

Halton Joint Strategic Needs Assessment 2015/16

Older People: Background, key findings and methodology



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Please quote the JSNA

We would like to know when and how the JSNA is being used. One way, is to ask people who use the JSNA when developing strategies, service reviews and other work to quote the JSNA as their source of information.

List of Abbreviations

BCF	Better Care Fund
CCG	Clinical Commissioning Group
DoLs	Deprivation of Liberty Safeguards
HBC	Halton Borough Council
HNA	Health Needs Assessment
HSCIC	Health and Social Care Information Centre
HWB	Health and Wellbeing Board
IMD	Index of Multiple Deprivation
IPC	Integrated personal commissioning
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
JWS	Joint Working Agreement
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
ONS	Office for National Statistics
OPEN	Older People's Empowerment Network
PHE	Public Health England
POPPI	Projecting Older People Population Information
STP	Sustainability and Transformation Plan
SUS	Secondary user system (used for accessing hospital admissions data)
UK	United Kingdom

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1. Introduction

The population of the UK has fluctuated greatly in the past 100 years. 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.^[1]

However, at the same time the number of babies being born in the UK has been steadily decreasing since 1964. 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. 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.^[2]

The population aged 65 and over will increase by 65% in the next 25 years with the older population making up nearly a quarter of the total population by 2037, from 16% in 2012.

Within this, the ‘oldest old’ is the fastest growing age group in the population. In 2013 it was estimated that there were over 475,000 people aged 90 and over in the UK, of whom 13,780 people were aged over 100 and 710 were aged 105 or older. By 2035, it is expected that there will be nearly 1.5 million people aged 90+ in the UK, of whom nearly 100,000 will be centenarians.^[3]

The scale of demographic change over the next 25 years is dramatic and has never been seen on this scale before. For the first time in history older people will outnumber the number of children under five years old.

Older people are as diverse a group of people as any other section of the population and within the overall numbers of older people quoted above lie significant differences in terms of characteristics, living arrangements, experiences and health outcomes. Socio-economic factors have a major impact on the experience of later life, resulting in very significant inequalities in life expectancy, and even greater inequalities in the length of time during which people can expect to live in good health. Prevalence of disability within older age groups also varies widely, depending on socio economic factors.

Less well known is that older people can be net contributors to the economy and there may even be the opportunity for councils to harness this demographic change for local economic benefit. However, not addressing ageing collectively and strategically now will store up problems for future years, placing further strain on social care funding and provision. Preparing for an ageing society is a place shaping opportunity and applying an ‘ageing lens’ to local functions will help to understand what needs to be done to improve the quality of life of this growing segment of the population. Older people make a huge contribution to society and need to be part of this conversation.

The impact of an ageing society extends well beyond social care and health, embracing all areas that affect older people’s lives, including transport, housing, culture and leisure and the built environment.

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 older people. The age profile of Halton's residents is slightly different to the national profile, with the new town development in the 1960s producing a population structure with a greater proportion of working age adults. However, the pattern of increasing proportions of the population being amongst those in the older age groups is now being replicated in the borough.

The chapters in this Joint Strategic Needs Assessment (JSNA) aim to set out the population trends within Halton and explore the various challenges these bring for local service providers. In addition to an overview of the health of older people in the borough, the needs assessment is structured around a number of key themes (see section 4.2.2. for a list of chapters):

These themes were selected in consultation with partner organisations across the borough, including Halton Clinical Commissioning Group (CCG) and Halton Borough Council (HBC) People and Economy Directorate, Age UK, Halton OPEN,^[a] Healthwatch and Halton and St Helens Council for Voluntary Services. They take us through older age from being an active, healthy older person to one who is living with a long-term health condition, through living independently to needing support to live independently or the need to live in a care home. They also cover some key issues that relate to older age such as dementia, safeguarding and end of life care.

a) OPEN = Older People's Empowerment Network

2. Policy Context for JSNA

2.1. What is JSNA?

The Joint Strategic Needs Assessment (JSNA) is a systematic way of assessing the health and social needs of the local population. The JSNA should enable strategic partnerships and commissioning leads to make informed decisions about local action and services across a wide range of needs. It not only looks at the overall health and social needs of older people across the borough, but considers inequalities in outcomes and experience for specific groups. This relates to older people living in areas of deprivation, to age and gender, to disability, and to vulnerable groups.

Increasingly JSNAs are being seen as a process of continuous development and improvement, rather than single documents produced once every few years.

Whilst there are no direct policy implications in revising the JSNA in itself, the findings should inform commissioning decisions. As such the findings may impact on policy and commissioning decisions. The value of the JSNA lies in the degree to which it is understood and valued by strategic partnerships and commissioning leads - the extent to which it is a useful tool to inform their decision making. To fulfil this, it needs their active engagement to ensure it is 'fit for purpose'.

The definition from the Department of Health's JSNA Guidance^[4] is:

"Joint Strategic Needs Assessment describes a process that identifies current and future health and wellbeing needs in light of existing services and informs future service planning taking into account evidence of effectiveness".

JSNA identifies 'the big picture', in terms of the health and wellbeing needs and inequalities of a local population. The basis of a high quality and robust JSNA is the analysis of current and predicted health and well-being outcomes. The JSNA process should be underpinned by partnership working, community engagement and evidence of effective interventions to address the issues identified.

Breaking the phrase down into its constituent parts is useful in defining what it means in practice:

Joint -The duty to undertake JSNA was introduced in 2007 in recognition that strategic planning for health and wellbeing was best done in partnership, and based on evidence. It is intended to provide a powerful model for joint working in every locality. The Health & Social Care Act sets out the role that JSNA, and its local evidence of need, should play in the work of the Health & Wellbeing Board (HWB) and the Joint Health & Wellbeing Strategy (JHWS).

Thus, a key element of the JSNA is that it should involve all the important stakeholders in identifying needs and acting upon them. Crucially the JSNA provides a new framework for health and social care to collectively work in partnership to identify the needs of the population they serve and to work together in commissioning services to meet those needs.

Strategic - the JSNA should identify those needs and service requirements that are most relevant and important to its population. The needs assessment process should provide health and social care organisations with evidence based identification of the key needs of its population and should therefore define the strategic direction in commissioning of services. This strategic direction should consider both today's and future health and social care needs.

Needs assessment - there are many definitions of needs assessment. In order to identify health and wellbeing needs the assessment process should make use of existing information, identify information gaps and should include the views of service users, patients and the population. Importantly the needs assessment must include outputs that can be translated into actions for the commissioning and delivery of health and social care services, health improvement and wellbeing programmes and other interventions. The process should consider social inclusion and should identify inequities and inequalities in health and well-being and in current service delivery.

2.2. How should a JSNA be done?

Whilst producing a JSNA is a mandatory requirement, keeping with the 'light touch' approach from national government, Department of Health guidance on the preparation of the JSNA allows for local initiative and discretion. The guidance does however make it clear that the JSNA should be seen as an evolving process of understanding local needs and establishing agreed priorities, rather than as a traditional planning document to be produced at a single point in time.

2.3. Local responsibility for developing the JSNA

The Health & Wellbeing Board has overall responsibility for the JSNA. Its development is led by the public health team.

Although the JSNA has been in existence since 2008 and has been used by commissioners to inform decision making, the impact of the Marmot review on health inequalities, has laid the foundations for local areas to relook at their approaches. The life course approach advocated by Marmot has been used in the development of the Health & Wellbeing Strategy and its action plans and is now used to summarise the JSNA on an annual basis.

A steering group, made up of a wide range of members from organisations, developed a framework for this older people's JSNA. 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 for Older People

3.1 National

3.1.1. 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.

In April 2013, HBC and NHS Halton CCG entered into a 3 year Joint Working Agreement (JWA) for the commissioning of services for people with Complex Care needs. With the introduction of the Better Care Fund (BCF) during 2015, a revised JWA, taking effect from 1st April 2015, was agreed to include the BCF allocation for 2015/16.

The focus on joint working and the pooling of resources between HBC Adult Social Care and NHS Halton CCG has continued to develop and strengthen since the introduction of the original JWA in 2013 and we currently have a pooled budget in the region of £42 million pounds.

Both NHS Halton CCG and the Council are committed to further developing our integrated approach to service delivery and transformation to improve the Health and Well-Being of Halton residents. The management of the current arrangements has been extremely successful, improving outcomes for individuals in addition to moving from a position of overspend for both organisations in relation to associated expenditure to that of financial balance.

As such both organisations are continuing with the current arrangements in place and have entered into a new JWA which will continue for another 3 years, until 31st March 2019.

