Adult Social Care – Joint Strategic Needs Assessment

Doncaster 2015

Doncaster Data Observatory

May 2016

Authors

- Laurie Mott (Doncaster Council)
- Lauren Edwards (Doncaster Council)

Contributors

- Jonathon Briggs (Doncaster CCG)
- Angelique Choppin (Doncaster Council)
- Sandra Conway (Doncaster Council)
- Andrew Goodall (Doncaster Council)
- Theo Jarrett (Doncaster Council)
- Natalie Pendleton (Doncaster Council)
- Michaela Pinchard (Doncaster Council)
- Trevor Smith (New Horizons)
- Denise Sholtysek (Doncaster Council)
- Lisa Swainston (Doncaster Council)
- Martin Walker (Doncaster Council)
- Allan Wiltshire (Doncaster Council)

Contents

Summary

The following report outlines some of the key challenges that face adult social care in Doncaster. Doncaster has an aging population and, compared to similar areas, has poor health outcomes. This is particularly true when measured as disability free life expectancy. This implies that Doncaster could face a future with an ageing population which is also living with above average levels of disability.

Disability or infirmities are not the only reasons that people need support from adult social care. But it does represent a significant challenge for those services. The report then highlights the increasing levels of demand that Doncaster's social services could face if nothing changes.

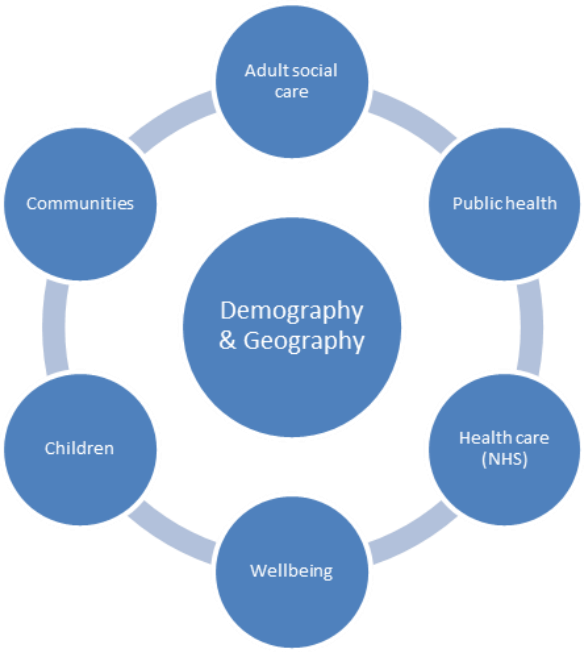
The report includes two appendices to the main report. The first outlines the potential advantages of an ageing population and the second looks at the social care and ethnicity.

It is important to note that Doncaster adult social care services are already embarked on an extensive programme of transformation to address many of the issues that are presented in this report.

Introduction

Joint Strategic Needs Assessment (JSNA) is an analysis of the current and future health and wellbeing needs in Doncaster. This report is intended to inform and improve strategic commissioning, support the health and wellbeing strategy, and help Doncaster's Health and Wellbeing Board address health inequalities[1]. This is the latest in a series of JSNAs that the Doncaster Data Observatory has produced, copies of which can be found on the Team Doncaster partnership website[2] .

This JSNA report reflects the structure outlined below. This graphic has seven domains: Public Health, Healthcare, Wellbeing, Children, Communities, and Adult social care. Underlying all of these is a comprehensive description of the demography and geography of the borough. This report describes some of the strategic challenges facing adult social care[3].

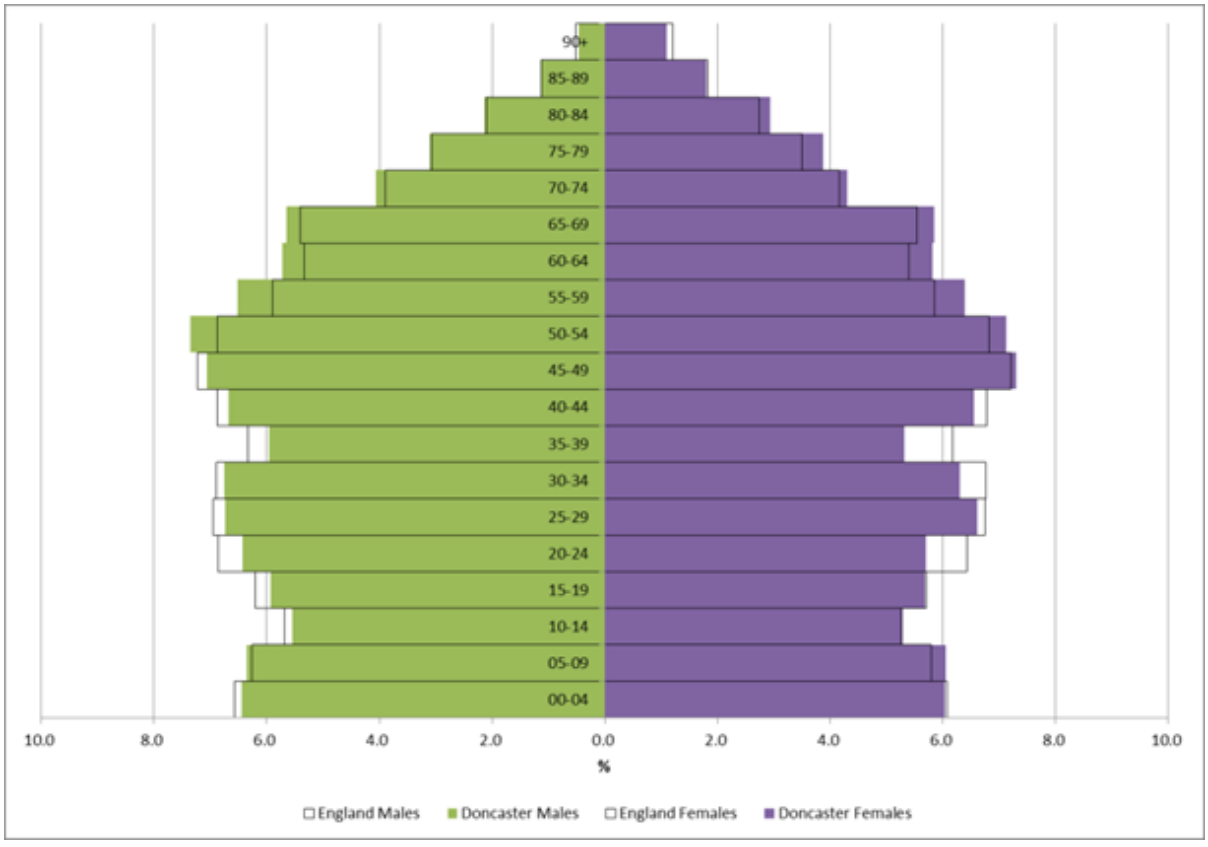


[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215261/dh_131733.pdf
[2] http://www.teamdoncaster.org.uk/Doncaster_Data_Observatory/joint_strategic_needs_assessment.asp
[3] A description of the commissioning process that lead to this themed approach can be found in the previous JSNA report.
http://www.teamdoncaster.org.uk/Images/Doncaster%20JSNA%202014_tcm33-110466.pdf

Doncaster's population

The resident population of Doncaster was, in 2014, estimated to be 304,185, 150,582 men and 153,603 women. The Doncaster population is on average a little older than the national average. The average age in Doncaster is 40.8 years and in England it is around 40.2 years. The population pyramid (Figure 1) shows that the age profile of the Doncaster population is broadly similar to the national population. Doncaster has slightly fewer people ages 20 to 49 years and slightly more aged 50 to 74 years.

