

PUBLIC HEALTH



Ageing Well

Supporting Information and Intelligence

2. Main Document

April 2017





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The appendix can be found in the document called “Ageing Well. Supporting Information and Intelligence Document: Part 3”



Introduction

i. Introduction to the document

This document is the second and main component of three documents created by East Riding of Yorkshire (ERY) Council Public Health Intelligence Team (PHI), regarding “Ageing Well - Supporting Information and Intelligence”. The documents aim to provide key points to inform recommendations, target interventions and potential commissioning decisions.

The document does not propose to provide a complete picture of Aging Well in the ERY, instead the structure of the document is based on the ERY Public Health England (PHE) Aging Well profile, released in 2016. This document takes examples of the indicators found in each of the sections within the PHE profile and expands on them. Since the document was started, PHI are aware that more up to date information has been made available from sources such as PHE, however it has not been updated here due to time limitations.

The ERY Aging Well document produced by PHE can be found on the JSNA website (www.eastriding.gov.uk/jsna) within the “Age Well and End of Life” section. A direct link to the document is provided here (<http://dataobs.eastriding.gov.uk/resource/view?resourceId=558>).

ii. Terminology used in this document

Definition of an older person

The [World Health Organisation \(WHO\)](http://www.who.int) states that most countries in the developed world agree that the definition of an older (or elderly person) is 65 years of age and over. This ERY Public Health Intelligence document uses a variety of information sources and where possible the age of 65 and over is used to represent older people. However not all data sources have available 65+ years of age and therefore some of the information presented may use a slightly younger age group to represent older people (e.g. 60 years and over) or a slightly older age group (e.g. 75+ years).

Local Authority CIPFA neighbours

This document also compares ERY with its CIPFA nearest neighbours. CIPFA (Chartered Institute of Public Finance and Accountancy) nearest neighbours allows comparison of local authorities with the 15 most statistically similar areas in terms of social and economic features. Further information can be found here: <http://www.cipfastats.net/resources/nearestneighbours/>. The ERY CIPFA neighbours include:

- Bath and North East Somerset
- Cheshire East
- Cheshire West and Chester
- Cornwall
- Herefordshire
- Isle of Wight
- North Somerset
- Northumberland
- Poole
- Sefton
- Shropshire
- South Gloucestershire
- Stockport
- Wiltshire
- Wirral



Local Authorities in the Yorkshire and Humber region

- Barnsley
- Bradford
- Calderdale
- Doncaster
- East Riding of Yorkshire
- Kingston upon Hull
- Kirklees
- Leeds
- North East Lincolnshire
- North Lincolnshire
- North Yorkshire
- Rotherham
- Sheffield
- Wakefield
- York

Directly standardised rates (DSR)

DSR are frequently used to try to eliminate the effects of age differences between different areas (such as wards) and allow for a more meaningful comparison. For example, if a ward has an older population then we might expect more deaths to occur there. The results of a simple crude rate would not factor in this population characteristic when comparing areas, allowing for a potentially misleading interpretation. The DSR would take account of an aging population, as it takes the age specific rates of an area and applies it to a standard or reference population (usually Europe).

NHS ERY CCG general practices and localities

Prior to mid-2016, the general practices of NHS ERY CCG were grouped into five localities, but this has since been reduced to four. However, this document still reports on five localities as much of the work was completed during the period of time when there were still five localities. The names of the localities were:

- Beverley & Driffield
- Bridlington
- Goole, Howdenshire and West Wolds
- Haltemprice
- Holderness

Further information about which practices are within each of the localities can be found in the appendix file (page 7 onwards).

NHS CCG clusters

NHS ERY CCG has been placed into a group of similar CCGs. These are:

- NHS Great Yarmouth & Waveney
- NHS Hambleton Richmondshire & Whitby
- NHS Herefordshire
- NHS High Weald Lewes Havens
- NHS Ipswich and East Suffolk
- NHS North Derbyshire
- NHS Northumberland
- NHS Shropshire
- NHS South Lincolnshire
- NHS South Norfolk
- NHS South Warwickshire
- NHS South Worcestershire
- NHS West Norfolk
- NHS West Suffolk

Further information about how the clusters have been compiled, can be found here:

<https://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/>



iii. Background information about ERY

General overview of ERY

East Riding of Yorkshire (ERY) is the largest unitary authority in England, with an area of 2,479 square kilometres. It is predominantly a rural area with over half of the population living in dispersed rural communities. The East Riding's largest town is Bridlington with 38,799 people resident on census night in 2011. Other major settlements are Beverley (32,068), Goole (20,810), Cottingham (17,649) and Hessle (15,000). By area, the East Riding is both the largest district and the largest unitary authority area in England. By population, it is the second largest non-metropolitan district (unitary or not) in England, after Bristol.

According to the 2011 Census 96.2% of the population in East Riding is White: British. This is higher than the regional average of 93.5% and the national average of 79.8%. The largest minority ethnic group is White: Other, 5345 people, representing 1.6% of the total population

Deprivation in ERY, using the Index of Multiple Deprivation (IMD) 2015

The English Indices of Deprivation 2015 are based on 37 separate indicators, organised across seven distinct domains of deprivation which are combined, using appropriate weights, to calculate the Index of Multiple Deprivation 2015 (IMD 2015). This is an overall measure of multiple deprivation experienced by people living in an area and is calculated for every Lower layer Super Output Area (LSOA), or neighbourhood, in England. Every such neighbourhood in England is ranked according to its level of deprivation relative to that of other areas.

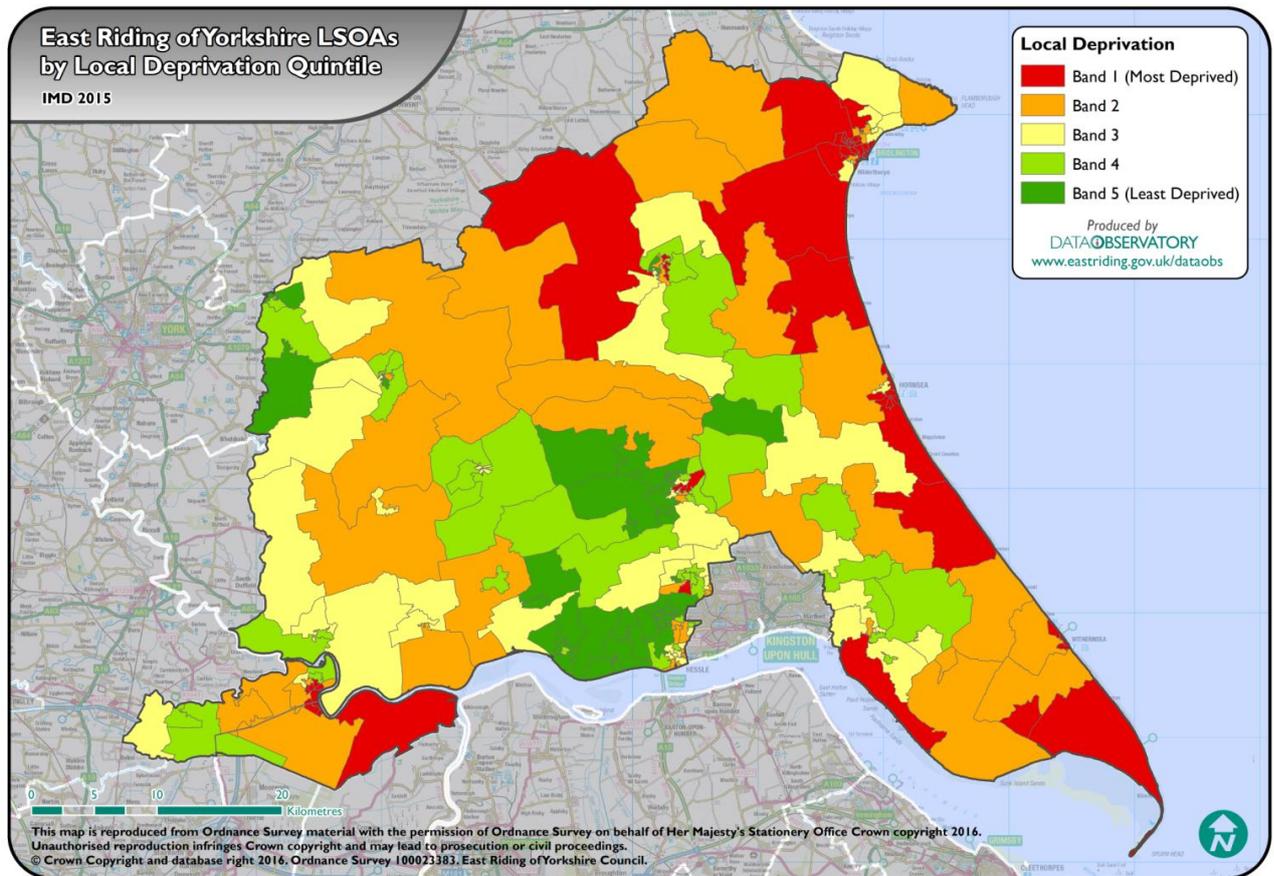
ERY is the 187th least deprived Local Authority out of 326 in England according to the Index of Multiple Deprivation 2015. However, there is substantial variation in deprivation levels under the surface of ERY the local authority, with some very deprived sections of the population.

In map i.i (on the next page), the ERY has been split into local deprivation quintiles based on LSOA IMD score. Please note these local quintiles differ substantially from national quintiles. As a result some areas previously considered not deprived when compared to the rest of the country, could now appear to be deprived when simply compared to the rest of ERY.



Map i.i IMD 2015 in ERY showing LSOA boundaries, split into local deprivation quintiles.

Source ERY Data Observatory



Wards in the ERY

The ERY is made up of 26 electoral wards, their geographic boundaries can be seen in the appendix file, in map A5.1. A number of the LSOAs (as illustrated in map i.i above) are combined to form the Wards.

Officially, wards are not allocated an IMD score, but as IMD is linked to LSOAs it is possible to calculate population weighted deprivation scores for each ward. Table i.ii below displays ERY wards ranked by deprivation, with the more deprived wards found at the top of the table.

Using the methodology described in the above paragraph, Bridlington South is calculated to be the most deprived ward in ERY and South Hunsley the least deprived.



Table i.ii. IMD (2015) LSOA values averaged to form Ward IMD rank

IMD 2015	IMD Rank	Ward
↑ More deprived wards	1	Bridlington South
	2	Bridlington Central and Old Town
	3	Goole South
	4	South East Holderness
	5	North Holderness
	6	Bridlington North
	7	Goole North
	8	East Wolds and Coastal
	9	Cottingham South
	10	Driffield and Rural
	11	Minster and Woodmansey
	12	Snaith, Airmyn, Rawcliffe and Marshland
	↓ Less deprived wards	13
14		Howdenshire
15		South West Holderness
16		Tranby
17		Hessle
18		Wolds Weighton
19		St Mary's
20		Howden
21		Cottingham North
22		Pocklington Provincial
23		Beverley Rural
24		Dale
25		Willerby and Kirk Ella
26		South Hunsley

General practice location and patient population numbers summary

To see maps showing the location of the practices in relation to the geographic wards of the local authority, please see map A5.2 in the appendix file (page 42).

Tables showing where the CCG practices population reside can also be found in the appendix (page 7 onwards). The tables have been split by locality and then the proportions of where patients live have been assigned to the wards.



I. Population structure

This section aims to give a summary of the different age groups that make up the population of ERY and the wards within it. Focus is primarily given to the 65 years of age and older age group. Population projections for the local authority are also presented.

I.1 Population structure of the East Riding of Yorkshire

Table I.1 divides the ERY population (ONS mid-year estimate for 2014) into 5 year age bands, displaying both the number of people in each age group and also what proportion of the total population that age group makes up.

The last column in the table shows that the age group with the highest population is the 65-69 year old group (7.8% of the total ERY population), followed by those aged 50-54 (7.7%), 45-49 (7.6%) and 55-59 (7.0%). The ERY has approximately 80,600 people aged 65 years and over, equating to nearly a quarter of the total population.

Table I.1 ERY population in 5 year age bands, mid-year estimate 2014. Source: ONS

Age Band	Males (no.)	Females (no.)	Total (no.)	Male age group as % of total population	Female age group as % of total population	M+F age group as % of total population
0-4	8,467	7,867	16,334	2.5%	2.3%	4.8%
5-9	8,964	8,570	17,534	2.7%	2.5%	5.2%
10-14	8,867	8,607	17,474	2.6%	2.6%	5.2%
15-19	10,125	9,622	19,747	3.0%	2.9%	5.9%
20-24	8,572	7,476	16,048	2.5%	2.2%	4.8%
25-29	7,739	7,675	15,414	2.3%	2.3%	4.6%
30-34	7,820	8,007	15,827	2.3%	2.4%	4.7%
35-39	8,483	8,878	17,361	2.5%	2.6%	5.1%
40-44	10,948	11,471	22,419	3.2%	3.4%	6.7%
45-49	12,450	13,060	25,510	3.7%	3.9%	7.6%
50-54	12,943	12,984	25,927	3.8%	3.9%	7.7%
55-59	11,572	11,941	23,513	3.4%	3.5%	7.0%
60-64	11,348	12,048	23,396	3.4%	3.6%	6.9%
65-69	12,771	13,434	26,205	3.8%	4.0%	7.8%
70-74	8,923	9,771	18,694	2.6%	2.9%	5.5%
75-79	7,101	8,235	15,336	2.1%	2.4%	4.5%
80-84	4,692	6,085	10,777	1.4%	1.8%	3.2%
85-89	2,408	3,736	6,144	0.7%	1.1%	1.8%
=>90	973	2,482	3,455	0.3%	0.7%	1.0%
Total	165,166	171,949	337,115	49.0%	51.0%	100.0%

Compared with England, the ERY has a higher than average older population and a lower than average younger population, this is illustrated in chart I.2. In the chart, the red bars represent the 5 year age bands of ERY shown as proportion of the total population, whereas the blue bars represent England.

This population pyramid noticeably displays a greater width in the younger age groups in England compared with those in ERY, however as the ages groups get older (45-49 years and over) the red bars of ERY become wider than those representing England. In each age group between 45-49 and 90+, the ERY has a larger proportion of people in its overall population than England.



Chart 1.2 Mid-year 2014 population pyramid comparing ERY and England. Source: ONS

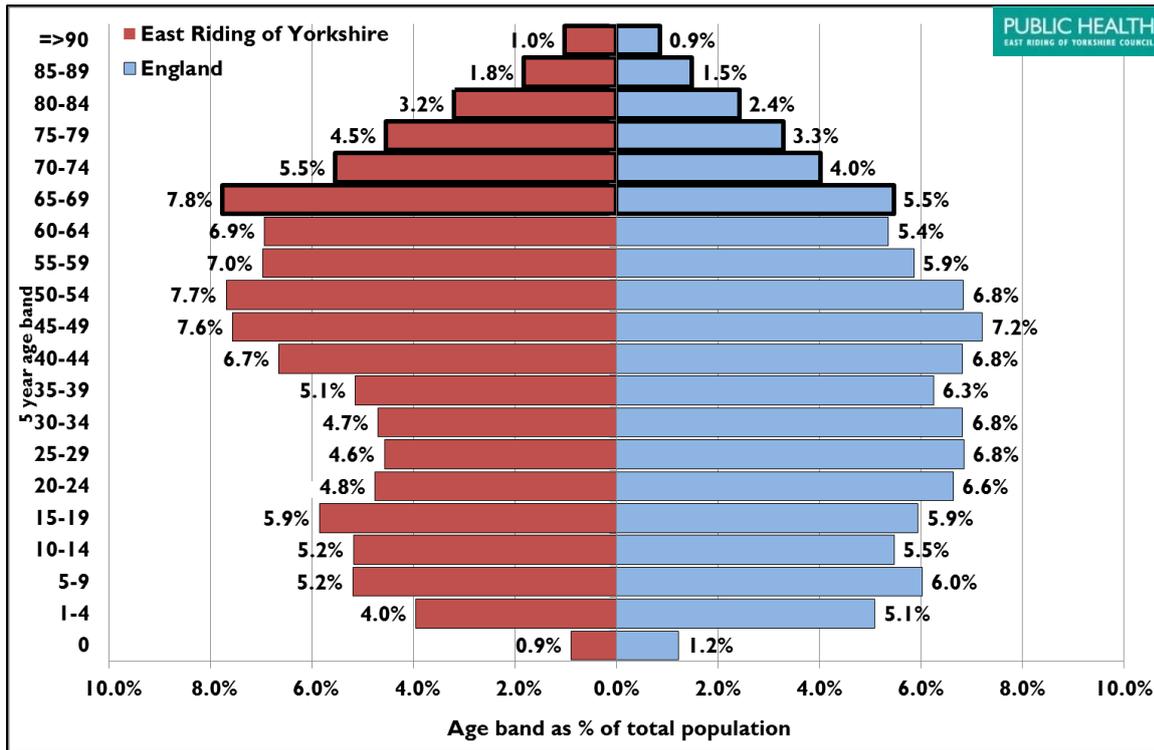
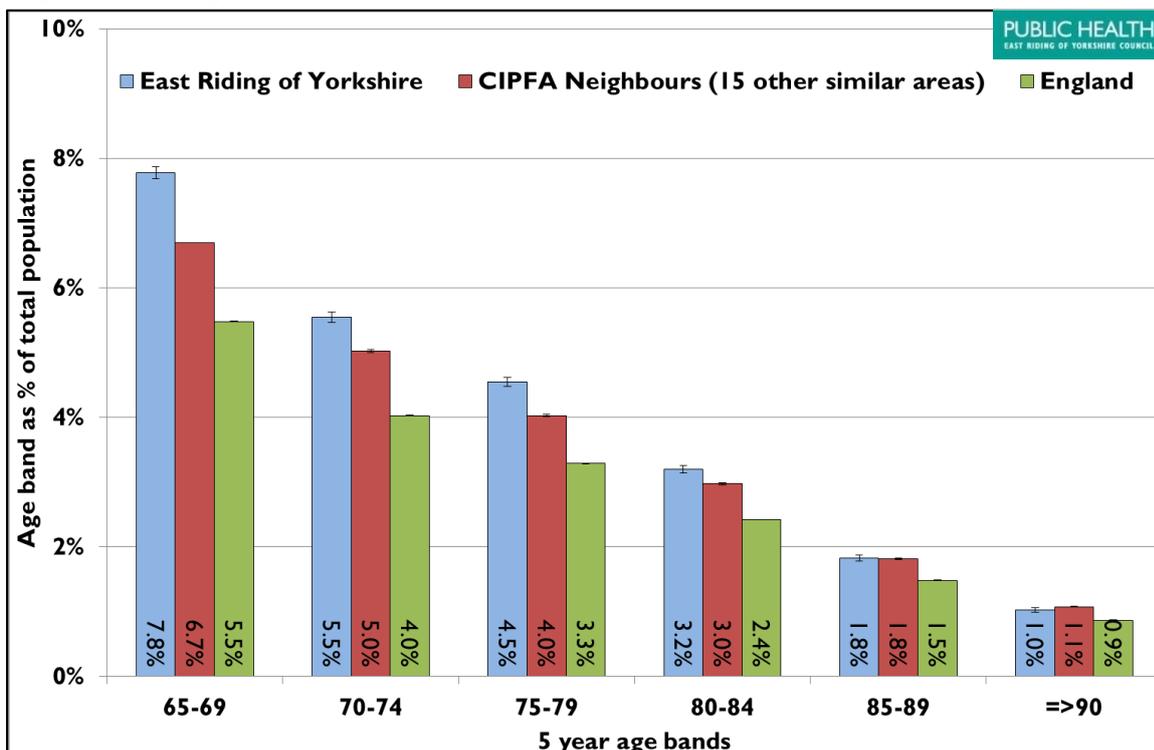


Chart 1.3 gives an alternative view of the same information and includes the CIPFA neighbours average to compare against. In all of the age bands between 65-69 and 80-84, ERY has a significantly higher proportion than both England and the CIPFA group. Only at the 85-59 age group does the CIPFA proportion catch and then overtake that of the ERY.

Chart 1.3 Five year age bands (65+ years of age, males and females combined), ERY versus CIPFA neighbours and England, mid-year 2014. Source: ONS



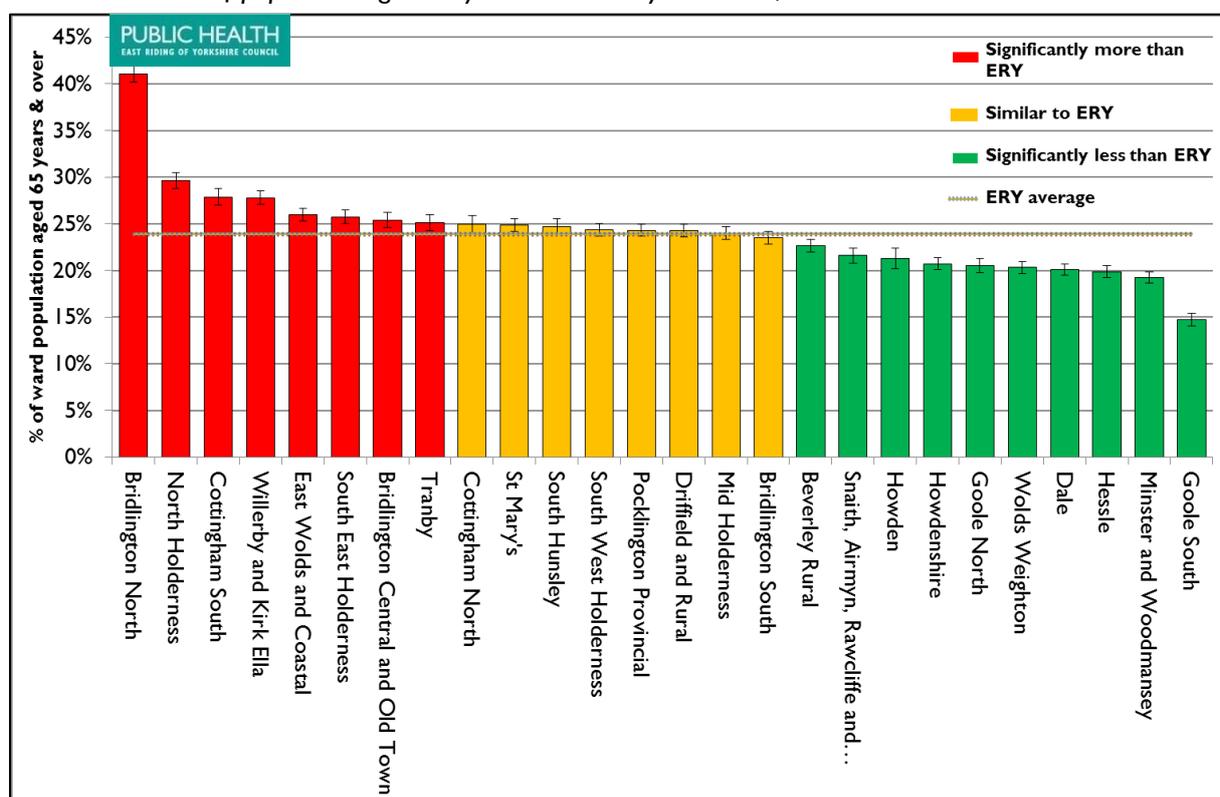
1.2 Ward populations - proportions 65 years & over by ward

The wards with the largest numbers of residents aged 65 years and over are: Bridlington North (5,410), Pocklington Provincial (3,944) and St. Marys (3,908). 16 of the 26 wards have in excess of 3,000 people in this age group. The wards with the smallest number of residents older residents are Howden (1,080) and Goole South (1,568). Table A1.2 in the appendix file displays the population for all ERY wards.

Chart 1.4 displays this age group as a proportion of the total ward population, as estimated by ONS for 2014. There are 8 wards with a significantly higher proportion of 65+ year olds than the ERY average and these are represented by the red bars. Bridlington North has the highest proportion (41.1%) which is over 11% higher (absolute difference) than the next highest ward (North Holderness) at 29.6%.

Those wards with a significantly lower proportion than the ERY average, are shaded green and range from Beverley Rural (22.7%) to Goole South (the ward with the lowest proportion) at 14.7%.

Chart 1.4 Percent of population aged 65 years and over by ERY ward, 2014. Source: ONS



1.3 Population projections

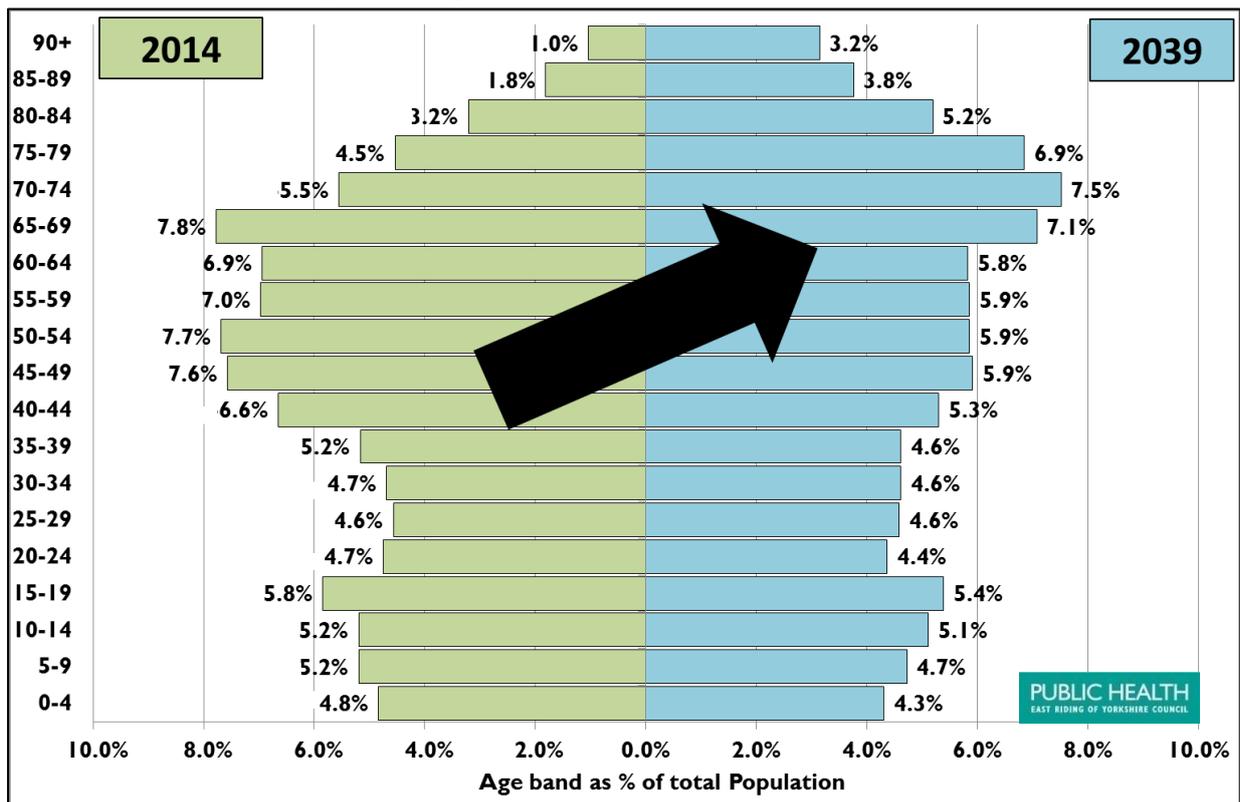
Chart 1.5 displays the estimated ERY population in 2014 and projected population in 2039, using 5 year age bands.

The black arrow on the chart indicates the shift in the population “bulge” with the highest proportions of the ERY population moving towards 65 years of age and over by 2039. The age groups representing children (0-19) suggest a decrease between 2014 and 2039.

Chart 1.6 highlights the 65-84 and 85+ age groups in the same period. The anticipated rise in 65-84 year olds is from 21% of the population (71,000 people) in 2014, to 27% (96,400 people) in 2039. 85+ year olds are projected to rise from 3% to 7% of the population (increasing from 9,600 to 25,000 people).

It should be noted that population projections do become less accurate over a longer period of time such as this, however it was considered useful to illustrate what ONS had calculated as the future population of ERY.

Chart 1.5 ERY local authority population structure displayed as 5 years bands in 2014 and projected to 2039. Source: ONS 2014 Population Projections.



The proportion of people aged over 65 is expected to increase at a much higher rate than the national average and this is shown in chart 1.7. This shows that between 2014 and 2039, the proportion of 65+ year olds in ERY is projected to rise from nearly 24% to 33.5% (an absolute difference of 9.5%). During the same period for England, it is projected to rise from approximately 18% to only 24% (an absolute difference of 6%).



Chart 1.6 65-84 and 85+ years olds in ERY, as a percent of total ERY local authority population, projected to 2039 (numbers of people in brackets). Source: ONS 2014 Population Projections.

