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Introduction
A Joint Strategic Needs Assessment (JSNA) identifies the needs and service requirements that are most relevant and important to a defined population. It brings together information from a range of sources to summarise the current picture.

People are living longer and the population of the whole of the UK is growing, it is also ageing. There are many challenges associated with an ageing population, not least for the individuals concerned. Quality of life, susceptibility to illness, keeping active and social isolation are just some of the issues facing the elderly in society. For organisations, the increasing need and the increasing cost of meeting that need is at odds with current budget levels. Keeping people active, independent and engaged at all ages is important, but the advantages for all in promoting and supporting healthy lifestyle choices, social inclusion and prevention strategies for older people are clear.

This document provides a high level summary of the current population of older people in Northamptonshire and then projects the growth anticipated in the next 15 years. It is an update from the previous JSNA that was developed in 2015. Wherever possible the data has also been presented at borough and district level.

For the purpose of this JSNA chapter, the term ‘older people’ has been defined as those over the age of 65. In some sections, data relating to a lower group has been included, either by necessity or to inform, as today’s 50-65 year olds are tomorrow’s older people. Also wherever possible the data has been split further by age as the ‘older’ (depending on the data source this means people aged over 75 or 85), will have more pressing and complex needs than their younger neighbours.

The JSNA for Older People for 2019 consists of this summary document that includes a health and social care data and an Excel Worksheet with a wide range of indicators at County and District level.

The Excel Worksheet was included to minimise the overall length of this summary report. It consists of 186 indicators at County level and 103 indicators for each district and includes data from a range of sources (i.e. Projecting Older People Population Information, Public Health England and Adult Social Care Outcomes framework). For each of the indicators it is possible to click on the link to view the data and trends in greater detail. A localised RAG system has been developed for the spreadsheet based on significance against the national average and trend direction. This helps to prioritise where specific geographical areas are outliers for a particular indicator.
Recommendations for commissioning

- Promote healthy ageing ensuring recognition of the importance of lifestyle service support for all ages and ensure lifestyle services are accessible for older people.
- Support the review of the intermediate care service and a single agreed referral/assessment process/criteria which includes those people living with dementia.
- Prioritisation of early intervention and hospital avoidance in frail patients via promoting healthy ageing, accessible lifestyle services for older people, the Supporting Independence Programme and social prescribing.
- Development of a single pathway across the spectrum of frailty incorporating primary, secondary and tertiary prevention, discharge to assess models, provision of short term care and re-ablement in people’s homes, ‘step down’ beds, integrated discharge teams etc.
- The Local Authority should continue to work with stakeholders and developers to enable new mixed tenure extra care housing schemes and age-exclusive housing to be developed to meet the needs of customers and self-funders.
- The Local Authority should continue to work with the care home market to provide sufficient capacity for those customers with the most complex needs at affordable rates.
- Support GP practices to identify their frail population and ensure there is the development of care plan and medicines optimisation for all those identified as moderate or severely frail.
- Increase awareness and provision of training and information to frontline health and social care workers of social prescribing that can help reduce social isolation and find ways to connect people to activities or organisations that can help.
- Work towards increased specialist dementia care in response to increasing need and to ensure people are able to stay at home for longer; ensure existing services are more integrated.
- Optimising use of the Public Health ‘Supporting Independence’ programme for people living with mild frailty.
Recommendations for needs assessment work

- Further needs assessments will need to be undertaken to understand disease specific issues. For example identifying the key needs for respiratory and CVD.
- More knowledge is required about the needs of carers in Northamptonshire. A needs assessment should be undertaken.
- It is important to ensure that the needs for older people are identified at a localised primary care network area level when they develop in the future. Specific analysis will need to be undertaken to identify the key needs for each Primary Care Network.
- Undertake analysis with the SHAPE tool to allow a targeted approach to Primary care locations to ensure local solutions to fuel poverty are delivered to the populations most in need. GP practices have been identified across the county.
The proportion of older people in Northamptonshire has been growing faster in Northamptonshire over the last 3 years than across England as an average. 12% more people in Northamptonshire are over 65 in 2017 than in 2014, the national average increase being a little over 5%. The percentage of residents aged 85 and over has grown a little less than national average, 4.7% in Northamptonshire compared to a national average of 6%.

The highest proportions of older people in the population are found in the more rural areas of Northamptonshire - Daventry, East Northamptonshire and South Northamptonshire. These areas have older populations of around 20%, contrasting with the more urban areas of Corby and Northampton where the proportion is 14% and 15% respectively. Approximate numbers, proportion and increases since 2014 are shown in the table below.
Distribution of older people in Northamptonshire

The following maps display the distribution of people aged 65 and over, 75 and over and 85 and over in Northamptonshire by Lower Super Output Area. The darker areas have a higher proportion of people in the relevant age group. The map shows that many rural areas have a higher proportion of older people than urban areas, demonstrating that many older people live in smaller communities, potentially some distance away from local services, companions, family, medical services and public transport.
Gender
Almost 54% of the over 65 population in Northamptonshire is female (2016). This statistic is similar across all of the seven districts and boroughs, Corby having the highest proportion of females at 55%, Daventry, East Northamptonshire and South Northamptonshire the lowest at 53%.

For more detailed population statistics, please see the ONS Population Estimates Analysis Tool.
Of Northamptonshire's current boroughs and districts, five are much less ethnically diverse than the national average. Northampton and Wellingborough are more diverse, the remaining five much less so. The diversity of the older populations across Northamptonshire is shown in the following chart.
Of the proposed unitaries, it is the west unitary that would be the most ethnically diverse for the over 65’s, due to Northampton having a larger population that Wellingborough and thus more impact when combined with the data from surrounding areas.

The ethnic make-up of Northamptonshire’s older population is less diverse than the younger adult cohort. 8.52% of 18 to 64 year olds in the county are from non-white ethnic backgrounds, compared to 2.8% of the over 65 population. As the population ages it becomes less diverse, just 1.4% of the population aged over 85 are from non-white backgrounds. The second of the charts in this section demonstrates the falling percentages of non-white residents as their age increases.
Old age dependency ratio

The Old Age Dependency Ratio is the number of people of retirement age for every 1,000 people of working age. The Northamptonshire average is the same as the national average at 303, but as the chart below shows there is wide disparity in this measure across Northamptonshire’s seven boroughs and districts.
Projections

The Office of National Statistics estimate Northamptonshire’s over 65 population in 2017 at 131,425. Within 5 years, this is estimated to grow to around 147,100 (2022) and in 10 years (2027) to 166,600. The ONS’ furthest projection at the time of writing was to 2041, where the estimated older population of Northamptonshire could be 217,500.

The proposals under consideration to split Northamptonshire into two unitary authorities would see the North unitary with approximately 62,200 over 65s and the West unitary with around 69,200 older residents. The following table shows the anticipated growth in the older population of Northamptonshire and the proposed two unitary authorities and the second table shows the anticipated growth for the seven borough and district councils within the county.
To find more detail about Northamptonshire’s growing population, please see the Office of National Statistics population projections.

Over time and with the trend of improvement in life expectancy measures particularly for males, the gender composition of the older population is set to be closer to balance over the 25 years of the ONS projection, in 2016 the gender split for the county was around 46/54 male to female. The ONS estimates that by 2019 this will have closed to 47/53, with gradual increases in the proportion of males over subsequent years.
Old Age Dependency Ratio - number of people of state pension age per 1,000 working age, projected to 2041
Deprivation

The maps below show the Index of Multiple Deprivation in Northamptonshire by quintile and the Index of Deprivation Affecting Older People Index (IDAOPi). The IDAOPi is a subset of the English Indices of Deprivation using the Income Deprivation Domain.

IDAOPi is based on the percentage of the population aged 60 and over who receive income support, income based job seekers allowance, pension credit or child tax credit claimants aged 60 and over and their partners (if also aged 60 or over). The darker areas represent areas with higher levels of deprivation.
Deprivation for older people is higher in similar parts of the County to that of the whole population, although there are fewer areas of Corby in the most deprived quintile.
Life expectancy
Northamptonshire has a growing and ageing population, between 1992 and 2017, the population aged 65 and over grew by 55%, compared to an increase of 16% in the 0-19 population over the same period. This is partly due to growth in the county across all age groups, but is also due to increased life expectancy. Public Health England publish three life expectancy indicators, life expectancy at birth, life expectancy at age 65 and health life expectancy.

79.4 – Life expectancy for a male in Northamptonshire
Life expectancy at age 65 – 18.9 years
Healthy life expectancy – 64.8 years

83 – Life expectancy for a female in Northamptonshire
Life expectancy at age 65 – 21 years
Healthy life expectancy – 64.4 years

The highest life expectancy at birth is in South Northants for female residents and Daventry for male residents. South Northants has the highest life expectancy at age 65 for both genders. Corby residents have the lowest life expectancy in both measures and for all persons. Life expectancy in Northamptonshire is statistically similar to the England average for all measures, however whilst healthy life expectancy is similar to this national benchmark, this indicator has seen a fall for both male and female residents of the county from 2013-15 to 2014-16.
Frailty

Frailty provides a method of understanding a person’s biological resilience or ability to cope with potential health events or stresses such as an infection or a fall. Frailty is a syndrome caused by the gradual loss of physiological resilience and may include loss of muscle mass and strength, energy, nutritional status, cognition or wellbeing. It means that an individual is more vulnerable to such things as infections or falls: if these happen the impact is greater and the individual takes longer to recover (than someone who is not frail) and then doesn’t always return to the same state of health.

