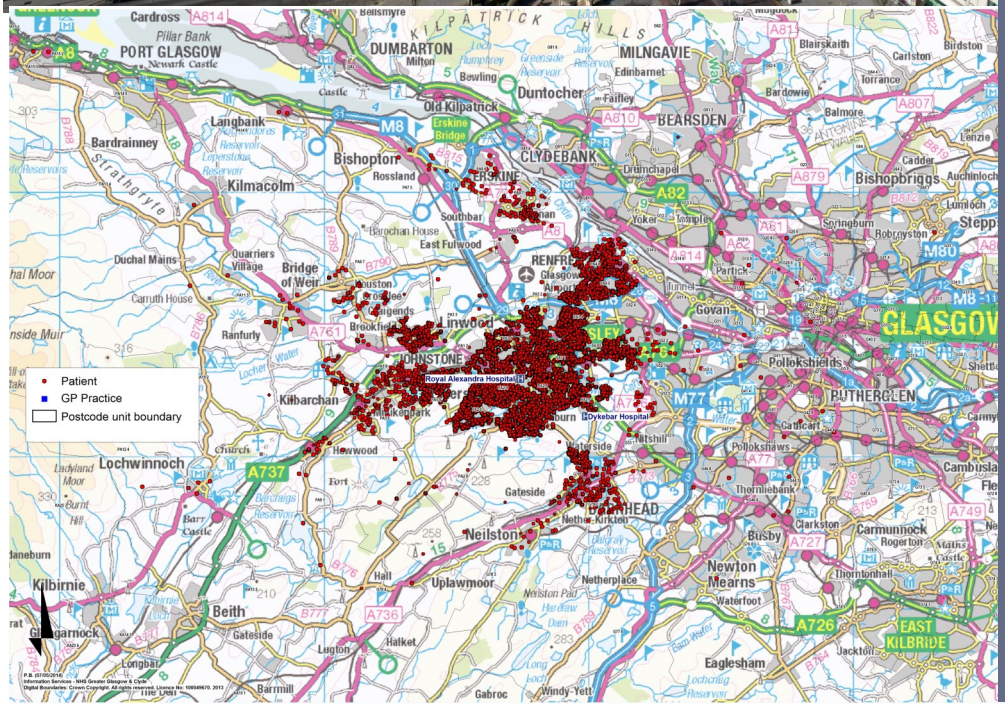
NHS Greater Glasgow and Clyde

UNDERSTANDING PAISLEY

Building a picture of Health & Social Care Needs **May 2014**



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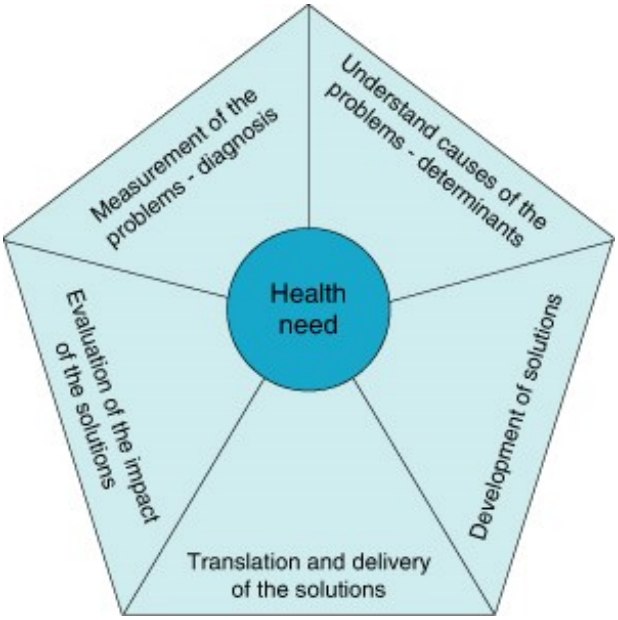


Health need: at the heart of our health & social care planning

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.