The development of the JWA has been possible under Section 75 of the Health and Social Care Act 2006, which allows local authorities and health organisations to pool funds. The Agreement itself provides the legal framework in which HBC and NHS Halton CCG work together in order to achieve their strategic objectives of commissioning and providing cost effective, personalised, quality services to the people of Halton.

3.1.2. 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.

Halton's Better Care Fund (BCF) in 2016/17 builds on the work undertaken by the fund in 2015 and develops further some key areas to enable people to access services they need more quickly and closer to their own home. The BCF focuses resources on a wide range of integrated, complex and

responsive services either fully funding services or contributing additional resources to increase capacity. This approach supported the achievement of key targets in the last BCF. In addition the BCF supports maintaining the eligibility criteria for social care and the Plan is integrated with the local Sustainability and Transformation Plan (STP).

NHS Halton Clinical Commissioning Group (CCG), Halton Borough Council (HBC) and Public Health are driven by a burning ambition to make Halton a healthier place to live and work, with a commitment to ensuring that local people get the right care and support at the right time and in the right place. We will continue to uphold the rights of people under the NHS Constitution, appropriate legislation e.g. Care Act 2014 etc. and positively push the boundaries of quality standards and patient experience.

Our vision is **‘to involve everyone in improving the health and wellbeing of the people of Halton’**.

Our purpose is to improve the health and wellbeing of the population of Halton by empowering and supporting local people from the start to the end of their lives by preventing ill-health, promoting self-care and independence, arranging local, community-based support whenever possible and ensuring high-quality hospital services for those who need them.

We want to support people to stay well in their homes, in particular to avoid crises of care that can result in hospital admission. General practices will support and empower individuals and communities by promoting prevention, self-care, independence and resilience.

We will work with local people and with partner organisations including healthcare providers and the voluntary sector. This will ensure that the people of Halton experience smooth, co-ordinated, integrated and high-quality services to improve their health and wellbeing.

3.1.3. 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. 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.^[7]

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

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.

Halton was not one of the pilot sites. However, moving forward, the learning from these sites will need to be considered.

3.1.4. 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:^[8]

- 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.

3.1.5. Safeguarding/ Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005.^[9] 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.

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.

3.1.6. 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.^[10] 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). 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.

3.1.7. NHS Five Year Forward Plan

The NHS Five Year Forward View recognises that, with an ageing population, increased long term conditions, and funding for health that is not keeping pace with demand, promoting well-being and preventing ill-health will become even more important to the capacity and financial viability of the NHS. Providing better support for carers is therefore critical to the future of the NHS.

3.2. Local

3.2.1. Joint Health and Wellbeing Strategy

As a result of the Health and Social Care Act 2012, each local area was obliged to set up a new Health and Wellbeing Board. One of the key responsibilities of the Health and Wellbeing Board was to develop a Health and Wellbeing Strategy to meet the needs of the local population. Halton's first Health and Wellbeing Strategy covered the period 2013-2016 and set out the vision for Health and Wellbeing in Halton. The Strategy was the overarching document for the Health and Wellbeing Board outlining the key priorities the Board has focussed on over the past three years. As the current strategy finishes at the end of 2016, the development of the next Health and Wellbeing Strategy is currently underway.

The new Strategy will not only have to ensure it remain evidence-based, using the JSNA to inform local priorities but is aligned with the developing system level plans across local authorities and the NHS. Since 2013 when first strategy was published there have been significant developments within the policy landscape. Of particular importance is the agreement between the government and the leaders of the Liverpool City Region to devolve a range of powers and responsibilities to the Liverpool City Region Combined Authority and the NHS Five Year Forward View requirement to produce a five year Sustainability and Transformational Plan (STP).

It is envisaged that many of the current priorities will remain, although perhaps with a different focus. They have yet to be agreed but in line with One Halton (see below) are likely to be:

- Child development
- Keeping people well
- Long term conditions
- Mental health
- Older people

Apart from child development all of these have relevance for older people, not just the older people specific priority.

3.2.2. Adult Social Care: People and Economy Directorate, Business Plan 2016 – 19

The Transformation Programme is a joint approach between Adult Social Care and the NHS to deliver personalisation and innovative approaches to support self-care, building on the work that has already been progressed in the borough. The 3 objectives of the programme are prevention, early intervention and managing complex care and care closer to home.

- Social care in practice
- Active ageing
- Telecare and telehealth
- Mental health service re-design
- Integrated hospital discharge teams
- Community Multi-disciplinary teams (MDTs)
- End of life services

3.2.3. One Halton

One Halton has emerged following the production of the Strategy for General Practice Services in which a new care model was set out focusing on integrated health and social care services working in the community. The goal of One Halton is to create a health care system that:

- works around each individual's needs
- supports people to stay well, and
- provides the very best in care, now and for the future

The objectives that have been developed for One Halton are:

- To work better together regardless of discipline
- To find or identify those 'hidden' people who don't access care
- To treat and care for people at the right time, in the right place by the right people

- To help people stay healthy and keep generally well
- To provide the very best in care, now and in the future

In moving One Halton forward, five areas of focus have been agreed. They are:

- Older people
- People with Long Term Conditions
- People with mental health conditions
- Families and children, and
- The generally healthy

3.2.4. Well North

Well North is a Department of Health response to the Due North Report which highlighted the disparity in wealth and circumstances between the North and the South of England. The DH Well North team allotted up to £9 million to be available to nine local areas to improve health via innovative approaches.

The Well North principles are to:

- Address inequalities by improving the health of the poorest, fastest
- Increasing resilience at individual, household and community levels
- Reducing levels of worklessness.

Well North recognised that for health inequalities to be addressed effectively, interventions must be built on developing community based programmes, which enable, empowerment, control, self-determination and the freedom to lead lives that people have reason to value. Designing such an environment will deliver healthy behaviours and match the emotional needs of people.

Halton's successful bid includes the following approaches:

- An extension of the new One Halton concept with an all-system approach to improve outcomes.
- Development of community assets into Intergenerational Family Centres supporting local communities.
- Multidisciplinary teams too offer services to children, young people and families and older people in the centres and via outreach into the community.
- It will target the 10% poorest people in the Borough including
- It will look to support paediatricians and geriatrician outreach into the communities.
- It will support the Cultural manifesto and social/community movement in prevention, self-care and wellbeing.

3.2.5. Healthy New Towns

Healthy New Towns provides an opportunity for Health and social care organisations, alongside planning and development agencies to consider novel approaches to prevention and the delivery models of care. Creating an environment where health and care are at the heart of the physical environment and help to shape communities where good health and wellbeing opportunities are built in to urban design and the physical infrastructure and where community psyche reflects a sea change people's approach to living well, living long and living independently.

3.2.6. Other local plans of relevance

There are a wide range of local strategies not mentioned above that will impact on, and give consideration to the needs of older people. The [Core Strategy local plan](#) is the strategic local plan for the borough. It sets out the spatial vision for the borough through to 2028, and a range of strategic objectives and policies. It was [adopted](#) in April 2013. It describes how land use will be developed to facilitate housing, economic development and regeneration and health. The Local Transport Plan considers the needs of those with disability and older people as does the Strategic Housing Market Assessment.

3.3. National Outcomes Frameworks

In recognition of the changes to the health and social care system, as a result of the Health & Social Care Act, three new outcomes frameworks have been developed:

- Public Health Outcomes framework
- NHS Outcomes Framework
- Social Care Outcomes Framework

There are many indicators which specifically look at the health and wellbeing of older population, with more being relevant. They are used throughout the JSNA.

4. Methodology

4.1. Local approach

As detailed in section 2 there is no set way of developing the JSNA. Locally, it was agreed that a standard approach to developing the individual elements of the JSNA may not be the most appropriate. Some issues may be best dealt with by short 'profiles' e.g. the section on detailing the population breakdown and socio-economic circumstances of older people in the borough. For other issues in-depth needs assessments would be more appropriate.

A number of strategies were written during 2014 and 2015. These include those written to support health & wellbeing strategy priorities as well as other public health, CCG and HBC priority issues. JSNA chapters on a range of long term conditions and on adults with physical and sensory disabilities were completed during 2014 and 2015, as were a number of lifestyle chapters. These have been used to inform the Older People's JSNA but the detail has not been duplicated in the relevant chapters.

4.2. Overseeing development of the JSNA

4.2.1. The steering group

Once it was agreed to undertake the older people's JSNA a small working group was established to take this forward. The group began by scoping and agreeing the approach to the JSNA, using a 'functional' lifecourse approach from describing the population to healthy older age through to complex health and social care needs. The JSNA also includes two important issues that do not just relate to older people but where their needs predominate. These were adult safeguarding and end of life care. To write the chapters members of the working group were identified as leads and formed a number of smaller chapter specific groups, supported by information leads from Public Health Performance, as well as a wider range of stakeholders.

