in terms of the implementation of the National Dementia Strategy.

5.3 LOCAL ISSUES

Local complementary strategies will also impact upon the health and well-being of older people in Derbyshire, including the Derbyshire Vision and Strategic Direction for Adult Mental Health 2007 - 2017[7], Ageing Well in Derbyshire; Improving Life for Local People[8], the Housing and Related Support Strategy for Older People in Derbyshire[9], Derbyshire Extra Care Housing Strategy (2005), Derbyshire Supporting People 5 year Strategy 2005-10, and the Independent Living Services Strategy. A Wellbeing Strategy is currently under development.

Consultation was conducted in 2008 on the contents of the Services for Older People Joint Commissioning Strategy, with over 450 people returning the survey. 99% of people agreed with the priority areas within the strategy, and they highlighted the need for low level services, preventative services, improved specialist services for people with dementia, and more support for informal carers, amongst other issues. The outcomes of the consultation have been incorporated into the strategy.

The profile of Derbyshire's older citizens has been compiled through the Joint Strategic Needs Assessment using a range of evidence and predictions including national Census information, General Survey information, Practice Based Registers, information collated by Public Health Observatories and information on current social care service provision. The full details and analysis is provided in the Appendix. The implications of this data have informed the Commissioning Intentions detailed in Chapter 6.

We will see a projected 16% (21,800) rise in the number of people aged 65 and over 2008-2013, and a 55% rise by 2028 (70,300), with clear ramifications for health and social care[10]. Although the numbers of older people are increasing substantially, and the complexity of needs and therefore the cost of care is increasing, Adult Care are actually providing services to reducing numbers of older people, demonstrating the need to focus services on prevention and also specialist support.

In terms of ethnicity, 0.4% of people in Derbyshire aged 65 or over stated they were from Black and Minority Ethnic (BME) communities in the 2001 Census. Whilst no more recent data is available it is clear that by 2025 the number and percentage will have slowly increased as younger minority populations' age. The challenge in Derbyshire is to focus on ensuring current mainstream services are accessible to all. Adult Care is aware that a significant number of older people from BME communities choose self directed support and personalised budgets. Through the 'Making Care Personal: Your Choice, Your Life' programme Adult Care aims to increase the numbers of older people from particular communities who receive self directed care.

The 2005/2006 Survey of English Housing reveals that one in five of the 866,000 people over 65 who are disabled as a result of a serious medical condition and living in private homes requiring specially adapted accommodation, thought that their

[7] Derbyshire Vision and Strategic Direction for Adult Mental Health 2007 - 2017 (Draft), Derbyshire Mental Health Foundation Trust, 14 December 2006
[8] Ageing Well in Derbyshire: Improving Life for Local People, Derbyshire County Council, Final Draft 31 July 2007
[9] Housing and Related Support Strategy for Older People in Derbyshire, Inter-agency document, December 06
[10] Revised ONS Mid Year Estimates, published September 2007.

accommodation was unsuitable. As the population ages, it is likely that this proportion will increase locally and nationally.

> ***Commissioning implication 1:***
> **To increase the housing options (and related specialist advice) available to a wider range of older people. To expand the range of 'housing with care' for the growing numbers of people who need higher levels of specialist care (such as those with cognitive disabilities including dementia).**

Low Income and Inequalities

There is clear link between low income and inequality, and the need for health and social care services. Data on low income households in Derbyshire is detailed in Appendix 3, table 13[11].

Almost a quarter of Derbyshire households with members aged 60 years and over are dependant on means tested Pension Credit. Bolsover and Chesterfield have higher rates while Derbyshire Dales, High Peak and South Derbyshire have significantly lower proportions of their older households' dependant on means tested benefits. A higher proportion of older people over 80 years old are dependant on this benefit, particularly women.

Low income pensioner households will generally have had lower incomes prior to retirement; and now have less income to eat well, keep warm or afford all the necessities of life. They will more often be living in poorer housing, without a car for transport (which will tend to reduce their access to services). Whilst in the short to medium term pensioner incomes are likely to increase somewhat as a higher proportion of pensioners retire with occupational pensions, a substantial proportion of pensioners will be left behind on low incomes.

> ***Commissioning implication 2:***
> **2a) Recognition that the impact of low income and inequality are likely to require a higher level of both preventative services and direct social care and health services in low income communities in order to provide equity.**
>
> **2b) Maximise access to welfare benefits through assessment processes to prevent avoidable poverty.**

Assistance with activities of daily living in a way which promotes dignity and independence.

Entitlement to Attendance Allowance or Disability Living Allowance is used as the best available indicator for people who have a serious disability or illness and have been adjudged to need assistance from others with 'bodily functions' or need supervision to avoid danger to themselves or others.

To be entitled to either benefit the claimant has to have a need for care and attention

with bodily functions at least several times throughout the day time (and/or during the night). Some claimants will receive informal care, some social care input, and others will 'manage' without the assistance they need.

25% of over 65 year olds are entitled to these benefits, rising to 66% of people aged 85 or over (Appendix 5, table 16). Bolsover and Chesterfield have significantly higher proportions of older people awarded these benefits (35 and 32% respectively), and Derbyshire Dales, High Peak and South Derbyshire have fewer.

Commissioning implication 3:
3a) Personal care will increasingly be required 24 hours a day, 7 days a week, to avoid unnecessary admissions to residential care and hospital.

3b) Expand the use of assistive technology in order to promote independent living, and to reduce the risk of falls, wandering etc.

Limiting long term illness

The information on limiting long term illness (Appendix 5, table 14) is based on self assessment of whether or not a person has a long term illness, health problem or disability which limits their daily activities or the work they can do. That includes problems that are due to old age. Forty percent of men aged 65 – 74 and 50% of men aged 75 and over judge themselves to have a limiting long term illness in 2001, but this varied across the county with Bolsover having the highest incidence. The pattern for women was slightly lower for the 65 – 74 age group, but generally higher for those aged 75 and over. Good long term conditions' management is underpinned by a holistic assessment of needs.

Commissioning implication 4:
4a) Improve the assessment and co-ordination of services for people with long term health conditions, including increasing the use of common assessments.

4b) Increase the use of Telecare, Telehealth and Community Alarm personal support systems for people with limiting long term conditions, aligned to expert patient programmes and self management.

Self Reported Health Status; estimated healthy life expectancy and estimated years in poor health

The life expectancy of men aged 65 in the East Midlands' is 16.1 years, whilst it is 19.1 years for females. In England and the East Midlands 9% of all people rated their own health as 'not good', with the proportion increasing with age to one third of people over 90 years old reporting their health as 'not good'.

Healthy Life Expectancy at 65 years

This data (Appendix 5, table 19) estimates the healthy years' life expectancy and years in poor health for people by gender at age 65. The years in poor health varies significantly by District, which is likely to have significant implications for commissioners of services. For males: the expectation is that Bolsover males will have one and a half times as many years in poor health as males in Derbyshire Dales unless health inequalities are successfully addressed.

It is important to note that within these statistics are increasing numbers of older people with a Learning Disability, most of whom will need to access mainstream service provision, with the requirement for specialist services where appropriate.

Commissioning implication 4c:
Increase the range of preventative services, targeted at specific groups and areas vulnerable to developing ill-health.

Disease Prevalence

Disease prevalence has been estimated using Practice Based Registers across Derbyshire.

Stroke

Stroke prevalence is higher in Chesterfield, High Peak and Dales, and North East Derbyshire. There appears to be a much lower than average occurrence of strokes in Derbyshire Dales and South Derbyshire. Implementation of the stroke pathway across the County, which has been developed, will ensure equity and quality of the services provided. This will include work on prevention, treatment, rehabilitation and long term management. These services can then be monitored by both national and locally agreed indicators.

Commissioning implication 5a:
To commission high quality, integrated stroke services across Derbyshire, supporting the implementation of the National Stroke Strategy including through appropriate spending of the Local Authority Grant.

Mental Health

Practice based diagnosis
Depression is the most common mental health problem for older people, affecting 10-15% of the population, with 40% of care home populations showing significant levels of depression.

***Commissioning implication 6a*:**
There is a need to carry out a more detailed needs analysis of our populations, and then to map service provision. This will include ensuring that dementia and depression pathways include prevention, early intervention and long term support, to support the local implementation of the National Dementia Strategy.

There is a higher than average prevalence of people being on the dementia register as a percentage of each practice's population in Chesterfield and High Peak and Dales, with a lower than average prevalence in South Derbyshire and Dales and Erewash.

A comparison between the actual number of people on the dementia registers and the number of residential and nursing beds available for dementia care is illustrated in the table below:

Area	*Beds Available*	*Number of People on Dementia Register*	*Ratio beds : number on register*
High Peak and Dales	124	571	1 : 4.6
Chesterfield	90	600	1 : 6.6
North East Derbyshire and Bolsover	167	710	1 : 4.3
Amber Valley	28	584	1 : 20.9
South Derbyshire and Dales	64	380	1 : 5.9
Erewash	11	404	1 : 36.7

Commissioning implication 6b:
Using information from the JSNA, work with providers to ensure a more equitable and appropriate spread of dementia care beds and specialist support now and in the future, and to ensure preventative technologies are used to support dementia care.

Estimates of dementia prevalence in people over 65

There is significant evidence of under diagnosis of dementia. The Alzheimer's Society published a report in early 2007, 'Dementia UK', providing estimates of people suffering from late onset dementia (after the age of 65) within each Social Services area. These estimate that whilst just 6.9% of 65 – 69 year olds have dementia, this increase to 30.0% of those aged 90 or over.

The table below applies the Alzheimer's methodology to Derbyshire districts using the projected increase in numbers of elderly people between 2005 to 2025, in line with population estimates provided by the Office for National Statistics.

Estimates of people with late onset dementia for 2005 to 2025

	2005	2010	2015	2020	2025	% increase from 2005 to 2025
Derbyshire	8,910	9,817	10,989	12,570	14,668	64.6
Amber Valley	1,451	1,582	1,741	2,016	2,351	62.1
Bolsover	884	963	1,056	1,227	1,410	59.6
Chesterfield	1,239	1,310	1,433	1,585	1,815	46.4
Derbyshire Dales	991	1,104	1,240	1,423	1,696	71.1
Erewash	1,244	1,355	1,534	1,740	1,996	60.5
High Peak	1,034	1,151	1,305	1,485	1,768	71.0
NE Derbyshire	1,259	1,426	1,647	1,896	2,209	75.4
South Derbyshire	845	952	1,096	1,300	1,555	84.0

From Table 21A in Appendix 5 it can be seen that some 55% of Derbyshire older people estimated to have dementia have mild dementia, with a further third moderate dementia; and just 13% severe dementia. We will respond to the National Dementia Strategy and respond to the challenge laid down in this document, to improve dementia care for people in Derbyshire. In addition we know that people with a Learning Disability are living longer, and that people with Down's Syndrome develop dementia, particularly Alzheimer's, much earlier than others. As a result there is a

growing need to promote appropriate assessment and care planning, and to ensure that housing and support services recognise and respond to the particular needs of those individuals with Downs Syndrome who are living with dementia.

Commissioning implication 6c:
Increase public and professional awareness of dementia to support a consistent diagnosis across the County, to capture accurate numbers of people with the condition.

Commissioning implication 6d:
Develop specialist dementia services from early intervention through to long term care, to support the individual throughout the pathway.

Palliative care

Palliative care is the active holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families.

The average percentage of General Practice populations receiving palliative care across Derbyshire is 0.10, equating to 719 people on the palliative care register. Most of these services are for people with a diagnosis of cancer. Nationally, there is a project underway to identify how best practice can be shared to improve end of life care for older people living at home, in hospital or care homes.

Commissioning implication 7:
Explore the pattern in palliative care provision against 'End of Life' standards to confirm that there is equity across the County; looking at sharing best practice, especially for those in care homes.

Emergency admissions

Emergency admissions caused by hip fractures, strokes and accidental falls

Older people are three times more likely to be admitted to hospital following an Accident & Emergency attendance, many of these could benefit from alternatives to admission to acute beds.

Amber Valley consistently scores at the upper end of the scale for incidence of emergency admissions caused by hip fractures, strokes and accidental falls, whilst High Peak consistently scores at the lower end. Of the three reasons for emergency admissions: hip fractures have the highest average length of stay at 28 days. The further development of an integrated fall service and the stroke pathway will help prevent unnecessary admissions and support timely discharge.

Commissioning implication 8a:
Develop good quality, evidence based falls prevention services and target these to reflect areas of high prevalence.

Other causes of emergency admissions

The top ten other primary diagnoses of emergency admissions include urinary tract infections; breathing and chronic obstructive pulmonary diseases with infection and chest pains, angina and atrial fibrillation.

Commissioning implication 8b:
Review models of prevention, early diagnosis, and treatment to ensure they are as effective and accessible as possible in preventing inappropriate admissions.

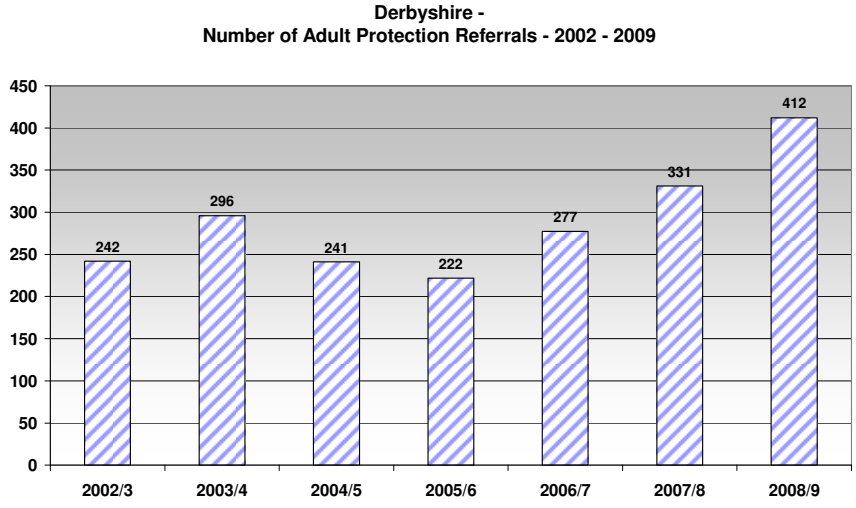
Safeguarding

Dignity in Care Campaign

The Dignity in Care campaign was launched by the Department of Health in November 2006, the aim was to create a care system where there is a zero tolerance approach to the abuse of and disrespect towards, older people. The Dignity in Care Campaign aims to eliminate tolerance of indignity in health and social care services through raising awareness and inspiring people to take action.

The Adult Care Department's star rating from the Care Quality Commission includes a rating for 'Maintaining Personal Dignity and Respect' and PAF Indicator NI128 has been added describing the promotion of dignity as fundamental. Lord Darzi's NHS Next Stage Review (published 30 June 2008) also states that dignity should be at the heart of health care services.

A project entitled 'My Home Life' has been commissioned by Adult Care and Derbyshire County PCT with Help the Aged as the strategic partner, and work commenced in April 2009. The scheme involves working with 13 independent sector residential care home providers and 2 Derbyshire County Council residential care homes regarding the 8 themes of 'My Life' approach. Together these themes offer a vision for care homes, a framework from which to promote dignity and deliver quality of life. This will support the ongoing work on improving quality standards in Care Homes across Derbyshire.



The year on year increase in Adult Protection referrals reflects the impact of training across all agencies, and the rising profile of safeguarding arrangements in partner agencies on the Safeguarding Vulnerable Adults Partnership.

An evaluation of the trend above suggests strongly that the planned publicity campaign will enhance the likelihood of referrals direct from the public and from the wide and increasingly diverse social care, health care and criminal justice workforce as well as provide an educative impact on the unacceptability of abuse and neglect of those least able to protect themselves.

Adult Care Service Provision

Residential provision

Tables 33 – 35 in Appendix 6 identify numbers of people who have been assessed by Adult Care who are living in care homes and care homes with nursing for older people in 2008/2009 – a total of 3,951 people in residential accommodation (21% living in Adult Care directly provided homes). From the total number of people living in a care home in Derbyshire, 2,150 (54%) were aged 85 or over. This constitutes 1.5% of all residents aged 65 and over; and 12% of those aged 85+. This does not include a significant proportion of people who were not assessed by Adult Care; and who made their own arrangements for moving into residential care. Whilst the proportion of older people in care has tended to diminish with increasing care in the community, and can be predicted to continue to diminish as a proportion of the total population as a result of innovative care arrangements, it is less clear what impact the increasing population will have on the absolute number of residential places required (with almost a doubling of the total number of 85 year olds by 2028).

Commissioning implications 9:
9a: Develop alternatives to long term residential and nursing care for older people
9b: Improve standards in residential and nursing care homes, with a focus on homes judged by the Care Quality Commission to be 0 or 1 star

Homecare

Between 01/04/08 and 31/03/09, 11,335 people aged 65 or over (8.4%) received homecare provided either directly by Adult Care domiciliary home care services, or commissioned through an independent or private service, or via direct payments to clients. Of these some 4,530 are aged 85 or over (25.6% of all people of this age).

Gradually, there has been an increase in more intensive home care and services (sometimes as a positive alternative to residential care). As the number of older people increases there is likely to be at least a proportionate growth in the numbers needing such assistance and / or the intensity of provision.

The provision of services must be responsive and reflect the outcomes valued by older people, set out in the Our Health, Our Care Our Say. More direction from older people and their carers on how the service is delivered will help achieve outcomes important to them. Self directed care will incorporate direct payments for older

people to employ their own care staff and 'call off' services that can be accessed directly by older people following an assessment.

Given the projected changes to the working age population available to provide care services, such changes are likely to result in a significant shift to the current pattern of provision, with the development of new forms of provision including social care enterprises and more use of assistive technology to support people to remain independent.

Commissioning implications 10:

10a: **Joint working between commissioners and providers to stimulate the market to ensure sufficient diversity of provision (including specialist support for people with dementia and other complex needs) is available to meet the needs of individuals and identified groups who wish to live independently in their own homes, matched to changing demographics and need across the County**

10b: **Explore the cost-effectiveness and benefits of using preventative or assistive technologies to support people to continue to be independent in their own homes in the community (including client satisfaction levels and outcomes achieved)**

10c: Develop re-ablement services within Social Care models of home care support, through the use of short term intensive interventions which maximise the potential for achieving independence, choice and quality of life, and minimise ongoing support required

10d) Review Intermediate Care services across health and social care to ensure they are fit for purpose and support pathways e.g. early supported discharge for stroke patients.

Meals on Wheels and laundry

Some 4,812 people aged over 65 currently receive a meal on wheels service (mainly via the delivery of frozen meals); and 2,608 clients a laundry service (with significant overlaps between the two groups (see tables 36 and 37 in appendix 3). Currently, these services are arranged through the social services care management services. Support for the emergence of self-directed care will require these services to be directly available to older people. That may require different models of service delivery.

Commissioning implication 11:

Work with local communities to consider partnership models to support low level services such as meals on wheels and laundry for the growing number of older people who are likely to require them, for example through Social Enterprises.

Day Activities

Our Health, Our Care, Our Say found that people using health and social care services valued access to leisure, social activities and life long learning as much as anyone else did. They also valued being able to maintain involvement in local

activities. There is a subsequent shift away from providing 'day care centres' to providing meaningful individual and group activities that can be undertaken during the day across a range of settings. This means that measurement of current day care provision across health and social care service in Derbyshire is patchy due to the range of settings and number of provider partnership arrangements in place. Day activity often has a dual function of providing support to the service user, whilst also giving the carer a break from their caring role.

Total sessions of day care (or equivalent community support) required to meet social care needs of people over 65 years old have been estimated using a strategic needs assessment tool and analytic service that estimates and projects levels of need for social care in the local population[12].

Commissioning implications 12:

12a) **Alternative models of day activities to be developed with a range of providers, to achieve a decrease in building based provision, and an increase in home and community based services, to reflect an emphasis on self-directed support, choice and control. To focus resources on specialist provision for those with complex needs such as dementia, to deliver day activities for them in the most appropriate setting.**

12b) **Work with local communities to support older people and their carers to access local leisure, social activities and life long learning opportunities as an alternative to traditional 'day care'**

12c) **Confirm therapeutic input and outcomes of health led day services to ensure individuals are appropriately referred to specialist resources. Specialist day opportunities will be commissioned for people with dementia/complex needs.**

Equipment and adaptations

Equipment and Minor Adaptations

In excess of 60,000 pieces of equipment and minor adaptations are provided to Derbyshire people annually by the Integrated Community Equipment Service (a service led by Derbyshire County Council but delivered jointly with Derbyshire Primary Care Trust). The equipment ranges in value from a few pounds to several thousand pounds per item. Audit Commission reports have highlighted the crucial role of such equipment in enabling people to remain at home. Demographic changes and the increasing number of people remaining in their own home are currently placing an increasing demand of about 2% per annum for community equipment and minor adaptations. When combined with inflationary costs this is putting increasing pressure on Community Equipment Services.

Major Adaptations

Although District Councils have the responsibility to provide Disabled Facilities Grants (DFG) it is the County Councils responsibility to advise if such adaptations (e.g. stairlifts, showers, extensions) are 'necessary and appropriate'. In addition to Occupational Therapy services the County Council funds a Disability Design Team and, in some circumstances, provides financial support to disabled people to help

[12] Planning4Care

them through the adaptation process. The County Council also provides a maintenance service and currently maintain almost 2,000 stair lifts.

Despite many District Councils finding additional funding and Derbyshire County PCT having contributed £1.4m in 2008/2009, the funding available to Derbyshire falls well short of demand and this continues to be the single greatest reason for any delays. The primary reason for this 'pent up' demand for adaptations is the historical lack of awareness of the needs of Disabled people when building houses. Given that no more than 1% of houses are replaced each year the shortfall of suitable properties will remain for many years.

