Wirral JSNA: Dementia

Summary

- There are currently 3,195 people aged 65+ who have a recorded diagnosis of dementia in Wirral.
- Overall, projections estimate that the number of people with dementia in Wirral will increase from 4,798 in 2015 to 7,019 in 2030
- Dementia rates are expected to increase in Wirral by 46% between 2015 and 2030. This is lower than the projected England increase of 59% over the same period.
- Wirral has an estimated diagnosis rate of 71.7% for late onset dementia (aged 65+) compared to the national average of 67.7%.
- Wirral has an estimated diagnosis rate of 72.7% for all age dementia, which is better than the national target of 66.7%.
- The elderly population (aged 90+) are estimated to experience the sharpest increase, 74% between 2015 and 2030.
- Contrastingly, the rate of early onset dementia (aged under 60) is estimated to decrease by 12% between 2015 and 2030.
- Despite increasing numbers of inpatients, the ratio of inpatient service use to recorded dementia diagnoses decreased between 2012/13 and 2014/15. This may be explained by the improving dementia diagnoses rates in Wirral.
- The largest proportion of dementia-related inpatient admissions typically lasted less than 7 days (49.8%) between 2013/14 and 2015/16.
- 97% of dementia-related inpatient admissions were by those aged 60 and over.
- Close to 80% of inpatient admissions came through Accident & Emergency (2013/14 to 2015/16).
- The most common primary diagnosis for dementia-related secondary diagnosis was “Urinary-tract infections” (6.9%).
- Dementia-related emergency admissions have increased between 2012/13 and 2014/15.
- In 2015, dementia was the leading underlying cause of death for females, and second most common in males.
- The actual costs involved in prescribing dementia drugs in Wirral decreased by 42.5% over the last 3 financial years (2013/14 to 2015/16).
- Services provided to those with a recorded condition of dementia by Wirral Department of Adult Social Services increased by 608% between 2012/13 and 2015/16.
- The largest single service provision was ‘Home Care – Personal Care’ (13.3%). However, an aggregation of residential services showed 1 in 5 people (19.4%) received support outside of the home environment.
- Claughton ward had the highest rate of service users with a recorded condition of dementia between 2012/13 and 2015/16.
- People with learning disability are more likely to develop dementia, more prominently those with Downs Syndrome having a 50% chance of developing dementia after the age of 60.
- There is expected growth in the number of people from BME communities who will develop dementia as the BME population ages.

Contents

What do we know?

Overview

Alzheimer's UK (2016) describes dementia as a set of symptoms that include memory loss and difficulties in cognition and language, which is caused when the brain is damaged by diseases such as Alzheimer's disease, a series of strokes or the narrowing of the arteries. As well as cognitive issues, a person with dementia may also experience changes to their moods or experience hallucinations.

It is a progressive condition, which means the symptoms will gradually get worse. This progression will vary from person to person and each person will experience dementia in a different way. Although the person will have some of the above symptoms, the degree to which they affect an individual will vary and not all people will have all of these symptoms.

Living with dementia is a challenge, but it is possible for people with dementia to experience positive relationships and communication can help to enable positive feelings such as contributing to their communities through local support groups and sharing experiences with others.

The Alzheimer's Society report, Dementia UK: Update (2014) estimates that 1 in every 79 people (1.3%) in the UK has dementia, with 1 in 14 of the population aged 65 and above (7.1%). The report also estimates that the total cost of dementia in the UK is £26.3 billion, of which £17.4 billion is paid by people with dementia and their families, by way of unpaid care or private social care. This averages at approximately £32,250 per person per year.

The World Alzheimer Report 2014, Dementia and Risk Reduction: An analysis of protective and modifiable factors critically examines the evidence for the existence of modifiable risk factors for dementia and suggest that evidence for possible causal associations with dementia are those of low education in early life, hypertension in midlife, and smoking and diabetes across the life course. The report goes onto suggest that improved detection and treatment of diabetes and hypertension, and smoking cessation, should be prioritised, including for older adults who are rarely specifically targeted in prevention programs.

The report also highlights the following aspects as requiring further consideration

- Increased physical activity and reduction in levels of obesity are also important.
- There is considerable potential for reduction in dementia incidence associated with global improvements in access to secondary and tertiary education.
- There is also consistent evidence from several studies for an inverse association between cognitive activity in later-life and dementia incidence. However, this association may not be causal, and the benefits of cognitively stimulating activities need to be tested in randomised controlled trials.
- There is no evidence strong enough at this time to claim that lifestyle changes will prevent dementia on an individual basis but rather should be considered with a range of other interventions

Research identifying modifiable risk factors of dementia is in its infancy. In the meantime, primary prevention should focus on targets suggested by current evidence.

These include

- Countering risk factors for vascular disease including diabetes,
- Midlife hypertension,
- Midlife obesity,
- Smoking and
- Physical inactivity

Facts and figures

Types of dementia

Dementia is usually categorised as 'early onset dementia' if the patient affected is under the age of 65 years old, with dementia occurring above this age deemed 'late onset dementia'. However, Alzheimer's UK (2014) included patients aged 60-64 years in the late onset dementia consensus, which has been reflected in this document.

Severity of dementia

Dementia UK (2014) estimate that around 55.4% of people with dementia have a mild form, with 32.1% having moderate dementia and 12.5% suffering with severe dementia. Applying these rates to the local and national estimates for 2016, would provide the following figures.

Table 1: Number of people by severity of Dementia, Wirral and England, 2016

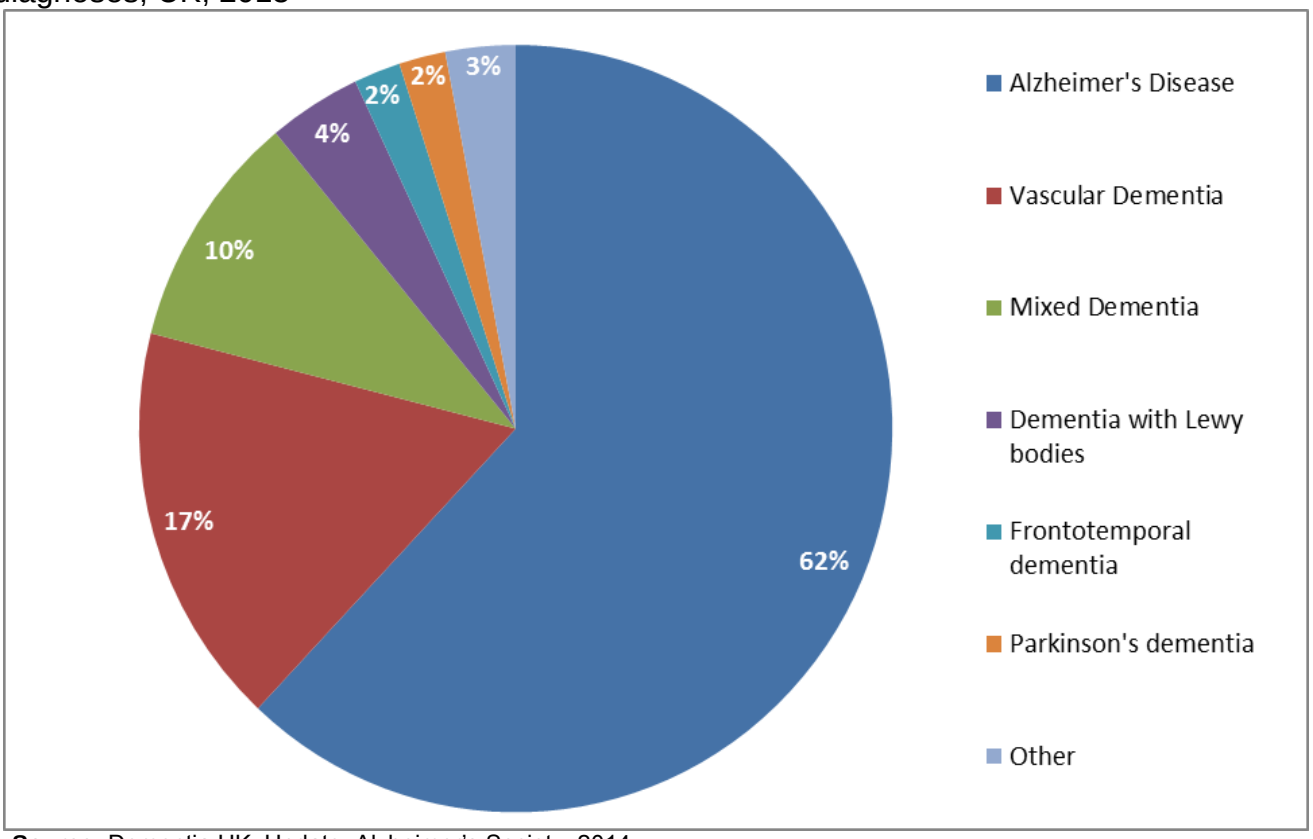
Severity of dementia	Wirral	England
Mild	2,768	396,677
Moderate	1,604	229,844
Severe	625	89,503
Total	**4,996**	**716,024**

Source: Dementia UK: Update, Alzheimer's Society, 2014

Subtypes of dementia

Alzheimer's UK (2014) suggests that the most common type of dementia is Alzheimer's disease, affecting about 62% of those with dementia. The next most common subtypes are vascular and mixed dementia, accounting for 27% of all cases.

Figure 1: Estimated prevalence of dementia sub-types as a proportion of all dementia diagnoses, UK, 2015



Source: Dementia UK: Update, Alzheimer's Society, 2014

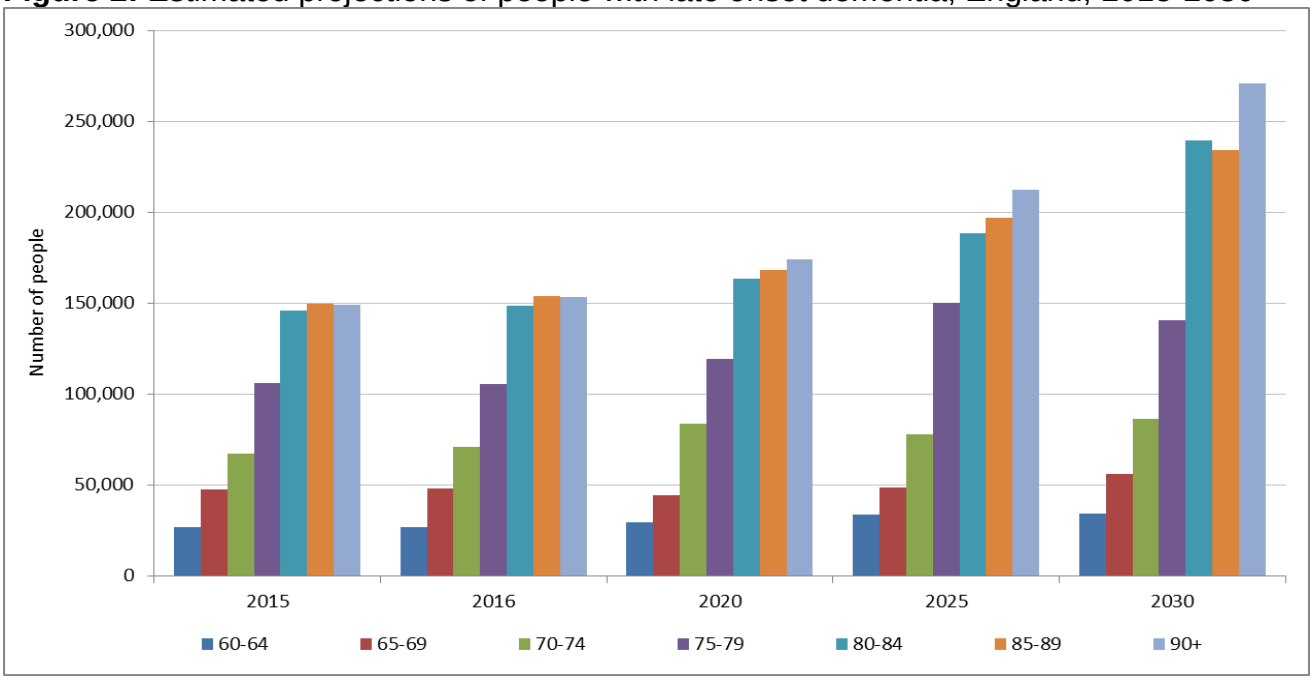
National

The Quality Outcomes Framework (QOF) for 2014/15, as published by NHS Digital, reports that there were approximately 419,073 (or 0.74%) people in England recorded as having dementia. In September 2015, QOF also provided figures for those aged 65 and over as 413,339, giving an estimated prevalence rate of 4.27% for this age group.

Alzheimer's Society (2014) estimates suggest that there were around 701,506 people with dementia in England in 2015. Comparing this to the number recorded for QOF suggests that approximately, only 60% of people with dementia have a registered diagnosis. More up to date figures are not yet available; however, the Prime Minister's Challenge on Dementia 2020 (2016) confirms that NHS England had hit the target of increasing diagnosis rates to 66.7% (or two thirds) by January 2016.

Figure 2 shows that the number of people with dementia in England is expected to increase between 2015 and 2030, with older age bands likely to see a sharper increase. For example, it is expected that those aged between 65-69 years will increase from 26,758 to 34,243 (an increase of 28%), whereas those aged 90+ will increase from 141,243 to 270,875 (an increase of 92%).

Figure 2: Estimated projections of people with late onset dementia, England, 2015-2030

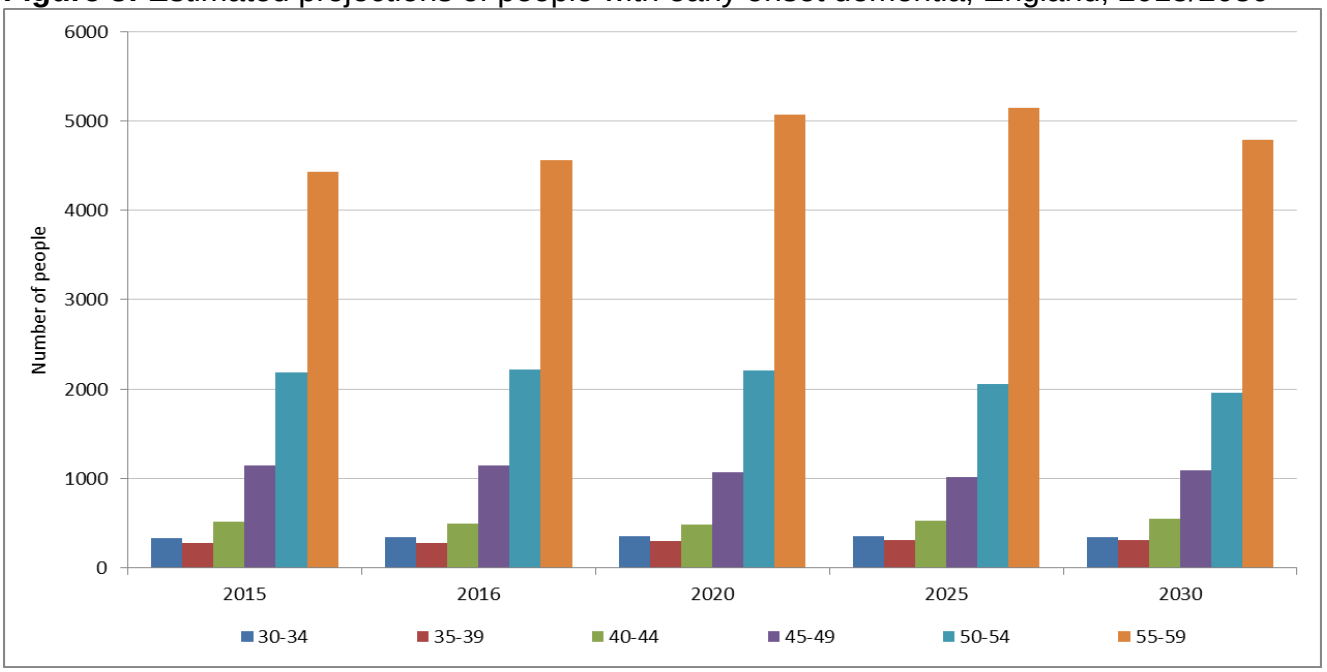


Source: Dementia UK: Update, Alzheimer's Society, 2014
Note: It should be noted that these projections have been calculated using the 2013 age-standardised prevalence estimates set out in the report by the Alzheimer's Society, Dementia UK: Update (2014) and the population projections published by ONS. The projections do not therefore take into account changes to prevalence rates and should be considered as a worse-case scenario.