A standard template with writing guidance notes was issued to each chapter lead. However, it was more important to cover each issue as information emerged rather than follow a template strictly. Therefore the breadth and depth of each chapter was dictated by the issues it covered rather than being restricted to headings and page limits. Some of the chapters had not featured to any great extent in previous JSNAs, others had been covered within topic-based chapters and a few subject to in-depth needs assessments over the last year or two. The working group continued to meet at regular stages of JSNA development to ensure momentum was maintained as well as dealing with consistency and duplication issues.

4.2.2. Frameworks for the JSNA

A framework for the development of the new JSNA has been agreed with authors identified for each section:

Chapter 1: Background, methods and key findings

Chapter 2: Population, social, economic and living circumstances

- Chapter 3:** Overall health and wellbeing of older people
- Chapter 4:** Lifestyles and prevention of ill health
- Chapter 5:** Ill health, frailty, unplanned care and support to live independently
- Chapter 6:** Mental health and emotional wellbeing
- Chapter 7:** Dementia
- Chapter 8:** Adult Safeguarding
- Chapter 9:** Health and wellbeing of older people living in care homes
- Chapter 10:** End of Life Care

Duplication with other chapters was discussed throughout the development of the chapter and an approach to dealing with it agreed.

4.3. Data analysis, including access to data and information

The JSNA uses a wide variety of data from both national and local sources, including:

- Office of National Statistics (census population data) (ONS)
- Index of Multiple Deprivation (IMD)
- Health & Social Care Information Centre (HSCIC)
- National organisations such as Public Health England (PHE) and the Projecting Older People Population Information (POPPI) website
- Halton Borough Council Care First 6: adult social care performance systems
- Secondary User System (SUS) data on hospital admissions was accessed via the Cheshire & Merseyside Commissioning Support Unit and the data analysed by the Public Health Evidence & Intelligence Team
- Local providers
- Research papers
- National policy

The JSNA uses routinely collected data to profile the local population in terms of numbers who may potentially be at risk of a range of developing a range of conditions and problems. Where appropriate, it uses research to stratify the overall population, according to different levels of severity and types of condition.

The JSNA uses estimated data as well as numbers known to services. In this way, it attempts to describe any gaps between the total population who may have a need/condition and those known to services.

In this way the JSNA uses the same methodology as in-depth health needs assessments (HNAs). HNAs are a way of estimating the extent and nature of a population so that appropriate support is planned accordingly. The needs assessment can help:

- Estimate the current and future needs of a population
- Indicate the distribution of need: geographically and/or by sub-groups within the population of interest
- Identify the gap between met and unmet need.

HNA is a systematic method for reviewing the health needs and issues facing a given population, leading to agreed needs (priorities) for that population. The starting point in HNA is a defined population. This population can be defined in a number of ways. By:

- Geographic location – e.g. people living in a neighbourhood or catchment area
- Setting – e.g. school, workplace, prison or hospital
- Social experience – e.g. age, ethnicity, homelessness
- Experience of a health condition – e.g. disease, mental illness or physical disability.

Various models have been developed but the main components of the model used by public health are:

- *An epidemiological approach* – an examination of available information on incidence and prevalence, including hospital and primary care contacts, local audits, and estimates from local and national surveys
- *A comparative approach* – comparing local estimates of disease and/or activity with other similar areas or national data to assess if need is greater or lesser than expected
- *A corporate approach* – this approach gathers information on perceived needs from a wide range of health professionals, other sectors, patients and the community. The benefit of this approach is that it can be responsive to local concerns and encourages ownership of the issues that need to be addressed. The disadvantage is that if it is carried out in isolation it can focus on the stakeholders concerns, which may be influenced by political agendas, and can identify demands rather than need.

Thus, evidence of population need is collected in a systematic way from multiple sources from which the most important needs will emerge from more than one source.

Being able to describe the needs, using epidemiological, comparative and expressed data is only part of the process of conducting a health needs assessment. It is also important to know which interventions are best suited to addressing which needs. Each chapter includes a list of national best practice from sources such as NICE (National Institute of Health & Clinical Excellence), Department of Health, Social Care Institute of Excellence (SCIE) and King's Fund.

The breadth and depth of the JSNA is only as good as the information we have access to. There were delays in accessing some of the previously routinely collected data. This has been managed by the Public Health Evidence and Intelligence Team, supported by Adult Social Care Performance and Policy team and the Customer Intelligence Unit, CCG colleagues, and steering group members, to ensure as much data as possible was available to inform the work. Access to outcomes data from services has been patchy with changes in both commissioning and provider organisations as well as IT changes having contributed to this, with some new systems still not operational. This meant authors had to, at times, take a pragmatic approach on data/information availability. Any core data not available at time of writing or that could not be accessed has been reported on in the specific chapter section it relates to.

Data was collated by the Public Health Team and provided to each chapter group.

5. Key Findings and Priorities from each chapter

Chapter 2: Population, living, economic and social circumstances

Population

16% of Halton's population is aged 65 and over (21,013), with 3.8% over the age of 80 (4,841). This proportion is lower than the England level but Halton's 65+ population has increased by a greater percentage since 2002; 3% compared to 1.7% nationally. The largest percentage growth has been in the most elderly groups and this pattern is set to continue.

The registered population for the 17 GP practices within NHS Halton Clinical Commissioning Group (CCG) is slightly smaller than the resident population. The proportion of the population aged 65+ in each GP practice varies greatly from 7.3% to 19.8%.

It is predicted that the older population will continue to grow, with growth in Halton continuing to be greater than the North West and England rates. The 65+ population is predicted to increase by 42% between 2012 and 2037 with the 85+ age cohort tripling, from 2,100 to 6,400, over this time period.

Population characteristics

An estimated 8,960 of Halton residents aged 65+ have a disability, more women than men. The predominant religion is Christian with over 87% of 65+ population stating this as their religion compared to 75% for all ages. The proportion stating they have no religion is smaller, between 3.3% to 6.3% depending on age group, compared to 18.7% of the total population.

Most older people are married, 66.5% or six out of 10, but this falls across the older age groups, with just 21% of those aged 85 and over being married. This is due to increasing numbers being widowed, just 14.9% at age 65 up to 71.8% of those aged 85+. Over 94% are heterosexual/straight.

Economic activity and deprivation

92% of residents aged 65+ are economically inactive, with 6.3% being employees and 1.5% self-employed. Having a well paid job impacts on the likelihood and amount of private pension income. No actual data is available on total income but Halton people aged 65 and over have fewer qualifications, especially higher level ones, and were less likely to have been employed in managerial or professional occupations than their peers across the North West or England. This is likely to mean the amount of private pension income available is less.

This is substantiated by data on the proportion of Halton pensioners living in deprived areas. A quarter of Halton older people live in the 10% most deprived parts of England, with nearly half living in the most deprived 20%. Despite this a recent survey of people aged 55 and over showed that 82% of respondents were satisfied with their income, higher than Knowsley and Liverpool and the same as the average for Cheshire & Merseyside. This breaks down as 70% quite satisfied and 12% very satisfied. 90% were confident managing their income, similar to the Cheshire & Merseyside average.

Living and housing circumstances

Those aged 50-64 are the least likely to live alone of any age group. The proportion living alone increases with age after age 65, with those aged 85 and over most likely to live alone (83.9%). The majority of over 65s own their own home outright (58%) or live in social rented accommodation (33%). The number of older people receiving minor adaptations through the local authority rose from 2013/14 to 2014/15. Halton older people are less likely to live in homes with no central heating than their peers in England but the levels compared to the North West are similar; 3.1% of 65-74 year olds and 4.4% of 75+ year olds, with rates varying from 0% to 9.4% at electoral ward level. Fewer Halton residents (all ages) are living in fuel poverty than England and the North West. Halton has the 4th lowest level of fuel poverty within its 18 statistical neighbours grouping.

Transport

Free off-peak concessional bus travel throughout England gives the opportunity for greater freedom and independence to around 11 million older and disabled people in England. Community transport is available in Halton for those who find using regular public transport difficult. Yet, national and local research shows that many older people find it difficult to travel to local facilities such as health centres. 33.8% of Halton residents aged 65+ have no access to private cars, a level higher than the North West and England averages and higher than the population as a whole (20.8% of Halton's total population have no access).

