End of Life Care for Adults December 2019

Cheshire East JSNA

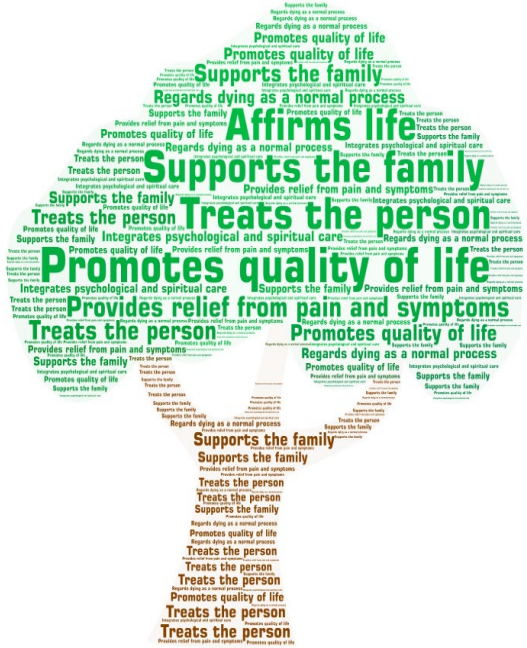
Cheshire West and Chester JSNA

End of life care (or palliative care) is support for people who are in the last months or year of their life. **End of life care** should help people to live as well as possible until they die and to die with dignity. People should be asked about their wishes and preferences as early as possible, and have these taken into account to plan their care. Family, carers or other people who are important to the person should also be supported at this time.

.oO0Oo.

In England and Wales, approximately half a million people die each year. This is expected to rise by 26% to 635,814 deaths by 2040 (*Bone, 2017*). In Cheshire East, the number of people who died in 2018 was 4,084 and in Cheshire West and Chester, this figure was 3,451, and these will rise in line with the above. Due to this increase, between 25% and 47% **more** people in England and Wales are estimated to require **end of life care** by 2040 (*Etkind, 2017*).

Contents	Page number

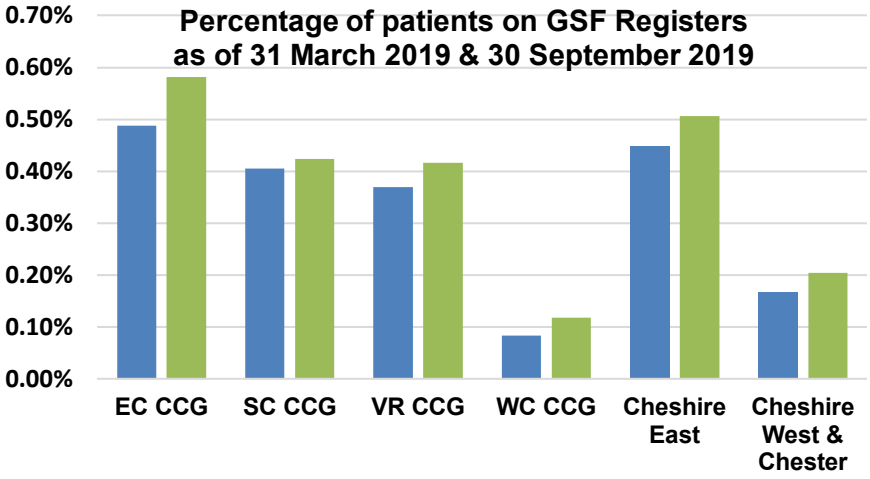


Key messages

- Cheshire has a varied community with widespread differences in services and needs around end of life care
- End of life care is improving in a number of different areas including Advance Care Planning, identifying people in the final year of life and developing innovative services to improve care
- There is a collective approach through the Strategic Collaborative Cheshire group to work jointly to identify specific areas of need and find workable solutions for improvements. Three key areas around communication, personalised planning and system leadership have been identified as priorities for the next 12 months as well as continuing to utilise data and information to target interventions and evaluate their effectiveness

How well are we identifying people at the end of life?

The following information considers how well we are identifying people at the end of life prior to death. Identifying as many people as possible in order to provide the most appropriate support and encourage early conversations about choice at end of life is essential (see page 8 for choices that are important for people, and their families, at the end of life and after death). A significant way of doing this is by the use of a register such as the Gold Standards Framework (GSF) Register http://www.goldstandardsframework.org.uk/ This is a register held in General Practice that details patients that they believe to be in the last 12 months of life, to improve their quality and co-ordination of care, and helping them to live well and die in a place of their choosing (as recommended in the recent NHSE Long Term Plan, 2019). Around 1% of the population dies each year and approximately three quarters of these deaths are likely to be deaths that could be anticipated i.e. excluding trauma, sudden deaths, etc. Therefore, it is expected that around 0.8% of a practice population should be recorded on an end of life register.



Clinical Commissioning Group (CCG) or Local Authority (LA)	Practice list size totals		No. with GSF codes		% with GSF codes	
	31 Mar 2019	30 Sep 2019	31 Mar 2019	30 Sep 2019	31 Mar 2019	30 Sep 2019
Eastern Cheshire CCG	209997	211105	1024	1227	0.49%	0.58%
South Cheshire CCG	189735	188333	769	797	0.41%	0.42%
Vale Royal CCG	108666	107974	402	449	0.37%	0.42%
West Cheshire CCG	266413	267369	221	316	0.08%	0.12%
Cheshire East LA	399732	399438	1793	2024	0.45%	0.51%
Cheshire West & Chester LA	375079	375343	623	765	0.17%	0.20%

The chart *(above left)* and table (*above right*) show the percentage (prevalence) of patients on a GP practice Gold Standards Framework (GSF) Register as of 31 March 2019 and 30 September 2019, based upon EMIS/EPaCCS data.

What does this tell us?

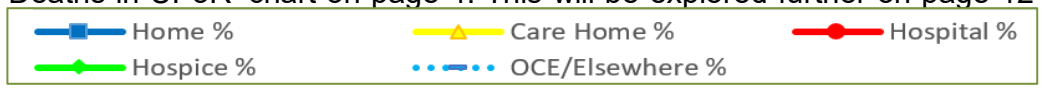
The numbers of people being identified on a GP practice GSF Register has been steadily increasing across most localities over the last few years and all areas have demonstrated an increase over the last 12 months. Work is underway to support the uptake of the registers with GP practices and this has included helping to identify appropriate people to add to the register, and regular reporting back to GP practices to support a reflection on action cycle.

