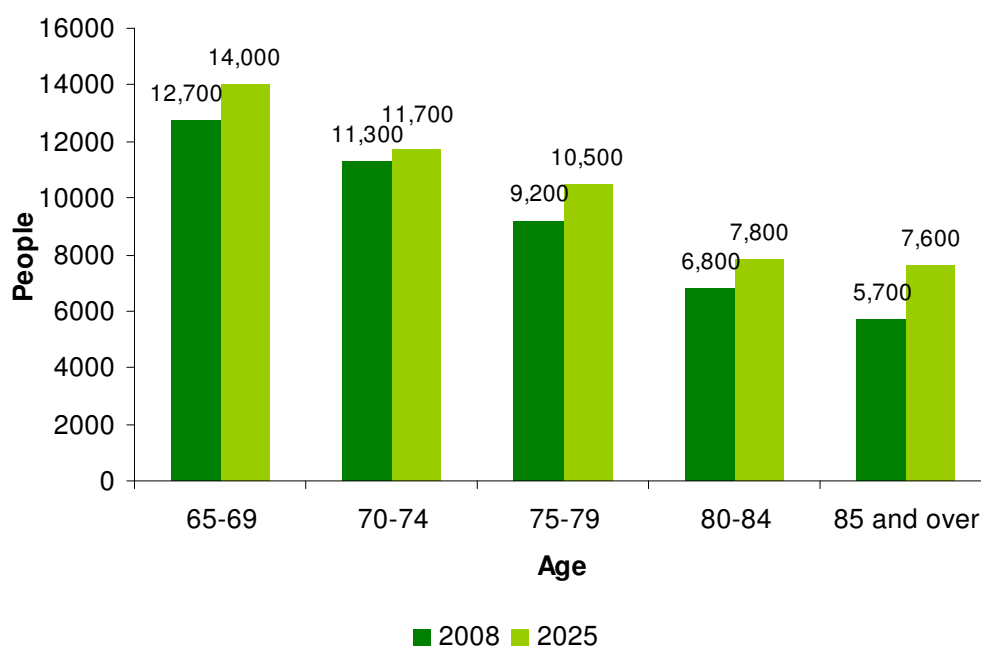


## 5 Supporting Independence

### 5.1 Older people

Sandwell's population is not aging as fast as England. This is primarily due to the lower life expectancy experienced by our population. Over the next 17 years the population aged over 65 (described as older people) is expected to grow by 13%, from 45,700 in 2008 to 51,600 by 2025 (Figure 5:1). In the same period across England the growth will be 37%.

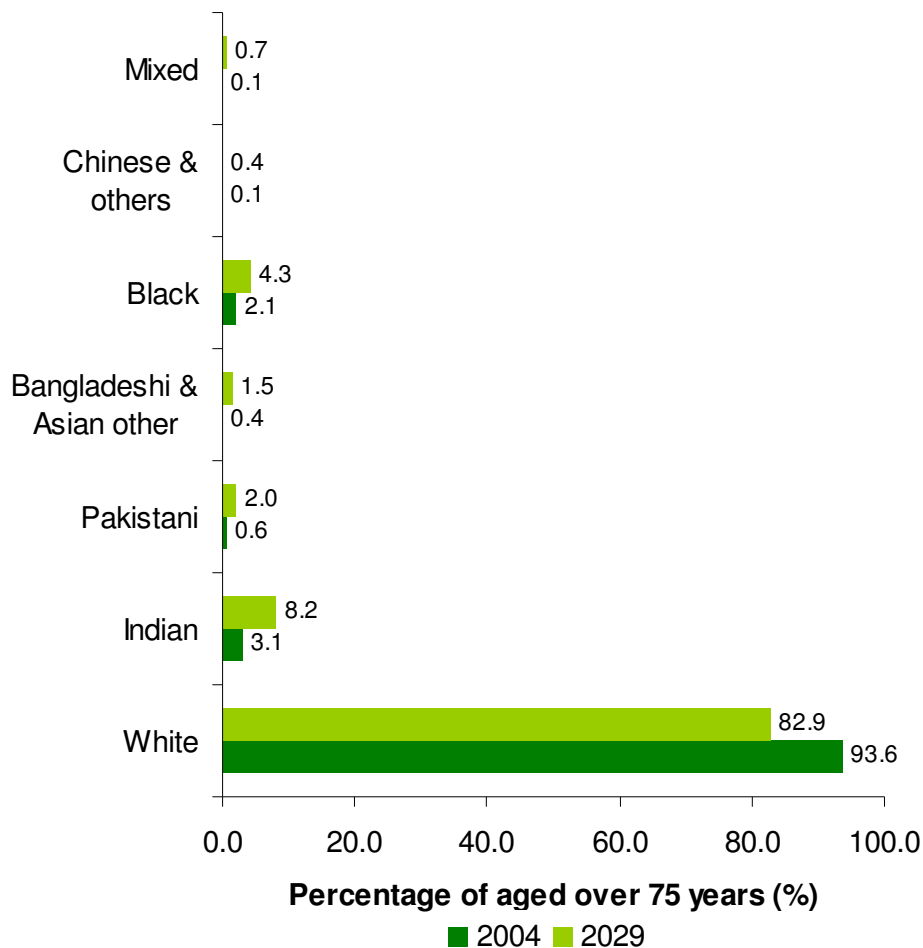
**Figure 5:1 Growth in older people in Sandwell, 2008 to 2025**



Source: POPPI, 2008

Much of the growth in those aged 75 and over is in the ethnic minorities, especially Black and Indian populations (Figure 5:2).

