REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **10th February 2016**
AGENDA ITEM:	**7**
SUBJECT:	**Joint Strategic Needs Assessment on Older Adults and Carers of Older Adults**
BOARD SPONSOR:	**Steve Morton, Head of health and wellbeing & acting joint director (with Dr Ellen Schwartz) , Croydon Council** **Dr Ellen Schwartz, Consultant in public health and acting joint director (with Steve Morton), Croydon Council**

BOARD PRIORITY/POLICY CONTEXT:

- This needs assessment supports a number of priorities in the 2013-18 Joint Health and Wellbeing Strategy. Specifically, the needs assessment focuses on the following areas;
  - preventing illness and helping older adults recover well in the community,
  - supporting older adults to be resilient and independent,
  - preventing premature death and better management of long term conditions
  - providing integrated older adult services
- Producing a local Joint Strategic Needs Assessment (JSNA) has been a statutory requirement since 2008. The Health and Social Care Act 2012 has reinforced the importance of JSNA in informing local commissioning decisions and given responsibility for the JSNA to health and wellbeing boards. Local authorities and clinical commissioning groups are required to collaborate to produce a Joint Strategic Needs Assessment.

FINANCIAL IMPACT:

The main financial implications will lie in unmet need that is identified and the projections of growing need in the future.

1. RECOMMENDATIONS

This report recommends that the health and wellbeing board:

1.1. Consider the findings of the Joint Strategic Needs Assessment on Older Adults and Carers of Older Adults. The conclusions and recommendations from the needs assessment are included below in section 3 – Detail.

1.2. Agree that delegated authority be granted to the Acting Director of Public Health, Executive Director, People Department, Croydon Council and Chief Officer of Croydon CCG to agree any final changes to the document if required.

2. EXECUTIVE SUMMARY

2.1 The JSNA on Older Adults is one of two needs assessments forming part of Croydon's 2014/15 JSNA, the other being a JSNA on Maternal Health.

2.2 This chapter's outline is based on the framework of goals and desired outcomes established as part of the Outcomes Based Commissioning Programme, such that future service provision and models of care may be directly influenced by the findings from, and recommendations put forward in this needs assessment.

2.3 This needs assessment aims to:

2.3.1 provide an understanding of the demographic characteristics, social determinants and health and social care needs of Croydon's Older Adults and carers that care for Older Adults (section 4 in chapter, pages 11-24)

2.3.2 appraise Croydon's existing support and care services specifically around prevention, self-care, primary and community intervention for Older Adults and Carers, using the outcome goals identified by service users, as part of the consultation exercise for Croydon's Outcomes Based Commissioning Programme (section 5 in chapter, pages 25-61)

2.3.3 identify gaps in Croydon's service provision in relation to these outcome goals (section 5 in chapter, pages 25-61)

2.3.4 inform discussions with health and social care commissioners, stakeholders and providers within the Outcome Based Commissioning landscape (section 6 in chapter, pages 62-64)

2.4 Areas in scope and out of scope for this needs assessment are listed along with a short rationale in Appendix A of this report.

2.5 This needs assessment describes the demographic and high level socio-economic circumstances, health and social care needs of the older adult population in Croydon. Further, it discusses current population need and recommendations for improvement within the areas of prevention and health maintenance, and management of deterioration and self-care in the community setting for Older Adults and Carers of Older Adults. The chapter outline is based on the framework of goals and desired outcomes established as part of the Outcomes Based Commissioning Programme, such that future service provision and models of care may be directly influenced by the findings from, and recommendations put forward in this needs assessment.

2.6 As the population over the age of 65 continues to increase, and becomes more diverse in its ethnic group composition, health and social care provision for older adults and carers of older adults in Croydon needs to evolve along with subsequently greater need for support in the community. In particular, services must evolve to reflect the increasing number of individuals who will be living longer with long-term and/or life limiting conditions.

2.7 A systematic and consistent approach with a greater focus on prevention and self-care/management in the community is recommended to reduce the rapid increase in service utilisation amongst older adults at the apex of intensity of need.

2.8 Nationally older adults account for more than 1/6th of the some health and social care resources. Most adult social care services are funded through local government. 46% of the local adult social care budget and nearly 40% of the NHS budget is spent on older adults, however the last 5 years have seen a 17% drop in spend on the social care services for older people2. Croydon council spent £49.7 million on older people's social care in 2012/13.