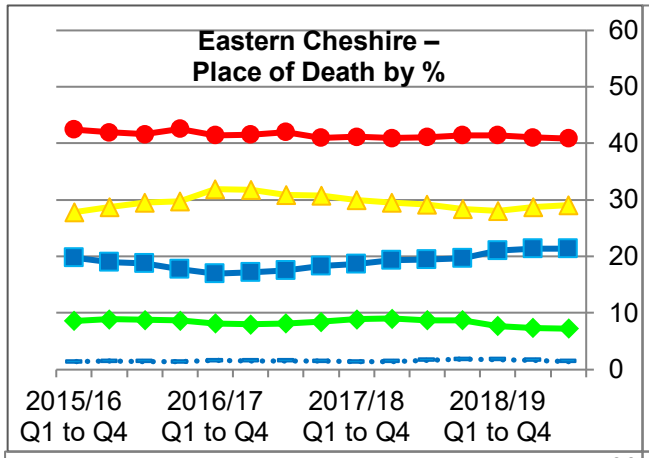
Source: EMIS/EPaCCS data based on GP registers as at 30 September 2019

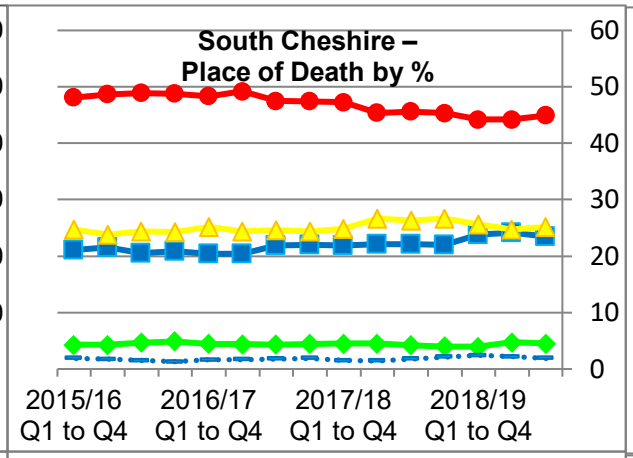
Where are people dying?

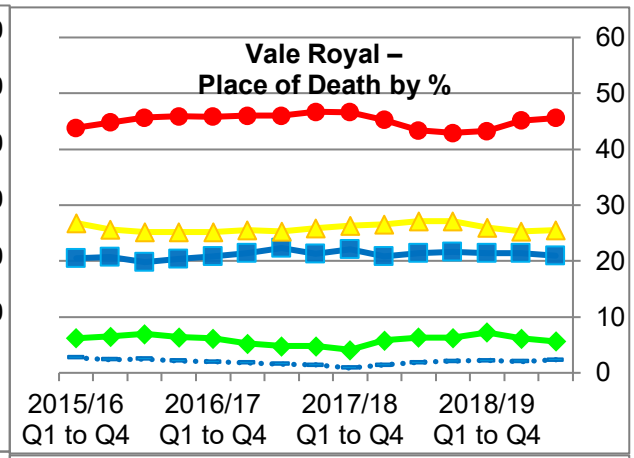
Where people choose to die is clearly a significant factor of end of life care. A survey by *the National Council for Palliative Care (2014)* found that 72% of the general public would want to die at home, 10% in a hospice, 6% in hospital and 2% in a nursing home with the remaining 10% not expressing a preference. However, people's preferences can vary considerably over their final months, with fewer people wanting to die at home and more people wanting to die in a hospice (*Sue Ryder, 2013*). It should be noted that hospitals are the preferred place of death for some people and not all hospital admissions at end of life should be viewed as negative (*Boase, 2014*). The following charts show Place of Death by care setting for each CCG/Local Authority – Home and Care Home are considered to be usual place of residence (UPoR) and are combined in the 'Deaths in UPoR' chart on page 4. This will be explored further on page 12 onwards. The full data set can be viewed on pages 15/16.

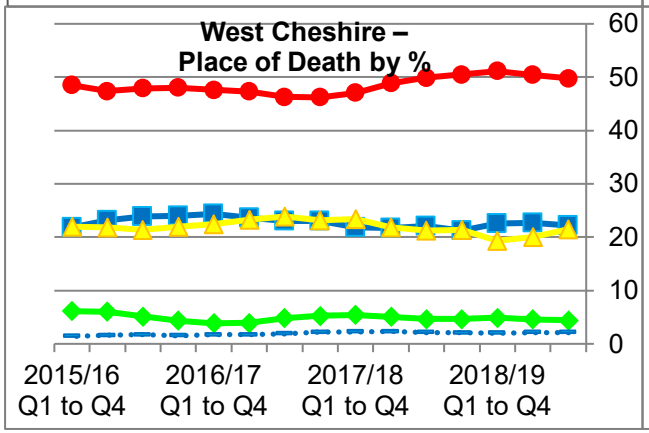
Source: Office for National Statistics (ONS)