**Figure 5:2 Projected ethnic population of those aged 75 and over in Sandwell, 2004 compared to 2029**



Source: Ecotech HDAM model

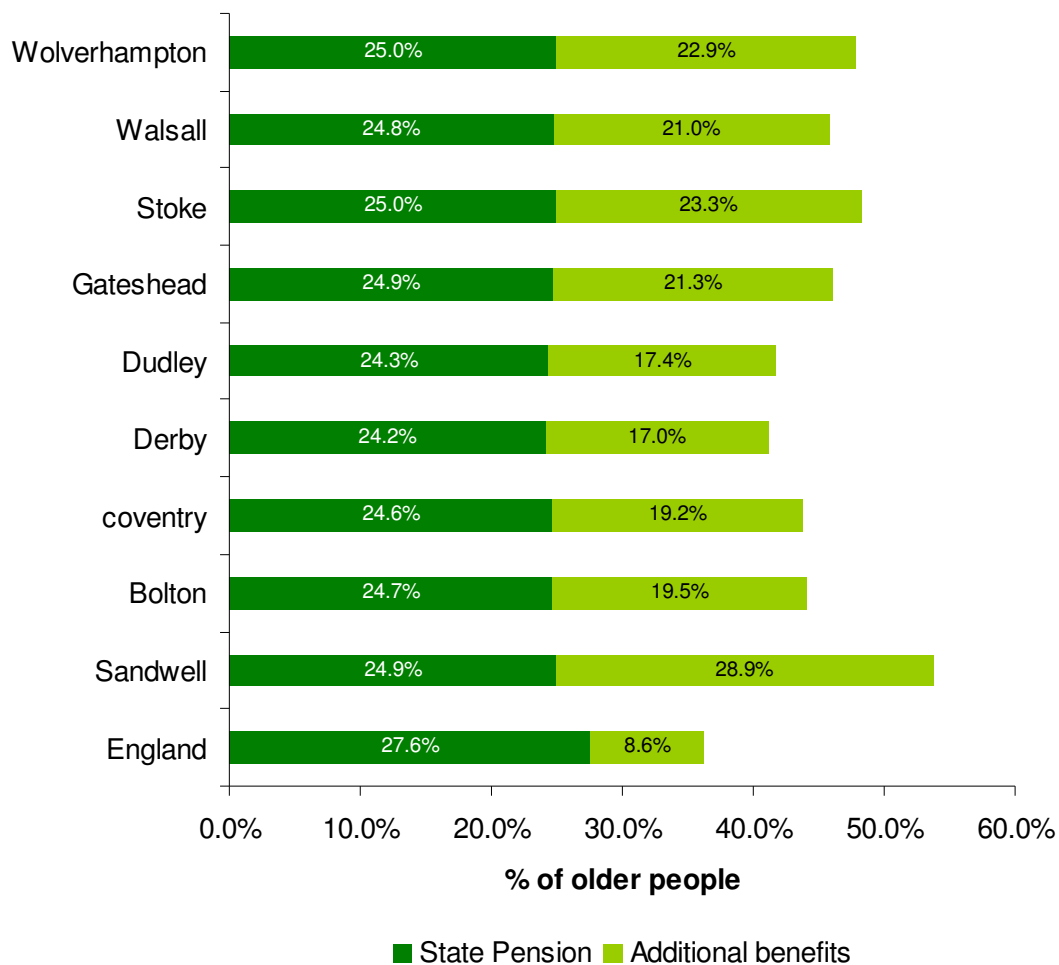
Much of the data in this section comes from a tool called POPPI<sup>5</sup> (Projecting Older People Population Information) that has been designed to give councils access to existing forecasts of the numbers and characteristics of older people in their locality.

<sup>5</sup> <http://www.poppi.org.uk/>

### 5.1.1 Income

More than one in two (53.8%) Pensioners in Sandwell are dependent on state benefits (Pension, Incapacity, carer, income related, disability, and bereavement). This is nearly 50% higher than England and is higher than all our comparator areas (Figure 5:3).

**Figure 5:3 Pensioners in receipt of state pension and other benefits, May 2007**

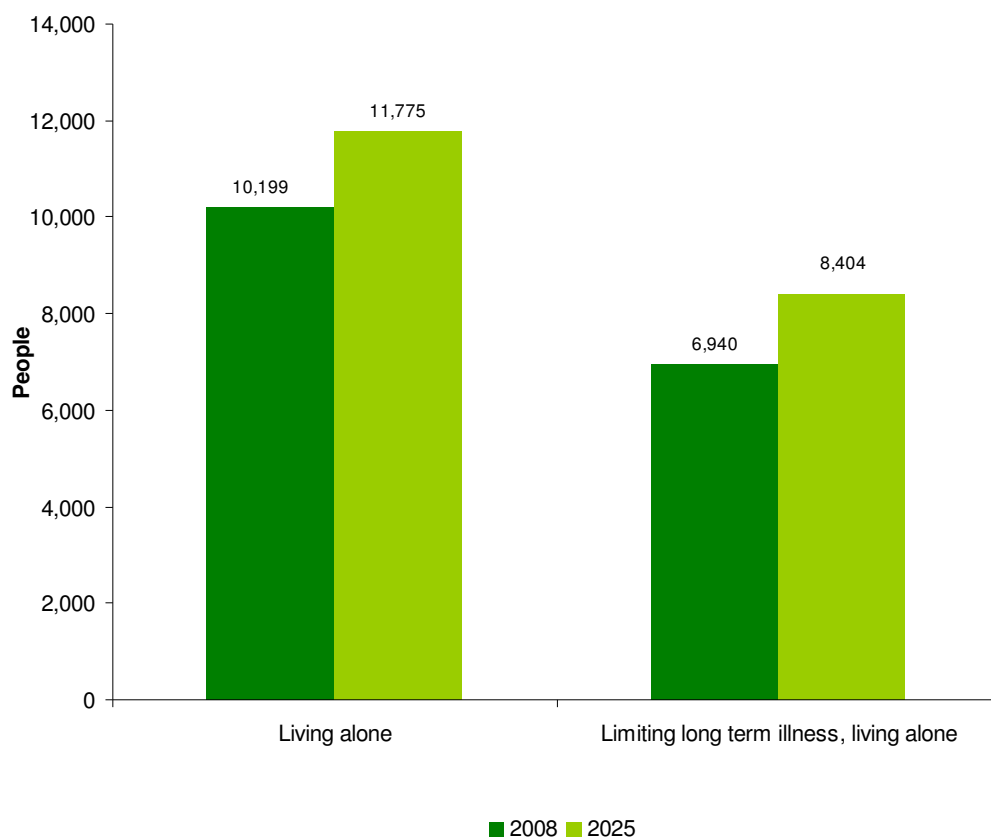


Source: POPPI, 2008

### 5.1.2 Living alone

There are 10,199 older people aged 75 and over living alone in Sandwell. This number is going to grow by 1,600 over the next 17 years (Figure 5:4). There will be a slight increase in the percentage of those living alone who have a limiting long term illness, up from 68% of households to 71% in 2025. However, this will be 20% growth in the number of people living alone with a limiting long term illness.