2.9 However, older adults and carers of older adults are not just consumers of health and social care services but also important contributors to society and local communities and have a wealth of experience to offer. It is important therefore that we facilitate this section of Croydon's population to continue to make a contribution to their own health and wellbeing, to society and to live lives to their full potential.

2.10 Achieving improved health and social care outcomes for Croydon's older adults and carers of older adults, is a joint priority for, Croydon CCG, the Local Authority and several local partners across the sectors.

2.11 Local commissioning and service provision strategies are taking into account and gradually enabling a greater shift towards individuals' holistic well-being; including prevention and self-care along with increased provision of care in the community and care closer to people's homes.

2.12 From a wider set of areas for improvement found in Appendix C of the full document, the chapter prioritises the following set of recommendations for implementation by relevant parts of the system and in particular driven forward as part of the Outcomes Based Commissioning Model of Care for Older Adults.

3. **DETAIL**

3.1 The needs assessment highlighted several areas for improvement that were then prioritised as recommendations for implementation, in collaboration with lead commissioners, the Croydon Accountable Provider Alliance (APA) that is leading on the model of care for delivery on the OBC programme, and community stakeholders.

3.2 The resulting prioritised recommendations (table below) can be found in section 6 (pages 62-64) of the chapter.

1. Promote Healthy Lifestyles and Behaviours (see section 5.1.1 and 5.1.2 in chapter)

Target immediate efforts at older adults at risk of malnutrition (those living in fuel poverty and those in particular care settings) - particularly during winter months

4% of Croydon's older adults lived in households without central heating and this figure is statistically significantly higher for Croydon compared with England (3%). Experiencing fuel poverty impacts older adults' food shopping and therefore their nutrition.

Additionally, national reports suggest that 10% of older adults across the country are at risk of malnutrition, this risk is greater particularly during winter months and more common than amongst younger adults. Evidence also suggests that 1/3 all older adults admitted to hospitals and care homes and 50% of all admitted to hospitals from care homes were at risk of malnutrition.

2. Support with Functional, Sensory Ability and Falls (see section 5.1.3 in chapter)

Increase awareness amongst and early identification of older adults with reducing functional ability (domestic and self-care tasks) and consider the provision of lower levels of support help service-users and their carers maintain independence for longer before requiring more intensive support

Age, long-term conditions, falls and reducing functional ability – lead to requiring support in the home (National evidence) to continue living independently.

Almost half of all older adults in Croydon (49%) report that they have any condition or disability which limits their daily activities in some way. However this proportion ranges from 27.2% to 68.0% across lower super output areas and appears to cluster to a greater degree within areas of higher deprivation, and areas with higher proportions of older adults from BAME backgrounds. The most common problems relate to movement, vision and hearing, and can reduce the ability of older people to look after themselves, remain mobile, and maintain their independence resulting in a need for personal care.

Although numbers of individual registered blind, visually impaired, deaf or hard of hearing are known, registration is not compulsory and therefore figures are likely to be underestimates.

40% of older adults report that they are unable to do at least one of their domestic tasks by themselves (48% of women and 28% of men) and 32% were unable to carry out at least one self-care task (38% of women and 25% of men). Inability to carry out domestic or self-care tasks increased significantly with age.

Physical disabilities and frailty were also found to be two of the most commonly reported reasons for requiring carer support, who themselves may be frail (older carers), disabled or have long-term conditions. 7% of carers known to the Croydon Carers Support Service are reported disabled themselves.

3. Support Greater Independence at Home and in the Community (see section 5.1.5 in chapter)

a) Strengthen low level community support and information services for older adults and carers of older adults; particularly to counter balance any increase in identified needs in the system but also to support those with needs but not eligible for social care.

b) Where appropriate consider increasing the provision of intensive home care (6 or more visits per week) in order to support older adults staying out of care homes for as long as is appropriate

c) Increase staff awareness of factors influencing potentially avoidable admissions into

care homes particularly, increase case finding of older adults with incontinence and at risk of falls. Increase awareness, skills and confidence amongst the wider workforce, in managing common frailty syndromes, confusion, falls, poly-pharmacy and safeguarding

Croydon is estimated to have the 3rd highest number of people in care homes in London, by 2030. An evidence review completed for this chapter, indicated the lack or make-up of alternative community services, perception of these services, actual or perceived timeliness of such services influenced decisions to admit to hospital/care homes

The evidence review suggests that the majority of those admitted to care homes had received some home care, but 50% didn't receive intensive home care (>6 visits per week). Functional impairment combined with lack of community support influences admissions to hospital, readmissions and major determining factor for admission to care homes.

