Enfield Older People

Living Alone and Social Isolation

Long Term Conditions

Older People with Complex Needs

Health Protection

Social Care Services for Older People

Carers

Falls and Fractures

Dementia

Excess Winter Deaths

End of Life Care
Results from the 2011 Census show that a total of 12,108 adults over the age of 65 reported themselves as living alone. This equates to 31% of the total population of residents aged over 65 in Enfield. The map above shows that areas with higher proportions of older people living alone are predominately in the North West of Enfield, with 15.1% of all households in Cockfosters being lived in by a lone person aged 65 or over, with similarly high proportions in Highlands (14.3%), Grange (13.5%) and Bush Hill park (13.4%).
As the graph above shows, 10.1% of all households in Enfield were occupied by an older person aged 65 or over living alone in 2011. Enfield had the 14th highest percentage across all London boroughs, being higher than the London average of 9.6%, but lower than the England average of 12.4%. Numerically, Enfield had the 5th largest number of households occupied by lone older people in London (12,108 households).

Living alone can increase the likelihood that an older person feels isolated in their community.

Social isolation and loneliness is a key determinant of the current and future health and social care needs of the older population. Loneliness and social isolation have been shown to have significant negative impacts on people’s health status, including a demonstrable effect on blood pressure and a strong association with depression.

It is estimated that about 20% of the older population is mildly lonely and another 8–10% is intensely lonely. 12% of older people feel trapped in their own home, with 6% of older people reporting leaving their house once a week or less. In Enfield in 2011, this could equate to 7,812 people over the age of 65 who are mildly lonely, between 3,125 and 3,906 who are intensely lonely, and 4,687 feeling trapped in their homes.

Given the projected rise in the number of older people both locally and nationally, with Enfield’s over 65 population projected to increase by 38% to 53,998 people by 2030, the numbers of older people that could be expected to be affected by loneliness and isolation can be set to rise significantly.

There are various ‘risks’ for loneliness which may make older people vulnerable to feeling isolated, including:

• Living alone
• Being aged 75+
• Being from an ethnic minority
• Being gay or lesbian
• Living on a low income, or living in an area of high material deprivation
• Bereavement
• Caring or ceasing a caring role
• Poor health or immobility
• Cognitive impairment
• Sensory impairments including sight and hearing loss, or dual impairment

Further information on this topic is available from:
Older People’s Health and Wellbeing Atlas

Long Term Conditions

About 15 million people in England have a long-term condition. Long term conditions or chronic diseases are conditions for which there is currently no cure, and which are managed with drugs and other treatment, for example: diabetes, chronic obstructive pulmonary disease, arthritis and hypertension\(^5\).

Nationally, people with long-term conditions now account for about 50% of all GP appointments, 64% of all outpatient appointments and over 70% of all inpatient bed days, with the treatment and care for people with long-term conditions being estimated to cost £7 in every £10 of total health and social care expenditure\(^6\). Long term conditions are more prevalent amongst older people, with national evidence suggesting that 58% of people suffering from long term conditions are over 60 years of age, compared to only 14% under the age of 40 years\(^7\).

Estimated percentage prevalence of long term conditions by age in Enfield: 2011

Source: APHO 2011 Disease Prevalence Models


\(^6\) The Kings Fund ‘Long term conditions and multi-morbidity’

\(^7\) The Kings Fund ‘Long term conditions and multi-morbidity’
Please note that diabetes prevalence estimates are not available by age band, so have not been included in the graph above.

As the graph above shows, the estimated prevalence of long term conditions amongst those aged 65+ is significantly higher than seen amongst those under 65 years of age. The prevalence of all the long term conditions increases with age, with 16-44 years olds having a lower prevalence of these conditions than 45-64 year olds, and the population aged 75+ years having a higher prevalence than those aged 65-74 years. Enfield’s projected prevalence of these long term conditions amongst over 65s is similar to the prevalence seen across London and England.

More information on the overall prevalence and impacts of long term conditions can be found in the ‘Adults’ chapter.

Further information on this topic is available from:

Cardiovascular Disease Outcomes Strategy
Cardiovascular Disease Profiles
Diabetes Community Health Profiles
Diabetes Prevalence Model
Enfield Joint Dementia Strategy: 2011 - 2016
Interactive Health Atlas for Lung Conditions In England
Kidney Care Profiles
Longer Lives
National End of Life Care Intelligence Network - Publications
NHS Atlas of Variation

Older People with Complex Needs

Introduction including subject of need and overview of topic
Older people with complex needs are: “people aged 65+ who need a lot of support in daily living due to physical frailty, chronic conditions or multiple impairments. Many are affected by factors such as poverty, disadvantage, ethnicity, lifestyle etc”. Such individuals are likely to need help in daily living, regardless of who provides this. It was estimated 7,200 older people (from 38,800 residents aged 65+) had 2+ problems in daily living due to underlying health conditions in Enfield in 2011, and are most likely to need significant support (often from family and friends but also from care services). This section explores:

- Risk factors for acquiring complex needs include: demographics, e.g. a greater number of women aged 85+ have complex needs; often multiple, health factors, with conditions like stroke and dementia influence peoples’ ability in daily living. Some conditions are under-identified in primary care in Enfield or in certain groups, e.g. those in care homes, suggesting a need for better identification and earlier support; and circumstantial factors, e.g. if a carer lives with them, their income, which influence outcomes and who provides or pays for care;
- A socially-defined outcomes framework to describe the needs of older people and how effective formal services are at meeting these needs, whether community-based services, specialist housing and care homes;
- Future demand, and expectations, of support, including the public health’s role in helping to limit (but not reduce) demand due to the ageing population, e.g. it is estimated there will be 20% more older people with significant disabilities in Enfield between 2011 & 2025 if people adopt more healthy lifestyles - but a 30% increase if not.

8 Association of Public Health Observatory (APHO) 2011 Disease Prevalence Models
Key issues and gaps
An Outcomes-Based Approach to Older People with Complex Needs
A framework is used to capture outcomes as a circle of need: feeling safe & secure; feeling healthy, clean & comfortable; feeling valued, respected and in control; being alert, active and engaged in meaningful activities; having company & contact; and feeling involved in the community. Key findings are: people want to remain at home even if it doesn’t fully meet their needs; older people are often anxious about health, but can be resilient in the face of poor or deteriorating health, and some are able to recover in the medium-term; and individuals value company, contact and continuing to do things they enjoy, but the support provided is not always tailored to them, and can focus on personal care at the expense of other outcomes.

Current Support for Older People with Complex Needs
The main source of support for older people is often informal care of family and friends: there was a 13% increase in the number in Enfield between 2001 & 2011, despite no increase in older residents. Many carers are older, and may have health problems themselves, but more could be done to support carers.

Time-limited, intensive Intermediate Care/Enablement Services to promote peoples’ health and independence after illness are effective in improving individuals’ ability to undertake daily living tasks. However, there’s a need for health and social care, and the voluntary sector, to work together to better identify, assess, treat and support people earlier, rather than present at crisis point in which care options may be limited.

The Council funded 3,935 older people to access on-going community-based services and 800 in care homes in 2011/12. There was an encouraging increase in Direct Payment take-up (to 505 out of the 3,935), a form of Council-funded finance provided directly to people for them to choose how to meet their eligible needs, offering greater flexibility and control. However, the vast majority of older people, faced with physical limitations in daily living, currently choose to fund traditional support, like home care, than solutions (e.g. Personal Assistants) which might meet their needs. A large number of older people fund their care privately, and this, together with the large numbers of NHS-funded and residents from outside of the Borough, means Enfield care home occupancy rates are 93%.

Many of the existing and diverse care services in Enfield are of generally high-quality, with high satisfaction levels in their ability to meet many older people’s needs, though this is not always everyone’s experience. As the Care Quality Commission reported nationally, a minority of people feel frustrated – or even are at risk of abuse and neglect - due to the quality of care being inconsistent or inflexible and not tailored to them. However, CQC more positively rated registered home care providers in Enfield than in England. Nonetheless, the Council and NHS jointly need to influence improved care services and encourage development of alternatives, to existing provision.

Recommendations for consideration by commissioners including short and long term priorities - where appropriate to include prevention options
• Improve the consistency, and individuals’ experience, of existing solutions in meeting peoples’ needs, including in accessing meaningful and consistent information and signposting;
• Support public health initiatives to promote healthy lifestyles to reduce the risk of chronic conditions in later life, particularly amongst groups such as women aged 50+ or those from black and ethnic minorities in deprived areas;
• Pro-active identification of older people with key conditions in primary care using risk stratification tools to help those with complex needs (and carers) in a multi-disciplinary integrated care approach at an early stage;

Develop an early preventative response to assessing, treating and helping older people in a multi-disciplinary Older People’s Assessment Unit to improve their health, quality of life and ability to undertake daily living tasks;

Further develop joint intermediate care/enablement solutions across health/social care to meet peoples’ needs, including those who with significant nursing or social care needs; and explore use of joint care solutions;

Develop more outcome-based commissioning of Council-funded social care solutions based on the needs of older people, and ensure they are facilitated to undertake daily living tasks, including by further developing technologically-aided solutions, Personal Assistant-based solutions, and short-break/respite care;

Work with owner-occupiers and Registered Social Landlords to ensure householders can consistently access grants/finance to improve accommodation’s suitability; and to develop older people’s specialist housing options;

Work with partners to improve procurement, governance of contractual arrangements and market management of community-based services and care homes; and to develop market alternatives;

Work with partners to support carers earlier, exploring the potential for carers’ enablement and provide training and support for carers to care for those, e.g. with advanced dementia;

Work with partners to understand, learn from and/or address the different support accessed by different ethnic groups, and ensure all commissioning intentions adequately reflect fairness for all.

Who’s at Risk & Why?

Important factors influencing the risk of people having complex needs are discussed below\(^1\). The greater the number and severity of such characteristics, often the greater the chance an individual will have complex needs.

**Demographic factors**
The risk of acquiring complex needs is associated with age and gender. There were 38,880 Enfield residents aged 65+ (57% female, 43% male), with 5,330 (69% F, 31% M) 85+, in 2011\(^2\). Those aged 85+ are more likely to have complex needs due to this group’s often higher level of multiple conditions and frailty. Some conditions have higher prevalence amongst specific ethnic groups.

**Health-related & Functional Dependency Issues**
Some groups of older people are at particular risk of having complex needs, with many people having a combination of \(^3\),\(^4\):

- Those with significant (often multiple) physical impairments preventing them from undertaking daily living tasks, with the risk increasing significantly if they have 2+ problems in daily tasks, due to frailty or long-term conditions;
- Many health conditions acquired by older people can result in problems in daily living, with many having multiple conditions;
- Those with substantial nursing care needs, including secondary health-related drivers exacerbating peoples’ inability to manage daily tasks, e.g. those suffering from poor mental health, incontinence, hypertension, poor balance (increasing risk of falls), diabetes and sensory, particularly visual, impairment.

**Circumstantial Factors**
These relate to issues about who may support those with complex needs:

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\(^{2}\) ONS Census


• One predictor of whether people will need support from the statutory sector and its intensity is the presence of an informal carer (a family member or friend), particularly living at the same address. Older people with complex needs living alone (with 31% of people aged 65+ living alone in Enfield) and with limited social networks may need help with daily living by the statutory sector, and have problems in accessing information, advice and support;

• Older peoples’ wealth and degree of deprivation: those in deprived areas are more likely to have poor health outcomes, resulting in higher prevalence of conditions and shorter disability-free life expectancy\(^\text{15}\). There are likely to be more very elderly individuals in affluent wards, though older people in deprived wards are likely to be at greater risk of acquiring many conditions than those of the same age in affluent wards. Enfield is less deprived than many London Boroughs, but has health inequalities between wards\(^\text{16}\). Those with lower incomes are more likely to need Council-funded support than those privately funding care;

• Suitability (or otherwise) of accommodation can influence the care needed; but can increase individuals risk of having complex needs, e.g. increasing falls risk.

Current Needs of Older People with Complex Needs and Carers
This section explores the health-related drivers of complex needs, what this mean for problems in daily living; and a more socially-defined analysis of need.

Health-Related Conditions & Functional Dependencies
It is estimated 7,200 people aged 65+ have 2+ problems with daily living tasks in Enfield, and 4,050 have 3+ problems, those likely to have the most complex needs. Individuals can suffer from a range of often multiple conditions but some are more likely to result in daily living problems (Figure 1, which estimates the number suffering from these (diagnosed or undiagnosed) conditions and the number likely to acquire daily living problems as a result\(^\text{17}\)). Table 1 summarises issues for those with these conditions based on national research and best practice.

Figure 1 Number of Older People in Enfield with Several Key Conditions & Their Impact on Daily Living

Source: Rasulo & Rickayzen, 2005

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\(^{15}\) Jagger et al. 2011 The impact of changing patterns of disease on disability and the need for long-term care. Eurohealth, 17(2), 7-10

\(^{16}\) Indices of Multiple Deprivation, 2010

\(^{17}\) Jagger et al. 2011 The impact of changing patterns of disease on disability and the need for long-term care. Eurohealth, 17(2), 7-10
<table>
<thead>
<tr>
<th>Condition</th>
<th>Enfield Numbers</th>
<th>Risk Factors</th>
<th>Impact on Daily Living</th>
<th>Issues for those in care homes or with complex needs</th>
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<tbody>
<tr>
<td>Dementia</td>
<td>2,700 people aged 65+; 1,225 with advanced dementia. 43% of those with dementia on GP registers</td>
<td>Risk increases with age, particularly 80+, women more at risk. Vascular dementia reduced by improved healthy lifestyle</td>
<td>Individuals can exhibit challenging behaviours, wandering &amp; disorientation with night/day cycles. This can lead to problems living with people increasing carers’ stress; Many report loss of family/friends contact; Anxieties from carers living elsewhere about those with dementia living alone at home.</td>
<td>Two-thirds of people with advanced dementia live in residential/nursing care or in supported accommodation, particularly as they develop significant problems in daily living</td>
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<td>Stroke/TIA</td>
<td>410 people 65+ suffer strokes per year, of those surviving 22% with severe problems – 100 older people</td>
<td>Risk increases with age, and men more at risk. Risk reduced by improved healthy lifestyle</td>
<td>Estimated 740 older people suffer stroke and result in long-standing problems in daily living, 535 aged 75+. Older people with stroke living to have particularly disabling problems in daily living tasks, but nearly all will be known to health/social care</td>
<td>Estimated 11% of people 65+ with stroke likely to be admitted to care home due to significant problems in daily living. Estimated 25% of people in homes have had a stroke</td>
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<td>Coronary Heart Disease (CHD)</td>
<td>3,750 people aged 65+. 63% of those with CHD on GP registers, but varies across GP practises</td>
<td>Risk increases with age and men more at risk. Risk reduced by improved healthy lifestyle. Often linked to other conditions, e.g. diabetes</td>
<td>Estimated 1,850 people with CHD with have at least one problem in daily living. A smaller proportion will have 2+ problems of daily living and are those most likely to need support – particularly those older.</td>
<td>Risk – and the severity of its impact – increases markedly with age, particularly for those aged 80+</td>
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<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>4,190 people aged 65+, 880 have severe COPD. 31% of those with COPD on GP registers, but varies across GP practises</td>
<td>Risk increases gradually with age; men more at risk. Risk reduced by improved healthier lifestyle. Often linked to other conditions, e.g. diabetes</td>
<td>Those with more severe COPD are most likely to have significant problems in daily living, with virtually all in this category having problems of daily living associated with physical activities, e.g. getting up stairs or around the house: 30% of those with severe COPD – around 265 will need assistance because they won’t be able to perform any daily living tasks. A proportion of these individuals are therefore likely to admitted to care, though this will be dependent on their circumstances (e.g. living alone), and will often have other conditions.</td>
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<td><strong>Musculo-skeletal (MSK) Disorders</strong></td>
<td>18,000 people 65+ have osteoporosis (2% of population), osteoarthritis (34%) or rheumatoid arthritis (2%)</td>
<td>Risk increases with age for many conditions, notably osteoporosis (25% of those aged 80+ affected). Women more at risk than men.</td>
<td>Those with more severe MSK disorders most likely to have significant problems in daily living, with 9,850 older people estimated to have pain in 3 or more joints. 70% of people (6,900) have at least one problem in daily living, with 40% of these needing help from someone else to carry out living tasks. People with the conditions, particularly osteoporosis, likely to be at risk of falls and fractures, including fracture neck of femur. Individuals risk in daily living increases if they have MSK disorders and other conditions such as dementia.</td>
<td>Estimated 10% of older people in care homes live with Parkinson’s Disease, although research suggests more people could be supported at home.</td>
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<td><strong>Parkinson’s Disease</strong></td>
<td>400 people aged 65+, with 150 in later stages of disease. Estimated 30%-40% can be undiagnosed</td>
<td>Risk increases with age, particularly 80+; men 1.5 times more at risk. Often linked to other conditions, e.g. dementia</td>
<td>Individuals particularly in later stages of disease will have severely limited functional abilities (e.g. restricted mobility and loss of balance) and in which they need intensive support in daily living.</td>
<td>25% of people in care homes likely to have condition, though only around half have a diagnosis.</td>
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<td><strong>Diabetes</strong></td>
<td>5,000 people 65+ have diabetes</td>
<td>Risk increases with age and men (15%) more at risk. Risk reduced by improved healthy lifestyle. Often linked to other conditions, see above</td>
<td>Condition is secondary driver of underlying health conditions</td>
<td>Falls contribute up to 20% of care home admissions in Enfield. Their residents are more likely to fall than those living in community due to their frailty, and unfamiliarity of home to new residents, e.g. with sight loss or dementia. 60% living in homes have recurrent falls each year, with up to 25% resulting in hospitalisation.</td>
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<td><strong>Falls</strong></td>
<td>Estimated 10,925 older people who had falls in 2012</td>
<td>Risk increases with age – 23% of people 65–79 have falls, 36% 80+; falls risk greater amongst men than women. Risk increases with conditions affecting mobility &amp; balance, e.g. MSK, Parkinson’s.</td>
<td>736 residents 65+ (616 75+) admitted as hospital emergency due to falls in 2011/12. 23% resulted in hip fracture, which has significant impact of people’s lives: 50% never regain former abilities and 20% die in 3 months</td>
<td>Facilities in Enfield are more likely to fall than those living in community due to their frailty, and unfamiliarity of home to new residents, e.g. with sight loss or dementia. 60% living in homes have recurrent falls each year, with up to 25% resulting in hospitalisation.</td>
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<td>Incontinence</td>
<td>8,000 people aged 65+ with bladder problems, with 80% having problems regularly. 1%-2% of those 65+ (600 people) living at home have problems with double incontinence</td>
<td>Risk increases markedly with age – 75+ for men, 80+ for women (one-third aged 80+ have bladder problems). Risk increases with problems of mobility, stroke and dementia</td>
<td>(Particularly faecal) incontinence has detrimental impact on individuals’ life quality &amp; self-esteem, though people affected can believe it is part of being older despite treatment available. People can be reluctant to seek advice &amp; treatment. Incontinence often under-recognised, and nationally care professionals can sometimes manage rather than treat underlying causes. Incontinence is a driver of need for assistance with personal care amongst those with complex needs, and can contribute to carers’ physical &amp; emotional stress</td>
<td>Can be under-recognised in care homes, due to insufficient assessment and treatment. Nationally, 40% of older people in care homes, hospitals and among those with severe disabilities suffer incontinence, twice as high as people living at home</td>
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<td>Hypertension</td>
<td>22,500 people 65+ have high blood pressure &amp; 4,100 people aged 85+. Often under-diagnosed 61% of those with hypertension on GP registers, but varies across practices</td>
<td>Risk increases with age and men (15%) more at risk. Risk reduced by improved healthy lifestyle. Often increases risk of other conditions, e.g. stroke</td>
<td>Condition is secondary driver of underlying health conditions</td>
<td>Can be under-recognised in care homes: nationally, there are lower hypertension diagnosis rates amongst older people living in residential/nursing care than at home due to under-recording</td>
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<td>Depression</td>
<td>6,200 people 65+, with 1,215 having severe depression. Depression in later life often under-recognised &amp; undertreated - can be seen as secondary to other conditions (&amp; people reluctant to seek help)</td>
<td>Rates of severe depression higher amongst those aged 85+ (4%) than 65+ (2%). Many people experience emotional distress due to factors linked to old age, e.g. poor health, feeling isolated, losing independence &amp; bereavement</td>
<td>Carers can become depressed due to stress of caring roles, heightening risk of breakdown. Self-help strategies to improve well-being, e.g. regular exercise, having company &amp; contact become increasing difficult as older people develop more complex needs</td>
<td>Older people living alone, in care homes and/or those with physical disabilities are most at risk, with an estimated 40% affected by depression in care homes</td>
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<td>Visual Impairment</td>
<td>3,525 aged 65+, 2,345 aged 75+. 1,210 have registrable eye disease, though under-diagnosed (680 on register), despite 50% of sight loss cases treatable</td>
<td>Risk increases with age. Age-related macular degeneration most common reason for sight loss. Risk reduced by improved healthy lifestyle, e.g. reducing smoking. Risk increases due to other conditions, e.g. hypertension</td>
<td>Impact of acquired sight loss on daily living significant, with many people having to adjust their lives. People with sight loss twice as likely to have multiple falls, with odds of hip fracture 1.6 times greater. A third of those with sight loss have depression, a far greater level than the population.</td>
<td>Risk of falls and fractures increase significantly if individual has to navigate an unfamiliar environment such as a care home. At least third of older people in care homes have sight loss – a far higher level than in the community.</td>
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Older People with Complex Needs: an outcomes approach