**Figure 5:4 People living alone in Sandwell, 2008 to 2025**

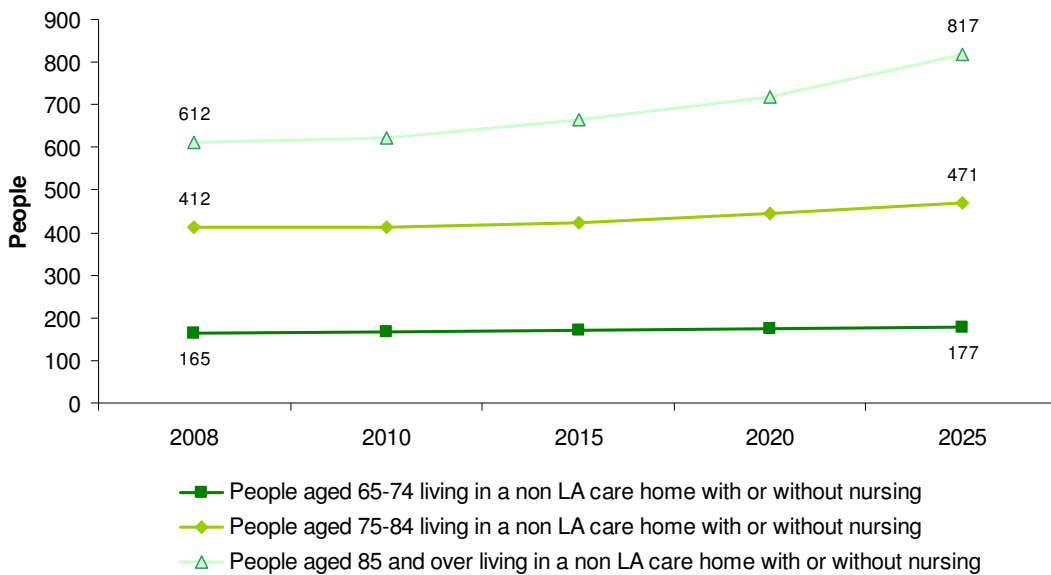


Source: POPPI, 2008

### 5.1.3 Living in homes

1,400 people live in care homes. Most of these are aged 85 and over, around 1 in 10 of those aged over 85 which is lower than England's 1 in 6. By 2025 the number of older people in care homes is predicted to grow by about 250, with greatest increase being in those aged 85 and over (Figure 5:5). This assume current housing provision and does not take into consideration the provision of extra-care type accommodation.

**Figure 5:5 People living in care homes in Sandwell, 2008 to 2025**



Source: POPPI, 2008

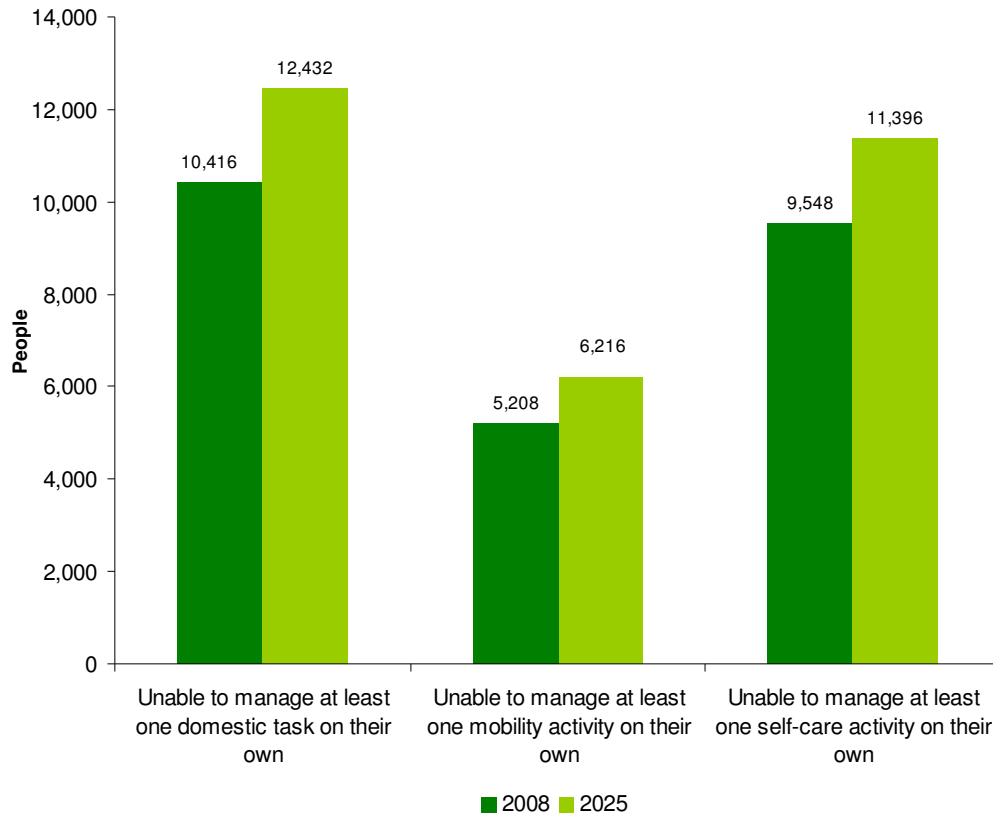
## 5.2 Ability to look after themselves

It has been estimated that:

- 10,416 people aged over 65 are unable to do at least one of these **Domestic** tasks alone: includes household shopping, wash and dry dishes, clean windows inside, jobs involving climbing, use a vacuum cleaner to clean floors, wash clothing by hand, open screw tops, deal with personal affairs.
- 9,548 people aged over 65 are unable to do at least one of these **Self care** tasks alone: includes bathe, shower or wash all over, dress and undress, wash their face and hands, feed, cut their toenails.
- 5,208 people aged over 65 are unable to do at least one of these **Mobility** tasks alone: includes going out of doors and walking down the road; getting up and down stairs; getting around the house on the level; getting to the toilet; getting in and out of bed.