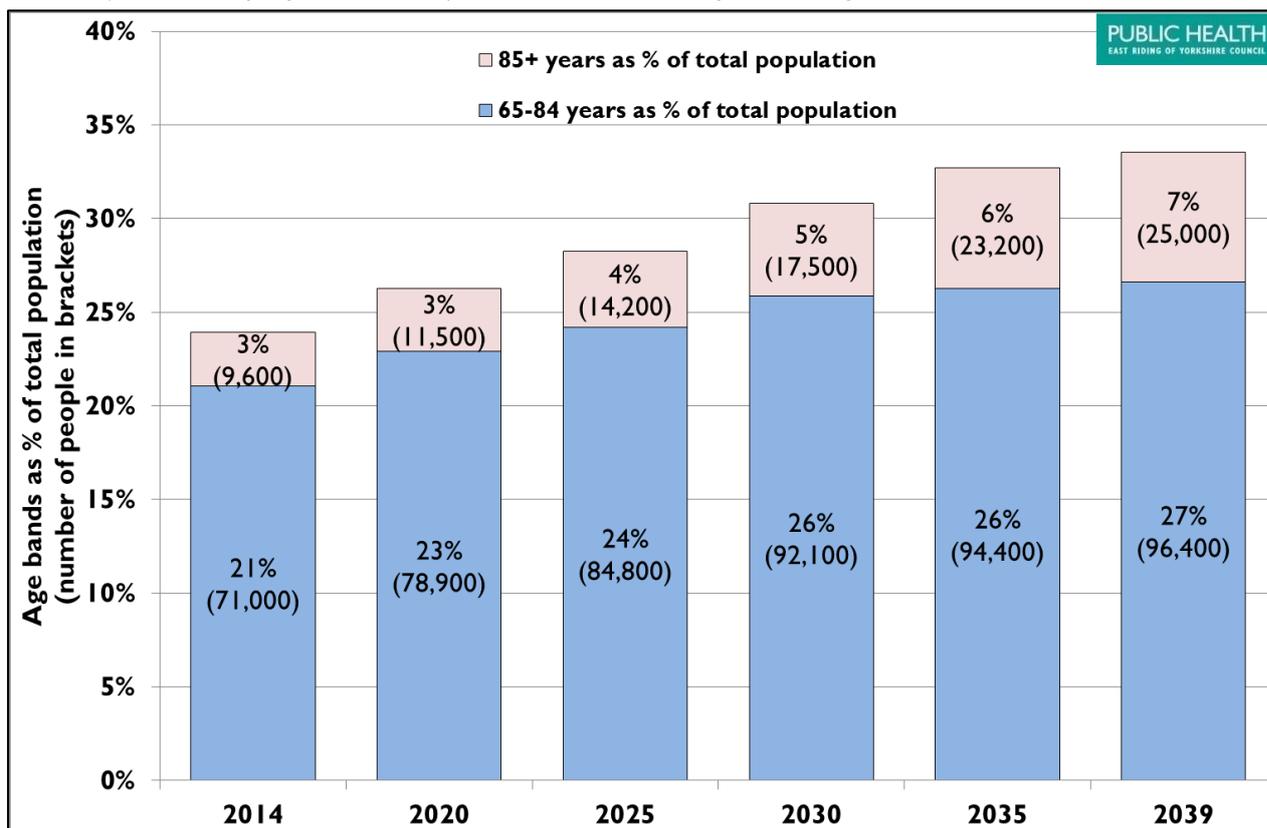
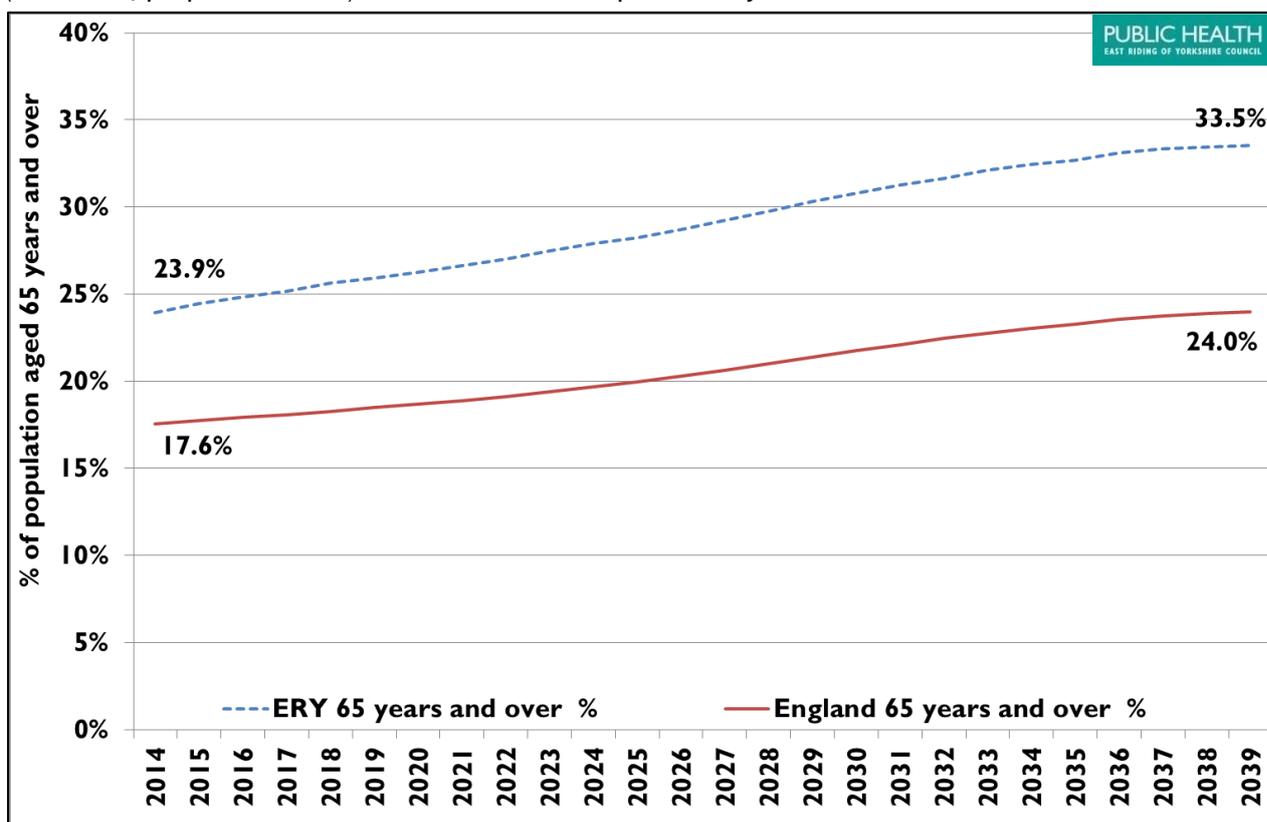


Chart 1.7 65+ years olds in ERY and England as a percent of total respective populations, projected to 2039 (numbers of people in brackets). Source: ONS 2014 Population Projections.



2. Healthy and independent living – living arrangements

This section starts with a focus on some of the characteristics of the local population using Customer Insight and then explores a number of wider determinants of health. The section concludes with a local perspective on potential isolation and loneliness in ERY.

2.1 Customer Insight by Experian

Experian's Mosaic Public Sector tool (using information gathered from a variety of sources) is an illustrative approach in describing the local population. Twelve bespoke segments for the East Riding of Yorkshire have been created (built up from household level data) and are illustrated in this section.

Image 2.1 describes each of these segments by providing a summary of the key characteristics associated with each of the populations. On the next page, table 2.2 displays what proportion the segments makes up of the wards population.

The segments that are of particular interest to this document are listed below, with details of which wards have the highest proportions:

- **Older with support needs**
 - *Characteristics:* supported with benefits, high health care needs, older singles.
 - *Wards with high prevalence:* Bridlington South, South East Holderness, Bridlington Central and Old Town.

- **Retired with support needs**
 - *Characteristics:* high health needs, elderly singles, social housing, high community transport users.
 - *Wards with high prevalence:* Bridlington North, Cottingham South, South West Holderness, Bridlington Central and Old Town.

- **Settled retirement singles**
 - *Characteristics:* health issues related to age, elderly singles.
 - *Wards with high prevalence:* Cottingham North, Beverley Rural, South Hunsley.

- **Rural community**
 - *Characteristics:* rural coastal areas, older singles or couples.
 - *Wards with high prevalence:* East Wolds and Coastal, Bridlington North, North Holderness, Wolds Weighton.

Maps visually displaying how the Customer Insight segments are dispersed amongst ERY wards, can be found in the Locality Profile documents on the JSNA website. (Please access them here: <http://dataobs.eastriding.gov.uk/jsna/hwbprofiles>, then go to the Local Area Profiles subsection).



Image 2.1 East Riding Segments. Source East Riding of Yorkshire Data Observatory

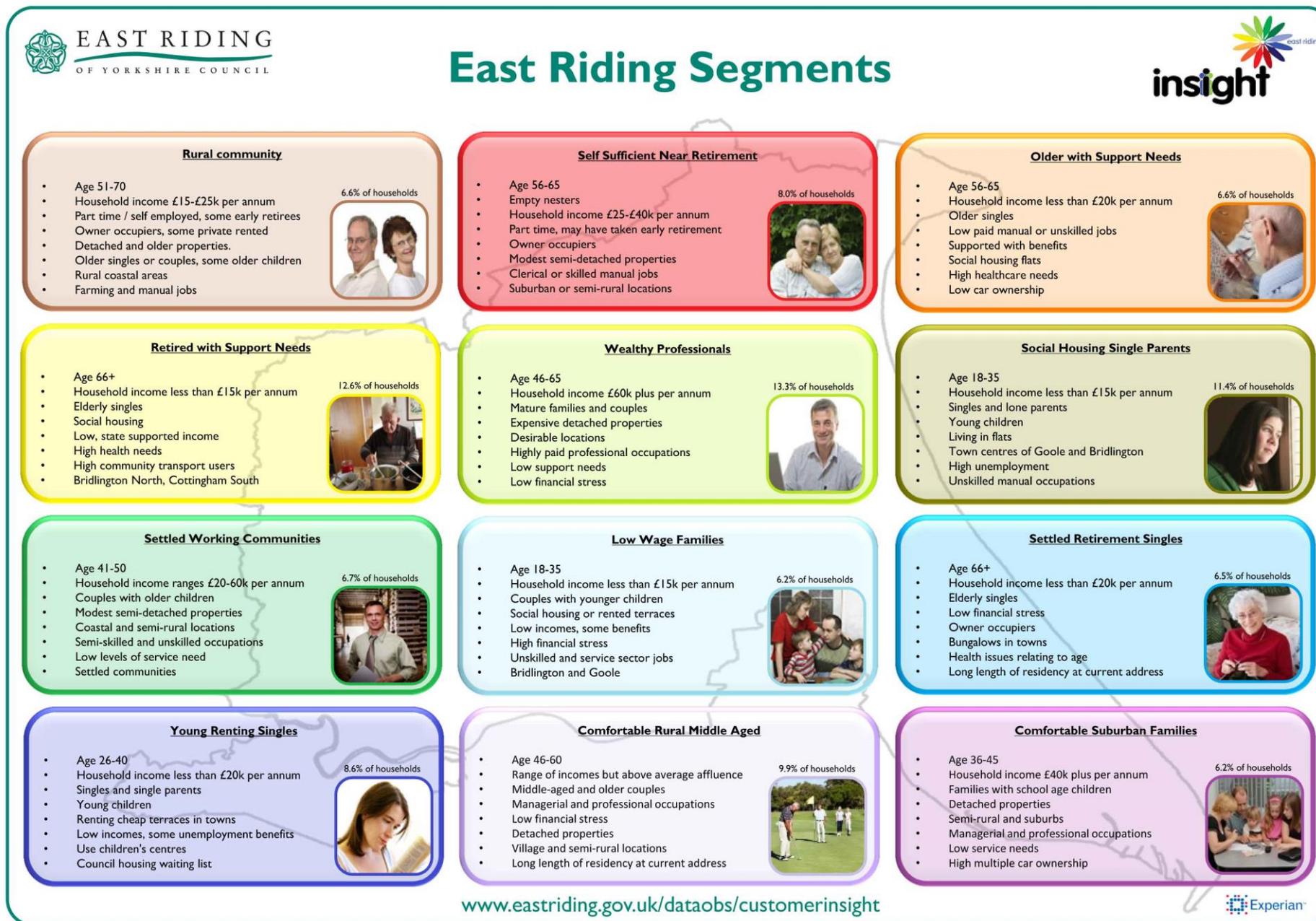


Table 2.2 Mosaic segmentation proportions by ward, 2015. Source: East Riding of Yorkshire Data Observatory.

Ward	Rural community	Self-sufficient near retirement	Older with support needs	Retired with support needs	Wealthy professionals	Social housing single parents	Settled working communities	Low wage families	Settled retirement singles	Young renting singles	Comfortable rural middle aged	Comfortable suburban families
Beverley Rural Ward	5.5%	10.1%	0.2%	3.1%	30.6%	2.3%	9.5%	0.0%	14.2%	3.4%	14.3%	6.9%
Bridlington Central and Old Town Ward	7.3%	1.7%	7.4%	21.2%	0.5%	26.2%	5.7%	18.1%	1.3%	6.5%	2.9%	1.1%
Bridlington North Ward	18.4%	6.3%	5.4%	32.6%	4.7%	3.8%	10.0%	1.0%	7.7%	3.2%	6.2%	0.8%
Bridlington South Ward	2.8%	2.1%	14.3%	9.6%	2.2%	28.8%	3.1%	20.4%	2.8%	7.0%	5.4%	1.4%
Cottingham North Ward	1.3%	13.8%	6.1%	6.5%	23.3%	4.0%	2.3%	1.0%	15.3%	10.5%	13.5%	2.4%
Cottingham South Ward	0.0%	10.4%	4.6%	23.0%	12.6%	11.4%	1.4%	3.5%	10.5%	13.2%	7.5%	1.7%
Dale Ward	1.0%	8.2%	1.1%	6.0%	25.3%	15.0%	3.7%	0.5%	11.2%	3.9%	8.3%	15.7%
Driffield and Rural Ward	5.5%	5.8%	3.6%	20.7%	6.0%	10.0%	6.9%	9.0%	5.0%	11.5%	7.9%	8.2%
East Wolds and Coastal Ward	33.2%	2.7%	1.7%	8.7%	9.8%	1.4%	18.3%	0.9%	5.4%	2.8%	13.1%	2.0%
Goole North Ward	0.4%	6.3%	4.5%	20.2%	3.1%	16.9%	1.6%	16.4%	3.7%	17.0%	4.3%	5.6%
Goole South Ward	0.4%	2.7%	6.4%	12.5%	0.7%	21.9%	0.8%	29.0%	0.8%	22.2%	1.8%	0.8%
Hessle Ward	0.0%	7.9%	2.8%	9.3%	13.0%	21.8%	0.1%	6.3%	3.0%	23.6%	5.1%	6.9%
Howden Ward	2.3%	6.0%	3.8%	8.8%	18.3%	9.1%	8.2%	6.7%	7.1%	8.5%	14.6%	6.6%
Howdenshire Ward	13.3%	5.6%	1.0%	12.1%	18.1%	6.3%	14.6%	0.4%	7.0%	4.1%	12.5%	5.0%
Mid Holderness Ward	9.4%	13.8%	1.4%	17.1%	9.2%	4.6%	11.5%	0.5%	8.4%	3.2%	14.9%	6.0%
Minster and Woodmansey Ward	0.7%	5.1%	4.1%	7.6%	7.1%	17.4%	1.0%	10.3%	4.6%	19.0%	10.4%	12.6%
North Holderness Ward	15.4%	4.0%	6.9%	18.1%	7.6%	4.8%	11.5%	6.4%	6.6%	6.4%	11.4%	1.0%
Pocklington Provincial Ward	2.4%	7.9%	2.8%	7.7%	21.8%	11.2%	7.0%	1.4%	10.4%	4.2%	13.0%	10.2%
Snaith, Airmyn, Rawcliffe and Marshland Ward	6.9%	8.2%	3.3%	8.9%	9.6%	4.3%	17.9%	6.6%	9.0%	5.9%	12.3%	7.3%
South East Holderness Ward	15.2%	3.9%	8.1%	17.9%	2.8%	9.8%	12.4%	10.6%	4.2%	4.8%	9.7%	0.7%
South Hunsley Ward	0.1%	8.8%	0.6%	3.9%	46.3%	5.5%	2.8%	0.0%	11.9%	1.6%	13.6%	4.8%
South West Holderness Ward	1.9%	10.7%	3.3%	22.5%	4.4%	12.1%	9.9%	2.7%	6.5%	9.8%	8.3%	7.9%
St. Mary's Ward	0.0%	12.8%	2.8%	11.2%	17.2%	11.9%	0.1%	2.4%	6.4%	10.9%	14.3%	10.0%
Tranby Ward	0.0%	15.6%	4.9%	20.5%	10.7%	12.7%	0.2%	8.4%	4.5%	12.6%	6.9%	3.2%
Willerby and Kirk Ella Ward	0.0%	16.2%	1.5%	11.7%	33.4%	5.9%	0.7%	0.1%	11.4%	5.5%	8.1%	5.5%
Wolds Weighton Ward	15.4%	4.4%	2.4%	6.9%	16.6%	7.9%	10.6%	1.7%	4.3%	4.7%	18.6%	6.6%
East Riding	6.5%	7.6%	4.0%	13.4%	13.3%	11.3%	6.7%	6.1%	6.9%	8.5%	9.9%	5.8%

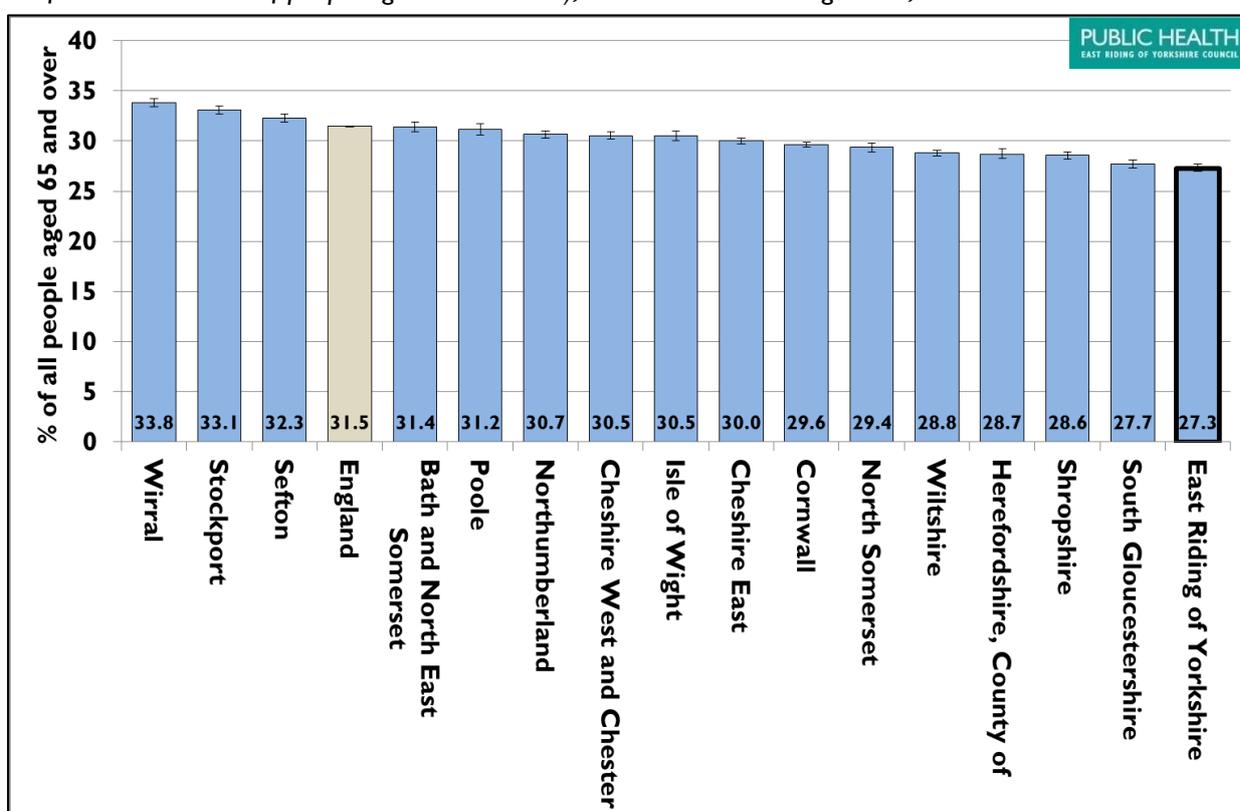
2.2 Older people living alone

Living alone is one of many risk factors that can contribute to feelings of loneliness. It is well documented that loneliness has a major detrimental impact on both physical and mental health.

On Census night 2011, there were 19,540 people (aged 65 years or over) in ERY living alone. This equated to 27.3% of the total population in that age group of 71,455. In comparison with England, ERY has a significantly lower proportion, with the national average reported to be 31.5%.

Chart 2.3 shows ERY to be the local authority with the lowest proportion of 65+ year olds living alone in its CIPFA group. The ERY value of 27.3% is significantly lower than every other value in the chart, bar South Gloucestershire (27.7%). Wirral had the highest value of all the CIPFA neighbours at 33.8%.

Chart 2.3 Older People Living Alone, aged 65+ years (Number of people aged 65 and over living alone as a % of the total number of people aged 65 and over), ERY versus CIPFA neighbours, 2011. Source: PHE



It is also possible to look at the number of older people living alone, from a sub-authority perspective such as wards. Table 2.4 presents the count and proportions of residents by ward (sorted in descending order by count) revealing Bridlington North to have had the highest count of residents living alone aged 65+ (n=1,268) and Howden the fewest (n=258).

Chart 2.5 focusses on the proportions by ward of this particular population. Goole South is observed to have the highest percentage at almost 36%, this value is significantly higher than every other ERY ward, except two. At the other extreme Snaith has the lowest ERY ward value of 22.2%.

Seven wards have a significantly higher proportion of 65+ years olds living alone compared to the ERY average (St. Marys ward and all those to the left of it on the chart). Whilst there are eight

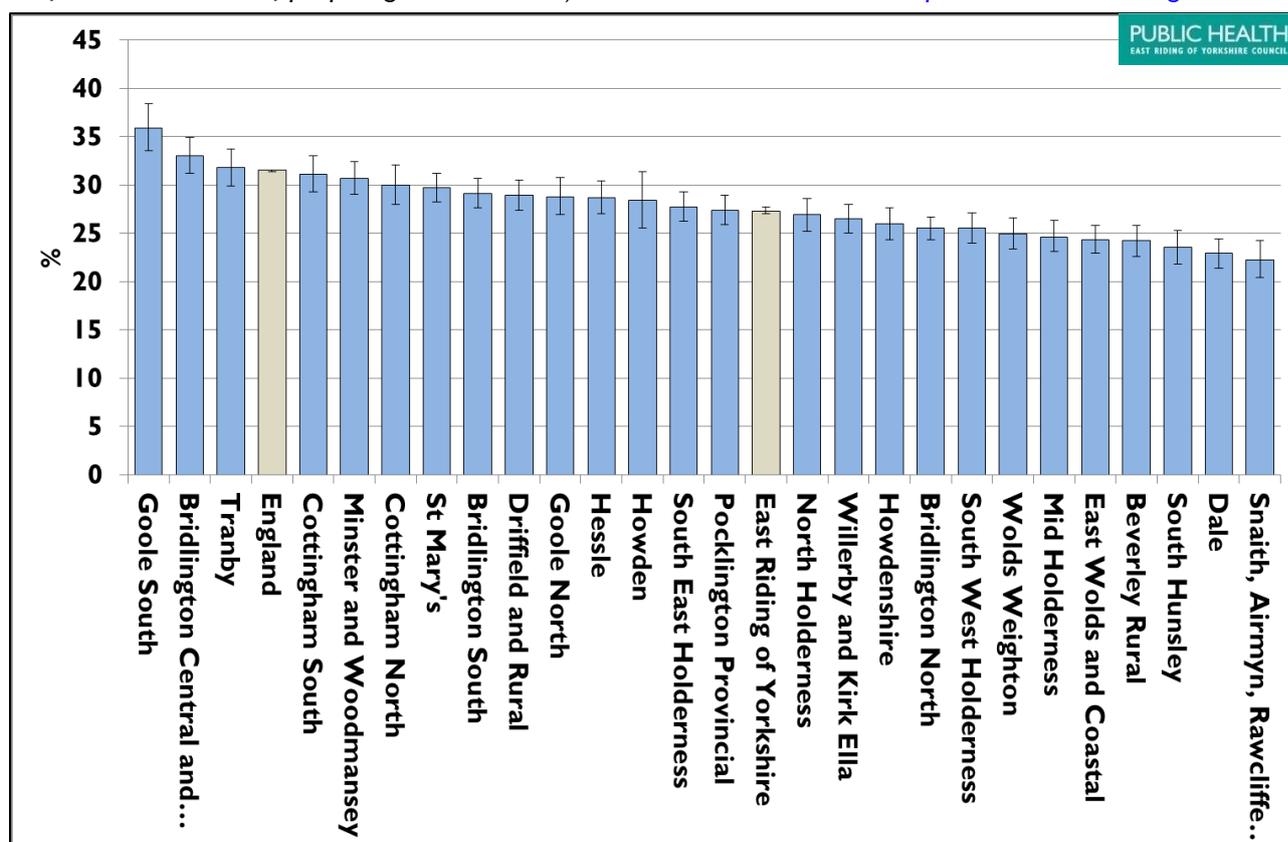


wards with a significantly lower proportion compared with the ERY average. All but three ERY wards have a lower proportion in comparison with the England average.

Table 2.4 Older People Living Alone, aged 65+ years (no. of people 65+ living alone as a % of total population aged 65+). ERY wards, 2011. Source: <http://www.localhealth.org.uk>

ERY wards - top half (by count)				ERY wards - bottom half (by count)			
Ward name	Number	All 65+ year olds	% Living alone	Ward name	Number	All 65+ year olds	% Living alone
Bridlington North	1,268	4,975	25.5%	North Holderness	715	2,660	26.9%
St Mary's	1,047	3,528	29.7%	Wolds Weighton	708	2,840	24.9%
Driffield and Rural	950	3,282	28.9%	Tranby	701	2,207	31.8%
Bridlington South	936	3,217	29.1%	Howdenshire	701	2,701	26.0%
South East Holderness	935	3,373	27.7%	Dale	698	3,048	22.9%
Pocklington Provincial	934	3,407	27.4%	Mid Holderness	695	2,820	24.6%
Willerby and Kirk Ella	887	3,351	26.5%	Beverley Rural	665	2,750	24.2%
Minster and Woodmansey	853	2,783	30.7%	Goole North	599	2,082	28.8%
Bridlington Central/O.T.	827	2,507	33.0%	Cottingham North	568	1,894	30.0%
East Wolds and Coastal	812	3,341	24.3%	Goole South	534	1,487	35.9%
Hessle	789	2,749	28.7%	South Hunsley	531	2,263	23.5%
South West Holderness	769	3,015	25.5%	Snaith, Airmyn...	417	1,876	22.2%
Cottingham South	743	2,389	31.1%	Howden	258	910	28.4%

Chart 2.5 Older People Living Alone, aged 65+ years (Number of people aged 65 and over living alone as a % of the total number of people aged 65 and over), ERY wards, 2011. Source: <http://www.localhealth.org.uk>



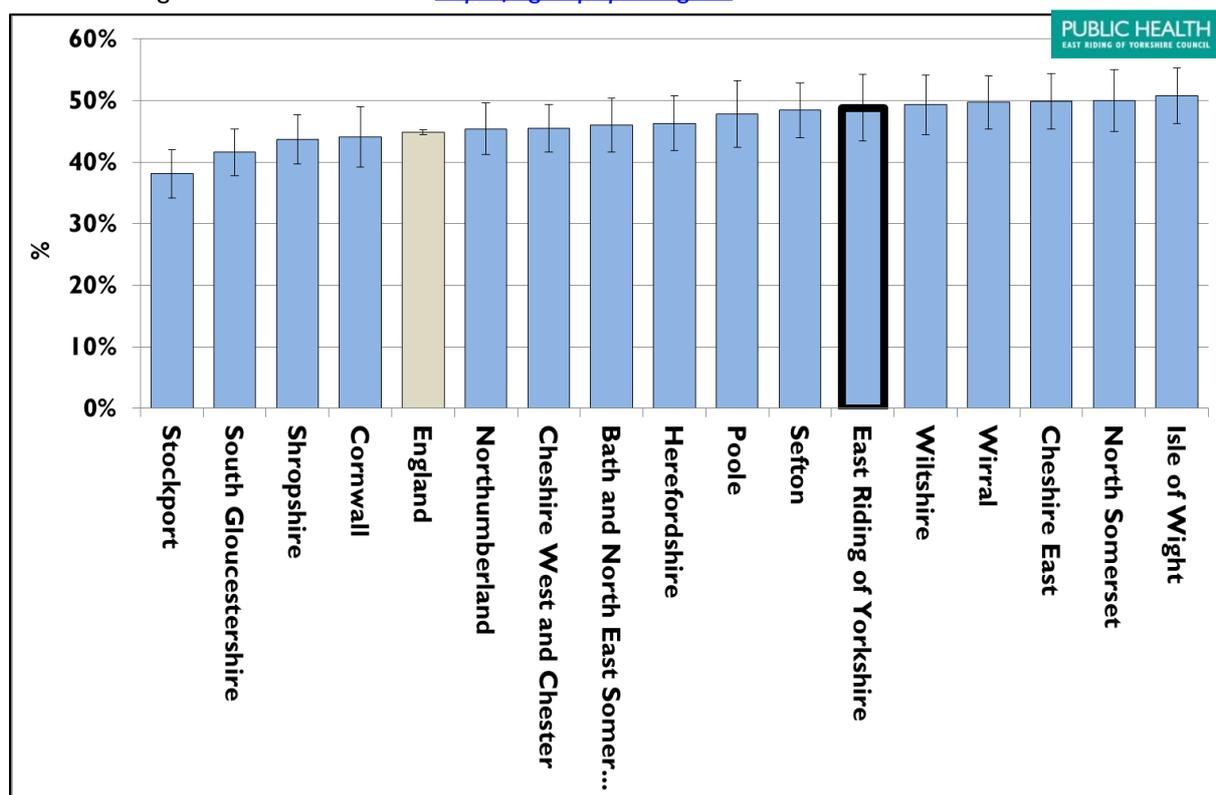
2.3 Adult social care users who have as much social contact as they would like

Enabling residents to remain connected to friends, families and the wider community is key in helping to help prevent loneliness. Whilst this indicator is not exclusive to just the elderly, with the population denominator stating any adults aged 18 years of age and over, the majority of adult care users are expected to fall within the elderly age groups. The source of the data is from self-reported levels of social contact, via the Adult Social Care Survey.

Comparison with other CIPFA neighbours places ERY within the top half of the group, see chart 2.6. Its value of 49% (of social care users receiving as much social contact as they would like) placed it as the 6th highest local authority on the chart, which was also higher (but not significantly) than the England average of 45%. Values in the CIPFA group, ranged from 39% in Shropshire to 50% in Northumberland.

