

# Cheshire & Merseyside PEOLC Population Based Needs Assessment

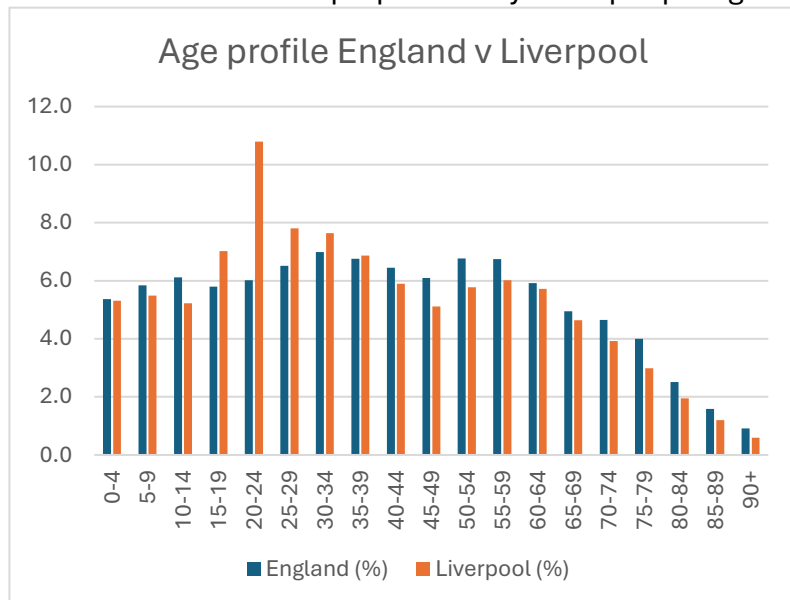
## Liverpool Locality Appendix

### 1 Population and Mortality Data

The population of Liverpool in 2022 was 495,849 (ONS

<https://www.ons.gov.uk/releases/subnationalpopulationprojections2022based>)

The age profile shows the population of Liverpool is generally younger than the England average. The chart below shows proportionally more people aged 15-40, and fewer people aged over 40.



Source: <https://www.ons.gov.uk/releases/subnationalpopulationprojections2022based>

The population is growing and aging: the overall population is predicted to increase by around 55,000 by 2035 and around 85,000 by 2047, up to 571,286 – overall this represents a 15% increase by 2047.

The population aged over 70 is increasing at a faster rate than the overall population. In 2022 there were 52,849 people aged 70 or over, this is predicted to increase to 69,654 by 2047, which is more than a 30% increase.

<https://www.ons.gov.uk/releases/subnationalpopulationprojections2022based>

The number of people who die is increasing, this is due to a combination of a growing and aging population. Although there are some annual variations (in particular seen during the COVID-19 pandemic) we can see that annual deaths between 2012 and 2023 have risen by around 12%. In 2023 there were 4798 registered deaths in Liverpool.

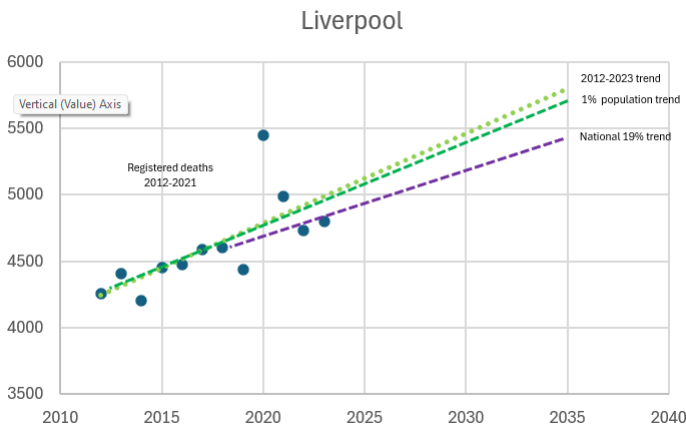
We can also see that over this period that the number of deaths is year is approximately 1.0% of the local population – which is in line with the national rate.

Local projections for future death trends are not available from any national sources such as ONS, therefore a number of assessments have been made, displayed in the graph below.

- If the reported deaths from 2012-23 are extrapolated to 2035, it suggests that there could be approximately 5760 local deaths each year.
- ONS have predicted a 19% national increase in registered deaths from 2018 to 2035, (2018 [Deaths registered in England and Wales - Office for National Statistics](#), and 2024 [National population projections - Office for National Statistics](#)). If Liverpool were to follow the national rate it would mean that there could be approximately 5476 deaths each year.

- If recent local trends for 1% of the population to die each year, based on 2025 ONS estimates for the local population, there could be approximately 5520 deaths each year.

These estimates suggest that there could be between 5476 and 5760 deaths each year in Liverpool by 2035 - this represents an increase of between 680 and 964 deaths each year, a rise of 14% to 20% compared to 2023.