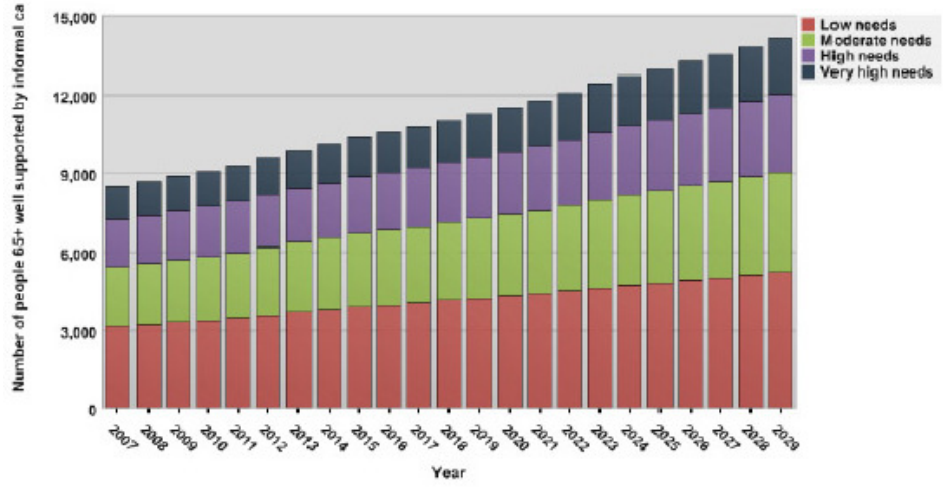
Commissioning implication 13a:
The Integrated Equipment Board (this is a combined Health and County Council service) will continue to review the service and advise on how best to meet increasing demand.
Commissioning implication 13b:
The County Council will continue to work with the all District Councils in Derbyshire to speed up the provision of Major Adaptations. A Senior Officers Group has been established and a five year strategy agreed.

Short breaks

In 2008/2009 Adult Care provided short term residential care for 1532 clients. This was in addition to short term intensive care at home. Short term residential care may be necessary following an illness or accident, or stay in hospital where improvement in condition is anticipated, or to enable carers a break from their caring role on occasions. There will be a growing need for the provision of breaks in a range of settings including care at home and as part of packages to support carers.

An estimate of the number of people supported by informal care has been undertaken by Planning4Care, using Census 2001 and General Household Survey data. The diagram below demonstrates that growth in the numbers of people with moderate, high and very high needs supported by informal carers will be significant.

Number of older people well supported by informal care, living in the same household:



***C**ommissioning implications (to be delivered through the Derbyshire Carer's Joint Commissioning Strategy):*

***14a)* Increase the numbers of carers receiving carer assessments, and promote contingency planning via the use of the carer's emergency card.**

14b) Develop the availability and variety of short breaks, to include planned and emergency support, including provision in a person's own home.

Resources

Adult Care

Central government has determined that all Local Authorities must demonstrate efficiency savings in public service spend, as part of this Adult Care has pledged to realise efficiency savings of 3%. The total efficiency target for Adult Care in 2009/10 is £3,152,000, of which £1,743,720 is the Older People's Service target. The total net budget for Older Peoples Services is £92,928,077 (from a total ASC Net Budget of £190,462,608).

6. COMMISSIONING INTENTIONS

The timescales are defined as short term (1-3 years), medium term (3-7 years) or long term (7-10 years). An Action Plan will be developed to facilitate the outcomes (some of which are stated in the column 'proposed outputs'). The Action Plan will be formulated by the responsible work stream, and will form a separate document.

6.1 Promote Health and Wellbeing and Reduce Health Inequalities: Stay healthy and recover quickly from illness, wellbeing focuses on prevention, early intervention and enablement.

	Action	Current Situation & Date	Target (Output) and Timescale	How we will know if we have been successful (Outcome)	Responsibility
6.1.1	Improve access to good quality, consistent information and advice on services for older people. **Short term target of 1- 3 years for completion**	The Information, Advice and Advocacy and Supported Access Project is now underway with a wide range of partners from Derbyshire organisations working together. Part of the project will build on the successful work undertaken in the High Peak and Derbyshire Dales to develop a multi-agency supported sign-posting scheme. This model known as First Contact will be rolled out across Derbyshire from August 2009.	Develop an integrated information, advice, advocacy and signposting service by April 2011 as part of the universal offer aspect of personalising services. Develop an online information platform to provide comprehensive health and wellbeing information.	Users and carers will be better informed about health and wellbeing, enabling better choice and control when accessing services. NI119 Self reported measure of people's overall health and wellbeing. Pathways are supported by consistent information.	Head of Wellbeing, Adult Care Falls, Stroke, and De Commissioning Grou

	Action	Current Situation & Date	Target (Output) and Timescale	How we will know if we have been successful (Outcome)	Responsibility
6.1.2	To commission high quality, integrated stroke services including the implementation of the primary prevention elements of the stroke pathway in an equitable way across the County. **Short term target of 1- 3 Years for completion**		Stroke Support Service to be developed by March 2010 (using the Local Authority Stroke Strategy Grant)	People experiencing strokes will receive consistent services across the pathway, regardless of where they live. A decrease in the number of people experiencing strokes. NI137: Healthy life expectancy at age 65 An increase in the number of people attending Stroke Support Networks, and staff attending Stroke training.	Stroke Action Plan (Public Health) Stroke Commissioning Group
6.1.3	Achieve high quality, consistent Falls Prevention services across Derbyshire, and the equitable co-ordination of resources / health promotion initiatives (including the improvement of data collection).	The County Falls Group and the Falls Implementation Group meet regularly and have representatives from social care and health. The newly appointed PCT Falls Commissioning Manager will undertake a key role in evaluating projects, sharing best practice and improving data collection and service	Increase the use of Telecare and Telehealth to support falls prevention– target of 200 new users of Telecare by the end of March 2010. Improve the collection of information about falls and near misses In Care Homes and hospital settings, and introduce new initiatives to reduce the number and impact.	Reduce the number of falls across Derbyshire, as measured by hospital admissions (hip fractures). Reduce the rate of admissions for alcohol related harm (which can often be related to falls)	County Falls Group Falls Advisory Group Falls Forum

	Action	Current Situation & Date	Target (Output) and Timescale	How we will know if we have been successful (Outcome)	Responsibility
	Short term target of 1- 3 Years for completion	coordination.	Promote the greater use of the Falls Assessment Tool among Health and Social Care staff, and improve liaison between organisations regarding people at risk of falls. Increase the availability and consistency of low level preventative services County wide to prevent falls, including Tai Chi, chair based exercise and walking. Update and implement Falls Strategies.		
6.1.4	Improve the health and wellbeing of older people in areas of high deprivation. **NI120: All age all cause mortality rate: 10% reduction in health inequalities by 2010 as**	There are health inequalities within Derbyshire by location, gender, level of deprivation and ethnicity. For example Bolsover is relatively deprived.	Provide appropriate advice and information in relation to reducing health inequalities Develop comprehensive healthier lifestyle management programmes Initiatives such as Comprehensive cardiovascular risk assessments	Inequality in life expectancy across Derbyshire is reduced by targeting causes of premature mortality amongst older people, particularly cardiovascular disease. Economic wellbeing is improved through access to benefits advice and welfare rights expertise.	Choosing Health Inequalities Programme Board Bolsover Spearhead Inequalities Group

	Action	Current Situation & Date	Target (Output) and Timescale	How we will know if we have been successful (Outcome)	Responsibility
	measured by life expectancy at birth. **Short term target of 1-3 years for completion**		Effective prescribing Access to welfare rights advice and representation is promoted to older people.		
6.1.5	Improve the assessment and care co-ordination of services for people with long term conditions across health and social care, using the common assessment framework, supporting people to be independent and in control of their condition (NI124) **Medium term target of 3-7 years for completion**	The introduction of a Unique Care Project with Shirebrook & Swadlincote Community GP practice to support people with Long Term Conditions, resulting in reduced hospital and care admissions. Adult Care have continued to provide packages of care to over 90% of local people within 7 days of their assessment.	Develop systems to allow personal budgets to be used upon introduction Continue to develop the role of community matrons and advocates, improving links to Social Care. Take forward the Telehealth project being developed to assist people with long term conditions to better manage their health	All people with a long term condition are assessed and receive an appropriate co-ordinated care plan. Older People receive a prompt response when accessing health and social care services.	Long Term Conditions Group

6.2 Increase Independent Living and Improve Quality of Life – Enabling people to live as independently as suits them

No.	Action	Current Situation & Date	Target (Output) and Timescale	How we will know if we have been successful (Outcome)	Responsibility
6.2.1	Review current day service models and day time activities to look at both the quantity and quality of current provision. Confirm therapeutic input and outcomes of health led day services. **Short term target of 1- 3 Years for completion**	Current day service provision varies greatly across the County, and there is an under supply of day activities for people with dementia and complex needs.	Develop joint health and social care services where appropriate as part of integrated pathways Identify the role of day services in relation to Pathways. Develop a menu of alternatives to building based day care facilitating access to local community services, e.g. leisure, lifelong learning etc. Review travel provision to ensure efficiency and take account of environmental issues. Develop high quality specialist services for people with more complex needs, e.g. dementia, end of life	Better choice and flexibility for older people and carers who need day time activities.	Older Peoples Strategic Commissioning Group
6.2.2	To develop targeted services to meet identified need for dementia care with a focus on early intervention. To link	A small 'Just Checking' Telehealth pilot is underway in	Write a Dementia Joint Commissioning Strategy by March 2010	By identifying gaps in service provision and developing services to better meet the needs of	Dementia Joint Commissioning Group

No.	Action	Current Situation & Date	Target (Output) and Timescale	How we will know if we have been successful (Outcome)	Responsibility
	these outcomes to those contained within the National Dementia Strategy. **Short term target of 1- 3 Years for completion**	Bolsover to support hospital discharge of patients with dementia.	Develop peer support services by March 2011 Develop equitable memory assessment services Dementia Care Advisor role to be explored Increase specialist support for people at home and in care homes To extend the use of telecare to support people to remain in independent accommodation for as long as possible and to reduce the environmental risks they may face.	people with dementia, from early diagnosis and support, people with dementia will receive appropriate services throughout their care through to end of life.	
6.2.3	To review the Intermediate Care pathway and services and commission according to need. NI125: Achieving independence for older people through rehabilitation/intermediate care	Current Intermediate Care services vary greatly between districts	Review Intermediate Care services across the County Improve access to and consistency of Integrated Care services across the County Develop and implement Adult Care re-ablement teams across the County to provide a short term intensive support.	Recovery from illness takes place in the most appropriate setting for Older People taking into account their individual needs. A reduction in avoidable admissions to care homes and hospitals.	Older People's Strategic Commissioning Group

No.	Action	Current Situation & Date	Target (Output) and Timescale	How we will know if we have been successful (Outcome)	Responsibility
	Short term target of 1-3 years for completion		Improved out of hour's response provision. Structured evaluation and performance criteria.		
6.2.4	Support more older people to live at home and support carers to continue with their caring role, with a reduced need for social care interventions. NI136: Increase the number of older people helped to live at home through Adult Care Services per 1000 of the population aged 65 or over. NI139: Older People receive the support they need to live independently at home. **NI135: Increase the number of Carers receiving needs assessments.** **Short term target of 1- 3 Years for completion**	A Carers Emergency Card has been introduced to support Carers should they fall ill or have an accident. Carers are being supported by the use of telecare that can alert them directly in the event of a problem	Promote Carers assessments and develop additional services for Carers through the Carer's Strategy. Develop a range of options for people to access short breaks.	Older people are supported to live at home as independently as they are able, and Carers are supported to continue their caring role. Continue to use telecare to reduce the size of the home care package where possible and delay admission to residential care. Reduction in number and size of social care support packages, and an increase in the number of people supported to live independently.	Carers Commissioning Group Older People's Strategic Commissioning Group

No.	Action	Current Situation & Date	Target (Output) and Timescale	How we will know if we have been successful (Outcome)	Responsibility
6.2.5	Expand and sustain the use of preventative technologies (including Telehealth and Telecare) to support older people to live independently at home, who are experiencing: ➢ Dementia ➢ Falls ➢ Long term conditions **Short term target of 1- 3 Years for completion**	We are supplying over 100 items of Telecare equipment per month.	Increase in the numbers of users of Assistive Technology including providing telecare to support carers, with a target of an additional 2000 users of Telecare by the end of March 2010.	People are supported to live at home where appropriate through the use of preventative technology.	Derbyshire Telecare Strategy Group Long Term Conditions Group
6.2.6	Build on existing guidelines/protocols for depression; and develop/implement these consistently across the County. **Medium term target of 3 – 7 years for completion**	Guidelines for the treatment of depression exist in Primary Care.	Increase the number of older adults who are offered services, in particular psychological therapies. Re-establish guidelines for depression and implement consistently across the County.	Older Peoples' Mental Health is improved, and Older People have improved access to bereavement support services.	Older Peoples Mental Health Commissioning Group Primary Care Strategic Commissioning Group
6.2.7	Commission specialist Domiciliary Care Services for people across the county, appropriate to different levels of dementia and other complex needs. **Short term target of 1- 3 Years for completion**	Currently there are limited specialist services for people with dementia and complex needs.	Develop home care services across the County with a specialist role to support people with complex needs such as end of life and dementia.	Older people with different levels of dementia are able to access appropriate support and care services. In turn more Older People will be able to stay at home and enjoy a good quality of life.	Dementia Commissioning Group

No.	Action	Current Situation & Date	Target (Output) and Timescale	How we will know if we have been successful (Outcome)	Responsibility
6.2.8	Increase the provision of 'housing with care' and associated services, for people with high levels of need (including people with dementia and complex needs). **Short term target of 1- 3 Years for completion**	Extra Care facilities are now open in Wirskwoth, Glossop and Dronfield Supporting People funding has enabled the provision of a Housing Options and Advice Project to be rolled out by Age Concern Derby & Derbyshire.	In accordance with the strategy there are plans to develop Extra Care schemes across the county. Create new Residential and Community Care Centres including those in Staveley by Summer 2010, and Swadlincote by Spring 2012. To re-commission Supporting People funded sheltered housing and community alarm services in 2010/11. To ensure equitable access to equipment and adaptations.	Increase the availability and range of housing options to better support older people with their daily living needs. The aim of the Extra Care and RCCC services will be to maintain people's independence for as long as practicable, along with sheltered housing these services offer real alternatives to long term residential/nursing care. Equipment and adaptations not only support people to remain at home as their care and support needs increase, they also support those providing home care to do this safely (assisting moving and handling).	Partnership Group for Accommodation and Support

6.3 Promote Choice and Control – People are able to exercise maximum control over their own lives

No.	Action	Current Situation & Date	Target (Output) and Timescale	How we will know if we have been successful (Outcome)	Responsibility
6.3.1	Ensure equitable services are available which support basic health care needs: e.g. Foot care, Dental, Orthoptic, Auditory, Continence. **Medium term target of 3 – 7 years for completion**	Equipment services are available / Increased investment in NHS dentists / Provision of foot care for people with identified health needs / Foot care awareness training available to aid self care / Continence procedure agreed to provide continence materials	Identify relevant lead groups to map services and produce actions. Implement the relevant aspects of the prevention package launched by the Department of Health in 2009.	People with specified health care needs receive appropriate service provision regardless of where they live.	Primary Care Strategic Commissioning Group
6.3.2	Increase the number of Social Care Service Users who are aged over 65 and receiving self-directed support Support health related self care programmes. **NI130: Social Care clients receiving self directed support. Short term target of 1-3 Years for completion**	399 Older People received a Direct Payment in 2008/09	Increase the use of direct payments for older people to 524. Assess the suitability of using Social Enterprises to facilitate self directed support via the commissioning of a strategic partner (Age Concern Derby & Derbyshire) to explore suitable models, by March 2011.	More older people are able to use their community care budget in a flexible way.	Personalising Social Care in Derbyshire Programme Board

6.4 Improve Inclusion and Contribution – People are able to participate as active and equal citizens

No.	Action	Current Situation & Date	Target (Output) and Timescale	How we will know if we have been successful (Outcome)	Responsibility
6.4.1	Improve networks and low level services to reduce social isolation and provide support to older people. NI138 Satisfaction of people over 65 with both home and neighbourhood PSA 17 **Medium term target of 3 – 7 years for completion**	The Derbyshire Handy Van Network is now operational across the County. Dronfield 50+ Forum has been launched, and there has been a 7% increase county wide in attendance at all the 50+ Forums Universal swim offer implemented and sustained across the County for over 60's.	Primary prevention initiatives 50+ Forum groups to develop intergenerational work such as Digital Inclusion Projects. Explore the feasibility of commissioning a community befriending service.	Vulnerable older people have better access to practical independent living support, leisure and learning activities and opportunities.	Health & Wellbeing Partnership
6.4.2	Ensure local people and communities are able to influence service developments and priorities. **Short term target of 1 – 3 years for completion**	Older people are represented on appropriate decision making groups e.g. Older Peoples Strategic Commissioning Group.	Work with Third Sector organisations to increase the participation in, and consultation on older people's work streams.	Services better meet the needs of Service Users.	Health & Wellbeing Partnership
6.4.3	Support the Third Sector to deliver services to Older People and Carers NI7: Environment for a thriving Third Sector **Short term target of 1 – 3 years for completion**	Adult Care and the PCT are reviewing Lead Agency arrangements and putting proposals forward regarding the potential streamlining of multiple contracts with the same organisation.	Review voluntary sector Service Level Agreements and contracts for Older People's Services by March 2010, tendering where required. Involve Derbyshire LINk and 3D in the implementation of	Services provided by the Third Sector are reviewed and updated in accordance with local needs data.	Contracting and Commissioning Teams

			this Strategy.		

6.5 Enhance Dignity and Safety – Retain maximum dignity and respect

No.	Action	Current Situation & Date	Target (Output) and Timescale	How we will know if we have been successful (Outcome)	Responsibility
6.5.1	Better emergency and planned care for people with ongoing and urgent personal care needs. **Short term 1 – 3 year target**	Admission avoidance exists via Intermediate Care and community services. End of Life Strategy agreed, including a specification to ensure services exist to enable people to die in their appropriate place of choice.	To develop a more responsive 24 hour service to support people to remain in their own home where possible, and to ensure access to appropriate assessments and interventions to support and promote independence.	A reduction in avoidable emergency admissions to care homes and hospitals, and better out of hour's response provision.	Urgent Care Board
6.5.2	Improve end of life care especially for people in care homes, and ensure services (including bereavement) are available and equitable. **NI129: End of life access to palliative care enabling people to choose to die at home.** **Medium term 3 – 7 year target**	A Gold Standard Framework is being rolled out across Community Hospitals & Care Homes, to be completed by April 2011.	Extend and improve the general palliative care service, ensuring consistency across Derbyshire Early identification of EOL and rollout of Advanced Care Planning. Commission EOL specialist training for health and social care staff. Develop the use of telecare	To ensure people at the end of their life have effective, high quality services and are given more choice in decisions about care and their appropriate preferred place of death.	End of Life Programme Board

No.	Action	Current Situation & Date	Target (Output) and Timescale	How we will know if we have been successful (Outcome)	Responsibility
			specifically to support end of life and provide help for carers.		
6.5.3	Support community safety initiatives in relation to older people. **Medium term 3 – 7 year target** Adult Care target: AG5102 Reduce the abuse and neglect of adults including those people who experience domestic abuse	Liberation Days and similar events are held annually Intergenerational practice aimed at tackling the fear of crime and improving community cohesion. Support of the Derbyshire Doorstep Crime Network Telecare is being used to reduce the risk of bogus callers taking advantage of vulnerable older people	Develop mechanism for Adult Care and PCT staff to contribute to community safety outcomes To promote the more widespread use of telecare to reduce bogus callers, provide alarms for people at risk of burglary and support people at risk of domestic abuse.	To reduce crime and the fear of crime amongst older people.	
6.5.4	Implement the Dignity Agenda **Short term target of 1 – 3 years**	My Home Life project has commenced.	Promote dignity in care principles and dignity champions.	Older people are treated with dignity and respect	
6.5.5	Safeguarding vulnerable people who use services delivered by and for Derbyshire County PCT and Adult Care **Short term target of 1 – 3**	The Trusted Trader Scheme has been launched. County wide network of Handy Vans services.	Promote zero tolerance of abuse and neglect and public reporting through a publicity campaign based on the revised public information leaflets and posters	Older People are protected from abuse, neglect and self-harm	

No.	Action	Current Situation & Date	Target (Output) and Timescale	How we will know if we have been successful (Outcome)	Responsibility
	years Adult Care target: AG5101 Work across agencies to ensure robust safeguarding policies and structures are in place and that staff are trained accordingly	The Safeguarding Policy and Procedures now include police procedures for addressing safeguarding vulnerable adults, also an alert and referral is made where there is unauthorised deprivation of liberty. Adult Care have developed the Independent Mental Capacity Advocacy service	Review the implementation of actions required from the partnership self assessments and the action plan derived from the Care Quality Commission "Safeguarding adults: A study of the effectiveness of arrangements to safeguard adults from abuse" November 2008		
6.5.6	To contract good quality care. **Short term target of 1 – 3 years**	Adult Care and PCT are improving service quality in registered services	Improve standards in 0 and 1 star care homes as measured by Care Quality Commission ratings, by offering expertise from health and social care via a programme of joint visits to be completed by March 2010.	Service Users can expect that quality is monitored on all commissioned services	

6.6 Organisational Outcomes – Leadership, planning, commissioning and value for money

	Action	Current Situation & Date	Target (Output) and Timescale	How we will know if we have been successful (Outcome)	Responsibility
6.6.1	People receive the health and / or social care service they need at the right time, in the right place. **Medium term target of 3 – 7 years** NI131/NI134: Ensure hospital discharges are not delayed or made to inappropriate settings, and do not lead to acute readmissions.	Single Assessment Process Pathway development ensuring a seamless transfer of care	Choosing Health Project Develop roles within services to facilitate and support people through the pathway, for example dementia and stroke. Individualise services. Develop early supported discharge services	Peoples' transition through pathways is seamless. People can expect to receive the right care, in the right place, at the right time. A reduction in the NI131 reporting of the delayed transfers of care.	Pathway Implementation Groups Single Assessment Process Steering Group
6.6.2	Hold regular meetings of the Older People's Joint Strategic Commissioning Group and the Dementia Joint Commissioning Group, to oversee the implementation of this Strategy **Short term 1 – 3 year target**	A joint commissioning work programme for 2009/10 has been agreed between Adult Social Services and Derbyshire County PCT	Agree a dementia joint commissioning strategy	Implementation of action plans relating to older peoples service provision.	Commissioning Groups
6.6.3	Ensure a skilled workforce exists to support the needs of the community **Short term 1 – 3 year target**	Contribution to and analysis of the National Minimum dataset for Social Care	Clarify the competencies required for health and social care staff to deliver effective and safe pathways of care at all levels (from awareness to skilled	Staff are skilled to provide the levels of support required.	Workforce development / HR Teams

	Action	Current Situation & Date	Target (Output) and Timescale	How we will know if we have been successful (Outcome)	Responsibility
			practitioner). Deliver training for specialist areas of work such as dementia and stroke.		
6.6.4	A Joint Strategic Needs Assessment to be completed and updated paying specific reference to the needs of Older People. **Short term 1 – 3 year target**		Social care and PCT colleagues work jointly to deliver the best possible primary care data at the (sub) district level which will further inform commissioning	Services are commissioned in accordance with evidenced need.	Head of Needs Intelligence, Adult Social Care
6.6.5	Ensure equality has a central role in this strategy including though the implementation of all the work streams		Complete an Equality Impact Assessment on this Strategy and on any changes in future services, or newly commissioned services.		