Local community and connections

Only 44% of Halton residents aged 55 and over are very satisfied with their local community; across Cheshire & Merseyside only Liverpool had a lower percentage at 43% with the Cheshire & Merseyside average being 55%. However, a greater proportion were generally satisfied, 49% compared to the average of 40%. Thus the overall level of satisfaction with their local community was only slightly lower, 93% in Halton compared to 95% on average. Only one in three had strong connections to the local community mostly through support from friends and neighbours. Despite this, a slightly higher proportion of Halton residents felt they had enough social support compared to the Cheshire & Merseyside average.

Older people are the mainstay of a large part of volunteering that takes place across the country. The slightly higher percentage of women do volunteering work compared to men apart from amongst the 75+ age group. Volunteering is highest in the 65-74 age group for both men and women.

Social isolation and loneliness

Despite some of the findings above, social isolation and loneliness increases with age, with the oldest old having the least everyday social contact. Strong social ties can have an impact on longevity as social isolation is associated with higher mortality in older people. There is a direct correlation between loneliness and poor physical and mental health outcomes. Using national research it is estimated that 4,203 Halton residents aged 65+ experience mild loneliness and a further 1,600-2,100 intense loneliness. As the population is predicted to rise, unless prevalence changes up to 7,000 will have mild loneliness and 2,800-3,500 intense loneliness by 2030. Local research shows many Halton people worry about becoming lonely in the future.

Being able to remain in their own homes, able to look after themselves and remain healthy are the most commonly cited concerns voiced by older residents in Halton. In terms of services they are most concerned about transport to key facilities and the amount of time they have to wait at medical appointments. The most common ways they find out about local services is through the local press and word of mouth. 15% use the Inside Halton newsletter and 10% use the internet to find out about local services.

Chapter 3: overall health and wellbeing

Older people are living longer and spending a greater proportion of their old age in relatively good health. Being healthy is one of the most important factors determining people's wellbeing. The Office for National Statistics (ONS) Annual Population Survey indicates that older people have some of the highest levels of wellbeing of any age with scores across the four indicators used being highest in the 65-74 group.

Despite the increase in life expectancy, levels are lower in Halton than the North West and England. Amongst women life expectancy at birth has shown a decrease for the first time during the latest reporting period. This is due to falls in life expectancy at 65, 75 and 85. However, it is too early to tell if this is simply a minor fluctuation or a change in the overall upward trend.

The greatest predictor of healthy life expectancy is employment at age 50-64 and levels in Halton are lower than the regional and national averages. Healthy life expectancy for both men and women in Halton is also lower than the North West and England averages. So not only do people in Halton not live as long on average but they spend less time in good health. This is reflected in data from the 2011 Census when only 42% of people living in Halton who were over the age of 65 said their health was very good or good (36% said it was fair and 22% said it was very bad or bad). The percentage in good health amongst those aged 65+ is the lowest of all the age groups and with each age group post-65 it continues to fall.

At an electoral ward level, Halton's 65+ population in very good or good health varies from just 30% in Windmill Hill to 60% in Birchfield, with levels highest in the more affluent areas and lowest in the more deprived areas.

Death rates amongst those aged 65+ have been falling both locally and nationally. Halton's rates were higher than the regional and national rates in 2006-08 and this relative position has remained unchanged over time. Cancers and circulatory diseases are the top two causes of death. Respiratory disease is the third cause and is the second cause amongst those aged 90+. Mental and behavioural disorders become a more prevalent cause of death from aged 85+, mainly due to dementia.

Both nationally and locally most people over age 65 rate the overall experience of their GP surgery very good or fairly good (over 90%). Most have confidence in their GP and nurse and find making an appointment convenient. Slightly less, though still the majority, are satisfied with opening hours and time spent waiting at the surgery. However, this last point was one highlighted by the Halton OPEN surveys as something people were concerned about.

The majority of those who wanted to have an NHS dental appointment were able to do so. However, Halton was joint lowest with Liverpool for the percentage of over-55s who go to the dentist.

Despite the fact that 45% of those registered blind and 59% of those registered as partially sighted are aged over 75, Halton has lower rates (both all age and 65+) for NHS sight tests compared to the North West and England.

Apart from Halton Lea, where levels of both elective and non-elective hospital admissions are high, electoral wards with high elective admissions have low non-elective admissions and visa versa. This difference is particularly so for older people from Riverside ward and to a certain extent in Kingsway ward also.

Chapter 4: lifestyles and prevention of ill health

Health related behaviours

Overall, older people have healthier lifestyles than younger adults. Data from the 2012/13 Merseyside Lifestyle Survey (MLS) shows that older people, i.e. those aged 65 and over are:

- Less likely to smoke (17% compared to 30% of all adults aged 18+)
- Eat more portions of fruit and vegetables than the average with the 18-24 age group eating the least
- A lower percentage drink alcohol and of those that do only 4% drink to harmful levels, with older men are more likely to do so than older women
- 1 in 5 drink skimmed milk most regularly
- They are least likely to add salt to food at the table

However, there are some areas where older people's health related behaviour is not as good as younger adults:

- Older people do not undertake moderate or vigorous exercise to the same extent as younger adults
- They spend more time per day sitting and less walking
- Those aged 45-64 are most likely to be overweight and obese. Although the percentages are lower for those aged 65 and over the percentage of older people who are overweight or obese is higher than the borough average

Sexual relationships remain important for older people. Yet many find it difficult to talk to their partner or a health professional about sex. Levels of sexually transmitted infections (STIs) are lower in the 65+ age group than in any other age group and this has been consistently so over time. Halton rates are lower than the England average.

Screening and vaccinations

Cancer screening levels in Halton are lower than the national targets; uptake of bowel screening is 48.8% compared to the target of 60% with breast screening uptake being much closer to target at 69.8% compared to the target of 70%. No practice in Halton achieves the bowel screening target, with uptake ranging from 39% to 56%. For breast screening 5 practices reach the target, with uptake ranging from 57.6% to 78.5%. For both these screening programmes Beaconsfield practice has the highest uptake rate.

Influenza vaccination is offered annually to all those over the age of 65. Halton uptake is higher than England at 73.8% but falls just short of the 75% target. Practice uptake varies from 67.2% to 79.4%, with 7 practices achieving uptake above target. More Halton older people receive the pneumococcal vaccination than England, 70.8% compared to 68.9% but the local rate is lower than across Merseyside which overall sees a 70.8% uptake. The newest vaccination programme for older people was introduced from September 2013 and is for shingles. Uptake amongst the eligible population varies greatly from 18.2% to 76.9%, with the average uptake being 47.8%. Offered to people at age 70 there is also a catch up programme. Again less than half those eligible take this up, just 46.8% with practice level variation of 15.6% to 80.6%.

Falls

There is no local or national falls register. Using national research, the estimated prevalence of falls amongst those aged 65+ is 3,266 women and 2,154 men (2015 figures). Assuming the underlying prevalence remains static, given the projected increase in older people, this is likely to rise to approximately 4,915 women and 3,375 men by 2030. In a survey of people aged 55+ across Cheshire & Merseyside, 36% of Halton residents stated they have ever had a fall, the third highest across Cheshire & Merseyside, behind Liverpool and Knowsley. The pattern seen across Cheshire & Merseyside suggests deprivation may be a factor.

There were 8,243 attendances at A&E departments between April 2012 and March 2015. At least 23% of these were due to falls. This percentage may be higher as Warrington hospital does not code falls as a primary injury type. Whiston does and here 47% of the injuries seen in those aged 65 and over were due to falls. Applying this higher rate would suggest as many as 3,874 attendances during the 3-year period were due to falls, or nearly 1,300 per year.

The rate of hospital admissions due to falls in the over 65s is statistically significantly higher in Halton than the national average, although the rates have fallen between 2010/11 and 2013/14. Halton's rate for 2013/14 was the highest of its statistical neighbours group, statistically higher than every local authority in the group apart from Salford. Rates rise substantially from aged 75+ and are highest in the 85+ age group for both men and women, with rates highest for women. Rates also vary by electoral ward and GP practice, lowest in Daresbury ward and Windmill Hill practice and highest in Broadheath ward and Hough Green practice. Only a small proportion of falls result in fractured neck of femur (hip fracture). Rates in Halton are statistically higher than comparators.

Unlike admissions, the mortality rate due to falls in the over 65s is relatively low in Halton compared to its statistical neighbours group. It is only the 5th highest (out of 18 local authorities in the group) for ages 65-74 and 6th highest for those aged 75+.