Should the prevalence rate of dementia remain the same, it is estimated that the total number of people aged 65 and over with dementia will rise from around 694,635 to approximately 1,064,095 (an increase of over 53% in 15 years). Figure 3 shows estimated projections for early onset dementia in England and suggests that this will increase slightly, from 8,886 in 2015 to 9,042 in 2030; an increase of less than 2%.

In 2015, research was published in The Lancet suggesting that dementia prevalence may not reach epidemic status. The study was performed across five western European countries, with the most significant change in prevalence occurring in the UK; a 22% decrease in dementia prevalence in 2011 than had been predicted in 1990. Details of the full study can be found on The Lancet website or a summary article has been published on The Guardian newspaper website.

Figure 3: Estimated projections of people with early onset dementia, England, 2015/2030

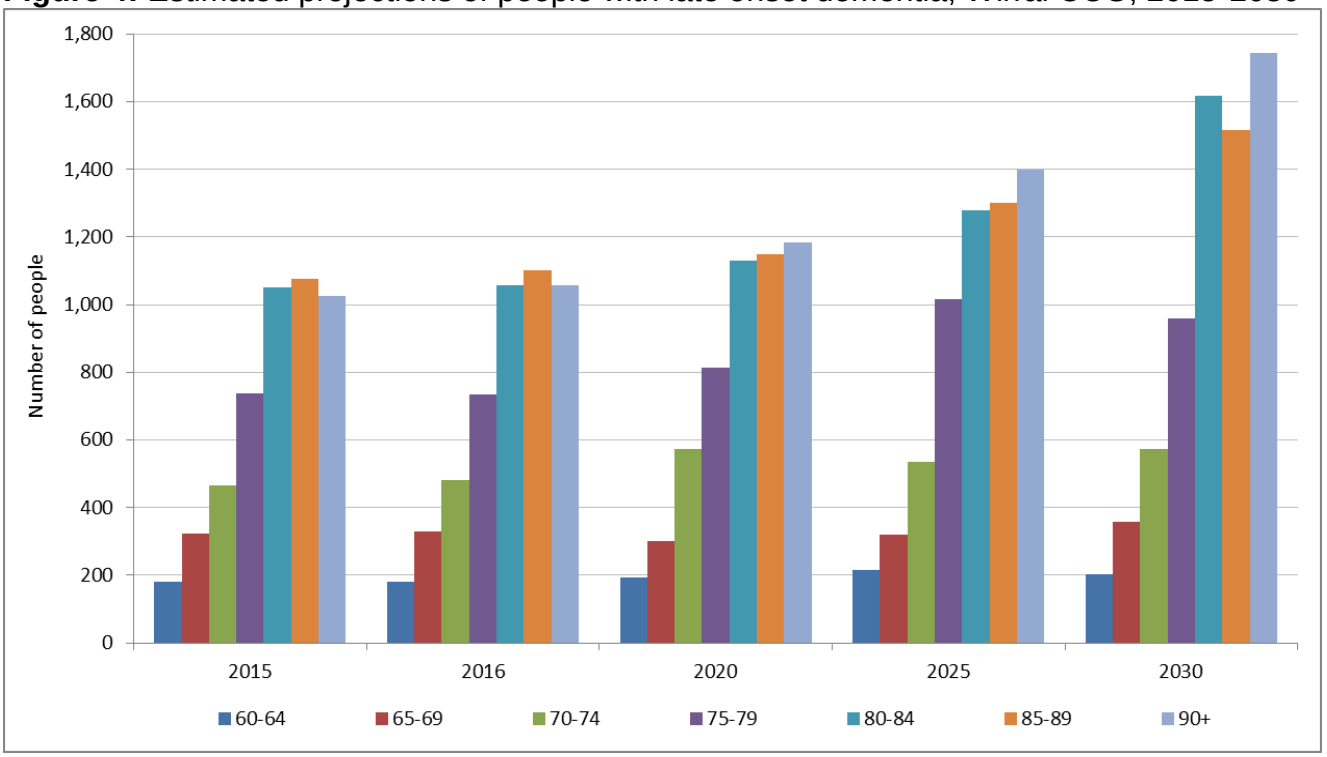


Source: Dementia UK: Update, Alzheimer's Society, 2014
Note: It should be noted that these projections have been calculated using the 2013 age-standardised prevalence estimates set out in the report by the Alzheimer's Society, Dementia UK: Update (2014) and the population projections published by ONS. The projections do not therefore take into account changes to prevalence rates and should be considered as a worse-case scenario.

Local

In October 2016, the number of Wirral residents, aged 65 and over with dementia, was recorded by QOF at 3,195 (or 4.8% of the 65+ population).

Figure 4: Estimated projections of people with late onset dementia, Wirral CCG, 2015-2030

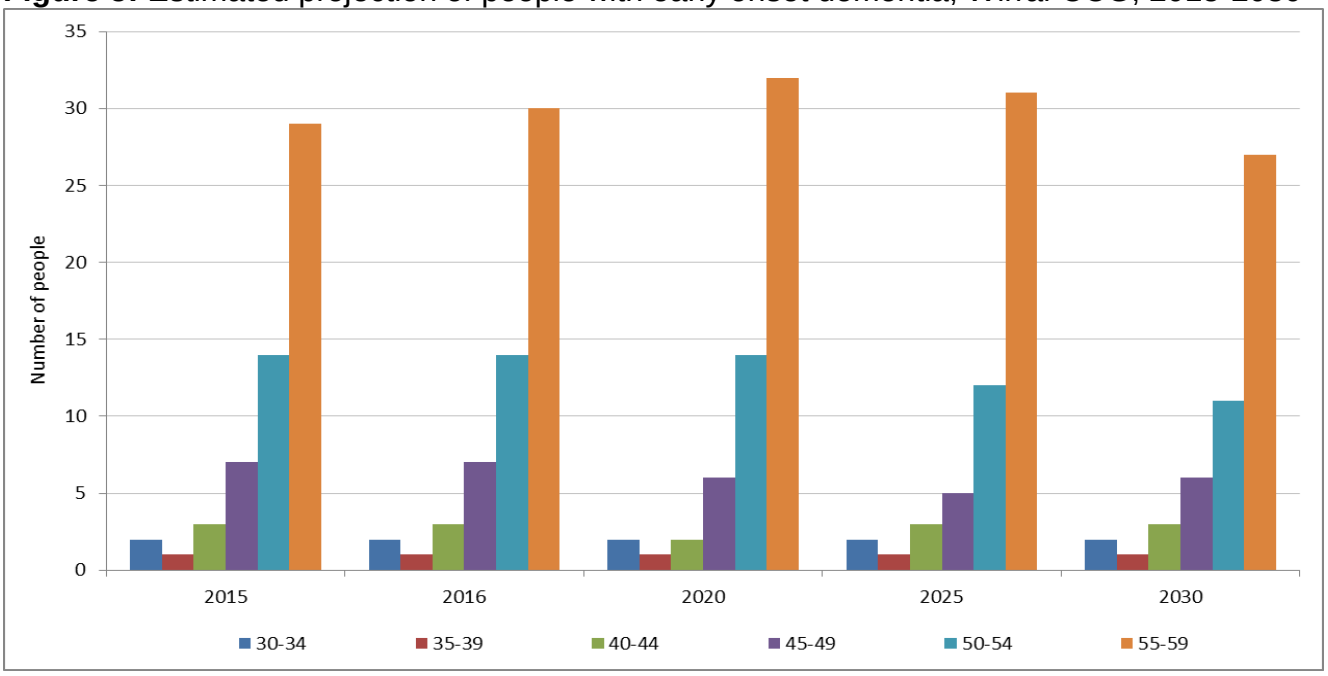


Source: Dementia UK: Update, Alzheimer's Society, 2014
Note: It should be noted that these projections have been calculated using the 2013 age-standardised prevalence estimates set out in the report by the Alzheimer's Society, Dementia UK: Update (2014) and the population projections published by ONS. The projections do not therefore take into account changes to prevalence rates and should be considered as a worse-case scenario.

Figure 4 shows that the number of people with late onset dementia in Wirral is expected to increase between 2015 and 2030. Similar to the national projections, it seems likely that sharper increases will be seen in older populations. For example, it is estimated that dementia in those aged 90+ will increase from 1,002 to 1,743, or a 74.0% increase, whereas dementia in those aged 65-69 will increase from 311 to 359, or a 15.4% increase.

Unlike late onset dementia, the number of people projected to be affected by early onset dementia is expected to decrease in Wirral. It is estimated that, in Wirral in 2015, 56 people were affected by early onset dementia. This is estimated to decrease to 50 people by 2030; a decrease of 12%.

Figure 5: Estimated projection of people with early onset dementia, Wirral CCG, 2015-2030



Source: Dementia UK: Update, Alzheimer's Society, 2014
Note: It should be noted that these projections have been calculated using the 2013 age-standardised prevalence estimates set out in the report by the Alzheimer's Society, Dementia UK: Update (2014) and the population projections published by ONS. The projections do not therefore take into account changes to prevalence rates and should be considered as a worse-case scenario.

Overall, projections estimate that the number of people with dementia in Wirral will increase from 4,798 in 2015 to 7,019 in 2030; an overall increase of approximately 46%, which is lower than the estimated increase in England overall of 59% for the same period.

In the UK, it is estimated that dementia costs approximately £26.3 billion per year, resulting in average annual cost of £32,250 per Dementia patient. It is estimated that the largest proportion of these costs is absorbed by unpaid care (Alzheimer's Society, Dementia UK: Update (2014). Applying these figures to the recorded number of Wirral dementia diagnoses (3,196) in October 2016, suggests that dementia potentially costs the Wirral economy just over £103 million annually:

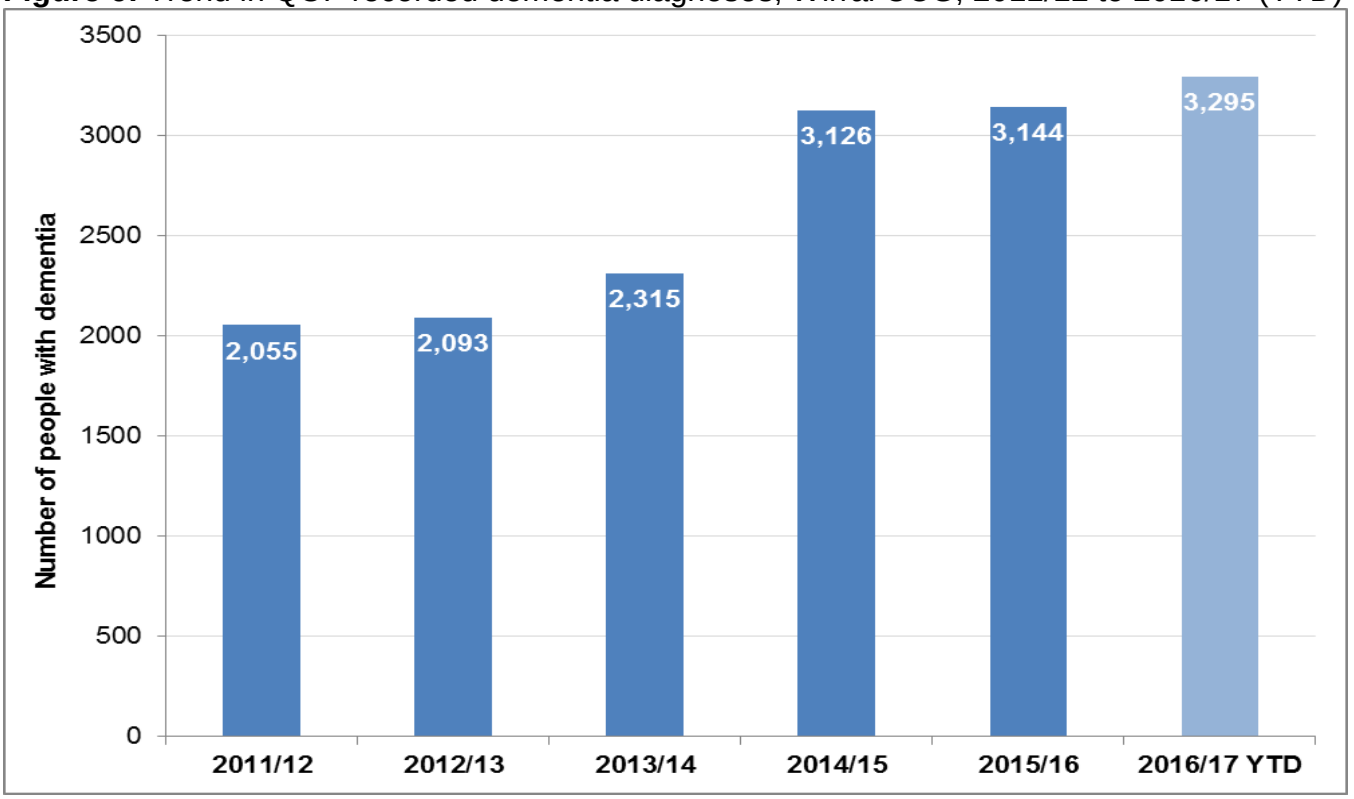
- Health Care ~ 16.4% = £16,898,355.00
- Social Care ~ 39.0% = £40,185,112.50
- Unpaid Care ~ 44.2% = £45,543,127.50
- Other ~ 0.4% = £412,155.00
- Total = £103,038,750.00

Furthermore, using the figure of 4,996 people in Wirral estimated to have dementia (both recorded and not recorded), would result in the cost of dementia in Wirral totalling over £160million per year.

Local Trend

Figure 6 shows that the number of people with dementia in Wirral has been steadily increasing since 2011/12. The most recent annual QOF figures show that there are currently 3,295 adults in Wirral with a recorded diagnosis of dementia. This equates to around 1.3% of the GP-registered adult population of Wirral.

Figure 6: Trend in QOF recorded dementia diagnoses, Wirral CCG, 2011/12 to 2016/17 (YTD)



Source: Public Health Outcomes Framework (PHOF), 2016
Notes: Data for 2016/17 is only for April to October 2016. **YTD** – Year to date

Key Dementia issues

Risk Factors

Mild Cognitive Impairment (MCI) is an intermediate stage between the mental decline expected through normal ageing and more severe mental decline seen in those with dementia; although not all cases of MCI lead to dementia.