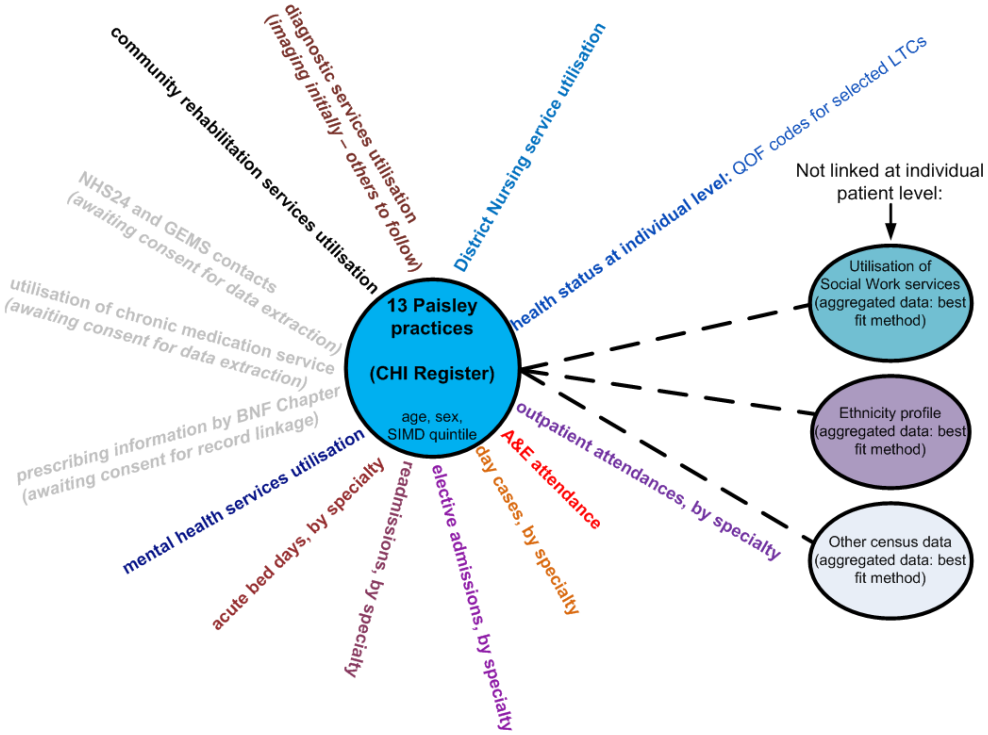
More than numbers ……..

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)