With regards to support in the community the literature favoured services that provided rapid support for exacerbations of conditions most amenable to intervention in the community (these included continence, falls, dementia, depression, visual impairment, stroke, diabetes. Additionally, the literature also recommended early identification and support before or in anticipation of crisis points. Continuity of care was cited as a barrier in achieving greater support in the community and out of care homes.

4. Reduce Fuel Poverty Amongst Older Adults in Croydon (see section 4.1.2 and 5.1.2 in chapter)

Take action at all 4 levels of intervention to address fuel poverty (particularly amongst older adults); i.e. energy efficiency measures, energy price support and switching, advice and support with practical and/or personal barriers, and maximising income.

4% of Croydon's older adults lived in households without central heating and this figure is statistically significantly higher for Croydon compared with England (3%).

Health problems amongst older adults may be exacerbated or indeed caused by living in cold home. It is important to emphasise that ill-health associated with cold homes is experienced during 'normal' winter temperatures and not just extreme weather. NICE recommend practical solutions to reduce the risk of death, ill-health and resulting pressures on health and social care services on account of fuel poverty and fuel debt.

5. Address Social Isolation (see section 5.1.3 in chapter)

Should develop a multi-agency strategy that aims to identify individuals and in particular older adults that are most at risk of longer term loneliness and/or social isolation and supports them to remain positively engaged with society and maintain meaningful relationships

Social Isolation and loneliness are both risk factors for ill-health, similar to or worse than smoking 15 cigarettes a day. They make it harder to regulate risky behaviours, makes people more prone to depression and more likely to use the system as a way to have some social interaction (1 in 10 of GP visits is due to their loneliness)

31% of Croydon's older adults live alone (compared to 16% adults aged under 65). National estimates suggest these are mainly women. Those living alone or in large family homes are said to be at greater risk. Additionally the chapter reference group also identified those with physical disabilities, and/or sensory impairments identified as sub-groups at greater risk.

Carers providing care for older adults are also at risk of social isolation and/or loneliness. 41% of Croydon's carers, reported having as much social contact as they would have liked

6. Management of Long Term Conditions in the Community (see section 5.2.1 in chapter)

a) Improve early identification, and preparation in anticipation of 'critical or crisis points' in the management of LTCs particularly amongst the very old for e.g. through the systematic and consistent use of risk stratification tools and support for professionals such as clinical decision support software, specifically for those LTCs highlighted in the literature as amenable to management in the community or through urgent response without admission into acute care

b) Commission and/improve self-management support for older adults with LTCs and for carers of older adults with LTCs

40% older males and 30% older females in Croydon have at least one long-term condition recorded; 12% males o65 and 8% females o65 have two or more; 2-3% have three LTCs or more. National estimates suggest these numbers are expected to increase by a 1/3rd over next ten years.

Croydon has a rate of emergency admissions at 29 per 100 o65s that increases steadily with age. It is estimated that emergency admissions for LTCs and ACS could be reduced by 8-18% through appropriate early support in the community.

Nationally, 'older adults with long-term conditions is' the fastest growing Emergency Department admission type – these are largely considered preventable and manageable in community. National literature suggests 70-80% of people with LTCs can be supported to self-manage.

The evidence review highlights that crisis points can be anticipated (for e.g. using GP risk stratification and decision support tools as possible mechanisms) and if managed don't necessitate admissions. In particular the following conditions were highlighted as specifically amenable to rapid response and management in the community; non-specific chest and or abdominal pain, angina, acute mental crises, COPD, DVT, UTIs, minor head injuries, falls, epileptic fit, cellulitis, blocked urinary catheter, hypoglycaemia, and diabetic emergencies.

Progressing self-care seen as significant factor in system sustainability. 80% of individual self-care most of the time, however, people tend to abandon self-care earlier than they need to due to; confidence, understanding of conditions, reassurance, felt need for a prescription. The literature highlights the following as factors that facilitate: patient education programmes, medicines advice, tele-"aid", psychological support, access to health records

7. Holistic Assessments and Reablement (see section 5.2.5 and 5.2.6 in chapter)

Capture and address the holistic needs (including psychological support) of older adults and carers of older adults around discharge from urgent and/or secondary care settings, at diagnosis and/or at reviews of LTCs (e.g. joint HSC assessment of patients discharged after stroke)

8. Medicines (see section 5.2.2 in chapter)

Consider the use of IT and decision support tools, educational information and outreach services led by pharmacy and nurses particularly amongst high risk groups, including improved systems to support safe transfer of medication information at admission and discharge. Develop the role of pharmacy or pharmacy trained staff in medicines reviews and adherence assessments.