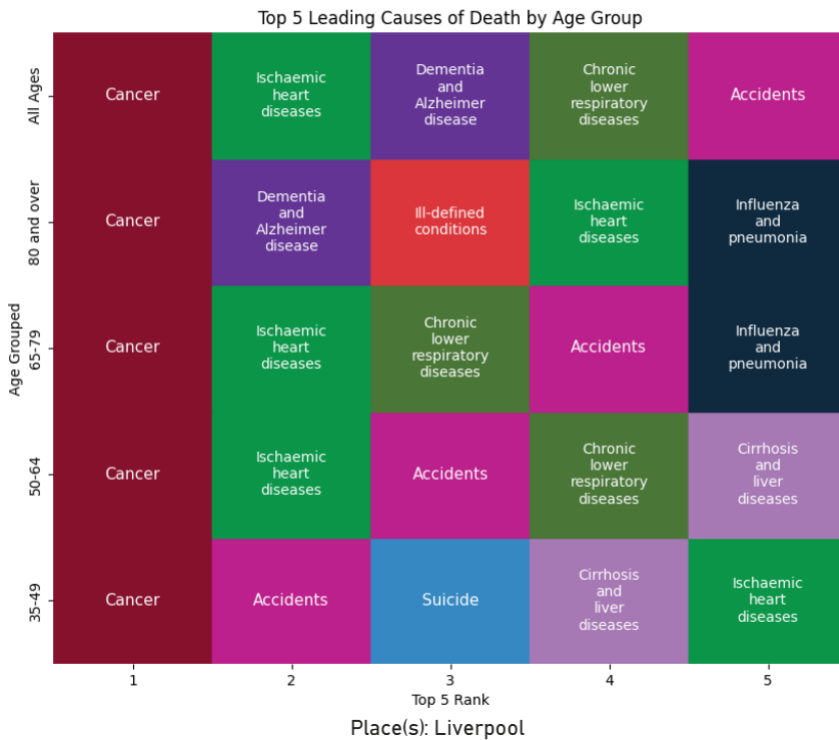
*Liverpool consistently experiences higher mortality rates than the national average for England, reflecting persistent health inequalities, higher rates of chronic illness, deprivation, and avoidable deaths in Liverpool compared to national averages.*

*It is clear that our local system needs to be prepared for additional deaths in the future. There are no local formal projections so we need to accept the projections above and expect that there could be between 5500 and 5800 deaths each year by 2035. As a local system we need to work together to prepare for this increase in deaths of between 800 and 1000 people, making sure each person receives the care and support they need.*

## 2 Major causes of death

The major causes of death in Liverpool are Cancer and Heart Disease, although we can see from the chart below that this does change across different age groups.

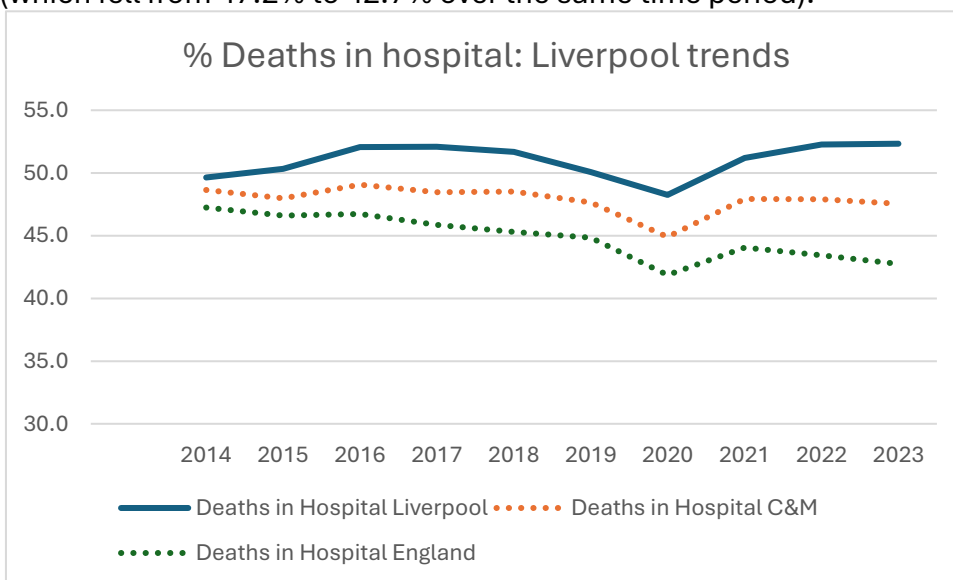
The major causes of death in Liverpool broadly mirror those across Cheshire and Merseyside and England although age of death tends to be lower and certain causes of death feature higher in some socio-economic groups.



