Nottinghamshire Health & Wellbeing Board

NOTTINGHAMSHIRE JOINT STRATEGIC NEEDS ASSESSMENT

Prevention and Equity in Adult Social Care

PROFILE PACK

July 2024

Topic Information		
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Nottinghamshire Health & Wellbeing Board

Executive Summary

Introduction

Adult social care covers a wide range of activities to help people who are older or living with disability or physical or mental illness to live independently and stay well and safe. An individual's need for social care and support, and the extent to which these needs are met or unmet, are complex concepts and challenging to measure. They are influenced by a variety of factors including available supply, a person's environment, their ability to source support for themselves, underlying health and disability status, and their expectations. As people live longer and with more complex conditions, more people are likely to need adult social care to support them to live the lives they want.

The Care Act 2014 requires local authorities to prevent, delay or reduce people's need for care and support. The focus is on being proactive and deploying early interventions to reduce dependency, rather than just providing intensive services at the point of crisis.

This Joint Strategic Needs Assessment (JSNA) summarises the factors that influence social care need and demand, with a focus on prevention and reducing inequalities, in order to support the vision of the Nottinghamshire Integrated Care Strategy, the Nottinghamshire Plan, and the Local Account to enable every person to enjoy their best possible health and wellbeing. enjoy their best possible health and wellbeing.

Factors Associated with Risk or Greater Need for Adult Social Care

The factors that affect the likelihood of developing preventable health conditions and a need for social support are often linked to wider social and community issues, rather than traditional medical needs. These form the building blocks of health such as education and skills, good quality housing, a stable income, and strong transport links.

Research shows that across England adults aged 65 and over from the most deprived areas are twice as likely to need help with activities of daily living as adults living in the least deprived areas. Moreover, those with unmet needs were also higher in more deprived areas.[1] This is because some of the building blocks of health in deprived areas are more likely to be weak or missing and there is a strong link between deprivation and unhealthy behaviours such as tobacco use, physical inactivity, and poor nutrition.[2] To create a society where everybody can thrive, we need all of the right building blocks in place.

[1] NHS Digital (2023) Health Survey for England, 2021 part 2 (Accessed May 2024). Available at: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2021-part-2/social-care

[2] Institute of Health Equity (2010) The Marmot Review, Fair Society Healthy Lives

Loneliness and social isolation are also risk factors which are preventable and addressing them can reduce the need for health and care services in the future. In Nottinghamshire, research suggests 23% of adults report feeling lonely always, often or some of the time which is similar to the England average of 22% but there is likely to be significant variation across districts (2022).[3]

Older People

Population ageing is and will remain the main driver of the projected numbers needing social care. Projections in Nottinghamshire show an increasingly ageing population, for both males and females, and a higher proportion of people aged 65+ will be 85+ which is increasing over time.

There are many ways in which ill health can be prevented in old age. For example, research shows that modifiable risk factors for dementia include smoking, obesity and low social contact.[4] Falls, an area of major concern because of the links with morbidity and mortality, can be prevented by removing home hazards and addressing deterioration in muscle strength.

Disabled People and Long-Term Conditions

People may need social care support because they have a disability. Disabled people are disproportionately affected by poverty, exclusion from education and employment, social marginalisation, and barriers to accessing healthcare, which contribute to poorer health status and outcomes.[5] In Nottinghamshire there is an increasing number of adults under 65 with disabilities. This is driven in particular by more people with learning disabilities being diagnosed and supported, and many are now living longer than they once did.

Research indicates certain long-term conditions are more likely to lead to disability, such as stroke and heart disease. This suggests that interventions to prevent and importantly slow down disability progression and/or improve recovery could significantly reduce social care needs and costs.[6]

People with multimorbidity (two or more long-term conditions) experience a range of challenges including higher rates of disability, poorer mental health, and reduced quality of life.[7] In Nottinghamshire there are significant inequalities related to sex and deprivation such that on

[3] Sports England (2022) Active Lives (Accessed May 2024). Available at: https://www.sportengland.org/research-and-data/data/active-lives/active-lives-data-tables#november-2021-22-32461
[4] Livingston G, et al (2020) Dementia prevention, intervention, and care: 2020 report of the Lancet Commission. Lancet. 2020 Aug 8;396(10248):413-446
[5] Banks LM, Kuper H, Polack S. Poverty and disability in low-and middle-income countries: A systematic review. PLOS ONE. 2017;12(12)
[6] Andrew Kingston, Raphael Wittenberg, Bo Hu, Carol Jagger, Projections of dependency and associated social care expenditure for the older population in England to 2038: effect of varying disability progression, Age and Ageing, Volume 51, Issue 7, July 2022
[7] Kingston A, Robinson L, Booth H, Knapp M, Jagger C; MODEM project. Projections of multi-morbidity in the older population in England to 2035: estimates from the Population Ageing and Care Simulation (PACSim) model. Age Ageing 2018; 47: 374–380

average, women in the most deprived areas have their first long-term condition 15 years before their peers in the least deprived areas. This 'health gap' is 8 years for men.

Frailty

As the population ages, the number of people living with frailty has been increasing. Frailty is strongly associated with experiencing a poor quality of life, inactivity, social isolation, loneliness, mental health challenges, and a range of adverse health outcomes, such as falls, and increased use of health and social care services. It is concerning that most older people with mild or moderate frailty are not known to services, which prevents help at an earlier stage when recovery may be possible and crises might be prevented.

Listening to the Voices of Local Communities

Studies show that closer working with and listening to people with lived experience of care and support can lead to better-informed decision-making, improved experience for people with care and support needs, and increased trust in support provided. Recent consultations and engagement activities in Nottinghamshire are very valuable in helping to understand the views and priorities of people who draw on care and support across the social care and health system. These are not restricted to views on prevention but highlight the areas of support that are important to people and those they would find most valuable. This shows the areas of opportunity where people are likely to be most receptive to intervention which could reduce, delay or minimise the need for social care support in the future, and reflect some of the recommendations identified by the data and literature review for the JSNA.

Evidence for Prevention Approaches and Interventions

The evidence of different prevention approaches can be summarised as:[8]

- **Advice and guidance**: evidence from health is promising but there's no evidence from the social care sector.
- **Physical activity promotion**: there's strong evidence of the impact of promoting exercise and movement, and the role of social care in this work should be further explored.
- **Social prescribing**: the evidence for social prescribing is uncertain, however, the number of these schemes is likely to increase which will give a better evidence base for assessing their effectiveness.
- **Reablement**: there's evidence to support that reablement improves health-related quality of life and improved service outcomes. Research is ongoing to consider the cost-effectiveness of the approach.

[8] Skills for Care (2019) Prevention in social care: where are we now?

- **Asset-based and strength-based approaches**: the complexity of this approach makes forming conclusions from the different types of evidence difficult, but there seems to be potential in developing this approach and a growing literature base to draw on.

Evidence Gaps

- Projections of healthy life expectancy are scarce and at present are not able to explicitly include changes in diseases, lifestyle factors or socio-economic status which might influence future trends.
- There is a need to develop our understanding of inequalities within the adult social care system by exploring disparities in access, outcomes and experiences of different groups.
- It is important to improve our understanding of shared risk factors, the effectiveness of prevention and how diseases progress (especially frailty).
- There is also a need to go beyond a focus on single conditions and start to understand how conditions interact with one another (multimorbidity) and how this might translate to different care needs.

Themes for consideration

This JSNA profile pack identifies themes for developing approaches to prevention within Adult Social Care and key partner organisations along with examples of the types of interventions that may be considered as part of the Adult Social Care Prevention Strategy which is in now in the early stages of development. There is already a lot of work taking place in the local social care and health system that promotes the themes identified below. This is about building prevention approaches and input collectively in the right places, where we can do more and where we can test and learn.

These themes are grouped under the headings of ‘Prevent’, ‘Reduce’ and ‘Delay’ in line with the duties set out in The Care Act 2014 to prevent, reduce and delay the need for care and support.

	Themes	Lead(s)				
		Nottinghamshire County Council	Placed Based Partnerships / ICB	Voluntary and Community Sector	Communities / people who draw on care and support	District and Borough Councils
	Prevent					
1.	**Promote the practice, behaviours and interventions that will help people to live and age well. We want to focus on:** • an increase in system-wide early screening and connecting people to existing community-based solutions using a Making Every Contact Count (MECC) approach • availability of physical activity sessions and groups in all parts of the county but targeted to areas of need identified in the JSNA • maximisation of the use of technology and home adaptations to improve people's homes, and • promotion of Nottinghamshire as an Age-friendly and Disability-friendly place to live.	/	/	/	/	/
2.	**Address loneliness and social isolation. We want to focus on:** • use of known risk factors and available data on loneliness to identify those at higher risk and to target support accordingly; • maximisation of existing support and resources and reviewing current investment in prevention services with a view to redirecting resources to increase appropriate support across the county.	/	/	/	/	/
3.	**Increase strengths-based approaches and support the building of community capacity. We want to focus on:** • strengthening relationships with the voluntary, community and social enterprise sector and community-based groups to build on existing support; and • continuing with the journey to embed strength-based and place-based approaches to supporting individuals and communities across the social care and health system in Nottinghamshire.	/	/	/	/	/

4.	**Use emerging and promising national evidence of most effective preventative support and increase local evaluation of support to understand what works in Nottinghamshire. We want to ensure that** • the County Council's Prevention Strategy for Adult Social Care is developed based on best practice in prevention. • future work includes a greater focus on mental health prevention and prevention for younger adults.	/	/	/	/	/
	Reduce					
5.	**Change our response to chronic disease and frailty – with our partner organisations in Nottinghamshire we want to:** • develop a joined-up approach to long term conditions across Nottinghamshire which is data and intelligence-driven • agree an integrated response to Frailty and ensure early intervention is possible • evaluate countywide Care Navigation and social prescribing support with a view to improving targeting and effectiveness; and • ensure sufficient investment in urinary incontinence services – a key risk factor for falls.	/	/	/	/	/
	Delay					
6.	**Targeted support and interventions to slow and reverse memory and cognition decline, and to identify people at risk of ill health and poor outcomes to maintain independence for as long as possible – we want to increase practice, behaviours and interventions:** • to mitigate the risk of dementia particularly in people with a mild cognitive impairment through a focus on modifiable risk factors, at an individual and community level • to use local health and social care data to target early support to people with disabilities and long term conditions - this could involve reablement, rehabilitation and intermediate care.	/	/	/	/	/

1. Introduction

Adult social care covers a wide range of activities to help people who are older or living with disability or physical or mental illness live independently and stay well and safe. It can include 'personal care', such as support for washing, dressing and getting out of bed in the morning, as well as wider support to help people stay active and engaged in their communities. Social care includes support in people's own homes (home care or 'domiciliary care'); support with employment and meaningful activities; care provided by care homes and nursing homes ('residential care'); 'reablement' services to help people regain independence; providing aids and adaptations for people's homes; providing information and advice; and providing support for family carers.

Though some services, such as advice and information, are available to anyone, most publicly funded social care in England is only available to people with the highest needs and lowest assets. People are usually expected to contribute towards the cost of publicly funded services from their income. Local authorities (LAs) are responsible for assessing people's needs and, if individuals are eligible, funding their care. However, most social care services are delivered by independent sector home care and residential care providers, which are mainly for-profit companies but also include some voluntary sector organisations.[9]

An individual's need for social care and support, and the extent to which these needs are met or unmet, are complex concepts and challenging to measure. They are influenced by a variety of factors including available supply, a person's environment, their ability to source support for themselves, underlying health and disability status, and their expectations. As people live longer and with more complex conditions more people are likely to need adult social care to support them to live the lives they want. The sector faces significant challenges, including long waiting lists and persistent workforce shortages. There have been various proposals over several decades for how to fund and improve adult social care.

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[9] The Kings Fund (2023) *Key facts and figures about adult social care.* Available at: https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/key-facts-figures-adult-social-care (Accessed May 2024)

1.1 What is social care need?

In general terms a social care need exists when there is a requirement to assist with activities of daily living, maintaining independence, social interaction, enabling the individual to play a fuller part in society, protecting them in vulnerable situations, helping them to manage complex relationships and (in some circumstances) accessing a care home or other supported accommodation.

