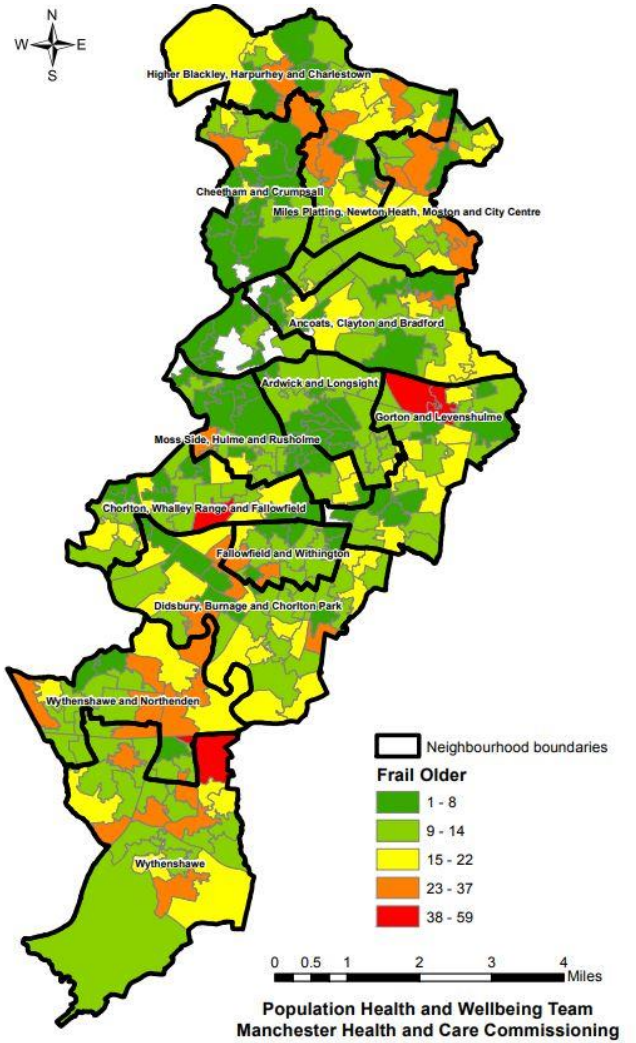
Manchester Health & Care Commissioning
A partnership between Manchester City Council and NHS Manchester CCG

MANCHESTER CITY COUNCIL

NHS Manchester Clinical Commissioning Group

Frail Older Adults
Health & Social Care Cohort Profile



Introduction to MHCC Neighbourhood & Cohort Profile Reports

The Locality Plan developed by Health & Social Care commissioners in Manchester sets an ambition that those sections of the population most at risk of needing care will have access to more proactive care, available in their local communities.

The key transformation is the establishment of 12 Integrated Neighbourhood Teams across the City based on geographical area as opposed to organisation. The teams focus on the place and people that they serve, centred around the ethos that 'The best bed is your own bed' wherever possible and care should be closer to home rather than delivered within a hospital or care home.

The ambition of this model is to place primary care (GP) services at the heart of an integrated neighbourhood model of care in which they are co-located with community teams. These teams could include Community Pharmacists, Allied Health Professionals (AHPs), Community Nursing, Social Care Officers, Intermediate Care teams, Leisure and health promotion teams, Ambulance teams and 3rd sector teams, with a link to educational and employment teams.

All services are based upon a 12/3/1 model of provision, where most services should be delivered at the neighbourhood* level (12) unless they require economies of scale at a specialist local level (3), or a single City-wide level (1).

The 12 neighbourhoods* and 3 localities are:
North Locality
Ancoats, Clayton and Bradford; Cheetham and Crumpsall; Higher Blackley, Harpurhey and Charlestown; Miles Platting, Newton Heath, Moston and City Centre
Central Locality
Ardwick and Longsight; Chorlton, Whalley Range and Fallowfield; Gorton and Levenshulme; Moss Side, Hulme and Rusholme
South Locality
Didsbury, Burnage and Chorlton; Fallowfield (Old Moat) and Withington; Wythenshawe (Baguley, Sharston, Woodhouse Park); Wythenshawe (Brooklands) and Northenden

This profile focuses on Frail Older Adults – as defined in Appendix A. The profile compares these adults with the overall population of adults aged 65+ registered with a Manchester GP.

This profile report is one of a series that have been produced jointly by The Business Intelligence and Public Health Knowledge & Intelligence Teams within Manchester Health & Care Commissioning and Adults Performance, Research & Intelligence Team within Manchester City Council. These reports describe the nature of the population living and using services in different parts of Manchester. This profile can be viewed alongside the full series of neighbourhood profile and cohort profile reports that are also available on the Manchester Joint Strategic Needs Assessment (JSNA) website. Further information on these reports is given in Appendix B.

Please note that data in some of the tables in this report have been suppressed in order to protect the confidentiality of individuals and avoid the risk of disclosure in line with ONS guidance for applying disclosure control to data. In a small number of tables it has also been necessary to apply secondary suppression to avoid disclosure by differencing. Where some form of suppression has been applied, the figures have been replaced with '-'.

* In May 2018 new electoral wards were established. The 12 neighbourhoods were established prior to May 2018 and are based around the previous electoral wards.