Limited trend data (between 2010/11 and 2014/15) show values relating to ERY residents have remained relatively static, at about 49%. When compared with England in the same four period, ERY has had a greater proportion of adults social care users receiving the desired level of social contact.

Chart 2.6 Adult social care users who have as much social contact as they would like, ERY compared to CIPFA and England. 2014/15. Source: <http://fingertips.phe.org.uk/>



2.4 Income deprivation affecting older people

This indicator is a measure of older people living in poverty and calculates adults aged 60 years or over living in pension credit households as a proportion of all aged 60+ year olds. It is a subset of the domain “Income Deprivation”, which calculates the percentage of the population experiencing deprivation, in relation to low income. The indicator includes those adults over 60 who receive:



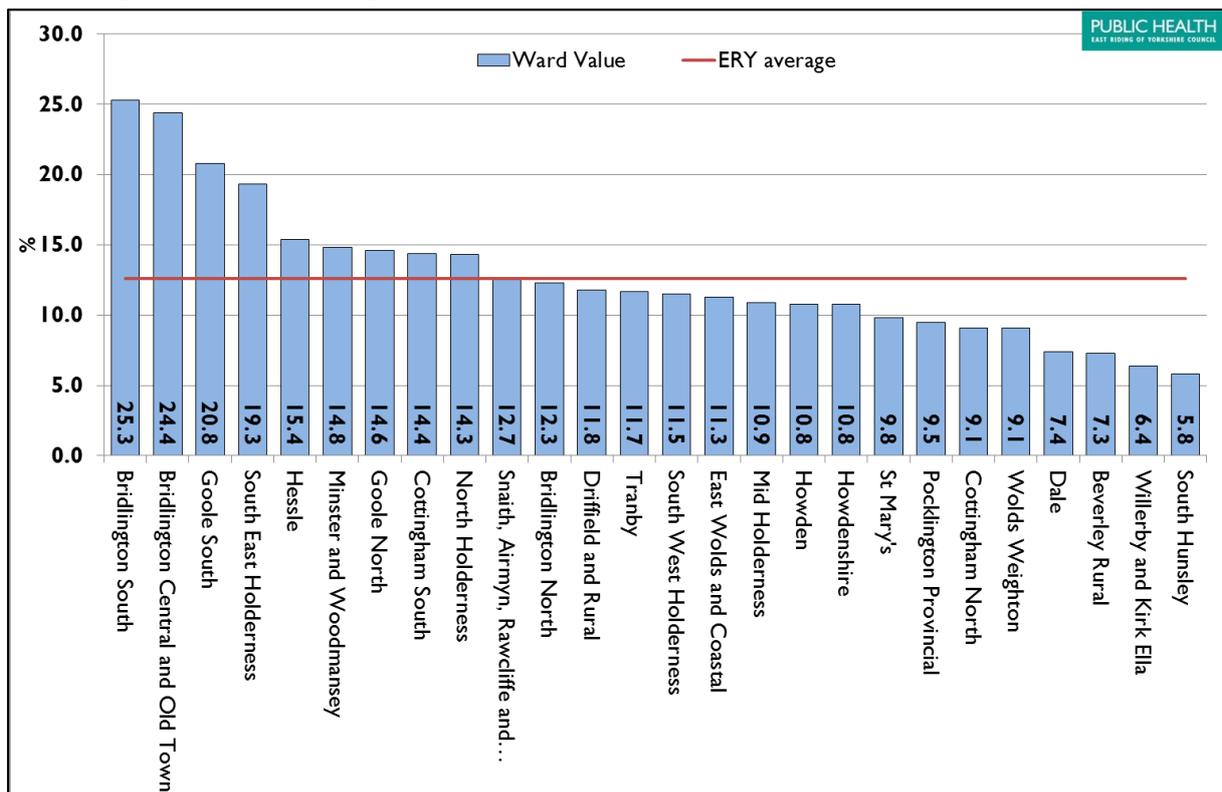
- Income Support
- Income-based Jobseekers Allowance
- Income-based Employment and Support Allowance or Pension Credit (Guarantee).

Nationally it is estimated that there are nearly two million residents aged over 60 living in income-deprived households, as proportion this represents 16.2% of the population (aged 60+ years). Within ERY the estimate is approximately 12,700 residents of the same age, equating to 12.6%, which is significantly lower than the England average. When ERY is compared to CIPFA neighbours, ERY is centrally placed amongst them, with values ranging from 10.2% in Cheshire East to 19.2% in Sefton.

The values for ERY wards (no confidence intervals were provided in the original data source to enable statistical comparison) are shown in chart 2.9, with four wards noticeably experiencing a higher proportion of older people living in poverty (Bridlington South, Bridlington Central and Old Town, Goole South and South East Holderness). At the other extreme, wards such as South Hunsley, Willerby and Kirk Ella and Beverley Rural appear well below the ERY average.

Chart 2.9 Income Deprivation Affecting Older People (60+ years), 2015, 60+ years of age.

Source: <http://www.localhealth.org.uk/>



2.5 Unpaid carers aged 65+ years of age

Current Looking after or giving help to friends and family without being in receipt of payment, classifies a person as an unpaid carer. The duration of being an unpaid carer might be short term (for example looking after someone recently admitted to hospital) or long term (assisting with physical or mental disabilities). The work of unpaid carers saves local authorities and local health



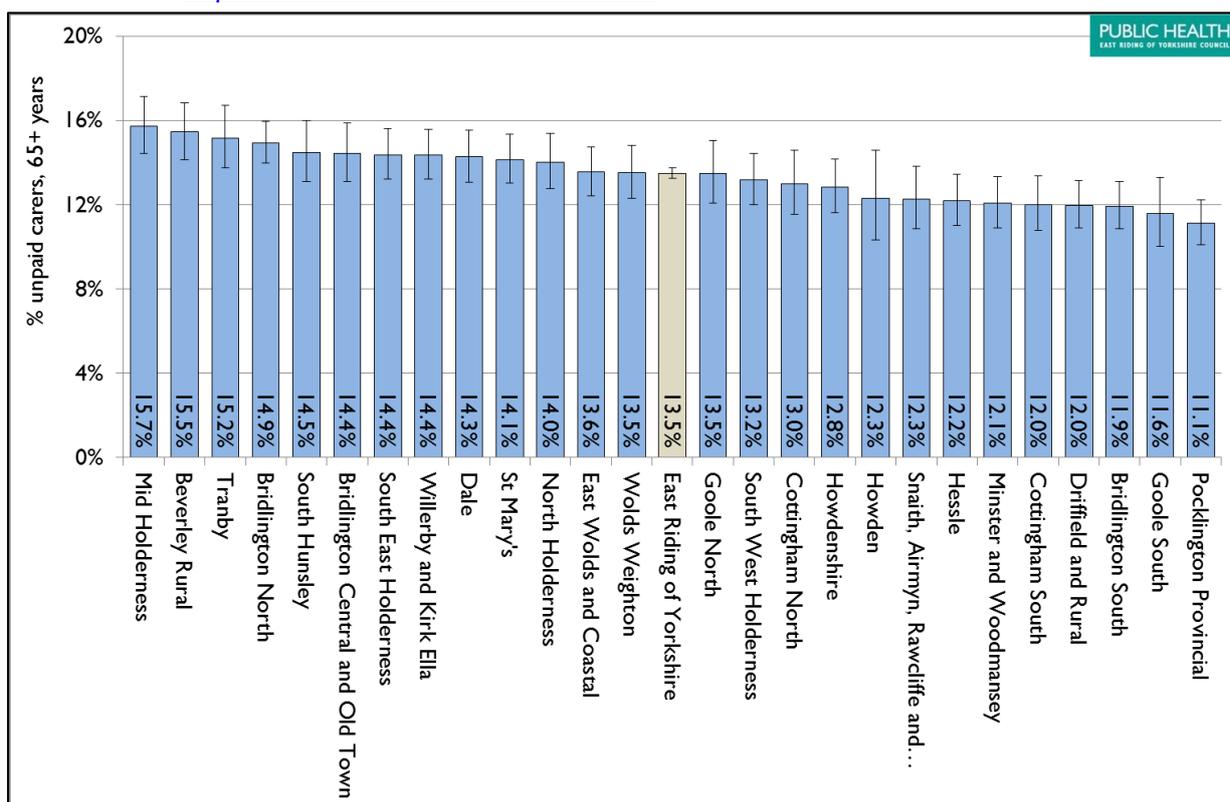
services millions of pounds every year, however not all unpaid carers will be known to health and social care sector. There is no guarantee that these carers are sufficiently supported through appropriate support services, nor aware of their entitlements. This section looks at those unpaid carers specifically aged 65 years of age or over.

It is estimated in 2011 that ERY had almost 10,000 unpaid carers of this age group. The proportion of unpaid carers aged 65+ in ERY (13.5%) is lower (but statistically similar) to the England average of 13.8%. ERY has the third lowest value compared to the other local authorities in the CIPFA group, ranging from 12.9% in Northumberland to 15.1% in South Gloucestershire.

The same indicator is examined at a ward level within ERY, in chart 2.10. Pocklington Provincial has the lowest proportion of unpaid carers aged 65+ at 11.1% and is the only ward that is significantly lower than the ERY average. At the other end of the scale Mid Holderness had the highest proportion (15.7%), this ward along with Beverley Rural (15.5%) and Bridlington North (14.9%), has a significantly higher proportion than the ERY average. In terms of numbers; the five wards with the highest numbers of unpaid carers aged 65+ are Bridlington North (n=743), St Mary's (n=499), South East Holderness (n=485), Willerby and Kirk Ella (n=481) and East Wolds and Coastal (n=453).

Chart 2.10 Unpaid Care by 65+ year olds as a proportion of all 65+ years, 2011. ERY wards.

Source: NOMIS <https://www.nomisweb.co.uk/census/2011/>



2.6 Unpaid care by 65+ year olds projected to 2030

The POPPI website has projected that the number of unpaid carers aged 65 and over in ERY will increase to approximately 15,000 people by 2030. This is almost a 28% increase on the 11,500 unpaid carers of this age group estimated to be within ERY in 2015.

The percent increase from 2015 to 2030, predicted for England as a whole, is higher at over 32%. Please see table 2.11 which compares ERY to England overall.

Table 2.11 Unpaid Care by 65+ year olds in ERY, projected to 2030. Source: <http://www.poppi.org.uk/>

Area	Number of carers (65+) by year				% Increase from 2015		
	2015	2020	2025	2030	2020	2025	2030
ERY	11,620	12,512	13,552	14,848	7.7%	16.6%	27.8%
England	1,384,497	1,497,552	1,642,547	1,832,479	8.2%	18.6%	32.4%

2.7 Isolation and loneliness – a local estimate based on selected criteria

In the paragraph below, Public Health England highlight the relevance of loneliness to overall health:

“There is clear link between loneliness and poor mental and physical health. A key element of the Government's vision for social care is to tackle loneliness and social isolation, supporting people to remain connected to their communities and to develop and maintain connections to their friends and family. This measure will draw on self-reported levels of social contact as an indicator of social isolation for both users of social care and carers.”

Public Health England, Public Health Profiles, 2016

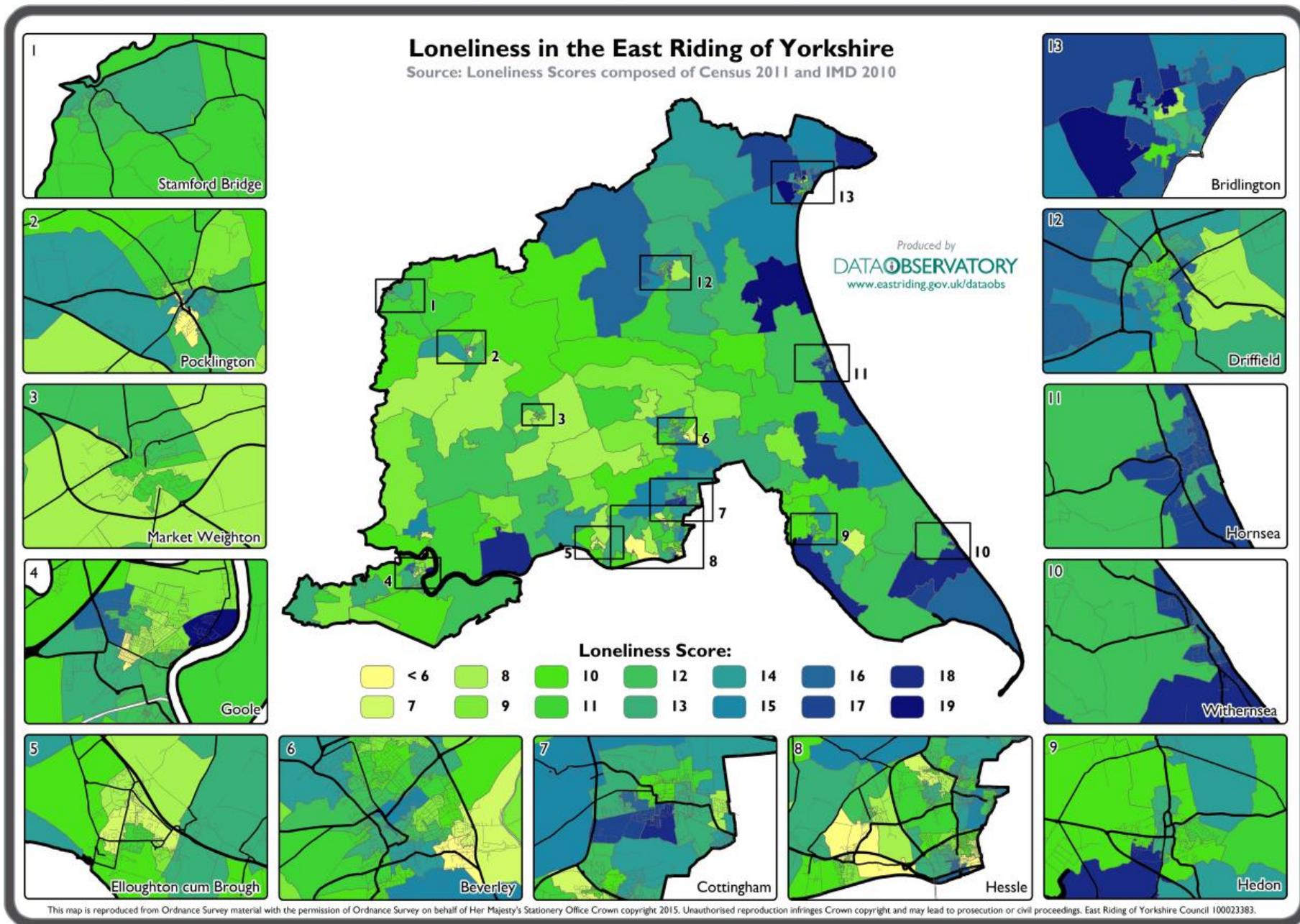
Map 2.12, created by the Data Observatory, tries to illustrate potential loneliness within ERY LSOAs, based on a ranking system using a combination of the following criteria:

- One person household Age 65 and over
- Day to day activities limited a lot
- Day to day activities limited a little
- IMD barriers to Housing and Services

The darker areas highlight there being a more likely chance of loneliness based on the criteria above, with coastal areas noticeably identified. In the South West of ERY, areas such as North Goole and Broomfleet are visibly darker on the loneliness scale. Moving east: Paull, Withernsea, Barmston and Carnaby are identified. Inland, an area south of Cottingham is highlighted.



Map 2.12 Map of potential loneliness in East Riding of Yorkshire. Higher score indicates higher chance of loneliness. Source: ERY Data Observatory



2.8 Urban and rural areas in ERY

The impact of rural living on the elderly can be difficult, as it may impact on the ability (for example) shop for food with limited facilities in the area or limit their ability to socialise due to transportation limitations.

Maps A5.3 and A5.4 (in the appendix, page 43 and 44) both display the spread of rural and urban classification across the ERY. The former map displays the names of the major towns and built up areas in ERY, whilst the latter map displays the names of the wards.

Using either map (as they display the same information, except for the labels) it is easy to see that ERY is predominantly made up of the two rural classifications: “rural hamlets” and “isolated dwellings and rural villages”. The other two categories (“rural town and fringe” and “urban city and town”) do exist within ERY but tend to be small pockets scattered around the local authority area.

2.9 Households with no car or van ownership

In a rural area, access to some form of transport to connect with the friends and family living elsewhere, is essential.

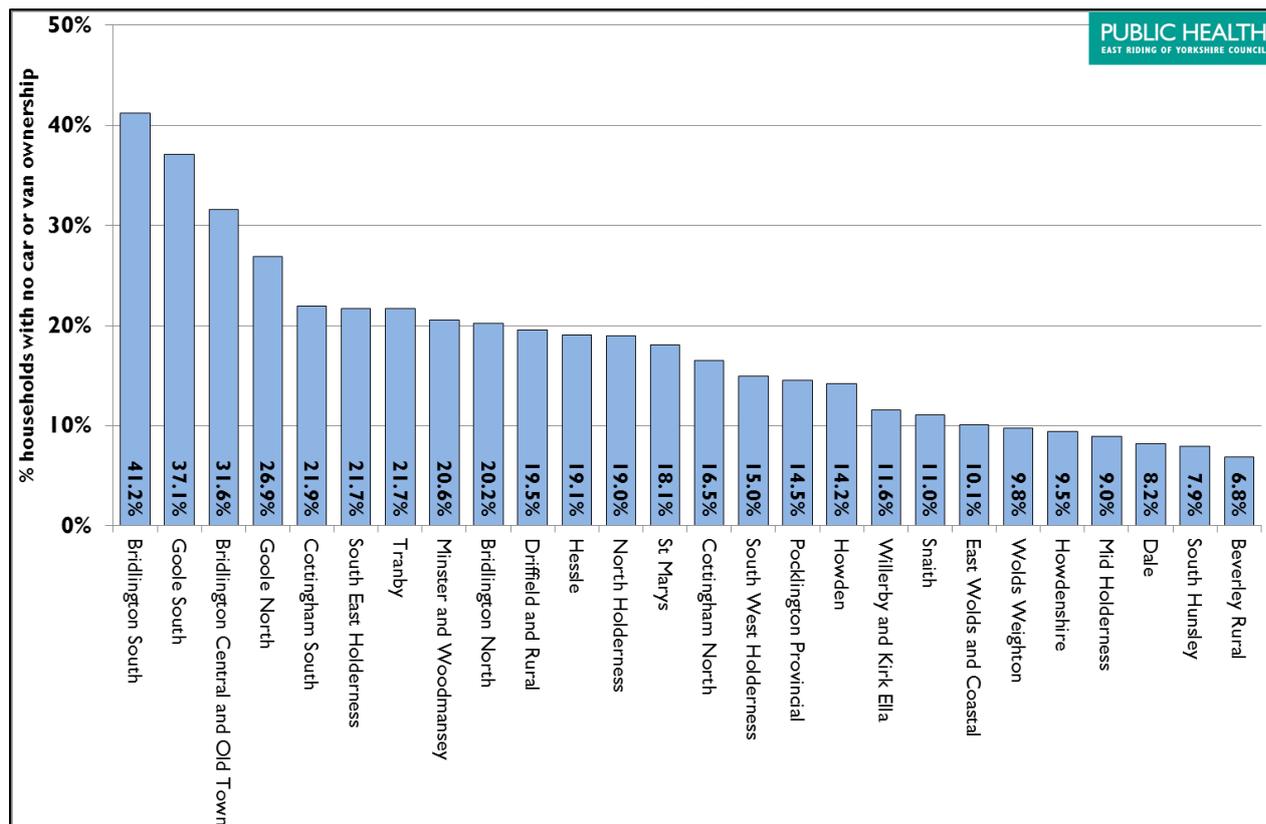
Table 2.13 below, shows the number of people in each ERY ward and the percent of households within each ward, not in ownership of a car or van. Chart 2.14 on the next page illustrates the percent of each wards population without car or van ownership. The chart is shown in descending order and the four wards with the highest proportion of no car/van ownership include Bridlington South (41%), Goole South (37%), Bridlington Central and Old Town (32%) and Goole North (27%).

Table 2.13 Percent of households with no car or van availability, 2011. Source: Census

Ward	Number	%	Ward	Number	%
Beverley Rural	398	7%	Howdenshire	585	9%
Bridlington Central & Old Town	1535	32%	Mid Holderness	524	9%
Bridlington North	1302	20%	Minster & Woodmansey	1462	21%
Bridlington South	2687	41%	North Holderness	854	19%
Cottingham North	568	17%	Pocklington Provincial	999	14%
Cottingham South	878	22%	Snaith	447	11%
Dale	580	8%	South East Holderness	1385	22%
Driffield and Rural	1293	20%	South Hunsley	328	8%
East Wolds and Coastal	626	10%	South West Holderness	931	15%
Goole North	1215	27%	St Marys	1276	18%
Goole South	1615	37%	Tranby	926	22%
Hessle	1203	19%	Willerby and Kirk Ella	657	12%
Howden	300	14%	Wolds Weighton	626	10%



Chart 2.14 Percent of households with no cars or van availability by ERY ward, 2011. Source: Census



2.10 Bus routes within East Riding of Yorkshire

Without access to private transportation, public transport becomes an essential local service. The PDF file titled “Public Transport Maps” on the JSNA website, displays bus routes within the East Riding of Yorkshire which are deemed to have suitable coverage throughout the day and evening. Suitable coverage means bus routes that have an outward journey before 9am and return journey leaving after 6pm. These services also run 6 days a week. The first map in the file shows an overall summary of these routes, whilst the maps that follow zoom in closer to show individual routes. The file can be accessed here: <http://dataobs.eastriding.gov.uk/resource/view?resourceId=446>.

2.11 Population Density in ERY

It is perhaps not surprising to find that as the majority of the ERY falls within the categories of “rural hamlets” and “isolated dwellings and rural villages” that the majority of the local authority area is sparsely populated.

Map A5.5 (in the appendix, page 45) shows ERY has overwhelmingly a population density of between 0.1-3.4 persons per hectare. The map does highlight and zoom into 13 major towns and villages within ERY, which show the variation in population density of these areas. Most of the areas highlighted around the edge of the main map are the main urban areas of ERY, all (with the exception of Stamford Bridge, Market Weighton, Hedon, Withernsea and Hornsea) contain population density which falls within the most dense category of 55-109.9 persons per category.



3. Healthy and independent living – life expectancy

3.1 Life expectancy at 65

Life expectancy at 65 is an estimate of the average number of years a 65 year old is expected to live for, if the current mortality rates for an area were to continue throughout his or her life.

Life expectancy can be calculated for any age (using the same methodology as life expectancy at birth), the difference is that *only* the mortality rates beyond the age chosen are used to calculate years of survival. For example life expectancy at 65 does not take account of mortality rates for those under 65 including infant and child mortality. The significance of using 65 years of age as an indicator is that it measures the estimated survival of those reaching pensionable age and whilst the default retirement age of 65 was abolished in 2011, the indicator is still frequently used.

Usually mortality rates (calculated from deaths from all causes and mid-year population estimates) are based on data aggregated over a three year period. Just as was the case with life expectancy at birth, the estimated number of years of life at 65 is not a guarantee, as the area's mortality rates will undoubtedly change at some point in the future and the individual could move to a different area.

3.2 Life expectancy at 65 - East Riding of Yorkshire (local authority)

Charts 3.1 and 3.2 show life expectancy at 65 for males and females respectively, comparing ERY to England in each chart. The latest life expectancy period available at a local authority level in this document is 2012-14. If a 65 year old today, in ERY experienced the ERY mortality rates of the period 2012-14 for their lifetime, then they would expect on average to live an additional 19.0 years (if male) or 20.9 (if female). The trend between 2002-04 and 2012-14 is upward for both genders, with ERY males seeing an increase from 16.4 years to 19 years between the two periods and females an increase from 19.2 to 21.1 years. Whilst male life expectancy at 65 in ERY appears to be continuing its steady climb and remaining above the England average male, for females the increase has flat lined (as it is has with England females).

Charts 3.3 and 3.4 compare ERY life expectancy at 65 with the CIPFA neighbours. It places ERY in the bottom third of the group for both genders. Values in the male group range from 18 years (Wirral) to 19.9 years (South Gloucestershire), with the ERY value statistically similar to England but significantly lower than the top four neighbouring local authorities. The females group ranges from 20.4 years (Wirral) to 22.2 years (South Gloucestershire) and finds ERY to be significantly lower than the top eight neighbours and the England average.



Chart 3.1 Life Expectancy at 65 - East Riding of Yorkshire males compared with England males. Pooled 3 year periods 2000-02 to 2012-14. Source: ONS

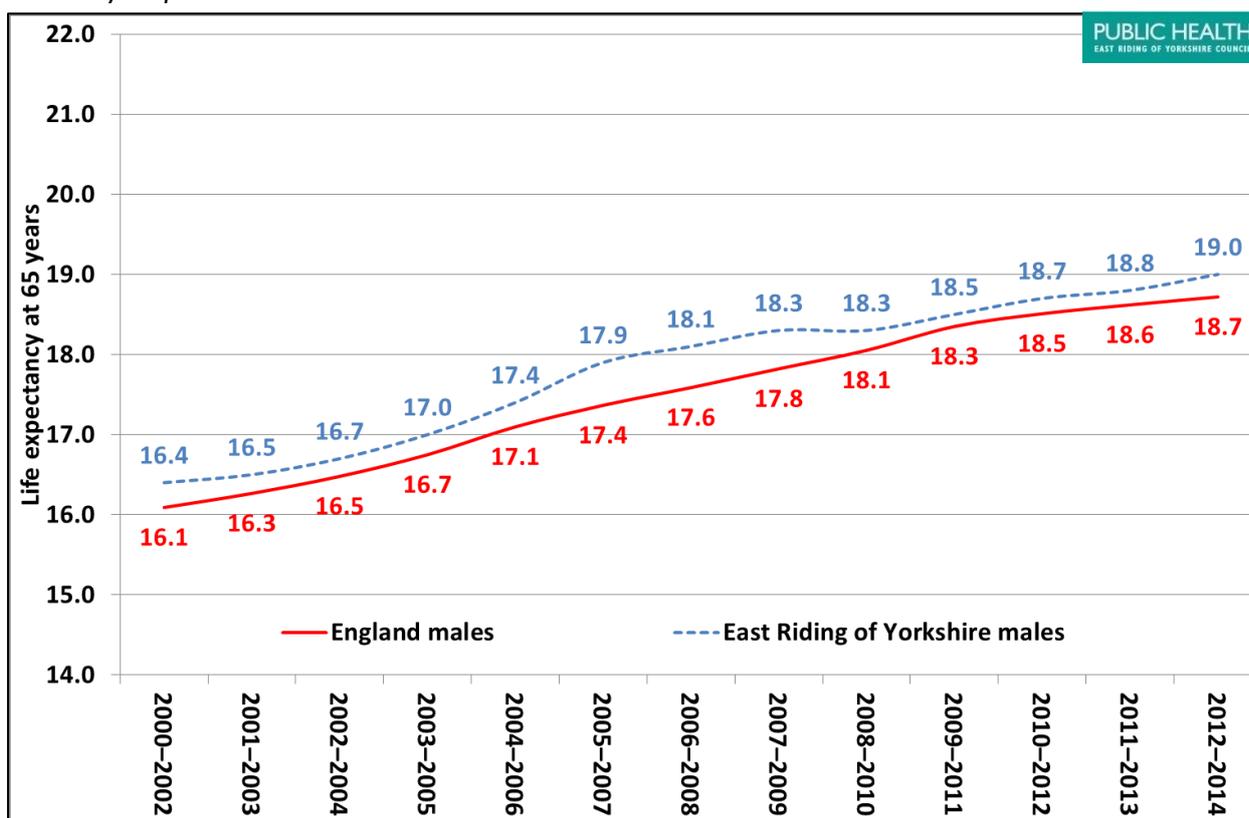


Chart 3.2 Life Expectancy at 65 – East Riding of Yorkshire females compared with England females. Pooled 3 year periods 2000-02 to 2012-14. Source: ONS

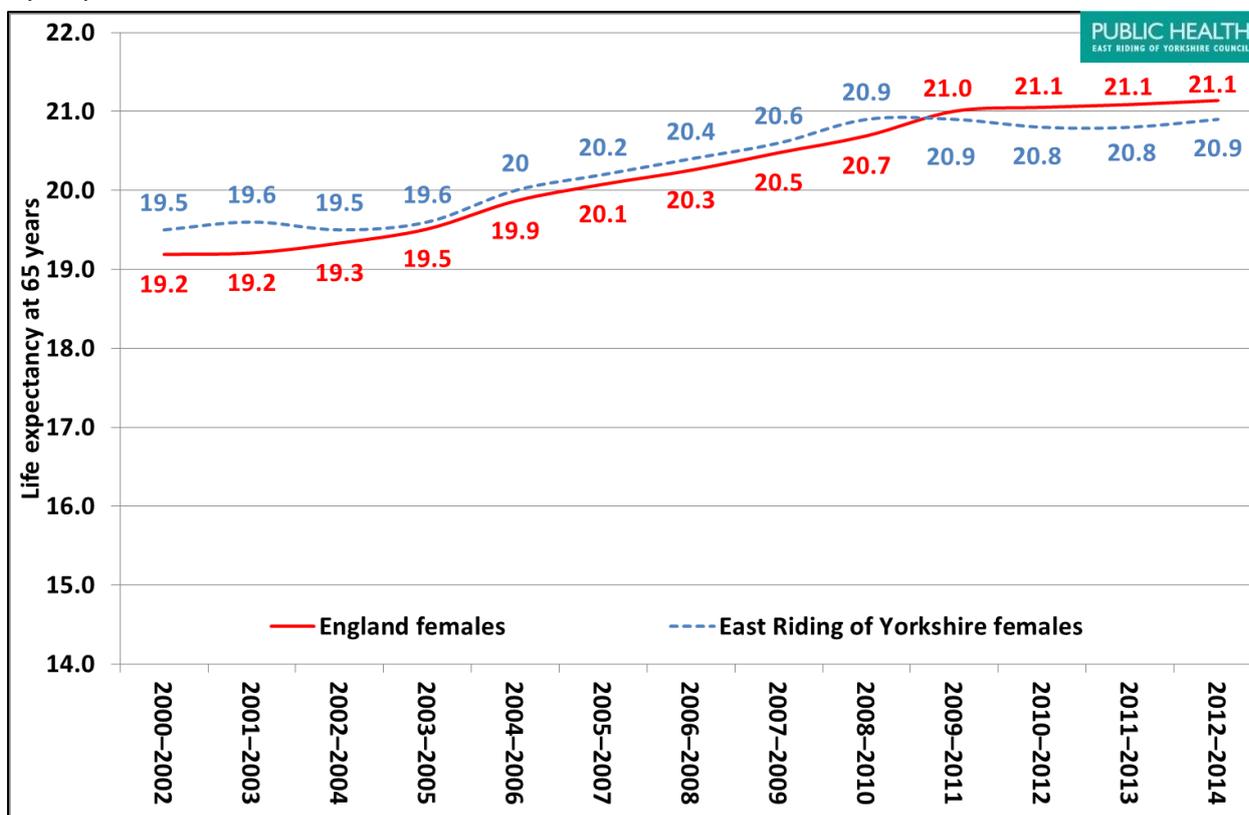


Chart 3.3 Male life expectancy at 65 - East Riding of Yorkshire males compared with its CIPFA nearest neighbours. Pooled 3 year periods 2012-14. Source: ONS.

