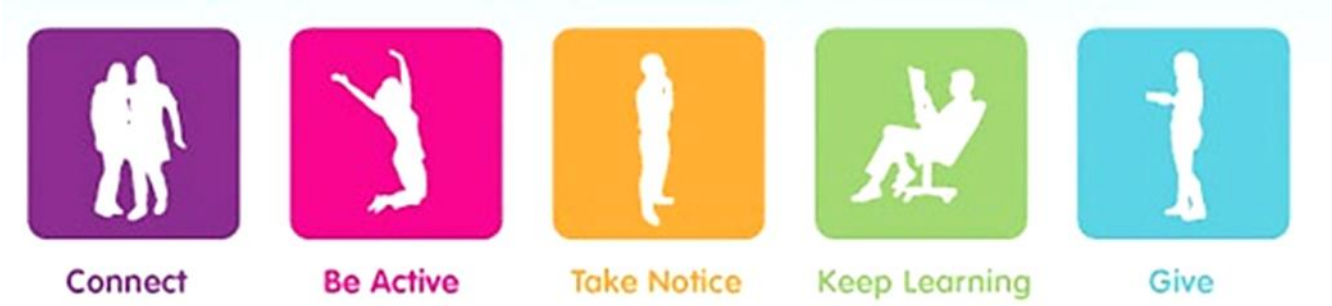
Liverpool City Council

Liverpool's Joint Strategic Needs Assessment

Older People Health Needs Assessment

June 2015



READER INFORMATION	
Title	**Liverpool's Joint Strategic Needs Assessment** **Older People Health Needs Assessment**
Team	Public Health
Author(s)	Richard Jones, Rebecca Mason
Contributor(s)	Sophie Kelly
Reviewer(s)	Chris Williamson Paula Parvulescu
Circulated to	
Version	3.0
Status	Final
Date of release	June 2015
Review date	None
Purpose	As well as providing an overview of the health of older people in the city, the needs assessment is structured around a number of key themes: • Dementia • Falls • Frailty & Re-ablement • Carers • Care Homes • End of Life Care These themes were selected in consultation with partners in Liverpool Clinical Commissioning Group and Liverpool City Council Adult Services, in addition to partner organisations.
Contact details	Rebecca.mason@liverpool.gov.uk Richard.Jones@liverpool.gov.uk

Table of Contents

1 EXECUTIVE SUMMARY

- In 2013, Liverpool was home to approximately 70,000 people aged over 65 years, with approximately 18,000 of these being over the age of 80.
- The number of older people living in the city has increased over the last decade, although not to the same extent as nationally (2% compared with 18%).
- The number of people over the age of 85 has increased significantly over the past decade, with a 10% increase in those aged 80-84, and a 17% increase in those aged over 85.
- The number of Liverpool people aged over 65 and 85 is expected to increase significantly by 2020, and then again by 2037.
- There has been a steady increase in life expectancy in Liverpool. Current life expectancy is 76.1 for men and 80.2 for women.
- However there is a significant life expectancy gap with men and women in the most deprived areas of the city dying over 9 years earlier than their neighbours in the most affluent areas.
- Cancer, and lung cancer specifically, account for most of the life expectancy gap in Liverpool
- Circulatory diseases, such as heart disease and stroke, are the second major cause of the life expectancy gap among males in Liverpool. However, among females, respiratory diseases such as COPD play a much larger role, accounting for 20% of the life expectancy gap, compared to 14% among men
- In 2011, one in four Liverpool residents aged over 65 years described their health as “bad or very bad”.
- Almost a fifth of older people smoke (equating to 14,000 people), a fifth are obese, approximately 1,500 drink hazardous or harmful levels of alcohol, and half do not do any moderate exercise.
- Cancer was the underlying cause for almost 3 out of 10 older person deaths in the city, whilst circulatory disease caused one in four deaths.
- Cancer screening uptake rates in Liverpool are, generally speaking, low. Bowel screening uptake rates have stagnated and breast screening uptake rates have fallen in recent years.
- In 2014 more than half of all Liverpool CCG responsible patients aged over 65 were on a disease register for hypertension. One in five patients were on the coronary heart disease register, one in six were on the diabetes register, and one in seven were on the depression register.
- The prevalence of dementia is increasing, however there are an estimated 1,795 Liverpool residents living with undiagnosed dementia.

- Liverpool has a higher than expected number of both elective and emergency hospital admissions for older people when compared with England, even when adjusted for age, sex and deprivation.
- The highest number of elective admissions in 2013/14 were for cataracts (2,418 admissions), osteoarthritis (1,119), and cancer of the prostate (1,060). These were all higher than the expected number of admissions when compared with England and adjusted for deprivation.
- The highest number of emergency admissions were for pneumonia (1,627 admissions), chronic obstructive pulmonary disease (1,080), and non-specific chest pain (820).

- There were 4,610 Ambulatory Care-Sensitive (ACS) emergency admission in 2013/14 which was 7% higher than would be expected compared with the national rate after adjusting for deprivation. These are conditions that should be effectively managed in primary care thereby preventing an admission to hospital.
- Emergency hospital admissions for falls are a significant issue in Liverpool, with 2,411 admissions by 2,215 older people admitted in 2013/14. Over a third of falls related admissions were for those aged over 85.

- Liverpool also has the second highest mortality rate for falls of all the core cities, with 92.6 deaths per 100,000 population.

- In 2013, just over half of over 65 year old deaths in Liverpool occurred in a hospital setting. Those aged over 85 years were statistically significantly less likely to die at home than all older people aged over 65 years (14% compared with 21%).
- Liverpool is home to over 9,000 older people providing unpaid care, which equates to 14% of the over 65 years population.
- There are 118 care homes in the city, and 71 specialise in caring for adults aged over 65 years, with 4 out of 10 providing a nursing service.
- There are over 3,600 care home beds in Liverpool with approximately 250 places available in these homes, indicating an occupancy rate of around 93%.

2 INTRODUCTION

The population of the UK has fluctuated greatly in the past 100 years [1]. The end of World War 2 saw a huge peak in the national birth rate which has then fluctuated and generally decreased in recent years. Improvements to the welfare state and increases in the standards of living have meant that those coming up to retirement today (the so-called "baby boomer generation") can expect to live much longer than their parents or grandparents lived.

However, at the same time the number of babies being born in the UK has been steadily decreasing since 1964 [2]. This fluctuation in births over the years has meant that the median age of the UK is rising with 10 million people in the UK aged over 65 years old [1]. This number is expected to rise significantly in the coming years with the retirement of the "baby boomer" generation. The latest projections are for 5½ million more elderly people in 20 years' time and the number will have nearly doubled to around 19 million by 2050 [1].

This change in the structure of the UK population brings with it some significant challenges. Much of today's public spending on benefits is focussed on providing pensions, health and social care services to elderly people [1]. The age profile of Liverpool's residents is slightly different to the national profile, as the mass exodus of working aged adults from Liverpool in the 1980s means that we will likely experience the rise in older people a little later. This health needs assessment aims to set out the population trends within Liverpool and explore the various challenges these bring for local service providers.

In addition to an overview of the health of older people in the city, the needs assessment is structured around a number of key themes:

- Dementia
- Falls
- Frailty & Re-ablement
- Carers
- Care Homes
- End of Life Care

These themes were selected in consultation with partners in Liverpool Clinical Commissioning Group and Liverpool City Council Adult Services, in addition to partner organisations. An outline of the planned work was also presented to the "Making It Happen Group for Older People and People with a Physical and/or Sensory Impairment". Whilst the themes cover a number of strategic priorities for older people, we acknowledge this is not an exhaustive list and additional areas of work have been identified through this needs assessment.

3 POLICY CONTEXT

3.1 The Healthy Liverpool Programme

In the summer of 2014 the Liverpool Clinical Commissioning Group (CCG) introduced The Healthy Liverpool Programme[3], as a response to the Mayor's 2013 Health Commission which found that only a wholesale comprehensive approach to the transformation of health would succeed in improving the health outcomes of the people of Liverpool[4]. The vision was that, "by 2020, all the people of Liverpool will be enjoying longer, healthier lives[4]. We want to create a future in which everyone receives consistent, high-quality healthcare, wherever we live in the city; with care delivered in the home, in our communities, and in our excellent hospitals[4]." "Healthy Ageing" was identified as one of six priority areas, and aims to enable people to retain the independence and live at home for longer, with the right support.

Liverpool City Council and Liverpool CCG jointly spend approximately £232m each year on health and social care services for older people[3]. Much of this is spent on providing specialist care for those who are in crisis, such as hospitals, nursing or long-term residential care. It is believed that re-focusing this funding to support people before they reach crisis would lead to significant improvements to the health of older people, and cost-savings to the wider health and social care economy[3].

The reform of the health and care of the elderly will focus on the following areas, and will be explored in more detail in this health needs assessment[3]:

- Ensuring services are in place to support those with dementia,
- Reablement which involves helping older people get better quickly after illness or a hospital admission
- Supporting carers of older people,
- Providing end-of-life care in the best possible way; in people's homes for instance,
- Ensuring a successful and stable care home sector.

3.2 Section 75

Section 75 of the NHS Act 2006 allows for budgets to be pooled between local health and social care organisations and authorities[5]. Resources and management structures can be integrated and functions reallocated between partners to provide more locally tailored services. The arrangements have allowed commissioning for new or existing services to be joined up.

The partnership being developed in Liverpool is about working as one integrated service. Often older people are admitted to institutional care for long periods when a package of assessment, treatment, rehabilitation and support in the community – or more support to their carers – might have served their needs, and maintained their independence. LCC Adult Social Care will be aligning its resource to localities and neighbourhoods during 2014/15 and a Section 75 Partnership Agreement will create scope for integration of services at neighbourhood level.

3.3 Better Care Fund

The £5.3bn Better Care Fund (BCF), formerly the Integration Transformation Fund, was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care[6]. It creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being at the heart of health and care services. The aim of the BCF is to support a shift in health spend from hospital contracts to more community based services, self-care and prevention programmes. The BCF becomes a requirement from 2015/16 with the financial budget determined in line with CCG allocations. For Liverpool this figure is £39.8M plus a further £5.1M in capital resource for 2015/16. However this funding includes approximately £20M of existing commitments, including the funding for reablement hubs and services to meet those with complex needs, including the £3.5M Disabled Facilities Grant. In addition to which there is a further £14m of pooled funding already in place for 2013/14 between LCCG and LCC under the existing s75 Agreement as agreed by the Health and Wellbeing Board in September 2013.

The key focus of the work will reflect the transformational areas identified within the Healthy Liverpool Programme including services for older people[7]. The £5.3bn Fund includes £130m of NHS funding for carers breaks. Local plans should set out the level of resource that will be dedicated to carer-specific support, including carers' breaks, and identify how the chosen methods for supporting carers will help to meet key outcomes (e.g. reducing delayed transfers of care). The Fund also includes £300m of NHS funding for reablement services. Local plans will therefore need to demonstrate a continued focus on reablement and will have to provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends.

The Better Care Fund (BCF) plan requires Liverpool CCG to formulate a joint plan with the local authority, for integrated health and social care and to establish a single pooled BCF budget to facilitate this joint working[7]. Joint plans are required to be approved through the Health and Well Being Board and will need to be agreed by both the CCG and City Council.

3.4 Integrated Personal Commissioning Programme

In July 2014, NHS England offered local councils across England a new option in which individuals could control their combined health and social care support[8]. Plans for a new Integrated Personal Commissioning (IPC) programme were set out, designed to blend comprehensive health and social care funding for individuals, and allow them to direct how it is used. Four groups of high-need individuals were to be included in the first wave from April 2015, and included "people with long term conditions, including frail elderly people at risk of care home admission." This new approach builds upon, but is in addition to, the Better Care Fund[8].

Under the new IPC programme, a combined NHS and social care funding endowment will be created based on each individual's annual care needs. Individuals enrolled in the programme will be able to decide how much personal control to assume over how services are commissioned and arranged on their behalf[8].

The goals of the programme are:

- People with complex needs and their carers have better quality of life and can achieve the outcomes that are important to them and their families through greater involvement in their care, and being able to design support around their needs and circumstances.
- Prevention of crises in people's lives that lead to unplanned hospital and institutional care by keeping them well and supporting self-management.
- Better integration and quality of care, including better user and family experience of care.

3.5 Continuing Healthcare

NHS continuing healthcare is the name given to a package of care that is arranged and funded solely by the NHS for individuals who are not in hospital but have complex ongoing healthcare needs. It can be received in any setting including[9]:

- At home – the NHS will pay for healthcare, such as services from a community nurse or specialist therapist, and personal care, including help with bathing, dressing and laundry.
- In a care home – as well as healthcare and personal care, the NHS will pay for care home fees, including board and accommodation.

NHS continuing healthcare is free, unlike social and community care services provided by local authorities where charges are dependent on income and savings. Eligibility is based on having a complex medical condition and substantial and ongoing care needs. Applicants must have a "primary health need", which means that the main or primary need for care must be health related. Where an individual is eligible for NHS continuing healthcare, the CCG is responsible for care planning, commissioning services and for case management[9].

3.6 Safeguarding/ Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005[10]. They aim to make sure that people who do not have the mental capacity (ability) to make decisions about their care or treatment living in care homes, hospitals and supported living, are looked after in a way that does not inappropriately restrict their freedom. The safeguards should ensure that a care home, hospital or supported living arrangement only deprives someone of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them[10].

The Mental Capacity Act says that someone who lacks mental capacity cannot do one or more of the following four things:

- understand information given to them
- retain that information long enough to be able to make a decision
- weigh up the information available and understand the consequences of the decision
- Communicate their decision – this could be by any possible means, such as talking, using sign

language or even simple muscle movements like blinking an eye or squeezing a hand.

3.7 Care Act

Under the Care Act (2014), local authorities have new functions to create a single, consistent route to establishing entitlement to public care and support[11]. It also creates the first ever entitlement to support for carers. The aim of the Care Act is to help improve people's independence and wellbeing and to ensure residents:

- receive services that prevent their care needs from becoming more serious, or delay the impact of their needs;
- can get the information and advice they need to make good decisions about care and support;
- Have a range of providers offering a choice of high quality, appropriate services.

Under the Act, there is more flexibility to focus on what the person needs and what they want to achieve, and to design a package of care and support that suits them. Depending on a person's finances, a local authority may ask an individual to contribute towards the costs of their care (up to and including the full amount)[11]. In cases where the costs of care would reduce a person's income below a set level, a local authority will pay some of the costs to make sure that the person is left with this minimum level of income.

The Act requires local authorities to provide information on:

- the types of care and support that are available – e.g. specialised dementia care, befriending services, reablement, personal assistance, residential care etc.;
- the range of care and support services available to local people, i.e. what local providers offer certain types of services;
- what process local people need to use to access the care and support that is available;
- where local people can find independent financial advice about care and support and help them to access it;
- how people can raise concerns about the safety or wellbeing of someone who has care and support needs.

From April 2016, the Care Act will introduce a cap on care costs and will provide new financial protection for those with modest wealth. The current estimated cost of implementing the Act in Liverpool is £47m by 2020/21, whilst the current funding formulae allocated to Liverpool is £37m, highlighting a significant funding gap[11].

4 LIVERPOOL CITY POPULATION

4.1 Resident Population

In 2013, 14.5% of the Liverpool population were over the age of 65, with 3.9% of the population over the age of 80. This equates to 68,278 Liverpool residents aged over 65 years and 18,128 over the age of 80 respectively.

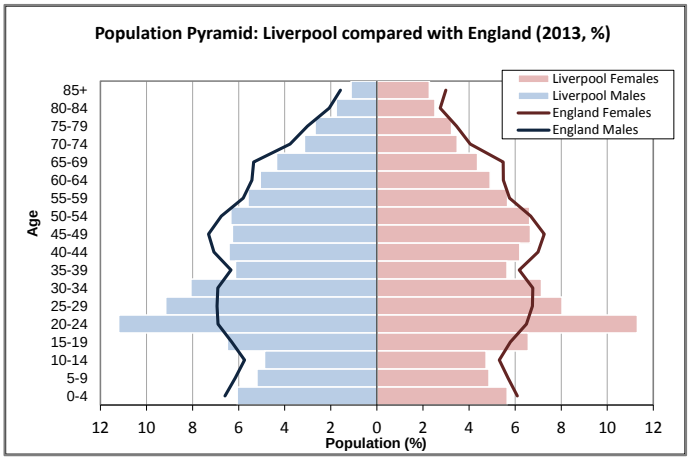
Although nationally the ageing population has increased in recent years, in Liverpool the percentage of the total population that is over the age of 65 has decreased slightly from 15% in 2002 to 14.5% in 2013. This compares to a rise from 15% to 17.3% nationally. All of the Core Cities experienced a similar reduction over the same period.

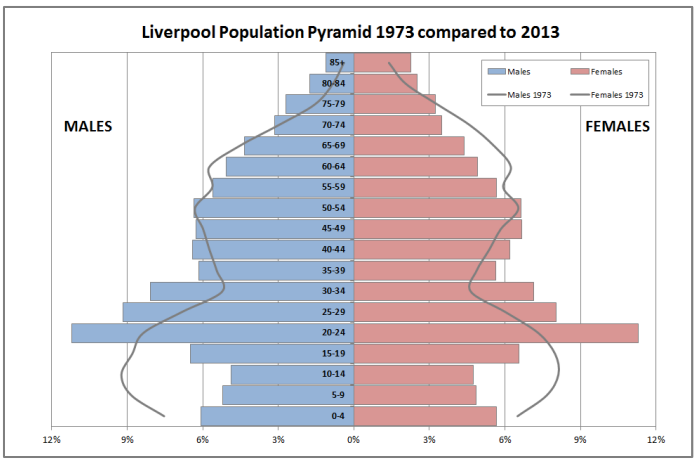
There has been growth in the more elderly cohorts with a 10% increase in the 80-84 years age-group and a 17% increase in the 85+ years age-group. These cohorts have particularly high needs in terms of health and social care provision, and account for 10,098 and 8,030 people of the total older person population of 68,278.

4.1.1 Population Pyramids

The population pyramids below depict the population structure for Liverpool and how it has changed over the years. The left hand chart below shows the current population structure, with an overlaid line depicting the England average. What becomes immediately apparent is the large difference in the younger age groups which is reflective of Liverpool's large and growing student population. The adjacent chart compares the current population structure with an overlaid line depicting the population structure in 1973. This shows that there are now many more people living in Liverpool who are aged over 85, whilst there are significantly fewer people aged 0-19.

Chart 1: Population pyramids (Source: ONS Mid-Year Population Estimates)





4.2 NHS Liverpool Clinical Commissioning Group Responsible Population

The CCG responsible population includes all of those patients that are registered with a GP Practice in Liverpool. It will therefore include patients that live outside the Liverpool local authority boundary, and exclude Liverpool residents who are registered at a practice in a neighbouring CCG.

4.2.1 Responsible Population by GP Neighbourhood

A GP neighbourhood is comprised of a cluster of GP practices that work closely together. There are currently 18 'neighbourhoods' within Liverpool.

In 2014 Liverpool CCG had a responsible population of 72,547 over 65 year olds. This was 6% higher than the resident population estimated by the Office for National Statistics. The proportion of the CCG responsible population aged over 65+ years was the same as for the resident population (14.5%).

Garston/ Allerton/ Aigburth, and Childwall neighbourhoods had the highest number of patients aged over 65 years (7,072 and 6,398 respectively). Gateacre/ Woolton and Belle Vale neighbourhoods had the highest proportion of their total populations that were aged over 65 years (21% and 19% respectively).

Of the 94 GP Practices in the city, the number over 65 year olds ranged from a low of 170 to a high of 2,360. As a proportion of the total practice population, the range at the GP Practice level was from 1.7% to 24.1%.

GP Neighbourhood	Total Population	65+ Years Population	%
Gateacre / Woolton	26,160	5,401	20.65
Belle Vale	13,837	2,576	18.62
Garston / Allerton / Aigburth	38,998	7,072	18.13
Childwall	35,389	6,398	18.08
Walton	30,510	4,948	16.22
Aintree	36,419	5,845	16.05
Dovecot & Old Swan	35,872	5,712	15.92
Tuebrook / Stoneycroft	36,876	5,799	15.73
Norris Green	23,233	3,437	14.79
Speke	19,854	2,820	14.20
Everton / Great Homer Street	14,671	2,060	14.04
Anfield	19,131	2,649	13.85
Kensington to Abercromby Neighbourhoods	26,290	3,508	13.34
Riverside	26,355	3,507	13.31
Croxteth	16,867	2,142	12.70
Wavertree	17,260	2,035	11.79
Picton	42,626	4,886	11.46
City Centre / Vauxhall	41,272	1,752	4.25
Liverpool	**501,619**	**72,547**	**14.46**

Table 1: Liverpool CCG older population (Source: Practice patient database, March 2014)

In 2014, Liverpool CCG was responsible for 32,505 male patients aged over 65 years. There were 3,230 more male patients aged 65+ years than in 2007 which represented an 11% increase. Since 2007 there has been a dramatic increase in the number of 80-84 and 85+ years patients with a 21% and 33% rise respectively.

In 2014, Liverpool CCG was responsible for 72,547 patients aged over 65 years. Since 2007, the number of 65+ year olds increased in number by almost 4,500 representing a 7% rise. The 65-69 years age-band has seen the largest growth, particularly over the last three years. There are also more than a thousand additional 85+ year old patients in 2014 than there were in 2007, with this cohort being the most likely to use health services.

4.3 Geographical Distribution

4.3.1 65+ Year Olds

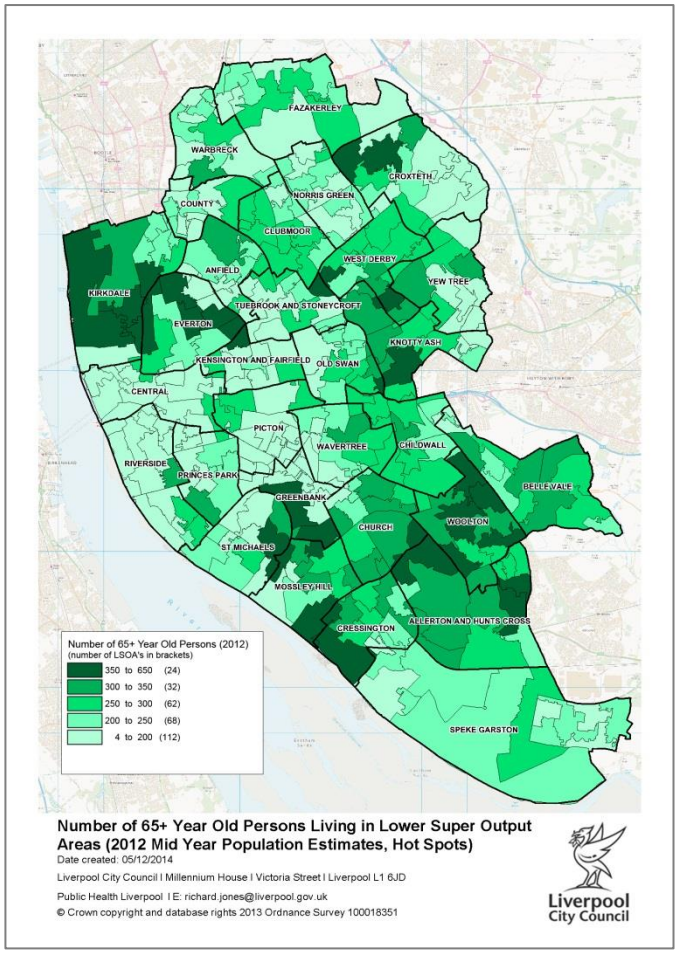
Map 1 illustrates the geographic distribution of Liverpool's 65+ year old **residents** at the lower super output area (LSOA) geography. What can be seen is that older people tend to live in the more affluent wards of Woolton, Allerton and Hunts Cross, although there are pockets in the more deprived areas including Kirkdale and Everton.

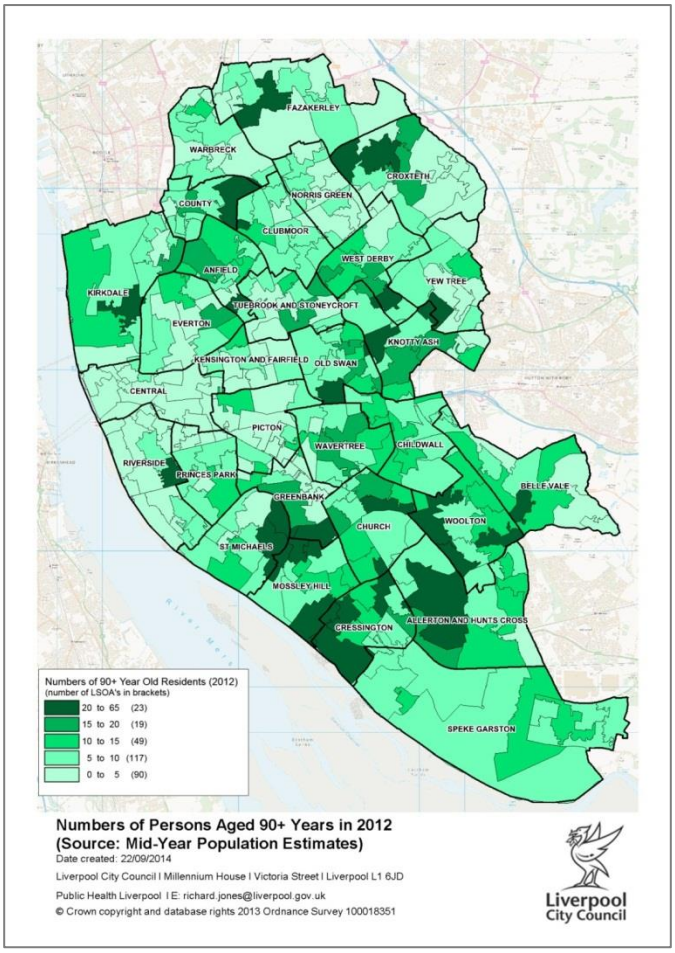
4.3.2 90+ Year Olds

Map 2 highlights those parts of the city where the largest concentrations of 90+ year olds live. In 2012 there were 2,592 people aged over 90 years living in Liverpool. The highest concentrations of 90+ year olds are towards the south end of Liverpool in Woolton, Allerton and Hunts Cross, Mossley Hill, Greenbank, and St Michaels, although there are pockets across the city.

Between a quarter and half of people in this demographic are estimated to be frail, which develops as a consequence of age-related decline in multiple body systems, resulting in vulnerability to sudden health status changes triggered by minor stress or events such as an infection or a fall at home.

Map 1: Numbers of 65+ and 90+ year olds (Source: ONS Mid-Year Population Estimates, 2012)





4.4 Population Projections

The Office for National Statistics population projections are trend-based, and make assumptions about future fertility, mortality and migration levels based on trends in recent estimates, usually over a five-year reference period. They give an indication of what the future population size and age and sex structure might be if recent trends continued. They are not forecasts and take no account of policy nor development aims that have not yet had an impact on observed trends.

The 2012-based projections suggested that Liverpool's total population was estimated to increase by 1.2% by 2020, but the city's over 65+ years population was projected to increase by 11%. This would equate to an additional 7,365 older people living in Liverpool. Those aged 85-89 years were estimated to increase in number by a fifth and those aged 90+ years by a third, equating to an additional 1,179 and 842 residents respectively. However, LCC's Adult Social Care team have predicted that the "age spike" will probably not occur in Liverpool until 2025. Although the demographic trend of an ageing population will be slower in Liverpool, the older population requiring permanent care and support will likely become increasingly complex[1].

The projections have been calculated to 2037, by which point Liverpool's total population is

estimated to increase by 5.6%. Liverpool's older population is estimated to increase by 46% by 2037 which is the equivalent of an additional 31,000 residents. The population aged 85+ years is estimated to more than double, meaning that there will be an additional 8,500 residents from this cohort in the city.

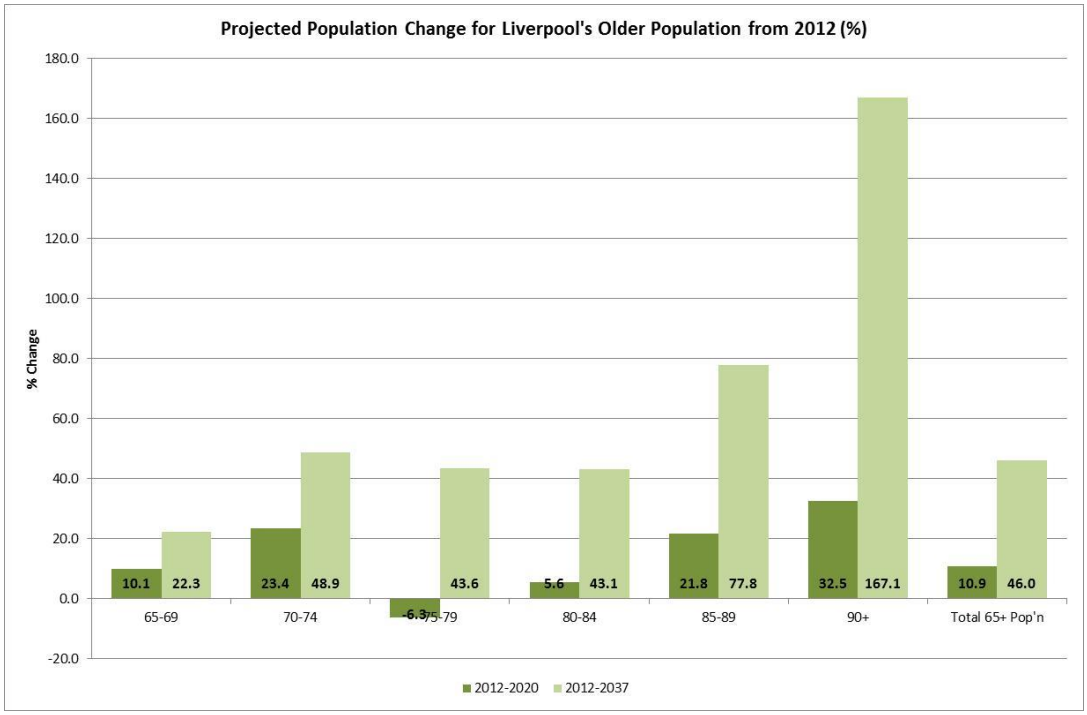


Chart 2: Percentage population change (Source: ONS 2012-based population projections)

4.5 Ethnicity

Research conducted by Age Concern highlighted how a combination of growing factors had led to the increasing isolation of older people within public life and raised barriers to accessing care[12]. These factors included lacking access to information and public services, prejudice and racism, poor public transport, fear of crime, ill health and lack of money or a lack of funding for BME voluntary organisations[12]. Furthermore it has been shown that older people receive a different level of service provision based upon their command of the English language[13]. In regards to health, both national and local research shows that BME older people are more likely to suffer from long term illnesses[13]. In turn this causes an increased likeliness of suffering from a debilitating condition in old age[13].