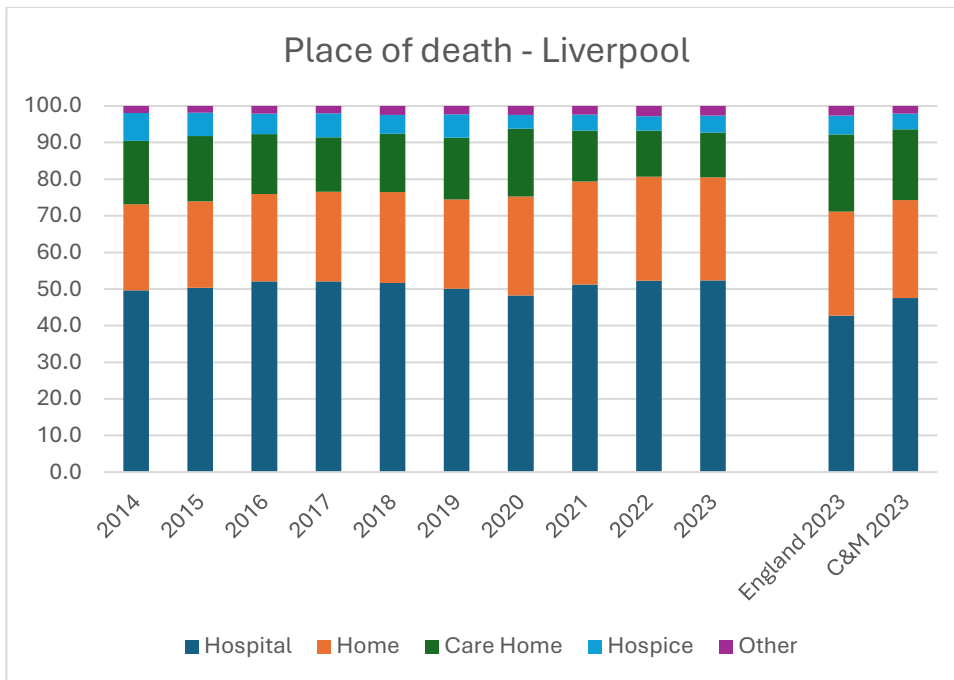
### 3 Place of death

We know that most people would prefer to die at home or in a hospice, yet many people die in hospital – the factors behind this are multifaceted and complex, but monitoring the place where people die, and in particular the proportion of people who die in hospital is widely seen as an important indicator of the strength of a palliative care system.

This chart shows that, across Liverpool, the proportion of people who die in hospital has risen over the last decade (from 49.6% in 2014 to 52.3% 2023). This is higher than and at odds with the Cheshire and Merseyside average (which fell from 48.7% to 47.5%), and the national average (which fell from 47.2% to 42.7% over the same time period).



In order to reach the national average, around 420 people who currently die in hospital each year will need to be supported to die elsewhere.



(Source: <https://fingertips.phe.org.uk/profile/end-of-life/>)

*Whilst we recognise that many people can have a good, dignified, experience of dying in hospital and that for many people being in a hospital setting may be the most appropriate for them to die, we recognise that for many, this isn't the case.*

*It is clearly a concern to see that the rates of people dying in hospital are significantly higher in Liverpool than the national or system averages, almost 10% higher than national and 5% higher than the rest of Cheshire and Merseyside, and that the gap appears to be getting wider. Factors behind this could include higher rates of emergency admissions, socio economic deprivation, limited access to end-of-life alternatives and hospital mortality metrics.*

*It is important that we understand the reasons behind this as we develop plans to improve. We can see from the data that rates of people who die at home or in a hospice are broadly in line with England averages, however the proportion of people who are supported to die in a care home is significantly below the national rates, approximately 10% lower. Helping to increase the numbers of people who die in care homes is a complex issue and involves training, education, advice and support lines and ensuring specialist palliative care leadership is maintained.*

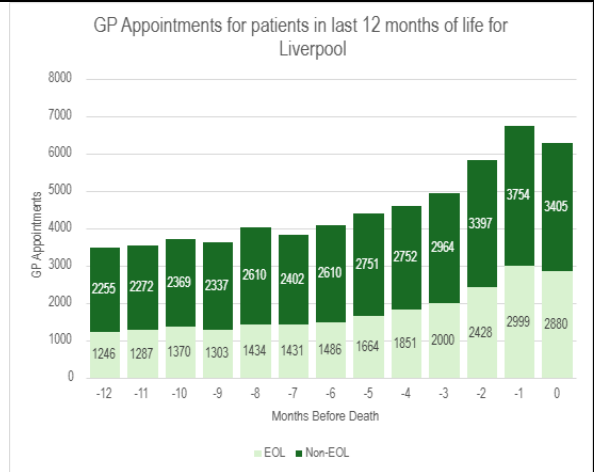
#### 4 Use of resources:

National and regional analysis shows how people use services such as their GP, hospital or district nursing in their last 12 months of life changes and how this rapidly increases in the last 3 to 4 months of life. Our analysis of activity in Liverpool shows the pattern of use of services is visually very similar to the rest of Cheshire and Merseyside, with only slight statistical differences.

Our analysis shows that Liverpool patients who died during 2024/25 attended 59,257 GP appointments in their last 12 months of life.

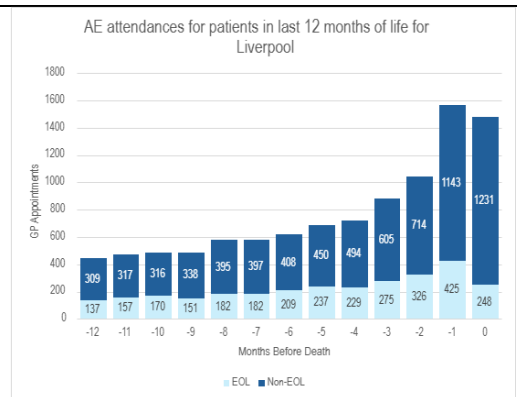
Visually this chart looks very similar to the Cheshire and Merseyside wide chart, it shows an increase in GP appointments in the final 3 months of life, in fact 31.8% of all appointments took place in these months (C&M average 32.6%).

