Manchester's Partnership for Older People Projects

Context Mapping the Situation of Older People for the Manchester Partnership for Older People Projects

By
Judith Sixsmith and Christina Purcell

Context Mapping the Situation of Older People for the Manchester Partnerships for Older People Project

July 2007

Research Institute for Health & Social Change
Manchester Metropolitan University

Judith Sixsmith and Christina Purcell

RIHSC: Research Institute for Health & Social Change

Published by: RIHSC: Research Institute for Health and Social Change

RIHSC Research Reports and Occasional Papers

Published occasionally by the RIHSC: Research Institute for Health and Social Change

For information contact the publishers at the address below

ISSN 1750-1571

ISBN 978-1-900139-18-2

Printed by the Manchester Metropolitan University

RIHSC: Research Institute for Health and Social Change:

RIHSC is a centre of international excellence and innovation in critical research and consultancy on social change, social inclusion, community participation, well-being, work and leisure, health and social care practices and policies, and the clinical biomedical, behavioural and forensic sciences.

RIHSC: Research Institute for Health and Social Change
Manchester Metropolitan University
Elizabeth Gaskell Campus
Hathersage Road
Manchester
M13 0JA

Tel: 0161 247 2563 / 2774
Fax: 0161 247 6842

Email: c.kagan@mmu.ac.uk

TABLE OF CONTENTS

Appendices

1. List of voluntary organisations schemes funded through POPP
2. Map 1: Percentage aged 60-74 in each Output Area
3. Map 2: Percentage aged 75 and over in each Output Area
4. Map 3: Percentage of Lone Pensioners by Output Area
6. Perceptions of Quality of Life: The Case of East Manchester
5. Glossary of ONS terminology

LIST OF TABLES

LIST OF FIGURES

1. Introduction

This report informs the Manchester's Partnership for Older People Project (POPP) and particularly the evaluation of this project. As a baseline study, its purpose is to outline key characteristics of older people's lives in Manchester in relation to the objectives of the POPP pilot project. As such, this report covers:

1. The context of ageing in the UK in order to provide an outline of key ageing population trends relevant to POPP. An overview of national policy background is presented as background to both Manchester's local strategy regarding its older residents, and the development of the POPP pilot scheme.

2. The demographic context of Manchester's older population in terms of population, geography and household characteristics, household tenure, and well as ethnic and religious affiliations.

3. The socio-economic context experienced by older people in Manchester with reference to indicators of economic and social deprivation.

4. The health environment, focusing on hospital admissions and discharges, help to remain in the home, falls, and hospital admissions, and the older people's mental health.

5. The personal and social care environment in relation to social care outcomes of improved perceived health and well-being, quality of life, choice and control, positive contributions to society and opportunities to volunteer, financial well-being, freedom from harassment and discrimination, and dignity and respect. These social care outcomes underpin POPP objectives.

6. Perceptions of everyday life in Manchester, looking at responses of Manchester's over 55 population to the Best Value Survey, providing an indication of the way in which this age group feels about their neighborhoods, leisure services and crime.

The structure of this report reflects the key objectives of the Manchester POPP pilot project, however, it is recognised that some important characteristics of older people's lives, where they fall outside of project objectives, are not covered. Given the complexity of unpacking the various dimensions of health, well-being and quality of life of older people, the different sections of this report should be read as mutually interconnected.

As much of the data presented here has been selected with reference to POPP performance indicators and social care outcome measures, it predates April 2006, i.e. before the start of the Manchester POPP pilot project. Key sources of data held within this report are:

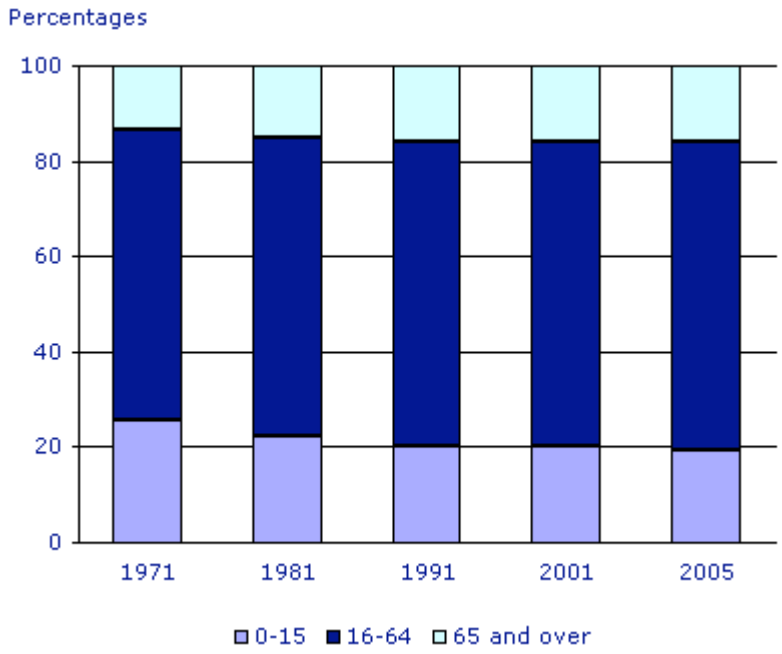
- The latest available Census data is used in this report, which where available is the 2005 ONS Mid-Year Population Estimates. However some data presented is based on the 2001 Census count, due to this being the only available secondary source data on specific topics relevant to the report. Use of 2005 ONS Mid-Year Population Estimates is clearly indicated in the text. Data from the Office of National Statistics is available from the National Statistics website: www.statistics.gov.uk. Crown copyright material is reproduced with the permission of the Controller of HMSO.
- Audit Commission, 2006, Corporate Performance Assessment;
- Commission for Social Care Inspection;
- English Longitudinal Study of Ageing;
- Joint Health Unit, Manchester City Council;
- Manchester City Council;
- Manchester Public Health Annual Report;
- The Information Centre for Heath and Social Care:

1.1 The Context of Ageing in the UK

Growing evidence across Europe, and specifically in the UK, indicates a

rapidly ageing population. In mid-2005, 16% of the UK population's 60.2 million were aged 65 or over. As can be seen in the figure below, this change in age structure has not occurred equally across age groups.

Figure 1: UK population by age



Source: Office of National Statistics[1]

While the proportion of the population aged 65 and over has increased since 1971 (from 13% to 16%), the proportion of young people has decreased. There have been even larger increases in the over 85 population in this period: from 7% to 12% from mid-1971 to mid-2005. Indeed, the number of people aged 85 and over grew by 64,000 (6 per cent) in the year to 2005 to reach a record 1.2 million. This reflects improved health and survival rates as well as the post World War One baby boomers who are now reaching this age group. Population ageing is set to continue as these baby boomers grow older. This is projected to rise to 27.2 million in 2031, with greater proportional increases in those at the older end of the age scale (the over 85's represent 5.5% of the older population, set to increase to 7.9% in 2031)[2].

Many older people lead active and healthy lives for many years over the age of 50. The modern blurring of lifecycle stages means that older people are as

[1] Office for National Statistics, 2003, Focus on Older people.
[2] Ibid.

varied as any other group, living independent lives and participating in society. In particular, employment rates for people in their fifties have risen in the past decade, they constitute the age group most likely to be providing unpaid care and use of technology amongst older people as a whole is growing. While statistics indicate that car use does decline with age and varies by gender with fewer older women having car access compared to men (64% and 77% respectively[3]), use of communication technologies has increased. Indeed, in 2002 figures show that 30% of men and 20% of women over 80 years claimed to own a mobile phone while 1 in 10 men and 1 in 20 women accessed the Internet[4]. Car access and enhanced modes of communication have all been linked to improved quality of life and make it easier for older people to participate in the social and civic life of their communities. Yet, for the very old, there may be barriers (eg financial, health, transport) which prevent participation in a wide variety of activities.

In terms of health and well-being, women live longer than men in the UK (this was 75.9 years for men at birth and 80.5 years for women in 2002), yet women tend to report more years in poor health. 2001 census data shows that two thirds of men and three quarters of women aged 85 and over were living with a long term illness or disability (LLTI) that restricted their daily activity. Despite this, many older people with LLTI consider themselves to be healthy and to enjoy good health. However, inequalities in health are evident with those living in more socially disadvantaged circumstances being more likely to report a LLTI and perceive their health to be poor.

Many older people in the UK today live in single households (women than men: 60% of women over 75 compared to 29 of men). The proportion of people aged 65 and over living in communal establishments declined slightly between the 1991 and 2001 census, from 5.1% in 1991 to 4.5% in 2001. The reduction in the proportion living in communal establishments was particularly marked for the 74-85 age group from 23.4% in 1991 to 20.1% in 2001. Women over 65 years of age are more likely than men of the same age group to be living in communals establishments, 5.9% of women over 65 compared

[3] English Longitudinal Study of Ageing, 2002.
[4] Ibid.

with 2.7% of men, often the result of changing family structures and bereavement. Since the majority of older people do continue to live in the community well into old age – nearly three quarters of people aged 90 and over were living in private households at the time of the 2001 census[5] - community care is a major source of social care for older people. Family members supply most of the social care provided to older people in the community,[6] and many of these were older people themselves – 2.8 million people in the UK provide unpaid care, 1.6 million of whom were women.[7]

ONS data suggest that there has been a significant increase during the last two decades in home care purchased or provided by councils in England, rising from 2.2 million hours of help in 1994 to 3.2 million in 2004. However, since the number of households receiving services has declined, the increase is due to councils providing more intensive services to fewer households.[8]

Projections for the future costs of long-term care for older people look increasingly ominous with UK spending projected to rise by around 315% in real terms between 2000 and 2051 (representing 1.4% of GDP in 2000 to 1.8% in 2051) to meet demographic shifts and encompass rises in care costs. Critically, the public share of total long term care costs is projected at 60% under current arrangements in 2051 but would rise to 80% for 2051 under a policy of free personal care[9].

1.2 The Policy Background to the Partnerships for Older People Projects

Government health and social care policy for older people has for some time centred on improving possibilities for independent living, recognising the cost implications of a growing demand for local health and adult social care services. Traditionally, the push towards independent living has targeted those in greatest need. More recently, this has evolved to take into account the situations of people living within community settings by identifying "low-

[5] Office for National Statistics, 2003, Focus on Older People.
[6] In 2001, 78% of all older people who reported suffering from mobility problems were helped by their spouse or other household member. Office for National Statistics, 2003, Focus on Older People.
[7] Office for National Statistics, 2003, Focus on Older People.
[8] Office for National Statistics, 2003, Focus on Older People.
[9] www.jrf.org.uk/knowledge/findngs/socialcare/944.asp

level" need that enables older people to remain in their communities for longer. "Low-level" supportive services such as a handyperson, house maintenance, housework and gardening services were identified by Clark, Dyer and Horwood (1998) as crucial components to quality of life and well-being in later life, as was social engagement[10]. Such services were seen as a means to prevent or delay the need for intensive and more expensive care.

These ideas were promoted to some extent in the 1998 White Paper "Modernising Social Services"[11], resulting in the establishment of 'prevention grants' to Local Authorities in order to support strategies promoting the quality of life of older citizens and prevent or delay dependency. The subsequent adoption by Local Authorities of preventative policies was the subject of an evaluative study by Lewis et al (1999). The study concluded that *"the value of investing in prevention needs to be judged not only by quantifiable reductions in expenditure on other services, but also in improvements in quality of life and independent living, as perceived by older people themselves and service professionals"* and that *"preventive approaches need to draw upon a range of organisations, professionals, communities and older people".*[12] In addition, and beyond the reduction of hospital admission and institutionalisation, improved quality of life in general has become an important goal of preventative measures.

This approach to prevention informs both the Local Strategic Partnership's promotion of well-being and the ex-Office of the Deputy Prime Minister's agenda for sustainable communities and neighbourhoods[13] as well as the Home Office proposals for community cohesion[14]. This has resulted in the promotion of partnership working between agencies in order to deliver better health and social care outcomes for older people, flowing from the interdependencies lodged within current understandings of preventative care.

[10] Clark H., Dyer S., Horwood J. (1998), That Little Bit of Help: The high value of low level preventative services for older people. The Policy Press.
[11] Department of Health (1998), Modernising Social Services.
[12] Lewis, H., Wistow, G., Abbott, S. & Cotterill, L. (1999) 'Continuing health care: the local development of policies and eligibility criteria', Health and Social Care in the Community, vol. 7, no. 6, pp. 455-63.
[13] See http://www.communities.gov.uk/index.asp?id=1139865
[14] See http://www.homeoffice.gov.uk/documents/cons-strength-in-diverse-170904/

The Better Government for Older People (BGOP) programme[15] has set the stage for formal engagement between older people and Local Authorities/Local Strategic Partnerships to enable older people to voice their concerns and needs as partners in decision-making. This emphasises the legitimate right of older people to have a say in decisions that affect them as well as a moral duty to help construct and maintain their communities[16]. Making a Difference, the Better Government for Older People Evaluation Report, highlighted the way in which BGOP pilots employed a range of approaches to consultation and engagement with older people to inform service delivery[17]. Initiatives such as Older People's Forums can create a space for networking around the creation of an agenda for improving the lives of older people whilst Partnership Boards can link networks with Local Strategic Partnerships. Such structures are intended to feed into the planning and delivery of preventative services for older people, but are seen as useful only when the involvement of older people is both meaningful, well supported and seen to be effective[18].

In 2001, the Department of Health issued a "National Service Framework for Older People"[19] which contained national standards for the health and social care of older people in England. Recognising the implications of a rapidly expanding ageing population for demand on local health and adult social care services, the Framework highlighted the need to increase the proportion of older people receiving support to maintain a high quality of life independently at home rather than in placement in residential care, and to reduce delayed discharge from acute hospitals. Issues of age discrimination, preventing older people from accessing treatment and services, were also identified as major impediments to equitable provision of care, as was the need to improve

[15] Better Government for Older People, First Year Report: Making it Happen, August 1999.
[16] Carter, T. and Beresford, P. (2000) Age and Change: Models of involvement for Older people. YPS for the Joseph Rowntree foundation.
[17] Making a Difference, The Better Government for Older People Evaluation Report highlighted the way in which BGOP pilots employed a range of approaches to consulatation and engagement with older people to inform service delivery.
[18] Reed, J., Cook, G., Bolter, V. and Douglas, B. (2006) Older People 'getting Things Done' Report for the Joseph Rowntree Foundation.
[19] The Framework can be downloaded here http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003066

specialist services for age-related health conditions and care needs, such as stroke and falls.

The Social Exclusion Unit has also been critically involved in developing policy for older people, identifying the relationships between social exclusion and age; in terms of exclusion from social relationships, service provision and material consumption. Exclusion from service provision and material consumption have been particularly highlighted as a problem for the population aged 80 and over. As a result, the Social Exclusion Unit has pinpointed both service provisions to meet the needs of those experiencing social exclusion and prevention of exclusion as important priorities for the well-being of the older population[20].

In response to this, the Social Exclusion Unit has recently developed a framework for tackling inequalities for older people by applying the Sure Start model to older people's services[21], building on the knowledge that adults facing severe or multiple disadvantages tend to be less likely to access services and, when they do, they are less likely to gain from them[22]. A multi-dimensional approach to service delivery via a single accessible gateway was promoted as a model to improve participation and prevention with reference to the following underlying principles:

Services for all which are;

- Joined up
- Flexible
- Accessible
- Co-located
- Community driven
- Working with older people
- Capacity building

[20] A Sure Start to Later Life: Ending Inequalities for Older People, A Social Exclusion Unit Final Report, Office of the Deputy Prime Minister, 2006.
[21] A Sure Start to Later Life: Ending Inequalities for Older People, A Social Exclusion Unit Final Report, office of the Deputy Prime Minister, 2006.
[22] Breaking the Cycle, Social Exclusion Unit, 2004.

More recent Government policy centres on reducing inequalities and improving the planning, commissioning and delivery of health and care services for older people, with the intention of improving outcomes for older people's health, independence and well-being,[23] as well as making financial gains by reducing the overall demand for hospital and long-term care services. Cost reduction and cost effectiveness within health and social care has been heralded in The Wanless Report (2006)[24] as a way forward for Local Authorities, whereby reorganized quality services matching local need should be based on strong evidence of improved outcomes for older people.

A number of papers have been released which set this agenda for social change, moving away from specific provision of services towards an outcome oriented perspective which puts older peoples health, quality of life and independence at centre stage. Amongst these, 'Opportunity Age' presents the Government's strategy for an ageing society which: seeks to end the perception of older people as dependent; ensure that longer life is healthy and fulfilling; and that older people are full participants in society. First published in 2005, 'Opportunity Age'[25] was coordinated and led by the DWP Secretary of State (in his role as Champion for Older People), with the Deputy Prime Minister as chair of the Cabinet Sub-Committee on Ageing Policy. The strategy focuses on three key areas:

1. Work and income – to achieve higher employment rates overall and greater flexibility for over 50s in continuing careers, managing any health conditions and combining work with family (and other) commitments.
2. Active ageing – to enable older people to play a full and active role in society placing older people more at the centre of active communities.
3. Services – that promote independence and control over our lives as we grow older, even if constrained by health problems

[23] Social Care Green Paper, Independence, Well-being and Choice: Our Vision for the Futher of Adult Social Card in England, Department of Health, 2005;Our Health, Our Care, Our Say: Making It Happen, Department of Health, 2006.
[24] Wanless, D. (2006) Securing Good Care for Older people: Taking a Long-Term View.
[25] Opportunity Age: Meeting the challenges of ageing in the 21st century, March 2005.

occurring in old age.

Furthermore, the recent Department of Health document*, A New Ambition for Old Age Next Steps in Implementing the National Service Framework for Older People*[26], sets out the priorities of the second phase of the National Service Framework for Older People. These priorities fall under ten activities: Dignity in Care; Dignity at the End of Life; Stroke Services; Falls and Bone Health; Mental Health in Old Age; Complex Needs; Urgent Care; Care Records; Healthy Ageing; Independence, Well-being and Choice.[27] These programmes have supported agencies such as the Care Services Improvement Partnership (CSIP) which seeks improvement in a wide range of services, including older people's services. Specific targets are set by the Public Service Agreement (PSA) which establishes national priorities for the NHS and social care. The Commission for Social Care Inspection and the Audit Commission carry out regular inspections of adult social care services in order to identify areas for improvement.

The priorities and objectives of the Partnerships for Older People's Project are securely situated within this national policy framework in which strategies for promoting intervention, independence, well-being, choice and control drive the programme, furthermore, a strong evaluation framework (located at both national and local levels) will demonstrate health and social care outcomes for older people as well as the cost effectiveness of services reconfigured around prevention.

1.3 POPP – Partnerships for Older Peoples Project

The Partnership for Older People's Project is a 3 year (2005-2008) national programme set up by the Department of Health. The first year was devoted to developing the programme and inviting applications from local partnerships to take part in pilot projects while years two and three have seen the setting up and current evaluation of the pilot projects (19 commissioned in round 1 and 10 in round 2). In keeping with the evolution of policy described above, the

[26] A New Ambition for Old Age Next Steps in Implementing the National Service Framework for Older People, Department of Health, 2006.
[27] A New Ambition for Old Age Next Steps in Implementing the National Service Framework for Older People, Department of Health, 2006.

aim of POPP is to improve the health, well-being and independence of older people, principally by shifting resources and cultures of service delivery towards prevention.