Differences in the health of black and other minority groups are most prominent in the following areas of health: mental health, cancer, heart disease and related illnesses such as stroke, Human Immunodeficiency Virus (HIV), Tuberculosis (TB) and diabetes[11]. Additionally an increase in the number of older black and other minority people in the UK is likely to lead to a greater need for provision of dementia services as well as the provision of culturally competent social care and palliative care[15].

The 2011 Census showed that 3.6% of Liverpool's over 65 years population were of a non-white ethnic background, compared with 4.7% nationally. When including the white Irish and other white

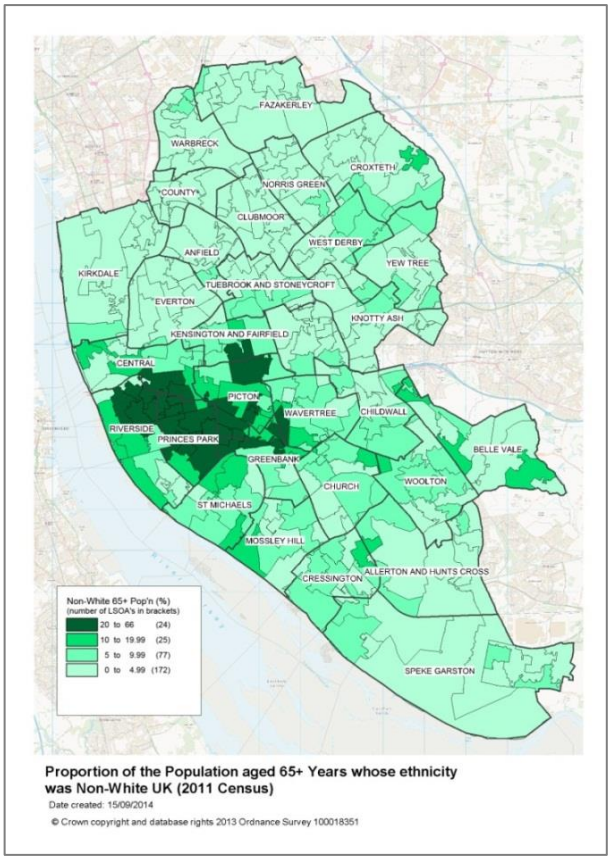
populations, Liverpool's minority elderly population is 6.1% (England = 8.4%). The largest older person ethnic minority groups in the city were:

- White Irish = 1,179 (1.8%)
- Chinese = 561 (0.9%)
- Other White = 456 (0.7%)

The 2011 Census asked people to describe their general health. Around 25% of Liverpool's 65+ years white UK population considered themselves in bad or very bad health, compared with 26.4% of the non-white UK population. Levels were notably higher among: mixed/multiple ethnic group (28%), Black/African/Caribbean/Black British (30%) and those from other ethnic groups (38%). Although Liverpool's over 65 years non-white UK population is relatively low, there are parts of the city that are over-represented. In Princes Park ward almost 40% of those aged over 65 years old are from a non-white UK ethnic background, compared with only 1.4% in Clubmoor ward.

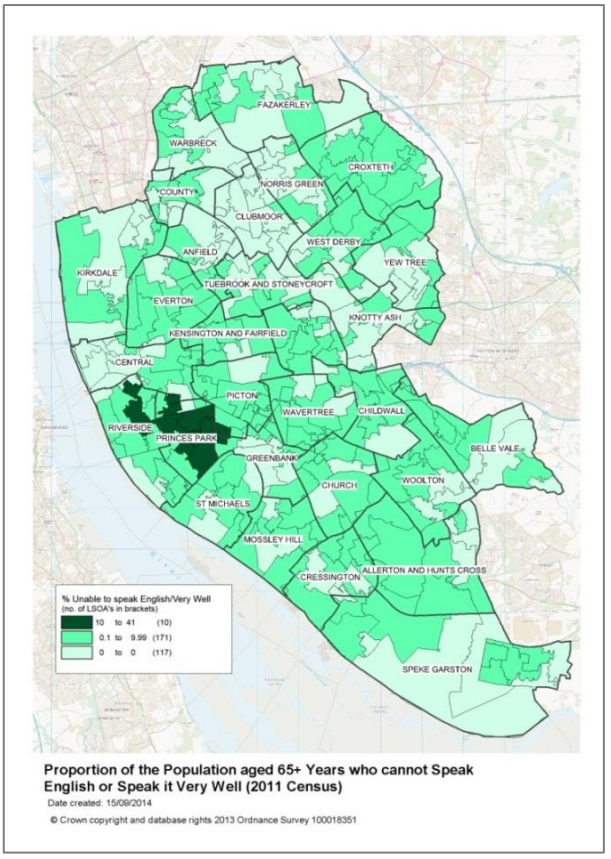
Map 5 illustrates the clustering of the non-white over 65 years old population in different areas of the city, along with the proportion that cannot speak English or speak it very well. In one area some 66% of the total non-white elderly population were of a non-white ethnic background. In these areas there is also a relatively high proportion of over 65 year olds who cannot speak English or speak it very well. This was the case for more than 4 out of 10 older people in one area of Princes Park.

Map 2: Non-white UK population by LSOA and the proportion who cannot speak English or speak it very well (Source: 2011 Census)



Proportion of the Population aged 65+ Years whose ethnicity was Non-White UK (2011 Census)

Date created: 15/09/2014



Proportion of the Population aged 65+ Years who cannot Speak English or Speak it Very Well (2011 Census)

Date created: 15/09/2014

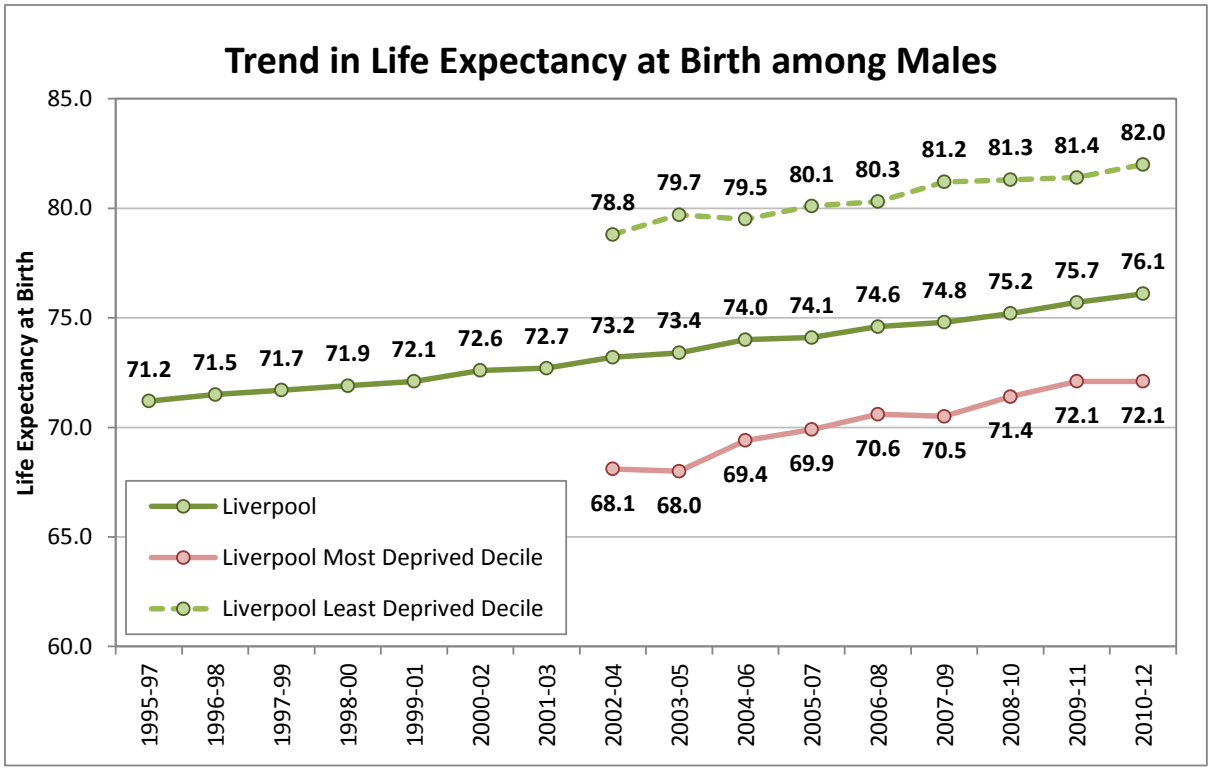
5 BURDEN OF DISEASE

5.1 Life Expectancy

Life expectancy at birth is used as an overarching measure of the health of the population. The charts below show how there has been a steady increase in life expectancy in Liverpool, with males expected to live 4.9 years longer than they were in 1995-97 and females 3.3 years longer. Current life expectancy in Liverpool stands at 76.1 years for males and 80.2 years for females. This compares to national levels of 79.2 and 83.0 respectively.

The charts also show the trend in life expectancy within the most deprived and least deprived areas of the city, and it is apparent that the overall increase for Liverpool as a whole masks wide variation. Men born in the least deprived areas of Liverpool are expected to live 9.9 years longer than their counterparts in the most deprived areas. Encouragingly, this gap does appear to be narrowing, down from 10.7 years in 2002-04.

In contrast, the life expectancy gap for females in Liverpool is widening, from 7.7 years in 2002-04 to 9.1 years in 2010-12. This has been driven by a levelling off in life expectancy among women in the most deprived communities in the city in recent years.



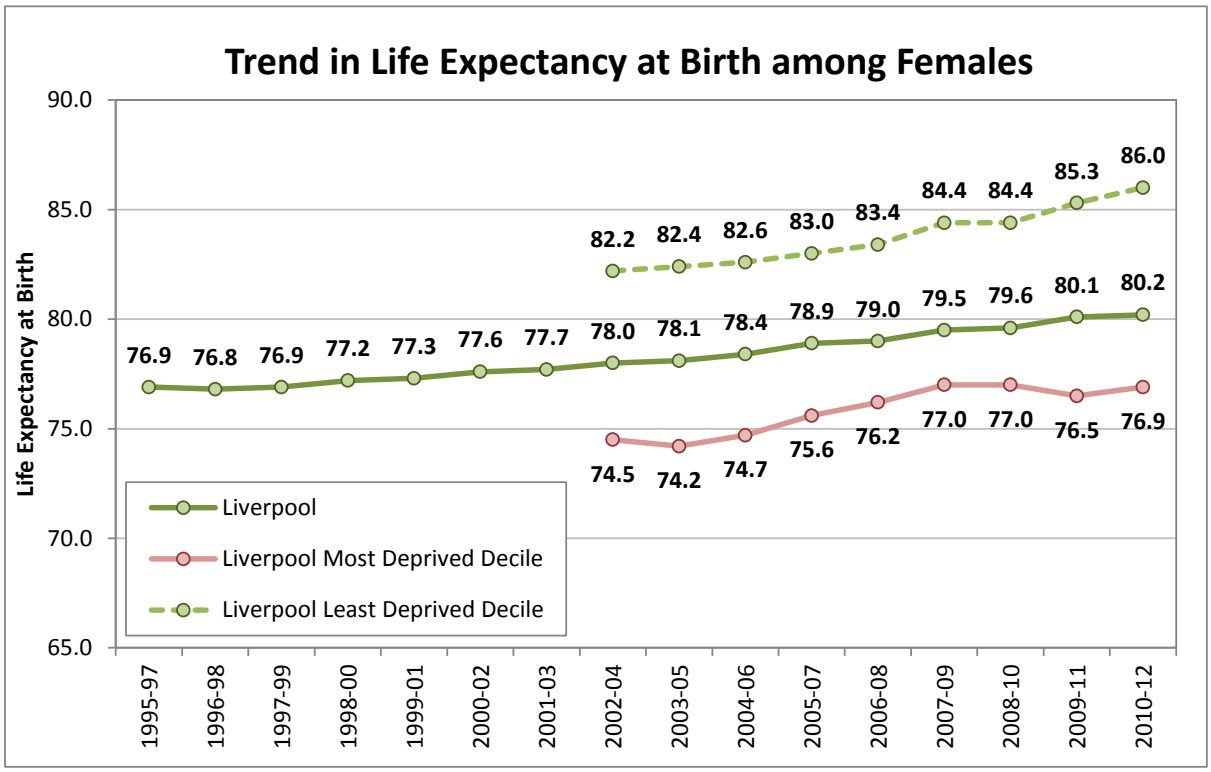


Chart 3: Life expectancy trends, 1995/97 to 2010/12 (Source: Office for National Statistics, Public Health England)

5.1.1 Causes of the Life Expectancy Gap

There is a significant gap in life expectancy between Liverpool and England, with males in the city living 3.1 years less and females living 2.8 years less. Through monitoring different causes of death it is possible to identify which conditions are driving this gap, enabling commissioners and policy

makers to target those areas where the greatest impact can be made.

The chart below shows the main causes of the gap in life expectancy in Liverpool for 2009-11, broken down by sex. For both males and females, cancer accounts for the majority of the gap with an estimated 585 excess deaths among men and 418 excess deaths among women. Lung cancer accounts for the bulk of these.

Circulatory diseases, such as heart disease and stroke, are the second major cause of the life expectancy gap among males in Liverpool. However, among females, respiratory diseases such as COPD play a much larger role, accounting for 20% of the life expectancy gap, compared to 14% among men[15].

"Other" causes of the gap include infections and mental & behavioural disorders, amongst other conditions. Together this group accounts for 472 excess deaths in the city, compared to England. The <28 days category relates to babies who died within this timeframe.

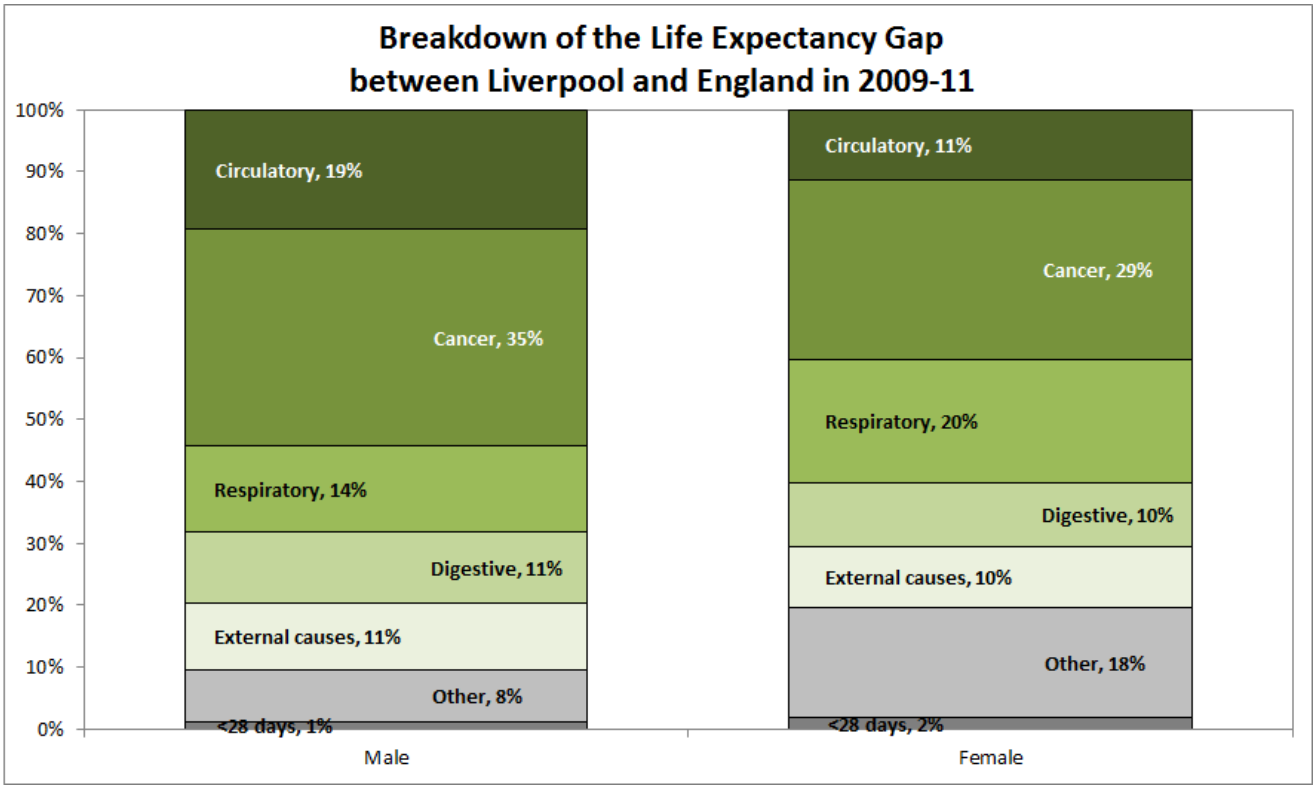


Chart 4: Life expectancy gap between Liverpool and England (Source: Public Health England-Life Expectancy Segmentation Tool)

5.1.2 Healthy Life Expectancy

Healthy life expectancy (HLE) is calculated by combining morbidity and mortality data to produce estimates of the span of life that a person can expect to live in very good or good health

For 2010-12, Liverpool males aged 65 years can expect to live another 16.6 years on average with a HLE of 6.3 years compared with 9.2 years nationally.

Liverpool females can expect to live another 19.2 years on average with a HLE of 6.9 years compared with 9.7 years nationally.

5.2 General Health

The 2011 Census asked people to describe their general health. In Liverpool, one in four residents aged over 65 years described their health as “bad or very bad”, compared with fewer than 1 in 10 for all residents.

There was a strong correlation between older people describing their general health as bad or very bad and deprivation. More than a third of older people living in Riverside, Kirkdale, and Everton wards described their health in this way, compared with around one in eight residents of the most affluent Church ward.

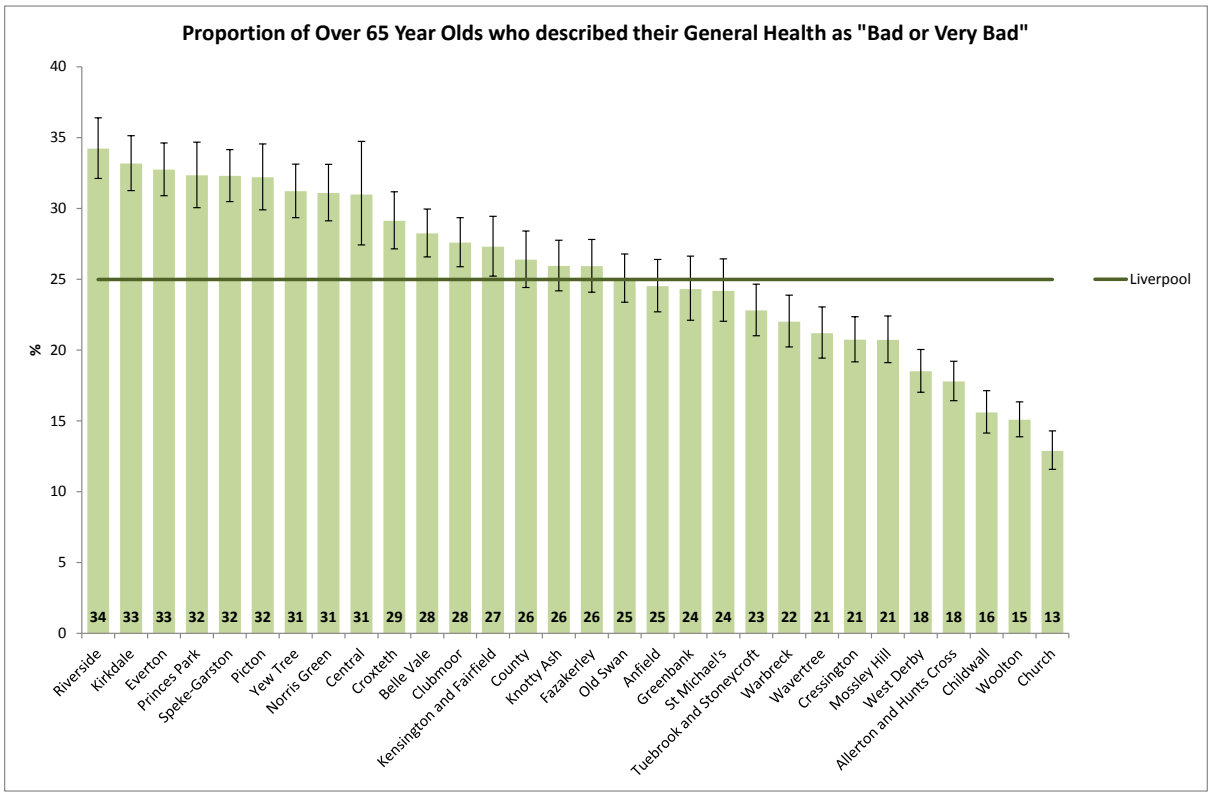


Chart 5: General health described as bad or very bad (Source: 2011 Census)

5.3 Underlying Cause of Death by ICD-10 Chapter

In 2013, there were 3,496 Liverpool resident older person deaths, which represented a 15% reduction from the 4,103 registered in 2003. The number of deaths registered with a Liverpool GP was 3,453.

Cancer was the underlying cause for almost 3 out of 10 older person deaths in the city, whilst circulatory disease caused one in four deaths. Some 7 out of 10 people aged over 65 years died as a result of cancer, circulatory, or respiratory disease.

Between 2003 and 2013 there was a 42% reduction in the number of older person circulatory

disease deaths. In 2003 circulatory disease accounted for 36% of all deaths, but by 2013 they represented 24% of all deaths. The number of deaths caused by mental and behavioural disorders, which in older people is predominantly dementia, has more than doubled and in 2013 accounted for 9% of deaths compared with 3% in 2003.

ICD-10 Chapter	2013		2003	
	Number of Deaths	% of All Deaths	Number of Deaths	% of All Deaths
Cancer	998	28.5	1,058	25.8
Circulatory disease	844	24.1	1,466	35.7
Respiratory disease	614	17.6	719	17.5
Mental and behavioural	321	9.2	116	2.8
Symptoms not elsewhere classified	150	4.3	165	4.0
Diseases of the digestive system	138	3.9	166	4.0
Diseases of the nervous system	120	3.4	112	2.7
External causes	90	2.6	74	1.8
Genitourinary system	72	2.1	52	1.3
Endocrine disease	44	1.3	62	1.5
Other	105	3.0	113	2.8
Total	**3,496**	**100.0**	**4,103**	**100.0**

Table 2: Number of over 65 years deaths by ICD-10 chapter (Source: ONS Vital Statistics Table 3)

Chart 6 compares the breakdown of deaths by ICD-10 chapter for Liverpool and England. The proportions are fairly similar, although nationally a higher proportion of older person deaths were caused by circulatory disease (29% compared with 24% for Liverpool).

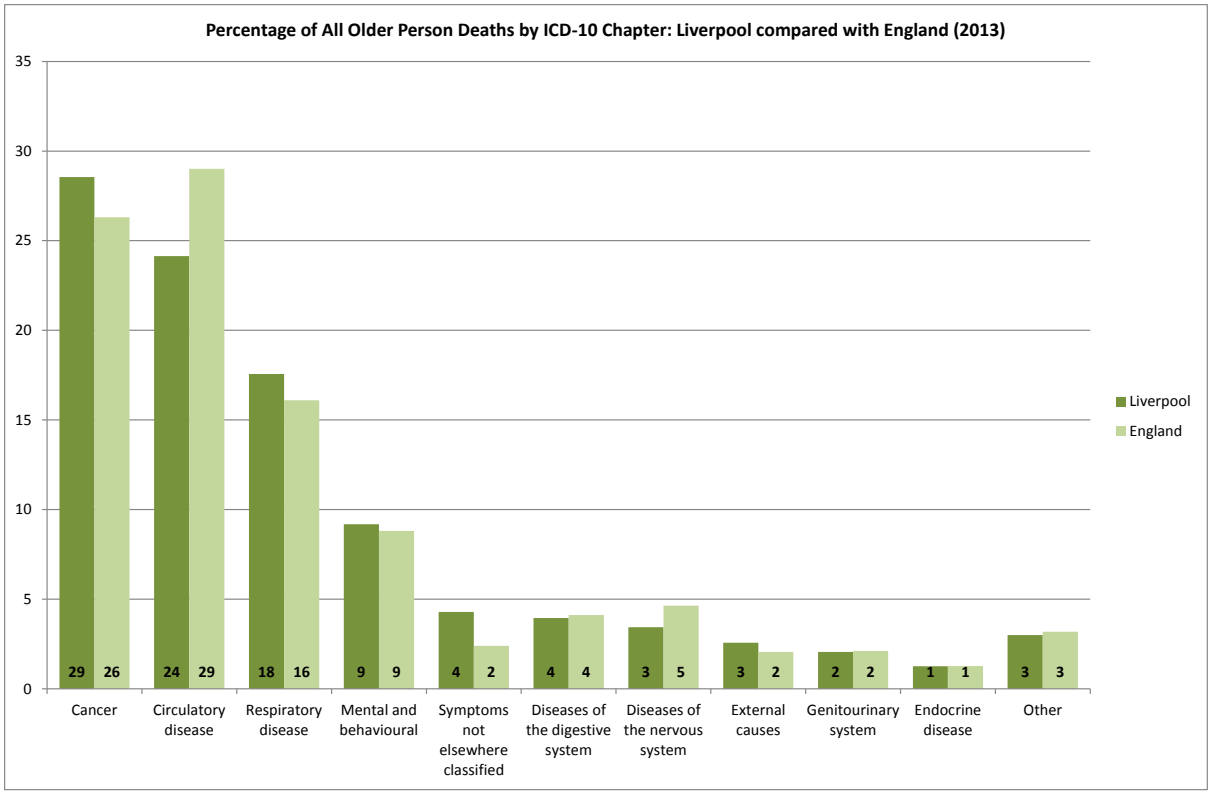


Chart 6: Percentage of all deaths by ICD-10 chapter

5.3.1 Ten Most Common Causes of Death by ICD-10 Sub-Chapter

Table 3 lists the ten most common deaths in over 65 year old Liverpool residents by ICD-10 sub-chapter. The most noticeable change is that in 2003 dementia was the ninth most common cause of death, but in 2013 it was the second most common. Whilst Ischaemic heart disease remains the leading cause of death among the elderly, the number of cases has fallen by more than half over the decade.

ICD-10 Sub-Chapter	2013 Deaths
Ischaemic heart diseases	373
Vascular and unspecified dementia	316
Lung cancer	305
COPD	292
Digestive cancer	284
Cerebrovascular diseases e.g. stroke	239
Pneumonia	204
Other heart diseases	154
Senility without mention of psychosis	145
Prostate cancer	57

ICD-10 Sub-Chapter	2003 Deaths
Ischaemic heart diseases	764
Cerebrovascular diseases e.g. stroke	399
Lung cancer	328
Pneumonia	320
Digestive cancer	300
COPD	279
Other heart diseases	173
Senility without mention of psychosis	163
Vascular and unspecified dementia	114
Colon cancer	69

Table 3: Ten most common causes of death (Source: ONS Vital Statistics Table 3)

5.4 Liverpool Resident Mortality Rates

In 2013 the European Standard Population which is used in the calculation of age standardised mortality rates was changed for the first time since 1976. This change allocated a greater weight to the older population to better reflect the ageing population across Europe. The effect of this has been to increase mortality rates for conditions commonly associated with older ages.

Chart 7 shows the directly age standardised mortality rate for those aged over 65. Although the mortality rate for Liverpool has been decreasing steadily for a number of years there is a significant difference between the mortality rates of Liverpool, the North West, and England. Chart 8 shows a similar difference for cancer related mortality, however the gap for circulatory disease mortality is significantly less.

Chart 10 shows a levelling off of the previous reductions in mortality related to respiratory diseases. This levelling off has also been seen in England and the North West, however the Liverpool rate is still significantly higher, highlighting a particular challenge for the wider public health system.