By 2025 it is estimated that these will have increased considerably; especially for those having problems with domestic tasks, rising by 2,000 older people by 2025 (Figure 5:6).

**Figure 5:6 People with at least one Domestic, Self-care or Mobility problem in Sandwell, 2008 to 2025**

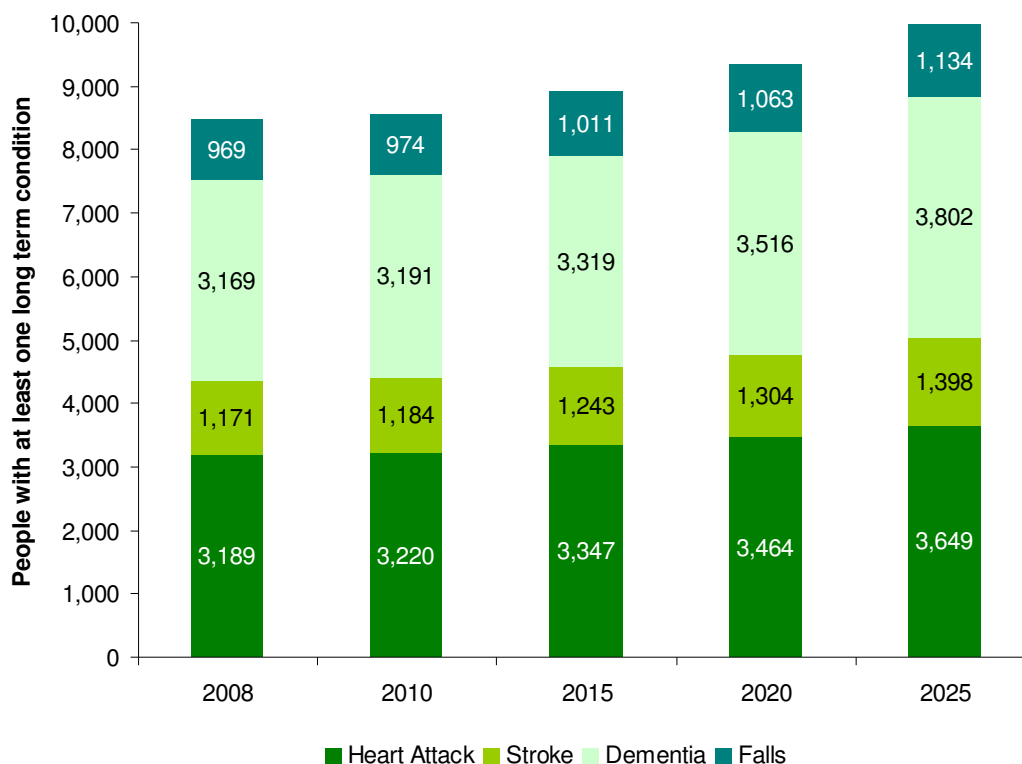


Source: POPPI, 2008

### 5.3 Long-term illnesses

Data on those with long-term illnesses is weak, especially for older people. The QOF data mentioned in the Improving Health section is broken down by neither age nor sex. Data from the POPPI system provides some insight into those with a long-term illness (Figure 5:7). This estimates that there are 3,169 people with dementia in Sandwell; however there are only 1,374 on GP registers prompting questions about the accuracy of the estimate and of diagnosis in health service.

**Figure 5:7 People with at least one long-term condition living in Sandwell, 2008 to 2025**



Source: POPPI, 2008

## 5.4 People who use our services

Adult and Community services in Sandwell look after 11,021 clients (April 2008)(Table 5:1). On the whole Adult and Community Services have seen an increase in the number of clients using their services apart from 2007-08 where there was a slight decrease.

**Table 5:1 Clients receiving services from Adult and Community Services in Sandwell, by age, 2003/4 to 2007/8, April 2008**

Client Type	2003-4		2004-5		2005-6		2006-7		2007-8	
	18-64	65+	18-64	65+	18-64	65+	18-64	65+	18-64	65+
<b>Physical Disability with Sensory Impairment</b>	627	4,936	971	5430	1129	6,355	1,467	7,388	1,495	7,442
Physical disability, and/or temporary illness	532	4,699	886	5,218	987	6,037	1,389	7,128	1,431	7,223
Hearing impairment	64	109	56	103	70	145	40	110	33	93
Visual Impairment	30	125	29	105	68	165	35	143	28	116
Dual Sensory loss	1	3	0	4	0	8	3	7	3	10
<b>Mental Health</b>	345	514	698	584	691	619	748	570	627	545
<b>Vulnerable People</b>	70	166	50	296	68	492	27	417	32	103
<b>Learning Disability</b>	546	47	585	70	508	61	611	57	679	91
<b>Substance Misuse</b>	7	6	11	5	4	6	0	2	3	4
<b>Total by age</b>	,1595	5,669	2,315	6,385	2,371	7,533	2,853	8,434	2,836	8,185
<b>Overall Total</b>		7,264		8,700		10,003		11,287		11,021

Source: Adult and Community Services, Sandwell MBC, 2008

The majority of these are looked after in the community (84.1%) (Table 5:2).

**Table 5:2 Clients receiving services in the community in Sandwell, Feb 2008**

Age group	Client Group	Gender		
		Men (%)	Women (%)	Total (%)
18-64	Learning Disability	78.9	84.4	81.3
	Mental Health	91.1	97.0	94.0
	Physical Disability & Sensory Impairment	96.3	98.2	97.4
	Substance Misuse	100.0		100.0
		90.0	95.2	92.7
Aged 65 & over	Learning Disability	57.5	58.1	57.8
	Mental Health	56.1	51.1	52.4
	Physical Disability & Sensory Impairment	86.3	82.5	83.6
	Substance Misuse	0.0	100.0	66.7
		83.9	80.0	81.2
All ages	Learning Disability	76.9	81.1	78.8
	Mental Health	79.9	71.1	74.6
	Physical Disability & Sensory Impairment	88.4	84.6	85.8
	Substance Misuse	66.7	100.0	80.0
All ages		86.0	83.1	84.1

Source: Adult and Community Services, Sandwell MBC, 2008

When community based services are broken down into its constituent services, it can be seen that Adult and Community Services provides an increasingly high number of people with equipment/adaptations (Table 5:3). In contrast, nationally local authorities place greater emphasis on homecare services. There will be an element of double counting because service users may have used more than one service throughout the year.

