

Croydon Joint Strategic Needs Assessment (JSNA) 2014/15

Key-Topic 2

Older Adults (aged 65 years and over) and Carers of Older Adults:

Maintaining Optimal Health and Supporting Independence in
the Community

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Note on data cut off period

NOTE 1: The data in this needs assessment was the most recent published data at the time they were accessed. Readers should note that more up-to-date data may have subsequently been published, and are advised to refer to the source shown under figures or listed in the appendices for the needs assessment for the latest information. For e.g. the 1st ever report of 'Community Services Data' was published after the cut-off date for data included in this chapter, nevertheless, data items from this report will have been included as they were published under previous national publications.

NOTE 2: In addition to published local data, in instances where local estimates were unavailable this needs assessment includes national data/prevalence estimates applied to the local population, giving local estimates.

NOTE 3: The vast majority of the data included in this chapter refers to older adults aged 65 years and over, with some exceptions for e.g. data on employment amongst older adults which includes those aged 50 years and above. This is because, as people approach and pass the state pension age, people are less likely to be in work.

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1 EXECUTIVE SUMMARY

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.

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. This is particularly important given variation in and/or clustering of the prevalence of disease and risk factors for disease by ethnicity. 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.

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.

Nationally older adults account for more than 1/6th of the some health and social care resources.¹ Most adult social care services are funded through local government. 46% of the local adult social care budget² and nearly 40% of the NHS budget³ 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 2012/13⁴.

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 offer⁵. 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.

¹ Focus on the Health and Social Care of Older People, Office for National Statistics, June 2014 [<http://www.hscic.gov.uk/catalogue/PUB14369>]

² The NHS in a nutshell, Spending on Social Care for Older People. The King's Fund. 12th March 2015. <http://goo.gl/9SVIa9>

³ 2010/11 JSNA chapter: Living well in later life

⁴ Personal Social Services Expenditure data, 2012/13

⁵ Older People Network, Presentation Slides

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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 sectors⁶.

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.

1.1 Key Demographic Characteristics of Croydon's Older Adults

1 in 8 Croydon residents are aged 65 years and over, the majority of which are of White ethnic background. When compared proportionally to England, Croydon has a 'younger' population, but an 'older' one when compared to London as a whole. Amongst its group of comparator Local Authorities (as per POPPI database), Croydon has the 6th highest older adult population in London.

Over the next 10 years, the proportion of older adults living in Croydon is expected to increase by 25% of current estimates, i.e. an increase of roughly 11,300 individuals over the next 10 years. Alongside this, the ethnic distribution of the older adult population is also expected to greatly increase.

A higher proportion of residents in the south of the Borough are older adults, however the north of Croydon is known to be more densely populated and comprises a higher proportion of older adults from Black and Asian minority ethnic groups.

Older adults in the north of the borough appear to experience worse health outcomes, greater deprivation including fuel poverty and income deprivation, and generally greater inequalities such as a 10 year difference in life expectancy between the most affluent and most deprived areas in Croydon. Additionally, when compared to Croydon's population under 65 years, a greater proportion of older adults (29%) live in the most deprived areas of the borough. There may be opportunities through for example the Croydon Gateway Service, to help older adults and carers of older adults maximise their income and reduce the income deprivation faced by these population groups.

Addressing this clustering of inequalities and its socio-economic determinants is likely to reduce inequalities and improve overall population health.

Among individuals who reach the age of 65, life expectancy for men in Croydon is 19.1 further years and for women is 21.5 further years (2011-1013 estimates). The most common causes of death among older adults in Croydon are cancer, circulatory diseases and respiratory diseases. Although life expectancy in Croydon

⁶ Outcomes Based Commissioning, NHS Croydon and Croydon Council.
<http://www.croydonccg.nhs.uk/about-us/our-plans/Pages/Outcomes-for-older-people-.aspx>

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1.2 Summary of Conclusions and Recommendations

From a wider set of areas for improvement found in Appendix C, section 7.3, 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.

1 Prevention and Health Maintenance

There is a significant and growing body of evidence to show a return on investment, potential for savings and rapid impact on improving life expectancy and health outcomes through greater investment, provision and adoption of primary and secondary prevention.

Currently, the focus on prevention (whether primary or secondary) is delivered through predominantly purpose-built or dedicated services. Evidence recommends a cross-organisational approach of a combination evidence based interventions either through universal measures or through targeting high risk groups and ranging from interventions aimed at individuals such as brief advice for behaviour change and community interventions to regulatory actions at a societal level such as for tobacco control and alcohol licensing. More needs to be done to integrate (in all settings), early intervention and encourage healthy lifestyle behaviours at the front-end of all patient-service interfaces.

1.1. Promote Healthy Lifestyles and Behaviours (see section 5.1.1 and 5.1.2)

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. It is important to emphasise that ill-health associated with cold homes is experienced during 'normal' winter temperatures and not just extreme weather.

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.

1.2. Support with Functional, Sensory Ability and Falls (see section 5.1.3)

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, leads to requiring support in the home 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 (Figure 17) 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.

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

- 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.

1.4. Reduce Fuel Poverty (see section 4.1.2 and 5.1.2)

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.

1.5. Address Social Isolation (see section 5.1.3)

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.

Despite 80% of people self-caring for the majority of the time, evidence suggests that people often abandon self-care earlier than they need to.

Achieving greater self-care/management for optimal health maintenance requires greater support for patients to make healthier choices and a fundamental shift in the patient-caregiver relationship into a collaborative partnership.

Patients and services users are often untapped resources of health and social care systems. Progressing Self Care is seen as a significant solution towards achieving a sustainable health and social care system. On the bases of widely published literature and findings from the Croydon data included in the chapter, the following recommendations have been prioritised, amongst other areas for improvement.

2. Management of Deterioration and Recuperation in the Community

Despite 80% of people self-caring for the majority of the time, evidence suggests that people often abandon self-care earlier than they need to.

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

- 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.

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.

2.2. Holistic Assessments and Regalement (see section 5.2.5 and 5.2.6)

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)

2.3. Medicines (see section 5.2.2)

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.

2.4. Shared Decisions (see section 5.2.4)

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.

2 Carers

Crucially relevant to the context of this needs assessment; evidence suggests that individuals without a carer are more likely to be admitted to nursing or residential care. Carers themselves may be frail, have mental health conditions, be disabled or have other long term conditions. 1 in 8 older adults in Croydon are currently self-reported carers themselves, of which a significant proportion provide more than 50 hours of care per week (35%). Based on widely published literature and findings from Croydon data, the following recommendations have been highlighted as priority areas for implementation amongst other areas for improvement.

2.5. Identifying Carers (see section 5.35.4.1)

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). Compared to other local authorities in London, Croydon is projected to have 3rd highest number of people aged 65+ providing unpaid care by 2030⁴⁶.

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.

2.6. Supporting Carers to care (see section 5.3)

Identify, assess, promote information services 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. In particular, support 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%)⁶¹ 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

2.7. Supporting carers at work (see section 5.3)

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.⁶⁴ 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.⁶⁴

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.

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

2 INTRODUCTION

This chapter forms part of the wider 2014/15 set of Joint Strategic Needs Assessment Chapters. Other chapters in the 14/15 set, focus on Smoking amongst Children and Young People and Maternal Health, and can be found along with this year's annual JSNA Key Dataset on the [Croydon Observatory website](#). Further information on Joint Strategic Needs Assessments, local governance arrangements, processes and outcomes can also be found on the Croydon Observatory website.

For the purposes of this chapter, the terms older adults will be used to refer to all individuals aged 65 years and over.

2.1 Chapter Aims

This needs assessment aims to identify 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.. Gaps in service provision may relate to the absence of particular services or further developments requires to service areas as recommended by evidence.

It furthers the recommendations made in the 2011/12 JNSA needs assessment entitled 'Living Well in Later Life' that specifically recommended a **preventative and holistic approach** to wellbeing and aims to support the local move to an **Outcomes Based Commissioning** approach.

The specific aims of this needs assessment are:

1. To provide an understanding of the demographic characteristics, social determinants and health and social care needs of Croydon's population aged 65 and over and carers of Croydon's population aged 65 and over
2. To summarise Croydon's existing support and care services specifically around prevention, self-care, primary and community intervention for Older Adults and Carers within the framework developed using the outcome goals identified by service users, as part of the consultation exercise for Croydon's Outcomes Based Commissioning Programme.
3. To identify gaps in Croydon's service provision in relation to these outcome goals
4. To inform discussions with health and social care providers within the future Outcome Based Commissioning landscape

2.2 Areas in scope

Primary Prevention: Onset of disease cannot be completely avoided, being part of the ageing process, but there is good evidence that healthy behaviours can address those risk factors which are modifiable and help to delay the onset of certain

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Secondary Prevention: Other ways of improving health amongst older adults that this needs assessment will also focus on includes secondary prevention i.e. early detection of conditions; prompt access to support and 3rd level prevention linking into self-care and optimum management of disease to prevent/delay deterioration⁸.

Supporting Independence in the Community and Self-Care and/or Self-Management: Prevention (both primary and secondary) and Health Maintenance can occur along a continuum ranging from early lifestyle choices and interventions outlined above; to the opposite end of the spectrum i.e. at the start of recovery after major trauma where self-care/management can begin again⁹

Self-Care/Management for optimal health maintenance can vastly improve health outcomes, patient/service-user experience, reduce unplanned hospital admissions and improve adherence to treatment – all of which are either strategic priorities or identified needs in Croydon.

Developing self-care confidence and ability amongst elders will increase feeling of being in control, minimise the constraints felt by them by their state of disability or ill-health, ensure they continue to make a contribution and remain resilient – all of which are also protective factors for improved mental health and mental well-being.

Carer Support: Most individuals will have caring responsibilities at one or more stages their lives. With the continuing and increasing shift away from institutional care to care at home or in the community, it is important to recognise the pressure this places on carers and the level of support required to enable carers to safely manage their own health and wellbeing alongside that of the older adult being cared for.

2.3 Areas out of scope

It was agreed that this needs assessment will not focus on Mental Health Services for Older Adults as this topic area and in particular Dementia, Depression and Serious Mental Illness were the focus of needs assessments in 2012/13. The Mental Health Older Adults project group have also completed an assessment in this area and recommendations are being taken forward through the Mental Health Older Adults Implementation Group. However physical health and social wellbeing of

⁷ 2010/11 JSNA chapter: Living well in later life

⁸ 2010/11 JSNA chapter: Living well in later life

⁹ The self-Care Forum; <http://www.selfcareforum.org/about-us/what-do-we-mean-by-self-care-and-why-is-good-for-people/>

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individuals with mental health illnesses will be included as part of the general
population analyses.

This needs assessment will also not include an assessment of hospital care
(unplanned or planned) for individuals within this population group in keeping with
the emphasis on prevention and health maintenance, self-care/self-management,
and recuperation in the community.

3 METHODOLOGY

1. The chapter begins with a **description of the demographic characteristics and of the social determinants of health** relevant to the group. This includes
 - a. Population numbers, population growth, age, sex, ethnicity, geographic distribution within the borough, (co)morbidity levels, including relevant indicators on the wider determinants of health where available
 - b. similar information on carers where available
 - c. Comparisons where possible between other Local Authorities/CCGs/statistical neighbours, regionally and nationally
2. The next main section comprises a **high level appraisal of the current level of health and social care needs in light of the outcome goals** as identified by service users and patients during public consultation conducted previously by the CCG. These outcome goals have been used as a framework for the high level
3. The discussion within the chapter and recommendations made as a result are very much **informed by local data in conjunction with the evidence base and policy framework** (found in Appendix D).
 - a. A desk based rapid evidence review on 'the reasons for inappropriate usage and dependence on acute &/or social care services and earlier admission to care/residential homes' was completed during December 2014.
 - b. NICE guidance in key areas or areas of concern as identified through the data and input from the Chapter Reference Group were also consulted. A summary of relevant guidance is provided in Appendix E: **NICE Guidance Summary of relevant recommendations**
 - c. Where relevant, the chapter also draws on the recommendations and results from analyses and reports conducted immediately prior to or alongside this needs assessment, especially where it is crucial to implementation or changes in local policy and/or practice.
4. **Recommendations were then prioritised** by key stakeholders with responsibility for the Health and Social Care of older adults within the new Croydon landscape of Outcomes Based Commissioning for Older Adults

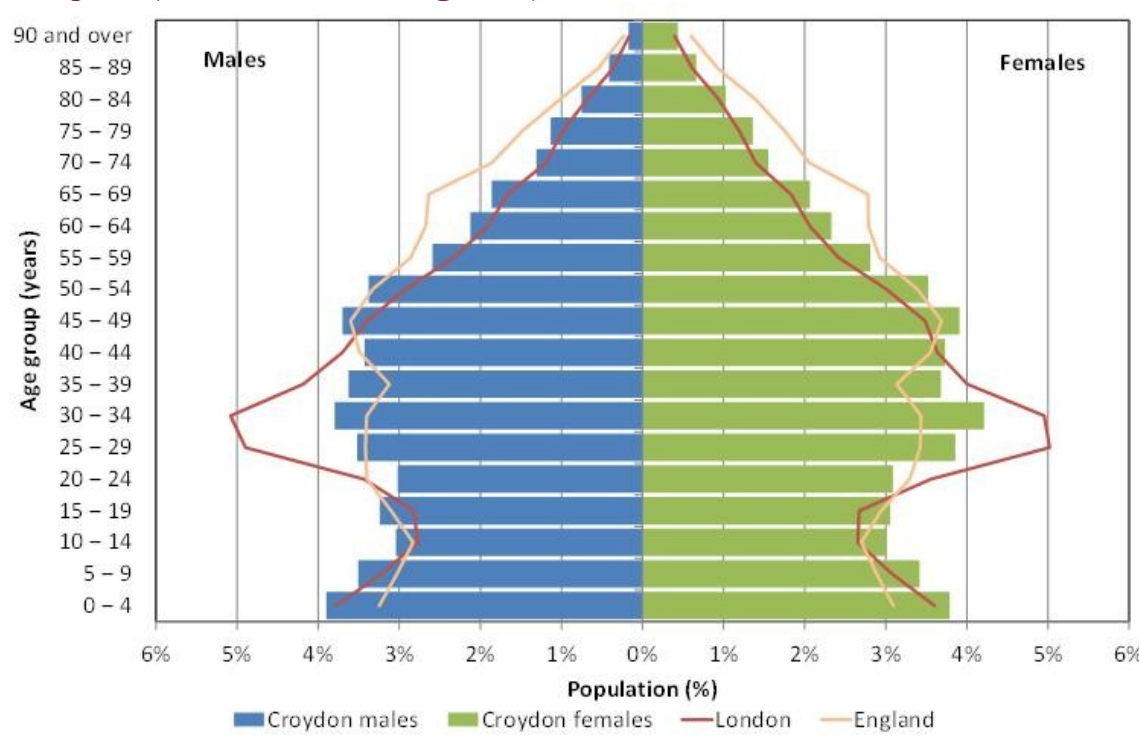
4 POPULATION DEMOGRAPHICS AND SOCIAL DETERMINANTS

4.1.1 Demographics

As at 2013, Croydon had an overall population of 372,752¹⁰, of which 47,476 were aged 65 years or older (older adults) equating to nearly 13% of the general population (i.e. 1 in 8 Croydon residents is an older adult).

The older adult population in Croydon (expressed as a proportion of its entire population), is statistically significantly smaller when compared to the older adults population for England, but higher than that of London as a whole. Figure 1 shows the age distribution of the Croydon population and compares it to that of London and England overall.

Figure 1 Population Pyramid; age distribution of population in Croydon, London and England, 2013



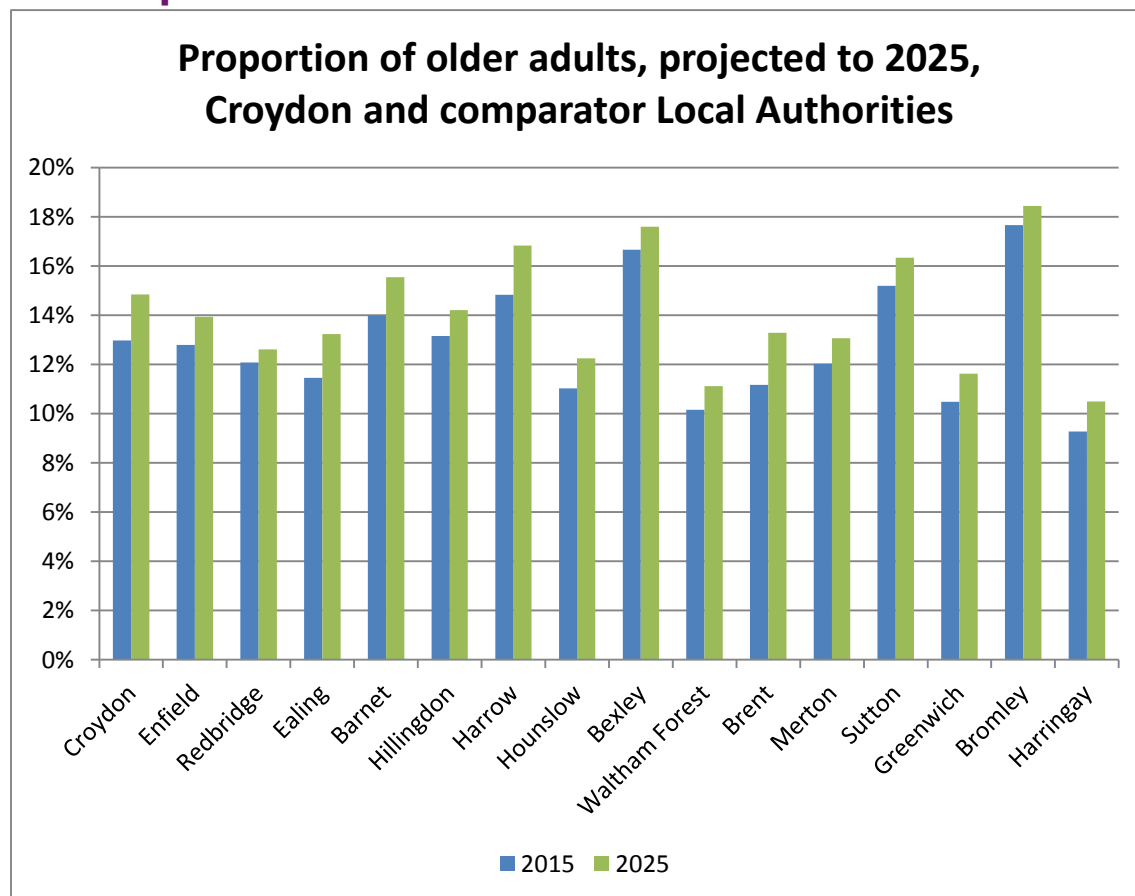
Source: Office for National Statistics, Population Estimates Mid 2013

Amongst its group of comparator Local Authorities, Croydon has the 6th highest older adult population¹¹. Figure 2 below shows how Croydon compares with its London comparators.

¹⁰ Office for National Statistics, Croydon Population Estimates Mid 2013

¹¹ Projecting Older People Population Information System

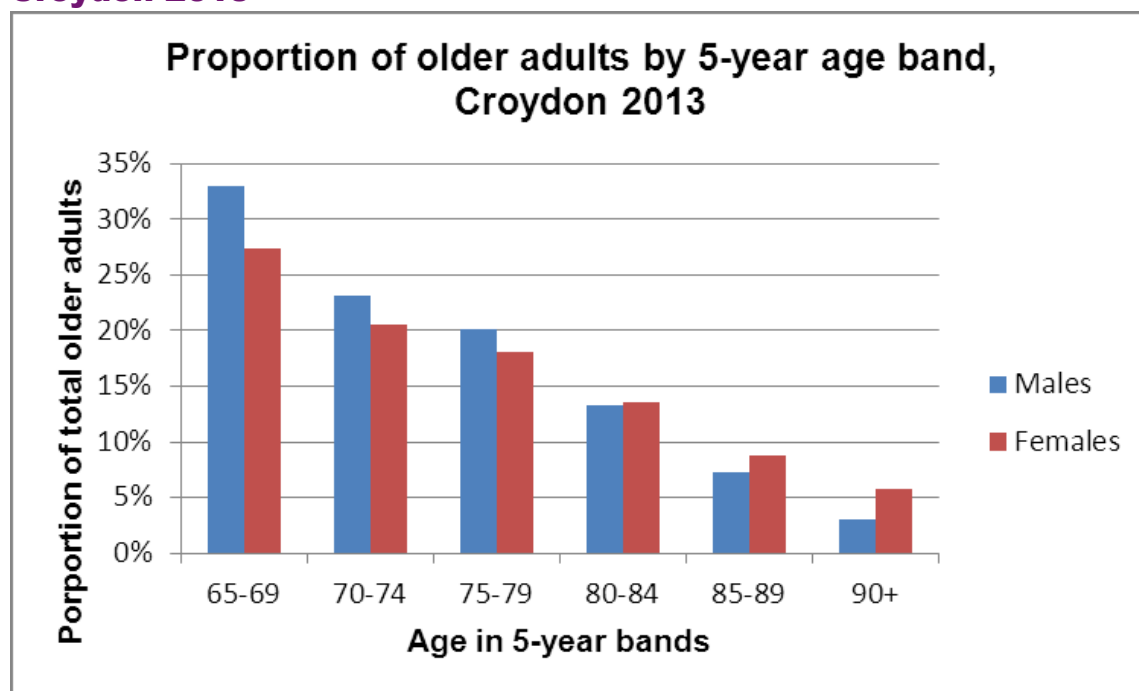
Figure 2 Proportion of older adults 2015, projected to 2025, Croydon and comparator Local Authorities



Source: Projecting Older People Population Information System (POPPI)

Just over half (53%) of older adults in Croydon are between the ages of 65 and 74 years, the rest of which make up the population aged 75 and over. The figure below shows a breakdown of older adults in Croydon by 5 year age bands.

