APPENDIX 5: HEALTH NEEDS ANALYSIS

Moray Health Profile

March 2015

This document provides analysis of the health and wellbeing needs of the adult population in Moray to determine the potential demand both now and in the future. It includes an examination of the social/economic factors that can impact on the health and wellbeing of adults in Moray. It informed our initial strategic planning discussions

Contents

Summary

At the end of 2014 a short-life, multi-agency group comprising NHS, community planning partnership, and local authority representatives made an initial consideration of strategic needs assessment to inform health and social care integration in Grampian. The group began from the Government's published outcomes for integration to achieve. By considering the necessary inputs and outputs required for the outcomes to be achievable, the group was able to sketch out the implications for individuals, communities, and health and social care organisations. This subsequent document combines that work with publicly available health statistics, as a logical 'next step' in assessing population health needs, in respect of integration.

Key observations

Moray's population is ageing, consistent with national trends. Increasing life expectancy is to be celebrated, and increasing age is observable as being associated with greater requirements for health and social care. The best health systems are proactive in maintaining and improving the health of their served population, not solely reactive to health problems only once they have occurred. Moray's 'older population' are young and middle-aged people now, so prevention efforts must include this whole population.

Moray tends to score well for the social and economic factors that underpin good health, when compared to the Scottish national average. However, its rurality is a known issue that can cause people difficulty in accessing services, and despite high average employment and low overall income deprivation, Moray has a higher proportion than average of households reported to be living in fuel poverty. Moray also has an above average level of road traffic accident casualties in Scotland.

Moray tends to have an overall health profile that is better than the Scottish national average. However behind this lies evidence of variation in health status, with some communities reporting greater levels of health problems than others.

In 2012/13 the cost of social care and NHS services totalled £172m (social care £51m, NHS £121m). The top five cost areas were emergency hospital admissions (£29m; 17% of total costs), community health services (£22m; 12%), care homes (£17m; 10%), prescription costs (£15m; 9%), and community based social care £15m, 9%).

Two percent (2%) of patients account for at least one third of all NHS costs.

It is recommended that the Integration Board consider how to:

- Create seamless care pathways and increase service efficiencies
- Strengthen provision of health care services, including palliative care, in community settings
- Resource hospital services to treat increasingly aged, frail, and complex patients
- Provide support to help people self-care for minor illnesses and self-manage diagnosed long-term conditions
- Maximise prevention through building community resilience and strengthening assets

Introduction

Population health and social care and health care

The population comprises **individuals** experiencing the full spectrum of health states.[1] At one end are those who are generally healthy, experiencing no impairment(s) in functioning or body structure, no limitations on activity, no restrictions on participation. At the other are those with permanent impairment(s), significant limitations, significant restrictions. People's health can be affected by innate factors (such as their genotype) and by external factors (such as exposure to microbiological agents or chemicals, or lack of exposure to essential nutrients).

At times people will have **felt needs** for health and care, often in response to an experience of symptoms. Felt needs can be physical, psychological, social, or spiritual/existential. Some of these will become **expressed needs**, when people seek care. The expression of need is influenced by a range of factors, including individual perception of symptoms, awareness of services, and the cultural norms of those around them. People also seek care in response to **normative needs**, which are those identified by professionals, such as monitoring through chronic disease clinics, or invitation to attend for screening or vaccination. People can seek care in different ways and with differing degrees of urgency.

In turn, individuals live in **communities**, whether of geography, interest, or identity. Communities offer resources and infrastructures to their members, which give context to the decisions made within them. In an analogous way to individuals, communities can experience felt, expressed, and normative needs.

In order to provide services that are appropriate to the needs of individuals and communities, **planners and commissioners** require analysis and evidence to inform their decision-making. Strategically assessing care and treatment services requires an understanding of current provision, and the gap between this and future requirements. The starting point must be broad enough to reflect the entire system, yet succinct enough to facilitate comprehension. From an initial simplified overview, priority areas for detailed work can then be identified.