The data shows that 44% of GP appointments in the final 3 months were used by people recognised as being end of life (EOL) this is higher than the proportion of people identified as being likely to be EOL (26%) which suggests EOL patients are being well supported by their GPs.



The data also shows that Liverpool patients attended A&E 10,045 times in their last 12 months of life. [Which is an average of 2.4 visits for each person who died (C&M average = 2.2). 12% of local patients attended at least 3 times in their last 3 months of life (C&M average 11%).

Again, visually this chart is similar to the Cheshire and Merseyside wide chart, it shows an increase in activity in the final 3 months of life. 44.2% of all visits to A&E take place in the final 3 months of life (C&M average 42.3%).

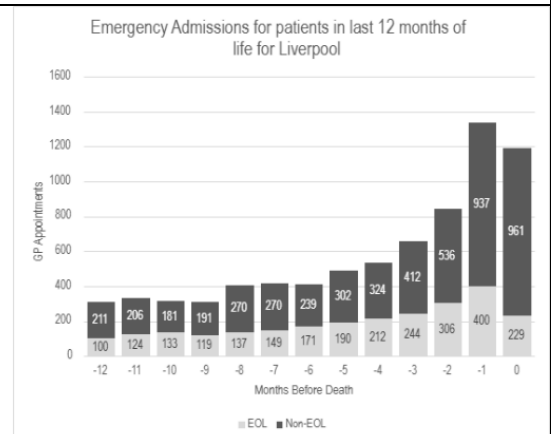


In this final 3 months, 25.1% of visits were by patients recognised as being EOL, which is in line with the proportion of patients identified as likely to be EOL (26%). Which suggests that EOL recognised patients are using non elective, urgent, services at the same rate as those non identified as being EOL.

Our research shows that Liverpool patients who died during 2024/25 were admitted to hospital on a non-elective (NEL) basis 7,554 times in their last 12 months of life staying in hospital for a total of 97,692 bed days.

7.6% of people who died were admitted NEL 3 or more time in their last 3 months of life (C&M average, 7.0%. England 7.0%)

Again, visually this chart is similar to the Cheshire and Merseyside wide chart, it shows an increase in activity in the final 3 months of life. 47.2% of all NEL admissions take place in the final 3 months of life (C&M average 46.5%).



28.5% of NEL admissions in the last 3 months were by patients recognised as being EOL, which is slightly higher than the proportion of patients identified as likely to be EOL. This may

suggests that EOL recognised patients are using non elective, urgent, services at a higher rate than those non identified as being EOL.

*Use of Services analysis is based on data from Cheshire and Merseyside NHS Business Intelligence, it does not represent all activity because around 10% of patients, or their GP practices, opt out of sharing their data.*

*Many of the figures could be increased by 10% to gain a fuller picture of use of services.*

<b>3 or more A&amp;E attendances in last 3 months of life:</b>		
Liverpool 12%	C&M 11%	
<b>% of all people who died who spent time in hospital</b>		
<b>At least one hospital admission in last 6 months of life:</b>		
Liverpool 74.1%	C&M 72.4%	England 68.2%
<b>At least one Non Elective admission in last 3 months of life:</b>		
Liverpool 66.8%	C&M 65.3%	England 60.3%
<b>3 or more Non Elective Admissions in last 3 months of life:</b>		
Liverpool 7.6%	C&M 7%	England 6.2%
<b>Average Length of Stay in hospital in last 3 months of life (people who had at least one admission):</b>		
Liverpool 19.3 days (mean)	C&M 18.4 days (mean)	18.5 days (mean)
<b>% bed occupancy (of all general and acute hospital beds) by patients in the last 3 months of life:</b>		
LUFT 21.2%	C&M 22.6% (all hospitals, including specialist)	England 23.9%
<i>All Trusts: LHCH 8.8% Walton 10.9% Liv Women 11.0% LUFT 21.2% MWL 21.8% MC 23% COCH 23.5% W&amp;H 23.8% ECT 24.1% Wir 25.1% Clatterbridge 37.5% (Model Health System, accessed 02/10/25)</i>		
<i>Data sources: C&amp;M BI , Fingertips.phe.org &amp; Model Health System</i>		

*At present, only around 26% of people who die in Liverpool had been identified as likely to die and added to the GSF or Palliative Care Register. However, it is reassuring to note that patients identified as likely to be near the end of life make better use of out of hospital services such as GP appointments and district nursing this shows the potential benefits of early identification and of advance care planning.*