Frailty occurs across a spectrum ranging from the majority who are mildly frail to those with moderate or advanced frailty. The degree of frailty is not static: it has been estimated that around 40% of those living with frailty will deteriorate to a more advanced state while 25% will improve. Frailty develops over time – usually five to 10 years – so is more commonly found in older people; although not all older people are frail and not all frail people are older. Nevertheless it is estimated that between a quarter and half of people older than 85 are frail and 9% of those over 75.

Impact of frailty

People living with frailty are more likely to die than those who are fit:

After five years 89.8% of those who are fit will still be living, 76.4% of those who are mildly frail, 55.5% of those with moderate frailty and 30.5% of those with severe frailty. Their health during this time is likely to be worse than those who are fit.
People with severe frailty are nearly five times more likely to be admitted to hospital or a care home as an emergency than those without frailty and once in hospital stay for an average of 11.1 bed days compared to 9 days for those not frail. It has been estimated that 10 days in a hospital bed leads to the equivalent of 10 years ageing in the muscles of people over the age of 80.

Source: Clegg et al (2016)

The level of risk of adverse events is associated with an individual’s level of frailty, those with the most severe frailty have the highest level of risk. Assessing an individual’s level of frailty is an important measure of understanding their future health and social care need.

Causes of frailty
Frailty occurs following a long period of gradual deterioration of multiple body systems of which there are multiple contributing or risk factors. Evidence shows that key contributing factors include:

- Loss of muscle strength and power. In Northamptonshire only 63.6% of the adult population meet recommended physical activity levels of at least 150 minutes
- Low nutritional status/intake
- Multiple medication use: usually prescribed for multiple long term conditions
- Social isolation – see section on social isolation.

Distribution
Key associations of frailty include age, gender and deprivation: the older a person is the more likely they are to be frail with increasing frailty seen with increasing age. Females are at greater risk of frailty than males and there is a negative correlation between degree of frailty and social deprivation; level of frailty increases as levels of deprivation increases with those areas with the highest levels of deprivation likely to have the highest degree of frailty.
Cost
NHS England RightCare have estimated that a standard care pathway for an individual living with frailty until their death costs around £35,000 including emergency transportation and admission to hospital and nursing home costs. This compares to £19,000 for an optimised pathway with greater emphasis on prevention and community support.

Estimated mean total 3 month systems costs in Germany for those with two syndromes of frailty (mildly frail) were €1,014, €1,616 for those with moderate frailty (three syndromes) and €3,659 for those with severe frailty (four or five symptoms). These estimates included informal care and all pharmaceuticals with researchers identifying inpatient and pharmaceutical costs having the strongest impact on overall costs.

Unpublished data from work carried out on the Kent Integrated Dataset (KID) have indicated the potential for significant savings if only 10% of the mildly frail population were fit.

Prevalence in Northamptonshire
The electronic frailty index uses GP patient records to estimate levels of frailty in the over 65 population. The index estimates that;

- 35% of over 65s are mildly frail
- 12% are moderately frail
- 3% are severely frail.

The Kent integrated dataset (KID) have used these figures to estimate age related prevalence of frailty which in turn have been applied to the Northamptonshire population. There are approximately 43,000 over 65 year olds in Northamptonshire who are living with mild frailty, 16,000 with moderate frailty and 4,000 living with severe frailty (Table 1). The largest proportion of people living with frailty is in Northampton reflecting the larger overall population of this borough. West Northamptonshire is estimated to have a higher number of people living with moderate and severe frailty than North Northamptonshire.

Number of people living in Northamptonshire by frailty score

<table>
<thead>
<tr>
<th></th>
<th>Total Over 65s</th>
<th>Fit (n)</th>
<th>Mild (n)</th>
<th>Moderate (n)</th>
<th>Severe (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northamptonshire total</td>
<td>128,629</td>
<td>67,200</td>
<td>41,549</td>
<td>15,621</td>
<td>4,204</td>
</tr>
<tr>
<td>Corby</td>
<td>9,613</td>
<td>5,045</td>
<td>3,109</td>
<td>1,151</td>
<td>303</td>
</tr>
<tr>
<td>Daventry</td>
<td>16,423</td>
<td>8,680</td>
<td>5,279</td>
<td>1,943</td>
<td>514</td>
</tr>
<tr>
<td>East Northants</td>
<td>18,422</td>
<td>9,643</td>
<td>5,942</td>
<td>2,230</td>
<td>600</td>
</tr>
<tr>
<td>Kettering</td>
<td>18,065</td>
<td>9,403</td>
<td>5,838</td>
<td>2,215</td>
<td>602</td>
</tr>
<tr>
<td>Northampton</td>
<td>33,134</td>
<td>17,162</td>
<td>10,743</td>
<td>4,099</td>
<td>1,115</td>
</tr>
<tr>
<td>South Northants</td>
<td>18,196</td>
<td>9,547</td>
<td>5,864</td>
<td>2,191</td>
<td>587</td>
</tr>
<tr>
<td>Wellingborough</td>
<td>14,777</td>
<td>4,775</td>
<td>4,775</td>
<td>1,793</td>
<td>482</td>
</tr>
</tbody>
</table>

Source: based on ONS mid-year estimates 2012 – 2016
Frailty in the future
The proportion of the population living with frailty is influenced by various factors, such as the size of the ageing population, health conditions and access to prevention activities. Projected estimates only take into account the growth in the older population (aged 65+) so may overestimate actual numbers.

Two datasets were applied in the projection of frailty population in Northamptonshire, North and West Northamptonshire Unitary Authorities.
- **2016 based subnational population projections** for local authorities published by ONS, 2018 (visit [ONS](https://www.ons.gov.uk) for methodology and quality information of this projection).
- **Kent Integrated Dataset (KID) on frailty prevalence**. This dataset gives the prevalence of frailty in the population aged 65+.

The estimated prevalence of frailty in the over 65 population of Northamptonshire is displayed in the following figure.

Source: Northamptonshire County Council’s Business Intelligence team, February 2019
By 2023 it is estimated that in Northamptonshire there will be 4,000 more over 65 year olds living with moderate frailty and 600 more living with severe frailty with a total of 49,942 over 65 year olds living with mild frailty, 19,362 with moderate frailty and 5,200 living with severe frailty. Of those with moderate frailty, 9,096 will live in North Northamptonshire and 10,208 in West Northamptonshire while 2,439 of those with severe frailty will be living in North Northamptonshire compared to 2,743 in West Northamptonshire. People living with severe frailty are likely to need a high level of health and social care input.

By 2038 it is estimated that in Northamptonshire there will be 70,747 over 65 year olds living with mild frailty, 29,433 with moderate frailty and 8,407 living with severe frailty.

Compared to West Northamptonshire and Northamptonshire, North Northamptonshire has a similar increase rate (%) in the numbers of people with mild, moderate and severe frailty in 2018 - 2027. However, it is projected that from 2028, the number of people with mild, moderate and severe frailty in North Northamptonshire will increase faster than its counterparts. By 2039, the number of people with severe frailty will be doubled, compared to the figure in 2017.

The following figure shows the expected projection of frailty in Northamptonshire, and the two proposed (at the time of writing) unitary authorities from 2020 to 2040 in five year intervals.

**Predicted number of people living in Northamptonshire the two future unitary areas by frailty score**

![Graph showing prediction of frailty](image_url)

Source: Northamptonshire County Council’s Business Intelligence team, February 2019
### Percentage of Increase in Frailty in Population aged 65+, Northamptonshire, North Northamptonshire and West Northamptonshire, 2018-2041

<table>
<thead>
<tr>
<th>Year</th>
<th>Northamptonshire</th>
<th>North Northants UA</th>
<th>West Northants UA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fit</td>
<td>Mild</td>
<td>Moderate</td>
</tr>
<tr>
<td>2017</td>
<td>68,447</td>
<td>42,710</td>
<td>16,092</td>
</tr>
<tr>
<td>2019</td>
<td>71,030</td>
<td>45,077</td>
<td>17,081</td>
</tr>
<tr>
<td>2020</td>
<td>72,334</td>
<td>46,233</td>
<td>17,514</td>
</tr>
<tr>
<td>2021</td>
<td>73,561</td>
<td>47,308</td>
<td>18,053</td>
</tr>
<tr>
<td>2022</td>
<td>74,752</td>
<td>48,598</td>
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<td>2023</td>
<td>76,132</td>
<td>49,942</td>
<td>19,362</td>
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<td>2024</td>
<td>77,593</td>
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<td>2025</td>
<td>79,188</td>
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<td>2026</td>
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<td>2027</td>
<td>82,207</td>
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<td>2028</td>
<td>83,710</td>
<td>56,815</td>
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<td>2029</td>
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<td>2030</td>
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<td>2041</td>
<td>103,848</td>
<td>73,622</td>
<td>31,161</td>
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</table>

*Source: ONS 2018*
Falls
Emergency admissions may be for any number of reasons but will include falls. People with frailty are over three times more likely to fall than non-frail adults while further studies have shown that those with a fear of falling and consequent avoidance of activities in daily life were more likely to fall within a one year follow up. Causes of falls are complex but frail older people are particularly vulnerable due to medical conditions such as delirium, problems with poor eyesight or poor muscle strength and mobility.