Figure 3 Current Proportion of Older Adults by 5-year age band, Croydon 2013



Source: ONS Population Estimates Mid 2013

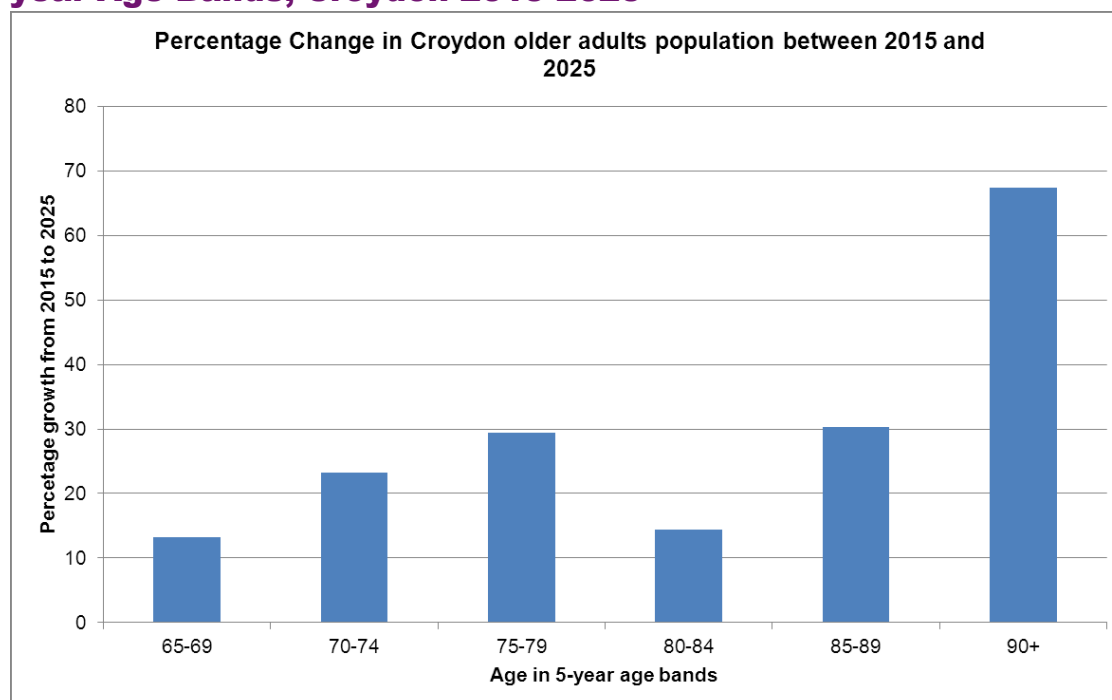
Over the coming years, Croydon is expected to continue to experience significant population growth across all age groups.

Whilst the overall population of Croydon is expected to grow by 8% of current levels over the next 10 years between 2015 and 2025, the proportion of older adults living in Croydon is expected to increase by 23% of current population estimates, i.e. an increase of roughly 11,300 individuals over the next 10 years¹².

Figure 4 shows the projected growth in Croydon's older adult population to year 2025, by 5-year age groups.

¹² Greater London Authority, Population Projections, 2015

Figure 4 Projected Ten Year Change in Older Adults Population by 5-year Age Bands, Croydon 2015-2025

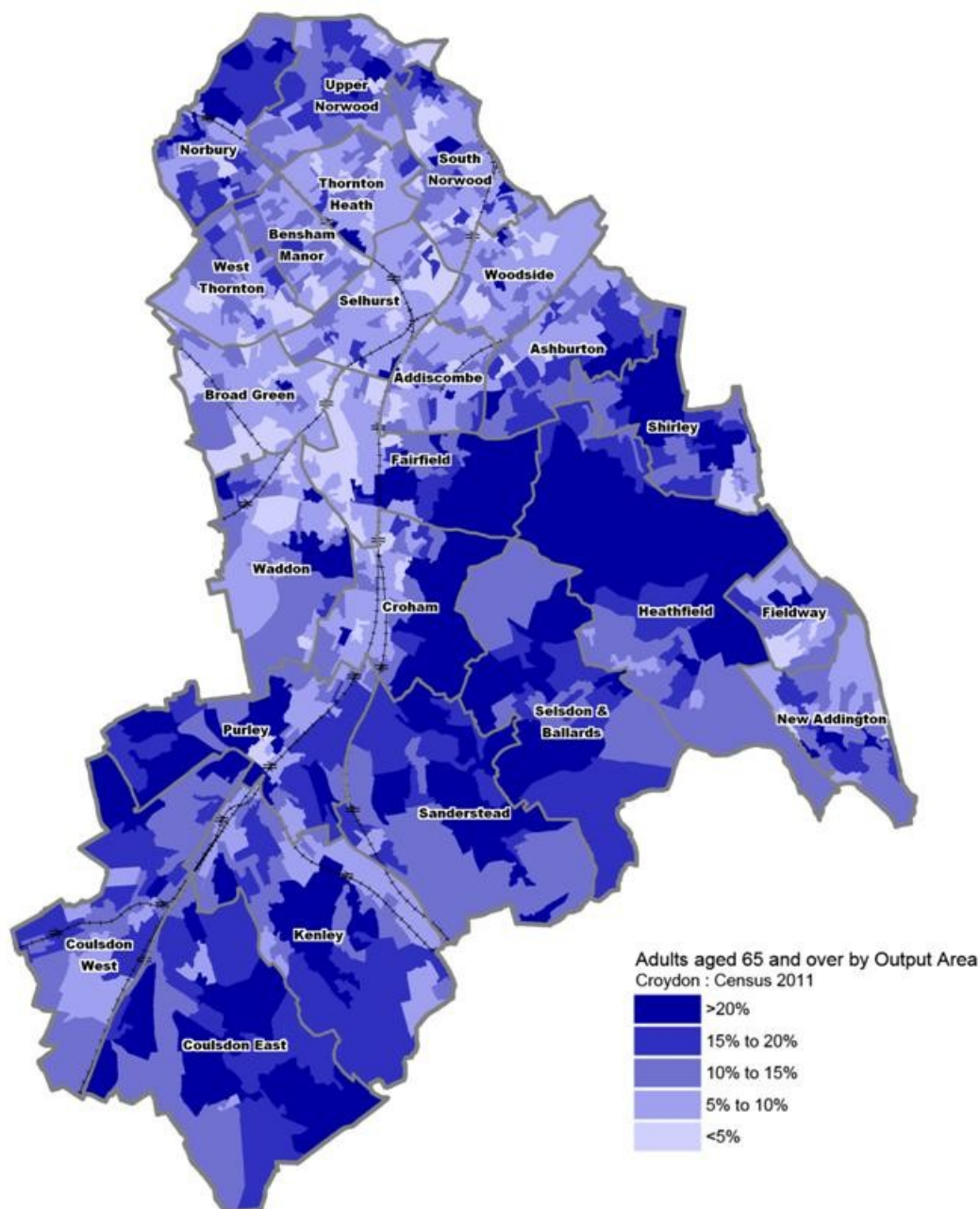


Source: Greater London Authority, *Population Projections for Croydon, 2015*

There are variations by age in the geographical distribution of Croydon's overall population. A higher proportion of residents in the south of the Borough are older adults. Figure 5 shows the geographical distribution of Croydon's older adults as a proportion of the population by output areas¹³.

¹³ The OA is the lowest geographical level at which census estimates are provided. They were designed to have similar population sizes and be as socially homogenous as possible based on tenure of household and dwelling type.

Figure 5 Geographical distribution of older adults by output area, Croydon, 2011



Source: Croydon Census data, 2011

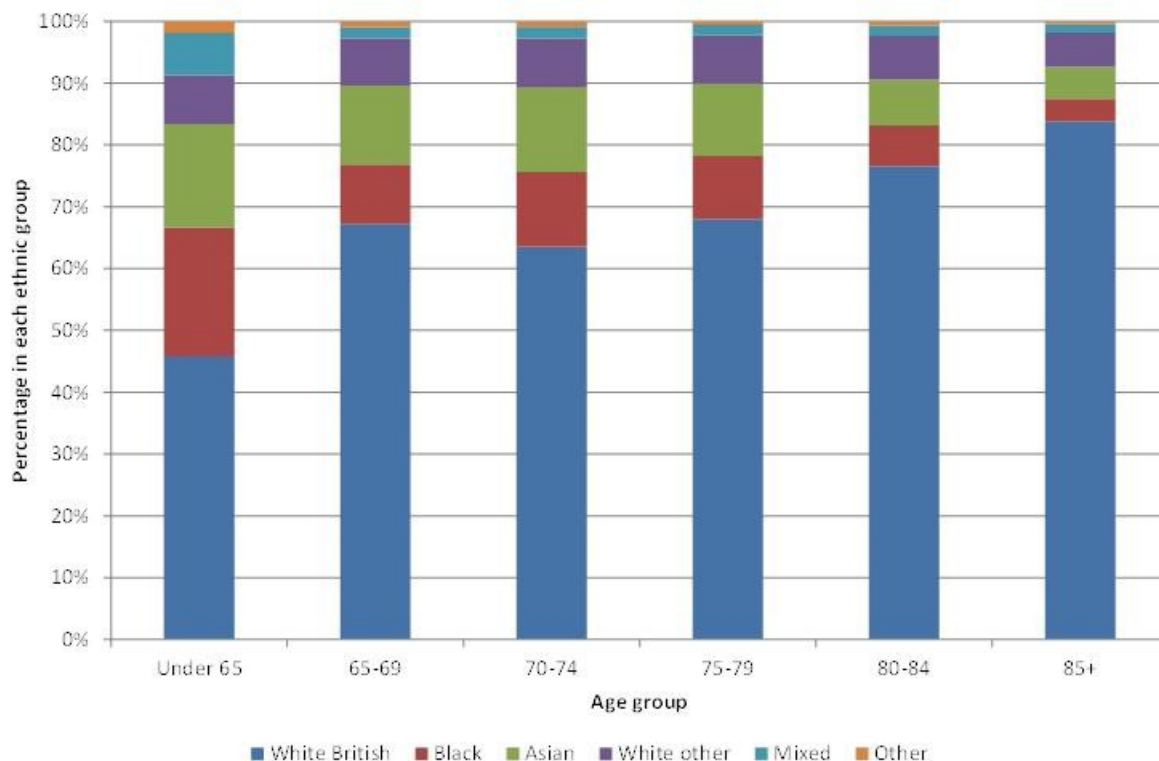
Ethnicity

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 under¹⁴.

¹⁴ Croydon Census data, 2011, accessed from the NOMIS website

Figure 6 shows 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.

Figure 6 Population ethnicity by age, Croydon, 2011



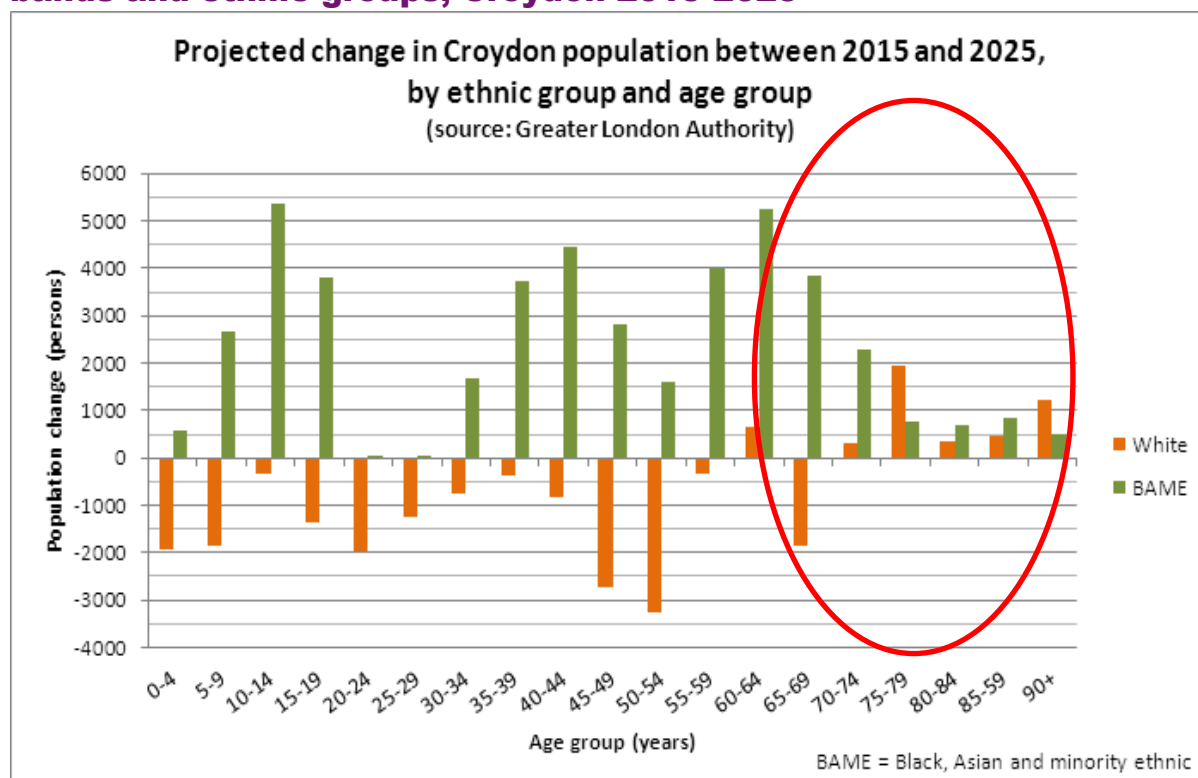
Source: Croydon Census data, 2011

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%. In numbers this equates to almost a doubling in the next 10 years of the number of older adults that are from BAME groups (i.e. 74% increase in numbers of BAME older adults)¹⁵.

Figure 7, shows the ten-year change in Croydon's Older Adults population by 5-year age bands and ethnic groups.

¹⁵ Greater London Authority Population Projections, Ethnicity data, 2015

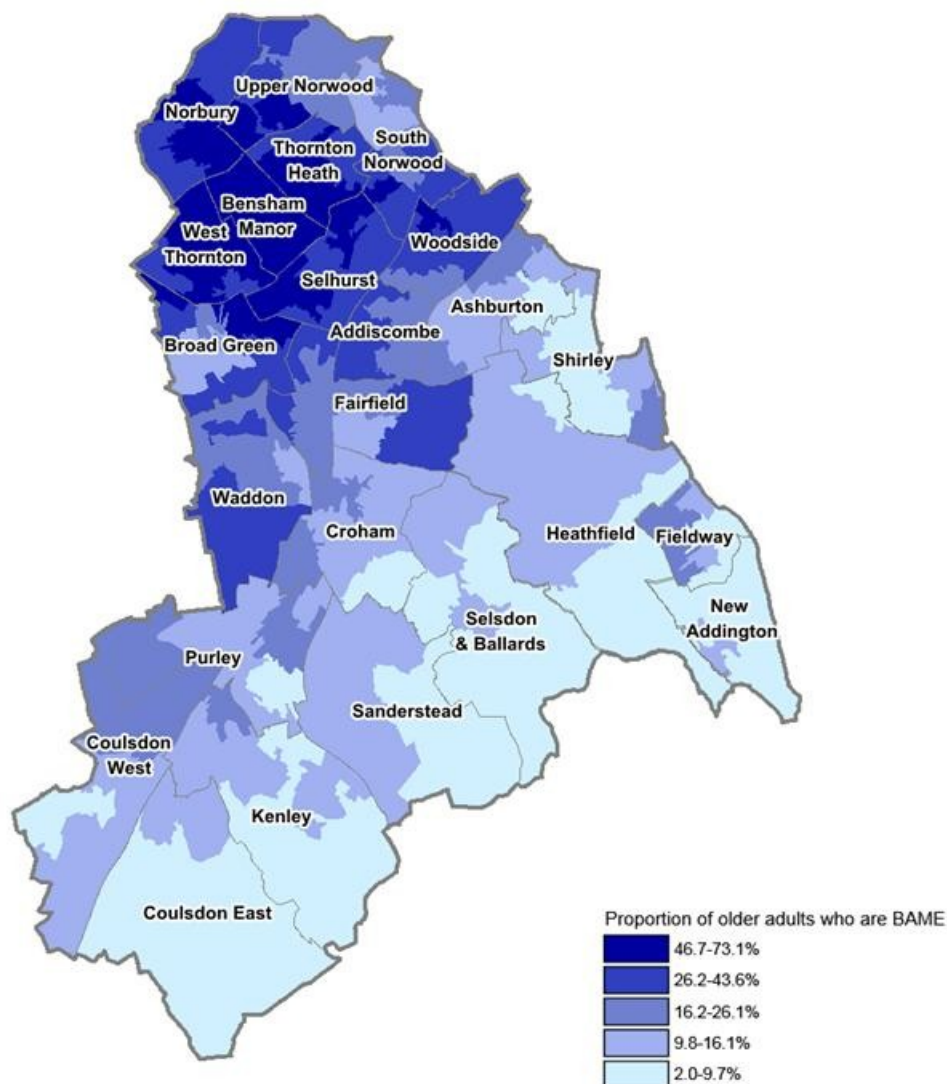
Figure 7 Projected Ten year Change in Population by 5-year age bands and ethnic groups, Croydon 2015-2025



Source: Greater London Authority 2013 round, capped Strategic Housing Land Availability Assessment, household size based

The majority of older adults from BAME groups reside in the north of the borough, as demonstrated in Figure 8

Figure 8 Proportion of older adults who are of Black, Asian and other minority ethnicities, Croydon output areas, 2011



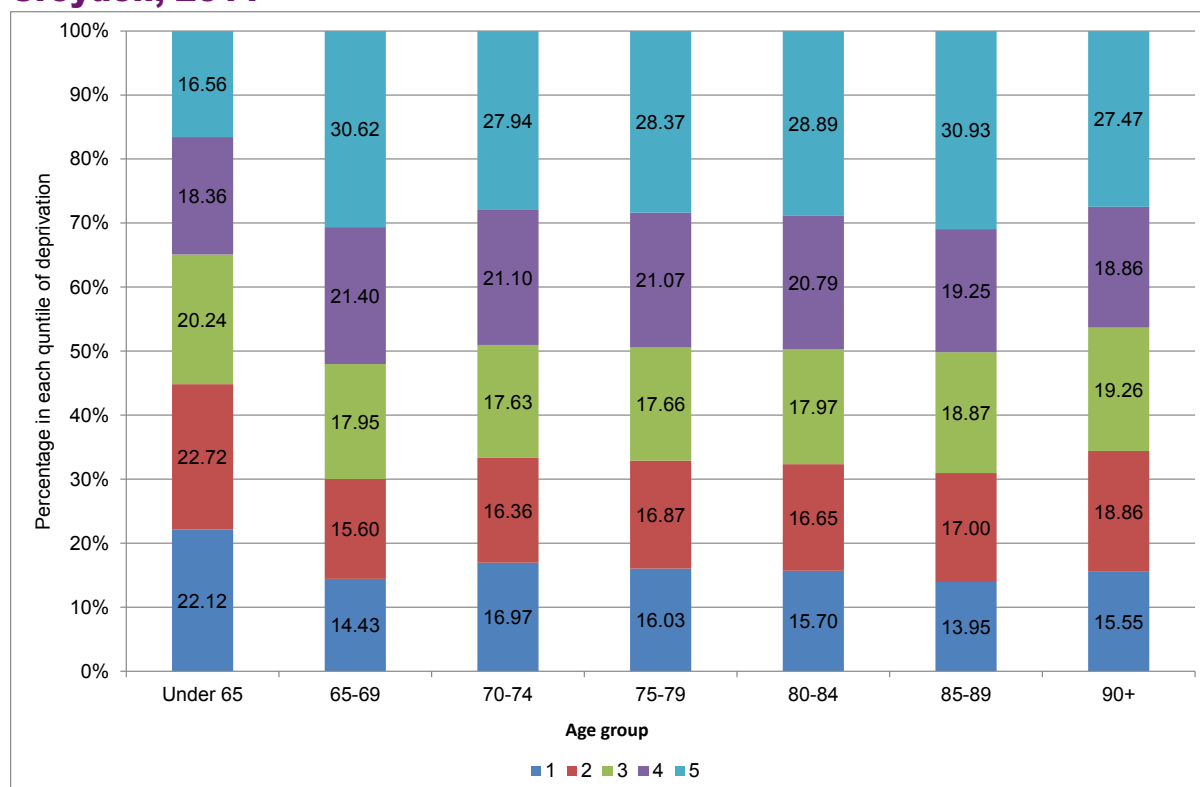
Source: Office for National Statistics, Census 2011, accessed from NOMIS website on 6 March 2015

4.1.2 Social Determinants, Deprivation and Inequitable Burden of Disease

A greater proportion of older adults (29%) live in the most deprived areas of the borough when compared to younger individuals (17%). Furthermore, 1 in 8 older adults in Croydon lives in areas considered to be some of the most deprived in England. This compares to 1 in 14 residents aged under 65.

Figure 9, shows the proportion of older adults in each quintile of deprivation, compared to population aged under 65 years.

Figure 9 Proportion of Older Adults in Deprivation Quintiles, Croydon, 2011



Source: ONS population data mapped to Index of Multiple Deprivation, 2011

Common lifestyle risk factors also tend to cluster in certain population groups, particularly disproportionately amongst the lowest socio-economic groups, and amongst most deprived population groups or areas. For example, people in socio-economic group V (unskilled manual workers) have a 60% higher chance of having a stroke than those in socio-economic group I (professionals), and the mortality rates from stroke are 50% higher in socio-economic group V than in socio-economic group I. The prevalence of stroke is also between about 40% and 70% higher in African-Caribbean and South Asian men than that of the general population.

This clustering of deprivation and lifestyle risk factors has a dramatic effect on creating inequalities in health outcomes, quality of life and life-expectancy. Addressing this clustering and its socio-economic determinants is likely to reduce inequalities and improve overall population health¹⁶.

Employment in older adults - Across the UK, there are reportedly more people over the state pension age, than there are children. By 2020, in the UK, it is estimated that people over the age of 50 will comprise almost a third (32%) of the

¹⁶ Transforming our health care system; Ten priorities for commissioners, April 2015. The King's Fund. <http://www.kingsfund.org.uk/publications/articles/transforming-our-health-care-system-ten-priorities-commissioners>

Key-Topic 1: Older Adults (aged 65 years and over) and Carers of Older Adults: Maintaining Optimal Health and Supporting Independence in the Community working age population and almost half (48%) of the adult population¹⁷. Older adults (aged over 50) are reportedly less likely than younger adults to remain unemployed for longer¹⁸.

Retirement is increasingly continuing to be an active phase of life, where people continue to contribute to society either through work or volunteering and increasingly take more responsibility for their own health and wellbeing.

The employment rate for older adults (both groups; those aged 50 years and above as well as those aged 65 years and above) has increased over the last decade, and this is more likely to be self-employment compared to younger workers. According to 2011 Census figures, an estimated 12% of older adults (65 years and over) in Croydon are in employment¹⁹.

However, whilst unemployment (see footnote²⁰ for definitions) is comparatively lower amongst older adults than younger workers, many older adults (50 years and above) do not look for work due to sickness or disability or because they are looking after the home or family.

Income Deprivation in older adults – Pension Credit is payable to people aged 60 or over who have a low income. 23% of adults aged 60 years and over in Croydon are pension credit claimants. This is significantly higher than the figure for England but significantly lower than the figure for London²¹. Additionally, the proportion older adults claiming pension credit is higher in the northern parts of the borough and in New Addington and Fieldway, areas considered most deprived within the borough.

