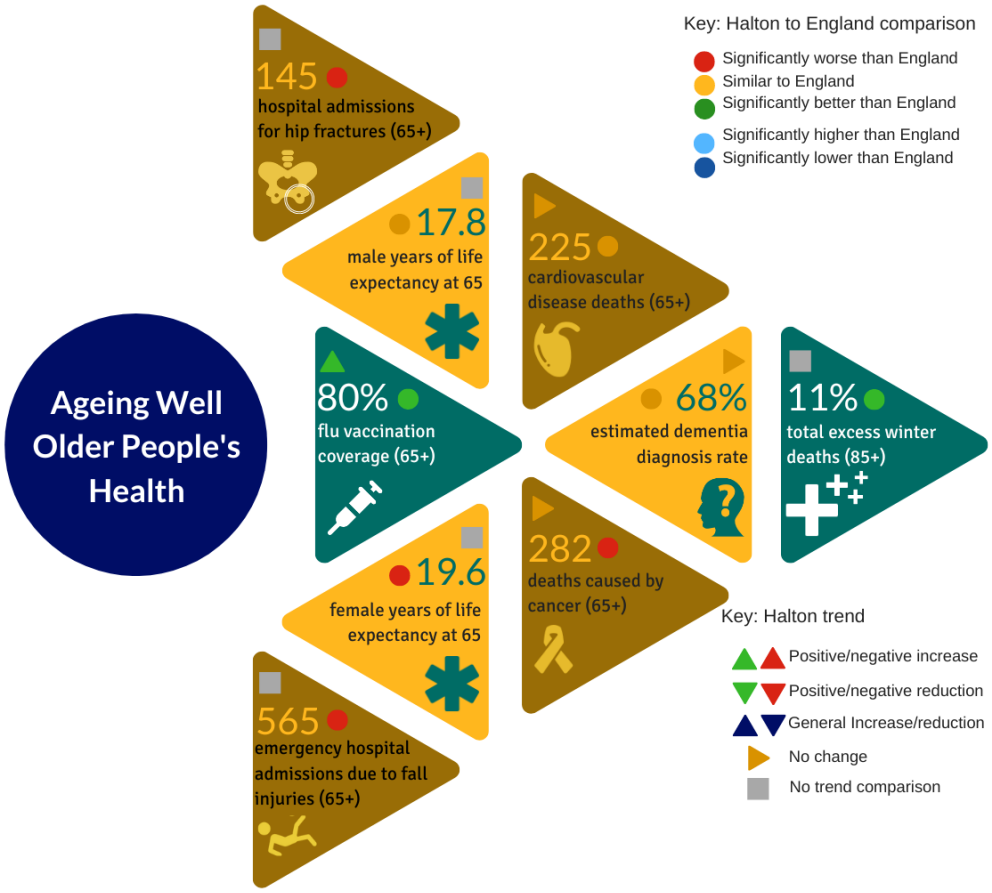
SUMMARY

- The older population is growing and will form a larger proportion of Halton's population, especially given the working age (18-64) and child populations are falling.
- A large proportion of Halton older people live in poverty. Whilst fuel poverty levels are similar for over65s as the general population over half live in the 1st and 2nd most fuel deprived quintiles. Health conditions associated with cold damp homes is higher in areas with highest fuel poverty.
- Although life expectancy at 65 for males is similar in Halton compared to England (2018-20), life expectancy among females is significantly lower than England. This is also the case for healthy life expectancy. Disability-free life expectancy in Halton is similar to England, due to the increase seen in the latest reporting period (2018-20).
- Admission rates to care homes are higher than in England but similar to the North West levels.
- Whilst levels of dementia are similar to Cheshire & Merseyside and England, numbers are predicted to rise nationally and locally. Of those currently diagnosed with dementia those living in the most deprived quintile have greater levels of long-term conditions and number of prescribed medications than those in the least deprived areas of the borough.
- 39.7% of Halton residents are of moderate or severe frailty (based on their electronic frailty score). This is a higher proportion than Cheshire & Merseyside.
- Just under 700 older people attend A&E departments due to falls, with the highest number occurring among those aged 86—steady declines with younger and older age from this year.
- Emergency admission rates due to falls and hip fractures are higher than the England average and some of the highest amongst the borough's statistical neighbours group of local authorities
- All age loneliness levels are similar to the regional and national averages. Using national survey results we estimate that 2,072 older people are widowed home owners with long-term conditions—a group at high risk of loneliness; we can further estimate that 1,451 older people may feel lonely often/always. Age UK data analysis shows wide variation across the borough.
- Halton's palliative care prevalence is higher than comparators. There is wide variation at GP level. The majority receiving palliative care are aged 75+ and over half live in the most deprived quintile
- 54.1% of Halton GP-registered patients for the year to September 2023 died in hospital, a higher level than NW and England. Over 30% of deaths in care homes were among people who were living there temporarily, and as such it was not their usual place of residence.
- Levels of 3+ emergency admissions in the final 90 days of life was similar in Halton to NW and England

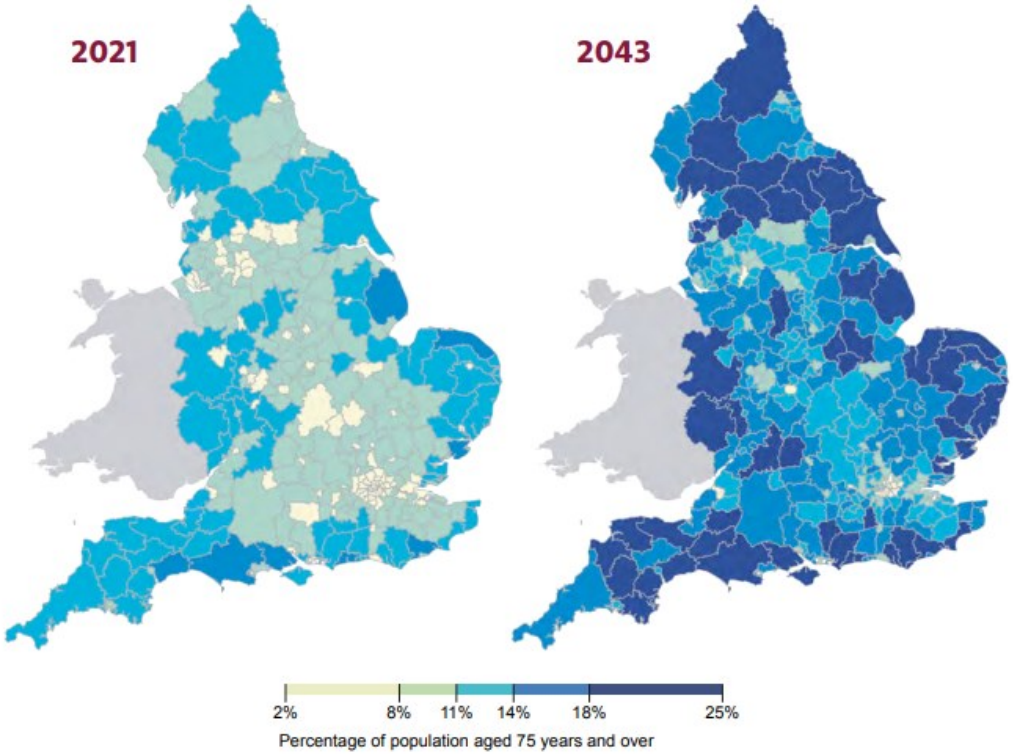


Chief Medical Officer's annual report 2023: health in an ageing society

The aim of the latest Chief Medical Officer's (CMO) annual report is to concentrate on issues which focus on improving the quality of life, rather than quantity, of an adult's later years. Some of the things we can do to allow people to have healthier lives in older age may, as a fortunate by-product, also extend their lifespan, but this report is not concentrating on these areas in particular.

Improving quality of life can broadly be divided into: 1) things which reduce disability and ill health, and 2) things which can be done to adapt the environment to allow an individual with a set amount of disability in older age to live as independent and enjoyable a life as possible.

- Most people now live into older age. For many, this is a period of great happiness but for some older age is a time of great difficulty.
- Older people have essential roles in society; however we are more likely to depend on the help of others in this period of life.
- We need to aim to compress periods of ill health and disability into briefest time possible.
- Even with optimal improvements in health we need to adapt the environment to enable independent living, including provision of adequate health and social care.
- For too long there has been too much focus on identifying and treating single conditions. However, there are more people living in older age with a greater number and heightened severity of long-term conditions.
- There is a clear link between the prevalence of multimorbidity (2 or more conditions) and both age and deprivation; people living in deprived areas not only live shorter lives, but also develop long-term conditions and multimorbidity earlier than those in less deprived areas.
- It is estimated that around 70% of adults living with frailty have multimorbidity, but less than a fifth of older adults with multimorbidity are living with frailty. There are inequalities in frailty prevalence, with higher rates and earlier onset in areas of deprivation.
- The CMO highlights the importance of primary prevention by government (both central and local) and secondary prevention by the NHS.
- We do what we measure. However we need to be aware of other important issues. For example we do not measure levels of incontinence but this issue can have significant impacts on older people's physical and mental health, and reduce their quality of life. Listening to what older people tell us is important is vital.