MCI is not a specific disease but a collective of symptoms such as mild problems with memory and reasoning. As such there is no readily available data available at a national or local level, however, Alzheimer's Society (2014) estimate that MCI affects between 5-20% of those aged 65 and over. Applying this estimate to Wirral's population indicates that between 3,350 and 13,400 of those aged 65+ in Wirral could have MCI.

Other risk factors include:

- Cardiovascular Diseases; diabetes type II, high blood pressure and high cholesterol
- Obesity
- Multiple Sclerosis
- Human Immunodeficiency Virus (HIV)
- Parkinson's disease
- Depression
- Down's Syndrome and other learning disabilities
- Lifestyle factors; physical activity, smoking, diet, alcohol consumption, social exclusion

More details on the above risk factors can be found in other JSNA chapters via these links

Alcohol related brain damage (ARBD) includes a number of specific conditions, the most common being alcohol-related dementia, however, none of these conditions come within the dementia umbrella. Unlike more commons causes of dementia, people with ARBD can make a full or partial recovery dependent following good care and abstaining from alcohol.

Table 2 compares the number of ABRD-related admissions and the number of dementia-related admissions between 2013/14 and 2015/16. The figures show that the gap between these two sets of admissions is closing; from 70% in 2013/14 to just 4% in 2015/16. As the number of ARBD-related admissions has not significantly changed and the number of dementia-related admissions has increased, the reduction of this gap could be explained by increased diagnosis of dementia.

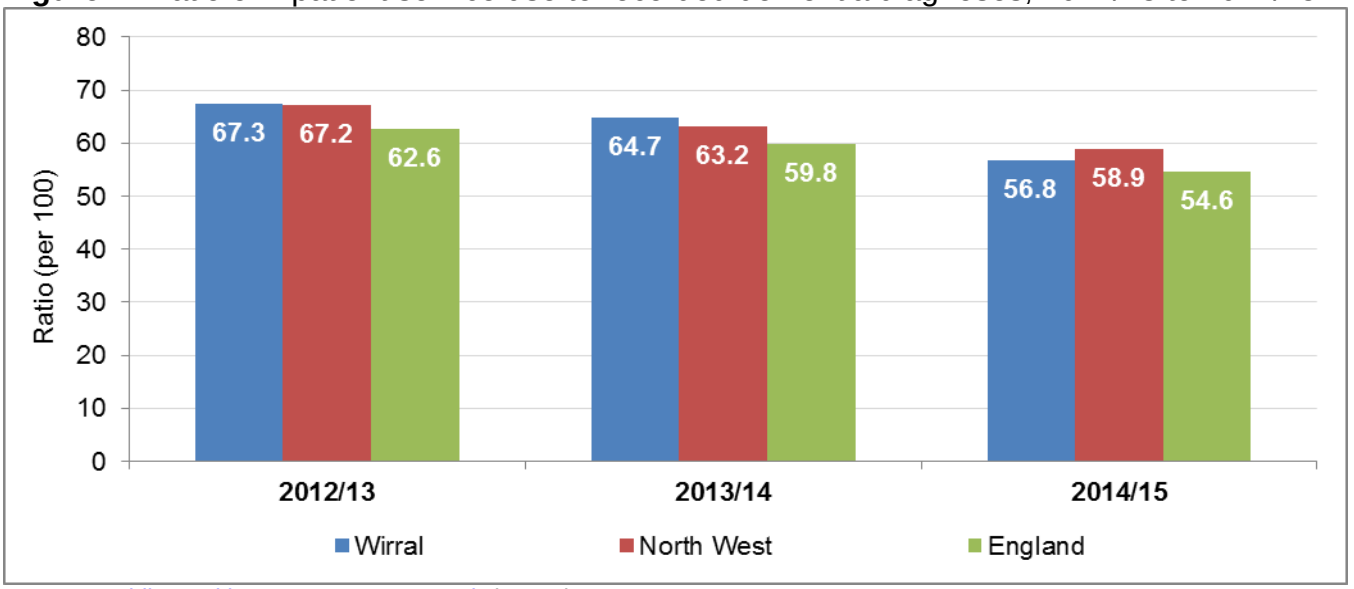
Table 2: Number of ARBD-related and dementia-related admissions, Wirral, 2013/14 to 2015/16

Year	2013/14	2014/15	2015/16	Total
ARBD-related Admissions	1,847	1,689	1,820	5,356
Dementia-related Admissions	1,087	1,391	1,746	4,227

Source: Secondary User Service (SUS) Data, Wirral CCG, 2016

Hospital admissions

Figure 7: Ratio of inpatient service use to recorded dementia diagnoses, 2012/13 to 2014/15



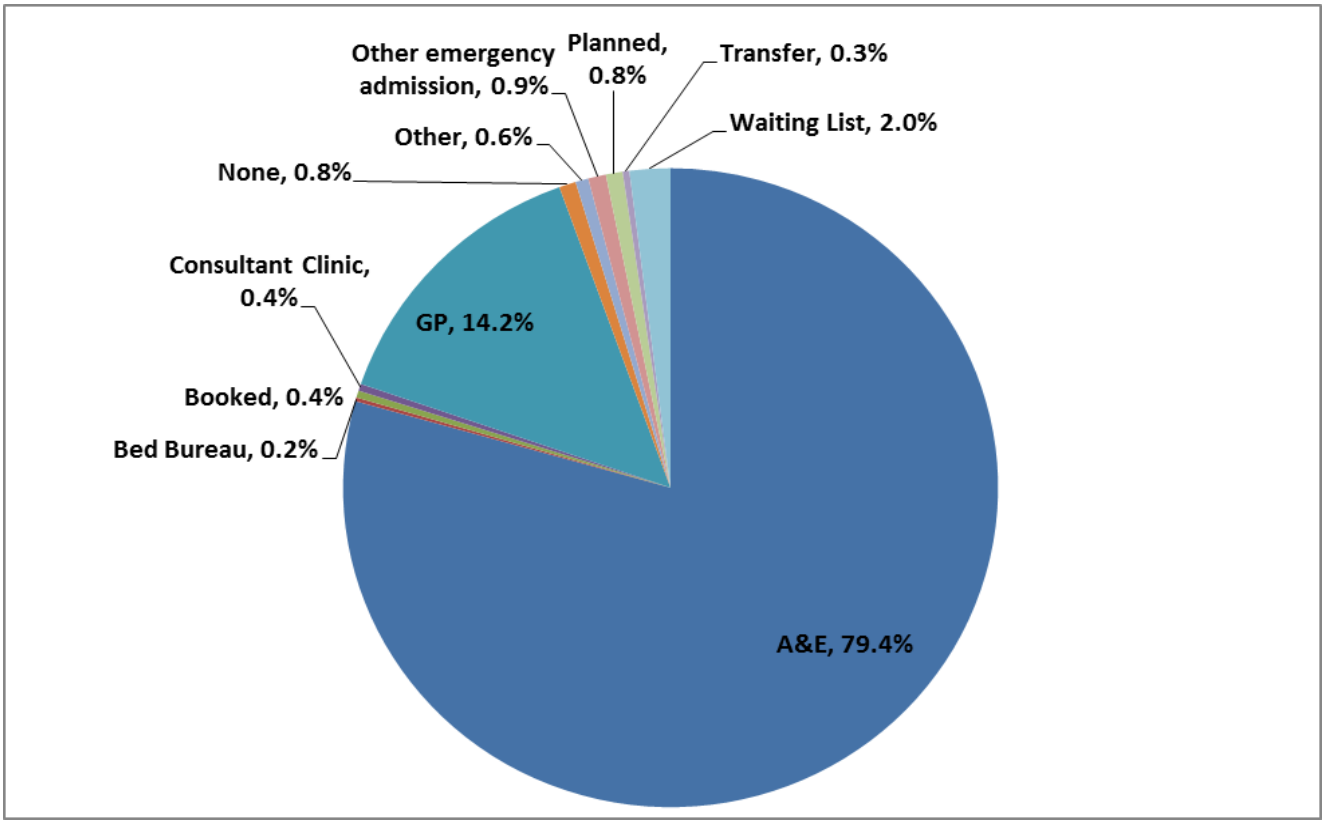
Source: Public Health Outcomes Framework (PHOF), 2015

Figure 7 shows that the ratio of inpatient service use to recorded dementia diagnoses has decreased in Wirral, North West and England over the last three financial years; Wirral has seen the greatest proportional decline of 15.6% compared to 12.4% and 12.8% for North West and England respectively.

Despite the ratio of inpatient service use to recorded dementia diagnoses decreasing as above, the figures for inpatient admissions has actually increased; from 1,089 in 2013/14 to 1,749 in 2015/16 (Secondary User Service Data, Wirral CCG, 2016). As noted in the previous 'Local Trend' section, the number of people with a recorded dementia diagnoses increased by over 800 between 2013/14 and 2014/15. This would account for the decreasing ratio figures (Figure 7) despite the upward trend in inpatient admissions.

Figure 8 shows the proportions of admission sources, with the largest proportion of dementia-related inpatient admissions coming through Accident & Emergency (79.4%). People with dementia can have more complex needs than those of the general population because of the condition, which can potentially result in the complex needs of such individuals being unaddressed and a more a likely outcome is that emergency hospital care is required (PHE, 2015).

Figure 8: Acute hospital sources of dementia-related inpatient admissions, Wirral, 2013/14 to 2015/16 (3 financial years pooled)



Source: Secondary User Service (SUS) Date, Wirral CCG, 2016

Table 3: Top 10 primary diagnoses for inpatients with a dementia-related secondary or other diagnosis, Wirral, 2013/14 to 2015/16 (3 financial years pooled)

Primary Diagnosis	%
Urinary tract infection, site not specified	6.9%
Lobar pneumonia, unspecified	5.4%
Tendency to fall, not elsewhere classified	4.8%
Fracture of neck of femur	3.1%
Pneumonia, unspecified	3.0%
Syncope and collapse	3.0%
Sepsis, unspecified	2.2%
Unspecified acute lower respiratory infection	1.9%
Alzheimer's disease, unspecified	1.9%
Cerebral infarction, unspecified	1.8%
Other (includes 588 other diagnoses)	66.0%

Source: Secondary User Service (SUS) data, Wirral CCG, 2016

Table 3 suggests that the most common primary diagnosis, during the period between 2013/14 and 2015/16, was a Urinary Tract Infection, which accounted for 6.9% of all dementia-related admissions. This was in fact the most common primary diagnosis for all three financial years;

7.8% (2013/14), 6.6% (2014/15) and 5.7% (2015/16). Similarly, Lobar Pneumonia was also the second most common diagnosis for all three financial year; 5.4% (2013/14), 5.8% (2014/15) and 4.7% (2015/16). Tables showing the ten most common diagnoses for individual years are included within Appendix 2.

This highlights the fact that people with dementia are more likely to have co-morbidities that consequently increases the risk of hospital admissions. Tables 4 and 5 are able to provide a comparison between the inpatient length of stay for those with dementia related diagnosis and the general hospital population for those aged under and over 60. About 91% of the general population stay less than 7 days compared to those with dementia related diagnosis (50%). However those with dementia tend to stay in hospital longer compared to the general population; 50% of dementia-related admissions compared to 9% of general admissions are admitted for at least 7 days. Tables for individual years are included within Appendix 3 and Appendix 4.

Table 4: Length of stay for **all inpatient admissions** by age group, Wirral,

Age Group	< 7 days	1 week to < 5 weeks	5 weeks < 12 weeks	4 - 12 months	Total admitted by age group
Under 60s	**52.1%**	**2.1%**	**0.2%**	**0.1%**	**54.5%**
61 - 65	6.7%	0.4%	0.1%	0.0%	7.3%
66 - 70	8.2%	0.6%	0.1%	0.0%	8.9%
71 - 75	7.4%	0.7%	0.1%	0.0%	8.2%
76 - 80	7.1%	0.9%	0.1%	0.1%	8.2%
81 - 85	5.5%	1.0%	0.2%	0.1%	6.8%
Over 85s	4.3%	1.4%	0.3%	0.0%	6.0%
Over 60s	**39.2%**	**5.1%**	**0.8%**	**0.3%**	**45.5%**
All Ages	**91.3%**	**7.2%**	**1.1%**	**0.4%**	**100.0%**

Source: Secondary User Service (SUS) data, Wirral CCG, 2016

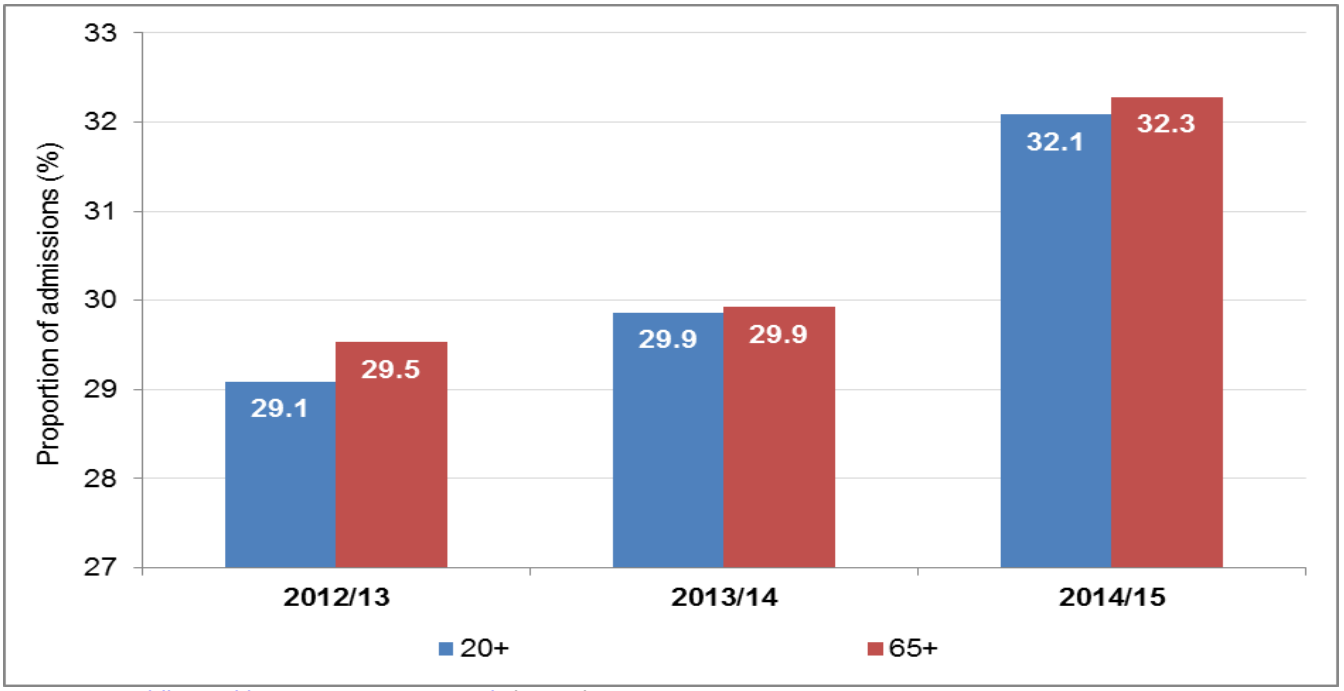
Table 5: Length of stay for **all dementia-related inpatient admissions** by age group, Wirral, 2013/14 to 2015/16 (3 financial years pooled)

Age Group	< 7 days	1 week to < 5 weeks	5 weeks < 12 weeks	4 - 12 months	Total admitted by age group
Under 60s	**2.1%**	**0.7%**	**0.3%**	**0.0%**	**3.0%**
61 - 65	0.8%	0.4%	0.1%	0.1%	1.5%
66 - 70	2.2%	1.3%	0.5%	0.4%	4.4%
71 - 75	3.9%	2.8%	0.8%	0.4%	7.9%
76 - 80	8.8%	5.7%	1.6%	0.6%	16.7%
81 - 85	13.7%	10.6%	2.5%	0.6%	27.4%
Over 85s	18.3%	16.5%	3.8%	0.6%	39.1%
Over 60s	**47.7%**	**37.3%**	**9.3%**	**2.7%**	**97.0%**
All Ages	**49.8%**	**37.9%**	**9.6%**	**2.7%**	**100.0%**

Source: Secondary User Service (SUS) data, Wirral CCG, 2016

In Wirral, 4,227 patients were admitted into acute hospital with a primary or secondary diagnosis of dementia between 2013/14 and 2015/16. Within this, 4,100 (or 97%) were aged over 60 years, which reflects that the risk of developing dementia increases with age. Table 5 also shows that the older population (60 and over) were more likely to stay in hospital for a longer period than their younger counterparts; 49.3% of admissions can be attributed to people aged 60 and over who were admitted for at least 1 week, compared to 1% in those aged under 60.