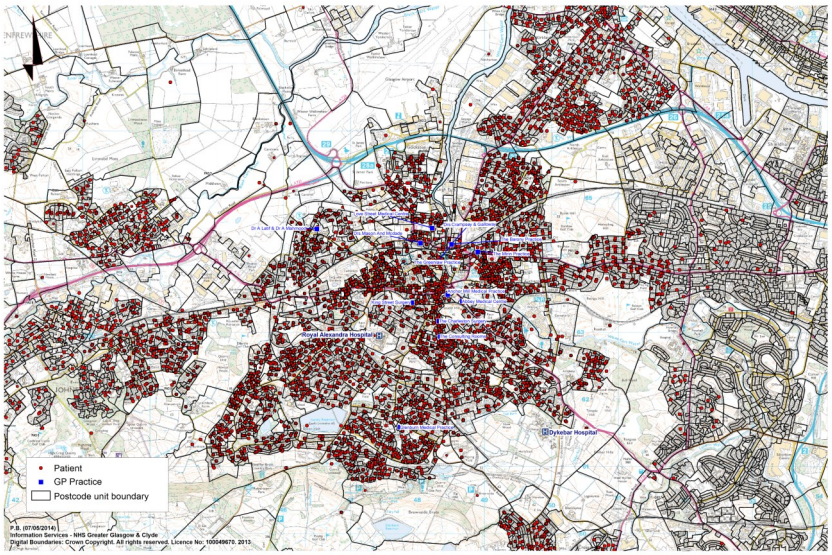
Methodology

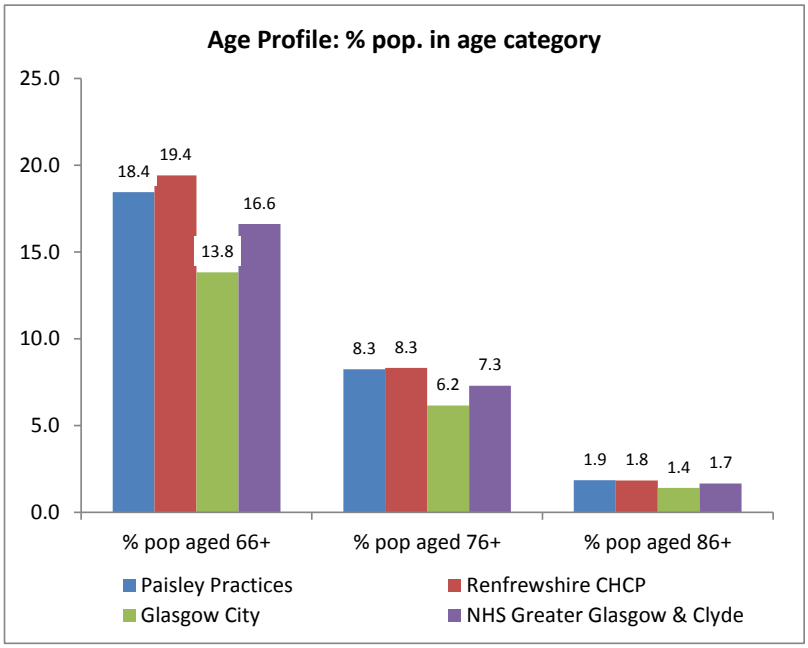
The population profile uses data derived from the local NHS CHI register for all patients within the practice population in the 13 participating practices: this forms the central anchor ('core dataset') to which the additional datasets shown above will be linked, via CHI (a unique NHS number), using 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.

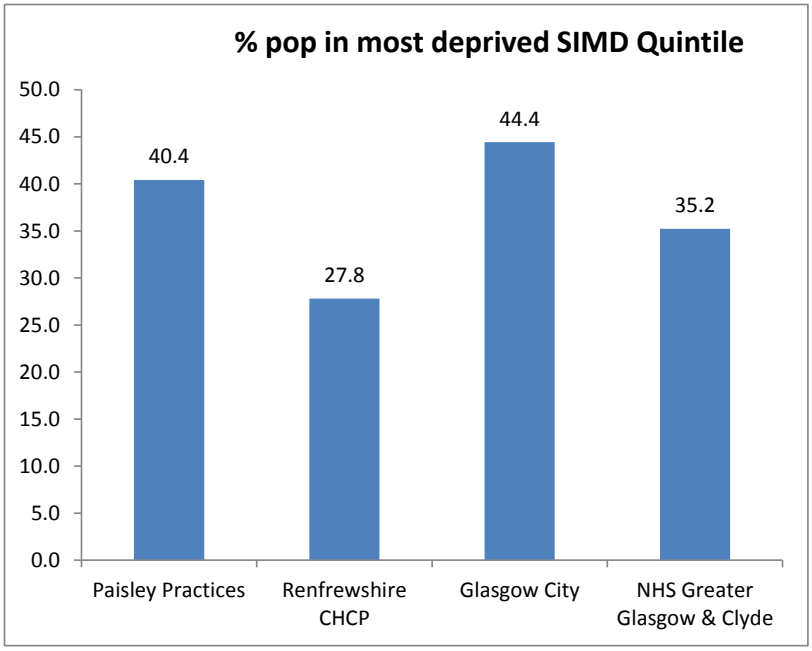
It had originally been intended that general practice utilisation (eg home visits, consultations, telephone consultations, etc) would also be part of the individual level dataset. Initial investigations have indicated substantial variations in recording and coding between and within practices, which 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.