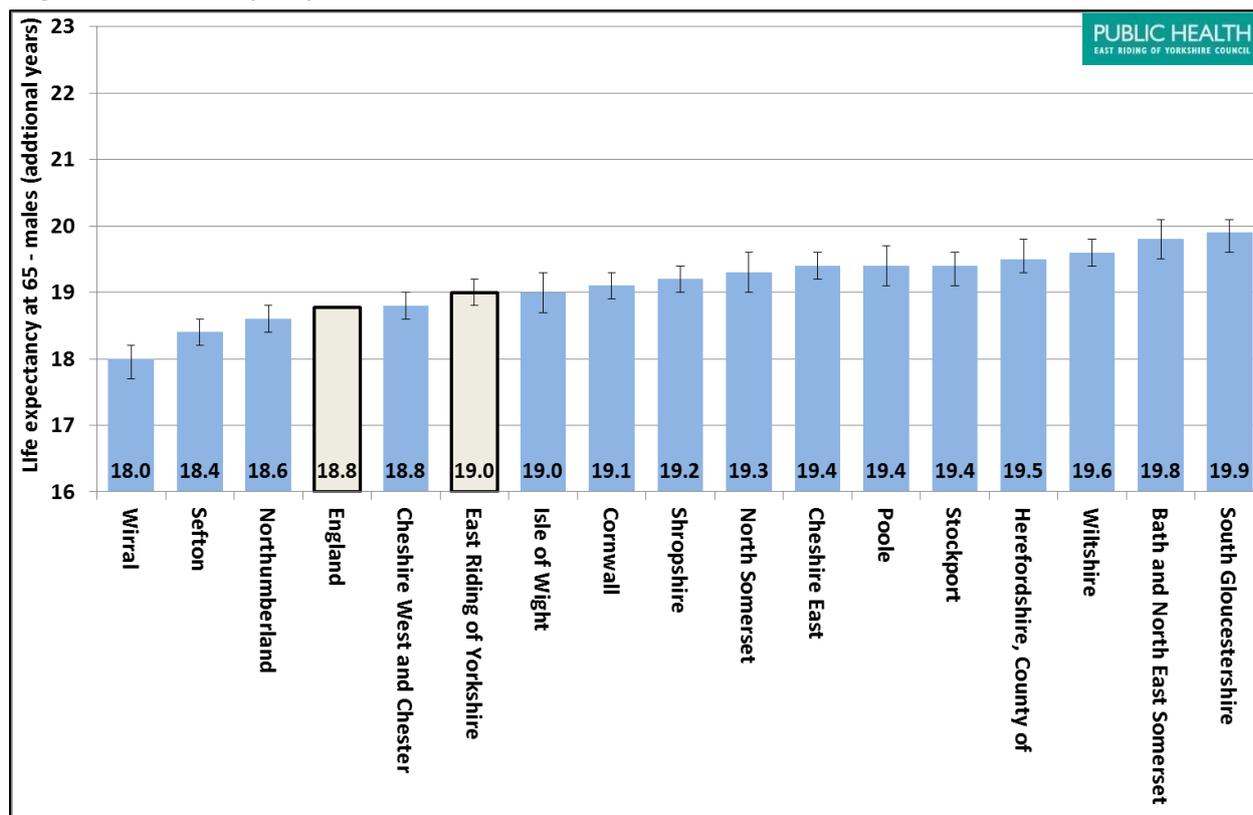
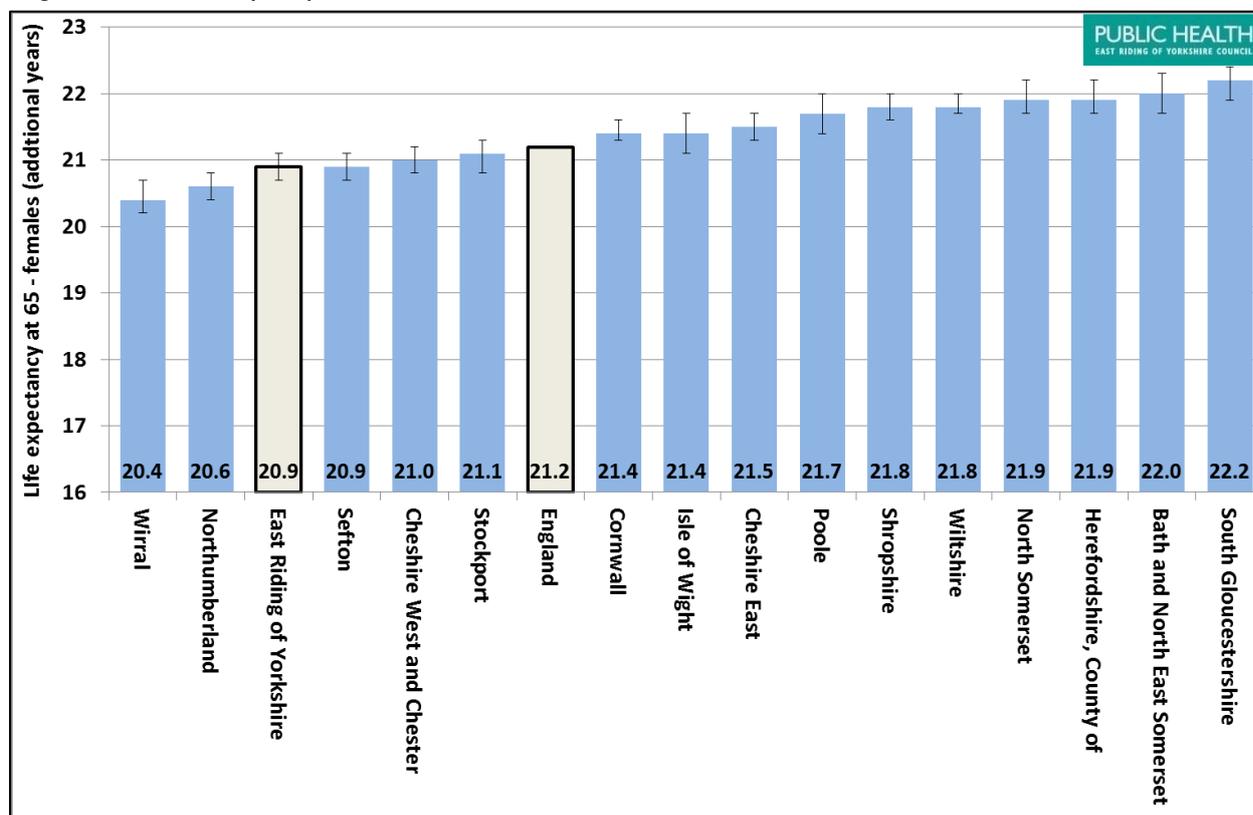


Chart 3.4 Female life expectancy at 65 - East Riding of Yorkshire females compared with its CIPFA nearest neighbours. Pooled 3 year periods 2012-14. Source: ONS.



3.3 Life expectancy at 65, East Riding of Yorkshire wards

Charts 3.5 and 3.6 on the following pages, display male and female life expectancy at 65 at ward level respectively, comparing 2001-03 estimates of each ward, with their corresponding 2011-13 estimates.

The red line crossing both charts is the ERY average life expectancy for each gender for the period 2011-13 (small dots either side of the line show the upper and lower 95% confidence intervals for the ERY average).

3.3.1 Life expectancy at 65, Males (wards)

Chart 3.5 shows that for males, life expectancy at 65 in (2011-13) varies from 20.8 years in Willerby and Kirk Ella to 16.7 years in Bridlington South, a significant difference of 4 years. Willerby and Kirk Ella and Beverley Rural are the only wards significantly higher than the ERY average, whilst Bridlington South is the only ward significantly lower.

All wards have experienced an increase between 2001-03 and 2011-13 with Pocklington Provincial and East Wolds and Coastal having the highest (both 3.5 years) and Cottingham South the lowest (0.7 years).

3.3.2 Life expectancy at 65, Females (wards)

Female life expectancy at 65 in the period 2011-13 (chart 3.6) ranges from 25.2 years (Beverley Rural) to 17.3 years (Hessle), a significant difference between the two wards of almost 8 years. Beverley Rural is significantly higher than the ERY average and two wards are significantly lower (Bridlington South and Hessle).

All but four wards saw an increase in life expectancy between 2001-03 and 2011-13, Tranby saw a loss of 5 years whilst Cottingham North, Howden and Hessle all experienced smaller losses. (none, including Tranby were significant decreases). The wards with the largest increase between the two periods were Goole North (2.9 years) and Willerby and Kirk Ella (2.2 years).

3.4 Life expectancy at 65 - East Riding of Yorkshire local deprivation quintiles

Charts 3.7 and 3.8 display life expectancy at 65 for the most and least deprived ERY quintiles (in the years 2001-03 to 2011-13), for males and females respectively.

For the least deprived quintile, male life expectancy at 65 has risen from 17.8 years in 2001-03 to 19.7 in 2011-13, in comparison the most deprived quintile in the same period rose from 15.2 years to 17 years. For males, the gap in number of years between the two quintiles has approximately remained the same when comparing 2001-03 against 2011-13, equating to a significant difference of 2.7 years in the latest year.

In females, life expectancy at 65 has risen from 20.8 years to 21.4 years for the least deprived and from 18.2 years to 19.9 for the most deprived, marking a gradual decrease between the quintiles between 2001-03 and 2011-13. The latest period (2011-13) shows a significant difference of 1.5 years between the most and least deprived quintiles.



Chart 3.5 Life Expectancy at 65, East Riding of Yorkshire males by Ward. Comparison of 2001-03 and 2011-13.

Original data source: Public Health Sciences, Hull City Council

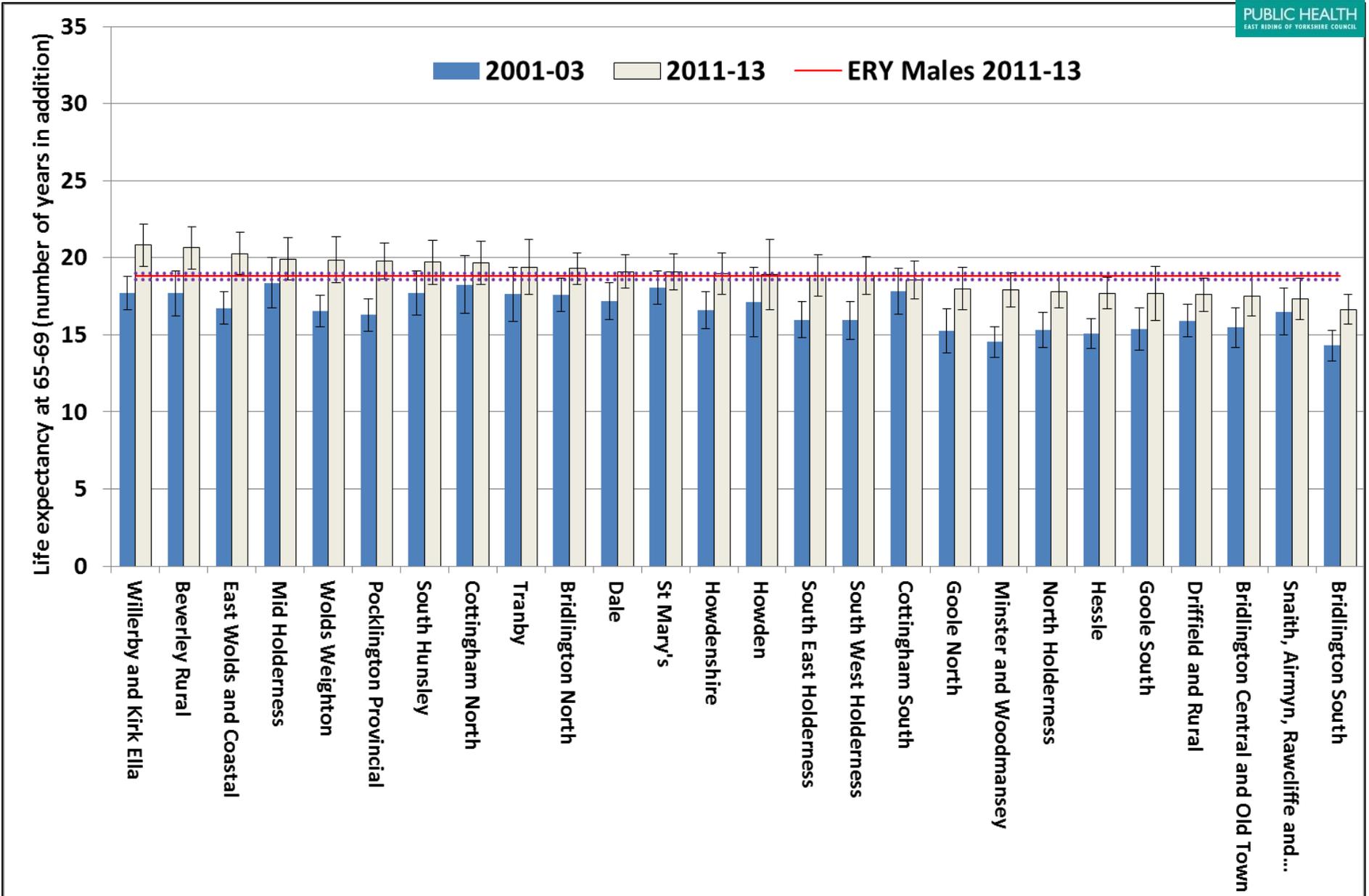


Chart 3.6 Life Expectancy at 65, East Riding of Yorkshire females by Ward. Comparison of 2001-03 and 2011-13.
Original data source: Public Health Sciences, Hull City Council.

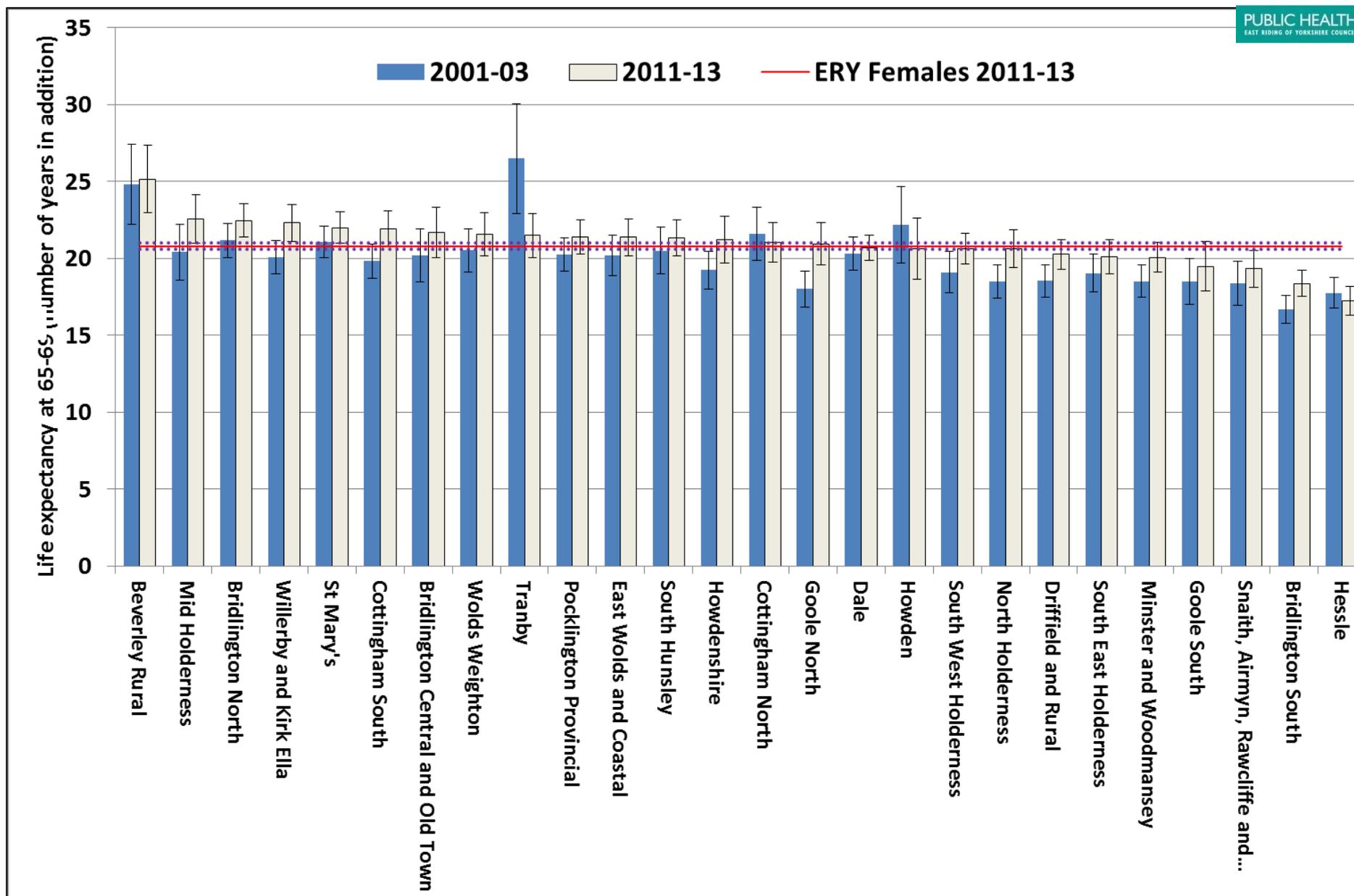


Chart 3.7 Life Expectancy at 65, East Riding of Yorkshire males (most deprived local quintile versus least deprived local quintile. Original data source: Public Health Sciences, Hull City Council.

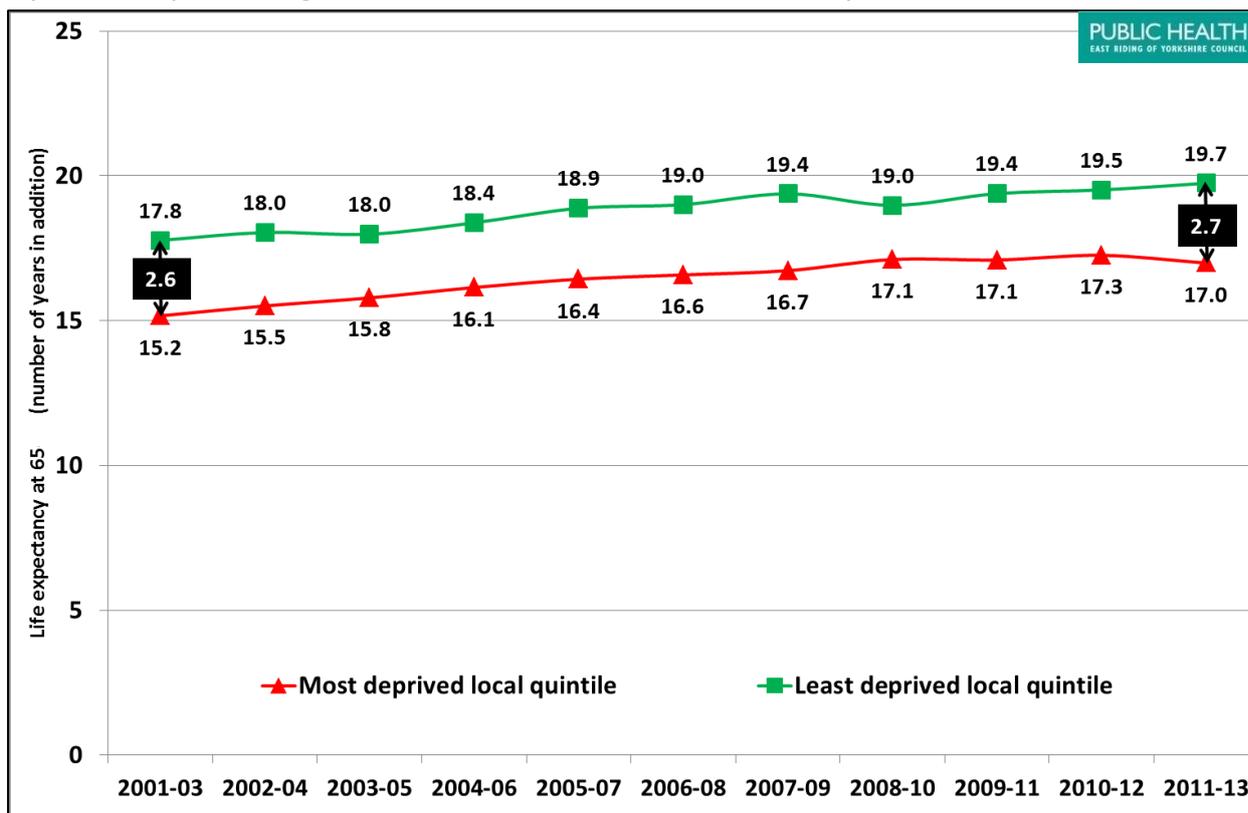
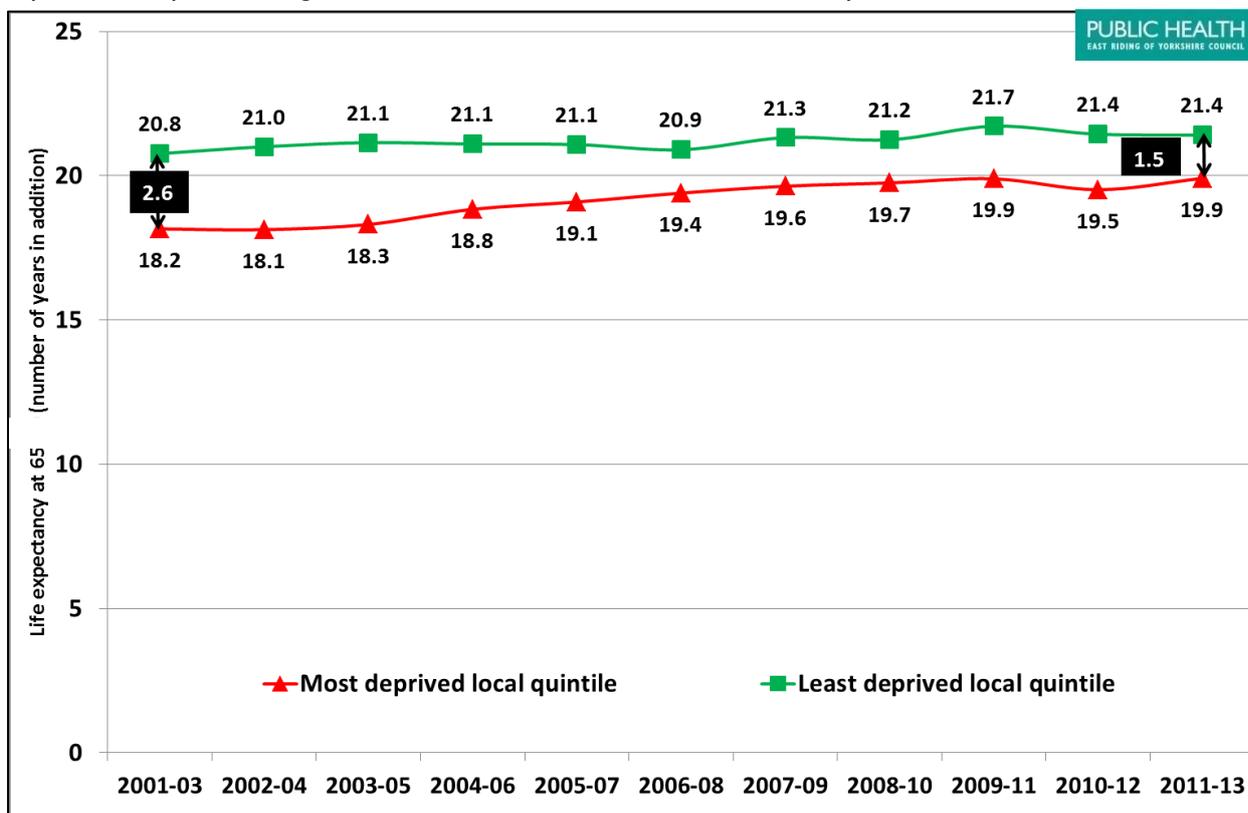


Chart 3.8 Life Expectancy at 65, East Riding of Yorkshire females (most deprived local quintile versus least deprived local quintile. Original data source: Public Health Sciences, Hull City Council.



3.5 Healthy life expectancy

Healthy life expectancy is an estimate of the average number of years a person is expected to live for in “very good” or “good” health, if the mortality rates and health status for an area (at a given period) were to continue throughout his or her life. The health status part of the calculation is derived from a self-reported survey question, asking about general health.

Mortality rates (calculated from deaths from all causes and mid-year population estimates) are based on data aggregated over a three year period. The estimated number of years of healthy life is not a guarantee, as the area’s mortality rates will undoubtedly change at some point in the future and the individual could move to a different area.

3.5.1 Healthy life expectancy - East Riding of Yorkshire (local authority)

The latest life expectancy period available at a local authority level in this document is 2011-13 and so if a baby born today in ERY experienced the ERY mortality rates and prevalence of good health of the period 2011-13 for their lifetime, then they would expect on average to have a healthy life expectancy of 65.2 years (if male) or 66.7 (if female).

The 2011-13 ERY figure for male healthy life expectancy has increased from the 64.9 years calculated for the previous two periods (2009-11 and 2010-12) and is significantly higher than the England average (63.3 years). Female ERY healthy life expectancy was also classified as significantly higher than England (63.9 years) in 2011-13, whilst the two periods previous to this were calculated to be 66.8 years and 65.4 years.

Comparisons with the CIPFA nearest neighbours are shown in charts 3.9 and 3.10. ERY males (chart 3.9) are placed centrally in the group which ranges from the lowest value of 59.8 years (Wirral) to the highest of 68.5 years (Wiltshire). The Female group (chart 3.10) again has Wirral as the lowest value (61.8 years), whilst Bath and North East Somerset is the area with highest (68.5 years). ERY is placed in the top third of the group.