7. APPENDICES

Appendix 1

Members of the Joint Older People's Strategic Commissioning Group

The group comprises:

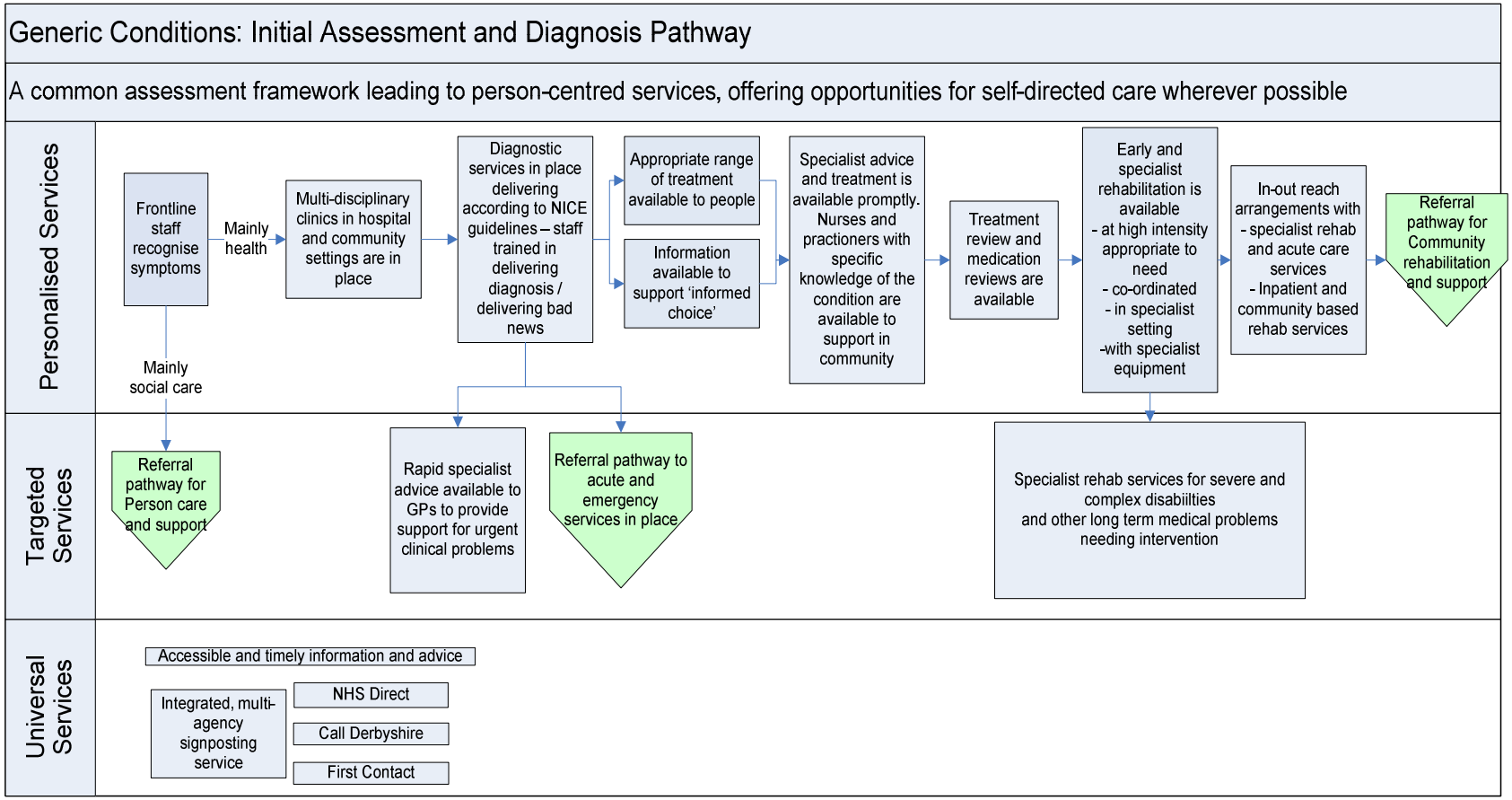
Role	***Organisation***	***Designator member***
Senior Manager with responsibility for commissioning – ***(shared chair)***	Derbyshire County PCT	Andy Layzell
	Derbyshire County Council Adult Care	James Matthews
Commissioners	Derbyshire County PCT	Jane Yeomans Sylvia Wilson
	Derbyshire County Council Adult Care	Julie Vollor Alice Sanghera
Public Health	Derbyshire County PCT	Alison Pritchard
Finance	Derbyshire County PCT	Phillip Barrett
Acute hospital trust commissioner / senior manager	Chesterfield and North Derbyshire Foundation Trust	Nicola Lawrence
	Derby Hospitals Foundation Trust	Kay Fawcett
Practice Based Commissioner	North / South	To be confirmed
Provider representative ????	Derbyshire County PCT	Tim Broadley / David Muir
	Derbyshire County Council	Kieran Hickey
	Independent sector Private / voluntary	To be confirmed
Head of Well-being	Derbyshire County Council	Jem Brown
User representatives	Derbyshire Older Person's Advisory Group	Christine Price
	Older Persons Congress	Ann Button
Carer representative	Derbyshire Carer Association	To be confirmed
	Derbyshire County PCT Head of Commissioning for Carers	Hilary Spencer
District Council representative	Through linked groups	To be confirmed

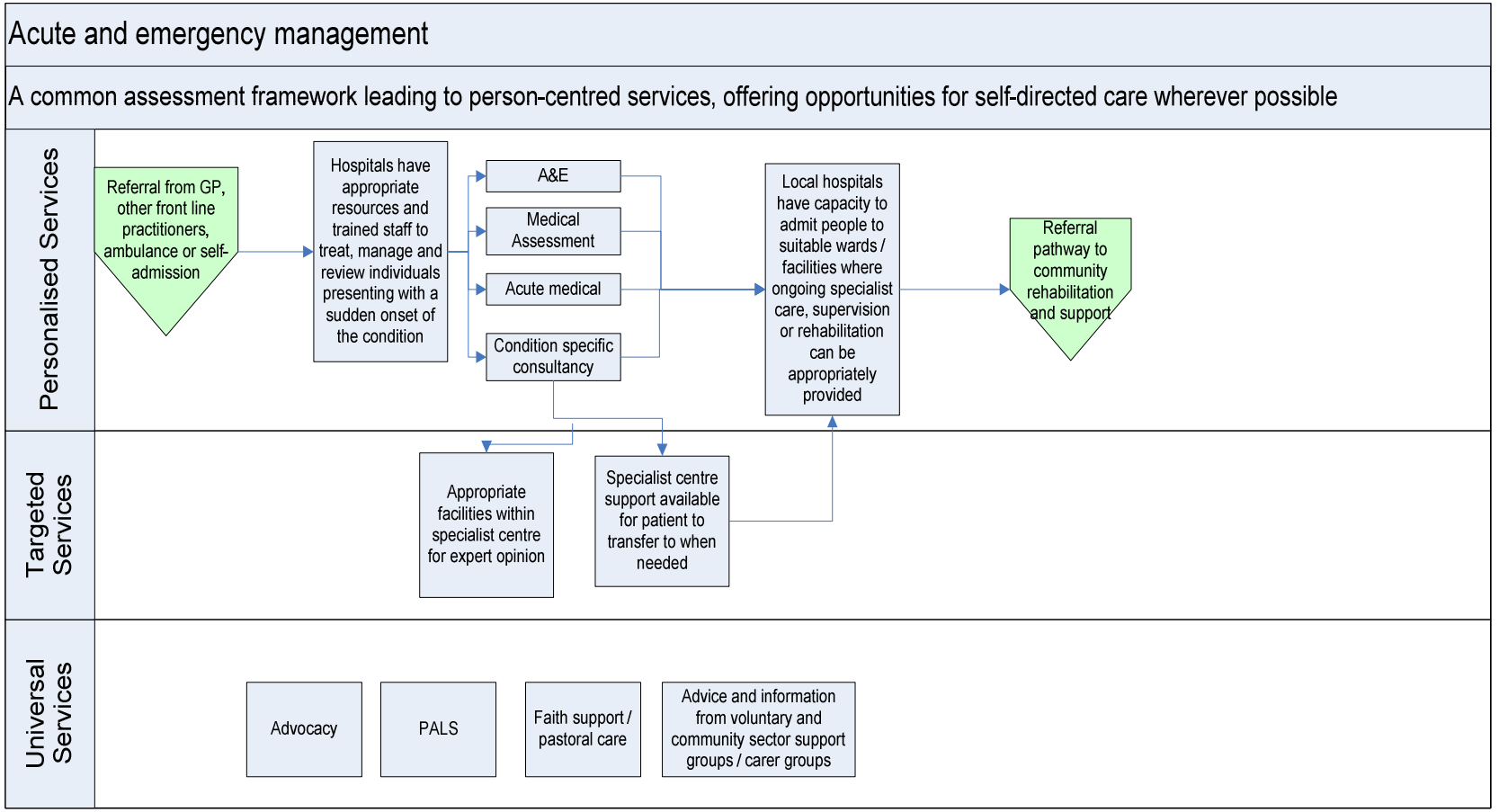
Other members are co-opted to the group as appropriate for specific areas of interest or tasks.

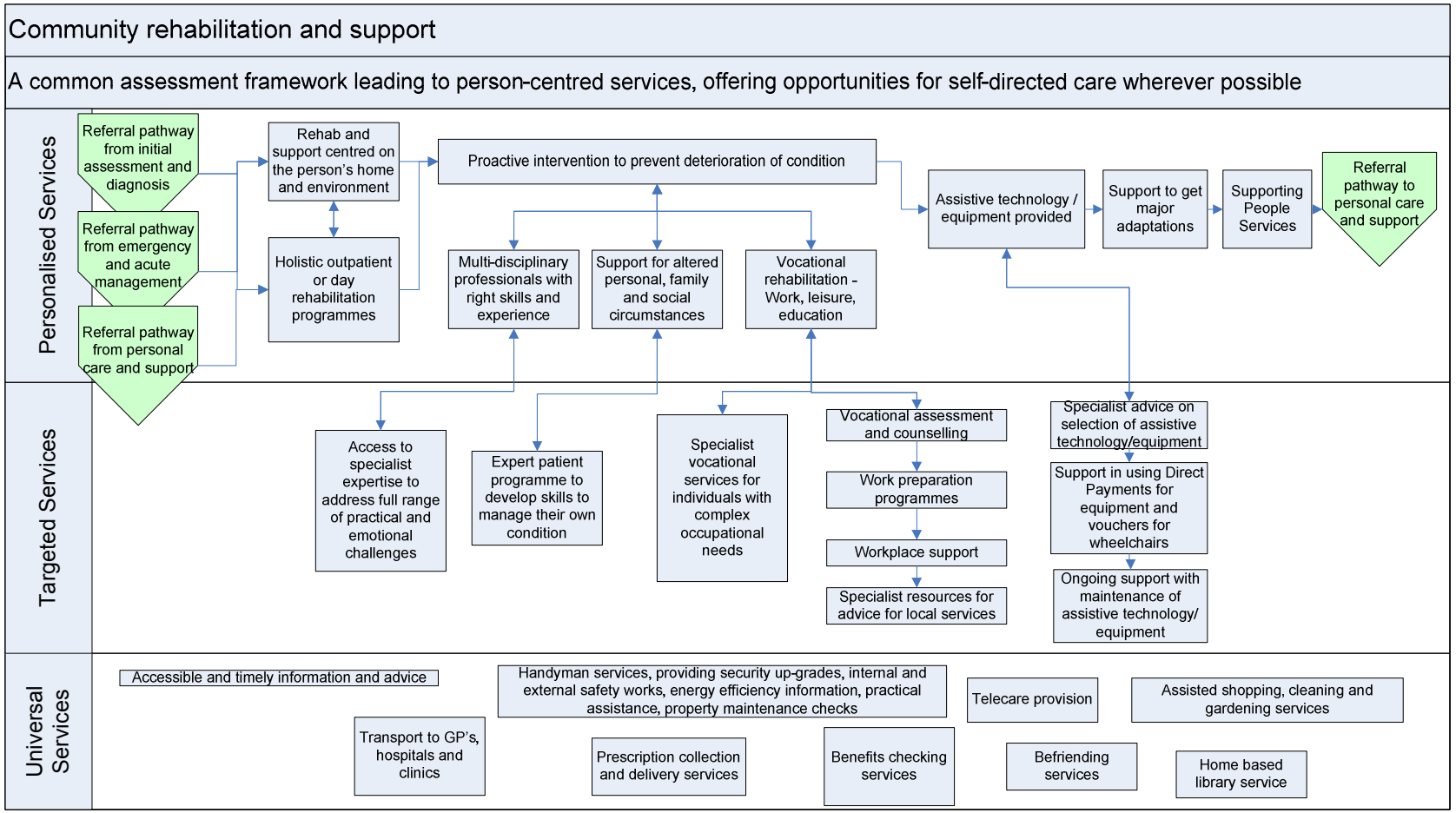
Members are empowered by their organisation to:

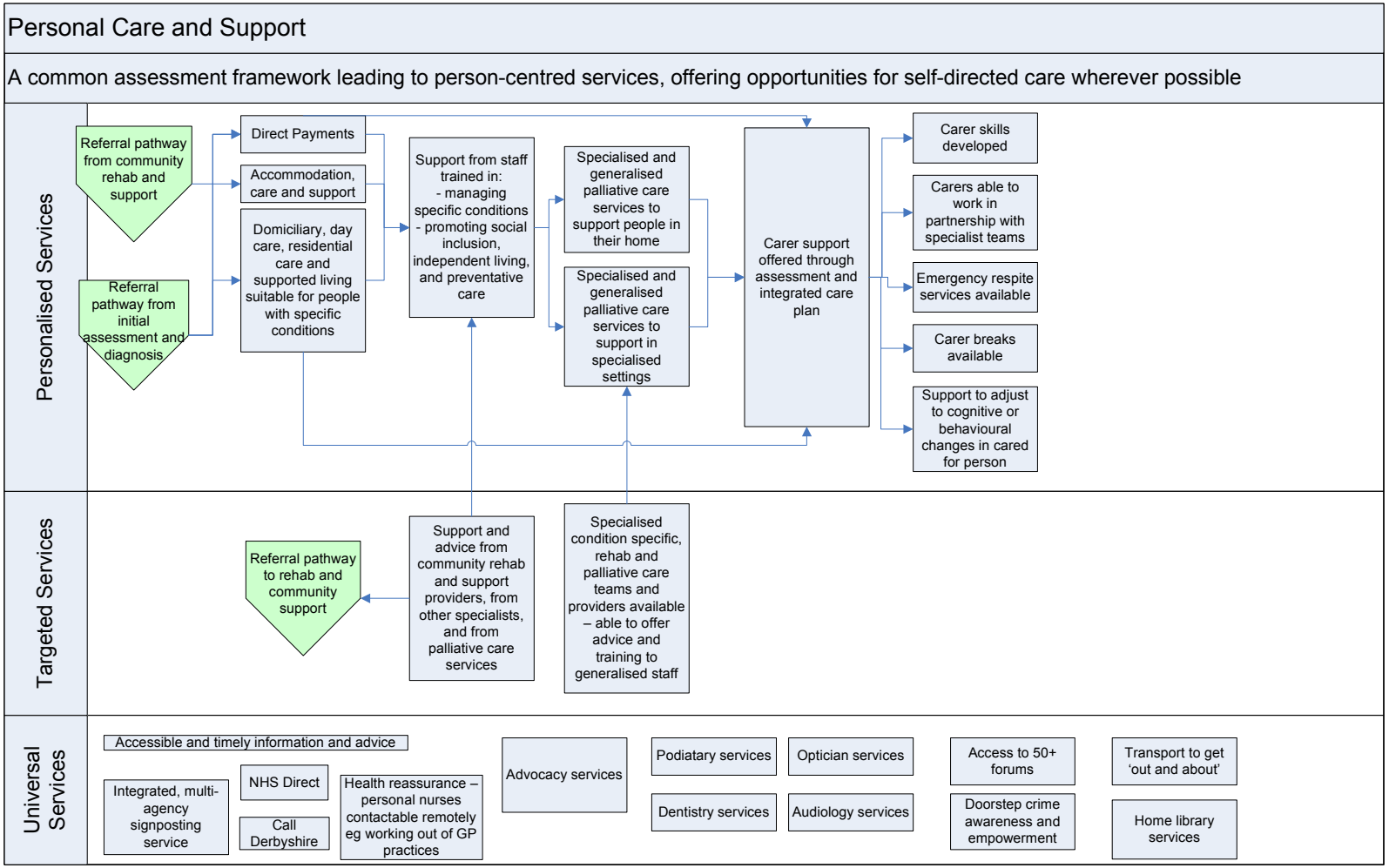
- represent organisational views
- clarify and confirm agency priorities within the multi-agency decision making process
- feedback key issues to members within their own organisation.

Appendix 2: Quality Care Pathway




Acute and emergency management
A common assessment framework leading to person-centred services, offering opportunities for self-directed care wherever possible
Personalised Services
Referral from GP, other front line practitioners, ambulance or self-admission
Hospitals have appropriate resources and trained staff to treat, manage and review individuals presenting with a sudden onset of the condition
A&E
Medical Assessment
Acute medical
Condition specific consultancy
Local hospitals have capacity to admit people to suitable wards / facilities where ongoing specialist care, supervision or rehabilitation can be appropriately provided
Referral pathway to community rehabilitation and support
Targeted Services
Appropriate facilities within specialist centre for expert opinion
Specialist centre support available for patient to transfer to when needed
Universal Services
Advocacy
PALS
Faith support / pastoral care
Advice and information from voluntary and community sector support groups / carer groups


Community rehabilitation and support
A common assessment framework leading to person-centred services, offering opportunities for self-directed care wherever possible
Personalised Services
Referral pathway from initial assessment and diagnosis
Referral pathway from emergency and acute management
Referral pathway from personal care and support
Rehab and support centred on the person's home and environment
Holistic outpatient or day rehabilitation programmes
Proactive intervention to prevent deterioration of condition
Multi-disciplinary professionals with right skills and experience
Support for altered personal, family and social circumstances
Vocational rehabilitation - Work, leisure, education
Assistive technology / equipment provided
Support to get major adaptations
Supporting People Services
Referral pathway to personal care and support
Targeted Services
Access to specialist expertise to address full range of practical and emotional challenges
Expert patient programme to develop skills to manage their own condition
Specialist vocational services for individuals with complex occupational needs
Vocational assessment and counselling
Work preparation programmes
Workplace support
Specialist resources for advice for local services
Specialist advice on selection of assistive technology/equipment
Support in using Direct Payments for equipment and vouchers for wheelchairs
Ongoing support with maintenance of assistive technology/ equipment
Universal Services
Accessible and timely information and advice
Handyman services, providing security up-grades, internal and external safety works, energy efficiency information, practical assistance, property maintenance checks
Telecare provision
Assisted shopping, cleaning and gardening services
Transport to GP's, hospitals and clinics
Prescription collection and delivery services
Benefits checking services
Befriending services
Home based library service


Personal Care and Support
A common assessment framework leading to person-centred services, offering opportunities for self-directed care wherever possible
Personalised Services
Referral pathway from community rehab and support
Referral pathway from initial assessment and diagnosis
Direct Payments
Accommodation, care and support
Domiciliary, day care, residential care and supported living suitable for people with specific conditions
Support from staff trained in: - managing specific conditions - promoting social inclusion, independent living, and preventative care
Specialised and generalised palliative care services to support people in their home
Specialised and generalised palliative care services to support in specialised settings
Carer support offered through assessment and integrated care plan
Carer skills developed
Carers able to work in partnership with specialist teams
Emergency respite services available
Carer breaks available
Support to adjust to cognitive or behavioural changes in cared for person
Targeted Services
Referral pathway to rehab and community support
Support and advice from community rehab and support providers, from other specialists, and from palliative care services
Specialised condition specific, rehab and palliative care teams and providers available – able to offer advice and training to generalised staff
Universal Services
Accessible and timely information and advice
Integrated, multi-agency signposting service
NHS Direct
Call Derbyshire
Health reassurance – personal nurses contactable remotely eg working out of GP practices
Advocacy services
Podiatary services
Optician services
Dentistry services
Audiology services
Access to 50+ forums
Doorstep crime awareness and empowerment
Transport to get 'out and about'
Home library services

Appendix 3: Population Profile, social care and health needs evidence and projection analysis

1. Population data by age, gender and ethnicity

Mid-2006 estimates of resident population: (Source: Office for National Statistics)

Table 1- Males

	All ages	65-69	70-74	75-79	80-84	85-89	90+	Total 65+ yrs	% 65+ yrs	Total 85+ yrs	% 85+ yrs
ENGLAND	24,926,400	1,074,900	905,900	713,800	476,100	233,200	90,500	3,494,400	14%	323,700	1.3%
EAST MIDLANDS	2,157,300	97,500	80,400	63,700	42,900	20,500	7,300	312,300	14%	27,800	1.3%
Derbyshire County	371,600	18,000	14,500	11,400	7,700	3,700	1,300	56,600	15%	5,000	1.3%
Amber Valley	59,000	2,900	2,300	1,800	1,200	600	200	9,000	15%	800	1.4%
Bolsover	36,300	1,800	1,500	1,100	800	300	100	5,600	15%	400	1.1%
Chesterfield	49,200	2,300	1,900	1,600	1,200	500	100	7,600	15%	600	1.2%
Derbyshire Dales	34,600	1,900	1,600	1,200	900	400	200	6,200	18%	600	1.7%
Erewash	54,000	2,500	2,100	1,600	1,000	500	200	7,900	15%	700	1.3%
High Peak	45,600	2,100	1,600	1,300	800	500	200	6,500	14%	700	1.5%
North East Derbyshire	48,100	2,700	2,100	1,700	1,100	500	200	8,300	17%	700	1.5%
South Derbyshire	44,900	1,900	1,500	1,200	700	300	100	5,700	13%	400	0.9%