Figure 1: Population of Doncaster and England by 5 year age bands, 2014



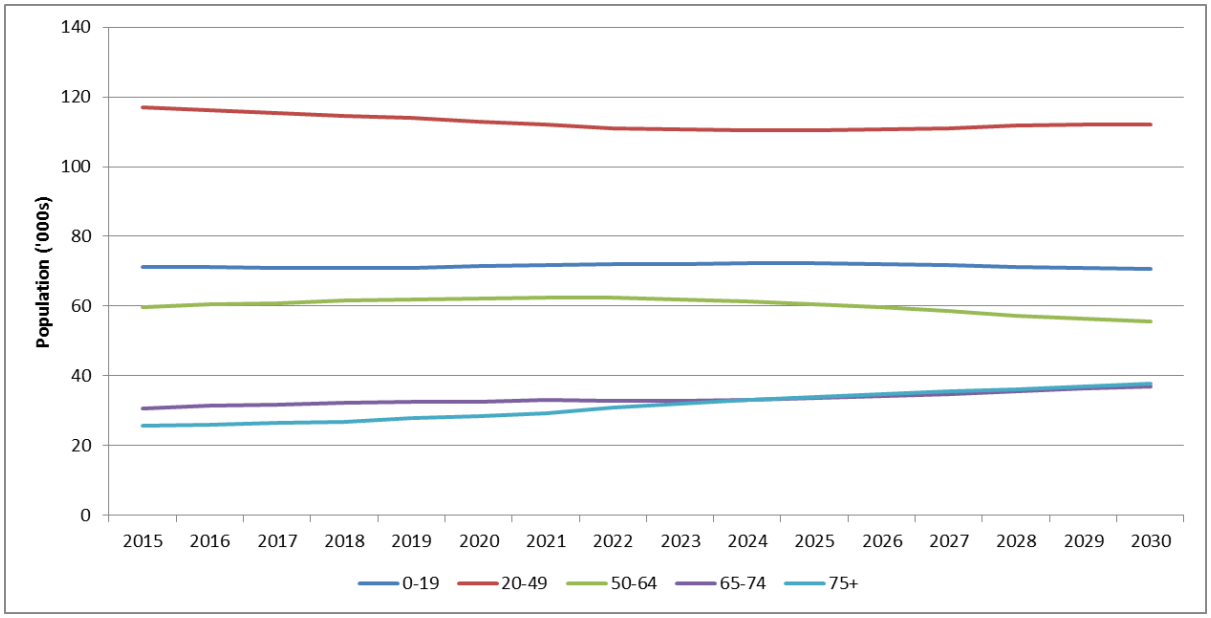
Source: Office of National Statistics (ONS)

Population Projections

The population of Doncaster in 2015 was around 304,200; by 2020 it is expected to be around 307,700 and by 2030 close to 313,000. Doncaster will add about 600 people each year to its resident population over the next 15 years. However these increases are not equally distributed across the age groups. The numbers of 0-19 year olds will actually fall over the next 15 years. The same is true for both the young working age population (20-49 years) and the older working age population (50-64 years). The numbers of people aged 65+ will increase. In 2015 around 18% of the population was over 64 years. By 2030 around 24% will be in this age group. This means almost 1 in 4 of the

population aged 65 years or older. The 65+ population will increase, on average by around 1,200 each year between 2015 and 2030. Doncaster, in common with most areas of the country, has an aging population[4].

Figure 2: Population change by age group in Doncaster, 2015-30



Source: Office for National Statistics (ONS)

Older people living in households

At the time of the 2011 census there were 297,200 people living in households in Doncaster[5], of these 16,179 (5.4%) were aged over 65+ were living alone[6]. In all there were 38,994 (13.1%) people in Doncaster living in households in which all were aged over 64 years old, this means that more than 1 in 10 of the population in Doncaster are households exclusively aged 65+.

Figure 3: Households composition in Doncaster, 2011

Household Type	Number	%
All Household residents	297,200	
One person households: Aged 65 and over	16,179	5.4
One family: All aged 65 and over	21,966	7.4
Other household types: All aged 65 and over	849	0.3

Source: Census 2011 (ONS)

[4] http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Ageing

[5] This figure excludes people living in communal establishments. Communal establishments include: care homes, prisons, university halls, boarding schools, and military establishments.

[6] A person living alone according to the 2011 census is: someone who lives alone and does not share cooking facilities and does not share a living room or sitting room or dining area.

As Doncaster has an ageing population the numbers of elderly people living alone is predicted to increase. The latest estimates show that there could be 20,500 people now living alone in 2015, by 2030 this could be 27,700[7]. This group will be predominantly women (see Figure 4)[8].

Figure 4: People aged 65+ predicted to live alone in Doncaster, 2015-30

	2015	2020	2025	2030
Males aged 65-74	2,960	3,160	3,260	3,620
Males aged 75+	3,570	4,148	5,032	5,678
Females aged 65-74	4,770	5,100	5,190	5,670
Females aged 75+	9,272	9,943	11,651	12,810
Total population aged 65-74	7,730	8,260	8,450	9,290
Total population aged 75+	12,842	14,091	16,683	18,488

Source: POPPI (Projecting Older People Population Information System)

Ethnicity in Doncaster

The most accurate data available about ethnicity in Doncaster is from the 2011 census. At the time of the census 95.3% of the population considered themselves to be 'White'. The largest Black and Minority Ethnic (BME) are from the Asian community accounting for 2.5% of the population. These figures show that Doncaster has a smaller BME community compared to England & Wales.

Figure 5: Ethnicity in England & Wales and Doncaster, 2011

	England and Wales		Doncaster	
	No.	%	No.	%
All Usual Residents	56,075,912	100.0	302,402	100.0
White	48,209,395	86.0	288,066	95.3
Mixed/Multiple Ethnic Groups	1,224,400	2.2	3,321	1.1
Asian/Asian British	4,213,531	7.5	7,614	2.5
Black/African/Caribbean/Black British	1,864,890	3.3	2,337	0.8
Other Ethnic Group	563,696	1.0	1,064	0.4

Source: 2011 Census (ONS)

Changes in the constituent ethnic communities in Doncaster are more difficult to gage, this because how ethnicity was measured changed between the 2001 and 2011 censuses. However using the numbers of people who considered themselves to be 'White British' in 2001 and 2011 it is clear that Doncaster has become considerably more ethnically diverse over these 10 years. In 2001 96.5% considered themselves to be in this category by 2011 this figure had fallen to 91.8%.

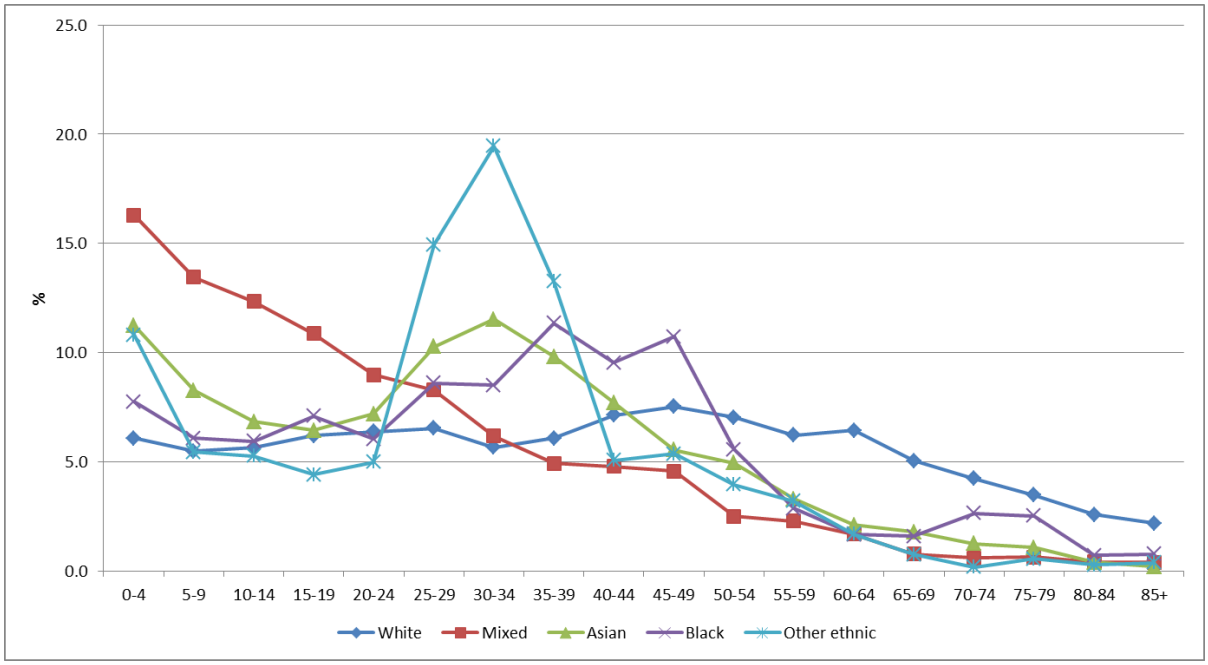
The BME population is, on the whole younger, than the white population. In the white population around 17.5% are aged 65 or more, while in the Asian population less than 5% are. It is important to note that BME populations will start to age more rapidly after 2021 and will therefore begin to find

[7] http://www.poppi.org.uk/

[8] The figures are calculated using the General Household Survey 2007. The General Household Survey is a continuous survey which has been running since 1971, and is based each year on a sample of the general population resident in private households in Great Britain.

they face some of the same health and wellbeing challenges as white community[9] .Black and Minority Ethnic communities' access to adult social care in Doncaster is explored further at the end of this report (Appendix 1).