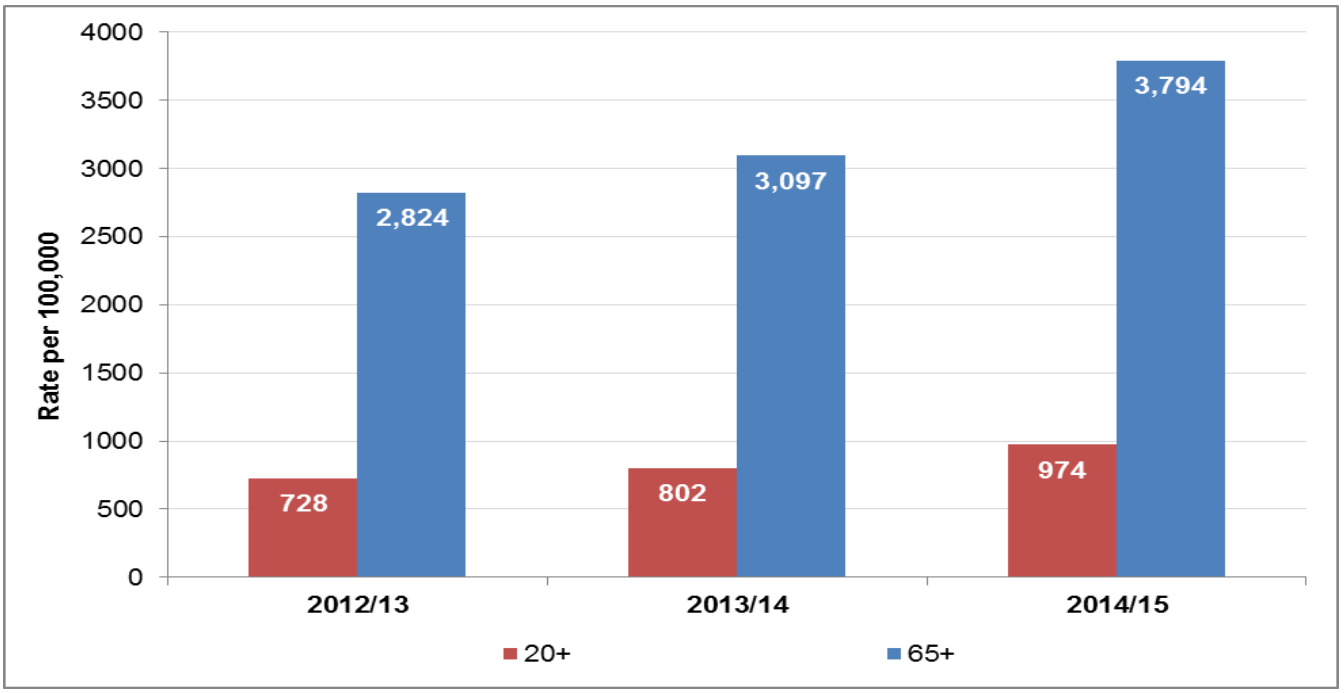
Figure 9: Proportion of dementia-related short stay emergency admissions, Wirral, 2012/13 to 2014/15



Source: Public Health Outcomes Framework (PHOF), 2015
Notes: Short stays are classed as 1 night or less. Dementia is mentioned in any diagnosis field.

As Figure 9 shows, the proportion of emergency short stay dementia-related admissions in those 65 and over is higher than for those aged 20 and over. It also shows that the proportion of dementia-related short stay emergency admissions has steadily increased between 2012/13 and 2014/15.

Figure 10: Directly Standardised Rate of dementia-related emergency admissions, Wirral, 2012/13 to 2014/15



Source: Public Health Outcomes Framework (PHOF), 2015
Notes: A Directly Standardised Rate (DSR) is an age-standardised rate that is used to allow comparison between populations which may contain different proportions of people of different ages.

Figure 10 shows that the rate of dementia-related emergency admissions is significantly higher in those aged 65 and over, than those aged 20 and over. For example, in 2014/15 the rate for those aged 65+ was 3,794 per 100,000, compared to just 974 in those aged 20 and over. Figure 10 also shows that the rate of these admissions has steadily increased since 2012/13 for both; the over 20 and over 65 populations.

Higher rates of admission for older people in Wirral are also reflected in the maps at the back of this document (Appendix 1). The maps show inpatient admissions by people with dementia in Wirral for 2013/14 to 2015/16 as a rate per 1,000 for both the 20+ and 60+ populations.

The increase in admissions mimics those increases shown in Figure 9; a small increase between 2012/13 to 2013/14 with a larger increase between 2013/14 and 2014/15. With estimates projecting the number of people with dementia expecting to increase by 46% by 2030, it could be expected that this will also impact the number of these admissions over the same time period.

Following a hospital discharge, a person with dementia may require additional services, such as a reablement service or personal care in the home. Details of current social care provisions are discussed later in this document.

Treatment

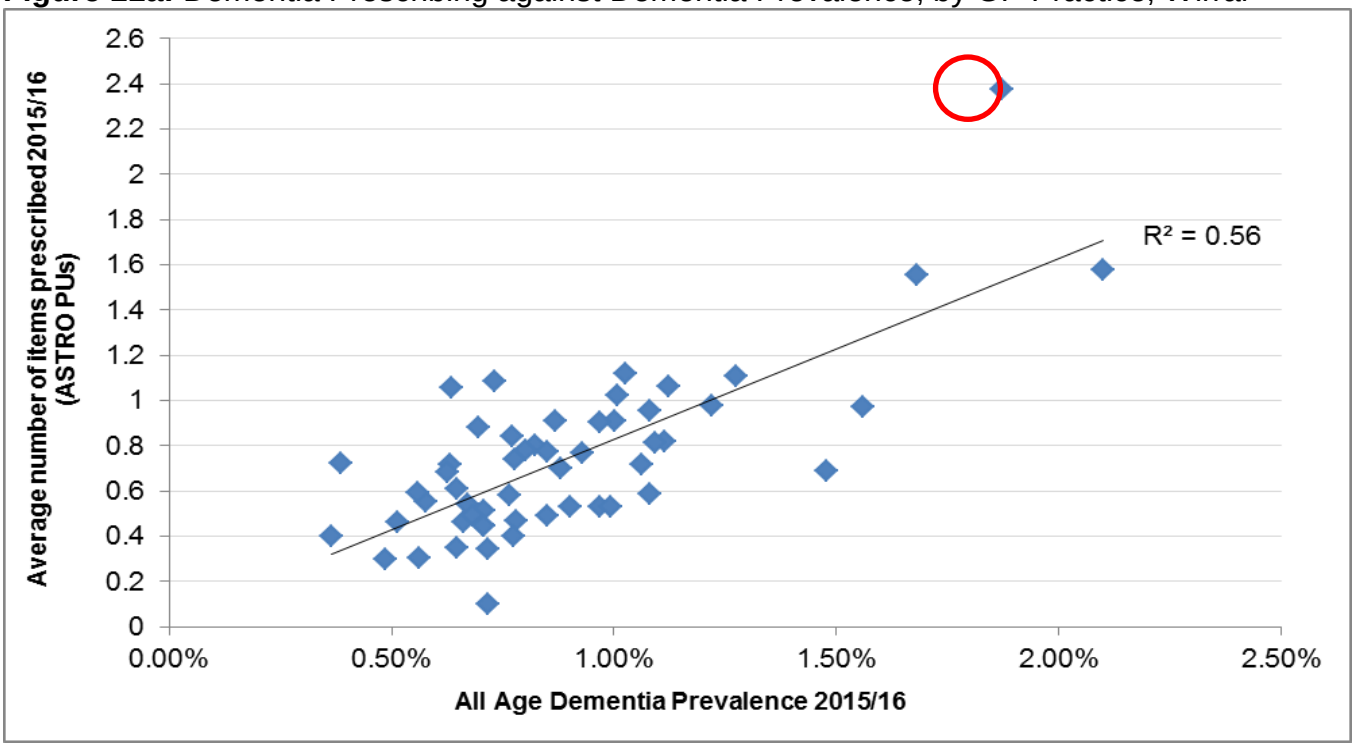
There is currently no known cure for dementia, however there are several ways in which the symptoms can be alleviated; drug treatment and non-drug treatment, such as talking therapies. People who suffer with mild to moderate Alzheimer's disease may be prescribed one of the following three medications; Donepezil, Rivastigmine or Galantamine. For people who cannot take any of the above medications, or suffer from more severe symptoms of Alzheimer's disease, another medication available is Memantine.

As Figure 11a shows, there is a strong positive correlation between the average number of dementia drug items being prescribed and the estimated prevalence of dementia in Wirral GP practices; the higher the prevalence of dementia the more items are prescribed. There is one distinct outlier highlighted above, where it appears that prescribing items are higher than average for the prevalence rate (highlighted by red circle in figure 11a)

As ASTRO PUs increase weighting of drug items for those in older age bands, one reason for this outlier could be that the practice has a larger number of people aged 65+ who have been prescribed dementia medication. Other reasons could include a higher prevalence of patients with a more severe dementia diagnosis, which could result in:

- Prescribing on a more frequent basis. For example, weekly blister packs may be provided for vulnerable patients unable to manage their medication without assistance
- Patients within Elderly Mentally Infirm (EMI) may have more complex needs,
- The prescribing of multiple items to achieve the correct dosage. For example, if 4.5mg of Rivastigmine is prescribed but the medication is only available in doses of 1.5mg and 3mg, two items would be prescribed instead of one.

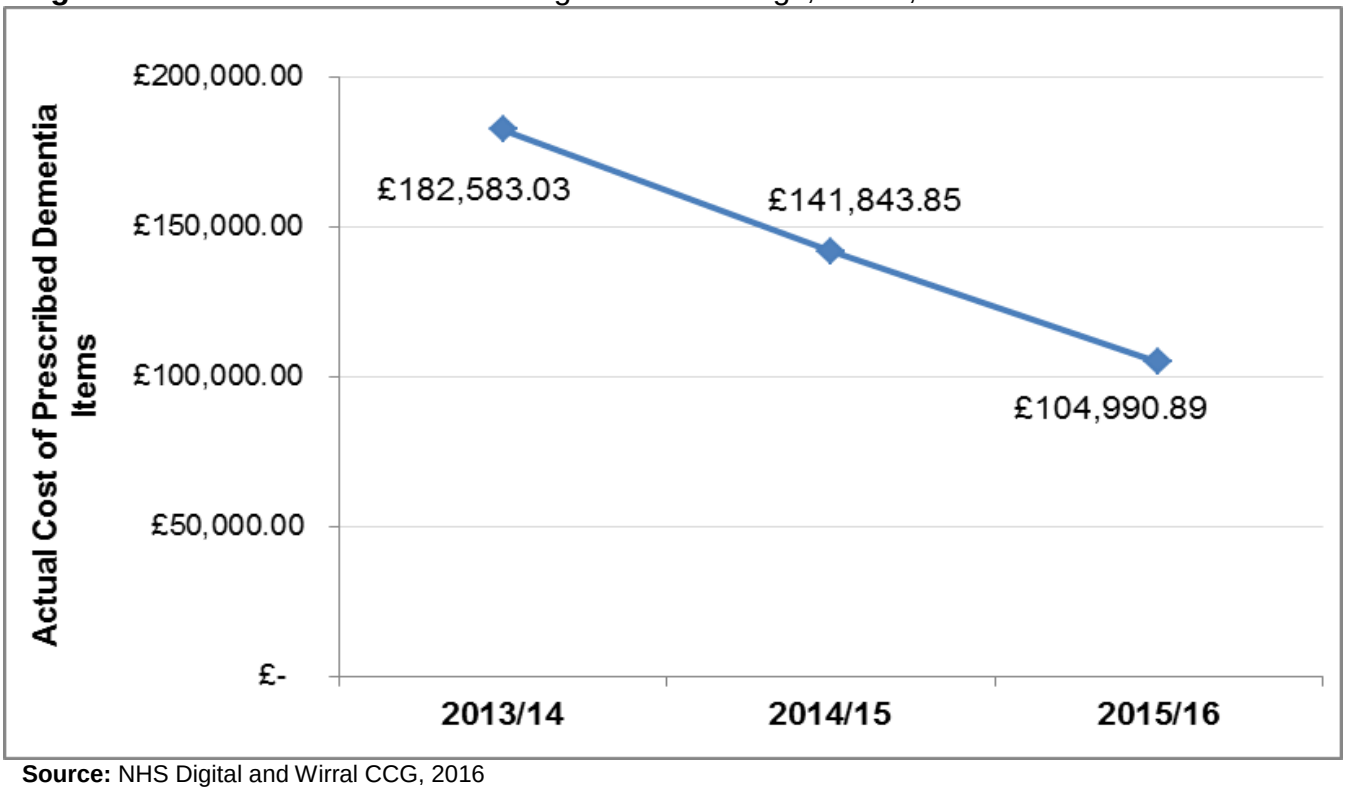
Figure 11a: Dementia Prescribing against Dementia Prevalence, by GP Practice, Wirral



Source: QOF recorded prevalence, 2015/16 (NHS Digital), Dementia Drug Prescribing, Wirral CCG, 2015/16
Note: R-value = 0.75, P-value = 0.00094. Prescribing data has been calculated using ASTRO PUs; see NHS Digital for full details.

Dementia is not only treated with drugs; there are non-drug alternatives such as talking therapies, cognitive stimulation therapy and other alternative therapies. Some of the services offered in Wirral include support groups, carer services and reading groups. More details of these services can be found in the later section, 'Current activity, services and tools'. As Figure 11b shows, prescribing costs for dementia has decreased over the last 3 financial years; 42.5% between 2013/14 and 2015/16.