Chief Medical Officer's annual report 2023: health in an ageing society - GOV.UK (www.gov.uk)

POPULATION: OLDER PEOPLE

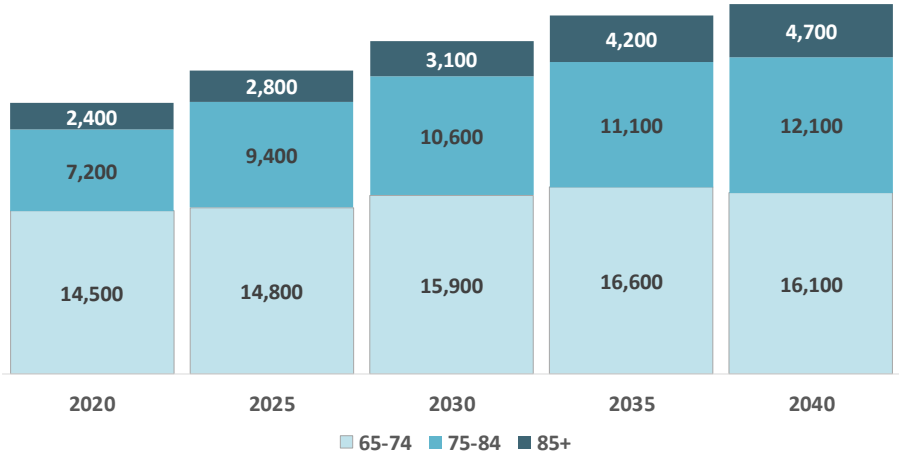
The population of Halton, like the rest of the country, is changing, with a larger proportion being of older age, 65+ than we have seen previously. Previously Halton's population was thought of as having a 'younger' age structure than England. For the 75 and over groups that is still the case, with a lower proportion in Halton compared to England. However Halton is estimated to have a higher proportion of its population aged 65-74 than the England average. There are a lot fewer Halton residents estimated aged 85 and over in the most recent year (2021) compared to the previous year (2020).

There are **23,959** older people in Halton (age 65+) according to the 2020 population estimate.

	65-69	70-74	75-79	80-84	85+
Males	3,469	3,412	2,070	1,274	914
Females	3,785	3,692	2,223	1,593	1,527

Halton & England population pyramid
Proportion of total area population, by 5-year age band and gender
Source: Census, 2021

5,500 more older people by 2030
8,800 more older people by 2040
(compared with 2020)



The age breakdown of Halton's population is expected to change over the next two decades. The proportion of people over the age of 70 is expected to swell and the proportion of children and people of working age is expected to contract. This is the case nationally also, but is predicted to be emphasised more so locally.

The old age dependency ratio show this changing population structure. This is the number of older people at State Pension Age and above per 1,000 people aged 16 to below State Pension Age. This ratio is growing in Halton, as it is elsewhere, although notably the ratio is higher in Halton than England and by 2030 is projected to be higher than both the North West and England.

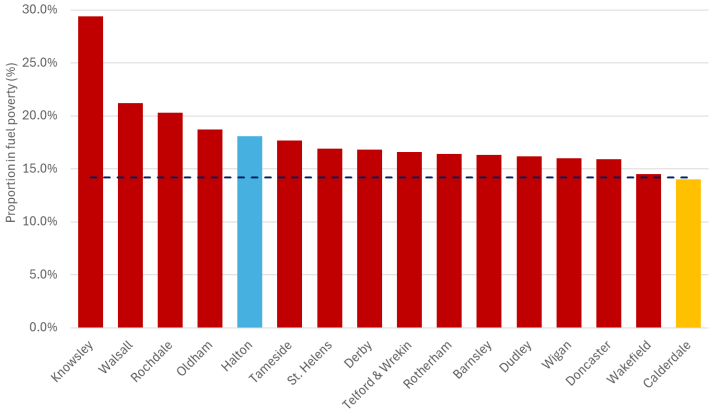
283 (2020) → **313** (2030) → **361** (2040)

POPULATION: DEPRIVATION & POVERTY

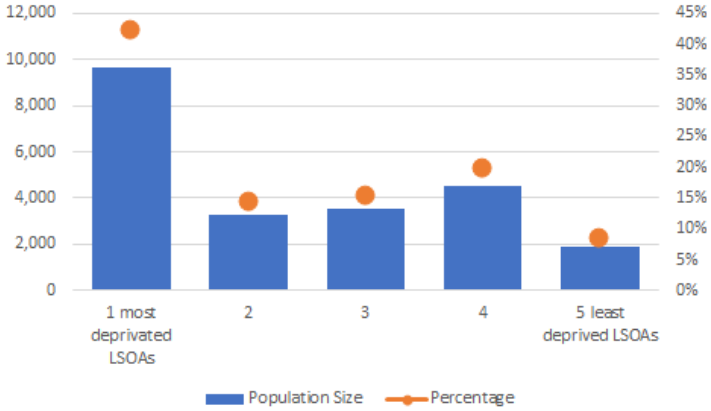
Based on the Indices of Multiple Deprivation (IMD) of 2019, almost one in five (18.1%) Halton residents aged 65 years and over, were living in the poverty . This figure is significantly higher than the figure of 14.2% seen nationally. The figure seen in Halton is also higher than the majority of our 'nearest neighbours', and the third highest in Cheshire and Merseyside. In fact, only Knowsley (29.4%) and Liverpool (30.0%) - two of the top three most deprived Local Authorities in the country - have greater proportions of their older people living in poverty.

Proportion of older people (aged 65+) living in poverty, 2019, Halton and statistical neighbours

Note: based on Indices of Multiple Deprivation (2019)



Population aged 65+ by LSOA of deprivation, by deprivation quintiles. ***Source: CIPHA***

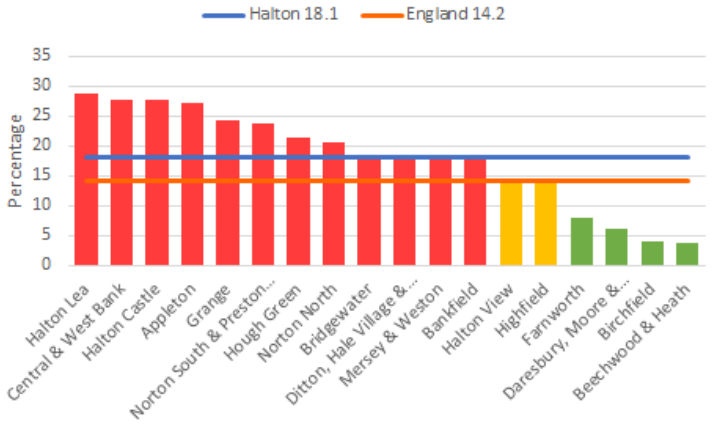


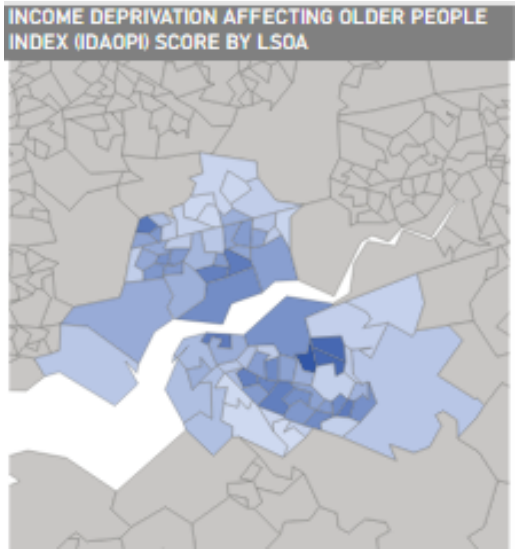
Levels of deprivation amongst older people are not experienced uniformly across the borough. At electoral ward level it varies from 28.7% in Halton Lea to 3.7 in Beechwood & Health ward. Most of Halton's electoral wards have rates (percentages) statistically higher than England (denoted by the red bars), 2 are statistically similar (amber) and 4 statistically better (green). Further breakdowns are available at lower super output area (LSOA). These are small geographical areas comprising of between 400 and 1,200 households and have a usually resident population between 1,000 and 3,000 persons.

42.3% of Halton's over 65's living in the most deprived quintiles, as at 20/01/24 this equates to 9,652 people. The gender split is similar, 43.21% female and 41.24% male.