Table 2- Females

	All ages	65-69	70-74	75-79	80-84	85-89	90+	Total 65+ yrs	% 65+ yrs	Total 85+ yrs	% 85+ yrs
ENGLAND	25,836,600	1,155,800	1,034,700	923,700	746,000	461,400	269,800	4,591,400	18%	731,200	2.8%
EAST MIDLANDS	2,206,900	101,500	89,700	80,000	63,900	38,900	21,800	395,800	18%	60,700	2.8%
Derbyshire County	382,500	18,400	16,400	14,400	11,800	7,500	4,000	72,500	19%	11,500	3.0%
Amber Valley	61,100	2,900	2,500	2,200	1,900	1,300	700	11,500	19%	2,000	3.3%
Bolsover	37,600	1,700	1,700	1,400	1,200	700	400	7,100	19%	1,100	2.9%
Chesterfield	51,300	2,500	2,200	2,100	1,800	1,100	500	10,200	20%	1,600	3.1%
Derbyshire Dales	35,200	2,000	1,800	1,500	1,300	800	500	7,900	22%	1,300	3.7%
Erewash	56,500	2,600	2,300	2,000	1,700	1,000	600	10,200	18%	1,600	2.8%
High Peak	46,400	2,100	1,800	1,600	1,200	900	500	8,100	17%	1,400	3.0%
North East Derbyshire	49,600	2,800	2,400	2,100	1,600	1,000	500	10,400	21%	1,500	3.0%
South Derbyshire	44,900	1,900	1,600	1,400	1,100	700	300	7,000	16%	1,000	2.2%

Table 3 - Persons

	All ages	65-69	70-74	75-79	80-84	85-89	90+	Total 65+ yrs	% 65+ yrs	Total 85+ yrs	% 85+ yrs
ENGLAND	50,762,900	2,230,600	1,940,600	1,637,600	1,222,000	694,500	360,400	8,085,700	16%	1,054,900	2.1%
EAST MIDLANDS	4,364,200	199,000	170,100	143,700	106,800	59,400	29,100	708,100	16%	88,500	2.0%
Derbyshire County	754,100	36,300	30,900	25,800	19,500	11,100	5,400	129,000	17%	16,500	2.2%
Amber Valley	120,000	5,700	4,800	4,000	3,100	1,800	900	20,300	17%	2,700	2.3%
Bolsover	73,900	3,500	3,200	2,600	1,900	1,100	500	12,800	17%	1,600	2.2%
Chesterfield	100,500	4,800	4,100	3,700	2,900	1,600	700	17,800	18%	2,300	2.3%
Derbyshire Dales	69,800	3,900	3,400	2,700	2,200	1,200	700	14,100	20%	1,900	2.7%
Erewash	110,400	5,000	4,400	3,600	2,700	1,500	800	18,000	16%	2,300	2.1%
High Peak	92,000	4,200	3,400	2,900	2,100	1,400	700	14,700	16%	2,100	2.3%
North East Derbyshire	97,700	5,400	4,500	3,800	2,700	1,500	600	18,500	19%	2,100	2.1%
South Derbyshire	89,800	3,800	3,100	2,600	1,800	1,000	500	12,800	14%	1,500	1.7%

Table 4 - Ethnic Group 2001 – 65+ years (Source: Census 2001)

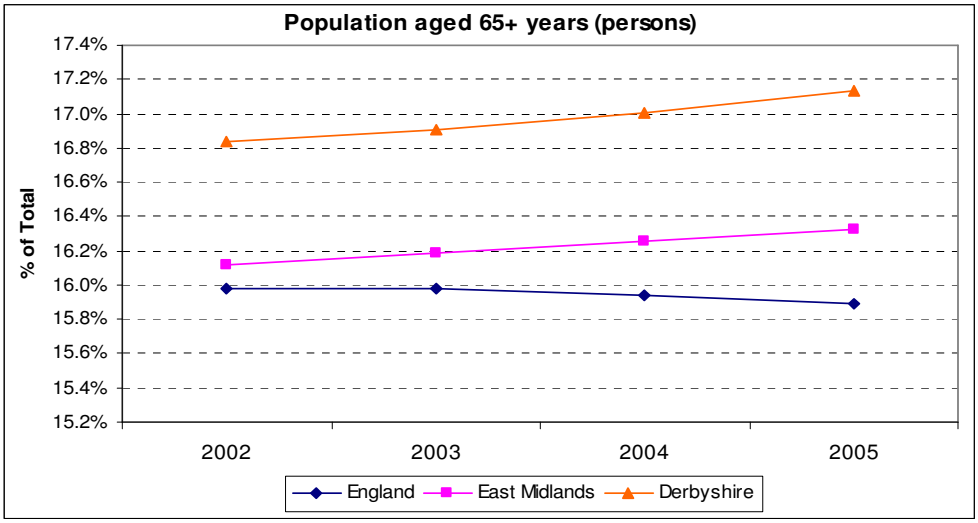
	White (includes British, Irish & Other White)		Mixed (White & Black Caribbean; White & Black African; White & Asian; Other Mixed)		Asian/Asian British (includes Indian; Pakistani; Bangladeshi; Other Asian or Asian British)		Black/Black British (includes Black Caribbean; Black African; Other Black or Black British)		Chinese or Other Ethnic Group	
ENGLAND	7,579,841	97.1%	18,556	0.2%	118,816	1.5%	73,256	0.9%	17,531	0.2%
Derbyshire County	122,412	99.6%	112	0.1%	205	0.2%	160	0.1%	65	0.1%
Amber Valley	19,425	99.7%	10	0.0%	28	0.1%	5	0.0%	10	0.1%
Bolsover	12,421	99.9%	5	0.0%	10	0.1%	5	0.0%	0	0.0%
Chesterfield	17,350	99.3%	35	0.2%	25	0.1%	45	0.3%	20	0.1%
Derbyshire Dales	13,121	99.9%	10	0.1%	5	0.0%	0	0.0%	5	0.0%
Erewash	17,311	99.4%	15	0.1%	40	0.2%	45	0.3%	15	0.1%
High Peak	13,742	99.4%	15	0.1%	20	0.1%	40	0.3%	10	0.1%
North East Derbyshire	17,262	99.7%	25	0.1%	20	0.1%	5	0.0%	5	0.0%
South Derbyshire	11,779	99.3%	5	0.0%	60	0.5%	10	0.1%	5	0.1%

Note: Numbers may not sum as small numbers rounded to nearest 5

Population Trends

Figure 1 shows the proportion of the resident population in Derbyshire aged over 65 years has slowly been increasing.

Figure 1



Population projections (Source: OFFICE FOR NATIONAL STATISTICS, 2004 based)

65+ years
In comparison to England, the County of Derbyshire has a higher proportion of people aged over 65 years (24.2% vs. 20.5%).

Within the County, Derbyshire Dales and North East Derbyshire are predicted to have the highest proportion of people aged 65+ years by 2025 at 30% and 28% respectively, representing an increase of around 50% from 2008.
Although overall proportions are lower, South Derbyshire and High Peak are expected to show the biggest growth in the over 65 population, rising by 65% and 51% respectively from 2008 to 2025. Erewash has a lower proportion and a lower predicted growth.

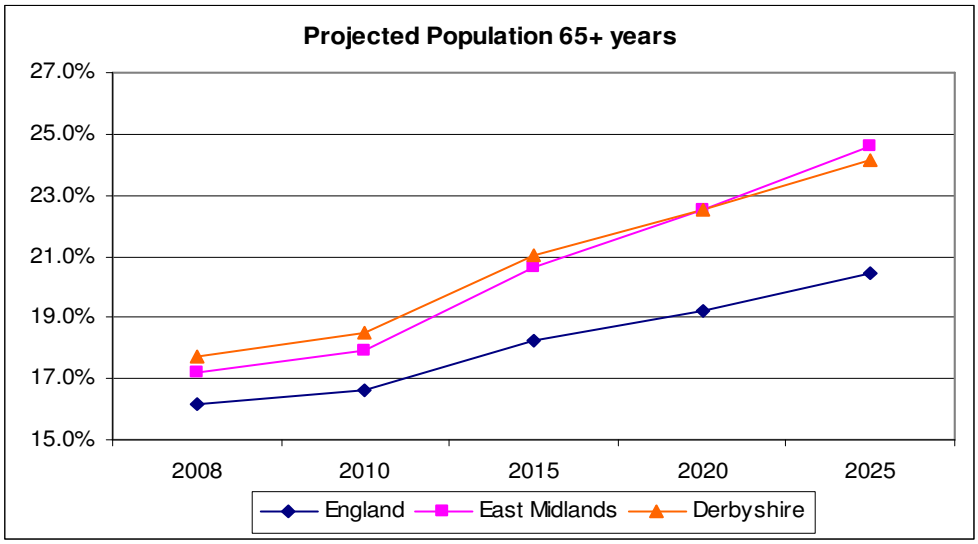
Table 5 - Numbers over 65 yrs (persons)

	2008	2010	2015	2020	2025	% Increase (2008 to 2025)
England	8,287,900	8,585,000	9,673,900	10,452,500	11,370,400	37%
East Midlands	736,000	773,400	893,800	981,600	1,078,000	46%
Derbyshire County	134,400	141,700	164,500	180,100	197,000	47%
Amber Valley	21,200	22,400	26,300	28,800	31,400	48%
Bolsover	13,200	14,000	15,900	17,300	19,200	45%
Chesterfield	18,100	18,700	21,300	22,900	24,900	38%
Derbyshire Dales	14,900	15,600	18,300	20,000	21,700	46%
Erewash	18,800	19,800	22,500	24,100	26,000	38%
High Peak	15,300	16,200	18,800	20,800	23,100	51%
North East Derbyshire	19,500	20,700	23,900	25,900	28,100	44%
South Derbyshire	13,600	14,500	17,600	20,000	22,400	65%

Table 6 - Percentage over 65 yrs (persons)

	2008	2010	2015	2020	2025
England	16.2%	16.6%	18.3%	19.2%	20.5%
East Midlands	17.2%	17.9%	20.6%	22.5%	24.6%
Derbyshire County	17.7%	18.5%	21.0%	22.5%	24.2%
Amber Valley	17.6%	18.4%	21.1%	22.5%	24.0%
Bolsover	17.6%	18.4%	20.3%	21.5%	23.3%
Chesterfield	18.0%	18.6%	20.9%	22.2%	23.8%
Derbyshire Dales	21.2%	22.2%	25.8%	27.8%	29.7%
Erewash	17.0%	17.8%	20.0%	21.1%	22.4%
High Peak	16.6%	17.4%	19.8%	21.4%	23.3%
North East Derbyshire	20.0%	21.2%	24.2%	26.0%	27.9%
South Derbyshire	14.8%	15.4%	17.7%	19.1%	20.6%

Figure 2



65+ yrs by gender

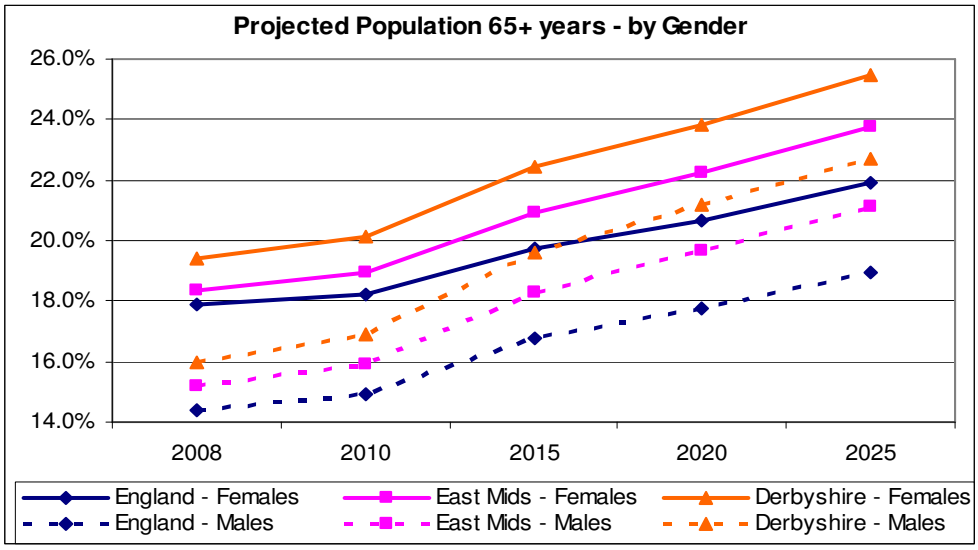
The proportion of the female population in Derbyshire aged 65+ yrs is projected to increase to around a quarter by 2025, with numbers increasing by 41% from 75,000 to 105,000. Derbyshire Dales and North East Derbyshire have the highest proportion of females aged 65+ yrs, but Amber Valley and South Derbyshire see the most growth in numbers.

Overall, the proportion of the male population aged over 65 yrs is lower compared to females at around a fifth, but the expected increase in numbers is bigger. Over a quarter of men in North East Derbyshire and Derbyshire Dales will be aged 65+ yrs by 2025 compared to 23% in Derbyshire and 19% in England. South Derbyshire has the lowest proportion at 20%, but this represents an increase in numbers of around 4,500.

Table 7 – Number and Percentage by Gender (65+ yrs)

	Females				% Increase	Males				% Increase
	2008		2025			2008		2025		
	Number	%	Number	%		Number	%	Number	%	
England	4,653,400	18%	6,150,700	22%	32%	3,634,500	14%	5,219,800	19%	44%
East Midlands	407,400	18%	576,900	24%	42%	328,400	15%	501,200	21%	53%
Derbyshire	74,900	19%	105,400	25%	41%	59,700	16%	91,300	23%	53%
Amber Valley	11,800	19%	17,200	26%	46%	9,400	16%	14,300	22%	52%
Bolsover	7,300	19%	10,100	24%	38%	5,800	16%	9,100	22%	57%
Chesterfield	10,400	20%	13,600	25%	31%	7,800	16%	11,200	22%	44%
Derbys. Dales	8,300	23%	11,600	32%	40%	6,500	19%	10,000	28%	54%
Erewash	10,600	19%	14,100	24%	33%	8,200	15%	11,900	21%	45%
High Peak	8,600	18%	12,300	25%	43%	6,900	15%	11,000	22%	59%
NE Derbyshire	10,700	22%	15,000	29%	40%	8,800	18%	13,100	26%	49%
South Derbys.	7,400	16%	11,500	21%	55%	6,300	14%	10,800	20%	71%

Figure 3



85+ years

The proportion of people aged over 85 years in Derbyshire is much closer to the regional and national picture, albeit slightly higher. Overall numbers are projected to have doubled by 2025, with people 85+ yrs accounting for around 4% of the total population.

Within local authorities, estimated numbers for 2025 are between 2,800 in Bolsover and 4,100 in North East Derbyshire. Derbyshire Dales is projected to have the largest proportion aged over 85 years at 4.7% compared to 3.8% in Derbyshire and 3.4% in England. South Derbyshire has the lowest proportion at 3.4%.

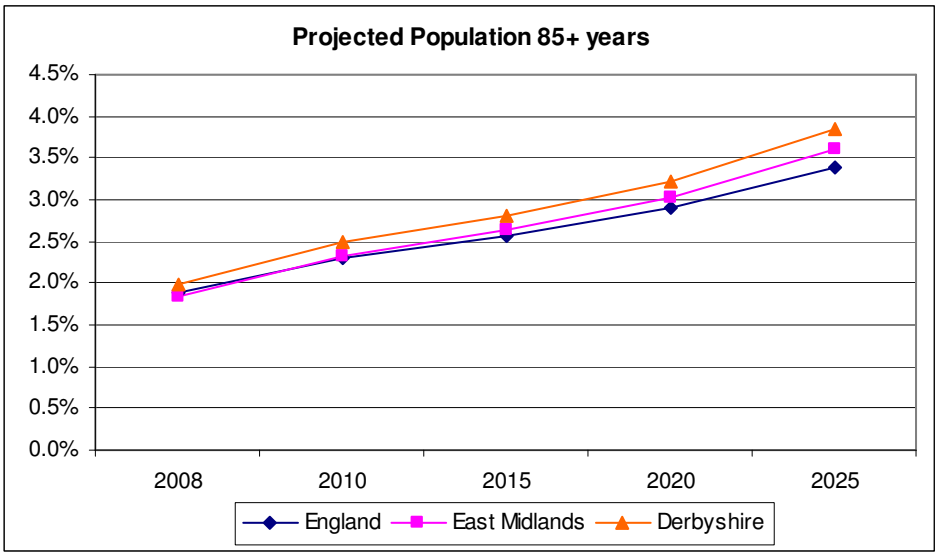
Table 8 - Numbers over 85 yrs (persons)

	2008	2010	2015	2020	2025	% Increase (2008 to 2025)
England	942700	1163100	1299700	1475900	1739200	84%
East Midlands	78300	100400	114400	131900	158500	102%
Derbyshire County	14700	18700	21100	24300	29100	98%
Amber Valley	2400	3100	3400	3900	4600	92%
Bolsover	1400	1800	2000	2300	2800	100%
Chesterfield	2000	2500	2800	3100	3600	80%
Derbyshire Dales	1700	2100	2300	2800	3300	94%
Erewash	2100	2600	2900	3300	4000	90%
High Peak	1800	2300	2600	3000	3600	100%
North East Derbyshire	1900	2500	2900	3300	4100	116%
South Derbyshire	1300	1800	2100	2500	3100	138%

Table 9 - Percentage over 85 yrs (persons)

	2008	2010	2015	2020	2025
England	1.9%	2.3%	2.6%	2.9%	3.4%
East Midlands	1.8%	2.3%	2.6%	3.0%	3.6%
Derbyshire County	2.0%	2.5%	2.8%	3.2%	3.8%
Amber Valley	2.0%	2.6%	2.8%	3.3%	3.8%
Bolsover	1.9%	2.4%	2.7%	3.1%	3.7%
Chesterfield	2.0%	2.5%	2.8%	3.1%	3.6%
Derbyshire Dales	2.4%	3.0%	3.3%	4.0%	4.7%
Erewash	1.9%	2.4%	2.6%	3.0%	3.6%
High Peak	2.0%	2.5%	2.8%	3.3%	3.9%
North East Derbyshire	2.0%	2.6%	3.0%	3.4%	4.2%
South Derbyshire	1.5%	2.0%	2.4%	2.8%	3.4%

Figure 4



85+ years by gender

In 2008, there are half as many men aged over 85 years as there are women and whilst this trend is projected to continue to 2025, the gap closes slightly as male numbers increase.

Around 6% of the female population and 4% of the male population in Derbyshire Dales are projected to be 85+ yrs in 2025, compared to 4% and 3% respectively in Derbyshire.

Table 10 – Number and Percentage by Gender (85+ yrs)

	Females				% Increase	Males				% Increase
	2008		2025			2008		2025		
	Number	%	Number	%		Number	%	Number	%	
England	756,200	2.9%	1,038,100	3.7%	37%	356,500	1.4%	701,000	2.5%	97%
East Midlands	64,100	2.9%	94,400	3.9%	47%	30,900	1.4%	64,100	2.7%	107%
Derbyshire	12,200	3.2%	17,600	4.3%	44%	5,500	1.5%	11,400	2.8%	107%
Amber Valley	2,100	3.4%	2,900	4.3%	38%	800	1.4%	1,700	2.7%	113%
Bolsover	1,200	3.1%	1,700	4.1%	42%	500	1.4%	1,100	2.7%	120%
Chesterfield	1,700	3.3%	2,200	4.1%	29%	700	1.4%	1,400	2.7%	100%
Derbys. Dales	1,400	3.9%	2,100	5.7%	50%	600	1.7%	1,300	3.6%	117%
Erewash	1,700	3.0%	2,400	4.0%	41%	800	1.5%	1,600	2.8%	100%
High Peak	1,500	3.2%	2,100	4.2%	40%	800	1.8%	1,600	3.3%	100%
NE Derbyshire	1,600	3.2%	2,500	4.9%	56%	800	1.7%	1,600	3.2%	100%
South Derbys.	1,100	2.4%	1,800	3.3%	64%	600	1.3%	1,200	2.2%	100%

Projected Old Age Dependency Ratio

The number of people aged 65 or over as a proportion of the number of people of working age (65 yrs/20-64 yrs) can be used to indicate changes in population structure over time. Derbyshire Dales and North East Derbyshire are all predicted to

have a high ratio of people eligible for pension to those of working age whilst Bolsover and South Derbyshire are lower than the County average.

Table 11 – Percentage of 65+ yrs/20-64 yrs

	2008	2010	2015	2020	2025
England	27.0%	27.7%	30.8%	32.8%	35.5%
East Midlands	28.2%	29.4%	33.7%	36.6%	40.1%
Derbyshire County	29.9%	31.4%	36.4%	39.5%	43.4%
Amber Valley	29.7%	31.1%	36.4%	39.5%	43.0%
Bolsover	29.9%	31.4%	35.0%	37.5%	41.6%
Chesterfield	30.4%	31.5%	35.9%	38.4%	42.3%
Derbyshire Dales	37.0%	39.0%	47.2%	52.1%	57.4%
Erewash	28.6%	30.0%	34.0%	36.2%	39.3%
High Peak	27.8%	29.0%	33.6%	36.9%	41.3%
North East Derbyshire	34.2%	36.7%	43.3%	47.3%	52.5%
South Derbyshire	24.4%	25.5%	29.8%	32.5%	35.6%

Appendix 4: Housing, income and social care needs

Housing Tenure
2001 Census data below on tenure by age band reveals over three in four Derbyshire pensioner households aged 65 to 74 years were owner occupied. This proportion, however, somewhat reduces with age to 58% for older people aged 85 or over. Conversely, whilst just 18% of pensioners aged 65 to 74 years lived in council and social housing, this increases to 26% for those aged 85+ with a further 14% in privately rented accommodation.

There is no district level data since 2001 on tenure by age, but the Survey of English Housing 2005/2006 provides national data. This reveals a similar proportion of owner occupiers aged 65 to 74 at 77%, reducing to 69% for those over 75 years.

Interestingly, however, the survey also shows that one in nine 65 to 74 year olds still have a mortgage, as do almost one in twenty of pensioner households aged 75+.