Chart 3.9 Healthy life expectancy - East Riding of Yorkshire males compared with its CIPFA nearest neighbours. Pooled 3 year periods 2011-13. Source: <http://fingertips.phe.org.uk/>

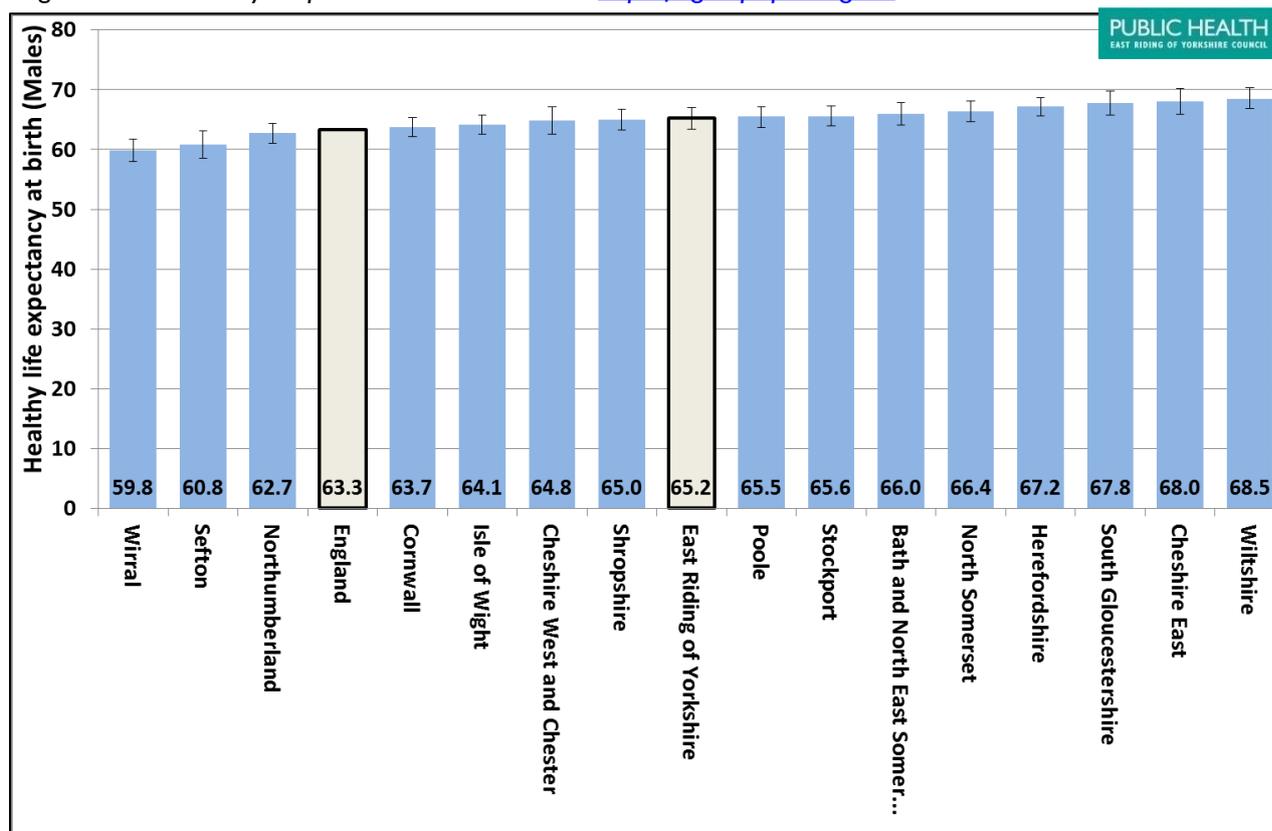
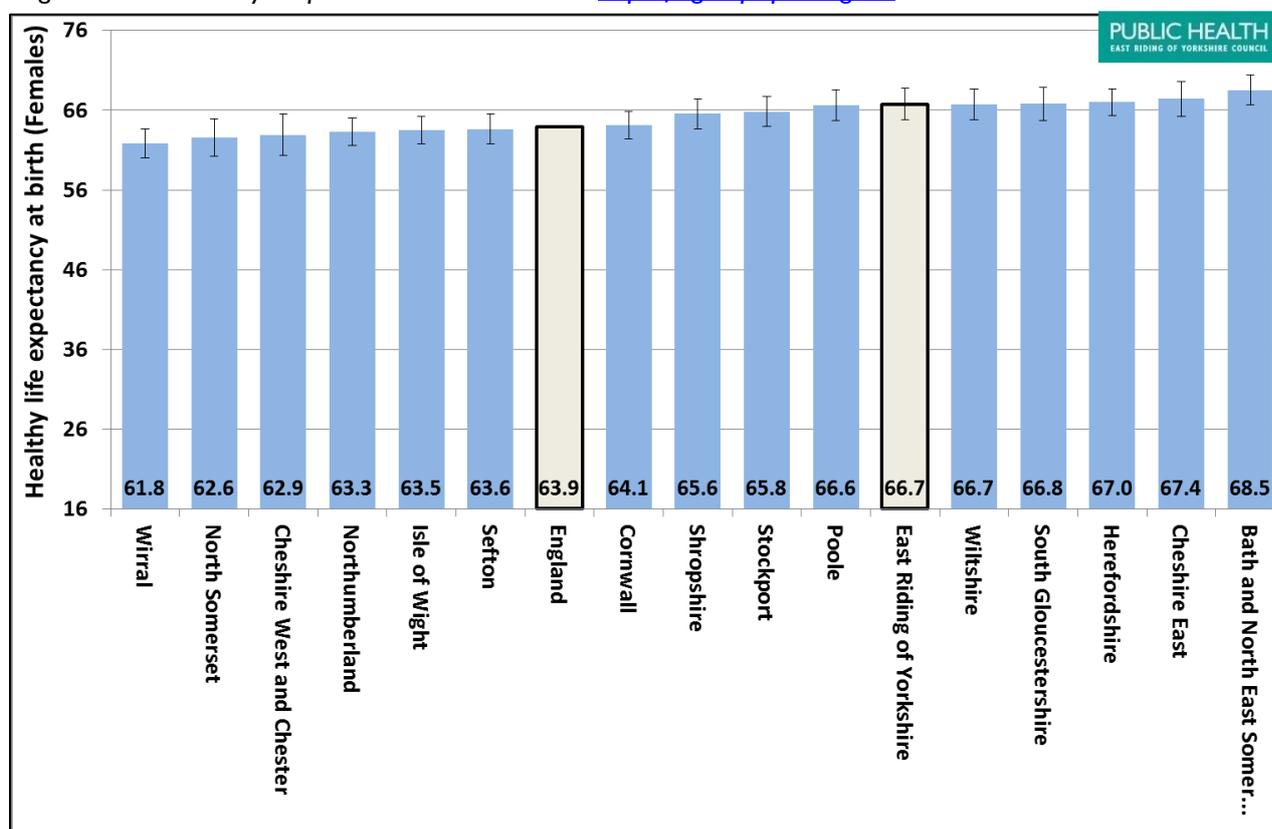


Chart 3.10 Healthy life expectancy - East Riding of Yorkshire females compared with its CIPFA nearest neighbours. Pooled 3 year periods 2011-13. Source: <http://fingertips.phe.org.uk/>



3.6 Disability Free Life Expectancy at 65 years of age

Disability free life expectancy is an estimate of the average number of years a person is expected to live free of disability, if the current patterns of mortality and disability were to continue throughout his or her life.

- **Male disability-free life expectancy at 65:** for the period 2012-14 ERY males have estimated to have almost 11 disability free years from the age of 65. This value is approximately central within the CIPFA neighbour values (ranging from 8.2 years to 13.0 years). ERY males have a higher disability-free number of years compared to England (10.3). Please see chart 3.11.
- **Female disability-free life expectancy at 65:** for the period 2012-14 ERY females have estimated to have 11.2 disability free years from the age of 65. This value is just within the bottom half of the CIPFA neighbour values (ranging from 9.4 years to 13.7 years). ERY females have a higher disability-free number of years compared to England (10.9). Please see chart 3.12.
- **Disability-free life expectancy at 65, past trends: 2006-08 to 2012-14.** Estimates for England show a steady increase between 2006-08 and 2010-12 but then a fall for the subsequent periods. The past estimates for ERY fluctuate much more wildly, as would be expected. For both genders in both ERY and England, disability life expectancy has increased between the two time periods. For ERY males it has increased from 10.2 years to 10.9 years, for ERY females it has increased from 10.4 years to 11.2 years.



Chart 3.11 Male disability-free life expectancy (DFLE) at age 65, 2012 to 2014. ERY compared to England and CIPFA. Pooled 3 year period 2012-14. Source: <http://www.ons.gov.uk/>

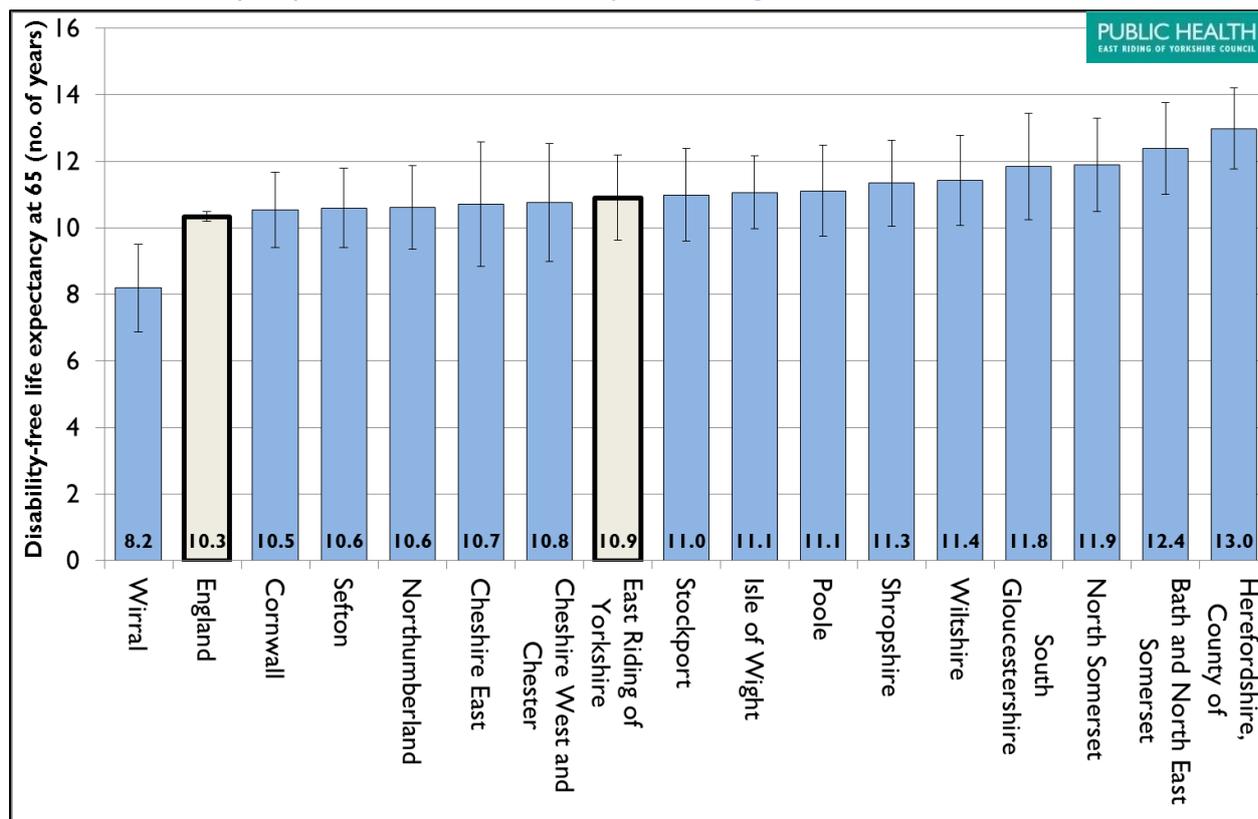
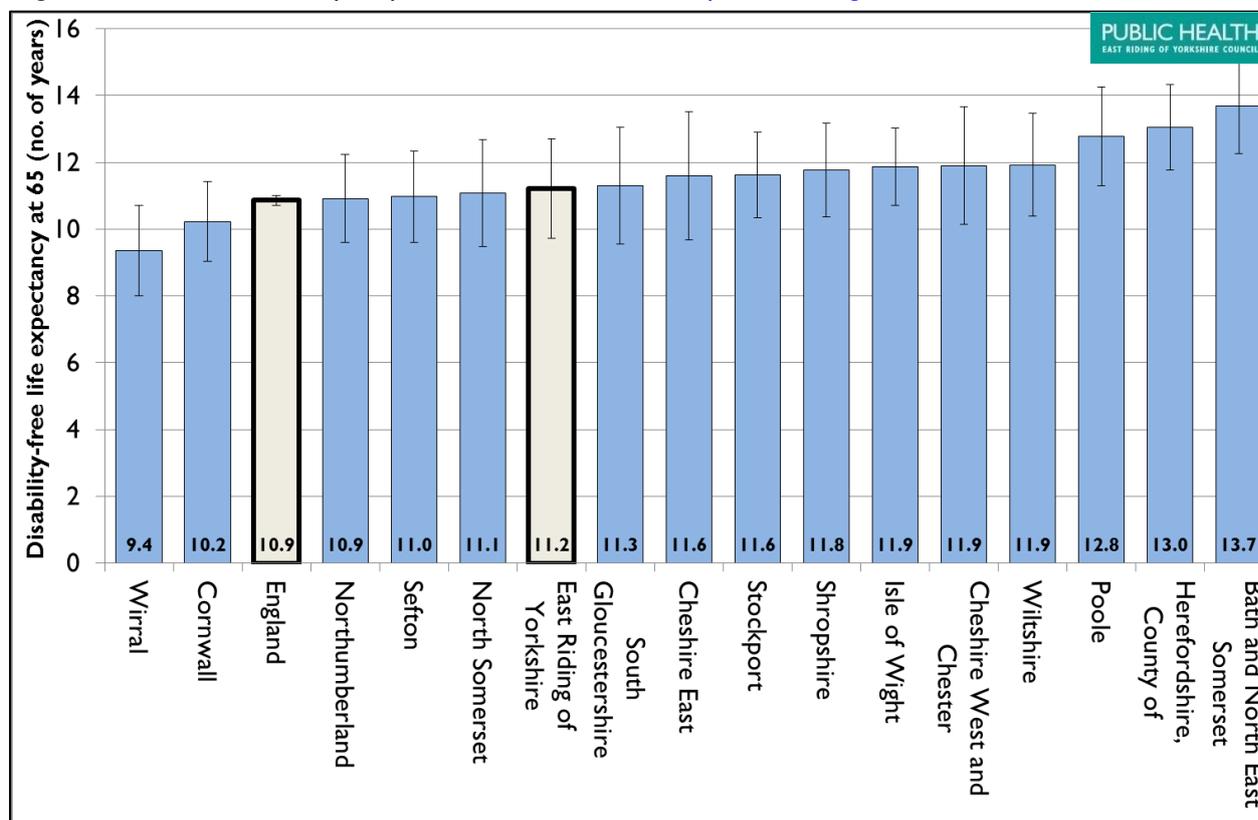


Chart 3.12 Female disability-free life expectancy (DFLE) at age 65, 2012 to 2014. ERY compared to England and CIPFA. Pooled 3 year period 2012-14. Source: <http://www.ons.gov.uk/>



4. Long term conditions

4.1 Quality and Outcomes Framework (QOF)

The recorded prevalence of disease is obtained via General Practice (GP) disease register data, part of the Quality and Outcomes Framework (QOF). From this source, the prevalence of disease is simply the number of patients at a practice who have been given a formal diagnosis, as a percentage of the whole list size. Some diseases are age specific (e.g. diabetes is for patients aged 17+) but most represent all ages.

It should be noted that this data is limited in a number of ways, two examples are given below:

- The disease register usually represents all patient ages, i.e. not just the elderly population (although there are some exceptions with specific diseases).
- A higher or a lower prevalence could be present due to a number of reasons (e.g. the prevalence is not age standardised, so some practices with an older populations as a result may have a higher prevalence of disease).

Charts A2.1 to A2.8 in the appendix file (page 12 onward) show the prevalence of a number of diseases from the QOF by NHS ERY CCG practice, for the periods 2006/07 and 2014/15. In most diseases the prevalence has increased between the two time periods. However, this could have occurred for any number of reasons, e.g. the population has got older and therefore there is a higher prevalence of the disease or it might be that diagnosis has improved between these two periods.

The bulleted list below provides a summary of some of the main points for each of the diseases. Please note that dementia appears in section 4.2.

- **Hypertension:** generally a higher prevalence in the Bridlington practices (2nd group on the chart), with 4 of those practices experiencing a prevalence of between 21% and 24% in 2014/15.
- **Obesity:** a higher prevalence in Bridlington (Wolds View practice at nearly 25%).
- **Diabetes (type 1 and type 2):** practices in Bridlington and Holderness have higher rates.
- **CHD:** Bridlington generally has a higher prevalence. The prevalence between the two different years is much closer in this disease compared to others.
- **COPD:** a higher prevalence in the Bridlington practices.
- **ERY compared to England:** ERY has a higher prevalence in all of the diseases displayed in charts 4.1 to 4.8. However with age being a risk factor for a number of the diseases (the prevalence figures are not age standardised) and ERY having an older population than England, then this is possibly to be expected.



4.2 Dementia

Dementia is a term used to describe a group of conditions whose clinical characteristics include loss of memory, confusion and problems with speech and understanding. These conditions include:

- Alzheimer's disease (one of the most common causes)
- Vascular dementia
- Mixed dementia
- Dementia with Lewy Bodies
- Fronto-temporal dementias
- Rarer causes of dementia

Dementia is a progressive disease (with the symptoms getting worse over time) and there are currently no cures for dementia, although there are NICE recommended treatments for Alzheimer's disease. The cost of dementia is estimated to be £26bn a year ([London School of Economics, 2014](#)) and its burden on health care will increase into the future as the population continues to get older. However, dementia is not an inevitable part of aging with some cases considered preventable. Stopping smoking, being more active, reducing alcohol consumption, improving diet and losing weight can help reduce the risk of dementia.

4.2.1 Prevalence

In trying to quantify the number of people with dementia in ERY, this section considers two sources: recorded prevalence and estimated prevalence.

4.2.2 Recorded prevalence

The recorded prevalence of dementia is obtained via the GP practice dementia register data, part of the Quality and Outcomes Framework (QOF). The prevalence of dementia is simply the number of patients at a practice who have been given a formal diagnosis, as a percentage of the whole list size. Table 4.1 and chart 4.2 provide some estimates for 2014/15 for NHS ERY CCG.

As already mentioned in section 4.1, it should be noted that this data is limited in a number of ways:

- The dementia register represents all patient ages, i.e not just the elderly population (although chart 4.3 has been included which does represent 65+ years of age only).
- A higher or a lower prevalence could be present due to a number of reasons (e.g. the prevalence is not age standardised, so some practices with an older populations as a result may have a higher prevalence of disease).



Table 4.9 displays the numbers of patients on the dementia register and their respective prevalence rates for the five NHS ERY CCG localities, prevalence rates range from 0.8% to 1.0%. A comparison is made with the CCG (0.9%) as a whole and also England (0.7%), but please note that there is no statistical comparison in this table. NHS ERY CCG is shown to have a higher prevalence of dementia than England, however as stated earlier, QOF is not age standardised. As ERY has a higher proportion of older people than the England average, then a higher prevalence of dementia might be expected.

Table 4.1 Number of patients on a practice dementia register, by locality*, 2014/15. Source: QOF, HSCIC

Area (based on registered patients)	Number of patients on dementia register	Full List Size	2014-15 Prevalence Rate %
Beverley & Driffield Locality	607	68,183	0.9%
Bridlington Locality	439	41,937	1.0%
Goole, Howdenshire and West Wolds Locality	559	63,672	0.9%
Haltemprice Locality	669	68,706	1.0%
Holderness Locality	499	59,217	0.8%
NHS ERY CCG	2,773	301,715	0.9%
England	419,073	56,324,887	0.7%

*Note that the localities in this table are made up of groups of NHS ERY CCG practices, not the number of residents within ERYC wards.

Chart 4.2 displays the prevalence of dementia by each NHS ERY CCG practice, in the two years 2006/07 and 2014/15. Data has again been obtained from the QOF dementia register. For all but one practice the prevalence of dementia has increased between the two periods of time, with the highest prevalence (from a locality average perspective) found in the Bridlington area. Caution should be taken with regard to the prevalence not being age standardised, some practices with an older population may have a higher prevalence of dementia for that reason. A higher prevalence between the two periods could have occurred for any number of reasons, e.g. the population has got older and therefore there is a higher prevalence of the disease or it might be that diagnosis has improved between these two periods.

Chart 4.3 displays the prevalence of dementia from GP practices located within local authority boundaries. In this instance ERY would include those patients located in the Pocklington practice, as the practice is situated within the local authority boundary. However, it should be clear that this still does not represent a true picture of “resident” recorded prevalence. Practices located within the ERY local authority boundary can still have patients registered with them from other local authorities. ERY residents can also be registered with Practices located outside of ERY (e.g. in Hull) and they won’t be counted in these results.



Chart 4.2 Proportion of practice patients on a dementia register 2006/07 versus 2014/15. Locality averages highlighted. Source: QOF, HSCIC

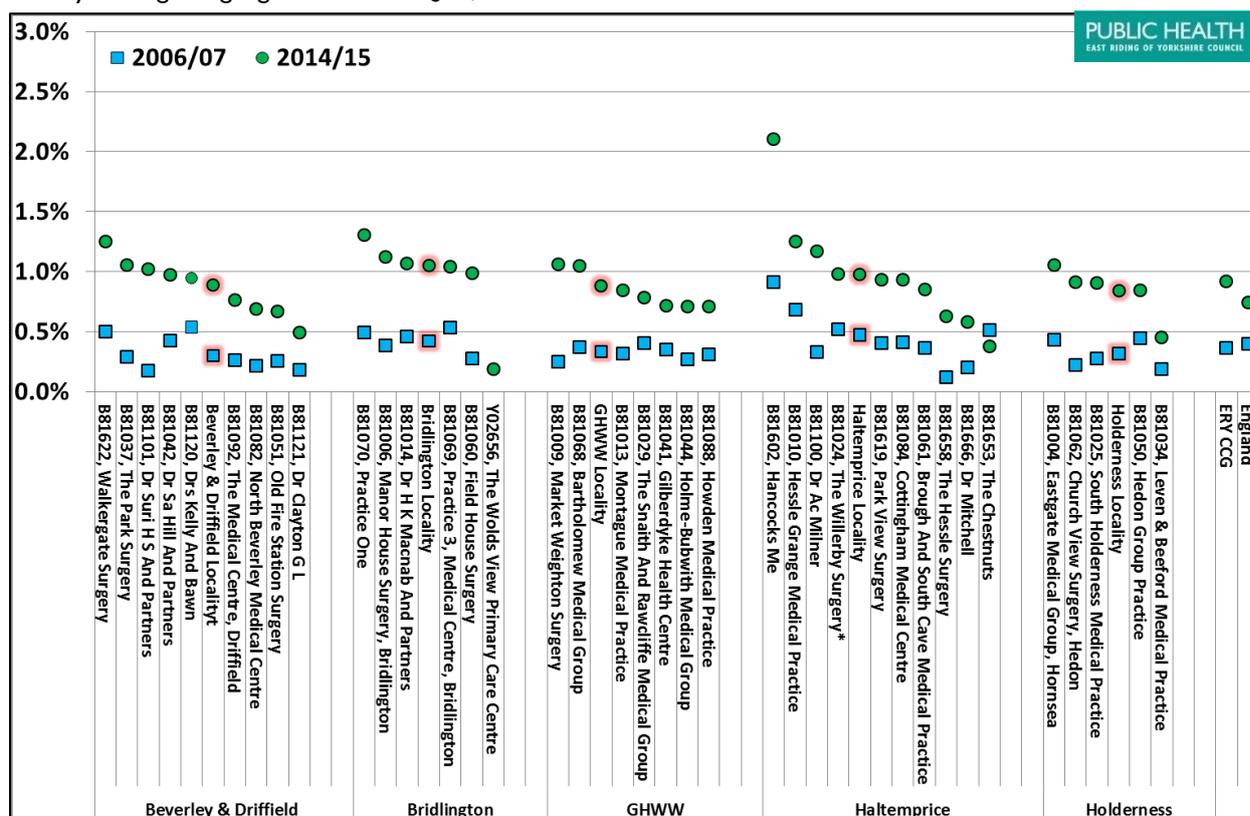
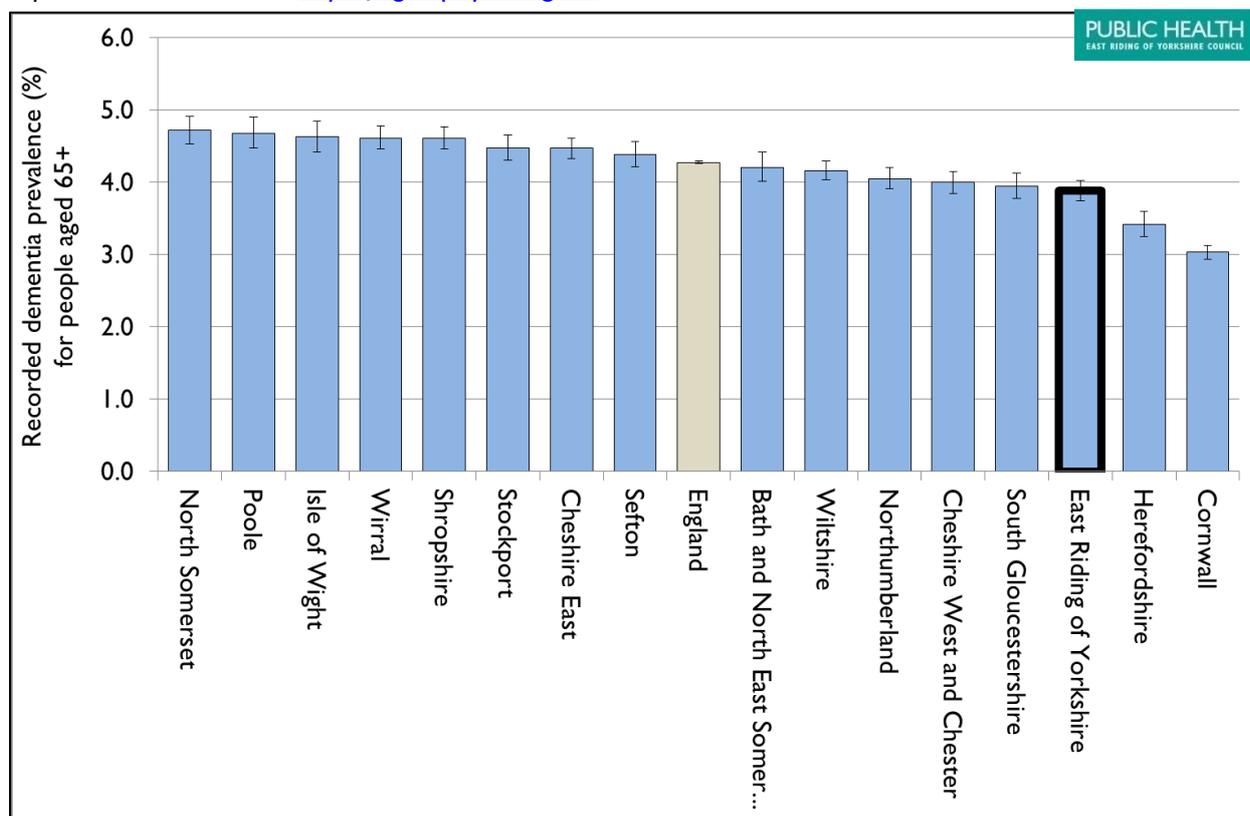


Chart 4.3 Recorded dementia prevalence (%) for people aged 65+ as recorded on practice disease registers. September 2015. Source: <http://fingertips.phe.org.uk/>



4.2.3 Dementia projections and estimates acquired from studies

The Projecting Older People Population Information System (POPPI) provides dementia prevalence estimates based on the 2007 Personal Social Services Research Unit (PSSRU) report “Dementia UK: A report into the prevalence and cost of dementia”.

In England, it was estimated that there were approximately 662,400 people in 2014 (aged 65 years or over) living with dementia and is projected to rise to over one million by 2030. In the same time period the number of people in ERY (aged 65 years or over) was estimated to be nearly 5,400 and projected to reach over 9,110 by the year 2030. This means that between these two periods, ERY is projected to see an additional 3,700+ person aged over 65 with dementia. Table 4.4 displays these numbers alongside other years in between.

Table 4.5 and chart 4.6 converts the numbers into a percentage increase, with ERY projected to see a 70% increase by 2030 in dementia in 65+ year olds, from 2014.

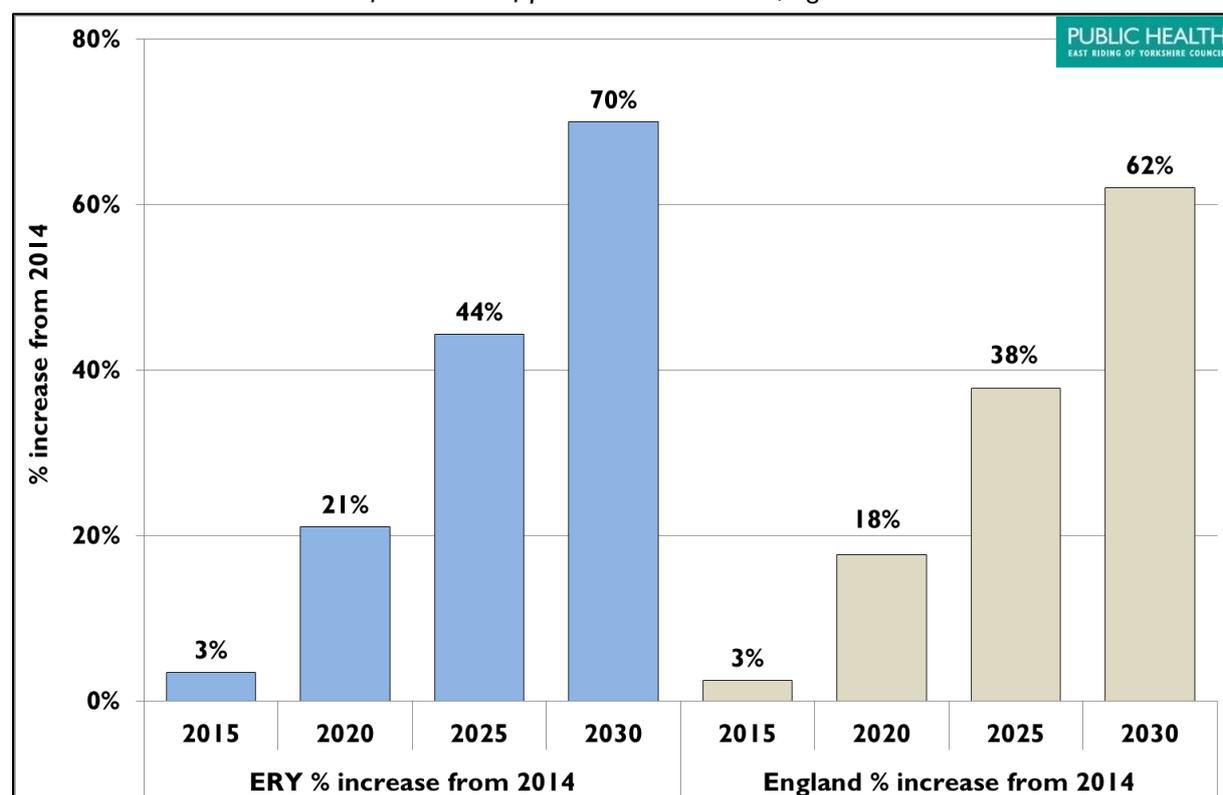
Table 4.4 Estimated numbers of 65+ year olds with dementia. Source: <http://www.poppi.org.uk/>

Age Group	Estimated number of people in ERY with dementia					Increase in number of people in ERY with dementia, from 2014			
	2014	2015	2020	2025	2030	2015	2020	2025	2030
65+ years & over	5,360	5,547	6,489	7,738	9,112	187	1,129	2,378	3,752

Table 4.5 Percent increase of 65+ year olds with dementia. Source: <http://www.poppi.org.uk/>

Age Group	ERY % increase of dementia from 2014				England % increase of dementia from 2014			
	2015	2020	2025	2030	2015	2020	2025	2030
65+ years & over	3%	21%	44%	70%	3%	18%	38%	62%

Chart 4.6 Estimated % increase from 2014 of persons with dementia, aged 65+. Source: POPPI



4.2.4 Hospital admissions related to dementia (brief overview)

In the appendix file, charts A2.28 to A2.31 (page 16 onward) display admissions information relating to dementia, comparing the ERY rate to the England average and the rates of CIPFA neighbours.