Index of Deprivation Affecting Older people, percentage of population, electoral ward, and LSOA, IMD 2019

Electoral ward





POPULATION: POVERTY & FUEL POVERTY

Fuel Poverty

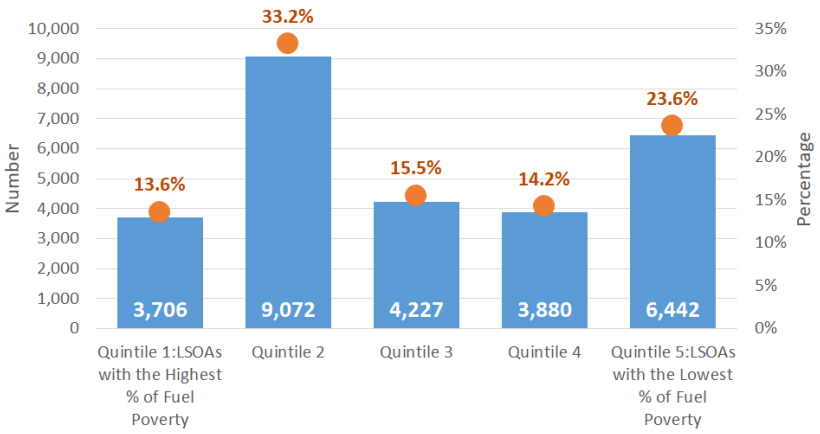
A 'fuel poor' household is a property with a 'fuel energy efficiency rating band D or below, and they spend the required amount to heat their home, but this leaves them with a residual income below the official poverty line.' Official statistics data on fuel poverty at local authority level is not available for specific age groups. National and overall local data, we can see that there are variations in fuel poverty across the local authorities in England, and nationally by age group. Levels of fuel poverty overall at slightly higher in Halton at 13.8% of households compared to 13.2% across England as a whole and % in the North West. Modelled estimates at electoral ward suggest levels vary from 19.5% in Central & West Bank to 4.5% in Birchfield.

Nationally, 24.3% of energy inefficient households (efficiency band D or lower) encompassing at least one person aged 60 years and over are fuel poor.

Age specific fuel poverty data is available through the Integrated Care Board (ICB) data platform known as CIPHA.[i] Using patient records and matching them to the official fuel poverty data at lower super output area (LSOA) we can see that 13.6% of Halton residents age 65+ live in LSOAs with the highest level of fuel poverty locally. This is similar to the overall figure.

Number and & of population aged years and over, living in areas of fuel poverty

Source: CIPHA



The majority of households in Halton have an energy efficiency rated home of D (D = 40.7%, C = 32%) or above. The average energy efficiency rating for a dwelling in England and Wales is band D.

i. CIPHA = Combined Intelligence for Population Health Action

NICE guidelines[ii] suggest a range of medical conditions can be made worse (exacerbated) by living in a cold damp home. Using this same CIPHA data we can see that overall there is higher prevalence of these conditions amongst those older people living in the LSOAs with highest level of fuel poverty.

Condition By Fuel Poverty Quintile

Cold Homes Condition	Quintile 1:LSOAs with the Highest % of Fuel Poverty	Quintile 2	Quintile 3	Quintile 4	Quintile 5:LSOAs with the Lowest % of Fuel Poverty
CVD					
Atrial fibrillation Register	11.1	10.7	11.3	11.4	9.6
Coronary heart disease (CHD) Register	18.2	16.6	15.8	15.3	14.0
Heart failure Register	5.6	5.0	4.9	4.6	4.1
Hypertension diagnosis Register	51.2	48.8	49.4	46.5	47.5
Peripheral arterial disease (PAD) Register					
Stroke/TIA Register	8.3	8.0	8.2	7.3	5.8
Disability					
Learning disability register	0.4	0.5	0.3	0.1	0.1
Physical disability	10.0	9.2	9.6	5.9	6.3
Mental Health					
Depression diagnosis register	3.5	3.3	3.6	3.4	2.9
Severe Mental Illness register	1.6	1.3	1.1	0.8	0.7
Respiratory					
Asthma diagnosis Register <= 18					
Asthma diagnosis Register 19+	2.0	2.0	2.4	2.6	2.2
Chronic obstructive pulmonary disease (COPD) Register	16.4	12.1	10.3	6.9	6.4

Ii Overview | Excess winter deaths and illness and the health risks associated with cold homes | Guidance | NICE

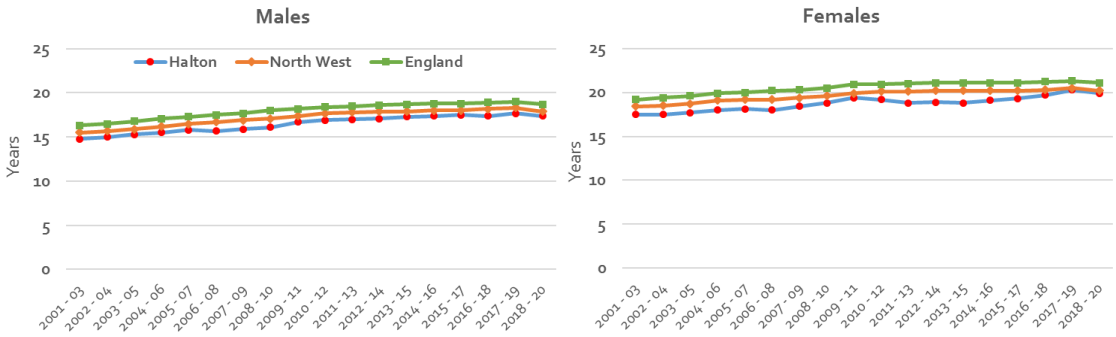
POPULATION: LIFE EXPECTANCY

Declining mortality in the 19th and 20th century saw a significant rise in life expectancy. 2011 marked a turning point in long-term mortality trends in England, with improvements slowing after decades of steady decline, prompting much debate about the causes. The emergence of Covid-19 in 2020 will have significant implications for life expectancy.

Life expectancy at age 65

Life expectancy in Halton is lower than England, for both men and women. The difference is statistically significantly worse than England.

trend in life expectancy at age 65



Disability-free life expectancy at age 65

Disability free life expectancy is also lower in Halton, for both men and women, compared to both the North West and England. The difference is statistically significant compared to England.

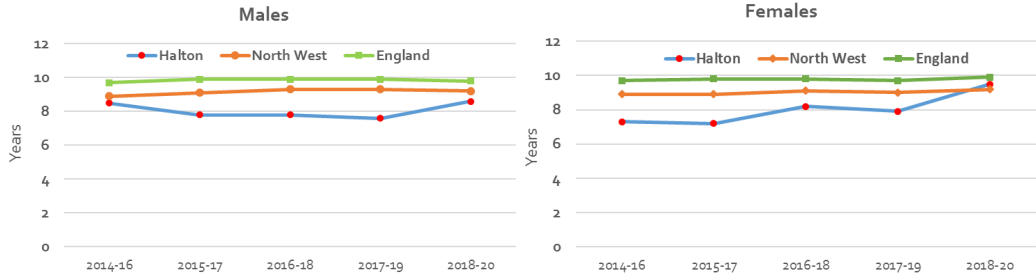
Healthy life expectancy at age 65

Another key measure of health inequality is how much time people spend in good health over the course of their lives, given how crucial good health is to wider quality of life and people's ability to do the things that they value.

Two important measures of the amount of time that people spend in good health are 'healthy life expectancy' and 'disability-free life expectancy'.

trend in healthy life expectancy at age 65

trend in disability-free life expectancy at age 65



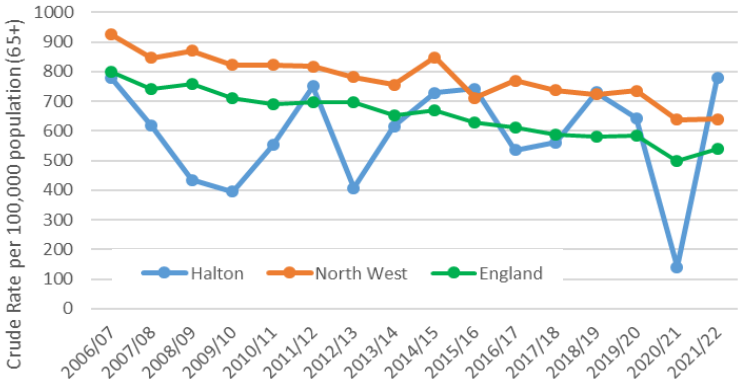
CARE HOMES

Adult Social Care, like many public services, has been impacted considerably by the COVID-19 pandemic. Operationally, local authorities will have responded to these challenges differently; some services may have been paused due to restrictions, or to support other activities, and the associated spend and activity may have been captured locally in different ways. As such, the pandemic is affecting trends and making comparisons over time difficult. Many year on year changes have been influenced by the pandemic, for example by the increased funding made available, and as local authorities worked out the best response in their area.

