NHS Warrington Clinical Commissioning Group

WARRINGTON Health & Wellbeing Board

WARRINGTON Borough Council

Warrington

Joint Strategic Needs Assessment (JSNA)

Older People

2016/17

EXECUTIVE SUMMARY

Introduction

This JSNA chapter explores the health, wellbeing and use of services across Warrington, the chapter combines two separate documents written in 2012 (burden of ill health and service uptake) to provide an overall picture of older people in Warrington. The chapter has been based on The Kings Fund 'Making our health and care systems fit for an ageing population' report which proposes ten components of care. Their report aims to provide a structure for the development, improvement and integration of care for older people.

Update on recommendations from previous JSNA chapters

The following recommendations were made within the burden of ill health chapter and have since been implemented within Warrington:

- ***It is important to ensure that the recommendations relating to older people from the Public Health White Paper, Healthy Lives, Healthy People: our strategy for public health in England, are built into strategy development and commissioning of services across all partners.*** The recommendations made in the White Paper fed into various documents, strategies and campaigns such as the Warrington Falls Strategy 2016-19, Healthy Ageing, Winter Health Plan, Flu/Immunisation programmes and the locally developed 11 Top Tips campaign;

- ***There is a need to ensure that people suffering from dementia are diagnosed early and receive appropriate services.*** Raising awareness of dementia through intelligence led local campaigns, the promotion of Dementia Friends and training of frontline staff have assisted with raising the profile of the disease in Warrington. Partnership working between the Council and Warrington CCG is contributing towards promoting earlier diagnosis;

- ***There is a need to fully develop the work force, and to ensure that staff are supported through the Making Every Contact Count (MECC), Prevention and Lifestyles Behaviour Change Competence Framework currently being developed through Public Health.*** This was implemented and continues to be part of the core MECC delivery programme, further training sessions have been developed as part of MECC which include Falls Awareness, the delivery of Dementia Friends sessions and Winter Health which details vital information around energy, insulation, boiler care/ checks and local services that can be cascaded by staff;

- ***It is important to develop robust, systematic mechanisms for reviewing local practice against national good practice recommendations;***
- ***There is a need to review all strategies to ensure that older people have fair access to health promotion programmes.*** These recommendations have been largely implemented; local practice is consistently assessed against national best

practice/evidence, as part of the assessment process fair access to services is also evaluated/reviewed, this programme is on-going.

Some recommendations were implemented after the publication of the previous JSNA chapter but are now in need of further refresh – the refresh can be informed by this JSNA chapter:

- ***There is a need to develop a comprehensive, joined-up, local healthy ageing strategy to address the needs of older people.***

The following recommendations were made within the Service Uptake (older people) chapter in 2012:

- ***In order to manage the significant increase in people that will potentially require services, there is a need to continue developing efficient and effective preventative services, which will support people remaining at home in a safe and secure environment. These services should minimise the risks and prevent deterioration in their health. The provision of equipment and telecare requires ongoing investment.*** Additional investment was made in telecare, aids and adaptations and assistive technology via capital monies within the Better Care Fund from 2015/16. Additional investment has been made in schemes to help people to remain healthy at home by providing a holistic assessment of need and a benefits check leading to the provision of housing adaptations and improvements to assist independence;

- ***Early intervention for people with signs of developing dementia may delay the illness and reduce or postpone the need for long-term complex care provision (National Audit Office, 2007).*** Dementia Action Alliance set up in 2013. Dementia Friends Training. A Dementia Strategy and action plan has been developed;

- ***There is an increased need for advocacy services to support the increasing numbers of people who lack mental capacity for day to day decision making. Advocacy services are a useful means of safeguarding the rights of people with dementia and ensuring that their voices are heard (Social Care Institute for Excellence, 2005).***

- ***Investment in reablement services is urgently required in order to minimise the long-term care needs of older people and, in some cases, avoid the need for care as a result of short-term interventions.*** Additional investment has been made in reablement services via the Better Care Fund. A Reablement service has been developed aligned to the current intermediate care offer and has been successful in reducing care needs and increasing a person's level of independence;

- ***It is very likely that there will be a need for increased numbers of residential and nursing Elderly Mentally Impaired (EMI) beds within Warrington over the next 5-10 years, unless a cure for dementia is found.*** Commissioners have worked with providers to develop a market position statement for Older people which highlights the need for more EMI Nursing provision in the town. Commissioners are actively working with providers to encourage change of registration and supporting planning applications for new providers who wish to provide this type of service;

- ***More frontline staff will be required to train as Best Interest Assessors. Best Interest Assessors complete statutory assessments under specific legislation for a small proportion of people without capacity, who, because of their complex needs, may need to be cared for in situations which may amount to a deprivation of liberty in a care home or hospital;***

- ***More services need to be developed within communities, in partnership with the third sector, in order to improve access to support which meets low level needs. These services should also offer low cost solutions for people to purchase equipment as an alternative to referring to adult social care. Some current examples of this include the Centre for Independent Living, who are able to sell equipment at a near cost price, as they are a registered charity, and Warrington Home Improvement Agency (WHiA) who are currently completing minor adaptations to clients homes. These services are also very effective at addressing social isolation and loneliness, which would promote positive mental health (Association of Directors of Adult Social Services, 2010);***

- ***Counselling services are needed to support people who are bereaved or have newly diagnosed conditions;***

- ***Increased investment in Disabled Facilities Grants (DFG) to assist more older people to adapt their homes and remain living within the community.*** Additional monies have been made available to all local authorities for Disabled Facilities Grants via the Better Care fund from April 2016. Warrington have increased its DFG programme as a result and invested in more minor adaptations too;

- ***More 'Extra Care' housing provision which supports the development of communities with no care needs, low level care needs and complex care needs. This should deliver good value for money, reduce isolation and prevent admissions into residential care. They also offer a good resource to local communities.*** Commissioners are developing a "Market position Statement" of older peoples housing including "Extra care" provision with a view to helping shape the Boroughs needs over the next 20 years matching provision to need. This work is linking in to the Warrington Local Housing Plan currently being developed.

Summary of Key Issues

- The Warrington Health and Wellbeing Survey (2013) found that people aged 65+ were more likely to rate their own health as fair/poor/very poor (41%) when compared to younger age groups. Over half of the respondents had a long standing illness or disability, and of those with a long standing illness or disability 21% felt that it limits their daily life a lot. Older people living in more disadvantaged areas are much more likely to have a long-standing illness, and more likely to rate their own health as fair/poor/very poor;

- Older people are much less likely to smoke (8%) and diet is generally better amongst older people. However, just over a fifth of older people are obese; older people are less likely to be physically active and 14% of people aged 65+ had unsafe levels of alcohol consumption. Most lifestyle risk factors are worse in more deprived areas, however high alcohol consumption is worst in least deprived areas;
- Many long-term conditions are age-related, with higher prevalence in older people. Disease prevalence models suggest that approximately three-quarters (74%) of people with COPD have been diagnosed, so there may be approximately 1,300 people undiagnosed in Warrington. The models also suggest that approximately just over half (53%) of people with hypertension are diagnosed with it, there may be approximately 25,400 people undiagnosed. Disease prevalence models for dementia suggest that there are 2,300 residents with the condition; however 1,591 patients have received a diagnosis. This suggests there may be approximately 700 people with dementia as yet undiagnosed (i.e. estimated diagnosis rate of 69% in 2014);
- Population projections estimate that by the year 2030, the 65+ population will increase by 43% (compared to 2014 populations), the percentage increases are more stark in the older age bands (for example a 90% increase in people aged 80+). The increase in population is likely to present a significant burden on the health and social care system. It has been estimated that by the year 2030, the number of people with dementia is likely to increase by 77%, whilst those with COPD, CVD and hypertension will increase by over 40%;
- Influenza vaccination uptake in the over 65's in Warrington does not meet nationally set targets. Low vaccination uptake could be partially attributable to the high proportion of emergency hospital admissions due to influenza and pneumonia and high excess winter mortality, especially for deaths caused by respiratory conditions;
- When older people are in need of emergency medical care or support, it has been found that the interventions/care provided tend to be more intensive than the levels of support provided to younger populations (most likely due to older people experiencing multiple health conditions). For example, 29% of over 65's who contacted the GP Out of Hours service received a home visit, compared to 8% of those aged 65 and under. Calls made to 111 (April 2015): 14% of calls made by patients aged over 65 years resulted in an ambulance being dispatched to the patient, compared to only 5% of calls for those aged less than 65 years. During 2014, over half (53%) of over 65's who attended an Emergency Department at hospital were then admitted; this was much higher than the younger age groups (11% under 15; 19% 15 to 64 year olds). Finally, the rates of emergency admissions into hospital are more than three times higher in the over 65's than in the younger population;
- It appears that there are positive outcomes from reablement/rehabilitation services within Warrington; however the numbers supported are quite small. Of the 5,515 discharges during 2014/15, 145 were offered reablement/rehabilitation services (2.7%), this was slightly lower than England (3.1%). However, of the 145 offered support, 83.7% (125) remained at home 91 days after discharge into reablement/rehabilitation services (2014/15); this was slightly higher than England (82.1%);
- The number and rate of need assessments conducted by adult social care have reduced over recent years. The number of older people in receipt of services

provided by Warrington Adult Social Care (Community care, residential and nursing care) reduced during 2013/14. Given the increase in the ageing population, this finding was not expected. The number of people receiving needs assessments and services reduced due to changes in the FACS (Fair Access to Care Services) eligibility criteria, reduction in council budgets, signposting clients to the third sector and an increase in the number of people in receipt of NHS Continuing Healthcare;

- Information collected by Healthwatch Warrington suggests that some older people in receipt of health and social care services are in contact with numerous professionals and agencies; this could lead to confusion for patients, repeating the same information at several appointments and referral delays between agencies.

Recommendations for Commissioning

- Providers of lifestyle services (e.g. smoking cessation, healthy weight, alcohol reduction) should ensure that the services they provide are promoted and accessible to older people;
- National influenza campaigns are ran each year to encourage people over the age of 65 (as well as those under 65 classed 'at risk') to receive their vaccination. However, it is suggested that a local influenza vaccine campaign should be explored to further increase uptake. It is also recommended that GP practices with consistently high influenza vaccination uptake share their good practice with other GP practices across the town;
- It is suggested that alternative models of urgent care are explored, more specifically the use of emergency care practitioners (ECPs) working with ambulance technicians or providing mobile care home services;
- Commissioners need to ensure that services that provide care to older people can adapt to the growing population. For example, ensuring that there are enough GP practices, clinics, residential/nursing/extra care/sheltered/retirement homes and/or places available to the older residents of Warrington.
- Actions are currently in place to further develop integrated care in Warrington with the establishment of the Accountable Care Organisation from April 2017;
- Commissioners to ensure that dementia care and support offered in Warrington meets the needs of this growing population, this should also include future housing needs for this particular population group;
- Commissioners should ensure that there are opportunities to reduce social isolation in older people;
- The Market Position Statement for older people should be updated with information and findings presented in this JSNA chapter.

1) WHO IS AT RISK AND WHY?

Age is a risk factor for most diseases. Prevalence rates of most conditions rise with increasing age. Most chronic or long term conditions are more prevalent amongst older people, and mobility issues associated with arthritis put older people at a greater risk of falls. Some mental health problems, notably dementia, are most common among older people, while other conditions may be more or less prevalent than among the general population.

The fact that populations are getting older is well documented. Numerous reports have been written describing the impact of this demographic shift; the likely pressure on health and social care services and the need to act now to ensure that systems are designed to meet the needs of older people, and that prevention is prioritised to ensure that older people are supported to live healthier lives for longer.

During 2014 two documents were published, both of which may have altered the health and social care services an older person might have received previously.

The Care Act 2014 resulted in a number of new requirements relating to the commissioning and provision of care. Some changes came into force in April 2015; the remaining changes that were due to come into force in April 2016 have been delayed until April 2020[i].

The NHS Five Year Forward View (2014) presented plans for how the NHS will maintain and improve the quality of care patients receive[ii] through the development of new models of care. The NHS Five Year Forward View proposes the dismantling of the traditional divides between primary care (GP services), community services and hospitals to an integrated approach to patient care.

The Better Care Fund (BCF) has been developed to help support the vision of the NHS Five Year Forward View by integrating health and care services. These services have traditionally been provided separately by the NHS and local government, the BCF encourages integration by pooling budgets from these organisations. The overall aims of the BCF are for people to manage their own health and wellbeing, live independently in their communities for as long as possible, improve patient experience, resulting in a better quality of life (NHS England, 2016).

'Stepping up to the Place' (2016) is a shared vision between the Association of Directors of Adult Social Care, Local Government Association, NHS Clinical Commissioners and NHS Confederation of what a fully integrated, transformed system should look like based on current evidence. The report calls for the following actions:

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[i] Further information about the implications of The Care Act 2014 and older people can be found at: http://www.ageuk.org.uk/brandpartnerglobal/shropshireandtelfordvpp/docs/ageuk-care-act-2014-presentation.pdf

[ii] Further information about proposals to improve patient care (especially for older people) can be found at: http://www.ageuk.org.uk/professional-resources-home/policy/health-and-wellbeing/nhs-five-year-forward-view/

- Local systems to embed integration as ‘business as usual’;
- A collective approach to achieving integration by 2020;
- Consensus and action on the barriers to making integration happen;
- Dialogue with national policy makers on ensuring integration is effective;
- Ongoing testing and evaluation to develop the evidence base;
- National partner action to enable the minimum requirements to integrate effectively.

(NHS Confederation, 2016a)

Additionally, the development of Sustainability and Transformation Plans (STPs) across all areas of England encourages the integration of health and care services.

The Kings Fund (2014) has documented evidence relating to 10 components of care. Their report aims to provide a structure for the development, improvement and integration of care for older people. Where possible, this chapter presents analysis on the local picture in relation to these components of care, and utilises evidence on best practice to highlight where services could be remodelled or delivered differently.

2) THE LEVEL OF NEED IN WARRINGTON

The Kings Fund 'Making our health and care systems fit for an ageing population' report proposes ten components of care. Analysis relating to key indicators within these components for the local population is presented in this section.

Figure 1: Components of Care for Older People. Kings Fund 2014

2.1 Age Well and Stay Well:

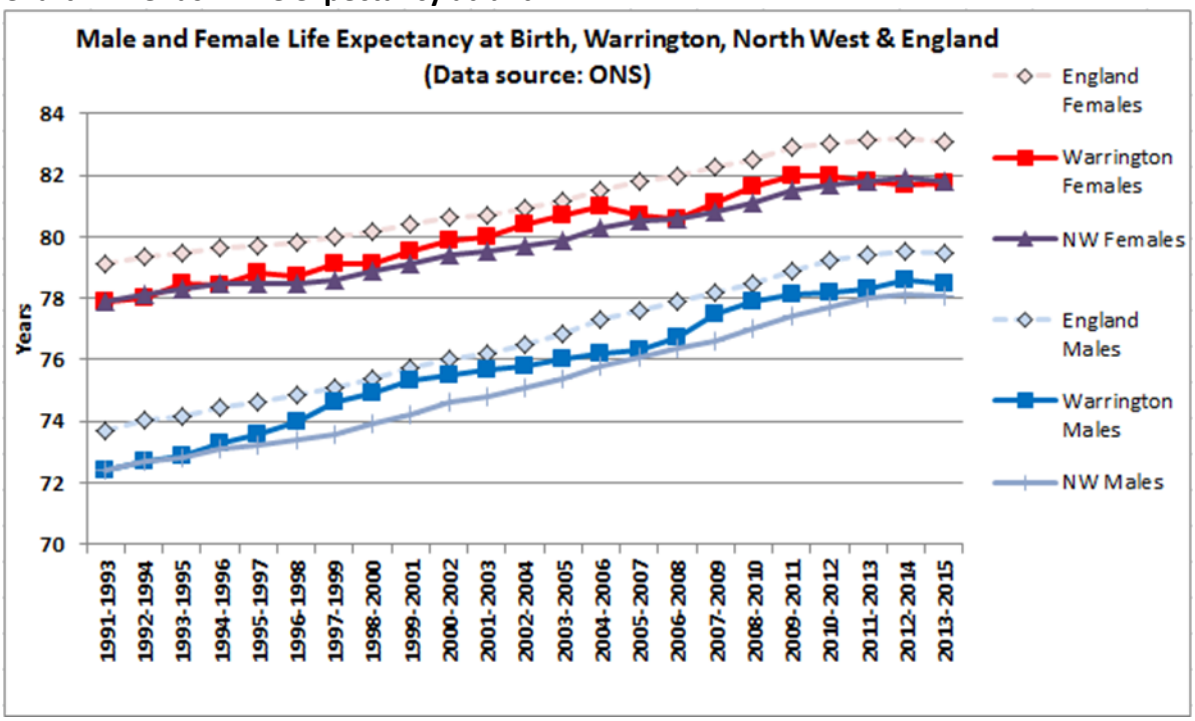
Population: The Office of National Statistics estimate that there are approximately 36,900 people aged 65 and over in Warrington borough in 2015 (20,100 women and 16,700 men).

