Introduction

NHSGGC is currently undertaking a major clinical services review (CSR), with the overall aim of creating a more integrated health and social care system ‘fit for the future’, designed to deliver:

- the right interventions
- to the right people
- in the right place
- at the right time

all with a much greater focus on prevention of ill health. The Paisley locality has been identified as the site for a Development Programme, which will bring together a range of emerging service models, allow these to be further developed and their collective impact to be evaluated. Whilst many of these interventions will be developed across the whole of Renfrewshire and the RAH, we are focusing on the Paisley locality for the detailed needs assessment and evaluation to provide a manageable size, working with a defined group of practices.

Health needs: at the heart of our planning

There can be no evidence-based decision-making without a clear understanding of population need. This short paper explains how we are building a picture of local health needs for the Paisley Development Programme, which will be discussed in full at a workshop on 14th May 2014. The following definition of need is used:

‘The capacity of people to benefit from a particular type of service or services’

Approach

The population profile will build as complete a picture as possible of the people of Paisley, their health status and their current utilisation of primary care, community care and acute healthcare services. It capitalises on the opportunities offered by small scale, working locally with a relatively small number of general practices and with social work partners.

Building the dataset

We are working towards a fully linked, anonymised dataset. Although it is taking time to work through data sharing issues with the different partners, it is only by combining different sources of data that an accurate understanding of health needs can be created. In particular, it is vital to understand how different facets of need combine and interact at individual patient level. Understanding the size and distribution of these characteristics within the population thus supports the design of the right mix of care systems.

Future evaluation

Some of the data collected for this baseline needs assessment will also help us with evaluation; individual level data are essential for this, as it is not possible to attribute causal effects to an intervention unless the characteristics of recipients are clearly defined.
More than numbers ........

Needs assessment is not the same as population health status assessment. In addition to the epidemiological profiling described opposite, wider aspects of needs assessment conventionally incorporate two additional dimensions:

A comparative component, which typically compares levels of current service receipt with a 'gold standard'. The evidence reviews already completed for the CSR should be used for this purpose.

A corporate component which canvases the demands and wishes of professionals, patients and other interested parties. Potential ways of doing this may include narrative accounts, eg 'A Week in the Life of the RAH', eg in the form of a photodiary.

Engagement of the local Paisley patient partnership forum will also use material already collected on patient experience.

Datasets within baseline health profile (NB indicators in pale grey still being sought)

Methodology

The population profile uses data derived from the local NHS CHI register for all patients within the practice population in the 13 participating practices: this forms the central anchor ('core dataset') to which the additional datasets shown above will be linked, via CHI (a unique NHS number), using existing information security protocols. For some datasets, agreement to secure record linkage is still being negotiated. These are shown in pale grey in the figure above.

It had originally been intended that general practice utilisation (eg home visits, consultations, telephone consultations, etc) would also be part of the individual level dataset. Initial investigations have indicated substantial variations in recording and coding between and within practices, which would render this exercise relatively meaningless at this point, so this is an area we would like to explore in partnership with our practice colleagues as we go forward.

Social work data are currently available only in aggregated form; this means that a 'best guess' of activity for this population has been derived from all residents who live in unit postcodes where a substantial (more than 50%) proportion of residents are registered with one of the 13 Paisley practices. Discussions are underway with social work colleagues to explore the possibility of record linkage at an individual level in the future.
Demography

The total practice population registered with these 13 practices was 82,448 as at 1 April 2014. This needs assessment focuses on the adult population, which totals 68,880. As shown in the map opposite, the population is largely resident in Paisley, but also has significant concentrations of patients in outlying small towns, such as Johnstone and Bridge of Weir.

Age profile

Further detail will be provided at the session on 14th May. However, as shown opposite, the Paisley practice population is broadly representative of Renfrewshire in terms of age, but less representative of the NHSGGC population as a whole, which contains relatively more younger people (under 35s).

Deprivation

40% of patients live in SIMD Quintile 1 (most deprived) datazones. This is midway between Glasgow City and the Health Board as a whole, but a significantly higher proportion than for Renfrewshire CHP.

Ethnicity (census)

A ‘best fit’ method of postcode sectors approximating to the practice population estimated that around 97% of the patient population is white, 2% Asian and the remainder other groups.
Mental health problems are a major driver of poor health, both in their own right and as a co-factor in worsening the impact of other long term conditions. A new diagnosis of depression was made in 6.5% of patients during the 2012/13 year in this group of practices. We are working towards a linked dataset of the Paisley practice population which will show how it is affected by multimorbidity, with important combinations of the above conditions.

During 2013, there were a total of 9,845 emergency admissions in this population; 2,705 individual patients accounted for these admissions. Their age profile is shown above, together with the leading cause of admission for the first episode in 2013, which varies strikingly across the lifecourse; injuries and external causes are proportionately higher in younger age groups.
Scottish Patients at Risk of Readmission and Admission (SPARRA) is a risk prediction tool which predicts an individual's risk of being admitted to hospital as an emergency inpatient within the next year. During 2013, SPARRA risk scores had been calculated for a total of 28,333 patients in this population; the distribution of scores is shown above. More analysis of this cohort will be shown at the session on 14th May.
### Health & Wellbeing Profiles 2014 (Renfrewshire)

**Notes:**
1. Five-year combined number, and 5-year average annual measure.
2. Three-year combined number and 3-year average annual measure.
3. Data available down to council (local authority) area only.
4. Denotes indicator where comparison is better or worse than comparator average in appropriate and data are subject to local interpretation.
5. The ESPOP2013 has been updated to calculate the rate for this indicator. Please see Appendix 1 of the technical report for further details.