Practice population







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).

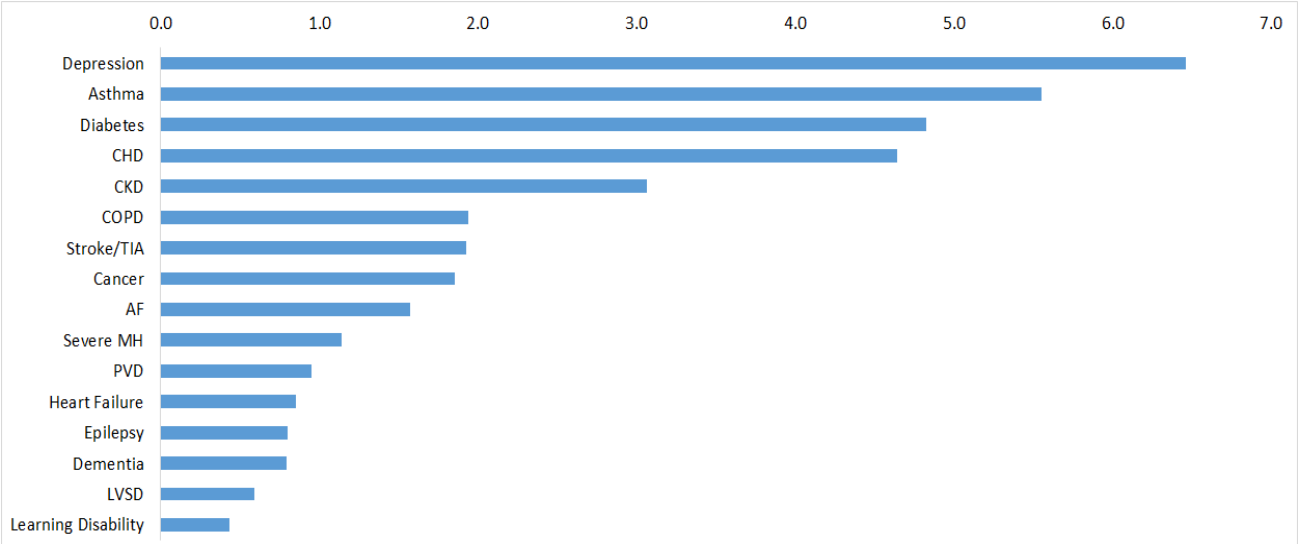
Deprivation

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.