**Table 5:3 The number of clients receiving a service throughout the year, 2003/4 to 2007/8**

	Year				
	2003/4	2004/5	2005/6	2006/7	2007/8
Home Care	3,542	3,257	3,121	3,160	3,221
Day Care	2,052	1,855	1,622	1,490	1,228
Meals	1,372	1,297	1,214	990	855
Overnight Respite	474	354	372	482	N/A
Short Term Residential	137	85	83	53	164
DP	134	131	194	225	386
Professional Support	107	557	909	1,117	1,085
Equipment	804	2,497	3,976	5,367	5,403
Other	12	0	102	133	55

Source: Adult and Community Services, Sandwell MBC, 2008

Across Sandwell fewer people describe themselves as a carer, 86.6% of the population of England provide care compared to 89.2% of Sandwell (Table 5:4). However, for those who report their health to be 'Not good' there are more carers in Sandwell (5.3% to 3.7%).

**Table 5:4 Self reported health and providing care, Sandwell and England, 2001**

		Sandwell		England
		People	%	%
Good Health	Provides no care	162,117	91.7	89.8
	1 to 19 hours	9,911	5.6	6.9
	20 to 49 hours	2,026	1.1	1.1
	50 or more hours	2,803	1.6	2.1
		176,857	100.0	100.0
Fairly Good Health	Provides no care	60,268	84.3	91.8
	1 to 19 hours	6,026	8.4	6.1
	20 to 49 hours	1,787	2.5	0.8
	50 or more hours	3,369	4.7	1.3
		71,450	100.0	100.0
Not Good Health	Provides no care	28,549	86.9	85.0
	1 to 19 hours	1,893	5.8	9.5
	20 to 49 hours	672	2.0	1.8
	50 or more hours	1,741	5.3	3.7
		32,855	100.0	100.0
All people	Provides no care	250,934	89.2	86.6
	1 to 19 hours	17,830	6.3	6.7
	20 to 49 hours	4,485	1.6	1.8
	50 or more hours	7,913	2.8	4.9
All people		281,162	100.0	100.0

Source: Census 2001, CAS0025

The proportion of carers receiving a 'carers break' or other specific carers service, or advice or information following a carer's assessment or review in Sandwell is half that of England (10.3% to 20.7%) (Table 5:5).

**Table 5:5 Carers receiving a 'carers break', Sandwell and Peer group 2006/7**

	Number of carers receiving a 'carers break'	Adults aged 18+ receiving community-based services	%
England	315,092	1,525,648	20.7
West Midlands	28,920	150,185	19.3
Bolton	1,929	8,952	21.5
Coventry	1,006	5,970	16.9
Derby	710	9,112	7.8
Gateshead	1,177	6,558	17.9
Stoke-on-Trent	634	7,196	8.8
Dudley	2,009	11,427	17.6
Walsall	742	6,480	11.5
Wolverhampton	1,619	6,980	23.2
Sandwell	986	9,611	10.3

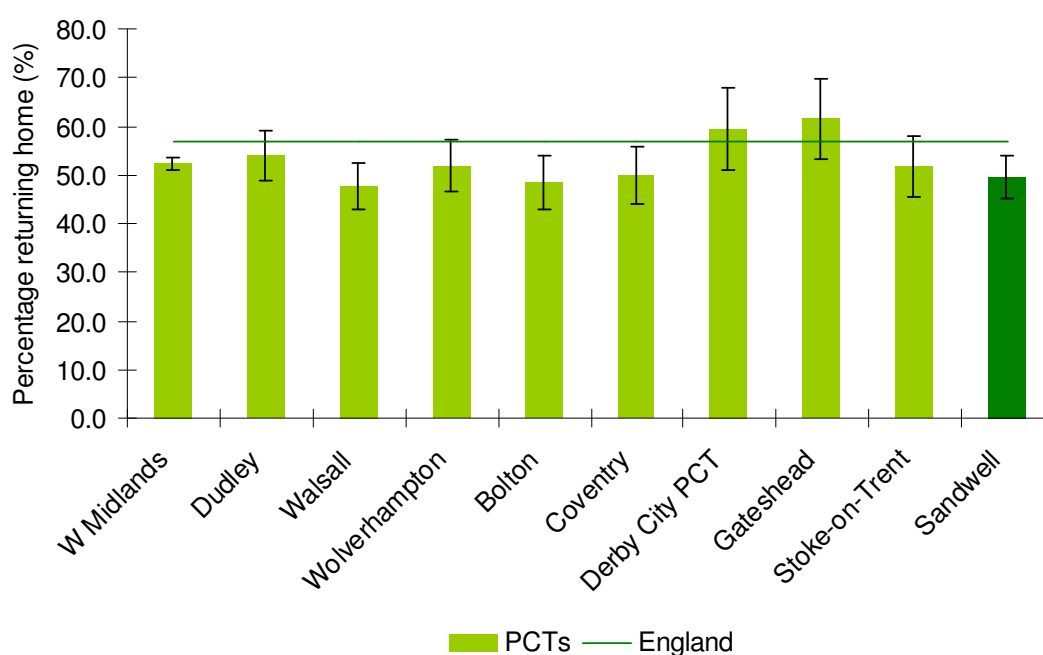
**Table 5:6 People receiving direct payments throughout the year split by age, 2006/7 Sandwell and Peer group, Rate per 100,000**

	Aged 18-64	Aged over 65	Aged over 18
England	99	217	123
West Midlands	101	229	128
Bolton	122	180	133
Coventry	138	604	229
Derby	130	326	171
Gateshead	68	89	73
Stoke-on-Trent	104	141	111
Dudley	84	123	92
Walsall	65	170	88
Wolverhampton	78	256	116
Sandwell	80	186	103

## 5.5 Returning home from Hospital

One possible measure of the ability of our patients to live independently is whether after discharge from hospital they are able to return home rather than are admitted into a nursing or residential care. Significantly fewer patients who have had a stroke return home in Sandwell than they do nationally, 49.6% compared to 56.7% (Figure 5:8). Compared to similar PCTs Sandwell's performance is in the bottom half, as three of the eight have similar percentages, whereas 4 achieve levels similar to England (the confidence intervals crossing the England line).