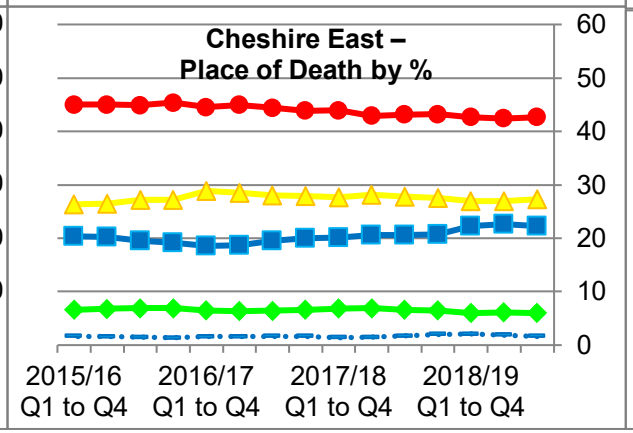


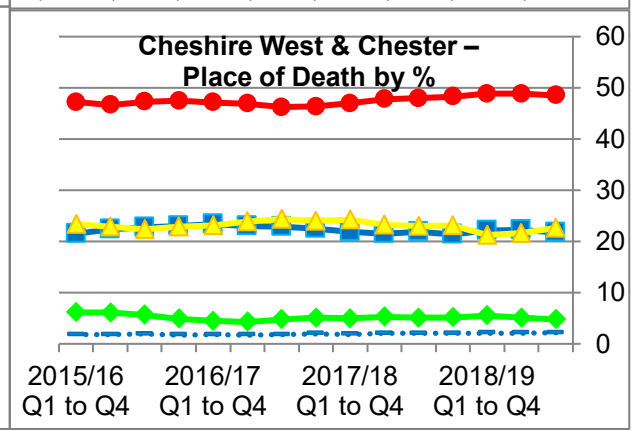






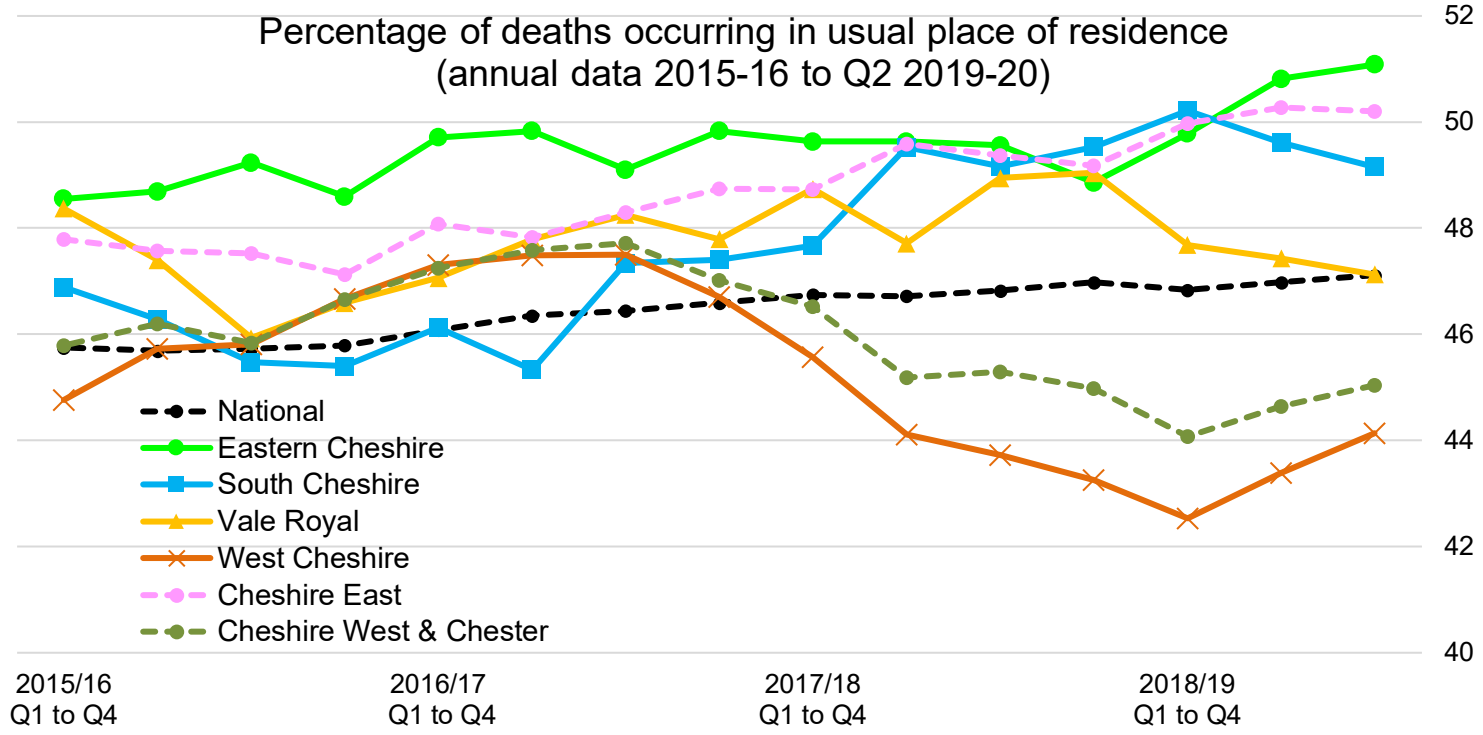






Are people dying in their usual place of residence?

A person's place of death, namely 'usual place of residence', is considered a proxy marker for quality for end of life care (*National End of Life Care Intelligence Network, 2019*). Historically, people living in England have been much more likely to die in hospital than their usual place of residence (including home and care home). However, in recent years, the proportion of people dying in their usual place of residence has increased, reflecting a change in reported preferences from 2010 which found that 64% of respondents would like to die at home *(Cicely Saunders International)* and 2014, when 72% of respondents stated a wish to die at home *(National Council for Palliative Care)*.



This chart shows the percentage of deaths that occurred in the usual place of residence (i.e., the recorded address for that person, which could be home or a permanent care home). It compares the two Local Authorities and their associated Clinical Commissioning Groups (CCG) to the England (National) average since 2015/16. See page 17 for the full data set. *Source: Office for National Statistics (ONS)*

What does this tell us?

Many of the localities are above the England national average, with others improving their position over the past 12 months. However, this does not mean that we can become complacent: we need to support more people to realise their choices and preferences for care. In addition to understanding where people die, we need to take into consideration the experience that people undergo at this time.

What are the causes of death?

The specific care needs of people towards the end of their life are influenced by their underlying illnesses. The table below identifies the local demographics in relation to the cause of death compared to the overall England average. This is important as it can indicate specific requirements for current and future services.

	England %	Eastern Cheshire %	South Cheshire %	Vale Royal %	West Cheshire %
Percentage of all people who died, with an underlying cause of cancer	27.56	25.60	27.12	26.16	28.18
Percentage of all people who died, with an underlying or contributory cause of dementia	18.65	25.09	16.08	18.04	20.12
Percentage of all people who died, with an underlying cause of chronic heart disease	11.04	9.74	11.16	11.40	11.06
Percentage of all people who died, with an underlying or contributory cause of chronic obstructive pulmonary disease (COPD)	10.96	7.51	8.38	9.12	12.51
Percentage of all people who died, with an underlying cause of stroke	5.98	6.03	6.00	6.64	4.86

Data above only available by CCG area
Source: The Atlas of variation for palliative and end of life care in England, 2017

Sig band 1 - significantly higher than England - 99.8% level
Sig band 2 - significantly higher than England - 95% level
Sig band 3 - not significantly different from England
Sig band 4 - significantly lower than England - 95% level
Sig band 5 - significantly lower than England - 99.8% level

What does this tell us?