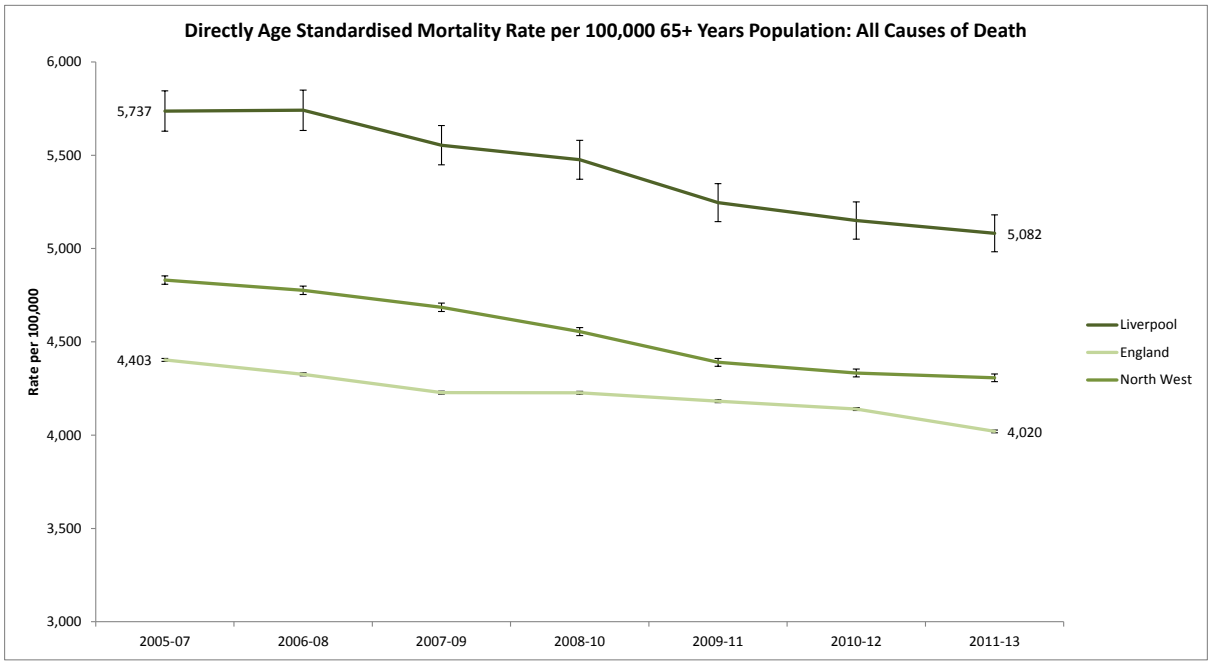


Chart 7: All causes of death mortality rate trend

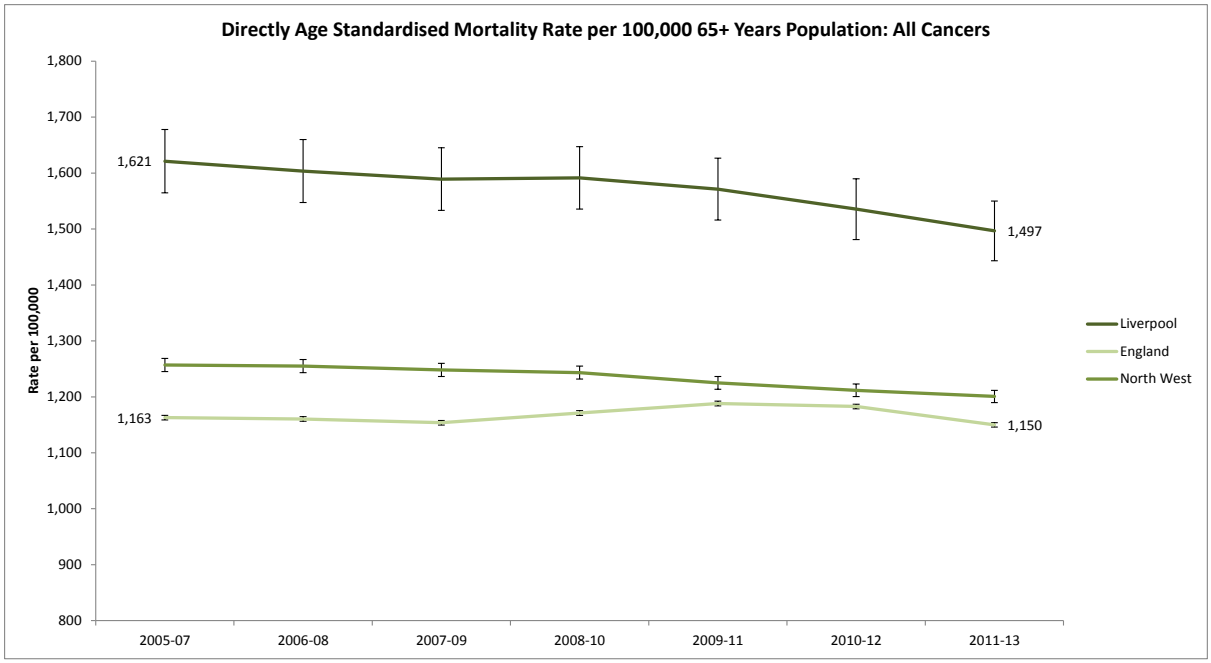


Chart 8: All cancers mortality rate trend

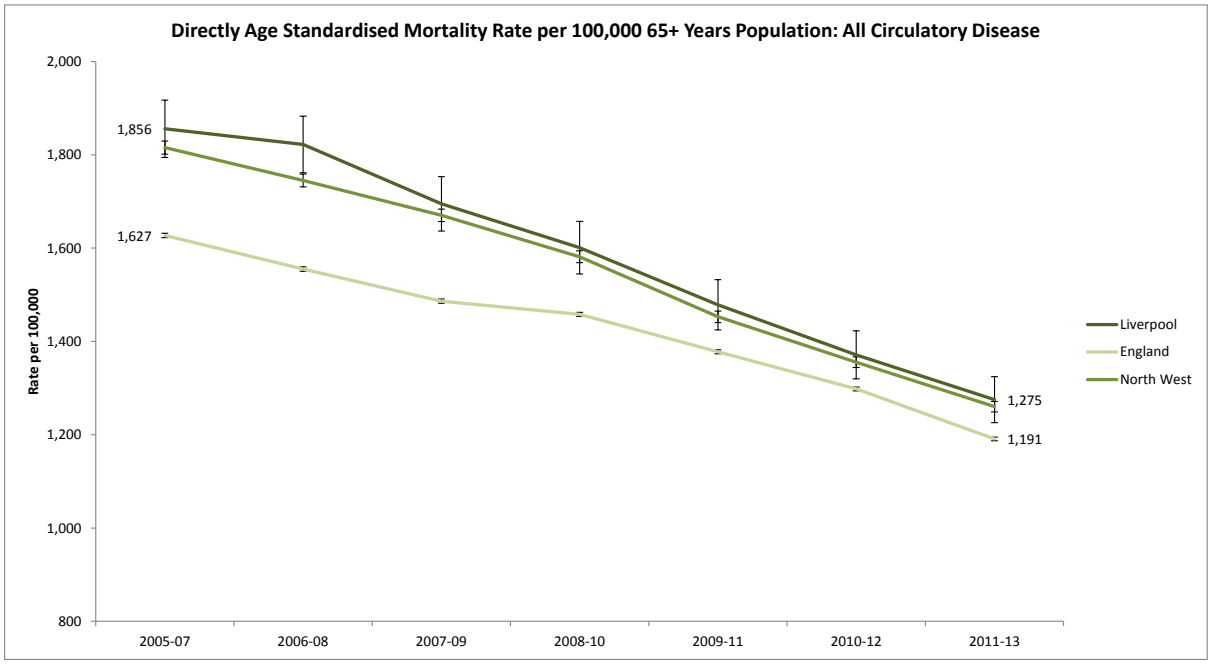


Chart 9: All circulatory disease mortality rate trend

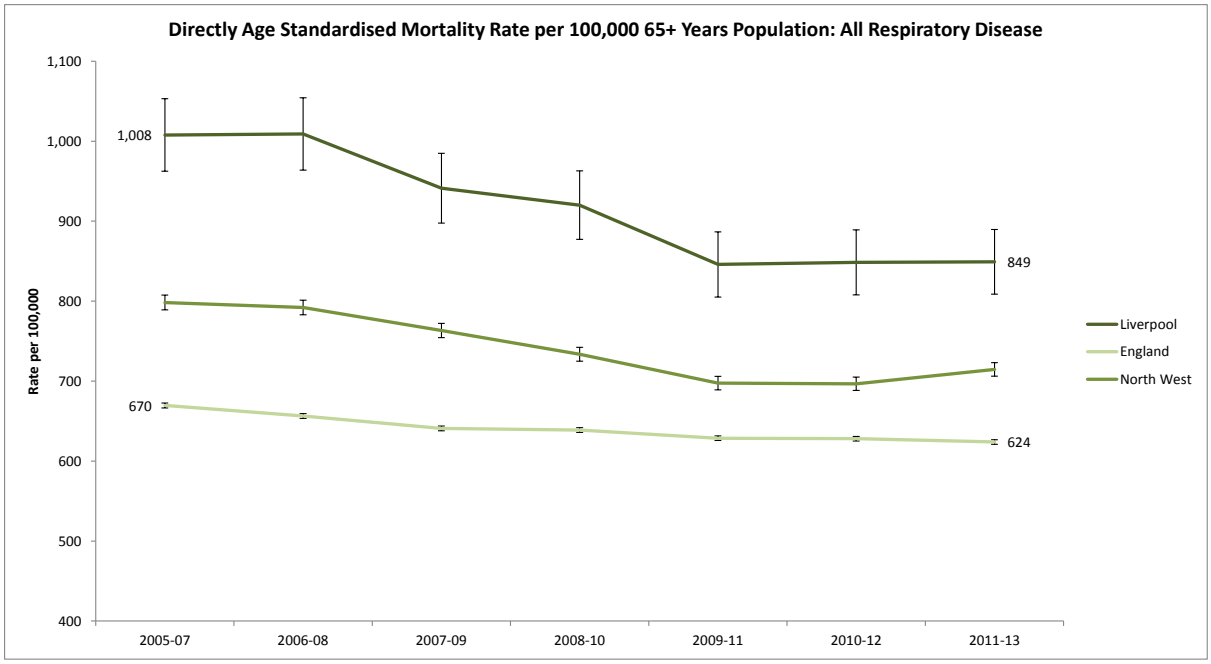


Chart 10: All respiratory disease mortality rate trend

5.5 Excess Winter Deaths

Excess Winter Deaths (EWD) is a measure used to monitor the extent to which mortality levels during the winter period exceed those in the rest of the year, and are calculated by comparing the number of deaths in winter with the non-winter period.

Between 2008/09 and 2011/12 there was a year-on-year decrease in the number of EWD in the city, although in 2012/13 the number more than doubled. However provisional figures for 2013/14 suggest that EWD in Liverpool are now at their lowest number ever recorded. There is a high correlation between low monthly temperatures and a high number of deaths (Pearson co-efficient r=0.77), and the relatively mild winter in 2013/14 (mean winter temperature of 44.5 degrees Fahrenheit) may partly explain the low number of EWD.

Older people are generally more likely to die during the winter period than younger people (although infants are also at a higher risk). Age UK have reported that older people are vulnerable because they are likely to have an existing health problem, are less able to judge if they are warm or cold, are more likely to live in older houses with inefficient heating systems, and are more likely to try to cut their energy bills and spend less money on food. The 2013/14 data suggests that there were no EWD in the under 65's age-group, 8% more EWD in the 65-84 age-group, and 17% more deaths in the 85+ years age-group. For 2013/14, of the main disease types, mental and behavioural disorders (predominantly dementia) had the highest number of EWD with 51 deaths, which was 61% higher than in the non-winter months.

5.6 GP Specific Mortality Rates

Over 65 years directly age standardised mortality rates for the main causes of death have been calculated for Liverpool CCG's GP practices and neighbourhoods.

5.6.1 All Causes of Death

The over 65 years all causes of death mortality rate at the GP practice level ranged from 2,566 deaths per 100,000 European standard population to 12,113 deaths per 100,000. In other words, one practice has an older person mortality rate almost five times that of another practice.

Of the GP Neighbourhoods, Croxteth had the highest standardised mortality rate with 7,176 deaths per 100,000 over 65 years population, which was double that of Wavertree that had the lowest rate. The neighbourhoods of Croxteth, Everton, City Centre/Vauxhall, Riverside, and Picton had rates that were statistically significantly higher than the Liverpool rate.

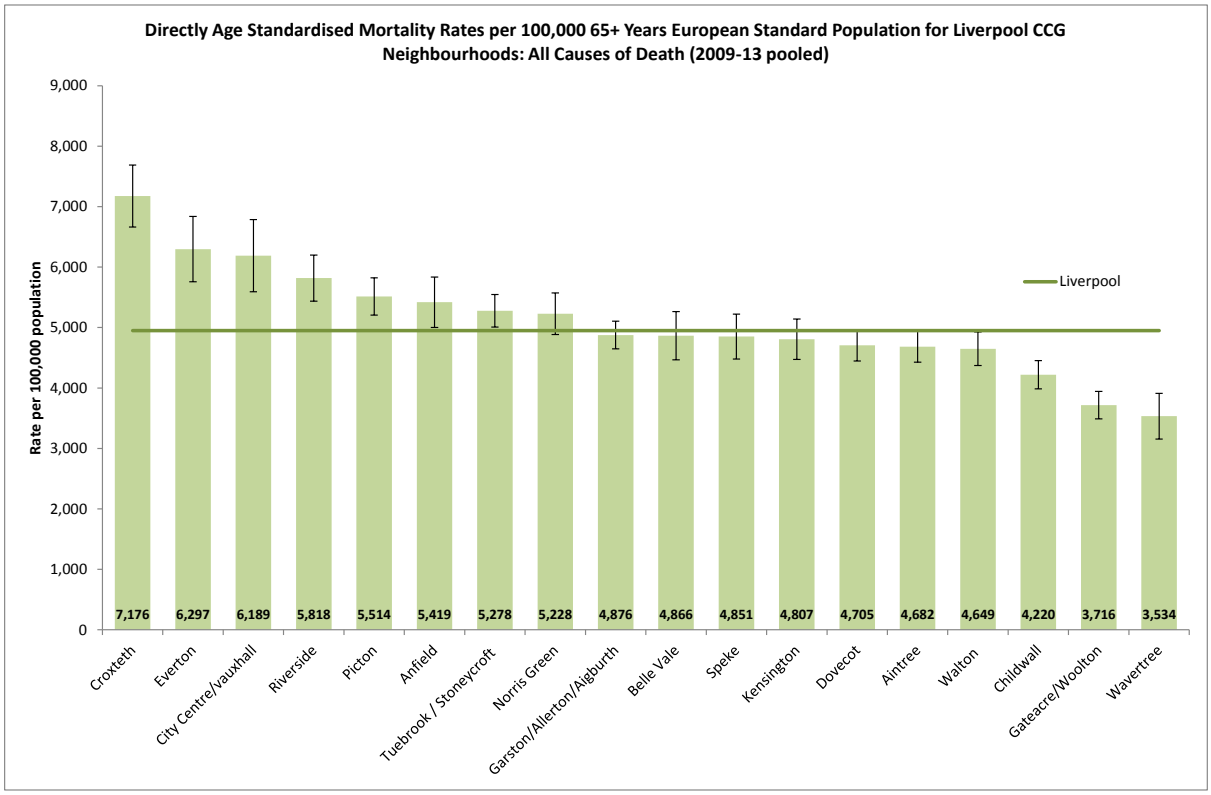


Chart 11: GP neighbourhood mortality rates, all causes of death (Source: Open Exeter Primary Care Mortality Database)

5.6.2 All Cancers

The over 65 all cancers mortality rate at the GP practice level ranged from 909 deaths per 100,000 European standard population to 2,405 deaths per 100,000.

Of the GP Neighbourhoods, City Centre/Vauxhall had the highest standardised mortality rate with 1,849 deaths per 100,000 over 65 years population, which was 70% higher than that of Wavertree that had the lowest rate. The neighbourhoods of City Centre/Vauxhall, Everton, and Anfield had rates that were statistically significantly higher than the Liverpool rate.

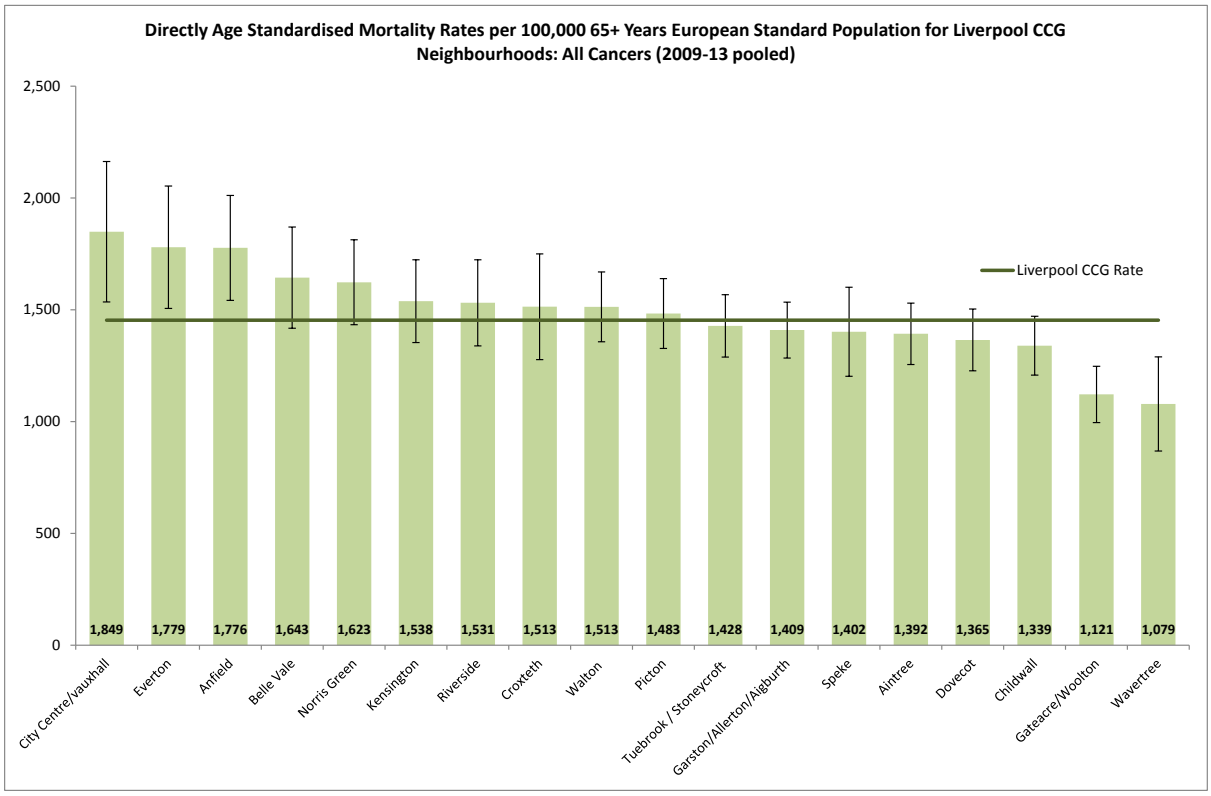


Chart 12: GP neighbourhood mortality rates, all cancers (Source: Open Exeter Primary Care Mortality Database)

5.6.3 All Circulatory Diseases

The over 65 years all circulatory disease mortality rate at the GP practice level ranged from 581 deaths per 100,000 European standard population to 3,026 deaths per 100,000.

Of the GP Neighbourhoods, Croxteth had the highest standardised mortality rate with 1,934 deaths per 100,000 over 65 years population, which was more than double that of Wavertree that had the lowest rate. Only Croxteth had a circulatory disease mortality rate that was statistically significantly higher than the Liverpool CCG rate. Childwall and Wavertree neighbourhoods had rates statistically significantly lower than the Liverpool rate.

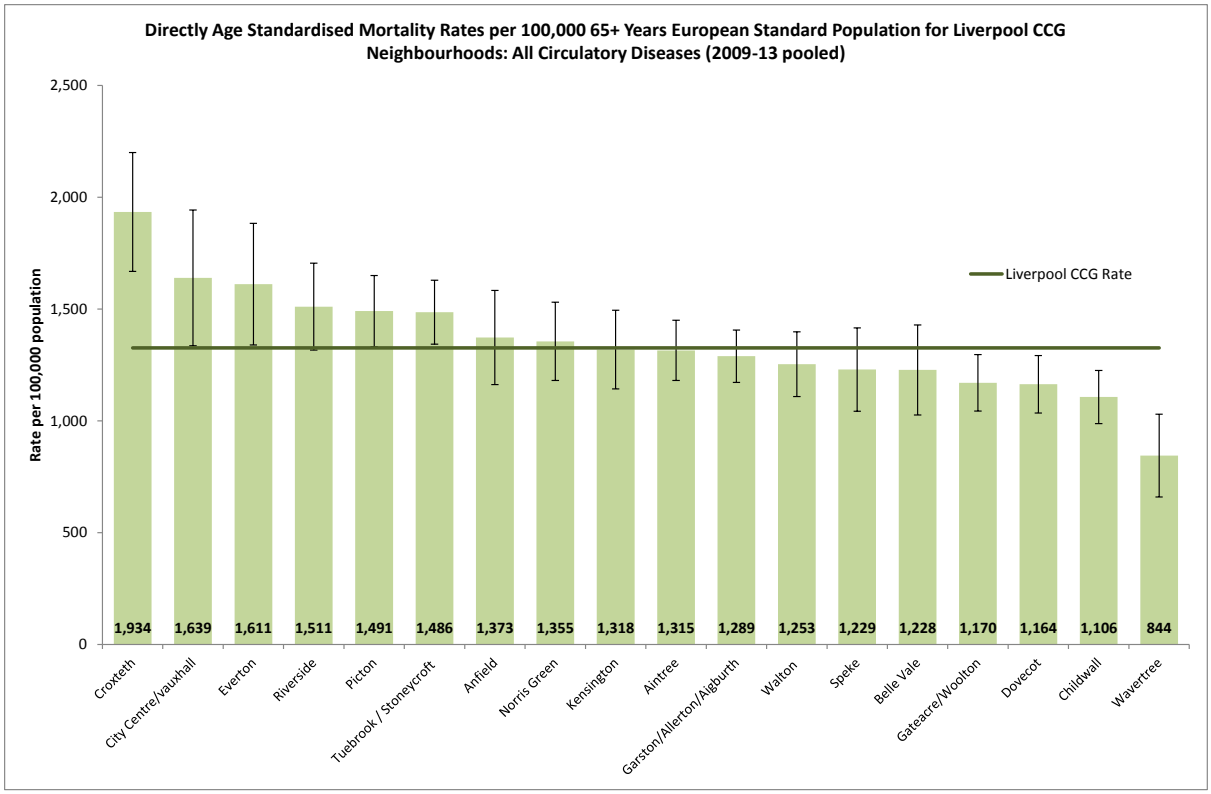


Chart 13: GP neighbourhood mortality rates, all circulatory diseases (Source: Open Exeter Primary Care Mortality Database)

5.6.4 All Respiratory Diseases

The over 65 years all respiratory disease mortality rate at the GP practice level ranged from 515 deaths per 100,000 European standard population to 1,275 deaths per 100,000.

Of the GP Neighbourhoods, Everton had the highest standardised mortality rate with 1,275 deaths per 100,000 over 65 years population, which was almost two and a half times that of Wavertree that had the lowest rate. Only Everton and Riverside had a respiratory disease mortality rate that was statistically significantly higher than the Liverpool CCG rate. Wavertree, Gateacre/Woolton, Garston/Allerton/Aigburth, and Childwall neighbourhoods had rates statistically significantly lower than the Liverpool rate.

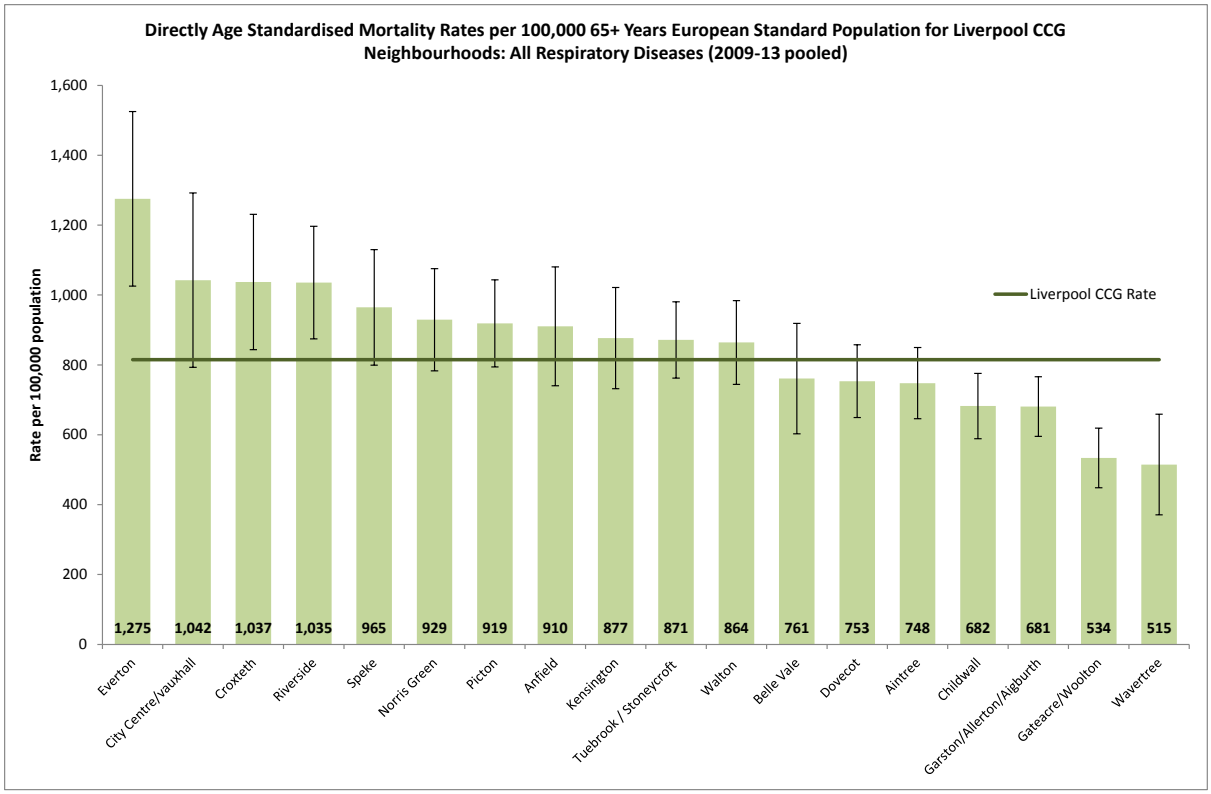


Chart 14: GP neighbourhood mortality rates, all respiratory diseases (Source: Open Exeter Primary Care Mortality Database)

The above mortality patterns show that certain neighbourhoods (particularly Everton, City Centre/Vauxhall, Croxteth) have high rates across all the main conditions, suggesting that the issues facing these areas are multi-faceted and not due to any single factor.

5.7 Disease Prevalence

5.7.1 Liverpool CCG Patients (2014)

In February 2014, more than half of all Liverpool CCG responsible patients aged 65+ years were on a disease register for hypertension. One in five patients were on the coronary heart disease register, one in six were on the diabetes register, and one in seven were on the depression register.

	Total Population	Over 65 Years	
	%	%	Number
Asthma	5.5	7.3	5,338
Cancer	2.5	10.6	7,751
COPD	2.8	13	9,505
CHD	3.6	18.2	13,307
Dementia	0.6	3.7	2,705
Depression	11.3	13.9	10,163
Diabetes	4.7	16.8	12,284
Epilepsy	0.8	1.2	877
Heart Failure	0.8	4.3	3,144
Hypertension	13.1	53.4	39,045

Table 4: Disease prevalence (Source: Liverpool CCG)

5.7.2 Comorbidities

The increasing prevalence of co-morbidities (people living with 2 or more long term conditions) is one of the major challenges facing the health and care system. People with multiple long term conditions require more complex care and support packages, and often face poorer health outcomes. Nationally, the overall prevalence of long term conditions is projected to remain relatively stable over the next 10 years, however the prevalence of comorbidities is expected to increase by more than 50%[14]. This increase in comorbidity is a significant driver for shifting the provision of care to a person centred approach which looks at the individual in a holistic way rather than on a condition by condition basis.

Chart 16 shows the percentage of people in Liverpool with two or more long term conditions by age and deprivation in September 2014. As expected, the prevalence of comorbidity increases with age, peaking at just over 70% for those aged between 85 and 89. However, there is a clear distinction between the most deprived and least deprived areas of the city, with the prevalence increasing at an earlier and faster rate among the most deprived communities. For the older population, the difference in co-morbidity between the most and least deprived communities becomes statistically significant.

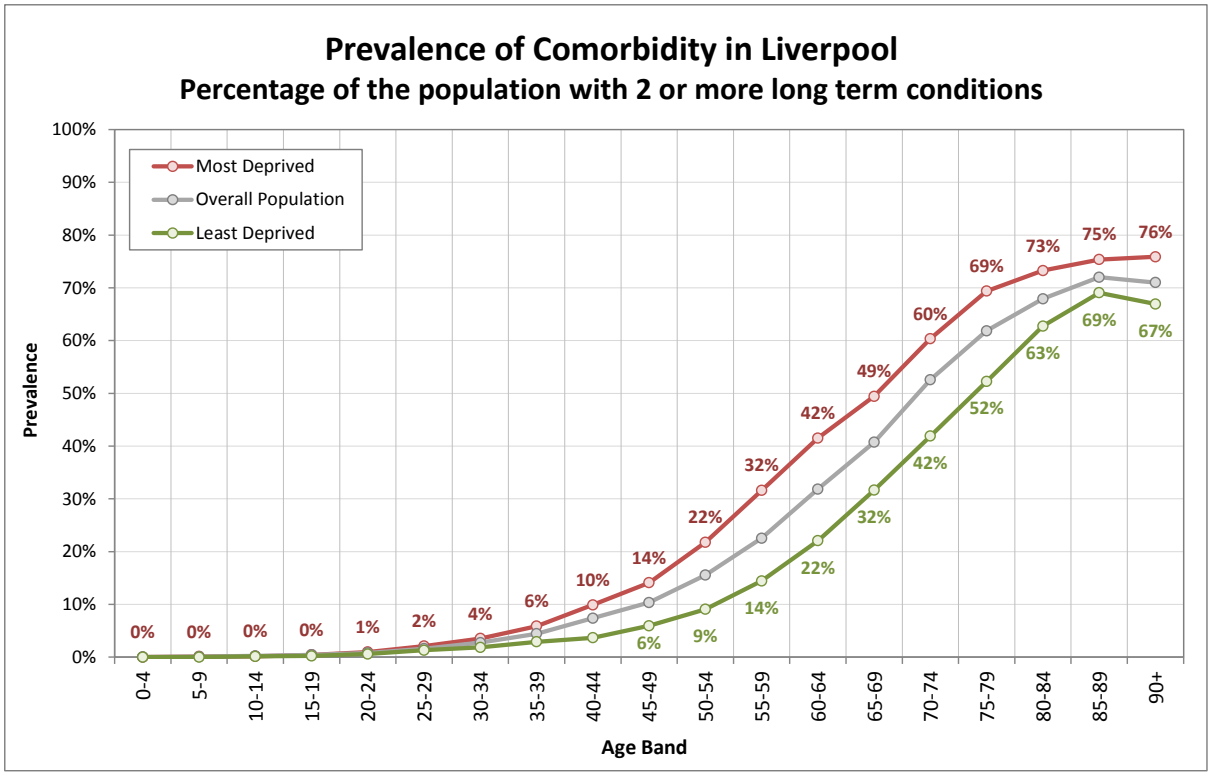


Chart 15: Prevalence of comorbidity in Liverpool in 2014 (Source: Liverpool CCG)

5.8 Projected Prevalence Trends

The Projecting Older People Population Information System (POPPI) has produced projected prevalence trends for a variety of disease types and health issues. Over the next 10 years the number of older people with the following is projected to increase by:

	Number of Older People		Increase	
	2014	2025	Liverpool (%)	England (%)
Limiting Long Term Illness	25,957	31,005	19.4	29.8
Depression	5,966	7,014	17.6	23.4
Severe Depression	1,892	2,254	19.1	27.3
Dementia	4,695	5,744	22.3	37.8
Long standing condition caused by Heart Attack	3,376	4,002	18.5	25.5
Long standing condition caused by Stroke	1,590	1,905	19.8	27.7
Long standing condition caused by Bronchitis and Emphysema	1,161	1,382	19.0	24.7
Bladder problem at least once a week	11,236	13,386	19.1	27.0
Diabetes	8,583	10,187	18.7	23.6

Table 5: Projected prevalence trends (Source: POPPI)

5.9 Visual Impairment

Good vision care impacts on other aspects of health such as the ability of patients to manage other chronic conditions and the avoidance of injurious falls. People with visual impairment are more likely to require residential and community care and additional support through adaptations of their environment.