The POPP pilot projects are constituted by Local Authority led partnerships (including at least one PCT partner), underpinned by a variety of service delivery mechanisms such as pooled budgets, joint commissioning and Local Area Agreements. Interestingly, these pilots have been commissioned to enable a comparison of different partnership and service delivery models across very different geographical and economic areas including urban and rural populations facing varying levels of deprivation. At the core of POPP is a commitment to the involvement of older people, carers and service delivery frontline staff.

POPP aims to bring about improvement in the following areas:

- Provision of more low level care and support in the community to improve the health, well-being and independence of older people, preventing or delaying the need for higher intensity and more costly care;
- Reduction in avoidable, emergency admissions and/or bed-days for older people;
- Support for more older people to live at home or in supported housing such as sheltered or extra-care housing as opposed to long-term residential care.

Ultimately, projects funded by and evaluated under the POPP programme are intended to enable central and local government to identify a range of approaches which are effective and potentially replicable in different health and social care communities. The findings of POPP are intended to inform future policy development across the Department of Health and other areas.

Local evaluations feed into an overarching national evaluation. Whilst it is possible and important to capture early positive effects and trends, the Department of Health recognises that the nature of preventative interventions means that outcomes are likely to be realised over the longer term. The

Department of Health has outlined the following factors that need to be taken into account for evaluating projects:

- How effective are the partnership and financial mechanisms in ensuring sustained investment in prevention?
- Does prevention lead to "improved well-being"? How can this be measured?
- How effective is prevention in reducing/delaying the need for high cost health and social care services? Is it cost-effective?
- What are the key factors and hindrances that impact on continuation or mainstreaming of pilot projects?

1.4 The Manchester POPP

The Manchester POPP Partnership comprises Manchester City Council, Manchester PCT and the Manchester Mental Health and Social Care Trust, as well as the following voluntary organisations: Age Concern Manchester, Manchester Alliance for Community Care (MACC), Manchester Care and Repair, The Manchester Carer's Forum and the Manchester Race and Health Forum.

The Manchester POPP programme aims to "increase and support the ability of the health and social care system as a whole – including the voluntary and community sector – to provide services that prevent, or delay, older people needing more intensive services".[28] In line with the the purpose of the national POPP Programmes[29] to provide person-centred and integrated care for older people and to encourage investment in preventative approaches which promote health, well-being and independence for older people, the **outcomes** expected from the Manchester POPP Programme are to:

- Provide more low level care and support in the community to improve the health, well-being and independence of older; people, preventing or delaying the need for higher intensity and

[28] http://www.manchester.gov.uk/adultsocialcare/popp/background.htm
[29] POPP Prospectus for Grant Applications, Department of Health, 2005.

more costly care. Here, the seven social care outcomes[30] drive the delivery of the project;

- Reduce avoidable falls, emergency admissions and/or bed-days for older people;
- Support more older people to live at home or in supported housing such as sheltered or extra-care housing as opposed to in long-term residential care.

The Manchester scheme views the reduction of emergency or long term care as possible only within a framework of other health and social care policy measures, such as active case management, services in primary health care, intermediate care and other re-enablement services in both health and social care, and extra care housing schemes in the community. In addition, Manchester POPP pays particular attention to capacity building for better service provision to older people, especially those who are in the most vulnerable situations, within the voluntary and community sector.

1.5 Operationalisation of POPP in Manchester

One of the central aims is to make better use of resources in order to generate better preventative health and social care outcomes for older people. The following schemes have been established to meet this:

a) Gateway: to provide up-to-date information and easy access to a range of services for older people by establishing better coordination between early intervention and support services, including low level services provided by both the local authority and volunteer or community organisations. The aim is to turn a "patchwork" of services into a "network" and provide access to a rounded package of support and care which will meet older people's needs and also improve their quality of life.

The objectives of Gateway are to:

- Create a "virtual" one-stop shop for information and advice;
- Ensure the service is rooted in Manchester's diverse

[30] Our Health, Our Care, Our Say: Making It Happen, Department of Health, 2006.

neighbourhoods;

- Liaise with a network of support agencies within each locality;
- Promote existing and new services to older people, their carers, families and local professionals.

b) Business Improvement Service (BIS): This service aims to increase the capacity and sustainability of voluntary and community sector organisations delivering services to older people by helping groups develop their skills and expertise in management and infrastructure (with special focus on BME groups). The BIS works together with groups to carry out a business 'health check' and supports the groups by providing information, advice and consultation (internally or externally supplied) on feasibility, quality assurance, workforce development, monitoring, evaluation and so on. The service will foster partnerships to develop a diverse range of providers with specialist skills in delivering services to older people.

c) Schemes Investment Fund: This aspect of the POPP pilot aims to fill gaps in services by making investments and creating fresh approaches to preventative services, in particular, identifying those who have difficulty in accessing support from mainstream services (e.g. with special attention to 'hard to reach' groups). Priorities for investment are based on tackling social exclusion and are focused on:

- Locally-based advocacy and support services
- Building social networks
- Community-based falls prevention schemes
- Creation of volunteering and other opportunities for older people
- Targeted services for BME elders
- Older people with mental health problems

POPP programmes are nationally evaluated according to the following criteria, which also partly drive the local evaluation:

- Reduction of emergency and unplanned admissions of older

people to hospital;

- Reduction of admissions to long-term, residential or nursing home care;
- Reduction of the number of falls amongst older people;
- Assistance given to older people to carry on living as independent a life as possible in their own homes.

Within Manchester, the seven social care outcomes (as outlined in the new outcomes framework produced by the Commission for Social Care Inspection[31]) underpin the programme, ensuring a focus on the following psycho-social aspects of the service delivery:

- Health and emotional well-being;
- Quality of life;
- Choice and control;
- Positive contributions;
- Financial well-being;
- Freedom from harassment and discrimination and
- Dignity and respect.

This framework for implementing Manchester POPP has evolved from a process of policy development, through consultations with various relevant agencies that have informed the Manchester POPP bid to the Department of Health. This process of policy development has promoted the recognition of the various interconnected dimensions of older people's well-being which currently underpins Manchester's strategy for older people and the recognition of the cross-cutting nature of older people's service provision.

1.6 Manchester City Council's strategy for older people

[31] CSCI (2006) A New Outcomes Framework for Performance Assessment of Adult Social Care 2006-2007: Consultation Document.

One of the pledges of Manchester's Community Strategy 2006-2015 is for Manchester to be a "pioneering city of the Third Age that values, respects and meets the needs of older people". According to the 2006 *Corporate Performance Assessment*, Manchester City Council has developed a "good strategic approach to older people and ageing".[32] National strategies for older people have been translated into local action via the following local initiatives:

- Older People's Commissioning Strategy which identifies a need to replace existing accommodation-based and floating support and social care provision to support independence and reduce the number needing long term residential and nursing home care;
- Valuing Older People (VOP) Quality of Life Strategy which consulted on developing a quality of life strategy in 2004. The strategy is delivered through the VOP board which includes older people's representatives;
- Health Priorities and Strategies – Making the links which ensure that unwell and frail older people have their health and support needs addressed in an integrated way;
- Manchester BME Housing Strategy which looks specifically at the needs of BME older people and frail elderly.[33]

One of the main vehicles for developing local strategy is VOP, which is a cross-cutting priority for the council. VOP's activities are aimed at engaging with older people and gathering their views on priorities for action, drawing in older people as representatives in consultation over matters that affect them. In addition, VOP has been described as part of the regeneration agenda, promoting positive images of ageing and involvement in intergenerational projects within the council wide strategy of combating social exclusion.

The *Corporate Performance Assessment* was positive with regards to the way that issues concerning age are increasingly mainstreamed within Council

[32] Corporate Performance Assessment, Audit Commission, 2006.
[33] Quality from Strong Foundations, Supporting People Five-Year Strategy 2005-2010

actions.[34] Engagement with older people has had an impact on council priorities; there are a number of examples of older people's involvement in regeneration projects, and training planned for older persons to act as evaluators for funded schemes. This appears to have resulted in older people feeling more confident about their ability to influence council priorities and the corresponding responsiveness of the council to their needs. However, the most vulnerable members of the older population are on the whole absent from these developments.[35]

Older people within the Black and Minority Ethnic (BME) community have been identified as having specific concerns that need both to be researched and acted upon.[36] Some work in this area has already been undertaken. The Manchester Partnership has successfully piloted a service targeted at older, low income owner-occupiers from BME communities in the private sector and identified a specific demand for home services catering for BME communities. The BME older community has been involved in the process of the design and evaluation of services, and in particular involved in the process of tendering for BME-specific home care services.

The Council has also been promoting quality of life, independent living and well-being via community capacity enhancement, which has led to projects such as the Longsight and Moss Side Community project which works with South Asian older people and their carers.

The *Corporate Performance Assessment* identified three areas in which Manchester City Council needed to improve its strategy for older people: housing; lifelong learning; and transport.

[34] Corporate Performance Assessment, Audit Commission, 2006.
[35] Corporate Performance Assessment, Audit Commission, 2006.
[36] 2003-2006 Supporting People Shadow Strategy, Manchester City Council

2. Demographic characteristics of Manchester's older population

The ONS Mid-Year 2005 Population Estimates puts Manchester City's population at 441,184, of which 15.4% are aged over 60. Table 1 provides a breakdown of the over 60 population, according to age band (5 year gaps).

Table 1: Manchester's older population by age group

Age	Total Number	Men	Women
60-64	15,078	7,182	7,896
65-69	14,246	6,840	7,406
70-74	12,358	5,762	6,596
75-79	10,883	4,550	6,333
80-84	8,466	3,040	5,426
85-89	4,298	1,398	2,900
90+	2,454	628	1,826
Total 60+	67,783	29,400	38,383

Source: Manchester City Council. Data from Office for National Statistics 2005.Mid-Year Population Estimates © Crown Copyright 2005

The total number of people in Manchester aged 60 and over is 67,783 or 15.35% of the whole population. 41,682 people in Manchester are aged 60-74, whilst the 75 plus population numbers 26,101. Women make up 56.6% of the 60 plus population. There is an initial steady increase in the proportion of women in successive 5-yearly cohorts. For 75 plus cohorts the increase in the proportion of women is much sharper, reflecting a longer life expectancy of women in relation to men. This has implications for service delivery since national data shows that older women are more likely than older men to use health services more frequently, report poorer health in general[37] and to live in communal establishments[38]. However, future older population cohorts will be affected by increasing live expectancy of men.

[37] Office for National Statistics, November, 2005.

[38] Among women aged 65 and over, 5% live in communal establishments, compared with 2% of men. For the population aged 85 and over 21% of women live in communal establishments compared with 11% of men. (ONS, 2001 Census). A resident in a communal establishment is

The proportion of Manchester's residents aged 60 and over is lower than the proportion for England as a whole, and especially in relation to other larger English cities. According to Department of Work and Pension figures, the percentage of residents of pensionable age in Birmingham, Bristol, Leeds, Newcastle, Nottingham and Sheffield, ranges from 16.5% to nearly 19%, compared to Manchester's 15.3%,[39] a decline from 18.4% in the 1991 census. Manchester City Council's 2001 'Census Topic Paper: Census Atlas', explains this by reference, on the one hand, to Manchester's relatively high level of deprivation (as measured by the Index of Multiple Deprivation, 2004), with the lowest life expectancy in England, and on the other hand to the tendency of older residents to leave the city for surrounding greener areas[40], provided they have the financial means to do so. However this may not be the whole picture as migration statistics are complex and complicated by transient movements in and out of the City. For example, improvements in Healthy Life Expectancy (see Section 4.1 below) will be affected by cohort numbers (distorted perhaps by the Baby Boomer generation) and may also be partially explained by in-migration of healthier younger cohorts or improved health of younger cohorts.

Table 2 presents the estimated population projections for the over 60 population in Manchester over the coming decades. Contrary to the rest of England, Manchester will see an initial drop in this population before it begins to increase again in the middle of the next decade, although Manchester will experience a continuous increase in the population aged over 85. By 2028, the over 60s in Manchester are expected to reach over 75,000, with the 85 plus population numbering nearly 9,000. These projections have important implications for the management and delivery of care given the expected corresponding increase in conditions such as coronary heart disease, cancer, diabetes and mental illness, as well as an increase in Limiting Long Term Illness.[41]

---

defined as any person who has been, or intends to live in a medical or care establishment for six months or more, ONS, 2005.

[39] Manchester City Council, M12, Core City Trends

[40] 2001 Census Atlas for Manchester, Manchester City Council, p.18

[41] Long-term illness, health problem or disability which limited their daily activities or the work they could do, including problems due to old age.

Table 2: Resident population projections of over 60s, Mid-2004 to Mid-2028

(in thousands)

Age group	2004	2011	2016	2021	2028
60-64	15.4	17.4	16.1	18.2	20.4
65-69	14.6	13.3	15.3	14.2	16.1
70-74	12.6	12.1	11.5	13.4	12.5
75-79	11.1	9.7	9.8	9.6	11.2
80-84	8.9	7.6	7.3	7.7	7.7
85+	6.3	7.5	7.7	8.9	8.9

ONS population estimates are presented in thousands and have been rounded to the nearest hundred.
Source: Manchester City Council. Data from Office for National Statistics © Crown Copyright 2006

Table 3 shows the proportion of different age bands for each Manchester ward. Older age cohorts are concentrated in a number of wards on the edge of North Manchester, particularly in Charleston, Higher Blackley, Crumpsall and Moston. Some wards in Central and South Manchester also have high concentrations of older people, such as Fallowfield and Woodhouse Park. The Woodhouse Park ward has the highest proportion of the population aged over 75 (9.4%). Taking all wards in South Manchester into consideration, there is a slighter higher proportion of the over 75 population than for North Manchester and Central Manchester (6.7% for South Manchester, compared with 6.4% for North Manchester wards and 4.5% for Central Manchester), whilst North Manchester has the highest proportion of the 65-74 age group (6.7%, compared with 6.2% for South Manchester and 5.1% for Central Manchester). See Appendices 2 and 3 for geographical maps of the percentages of these age groups by Output Area indicating areas of concentration of older people across the city.

Table 3: Estimated Resident Population by Age Group, Ward Level Data, Mid-2005

Ward of residence	Total Population	Percentage of population aged:				
		Under 15	15-44	45-55	65-74	75+
North Manchester	**135,756**	**18.0%**	**49.0%**	**19.9%**	**6.7%**	**6.4%**
Ancoats and Clayton	12,042	20.6%	45.8.0%	19.9%	7.1%	6.5%
Bradford	12,315	20.7%	43.9%	22.3%	7.0%	6.1%
Charlestown	12,453	18.4%	41.8%	22.5%	8.6%	8.6%
Cheetham	15,548	23.6%	50.1%	16.6%	5.3%	4.3%
City Centre	7,704	2.3%	86.0%	8.0%	2.4%	1.4%
Crumpsall	14,475	17.7%	47.9%	19.2%	7.0%	8.2%
Harpurhey	16.141	19.6%	45.2%	21.7%	6.8%	6.7%
Higher Blackley	13,818	19.1%	41.2%	23.1%	8.1%	8.5%
Miles Platting and Newton Heath	16,265	19.3%	44.5%	22.1%	7.4%	6.7%
Moston	14,995	18.4%	43.6%	23.2%	7.4%	7.4%
Central Manchester	**154,396**	**16.9%**	**58.5%**	**15.0%**	**5.1%**	**4.5%**
Ardwick	14,088	16.9%	60.3%	14.1%	4.8%	3.9%
Chorlton	14,379	13.8%	61.1%	14.9%	4.7%	5.5%
Fallowfield	13,611	13.1%	62.1%	13.3%	5.8%	5.7%
Gorton North	15,837	20.9%	44.2%	20.7%	7.1%	7.1%
Gorton South	15.830	21.2%	47.7%	19.0%	6.2%	6.0%
Hulme	11,657	13.1%	70.1%	10.5%	3.8%	2.5%
Levenshulme	13,912	15.2%	58.7%	13.2%	4.3%	3.1%
Moss Side	14,964	19.2%	58.1%	14.2%	5.2%	3.3%
Rusholme	14,199	13.9%	68.0%	11.5%	3.6%	2.9%
Whalley Range	13,695	16.7%	56.2%	17.4%	5.3%	4.4%
South Manchester	**151,031**	**17.0%**	**52.3%**	**17.9%**	**6.2%**	**6.7%**
Baguley	13,967	20.1%	44.8%	21.6%	7.0%	6.5%
Brooklands	13,478	19.4%	45.6%	19.2%	7.5%	6.5%
Burnage	14,291	21.4%	46.3%	19.0%	6.9%	6.5%
Chorlton Park	13,092	16.4%	54.1%	17.3%	6.3%	6.0%
Didsbury East	14,177	16.0%	51.0%	20.3%	6.2%	6.6%
Didsbury West	13,102	9.1%	65.6%	13.9%	4.2%	7.2%
Northenden	13,767	19.7%	44.7%	20.9%	7.1%	7.5%
Old Moat	13,981	13.7%	62.4%	13.8%	5.1%	5.1%
Sharston	15,245	21.3%	47.3%	19.2%	6.1%	6.1%
Withington	12,404	9.3%	69.8%	12.1%	3.9%	4.8%
Woodhouse Park	13,527	20.3%	43.5%	19.3%	7.6%	9.4%
Manchester	**441,184**	**17.6%**	**52.7%**	**17.7%**	**6.0%**	**5.9%**

Source: Manchester City Council. Data from Office for National Statistics © Crown Copyright 2005

Nearly 42,000 households in Manchester have a Household Reference Person[42] of pensionable age. Of these households, 32% live in accommodation provided by the council. Pensioner households (i.e. households with at least one pensioner) make up 20.1% of all Manchester households, 14.7% of these are single pensioner households.