Population cohorts

For this series of profiles, the population (people registered with a GP practice in Manchester, living inside and outside Manchester, who have consented for their data to be shared) has been divided into 10 "cohorts" mainly using a range of data based on their history of accessing Primary Care (GP), Acute Hospital and Mental Health services.

Each person is allocated to a single cohort (population type) determined in the following order: Children and Young people with Long Term Conditions, Learning Disabilities or Mental Health Needs; Frail Older People; People with Complex Lifestyles Mental Health, Learning Disabilities & Dementia; Maternity; Adults with Multiple Long Term Conditions / End of Life; Adults with Wider Determinants of Need; Good Health Older People, Good Health Children and Good Health Adults (Under 65s). Further details are in Appendix A.

The table on the right shows the number and percentage of adults in each cohort.

Cohort	No. of Adults	% of Age Band
Good Health Older People	6053	10.0%
Frail older people	4081	6.7%
Complex Lifestyles	732	1.2%
Mental Health, Learning Disabilities, Dementia	6212	10.3%
Adults with Multiple Long Term Conditions / End of Life Care	24204	40.0%
Adults with Wider Determinants of Need	19182	31.7%
Older People (65+)	**60464**	**100.0%**

Demographics

Age

The table on the right looks at the age of adults in the cohort and compares them to the population of adults aged 65+ registered with a Manchester GP.

It shows that 4,081 adults are in the Frail Older cohort. This equates to 6.7% of the adult population aged 65+. The table also shows that the proportion of adults aged 65+ in the cohort increases with age from 3.3% of those aged 65 – 69 to 15.2% aged 85+.

	Age Band					
No. of People	**65 - 69**	**70 -74**	**75 - 79**	**80 - 84**	**85+**	**All Ages**
Cohort	619	764	768	793	1137	**4081**
Manchester	18862	15184	10814	8117	7487	**60464**
Percentage of Mcr Population in the Cohort	3.3%	5.0%	7.1%	9.8%	15.2%	**6.7%**

Gender

The gender split for adults in the cohort is different to the overall adult population aged 65+ (59% female and 41% male versus 53% female and 47% male).

	Cohort		Manchester	
	No. of People	**Percentage (where known)**	**No. of Adults Aged 65+**	**Percentage (where known)**
Female	2420	59%	32100	53%
Male	1661	41%	28364	47%
Unknown	-	-	-	-
Total	4081	100%	60464	

Neighbourhood of Residence

The table on the right relates to adults aged 65+ registered with Manchester GPs. It shows that the proportion of adults in the cohort living in each neighbourhood varies. This ranges from 5.7% (187) in Cheetham & Crumpsall to 8.0% (492) in Baguley, Sharston & Woodhouse Park.

There are also 'hotspots' within each neighbourhood that contain particularly high concentrations of adults in this cohort. These can be seen on the map on the front page.

Neighbourhood	Cohort	Adults Aged 65+	% of Population
Ancoats, Clayton and Bradford	202	3067	6.6%
Cheetham and Crumpsall	187	3287	5.7%
Higher Blackley, Harpurhey and Charlestown	401	6073	6.6%
Miles Platting, Newton Heath, Moston and City Centre	353	4654	7.6%
North	**1143**	**17081**	**6.7%**
Ardwick and Longsight	146	2510	5.8%
Chorlton, Whalley Range and Fallowfield	299	4227	7.1%
Gorton and Levenshulme	382	5015	7.6%
Moss Side, Hulme and Rusholme	207	3323	6.2%
Central	**1034**	**15075**	**6.9%**
Didsbury, Burnage and Chorlton	463	7127	6.5%
Fallowfield (Old Moat) and Withington	186	2570	7.2%
Wythenshawe (Baguley, Sharston, Woodhouse Park)	492	6112	8.0%
Wythenshawe (Brooklands) and Northenden	264	3656	7.2%
South	**1405**	**19465**	**7.2%**
Outside Manchester	498	8823	5.6%
Unknown	1	20	-
Total	**4081**	**60464**	**6.7%**

Mosaic Analysis

Mosaic Public Sector classification by Experian ™ is a population segmentation tool that uses a range of data and analytical methods to identify 15 summary groups and 66 detailed types of people. It is based on an underlying principle that similar people live in similar places, do similar things, have similar lifestyles and share similar views.

Mosaic helps us to understand a person's demographic characteristics (age, gender and ethnic group etc.), lifestyle, attitudes and behaviours. It gives us an insight into how and why people make decisions about their health and care and how they are likely to respond to services. The use of Mosaic analysis enables us to tailor services in specific locations in line with the needs and preferences of the types of people living in those areas.

Comparing the Mosaic Groups in the cohort versus the population registered with a Manchester GP, people in this cohort are more likely to be in the Mosaic Groups "Vintage Value"(20.0% v 15.7%) and "Municipal Challenge".