Figure 2 shows an outcome framework developed with older people. Some outcomes, e.g. feeling safe, are more basic than other higher-order ones (e.g. feeling involved in the community). Key issues are:

- People's sense of safety improves if they live in good, accessible and warm accommodation. Familiarity and attachment underpins this, especially for those with cognitive or visual impairment, but poor or unfamiliar environments impacts on health and independence;
- The vast majority of people want to remain in their homes for as long as possible, even if this doesn’t fully suit them. A small minority would prefer to live in well-designed supported housing “with a front door” as an alternative;
- People are concerned about deteriorating health, particularly loss of memory and over bodily functions. Older people are often resilient in managing health, and can live positively with its impact. Some people with complex needs have the capacity to improve health and independence in the medium-term, but this may be under-recognised by professionals;
- People report they can feel like passive healthcare recipients. Support can focus on managing individuals’ personal care, safety and comfort, particularly in care homes, at the expense of higher-needs;
- Older people, including those with dementia, reported sustaining personal relationships with partners, family and friends, is important to them, and a significant factor in sustaining emotional well-being and identity;
- People need to feel valued and respected for who they are and their life experiences, emphasising the importance of identify and self-esteem in promoting life quality - an enabler is feeling in as much control, or able to hold on to parts, of their lives, e.g. having choices in their care;
- Many people reported they found it hard to adjust to being dependent, though most reported they would prefer their family to be involved in their care but were concerned about “being a burden”, though with greater expectations of spouses;
- Older people often worry about having sufficient money to remain independent and enjoy a good quality of life now or in the future.
- Many report they found access to information haphazard, tending to receive, rather than seek information (notably at a crisis) and don’t always find its accessibility, quality and consistency good;
- Older people report they want to feel they have a sense of purpose through roles, activities, relationships or their home, despite the difficulties they face. Not having this can result in poor mental well-being or depression;
- Retaining existing social support networks (friends or families) or developing new ones in shared activities or communal settings is important. This can be difficult if an individual develops conditions which they or others perceive as having a stigma, e.g. dementia or incontinence;
- Older people, including those with dementia, reported being able to get out and about as important. Opportunities to experience familiar sights, smells, music and touch can benefit those with advanced dementia;
- Some people can continue with responsibilities or take up new ones if given practical help and encouragement, but these opportunities aren’t always afforded to them.

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19 Williamson, 2010, My Name is not Dementia: people with dementia discuss quality of life indicators. Alzheimer’s Society
21 Blood et al. (2010) Equality and diversity and older people with high support needs
23 Bowers (2009) Older people’s vision for long-term care
24 Bowers (2009) Older people’s vision for long-term care
28 Bowers (2009) Older people’s vision for long-term care
Needs of carers (family and friends) of older people with complex needs

There was a 13% increase to 27,624 in the number of people providing unpaid care to an adult between 2001 and 2011 in Enfield, and a 28% increase to 6,194 in the number providing 50+ hours per week.\(^{30}\) This is due to an increase in the severity of the daily living problems older people face, as the number of older people in Enfield remained unchanged over this period.

Many carers are spouses of older people with complex needs they care for and live in the same household: such carers often have the most intensive caring responsibilities. It also means individuals are less likely to receive as much statutory support as those without access to such carers, and are at less risk of admission to hospital or care homes.\(^{31}\) Older carers often have their own care needs – 80% of carers report their caring responsibilities had an adverse effect on their health.\(^{32}\) Younger adult carers often have differing needs than older carers: they may have other calls on time and resources. Older people feel they are becoming a burden; though many expect, and receive support, from their families.\(^{33}\)

Meaningful and timely access to information, advice and solutions (including helping managing Direct Payments) fitting around carers’ own needs is important in sustaining a caring role. There is also a need to build on the help available to carers in caring for some groups, e.g. those with advanced dementia with challenging behaviours.

Current Solutions for Older People with Complex Needs and Carers

It should be acknowledged that carers – family and friends – continue to provide most of the support to those with complex needs. However, a variety of other support exists to help individuals. This section explores the availability of these solutions, their take-up and effectiveness in meeting needs.

Voluntary Sector Support

Enfield’s voluntary sector organisations provide a range of solutions to support the diverse population of older people, including those with complex needs, and carers. Examples (amongst many others) include day and social networking opportunities, counselling and dedicated workers (e.g. to support those with dementia) for older people provided by Age UK, Alzheimer’s Society, Enfield Asian Welfare Association, Enfield Carers’ Centre and many other organisations. The sector has an invaluable role in helping people access information, providing advice and guidance through what some people can feel is a complex care system.

Short-Time Intermediate Care & Enablement

The NHS and Council provide Intermediate Care and Rehabilitation Services (NHS: Barnet, Haringey and Enfield MH Trust) and Enablement Services (in-house Council Service) (Table 1). The purpose of these short-term, intensive interventions is to help people regain their ability to undertake daily living tasks as part of recovery from illness after discharge from, or to avoid admission to, hospital. The services involve a range of professionals working together, e.g. Occupational Therapists (OTs), physiotherapists, nursing staff, enablement assistants and social workers. As well as improving individuals’ daily living skills, another objective is to reduce the need for, and intensity of, long-term care or emergency hospital admission. Both services are effective in meeting these objectives, e.g. 88% of older people discharged from hospital between Oct-12 and Dec-12 to these services continued to live at home 91 days post-discharge, better than the average for England. Feedback from customers was also very positive, with people reporting they felt involved in planning their short-term support and it had a longer-term benefit, e.g. 92% of those accessing the Intermediate Care Team reported they had improved their independence in Oct–Dec-12.

\(^{29}\) Blood (2010) Older people with high support needs: how can we empower them to enjoy a better life  
\(^{30}\) ONS Census  
\(^{32}\) Enfield Carers’ Strategy, 2013  
\(^{33}\) Allen, Outcomes-Based Commissioning for Integrated Care for Older People: Consultation, 2013
### Table 2 – Discharges from Intermediate/Care & Enablement Services in Enfield Apr-Dec-12

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Number of People Discharged</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermediate Care Team</td>
<td>925</td>
</tr>
<tr>
<td>Community Rehab Stroke Team</td>
<td>166</td>
</tr>
<tr>
<td>Enfield Community Services (for Stroke Rehab)</td>
<td>40</td>
</tr>
<tr>
<td>Enablement Service for those aged 65+</td>
<td>952</td>
</tr>
<tr>
<td>Total (NB: Some people may access more than one service)</td>
<td>2,083</td>
</tr>
</tbody>
</table>

**Integrated Care across Primary and Secondary health care and social care**

GPs, community-based nursing and hospital-based hospital staff such as geriatrician consultants and social workers are working more closely together as part of an approach to better coordinate management of the cases of older people with the complex needs and their carers (integrated care). Further development of integrated care is anticipated in 2013/14 (see Commissioning Intentions), but this multi-disciplinary approach is being successfully rolled out to identify, target, treat and help those primary care patients most at risk of hospitalisation in several GP surgeries in the Borough.
Figure 2 Summary of Needs of Older People with Complex Needs

- Need to sustain existing social networks or establish new ones, including with peers, to avoid social isolation
- People see good relationships with formal carers & professionals as important
- Structured & communal activities can be important in promoting social networks
- Lack of stimulation/interests can result in demotivation or depression leading to poor outcomes
- Need to support people to participate in activities previously enjoyed; or develop new interests
- Sense of purpose key to ensuring people mentally stimulated
- Respecting individuals’ views & diverse social, cultural etc. needs key to individuals’ retaining self-esteem
- Greater scope for people to choose opportunities to fulfil their needs associated with greater financial resources
- Lack of meaningful, accessible information biggest barrier to choice & control different mechanisms for different groups
- Control over daily needs important as endor, e.g. in drive to live at home, if flexible & built on care relationships
- People recognising becoming more dependent on others, but don’t want to feel a burden
- Sustaining existing & meaningful relationships and memories vitally important
- People & carers need reassurance people can live safely
- People & carers would like suitably adjusted accommodation, if do move, they want own front door
- People can feel like passive care recipients
- Combination of conditions increases complexity of needs
- Peoples’ resilience in coping with health issues under-recognised – also some have capacity for long-term improvement of health & abilities
- Focus often to meet personal care needs – at expense of other needs?
- Concerns over future health: cognitive impairment, incontinence & mobility, People motivated to improve health
Impact of Enablement and Long-Term (On-going) Community-Based Services

There was no increase in the number of older people with community-based services in 2012 because the increase in the number receiving enablement helped limit the number who needed long-term care. Some 60% of those accessing enablement needed no long-term care, though some would not have needed such care without enablement (although even small improvements in people’s ability to do daily living tasks can improve quality of life). In fact enablement is likely to help remove the need for long-term care for those who would otherwise need it in 25%-30% of enablement cases, whilst it is also effective in helping reduce the intensity of the on-going care for those with complex needs.

The Council has a Community-Based Service (with social workers and OTs) to work with people with long-term conditions to assess their eligible needs within the Community Care Act. The Service works with people to develop care plans tailored to needs and preferences, including those self-funding care. Each plan for those eligible has a Personal Budget to allocate finances to meet needs, with individuals deciding to take this finance directly (via a Direct Payment) or to allow the Council to manage their budget. The Brokerage Service can assist people to choose a provider right for them.

Table 2 discusses the number of older people provided with different Council-funded services. The number of older people receiving a Personal Budget increased from 705 to 2,380 between ends of Mar-10 and Mar-12, whilst the number choosing a Direct Payments increased from 155 to 505. This means 60% of older people with on-going community-based services received a Personal Budget/Direct Payment at end Mar-12, with 22% of those with such services choosing Direct Payments. However, many older people, faced with physical limitations in daily living, choose to fund more traditional support, e.g. home care, than Personal Assistants: the issue is whether these payments helped them exercise greater choice, flexibility and day-to-day control with these providers.

The Council undertook a User Survey of those receiving Council-funded community-based services in 2011/12. The results are for all adults, though 65% of those surveyed were 65+. Some 83% of respondents reported receiving care from carer(s), with 39% reporting a carer lived with them. More respondents reported experiencing problems with bathing/showering than washing hands/face, perhaps due to problems in accessing showering facilities at home. Their perceptions of their health seemed to reflect the Needs Section’s findings: many were concerned about it – 60% anxious or depressed – but tended to be relatively resilient, e.g. 75% reported their health as “fair” or “good”.

Figure 3 Summary of Results from Service User Survey 2011-12 about rating aspects of life

<table>
<thead>
<tr>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling Clean and Presentable</td>
<td>% of Respondents (Net Satisfaction = Positive - Negative)</td>
</tr>
</tbody>
</table>

Source: London Borough of Enfield
Please note: Some of the questions in the Service User Survey include the option of a neutral response, i.e. neither positive nor negative. These neutral responses have not been included in the graph above, and as such, not all of the above bars total 100%.

Table 3 – Number of people aged 65+ receiving Council-funded support in 2011/12 - (NB: People can access more than one service in their care plan, e.g. home & day care)

<table>
<thead>
<tr>
<th>Type</th>
<th>Service</th>
<th>Number</th>
<th>Service &amp; Impact</th>
<th>Additional Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing community-Based Services</td>
<td>Home Care</td>
<td>1,780</td>
<td>Home care helps those who need help with daily tasks (e.g. getting out of bed and personal care). Council commissions private-sector home care providers to provide care to households privately. Of 1,220 people provided with Council-funded home care per week, 46% had 10+ hours reflecting intensity of care needs, with 7% receiving &lt;2 hours. Service needs to be tailored to daily needs &amp; longer-term needs to help people retain independence. As nationally, peoples’ experience of home care isn’t consistent, despite generally good quality care.</td>
<td>Enfield’s home care market contained 36 CQC-registered private- &amp; voluntary-sector providers in 2010, 12 CQC-rated as “excellent”, remainder “good”, i.e. generally higher &amp; consistent quality standards than nationally. Local homecare market can respond to most customers’ needs, reflecting much of diverse cultural needs with more specialist providers targeting communities, e.g. Asian, Cypriot &amp; Turkish. Council contracts with 4 home care providers as part of management of customers' care plans. However, customers can use Direct Payments or privately fund support from 36 local providers should they wish, as many older people do. Providers have capability to address needs of people with dementia, stroke &amp; palliative care.</td>
</tr>
<tr>
<td></td>
<td>Day Care</td>
<td>490</td>
<td>Day care, day opportunities &amp; social networks provide opportunities to help promote social inclusion. They could be funded directly via Council (e.g. via Direct Payments) or provided by voluntary sector which Council grant assists.</td>
<td>Older people with complex needs may value more structured day care activities with Council &amp; voluntary sector running different groups, including for specific specialist groups, e.g. those with dementia.</td>
</tr>
<tr>
<td></td>
<td>Meals</td>
<td>165</td>
<td>Meals are provided via Council contracting with voluntary sector.</td>
<td>Voluntary sector also provides grant-assisted luncheon clubs for older people.</td>
</tr>
<tr>
<td></td>
<td>Short-Break Care/Respite</td>
<td>25</td>
<td>Short breaks, short-term care, or respite services arranged over a period, e.g. if someone is recovering from illness and needs interim placement between hospital and home; or to help carers take a break, with care provided for those they care for. Short-breaks can be provided in peoples’ homes or in Council-run or private residential care.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Direct Payments</td>
<td>650</td>
<td>See above discussion of Direct Payments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Professional Support</td>
<td>25</td>
<td>This relates to routine involvement of social care professionals in the Case Management Service outside of assessment/review. Professional support is most likely to form part of the care plans of individuals with complex needs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Equipment or Minor Adaptations</td>
<td>2,745 (maintained items)</td>
<td>Council &amp; NHS Enfield commissioned a Council-run Integrated Equipment Service, to provide or install equipment, e.g. beds, grab rail, bath lifts etc, with equipment prescribed by care staff. In 2012, Council or NHS prescribed 7,920 one-off or maintained items, of which 96% were delivered in 7 working days. OTs can advise specialist equipment for those with more complex conditions.</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>60</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>3,935</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: RAP Return, HSCIC

The Survey results showed a high level of satisfaction with services and the outcomes they helped achieve (Figure 4), with 91% saying services helped improve quality of life. At +87%, net satisfaction of respondents (i.e. the difference between those positive compared to those negative) with their care was extremely high.
Most were positive about their needs being met, regardless of which aspect of need. However, respondents were more positive about the basic needs of feeling safe and secure (net satisfaction: +89%) than higher-order needs such as having control over their daily living (+43%). People are more likely to believe services help keep them safe and secure (70%) than, e.g. helping maintain social contact (38%), suggesting older people’s expectations of services are centred on personal care. People were likely to report their home was suitable to meet their needs (+66%) than one might expect given over half reported they had problems getting around their homes or in bathing/showering, emphasising peoples’ attachment to their homes. Respondents were least likely to believe they could get about in the local area (+6%) with 23% stating they were unable to get out.