Chapter 5: ill health, frailty, unplanned admissions and support to live independently

One of the key concerns of local older people is their ability to remain healthy and independent. For those with long-term illness, disability and frailty being able to realise this can often depend on the availability and quality of domiciliary support, both through formal routes provided by social care, working in partnership with primary and community healthcare, and the role of informal, unpaid carers. Many people live to an advanced age while maintaining physical and cognitive function, functional independence and a full and active life, with ill health and disability compressed into a relatively short period before death.^[11] However, in a proportion of people, the normal gradual age-related decline in multiple body systems is accelerated, resulting in limited functional reserve, so that even a relatively minor illness or event has a substantial impact on health.^[12] This increased vulnerability is termed frailty. Whilst previous chapters in this Joint Strategic Needs Assessment (JSNA) have looked at overall health and lifestyles issues, this chapter explores the issues facing people with long-term illness and disability living in the community (a separate chapter looks at the needs of people living in care homes).

There is no official dataset on the number of people who are frail. This means we have to rely on national research and apply its prevalence rates to the local population. Doing this suggests there may be 2,000 Halton residents aged 65 and over who are frail with a further 8,741 pre-frail. Assuming the prevalence rates remain static, these numbers are predicted to nearly double over the next 21 years to 3,917 frail and 14,061 pre-frail by 2037.

The percentage of Halton residents with limiting long-term illness (LLTI) or disability increases with age, as it does nationally. Data from the 2011 Census shows that two out of ten (20.9%) of the total population has such a condition, whereas double that percentage 4 out of ten (42%) of those over the age of 65 do so; over half of 65-74 year olds do (52%), two in three 75-84 year olds (70%) and 85% of those aged 85+. This equates to 10,956 people aged 65 and over with a LLTI. Whilst not directly comparable, data from the annual GP survey supports this; it asks the respondents about how their health today affects their ability to carry out daily activities rather than long-term illness.

Data from the English Longitudinal Survey of Ageing (ELSA) shows that difficulties dressing and washing are the most prevalence difficulties people face with their daily activities. Nationally 6.7% of older people (aged 65+) living in their own residence have 3 or more activity of daily living (ADL) difficulties which equates to over half a million people. For Halton, applying these findings suggests 1,500 local residents aged 65+ with 3 or more ADL difficulties.

The Census shows that 10,956 older people indicated that difficulties with mobility limit their lives, 6318 a lot (ranging from 28% of those aged 65-74 up to 59% of those aged 85+) and 4,638 a little. Not surprisingly then, nearly half of all those in receipt of adult social care have physical impairments which affect their mobility.

Older people are especially prone to falling with an estimated one in three people over the age of 65 falling at least once a year rising to one in two of those aged 80+. National research suggests only 5% of falls results in a fracture and/or admission to hospital. This means most older people who have a fall do not come in to immediate contact with services and so it is not possible to put an actual number to the number of falls happening in the borough. Applying national research suggests

around 3,266 women and 2,154 men aged 65+ have a fall each year. As the number of older people increases so too will the number of falls. Unless successful interventions can be implemented these numbers will rise to 4,915 women and 3,375 men having a fall by 2030; a 51% increase for women and 57% increase for men. Halton has a much higher hospital admissions rate due to falls than the North West and England and the difference is statistically significant. This remains the case despite a reduction in the rate 2013/14 compared to 2010/11 against a static position for the comparators.

Looking at a range of specific conditions, there are substantial numbers suffering with incontinence, sensory impairments and long-term, incurable illnesses, including multiple illnesses. Incontinence is a significant, embarrassing and socially disabling condition, with an estimated 1,851 Halton older residents suffering from bladder problems and nearly as many suffering from faecal incontinence (some will have both). Over 80% (8 out of 10) people aged 60 and over have visual impairments and 75% hearing impairments. One in five (22%) have both to varying degrees of severity. Prevalence and severity increases with age.

Whilst there are various condition-specific long term condition (LTC) GP disease registers as part of the Quality Outcomes Framework (QOF) contract, these only count total numbers with the condition and are not available by gender and age breakdowns. However, national research shows LTCs tend to develop in middle age and prevalence increases with age, especially having multiple LTCs. The census data shows Halton has higher prevalence of LLTI and disabilities than nationally and regionally, 11.6% compared to 10.3% for the North West and 8.3% for England. Within this borough rate there is substantial variation at electoral ward level; 34.5% of 65-74 year olds in Birchfield compared to 95.7% of 85+ year olds in Norton South. In a telephone survey of 55+ year olds conducted by Liverpool John Moores University, more Halton older people said they had a LTC than any other borough in Cheshire & Merseyside, 65% against the survey average of 58%. Data from the latest available annual GP survey also shows an increase in LTCs by age; 58% of total respondents compared to 95% amongst those over age 85. High blood pressure, arthritis and lower back pain being especially prevalent.

According to respondents to the annual GP survey, the majority of older people feel they definitely or at least to some extent have enough support from services to manage their LTCs. Most felt very or fairly confident in managing their own health.

Co-morbidities (having more than one illness) commonly involve mental health problems. People with LTCs are 2-3 times more likely to experience mental health problems than the general population. At least 4 million of the 15 million people in England with long-term physical health problems also have a mental health problem. National research also shows that outcomes for older people with co-existing mental health problems admitted to hospital are generally poor with only one in three (31%) not being readmitted or moved to a care home and only 4 out of 10 recovering to their pre-acute illness level of functioning.

Levels of dementia are increasing with an estimated 1,347 Halton people aged 65+ with the condition. Whilst the level of diagnosis has been improving this estimate remains higher than those with a diagnosis registered with their GP – 893 in 2014/15. This gives a diagnosis rate of 66.3%, leaving over 1 out of every 3 possible cases of dementia undiagnosed (although the gap has been closing and efforts continue to close it even further).

With high levels of long-term illness or disability it is unsurprising that the majority of the 65+ respondents in the 2014/15 GP survey said they had some level of daily pain or discomfort. This can have a negative influence on quality of life and on mental wellbeing. Yet national research also shows that older people are less likely to receive good pain management. Based on data from the Health Survey for England and local GP survey prevalence rates, it can be estimated that over 5,000 Halton older people aged 65-74, 4,000 aged 75-84 and 800-900 aged 85+ (estimated total 9,773-10,887 65+) are in some level of pain and discomfort.

There has been an increase in attendance rates at Accident & Emergency (A&E) departments amongst Halton 65+ residents. Despite some recent reduction in the rates, it still represents nearly twice as many attendances in 2014/15 compared to 2010/11. There are significant ward level variations with seven wards statistically higher than the Halton average.

Data for England shows that 4 out of every 10 admissions to hospital amongst those aged 65+ are via the emergency route and this is higher than for those under age 65 (3 out of every 10). Amongst Halton older people, the most common reasons for emergency admissions were respiratory conditions as well as urinary tract infections and heart problems. Whilst the length of stay fell between 2012/13 and 2013/14 it rose very slightly in 2014/15. With increasing numbers and costs per admission, the cost of hospital admissions for those aged 65+ is increasing. As with A&E attendances, there are significant ward level variations with a nearly ten-fold increase across the borough from 6,308.5 per 100,000 in Hale to 60,202.4 per 100,000 in Riverside wards. This is against a backdrop of increasing borough rate. The rate in 2014/15 was slightly higher for males than females.

For many older people their level of functioning deteriorates once they have been admitted to hospital. Reablement services aim to help people regain independence following events such as falls or hospital admissions. The number of older people still at home 91 days after discharge from hospital into a reablement/rehabilitation service is measured as part of the Adult Social Care Outcomes Framework. In 2014/15 65.6% of Halton people aged 65+ were still at home 91 days after discharge. This was slightly higher than the previous year but is below the borough statistical neighbours group average, regional and England averages. Conversely, Halton has a slightly higher percentage of people aged 65+ receiving reablement services following a stay in hospital than its comparators. Halton also has a lower delayed transfers of care rate and delayed transfers of care attributable to social care than comparators. These demonstrate good integration between health and social care and responsiveness on onward care package provision.

Older people may require an ongoing package of care post-reablement or they may become known to Adult Social Care due to reduced ability to cope on their own, even with the support of an unpaid carer. The number of clients and number of care packages has increased over the last five years. Halton has a lower rate of people entering care homes, although the numbers are increasing as the older population increases. Many older people will be in receipt of multiple services to meet complex needs. Short-term services aim to reable people and promote independence. Compared to its statistical neighbours group, North West and England rates, Halton has a higher percentage of new clients who receive such services, where the sequel is that they need no ongoing support or support of a lower level. This demonstrates that the borough has greater success in helping people to remain independent. Part of this success may also be that Halton has a high level of unpaid

carers, one of the highest percentages in England for the provision of 50 or more hours unpaid care per carer; 13.6% of the total population provides unpaid care compared to 11.4% England average with 19.1% of Halton residents aged 65+ providing unpaid care compared to 16% nationally. For 50+ hours of care provision 4.1% of Halton's population provides this level of unpaid care compared to 2.6% nationally, with the highest percentage providing this level of care being amongst those aged 65+, 9.9% in halton compared to 6.1% in England as a whole. In Halton 30.4% of unpaid carers provide 50+ hours care per week compared to 23.1% nationally and over half of all carers aged 65+ provide this level of care (England 38.4% of 65+ cares do so). It is therefore vital the the health of carers is looked after.