Social care needs are directly related to the type of welfare services that LAs have a duty or power to provide. These include but are not limited to social work services; advice; support; practical assistance in the home; assistance with equipment and home adaptations; visiting and sitting services; access to employment, provision of meals; facilities for occupational, social, cultural and recreational activities outside the home; assistance to take advantage of educational facilities

1.2 Prevention in Adult Social Care

The Care Act 2014 highlighted prevention as one of the seven key responsibilities for local authorities, linking this with the fundamental principle of promoting wellbeing. The Care Act Statutory Guidance goes further indicating prevention is about the care and support system actively promoting independence and wellbeing. This suggests an emphasis on intervening early to support individuals, helping people retain their skills and confidence, and preventing need or delaying deterioration wherever possible. Prevention approaches implemented earlier in the life course (i.e. during childhood) will clearly influence people's need for social care services later in their adult life but these have not explicitly been considered within the scope of this particular JSNA as they are core components of other programmes of work (e.g. 'Best Start').

The Department of Health and Social Care (2018) set out a vision based on prevention in the context both of an ageing population and greater numbers of people living with multiple complex conditions. The message is obvious: we need to keep people well and out of hospital for longer.

> *"Prevention is about helping people stay healthy, happy, and independent for as long as possible. This means reducing the chances of problems from arising in the first place and, when they do, supporting people to manage them as effectively as possible. Prevention is as important at seventy years old as it is at age seven."*[10]

However, there is little clarity about how this national obligation translates into effective local practice. Some councils had remained focused on interventions linked to demand management, whilst others were looking at a more progressive approach seeking a "reset" of the relationship

[10] DHSC (2018) Prevention is better than cure: Our vision to help you live well for longer

between services, citizens and communities that emphasised enabling opportunity, support and building social connections[11], community assets and community building and providing accessible 'strengths-based' conversations when people were running into difficulties[12].

Evidence about what works to prevent or reduce needs for social care tends to be underdeveloped so local policymakers lack information about how best to invest their resources. Despite continuing policy expectations that preventative care will deliver cost savings to adult social care and wider systems, formal evidence is neither extensive nor robust.

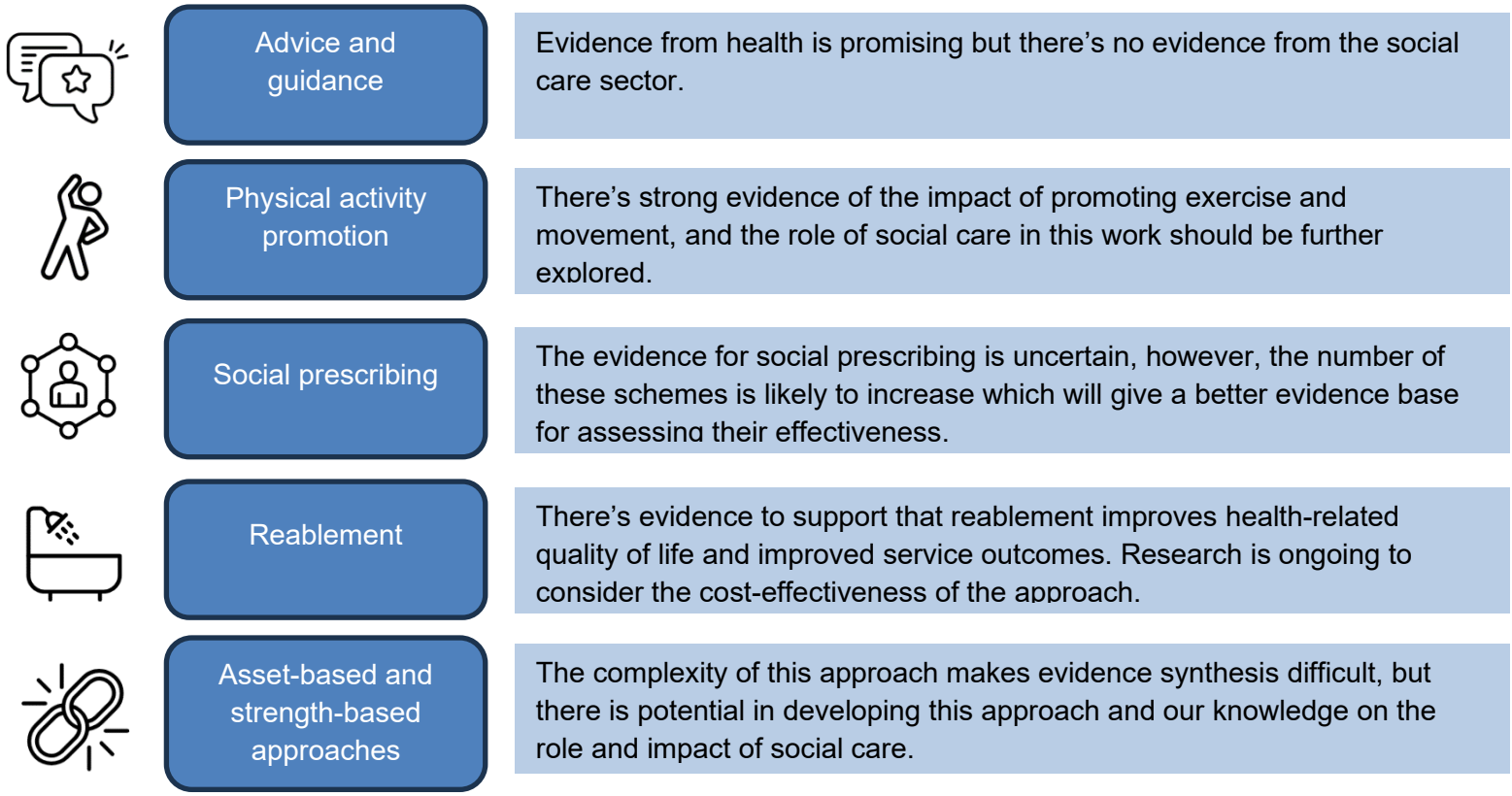


Figure 1: Five key approaches to prevention, Skills for Care (2019) Prevention in Social care: where are we now?

[11] Tew et al (2020) How has the idea of prevention been conceptualised and progressed in adult social care in England? Journal of Social Policy, pp. 1 - 19
[12] Department of Health (2017) Strengths-based social work practice with adults: Roundtable report

Prevent

A general approach applied to everyone, that encompasses a range of services, facilities and resources to promote wellbeing, build community capacity for individuals - to help avoid the need for escalating care and support - and maintain independence. It could include access to good quality information and advice, promoting healthy and active lifestyles, combating ageism, supporting safer neighbourhoods, and reducing loneliness and isolation.

Reduce

An approach targeted at individuals at greater risk of developing needs where support may slow this process or prevent other needs from developing. It could include screening and case finding to identify individuals at risk of specific health conditions or events, carer support, fall prevention, housing adaptations, support to manage money and debt or support for those with low-level social care needs.

Delay

The third approach is aimed at people with established complex health or social needs, to minimise the effects, support them to regain skills and reduce their needs wherever possible. The focus is on maximising people's independence through interventions such as rehabilitation / reablement services, meeting a person's needs at home, and providing respite care, peer support, emotional support and stress management for unpaid carers.

Figure 2: Care Act 2014 duty to prevent, reduce and delay needs

2. Population and Demographics in Nottinghamshire

Nottinghamshire's population is ageing. It is known population ageing is the main driver of increasing demand for care. This is because morbidities (illnesses) and disabilities increase with age.

Nottinghamshire has an estimated population of 824,800 people (Census 2021). In Nottinghamshire 20% (168,500) of the population are children (0-17 years old), 59% (489,800) are working age (18-64 years old), and 21% (175,100) are over 65 years old. It is predicted that by 2040, the population aged 65 and over will grow by 30%. This will be highest in Ashfield (35%) and lowest in Broxtowe (25%).

2.1 Life Expectancy and Healthy Life Expectancy

Life expectancy at birth shows the average number of years that a newborn baby would survive if they experienced the current mortality rates for people of different ages in that area throughout their life. In Nottinghamshire, this is **79.5 years** for men and **83.6 years** for women (2016-20). However, this masks vast inequalities between communities within Nottinghamshire.

Healthy Life Expectancy is a measure of the average number of years that a person would expect to live in good health. In Nottinghamshire, **60 years** is the average age when females report not being healthy, which is worse than the England average of 63.9 years. The average age that males in Nottinghamshire report not being healthy is **62.4 years**, which is similar to the England average of 63.1 years (2018-20). This data is not available at a smaller geographical level, but we can expect that there will be communities where Healthy Life Expectancy is much better than the Nottinghamshire average, and some where it will be worse.[13]

More information can be found in the Nottinghamshire Health & Wellbeing JSNA Dashboard.

[13] OHID. Public health profiles. [Accessed May 2024]. Available from: https://fingertips.phe.org.uk/

3. Factors Associated with Risk or Greater Need for Adult Social Care

3.1 Deprivation

The factors that affect the likelihood of developing preventable health conditions and a need for social support are often linked to wider social and community issues, rather than traditional medical needs. These form the building blocks of health such as education and skills, good quality housing, a stable income, and strong transport links.

Research has shown that variation between councils in terms of social care needs was to some extent shaped by contextual factors such as deprivation and demographics. Data from the Health Survey for England demonstrated adults aged 65 and over from the most deprived areas were twice as likely to need help with activities of daily living and instrumental activities of daily living as adults living in the least deprived areas. Moreover, those with unmet needs were also higher in more deprived areas.[14]

Some reasons for this might be that people in deprived areas tend to have poorer infrastructure, a lack of amenities and services that support active and connected lifestyles, poorer housing, as well as more environmental challenges. There are also links between deprivation and unhealthy behaviours such as tobacco use, physical inactivity, and poor nutrition which have been well demonstrated.[15] Given that older people tend to have more social care needs overall, and that older adults in deprived areas have greater needs, it was appropriate to consider deprivation measures that might illuminate the impact of this. The Income Deprivation Affecting Older People Index (IDAOPI) measures the proportion of people aged 60 or over who experience income deprivation.

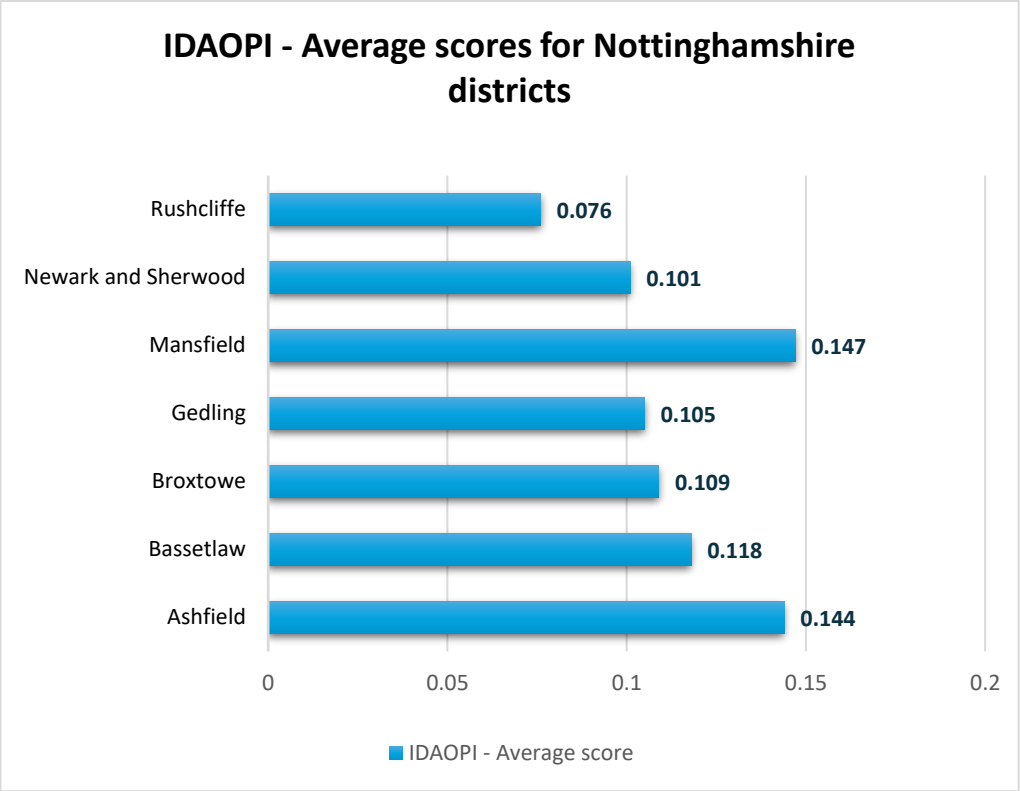


Figure 3: The Income Deprivation Affecting Older People Index (IDAOPI) for Nottinghamshire, Index of Multiple Deprivation 2019

[14] NHS Digital (2023) Health Survey for England, 2021 part 2 (Accessed May 2024). Available at: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2021-part-2/social-care

[15] Institute of Health Equity (2010) The Marmot Review, Fair Society Healthy Lives

3.2 Transport

Transport can affect health indirectly through its relationship with other factors such as limiting social and economic participation, loneliness and access to public services. Research shows that people who rate public transport as 'good' are close to three times more likely than those who rate it as 'poor' to be able to access public services such as health care, food shops or education. They are also slightly less likely to report feeling under strain, being dissatisfied with life or experiencing mental health problems.[16] Without access to a car, public transport is very important, and it should be noted that Nottinghamshire has a large rural community with poorer transport links.