**Housing & Specialist Accommodation**

It was estimated 79%, 73% and 65% of people aged 65-74, 75-84 and 85+ owned their homes in Enfield in 2010, although there were variations across wards. Nearly 5,400 residents with a long-term illness were owner-occupiers, compared to 1,640 renting social housing. Table 3 summarises some key facts about more housing related support for older people in Enfield.

**Table 4 – Housing Related Support Services in Enfield**

<table>
<thead>
<tr>
<th>Service</th>
<th>Metrics</th>
<th>Description</th>
<th>Additional Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Alarm &amp; Tele-care Service (Assistive Technology: AT)</td>
<td>2,850 households provided with AT in Enfield in 2012. 141 of households had people with ongoing care packages – 6% of latter total</td>
<td>Council has in-house Community Alarm &amp; Tele-care Service providing households &amp; personal alarms/sensors, e.g. property exit sensors, personal alarms, fall detectors etc. to provide reassurance to people</td>
<td>Potential for more widespread use of Tele-care amongst those with complex needs and ongoing care. Evidence nationally early introduction of Tele-care to support those with moderate needs can result in positive benefits in maintaining people at home longer.</td>
</tr>
<tr>
<td>Minor Repairs &amp; Adaptations through Disabled Facilities Grant (DFG)</td>
<td>In 2012/13, 330 households helped with minor repairs via Age UK’s Handyperson Service. 156 DFG applications in 2012/13</td>
<td>Council has in-house Care &amp; Repair Service to improve housing for vulnerable people. It has home improvement function to signpost people for help with minor repairs to properties including making sure they are safe (e.g. reduced risk of falls). Service provides DFGs for those people assessed to need property adapted to live at home.</td>
<td>Potential for greater use of this service for older people with complex needs</td>
</tr>
<tr>
<td>Sheltered Accommodation</td>
<td>2,120 units (70% for social rent) of in 2010, with Enfield Homes &amp; other Register Social Landlords (RSL) and private providers providing 832 &amp; 1,288 units</td>
<td>Recognise significant proportion of Enfield Homes sheltered accommodation needed re-development or replacement, e.g. 14/38 schemes were lifted to allow access to upper floors in 2010. Enfield Homes initiated long-term development to improve housing, including sheltered accommodation.</td>
<td>Council financially supported number of RSL sheltered accommodation schemes via housing-related support funding. Sheltered accommodation fairly evenly distributed across Enfield. Areas with high populations of people with support needs, e.g. Highlands &amp; Cockfosters, well served. Some areas less well-served for high-quality accommodation: NE Enfield (e.g. Turkey Street), South Central Enfield (e.g. Bush Hill Park), &amp; SE (e.g. Upper Edmonton) &amp; SW Enfield (e.g. Southgate).</td>
</tr>
<tr>
<td>Specialist Housing</td>
<td>217 units of specialist housing (“Extra Care”) in 2010, 123 for social rent, but others available for market rent and ownership</td>
<td>Specialist housing provides individuals with their own front door, but also provides home care to support people with complex needs with daily living, e.g. personal care 24/7</td>
<td>Specialist housing distributed chiefly across Enfield’s southern wards: Lower Edmonton (10 units), Edmonton Green (10); Enfield Highway (10); Jubilee (45); Winchmore Hill/Palmers Green (48); Southgate (73); Southgate Green (21). Some West &amp; Central wards not well served. Priority to work with partners to develop solutions in these areas</td>
</tr>
</tbody>
</table>

**Permanent Residential & Nursing Care**

Despite older peoples’ preference to stay at home, people and families can feel those with complex needs cannot continue to live at home because they have (Mainwaring, 2011):

- Reached a crisis (e.g. a hospital admission), or an extended period, in which individuals’ health condition(s) deteriorate resulting in significant impairment to their ability to undertake living tasks;
- A significant change in circumstances (e.g. death of a spouse caring for them);
• Carer fatigue, i.e. carers feeling they can no longer cope with the needs of those they care for

People with complex needs may become known to the Council relatively late, at which point their care options may feel limited. Some of these situations could have been prevented, or their impact reduced, if individuals and families received consistent and meaningful information, advice, person-centred planning and support earlier34: in Enfield, just under half of those admitted to care homes in 2012/13 were either not known previously to the Council or who had received a Council-funded community-based service no more than 2 months prior to admission.

Enfield has a large residential and nursing care home sector (Table 2). Those individuals in care homes are a mixture of Enfield Council-funded customers, those funded via NHS Continuing Health Care, those funding their care privately (“self-funders”) and other Boroughs’ residents. The Council also places Enfield residents out-of-Borough if that is what they prefer, e.g. nearer their families.

Despite the increased demand from people with complex needs, the number of older people admitted to Council-funded care homes declined by 20% to 205 between 2008/09 and 2011/12, as more people were supported at home. This suggests future increases in the number of people with complex needs to 2020 may not necessarily result is the same level of increase in the number of placements as more people can be supported at home. The Council and NHS will need to manage the local market to meet demand, but also continue to support more residents to live at home. In fact, business analysts report they expect market growth in specialist accommodation (not residential care) and NHS- or self-funded nursing/dual-registered care over the next 3 years. The needs of people in residential care are likely to become more complex, whilst those in nursing homes are likely to need more intensive nursing, though differences between residents using these two types of care homes has blurred, with a greater number of dual-registered homes35.

The average age of Enfield residents admitted to care is around 84-85 years, whilst most people admitted – nearly 60% - were diagnosed with dementia. Around a third had musculoskeletal conditions and a further third had hypertension, with proportionately fewer older people admitted due to stroke/TIA (17%), coronary heart disease (10%) or COPD (5%). The proportions suffering from diabetes (16%) or incontinence (15%) is likely to be an under-estimate due to poor recording on social care systems or under-diagnosis of these conditions (see Needs Section).

Nationally, the Care Quality Commission highlights the quality of care in care homes is generally improving. Many older people benefit from a well-managed, suitable and supportive home environment in which well-trained and dedicated staff meet individuals’ needs in the way that values them, how they prefer to live and how they want this support delivered. However, nationally this is not this everyone’s experience of living in a care homes, with the quality of care inconsistent or inflexible, and individuals not always benefiting from personalised support36.

Evidence of Effective Interventions

This document draws on Department of Health evidence-based policy since 2000, which emphasises the need to help people at an early stage to improve their health and independence to ensure chosen solutions are tailored to their needs; academic studies; and best practise from other Councils.

Equality Impact Assessment

This document focuses on the needs of specific groups in Enfield, notably those who acquire life-limiting conditions (and disabilities) as they age. The needs of people with life-long (e.g. learning) disabilities will be included in other section of the Enfield JSNA. This document also analyses issues associated with age and gender, recognising women aged 85+ are more likely to have complex needs.

Research suggests older people from South East Asian backgrounds in the UK are 3 times, and those from black backgrounds are 60% (reflecting a typically higher level of deprivation amongst this group), more likely to develop disabilities than those from white backgrounds37,38. The proportion of older people from

34 The Wanless Review: Securing Good Care for Older People – Taking a Long Term View (2006), The Kings Fund
36 Care Quality Commission (2013) State of Care 2012/13
different ethnicities who received Council-funded community-based services is statistically representative of Enfield’s ethnic groups. However, there were fewer people from ethnic groups other than white European in care homes than one would expect given their proportionately higher levels of disabilities. This is an area for further exploration: it may be those from some ethnic backgrounds are more likely to be supported by family networks or because they may be less able to access meaningful information and advice about care options.

Public and user/patient and carers views
The results from this research are incorporated in the relevant sections, e.g. qualitative research with individuals; and User Surveys about Council-funded care.

Future Needs
Figure 6 shows indicative projections of the number of older people with significant disabilities (driven by individuals acquiring health conditions) and thus problems in daily living in Enfield to 2025\(^39\). Disease prevalence will vary depending on changes to population health lifestyles, e.g. reduced obesity and increased physical activity. Figure 6 shows differing public health scenarios. Improving lifestyles amongst those aged 50+ (including those living in deprived communities will reduce the risk of people acquiring diseases at each age group, but even if health programmes are successful, it will act to limit, not reduce, the number of those with disability by 2025 due to a greater number of older people forecast to be living in Enfield. However, the difference between improving and worsening public health scenarios equates to over 10% in the differing numbers by 2025.

Figure 4 Likely Increase in the Number of Older People with more Significant Disabilities in Enfield under Different Scenarios

![Graph showing likely increase in the number of older people with more significant disabilities in Enfield under different scenarios.](image)

Source: Jagger et al 2011 applied locally as part of amends to Wanless review

The “no change” scenario shows disability drivers will be due to increased prevalence of musculoskeletal disorders (50% between 2010 and 2030), heart disease (50%), dementia (80%), diabetes (44%) and stroke (57%). The proportion of people aged 85+ years with significant disabilities is expected to increase by 14% and 45% under this scenario to 2,145 and 2,730 by 2015 and 2025.

Given current trends, it is likely the number of people providing unpaid care will continue to increase, with a greater number of older carers. However, this rise is unlikely to be at the same rate as the number of people with problems of daily living\(^40\), with more people living alone as they enter old age. This will mean a greater proportion of older people with problems in daily living will need to self-fund, or rely on the state to fund, formal care over the next 10 years.

The expectations and assets of households with older people are likely to change over the next decade. This will have many positives, including people benefiting from greater (and technologically-enabled) choice about high-quality and personalised solutions available to them, including greater use of Personal Assistants and Direct Payments. Another trend is the extent to which the older people will have greater assets with which to support their care needs, although wealth won’t be evenly distributed across all families and communities in Enfield given the economic downturn.

Unmet Needs, Gaps & Inconsistencies in Support

Many support solutions in Enfield are of high-quality, highly valued and improve older peoples’ independence, well-being and quality of life. However, two key improvement areas are:

- **Ensuring existing solutions are accessed by those who may need them**, which is dependent on meaningful and consistent advice, information, guidance and signposting being available;
- **Ensuring everyone accessing existing services consistently experiences high-quality support centred on their and their carers’ needs**

Further areas for consideration are:

- **Improving health outcomes for those aged 50+** to limit the number of those with complex needs (and severity of disabilities) and ensure older carers are healthier;
- **Early Identification**: Care solutions often focus on meeting people’s needs once known. Many people have good experiences of support, but some present at crisis in which options are limited;
- **Coordination of health and social care solutions**: Individual services are of high-quality, but people don’t always experience as seamless a pathway of support as they could. Areas to consider are:
  - A more coordinated approach across primary and secondary health and social care, in collaboration with the voluntary sector, to identify, assess, treat, signpost and support older people with complex needs at risk of admission to hospital and/or care homes;
  - Improved access to, coordination across and support options associated with time-limited intermediate care, including wider deployment of technology to support vulnerable people and better access to step-down/step-up solutions;
  - As nationally, the difference between social and health care has begun to blur, e.g. home care staff able to perform basic nursing tasks; or the Council’s Community Alarm Service acting as “first-responders” to residents rather than paramedics. However, there are cross-organisational risks that need to be appropriately governed in such arrangements.
- **Available care solutions are not always meeting, or developed to meet, the ongoing requirements of older people**: Care solutions may be better at meeting basic outcomes than fulfilling higher-order needs. This is often appropriate because some services are designed or contracted to serve part of people’s needs, but older people are less likely to use Personal Assistants, which may provide opportunities to meet their needs more comprehensively, than younger adults with disabilities. Existing ongoing services also don’t reflect the fact some older people can improve living skills in the medium-term, with an emphasis on services doing, rather than facilitating, tasks;
- **Better utilisation or development of housing-related solutions for older people**;
- **Support for Carers of Older People with Complex Needs**: Many carers benefit from the support provided, but improvement areas are to better recognise and encourage particularly older carers to get help before a crisis and work to improve access to information, advice, guidance and solutions, including reassurance help is close at hand if they or the person they care for need it;
- **Better Manage Care Markets** building on existing engagement to ensure providers are able to meet the needs of older people. Despite many having high-quality services in Enfield, more could be done to improve providers’ consistency and quality, and how alternatives could be developed;
- **Consider how existing or new solutions can be made more accessible to, and meeting the requirements of, all older people with complex needs**.

Recommendations for Commissioners

The following commissioning possibilities for older people with complex needs are emerging based on the principles of pursuing preventative solutions in the resources available to families and organisations that can help them:
• Work with others to improve the consistency, and individuals’ experience, of existing solutions in meeting their needs and preferences;
• Develop public health initiatives to promote healthy lifestyles to reduce the risk of chronic conditions in later life amongst groups at risk, e.g. women aged 50+ in deprived areas of Enfield;
• Improve pro-active identification of those who may have key conditions or are at risk of poor outcomes (and carers) via a multi-disciplinary care approach, including with the voluntary sector, before crisis by combining local intelligence with a risk stratification tool41;
• Develop early preventative response to assessing, treating and helping those with complex needs in a multi-disciplinary Older People’s Assessment Unit to improve their health and independence;
• Further develop joint intermediate care/enablement solutions across health/social care to meet peoples’ needs, including those who may need significant nursing or social care (e.g. Continuing Health Care or at risk of care admission); and to explore use of well-governed joint care solutions;
• Develop more outcome-based commissioning of Council-funded social care solutions based on the needs of older people, and ensure they are facilitated to undertake daily living tasks, including by technologically-aided solutions. This includes further developing Personal Assistant-based solutions, short-break care/respite and befriending solutions;
• Work with owner-occupiers and Registered Social Landlords to ensure householders can more consistently access grants/finance to improve accommodation’s suitability;
• Work with partners to develop housing options, increasing availability of lifetime homes and explore the potential for floating support, home-share, co-ownership and specialist housing;
• Work with partners to improve procurement, governance of contractual arrangements and market management of community-based services and care homes; and to develop market alternatives;
• Work with partners to support carers earlier, exploring the potential for carers’ enablement and provide training and support for carers to care for those, e.g. with advanced dementia;
• Work with partners to understand, learn from and/or address the different support accessed by different ethnic groups, and ensure all commissioning intentions adequately reflect fairness for all.

Recommendations for Further Needs Assessment

There is a need to build on this initial analysis and conduct further needs analysis:
• To better detail the “Enfield experience” of older people with complex needs and their carers living in Enfield and the professionals working with them;
• To better forecast the financial impact of demographics and policy interventions – Dec-13;
• The need to provide a more comprehensive equalities impact assessment relating to ethnicity, religion/belief and sexual orientation as part of this needs analysis – Autumn 2013;

The need to provide a companion document relating to older people who have less complex needs, but may benefit from a “little bit of help”42

Additional Information on Older People with Complex Needs

The number and combination of co-morbidities (such as existing or age-related physical impairments, life-limiting health conditions, or additional health needs) that affect daily living can affect the complexity of people’s needs, and often the level of support or care they require.

The most commonly reported health condition that affects daily life amongst over 65’s is arthritis and other musculoskeletal disorders, with an estimated 18,000 people aged 65 or over in Enfield living with musculoskeletal disorders in 2011.

Future projections suggest that by 2020, there may be 21,210 in Enfield people over the age of 65 years living with at least one limiting long term illness43, a 15% increase from the 2012 estimate of 18,437 people. Similar rises have also been projected for the prevalence of a number of other conditions that can cause problems with daily life amongst over 65s, as shown in the table below:

41 Nuffield Trust (2011) Predicting social care costs: a feasibility study
43 Projecting Older People’s Population Information System (POPPI
The GP Patient Survey

The National GP Patient Survey is conducted at every GP practice in England, being most recently conducted between January and September 2012. The survey collects a broad range of information designed to indicate patient satisfaction with aspects of GP services and includes 4 questions relating to long-term conditions. Results have been broken down by age group below to focus on responses from those adults over 65 years old.

Proportion of Respondents in Enfield Reporting having at least One Long Term Health Condition, by age group: 2012 (weighted results)

The proportion of respondents reporting having one or more long-term health conditions increases with age group, with respondents over the age of 65 years having significantly higher rates of long term conditions compared with the Enfield average across all age groups of 43%. The most commonly reported long term conditions amongst respondents over 65 years old were high blood pressure, arthritis and joint problems, diabetes, and long-term back problems. The prevalence of some conditions amongst
respondents increased with age, particularly high blood pressure, deafness, and angina or other long term heart problems.

Responses to the Question "In the last 6 months, have you received enough support from local services or organisations to help you to manage your long-term health condition(s)? Please think about all services and organisations, not just health services" from Enfield Respondents, by age group: 2012 (weighted results)

The majority of respondents aged 65 and over reported that they had either definitely received enough support (39%) or had received enough support to some extent (21%) from health and other services to help manage their own long-term condition, with 68% of over 85 year olds reporting that they definitely had, or to some extent had received enough support. Amongst all respondents aged 18 and over, 56% of people felt they had definitely received or had somewhat received enough support, which is slightly lower than amongst the older age groups.

A significant number of respondents aged 65 years or more also reported that they had not needed any support to manage their long-term health conditions.

Responses to the Question "How confident are you that you are able to manage your own health?" from Enfield Respondents, by age group: 2012 (weighted results)

Source: GP Patient Survey 2012

N.B. Please note that small numbers of responses (below 10 people) have been suppressed, which is why columns for some responses are absent.
Despite the high proportion over the 85 age group respondents who feel that they had received sufficient support from services with their long-term health conditions, this group appeared to be the least confident in being able to manage their own long-term health conditions, with 21% of this group reporting being either ‘not very confident; or ‘not confident at all’.

Research has identified that people from ethnic minority groups can have different experiences and outcomes of long term conditions. Unfortunately, very small numbers of people from different ethnic backgrounds responded to the survey, so the majority of the results broken down by ethnicity have been suppressed to ensure patient anonymity. As such, it was not possible to perform a breakdown of the above data by ethnic group, to look at how older people from different ethnicities have been affected by long term conditions.