Figure 10, shows income deprivation affecting Croydon's older adult population (aged 60 and over) by deprivation decile. (Note: LSOAs in the 1st decile are in the top 10% most deprived areas in the country)

¹⁷ Older workers statistical information booklet: quarter 2, 2013

<https://www.gov.uk/government/statistics/older-workers-statistical-information-booklet-quarter-2-2013>

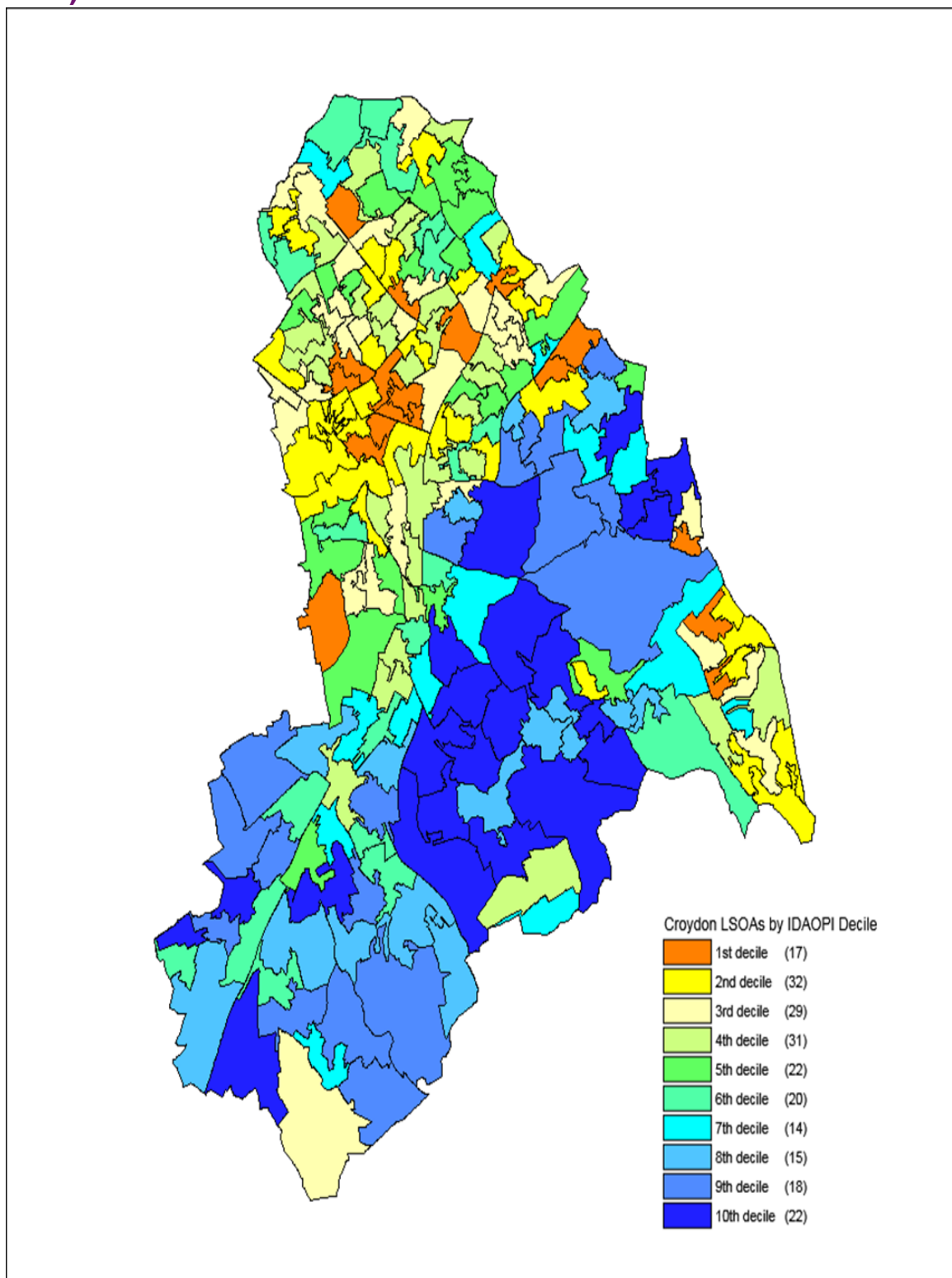
¹⁸ Policy of the 2010 to 2015 Conservative and Liberal Democrat coalition government accessed at <https://www.gov.uk/government/publications/2010-to-2015-government-policy-older-people/2010-to-2015-government-policy-older-people>

¹⁹ 'In employment' – defined as: People who did some paid work in the reference week (whether as an employee or self-employed); those who had a job that they were temporarily away from (e.g., on holiday); those on government-supported training and employment programmes; and those doing unpaid family work

²⁰ 'Unemployed' – defined as: people without a job who were available to start work in the two weeks following their interview and who had either looked for work in the four weeks prior to interview or were waiting to start a job they had already obtained.

²¹ Croydon Council Observatory [<http://www.croydonobservatory.org/profiles>]

Figure 10 Income Deprivation Affecting Older Adults (Aged 60 and over) Index 2015



Source: Croydon Strategic Intelligence Unit (using DCLG Index of Multiple Deprivation 2015 and Ordnance Survey. Crown Copyright)

Fuel poverty amongst older adults – As at 2013, 9.9% of all households in Croydon experienced Fuel Poverty²². Older adults, particularly those living alone and/or in larger family homes, those with disabilities and those with existing long term conditions (physical or mental) are amongst those considered to be most vulnerable to fuel poverty and the impacts cold damp homes²³.

Nationally, over a quarter of 60+ households (26.1%) are reported live in a non-decent home²⁴. 4% of older adults in Croydon live in accommodation without central heating compared to 1.9% of younger individuals. This figure for older adults is statistically significantly higher for Croydon compared with England (3%).⁶²

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.

See section 7.5.4 for **NICE Public Health Guidance** on practical actions to reduce the associated risk of death, ill-health and resulting pressure on health and social care services by reducing fuel poverty and the risk of fuel debt.

Apart from affecting physical health and exacerbating cardiovascular conditions, fuel poverty can also have a detrimental impact on some older adults' ability to afford food shopping.³⁶ Section 5.1.2 briefly covers healthy eating and malnutrition amongst older adults.

The national cost of cold homes to the NHS in England arising from increase in hospital admissions and additional GP consultations is estimated to be £1.36 billion per year³⁶.

Winter fuel payments are paid to all those above a certain age (62 years in 2015) that will be living in the UK throughout a defined period. During 2014-15, over 47,000 older adults were in receipt of winter fuel payments²⁵.

Cold weather payments (not the same as winter fuel payments) help people that are most vulnerable to the cold (including older adults receiving pension credit) to meet additional heating costs, during periods of extreme cold.

4.1.3 Life Expectancy: Are Croydon's Older Adults Living Longer Healthier Lives?

Life expectancy at birth in Croydon is 80.0 for men and 83.5 for women (2011-2013 estimates). Overall life expectancy (LE) for men and women in Croydon has

²² Sub-regional Fuel Poverty England (2013 data). Department of Energy and Climate Change, May 2015

²³ Fuel Poverty: How to improve health and wellbeing through action on affordable warmth: A guide to delivering action on fuel poverty for public health professionals, health and wellbeing boards, and local authorities in England, January 2015. UK Health Forum

²⁴ Key stats on older people, ageing and Age UK, November 2014

²⁵ Winter fuel payments statistics, October 2015. Department of Work and Pensions

Key-Topic 1: Older Adults (aged 65 years and over) and Carers of Older Adults: Maintaining Optimal Health and Supporting Independence in the Community increased year on year; over the last decade it has increased by 4.1 years for men and 3.0 years for women.

Among individuals who reach the age of 65, life expectancy for men in Croydon is 19.1 further years and for women is 21.5 further years (2011-1013 estimates). This is above the England average (M=18 further years, F=21 further years). By the age of 75, life expectancy among men in Croydon 11.5 years and for women is 13.3 years (2010-12 estimates).

Although these estimates are similar to those for London overall and England overall, compared to the rest of England Croydon' performance is worsening (Table 1: Spine charts of life Expectancy indicators from Croydon Key dataset, 2013-14Table 1). Life expectancy in Croydon has increased, however national data indicate that life expectancy and disability free life expectancy are not increasing at the same rate. As the population over the age of 65 continues to increase services must evolve to reflect the increasing number of individuals who will be living longer with long-term and/or life limiting conditions.

Disability free Life Expectancy at 65 for Males is 10 years and for Females is 11 years; therefore some level of increased services usage can be expected by the age of 75. There exists variation in LE (overall and health LE) between BAME and White groups¹.

A summary comparing life expectancy in Croydon to that in London and England is shown in Table 1.

Croydon Joint Strategic Needs Assessment 2014/15

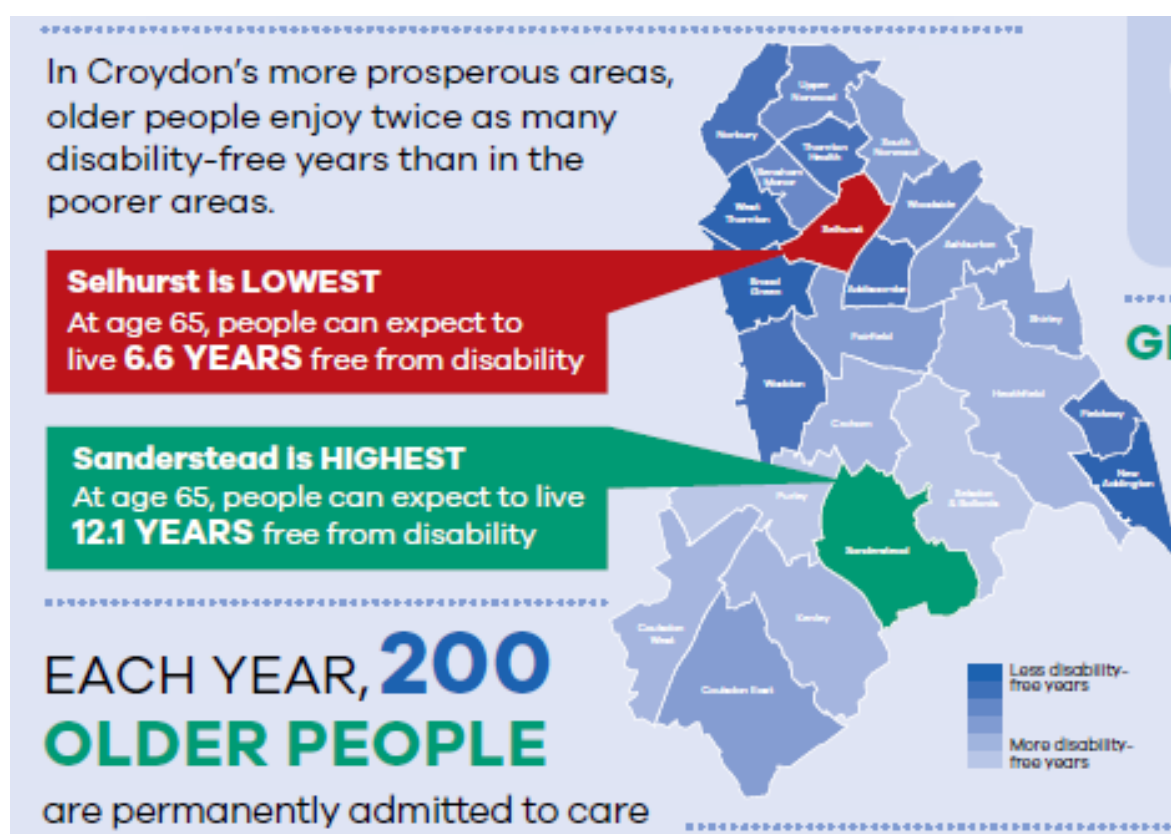
Key-Topic 1: Older Adults (aged 65 years and over) and Carers of Older Adults: Maintaining Optimal Health and Supporting Independence in the Community

Table 1: Spine charts of life Expectancy indicators from Croydon Key dataset, 2013-14²⁶

Domain	Indicator	Croydon	London	England	England Range	1 Year Trend	3 Year Trend	Time Period	Frame-works
Life expectancy	138 Life expectancy at birth (men) in years	79.2	79.7	79.2		◀	◀	2010 - 12	PHOF
	139 Life expectancy at birth (women) in years	83.2	83.8	83.0		▶	◀	2010 - 12	PHOF
	140 Life expectancy at age 75 (men) in years	11.5	12.0	11.5		◀	◀	2010 - 12	NHSOF
	141 Life expectancy at age 75 (women) in years	13.3	13.9	13.3		▶	—	2010 - 12	NHSOF
Healthy life expectancy	142 Healthy life expectancy at birth (men) in years	63.2	63.2	63.4		▶	no data	2010 - 12	PHOF
	143 Healthy life expectancy at birth (women) in years	65.4	63.6	64.1		—	no data	2010 - 12	PHOF
Disability-free life expectancy	144 Disability-free life expectancy at birth (men) in years	63.2	64.5	63.9		◀	◀	2009 - 11	n/a
	145 Disability-free life expectancy at birth (women) in years	68.1	65.2	64.4		—	◀	2009 - 11	n/a
Inequality between areas of deprivation	146 Inequality in life expectancy between areas of deprivation (men) in years	9.1	7.3	8.4		◀	◀	2010 - 12	PHOF
	147 Inequality in life expectancy between areas of deprivation (women) in years	7.7	4.6	5.6		◀	◀	2010 - 12	PHOF
Inequality between socio-economic classes	148 Inequality in health status between socio-economic classes (men)	17.2	20.2	17.3		no data	no data	2011	n/a
	149 Inequality in health status between socio-economic classes (women)	18.2	20.2	18.0		no data	no data	2011	n/a

²⁶ Note that these data do not exactly match data within the text as they refer to different years and data has been updated

Additionally, life expectancy varies by area of residence within Croydon and the difference in life expectancy between individuals who live in the most affluent areas of the borough compared to that of individuals who live in the most deprived areas of the borough are stark. In the most deprived parts of Croydon, life expectancy is nearly ten years lower for men and nearly six years lower for women than in the least deprived areas. Whilst the gap for women is similar to England as a whole, for men, the gap is two years higher than for London and England.



Mortality

The most common causes of death among older adults in Croydon are cancer, circulatory diseases and respiratory diseases.

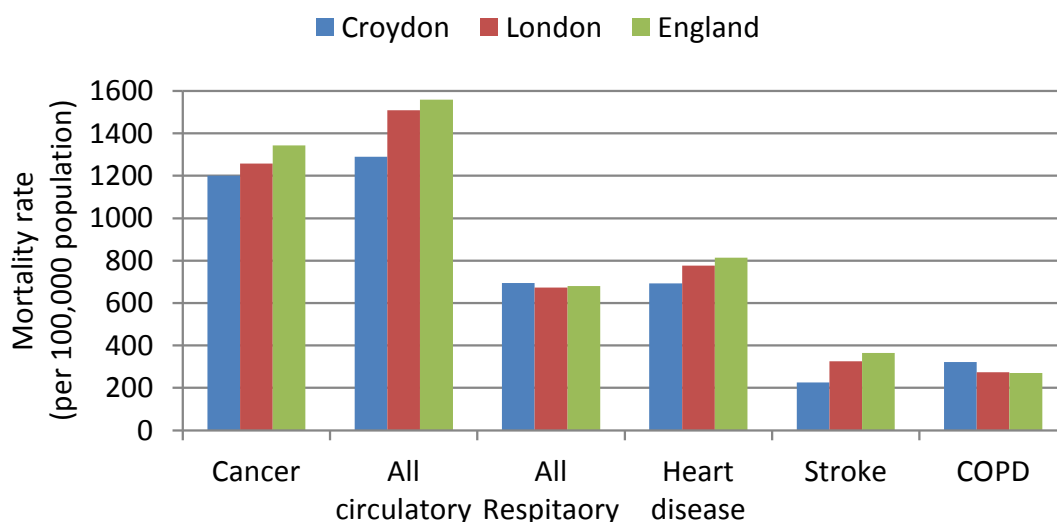
Compared to England as a whole, Croydon has significantly lower standardised mortality rates among men for all circulatory disease and in particular for stroke (Figure 4a). However, compared to England as a whole Croydon has significantly higher standardised mortality rates among women for respiratory disease (Figure 4b)

Among men (over the age of 65) who died in 2012, 30% of deaths were due to cancer, 29% to circulatory diseases and 16% due to respiratory diseases

Among women (over the age of 65) who died in 2012, 22% died of cancer, 30% of circulatory disease and 20% of respiratory disease.

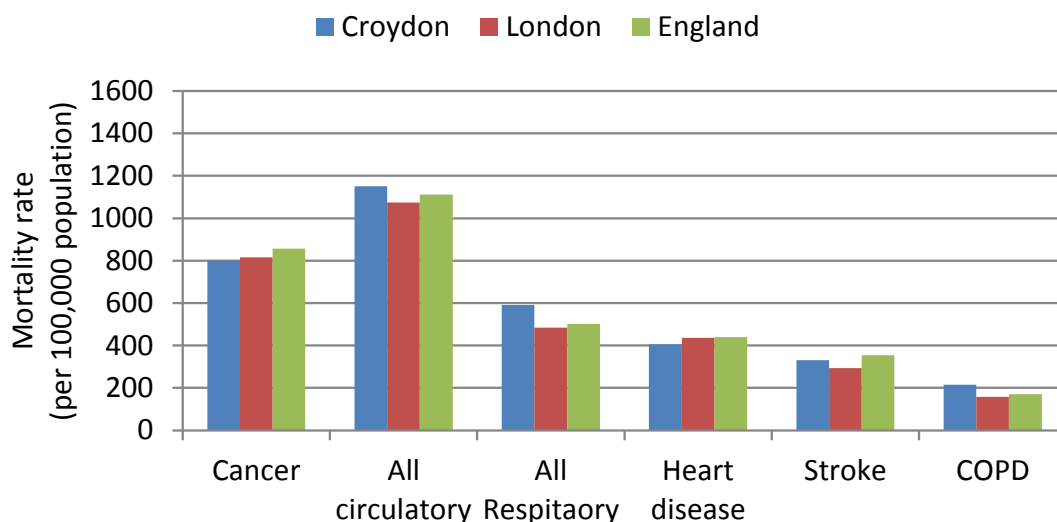
Figure 4: Directly standardised mortality rates for common causes of death

Directly standardised mortality rates for common causes of death in males aged 65 and older, 2009-11



Source: West Midlands Public Health Observatory, Older People's Atlas

Directly standardised mortality rates for common causes of death in females aged 65 and older, 2009-11



Source: West Midlands Public Health Observatory, Older People's Atlas

5 AN OUTCOMES BASED APPROACH TO PREVENTION AND HEALTH MAINTAINENCE

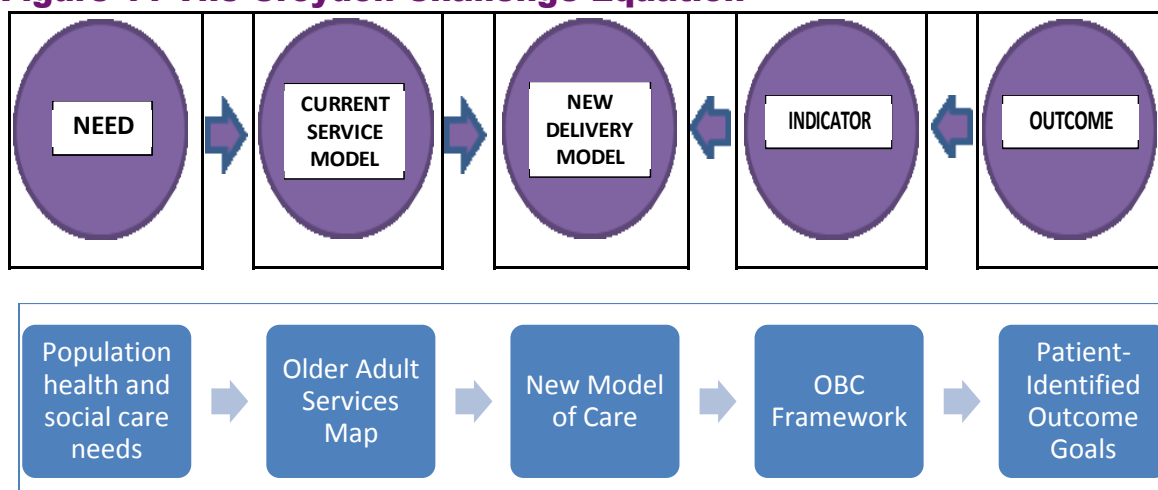
As part of the Outcomes Based Commissioning Programme, outcomes have been identified by service users through consultation and engagement with commissioners that reflect what service users need and require from their local health and social care system. Several **'I want to... statements'** emerged as particularly relevant to focus areas for this chapter. For an overview of the framework being used for the Outcomes Based Commissioning (OBC) Programme please see Appendix A.

The service map in Figure 12 aims to provide an overview of the current health and social care services for older adults and also identifies the current commissioners of these services. [Note: Please be advised that there are likely to have been changes to this map since its development]

A key aim of this joint strategic needs assessment chapter is to identify gaps in the current provision within areas of 'prevention and health maintenance' and in 'the management of deterioration and recuperation' within the community. Identifying those at risk and intervening early is one of the most effective ways that the widening gap in life-expectancy and health-outcomes can be reduced.

What follows ahead, is a high level appraisal of current service provision against these **'I want to... statements'** identified by service users and the public as important to them. This framework or outline is typical of Croydon Joint Strategic Needs Assessments; the concept of which has recently been crystallised in the 'Croydon Challenge Equation' demonstrated below.