	No access to car or van		Total number		No access to car or van (%)	
	Households	**People**	**Households**	**People**	***Households***	***People***
Ashfield	11,228	18,669	54,508	125,185	*20.6*	*14.9*
Bassetlaw	8,833	13,883	51,458	115,553	*17.2*	*12.0*
Broxtowe	9,609	15,500	48,361	108,923	*19.9*	*14.2*
Gedling	9,760	15,579	51,551	116,654	*18.9*	*13.4*
Mansfield	10,501	17,754	48,030	109,697	*21.9*	*16.2*
Newark and Sherwood	8,620	13,669	53,331	120,606	*16.2*	*11.3*
Rushcliffe	6,710	9,931	49,883	116,531	*13.5*	*8.5*
Nottinghamshire	**65,261**	**104,985**	**357,122**	**813,149**	***18.3***	***12.9***

Table 1: Access to car/van in Nottinghamshire by household, 2021 Census

[16] The Health Foundation (2021) How transport offers a route to better health (Accessed May 2024). Available at: https://www.health.org.uk/publications/long-reads/how-transport-offers-a-route-to-better-health

3.3 Loneliness and Social Isolation

Both loneliness and social isolation are associated with increased mortality, morbidity and reduced functional status.[17] Loneliness is also a risk factor for care home admission.[18] Loneliness and social isolation are preventable and addressing them can reduce the need for health and care services in the future.

Social isolation is defined as having few or infrequent social contacts. By contrast, loneliness is described as a subjective dissatisfaction with the discrepancy between the actual and preferred level and quality of social contact.[19] Loneliness and social isolation operate independently: an individual can be socially isolated but not feel lonely, or lonely while having social contacts.

The number of people living alone in the UK in 2022 was 8.3 million, this represents 30% of all households; the majority (53%) of these households were women living alone. Half of those living alone are aged 65 years and over (51% in 2022) which has increased since 2012 (45%). In 2022, more than 1 in 5 men and 1 in 3 women living alone were aged 75 years or over.[20]

The percentage of all people aged 65+ living alone is approximately 30% across the County. Districts with the highest percentage of older people living alone are Newark, Gedling and Bassetlaw.

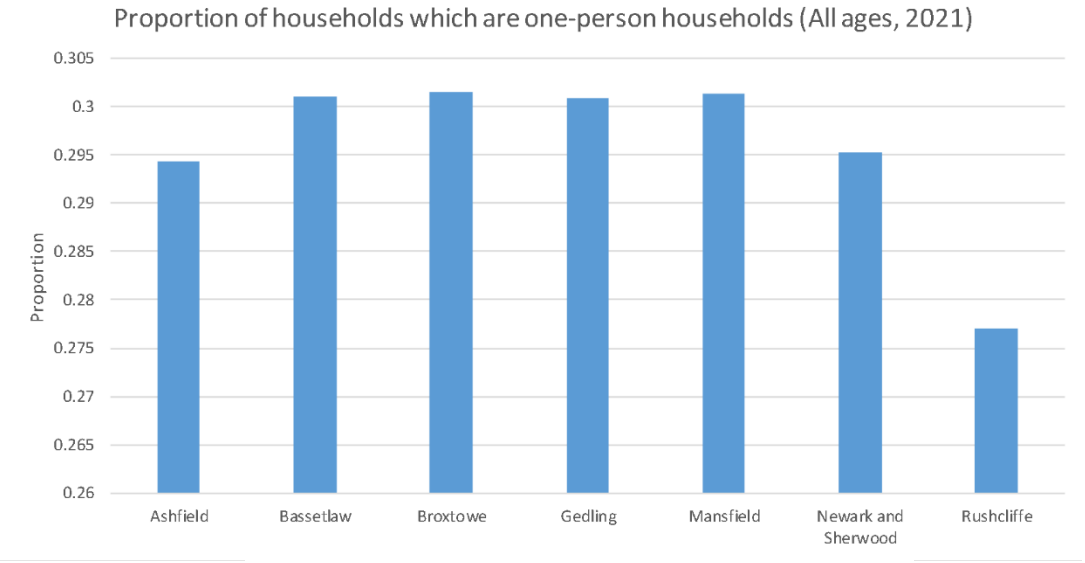


Figure 4: Proportion of people living alone in Nottinghamshire by district/borough, ONS 2021

[17] Leigh-Hunt N Bagguley D Bash K et al. (2017) An overview of systematic reviews on the public health consequences of social isolation and loneliness.
[18] Hanratty B et al. (2018) Loneliness as a risk factor for care home admission in the ELSA
[19] Ong AD Uchino BN Wethington E. (2016) Loneliness and health in older adults: a mini-review and synthesis. Gerontology. 2016; 62: 443-449
[20] ONS (2023) Families and households in the UK: 2022 (Accessed May 2024). Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/families/bulletins/familiesandhouseholds/2022#living-alone

In Nottinghamshire, research suggests 23% of adults report feeling lonely always, often or some of the time which is similar to the England average of 22% (2022).[21]

Social care data shows the proportion of adult social care users who have as much social contact as they would like. Nottinghamshire's latest report appears better than the East Midlands and England for service users. The time series suggests a largely improving picture over the past few years for all adults and working-age clients, but for those aged 65+ years there is fluctuation.

Population groups	2018-19	2019-20	2020-21*	2021-22	2022-23	2023-24+
All adults, England	45.9	45.9	34.4	40.6	44.4	
England 18-64	49.6	49.8	36.8	45.1	48.5	
England 65+	43.5	43.4	32.7	37.3	41.5	
Females	44.6	45.1	33.3	38.9	43.3	
Males	47.8	47.1	36.0	42.8	45.9	
All adults, Nottinghamshire	39.7	42.7	n/a	43.3	44.9	*43.0*
Notts 18-64	40.4	49.2	n/a	47.5	52.7	*46.0*
Notts 65+	39.2	38.1	n/a	40.3	39.1	*39.7*
Females, Notts	38.2	40.6	n/a	46.0	45.3	*40.5*
Males, Notts	41.9	45.8	n/a	39.6	44.6	*44.0*

+ From the latest survey, figures provisional results for Nottinghamshire
** In 2020-21 only 18 councils submitted figures due to the pandemic*

Table 2: social contact: proportion of people who reported they had as much contact as they would like by age and sex, Adult Social Care Outcomes Framework

[21] Sports England (2022) Active Lives (Accessed May 2024). Available at: https://www.sportengland.org/research-and-data/data/active-lives/active-lives-data-tables#november-2021-22-32461

4. Older People

Population ageing is and will remain the main driver of the projected numbers needing social care. Projections in Nottinghamshire show an increasingly ageing population, for both males and females and a higher proportion of people aged 65+ will be 85+ which is increasing over time. A common concern with increasing lifespan is that this will translate into a decline in capability and independence, with increased demands for health and social care services.

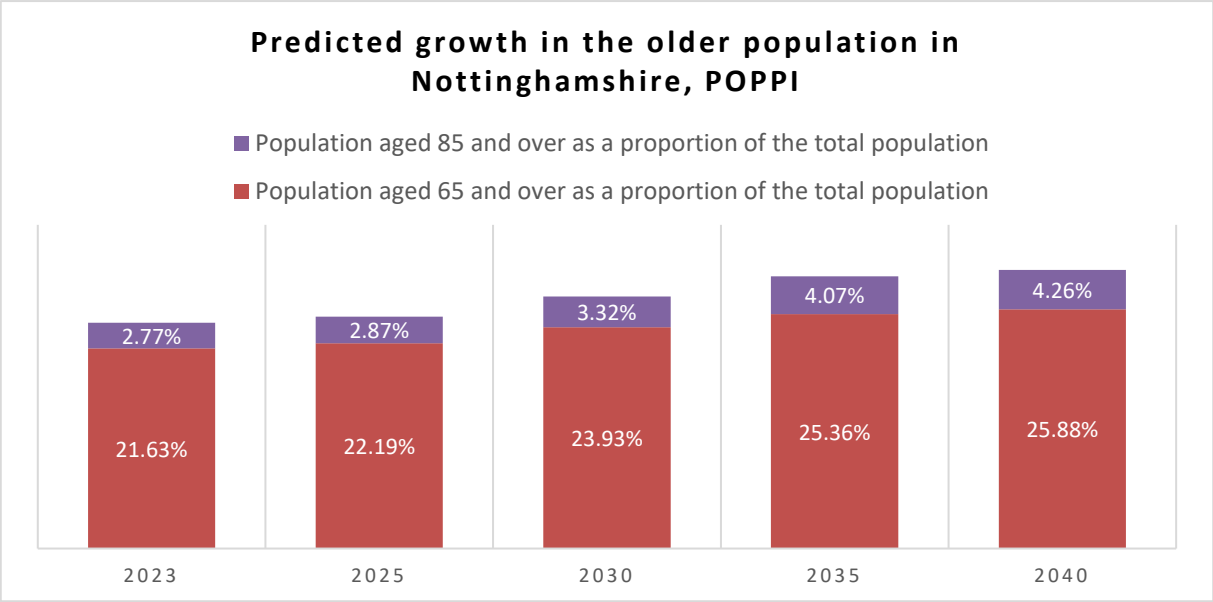


Figure 5: Predicted growth in the older population in Nottinghamshire, Projecting Older People Population Information (POPPI) 2023

Considering districts, currently the highest percentage of older people are found in Newark & Sherwood and Bassetlaw and the lowest in Mansfield and Ashfield. By 2043, the highest percentage of people aged 65+ will be found in Bassetlaw (29.3% for females and 26.6% for males), whereas the lowest will be in Ashfield (24.12%).

Population ageing is also expected to increase the proportion of people in England who are retired, relative to people of working age. The Old Age Dependency Ratio (OADR) shows the balance between adults aged 20-64 and over 65s. This is expressed as the number of over 65s per 1000 people under 65 and is the most common way to assess and compare the burden of population ageing. It is often used to measure the financial pressure on the actively working population of a community. The higher the ratio, the greater the burden is carried by working-age people. Lower ratios indicate more people are working who can support the dependent population. The East Midlands has an OADR of 313.93, whilst Nottinghamshire's OADR is higher at 341.70.