		Cohort		All Adults Aged 65+	
Mosaic Group	**Description**	**No. of People**	**Percentage (where known)**	**No. of People**	**Percentage (where known)**
A Country Living	Well-off owners in rural locations enjoying the benefits of country life (typical age 66-70)	-	-	-	-
B Prestige Positions	Established families in large detached homes living upmarket lifestyles (typical age 61-65)	64	1.6%	1,237	2.1%
C City Prosperity	High status city dwellers living in central locations and pursuing careers with high rewards (typical age 31-35)	50	1.3%	1,142	1.9%
D Domestic Success	Thriving families who are busy bringing up children and following careers (typical age 41-45)	197	5.0%	3,320	5.6%
E Suburban Stability	Mature suburban owners living settled lives in mid-range housing (typical age 56-60)	66	1.7%	1,488	2.5%
F Senior Security	Elderly people with assets who are enjoying a comfortable retirement (typical age 76-80)	248	6.2%	3,747	6.3%
H Aspiring Homemakers	Younger households settling down in housing priced within their means (typical age 31-35)	206	5.2%	3,278	5.5%
I Urban Cohesion	Residents of settled urban communities with a strong sense of identity (typical age 56-60)	417	10.5%	7,402	12.4%
J Rental Hubs	Educated young people privately renting in urban neighbourhoods (typical age 26-30)	335	8.4%	5,367	9.0%
K Modest Traditions	Mature homeowners of value homes enjoying stable lifestyles (typical age 56-60)	200	5.0%	2,960	4.9%
L Transient Renters	Single people privately renting low cost homes for the short term (typical age 18-25)	454	11.4%	6,816	11.4%
M Family Basics	Families with limited resources who have to budget to make ends meet (typical age 31-35)	556	14.0%	8,645	14.5%
N Vintage Value	Older people reliant on support to meet financial or practical needs (typical age 76-80)	795	20.0%	9,412	15.7%
O Municipal Challenge	Urban renters of social housing facing an array of challenges (typical age 56-60)	388	9.8%	4,998	8.4%
U Unknown	Unknown	105		652	
Total		4,081		60,464	

Long Term Conditions

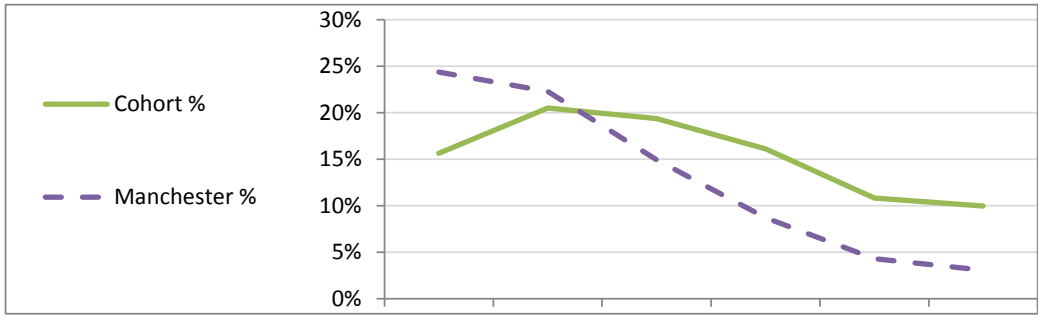
This section compares adults in the cohort with all adults registered with a Manchester GP.

The graph and table on the right relate to the number of Long Term Conditions (LTCs) people have (from a list of 19 LTC registers used in our cohort definitions).

For the Frail Older cohort 15.6% have one long term condition, while 75% have two or more long term conditions. This compares to nearly 25% and just over 50% for the overall older adult population (aged 65+). In addition the graph on the right also shows that the Frail Older cohort have higher proportions of adults with higher numbers of long term conditions.

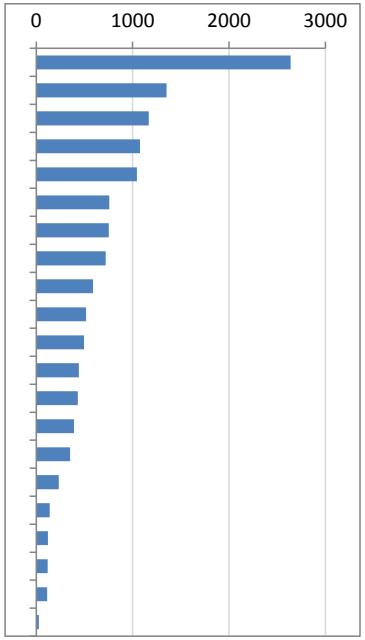
The charts on the right show the number and percentage of people on each of the LTC registers counted above, along with smoking and obesity.

For the cohort, by far the largest LTC register is for hypertension (2,639 adults / 64.7%) followed by stroke (1,353 adults / 33.2%) and CKD (1,167 / 28.6%). In almost every instance, there is a higher proportion of adults in the cohort on each LTC register than the overall older adult population.



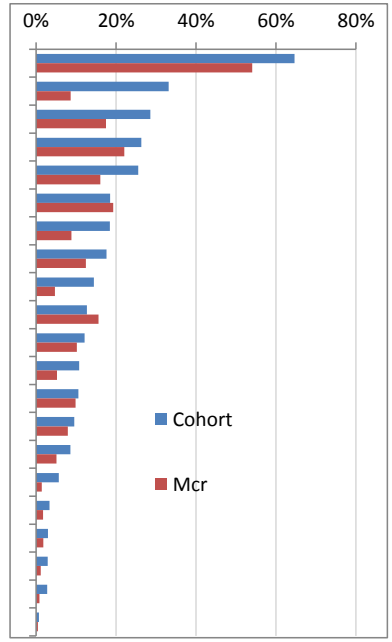
	Pop'n	0	1	2	3	4	5	6+
Cohort	4081	309	638	837	790	658	442	407
All Aged 65+	60464	13484	14736	13469	9034	5270	2605	1866
Cohort %		7.6%	15.6%	20.5%	19.4%	16.1%	10.8%	10.0%
Manchester %		22.3%	24.4%	22.3%	14.9%	8.7%	4.3%	3.1%