Summary points for each chart are made in the bulleted list below:

- **Inpatient hospital admissions (planned & unplanned) with a mention of vascular dementia, aged 65+, 2013/14.**

Vascular dementia is the second most common type of dementia, after Alzheimer's disease, affecting approximately 150,000 people in the UK. It is caused by a reduced blood supply to the brain due to diseased blood vessels.

The ERY DSR rate of 323 per 100,000 (n=242) places it second from bottom in the CIPFA group, significantly lower than the England average. Whilst the trend of ERY vascular dementia admissions is slowly increasing (as has the England average), it is has always been significantly lower than the national rate.

- **Inpatient hospital admissions (planned & unplanned), with a mention of Alzheimer's disease, aged 65+, 2013/14.**

The ERY DSR rate of 319.2 per 100,000 (n=287) places it third from bottom in the CIPFA group, significantly lower than the England average. Past trends show ERY inpatient admissions to be increasing in line with national trends, but the ERY DSR has always been significantly lower than England in all previous periods.

- **Emergency hospital admissions of people with a mention of dementia aged 65+, 2013/14.**

The ERY DSR rate of 2,658 per 100,000 (n=1,978) places it within the top half of the CIPFA group, but again significantly lower than the England average. This would suggest ERY residents are having more inpatient admissions with a mention of dementia than a number of other areas but not as many as the England average. Trends over time appear to show a gradual increase for ERY residents, but the England rate has always been higher and increasing more quickly.

- **Percentage of emergency admissions for people with dementia that are short stays, aged 65+, 2013/14.**

Levels of anxiety and stress for individuals increase when there is a change in the surrounding environment, this is particularly relevant to people with dementia who are potentially more susceptible to such changes. Short durations in hospital should therefore be avoided, where possible, for patients with dementia.

The percentage of short stay emergency admissions for people with dementia was 19.5% in 2013/14. This placed ERY second from bottom in the CIPFA group, significantly lower than the England average, suggesting fewer ERY residents had short stays in comparison other areas. This has also been true in past periods with ERY a having significantly lower percent of short stays compared to England. However it has been observed that the trend of shorter stays is beginning to increase.



4.3 Hypertension

Hypertension (also referred to as high blood pressure) rarely has noticeable symptoms and if left untreated can put strain on the heart and blood vessels, increasing the risk of a stroke or heart attack. It has been estimated that there up to 7 million people within the UK who have undiagnosed blood pressure and is commonly found in older people.

In ERY there are 34,800 patients diagnosed with hypertension, this is 60.5% of the total number of residents estimated to have the disease, which leaves almost 35,000 residents undiagnosed and at risk. The proportion of patients diagnosed in ERY is significantly higher than the percentage for England as a whole (55.8%). ERY also has a significantly higher percentage of patients who have controlled hypertension compared to England (48.5% versus 44.9% respectively). Table 4.7 below, compares ERY to other areas.

Table 4.7 Diagnosis and control of hypertension within ERY. Source: 2015 PHE Hypertension profile

Indicator	ERY Number	ERY %	ONS similar %*	Region %	England %
Residents diagnosed with hypertension	53,300	60.5%	58.1%	56.7%	55.8%
Estimate of residents with undiagnosed hypertension	34,800	39.5%	41.9%	43.3%	44.2%
Total residents with hypertension (est.)	88,100				
People with controlled hypertension	42,700	48.5%	41.6%	48.9%	44.9%

* these are not CIPFA neighbours as used elsewhere in this document, but the ONS "Prospering Smaller Towns - B" cluster

In the appendix file, chart A2.9 displays the individual general practices of NHS ERY CCG and their respective "observed versus expected" ratio of hypertension prevalence. A lower ratio would suggest that a practice has only diagnosed a small proportion of their patients with hypertension, with many more patients potentially at risk from undiagnosed hypertension.

The values range from a ratio of 0.43 in Park View Surgery, to a ratio of 0.73 in Dr Suri's practice, with an overall NHS ERY CCG ratio of 0.61.



4.4 Age-Related Macular Degeneration (AMD)

Age related macular degeneration (AMD) is a major cause of ocular morbidity in high income countries, accounting for over half of blind and partial sight certifications in the UK. AMD is a progressive condition that causes loss of vision and leads to loss of independence. Therefore, it is important to have an accurate estimate of projected numbers who have, or will develop, this disorder.

As the name implies, the condition is associated with ageing, and it is a leading cause of visual impairment among the elderly. As AMD progresses a person will gradually lose the ability to see things in their central field of vision, which is needed for important activities, such as reading, writing and driving. There are two different types of the disease: dry AMD and wet AMD (also called neovascular AMD or NVAMD). Wet AMD involves the formation of new blood vessels.

Blood vessel growth of wet AMD is usually treated by laser, photodynamic (light) drugs or injections of drugs that prevent the growth of the abnormal blood vessels (called anti-vascular endothelial growth factors, anti-VEGFs). Anti-VEGF treatment has made a significant impact on the vision and lives of people affected with these conditions. In the case of 'wet' AMD the treatments have stabilised the sight in over 90% of cases and resulted in significant improvement in up to 30-40% of people.

Estimates for Wet AMD have been calculated for ERY residents in table 4.8. These tables are based on prevalence estimates from the study "The estimated prevalence and incidence of late stage age related macular degeneration in the UK" by Owen, Jarrar, Wormald, Cook, Fletcher and Rudnicka (2012).

Table 4.8 Prevalence and estimated numbers of people with wet AMD (NVAMD), by age group.

Source of prevalence estimates: Owen et al (2012)

Age Group	Prevalence by age group	ERY 2014 population*	ERY projected population in 2030**	Estimated number of people in ERY with the condition, in 2014	Estimated number of people in ERY with the condition in 2030
50 & over	1.2%	153,447	179,400	1,841	2,153
65 & over	2.5%	80,611	109,600	2,015	2,740
80 & over	6.3%	20,376	37,100	1,284	2,337

* ONS 2014 midyear population estimates

** ONS 2014 population projection estimates for 2030



4.5 Disease projections overview in 65+ year olds

The POPPI website (<http://www.poppi.org.uk/>) provides estimates and projections for a number of long term and other health related conditions, at a local authority level.

In the first part of table 4.9 the estimated numbers of residents are shown for each year, starting with 2015 and projecting through to 2030. The second part of the table shows the projected increase from 2015, as a percentage.

In the table some of the larger numbers and percentage increases have been ringed with the intention of highlighting potential increases of demand for services in the future.

- By 2030, residents whose activities are limited a lot are projected to increase by 44.3% from 2015, to an estimated total of almost 25,000 residents.
- Residents whose health has been affected by a stroke is predicted to rise almost 40% by 2030.
- Visual impairment in 75+ year olds projected to rise by over 60%.
- The number of 65+ year olds with a hearing impairment is estimated to be almost 46,000 by 2030.
- The number of 65+ year olds unable to manage at least one activity is estimated to be almost 19,000 by 2030.

Table 4.9 Estimated numbers of ERY residents with specified conditions, by age group.

Source <http://www.poppi.org.uk/>

Condition	Detail	Numbers of residents by year				% increase from 2015		
		2015	2020	2025	2030	2020	2025	2030
Diabetes	People aged 65+ predicted to have diabetes	10,338	11,330	12,445	13,761	9.6%	20.4%	33.1%
Activities limited a lot	People aged 65+ with a limiting long term illness whose day-to-day activities are limited a lot	17,157	19,286	22,130	24,761	12.4%	29.0%	44.3%
Depression	People aged 65+ predicted to have depression	7,119	7,802	8,593	9,513	9.6%	20.7%	33.6%
Heart attack	People aged 65+ predicted to have a longstanding health condition caused by a heart attack	4,032	4,458	4,979	5,507	10.6%	23.5%	36.6%
Stroke	People aged 65+ to have a longstanding health condition caused by a stroke	1,903	2,122	2,398	2,653	11.5%	26.0%	39.4%
Bronchitis & emphysema	People aged 65+ predicted to have a longstanding health condition caused by bronchitis & emphysema	1,363	1,395	1,539	1,705	2.3%	12.9%	25.1%
Visual impairment	People aged 75+ predicted to have a moderate or severe visual impairment	4,563	5,320	6,609	7,316	16.6%	44.8%	60.3%
Hearing impairment	People aged 65+ predicted to have a moderate or severe hearing impairment	33,200	33,990	38,679	45,757	2.4%	16.5%	37.8%
Unable to manage one activity	People aged 65+ unable to manage at least one activity on their own	14,288	14,661	16,836	19,305	2.6%	17.8%	35.1%

Other disease projections compiled by POPPI for ERY, are available to view in the appendix file, page 19 onward.



4.6 Patients or residents with multiple long term conditions (LTCs)

The annual QOF data extracts (provided by HSCIC) provides us with a reasonable estimate of the numbers of patients recorded as having a long term condition (LTC). However, without access to individual records, it is much more difficult to estimate numbers of patients with *multiple* LTCs.

Therefore estimating the numbers of ERY patients (or residents) with multiple LTCs, requires applying national prevalence estimates from publications and then applying these to the local population. This obviously does not take account of the unique characteristics of a local population and therefore the true prevalence could potentially be extremely different.

Two different publications have been used in this section, to make estimates of multiple LTCs within two different age groups of ERY residents. Please see sections 4.6.3 and 4.6.4 for these estimates.

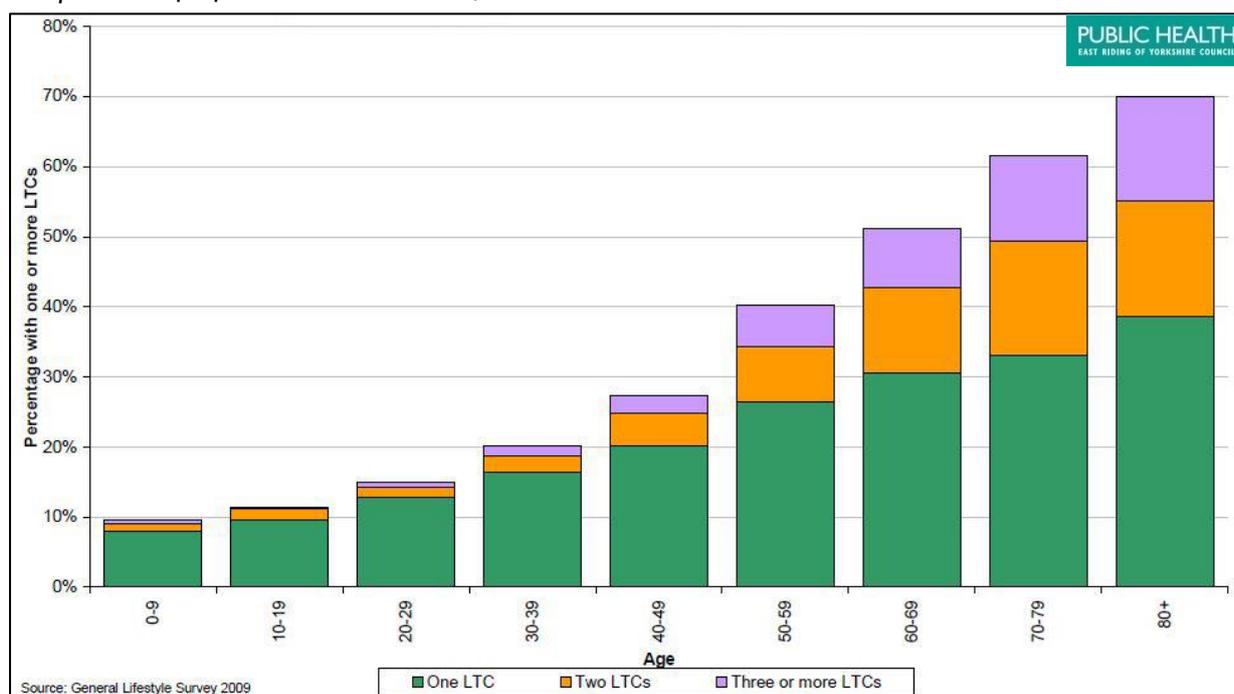
4.6.1 Estimating number of people with multiple long term conditions by age group

One publication which displays prevalence estimates for multiple long term conditions (from a national perspective) is the LTC Compendium of Information: Third Edition by DoH (2012). The LTC data within the report is derived from the 2009 General Lifestyle Survey and states:

- 14% of those aged under forty report having a LTC
- 58% of those aged 60 and over report having a LTC
- 25% of over 60s having two or more LTCs

Chart 4.10 below, is taken from the report and displays the prevalence of a different number of LTCs by age group. As might be expected the proportion of one LTC increases as the age groups get older, as does the prevalence of two LTCs and three or more LTCs, particularly with the 50-59 age group onwards.

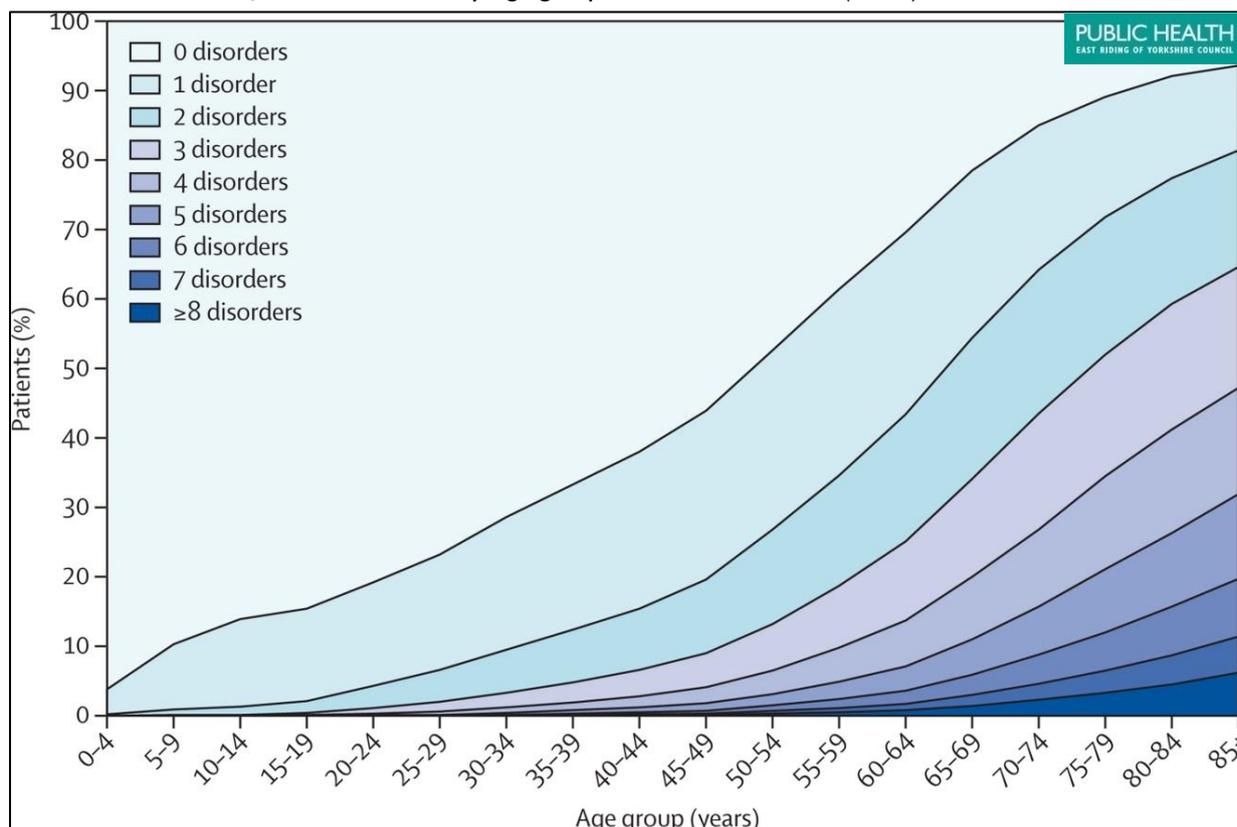
Chart 4.10 Proportion of people with LTCs by age, England 2009. Source: DoH: Long Term Conditions Compendium of Information: Third Edition, 2012



Another example of a study, which estimated the prevalence of LTCs by age was Barnett & al (2012) which analysed information based on over 1.7m patients in Scotland. The study found that by the age of 50, half of the population had at least one LTC and by age 65 years, most had more than one LTC.

Chart 4.11 (similarly to chart 4.10) displays the prevalence of one or more LTCs by age group, as found in this particular study. The chart illustrates that as the age groups get older, the proportion of patients with a larger numbers of LTCs gets larger.

Chart 4.11 Number of chronic disorders by age-group. Source: Barnett et al (2012)



4.6.2 Long term conditions (LTCs) and deprivation

It is well referenced, by organisations such as the [Kings Fund](#), that LTCs are not only more common in the elderly but also more prevalent in people living in some of the most deprived communities. Chart 4.12 features findings from the Barnett et al (2012) study and displays the prevalence of multiple LTCs by age group. The most deprived decile (represented by the red line) is shown to have a higher prevalence of multiple LTCs at a much earlier age than the least deprived decile (represented by the blue line). For example, approximately 45% of the 55-59 age group in the most deprived decile are shown to have multiple LTCs but this level of prevalence in the least deprived decile does not occur for another 10 years.

Chart 4.13 illustrates the connection of four common LTCs in the study (coronary heart disease, diabetes, COPD and Cancer) to other LTCs that the patients had. Results have been separated into the most affluent and the most deprived (the latter appearing to have a higher proportion of co-morbidities of painful condition, depression and anxiety).



Chart 4.12 Prevalence of multi-morbidity by age and socioeconomic status. Source: Barnet et al (2012)

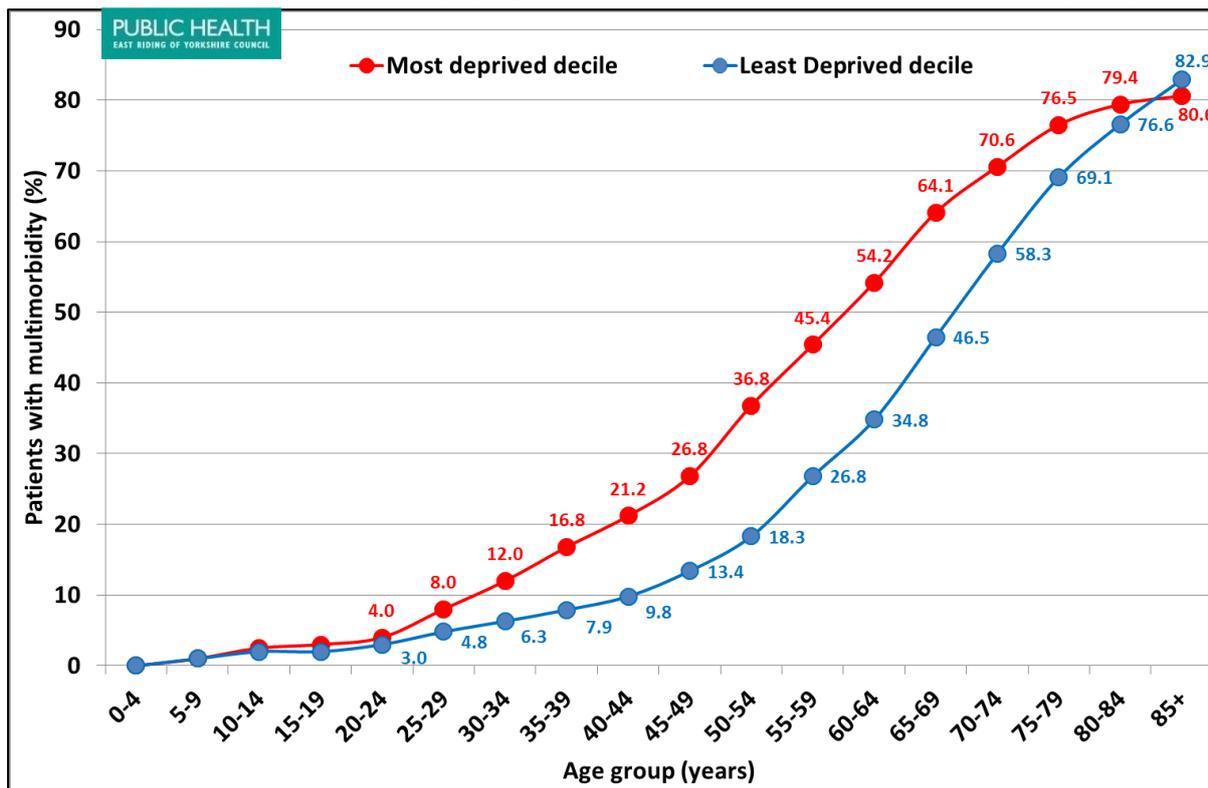
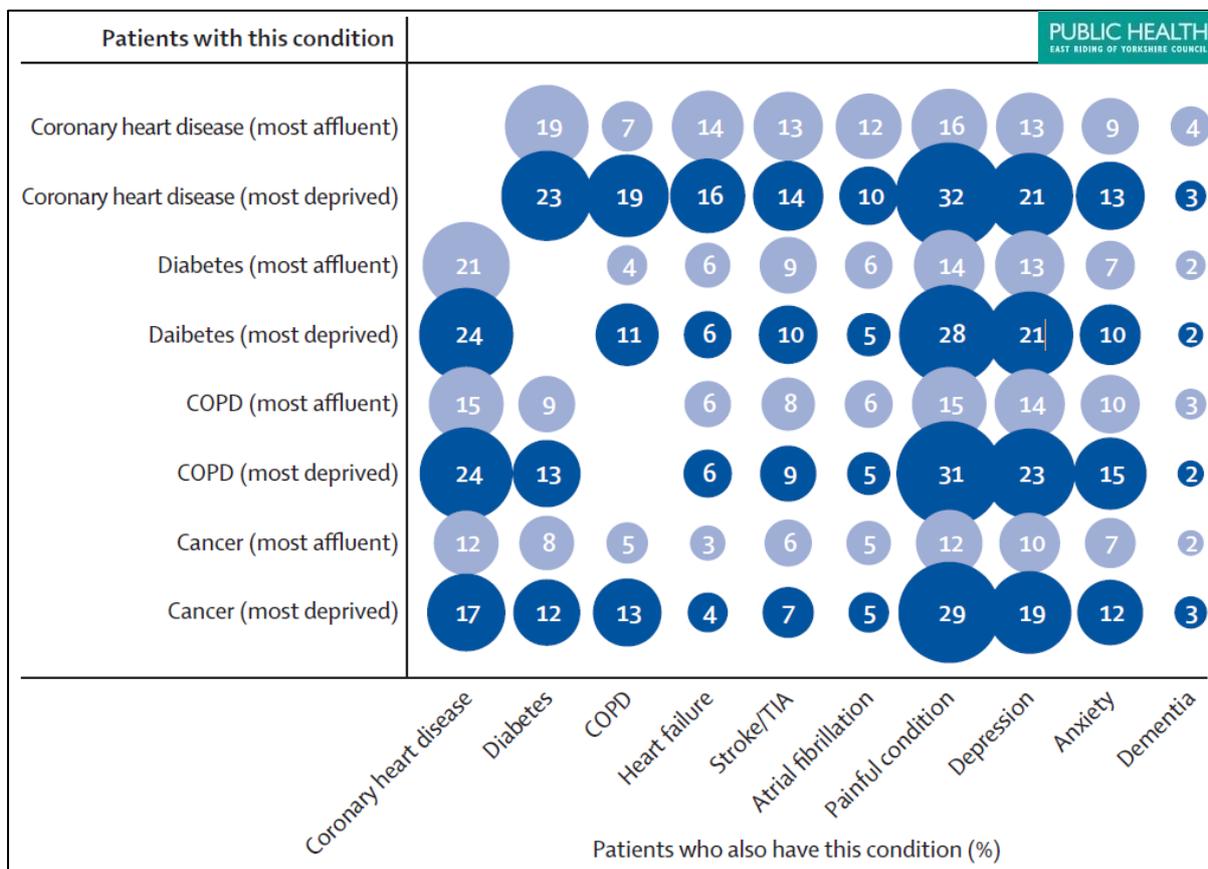


Chart 4.13 Selected comorbidities in people with four common, important disorders in the most affluent and most deprived deciles. Source: Barnet et al (2012)



4.6.3 Estimating long term conditions in ERY residents aged 18-64

The LTC Compendium of Information has been mentioned as one source of prevalence estimates for LTC, the 2012 Health Survey for England is another. A summary of the latter's prevalence estimates for LTCs (excluding mental health conditions) in the 18 to 64 age group, can be found below:

- 71.3% of this age group reported to have no LTCs
- 18.8% reported to have one LTC
- 9.8% reported to have two or more LTC

Table 4.14 applies these prevalence figures to the same age group of the ERY population, with over 36,000 residents (aged between 18 and 64) estimated to have one LTC and nearly 19,000 residents of this age group estimated to have two.

Table 4.14 Number and proportion of people with long standing illness/LTC aged 18-64 years, 2015. Source: Health Survey for England 2012 (applied to 2015 mid-year ONS population estimates for ERY)

Number of LTCs	Prevalence	Estimated number in ERY (aged 18-64) with LTC
No LTC	71.3%	137,868
One LTC	18.8%	36,352
Two or more LTC	9.8%	18,950

4.6.4 Estimating long term conditions in ERY residents aged 60 years of age and over

As already discussed in section 4.6.3, the LTCs Compendium of Information (DoH, 2012) has specified prevalence estimates for people aged 60 years and over.

Table 4.15 applies these prevalence estimates to the ERY population (ONS mid-year, 2015). Based on these prevalence figures it is estimated that there are approximately 60,000 ERY residents aged over 60 with one LTC and over 26,000 with two or more LTCs.

Table 4.15 Proportion of people with LTCs by age, England 2009 applied to ERY population (ONS mid-year 2015). Source: DoH: Long Term Conditions Compendium of Information: Third Edition, 2012

LTC (numbers)	Prevalence	ERY population 60 years & over (mid-year 2015 estimates, ONS)	Estimated numbers of ERY residents aged 60 years & over with LTC(s)
One LTC	58%	105,573	61,232
Two or more LTC	25%	105,573	26,393



5. Health Care

5.1 Hospital admissions for injuries due to falls

The significance of falls in the elderly population is that they are the largest cause of emergency admission within this age group and as a consequence can limit the independence of individuals (for example the individual will have to leave their home to become a resident in a care or nursing home). PHE state that the 65+ age group has the highest risk of falls. They estimate that approximately 30% of this age group living at home and about 50% of residents aged 80+ (living in residential care) will experience a fall at least once a year. PHE also put that the cost of falls nationally at £2 billion a year, accounting for over four million bed days.

The appendix file (pages 27-28) displays a number charts relating to the commentary in this section. Chart A3.1 displays emergency hospital admissions for injuries due to falls in persons aged 65-79 in 2013/14, comparing ERY with England and CIPFA neighbours. ERY residents had 454 emergency admissions due to a fall in this age group. As a rate, it is significantly lower than England and ERY has the fourth lowest rate compared to other local authorities in the group. The data in chart A3.2 shows ERY to have a lower rate than England between 2010/11 and 2013/14.

For the same indicator in residents aged 80+, ERY had 962 emergency admissions. As a rate it places ERY mid-table in comparison to other local authorities and is shown to be statistically similar to England. Between 2010/11 and 2013/14 the ERY rate of emergency admissions was lower than England but the direction of trend appears to be moving upward. Charts A3.3 and A3.4 illustrate the points made in this paragraph.

5.2 Emergency admissions for fractured neck of femur

A common consequence of a fall in an elderly person is an emergency admission for a fractured neck of femur. This is crack or break in the top end of the femur, close to the hip joint.

The occurrence of a hip fracture can severely limit the future independence of an elderly person, with two thirds of those people experiencing it, no longer being able to conduct the same lifestyle they had previously. Those people who were once independent in their own home may find themselves with no option but to move into long-term care.

PHE state that nationally:

- The average age of a person with hip fracture is about 83 years.
- 73% of fractures occur in women.
- There is a high prevalence of comorbidity in people with hip fracture.
- Mortality from hip fracture is high (estimates suggest about one out of ten die within 1 month, one in three die within 12 months).

In 2013/14 there were 414 emergency admissions for fractured neck of femur in ERY residents aged 65+, which equated to a lower (but not significantly) rate per 100,000 persons than England. Compared with other local authorities in the CIPFA group, ERY had the third lowest rate, but all rates were statistically similar. Between 2010/11 and 2013/14 the ERY rate has fluctuated both above and below the England rate. Please refer to charts A3.5 and A3.6 in the appendix file (page 29).