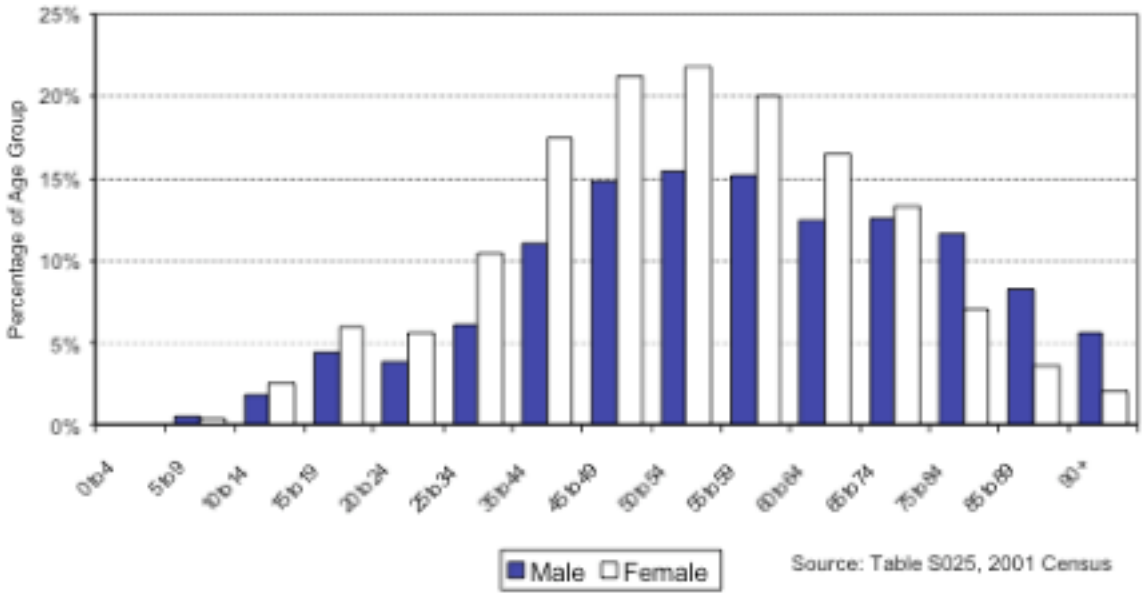
The highest concentrations of lone pensioner households occur in parts of Sharston ward[43] (reaching 70% in some Output Areas[44]). There are also high proportions of lone pensioner households parts of Baguley, Brooklands and Northenden.[45]

41% of all people aged 60 and over are living together in a married couple family, whilst for the population aged 75 and over, 49% are living alone. The last decade has seen a sharp increase in the percentage of lone male pensioners over 85: households containing lone males aged 85 and over rose by 49% between 1991 and 2001. Households containing lone females rose by 16%.[46]

Unpaid care has an impact on well-being.[47] Although the highest rates of unpaid care provision occur in the 45-59 age groups (see Figure 1), unpaid care is also an aspect of older age cohorts' lives. Whilst unpaid care declines progressively from the aged of 60 onwards, the gender make-up of carers changes. Up to the age of 74 it is women who are more likely to provide unpaid care. After age 75, this situation reverses, declining progressively with males more likely to provide unpaid care. The likelihood of a household containing a carer increases if that household contains a person with a Limiting Long-Term Illness (LLTI)[48].

[42] HRP - defined by ONS as either the sole occupier, person with highest income or in the case of equal incomes, the oldest person in a household.
[43] The 2001 Census A Profile of Older People in Manchester, Manchester City Council, 2003.
[44] Output area level - output area is the smallest area for which the Census data available and included average 125 households.
[45] 2001 Census Atlas for Manchester, Manchester City Council.
[46] The 2001 Census A Profile of Older People in Manchester, Manchester City Council, 2003.
[47] Caring about carers, a national strategy for carers, Department of Health, 1999.
[48] 2001 Census Topic Paper Health, Manchester City Council.

Figure 2: Unpaid care in households by age and gender



Source: ONS ©Crown Copyright 2001. Data is based on 2001 census count

2.1. Ethnicity

Manchester is an ethnically diverse city. However, the ethnic profile of Manchester's older population reflects the age structure of the different ethnic groups resident in Manchester (see Table 4). Manchester's population consists predominantly of White Ethnic Groups (81%). This varies according to age structure with significant increases for the over 65 age group, at nearly 93%. Conversely, 19% of the whole population of Manchester come from Ethnic Minority Groups, but this proportion decreases significantly for the over 65s.[49]

Pensioner household composition also varies considerably between the white majority and ethnic minority groups, whereby only 5.9% of all minority ethnic pensioners were living alone compared to 16.1% for all white groups (see Figure 2).

[49] Source: Manchester city council based on ONS 2004 Mid-Year Population Estimates (experimental data).

Table 4: Estimated resident aged 60/65+* population by ethnic group

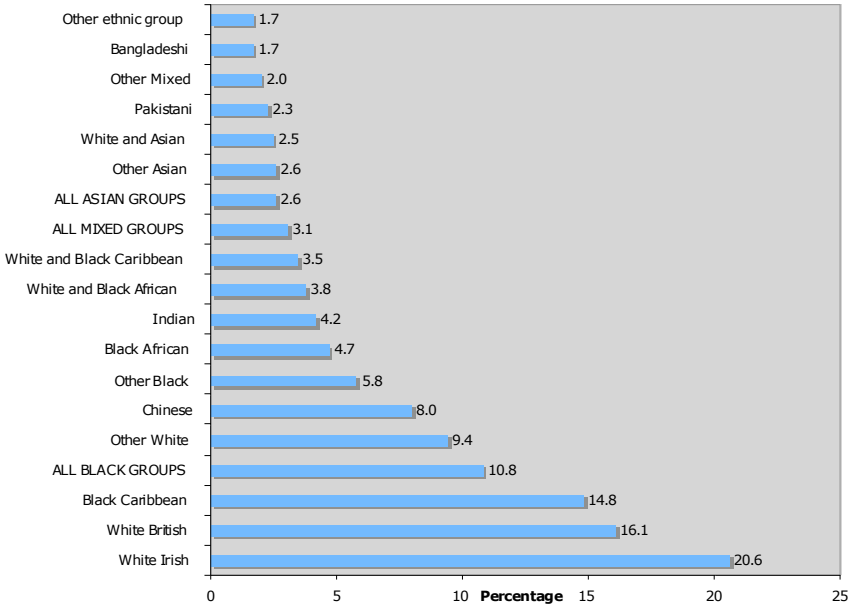
Figures in thousands

Ethnic group	All persons 60/65+**	Men aged 65+	Women aged 60+
White British	49.6	17.6	32.0
White Irish	5.1	2.0	3.1
Other White	1.3	0.5	0.8
White and Black Caribbean	0.1	0.1	0.1
White and Black African	0.1	0.0	0.0
White and Asian	0.0	0.0	0.0
Other Mixed	0.1	0.0	0.0
Indian	0.5	0.2	0.3
Pakistani	1.3	0.6	0.7
Bangladeshi	0.2	0.1	0.1
Other Asian	0.2	0.1	0.1
Black Caribbean	1.8	0.8	1.0
Black African	0.4	0.2	0.2
Other Black	0.1	0.0	0.1
Chinese	0.5	0.2	0.3
Other	0.1	0.1	0.1
All Groups	61.4	22.5	39.0

65 and over for males; 60 and over for females
Source: Manchester City Council based on ONS 2004 Mid-Year Population Estimates (experimental data) ONS ©Crown Copyright 2004[50]

[50] It should be noted that these nationally recognised ethnic categories do not illustrate fully the picture of ethnicity in Manchester. For example, within the Black African category, further classification would reveal a high number of Somalians.

Figure 3: Lone Pensioner households by ethnic groups (in %)



Source: ONS © Crown Copyright 2001. Data is based on 2001 Census count

2.2. Religious affiliations

Table 5 and Figure 3 provide a picture of the broad age structures of religious groups in Manchester. The Jewish population represents the group with the oldest age structure, with 31.8% of its population at pensionable age (although this is a relatively small population with pensioners numbering only 979). The Muslim and Sikh population have the youngest age structures with only 4.2% of their populations being of pensionable age and over. The variations of age structures represent different patterns of immigration. The older Jewish community reflects an earlier wave of immigration that has since ceased, as compared to other patterns of more recent immigration. These current age structures again offer some insight into the composition of future age structures.

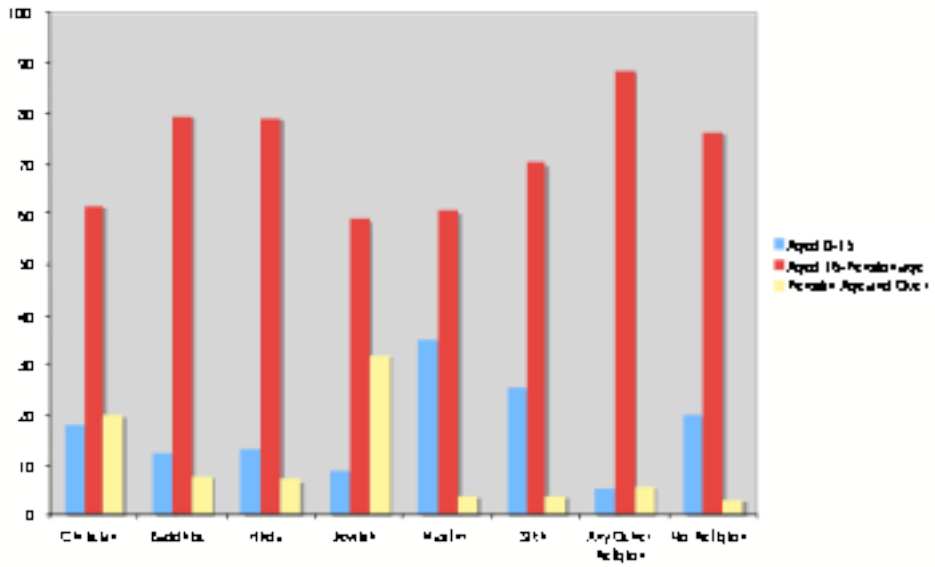
Whilst Christians currently constitute the overwhelming majority of people of pensionable age – numbering nearly 50,000, compared to 1,500 for the next largest religious group which is the Muslim population – this will change in the future, as the religious make-up of younger cohorts feed into future older cohorts.

Table 5: Age structures of resident population by religion

Age group	Christian	Buddist	Hindu	Jewish	Muslim	Sikh	Other Religion	No Religion	Religion Not Stated
All of group	245,203	2,144	2,849	3,076	35,806	1,708	1,111	62,744	37,178
0-15	44,631	270	385	283	12,568	434	61	12,674	11,079
Percentage of group	18.2%	12.6%	13.5%	9.2%	35.1%	25.4%	5.5%	20.2%	29.8%
16-Pension Age	151,289	1704	2,254	1,784	21,770	1,201	984	47,874	20,634
Percentage of group aged 16-Pension Age	61.7%	79.5%	79.1%	58.0%	60.8%	70.3%	88.6%	76.3%	55.5%
Pension Age+	49,285	169	210	979	1,504	72	67	2,133	5,428
Percentage of group aged Pension Age+	20.1%	7.9%	7.4%	31.8%	4.2%	4.2%	6.0%	3.4%	14.6%

**Pensionable age: 65 for males; 60 for women*
Data is based on 2001 census count. ONS ©Crown Copyright 2001
Source: Manchester City Council (2003), The 2001 Census A Profile of Older People in Manchester

Figure 4: Broad Age Structures of Religious groups



Data is based on 2001 census count. ONS ©Crown Copyright 2001
Source: Manchester City Council (2003), The 2001 Census A Profile of Older People in Manchester

3. Economic and Social Deprivation

The 2004 Index of Multiple Deprivation ranked 155 of Manchester's 259 Super Output Areas amongst the worst 10% in the country. The IDM measures deprivation at lower level Super Output Area (SOA)[51] and districts (rather than wards). The Income Deprivation Affecting Older People Index (IDAOPI) is a subset of the IDM, comprising the percentage of a Super Output Area's population aged 60 and over who are on Income Support/Job Seeker's Allowance-Incapacity, or are in receipt of Benefit Claims. The high level of deprivation embodied in the IDM data is reflected in scores for the IDAOPI. 20 SOAs in Manchester are amongst the worst 1% in England in the IDAOPI. The city centre part of Manchester's central area ranked 5th in the whole of England, (where one is the most deprived and 32, 482 is the least deprived). However, given the specificity of the city centre's composition – city centres tend to be more transient than suburban on rural populations with student populations, for example, contributing to high turnover rates – data on this part of Manchester should be treated with caution. Manchester was identified as the local authority with the third highest rate of pensioner poverty.[52] Significant sections of Manchester's older population suffer high levels of deprivation.

Data for persons aged 50 and over is relevant to our understanding of current and future trends in service needs for an older age population. Persons aged 50 and over make up 24.2% of the population (107,163 people based on 2005 Mid-Year Estimates). The 50-59 age group alone amounts to 39,380 people. The 2001 Census Topic Paper on older people highlights the following features of the 50 plus age group in comparison with England as a whole[53]:

- 65% of people aged 50 to 74 were economically inactive compared to 54% in England.
- 19% of people aged 50 to 74 said they were permanently sick or disabled compared to 9% in England.

[51] Super Output Area (SOA): SOAs are a unit of geography used by the ONS for statistical analysis.
[52] VOP, Developing a Life Strategy for Older People, Manchester City Council, 2003.
[53] It should be noted that data on the over 50 population presented here is based on the 2001 census count, prior to adjustment following the census matching study.

- 71% of people aged 50 to 74 said they had no qualifications or the level was unknown compared to 61% in England.
- 48% of people aged 50 and over said they had no car or van compared to 26% in England (See Figure 4).

Table 6 shows that people aged 50 and over in Manchester are more likely to own their own homes outright than all age groups but this percentage (34%) is lower than the national average of 51%. Over 50s are also more likely to rent from the council than private landlords.

Table 6: Housing Tenure by selected age groups

	Number of:			Percentage of:		
Tenure	**All people in househouds**	**All aged 50 and over**	**All pensionable age**	**All people in households**	**All aged 50 and over**	**All pensionable age**
All people	3770,383	100,143	57,127	100%	100%	100%
Owns outright	56,250	33,538	23,354	14.9%	33.8%	40.9%
Owns mortgage/loan	109,851	17,898	4,909	29.1%	17.9%	8.6%
Shared ownership	2,499	671	420	0.7%	0.7%	0.7%
Rented from council	102,219	29,179	17,114	27.1%	29.1%	30.0%
Private rented	61,949	5,065	2,541	10.4%	5.1%	4.4%
Living rent free	8,774	2,981	2,061	2.3%	3.0%	3.6%

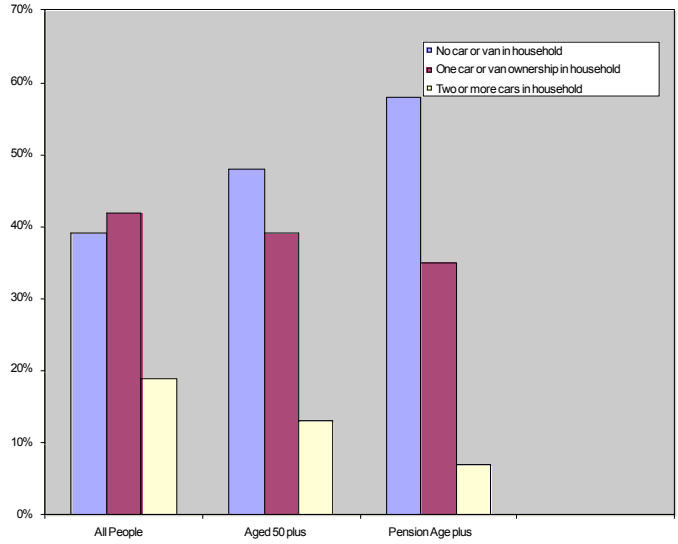
Data is based on 2001 census count. ONS ©Crown Copyright 2001
Source: Manchester City Council (2003), The 2001 Census A Profile of Older People in Mancheste

Lack of private car ownership, illustrated by Figure 4, is generally considered to be an indicator of disadvantage[54], and can negatively affect the quality of life of older people who may have difficulty accessing facilities and services without transport, leading to social isolation. However, public transport schemes and especially those targeted towards older people are important in

[54] The inclusion of lack of personal transport ownership as an indicator of deprivation and isolation may be controversial in that, particularly in areas of reasonable public transport, lack of car ownership may be a personal choice.

combating problems of access and social isolation, particularly in localities where private transport is limited.

Figure 5 Car or Van Ownership by age group



Data is based on 2001 census count. ONS ©Crown Copyright 2001
Source: Manchester City Council (2003), The 2001 Census A Profile of Older People in Manchester

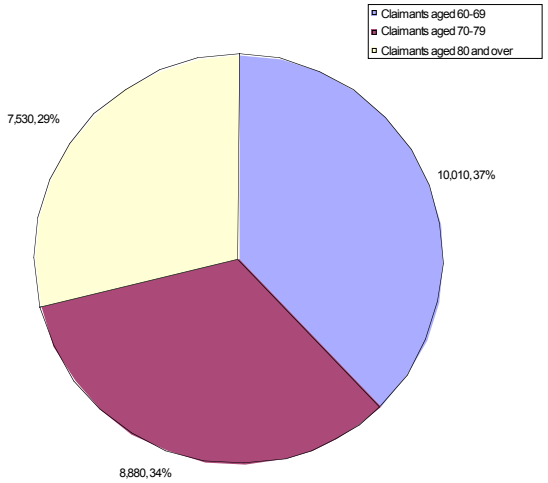
The highest rates for economic inactivity due to permanent sickness or disability occur in the 60-64 age group for men (35%) and in the 55-59 age-group for women (27%). For the whole of Manchester's 60 plus population, 5.4% claim Incapacity Benefit or Severe Disability Allowance. The highest proportions are to be found in Ardwick (8.9%), Cheetham (8.63%) and Hulme (8.59%).[55] For all working age populations in Manchester, rates of economic inactivity due to permanent sickness are nearly double the England average, which is 5.3%.[56]

Figure 5 shows the number people in receipt of pension credits[57] by age, whilst Figure 6 shows the household composition of those in receipt of pension credits. 38% of Manchester residents of pensionable age claim pension credit, 26, 430 people in all, just under two thirds of which are women. 15% of pension credit claimants are in single person households.

[55] The 2001 Census A Profile of Older People in Manchester, Manchester City Council, 2003.
[56] 2001 Census Topic Paper Health, Manchester City Council.
[57] Pension credit is a state benefit designed to encourage saving towards pensions which guarantees everyone over 60 an income of £119.05 per week for a single pensioner and £181.70 for pensioner couples.

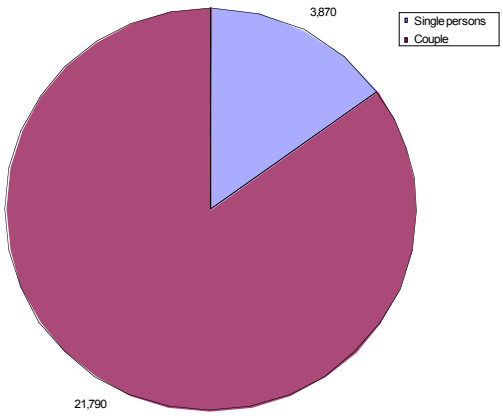
Pension credit, which replaced the Minimum Income Guarantee in 2003, is a key indicator of low income amongst the pensioner population.

Figure 6: Pension Credit Claimant by Age



Source: DWP Information Directorate: Work and Pensions Longitudinal Study, 2006

Figure 7: Pension Credit Claimants by Household Composition



Source: DWP Information Directorate: Work and Pensions Longitudinal Study, 2006

Table 7 shows the levels of qualifications for all adults aged 16 to 74, compared to those aged 50 to 74, and those of pensionable age to 74. 73% of people aged 50 to 74 in Manchester had no qualification or the level was unknown,compared with 61% for people of the same age in England as a whole.