Number of adults aged 65+ on each LTC Register



Hypertension	2639
Stroke	1353
CKD	1167
Diabetes	1075
CHD	1043
Smoking	757
AF	753
COPD	719
Dementia	589
Obesity	518
Cancer	496
Heart Failure	441
Asthma	431
Hypothyroid	391
PVD	350
Osteoporosis	233
MH	138
Arthritis	121
Epilepsy	119
Parkinsons	113
LD	28

Percentage on each LTC Register



Cohort	Mcr
64.7%	54.1%
33.2%	8.7%
28.6%	17.5%
26.3%	22.1%
25.6%	16.1%
18.5%	19.3%
18.5%	8.9%
17.6%	12.5%
14.4%	4.7%
12.7%	15.6%
12.2%	10.2%
10.8%	5.2%
10.6%	9.9%
9.6%	7.9%
8.6%	5.1%
5.7%	1.4%
3.4%	1.7%
3.0%	1.8%
2.9%	1.2%
2.8%	0.9%
0.7%	0.4%

Social Services provided by MCC Adult Social Care

Manchester City Council (MCC) Adult Social Care offers information and advice, assessments of need, equipment and care to people living in Manchester. People over the age of 18 who live in Manchester can request information and advice or an assessment of need, regardless of whether they pay for services themselves.

Adult Social Care activity begins with making contact – a member of the public may call up to enquire about services for themselves or someone else, or a referral may be made by another service e.g. Primary Care, Prisons, and this is recorded as a contact.

Some (but not all) contacts result in an assessment by a Social Worker or associated professional. Information is gathered on a person's needs so that appropriate services (called a care package) can be provided if needed. Reviews and reassessments review those needs again when a person's circumstances change or they have been in receipt of certain types of care e.g. home care for a year.

This analysis is based on the 12 months to 30th June 2018, and relates to *adults registered with a Manchester GP** who have been in contact with or received a social care service from Manchester City Council.

Contacts

While the cohort equates to 6.7% of the adult population (aged 65+) registered with a Manchester GP, they accounted for a much higher proportion (28.2%) of contacts.

	Cohort	*Registered Adults * Aged 65+*	%
Population	4081	60464	6.7%
No. of People with a Social Care Contact	1455	5160	28.2%

**Between July 2017 and June 2018, 12,589 adults aged 65+ had a contact with MCC Adult Social Services. Of these, 41% (5,160 adults) were identified as registered with a Manchester GP.*

Social Care Assessments / Reassessments

Assessments gather information around people's needs so that appropriate services can be provided to support these needs. Reviews and reassessments are used to review those needs when a person's circumstances change, or they have been in receipt of certain types of care e.g. home care for a year.

While the cohort equates to 6.7% of the adult population aged 65+, they accounted for a much higher proportion of assessments - General (35.7%), equipment (25.5%), drug and alcohol (35.3%).

	Cohort	*Registered Adults * Aged 65+*	%
Population	4081	60464	6.7%
Type of Assessment			
General	939	2633	35.7%
Equipment	334	1310	25.5%
Drugs & Alcohol	6	17	35.3%

**Between July 2017 and June 2018, 6,751 adults aged 65+ had an assessment of some form. Of these, 50% (3,387) were identified as registered with a Manchester GP.*

Packages of Social Care

When services are provided via MCC Adult Social Care, these are referred to as Care Packages. One of the most common services is the provision of equipment, which is a one-off service. However, this analysis focuses on care packages that provide on-going care and support, both long term and short term.

A person assessed as having a need can receive multiple care packages, of different types, over any given period of time. Descriptions of the different types of service are given in Appendix C. Analysis of the different types of care shows:

The Frail Older cohort equates to 6.7% of the adult population (aged 65+) registered with a Manchester GP. In all instances, the proportion of adults in the cohort receiving each type of care package is far greater than 6.7%.

	Cohort	***Registered Adults * Aged 65+***	**%**
Population	4081	60464	6.7%
Type of Care Package			
Community Alarm	515	1546	33.3%
Home Care	509	1373	37.1%
Reablement	306	685	44.7%
Permanent Residential Care	164	583	28.1%
Permanent Nursing Care	66	235	28.1%
Temporary Residential Care	66	136	48.5%
Direct Payments	38	156	24.4%
Extra Care Sheltered Housing	37	109	33.9%
Respite	23	96	24.0%
Day Care	16	78	20.5%
Sitting/Befriending	7	24	29.2%

** Between July 2017 and June 2018, 6,858 adults aged 65+ were in receipt of one or more packages of care from MCC Adult Social Care. Of these, 51% (3,523) were identified as registered with a Manchester GP.*

Acute Hospital Care

This section compares the extent to which different types of acute hospital (secondary care) services were used from July 2017 to June 2018 by adults aged 65+ registered with a Manchester GP at the time of their attendance or admission.

Calculation of rates per person:
To calculate rates per person in this section, activity is looked at over a 12 month period and then compared against the population at any single given point in time – a "snapshot". The snapshot population figures are based on adults aged 65+ registered with a Manchester GP in July 2018.