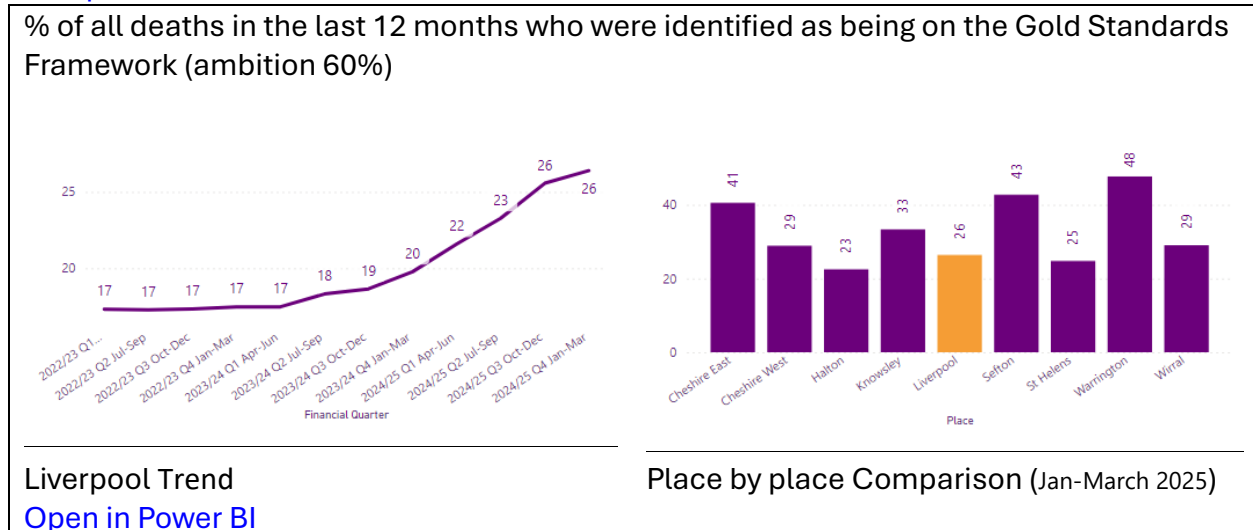
*The figures linked to unplanned hospital care reveal some significant concerns, with rates of A&E attendances, hospital admissions and time spent in hospital in the last few months of life all higher than national averages and some of the highest rates in the Cheshire and Merseyside system. This is clearly something we need to improve on and work as partners to understand how best to achieve this.*

## 5 General Practice PEOLC Care Registers

### Identifying people who are likely to be in the last 12 months of life

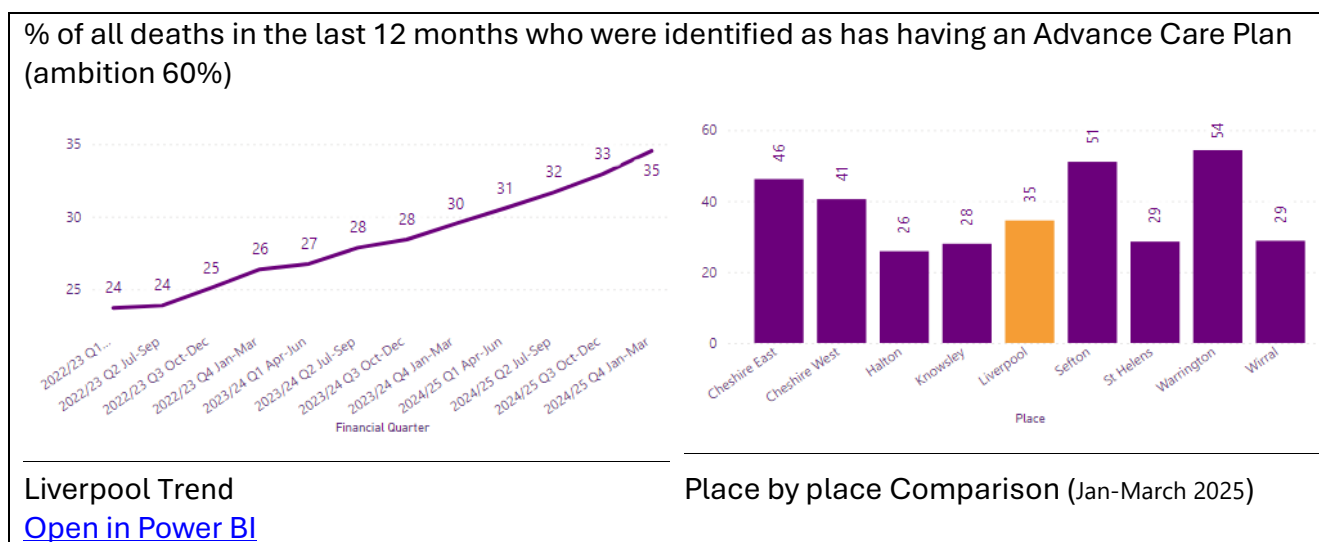
Early identification of patients who may be in the last 12 months of their life is important because it gives people the opportunity to be involved in planning for their future care. This could include thinking about the type of care they would like or would not like, where they would like to be cared for, who should be involved in their care and can help with planning for loved ones.