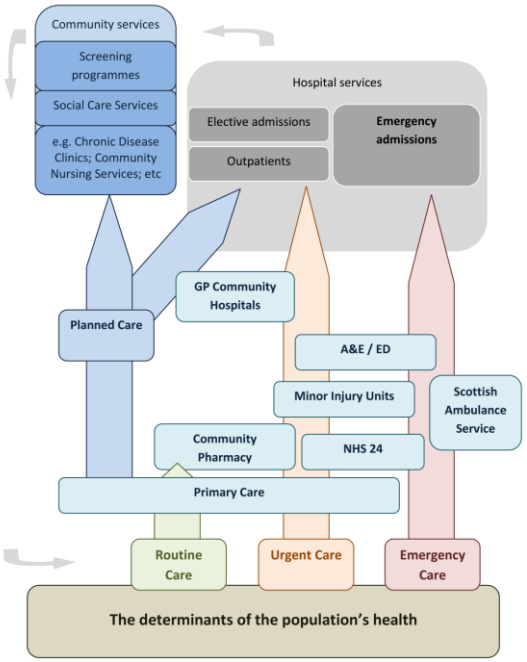

Figure 1

A simplified model of the statutory health and social care system in Grampian is shown in Figure one. This initial **health profile** starts with the nine national outcomes[2], informed by the work of a short-life multi-agency working group, to capture initial ideas and values to inform normative needs assessment. This will require subsequent enrichment from participatory needs assessment.

[1] www.who.int/classifications/icf/en/
[2] www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes

Outcome 1 People are able to look after and improve their own health and wellbeing and live in good health for longer

What principles underlie this outcome, and what is necessary for it to be achievable?	• individual autonomy and responsibility and interdependent support • resilience of individuals, communities, and organisations • availability and accessibility of resources (including fundamental determinants of health[3] and health and social care services) to support capabilities and functionings[4] • participation in, and ownership of, decision-making
What does this mean for individuals?	

• People should
  • be fully participant in their own decisions
  • feel safe from threat and be free from violence
  • be able to live in a warm and dry home
  • be able to drink clean water, breathe clean air, and access 'purplespace'
  • be able to obtain safe and healthy food and eat a healthy diet
  • have access to reliable information and advice
  • have someone to turn to, and advocacy if required
  • have access to opportunities for social connection with others
  • have access to education and training opportunities
  • have opportunities to obtain meaningful employment that pays a living wage
  • not have to rely on debt with exorbitant interest rates to make ends meet
  • not feel compelled to use tobacco, alcohol, or drugs to cope	

What does this mean for communities?	

• Communities should[5]
  • be listened to, have a voice in meaningful, participative decision-making
  • be safe places to live, which provide access to leisure and recreation facilities
  • feel a collective sense of opportunity to work together to develop and improve the environment for all who live there	

What does this mean for health and social care organisations?	

• health and social care organisations should
  • ensure that all service developments take account of the predicted changes in Scotland's demography[6,7]
  • facilitate public participation in their decision making processes
  • consider the potential consequences of their policy decisions[8]
  • be active participants in national and local actions to support infrastructure planning, housing, community safety, environmental protection, food safety, financial provision, and health protection
  • work together routinely (public, community, and voluntary sector) to maximise our assets
  • ensure all services are founded on personalisation, trust and respect for autonomy, while meeting statutory requirements to protect people who are at risk of harm	

[3] www.healthscotland.com/uploads/documents/22627-HealthInequalitiesActionFramework.pdf
[4] http://plato.stanford.edu/entries/capability-approach/
[5] www.thinklocalactpersonal.org.uk/_library/Resources/BCC/Report/TLAP_Developing_the_Power_Brochure_FINAL.pdf
[6] www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf
[7] www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf
[8] www.healthscotland.com/resources/networks/shian.aspx

Outcome 1 People are able to look after and improve their own health and wellbeing and live in good health for longer

- promote self-directed support packages
- ensure a focus on the prevention of illness and disease, recovery following illness or disease, and the provision of support to increase self-care skills and self-management of long-term conditions[9,10,11]

What existing strategies and plans address this outcome?

- Moray Joint Commissioning Strategy for Older People 2013 - 2023[12]
- Moray Single Outcome Agreement
- NHS Grampian Director of Public Health Report 2012 highlights healthy working lives, cancer prevention, and healthy lifestyles
- NHS Grampian Director of Public Health Report 2013/14[13] highlights individual, community and organisational resilience
- NHS Grampian Health and Care Framework[14] highlights modernisation of healthcare services

What can we tell from published data?