Types of acute hospital service
Acute hospital services can be split into two categories:

1. Planned care – Services and treatments which are not carried out in an emergency. This includes consultations and procedures carried out in an outpatient setting (where a hospital bed is not needed) and procedures carried out in an inpatient setting (where a bed and possibly an overnight stay are needed).

2. Urgent care – Services and treatments which are carried out as an emergency. This includes A&E attends and Emergency Admissions.

The table on the right shows a total spend on secondary care in the 12 months of £97m for adults aged 65+. Approximately £21m of this related to adults in the cohort.

For adults in the cohort 75% of secondary care costs relate to urgent care whereas for the overall adult population aged 65+ planned care and urgent care are split 39/61. Planned Care costs are 2.1 times higher for adults in the cohort while urgent care costs are 4 times higher.

	Totals		Per Person		
	Cohort	All 65+	Cohort	All 65+	Ratio Cohort v All
No. of People	4081	60464			6.7%
Planned Care	£5,354,734	£37,773,997	£1,312	£625	2.1
Urgent Care	£15,896,579	£59,432,631	£3,895	£983	4.0
Overall	£21,251,313	£97,206,628	£5,207	£1,608	3.2
% Planned Care	25%	39%			
% Urgent Care	75%	61%			

The cost of acute hospital activity has been broken down further into key areas (known as Programme Budget Categories).

Trauma & Injury is the highest area of spend for the cohort (£4.1m / 19%) while for the overall adult population (aged 65+)this only accounts for 7% of spend.

Circulation is the next highest area of spend (£3.96m / 19%) compared to 14% for the overall adult population aged 65+.

Cohort		
Area of Spend	**Cost**	**% of Cost**
Trauma & Injury	£4,124,215	19%
Circulation	£3,956,234	19%
Respiratory	£2,455,921	12%
Musculo Skeletal	£2,349,932	11%
Genito Urinary	£1,632,067	8%
Neurological problems	£1,316,289	6%
Gastro Intestinal	£1,070,285	5%
Infectious Diseases	£643,302	3%
Other Areas of Spend/Conditions	£619,756	3%
Adverse effects and poisoning	£518,847	2%
Other Areas	£2,564,466	12%
Total	**£21,251,313**	**100%**

All Aged 65+		
Area of Spend	**Cost**	**% of Cost**
Respiratory	£14,523,955	15%
Circulation	£13,866,781	14%
Gastro Intestinal	£9,547,615	10%
Musculo Skeletal	£8,939,658	9%
Genito Urinary	£8,812,193	9%
Trauma & Injury	£6,977,645	7%
Cancers & Tumours	£6,840,233	7%
Vision	£4,922,511	5%
Neurological problems	£4,426,125	5%
Infectious Diseases	£4,088,914	4%
Others	£14,260,997	15%
Total	**£97,206,628**	**100%**

Planned Care

The tables on the right show that activity rates and costs for different types of planned care are higher for adults in the cohort compared to the overall adult population registered with a Manchester GP.

Activity rates are roughly 1.5 times higher for outpatient activity and increase to 2.5 times higher for elective admissions. A similar pattern exists for activity costs, although elective admission costs are 3.6 times higher.

	Cohort	All Aged 65+
Population	4081	60464

Planned Care Activity	Total		Per 1000 people		
	Cohort	**All Aged 65+**	**Cohort**	**All Aged 65+**	**Ratio - Cohort v All**
Outpatient Attends	23184	189246	5681	3130	1.8
Outpatient Procedures	3061	31174	750	516	1.5
Day Case	1580	17033	387	282	1.4
Elective Admission	572	3368	140	56	2.5

Planned Care Costs	Total		Per 1000 people		
	Cohort	**All Aged 65+**	**Cohort**	**All Aged 65+**	**Ratio - Cohort v All**
Outpatient Attends	£1,521,896	£13,142,979	£372,922	£217,369	1.7
Outpatient Procedures	£393,422	£4,071,455	£96,403	£67,337	1.4
Day Case	£1,059,885	£10,858,354	£259,712	£179,584	1.4
Elective Admission	£2,379,531	£9,701,209	£583,076	£160,446	3.6
Total	£5,354,734	£37,773,997	£1,312,113	£624,735	2.1

Urgent Care

The table on the right shows that adults in the cohort are three times more likely to attend A&E compared to the overall adult population aged 65+ registered with a Manchester GP.

They are also more likely to be admitted as a result of the A&E attend, with 70% of A&E attends resulting in admission, compared to 57% for all adults aged 65+.

The vast majority of urgent care costs relate to emergency admissions rather than A&E attends.

The average cost per person of emergency admissions for adults in the cohort is 4 times higher than for all adults aged 65+.

	Cohort	All Aged 65+
Population	4081	60464

	Total		Per 1000 people		
	Cohort	**All Aged 65+**	**Cohort**	**All Aged 65+**	**Ratio - Cohort v All**
A&E Attends	7283	35412	1785	586	3.0
Emergency Admissions	5093	20173	1248	334	3.7
Percentage of A&E attends resulting in Emergency Admission	70%	57%			

	Total		Per 1000 people		
Urgent Care Costs	**Cohort**	**All Aged 65+**	**Cohort**	**All Aged 65+**	**Ratio - Cohort v All**
A&E Attends	£1,048,348	£4,621,092	£256,885	£76,427	3.4
Emergency Admissions	£14,848,231	£54,811,538	£3,638,381	£906,515	4.0
Total	£15,896,579	£59,432,631	£3,895,266	£982,942	4.0

As well as being more likely to be admitted from an A&E attend, adults in the cohort stay in hospital for longer than the overall adult population aged 65+. The average length of stay for adults in the cohort is 9.9 nights compared to 8.7 nights.