There have been reductions in the number of people dying from stroke and heart disease, especially between 75 and 84 years of age. However, for people aged 50 and over, long-term diseases and conditions are still the leading causes of death. Currently, 15 million people in England live with one or more long-term condition. The changing demographic structure of England and the growing number of older people with degenerative diseases and dementia will mean that the balance of disease-modifying options compared with palliative treatments (aimed at relieving suffering and maintaining quality of life) will need to change. Across the Cheshire footprint, particularly in Cheshire East, population projections to 2035 show higher increases in the proportions of over 65s than in most surrounding areas-this increase is even more marked in the over 85 group, with a steep rise from 2025 onwards. This is likely to mean similar rises in dementia diagnosis rates, and in falls requiring admission to hospital. *Source: ONS 2018*

Dementia and end of life care

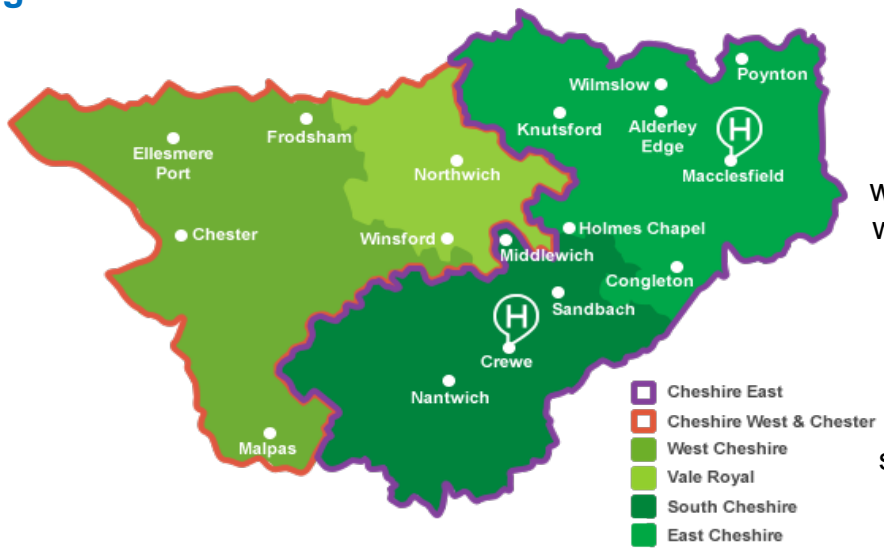
The number of people dying with dementia recorded as an underlying or contributory cause of death has increased considerably. The future is likely to see this trend continue, with even more people at the end of their life suffering from dementia due to the expected increase in the number of people dying in their late 80s or later. It also indicates that as people live longer, they are developing more complex needs. Planning for the end of life is important for anyone who has a life-limiting condition. For a person with dementia, it is important to try and have these conversations as early as possible, while they can make decisions for themselves.

What does this tell us?

All localities will see an increase in the number of people with dementia, thus an increased need for end of life care for those people. In particular, the Eastern Cheshire CCG area has a significantly higher percentage (prevalence) of people with a formal diagnosis of dementia – for those over 65 years, this is 5.16% (the other 3 Cheshire CCG rates are around 4%). However, it is estimated that up to a third of people with dementia nationally do not have a formal diagnosis – in Cheshire the estimated CCG-level diagnosis 'rate' (those with a formal diagnosis compared to the estimated number of those with dementia) varies from 64.2% to 77.9%. Many services aimed at people with dementia focus on diagnosis and early care, but given that the average survival time for people diagnosed with dementia is about four and a half years, there has to be a greater consideration to end of life care.

What are we doing?

In West Cheshire, there is currently work underway with care homes to identify and refer residents who have undiagnosed dementia in order to improve care and continuity for this group of patients.



In Eastern Cheshire, Vale Royal and South Cheshire CCGs, the Advanced Dementia Support Team (ADST) are a small team of specialist professionals who provide consultancy to professionals or family carers who care for someone with advanced dementia who require 24/7 supervision, either at home or in a care setting.

The ADST work alongside other professionals to explore clinical concerns. They provide education, facilitation and resources using our specialist knowledge and skills and are a support for health and social care services and not intended to be a replacement.

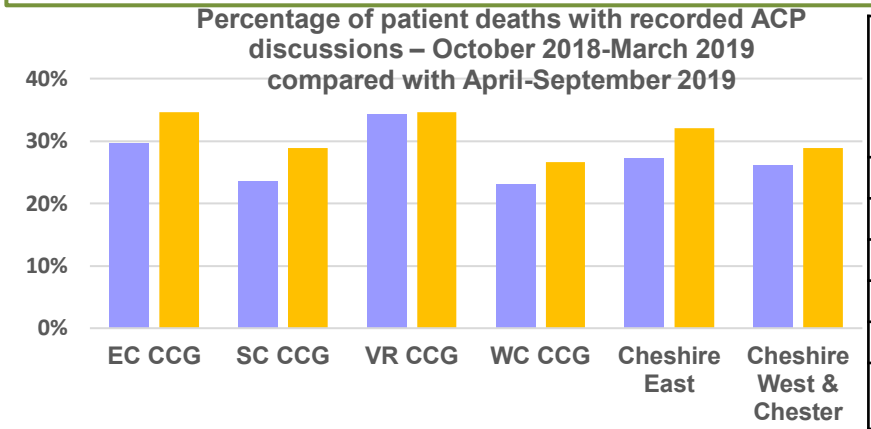
Planning for our future lives

What is Advance Care Planning? Advance care planning is a process of discussion between a person and those who provide care for a person, for example nurses, doctors, care home manager or family members. During this discussion the person may choose to express some views, preferences and wishes about their future care. With good advance care planning, people are more likely to die in their preferred place of death

Aspects of Advance Care Planning

- Opening the conversation and identifying wishes and preferences
- Refusing specific treatments
- Ask someone to speak for a person or appoint someone to make decisions for a person using a Lasting Power of Attorney
- Sharing the person's wishes with others

Dying Matters (www.dyingmatters.org) offers guidance and resources around Advance Care Planning



Clinical Commissioning Group (CCG) or Local Authority (LA)	Number of deaths		No. with ACP codes		% with ACP codes	
	Oct 18-Mar 19	Apr-Sep 19	Oct 18-Mar 19	Apr-Sep 19	Oct 18-Mar 19	Apr-Sep 19
Eastern Cheshire CCG	1209	1057	360	366	29.78%	34.63%
South Cheshire CCG	878	868	208	251	23.69%	28.92%
Vale Royal CCG	498	476	171	165	34.34%	34.66%
West Cheshire CCG	1293	1182	299	315	23.12%	26.65%
Cheshire East LA	2087	1925	568	617	27.22%	32.05%
Cheshire West & Chester LA	1791	1658	470	480	26.24%	28.95%

The chart *(above left)* and table *(above right)* compare the percentages of people who died between October 2018-March 2019 and April-September 2019 who had Advance Care Plan (ACP) Read codes. Read codes are used to extract data relate to items commonly considered during ACP discussions with people and their loved ones about their preferred priorities for care. These include Preferred Place of Care and Death, Best Interest Decisions and Advance Statements, Advance Decisions to Refuse Treatment (ADRT), Lasting Power of Attorney (LPoA), and records of discussions offered but declined or inappropriate.