Residential and nursing care

Rate of admissions into nursing/residential care admissions in Halton, per 100,000 population

Source: Aristotle, 2023



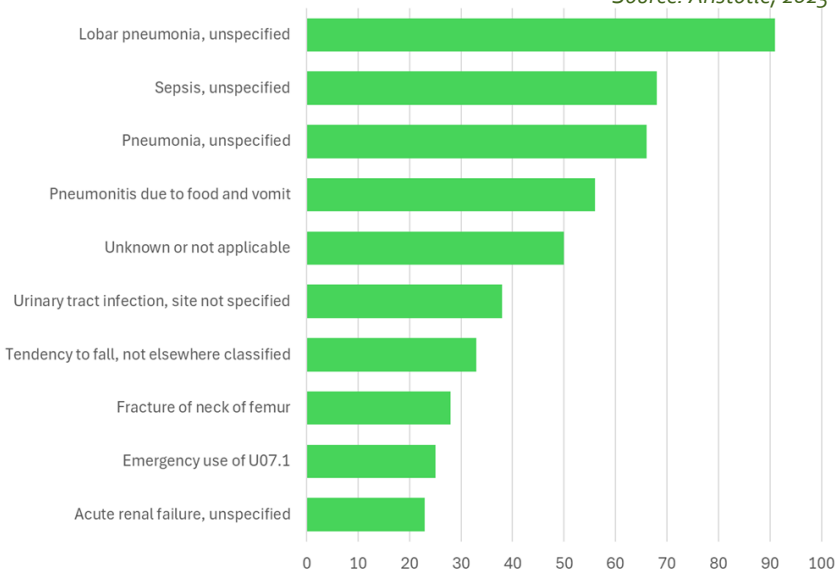
Overall, rates of people entering nursing or residential care has fluctuated greatly in Halton. However, this mainly due to the much smaller population in the borough, and in the case of 2020/21, due to the COVID-19 pandemic altering the way in which residential and nursing care homes could work, and their ability to accept new residents. With that said, in the main, the rate of residential or nursing care home admissions in Halton was very similar to the North West and England between 2013/14 and 2019/20.

Secondary Healthcare use by residential and nursing care residents

Living in a good quality care home can increase the level of care a person receives, and reduce the likelihood of A&E attendances and hospital admissions[1]. However, movements into care homes, particularly nursing care, comes as a result of increased care need due to progression of health conditions and care need exceeding capacity for care at home[2]. In Halton in 2021/22, there were 1,129 A&E attendances and in 2022/23, there were 1,212 admissions to hospital, by residential or nursing home residents registered with Halton GPs.

Top 10 causes for Emergency Hospital admissions by Halton residential/nursing home residents, 2022/23

Source: Aristotle, 2023



Over a third (36.7%) of such hospital admissions (aged 65+) stayed longer than one day. As shown below, the main reasons for care home residents having an emergency hospital admission during 2022/23 were pneumonia, infections and falls.

Temporary residential and nursing care use and long-term care needs

In 2022, more than a third (36.6%) of deaths that occurred in care/residential homes were among those who had moved into these facilities temporarily. In terms of overall deaths in care/residential homes, there were greater numbers with increasing age, with 105 (25.0%) of those among people aged 85 and over. In 2022/23, a lower rate of Halton residents had long-term support needs met by a residential/nursing care move, than in England[3].

[1]Lloyd et al., 2019. Effect on secondary care of providing enhanced support to residential and nursing home residents: a subgroup analysis of a retrospective matched cohort study. BMJ Qual Saf. 28(7):534-546. doi: 10.1136/bmjqs-2018-009130
[2]The King's Fund, 2014. Admission to a nursing home can never become a 'never' event. [Online] Available from: https://www.kingsfund.org.uk/blog/2014/08/admission-nursing-home-can-never-become-never-event
[3]https://lginform.local.gov.uk/reports/lgastandard?mod-metric=4282&mod-area=E06000006&mod-group=AllUnitaryLaInCountry_England&mod-type=namedComparisonGroup&mod-period=1

DEMENTIA

Prevalence, Incidence and Impact

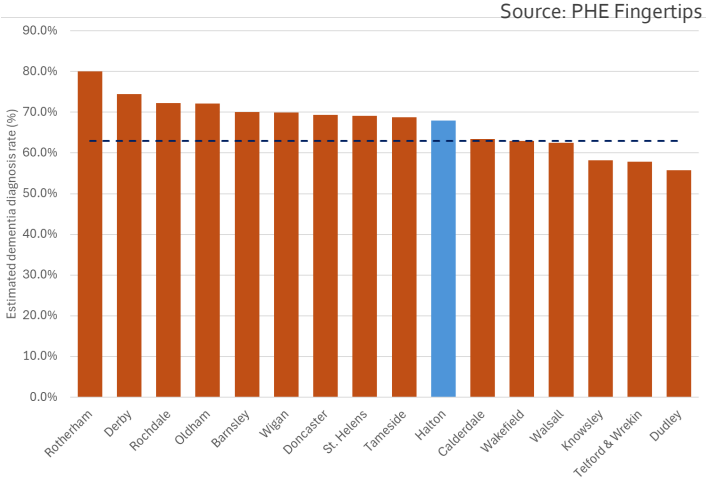
There are approximately 1 million people estimated to be living with dementia in the UK[1]. In 2040, the UK's population of people living with dementia is projected to reach 1.7 million[2], which the majority the greatest proportion increase set to be among people with more severe symptomatology, and therefore greater, and more acute health and social care needs[3].

Living with unmet care needs—whether that be delayed diagnosis, late treatment, or lack of formal social care—can have profound impacts on the person living with dementia, and their unpaid carer(s)[4]. Lack of formal care and treatment can impact on their physical and mental health, and increase feelings of isolation, carer burden. Unmet care needs, and the resultant negative outcomes are something felt more acutely among the most disadvantaged groups in society[5], with variations by deprivation, ethnicity, gender, age etc.[7]

There are many people estimated to be living with dementia, but not having received a diagnosis. As of 2023, over a third of people in England thought to have dementia, did not have a formal diagnosis. A similar picture is seen in Halton, with 68% of people thought to have dementia, having actually received a formal diagnosis—and 66.9% in the North West region.

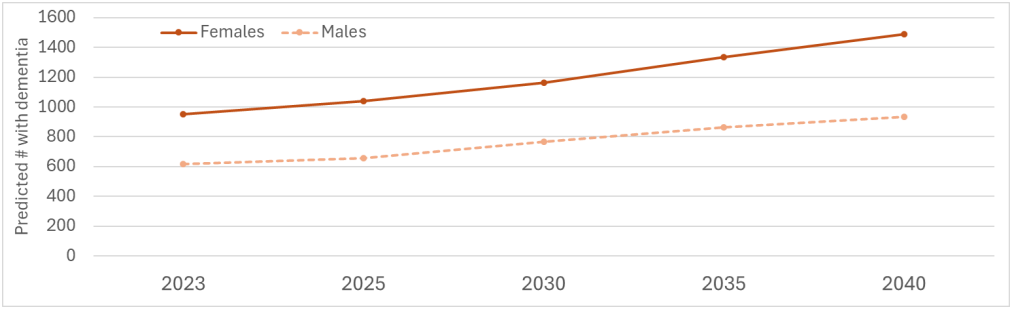
Estimated dementia diagnosis rate in Halton and CIPFA neighbour comparators, 2023

Source: PHE Fingertips



People aged 65+ in Halton predicted (2023) and projected to have dementia (2025-2040), by gender,

Source: POPPI, 2024



From QOF data for 2022/23, there were 985 people registered with Halton GPs who were on practice registers with a formal diagnosis of dementia. This figure reflects 0.73% of the entire population of the borough, figures similar to those seen regionally (C&M ICB) and nationally (0.82% and 0.74% respectively). However, given underdiagnosis of dementia it is important to note the potential for many people to be living with undiagnosed young- (aged under 65) and late-onset (aged 65+) dementia. There are estimated to be over 70,000 people in the UK living with young-onset dementia[6], and given the difficulties in accessing diagnoses for dementia when younger or with less common subtypes, as well as undiagnosed late-onset dementia[6], this represents a proportion of people with the condition facing delays and barriers to support.

When looking at people on QOF dementia registers, referring to those people who have received dementia diagnosis, the proportion varies greatly by deprivation quintile. In fact, there is a greater proportion of the population living in the most deprived 20% of Halton (1.15%), who are on dementia registers, than there are in the entirety of the other four quintiles (0.75%).