2016/17 figures show that in Northamptonshire, for every 100,000 population 2,514 over 65s were admitted to hospital as an emergency resulting from a fall. For those aged between 65 and 79 years there were 1,157 emergency admissions resulting from a fall and 6,452 emergency admissions per 100,000 for over 80s. All falls rates per 100,000 population in Northamptonshire are significantly higher than the England average.

Care home and hospital admission
Frail older people can suffer harm from receiving care in an acute setting when this is not absolutely necessary with a fourfold variation between organisations in admission rates for people aged 65 and over indicating the variation in admissions criteria for differing organisations.

Evidence suggests that 28 day re-admission rates to hospital in over 75 year olds are proportionately higher than those in the 16 – 74 year olds (15.3% compared to 10.1%) with discharge to alternative destinations to home (such as care homes) not just being linked to need but to other factors such as deprivation meaning that those living in more deprived areas are more likely to be discharged to a care home regardless of their level of need.

In Northamptonshire, permanent admissions to a residential or nursing care home in the over 65 year old population was 537.9 people per 100,000 of the population in 2017-18, a significantly lower figure than the England average.

Frailty and dementia
Dementia is considered as a risk factor for frailty with the degree of dementia comparable to the degree of frailty. For example, someone with mild dementia is likely to have a similar level of frailty. See the dementia section for more information.

Addressing frailty
Older people with frailty can be readily identified and are often known to health professionals. They typically walk slowly, get exhausted easily and struggle to get out of a chair or climb stairs.

Opportunities to improve are dependent on an individual’s level of frailty. NHS England recommends the following for people living with frailty;

- **Mild frailty** – awareness of condition, providing tools people need to self-manage their condition and enable them to access appropriate support when they need to from families, carers, community and voluntary sectors organisations as well as from health and care services.

- **Moderate frailty** – comprehensive geriatric assessment in addition to approaches for mild frailty. Key areas include falls risk assessment, medicines optimisation and cognitive assessment.
Severe frailty – adds the principles described above with continued needs focussed care review, assessment and care planning. Timely recognition of advancing frailty. People living in care homes are likely to be living with higher levels of frailty and therefore merit particular attention.

The majority of studies exploring frailty have identified increasing physical activity as being of benefit either as a standalone intervention, alongside nutrition support, nutrition and memory training or supplementation. These link with the recognised contributory factors to frailty: loss of muscle power and strength, poor nutrition and cognitive impairment. Medication reviews and support to reduce social isolation or loneliness are also recognised as beneficial alongside usual lifestyle support around smoking, alcohol and physical activity.

Integrated care pathway
NHS England outline an approach to frailty following an integrated pathway providing evidence based interventions for all stages of frailty. These include identification and case finding of people living with frailty and for different stages of fitness and frailty;

- Health active ageing and supporting independence: vaccination treatment for minor conditions that limit independence, support to maintain healthy lifestyle
- Living well with simple or stable long term conditions: personalised care planning and shared decision making
- Living well with complex co-morbidities, dementia and frailty: systematic targeted case finding including primary care screening, proactive CGA, identification of a key worker, services to reduce polypharmacy
- Rapid support close to home in a crisis
- Good acute hospital care when (and only when) needed.

Identification of those living with frailty
Identifying over 65s living with frailty now forms part of the GP contract with NHS England. Since 2017/18, practices are required to identify those living with moderate and severe frailty and carry out a comprehensive assessment of their needs.

Practices covered by Nene CCG carried out 9,798 assessments in the year 2017/18, representing 8% of their over 65 population. Practices covered by Corby CCG carried out 396 assessments, representing 4% of their over 65 population. Both areas compare poorly to their Rightcare similar 10 CCGs, the best carried out assessments on 58% (Nene similar) and 47% (Corby similar) of their relevant population. This represents significant opportunity to increase identification and support of those living with frailty.
Isolation

In 2015, Northamptonshire County Council’s Business Intelligence team conducted a study into loneliness and social isolation in Northamptonshire.

Loneliness can have significant and lasting effect on health. It is associated with higher blood pressure and depression and leads to higher rates of mortality, indeed comparable to those associated with smoking and alcohol consumption. It is also linked to a higher incidence of dementia with one study reporting a doubled risk of Alzheimer’s disease. Lonely people tend to make more use of health and social care services and are more likely to have early admission to residential or nursing care.

Loneliness and isolation, whilst often connected, are two separate concepts. Loneliness is a subjective state, taking numerous forms whilst isolation is an objective state and measurable.

Over 64,400 older people live alone in Northamptonshire. The percentage of over 65 respondents to the Adult Social Care Survey in Northamptonshire who stated they had as much social contact as they would like in Northamptonshire is lower than the national average, 36.1% compared to 44%. The trend is worsening overall driven by a worsening trend in female residents. The trend for male residents has shown improvement between the last data point and the most recent in 2017/18.

The study looked at the local impact of the Campaign to End Loneliness’ common reasons for isolation and/or loneliness. Of these factors, including fear of crime, lack of public transport, physical environment, housing, population turnover, demographics and technological changes, it appeared that the two main factors in Northamptonshire were fear of crime and population turnover. Northamptonshire was rated as a medium risk for digital isolation.

An index of isolation was compiled using a methodology devised by Gloucestershire County Council, the resulting mapping showed that the areas of the county where older people were most likely to experience loneliness and/or isolation were the more deprived areas of the larger urban centres, the top ten LSOAs were in urban settings in Northampton, Kettering, Wellingborough and Corby.

Ten LSOA areas were chosen across the county mixed between deprived, high density urban areas, smaller towns and relatively affluent rural areas. The impact of the CEL risk factors on each of these LSOAs was analysed. For more information, please see the report on the Northamptonshire County Council website.
Fuel poverty

Fuel poverty is related to low income, high fuel costs and poorly insulated housing. It is linked with excess winter deaths and cold related illness admissions, for example respiratory illnesses. Households are deemed to be fuel poor if they spend more than 10% of their net income on heating. Fuel poverty is caused by a combination of low incomes, high fuel prices and poor energy efficiency of dwelling stock.

The Department for Business, Energy and Industrial Strategy (BEIS) 2017 data for Northamptonshire shows a number of LSOAs with fuel poverty levels in the highest 10%. The most marked areas of fuel poverty are in central Northampton (25-30% of households experiencing fuel poverty) and at least one LSOA in Daventry, Kettering and Corby featuring in the top 10% most fuel deprived (>15% households experiencing fuel poverty). Of these fuel poor households, the majority are populated by households in the mid 30’s age ranges.

Corby 004D, the area around Kingsthorpe Avenue and Grafton Drive, has 12% fuel poverty and an over 65 population of 20-25%.

Northampton 024B, the area of Duston around Lyncrest Avenue, The Avenue and Trevor Crescent, has a 13.4% fuel poor households and an over 65 population in excess of 25%.

East Northamptonshire 005F, West Central Raunds (Grombold Avenue, Cricket Ground), has 14% of households experiencing fuel poverty and a proportion of over 65s of 16%.

Elsewhere the proportion of older households experiencing fuel poverty ranges between 8 and 11%.

Excess winter deaths in older persons also shows an upward trend in those same districts with fuel poverty hotspots populated by older residents.

Since 2014, Northamptonshire has been involved with initiatives to combat fuel poverty with National Energy Action from 2014 to 2016 and with the NESS service since June 2018.

The Northamptonshire Energy Saving Service (NESS) is a fully grant funded programme led by the Energy and Carbon Management Team supported by Public Health for Northamptonshire County Council and is delivered by the voluntary and community sector (Community Law, Citizens Advice Bureaus in Kettering and Corby, Care and Repair and the South Northamptonshire Volunteer Bureau). It will deliver a community and outreach project to address fuel poverty over the three years between 2018 and 2021.
Fuel poverty in Northamptonshire in 2015 at LSOA level

Source: Department for Business, Energy and Industrial Strategy, 2017
Prepared by Bi&PM, August 2017
Lifestyles
According to the Global Burden of Disease study, over 90% of years of life lost in Northamptonshire and the East Midlands are due to the following risk factors;

- Excess alcohol intake
- Tobacco smoking
- High blood pressure and high cholesterol
- Obesity and poor nutrition
- Physical inactivity
- High blood sugar
- Poor air quality
- Poor mental health

Of the top 10 risk factors, the majority are linked directly or indirectly to lifestyle and behavioural factors; type and quantity of food eaten, exercise not taken, alcohol drunk and tobacco consumed. **These risk factors do not exist in isolation, but cluster.**

- A significant minority, around 25%, of English adults have **three or more risk factors**.
- Multiple risk factors are not randomly distributed across populations but are more common in some groups than others.
- The level of risk of adverse events is associated with an individual’s level of frailty.