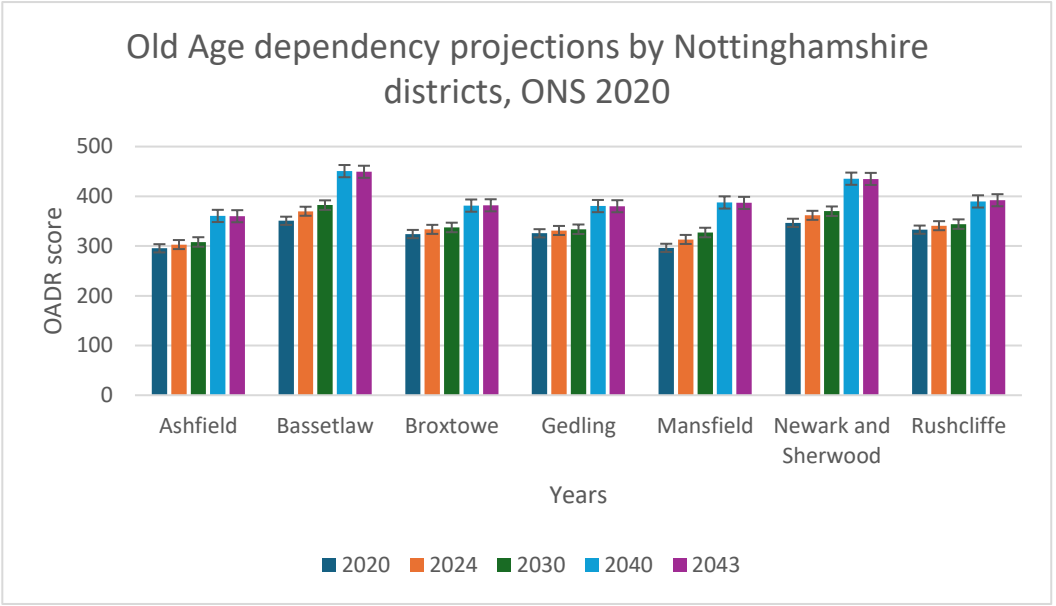


Figure 6: Old Age Dependency Ratio in Nottinghamshire, ONS 2020

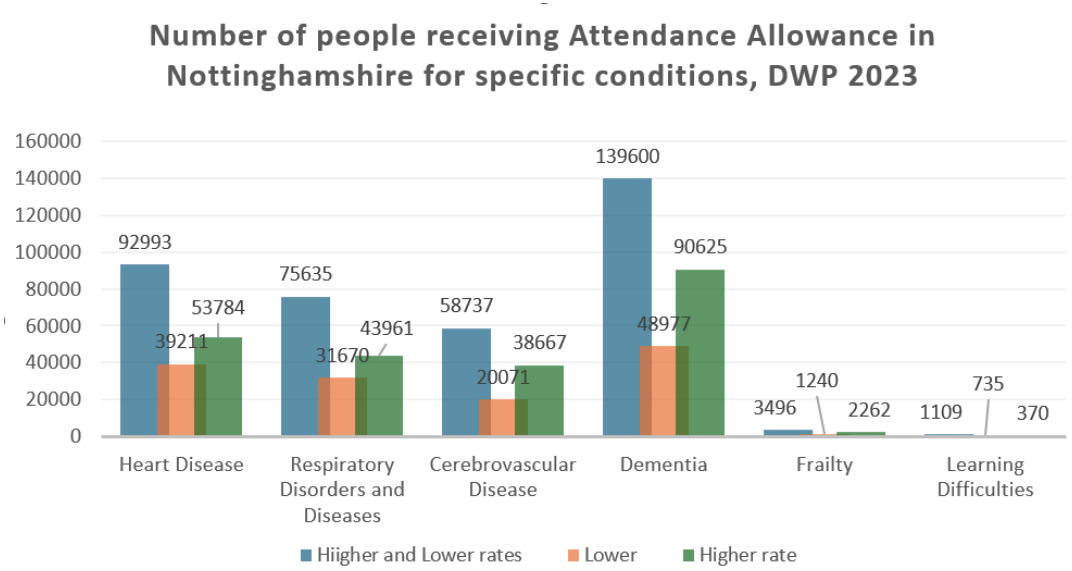


Figure 7: Numbers receiving Attendance Allowance in Nottinghamshire, DWP 2023

Attendance allowance is paid to those who need frequent help or constant supervision, and the eligibility criteria have similarities to those for social care. In Nottinghamshire, the percentage receiving attendance allowance increases as people age as in England. The most common reason for receipt of this benefit is dementia, which is important because dementia is expected to exert considerable pressure on care services.

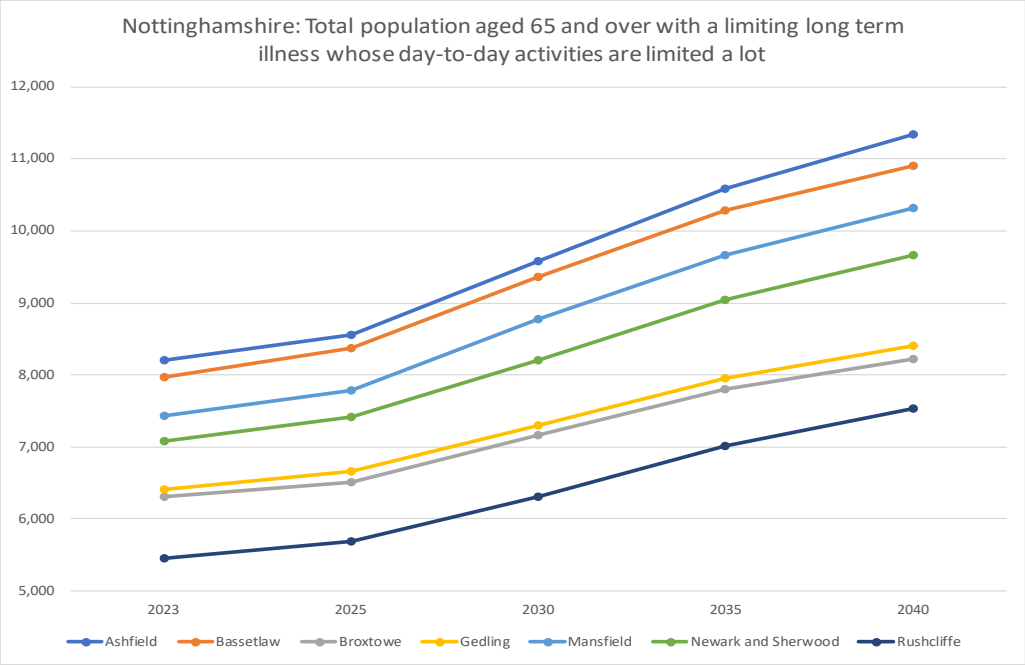


Figure 8: Nottinghamshire projections for population aged 65 and over with a limiting long-term illness whose day-to-day activities are limited a lot, POPPI 2023

The chart above shows how limiting long-term illnesses with activity limitation is projected to increase in all districts in Nottinghamshire in the 65+ population.

The number of older people with dementia and the cost of caring for them, already substantial, are expected to rise due to population ageing. There is a growing body of evidence that supports that there are nine potentially modifiable risk factors for dementia. These are less education, hypertension, hearing impairment, smoking, obesity, depression, physical inactivity, diabetes, and low social contact. Recent research and evidence review by the Lancet Commission suggests three other factors, namely: excessive alcohol consumption, traumatic brain injury, and air pollution.[22]

[22] Livingston G, et al (2020) Dementia prevention, intervention, and care: 2020 report of the Lancet Commission. Lancet. 2020 Aug 8;396(10248):413-446

Falls are another major area of concern since they are an important cause of morbidity and mortality. Fall rates vary among older adults according to age, but it is estimated that 30% of people over the age of 65 fall each year, and that this percentage increases up to 50% among people over 80.[23] Women are more prone to falls than men, although fall-related mortality is higher among older men. Falls among older people are associated with living alone.[24] Many falls are preventable by removing home hazards, addressing deterioration in muscle strength, balance, and vision, and being alert to medication issues.

Stroke is a significant problem and many stroke survivors live with disabilities in the community meaning this condition has significant social care service implications. It is the most common cause of disabilities.[25] This suggests that describing and projecting future epidemiological impacts of stroke can help in planning prevention, treatment, and support services.

It has been estimated that between 2015 and 2035, the number of strokes in the UK each year is projected to increase by 60%. Stroke prevalence is projected to increase by 120% between 2015 and 2035. These numbers are increasing due to population ageing and because treatment improvements have led to better survival rates.[26]

Stroke prevalence across all Nottinghamshire districts is 2.2% (2022/23). Smoking deaths attributable to stroke are 9.0% in Nottinghamshire which indicates the importance of changes in health behaviours.[27]

[23] Pereira CB, Kanashiro AMK. (2022) Falls in older adults: a practical approach. Arq Neuropsiquiatr. 2022 May;80(5 Suppl 1):313-323.
[24] Petersen N, König H-H, Hajek A. (2020) The link between falls, social isolation and loneliness: a systematic review. *Arch Gerontol Geriatr.* 2020.
[25] Ju YW, Lee JS, Choi YA, Kim YH. (2022) Causes and Trends of Disabilities in Community-Dwelling Stroke Survivors: A Population-Based Study. Brain Neurorehabil. 2022 Mar 17;15(1)
[26] Derek King, Raphael Wittenberg, Anita Patel, Zahid Quayyum, Vladislav Berdunov, Martin Knapp. (2020) The future incidence, prevalence, and costs of stroke in the UK. Age and Ageing 2020; 49: 277–282
[27] OHID. Public health profiles. [Accessed May 2024]. Available from: https://fingertips.phe.org.uk/

5. Disabled People and Long-Term Conditions

People may need social care support because they have a disability. A disability is any condition of the body or mind that makes it more difficult for the person with the condition to do certain activities (activity limitation) and/or interact with the world around them (participation restrictions).

The latest estimates from the Department for Work and Pensions' Family Resources Survey indicate that 16 million people in the UK had a disability in 2021/22. This represents 24% of the population nationally, which has risen by 6% since 2002/03. In the East Midlands prevalence is higher at 27%.

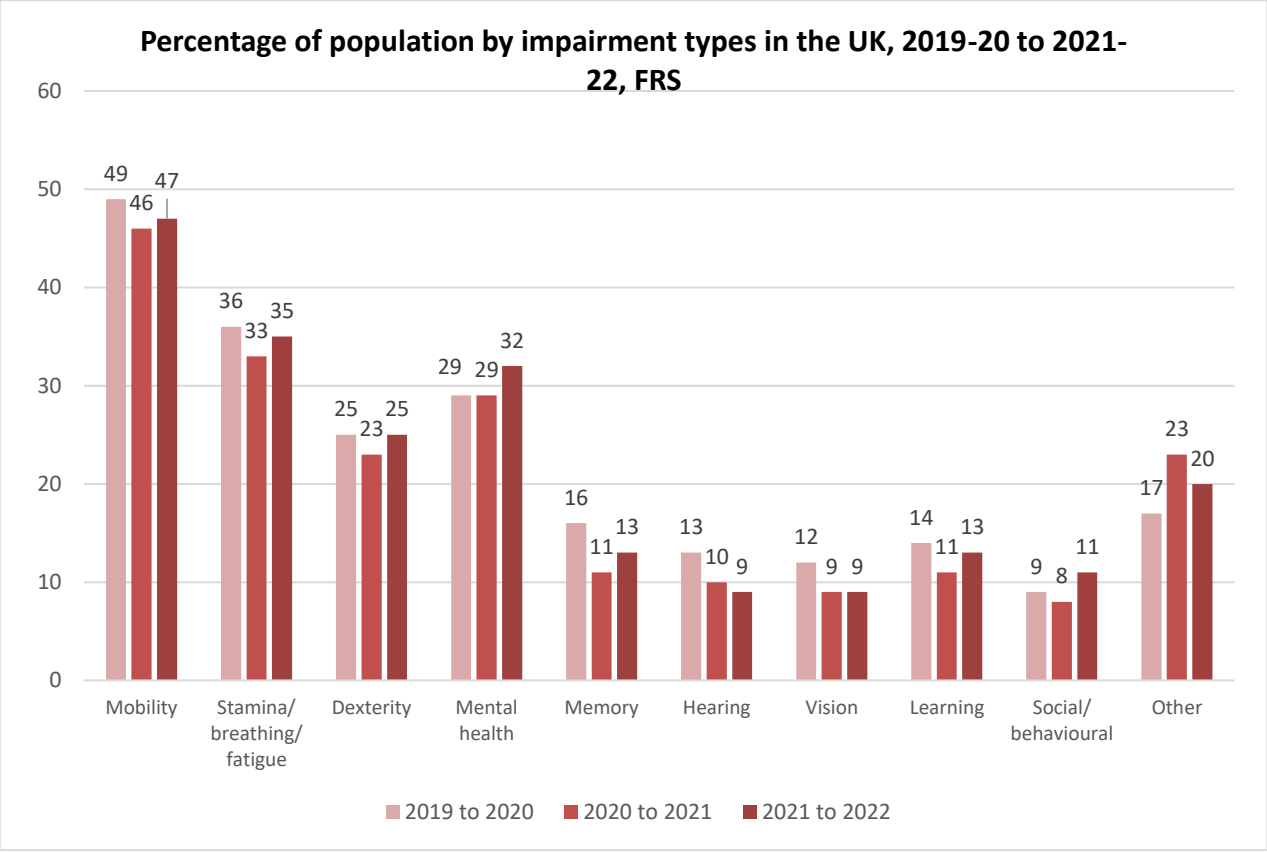


Figure 9: Percentage of population by impairment types in the UK, 2019-20 to 2021-22, Family Resources Survey

In Nottinghamshire, the district with the highest proportion of non-disabled households was found in Rushcliffe at 70.8%, which also had the lowest proportions of households with 1 or 2 or more disabled persons (2021). Ashfield and Mansfield had the largest proportion of households with more than 1 disabled person in residence (29.4% and 29.3% respectively).