[1]Alzheimer's Research UK, Dementia Statistics Hub, 2023

[2]Chen et al., 2023. Dementia incidence trend in England and Wales, 2002-2019, and projection for dementia burden to 2040: analysis of data from the English Longitudinal Study of Ageing. Lancet Public Health. 8(11): e859-e867. doi: 10.1016/S24682667(23)00214-1

[3]Wittenberg et al., 2019. The costs of dementia in England. Int J Geriatr Psychiatry. 2019 Jul;34(7):1095-1103. doi: 10.1002/gps.5113

[4]Brodaty and Donkin, 2009. Family caregivers of people with dementia. Dialogues Clin Neurosci.11(2):217-28. doi: 10.31887/DCNS.2009

[5]Institute of Health Equity, 2016. Inequalities in Mental Health, Cognitive Impairment and Dementia Among Older People. {Online] Available from: Inequalities in Mental Health, Cognitive Impairment and Dementia Among Older People - IHE (instituteofhealthequity.org)

[6]Alzheimer's Research UK, Dementia Statistics Hub, 2023. [Online] Available from: https://dementiastatistics.org/about-dementia/subtypes/

[7]Watson et al., 2021. Use of routine and cohort data globally in exploring dementia care pathways and inequalities: A systematic review. Int J Geriatr Psychiatry, 36: 252-270. https://doi.org/10.1002/gps.5419

DEMENTIA: Additional health conditions and medications

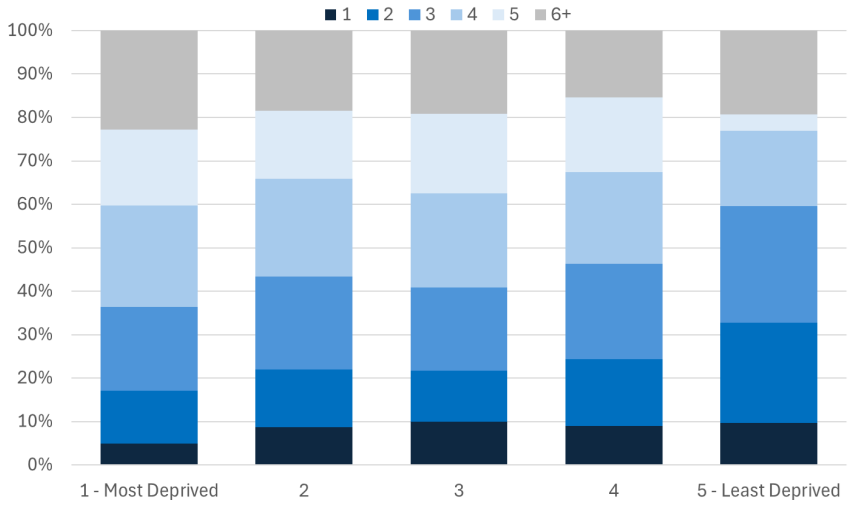
Dementia and long-term health conditions

Increasing age, particularly into older age, increases the likelihood of a higher number of long-term health conditions, and the accompanied need for health and social care[1]. Furthermore, people living with dementia, particularly those with later, or more severe symptomatology in dementia, are even more likely than the general population, to have a greater number, and greater severity of additional health conditions[2].

Greater care needs are associated with both the complexity of dementia, and a likely greater number of additional healthcare needs. These additional, and complex needs are likely to increase the risk of using emergency secondary healthcare[3], particularly of being admitted to hospital, as well as increased risk of poor health outcomes, including faster dementia progression, worse quality of life and higher mortality risk[4].

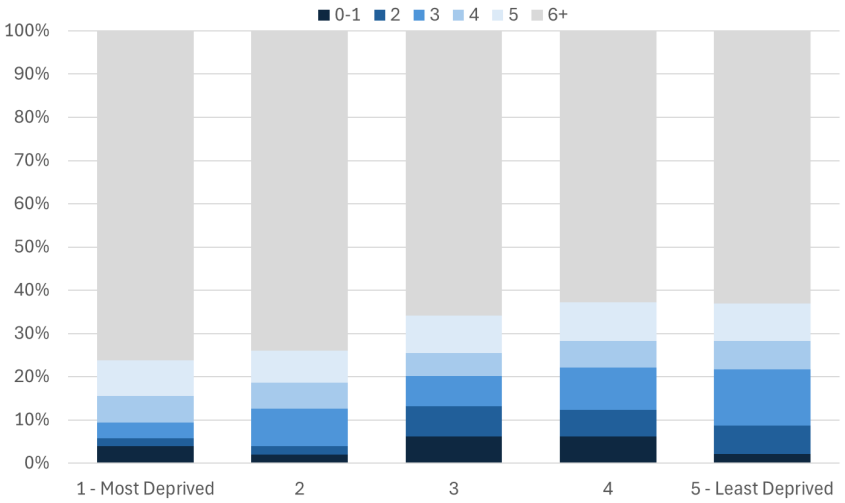
Proportion of people with diagnosed dementia in Halton, by deprivation quintile and number of additional, diagnosed long-term conditions

Source: CIPHA (data as of 19/01/2024)



Proportion of people with diagnosed dementia in Halton, by deprivation quintile and number of medications prescribed

Source: CIPHA (data as of 19/01/2024)



Increasing levels of deprivation also increase the likelihood of greater number of both additional long-term health conditions, and of prescribed medications among people living with dementia. This is a picture largely reflected in Halton. With increasing deprivation, there is an increasing proportion of the respective population with 6+ prescribed medications, and 6+ prescribed additional long-term health conditions. In the most deprived quintile, the proportion of the population diagnosed with dementia who have 6 or more additional long-term conditions is 22.8% - compared to 15.4% in the second least and 19.2% in the least deprived quintiles respectively. In the most deprived quintile, the proportion of the population diagnosed with dementia who have prescriptions for 6 or more medications is 76.2% - compared to 63.0% in the least deprived quintiles of the borough. This is compared to much lower proportions of people living with dementia in the most deprived quintile having only one additional health condition (4.9%) or 1 or fewer prescribed medications (5.7%).

[1]AgUK, 2023. The State of Health and Care of Older People, 2023. [Online] Available from: https://www.ageuk.org.uk/

[2]Bunn et al., Comorbidity and dementia: a scoping review of the literature. BMC Med. 2014 Oct 31;12:192. doi: 10.1186/s12916-014-0192-4

[3]Griffith et al., 2016. Patterns of health service use in community living older adults with dementia and comorbid conditions: a population-based retrospective cohort study in Ontario, Canada. BMC Geriatr. 2016 Oct 26;16(1):177. doi: 10.1186/s12877-016-0351-x

[4]Watson et al., 2021. Use of routine and cohort data globally in exploring dementia care pathways and inequalities: A systematic review. Int J Geriatr Psychiatry, 36: 252-270. https://doi.org/10.1002/gps.5419

FRAILTY

Chief Medical Officer of Health 2023 Annual Report: Health in an Ageing Society

Frailty is used to describe a state of health experienced by some generally older adults. It describes how some individuals lose their in-built reserves and become increasingly vulnerable to sudden changes in their health, which may be triggered by events such as an infection or change in medication or environment. Clinically, frailty is used to identify the group of older people who have the highest risk of adverse outcomes such as disability, falls, hospital admission, and the need for long-term care. Early identification of frailty can slow its progression and delay loss of independence. Frailty is not the same as multimorbidity, but there is often overlap. It is estimated that around 70% of adults living with frailty have multimorbidity, but less than a fifth of older adults with multi-morbidity are living with frailty.8 There are inequalities in frailty prevalence, with higher rates and earlier onset in areas of deprivation.

Cheshire & Merseyside CIPHA report on Frailty

NHS England requires all GP practices to Identify all patients aged 65 and over who may be living with moderate or severe frailty using an appropriate tool. The Electronic Frailty Index (eFI) is a tool available to all practices and has been used in Cheshire & Merseyside to create a dashboard to understand the picture of frailty in the area. It is set to a default of aged 65 and over but can be adjusted to any age in recognition that frailty can happen at any age.

The eFI is split into 4 categories. NHS England estimate they would expect around 3% of the 65+ population to be identified with severe frailty. Other estimates put it higher at 10%.[1] Based on resident population analysis we can see that levels of moderate, and severe frailty are higher in Halton that the Cheshire & Merseyside average. Both are significantly over the NHS England estimate.

	Halton		Cheshire & Merseyside
	Number	%	
Fit	7,080	30.39%	37.64%
Mild	6,832	29.33%	30.48%
Moderate	4,681	20.09%	17.80%
Severe	4,566	19.60%	13.98%
Unknown	138	0.59%	0.11%
Total population	23,297		488,988

Source: CIPHA

1. fff_full.pdf (bgs.org.uk)

The majority of those aged 65+ have multiple long term conditions (multi-morbidity). According to the cumulative deficits model frailty can be conceptualized by counting health deficits (symptoms, laboratory values, disabilities, and comorbidities) . It can encompass the physical, psychological, and social domains of function. Frailty increases with deficit accumulation over the lifespan, leading to many adverse outcomes, including mortality or institutionalization, and may be understood as biological as opposed to chronological age.