Life Expectancy: Life expectancy is an internationally accepted measure of the overall health of a population the expected number of years of life remaining at a given age. It is a summary measure which provides a useful indicator of the general state of health of a population and allows for comparisons between groups. The most commonly used measure of life expectancy is life expectancy at birth, but comparative figures are also available at age 65.

Life expectancy at birth: Both nationally and in Warrington, life expectancy at birth is consistently higher for females than males. Life expectancy at birth for both males and females in Warrington has generally increased over time, although both have consistently been lower than the England average. Office of National Statistics data for the 2013-2015 time period suggests that male life expectancy at birth in Warrington is 78.5 years, compared to 79.5 years in England (a 1 year gap), and that female life expectancy at birth in Warrington is 81.8 years, compared to 83.1 years in England (a 1.3 year gap). The long term

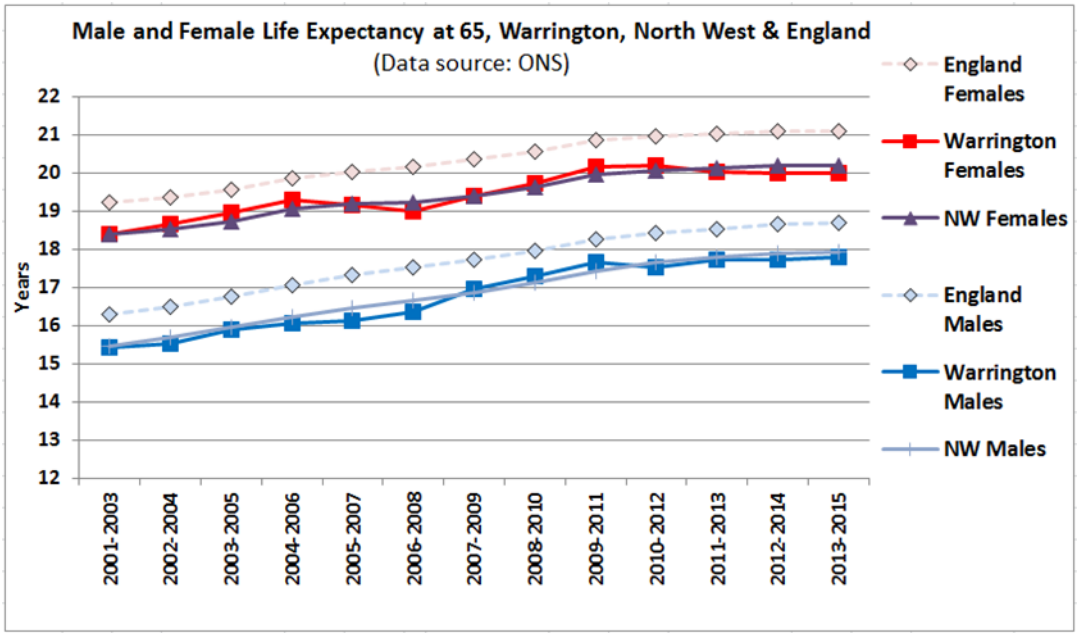
trend has shown a steady increase in life expectancy nationally, in the North West and in Warrington, although it seems to have levelled out over the past 3 time periods.

Chart 1: Trends in life expectancy at birth



Life expectancy at age 65: Both nationally and in Warrington, life expectancy at 65 is consistently higher for females than males. Life expectancy at age 65 for both males and females in Warrington has generally increased over time, although both have consistently been lower than the England average. Office of National Statistics data for the 2013-2015 time period suggests that male life expectancy at age 65 in Warrington is 17.8 years, compared to 18.7 years in England (a 0.9 year gap), and that female life expectancy at age 65 in Warrington is 20.00 years, compared to 21.1 years in England (a 1.1 year gap). In both males and females, life expectancy at 65 has shown a long term increasing trend in England, the North West and in Warrington, although the rate of increase seems to have slowed since approximately 2009-2011.

Chart 2: Trends in life expectancy at age 65



In terms of time spent living without a disability, the most recent Office of National Statistics data for disability-free life expectancy (DFLE) are for the 2013-2015 time period. DFLE at age 65 is the amount of time that an individual, on average can expect to live disability-free.
For 2013-15, DFLE at age 65 is shown in the following table. Female DFLE was the same in Warrington (10.2 years) as the England average (10.2 years), but male DFLE in Warrington (10.7 years) was higher than England (10.0 years). In Warrington, the expected time living with a disability is 6.7 years for men and 10.2 years for women.

Table 1: Life Expectancy at 65 and Disability-free Life Expectancy at 65

	WARRINGTON			ENGLAND	
Time period 2013-15	**MEN**	**WOMEN**		**MEN**	**WOMEN**
Life expectancy at 65	17.8	20.0		18.7	21.1
Expected age at death	82.8	85.0		83.7	86.1
Disability-free life expectancy at 65	10.7	10.2		10.0	10.2
Total expected disability-free years	75.7	75.2		75.0	75.2
Expected years with a disability	7.1	9.8		8.7	10.9

Excess Winter Mortality: The number of excess winter deaths depends on the temperature and the level of disease in the population as well as other factors, such as how well equipped people are to cope with the drop in temperature. Most excess winter deaths are due to circulatory and respiratory diseases, and the majority occur amongst the elderly population (Public Health England, 2015a). Nationally there were an estimated 17,600 excess winter deaths in people aged over 75 in 2015/16, compared with 6,700 in people aged under 75 (ONS, 2016).

Between August 2015 and July 2016 there were 1,886 deaths in Warrington, 52 of these deaths classed as 'excess winter deaths'. Deaths during the winter period of December 2015

to March 2016 were 8.4% higher than the average of the non-winter periods (August to November 2015 and April to July 2016). In 2015/16, the older age group of 85 years and above had a significantly higher proportion of excess winter deaths than all ages. Winter deaths were 23.5% higher for those aged 85 years and above. Respiratory disease was the largest contributor to excess deaths (a pattern seen both nationally and in Warrington), deaths from respiratory disease were 40% higher during the winter months.

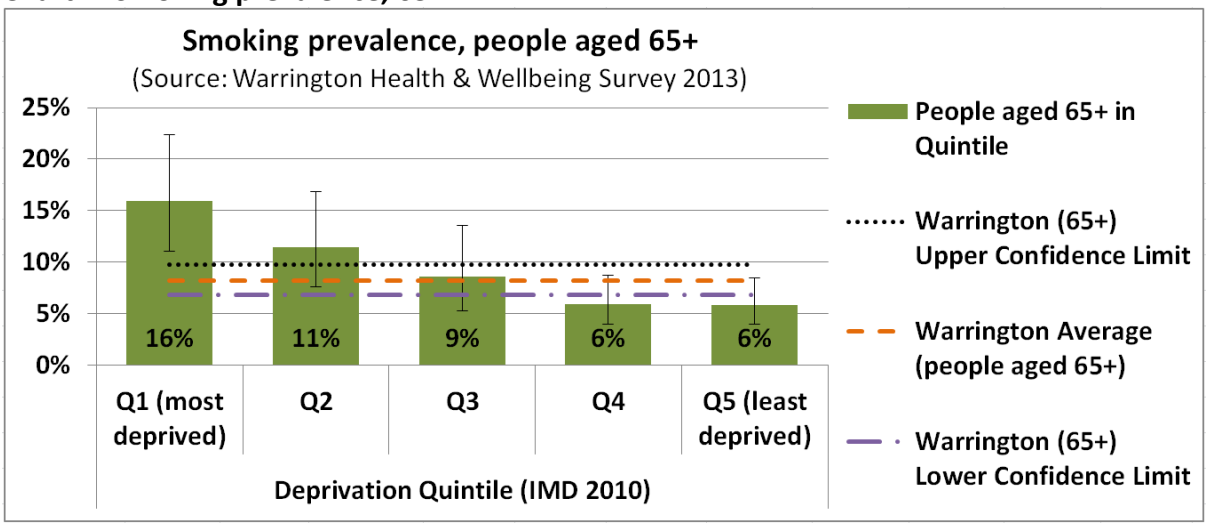
Lifestyle Risk Factors, Emotional Wellbeing and Wider Determinants of Health

The following section sources information gathered through the Warrington Health and Wellbeing Survey 2013. For further information about the survey and guidance in the interpretation of the following information, please see Appendix A.

Lifestyle factors

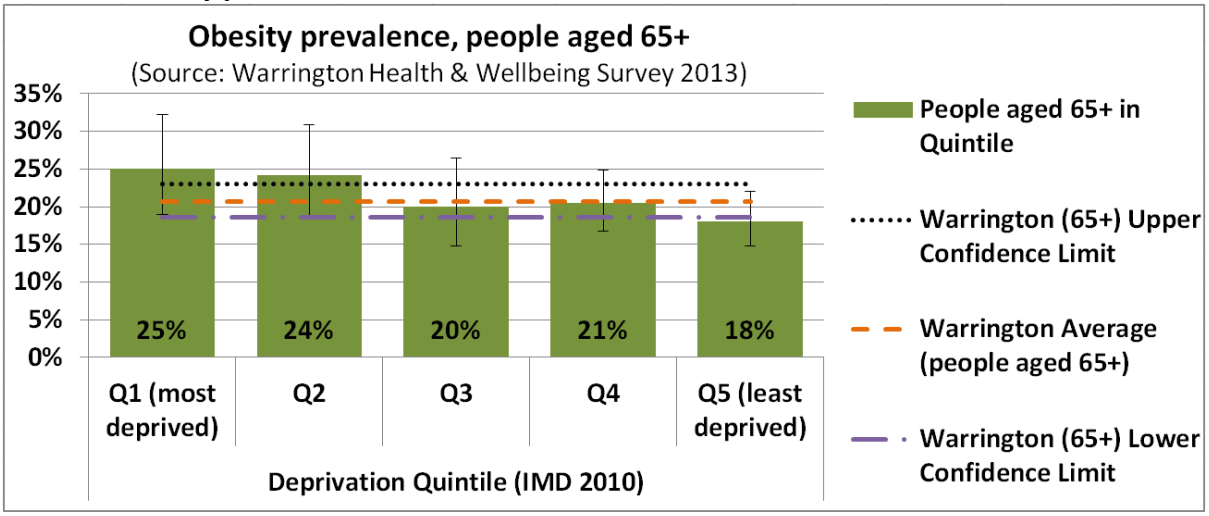
Smoking: Overall, 8% of people aged 65+ said they were a current smoker. Applied to Warrington 2014 population estimates, this represents approximately 2,900 people. There was little difference between men and women, but a very strong link with deprivation. Of people aged 65+, 16% in the most deprived areas (Quintile 1) said they smoked, steadily reducing to 6% in the least deprived. Quintile 1 was statistically significantly worse than the Warrington average for people aged 65+.

Chart 2: Smoking prevalence, 65+



Obesity: Obesity prevalence in the 65+ age-band (21%) and the 40-64 age-band (23%) was significantly higher than in the 18-39 age-band (14%). Applied to Warrington 2014 population estimates, this represents approximately 7,500 people aged 65+. It was noticeably higher in the more deprived quintiles (Q1 and Q2) than the other, less deprived areas, although no quintile was statistically significantly different to the Warrington average for people aged 65+. In women it was highest in the two most deprived quintiles (Q1 and Q2), and lowest in the least deprived quintile (Q5). In men, there was less difference between quintiles, although the most deprived quintile had highest prevalence.

Chart 3: Obesity prevalence, 65+



Diet:

- People aged 65+ were significantly more likely to eat 5 or more portions of fruit/veg per day (64%), than people in the younger age-bands (57% of 40-64 year-olds and 52% of 18-39 year-olds). In the 65+ age-band, 66% of women and 61% of men said they ate 5 or more portions of fruit and veg per day.
- Eating takeaways or fast food varied greatly with age and between men and women. 20% of people aged 65+ said they ate a takeaway or fast food at least once per week, compared to 25% of 40-64 year-olds and 38% of 18-39 year-olds. In people aged 65+, 15% of women and 26% of men said they ate a takeaway or fast food at least once per week.
- Eating convenience foods also varied greatly with age and between men and women, with older people less likely than younger people to eat convenience foods, and women less likely than men. 8% of people aged 65+ said they ate 3 or more convenience foods per week, compared to 12% of 40-64 year-olds and 23% of 18-39 year-olds. In people aged 65+, 5% of women and 12% of men said they ate 3 or more convenience foods per week.
- In general, diet behaviours were much better in the 65+ age-band, and by far the worst in the 18-39 age-band. Those aged 65+ were significantly less likely to have 2 or more of the poor diet behaviours (12%), compared to 18% of 40-64 year-olds and 31% of 18-39 year-olds. In the 65+ age-band, 8% of women and 18% of men said they had 2 or more of the poor diet behaviours.

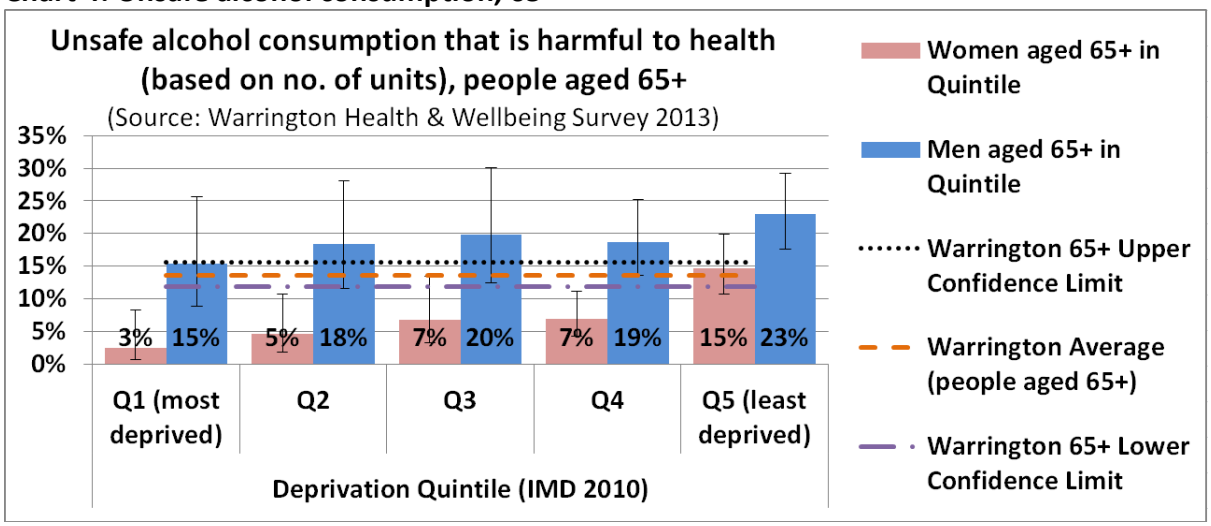
Alcohol Consumption: At the time of the survey in 2013, Department of Health guidance stated that in order to protect health, men should not regularly exceed 3-4 units per day, and women should not regularly exceed 2-3 units per day. The survey analysis used the following to determine 'unsafe alcohol consumption': 22 or more units/week for men and 15 or more units/week for women. (Since then, the DH has revised this guidance; both men and women should not regularly exceed 2-3 units per day).

- Overall 14% of people aged 65+ had unsafe levels of alcohol consumption (based on weekly units), but this varied widely with age, deprivation, and between men and

women. Applied to Warrington 2014 population estimates, this represents approximately 4,900 people aged 65+.

- In general, women were much less likely than men to drink alcohol to unsafe levels. Women aged 65+ are much less likely to drink alcohol to unsafe levels (9%) than younger women (16% of 40-64 year-olds and 13% of 18-39 year-olds). In men the difference by age-band and by deprivation is less extreme. 20% of those aged 65+, compared to 26% of 40-64 year-olds and 18% of 18-39 year-olds drink alcohol to unsafe levels.
- Most lifestyle risk factors are worse in more deprived areas. However high alcohol consumption is worst in least deprived areas.
- Men aged 65+ from the least deprived areas (Quintile 5) are more likely to do so (23%), those from the most deprived areas (Quintile 1) are less likely (15%). Women aged 65+ from the least deprived areas (Quintile 5) are much more likely to do so (15%), compared to the other deprivation quintiles (between 3% and 7%).
- Compared to the Warrington average for people aged 65+, unsafe alcohol consumption is significantly higher in men from the least deprived areas (Quintile 5), and significantly lower in women from the two most deprived quintiles.