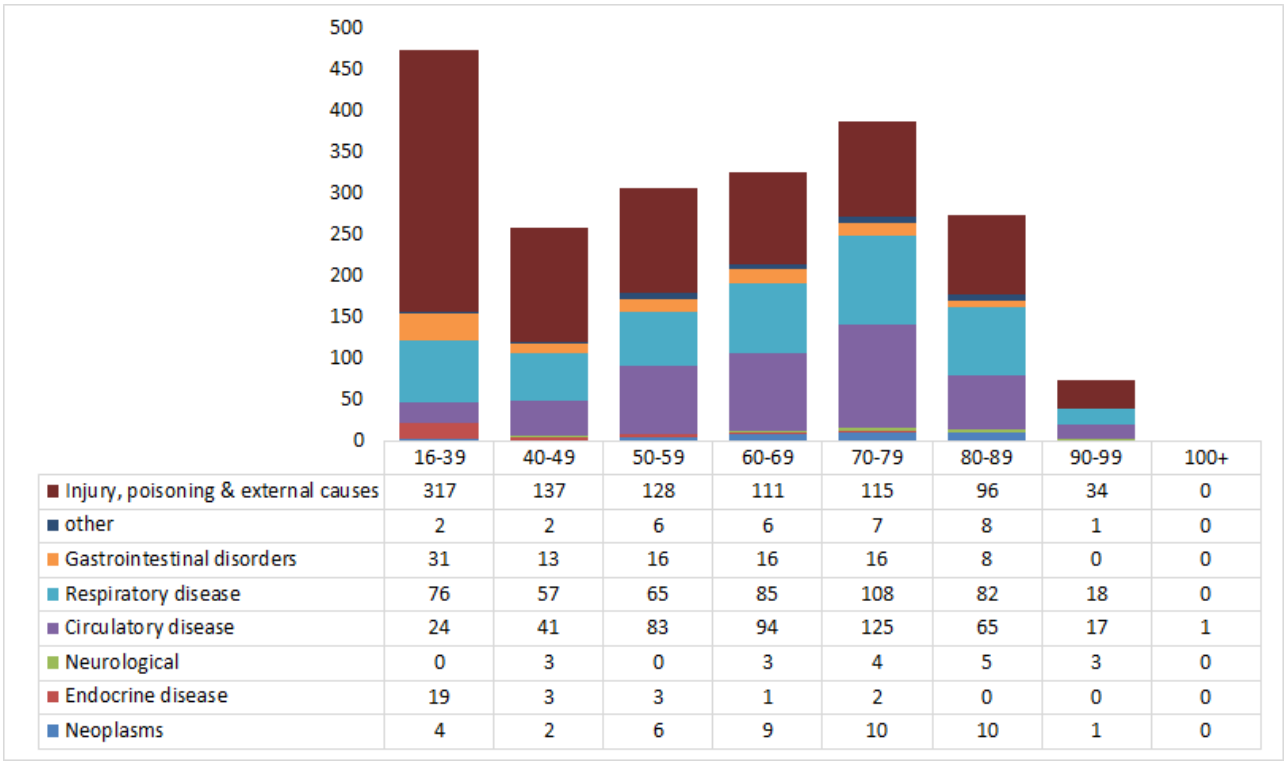
Health status: % Paisley practice population with selected long term conditions, 2013



	Learning Disability	LVSD	Dementia	Epilepsy	Heart Failure	PVD	Severe MH	AF	Cancer	Stroke/TIA	COPD	CKD	CHD	Diabetes	Asthma	Depression
%	0.4	0.6	0.8	0.8	0.9	1.0	1.1	1.6	1.9	1.9	1.9	3.1	4.6	4.8	5.6	6.5

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.