### Domains

#### Life Expectancy & Mortality
- **1. Life expectancy (Males):** 2009: 75.6 yrs, 2011: 75.6 yrs
- **2. Life expectancy (Females):** 2009: 80.4 yrs, 2011: 80.4 yrs
- **3. Deaths at all ages:** 2012: 1,106.7 yrs
- **4. Early deaths from CHD (<75a):** 2012: 63.1 yrs
- **5. Early deaths from cancer (<75a):** 2012: 174.3 yrs
- **6. Early deaths from cardiovascular disease (<75a):** 2012: 20.8 yrs
- **7. Estimated smoking attributable deaths:** 2012: 23.9 %
- **8. Smoking prevalence:** 2012: 23.9 %
- **9. Alcohol-related hospital discharges:** 2012: 23.9 %
- **10. Deaths from alcohol conditions:** 2012: 23.9 %
- **11. Drug-related hospital discharges:** 2012: 23.9 %
- **12. Active travel to work:** 2012: 23.9 %
- **13. Smoking participation:** 2012: 23.9 %

#### Sexual Health & Injury
- **14. Patients registered with cancer:** 2012: 6492.2 yrs
- **15. Patients hospitalised with chronic obstructive pulmonary disease (COPD):** 2012: 252.6 yrs
- **16. Patients hospitalised with coronary heart disease:** 2012: 452.5 yrs
- **17. Patients hospitalised with cerebrovascular disease:** 2012: 280.0 yrs
- **18. Patients hospitalised with asthma:** 2012: 475.0 yrs
- **19. Emergency medical admission patients:** 2012: 7360.0 yrs
- **20. Patients (ID) with multiple hospitalisations:** 2012: 5201.6 yrs
- **21. Road traffic accident casualties:** 2012: 598.8 yrs

#### Mental Health
- **22. Patients prescribed for anxiety/depression/psychosis:** 2012: 16.2 yrs
- **23. Patients with a psychotic hospitalisation:** 2012: 320.3 yrs
- **24. Deaths from suicide:** 2012: 11.3 yrs
- **25. People (ID) receiving free personal care at home:** 2012: 5.2 yrs
- **26. Adults claiming incapacity benefit/low disability allowance:** 2012: 4.4 yrs
- **27. People (ID) with intensive care needs cared for at home:** 2012: 32.1 yrs
- **28. Children living with lone family:** 2012: 1.3 yrs
- **29. Single adult dwellings:** 2012: 37.7 yrs
- **30. Households in extreme fuel poverty:** 2012: 7.3 yrs

#### Social Care & Housing
- **31. Average tariff score of all pupils on the 04 roll:** 2012: 108.0 yrs
- **32. Primary school attendance:** 2012: 15.9 yrs
- **33. Secondary school attendance:** 2012: 8.9 yrs
- **34. Working age adults with low or no educational qualifications:** 2012: 23.9 yrs
- **35. Population income deprived:** 2012: 14.7 yrs
- **36. Working age population employed deprived:** 2012: 13.3 yrs
- **37. Working age population claiming Jobseeker's Allowance:** 2012: 4.3 yrs
- **38. Dependence on out of work benefits or child tax credit:** 2012: 47.3 yrs
- **39. People claiming pension credits (aged 60+):** 2012: 8.8 yrs
- **40. Crime rate:** 2012: 41.3 yrs
- **41. Prisoner population:** 2012: 171.2 yrs
- **42. Patients to Children's Reporter for violence-related offences:** 2012: 3.1 yrs
- **43. Patients hospitalised after an assault:** 2012: 85.7 yrs
- **44. Population within 500 metres of detrit site:** 2012: 45.5 yrs
- **45. People living in 10% most 'access deprived area' 2012: 59.5 yrs
- **46. Adults rating their housing as a very good place to live:** 2012: 55.2 yrs
- **47. Teenage pregnancies:** 2012: 172.9 yrs
- **48. Mothers smoking during pregnancy:** 2012: 20.7 yrs
- **49. Low birth weight babies:** 2012: 2.4 yrs
- **50. Babies exclusively breastfed at 0-5 weeks:** 2012: 26.3 yrs
- **51. Child dental health in primary 1:** 2012: 86.4 yrs
- **52. Child dental health in primary 7:** 2012: 45.2 yrs
- **53. Child obesity in primary 1:** 2012: 9.6 yrs
- **54. Child obesity in primary 7:** 2012: 9.6 yrs

#### Immunizations and Screening
- **55. Breast screening uptake:** 2012: 74.1 yrs
- **56. Cervical screening uptake:** 2012: 54.5 yrs
- **57. Immunisation uptake at 24 months - MMR:** 2012: 94.1 yrs
- **58. Immunisation uptake at 24 months - 5 in 1:** 2012: 98.2 yrs

**Spine Chart Key:**
- 'Worse' Area: Statistically significantly worse than National average
- 'Scotland Average': Statistically not significantly different from National average
- 'Better' Area: Statistically significantly better than National average
- No significance can be calculated

**ScotPHO Values:**
- 5th Percentile
- 25th Percentile
- 75th Percentile
- 95th Percentile

See the detailed Definitions and Sources table for indicator information and Technical Report for further guidance on interpreting the spine.