In Liverpool 2,510 people were registered either blind or partially sighted in 2013-14, however estimates by the RNIB indicate that over 11,800 people in the city are believed to live with some degree of sight loss. This suggests that only around a 1 in 5 cases are registered. The prevalence of sight loss increases with age, with more than half of people registered blind in Liverpool aged over 75. With this being the case, many people also live with additional health needs. More than half (56%) of people in Liverpool who are registered blind have additional disabilities, with the most common need identified being physical disability (1 in 5 people). As the number of older people in the city increases further, projections indicate there will be a corresponding increase in the number of people who are visually impaired. The NHS offers free eye tests to anyone aged over 60 years.

Condition	Description	Prevalence
Age-Related Macular Degeneration (AMD)	Age-related macular degeneration is a condition commonly affecting people over the age of 50 and is the leading cause of blindness in people over the age of 65. **Wet AMD** can develop quickly affecting central vision in a short period of time. Early identification and treatment of wet AMD is vital. Treatment can halt the further development of scarring but lost sight cannot be restored. **Dry AMD** can develop slowly and take a long time to progress to its final stage. There is currently no treatment for dry AMD.	**3,810 people**
Wet AMD		**2,590 people**
Dry AMD		**1,210 people**
Cataracts	This is a common eye condition that is prevalent in older people. The lens becomes less transparent and turns misty or cloudy. Cataracts over time can get worse and impact upon vision. A straightforward operation replaces the lens with an artificial one.	**3,900 people**
Glaucoma	This is a group of eye conditions in which the optic nerve is damaged due to changes in eye pressure. Damage to sight can usually be minimized by early diagnosis in conjunction with careful regular observation and treatment. Many glaucoma patients will attend regular appointments and take eye drops for the rest of their lives to prevent deterioration of vision. Some forms of glaucoma can be treated with laser surgery.	**3,760 people**
Diabetic Retinopathy	This is a complication of diabetes and is the leading cause of blindness in the working population in the developed world. Diabetic retinopathy, if left untreated, can lead to sight loss which can have a devastating effect on the individual and their families. By promptly identifying and treating the disease, these effects can be reduced or avoided completely.	**2.7 per 100,000** **2 patients**

People with sight loss		**11,810 people**

Table 6: Estimated prevalence of sight threatening conditions in Liverpool

5.10 Hearing Impairment

Deafness, and hearing loss in general can be very disabling. Hearing loss and deafness can lead to barriers to inclusion and feelings of isolation. As the prevalence of hearing loss increases with age, many people also live with additional long term conditions, and managing hearing loss is an important factor in effectively managing these conditions. With the projected growth in the number of elderly people in the city, this will become increasingly important.

There are different levels of hearing loss and deafness:

- **Moderate deafness**: People with moderate deafness have difficulty in following speech without a hearing aid. The quietest sounds they can hear in their better ear average between 35 and 49 decibels.

- **Severe deafness**: People with severe deafness rely a lot on lip-reading, even with a hearing aid. British Sign Language (BSL) may be their first or preferred language. The quietest sounds they can hear in their better ear average between 50 and 94 decibels.

- **Profound deafness**: People who are profoundly deaf communicate by lip-reading. BSL may be their first or preferred language. The quietest sounds they can hear in their better ear average 95 decibels or more.

The World Health Organisation predict that by 2030 adult onset hearing loss will be in the top ten disease burdens in the UK, above diabetes and cataracts[16]. The table below illustrates the estimated prevalence of hearing loss in Liverpool. Current estimates suggest that there are around 40,320 adults in the city with some form of hearing loss, the equivalent of around 1 in 10 people. The majority of these are elderly, with 55% of those with moderate or severe hearing loss and 62% of those with profound hearing loss aged over 75. Projections indicate the number of people with some form of hearing loss in the city will increase by almost 10,000 by 2030, driven by the increasing number of elderly people.

Age	Moderate or Severe Hearing Loss	Profound Hearing Impairment
18-24	109	-
25-34	343	-
35-44	807	-
45-54	3,414	28
55-64	5,767	63
65-74	7,016	224
75-84	14,995	152
85+	7,045	357
Total	**39,496**	**824**

Table 7: Estimated numbers of people living with hearing loss or impairment, 2013 (Source: Projecting Adult Needs & Service Information)

5.11 Autistic Spectrum Disorders

Autistic spectrum disorder (ASD) is a condition that affects social interaction, communication, interest and behaviour, and includes autism, Asperger syndrome and pervasive developmental disorders. The prevalence of ASD has been estimated at 1% of the adult population in England (Men=1.8%, Women=0.2%), which if applied to Liverpool's older population would mean that approximately 600 of our older residents are living with ASD and this is expected to rise to 850 by 2030 (POPPI, 2014).

The Autism Act (2009) was the first condition-specific legislation of its type in the country, illustrating the importance that central government places on ASD. Recently published 'Statutory guidance for Local Authorities and NHS organisations to support implementation of the Adult Autism Strategy' (2015) emphasised the need for partners to identify people with ASD and provide the right support.

5.12 Dental Health

In 2012/13, Public Health England carried out a survey that sought to find out the oral health policies, practices, and problems of three different services for older people in the North West.

Some of the main findings showed:

- Access to treatment services was an issue with people having problems travelling to and climbing stairs to dental surgeries.
- Difficulties in obtaining domiciliary care and emergency care were mentioned as a widespread concern.
- There was a clear demand for training by professionals and provision of leaflets and guidance.

In 2014/15 the Centre for Public Health at Liverpool John Moore's University conducted a telephone survey of older people across Cheshire and Merseyside, and found that, of all the local authorities in the patch, Liverpool had the lowest proportion of respondents who attended a dentist (67%).

6 SCREENING AND IMMUNISATIONS

6.1 Introduction

There are numerous health tests that are offered by the NHS to older people including screening for cancers, diabetes, aortic aneurysms, cholesterol, anaemia, thyroid, respiratory system, bone disease, kidney disease, glaucoma, as well as a general health check.

6.2 Cancer Screening

There are three cancer screening programmes delivered by the NHS; bowel, breast, and cervical. They are coordinated by the national office of the NHS Cancer Screening Programmes which is part of Public Health England.

Screening for bowel cancer (the third most common cancer in the UK) reduces deaths in the screened population by 16%[17]. Screening can also detect polyps which may develop into cancers over time. These can be easily removed, reducing the risk of bowel cancer developing. Screening is offered to men and women aged 60-75 years in the form of a faecal occult blood testing kit in the post. After this age bowel cancer screening can be requested, but people aren't invited automatically[17].

Almost a third of breast cancers are detected through screening which is offered to all women aged 47-73 years. The screening involves a mammogram of each breast which can detect small changes in breast tissue and may indicate cancers which are too small to be felt by hand[17].

Locally NHS England is responsible for administering the screening programmes.

6.2.1 Bowel Cancer Screening

In 2013/14, only 45% of Liverpool's 60-74 year olds who were sent the bowel screening kit adequately completed it, which was significantly below the national target of 60%. This was a reduction from the 48% that completed the screening in 2012/13.

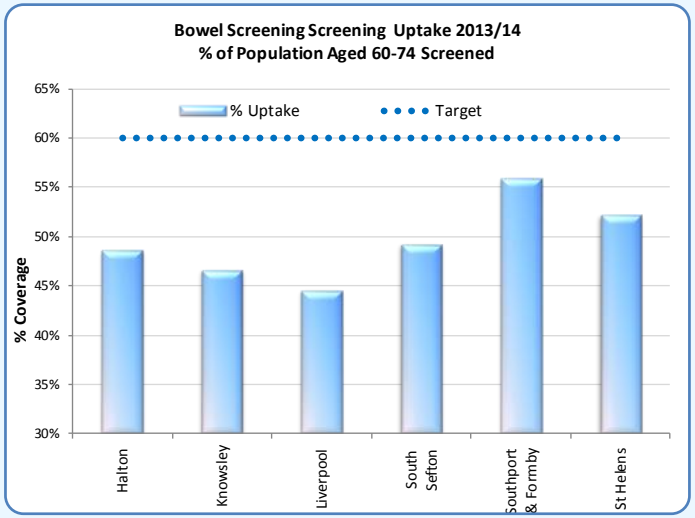
There was a wide degree of variance at the GP practice level ranging from 29% to 63%. There was also a strong relationship between uptake rates and deprivation with the most deprived parts of the city with poorest health outcomes having the lowest screening rates.

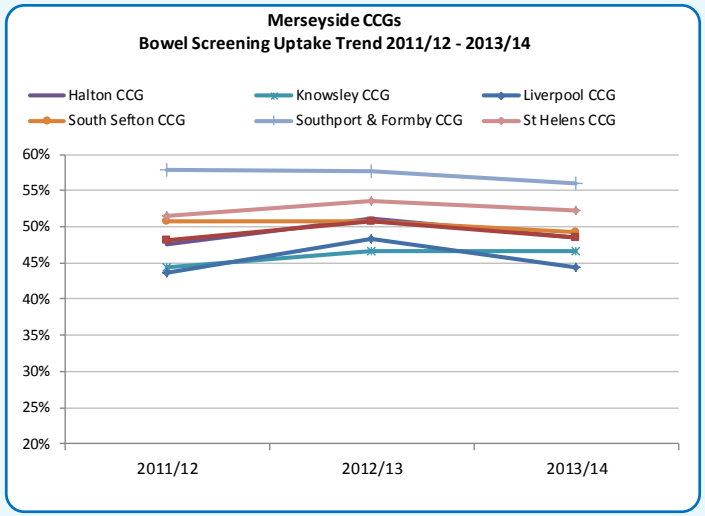
Approximately 300 patients per annum are identified as having a definitive abnormal test result, suggesting that bowel cancer screening can be an effective tool for preventing and/or detecting early symptoms of cancer.

6.2.2 Breast Cancer Screening

In 2012/13, Liverpool had a breast screening uptake rate of 71.6% which was above the national target of 70%. However there was a degree of variance at the GP practice level ranging from 54% to 83%.

NHS Merseyside Bowel Screening Uptake 2013/14





CCG Name	% Of Population Aged 60-74 Screened 2013/14							Uptake Range Across GP Practices	
	2013/14								
	Number Invited	Adequately Screened	% Uptake	No. Required to Meet 60% target	% Positivity	2012/13	2013/14 variance from 2012/13	Lowest % Uptake	Highest % Uptake
Halton	10119	4916	48.6%	1155	1.9%	51.2%	-2.6%	37.2%	55.6%
Knowsley	11398	5305	46.5%	1533	1.9%	46.6%	-0.01%	34.4%	56.2%
Liverpool	33285	14805	44.5%	5166	2.0%	48.2%	-3.8%	28.8%	62.9%
South Sefton	11132	5477	49.2%	1202	1.6%	50.7%	-1.5%	29.8%	61.1%
Southport & Formby	10634	5948	55.9%	432	1.1%	57.6%	-1.7%	36.5%	64.6%
St Helens	16417	8574	52.2%	1276	1.5%	53.6%	-1.3%	26.5%	64.1%
Merseyside	92985	45025	48.4%	10766	1.7%	50.8%	-2.3%	26.5%	64.6%

Source: OBIEE Dashboard

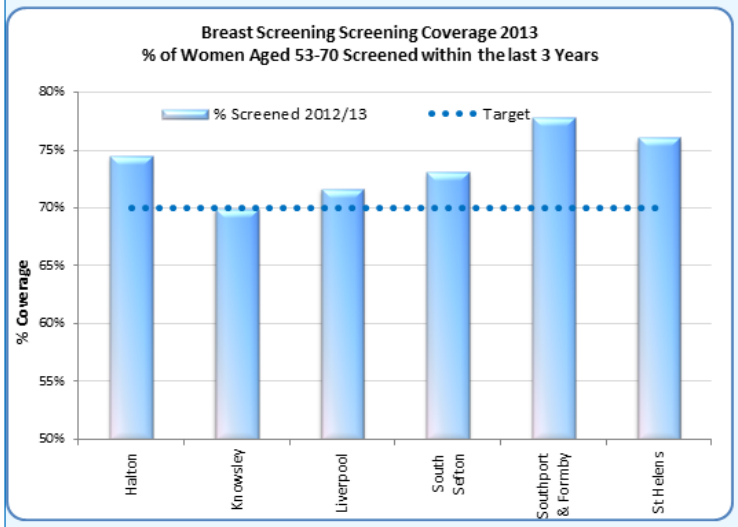
Compiled by the NHS Merseyside Screening & Immunisation Team

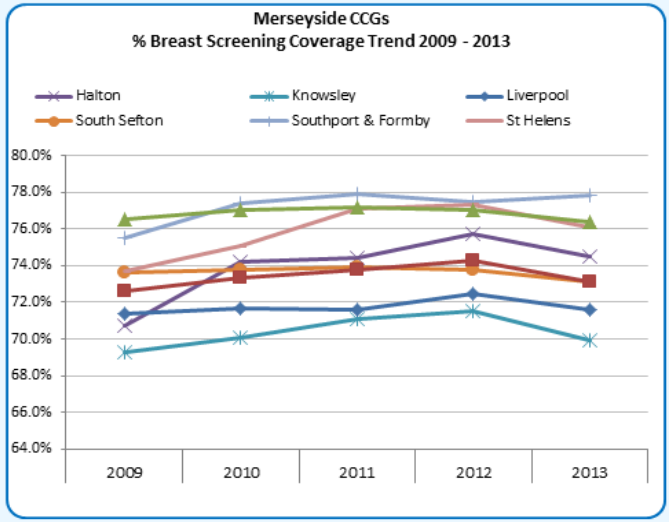
Narrative

- About half of those invited, take up the test using the postal kit sent from Rugby
- Southport and Formby, then St Helens, have the best uptake in Merseyside
- Uptake is falling year on year in all parts of Merseyside: biggest fall is in Liverpool
- Highest uptake is 64.6% in a Southport & Formby practice, lowest is 26.5% in a St Helens practice

Figure 1: Bowel cancer screening uptake and trends (NHS Merseyside Screening and Immunisation Team

NHS Merseyside Breast Screening Coverage 2012/13





	% Of Women aged 53-70 Screened Within the last 3 Years							Coverage - Range across GP Practices	
	2012/13								
CCG Name	Eligible Females	Ineligible Females	Number Screened	% Screened 2012/13	No. Required to Meet 70% target	2011/12	2012/13 variance from 2011/12	Highest %	Lowest %
Halton	13762	7	10246	74.5%		75.7%	-1.2%	60.0%	80.1%
Knowsley	16020	23	11202	69.9%	12	71.5%	-1.6%	56.5%	80.1%
Liverpool	46428	80	33260	71.6%		72.5%	-0.9%	54.3%	82.8%
South Sefton	16895	28	12343	73.1%		73.8%	-0.7%	58.2%	82.8%
Southport & Formby	15086	29	11737	77.8%		77.5%	0.3%	49.6%	84.5%
St Helens	21616	37	16448	76.1%		77.3%	-1.2%	63.7%	83.3%
Merseyside	129807	204	95236	73.4%	12	74.3%	-0.9%		

Source: KC63

Compiled by the NHS Merseyside Screening & Immunisation Team

Narrative

- About seven out of ten eligible women have been screened in the past three years
- Trendline is fairly flat, with a decline evident over the last year.
- Screening participation has improved in

Figure 2: Breast cancer screening uptake and trends (NHS Merseyside Screening and Immunisation Team

6.3 Vaccination

Influenza and Pneumonia account for the largest proportion of emergency hospital admissions in England each year (13%), at a cost of £286m[18]. Many of these cases could have been prevented by vaccination[18].

6.3.1 Flu Vaccination

Flu vaccination by injection, commonly known as the "flu jab" is available every year on the NHS to all over 65 year olds to protect people from the risk of flu and its complications[19]. Those who are aged over 65 are at a much greater risk from experiencing complications relating to flu, such as pneumonia. This is why flu vaccination is strongly recommended, and available free of charge via their GPs each winter. It takes up to two weeks for a person to develop a full immune response to the vaccine, hence why it is important to get it at the beginning of winter (October/November) before flu levels start to increase[19].

For 2014/15, some 76.5% of older people in Liverpool had the seasonal flu vaccination which was higher than the national target of 75%. However this still leaves a significant proportion of the local at risk population unvaccinated. There is also a wide variation in uptake of the vaccine among General Practices in the city, ranging from 62.6% to 86.3%.

6.3.2 Pneumococcal Vaccination

The Pneumococcal vaccine protects against one of the most serious forms of pneumonia, Streptococcus Pneumoniae[20]. This accounts for approximately 50% of all cases of community acquired pneumonia (the others being viral causes such as Influenza and the Respiratory Syncytial Virus) [20]. Pneumococcal vaccination is believed to be 50-70% effective at preventing virtually all (96%) of the types of pneumococcal bacteria that cause serious disease in the UK[20]. Observational studies also show that vaccination can reduce 50-70% of hospitalisations for invasive pneumococcal disease[21].

The vaccine itself is offered to all those aged over 65, and is only required as a one off vaccination, rather than the annual flu vaccination[20]. Data in Liverpool shows that 70% of the eligible population have been vaccinated, however this is based on reporting from only 69% of practices, therefore it may not be a true indication of uptake. However, it is broadly comparable with the England and Merseyside Area Team coverage levels of 68.9% and 71.7% respectively.

A recent Cochrane review of the efficacy of pneumococcal vaccination suggests that there is strong evidence that the vaccine is effective in preventing invasive pneumococcal disease[22]. It is recommended that a review be carried out locally to look at how increasing uptake may impact on the health of the local population.

7 HOSPITAL ADMISSIONS

In 2001 the Department of Health published its National Service Framework for Older People which outlined the government's aim to prevent unnecessary hospital admissions[23]. The King's Fund analysed peer-reviewed literature providing evidence of what works in avoiding hospital admissions[24]. They found good evidence to support the following interventions:

- Self-management training for patients with ambulatory care sensitive (ACS) conditions
- Senior clinician review in A+E
- Continuity of care with a family doctor
- Healthcare professionals providing treatment at the patient's home. These schemes can deliver similar outcomes to admission at equivalent or lower cost
- Structured discharge planning[24]

7.1 Elective Admissions by Diagnosis Chapter

The Standardised Admission Ratio (SAR) compares actual hospital activity against expected activity. The expected figure is calculated from national average data adjusted for practice size, sex, age, and deprivation. Data highlighted in red in the following tables denotes that the SAR was significantly higher than expected when compared with England, and data in green that the SAR was significantly lower.

In 2013/14 there were 24,291 elective hospital admissions for older people in Liverpool CCG giving a rate of 340 per 1,000 65+ years population. The Standardised Admission Ratio (SAR) was 108 meaning that Liverpool had 8% more elective admissions than expected when compared with England.

The most common elective admissions for Liverpool's older population were neoplasms with 78 admissions per 1,000 population, followed by symptoms relating to the digestive system, and then the eye.

Diagnosis Chapter	Actual Admissions	Actual Rate per 1,000	Expected Admissions	Expected Rate per 1,000	SAR
ALL ELECTIVE ADMISSIONS	24,291	339.9	22,492	314.7	108
Neoplasms	5,535	77.5	5,649	79	98
Digestive	4,617	64.6	3,461	48.4	133.4
Eye	3,494	48.9	3,488	48.8	100.2
Musculoskeletal	2,901	40.6	2,490	34.9	116.5
Circulatory	1,657	23.2	1,424	19.9	116.3
All Other Diagnoses	1,461	20.4	1,349	18.9	108.3
Genito-Urinary	1,119	15.7	1,550	21.7	72.2
Blood	913	12.8	765	10.7	119.3
Respiratory	546	7.6	384	5.4	142.2
Symptoms and Signs	447	6.3	417	5.8	107.3
Injuries and Poisonings	379	5.3	302	4.2	125.5
Skin	369	5.2	335	4.7	110.3
Nervous System	327	4.6	343	4.8	95.5
Endocrine	289	4	261	3.7	110.5
Infectious and Parasitic	133	1.9	120	1.7	110.7
Ear	63	0.9	59	0.8	106
Congenital Malformations	30	0.4	20	0.3	150.5
Mental Health	11	0.2	73	1	15

Table 8: Elective admissions among people 65+ by diagnosis chapter, 2013/14

(Source: Dr Foster Practice and Provider Monitor)

7.1.1 All Elective Admissions by GP Practice (2013/14)

At the GP Practice level, elective admissions ranged from 163 per 1,000 patients to 502 per 1,000. Some 62 practices had a standardised admission ratio above the England average (36 were statistically significantly higher than nationally).

7.1.2 Ten Highest Elective Admissions (2013/14)

This section examines elective or planned hospital activity by diagnosis sub-group. Table 20 shows the ten most common planned hospital admissions for older people registered to a Liverpool GP for 2013/14.

The most common planned hospital admission was for “cataract” with 34 per 1,000 65+ year olds attending hospital for this ailment, although this admission ratio was not significantly higher than expected. The second highest admission was for “osteoarthritis” and the SAR was significantly higher than expected, as was cancer of the prostate that had an admission rate more than four times than would be expected.

Diagnosis Sub-Group	Actual Admissions	Actual Rate per 1,000	Expected Admissions	Expected Rate per 1,000	SAR
ALL DIAGNOSIS	**24,291**	**339.9**	**22,492**	**314.7**	108.0
Cataract	2,418	33.8	2,344	32.8	**103.1**
Osteoarthritis	1,119	15.7	904	12.7	123.8
Cancer of prostate	1,060	14.8	248	3.5	427.3
Other gastrointestinal disorders	814	11.4	623	8.7	130.7
Oesophageal disorders	788	11	511	7.1	154.3
Deficiency and other anaemia	661	9.2	626	8.8	**105.6**
Gastritis and duodenitis	631	8.8	302	4.2	208.8
Leukaemias	595	8.3	587	8.2	**101.3**
Other non-epithelial cancer of skin	573	8.0	612	8.6	**93.6**
Rehabilitation care, fitting of prostheses, and adjustment of devices	571	8.0	398	5.6	143.6

Table 9: Ten highest elective admissions among people aged 65+ (Source: Dr Foster Practice and Provider Monitor)

7.2 Emergency Admissions by Diagnosis Chapter (2013/14)

An emergency hospital admission is distressing for patients and carers, is associated with a greater risk of mortality and longer-term morbidity, and is expensive to the healthcare system. One of the overarching aims of Liverpool CCG is to reduce the number of emergency admissions for older people.

In 2013/14, there were 22,238 older person emergency hospital admissions for Liverpool CCG patients, giving a rate of 311 admissions per 1,000 population. The Standardised Admissions Ratio was 111 meaning that Liverpool had 11% more admissions than expected when compared with England. The most common cause of emergency admission related to respiratory, circulatory, and injury problems which were all statistically significantly higher than England.

Diagnosis Chapter	Actual Admissions	Actual Rate per 1,000	Expected Admissions	Expected Rate per 1,000	SAR
ALL EMERGENCY ADMISSIONS	22,238	311.2	19,989	279.7	111.3
Respiratory	3,880	54.3	3,637	50.9	106.7
Circulatory	3,662	51.2	3,401	47.6	107.7
Injuries and Poisonings	2,818	39.4	2,302	32.2	122.4
Symptoms and Signs	2,298	32.2	1,777	24.9	129.3
Digestive	1,824	25.5	1,611	22.5	113.2
Genito-Urinary	1,777	24.9	1,769	24.7	100.5
Musculoskeletal	1,447	20.2	1,241	17.4	116.6
Nervous System	786	11	645	9	121.9
Infectious and Parasitic	716	10	603	8.4	118.7
Neoplasms	668	9.3	786	11	85
Mental Health	521	7.3	582	8.1	89.6
Skin	514	7.2	440	6.2	116.8
Endocrine	501	7	497	7	100.8
Blood	274	3.8	260	3.6	105.5
Ear	210	2.9	145	2	145.2
All Other Diagnoses	201	2.8	217	3	92.7
Eye	138	1.9	73	1	187.9

Table 10: All emergency admissions among people aged 65+ by diagnosis chapter (Source: Dr Foster Practice and Provider Monitor)

7.2.1 All Emergency Admissions by GP Practice (2013/14)

At the GP Practice level, emergency admissions ranged from 58 per 1,000 patients to 162 per 1,000. Some 70 practices had a standardised admission ratio above the England average (39 were statistically significantly higher than nationally).

7.2.2 Ten Highest Emergency Admissions (2013/14)

When looking at ICD 10 sub-chapters, the most common emergency hospital admission was for pneumonia with 23 per 1,000 65+ year olds attending hospital for this ailment, and this admission ratio was 28% higher than would be expected. The second highest number of admissions was for chronic obstructive pulmonary disease although the ratio was not higher than expected.

Diagnosis Group	Actual Admissions	Actual Rate per 1,000	Expected Admissions	Expected Rate per 1,000	SAR
ALL DIAGNOSES	**22,238**	**311.2**	**19,989**	**279.7**	**111.3**
Pneumonia	1,627	22.8	1,272	17.8	**127.9**
Chronic obstructive pulmonary disease and bronchiectasis	1,080	15.1	1,102	15.4	**98.0**
Nonspecific chest pain	820	11.5	746	10.4	**109.9**
Urinary tract infections	804	11.3	1,031	14.4	**77.9**
Cardiac dysrhythmias	761	10.6	504	7	**151.1**
Other connective tissue disease	669	9.4	612	8.6	**109.3**
Acute cerebrovascular disease	657	9.2	621	8.7	**105.7**
Coronary atherosclerosis and other heart disease	657	9.2	500	7	**131.5**
Superficial injury, contusion	542	7.6	379	5.3	**143.0**
Fracture of neck of femur (hip)	503	7	481	6.7	**104.7**

Table 11: Ten highest emergency admissions among people aged 65+ (Source: Dr Foster Practice and Provider Monitor)

7.2.3 Ambulatory Care-Sensitive Conditions

Ambulatory Care-Sensitive (ACS) conditions are those for which effective management and treatment should prevent admission to hospital. There are 19 such conditions including asthma, COPD, and hypertension.

In 2013/14 there were 4,610 ACS emergency admissions by older Liverpool patients giving an unadjusted SAR of 135. When adjusted for deprivation the SAR was 107, meaning that Liverpool had 7% more emergency ACS admissions than expected compared with the national rate.

The King's Fund have described higher than expected ACS conditions as an "indication of poor co-ordination between the different elements of the health care system, in particular between primary and secondary care."[18]

7.3 What does this mean for Liverpool?

The hospital admissions data for Liverpool shows that whilst cataracts account for most elective hospital admissions, the rate is not significantly higher than expected. The rate of elective admissions for prostate cancer in Liverpool is over four times higher than expected, with over 1,000 admissions in 2013/14 compared to an expected number of 248. Following discussions with the hospital trusts, a likely reason for this high rate may be the administration of Goserelin injections, which are a type of hormone therapy that stop the body from making testosterone which slows down the growth of the cancer. These need to be given to the patient either every 4 or 12 weeks

and are counted as an admission.

Pneumonia is the most common reason for a person being admitted to hospital as an emergency, with a third more admissions than expected. Studies suggest that bacterial pneumonia accounts for approximately 50% of all pneumonia cases, with other studies suggesting that 50-70% of these could be prevented by pneumococcal vaccination[22]. Therefore it is likely that an increase in pneumococcal vaccination uptake would have a positive effect on rates of pneumonia and pneumonia related emergency hospital admissions locally.

8 Healthy Lifestyles

Between September 2012 and January 2013 over 13,000 interviews were conducted with Merseyside residents asking them about their general health, physical activity levels, smoking and drinking habits, and diet. In Liverpool, there were over 5,000 participants in the survey with 17% of these aged over 65 years.

8.1 General Characteristics

The 891 older person participants in the survey had the following characteristics:

- There were slightly more females than males (53% compared with 47%).
- Almost half (46% were married) whilst more than a third (35%) were widowed.
- Two-thirds owned their properties, and 3 out of 10 were social renters.
- Some 4 out of 10 had a long term illness, disability or health problem.
- Almost half (47%) were overweight or obese.

8.2 Physical Activity

The benefits of being active daily helps to maintain cognitive function, reduces cardiovascular risk, helps to maintain the ability to carry out daily living activities, improves mood and self-esteem, and reduces the risk of falls[24].

Only 5% of older people that were surveyed participated in vigorous intensity physical activity for at least 10 minutes continuously compared with a Liverpool average of 23%. For moderate intensity physical activity, that could include brisk walking, dancing, or swimming, only 17% of older people undertook such activities for at least 10 minutes continuously which was half the Liverpool average. Understandably older people with a limiting long term illness were less likely to undertake moderate activity than those who did not have a long-term illness (13% compared with 20%), and smokers were also less likely to exercise than ex-smokers (11% compared with 25%).

Older people spent an average 55 minutes walking on a typical day which was lower than the 81 minutes for the average Liverpool resident. Conversely they spent 5.9 hours sitting or reclining on a

typical day compared with a mean of 4.48 hours for Liverpool.

8.3 Smoking

Smoking prevalence decreases with age and older smokers who decide to give up have been shown to be more successful at quitting than younger people[24]. Older people can expect a range of benefits if they stop smoking, many of which can be seen quite quickly, and include[24]:

- being able to breathe easier,
- any existing heart or lung problems are less likely to become serious,
- being less likely to have a stroke or heart and lung problems,
- being able to recover from an operation more quickly,
- living longer.

Almost a fifth (19%) of older people who participated in the Lifestyles Survey were current smokers compared with a city prevalence rate of 29%. If this prevalence was applied to the Liverpool CCG population this would equate to almost 14,000 older smokers.

8.4 Alcohol Consumption

Although the majority of older people across the country drink alcohol within recommended guidelines and do not harm their health, there are dangers in consuming alcohol for certain groups of older people:

- alcohol can add to the effect of some medications e.g. painkillers or sleeping tablets,
- alcohol can reduce the effects of some medications e.g. warfarin, which thins the blood and can increase the risk of bleeding or develop blood clots,
- balance deteriorates with age and even a small amount of alcohol can increase the risk of falls.

Nationally, about a third of older people with drinking problems develop them for the first time in later life[24]. Bereavement, physical ill-health, difficulty getting around and social isolation can lead to boredom and depression, so it can be tempting to use alcohol to make these difficulties more bearable. It can then become part of daily routines and difficult to give up. There may be less pressure to give up drinking than for a younger person, fewer family responsibilities, and no pressure to go to work each day[24].