Adult social care services range from preventative to supporting those with complex needs to remain independent (and support to make to a care home when necessary). The use of telecare offers a cost-effective way of increasing older and disabled people's confidence in living independently knowing there is 'at the press of a button, at the end of a phone line 24/7 support' if difficulties arise such as having a fall. As people's health and social circumstances change they may find their home design no longer meets their needs. Rather, than having to move home or move into a care facility, equipment, minor and/or major home adaptations can help with mobility around the home and ability to maintain activities of daily living. Halton Borough Council has been providing an increasing number of minor adaptations over recent years. HBC Home Improvement Agency supports people applying for the means-tested Disabled Facilities Grant (DFG). Once approved they assist with all aspects of the home improvement being carried out, liaising with Occupational Therapists/ Community Health Worker to ensure the work needs needs, applying for planning permissions and overseeing contractors work.

It is not just the public sector that supports older people to maintain independence. The voluntary sector provides a wide range of services via faith organisations, charities such as Women's Institute and Royal Voluntary Services, support groups such as Halton Cancer Support Group and many others. Age UK Mid-Mersey also provides a wide range of advise and services to people aged 50+ in Halton, including Helping Hands, a DIY-type service offering volunteers who can do minor jobs around the house.

Recently Halton Borough Council has been leading a review to ensure collectively, the most is made of the wide range of servives operating in the borough. A number of improvement araes have been identified which are being worked on currently:

- Guidance on recognising frailty amongst both health and social care sectors, including the use of the Comprehensive Geriatric Assessment tool when older people present to services (including A&E)
- Rapid assessment 'close to home' and at hospital including management of frailty and improved discharge processes, including the use of voluntary sector
- Review of capacity, demand and models in Intermediate Care provision
- Outcome-based domiciliary care commissioning and contracting
- Strengthening of the existing primary and secondary falls prevention work

Chapter 6: Mental health and wellbeing

Local demographics

In Halton there are a higher proportion of females accessing secondary care mental health services to males and only a very small number of ethnic minority individuals, compared to white British. More work needs to be done to understand why this is and what can be done to change it. It may link to pride in males seeking help and for ethnic groups, religion and culture plays a strong part in not speaking out about mental health.

Increasing Older Population

Due to an increasing population nationally, there is forecast to be an increase in the number of older people with depression, within a few years. However, the resources available for health services given the current financial restraints, will at best remain the same, requiring the development of new service models to meet the need using a holistic approach.

Social Isolation and Loneliness

It is clear that loneliness and mental wellbeing are closely connected. In Halton there are approximately 21,013 older people. Of these: 2000 are likely to report feeling very or always lonely-likely to rise to 2800 by 2021 if unchecked,. In Halton 5000 of our over-75's live alone. We know loneliness is a danger to older people's mental health with an increased risk of depressive symptoms including depression, fatigue and poor levels of sleep. The Mental Health Foundation estimates that depression affects 20% of adults aged over 65 living in the community.

Information - There is no effective Directory of Services in Halton for older people. Many attempts have been made to create one but have usually been defeated due to cost or technical difficulties. Advocacy is a critical area.

Transport- There is a lack of evening transport around the borough, expensive taxi rates, and capacity issues with Dial-a-Ride. There is currently a CCG transport group trying to develop options around transport which I chair. Transport funding has been regularly cut over the past five years and there are likely to be further cuts going forward. Some investment in this area would result in better mental health outcomes.

Technology- there is a gap in providing simple Skype type devices for isolated older people. The Visbuzz system was piloted with 100 older people in the borough but was not adopted due to technical difficulties with the units. Again investment in this area would result in better mental health outcomes.

Befriending-There is evidence that befriending schemes can alleviate loneliness and other mental health issues. While there are some services which offer befriending through volunteers (Sure Start to Later Life/Age UK) they tend to have waiting lists of up to a year. A more local telephone befriending service would result in better MH outcomes for older people.

Bereavement Counselling - Older people who have suffered bereavement from the loss of their partner do not have access to a local counselling service other than waiting 6 months for general

counselling via the GP. Older people would benefit from a bereavement counselling/support service, where they can be fast tracked to counselling if they have lost a partner, due to their age and higher risks of complications.

Group activities- Current research leans towards group interventions producing better mental health outcomes around loneliness and older people. While Age UK/SSLL/ Wellbeing Enterprises organise group interventions funding to develop a broader range of group activities/events aimed at lonely older people would pay dividends. NICE guidelines on older people: independence and mental wellbeing(NG32) go into more detail about good practice in this area, especially around the effectiveness of education and learning activities, volunteering and intergenerational activities. They are seen as cost effective mental health interventions and a good use of public money.

Commissioners should strive to deliver measures to address loneliness at a neighbourhood (or even ward) level as older people spend more time in, and often feel more committed to their neighbourhood. Breaking down areas at neighbourhood level can also be more manageable and allow effective targeting of initiatives and enables outreach efforts. The reduction in the HBC Community Development Team has meant a lessened focus on such community development work.

Risk factors of depression

Older people's mental health needs are complex. They cause substantial impact on wellbeing and the ability to lead a normal life. They have wider impacts on the family and other carers. Mental health needs interact in complex ways with long-term physical health problems. People with severe mental illness have a substantially reduced life expectancy due to both mental and physical ill health. There is often inequality of access to health services for physical illness for people who use mental health services. Physical health and mental health are inseparable and demand a holistic approach to the care of all patients with mental health problems. In light of this and the recognition of the parity of esteem agenda, there will be an opportunity later in the year for commissioners to bid for recurrent funding to incorporate Long Term Conditions (LTC) Services into the Improving Access to Psychological Therapies (IAPT) Service for low to moderate mental health problems.

Acute Bed Base

Halton do not currently commission secondary and acute care mental health services specifically for older people, as they provide the same support for older people as they do adults. It has been identified as part of the 5 Boroughs Partnership (5BP) Footprint Review (*see 5 keys areas below*) that there is a significant cohort of older people whose specific clinical needs would be better met within a dedicated facility and by staff who are trained and experienced in managing their needs. Local MH providers and commissioners have been asked to ensure that the needs of each individual will be better met by adopting a more appropriate clinical bed model.

Five Borough Partnership (5BP) Independent Review

The mental health services provided across Halton are complex and varied. There are many areas of positive work being undertaken in each of the services which should be commended, particularly at a time when resources are stretched and also under threat of being reduced. There are also a number of areas for improvement both in relation to individual services and also the wider system they operate within, many have been identified within the independent review of the adult

and older adult acute care pathways within the 5 Boroughs Mental Health Trust undertaken in 2015.

The following **five key areas** for future development were identified within the 5BP footprint review:

1. The interface between primary and secondary care - The way in which people are supported in primary care and also move between primary and secondary care
2. How people with a personality disorder or highly distressed emotional disorders are supported by the whole system
3. The whole service model across the Borough (including 5 Boroughs Partnership NHS Foundation Trust services and all others)
4. Step down from in-patient services and the use of out of areas placements in the private sector
5. The proposed future bed model

All of the five key areas mentioned above are inter-dependent and will all be implemented as part of a whole system approach to delivering the best quality, most efficient and value for money services that are possible within the resources available across the footprint.

Finally, the older people who use these services and families and carers require their voice to be heard within the on-going changes that will occur. How this is achieved needs to be agreed, but their voice is of great importance, whether through “user” / “carer” representatives or professional organisations acting on their behalf.

Chapter 7: dementia

The number of people with dementia has been rising in recent years and this is predicted to continue. Whilst some of this is due to greater awareness and diagnosis, the main driver is the increase in the older population (onset of dementia is rare before the age of 65).

Research has been emerging that shows whilst many of the causes of dementia are not amenable to change, there are several lifestyle risk factors, for both onset and progression of the condition. These include obesity, alcohol misuse and hypertension (high blood pressure). Levels of all these risk factors are higher in Halton than nationally, potentially putting the borough’s population at greater risk.

It is estimated from national research that 1,287 people in Halton may have dementia. This is higher than the 895 people diagnosed in primary care. However, the difference has been reducing. In 2009/10 less than half the estimated numbers had been diagnosed (46%). By 2014/15 this was 69.9%. Due to the concerted efforts of all partners, including families of those with dementia, and especially amongst primary care staff, this ‘diagnosis rate’ should continue to increase, despite the increasing numbers.