What does this tell us?

The number of Advance Care Planning discussions that have been recorded are increasing. This may indicate that either more discussions are taking place or that more are being recorded/coded. In the future, increasing understanding of the nature of these will help to continue to support individual's choices, wishes and preferences.

Source: EMIS/EPaCCS data based on GP registers as at 30 September 2019

What do we know about the experience of end of life care?

Public Health England National End of Life Care Intelligence Network (NEoLCIN) published a report that summarised the key findings of the network in 2014. These new findings show there is a growing understanding within the health sector of what is important to people at the end of life. The key findings from the report include:

- Factors of most importance to people at the end of their life were: having pain and other symptoms managed effectively, being surrounded by loved ones and being treated with dignity
- More GPs are having conversations with people about their end of life care wishes, but 25% still say they have never initiated such a conversation
- The proportion of people dying at home or in care homes continues to increase, in line with reported preferences
- Two in five people with dementia die in hospital, indicating that the trend towards increasing hospital deaths for people living with dementia has reversed
- People with an Electronic Palliative Care Co-ordination System (EPaCCS) record and those receiving palliative care services such as hospice at home, Gold Standards Framework or Macmillan services are more likely to die in the place of their preference

From the previous pages, we can see that locally we are similar to many of the findings from the NEoLCIN report, but we are less consistent across the area in broadly understanding what experiences people are having…

How do we understand local needs and experiences?

- Within different care settings, there are a variety of ways in which experiences are gathered. They tend to be setting specific (so focus on the care etc. in a given setting) and are subsequently responded to within that context.
- Testing ways to gain feedback about local people's experiences will increase the amount of co-ordinated and comprehensive feedback to be able to act upon.
- In recognition of this, the Strategic Collaborative Cheshire (see page 9) identified a new High Level Outcome to "find a mechanism that will consistently measure patient (and/or carer) experience* at the end of life. *Experience is taken to mean any combination of satisfaction, expectations and experience, so long as it relates to feedback provided by people using services or their family or carers (*The Health Foundation, 2013*). To support this, a project is underway to scope the current local activities around gaining and utilising patient/carer experiences.

Personalised end of life care

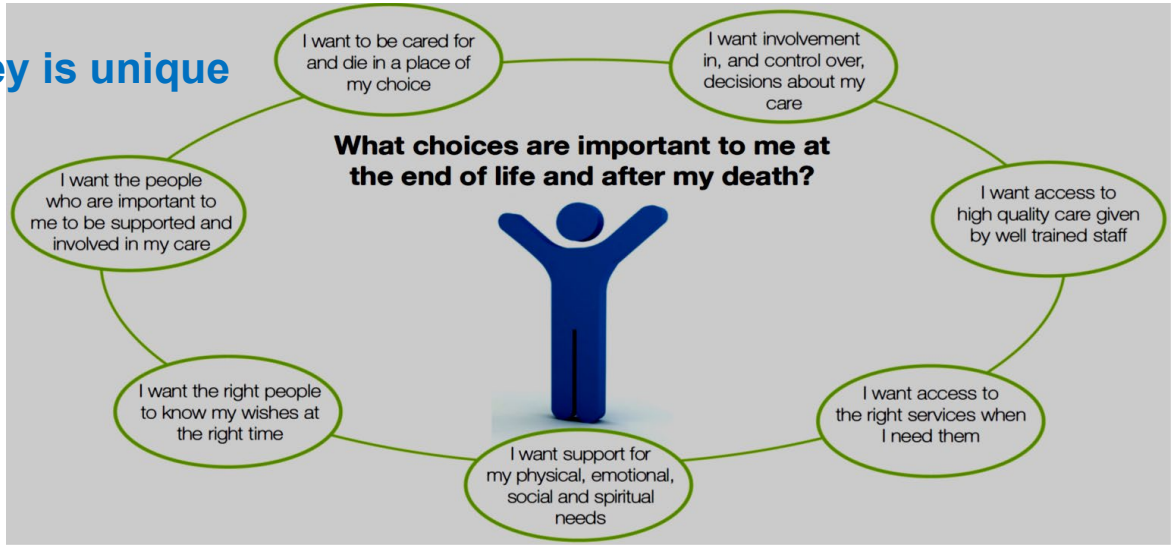
The changing demographics of an ageing population, longer chronic disease trajectories, and greater co-morbidity, provide further incentives to improve and expand palliative care and end of life care provision. In the North West alone, it is estimated that the number of people with long term conditions will double to 3 million by 2030.

The North West vision for end of life care is for people to be supported, to be cared for and, separately, **die well in the place of their choice**, with a broad aim to reduce avoidable hospital admissions for people at the end of life and to expedite discharge for those who are admitted to hospital for emergency care.

The North West End of Life Care Model (*figure below)* uses a whole systems approach for all adults with a life limiting illness, regardless of age and setting, moving from recognition of need for end of life care, to care after death. In order to apply the model, it is important that staff across different organisations understand the needs and experiences of people and their carers.

Every person's end of life journey is unique

The document '*What's important to me' (2015)* identified these areas of importance to a person. These have underpinned the work around end of life care across Cheshire East and Cheshire West and Chester and its associated CCGs for the last three years, with current work being undertaken by the Strategic Collaborative Cheshire (SCC) to update these and this will be addressed on the next page.



Source: Ambitions for Palliative and End of Life Care. A national framework for local action 2015-2020

The Strategic Collaborative Cheshire Working Together

Who are the Strategic Collaborative Cheshire?

The Strategic Collaborative Cheshire is made up of twenty different organisations from across Cheshire whose focus and purpose is "to drive a collaborative approach to enable and support personalised end of life care for people in Cheshire".