45% prescriptions in the UK are for older adults. More than a third of people aged 75 years and older take 4 or more medications. These figures increase for those in care homes. It is also estimated that 20% admissions amongst older adults are directly or indirectly drug related, and tend to particularly be more common amongst frail older patients in nursing

homes.

Local commissioner intelligence suggests, up to 50% people do not adhere to medication schedules.

9. Shared Decisions (see section 5.2.4 in chapter)

Support professionals to achieve a greater and faster shift towards more shared decision making with service users. Evaluated models to encourage, facilitate and measure shared decision-making exist that could be considered for use in Croydon.

The evidence review suggests that decisions tended to be made by professionals and were often at crisis points. Additionally professionals' perception that decisions were made jointly wasn't matched by their service users' perception.

In Croydon, proportion of carers who feel that they "always" or "usually" felt consulted in decisions was 63% compared to 72% in England

Timely information and shared decisions have been highlighted in the literature as effective enablers for behaviour change for increased self-care/management and is essential for onward planning. Similarly not being properly informed about illness and treatment options was cited as main reason for dissatisfaction.

Support among professionals for integrated, condition specific care pathways that involve the patient and their carer(s) is warranted in order to support rapid decision making. Evaluated models to encourage, facilitate and measure shared decision-making exist that could be considered for use in Croydon.

10. Identifying Carers (see section 5.3 in chapter)

a) Increase identification of new carers and self-recognition amongst care givers in order to widen the reach of the service to new service users; in particular, capture older adults' own caring responsibilities and refer for carer assessments where appropriate, and encourage recognition of 'care giver' role amongst BAME groups

According to the latest Census, there are 33,635 self-reported carers (all ages) in Croydon (9% of total Croydon population). 20% of self-reported carers (all ages) provide 50 hours or more unpaid care per week. Analysis of the carers' registry data (September 2014) suggests only 1 in 7 of the total estimated number of carers in Croydon are known to the Croydon Carers Support Service.

Although it is vital to recognise choice amongst the carer population with regards to accessing services; it is equally important that services are proactive in their approach to take support services to carers. This is also supported by that fact that Croydon Carers Support Service data that shows the means through which services users became aware of the service appear in the vast majority to be through previous contact. More work is needed to identify and support 'new carers' than currently known to Croydon services.

1/8 of all carers are older carers (i.e. aged over 65years themselves); 35% of these provide over 50 hours unpaid care per week (higher than all age carers). Croydon projected to have 3rd highest older carers by 2030.

Although Census data does not provide the age of the person cared being cared for, data on carers known to the Local Authority suggests that parents are the third most commonly cared for group of individuals after children and partners. Carer health deteriorates with increase in hours of care provided.

11. Supporting Carers to care (see section 5.3 in chapter)

Identify, assess and support the health and social care needs of carers of older adults with physical and/or sensory disabilities, complex needs and/or (multiple) LTCs, as well as

promoting information services, particularly for those providing more than 50 hours of care per week, as a way to reduce unplanned decisions and admissions into acute settings and/or care homes.

Evidence suggests that individuals without a carer are more likely to be admitted to nursing or residential care; carer stress accounts for 38% of admissions, whilst family breakdown including loss of a carer accounts of 8% of admissions.

Carers themselves may be frail, have mental health conditions, be disabled or have other long term conditions. Croydon data from the 2011 Census indicates that amongst the older carer population, 10% self-reported as being in 'bad or very bad health', and 36% in fair health. General health of carers deteriorates incrementally with the increasing number of hours of care provided.