Given the projected rise in the number of older people in Enfield, and increasing prevalence of long-term, often multiple conditions, it will be important to ensure that older people are effectively supported to develop the skills and confidence to manage their own health conditions to a level with which they are comfortable and able.

Further information on this topic is available from:

Cardiovascular Disease Outcomes Strategy
Cardiovascular Disease Profiles
Community Mental Health Profiles
Diabetes Community Health Profiles
Diabetes Prevalence Model
Disease Prevalence Models
Enfield Joint Carers Strategy: 2013 - 2016
Enfield Joint Dementia Strategy: 2011 - 2016
Enfield Joint Intermediate Care and Re-ablement Strategy: 2011 - 2014
Enfield’s Joint Commissioning Strategy for End of Life Care: 2012 - 2016
Enfield Local Account - How Well are we Delivering Adult Social Care Services? 2012
Fair Society, Healthy Lives (The Marmot Review)
Immunisation Information for Health Professionals and Immunisations Practitioners
Interactive Health Atlas for Lung Conditions In England
Kidney Care Profiles
Longer Lives
NHS Atlas of Variation
Older People’s Health and Wellbeing Atlas

Health Protection

Seasonal Flu Vaccination

People aged 65 years and older are more susceptible to suffering from serious health consequences of influenza infections, which can result in hospitalisation, disability or even death. As such, all people aged 65 or above are offered an annual seasonal influenza vaccination, between September and February, to help protect them against circulating strains of flu. Vaccination needs to be given annually to ensure that older people are protected against newly emerging and circulating strains (NHS England, 2013).

Seasonal flu vaccinations are also offered to at-risk people aged between 6 months and 65 years, for example those with long term conditions or a weakened immune system. Levels of, and trends in, uptake of this vaccination are included in The Health and Wellbeing of Adults: Prevention chapter.


The government target is to achieve 75% uptake of influenza vaccination in those aged 65 years and over. Uptake in Enfield, London and England has been significantly lower than this 75% target in every year since 2010/11. Uptake in Enfield fell between 2011/12 and 2013/14, from 74.6% to 71.8%, but has increased in the last year to 72.8%.

Enfield has the 4th highest vaccination rate in London in 2014/15, where uptake ranged from 75.4% in Tower Hamlets to 61.7% in Hammersmith and Fulham. Over 30,500 eligible older people were vaccinated in 2014/15 in Enfield, giving 72.8% uptake, which is significantly higher than the London average.
**Pneumococcal Vaccination**

Pneumococcal infections can cause a range of diseases, including pneumonia and meningitis. Older people aged 65 and above, and those with long term health conditions, are at particular risk, so these groups are targeted to receive the pneumococcal vaccination (PPV), which is generally a one-off injection.


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**Source:** Public Health Outcomes Framework, and Gov.uk

**Note:** Data prior to 2013/14 were collected at a PCT level and converted to LA level by Public Health England
PPV vaccination coverage amongst the population aged 65 and older has remained fairly stable in London and England but has fluctuated in Enfield during the period 2010-2015. Coverage was significantly higher than the London average in 2010/11, 2012/13 and 2013/14 but significantly lower in 2011/12. It has been significantly lower than the England average throughout this period. In 2014/2015 the level of coverage in Enfield, London and England increased. In Enfield, the increase was 2.2%, from 66.3% in 2013/14 to 68.5% in 2014/15.

Coverage of PPV (Pneumococcal) vaccination amongst population aged 65 and over, by London Borough: 2014/2015

As the graph above shows, Enfield had the 7th highest rate of PPV vaccination coverage in London in 2014/15, with coverage of 68.5%. A cumulative total of 28,490 people over the age of 65 in Enfield had received the PPV vaccine in 2014/15.

Further information on this topic is available from:
- Excess Winter Deaths in England
- Immunisation Information for Health Professionals and Immunisations Practitioners
- NHS Vaccination Schedule
- The Health and Wellbeing of Adults: Prevention

Enfield Joint Strategic Needs Assessment – 2013
Page Updated: April 2016

References
Social Care Services for Older People

Demographics and Service Type

In 2012/13, a total of 5,357 older people received one or more community service from Enfield Council. The types of community services received by residents are shown in the graph below, and include home care, home meals and specialist equipment or adaptions.

People receiving these services were predominately female, with 3,683 (69%) female service users, compared to 1,674 males (31%). The majority (74%) of service users were 75-94 years of age.

In terms of service user ethnicity, White British and White Irish service users made up 66% of all people receiving services, while 8% service users were of Black African or Caribbean ethnicity. Given the ethnic breakdown of Enfield’s 65+ population, this represents a slight under-representation of White British and Irish service users (accounting for 71% of Enfield’s population aged 65 and over), while the proportion of Black African and Caribbean services users was close to the population figure of 6%. People of White Other ethnicity represented 15% of service users, representing a slight overrepresentation compared to the 65+ population of which 12% are White Other.

Breakdown of Community Based Services Provided to People Aged 65 and Over in Enfield: 2010/11, 2011/12 and 2012/13*

<table>
<thead>
<tr>
<th>Category</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short Term Residential - not respite</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct Payments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional Support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equipment &amp; Adaptations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: National Adult Social Care Intelligence Service (NASCIS)

*Please note that data for 2012/13 is currently provisional

A significant proportion of the community services provided involve the provision of equipment or adaptions, to support service users in remaining safe and independent in their homes in the community.

While the graph shows a decline in the number of people receiving equipment and adaptions, this trend was partly influenced by a change in data reporting, which saw the number of residents receiving Enfield’s Community Alarm service no longer being counted towards this figure after 2010/11. In 2011/12, a total of 261 people aged over 65 years received a community alarm service in Enfield, rising to 452 in 2012/13.

For more information about the Enfield Community Alarm service, please visit the Community Alarm and Telecare webpage.

For more information about the full range of social care services provided in Enfield, please visit the Council’s Health and Adult Social Care webpage.
Enhancing quality of life for people with care and support needs

Social Care Related Quality of Life

‘Social Care Quality of Life’ is a measure that gives an overall indication of reported outcomes for people using social care services. Quality and outcomes are measured with 8 questions within the Adult Social Care Survey, focusing on service user control, personal care, food and nutrition, accommodation, safety, social participation, occupation, and dignity. The response of the service user will only be taken into account in the calculation of the council’s final score if all 8 of the questions have been answered. The maximum score possible is 24, and the minimum is 0. At present, this measure does not identify the contribution of the Councils’ adult social care services towards these outcomes.

Social Care-Related Quality of Life for Respondents Aged 65 and Over: 2012/13*

As the graph above shows, Enfield had an overall score of 18.6 out of 24, which was the 8th highest score across London, though scores did not vary greatly between the highest and lowest scoring boroughs (17.5 in Brent and 19.6 in Redbridge). This was an increase in score of 0.1 from 2011/12, which saw Enfield draw level with the England score, and remain higher than the London score of 18.2.

Service User Choice and Control

Information is a core universal service and a key factor in early intervention and reducing dependency. Improved and/or more information benefits service users and carers by helping them to have greater choice and control over their lives. Improving choice and control through information may help to sustain caring relationships through, for example, reduction in stress, improved welfare and physical health improvements. These benefits accrue only where information is accessed that would not otherwise have been accessed, or in those cases where the same information is obtained more easily.
Proportion of Respondents Aged 65 and Over Who Felt They Had Control over Their Daily Life: 2012/2013*

As the graph above shows, Enfield had the 17th highest rate in London of respondents who felt they had choice and control over their daily life in 2011/12. Enfield's rate of 70.9% was just above the London average of 70.7%, but below the England of 75.9%. Enfield's 2012/13 figure was a decrease from 74.2% in 2011/12.

Self-Directed Support and Personal Budgets

The personalisation of adult social care in Enfield is designed to give people more choice and control about how they live their lives, by empowering people to identify their needs, their budget allocation and to choose and control the support or care they require. People have the choice to buy services that are customised to suit specific needs, preferences and circumstances, giving service users greater flexibility to live as independently as possible.

After an assessment to identify an individual’s care needs, and how much support they would require to live independently in the community, a personal budget can be allocated. The service user (with support and advice from the council if needed) can decide how to spend their personal budget to best meet their care needs, whether this be through purchasing social care services, paying for leisure or social activities or a mixture of different services and activities. This service-user centred care planning is known as self-directed support.

Personal budgets are the financial allocation available for each individual, depending on their specific support needs. Personal budgets can be managed on behalf of a service user by Enfield council, or service users can choose to receive direct payments to manage the cost of meeting their support needs directly with providers.

Research has indicated that personal budgets have a positive effect in terms of impact on well-being, increased choice and control, cost implications and improving outcomes. Studies have shown that direct payments make people happier with the services they receive. 55% of services users receiving self-directed support or direct payments were aged 65 or over in 2012/1315.
Number of Adults, Older People and Carers (aged 18 and over) Receiving Self-Directed Support as a Percentage of All Service Users Receiving Community-Based Services or Carers Receiving Carer Specific Services, by London Borough: 2012/2013*

As the graph above shows, 79.5% of adults, older people and carers who used Enfield adult social care services were receiving self-directed support in 2012/13, giving Enfield the 7th highest rate in London, being well above the London and England averages. Enfield rate of 79.5% was an 18.7% increase in levels of self-directed support from 2011/12, when Enfield's rate was 60.8%.

Source: National Adult Social Care Intelligence Service (NASCIS)

*Please note that data for 2012/13 is currently provisional
As the graph above shows, 24.7% of service users who received community-based services and carers who received carers’ specific services were receiving direct payments during 2012/123. This was above the London rate of 19.3% and above the England rate of 16.4%, and gave Enfield the 8th highest rate of direct payments across London local authorities. There was an increase of 8.1% of the proportion of people receiving direct payments from 2011/12, when the rate in Enfield was 16.6%.

Given the drive to provide service users with personalised services, services users experience and satisfaction with services is a key way to determine how well services are adapting to meet individual service user’s needs.

The Adult Social Care survey measures the satisfaction with services of carers of people using adult social care, which is directly linked to a positive experience of care and support. Analysis of user surveys suggests that reported satisfaction with services is a good predictor of the overall experience of services and quality.

### Proportion of Service Users Aged 65 and Over Who Answered "I am extremely satisfied" or "I am very satisfied", or "I am very happy with the way staff help me, it's really good", by London Borough: 2012/2013*

<table>
<thead>
<tr>
<th>London Borough</th>
<th>% of respondents who answered I am extremely satisfied or I am very satisfied or I am very happy with the way staff help me, it’s really good</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of London</td>
<td>40.3%</td>
</tr>
<tr>
<td>Brent</td>
<td>41.2%</td>
</tr>
<tr>
<td>Barking and Dagenham</td>
<td>41.3%</td>
</tr>
<tr>
<td>Bexley</td>
<td>40.4%</td>
</tr>
<tr>
<td>Broxbourne</td>
<td>40.9%</td>
</tr>
<tr>
<td>Borough of Enfield</td>
<td>56.5%</td>
</tr>
<tr>
<td>Bromley</td>
<td>42.7%</td>
</tr>
<tr>
<td>Camden</td>
<td>42.8%</td>
</tr>
<tr>
<td>City of London</td>
<td>40.3%</td>
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<tr>
<td>City of London</td>
<td>40.3%</td>
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<tr>
<td>Croydon</td>
<td>40.4%</td>
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<td>Croydon</td>
<td>40.4%</td>
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<tr>
<td>Croydon</td>
<td>40.4%</td>
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<tr>
<td>Ealing</td>
<td>42.5%</td>
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<tr>
<td>Ealing</td>
<td>42.5%</td>
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<tr>
<td>Enfield</td>
<td>64.5%</td>
</tr>
<tr>
<td>Epsom and Ewell</td>
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</tr>
<tr>
<td>Greenwich</td>
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<td>Greenwich</td>
<td>41.5%</td>
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<td>Havering</td>
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<td>Lambeth</td>
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<td>Merton</td>
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<td>Southwark</td>
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<td>40.3%</td>
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<tr>
<td>Waltham Forest</td>
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<td>Waltham Forest</td>
<td>41.6%</td>
</tr>
<tr>
<td>Watford</td>
<td>40.4%</td>
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<tr>
<td>Watford</td>
<td>40.4%</td>
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<tr>
<td>Westminster</td>
<td>40.5%</td>
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<tr>
<td>Westminster</td>
<td>40.5%</td>
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</tbody>
</table>

Source: National Adult Social Care Intelligence Service (NASCIS)

*Please note that data for 2012/13 is currently provisional

As the graph above shows, Enfield had the 9th highest percentage of positive responses about the satisfaction of service users aged 65 and over with the social care services they receive through Enfield Council, with 64.5% reporting being ‘extremely’ or ‘very’ satisfied with services. Enfield’s performance against this measure was above the London and England rates of 56.5% and 61.8% respectively, though was a slight decrease on 2011/12’s performance of 65.2%.

Looking at service users under the age of 65 years, respondents in Enfield were generally more positive about social care services, with 73.4% of respondents aged 18-64 years saying they were satisfied with the services they received. Across all age groups, 67% of respondents in Enfield reported being satisfied with the social care they received.

Safeguarding people whose circumstances make them vulnerable and them protecting from avoidable harm Safety is fundamental to the wellbeing and independence of people using social care, and the wider population. Feeling safe is a vital part of service users’ experience of the care and support they receive.

There are legal requirements around safety in the context of service provision, such as Care Quality Commission (CQC) standards, which are designed to enhance service user safety across all types of services.
As the graph below shows, 59.1% of service users aged 65 and over who completed that adult social care survey reported feeling safe in 2012/13, just below the London rate of 60.2% and below the England rate of 65.0%. Enfield’s 2012/13 rate of 59.1% represented a slight decrease on the 2011/12 performance of 63.9%.

Proportion of Service Users Aged 65 and Over Who Said They Felt Safe, by London Borough: 2012/2013*

*Please note that data for 2012/13 is currently provisional

As well as measuring overall feelings of safety, the adult social care survey also reflects the extent to which users of care services feel that their care and support has contributed to making them feel safe and secure. As such, it goes some way to separate the role of care and support in helping people to feel safe from the influence of other factors, such as crime levels and socio-economic factors.

As the graph below shows, 83.2% of service users aged 65 and over reported that the services they received helped them to feel safe (this is regardless of whether they had felt safe or not in the previous question above). This was the 7th highest percentage across London, above the London and England rates of 71.6% and 77.4% respectively. This was a rise of 18.6% on Enfield’s performance for 2011/12, which was 64.6%.

Source: National Adult Social Care Intelligence Service (NASCIS)
Proportion of Service Users Aged 65 and Over Who Said That Those Services Had Made Them Feel Safe and Secure, by London Borough: 2012/2013*

*Please note that data for 2012/13 is currently provisional

Looking at service users under the age of 65 years, respondents in Enfield reported feeling slightly safer as a result of their adult social care services compared to over 65s, with 85.2% of respondents aged 18-64 years saying they felt safe because of their services. Across all age groups, 84% of respondents in Enfield reported that their adults social care services made them feel safe.

Delayed Transfers of Care

Information is routinely collected about the delay of transfers of care from hospital services to community-based care in facilitating timely and appropriate transfer from all hospitals for adults. This information gives an indication of the ability of the whole system to ensure appropriate and timely transfers from hospital for the entire adult population. It is an important measure of the effectiveness of joint working of local services and partners, and the interface between health and social care. Minimising delayed transfers of care and enabling people to live independently at home are key desired outcomes of social care.
As the graph above shows, Enfield has the 11th lowest rate of delayed transfers of care for adults aged 18 and over, of 5.5 per 100,000 population, decreasing from 5.8 per 100,000 in 2011/12. Enfield’s rate was below the average rates for London (6.9 per 100,000) and England (9.5 per 100,000). Significant variation in the delayed transfer rate was seen across London, ranging from only 2.5 per 100,000 in Merton to 11.9 per 100,000 in Barking and Dagenham. As the measure captures all delayed transfers of care, this can include delays solely due to the NHS, solely due to the local authority, jointly due to the NHS and local authority, or for other reasons, such as family decisions.
Average Number of Delayed Transfers of Care That are Attributable to Social Care or Jointly to Social Care and the NHS, as a Proportion of the Adult Population Aged 18 and Over, per 100,000 Population, by London Borough: 2012/2013*

*Please note that data for 2012/13 is currently provisional

Relating specifically to the rate of delays that could be determined to have been caused by adult social care delays, or caused jointly by delays with the NHS and adult social care, the graph above shows that Enfield had a delay rate of 1.7 per 100,000, the 12th lowest rate in London, and below the London (2.7 per 100,000) and England (3.3 per 100,000) rates. This indicates that of the total 5.5 delays in transfer of care per 100,000, 1.7 per 100,000, or 31% of delays in Enfield were caused or contributed to by delays with adult social care services.

Intermediate Care - Enablement Service

Enablement is a person-centred service that offers short term, practical support to people who have been affected by deteriorating physical and/or mental health. The service is designed to support people to regain and retain essential skills for daily living, helping to reduce their need for on-going care.

After an initial assessment, service users are supported to develop a goal-based action plan that meets their individual needs. This may include a range of support services, such as help with washing, dressing, or preparing meals, with access to a full range of information, advice and support services, including equipment, adaptations and other assistive technology.

Enablement is a key way to manage the ever-increasing demand for domiciliary services. By prioritising prevention, early intervention and promoting greater wellbeing, health and social care services can support people to live independently in the community for longer, helping to delay the development of complex support needs. In 2012/13, a total of 1,451 people received enablement services.
Of the 1,451 adults receiving enablement services in 2012/13, 949 were women, meaning there is an over-representation of female service users. The majority of service users were between the age of 70 and 94 years, representing just over three quarters (76%) of all service users. Numbers of service users were lower within the age groups covering people aged 18-69, which is likely to reflect the reduced level of need of this service type amongst the population. Those aged 95 years and older may have more complex needs and more difficulty remaining in the community, which may have resulted in the significant drop in client numbers in these age groups. Only 2 service users below the age of 24 were supported by the enablement service.
Of the 1,451 service users who received any enablement services 1,163 (80%) completed the full length of their service package. Of those completing their enablement, 54.7% (636) did not require any long term service, and a further 13.6% (158) saw a decrease in the level of long term service they required (compared to before receiving enablement services). 15% (174) of services users saw no change in their level of service need after enablement, while 16.7% (194) had an increased service need.