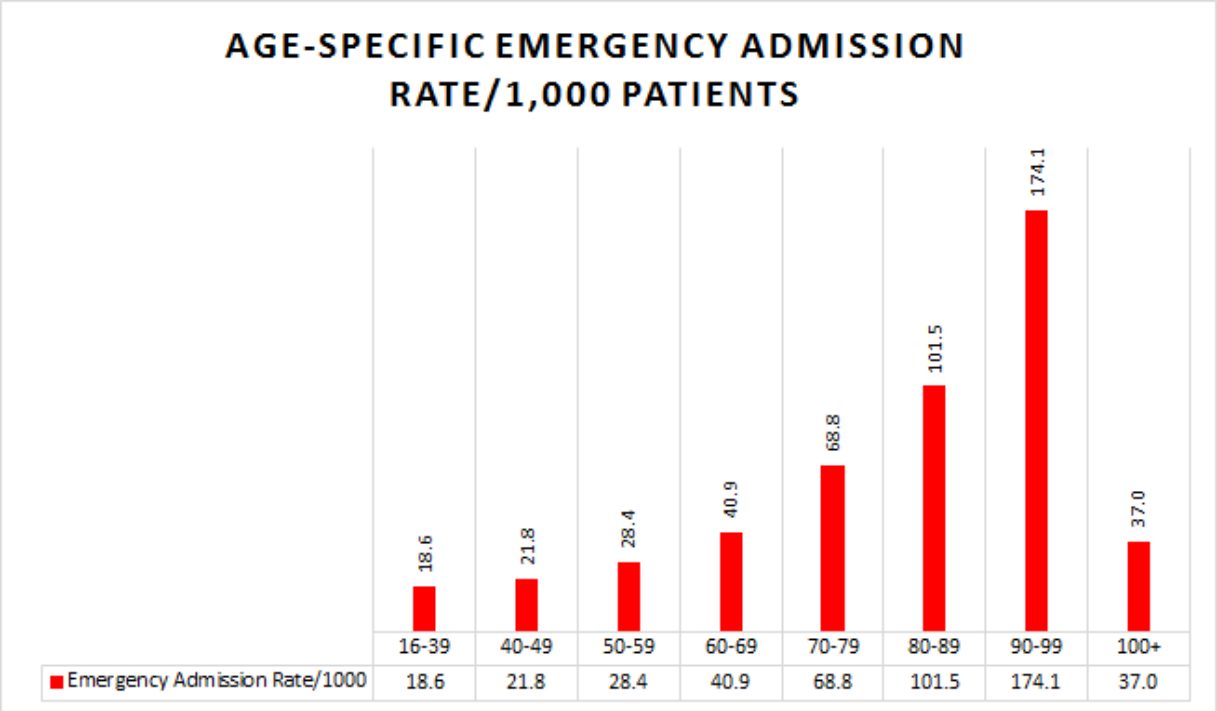
Morbidity: patients with one or more emergency hospital admissions in 2013, by main cause



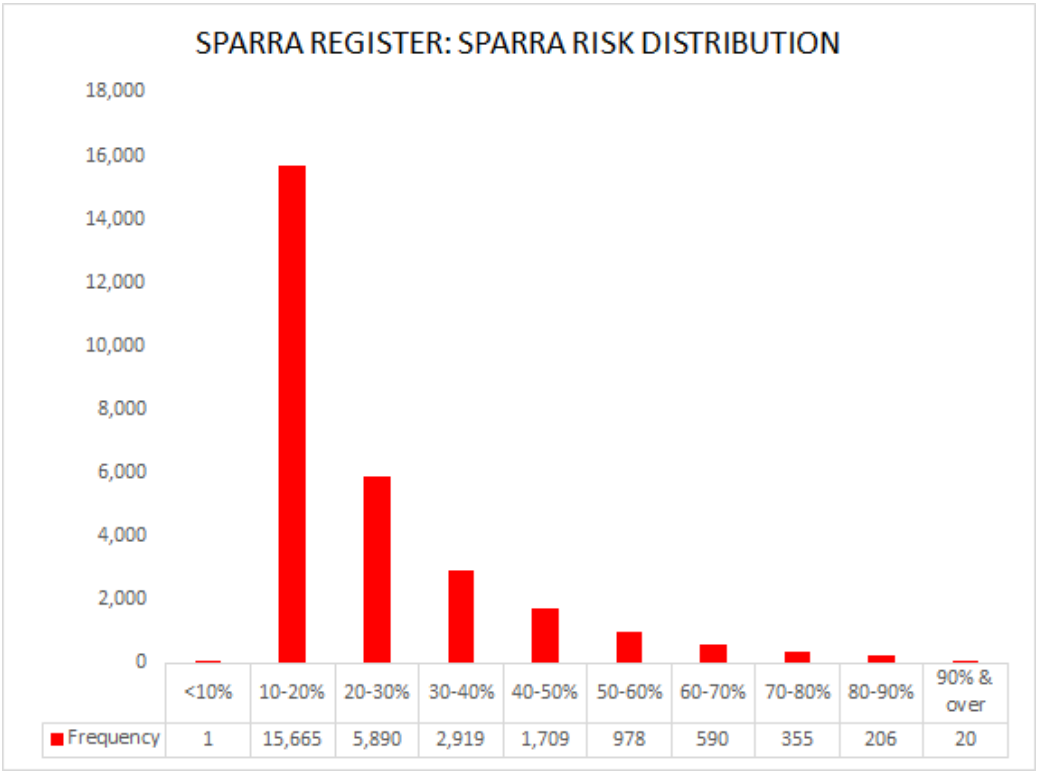
	16-39	40-49	50-59	60-69	70-79	80-89	90-99	100+
Injury, poisoning & external causes	317	137	128	111	115	96	34	0
other	2	2	6	6	7	8	1	0
Gastrointestinal disorders	31	13	16	16	16	8	0	0
Respiratory disease	76	57	65	85	108	82	18	0
Circulatory disease	24	41	83	94	125	65	17	1
Neurological	0	3	0	3	4	5	3	0
Endocrine disease	19	3	3	1	2	0	0	0
Neoplasms	4	2	6	9	10	10	1	0