We can see from this analysis that levels of these frailty deficits are higher in Halton

	Halton	C&M
Hypertension	63.80%	59.27%
Arthritis	50.28%	45.78%
Respiratory disease	43.91%	38.52%
Urinary system disease	42.31%	40.40%
Ischemic heart disease	42.18%	35.88%
Dsypnoea	37.88%	28.15%
Visual impairment	37.49%	33.56%
Dizziness	34.12%	28.59%
Hearing impairment	32.18%	27.77%
Housebound	27.02%	15.94%
Falls	26.35%	21.30%
Heart failure	24.90%	20.36%
Diabetes	24.70%	21.43%
Anaemia & haematinic deficiency	24.63%	24.89%
Memory & cognitive problems	18.23%	15.42%
Mobility & transfer problems	18.05%	13.28%
Foot problems	16.41%	9.69%
Urinary incontinence	13.20%	11.67%
Fragility fracture	13.18%	12.17%
Social vulnerability	11.08%	10.53%

Souece: CIPHA

	Emergency		Elective	
	Halton	C&M	Halton	C&M
Fit	0.88%	1.29%	2.07%	3.75%
Mild	2.07%	6.69%	1.65%	11.30%
Moderate	11.57%	14.62%	7.44%	14.78%
severe	67.97%	43.94%	21.49%	21.92%

Source: CIPHA

One of the impacts of frailty is an increase in hospitalization. Whilst Halton residents with mild and moderate frailty have a lower percentage of admissions in the last 12 months than Cheshire & Merseyside average, those with severe frailty had a higher percentage of emergency admissions

FALLS

Falls: Hospital Admissions

As described in the previous section, ageing and increased morbidity can increase the risk of a fall. Conditions related to loss of muscle mass or bone density, including arthritis, osteoporosis, and other conditions, such as diabetes or other heart conditions, as well as neurocognitive conditions, including mild cognitive impairment, dementia, as well as symptoms brought on by changes in medications[1]. A previous fall increases the likelihood of having another fall in the future, which isn't necessarily as a result of changes in physical health, but can be partly due to becoming more risk averse and worried about the potential of falls[2]. The most severe falls can result in injuries, including broken bones (e.g. hip fractures, leading to extended stays in hospital, particularly among those who may already have been frail prior to their fall[3].

Accident & Emergency department attendances

Less severe falls may not result in an admission to hospital but may still a medical assessment of an injuries that result from the fall. NHS England note that as not all falls result in serious injury, and a proportion of falls (level one and two) can be responded to by community-based response services, supporting NHS statutory services such as ambulance services to prioritise higher acuity patients. Whilst these services are already in place in many areas, there is variation in coverage across geographical footprints and population groups. That all integrated care boards (ICBs) should have full geographical coverage between the hours of 0800 and 2000, 7 days a week, of community-based alternatives to double crewed ambulance response for level one and two falls. This applies to all falls for adults over 18 in people's own homes or the place they call home, including care homes.[4]

Data from North West emergency departments shows just under 700 attendances amongst Halton residents aged 65 and over in 2022. 2023 data is not yet complete but is likely to be similar. There are higher numbers of women attending compared to men. Numbers increase from age 65 peaking at age 86.

A&E attendances due to falls; Halton residents aged 65+, by month in 2023

Source: Liverpool John Moores University

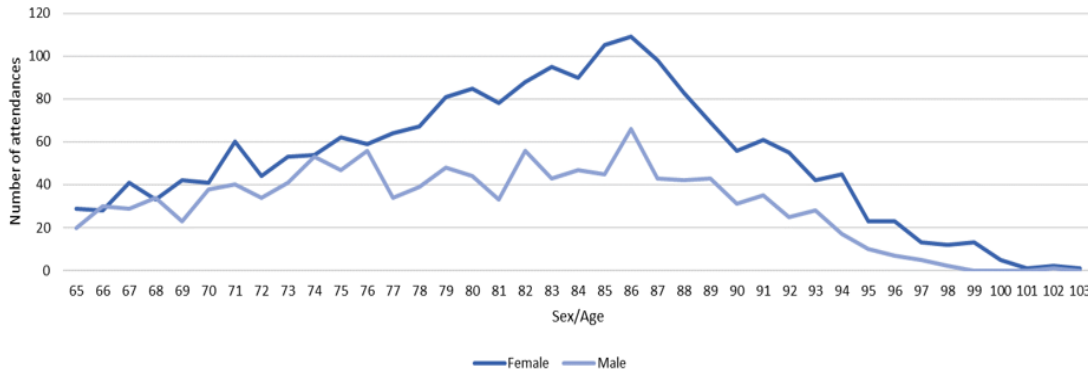
Halton resident (65+) fall attendances (January 2019 to November 2023)

Month/year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2019	51	50	48	56	45	54	52	49	53	52	61	62	633
2020	39	56	40	38	60	46	61	44	59	45	49	59	596
2021	57	45	49	60	67	64	60	70	51	52	47	47	669
2022	59	40	69	48	62	66	62	49	38	51	60	72	676
2023	51	51	59	51	52	57	49	54	73	69	59	not available	625
Total	257	242	265	253	286	287	284	266	274	269	276	240	3199

Source: Liverpool John Moores University

A&E attendances due to falls; Halton residents aged 65+, in 2023 by age and gender

Source: Liverpool John Moores University



[1]National Institute for Ageing, 2022. Falls and Fractures in Older Adults: Causes and Prevention. [Online] Available from: https://www.nia.nih.gov/health/falls-and-falls-prevention

[2]Liu et al., 2021. Fear of falling is as important as multiple previous falls in terms of limiting daily activities: a longitudinal study. BMC Geriatr 21, 350. https://doi.org/10.1186/s12877-021-02305-8

[3]Office for Health Improvement and Disparities, 2022. Falls: Applying All Our Health. [Online] Available from: Falls: applying All Our Health - GOV.UK (www.gov.uk)

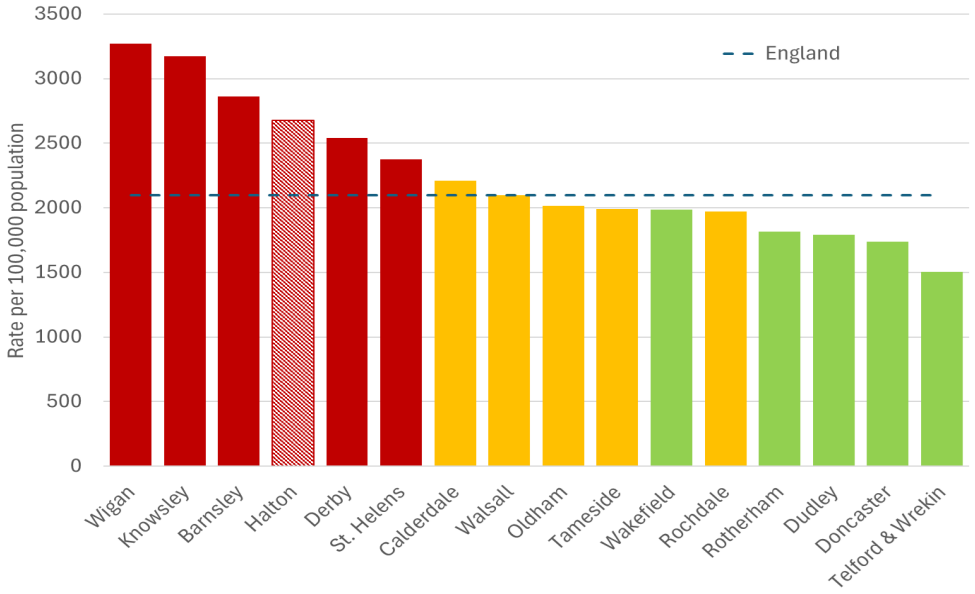
[4] NHS England » Going further for winter: Community-based falls response

Falls: Hospital Admissions

As described in the previous section the most severe falls can result in injuries, including broken bones (e.g. hip fractures, leading to extended stays in hospital, particularly among those who may already have been frail prior to their fall[1].

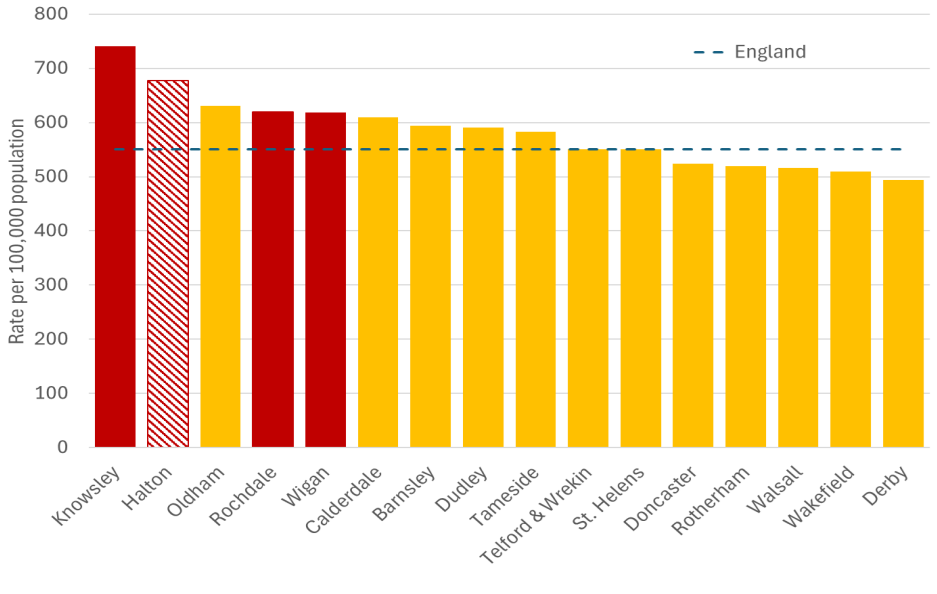
Rate (per 100,000) of emergency admissions due to falls (aged 65+), in Halton and CIPFA neighbour comparators, 2021/22

Source: PHE Fingertips



Rate (per 100,000) of emergency admissions due to hip fractures (aged 65+), in Halton and CIPFA neighbour comparators, 2021/22

Source: PHE Fingertips



Among residents aged 65 years and over, Halton has a significantly higher rates of both emergency admissions due to falls, and emergency admissions due to hip fractures. When compared to our nearest 'data neighbours', of the sixteen local authorities, Halton had the fourth highest emergency admissions due to falls, and second highest emergency hip fracture admissions.