Chart 4: Unsafe alcohol consumption, 65+

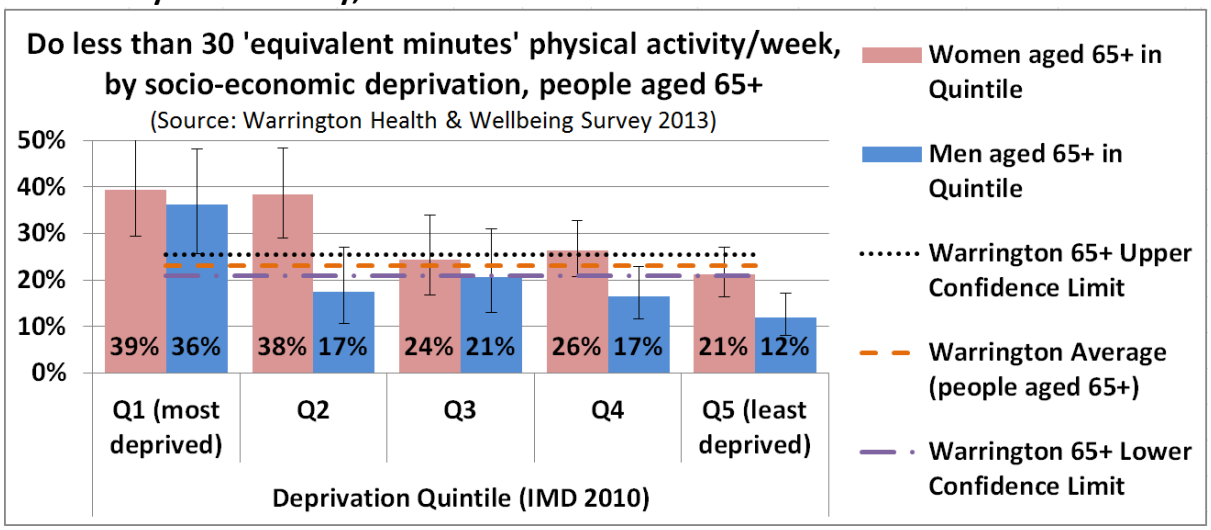


Physical Activity: "Equivalent" minutes of physical activity is defined as the number of minutes of moderate activity + 2 times the number of minutes of vigorous activity. This analysis classifies a very low level of physical activity to be less than 30 'equivalent' minutes per week.

- Unsurprisingly, people in the 65+ age-band were more likely to have very low levels of physical activity (23%) compared to the younger age-bands (13% of 40-64 year-olds and 8% of 18-39 year-olds). Applied to Warrington 2014 population estimates, this represents approximately 8,400 people aged 65+.
- In the 65+ age-band, women aged 65+ were much more likely to report very low levels of physical activity (28%) than men (18%). This may be partially explained by there being many more women than men in the upper age-bands, e.g. 80+.
- Compared to the Warrington average for people aged 65+, a very low level of physical activity was significantly worse in women from the most deprived 2 quintiles

(Q1 and Q2); in men, it was significantly worse in the most deprived quintile (Q1). It was significantly better in men from the least deprived quintile.

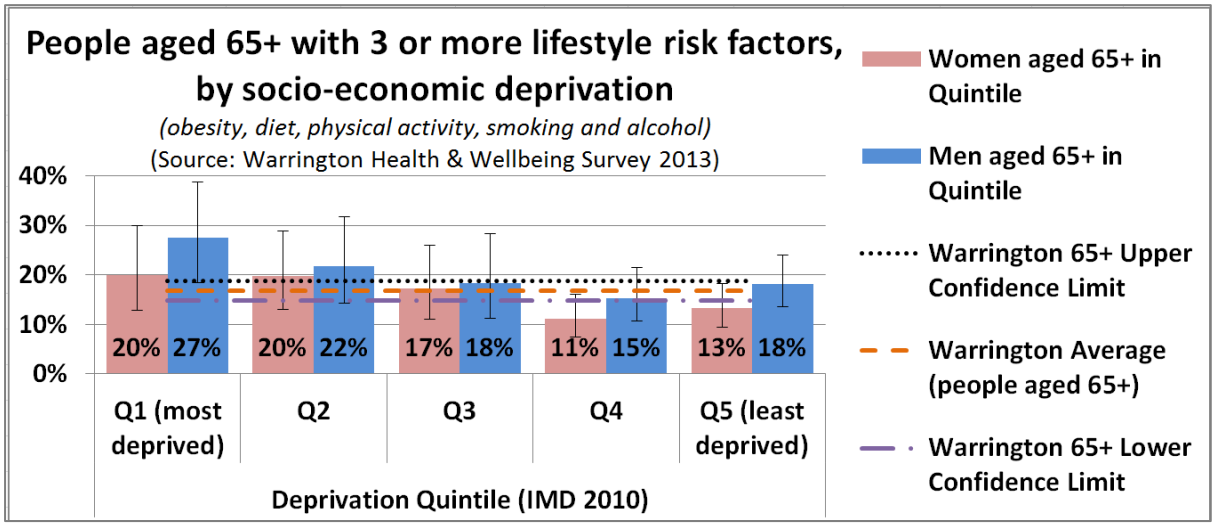
Chart 5: Physical inactivity, 65+



Multiple Lifestyle Risk Factors: Key modifiable lifestyle factors that increase the risk of cardiovascular disease (CVD) are: smoking, poor diet, obesity, lack of physical activity and high alcohol consumption. These risk factors tend to 'cluster' together. The 5 risk factors used for this analysis are: overweight/obese, low physical exercise, <5 fruit/veg per day, excess alcohol consumption, and smoking. This analysis looks at whether people had 3 or more of these risk factors.

- Overall, 17% of people aged 65+ had at least 3 of the risk factors. Applied to Warrington 2014 population estimates, this represents approximately 6,000 people.
- In all deprivation quintiles and all age-bands, a higher proportion of men than women had at least 3 of the risk factors (in people aged 65+, 19% men and 15% women).
- In men, there were big differences by age; 22% in 18-39 year-olds, 30% in 40-64 year-olds and 19% in people aged 65+. In women, there was little difference between age-bands.
- Having 3 or more risk factors was strongly linked to deprivation. In men aged 65+, more than a quarter (27%) in the most deprived quintile had 3+ risk factors (the other quintiles ranged from 15% to 22%). In women aged 65+, 20% of women in quintiles 1 and 2 had 3+ risk factors (the other quintiles ranged from 11% to 17%).

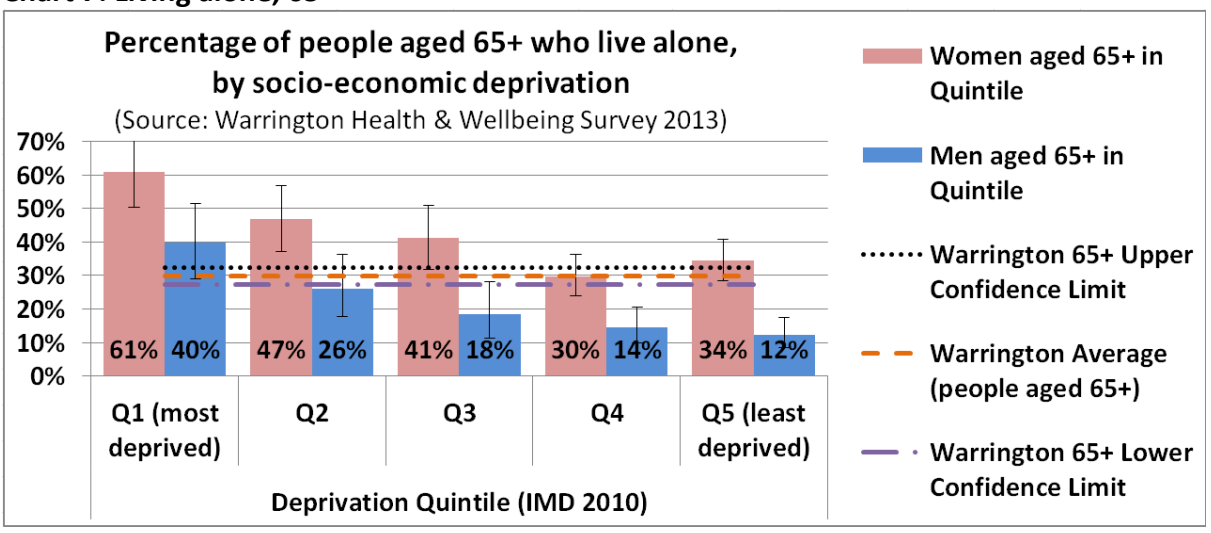
Chart 6: Three or more lifestyle risk factors, 65+



Living alone:

- Unsurprisingly, a higher proportion of people aged 65+ live alone (30%) compared to 16% of 40-64 year-olds and 10% of 18-39 year-olds.
- In the 65+ age-band, a much higher proportion of women (39%) than men (19%) lived alone.
- It varied substantially by socio-economic deprivation. In the most deprived areas (Quintile 1) 61% of women aged 65+ said they lived alone, much higher than Quintile 4 (30%) and Quintile 5 (34%). In the most deprived areas (Quintile 1) 40% of men aged 65+ said they lived alone, much higher than Quintile 4 (14%) and Quintile 5 (12%).
- Compared to the Warrington average for people aged 65+, a significantly higher proportion of women from the two most deprived quintiles live alone, and a significantly lower proportion of men from the two least deprived quintiles, live alone.

Chart 7: Living alone, 65+



Contact with family/friends/neighbours: Respondents were asked whether they had had any contact with their family, friends or neighbours (excluding the people they lived with) in the last 2 weeks. 99% of people aged 65+ said that they had. 99% of people aged 65+ also said they had had face-to-face contact with family/friend/neighbours (excluding the people they lived with) in the past 2 weeks, and this was significantly higher than people in the younger age-bands. There was little difference between men and women, and between deprivation levels.

Loneliness: Although there is perhaps a general assumption of there being more social isolation and loneliness in older people, this was not born out in the Health and Wellbeing Survey, in which there was little difference between age-bands. Overall, 7% of people aged 65+ said they felt lonely most of the time or quite often, and there was relatively little difference between men and women. There was a slight link with deprivation, with 13% of people aged 65+ in the most deprived areas (Quintile 1) saying they felt lonely most of the time or quite often, compared to 9% in Quintile 2, and 5% or 6% in other areas.

Finances: The survey was undertaken in 2013. Since then there have been major changes to the social security benefits system. If the survey were re-run now, it might give substantially different results, although not necessarily specifically to people aged 65+.

- **Struggling financially:** People aged 65+ were much less likely to say that they were struggling to manage financially (3%), than 40-64 year-olds (9%) and 18-39 year-olds (11%). There was little difference between men and women in the 65+ age-band, and surprisingly, there was no link with deprivation, with quintiles ranging from 2% to 4%. (NB there was a very strong link with deprivation in the younger age-bands).
- **Went without food:** The percentage of people aged 65+ who said they had gone without food in order to manage financially was much lower (1%) compared to 40-64 year-olds (5%) and 18-39 year-olds (7%). In the 65+ age-band there was little difference between men and women, and there was no link with deprivation (although there was a link in the younger age-bands).
- **Went without heating:** The percentage of people aged 65+ who said they had gone without heating in order to manage financially was lower (7%) compared to 11% in the younger age-bands. However, going without heating may affect the health and wellbeing of older people to a greater extent than younger people. In the 65+ age-band, there was little difference between men and women, but there was a slight link with deprivation; 5% in the least deprived quintile (Quintile 1) and 8%-10% in other areas.
- **Borrowing:** Only 1% of people aged 65+ said they borrowed to buy basic necessities, compared to 10% of 40-64 year-olds and 20% of 18-39 year-olds. Although only 1% of people aged 65+ said they borrowed, this ranged from almost 0% in least deprived areas (Quintiles 4 and 5) to 4% in the more deprived areas (Quintiles 1 and 2). There was very little difference in men and women aged 65+.

Feelings of safety: Respondents were asked whether they felt safe during the day and after dark, in their home and out in their local neighbourhood.

Felt unsafe at home during the day:

- 3% of people aged 65+ said they felt very or fairly unsafe in their home during the day. This was similar to the younger age-bands. Applied to Warrington 2014 population estimates, this represents approximately 1,000 people aged 65+.
- In people aged 65+, it ranged from 2% in the least deprived quintile to 5% (i.e. 1 in 20) in the most deprived.
- There was little difference between men and women.

Felt unsafe at home after dark:

- 11% of people aged 65+ said they felt very or fairly unsafe in their home after dark. This was reasonably similar to the younger age-bands. Applied to Warrington 2014 population estimates, this represents approximately 4,100 people aged 65+.
- There was a strong link with deprivation; in people aged 65+, it ranged from 17% (i.e. 1 in 6) in the most deprived quintile to 8% in the least deprived.
- Women in all age-bands were more likely than men to feel unsafe. In people aged 65+, 13% of women and 9% of men felt unsafe.

Felt unsafe out in the neighbourhood during the day:

- 7% of people aged 65+ said they felt very or fairly unsafe out in their neighbourhood during the day. This was slightly higher than the younger age-bands (4%-5%). Applied to Warrington 2014 population estimates, this represents approximately 2,500 people aged 65+.
- There was a strong link with deprivation; in people aged 65+, it ranged from 15% (i.e. 1 in 7) in the most deprived quintile to 4% in the least deprived.
- In people aged 65+, there was little difference between men (6%) and women (8%).

Felt unsafe out in the neighbourhood after dark:

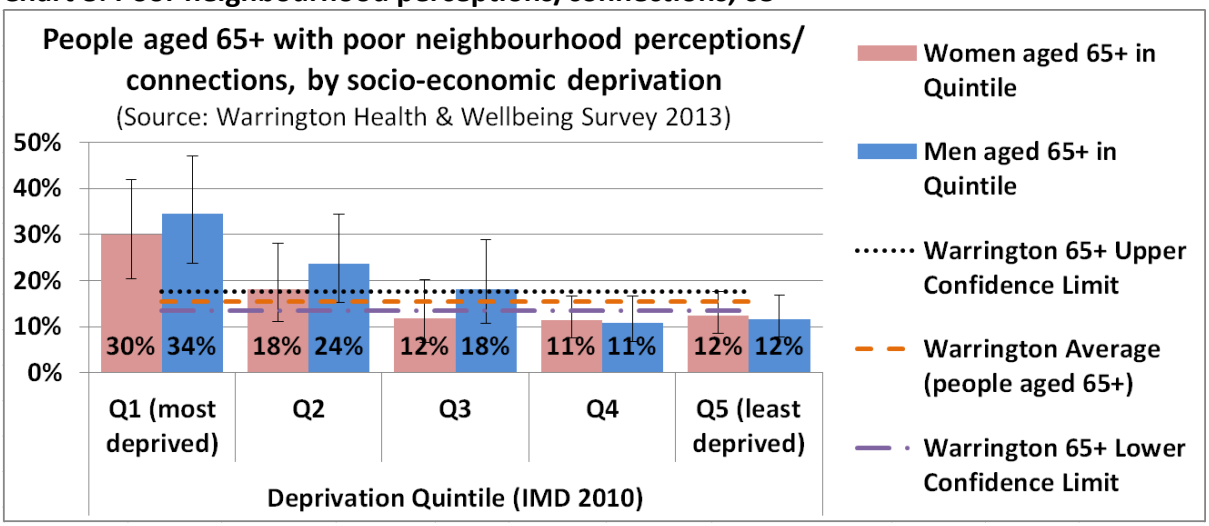
- People aged 65+ were more likely to say that they felt very/quite unsafe out in their neighbourhood after dark (35%), compared to 25% of 40-64 year-olds and 29% of 18-39 year-olds. Applied to Warrington 2014 population estimates, this represents approximately 12,700 people aged 65+.
- In all age-bands, feeling unsafe was very different for men and women; in the 65+ age-band, 44% of women and 25% of men.
- There was a very strong link with deprivation; in women aged 65+ it ranged from 57% in the most deprived areas (Quintile 1) to 38% in the least deprived areas (Quintile 5). In men aged 65+ it ranged from 44% in the most deprived areas (Quintile 1) to 16% in the least deprived areas (Quintile 5).
- Compared to the Warrington average for people aged 65+, a significantly higher proportion of women from the two most deprived quintiles, and a significantly lower proportion of men from the two least deprived quintiles, said they felt unsafe out in their neighbourhood after dark.