63% of emergency admissions are for 2 or more nights compared to 61% and average costs are £2915 compared to £2717.

	Total		Percentage	
Emergency Admissions	**Cohort**	**All Aged 65+**	**Cohort**	**All Aged 65+**
Same Day Emergency Admissions	1037	4873	20%	24%
Short Stay (1 night) Emergency Admissions	832	3006	16%	15%
Longer (2+ nights) Emergency Admissions	3224	12294	63%	61%
Total Emergency Admissions	5093	20173		

Length of Stay	50597	174714	9.9	8.7
Cost	£14,848,231	£54,811,538	£2,915	£2,717

Based on the reasons for admission (diagnoses) and the procedures that were performed, it is possible to determine if an admission was preventable or ambulatory care sensitive (ACSC) i.e. conditions for which effective management and treatment should limit emergency admission to hospital.

22.6% of emergency admissions for the cohort could be classed as preventable or Ambulatory Care Sensitive – 12.2% preventable and 10.4% for ACSCs. This is lower than the overall adult population aged 65+ where the comparable figures are 14.5% and 14.1%. The comparisons are similar when looking at costs.

	No. of Admissions		**Cost of Admissions**	
Emergency Admissions	**Cohort**	**All Aged 65+**	**Cohort**	**All Aged 65+**
Preventable	622	2931	£1,941,587	£8,791,692
Ambulatory Care Sensitive (ACSC)	531	2841	£1,194,446	£6,181,250
Neither	3940	14401	£11,712,198	£39,838,596
Total	5093	20173	£14,848,231	£54,811,538
% Preventable	12.2%	14.5%	13.1%	16.0%
% ACSC	10.4%	14.1%	8.0%	11.3%

Looking at the preventable admissions for the cohort, approximately 40% a third were for Pyelonephritis & Kidney or Urinary Tract Infections costing nearly £900k, while admissions for Flu & Pneumonia cost nearly £650k.

Preventable Admissions	No. of Admissions	Cost	% of Admissions
Pyelonephritis & Kidney or Urinary Tract Infections	256	£877,945	41%
Flu & Pneumonia	184	£647,123	30%
Cellulitis	78	£182,563	13%
Dehydration & Gastroenteritis	55	£117,871	9%
Convulsions & Epilepsy	18	£37,816	3%
Others	31	£78,269	5%
Total	**622**	**£1,941,587**	**100%**

For ambulatory care sensitive conditions, 42% of admissions for the cohort were for CVD, costing £494,000 and 39% of admissions were for Respiratory, costing £462,000.

Admissions for Ambulatory Care Sensitive Conditions	No. of Admissions	Cost	% of Admissions
CVD	221	£493,826	42%
Respiratory	208	£462,043	39%
Neuro	37	£104,565	7%
Mental & Behaviour Disorders	29	£20,572	5%
Diseases of Blood	19	£55,517	4%
Others	17	£57,924	3%
Grand Total	**531**	**£1,194,446**	**100%**

Risk of Emergency Hospital Admission

The tables on the right look at a relative risk of emergency hospital admission based on scores (From 0 – 100) generated by the Combined Predictive Model (CPM). This model uses data from secondary care (inpatient, outpatient and A&E visits) and GP practices (clinical diagnoses and prescribing).

Both tables look at adults aged 65+ registered with a Manchester GP, living both within Manchester and outside the area in July 2018.

Adults in the cohort are far more likely to be in the High / Very High risk categories (31.4%) than the overall adult population aged 65+ (8.1%).

There is also some variation across localities in the proportion of the cohort in the High / Very High risk categories – 36.1% in North, 31.6% in Central and 28.4% in South.

Cohort		Admission Risk Band						
Locality	Total	Unknown	Low (Score <26)	Moderate (Score 26 - 50)	High (Score 51 - 75)	Very High (Score 76+)	High / Very High (Score 51+)	% High / Very High (where known)
North	1143	12	306	417	281	127	408	36.1%
Central	1034	17	316	380	230	91	321	31.6%
South	1405	11	436	562	276	120	396	28.4%
Out of Area / Unknown	499	2	172	183	94	48	142	28.6%
Grand Total	**4081**	**42**	**1230**	**1542**	**881**	**386**	**1267**	**31.4%**

All Aged 65+		Admission Risk Band						
Locality	Total	Unknown	Low (Score <26)	Moderate (Score 26 - 50)	High (Score 51 - 75)	Very High (Score 76+)	High / Very High (Score 51+)	% High / Very High (where known)
North	17081	110	12141	3223	1217	390	1607	9.5%
Central	15075	177	10880	2784	987	247	1234	8.3%
South	19465	188	14464	3441	1106	266	1372	7.1%
Out of Area / Unknown	8843	103	6577	1555	460	148	608	7.0%
Grand Total	**60464**	**578**	**44062**	**11003**	**3770**	**1051**	**4821**	**8.1%**

Appendix A – Population Cohorts

A person is allocated into a cohort if they meet the age limit and meet one or more of the criteria for the cohort. Each person is only allocated to one cohort, based on the priority order shown below:

Cohort 1 - Children & Young People with Long Term Conditions, Mental Health Needs or Learning Disabilities

- Aged under 19
- One or more Long Term Conditions recorded in Primary Care (see list at end of Appendix)
- Children / Young People currently on a Palliative Care Register in Primary Care
- Meeting any of the criteria for the Mental Health, Learning Disabilities & Dementia cohort

Cohort 2 - Frail Older People

- Aged 65 and above
- Admission to hospital for a hip fracture, hip replacement, stroke, or injury due to a fall in the last 2 years.