When compared to the Local Authorities in the North West region, Halton once again had much higher rates of emergency admissions for falls (4th highest of 23) and hip fractures (7th highest of 23). There is a similar picture when looking at the oldest people in society. Among those aged 80 years and over, compared to the local authorities in the North West region, Halton has the second highest rate of emergency admissions due to falls, and second highest rate of emergency admissions due to hip fractures (of 23 Local Authorities.

Note: trend data is not currently available due to changes in methodology from analyzing admissions data using a three-year average to annual . It will be available subsequent to 2021/22

[1]Office for Health Improvement and Disparities, 2022. Falls: Applying All Our Health. [Online] Available from: Falls: applying All Our Health - GOV.UK (www.gov.uk)

LONELINESS

Loneliness is a personal experience and can mean different things to different people; establishing a definition is important to ensure that our local strategy has a clear scope and guides us to an effective response. “Social isolation” and “loneliness” are sometimes used as if they were synonymous, but they refer to two different concepts: § Social isolation refers to the inadequate quality and quantity of social relations with other people at the different levels where human interaction takes place (individual, group, community and the larger social environment) § Loneliness is a subjective, unwelcome feeling of lack or loss of companionship. It happens when we have a mismatch between the quantity and quality of social relationships that we have, and those that we want. Even people who are not socially isolated can experience a sense of loneliness. On the other hand, not all of those who are socially isolated may perceive themselves as lonely. The evidence suggests that one of the most effective ways of combating loneliness is to combat isolation (PHE, 2015) Interventions to reduce social isolation – local actions on health inequalities).

Levels of loneliness ay local authority level are available from Office for National Statistics (ONS). They show levels are statistically similar to the North West and England values.

	Often/ always	Some of the time	Occasionally	Hardly ever	Never	Felt lonely in past 7 days
ENGLAND	7.26	19.50	24.60	28.92	19.72	38.44
NORTH WEST	7.84	19.93	24.08	28.55	19.61	40.08
Halton	7.42	25.75	31.69	15.32	19.81	33.43

Source: Office for National Statistics

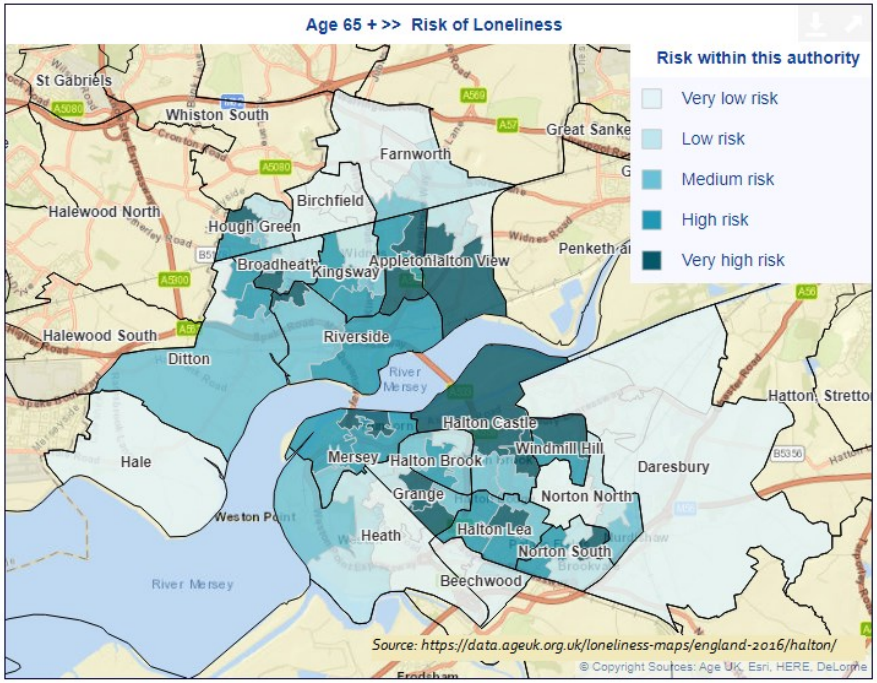
However, this is all age levels of loneliness. Analysis of the Community Life Survey by ONS reveals that for older people (those aged 65 and over) widowed older homeowners living alone, with a long-term health condition are at particular risk. Using the custom data tool from the 2021 Census we can combine these factors (using general health status: not good as a proxy for long-term health condition) to show that in Halton there were **2,072** widowed older (aged 65+) homeowners (own home outright or with a mortgage) who were not in good health.

The Community Life Survey in 2021/22 found 6% of respondents (approximately 3 million people in England) said they feel lonely often or always. This is the same as in 2019/20 and 2020/21. 19% said they felt lonely some of the time and 22% occasionally.

Using ONS mid-year population estimates (Census based) for 2021 of 24,176 people aged 65+, this would give an estimated **1,451** older people feeling lonely often/always, **4,593** feeling lonely some of the time and **5,319** feeling lonely occasionally.

Whilst quite old now and based on data from the 2011 Census the map below on risk of loneliness amongst older people provides and more localized estimate. Using lower super output area level data on marital status, self-reported health status, age and household size. (Note: it was produced before Halton ward boundary changes)

These four factors predict around 20% of the loneliness observed amongst older people 65 and over as represented in the English Longitudinal Study of Ageing (ELSA)



END OF LIFE CARE: PALLIATIVE CARE

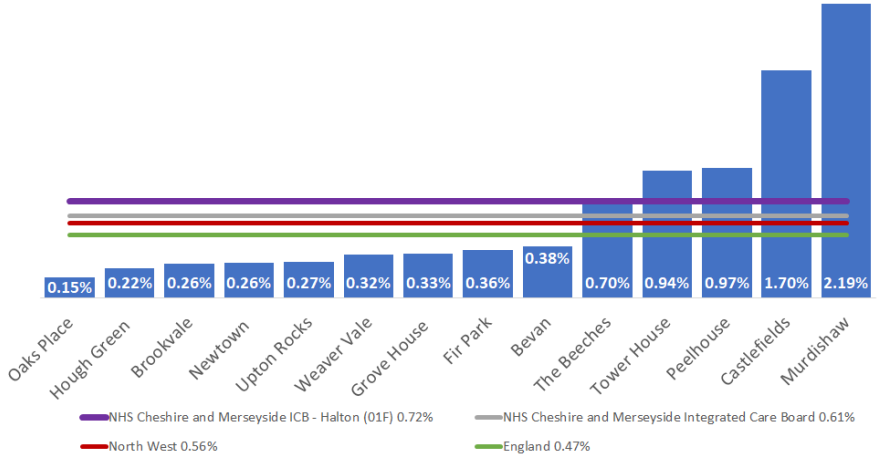
Good quality and effective end of life and palliative care can help to support the person themselves, and their family and friends through a difficult time. It can even help the individual to achieve a better quality of life, and families to reflect more positively, or less negatively about the experience if their symptoms and health condition(s) are managed effectively[1], and in the location that they want to be in, whether that be at home, or in a residential care or nursing facility[2]. However, it is not always possible, and so many, particularly older people, are dying away from home, instead of being supported to achieve a 'good death' at home[3].

Palliative care

For the financial year 2022/23 there were 969 Halton registered patients on the palliative care register. This ranged substantially from 6-234 per GP practice, giving a Halton average prevalence of 0.72% (range 0.15% -2.19%)

Patients of the GP palliative care register, 2022/23

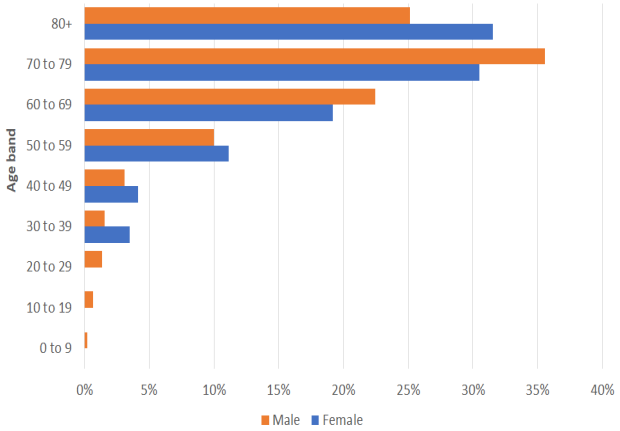
Source: QOF, NHS England



Using CIPHA data from their Enhanced Case Finding tool we can split these overall figures by some key demographics. There are slightly fewer palliative care patients using CIPHA data. This may be due to patients choosing to opt out of their records being used for such secondary surveillance. However, it may also reflect a different time period as CIPHA data is refreshed daily. This snapshot taken using data as at 19/01/2024 shows 935 patients, 485 female (52%) and 450 male (48%). The majority of people under palliative care are aged 75 and over. Over half live in the most deprive quintile.