Hospital Readmissions within 91 days of Discharge

Another key way to measure the effectiveness of enablement and rehabilitation services is readmission rates with 91 days of hospital discharge amongst over 65s.

Number of People Aged 65 and Over Discharged From Hospital to Their Own Home or to a Residential or Nursing Care Home or Extra Care Housing for Rehabilitation, Who Are Still There 91 Days Post Discharge, as a Percentage of the Total Number of People Aged 65 and Over Discharged Alive From Hospital in England, by London Borough: 1st October 2012 to 31st December 2012*
*Please note that data for 2012/13 is currently provisional. Data for this indicator is collected for a cohort of older people who were offered and received an enablement or rehabilitation service after being discharged from hospital between October 2011 and December 2011. This cohort was then followed up between January 2013 and March 2013 to determine if they had remained out of hospital for the 91 days post discharge.

As can be seen from the chart above, the percentage of people aged 65 and over not requiring re-admission to hospital in Enfield was 88.2% in 2012/13, which was better than both the London and England averages of 85.9% and 81.5% respectively. This ranked Enfield 15th in London compared to other London boroughs.

**Permanent Admissions to Residential or Nursing Care**

Avoiding permanent placements in residential and nursing care homes is a good measure of maintaining independence, and requires local health and social care services to work together to reduce avoidable admissions to residential care or nursing homes. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care, so wherever possible, adult social care and health services should support people in this wish for as long as is practicable and safe.

<table>
<thead>
<tr>
<th>London Borough</th>
<th>Number of Council-Supported Permanent Admissions of People Aged 65 and Over to Residential and Nursing Care, Per 100,000 Population Aged 65 and Over: 2012/2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enfield</td>
<td>527.4</td>
</tr>
<tr>
<td>London</td>
<td>493.7</td>
</tr>
<tr>
<td>England</td>
<td>708.8</td>
</tr>
</tbody>
</table>

As the graph above shows, Enfield’s rate of 527.4 per 100,000 residents aged 65 and over was the 15th highest rate in London, and was above the London rate of 493.7 per 100,000 and lower than the England rate of 708.8 per 100,000 residents. Having a lower rate of permanent admissions suggests that a greater proportion older people are living in their own homes, which may be supported by community-based social care services or support from unpaid carers.

For further information on this topic is available from:

*Enfield Joint Carers Strategy: 2013 - 2016*
*Enfield Joint Intermediate Care and Re-ablement Strategy: 2011 - 2014*
*Enfield Local Account - How well are we Delivering Adult Social Care Services? 2012*
Carers

A carer is someone who looks after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid.

A carer can be any age including children and young people who is providing care to someone who:

- Has a physical disability, or
- Has a sensory impairment, or
- Has a learning difficulty, or
- Has mental health support needs, or
- Has problems with drug or alcohol misuse, or
- Has a long term or chronic illness, or
- An older person who is physically or mentally frail, or
- Is a child with a disability or long term or chronic illness, or
- Any combination of the above

Care is defined in a wide-ranging way and includes emotional and administrative support as well as physical care and domestic tasks.

The 2011 Census tells us that there are 27,576 carers within the Borough of Enfield. Of these, more than 6,000 are known to provide over 50 hours of care per week.

Due to the demands of a caring role, carers are at risk of:

- Poor health, especially mental health and stress-related conditions
- Financial hardship
- Giving up work to care
- Social isolation

Therefore it is essential that support for carers is available, in order that they are able to manage their own health and wellbeing and be able to continue with their caring role.

The London Borough of Enfield and Enfield Clinical Commissioning Group are committed to reducing the risk to carers, through the implementation of the Enfield Joint Carers Strategy 2013-16. The Strategy addresses the priorities outlined above, and has a clear action plan and governance structure to report, implement and monitor the delivery of the Strategy.

Key issues and gaps – summary

- Investment into preventative support to carers has a clear and proven cost benefit to the local authority and therefore must be considered as part of the Efficiencies agenda
- Carers fatigue or breakdown is a significant risk to the Council and CCG
- The vast majority of carers in Enfield are not known or recorded by Health and/or Social Care
- Any further work into extending direct payments should acknowledge and recognise the carers role with the financial management and provide appropriate training, information and support
- 37.5% of carers who completed the ‘Adult Social Care Outcomes Framework - Carers Survey 2012/13’ stated they found information ‘fairly difficult’ or ‘very difficult’ to find in Enfield

Recommendations for consideration by commissioners including short and long term priorities - where appropriate to include prevention options

- To implement the Joint Carers Strategy 2013-16
- To develop and build partnership working to improve service provision for carers
- Additional support and advocacy to those carers affected by Welfare Benefits reform
- Acknowledgement and support to carers managing direct payments
- Additional resources and commitment to be allocated to strengthen and increase preventative support to carers
- Focus on identification of ‘hidden’ carers and those who do not access services who would benefit from support.
- Coordination of carers information and registers across social care, health and mental health
• Improved access to information
• Increased and better quality training for practitioners to effectively support carers
• Borough wide needs assessment
• Analysis into the impact of Welfare Benefits and Social Care reform on carers
• Review of funding through Carers Grant
• Implementation of carer specific Health Checks

Who is at risk and why?

Carers of all ages

A carer is someone of any age who provides unpaid support to family or friends who could not manage without this help. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problem.

Anyone can become a carer; carers can come from any background or culture and be of any age. Many do not identify with being a ‘carer’. They just see themselves as doing what any other son, daughter, mother, father, partner or best friend would do. Because of this carers can often be isolated and unaware of the network of support available.

Financial

The financial costs of caring can be significant\(^\text{45}\). Research by Carers UK found that 72% of carers were worse off financially as a result of becoming carers. The reasons given for this include the additional costs of disability, giving up work to care, the inadequacy of disability benefits.. Carers can face higher bills than the rest of the population (including extra heating, laundry and transport costs) and many do not get support from social services, meaning that they have to pay for care themselves. Carers UK’s most recent research\(^\text{46}\) reveals that nearly two thirds are spending their own income or savings to pay for care for the person they look after.

The same research also found carers reporting financial hardship in a number of areas. More than half (54%) were in debt as a result of caring. Three-quarters struggled to pay essential bills (74%) and could not afford repairs to their house (78%). Half of all carers are cutting back on food just to make ends meet (52%). 32% of those paying rent or a mortgage say they cannot afford to pay it.

Health

Analysis of the 2011 Census findings tells us that those caring for 50 hours a week or more are more than twice as likely to be in poor health as those not caring. Whilst 5.17% of those providing no unpaid care in Enfield reported their general health as "bad or very bad", the figure for those providing over 50 hours a week of unpaid care in Enfield was 11.98%. These figures are similar to those observed across England as a whole, at 13.01% for those providing over 50 hours of unpaid care per week.

If we look more closely at the demographics of carers in Enfield, the 2011 Census shows us that where individuals have reported their health as bad or very bad, these are most likely to come from the over 65 age group and be providing over 50 hours or more of unpaid care per week. 43.17% of individuals in this category reported their health as "bad or very bad" in the 2011 Census. This compares with a figure of 37.48% for those aged 65 or over and providing no unpaid care.\(^\text{47}\)

Altogether in England, just over 196,000 people provide some form of unpaid care whilst describing themselves as suffering from a long term sickness or disability. Over 83,000 of these people provide 50 hours or more of unpaid care each week.

Those providing care over a long period of time are at particular risk of poor health and both mental and physical health are likely to deteriorate the longer a carer has been caring. A 2002 study found that carers were over twice as likely to have mental health problems if they provided substantial care; 27% of those providing over 20 hours a week had mental health problems compared to 13% of those providing less than 20 hours of care.

\(^\text{45}\) Carers UK . (2007), 'Real Change not Short Change', London
Other factors contributing to poor health amongst carers are low incomes and lack of breaks. Research by Carers UK found 62% worried about their finances and 53% believed this had an effect on their health.48 Other research has found that those not receiving a break were far more likely to suffer from mental health problems, 36% compared to 17% of those carers getting a break.49

**Employment**

The 2011 Census found that across England, a total of 2.88 million people combine work with caring responsibilities for a disabled, ill or frail relative or friend. This is equivalent to just less than 1 in every 9 workers in England, and means that approximately 11.38% of people in England combine caring responsibilities with employment.

In Enfield, 14,928 people were recorded by the 2011 Census as being in employment and providing unpaid care. This was equivalent to 10.79% of the workforce, and is broadly in line with the national rate.

Across England, over 350,000 individuals provide 50 hours or more of unpaid care each week, whilst being in employment. In Enfield, 1,702 were recorded by the 2011 Census as being in employment whilst providing 50 hours or more of unpaid care.

Combining paid work and looking after a relative or friend causes stress and can lead to carers giving up work. Carers UK’s Real Change Not Short Change survey50, which had a higher proportion of heavy end and older carers, found that more than half (54%) had given up work to care. Many had retired early due to their caring responsibilities – an average of 8 years early.

Nearly nine in ten (87%) working age carers looking after their partner had no-one in the household in paid work. The carers who responded to this survey had lost an average of £11,000 per year in earnings because of giving up work, cutting their hours or taking a more junior job.

**Social Exclusion**

Carers face social exclusion due to the isolation and the difficulties around the practicality of caring. A major issue raised by carers is how inflexible or unreliable transport services cause frequent care emergencies which have been particularly problematic for working carers.

Carers also have problems accessing leisure services and other social activities due to the cost, lack of accessibility and lack of replacement care.

**Local prevalence/level of need in the population**

The 2011 Census told us the following about carers in Enfield:

- 27,576 people identified themselves as carers. The number of carers recorded by the Census rose approximately 13.42% in Enfield between 2001 and 2011.
- The 2011 Census recorded that there were 6,171 carers providing more than 50 hours care a week in Enfield, an increase of 1,349 since the 2001 Census.
- The 2011 Census recorded that there were 4,123 carers providing care for 20-49 hours per week, an increase of 1,273 since the 2001 Census.
- The remaining 17,282 carers recorded by the 2011 Census provide between 1 and 19 hours of unpaid care per week, an increase of 641 since the 2001 Census.
- The highest number of carers live within the Town, Bush Hill Park and Cockfosters wards.
- The highest number of carers caring for more than 50 hours a week live within the Turkey Street, Haselbury and Upper Edmonton wards.
- The 2011 Census recorded 642 carers aged 0 – 15 years old providing care in Enfield.

**Local Information**

- 491 carers had an assessment in their own right in 2012/13

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• 2,480 carers had a ‘Party to Event’ assessment with the person they care for – a joint assessment looking at both the needs of the cared for and carer
• 735 carers received a service as an outcome of their Carers Assessment
• A further 2236 carers received information and advice only.
• 73 carers declined an assessment
• Approximately 2,150 carers are on Enfield’s Carers Register. (November 2013)
• 601 carers have the Carers Emergency Card (March 2013)

Describe the existing ‘local offer’

2,050 carers receive Carers Allowance

Currently carers can receive support through the Community Care assessment for the people they care for – provision of home-based care and/or respite provision.

Carers are also entitled to a joint assessment or a stand-alone Carers Assessment to address their needs. Through this assessment they may be offers a one-off payment or a direct payment, depending on their eligibility.

In 2012/13 the total cost of respite, sitting services, replacement care and carers direct payments was £1.7 million.

In addition, the Local Authority funds the Voluntary and Community Sector to the amount of £885,000 to provide preventative carers services such as information, support, respite and relaxation therapies. This also includes the funding to Enfield Carers Centre, a hub for carers information, support and activities. These services can reduce carer fatigue and breakdown, reduce social isolation and keep carers physically and mentally well.

The local offer includes work under the Enfield Joint Carers Strategy workstream. The Action Plan for delivery is available as part of the Strategy document on the Enfield Council website. In order to deliver the Action Plan a number of sub groups to the Carers Partnership Board have been created.

Enfield Joint Carers Strategy Workstream

Currently carers can access the following support through the Voluntary and Community Sector without assessment:
• Carers Registration ‘Gold’ card which provides discounts and benefits
• Carers Emergency Card
• Support groups
• One-to-one information and support
Complementary therapies
- Counselling
- Respite activities
- Advocacy and befriending service
- Benefits and legal advice
- Wellbeing workshops
- Training

Carers can also request and apply for:
- Carers Direct Payment through Enfield Carers Centre
- Carers Assessment from Social Services resulting in their own support plan

In addition there are targeted projects to improve recognition, support and referral of carers through Primary Care, Acute admissions and hospital discharge, Jobcentre Plus and the Mental Health Trust. A Carers Nurse, funded through the Clinical Commissioning Group, is also currently being recruited. This post will provide health checks, vaccinations and health and wellbeing support to carers across the Borough.

Projected service use and outcome

Research by Carers UK and Cass Business School found the following:

"Population data for the UK show that ratio of people aged 20-64 to those aged 65+ peaked in 2008 at 3.7 and is now in long term decline and set to reach 2.5 by 2030, so there will be fewer younger adults to provide potential support. A support ratio based on the number of 20-79 year olds to those aged 80+, falls from 15 to 9 over the same period. This not just an issue confined to the older population as young adults with disabilities are also tending to live for longer so their numbers will also increase in future.

With the frontiers of the welfare state receding in areas such as social care and benefits, it will fall to families and households to absorb a majority of any additional burden either financially or through providing care in kind. There are major changes ahead to which the outlook for carers will be strongly tied. These include acceptance of the recommendations of the (Dilnot) Commission on Funding Care and Support, wider benefits reforms for example to Disability Living Allowance which will become the Personal Independence Payment, and the introduction of the Universal Credit, and NHS reforms\(^\text{51}\)."

Therefore a significant increase is expected in the number of carers as well as an increase in the hour of care that existing carers provide. Enfield saw an above average rise in the number of carers between the Census in 2001 and 2011 of 13%, the national average was 11%.

Carers UK has predicted that there will be 9 million carers nationwide by 2037.

It is expected that the impact of the Welfare Reforms and the Austerity drive will affect many carers – there is the possibility of the loss of benefits including carers allowance, additional costs around housing and council tax benefits and reduction in the level/number of services received. With many carers already experiencing mental ill health, additional stress cause have a detrimental effect on their ability to continue caring. The introduction of a Carer health check – looking at mental as well as physical health – could identify problems early and prevent carer breakdown and led to better quality of life outcomes.

Evidence of effective interventions - what works and makes a difference

Whilst there is no ‘duty’ placed upon local authorities to provide Carers Services, the cost effectiveness of such services which enable the carer to continue caring must be recognised as a ‘best value’ option. The Carers and Disabled Children Act 2000 states ‘Such services, if targeting purposively, can be of genuine assistance in sustaining the caring relationship and be cost effective\(^\text{52}\).’

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\(^\text{51}\) Mayhew, Prof L (2012) The UK Care Economy-Improving Outcomes for Carers' Carers UK and Cass Business School
Evaluation of the Carers Demonstrator Sites\textsuperscript{53} showed that:

- Support of the type offered in the Breaks and NHS Support Demonstrate\textsuperscript{r}r Sites filled an important gap in services for carers, and services of this kind should be prioritised. The well-being support offered in Health Checks sites was a new form of support for most who received it, filling a previously unmet need, and should also be developed.
- Flexible and personalised breaks support is life-enhancing for many carers. It has the potential to prevent carer burn-out / health deterioration and to help sustain their caring role.
- Health and well-being checks led to sustained self-care and healthier behaviour for some carers. Arrangements for signposting carers to support need to be carefully monitored for their suitability and effectiveness in each individual case.
- Staff in the NHS, local authorities and voluntary sector organisations, working together, developed a wide range of creative and sometimes innovative approaches which worked flexibly for carers and offered them personalised support.
- Standardisation and uniformity is not appropriate in developing and delivering carers’ services, but flexibility and responsiveness to local circumstances can work well. The allocation of leading and supporting roles within partnerships should reflect local priorities, needs and circumstances.
- Some carers derive significant benefit from relatively low-cost support at appropriate points.
- Well-being support was offered in a variety of settings, in different ways: some options valued by carers do not rely exclusively on input from fully qualified clinical staff.
- Some success was achieved through establishing ‘carers’ champion’ roles in GP practices, linked to other partner agencies and support. In hospitals, successful practices included ward-based initiatives, co-ordinated and led by voluntary sector agencies, which involved nurses, doctors and health care assistants and made services and support available to carers in the hospital setting.
- Carers access support via different routes, according to their own caring circumstances. Services need to be accessible at key points in the carer’s journey, especially when caring first arises, at points of change or stress in their caring situation and on a regular basis when caring is long-term and intensive.
- Portfolios of carer support need to be agreed locally between local authorities, NHS organisations, voluntary sector organisations and other organisations where appropriate. Carers need support with: health problems and stress; information on how to access suitable support, services, equipment and home adaptations for those they care for; income maintenance and pensions protection during and after caring; self-care, healthy lifestyles and maintaining a life outside of caring; access to education, training, work and leisure; emergency planning; and how to access occasional or regular breaks from their caring role.
- Hospitals should routinely provide mechanisms to identify and support new carers, centring their efforts on wards where patients have received a new diagnosis or are due to be discharged and on outpatient clinics where patients are likely to be accompanied by those who care for them. Timely and co-ordinated support for new carers and carers with changing care responsibilities, linked to follow-up services, should be available in every acute hospital and advertised in all out-patient clinics.
- All GP practices have contact with carers, even if this is not always recognised locally. Every GP practice should be encouraged to identify a lead worker for carer support, who can assist in carer identification, help in referring carers to suitable local services, and ensure carers’ access to health appointments and treatments is not impeded by their caring circumstances. These workers may require carer awareness and carer support training. The action guide ‘Supporting Carers’, for GPs and their teams, published by the Carers Trust and the Royal College for General Practitioners in October 2011 provides detailed suggestions for practical ways of taking this forward.
- All staff who interact with carers, in hospitals, GP practices, local authorities and in the voluntary sector should be trained to consider how caring responsibilities can impact on a carer’s health and well-being and be equipped to advise on how a carer can access a health and / or well-being check.