Almost half (47%) of older people in Liverpool drink alcohol (Liverpool average was 56%), and the vast majority do so within recommended guidelines (77%). However almost a quarter (23%) drink at hazardous or harmful levels, which is roughly the same as for older people nationally[24]. If this prevalence was applied to the Liverpool CCG population, this would equate to almost 1,500 older people. Older men were more likely than older women to drink at hazardous levels (28% compared with 15%), and social renters more likely to drink at these levels than owner occupiers (29%

compared with 20%).

8.5 Body Mass Index

An Australian study[25] of older people looking at obesity and coronary heart disease, found that mortality risk was lowest in overweight participants, and significantly higher for underweight participants. The authors argued that their results supported the claims by other studies that "the BMI thresholds for overweight and obese are overly restrictive for older people." [25]

Findings from the Lifestyles Survey showed that 2.4% of older people surveyed were underweight which was in line with the Liverpool average of 2.7%. A fifth were classified as obese which again was similar to the city average. Older people with a limiting long-term illness were more likely to be obese (26% compared with 16% without a long-term illness), as were non-smokers (22% compared with 15% for daily smokers), and binge drinkers (19% compared with 17%).

8.6 Sexual Health

In a Sheffield study of older people[26], 24% of the respondents reported current sexual health concerns. Other studies have found a strong link between erectile dysfunction and cardiovascular disease, suggesting that patients presenting with erectile dysfunction should be investigated for cardiovascular disease. A number of risk factors associated with erectile dysfunction include obesity, smoking, hypertension, metabolic syndrome, and physical inactivity[26].

Other relatively common sexual problems include ejaculation problems, lack of sexual interest, inability to reach orgasm and lubrication difficulties (11%) in women[26].

Although sexually transmitted disease does occur in older people the rates are significantly lower than for all other cohorts. In 2013, for instance, no 65+ year olds attended a clinic in Liverpool with infectious syphilis or gonorrhoea and there were <3 attendees for chlamydia, ano-genital herpes and ano-genital warts.

9 Housing, Isolation and Economic Deprivation

9.1 Housing

The Liverpool Housing Condition Survey[27] suggests that 33.2% of private dwellings are considered non-decent, 13.1% have category 1 hazards within the Housing Health Safety Rating System (the most serious of hazards, relating to a range of hazards, including falls) and 22% failed the decent homes standard, with the private rental sector accounting for the poorer conditions. In 2010, 22.8% of Liverpool households were classified as being in fuel poverty (those spending more than 10% of total household income on energy bills to achieve adequate warmth, including heating, water, lighting and cooking) compared to 20.3% in the North West and 16.4% nationally. Within Liverpool itself the rates ranged from 5.7% in one area in Croxteth, to 41% in an area of Norris Green. Fuel poverty is thought to impact most severely on both younger and older populations, and those living in older properties and privately rented accommodation[27]. Cold housing is said to impair dexterity and lead to greater numbers of accidents in the home[28].

According to the 2011 Census some 7% of older people in Liverpool lived in private rented accommodation (significantly lower than the general population rate of 23%), with Kensington and Central wards having the highest proportions. Where people described their health as bad or very bad, some 9% lived in private rented housing with Tuebrook and Stoneycroft (15%), Old Swan (14%), and Central wards having the highest proportions.

9.2 Isolation

Loneliness is a subjective, negative feeling associated with lack or loss of companionship[29]. If you feel lonely, you are lonely. 'Social isolation' is a sociological category relating to imposed isolation from normal social networks. This can lead to loneliness and can be caused by loss of mobility or deteriorating health. It is possible to be lonely whilst not isolated, for example amongst those caring for a dependent spouse with little help[29].

Research on loneliness and social isolation has tended to focus on older people as they are especially vulnerable to loneliness, due to loss of friends and family, loss of mobility or loss of income[29]. The Campaign to End Loneliness[30] (CEL) estimate that between 6% and 13% of people aged 60 and over often or always feel lonely, equating to between 5,500 and 11,900 people in Liverpool. As the population ages over the next decade, the number of older people experiencing loneliness is projected to increase to between 6,500 and 14,100 people.

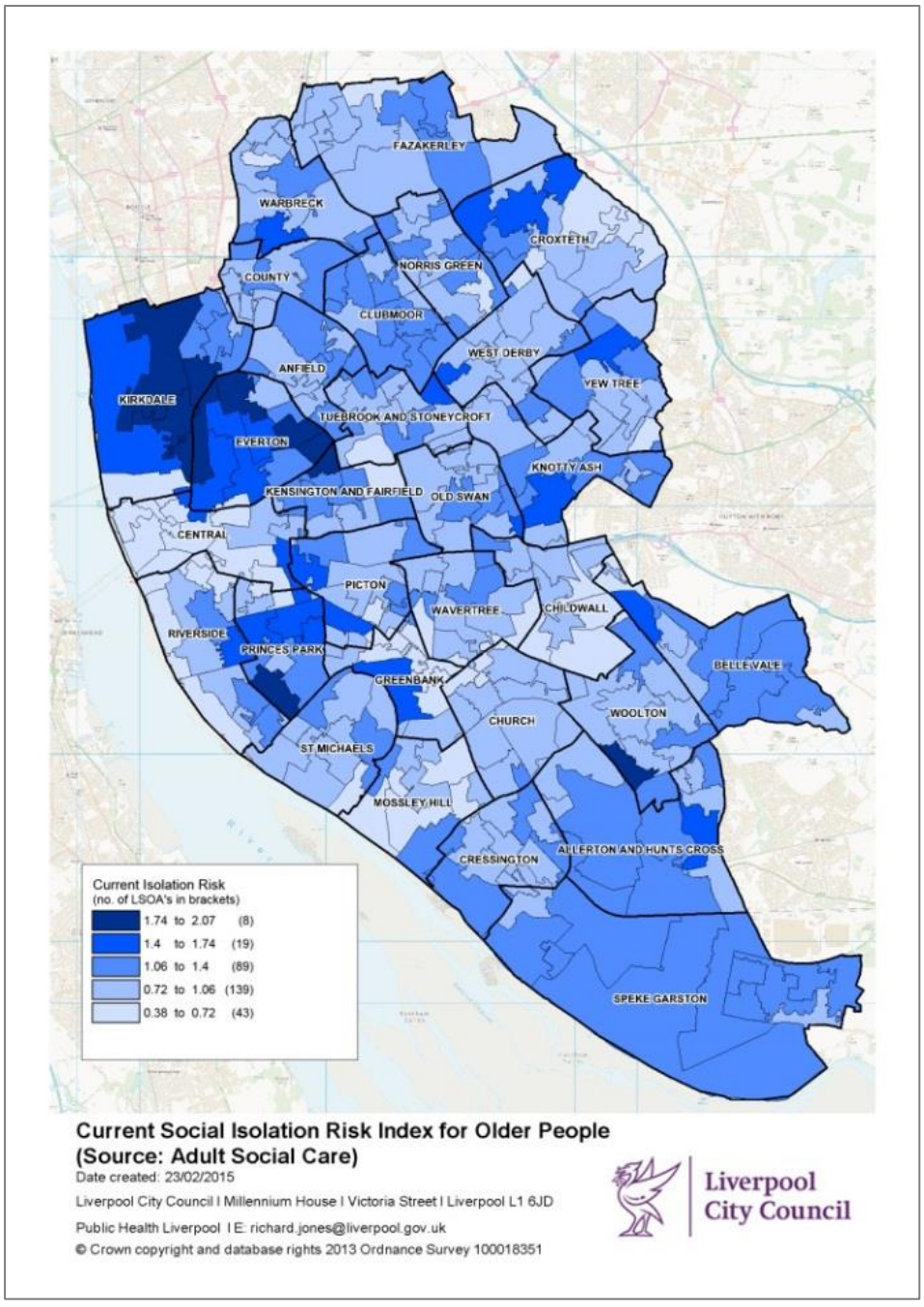
A number of groups have been identified as being at high risk of social isolation and loneliness by the CEL, including:

- Lone pensioners
- Older carers
- People over 75
- Recently bereaved people
- Older people with sensory impairment
- People over 65 living in deprived areas

9.2.1 Isolation Risk Index

The General Household Survey has identified over 25,000 older people who were living alone in Liverpool in 2014. The Projecting Older People Information System (POPPI) have estimated that this figure will increase to 30,000 over the next 10 years; an increase of 17%. This is lower than the 28% increase projected nationally.

The Adult Social Care Team have used a variety of indicators to produce a current social isolation risk index for older people by lower super output area. The main areas potentially at risk include Kirkdale and Everton, followed by Princes Park and parts of Croxteth and Woolton.



Map 3: Social isolation risk index for older people (Source: Adult Social Care)

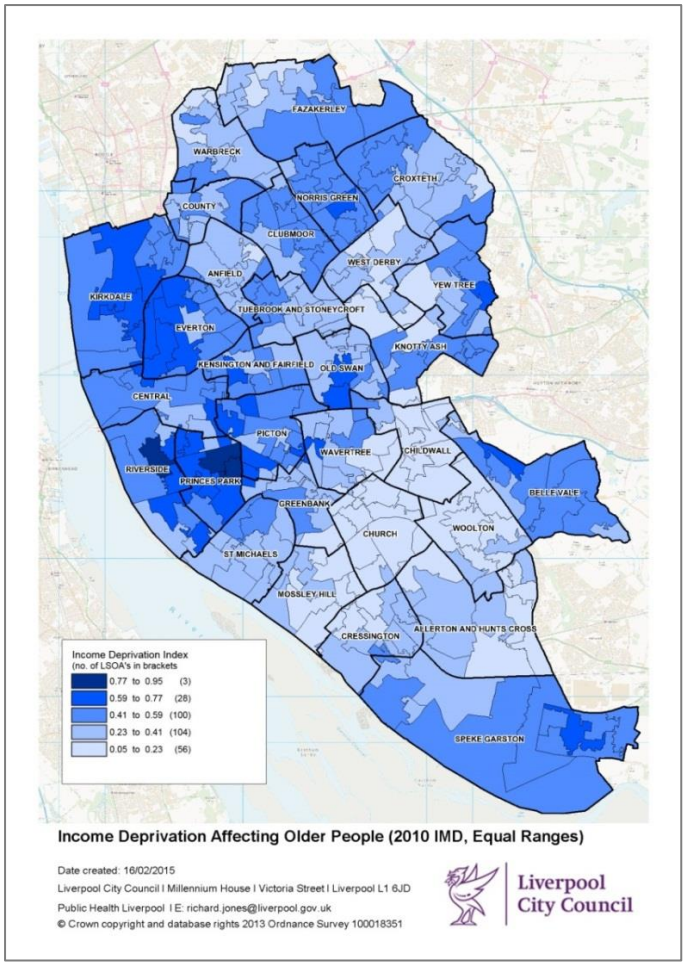
9.3 Economic Deprivation

A study by the Institute of Fiscal Studies concluded that during the relatively recent recession, pensioner household incomes increased relative to other population cohorts. However, as part of the Welfare Reform Act (2012), the Coalition Government have initiated major changes to the benefits system that particularly affect people of working age, although some changes will affect older people too. The main change is Universal Credit which will have been rolled out nationally by 2017 and will replace income support, jobseekers allowance, income-related employment and support allowance, working tax credit, child tax credit, and housing benefit.

State pension age is also changing. If you are a woman born on or after 6 April 1950, you will no longer be able to claim a State Pension at the age of 60 and if you are a man born on or after 6th December 1953 you will no longer be able to claim a State Pension at the age of 65. If you fall into one of these groups of men or women, the age when you can claim your State Pension depends on your date of birth. Benefits affected by changes to State Pension age include pension credit and winter fuel payments.

9.3.1 Income Deprivation Affecting Older People

The 2010 Index of Multiple Deprivation included a supplementary index that represented income deprivation affecting older people (IDAOP) and was expressed as the proportion of adults aged 60 or over living in Income Support or income-based Jobseeker's Allowance or Pension Credit families. Half of Liverpool's lower super output areas were in the most income deprived 10% of LSOA's nationally. The map below illustrates the geographic distribution of the IDAOP with the wards of Princes Park and Riverside having the highest concentration of income deprived older people.



Map 4: Income Deprivation Affecting Older People Index (Source: Index of Multiple Deprivation 2010)

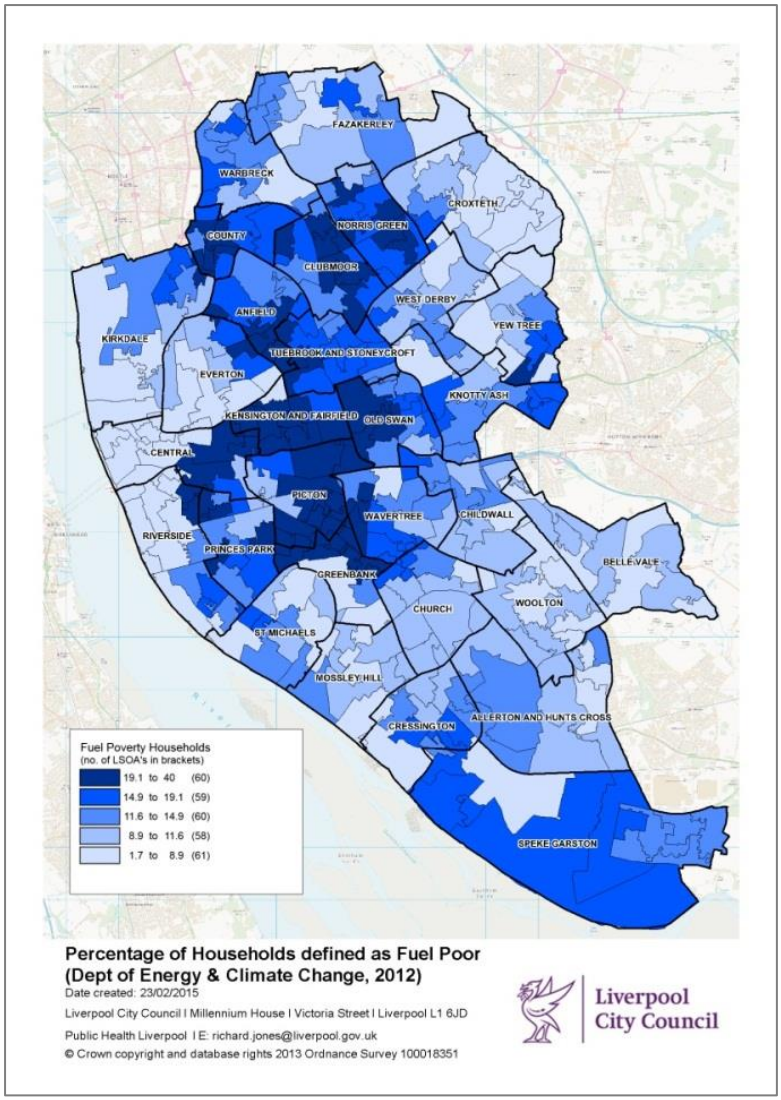
9.4 Fuel Poverty

In 2012, the number of households in fuel poverty in England was estimated at around 2.28 million, representing approximately 10.4 per cent of all English households. Under the Low Income High Costs definition, a household is considered to be fuel poor if:

- they have required fuel costs that are above average (the national median level)
- were they to spend that amount, they would be left with a residual income below the official poverty line

Liverpool had an estimated 29,484 fuel poor households which represented 14.4% of all households in the city.

Nationally a quarter of all fuel poor households contained someone aged over 60 years, and 9% someone aged over 75 years. Some 6% of older Liverpool residents lived in properties without central heating (2011 Census), compared with 4% for all residents. County and Old Swan wards had the highest proportion of older residents without central heating (12%) whilst Woolton had the lowest (2%).



Map 5: Percentage of households defined as fuel poor by lower super output area (Source: Department for Energy and Climate Change, 2012)

10 DEMENTIA

10.1 National Policy Context

There are about 800,000 people in the United Kingdom (UK) with dementia[31]. The current overall financial cost of dementia is £23 billion a year to the NHS, local authorities and families. This cost is expected to grow to £27 billion by 2018; approximately 55% of which is met by unpaid carers, 40% by social care and 5% by health care.

Most caregiving is provided informally by spouses, adult children, other family members and friends, which can have a psycho-social and economic impact as they may be forced to stop working, cut back on work, or take a less demanding job to care for a family member with dementia

The National Dementia Strategy (2009)[32] set new standards for dementia care outlining improvements that were needed in improved awareness, earlier diagnosis and intervention, and improved quality of care. The Prime Minister launched the Dementia Challenge in March 2012 designed to drive forward improvements in dementia care, create dementia friendly communities, and improve research. In April 2013, NICE published quality standard guidance aimed at supporting people to live well with dementia.

10.2 Local Policy Context

Through LCCGs 'Healthy Liverpool Programme', dementia has been identified as a priority area and joint work is underway with the Local Authority to develop an integrated model of dementia care for the city. This will include the establishment of a local Dementia Action Alliance, as recommended by the All-Party Parliamentary Group (APPG).

Liverpool City Council (LCC) has an integral role in delivering better outcomes for people with dementia and their carers. LCC commission and provide generic and specialist services to support people with dementia and their carers by working with partners to design, procure, and monitor social care and housing-related support services. LCC work in partnership with LCCG to offer an integrated service and joint commissioning arrangements are in operation via a Section 75 agreement. This agreement allows the pooling of funds where payments can be made towards expenditure incurred in the exercise of any NHS or 'health-related' local authority functions.

10.3 Dementia Prevalence in Liverpool

Prevalence of dementia increases with age and is estimated to be approximately 19.7% for males and 25.2% for females at 85 years of age and over, with prevalence higher in women due to their longer lifespan. Overall dementia prevalence in Liverpool is significantly lower than the England average (0.59% compared to 0.69% nationally). In 2013/14 there were 2,958 registered patients in the city with a diagnosis of dementia, an increase equating to 251 patients from 2012/13. The Liverpool rate is the second lowest on Merseyside and within the mid-range

among the core cities.

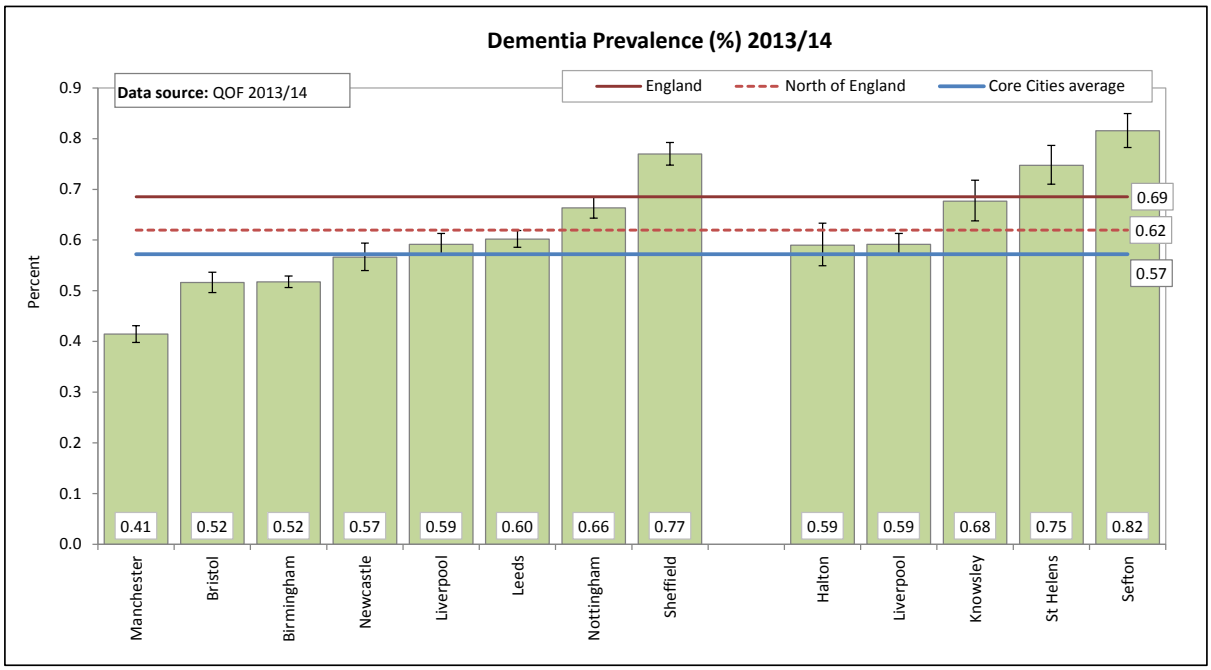


Chart 16: Dementia prevalence (Source: QOF, 2013/14)

Although current prevalence of dementia is lower than the national average, it has been steadily increasing in Liverpool over a number of years. The number of patients with a diagnosis of dementia has increased by 996, up from 1,962 registered patients in 2006/07 to 2,958 registered patients in 2013/14, equating to a 50.8% increase.

When dementia prevalence was standardised by age and sex and analysed at GP neighbourhood level, Croxteth, Everton and Riverside neighbourhoods were found to have significantly higher prevalence of dementia than the Liverpool average. By comparison, prevalence was significantly lower in Walton, Kensington, Speke, Anfield, Wavertree, Norris Green and Gateacre/Woolton neighbourhoods.

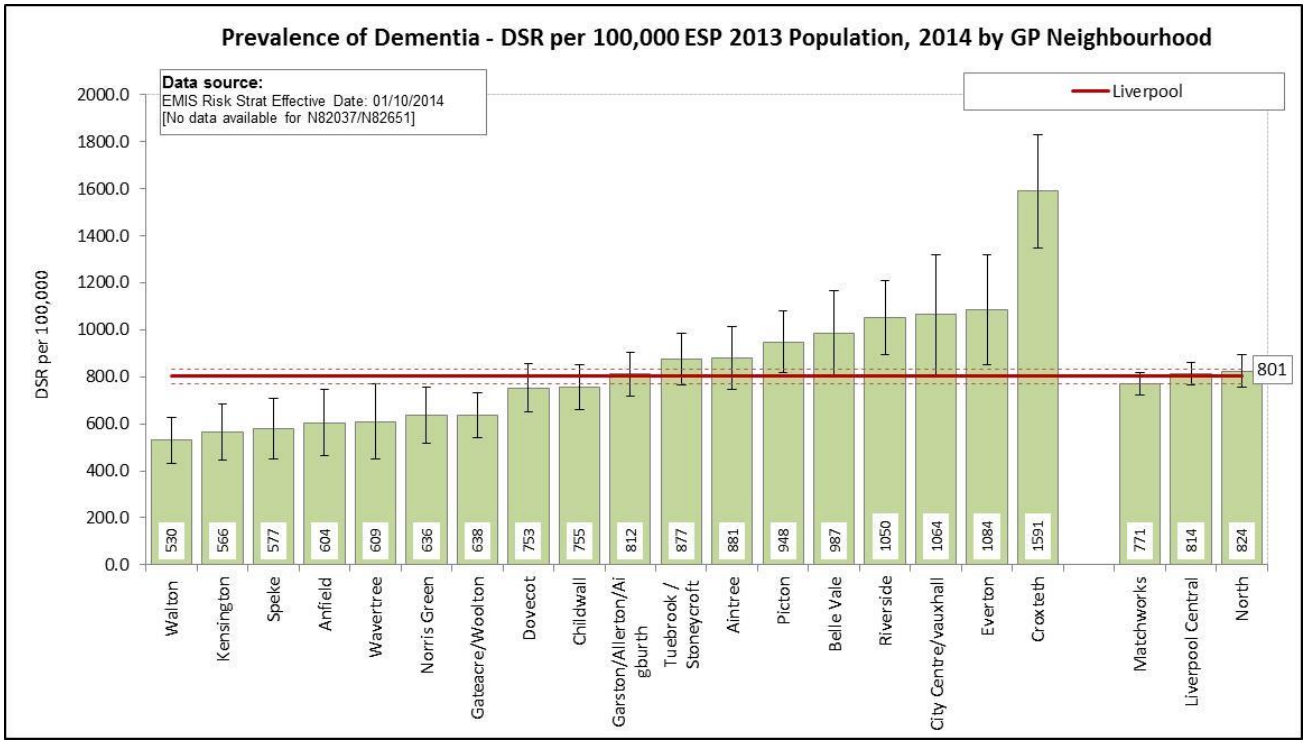


Chart 17: Prevalence of dementia, rate per 100,000 population (Source: EMIS Risk Stratification Tool, 2014)

10.3.1 Actual Versus Expected Prevalence

By applying estimates of expected dementia prevalence by age and sex to the latest registered population estimates for the city we are able to estimate the number of people living with dementia and to compare this against numbers actually diagnosed. Data from GP clinical systems shows 3,171 patients in the city have a diagnosis of dementia (PCQF Dec-14), and it is estimated a further 1,795 patients are living with undiagnosed dementia. This suggests the city has an achievement rate of 63.9% for actual prevalence against expected which is significantly above the England average of 47.8% (Dementia Calculator 2012/13).

The chart below illustrates the actual prevalence of dementia at GP neighbourhood level versus what we might expect given the characteristics of our population. The lowest achievement rate is in Kensington neighbourhood (41.5%) and the highest in Croxteth neighbourhood (119.8%). Rates of achievement were significantly lower than the Liverpool average in Kensington, Speke, Walton, Wavertree, Anfield, Norris Green, Gateacre/Woolton and Childwall neighbourhoods and significantly higher in Aintree, Picton, City Centre/Vauxhall, Belle Vale, Riverside, Everton and Croxteth neighbourhoods.

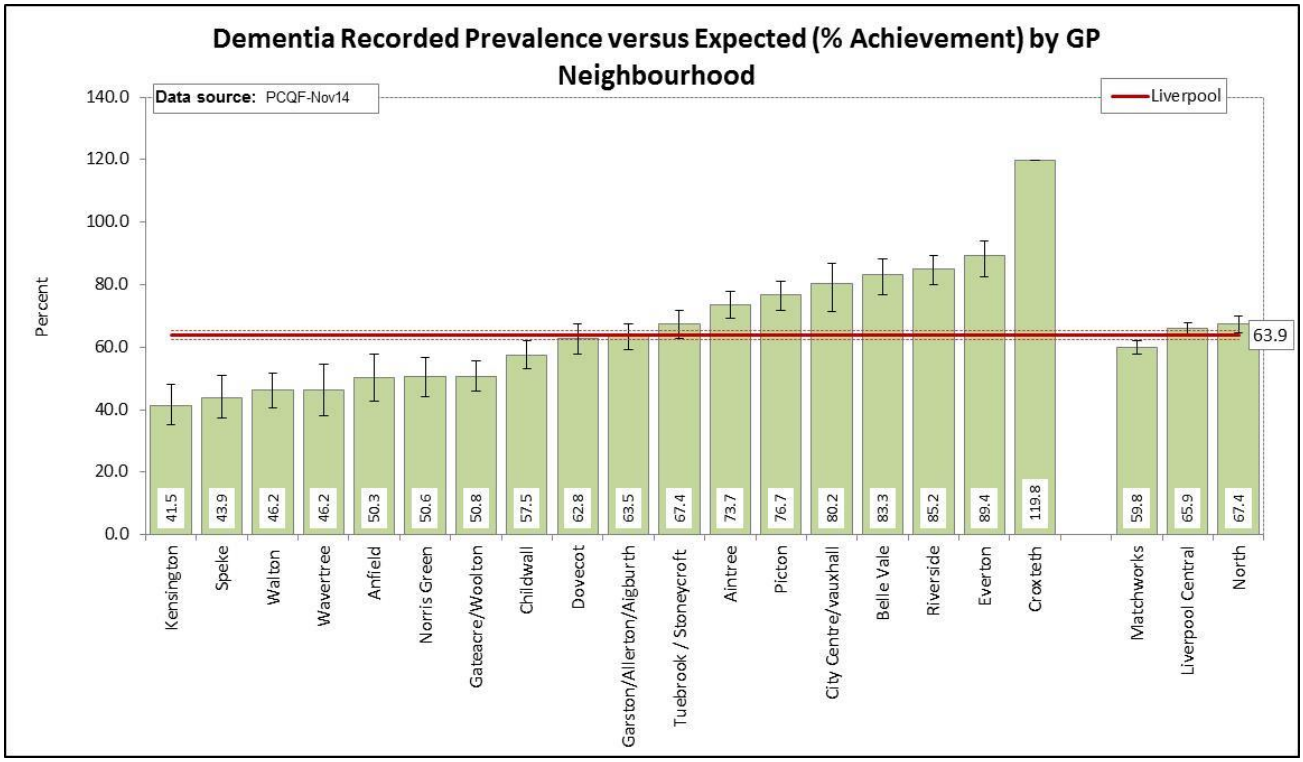
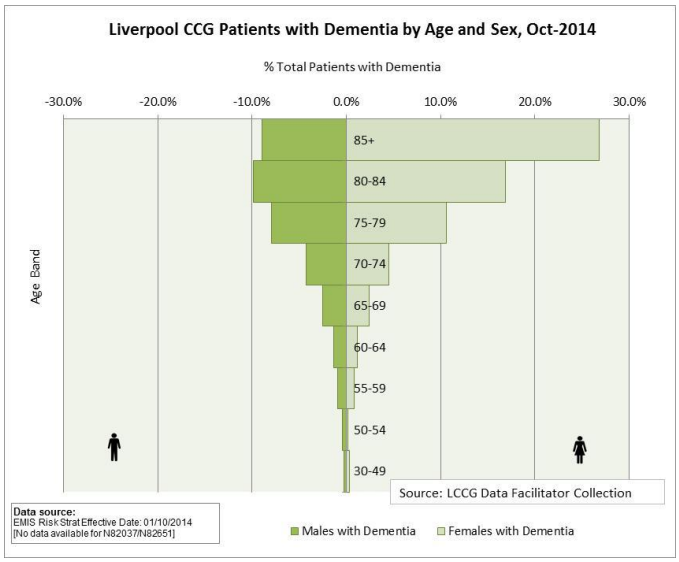


Chart 18: Dementia recorded prevalence versus expected (Source: PCQF, Nov-14)

Using the latest available subnational population projections released by the Office for National Statistics in September 2012 and applying consensus estimates of population prevalence of dementia by age and sex to practice registered populations we are able to predict the numbers of people expected to have dementia in 2021. The estimated number of people with dementia is predicted to rise in the city between 2014 and 2021 by 14.9% for males (from 1,811 to 2,081), by 4.4% for females (from 3,155 to 3,294) and by 8.2% overall (from 4,966 to 5,374) largely due to increases in the older population.

When dementia prevalence by age and sex was compared to consensus estimates of population there was an estimated shortfall of 1,794 patients. More patients than expected have been diagnosed with dementia among men aged between 60-64 and women aged between 55-59 and 60-64. The category with the greatest number of undiagnosed patients was women aged 85+.

Figures for Liverpool indicate around two-thirds of people diagnosed with dementia are females, and women aged over 85 years account for almost a quarter of all dementia patients in the city. Some 5.5% of patients have a diagnosis of early onset dementia (around 150 patients were aged less than 65 years).