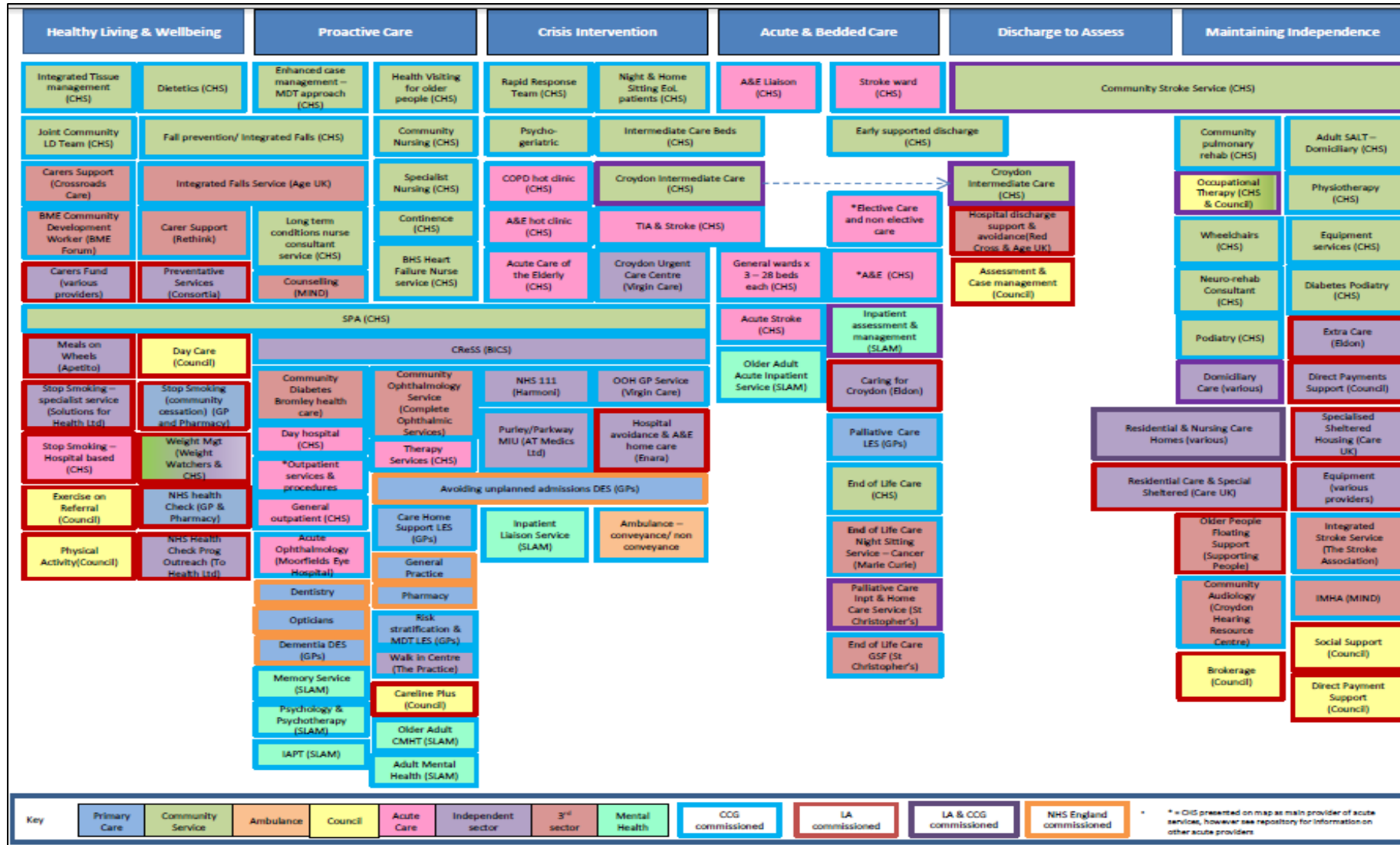
Figure 11 The Croydon Challenge Equation



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Figure 12 Borough Wide Commissioned Services for Older Adults



Source: South London Commissioning Support Unit for Croydon Clinical Commissioning Group

5.1 Prevention and Health Maintenance

The vast majority of long-term conditions could be avoided if common lifestyle risk factors were eliminated. **'Primary Prevention'**, i.e. taking action early in life to reduce the incidence of disease/ill-health, whilst earlier the better, is beneficial at any point in life. There is a significant and growing body of evidence to show a return on investment and potential for savings through greater investment, provision and adoption of primary prevention.¹⁶

The early detection of disease/ill-health and prevention of deterioration is called **'Secondary Prevention'**, is highly cost-effective and if successfully and systematically implemented at scale can deliver a rapid impact on improving life-expectancy and reducing complications¹⁶. Secondary prevention interventions include participation in national screening programmes, such as cancer screening or diabetic retinopathy, immunisations such as for influenza and taking up invitations to NHS Healthchecks.

5.1.1 I want to stay healthy and active for as long as possible²⁷

Influenza causes substantial ill health in older people, including hospitalisation. A seasonal flu vaccine is offered on the NHS to protect certain at risk groups (including older adults) in whom flu and its complications can be more severe. Overall uptake in Croydon of the seasonal influenza vaccine amongst older adults, during 2012, was below the nationally set target of 75% (i.e. 67.5% for men and 67.3% for women). The uptake among those aged 75 and older was significantly higher: 75.0% for men and 72% for women²⁸, how the uptake amongst 64-75 year olds was lower than the target and national average.

Increasing the uptake of the flu vaccine has more important outcomes than simply achieving a set target percentage. Part of the basis for effectiveness of vaccines in a population group, is the concept of 'herd immunity' or 'community immunity', which simply means most members of a population group are protected when a critical number within that population group are vaccinated/immunised, because there is little opportunity for an outbreak to occur.

It is therefore not only in the interest of older adults and carers of older adults, but also in the interest of providers of adult services to increase the uptake of the seasonal flu vaccine in Croydon.

See 7.5.1 for **NICE Public Health Guidance** on increasing uptake in clinical risk groups and healthcare workers.

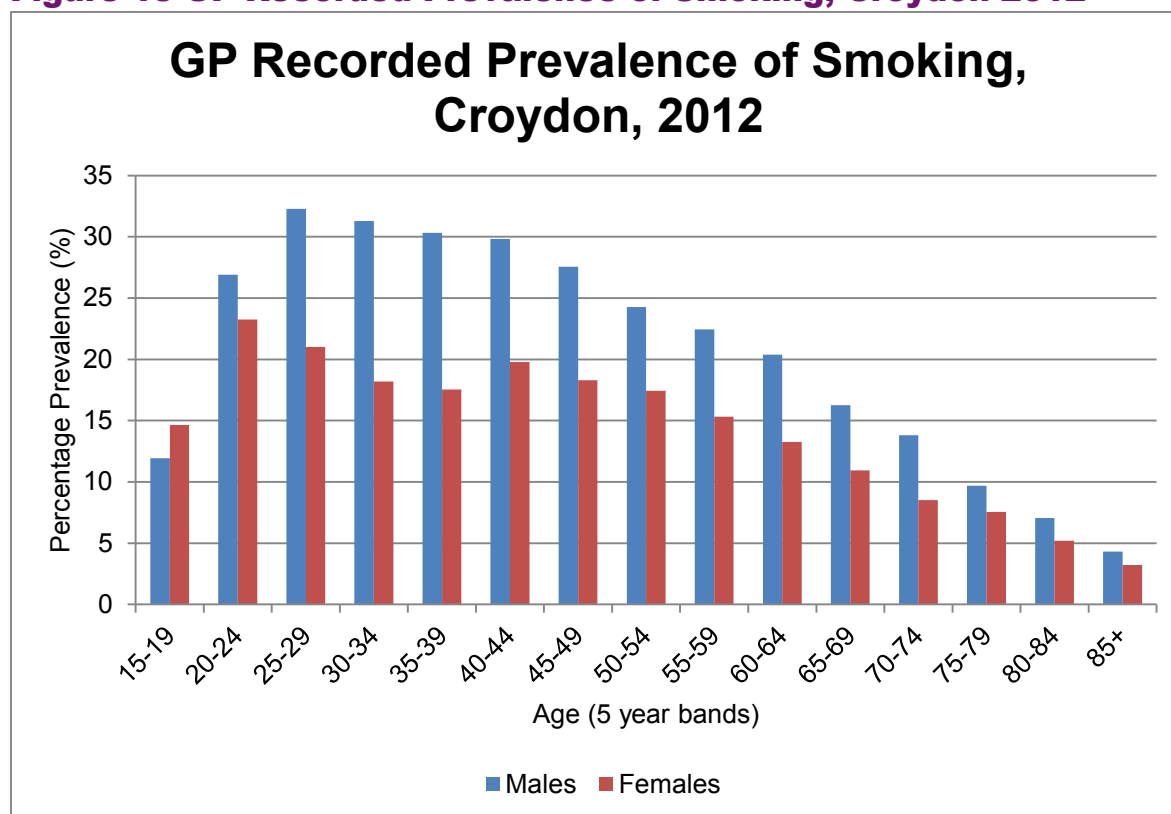
The overall GP recorded **prevalence of smoking among older adults** in Croydon is 12% for men and 8% for women.²⁸ However prevalence rates vary greatly by age

²⁷ Croydon Outcomes Based Commissioning for Older Adults, patient-identified outcome goals, 2015

²⁸ Data from Croydon General Practices, 2012

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 and decrease as age increases. The chart below shows a breakdown of GP
 recorded smoking prevalence by age. It may be assumed that older adults that are
 current smokers will have a long history of smoking which is likely to have negatively
 impacted respiratory health.

Figure 13 GP Recorded Prevalence of Smoking, Croydon 2012



Source: Data from Croydon General Practices, 2012

As is evident from the prevalence rates of smoking and obesity (presented below) across all age groups, it is essential that efforts to improve healthier lifestyles are essential far earlier in the life course, and as early as childhood and youth.

All individuals aged 40-74 are eligible for **NHS health checks**. In Croydon, in 2012/14 only 2.0% of eligible individuals had received an NHS health check. This is significantly worse than the figure for England (9%) and that for London (10%)²⁹.

There is evidence that people who smoke are receptive to smoking cessation advice in all healthcare settings. It is therefore important that healthcare practitioners proactively ask people if they smoke, and offer advice on how to stop. Smoking cessation services provide the most effective route to stopping smoking, but many people who smoke do not use these services when they try to stop. It is important therefore that practitioners across all settings are aware of and use opportunities to refer people on to smoking cessation services.

²⁹ Public Health England, Public Health Outcomes Framework

Alcohol consumption - Alcohol is a major cause of ill-health in England and is a risk factor for a number of cancers. About a third of people in Croydon drinking at increasing and high risk levels are aged over 50 (the majority of these between 50-65 years of age) and roughly 10% in the older age groups that are likely to be either, affluent, highly educated or of White ethnic background. The home is now the most common place where alcohol is consumed, particularly amongst older adults³⁰.

In addition to the physical and system benefits that early intervention brings from avoiding extensive harm due to alcohol, raising awareness with relevant individuals of the risks they are taking (or harm they may be doing) at an early stage makes it most likely that they will change behaviour if it is tackled early.

See section 7.5.3 for **NICE Public Health Guidance and Quality Standards** for services on preventing harmful use of alcohol in the community, diagnosis, assessment and management of harmful drinking and alcohol dependence.

5.1.2 I want to eat well and keep active from a younger age²⁷

Healthy Weight - 24% of men aged 65 and older and 31% of women aged 65 and older in Croydon are obese.²⁸ Obesity rates are consistently higher amongst females and show an overall decrease with age across both genders. Obesity is a key risk factor for cardiovascular diseases such as Diabetes in later life.

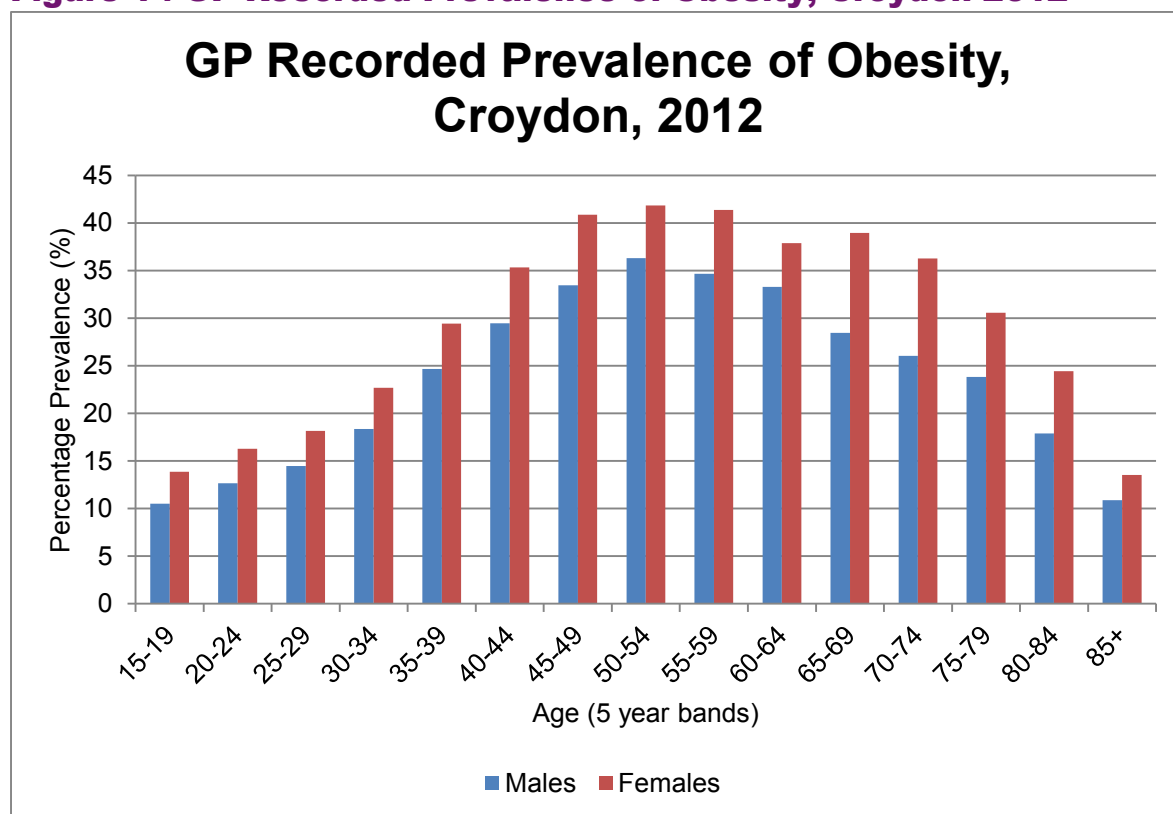
Reducing the proportion of adults that are obese and/or overweight in order to reduce the population risk of developing long term conditions such as diabetes is a key priority improvement area for the Croydon Health and Wellbeing Board Strategy 2013-2018³¹.

³⁰ Croydon Joint Strategic Needs Assessment on Alcohol, 2013/14

<file:///lbcbau/userdata/documents/093102/My%20Documents/Downloads/JSNA%20Alcohol%20chapter%202013-14%20FINAL.pdf>

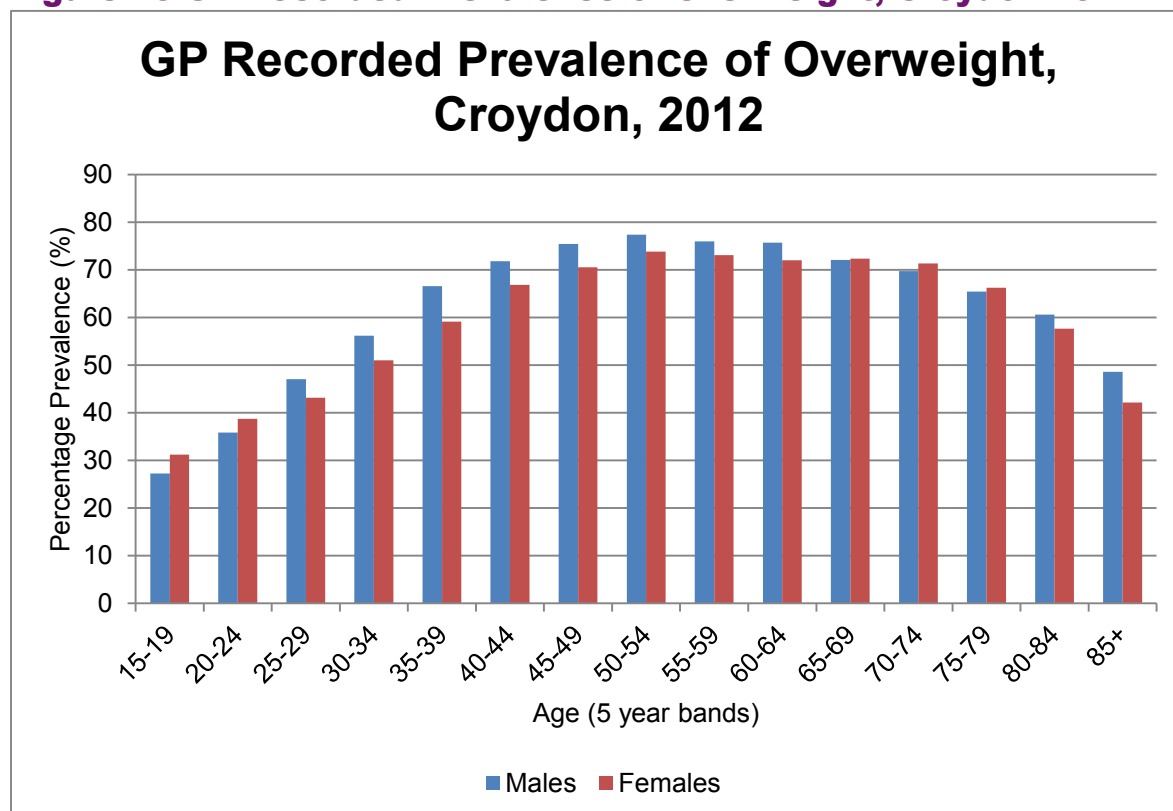
³¹ see PSSS

Figure 14 GP Recorded Prevalence of Obesity, Croydon 2012



Source: Data from Croydon General Practices, 2012

Figure 15 GP Recorded Prevalence of Overweight, Croydon 2012



Source: Data from Croydon General Practices, 2012

Data on **physical activity and nutrition** at a population level is not collected as routinely or comprehensively as some other indicators of health and wellbeing, however, national prevalence models have been used to estimate the extent of physical activity and healthy nutrition amongst older adults in Croydon. Croydon's older adult OBC programme places an emphasis on providers of older adult services to increase the level of physical activity and improve healthy nutrition amongst its older adult service users.

Older adults are less likely to achieve the required amounts of **physical activity** necessary to achieve healthy benefits. Nationally, 19% of 65-74 year olds and 7% of those aged 75 year and over report meeting required levels. Reportedly popular activities amongst those who keep active are recreational walking, swimming and bowls. Reasons cited for not engaging in physical activity were lack of interest or poor health³⁶.

National estimates suggest that 37% of older adults meet the recommended 5 servings of fruit and vegetables daily³⁶. On the other end of the spectrum, it is estimated that nationally over 1 million older adults (10% of older adults) suffer from malnutrition, the vast majority of which live in the community. Age UK reports that nationally, nearly one third of all older adults admitted to hospitals and care homes are at risk of malnutrition and 50% of all older adults admitted to hospital from care homes were at risk of malnutrition.

Malnourished patients tend to stay an average of 5-10 days longer in hospital. Folate deficiency is most common and estimated to be present in about a third of older adults. National evidence suggests issues around the acceptability of food provided whilst in care and availability of help to assist with eating meals.³⁶

Amongst those admitted to hospital (all ages), there was a 20% increase during the winter months, in the proportion of individuals suffering malnutrition (more common in women than men). Older adults in particular, hospitalised during the winter months were 37% more at risk of malnutrition compared to younger adults. There appears to be evidence to link malnutrition in a small proportion of older adults and fuel poverty (i.e. costs to heat their homes).³⁶

5.1.3 I want to meet my full physical, mental and social potential²⁷

Functional Ability/Limitations - A national survey in 2001 showed that 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 as shown in the table below.

Figure 16 Table showing decrease in ability to carry out domestic/self-care tasks with increase in age, Croydon

Age		65-69 years	85 and over
Unable to do at least one domestic task by themselves	M	16%	68%
	F	28%	82%
Unable to carry out at least one self-care task	M	18%	51%
	F	21%	74%

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 (Figure 17) and appears to cluster to a greater degree within areas of higher deprivation, and areas with higher proportions of older adults from BAME backgrounds.

Disability amongst older adults – Nearly half of all disabled people are aged 65 year or older. The most common problems relate to movement, vision and hearing. These disabilities can reduce the ability of older people to look after themselves, remain mobile, and maintain their independence resulting in a need for personal care³².

Older people with physical disability and those with sensory impairments were identified as sub-groups particularly at risk of social isolation and loneliness.

Additionally physical disabilities (all ages) and frailty amongst older adults are two of the most commonly reported reasons for requiring carer support³³. Carers themselves may be frail, disabled or with long term conditions.

Sensory Impairments – There are 650 adults over the age of 65 in Croydon who are registered blind (a rate of 1465 per 100,000 population). This is lower than the rate for London (1679 per 100,000) but higher than the rate for England. There are an additional 505 adults over the age of 65 who are registered as partially sighted in Croydon³⁴.

As at 2010, there were 110 individuals over the age of 65 in Croydon who are registered as deaf (a rate of 248 per 100,000 population). There is no significant difference between the rate in Croydon and that in London or England. There are an additional 1370 over 65 year olds in Croydon registered as hard of hearing (a rate of

³² Department of Health National Service Framework for Older People, 2001
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198033/National_Service_Framework_for_Older_People.pdf

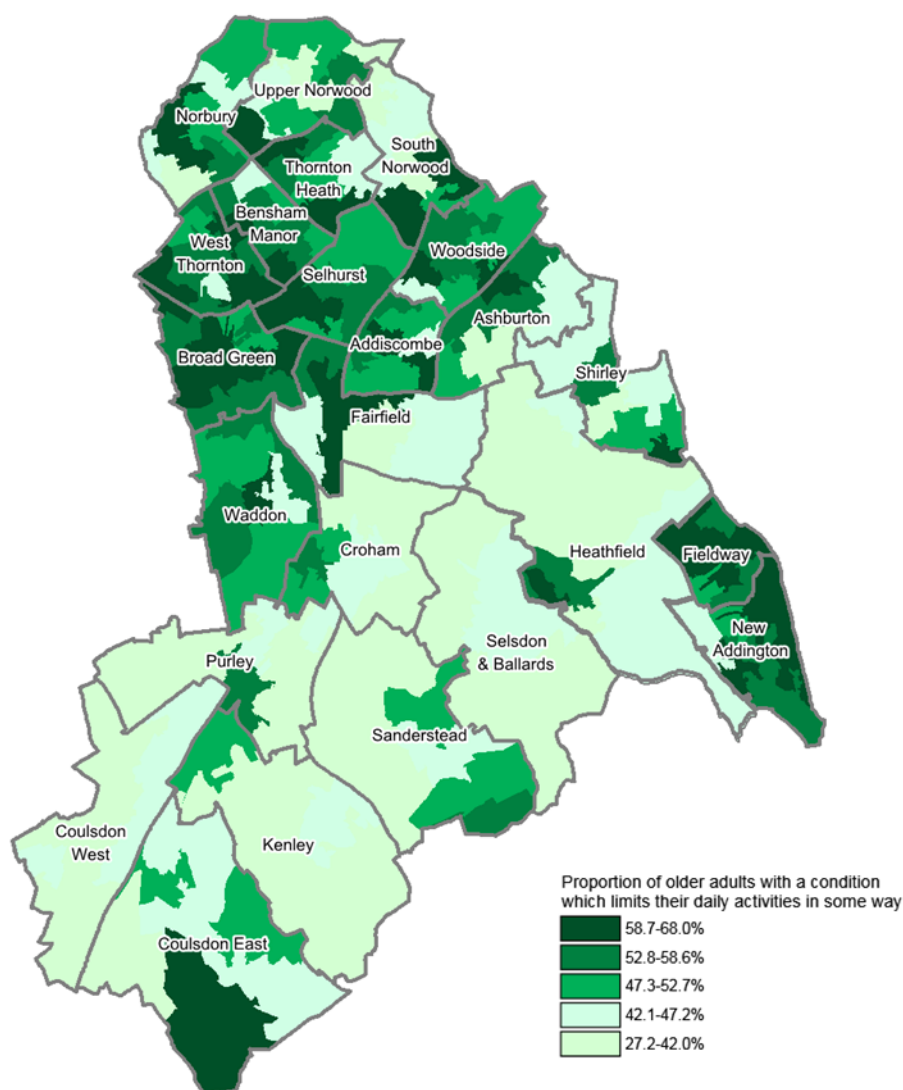
³³ Carers Support Service Data

³⁴ RNIB: supporting people with sightloss

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It is important to note that registration is not compulsory and therefore may not provide a complete picture of those who are blind or hard of hearing. Reporting levels may differ between boroughs and so geographical comparisons may be unreliable.