The group are currently working on a new collaborative plan (2020-2025) and have identified and agreed the following **three priority areas** that will be included, as well as **three key enablers** that are needed to support the priority areas.

Priority Areas

- Effective 2-way communication and engagement with patients, carers and staff to gain an understanding of experience and bridge the gap between strategy and practice
- Personalised care planning and coordination (including ACP and Early Identification)
- Collective System Leadership

Enablers

- Data gathering and information sharing (e.g. EPaCCS)
- Community Development including bereavement
- Education and Training

Moving forward

A task and finish group for each priority area is currently being agreed through the Strategic Collaborative Cheshire. There will be representation from each of the different localities, health and social care settings and professional groups to ensure that the priority areas are addressed in a collaborative and inclusive manner. Once these have been completed, it will become the responsibility of all member groups of the SCC to ensure that the agreed outcomes are achieved. Working together towards a single purpose in this way is very innovative and Cheshire have been commended for adopting this approach.

What are we currently doing (1)?

The majority of the services described in the table support people throughout or at various points along the end of life pathway (*right*). Some services are only provided within the last 12 weeks of life and are indicated with an asterisk *

	Specialist Palliative and End of Life care	Generalist care that supports people at the end of life	Community based support for people at the end of life
Eastern Cheshire	• East Cheshire Hospice, Macclesfield Inpatient care (10 beds) Sunflower Wellbeing Centre Outpatient clinics, Complementary Therapies, Bereavement Support and Social Care etc. Hospice at Home Service* • Specialist Palliative Care team (working across Macclesfield DGH and community)	• District Nursing • Primary Care (GP Practices) • Residential and Nursing Care Homes • Fast Track NHS Continuing Health Care Funded Care Packages (Agency care)* • Carers Trust 4 All • Marie Curie Night Care	• Compassionate Communities: Chelford • East Cheshire Hospice Community Dementia Companion Services
South Cheshire and Vale Royal	• St Luke's (Cheshire) Hospice, Winsford Inpatient care (10 beds) Day Hospice Outpatient clinics, Complementary Therapies, Bereavement Support and Social Care etc. • Specialist Palliative Care team (Leighton Hospital) • Specialist Palliative Care team (Community)	• District Nursing • Primary Care (GP Practices) • Residential and Nursing Care Homes • Fast track NHS Continuing Health Care Funded Care Packages (Agency care)* • *Palliative Care in Partnership* * • Hospital Care at Home • Night Care	• Compassionate Communities: Winsford Nantwich Wrenbury • St Luke's Hospice, Befriending Service
West Cheshire	• Hospice of the Good Shepherd, Chester Inpatient care (? beds) Living Well Centre Outpatient clinics, Complementary Therapies, Bereavement Support and Social Care etc. • Specialist Palliative Care team (Countess of Chester Hospital) • *Specialist Palliative Care team (Community)*	• District Nursing • Primary Care (GP Practices) • Residential and Nursing Care Homes • Fast Track NHS Continuing Health Care Funded Care Packages (Agency care)* • Hospital at Home	• Compassionate Communities: Tarporley

The End of Life Partnership

Compassionate Communities, Education and Training, Leadership and Innovation, Knowledge and Informatics

What are we currently doing (2)

HOSPITAL

Locations
Countess of Chester NHS Foundation Trust; Macclesfield District General Hospital; Mid Cheshire Hospitals NHS Foundation Trust

The last decade has seen a significant reduction in the proportion of deaths that occur in hospital – down by 10.5%, from 55.9% in 2007 to 45.4% in 2019 (*England average - local current figures shown on page 3*). Hospitals are important places of care towards the end of life for many people even if they die in the community. Given the importance of hospitals in caring for people approaching the end of life there have been a number of initiatives to improve the quality of palliative and end of life care. Factors associated with a higher risk of dying in hospital include age, gender, social deprivation, underlying or contributory cause of death, ethnicity and marital status. There is some suggestion that not all people who die in hospital have medical needs requiring them to be there, however, this needs further evaluation to quantify more accurately.

A current initiative
All hospitals offer access to Specialist Palliative Care services on the basis of need not diagnosis. Outpatient clinics and home visits are designed to facilitate the transfer of the patient from the curative to the palliative approach of their incurable illness.

CARE HOME

Care homes (with nursing) = 80 (4327 beds)
Care homes (residential) = 63 (1980 beds)
Total of care homes = 143 (6307 beds)

The numbers of people dying aged 85 years or more is expected to rise from 40% in 2014 to 53% in 2040. Due to a shift from deaths in hospital, deaths in care homes, homes and hospices is projected to almost double by 2040, accounting for 76% of all deaths and care home deaths are projected to become the most common place of death by 2040. This rise of deaths in care homes is striking and warns of an urgent need to ensure adequate bed capacity, resources and training of staff in palliative care in all care homes in the country. There is a risk that if capacity does not increase and these additional deaths instead occur in hospital, the decline in hospital deaths will reverse by 2023, rising to 40.5% of all deaths by 2040 (*Source: Kings College London, 2017).*

A current initiative
The Six Steps for care homes programme is being delivered across all localities. It aims to both influence practice within the care home as well as informing and educating the workforce. The programme has an integrated audit, and positive results to date have included an increase advance care planning and decrease in inappropriate hospital admissions.

What are we currently doing (3)

HOME

Includes:
17 Care Communities (Strategic Development Groups); 87 GP practices; 3 Community Health Care providers

Dying at home surrounded by family and friends is considered by many to be the 'gold standard' for a good death. Yet achieving this depends on a number of different factors including the person's diagnosis, duration of illness support of families, the input of a wide range of health and social care professionals, the involvement with other agencies and coordinated care with clear communications. In order to move forward, the changes that are needed are three-fold: at the level of individual professionals; across the whole system of health and social care and, importantly, in society (*Bee Wee, 2017*). It is accepted that home based end of life care increases the chances of dying at home *(Cochrane, 2016),* but in the UK, the ways in which this can be achieved still need to be better understood.

A current initiative
From the previous JSNA, a gap around developing and implementing care and service coordination was identified. Since then, the Palliative Care in Partnership (PCiP), a collaboration between the End of Life Partnership, Central Cheshire Integrated Care Partnership (CCICP) and St Luke's Hospice in Cheshire. The service provides end of life care for people who want to spend their last days and weeks at home.