Neighbourhood Connections/Perceptions: Survey respondents were asked a series of nine questions from a Neighbourhood Cohesion Scale (Buckner's Social Cohesion Instrument). They were asked how strongly they agreed/disagreed with 9 statements concerning neighbourhood value (such as "*I feel like I belong to this neighbourhood*" and "*I would be willing to work together with others on something to improve my neighbourhood)*.

- Overall, 28% of survey respondents had poor neighbourhood connections/perceptions. The 65+ age-band (15%) was significantly better than the younger age-bands (25% of 40-64 year-olds and 38% of 18-39 year-olds).

- There was a very strong link with deprivation; in women aged 65+ it ranged from 30% in the most deprived areas (Quintile 1) to 18% in Quintile 2, to 11-12% in the less deprived areas (Quintiles 3, 4 and 5). In men aged 65+ it ranged from 34% in the most deprived areas (Quintile 1) to 11-12% in the less deprived areas (Quintiles 4 and 5).
- Compared to the Warrington average for people aged 65+, a significantly higher proportion of men and women aged 65+ from the most deprived quintile had poor neighbourhood connections/perceptions.

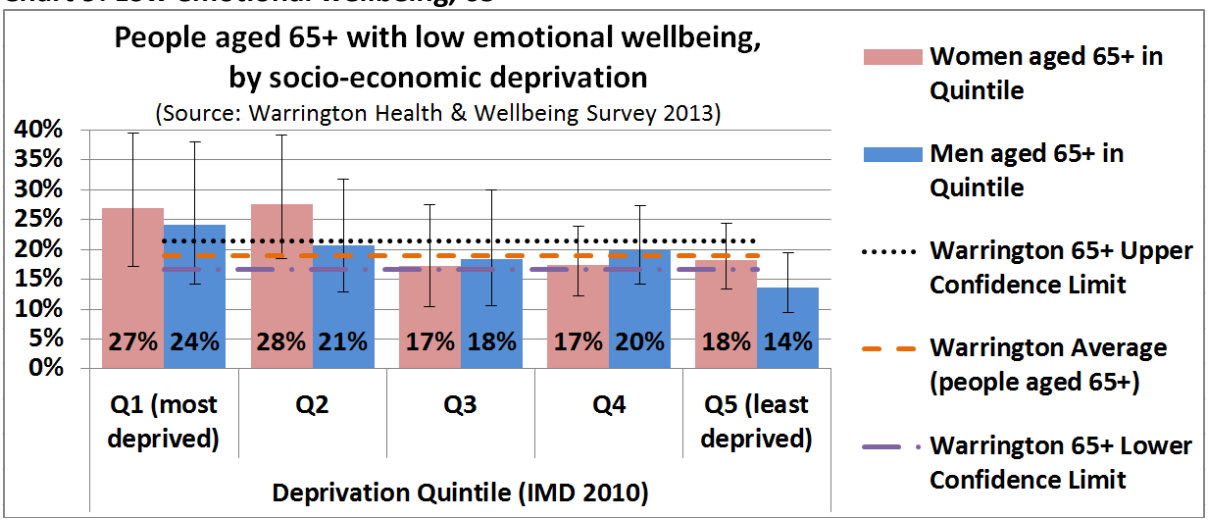
Chart 8: Poor neighbourhood perceptions/connections, 65+



Low Emotional-Wellbeing: *(Data based on WEMWBS (Warwick-Edinburgh Mental Wellbeing Scale)*

- Overall, people aged 65+ were *less* likely to have low emotional wellbeing, compared to the younger age-bands; 19% of those aged 65+ compared to 25% of 18-39 year-olds and 40-64 year-olds. Applied to Warrington 2014 population estimates, this represents approximately 6,900 people aged 65+.
- There seemed to be a link between socio-economic deprivation and emotional wellbeing, with low emotional wellbeing more likely in deprived areas, although no quintile was statistically significant compared to the Warrington average for people aged 65+.
- Amongst women aged 65+, low emotional wellbeing was more prevalent in the more deprived areas (28% in quintile 1 and 27% in quintile 2), than in the other 3 quintiles (17%-18%). Amongst men aged 65+, low emotional wellbeing was most prevalent in the most deprived quintile (24%) and least prevalent in the least deprived quintile (14%).

Chart 9: Low emotional wellbeing, 65+



Vaccinations and Immunisations: Influenza (also known as Flu) is a highly infectious viral illness spread by droplet infection. The flu vaccination is offered to people who are at greater risk of developing serious complications if they catch flu. Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Immunisation is one of the most effective healthcare interventions available and flu vaccines can prevent illness and hospital admissions among these groups of people. Government policy is to recommend immunisation for people aged 65 years and over (as well as those under 65 years in at risk groups and a new childhood influenza programme was started in 2013/14). The ambition is to achieve 75% uptake in those aged 65 years and over (Public Health England, 2015b).

Within Warrington, the uptake of the flu vaccination for people aged 65 years and over has consistently been significantly lower than the national target of 75%. The latest uptake figures from 2015/16 shows that 70.4% of people aged 65 and above received their flu vaccination in Warrington. This percentage uptake is the lowest seen in Warrington over the past 6 years.

Screening Programmes: Detailed information about NHS Cancer screening programmes can be found within the 2015 Cancer JSNA chapter.
– Breast: The NHS Breast Screening Programme provides free breast screening every three years for all women aged 50 and over. Breast screening is a method of detecting breast cancer at a very early stage. The mammogram can detect small changes in breast tissue which may indicate cancers which are too small to be felt either by the woman herself or by a doctor (NHS Cancer Screening Programmes, 2015a).

Since 2012, the percentage of eligible women who were screened for breast cancer has reduced very slightly year on year in England. 2015 saw the lowest uptake of screening for a number of years, 75.4% of eligible women were screened; whilst in 2011 the screening rate was 77.1%. A reduction in the percentage of women screened during 2015 was also seen in the North West (72.6%). However, locally in Warrington the percentage of women screened increased during 2015 from 77.9% in 2014 to 78.5%. The percentage of women

from Warrington who were screened was significantly higher than England for the last four years.

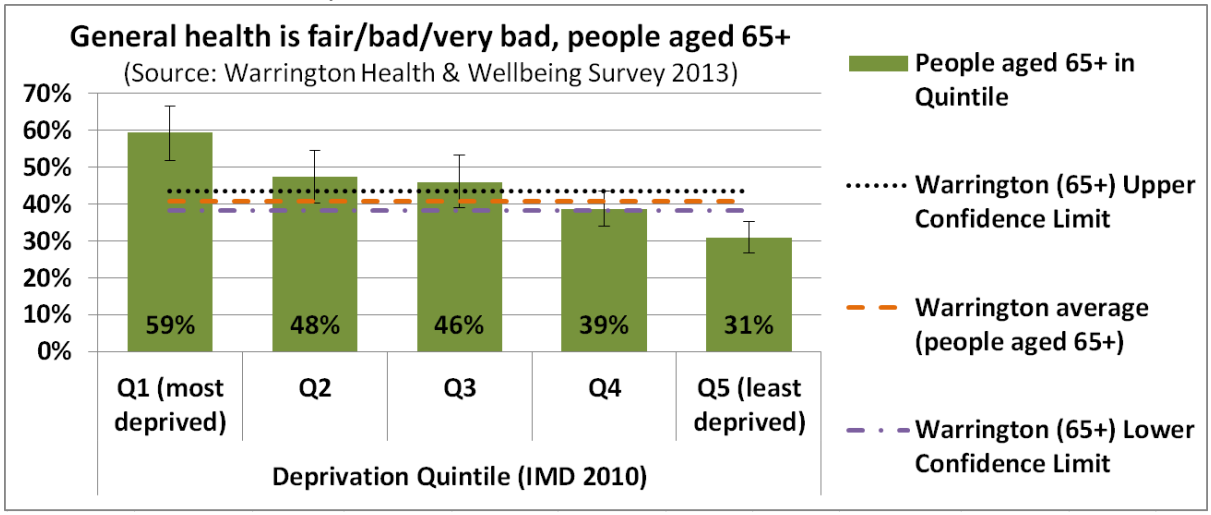
- Bowel: Bowel cancer screening aims to detect bowel cancer at an early stage (in people with no symptoms), when treatment is more likely to be effective. The NHS Bowel Cancer Screening Programme offers screening every two years to all men and women aged 60 to 74 (NHS Cancer Screening Programmes, 2015b). During 2015, 57.5% of eligible people were screened for bowel cancer; this percentage was slightly higher than the national average (57.1%).

- NHS Health check: The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes and kidney disease. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited (once every five years) to have a check to assess, raise awareness and support them to manage their risk of cardiovascular disease. A high take up of NHS Health Check is important to identify early signs of poor health leading to opportunities for early interventions (Public Health England, 2015c). Since 2013/14, 30.6% of the eligible population in Warrington have received an NHS Health Check; this percentage is significantly higher than England (27.4%).

2.2 Live Well with Long-Term Conditions:

Self-reported General Health: Overall, 41% of people aged 65+ said their general health was fair/bad/very bad. Applied to Warrington 2014 population estimates, this represents approximately 14,700 people. There was little difference between men and women, but a very strong link with deprivation. Of people aged 65+, 59% in the most deprived areas (Quintile 1) said their general health was fair/bad/very bad, steadily reducing to 31% in the least deprived (Quintile 5). Quintile 1 was statistically significantly worse than the Warrington average for people aged 65+, and Quintile 5 significantly better.

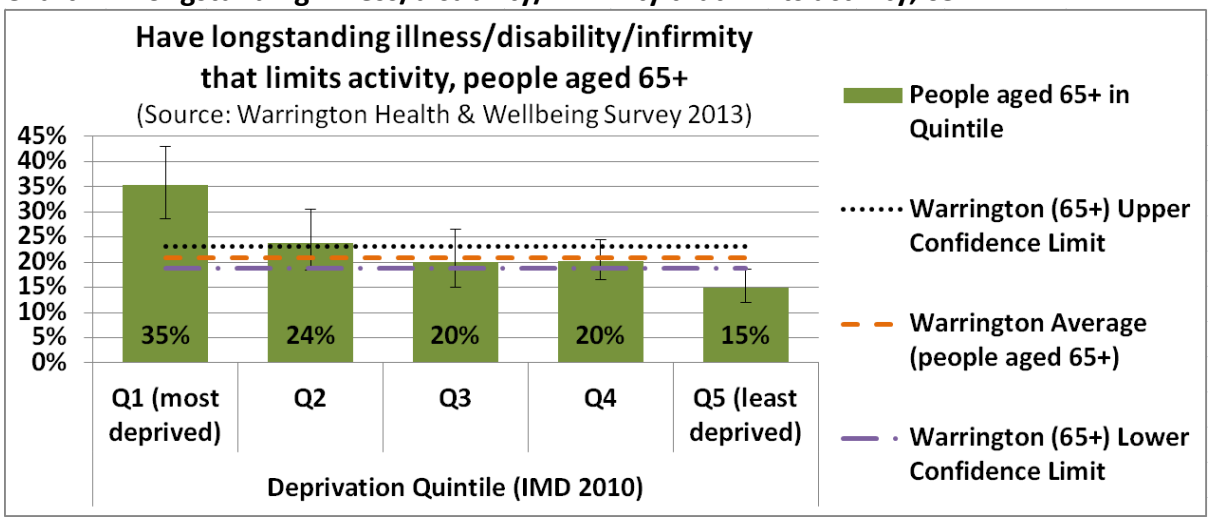
Chart 10: General health, 65+



Long-standing Illness/Disability/Infirmity that Limits Activity: Overall, 21% of people aged 65+ said they had a long-standing illness/disability/infirmity that limited their activities a lot.

Applied to Warrington 2014 population estimates, this represents approximately 7,500 people. There was little difference between men and women, but a very strong link with deprivation. Of people aged 65+, 35% in the most deprived areas (Quintile 1) said they had a long-standing illness/disability/infirmity that limited their activity, steadily reducing to 15% in the least deprived (Quintile 5). Quintile 1 was statistically significantly worse than the Warrington average for people aged 65+, and Quintile 5 significantly better.

Chart 11: Longstanding illness/disability/infirmity that limits activity, 65+



Long Term Conditions (including dementia): Many long-term conditions are age-related, with higher prevalence in older people. For several long-term conditions, the numbers of people diagnosed at each GP practice are reported at GP Practice level through the Quality and Outcomes Framework (QOF). Prevalence is also reported (although this only includes patients who have been diagnosed, and excludes anyone who has the condition but is as yet undiagnosed). Lower prevalence in QOF data may be due to a genuinely lower prevalence in the population, or may be due to under-diagnosis. The following table lists some of these conditions. The data is not reported specifically for the 65+ age-band.

Table 2: Number of people diagnosed with selected long-term conditions

Primary Care data (Quality and Outcomes Framework, QOF), 2015-16			
Long-term condition	**No. people diagnosed in Warrington**	**Prevalence, Warrington**	**Prevalence, England**
Cardiovascular group of conditions:			
Atrial Fibrillation	3,523	1.75%	1.71%
Coronary Heart Disease (CHD)	7,341	3.65%	3.20%
Heart Failure	1,614	0.80%	0.76%
Hypertension	28,063	13.94%	13.81%
Peripheral Arterial Disease	1,615	0.80%	0.61%
Stroke and Transient Ischaemic Attack	3,585	1.78%	1.74%
Chronic Obstructive Pulmonary Disease (COPD)	3,684	1.83%	1.85%
Cancer	4,985	2.48%	2.42%
CKD - Chronic Kidney Disease (age 18+)	5,945	3.72%	4.10%
Dementia	1,508	0.75%	0.76%
Diabetes Mellitus (age 17+)	10,836	6.68%	6.55%
Obesity (age 16+)	15,096	9.44%	9.45%
Palliative Care	494	0.25%	0.34%

Cardiovascular disease (CVD) is a common condition caused by atherosclerosis (a hardening of the arteries). It represents a single family of diseases and conditions linked by common risk factors. These include coronary heart disease (CHD), stroke, diabetes, hypertension (high blood pressure), chronic kidney disease, hypercholesterolemia (high cholesterol), peripheral arterial disease and vascular dementia. Mortality rates from CVD continue to fall, but it still remains the biggest killer in the UK. The burden of these conditions falls disproportionately on people living in deprived circumstances and on particular ethnic groups. CVD is reported not reported as a whole, but as several separate related diseases.

Chronic obstructive pulmonary disease (COPD) is a lung disease characterised by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible. As described by the World Health Organisation, (WHO) the more familiar terms 'chronic bronchitis' and 'emphysema' are no longer used, but are now included within the COPD diagnosis. There were 3,684 registered patients on the COPD registers of Warrington GP practices (QOF 2015/16). This was 1.83% of patients, very slightly lower than England (1.85%).

Hypertension is the single biggest risk factor for stroke. It also plays a significant role in heart attacks. There were 28,063 registered patients on the hypertension registers of Warrington GP practices (QOF 2015/16). This was 13.94% of patients, slightly higher than England (13.81%).

Dementia is a condition in which there is a gradual loss of brain function. Symptoms include memory loss, problems with reasoning and communication, and a reduction in ability to carry out daily activities. There are various forms of dementia, although the most common

ones predominantly affect older people. Recent research (University of Cambridge, 2014) suggests that 7 key risk factors associated with dementia are: diabetes, midlife hypertension, midlife obesity, physical inactivity, depression, smoking and low educational attainment. There were 1,508 registered patients on the dementia registers of Warrington GP practices (QOF 2015/16). This was 0.75% of patients, very slightly lower than England (0.76%).

Public Health Observatory disease prevalence models use age-specific prevalence to provide estimates of the number of people with chronic obstructive pulmonary disease (COPD), cardio-vascular disease (CVD) and hypertension, by age-band. These prevalence rates were applied to population projections to estimate projected numbers of people with each condition in 2015 and 2030. (This assumes that prevalence rates do not change over time). The estimates include both diagnosed and undiagnosed people. (Available from www.apho.org.uk/diseaseprevalencemodels).

The table shows how the prevalence of each condition increases with age. It also shows the estimated number of Warrington residents (including undiagnosed) with each condition, the number diagnosed in Warrington GP practices (only reported for all ages, not 65+), and an estimated diagnosis rate. These suggest that less than three-quarters (72%) of people with COPD are diagnosed with it, so that there may be approximately 1,450 people undiagnosed. These also suggest that approximately just over half (51%) of people with hypertension are diagnosed with it, so that there may be approximately 26,400 people undiagnosed.