<https://www.cheshire-epaige.nhs.uk/wp-content/uploads/2023/03/EARLY-Toolkit-V2.0-March-2023.pdf>



### Advance Care Plans

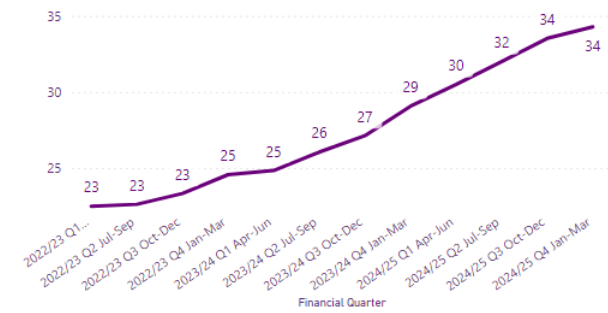
Advance Care Planning is a personalised process that emphasises reflection, choice and communication and gives people the chance to think about and write down what is important to them. As part of the process a person might choose to describe the type of care they would like at the end of their life. [What is advance care planning? | For professionals | Marie Curie](#)



### DNACPR

A DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) decision is important because it allows individuals, along with their healthcare team, to make informed decisions about an important part of their end-of-life care and ensures their wishes are respected. It provides guidance to healthcare professionals on what actions should or should not be taken if a person experiences a cardiac arrest or dies suddenly. DNACPR decisions are crucial for ensuring a patient's dignity and comfort at the end of life and preventing unnecessary, potentially painful or unsuccessful interventions. [CPR Recommendations, DNACPR and ReSPECT | Resuscitation Council UK](#)

% of all deaths in the last 12 months who were identified as having had a CPR discussion / decision



Liverpool Trend  
[Open in Power BI](#)

Place by place Comparison (Jan-March 2025)  
[Open in Power BI \(link\)](#)

PCN	GSF %	ACP %	CPR %	GSF & ACP & CPR %
Anfield & Everton PCN	12.13	27.21	25.00	5.51
Brownlow Health PCN	37.88	41.29	44.70	25.76
Central Liverpool PCN	33.93	39.04	31.53	21.32
Childwall & Wavertree PCN	23.03	34.24	35.15	9.39
IGPC PCN	27.83	43.63	45.42	17.06
Liverpool First PCN	18.44	15.27	19.88	4.61
North Liverpool PCN	28.18	35.83	32.83	14.71
SWAGGA PCN	27.95	37.50	33.64	17.05
The Picton PCN	20.74	24.47	38.30	8.78

(C&M EOL Dashboard Jan-March 2025)

*There are strongly held views locally that it is not always appropriate to make use of palliative care codes before a conversation has been had as this may be distressing for patients and their families who can now readily access their GP records. So that patients who may benefit from care are not be missed the use of supportive care codes is encouraged with regular review.*

*However, we recognise that Liverpool has some of the lowest rates of coding of early identification and advance care planning in the Cheshire and Merseyside system, and that if we are to if we are to achieve or ambitions to see fewer people dying in hospital and more people dying in their preferred place of death, we will strive to improve.*

*At Liverpool Place we are working with Practices through the local Quality contract to improve identification of people who may be in the last 12 months of life and promoting the use of supportive and palliative care eMIS templates, I CARE & Share to record advance care plans and audit and reflection. We will include promotion of tools such as Early to identify more patients. This work is supported by regular Community of practice meetings for Practice and PCN clinical and non-clinical leads.*

## 6 Specialist Palliative Care (SPC) Beds

An assessment of SPC beds across Cheshire and Merseyside is given in the main report set against internationally recognised standards. It is difficult to provide a locality-by-locality assessment for the need for or supply of specialist beds as the populations served by each individual hospice rarely align to NHS locality boundaries, therefore an assessment of needs for the wider Cheshire Devolution area and Mersey City Region area have been made.

<b>Liverpool City Region Assessment</b>	
Total population of Halton, Knowsley, Liverpool, Sefton, St Helens and Wirral.	1,746,772
PC beds	
Halton Haven Hospice	10
Queenscourt Hospice	6
Willowbrook Hospice	10
Wirral Hospice St John's	14
St Josephs Hospice	31
Woodlands Hospice	15
Claire House (Children & Young People)	5
Royal Liverpool Hospital (NHS Hospital)	8
Arrowe Park (NHS Hospital)	4
Total	103
Recommended number of beds for total population	139-175
Deficit of SPC beds for the Liverpool City Region area	36-72
Removing St Joseph's beds as non-specialist would increase this deficit to 67 – 103 for the Liverpool City Region	