Figure 11b: Actual Cost of Prescribing Dementia drugs, Wirral, 2013/14 to 2015/16

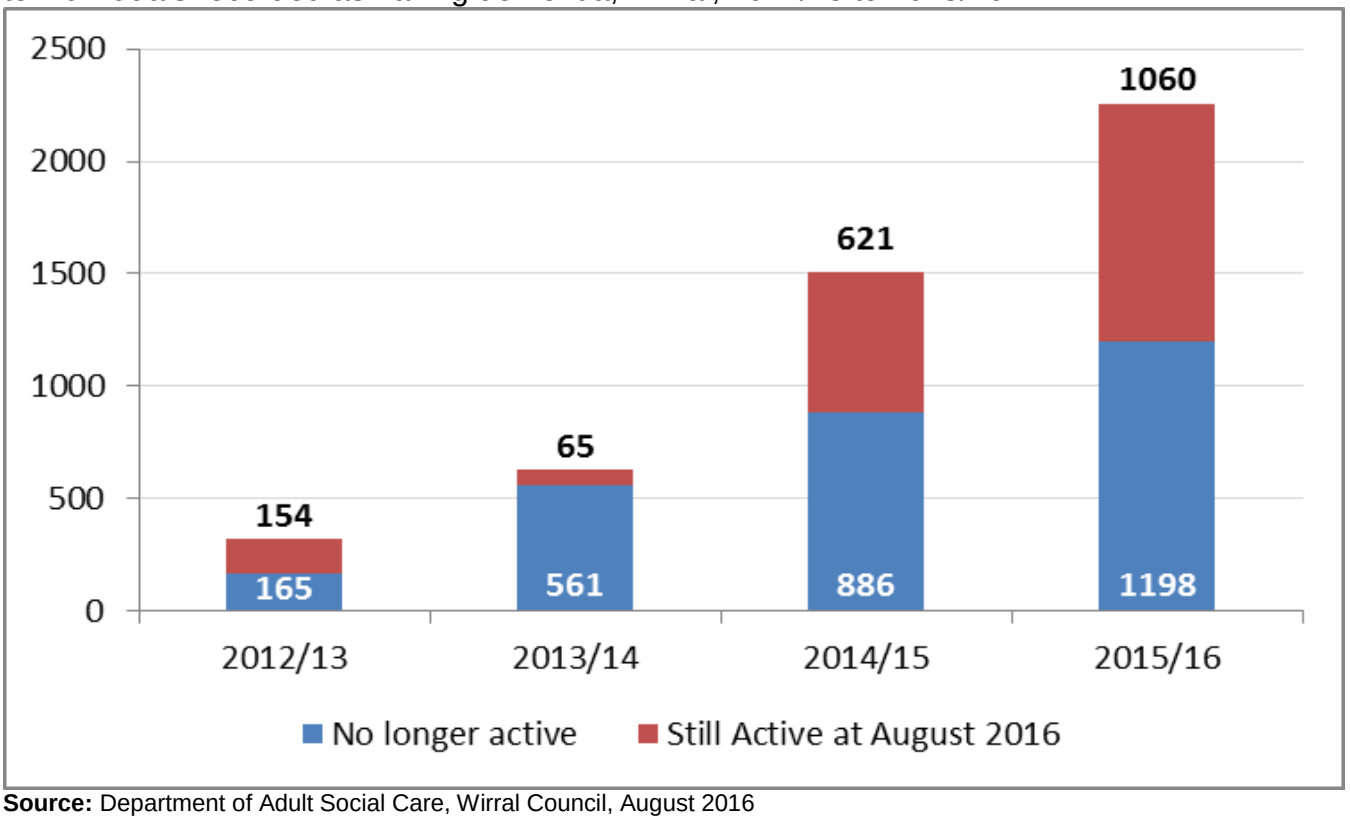


Source: NHS Digital and Wirral CCG, 2016

Social Care

As at August 2016, there are around 728 people in Wirral were receiving social care services with a record of having dementia. Of these, 98% are aged 65 and over, with 2% aged between 49-64 years.

Figure 12: Number of services provided by Wirral Department of Adult Social Services (DASS) to individuals recorded as having dementia, Wirral, 2012/13 to 2015/16



Source: Department of Adult Social Care, Wirral Council, August 2016
Notes: These figures represent services provided, not individuals, i.e. one individual may have multiple services provided to them by Wirral DASS. No longer active = the service provision has ended in year e.g.in 2015/16 there were 2,258 services were active with 1,198 ending in that year.

As Figure 12 shows, the number of individuals with a recorded condition of dementia by Wirral Adult Social Care services has increased significantly between 2012/13 to 2015/16. In 2012/13 there were 319 services being provided to individuals with a recorded condition of dementia, compared to 2,258 in 2015/16. This is an increase of close to 600% over 4 years. The increase in services being provided could be as a result of improving diagnosis rates in Wirral together with an ageing population.

Table 6: Top 3 social care provisions for individuals actively receiving support and recorded as having dementia, Wirral, August 2016

Service Provision	% using service provision
Home Care - Personal Care	13.3%
Assistive Technology	12.9%
Home Care - STAR Reablement	8.6%

Source: Department of Adult Social Care, Wirral Council, August 2016

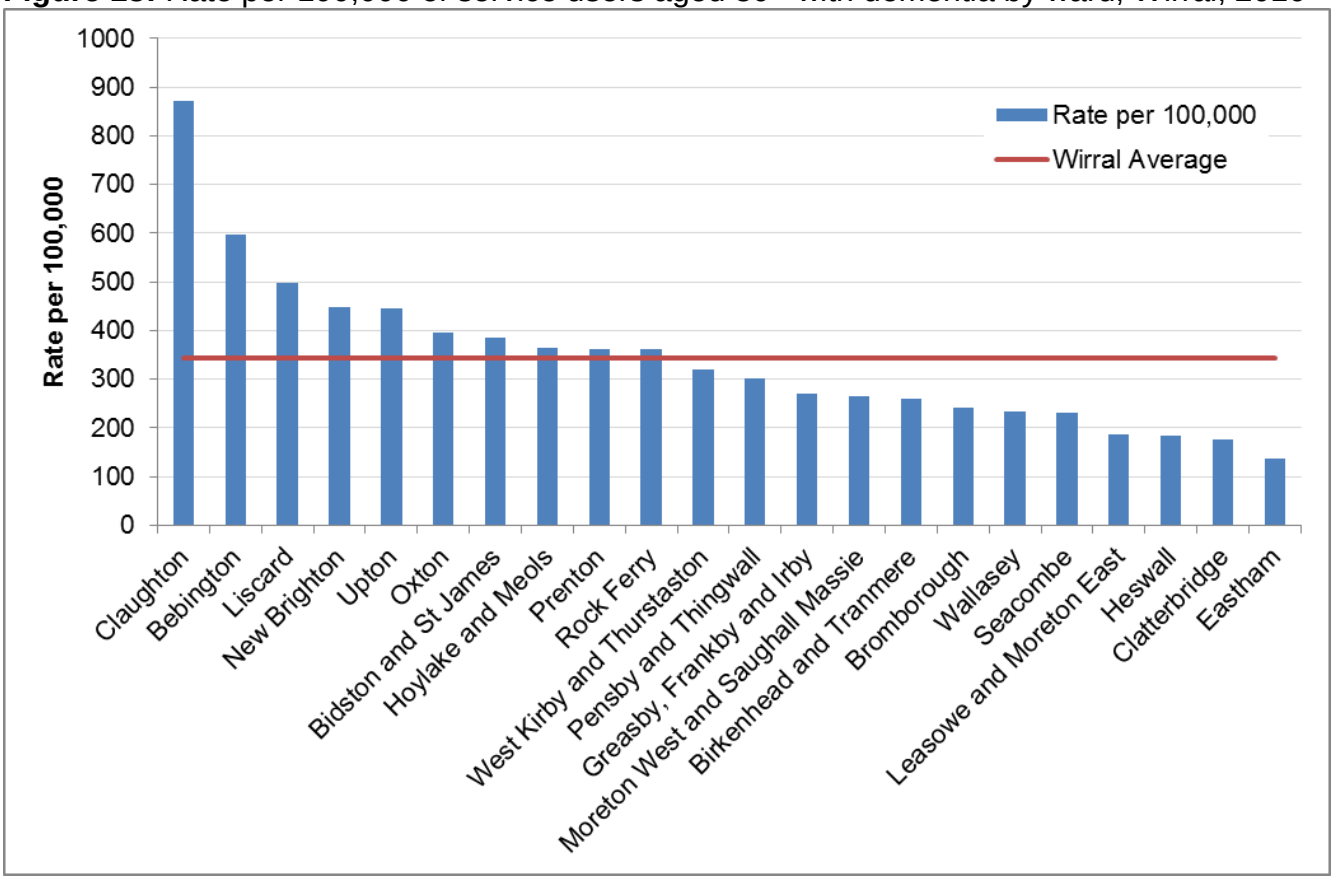
Table 6 shows that the three largest proportions of services used by those with a recorded condition of dementia are all 'community' services i.e. they are usually provided within an individual's usual place of residence rather than for those in residential care. However, when the number of those receiving residential care services are aggregated this represents 19.4% (or one in 5) of those with dementia who are currently receiving support (see Table 7).

Table 7: Residential care provision for individuals actively receiving support and recorded as having dementia, Wirral, August 2016

Residential Care Provision	% using service provision
Residential Care (all)	19.4%
Long term (Elderly Mental Infirm unit)	7.7%
Short term (Elderly Mental Infirm unit)	3.4%
Long term	6.0%
Short term	2.3%

Source: Department of Adult Social Care, Wirral Council, August 2016

Figure 13: Rate per 100,000 of service users aged 30+ with dementia by ward, Wirral, 2016



Source: Department of Adult Social Services, Wirral Council, August 2016
Note: The rate has been calculated using the mid-2014 ward population estimates produced by ONS as mid-2015 figures are not yet available at this granularity.

Figure 13 shows us that the ward with the highest rates of service users with dementia is Claughton, with 871 people aged 30+ receiving social care provision(s) per 100,000. The lowest rate can be seen in Eastham, where 137 people aged 30+ with dementia are receiving social care provision(s) per 100,000.

Older people living in care homes

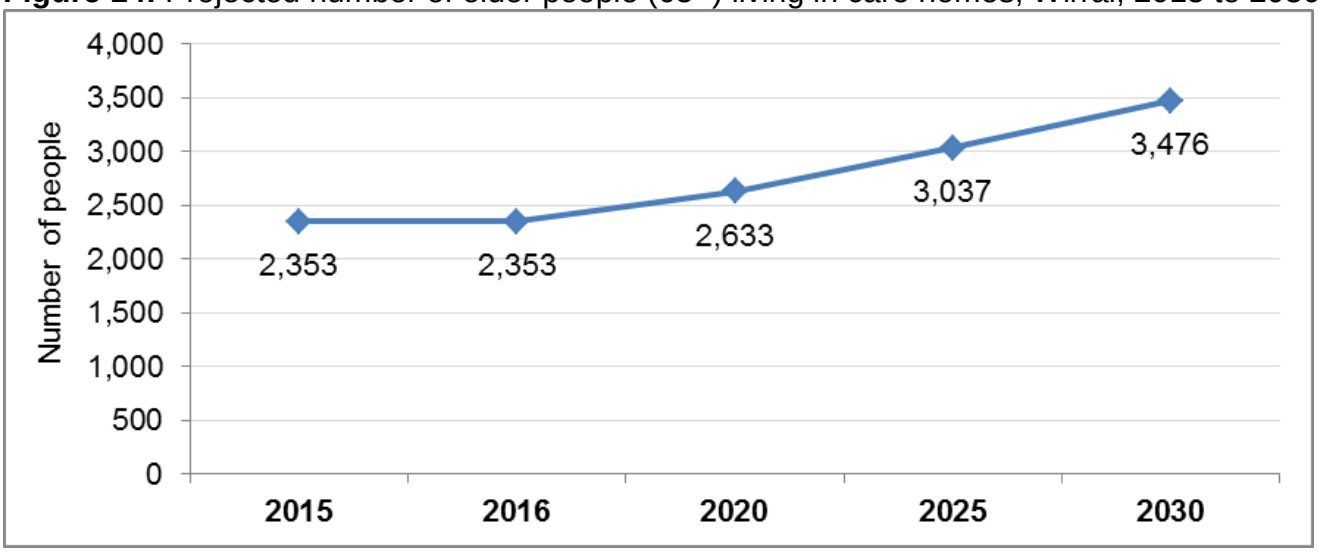
Table 8: Older people (65+) living in care homes, by care home type, Wirral, 2011/12 to 2013/14

Residential Type	2011/12	2012/13	2013/14
Residential Care	1,460	1,345	1,285
Nursing Care	895	855	775
Adult Placement	5	5	5
Total	2,360	2,205	2,065

Source: NASCIS, 2016
Note: Figures shown are a rate per 100,000 residents aged 65 and over

Table 8 shows that the number of people living in care homes decreased in Wirral between 2011/12 and 2013/14. However, Figure 14 shows that this number is estimated to increase to approximately 3,476 by 2030; an increase of around 68% from 2013/14.

Figure 14: Projected number of older people (65+) living in care homes, Wirral, 2015 to 2030

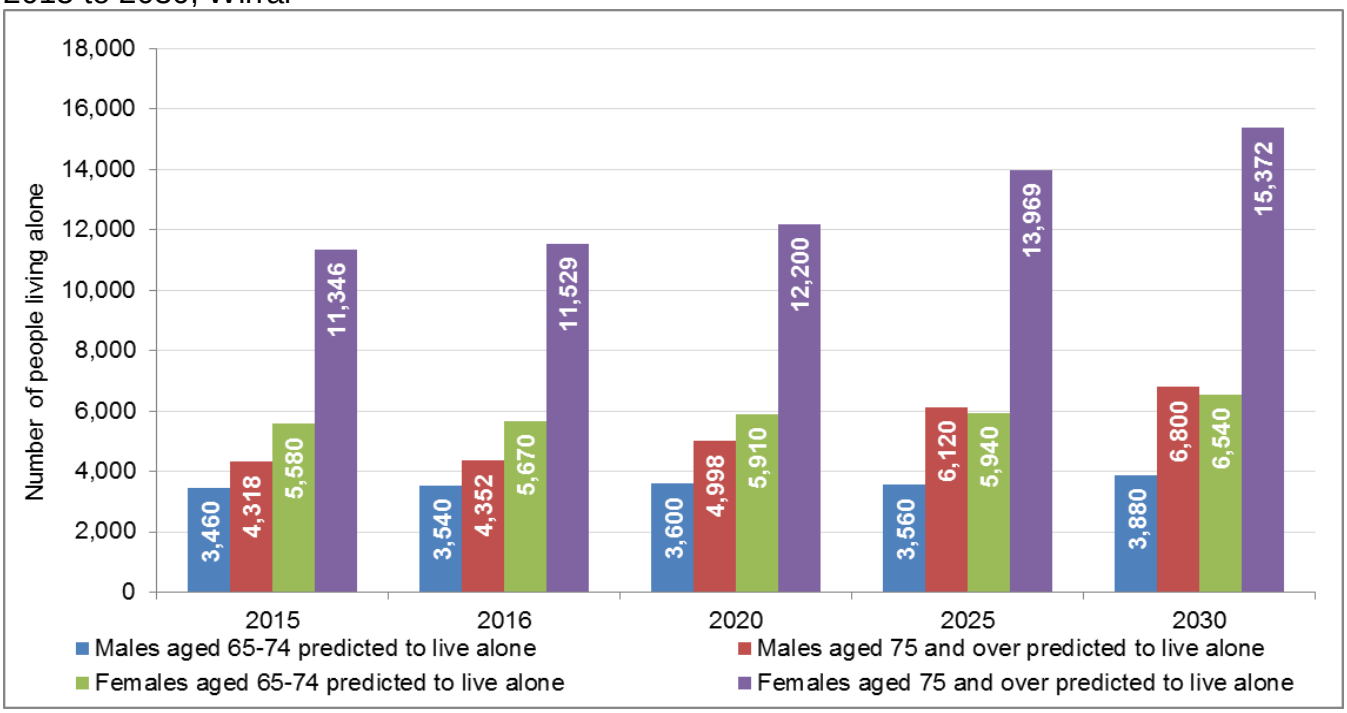


Source: POPPI, 2016

Older people living alone

Figure 15 shows that the number of people aged 65 and over living alone will increase over the next 15 years. The chart also highlights the largest group of older people who live alone will be females aged 75 and over. Alzheimer's Society (2016) describes how evidence is emerging that shows being socially active can reduce the risk of dementia and other risk factors such as depression.