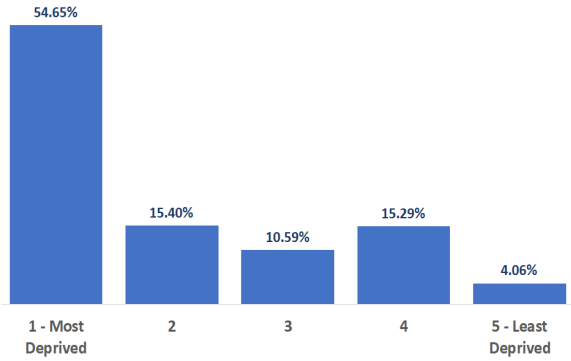
Palliative care patients by age group and gender

Source: CIPHA (data as of 19/01/2021)



Palliative care patients by deprivation quintile

Source: CIPHA (data as of 19/01/2021)



[1]Mitchell et al., 2022. Understanding patient views and experiences of the IDENTIfication of PALLiative care needs (IDENTI-Pall): a qualitative interview study protocol. BMJ Open. 12(6):e062500. doi: 10.1136/bmjopen-2022-062500

[2]Ali et al., 2019. The importance of identifying preferred place of death. BMJ Support Palliat Care. 9(1):84-91. doi: 10.1136/bmjspcare-2015-000878

[3]Clark D. Between hope and acceptance: the medicalisation of dying. BMJ. 2002 Apr 13;324(7342):905-7. doi: 10.1136/bmj.324.7342.905

[4]Public Health England, 2020. Emergency admissions in the last 3 months before death. [Online] Available from: https://www.gov.uk/government/publications/

END OF LIFE CARE: PLACE OF DEATH

Location of death

Location of death among Halton GP registered patients, for the year to September 2023

Source: Office for Health Improvement and Disparities, Department of Health and Social Care

Location of death	Halton	North West	England
Care home	11.2%	19.0%	21.0%
Home	27.5%	27.6%	28.5%
Hospice	4.9%	4.9%	5.2%
Hospital	54.1%	46.0%	42.8%
Other places	2.3%	2.5%	2.6%

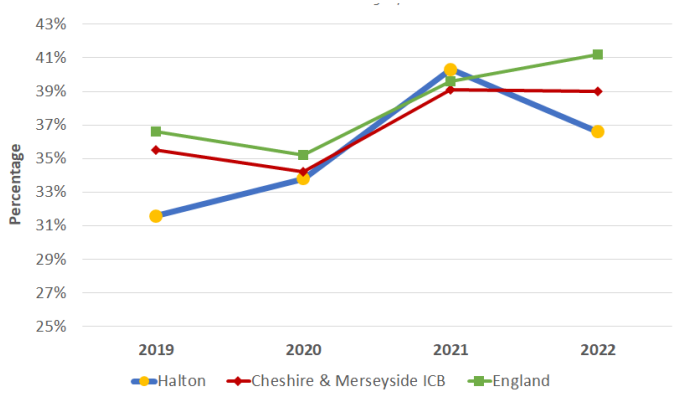
The specific location of death is not strictly illustrative of good care or support, particularly during end of life. For some people a hospice could be their preferred place of death, or the best place to support their needs before death. For some, their care or residential home will be the place they call home. With that said, in the 12-month period to the end of September 2023, the majority of people who died in Halton, did so in hospital (54.1%). Just over a quarter of people who died in Halton during this 12-month period did so at home (27.5%). A further 11.2% died in a care home, and 4.9% died in a hospice. More people in Halton died in hospital, compared to both the North West (46.0%) and England (42.8%). A lower proportion of people who died in Halton did so in a care home (11.2%), than in the North West (19.0%) and England (21.0%).

Having a preferred place of death (PPOD) agreed with a person's GP is rare. Data for 2022/23 and 2023-22/12/23 shows only 6-6.35% deaths had a PPOD recorded. Few deaths with PPOD recorded died at this place.

Trend in temporary, residential carer home deaths, all ages

Source: ONS via PHE Fingertips

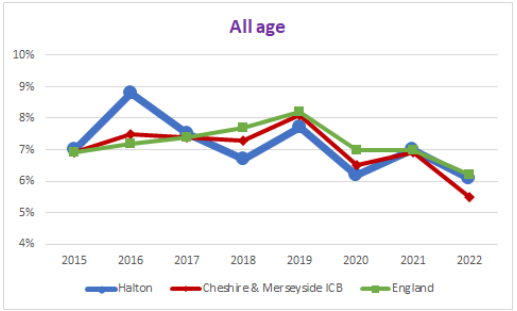
To understand the trends and variations in place of death as proxy indicator for quality of end of life care. OHID have developed an indicator using the ONS death registrations to look at the proportion of registered deaths where the place of death is recorded as care home but the care home is not the usual place of residence. Although levels for 2022 were slightly lower in Halton than elsewhere the difference is statistically similar to England with over 30% of deaths in care homes being a temporary home not the persons usual place of residence.

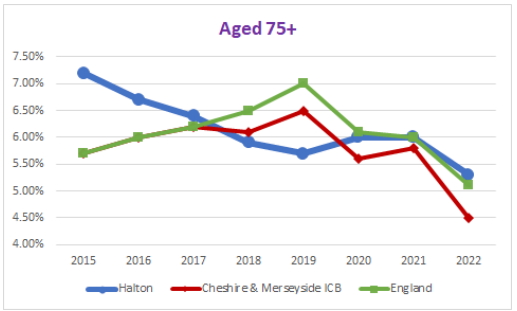


In the final 3 months before death, the likelihood of emergency admissions to hospital can increase. Few people would choose to die in hospital, and the risk of poor health outcomes and lower quality of life are heightened with greater use of secondary healthcare. The likelihood of repeated admissions to hospital shortly before death can vary by geography, deprivation, and other personal characteristics (age, gender ethnicity)[4]. Analysis shows the trend in Halton is similar to the ICB and England as are the percentages.

Percentage of deaths with three or more emergency admissions in the last 90 days of life

Source: Hospital Episode Statistics (HES) data from NHS Digital linked to ONS Mortality database





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[4]Public Health England, 2020. Emergency admissions in the last 3 months before death. [Online] Available from: https://www.gov.uk/government/publications/

ELECTORAL WARD LEVEL METRICS

Most of the data presented in this report is at Halton borough level. This is mostly due to data availability. In some cases data is available at lower geography. The table below is a selection of that data pertaining to the 65 and over population. This snapshot of electoral ward data shows some consistent patterns of ill health across the borough.

	Appleton	Bankfield	Beechwood & Heath	Birchfield	Bridgewater	Central & West Bank	Daresbury, Moore & Sandymoor	Ditton, Hale Village & Halebank	Farnworth	Grange	Halton Castle	Halton Lea	HALTON	ENGLAND
Indices of deprivation affecting older people index	27	18	4	4	18	28	6	18	8	24	28	29	**18**	**14**
Single person households (age 66+)	14	16	16	8	10	12	8	13	13	14	14	13	**13**	**13**
Frailty (rate per 1,000 population)	55	71	116	44	66	48	32	54	66	62	67	35	**58**	
Dementia (rate per 1,000 population)	6	6	3	1	5	2	3	5	1	2	4	10	**4**	
Hip fractures (age 65+, 5 year admission ratio)	147	146	86	70	98	118		149	81	79	86	243	**119**	**100**
Life expectancy at birth: males	76	76	81	83	76	75	85	78	81	76	73	72	**77**	**79**
Life expectancy at birth: females	78	78	84	84	81	78	90	79	85	78	82	76	**80**	**83**
Life expectancy at age 65: males	16	17	19	20	16	17	23	17	18	17	15	14	**17**	**19**
Life expectancy at age 65: females	18	18	22	23	19	19	27	18	23	18	23	15	**19**	**21**
Deaths from cancer aged under 75 (rate per 100k)	135	133	96	83	139	160	62	131	87	150	123	164	**126**	**100**
Deaths from circulatory diseases aged under 75 (rate per 100k)	184	147	78	71	128	188	52	117	70	148	142	143	**122**	**100**
Deaths from respiratory diseases (all ages, rate per 100k)	139	154	75	68	159	178	74	164	92	165	139	242	**144**	**100**

Significantly higher than England		
Not significantly different to England		
Significantly lower than England		

n.b. England comparison not available for frailty and dementia data