Figure 17 Proportion of older adults, who have a condition or a disability which limits their daily activities in some way, Croydon 2011



Source: Census 2011

Social Isolation and Loneliness are well established as risk factors for poor health and wellbeing, with detrimental effects comparable to those of smoking and obesity. Most commonly evidenced detrimental effects are depression and cardiovascular

³⁵ HSCIC, People registered as hard of hearing or deaf 2009/10

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disease. Gaps in the evidence-base due to complex and contested definitions and measurements have made prescribing best practice difficult.

Social isolation is an objective experience and relates to the lack of a number or frequency of social contacts, interactions or social support structures, or the lack of input into wider community activities or structures.

Loneliness is a subjective experience which relates to the evaluation of the quality of social contacts an individual has. You can be lonely in a room full of people.

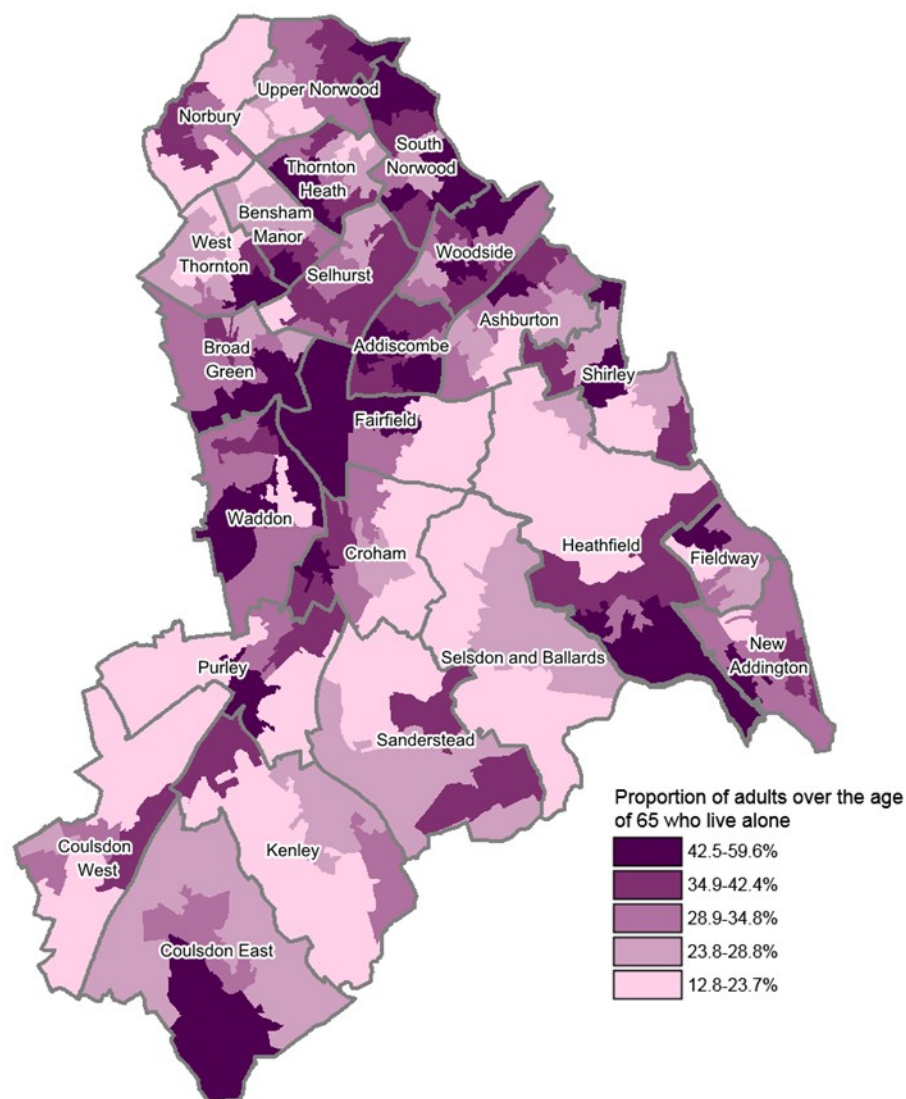
Whilst not everyone who lives alone is isolated, nearly everyone who is isolated lives alone. 31% of older adults in Croydon live alone compared to 16% of adults under the age of 65. Figure 18 shows areas of Croydon where a higher proportion of older adults live by themselves. National estimates suggest the majority of older adults that live alone tend to be women³⁶.

Carers, through the number of hours spent caring, also are at risk of experiencing social isolation or loneliness. Roughly 1 in 2 or 3 (41%) adult carers reported having as much social contact as they wanted (**Carer Isolation**) (Croydon Key dataset, 2014/15)

Croydon's Opportunity and Fairness Commission puts a spotlight on social isolation, and highlights the role of local services and organisations to provide the framework for greater local support.

³⁶ Later Life in the United Kingdom, Age UK, January 2015

Figure 18 Proportion of older adults that live alone, Croydon output areas, 2011



Source: Census 2011

Although mental health in older adults is not within the scope of this needs assessment, it is useful to note that the National Institute for Health and Care Excellence (NICE) has released guidance in November 2015 around maintaining independence and mental wellbeing in older people³⁷.

5.1.4 I want to prevent falls and injuries from falls²⁷

Falls are a major cause of disability (loss of mobility) and the leading cause of mortality due to injury in older people aged over 75 in the UK.

³⁷ Older People – Independence and Mental Health
<http://www.nice.org.uk/guidance/indevelopment/gid-phq65>

Studies have shown that the strongest risk factor for fracturing in older people is falling and not osteoporosis³⁸. Falls are also responsible for significant mortality and morbidity and costs. Older adults are the main section of the population at risk of falls that increases with age and is higher in women than men.

Croydon has a higher rate of hospital admission due to injuries from falls when compared to England (particularly amongst women), despite a relatively smaller older adult population (expressed as a proportion of its entire population) than that of England. Croydon compares similarly to London.

Evidence exists of significant under-coding of co-morbidities for falls patients, particularly for dementia. The average costs for all services compared to cost of admission, for each patient that fell was 4 times as much in 12 months following admission³⁹. Comparing the 12 months before and after admission:

- 160% increase in community care costs
- 37% increase in social care costs
- 35% increase in acute hospital care costs

Prevention is therefore crucial, and is a key recommendation in the Croydon Falls Needs Assessment that also highlights the growing body of evidence around the effectiveness and cost-effectiveness of falls prevention.

Local data from the needs assessment on falls shows that in Croydon the risk group is projected to significantly increase in size in the coming years. There are also associated increases in; the number of falls, mortality associated with falls and hospital admissions for falls. Current data about admissions for falls in Croydon shows the average length of stay for these cases is 6 days. The areas with higher than average rates of admission for falls are, Broad Green, Fairfield, New Addington, Norbury, Selhurst, Shirley and Waddon. The most common diagnoses in those over 65 years who fall in Croydon are syncope with collapse, cerebral infarction, fracture of femur and senility. Most people admitted for falls are admitted as an emergency from home, but some also come from residential care. Most patients are discharged back to their home, but a significant proportion become increasingly dependent and require an increased level of care⁴⁰.

Table 2: Rate of hospital admission due to injuries from falls, 2012/13

Age	Sex	Rate of hospital admissions per 100,000 population		
		Croydon	London	England

³⁸ Shifting the focus in fracture prevention from osteoporosis to falls, BMJ;336;124-126 January 2009. Available from URL: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2206310/>

³⁹ Exploring the system-wide costs of falls in older people in Torbay

⁴⁰ Croydon Falls Needs Assessment, March 2013

>65	Male	1,734	1,873	1,602
	Female	2,902	2,610	2,420
	All persons	2,318	2,242	2,011
65-79	All persons	1,706	1,108	975
>80	All persons	5,921	5,528	5,015

Source: PHE Public Health Outcomes Frame work

The Falls Needs Assessment identifies specific areas (see footnote ⁴¹) where Croydon is performing worse than the London and England average, and recommends service improvements are made in these areas to achieve the best outcomes for service users. Crucially, it recommends that the Croydon Integrated Falls Service;

- Focuses its efforts towards being more pro-active in early case finding of high risk individuals including multifactorial risk assessments and associated interventions in primary care
- Focuses on patients with fragility fractures
- Includes screening for poor bone health amongst older adults as well as promotes greater physical activity as primary prevention

Additionally, given the growing older adult population in Croydon, it is important that the existing falls service is adequate in both scale and scope of the existing falls prevention service for the needs of the current and future Croydon older adult population. This includes the level of integration required specifically with other services like the PDSI support service, with the view to better support at risk users with overlapping needs, early.

5.1.5 I want to be supported to be independent, have access to suitable housing and housing adaptations²⁷

74.9% social care clients in Croydon reported having **control over their daily life** (Croydon Key Dataset, 2014/15), similar to England and better than London.

Home Care – Ageing leads some older adults to need support to continue living in their own home including adapting their homes to facilitate living safely and independently with long-term conditions or disabilities⁴². People use home care to respond to long-term need or for shorter term arrangements for example recuperation from an operation or until alternative living arrangements are found. People that live alone are more likely to be depended on home care support.

⁴¹ Areas for improvement recommended in the Croydon Falls Needs Assessment, 2013: early admission, pain relief and surgery for cases; reducing pressure sores; reducing length of acute hospital stay and bone strengthening medication assessment and administration

⁴² Providing housing support for older and vulnerable people, Housing and Communities Agency, Nov 2012 <https://www.gov.uk/government/policies/providing-housing-support-for-older-and-vulnerable-people>

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Home care is the most accessed local authority funded community service followed by equipment and adaptations, and is in the main by the independent sector⁴³. However despite the rising older adult population, the number receiving publically funded care (nationally) is decreasing; just over 2/5ths receiving home care get intensive support (defined as more than 10 hours per week with overnight live-in or 24 hours services)¹.

Over 2/3rds of social care clients are older adults¹. In Croydon, During 2013/14 over 5000 older adults were provided a care package and 87% of these were supported to live independently through community based services⁴⁴.

See section 7.5.5 for **NICE guidance on home care**; provision of personal care and practical support to older people living in their own homes

There is national tendency towards a decrease in older adults that are permanently admitted to residential and care home, indicating greater care in the community is occurring within the primary and community setting.

For those that are admitted, an audit of case files in Oxfordshire identified the following **key characteristics as determining admissions to care homes**⁴⁵:

- 51% incontinence (urinary/bowel or both)
 - Urinary incontinence 45%,
 - Bowel incontinence 34%,
- Dementia 40%,
- Depression 25%,
- Visual impairment 21%,
- Stroke 19%,
- Diabetes 17%

Croydon has the highest number of Care Homes of all other London Boroughs (approx.180). During 2013/14, 421.3 per 100,000 older adults in Croydon were permanently admitted to residential care homes. Croydon compares similarly to London and favourably to England in this regard. Note that this figure does not include 'self-funders'. However at current rates, future projections indicate that

⁴³ Home Care: Delivering Personal Care and Practical Support to Older People Living in Their Own Homes, NICE, September 2015
<http://www.nice.org.uk/guidance/GID-SCWAVE0713/documents/home-care-draft-full-guideline2>

⁴⁴ Croydon's adult social care local account – annual report to residents 2014.
<https://www.croydon.gov.uk/sites/default/files/Croydon%20adult%20social%20care%20local%20account%202014.pdf>

⁴⁵ Croydon Rapid Evidence Review to Support JSNA on Older Adults

Key-Topic 1: Older Adults (aged 65 years and over) and Carers of Older Adults: Maintaining Optimal Health and Supporting Independence in the Community
Croydon will have the 3rd highest number of people aged 65+ in care homes by 2030⁴⁶.

Urinary Incontinence – The issue of incontinence was also reported in a study from the United States, along with falls as significant determinants of permanent care home admission, independent of gender, age and other disease. The study concluded that all the cases admitted to residential care had needed to at the point of admission, but that there could have been opportunities to support people earlier on in the care pathway and in particular, to support carers⁵⁴.

Nationally, an estimated 21% of men and 22% of women report that they suffer from any bladder problems. For both men and women this proportion increases with age from 16% of men and 19% of women age 65-69 to 31% of men and 34% of women aged 85 and older⁴⁷.

Worryingly, 21% of men and 46% of women who reported bladder problems had not consulted any professional about these problems⁴⁷.

No Borough level data is available, however, applying these percentage to Croydon population equates to a total of 7,911 individual aged 65 and older suffering from any bladder problem at least once a week and 1547 suffering from a bladder problem less than once a week⁴⁷.

Deteriorating ability to self-care was cited in several reviews, suggesting functional impairment combined with lack of community support impacts on admission to hospital, readmission and is a major contributory factor to care home referral⁴⁵. This is recognised in the Croydon CCG Prevention, Self-Care, Self-Management and Shared Decisions (PSSS) strategy, which emphasises the need to maintain self-care and suggests embedding use of technology in service design could support older adults longer to maintain independence.

A rapid review of the evidence on factors determining admissions to residential care revealed **System factors** largely included the lack or make-up of alternative services in the community (or perception thereof amongst professionals, carers and older adults), in particular actual or perceived timeliness in response of such services and support for carers to cope particularly with incontinence and falls.

The ability of ambulatory staff to treat people at home or in the community was also dependent on the availability of alternative services, making admission to Emergency Departments (ED) the easy and safe option for both ED and ambulatory staff where such services were lacking or perceived to be lacking.

Lack of capacity within the system can be compounded by having limited (or no) information about what services are available⁵⁵.

⁴⁶ POPPI?

⁴⁷ Health Survey for England, 2005

Findings also highlighted the lack of/insufficient intermediary care e.g. step-up beds and of availability of primary care in place of individuals' residence as system barriers increasing dependency on the acute system. Evidence suggests that intermediary care infers the most benefit for those using acute beds and going into long term residential care since it reduces the risk of rushed decisions⁴⁵. The lack of intermediary care services influences premature decisions to admit older people into residential or care homes. More capacity in acute settings is suggested to potentially result in supply driven demand.

Services that could provide rapid support for exacerbations of conditions most amenable to intervention in the community and that can be prevented were most valued, for e.g. the literature largely focussed on intermediary care and reablement services. Maintaining continuity of care (less fragmentation i.e. less pillar to post) was cited as a barrier to self-care and self-management in the community.

Budgetary constraints and the fact that often older people have complex needs often delays confirmation of public funded social support and can add to decisions to refer people into care⁴⁵.

There is further evidence that the majority of older people admitted to care homes had received some home care but estimated 50% had not received intensive home care (6 or more visits per week), therefore a consideration to increase the provision of intensive home care is warranted⁴⁸.

Workforce awareness, skills and confidence in managing common frailty syndromes, confusions, falls and polypharmacy along with safeguarding issues is essential to secondary prevention and adequate early support in the community.

Direct Payments and Managed Personal Budgets – 78.6% social care clients (all ages) receive self-directed support⁴⁹ (Croydon Key Dataset 2014/15), Significantly better than England and better than London.

Published literature suggests commissioners viewed direct payments as offering more choice and independence to older people (aged 75+) than managed personal budgets. However from an older adult service user's perspective research suggests older adults were often not aware they were in receipt of a managed budget and the amount, and that direct payments did not always confer control, albeit received as a welcome idea.

Low uptake of direct payments was felt often to be due to limited due to lack of choice, administrative burden, low expectations, lack of information, stress over logistics of operationalising support and risk averse staff.

⁴⁸ Croydon Rapid Evidence Review to Support JSNA on Older Adults

⁴⁹ Defined as: Number of clients and carers receiving self-directed support in the year to 31 March as a percentage of clients receiving community-based services and carers receiving carer specific services (aged 18 and over).

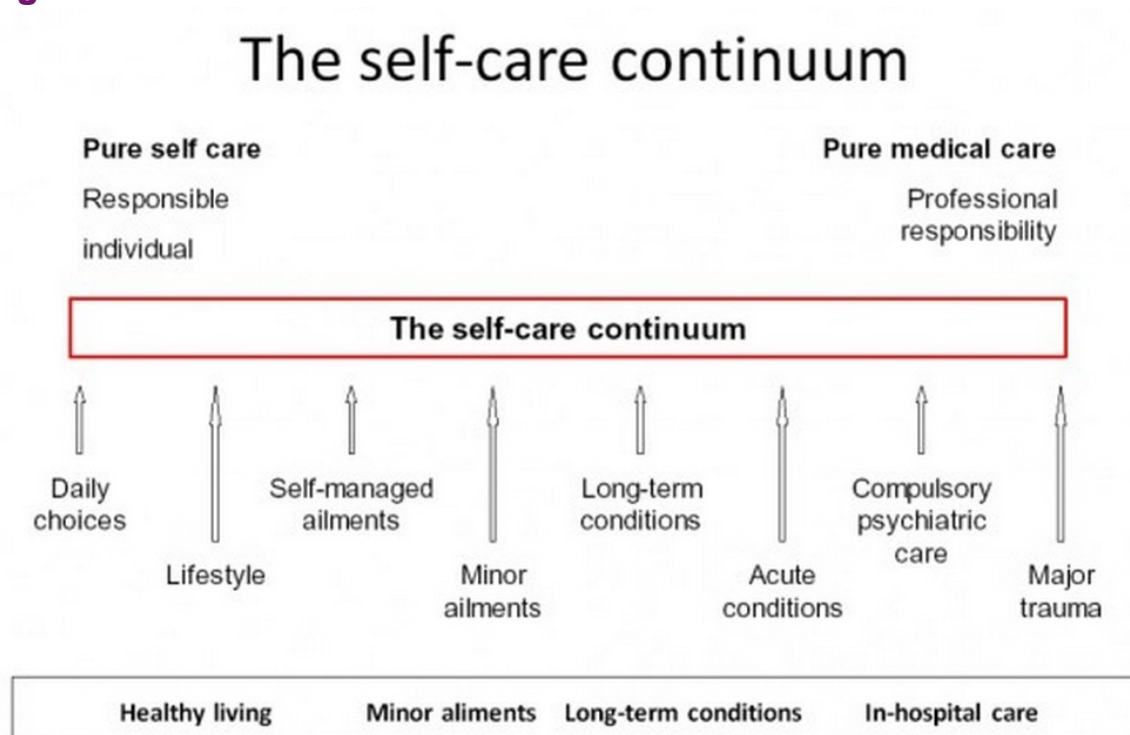
Key-Topic 1: Older Adults (aged 65 years and over) and Carers of Older Adults: Maintaining Optimal Health and Supporting Independence in the Community
Crucially little difference in relation to health, stress and social care related quality of life, was noted by research amongst recipients of direct payments and/or managed personal budgets. Although needs around personal care were largely met, needs around control, social contact and occupation were often not.

As such evidence suggests inequalities may exist between younger and older adults groups, in the effectiveness of direct payments/managed personal budgets to enable desired personal outcomes. Research suggests policy to offer personal budgets to all eligible may be skewed towards younger people than older adults⁵⁰.

Abuse and independence – National estimates suggest that 2.6% of older adults suffer abuse (physical, psychological, financial and neglect). Effects can be wide ranging from physical such as fractures, malnutrition and dehydration to psychological such as increased dependence, apathy and mental ill-health. This can have a significant impact on the ability of older adults to remain independent. Evidence suggests the greatest barrier to preventing and stopping abuse is overcoming denial.

5.2 Management of Deterioration and Recuperation in the Community

Figure 19 The Self-Care Continuum



Source: *The Self-Care Forum*

⁵⁰ Are personal budgets always the best way of delivering personalised social care to older people? NIHR School for Social Care Research, November 2011.

Despite 80% of people self-caring for the majority of the time, evidence suggests that people often abandon self-care earlier than they need to, due to reasons such as;

- lack of confidence in understanding the normal progression of symptoms (i.e. a cold can last up to 14 days)
- perceived severity and duration of symptoms
- reassurance that nothing more serious is wrong
- felt need for a prescription to cure the illness even when the same medicine may be available over the counter

Achieving greater self-care/management for optimal health maintenance requires greater support for patients to make healthier choices and a fundamental shift in the patient-caregiver relationship into a collaborative partnership

Patients and services users are the prime justification for and so far untapped resources of health and social care systems. Progressing Self Care is seen as a significant solution towards achieving a sustainable health and social care system.⁹

5.2.1 I want to manage my long-term condition well²⁷

Evidence suggests that the fastest growth in Emergency Department admissions is among older people and long term conditions (LTCs) for a significant proportion of these (80%) among over 65s⁵¹.

Older adults with LTCs are the most frequent users of health care services, accounting for 70% of government health and social care spending and costs per individual increasing with the number of LTCs the person has. A small number of LTCs contribute most to care home referrals and emergency hospital admissions (include mental ill health, stroke, diabetes, and asthma) and are considered largely to be preventable and manageable in the community⁵³.

Given the overlap between emergency admissions for older adults and the prevalence of LTCs in older adults, managing LTCs and/or ambulatory care-sensitive (ACS) conditions is a priority in this population group and can be achieved through better disease or case management, and better self-management. Evidence suggests that about 70-80 percent of people with LTCs can be supported to manage their own condition and at the heart of the chronic disease management is an informed and empowered patient with access to continuous self-management support.