Table 3: Prevalence estimates of selected long-term conditions

	Prevalence estimates by age-band				Estimated no. Warrington residents with each condition, including undiagnosed (to nearest 100)		No. patients diagnosed in Warrington GP Practices	Estimated diagnosis rate
					Aged 65+	All ages	All Ages	All Ages
	16-44	45-64	65-74	75+	2015	2015	(QOF 2015/16)	
COPD	0.9%	3.3%	6.9%	7.4%	2,600	5,100	3,684	74%
CVD	3.9%	9.3%	27.4%	38.4%	11,900	20,100	n/a	n/a
Hypertension	9.6%	39.6%	64.9%	71.5%	25,000	54,500	29,092	53%

Dementia prevalence rates rise steeply with age as shown in the table, and are different for men and women. Applying these prevalence rates to the 2015 (ONS) resident population in Warrington of men and women in each age-band suggests there may be approximately 2,300 Warrington residents with dementia. However, there will still be some people with dementia as yet undiagnosed. The large difference between the number on GP dementia registers (1,508 patients), and the estimate using prevalence rates (2,300 Warrington residents), suggests there may be approximately 800 people with dementia as yet undiagnosed (i.e. estimated diagnosis rate of 66% in 2015).

Table 4: Estimated diagnosis rate of dementia

	Estimated dementia prevalence by age-band, % (research undertaken for Alzheimer's Society)					Estimated Warrington residents with dementia, including undiagnosed (to nearest 100)	No. patients diagnosed with dementia in Warrington GP Practices	Estimated diagnosis rate
	70-74	75-79	80-84	85-89	90+	2015	(QOF 2015/16)	
Male	3.1%	5.1%	10.2%	16.7%	27.9%	2,300	1,508	66%
Female	2.4%	6.5%	13.3%	22.2%	30.7%			

Caring responsibilities: The number of known older people with caring responsibilities is limited as figures only relate to those known to council services. Age UK (2016) estimates there are 417,000 carers aged over 80 years, an increase of nearly 39% in 7 years. It is estimated that 1 in 7 people aged 80 and over provide some form of care to family or friends, this would equate to approximately 1,200 older people in Warrington.

2.3 Support for Complex Co-Morbidities and Frailty:

Complex co-morbidities:

Polypharmacy

Polypharmacy refers to the concurrent use of multiple medication items by one individual. Polypharmacy is becoming more common due to a combination of an ageing (and increasingly frail) population and the increasing prevalence of individuals living with several long-term conditions. Polypharmacy can be harmful as some drugs prescribed to a patient may have adverse reactions to each other, therefore making it difficult for the patient to continue taking their medication and impacting on their quality of life. However, by prescribing multiple appropriate treatments can improve outcomes for patients (Duerden et al, 2013).

On average in Warrington, each patient receives 17.4 prescribed items (2014/15); this is a slight increase from the previous two years (17.1 items per year). It is not possible to state the number of older people who are currently in receipt of polypharmacy in Warrington. A study in Scotland found that 16.5% of older patients aged 65 years and above were receiving 10 or more medications (Duerden et al, 2013). If this percentage was applied to the Warrington population, approximately 5,951 people aged 65 years and above would be in receipt of polypharmacy.

To help ensure patients are taking their prescribed medication correctly, that they understand why they have been prescribed their medication and allow patients the opportunity ask any questions about their medication, pharmacies offer a Medicines Use Review.

During 2014, there were 13,093 Medicines Use Reviews conducted in Warrington; there were 3.53 MURs conducted per 1,000 prescription items dispensed, this was slightly higher than the England average of 3.26 (NHS England, 2015). Unfortunately it is not possible to explore the number of MURs by age band.

Frailty

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years (British Geriatrics Society, 2014).

The following table presents the 2015 population estimates of people aged 65 years and above in Warrington along with population projections for 2030. The table shows that it is expected that there will be substantial increases in the over 65 population in Warrington. Based on the prevalence provided by the British Geriatric Society, it is estimated that there are 3,688 people aged 65 and above having frailty, it is estimated that this will increase to 5,160 by 2030. For those aged over 85 years, it is estimated that there are between 1,023 and 2,046 people with frailty, this is expected to increase to somewhere between 2,100 and 4,200 people by 2030.

Table 5: Population estimates and projections of frail older people

Age group	2015	2030	Percentage change
65+	36,876	51,600	40% increase
75+	15,990	26,000	63% increase
80+	8,753	16,800	92% increase
85+	4,092	8,400	105% increase
90+	1,454	3,500	141% increase
Estimates of frail population – 65+			
Age group	**2015**	**2030**	
65+	3,688	5,160	
Estimates of frail population – 85+			
Age group	**2015**	**2030**	
85+	Between 1,023 and 2,046	Between 2,100 and 4,200	

Falls

Falls and falls related injuries are a major challenge to health and social care systems and to the older people who suffer them.

People aged 65 and over have the highest risk of falling, with nearly a third of people aged over 65, and half of people over 80 falling at least once a year. Although most falls do not result in serious injury, it is estimated that annually around 5% of older people living in the community who do fall suffer a fracture or need to attend hospital. Furthermore, falls are the main cause of mortality as a result from injury in people aged over 75 in the UK (Warrington Borough Council, 2015b).

Findings from the Warrington 2015 Falls Health Needs Assessment found that:

- Females tend to account for the majority of falls, particularly females aged 75 and over;
- Just over half of falls occurred in the home, followed by falls in residential institutions accounting for nearly a quarter of falls;
- Over half of fallers attending A&E were admitted to hospital; a third were discharged, with half of those discharged to have follow-up care from their GP;
- Penketh & Cuerdley and Fairfield & Howley wards have significantly higher rates of hospital admissions per 100,000, due to falls; specific LSOAs within these wards have been highlighted several times in different data sets as having the highest number of falls. Nearly all these LSOAs have care homes located within them (Warrington Borough Council, 2015b).

2.4 Accessible, Effective Support in Crisis:

GP Out of Hours (GP OOH)

During 2014/15 a total of 27,462 calls were made by Warrington patients to the GP OOH service, of these calls 23% were made by patients aged 66 years and above (6,218 calls). Over a third (36%) of the calls resulted in the patient receiving clinical advice (2,261 calls);

whilst 29% resulted in the patient receiving a home visit. This was a much higher percentage than the overall population as 8% of calls resulted in a home visit.

111

During April 2015 4,559 calls were made to 111 by Warrington patients, of these 968 were made by patients aged over 65 years (21%). Over half of the calls made by the over 65's (56%) resulted in the patient being advised to attend primary and community care, this was lower than the under 65 population where approximately 70% of patients were advised to attend primary and community care. 14% of calls in the over 65's resulted in an ambulance being dispatched to the patient; this percentage was much higher than the under 65 population (5% of calls resulted in an ambulance being dispatched). 4% of phone calls resulted in the patient being advised to attend A&E.

A&E Attendances

During 2014 there were approximately 64,500 attendances made by Warrington patients at A&E departments. Of these attendances, 12,487 were made by patients aged over 65 years (19% of all attendances). For patients aged over 65, almost two thirds (64%) spent between two and four hours in the A&E department before being treated, admitted or discharged. However, almost one fifth (18%) spent more than four hours in A&E; this percentage was substantially higher than patients aged less than 15 (1%) and patients aged between 15 and 64 years (6%).

Once triaged in A&E, 53% of patients aged over 65 years were admitted into hospital; this percentage was much higher than patients aged less than 15 (11%) and patients aged between 15 and 64 years (19%).

Emergency (non-elective) Admissions

The rate of hospital admissions during 2014/15 for patients aged over 65 years was more than three times higher (266.3 per 1,000) than patients aged less than 15 (81.3 per 1,000) and patients aged between 15 and 64 (81.2 per 1,000). In total there were 23,440 emergency hospital admissions made by Warrington residents, of which 41% were for patients aged over 65 years.

More than one third (34%) of patients aged over 65 were kept in hospital for more than seven days, this proportion was substantially higher than patients aged less than 15 (1%) and those aged between 15 and 64 years (8%). One fifth of admitted patients aged over 65 years stayed in hospital for less than one day.

Older people aged 75 years and over admitted to hospital as an emergency but with a length of stay of less than 24 hours comprise a group of people most of whom do not need hospital care, and who could benefit from alternative care provision (Public Health England, 2015d).

During 2012/13 Warrington CCG had the 14th highest admission rate nationally for people aged 75 years and over with a length of stay less than 24 hours (8,741.6 per 100,000

population). Warrington CCG was placed in the highest quintile (highest 20% of all CCGs) for the rate of hospital admissions (Public Health England, 2015d).

2.5 High-Quality, Person-Centred Acute Care:

Emergency (non-elective) admissions

During 2014/15 there were 9,604 emergency hospital admissions made by Warrington residents aged 65 years and above. Over a fifth (21%) of admissions could not be coded with a specific cause of admission; these admissions were coded as symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified. The next most common cause of admission was due to injury, poisoning and certain other consequences of external causes. The following table presents more detailed causes of admission for this specific age group.

Table 6: Top five causes of emergency admission, average length of stay and total number of bed days for patients aged 65+, 2014/15

Cause of admission	Number of admissions	Average length of stay (days)	Total number of bed days
Symptoms and signs involving the circulatory and respiratory systems	671	3.5	2,389
Influenza and pneumonia	655	11.9	7,795
Other forms of heart disease	492	8.1	3,985
General symptoms and signs	483	7.0	3,381
Injuries to the head	481	4.6	2,213

As the age of the patient increases, the cause of admission changes slightly. For patients aged over 75 years, the most common cause of admission to hospital was due to influenza and pneumonia (488 admissions); whilst for patients aged over 85 years, injuries to head was the most common cause of admission (216 admissions). The high number of admissions due to influenza and pneumonia and resulting total number of bed days, emphasises the need to ensure that people aged over 65 receive their annual free flu vaccination and the one off pneumococcal vaccination.

Planned (elective) admissions

During 2014/15 there were 11,901 planned admissions for Warrington residents aged over 65 years. The majority (84%) of the planned admissions had a length of stay of less than one day, this is most likely due to day case procedures. The most common reason for the planned admission is due to diseases of the eye and adnexa (22% of all admissions); more specifically 16% of all admissions were due to disorder of the lens (1,919 admissions). The following table presents more detailed causes of admission for this specific age group.

Table 7: Top five causes of elective admission, average length of stay and total number of bed days for patients aged 65+, 2014/15

Cause of admission	Number of admissions	Average length of stay (days)	Total number of bed days
Disorders of lens	1,919	0.01	19
Arthropathies (includes arthritis)	799	2.5	1,998
Diseases of oesophagus, stomach and duodenum	727	0.04	29
Dorsopathies (spinal disease)	635	0.2	127
Other diseases of intestines	522	0.2	104

As the age of the patient increased, the main cause of admission remained the same (disorders of lens).

2.6 Good Discharge Planning and Post-Discharge Support:

Length of stay

The average length of stay in hospital for a Warrington patient aged over 65 years during 2014/15 was 8.4 days for patients who were admitted as an emergency and 0.6 days for patients who were a planned admission. In total, the planned admission patients accounted for 7,141 bed days, whilst the patients who were admitted as an emergency were in hospital for a total of 80,674 bed days. This illustrates the burden emergency hospital admissions in the over 65's place on hospital trusts, it also highlights the importance of arranging timely, appropriate and supportive discharges for patients. Delayed discharges increase the length of time a patient is kept in hospital, using a bed that could be required for another patient. However, a patient being released too early from hospital or to an environment not catered to their needs can increase the risk of readmission to hospital.

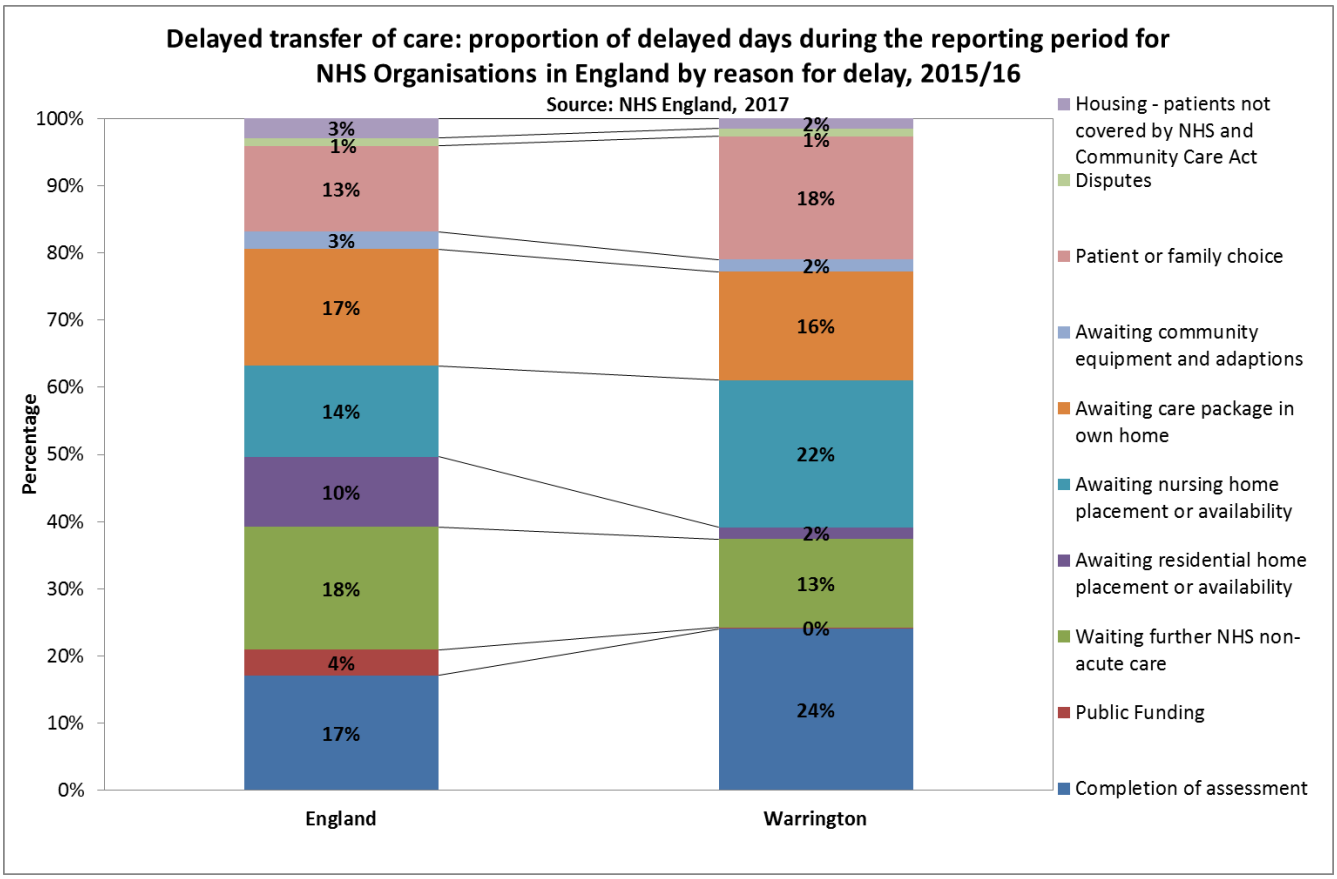
Delayed Discharges

Data provided by NHS England shows that during 2015/16, there were a total of 5,294 delayed days (delays in discharge from hospital). This figure is based on all patients, however it would be reasonable to assume that a sizable proportion of the delayed days would have affected patients aged over 65 years. The following chart further examines delayed days by the reason for delay during 2015/16.

The chart illustrates that almost a quarter (24%) of delayed days were due to completion of assessment, 22% of the delayed days were due to awaiting nursing home placement or availability, whilst 18% of delayed days were due to patient or family choice. Unfortunately, it is not possible to state the proportion of delayed discharges that affected patients over the age of 65; however data collected by Warrington Adult Social Care (as at December 2015) suggests that of those who are in receipt of council funded nursing residential care and residential care, almost 9 out of 10 were aged over 65. Therefore, it would be appropriate to assume that a very large proportion of the delayed days due to awaiting

either residential home or nursing home placement or availability would have been for patients over the age of 65.

Chart 12: Delayed transfer of care, 2015/16



Readmission to hospital

During 2011/12 (latest time period available) 16% of hospital admissions made by patients aged 75 and above were an emergency readmission within 28 days of discharge from hospital (812 emergency readmissions out of 5,071 total admissions), this was slightly higher than England at 15.7%. Nationally, there has been a steady increase in the rate of readmissions for patients aged over 75 years, 11.6% of patients over 75 were readmitted during 2002/03 (15.7% in 2011/12). A similar pattern was observed in Warrington, with the exception of the two latest years of data (2010/11 and 2011/12) where a reduction in the percentage of patients being readmitted was observed (based on data supplied by the HSCIC, 2014). Unfortunately, this data set does not present the reason for readmission (whether it was related to the original cause of hospital admission) and further interpretation of the analysis is not possible.