Figure 6: Ethnic communities by age group in Doncaster, 2011



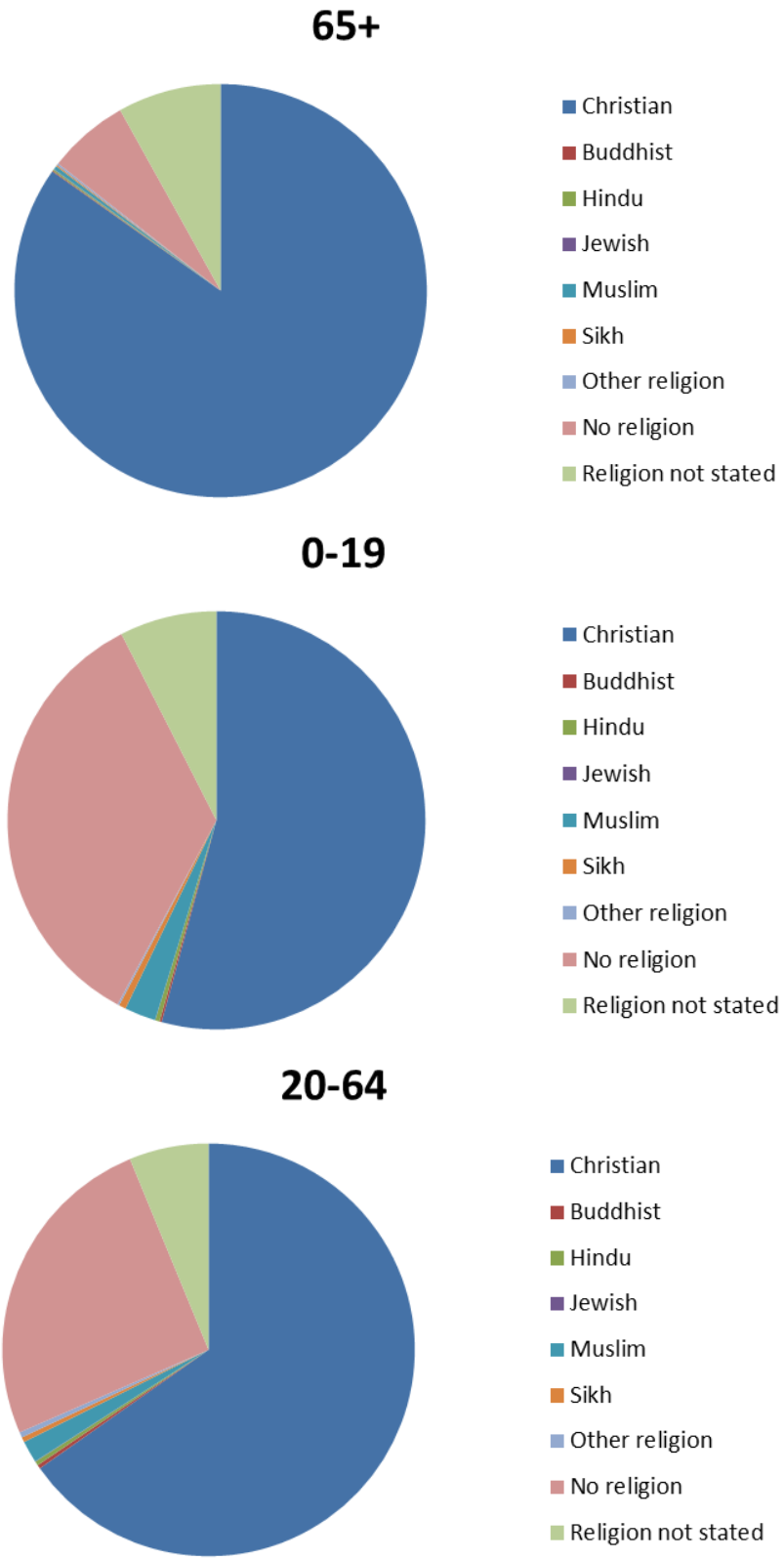
Source: Census 2011 (ONS)

Religion

The 2011 census asked a question about religion. The question is not compulsory and people can choose not to answer. People predominantly reported that they were Christian (66%) or had no religious affiliations (24%). This pictures changes with age, older people are more likely to report that they have a religion and are more likely to be Christian, younger groups are much less likely to have a stated religion. Religion can have some influence on the health of communities. Evidence from Scotland has found that Hindus often report better subjective health compared to other religions and Muslims, Hindus and Buddhists as well as some Christian denominations are least likely to report excessive drinking. The consumption of 5-a-day fruit and vegetables is greatest in Buddhists and Muslims[10].

[9] http://www.cpa.org.uk/BMEprojections/BMEprojections.html
[10] http://www.gov.scot/Topics/People/Equality/Equalities/DataGrid/Religion/RelHealth

Figure 7: Proportion of the Doncaster population by religion and age, 2011



Source: 2011 Census (ONS)

Life Expectancy in Doncaster

Over the last 30 years life expectancy has been improving nationally[11]. In Doncaster life expectancy (at birth) has been rising since at least the beginning of the 1990s. Male life expectancy has improved from 72.8 years (1991-93) to 77.5 years (2012-14). Among women in the same period it has improved from 78.1 years to 81.6 years.

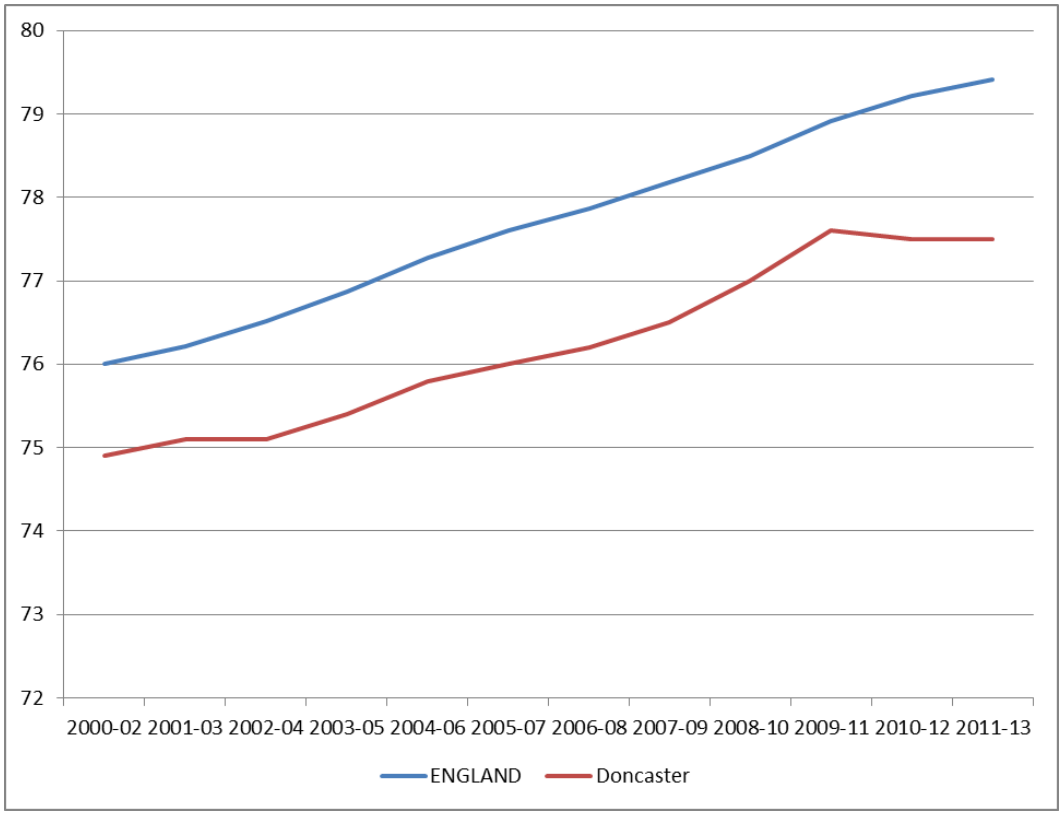
In the past life expectancy improved as infant mortality rates and deaths among younger people began to fall. However, the improvements in life expectancy that have happened in Doncaster (and nationally) are largely the result of improving mortality rates in older people. Life expectancy has been rising among older people. Life expectancy at age 65 among both men and women increased at more or less the same rate as life expectancy at birth.

These increases in life expectancy are making a significant contribution to the ageing population outlined in the previous section. People in Doncaster are living longer.