- *Overall* Moray has:
  - high life expectancy
  - above average educational attainment, employment, income
  - below average crime, homelessness, alcohol-related mortality and hospital admissions
  - average smoking rates
  - health condition prevalence rates that are similar to, and often lower than, the national average; some emergency hospital admission rates that are higher than elsewhere in Grampian
  - above average fuel poverty, traffic accident casualties, and potential geographical challenges to equal access to services
- *Within and across* Moray, not all communities are exposed to the underlying causes of health equally, and health condition prevalence and emergency hospital admission rates show observable variation by geography
- *Predicted* growth in older adult population over next twenty years, suggests expectation for increasing service demands
- (figures 1.1 – 1.6; 2.1 – 2.16; 3.1 – 3.27)
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What do people tell us?

What knowledge gaps do we need to address?

We need to better understand:

- How to measure and compare community resilience, including the availability of local assets and resources that support people in looking after their own health
- How to measure communities' collective abilities to support people to self-manage long-term conditions
- How to support the transition from hospital to community provision of services

[9] www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/improving-the-publics-health-kingsfund-dec13.pdf
[10] www.scotland.gov.uk/Publications/2008/10/GaunYersel
[11] www.skillsforcare.org.uk/Skills/Self-care/Self-care.aspx
[12] www.moray.gov.uk/moray_standard/page_83700.html
[13] Director of Public Health Report 2013/14, NHS Grampian
[14] www.nhsgrampian.org/grampianfoi/files/item05.1Paper1HCFBoardOct270911paper1.doc

Outcome 2 People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

What principles underlie this outcome, and what is necessary for it to be achievable?	• communities and their infrastructures (e.g. housing, shops, transport) are age and long-term condition friendly • increasing coproduction with people and community and voluntary organisations • proactive planning of personalised care[15] • high health literacy and self-care and self-management skills • community-focused health and social care services
What does this mean for individuals?	

• people should
  ○ only be admitted to hospital if that is the best place
  ○ have access to 'low level supports' to help us continue to live independently
  ○ be able to contribute and 'pay something back'
  ○ have more opportunities to help develop local solutions to local challenges
  ○ have easy access to trustworthy and reliable health information and advice
• be supported to develop self-care and self-management skills	

What does this mean for communities?	
• As per outcome 1	
What does this mean for health and social care organisations?	

• Health and social care organisations should
  ○ support the requirements for health as per outcome 1
  ○ provide evidence-based, safe and effective models of care for primary and community healthcare, social care, and effective alternatives to a system default of hospital admission
  ○ predict future demand for assistive technologies, housing adaptations, sheltered and assisted housing, communal living, and nursing home care
  ○ work with partners to reduce and remove barriers in the built environment and transport infrastructure
  ○ make increased use of telecare and telehealth care
  ○ promote ability not disability
  ○ listen to what people say and respond appropriately
  ○ communicate with other services and providers to make sure that service response is as holistic as possible
  ○ ensure the workforce has the capacity and capability to deliver in a changing health and care environment
  ○ implement shared systems to assess risk for declining independence to allow anticipatory care planning
  ○ contribute to ensure the availability of local assets, providing information and advice, activities, and support services, to support self-care and self-management
  ○ provide extra help to those who struggle to navigate the system to stay in control of their care	

[15] http://coalitionforcollaborativecare.org.uk/aboutus/house-of-care/

Outcome 2 People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

What existing strategies and plans address this outcome?

- NHS Grampian primary and secondary care modernisation programmes informed by the Health Fit 2020 strategic vision[16]
- See also HSJ/Serco Commission on Hospital Care for Frail Older People (2014)[17]

What can we tell from published data?

(see figure 3.23)

- The number of emergency acute hospital admissions is not reducing
- The number of delayed discharges from hospital remains a challenge
- The number of people from Moray who readmitted to hospital within 30-days of discharge has been increasing, with the exception of Dr Gray's Hospital where the rate is reducing

What do people tell us?

What knowledge gaps do we need to address?

Which evidence-based interventions to keep people 'at home' fit best with the local context in Moray?

[16] www.nhsgrampian.org/grampianfoi/files/Item_1_2020_Vision.pdf

[17] www.hsj.co.uk/comment/frail-older-people/commission-on-hospital-care-for-frail-older-people-main-report/5076859.article?blocktitle=Main-report&contentID=15796

Outcome 3 People who use health and social care services have positive experiences of those services, and have their dignity respected

What principles underlie this outcome, and what is necessary for it to be achievable?	• personalisation[18] • respect and compassion, time and trust • effective communication • responsive 'learning organisations'

What does this mean for individuals?