Hospital admissions from care homes

The rate of admission to hospital for people aged 75 years and over from nursing home or residential care home settings (per 1,000 population) during 2012/13 (latest data available) was 17.7 per 1,000 (NHS Atlas of variation in Healthcare 2015). The rate for Warrington falls within the top quintile (highest admission rates nationally). Admission rates within this

quintile range from 5.0 per 1,000 in NHS Dorset through to 61.5 per 1,000 in NHS Tameside and Glossop.

The wide variation in the rate of admission within quintile 1 may be due to differences in:

- the numbers of local authority-funded and private care homes in relation to the local population of older people;
- the use of care homes as temporary residential placements;
- accuracy of coding for the admission "source" (Rightcare, 2015).

2.7 Effective Rehabilitation and Reablement:

"Rehabilitation services become pivotal when an older person experiences acute health and social care crises. For instance, admission to hospital for an older person with frailty can cause a decline in mobility through a loss of muscle strength. For every seven days of inactivity, there will be a 10% loss of muscle strength, which represents a considerable loss in people with frailty and, in the absence of appropriate rehabilitation and reablement services to help a person regain independence, can be a precipitating factor in permanent admission to a nursing or residential care home. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care" (p179 Rightcare, 2015).

Older people offered rehabilitation following discharge from hospital

2.7% of older people (65 and over) in Warrington were offered rehabilitation following discharge from acute or community hospital (145 people out of 5,515 people discharged) during 2014/15. The percentage in Warrington was slightly lower than England (3.1%) and the North West (3.2%) (HSCIC, 2015).

Older people remaining at home after discharge from hospital into reablement/rehabilitation services

During 2014/15, 83.7% of older people (aged 65 and over) were still at home 91 days after discharge from hospital into reablement/rehabilitation services (out of 145 people discharged, 125 were still at home after 91 days). The percentage for Warrington (83.7%) was slightly higher than England (82.1%) and the North West (80.9%) (HSCIC, 2015).

Permanent admissions to nursing home and residential care home settings

During 2013/14, Warrington had a rate of 735.5 per 100,000 population (aged 65 and over) for council supported permanent admissions of people aged 65 years and over to nursing home and residential care home settings; the rate for Warrington falls within quintile 2 (the second highest group) (NHS Atlas of variation in Healthcare 2015). The rate of permanent admissions in Warrington was higher than England (668.4 per 100,000) and slightly lower than the North West (776.6 per 100,000).

Older people discharged from hospital into reablement /rehabilitation services

9.1% of older people (aged 65 years and over) were discharged from hospital into reablement/rehabilitation services during 2013/14 in Warrington. This percentage was significantly higher (better) than England (3.3%) and the North West (3.1%) (ASCOF, 2016).

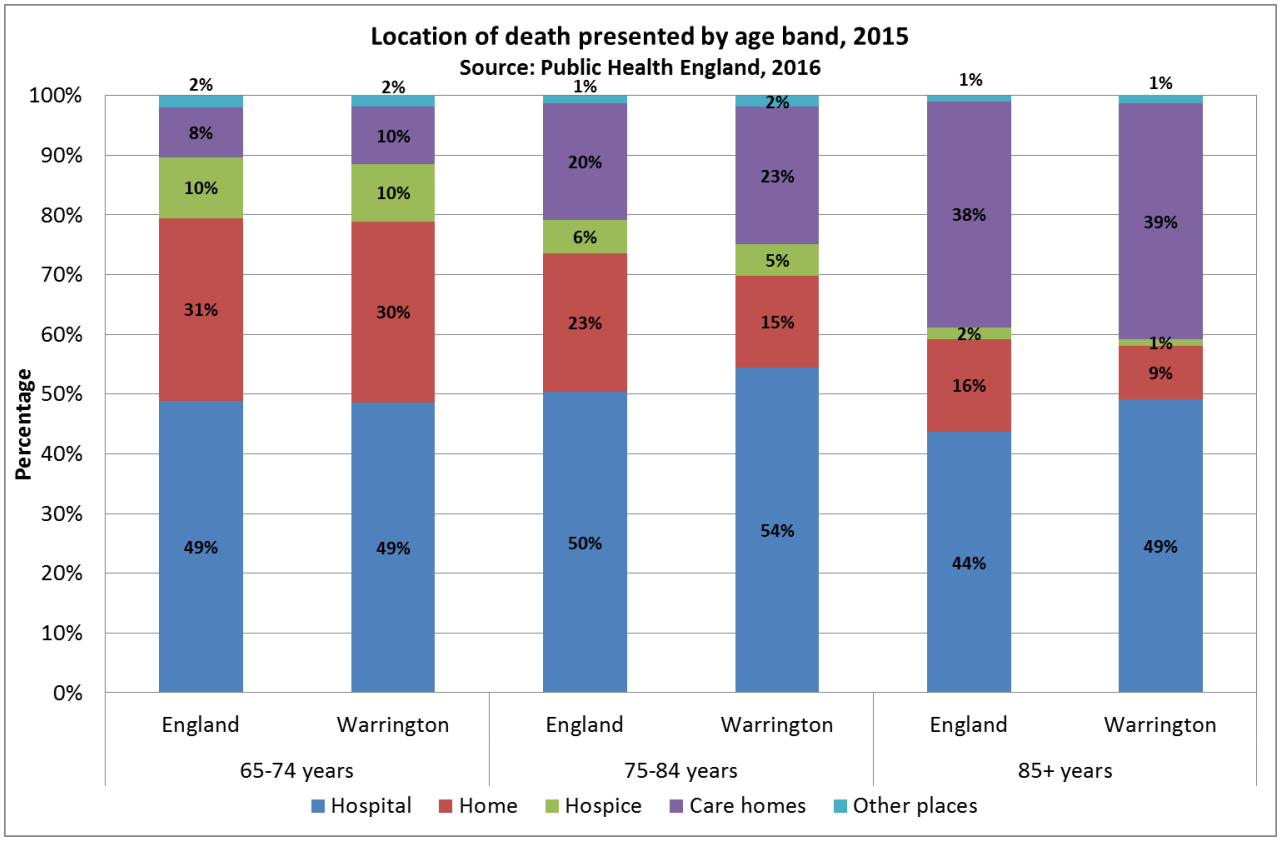
2.8 Support, Control and Choice at End of Life

Location of Death

"Place of death can be a critical contributor to the quality of death but its contribution is complex, as it is not simply the nature of the physical building but how this impacts upon the desires of the patient, in particular in relation to their psychological, physical, social and spiritual comfort, the opportunities for adequate control of distressing symptoms, and the possibility for family and friends to be present during the final days and hours" (National End of Life Care Programme, 2010).

The following chart examines the location of death for persons aged 65 years and above for England as a whole and locally within Warrington during 2015. The chart illustrates that a large proportion of older people died in a hospital setting. For each of the age bands illustrated, with the exception of 65-74 years, the percentage of deaths that took place in hospital were slightly higher in Warrington when compared to England. The proportion of deaths that occur in care homes in Warrington is also higher than national figures. The proportion of deaths that take place in the home is lower in Warrington when compared to national figures (with the exception of 65-74 year olds).

Chart 13: Location of death, 2015



Many people express the desire to die in their 'own' home but it is important to remember that for many older adults their normal 'home' is a nursing or old people's home. To account for this, a national monitoring indicator has been developed which looks at the

percentage of deaths that took place at the usual residence (Deaths in Usual Place of Residence (DiUPR)). Usual residence is defined as home, care home (local authority and non-local authority) and religious establishments[iii]. There has been a push by the NHS over recent years to increase the proportion of DiUPR, the proportion of DiUPR has increased by 12% points between 2005 and 2015 nationally (36% in 2005 increasing to 48% in 2015), the increase locally in Warrington has been lower at 7% points (36% in 2005 increasing to 43% in 2015).

3) CURRENT SERVICES IN RELATION TO NEED

3.1 Level of Need

Table 8: Number of Needs Assessments carried out by Warrington Adult Social Care staff for people aged 65+, 2011/12 to 2013/14

Year	Number of new assessments	Percentage change on 2009/10 baseline	Rate per 100,00 population (Warrington)	Rate per 100,00 population (England)
2009/10	1,755	-	5,665	5,800
2010/11	1,870	7%	5,895	5,305
2011/12	1,900	8%	5,850	4,740
2012/13	1,400	-20%	4,120	4,555
2013/14	1,315	-25%	3,745	4,380

(Source: NASCIS table A6)

The numbers of assessments for newly-referred older people carried out by Adult Social Care declined by 25% between 2009/10 and 2013/14. The rate of assessments conducted in Warrington had been higher than national rates for the years 2010/11 and 2011/12; however the Warrington rate fell below the national average for the years 2012/13 and 2013/14.

3.2 Current service use and historical trends

The data in Tables 9 and 10 relate to the number of people in receipt of services during the year. 'Community Care' refers to services that enable a person to remain living in the community, such as home care, day care and supported accommodation. 'Residential and Nursing care' relates to 24 hour permanent care in a residential or nursing home. Short-term respite care is classed as a community care service.

[iii] This indicator excludes deaths that were from external causes**.**

Table 9: Older people in receipt of services provided by Warrington Adult Social Care

	2009/10	2010/11	2011/12	2012/13	2013/14
Community care	3,406	3,361	3,045	2,912	2,510
Residential and nursing care	1,253	1,352	1,327	1,313	1,205

(Source: CareFirst September 2015)

'Residential and nursing care' can be further broken down into 'residential' or 'nursing' care. The totals do not match, as it is possible for a person to have been in both residential and nursing care during the year.

Table 10: Older people in receipt of Residential or Nursing care commissioned or provided by Warrington Adult Social Care

	2009/10	2010/11	2011/12	2012/13	2013/14
Residential care	710	760	810	770	720
Nursing care	640	665	685	715	660

(Source: NASCIS table P1 2013/14)

The number of community care users has been steadily decreasing since 2009/10, during 2013/14 the number of people receiving community care was 26.3% lower. In contrast, the number of people in residential and nursing care has remained fairly steady over the last five years, and is now slightly lower than the 2009/10 baseline. The numbers in residential care increased between 2009/10 and 2011/12, but reduced from 2012/13 to 2013/14, so that the numbers at 2013/14 were 1.4% above the 2009/10 baseline. The numbers in nursing care increased between 2009/10 and 2012/13, but reduced in 2013/14, so that the numbers in 2013/14 were 3.1% above those in the 2009/10 baseline

3.2.1 Elderly Mentally Infirm (EMI) Care (Over 65)

The number of older people in receipt of 24 hour EMI care has increased by 9.6% over the last five years, from 479 to 525. However, the 2013/14 figure is a decrease from the peak of 562 people in 2011/12.

Table 11: Number of people aged 65+ in receipt of EMI care in Warrington

	2009/10	2010/11	2011/12	2012/13	2013/14
Residential	258	284	332	310	291
Nursing	221	222	230	235	234
Total	**479**	**506**	**562**	**545**	**525**

(Source: SRDB September 2015)

Table 12: EMI care as a percentage of all Residential/Nursing care provided through Warrington Borough Council for people of aged 65+

	2009/10	2010/11	2011/12	2012/13	2013/14
Residential	36%	37%	41%	40%	40%
Nursing	34%	33%	33%	33%	35%

(Source: SRDB September 2015)

Despite the increase in older populations, it is not surprising that there has been a decrease in the number of people offered adult social care services and support. There have been a number of big changes that have led to this situation; there was a change in the FACS (Fair Access to Care Services) eligibility criteria (which are split into four categories of low, moderate, substantial and critical) in which Warrington Council moved from providing services to moderate and above clients, to clients categorised as substantial and critical only.

There have been a number of changes to council budgets which has meant that some services are no longer offered; including day-care, transport and some low level services, clients are instead signposted to the third sector. Directing clients straight to the third sector has reduced the number of assessments conducted by adult social care. The change in referral pathway by Warrington Council was a planned way to reduce costs.

There have been some other changes implemented, such as signposting people away from Council provided services and a decision to keep community based clients in their homes for as long as possible to try to keep permanent admissions to residential/nursing care down. The reduction in the number of people receiving residential/nursing council commissioned services may have reduced due to some impact from reablement programmes (see section 3.7) which aim to keep people out of the social care system for longer by being able to live in their own home.

Furthermore, there have also been system changes, changes to recording practices and different people providing the information for the statutory returns which may have impacted on the methodology used to obtain the data. There may also be other reasons for the reduction in the number of people supported by Warrington Council for which there is no available data, such as a wealthier older population who self-fund their care (Warrington Council do not know how many self-funders there are as this population is not needed to be known to adult social care).

Nationally, the number of people in receipt of NHS Continuing Healthcare has increased. NHS Continuing Healthcare refers to a package of on-going care for adults that is arranged and funded solely by the NHS where the person has a 'primary health need'. This care is provided to meet needs that have arisen as a result of disability, accident or illness. NHS Continuing Healthcare provision might take the form of a care home placement, or a package of care in the individual's own home or elsewhere. The national spend on NHS Continuing Healthcare currently totals around £2.5 billion per annum and around 60,000 individuals are in receipt of NHS Continuing Healthcare at any given time[iv]. As at the end of the second quarter of 2015-16, 62,854 people were eligible which equates to 69.3 patients per 50,000 population aged 18 or over[v]. This represents an increase on the same period of the previous year of 0.8%.

[iv] https://www.england.nhs.uk/wp-content/uploads/2015/03/ops-model-cont-hlthcr.pdf

[v] http://www.hscic.gov.uk/catalogue/PUB19312/nhs-chc-eng-q2-2015-16-exp-rep.pdf

It is likely that this national picture is replicated locally with the NHS commissioning care for eligible individuals. During 2015-16, 498 people were eligible for NHS Continuing Healthcare in Warrington. This may explain the decrease in the number of assessments and places funded by the Council as the NHS would be commissioning and funding these care packages which will include care home placements along with care at home.

NHS commissioned initiatives, such as Hospice at Home, which launched in 2015 are aimed at enabling people to remain in their own home at end of life as opposed to moving into care homes or acute hospital. Similarly, Personal Health Budgets (which can include Direct Payments made by the NHS), for people eligible for NHS Continuing Healthcare, allow greater individual freedom and choice around how care at home is delivered. Some research suggests this can reduce other service use alongside improving health and wellbeing outcomes[vi]. In Warrington there are currently around 40 personal health budgets in place.

3.3 Residential, nursing and extra care homes

Within Warrington there are 27 care homes (of which 17 offer nursing), this equates to approximately 1,500 places available. However, it should be noted that the places available are not exclusively offered to older people as younger people with mental and physical disabilities may require these services. There are 3 extra care housing sites offering a minimum of 333 places to older people (some housing can cater for couples or offer two bedroom properties). In addition to the residencies stated above, there are a further 26 retirement/sheltered housing/age exclusive sites available within Warrington, these sites offer a minimum of 924 places to older people (as with extra care housing, some properties accommodate couples or offer two bedroom properties) [vii].

Within Warrington there are 2,102 individuals working within adult residential care[viii], with over two thirds (68%) providing direct care to residents. However, at present there are 1,110 vacancies within adult residential care, with two thirds of vacancies (66%) for those who provide direct care. Positively, the vacancy rate in Warrington (3.3%) is lower than England (5.9%). High staff turnover can have a negative impact on the quality of care provided to residents in care home settings. Skills for Care (2013) found that managers from establishments with high staff retention rates reported that the main benefit of long term employees was continuity of care. Staff are able to build relationships with service users, and service users are put at ease with familiarisation of staff. Within Warrington, just over a fifth (22.2%) of staff working within adult residential care had moved to that role within the previous 12 months, this was slightly lower than England (26.4%).

[vi] https://www.guidelinesinpractice.co.uk/oct_13_fitzgerald_gen_oct13

[vii] Based on information gathered from http://www.housingcare.org on 9/06/2016

[viii] Based on information gathered from http://www.skillsforcare.org.uk/NMDS-SC-intelligence/NMDS-SC/Discover-NMDS-SC.aspx on 09/06/2016

3.4 Dementia care

In 2014, the Dementia Action Alliance was started to help raise awareness of dementia and establish Warrington as a 'dementia friendly town'. There are almost 30 member organisations of the Alliance and as part of their strategy are developing new models of care including establishing a micro dementia friendly village in Penketh which includes both housing and care providers. Dementia Friends was created by the Alzheimer's Society to give people an understanding of what it's like to live with dementia and the small things everyone can do to make a difference to people living with the condition. As part of a national campaign to recruit one million people, Warrington set a target of getting 1,000 people to sign up by March 2015, Warrington exceeded this target. As a result of the programme Warrington now has 2,606 Dementia Friends (Warrington Borough Council, 2015b).