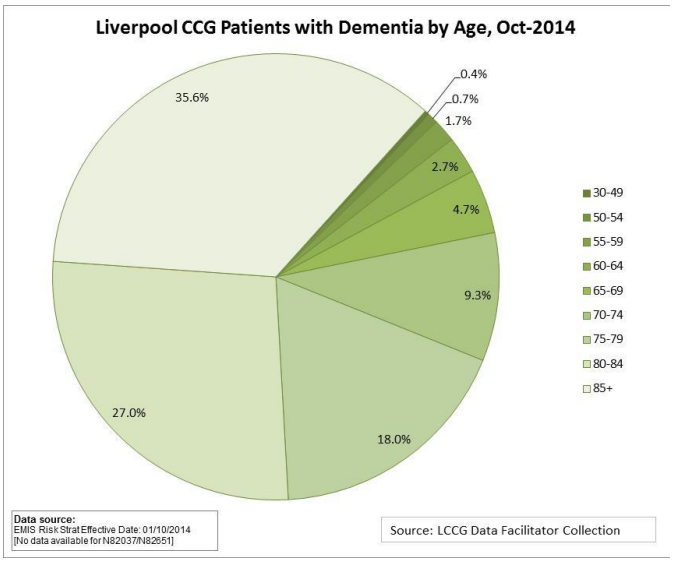


Chart 19: Patients with dementia, age and sex (Source: EMIS Risk Strat, Oct-14)

10.4 Dementia Diagnosis

Timely identification of those with dementia is advocated, with a recommendation to implement targeted screening programmes. Liverpool Clinical Commissioning Group has developed a target to increase diagnosis rates for dementia in those aged over 65 by 7% by 2014/15, with a target prevalence rate of 57.7% (using the 2012 baseline of 50.6%). This suggests an increase of 511 newly diagnosed individuals. Current initiatives to identify and treat people with dementia include incentivising organisations through the use of commissioning for quality and innovation (CQUIN) incentives and directly enhanced service (DES) schemes in primary care.

In England, less than half of all cases of dementia are routinely recognised, and when a diagnosis is made, it is often at a relatively late stage of the disease. According to the NHS Dementia Calculator, the Liverpool dementia diagnosis rate is 64.7% (correct as of December 2014), meaning that it is believed that 64.7% of those with dementia have a diagnosis. The diagnosis rate was 50.9% in 2013, which highlights the recent improvements in case finding locally.

10.5 Dementia Mortality

Whilst deaths from dementia are relatively low when looking at underlying cause of death, the Alzheimer's Research Trust estimates that 1 in 3 people aged 65+ will have some form of dementia when they die[32]. In Liverpool during the 5 year period 2008-12 there were 3,331 deaths among residents aged 65 and over where dementia was stated as a cause of death on the death certificate (19% of all deaths in this age group). This means almost 1 in 5 people in the city aged 65 and over have a form of dementia when they die, although this is likely to be higher due to undiagnosed cases.

Eight GP practices did not have any registered dementia deaths between 2009 and 2013.

Of the GP Neighbourhoods, Garston/Allerton/Aigburth had the highest standardised dementia mortality rate with 403 deaths per 100,000 over 65 years population, which was more than four times that of Kensington that had the lowest rate. Although confidence intervals are wide, we can see that dementia mortality rates in Garston/Allerton/Aigburth and Picton Neighbourhoods is significantly above the city average.

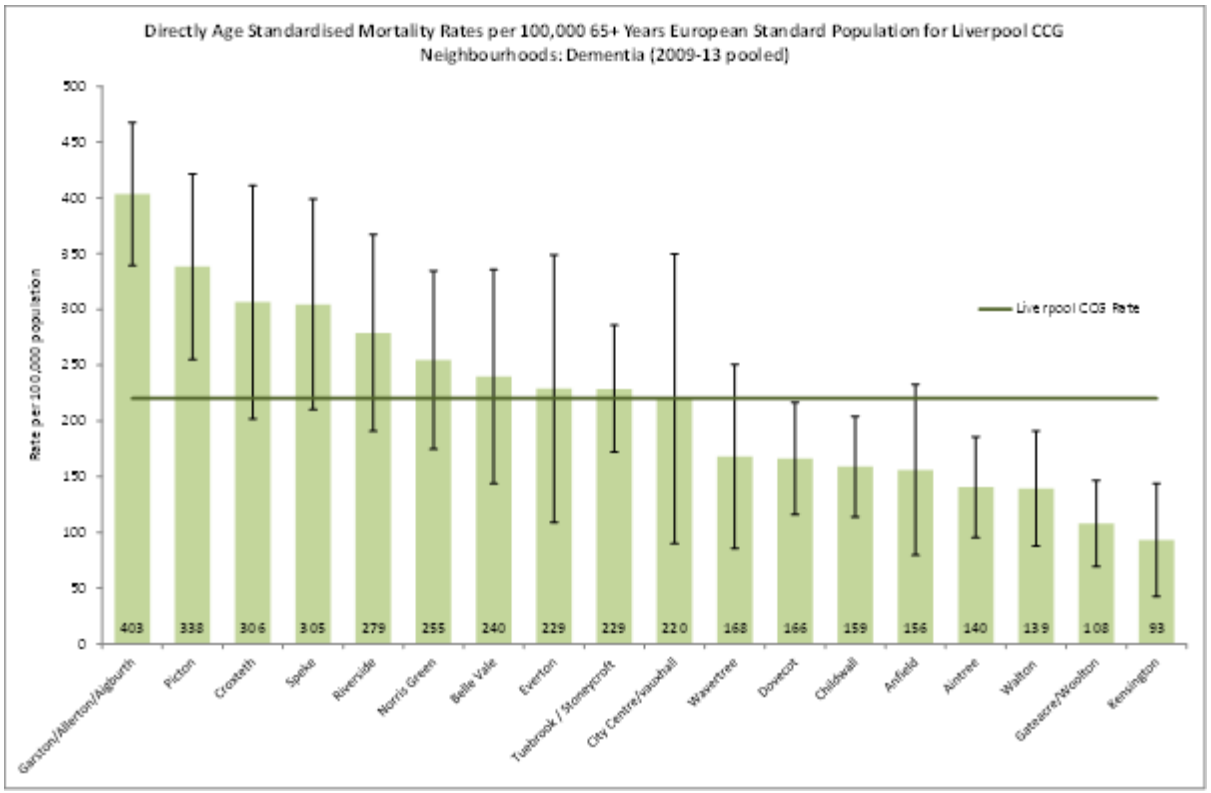


Chart 20: GP neighbourhood mortality rates, dementia (Source: Open Exeter Primary Care Mortality Database)

10.6 Factors associated with increased risk of dementia

Certain groups are at an increased risk of dementia including those with; cardiovascular disease; those with Down's syndrome; people with learning disabilities; those with long-term neurological conditions; those with alcohol dependency and those with mild cognitive impairment[32].

Reducing the risk of developing dementia can be supported through the adoption of a healthy lifestyle. Diet, healthy weight and physical activity play a significant role in reducing the risk of dementia.

10.7 Living with dementia

Dementia UK[19] estimates that 63.5% of people with late onset dementia live in private households (in the community) and 36.5% live in care homes. The proportion of those with

dementia living in care homes rises steadily with age, from 26.6% among 65–74 year olds to 60.8% among ages 90 and over. Based on these estimates of dementia, in Liverpool it is estimated that 3,161 people with dementia live in the community and 1,651 may require a care home.

Age Group	< 65	65-69	70-74	75-79	80-84	85-89	90-95	95+	Totals
Living in Community	120	176	349	602	866	609	378	61	3,161
Living in Care Homes	0	88	88	279	279	375	375	167	1,651
Total	120	264	437	881	1145	984	753	228	4,812

Source: NHS Dementia Calculator, Liverpool CCG, July 2013

10.8 Severity of Dementia

Among people with late onset dementia (ages 65 and over), it is estimated that 55.4% (2,648) have mild dementia, 32.1% (1,570) have moderate dementia and 12.5% (598) have severe dementia. The proportion considered to have severe dementia increases with age, from 6.3% for those aged 65 to 69 years to 23.3% for those aged 95 years and over.

Age Group	< 65	65-69	70-74	75-79	80-84	85-89	90-95	95+	Totals
Mild	60	163	274	502	650	534	368	97	2,648
Moderate	60	85	133	278	365	321	249	79	1,570
Severe	0	17	31	102	130	129	136	53	598
Total	120	265	438	882	1145	984	753	229	4,816

Source: NHS Dementia Calculator, Liverpool CCG, July 2013
NB: Numbers may not sum due to rounding

10.9 Disability Adjusted Life Years (DALYs)

The Disability Adjusted Life Year (DALY) is a measure of the years of healthy life lost due to illness or injury - one DALY is equivalent to one lost year of 'healthy' life. It is estimated that in 2013 residents in the city will lose 2,324 healthy years due to dementia. As can be expected, the greatest burden falls among persons aged 60 and over who account for 92% of total Dementia Disability Adjusted Life Years (DALYs). Among persons aged 60 and over in the city, healthy years lost due to dementia accounted for 8.99% of total DALYs for this age group.

10.10 Hospital Admissions

In 2013/14 there were 2,898 admissions to hospital from 2,000 patients in the city with a primary or secondary diagnosis of dementia. The city has a directly age standardised admission rate of 800 per 100,000 population. When the rates are broken down to GP neighbourhood only Croxteth had a statistically significantly higher rate than Liverpool. There were 5 neighbourhoods where admission rates were statistically significantly lower than the Liverpool rate, these were: Wavertree, Walton, Gateacre/Woolton, Speke and Childwall.

In 2013/14 almost a quarter of all dementia related admissions were due to symptoms, signs and

abnormal clinical findings (ill-defined conditions such as nausea, headache, collapse where the primary cause is unknown at the point of admission). Other high ranking causes of admission included injury, poisoning and other external causes (falls included), as well as diseases of respiratory system (such as influenza and pneumonia).

10.11 Prescribing

Prescribing costs in Liverpool for dementia drugs are approximately £109 per patient, and have been decreasing in recent years. Current spend equates to approximately £300k per year.

Anti-psychotic drugs can be prescribed for behavioural and psychological symptoms in dementia. For mild and moderate symptoms, NICE recommends that such drugs should not be prescribed in the first instance, and non-drug treatments should be used before antipsychotics are considered. Across Liverpool some 13% of patients with dementia are prescribed anti-psychotic medication (Jan-14, PCQF), exceeding the threshold set by the CCG of 19.7%. The range across practices is from 0% to 50% of patients, although numbers at practice level are small.

11 FALLS

11.1 National Policy Context

Falls and falls related injuries are a common and serious problem for older people.Falls can have a significant physical and psychological impact amongst older people, as they can often cause injury and/or loss of confidence. These in turn can cause people to become withdrawn and feel they have lost their independence[33].

There are a number of common health conditions that can increase the likelihood of having a fall:

- Chronic health conditions such as coronary heart disease, dementia and low blood pressure
- Poor vision
- Muscle weakness
- Osteoporosis

The Royal Society for the Prevention of Accidents (ROSPA) estimates that one in three people aged 65 years and over experience a fall at least once a year – rising to one in two among 80 year-olds and older[34]. Approximately 5% of older people in the community who fall in a given year experience a fracture or require hospitalisation[35].

Incidence rates for falls in nursing homes and hospitals are two to three times greater than in the community and complication rates are also considerably higher. The key issue of concern is not simply the high incidence of falls in older people – but rather the combination of a high incidence and a high susceptibility to injury[35].

Standard 6 of the National Service Framework for Older People stated that the NHS in partnership with councils had to take action "to prevent falls and reduce resultant fractures or other injuries in their populations of older people." It further advised that people who had fallen receive effective treatment and rehabilitation and receive advice through a specialised falls service.

11.2 Liverpool Falls Prevalence

Using Department of Health (DH) analysis and Liverpool's registered practice population, it is estimated that:

- 34.4% (24,505 patients) over 65 will fall each year, compared to around 30% nationally
- 14.8% (10,600) of this population will fall twice or more in a year, though most will not seek help
- An estimated 4.8% (3,476) will call an ambulance and attend accident and emergency (A&E) department
- Around 2.7% (1,973) will sustain a fracture, of which 28% (568) will be a hip fracture

11.3 Mortality

Of the Core Cities, Liverpool had the second highest mortality rate of falls among the over-65s (2009-2013), significantly higher than both regional and national levels. The rate in Liverpool was almost five and a half times that in Nottingham which had the lowest rate.

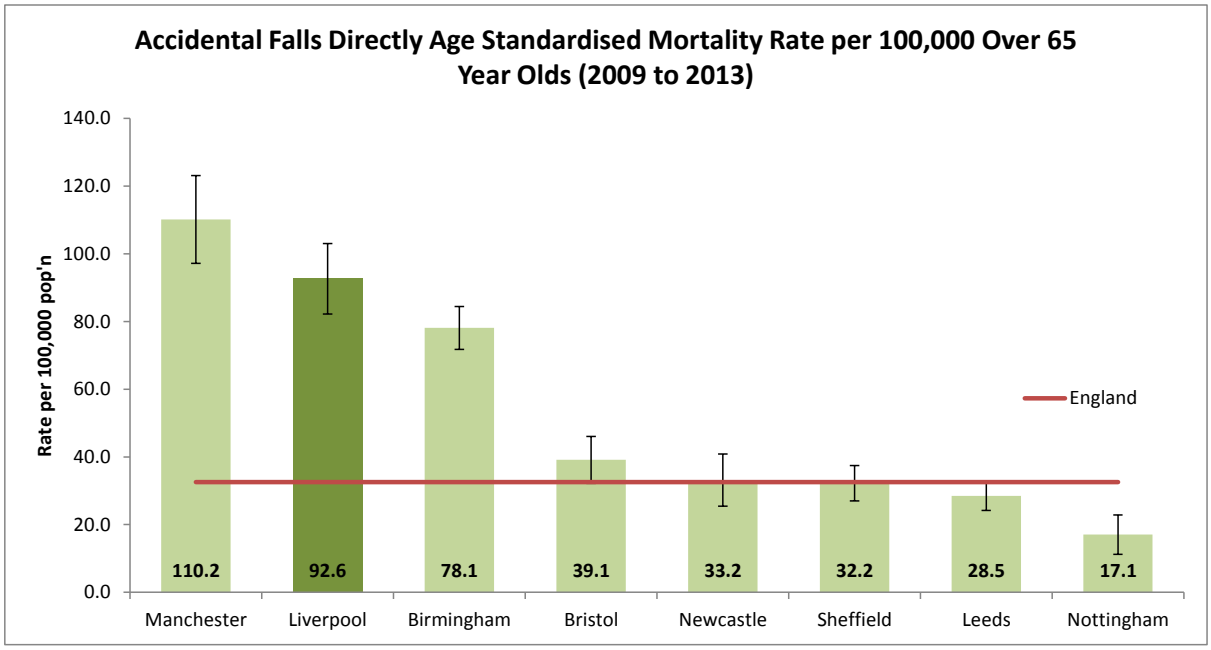


Chart 21: Over 65 years accidental falls mortality rate

11.4 Disability Adjusted Life Years

The Disability Adjusted Life Year (DALY) is a measure of the years of healthy life lost due to illness or injury - one DALY is equivalent to one lost year of 'healthy' life. Applying UK estimates of DALYs to the Liverpool population's rates of falls and other injuries, it is estimated that in 2013 falls were responsible for 495 DALYs in Liverpool accounting for 15% of the burden for all intentional and unintentional injuries; and 0.8% of the total disease burden.

11.5 Hospital Admissions

In 2013-2014 there were 2,411 emergency admissions recorded as a fall (ICD-10 W0* -W1*) among patients aged 65 and over. Of those 2,411 admissions, there were 877 (36%) which involved a primary diagnosis that was clearly identifiable as a fracture. There was a range of 58 different fractures, but the most common were of the hip – fracture of neck of femur (278 cases) and pertrochanteric fractures, (128 cases). Other common fractures included fractures of; pubis, upper end of humerus and lower end of radius and lumbar vertebrae.

The chart below shows the number of emergency hospital admissions by the individual age of patient, with those Liverpool patients aged 84 years having the highest number. More than a third (37%) of falls related admissions were to over 85 year olds.

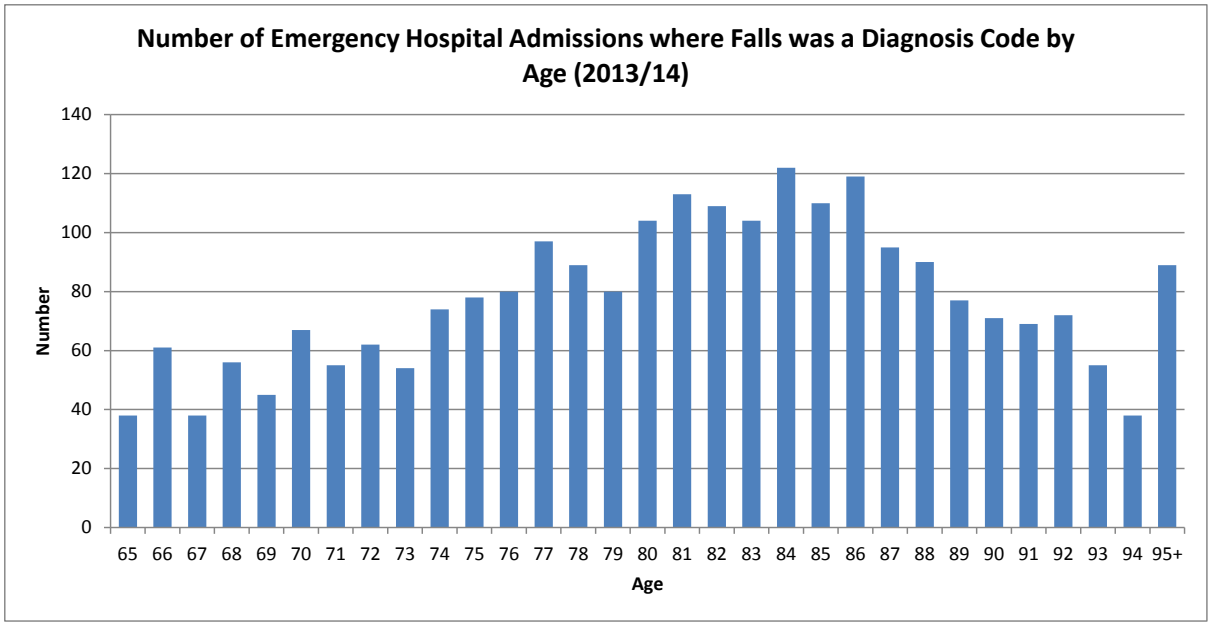


Chart 22: Number of emergency hospital admissions for falls by age (Source: SUS Database, 2013/14)

There is a marked variation in the emergency admission rate for falls across the city, with figures for 2013-14 showing that the crude rate in Princes Park ward is more than three times that in Warbreck. The level of emergency admissions in Princes Park, Anfield, Greenbank, and Kirkdale are significantly above the rate for Liverpool as a whole.

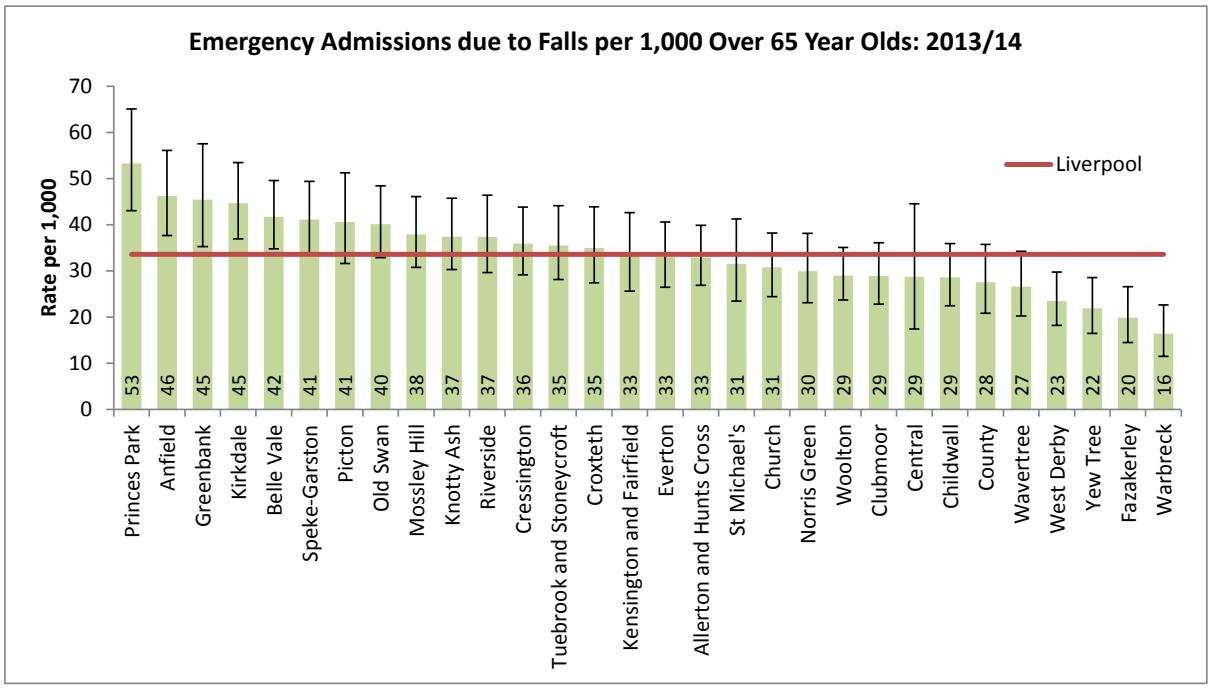


Chart 23: Emergency falls admissions by ward

11.6 National Institute of Clinical Excellence (NICE) Guidance

NICE has published a suite of guidance in relation to falls prevention and risk assessment, including identifying those at risk of fragility fractures. This includes a 2013 update on their original guidance published in 2004.

Falls Prevention:

There is clear evidence outlined within the NICE guidance about what works and what doesn't in relation to falls prevention. Much of the NICE guidance for falls in a community setting were unchanged and included[36]:

- Case/risk identification: Older people reporting a previous fall or considered at risk of falling should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve balance and mobility

- Falls risk assessment: Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a falls risk assessment. This should be carried out by healthcare professionals with appropriate skills and experience, normally within the setting of a specialised falls service. Falls risk assessments can include: assessment of gait, balance and mobility and muscle weakness; assessment of osteoporosis risk; assessment of visual impairment; assessment of home hazards; cardiovascular examination; and, medication review.

- Multifactorial interventions: All older people with recurrent falls, or assessed as being at increased risk of falling should be considered for an individualised multifactorial intervention. Common components of such interventions include: strength and balance training; home hazard assessment and intervention; vision assessment and referral; medication review with modification/withdrawal.

Fragility Fractures:

Fragility fractures are fractures that result from forces that would not ordinarily result in a fracture, otherwise known as 'low-level trauma. Reduced bone density from conditions such as osteoporosis is a key risk factor for fragility fractures, with post-menopausal women most at risk.

Targeting those at risk of poor bone health in primary and secondary care may be an effective way to reduce the risks of those people going on to experience falls in the future.

12 FRAILTY AND REABLEMENT

12.1 Definition

Reablement is defined by The Social Care Institute for Excellence (SCIE) as the provision of services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living[37]. The focus of reablement is on restoring independent functioning rather than resolving health care issues, and on helping people to do things for themselves rather than the traditional home care approach of doing things for people that they cannot do for themselves. Although reablement overlaps with intermediate care, its focus on assisting people to regain their abilities is distinctive[37].

Locally, the aim of reablement is to reduce the number of people being admitted unnecessarily to hospitals, and reducing both length of stay and the number of referrals into acute care. The goal is to enable independent living in the community and prevent long term placements in residential/nursing care homes.

Reablement is viewed as a continuum incorporating:

- Prevention and self-care
- Addressing Social Isolation
- Proactive and reactive Primary and Community based care and support (inc. Discharge to Assess)
- Intermediate care
- Rehabilitation
- Reablement Hubs
- Improved 'step up' from primary care
- Community Crisis Response
- Reactive Hospital based care

12.2 National Policy Context

The concept of intermediate care and reablement first began following the publication of the National beds enquiry in 2000. This was followed by the NHS plan that outlined significant intended reforms to the NHS. The basis for these changes was the need to create services outside hospital due to increasing numbers of admissions (mainly older people) at a time when bed numbers were falling. Intermediate care was first implemented through the National Service Framework (NSF) for Older People in 2001 via the concept of 'Care Closer to Home'. It was based on the use of Comprehensive Geriatric Assessment (CGA) by Multi-disciplinary Teams (MDTs). Interventions were designed to be short term, typically lasting less than 6 weeks

Updated guidance in the form of 'Intermediate Care – Halfway Home' was published in July 2009,

and re-emphasised that services be provided to avoid unnecessary hospital admissions, provide safe early supported discharge, and prevent premature entry into long-term care. Halfway Home also suggested that some form of intermediate care acts a default pathway before any decision is made about entry into long term care. The National Service Framework states that no older person should enter long term care directly from an acute hospital bed. Re-ablement is the term often associated with this process and refers to services primarily designed to optimize the individual, helping them practice daily living tasks and accessing other services and also their environment, using equipment and telecare.

12.3 Local Policy Context

The Intermediate Care Strategy for Liverpool was launched in July 2008. It was a joint strategy agreed between the Primary Care Trust and Social Services. An updated version of this forms the framework for the North Mersey Urgent Care Integrated Care QIPP service improvement programme. The development of this strategy was based on a needs analysis for Integrated Care that scoped the current resources and identified gaps. Key findings were that a significant number of elderly people in hospital (33%) could be cared for at home, 17% of new admissions to Care Homes functionally improved such that they no longer needed to be there, and that 27% of patients in bed-based IC could have received support at home.

Since the development of the Liverpool IC strategy, there have been a number of changes in the definitions of the level and type of IC. Initially there were 6 levels, but now there are only 3:

1. Sub-acute
2. Nurse led in private sector Care Home
3. Social care led reablement

12.4 Frailty

Frailty develops as a consequence of age-related decline in multiple body systems, which results in vulnerability to sudden health status changes triggered by minor stress or events such as an infection or a fall at home. Between a quarter and a half of people over 85 are estimated to be frail, with overall prevalence in people aged 75 and over approximately 9%[38]. A significant number of frail older Liverpool patients with complex needs who have presented at hospital have been triaged to short stay units or specialty based wards and have not received a specialist comprehensive geriatric assessment (CGA). Evidence suggests that a CGA in a specialist unit results in improved outcomes, with reduced length of stay, a reduction in delirium, reduced dependence and lower rates of institutionalisation[38].

12.5 Reablement

In 2013 the Emergency Care Intensive Support Team undertook a review of the intermediate tier of services in Liverpool that raised some key challenges:

- The number and use of the intermediate care beds

- Length of stay for those within those beds
- Clear and consistent documentation for all patients that addressed several questions:
    - What is wrong with me?
    - What is being done to fix it?
    - What do I need to be able to do to go home and has someone asked me?
    - When will I be going home?
- Focus on disparity in relation to outcomes for those in 'spot purchased' beds which needed to be addressed.

Following the ECIST review three reablement projects have been initially established locally;

- The Falls Service project – the community reablement team will be commissioned to deliver a citywide falls service within the community as a step-up for general practice and an alternative to hospital for ambulance services. The falls service will link with existing infrastructure and services in place to support independent living e.g. Telecare.
- The Frailty Unit project led by the Royal Liverpool University Hospitals Trust (RLBUHT) working in partnership with Liverpool Community Health NHS Trust (LCH) and Liverpool City Council (LCC)
- The Discharge to Assess (D2A) project, closely connected to the Frailty Unit project led by LCH with LCC (via the s.75 Partnership Agreement between the two organisations), in partnership with RLBUHT.

12.6 Reablement Care Homes

In Liverpool there are a total of 76 reablement 'beds' provided by the City Council across three locations, offering a range of provision:

Granby Care Home in Toxteth has 30 beds, conducts a comprehensive review of all new patients, has planned GP visits three times a week, a multi-disciplinary team that is attended by a GP, and monthly critical event meetings to discuss admissions and other concerns.

Sedgemoor Care Home is a purpose built single story building in Norris Green that accommodates 30 people requiring respite care, short-term care as well as permanent residential care.

Venmore Community Centre is a purpose built building with accommodation over three floors in Anfield. Although it provides accommodation and support for some long standing residents its primary purpose is to provide intermediate care for a period of up to six weeks for people who have been discharged from hospital and need rehabilitation or support following a stroke. There are 16 beds for reablement and 5 for people who are recovering from a stroke.

All of the above care homes have met all the required standards on their last inspection by the Care

Quality Commission. They usually operate at 80%-90% capacity due to the turnover of patients and the need to keep beds free for emergencies.

12.7 Acute Frailty Unit

Liverpool CCG, as part of the Healthy Liverpool Programme, has approved the investment of £298k to develop an Acute Frailty Unit at the Royal and Broadgreen University Hospital Trust that would improve the care of frail patients and facilitate timely discharges to the most appropriate setting. The total cost of the unit would be over £3M annually.

From November 2014, a frailty clinical pathway was implemented consisting of three integrated components:

1. The **Acute Frailty Assessment Team** based on the acute floor of the Royal Liverpool Hospital, providing seven day rapid screening, triage, and assessment of frail patients.

2. The **Acute Frailty Unit** consisting of 18 beds facilitating rapid multi-professional assessment and treatment of frail patients allowing timely discharge to appropriate alternative places of care within a median Length of Stay (LoS) of 72 hours.

3. **Discharge to Assess (D2A)** Community Frailty Service that will move the focus of functional assessments out of the hospital and into the patients' home and consists of rapid care planning, therapy support and rapid access to intermediate care beds to move patients out of the acute bed base. This service is provided by a provider collaborative which includes Liverpool Community Health Trust, Merseycare Trust and Liverpool City Council.

Once discharged, patients will have an integrated team of therapists, social care, mental health and nursing support to go home with and support them intensively for a period of 5 days post discharge, whilst carrying out an assessment of patient's ongoing needs. The community frailty team will be supervised and led by a community geriatrician who will be the first point of contact of all medical and other queries from the community frailty team in the first 5 days post discharge from hospital.

There has been an Acute Frailty Unit based at Aintree Hospital since winter 2013/14 that intended to reduce the number of unnecessary hospital admissions by quickly assessing patients, treating them, and getting them back to their own homes as soon as possible. It has been proposed to adapt the Aintree Frailty Unit to the LCCG preferred clinical model as outlined above in Spring 2015 so that both acute trusts provide a similar service.