Figure 15: Projected numbers of people aged 65 and over living alone, by age and gender, 2015 to 2030, Wirral



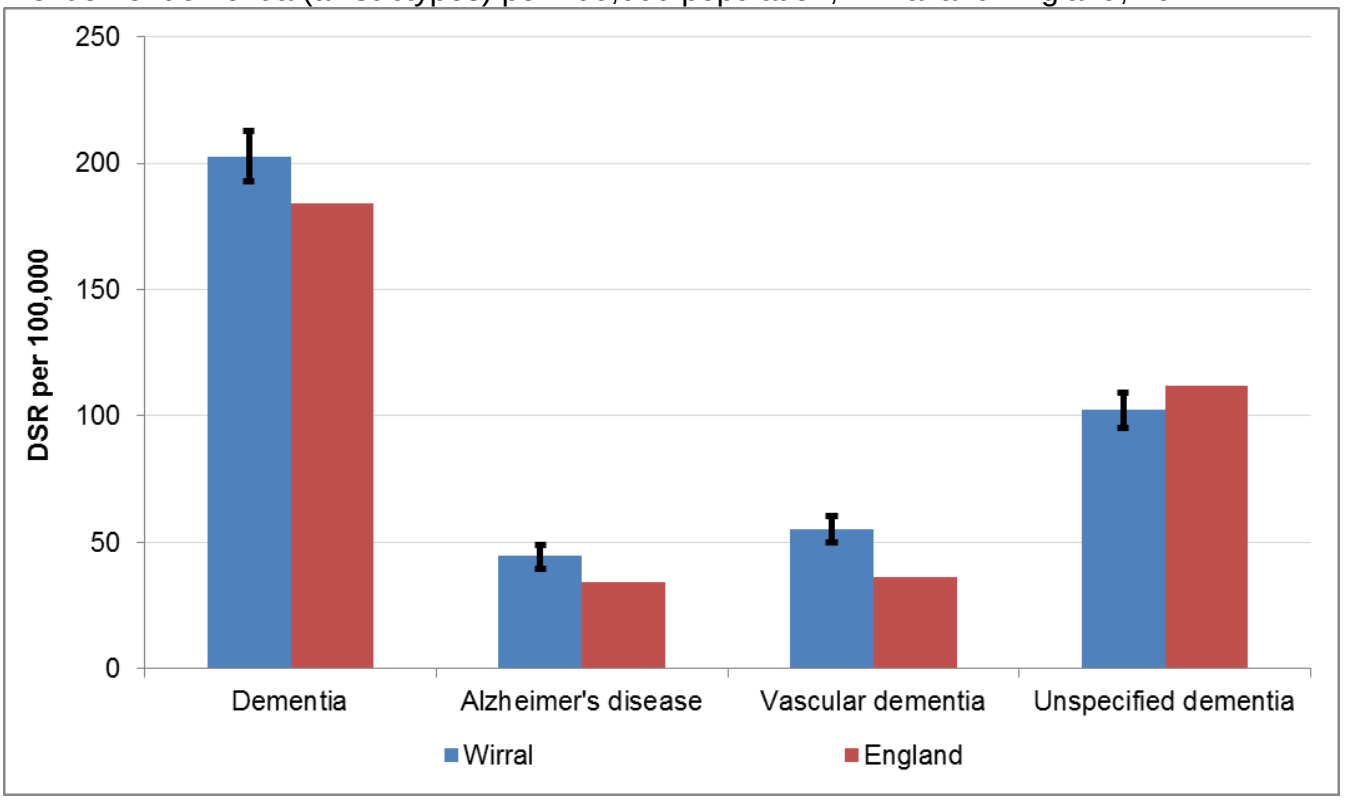
Source: POPPI, 2016

Mortality

In 2016, the Office for National Statistics published data that dementia was the leading underlying cause of death in females in 2015 in England and Wales, and the second most common underlying cause in males, contributing to 15.2% and 7.9% of all deaths respectively.

As Figure 16 shows, Wirral has higher mortality rates for dementia, Alzheimer's disease and vascular dementia, than England. However, England has a higher rate of mortality for unspecified dementia, suggesting that Wirral overall has a higher rate of subtype diagnosis.

Figure 16: Directly Age-Standardised Rate of Mortality in persons (aged 20+) with a recorded mention of dementia (all subtypes) per 100,000 population, Wirral and England, 2012-14



Source: NMHDNIN, 2016
Notes:

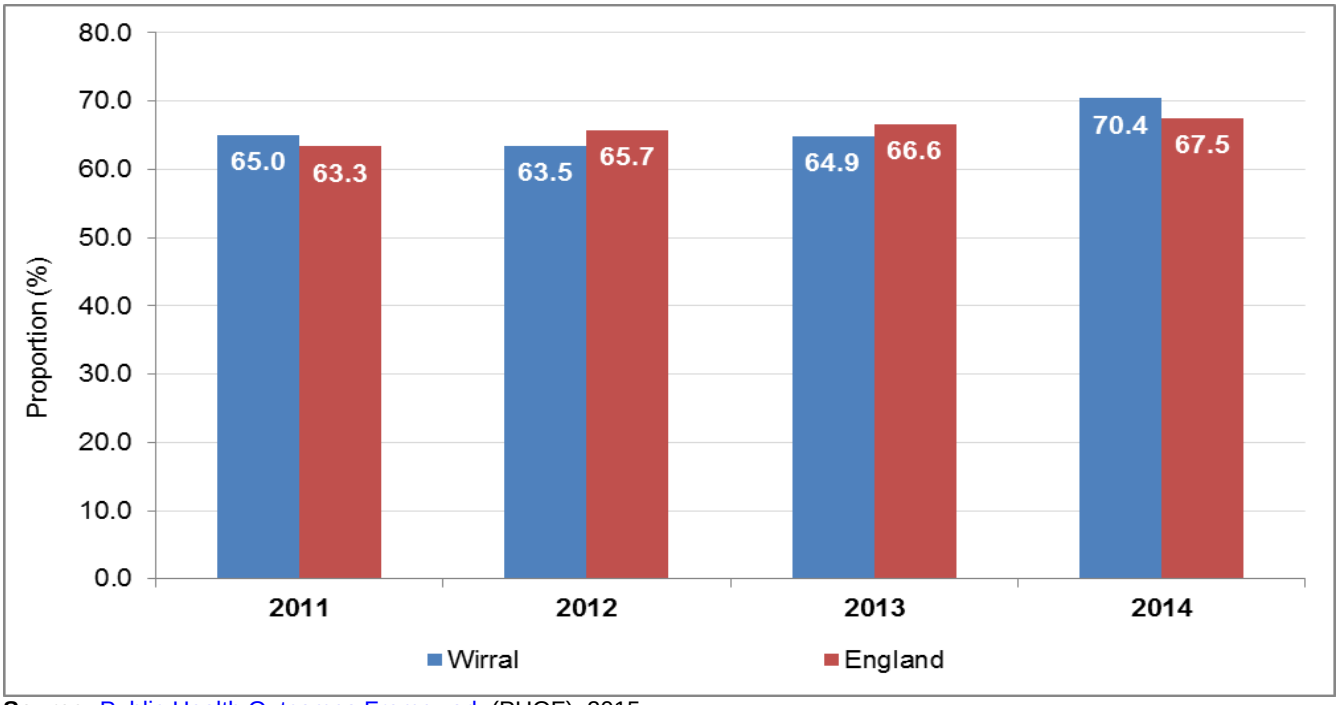
The National Dementia Intelligence Network and National End of Life Care Intelligence Network published a Dying with Dementia briefing in August 2016, which summarises the following key messages:

- Mortality rates for deaths mentioning dementia significantly increased between 2001 and 2014
- Data suggests that people with dementia who live in more deprived areas are more likely to die younger
- More than half of dementia deaths occurred in care homes, compared to around 25% in the general population
- More than a third of dementia deaths had a record of respiratory disease. Also, more than a third of dementia deaths had a record of circulatory disease.

The full briefing and supporting documents can be found here: YHPHO - Dying with dementia

Figure 17 shows the proportion of all dementia-related deaths that occurred in a person's usual place of residence. From the chart, it can be seen that the proportions for both Wirral and England remained consistent between 2011 and 2013 before observing a small increase in 2014.

Figure 17: Proportion of dementia-related deaths that occurred in a person's usual place of residence, Wirral and England, 2011 to 2014



Source: Public Health Outcomes Framework (PHOF), 2015

Living with dementia

Dementia has a significant impact on an individual's health and quality of life. It can result in a range of health and social problems which can be challenging for the person with dementia, their carers, and health and social care professionals. The prognosis for a person with dementia varies depending on the cause of the dementia and the pattern of symptoms (see 3.7 *Dementia and Mortality* below*).*

As the dementia progresses, people with dementia experience severe cognitive impairment and memory loss. Psychological and behavioural problems such as depression, disorientation, and aggression will develop and get worse over time and can be difficult to manage.

Research shows that large proportions of people with dementia feel unsupported and do not feel part of their community. They often experience anxiety and depression and three quarters do not feel society is geared up to deal with dementia (Alzheimer's Society, 2012).

While a survey undertaken by the Alzheimer's Society (Alzheimer's Society, 2013) suggests that progress is being made, with almost two-thirds (61%) of respondents reporting that they were living well with the condition, the report also found that quality of life is still varied for a significant number of people with dementia. Environment, presence of depression, social isolation and loneliness are key drivers for quality of life for people with dementia.

In addition to this, as life expectancy increases for people with complex disabilities, parent carers may develop dementia which will affect their ability to provide care. Many parent carers are single parents, which is an additional risk factor delaying identification.

Impact on carers

Nationally, provision of unpaid care for those with dementia contributes more in financial terms than contributions from any other agency (45% of the total, with social care second providing 40% (Kings College London & London School of Economics, 2014). Carers are often old themselves, more likely to be women, and are likely to be providing a substantial number of hours of support (JSNA Hammersmith and Fulham, Kensington and Chelsea and Westminster 2015).

Research on carers has found that those providing care are more likely to be in poor health than those not providing care11 (Pinquart & Sorensen, 2003). Emotional and mental health problems tend to be more often associated with care giving than physical health problems: nationally, carers providing substantial levels of care are twice as likely to have mental health problems as those providing a lower level of care (27% against 13%). One review suggests that carers of people with dementia have worse health outcomes than other carers (Pinquart & Sorensen, 2003)

In addition to poorer physical and mental health, carers can often suffer from social deprivation, isolation, fewer opportunities to paid employment or education, or having time to themselves or with friends. For young carers, it can often mean life chances are severely limited.

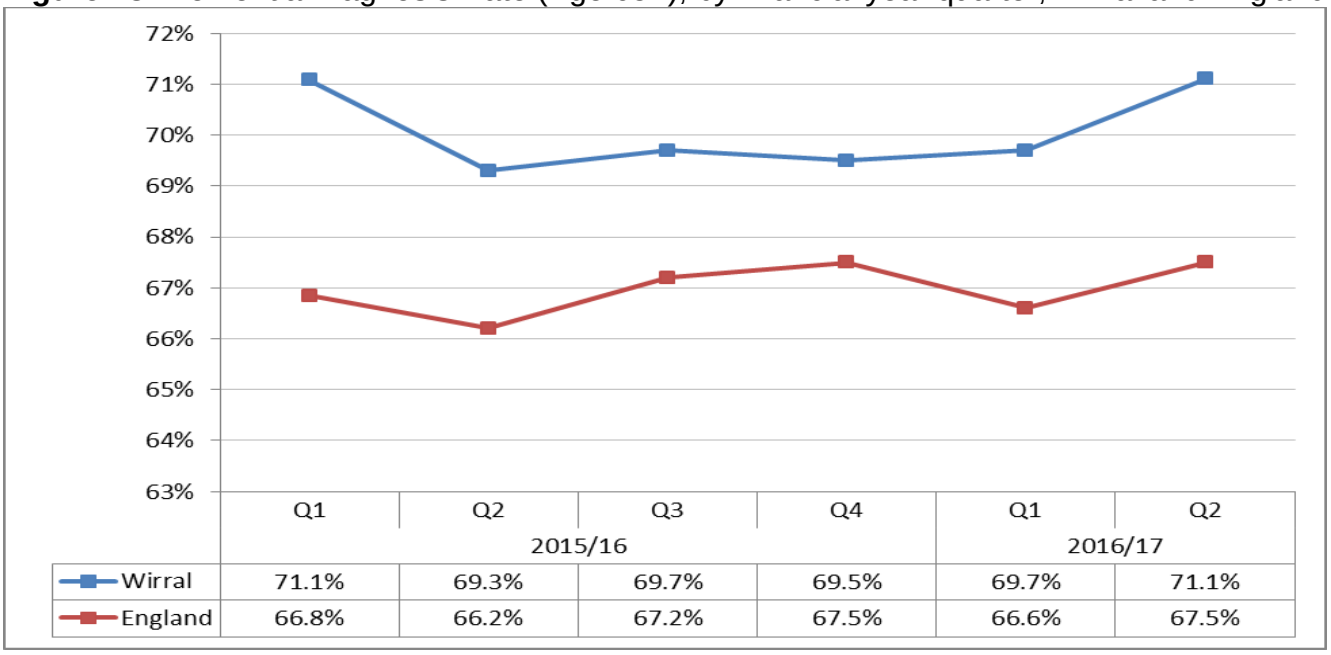
Caring responsibilities are likely to have a significant impact on carers' quality of life and possibly poorer again for those looking after someone with dementia than carers generally.

Targets and Performance

NHS England has set a national target for CCGs to diagnose at least two thirds (67.7%) of their expected dementia population. The Prime Minister's Challenge on Dementia 2020 (2016) confirms that NHS England had hit the target of increasing diagnosis rates to 66.7% (or two thirds) by January 2016.

The diagnosis rate for Wirral is 72.7% (all ages, as at September 2016), meaning Wirral has better diagnosis rate than the national standard of 66.7%. Wirral's dementia diagnosis rate for those aged 65 and over is also above the national average; 71.7% as at October 2016 compared to 67.7% in England.