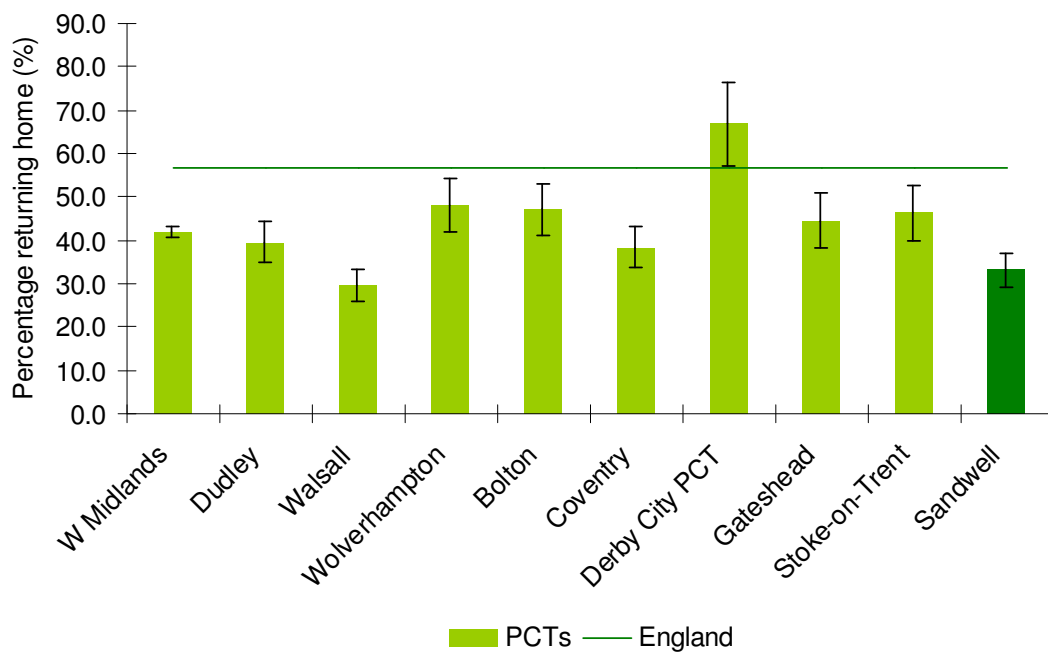
**Figure 5:8 Patients returning home after treatment for a stroke, 2005-6**



Source: NCHOD, 2007

For those treated for a fractured hip (proximal femur) Sandwell's performance is far worse. Only 1 in 3 patients return home compared to more than one in two nationally. Sandwell is next to bottom when compared to the other PCTs (Figure 5:9).