Table 12 (Source: Census 2001)

	Aged 65 - 74				Aged 75 - 84			Aged 85+		
District	**Owner Occupied %**		**Council & Social Housing %**	**Privately Rented %**	**Owner Occupied %**	**Council & Social Housing %**	**Privately Rented %**	**Owner Occupied %**	**Council & Social Housing %**	**Privately Rented %**
Amber Valley	81.4%		13.9%	4.7%	70.3%	20.6%	9.1%	64.6%	21.3%	14.1%
Bolsover	72.0%		23.2%	4.8%	55.4%	35.9%	8.7%	46.8%	41.7%	11.5%
Chesterfield	71.9%		24.2%	3.9%	58.9%	36.0%	5.1%	49.2%	41.9%	8.9%
Derbyshire Dales	78.8%		13.3%	7.9%	68.3%	21.3%	10.4%	60.7%	26.9%	12.4%
Erewash	81.6%		14.7%	3.8%	70.4%	23.6%	6.0%	60.9%	27.9%	11.1%
High Peak	78.0%		15.9%	6.2%	69.2%	21.4%	9.4%	60.2%	25.3%	14.6%
North East Derbyshire	72.9%		24.8%	2.3%	60.0%	35.0%	5.0%	54.9%	38.1%	7.0%
South Derbyshire	80.3%		14.2%	5.6%	67.5%	22.4%	10.1%	59.6%	26.1%	14.4%
Derbyshire	77.1%		18.1%	4.7%	65.0%	27.2%	7.7%	57.7%	30.6%	11.7%

Low income and Inequality

Low income is closely correlated with deprivation and poorer health. Table 13 shows the proportion of people over 60 who are Pension Credit claimants. Bolsover and Chesterfield have high proportions in receipt, with Derbyshire Dales, High Peak and South Derbyshire relatively low proportions. Pension Credit is means tested and replaced its predecessors 'Income Support' and 'Minimum Income Guarantee'. Some 25.1% of Derbyshire claimants are in receipt of the 'savings credit' only: who would not have been eligible to the predecessor benefits. Early in 2008, more comprehensive data will be available regarding people aged over 60 claiming any one of the three major means tested benefits. Previously, 2001 data showed a relatively higher proportion of High Peak older people in receipt of one of these benefits than table13 below indicates.

Table 13a - Pension Credit Claimants (aged 60 plus) and Partners - Aug 2006
(Source: DWP - Department of Work and Pensions)

	Thousands	***Thousands***	***Thousands***	
	Claimants Aged 60+	Partners of Claimants	Total Claimants & partners	PC Claimants & Partners as % of people aged 60+
Amber Valley	5,800	1,370	7,170	25.61
Bolsover	4,050	1,000	5,050	29.02
Chesterfield	5,900	1,390	7,290	30.63
Derbyshire Dales	2,750	570	3,320	17.29
Erewash	5,170	1,200	6,370	25.89
High Peak	3,540	720	4,260	21.30
North East Derbyshire	5,070	1,280	6,350	24.90
South Derbyshire	3,080	690	3,770	21.06
Derbyshire	35,360	8,220	43,580	24.72

Table 13b Proportion of Derbyshire people over 65 awarded Attendance

	AA or DLA Care	
	Total number entitled	**% of population aged 65+**
Derbyshire	33,880	26.5
Amber Valley	5,390	27.0
Bolsover	4,490	35.4
Chesterfield	5,680	32.1
Derbyshire Dales	2,880	20.6
Erewash	4,430	24.5
High Peak	3,200	22.1
NE Derbyshire	4,760	25.9
South Derbyshire	3,040	23.9

Allowance or Disability Living Allowance (Care)

Table 13c Estimate of numbers of residents needing given levels of care
Source: Planning4Care, based on Wanless report

Area name	Wanless level of need	2007	2007 % of population 65+	2010	2015	2020	2025	Growth 2007 - 2025 (Number)	Growth 2007 - 2025 (%)
Derbyshire	Low needs	13,230	10.3	14,150	16,380	18,140	20,270	7,040	53.2
Derbyshire	Moderate needs	14,240	11.0	15,160	17,340	19,280	21,780	7,540	52.9
Derbyshire	High needs	10,500	8.1	11,170	12,780	14,200	16,050	5,550	52.9
Derbyshire	Very high needs, physical	10,790	8.4	11,520	13,270	14,630	16,340	5,550	51.4
Derbyshire	Very high needs, cognitive	3,360	2.6	3,530	3,940	4,490	5,290	1,930	57.4
Amber Valley	Low needs	2,080	10.2	2,240	2,600	2,900	3,220	1,140	54.8
Amber Valley	Moderate needs	2,280	11.2	2,430	2,790	3,140	3,540	1,260	55.3
Amber Valley	High needs	1,680	8.3	1,800	2,060	2,320	2,610	930	55.4
Amber Valley	Very high needs, physical	1,720	8.5	1,850	2,150	2,400	2,670	950	55.2
Amber Valley	Very high needs, cognitive	550	2.7	570	630	720	850	300	54.5
Bolsover	Low needs	1,170	9.1	1,270	1,430	1,600	1,790	620	53.0
Bolsover	Moderate needs	1,890	14.8	2,040	2,280	2,550	2,860	970	51.3
Bolsover	High needs	1,440	11.3	1,550	1,730	1,940	2,170	730	50.7
Bolsover	Very high needs, physical	1,610	12.6	1,740	1,950	2,170	2,410	800	49.7
Bolsover	Very high needs, cognitive	330	2.6	350	380	440	520	190	57.6
Chesterfield	Low needs	1,690	9.5	1,750	1,970	2,110	2,340	650	38.5
Chesterfield	Moderate needs	2,290	12.9	2,380	2,660	2,870	3,230	940	41.0
Chesterfield	High needs	1,720	9.7	1,790	2,000	2,160	2,430	710	41.3
Chesterfield	Very high needs, physical	1,860	10.4	1,930	2,170	2,330	2,600	740	39.8
Chesterfield	Very high needs, cognitive	460	2.6	480	530	580	670	210	45.7
Derbys Dales	Low needs	1,490	10.6	1,600	1,840	2,050	2,290	800	53.7
Derbys Dales	Moderate needs	1,160	8.2	1,250	1,410	1,590	1,810	650	56.0

Area name	Wanless level of need	2007	2007 % of population 65+	2010	2015	2020	2025	Growth 2007 - 2025 (Number)	Growth 2007 - 2025 (%)
Derbys Dales	High needs	830	5.9	890	1,010	1,130	1,290	460	55.4
Derbys Dales	Very high needs, physical	740	5.2	800	920	1,020	1,140	400	54.1
Derbys Dales	Very high needs, cognitive	370	2.6	390	440	510	600	230	62.2
Erewash	Low needs	1,990	11.1	2,120	2,420	2,640	2,890	900	45.2
Erewash	Moderate needs	1,840	10.2	1,950	2,210	2,430	2,700	860	46.7
Erewash	High needs	1,340	7.4	1,410	1,600	1,770	1,960	620	46.3
Erewash	Very high needs, physical	1,330	7.4	1,420	1,610	1,760	1,920	590	44.4
Erewash	Very high needs, cognitive	470	2.6	490	550	620	720	250	53.2
High Peak	Low needs	1,660	11.3	1,750	2,060	2,270	2,590	930	56.0
High Peak	Moderate needs	1,390	9.5	1,450	1,700	1,870	2,150	760	54.7
High Peak	High needs	1,000	6.8	1,040	1,220	1,340	1,540	540	54.0
High Peak	Very high needs, physical	950	6.5	1,000	1,170	1,280	1,450	500	52.6
High Peak	Very high needs, cognitive	390	2.7	410	470	530	630	240	61.5
NE Derbyshire	Low needs	1,850	10.0	1,990	2,320	2,570	2,840	990	53.5
NE Derbyshire	Moderate needs	2,070	11.2	2,220	2,570	2,850	3,180	1,110	53.6
NE Derbyshire	High needs	1,540	8.3	1,640	1,900	2,100	2,360	820	53.2
NE Derbyshire	Very high needs, physical	1,610	8.7	1,730	2,010	2,200	2,430	820	50.9
NE Derbyshire	Very high needs, cognitive	460	2.5	480	550	640	740	280	60.9
S Derbyshire	Low needs	1,310	10.2	1,440	1,740	1,990	2,310	1,000	76.3
S Derbyshire	Moderate needs	1,320	10.3	1,440	1,720	1,970	2,320	1,000	75.8
S Derbyshire	High needs	970	7.6	1,060	1,260	1,440	1,700	730	75.3
S Derbyshire	Very high needs, physical	990	7.7	1,080	1,300	1,480	1,720	730	73.7
S Derbyshire	Very high needs, cognitive	320	2.5	340	400	470	570	250	78.1

Appendix 5: Ill Health, Disability and Healthy Life Expectancy

Limiting Long Term Illness: Source: Census 2001
These data are based on self assessment of whether or not a person has a limiting long-term illness (LLTI), health problem or disability which limits their daily activities or the work they can do, including problems that are due to old age.

In England and the East Midlands around 40% of all men aged 65-74 yrs and 50% of all men aged over 75 years reported they had a LLTI in 2001. In Bolsover, this was 58% and 66% respectively, the highest proportion in Derbyshire. A quarter of all people in Bolsover reported LLTI compared to 17% in the region. Chesterfield had similar levels to Bolsover. Derbyshire Dales had the lowest proportion of men with LLTI in Derbyshire.

Table 14 – Male Self-reported LLTI

	65-74			75 & over			All ages	
	Number	% of Pop	Standardised Illness Ratio	Number	% of Pop	Standardised Illness Ratio	Number	% of Pop
ENGLAND	794510	41%	98.5	733244	54%	99.3	3907050	16%
EAST MIDLANDS	71685	42%	101.0	65228	54%	101.3	345561	17%
Amber Valley	2167	45%	107.1	2064	60%	111.4	10343	18%
Bolsover	1793	58%	137.9	1432	66%	126.7	8831	25%
Chesterfield	2108	51%	121.1	1939	61%	115.1	10534	22%
Derbyshire Dales	1202	37%	88.2	1260	54%	99.3	5433	16%
Erewash	1926	44%	105.9	1648	54%	101.1	8960	17%
High Peak	1437	42%	99.3	1297	54%	98.6	7074	16%
NE Derbyshire	2152	48%	115.3	1875	61%	113.0	9913	21%
S Derbyshire	1370	44%	105.9	1223	57%	106.0	6493	16%

In England, the proportion of women aged 65-74 yrs who rated themselves as having a LLTI was slightly lower compared to men, but the same in those aged 75+ years. The proportion of women of all ages was higher than that of men. Bolsover, Chesterfield and North East Derbyshire had the highest proportions of women aged over 65 years reporting a LLTI.

Table 15 – Female Self-reported LLTI

	65-74			75 & over			All ages	
	Number	% of Pop	Standardised Illness Ratio	Number	% of Pop	Standardised Illness Ratio	Number	% of Pop
ENGLAND	854786	39%	98.7	1277953	54%	99.4	4462124	18%
EAST MIDLANDS	74888	40%	100.7	108142	55%	102.0	383415	18%
Amber Valley	2312	44%	111.1	3553	59%	109.8	11494	19%
Bolsover	1875	53%	133.0	2286	63%	118.3	8906	24%
Chesterfield	2263	47%	118.4	3302	61%	114.0	11306	22%
Derbyshire Dales	1233	35%	87.2	2157	54%	98.5	6270	18%
Erewash	2029	42%	105.9	3050	58%	107.3	10301	18%
High Peak	1516	40%	99.7	2366	57%	103.8	7863	17%
NE Derbyshire	2234	45%	114.3	3025	62%	112.9	10327	21%
South Derbyshire	1336	40%	101.7	2003	60%	111.6	7060	17%

Entitlement to Attendance Allowance or DLA Care (High)
Those awarded one of these benefits have by definition substantial disabilities or loss of capacity whether caused by illness or the effects of ageing.

Attendance Allowance and Disability Living Allowance (Care) are essentially the same benefit depending if it was applied for prior to the claimants 65th birthday or before. Entitlement is based on requiring 'attention with bodily functions' or supervision throughout the day; or for the highest rate needing additionally attention at night (or being terminally ill). Claims have to be supported by (medical) evidence. The data in Table 16 below is for people who have been awarded Attendance Allowance or Disability Living Allowance (Care), with the number receiving payment slightly lower (since a minority of eligible people in residential care homes and nursing homes who are not self funding or who have been in hospital for more than 8 weeks will not be receiving payment).

Around a third of all people over 65 years of age in Bolsover and Chesterfield are in receipt of Attendance Allowance or Disability Living Allowance compared to a countywide average of a quarter.

The proportion of the population entitled to these benefits increases by age, so that a total of 66.5% of Derbyshire over 85 year olds have been awarded them, as compared to just 14.2% of those aged 65 to 74 years. In Chesterfield and Bolsover three out of every four people aged 85 or over have been awarded Attendance Allowance or DLA (Care).

It is a particularly important data set, given its relation to the need for social care, whether that need is met by spouses or other relatives, through Derbyshire's Adult Social Services Department or remains unmet.

Table 16

AA/DLA(care) Entitled Cases August 2006 aged 65 years or over

	AA or DLA Care		AA (High) or DLA care (High)					AA (Low) or DLA care (Medium)				
				% of population entitled aged:					% of population entitled aged:			
	Total number entitled	% of population aged 65+	Total AA/DLA High Care	% 65+	% 65-74	% 75 - 84	% 85+	Total AA (Low) or DLA Medium	% 65+	% 65 - 74	% 75 - 84	% 85+
Derbyshire	**33,880**	**26.5**	**15,200**	11.9	4.9	14.9	32.9	**15,870**	12.4	5.5	15.3	33.6
Amber Valley	**5,390**	**27.0**	**2,410**	12.1	5.0	14.8	32.3	**2,590**	13.0	5.3	15.9	35.0
Bolsover	**4,490**	**35.4**	**1,980**	15.6	7.4	20.4	35.6	**2,000**	15.7	8.3	19.6	35.6
Chesterfield	**5,680**	**32.1**	**2,480**	14.0	5.7	17.8	37.1	**2,720**	15.4	7.5	18.7	38.1
Derbyshire Dales	**2,880**	**20.6**	**1,370**	9.8	3.6	11.2	31.1	**1,370**	9.8	3.2	12.2	30.0
Erewash	**4,430**	**24.5**	**1,860**	10.3	4.3	12.5	30.0	**2,150**	11.9	5.0	14.4	34.5
High Peak	**3,200**	**22.1**	**1,670**	11.5	4.4	13.7	33.7	**1,340**	9.2	4.1	11.4	23.7
NE Derbyshire	**4,760**	**25.9**	**2,120**	11.5	4.7	15.2	33.0	**2,200**	12.0	5.3	14.8	36.0
South Derbyshire	**3,040**	**23.9**	**1,310**	10.3	4.3	13.0	31.4	**1,490**	11.7	4.9	15.0	35.0

The data in16 above is in respect people who have been awarded Attendance Allowance or Disability Living Allowance (Care), with the number receiving payment slightly lower (since a small minority of eligible people in residential care homes and nursing homes who are not self funding or who have been in hospital for more than 8 weeks will not be receiving payment).

Self Reported Health Status: Source: Census 2001

In England and the East Midlands, 9% of all people rated their health as "not good". Unsurprisingly, this proportion increases with age to over a third of all people aged 90+ years.

Overall, a higher percentage of people in the north of the County rated their health as not good, and within the south, Amber Valley had the highest levels of self rated poor health.

Table 17 – Number of persons rating health as "Not Good"

	All Ages	65+	65-69	70-74	75-79	80-84	85-89	90+
England	4,249,859	1,678,885	367,477	385,720	381,772	289,496	180,536	73,884
East Midlands	365,057	147,107	31,835	34,377	34,237	25,758	15,011	5,889
Amber Valley	11,313	4,948	991	1,084	1,164	960	540	209
Bolsover	9,459	3,792	964	928	869	617	306	108
Chesterfield	11,602	4,830	994	1,131	1,203	866	464	172
Derbyshire Dales	5,366	2,481	487	539	543	470	305	137
Erewash	9,681	3,946	811	915	881	714	448	177
High Peak	7,511	2,997	649	658	693	509	336	152
NE Derbyshire	10,445	4,581	939	1,123	1,134	797	437	151
S Derbyshire	6,747	2,678	555	607	663	485	264	104

Table 18 – Percentage of persons rating health as "Not Good"

	All Ages	65+	65-69	70-74	75-79	80-84	85-89	90+
England	9%	23%	17%	20%	24%	28%	33%	34%
East Midlands	9%	23%	17%	21%	25%	29%	34%	35%
Amber Valley	10%	27%	19%	23%	29%	36%	42%	42%
Bolsover	13%	32%	28%	30%	34%	37%	42%	46%
Chesterfield	12%	29%	22%	26%	31%	36%	41%	44%
Derbyshire Dales	8%	20%	13%	17%	20%	27%	32%	37%
Erewash	9%	24%	17%	22%	25%	31%	38%	36%
High Peak	8%	23%	17%	19%	26%	27%	34%	37%
North East Derbyshire	11%	28%	19%	26%	31%	34%	43%	44%
South Derbyshire	8%	24%	17%	20%	27%	32%	37%	38%

Healthy Life Expectancy: Source: Office for National Statistics, based on Census 2001

Although life expectancy is increasing this does not necessarily mean the extra years are lived in good health, with life expectancy increasing at a faster rate than healthy life expectancy.

Life expectancy is higher for females than for males but the gap in healthy life expectancy between males and females is much smaller. In 2001, healthy life expectancy at birth was 67.0 years for males and 68.8 years for females, a gap of 1.8 years compared to a gap of 4.7 years in total life expectancy.

The difference between life expectancy and healthy life expectancy can be regarded as an estimate of the number of years a person can expect to live in poor health. Females can expect to live longer in poor health than males.

In comparison to England and the East Midlands, men living in Amber Valley, Bolsover, Chesterfield and North East Derbyshire and women living in Amber Valley, Bolsover, Chesterfield, Erewash, High Peak and North East Derbyshire can expect to live more years in poor health.

Table 19 – Healthy Life Expectancy at 65 years

	Males			Females		
	Life expectancy at 65	Estimated Healthy Life Expectancy	Estimated years in poor health	Life expectancy at 65	Estimated Healthy Life Expectancy	Estimated years in poor health
England	16.1	12.5	3.6	19.2	14.5	4.7
East Midlands	16.1	12.4	3.7	19.1	14.3	4.8
Amber Valley	15.6	11.5	4.1	19.1	13.7	5.5
Bolsover	15.2	10.2	4.9	18.5	12.2	6.2
Chesterfield	15.5	11.1	4.4	18.6	12.9	5.7
Derbyshire Dales	17.1	13.7	3.3	19.6	15.1	4.5
Erewash	15.8	12.2	3.5	18.7	13.8	5.0
High Peak	16.0	12.5	3.5	19.3	14.4	4.9
North East Derbyshire	15.9	11.7	4.2	18.7	13.1	5.7
South Derbyshire	15.9	12.1	3.8	18.6	13.9	4.7

Bolsover District has the lowest life expectancy, highest number of years in poor health, highest limiting long term illness rates and highest proportion of over 65 year old in receipt of Attendance Allowance or Disability Living Allowance (Care).

Morbidity (disease or condition) & Mortality (Death)

Morbidity - QoF Prevalence

Table 20 shows estimates of disease prevalence taken from practice based registers. The registers for Stroke/TIA and dementia are cumulative in that they include patients ever diagnosed since the introduction of the Quality and Outcome Framework in 2003. The palliative care register excludes patients <18 years and is prospective from 1st April 2006 recording patients predicted to die within 12 months, and/or those with prognostic clinical indicators of advanced or irreversible disease, and/or those in receipt of the DS 1500 form (accelerated payment of benefits due to terminal stage of illness).

Table 20 - Practice Disease Registers as at 31/03/2007

	Stroke/TIA		Dementia		Palliative Care	
	No. on Register	% Practice Pop	No. on Register	% Practice Pop	No. on Register	% Practice Pop
Derbyshire County PCT	14050	2.02	3249	0.47	719	0.10
Derby City PCT	4398	1.55	1006	0.35	264	0.09
Amber Valley PCT	2595	1.96	584	0.44	111	0.08
Chesterfield PCT	2380	2.11	600	0.53	161	0.14
DDSD PCT	1473	1.57	380	0.40	61	0.06
Erewash PCT	1982	1.95	404	0.40	83	0.08
High Peak & Dales PCT	2336	2.22	571	0.54	124	0.12
North East Derbyshire PCT	3284	2.22	710	0.48	179	0.12

Estimates of people aged 65+ with Dementia

There is, however, significant evidence of under diagnosis of dementia. The Alzheimer's Society earlier this year in their report 'Dementia UK' published expert Delphi consensus estimates of people suffering from late onset dementia (after the age of 65) with estimates of numbers at Social Services area. These estimate that whilst just 6.9% of 65 – 69 year olds have dementia, this increase to 30.0% of those aged 90 or over. The methodology has been applied below at Derbyshire district level, (but did not make separate estimates for those in residential or nursing care given changes in the number of residents since the 2001 Census).

The estimated increase in numbers from 2005 to 2025 is driven solely by projected increase in the numbers of elderly people as anticipated in the Office for National Statistics 2004 Population estimates.