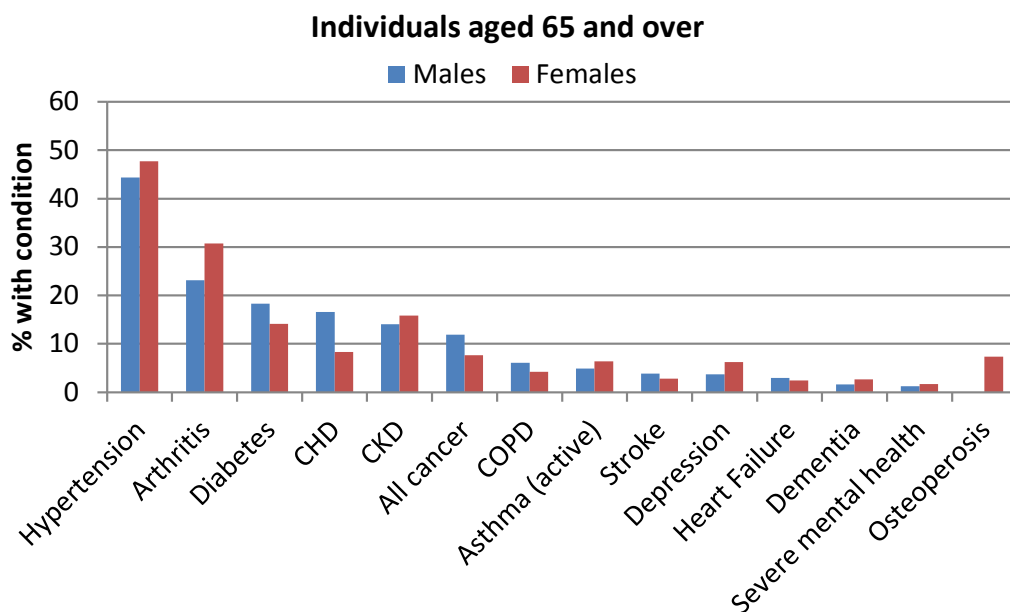
40% of men and 33% of women, over the age of 65 in Croydon have at least one **long term condition** recorded in their GP records. 12% of men and 8% of women have 2 or more and 3% men and 2% of women have 3 or more long term conditions recorded in their GP records⁵². Age increases the likelihood of having more than 1

⁵¹ Croydon Rapid Evidence Review to Support JSNA on Older Adults.

⁵² GP Practice Data, March 2012

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 LTC and nationally the number of people with long term conditions is expected to increase by a third over the next ten years⁵³. The figures below show the prevalence of select LTCs amongst older adults in Croydon, which increases with age.

Figure 20 Prevalence of selected long term conditions among older adults (aged 65 and over) in Croydon, 2012



Source: GP Practice Data, March 2012

5.2.2 I want to have a flexible long-term plan that anticipates crisis²⁷

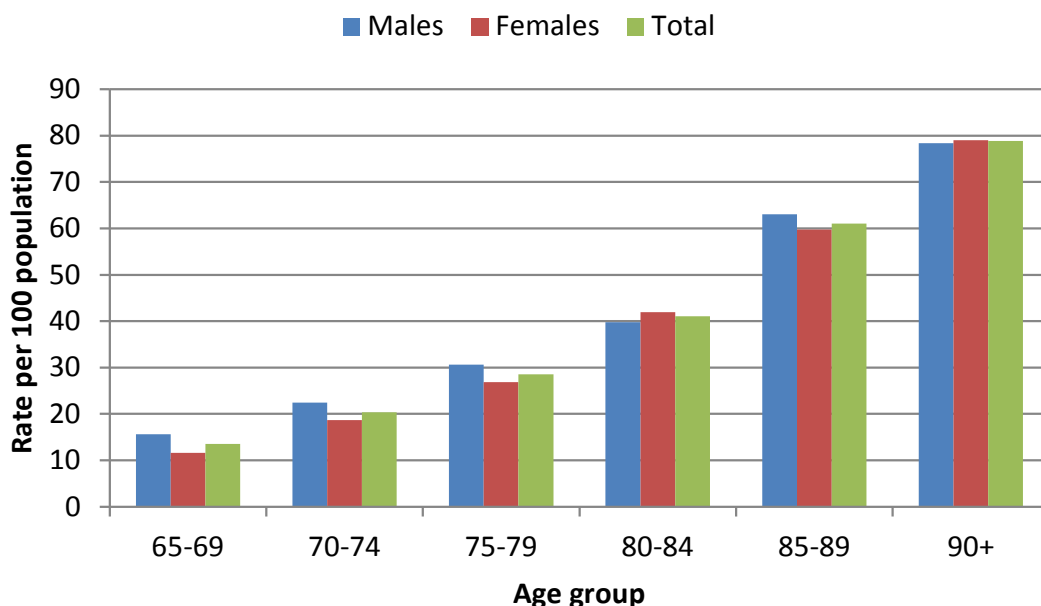
There are critical 'crisis' points that can be anticipated for in the management of LTCs, that if planned for, do not necessitate admissions to acute care. Published literature identifies conditions for which exacerbations could be managed by well performing emergency and urgent care systems, without the need for admission. These include 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 emergencies⁵⁴.

Overall, during 2013/14 there were 13748 **emergency hospital admissions** among older adults in Croydon: a rate of 29 per 100 population which increases steadily with age (Figure 21).

⁵³ Transforming our health care system: Ten priorities for commissioners. King's fund. 28 March 2013, <http://www.kingsfund.org.uk/publications/articles/transforming-our-health-care-system-ten-priorities-commissioners>

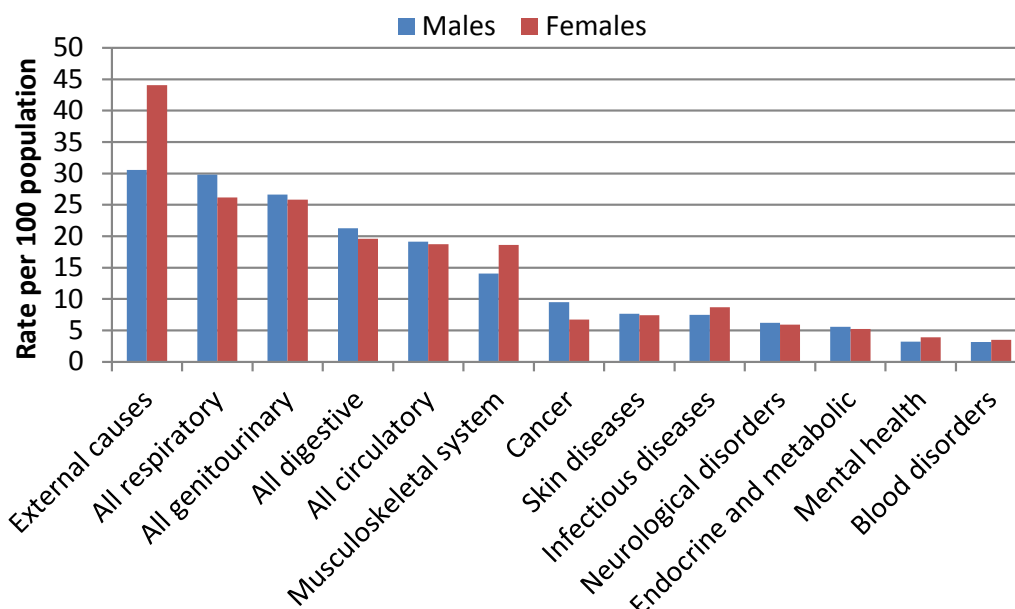
⁵⁴ Croydon Rapid Evidence Review to Support JSNA on Older Adults

Figure 21 Rates of hospital admissions among older adults in Croydon, 2013/4



Source: Secondary User Services, hospital admission data, 2013/14

Figure 22 Rates of hospital admissions among older adults in Croydon, by primary diagnosis 2013/14



Source: Secondary User Services, hospital admission data, 2013/14

Emergency admissions for ACS and/or LTCs could be reduced by between 8-18% simply by tackling variations in how effectively ACSs/LTCs are managed in the community and through systematically applying existing good practice. Early identification is crucial for e.g. through GP risk stratification tools and clinical decision support software.

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NICE have recently released draft guidance on social care of older people with complex needs and/or multiple long-term conditions and the needs of their carers⁵⁵. It focusses on what works to deliver safe, high quality services that promote independence and choice in an integrated manner.

Although mental health in older adults is not a focus in this chapter, it is noteworthy that the risk of depression is 7 times higher in those with two or more long-term conditions or chronic health complaints, however relevant to this chapter is the likelihood that these depressive symptoms can often go untreated and affect the abilities of older people to manage their own conditions. This guidance is therefore particularly relevant to improving the health and social care of older adults and in supporting management and older adult independence in the community without admission into acute settings.

Medicines optimisation – Forty five per cent of prescriptions in the UK are for people aged 65 and over. Eighty per cent of people aged 75 and over take at least one medicine and more than a third take four or more¹. Studies have indicated that this figure rises significantly for those living in care homes as they tend to be frailer with several co-morbidities.

The Care Homes Use of Medicines Study (CHUMS) found that care home residents (mean age 85 years) were taking an average of 8 medicines each and on any one day 7 out of 10 patients experienced at least one medication error:

There is a clear link between poly-pharmacy and drug-related hospital admissions with 6.5% of all acute admissions in the UK being drug related. This rate varies between 2% and 20% depending on the definition of 'adverse drug event' and according to age range. Adverse drug reactions are particularly common amongst frail older patients in nursing homes. Evidence suggests that the rate of ADRs necessitating admission into hospital is increasing⁵⁶.

Studies estimate that up to 50% of individuals do not take their medicines as the prescriber intended and of these 45% do so intentionally. Of relevance particularly to medicines optimisation, adherence and compliance and associated impacts of adverse drug reactions, evidence suggests more could be done in community pharmacies to support medicines adherence and avoid adverse incidents which may lead to emergency admissions and/or poor patient outcomes

The chapter reference group members highlighted the need to improve practice of prescribing in consultation with patient and carer to improve patient adherence to medicine regimens (“a lack of shared decision making coupled with lack of patient’s awareness about their medication leads to non-adherence”). Patient confidentiality

⁵⁵ Social Care of Older People with Complex Needs and Multiple Long-Term Conditions, NICE, June 2015. <http://www.nice.org.uk/guidance/gid-scwave0715/resources/social-care-of-older-people-with-complex-care-needs-and-multiple-longterm-conditions-full-guideline2>

⁵⁶ Croydon CCG Pharmacy Team

Key-Topic 1: Older Adults (aged 65 years and over) and Carers of Older Adults: Maintaining Optimal Health and Supporting Independence in the Community was noted as a potential barrier in involving carers in the 'cared-for' patient's prescription consultations. It is most likely that carers could support to communicate when medication not being taken.

The group also noted the need for pharmacy trained staff (alternatives to GPs) to conduct medicines reviews and adherence assessments along with other patient assessments such that alternatives may be adopted to improve patient acceptability and improve patient adherence to medicine regimens. This is supported by the evidence which also includes recommended use of IT and decision support tools, educational information and outreach services led by pharmacy and nurses particularly amongst high risk groups, and improved systems to support safe transfer of medication information at admission and discharge.

Croydon's Community Pharmacists provide a Domiciliary Medicines Review Service for housebound people (housebound in their own homes/community, not in care homes or residential care). In 2014/15, 20 accredited pharmacies in Croydon, reviewed 145 patients. Internal analyses of service data conducted by the pharmacy team, estimated an avoidance of 27 emergency admissions.

5.2.3 I expect care from the right person at the right time in the right place²⁷

Planning and communication - When older adults present in urgent care settings, often a full and **holistic assessment** of their needs tends not to be undertaken, with staff tending to focus on the urgent problem. The stroke service in Croydon appears to have achieved 87% of its service users discharged (after stroke) with **joint health and social care plan** (Source: HSCIC, Dec 2014).

Continuity in care was also cited as an issue in the evidence review conducted for this chapter, in particular with patients sometimes being taken to different hospitals, different care managers and alterations to care packages.

In some studies, the most cited reasons for admission were lack of **advance care plans**, access to Out of Hours services, palliative care and specialist nurses, and poor communication between those involved in the patient's care⁵⁴.

Although planning and communication can be improved through care pathways, this specific point has been outlined as a reason for inappropriate admission to emphasise that care pathways can help, where they are employed in a multiagency way, meaning relational, managerial and communication all determine the effectiveness.

5.2.4 I want to feel I am a partner in decisions about my care, including identifying risks and making informed choices²⁷

Access to **timely and relevant information** is highly valued by older adults as it gives them choice and empowers *them* to make decisions which address their

Key-Topic 1: Older Adults (aged 65 years and over) and Carers of Older Adults: Maintaining Optimal Health and Supporting Independence in the Community needs⁵⁷. Evidence suggests older people may not have complete and clear information on their entitlements or funding options, leading them not to claim support and leaving needs unmet.⁵⁵

The provision of simple but effective communication/information can be effective to enable behaviour change for increased self-care/management, for e.g. involving patients in their care through shared decision making during GP consultations.

Clear and honest communications and shared decision making with the patient and with others involved in their care is essential in onward planning for the patient. The most common reason for dissatisfaction cited in the literature was not properly being told about the illness and the options for treatment i.e. treatment is done to patients/service users rather than taken up. Clinicians' perception that decisions are shared isn't matched by that of their patients. GPs believe patient involvement took place only within the consultations and felt they had limited time to engage.

Evidence suggests decisions tended to be made by professionals and informal carers, usually at crisis points in the management of LTCs, which may be inevitable but if anticipated and appropriately managed, may not necessitate admissions. A study of choice and decision making in determining care pathways of older adults found that only 19% of the older people interviewed said they had asked to be moved into a care home, with no significant difference between people entering local authority or private accommodation. Key decision makers were carers and primary care professionals.

There is limited evidence on socio-cultural reasons specific to older adults and findings suggest that rarely are older adults actively involved in decisions regarding their acute care. These decisions tend to be made by health and social care professionals and informal carers at a point when it is considered there is no other available option. Entry is often at 'crisis' points, which may be inevitable but can also be prepared for.

Although at the point of admission, need for admission was assessed as being appropriate, supporting carers to support the cared-for was highlighted as a specific opportunity to support people earlier on in the care pathway. The evidence indicated the need for support among professionals for integrated, condition specific care pathways that involve the patient and their carer(s) to support rapid decision making⁴⁵, which should take into account the patient's beliefs and values, around what outcomes matter most¹⁶.

The needs of older adults with difficulties in communication such as those with sensory impairments or mental health conditions such as learning disabilities must

⁵⁷Evaluation of the Tower Hamlets LinkAge Plus Pilot, April 2013.

<https://www.gov.uk/government/publications/linkage-plus-tower-hamlets-pilot>

Key-Topic 1: Older Adults (aged 65 years and over) and Carers of Older Adults: Maintaining Optimal Health and Supporting Independence in the Community also be taken into account in all attempts to enhance shared decision making and provision of information and advice.

Section 5.4.2 talks about carers being consulted in decisions about the cared-for person.

Carers of individuals play an important role in decisions concerning admission to acute care and referral to care homes and as such can be influential in generating inappropriate admissions (Kings Fund, 2011). The Carers Strategy identifies a need to improve information for carers to make them aware of support, both for themselves and the person they are caring for. This could be built on to ensure where alternative services are available, these are considered and discussed with both the older person and their carer.

Croydon Health Services' Adult Community Services Programme aims to promote **prevention, self-care and shared decision making** so as to achieve greater proportions of the older adult population self-managing their conditions or being treated within primary and/or community care settings.

Evaluated models to encourage and facilitate shared decision-making exist, that Croydon may wish to consider improving decision support and counselling skills amongst its Health and Social Care Professionals⁹. Tools to measure and record the level of shared decision making exist and could also be considered locally to drive the emphasis on shared decision making.

Recent reviews of research evidence suggest tailored interventions with the opportunity for patients to co-create a personalised self-care/management plan are likely to be more effective particularly if they include⁵⁸.

- disease management and support for self-management for those with LTCs
- patient and carer education programmes to increase health literacy
- medicines management advice and support
- advice and support about diet and exercise
- use of telecare and telehealth to aid self-monitoring
- psychological interventions (e.g. coaching for behavioural change)
- telephone based health coaching and counselling
- pain management
- patient access to their own records

Locally, the CCG PSS strategy and JSNA on dementia in recent years highlight the need for improved care pathways and implementation of patient decision aids (PDAs) to encourage patient involvement. PDAs have been shown to reduce hospital activity and associated costs — up to 38% fewer procedures and savings of 12% to 21% in a study of patients eligible for hip and knee replacements. In Croydon

⁵⁸ NHS England - <https://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/>

Key-Topic 1: Older Adults (aged 65 years and over) and Carers of Older Adults: Maintaining Optimal Health and Supporting Independence in the Community during 2013/14 the CCG planned to introduce primary care mental health pathways and develop the pathways for diabetes, cardiology, respiratory, cancer and dementia. These could impact on reducing inappropriate admission and increased shared decisions.

5.2.5 I want to have timely recovery that gets me back to my maximum possible level of health and achieve independence post discharge from hospital²⁷

Recuperation – 85% of older adults in Croydon were still home 91 days post hospital discharge (Croydon Key Dataset 14/15), which is similar to England but worse than London performance.

However only 2% of older adults were **offered reablement services after discharge** which is significantly worse than England and worse than London performance (Croydon Key Dataset 2014/15)

A recent attempt to review the Croydon Reablement work streams revealed that a number of these schemes are not collecting and reporting data/ analysing this data/ reporting on outcomes, in a regular and uniform or systematic way. It was recommended that activity and outcome metrics and reporting for each scheme be established and that these be reviewed by the Better Care Fund (BCF) Executive Board to monitor and evaluate the effectiveness of each of the work streams.

NICE guidance on Short-Term Interventions for regaining Independence (intermediate care and reablement) is expected in July 2017; however a scope is expected shortly. Stakeholders are recommended to engage in related consultations and review current service provision in light of findings and evidence.

5.2.6 I expect integrated and co-ordinated healthcare, social care and voluntary services²⁷

Integration

The Department for Work and Pensions in November 2010 reported the following key findings from qualitative research into local delivery of joined up services for older adults;

- Successful attempts at joined-up working were those that embraced not only just health and social care needs but also support and services that promote independence and well-being, a full range of providers and modes of provision (including private and community support agencies/groups) and shift in organisational culture, and working practices at all levels
- Principles that underpinned successful implementation included engagement and shared decision making with older adults at every stage, co-design and co-delivery of local services with local communities as equal partners, continuous evolution reflecting robust evaluation

- Drivers of change included effective structures and support for partnership working at a strategic level, involving older people in decision making at the partnership level (?), local champions and funding or lack thereof
- Barriers to change included organisational culture and structures un-conducive or resistant to change, loss of sustainable results and partnerships through constant reorganisation, lack of innovative thinking and lack of funding

NICE guidance on best practice in managing the transition between inpatient hospital settings and community or care home settings was published in November 2015 and although covers adults of all ages with identified social care needs and will include amongst other best practice, guidance on all aspects of care planning and provision involved in supporting transition, at referral and discharge, including Interventions, services and elements of care packages (ranging from information and advice to housing support) to support effective and timely transitions between hospital and community or care home settings.

5.3 Barriers to Self-care/management

The literature identifies and classifies barriers to self-care/management into factors at the system, provider and individual level.

System level:

- information on effectiveness of existing interventions, knowledge gap to find ways to engage most hard to reach/vulnerable groups
- lack of holistic assessment, with a focus on the immediate – impaired onward planning subsequently impacting dependence – feedback from Croydon MDT is that lower level support is required for several patients on their lists through for e.g. Social Prescribing to enable and maximise optimum management of conditions within the community
- Lack or insufficiency of step-up beds and unavailability of primary care in place of residence were highlighted as barriers increasing dependence on the acute system
- lack of intermediary services influences premature decisions to admit older people into residential or care homes
- limited use of assistive technology
- (fragmentation) maintaining continuity of care was cited as a barrier to self-care and self-management in the community
- constant reorganisation resulting in loss of sustainable results and partnerships

Provider level:

- Lack of understanding about how to use telecare and health behaviour change training

- Lack of understanding of staff training needs in terms of skills and knowledge that will support patient self-management
- Lack of referrals from providers to community self-management programmes (if these exist)
- Uncertainty over how regularly staff are asking patients about their goals including their self-management goals
- Limited inter-professional team based care to help staff to support people with complex conditions

Individual level:

- Population health literacy (awareness of the system and of the appropriateness of choice of services)
- Individual's reliance on health and social care providers/ professionals to manage their health and social care issues
- Lack of awareness of self-management options available to them⁵⁹

5.4 Carers' needs and support

Crucially relevant to the context of this needs assessment; 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 admissions⁶¹. The Croydon Carers Strategy 2011-2016 highlighted that carers support older people to stay at home and recognises that there are many people supporting others who do not realise they are playing a carer role.

5.4.1 My carers and/or family have their needs recognised and are given support to care for me

Population estimates are available through the Census indicate that the local carer population are largely not in contact with local social care and support services, as reflected in local service user databases. Analysis of the carers' registry data (September 2014)⁶⁰ suggests only 1 in 7 or 8 of the total estimated number of carers in Croydon are known to the Croydon Carers Support Service. Additionally given Croydon's ethnically diverse population, it is noteworthy that a Carers UK report indicated that ethnic minority carers provide more care than average⁶¹.

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

⁵⁹ <http://www.gov.mb.ca/health/primarycare/docs/smpcm.pdf>

⁶⁰ Analyses of carers registry data, Carers Support Centre, September 2014

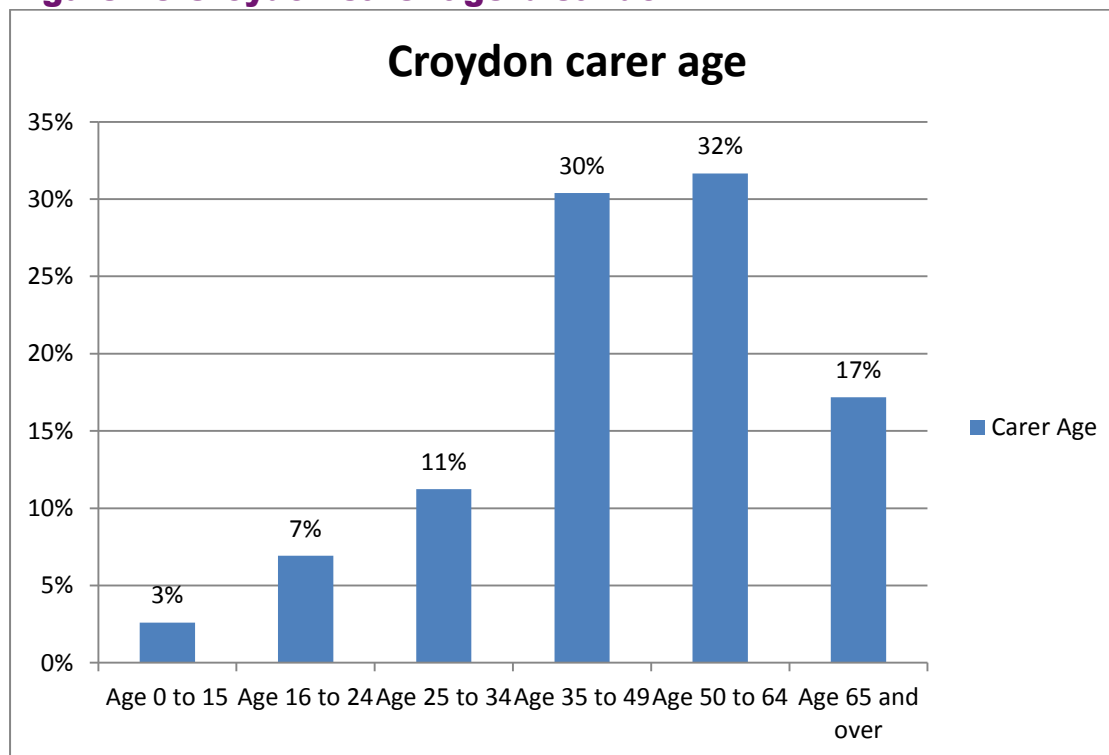
⁶¹ Carers Strategy 2011-2016: the next steps for carers in Croydon

[\[https://www.croydon.gov.uk/sites/default/files/articles/downloads/carestr11-16.pdf\]](https://www.croydon.gov.uk/sites/default/files/articles/downloads/carestr11-16.pdf)

Croydon Joint Strategic Needs Assessment 2014/15
 Key-Topic 1: Older Adults (aged 65 years and over) and Carers of Older Adults: Maintaining Optimal Health and Supporting Independence in the Community
 users became aware of the service appear in the vast majority to be through previous contact.