Table 7: Qualifications by Selected Age Groups, 16-74

Age group	No qualifications or level unknown	Lower level qualifications	Higher level qualifications
All adults 16-74	39%	40%	21%
Aged 50 to 74	73%	16%	12%
Pension Age to 74	80%	12%	9%

Source:ONS 2001 Census Data. Crown Copyright

4. POPP Related Health Characteristics of Manchester's Older Population

As stated earlier, one of the key objectives of POPP is to improve the health of older people and to promote preventative measures to facilitate improvements in health. The data presented in this section provides an overview of the health of Manchester's older population in terms of POPP objectives related to physical and mental health, self-reported perceptions of health, falls and emergency hospital admissions.

4.1 Physical health

Data from the 2001 Census suggest that Manchester's older people are in poorer health, or perceive themselves to be in poorer health, than the older population of England taken as a whole. Key data for health starkly illustrates this:

- Standardised Mortality Rates (SMRs)[58] for all ages and causes of death are 21% higher than in England as a whole, and within the city, North Manchester has higher mortality rates than Central and South Manchester. 37 Lower Tier Super Output Areas (LSOAs) have a SMR significantly higher than the national average. These LSOAs are in the most deprived 20% of LSOAs in Manchester. These LSOAs are to be found the following wards: Ancoats and Clayton, Ardwick, Bradford, Charlestown, Cheetham, Harpurhey, and Miles Platting and Newton Heath. [59]
- 51% of people aged 50 and over said they had a long-term limiting illness compared to 38% in England;

[58] Standardised Mortality Rates (SMRs) are a way of adjusting mortality rates to take account of differences in the age/sex structure of the population.
[59] Mortality in North Manchester is 30% higher than the national average, in Central Manchester, 24% higher and in South Manchester 11% higher. Working in Partnership for Good Health in Manchester. Manchester Public Health Annual Report, 2006

- 13% of people aged 50 and over said they provided unpaid care to another person compared to 9% of the population as a whole.[60]
- 30% of people aged 50 and over said that their health was "Not Good" compared to 19% in England;
- 3,993, deaths of Manchester residents were registered in 2005. The main causes of death were circulatory diseases (38% of deaths), cancers (24%) and diseases of the respiratory system (16%).[61]

Manchester's relatively poor health record has led to it being designated a "Spearhead" area by national government, with specific targets to reduce inequalities between the local area and the England population by narrowing the gap in all-age all-cause mortality.[62]

Self-reported health and LLTI are recognised (but nevertheless contested) measures of health status. Self-reported general health appears to decline with age (See Table 8). However interpretation of this data is complicated by the differing perceptions of what constitutes ill health. For example, older people may consider themselves to be in reasonable health, despite experiencing problems which they associate more with growing old than with poor health.

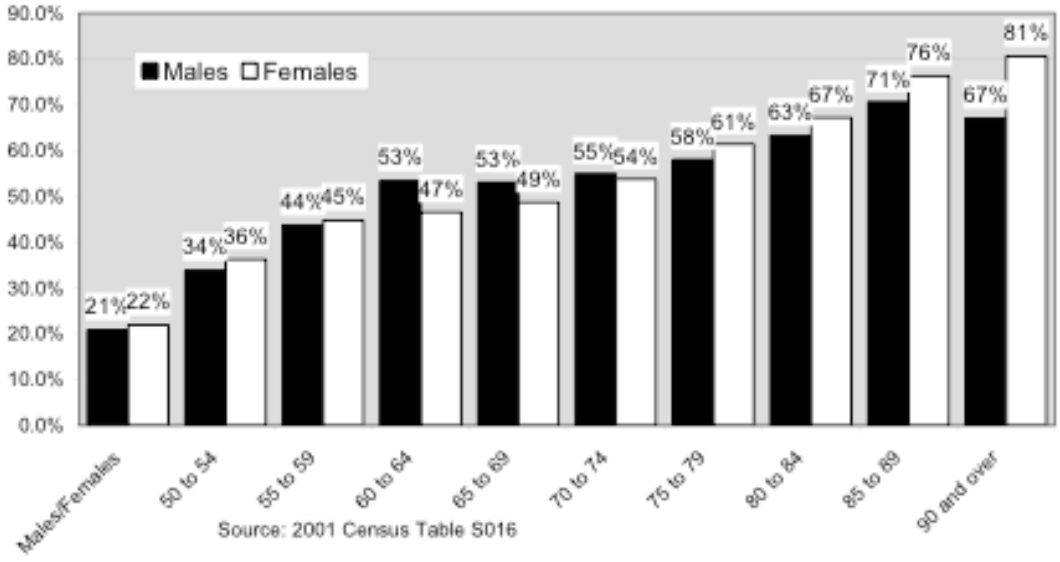
For the older population, Manchester's self-reported perceptions of health are more likely to be negative than for England as a whole: 30% of people aged 50 and over and 31% of persons of pensionable age in Manchester reported that their general health was "Not Good" in the 12 months prior to the 2001 census, compared to 19% and 22% respectively in England as a whole. Manchester's older residents are also more likely to suffer from Limiting Long Term Illness (LLTI). For the over 50s, 51.5% reported a Limiting Long Term Illness, significantly higher than the percentage for England as a whole at

[60] The 2001 Census A Profile of Older People in Manchester, Manchester City Council, 2003.
[61] Working in Partnership for Good Health in Manchester, Manchester Public Health Annual Report, 2006
[62] Working in Partnership for Good Health in Manchester, Manchester Public Health Annual Report, 2006

38% (See Figure 7). For Manchester's residents of pensionable age, the percentage reporting Limiting Long Term Illness rises to 58% compared to 48% for the whole of England.[63]

Overall, women were slightly more likely than men to report having a LLTI (22% compared to 21%), however, the pattern of LLTI among men and women changed with age. In younger age-groups, men were more likely than women to report a LLTI. Over the age of 65 the situation is reversed. The wards with the highest LLTI ratio scores were Benchill, Harpurhey and Ardwick in the North of the City. The wards with the lowest levels of LLTI were Chorlton, Withington and Didsbury in the South.[64]

Figure 8: Limiting Long-Term Illness by Older Sex-Age Groups



[63] 2001 Census Topic Paper Health, Manchester City Council.
[64] 2001 Census Topic Paper Health, Manchester City Council.

Table 8: General Health by Selected Age Groups

	Number of:			Percentage of		
	ALL PEOPLE*	**All aged 50 and over**	**All Pensionable Age**	**ALL PEOPLE**	**All aged 50 and over**	**All Pensionable Age**
All PEOPLE	**392,819**	**103,444**	**60,005**	**100%**	**100%**	**100%**
Good Health	253,665	34,319	16,811	64.6%	33.2%	28.0%
Fairly Good Health	90,039	38,214	24,445	22.9%	36.2%	40.7%
Not Good Health	49,115	30,911	18,749	12.5%	29.9%	31.2%

Data is based on 2001 census count. ONS ©Crown Copyright 2001
Source: Manchester City Council (2005) Census Topic Paper: Health,

Self-reported health differs according to ethnic groups. Older people from Asian and Black Ethnic Minority Groups were more likely to report a LLTI than older people from White and Mixed Ethnic Minority Groups. Amongst residents aged 65 and over, 64.9% of Asian respondents and 62.8% of Black respondents reported a LLTI, compared with 60.0% of White respondents.[65]

Whilst there has been a significant improvement in Manchester's average life expectancy at birth in recent years, with rapid rates of increase between 2000 and 2004[66], it is still lower than for England as a whole (see Table 9). During the 1990s, average life expectancy at birth had been increasing at a much slower rate than for the whole of England. Healthy Life Expectancy (number of years in good health) is also lower in Manchester (see Table 10).

[65] 2001 Census Topic Paper Health, Manchester City Council.
[66] ONS, 2006

Table 9: Life Expectancy and Healthy Life Expectancy at Birth

	Life expectancy at birth		Years in 'good health'	
	Males	**Females**	**Males**	**Females**
Manchester	71.0	77.3	61.1	65.4
North West	74.5	79.4	66.4	69.9
England	76.0	80.6	69.0	72.3

Notes: At local authority level, expected years of life in 'good' health are derived from the 2001 Census question on general health. Regional and national figures are derived from an equivalent question in the General Household Survey (GHS).
Source: ONS ©Crown Copyright 2006

Table 10: Life Expectancy and Healthy Life Expectancy at Age 65

	Life expectancy at 65 (years)		Years in 'good health'	
	Males	Females	Males	Females
Manchester	14.0	17.7	9.7	12.0
North West	15.3	18.4	11.4	13.3
England	16.1	19.2	12.5	14.5

Notes: At local authority level, expected years of life in 'good' health are derived from the 2001 Census question on general health. Regional and national figures are derived from an equivalent question in the General Household Survey (GHS).
Source: ONS ©Crown Copyright 2006

4.2 Falls

Older people are susceptible to fall, the consequences of which can have negative impacts on health and well-being. Falls can result in loss of mobility, confidence and even loss of independence.[67] Fractured proximal femur (hip fracture) is the most common serious injury related to falls in older people and is therefore a good proxy for rates of falls.[68] Table 11 shows rates of hospital emergency admissions for fractured proximal femur from 1999 to 2004.

[67] Public Health Annual Report, Manchester City Council, 2006.
[68] Public Health Annual Report, Manchester City Council, 2006.

Table 11: Emergency hospital admissions for fractured proximal femur, data standardised to persons 2001/2002

	Number of Admission Continuous Inpatient Spells	Indirectly age and sex standardised rate per 100,000	Percentage Improvement from previous year
2004/03	364	105.25	-3.55
2002/03	354	101.51	-3.97
2001/02	341	97.63	-17.32
2000/01	291	83.22	+26.16
1999/00	391	112.71	-5.68

Source: ONS ©Crown Copyright 2005

4.3 Hospital Admissions

Table 12 shows the number of admissions in year 2005/06 according to selected diagnoses. The 65 plus population accounts for 37,159 admissions out of 130,281 admissions for all age groups combined. Admissions for circulatory diseases were the most common for the over 65s, followed by respiratory diseases and cancers. Over 65s made up roughly a third of admissions for accidents.

Table 12: Hospital Admissions for selected diagnoses by age group, April 2005-March 2006

Primary diagnoses	0-15	16-24	25-44	45-64	65+	Total
Cancers	424	266	726	2,856	4,985	9257
Circulatory Diseases	96	78	568	3,306	8,455	12,503
Mental Health	344	489	2273	1,774	1,777	6,621
Respiratory Diseases	2,872	882	2,039	2,940	5,490	14,223
Accidents	485	346	568	416	924	2,739
All Admissions *(including those for diagnoses not listed above)*	13,610	13,868	37,314	28,330	37,159	130,281

Source: Secondary Care Database Inpatient CDS, 2005/06

Table 13 presents data from Hospital Episode Statistics on the number of emergency bed days. Again, this data is based on the pre-November 2006 re-structuring of Manchester's three PCTs into one Manchester PCT. North Manchester and South Manchester PCTs saw a reduction in emergency bed days from 2003/4 to 2004/5. Central Manchester PCT saw an increase over the same period.

Table 13: Emergency Bed Days

	2003-4	2004-5
North Manchester PCT	146,560	137,366
South Manchester PCT	115,534	110,318
Central Manchester PCT	122,061	128,881

Source: The Information Centre, 2007

4.4 Residential and community-based health care

Nearly 2000 of Manchester's over 65 population were housed in communal care residential and nursing establishments in the year up to March 2006 (see Table 14). Tables 15 and 16 show the numbers of people aged 65 and over receiving health services according to client type and type of care , including those receiving care community-based services.

Table 14: Council supported residents in care homes of persons aged 65 and over, Year to March 2006

Type of Care	People aged 65-74	People aged 75-84	People aged 85 and over	Total Numbers
Permanent *(of which)*	**315**	**670**	**895**	**1,880**
Residential	190	445	660	1,295
Nursing	125	225	235	558
Temporary *(of which)*	**15**	**25**	**5**	**45**
Residential	15	25	5	45
Nursing	**-**	**-**	**-**	**-**
Total Numbers	**330**	**695**	**900**	**1925**

Source: The Information Centre, 2006 Tables S5 and S6

Table 15: Number of clients aged 65 and over receiving services by primary client type and service type, Year to March 2006

Type of Care	Physical disability, frailty and sensory impairement	Learning Disability	Mental Health	Total Numbers
Independent Sector Residential Care	1,120	0	..	1,120
Nursing Care	560	0	..	560
Community-based services	7,260	70	40	7,360
Total number of clients receiving services	8,930	70	40	9,040

Source: The Information Centre, 2006 Table P1.1c

Table 16: Number of clients aged 65 and over receiving community-based services by primary client type and components of service, Year to March 2006

Type of Care	Physical disability, frailty and sensory impairment	Learning Disability	Mental Health	Total Numbers
Home Care	2,730	20	20	2,760
Short term residential – not respite	70	..	..	70
Direct Payments	100	..	..	100
Professional support	100	40	..	140
Day Care	840	0	..	860
Meals	860	0	..	860
Overnight respite – not client's home	50	..	0	50
Equipment and adaptions	730	0	0	730
Other	4,510	..	..	4,510
Total number of clients receiving services	7,260	70	40	7,360

Source: The Information Centre, 2006 Table P2f.1c

People living in communal establishments, including residential and nursing care homes, are more likely than the population as a whole to have LLTI (24% compared with 22%). Within the communal residential population, people in medical and care establishments have higher rates of LLTI than those in other types of communal establishments.[69]

[69] 2001 Census Topic Paper Health, Manchester City Council.

4.5 Mental Health

Manchester has one of the highest rates of mental health problems in England.[70] Economic deprivation and social isolation have been found to be associated with mental ill health, with evidence suggesting that deprived areas have higher prevalence rates of mental illness.[71] Section 2 above has outlined the deprivation and social isolation suffered by many of Manchester's older residents, relative to England as a whole, providing the socio-economic context in which the mental health of Manchester's older population is situated.

The data on the incidence (new cases) and prevalence (total number of cases) of mental health problems in older people presented here is taken from the recent Manchester City Council Joint Health Unit topic paper on mental health problems in older people.[72] The relevant population used is the "registered population" (not the "resident population").[73] Data are based on accepted prevalence rates and have not been weighted for social deprivation. As such, these figures are likely to underestimate the real extent of both low level and severe mental health problems. In addition, future trends in mental health need to take into account the differential rates of some conditions according to ethnicity, for example, vascular dementia. Also, for the older population living in residential care, prevalence rates for mental ill health can be double or more than prevalence rates for older people living in care.[74]

Estimated data derived from various studies of prevalence rates of mental health problems provide the following estimate of prevalence rates for Manchester's older population[75]:

[70] See http://www.manchester.gov.uk/health/healthplan/diseases/mental.htm
[71] Mental Health Problems in Older People in Manchester, Joint Health Unit, Manchester City Council, February, 2007.
[72] Mental Health Problems in Older People in Manchester, Joint Health Unit, Manchester City Council, February, 2007.
[73] The registered population is affected by delays in taking people on and off GP lists and by movements between GP practices in different PCTs. The difference between the registered population and the resident population (based on Census data) is referred to as list 'inflation'. List inflation in Manchester is estimated to be approximately 10%, which means the registered population is 10% higher than the resident population.
[74] Mental Health Problems in Older People in Manchester, Joint Health Unit, Manchester City Council, Februay, 2007
[75] This data is based up a number of studies on population prevalence rates: Lobo A, Launer LJ, Fratiglioni L et al (2000). Prevalence of dementia and major subtypes in Europe: A

- 2,970-5,941 cases of undifferentiated dementia (depending on severity);
- 5,941 cases of depression;
- 59-297 cases of schizophrenia and 238-594 cases of Bipolar Disorder;
- 6,356 cases of phobic disorder, 2,733 cases of generalised anxiety disorder, 178 cases of panic disorder and 297 cases of Obsessive Compulsive Disorder (OCD);
- 3,240 of cases of psychiatric illness among older people with an intellectual disability.

Source: Mental Health Problems in Older People in Manchester, Joint Health Unit, Manchester City Council, 2007

The tables below present a more detailed account of this data indicating the prevalence and incidence of Alzheimer's disease, depression, neurotic disorders and 'intellectual functioning' disabilities. It should be noted that the data are based on pre-November 2006 PCT structure. The three PCTs below are now merged into one Manchester PCT.

Table 17: Prevalence and incidence of undifferentiated dementia in people aged 65 and over in Manchester

PCT of registration	Population aged 65+	Prevalent Cases*		Incident Cases	
		Low Severity	High Severity	Total**	Alzheimer's disease***
North Manchester PCT	22,886	2,287	1,144	229	137
Central Manchester PCT	17,358	1,736	868	174	104
South Manchester PCT	19,192	1,919	960	192	115
Manchester Total	59,405	5,941	2,970	594	356

Source: Mental Health Problems in Older People in Manchester, Joint Health Unit, Manchester City Council, 2007

collaborative study of population – based cohorts. Neurological diseases in the elderly research group. *Neurology* 54 (11): 54-9; Morgan K, Luley JM, Arie T, Byrne EJ, Jones R, Waite J (1993). Incidence of dementia in a representative British sample. *British Journal of Psychiatry* 163, 467-470; Wilson KCM, Chen R, Taylor S, McCracken CFM, Copeland JTM (1999). Socio-economic deprivation and the prevalence and prediction of depression in older community residents. *British Journal of Psychiatry* 175, 549-553 and Ritchie et al (2004). Mild cognitive impairment. International Psychogeriatric Association Expert Conference on mild cognitive impairment. *British Journal of Psychiatry* 184:147-52. The relevant population is the Department of Healths population reference, which reconciles GP "registered" population and "resident" population figures. Source, Mental Health Problems in Older People in Manchester, Joint Health Unit, Manchester City Council.

Table 18: Prevalence and incidence of depression in people aged 65 and over in Manchester

PCT of registration	Population aged 65+	Prevalent Cases*	Incident Cases**
North Manchester PCT	22,886	2,287	824
Central Manchester PCT	17,358	1,736	625
South Manchester PCT	19,192	1,919	691
Manchester Total	59,405	5,941	2,139

* *10% of >65 years population*
** *3.6% of population >65 years at risk*
Source: Mental Health Problems in Older People in Manchester, Joint Health Unit, Manchester City Counci, 2007l

Table 19: Estimated number of cases of Neurotic disorders among people aged 65 and over in Manchester

PCT of registration	Population aged 65+	Prevalent cases (All Persons)			
		Phobic disorder	Generalised Anxiety	Panic disorder	OCD
North Manchester PCT	22,886	2,449	1,053	69	114
Central Manchester PCT	17,358	1,857	798	52	87
South Manchester PCT	19,192	2,054	883	58	96
Manchester Total	59,405	6,356	2,733	178	297
Prevalence		*10.7%*	*4.6%*	*0.3%*	*0.5%*

Source: Mental Health Problems in Older People in Manchester, Joint Health Unit, Manchester City Council, 2007

Table 20: Prevalence of 'intellectual functioning' disabilities in Manchester residents aged 60 and over by severity of condition (resident population)

Severity category*	Number of Adults	
	60-74 years	75+ years
1-2	157	78
3-4	444	197
5-6	641	695
7-8	561	746
9-10	582	1,137
All Types	2,385	2,852
% of adults	5.6%	10.8%

Source: Chief Executive's Policy Unit (Analysis), Manchester City Council (April 2006).