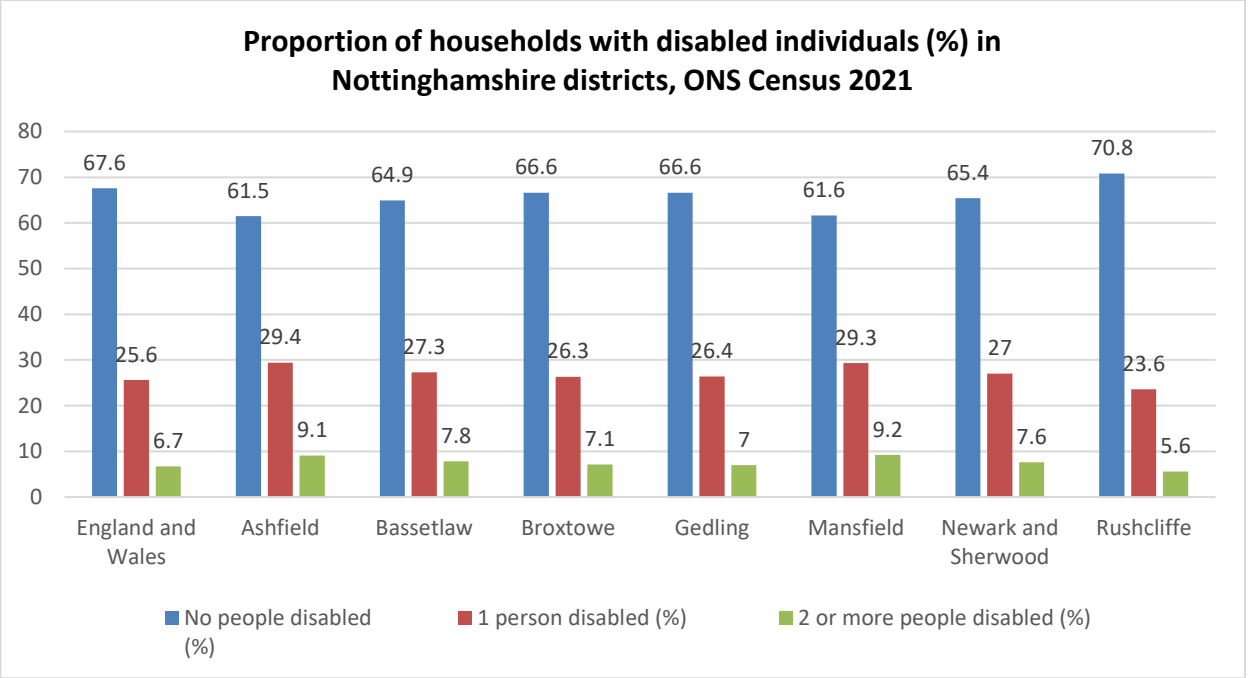


Figure 10: Proportion of households with disabled individuals (%) in Nottinghamshire districts, ONS Census 2021

As might be expected, age generally increases the level of impairment apart from mental health impairment which is most prevalent in working age adults nationally (44%). There is a relationship between sex and the presence of disability, with women experiencing more impairment than men.

People with disabilities are disproportionately affected by poverty, exclusion from education and employment, social marginalisation, and barriers to accessing healthcare which can contribute to poorer health status and outcomes, as well as lower life expectancy.[28] People in the most deprived areas face a four-fold challenge when it comes to disability. They are the most likely to have a disability. They have the highest likelihood of that disability limiting their ability to carry out daily activities. And they are the most likely to need help – but the least likely to receive it.[29]

Research indicates certain chronic diseases are more likely to lead to disability suggesting that more disability-free years could be gained by focusing on these.[30] There is some disagreement on which long-term conditions reduce disability-free life expectancy (DFLE) the most, but the

[28] Banks LM, Kuper H, Polack S. Poverty and disability in low-and middle-income countries: A systematic review. PLOS ONE. 2017;12(12)
[29] Centre for Ageing Better (2024) Health and Wellbeing: The State of Ageing 2023-24 (Accessed May 2024). Available at: https://ageing-better.org.uk/health-and-wellbeing-state-ageing-2023-4?gad_source=1&gclid=EAIaIQobChMIjvLT4fGqhQMVCpJQBh0HpQd2EAAYASAAEgKx4_D_BwE
[30] Lourida I, Bennett HQ, Beyer F, Kingston A, Jagger C (2022) The impact of long-term conditions on disability-free life expectancy: A systematic review. PLOS Glob Public Health 2(8)

list usually includes conditions such as stroke, cognitive impairment, depression, diabetes, arthritis, and/or sensory impairments. As these lead to more disability, these may be responsible for a greater need for social care in individuals. This suggests that interventions to prevent and importantly slow down disability progression and/or improve recovery could significantly reduce social care needs and costs.[31]

Some of these conditions are explored further below.

Condition	Increases the chance of onset of disability*	Increases the chance of death*
Stroke	Yes	Yes
Peripheral vascular disease	No	No
Coronary heart disease (angina & heart attack)	Yes	Yes
Treated hypertension	No	No
Arthritis	Yes	No
Treated diabetes	No	Yes
Chronic airways obstruction	Yes	Yes
Parkinson's disease	Yes	Yes
Hearing problems	No	No
Eyesight problems	Yes	No
Cognitive impairment: mild and severe	Yes	Yes

*Yes = a significantly greater than zero chance. No = a not significant or negative chance.

Table 3: Self-reported diseases associated with the onset of disability and death, (the 'Jagger' conditions)[32]

5.1 Learning Disabilities

A learning disability affects the way a person learns new things, understands information and how they communicate. People with learning disabilities are among the most vulnerable in our society, generally having greater and more complex health needs than the general population, and often these needs are not identified or treated.[33]

[31] Andrew Kingston, Raphael Wittenberg, Bo Hu, Carol Jagger, Projections of dependency and associated social care expenditure for the older population in England to 2038: effect of varying disability progression, Age and Ageing, Volume 51, Issue 7, July 2022
[32] Jagger C, Matthews R, Matthews F, Robinson T, Robine JM, Brayne C, et al. The burden of diseases on disability-free life expectancy in later life. Journals of Gerontology Series A-Biological Sciences & Medical Sciences. 2007; 62(4):408–14
[33] Nottinghamshire County Council (2019) JSNA: Learning Disabilities (Accessed May 2024). Available at: https://nottinghamshireinsight.org.uk/research-areas/jsna/adults-and-vulnerable-adults/learning-disabilities-2019/

People with learning disability often have other needs related - but distinct - from their disability such as mental health conditions including severe anxiety or depression. Studies suggest that whereas multi-morbidity (2 or more long term conditions) is common in the general population in older age groups, particularly those aged 50–54 and older, it is common in all age groups in adults with intellectual disabilities.[34]

Projections using POPPI/PANSI data suggests that the number of people predicted to have a learning disability will show a gradual rise over time.

Appropriate accommodation can have a strong impact on the safety and overall quality of life of those with learning disabilities. Moreover, favourable living arrangements can lower the need for social care and improve psychological health. Data from 2022/23 shows that adults with a learning disability who live in stable and appropriate accommodation in Nottinghamshire (74.8%) is worse than the England average (80.5%).[35]

5.2 Autism

Autism is a lifelong developmental disability which affects how people communicate and interact with the world. The way that autism is expressed in individual people differs at different stages of life. People with autism are generally more disabled and many have a poor quality of life.[36] They can have a range of health and social problems which require support including relationships, employment, independent living, and mental health.

In the UK, the estimated prevalence in adults is about 1 in 100. The proportion of males to females diagnosed with autism spectrum disorder (ASD) varies across studies but always shows a greater proportion of males to females, mostly ranging from 3:1 to 5:1, although this is largely thought to be a result of women being better at camouflaging their difficulties and 'fitting in' with societal expectations.

Locally one of the key issues for adults with autism is that they risk falling into the gap between services for people with learning disabilities and services for people with mental health conditions if they have no diagnosed or recognised comorbidities (more than one disease or condition at the same time) so could struggle to receive the help they need.[37]

[34] Takenoshita S, Terada S, Inoue T, Kurozumi T, Yamada N, Kuwano R, Suemitsu S. Prevalence and modifiable risk factors for dementia in persons with intellectual disabilities. Alzheimers Res Ther. 2023 Jul 18;15(1):125.
[35] OHID. Public health profiles. [Accessed May 2024]. Available from: https://fingertips.phe.org.uk/
[36] Ayres, M., Parr, J.R. and Rodgers. J. et al. (2018) A systematic review of quality of life of adults on the autism spectrum. Autism 22(7), 774-783
[37] Nottinghamshire County Council (2019) JSNA: Autism (Accessed May 2024). Available at: https://nottinghamshireinsight.org.uk/research-areas/jsna/adults-and-vulnerable-adults/autism-2019/

5.3 Arthritis

Arthritis and musculoskeletal (MSK) conditions affect over 17 million people across the UK; of these, over 10 million have arthritis. The personal impact of living with long-term pain and disability is great, including impacts on mental health, wellbeing, and the ability to remain independent. Collectively, musculoskeletal conditions account for the largest number of years lived with disability in this country. These conditions disproportionately affect those who are socially and economically disadvantaged. People who live in the most deprived fifth of society are more likely to report arthritis or a long-term MSK condition compared to those living in the least deprived fifth.[38]

Conditions such as arthritis are disabling, rather than fatal, meaning people can live with them for many years and so will have a greater impact on disability free life expectancy. The impact of arthritis can be immense affecting an individual's quality of life, ability to work and conduct everyday tasks and activities, care for a family, move without pain and live independently. This means it can lead to greater care needs.

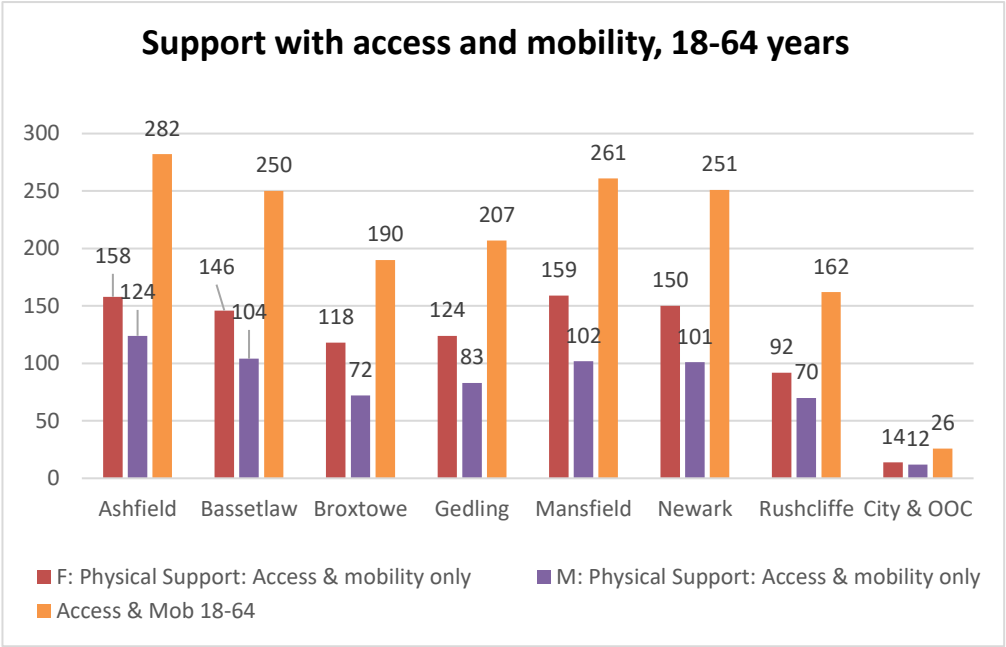


Figure 11: Support to clients with mobility and access issues for Nottinghamshire residents aged 18-64, client-level data, MOSAIC, 2024

Mobility can be a problem for those with arthritis which is essential for living independently. Moreover, problems with mobility can increase the number and severity of falls (considered in the older people's section) and make it more difficult to socialise and conduct activities independently which could lead to social isolation. PANSI data projections show the numbers of residents aged 65 and over in Nottinghamshire unable to manage at least one mobility activity on their own are predicted to increase considerably to 2040.