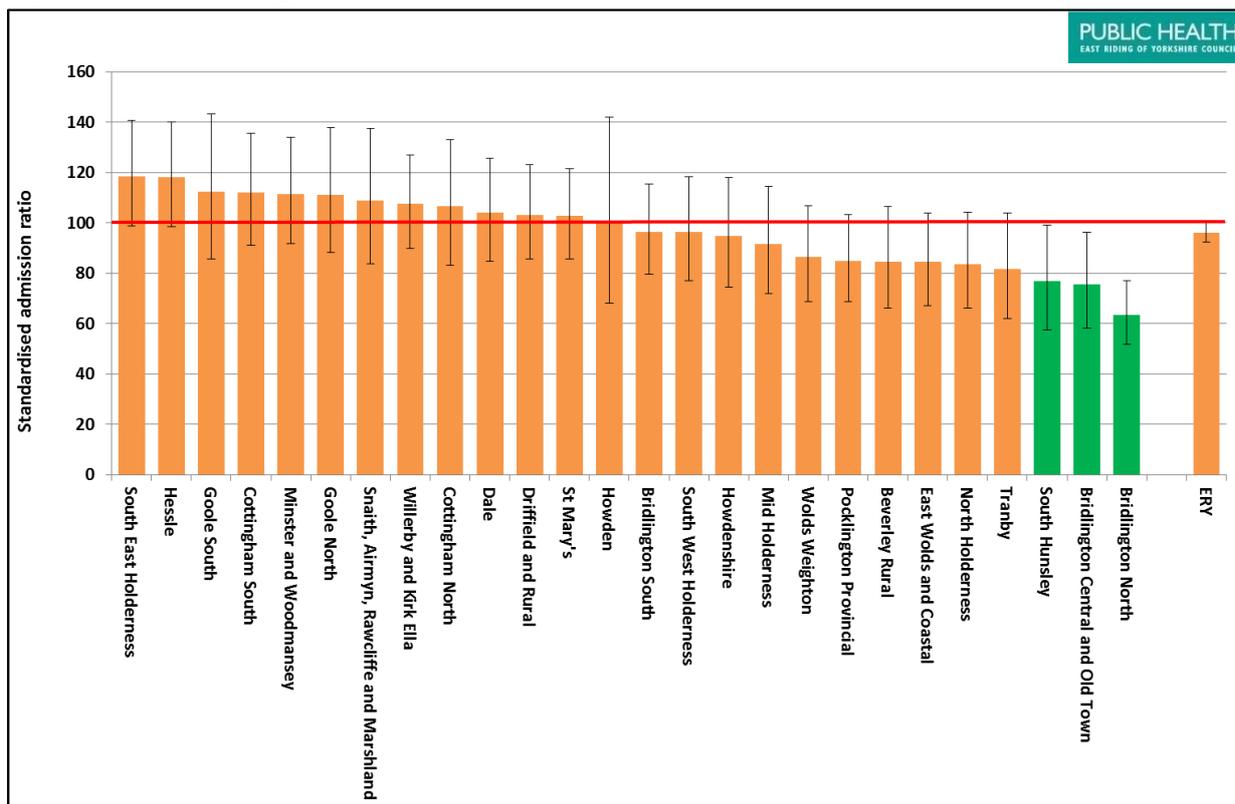


In the same year there were 297 emergency admissions for fractured neck of femur for ERY residents aged 80+. Similarly to the 65+ year olds, the rate of admissions for those aged 80+ in ERY was lower than the England rate and all (but four) of the other local authorities in the group. Again, all rates were statistically similar to one another in the chart. Between 2010/11 and 2013/14 the ERY rate in 80+ year olds has fluctuated both above and below the England rate. Please see charts A3.7 and A3.8 in the appendix file (page 30).

Chart 5.1 below, displays emergency hospital admissions for hip fracture in 65+ year olds, in the five year period 2008/09 to 2012/13, by ERY ward. For each of the wards the rate (based on standardised admission ratios, x100) were mainly considered to fall within the expected rate. Wards such as South East Holderness, Hessle, Goole South (through to) St. Marys all had higher than expected rates, but not significantly so. The two wards with the highest values (South East Holderness and Hessle) had almost 20% more admissions for hip fractures in 65+ years olds, than would be expected, based on their population composition.

There were three wards with significantly lower than expected rates of emergency hospital admission for hip fracture in 65+ and these were South Hunsley, Bridlington Central & Old Town and Bridlington South.

Chart 5.1 Emergency hospital admission for hip fracture in 65+ (SAR) 2008/09 to 2012/13. Source: <http://www.localhealth.org.uk/>



5.3 Alcohol Admissions

According to Public Health England, nationally, alcohol is the third biggest risk factor for illness and death, and alcohol misuse is estimated to cost the health service £3.6bn per year. This section aims to examine the impact of alcohol on the local population (for all ages and those residents aged 65 years and over) through hospital admissions.

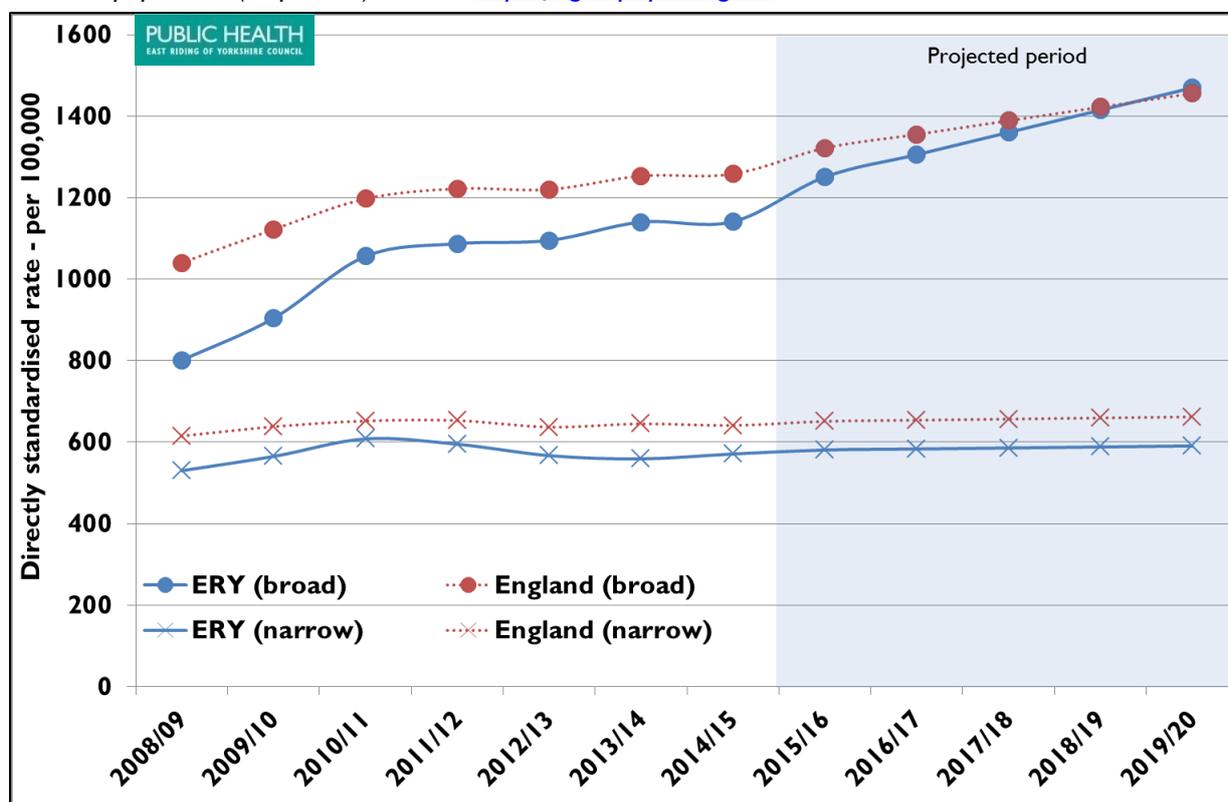
Within this section two definitions of hospital admissions related to alcohol are frequently mentioned:

- Broad: persons admitted to hospital where the primary diagnosis or any of the secondary diagnoses are an alcohol-attributable code. Advantages: is a better measure of the total burden that alcohol has on community and health services.
- Narrow: persons admitted to hospital where the primary diagnosis is an alcohol-attributable code or one of the secondary codes is an external alcohol-attributable code. Advantages: less sensitive to the changes that have occurred in coding over the years and therefore enables fairer comparison between levels of harm in different areas and over time. More responsive to change resulting from local action on alcohol.

5.3.1 Alcohol admissions in ERY, all ages

Chart 5.2 below, displays alcohol admissions using both broad and definitions, comparing ERY against England.

Chart 5.2 Alcohol-related hospital admission (broad and narrow indicators): directly age standardised rate per 100,000 population (all persons). Source: <http://fingertips.phe.org.uk/>



The “broad” indicator has shown ERY to historically have a lower rate than England between 2008/09 and 2014/15, however in recent years ERY has started to close in on the England rate, with projections predicting ERY to be higher by 2019/20. The “narrow” indicator places ERY lower than England and is projected to remain so in the short term future.

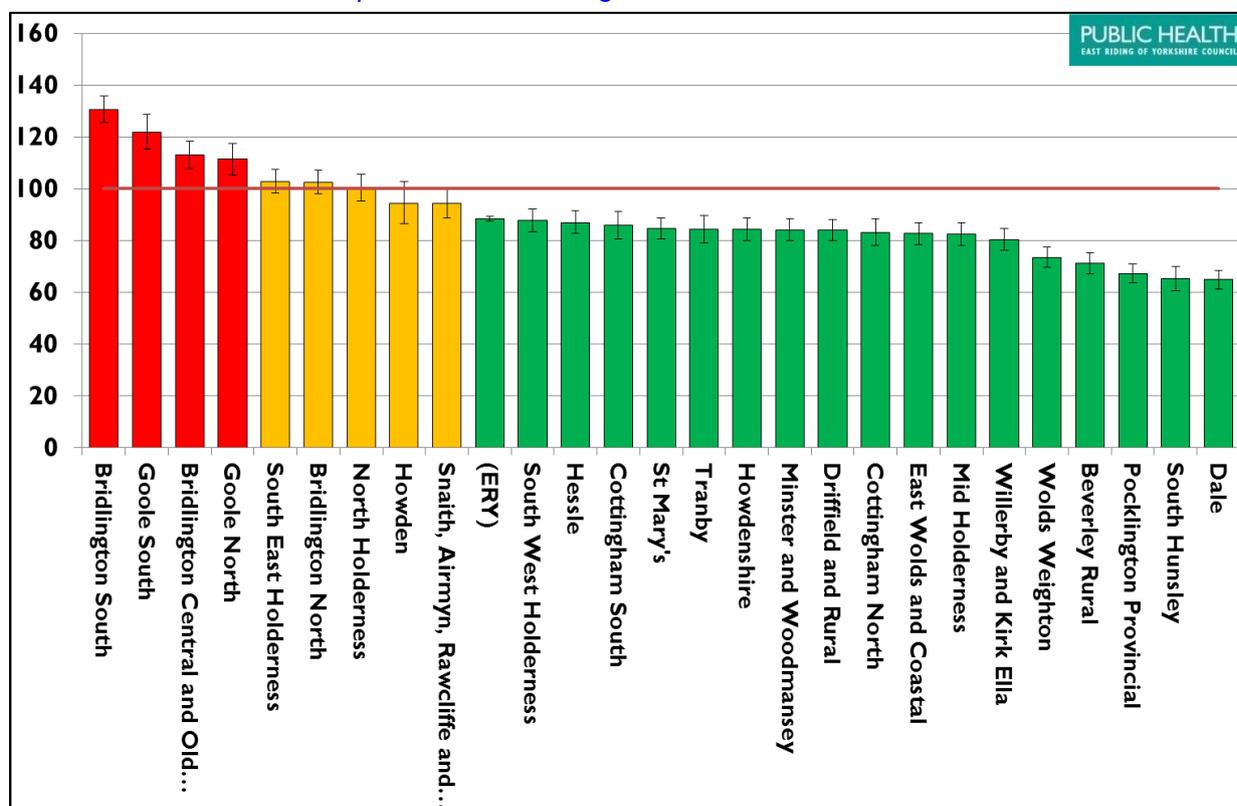
5.3.2 Alcohol admissions – ERY wards, all ages

Chart 5.3 displays the standardised admission ratio (multiplied by 100) for alcohol attributable conditions in all the ERY wards, for the five year period 2008/09 to 2012/13. A Standardised Admission Ratio (SAR) is defined as the ratio of the observed number of admissions in an area to the number expected if the area had the same age specific rates as England.

Both Goole wards and two of the Bridlington wards experienced significantly higher ratio of alcohol attributable admissions than would be expected. More specifically the ward with the highest ratio, Bridlington South, was 30% higher than expected whilst second highest (Goole South) was 20% higher. The third Bridlington ward (Bridlington North) also had a higher than expected ratio, but not significantly. ERY as whole and eighteen of its wards (coloured green in the chart) were all significantly lower than expected.

These rates are also illustrated in map A5.6, which can be found in the appendix file (page 46).

Chart 5.3 Hospital admissions for alcohol attributable conditions, standardised admission ratio (x100), 2008/9 - 2012/13. Source: <http://www.localhealth.org.uk/>



5.3.3 Admission episodes for alcohol-related conditions, persons aged 65+

In 2014/15, there were 783 admissions for alcohol-related conditions in East Riding residents (all persons) aged 65+. As a rate, ERY was classed as statistically similar to England (with directly standardised rates per 100,000 of 190.2 and 190.5 respectively). Please see chart A3.9 in the appendix file.

Compared with its CIPFA neighbours, the 2014/15 rate placed ERY as fourth highest (behind Northumberland, Shropshire and Cornwall) and significantly higher than the bottom five local authorities.

When split by gender (not shown), both males and females aged 65+ in ERY were centrally placed compared to CIPFA neighbours. ERY males experienced a lower rate than England, however ERY females had a higher rate than the England equivalent.

Between 2008/09 and 2014/15, ERY (all persons) experienced a lower rate than England for admission episodes for alcohol-related conditions, but only in 2008/09 was it significantly lower. Please refer to chart A3.10 in the appendix file.

Between 2008/09 and 2014/15, the trend for ERY males aged over 65+ whilst below the England male rate in each year, has begun to show signs of an upward direction. In this period the number of ERY male admissions aged 65+ has risen from 369 to 501 (with the DSR rising from 244.4 to 269.4). The rate for ERY females aged 65+ in the same period fluctuated in being higher and lower than the equivalent England rate, but is showing a more defined upward direction than ERY males. In the same period the number of ERY female admissions aged 65+ has risen from 182 to 282 (with the DSR rising from 95.7 to 127).

5.3.4 Wholly alcohol attributable conditions by NHS ERY CCG localities (practice based), all ages

NHS ERY CCG localities exist primarily as groupings of GP surgeries, although other JSNA work has grouped together geographic wards and referred to them as localities too.

Analysis of wholly attributable alcohol conditions (where alcohol is 100% contributory, e.g. alcoholic liver disease) was conducted on patient admissions (of all ages) belonging to each locality for the three year period 2010-12. The directly standardised rates produced for each locality were compared with the NHS ERY CCG average and a summary can be found below:

- Bridlington: significantly higher than the NHS ERY CCG average.
- Goole Howden and West Wolds: similar to the NHS ERY CCG average.
- Holderness: similar to the NHS ERY CCG average.
- Beverley and Driffild: significantly lower than the NHS ERY CCG average.
- Haltemprice: significantly lower than the NHS ERY CCG average.

A number of individual practices throughout the ERY were found to have significantly higher admissions rates for alcohol conditions than the ERY average, however for sensitivity purposes they are not shown in this document.



5.3.5 Admission episodes for alcohol-related cardiovascular disease (CVD) conditions

Whilst the calculation of this indicator is based on residents of all ages, more older people are admitted to hospital with alcohol-related conditions than the younger age groups. Generally, the risk of CVD also increases with advancing age too.

Chart 5.4 places ERY as the second highest local authority within its CIPFA group for admission episodes for alcohol-related cardiovascular disease conditions in 2014/15, with a DSR rate of 1,189 significantly higher than the England equivalent (1,077). Chart 5.5 displays the clear rising trend of ERY admission rates for this condition between 2008/09 and 2014/15, with ERY catching and then passing the England rate.

When split by gender (not illustrated in this document) ERY males have the highest rate of alcohol-related cardiovascular disease admissions in its CIPFA group, significantly higher than the England rate. The rising trend has seen an increase in ERY male admissions of 1,335 (DSR rate of 842) in 2008/09 to 3,200 admissions (DSR rate of 1,771) in 2014/15. Whilst there was a drop between 2013/14 and 2014/15, the upwards trend is starkly apparent.

ERY females have a higher rate than England females, but not significantly and are placed third highest within the CIPFA group. The rising trend in admissions of ERY females for this condition had been increasing year on year between 2008/09 (625 admissions, DSR rate of 325) and 2013/14 (1,525 admissions, DSR rate of 772), but was halted in 2014/15 with a reduction to a DSR rate of 724.

Chart 5.4 Admission episodes for alcohol-related cardiovascular disease conditions (Broad) in all persons. DSR per 100,000. ERY versus England & CIPFA group. 2014/15. Source: <http://fingertips.phe.org.uk/>

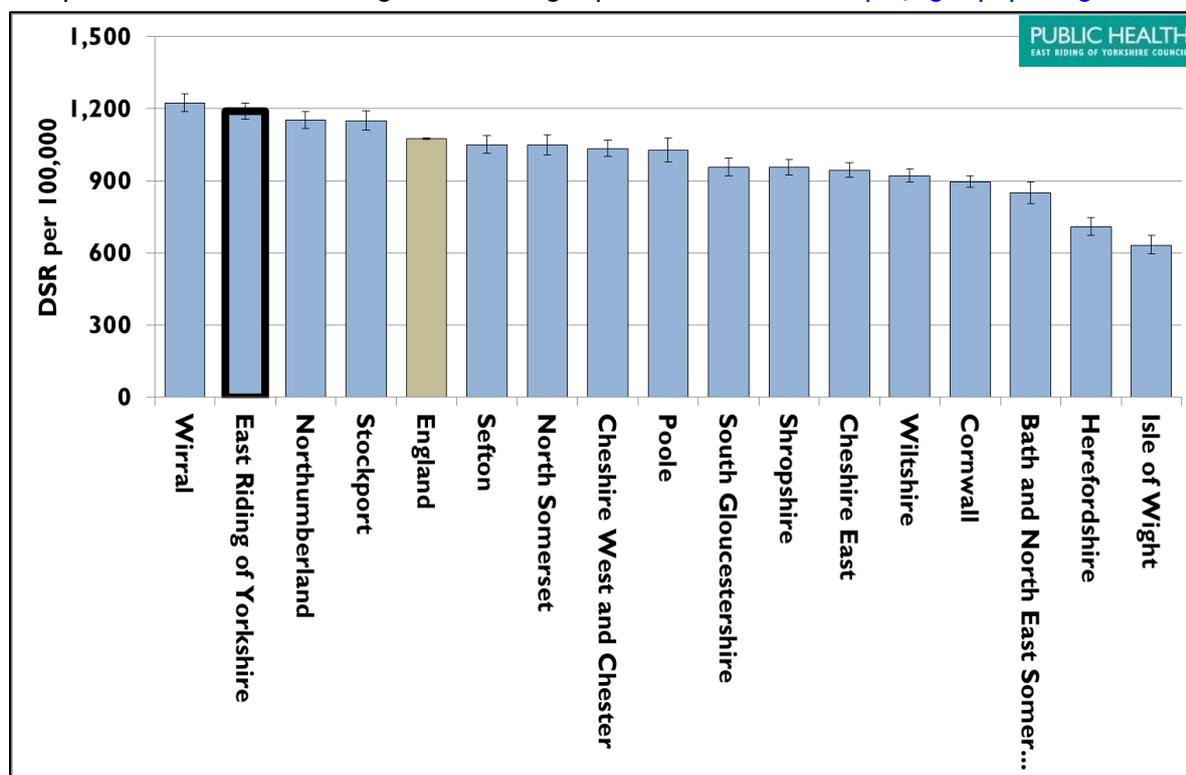
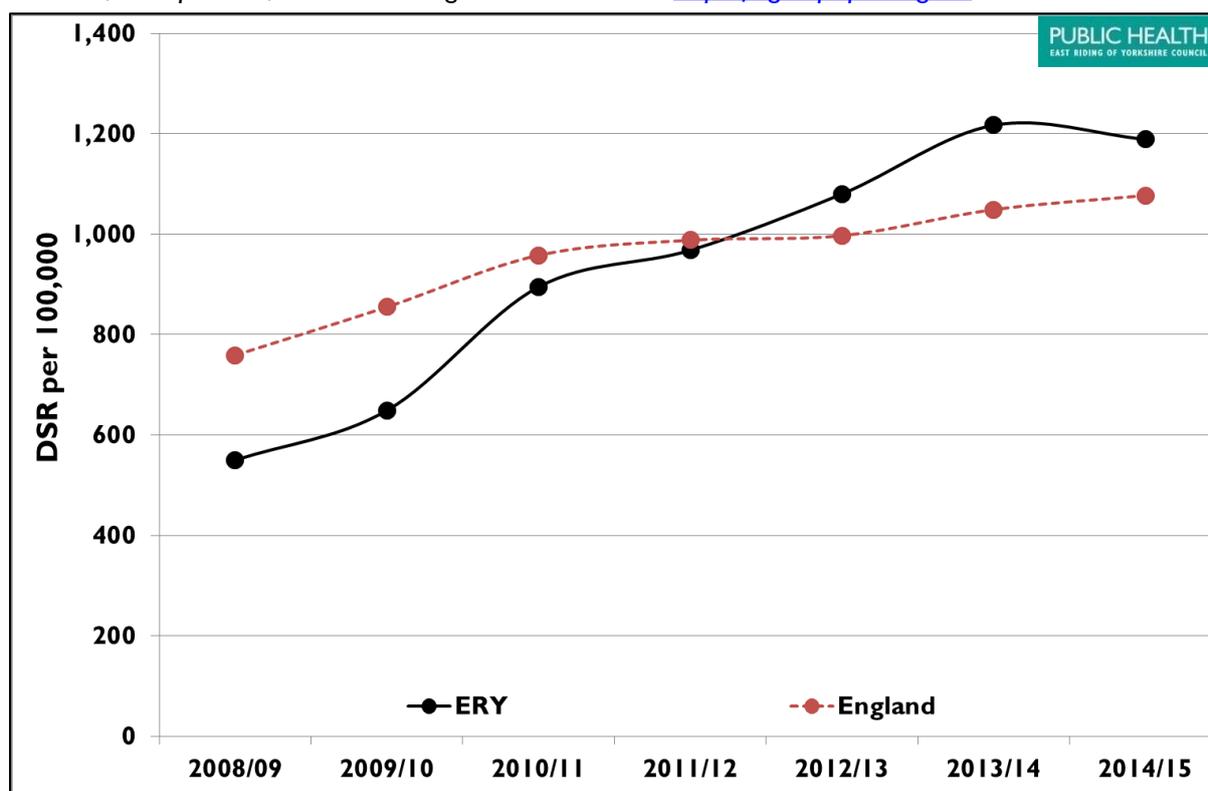


Chart 5.5 Admission episodes for alcohol-related cardiovascular disease conditions (Broad) all persons. 2014/15, DSR per 100,000. ERY & England trend. Source: <http://fingertips.phe.org.uk/>



5.3.6 Incidence rate of alcohol-related cancer

Alcohol consumption is a contributing factor to a diverse range of conditions and there is a strong scientific consensus of an association between excessive alcohol consumption and several types of cancer. This section looks at the incidence (newly diagnosed) rate of alcohol-related cancer in residents of all ages.

In the three year period 2012-14 there were 421 new cases of alcohol related cancer diagnosed within ERY residents, equating to a DSR of 36.7 per 100,000. This rate was lower (but statistically similar) to England and placed ERY third lowest in its CIPFA group (chart A3.11 on page 32 of the appendix file). The rate has fluctuated between 2004/06 and 2012/14 but in all but two periods remained lower than the England DSR (chart A3.12 in the appendix).

When split by gender the male DSR places it in the bottom third of its CIPFA group in 2012-14 with a DSR of 37.4 per 100,000 (202 new cases), which was similar to the DSR of 2004-06 (37.9, equating to 171 new cases).

ERY females have the third lowest value within the CIPFA group but have seen a rise in the DSR from 33.5 in 2004-06 (181 new cases) to a DSR of 36.5 (219 new cases) in 2012-14.



5.4 Seasonal Flu Programme 2016/2017

A Seasonal Flu Co-ordination Group was been established to ensure that seasonal flu activity is understood and owned by all organisations across the East Riding in order to maximise uptake against key targets, minimise any disruption to essential services that a flu outbreak could cause if health and social care staff are not vaccinated, and importantly, protect the health of the most vulnerable people within the population. The main focus will be to increase staff awareness and vaccination uptake, exploring different delivery models. There will be a focus on young children, carers and pregnant women, particular groups where the take up rate needs to be increased.

NHS England Public Health Team has established a Local Seasonal Influenza Programme Groups with the aim to co-ordinate and plan for the demands of flu across East Riding of Yorkshire, Hull, North Lincolnshire, North East Lincolnshire, North Yorkshire and York. These groups report to the Immunisation Programme Boards.

The overall purpose of the Seasonal Influenza Programme Groups is to provide a clear framework for the coordination, planning, delivery and implementation of Seasonal Influenza Programme across East Riding of Yorkshire, Hull, North Lincolnshire, North East Lincolnshire, North Yorkshire and York areas ensuring provision of a high quality service, which meets the required standards whilst addressing inequalities in health.

As in previous years, PHE has centrally procured flu vaccine for children included in this year's phase of the roll out and those aged from six months to less than 18 years old in clinical risk groups. This is to simplify the supply of LAIV and inactivated flu vaccine for GPs and other providers during the phased implementation of the programme. With the exception of the central procurement of vaccine for children less than 18 years of age, it remains the responsibility of GPs and other providers to order sufficient flu vaccine directly from manufacturers for older eligible patients of the flu programme in 2016/2017.

Table 5.5 Reports of influenza infection made to PHE, by week of report. Source: PHE

Week	Week 35	Week 36	Week 37	Week 38	Week 39	Total
Week ending	04/09/2016	11/09/2016	18/09/2016	25/09/2016	02/10/2016	
Influenza A	14	22	9	18	16	79
Isolation	–	–	–	–	–	–
DIF *	–	–	1	–	–	1
PCR	13	14	8	15	15	65
Other †	1	8	–	3	1	13
Influenza B	3	5	4	3	–	15
Isolation	1	–	–	–	–	1
DIF *	–	–	–	–	–	–
PCR	2	1	4	3	–	10
Other †	–	4	–	–	–	4

* DIF = Direct Immunofluorescence.

† Other = “Antibody detection - single high titre” or “Method not specified”.



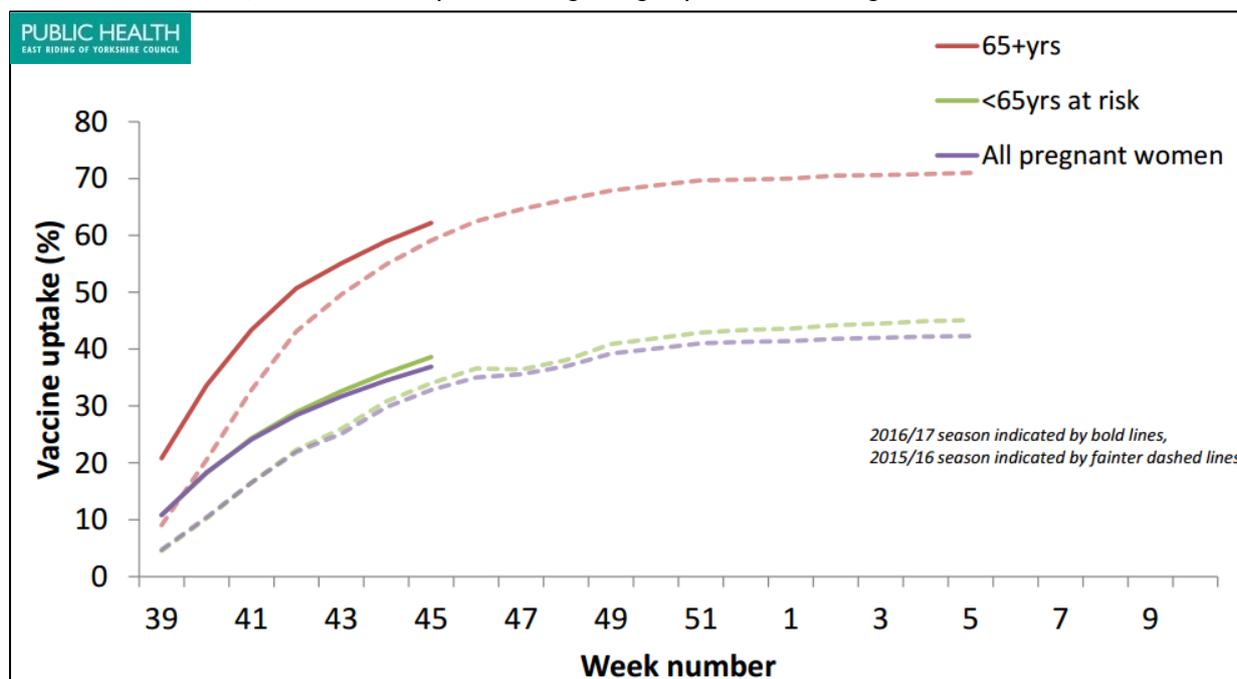
At the start of the 2016/2017 influenza season, activity is at low levels in week 43 (ending 27 October 2016). GP respiratory indicators showed seasonal increases in week 42. Thirteen new acute respiratory outbreaks have been reported in the past 7 days. Twelve outbreaks were from care homes where two tested positive for rhinovirus. The other outbreak was from a school and tested negative for influenza and other respiratory viruses.

The overall weekly influenza-like illness (ILI) GP consultation rate was 6.4 per 100,000 in England and is below the baseline threshold. Four admissions to ICU/HDU with confirmed influenza were reported across the UK. No other hospitalised confirmed influenza cases were reported. No confirmed influenza admissions have been reported from the six Severe Respiratory Failure centres in the UK.

Up to week 42 2016, in 86.9% GP practices reporting weekly to Immform, the provisional proportion of people in England who had received the 2016/17 influenza vaccine in targeted groups was as follows: 28.9% in under 65 years in a clinical risk group, 28.4% in pregnant women, 50.7% in 65+ year olds. In 89.5% of GP practices to Immform, the provisional proportion of children in England who had received the 2016/17 influenza vaccine was as follows: 14.1% in all 2 year olds, 15.0% in all 3 year olds and 11.3% in all 4 year olds. Chart 5.6 below, demonstrate an increase in uptake of seasonal flu vaccinations compared with this stage in 2015/2016.

Globally, influenza activity is low and at inter-seasonal levels in the Northern Hemisphere but showing signs of decreasing in the Southern hemisphere.