* Severity categories are defined from 1 to 10, with 1 as the least severe and 10 as the most severe. People in severity category 1 and 2 are unlikely to have any contact with health and social care services, whereas people with disabilities in category 9-10 are likely to require full-time care, very possibly in a care home.

Disorders such as neurotic and other psychiatric disorders are not necessarily associated with old age, but can manifest themselves earlier in life. However they may be persistent and therefore also present in later life. Other disorders, such as dementia, are associated with old age and therefore wards with large numbers of older people in their population may be affected by higher rates of mental health problems (see Table 15).

Older adults with a learning disability are susceptible to mental health problems. Using estimates on the number of Manchester residents aged 65 with learning disabilities, a broad brush estimate of the number of this population likely to have suffered from a mental health problem is 3,240.[76]

Future demand on local mental health service will also depend on changes in population structure. Table 16 shows the estimated future prevalence rates of mental illness for the 65 plus population. By 2029[77], it is estimated that there will be an extra 455 cases of undifferentiated dementia in the population aged 65 and over, 910 cases of depression, and 974 cases of phobia. Increases in the numbers of the very elderly in the population may lead to an increase in the average prevalence of mental health problems in the population.

[76] Mental Health Problems in Older People in Manchester, Joint Health Unit, Manchester City Council, February, 2007.
[77] Mental Health Problems in Older People in Manchester, Joint Health Unit, Manchester City Council, February, 2007.

Table 21: Prevalence of mental health problems in older people by ward

Ward of residence	Population aged 65+		Estimated Number of Cases (Mid-2005)			
	Number aged 65+	% of all people	Dementia	Depression	Generalised Anxiety	Phobic disorder
Ancoats & Clayton	1,635	13.6	82	164	175	75
Ardwick	1,235	8.8	62	124	132	57
Baguley	1,888	13.5	94	189	202	87
Bradford	1,614	13.1	81	161	173	74
Brooklands	2,125	15.8	106	213	227	98
Burnage	1,902	13.3	95	190	204	87
Charlestown	2,151	17.3	108	215	230	99
Cheetham	1,505	9.7	75	151	161	69
Chorlton	1,474	10.3	74	147	158	68
Chorlton Park	1,605	12.3	80	161	172	74
City Centre	290	3.8	15	29	31	13
Crumpsall	2,199	15.2	110	220	235	101
Didsbury East	1,807	12.7	90	181	193	83
Didsbury West	1,498	11.4	75	150	160	69
Fallowfield	1,565	11.5	78	157	167	72
Gorton North	1,967	14.2	98	197	210	90
Gorton South	1,922	12.1	96	192	206	88
Harpurhey	2,172	13.5	109	217	232	100
Higher Blackley	2,294	16.6	115	229	245	106
Hulme	739	6.3	37	74	79	34
Levenshulme	1,352	9.7	68	135	145	62
Longsight	1,052	7.4	53	105	113	48
Miles Platting & Newton Heath	2,289	14.1	114	229	245	105
Moss Side	1,266	8.5	63	127	135	58
Moston	2,221	14.8	111	222	238	102
Northenden	2,014	14.6	101	201	215	93
Old Moat	1,419	10.1	71	142	152	65
Rusholme	931	6.6	47	93	100	43
Sharston	1,865	12.2	93	187	200	86
Whalley Range	1,329	9.7	66	133	142	61
Withington	1,085	8.7	54	109	116	50
Woodhouse Park	2,293	17.0	115	229	245	105
Manchester	**52,705**	**11.9**	**2,635**	**5,271**	**5,639**	**2,424**

Note: These population figures are derived from the 2001 Census age-sex groups by Output Area and aggregated by best fit to 2004 ward boundaries. They are then applied to ONS 2005 Mid-Year Estimate and controlled to age groups.
Source: Office for National Statistics © Crown Copyright 2005

Table 22: Estimated future prevalence of mental health problems in the population aged 65 and over in Manchester 2004-2029

Year	Population aged 65+	Estimated Number of Cases					
		Dementia	Depression	Phobia	Anxiety	Panic	OCD
2004	59,000	2,950	5,900	6,313	2,714	177	295
2009	56,600	2,830	5,660	6,056	2,604	170	283
2014	58,200	2,910	5,820	6,227	2,677	175	291
2019	59,800	2,990	5,980	6,399	2,751	179	299
2024	62,800	3,140	6,280	6,720	2,889	188	314
2029	68,100	3,405	6,810	7,287	3,133	204	341
Change 2004-29	9,000	455	910	974	419	27	46

Source: Mental Health Problems in Older People in Manchester, Joint Health Unit, Manchester City Council, 2007

Older people are particularly vulnerable to poor mental heath, due to a multiple factors related to both physiological changes and life cycle events, which can lead to memory problems depression and anxiety being common amongst the older population.[78] Table shows that in line with expectations of a growing population of older people, especially of the very old age groups, it is expected that the prevalence of people presenting with mental health problems of dementia, depression, phobias, anxiety, panic attacks and obsessive compulsive disorders will increase. Demands on mental health and social services are likely to increase as a result.

[78] Lee, M (2006) Promoting mental health and well-being in later life. A first report from the UK inquiry into mental health and wellbeing in later life. Age Concern & the Mental Health Foundation.

5. Personal and Social Care: How do Manchester's Older People Fare?

Independence, well-being and choice are all integrally linked to receipt of adequate care to meet levels of personal and social need. Care needs are, in part, organised and monitored with reference to the Performance Assessment Framework (PAF), and are assessed via the Fair Access to Care criteria whereby council provision is offered for those people who demonstrate substantial or critical need. Information in relation to the Manchester's achievement of PAF targets for older people is given below, concentrating particularly on those PAF targets linked to POPP objectives.

In addition, the Department of Health has identified a number of dimensions which have an impact on levels of independence, well-being and choice for older people. These dimensions are encapsulated in the adult social care standards against which the performance of adult social care can be measured:

- Health and emotional well-being;
- Quality of life;
- Choice and control;
- Making a positive contribution;
- Economic well-being;
- Freedom from discrimination and harassment;
- Personal dignity.

Taken together these standards are intended to improve the lives of any service user, including older people, by giving them more control, more choices, more opportunities to participate in social life, and better quality services, with support and protection for the most vulnerable. As these standards inform the Manchester POPP project, contextual information is presented here to provide a basic overview of some of the ways in which Manchester is working to improve the everyday life of its older residents with reference to these standards. Whilst the factors that contribute to these dimensions and the outcomes of actions related to them inevitably overlap,

aspects of local authority strategy have been linked to particular dimensions below.

5.1 Personal Care

Table 23 presents data from for the 2005-2006 PAF (Performance Assessment Framework) indicators illustrating older people's access to personal care in Manchester either at home or in residential establishments. PAF indicators C31 (adults with mental health problems), C72 (older people admitted on a permanent to residential or nursing care), and D41 (delayed discharges) relate specifically to POPP outcome indicators. Table 24 provides data related to assessments for care. Indicator E50 (assessments of adults and older people leading to provision of service) in this table related to POPP outcomes In total, 903 people over 65 are in receipt of Home Care, or 16.60 per 1000 population.[79] The highest proportions are found in Harpurhey, Crumpsall and Moss Side, the lowest in Burnage, Sharston and Brooklands. Data from the last reporting period suggests a high level of satisfaction with care packages provided in the home amongst the over 65 population (64%). This is an improvement on responses to the previous survey, where 48% of respondents were extremely or always satisfied with the services received and higher than the latest positive response rate for England as a whole (59%).[80]

[79] Ward Reporting Data, 2006, based on MYE for 65+ population
[80] Personal Social Services Survey of Home Care Users in England, carried out in 2002-03 and 2005-06, The Information Centre

Table 23. Performance Indicators of Access to Personal Care

PAF INDICATOR	2004-05	2005-06
AO/C72.1 The number of older people aged 65 or over admitted to supported permanent residential and nursing care during the year.	N/A	534
AO/C72 Older people aged 65 or over admitted on a permanent basis in the year to residential or nursing care per 1,000 population aged 65 or over *N.B: Data for Q1/Q2 2006: 115.38*	N/A	101
AO/C28 Households receiving intensive home care per 1,000 population aged 65 or over.	20.5	23.5
A/O/C31 Adults with mental health problems helped to live at home per 1,000 population 18-64	--	2.67
AO/C32.1 Older people aged 65 or over helped to live at home at 31 March.	4897	5704
AO/C32 Older people helped to live at home per 1,000 population aged 65 or over	91	108
AO/D41 The number of delayed transfers of care per 100,000 population aged 65 or over *N.B: Data for Q1/Q2 2006: 33.28*	37	38
AO/D52 Percentage of respondents to older people receiving home care survey claiming they were 'extremely satisfied' or 'very satisfied' with help form Social Services in their own home	N/A	64%
AO/D71 Percentage of respondents to older people receiving home care survey claiming their care workers 'always' do things that they want done.	N/A	65%
Older people in receipt of a Community alarm*		3098
Older people in receipt of a Meals on Wheels service*		546
Older people in receipt of a Meals on Wheels service* per 1000 population aged 65+		10.20
Older people in receipt of a Community alarm* per 1000 population aged 65+		54.00
Population aged 65+ based on Mid-year estimates	53557	52705

Source: Ward Data Reporting, 2006, and CSCI Performance Assessment Framework Performance Indicators, http://www.csci.org.uk/care_professional/councils/paf/paf_reports_and_data.aspx

Table 24: Waiting times for assessments and completion of assessments process according to relevant PAF indicators

PAF INDICATOR	2004-05	2005-06
E50 Assessments of adults and older people leading to provision of service *NB: Rate for Q1/Q2 2006 68.78*	--	71
AO/D55.1 Number of new older clients for whom contact was made with the client, the number for whom length of time from first contact to contact with the client was less than or equal to 48 hours (that is, 2 calendar days). (This time includes weekends and bank holidays).	535	1,342
AO/D55.2 The total number of new clients aged 65 or over for whom contact was made with the client in the year regardless of which year the first contact was made.	1,236	2,313
AO/D55.3 Of new older clients for whom the assessment process was started, the percentage for whom length of time from first contact to contact with client was less than or equal to 48 hours (that is, 2 calendar days). (This time includes weekends and bank holidays).	43%	58%
AO/D55.4 Of new older clients in the denominator, the number for whom length of time from first contact to completion of assessment was less than or equal to 4 weeks (that is, 28 calendar days)	430	1,452
AO/D55.5 The total number of new clients aged 65 or over whose assessments were completed in the year regardless of which year the first contact was made.	640	2,084
AO/D55.6 Of new older clients whose assessments were completed in the year, the percentage for whom length of time from first contact to completion of assessment was less than or equal to 4 weeks (28 calendar days).	67%	70%
AO/D56.1 Of new older clients in the denominator, the number for whom length of time from completion of assessment to provision of all services in a care package is less than or equal to four weeks (that is 28 calendar days).	338	1,077
AO/D56.2 The total number of new clients aged 65 or over whose assessment was completed and went on to receive all services during the reporting year	520	1,461
AO/D56 For new older clients, the percentage for whom the time from completion of assessment to provision of all services in the care package is less than or equal to 4 weeks.	65%	76%

Source: Ward Data Reporting, 2006, and CSCI Performance Assessment Framework Performance Indicators, http://www.csci.org.uk/care_professional/councils/paf/paf_reports_and_data.aspx

Assessment of care needs is an important factor for appropriate care. In the period from 1st April 2005 to 31st March 2006 2060 people aged 65 and over were in receipt of an Assessment, the highest proportion concentrated in Moss Side with 70.03 per 1000 population 65 and over, a proportion far higher than Ancoats and Clayton, and the City Centre at 49.05 and 48.89 respectively.[81]

5.2 Seven Social Care Outcomes

5.2.1 Health and Emotional Well-being

Council strategy to improve the health of older people, both physical and mental, has focused more recently on preventative measures to keep older people healthier for longer. Falls prevention has been identified as a key preventative health measure (see Section 4.4 above). A number of services have been established to assist both prevention and after falls care:

- Steps to safety scheme: a free self-referral service for the over 60s aimed at preventing falls and other accidents;
- Falls Prevention service: to promote independence, confidence, balance and mobility, following assessment and referral;
- Experts Patient Programme: a free self-referral service to support people who have fallen or are risk of a fall, to regain control and confidence, open to anyone with long-term health conditions;
- Manchester Equipment and Adaptations Partnership, which provides equipment to prevent falls and maximise independence, available on assessment;
- GATE (Getting Active Through Exercise) is a referral service which promotes the benefits of exercise in the over 65s to improve health (and also prevent falls).

Preventative health strategy also extends to wider life dimensions. In March 2004, the Council established a Walks Development Worker position. Since

[81] Ward Reporting Data, 2006, based on MYE for 65+ population

then, 93 walks have taken place involving 165 individuals aged 55 and over (predominantly women). Most (approx 90%) of these people had previous led sedentary live and lived in some of the poorest Manchester wards. Twenty-four walkers have now become regular walkers. Improvements in physical and mental well-being were reported by all the participants. The walks have succeeded in attracting an older population: 32% are 65+, there are 3 over 80 years of aged.

A number of other more localised services exist such as the Zest North Manchester Healthy Living Network, which runs activities for older people such as yoga, dancing, swimming, crafts and social events, as well as directing people to other health services and activities in Manchester.

Longsight/Moss Side Community Project

" I go to the group at the Clayton Centre. Its pretty good for Asian women because there are disabled people and people who are old and have nothing to do at home, so we gather there.
A lot of people are going now. We have a cup of tea and a chat and do exercise. Sometimes the doctor or health workers go. Its pretty good for everybody.
Then we have the meeting in the library every month. Dieticians, mental health workers and people from the hospital go there. They get social workers and people from pension credit. They meet us and get help if we have a problem. Its very good fro getting information."
Kiswar Saeed, aged 62, from Victoria Park
Source: Valuing Older People, A Guide to Live in Manchester

The Commission for Social Care Inspections identified mental health care in Manchester as an area in need of improvement.[82] Community Care Statistics for 2005-2006 show that 739 adults aged 18-64 with mental health problems helped to live at home, or 2.5 per 1000 population aged 18-64. This is an increase on data for the previous recording period which put the number of adults with mental health problems helped to live at home at 550, or 1.9 per 1000 population.[83] The rate of emergency psychiatric readmissions is an important indicator for service performance. In 2005/6, the rate of emergency psychiatric readmissions was 7.6, and 8.7 for Quarter 1 and Quarter 2 of

[82] Commission for Social Care Inspections, 2006.
[83] 2005-06 and 2004-05 Performance Assessment Framework Performance Indicators

2006. Whilst the 2005 performance rating for Manchester Mental Health and Social Care Trust's rate of psychiatric readmissions for older people was 3 (where 1 is poor and 5 is good). This suggests that there is still some work to be done in improving mental health support provided in the community.

The degree to which community health teams (CMHTs) serving older people have integrated working between health and social care staff is a key indicator of whether effective person-centred care is being provided. The National Service Framework (NSF) for Older People Standard 7 which relates to mental health stipulates that older people who have mental health problems have access to integrated mental health services provided by the NHS and councils" with the aim of sharing information and care planning and enable a single assessment process. The Manchester Mental Health and Social Care Trust was placed in band 1 (poor) for CMHT integration (older people).

The City Council has recognised the need to improve mental health services for older people and aims to do this through the incorporation of older people in "Change in Mind", a consultation exercise on mental health care services. The setting up of community health teams is also expected to lead to improvements in older people's mental health services.

The CSCI report also highlighted the lack of health care home places commissioned for older people with dementia, relative to national data. The City Council has responded by developing a specification to contract care for this group.

5.2.2 Quality of life

The Department of Health's National Standards aims to improve quality of life for older people by improved access to leisure, social activities, life-long learning and public and commercial activities. The data presented below presents a tentative picture of how these aspects of quality of life are perceived within Manchester's older population.

According to the Best Value Survey (see Section 6) over 55s in Manchester are on the whole satisfied with sports, leisure and cultural facilities provided by the council. However access to such services will be determined by access

to transport. Given the relatively low level of car ownership amongst older people in Manchester, public transport is likely to be key factor for quality of life for this population. The Greater Manchester Public Transport Enterprise (GMPTE) operates a number of services to enhance transport facilities for disabled and older persons and there is a comprehensive concessionary transport scheme for older people.

Transport: Greater Manchester's Ring and Ride service provides accessible demand responsive transport for those who experience difficulties using the conventional bus network due to mobility problems. These services are very popular, so much so that the Greater Manchester Public Transport Entreprise (GMPTE) has recognised that demand in peak time travel and travel to longer-distance destinations is outstripping current service resources.[84] The Greater Manchester Public Transport Authority (GMPTA) has identified other agencies that may play a role in easing demand for demand responsive services, for example, non-emergency ambulance, social services or community transport operations. Co-operation between different agencies to achieve a fully intergrated system capable of providing an adequate service has been promoted as a way of supplementing current and future public transport delivery.[85]

> ***Peter Brown is 69 and lives on a council estate in Manchester. He has limited contact with family and has no friends that live in the area and feels that "nobody cares about you anymore". Ten years ago he left work to become a full-time carer to his mother. After his mother died, he was unable to find employment and, as a result, has a limited income. His neighbourhood is a source of stress, with his daily activities constrained by anxiety about street crime: "It's not nice traveling round here at night." The absence of meaningful social ties and daily challenges associated with living in his neighbourhood have led Mr. Brown to question the quality of his life: "I'm not interested in this house … I'm not interested in anything round here … come to think about it, I'm not really that interested about living."***
>
> *Source: A Sure Start to Later Life: Ending Inequalities for Older People*

[84] Greater Manchester Local Transport Plan 2, March 2006, GMPTE.
[85] Greater Manchester Provisional Bus Strategy, July 2005, GMPTE.

Life-long Learning and Cultural Activities: The City Council has initiated life-long learning activities for older people. For example, twenty-five people over the aged of 55 who were long-term unemployed or claiming incapacity benefit were identified to train as construction tutors.[86]

The following offer opportunities for continuing education in either a formal or an informal setting:

- University of the Third Age, based at Abraham Moss in Crumpsall;
- Manchester Libraries offers drop-in learning sessions on comupter and internet use;
- The Manchester Adult Education Service offers courses throughout Manchester;
- The Workers Educational Association and the Centre for Continuing Education also provide educational courses.

The City Council sees itself as being committed to offering older people a diverse cultural life, with a wide range of choice and opportunities as accessible to older people as they are to the rest of the community. The Library Theatre Company, for example, is home to two over-50s play-reading groups and 'solos' evenings to encourage people to visit the theatre as part of a group, with matinee performances to enable older people to visit the theatre during the day.

Changes to the funding of adult education programmes means that financial support for leisure courses will be discontinued, with the possible exclusion of some older people due to lack of means, with consequent detrimental effects on well-being.