A newly developed Warrington Dementia Strategy[ix] (2016-2019) has identified five action areas that health and social care commissioners are aiming to deliver over the next four years:

- Public awareness and community competency in relation to dementia;
- Specialist training;
- Early diagnosis and effective primary care for dementia;
- Social support and engagement;
- Social care services for dementia.

3.5 Day and residential services

In 2014/15 a new social enterprise took its place as a major provider of social care services in Warrington. In partnership with the Council's Adult Social Care Services, a staff-led social enterprise called 'Catalyst Choices' took over delivery of a number of day and residential services for older people and people with disabilities. In Warrington, there is a range of support available to residential and domiciliary care providers to make sure that the quality of care offered meets the standards set out by the Care Quality Commission (Warrington Borough Council, 2015c).

3.6 Falls service

To help reduce the number of people who have to go to hospital because of falls, the council works with health partners to offer falls prevention, treatment, and rehabilitation services for people who fall or are at risk of falls in Warrington. The Occupational Therapy Team arrange for equipment (hand rails, non-slip treads, raised toilet seats, grab bars and bath / shower seats) and property adaptations all of which can help to prevent falls (Warrington Borough Council, 2015c).

3.7 Intermediate care and reablement services

In Warrington intermediate care and reablement services work closely with health providers to make sure that people are discharged safely from hospital and that they have the support

[ix] The full strategy can be requested from Warrington CCG

in place which helps their recovery and mobility at home. It means that people can be discharged from hospital much quicker and remain living in their own homes (Warrington Borough Council, 2015c).

3.8 Healthy Lifestyles

All health improvement initiatives (for example, smoking cessation, losing weight, improving diet, increasing physical activity, reducing alcohol consumption, stopping substance misuse) are aimed at all age groups including older people. There are some services aimed specifically at older people.

Stay on your feet: is predominately for people aged 65 and over that want to get involved in a weekly exercise class to progressively improve overall fitness. To be eligible for the 8 week programme an individual will have to be referred by their GP.

3.9 Integrated Care in Warrington

Warrington has been piloting integrated care for specific care pathways (examples include out of hospital services and complex packages of care) by pooling monies across Warrington CCG and Warrington Council in the Better Care Fund. Commissioners and providers in Warrington want to build on this experience by introducing a phased approach to a whole population integrated model of care by 2020, as recommended in Stepping up to the Place (2016). This will be achieved by the establishment of an Accountable Care Organisation[x] (ACO) which will comprise of resources from Warrington providers and commissioners and will be overseen by a newly formed board from 1st April 2017. The aim of this approach to integration is:

- To deliver better health and care outcomes whilst improving the experience of service users and carers;
- To develop sustainable service models which support the workforce to deliver high quality care; and
- To reduce overall system costs.

3.10 Market Position Statement for Older Adults

The Market Position Statement (MPS) for Older Adults is intended for use by existing and prospective providers of care and support to individuals, families and communities. It is designed to describe the state of the care and support provision in Warrington and gives an indication of how that may be expected to change over time. The current MPS for Older People was written in 2014 and contained information sourced from JSNA chapters which focussed on older people. The document can be accessed here.

4) PROJECTED SERVICE USE AND OUTCOMES

4.1 Long Term Conditions projections

[x] Accountable care involves a group of providers and commissioners agreeing to take responsibility for the care and its quality, for a given population over a defined period under a contractual arrangement with commissioners. They are held accountable for achieving a set of pre-agreed quality outcomes within a given budget.

Age-specific prevalence rates can be applied to population projections to estimate the number of people with each condition in the future (assuming that prevalence rates do not change over time). The growing older population means that the number of people with each condition is likely to increase. Table 13 and Chart 14 shows estimates for 2030, and compares them to the 2015 estimates. The estimates include both diagnosed and undiagnosed people.

Table 13 shows how the prevalence of each condition increases with age. Estimates for COPD are a rise from 2,600 people aged 65+ in 2015 to 3,700 in 2030. Estimates for CVD are a rise from 11,900 people aged 65+ in 2015 to 17,000 in 2030. Estimates for hypertension are a rise from 25,000 people aged 65+ in 2015 to 35,200 in 2030. Each of these represent over a 40% increase.

Table 13: Projected prevalence of specific long-term conditions

	Prevalence estimates by age-band		Estimated no. people aged 65+ in Warrington with each long-term condition (to nearest 100)		% increase from 2015 to 2030 (People aged 65+)
	65-74	75+	2015	2030	
COPD	6.9%	7.4%	2,600	3,700	42%
CVD	27.4%	38.4%	11,900	17,000	43%
Hypertension	64.9%	71.5%	25,000	35,200	41%

For dementia, assuming that age/sex prevalence rates stay the same, the estimate in Warrington will increase from about 2,200 people in 2015 to about 4,000 by 2030 (a 77% increase).

Table 14: Projected prevalence of dementia

Estimated dementia prevalence by age-band, % (from research undertaken for Alzheimer's Society)					Estimated no. people aged 65+ in Warrington with each long-term condition (to nearest 100)		% increase from 2015 to 2030 (People aged 65+)
70-74	75-79	80-84	85-89	90+	2015	2030	
3.1%	5.1%	10.2%	16.7%	27.9%	2,300	4,000	77%
2.4%	6.5%	13.3%	22.2%	30.7%			

Chart 14: Projected number of people aged 65+ with specific long-term conditions

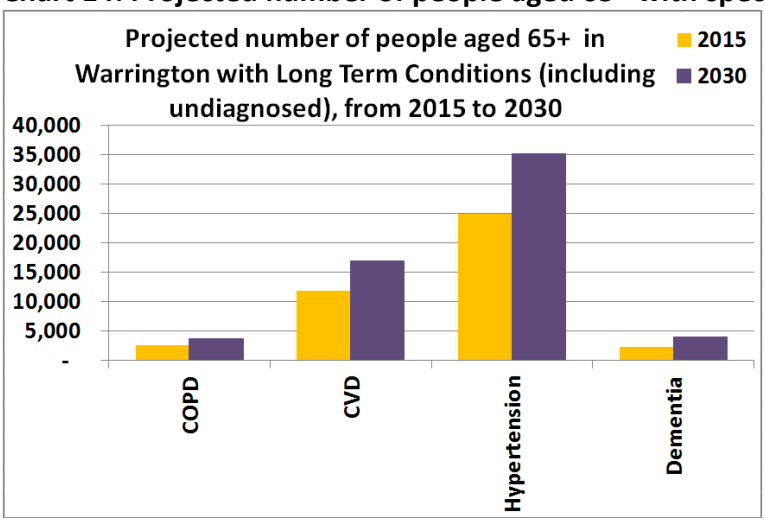
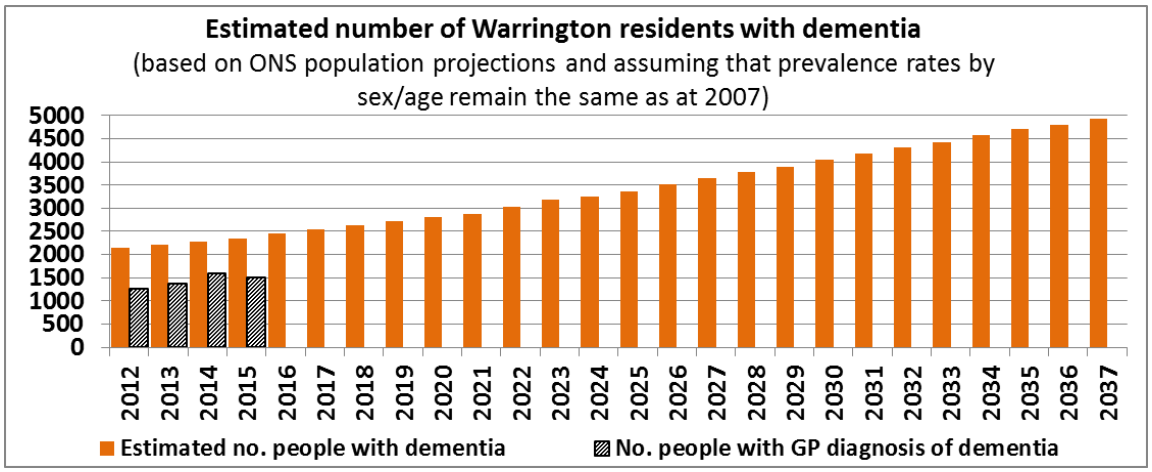


Chart 15 shows the rise in the estimated number of Warrington residents with dementia from 2012 to 2030, along with the number of people diagnosed in Warrington GP practices.

Chart 15: Estimated number of Warrington residents with dementia



4.2 Community Care

Table 15: Percentage population increase for people aged 65+, with projected numbers of Community care users (2014 baseline)

	2014	2015	2020	2025	2030
England	0%	2%	12%	24%	39%
North West	0%	2%	10%	21%	34%
Warrington	0%	3%	13%	26%	43%
Warrington population	36,000	36,900	40,700	45,300	51,600
Community care users	3,101	3,179	3,506	3,902	4,445
Community care users as % of population	8.61%	8.61%	8.61%	8.61%	8.61%

(Source: NASCIS/POPPI & "Your care and support in Warrington: Local Account 2013 - 14")

Table 15 projects the expected number of community care users if the current proportion of over 65's receiving community care remains static (8.6%) at 2014 levels. Based on 65+ population projections alone, it is projected that the number of community care users will increase by 43% by the year 2030. However, by 2030 there will be over 95% more people aged 80 or over living in Warrington than there were in 2014, it is likely that a greater proportion of people aged over 80 years will require community care when compared to the over 65 population. Therefore, this may mean that the actual number of services users from 2014 onwards will be higher than those projected here.

4.3 Residential and Nursing Care

Table 16: Projected numbers of Residential/Nursing care users (aged 65+)

	2014	2015	2020	2025	2030
Residential/Nursing care users	1,380	1,413	1,579	1,964	2,319

(Source: POPPI & NASCIS table P1*)*

In terms of residential care, 3.83% of the over 65 population were in residential or nursing care in 2014. POPPI have projected the number of service users could increase to 2,319 by 2030 and would require an additional 939 residential nursing bed places in Warrington.

4.4 EMI Care

Table 17: Percentage population increase for people aged 65+, with projected numbers of EMI care users (2014 baseline)

	2014	2015	2020	2025	2030
England	0%	2%	12%	24%	39%
North West	0%	2%	10%	21%	34%
Warrington	0%	3%	13%	26%	43%
Warrington population	36,000	36,900	40,700	45,300	51,600
EMI care users	525	539	594	661	753
EMI care users as % of population	1.46%	1.46%	1.46%	1.46%	1.46%

(Source: NASCIS/POPPI & SRDB September 2015)

In 2014, 525 (1.46%) of the over 65 population were in EMI care (see Table 17). By 2030, this will have increased to 753 people. Of the additional 596 residential nursing beds required (see section 4.3) at least 228 will need to be EMI places. This is based on an assumption that the 2014 proportions of EMI/non-EMI residential placements remain the same. However, as with section 4.2 and 4.3, these projections are based only on the 65+ population; the number requiring EMI care in future will most likely be much higher than those stated in the table.

5) EVIDENCE OF WHAT WORKS

This chapter has highlighted the increasing budgetary pressure experienced by Warrington Borough Council (and other local authorities across the country), subsequent changes to thresholds for clients to receive assessments for their needs, an increasing older population with multiple health needs and further pressures experienced by NHS services, highlights that sustainable alternatives to council funded care must be explored.

Clients who require nursing/residential care have usually reached a crisis point where the only option for support is admission to nursing/residential care (NICE, 2015). There are a number of interventions that can be implemented at a local level to ensure that the number of older people reaching crisis point remains at a minimum.

Extra Care Housing (also called very sheltered housing, assisted living or close care schemes): These are establishments where residents can either own or rent (through private landlords or housing associations) self-contained accommodation with care and support available on site, these are often seen as an alternative to residential care. Some extra care schemes offer leisure activities, communal areas to socialise in and office space for staff (Housing LIN, 2015). Extra care housing can offer savings to local authorities as the schemes offer continued independence for households and therefore do not require residential care. Research shows that each year a resident postpones moving into residential care, the State saves on average £28,080 (HACT 2010 cited in London Borough of Richmond Upon Thames, 2015).

Some evidence has shown that there are benefits to the health and wellbeing of residents living in extra care housing, for example residents of extra care housing are less likely to suffer a fall and they are less likely to be admitted to hospital. Extra care housing residents have a good quality of life and good levels of wellbeing, this is most likely due to opportunities to meet with neighbours and the offer of meaningful leisure activities (London Borough of Richmond Upon Thames, 2015).

Housing and dementia: Approximately two thirds of people with dementia live in the community (with differing levels of support) with the remaining third living in a care home (Alzheimer's Society, 2016a). Findings from the 2012 Alzheimer's Society report 'Home truths' found that individuals with dementia and their carers had differing requirements of their housing needs. Some wanted to be supported in their current homes, whilst others preferred the option of extra care housing. Home truths states that extra care housing can potentially fill a gap between mainstream homes and care homes for some people with dementia (Alzheimer's Society, 2016b).

Home truths recommends that:

- Local authorities, homebuilders and governments should recognise that appropriate housing services and support are key mechanisms for effective support of people with dementia in the community;
- There should be a choice in housing options and tenures available to people with dementia, including mainstream and specialist housing;
- People with dementia, their families and carers should have access to information and advice on housing options, handyperson services and sources of funding for adaptations and alterations;
- People with dementia should have access to homes designed with their needs in mind.

Dementia Care (2015) highlights the issue of there being too few specialist housing for people with dementia, research has highlighted that most local authorities have no or very low number of specialist housing units, either in existence or planned. Dementia Care has suggested that there should be six units of specialist housing for people with dementia per 1,000 population aged 75+ years, this would equate to a total of 26,443 units across England rising to 43,569 by 2034 (Dementia Care, 2015).

Where the only option remaining for an older person is to enter a care home, NICE have produced the following guidance for local authorities:

NICE advice (LGB25) Older people in care homes (2015): provides the following advice to local authorities to improve the health and wellbeing of older people in care homes:

- Ensure wellbeing and safeguarding responsibilities are met by:
    - Provide meaningful, person-centred activities;
    - Reduce medication errors;
    - Monitor for malnutrition;
    - Prevent falls;
    - Reduce healthcare-related infections;

    - Avoid delirium and monitor for depression.
- Reduce the costs of care by:
    - By keeping residents fit, well and mentally alert increases their independence and reduces the level of support they require;
    - Improving the health and wellbeing of people in residential care will help reduce safeguarding investigations and their subsequent costs.
- Help tackle inequalities by:
    - Helping people retain their independence and identity;
    - Support people with dementia.
- Meet indicators in the Adult Social Care Outcomes Framework.

Health Care Systems (Kings Fund, 2014, page vi): As presented in section 2, the needs of the older population in Warrington have been presented by the proposed ten components of care as stated in *Making our health and care systems fit for an ageing population*. Improving services for older people requires consideration of each component of care, since many older people use multiple services, and the quality, capacity and responsiveness of any one component will affect others.

The key components set out are:

- Healthy, active ageing and supporting independence;
- Living well with simple or stable long-term conditions;
- Living well with complex co-morbidities, dementia and frailty;
- Rapid support close to home in times of crisis;
- Good acute hospital care when needed;
- Good discharge planning and post-discharge support;
- Good rehabilitation and re-ablement after acute illness or injury;
- High-quality nursing and residential care for those who need it;
- Choice, control and support towards the end of life;
- Integration to provide person-centred co-ordinated care.

The report also recommends that:

- Transforming services for older people requires a fundamental shift towards care that is co-ordinated around the full range of an individual's needs (rather than care based around single diseases) and care that truly prioritises prevention and support for maintaining independence. Achieving this will require much more integrated working to ensure that the right mix of services is available in the right place at the right time;
- Incremental, marginal change is not sufficient; change is needed at scale and at pace. The paper does not aim to address the barriers and opportunities that can respectively hinder or help bring about this service transformation, although those of course exist. Instead, it aims to give local service leaders in England and beyond a framework and tools to help them examine and improve the services they provide for older people.

New workforce models of urgent care: literature is emerging about the implementation of emergency care practitioners[xi] (including paramedic practitioners and extended care paramedics as well as ECPs); ECPs can reduce patient transport to emergency departments, though this appears dependent on the setting. A systematic review found that ECPs were less likely than conventional ambulance crews to take patients to the emergency department. However, the size of the effect varied widely between studies. ECPs were 1.6 to 26 times more likely to discharge patients at the scene than conventional ambulance crews.