[38] Versus Arthritis (2021) The State of Musculoskeletal Health 2021: Arthritis and other musculoskeletal conditions in numbers (Accessed May 2024). Available from: https://www.versusarthritis.org/media/24653/state-of-msk-health2-2021.pdf

5.4 Sensory Impairment

The main types of sensory disabilities include blindness and low vision, hearing loss and Deafness, deaf blindness (also known as dual sensory loss), and sensory processing disorder. In the UK, one in 30 people has sight loss, nine million are deaf or hard of hearing, and 23,000 deaf-blind people have developed hearing loss. By 2050, the number of people with sight loss is set to double due to increases in risk factors such as obesity, diabetes and age.[39]

The prevalence of visual and hearing impairment is greater in certain groups than in the general population. It has been estimated that visual impairment is 10 times more prevalent in people with learning disabilities, and hearing impairment is anything from 40 to 100 times above the rate in the general population. Approximately 40% of people with learning disabilities are reported to have a hearing impairment, with people with Down's syndrome at particularly high risk of developing vision and hearing loss.[40] Evidence also shows a link between deprivation and higher levels of sensory impairment and difficulty accessing sensory impairment services.[41]

ONS projections suggest a worsening picture for hearing loss across all Nottinghamshire districts compared to England. POPPI projections show predicted numbers of people in Nottinghamshire with visual impairments will increase in people aged 65 and over.

5.5 Diabetes

Diabetes is known for multiple vascular and neuropathic complications and increased risk of disability including difficulties with the ability to carry out activities of daily life and loss of mobility. Estimates also place diabetes among the top ten leading causes of increased years of disability in recent decades.[42] The current population prevalence of diabetes from published figures is between 4% and 5%. The risk factors of type 2 diabetes are multiple and complex. They include age, family history and ethnicity, as well as being overweight or obese.

Socioeconomic factors not only influence outcomes for people with diabetes but also increase the risk of developing type 2 diabetes. Deprivation is associated with unhealthy behaviours which increase the risk of obesity, and hence of type 2 diabetes, including access to nutritious food and sedentary lifestyles.[43]

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[39] North Somerset Council (2011) JSNA: Sensory Impairment (Accessed May 2024). Available at: https://www.n-somerset.gov.uk/sites/default/files/2020-02/sensory%20impairment%20chapter.pdf

[40] Carvill S. Review: Sensory impairments, intellectual disability and psychiatry. Journal of Intellectual Disability Research, 2001. 45: p. 467-483

[41] Ng WS and others. The effect of socio-economic deprivation on severity of glaucoma at presentation. British Journal of Ophthalmology, 2010. 94(1): p. 85-7

[42] Vos T, Abajobir AA, Abate KH, Abbafati C, Abbas KM, Abd-Allah F, et al. Global, regional, and national incidence, prevalence, and years lived with disability for 328 diseases and injuries for 195 countries, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016. The Lancet. 2017;390(10100):1211–5

[43] Kilvert, A. and Fox, C. (2023), Health inequalities and diabetes. Pract Diab, 40: 19-24a.

5.6 Mental Health

Mental health problems impact on individuals, families, communities and society as a whole, with immense social and financial costs and is a contributing factor to the perpetuating cycles of inequality through generations. Globally mental health disorders account for over 10% of the total disability among older adults, with the most common mental health conditions being depression and anxiety.[44]

Support for people with mental health problems, their families and carers, is often overlooked. People experiencing mental health problems, including those living with severe mental illness, often say things like better housing, meaningful occupations, enough money, more friends, and close relationships would make a positive difference in their lives. Most people would agree maintaining social connection is important to living better lives. Balanced, high-quality local mental health systems should account for this when supporting individuals, families and communities.[45]

Around one in six adults (17%) surveyed in England met the criteria for a common mental disorder (CMD) in 2014. Women were more likely than men to have reported CMD symptoms with one in five women (19%) reporting CMD symptoms, compared with one in eight men (12%).[46] Nottingham and Nottinghamshire Integrated Care System has one of the highest percentages of people reporting a mental health problem in England (14.5% as opposed to 13% in England).[47]

The Covid-19 pandemic had a significant impact on people's mental health with estimates of up to 10 million people in the UK likely to need new or additional mental health support as a direct result. Crucially, it also worsened existing inequalities for people with pre-existing mental health problems and people with long-term conditions, among other marginalised groups.[48]

[44] WHO (2023) Mental health of older adults (Accessed May 2024). Available at: Mental health of older adults (who.int)
[45] DHSC (2024) Collaboration spurs mental health social care research (Accessed May 2024). Available at: https://socialworkwithadults.blog.gov.uk/2024/05/21/collaboration-spurs-mental-health-social-care-research/
[46] Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014
[47] NHS England's annual GP survey, 2023
[48] CQC (2022) Rising demand for mental health care (Accessed May 2024). Available at: https://www.cqc.org.uk/publications/major-reports/soc202021_01d_mh-care-demand

5.7 Multimorbidity

As the population lives longer, more than two-thirds of those aged 65 years and over will live with two or more long-term conditions (LTCs). People with multimorbidity experience multifaceted challenges, including functional decline, higher rates of disability, poorer mental health, and reduced quality of life.[49] Typically, people with multimorbidity have a disproportionally higher need for social care resulting from frailty, reduced mobility, housing problems, social isolation and economic instability.[50]

A recent CQC survey of people aged 65 and over who had recently used health or social care services found that older people living in the most deprived areas were more likely to report that they had a LTC, disability, or illness, compared with those living in less deprived areas.[51]

Analysis of local primary care data shows that sex and deprivation are important factors in the prevalence of LTC. This chart shows on average women in the most deprived areas in Nottinghamshire have their first long-term condition 15 years before their peers in the least deprived areas. This 'health gap' is 8 years for men.

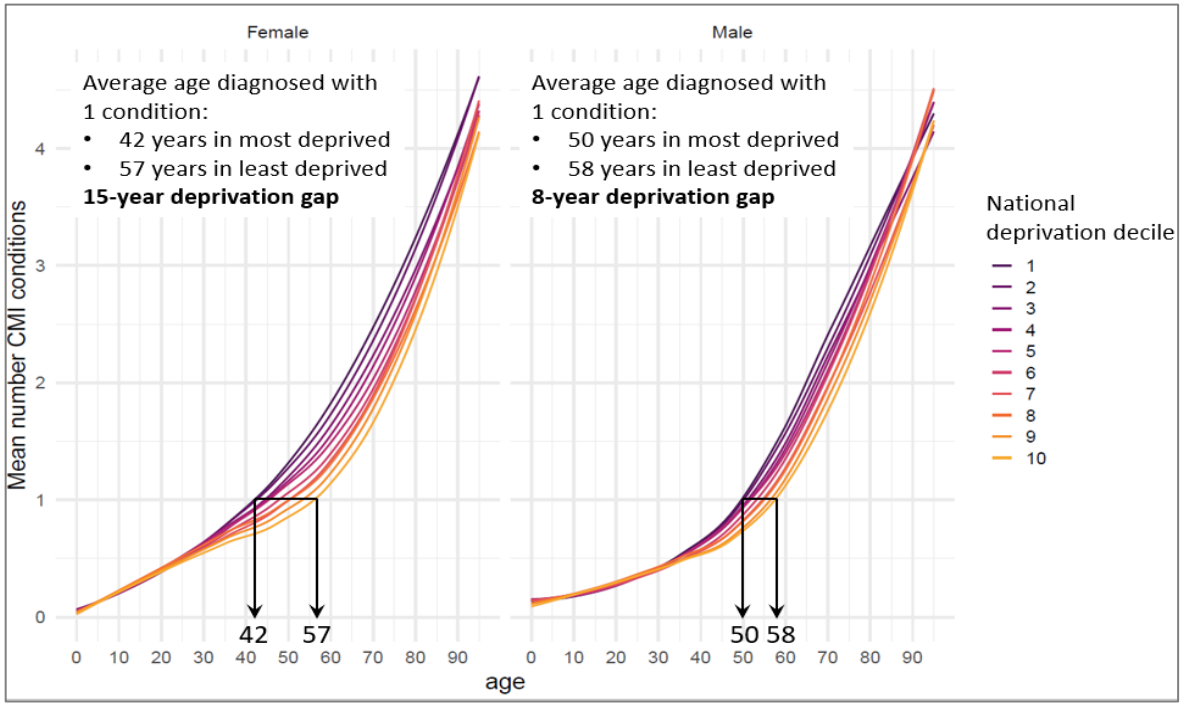


Figure 12: Mean number of LTCs by age, sex and deprivation in Nottinghamshire, Nottinghamshire primary care data 2024

The evidence suggests that the LTCs with the greatest effect on DFLE are strongly associated with unhealthy behaviours. This reinforces the message that investing in interventions to reduce known risk factors such as smoking, physical inactivity and obesity in younger adults might be

[49] Kingston A, Robinson L, Booth H, Knapp M, Jagger C; MODEM project. Projections of multi-morbidity in the older population in England to 2035: estimates from the Population Ageing and Care Simulation (PACSim) model. Age Ageing 2018; 47: 374–380

[50] ADR UK (2019) Multimorbidity and the use of health and social care (Accessed May 2024). Available at: https://www.adruk.org/our-work/browse-all-projects/multimorbidity-and-the-use-of-health-and-social-care-71/

[51] CQC (2022) State of Care 2021/22 (Accessed May 2024). Available at: https://www.cqc.org.uk/publication/state-care-202122/inequalities

critical in preventing, delaying, or significantly reducing disability and allowing individuals to live independently with minimal or mild disability in older age.[52]

Continuing to focus on extending life at older ages, with little or no consideration for alleviating or postponing the disabling consequences of disease will result in more older people with greater levels of disability that need care, in addition to the rise resulting from the ageing of the population.

[52] Lourida I, Bennett HQ, Beyer F, Kingston A, Jagger C. The impact of long-term conditions on disability-free life expectancy: A systematic review. PLOS Glob Public Health. 2022 Aug 5;2(8).

6. Frailty

As the English population ages, the number of people living with frailty has been increasing. Frailty is a distinctive health state related to the ageing process, in which multiple body systems gradually lose their in-built reserves. Frailty is different from the expected physiological decline that occurs with ageing because it involves a more rapid decline of stability and abilities, rather than occurring systematically and progressively.[53] This leaves people with frailty vulnerable to sudden changes in health triggered by seemingly small events such as a minor infection or a change in medication or environment.

Frailty behaves exactly like a long-term condition. It is progressive, it impacts adversely on life experience and – if unmanaged – it can cause the sufferer to become very sick, very quickly. This means that at an individual level, those living with frailty are more susceptible to greater functional declines in health from illnesses or adverse events considered minor such as mild respiratory disease or experiencing a fall. What is of concern is that most older people with mild or moderate frailty are not known to services, which prevents help at an earlier stage when recovery may be possible and crises might be prevented.

As might be expected frailty prevalence is higher among older people. It is also higher in women and those living in deprived areas. The 2020 England prevalence of pre-frailty and frailty among adults aged 65+ years has been estimated at 2.7% and 1.2%, respectively. Those estimates were higher among women (3.4% for pre-frailty and 1.5% for frailty) than men (2.0% for pre-frailty and 0.8% for frailty).[54]

Frailty is strongly associated with experiencing a poor quality of life, inactivity, social isolation, loneliness, mental health challenges, and a range of adverse health outcomes, such as falls, and increased use of health and social care services.