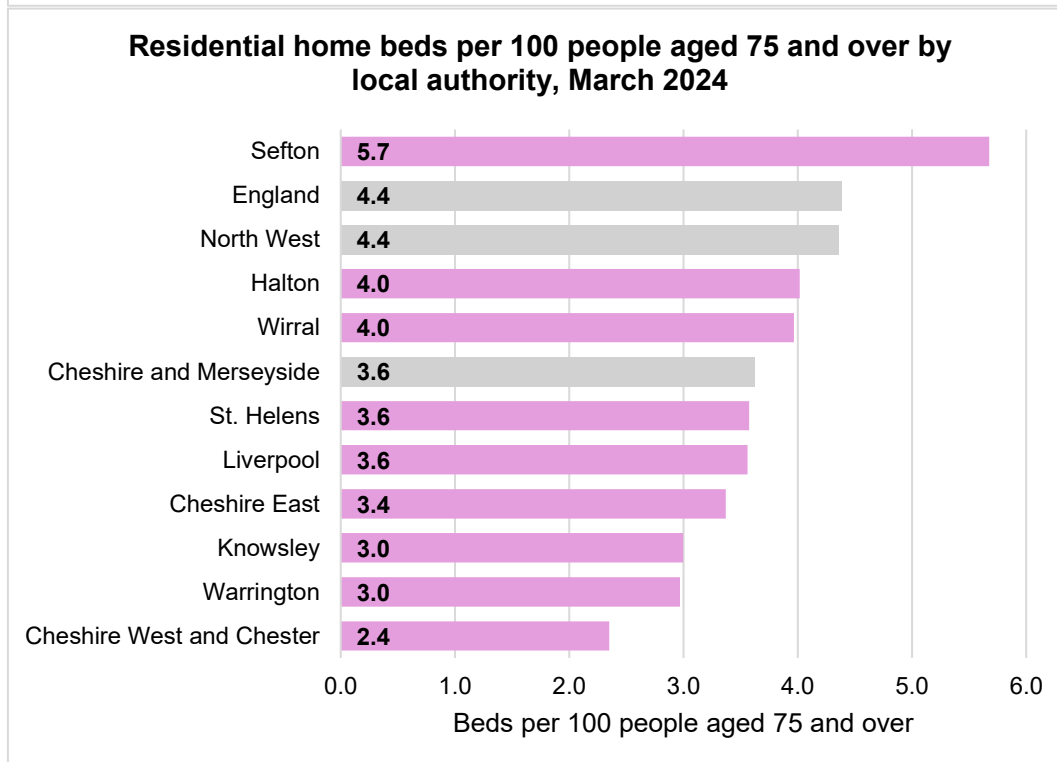
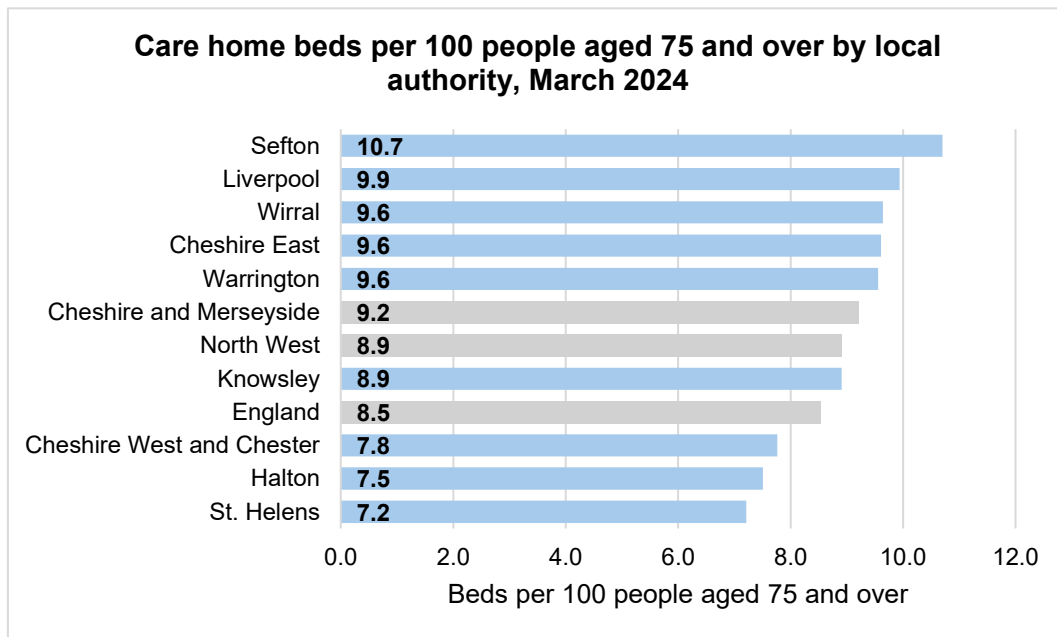
*The need for additional palliative care beds for the Liverpool area is clear in the work we do every day. The need for specialist inpatient palliative care beds for the Liverpool area is clear in the work we do every day. Liverpool Place have recognised the importance of ensuring sufficient Palliative Care beds and is working to ensure the beds lost due to the closure of the inpatient unit at Marie Curie (Liverpool) are replaced with appropriately staffed and resourced beds within the local health system. This is obviously a challenge given the resource challenges faced locally and the more general challenge of recruiting suitably experienced and qualified staff to support such beds.*