It should be noted that the improvements in life expectancy in Doncaster have slowed recently. This may be the result of natural changes over time but should be closely monitored in the future.

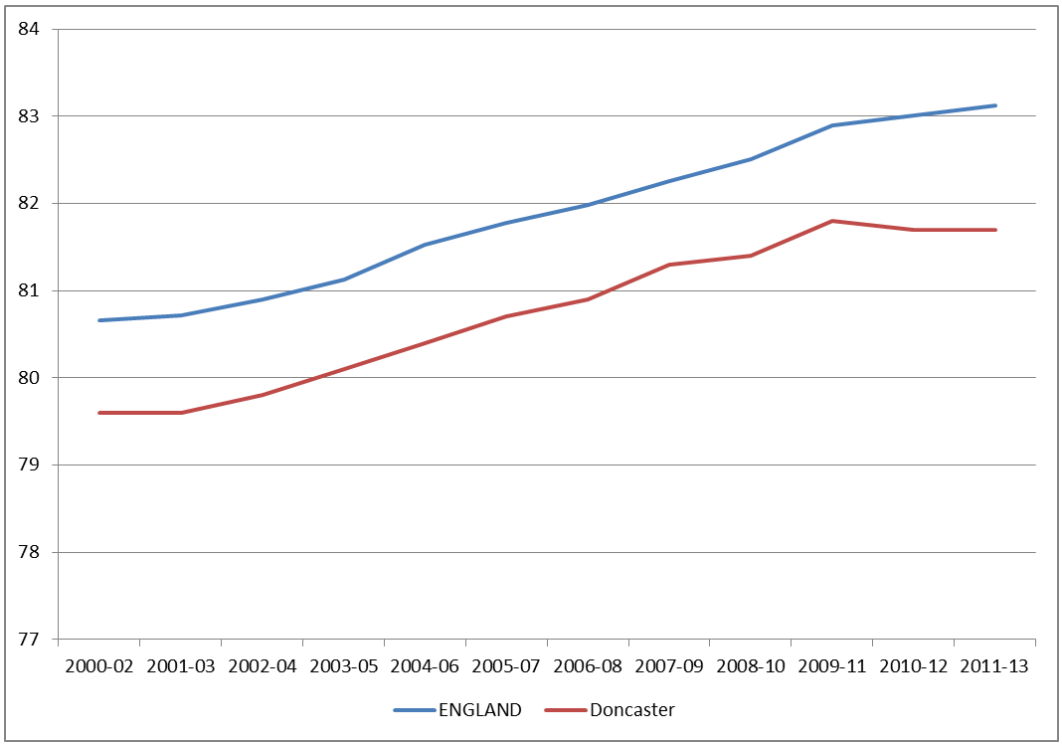
[11] Recent Trends in Life Expectancy at Older Ages, February 2015, Public Health England. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/403477/Recent_trends_in_life_expectancy_at_older_ages.pdf

Figure 8: Male Life expectancy at birth in Doncaster and England



Source: Health and Social Care Information Centre, Office for National Statistics

Figure 9: Female Life expectancy at birth in Doncaster and England



Source: Health and Social Care Information Centre, Office for National Statistics

Disability free life expectancy

Life expectancy measures mortality but does not capture how people live with poor health or disability. It is a poor measure of wellbeing and morbidity[12]. The Office for National Statistics (ONS) has produced data to address this deficit. The Office for National Statistics routinely publishes two types of health expectancies. The first is Healthy Life Expectancy (HLE), which estimates lifetime spent in 'Very good' or 'Good' health based upon how individuals perceive their general health. The second is Disability-Free Life Expectancy (DFLE), which estimates average lifetime free from a limiting persistent illness or disability. This is based upon a self-rated assessment of how health limits an individual's ability to carry out day-to-day activities[13].

The DFLE is based on a survey question used as part of the Annual Population Survey (APS)[14]. The results of these surveys have been aggregated over three years to provide sufficiently large local samples in each local authority.

The Question used to assess disability is:

Do you have any health problems or disabilities that you expect will last for more than a year? Yes/No

If 'Yes' the respondent is then asked the following question:

Do these health problems or disabilities, when taken singly or together, substantially limit your ability to carry out normal day-to-day activities? If you are receiving medication or treatment, please consider what the situation would be without the medication or treatment.
Yes/No

A person is considered to have a disability or limiting persistent illness if they answer yes to both questions in the box above. These questions are subjective and will relate closely to how the person perceives their health, and these perceptions are influenced by age, gender and social economic position. Nevertheless self-assessment of general health or disability have been found to be good at predicting the need and demand for health care as well as demand and usage of secondary care and nursing homes.

In Doncaster men have DFLE of 60.1 years and women 61.8 years (2009-13). This means that men on average live 22.4% of their lives with a disability and women, because they tend to live longer live

[12] James Nazroo, April 2015, Addressing inequalities in healthy life expectancy, Government Office for Science. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/455811/gs-15-20-future-ageing-inequalities-healthy-life-expectancy-er15.pdf

[13] http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/disabilityfreelifeexpectancybyuppertierlocalauthorityengland/2014-07-24

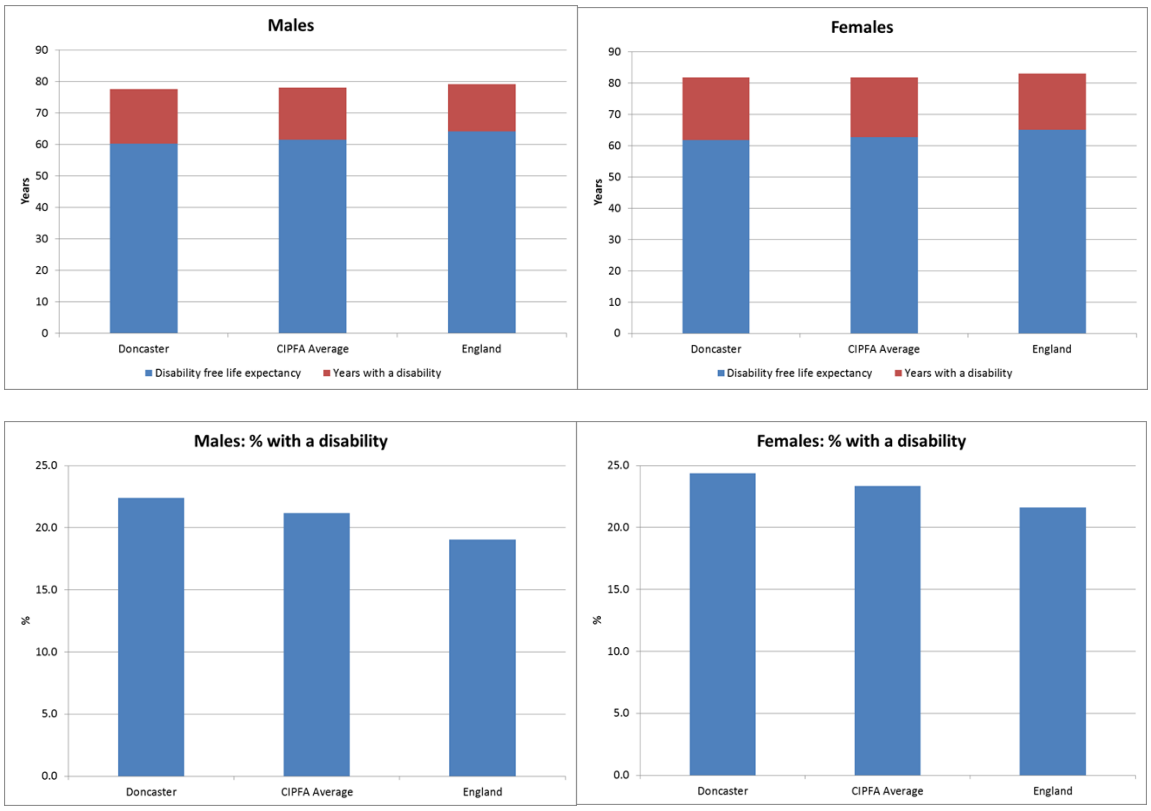
[14] https://www.nomisweb.co.uk/articles/873.aspx

around 24.4% of their lives with a disability. In England DFLE is 64 years in men and 65 years in women, a difference of almost 4 years in men and more than 3 years in women.

A further analysis of these data revealed, not only do Doncaster residents have a lower DFLE than the national average, the DFLE is lower than the average for similar areas. The Charted Institute of Public Finance and Accountancy (CIPFA) have identified groups of local authorities with similar characteristics[15]. When this group is compared to Doncaster it shows that DFLE is greater for both men and women. This implies that levels of disability and hence potential demand of social care is higher in Doncaster and may be even higher than in peer local authorities.