**Figure 5:9 Patients returning home after treatment for a fractured hip, 2005-6**

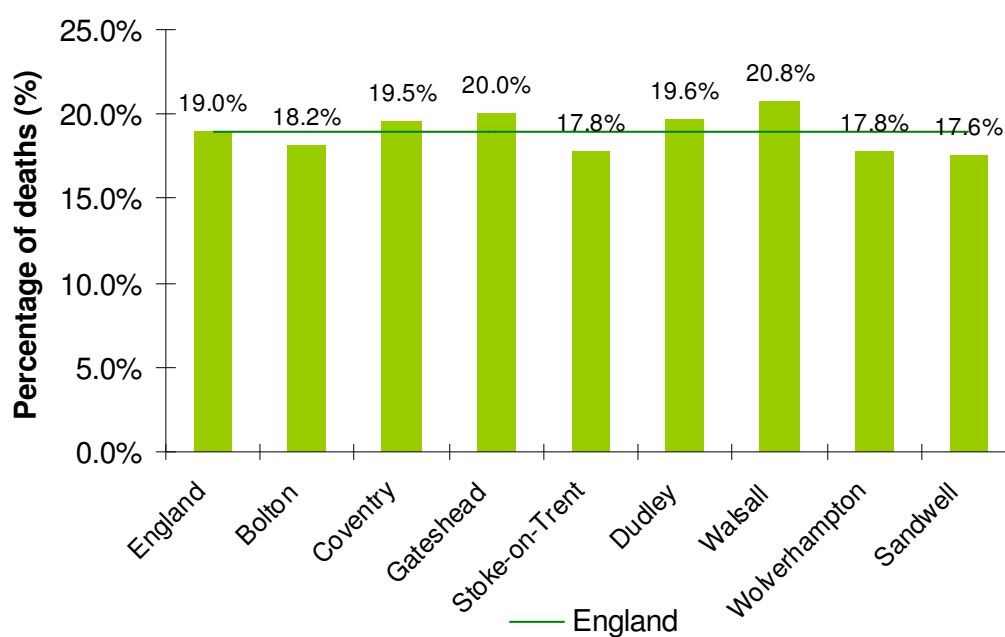


Source: NCHOD, 2007

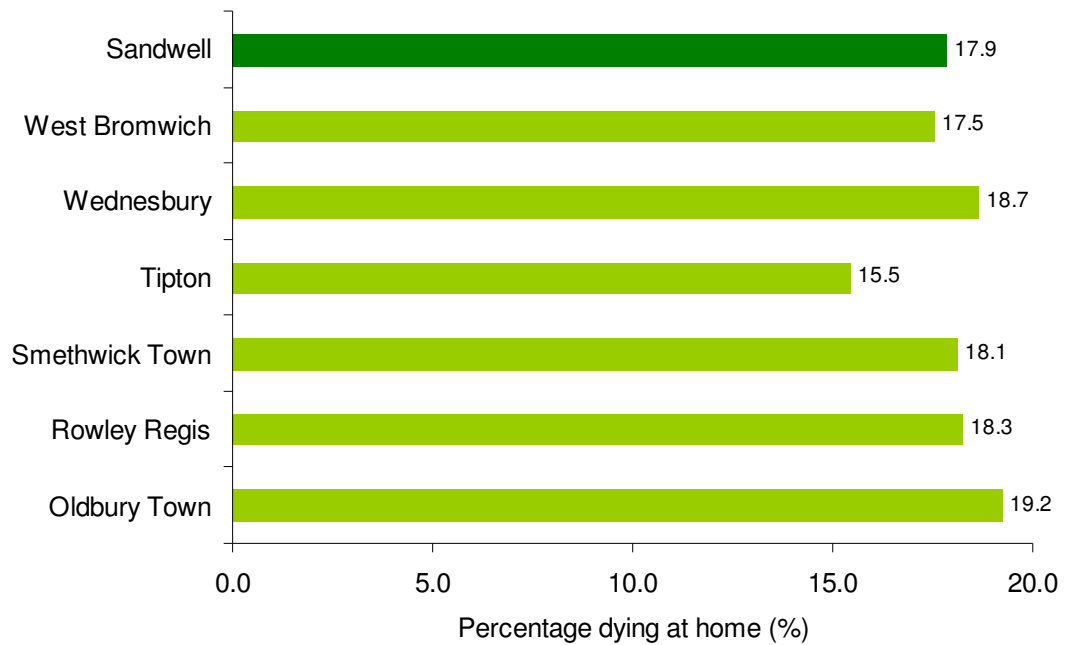
## 5.6 Dying at home

It is important that at the end of life a patient is given a choice of where they wish to die. There is a major mismatch between people's preferences for where they should die and their actual place of death. Across England less than one in five people who have a condition that could be managed at home die at home and for Sandwell it is even lower at 17.6% (Figure 5:11). There are substantial differences across the towns with only 15.5% in Tipton dying at home compared to 19.2% in Oldbury (Figure 5:11).

**Figure 5:10 Deaths occurring at home by Local Authority District, 2002-06**



**Figure 5:11 People dying at home, across Sandwell and the 6 Towns, 2002-2007**



Source: ONS and Sandwell PCT – Public Health

## **5.7 What are we doing to address the challenges we face**

### **5.7.1 Modernisation programme**

Adult and Community services is changing the way it will provide social care to clients, with the emphasis placed on enabling people to do things for themselves with support. This is essential because the current model could not cope with an aging population being referred in the main to residential/nursing homes. Therefore the following services will be set up:

Intermediate care (STAR service) A support service (up to a maximum of 6 weeks) that focuses primarily upon short-term assessment and re-ablement to promote rapid improvement in independence and function which is delivered to people in their own homes. This will help clients avoid admissions/re-admissions to hospital, residential or nursing care, Increase in the number of people supported to live at home, Improve quality of life and well being and Improve support for older carers and carers of older people.

Fast Response Provides support to people in a crisis in their own homes or wherever they live in the community This will help clients avoid admissions/re-admissions to hospital, residential or nursing care, Increase in the number of people supported to live at home, Improve quality of life and well being.

OPMH (older people's mental health) service Provide support which focuses on the long term care and support for older people, including people with mental health problems. This will be delivered in the clients home and it's primary aims are to prevent hospital admission due either mental health condition or social care needs

The model will also address issues around demographic changes and a prime example of this would be dementia, where additional extra care housing units are being built to cope with the extra demand.

### **5.7.2 Commissioning strategies**

Commissioning strategies have been developed around the different client groups and in conjunction with health, to reflect demographic changes. The approach to all these strategies is to align them towards the 2010 model, which changes the way we provide social care to people. There will be greater emphasis on partnership agencies working together to develop Local Area Agreements, which will make the best possible use of available resources and demonstrate value for money.

### 5.7.3 LAA Targets

NI 142	Number of vulnerable people who are supported to maintain independent living (core indicator)
NI 124	People with a long-term condition supported to be independent and in control of their condition
NI 130	Social care clients receiving Self Directed Support (Direct Payments and Individual Budgets)
Local Stretch	Older people helped to live at home per 1000 pop. Aged 65 or over (existing stretch indicator)
Local Stretch	Households receiving intensive home care per 1000 pop. Aged 65 or over (existing stretch indicator)
Local Stretch	No. of people aged 65 and over admitted permanently to nursing or residential home care (existing stretch indicator)

### 5.7.4 Key strategies and reports

#### Joint Commissioning Strategy for Health and Well-Being in Later Life 2007 - 2010

Strategies, Priorities or Key recommendations:

Joint commissioning key shared areas [P6]:

- Wellbeing and prevention.
- Integrated and person-centred care.
- Care closer to home.

Shared outcomes to enable older people: [P8]

- To stay healthy.
- To stay safe and independent.
- To have lifelong enjoyment and learning.
- To be equal, active and involved citizens.
- To maintain economic well-being.

Shared values to [P8]:

- Listen to the voice of the community.
- Value the rich diversity that is present in Sandwell.
- Build effective partnership outcomes.

- Be accountable.
- Support and develop a confident, competent and effective workforce.

Actions:

- Establish Joint Commissioning Strategy team in 2007 [P10].
- New Later Life Commissioning Team (LLCT) to agree framework for monitoring and evaluation [P11].

## **Adult Mental Health Joint Commissioning Strategy 2007 - 2010**

Strategies, Priorities or Key recommendations:

Key desired outcomes [P10] :

- To improve physical health.
- To provide home-based care as the norm.
- To provide services that are local and easily accessible.
- To manage the flow between services effectively.
- To meet the needs of diverse individuals and communities.
- To provide choice at all service levels.
- To support economic well-being and employment opportunities.
- To provide quality education and information.
- To enable individuals to exercise independence and control.
- To value the involvement and contribution of people with mental health problems.
- Maintain personal dignity and respect.
- Support freedom from discrimination and harassment.
- Deliver value for money.

Performance indicators targets and outcomes [p22 – 26], summarised as:

- Assertive outreach services.
- Intensive support in the home.
- Quick diagnosis of the first onset of a psychotic disorder.
- Prompt follow-up after discharge.
- National 20% reduction in mortality from suicides.
- Monitor the reduction of health inequalities related to ethnic diversity.

- Improved health and emotional well being.
- Improved quality of life.
- Increased choice and control.
- Freedom from discrimination and harassment.
- Maintaining personal dignity and respect.
- Commissioning.