A simple example is that tobacco consumption and alcohol consumption often occur together and obesity and low physical activity may also occur together.

The First for Wellbeing/Public Health model has been to approach lifestyle improvement interventions via mental wellbeing, recognising that poor mental wellbeing often leads to risky lifestyle behaviour. This focus is shifting to one which directly combats the development of frailty.

Smoking
Cigarette smoking is implicated in eight of the top fourteen causes of death for people 65 years of age or older. Smoking causes disabling and fatal disease, including lung and other cancers, heart and circulatory diseases, and respiratory diseases such as emphysema. It also accelerates the rate of decline of bone density during ageing. At age 70, smokers have less dense bones and a higher risk of fractures than non-smokers. Female smokers are at greater risk for post-menopausal osteoporosis. Half of long-term smokers die of tobacco related illnesses, most prematurely, and many suffer from a variety of chronic conditions related to smoking.

Smoking prevalence is steady in much of Northamptonshire at 15.9% of adults, with the exception of Kettering and Northampton where it is increasing. Almost 22% of Northampton adults smoke tobacco products.

Stop smoking services record the number of over 40s accessing the service to quit. Approximately 50-55% of clients are over 40. However there are fewer clients setting a quit date in deprived LSOA s than others.
Smoking is a the leading risk factor in disease and disability causing 1901 hospital admissions per 100,000 population in Northamptonshire and 571 acute A&E admissions with Respiratory problems linked to Chronic Obstructive Pulmonary disease (COPD) alone.

62% of quit dates set with the Public Health /Frist for Wellbeing Stop smoking team were for people aged over 40 years old, of which 48% were male.

Many of the negative health effects of smoking can be reversed with cessation. Doll et al (2004) reported on a 50 year cohort study examining the impact of smoking cessation on survival. The study found that quitting smoking beyond middle age still had a positive effect on total mortality. Overall, the British doctors cohort study found that stopping smoking at age 50 halved the hazards of smoking; cessation at 30 avoided almost all of it. Stopping smoking at age 60, 50, 40, or 30 gains, respectively, about 3, 6, 9, or 10 years of life expectancy. Smokers who quit at 65-74 years of age had age-specific mortality rates beyond 75 years which were lower than smokers who do not quit.

Weight management

Obese people have an increased risk of dying prematurely and obesity is responsible for more than 9,000 premature deaths per year in England. It increases risk of developing cardiovascular disease, type 2 diabetes, hypertension, dyslipidaemia, some cancers, musculo-skeletal problems

65.7 % of Northamptonshire residents were classified as obese or overweight in 2016/17

There is a lack of data on the prevalence of obesity in older adults in Northamptonshire. There is no routine data collection and special surveys are hampered by lack of agreement in the most appropriate measure to use.

Evidence for effectiveness of weight management delivery methods is limited. First For Wellbeing/Public health offer commercial weight management service to those meeting eligibility thresholds. 99% of those accessing weight management this way have had an NHS health check; 80% were female a 30% were aged 50-64 and 45% lived in the lowest IMD deciles (most deprived).

Successful weight loss has been measured against NICE guidelines, but it should be noted that a 3% weight loss with a starting weight of 90Kg and a BMI of 30 or above will not take that person out of obesity or into a healthy weight.

Recommendations going forward are to offer alternate evidence based weight loss interventions and diet programmes to improve the amount of weigh lost in a 12 week period and weight loss maintained beyond the 12 week intervention time frame.

Physical activity

For people of all ages, physical activity improves the quality of life in many ways. Physical benefits include improved and increased balance, strength, coordination, flexibility and endurance. Physical activity has also shown to improve mental health, motor control and cognitive function.

Active lifestyles provide older persons with regular occasions to make new friendships, maintain social networks, and interact with other people of all ages. Improved flexibility, balance, and muscle
Tone can help prevent falls—a major cause of disability amongst older people. It has been found that the prevalence of mental illness is lower among people who are physically active.

23.4% of Northamptonshire residents are physically inactive. Less half walk 5 times per week and less than 1 in 5 use outdoor space for exercise or activity. Inactivity is worst in Wellingborough and worsening across the county.

Physical inactivity is linked with an increasingly large range of diseases including overweight, cardiovascular disease, cancer, diabetes, musculoskeletal problems and falls.

Commissioned services for weight loss are also encouraged to include physical activity via exercise classes or walks. The county sport partnership, N Sport are working to Sport England’s strategy goal of getting 12,000 extra inactive people into sustainable exercise by 2020.

It is also hoped going forward that the Social prescribing social impact bond will include among its many community and voluntary sector referral options, physical activity options in all county areas for all ages.

**Alcohol**

Even modest alcohol use in old age may be potentially harmful as a contributor to falls, compromised memory, medicine mismanagement, inadequate diet and limitations on independent living. NICE guidance on alcohol dependence and harmful alcohol use is expected in February 2011.

In 2016, there were 3,717 years of life lost in Northamptonshire due to alcohol related conditions and 15,718 alcohol related hospital admissions (all age).

Public Health alcohol harm prevention occurs via;

- **Tier 1 interventions**: alcohol related information and brief advice via the First for Wellbeing direct health improvement services, delivered by Supporting Independence and the self-service portal on the Public Health website (currently in development)
- **Tier 2 interventions**: open-access non-care planned alcohol specific advice and counselling
- **Prevention board/Healthy Living Alliance**: reducing alcohol harm in the population through targeted health improvement activity. This includes, but is not limited to promotional campaigns, awareness raising, social marketing and community engagement.

In 2017/18, 882 people received structured treatment for alcohol use only (no concurrent drug use). 4.4% were aged 60 to 64 at the time of presenting to services and 5.1% were aged 65 and over. On November 1\textsuperscript{st} 2018 there were 332 people in structured treatment for alcohol use only. 8.1% were aged 60 to 64 and 4.5% were aged 65 and over.
Dementia

Dementia is a common condition that affects about 800,000 people in the UK. The risk of developing dementia increases as you get older, and the condition usually occurs in people over the age of 65. Dementia is a syndrome (a group of related symptoms) associated with an ongoing decline of the brain and its abilities. This includes problems with:

- Memory
- Thinking speed
- Mental agility
- Language
- Understanding
- Judgement

Other symptoms can include:

- Increasing difficulties with tasks and activities that require concentration and planning
- Depression
- Changes in personality and mood
- Periods of mental confusion
- Difficulty finding the right words

It is predicted that nearly 10,000 people aged 65 and over will live with dementia in Northamptonshire by 2021. It will increase more than 1,000 compared to 2017’s figure. The increase rate is 13.6%.

Compared to West Northamptonshire, it is estimated that the number of people living with dementia will increase slightly faster in North Northamptonshire in 2017-2021, 12.9% (CI 11.7% - 13.9%) vs. 12.2% (CI 11.3% -13.1%).

It is predicted that by 2021, those aged 75-79 will have the biggest increase in the number of people living with dementia (the percentage of increase is 26%). North and West Northamptonshire reveals a similar pattern.

By 2035, people aged 90 and over living with dementia will rise by 150%. A quarter of people aged 65+ with dementia will be those aged 90 and over. Ageing population and increasing life expectancy are the driving force behind this projected rise.
People aged 65 and over predicted to have dementia by age, Northamptonshire, 2017-2035

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Source: Northamptonshire County Council’s Business Intelligence team, February 2019

People aged 65 and over predicted to have dementia by age, North Northamptonshire, 2017-2035

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Source: Northamptonshire County Council’s Business Intelligence team, February 2019

People aged 65 and over predicted to have dementia by age, West Northamptonshire, 2017-2035

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Source: Northamptonshire County Council’s Business Intelligence team, February 2019

Dementia is the second most common mental health problem in older people and 20 % of people over 85, and 5 % over 65, have dementia. Dementia is the name given to a group of diseases that affect the normal working functions of the brain. This can lead to a decline of mental ability, affecting memory, thinking, problem solving, concentration and perception.
There are a number of different causes of dementia but the most common cause and the best studied is Alzheimer’s disease (AD) (approximately 60% of all causes). Other causes are vascular dementia (VaD) (20%), dementia with Lewy bodies (DLB) (10%) and frontotemporal dementia (FTD) (2%). These diseases are not mutually exclusive and mixed pathologies are common. Heavy alcohol consumption is a predisposing factor.

Patients with dementia are at risk of financial and physical abuse (including neglect) and early advice regarding lasting power of attorney, financial aid e.g. attendance allowance, and local support networks for carers is an essential part of management.