A further study found marked differences between settings in the likelihood of patients being discharged rather than referred. In ambulance and care home settings, patients were significantly more likely to be discharged by the ECP service than the usual care provider. By contrast, in more static services such as the OOH service and urgent care centre, patients were significantly less likely to be discharged by ECPs. A cost effectiveness analysis included in the full report of the study found that only ECP services with a mobile element (e.g. ambulance or mobile care home services) reduced costs compared with usual care providers (University of York, 2014).

6) (TARGET) POPULATION/SERVICE USER VIEWS

Healthwatch Warrington[xii] has conducted a number of projects with older people to gain their views and experiences on health and social care issues. During 2016 a report[xiii] was produced by Healthwatch Warrington which explored the quality and safety of care delivered at home.

This report consisted of 135 survey responses of which 96% were aged 50 and above. The report found that most participants were satisfied with the home care they receive and felt safe. In particular, participants appreciated the professionalism and compassion that their carers showed towards them. These relationships make a difference to ensuring the comprehensive wellbeing of care recipients, beyond simply meeting their basic care requirements.

There were certain elements of home care that participants felt could be made better, in some cases:

- Care plans;
- Consistency and training of carers;
- Recording and reporting of safeguarding incidents;
- Medicines management;

[xi] Emergency care practitioners are generic practitioners drawn from paramedic and nursing communities…(they) receive formal training to equip them to work across traditional boundaries in emergency and unplanned care (NHS Confederation, 2016b).

[xii] Independent consumer champion created to gather and represent the views of the public in health and social care.

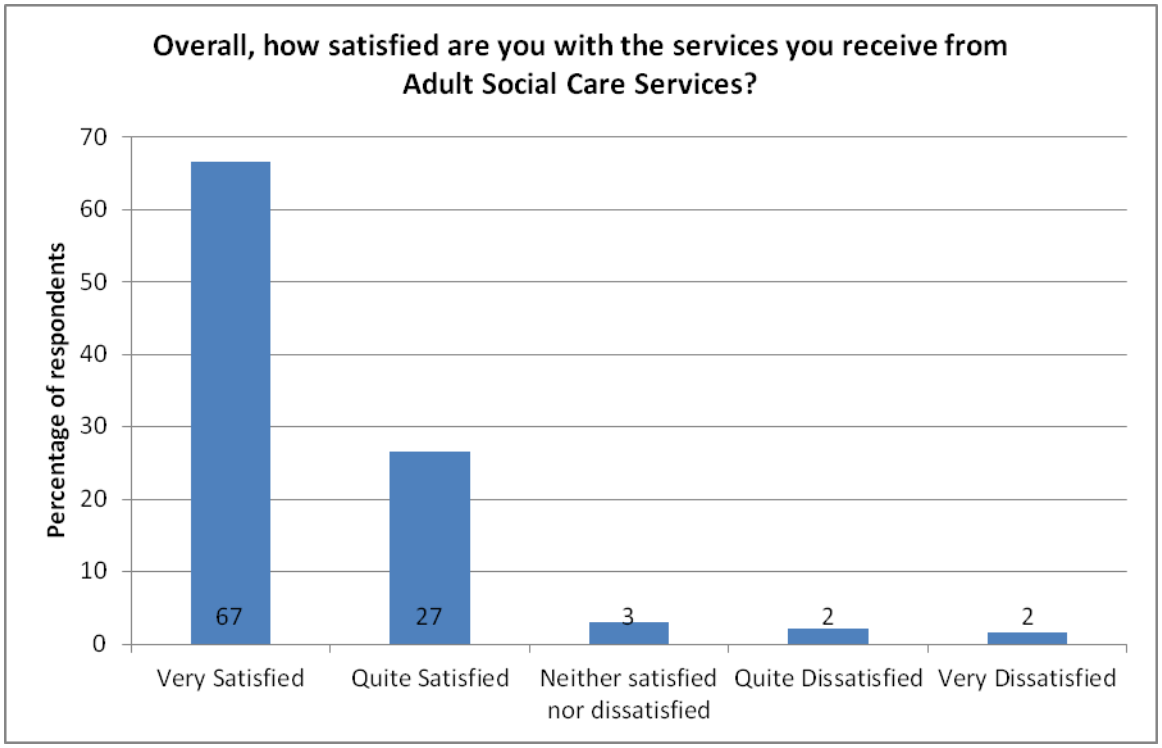
[xiii] The full report can be accessed at the following link: http://www.healthwatchwarrington.co.uk/wp-content/uploads/2015/07/Dom-Care-Project-Report-Final-Version.pdf

- Communication, flexibility, length & timeliness of appointments.

(Healthwatch Warrington, 2016)

Further information gathered by Healthwatch Warrington and presented to the Warrington Health and Wellbeing Board illustrated that some older people experienced confusion, communication inefficiencies and delays in referrals between multiple health and care providers. An example was provided of an individual and their spouse navigating a care system which consisted of 17 different professionals from 8 different agencies. It is envisaged that circumstances described in the previous example will be eradicated with the introduction of the Accountable Care Organisation (as described in section 3.9).

Chart 16: Satisfaction with Adult Social Care Services



(Source: Adult Social Care Survey 2014)

Warrington Borough Council participates in the annual national statutory survey of Adult Social Care Users. These responses are not specifically broken down by age group, but the majority of responses are from older people.

Chart 16 shows the overall satisfaction of service users. 94% of respondents were very or quite satisfied with the services they received.

7) UNMET NEEDS AND SERVICE GAPS

- Findings from the Warrington Health and Wellbeing Survey showed that unhealthy lifestyle choices were more likely to be reported by older people living in the most deprived areas of Warrington, with the exception of alcohol consumption (this pattern was also seen for all ages);

- Influenza vaccination uptake in the over 65's in Warrington does not meet nationally set targets. Low vaccination uptake could be partially attributable to the high proportion of emergency hospital admissions due to influenza and pneumonia and high excess winter mortality, especially for deaths caused by respiratory conditions;
- When older people are in need of emergency medical care or support, it has been found that the interventions/care provided tends to be more intensive than the levels of support provided to younger populations;
- It appears that there are positive outcomes from reablement/rehabilitation services within Warrington, however the numbers supported are quite small. Of the 5,515 discharges during 2014/15, 145 were offered reablement/rehabilitation services (2.7%), this was slightly lower than England (3.1%). However, of the 145 offered support, 83.7% (125) remained at home 91 days after discharge into reablement/rehabilitation services (2014/15); this was slightly higher than England (82.1%);
- The 65+ population is expected to increase by 43% by 2030, therefore it is possible that current services in place for older people may not be able to continue in their current form given the expected increases in population;
- The number and rate of need assessments conducted by adult social care have reduced over recent years. The number of older people in receipt of services provided by Warrington Adult Social Care (Community care, residential and nursing care) reduced during 2013/14. Given the increase in the ageing population, this finding was not expected. The number of people receiving needs assessments and services reduced due to changes in the FACS (Fair Access to Care Services) eligibility criteria, reduction in council budgets, signposting clients to the third sector and an increase in the number of people in receipt of NHS Continuing Healthcare;
- Information collected by Healthwatch Warrington suggests that some older people in receipt of health and social care services are in contact with numerous professionals and agencies; this could lead to confusion for patients, repeating the same information at several appointments and referral delays between agencies.

9) RECOMMENDATIONS FOR COMMISSIONING

- Providers of lifestyle services (e.g. smoking cessation, healthy weight, alcohol reduction) should ensure that the services they provide are promoted and accessible to older people;
- National influenza campaigns are ran each year to encourage people over the age of 65 (as well as those under 65 classed 'at risk') to receive their vaccination. However, it is suggested that a local influenza vaccine campaign should be explored to further increase uptake. It is also recommended that GP practices with consistently high influenza vaccination uptake share their good practice with other GP practices across the town;
- It is suggested that alternative models of urgent care are explored, more specifically the use of emergency care practitioners (ECPs) working with ambulance technicians or providing mobile care home services;
- Commissioners need to ensure that services that provide care to older people can adapt to the growing population. For example, ensuring that there are enough GP

practices, clinics, residential/nursing/extra care/sheltered/retirement homes and/or places available to the older residents of Warrington;

- Actions are currently in place to further develop integrated care in Warrington with the establishment of the Accountable Care Organisation from April 2017;
- Commissioners to ensure that dementia care and support offered in Warrington meets the needs of this growing population, this should also include future housing needs for this particular population group;
- Commissioners should ensure that there are opportunities to reduce social isolation in older people;
- The Market Position Statement for older people should be updated with information and findings presented in this JSNA chapter.

10) RECOMMENDATIONS FOR NEEDS ASSESSMENT WORK

It is recommended that further work is undertaken to explore the impact of the growing older population will have on current services in place for older people. Commissioners need to be informed of the expected changes so that services can be altered/created to meet the needs of older people.

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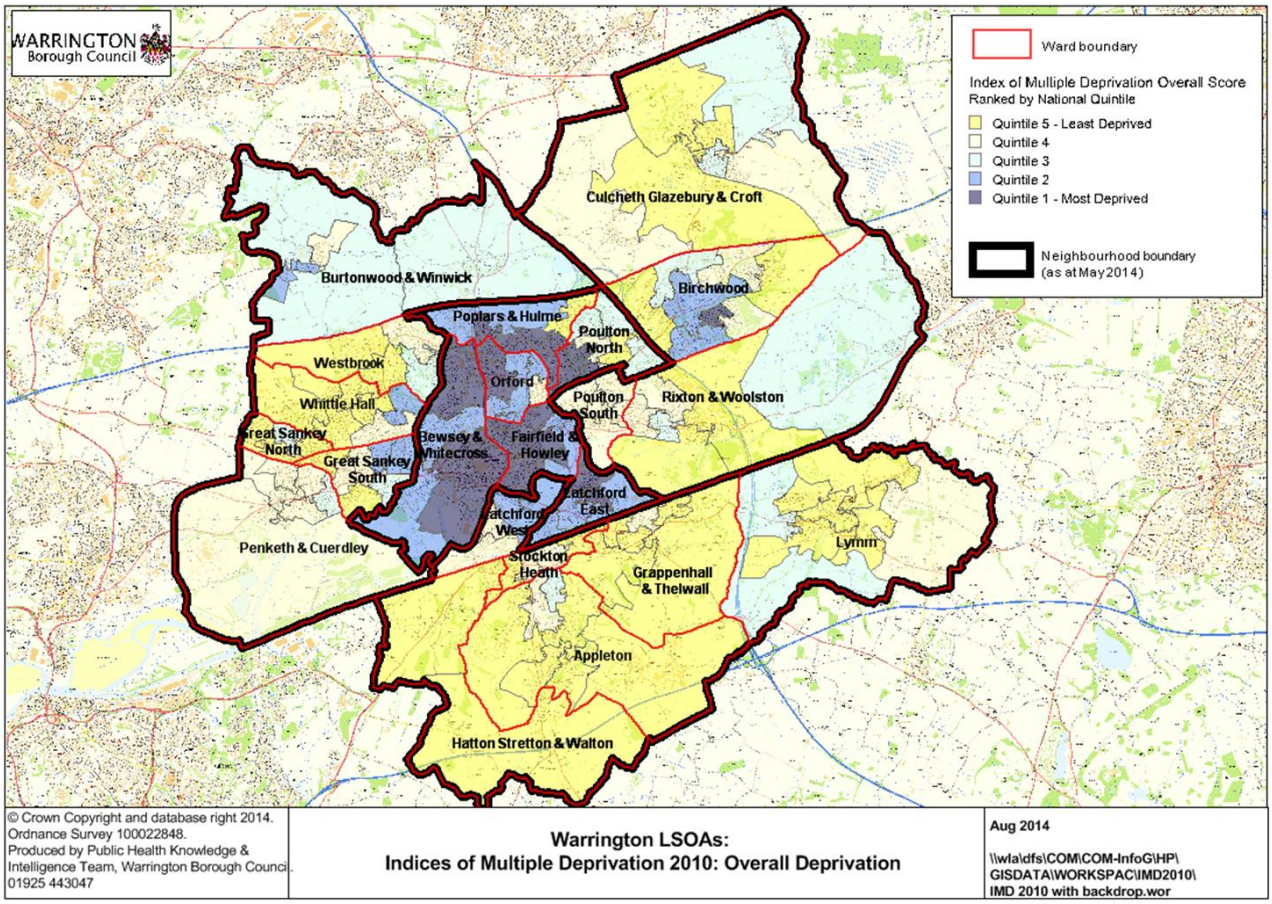
HACT see Housing Associations Charitable Trust
NICE see National Institute for Health and Care Excellence

Appendix A:

Health and Wellbeing Survey, 2013: A comprehensive, large scale survey of Warrington residents (aged 18+) was undertaken early in 2013 by Public Health Team, Warrington Borough Council. It collected information on a wide range of factors that impact on an individual's health and wellbeing, including general health, emotional wellbeing, living alone, social contact, finances, feelings of safety lifestyle, and factors such as obesity, diet, physical activity, alcohol and smoking. Questionnaires were posted to a randomly selected sample of adults living within the Warrington borough boundary and 6,673 valid returns were received, of which 2,437 were from people aged 65 and over. Respondents were weighted for non-response based on age-band, sex and level of deprivation (IMD 2010) where the respondent lived. This data has been analysed by age-band, sex and socio-economic deprivation.

Measuring deprivation: Much of the analysis is analysed by levels of socio-economic deprivation. Measuring Socio-Economic Deprivation (see map of deprivation in Warrington). Lower Super Output Areas (LSOAs) are small geographical units. Deprivation was measured using the Index of Multiple Deprivation (IMD) 2010. For each LSOA, a deprivation score is calculated covering a broad range of issues: income, employment, health and disability, education and skills, housing and services, crime, and living environment. All LSOAs in England are ranked by IMD score and then split into 5 equal sized groups (called quintiles). Warrington contains 127 LSOAs; these are grouped according to which national quintile they are in (Quintile 1 is the most deprived; Quintile 5 the least). The map shows deprivation levels across Warrington. The most deprived areas, Quintile 1, are shaded dark blue, and the least deprived, Quintile 5, are shaded yellow. For further information, see the Warrington JSNA chapter on socio-economic deprivation (Warrington Borough Council, 2015a).

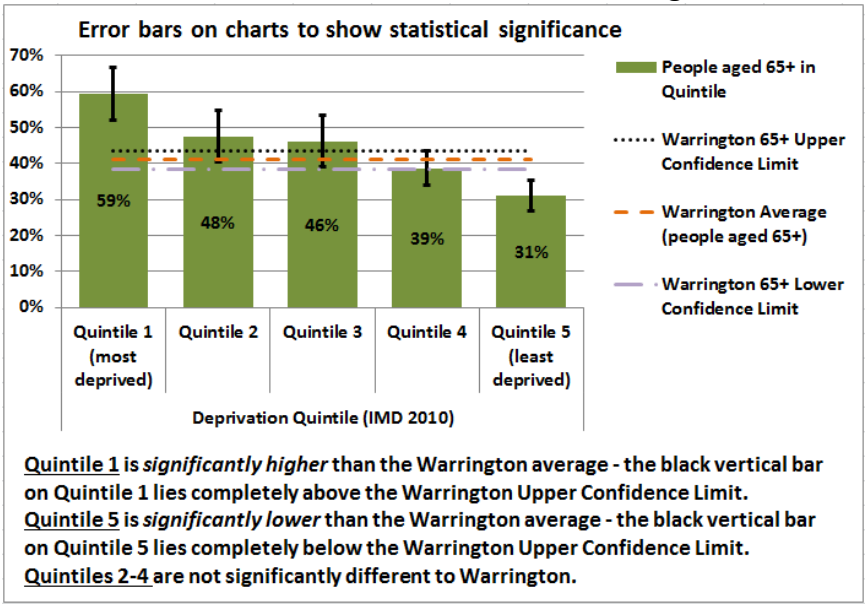
Figure 2: Index of Multiple Deprivation 2010



Interpretation of charts: statistical significance and confidence intervals

In the following bar charts, 95% confidence intervals are shown as vertical black lines on each bar. These indicate the level of uncertainty about each value on the chart. Wider intervals mean more uncertainty. Where confidence intervals do not overlap the difference is said to be statistically significant. The top of the black bar is called the Upper Confidence Limit (UCL) and the bottom is called the Lower Confidence Limit (LCL); there is a 95% chance that the true value of whatever is being measured will lie between the LCL and UCL.

Chart 17: Error bars on charts to show statistical significance



Quintile 1 is *significantly higher* than the Warrington average - the black vertical bar on Quintile 1 lies completely above the Warrington Upper Confidence Limit.
Quintile 5 is *significantly lower* than the Warrington average - the black vertical bar on Quintile 5 lies completely below the Warrington Upper Confidence Limit.
Quintiles 2-4 are not significantly different to Warrington.