Table 21 - Estimates of numbers with late onset dementia for 2005 to 2025

	2005	2010	2015	2020	2025	% increase from 2005 to 2025
Derbyshire	8,910	9,817	10,989	12,570	14,668	64.6
Amber Valley	1,451	1,582	1,741	2,016	2,351	62.1
Bolsover	884	963	1,056	1,227	1,410	59.6
Chesterfield	1,239	1,310	1,433	1,585	1,815	46.4
Derbyshire Dales	991	1,104	1,240	1,423	1,696	71.1
Erewash	1,244	1,355	1,534	1,740	1,996	60.5
High Peak	1,034	1,151	1,305	1,485	1,768	71.0
NE Derbyshire	1,259	1,426	1,647	1,896	2,209	75.4
South Derbyshire	845	952	1,096	1,300	1,555	84.0

Figure 5
Projection of estimated females by age band with late onset dementia 2005 to 2025

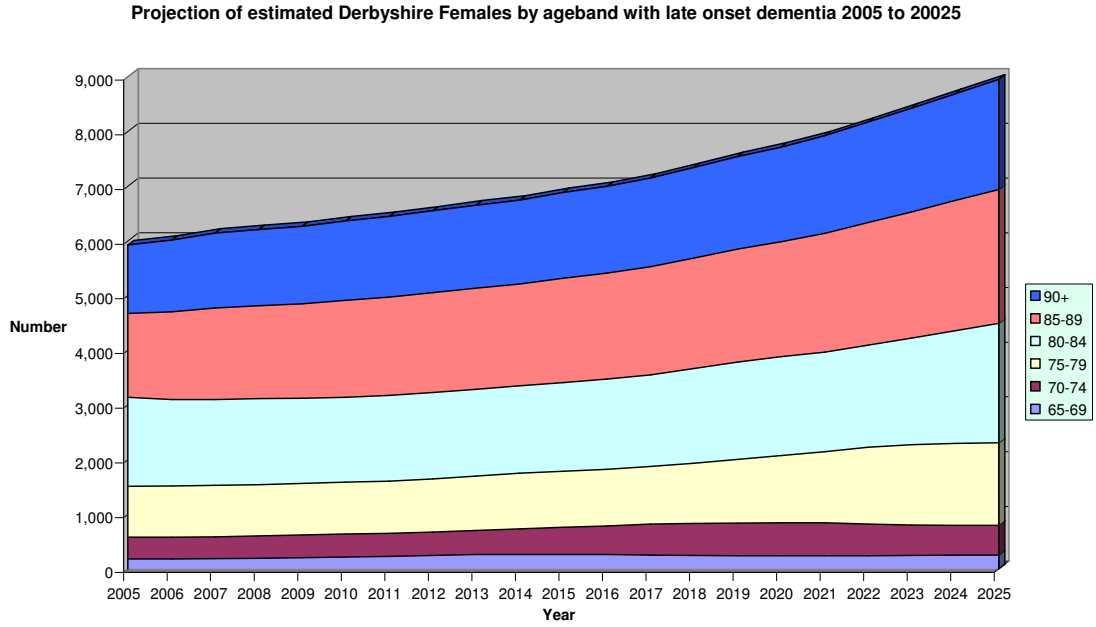
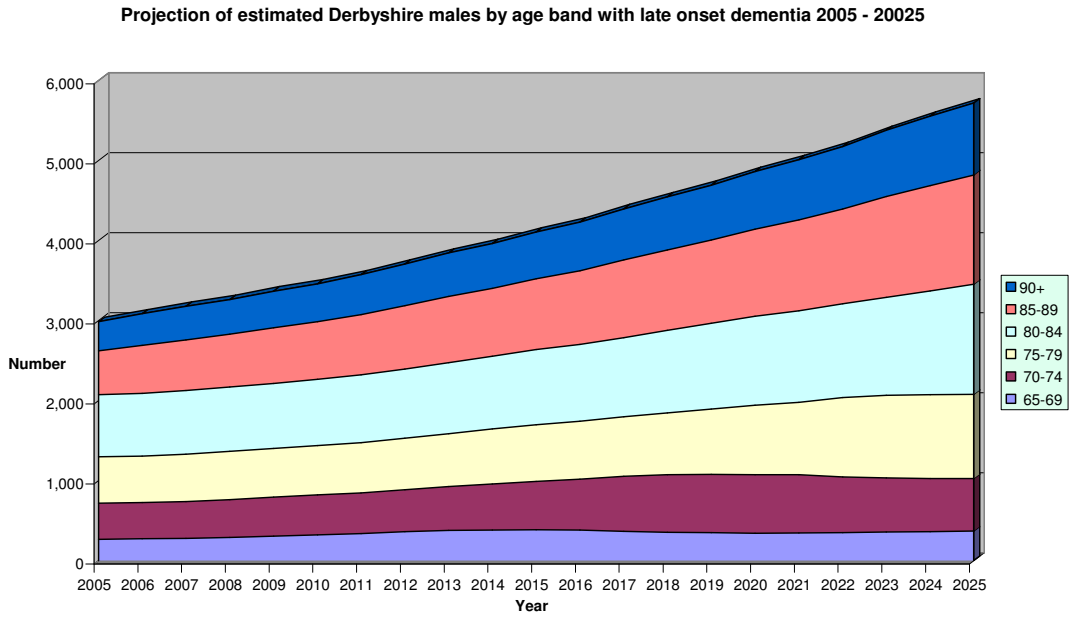


Figure 6
Projection of estimated females by age band with late onset dementia 2005 to 2025



As can be seen below, Countywide some 55% of the estimated sufferers of late onset dementia are estimated to have mild dementia, with a further 32% moderate dementia and just 13% severe dementia.

Table 21A - Estimates of numbers with late onset dementia by stage - 2007 to 2025

	Stage of dementia	2007	2010	2015	2020	2025	Increase from 2007 to 2025	% increase
Amber Valley	Mild	826	871	961	1,112	1,293	467	56.5
Amber Valley	Moderate	483	510	561	648	757	274	56.7
Amber Valley	Severe	192	202	221	256	302	110	57.1
Bolsover	Mild	500	533	585	679	778	277	55.5
Bolsover	Moderate	290	310	340	395	454	164	56.6
Bolsover	Severe	113	121	132	154	179	66	58.7
Chesterfield	Mild	707	727	796	880	1,005	298	42.2
Chesterfield	Moderate	409	421	461	509	584	175	42.8
Chesterfield	Severe	158	163	178	196	227	69	43.8
Derbyshire Dales	Mild	572	607	683	783	928	355	62.0
Derbyshire Dales	Moderate	335	355	399	458	547	212	63.4
Derbyshire Dales	Severe	133	142	158	182	222	89	66.7
Erewash	Mild	718	747	846	959	1,096	378	52.7
Erewash	Moderate	418	436	494	560	643	225	53.7
Erewash	Severe	165	172	195	222	258	92	55.9
High Peak	Mild	607	633	718	817	969	361	59.5
High Peak	Moderate	357	371	420	478	570	213	59.8
High Peak	Severe	143	148	167	190	229	86	60.4
NE Derbyshire	Mild	737	783	904	1,038	1,204	466	63.3
NE Derbyshire	Moderate	432	459	530	611	713	281	65.0
NE Derbyshire	Severe	173	184	213	248	293	120	69.5
South Derbyshire	Mild	488	528	609	722	861	373	76.5
South Derbyshire	Moderate	282	306	352	418	500	218	77.1
South Derbyshire	Severe	109	118	135	161	194	85	78.1
Derbyshire	Mild	5,149	5,425	6,079	6,952	8,083	2,934	57.0
Derbyshire	Moderate	2,995	3,158	3,535	4,041	4,722	1,727	57.6
Derbyshire	Severe	1,175	1,239	1,380	1,581	1,868	693	59.0

Emergency Hospital Admissions - Directly Age and Sex Standardised Rates per 100,000 for 65+ years

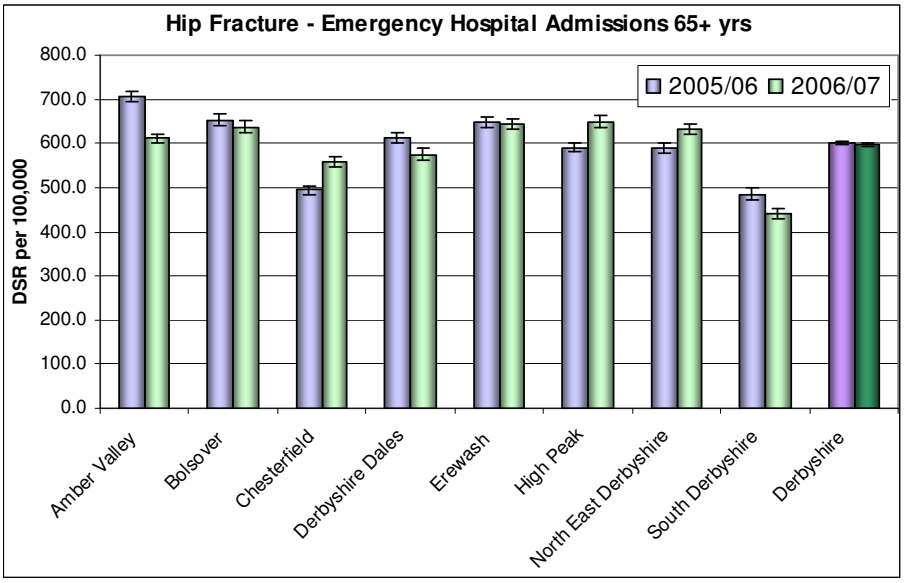
Hip Fracture: based on primary diagnosis ICD 10 codes S720, S721 and S722

Bolsover and Erewash had significantly higher rates in comparison to Derbyshire for both 2005/2006 and 2006/2007. Chesterfield and South Derbyshire had significantly lower rates. The rate in Amber Valley and Derbyshire Dales reduced significantly between 2005/2006 and 2006/2007 whilst it increased significantly in Chesterfield.

Table 22 – Hip Fracture DASR

	2005/06			2006/07		
	Observed	DASR	95% CI	Observed	DASR	95% CI
Amber Valley	183	706.1	694.4, 717.7	164	611.2	600.6, 621.8
Bolsover	110	653.2	639.4, 666.9	104	637.1	623.2, 651.0
Chesterfield	111	494.4	483.9, 504.9	124	558.4	547.1, 569.6
Derbyshire Dales	117	613.7	601.2, 626.3	103	575.2	562.6, 587.8
Erewash	150	646.2	634.6, 657.8	148	642.9	631.2, 654.6
High Peak	118	590.8	578.7 - 602.8	125	649.1	636.1, 662.0
North East Derbyshire	139	590.3	579.3, 601.3	142	633.2	621.5, 644.9
South Derbyshire	73	485.5	473.1, 498.0	69	442.4	430.7, 454.0
Derbyshire	1001	601.1	596.9, 605.3	979	598.0	593.8, 602.2

Figure 7

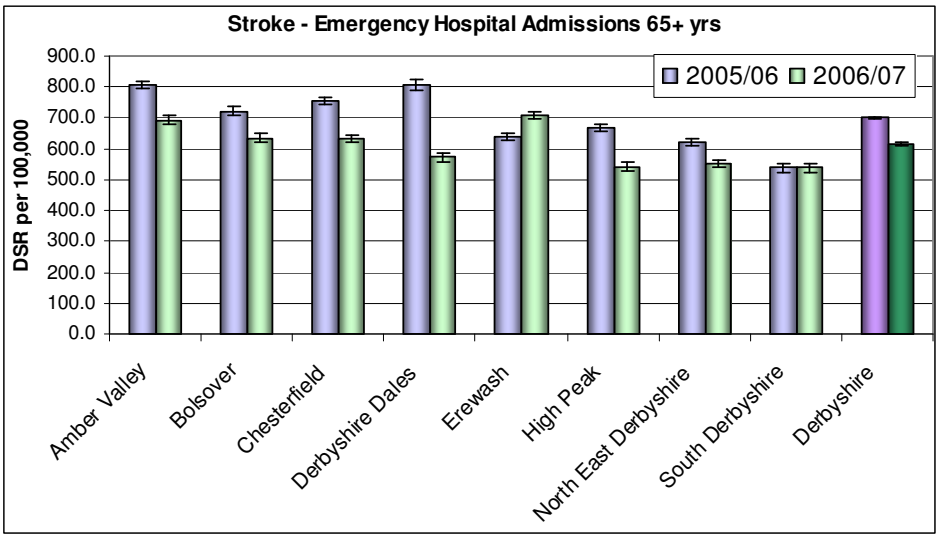


Stroke: based on primary diagnosis ICD codes I61, I63 and I64

Table 23 – Stroke DASR

	2005/06			2006/07		
	Observed	DASR	95% CI	Observed	DASR	95% CI
Amber Valley	198	808.5	795.7, 821.4	171	692.8	680.9, 704.6
Bolsover	105	721.5	705.8, 737.2	94	634.3	619.7, 649.0
Chesterfield	162	754.1	740.8, 767.4	133	631.9	619.5, 644.3
Derbyshire Dales	140	807.7	792.5, 823.0	100	573.6	560.7, 586.4
Erewash	144	638.1	626.3, 649.9	152	708.3	695.5, 721.1
High Peak	121	667.4	653.9, 680.9	93	542.2	529.6, 554.8
North East Derbyshire	132	621.6	609.6, 633.6	113	553.5	542.0, 565.1
South Derbyshire	78	538.0	524.5, 551.4	78	538.6	525.0, 552.1
Derbyshire	1080	699.9	695.2, 704.6	934	616.1	611.6, 620.6

Figure 8

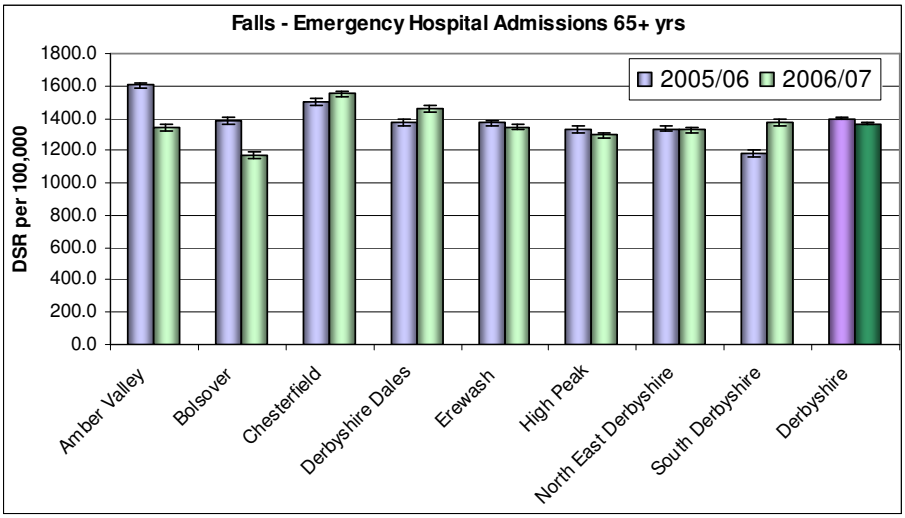


Accidental Falls: based on primary diagnosis S or T (accidental injury) and 3 secondary diagnoses ICD 10 codes W00-W19 (falls)).

Table 24 – Accidental Falls DASR

	2005/06			2006/07		
	Observed	DASR	95% CI	Observed	DASR	95% CI
Amber Valley	402	1605.7	1587.8, 1623.6	342	1341.8	1325.6, 1358.0
Bolsover	213	1385.4	1364.2, 1406.5	181	1170.4	1151.0, 1189.8
Chesterfield	326	1500.0	1481.3, 1518.7	338	1549.9	1531.0, 1568.9
Derbyshire Dales	248	1370.6	1351.3, 1389.9	254	1463.6	1443.1, 1484.0
Erewash	303	1372.5	1355.0, 1389.9	292	1346.0	1328.5, 1363.5
High Peak	249	1334.2	1315.3, 1353.1	236	1294.6	1275.7, 1313.5
North East Derbyshire	293	1335.6	1318.4, 1352.9	292	1330.1	1312.9, 1347.3
South Derbyshire	176	1179.9	1160.3, 1199.5	208	1376.2	1355.2, 1397.2
Derbyshire	2210	1398.5	1391.9, 1405.1	2143	1364.7	1358.2, 1371.3

Figure 9



Emergency Admissions - Ten most common primary diagnoses
Table 25 (2006/07)

ICD	Description	Derbyshire County	% of Total Emergency Admissions
N390	Urinary tract infection, site not specified	1167	4.09%
S720	Fracture of neck of femur	608	2.13%
J22X	Unspecified acute lower respiratory infection	638	2.24%
J181	Lobar pneumonia, unspecified	569	1.99%
R55X	Syncope and collapse	640	2.24%
R074	Chest pain, unspecified	535	1.88%
I209	Angina pectoris, unspecified	501	1.76%
I48X	Atrial fibrillation and flutter	534	1.87%
R54X	Senility	539	1.89%

J440	Chronic obstruct pulmonary dis with acute lower resp infec	498	1.75%

Elective Admissions - Ten most common primary diagnoses (2006/07)

ICD	Description	Derbyshire County	% of Total Elective Admissions
N180	End-stage renal disease	8977	9.6%
H269	Cataract, unspecified	2023	2.2%
H259	Senile cataract, unspecified	1575	1.7%
K029	Dental caries, unspecified	1197	1.3%
C679	Bladder, unspecified	1186	1.3%
K409	Unilat or unspec inguin hernia without obstruct or gangrene	1174	1.3%
I251	Atherosclerotic heart disease	1139	1.2%
G560	Carpal tunnel syndrome	1075	1.1%
R31X	Unspecified haematuria	1037	1.1%
Z080	Follow-up examination after surgery for malignant neoplasm	966	1.0%

Elective Admissions - Ten most common primary procedures
Table 26 (2006/07)

OPCS	Description	Derbyshire County	% of Total Elective Admissions
C751	Insertion of prosthetic replacement for lens NEC	4835	6.0%
G451	Fibreoptic endoscopic examination and biopsy of lesion of upper gastrointestinal tract	3945	4.9%
M459	Unspec diagnostic endoscopic examination of bladder	3807	4.7%
G459	Unspec diagnostic fibreoptic endoscopic examination of upper gastrointestinal tract	1840	2.3%
H229	Unspec diagnostic endoscopic examination of colon	1754	2.2%
H221	Diagnostic fibreoptic endoscopic exam and biopsy of lesion of colon	1494	1.8%
S069	Unspecified other excision of lesion of skin	1448	1.8%
X339	Unspecified other blood transfusion	1378	1.7%
X362	Venesection	1287	1.6%
S065	Excision of lesion of skin of head or neck NEC	1215	1.5%

Average Length of Stay for Emergency Admissions
The average length of stay for hip fracture emergency admissions in Derbyshire is 28 days, the highest of all three conditions analysed. On average, the length of stay for local authorities in the north of the county was higher, whilst it was lower in those in the south of the county. There was a reduction in length of stay from 05/06 to 06/07 across most areas.

Table 27 - Hip Fracture

	2005/06	2006/07	Total
Amber Valley	23.0	22.3	22.7
Bolsover	25.2	24.7	25.0
Chesterfield	27.8	32.4	30.2
Derbyshire Dales	30.2	27.6	28.9
Erewash	26.0	21.5	23.8
High Peak	28.8	31.6	30.3

North East Derbyshire	31.8	29.2	30.5
South Derbyshire	26.1	22.7	24.4
Derbyshire	27.1	26.3	26.7

The average length of stay for stroke in the County is 21 days. Unlike hip fracture, areas in the north of the County tended to be lower than the Derbyshire average and vice versa. Erewash had the highest average at 27 days; although did show a slight reduction from 2005/2006 to 2006/2007. North East Derbyshire had the lowest average at 17 days.

Table 28 - Stroke

	2005/06	2006/07	Total
Amber Valley	22.9	22.4	22.7
Bolsover	19.2	20.1	19.6
Chesterfield	16.8	15.7	16.3
Derbyshire Dales	21.8	21.7	21.8
Erewash	33.4	21.8	27.4
High Peak	25.9	28.9	27.4
North East Derbyshire	17.4	16.5	17.0
South Derbyshire	26.7	13.4	20.0
Derbyshire	22.6	19.9	21.4

On average, length of stay for emergency admissions for accidental falls was 14 days. Amber Valley and Derbyshire Dales were higher at 16 and 18 days respectively. Bolsover was the lowest with an average of 11 days.

Table 29- Accidental Falls

	2005/06	2006/07	Total
Amber Valley	16.2	15.1	15.7
Bolsover	10.0	12.2	11.0
Chesterfield	12.1	12.7	12.4
Derbyshire Dales	18.4	16.6	17.5
Erewash	17.1	11.8	14.5
High Peak	15.6	14.3	14.9
North East Derbyshire	13.0	15.3	14.2
South Derbyshire	17.5	11.8	14.5
Derbyshire	15.0	13.8	14.4

Mortality - Directly age and sex standardised rates per 100,000 based on 3 year pooled deaths and underlying cause of death.

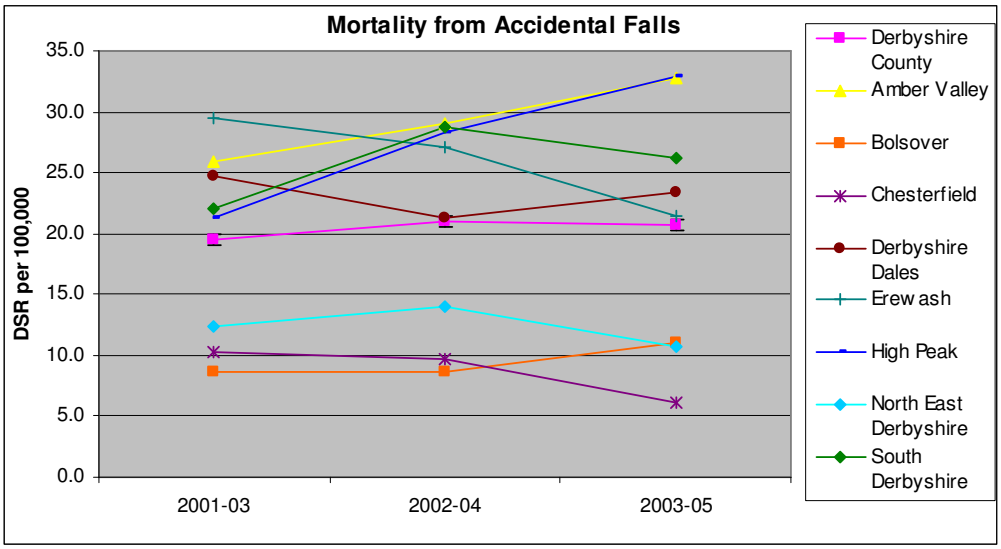
Accidental Falls

The mortality rate from accidental falls has remained fairly constant across Derbyshire as a whole. In Amber Valley and South Derbyshire the rate has increased and been significantly higher than Derbyshire across all three time periods. Derbyshire Dales has a rate above that of Derbyshire, which was significantly higher in 2003-05. High Peak was significantly higher for 2002-04 and 2003-05. In contrast, the other local authorities in the north of the County have been consistently lower than Derbyshire as a whole.