In the management of dementia, a large focus is on helping carers to cope with the increased dependence of patients as the disease progresses or with the emergence of troublesome neuropsychiatric symptoms. Co-existing physical problems complicate management. Despite improved public awareness of dementia, and in particular AD, there is still a large amount of stigma perceived to these diseases, and this can prevent some carers from seeking help. A systematic review of the management of dementia in primary care concluded that caring for people with dementia requires the same systematic approach as the management of other long term conditions. The systematic follow-up of both people with dementia and their carers should be integrated into primary care. Reframing dementia, with an emphasis on abilities retained may allow people with dementia and their families to develop more effective coping strategies; an increase in skill mix within primary care is required to deliver this and may also improve the management of behavioural problems. The potential benefits of person-centred interventions, like advance care planning, and alternative models of service delivery, such as a structured, collaborative care approach which promotes integrated case management within primary care, require further evaluation.

A systematic review of the factors associated with risk for and prevention of cognitive decline in later life found little strong evidence of evidence that supported the benefits of selected nutritional factors or cognitive, physical, or other leisure activities was limited.
Mobile technology monitoring devices can help support people with dementia. Currently a range of monitoring devices are utilised either linked to a pager, telecare or web based with notifications/text messages. There are pager devices that are used in the home, where the customer has a carer with them all the time. These alerts can be used to inform the carer if the customer is out of bed, opens the front door, moves from the chair, etc. Some monitoring device can detect temperature and light levels. There are some devices that focus around the customer being active and accessing the community on their own but with the potential risks of purposely walking and getting lost. The device activates when movement is detected and can be programmed to dial up to 3 people if the SOS button is pressed. The authorized users will be able to request the location of the device, at any given time, and also dial in, automatically answers and allows two way communication.

Utilising this support has provided a lot of reassurance to families as they know, by logging into the system, the person they care is active, had a good night sleep, didn’t leave the house etc.
Long term conditions

The most common long term conditions (LTCs) are [http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_082067.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_082067.pdf). LTCs are the main contributors to reduced life expectancy and are to a large degree preventable.

Age is the single biggest factor associated with having LTC and 60% of people aged 65 and over are affected, but lifestyle factors such as smoking, excessive alcohol consumption, unhealthy diets and physical inactivity are estimated to cause approximately 50% of LTCs.

Many people live with a LTC that limits their ability to cope with day to day activities, including physical, psychological and social aspects. For some people, especially older people, their carers and those who have more than one condition, discomfort and stress is an everyday reality. For those living in disadvantaged circumstances or those for whom English is not their first language, the challenges are even greater. For the most vulnerable, a lack of co-ordinated personalised care can lead to a significant deterioration in health and often avoidable hospital admissions.

The NHS long term plan highlights the importance of prevention and providing education programmes to reduce the premature deaths associated with LTCs.

Diabetes

A consequence of a population living longer, combined with the trend for the weight of the population to increase and their levels of physical activity to decrease is a rise in the incidences of diabetes. Many cases of diabetes could be avoided with a healthy diet, regular exercise and lower BMI.

The management of diabetes is not as simple as reducing fat and sugar content of foods. Irregular eating habits can be a trigger for hypoglycaemic attacks, so the importance of eating regularly and healthily is higher for those with diabetes.

Factors that can influence the development of diabetes include inactivity and in older people this may be due to a disability or physical impairment.

Older people can be more susceptible to a hypoglycaemic attack through poor food intake, kidney problems, prescription medicines and other illnesses. The signs of a hypoglycaemic attack are also less recognisable and with an increasing population living alone, the risks of this can be considerable.

A [county-wide profile](#) was created in relation to diabetes.
Cardiovascular disease

Cardiovascular disease is the most common cause of death throughout the world, responsible for 3 out of every 10 deaths on the planet. Tobacco use is a major cause of many of the world’s top killer diseases.

Cardiovascular diseases (CVDs) are a group of disorders of the heart and blood vessels and they include:

- coronary heart disease – disease of the blood vessels supplying the heart muscle
- cerebrovascular disease (disease of the blood vessels supplying the brain)
- peripheral arterial disease (disease of blood vessels supplying the arms and legs)
- rheumatic heart disease (damage to the heart muscle and heart valves from rheumatic fever, caused by streptococcal bacteria)
- congenital heart disease (malformations of heart structure existing at birth)
- Deep vein thrombosis and pulmonary embolism (blood clots in the leg veins, which can dislodge and move to the heart and lungs).

Heart attacks and strokes are usually acute events and are mainly caused by a blockage that prevents blood from flowing to the heart or brain.

There are several risk factors for CVD. The more risk factors present, the higher the risk of developing CVD. And even though people can’t change all their risk factors, there is plenty that can be done to reduce risks and help to protect the heart.
Risks include:

- Smoking
- High blood pressure
- High blood cholesterol
- Being physically inactive
- Being overweight or obese
- Diabetes
- Family history of heart disease
- Ethnicity - for example people from a South Asian background have an increased risk of developing coronary heart disease
- Gender - men are more likely to develop CVD at an earlier age than women
- Age - the older you are, the more likely you are to develop CVD.

How you deal with stress, the amount of alcohol you drink, as well as the type of job you do may also influence your risk of developing CVD.

Unlike deaths from cancer, which are more likely amongst the 65-84 population than older people, the situation is reversed for cardiovascular related death; they are more common amongst those over 85. Northamptonshire CCGs tend to show lower percentages of deaths from CVD than England as a whole, but for males aged 65-84 in Corby and females aged 65 to 84 in the Nene CCG, rates are higher.

**Under 75 mortality rate from cardiovascular disease considered preventable 2015 – 17,** directly standardised rate - per 100,000 Source PHE 2018

The data shows that the under 75 mortality rate for Northamptonshire is similar to the England average.
Respiratory disease

Chronic respiratory diseases are chronic diseases of the airways and other structures of the lung. Some of the most common are:

- asthma
- chronic obstructive pulmonary disease (COPD)
- respiratory allergies
- occupational lung diseases and
- pulmonary hypertension

Deaths caused by respiratory diseases are most likely in the 85+ population, however respiratory disease is the cause of death for 22.82% of females between 65 and 84 in Corby compared to 17.51% in the neighbouring Nene CCG and 16.38% in England. Apart from this, death rates from respiratory disease are close to the average for England in the 65-84 year old population but worse for the 85 and over population.

Under 75 mortality rate from respiratory disease considered preventable 2015 – 17, directly standardised rate - per 100,000 Source PHE 2018

COPD is a general term which includes the conditions chronic bronchitis and emphysema. It is common. It is estimated that another half million people have the condition but are undiagnosed. COPD becomes more common with increasing age. The average age of diagnosis is around 67 years. It is more common in men than women. It accounts for more time off work than any other illness. Smoking is the cause in the vast majority of cases. The lining of the airways becomes inflamed and damaged by smoking. About three in 20 people who smoke one packet of cigarettes (20 cigarettes) per day, and one in four 40-per-day smokers, develop COPD if they continue to smoke. For all smokers, the chance of developing COPD is between one in 10 and one in four.
Liver disease

**Causes and risk factors of liver disease include the following:**

- Alcoholism
- Autoimmune diseases (e.g., autoimmune hepatitis)
- Bile duct disorders (e.g., primary biliary cirrhosis, primary sclerosis cholangitis)
- Exposure to toxins through ingestion, inhalation, or skin absorption (e.g., toxic hepatitis)
- Hereditary conditions (e.g., Wilson’s disease, hemochromatosis, galactosemia, Alagille syndrome, alpha-1 antitrypsin (AAT))
- Obesity
- Severe reactions to certain prescription or over-the-counter (OTC) medications
- Viruses (primarily hepatitis A, B and C)

The risk of developing liver disease varies, depending on the underlying cause and the particular condition. Being obese or overweight increases the risk for liver disease. Obesity often results in the accumulation of fat cells in the liver.

Deaths from liver disease for Northamptonshire are close to national figures.

**Deaths from liver disease considered preventable 2015-17, directly standardised rate per 100,000. Source PHE 2018**

The table shows the recent trend, neighbour rank, count, value, and 95% lower and upper confidence intervals for different areas including England, East Midlands region, Derbyshire, Leicester, Lincolnshire, Northamptonshire, Nottingham, and Rutland. The confidence intervals range from 16.1 to 27.5 for the lower and 16.5 to 36.7 for the upper confidence intervals.
Intermediate care

Intermediate care services are provided to frail patients, usually older people, when they are at risk of being sent to hospital or after they leave hospital. Services are mainly delivered by Northamptonshire County Council (NCC) and Northamptonshire Healthcare NHS Foundation Trust (NHFT) and there is close partnership working with the voluntary, community and independent sectors and both acute hospitals.

There are three main aims of intermediate care:

- to help people avoid going into hospital unnecessarily;
- to help them be as independent as possible after discharge from hospital; and
- to prevent people having to move into residential or nursing homes until they really need to.

There are higher unplanned hospital admissions for those who are aged 65 and above than comparable areas (Worcestershire is best of our peers). Local data shows us that in 2016/17 there were 4,487 emergency admissions in Northamptonshire for patients aged 65 and over that were classed as “not usually requiring a hospital admission”.