Only 29.2% of carers in Croydon reported that they were "extremely" or "very" satisfied with the care and support that they are the person they care for had received from social services. This is significantly worse than the 42.7% reported for England as a whole and but is not significantly different to the figure for London (35.2%)**Error! Bookmark not defined.** Nearly a third of respondents to Croydon Carer Survey reported needing some or a lot more support hours than they were currently being offered (Croydon average higher than London average)

Supporting carers to care will require developments in the quality and range of support services provided to ensure identified and assessed need is addressed, specifically, the balance of support on offer, ranging from preventative services, direct access services to on-going personal budgets

12. Supporting carers at work (see section 5.3 in chapter)

Review and advocate borough wide employment and working policies that, are 'carer friendly', allow flexibility in working hours, support with information on benefits and other sources of income, particularly taking into account the lower than previously recognized threshold (10 or more care hours provided per week as opposed to 35 hours) at which carers are at risk of leaving employment

Individuals' ability to stay in fulltime employment whilst providing care is greatly reduced.**Error! Bookmark not defined.** Flexibility in working hours was reported to be the most important factor enabling carers to return or stay in employment. Several carers of working age feel forced to give up work, may find it difficult to return to work after their caring responsibilities have come to an end or have significantly reduced earnings.**Error! Bookmark not defined.**

A key threshold at which carers are at the risk of leaving employment occurs when 10 or more hours of care per week are being provided. Large numbers of carers therefore could be at risk of unemployment or reduced income.

There is an opportunity therefore to better support carers to care and carer independence by supporting carers to stay in employment.

4. CONSULTATION

4.1 The older adults JSNA is framed on the outcome goals previously established through consultation with service users and the public for the Outcomes Based Commissioning Programme.

4.2 The chapter has been shared widely during the JSNA process. Input and direction have been obtained from a wide range of stakeholders across Croydon, including community geriatrician input, via membership of a chapter-specific sponsor group and reference group. There have been opportunities for CCG input at earlier stages via involvement in the JSNA prioritisation processes, membership of the JSNA Governance group, the JSNA Steering Group and the CCG SMT and Governing Body.

5. SERVICE INTEGRATION

5.1 As stated above, a key objective of this chapter is to support the Outcomes Based Commissioning programme for older adult services in Croydon. This programme of work has a key objective of transforming care for older adults in Croydon and increasing the proportion of older adults that are supported to be independent in their own homes and in the community. This includes greater integration in service delivery so as to achieve and fulfil the holistic (joint health, social care and wellbeing) needs of older adults and carers of older adults.

6. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

6.1 The key aim of this JSNA chapter is to improve outcomes for older adult service users and carers through influencing the Outcomes Based Commissioning Programme.

6.2 Nationally older adults account for more than 1/6th of the overall health and social care resources. Most adult social care services are funded through local government.

6.3 46% of the local adult social care budget and nearly 40% of the NHS budget is spent on older adults. Croydon council spent £49.7 million on older people's social care in 2012/13. NHS expenditure is not categorised by age group so it is not possible to provide an exact figure for Croydon.

6.4 It is the responsibility of commissioners to agree how to make use of the financial resources available to address the recommendations of the JSNA chapter on Older Adults and Carers of Older Adults. Funding decisions will need to be made in the context of the development by the Accountable Provider Alliance of the new Model of Care.

6.5 A number of organisations were involved in the development of the chapter including service providers, the voluntary sector and service users. A failure to take account of the recommendations in future commissioning decisions could represent a reputational risk to the constituent organisations

7. LEGAL CONSIDERATIONS

7.1 Producing a local JSNA is a statutory duty for the health and wellbeing board.

8. EQUALITIES IMPACT

8.1 The chapter has considered equality and diversity implications by examining the health and wider determinants of older adult service user and carers, and identifying risk factors that impact on health, social care and wellbeing outcomes for both older adults as well as carers of older adults.

8.2 Overall, 55% of Croydon population are of white ethnicity and 45% are of Black and Asian minority ethnic (BAME) groups (either Black, Asian, mixed or other). However, among older adults, the proportion of individuals who belong to BAME groups is 23% compared to 46% among those aged 65 years and under.

8.3 There is a decrease in the proportion of individuals from BAME groups as age increases and that older adults are more likely to be of white ethnicity. However, over the next 10 years between 2015 and 2025, the proportion of older adults who are of BAME groups is expected to grow to 35% of the overall population.

8.4 There exist inequalities in health outcomes by ethnic groups. The chapter recognises also that more needs to be done to increase and encourage recognition of 'care-giver' role amongst BAME carers.

8.5 The chapter also includes consideration of health and social outcomes and services for older adults with disabilities or reduced functional ability.

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BACKGROUND DOCUMENTS

JSNA Chapter can be viewed online here:
https://secure.croydon.gov.uk/akscroydon/users/public/admin/kabatt.pl?cmte=WEL&meet=18&href=/akscroydon/images/att6706.pdf