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.

Healthcare utilisation: age-specific emergency admission rates in practice population, 2013



Healthcare utilisation: SPARRA risk profile in Paisley practice population, 2013



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.

ScotPHO
Period: 2013

Health & Wellbeing Profiles 2014 (Renfrewshire)

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Domain		Indicator	Period	Number	Measure	Type	National Average	'Worst' Scotland Comparator 'Best'
Life Expectancy & Mortality	1	Life expectancy (Males)	2009	n/a	73.8	yrs	75.8	
	2	Life expectancy (Females)	2009	n/a	79.5	yrs	80.4	
	3	Deaths all ages [2,11]	2011	5,883	1,297.1	sr3	1,156.7	
	4	Early deaths from CHD (< 75s) [2,11]	2011	300	67.4	sr3	63.1	
	5	Early deaths from cancer (< 75s) [2,11]	2011	805	180.4	sr3	174.3	
	6	Early deaths from cerebrovascular disease (< 75s) [2,11]	2011	126	28.6	sr3	20.8	
Behaviours	7	Estimated smoking attributable deaths				%		
	8	Smoking prevalence [3]	2012	n/a	28.5	%	22.9	
	9	Alcohol-related hospital discharges [11]	2011	1,626	958.6	sr3	748.6	
	10	Deaths from alcohol conditions [11]	2011	46	27.9	sr3	24.6	
	11	Drug related hospital discharges [11]	2011	231	134.2	sr3	117.5	
	12	Active travel to work [3]	2012	n/a	8.2	%	15.7	
	13	Sporting participation [3]	2012	n/a	71.9	%	74.2	
Ill Health & Injury	14	Patients registered with cancer [2,11]	2010	3,106	667.3	sr3	649.2	
	15	Patients hospitalised with chronic obstructive pulmonary disease (COPD). [2,11]	2011	1,272	267.0	sr3	252.6	
	16	Patients hospitalised with coronary Heart disease [2,11]	2011	2,369	503.2	sr3	455.5	
	17	Patients hospitalised with cerebrovascular disease [2,11]	2011	1,479	320.6	sr3	280.0	
	18	Patients hospitalised with asthma [2,11]	2011	2,018	367.0	sr3	475.0	
	19	Emergency medical admission patients [2,11]	2011	41,606	8,354.1	sr3	7,388.9	
	20	Patients (65+) with multiple hospitalisations [2,11]	2011	4,953	5,775.2	sr3	5,201.6	
	21	Road traffic accident casualties [2,11]	2011	269	52.5	sr3	59.8	
Mental Health	22	Patients prescribed drugs for anxiety/depression/psychosis	2012	30,441	17.5	%	16.2	
	23	Patients with a psychiatric hospitalisation [2,11]	2009	1,934	384.5	sr3	320.3	
	24	Deaths from suicide [1,11]	2010	148	17.3	sr3	15.0	
Social Care & Housing	25	People (65+) receiving free personal care at home [3]	2011	1,260	4.3	%	5.2	
	26	Adults claiming incapacity benefit/severe disability allowance or employment support allowance.	2012	10,415	7.2	%	6.4	
	27	People (65+) with intensive care needs cared for at home [3]	2011	295	20.6	%	33.1	
	28	Households assessed as homeless [3]	2012	841	1.0	%	1.3	
	29	Children looked after by local authority [3,9]	2011	786	21.3	cr2	14.7	
	30	Single adult dwellings [9]	2012	34,939	42.0	%	37.7	
	31	Households in extreme fuel poverty [3]	2011	n/a	2.5	%	7.3	
Education	32	Average tariff score of all pupils on the S4 roll	2011	n/a	166.0	mean	188.0	