Figure 10 illustrates these findings. The average DFLE for Doncaster men is 60 years but the CIPFA average is almost 62 years. In women DFLE is around 62 years and for the CIPFA group nearly 63 years.

Figure 10: Disability free life expectancy



[15] Stockton-on-Tees, Darlington, Warrington, North Lincolnshire, Telford and Wrekin, Durham, Bury, Wigan, St Helens, Barnsley, Doncaster, Rotherham, Dudley, Calderdale, Kirklees, Wakefield.

Impact on Social care

To try to measure the potential impact of an aging population on adult social care in Doncaster a simple model was created to estimate how estimated levels of need would change over the next 15 years. In 2014 Doncaster council developed eligibility criteria to assess potential clients, this included a set of new needs based assessments:

- Carry Out Personal Care (dressing /undressing, personal grooming, personal hygiene, toileting/continence care),
- Preparing And Having Food And Drink (food Safety, food shopping, nutritional needs, food and drink preparation),
- Household Activity and Management (correspondence, laundry, cleaning the home, money management),
- Carry Out Tasks Of Being A Parent (family breakdown, parenting tasks),
- Relationships With Family And Friends (maintain/improve/establish relationships with family/friends),
- Being Part Of The Community (socially isolated, getting out and about, volunteering, employment, learning opportunities, meaningful activities, limited cultural opportunities),
- Keeping Safe (medication administration/prompting, service user poses a risk to themselves or others, accommodation, mobility),
- Behaviour Needs (anger, powerlessness, lack of confidence, victim of hate crime, fear, low self-esteem),
- Communication And Sensory Needs (specialist visual support, specialist hearing support, limited or no English language),
- Mental Well-Being/Psychological (bereavement and loss, reliance on prescribed medication, unhealthy relationships, stress, anxiety/depression/panic attacks),
- Carer Support (carer in ill health, carer is unable to cope, carer needs a break from caring role, carer unable to continue in caring role without support, carer choice to discontinue in caring role).

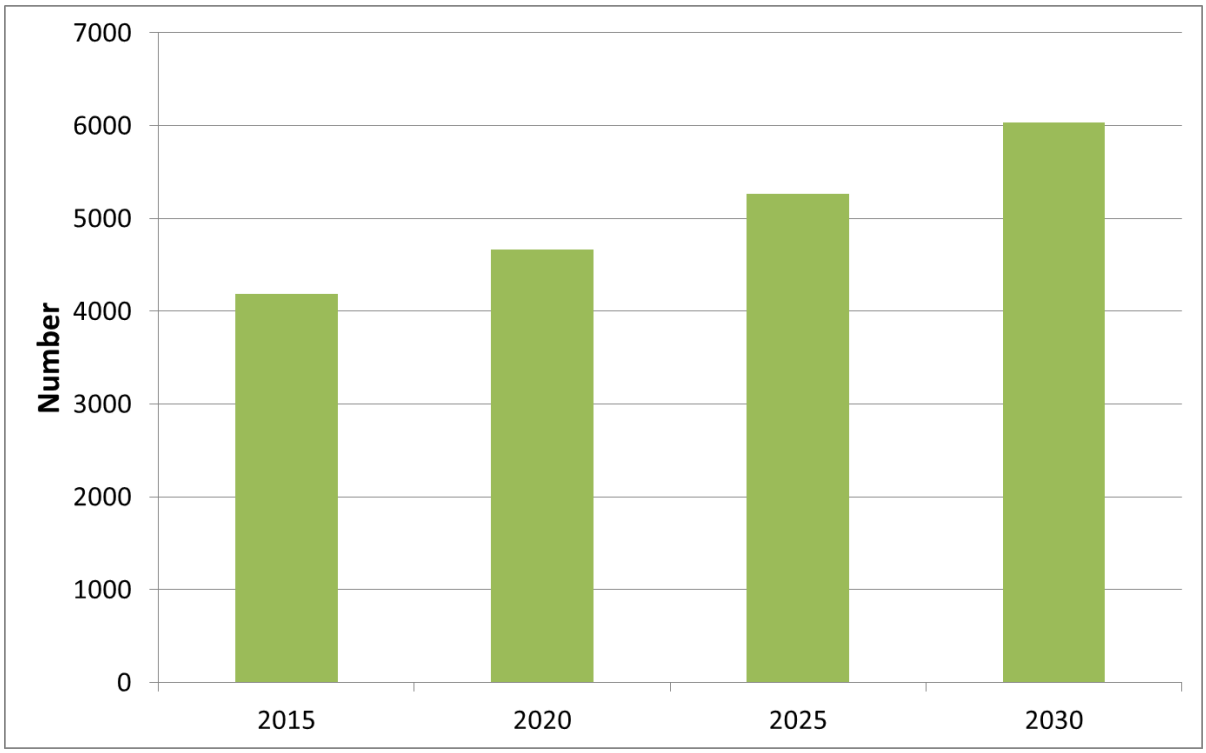
Not all clients, at the time of the analysis, had been assessed using the new needs domains. So the modelled needs were based on the 715 clients who had had their needs assessed against these new criteria. The model then adjusted this sample to reflect the current client population in Doncaster.

It is important to remember that the projections presented in this report are modelled and assume that there will be no changes in the commissioning and delivery of services in the future. Doncaster is already undertaking and developing an extensive programme of modernisation and improvement. However these figures will give both a sense of the scale of the challenge facing adult social care and a benchmark against which to measure the success of the modernisation and improvement programmes.

Personal care

Personal care includes help with dress toileting and personal grooming. This is a vital component in maintaining people's self-esteem, dignity and self-respect[16]. The modelling undertaken to support this report found that in 2015 there were just over 4,000 people needing personal care. By 2025 this could have grown to more than 5,000 and by 2030 it could be almost 6,000.

Figure 11: People with a need for help with personal care (modelled projections)