- People should
  - tell 'their story' only once to those who need to know
  - have a 'plan of action' for our care which is devised and available to all subsequent members of the care team
  - know who is responsible for reviewing our 'plan of action' with us
  - know who to speak to when things aren't going right
  - be admitted to hospital because it is the right place for our care
  - know where to go for help and what we can expect
  - be listened to and have our views taken into account
  - receive advocacy and/ or communication support if we need it
  - be treated with respect and dignity and that our choices will be informed
  - know there are effective feedback mechanisms both for when things go wrong and to highlight and reflect good practice
- have confidence that their wishes and needs, and those of carers and families, are taken into account

What does this mean for communities?

- confidence in the care system and in the care of their relatives
- clear expectations of the range of care available in the community and its purpose
- recognised routes of communication with services

What does this mean for health and social care organisations?

- a commitment to 'continual improvement' in leadership, governance, and organisational culture
- personalisation of service delivery, active listening and communicating
- a growing confidence in multi-professional, multi-agency roles and responsibilities

What do we already know?

- Levels of satisfaction with the care received in health and social care services[19,20]
- Information from user panels
- USC inpatient survey

What knowledge gaps do we need to address?

How can we best collate and use the qualitative information contained within these existing information systems?

[18] http://coalitionforcollaborativecare.org.uk/aboutus/house-of-care/
[19] www.healthcareexperienceresults.org/gp/?174
[20] www.careexperience.scot.nhs.uk/Results2014/HB-Reports/NHS-Grampian-2014.pdf

Outcome 4 Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

What principles underlie this outcome, and what is necessary for it to be achievable?	• individual autonomy and responsibility and interdependent support • resilience of individuals, communities, and organisations • availability and accessibility of resources to support capabilities and functionings • achievement of a constructive balance between the views of professional providers and the preferences and values of people who use services

What does this mean for individuals?

- People should
  - feel supported and confident in maintaining independent living
  - feel valued and included in their community
- feel they have influence

What does this mean for communities?

- A sense of trust and neighbourliness

What does this mean for health and social care organisations?

- Health and social care services should
  - take a whole person perspective aimed at preventing future disease and supporting self-care and self-management, as well as assessing, diagnosing, treating, and assisting rehabilitation
  - be locally designed and delivered in partnership with citizens and community and voluntary organisations, in order to increase people's access to the assets and resources in their local communities
  - accept people's values and views as paramount when agreeing their care
- facilitate people's access to local community assets and resources that support good health, self-care and self-management

What existing strategies and plans address this outcome?

- PHE (2014) Developing the power of strong, inclusive communities[21]

What can we tell from published data?

What do people tell us?

What knowledge gaps do we need to address?

What measure of 'quality of life' is most appropriate and how can we use this across Moray?

[21] www.thinklocalactpersonal.org.uk/Latest/Resource/?cid=10346

Outcome 5 Health and social care services contribute to reducing health inequalities

What principles underlie this outcome, and what is necessary for it to be achievable?	• reduce observed differences in preventable morbidity and mortality within a population • 'social justice' – Government and public service action to ensure more equitable opportunities and outcomes • Early intervention, from conception, throughout childhood, and adulthood • addressing the 'causes of the causes', the fundamental determinants of health[22] • promoting a culture in which people value their own health, the health of their communities and of society as a whole • ensuring the challenges of rurality are appropriately reflected in identifying and targeting those in greatest need
	What does this mean for individuals?
	• as per outcome 1, plus • that people want to see improving health for themselves and their families, and believe they have a realistic prospect of achieving that • a reduction in socio-economic as well as health inequalities
	What does this mean for communities?
	• as per outcome 1, plus • that there is support for people to acquire the skills to be continuously employable for those for whom conventional education is less effective, including literacy and numeracy support • agreeing to assist people who have poorer health outcomes, make better use of everyone's assets to achieve better outcomes • create an integrated web of support across communities and agencies to support people to have increasing opportunities for improved outcomes
	What does this mean for health and social care organisations?
	• create the conditions by 'putting inequalities at the heart of what we do, in common cause with our communities to reduce health inequalities within a generation'[23] • focus on inequalities-sensitive practice at every level • tackle the 'causes of the causes' of health inequalities • all health and social care services (statutory and sub-contracted) should guarantee their employees (at minimum) the living wage and, where wanted by the employee, a guaranteed minimum number of hours per week • provision of resources proportionate to need, including the provision of evidence-based, targeted intensive services and other forms of support • support during pregnancy, and childhood and the transition to adulthood • people should be able to access recognition and reward for voluntary input to health and social care services (e.g. time banking) • all health and social care policies should undergo screening for health impact assessment • develop and maintain an inequalities dataset to inform community action, workforce and service modernisation