Cohort 4 - Complex Lifestyles

- Aged 19 and above
- Hospital admission in the last 12 months for alcohol misuse, drug misuse or self harm
- Attendance in the last 12 months at a hospital based (secondary care) addiction service
- Hospital admission in the last 12 months where homelessness has been recorded
- Homelessness recorded in Primary Care (GP systems) – no date limit

Cohort 5 - Mental Health, Learning Disabilities or Dementia

- Aged 19 and above

Mental Health

- Admission or attendance in the last 24 months at Inpatient, Outpatient or Community Services provided by Greater Manchester Mental Health NHS Foundation Trust
- Hospital admission in the last 12 months with a mental health related diagnosis or procedure recorded
- Attendance in the last 12 months within a hospital based (secondary care) Mental Health specialty
- Mental Health recorded in Primary Care as a Long Term Condition

Learning Disabilities

- Hospital admission in the last 12 months with a Learning Disability related diagnosis recorded
- Attendance in the last 12 months within a hospital based (secondary care) Learning Disability specialty
- Learning Disability recorded in Primary Care as a Long Term Condition

Dementia

- Hospital admission (no time limit set) with a Dementia related diagnosis recorded
- Dementia recorded in Primary Care as a Long Term Condition

Cohort 6 - Maternity

- Age 10 and above (to eliminate new born babies and include young mothers)
- Birth in the last 12 months recorded by a secondary care provider
- Attendance in the last 12 months at antenatal services (including specialty 560, Midwifery) provided within secondary care

Cohort 3 - Adults with Multiple Long Term Conditions or End of Life

- Age 19 and above
- Two or more Long Term Conditions from the defined list (see bottom of Appendix)
- People currently on a Palliative Care Register in Primary Care
- Hospital admission in the last 12 months with a Palliative Care related diagnosis recorded
- Attendance in the last 12 months within a hospital based (secondary care) Palliative Care specialty

Cohort 10 - Adults with Wider Determinants of Need

- 19 and above
- One Long Term condition from the defined list (see bottom of Appendix)
- Adults living within a geographical area with a Mosaic Intensity code of 4 or 5.

Cohort 7 - Good Health Older People

- Age 65 and above
- Not included in any other group.

Cohort 8 - Good Health Children

- Age under 19
- Not included in any other group.

Cohort 9 -Good Health Adults

- Age 19 - 64
- Not included in any other group.

Long Term Conditions used to allocate the population into cohorts

Asthma
Atrial Fibrillation
Cancer
CKD
COPD
Coronary Heart Disease
Diabetes
Epilepsy
Heart Failure
Hypertension
Hypothyroidism
Osteoporosis
Parkinson's
Peripheral Vascular Disease
Rheumatoid Arthritis
Stroke

Mental Health *
Learning Disability *
Dementia *

Current Smoker **
Obesity **

*Based on current priority order for cohorts, people on the Mental Health, Learning Disability or Dementia registers will be allocated into the Mental Health, Learning Disability & Dementia cohort.

** Smoking and Obesity are only used to allocate people into the Adults with Wider Determinants cohort.

Appendix B – Additional Sources of Information on the JSNA website

The following neighbourhood profile reports and cohort profile reports are available in the Area Profiles section of the Manchester Joint Strategic Needs Assessment (JSNA) website.
Manchester Joint Strategic Needs Assessment (JSNA)
http://www.manchester.gov.uk/jsna
Area Profiles section
http://www.manchester.gov.uk/info/500230/joint_strategic_needs_assessment/7011/area_profiles
Neighbourhood profile reports
http://www.manchester.gov.uk/info/500230/joint_strategic_needs_assessment/7011/area_profiles/2

Place Report
This report draws upon the data that is available within Public Health England's Local Health tool which contains quality assured data that can be used to compare any area (or combination of areas) with the local authority and England averages for a range of indicators. These reports provide information about broader health outcomes as well as the factors that affect them (the so called 'wider determinants of health'). The start of the report provides a user-friendly summary highlighting the key features of the neighbourhood and the areas in which the neighbourhood has significantly worse and/or better health and care outcomes compared with England as a whole.

Mosaic Profile
These reports provide more detailed information about the types of household in different parts of each neighbourhood area. Mosaic Public Sector classification by Experian ™ uses a range of data and analytical methods to identify 15 summary groups and 66 detailed types of people. It is based on an underlying principle that similar people live in similar places, do similar things, have similar lifestyles and share similar views. Mosaic helps us to understand demographic characteristics (age, gender and ethnic group etc.), lifestyle, attitudes and behaviours. It gives us an insight into how and why people make decisions about their health and care and how they are likely to respond to services.

Population Forecasting Model
This is a one page summary for each neighbourhood of the findings of the Manchester City Council Population Forecasting Model (MCCFM), looking at the changes to the size and age structure of the population living in the neighbourhood that are forecast to occur over the next 10 years.