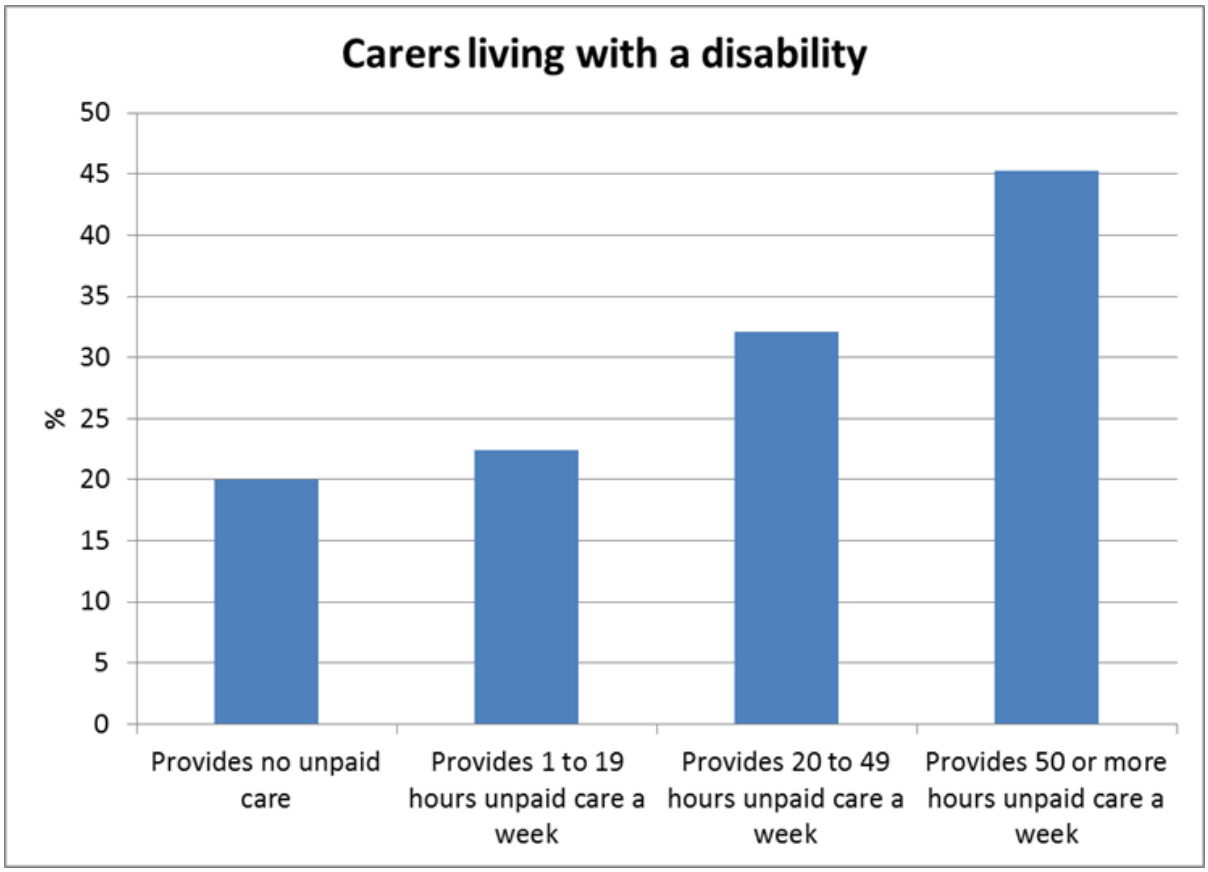
Source: Doncaster Council

[16] http://www.scie.org.uk/publications/guides/guide15/factors/personalhygiene/

Carers

A carer is someone who provides help to someone in their day to day life. The 2014 Care Act has given local authorities a legal duty to provide an assessment and made these assessments more widely available[17]. The council will then provide support to carers deemed eligible for support. Carers can themselves also be facing significant challenges regarding their own health. The census has shown that the more care a person provides, the great likelihood they will report that they are living with a disability themselves. Amongst people who provide no unpaid care only around 20% reported that they were living with a disability. Amongst people who provide 50 or more hours this rate increases to 45%, more than double. It should be noted that this is largely because older people are more likely to to be informal carers and are also more likely to report that they are living with a disability.

Figure 12: Carers providing unpaid care living with a disability in Doncaster

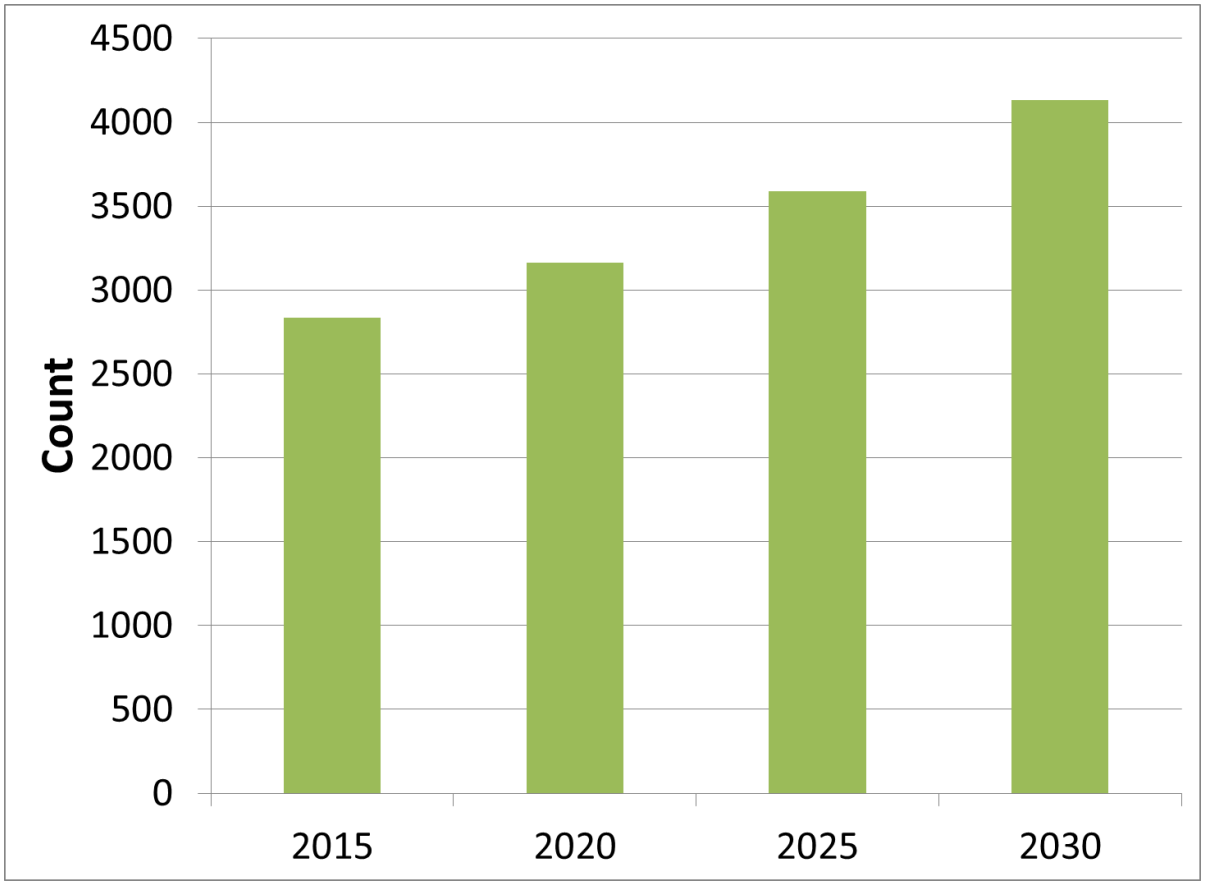


Source: Office of National Statistics

[17] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted/data.htm

The figure below illustrates the increase demand that could result just as a result of Doncaster's aging population. In 2015 there were around 2,800 people requiring carer support, by 2025 this could be 3,500 and by 2025 more than 4,000.

Figure 13: Carers need social care support in Doncaster (modelled projections)



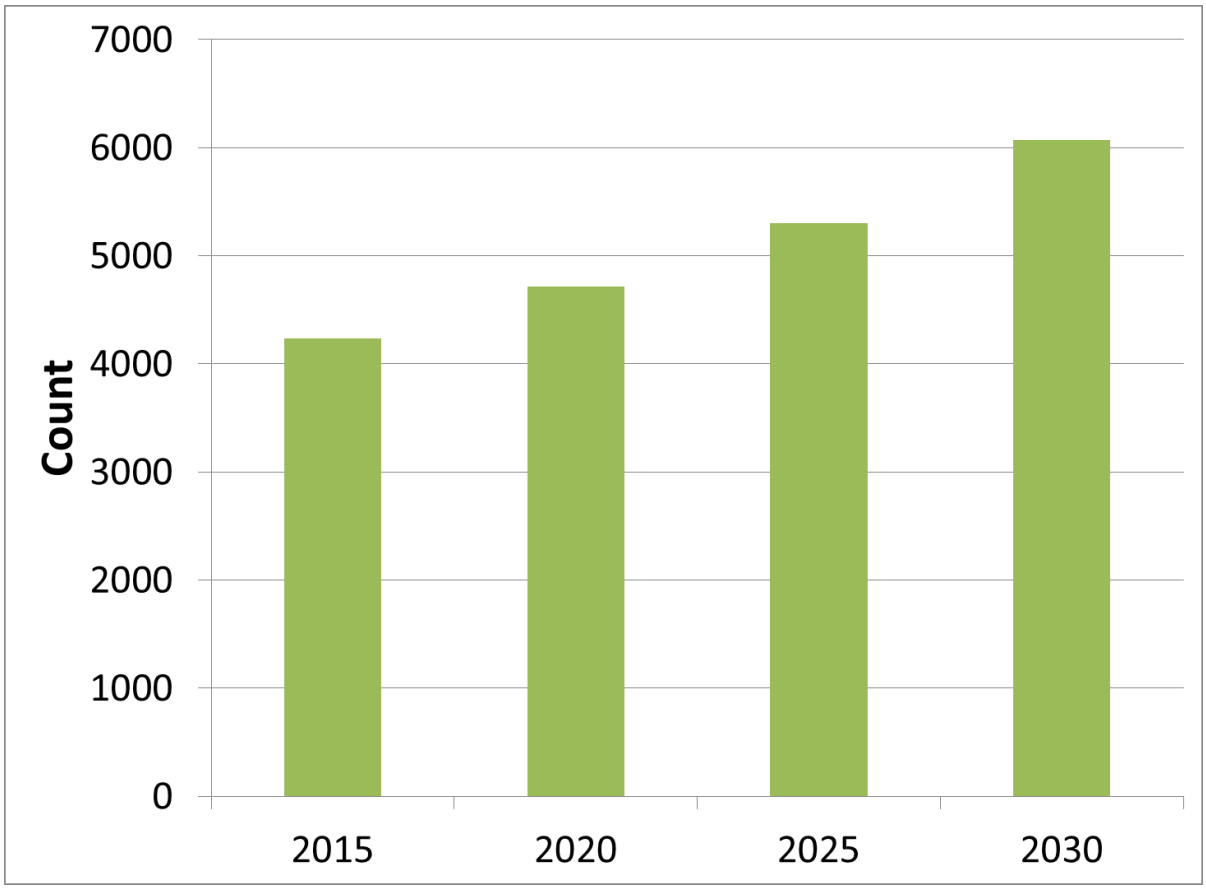
Source: Doncaster Council

Being part of the community

Social isolation and loneliness are related but slightly different things. It is defined as a subjective negative feeling that can encompass emotional loneliness – the absence of a significant other (for example, a partner or close friend), and social loneliness – the absence of a social network (for example, a wider group of friends, neighbours). In contrast, social isolation tends to be defined as an objective state referring to the number of social contacts or interactions[18].