[22] www.healthscotland.com/uploads/documents/22627-HealthInequalitiesActionFramework.pdf
[23] Director of Public Health Report 2013/14, NHS Grampian

- use, routinely, a resource allocation and decision-making framework to better align available resource to address inequalities assessment

What existing strategies and plans address this outcome?

- Equally well (Scottish Government Ministerial Taskforce on Inequalities)[24]
- Scottish Index of Multiple Deprivation[25]
- Health Scotland *Best preventative investments in Scotland*[26]
- Scottish Public Health Observatory *Informing Investment to reduce health Inequalities*[27]
- Moray Alcohol & Drug Partnership Strategy
- NHS Grampian Dental Plan 2020[28]
- DPH Annual Report 2012 and 2013/14
- NHS Grampian's Health Traffic Lights[29]

What can we tell from published data?

There is observable variation:

- in the *causes* of health across Moray
- in the experience of disability and illness
- in hospital admission rates

(see figures 1.1 – 1.6; 2.1 – 2.16; 3.1 – 3.27)

What do people tell us?

What knowledge gaps do we need to address?

What metric should we use to summarise the gap in health outcomes across Moray?

What are peoples' attitudes about health and social care Boards using public funds to necessarily address the *causes* of health inequalities (see also appendix 1)?

[24] www.scotland.gov.uk/Topics/Health/Healthy-Living/Health-Inequalities/Equally-Well
[25] www.scotland.gov.uk/Topics/Statistics/SIMD [Scottish Index of Multiple Deprivation, SIMD]
[26] www.healthscotland.com/documents/24575.aspx
[27] www.scotpho.org.uk/comparative-health/health-inequalities-tools/intervention-tools/informing-investment-to-reduce-health-inequalities-iii
[28] www.hi-netgrampian.org/hinet/file/8477/item05.1DentalPlanFinalv7.doc
[29] www.nhsgrampian/traffic lights

Outcome 6 People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being

What principles underlie this outcome, and what is necessary for it to be achievable?	• Carers are an integral part of health and social care • People, communities and organisations are dependent socially and economically on the availability, fitness, and willingness of carers to care • The health of carers is as important as the health of those for whom they are caring • Carers need to be recognised and supported in their key role • Health and social care services will involve unpaid carers as part of the care team, taking a whole person perspective. This will include considering the needs of carers
What does this mean for individuals?	
• people who care will be included when health and social care services are establishing consents, and developing plans of care for those we care for • people who care will be routinely asked about their own health, to ensure they have all the support they need • carer's assessments will be carried out and appropriate supports identified, including respite and short breaks • parity of access to respite provision regardless of where you live	
What does this mean for communities?	
• Communities include people who care in assessing service priorities • Communities enhance the visibility of the vital role of carers • Communities nurture respect for people who care	
What does this mean for health and social care organisations?	
• clear policies for staff • knowledge of local assets, resources and services for carers • enhancing the culture of organisations to engage with carers through relevant awareness raising and training	
What existing strategies and plans address this outcome?	
• *Caring together, The Carers' Strategy for Scotland, 2010 -2015*[30]: 'Without the valuable contribution of Scotland's carers, the health and social care system would not be sustained. Activity should focus on identifying, assessing and supporting carers in a personalised and outcome-focused way and on a consistent and uniform basis'	
What can we tell from published data?	
• National needs assessment[31] revealed that one in eight (12%) of people aged 65 and over have a carer role	

[30] www.scotland.gov.uk/Publications/2010/07/23153304/0

[31] www.scotphn.net/projects/previous_projects/health_and_social_care_needs_assessment_of_older_people_reports

Outcome 6 People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being

What do people tell us?
What knowledge gaps do we need to address?
How can we best engage with carers in order to understand their needs and measure progress in meeting these?