Many people who were admitted could have been managed at home or through day attendance at hospital or a local health centre. For example, in 2016/17 there were 2,612 non-elective (emergency) admissions for conditions which effective community care and case management should prevent the need for such an admission, also known as ambulatory care.

For those who are admitted to hospital, comparison with similar areas shows that there are too many people staying for more than 21 days (twice as many as South Derbyshire) in Northamptonshire. This can lead to an increase in adverse patient outcomes including longer rehabilitation / reablement times, mortality, hospital acquired infections, and hospital re-admission rates. It also puts pressure on acute beds and limits the amount of elective work the two acute hospitals can undertake.
Social care – services in relation to need

Sources of new requests for social care

There are two main routes that new requests for social care are made, either directly to the local authority or via a discharge from hospital. Older people are more likely to have more complex needs following a stay in hospital and therefore the cost of provision of care is likely to be higher.

The 2017-18 SALT return shows that the 58% of new requests for social care originate directly from a hospital discharge, this figure is significantly greater than the other social care authorities in the East Midlands. There are only two authorities in England with a higher proportion of new requests for social care originating from a hospital discharge - Camden (66.16%) and Bromley (61.76%). The nearest shire county is Warwickshire (48.50%).

Whilst the proportion of new requests from a Hospital discharge is higher in Northamptonshire, the number requests is not any greater than other parts of the East Midlands, or indeed the national figures. The significant difference, and the reason for the higher proportion figure, is the number of new requests that are accepted at the ‘front door’ of social care - In 2017-18 Northamptonshire had 3,460 new requests for services from those aged over 65, this is significant lower than the average across the East Midlands in the same period, which was 11,069 new requests.

This is due to the recording mechanism in Northamptonshire, which can also be seen in other authorities across the country, where the number of requests for adult social care are only counted once the referral is passed to the Adult Social Care team and does not include the number of requests that are signposted or diverted away from Adult Social Care altogether. This has the impact of showing the overall number of referrals for new requests for Adult Social Care in Northamptonshire as being lower than it actually is.

Even considering the above caveat regarding the number of new requests we can still see that the proportion of requests in Northamptonshire has shifted more towards discharge from hospital over the last 3 years. As seen below, the proportion of ASC clients from hospital to social care has increased by 12 percentage points over the past 3 years.
Social care service utilisation

In December 2018, a total of 6,748 people aged 65 and over were accessing 11,704 services, an average of 1.73 different services per individual.

The figures below show the numbers of individuals accessing services by age and gender, the number of services provided by age and gender and the average number of services provided per person by age and gender. The charts show the peak demand being between ages 85 and 95, and the number of services received peaks at the oldest ages, 100 and over.
As the borough with the highest population, it’s unsurprising to discover Northampton is home to the highest number of Adult Social Care clients. East Northamptonshire and Kettering have a similar numbers with Wellingborough slightly lower. Daventry and Corby have the lowest numbers, Corby’s total being around a third of the Northampton total. As a proportion of the over 65 population, Corby and Wellingborough have the two highest proportions, Daventry and South Northamptonshire the lowest.

The next table shows the primary support reasons for Adult Social Care clients aged 65 and over. It is commonplace for a customer to have a long term support reason and not a short term reason or vice-versa – it also occurs that a customer has both a long and short term reason.
This is a count of services provided – not a count of adults receiving services. This means that when a 65 year old male receives two services during the 17-18 year, he’ll appear twice in the table.

Note that following the ordinary usage of “over 65” within NCC context, all of the reporting in this document includes adults aged 65 and over.

“Campus Reprovision” was a package of community-based services given to customers with Mental Health and Learning-disability based needs. It has been phased out and any new customers will be given care through alternative services – this may explain why it diminishes even as the total number of services per age band increases.

The age band 85-89 requires the highest number of services, with 2,673 total services provided, however this isn’t much higher than the average of 2,329 services provided to adults aged 80-94.

Throughout the age bands, home care remains the most subscribed service. This tails off from the 95-99 age band onward, but the number of services (and the number of customers) at that band begins to tail off significantly, replaced by the need for a smaller amount of more intensive and expensive care, such as residential.
The life expectancy for people with a learning disability has been increasing in recent years and now stands at 64 for females and 60 for males. As a result, adults with learning disabilities are accessing services at older ages. The number of Adult Social Care customers with ‘Learning Disability’ listed as their primary need are shown by age and gender in the figure below. Please note that some data points have been redacted due to low numbers and these are shown as 0 on the chart.
Accessing adult social care by ethnicity

Public Health analysts examined whether there is health inequality on access to adult social care service in clients aged 65 and above. Adult social care data was extracted from Northamptonshire County Council’s CareFirst system between April 2015 and September 2018. Clients who used the service during this time period AND aged 65 years and above were included in the analysis.

Two proportions were calculated and compared

- The proportion of ethnic groups among all clients who aged 65 and above and used the service during this time period;
- The proportion of ethnic groups among the total population aged 65 and above in Northamptonshire in 2011 (the latest available data).

Confidence intervals were calculated to determine statistical significance (see table 1). Statistical tests (such as Kruskal-Wallis test and Mann-Whitney tests) can’t be applied due to the large sets of ethnic groups. Repeat comparisons across the groups increase the chance of making a Type 1 error to the findings.

Findings

The vast majority of the clients who used adult social care service in April 2015 to September 2018 were White British (92.31% of the total clients).

Comparison to the proportions of ethnic groups among total population aged 65+ shows

- a significantly higher proportion of any other White Background, Caribbean and any other Black background had accessed the service (see Figure 2 and table 1 for other significantly higher groups);
- a significantly smaller proportion of White British and White Irish used the service (see Figure 1 and 2);
- a smaller proportion of White and Black Caribbean, Chinese, White and Asian used the service. However, due to sample size, statistical tests cannot be applied to test significance level.
## Accessing adult social care service by ethnicity, April 2015 to September 2018

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>No. of clients aged 65+</th>
<th>% *</th>
<th>UCI</th>
<th>LCI</th>
<th>UCI</th>
<th>LCI</th>
</tr>
</thead>
<tbody>
<tr>
<td>W - White British</td>
<td>11,455</td>
<td>92.31</td>
<td>92.77</td>
<td>91.83</td>
<td>93.53</td>
<td>93.67</td>
</tr>
<tr>
<td>W - Any other White Background</td>
<td>262</td>
<td>2.11</td>
<td>2.38</td>
<td>1.87</td>
<td>1.52</td>
<td>1.60</td>
</tr>
<tr>
<td>W - White Irish</td>
<td>211</td>
<td>1.70</td>
<td>1.94</td>
<td>1.49</td>
<td>2.15</td>
<td>2.24</td>
</tr>
<tr>
<td>A - Indian</td>
<td>126</td>
<td>1.02</td>
<td>1.21</td>
<td>0.85</td>
<td>0.92</td>
<td>0.98</td>
</tr>
<tr>
<td>B - Caribbean</td>
<td>124</td>
<td>1.00</td>
<td>1.19</td>
<td>0.84</td>
<td>0.72</td>
<td>0.77</td>
</tr>
<tr>
<td>A - Any other Asian background</td>
<td>48</td>
<td>0.39</td>
<td>0.51</td>
<td>0.29</td>
<td>0.16</td>
<td>0.18</td>
</tr>
<tr>
<td>D - Any other ethnic group</td>
<td>42</td>
<td>0.34</td>
<td>0.46</td>
<td>0.25</td>
<td>0.08</td>
<td>0.10</td>
</tr>
<tr>
<td>M - Any other mixed background</td>
<td>28</td>
<td>0.33</td>
<td>0.53</td>
<td>0.16</td>
<td>0.12</td>
<td>0.14</td>
</tr>
<tr>
<td>B - Any other Black background</td>
<td>26</td>
<td>0.21</td>
<td>0.31</td>
<td>0.14</td>
<td>0.05</td>
<td>0.07</td>
</tr>
<tr>
<td>A - African</td>
<td>21</td>
<td>0.17</td>
<td>0.26</td>
<td>0.11</td>
<td>0.10</td>
<td>0.12</td>
</tr>
<tr>
<td>A - Pakistani</td>
<td>20</td>
<td>0.16</td>
<td>0.25</td>
<td>0.10</td>
<td>0.09</td>
<td>0.11</td>
</tr>
<tr>
<td>A - Bangladeshi</td>
<td>18</td>
<td>0.15</td>
<td>0.23</td>
<td>0.09</td>
<td>0.13</td>
<td>0.15</td>
</tr>
<tr>
<td>M - White and Black Caribbean</td>
<td>8</td>
<td>0.06</td>
<td>0.14</td>
<td>0.16</td>
<td>0.12</td>
<td></td>
</tr>
<tr>
<td>D - Chinese</td>
<td>6</td>
<td>0.05</td>
<td>0.12</td>
<td>0.14</td>
<td>0.10</td>
<td></td>
</tr>
<tr>
<td>M - White and Asian</td>
<td>4</td>
<td>0.03</td>
<td>0.12</td>
<td>0.10</td>
<td>0.12</td>
<td>0.08</td>
</tr>
<tr>
<td>W - Gypsy/Traveller</td>
<td>4</td>
<td>0.03</td>
<td>0.04</td>
<td>0.03</td>
<td>0.04</td>
<td>0.02</td>
</tr>
<tr>
<td>D - Arab</td>
<td>3</td>
<td>0.02</td>
<td>0.01</td>
<td>0.02</td>
<td>0.01</td>
<td></td>
</tr>
<tr>
<td>M - White and Black African</td>
<td>1</td>
<td>0.01</td>
<td>0.02</td>
<td>0.03</td>
<td>0.02</td>
<td>0.02</td>
</tr>
<tr>
<td>Not recorded</td>
<td>484</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>12,891</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Proportion of an ethnic group that used adult social care services among the total clients who used the service during 2015/16 to September 2018.