Chart 5.6 Seasonal influenza vaccine uptake in targeted groups, 2016/17, England. Source: PHE



5.5 Shingles

From 1 September 2016, shingles immunisation should be offered to individuals aged 70 for the routine programme, and aged 78 for the catch-up programme. Eligibility is determined by the patient's age on 1 September 2016. GPs should also continue to offer immunisation to all those who became eligible from 1 September 2013 (i.e. those aged 71 to 73, and 79 on 1 September 2016), if they have not already been immunised, until their 80th birthday.

By the end of March 2016 just under half of eligible 70 and 78 year olds had been vaccinated against shingles for the current year of the programme. GPs are urged to use every opportunity to offer shingles vaccination to eligible patients to help to protect as many elderly people as possible from this painful and debilitating condition. This applies both in the remainder of this shingles year (i.e. up to 31 August), and next year (i.e. from 1 September).

The annual shingles immunisation letter introducing the fourth year of the programme has been published. The shingles guidance and vaccination programme online page is available. The Shingles vaccination calculator for adults aged 70, 78 or 79 years of age has now been updated. The main shingles leaflet has been updated and is available to download now.



7. End of life and mortality

7.1 Causes of death in ERY

On average 3,500 East Riding residents die each year. The cause of death for residents of all ages and those aged less than 75 (classed as premature death) are displayed in tables 7.1 and 7.2 respectively. The time period shown in the tables is a three year pooled period, 2013-15.

Table 7.1 shows that heart disease is the main cause of death in ERY residents of all ages (7.8%, n=878), followed by dementia (6.9%, n=772) and then bronchus/lung cancer (6.2%, n=694).

For ERY residents who died prematurely, 7 out of the 10 diseases listed were a form of cancer. Table 7.2 shows bronchus/lung cancer as the largest cause of death (10.1%, n=324) in this age group. Chronic obstructive pulmonary disease (COPD), which is a closely linked with smoking, was the 4th biggest killer in this age group at 4.9% (n=157).

Table 7.1 Top 10 causes of death in ERY residents (all ages), 2013-15 (3 years pooled). Also shows each cause as a % of total deaths, in same time period. Source: PHE.

Top 10	ICD_10	Description	Count of deaths	Cause as % of total deaths
1	I25	Chronic ischaemic heart disease	878	7.8%
2	F03	Unspecified dementia	772	6.9%
3	C34	Malignant neoplasm of bronchus and lung	694	6.2%
4	J44	Other chronic obstructive pulmonary disease	595	5.3%
5	J18	Pneumonia, organism unspecified	566	5.0%
6	I21	Acute myocardial infarction	566	5.0%
7	I64	Stroke, not specified as haemorrhage or infarction	437	3.9%
8	C50	Malignant neoplasm of breast	251	2.2%
9	C61	Malignant neoplasm of prostate	238	2.1%
10	I67	Other cerebrovascular diseases	203	1.8%
All ERY resident deaths (2013-2015), all ages			11,234	

Table 7.2 Top 10 causes of death in ERY residents aged under 75 years, 2013-15 (3 years pooled). Also shows each cause as a % of total deaths under 75 years of age, in same time period. Source: PHE.

Top 10	ICD_10	Description	Count of deaths	Cause as % of total U75 deaths
1	C34	Malignant neoplasm of bronchus and lung	324	10.1%
2	I25	Chronic ischaemic heart disease	234	7.3%
3	I21	Acute myocardial infarction	211	6.6%
4	J44	Other chronic obstructive pulmonary disease	157	4.9%
5	C50	Malignant neoplasm of breast	129	4.0%
6	C18	Malignant neoplasm of colon	86	2.7%
7	C25	Malignant neoplasm of pancreas	83	2.6%
8	C71	Malignant neoplasm of brain	73	2.3%
9	C15	Malignant neoplasm of oesophagus	63	2.0%
10	C80	Malignant neoplasm without specification of site	62	1.9%
All ERY resident deaths (2013-2015) aged less than 75 years			3,216	



7.2 Cause of death in ERY wards, using directly standardised rates (DSR)

This page provides a summary of where the mortality rates of ERY wards are significantly higher or lower than the ERY average. All of them (with one exception) examine the mortality rate that occurred in people of all ages.

Charts A4.1 to A4.6 (page 33 onwards, in the appendix file) illustrate the observations made below

- **All-cause mortality, all ages**

Compared to the ERY average, there are significantly higher rates of all-cause mortality in Bridlington South, Hessle, Goole South, Snaith, North Holderness and Driffield and Rural wards. Rates that are significantly lower are found in Mid Holderness, Willerby & Kirk Ella and Beverley Rural.

- **All-cause premature mortality, under 75 years of age**

There are significantly higher rates of all-cause premature mortality in the wards of Bridlington South, Goole South and Bridlington Central and Old Town. Rates that are significantly lower include Willerby & Kirk Ella, Cottingham North, Beverley Rural and Dale.

Chart 7.3 on the next page, displays the varying rates of premature mortality described above.

- **All cancers, all ages**

There are significantly higher rates in Bridlington South and Hessle, whilst significantly lower rates are found in Beverley Rural and South West Holderness.

- **Coronary Heart Disease (CHD), all ages**

Bridlington South has a significantly higher rate of CHD mortality, whilst Willerby and Kirk Ella is significantly lower.

- **Chronic obstructive pulmonary disease (COPD), all ages**

There are significantly higher rates in Goole South and Howden. Bridlington North and Willerby and Kirk Ella experience significantly lower rates.

- **Cardio Vascular Disease (CVD), all ages**

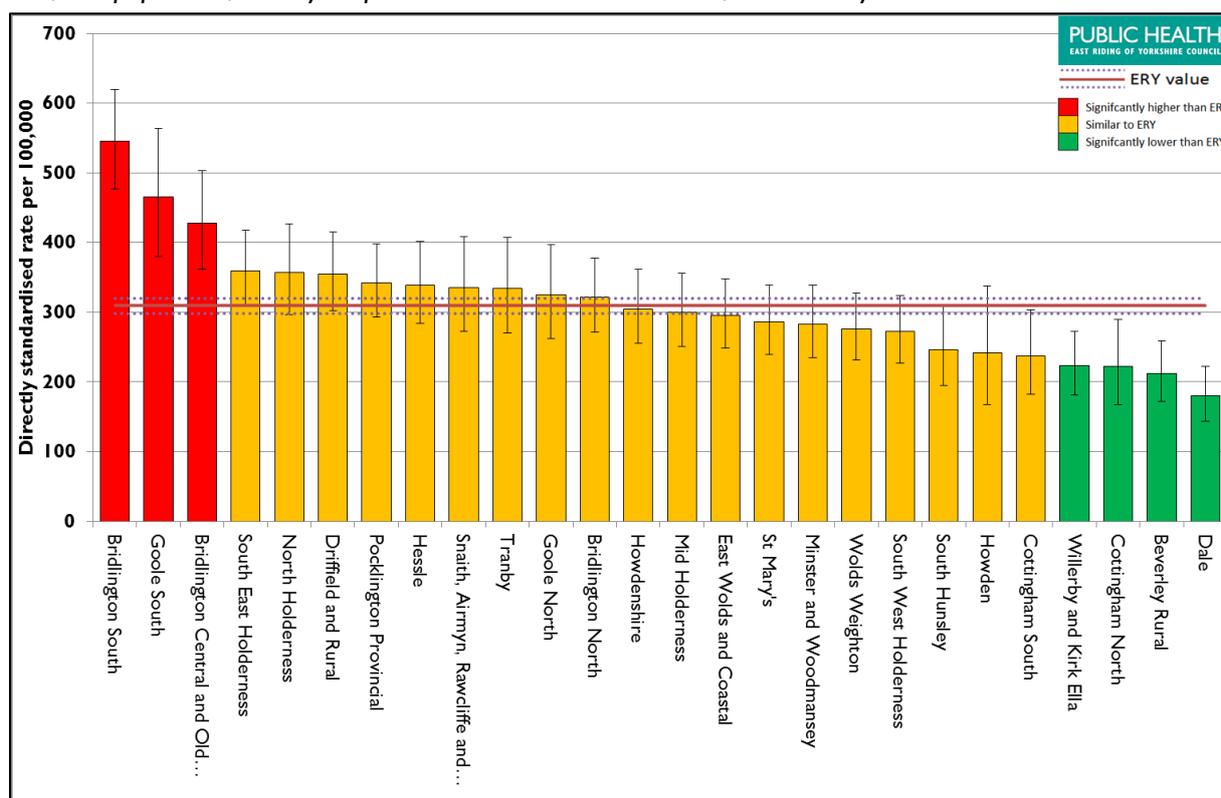
Bridlington South has a significantly higher rate, whilst Willerby and Kirk Ella and Beverley Rural experience significantly lower rates.

- **Dementia, all ages**

Snaith, Hessle, Goole North, Bridlington South and North Holderness, all have significantly higher rates. All but one of the 10 wards with the lowest dementia mortality rates are significantly lower than the ERY average.



Chart 7.3 ERY wards: all-cause mortality in all persons aged <75 years. Directly standardised rate per 100,000 population, three year period 2012-14. Source: PCMD, via Hull City Council Public Health Sciences



7.3 Cause of death in ERY wards, using standardised mortality ratios (SMR)

Another way to examine mortality in an area is to use standardised mortality ratio (SMR), also known as indirect standardisation. SMR is the ratio between the observed number of deaths in ward and number of deaths that would be expected based on the age and sex-specific rates in a standard population (in this case, England). An SMR equal to 100 suggests that the mortality rate is the same as the standard mortality rate, a number higher than 100 implies a mortality rate in excess of the standard mortality rate and a number below 100 implies below average mortality. Unlike DSR, direct comparisons between wards using SMR should not be undertaken.

The chart on the next page and those in the appendix file (pages 36 to 39) show that any ward coloured red is significantly worse than the standard rate, those coloured amber are statistically similar and any coloured green are significantly better.

It is clear from the charts that the wards which have significantly higher than expected rates of mortality (both all age and premature mortality) are generally the more deprived wards within ERY. The wards with significantly less than expected mortality, are generally the least deprived wards of ERY. The two ERY wards considered most deprived (Bridlington South and Goole South) are identified as both having higher than expected mortality for most causes of premature death.

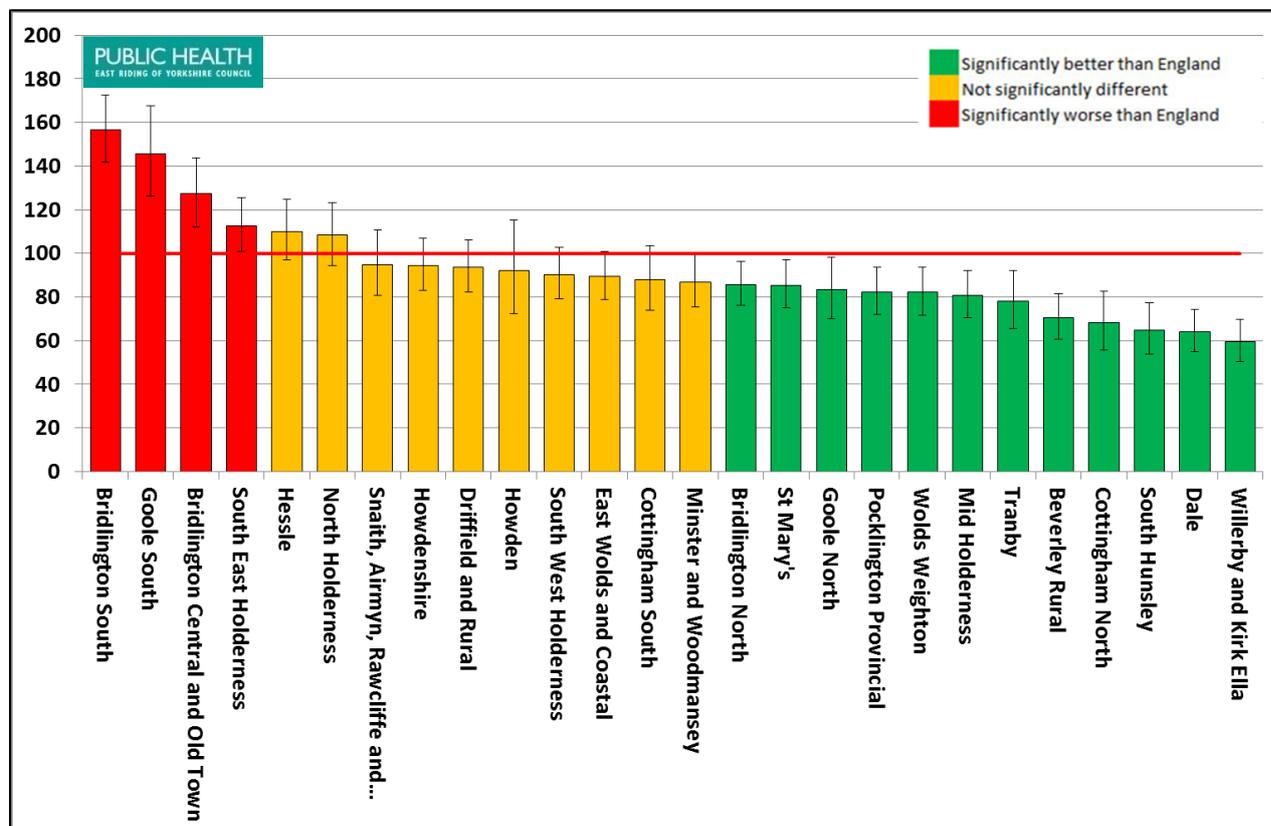
Chart 7.4 illustrates that Bridlington South has 50% more premature death than would be expected based on its population structure and Goole South has over 40% more. Other deprived wards such as South East Holderness also feature frequently as having a higher than expected rate of mortality.



Please refer back to section iii. at the beginning of this document for further detail about the most and least deprived wards.

Chart 7.4 Deaths from all causes, under 75 years of age, Standardised Mortality Ratio (SMR), 2008-12.

Source: <http://www.localhealth.org.uk/>



7.4 Excess Winter Deaths

Excess Winter Deaths compares the number of extra deaths that occurred in the Winter months (December to March), compared to the average number of deaths in the four months either side. The majority of winter deaths occur amongst the elderly population.

The number of excess winter deaths depends on the temperature, the prevalence of disease in the population and how well equipped people are to cope with a drop in temperature. Most excess winter deaths are due to circulatory and respiratory diseases. The Eurowinter Group (and other researchers) found that the mortality rate in winter increases more in England and Wales, compared to other European countries with similarly colder climates. This would suggest that a number of deaths could be preventable within England and Wales.

The Excess Winter Deaths Index (EWD Index) presented here, is calculated as: (excess winter deaths / average non-winter deaths) x 100. The information is presented as 3 year pooled periods (e.g. August 2012 to July 2015), to compensate for fluctuations found in individual years.



7.4.1 Excess Winter Deaths: residents of all ages

Over the past 5 periods (August 2008 to July 2015) the average annual number of excess winter deaths in ERY was 573 per year. In the latest period (August 2012 to July 2015), there were 668 excess winter deaths (303 male and 365 female). The ERY EWD index of 19.1 placed it within the bottom third of values within its CIPFA group and was similar to the England average of 19.6. Since August 2001, the ERY excess winter deaths index has faithfully followed national trends, remaining statistically similar. Similar findings were also made when excess winter deaths were examined by gender.

7.4.2 Excess Winter Deaths: residents aged 85 years and over

Between August 2008 and July 2015 (the latest 5 periods) the average number of excess winter deaths in ERY 85+ year olds, was 349 per year. In the latest three year period there were 488 deaths in ERY, equating to an EWD index of 35.3, higher (but not significantly) than the England average of 28.2

However, it was observed that the ERY value placed it second highest within its CIPFA group and highest of all the Yorkshire and the Humber local authorities. Trends, going back to 2006-09 found that ERY generally mirrored the national trend, until 2012-15, when the ERY index suddenly increased away from the national average. EWD in females was not the cause of the rise, as the index value for recent periods were statistically similar to England; instead the cause of the increase was due to the excess deaths in 85+ year old males. The EWD index for 2010-13, found ERY males to have a significantly higher value than England and placed ERY at the top of both the CIPFA and regional comparator groups. Further investigation discovered that the single year of August 2012-July 2013 was the cause of the whole three year period to be significantly higher, as it was the only year when ERY males had a significantly higher index than that of England.

To illustrate these points, chart 7.5 compares ERY males (aged 85+) to the rest of the CIPFA neighbours; whilst chart 7.6 displays the trend for 85+ year old males between 2001-04 and 2012-15. The red circle in the last period signifies that the ERY value is significantly higher than England.



Chart 7.5 Excess Winter Deaths Index (3 year pooled periods), males 85+ years of age. August 2012 – July 2015. ERY compared to England and CIPFA neighbours. Source: <http://fingertips.phe.org.uk/>

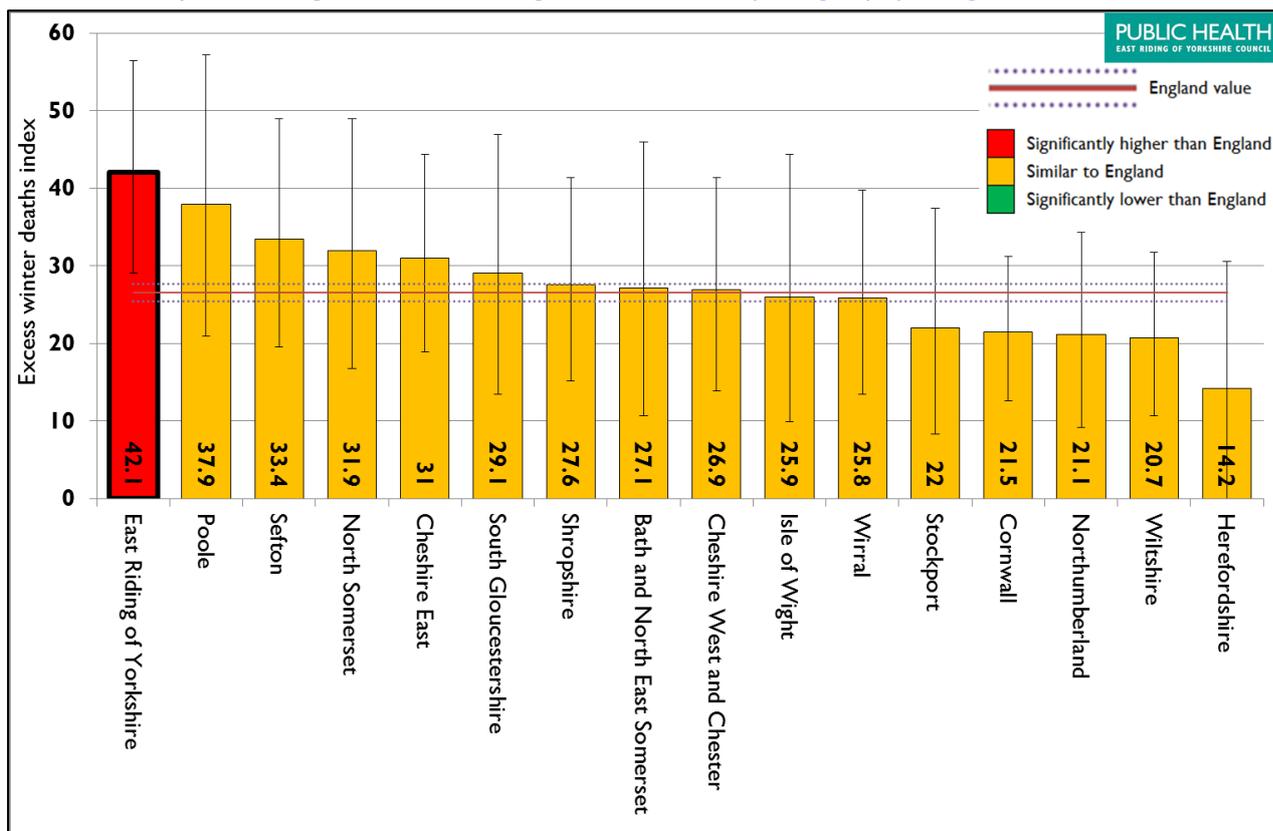
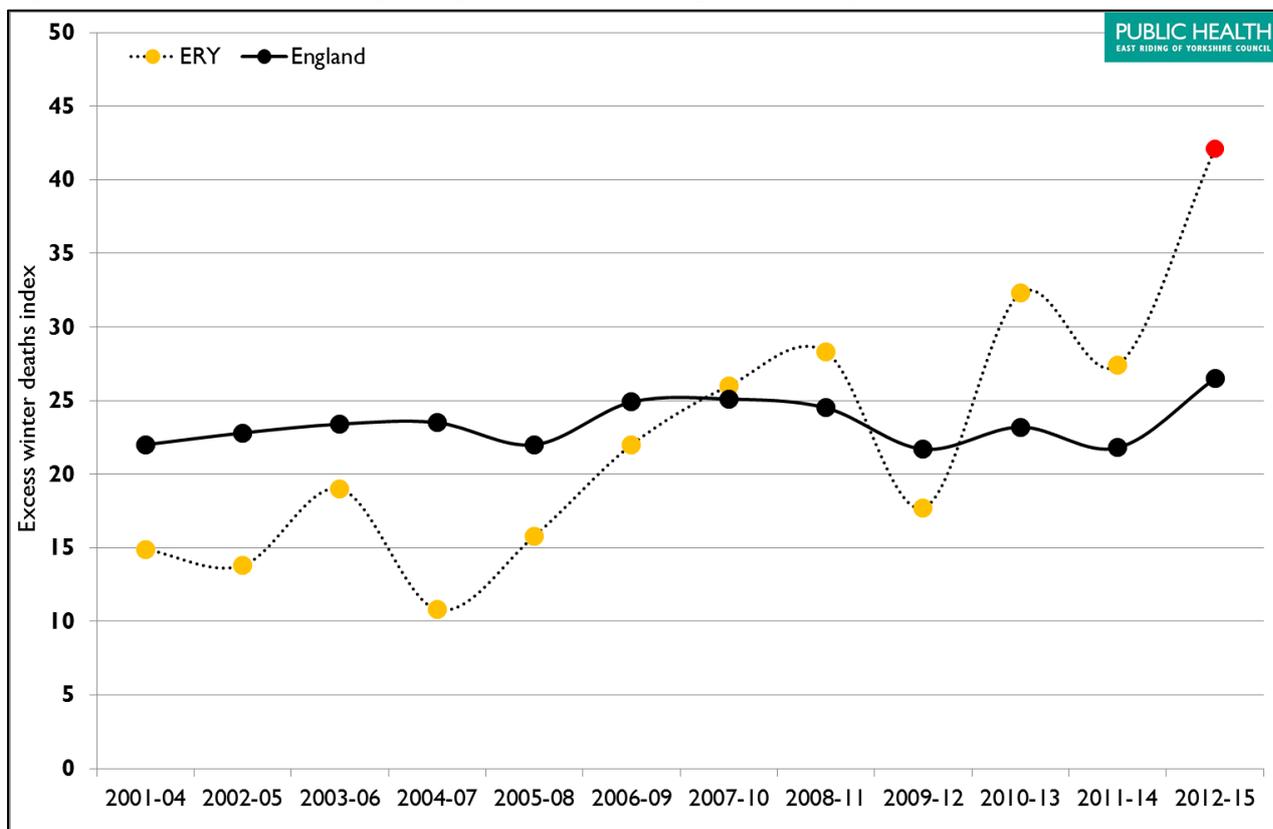


Chart 7.6 Excess Winter Deaths Index (3 year pooled periods), males 85+ years of age. ERY trend versus England. Each year represents August to July. Source: <http://fingertips.phe.org.uk/>



7.5 Deaths at a specific location

7.5.1 Deaths at a specific location summary

Table 7.7 provides a summary of where deaths occurred in ERY residents of all ages. The proportion in each location are compared to the equivalent in England.

Table 7.7 Deaths at a specific location, ERY residents of all ages, 2015. Source: PHE

Location	Number of deaths	Location as % of all deaths		Comment about ERY %, compared to England
		ERY	England	
Hospital deaths	1,671	47.0%	46.7%	Similar
Care home deaths	931	26.2%	22.6%	Significantly higher
Home deaths	722	20.3%	22.8%	Significantly lower
Hospice deaths	149	4.2%	5.6%	Significantly lower
Deaths in Other Places	82	2.3%	2.2%	Similar
Total	3,555	100.0%	100.0%	

7.5.2 Deaths in usual place of residence (all ages)

'Usual place of residence' includes deaths that have occurred at home, care home or religious establishment, but excludes deaths from external causes. It is generally regarded as one of the most important indicators for mortality and end-of-life, as it can be used as a proxy to assess the standard of choice and access. This is because survey data suggests that the preference of most people would be to die at home, rather than in a hospital.

In 2015, 47% of ERY residents died in their usual place of residence, which was statistically similar to the England average (46%), but placed ERY within the bottom third of the CIPFA neighbours. Since 2004 the proportion of residents dying in their usual place of residence has steadily been on the increase, rising from 38% (n=1,308) in 2004 to 47% (n=1,790) in 2015.

7.5.2 Deaths in a hospital (all ages)

ERY had the 4th highest proportion of deaths in hospital (47%) in 2015 compared to its CIPFA neighbours, which was statistically similar to the England average of 46.7%. The proportion of ERY deaths in hospital has fluctuated since 2004, but is generally decreasing following national trends. The proportion has reduced from 57.7% (n=2,044) in 2004 to 47% in 2014 (n=1,847).

7.5.3 Deaths in a hospice (all ages)

4.2% of ERY residents died in a hospice in 2015 (n=164), a proportion that was significantly lower than the England average of 5.6%. The proportion also placed ERY within the bottom half of values within its CIPFA group. Between 2004 and 2013 deaths in a hospice remained relatively static (and significantly lower than England) at approximately 2.2%, but in 2014 this increased to 4.1% and increased again in 2015.

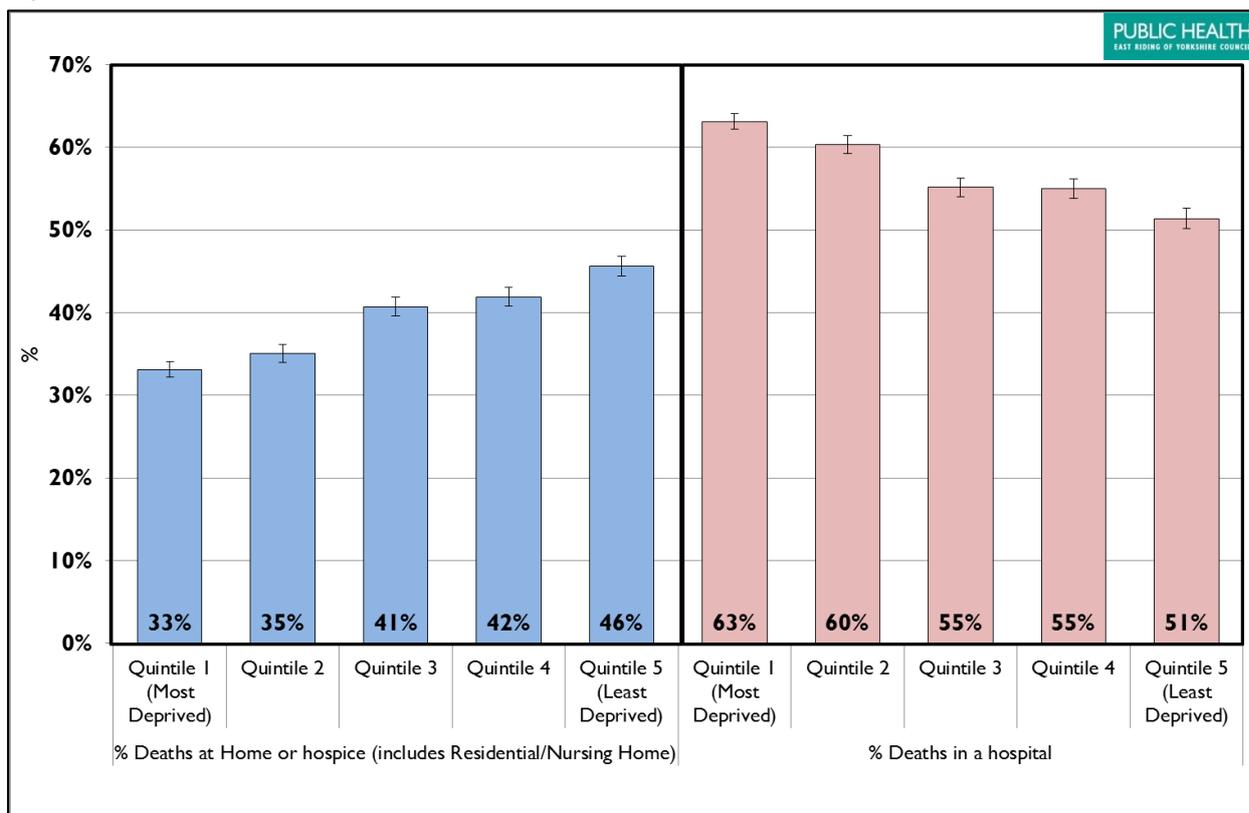


7.5.4 Location of deaths by deprivation quintile (all ages)

Chart 7.8 uses mortality data for the pooled period 2001 to 2011 and illustrates the location of death by the different local deprivation quintiles. The least deprived quintiles are shown to have the highest proportion of deaths at home or a hospice and the lowest proportion of deaths in hospital. In contrast, the most deprived quintiles have a higher proportion of deaths in hospital and a lower proportion at home or a hospice.

In the near future this analysis will be conducted again, with more recent data, to see if these inequalities still exist.

Chart 7.8 Location of place of death, ERY residents 2001 to 2011, all ages. IMD 2015 using local deprivation bands. Source: ONS



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Public Health Intelligence Team
East Riding of Yorkshire Council
JF80, J Block, County Hall
Cross Street, Beverley
HU17 9BA

phintelligence@eastriding.gov.uk

www.eastriding.gov.uk/jsna