[53] Thandi, M., Wong, S.T., Price, M. et al. Perspectives on the representation of frailty in the electronic frailty index. BMC Prim. Care 25, 4 (2024).
[54] NHIR (2020) Using individual and neighbourhood profiles and trends to understand frailty with nationally representative population data. Part 1: Frailty among older adults and its distribution in England (Accessed May 2024). Available at: https://documents.manchester.ac.uk/display.aspx?DocID=58963#:~:text=Results-,Pre%2Dfrailty%20and%20frailty%20prevalence,and%200.8%25%20for%20frailty)

Several studies have shown the influence of psychosocial factors and levels of frailty and demonstrated significant correlations between these, which are:

- Depression
- Perceived health status
- Self-esteem and self-image
- Participation in leisure activities
- Loneliness
- Intergenerational relationships including number of children and contact with children
- Marital status

Results show that frailty is the strongest predictor of formal social care costs. Mean social care costs for people who are not frail are £321, compared with £2,895 for individuals with frailty.[55] Interventions avoiding or postponing the onset of frailty therefore have the potential to considerably reduce social care costs.

District Council	Pre-frail (%)	Frail (%)
Ashfield	2.9	1.1
Bassetlaw	3.4	1.3
Broxtowe	2.6	1.0
Gedling	2.6	1.0
Mansfield	3.0	1.5
Newark and Sherwood	2.7	0.8
Rushcliffe	2.4	0.7

Table 4: Frailty and Pre-frailty in Nottinghamshire districts, 2020, NIHR

[55] Rodríguez Mañas L, García-Sánchez I, Hendry A et al. Key messages for a frailty prevention and management policy in Europe from the ADVANTAGE JOINT ACTION Consortium. Journal of Nutrition Health and Ageing 2018: 22 (8); 892-897 http://dx.doi.org/10.1007/s12603-018-1064-y

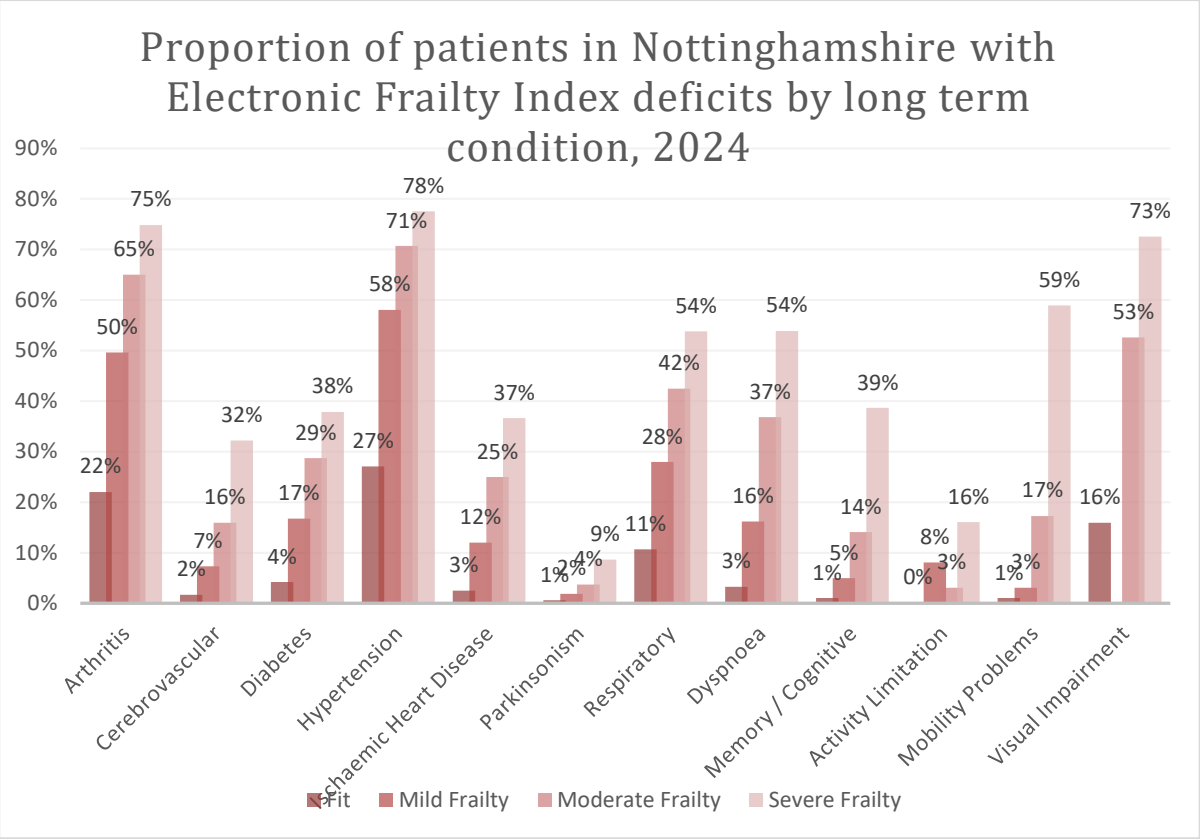


Figure 13: Proportion of patients in Nottinghamshire with Electronic Frailty Index deficits by long term condition, Nottinghamshire primary care data 2024

Using the disability components of the Electronic Frailty Index (eFI) for patients in Nottinghamshire, it was possible to explore the impact on men and women. It appears that these disability deficits are worse in women in most cases. This is particularly true in severe frailty where only hearing impairment is worst in males (52%). Women are much more likely to be housebound (68% vs 58%) and be seen as socially vulnerable (73% compared to 60%). Moreover, women are more likely to be visually impaired at all three levels of frailty.

Greater use of eFI by health and care staff might help support timely care interventions and better of planning community services for the frail population.

7. Social Care spending and activity

Nationally demand for social care has been increasing. However, the number of older adults receiving local authority long-term support has generally decreased over the period, whilst short-term support offered has remained stable. Research indicates that receipt of disability benefits and receipt of council funded care rises as disability increases with a strong concentration on those with the highest levels of disability, meaning that social care data can be used to indicate levels of disability.[56]

The County Council's social care record system (MOSAIC) has been used to try to understand the patterns of care in Nottinghamshire as a whole and across the districts. Some of the activity may be due to need, some due to rising expectations and other activity patterns could reflect the availability of services at local level that prevent need.

7.1 New requests for services

New requests to local authorities for support are the best available marker of demand for adult social care.

Year	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Number of new requests for support: Age 18-64	508,620	523,920	550,435	560,350	577,765	611,505	611,590
Number of new requests for support: Age 65 and over	1,305,795	1,320,000	1,364,095	1,370,205	1,337,875	1,367,045	1,390,465
% Growth since 2015-16: Age 18-64	1.6%	4.6%	9.9%	11.9%	15.4%	22.1%	22.2%
% Growth since 2015-16: Age 65 +	-0.3%	0.8%	4.1%	4.6%	2.1%	4.3%	6.1%

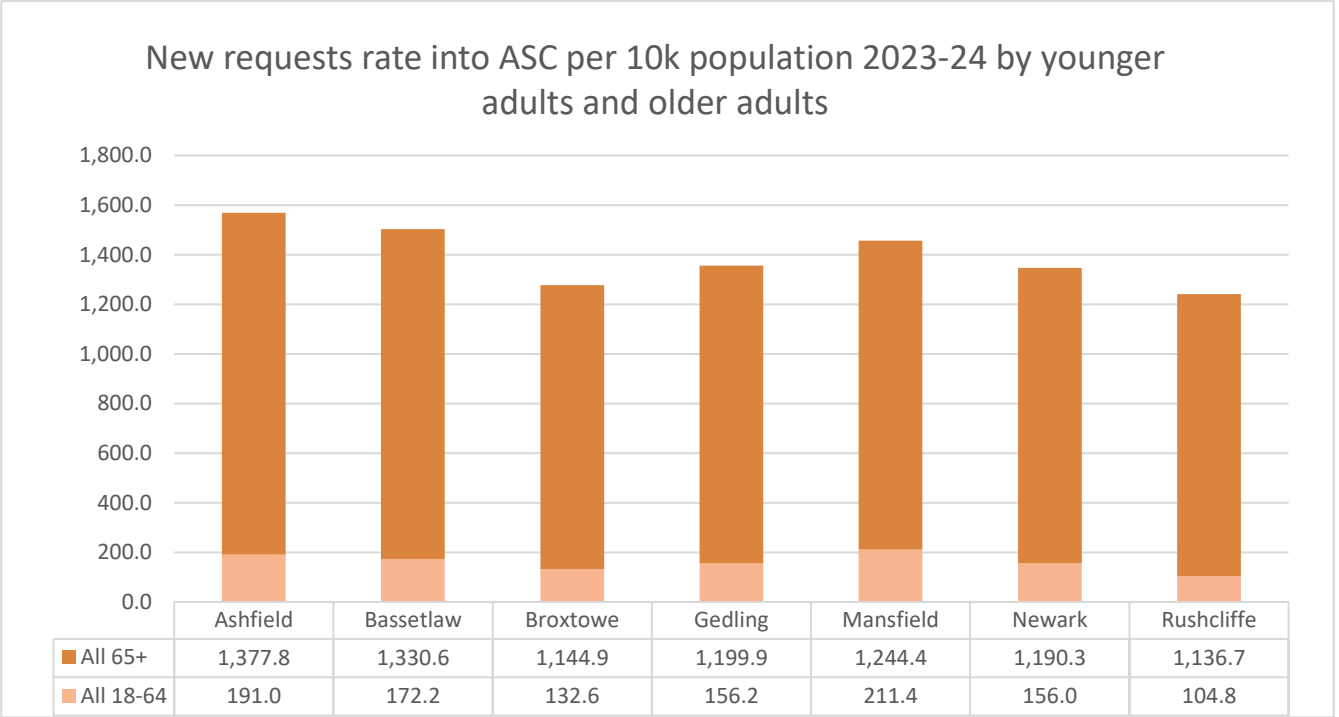
Table 5: Demand for Social Care 2016-2023 (The King's Fund, Social Care 360: access, March 2024)

Within the UK, the number of new requests for support increased from 1.98 million in 2021/22 to 2.0 million in 2022/23. The main reason for this was an increase in requests from older people. Moreover, there have been increases seen from working-age adults which in the same

[56] Hancock, R., Morciano, M. and Pudney, S. (2019), Public Support for Older Disabled People: Evidence from the English Longitudinal Study of Ageing on Receipt of Disability Benefits and Social Care Subsidy†. Fiscal Studies, 40: 19-43. https://doi.org/10.1111/1475-5890.12169

period has seen an increase of 33,825. When looking at growth as a proportion over the last five years, increases in new requests are particularly evident in the **18-64 age group**. Studies suggest that any increase in requests from working-age adults is likely to reflect increasing disability among adults aged 18–64.[57]

Nottinghamshire data indicates the rate of new people requesting support is lower in the 18–64-year age band compared to both England and East Midlands, whereas the requests from older adults are comparable with the England rate and lower than East Midlands. The chart below shows the rate of new requests across the districts. There is more demand in the 65+ population in all districts (Ashfield has the highest rates). Mansfield and Ashfield show higher request rates for working-age adults. Rushcliffe has the lowest rates for younger and older adults. Compared to previous years there has been a large increase in 2023-24.



	Ashfield	Bassetlaw	Broxtowe	Gedling	Mansfield	Newark	Rushcliffe
All 65+	1,377.8	1,330.6	1,144.9	1,199.9	1,244.4	1,190.3	1,136.7
All 18-64	191.0	172.2	132.6	156.2	211.4	156.0	104.8

Figure 14: Rate of new requests (per 10K population) for younger and older adults, 2023-2024 in Nottinghamshire, MOSAIC

[57] The Kings Fund (2023) Demand for adult social care hits record high while support from local authorities drops (Accessed May 2024). Available at: https://www.kingsfund.org.uk/insight-and-analysis/press-releases/demand-adult-social-care-hits-record-high-support-local-authorities-drops

The most frequent outcome of new requests for support from community settings is no further action; this would be because the individual is signposted to universal services, given information and advice or did not require a formal support service. For requests from hospital discharge the most frequent outcome for clients is short term care and progression to reablement.

7.2 Primary support reason – indicators recorded in the Adult Social Care Outcomes Framework

The Primary Support Reason is essentially what is recorded as why an individual requires and receives support. As part of the Adult Social Care Outcomes Framework, this information is reported nationally.