** Proportion of an ethnic population aged 65 and above among total population aged 65 and above in Northamptonshire in 2011.

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**Access to Adult Social Care Service in White British aged 65+,** 2015/16 to September 2018  
source: Care First 2018
Delayed transfer of care

A ‘delayed transfer of care’ occurs when a patient is ready to leave a hospital or similar care provider but is still occupying a bed. Delays can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice.

Delayed transfers – also referred to as ‘DTOCs’ or sometimes, often in the media, described as ‘bed-blocking’ – can cause considerable distress and unnecessarily long stays in hospital for patients. They also affect waiting times for NHS care, as delayed transfers reduce the number of beds available for other patients.

NHS England, the body responsible for monitoring delayed transfers of care nationally, defines a patient as being ready for transfer when:

- A clinical decision has been made that the patient is ready for transfer, and
- A multidisciplinary team has decided that the patient is ready for transfer, and
- The patient is safe to discharge/transfer.

As soon as a patient meets these three conditions and remains in a bed, the ‘clock’ starts and they are classified as ‘a delayed transfer’. The definition of delayed transfers of care used by NHS England is very specific. For example, data on delayed transfers does not include delays in transferring a patient between different wards in the same hospital, or between different hospitals, if the patient still requires acute hospital treatment.
Each month NHS England publishes two measures of delayed transfers.

The **total number of delayed days** taken up by all delayed patients across the whole calendar month. Over the last 12 months, delayed days in Northamptonshire have decreased. December 2018 had the lowest number of delayed days and there had been a considerable reduction since September 2018.

![Delayed Days](image1)

Northamptonshire County Council’s Business Intelligence team, February 2019

The number of people delayed on an average day decreased over the year, with a considerable decrease from social care between September 2018 and December 2018.

![Number of People Delayed on an Average Day](image2)

Northamptonshire County Council’s Business Intelligence team, February 2019

Patients can often be delayed waiting for onwards care. For example, intermediate care services occupy an important middle ground between primary and hospital care for patients leaving hospital. These services include bed-based care, rehabilitation and reablement services, which often provide a much-needed ‘step-down’ service for people moving between more intensive hospital care and independent living or social care.
Northamptonshire County Council’s Business Intelligence team create a DTOC performance summary each month, the following are the key performance facts noted in the December 2018 summary, published in February 2019.

- Overall Delayed Days in December (1,901) increased by 39 (2%) compared to the previous month (1,862).
- Overall Delayed Days in December were nearly half (48%) that seen in December 2017.
- Social Care attributable Delayed Days of 788 days in December, were 2% lower than in November (808).
- Social Care attributable Delayed Days were 54% lower than in December 2017 (1,698).
- Jointly attributable Delayed Days of 192 days, were 129% higher than the previous month (84).
- NHS attributable Delayed Days of 921 days for December, were 5% lower than the previous month (970).
- DTOC attributable to Social Care per 100k population for December, ranked 128th out of 151.
- DTOC attributable to Social Care per 100k population for 2018/19 Year to Date ranked 146th.

This metric is now reported as the average number of bed days lost per day in the reporting period.

Health and social care face a nationally recognised issue with regards to DTOCs. The population is aging and over 75s admissions are rising. The main priority though remains getting people home safely and in a timely way and we are working together to reduce these delayed transfers.

There have been considerable improvements in performance from a result of using new real time reporting and planning tools and working in an integrated way with partners. This has had regional and national attention and for social care this means that Northamptonshire has the lowest levels of DTOCs since September 2016.
Carers

It is estimated that over 17,000 people aged 65 and over provide unpaid care in Northamptonshire. Over 6,000 of these unpaid carers provide in excess of 50 hours a week of care. Across the country it is estimated that 11.8% of the female population and 8.9% of the male population provide unpaid care.

Unpaid care has many benefits, as it is often better for the older person receiving care as they will be looked after by someone they know and trust. However, providing unpaid care is often stressful and comes with great sacrifices from the carers. If we wish to continue to promote unpaid care then it is important that the needs of the carer are taken into account and that carers are supported to meet their own outcomes.

There is a small specialist Carer Support Team in Northamptonshire County Council, working to provide information and support to Carers with a range of caring responsibilities, including Young Carers.

Voluntary organisations like Crossroads Care, Age Concern, Speaking Up and Alzheimer’s Society provide individual and group support to Carers and the people they care for, both through independent fund raising and/or on a commissioned basis on behalf of health and social care services.

Commissioned services for Carers in Northamptonshire include Open Access Carers Breaks, Carers Emergency Planning, Carers’ Support Groups and Carers Advocacy, GP Enhanced Services to Carers, and Opportunities after Caring.

National data shows that Northamptonshire has a lower proportion in comparison to the England average of carers aged over 85 who receive self-directed support and Carers who receive direct payments aged over 65 years old.
Service user views

All councils with Adult Social Services Responsibilities (CASSRs) in England must complete an annual postal survey of their clients. This is the ‘Personal Social Services Adult Social Care Survey’ (ASCS). The survey asks clients about their quality of life, how services influence their quality of life and their general health and well-being. The data collected are sent to NHS Digital and are used in national Official Statistics reports and populate some of the Adult Social Care Outcomes Framework (ASCOF) indicators.

The 2017-18 survey looks at clients that were in receipt of council funded long term social care support services on 4th December 2017. These clients make up the ‘eligible population’ for the survey and equated to 6,690 clients. A sample of the eligible population was taken through stratified random sampling. This involved dividing the eligible population into 4 strata and drawing a sample from within each stratum. The 4 strata are:

- Learning disability support, all ages, all settings.
- Any excluding learning disability support, aged 18-64, all settings.
- Any excluding learning disability support, aged 65+, residential or nursing care.
- Any excluding learning disability support, aged 65+, community based services including supported living.

The Adult Social Care Survey data return sheet provides weighted ASCOF outcome scores for measures that are derived from the Adult Social Care Survey. Below is a table showing the outcomes for Northamptonshire in comparison to East Midlands and England averages.

The only indicator that shows Northamptonshire in a considerably worse light is ‘The proportion of people who use services who reported that they had as much social contact as they would like’. This measure of social isolation has shown sharp decline in the past 3 years, down from 47% in 2015-16.

<table>
<thead>
<tr>
<th>ASCOF Indicators – 2017-18 data</th>
<th>Northants</th>
<th>East Midlands</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1A) Social care-related quality of life</td>
<td>19.1</td>
<td>18.9</td>
<td>19.1</td>
</tr>
<tr>
<td>(1B) The proportion of people who use services who have control over their daily life</td>
<td>78.7%</td>
<td>77.7%</td>
<td>77.7%</td>
</tr>
<tr>
<td>(111) The proportion of people who use services who reported that they had as much social contact as they would like</td>
<td>39.7%</td>
<td>48.1%</td>
<td>46.0%</td>
</tr>
<tr>
<td>(3A) Overall satisfaction of people who use service with their care and support</td>
<td>67.7%</td>
<td>63.6%</td>
<td>65.0%</td>
</tr>
<tr>
<td>(3D1) The proportion of people who use services who find it easy to find information about services</td>
<td>73.1%</td>
<td>72.0%</td>
<td>73.3%</td>
</tr>
<tr>
<td>(4A) The proportion of people who use services who feel safe</td>
<td>69.6%</td>
<td>67.4%</td>
<td>69.9%</td>
</tr>
<tr>
<td>(4B) The proportion of people who use services who say that those services have made them feel safe and secure</td>
<td>90.2%</td>
<td>88.7%</td>
<td>86.3%</td>
</tr>
</tbody>
</table>

Northamptonshire has performed better

Northamptonshire has performed worse
Northamptonshire’s [Social Isolation JSNA](#) states that Loneliness is a chronic condition with many impacts on health, it is associated with higher blood pressure and depression and leads to higher rates of mortality, indeed comparable to those associated with smoking and alcohol consumption. It is linked to a higher incidence of dementia with studies reporting a doubled risk of Alzheimer’s disease. Lonely people tend to make more use of health and social care services.
Adult social care 75+ accommodation needs – covering the full market for both private and Local Authority supported individuals

The figures below show the accommodation needs for the over 75 population for each district and Northamptonshire. They have been developed using the published accommodation needs model of University Hallam Sheffield (Housing for Older People Supply Recommendations (HOPSR) https://www4.shu.ac.uk/research/cresr/news/housing-older-people-supply-recommendations-hopsr

Northamptonshire County Council have been able to highlight the gap between the ideal number of accommodation units required for the ONS projected population and the number of currently existing and future pipeline units (Data provided by Districts and Boroughs).