Ward based information
More detailed information for the individual wards that make up each neighbourhood has also been collated within the Compendium of Statistics for Manchester ("A Picture of Progress"). The Compendium consists of a series of tables which contain the latest available data for a wide range of indicators for both Manchester as a whole and, where available, each of the 32 wards within the city. The tables have been ordered in a way that follows a life course approach – from pre-birth through to adults and older people. This is also available through the Manchester City Council Intelligence Hub.

http://www.manchester.gov.uk/downloads/download/5724/compendium_of_statistics-manchester

Cohort Profiles
The full set of Cohort Profile Reports, are also available on the JSNA website.
http://www.manchester.gov.uk/info/500230/joint_strategic_needs_assessment/7011/area_profiles/3

Appendix C – Descriptions of services provided via MCC Adult Social Care

Adult Placement Scheme (Shared Lives Service)
Manchester Shared Lives / Adult placement (AP) offers people an alternative, highly flexible form of accommodation and person-centred support, which is provided by ordinary individuals or families (adult placement carers) in the local community. This enables individuals to share in the life of the adult placement carer. Sometimes this can be long-term, sometimes for a short period, or even on a day support basis.

Casework support
For a client to be considered as having casework support, the service must be included as part of their support plan. This does not include the process of care management (i.e. assessing or reviewing care needs), but typically occurs when the care manager goes on working with the client after the care management process has been completed (as part of the support plan/package), or another professional is involved to provide active, ongoing support which may take the form of therapy, support or professional input, e.g. counselling.

Active Casework Support could be for example a support professional telephoning a client on a weekly basis to ask how things are and discuss any issues the client might have. In contrast to the client having a phone number that they could call if they felt there was anything they would like to discuss - this would be more "passive" support.

Community Alarm/Assistive Technology
The Community Alarm Service (CAS) provides a range of services to support our most vulnerable Citizens by enabling them to remain independent in their own homes. This includes things such as pendants, alarm or sensor triggers, and staff from Community Alarm calling to offer advice and reassurance, and where necessary, contacting a nominated person, your next of kin or the emergency services.

Day Care
Daytime Support provides a range of meaningful activities away from a citizen's home, to people who are assessed as requiring high levels of support. This service provides essential daytime support to families and enables vulnerable citizens to stay at home with their families

Direct Payments
Self-directed support helps a citizen to self-direct their care or support personal budget in a number of different ways, and a direct payment is money that is paid directly to you so you can arrange your own appropriate support in line with your care plan.

Extra Care / Neighbourhood Apartments
Extra Care Housing is a form of retirement housing with the addition of personal care and 24-hour support available for those who need it. The care can increase or decrease flexibly to meet changing needs.

It is a realistic alternative to traditional residential and nursing accommodation, and offers a self-contained 'home of your own' in a scheme where facilities such as hairdressing and beauty salons, bistros, gardening clubs and social activities give plenty of opportunity to socialise for those who wish to. Schemes can also support people with dementia, to varying degrees.

A small number of units have been turned into Neighbourhood apartments (or also known as step up/step down beds) and take referrals directly from hospital or community. Here, specialist support, including housing advice and access, can help people move to more appropriate accommodation after recovery or return home

Home Care
Home care services help people stay in their homes for longer, supporting them with the tasks of everyday life. These services are provided by a number of private care companies who are commissioned by the City Council. Home care is provided to ensure our citizens have the appropriate level of support for their needs. This may include help with personal care, making meals, and getting out and about.

Reablement
Reablement provides short term support for up to six weeks on discharge from hospital to enable citizens to return home safely and remain at home independently. Referrals are made directly by health and social care practitioners. Also including Intermediate Care, this is a concept in health care which may offer attractive alternatives to hospital care for patients, particularly older people, and promotes independence.

Residential Care / Nursing Care
Residential care homes provide round-the-clock care for people who are frail or have complex needs that cannot be met in their community. This can include help with washing, dressing, feeding and help with day to day activities. Nursing homes cater for those who have general care needs and also require input or supervision from qualified nurses. This can include those with specific or complex health needs. People can benefit from a short stay in residential care to provide a carer break or move there on a more permanent basis following a detailed assessment by a qualified social worker.

Respite / Short Breaks
Short breaks offer a mixture of 24hr personal care and more general support, which allows carers to have a break from their caring responsibilities. Short Breaks also includes emergency respite in times of crisis and to support hospital discharges.

Supported Accommodation
Supported accommodation is short term housing related support for vulnerable people. This may include those suffering domestic violence, recovery from mental illness, and sexual abuse. Support is available in single-gender premises. The support might be needed for a wide range of reasons, and is tailored to address the issues people are facing, whilst developing better life skills to improve their quality of life, and to promote independent living

Disability Supported Accommodation has properties (where appropriate) that are fitted with state-of-the-art assistive technology tailored to an individual's needs, to ensure dignity in a safe and independent living environment.

Sources

The following data sources have been used in this Profile:
Manchester City Council Social Care Data Extracts (July 2018)
SDE Primary Care Data Extracts (July 2018)
Secondary Uses Service – Acute Hospital Activity Datasets (July 2018)

Authors

This profile has been produced on behalf of Manchester Health and Care Commissioning by the Business Intelligence and Public Health Knowledge and Intelligence Teams**.**