The majority of people with dementia who are admitted to hospital are over the age of 80 but are not admitted due to their dementia. The most common reasons are injuries, respiratory illnesses and conditions of the urinary system. This underlines the need for all hospital staff to have an awareness of the needs of people with dementia during hospital stays and also as part of discharge planning.

- **Prevention:** Local Public Health Teams should have a role to play not only in increasing awareness of dementia signs and symptoms, but also in promoting where risks of developing particular types of dementia can be modified, and what protective behaviours can make a difference
- **Public and Professional Awareness:** Health, social care, 3rd sector stakeholders, Commissioners and service providers should be mindful of how the 'dementia demographic' is likely to change over future years, in particular young onset dementia and the potential for an increase in numbers of people with a learning disability developing a dementia. Awareness of signs, symptoms and needs of diverse cohorts of people
- **Pre diagnosis Support:** Commissioners should consider the demand for, potential value of and methods of pre diagnostic support, for people in the investigation stage and earlier
- **Diagnosis:** There should be a continued focus on early and timely diagnosis. Primary and secondary care should continue to be linked in to regional groups (such as the NHS Clinical Strategic Network for Dementia) that provide direction and learning to support GP in diagnosis and condition management
- **Increase awareness across hospital ward staff and take into account the approach to treatment where patients have suspected dementia or a dementia diagnosis:** Trusts should provide Tier 1 and Tier 2 Dementia Training to NHS staff. Admission to hospital offers an opportunity to identify undiagnosed dementia in older age patients. Where this is not already in practice, Trusts should consider undertaking a short cognitive assessment on admission that could identify signs of dementia, delirium or depression. Consideration should be given to the benefits of the physical ward environment for people living with dementia, in reducing risks of falls, for example, and aiding their recovery
- **Prescribing:** Commissioners and primary/secondary health colleagues to work together to better understand the prescribing of anti-psychotics to those with dementia. This should include both the individual context for use, adherence to guidance and care planning and review arrangements
- **Post diagnosis:** Consideration by commissions should be given to a Prime Provider model for a post diagnosis community pathway. Consideration should be given to the potential benefits of a single point of access , single assessment of initial need, promotion of, and access to, services on a prime provider pathway, information sharing etc, that could facilitate appropriate, flexible and timely support for the person and carer
- **Quality of Services:** All services that support people living with dementia, and their carers, should be reflective of the NICE Dementia Quality Standards (QS1 And QS30), and demonstrate that they have considered national best practice
- **Appropriateness of Services:** Commissioners should consider the diversity of provision to meet the needs of older people, younger people and people with a learning disability living with dementia. The needs of younger carers and carers who are in employment must also be considered
- **Respite:** Commissioners should consider the level and types of respite available, and barriers that inhibit people living with dementia and their carers using respite to enable a flexible respite model that meets the needs of a diverse cohort of people
- **Identifying and supporting carers:** Identifying carers should be a priority of every professional stakeholder involved from pre to post diagnosis. Carers provided with timely information, advice and guidance to help them make effective decisions about care and support can help them develop effective caring strategies, help them maintain their own wellbeing and build resilience

Chapter 8: care homes

Care homes now provide more beds than the NHS, for a predominantly older population with increasingly complex health needs

The care home population (aged 65+) has remained fairly stable increasing by just 0.3% between the 2001 and 2011 Census despite a growth in the 65+ population being 11% over this time period. This is likely due to the increased emphasis on care at home to aid independence for as long as possible. However, this means that the care home population is ageing with those over age 85 over-represented. It also means it is those with the most complex health and social care needs that are moving to live in care homes. The continued ageing of the population does mean there will be an increase in numbers in the future. Indeed this is starting to happen already with the downward trend in both temporary and permanent admissions to care homes starting to reverse both nationally and locally.

In Halton 578 people live in care homes representing 2.8% of the 65+ population. This rises to 12.1% of those aged 85 and over. There are clusters of care homes in certain parts of the borough; Halton Lea, Appleton, Broadheath and Riverside wards have the highest number of people living in care homes reflecting care home locations.

The current model of primary care provision supports residents remaining with their existing GP following admissions to a care home. Whilst this provides continuity of care for the individual it does mean homes having to liaise with multiple practices. For the majority of care homes this is 5 or more up to a maximum of 10. Despite their more complex health needs, national research shows some primary care staff perceive care home residents to be lower risk and therefore of less priority. Changes in the GP contract and additional funding for services for patients aged 75+ offers opportunities for improving primary health care in care homes.

Personal care support is the dominant reason for Halton residents moving to live in a care home, with mental health support and memory & cognition support needs making up most of the remaining causes. This pattern is seen in both residential and nursing care. As people are remaining at home for longer, the length of stay in a care home before death has been decreasing in the borough from 2.1 years in 2010/11 to 1.2 years in 2014/15; for nursing homes this has been a reduction from 1.2 years in 2010/11 to 0.8 years in 2014/15.

National research shows nearly 2 out of 3 (68%) of care home residents do not have regular medical reviews or medication reviews (66%) and only 3% have access to occupational therapists. This appears to be a long standing issue. It leads to a lower percentage of patients being managed to quality targets.

Many care home residents have dementia and/or exhibit forgetfulness or confusion; mobility difficulties and incontinence affects over half of all residents, with the prevalence of long term conditions being higher than in the community-dwelling older population. Research also suggests as many as 1 in 5 are malnourished on admittance. The need to maintain mobility and levels of social activity, retain personal identity and intimate relationships are important considerations to maintain quality of life for residents moving to a care home.

As in the general population, hospital admissions increase with age amongst care home residents. However, national datasets on health outcomes, primary care and hospital admissions do not differentiate the needs of care home residents. Local analysis using postcode of care homes as a proxy for care home residents shows that amongst the just under 600 care home residents for 2013/14 to 2014/15 there were 2,574 hospital admissions with 1,960 of these amongst residents aged 65+.

Research indicates residents in care home are less likely to have advanced end of life care planning in place. Yet research also shows that having this in place can reduce the number of days spent in hospital, improve the quality of life during this period and reduce the number of deaths taking place in hospital. Amongst the 65+ population as a whole, 75% of all deaths due to unspecified dementia and 80% of deaths due to other forms of dementia take place amongst care home residents as do 56% of all deaths due to cerebrovascular disease and over half of deaths due to diseases of the urinary system. Between 2010 and 2014 more Halton residents aged 65+ died in a care home than any other single location (2010 deaths out of a total of 4,611 during the 5-year period). A higher proportion of deaths in women aged 65+ occur in care homes than for men aged 65+, 48% compared to 37.5%. For both genders the percentage increases with age.

Key issues

- Develop integrated systems that support the personalisation agenda
- Develop an integrated Halton Borough Council and NHS Halton CCG Care Home Commissioning Strategy (informed by both national and local qualitative and quantitative research)
- Develop a GP care home model to reduce unwarranted variation in clinical practice and supports the delivery of high quality care
- Develop a care home nursing model which will promote and improve care
- Develop a workforce strategy with Providers which will support recruitment, retention and development of staff
- Develop a Care Home MDT Model which will include a re-alignment of community resources (including a 'named' care home social worker and complex care nurse) with an emphasis on person centred care, resulting in enhanced clinical decision making, better coordinated care and improved outcomes
- Develop Care Home 'Champions' to further improve care and quality of life for individuals
- Develop an integrated (primary care and care homes) patient management system to support and improve care
- Develop technology enabled care services that will support new models of care, co-ordinated around individual needs
- Develop clinical pathways which have a favourable impact on health outcomes
- Develop 'in and out of hospital' pathways to ensure appropriate admission and discharge processes
- Develop a fully integrated Halton Borough Council and NHS Halton CCG quality system, including an integrated dashboard composed of new metrics that provides assurance to both organisations of the quality of care delivered in care homes. Consideration should be given to the Safeguarding Adult Board to drive this development
- Develop a local Joint Intelligence Group, with members from adult health and social care to ensure the delivery of high quality care

- Develop a Care Home Partnership Network which includes representatives from care home providers (whose contribution will include views from residents), Halton Borough Council NHS Halton CCG, primary care and NHS providers to bring about improvements in care
- Develop a formal medicines management arrangement (including data sharing agreements) between Halton Borough Council and NHS Halton CCG, that will result in improved care
- Develop a Halton Borough Council and NHS Halton CCG joint policy ratification process for care home medicines management policies
- Introduce into the Halton Borough Council and NHS Halton CCG Falls Strategy a number of evidence based care home specific interventions
- Develop a multi-agency approach to improve the Vitamin D status of care home residents to lower their risks for falls and fractures
- On admission to a care home, unpaid carers systematically referred for a Carers Assessment
- Develop, support and monitor local arrangements to enable individuals in care homes are able to access opportunities both within the care home and in the wider community, to participate in meaningful activities that promotes their health and mental wellbeing

Chapter 9: Safeguarding

Key Findings

The rate of adult safeguarding referrals was higher in Halton than amongst its comparator groups for 2014/15. Changes in referrals processes during 2015/16 mean it is expected that the rate will have fallen during 2015/16 and there are indications that this has happened. However, at least for this initial year after the changes, it is likely the rate will remain higher than comparators. Despite the difference in rate of referrals, the age and gender profile in Halton is similar to comparators and has remained fairly constant over recent years. About 30+ per cent are amongst people aged 18-64, with 60+ per cent being aged 65 and over. These same percentage differences are seen for gender, with the smaller percentage being amongst males.