Carers and to offer guidance on suitable support. Local partnerships should consider resourcing local voluntary sector organisations to deliver well-being checks for carers.

- Many workers in the health and social care system, particularly (but not only) in the NHS, could provide more effective support to carers if they had benefitted from carer awareness training. All relevant organisations should regularly offer carer awareness training to their staff. Training need not be costly.

Research has shown that support to carers helps to improve outcomes for patients and those with support needs. A study found that support for the family of stroke patients was linked to reduced depression for the stroke patient (by between 17-27%) and a reduced need for physiotherapy. 54

Another study evaluated the effectiveness of providing personal care training to carers – three-five sessions lasting under an hour. The results showed a higher percentage of stroke patients achieving independence earlier and a reduced need for physiotherapy and occupational therapy. Alongside this it found a significant decrease in carer burden and an increase in mood and quality of life for carers and the recipients. 55

Problems with the carer can also lead to costly readmission to hospital following discharge – one study showing that in 62% of readmissions, carer breakdown or fatigue was a significant factor. 56 Another study highlighted that in 38% of cases the reason for admission to nursing or residential care is a carer-related reason. 57

Public and user/patient/carer views including quality assurance

Please refer to Summary of Submissions from Enfield Joint Carers Strategy.

It is acknowledged that more work needs to be undertaken to listen and engage with carers and to involved in service planning and evaluation.

As part of the Strategy implementation we have carers representatives on the Carers Partnership Board, including a Carer Co-Chair, the Strategy Implementation Group and structured and frequent consultation will take place through the governance of the Carers Communication Group.

Within the Council the Carers Action Group has been established and is made up of employees who have a caring responsibility. The purpose of the group is to look at ways that the Council can support them to balance their caring role with their working role and to propose policy and procedure to HR and relevant departments. Further work will be to share our learning with the business community in Enfield to provide them with support and advice about supporting carers in their workplace.

A new addition from the Strategy is the establishment of quarterly Carers Forums. These open forums will give carers a chance to express their views to senior members of the Council and Health. The forums will also give opportunity to the Council and Health to promote services that benefit carers, a forum to consult and speak directly to carers.

Equality Impact Assessments – predictive and retrospective and any planned assessments

Predictive Equality Impact Assessment undertaken in November 2012 in line with Joint Enfield Carers Strategy 2013-16 governance process. This EIA covers planned services and activities that will be delivered over the next three years

Identified unmet needs and service gaps

As of November 2013, there were approximately 2,150 carers on the Enfield Carers Register, with an additional 4000 known to Adult Social Care and 300 young carers known to the contracted young carers service. It is therefore apparent that there are huge gaps between the carers known to us and the number of carers in Borough. As part of the Enfield Joint Carers Strategy a Communications Plan will be established to look at identification, referral and assessment of those ‘hidden’ carers. An essential part of the identification is for the local authority and the CCG to foster even stronger links to ensure carers are identified earlier through their GPs.

57 Bebbington, Darton, Netton (2001) ‘Care Homes for Older People: Volume 2, Admissions, needs and outcomes’, University of Kent
A greater evidence base is required to the needs of carers and what support and activities will work locally.

Coordination between carers registers and databases is required to ensure carers receive consistent information and support and that all carers are recorded in one central system. Further work needs to be undertaken to identify the costs of carer breakdown to the Local Authority. Whilst we have research that has been undertaken nationally, a definite cost analysis for Enfield needs to be undertaken. This will be a key project for 2014/15.

Recommendations for consideration by commissioners

- To implement the Joint Carers Strategy 2013-16
- To develop and build partnership working to improve service provision for carers
- Additional support and advocacy to those carers affected by Welfare Benefits reform
- Acknowledgement and support to carers managing direct payments
- Additional resources and commitment to be allocated to strengthen and increase preventative support to carers
- Focus on identification of ‘hidden’ carers and those who do not access services
- Coordination of carers information and registers across social care, health and mental health
- Improved access to information
- Increased and better quality training needed for practitioners to effectively support carers

Recommendations for further needs assessment work

- Substantial work required to identify carers within the Borough
- Borough wide needs assessment
- Cost analysis of carer breakdown on the Enfield economy
- Analysis into the impact of Welfare Benefits and Social Care reform on carer

Further Information

Hidden Carers

Currently only 1,500 carers are on the Enfield Carers Register, with an additional 4,000 known to Adult Social Care and 300 young carers known to the contracted young carers service. It is apparent that there are huge gaps between the carers known to the Council and carers services, and the number of carers in Borough. As part of the Enfield Joint Carers Strategy, a communications plan will be established to look at identification, referral and assessment of those ‘hidden’ carers. An essential part of the identification is for the local authority and the Enfield Clinical Commissioning Group (CCG) to foster even stronger links to ensure carers are identified earlier through their GPs and hospitals.

A greater evidence base around the needs of carers is required, and what support and activities would work locally.

Support and Services for Carers

Currently carers can receive support through the community care assessment for the people they care for – provision of home-based care and/or respite provision. Carers are also entitled to a joint assessment or a stand-alone Carers’ Assessment to address their needs. Through this assessment they may be offered a one-off payment or a direct payment, depending on their eligibility. In Enfield, 2,418 carers were reviewed or jointly reviewed for services and received information or advice during September 2011 to October 2012.

Carers Survey

Carers surveys are completed every two years, with a sample of carers known to Enfield Council. Of 989 Enfield carers invited to complete the Carers Survey in 2010/11, 332 carers returned a completed survey. This was 5 below the target of 337 completed surveys required to produce a numerically representative sample size, based on Enfield’s population.
Carers were asked a broad range of questions about their experiences of using social care services, the results of which are summarised below.

**Carer reported quality of life**

Carers were asked to rate the extent to which their needs were met by social care services, against six key domains; Occupation, Control, Personal Care, Safety, Social Participation and Encouragement and Support. The responses of the 298 carers who answered all of the questions relating to this measure were used to produce a weighted score - Enfield scored 8.2 out of a possible 12 for the self-reported overall quality of life amongst carers.

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<th>Responses of Enfield Carers Relating to Carer Related Quality of Life: 2012/2013</th>
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As the graph above shows, carers were most satisfied that they had had their needs met in relation to safety (82% had no unmet needs) and personal care (62%).

The area that the greatest proportion of carers felt that they had none of their needs met was encouragement and support, which was reported by 19% of carers asked. However, the areas with the greatest number of unmet or only partially met needs were occupation (for which 73% of carers reported some unmet needs or no needs met) and control (68% of carers reported some unmet needs or no needs met).

Compared to other London boroughs, Enfield had the 5th highest score for carer satisfaction of 8.2. This was above the London and England rates of 7.7 and 8.2 respectively.
Of the survey respondents, 276 carers had received support or services from the Council in the past 12 months. These carers were asked to rate how satisfied they were with the services they had received. As the graph below shows, 42% of respondents were either extremely or very satisfied, with only 8% reporting feelings of dissatisfaction about the services they received.

Compared to other London boroughs in 2012/13, Enfield had the 8th highest proportion of carers reporting that they were extremely or very satisfied with social services they had received. Enfield’s rate was above the London average of 35.2%, but just below the England rate of 42.7%.

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*ASCOF 2012-13 results, National Adult Social Care Intelligence Service (NASCIS)
222 carers responded to a question asking how involved or consulted they felt during discussions about the support or services provided for the cared for person. 73% of carers felt they had always or usually been consulted, but 27% of carers felt they had only sometimes been consulted, or never consulted about the person they care for.

The Proportion of Carers in Enfield Who Report That They Have Been Included or Consulted in Discussions About the Person They Care For: 2012/2013

Source: Enfield Carers Survey 2012/13 results, Adults Performance Team, LBE

In 2012/13, Enfield had the 3rd highest proportion of carers reporting being always or usually involved in discussions about the person they care for in London, with Enfield’s rate being above the London rate of 66%, and in line with the England rate of 73%59.

Carer’s experience of finding information and advice: 2012/13

Source: Enfield Carers Survey 2012/13 results, Adults Performance Team, LBE

59 ASCOF 2012-13 results, National Adult Social Care Intelligence Service (NASCIS)
205 carers responded advising how easy or difficult it was to find information and advice about services or benefits. 62% of carers felt that information was easy or fairly easy to find, compared to 38% of carers who felt information was fairly or very difficult to find. In 2012/13, this was the 14th lowest rate across London, with Enfield’s rate below the London and England rates of 64% and 69% respectively.\footnote{ASCOF 2012-13 results, National Adult Social Care Intelligence Service (NASCIS)}

While the carers survey provides useful information about the opinions of carers about the services that they and the person they care for receive from Enfield Council, it should be noted that the survey is only completed by carers who are known to Enfield adult social care services, so does not capture, and as such may not reflect the opinions of hidden carers or those who do not receive specific services.

Further information on this topic is available from:

- Enfield Joint Carers Strategy: 2013 - 2016
- Enfield Local Account - How Well are we Delivering Adult Social Care Services? 2012

**Falls and Fractures**

Older people are more prone than younger people to unpredictable and unexpected falls, and the risk of falling increases with increasing age, with falls affecting a third of those aged 65 years and over, rising to over 40% in those aged 80 years and above.\footnote{Department for Work & Pensions ‘Falls in older people’ http://www.dwp.gov.uk/publications/specialist-guides/medical-conditions/a-z-of-medical-conditions/falls/}

Falls may occur as a result of a simple "trip", or may be caused by a variety of health-related issues, including weak or stiff joints, poor balance, general frailty, or as a result of immediate acute medical causes such as heart attacks or strokes. Risk factors associated with falls include lower limb weakness, previous history of falls, visual impairment, arthritis, cognitive impairment and incontinence.

The experience and consequences of a fall can be devastating, both physically and emotionally. The after effects of even the most minor fall can be catastrophic for an older person’s physical and mental health, and can result in loss of function, mobility, independence, confidence and even death.\footnote{Department of Health (2001) National Service Framework for Older People}

Falls are the commonest cause of injury-related hospitalisation in persons aged over 65 years, accounting for about 30% of all medical emergency admissions. Hip fractures, as a result of falling, can significantly impact on the quality and length of a person’s life. Following osteoporotic hip fracture, 50% of people will no longer be able to live independently, with fewer than half returning to their initial place of residence.

10% of people sustaining a hip fracture die within a month of admission, and 30% will have died at one year following admission. In 2008, it was estimated that the NHS in England and Wales spends an average of £15 million annually on fall-related injuries; this excludes hip fracture, which costs the NHS in the UK £1.7 billion annually.\footnote{Anderson (2008) ‘Falls in the Elderly’ J R Coll}

Enfield’s rate of emergency admissions due to hip fractures has dropped significantly between 2008/09 and 2010/11, to well below the London and England. The rate of emergency admissions for hip fractures is significantly higher amongst adults aged over 80, with rates in Enfield for the over 80’s being 1,306 admissions per 100,000 compared to 171.9 per 100,000 aged 65-79 years. In 2010/11, Enfield had the 7th lowest rate of emergency admissions for hip fractures in London.

As can be seen in the figure below, Enfield had one of the lowest rates in London of hospitalisation for over 65s due to fall injuries, well below both the London and England averages.

Directly Age-Sex Standardised Rate of Emergency Hospital Admissions for Injuries Due to Falls in Persons Aged 65 and Over per 100,000 Population, by London Borough: 2011/2012

Source: Health and Social Care Information Centre (HSCIC)

Source: Public Health Outcomes Framework Data Tool
Predictions suggest that in 2012 approximately 842 Enfield residents over 65 would have been admitted to hospitals as a result of falls. However, for the same period it is predicted that a total of 10,704 people over 65 would have had a fall at some point, indicating that majority of fall cases did not result in admission.

Further information on this topic is available from:

**Injury Profiles**

**Dementia**

Dementia is a term for a range of progressive, terminal organic brain diseases. Symptoms include decline in memory, reasoning and communication skills; reduced ability to carry out daily activities; and loss of control of basic bodily functions, which are caused by structural and chemical changes in the brain. Alzheimer’s disease is the most common form of dementia and age is the main risk factor in dementia. There are also a number of modifiable risk factors including smoking, excessive alcohol consumption and obesity.

In 2011/12, it is thought that 0.4% of Enfield’s population has been diagnosed with dementia, equating to 1,188 people. Enfield’s diagnosed dementia prevalence is below that of the National average of 0.5%.

**Trend in the Actual and Forecasted Dementia Prevalence and Diagnosis Rates Amongst Adults of All Ages in Enfield: 2010/2011 - 2014/2015**

As the graph above shows, the number of expected cases of dementia is significantly higher than the number of cases diagnosed, with only 39.9% of people living with dementia thought to have been formally diagnosed in 2011/12, compared to the estimated England average diagnosis rate of 44.2%, and London average of 44.6%. Enfield was ranked 149th out of the 178 Clinical Commissioning Groups (CCGs) in England, and 8th out of the London CCGs for its estimated dementia diagnosis rate in 2011/12.

Projections for 2012 suggest that approximately 7.2% of the over 65 population in Enfield may be suffering from dementia. Further projections suggest that the number of people aged 65+ living with dementia in...
Enfield by 2020 may reach 3,480, while cases of early onset dementia (amongst adults aged 30-64 years) are predicted to rise in Enfield from 69 cases in 2012 to 82 cases in 2020 – an increase of 19%.

The above chart suggests an improvement in the dementia diagnosis rate in Enfield to 59.5% by 2014/15, however future interventions to improve early identification of dementia may affect this predicted rate. Improving the rate of dementia diagnosis in the population is a key performance indicator for Enfield, and Enfield CCG aims to increase dementia diagnosis rates above the forecasted rate.

Further information on this topic is available from:

- Community Mental Health Profiles
- Enfield Joint Dementia Strategy: 2011 - 2016

Excess Winter Deaths

Excess Winter Deaths (EWD) is defined as the difference between the number of deaths during the winter months (December – March) and the average number of deaths during the preceding four months (August – November) and the following four months (April – July) (Office for National Statistics (ONS), 2014). The Excess Winter Deaths Index (EWDI) indicates whether there are higher than expected deaths in the winter compared to the rest of the year. The greater the number of winter deaths compared to the expected number, the higher the EWDI percentage.

The Cold Weather Plan for England 2014 identifies a number of ‘at risk’ groups who may be more susceptible to harm from cold weather, including:

- children under age 5
- elderly people living alone without additional support from social services
- people over 75 years old
- those with pre-existing chronic medical conditions
- individuals with learning difficulties
- people with mental ill-health affecting their ability to self-care (including dementia)
- those at risk of recurrent falls
- people with poor mobility or who are housebound
- those who are fuel-poor, live in deprived circumstances or are homeless (Public Health England (PHE), 2014a).

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69 Projecting Older People Population Information System (PANSI)
70 Projecting Adult Needs and Service Information System (PANSI)
During the period 2010-13, Enfield’s EWDI for people of all ages was 26.1%, which was significantly higher than London (18.0%) or England (17.4%). In 2010-13, Enfield’s actual number of excess winter deaths was 464, giving an estimated annual average of 154.7 excess winter deaths. The level of EWDs can vary greatly year on year. For this reason, cumulative data is often used to ensure a sufficient sample size for reliable estimates.
During 2010-2013, the Excess Winter Deaths Index (EWDI) was higher (although not significantly higher) for Enfield males compared with London (16.2%) and England males (15.5%). A similar pattern was also seen for females, in which the EWDI was considerably (but not significantly) higher for Enfield females (28.1%), compared with London (19.9%) and England (19.3%). However, this may be due to the relatively small numbers of excess winter deaths in Enfield during that period.

### Excess Winter Deaths (EWD) Index (%), all persons, by underlying cause of death, England and Wales, 2010/11 to 2012/13

![Graph showing the Excess Winter Deaths Index for different causes of death across different years.](image)

Source: Office for National Statistics (ONS); Excess Winter Deaths (EWD) Index = excess winter deaths divided by the average non-winter deaths and expressed as a percentage. The standard ONS methodology for calculating excess winter deaths (EWD) defines the winter period as December to March and uses the difference in deaths between non winter and winter months to produce a figure for excess winter deaths (EWD).

During 2012/13, the largest number of excess winter deaths in England and Wales was due to respiratory diseases, accounting for 37% of these deaths. During that year, 54.1% more people died from respiratory diseases in the winter, compared to the non-winter period. This compares with 18.4% for circulatory diseases, 37.1% for dementia and Alzheimer’s disease and 9.7% due to injury and poisoning (which includes accidental falls, that increase during winter, due to icy pavements) (Office for National Statistics (ONS), 2014).

During the winter of 2012-13, there were around 31,000 deaths in the UK, linked to the cold weather, compared to about 18,000 excess winter deaths during 2013/14 (ONS, 2014). Cold homes can be very damaging to health and one of the best ways to stay healthy during winter is to stay warm. Keeping warm helps prevent a variety of conditions associated with colder weather, such as colds and flu as well as more serious ailments such as; pneumonia, heart attacks, strokes and depression. However, there are currently about 2.46 million households in England in fuel poverty (where the household is living below the poverty line and has higher than average energy bills). In such circumstances, children, the elderly and disabled people are particularly at risk (NHS Choices, 2014). At a national level, the impact of cold homes on the health of older people is substantial, costing the NHS about £1.36 billion in primary and hospital care annually (Age Concern, 2012).

The relationship between temperature, influenza and excess winter mortality is a complex one (Office for National Statistics (ONS), 2014). England experiences large numbers of excess winter deaths, even when compared with Northern European countries, despite their more extreme winters. At present, England is
seen as “the cold man of Europe” due to its high level of fuel poverty and poorly insulated homes. In contrast, Sweden, where people face higher fuel prices and colder winters, generally has better insulated homes, leading to lower rates of fuel poverty and excess winter deaths (Association for the Conservation of Energy, 2013).

People who live in warmer countries tend to live in homes with poorer thermal efficiency (i.e. less cavity wall insulation and double glazing) and take fewer precautions against the cold, such as wearing warm clothing in cold weather (Healy, 2003). Low indoor temperature has also been associated with increased mortality from cardiovascular diseases (Wilkinson et al., 2004).