Outcome 7 People who use health and social care services are safe from harm

What principles underlie this outcome, and what is necessary for it to be achievable?	• "quality" of health[32] and social care services • evidence-based practice and robust data surveillance systems • robust governance arrangements • a culture which values safe practice but without being risk averse • health and social care services, with their partners, deliver on the duty to support and protect adults at risk of harm (Adult Support and Protection (Scotland) Act 2007)

What does this mean for individuals?

- the concept of "harm" may vary between individuals, so personalisation of risk-assessment will be key
- Adults at risk of harm are supported and protected

What does this mean for communities?

- confidence that systems are in place for the identification, reporting, and prevention of harm

What does this mean for health and social care organisations?

- healthcare investigations and treatments should not cause injury or harm that is both predictable and avoidable
- provision of knowledge management systems to inform evidence-based practice
- clear and robust governance arrangements
- commitment to continuous service improvement including training for staff
- provision of an integrated data system that allows intelligence to be used at all levels of the organisation, from front-line services, to senior operational management, to strategic executive management
- a culture which places safety at the heart of care through high quality leadership and example at every level
- Active participation in the Adult Protection Committee

What existing strategies and plans address this outcome?

- Adult Support and Protection[33]
- Healthcare Improvement Scotland (2014) *Report on the review of the quality of care at Aberdeen Royal Infirmary* [34]
- the Scottish Patient Safety Programme, [35] reducing harm in primary care, maternity, acute adult, children, and mental health with the ten 'patient safety essentials'[36]

What can we tell from published data?

NHS Grampian performs well as reported under the Scottish Patient Safety Programme www.scottishpatientsafetyprogramme.scot.nhs.uk/

[32] www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf
[33] www.scotland.gov.uk/Topics/Health/Support-Social-Care/Adult-Support-Protection
[34] www.healthcareimprovementscotland.org/our_work/governance_and_assurance/programme_resources/ari_review.aspx
[35] www.scottishpatientsafetyprogramme.scot.nhs.uk/
[36] http://news.scotland.gov.uk/News/Patient-safety-34a.aspx

Outcome 7 People who use health and social care services are safe from harm

	What do people tell us?
	What knowledge gaps do we need to address?

Outcome 8 People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

What principles underlie this outcome, and what is necessary for it to be achievable?	• continuously ensure a resilient and sustainable workforce • increase workforce integration , adaptability and flexibility • ensure workforce is multi-skilled to shape care and services to the needs of patients • build a culture in which health , as well as care, is central to our business • The workforce have an opportunity to shape and influence the development of policy, strategy and plans

What does this mean for individuals?

- People:
  - are motivated to come to work
  - believe they have the appropriate tools to do the job
  - feel supported by colleagues and management, and valued by colleagues and people for whom they provide care
  - provide high quality care
  - access to occupational health services

What does this mean for communities?

- confidence in service providers
- value service providers
- realistic expectations of service providers
- realistic expectations of their role in working with service providers

What does this mean for health and social care organisations?

- adequate staffing levels and clear recruitment and retention strategies
- training provision, particularly during change implementation
- clear lines of accountability and reporting
- feedback mechanisms
- ability to participate in decision-making
- provision of necessary equipment and infrastructure to undertake roles
- fair reward

What existing strategies and plans address this outcome?

- SSSC workforce development[37]
- Healthcare Improvement Scotland (2014) *Report on the review of the quality of care at Aberdeen Royal Infirmary* [38]
- NHSG Work Plan 2014

What can we tell from published data?

- NHSScotland Staff Surveys (www.staffgovernance.scot.nhs.uk/monitoring-employee-experience/staff-survey/)
- Workforce data on recruitment and retention

[37] www.sssc.uk.com/workforce-development

[38] www.healthcareimprovementscotland.org/our_work/governance_and_assurance/programme_resources/ari_review.aspx

Outcome 8 People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

• Sickness rates
What do people tell us?
What knowledge gaps do we need to address?