Census 2011 data indicates there are 33,635 self-reported carers in Croydon equating to 9% of the total Croydon population. Figure 23 shows the age break-down of the Croydon carer population. 20% of the total number of self-reported carers (all ages) in Croydon provide 50 hours or more of care per week (i.e. 6,870 are full-time carers)

Figure 23 Croydon carer age breakdown



Source: Census 2011

Older carers and caring for the elderly

1 in 8 (13%) older adults in Croydon are currently self-reported carers of which 35% are provide 50 hours of care or more per week (i.e. roughly 2,000 are full time carers)⁶². Compared to other local authorities in London, Croydon is projected to have 3rd highest number of people aged 65+ providing unpaid care by 2030⁴⁶.

1 in 3 (30.5%) of adults aged 35 to 64 years in Croydon are self-reported carers.⁶² 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.⁶⁰

Due to lack of the availability of data on the age of person cared for, it is difficult to estimate the proportion of carers in Croydon that care specifically for older adults.

⁶² Census 2011

Key-Topic 1: Older Adults (aged 65 years and over) and Carers of Older Adults: Maintaining Optimal Health and Supporting Independence in the Community
Common conditions amongst the cared for individuals appear to be (Note: It is unclear why certain conditions are recorded whilst others may not be)

- Learning disabilities
- Medical conditions
- Physical disabilities
- Frailty amongst older people
- Mental health problems including Alzheimer's and Autism Spectrum Disorders

Carer Employability – Individuals' ability to stay in fulltime employment whilst providing care is also greatly reduced.⁶⁶ 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.⁶⁶

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. Evidence suggests Local Authorities tend to focus support to carers providing 35 or more hours of care per week, unknowingly allowing large numbers of carers to continue to be at risk of unemployment or reduced income. There is a lack of evidence around the effectiveness of respite care as a means to support carers' employment⁶³.

5.4.2 Carers are included or consulted in decisions about the person they care for

In addition to the vast majority of carers being unknown to social services, clear and honest communications and shared decision making are recognised as being important factors in improving carer experience and outcomes for individuals cared for.

In Croydon, proportion of carers who feel that they "always" or "usually" felt consulted in decisions was 63% compared to 72.9% in England.

5.4.3 Carers find it easy to find information and advice about support services or benefits

Ease of access to information scored at 60.0 by carers in Croydon which compares statistically significantly worse than England, and worse than London⁶⁴. The Croydon Information Strategy for older people and newly commissioned information directory (CarePlace) aim to improve the information and communications to Carers in Croydon.

⁶³ Overcoming barriers: Unpaid care and employment in England. NIHR School for Social Care Research, January 2011

⁶⁴ Croydon Key Dataset 2014/15

5.4.4 Carers satisfaction with the care and support received

Estimates of support currently provided

- 3,500 carers in receipt of carers allowance (i.e. 12.5% working age carers only). Although, national estimates suggest only 60% of those eligible for a carers allowance actually claim the benefit, Croydon's 12.5% is far below the national estimate
- 200 carers (estimated) accessing direct access respite services commissioned as block contracts via the Council
- 376 unique carer assessments recorded in AIS in 2013/14
- 77 carers receiving sitting services or an ongoing direct payment from the Council

Carer's experience of care and support – 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%)⁶⁹ 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)⁶¹

A detailed review of the support services provided for carers in Croydon is not within the scope of this needs assessment however, published evidence suggests the identification of carers' needs appeared mainly to take place when the person cared for is being assessed, which disadvantages carers of older adults who may not be eligible for or who refuse to access social care support, leading to inequalities in access to care and support for carers. The Care Act 2014 now gives carers parity of esteem with those they support, in particular with regards to access to assessments for their own health and wellbeing needs and entitlement to support in case of eligible need⁶⁵.

The **Croydon Carer Strategy** aligns itself with 4 priority areas identified in the Second National Action Plan for Carers 2014-2016 to support improvements in the care and support offered to, and outcomes experienced by carers in Croydon⁶⁶.

- Identification and recognition
- Realising and releasing potential
- A life alongside caring
- Support to carers to stay healthy

⁶⁵ Care Act 2014 Factsheet: Factsheet 8: the law for carers. Department of Health, February 2015. <https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-act-factsheets--2#factsheet-8-the-law-for-carers>

⁶⁶ Carers Strategy: Second National Action Plan 2014-2016. Department of Health, October 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/368478/Carers_Strategy_-_Second_National_Action_Plan_2014_-_2016.pdf

A recent analysis of the support for carers in light of the **Care Act 2014**, suggests a risk of increasing demand in coming years for carers' assessments associated with interpretation of the new eligibility criteria and nationally developing case law that will need to be reflected in local policy and practice⁶⁷.

Along with increasing the amount of 'replacement care' available for cared for individuals, this will require developments in the quality and range of support services provided to carers to ensure identified and assessed need is addressed.

The report also highlights various local system dynamics and drivers apart from population demographics that the Local Authority has the ability to influence and control. In addition to local business processes, and with regard to future demand for carer support, these crucially include;

- The balance of support on offer ranging from preventative services, direct access services to on-going personal budgets.
- The interface between the Carer Support Centre and Care Management, in particular the role and effectiveness of triage or first points of contact in appropriately managing the cases that lead on to assessments where support is likely to be limited to universal, preventative or direct access services.

5.4.5 Carer health

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. The Croydon Carers Support Service database indicates roughly 7% of its services as being disabled themselves.

General health of carers deteriorates incrementally with the increasing number of hours of care provided. Nationally 5.2% of carers reported their own health as 'not good'; however this rose to 16% amongst those providing more than 50 hours of care per week.⁶⁶ Croydon data on health related quality of life scores amongst carers suggests similar scores to London and England but a worsening 1 year trend in Croydon.⁶⁴ In the 2012/13 survey⁶⁸, carers in Croydon, on average score 7.7/12 for quality of life and compares similarly to that of London and England⁶⁹. It is estimated the 1/3rd of carers of older people with dementia have depression themselves.

⁶⁷ Social care practice with carers: What social care support is provided to family carers? What support do family carers want?

⁶⁸ The Carers' Survey, carried out biennially, asks a series of 6 questions related to quality of life of carers. Responses are combined to give a total quality of life score. These outcomes are mapped to six domains (occupation, control, personal care, safety, social participation and encouragement and support). This measure gives an overall indication of the reported outcomes for carers: it does not, at present, identify the specific contribution of a local authority's adult social care services towards these outcomes.

⁶⁹ HSCIC, ASCOF

Although the Croydon approach so far, of 'little support at the right time' may enable carers to carry out essential everyday tasks; it currently appears to be provided in an ad-hoc and reactive manner through small projects rather than through a consolidated and holistic wellbeing approach.

Although smaller scale initiatives exist to aid carers with their own health needs, the majority of Croydon Council carer support services has largely comprised of sitting or respite breaks, advice, advocacy, information/awareness raising and carers' assessments. A large proportion of the carer support services appear to be provided by voluntary organisations⁶¹.

5.5 Primary, Community and Voluntary Services for older adults in Croydon

Croydon Community Health Services provides over 90% of community health care services and has focus on prevention, self-care and shared decision making so as to achieve greater proportions of the adult population (including older adults) self-managing their conditions or being treated within primary and/or community care.

Transforming Adults Community Services has been the key programme in trying to achieve these overall aims and services are arranged across 4 main streams of work;

- Single point of assessment – allowing clinicians to be signposted to the appropriate services
- Rapid response (urgent: under 2 hours) – urgent response for patients in the community aiming to provide more care close to home and avoiding hospital admissions
- Proactive Response: identify and deliver care before they go into crisis & avoiding hospital admission
- Care implementation: supports patients post discharge, helps avoiding unnecessary admissions and supporting people with more routine care needs

A review of the TACS programme (for all ages) was attempted during 2014/15 by the Commissioning Support Unit and (excluded therapy/Clinic based services) [conducted by the Croydon Clinical Commissioning Group, Commissioning Support Unit].

Collection of data is reportedly very limited and monitoring information is activity based and not outcomes-focussed, therefore does not allow adequate evaluation of effectiveness of the service. The Lack of quantifiable data for purposes of the review has resulted therefore in qualitative findings that are based on discussions and informal interviews with commissioning managers and the service provider. Benchmarking Croydon at regional and national level is also lacking due to lack of consistent data recording and reporting mechanisms. It was felt that changes

Key-Topic 1: Older Adults (aged 65 years and over) and Carers of Older Adults: Maintaining Optimal Health and Supporting Independence in the Community towards successful Outcomes Based commissioning will require time for change to embed within organisational culture and processes for both provider and commissioner in particular around the existing data systems that are perceived not to be facilitative. A national community information dataset is planned but a date for providers to collect this data has not been set but is likely to begin during 2016.

Summary findings from the review highlighted;

- increased pressure in Croydon than some other London or England areas due to overall changing demographic with a greater proportion of ethnic mix, subsequently requiring greater capacity
- The need for more integrated working across the whole system of health and social care, although links with some areas of social care, acute care of the elderly (ACE) and emergency services appear to be good
- A delay in embedding changes particularly with primary care and 'enhanced Multi-Disciplinary Teams (MDTs)
- The use of step up beds reportedly at risk from pressures to support early discharge and needed addressing to ensure their appropriate use⁷⁰.
- Although outside the scope of this needs assessment it is helpful to note, findings that joint working with mental health services required particular improvement. Significant number of people with combined physical and mental health issues are not cared for holistically therefore limiting the ability of the service to support these patients fully and achieve its aims in avoiding admissions

Direct Access Services cater to people with both short and long term conditions, delivered largely as single specialty services, with referrals mainly from primary care, adult nursing services and acute services. Occupational therapy is jointly commissioned delivering both health and social care needs

Summary findings from the review related to direct access services highlighted;

- the need for better links with primary care,
- issues with inappropriate referrals to some services such as podiatry,
- earlier discharge from hospital leading to increase pressure on teams due to a greater level of need amongst these patients and,
- an increase in housebound patients requiring greater nutritional intervention and support

With regards to Spend on community health care services, overall findings show a lower spend on adult services (all ages) when compared to neighbouring CCGs, particularly, around community nursing, rehabilitation, dietetics and podiatry, Learning Disability community Service and specialist nursing. The findings highlighted a slightly higher spend on physiotherapy service. It is important to note

⁷⁰ Internal Review of Croydon Community Health Services

Key-Topic 1: Older Adults (aged 65 years and over) and Carers of Older Adults: Maintaining Optimal Health and Supporting Independence in the Community that service specifications for community care in boroughs neighbouring Croydon aren't exactly comparable and therefore findings on relative spend, must be viewed with caution.

The review emphasised that solutions may not necessarily require increasing spend but removing duplication, increasing integration and more robust evaluation mechanisms

Voluntary Sector:

An estimated £11m is committed to support services (for the period of their entire contract) in the voluntary sector on a combination of CCG and LA contracts specifically for Carers and Older People. There are further services in place that cater to the general population that have not been included in this estimate.

Similar services for carers and older people are being commissioned and managed separately across both CCG as well as LA. The report highlighted opportunities for improving outcomes and greater support for service users through service integration and redesign, improved contract management possibly.

In particular greater consistency in provision of information, advocacy services may be achieved through CarePlace if all services have CarePlace as their Master source of information. A shift to commissioning based on achievable outcomes rather than activity has also been highlighted and recommended and will be achievable through the new model of care as part of Outcomes Based Commissioning

There, appeared to be a low spend in the voluntary sector on people with learning disabilities which could be because there are other council or CCG provided services in this area.

The Primary and Community Workforce – Supporting people to maintain their independence and shifting care from more acute settings into primary and community care settings will require a commensurate shift in the workforce particularly in services that have most impact in achieving/maintaining independence.

The manner in which local healthcare and social care professionals interact with service users to achieve prevention, health maintenance and self-management goals needs to be systematically developed⁷⁸.

The health and social care workforce ranging from managers and assessors to primary and community care practitioners needs to take a wider social determinants view whilst assessing a person's or their carer's needs. This means training assessors on interpreting what health and well-being personalised to the individual in question means.

Key-Topic 1: Older Adults (aged 65 years and over) and Carers of Older Adults: Maintaining Optimal Health and Supporting Independence in the Community
An in-depth review of the primary and community care workforce in Croydon compared to its neighbouring boroughs, found;

- Croydon has fewer GPs and fewest per 100,000 across south west London, despite having greater needs per weighted population (all ages).
- Demands are likely to be exacerbated as out of hospital care increases and population needs grow
 - Croydon Community Health Services provides the fewest community nurses (FTE) per 100,000 weighted population when compared to South West London
 - Majority of London GPs agreed that their workload was unsustainable
 - 90% required more staff but lacked funding
 - As at 2014 1/5th GP workforce aged 60 or more and as at 2012 estimates, 54% GPs aged 50 or over expected to stop providing patient care within next 5 years. The report also highlighted a larger proportion of nurses approaching retirement age.
 - Croydon also has the fewest directly employed FTE social care staff⁷¹ per 100,000 weighted population, when compared to South West London

Recommendations from the report include:

- Significant gap (~570 additional staff) in workforce across 1ry, community and social care sectors required to support the shift to integrated care provided outside of hospital. In particular,
 - More GPs, nurses in primary care and the community, healthcare assistants and therapists are required
- Scale is likely to be underestimate given increasing amounts and types of out-of-hospital interventions that will be required to shift activity into the community
- Scale demands urgent/immediate action, but also particularly because time to demonstrable results can be long
- Financial restraints in achieving these staffing levels – therefore focus needs to be on retraining and reassigning existing staff to work more innovatively and with more flexibility
 - For example by supporting community placements
 - Increasing the number of extended⁷² and advanced⁷³ nurses in the existing workforce

⁷¹ Direct care social care staff includes care workers and community support and outreach workers

⁷² For E.g. extended role nurses and practice nurses who have received additional training in a specialist area such as diabetes or asthma. Practice employed community nurses, midwives, health visitors, and school nurses

⁷³ For E.g. advanced nurse practitioner, prescribing nurse, nurse clinician, nurse manager, practice development nurse, physician associate and assistant practitioner

Key-Topic 1: Older Adults (aged 65 years and over) and Carers of Older Adults:
Maintaining Optimal Health and Supporting Independence in the Community

- Greater integration between health and social care and supporting staff to work increasingly in multi-professional teams and unfamiliar settings will determine the degree of impact MDTs can have.
- Increase in workforce development at the scale and pace required to deliver the necessary skill mix that is led by commissioners based on the need and evidence.
- The report suggests particular areas of focus;
 - Adapting to 7 day working in the community
 - Integrated working across organisational boundaries
 - Up-skilling the incoming community workforce
- Greater consistency and standardisation of the roles and working practices in primary care are required in order to reduce variation in delivery of more care in the community through such settings
- IT training for staff

6 CONCLUSIONS AND RECOMMENDATIONS: 'THE WHAT NEXT'

In order to prioritise areas of improvement into recommendations for implementation, a workshop was held 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.

The group reviewed areas for improvement and reflected on how the current services reflect Croydon's future vision for older adults' service provision and service users' outcome goals.

The set of recommendations prioritised for implementation are as follows;

Prevention and Health Maintenance

Evidence recommends a cross-organisational approach of a combination evidence based interventions either through universal measures or through targeting high risk groups and ranging from interventions aimed at individuals such as brief advice for behaviour change and community interventions to regulatory actions at a societal level such as for tobacco control and alcohol licensing.

Currently, the focus on prevention (whether primary or secondary) is delivered through predominantly purpose-built or dedicated services. More needs to be done through a cross-organisational approach as recommended by the evidence to **integrate (in all settings), early intervention and healthy lifestyle interventions at the front-end of all patient-service interfaces.**

6.1 Promote Healthy Lifestyles and Behaviours (see section 5.1.1 and 5.1.2)

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

6.2 Support with Functional, Sensory Ability and Falls (see section 5.1.3)

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

6.3) Support Greater Independence at Home and in the Community (see section 5.1.5)

- 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

6.4) Reduce Fuel Poverty (see section 4.1.2 and 5.1.2)

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.

6.5) Address Social Isolation (see section 5.1.3)

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

Management of Deterioration and Recuperation in the Community

6.6) Management of Long Term Conditions in the Community (see section 5.2.1)

- 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

6.7) Holistic Assessments and Reablement (see section 5.2.5 and 5.2.6)

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)

6.8) Medicines (see section 5.2.2)

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.

6.9) Shared Decisions (see section 5.2.4)

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.

Carers

6.10) Identifying Carers (see section 5.35.4.1)

- 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
 - a. 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

6.11) Supporting Carers to care (see section 5.3)

Identify, assess, promote information services 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. In particular support 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.

6.12) Supporting carers at work (see section 5.3)

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

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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

7 APPENDICES

7.1 Appendix A: OBC Framework of Indicators

Overview of the Outcomes Framework

<p>Domain 1: I want to stay healthy and active for as long as possible</p> <p>Eat well and keep active from a younger age</p> <p>Meet my full physical, mental and social potential</p>	<p>Have appropriate help to navigate my way through the system</p> <p>Have equality of access to services regardless of where I live and my financial status</p>
<p>Domain 2: I want access to the best quality care available in order to live as I choose and as independent a life as possible</p> <p>I need to have a flexible long term plan, including access to appropriate housing, to keep me as independent and healthy as possible</p> <p>I feel safe</p> <p>I have a timely recovery that gets me back to my maximum possible level of health</p>	<p>Domain 4: I want to be supported as an individual, with services specific to me</p> <p>I expect to have a care plan that anticipates crises</p> <p>Feel I am a partner in decisions about my care, including identifying risks and making informed choices</p> <p>My carer/family have their needs recognised and are given support to care for me</p>
<p>Domain 3: I want to be helped by a health and social care team that has had the training and has the specialist knowledge to understand how my health and social care needs affect me</p> <p>Expect integration and co-ordinated healthcare, social care and voluntary sector involvement</p>	<p>Domain 5: Clinical – disease or pathway specific</p> <p>I want to be supported to manage my long-term conditions so that I stay as health as possible for as long as possible</p>

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7.2 Appendix B

Sr. No.	Item	Year	Croydon	London	England	Compared to England	1Year Trend	Source
1	Proportion of total population that is aged 65 and over	2013	13%	11%	17%	-	-	ONS Mid 2013 Estimates
2	Older people in poverty (% of people aged over 60)	2010	21%	27%	21%	-	-	Croydon Key Dataset
3	Number of council-supported older adults (aged 65 and over) whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population	2014/15	426	492	669	-	-	ASCOF
4	Older people still at home 91 days after discharge from hospital into reablement/rehabilitation services (%)	2014/15	82%	82%	79%	-	-	ASCOF
5	Older people who were offered reablement services after discharge from hospital (%)	2014/15	2%	4%	3%	-	-	Croydon Key Dataset
6	Life expectancy at birth (men) in years	2011-13	80	80	79.4	Better	Improving	Croydon Key Dataset
7	Life expectancy at birth (women) in years	2011-13	83.5	84.1	83.1	Better	Improving	Croydon Key Dataset
8	Life expectancy at age 75 (men) in years	2011-13	12	12.1	11.5	Better	Improving	Croydon Key Dataset
9	Life expectancy at age 75 (women) in years	2011-13	13.5	14	13.3	-	Improving	Croydon Key Dataset
10	Healthy life expectancy at birth (men) in years	2011-13	63.2	63.4	63.3	-	-	Croydon Key Dataset
11	Healthy life expectancy at birth (women) in years	2011-13	62.3	63.8	63.9	-	Deteriorating	Croydon Key Dataset
12	Disability-free life expectancy at birth (men) in years	2009-11	63.2	64.5	63.9	-	Deteriorating	Croydon Key Dataset
13	Disability-free life expectancy at birth (women) in years	2009-11	68.1	65.2	64.4	Better	-	Croydon Key Dataset

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14	Inequality in life expectancy between areas of deprivation (men) in years	2011-13	9.1	7.1	8.4	-	-	Croydon Key Dataset
15	Inequality in life expectancy between areas of deprivation (women) in years	2011-13	7.7	4.9	6.2	-	-	Croydon Key Dataset
16	Inequality in health status between socio-economic classes (men)	2011	17.2	20.2	17.3	-	-	Croydon Key Dataset
17	Inequality in health status between socio-economic classes (women)	2011	18.2	20.2	18	-	-	Croydon Key Dataset
18	Excess winter deaths (expressed as % of deaths during non-winter months)	Aug 2010-July 2013	15%	18%	17%	-	-	Croydon Key Dataset
19	Flu vaccination coverage (ages over 65)	2014/15	66%	69%	73%	Worse	Improving	Croydon Key Dataset
20	PPV vaccination coverage (ages over 65)	2013/14	62%	64%	69%	Worse	Deteriorating	Croydon Key Dataset
21	Injuries due to falls (rate per 100,000 population aged over 65)	2013/14	2,574	2,197	2,064	Worse	Deteriorating	Croydon Key Dataset
22	Admissions for hip fracture (rate per 100,000 population aged over 65)	2013/14	524	530	580	-	Improving	Croydon Key Dataset
23	Patients receiving collaborative orthogeriatric care (% of patients with hip fracture)	2013	98%	94%	94%	Better	-	Croydon Key Dataset
24	Patients receiving timely surgery (% of patients with hip fracture)	2013	74%	73%	75%	-	-	Croydon Key Dataset
25	Patients receiving multifactorial falls risk assessment (% of patients with hip fracture)	2013	100%	99%	97%	Better	-	Croydon Key Dataset
26	Health related quality of life for older people (score)	2012/13	0.73	0.72	0.73	-	-	Croydon Key Dataset
27	Breast screening rate (% of women aged 53-70)	2014	67%	69%	76%	Worse	Deteriorating	Croydon Key Dataset
28	Incidence of prostate cancer (rate per 100,000 population)	2010-12	178	175	174	-	Improving	Croydon Key Dataset
29	Health-related quality of life for people (all ages) with long-term conditions (score)	2013/14	0.75	0.75	0.74	-	Deteriorating	Croydon Key Dataset
30	People (all ages) feeling supported to manage their long-term condition (% of survey respondents)	2013/15	59%	60%	65%	-	Deteriorating	Croydon Key Dataset
31	NHS sight tests (rate per 100,000 population) (all ages)	2012/13	17,647	18,850	23,276	Worse	-	Croydon Key Dataset