Figure 18: Dementia Diagnosis Rate (Age 65+), by financial year quarter, Wirral and England



	Q1	Q2	Q3	Q4	Q1	Q2
	2015/16				2016/17	
Wirral	71.1%	69.3%	69.7%	69.5%	69.7%	71.1%
England	66.8%	66.2%	67.2%	67.5%	66.6%	67.5%

Source: NHS England, 2016

Figure 18 shows the recent trend of dementia diagnosis rates in the population aged 65 and over, from Quarter 1 (April to June) in 2015/16 to Quarter 2 (July to September) in 2016/17. These rates are found by using recorded dementia diagnosis against the estimated number of people in an area. As can be seen in Figure 18, Wirral has consistently performed better than England during this time.

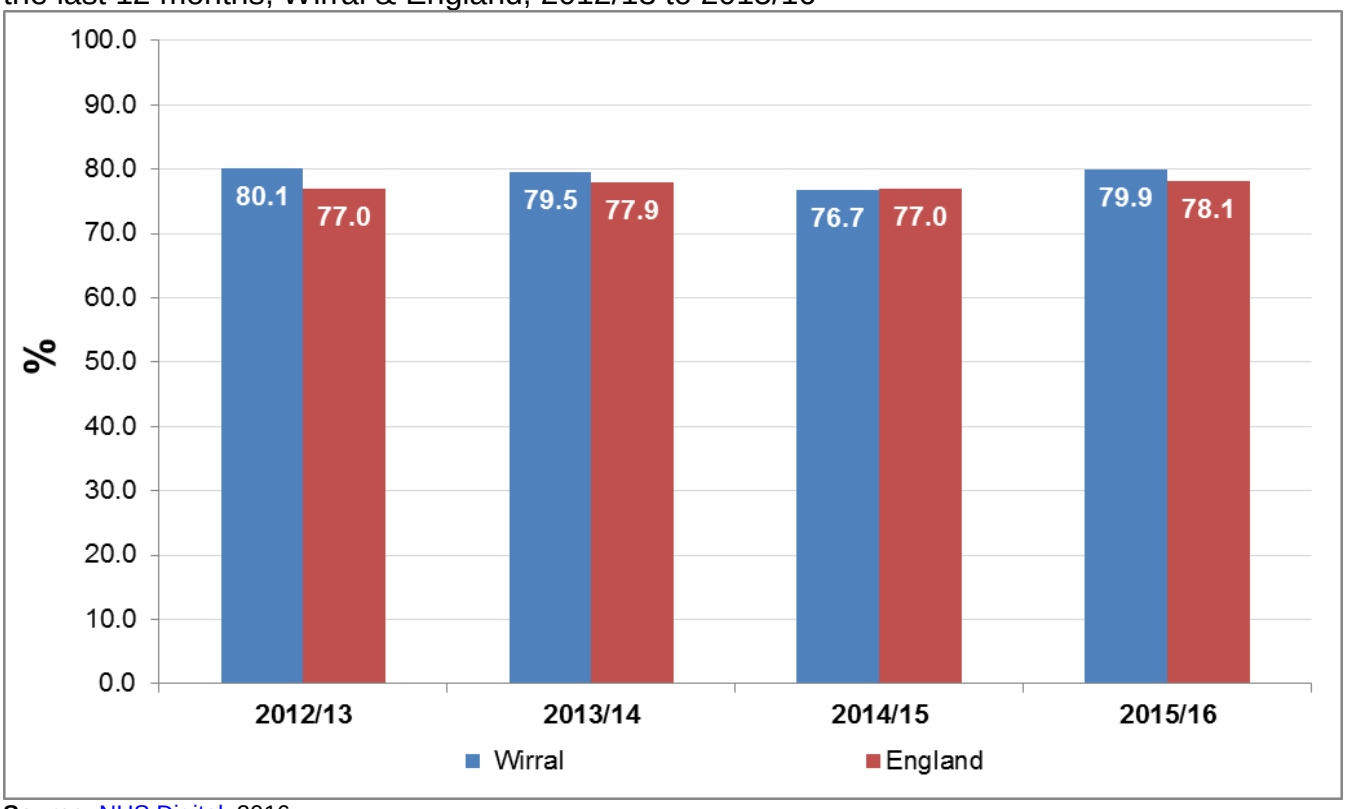
The Prime Minister's Challenge on Dementia 2020 (2016) also sets out the vision for the UK to

be world leaders in dementia care, support, research and awareness. This will be measured against the new Dementia Profile and within the CCG Improvement and Assessment Framework (CCGIAF 2016/17). The two indicators that will be included within the CCGIAF are:

- Estimated diagnosis rate for people with dementia
- Dementia care planning and post-diagnostic support

Review of Care

Figure 19: Rate (%) of patients diagnosed with dementia whose care has been reviewed in the last 12 months, Wirral & England, 2012/13 to 2015/16



Source: NHS Digital, 2016

As Figure 19 shows, the proportion of people with a recorded diagnosis of dementia that have undergone a review of care within 12 months, has decreased steadily at a Wirral level, from 80.1 in 2012/13 to 79.3 in 2015/16. Despite this however, the chart does show that Wirral tends to have a slightly higher rate than that seen at an England level, for example, in 2012/13, 79.3% of dementia patients had their care reviewed in the previous 12 months, compared to 77.0% in England.

In 2015/16, the Quality Outcome Framework targets for dementia were amended to better incentivise practices to perform a review of care within 12months for those who have a recorded dementia diagnosis. Wirral Clinical Commissioning Group (CCG) also commissions an enhanced service from all Wirral GP practices that requires a bi-annual review to be carried out of all those receiving medication for their dementia management. In light of these two elements, it is anticipated that the number of care reviews taking place in Wirral for those with a recorded diagnosis of dementia will increase.

Review of evidence and models of care

This following section contains information collated and published by JSNA Leads from Hammersmith and Fulham, Kensington and Chelsea and Westminster in producing their Dementia JSNA in 2015.

It provides a brief review of published evidence on the efficacy and effectiveness of

interventions for dementia care, management, support and prevention. The review focuses on the following areas:

- prevention of dementia
- management and care of people with dementia
- living well with dementia
- dementia friendly communities
- telehealth/telecare for people with dementia
- support for carers

Review this content here

The details will likely continue to be accurate since its production but we advise readers to review later sources for any newer updates. The full Dementia JSNA for Hammersmith and Fulham, Kensington and Chelsea and Westminster can be accessed here or via this link: https://www.jsna.info/document/dementia

Another useful document has been published by the House of Commons, "Dementia: policy, services and statistics" (October 2016) outlining Government strategies, policies and national statistics.

The full report can be found on the UK Parliament website: Dementia: Policy, services and statistics

What is this telling us?

Overview

Dementia continues to be a major contributor to the ill – health of residents, with ongoing impact upon to families as carers and a growing significant cost to local services and wider economy. Wirral has identified more people with dementia than the national average and continues to work towards improved and effective outcomes.

Albeit a positive picture in terms of action being undertaken to support improved diagnosis and awareness the impacts on individuals and families are substantial and continue over time. It is with this in mind that local residents, carers, partner organisations, commissioners and service providers must continue to gather the best evidence, information and insight to publish through the JSNA so that decision making processes can be well informed.

Local views

Awaiting further information – when this is offered by partners we will produce a later version of this JSNA section

Public Health England included a dementia module within their 2015 British Social Attitudes (BSA) survey and in June 2015 published "Attitudes to dementia" reporting the findings, which are summarised at the beginning of the paper within the following infographic:

52% choose dementia as either their first, second or third priority from a list of health conditions for doctors and scientists to try to prevent. 12% see dementia as the highest priority for prevention.

59% know someone with dementia

The majority recognise the following symptoms of dementia:

87% difficulty recognising people

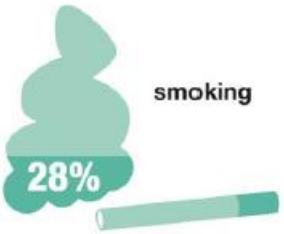
73% putting things in the wrong place

71% feeling lost in new places

Public knowledge of risk factors for dementia is considerably lower than knowledge of symptoms of dementia. 21% fail to identify any of seven risk factors correctly, while 43% identify just one or two risk factors.

Only a minority are aware of the following risk factors of dementia:

drinking heavily



smoking

high blood pressure

Around half of people agree that "people with dementia can enjoy life to the full" (52%) and disagree that "I would find it hard to talk to someone with dementia" (57%). A substantial majority hold relatively negative views about caring for someone with dementia. Only 39% agree that "caring for someone with dementia is often very rewarding" and as many as 71% agree that "caring for someone with dementia often means that your own health suffers".

Source: BSA Survey 2015, NatCen Social Research & Public Health England (PHE), June 2015

The full "Attitudes to Dementia" report can be found on the NatCen website: ["Attitudes to Dementia - British Social Attitudes - June 2015"]

National and local strategies

All-Party Parliamentary Group on Dementia, 2016, Dementia rarely travels alone: Living with dementia and other conditions
https://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=3008

All-Party Parliamentary Group on Dementia, 2013, Dementia does not discriminate: The experiences of black, Asian and minority ethnic communities
http://www.lifestorynetwork.org.uk/wp-content/uploads/downloads/2013/07/APPG-Report-2013-Update.pdf

Department of Health - Dementia - A state of the nation report on dementia care and support in England (2013)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/262139/Dementia.pdf

Challenge on dementia 2020: implementation plan (2016)
https://www.gov.uk/government/publications/challenge-on-dementia-2020-implementation-plan

Dementia-friendly health and social care environments (HBN 08-02) (2016)
https://www.gov.uk/government/publications/dementia-friendly-health-and-social-care-environments-hbn-08-02

Dementia advisers survey (2016)
https://www.gov.uk/government/publications/dementia-advisers-survey

Investigation into the cost of dementia in London and the savings needed to ensure investment in memory services is cost neutral (2011)
http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/06-Cost-of-dementia.pdf

Dementia: post-diagnostic care and support (2016) - A shared approach to improving the care and support people with dementia, their families and carers receive following a diagnosis.
https://www.gov.uk/government/publications/dementia-post-diagnostic-care-and-support

The National Dementia Strategy 'Living Well with Dementia' 2009
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/168220/dh_094051.pdf

The Joint Commissioning Framework for Dementia (DH June 2009)
http://www.dhcarenetworks.org.uk/_library/Resources/Dementia/National_Dementia_Strategy_-_Joint_Commissioning_Framework.pdf

Nice guidance clinical guidance CG 42 (Updated May 2016) and Pathway
https://www.nice.org.uk/guidance/cg42
https://pathways.nice.org.uk/pathways/dementia

Extra Care Housing and People with dementia Scoping Review 2009 Housing & Dementia Research Consortium (Joseph Rowntree).
http://www.housing21.co.uk/files/7812/4964/7502/SUMMARY%20of%20FINDINGS%20from%20a%20Scoping%20Review%20of%20the%20Literature%20.pdf

Wirral Dementia Strategy 2013
http://www.wirralccg.nhs.uk/Downloads/News/High%20Level%20Dementia%20Plan%20version%20-%20Public%20version%20for%20website%20May%202013.pdf
Transforming the Quality of Dementia Care, a consultation document proposing

improvements to dementia care published during 2008
http://www.jrf.org.uk/sites/files/jrf/dementia-care-strategy.pdf

Inequalities in Mental Health, Cognitive Impairment and Dementia among Older People, Institute of Health Equity, 2016, http://www.instituteofhealthequity.org/projects/inequalities-in-mental-health-cognitive-impairement-and-dementia-among-older-people

"Dementia: Policies, services and statistics", House of Commons Library, October 2016
http://researchbriefings.files.parliament.uk/documents/SN07007/SN07007.pdf

Current activity, services and tools

In Wirral, there are several services provided by the voluntary sector. A summary of these services, including a service description and contact details, can be found via this link

Awaiting further information – when this is offered by partners we will produce a later version of this JSNA section

Key inequalities

Life Risk factors

In October 2016, the Institute of Health Equity published a report "Inequalities in Mental Health, Cognitive Impairment and Dementia among Older People", which focuses on the inequalities throughout the life course that may contribute to the development of poor mental health, including dementia, in later years. There are several risks identified, including factors such as educational attainment, unemployment, housing conditions and deprivation. The full report can be accessed here: Inequalities in Mental Health, Cognitive Impairment and Dementia among Older People - IHE.

Visual Impairment

New data from a study published by National Institute for Health Research (NIHR, 2016) shows that around a third of people with dementia have serious vision problems, such as cataracts or short sightedness, more than the general population of that age. Levels are higher still for people with dementia in care homes where about half have vision problems.

The study also shows that these conditions were treatable; almost half of those found to be visually impaired were provided with prescription glasses to correct visual problems, with around 25% being impaired as a result of cataracts, which could be surgically removed.

Black & Minority Ethnic (BME) Population

The All-Parliamentary Party Group report "Dementia does not discriminate" (2013) estimates that in 2013 there were around 25,000 people with dementia from BME communities in England and Wales, with projections estimating that this will increase to nearly 50,000 by 2026.

The report also suggests that people from BME communities are under-represented in dementia services and are less likely to be diagnosed or are diagnosed at a later stage. Reasons for this could be due to communication issues, cultural bias and lack of awareness about the condition.

People from BME communities, more specifically Asian and Black Caribbean communities, are also likely to be at an increased risk of developing dementia as high blood pressure, diabetes, stroke and heart disease, which are risk factors for dementia, are more common in these

communities.

Down's Syndrome

Down's syndrome, also known as Down syndrome, is a genetic condition caused by an extra copy of chromosome 21 in cells. This typically causes some level of learning disability and characteristic physical features. Research has also acknowledged that the additional copy of this chromosome contains a gene that produces proteins involved in changes in the brain caused by Alzheimer's, which is why those with Down's Syndrome have a higher risk of developing dementia, most commonly Alzheimer's.

It is currently estimated that there are around 21,239 adults in England and 118 adults in Wirral with Down's Syndrome (POPPI and PANSI, 2016). The Alzheimer's Society estimate that 1 in 50 people (or 2%) with Down's Syndrome develop dementia in their 30s. This rate rises to more than 50% for people with Down's Syndrome who live into their 60s, compared to the estimate of 1.3% for people aged 60-69 without a learning disability.

Key gaps in knowledge and services

- More detailed information at borough level to inform local service design.
- Gathering of current and future public voice on and around dementia to inform JSNA and commissioning processes
- Number of people from BME communities with a diagnosis of dementia or a dementia subtype in Wirral
- Number of people with a dementia or subtype diagnosis who are visually impaired in Wirral
- Number of people in Wirral with Down's Syndrome and those who also have dementia

What further actions could be considered?