12.8 Discharge to Assess Project

The Discharge to Assess (D2A) project, closely connected to the Frailty Unit project, is led by Liverpool Community Health with Liverpool City Council (via the section 75 Partnership Agreement between the two organisations), in partnership with the Royal Liverpool and Broadgreen University Hospitals.

The key principle in the evolution of the D2A model of care is that the best place to assess people is in their own home rather than in hospital. The D2A Team will work alongside the Frailty Unit MDT to identify the earliest opportunity when a hospital patient is deemed not to require an acute stay and

then organise a rapid discharge; the primary focus being on discharging a person to their usual place of residence, or failing that to a short stay reablement bed based service. The D2A team will then conduct a thorough assessment once the patient has arrived home or at an intermediate care bed.

When patients return home the D2A team will ensure that all nursing, therapy and care risks/needs are met to help minimise the risk of deterioration and potential readmission for the more dependent people. The community nursing and in house care provision will be operational 24 hours/day for up to 5 days. The service will link with existing infrastructure and services in place to support independent living e.g. Telecare.

13 CARERS

13.1 Definition

A carer is someone who helps another person, usually a relative or friend, in their day-to-day life[39]. This is not the same as someone who provides care professionally, or through a voluntary organisation. For this needs assessment the following carers will be considered:

- Older people who care for other older people
- Those who care for older people

There are an estimated 6.5 million carers in the UK – this equates to about 1 in 8 of the adult population. Unpaid care is estimated to save the state about £119 billion per year. Benchmarking has shown Liverpool to have the greatest level of unpaid carers among the eight core cities with higher than national figures. Similarly the proportion of carers providing >20 hours of care in Liverpool is substantially above national estimates and those providing >50 hours of care is the highest among the core cities. It is estimated that carers in Liverpool are saving the Liverpool economy £1,114m per year in potential care costs[39].

13.2 National Policy Context

The Care Act 2014 is the most significant piece of legislation in the social care sector since the establishment of the welfare state[37]. In the Act carers are given significant new entitlements with a view that they will maintain their caring role for longer with this additional support. Needs or carers assessments must be carried out where it appears to an authority that they are necessary. The assessment should be appropriate, proportionate, person-centred and ensure a focus on the duty to promote wellbeing.

The Act also establishes a national minimum threshold at which people will be eligible for support. Once support is agreed there will be a duty on local authorities to produce care and support plans and to offer a personal budget.

Local authorities are preparing to implement most of the provisions of the Act by April 2015, the following year in April 2016 the funding reforms will come into place and with them the expected rise in demand for assessments.

13.3 Local Policy Context

Liverpool implemented a new approach to undertaking carers' assessment in February 2012 when a comprehensive care pathway for adult carers of other adults was introduced across the city. This was designed to ensure there is 'no wrong door' for carers accessing information, advice and support including access to a break. Despite recent developments the assessment and support of parent carers and young carers remain separate and fragmented from that of adult carers caring for other adults.

It is envisaged that carers will:

- be identified at an early stage particularly within primary and secondary health

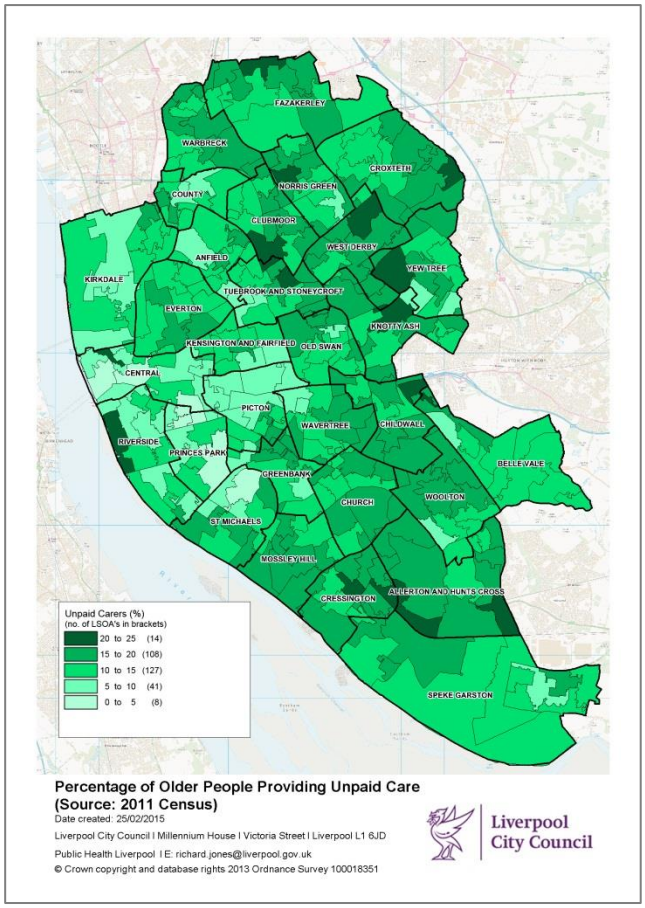
- be supported to identify themselves as ‘carers’
- have access to a range of information they need to support them in their caring role
- have access to a statutory Carers Assessment and Support Plan
- have access to the integrated and personalised services they need to support them
- have access to appropriate personalised breaks
- be supported to remain mentally and physically well
- will be supported to fulfil their education and employment potential where appropriate

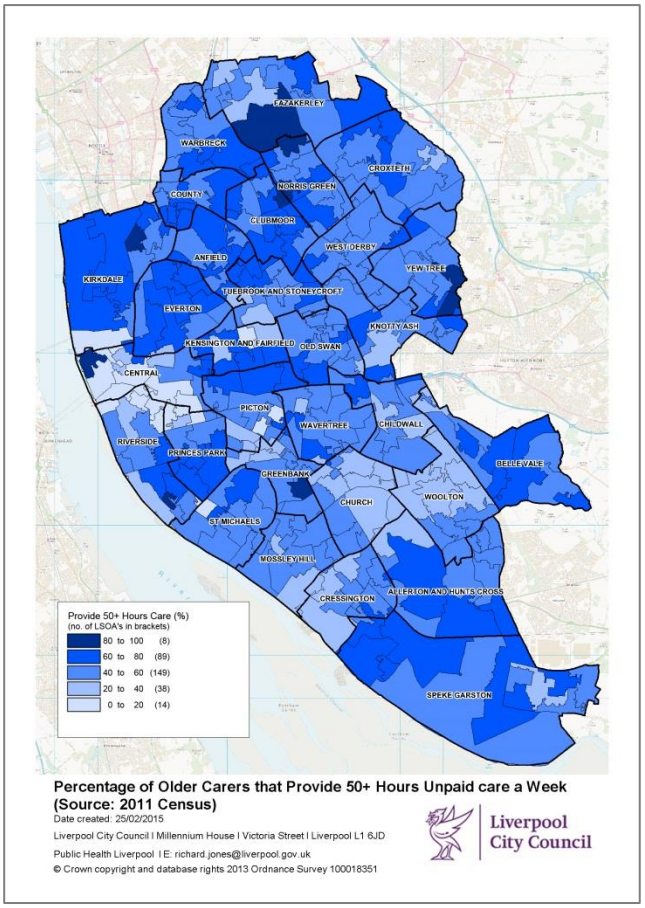
13.4 The Liverpool Picture

According to the 2011 Census, over 50,100 people in Liverpool stated they provided unpaid care (Census Table: DC3301EW), and of these some 9,300 were aged over 65 years (14% of all older people in the city). Allerton and Hunts Cross (17.2%), Childwall (17.0%), and Cressington (16.7%) wards had the highest proportions of older people providing unpaid care, whilst Central (7.5%) and Princes Park (8.5%) had the lowest proportions. Liverpool had a higher proportion of older carers than England (13.8%), and had the third highest rate of the core cities.

More than half (53%) of older carers, provide care for more than 50 hours per week which is significantly higher than the national average of 38%. Of the core cities, Liverpool had the highest proportion of older people providing 50+ hours unpaid care a week. Almost two-thirds of older carers in Everton provide 50+ hours a week unpaid care, followed by Kirkdale (62%), and Clubmoor (62%), whilst Woolton (35%) and Church (37%) had the lowest proportions.

The Projecting Older People Population Information System (POPPI) has estimated that the number of unpaid carers in Liverpool may increase by 18% over the next 10 years, slightly lower than the 21% projected national increase. The number of carers providing 50+ hours of unpaid care in Liverpool is also forecast to increase by 18%.





Map 6: Provision of unpaid care by older people (Source: 2011 Census)

In 2012-13, 290 unpaid carers of people with dementia in Liverpool completed a carer assessment with LCC. An audit of Liverpool GP clinical systems in September 2013 showed 386 patients with dementia had a registered carer recorded in the last 12 months (13.3%). Based upon the earlier Census figures, these figures are likely to under-estimate the true prevalence of carers for those with dementia in Liverpool.

13.5 Impact on Carers

The Royal College of General Practitioners (RCGP) describe the impact that being a carer can have on an individual:

- Up to 40% of carers experience psychological distress or depression
- Carers have an increased rate of physical health problems – e.g. providing high levels of care is associated with a 23% higher risk of stroke
- Older carers who report 'strain' have a 63% higher likelihood of death in a year than non-carers or carers not reporting strain

13.6 Impact of the Care Act

From April 2015, local authorities have a legal duty to assess any carer who requests an assessment or who appears to need support. Currently a carer's assessment involves social services considering whether there is any risk that a person's caring role could break down, with the risk being graded as critical, substantial, moderate, or low. From April the assessment will look at the different ways caring affects the carer's life, and work out how the carer can carry on doing the things that are important to them. The physical, mental and emotional wellbeing of the carer will be at the heart of the assessment. On completion, the local authority will decide whether the carer's needs are eligible for support.

Liverpool City Council's Adult Social Care Team has projected the potential demand on the service that the change in carer's assessments may have. By 2017/18 they have estimated that an additional 2,000 annual assessments may be needed (high end estimate) in addition to the usual 2,100 assessments delivered. This is for all residents and not just older people.

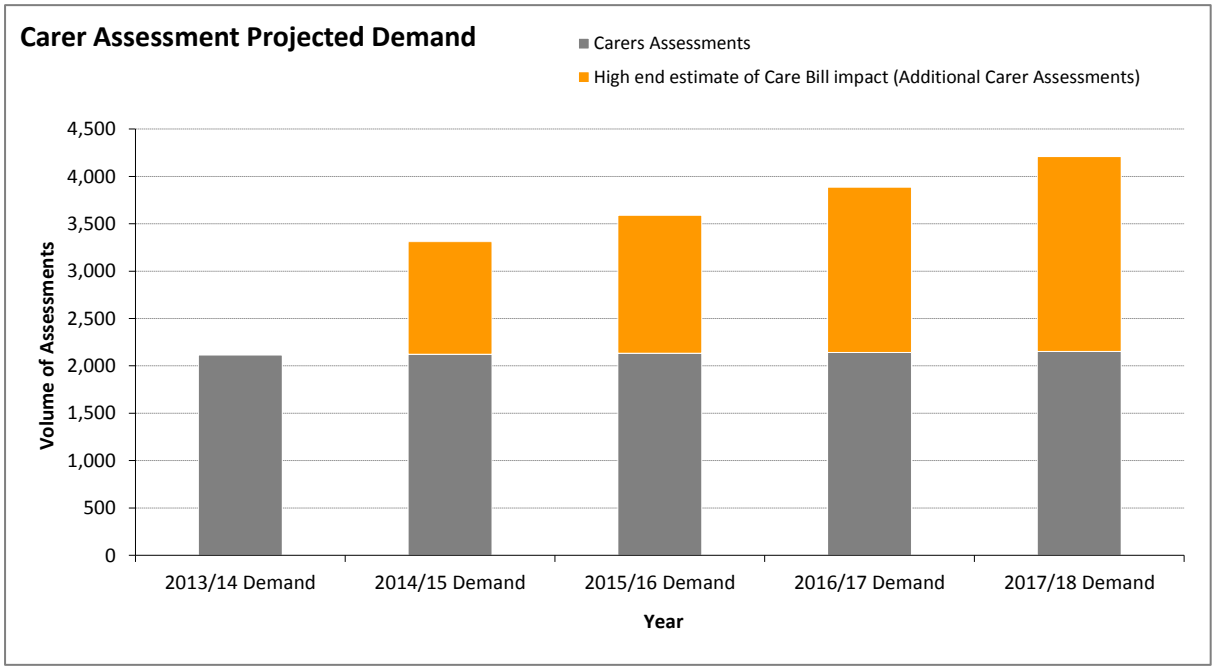


Chart 24: Carers assessment projected demand (Source: LCC Adult Social Care)

If the demand for assessments increases as forecast then the annual cost of delivering them is expected to be £325,000 by 2020, which is £109,000 higher than the pre Care Bill estimates.

14 CARE HOME PROVISION

14.1 Definition

There are a number of types of care homes for older people that provide a range of services and can be privately owned or run by charities or councils. The two main types are:

- personal care homes which offer support ensuring basic personal needs are taken care of,
- nursing care homes which might specialise in certain types of disability or conditions such as dementia.

14.2 National Policy Context

Where a local authority is funding accommodation, it must allow a person entering residential care to choose which care home they would prefer, within reason. Local authority help with the cost of residential care is means-tested and the Care Act is changing how people pay for their own care. The deferred payment scheme allows a person entering care to ask the local authority to pay the costs whilst their home is being sold.

If a person has been assessed as needing fully funded NHS care, the NHS is responsible for paying all care home fees. The local CCG is responsible for carrying out an assessment and if a person is assessed as qualifying for fully funded care the NHS will make the arrangements and the local council will not be involved.

14.3 Local Policy Context

The traditional service route that was used by Liverpool City Council and partners was that early interventions or first contact with an older person in need of some care would likely include some form of equipment or adaptation to their home. Any minor hospital admission that did not significantly increase the service user's need or restrict their independence would likely result in some form of home care or day support, whilst a major admission, that significantly reduced their independent living, would likely result in a permanent admission to either residential or nursing care.

In 2012 a new Model of Care Route was introduced which had the following strands:

- Early interventions / first contact would henceforth focus on access to universal services and community based support mechanisms. Low-level equipment and minor adaptations may be provided to prolong independent living.

- Any minor hospital admission, which did not significantly increase the service user's needs or restrict their independence, would likely result in a minimum period of home-based reablement / rehabilitation to reduce the dependency of social care support and need for long term care. Interventions such as access to community based services, day support and

assistive technologies, such as Telecare were aimed at extending independence.

- Any major hospital admission, which significantly reduced the capacity of the service user's independent living, would likely result in a minimum period of bed-based reablement / rehabilitation (e.g. hubs) to maximise service user's independent living skills and reduce the levels of care required. Enhanced community support and services were to be utilised, such as Extra Care Housing, further extending service user's independence. As a last option, permanent admission to either Residential or Nursing care would be considered.

The 2012 Model of Care was designed around the service user and the drive to maintain as much independence as possible, with the aim to minimise the necessity of social care interventions or services.

14.4 Support Plans

A support plan is a personalised care package that can include a wide range of different support including help with preparing meals, getting dressed or ready for bed, help with taking medicines, or safety in the home.

Residential and nursing care comprises 16% of all care packages commissioned by Liverpool City Council. Home care (20%), equipment and adaptations (22%), and other community services such as supported accommodation (24%) are the other most commonly commissioned packages.

14.5 Care Homes

Permanent placement in residential or nursing care is always seen as a final option where the risk to independence is so high that it is deemed necessary. There are 118 Care Homes in Liverpool registered on the Care Quality Commission (CQC) Providers Directory, and 71 specialise in caring for adults aged over 65 years. Some 4 out of 10 of the Care Homes provide a nursing service.

Care Home Types	Total	%
Care Home With Nursing	44	37.3%
Care Home With Nursing - Rehabilitation (Illness Or Injury)	4	3.4%
Care Home Without Nursing	62	52.5%
Care Home Without Nursing - Care In Your Home and Supported Living	1	0.8%
Care Home Without Nursing - Rehabilitation (Illness Or Injury)	6	5.1%
Care Home Without Nursing - Treatment And Rehabilitation (Substance Misuse)	1	0.8%
Grand Total	**118**	**100%**

Table 12: Care home types (Source: LCC Adult Social Care)

In October 2014, there were 3,658 care home beds in the city. The distribution of beds across the city ranged from no provision in the wards of Central and County to 313 in Knotty Ash. There are approximately 250 places available in these homes, indicating a current occupancy rate of around 93%.

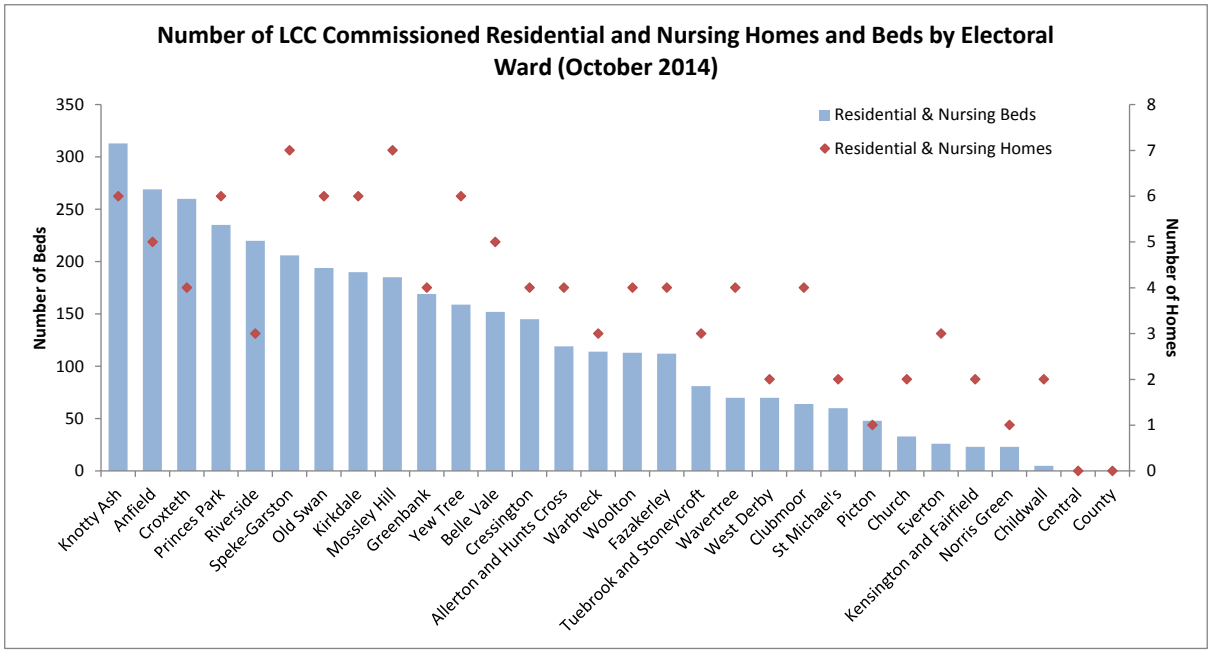
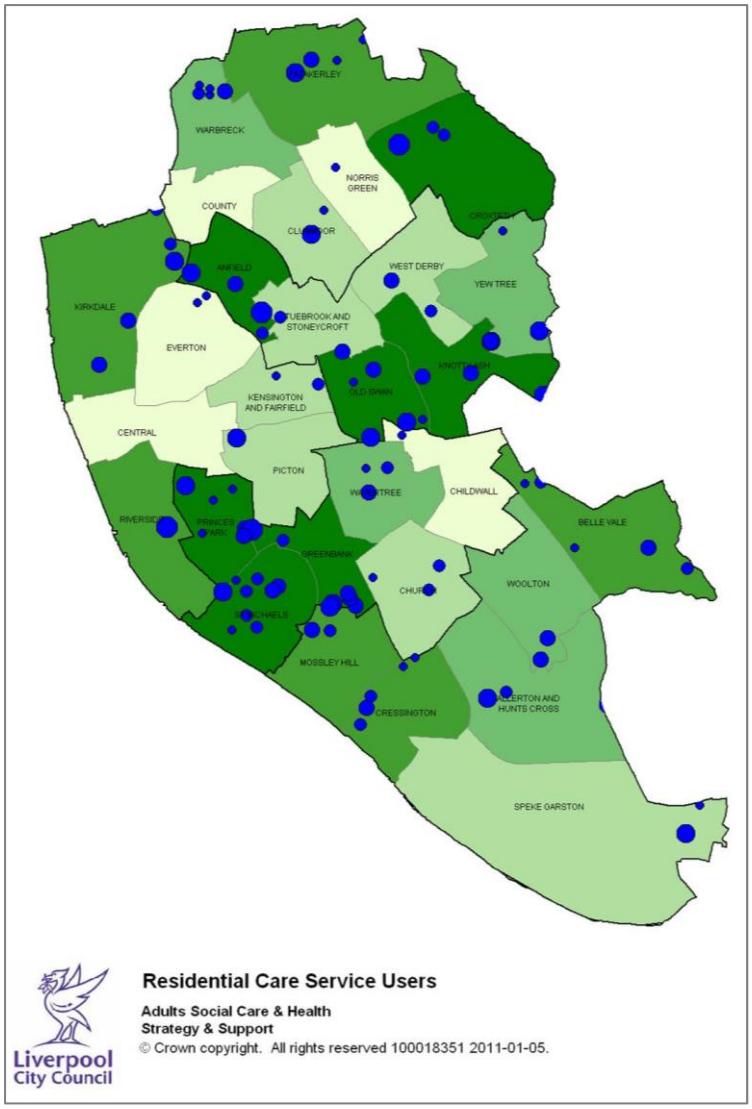


Chart 25: Number of LCC commissioned residential and nursing homes and beds by electoral ward (Source: Adult Social Care, October 2014)

Applying projected population figures to data from the 2011 Census the Projecting Older People Population System (POPPI) suggests that there will be a small increase in the number of older people living in a care home in Liverpool over the next five years. However by 2030 it is projected that there will be a 38% increase in this number equating to an additional 760 people, with a 50% increase in the number of over 85 year olds living in care homes which would be 460 more people. The increase in the cohort of people over 85 has substantial implications for service provision as they are more likely have more complex health and care needs.

Map 7 illustrates the geographic distribution of care homes across the city as well as all service users. The blue dots on the map indicate the location of a Residential or Nursing Home in Liverpool. The larger the dot means more people are currently in the home. The green thematic background is based on ward, so the darker the shade of green, the greater the number of care home placements in the ward. There is an obvious clustering of homes in areas where there are high volumes of placements showing that these facilities are well-placed to respond to demand. The challenge for these services is to become more outward-facing and to form links with their surrounding local communities.



Map 7: Residential care service users (Source: LCC Adult Social Care)

Table 13 illustrates the number of permanent **residential placement** support plans for older people provided by LCC. In 2014 there were 1,475 plans with almost half (48%) provided to those aged over 85 years. Three-quarters of the plans were for physical support whilst 15% were for support with memory and cognition.

Primary Support Reason	Age 65-74	Age 75-84	Age 85-94	Age 95+	Total
Physical Support - Access and Mobility Only	<5	<5	<5	0	8
Physical Support - Personal Care Support	119	397	482	85	1,083
Sensory Support - Support for Hearing Impairment	<5	<5	<5	<5	8
Sensory Support - Support for Visual Impairment	<5	5	<5	<5	15
Sensory Support - Support for Dual Impairment	<5	<5	<5	<5	4
Learning Disability Support	20	13	<5	<5	36
Mental Health Support	39	36	15	<5	91
Support with Memory and Cognition	30	88	89	16	223

Social Support - Asylum Seeker Support	<5	<5	<5	<5	5
Social Support - Substance Misuse Support	0	0	0	0	0
Social Support - Support for Social Isolation / Other	<5	<5	<5	<5	<5
Total	**218**	**547**	**599**	**111**	**1,475**

Table 13: Current permanent residential placement support plans by primary support reason (Source: LCC Adult Social Care)

Table 13 illustrates the number of permanent **nursing placement** support plans for older people provided by LCC. In 2014 there were 594 plans with 44% provided to those aged over 85 years. More than three-quarters of the plans (77%) were for personal care physical support whilst one in five were for support with memory and cognition or mental health support.

Primary Support Reason	Over 65 Plans
Physical Support - Access and Mobility Only	<5
Physical Support - Personal Care Support	456
Sensory Support - Support for Hearing Impairment	5
Sensory Support - Support for Visual Impairment	6
Sensory Support - Support for Dual Impairment	0
Learning Disability Support	8
Mental Health Support	42
Support with Memory and Cognition	72
Social Support - Asylum Seeker Support	<5
Social Support - Substance Misuse Support	0
Social Support - Support for Social Isolation / Other	<5
Total	**594**

Table 14: Current permanent nursing placement support plans by primary support reason (Source: LCC Adult Social Care)

It has been estimated by Adult Social Care that there will be a 3% increase in the demand for residential or nursing care over the next five years, predominantly a result of increasing life expectancy and subsequent care package durations. However the number of new permanent admissions into residential and nursing homes has been generally declining in recent years and this decrease is forecast to continue. This is largely due to the increased trend of placing service users into community based settings, with the aim of allowing service users to live independently in their own homes. This includes a shift towards the reablement model of care, which aims to reduce permanent admissions, increase in Extra Care Housing schemes, as well as adapting people's homes to enable them to live there longer without the need for Residential Care.

There were also 3,603 long term community based support plans for older people across the city.

14.6 Infection Control

Older care home residents, due to their advanced age and waning immunity, are susceptible to infection, including reactivation of latent infections such as shingles. A number of the city's care homes are ageing and date from the Victorian and Edwardian eras and some are listed. This poses challenges in the provision of safe residential care where the layout is complex and difficult to clean. Some have numerous corridors, rooms that are difficult to access, damp and ageing structures

(particularly in basement areas), narrow staircases, sloping floors, no lifts and a few are in a general state of decay. In order to make residential homes 'homely' they are carpeted with a lot of soft furnishings which can challenge cleaning efforts, particularly following a spillage or during an outbreak. In addition residential care homes are staffed by dedicated but non-clinical staff which might challenge the recognition of a single infection, incidents and outbreaks. The combination of the vulnerable patient cohort, the challenging environment and the largely non-clinical workforce (with variable training and support) can, together or separately, provide opportunities for infection transmission.

Since April 2013, Liverpool's infection prevention and control (IPC) community team has been directly commissioned by the Liverpool Director of Public Health. Each care home has a named infection control nurse and contact details to obtain advice or be able to report an incident/ outbreak. There is a daily outbreak report completed by the IPC team to support bed management across the city. It reports on outbreaks in care homes (as well as intermediate care) in terms of number of patients/ staff affected, the reason for the outbreak, the number of days closed and, where possible, a predicted date for re-opening. This is circulated to local Trusts (Aintree and the Royal) to support throughput, to Health Protection Leads and the adult social care team, Liverpool Local Authority, Liverpool Community Health and Liverpool CCG to support the urgent care agenda.

In 2014/15, there were a total of 74 outbreaks in Liverpool care homes, up from 59 recorded in 2013/14. All were norovirus related and there were no outbreaks of flu.

14.7 Home Care

There are many different types of home care and this approach can suit people if they need:

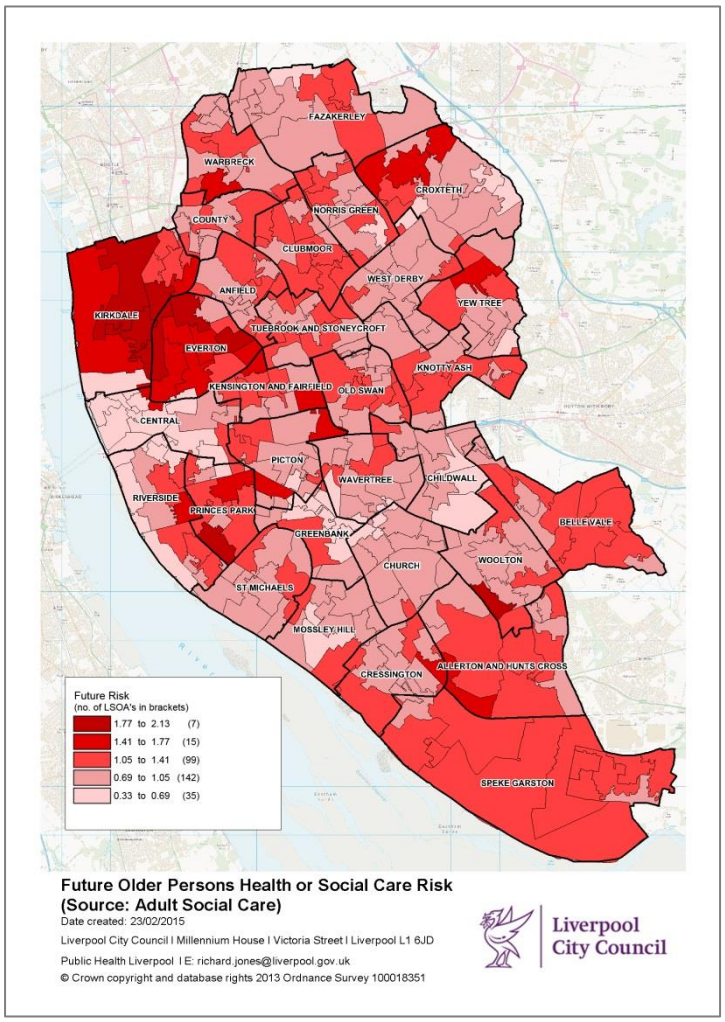
- personal care, such as washing or dressing
- housekeeping or domestic care
- cooking or preparing meals
- nursing and health care
- companionship

One fifth of care packages provided by LCC were for home care services, and in a typical week some 2,400 service users received home care from an external service provider. There were approximately 19,500 hours of home care provided each week by externally commissioned providers. There are currently seven externally commissioned providers in the city, all with varying volumes of service users and hours provided. Some 4 out of 10 service users require under 5 hours home care per week, and 7 out of 10 fewer than 10 hours. Only 4% (100 people) require more than 25 hours care per week.

The Projecting Older People Population Information System (POPPI) has estimated that there are 28,000 older people in Liverpool who are unable to manage at least one domestic task on their own (defined as household shopping, washing dishes, cleaning, or dealing with personal affairs), and 23,000 who are unable to manage at least one self-care activity on their own (which includes bathing, dressing, and taking medicines). This estimate is almost 12 times greater than the actual number of care packages provided by LCC. People who are deemed to have low or moderate need

are not provided with this type of support from LCC and either have to fund their care themselves or rely on relatives or friends to help or use services provided by Liverpool Charity and Voluntary Services. This number is expected to increase by a fifth over the next 10 years which may result in a greater demand on home care requirements.