All districts (excluding Northampton) show a current under supply of housing (extra care, age exclusive) and care beds (Residential and Nursing homes).

Due to the increase in population of 75+ (both private and Local Authority supported individuals) between now and 2039 the gap will significantly increase within the County for both Care Homes and extra care/age exclusive housing should no further accommodation be built.

It has been assumed that demand for sheltered housing for rent will not increase. Retirement housing for sale has been included within the definition of age exclusive housing.

Northamptonshire County Council (NCC) has a long-term ambition to significantly reduce the number of older people being placed into residential/nursing care by providing them with a choice of lifestyle including a choice of quality, independent living accommodation.

NCC will work in partnership with the district and borough councils, housing associations and private sector partners to develop specialist accommodation which could be provided in conjunction with its Care and Support in Specialist Housing framework.

It is the aspiration of NCC to enable the development of independent living housing schemes, while reducing the numbers of residential/nursing care placements being agreed through the care pathway. NCC anticipates that the primary delivery mechanism for adult social care accommodation for those aged 55+ will be Extra Care Housing, which involves independent accommodation with 24 hour on site care.

Northamptonshire’s growing elderly population is forecast to generate an increasing demand of Extra Care Housing each year and this is already on top of an existing shortfall. This demand is both for rent and for sale and includes self-funders. NCC will seek nomination rights to a proportion of the new units developed for the customers it funds.

Although NCC’s policy is to enable customers to live in their own homes as long as possible a significant number of older people are placed in care homes, which is not financially sustainable in the long term. To ensure we can address current needs, growing demand, and increasing complexity, we need to move to a model of care that is financially sustainable, whilst also delivering positive outcomes for our customers. Increased access to Extra Care Housing will enable customers
to live in an independent setting with care and will provide an alternative to a care home placement, whilst ensuring customers have better outcomes and maintain or increase independence.

The number of care home required across Northamptonshire is projected to increase as the population ages and NCC intends to work with the care home market to meet the needs of those customers with the most complex needs who are unable to live in a more independent setting.
Recommendations for commissioning

- Promote healthy ageing ensuring recognition of the important of lifestyle service support for all ages and ensure lifestyle services are accessible for older people.
- Support the review of the intermediate care service and a single agreed referral/assessment process/criteria which includes those people living with dementia.
- Prioritisation of early intervention and hospital avoidance in frail patients via promoting healthy ageing, accessible lifestyle services for older people, the Supporting Independence Programme and social prescribing.
- Development of a single pathway across the spectrum of frailty incorporating primary, secondary and tertiary prevention, discharge to assess models, provision of short term care and re-ablement in people’s homes, ‘step down’ beds, integrated discharge teams etc.
- The Local Authority should continue to work with stakeholders and developers to enable new mixed tenure extra care housing schemes and age-exclusive housing to be developed to meet the needs of customers and self-funders.
- The Local Authority should continue to work with the care home market to provide sufficient capacity for those customers with the most complex needs at affordable rates.
- Support GP practices to identify their frail population and ensure there is the development of care plan and medicines optimisation for all those identified as moderate or severely frail.
- Increase awareness and provision of training and information to frontline health and social care workers of social prescribing that can help reduce social isolation and find ways to connect people to activities or organisations that can help.
- Work towards increased specialist dementia care in response to increasing need and to ensure people are able to stay at home for longer; ensure existing services are more integrated.
- Optimising use of the NCC Public Health ‘Supporting Independence’ programme for people living with mild frailty.
Recommendations for further needs assessment work

- Further needs assessments will need to be undertaken to understand disease specific issues. For example identifying the key needs for respiratory and CVD.
- More knowledge is required about the needs of carers in Northamptonshire. A needs assessment should be undertaken.
- It is important to ensure that the needs for older people are identified at a localised primary care network area level when they develop in the future. Specific analysis will need to be undertaken to identify the key needs for each Primary Care Network.
- Undertake analysis with the SHAPE tool to allow a targeted approach to primary care locations to ensure local solutions to fuel poverty are delivered to the populations most in need. GP practices have been identified across the country.
Appendix – indicators from complementary spreadsheet

The accompanying spreadsheet contains a wide range of indicators that need to be read in conjunction with this summary report. There are 186 indicators at County level and 103 indicators for each district and includes data from a range of sources (ie Projecting Older People Population Information, Public Health England and Adult Social Care Outcomes framework). For each of the indicators it is possible to click on the link to view the data and trends in greater detail. A localised RAG system has been developed for the spreadsheet based on significance against the national average and trend direction. This helps to prioritise where specific geographical areas are outliers for a particular indicator. This document highlights the red RAG indicators for each geographical area. An indicator is RAG rated red when it is statistically worse than the England average and the trend is showing that it is becoming worse over time. The indicators that are RAG rated red for each area follow.

Northamptonshire

- % Social Care clients aged 65+ receiving Self Directed Support
- People using social care who receive self-directed support and those receiving direct payments
- Emergency hospital admissions due to falls in people aged 65 and over
- Older people (65 and over) who were still at home 91 days after discharge from hospital
- Social care-related quality of life score - Over 65
- People who use services who have control over their daily life - over 65
- Carers who receive self-directed support - over 85
- Carers who receive direct payments - 65 to 84
- Carers who receive direct payments - over 85
- People who use services who reported that they had as much social contact as they would like - over 65
- People who use services who reported that they had as much social contact as they would like - Female
- The proportion of older people (aged 65 and over) who received reablement/rehabilitation services after discharge from hospital - Female
- People (aged 65 and over) who received reablement/rehabilitation services after discharge from hospital - 75 to 84
- Delayed transfers of care from hospital, per 100,000
- People who use services who feel safe - Female
- Under 75 mortality rate from respiratory disease (Male)
Corby

- Life expectancy at age 65 for males
- Deaths from Respiratory Disease among people aged 65 years and over
- Hip fractures in people aged 65 and over
- Emergency hospital admissions due to falls in people aged 65 and over
- Emergency hospital admissions due to falls in people aged 65 and over - 65 to 79
- Fuel poverty
- Excess winter deaths index (single year, age 85+) (Female)
- Under 75 mortality from all cardiovascular diseases (Female)
- Under 75 mortality from cancer (Male)
- Under 75 mortality rate from respiratory disease (Persons)
- Under 75 mortality rate from respiratory disease (Male)
- Under 75 mortality rate from respiratory disease (Female)
- Under 75 mortality rate from cancer considered preventable (Male)
- Under 75 mortality rate from respiratory disease considered preventable (Female)

Daventry

- Emergency hospital admissions due to falls in people aged 65 and over
- Emergency hospital admissions due to falls in people aged 65 and over - over 80

East Northamptonshire

- Fuel poverty
- Excess winter deaths index (single year, age 85+) (Male)

Kettering

- Fuel poverty
- Under 75 mortality from cancer (Female)
- Under 75 mortality rate from breast cancer
Northampton

- Smoking prevalence in adults (all ages)
- Deaths in usual place of residence among people aged 65 years and over
- Emergency hospital admissions due to falls in people aged 65 and over
- Emergency hospital admissions due to falls in people aged 65 and over - 65 to 79
- Emergency hospital admissions due to falls in people aged 65 and over - over 80
- Under 75 mortality rate from all causes (Persons)
- Under 75 mortality rate from all causes (Female)
- Under 75 mortality from all cardiovascular diseases (Persons)
- Under 75 mortality from all cardiovascular diseases (Male)
- Under 75 mortality from heart disease
- Under 75 mortality rate from cardiovascular diseases considered preventable (Persons)
- Under 75 mortality rate from cardiovascular diseases considered preventable (Male)
- Under 75 mortality rate from cancer considered preventable (Persons)

South Northamptonshire

- Emergency hospital admissions due to falls in people aged 65 and over - over 80

Wellingborough

- Emergency hospital admissions due to falls in people aged 65 and over
- Emergency hospital admissions due to falls in people aged 65 and over - over 80
- Fuel poverty
- Under 75 mortality rate from all causes (Persons)
- Under 75 mortality rate from all causes (Female)
- Under 75 mortality from all cardiovascular diseases (Female)
- Under 75 mortality from cancer (Persons)
- Under 75 mortality from cancer (Female)
- Under 75 mortality rate from respiratory disease (Persons)
- Under 75 mortality rate from respiratory disease (Male)
- Under 75 mortality rate from cardiovascular diseases considered preventable (Female)
- Under 75 mortality rate from cancer considered preventable (Persons)
- Under 75 mortality rate from cancer considered preventable (Female)
- Under 75 mortality rate from respiratory disease considered preventable (Persons)
- Under 75 mortality rate from respiratory disease considered preventable (Males)