Older people are at increased risk of experiencing social isolation, they are also more likely to face ill-health and caring responsibilities, these are also risk factor that can predict loneliness and social isolation[19].

Figure 14: People needing help to be part of their community (modelled projections)



Source: Doncaster Council

The chart above illustrates the increases in the numbers of people who require support to live more fully in their communities, from more than 4,000 in 2015 to over 6,000 in 2025.

[18] Loneliness and Social Isolation Among Older People in North Yorkshire, Sylvia Bernard, April 2013, University of York
http://www.york.ac.uk/inst/spru/research/pdf/lonely.pdf

[19] Reducing social isolation across the lifecourse, UCL Institute of Health Inequality, September 2015
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/461120/3a_Social_isolation-Full-revised.pdf

It is important to remember that all of these increases in demand for social care are modelled and assume that there will be no changes to the way that social care will be delivered over the next 15 years. They are merely intended to be illustrative of the kinds of challenges that Doncaster could face as its population gets older during this period

Safeguarding

The council has a duty to keep people safe from abuse and neglect. Prevalence data from a study by the Department of Health found that 2.5% of people aged 66 and older reported that they had experienced mistreatment involving a relationship of trust (friend, neighbour, or partner). This research only included people in households and so excludes nursing homes and other institutions[20].

An individual is at greater risk of abuse if:

- they are isolated and don't have much contact with friends, family or neighbours
- they have memory problems or have difficulty communicating
- they become dependent on someone as a carer
- they don't get on with their main carer
- their carer is addicted to drugs or alcohol
- their carer relies on them for a home, or financial and emotional support[21]

As Doncaster's population ages it will probably become more demanding of social care services and is those services find themselves increasingly stretched. There is a danger that a more isolated and a more ill population could find itself with more cases of neglect or abuse as carers are increasingly put under pressure.

Conclusions

Doncaster faces some significant challenges as its population ages. One clear part of this challenge will be increasing demands places on social care services.

[20] UK study of abuse and neglect of older people: prevalence survey, O'Keeffe et al, June 2007, Department of Health.
http://www.natcen.ac.uk/media/308684/p2512-uk-elder-abuse-final-for-circulation.pdf
[21] http://www.nhs.uk/conditions/social-care-and-support-guide/pages/vulnerable-people-abuse-safeguarding.aspx

Appendices

Ethnicity and social care

People from Black and Minority Ethnic (BME) communities tend to have poorer health than their white counterparts. People from BME communities tend to report age-related health problems earlier in life and consequently health inequalities are often greater amongst older people[22]. The reasons for these differences are largely due to the challenging social and economic circumstances that many people from these communities find themselves in. These conditions in combination the impact of discrimination and racism lead to poorer health outcomes[23].

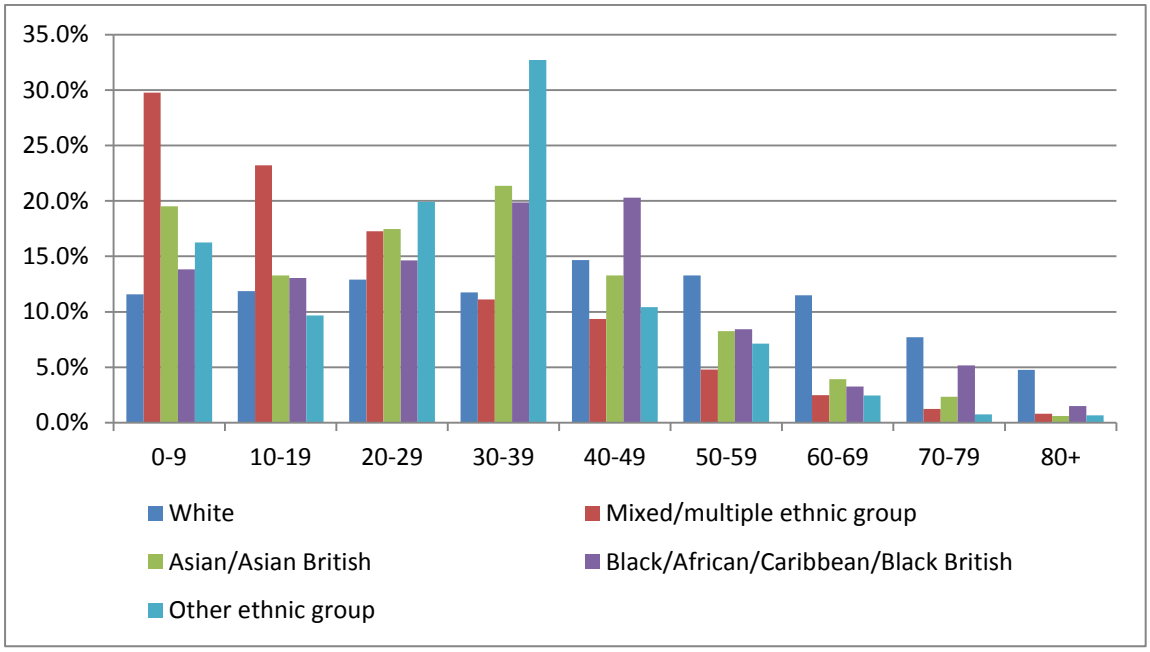
The health experiences of people from BME communities are not uniform. Some people from BME communities find that the health of first generation migrants is often better than those born in the UK[24]. Research from the Joseph Roundtree Foundation has found that people from the Chinese and Black African communities tend to report better health and people from the Bangladeshi and Pakistani communities much poorer health. The community with the worst health is the Gypsy and traveller community[25]. People of South Asian back ground have increased risk of developing coronary heart disease and stroke, people from African Caribbean background tend to have higher blood pressure and higher prevalence of type 2 diabetes[26].

As people from BME communities generally suffer from poorer health and these heath inequalities become more marked as the MBE community ages, it is to be expected that these communities might be making greater demands in the social care system. However older people from BME communities tend to be less aware of services available to them and can face the additional barriers of language and culture[27].The use of adult social care and the experience of BME communities of these services is an under-researched area[28].

In Doncaster the BME community is around 4.7% of the resident population[29]. It is a younger population than the white community. Figure 15 illustrates that at the time of the census over 50% of the BME community were aged under 30 years and less than 4% were aged 70 or over. In the white community just over 37% are under 30 and around 12% are 70 or older.

[22] Jo Moriarty, July 2008, Better Health Briefing 9: The health and social care experiences of Black and minority ethnic older people, Race Equality Foundation & Department for Communities and Local Government. http://www.better-health.org.uk/sites/default/files/briefings/downloads/health-brief9.pdf
[23] Postnote: ethnicity and health, January 2007, Parliamentary Office of Science and Technology. http://www.parliament.uk/documents/post/postpn276.pdf
[24] Ibid.
[25] Which ethnic groups have the poorest health? Ethnic health inequalities 1991 to 2011, October 2013, Joseph Rowntree Foundation & University of Manchester. http://www.ethnicity.ac.uk/medialibrary/briefingsupdated/which-ethnic-groups-have-the-poorest-health.pdf
[26] https://www.bhf.org.uk/heart-health/preventing-heart-disease/your-ethnicity-and-heart-disease
[27] http://www.kcl.ac.uk/sspp/policy-institute/scwru/pubs/2012/reports/moriarty2012update9.pdf
[28] Tom Vickers, Gary Craig & Karl Atkin, 2012, Research with black and minority ethnic people using social care services, School for Social Care Research & National Institute for Health Research. https://www.lse.ac.uk/LSEHealthAndSocialCare/pdf/SSCR_Methods_Review_11_web.pdf
[29] BME: Mixed/multiple ethnicity, Asian/Asian British, Black/African/Caribbean/Black British, Other ethnic groups. A broader definition of BME communities which includes: Irish, Gypsy traveller and other white groups would increase this to 8.2%.