Table 30 – Accidental Falls DASR

	2001-03			2002-04			2003-05		
	DASR	LL CI	UL CI	DASR	LL CI	UL CI	DASR	LL CI	UL CI
Amber Valley	25.9	24.5	27.2	29.1	27.7	30.5	32.8	31.4	34.3
Bolsover	8.6	7.6	9.6	8.7	7.6	9.8	11.0	9.8	12.2
Chesterfield	10.3	9.5	11.2	9.7	8.9	10.6	6.1	5.5	6.7
Derbyshire Dales	24.7	23.1	26.4	21.3	19.9	22.7	23.4	22.0	24.8
Erewash	29.5	28.1	30.9	27.1	25.7	28.5	21.5	20.2	22.8
High Peak	21.3	20.0	22.6	28.3	26.9	29.8	32.9	31.2	34.5
North East Derbyshire	12.3	11.4	13.3	14.0	13.0	15.1	10.8	9.9	11.7
South Derbyshire	22.0	20.5	23.6	28.8	27.0	30.5	26.1	24.5	27.8
Derbyshire	19.5	19.1	20.0	21.0	20.5	21.5	20.7	20.2	21.1

Figure 10



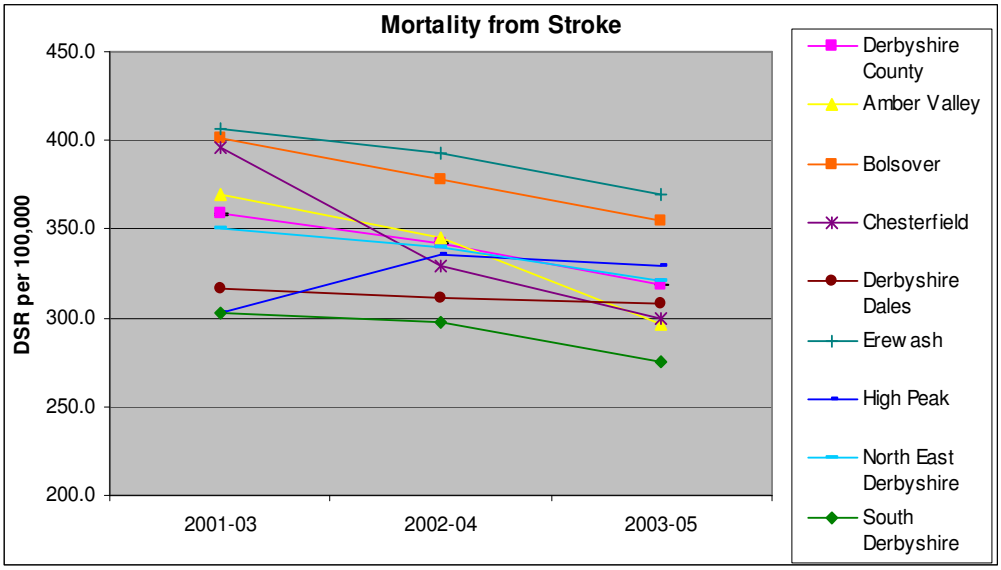
Stroke

The overall mortality rate from stroke has been decreasing in Derbyshire. The mortality rate from a stroke in Bolsover and Erewash has been significantly higher than Derbyshire across all three time periods; however the rate has also been decreasing over this time. In Derbyshire Dales and South Derbyshire the mortality rate has been consistently significantly lower than the County average.

Table 31 – Stroke DASR

	2001-03			2002-04			2003-05		
	DASR	LL CI	UL CI	DASR	LL CI	UL CI	DASR	LL CI	UL CI
Amber Valley	369.6	364.7	374.5	344.8	340.1	349.5	296.2	291.8	300.5
Bolsover	401.7	395.1	408.3	378.3	371.9	384.6	354.7	348.6	360.8
Chesterfield	395.6	390.2	401.1	329.5	324.6	334.4	299.4	294.8	304.1
Derbyshire Dales	316.3	311.0	321.6	310.8	305.6	316.0	308.2	302.9	313.4
Erewash	407.0	401.6	412.3	392.3	387.1	397.6	369.4	364.3	374.4
High Peak	302.4	297.3	307.5	335.8	330.4	341.2	329.0	323.5	334.4
North East Derbyshire	350.3	345.2	355.3	340.3	335.3	345.4	320.4	315.6	325.3
South Derbyshire	302.9	297.3	308.5	297.8	292.2	303.4	274.9	269.6	280.3
Derbyshire	358.4	356.5	360.3	342.5	340.6	344.3	318.6	316.8	320.4

Figure 11



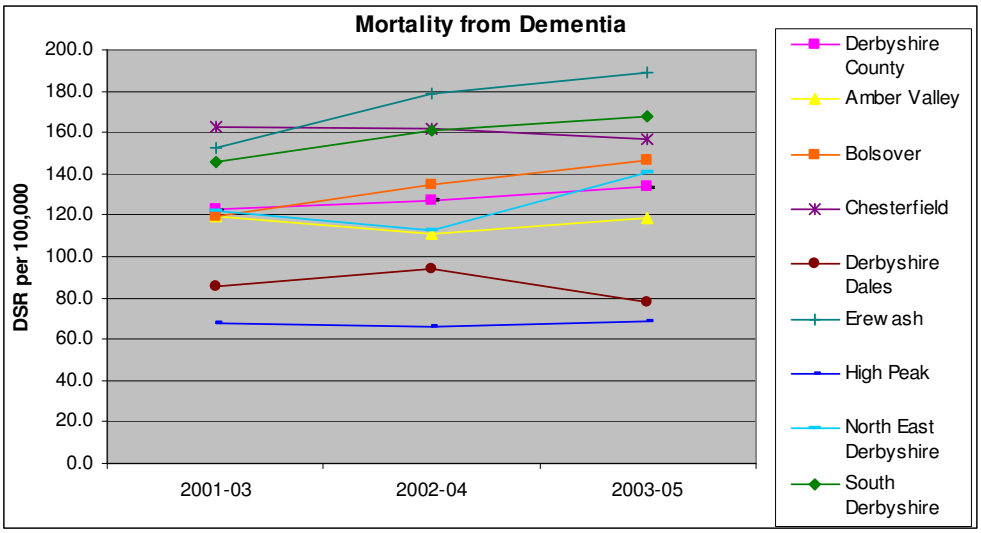
Dementia

Mortality rates from Dementia have been increasing in Derbyshire although the picture is more varied within local authorities. Chesterfield, Erewash and South Derbyshire were significantly higher than the County for each time period. Rates have decreased slightly in Chesterfield but increased in Erewash and South Derbyshire. Following an increase in mortality rates, Bolsover was significantly higher than Derbyshire for the last two time periods. High Peak, Derbyshire Dales and Amber Valley are consistently lower than Derbyshire.

Table 32 – Dementia DASR

	2001-03			2002-04			2003-05		
	DASR	LL CI	UL CI	DASR	LL CI	UL CI	DASR	LL CI	UL CI
Amber Valley	119.2	116.6	121.8	111.0	108.4	113.5	118.4	115.8	121.1
Bolsover	119.8	116.4	123.2	134.4	130.7	138.0	146.9	143.2	150.6
Chesterfield	162.7	159.4	166.0	162.1	158.8	165.5	156.8	153.5	160.0
Derbyshire Dales	85.2	82.6	87.8	94.4	91.6	97.1	78.2	75.7	80.7
Erewash	152.8	149.6	156.1	178.8	175.3	182.2	189.4	185.8	193.0
High Peak	67.6	65.2	69.9	65.9	63.7	68.2	68.7	66.4	70.9
North East Derbyshire	122.2	119.3	125.1	112.7	110.0	115.5	141.0	137.8	144.1
South Derbyshire	145.8	142.0	149.7	161.4	157.4	165.4	167.5	163.4	171.6
Derbyshire	122.8	121.8	123.9	127.5	126.4	128.6	133.6	132.5	134.7

Figure 12



Appendix 6: Resources

Adult Care funded provision in the period 01/04/2008 to 31/3/2009

Residential and Nursing Care arranged through Derbyshire Adult Care

Table 33 Residential Care Homes (Independent Sector)

AREA	Age Group 65-69	70-74	75-79	80-85	Over 85	**Aged 65+**
High Peak & North Dales	15	21	34	69	186	325
Chesterfield	9	17	38	99	165	328
NE Derbyshire	16	15	32	81	155	299
Bolsover	6	21	21	72	133	253
Amber Valley	8	13	32	50	151	254
Erewash	6	10	17	49	108	190
South Derbyshire & South Dales	7	10	21	60	107	205
Derbyshire	67	107	195	480	1005	1854

Table 34 Nursing Homes

AREA	Age Group 65-69	70-74	75-79	80-85	Over 85	**Aged 65+**
High Peak & North Dales	12	12	26	47	105	202
Chesterfield	21	13	17	43	60	154
NE Derbyshire	10	13	34	45	79	181
Bolsover	9	14	34	45	79	117
Amber Valley	14	16	24	53	121	228
Erewash	10	16	27	55	111	219
South Derbyshire & South Dales	9	14	24	34	71	152
Derbyshire	85	98	167	310	593	1253

Table 35 Derbyshire County Council Residential Homes for Older People

AREA	Age Group 65-69	70-74	75-79	80-85	Over 85	**Aged 65+**
High Peak & North Dales	2	3	4	24	79	112
Chesterfield	3	6	15	25	82	131
NE Derbyshire			3	4	18	25
Bolsover	1	5	8	26	90	130
Amber Valley	1	4	10	33	91	139
Erewash	6	8	24	46	119	203
South Derbyshire & South Dales	2	4	8	17	73	104
Derbyshire	15	30	72	175	552	844

Care in the Community: provided by (or for) Derbyshire Adult Care in the period *01/04/2008 to 31/3/2009*

A range of services are provided for older people in the community, with data provided on some of these below. Some people will be receiving a number of services.

Table 36 Meals on Wheels

AREA	Age Group 65-69	70-74	75-79	80-85	Over 85	**Aged 65+**
High Peak & North Dales	**26**	**48**	**110**	**257**	**401**	**842**
Chesterfield	**27**	**46**	**79**	**209**	**297**	**658**
NE Derbyshire	**21**	**45**	**99**	**207**	**305**	**677**
Bolsover	**27**	**57**	**125**	**177**	**214**	**600**
Amber Valley	**26**	**39**	**70**	**200**	**333**	**668**
Erewash	**32**	**55**	**94**	**189**	**317**	**687**
South Derbyshire & South Dales	**28**	**53**	**84**	**207**	**308**	**680**
Derbyshire	**187**	**343**	**661**	**1446**	**2175**	**4812**

Table 37 Laundry Service Provided

AREA	Age Group 65-69	70-74	75-79	80-85	Over 85	**Aged 65+**
High Peaks & North Dales	**20**	**33**	**58**	**128**	**253**	**492**
Chesterfield	**29**	**43**	**65**	**164**	**235**	**536**
NE Derbyshire	**9**	**18**	**50**	**101**	**145**	**323**
Bolsover	**12**	**21**	**40**	**92**	**90**	**255**
Amber Valley	**14**	**29**	**61**	**122**	**213**	**439**
Erewash	**10**	**23**	**24**	**58**	**87**	**202**
South Derbyshire & South Dales	**18**	**27**	**46**	**115**	**155**	**361**
Derbyshire	**112**	**194**	**344**	**780**	**1178**	**2608**

Table 38 Homecare Commissioned from Independent or Private Provider

AREA	Age Group 65-69	70-74	75-79	80-85	Over 85	**Aged 65+**
High Peaks & North Dales	**18**	**29**	**49**	**93**	**128**	**317**
Chesterfield	**33**	**61**	**82**	**186**	**213**	**575**
NE Derbyshire	**26**	**48**	**110**	**194**	**260**	**638**
Bolsover	**13**	**26**	**43**	**73**	**72**	**227**
Amber Valley	**45**	**66**	**97**	**193**	**230**	**631**
Erewash	**24**	**30**	**48**	**111**	**130**	**343**
South Derbyshire & South Dales	**37**	**70**	**102**	**173**	**245**	**627**
Derbyshire	**196**	**330**	**531**	**1023**	**1278**	**3358**

Table 39 Homecare Provided Directly by Derbyshire Adult Social Services						
	Age Group					
AREA	65-69	70-74	75-79	80-85	Over 85	**Aged 65+**
High Peaks & North Dales	**88**	**123**	**206**	**429**	**654**	**1500**
Chesterfield	**73**	**110**	**186**	**391**	**501**	**1261**
NE Derbyshire	**56**	**77**	**191**	**308**	**463**	**1095**
Bolsover	**43**	**103**	**181**	**326**	**398**	**1051**
Amber Valley	**83**	**117**	**204**	**391**	**518**	**1313**
Erewash	**55**	**100**	**112**	**333**	**407**	**1007**
South Derbyshire & South Dales	**35**	**77**	**115**	**212**	**311**	**750**
Derbyshire	**433**	**707**	**1195**	**2390**	**3252**	**7977**

The County Council currently provide directly 70% of the home care service provided to 11,335 clients. There is an intention that clients should have more control over the services they have, or self directed care, and there will be attempts to stimulate the care market accordingly best using the skills in the independent, private and in house provision in order to best meet people's needs. This may result in shifts in who is best placed to provide which services.

Table 40 Direct Payments for Clients to Provide their Own Homecare, etc						
	Age Group					
AREA	65-69	70-74	75-79	80-85	Over 85	**Aged 65+**
High Peaks & North Dales	**13**	**10**	**12**	**19**	**27**	**81**
Chesterfield	**9**	**9**	**7**	**18**	**14**	**57**
NE Derbyshire	**9**	**3**	**4**	**6**	**9**	**31**
Bolsover	**7**	**8**	**4**	**5**	**7**	**31**
Amber Valley	**16**	**12**	**14**	**24**	**16**	**82**
Erewash	**12**	**9**	**8**	**11**	**16**	**56**
South Derbyshire & South Dales	**6**	**14**	**4**	**12**	**15**	**51**
Derbyshire	**72**	**65**	**53**	**95**	**104**	**389**

Table 41 Day Care Provided to Clients						
	Age Group					
AREA	65-69	70-74	75-79	80-85	Over 85	**Aged 65+**
High Peaks & North Dales	**23**	**27**	**65**	**104**	**213**	**432**
Chesterfield	**24**	**43**	**57**	**140**	**145**	**409**
NE Derbyshire	**6**	**16**	**30**	**34**	**48**	**134**
Bolsover	**13**	**28**	**65**	**125**	**133**	**364**
Amber Valley	**23**	**23**	**33**	**62**	**66**	**207**
Erewash	**6**	**8**	**4**	**11**	**14**	**43**
South Derbyshire & South Dales	**17**	**34**	**59**	**109**	**144**	**363**
Derbyshire	**112**	**179**	**313**	**585**	**763**	**1952**

Table 42 Equipment Provided (Excluding Major Adaptations)						
	Age Group					
AREA	65-69	70-74	75-79	80-85	Over 85	**Aged 65+**
High Peaks & North Dales	**94**	**134**	**187**	**333**	**381**	**1129**
Chesterfield	**57**	**72**	**102**	**209**	**242**	**682**
NE Derbyshire	**77**	**87**	**158**	**225**	**264**	**811**
Bolsover	**52**	**69**	**126**	**215**	**198**	**660**
Amber Valley	**69**	**123**	**166**	**296**	**298**	**952**
Erewash	**78**	**108**	**135**	**243**	**261**	**825**
South Derbyshire & South Dales	**68**	**104**	**162**	**241**	**287**	**862**
Derbyshire	**495**	**697**	**1036**	**1762**	**1931**	**5921**

The data relates to equipment supplied to clients through 'mediquip' some of which are small items whilst other may cost several thousands of £s.

Table 43 Service Contracts for Hoists Installed in Client Homes						
	Age Group					
AREA	65-69	70-74	75-79	80-85	Over 85	**Aged 65+**
High Peaks & North Dales	**4**	**7**	**5**	**8**	**12**	**36**
Chesterfield	**3**	**0**	**5**	**8**	**7**	**23**
NE Derbyshire	**9**	**8**	**10**	**10**	**6**	**43**
Bolsover	**3**	**6**	**2**	**7**	**9**	**27**
Amber Valley	**4**	**4**	**7**	**8**	**12**	**35**
Erewash	**3**	**6**	**6**	**11**	**7**	**33**
South Derbyshire & South Dales	**4**	**7**	**11**	**7**	**6**	**35**
Derbyshire	**30**	**38**	**46**	**59**	**59**	**232**

Table 44 Service Contracts for Stair Lifts Installed in Clients Homes						
	Age Group					
AREA	65-69	70-74	75-79	80-85	Over 85	**Aged 65+**
High Peaks & North Dales	**55**	**75**	**95**	**159**	**130**	**514**
Chesterfield	**18**	**24**	**16**	**47**	**50**	**155**
NE Derbyshire	**40**	**42**	**60**	**77**	**68**	**287**
Bolsover	**12**	**12**	**19**	**35**	**32**	**110**
Amber Valley	**19**	**31**	**41**	**74**	**62**	**227**
Erewash	**30**	**46**	**41**	**80**	**74**	**271**
South Derbyshire & South Dales	**24**	**24**	**38**	**41**	**49**	**176**
Derbyshire	**198**	**254**	**310**	**513**	**465**	**1740**

Sometimes clients may require short residential care before returning to their homes.

Table 45 Short Term Care						
AREA	Age Group 65-69	70-74	75-79	80-85	Over 85	**Aged 65+**
High Peaks & North Dales	**11**	**20**	**35**	**70**	**152**	**288**
Chesterfield	**14**	**28**	**27**	**87**	**95**	**251**
NE Derbyshire	**10**	**15**	**41**	**69**	**100**	**235**
Bolsover	**3**	**7**	**33**	**71**	**94**	**208**
Amber Valley	**13**	**15**	**20**	**48**	**84**	**180**
Erewash	**7**	**19**	**20**	**49**	**86**	**181**
South Derbyshire & South Dales	**9**	**12**	**28**	**56**	**84**	**189**
Derbyshire	**67**	**116**	**204**	**450**	**695**	**1532**

Appendix 7: Commissioning

The commissioning of services for older people is at the forefront of dealing with the implications of an ageing population and in re-defining their role and place within their local communities. This requires a move away from the attitude of 'doing for' older people, towards a positive appreciation of the knowledge, skill and experience older people have about how best they can be helped both as individuals and within their community.

Putting people at the centre of commissioning involves giving people greater choice and control over services and treatments (including self-care), and access to good information and advice to support these choices. The commissioning strategy will involve older people in shaping services by:

- Continuing to consult local people on their priorities and desired outcomes from services;
- Using information from local people to inform the planning and delivery of services, for example, user experience surveys, public satisfaction surveys, comments and complaints feedback;
- Using an agreed common (single) assessment framework for health and social care workers to work with individuals to develop tailored treatment, care and support to meet individual needs.

Commissioning equitably will require involvement of a wide range of older people's representatives, which will be achieved by:

- monitoring of minority groups within the community to ensure commissioners and service providers are aware of specific issues and requirements;
- seeking out the views of different groups and individuals on commissioning issues;
- addressing any access issues;
- considering whether specific resources need to be devoted to addressing differential need or hard-to-reach populations or individuals;
- development of appropriate standards;
- ongoing monitoring and evaluation;
- outcome based commissioning;
- reporting back on performance in terms of this Strategy.

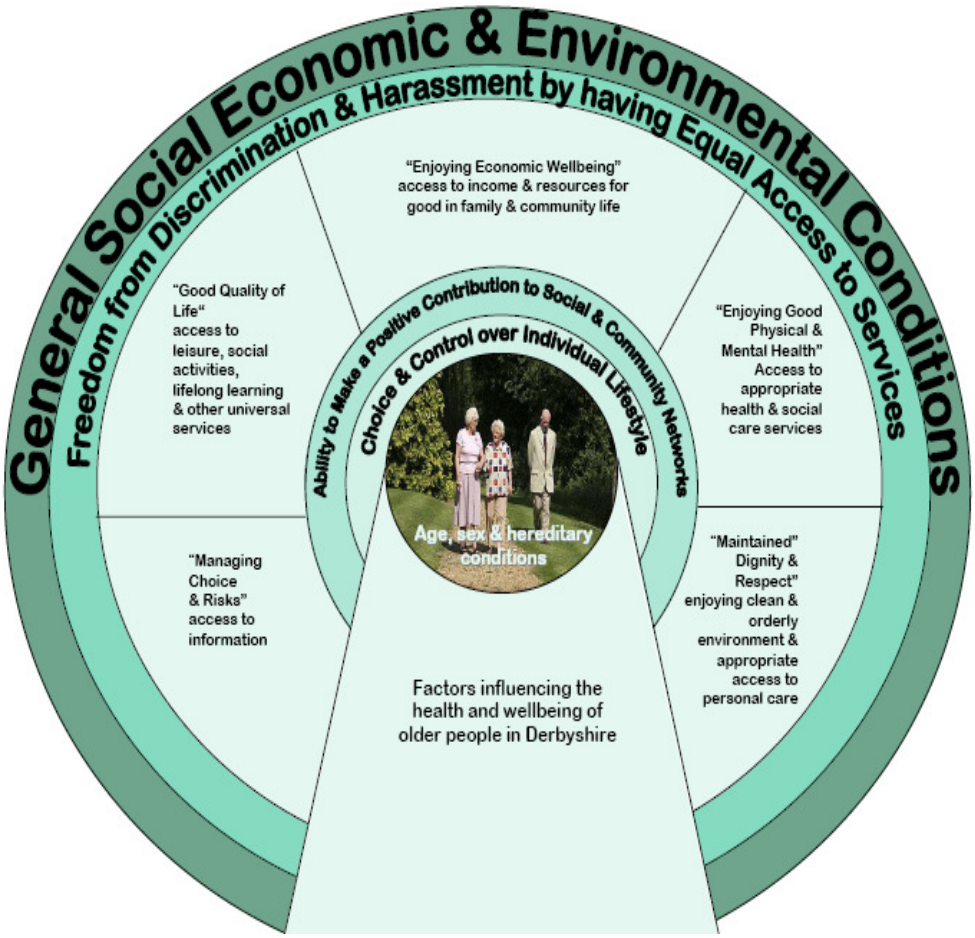


Diagram 1: Adapted from Dahlgreen and Whitehead, 1991[13]

This Commissioning Strategy will focus primarily on ensuring that older people have access to appropriate and personalised health and social care services. Health and well-being of older people in Derbyshire will be achieved by close collaboration between those working to commission services for older people and those working to promote economic, social and environmental well-being within other strategic partnership work programmes.