HOSPICE

Locations
East Cheshire Hospice, Macclesfield; Hospice of the Good Shepherd, Chester; St Luke's Hospice, Winsford

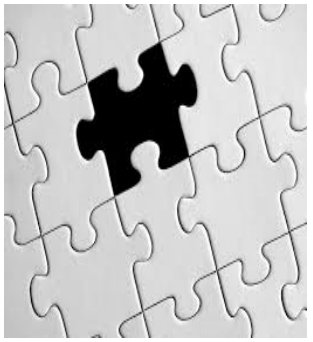
Hospices provide care for people from the point at which their illness is diagnosed as terminal to the end of their life, however long that may be. Hospice care aims to look after all their medical, emotional, social, practical, psychological, and spiritual needs, and the needs of the person's family and carers. *(NHS UK, 2019).* However, hospices are currently facing a number of challenges where demand is growing but are unable to afford to do the things they once did *(Clarke, 2019).* Hospices are meeting these challenges by working in different ways, establishing new partnerships and ensuring that innovations are rigorously evaluated for effectiveness and cost-effectiveness.

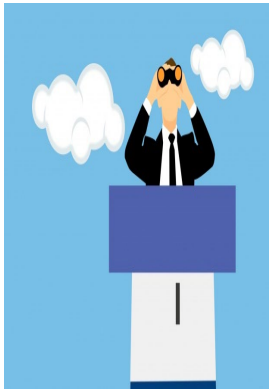
A current initiative
The Hospices Leadership Programme has been developed with the Cheshire Hospices to build leadership capacity within the workplace. The programme has been evaluated very well, and a wide range of projects have been completed, including developing a patient voice and developing a holistic well being service. The programme has recently won an Excellence in Learning and Development award from the Association of Business Psychology.

JSNA contributors:
Carers Trust 4 All, Central Cheshire Integrated Care Partnership (CCICP), Cheshire and Wirral Partnership (CWP), Cheshire East Council, Cheshire West and Chester Council, Countess of Chester Hospital, Eastern Cheshire Clinical Commissioning Group, East Cheshire Hospice, East Cheshire NHS Trust, Greater Manchester and East Cheshire Strategic Clinical Network, Home Instead, Hospice of the Good Shepherd, Macmillan Cancer Support, Mid Cheshire Hospitals NHS Foundation Trust, North West Coast Strategic Clinical Network, South Cheshire Clinical Commissioning Group, St Luke's Cheshire Hospice, The End of Life Partnership, University of Chester, Vale Royal Clinical Commissioning Group, West Cheshire Clinical Commissioning Group

Gaps

- A greater understanding about the experience/quality of end of life care from patient and family perspectives, but to also understand the experiences of professionals providing care and services - Is it seamless? Are there additional needs that are not being met? How do we hear this? How do we incorporate this to influence whole service improvements?
- Understanding the full impact of initiatives that set to improve end of life care, particularly in how they may improve Patient Related Outcome Measures (PROMS)





Opportunities for improvement and future developments

- Increasing identification of people in the final year of life which includes both recognising, recording and sharing this information
- Know what people want at the end of life, for example, how many people plan/create/are offered Advance Care Planning and understand better how this can feed into service provision
- Using already established person-centred end of life care to link to the new personalised care agenda to give choice and control to people towards and at the end of life
- Utilising the strengths of the Strategic Collaborative Cheshire to support a collective system leadership
- Locally, we are building on our knowledge by the use of local data. We can maximise the use of this further by developing a local repository to enhance sharing of data and by improving its' analysis and application

Publication date	Changes made	Sign-off
		Tracey Wright / Lesley Hilton

Appendices – data charts (1)

Full data set from page 3 showing the place of death by care setting for each location and CCG across Cheshire East and Cheshire West and Chester. *Source: Office for National Statistics (ONS)*

Eastern Cheshire	2015/16 Q1 to Q4				2016/17 Q1 to Q4				2017-18 Q1 to Q4				2018-19 Q1 to Q4	Q2 18-19 to Q1 2019-20	Q3 18-19 to Q2 2019-20
Home %	19.79	19.04	18.72	17.75	16.95	17.19	17.48	18.32	18.65	19.28	19.39	19.67	21.06	21.31	21.37
Care Home %	27.83	28.67	29.49	29.69	31.91	31.8	30.9	30.8	30	29.46	29.19	28.36	28.06	28.73	29.11
Hospital %	42.47	41.93	41.59	42.57	41.41	41.55	41.98	41	41.16	40.90	41.07	41.45	41.44	41.01	40.88
Hospice %	8.57	8.87	8.77	8.64	8.15	7.96	8.13	8.44	8.86	8.97	8.73	8.69	7.67	7.33	7.26
OCE/Elsewhere %	1.35	1.49	1.43	1.35	1.57	1.50	1.50	1.44	1.33	1.39	1.62	1.83	1.77	1.62	1.38

South Cheshire	2015/16 Q1 to Q4				2016/17 Q1 to Q4				2017-18 Q1 to Q4				2018-19 Q1 to Q4	Q2 18-19 to Q1 2019-20	Q3 18-19 to Q2 2019-20
Home %	21.04	21.54	20.57	20.83	20.41	20.42	21.86	21.97	21.89	22.06	22.15	21.97	23.81	24.19	23.47
Care Home %	24.67	23.80	24.32	24.22	25.21	24.32	24.58	24.35	24.87	26.62	26.28	26.63	25.67	24.71	25.21
Hospital %	48.13	48.67	48.93	48.78	48.33	49.21	47.46	47.4	47.23	45.37	45.60	45.31	44.21	44.18	44.92
Hospice %	4.27	4.30	4.68	4.89	4.47	4.36	4.35	4.42	4.49	4.51	4.19	3.97	3.94	4.72	4.49
OCE/Elsewhere %	1.90	1.70	1.50	1.28	1.58	1.69	1.75	1.87	1.52	1.45	1.78	2.12	2.38	2.19	1.91