Figure 15: Ethnicity by age group, 2011

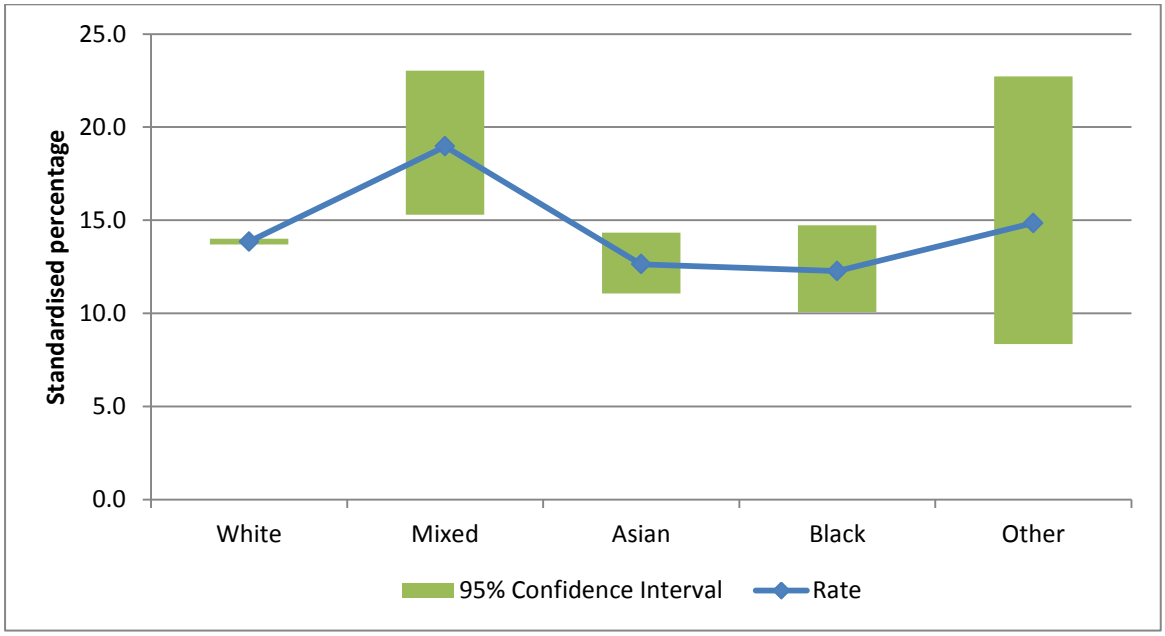


Source: 2011 census

Because of these disparities in the age structures of different ethnic populations it is important to age-standardise reported ill-health and service uptake rates. This will enable fair comparisons to be made between groups.

Figure 16 shows that long-term disability is significantly higher in people from mixed ethnic groups. The other groups show no statistical difference compared to the Doncaster average.

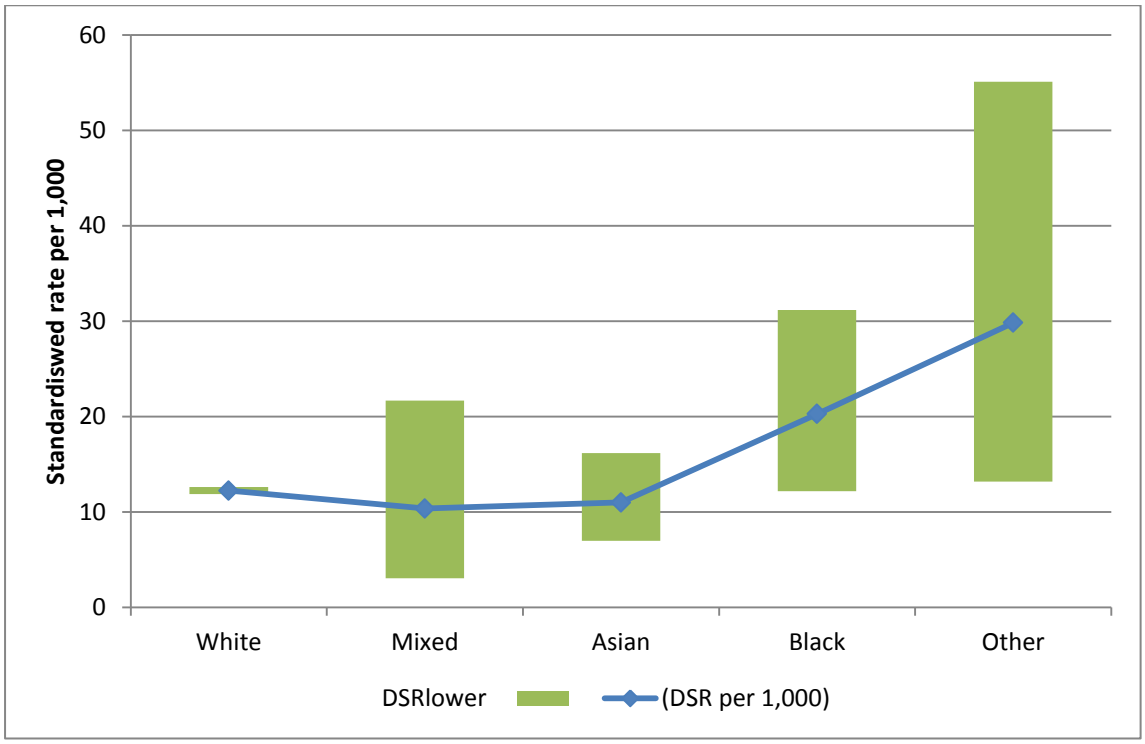
Figure 16: Limiting long term illness or disability by ethnic group, 2011



Source: 2011 Census

Access to Adult social care was measured using the same age standardisation methodology (Figure 17). This shows that on the whole no one ethnic community has better or poorer access to adult social care. It is worth noting that the community with the lowest client rate is those from mixed ethnic back grounds but this is also the group with the highest levels of reported disability.

Figure 17: Social care clients by ethnicity



Source: Doncaster council

The following caveat should be noted. These data only reflect the current clients identified on Doncaster Council's care system. It does not provide insight in to the quality of the experiences of these clients. There is some evidence here that clients from different BME groups are able to access an equitable service, however this does mean that the services they receive are culturally appropriate and not base on cultural assumptions and generalisations[30].

[30] https://www.jrf.org.uk/report/experiencing-ethnicity-discrimination-and-service-provision

The advantages of an ageing population

Much of this report has focused on the challenges that an ageing population presents in Doncaster. Conventional wisdom asserts that with an ageing population will come significant challenges to the health and social care system. The annual costs of health and social care are greater for older people, hospital admissions are raising more rapidly in older people in any other age group. Older people will increasingly be living alone with an attendant increase in the demand for care[31].

However it is important to remember that an ageing population is not necessarily a sicker population many people are living longer and remaining healthier much later in life. The 'Wanless report' noted that a significant proportion of the costs for an individual occur in the last year of life[32]. This cost does not appear to rise with age and there is even some evidence that with increasing age, end of life costs actually fall[33].

The latest data from the Office of National statistics has found that people aged 65-79 report the highest average levels of personal wellbeing. People in their 90s were reporting their levels of happiness to be greater, on average, than people in their middle years. Older people's wellbeing did fall after 75, if they felt their activities were not 'worthwhile'[34].

Older people are a large and growing resource for the voluntary sector. These volunteers will not only improve their own health by volunteering but will be bringing the advantages of their previous experience to their wider communities[35]. Evidence indicates that 'grand-parenting' instils benefits in young children[36]. Older people are also increasingly remaining engaged in paid employment, nationally the proportion of people remaining in work over 65 has been increasing since at least 2001[37]. Older people are, on the whole, more law abiding and so use fewer resources maintaining community safety[38].

In conclusion while an aging population could represent a significant challenge to the future of adult social care delivery there is evidence when considered across all aspects of older people's lives people over 65 are in fact net giver to society rather than net receivers.

[31] http://www.kingsfund.org.uk/time-to-think-differently/trends/demography/ageing-population
[32] http://webarchive.nationalarchives.gov.uk/20130129110402/http://www.hm-treasury.gov.uk/consult_wanless04_final.htm
[33] http://www.tai.org.au/documents/downloads/DP63.pdf
[34] http://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/measuringnationalwellbeing/2015-09-23
[35] https://www.ucl.ac.uk/news/news-articles/1204/24042012-Ageing-population-could-boost-economy
[36] http://www.scotlandfutureforum.org/assets/library/files/application/1213786643.doc.
[37] http://www.kingsfund.org.uk/time-to-think-differently/trends/demography/ageing-population
[38] http://www.scotlandfutureforum.org/assets/library/files/application/1213786643.doc.