5.2.3 Choice and control

The proposition that more choice and control enhances independence in everyday life underpins much of national government policy on health and social care. Choice and control in terms of equal access and availability of

[86] Manchester City Council website.

services can be facilitated by well advertised, accessible and, more targeted, information and the opportunity to manage risks in personal life. Facilitating access to information is one of the objectives of the Gateway service. Since the beginning of the POPP in April 2006 the Gateway service has produced the following data:

	April 2006 to March 2007
Percentage of Gateway contacts signposted or referred to non-assessment Adult Social Care services	**1.2%**
Percentage of Gateway callers calling with repeat issues	**2.1%**
Percentage of Gateway contacts where gap in current service provision is identified	**3.0%**

Direct payments[87] have been promoted as a way of giving greater choice and control of care services and personal assistance by providing personalised budgets for all adults who have assessed needs. Table 25 shows the increase in the number of older people in receipt of direct payments from 2004/05 to 2005/06.

Table 25: Older People aged 65 and over received direct payments

	2004-05	2005-06
Older people aged 65+ receiving direct payments (PAF C51) *NB: Data for Q1/Q2 April to Sept 2006 90.09*	48	84
Older people receiving direct payments per 100,000 population aged 65+	90	159

Source: Ward Data Reporting, 2006, and CSCI Performance Assessment Framework Performance Indicators, http://www.csci.org.uk/care_professional/councils/paf/paf_reports_and_data.aspx

Manchester has also recently introduced Individual Budgets[88] as part of a pilot programme currently under evaluation. Individual Budgets are designed to further enhance the control of service-users in accessing individualised care

[87] A direct payment is money given to the person needing care services or personal assistance. The recipient can then choose either to find their own staff to carry out these services or use an agency to provide the service.

[88] Individual budgets allow the recipient of care services to access funds in their individual budgets in order determine their own care package. Like direct payments, individual budgets are promoted as a way of giving control and choice to the person receiving care or services.

and support, and to promote self-directed support.

5.2.4. Making a positive contribution

The Department of Health standard refers to active participation in the community through employment or voluntary opportunities. The availability of volunteering qualifications is promoted as a stepping stone into employment for older people.[89] Harnessing the untapped resources that older people can offer has been identified by the City Council as a way engaging older people actively in the life of the community, providing local services and combating social isolation.[90]

In Manchester, there is a wide range of agencies and local groups which both provide services and opportunities for older people to engage within their communities. One example of this, highlighted on the City Council website, is the Minehead Centre in Withington which works with Age Concern and the Adult Education Service to train local older people in gardening skills that can be used to help tend the gardens of other local older people. Other examples include the work of organisations such as:

The **Manchester Alliance for Community Care/Manchester Older People's Network**, brings together people aged over-50 to influence service delivery, particularly in health and social care, in order to enhance collective choice and control in older people's services. It campaigns to extend user involvement in service delivery by hosting regular meetings and providing information about public consultations.

The **Manchester Health Watchdog**, previously 'The Patient and Public Involvement Forum' is carrying out a consultation exercise with older people around what is important for them in relation to health and well-being.

The Generation Project provides a one-to-one information and advocacy service for the over-55s, aiming to ensure, through supported collective advocacy, that those providing services have access to the opinions of their target group.

[89] http://www.manchester.gov.uk/health/older/strategy/economic.htm
[90] Developing a Quality of Life Strategy for Older People, Manchester City Council, 2004.

VOP has generated volunteering activities such as initiating a radio show in Wythenshawe run by and for the over 50's.

The emphasis on engaging older people in service delivery is central to the VOP approach which is implemented through VOP structures and a wide range of service and locality-based mechanisms. VOP task groups include older person representatives. Opportunities to volunteer exist within these mechanisms for older persons' advocacy, and in wider schemes such as intergenerational projects, and regeneration programmes, thereby bringing in older people as actors within a community-wide setting.

The VOP database contains information on one hundred local voluntary organisations that provide services for older people, giving one indication of opportunities for participation for older people across Manchester city. Table 26 below presents a categorisation of these services and an indication of the coverage of services offered by local voluntary organisations. Table 27 provides a broad mapping of these organisations by type of service provided.

Table 26: Prevalence of service type offered by local organisations

Type of Service	Percentage of local organisations on the VOP database offering this service
Information/advice or advocacy	76%
Arts/culture/reminiscence/other social activities	73%
Physical activities	58%
Opportunities for volunteering	58%
Promotions/Campaigns	39%
Personal care/assistance	19%
Support with shopping/gardening	19%

Source: Valuing Older People

Table 27: Mapping of Local Voluntary Organisations

	Arts/Culture/ Reminiscence/ Other social	Advocacy /Information	Physical activities	Promotion/ Campaigns	Opportunities for volunteering	Transport	Personal Care/ Assistance	Help with shopping / gardening
ACM - 'Out in the City'	Yes	Yes		Yes	Yes			
ACM - Alf Morris Court	Yes	Yes	Yes	Yes	Yes			
ACM - Broomfield Court	Yes	Yes	Yes	Yes	Yes			
ACM - Crossacres Day Centre	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
ACM - Hurst Court	Yes	Yes	Yes	Yes	Yes			
ACM - Kenneth Collis Court	Yes	Yes	Yes	Yes	Yes			
ACM - Levenshulme		Yes	Yes	Yes	Yes			
ACM - Miles Platting day centre	Yes	Yes	Yes				Yes	
ACM - Moorside	Yes	Yes	Yes	Yes	Yes			
ACM - The Grange	Yes	Yes	Yes	Yes	Yes			

	Arts/Culture/ Reminiscence/ Other social	Advocacy /Information	Physical activities	Promotion/ Campaigns	Opportunities for volunteering	Transport	Personal Care/ Assistance	Help with shopping/ gardening
ACM - Westfields	Yes	Yes	Yes	Yes	Yes			
ACM Cheetham Hill Shop	Yes	Yes	Yes	Yes				
ACM Chorlton Shop	Yes	Yes	Yes	Yes				
ACM Gorton Shop	Yes	Yes	Yes	Yes				
ACM Moston Shop	Yes	Yes	Yes	Yes				
ACM Openshaw Shop	Yes	Yes	Yes	Yes				
ACM Withington Shop	Yes	Yes	Yes	Yes				
ACM Wythenshawe Shop	Yes	Yes	Yes	Yes				
Active Age		Yes	Yes	Yes	Yes			
Afro-Caribbean Care Group	Yes	Yes	Yes		Yes	Yes	Yes	
Alzheimers Society		Yes		Yes	Yes	Yes		

	Arts/Culture/ Reminiscence/ Other social	Advocacy /Information	Physical activities	Promotion/ Campaigns	Opportunities for volunteering	Transport	Personal Care/ Assistance	Help with shopping/ gardening
Beacons Older people's Well-being group				Yes	Yes			
BHA (Black Health Agency)		Yes		Yes	Yes			
BLOOM	Yes	Yes	Yes		Yes			
Broad African Representative Council (Manchester)	Yes	Yes			Yes			Yes
Burnage Good Neighbours	Yes	Yes			Yes	Yes		Yes
Carers Forum	Yes	Yes	Yes		Yes			
Chorlton Good Neighbours	Yes	Yes			Yes	Yes		Yes
Chorlton Insight Group		Yes			Yes		Yes	
Chorlton Workshop	Yes	Yes			Yes			
College of the Third Age	Yes		Yes					
Combined Association Wythenshawe Tenants	Yes	Yes		Yes	Yes			Yes

	Arts/Culture/ Reminiscence/ Other social	Advocacy /Information	Physical activities	Promotion/ Campaigns	Opportunities for volunteering	Transport	Personal Care/ Assistance	Help with shopping/ gardening
Community Arts North West	Yes	Yes						
Croydon Estate Tenants Association					Yes			
Days Away for Recycled Teenagers	Yes					Yes		
Dell Service Users	Yes				Yes	Yes	Yes	Yes
Didsbury Care Group	Yes				Yes	Yes		Yes
Expert Patients Network					Yes			
Frank Cohen Support Group	Yes		Yes	Yes	Yes	Yes	Yes	Yes
Golden Friendship Group 'Women's Group'	Yes		Yes		Yes			
Great Western Street Residents Association	Yes			Yes				Yes

	Arts/Culture/ Reminiscence/ Other social	Advocacy /Information	Physical activities	Promotion/ Campaigns	Opportunities for volunteering	Transport	Personal Care/ Assistance	Help with shopping/ gardening
Greenacres Club for the Elderly	Yes		Yes			Yes		
Hall Lane Resource Centre			Yes			Yes	Yes	
Heart Beat Group			Yes					
Haven of Peace (7th Day Adventists) luncheon club	Yes				Yes			
Henshaws Society for Blind People	Yes		Yes			Yes		
Hulme Alliance Community Association	Yes			**Yes**		Yes		
Hurst Court (Housing 21)	Yes		Yes					
Indian Senior Citizens Centre	Yes		Yes	Yes	Yes	Yes	Yes	Yes
Irish Community Care	Yes	Yes	Yes		Yes			

	Arts/Culture/ Reminiscence/ Other social	Advocacy /Information	Physical activities	Promotion/ Campaigns	Opportunities for volunteering	Transport	Personal Care/ Assistance	Help with shopping/ gardening
Kirkmanshulme Lane Club for the Elderly (Kirkley Club)	Yes		Yes		Yes			
Ladybarn Community Association Care Project	Yes	Yes				Yes		Yes
Library Theatre Company Over 50s Theatre Group	Yes		Yes					
Lily Thomas Tenants Association	Yes	Yes	Yes					
Link Age Advocacy		Yes			Yes			
Longsight & Moss Side Community project		Yes	Yes	Yes	Yes			
ManCAT Gym Session Group			Yes					
Manchester Independent Living Service	Yes	Yes			Yes		Yes	

	Arts/Culture/ Reminiscence/ Other social	Advocacy /Information	Physical activities	Promotion/ Campaigns	Opportunities for volunteering	Transport	Personal Care/ Assistance	Help with shopping/ gardening
Manchester Older Peoples Network		Yes		Yes	Yes			
Manchester People First		Yes		Yes	Yes			
Manchester Race-Health Forum		Yes	Yes	Yes				
Manchester Settlement Pensioners Club		Yes		Yes	Yes	Yes		
Miles Platting Ancoats and Collyhurst VOP working group			Yes					
Mobility & Falls Prevention project		Yes	Yes	Yes	Yes		Yes	
Moss Side Leisure Centre Women's group	Yes		Yes					
Neesa Women Drop in Centre	Yes				Yes	Yes		
New Moston Over 60s Club	Yes	Yes		Yes			Yes	

	Arts/Culture/ Reminiscence/ Other social	Advocacy /Information	Physical activities	Promotion/ Campaigns	Opportunities for volunteering	Transport	Personal Care/ Assistance	Help with shopping/ gardening
Newall View	Yes	Yes	Yes		Yes		Yes	Yes
Nicky Alliance (for Visually Impaired people)		Yes			Yes	Yes	Yes	
North Manchester Royal Naval Association	Yes	Yes	Yes		Yes		Yes	
North Road (sheltered housing) Tenants Association	Yes	Yes						Yes
Northmoor Live at Home	Yes	Yes	Yes		Yes	Yes		
Our Ladys over 50s Club	Yes		Yes		Yes			
Over 50's Sports Morning			Yes					
PACE	Yes		Yes	**Yes**	Yes			
Pakistani Resource Centre	Yes	Yes						

	Arts/Culture/ Reminiscence/ Other social	Advocacy /Information	Physical activities	Promotion/ Campaigns	Opportunities for volunteering	Transport	Personal Care/ Assistance	Help with shopping/ gardening
Paul House & Northern Moor Tenants & Residents Assoc.		Yes	Yes	**Yes**	Yes	Yes		
PRAGMA (Pre-retirement Association of Gr. M/c)		Yes						
Sheltered Housing Warden Service (M/c Housing)	Yes	Yes	Yes	Yes				
Simpson Dancers			Yes					
Sound Heart Support Group		Yes	Yes					
South Manchester Healthy Living Network		Yes	Yes		Yes			Yes
Strollers (North Park Wardens)			Yes					
Sugar Group (re diabetes etc)		Yes	Yes		Ye			

	Arts/Culture/ Reminiscence/ Other social	Advocacy /Information	Physical activities	Promotion/ Campaigns	Opportunities for volunteering	Transport	Personal Care/ Assistance	Help with shopping/ gardening
Tai Chi Group			Yes					
Tea Dance Group			Yes					
St Paul's Wanderers	Yes				Yes			
Phoenix Club	Yes	Yes	Yes		Yes	Yes		
Tree of Life	Yes	Yes	Yes		Yes			
Trinity Club for Disabled	Yes	Yes	Yes	Yes	Yes	Yes		
TUC Pensioner's Association				Yes				
Tung Sing Housing Association		Yes						
Victoria Square Tenants Association		Yes						Yes
Wai Yin Chinese Womens Society	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Whalley Range Forum	Yes	Yes			Yes			
Wythenshawe Pensioners' Association		Yes		Yes		Yes		

Source:http://www.healthprofile.org.uk/(S(45nppdmrnu2iod552zqc3kjn))/code/MasterFrame/MasterFrame.aspx?type=BrowseSys

While not a fully comprehensive overview of organisations and participation opportunities, Table 27 above illustrates the broad and diverse range of voluntary organisations involved in catering for older people's needs at the local community level. However, arts and cultural services, advocacy and campaigning are overwhelmingly the main areas covered by such organisations as indicated in Table 26. Only 15 organisations listed provide personal care or assistance and the same number of organisations provide help with shopping and/or gardening.

There are a number of groups which cater specifically for BME communities., providing cultural services alongside advocacy and physical activities for specific BME groups, such as the Afro-Caribbean Care Group, Indian Senior Citizens Centre and the Wai Yin Chinese Women's centre.

5.2.5. Economic Well-being

An essential component of well-being relates to having sufficient income resources for a good diet, accommodation, and participation in family and community life.[91] Older people in poverty are at higher risk of social exclusion in terms of employment and educational opportunities, service use and social participation.[92] Since poverty and unemployment in mid-life tend to lead to poverty in old age (i.e. there is evidence of cumulative social exclusion[93]), one of the ways of tackling future poverty in old age is by tackling the poverty of younger cohorts, and by, for example, tackling age discrimination in society at large which acts as a barrier to employment, or gaps in skills.

Manchester's Employment Plan[94] identified people aged 50 plus as a priority group for whom access to employment needs to be improved. Agencies in Manchester have been drawn into partnership with the Council to improve access to jobs and to put into place local work-focused training for older

[91] Independence and Well-being of Old People, A Baseline Report Department of Work and Pensions, 2006.
[92] Breaking the Cycle: Taking Stock of Progress and Priorities for the Future. A Report by the Social Exclusion Unit, 2004 (Available online at: http ://www.socialexclusi on.gov. uk/downloaddoc.asp?id=262).
[93] Phillipson, C. and Allan, G., (2004) Social Networks and Social Exclusion: Sociological and Policy Perspectives. Ashgate Publishing.
[94] Manchester Employment Plan 2004-2004, January 2004, available online http://www.manchesterpartnership.org.uk/page/9/

people. A dedicated team has been established to work with private and public agencies, such as the Council and the NHS, to promote the recruitment and work-related training of older people.

Moreover, lack of uptake of benefits can add to the poverty trap endured by some of Manchester's poorest older residents. It is estimated that £5 million plus in Pension Credit goes unclaimed each year in Manchester. Manchester Advice and community groups are working to improve entitlement take up.

Housing was identified as an area in need of improvement in the 2006 *Corporate Performance Assessment.* The identified poor quality of social housing stock means that there is limited choice for older people in need of decent housing.

5.2.6. Freedom from discrimination and harassment

This refers to equality of access to services and not being subject to abuse. As part of the council strategy to address the needs of the elderly BME populations, PRIAE (the Policy Research Institute on Ageing and Ethnicity, based in Leeds) will be working with Manchester City Council, undergoing research on the needs of these communities with a view to informing the Council's Agenda 2010.

In terms of access to adult social care services, there appears to have been a slight improvement in the percentage of clients from BME groups, as illustrated in Table 28 below.

A specialist services has been established to offer housing support for Lesbian, Gay, Bisexual and Transgender older people who may be victims of discrimination and harassment.

The report from the Commission for Social Care Inspection highlighted the relatively few health care homes available for older people suffering from dementia, in comparison with national date. The council has now developed a specification to contract care for this group.

Table 28. Black and Minority Ethnic group population in receipt of assessment

PAF INDICATOR	2004-05	2005-06
AO/E47.1 The number of older clients with completed assessments during the year whose ethnic origin is Mixed, Asian or Asian British, Black or Black British, or Chinese or other ethnic group.	361	193
AO/E47.3 The number of older clients with completed assessments during the year whose ethnic origin is Mixed, Asian or Asian British, Black or Black British, or Chinese or other ethnic group as a percentage of all such clients of these or White ethnic origin.	7%	9%
AO/E47 Percentage of older service users receiving an assessment that are from minority ethnic groups, divided by the percentage of older people in the local population that are from minority ethnic groups	0.94%	1.31%
AO/E48.1 Of the clients in the denominator, the number whose anticipated sequel to assessment was 'Some or all (new) services intended or already started (incl. those started and finished)', or 'New service(s) offered but declined' and whose ethnic origin is Mixed, Asian or Asian British, Black or Black British, or Chinese or other ethnic group.	275	139
AO/E48.3 The percentage of older clients with completed assessments during the year whose anticipated sequel to assessment was 'Some or all (new) services intended or already started' or 'New service(s) offered but declined' who were from an ethnic minority group.	6%	9%
AO/E48.4 The number of older clients with completed assessments during the year whose ethnic origin is Mixed, Asian or Asian British, Black or Black British, or Chinese or other ethnic group.	--	193
AO/E48.6 The number of older clients with completed assessments during the year whose ethnic origin is Mixed, Asian or Asian British, Black or Black British, or Chinese or other ethnic group as a percentage of all such clients of these or White ethnic origin.	N/A	9%
AO/E48 The percentage of older service users receiving services following an assessment that are from a minority ethnic group, divided by the percentage of older service users assessed that are from a minority ethnic group.	0.91%	0.94%

Source: Ward Data Reporting, 2006, source for other data in CSCI Performance Assessment Framework Performance Indicators, http://www.csci.org.uk/care_professional/councils/paf/paf_reports_and_data.aspx

5.2.7. Personal dignity

In terms of Social Care Outcome definitions[95], personal dignity refers to a clean and orderly environment with the availability of appropriate personal care (see Section 5.1 for information in relation to personal care). The aim is to ensure that service users and carers are regarded as valued individuals, with respect for their dignity and privacy. In this sense, Manchester's health and social care services, as well as services within the voluntary and community sectors, should be provided in order to support social and civic participation, alleviate suffering and meet needs in ways which emphasise a person-centred, humanistic approach regardless of age, gender, ethnic origin, faith, ability, or sexuality.