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32	New sight loss certifications (rate per 100,000 population) (all ages)	2013/13	34.3	30.2	42.5	Better	-	Croydon Key Dataset
33	Registered blind or partially sighted (rate per 100,000 population)	2013/14	487	504	549	Better	-	Croydon Key Dataset
34	Abdominal aortic aneurysm screening (% of eligible men (ages 65) who had an initial offer of screening)	2013/14	100%	100%	96%	Better	-	Croydon Key Dataset
35	Discharged from hospital with a joint health and social care plan (% of people with stroke)	2013/14	87%	90%	69%	Better	-	Croydon Key Dataset
36	Emergency admissions for acute conditions that should not require admission (rate per 100,000 population) (all ages)	2013/14	751	1,052	1,181	Better	Improving	Croydon Key Dataset
37	Emergency admissions for chronic ambulatory care sensitive conditions (rate per 100,000 population) (all ages)	2013/15	596	788	791	Better	Improving	Croydon Key Dataset
38	Social care-related quality of life score	2014/15	18.3	18.4	18.4	-	-	ASCOF
39	The proportion of people who use services who have control over their daily life	2014/15	69%	69%	75%	-	-	ASCOF
40	The proportion of people who use services who receive self-directed support	2014/15	99%	86%	87%	-	-	ASCOF
41	The proportion of people who use services who receive direct payments	2014/15	5%	20%	17%	-	-	ASCOF
42	The proportion of service users who use services who find it easy to find information about support	2014/15	72%	74%	76%	-	-	ASCOF
43	Proportion of service users (respondents to ASCS question 8a) aged 65 and over who have as much social contact as they would like (%) - weighted values	2014/15	43%	41%	43%	-	-	ASCOF
44	Proportion of new service users (aged 65 and over) that received a short term service during the year where the sequel to service was either no ongoing support or support of a lower level (%)	2014/15	65%	70%	74%	-	-	ASCOF
45	Older Adults Satisfaction with Services - Proportion of respondents aged 65 and over to ASCS question 1 who said they were satisfied with their care and support (%) -	2014/15	55%	58%	63%	-	-	ASCOF

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	values are weighted							
46	The proportion of people who use services who feel safe	2014/15	67%	66%	70%	-	-	ASCOF
47	The proportion of people who use services who say that those services have made them feel safe and secure	2014/15	74%	80%	84%	-	-	ASCOF
48	Carer (all ages) reported quality of life score	2014/15	7.6	7.8	8.1	Worse	-	Croydon Key Dataset
49	Health-related quality of life score for carers (all ages)	2013/14	0.8	0.8	0.8	-	Deteriorating	Croydon Key Dataset
50	Isolation in adult carers (% of survey respondents who had as much social contact as they would like)	2012/13	41%	37%	41%	-	-	Croydon Key Dataset
51	Overall satisfaction of carers all ages with social services (% satisfied of survey respondents)	2014/15	26%	35%	41%	-	-	ASCOF
52	Carers (all ages) who report being included or consulted in discussions (% of survey respondents)	2012/13	69%	65%	72%	-	-	ASCOF
53	The proportion of carers (all ages) who find it easy to find information about support	2014/15	60%	62%	66%	-	-	ASCOF
54	The proportion of carers who receive direct payments	2014/15	31%	59%	59%	-	-	ASCOF
55	Proportion of carers (respondents to CS question 11) aged 65 and over who have as much social contact as they would like (%)	2014/15	33%	38%	40%	-	-	ASCOF

7.3 Appendix C: Areas for Improvement (Longer list)

This list presents the longer list of areas for improvement identified from the data and literature contained within this chapter and was used as the initial list from which final recommendations for implementation were prioritised by lead commissioners and stakeholders.

1. Prevention and Health Maintenance

a. Health Promoting Behaviours, Lifestyles and Interventions

i. Maintaining Healthy Weight and Nutrition (see section: 5.1.2)

1. Should/must identify early and manage weight and nutrition for older adults on both extremes of the BMI spectrum, in ways that are aligned with the borough's healthy weight and obesity strategy, are evidence based and specific and sensitive to Croydon's ethnic mix
2. Should 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.

ii. Physical Activity (see section 5.1.2)

1. Borough-wide spatial planning, travel and regeneration strategies must consider the needs of older adults in ensuring age-friendly spaces and travel; facilitating greater physical activity and use of recreational outdoor areas amongst older adults
2. Should increase the current range of physical activities (commissioned or otherwise) that evidence suggests to be popular amongst older adults
3. Consider ways to identify and encourage inactive older adults (those not achieving any physical activity)

iii. Smoking cessation and Alcohol (see section 5.1.1)

1. Professionals across all settings should identify health harming behaviours at early ages, deliver brief advice, and where appropriate, utilise the opportunity to refer individuals to smoking cessation or alcohol treatment services. In the case of alcohol, target advice particularly at older adults in higher socio-economic groups, of higher educational qualification and white ethnic backgrounds.

iv. Screening and Vaccinations (see section 5.1.1)

1. Improve the uptake of local screening programmes amongst older adults of eligible ages particularly the NHS Health Checks Programme, breast and bowel cancer screening

2. target 65-74 year olds in particular with efforts to increase the uptake of the influenza vaccine amongst this age group of older adults

b. Functional and Sensory Ability (see section 5.1.3)

1. Review and evaluate the 2011-2014 Council strategy and action plan for people with physical disability and/or sensory impairments – particularly in regard to the extent of support currently being provided against the extent of need prevalent within Croydon and also in regard to variation in need and uptake of support between ethnically diverse areas and/or areas of higher deprivation
2. 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

c. Falls are a major cause of loss of mobility (see section 5.1.4)

1. Should improve in areas for concern as highlighted in the Croydon Needs Assessment on Falls including reducing geographical inequalities in admission rates from falls
2. Should ensure the existing falls service is adequate to cater to a growing older adult population; with a particular review compliance with and/or implement NICE guidance (CG161)⁷⁴ and Quality Standard (QS86)⁷⁵ specifically focussed on prevention and early case finding of high risk individuals.
3. Review the level of integration required between the falls prevention service and PDSI support service to better support services users with overlapping needs

d. Supporting Independence at Home and in the Community (see section 5.1.5)

1. 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.
2. Consider Social Prescribing as a mechanism to provide preventative and community services to meet carers' and services users' needs without entering formal social care system
3. Review uptake of personal budgets with regards to inequalities between age groups (i.e. under 65 vs over 65) and address barriers as suggested in the

⁷⁴ Falls: assessment and prevention of falls in Older People

<https://www.nice.org.uk/guidance/cg161>

⁷⁵ Falls in Older People: Assessment after a fall and preventing further falls

<https://www.nice.org.uk/guidance/gs86>

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evidence base; particularly around lack of choice, perceived administrative burden, low expectations, lack of information, and stress over logistics of operationalising support and/or risk averse staff.

4. Ensure Croydon's provision of Home Care is in line with recently published NICE guidance (currently in draft form) and/or implement recommendations from the guidance where applicable⁴³
5. 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
6. 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, polypharmacy and safeguarding
7. NICE guidance on Short-Term Interventions for regaining Independence (intermediate care and reablement) is expected in July 2017 however a scope is expected shortly. Stakeholder are recommended to engage in related consultations and review current service provision in light of findings and evidence
8. alternatives to services in acute setting – awareness and perceptions amongst professionals of alternative support services and their effectiveness
9. Adequate intermediate care that provide rapid support for exacerbations of conditions most amenable to intervention in the community and prevented
10. Train front line carer staff in the types of abuse, recognising abuse, and most common perpetrators

e. Fuel Poverty (see section 4.1.2 and 5.1.2)

1. Must prioritise identification of older adults experiencing or at risk of experiencing fuel poverty and improvements to such properties
2. Action at all 4 levels of intervention to address fuel poverty; i.e. energy efficiency measures, energy price support and switching, advice and support with practical and/or personal barriers and maximising income.

f. Social Isolation (see section 5.1.3)

1. 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
2. Raise awareness amongst front line staff of risk factors for social isolation and loneliness in attempts to facilitate increased identification of those at risk

c) Management of Deterioration and Recuperation in the Community

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

1. 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
2. Consider advance geriatrician input into joint health and social care planning; possibly targeted at those whose social care needs are likely to increase to substantial or critical or those who may need to go into nursing home
3. Commission and/improve self-management support for older adults with LTCs and for carers of older adults with LTCs
4. Improve compliance with best practice guidance such as NICE Guidance in the management of long-term conditions
5. Review Social Care for older adults with complex needs and/or multiple long-term conditions in light of recent draft NICE guidance and implement recommendations from the same, particularly around skills within the social care workforce to manage and support older adults with complex or specialist health needs

h. Holistic Assessments and Reablement (see section 5.2.5 and 5.2.6)

1. Consider capturing and addressing 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)
2. Improve the offer of reablement to older adults discharged from acute settings

i. Medicines (see section 5.2.2)

1. Consider community pharmacies as a means to identify and reduce medicines non-adherence and any resulting adverse incidents which may lead to emergency admissions and/or poor patient outcomes
2. Consider the use of IT and decision support tools, educational information and outreach services led by pharmacy and nurses particularly amongst high risk groups, and improved systems to support safe transfer of medication information at admission and discharge. Greater role of pharmacy or pharmacy trained staff in medicines reviews and adherence assessments.

j. Shared Decisions (see section 5.2.4)

1. support professionals to achieve a greater and faster shift towards more shared decision making with service users than currently for e.g. Improve practice of prescribing in consultation with the patient and/or carer and minimise limitations in involving carers in consultations on account of patient confidentiality
2. Increase and measure the level of access to timely and relevant information and clear communication (in accessible formats for older adults with communication difficulties, mental health conditions or sensory impairments) early-on during the decision making process to facilitate greater planning well in advance of crisis points and an increase in the decisions 'owned' by older adults and carers of older adults
3. Subject to cared-for service user consent, involve carers at all stages of care planning, decision making and delivery with the equal thought and attention as for the cared-for service user

d) Carers

k. Identifying Carers (see section 5.35.4.1)

1. Increase identification of new carers and self-recognition amongst care givers in order to widen the reach of the service to new service users;
 - a. Enquire during older adults' health and/or social care assessments about their own caring responsibilities and refer for carer assessments where appropriate
2. Improve overall, the Council-held data on carers but also specifically data collected on the person-cared-for (particularly age and conditions) to be better able to identify need and plan for types and level of support for older adults and the care themselves

l. Supporting Carers to care (see section 5.3)

1. 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, particularly of 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
2. Improve information services for carers to make them aware of support, both for themselves and the person they are caring for. including information on alternative services
3. Continue efforts to collaborate/integrate with other Carer Support Services not commissioned by the Local Authority in order to achieve a greater range of services and seamlessness in support to carers

4. review service capacity and readiness in light of the expressed need (Croydon carer survey) for more support hours than currently being on offer and ability to support the culturally diverse population in Croydon, particularly with regards to combating stigma amongst BAME groups

m. Supporting carers at work (see section 5.3)

1. 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 recognized threshold (10 or more care hours provided per week as opposed to 35 hours) at which carers are at risk of leaving employment
2. review the evidence for alternatives to respite as a means to support carers' employment
3. support for former carers to regain their own independence including employment, where caring responsibilities have come to an end

Add each individual appendix on a new page.

7.4 Appendix D: Brief National and Local Policy

Context

The Care Act⁷⁶ in England has been the most significant change to social care legislation in the country for almost 60 years. It sets out how care and support needs should be met, how needs assessments should be conducted and introduced the right to unique assessment for anyone, including carers. Crucially it has a well-being focus and therefore emphasises assessing and supporting individuals' holistic well-being needs. Additionally it aimed to standardised eligibility criteria for assessments and support with needs.

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 sectors⁷⁷.

Local commissioning and service provision strategies are taking into account and gradually enabling 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.

- Older people's health, prevention of ill-health, self-management, and primary and community services, are 3 of 9 priority areas identified in Croydon's **Three Year Integrated Strategic Plan 2013/16** and **Croydon CCG Operating Plan 2013/14**⁷⁸.
- Through the **Outcomes Based Commissioning Programme** specifically for Older Adult Services, Croydon Council and Croydon Clinical Commissioning Group are jointly working towards a model for commissioning care and support services for older adults that will shift the focus on to *outcomes for people* and away from what services *offer*. This is a core determinant for enabling whole person integrated care.
- Croydon's **Prevention, Self-Care, Self-Management and Shared Decision Making Strategy** also aims to drive this emphasis on holistic, integrated care that is person-centred, with its emphasis and recognition of the association between an individual's physical and mental health and need for social care support. In it, the CCG commits to ensuring that all relevant commissioning decisions will take account of and enhance the protective factors for mental health and wellbeing, support self-care and prevention for physical health, frontline behaviour change interventions include the 5 ways to wellbeing⁷⁸

⁷⁶ The Care Act 2014,

<http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted/data.htm>

⁷⁷ Outcomes Based Commissioning, NHS Croydon and Croydon Council.

<http://www.croydonccg.nhs.uk/about-us/our-plans/Pages/Outcomes-for-older-people-.aspx>

⁷⁸ Croydon CCG Prevention, Self-Care and Shared Decision Making Strategy

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- **Croydon's Opportunity and Fairness Commission** puts a spotlight on social isolation, and highlights the role of local services and organisations to provide the framework for greater support.
- The South West London Collaborative Commissions **5 Year Strategic Plan, 2014** also commits to improvements in Primary Care including workforce transformation to support prevention and self-management within the primary and community settings

7.5 Appendix E: NICE Guidance Summary of relevant recommendations

NICE recommendations specifically relevant to Older Adults can be found at <http://www.nice.org.uk/guidance/population-groups/older-people> and includes;

- NICE pathways
- NICE quality standards
- NICE guidelines
- NICE local government advice briefings
- NICE interventional procedure guidance

Initial findings from the date and meeting with the Chapter Reference Group highlighted certain key themes that were chosen as areas in which to review the evidence base and best guidance.

The databases mentioned below were searched for relevant evidence papers and best practice guidance documents in these 'key areas', using the following search-terms;

National Institute for Health and Care Excellence (NICE) database:	<ul style="list-style-type: none">• Population group older people• Medicines management• Social isolation• Carer support
Scottish Intercollegiate Guidelines Network (SIGN) database:	<ul style="list-style-type: none">• Population group older people• Medicines management• Social isolation• Carer support
Social Care Institute for Excellence database:	<ul style="list-style-type: none">• Social prescribing• Carers/carer support• NOT care homes
Turning Research into Practice (TRIP) database:	<ul style="list-style-type: none">• Carer support• Social isolation• Step down beds• Step up beds• Intermediate care

These recommendations have been summarised – for the detailed recommendations, guidance or evidence base please refer online to the relevant database/evidence store

NOTE: Not all the NICE recommendations below are specifically relevant to older adults but may hold relevance to this age group.

7.5.1 Flu

NICE Public Health Guidance (GID – PHG96): Increasing Uptake in Clinical Risk Groups and Healthcare Workers (anticipated publication date: October 2017) – no scope or draft scoping documents have been produced yet.

7.5.2 Smoking cessation

Apart from the work done by trained and qualified smoking cessation practitioner, these guidance documents make relevant recommendations to other health and social care practitioners across all settings including – identification and brief advice (one step before actually making a referral) including information on the use of licensed nicotine-containing products that reduce harm from smoking

NICE Public Health Guidance (PH45): on smoking harm reduction makes several recommendations for those that do not wish to or are not able to stop in ‘one-go’. Apart from identifying and referral individuals to smoking cessation services this includes but is not limited to

- use of professional judgement by trained professionals on the best ‘approach’ to stop smoking i.e. a ‘one-step’ approach or a harm reduction approach that may include, licensed nicotine-containing products, cutting down with the aim to quit entirely, or temporary abstinence.
- raising awareness and provision of information in a range of languages on the use of licensed nicotine-containing products as a partial or complete substitute for tobacco either temporarily or in the long-term
- offer behaviour support to quit smoking permanently or temporarily, including setting goals and timescales based on the individuals smoking behaviour
- supply of licensed nicotine-containing products by practitioners named on a Patient Group Directive
- ensure staff providing smoking cessation or harm reduction advice are trained to the relevant standards

NICE Public Health Guidance, 2013 (PH48): on smoking in acute, maternity and mental health services also recommends as a harm reduction approach the provision of information and advice by trained professionals before or at planned or anticipated use of secondary care. This includes but is not limited to information and advice on the types of support available to help them stop, or temporarily abstain from, smoking before, during and after an admission or appointment, the different therapies available to them to stop or temporarily abstain from smoking, how to obtain these and how to used them.

Additionally the following sets of documents from NICE provide further guidance in specific areas within the smoking cessation or harm reduction.

- NICE Quality Standard (QS92), 2015: on harm reduction

- NICE Quality Standard (QS82), 2015: on reducing and preventing tobacco use
- NICE Quality Standard (QS43), 2013: on supporting people to stop smoking recommends amongst other action, that systems are in place across all settings, for people to be asked if they smoke and for those who smoke to be offered advice on how to stop (of particular relevance to the theme of gaps in service provision).
- NICE Public Health Guidance, 2008 (PH10): on smoking cessation services
- NICE Public Health Guidance, 2007 (PH5): on workplace interventions for smoking
- NICE Public Health Guidance, 2006 (PH1): on brief interventions and referrals

7.5.3 Alcohol

NICE Public Health Guidance, 2010 ((PH24): on prevention of alcohol use disorders includes recommendations such as (but not limited to)

- raising awareness with the respective individuals of the risks they are taking (or harm they may be doing) at an early stage
- prioritising (by commissioners) prevention of alcohol-use disorder interventions as invest to save measures
- consider delivering screening as an integral part of service followed by brief, extended advice or referral to specialist services, and/or focus on groups that may have increased risk of harm from alcohol or people who already have alcohol related problems
- ensure staff are well trained and equipped with recognised, evidence base packs when delivering identification and brief advice (i.e. short guide on how to deliver a brief intervention, a validated screening questionnaire, a visual presentation (to compare the person's drinking levels with the average), practical advice on how to reduce alcohol consumption, a self-help leaflet and possibly a poster for display in waiting rooms
- consider based on local demand the need to deliver extended brief interventions

NICE Public Health Guidance, 2011 (CG115): on diagnosis, assessment and management of harmful drinking and alcohol dependence includes priorities for implementation such as (but not limited to)

- identification by trained and competent staff of individuals who potentially misuse alcohol, and if not adequately trained or competent to assess the need for intervention should be able to refer people to local services that can provide an assessment of need
- offering interventions to promote abstinence as part of intensive community based programmes, particularly amongst other key groups, to people with moderate to severe alcohol dependence that have very limited social support

NICE Quality Standard, 2015 (QS83): sets out the minimum standards recommended for preventing harmful use in the community

7.5.4 Fuel Poverty

NICE Guidelines, 2015 (NG6): on excess winter deaths and illness and the health risks associated with cold homes. The guideline is for commissioners, managers and health, social care and voluntary sector practitioners who deal with vulnerable people who may have health problems caused, or exacerbated, by living in a cold home.

The health problems associated with cold homes are experienced during 'normal' winter temperatures, not just during extremely cold weather. Year-round action by many sectors is needed to combat these problems. This includes practical actions such as (but not limited to):

- identify people at risk of ill-health from living in a cold home
- making every contact count (including by non-health and social care workers visiting people at home) and assessing the heating needs of people who use primary health and home care services
- prioritising which homes are tackled first
- ensuring there is a single point of contact health and housing referral service for people living in cold homes
- discharge of people from health and social care settings into warm homes
- training and accreditation of front line staff from all sectors to sensitively identify and refer or deal with heating concerns

7.5.5 Home Care

NICE Guidelines, 2015 (NG21): on Home care; delivering personal care and practical support to older people living in their own homes. This guidance is relevant to health and social care practitioners, managers and workers, home care provider organisations, older people using or planning to use home care service and their carers. Commissioners should ensure any service specifications take into account the recommendations from this guidance. These include but are not limited to detailed recommendations on:

- ensuring care is tailored to the aspirations, goals and priorities of the person, and is focussed on what they would like to do to maintain their independence rather than 'one-size fits all' services or on what they cannot do
- prioritising continuity of care with the same home care worker(s)
- provision of information about care and support options in user friendly formats and in a variety of languages depending on the individual's need

- planning and reviewing home care and support; including consideration to the provision of home care to people with low to moderate needs to avoid, delay or reduce future dependency on health and/or social care services
- recognise that people who use home care often need support that goes beyond their personal care needs, and ensure therefore that home care packages address social care related quality of life and the person's wider well-being
- Considering involving people with experience of using direct payments for home care to help provide training, support and advice to others thinking or planning on doing the same
- ensure care is provided through a coordinated group of workers from all relevant settings that reflects the person's needs and circumstances, and is led by a named care coordinator
- ensuring that along with other aspects, care plans are informed by the experience, skills and insights of carers and address the full wellbeing needs of the person (particularly medicines management, pain management, overall skin integrity and preventive care), make explicit the role of family or carers and the need to review this if circumstances change, and address the potential negative effect of social isolation and/or loneliness on people's health and wellbeing.
- ensure people and their carers are given a copy of their home care plan, and a care diary is maintained which contains a day-to-day log as well as a reflection of the persons needs and preferences, is detailed enough to keep workers and the people receiving care well informed about what has been provided
- Service contracts should factor in enough time for care professionals to provide quality care including time to talk to the individual and to travel between appointments. The detailed recommendations include criteria for home care visits shorter than half an hour.
- Closely monitor risk associated with missed visits, take prompt action and/or ensure plans are in place to manage the risk, including notifying the individual and/or carer in advance and other relevant professionals
- Recruiting, training and supporting home care workers that understand common conditions affecting people using home care, know how to navigate the local and wider national support system, and understand the general principals of involving service users as equal partners in decision making

7.5.6 Older People with Social Care Needs and Multiple Long-Term Conditions

NICE Guidance 2015, (NG22): This guideline covers planning and delivering social care and support for older people who have multiple long-term conditions. It promotes an integrated and person-centred approach to delivering effective health

Key-Topic 1: Older Adults (aged 65 years and over) and Carers of Older Adults: Maintaining Optimal Health and Supporting Independence in the Community and social care services. The guidance includes (not exhaustive list of recommendations);

- Identifying and assessing social care needs
- Care planning, including the role of the named care coordinator
- Supporting carers
- Integrating health and social care planning
- Delivering care
- Preventing social isolation
- Training health and social care practitioners

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