A greater percentage of Halton referrals in 2014/15 were previously unknown to the council compared to the national, regional and statistical neighbours averages. The location of alleged abuse remains predominantly the person's own home followed by in a care home. These 'usual residence' locations make up nearly 90% of all referrals.

There is a significant geographical variation across the borough, with the rate of referrals ranging from 140 per 100,000 population aged 18+ to nearly 1,700 per 100,000 population aged 18+, a nearly ten-fold difference. Deprivation is only weakly associated with this variation, determining about 36% of the relationship. The distribution of the older population (percentage of ward population aged 65+) appears more closely associated with the distribution of referrals. The location of care homes affects this age distribution pattern and so is also a factor in safeguarding referral patterns.

Physical abuse/risk and neglect & omission remain the two main types of alleged abuse. Although relatively small in comparison, financial abuse is of growing concern locally. This includes scams targeted at vulnerable people. A Trading Standards project has been successful in helping scam victims recoupate money from scammers and also in how to be more resistant to future scams.

Amongst male victims the most common relationship with the alleged perpetrator is community care staff followed by family. This is the reverse of the position for women but for both these are

the two most prevalent relationships. For both genders, service users/ other vulnerable people and residential care staff are the third and fourth most common relationships.

In Halton over 2 out of 3 cases investigated results in action taken and risk reduced. This is a much higher percentage than seen elsewhere, with borough comparators seeing less than half of cases with this outcome. In 65% of cases in Halton the allegation is fully substantiated. This is nearly twice as higher as the borough's comparators. Only 13% of cases in Halton are not substantiated compared to 30% elsewhere.

There has been an increased concern and local focus on medication errors. These occur predominantly in care homes due to preparation and administration errors. This is currently being investigated to reduce the number of errors and therefore risk to the individual.

There are clear links between adult safeguarding and domestic abuse. Halton has a higher rate of domestic abuse incidence reported to the police than other parts of Cheshire, with all borough's in Cheshire having lower rates than England. Halton has a lower rate of MARAC^[b] cases discussed each quarter than other boroughs in Cheshire.

DOLS applications have increased ten-fold nationally between 2013/14 and 2014/15 since the Supreme Court landmark ruling lowered the threshold for what constitutes a deprivation of liberty.

Safeguarding is everyone's business and all major organisations operating in the borough have adult (and where appropriate child) safeguarding policies and procedures. The Integrated Adult Safeguarding Unit is a Halton Borough Council (HBC) and NHS Halton CCG funded team based in HBC. They deal with safeguarding referrals and investigations on behalf of all organisations in the borough. They also deal with Deprivation of Liberties (DoLS) cases and offer advice to care management teams in all organisations. This ensures consistency in referral criteria/approaches and best practice is maintained throughout the borough. This co-ordination role also ensures new guidance is cascaded swiftly and is consistently implemented.

Key priorities for Action

- Develop a Prevention Strategy and associated action plan to monitor progress
- Establishment of a Self-Neglect Panel
- Development of a Self-Neglect Strategy for Halton
- Continued identification and reporting of key themes and trends to Halton Safeguarding Adults Board
- Halton Safeguarding Adults Board to identify specific work streams required to respond effectively to identified key themes and trends in safeguarding
- Ensure any new policies and procedures developed are compliant with Care Act 2014 requirements
- Continue to monitor medication errors and investigate the reasons. Feed these in to the Halton Safeguarding Adults Board and CCG Governance.
- Continue to raise awareness amongst professionals and the public to ensure safeguarding concerns are appropriately referred to Halton Borough Council

b) MARAC = Multi-Agency Risk Assessment Conference

Chapter 10: End of Life Care (EOLC)

There has been a significant shift in the place where the majority of people die over the last century, from the majority of people dying at home to over half now dying in hospital. Yet, despite this, surveys show that home remains the preferred place of death for the majority of people.

People are generally regarded as approaching the end of life when they are likely to die within the coming 12 months. Palliative care supports people nearing the end of their lives to live as well as possible. This may be through specialist palliative care but for most generic services, well planned and provided will suffice. Whichever group of staff is involved, the complexity and personalised nature of need requires effective, multi-disciplinary working within and between health and social care services, which includes the active involvement of family and friends.

National research shows that most people express a wish to die at home but only about one in five do so. In Halton just under four out of ten (40%) die in their usual residence, defined as either the own home or a care home. This is lower than England and Cheshire & Merseyside (approximately 45% and 43.5% respectively). This places NHS Halton CCG 36th lowest in England out of 211 CCGs and lowest in Cheshire & Merseyside for the last reporting period available.

The majority of deaths occur in those aged 65 and over, nearly 8 out of 10. The percentage of deaths occurring in hospital varies little with age. Whilst the percentage who die in their own home decreases with age, the percentage dying in a care home increases from 13.5% amongst those aged 65-84 to 32.2% amongst those aged 85 and over.

From age 65, a slightly lower percentage of men die in their own residence compared to women. However, the most significant gender difference is the higher percentage of women dying in a care home; 16.4% amongst those aged 65-84 and 35.7% at age 85+ compared to 10.7% and 25.6% for men of the same age.

Whilst hospitals continue to be the dominant place of death, there has been a reduction in the percentage in recent years, with a corresponding increase in the percentage of deaths occurring in care homes and a small increase in the percentage dying in their own residence. This means a key role for hospitals remains the delivery of high quality EOLC including support to families. There have been improvements in access to specialist palliative care but still, only 4 out of 10 hospitals provide 9am-5pm, 7 days a week access in the 2014 national audit (compared to 3 out of 10 during the 2013 audit). In the 2014 audit both Halton's main acute hospital trusts reported they had this provision in place.

The 2014 hospital audits of palliative care showed that St Helens & Knowsley Hospital had a higher percentage of cases reviewed than Warrington Hospital Trust. Warrington did not have in-house training for staff but St Helens did. Overall, both trusts performed similar or better than the England average.

Halton has had a higher percentage of all age 'terminal admissions' admitted as an emergency than England but lower amongst those aged 85+. The most common cause of death is cancers at 30%, followed by cardiovascular disease at 25% and respiratory disease at 15%. Overall people both nationally and locally are more likely to die in hospital if they live in more deprived areas.

National research shows that people with dementia, those who are Lesbian, Gay, Bisexual or Transgender (LGBT), are homeless or have a learning disability all face barriers/difficulties in accessing high-quality EOLC. Staff may be unaware of their particular needs and/or how to meet them. Families of children with terminal illnesses also have specialist needs.

Whilst in theory, the majority of deaths can be predicted and therefore EOLC planning established (NICE put this at about 75% predictable), in practice there is a wide margin for error, mostly due to over-optimism of prognosis. There are just over 1,000 deaths in Halton per year but only 382 people were on the palliative care register in 2014/15. Nevertheless this means the prevalence rate for palliative care for Halton CCG was similar to the North West and the same as the England average. All identified patients have regular reviews, a higher proportion than the North West and England.

Advanced Care Planning (ACP) is a key element of the end of life care pathway and policy which is reflected in the adoption of the Coordinate My Care tools to allow appropriate professionals involved in the care of the patients to access their care plan. Locally, people who are believed to be in the last year of life are coded using the North West End of Life care Model. The tool is used in care homes and all people on the GP Gold Standards Framework (GSF) are thus coded. The Community Integrated Advanced Care Planning Service provides ACP for Halton and delivers training to staff from key providers of EOLC.

Whilst only a couple of Halton's care homes have achieved GSF for Care Homes, many more have received training and are at various stages of working towards it. Of the people with an ACP over 90% have achieved their Preferred Place of Care (PPC) consistently over the last five years.

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