## 7 Care Homes

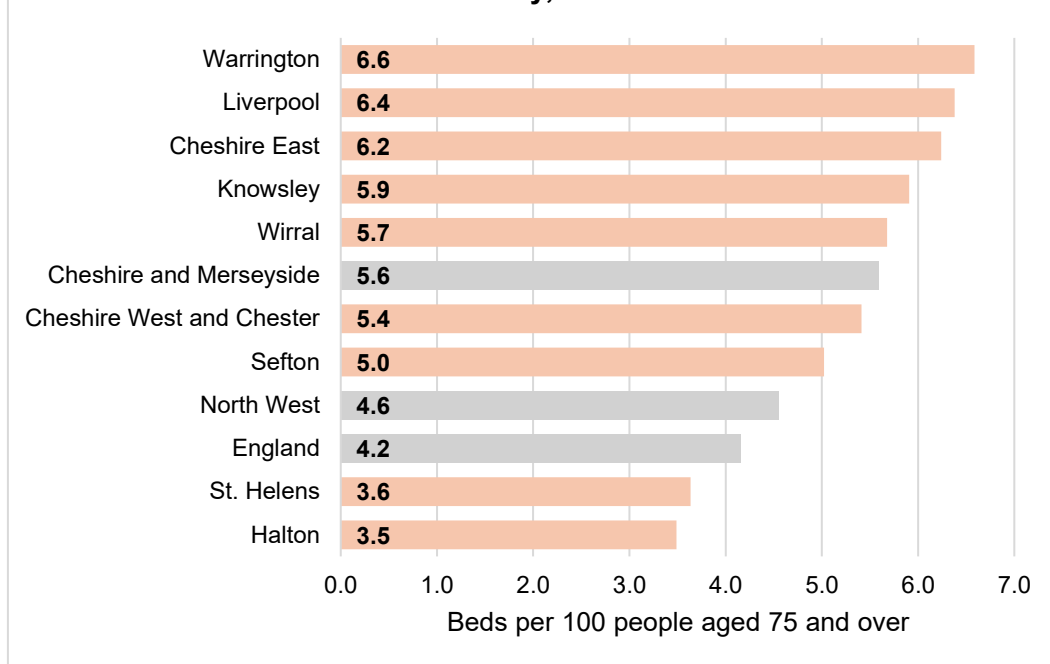
There are 85 care homes in Liverpool with 3,378 beds, this includes 45 residential care homes with 1,210 beds plus 40 nursing homes with 2,168 beds.

Comparing the availability of residential care home and nursing home beds for the local over 75 population is seen as a good indicator of the capacity of the local system to care for the needs of an aging population by supporting people in the community.

We can see from the charts below that Liverpool is higher than national and Cheshire and Merseyside averages for overall care home beds and nursing home beds, but is lower for residential care home beds.



### Nursing home beds per 100 people aged 75 and over by local authority, March 2024



*It is reassuring to see that Liverpool has higher rates of care home beds, and particularly nursing home beds than national or regional comparisons. However, it is concerning that we can see from the data on Place of Death that proportionately fewer people die in care homes than regional or national averages. It will be important to understand the reasons behind this as we work as a system to increase the proportion of people who are supported to die outside of hospital settings.*

## 8 Specialist Palliative Care Services

National bodies have repeatedly called for Specialist Palliative Care Services to be available to patients 7-days per week and for non-specialist providers of palliative care to be able to access advice at all times of the day or night.

- 24/7: Marie Curie Hospice and Woodlands Hospice both provide a 24/7 advice line for health and care professionals and patients and carers.
- 7/7: Hospital and community Specialist Palliative Care teams provide 7-day face to face assessments.
- Hospice admissions: Woodlands Hospice allow for admissions out of normal hours for urgent cases

## 9 Community Pharmacy

Timely access to end of life medications is extremely important for adequate management of patient symptoms and convenience of access for professionals and carer/families.

Currently there is unwarranted variation across Cheshire and Merseyside in terms of the number of pharmacies that stock vital end of life medications, the range of medications stocked and in the accessibility of these outside of normal hours.

Following an ICB review in 2025, the following arrangements will be in place for the provision of end of life medications across Cheshire & Merseyside:

	Current no. of pharmacies	Proposed no. of	Out of Hours arrangements

		<b>pharmacies</b>	
<b>Cheshire</b>	33	24	Only 1 pharmacy open from 8am Coverage until 21:00 at 4 pharmacies
<b>Halton</b>	5	5	Only 1 pharmacy open from 8am 2 pharmacies open later than 18:00
<b>Knowsley</b>	5	4	None
<b>Liverpool</b>	22	18	Only one pharmacy open from 8am Majority of pharmacies open past 18:30
<b>Sefton</b>	6	6	Yes
<b>St Helens</b>	9	8	None
<b>Warrington</b>	9	8	No coverage 8-8.45am Coverage in the evenings
<b>Wirral</b>	11	11	None
<b>Total</b>	100	84	

*It is disappointing to see a potential reduction in local pharmacies that stock vital end of life medication, but it is reassuring to see that most are open past 18:30 (although we cannot tell how late some of these remain open). We recognise that opening times for pharmacies regularly changes, so it is important that members of the public can easily find information on opening times.*

*It is important to recognise that any pharmacy can obtain stock with sufficient notice, therefore the more people identified as GSF with Advance Care Plans will help to ensure this medication is available when needed.*