Vale Royal	2015/16 Q1 to Q4				2016/17 Q1 to Q4				2017-18 Q1 to Q4				2018-19 Q1 to Q4	Q2 18-19 to Q1 2019-20	Q3 18-19 to Q2 2019-20
Home %	20.48	20.76	19.77	20.37	20.89	21.41	22.34	21.31	22.04	20.88	21.38	21.61	21.36	21.37	20.90
Care Home %	26.79	25.59	25.16	25.21	25.15	25.57	25.32	25.87	26.35	26.61	27.11	27.11	25.98	25.31	25.49
Hospital %	43.80	44.81	45.65	45.88	45.84	45.99	45.98	46.68	46.62	45.28	43.34	42.93	43.23	45.14	45.61
Hospice %	6.20	6.47	6.94	6.38	6.14	5.25	4.77	4.76	4.11	5.82	6.32	6.29	7.22	6.16	5.66
OCE/Elsewhere %	2.73	2.36	2.48	2.16	1.98	1.78	1.59	1.39	0.88	1.41	1.85	2.06	2.21	2.02	2.34

West Cheshire	2015/16 Q1 to Q4				2016/17 Q1 to Q4				2017-18 Q1 to Q4				2018-19 Q1 to Q4	Q2 18-19 to Q1 2019-20	Q3 18-19 to Q2 2019-20
Home %	21.87	23.12	23.88	24.01	24.33	23.70	23.04	23.07	21.80	21.77	22.04	21.31	22.55	22.64	22.22
Care Home %	21.99	21.87	21.32	22.0	22.43	23.26	23.91	23.23	23.40	21.90	21.26	21.43	19.33	20.11	21.45
Hospital %	48.49	47.36	47.88	48.01	47.61	47.29	46.24	46.18	47.05	48.84	49.86	50.45	51.14	50.40	49.75
Hospice %	6.20	6.04	5.19	4.41	3.89	3.98	4.86	5.28	5.44	5.12	4.66	4.70	4.91	4.65	4.42
OCE/Elsewhere %	1.45	1.61	1.73	1.57	1.75	1.77	1.95	2.24	2.32	2.37	2.18	2.10	2.07	2.20	2.17

Appendices – data charts (1)

Full data set from page 3 showing the place of death by care setting for each location and CCG across Cheshire East and Cheshire West and Chester. *Source: Office for National Statistics (ONS)*

Cheshire East	2015/16 Q1 to Q4				2016/17 Q1 to Q4				2017-18 Q1 to Q4				2018-19 Q1 to Q4	Q2 18-19 to Q1 2019-20	Q3 18-19 to Q2 2019-20
Home %	20.36	20.19	19.56	19.15	18.51	18.63	19.47	19.96	20.14	20.57	20.66	20.74	22.30	22.62	22.33
Care Home %	26.39	26.43	27.15	27.2	28.9	28.46	28.04	27.89	27.64	28.14	27.85	27.56	26.97	26.92	27.32
Hospital %	45.04	45.03	44.91	45.39	44.53	44.97	44.46	43.88	43.95	42.97	43.16	43.24	42.69	42.44	42.73
Hospice %	6.61	6.76	6.92	6.93	6.49	6.36	6.42	6.63	6.86	6.90	6.63	6.50	5.98	6.15	5.99
OCE/Elsewhere %	1.6	1.59	1.46	1.32	1.58	1.58	1.61	1.63	1.41	1.42	1.69	1.96	2.05	1.88	1.62

Cheshire West and Chester	2015/16 Q1 to Q4				2016/17 Q1 to Q4				2017-18 Q1 to Q4				2018-19 Q1 to Q4	Q2 18-19 to Q1 2019-20	Q3 18-19 to Q2 2019-20
Home %	21.48	22.45	22.75	23	23.36	23.04	22.83	22.55	21.87	21.51	21.85	21.40	22.20	22.25	21.82
Care Home %	23.35	22.92	22.38	22.89	23.19	23.93	24.33	24.01	24.29	23.29	23.00	23.11	21.30	21.70	22.68
Hospital %	47.17	46.64	47.26	47.42	47.11	46.91	46.17	46.33	46.92	47.78	47.92	48.23	48.80	48.80	48.49
Hospice %	6.2	6.16	5.67	4.95	4.52	4.35	4.83	5.12	5.04	5.33	5.15	5.17	5.59	5.11	4.80
OCE/Elsewhere %	1.81	1.82	1.94	1.74	1.81	1.77	1.84	1.99	1.89	2.09	2.08	2.09	2.11	2.14	2.22

Appendices – data charts (2)

Full data set from page 4 showing the percentage of deaths that occurred in the usual place of residence for each location and CCG across Cheshire East and Cheshire West and Chester. *Source: Office for National Statistics (ONS).*

The charts on pages 3-4 and tables on page 15-17 represent rolling annual data.

Q1 – April, May and June
Q2 – July, August and September
Q3 – October, November and December
Q4 – January, February and March

	Percentage of Deaths in Usual Place of Residence (DiUPoR)														
Area – CCG/LA	2015/16 Q1 to Q4	2015/16 Q2 to 2016/17 Q1	2015/16 Q3 to 2016/17 Q2	2015/16 Q4 to 2016/17 Q3	2016/17 Q1 to Q4	2016/17 Q2 to 2017/18 Q1	2016/17 Q3 to 2017/18 Q2	2016/17 Q4 to 2017/18 Q3	2017/18 Q1 to Q4	2017/18 Q2 to 2018/19 Q1	2017/18 Q3 to 2018/19 Q2	2017/18 Q4 to 2018/19 Q3	2018/19 Q1 to Q4	2018/19 Q2 to 2019/20 Q1	2018/19 Q3 to 2019/20 Q2
England	45.75	45.69	45.73	45.79	46.08	46.35	46.44	46.59	46.74	46.72	46.82	46.98	46.83	46.98	47.11
Eastern Cheshire	48.55	48.69	49.23	48.59	49.71	49.83	49.10	49.83	49.63	49.63	49.56	48.86	49.78	50.81	51.08
South Cheshire	46.88	46.28	45.47	45.40	46.12	45.33	47.34	47.40	47.67	49.52	49.16	49.53	50.21	49.61	49.16
Vale Royal	48.37	47.40	45.93	46.59	47.06	47.79	48.25	47.79	48.74	47.71	48.94	49.04	47.68	47.43	47.13
West Cheshire	44.76	45.73	45.81	46.67	47.30	47.49	47.50	46.70	45.57	44.11	43.73	43.26	42.53	43.39	44.13
Cheshire East	47.79	47.57	47.52	47.13	48.08	47.82	48.30	48.74	48.73	49.58	49.37	49.17	49.97	50.27	50.20
Cheshire West & Chester	45.79	46.20	45.84	46.65	47.24	47.58	47.72	47.02	46.52	45.18	45.29	44.98	44.08	44.64	45.04