Interestingly, although excess winter mortality is associated with lower temperatures, illnesses directly related to the cold (e.g. hypothermia) are not the main cause of this increased mortality. Instead, the majority of deaths attributable to excess winter mortality are due to circulatory and respiratory diseases. Colder home temperature below 18°C has been linked to increased blood pressure (Bruce, 1991). In addition, there is an established link between influenza and winter conditions (NHS Choices, 2013). However, although mortality does increase as it gets colder, outdoor winter temperature only explains a small amount of the variance in excess winter mortality. It could be that older people are less likely to be able to respond to cold conditions when needed to, by turning heating on/up or wearing appropriate clothing. Younger people are also better able to discriminate between very small differences in temperature in a cold environment (Collins et al., 1977).

The currently available evidence base suggests that heating homes to at least 18°C poses minimal risk to the health of a sedentary person, wearing suitable clothing. At below 18°C, negative health effects may occur, such as increases in blood pressure and the risk of blood clots which can lead to strokes and heart attacks (PHE, 2014b).

Further information:
Public Health Outcomes Framework

References:

Age Concern (2012). Cold homes costing NHS £1.36 billion.


NHS Choices (2014). Keep warm, keep well.
**End of Life Care**

Many people are living longer due to improved lifestyles & treatments of previously fatal long-term diseases such as cancer. This is welcome, but also means people are less familiar with dying & death, and often find it difficult to talk about & prepare for. Many people die where & as they would like, but some do not, whilst the quality of care they receive is often, but not always, good.

End-of-life care is about helping those with advanced & incurable illness to live as well as possible until they die. It helps make sure the needs & preferences and care & support needs of patients & families are known, planned for & met in their last months & days. It includes pain & symptom management and ensures psychological, social, spiritual & practical needs are met.

Despite much good practise, not everyone is benefiting from coordinated care between specialist end-of-life providers like hospices, general healthcare, such as GPs, and other support, e.g. from the voluntary sector & social care. As a result, Enfield’s Joint End-of-Life Strategy was developed to set out how the NHS, Council & partners will work together to tackle these issues. This Factsheet’s analysis is based on the Strategy & its progress to date.

**Key Issues and Gaps**

Death rates from serious illnesses such as cancer and heart disease have fallen in Enfield over the past 10 years, and remain below the England average. For those individuals born between 2006 and 2010, male and female life expectancies are 78.8 & 82.7 years (and these are likely to improve year-on-year), both above the England average, although there are significant variations in mortality rates across Enfield, largely due to underlying deprivation.

There were 1,950 average annual deaths of Enfield residents between 2009 & 2011, a continuing decrease from 2001, as people’s life expectancy is increasing, with 75% of deaths of those aged 70+. A primary cause of death is progressive diseases like dementia, heart disease or cancer, with the last two the reason for half the deaths. Many deaths are therefore due to these illnesses in which people might benefit from end-of-life care: the Marie Curie Care Atlas suggested 1,550 adults with an incurable disease in Enfield could benefit from end-of-life services. This number is expected to fall until 2016 before increasing: it is predicted there will be a 6% increase in the number of people who might benefit from end-of-life care between 2011 & 2023 and these individuals are more likely to be older, frailer and suffer multiple long-term conditions.

The experience of people nearing end-of-life & families using services is generally positive and in line with national findings. Although more Enfield residents need to benefit from the approach, these findings may reflect the range of high-quality & well-coordinated care & support across different sectors, strengthened by development of a Palliative Care Community Support Service, which helped people plan for & die at
home if this is where they would prefer. Major improvement areas were identified: for example, making sure general care providers, such as care homes & GP practises, have better awareness of, & can better support, end-of-life patients; and making sure more people can choose to die where they wish (often at home) – two-thirds of Enfield residents died in hospital in 2008-2010, one of the highest figures in London.

Recommendations for consideration by commissioners

Enfield’s End-of-Life Strategy (2012) sets out good practice objectives which provides a framework for commissioning across partners:

- Encourage people to discuss death and dying: Doing so with their family and friends makes it more likely all of us will plan for end of life;
- Identifying all people nearing the end of life is the first step to making sure people’s needs are met; sadly the evidence clearly indicates not everyone is known to the right services at the right time;
- Involve carers & families in planning & making decisions about care and ensure they are supported in their own right;
- Effective Care Planning: Everyone approaching end of life will need their needs assessed, their wishes discussed and their choices about care recorded in a plan: there is a need to ensure this happens more consistently;
- Co-ordinated care across different organisations is vital to make sure people have timely access to high-quality services;
- Develop & review rapid access to end-of-life care 24/7: The Palliative Care Community Support Service has fulfilled a key element of this role over the last 18 months, and, although the signs are promising, the service & its outcomes it has achieved need to be reviewed;
- Ensure good care in the last days of life: When an someone reaches this point, It is vital those caring for them recognise this and make sure death is as pain-free as possible, so they and their family suffer as little as possible;
- Involve & support friends & families as partners in providing care, and involving them in decision-making, whilst recognising their needs;
- Need to implement a robust end-of-life performance framework to ensure the above outcomes are delivered consistently & equitably in a way that reflects the Borough’s diverse population’s needs in relation to end-of-life care;
- Ensure services provide consistent, high quality care: Despite the training since 2011, care organisations still need encouragement to obtain Gold Standards Framework training & accreditation in working with people near end-of-life;
- Develop the workforce to make sure health and social care staff have the right knowledge, skills, behaviours and attitudes;
- Make sure the Strategy represents good value and hospice services are sustainable

Who is at Risk and Why?

Nearly 314,000 people lived in Enfield in 2011, of which 86,400 were aged 50+ (27% of the overall population), 38,800 aged 65+ (12.5%); & 5,300 85+ years (1.7%). The health of Enfield residents is similar to the England average. As people age beyond 55, however, they are more likely to develop life-limiting conditions - 58% of those with such conditions are aged 60+, whilst 70% of 85+ year olds have 3+ conditions (Collerton, 2009). The most common conditions, alongside diabetes and hypertension, affecting older people are: cancers, chronic obstructive pulmonary disease, musculoskeletal diseases (e.g. rheumatism, arthritis), stroke, dementia, heart disease, cardiovascular disease and neurological conditions like Parkinson's Disease (Figure 1). Many of these conditions – such as stroke and cancers – are life-threatening, whilst some are incurable diseases (e.g. dementia) or may not respond to treatment in individual cases. The risk of developing – and having severe forms of – specific long-term conditions often varies according to age, gender, ethnicity and personal circumstances and lifestyles, including deprivation (see Older People with Complex Needs for further discussion).
Estimated Percentage Prevalence of Long Term Condition* amongst people aged 16-64 years and 65 years and over in Enfield: 2011

![Graph showing estimated percentage prevalence of long term conditions by age group and condition.]

Source: Association of Public Health (APHO) 2011 Disease prevalence models

*Please note that diabetes prevalence estimates are not available by age band, so have not been included in the graph above.

Mortality rates from serious illnesses such as cancer and heart disease have fallen in Enfield over the past 10 years, and remain below the England average. For individuals born between 2006 and 2010, male and female life expectancies are 78.8 & 82.7 years, both above the England average. However, there are large disparities between life expectancy in different parts of the Borough, with a 10-year difference between life expectancy in the south eastern and north western wards. This largely reflects significantly differing levels of deprivation.

Wards in the east, including areas of Edmonton Green, Ponders End & Turkey Street, rank in the most deprived 10% of sub-wards in England. In contrast, wards in the west, e.g. Cockfosters, Grange & Highlands are amongst the least deprived. Table 1 shows Enfield’s ward-based standard mortality rates (SMR) – in the table, a value of 100 means mortality rates are average for England; a higher figure that mortality rates are worse than England average, a lower figure, better than average. It shows Cockfosters, Grange & Highlands had significantly lower than average mortality rates, but others, including deprived wards – Upper Edmonton & Enfield Lock – but also Chase, have higher mortality rates.
There is a need for everybody to think and talk about, and prepare for, death and feel able to make decisions about life, care & treatment with families and professionals at the right time for them. This is particularly important if people know they are approaching end of life, but sadly not everyone is able to, or is provided, with the opportunity to do so.

There were 1,950 average annual deaths of Enfield residents between 2009 & 2011, a continuing decrease from 2001, as people’s life expectancy is increasing, with 75% of deaths of those aged 70+. A primary cause of death is progressive diseases like dementia, heart disease or cancer, with the last two the reason for half the deaths in 2007-2009 (Figure 2): Many deaths were due to incurable forms of these illnesses in which people might benefit for end-of-life care. Estimates from the Marie Curie Care Atlas suggested 1,550 adults with an incurable disease in Enfield could benefit from end-of-life care in 2010. Sadly, not all these individuals were known to services and did not benefit from specialist & coordinated care. As a result, making sure people are known to services is an objective in Enfield’s End of Life Strategy. Furthermore, different age groups have different causes of death: 20% of people under 35 die from cardiovascular disease & cancers, but three-quarters of deaths in the 65-74 year age group are caused by these conditions.

<table>
<thead>
<tr>
<th>Ward</th>
<th>SMR</th>
<th>SMR Significance</th>
<th>Ward</th>
<th>SMR</th>
<th>SMR Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowes</td>
<td>89</td>
<td>Orange</td>
<td>Lower Edmonton</td>
<td>128</td>
<td>Red</td>
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<td>Bush Hill Park</td>
<td>88</td>
<td>Orange</td>
<td>Palmers Green</td>
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<td>Orange</td>
</tr>
<tr>
<td>Chase</td>
<td>124</td>
<td>Red</td>
<td>Ponders End</td>
<td>115</td>
<td>Red</td>
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<td>Green</td>
<td>Southbury</td>
<td>91</td>
<td>Orange</td>
</tr>
<tr>
<td>Edmonton Green</td>
<td>125</td>
<td>Green</td>
<td>Southgate</td>
<td>71</td>
<td>Green</td>
</tr>
<tr>
<td>Enfield Highway</td>
<td>85</td>
<td>Orange</td>
<td>Southgate Green</td>
<td>88</td>
<td>Orange</td>
</tr>
<tr>
<td>Enfield Lock</td>
<td>137</td>
<td>Red</td>
<td>Town</td>
<td>86</td>
<td>Orange</td>
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<tr>
<td>Grange</td>
<td>74</td>
<td>Green</td>
<td>Turkey Street</td>
<td>102</td>
<td>Orange</td>
</tr>
<tr>
<td>Haselbury</td>
<td>85</td>
<td>Orange</td>
<td>Upper Edmonton</td>
<td>162</td>
<td>Red</td>
</tr>
<tr>
<td>Highlands</td>
<td>62</td>
<td>Orange</td>
<td>Winchmore Hill</td>
<td>112</td>
<td>Orange</td>
</tr>
<tr>
<td>Jubilee</td>
<td>104</td>
<td>Orange</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
Figure 3 uses a staged approach (based on the Department of Health model (2008)) to describe the needs of people - and their families - approaching end-of-life from beginning to have a conversation about their end of life through to the end of their days and beyond. Some issues at each stage are common, e.g. feeling psychological, social, spiritual and cultural needs are being met.

VOICES' was a national survey of people using end-of-life care and their relatives about their experiences conducted in 2011. The results were published at North Central London level (Enfield, Barnet & Haringey), so they are indicative for Enfield. Key results about individuals’ experiences were very similar to the national picture:

- 42% and 39% of individuals received end-of-life care strongly agreed their nursing and personal care needs, respectively, were met, both similar to the corresponding England averages;
- 53% strongly agreed their privacy was adequately respected, slightly higher than the England average (49%);
- Only 14% and 37% of respondents agreed those receiving end-of-life were completely free of pain at home and in hospice/hospital, respectively, 3 months before their death, both similar to the corresponding England averages. The difference in experiences acts as a barrier to people ending their days at home;
- 50% of respondents agreed those receiving end-of-life had the support they needed to stay where they wanted, and the same proportion agreed they received excellent care 2 days before death similar to England averages;
- 37% and 39% agreed those receiving end-of-life felt the emotional and spiritual support, respectively, was excellent 2 days before death, both similar to the corresponding England averages;
- 37% agreed those receiving care had relief from symptoms other than pain 2 days before death similar to the average
Outcomes at Each Stage of End of Life

**Stage 1:** Individuals and families beginning to come to terms with a prognosis of end of life and feeling there is adequate and meaningful advice, information and support to do so; and feel supported in making decisions about the remainder of their lives, including practical steps to put their affairs in order;

**Stage 2:** Expecting, planning and receiving professional help from a range of agencies tailored to individuals’ needs & preferences. There is a vital need to make sure care planning & support is coordinated & personalised, and is of high quality, whilst respecting individuals’ dignity and people feel confident to make decisions about their future, e.g. in Advanced Care Planning. Sadly, not everyone experiences the benefit of this approach, often because care planning is not as joined up as it could be. This heightens the importance of being able to identify all individuals approaching end-of-life;

**Stages 3 & 4:** When an individual reaches the last few days of life, it is important those caring for them recognise this and help make sure death is as pain-free as possible, and they, their family and friends, suffer as little as possible. There is a need to respect the individuals’ wishes (e.g. Do Not Attempt Resuscitation notices and Advanced Care Planning directives), which are likely to extend to what happens after death; and it is important to support those who may be close to the individual with their own needs.

The survey also focussed on meeting the needs of those close to the individual receiving end-of-life care.

This provides a mixed picture: good engagement and support near the time of death, but less afterwards:

- **57%** agreed no decisions were made about care the patient wouldn’t have wanted lower than the average (63%);
- **83%** agreed they felt involved in decision-making about an individuals’ care better than average (78%);
- **48%** agreed the individual had a choice about where to die, slightly lower than the England average (51%);
- **58%** agreed the family had sufficient help and support at the time of death, whilst **91%** felt professionals dealt with the family sensitively afterwards, both similar to the corresponding England average;
Only 11% of respondents reported they had talked to anyone about their loss since the patient’s death, slightly lower than the England average (15%).

Place of Death

An important consideration for those approaching end-of-life is where they would like to die. The majority of people suffering from a terminal illness would prefer to die at home: a YouGov/Marie Curie Cancer Care Survey showed only 4% of Britons would prefer to die in hospital, with around two-thirds preferring to die at home and a quarter in a hospice. Unfortunately, as nationally, these preferences were not realised in Enfield to 2010 (Table 2): the majority of deaths remain in hospital, and, in fact, Enfield had the highest such rates in North London. Research suggests people receiving good, well-coordinated end-of-life care tailored to their & their families' needs are much more likely to have their preferred place of death considered and put in place. For many people this will therefore mean dying at home or in a hospice rather than in hospital. Making this change happen is a key aim of Enfield's Joint End of Life Strategy.

Proportion of Deaths by Place of Death 2008-2010 (Yearly Average)

<table>
<thead>
<tr>
<th>Place of Death</th>
<th>Percentage of Total Deaths</th>
<th>Number of deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>67%</td>
<td>4107</td>
</tr>
<tr>
<td>Own Residence</td>
<td>16%</td>
<td>985</td>
</tr>
<tr>
<td>Hospice</td>
<td>4%</td>
<td>273</td>
</tr>
<tr>
<td>Nursing Home/Residential care</td>
<td>11%</td>
<td>674</td>
</tr>
<tr>
<td>Other</td>
<td>2%</td>
<td>108</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>6147</td>
</tr>
</tbody>
</table>

Source: Enfield's Joint Commissioning Strategy for End of Life Care: 2012-2016

The place people died also varied depending on their illness (Figure 4). Nearly 80% of deaths of Enfield residents due to respiratory diseases were in hospital compared to just over half of deaths of people with cancer in 2009, with a much higher proportion of individuals with cancer dying in hospices: in fact, relatively few individuals with other conditions died in hospices.
Current services (including quality assurance) and assets in relation to need

Enfield’s end-of-life services have been developed to help ensure people & families are known to all services they need at the right stage in their illness in the way described in the Needs Section. It is often very important to coordinate this care, so partner organisations developed a care network for those who needed end-of-life care to reflect this aspiration (Figure 5).

End-of-Life Care Network
This care network reflects the 3 different types of services which work together to support individuals (Table 3)

- **Specialist End-of-Life Care** provided in hospice, hospital & in the community. These services provide specific expertise for those with complex needs and help provide symptom control, pain management, psychological & spiritual care delivered through specialist palliative care consultants, clinical nurse specialists, physiotherapists & social workers. These organisations offer best practise advice, training and development about end-of-life to others, such as GPs;

- **General healthcare services** supporting people approaching end of life. This includes care from GPs, community nurses, pharmacists or in hospital or care homes. In such settings, it is important staff have the knowledge, skills & attitudes to help people plan, and provide care, at end of life in line with national standards & patients’ expectations;

- **Other types of service** at home, in hospital or in residential and nursing care. Such services include the vital – practical, emotional and spiritual – support, advice and information provided by the voluntary sector and social care.

There are also pan-London or national initiatives aimed at improving the quality of care amongst providers in Enfield’s care network:

- **Gold Standard Framework (GSF)** is a systematic evidence-based approach to good management of care of patients nearing end-of-life, helping people live well until the end, including care in the final year. It is aimed at primary care, hospitals, care home & home care organisations & their staff. Its provides a framework for staff to improve patient care by: improving their skills & knowledge about end-of-life, including in communication and coordinating care; controlling symptoms as much as possible; enabling patients to live & die well in their preferred place of care and reducing their risk of crises or hospital admission; providing advice, information, security & support, including in advance care planning; and making sure carers are supported, informed, enabled & empowered.