Using a range of population, socio-economic, and health indicators, Map 8 shows those parts of the city where the greatest older person health and social care risk may be by 2020.



Map 8: Future older person's health or social care risk index (Source: Adult Social Care)

15 END OF LIFE CARE

15.1 Definition

The General Medical Council's definition of people approaching the end of life as those likely to die within the next 12 months[40]. This includes people whose death is imminent (expected within a few hours or days) and those with:

- advanced, progressive, incurable conditions
- general frailty and coexisting conditions that mean they are expected to die within 12 months
- existing conditions if they are at risk of dying from a sudden acute crisis in their condition
- life threatening acute conditions caused by sudden catastrophic events

Given this, any palliative care within the last 12 months of life is regarded as end of life care. However it has been acknowledged by NHS England that the trajectory of different conditions mean that for some, 'end of life care' refers to the last few years of life. In the case of sudden unexpected death, the predominant focus of 'end of life care' may be on the period following death.

15.2 National Policy Context

The Leadership Alliance for the Care of Dying People (LACDP) has published a new approach to caring for people in the last few days and hours of life[41] based on five new priorities of care:

1. The possibility that the person may die within the coming days and hours is recognised and communicated clearly, decisions about care are made in accordance with the person's needs and wishes, and then these are reviewed and revised regularly.

2. Sensitive communication takes place between staff and the person who is dying and those important to them.

3. The dying person, and those identified as important to them, are involved in decisions about treatment and care.

4. The people important to the dying person are listened to and their needs are respected.

5. Care is tailored to the individual and delivered with compassion – with an individual care plan in place.

The approach has been developed in response to recommendations in the Neuberger report produced by an independent panel reviewing the use and experience of the Liverpool Care Pathway (LCP) in England, which was phased out in July 2014.

The National Institute for Health and Care Excellence (NICE) has produced a quality standard for end of life care for adults that described 16 statements for health and social care staff[42]:

1. People approaching the end of life are identified in a timely way.

2. People approaching the end of life and their families and carers are communicated with, and offered information, in an accessible and sensitive way in response to their needs and preferences.

3. People approaching the end of life are offered comprehensive holistic assessments in response to their changing needs and preferences, with the opportunity to discuss, develop and review a personalised care plan for current and future support and treatment.

4. People approaching the end of life have their physical and specific psychological needs safely, effectively and appropriately met at any time of day or night, including access to medicines and equipment.

5. People approaching the end of life are offered timely personalised support for their social, practical and emotional needs, which is appropriate to their preferences, and maximises independence and social participation for as long as possible.

6. People approaching the end of life are offered spiritual and religious support appropriate to their needs and preferences.

7. Families and carers of people approaching the end of life are offered comprehensive holistic assessments in response to their changing needs and preferences, and holistic support appropriate to their current needs and preferences.

8. People approaching the end of life receive consistent care that is coordinated effectively across all relevant settings and services at any time of day or night, and delivered by practitioners who are aware of the person's current medical condition, care plan and preferences.

9. People approaching the end of life who experience a crisis at any time of day or night receive prompt, safe and effective urgent care appropriate to their needs and preferences.

10. People approaching the end of life who may benefit from specialist palliative care, are offered this care in a timely way appropriate to their needs and preferences, at any time of day or night.

11. People in the last days of life are identified in a timely way and have their care coordinated and delivered in accordance with their personalised care plan, including rapid access to holistic support, equipment and administration of medication.

12. The body of a person who has died is cared for in a culturally sensitive and dignified manner.

13. Families and carers of people who have died receive timely verification and certification of the death.

14. People closely affected by a death are communicated with in a sensitive way and are offered immediate and on-going bereavement, emotional and spiritual support appropriate to their

needs and preferences.

15. Health and social care workers have the knowledge, skills and attitudes necessary to be competent to provide high-quality care and support for people approaching the end of life and their families and carers.

16. Generalist and specialist services providing care for people approaching the end of life and their families and carers have a multidisciplinary workforce sufficient in number and skill mix to provide high-quality care and support.

15.3 Local Policy Context

Locally, work streams have been set up to address the issues highlighted by the recent changes in national policy.

The Healthy Liverpool Programme has pledged to enable people to be supported and die in a location of their own choosing; research suggests some 70% of people would prefer to die in their home rather than in hospital.

15.4 Place of Death Analysis

The Office for National Statistics records mortality from information collected when deaths are certified and registered. Place of death falls into three broad categories:

- **Hospital or some other 'Communal Establishment'**, in which case a unique code is assigned to it by the registrar. These establishments include nursing homes, residential homes, schools, religious establishments and hostels. Care homes include residential and nursing homes run privately, by the NHS or by local authorities and they range from independent sheltered accommodation to full nursing homes. People may have been long term residents or have been admitted shortly before they died.
- **"Home"** is defined as a person's usual place of residence, and excludes care homes or other establishments where people live communally.
- **"Elsewhere"** – possibly another private residence, a public place or not in a building

15.4.1 All Causes of Death by Age (2013)

In 2013, just over half of over 65 year old deaths in Liverpool occurred in a hospital setting. There was no statistically significant difference across the older person age groups for the proportion of deaths in hospital.

Those aged over 85 years were statistically significantly less likely to die at home than all older people aged over 65 years (14% compared with 21%), and were more likely to die in a care home

(29% compared with 18%).

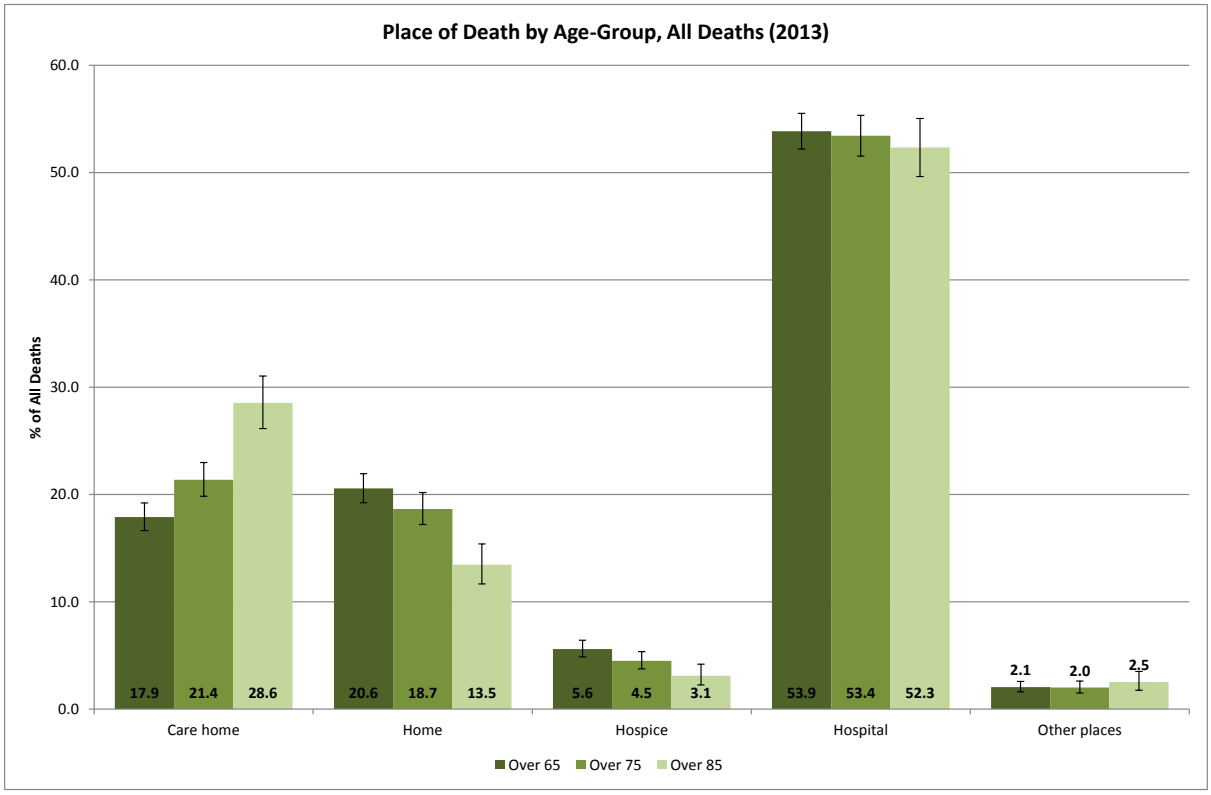


Chart 26: Place of death by age group, 2013 (Source: Open Exeter Primary Care Mortality Database)

15.4.2 Quarterly Trend – All Deaths

The charts below show the trend in place of death for Liverpool residents aged over, as well as under, 65 years.

Over 65 year olds are more likely to die in a hospital than those aged under 65 years (52% compared with 48%) although this difference is not statistically significant. Older people are less likely to die at home, although a fifth die in a care home which may be classed as their usual place of residence.

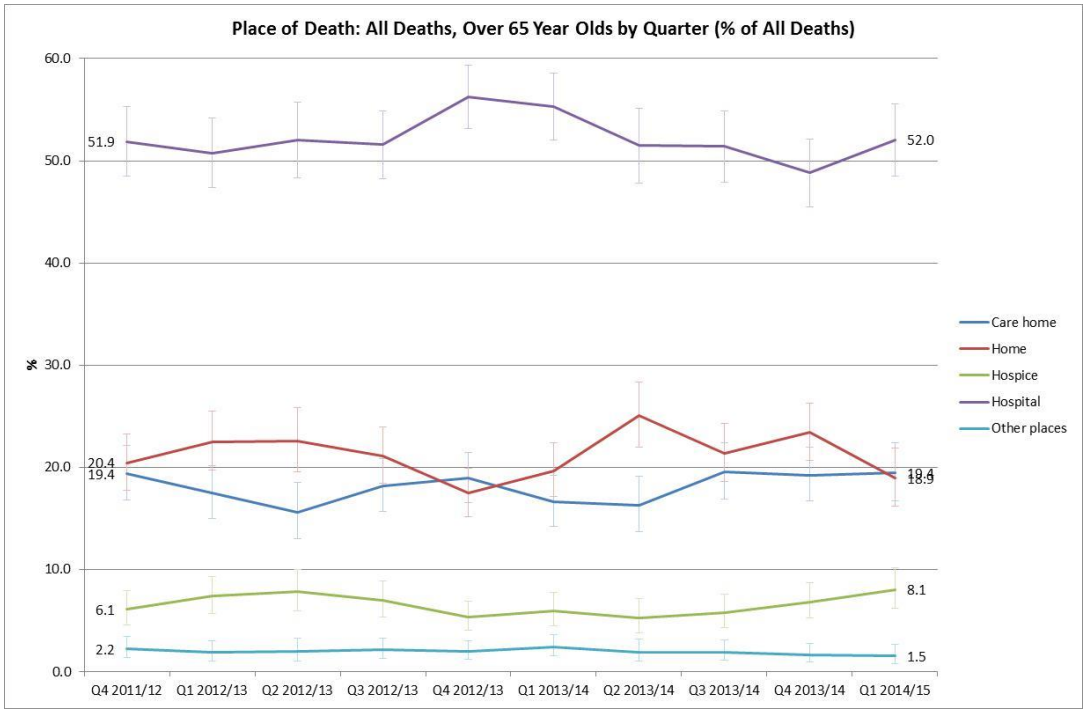


Chart 27: Quarterly trends in place of death, all deaths

15.4.3 Quarterly Trend – Disease Type

There are substantial variations in the place of death of older people for the main disease types of cancer, circulatory, respiratory, and mental and behavioural disease.

Chart 28 illustrates the percentage of deaths by place of death for these main disease types. It shows that 4 out of 10 care home deaths are from people with mental and behavioural disease, half of all deaths at home are from people dying from cancer, more than 9 out of 10 deaths in a hospice are from people dying from cancer, the proportion of hospital deaths are fairly evenly distributed amongst people dying from cancer, cvd, or respiratory disease.

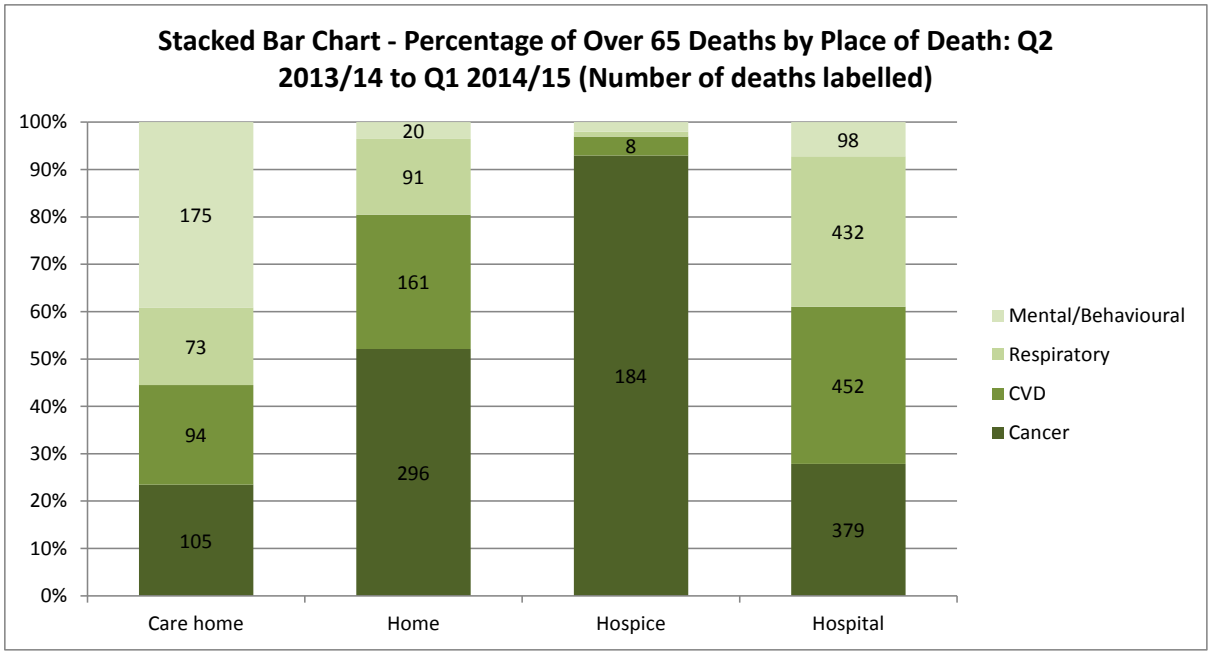


Chart 28: Percentage of over 65 deaths by place of death

15.5 Local Perceptions about Death and Dying

Earlier this year, Public Health Liverpool and Liverpool CCG conducted insight research with local people to understand how we communicate effectively with our local population about death and dying. Recent recommendations in this area have highlighted that as well as the changes that are happening in end of life care, there needs to be a 'national conversation' about dying to support this. The primary aim of this work was therefore to gain a solid understanding of a representative sample of the local population's views of death and dying and the appropriate language, communication and engagement approaches to begin the conversation around this topic, so that this becomes the social norm.

Some of the more pertinent findings following a series of focus groups and interviews included:

- Death and dying is recognised as a very difficult topic for people to discuss, despite the recognition that it was an inevitable part of life. Fear and heightened emotions hamper people's efforts to address the topic.
- Superstition is also a barrier to engagement with the belief that somehow talking about it will bring death closer.
- Family dynamic is strong in Liverpool and can also be a barrier to initiating conversations around this topic. Younger people struggled most with the concept of death and dying and as a result were most resistant to discussing the topic with loved ones.
- There is a need for a public facing communications to initiate and facilitate discussions and it was evident that individuals need help to negotiate this difficult and sensitive topic by disaggregating it into clear and practical steps or tasks.
- Older participants in particular were fearful about the quality of end of life care; loss of

dignity and capacity were primary concerns.

- Overall it was felt that further guidance was needed, so that individuals are able to plan for their own deaths and have the necessary conversations to share this with their loved ones. Clear advice and links to local resources/organisations that can help with this and in particular, guidance and support in preparing for and thinking about end of life care is needed that should involve the whole family.

The findings of this insight research will be used to inform future public facing communications around this topic and to build on the work of local initiatives working to encourage the conversation around death, dying and loss. Where possible, findings will also be used to inform communication approaches used by health professionals and organisations in end of life care, as well as resources to support people during this time.

16 RECOMMENDATIONS

The following are recommendations based on the findings from this needs assessment which may be taken into consideration.

Population

- Liverpool's older population (those aged over 65 years) has been increasing in recent years, and is projected to continue to increase, with the "age spike" predicted by LCC's Adult Social Care Team to occur by 2025. In just over 20 years from now Liverpool's older population is expected to have increased by an additional 31,000 residents (46% growth), with those aged over 85 years more than doubling. Although strategies, such as the Healthy Liverpool Programme, have recently been implemented that take this ageing population into account, further long-term planning may be required modelling the potential impact on health and social care services from this increasing population cohort.

- The geographic distribution of Black and Minority Ethnic older populations across the city that have varying levels of need and potential cultural barriers to accessing services (e.g. screening) may need to be considered when planning and commissioning health care services.

Burden of Disease

- There is a large degree of variance of older person mortality rates across the city by GP practice, with the all-cause mortality rate in the practice with the highest rate almost five times that of the practice with the lowest rate. Statistical process control charts for the main disease types may be considered highlighting those practices that are "outliers" and the reasons why be established. Further work, if deemed necessary, to be undertaken with identified practices.

- The increasing prevalence of co-morbidities (people living with 2 or more long term conditions) is one of the major challenges facing the health and care system. People with multiple long term conditions require more complex care and support packages, and often face poorer health outcomes. Nationally, the overall prevalence of long term conditions is projected to remain relatively stable over the next 10 years, however the prevalence of comorbidities is expected to increase by more than 50%. Co-morbidity increases rapidly with age. Within Liverpool 70% of people in their 80's have 2 or more long term conditions.

- Many of the health issues faced by older people are linked to unhealthy lifestyle factors earlier in life. Focussing attention on prevention of smoking, obesity and lack of exercise will likely ensure that future generations of older people will live healthier lives.

- Improving opportunities for Self Care, including integrated / person centred care, may reduce the impact of co-morbidities on secondary care.

Screening

- Cancer screening uptake rates in Liverpool are low, and the city is not hitting national targets. Approximately 300 patients per annum over the age of 60 are identified as having a definitive abnormal test result due to the bowel cancer screening programme, yet the screening coverage in Liverpool is significantly below the national target and is the lowest on Merseyside. Efforts to increase cancer screening coverage for the bowel, breast and cervical screening programmes should identify more patients with the early symptoms of the disease. Increasing bowel screening coverage to the national target of 60% could potentially identify an additional 100 patients with abnormal findings a year.

Hospital Admissions

- Liverpool has a higher than expected number of both elective and emergency hospital admissions for older people when compared with England (8% and 11% higher respectively), even when adjusted for age, sex and deprivation. One of the aims of the Healthy Liverpool Programme is to reduce the number of hospital admissions for older people, to prevent them reaching crisis point where an admission becomes inevitable. It is suggested that further analysis focusing on re-admissions, length of stay, surgical procedures, waiting times, to give some examples, be undertaken, particularly for the main admission groups, to better understand why older people are being admitted to hospital.

- In 2013/14 Liverpool had an Ambulatory Care-Sensitive (ACS) emergency admission rate that was statistically significantly higher than nationally. These are avoidable admissions which should be effectively managed and treated in primary care. Increasing vaccination rates (flu, pneumococcal), and improved diagnosis and management of long term conditions within primary care should help to reduce ACS admissions.

Healthy Lifestyles

- Generally speaking in comparison with national figures, Liverpool's older population is in poor health, particularly in the more deprived areas of the city. Older people are less likely to participate in moderate-intensity exercise and spend almost 6hours sitting or reclining on a typical day. Almost a fifth are smokers, a fifth are obese, and a quarter of those who drink alcohol do so at hazardous or harmful levels. The benefits of a healthy lifestyle for older people have been highlighted in this needs assessment, so a concerted plan to increase physical activity and reduce smoking prevalence and alcohol consumption among older people should be considered.

Dementia

- Dementia in now the second biggest cause of death in Liverpool's older population, and the number of dementia deaths have more than tripled over the last decade. However, only 3.7% of older people are on a GP dementia register suggesting, perhaps, that patients with dementia are not being identified. The number of patients on this register is below the

expected number according to the Projecting Older People Population Information System (POPPI). The All-Party Parliamentary Group on dementia reported that only a third of people with dementia were getting a diagnosis. Liverpool CCG has set a local target to increase dementia diagnosis rates and provided financial incentives to help this be reached. However, a campaign to raise awareness of the symptoms of dementia for both patients and GP's may also be required, to run in conjunction with the national "Dementia Friend" campaign by Public Health England.

- Research has shown that reducing the risk of developing dementia can be supported through the adoption of a healthy lifestyle, with diet and maintaining a healthy weight as well as increased physical activity playing a significant role in reducing risk.

Carers

- More than half of Liverpool's 9,000 older people who provide unpaid care do so for more than 50 hours per week which is significantly higher than the national average, and the highest rate of the core cities. Providing unpaid care can cause psychological distress or depression, have a negative impact on physical health, and can even increase the likelihood of premature death. Additional research into the needs of older carers and the amount and type of support they may need should be considered, whilst also contemplating current financial constraints.

Care Home Provision

- Both nationally and locally there continues to be a shift in policy towards assisting older people in living in their own home and more independently, which have contributed to a recent reduction in the number of new permanent admissions into care homes. In the short-term this decrease is expected to continue, but long-term projections suggest that by 2030 there will be a 38% increase in the number of older Liverpool residents living in a care home, with a 50% increase in those aged over 85 years. Current care home provision could not sustain this potential future demand, so it is recommended a feasibility study be conducted in this area.

General Recommendations

1. Obviously older people live across the whole of Liverpool. However there are some parts of the city that recur throughout this needs assessment that may benefit from further analysis or require specific, tailored neighbourhood plans. These include:

    - **Kirkdale** – high, and increasing, numbers of older people in poor health. High isolation risk, and high number of older carers providing 50+ hours a week of unpaid care. There are a large number of residential and nursing homes in this area. High future health or social care risk.
    - **Everton** – high numbers of older people in poor health and with significantly high mortality rates and high dementia prevalence. High isolation risk, and high number of older carers providing 50+ hours a week of unpaid care. There are a low number

of residential and nursing beds in this area. High future health or social care risk.

- **Croxteth** – high number of older people with high emergency hospital admission and mortality rates, and high dementia prevalence. Parts of the area have a high isolation risk. There are a large number of residential and nursing beds in this area.
- **Woolton** – high numbers of 65+ and 90+ year olds, and high emergency hospital admissions. Parts of the area have a high isolation risk.

2. The rising elderly population over the coming decade will increase demand on the health and care system at a time of severe financial pressure. There is already a significant body of evidence that identifies best practice, however implementing this is often a challenge. It is recommended that a systematic evidence review be undertaken to identify examples of successful implementation of best practice guidelines. Particularly around:

    - Increasing screening rates amongst older people
    - Increasing physical activity rates amongst older people
    - Reducing older person emergency hospital admissions
    - End of life care

3. Due to the range of topics covered within this Health Needs Assessment, it has not been possible to cover each in depth. It is recommended that future needs assessments are conducted, that target specific populations such as frail elderly residents for example, and that topics be tailored to specific service areas.

4. The needs assessment has identified some of the following potential gaps in both information and/or knowledge concerning Liverpool's older population.

    - A definitive economic evaluation of the impact on all public sector and stakeholder services of the projected increase in the numbers of older people living in the city.
    - Dental health is a gap in terms of both data and knowledge in how our older residents access or view services.
    - The extent of social isolation and/or loneliness amongst Liverpool's older people needs to be explored further and ways to address this issue be determined.

5. Better data linkage between the different health and social care systems be explored allowing the full healthcare pathway of older people to be interrogated, which would facilitate better planning of services and support integrated working between front line health and care professionals. This would require a "buy-in" from Liverpool's GP's.

REFERENCES

1. Parliament Report; The ageing population. London: Parliament; 2010. [Accessed 9th February 2015]. Available from http://www.parliament.uk/documents/commons/lib/research/key_issues/Key-Issues-The-ageing-population2007.pdf
2. Office for National Statistics. Statistical Bulletin; Births in England and Wales, 2013. London: ONS. 2014. [Accessed 9th February 2015] Available from http://www.ons.gov.uk/ons/dcp171778_371129.pdf
3. Liverpool Clinical Commissioning Group; Healthy Liverpool Programme. Liverpool: Liverpool Clinical Commissioning Group. [Accessed 9th February 2015] Available at http://www.healthyliverpool.nhs.uk/
4. Liverpool City Council. The Mayoral Health Commission; all change – the platform to a healthier Liverpool. Liverpool: Liverpool City Council. [Accessed 9th February 2015] Available at http://liverpool.gov.uk/media/770697/healthcommissionerport2.pdf
5. National Health Service Act 2006. London; Legislation. 2006. [Accessed 9th February 2015] Available at http://www.legislation.gov.uk/ukpga/2006/41/pdfs/ukpga_20060041_en.pdf
6. Local Government Association; Better Care Fund. London: Local Government Association. 2015. [Accessed 20th February 2015] Available at http://www.local.gov.uk/health-wellbeing-and-adult-social-care/-/journal_content/56/10180/4096799/ARTICLE
7. Liverpool City Council. Health and Wellbeing Board Minutes February 2014. Liverpool: Liverpool City Council 2014. [Accessed 20th February 2015] available at http://councillors.liverpool.gov.uk/documents/s132217/BCF%20Report%20Draft.pdf
8. NHS England. Integrated personal commissioning prospectus; making a reality of health and social care integration for individuals. London: NHS England, 2014. [Accessed 20th February 2015] Available at http://www.rcpsych.ac.uk/pdf/IPC%20PROSPECTUS.pdf
9. Department of Health. National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care. 2012. [Accessed 20th February 2015] Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf
10. Health and Social Care Information Centre. Mental capacity act deprivation of liberty safeguarding collection. 2014. [Accessed 20th February 2015] Available at http://www.hscic.gov.uk/dols
11. Legislation. Care Act 2014, chapter 23. [Accessed 9th February 2015] Available at http://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf
12. Age UK. Loneliness and Isolation Evidence Review. London: Age UK. 2014. [Accessed 20th February 2015] Available at http://www.ageuk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation.pdf?dtrk=true
13. Age UK. Age and…multiple discrimination and older people; a discussion paper. London; Age UK. 2005. [Accessed 20th February 2015] Available at http://www.ageuk.org.uk/Documents/en-GB/For-professionals/Research/Age%20and%20Multiple%20Discrimination%20(2005)_pro.pdf?dtrk=true
14. Office for National Statistics. Looking back to look forward: lessons from four birth cohorts

for ageing in the 21st Century. London: Office for National Statistics. 2010
15. Liverpool City Council. Annual Report of the Director of Public Health 2013-2014. Liverpool: Liverpool City Council. 2014
16. WHO. Updated projections of global mortality and burden of disease, 2002-2030: data sources, methods and results. 2005.
17. PHE. NHS cancer screening programmes. 2014. London; Public Health England [Accessed 20th February 2015] Available at http://www.cancerscreening.nhs.uk
18. Kings Fund. Emergency hospital admissions for ambulatory care-sensitive conditions: identifying the potential for reductions. London: King's Fund. 2012. [Accessed 10th February 2015]. Available at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/data-briefing-emergency-hospital-admissions-for-ambulatory-care-sensitive-conditions-apr-2012.pdf
19. Department of Health. Green Book; influenza. London: DH. 2014. [Accessed 10th February 2015]. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/385226/Green_Book_Chapter_19_v8_2.pdf
20. Department of Health. Green Book; pneumococcal. London: DH. 2013. [Accessed 20th February 2015]. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/263318/Green-Book-Chapter-25-v5_2.pdf
21. Dominguez A, Effectiveness of Pneumococcal Vaccination for Elderly People in Catalonia, Spain: A Case-Control Study. Clinical Infectious Diseases: Oxford. 2005.
22. Moberley S, Holden J, Tatham DP, Andrews RM. Vaccines for preventing pneumococcal infection in adults. Cochrane Database of Systematic Reviews 2013, Issue 1. Art. No.: CD000422. DOI: 10.1002/14651858.CD000422.pub3
23. Department of Health. National Service Framework for Older People. 2001. [Accessed 10th February 2015] Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198033/National_Service_Framework_for_Older_People.pdf
24. King's Fund. Avoiding hospital admissions; What does the research evidence say? [Accessed 10th February 2015]. Available at http://www.kingsfund.org.uk/sites/files/kf/Avoiding-Hospital-Admissions-Sarah-Purdy-December2010.pdf
25. Wang Z. Age-dependent decline of association between obesity and coronary heart disease: a cohort study in a report Australian Aboriginal community. BMJ Open: London. 2013
26. Gott, M. Are older people at risk of sexually transmitted infections? A new look at the evidence. 2004. Reviews in Clinical Gerontology.
27. Liverpool City Council. Liverpool's House Condition Survey 2010. Liverpool: Liverpool City Council
28. Marmot, M. Fair Society; healthy lives. 2010. London: Institute of Health Equity
29. Age UK. Loneliness and Isolation Evidence Review. (undated). London: Age UK
30. http://www.campaigntoendloneliness.org/
31. The Alzheimer's Society. Accessed on 1st November 2013 at: http://www.alzheimers.org.uk/infographic
32. The Alzheimer's Society 2013.What is Dementia? Factsheet 400LP. Accessed at:

http://www.alzheimers.org.uk/site/scripts/download_info.php?downloadID=1092
33. NHS Choices. Falls. 2015. [Accessed 10th February 2015] Available at http://www.nhs.uk/conditions/Falls/Pages/Introduction.aspx
34. ROSPA. Facing up to falls. 2014. [Accessed 11th February 2015] Available at http://www.rospa.com/home-safety/advice/older-people/
35. Rubenstein LZ.. Falls in older people: epidemiology, risk factors and strategies for prevention. 2006. Age Ageing.
36. NICE. Falls: assessment and prevention of falls in older people. 2013. [Accessed 1st March 2015] Available at http://www.nice.org.uk/guidance/cg161/resources/cg161-falls-full-guidance2
37. Social Care Institute for Excellence. Maximising the potential of reablement. 2013. London: SCIE
38. Collard, RM. Prevalence of frailty in community-dwelling older persons: a systematic review. 2012. Journal of American Geriatric Science.
39. Buckner L. Valuing Carers. 2012. London: Carers UK
40. GMC. End of life treatment and care: good practice in decision making. Undated. London: GMC
41. Leadership Alliance for the Care of Dying People. One Chance to Get it Right; improving peoples experience of care in the last few days and hours of life. 2014. London: LACDP
42. NICE. Quality standard for end of life care for adults (QS13). 2011. London: NICE