[13] Policies and Strategies to Promote Social Equity in Health, Institute of Future Studies

Our challenge is to develop a commissioning framework that facilitates the development of more self-sustaining, cohesive communities in which ill-health is prevented and well-being is maintained for a majority of people, enabling scarce resources to be tailored for those requiring specialist personalised services. Over time, commissioning will continue to move away from a narrow focus on those older people in most need, usually dealt with on a post crisis, reactive basis, to a much more pro-active approach of targeted prevention aimed at reducing the number of crises, promoting independence, and enabling many more older people to continue living in the community for as long as they wish.

Commissioning teams within Derbyshire have already started to work in partnership with other agencies to ensure services are provided at three levels of intervention:

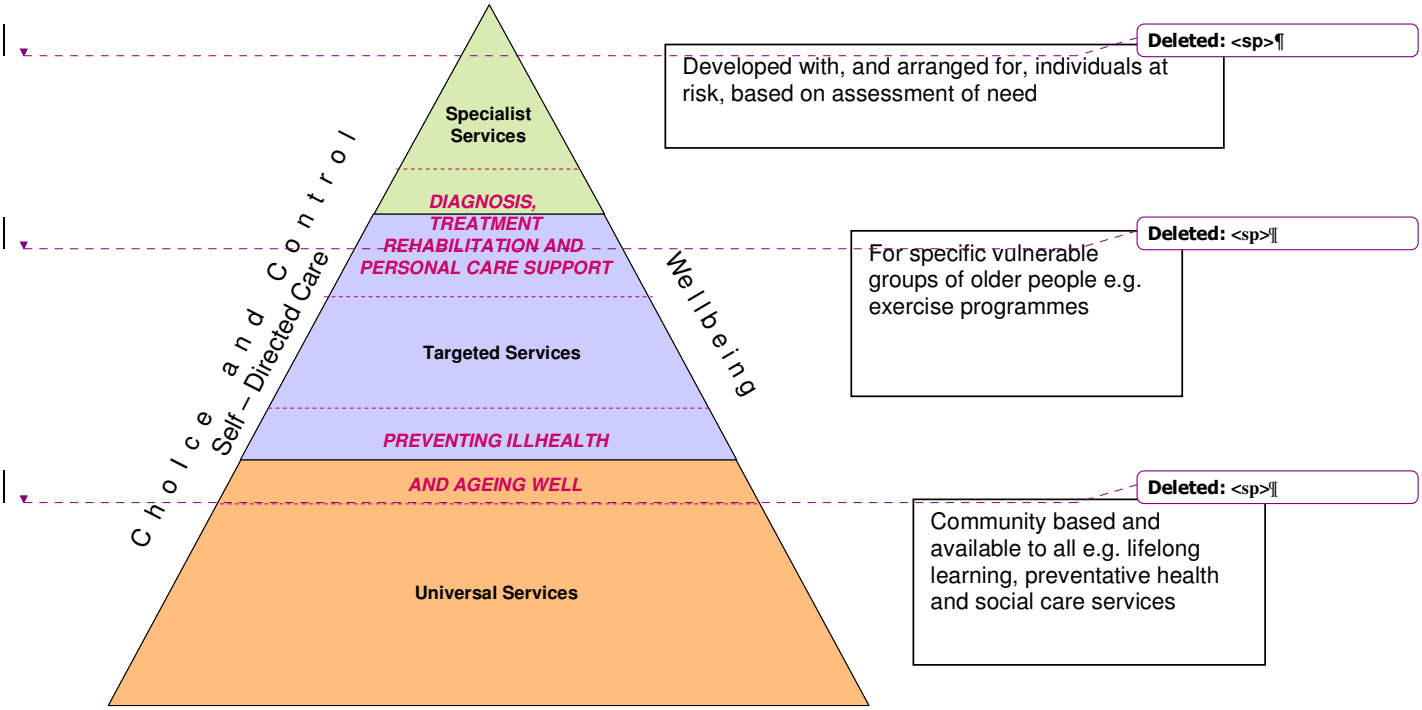


Diagram 2: Pyramid of care and Levels of Service/Intervention

These three levels are linked and have to be co-ordinated within our commissioning framework. Health and social care commissioners are not directly responsible for all universal and targeted services, but do face the challenge of facilitating appropriate opportunities for older people to access them.

Changing to a philosophy of 'putting people at the centre of commissioning, within Derbyshire' will require an emphasis to be placed within all service specifications that care and support is partnership. This means assessors and providers working with people to ensure statutory services provided complement an individual's own resources and the resources of their families and local communities.

Appendix 2 provides a detailed example of the quality standards that should be in place to meet the ten steps within a generic care pathway. The pathway is divided into four inter-related parts: initial contact and diagnosis; access to emergency and

acute support, access to community rehabilitation and support and ongoing personal care and support.

The Department of Health has launched a world class commissioning[14] programme, which will transform the way health and care services are commissioned.

World class commissioning will deliver a more strategic and long-term approach to commissioning services, with a clear focus on delivering improved health outcomes.

There are four key elements to the programme; a vision for world class commissioning, a set of world class commissioning competencies, an assurance system and a support and development framework.

World class commissioning will deliver better health and well-being for all:

- People will live healthier and longer lives
- Health inequalities will be dramatically reduced.

It will deliver better care for all:

- Services will be evidence-based and of the best quality
- People will have choice and control over the services that they use, so they become more personalised.

It will deliver better value for all:

- Investment decisions will be made in an informed and considered way, ensuring that improvements are delivered within available resources
- PCTs will work with others to optimise effective care.

The Commissioning Strategy sets out expectations for the purchasers and providers in Derbyshire. We will respond to the challenge laid down through the World Class Commissioning vision, by implementing these outcomes within this Strategy. The Joint Commissioning Group for Older People will build on current purchaser partnership arrangements with a wide range of providers to develop transparent and fair purchasing arrangements leading to innovative provision, tailored to the needs of individuals. The commissioning / purchasing / contracting relationship is set out in the diagram below.

[14] World Class Commissioning vision, Department of Health, 3 December 2007

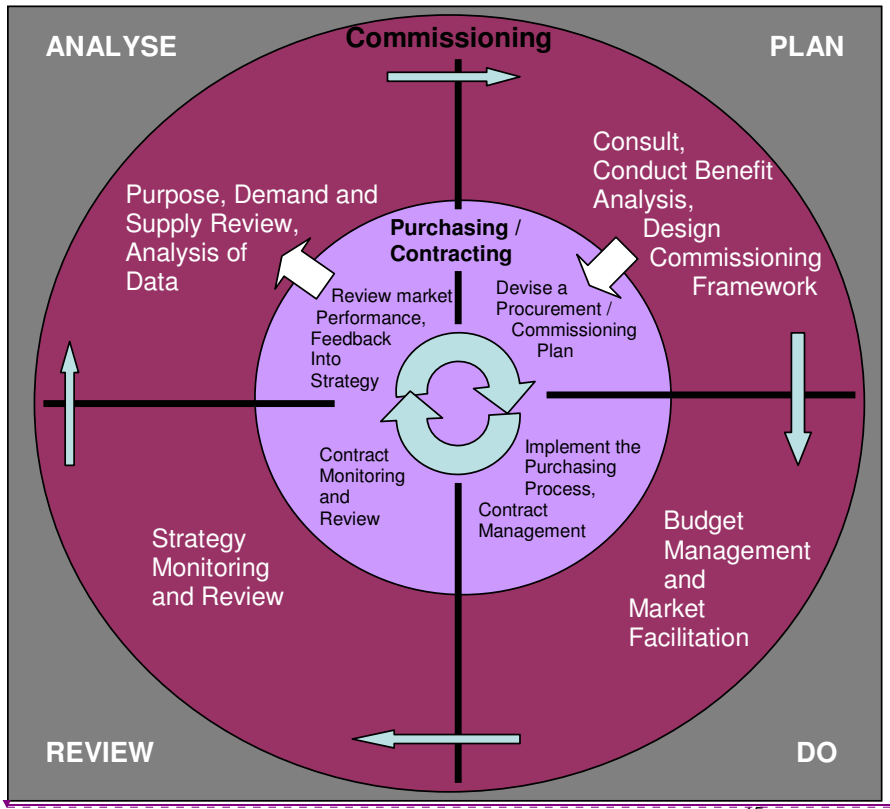


Diagram 3: The Commissioning and Contracting Framework[15]

It is intended that this Commissioning Strategy will be updated as part of a dynamic process including by working with a range of providers over time. A Provider Reference Group will be used to engage in discussion around the results of the Joint Strategic Needs Assessment[16] and review of current market arrangements as part of the analysis required in the top left quadrant of the commissioning cycle.

General practitioners are key in developing and shaping the joint strategic priorities as a result of their responsibility for practice based commissioning.

Further consultation will be undertaken routinely with both the Provider Reference Group and with a wider range of older people and providers as part of the processes for developing procurement/commissioning; setting up purchasing processes and reviewing contract management.

Detailed discussion with providers to help match market capacity to demand will be undertaken through provider consultation groups, including: Care Homes and Home Care Consultation Groups, voluntary sector providers and PCT Groups.

[15] Taken from 'Key Activities in Commissioning: Lessons from the Care Services Improvement Partnership; Commissioning Exemplar Project, Second Edition

[16] Joint Strategic Needs Assessment – a statutory requirement for the Directors of Adult Social Services and Public Health set out within the Local Government and Public Involvement in Health Bill. Designed to inform planning over a range of timescales – annual, medium and long-term, conducted by upper tier local authorities in consultation with district authorities.

Appendix 8: Estimates of level of social care need

The Wanless Report[17] categorised 5 different levels of need, based on whether people can undertake core activities relating to daily living. The four core 'Activities of Daily Living (ADL) are to: get in or out of bed (or chair); use the toilet; get dressed and undressed; and feed oneself. Additionally, Wanless recognised five Instrumental Activities of Daily Living (IADL), shopping; laundry; vacuuming; cooking a main meal; and managing personal affairs (for example paying bills etc).

The resulting five levels of need are:

Independent/No Needs: No care needs - people able to perform activities of daily living (personal care) tasks and instrumental activities of daily living (domestic care) tasks without difficulty or need for help

Low Needs: People who have difficulty in performing domestic care tasks and/or have difficulty with bathing, showering or washing all over but not with other activities of daily living

Moderate Needs: People who have difficulty with one or more other personal care needs tasks

High Needs: People who are unable to perform one personal care need task without help

Very High Needs: People who are unable to perform two or more personal care need tasks without help. That may be subdivided into:

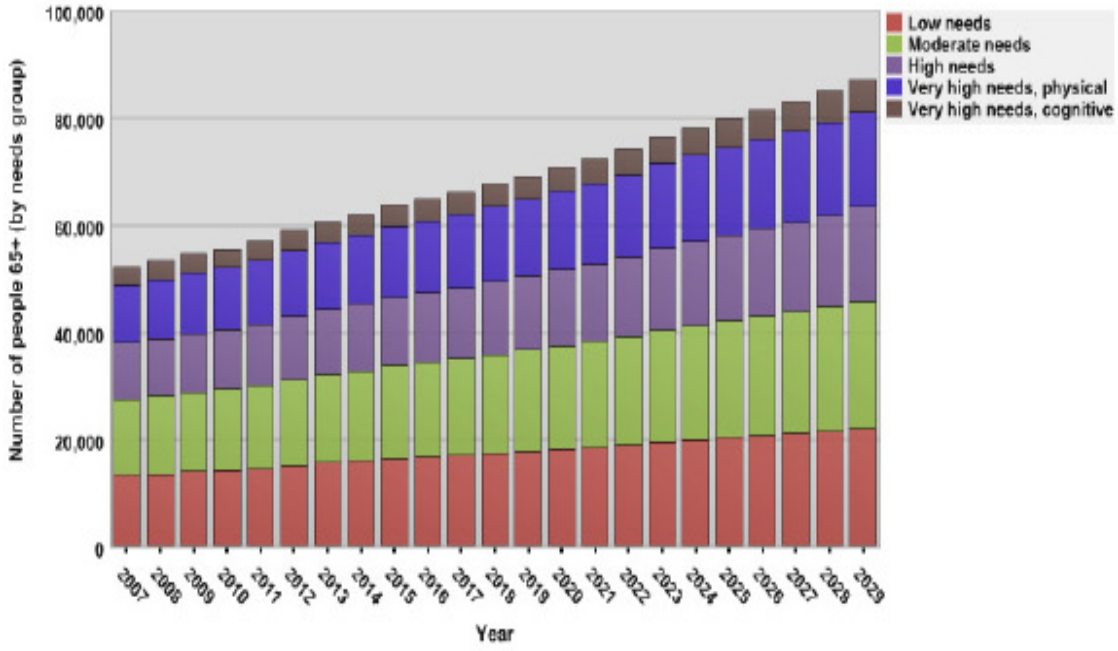
- **Very High Needs, Physical**: people for whom need for support is due primarily to physical impairment;

- **Very High Needs, Cognitive**: people for whom need for support is due primarily (or equally) to cognitive impairment (e.g. people showing symptoms consistent with a diagnosis of dementia).

The projected population of people with different levels of need in Derbyshire from 2007 to 2025 (see Appendix 3, table 13c for detailed figures) is summarised in the diagram below, illustrating a growth of between 51 and 58% across the range of levels of need.

[17] Wanless Social Care Review: securing good care for older people; taking a long-term view, 2006

Diagram: Projected People in the Wanless Levels of Care Group in Derbyshire 2007 - 2025



Appendix 9: Analysis of service pathways against the quality outcomes required by older people in Derbyshire

Commissioning targeted and personalised services is complex; there are numerous pathways that people might follow, dependent upon their needs and their current resources and support networks. Examples of clinical pathways include falls, strokes, dementia, depression, chronic obstructive pulmonary disease, heart failure, neurological conditions, back pain, diabetes, arthritis, as well as a host of smaller conditions which taken together could be classed as chronic multiple disabilities (such as hearing or visual impairment, foot problems, ulcers etc).

A New Ambition for Old Age; next steps in implementing the National Service Framework for Older People[18] set out ten programmes to improve the experience of older people within the health and social care system. Those ten programmes of activity were under three themes; dignity in care, joined up care, and healthy ageing.

Dignity in Care

Older people are more likely than younger people to become seriously ill and to face the prospect of dying. They and their families need to know that they will be treated with respect for their dignity if they become frail or ill and that they will receive good end of life care. It is important that care in all settings is geared to the needs of older people.

Joined up Care

A key principle in the care of frail older people is that of timely intervention through joined-up care. This involves early identification of problems and treatment to prevent a crisis and rapid response to a crisis when it occurs to quickly restore health, independence and well-being. Care systems are being strengthened for people with stroke, falls, dementia and with multiple conditions to improve prevention, treatment, rehabilitation and care. Good long-term conditions management is underpinned by a holistic assessment of need wherever and whenever older people come into contact with the care system.

Healthy Ageing

Most older people want to remain healthy and live independent lives for as long as possible. Health and well-being promotion activities from a broad range of organisations are needed to support older people, especially socially excluded groups, to enjoy active ageing.

The clinical pathways and the key themes within the New Ambition for Old Age document can accommodate both those people who may have been affected by a

[18] A New Ambition for Old Age; Next Steps in Implementing the National Service Framework for Older People (2006), A report from Professor Ian Philip, National Director for Older People, Department of Health

sudden deterioration or period of acute illness, and those people who are likely to have fluctuations in health over a long period which may involve a period of acute illness. For the former there is potential to regain some level of skill through rehabilitation, for the latter there is likely to be a gradual reduction in capacity over an extended period

Although different conditions have diverse effects on the people who live with them, common features are that there are potentially a high number of professionals and agencies likely to be involved, and service provision is likely to be specialised and interdependent. Individuals' needs change over time; requiring tailored and timely services. As well as being commissioned by primary health and social care colleagues on behalf of the individual, such services are increasingly likely to be secured through Direct Payments/individual budgets, or from individuals' own resources.

This Commissioning Strategy clarifies the service pathways and standards expected, no matter who the commissioning agent, so that the individual has a consistent experience.

Underpinning a good quality experience throughout the different pathways is:

i. Access to information and preventative services to promote well-being

ii. Access to timely information to enable effective diagnosis, and choice and control over treatments, care and support in the most appropriate settings

iii. Co-ordination of general and specialist services to support an individual to design, review and redesign their service pathway and to ensure, on behalf of commissioners, that each provider contributes to the overall service according to their contracted role

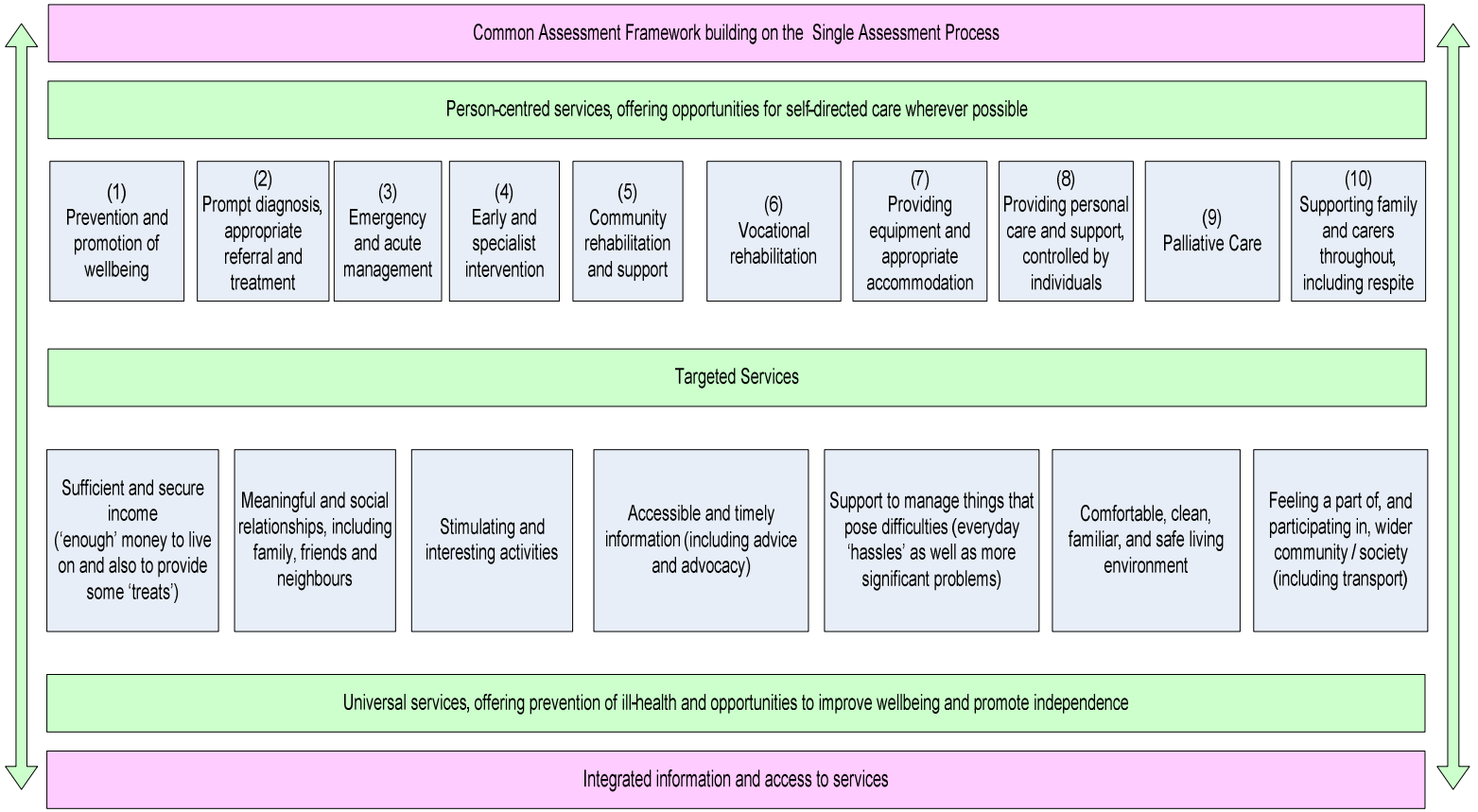
iv. Access to technological developments to support independent living

v. Inclusion of carers in assessment and care planning support to achieve outcomes important to service users/patients

Services to prevent ill-health and promote ageing well are usually universally available, or may be targeted at specific groups of the community. Services to support people who have acute or long term conditions are usually individually tailored, with use of appropriately targeted services. Targeted services can overlap both preventative and tailored services, as shown in Diagram 4 on page 12.

Diagram 5 sets out generic 'steps' that an individual should expect to travel on their care pathway journey. Not all individuals will travel all 10 steps, and not all will be experienced in the same order. The priority placed on each of the different steps will vary according to the needs of individuals and their families. Appendix 2 provides a detailed example of the quality standards that should be in place to meet the ten steps within a generic care pathway. The pathway is divided into four inter-related parts: initial contact and diagnosis; access to emergency and acute support, access to community rehabilitation and support and ongoing personal care and support.

Diagram 5: Ten Generic Steps to support a good quality experience for individuals within Derbyshire Care Pathways:



Appendix 9: Consultation

A workshop[19] to explore how the current assessment and service provision in Derbyshire fits the ten generic steps needed to achieve the quality care pathway revealed the following points for consideration:

1. Set realistic expectations for service users/patients by improving professionals (including discharge teams in acute hospitals) understanding of each others' roles and eligibility criteria to access services

2. Work across agencies, including GPs, to support individuals by developing a shared 'First Contact' signposting service across primary health and social care

3. Develop preventative screening and early access to preventative services to maintain health and independence

4. Develop shared community rehabilitation and support teams using a mix of multi-disciplinary or inter-disciplinary teams

5. Consider models of providing joint packages of personal care and support, including exploring the possible role of 'brokers' to support individuals to access appropriate services across the range of agencies

6. Develop advocacy services to support older people throughout the pathway where appropriate.

These six points are built into the commissioning intentions in Chapter Six of the Strategy.

In addition consultation in terms of the content of the Strategy took place with a cross section of older people. A wide range of voluntary agencies; members of the 50+ forum; district councils, housing agencies; members of the Derbyshire BME forums; and GPs and their staff were invited to send in their comments via a short survey. Community based commissioners and other provider social and health care staff as well as Derbyshire Mental Health Trust and Hospital Trusts were asked for their comments via a workshop and group discussions.

[19] Joint Commissioning for Older People Strategy: Care Pathway Workshop; 29th August 2007