- **Liverpool Care Pathway (LSP)** is a clinical pathway that provides guidance to clinicians on how to improve care of the dying in the last hours/days of a patient’s life. This includes guidance about comfort, medication prescribing, discontinuing inappropriate interventions and meeting personal wishes for the last days of life. A Department of Health national review of LSP recommends it should be replaced by a personalised end of life care plan together with good practice guidance specific to disease groups, in 2014;

- **Preferred Priorities of Care (PPC)** is a patient-held document facilitating patient choice about end-of-life care developed between patient, carers & professionals to help share information about patient/carer choices. Each plan’s development provides an opportunity to discuss difficult issues, including where they would prefer to end their days and helps prevent patients having admissions, treatments or interventions;

- **Mental Capacity Act (2005)** sets out the legal framework for how decisions are made on behalf of people with impaired capacity. This includes people nearing the end of life, e.g. if they have advanced dementia, have impaired function or are unconscious. A national framework, with a guidance toolkit, help care providers meet MCA’s requirements including: making sure the person’s interests are at the heart of person-centred planning of care; tests to assess capacity & determine an individuals’ best interests; consulting next-of-kin about best interests and court powers to appoint deputies; advanced care planning to guide decisions about treatment; and advocacy;

- **A new pan-London IT system, Coordinate My Care,** has made it possible for different organisations – GPs, hospices and hospitals – to share and add to a common health record about patients receiving end-of-life care in 2013. This will improve the coordination and effectiveness of end-of-life care, including out-of-hours support. The out-of-hours process (including access to palliative care drugs) was re-designed to include the national 111 non-emergency number in 2013.
<table>
<thead>
<tr>
<th>Service</th>
<th>Description &amp; Aims</th>
<th>Facts &amp; Figures about Service</th>
<th>Customer Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>End-of-Life Inpatient Facilities</strong></td>
<td>Provided for patients with complex problems who can’t be managed adequately in other settings and who would benefit from continuous support from a multidisciplinary end-of-life care team. Care is provided in affiliation with local hospitals in North Finchley manages the specialist Palliative Care Service and offers care to people in their advanced stages of illness. Enfield and Haringey. Advice &amp; care provided to people at home, at the Hospice’s Day Centre (at Sawmill Green) and in the In-Patient Unit. Inpatient hospice care for Enfield residents is also provided by St. Joseph’s Hospice in Hackney and Marie Curie (Ella Harold) in Hampstead, who also provide day services.</td>
<td></td>
<td>The views of patients using these specialist services are overwhelmingly positive. The VOICES Survey (2011) indicated 42% of individuals receiving end-of-life care strongly agreed that their nursing care needs were met similarly to the corresponding England average. Furthermore, 37% of respondents agreed that receiving end-of-life care was completely free of pain in the last 3 months before their death, similar to the England average.</td>
</tr>
<tr>
<td><strong>Specialist Palliative Care Team – Hospital</strong></td>
<td>Provides a weekly visit visiting service for patients nearing end of life with cancer or with complex symptom management needs. There are weekly clinics at both hospitals and a social worker on staff at Chase Farm Hospital.</td>
<td></td>
<td>In 2009/10 there were 44 deaths recorded for Enfield residents in Barnet and Chase Farm Hospital and North Middlesex Hospital under the care of the Specialist Palliative Care Team. This compares with the 692 deaths in those hospitals over the same period.</td>
</tr>
<tr>
<td><strong>Specialist Palliative Care Support Services – Community</strong></td>
<td>Provides symptom control, counseling, advice and care to patients, families &amp; friends in their home via a multi-disciplinary team approach, working with GPs, district nurses &amp; other professionals. Community nurses are on call every weekday, with urgent visits nurses providing 24/7 support to provide rapid responses to those who need information, advice &amp; support as part of the service re-development. A new day care facility opened in Enfield in 2012/13.</td>
<td></td>
<td>The VOICES Survey showed 57% &amp; 50% of people receiving end-of-life care thought hospital doctors &amp; nurses, respectively, always treated them with dignity &amp; respect, slightly lower than the England average. The survey also indicated 40% &amp; 30% of respondents thought the quality of care provided by doctors &amp; nurses was excellent, compared to 36% &amp; 35% for England.</td>
</tr>
<tr>
<td><strong>Palliative Care Support Services</strong></td>
<td>In conjunction with its Community Support and working with Community Care, North London Hospice also provides Palliative Care Support Services into patient’s homes. The service provides a rapid response to patients &amp; families to reduce anxiety &amp; protect hospital admission to enable patients to remain at home if that is their wish.</td>
<td></td>
<td>A North London survey showed 76% &amp; 66% of patients &amp; relatives using the Community Services made positive comments about the service, although everyone said responded with the service in 2012/13. Furthermore, the patients of the service who died in 2012/13, 86% died at home, and only 20% in hospital. However, challenges remain for end-of-life patients in Enfield. The VOICES Survey reported 30% of people receiving end-of-life care thought the quality of care out of hours was excellent, albeit higher than the England average (26%). Improving the quality of care out of hours supports across the health system, including GPs, is therefore a priority.</td>
</tr>
<tr>
<td><strong>Marie Curie</strong></td>
<td>Marie Curie provides home-based nursing for terminally ill patients, but increasingly all patients who are requiring terminal care at home.</td>
<td></td>
<td>Following the removal of the Palliative Care Support Services, 96% of the people who accessed PCS did so at home. Significantly higher than the overall population in the area. As a whole, feedback from these patients about the support offered was generally positive: “The care, time, patience, knowledge, interest in both the patient &amp; the family was done really well. The staff doing their job &amp; it was a hard time...”</td>
</tr>
<tr>
<td><strong>Gentle Dust</strong></td>
<td>A specialist end-of-life training organisation to raise awareness and train &amp; support volunteers to provide advice, help and support to people at the end-of-life and their families to live as fulfilling a life as possible and plan their last days.</td>
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</table>
Emotional, practical and bereavement support for patients and families is an important part of the care pathway, including after death. Specialist end-of-life providers generally have trained staff and volunteers able to offer bereavement information, support and counselling after death. Information about bereavement and registering deaths is also available to all residents from the Council’s Registrar’s Office.

There are many organisations providing (often peer or self-help) bereavement support, information & resources face-to-face, via telephone or on-line (Table 3).

Projected service use and outcomes over the next 10 years

Key factors in understanding future demand for end-of-life care are predicted and welcome increases in both the number of older people and average life expectancy, though there will be health-related consequences:

- The number of Enfield residents aged 65+ is set to increase by 17% to 45,540, and the number 85+ by 31% to 7,150, by 2022;
- As a result, there will be a corresponding increase in the number of people with life-threatening conditions, the size of the increase dependent on residents’ lifestyles as they age, e.g. those who smoke or have less active lifestyles are at greater risk of conditions like heart disease. Unless there is an improvement in Enfield’s population health in the future, this will lead to increased prevalence of musculoskeletal disorders (50% between 2010 & 2030), heart disease (50%), dementia (80%) & stroke (57%) by 2025 (Jagger, 2011);
- However, even if the population adopted healthier lifestyles due to health programmes amongst those aged 50+, this will act to limit, rather than reduce, the number of those with long-term conditions by 2025, simply because there will be more older people;
- The increase in the number of people with life-limiting conditions will mean more people needing health & social care, including end-of-life care. However, it is expected more people will live longer, or survive, these conditions due to earlier disease diagnosis & treatment and healthier lifestyles. These trends mean the number of annual deaths in Enfield is expected to decrease gradually to 2016 before beginning to increase after this. Nationally, the number of deaths is predicted to increase by 17%
between 2012 & 2030, with people dying at typically older ages – it is predicted all deaths of people aged 85+ will rise from 32% to 44% between 2003 & 2030 (Gomes & Higginson, 2008);

- The number of UK residents living with cancer will double between 2010 & 2030, with 19% of people aged 65+ having cancer diagnoses by 2030 compared to 13% in 2010 (Madden et al, 2012). However, the proportion of deaths from cancers will increase by 30% & 12% for men & women between 2003 & 2023, as more people survive (Olsen et al, 2008).

If the above analysis was applied to Enfield, it would mean the number of deaths would increase from 2,066 to 2,150 (50:50 gender split) between 2009 & 2023, after decreasing until 2016, with the corresponding number of deaths from cancer increasing from 550 to 670 (55% men). It would also mean the number of patients who could benefit from end-of-life care is expected to increase by 6% to 1,655 between 2011 & 2023 (Marie Curie End of Life Atlas, 2013).

There are societal changes likely to impact on future end-of-life care requirements. One issue is likely to be greater expectation amongst people they can end their days in the place they choose – with an increasing majority wanting to do so outside hospital. In the future, however, enabling this will present challenges:

- People are likely to be, on average, older & frailer when approaching end-of-life, and have multiple conditions - 70% of people aged 85+ have 3+ long-term conditions. This means there will be a greater risk of hospital admissions amongst these individuals, with their care management becoming typically more complex;
- The increases in the number of people suffering some long-term conditions, e.g. dementia, may mean more people won’t be able to make choices about care at the point they are approaching end-of-life. This highlights the need for effective advanced planning of care;
- An important enabler in ensuring people with such conditions are supported to live & die at home is likely to be making sure their carers’ physical and emotional well-being is well supported. It is likely both the number of people providing unpaid care and the number of older carers in Enfield will continue to increase in line with national findings (Enfield Carers’ Strategy, 2013). However, this increase is likely to lower than that of the number of people with long-term conditions (Wanless, 2006).

Evidence of effective interventions - what works and makes a difference

Successive UK Governments have developed policies to improve the coordination, person-centred nature and quality of end of life care for people with terminal illness. These policies, which were translated into local objectives and commissioning intentions based on local need in Enfield’s Joint End-of-Life Strategy, include:

The Department of Health’s End of life Care strategy (2008), informed by findings from the NHS next stage review (2008) and the National Institute for Health and Clinical Excellence Guidance about end-of-life care, including cancer;

The NHS End of Care Life Program (2004) incorporated rollout of programmes such as the Gold Standards Framework (GSF), the Liverpool Care Pathway (LCP), the Advance Care Planning (ACP) and the Preferred Priorities for Care (PPC). These are all evidence-based approaches to delivering high-quality care as people approach end of life;

The Marie Curie Delivering Choice Programme (2004) aims to evaluate models of care aimed at doubling the number of people with a terminal illness who are cared for and spend their final days at home.

Other national policies relevant to the provision of end-of-life care, include:

- The Cancer Reform Strategy (2007)
- Caring for Our Future: Reforming Care & Support (2012)
- Mental Capacity Act (2005)
- National Dementia Strategy (2009)
- National Service Frameworks for: Heart Disease, Older People, Long Term Conditions, Renal & Neurological Conditions
Putting People First (2008)

Public and user/patient and carers views including quality assurance

Enfield’s End of Life Strategy underwent extensive public consultation in its development & production, and feedback from patients & families is generally positive about the support they receive, particularly in specialist care. Feedback from patient and families from the national VOICES Survey, a self-completed patient/family questionnaire about their experiences of end-of-life care from 2011, is included in the Needs Section. Despite this, however, there remains a need to incorporate patients’ views in a more systematic way to inform end-of-life care, particularly those in more general care settings.

Equality Impact Assessments

This Factsheet focuses on the needs of adults with life-threatening conditions, with other sections analysing the age & gender of individuals likely to acquire such conditions now & in the future, with older people known to be at greater risk. Other issues are explored below.

Ethnicity: Enfield is a highly diverse Borough, but with greater ethnic diversity in deprived south & eastern wards than in the more affluent west. Based on the 2011 ONS Census, 43% of residents were ‘White British/Irish’. Other major groups include:

- White Other – 18%, the majority of whom are Greek/Greek Cypriot (5.8%) or Turkish/Turkish Cypriot (8.6%);
- Black - 17%, the majority Black African (9.0%) or Black Caribbean (5.5%);
- Asian – 7%, the majority Indian (3.7%) or Bangladeshi (1.9%);
- Mixed – 5.5%
- Ethnic diversity varies significantly by age: 83% of residents aged 65+ were "White", 5% "Black Caribbean" & 4% "Indian".

The degree to which residents are at risk of acquiring long-term conditions varies depending on several factors, e.g. deprivation, lifestyle & ethnicity. However, successive Department of Health’s England Health Surveys found black & minority ethnic groups are more likely to report ill health, and long-term ill health begins at a younger age than for those "White British". For example, older people from SE Asian backgrounds are 3 times, and those from black backgrounds are 60%, more likely to develop disabilities due to underlying ill health than those from white backgrounds (Williams et al, 2012; Dunlop et al, 2007).

In fact, different ethnic groups are at differing risk of the same life-limiting condition. For example, those from SE Asian & Black Caribbean ethnicities are at greater risk of dying from heart disease or stroke than those from White backgrounds, but the reverse is true for most cancers, notably lung cancer (Gill et al, 2009). This means the number of people from different ethnic groups needing end-of-life care for specific conditions varies, as does the cultural, spiritual and/or religious needs of many individuals from these groups. Despite this, black & ethnic minority groups are reported to have less access to end-of-life care services nationally than those "White British" due to lack of referrals, lack of awareness or information in relevant languages or formats and family/religious values conflicting with the idea of hospice care (Calazani et al, 2013).

Disability: In Enfield, there were 4,480 people aged 18-64 with a learning disability (1,003 with significant disabilities), and this will increase to 4,832 (1,129) by 2030. People with these disabilities are likely to be at risk of acquiring life-threatening diseases at least 5-10 years earlier than the general population and die younger. There can be challenges in providing high quality end-of-life services to these individuals, including their additional health problems, problems in communication with professionals & lack of specialist knowledge & skills about disabilities amongst end-of-life professionals (Disability Rights Commission, 2006). The Integrated Learning Disability Services in Enfield is a combined NHS and Council team designed to meet specialist health & social care needs and provides care combining specialist end-of-life and learning disability care to address these issues.

Unmet needs and service gaps
Enfield’s Joint End of Life Strategy (2012) contains an analysis of unmet need based on much of the evidence presented in this Fact sheet and identified improvement objectives based on the National End-of-Life Strategy. These objectives provides a framework to discuss gaps:

- Encourage people to discuss death and dying: Doing so with their family and friends makes it more likely all of us will plan for the end of our life – but clearly there is more that can be done to promote this;
- Identify all people nearing the end of life is the first step to making sure people’s needs are met; sadly the evidence clearly indicates not everyone is known to the right services at the right time;
- Involve carers & families in planning & making decisions about care and they are supported in their own right – it is clear that whilst there is much good practise, there is evidence of the need to make this more consistent;
- Effective Care Planning: Everyone approaching end of life will need their needs assessed, their wishes discussed and their choices about care recorded in a plan: there is a need to ensure this happens more consistently;
- Co-ordinated care across different organisations is vital to make sure people have timely access to high-quality services;
- Develop rapid access to care: As an individual’s condition may change quickly, it is important support is well-organised rapidly, including 24/7 services so more people live and die in the place of their choosing and not in hospital following an emergency. The remodelled Palliative Care Support Service has fulfilled an important part of this role over the last 18 months, and, although the signs are promising, the service & its outcomes it has achieved need to be reviewed;
- Ensure good care in the last days of life: When an someone reaches this point, It is vital those caring for them recognise this and make sure death is as pain-free as possible, so they and their family suffer as little as possible;
- Involve and support friends and families as partners in providing care, and involving them in decision-making, whilst recognising they have their own needs;
- Need to implement a robust end-of-life performance framework to ensure the above outcomes are delivered consistently & equitably in a way that reflects the Borough’s diverse population’s needs in relation to end-of-life care;
- Ensure services provide consistent, high quality care: Despite the training since 2011, care organisations still need encouragement to obtain Gold Standards Framework training & accreditation in working with people near end-of-life;
- Develop the workforce to make sure health and social care staff have the right knowledge, skills, behaviours and attitudes;
- Make sure the Strategy represents good value and hospice services are sustainable.

Recommendations for consideration by commissioners

The objectives in the Unmet Needs Section also provide a framework for commissioning intentions (Table 4). Furthermore, Enfield’s End-of-Life Strategy committed partners to achieve the following targets by 2015/16 as a measure of its success:

- All GP practices will have a complete register available of all patients in need of end-of-life care (by 2014);
- 90% of Care Homes will have attained Gold Standards Framework accreditation;
- 90% of GP practices will have attained Gold Standards Framework accreditation;
- 90% of people who have died from incurable illness will be enabled to exercise a positive choice about their place of death;
- 90% of people who have been receiving End of Life Care die with an End of Life care plan in place
- The number of deaths that occur in hospital will be reduced from 68% to 50% of all deaths;
- All health and social care staff will receive appropriate training in End of Life Care.

Commissioning Intentions
Recommendations for further needs assessment work

This will be included in the End-of-Life Strategy Update to be published in 2013.

Further information

End of Life Care is an important issue, not only because of the challenges on-going demographic trends will place on the systems to support people in the latter stages of their life, but also because national evidence suggests there is unmet need for palliative care and end of life care services.
While the majority of people express the wish to die at home, most people (two out of three) die in hospital. A recent study has estimated that if past trends in terms of levels in home deaths continue, in order to meet the projected increase in the numbers of annual deaths nationally (585,000 in 2030) there would be a need to expand inpatient facilities by over 20%.

National evidence suggests that there is still inequitable access to high quality palliative and end of life care across the country. A report from the National End of Life Care Intelligence Network has highlighted that people living in the most deprived quintile are more likely to die in hospital (61%) than people living in other quintiles (54–58%). Even after taking into account the combined effects of deprivation quintile, age at death, gender and cause of death, death in hospital is more common in the most deprived quintile. In contrast, death in care or nursing homes or hospices was most common in the least deprived quintiles least common in the most deprived quintile. There is no clear gradient across deprivation quintiles for the proportion of deaths at home (average 20%).

Proportion of Deaths of Those Aged 65 and Over by Location, for Enfield: 2008 – 2010

Between 2008-10, 3,380 people were recorded as dying in hospital. Despite being a reduction from the 2007-09 figure (68.2%), the percentage of in-hospital deaths remains well above the London (61.0%) and England (54.4%) average, with Enfield having the 4th highest rate in London.

72 Deprivation and death: Variation in place and cause of death. National End of Life Care Intelligence Network, February 2012.
Estimates from the Marie Curie End of Life Care Atlas suggest that 0.52% of Enfield’s population (or 1,547 people) required palliative care during 2008-2010.

Further information on this topic is available from:

Enfield’s End of Life Care Strategy 2012-16
National End of Life Care Intelligence Network