- Continuous improvement of the advice, information and guidance for people with dementia and their carers
- Continuous improvement of the support provided for carers
- Continuous improvement of access to intermediate care for people with dementia
- Continuous improvement of the quality of hospital care for people with dementia including the pathway into and out of hospital
- Continued development of dementia case registers for the general population
- Consistent recording within all services of people who have dementia as a diagnosis
- Consistent recording of learning disability in people who have dementia
- Consistent recording of ethnic origin of people who have dementia as a diagnosis
- Ongoing workforce training to improve awareness and understanding of dementia and to improve the quality of assessment to increase the rate of detection and diagnosis

Links

Evidence in Mind, Dementia Bulletin (Merseycare NHSFT)
Evidence in Mind is a website containing resources for mental health evidence in 5 areas; dementia, depression, learning disabilities, suicide prevention and current bytes - http://www.evidenceinmind.co.uk/services/bulletins/

JSNA chapters to risk factors and related content:

- Adult Obesity
- Alcohol
- Black Asian and Minority Ethnic residents
- Cardiovascular Disease
- Diabetes
- Hypertension (High Blood Pressure)
- Learning Disabilities and Autism
- Mental Health
- People with Long Term Conditions
- Sexual Health
- Sight Loss - Adults and Sight Loss – Children and Young People
- Social Isolation and Loneliness
- Tobacco (Smoking)

Contact Us

For further details please contact
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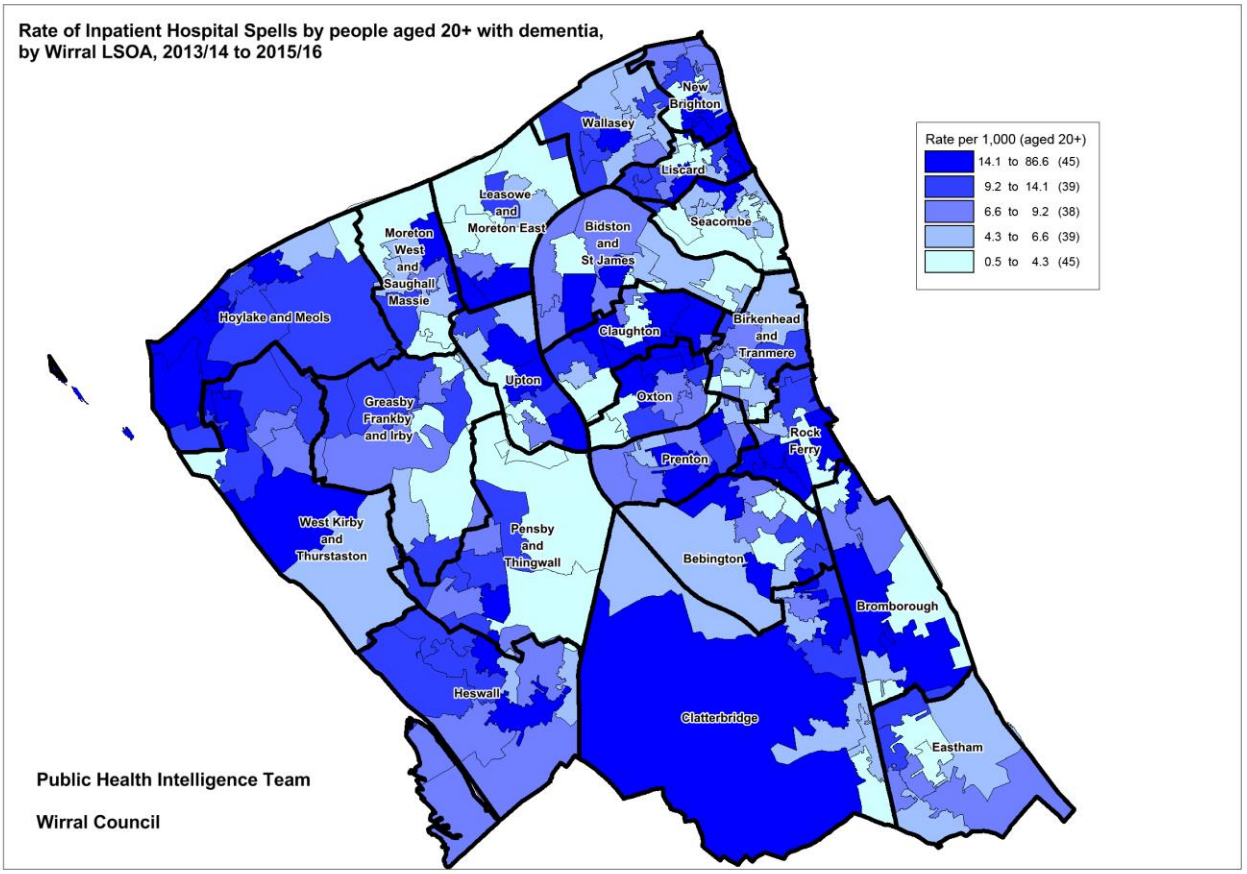
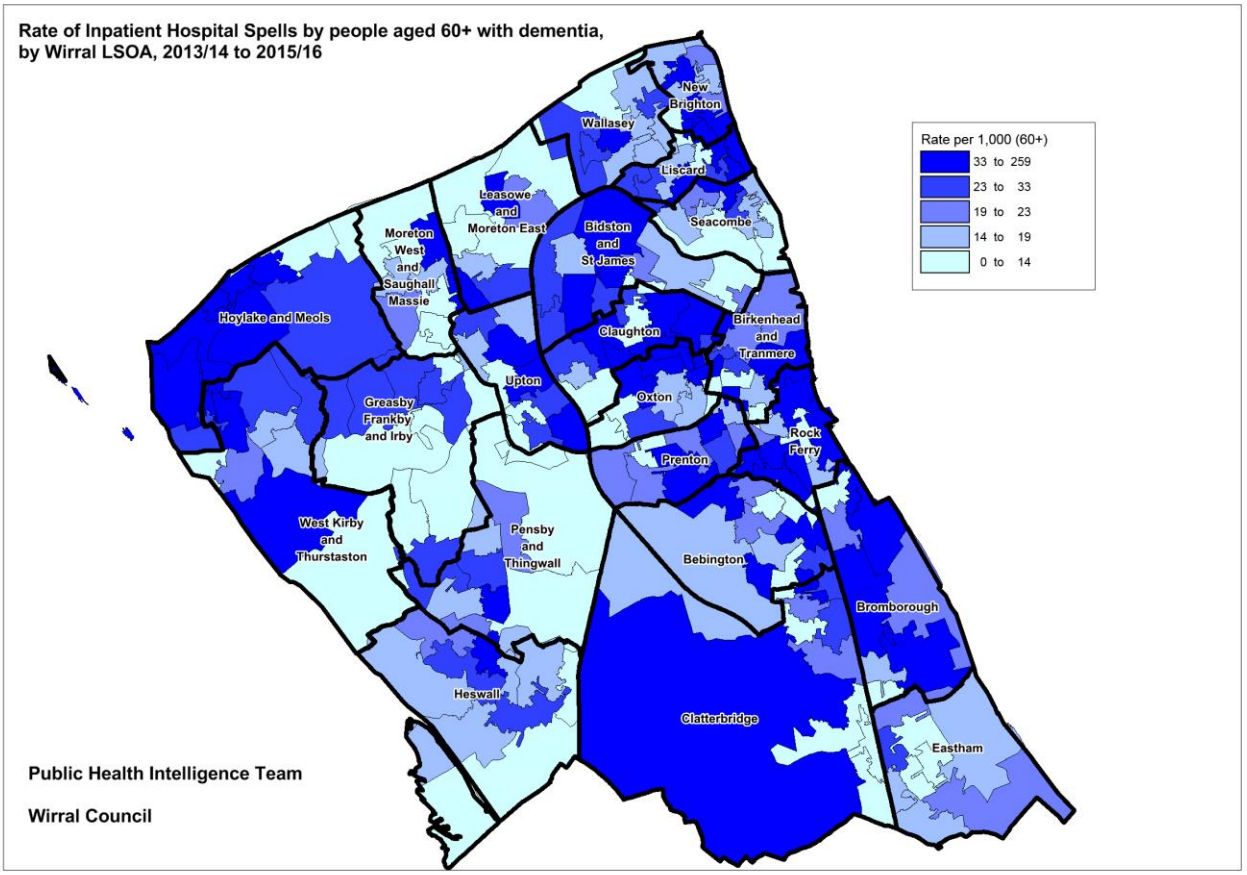
Appendix

Appendix 1





Appendix 2

10 Most Common Primary Diagnosis in Dementia-related Inpatient Admission (2013/14)	%
Urinary tract infection, site not specified	7.8%
Lobar pneumonia, unspecified	5.4%
Tendency to fall, not elsewhere classified	4.9%
Sepsis, unspecified	3.9%
Cerebral infarction, unspecified	3.3%
Fracture of neck of femur	2.8%
Pneumonia, unspecified	2.8%
Syncope and collapse	2.4%
Acute renal failure, unspecified	2.3%
Pneumonitis due to food and vomit	2.1%
OTHER (includes 355 other diagnoses)	62.2%

10 Most Common Primary Diagnosis in Dementia-related Inpatient Admission (2014/15)	%
Urinary tract infection, site not specified	6.6%
Lobar pneumonia, unspecified	5.8%
Tendency to fall, not elsewhere classified	4.9%
Fracture of neck of femur	3.3%
Pneumonia, unspecified	3.3%
Syncope and collapse	2.6%
Unspecified acute lower respiratory infection	2.2%
Alzheimer's disease, unspecified	2.0%
Pertrochanteric fracture	2.0%
Disorientation, unspecified	1.6%
OTHER (includes 377 other diagnoses)	65.7%

10 Most Common Primary Diagnosis in Dementia-related Inpatient Admission (2015/16)	%
Urinary tract infection, site not specified	5.7%
Lobar pneumonia, unspecified	4.7%
Tendency to fall, not elsewhere classified	4.6%
Syncope and collapse	4.4%
Fracture of neck of femur	3.3%
Pneumonia, unspecified	3.0%
Cerebral infarction due to unspecified occlusion	3.0%
Unspecified acute lower respiratory infection	1.9%
Alzheimer's disease, unspecified	1.9%
Pneumonitis due to food and vomit	1.8%
OTHER (includes 306 other diagnoses)	65.9%

Appendix 3

Length of stay for dementia-related inpatient admissions by age group, Wirral, 2013/14					
Age Group	**<7 days**	**1week to < 5 weeks**	**5 weeks < 12 weeks**	**4 - 12 months**	**Total admitted by age group**
Under 60s	**1.7%**	**1.0%**	**0.3%**	**0.1%**	**3.0%**
61 - 65	1.1%	0.7%	0.2%	0.1%	2.1%
66 - 70	2.1%	1.6%	0.8%	0.3%	4.8%
71 - 75	3.7%	2.9%	0.7%	0.1%	7.5%
76 - 80	8.6%	6.8%	2.4%	0.8%	18.6%
81 - 85	15.0%	11.8%	2.3%	0.6%	29.6%
Over 85s	14.9%	15.9%	2.9%	0.6%	34.4%
Over 60s	**45.4%**	**39.7%**	**9.4%**	**2.5%**	**97.0%**
ALL	**47.0%**	**40.8%**	**9.7%**	**2.6%**	**100.0%**

Length of stay for dementia-related inpatient admissions by age group, Wirral, 2014/15					
Age Group	**<7**	**1week to < 5 weeks**	**5 weeks < 12 weeks**	**4 - 12 months**	**Total admitted by age group**
Under 60s	**1.9%**	**0.6%**	**0.3%**	**0.0%**	**2.9%**
61 - 65	0.6%	0.5%	0.0%	0.1%	1.3%
66 - 70	2.4%	1.2%	0.4%	0.4%	4.5%
71 - 75	4.2%	2.7%	0.8%	0.5%	8.3%
76 - 80	9.2%	5.4%	1.4%	0.4%	16.4%
81 - 85	14.4%	11.6%	2.6%	0.5%	29.1%
Over 85s	18.8%	15.0%	3.3%	0.4%	37.5%
Over 60s	**49.7%**	**36.5%**	**8.5%**	**2.4%**	**97.1%**
ALL	**51.7%**	**37.2%**	**8.8%**	**2.4%**	**100.0%**

Length of stay for dementia-related inpatient admissions by age group, Wirral, 2015/16					
Age Group	**<7 days**	**1week to < 5 weeks**	**5 weeks < 12 weeks**	**4 - 12 months**	**Total admitted by age group**
Under 60s	**2.4%**	**0.5%**	**0.2%**	**0.0%**	**3.1%**
61 - 65	0.8%	0.2%	0.1%	0.1%	1.2%
66 - 70	2.1%	1.2%	0.4%	0.5%	4.2%
71 - 75	3.8%	2.8%	0.8%	0.5%	7.8%
76 - 80	8.6%	5.1%	1.4%	0.6%	15.7%
81 - 85	12.3%	9.0%	2.5%	0.8%	24.6%
Over 85s	19.9%	18.0%	4.7%	0.7%	43.3%
Over 60s	**47.5%**	**36.4%**	**9.9%**	**3.1%**	**96.9%**
ALL	**49.9%**	**36.8%**	**10.1%**	**3.1%**	**100.0%**

Appendix 4

Length of stay for all inpatient admissions by age group, Wirral, 2013/14					
Age Group	**< 7 days**	**1week to < 5 weeks**	**5 weeks < 12 weeks**	**4 - 12 months**	**Total admitted by age group**
Under 60s	**52.7%**	**2.2%**	**0.2%**	**0.1%**	**55.2%**
61 - 65	6.9%	0.5%	0.1%	0.0%	7.5%
66 - 70	8.0%	0.7%	0.1%	0.0%	8.8%
71 - 75	7.2%	0.7%	0.1%	0.0%	8.1%
76 - 80	6.8%	1.0%	0.2%	0.0%	7.9%
81 - 85	5.5%	1.1%	0.2%	0.0%	6.8%
Over 85s	3.9%	1.4%	0.3%	0.0%	5.6%
Over 60s	**38.3%**	**5.4%**	**0.9%**	**0.2%**	**44.8%**
ALL	**91.0%**	**7.6%**	**1.1%**	**0.3%**	**100.0%**

Length of stay for all inpatient admissions by age group, Wirral, 2014/15					
Age Group	**< 7 days**	**1week to < 5 weeks**	**5 weeks < 12 weeks**	**4 - 12 months**	**Total admitted by age group**
Under 60s	**51.8%**	**2.1%**	**0.2%**	**0.1%**	**54.2%**
61 - 65	6.5%	0.4%	0.1%	0.0%	7.0%
66 - 70	8.4%	0.6%	0.1%	0.0%	9.1%
71 - 75	7.3%	0.7%	0.1%	0.0%	8.2%
76 - 80	7.2%	0.9%	0.1%	0.0%	8.3%
81 - 85	5.8%	1.0%	0.2%	0.0%	7.1%
Over 85s	4.4%	1.4%	0.3%	0.0%	6.2%
Over 60s	**39.7%**	**5.0%**	**0.8%**	**0.2%**	**45.8%**
ALL	**91.5%**	**7.1%**	**1.1%**	**0.3%**	**100.0%**

Length of stay for all inpatient admissions by age group, Wirral, 2015/16					
Age Group	**< 7 days**	**1week to < 5 weeks**	**5 weeks < 12 weeks**	**4 - 12 months**	**Total admitted by age group**
Under 60s	**51.9%**	**2.0%**	**0.2%**	**0.1%**	**54.3%**
61 - 65	6.8%	0.4%	0.1%	0.1%	7.3%
66 - 70	8.2%	0.6%	0.1%	0.1%	8.9%
71 - 75	7.7%	0.7%	0.1%	0.0%	8.5%
76 - 80	7.2%	0.9%	0.1%	0.0%	8.3%
81 - 85	5.3%	1.0%	0.2%	0.0%	6.5%
Over 85s	4.5%	1.4%	0.3%	0.0%	6.2%
Over 60s	**39.7%**	**4.9%**	**0.8%**	**0.3%**	**45.7%**
ALL	**91.6%**	**6.9%**	**1.1%**	**0.4%**	**100.0%**