The cornerstone of personal dignity revolves around the notion that confidential services are offered and that service providers safeguard clients against abuse, neglect and poor treatment while using services. In this respect, Manchester's Multi-agency Policy for the Protection of Vulnerable Adults from Abuse is based on an inter-agency collaborative partnership in the city which supports effective joint working. Partners to this include: Commissioners of health and social care, Providers of health and social care, Providers of supported or wardened housing, Regulatory bodies for services and agencies, Voluntary and independent sector agencies' Carer support groups, User led groups and services, Advocacy services, Police force, Probationary services, Judicial and legal services, Benefit agency, Advice and support agencies and Community groups. An inter-agency policy management group is charged with overseeing the application and review of policy within Manchester.

Several principles underpin policy[96] which are to:

- Recognise those individuals to which the policy refers;
- Work jointly based on the recommendations in the "no secrets" guidance[97];

[95] Social Care Institute for Excellence (2005) Consultation: Independence, well-being and choice: Our vision for the future of social care for adults in England
[96] http://www.manchester.gov.uk/adultsocialcare/nosecrets/policy.htm

- Positively promote the rights and well being of vulnerable adults through service support and delivery;
- Support the rights of individuals by respecting self-determination and informed choice;
- Acknowledge risk as an integral part of choice and decision-making, but ensure that the risks taken are assessed, discussed recorded and, where possible, minimised;
- Ensure that vulnerable adults are safeguarded by effectively integrating policies, strategies and procedures that are relevant to abuse and harm;
- Safeguard the continuation of the right to independence of vulnerable adults by ensuring that risk packages, and appropriate support is provided when possible;
- Understand the law and statutory requirements that provide protection and access to the judicial process for vulnerable adults.

The main function of this strategy for the Protection of Vulnerable Adults is to ensure:

- agencies have policy relevant procedures and joint protocols for shared practice related to vulnerable adults;
- identification of specifics which should be contained in the contracts of service providers who cater for vulnerable adults or potential abusers;
- a plan of action for educating agency staff, officers, carers, service users and the general public;
- an inter-agency development plan, supported by commissioners, to identify unmet need and the services required to alter the situation.

The tenets of this policy apply to all statutory, voluntary, independent and not for profit agencies in Manchester involved with vulnerable adults.

[97] Department of Health and Home Office (2000), No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse.

6. Older People's Perceptions of Life in Manchester: The Best Value Survey

The Best Value Survey is a yearly survey to identify how residents and businesses feel about council services and local city services in general, in order to inform city-wide priorities. This section of the report presents responses from the over 55s from the 2004/2005 survey.

6.1 What Makes a Good Neighbourhood?

For the over 55s, a **low level of crime** was the most frequently cited condition for a good neighbourhood (cited by 83% of respondents over 55), followed by **clean streets** (61%) and **health services** (54%), affordable decent housing: (47%), shopping facilities and public transport (44%). The percentage of respondents aged 55 plus citing education, facilities for young children and activities for teenagers, did not differ significantly from responses for all age groups combined, suggesting an interest in wider concerns about the neighbourhood, above and beyond more direct personal interests.

When asked about how they felt about their neighbourhood, over 55s did not differ significantly from all respondents. 49% spoke highly of their neighbourhood, either spontaneously (17%) or when asked (32%) against 40% who were critical, either spontaneously (27%) or when asked (13%).

Attachment to Manchester differed slightly when compared with overall results of the survey. In all 84% of over 55s claimed to be attached to the City against 83% of all respondents. However, the degrees of attachment differed. 58% of the over 55s were strongly attached compared to 52% of all respondents. Attachment to the local area was lower, 34% of over 55s being strongly attached and 38% being slightly attached, with 23% not being attached to their local area compared to 14% of over 55s not attached to the City of Manchester. Unsurprisingly, given the demographic characteristics of older age cohorts, over 55s were significantly more attached to the North West, England and to Britain.

The following factors which contribute to quality of life were most frequently cited as being in need of improvement by over 55s:

- Tackling crime levels: 69%
- Clean streets: 55%
- Road/pavement repairs: 47%
- Activities for teenagers: 38%
- Public transport: 34%
- Shopping facilities: 33%.

6.2 Leisure Services

Over 55s were less likely to use sports and leisure facilities and events provided by the City Council than all respondents in the Best Value Survey. 55% never used such services, compared with 35% of all respondents. There was a mixed response to the use of library services with 29% visiting libraries once a month (compared with 26% of all respondents) whilst 26% had never used library services (compared with 20% of all respondents).

Older people in Manchester also visit museums and galleries less than all age groups combined, with 10% visiting museums and galleries once a month (compared with 15% of all respondents), 24% visiting once in the previous 6 months (compared with 28% of all respondents) and 33% never using museums or galleries (compared with 21% of all respondents).

Parks and open spaces provided for or supported by Manchester City Council were more popular with this age group, with 11% visiting such places every day, 22% at least once a week and 23% at least once a month. Community festivals were the least used cultural service, with 48% not attending a community festival in the previous 12 months.

On the whole over 55s who responded to the survey tended to be satisfied with sports, leisure and cultural facilities provided by the council.

6.3 Participation

Over 55s in the Best Value Survey had a higher rate of positive responses, relative to the responses of all age groups taken together, to questions related to perceived ability to affect and change conditions in local neighbourhoods, knowledge about changes taking place and the ability to be heard by decision

makers, suggesting a higher level of confidence with regard to local governance. However, rates of positive responses were still low in comparison with negative and neutral responses.

6.4. Crime

Low crime featured very prominently as a factor contributing to a good neighbourhood, being by far the most frequently cited factor for over 55s (see 4.1.1 above). Similarly, crime was the most often citied factor that this aged group perceived to be in need of improvement. This age group also links crime to health. Less crime was the most frequently cited factor likely to contribute to improved health (44%), with more exercise ranking second (37%), followed by higher income (34%), reduced pollution (33%) and easier access to a GP (31%). The emphasis given to crime corresponds to national data which suggest that older people have a high level of fear of crime, despite being the least likely to become victims of crime (see Table 29).

Table 29: Older people as a percentage of crime victims

Type of Crime	Percentage of Victims aged 51 or over
Burglary	23.5
Robbery	10.2
Street Violence	5.6
Vehicle Crime	16.3
Vandalism	22.8

Source: Manchester Crime and Disorder Reduction Partnership Draft Audit, November 2004

However, for older people, perceptions of crime, and of being at risk of crime, can have a serious impact on quality of life. Increased fear of crime can lead to social isolation and therefore have a detrimental affect on the well-being of older persons. Whilst national research suggests that older people have a disproportionate fear of crime in relation to their rates of victimisation. research into fear of crime among older people in deprived areas of the UK

including Manchester has suggested that the traditional crime surveys underestimate older people's experience of crime.[98] The City council has been working with other agencies to make vulnerable people, including older people, feel more secure in their neighborhood, securing properties and installing alley-gates. There are also schemes in place which try to raise awareness of bogus callers amongst older people (e.g. Crucial Crew).

[98] Growing Older in Socially Deprived Areas, Help The Aged, 2002.

7. Conclusion

This aim of this report has been to bring together data on older people in Manchester with specific reference to the POPP priorities, as well as presenting the social policy context which provides the framework for health and service care for this age group.

A number of demographic and socio-economic characteristics have been identified by the report: the high level of social and economic deprivation experienced by some of Manchester's older population; the ethnic diversity of the city which will have an impact on future service delivery; the low proportion of residents aged 60 and over relative to England as a whole; Manchester's status as a "Spearhead" area in terms of health inequalities compared to England as a whole.

High levels of social and economic deprivation and health inequalities in Manchester require strong mechanisms to be into place to overcome barriers to health, well-being and quality of life in older age, particularly for disadvantaged and 'hard to reach' groups.

By establishing older people's health and well-being as a cross-cutting priority, local strategy is aiming to overcome these barriers, for instance the Valuing Older People initiative has encouraged the mainstreaming of older people's concerns, bringing together partner organisations and older people's representatives. As a result, strategy towards older people has begun to inform a broad range of policy decisions and the 2005/06 action plan developed by VOP board has been implemented, from awareness-raising activities through to consultation processes designed to improve strategy.

Through the Manchester POPP project, the development and coordination of a network of health, social care, voluntary and community based agencies providing a range of services has begun to be established, providing enhanced preventive services, access to information and business improvement advice and oppoortunities. The establishment of an up-to-date and regularly maintained mapping of service organisations and available services for older people in a designated database will be an important tool in

establishing an effective network. Care in the community for older people should be enhanced by this.

A key challenge facing Manchester's social and health care providers lies in reaching vulnerable groups. Black and Minority Ethnic groups who often face high levels of economic deprivation, have been identified as 'hard to reach' by the local partnership, and there are plans to better research and address their needs. Similarly, older people suffering from poor physical and mental health as well as multiple social exclusions have also been identified as groups of people for whom access to services and opportunities for participation needs to be improved. These important areas in need of innovative and joined-up service provision have been targeted, among other mechanisms for change, as part of a reconfiguration of service provision for older people by the Manchester POPP programme. This baseline analysis has outlined key social, economic and health contexts within which critical challenges facing such a reconfiguration are based.

Appendix 1

List of voluntary organisations schemes funded through POPP

Organisation	Scheme
Wai Yin	Additional support for Sheung Lok (Happiness) Club Luncheon service for Chinese Elderly.
Link Age Advocacy Project	Advocacy support for isolated older people living in residential/nursing homes.
Indian Senior Citizens Centre	Advocacy support for Indian elderly
The Sugar Group	Exercise service for older people with diabetes.
Landridge House	Establishment of a forum where disabled elderly can speak up on matters of concern.
Lime	Provision of creative workshops in photography, creative writing and dance to elderly people in resource/day care centres and establishment of two mobile library routes for elderly persons
Willow Park Housing Trust	Social, Health and Learning and Development sessions for older people and work on an in-house volunteer programme.
The Generation Project	Establishment of a neighbourhood care scheme in East Manchester with the aim of providing older people with easy access to low level holistic support.
Manchester Care and Repair Ltd	Extension of a pilot project aimed at older carers to provide the redecoration of one room in their home.
Eastserve – New Deal for Communities	To enable older people to access the Eastserve and benefit from increased ICT knowledge.
Cheetham Al-Hilal Community Project	Community projects focusing on the needs of elderly BME men.
Ladybarn Community Centre	Residential for 15 older people aimed at empowering them as individuals and holding a forum for influencing the strategic direction of older people's services within local community.
Neesa Well Women Dropin project	Improve the health and well being of hard to reach elderly Asian women carers. Provision of information about culturally appropriate healthy diets and run exercise classes.
Age Concern Manchester (VOP Garden	Facilitate inclusion of older people at the Wythenshawe Festival.

Party)	
Age Concern Manchester (costume making project)	Carnival costume making project involving 15 older people and 15 young people who will be assisted to design and make costumes to be worn at the Annual Christmas Lantern Parade in December

Gaddum Centre	Provide an independent holistic 'social health care check' via a home visit, for patients of GPs in Central Manchester. The result will be a qualitative view of an individual's social need and an action plan to improve quality of life, prevent deterioration and increase social participation.
Barlow Moor Community Association	Decrease social isolation and increase community social activity amongst the over 60s age group in the Merseybank Estate and environs by delivery of befriending activity, low level domestic assistance and provision of mature movers exercise in the home. Delivered by support worker who will recruit volunteers from the community. Worker will 'build on', enhance and vary the activities of the present Community Centre's over 60s luncheon and social club.
Age Concern	The application is for the full costs of employing a hospital discharge team leader to provide practical support to older people leaving Wythenshawe hospital using a team of dedicated volunteers.
Manchester Jewish Federation	Support the elderly Jewish Community of Manchester by facilitating 'joined up' low level services. Will enhance volunteering opportunities for older people encouraging them to remain active and involved. Promoting health, independence and reducing risk are central to this project.
Age Concern	We wish to fund an Ageing Well worker to contact Sheltered Housing schemes, and acting as both facilitator and participator, to encourage older people in social interaction, lifelong learning, and economic empowerment through a wide range of activities.
Assist Neighbourhood Care Group	Development and enhancement of volunteer work. A more sustainable visiting service improving skills and confidence of new/existing volunteers and to extend their service to reach older people with more challenging issue, including those with low level mental health problem
Manchester Care and Repair	Extension of existing falls prevention work to cover a wider range of information, advice and security issues. Providing training in falls prevention resources to front-line staff working with older people living at home. Extend the current handyperson service across wards and tenures so that it is more visible to service users and commissioners.

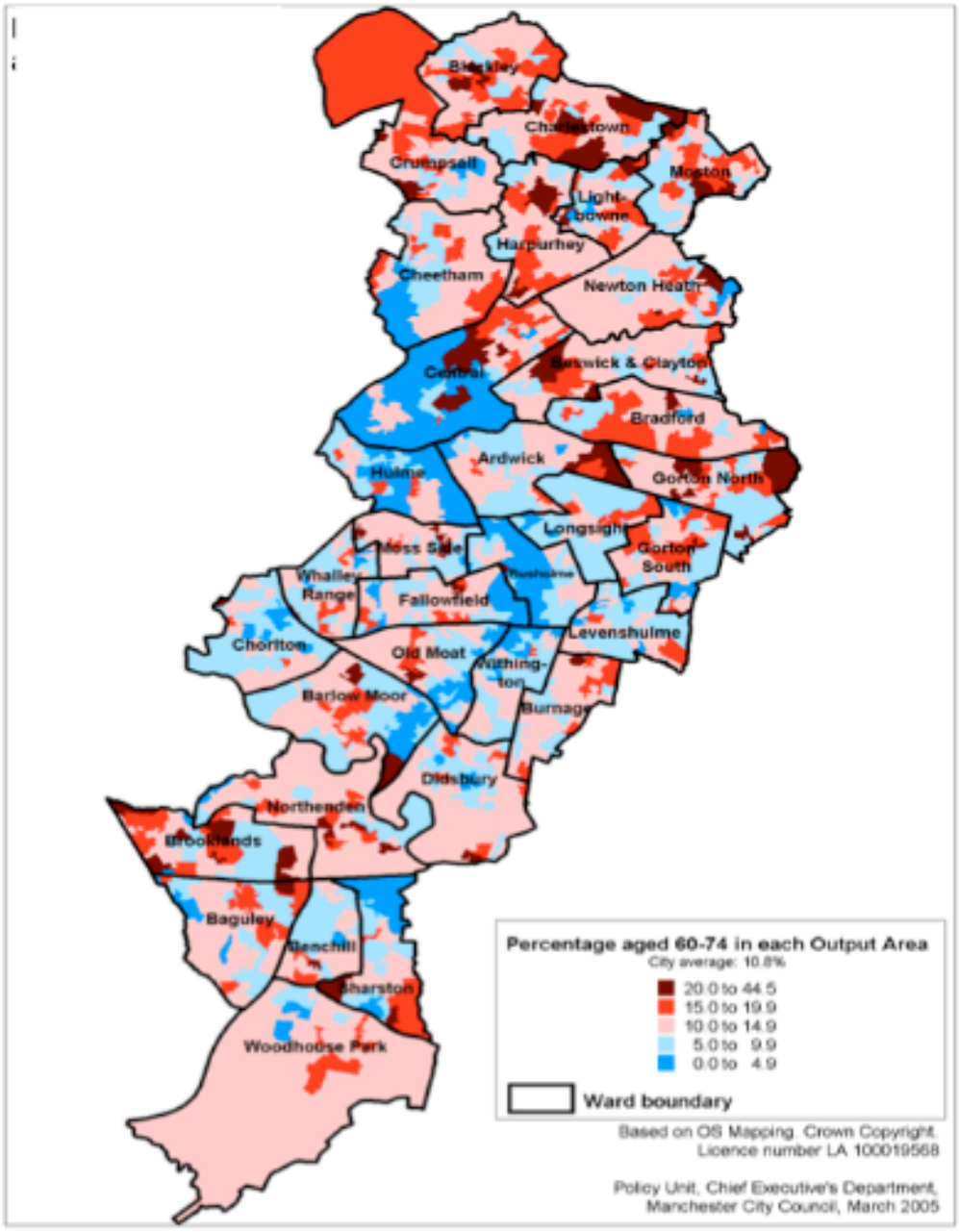
Nephra Residents Association	Luncheon club; used as a vehicle to entice older more isolated residents of New Moston into Café\Lunch Club. Opportunities for a healthy lunch, light exercise – dance, gardening, curling etc. and just as important, advocacy and advice sessions, aimed at improving the overall quality of life for our older residents. Using the Club\Café as a springboard, it's our intention to develop an Older Peoples Forum. Here we will focus upon solving problems and developing services, which promote a healthier, fun filled, and most importantly independent retirement.
Residents of Gordon Street Area	The project proposes to offer several daytrips to elderly residents of the area, including visits to the theatre. They want to do this in February, a cold dark month when the elderly may feel particularly isolated and vulnerable. Dunstan Court Card and craft sessions will keep minds active. Massage and aromatherapy sessions offer the chance to relax without resorting to increased medication. For residents of Dunstan Court and local neighbourhood
Manchester Bangladeshi Womens Organisation	World Mental Health Day celebration for older Asian women and their families, to raise awareness of the issue of mental health.
Peel Hall Moatwatch	Exercise for local elderly, getting them out of the house whilst improving their general mobility and movement. In partnership with Health Living Network.
St Mark's United Reform Church	Intergenerational project with Children from Woodhouse Park Family Centre, skill sharing and engagement between older and younger people.
Izhar-E-Rai, Neesa Well Women's, North Manchester African and Caribbean Elders Care Group (NMACECG)	Funding for an open day to attract members of community not currently receiving services, develop ongoing community engagement and evaluation.
Landridge House	To produce a newsletter in a format accessible for adults with learning disabilities promoting the older person's group. It will be produced quarterly with input from people using the service.
Afro Caribbean Care Group (ACCG)	To utilise Black History Month activities to publicise the work of ACCG, thus increasing uptake of services, which include the prevention of social isolation. Opportunity will also be taken to raise awareness around diabetes, hypertension and sickle cell disease.
Indian Senior Citizens Centre	Provision of new chiropody service for disabled Indian elderly across the city. Employment of a chiropodist 3 hours a week for 26 weeks.