## **Older People Mental Health Joint Commissioning Strategy 2007 – 2010**

Strategies, Priorities or Key recommendations:

Purpose and scope is to provide a service that is [P6]:

- Flexible around need.
- Has equality of access irrespective of age and location.
- Is measurable and evaluated.
- Has established communication channels and integrated ways of working.
- Has care co-ordination and management that follows assessment.
- The service will be founded on three parts [P7]:
  - i. Older people community mental health teams (OPCMHT).
  - ii. Acute Liaison Function (ALF).
  - iii. In-reach function.

Performance, targets and outcomes [P15], Current activity suggests the need for:

- The development of varied services in keeping with disease severity.
- Carer support.
- The development of a preventative program.
- Budget setting subject to age-weight inflator.

Strategic Model/Vision:

- Phase 1 – Older People Mental Health teams [P21]:
- Three teams across Sandwell. A full description of the service is on pages 8 to 12 of the OPMH Strategy.
- Phase 2 – Acute Liaison Function [P21]:

- To promote education and to provide supporting assessment and intervention.
- Phase 3 – In reach-function [P22]:
- Purpose is to provide domiciliary support, and an educational and advisory service.

Key recommendation [P40]:

- Commit to the model by using option three of phased approach (all options described on P39)

## **Learning Disability Services Joint Commissioning Strategy 2007 - 2010**

Strategies, Priorities or Key recommendations:

Key areas in scope [P5]:

- Adults with a learning disability.
- Valuing People.
- Parents with a learning disability.
- Complex care management.
- Forensic services.
- Carers.
- Employment and skills.
- Housing and Accommodation.
- Culture and leisure.
- Autistic Spectrum Disorders.

Shared Values [P7]:

- To listen to the voice of the community.
- To value the rich diversity that is present in Sandwell.
- To build effective partnership outcomes.
- To be accountable.
- To support and develop a confident, competent and effective workforce.

Shared outcomes – to deliver services that [P8]:

- Are flexible, responsive and proactive.
- Promote equality.

- Are of a consistently high standard and quality.
- Promote and enhance independence, health, well being and choice.
- Provide appropriate and convenient alternatives to hospital care.
- Provide care and support close to home.
- Are community focussed.
- Enable people to stay in their own homes.
- Provide value for money.

Strategic objectives of the modernisation strategy [P9]:

- Promote person centred support and pursue independent living.
- To work in partnership with people with learning disabilities and their families.
- Support people with learning disabilities to participate and make a full contribution.
- Promote, facilitate and support access to universal services at all times.
- Provide support close to home and in the community.
- Develop integrated support pathways.
- Release secondary care skills and capacity.
- Ensure that commissioning and design of services are cultural, age, ethnicity and gender sensitive.
- Commission and deliver services and support that will address current inequalities.
- Ensure that specialist services are used effectively and efficiently.
- Ensure that we promote a comprehensive service for all.

## **Supporting Carers in Sandwell Strategic Plan 2007 – 2010**

Strategies, Priorities or Key recommendations:

Aim [P5]:

- To help organisations involved in community care and community development to promote and address the health, well-being and independence of carers in Sandwell.
- 

Objectives [P5]:

- Raise the profile of carers.
- Create a broad strategic framework for developing carer support.

- maximise the impact of finite resources in health and social care, gaining added value for carers wherever possible.
- Make a positive difference to carers' lives

#### Underpinning themes of strategy [P16-17]:

- Greater control and choice.
- Emphasis on prevention.
- Outcomes-based approach.
- Developing partnerships.
- Addressing Diversity.

#### Priority Themes [P24]:

- Identification and recognition.
- Provision of accurate and accessible information.
- Time-off for carers.
- Emotional support.
- Training and skills to care and life-long learning.
- Financial security.
- A voice for carers during service provision.
- Quality services.
- Equity of access and culturally and age appropriate support.
- Preparing for emergencies.

### **Physical and Sensory Impairment Strategy 2007 - 2010**

#### Strategies, Priorities or Key recommendations:

##### Philosophy of the service [P7]:

- To provide a responsive quality service that supports and empowers people to have maximum choice and control over how they live their lives and influence future services to ensure equality of opportunity.

##### Specific Agreed Outcomes [P7]:

- To establish a PDSI stakeholder group.
- To establish current and future needs of people with PDSI.
- To provide specific accessible information in appropriate formats around PDSI.

- To provide the most accessible services possible for people with PDSI.
- To raise awareness with agencies, providers and the general public around meeting the day-to-day needs of people with a disability or sensory impairment.
- To provide a seamless service and ensure partnership between agencies.

Priority outcomes [P21]:

- To increase the support, care and protection for people with a physical or sensory impairment.
- To provide information and enable customers to make service choices.
- Support the Towards 2010 programme.
- Review physical disabilities and sensory impairment services to achieve better integration of services.

## **Cultural Services Division Business Plan 2006 – 10, Sandwell MBC**

Strategies, Priorities or Key recommendations:

Aims [P47-61]:

1. Use cultural activities to improve the quality of life for all Sandwell people.
2. Use cultural opportunities to support formal and informal lifelong learning.
3. Use culture to celebrate the diversity of Sandwell's communities, ensure inclusive participation and promote community cohesion.
4. Use culture to improve the health and well-being of Sandwell citizens.
5. Use culture to support the economic vitality of Sandwell, including maximising the visitor potential of residents and tourists.

### **5.8 What do we need to know?**

- We know very little about how patients receive services from both health and social care. Each service knows a great deal about its own activities but little about the other services a patient receives. There is guidance from the Care Services Efficiency Delivery programme on a structured approach to delivering better outcomes that highlights seven areas where information could improve the delivery of services.

- Need to have a data matching exercise to ensure that all services are aware of the people who are in need of services from Health or Council or both.
- Need more information on the choices that the population wants from services and how they want them delivered.

## **5.9 Recommendations**

1. To build better stronger relationships between the information departments to deliver:
  - a. Data linkage, under the governance of a shared information sharing protocol
  - b. A Health Needs Assessment is undertaken for those aged over 75 to fully explore what it means to be a older person in Sandwell and that services are commissioned that reflect the findings of this work.