In Nottinghamshire, **in the working age adult age range** the primary support reason overall was learning disability at nearly 25% of support received. For learning disability support, a higher percentage was seen in Newark and Sherwood (30.5%) with Mansfield the next highest at 26.6%. Support for access and mobility was given to around 17% of people overall with Bassetlaw having the highest proportion (18.9%) with Gedling next at 18.7%.

Around a third of those aged **65-84 years** received personal care support (the highest Primary Support Reason in this age group). Personal care support provides more intensive support and often includes support with access and mobility. For personal care, Gedling was the highest at 39%, followed by Broxtowe (38.6%). However, the districts showing the highest rates of support received (compared to the local population) are Mansfield and Ashfield. Just under 25% across all districts receive support for access and mobility. Bassetlaw received the highest percentage of support (28%) for access and mobility. Support for memory and cognition stands at around 10% across Nottinghamshire districts. Rushcliffe received greater support for memory and cognition (12.1%) as a percentage, but the rates (compared to the local population) were higher in Mansfield and Ashfield.

In those **aged 85+**, nearly half across all districts received social care support for personal care. Mobility support was around 20% across districts and support for memory and cognition was about 12%. Newark and Sherwood had the highest percentage of social care support for personal care (52%), whereas Bassetlaw had the highest percentage (22.6%) for mobility issues. Memory and cognition support was highest in Mansfield (14.5%), but Rushcliffe was not far behind at 14.1%. Considering rates, all districts were similar for personal care, and mobility support rates were higher in Bassetlaw. Support rates for memory and cognition were highest in Mansfield.

7.3 Long-term support

Social care is often broken down into two broad categories - short-term and long-term care. Short-term care refers to care and support that is time-limited and has the intention of maximising the independence of an individual and eliminating their need for ongoing support. Long-term support is provided on an ongoing basis and can range from high-intensity services to lower-intensity community support.

Despite the focus of this work on intervention upstream to reduce the need for social care and maximise independence, it is useful to consider the nature of the long-term support currently provided as this could help with understanding how this might be minimised in future.

The primary reason for long-term support in those aged 65+ is sensory impairments, memory and cognition and personal care support. There are some multidisciplinary interventions for management and prevention, including assistive technology and equipment, exercise programmes and cognitive strategies that might support both sensory and cognitive impairments and decline.

In terms of sex, other than substance misuse, mental health and learning disability which are higher in men, most long-term support is received by females. The greatest proportion - at nearly 87% - is carer support, followed by support for social isolation, hearing and visual impairment (the primary support reason in nearly 70% of cases).

The low numbers of ethnic minorities (and the fact there are cases where ethnicity not known) make it difficult to reach many conclusions, however, the highest levels of social care support for all Primary Support Reasons are found in the white population.

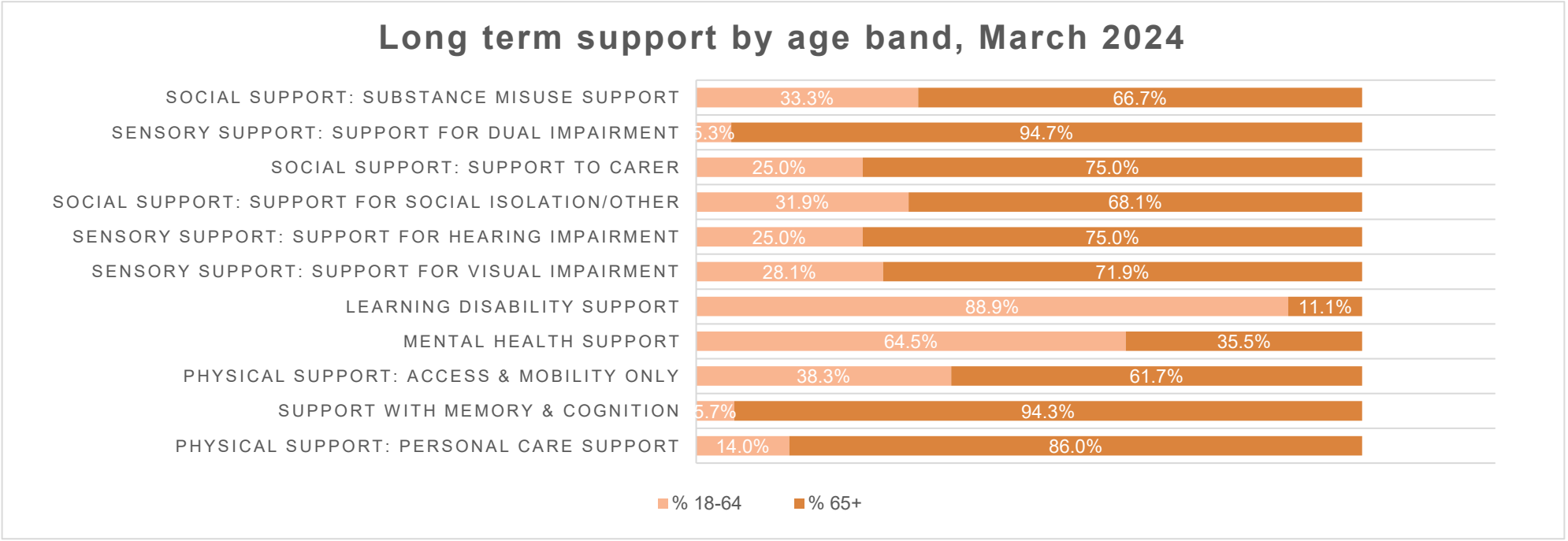


Figure 15: Long term support by age in Nottinghamshire, March 2024, MOSAIC

7.4 Listening to the voices of local communities

Studies show that closer working with and listening to people with lived experience of care and support can lead to better-informed decision-making, improved experience for people with care and support needs, and increased trust in support provided.

As mentioned, the Adult Social Care Outcomes Framework (ASCOF) draws on data from Local Authority collections and returns and conducts surveys of people with care and support needs to provide measures of how well care and support services achieve the outcomes that matter most to people. This includes several measures to explore quality of life and service satisfaction.

Recent results in Nottinghamshire demonstrate that overall social care-related quality of life has remained static, but Nottinghamshire is performing marginally better than the East Midlands or England overall. In terms of sex differences, females generally expressed that they had a lower quality of life than males (except in years 21/22). This reflected both the England and East Midlands findings where women again expressed lower satisfaction.

Years	Nottinghamshire	East Midlands	England
18/19	19.1	19.1	19.1
19/20	18.8	19.1	19.1
20/21	n/a	n/a	19.0
21/22	19.2	18.8	18.9
22/23	19.1	18.9	19.0
23/24	19.0		

Table 6: Social care-related quality of life score in Nottinghamshire, 2018/19 – 2022/23, ASCOF

Recent consultations and engagement activities in the county are very valuable in helping to understand the views and priorities of people who draw on care and support across the social care and health system. These are not restricted to views on prevention but highlight the areas of support that are important to people and those they would find most valuable. This shows the areas of opportunity where people are likely to be most receptive to intervention which could reduce, delay or minimise the need for social care support in the future, and reflect some of the recommendations identified by the data and literature review for the JSNA.

Where and how were people's views heard?

- **The Big Conversation 2023** - Nottinghamshire County Council Adult Social Care and Health department worked with social enterprise, Community Catalysts, on the 'Big Conversation' – which was designed to hear from people who use social care and unpaid carers in Nottinghamshire.
- The County Council has worked with carers to co-produce the **Nottingham and Nottinghamshire All Age Carers Strategy 2023-2028**
- **Carers' Joint Strategic Needs Assessment** - focus group 2023
- **Nottinghamshire County Council's Day Opportunities Strategy 2022-2027 –** consultation November 2020
- **Developing an Integrated Care Strategy for Nottingham and Nottinghamshire Integrated Care System: Insight report** 2023

From these consultations and discussions, there were some recurring issues and themes which might help to understand what kind of support and resources are useful to people and which they are most likely to use. Many of the issues relate strongly to interventions and ways of living that could reduce the need for social care. These include:

- Importance of having a purpose and contributing to society- doing things for others and/or in their community or neighbourhood.
- Importance of keeping fit and active and having opportunities for exercise and physical activity.
- How good home adaptations and equipment could make life easier.
- Feeling isolated and lonely at home.
- Need for a range of helpful information sources. Making information more accessible and easier to find was a priority. People say not everyone has a computer or uses the internet.
- The importance of being able to get in contact with a real person or access the person they need to speak to.
- Concerns about income deprivation and not being able to afford to live their lives. They also talked about a lack of help to manage their money and a lack of accessible finance and benefits advice.
- Importance of social connections and networks and having opportunities to see family and friends and socialise.
- The value of opportunities to undertake a variety of activities and to access these in their local community.
- How local communities are key partners that should be involved in decision-making and building healthier communities. Implicit in this was the need to embrace the notion of doing with, rather than doing to, or for people. Health and care should be more person-centred with services co-produced with people with lived experience.
- Communities were also cited as being a key enabler to support individuals to access health and care services and support.
- Poverty, including fuel poverty, food insecurity, digital poverty and access to sustainable employment opportunities was highlighted in the more deprived areas of the county.
- The value placed on the role of the Voluntary, Community and Social Enterprise sector and recognising the extensive support they can offer to communities, especially to support the prevention of ill health.
- Greater focus on mental health support and the impact that good physical health and activities have on mental health.

What should we do next?

5. Themes for consideration

This JSNA profile pack identifies themes for developing approaches to prevention within Adult Social Care and key partner organisations along with examples of the types of interventions that may be considered as part of the Adult Social Care Prevention Strategy which is in now in the early stages of development. There is already a lot of work taking place in the local social care and health system that promotes the themes identified below. This is about building prevention approaches and input collectively in the right places, where we can do more and where we can test and learn.

These themes are grouped under the headings of Prevent, Reduce and Delay – in line with the duties set out in The Care Act 2014 to prevent, reduce and delay the need for care and support.

	Themes	Lead(s)				
		Nottinghamshire County Council	Placed Based Partnerships / ICB	Voluntary and Community Sector	Communities / people who draw on care and support	District and Borough Councils
	Prevent					
1.	**Promote the practice, behaviours and interventions that will help people to live and age well. We want to focus on:** • an increase in system-wide early screening and connecting people to existing community-based solutions using a Making Every Contact Count approach • availability of physical activity sessions and groups in all parts of the county but targeted to areas of need identified in the JSNA • maximisation of the use of technology and home adaptations to improve people's homes, and • promotion of Nottinghamshire as an Age-friendly and Disability-friendly place to live.	/	/	/	/	/
2.	**Address loneliness and social isolation. We want to focus on:** • use of known risk factors and available data on loneliness to identify those at higher risk and to target support accordingly; • maximisation of existing support and resources and reviewing current investment in prevention services with a view to redirecting resources to increase appropriate support across the county.	/	/	/	/	/
3.	**Increase strengths-based approaches and support the building of community capacity. We want to focus on:** • strengthening relationships with the voluntary, community and social enterprise sector and community-based groups to build on existing support; and • continuing with the journey to embed strength-based and place-based approaches to supporting individuals and communities across the social care and health system in Nottinghamshire.	/	/	/	/	/

4.	**Use emerging and promising national evidence of most effective preventative support and increase local evaluation of support to understand what works in Nottinghamshire. We want to ensure that** • the County Council's Prevention Strategy for Adult Social Care is developed based on best practice in prevention. • future work includes a greater focus on mental health prevention and prevention for younger adults.	/	/	/	/	/
	Reduce					
5.	**Change our response to chronic disease and frailty – with our partner organisations in Nottinghamshire we want to:** • develop a joined-up approach to long term conditions across Nottinghamshire which is data and intelligence-driven • agree an integrated response to Frailty and ensure early intervention is possible • evaluate countywide Care Navigation and social prescribing support with a view to improving targeting and effectiveness; and • ensure sufficient investment in urinary incontinence services – a key risk factor for falls.	/	/	/	/	/
	Delay					
6.	**Targeted support and interventions to slow and reverse memory and cognition decline, and to identify people at risk of ill health and poor outcomes to maintain independence for as long as possible – we want to increase practice, behaviours and interventions:** • to mitigate the risk of dementia particularly in people with a mild cognitive impairment through a focus on modifiable risk factors, at an individual and community level • to use local health and social care data to target early support to people with disabilities and long term conditions - this could involve reablement, rehabilitation and intermediate care.	/	/	/	/	/

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