	33	Primary school attendance	2012	11,634	94.5	%	93.8	
	34	Secondary school attendance	2012	9,095	88.8	%	88.9	
	35	Working age adults with low or no educational qualifications [3]	2010	n/a	16.7	%	14.7	
Economy	36	Population income deprived	2010	25,055	14.7	%	13.4	
	37	Working age population employment deprived	2010	16,110	14.4	%	12.3	
	38	Working age population claiming Jobseeker's Allowance	2012	5,930	5.2	%	4.3	
	39	Dependence on out of work benefits or child tax credit	2011	18,940	48.3	%	47.3	
	40	People claiming pension credits (aged 60+)	2012	4,220	10.3	%	8.8	
Crime	41	Crime rate	2010	7,994	47.0	cr2	41.3	
	42	Prisoner population [11]	2012	289	213.3	sr3	171.2	
	43	Referrals to Children's Reporter for violence-related offences [9]	2012	30	2.0	%	3.1	
	44	Patients hospitalised after an assault [2,11]	2011	302	57.4	sr3	65.7	
Environment	45	Population within 500 metres of derelict site	2012	57,697	33.1	%	30.8	
	46	People living in 15% most 'access deprived' area	2010	14,700	8.6	%	15.0	
	47	Adults rating neighbourhood as a very good place to live [3]	2012	n/a	54.8	%	55.2	
Women's & Children's Health	48	Teenage pregnancies [3,9]	2010	728	46.1	cr2	47.9	
	49	Mothers smoking during pregnancy [3]	2010	1,137	20.8	%	20.7	
	50	Low weight live births [3,9]	2010	145	2.8	%	2.4	
	51	Babies exclusively breastfed at 6-8 weeks [3]	2011	1,053	20.1	%	26.3	
	52	Child dental health in primary 1	2013	1,050	63.3	%	66.4	
	53	Child dental health in primary 7	2013	621	40.0	%	45.2	
	54	Child obesity in primary 1	2011	167	9.6	%	9.8	
Immunisations and Screening	55	Breast screening uptake [12]	2010	5,163	73.6	%	74.1	
	56	Bowel Screening uptake [12]	2010	14,109	55.1	%	54.5	
	57	Cervical screening uptake		n/a		%		
	58	Immunisation uptake at 24 months - MMR [3]	2011	5,449	93.9	%	94.1	
	59	Immunisation uptake at 24 months - 5 in 1 [3]	2011	5,740	98.9	%	98.2	

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.
9. Denotes indicator where categorisation as better or worse than comparator average is not appropriate and data are subject to local interpretation.
11. The ESP2013 has been used to calculate the rate for this indicator. Please see Appendix I of the technical report for further details.
12. Three-year average number, and 3-year average annual measure.

Spine Chart Key:

- % =percent
- cr2 =crude rate per 1,000 population
- mean=average
- sr3 =age-sex standardised rate per 100,000 population to ESP2013. Please see Appendix I in the technical report.
- yrs =years

Spine Chart Key:

- Statistically significantly 'worse' than National average
- Statistically not significantly different from National average
- Statistically significantly 'better' than National average
- Statistically significant difference compared to National average
- No significance can be calculated

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