Generation Project	Embedding the Gateway in the East Manchester area to ensure that older people can benefit from the city-wide Gateway by working in innovative ways locally to give information and support to older people.
MERCi	The Healthy and Independent People (HIP) Project provides a package of support and social care, delivered around the central theme of food, both within the home and in the community, with the overall aim to help older people live more independent lives in their own homes.
Anchor Staying Put	A caseworker/technical position to compliment work achieved by the Home from Hospital Service at MRI. The caseworker assists with discharge and return home to independent living. The service in existence since 2004 is now stretched beyond capacity. A proven track record means the proposed expansion can start immediately.
The Roby	Part-time worker to initiate a South Asian men's activity-therapeutic group for elderly people from the BME community to improve their capacity to identify their own health needs, address them appropriately, improve well being and prevent social exclusion and mental health problems.
Stroke Association /Carers Forum	To hold an eight week course for people who have had a stroke. This would be followed by a one hour education programme on subjects linked to stroke, lifestyle advice and health promotion. A parallel group would be held for their carers.
City Wide Resource Centres	A series of rotating activities to older people via carers/volunteers with the aim of increasing the use of Heathfield Resource Centre in Newton Heath by the local community.
Indian Social and Sports Centre	Provision of hot vegetarian lunches, transport and advice on local issues. Wish to provide support to people when leaving hospitals, help overcome barriers to access, home visits, advocacy services, escorting services such as to local GPs, hospitals, shopping, collect pensions etc. Wish to provide elderly services to enable them to gain and regain their skills and confidence.
Partnership of Somali Groups (Somali Brava Sister, Banadir Unity, Somaliland Community Centre)	Day Centre for elderly people, run by a Support Worker and volunteers, with travel provided. Centre in Moss Side to provide a range of social support and recreational activities for the service users.
Burnage Good Neighbours	Through a partnership between 7 established Neighbourhood Care Groups a project worker based at, and managed by Burnage Care Group will develop a volunteering project will meet the needs of isolated older people currently not receiving a service in Burnage, Didsbury,

	Brooklands, Chorlton, Northern Moor, Withington and Ladybarn.
Mood Swings	Promotion of existing support services to older people. The tailoring of service to meet the particular needs of this group. The service will provide information, advice and support in a friendly relaxed setting, aimed and helping older people to cope with anxiety and depression.
Admiral Nursing Service	This city wide service will, via a dedicated project worker, recruit and enable carers of those people with dementia to become peer mentors to other family carers thereby enabling them to pass on skills acquired through their own personal experience.
Memories Dementia Café	To develop an existing Dementia Care Café in Didsbury, South Manchester and establish another in the Wythenshawe area. A service to support the mental and social wellbeing for people with dementia and their carers in an environment away from that of an institution. Open to any member of the community.
Alzheimers Society	The 'Advice and Liaison Service' (ALS) will focus on older adults with dementia and their carers to provide befriending opportunities, support to live safely at home, information, welfare benefits and financial advice. The service will primarily be available to Care Trust discharges, however the option to support general hospital discharges will be considered.
Manchester Deaf Centre	To provide advice, training and consultation to statutory, private and voluntary sector agencies that provide services to older Deaf people in Greater Manchester. The aim of the project is to improve accessibility, choice and the quality of support available to a diverse

Appendix 2

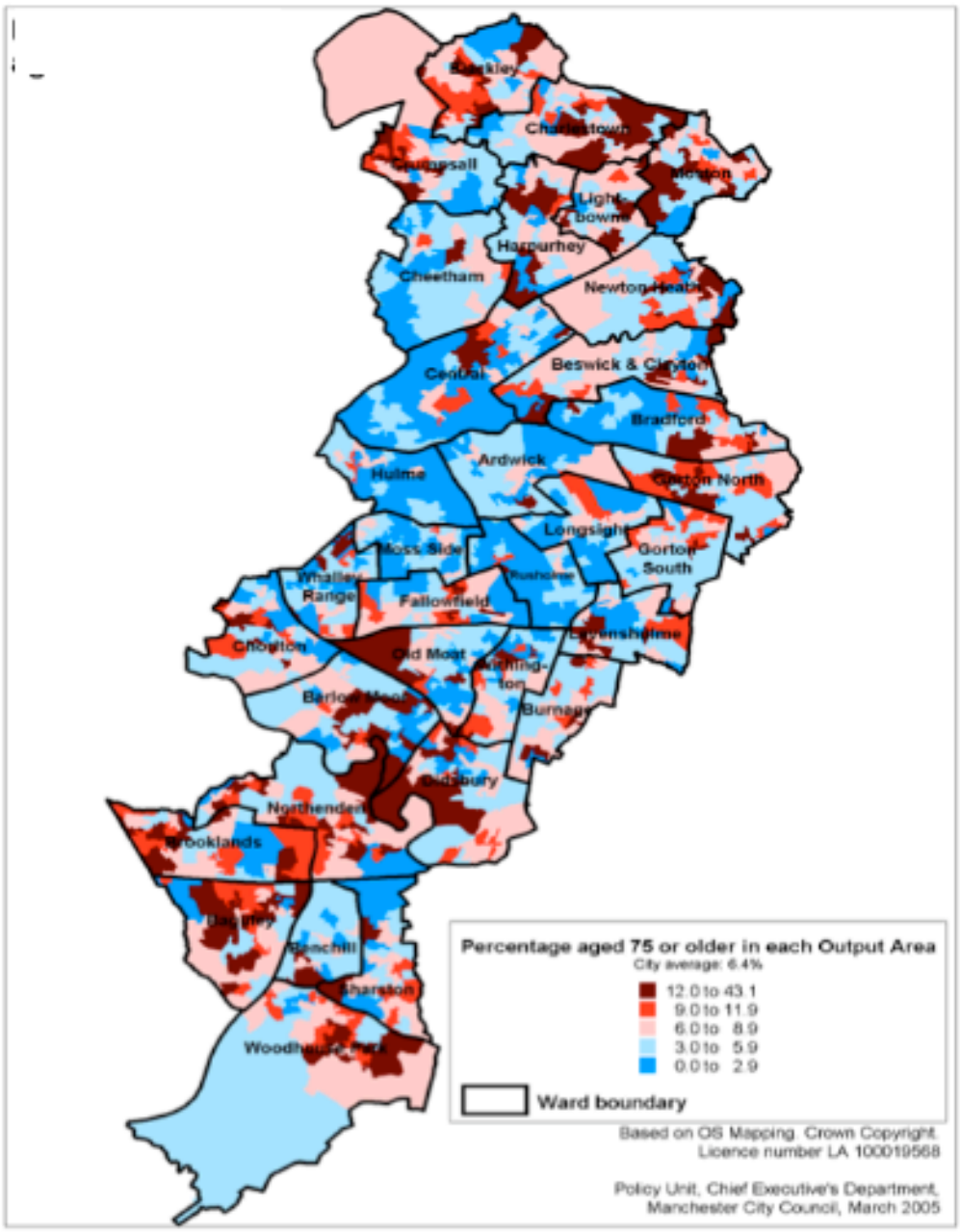
Map 1: Percentage aged 60-74 in each Output Area



Note: Ward boundaries presented here are pre-2004 ward boundaries. However, data is organised according to Output Areas which are not limited to ward boundaries.

Appendix 3

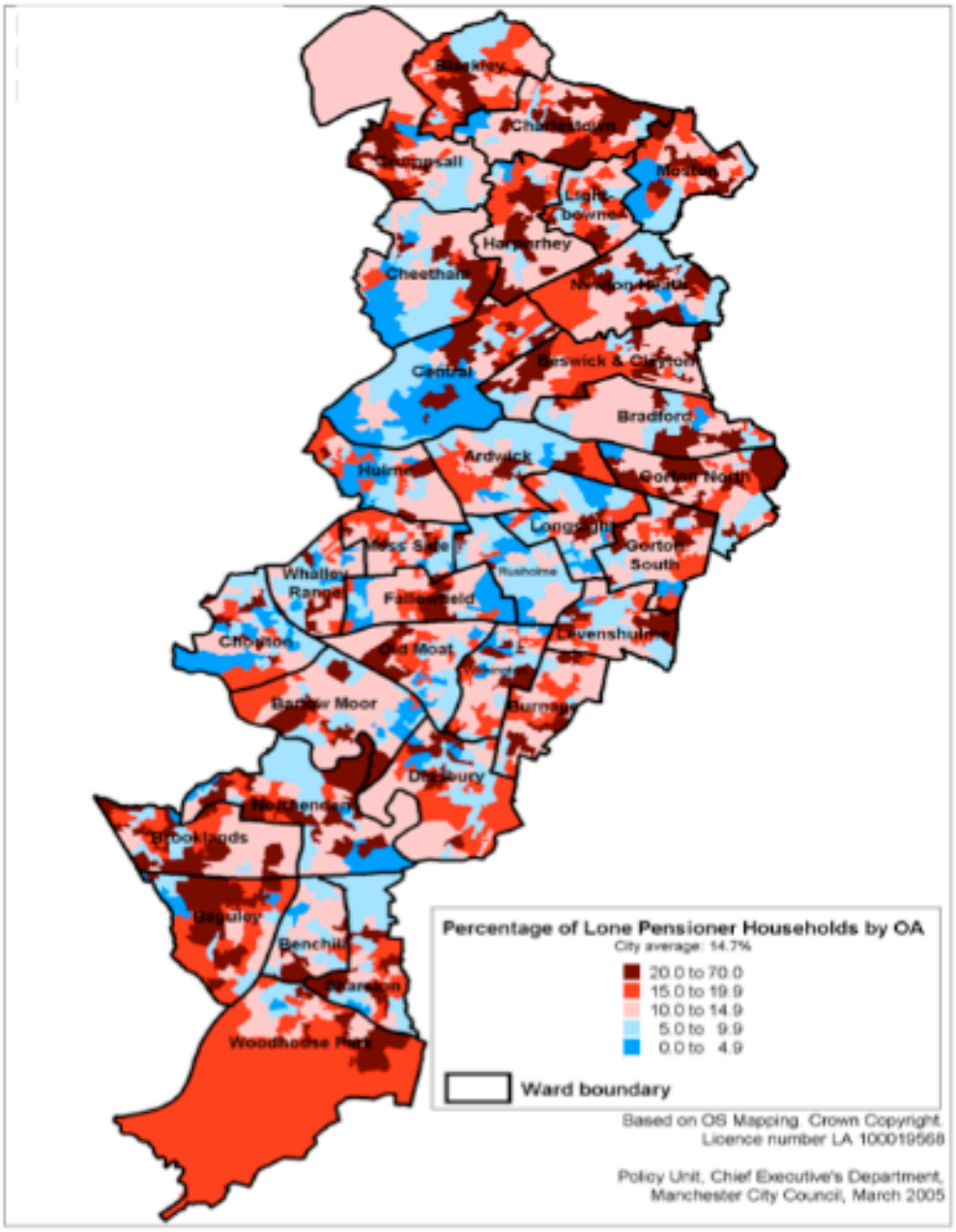
Map 2: Percentage aged 75 and over in each Output Area



Note: Ward boundaries presented here are pre-2004 ward boundaries. However, data is organised according to Output Areas which are not limited to ward boundaries.

Appendix 4

Map 3: Percentage of Lone Pensioner Households by Output Area



Note: Ward boundaries presented here are pre-2004 ward boundaries. However, data is organised according to Output Areas which are not limited to ward boundaries.

Appendix 5

Perceptions of Quality of Life: The Case of East Manchester

East Manchester is a particularly deprived area of the City. An analysis of older people's perceptions of quality of life in this part of Manchester provides a useful insight into the effect of deprivation on older people, and is therefore relevant for other deprived areas of the city.

East Manchester is characterised by many of the socio-economic conditions and problems of other inner city areas in Britain's large cities. However, the scale of deprivation over such a large area (three times the size of the city centre, with a population of 30,000) presents particular issues for the quality of life of residents, among whom older people will have specific needs and concerns. The following provides an insight into some of the problems of East Manchester that are of relevance to the older population.

- a large number of unregulated, poorly serviced private-rented accommodation due to decline in property prices creates specific challenges;
- high crime rates – burglary, juvenile nuisance and domestic violence all substantially above the city average;
- poor health – the incidence of lung cancer is almost three times the UK average, and heart and circulatory diseases more than twice the national average; poor quality infrastructure and environment.

East Manchester has been the focus of regeneration initiatives over a numbers of years, which have included surveys to capture the effect of regeneration schemes on the well-being of residents. A Household Perceptions Survey has been carried out over a number of years in order to analyse perceptions of change in the area around dimensions linked to well-being. Data from 2002 drawn from responses from the 55 plus age group is presented below.

Socio-economic Characteristics of Older People in East Manchester

East Manchester's older people constitute a stable community with very little migration either in or out of the area. Nearly 80% of respondents aged 60 plus have lived in the area for more than 21 years with very few having moved into the area in the last decade. Reasons given for living in East Manchester were either to do with proximity of family/friends or lack of alternative options.

This area has a high proportion of people living alone (approximately 55%), which increases with age – 73% of over 75s live alone. Some of these are likely to be among the high percentage of respondents who have a physical or mental disability, nearly 40% of the 60 plus age group.

Rates of car ownership are low. Under of the 60-64 year olds have a car or van in the household. This falls to 32% for the 65-74 age group, revealing a high level of income deprivation, and has important implications for accessibility, the lack of which can lead to social isolation.

Quality of Life

Attitudes to the quality of life indicators in the area were mixed, illustrating the complex nature of quality of life. Whilst a high percentage of respondents felt that the reputation of their area had got worse over the previous three years (40%) compared with 21% of thought that it had improved, 40% were satisfied with their neighbourhood, with 13% stating they were very satisfied with their area. Again 76% described their quality of life as very or fairly good. Only slight more respondents (36%) considered that their area was improving, than those who thought it was getting worse (32%).

Attitudes to services varied according to the service. Health facilities were rated highly, 70% stating they were good or very good, whilst only 25% rated social and leisure facilities as good or very good. This may be to do with lack of use, given the relatively high number of respondents not in a position to respond ("don't know"). Parks and green areas rated highly, as did street lighting and rubbish collection.

Local services (such as chemist, post office, dentist and local shops) were considered easy to access (hospitals were seen as the most difficult to access). However 46% of over 60s felt that local shops and facilities had deteriorated in the previous three years, compared with 19% who felt they had

improved. Transport fared slightly better, with 28% feeling that there was improvement in transport, against 16% who though that transport was worse.

Health

Whilst 30% describe their health as "good" over the last 12 months, 27% described their health as "poor" and only 11% felt that their health had changed for the better over the last 12 months. 45% of respondents had a long-standing illness, disability or infirmity, which for 84% has a limiting effect on their life.

Exercise did not figure very much in the lives of this sample, with 96% not taking part in planned exercise.

25% of older people were smokers at the time of the survey, with 64% of these smoking more than 10 cigarettes a day.

Crime

Tackling crime was not seen as the most important factor to improving quality of life. Improving shops and reducing anti-social behaviour were seen as the most significant factors. It may be that despite the high levels of crime in East Manchester, on a daily basis these other factors are more relevant to improving quality of life.

On the other hand, nearly a quarter of older people felt "less safe than they did 2 years ago", the main reason cited being a neighbour/friend who had been a victim of crime. Principal concerns are "having the house broken into", "physical assault" and "vandalism". 72% of older people feel unsafe (a little or very) when walking in the area after dark.

Community and participation

15% of older residents did not feel part of the community. However the most cited reason given for this was that they were "not interested", which suggests that there may be an element of personal choice. 55% felt that there was a lot of community spirit in the area compared to 31% who did not, which may

reflect the long-term resident status of this age group. Similarly, 75% described the neighbourhood as one where "people look out for each other".

Only 24% of older residents felt that they could influence decisions made in the local area. Slightly less knew a moderate amount about plans to improve the area, compared with 63% who knew "little or nothing". These responses are similar to responses given to analogous questions amongst the over 55 respondents in the Best Value Survey.

Appendix 6

Glossary

2001 Census Concepts and Definitions

Economically inactive - this category includes all people who are not economically active. Reasons for economic inactivity include: retired, student (excludes those students who were working or in some other way were economically active), looking after family/home, permanently sick/disabled and other.

Ethnic group - the ethnic group question records each person's perceived ethnic group and cultural background. Although the questions differ between different parts of the UK, the same detailed codes were used across the UK to code the write in responses. In standard output the most detailed classification used is 16 ethnic groups in England & Wales.

White group: British, Irish, Other White

Mixed group: White and Black Caribbean, White and Black African, White and Asian, Other Mixed

Asian or Asian British group: Indian, Pakistani, Bangladeshi, Other Asian

Black or Black British group: Caribbean, African, Other Black

Chinese or Other ethnic group: Chinese, Other Ethnic Group

It should be noted that the ethnic group classification as used in the 2001 Census is not same as the 1991 classification. Any direct comparability with the 1991 Census classifications is not possible.

General Health - the question asked whether over the previous 12 months the person's health had been on the whole been good, fairly good or not good. It was intended to be judged subjectively by the form-filler.

Household - a household comprises one person living alone, or a group of people (not necessarily related) living at the same address with common housekeeping –that is sharing either a living room or sitting room or at least one meal a day.

Household reference person (HRP) - the term used in 2001 output instead of the term 'Head of Household' which was applied in 1991 Census. For a person living alone, it follows that this person is the HRP. If the household contains only one family (with or without ungrouped individuals) the HRP is the same as the Familiy Reference Person (FRP). If there is more than one family in the household, the HRP is chosen from the FRPs using the same criteria as for choosing the FRP (economic activity, then age, then order on the form). If there is no family, the HRP is chosen from the individuals using the same criteria.

Household tenure - the tenure of a household is derived from the response to the question asking whether the household owns or rents its accommodation and, if rented, from the response to the question asking who is the landlord.

Limiting long-term illness - everyone was asked whether they had any long-term illness, health problem or disability which limited their daily activities or the work they could do, including problems due to old age.

Outer and inner City areas -

Outer City areas comprise the wards (2004 boundaries): Ancoats, Ardwick, Bradford, Cheetham, City Centre, Fallowfield, Gorton North, Gorton South, Harpurhey, Hulme, Levenshulme, Longsight, Moss Side,Miles Platting/Newton Heath, Rusholme and Whalley Range.

Inner City areas comprise the wards (2004 wards): Baguley, Brooklands, Burnage, Charlestown, Chorlton, Chorlton Park, Crumpsall, Didsbury West, Didsbury East, Higher Blackley, Moston, Northenden, Old Moat, Sharston, Withington and Woodhouse Park.

Output area level - output area is the smallest area for which the Census data available and included average 125 households.

Owned - this includes accommodation that is either owned outright, owned with a

mortgage or loan, or shared ownership (paying part rent and part mortgage).
PCT - Primary Care Trusts: NHS organisations responsible for planning and commissioning health care services for their local populations.
Pensioner - is a 'person of pensionable age'. Pensionable age is 65 and over for males and 60 and over for females.
Permanently sick or disabled - the Census questions on economic activity give a measure of the number of people aged 16-74 who are unable to work because they are permanently sick or disabled. There is no direct connection with limiting long-term illness.
Population base - the 2001 Census has been conducted on a resident basis. This means the statistics relate to where people usually live, as opposed to where they are on Census night. Students and schoolchildren studying away from the family home are counted as resident at their term-time address.
Private rented - this includes accommodation that is rented from a private landlord or letting agency, employer of a household member, relative or friend of a household member or other non-social rented.
Qualifications - the term 'no qualifications' describes people without any academic, vocational or professional qualifications. The term 'lower level' qualifications is used to describe qualifications equivalent to levels 1 to 3 of the National Key Learning Targets (i.e. GCSE's, 'O' levels, A levels, NVQ levels 1-3). The term 'higher level' refers to qualifications of levels 4/5 (i.e. first degree, higher degree, NVQ levels 4 and 5, HND, HNC and certain professional qualifications).
Social rented - this includes accommodation that is rented from a Council or a Housing Association, Housing Co-operative, Charitable Trust, Non-profit housing company or Registered Social Landlord (RSL).
Spearhead area - The local authority areas in England with the poorest health indicators. The government expects these areas to improve at a faster rate than the national average

ISSN 1750-1571

ISBN 978-1-900139-18-2

£7.50