Outcome 9 Resources are used effectively and efficiently in the provision of health and social care services

What principles underlie this outcome, and what is necessary for it to be achievable?	• money can only be spent once – spending on *x* means forgoing *y* – thus vital that *x* represents the best use of the money • health economics (technical, productive, allocative efficiency[39]) • health technology appraisals (e.g. NICE) • evidence-based practice (e.g. SIGN guidelines) • inclusive and participative decision making • Resource allocation decisions must be based on a transparent process where evidence is used to identify options and choose between them • Outcomes must be measurable, and surveillance systems to collect outcome data must be complete, systematic, timely, and robust
	What does this mean for individuals?
	• people will understand how health and social care organisations make their decisions • people will be confident that public funding is being used to best effect
	What does this mean for communities?
	• understanding of how health and social care organisations make decisions • confidence that public funding is being used to best effect • communities collaborate with organisations to identify where local assets can be used to help meet health and social care needs
	What does this mean for health and social care organisations?
	• decision-making processes that are consistent, fair, and transparent • ensuring that the right people with the right skills and knowledge participate in decision-making groups • decision-making groups have timely access to up-to-date evidence of effectiveness and cost-effectiveness • decision-making groups have timely access to up-to-date health intelligence, including 'local intelligence' analyses • local authorities sign up to the ISD *Health and Social Care Data Integration and Intelligence Project*[40]
	What existing strategies and plans address this outcome?
Guidance has been published to help with decision making in NHS Scotland[41] • draws on Daniels and Sabin's *Accountability for Reasonableness*, which specifies four conditions to be met: ○ **publicity** the public should be able to access information about decisions and the reasons for these decisions ○ **relevance** the reasons for decisions must be based on evidence, reasons and principles that all fair minded parties can agree are relevant to deciding how to meet the diverse needs of a population ○ **appeals and revisions** there must be a mechanism to challenge and dispute	

[39] http://dx.doi.org/10.1136/bmj.318.7191.1136
[40] www.isdscotland.org/Products-and-Services/Health-and-Social-Care-Integration/
[41] www.isdscotland.org/Products-and-Services/Health-and-Social-Care-Integration/Data-Collection/

Outcome 9 Resources are used effectively and efficiently in the provision of health and social care services

decisions ○ **enforcement** some form of regulation to ensure that the first three conditions are met • NHS Grampian developed a decision-making process as part of its health fit strategy • Decision support tools are available from external sources[42]
What can we tell from published data?
Current funding allocation to NHS and Social Care (figures 4.1, 4.2)
What do people tell us?
What knowledge gaps do we need to address?

[42] www.health.org.uk/learning/star/

Population

Increasing longevity has been a spectacular success in Moray, as elsewhere...

FIGURE 1.1
Life expectancy at birth has been continually rising...

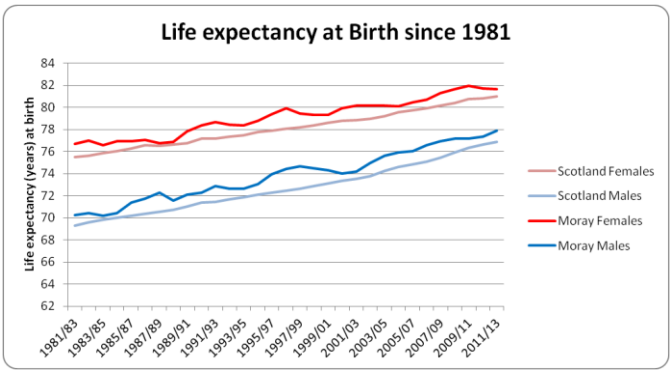


FIGURE 1.2
...as has life expectancy at age 65

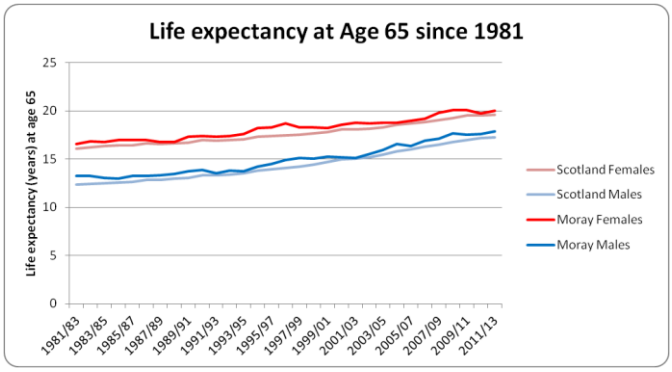


FIGURE 1.3
... and (partly) as a result, Moray's population has grown by around one third since 1981, from around 80,000 to over 90,000 people...

Source: National Records of Scotland

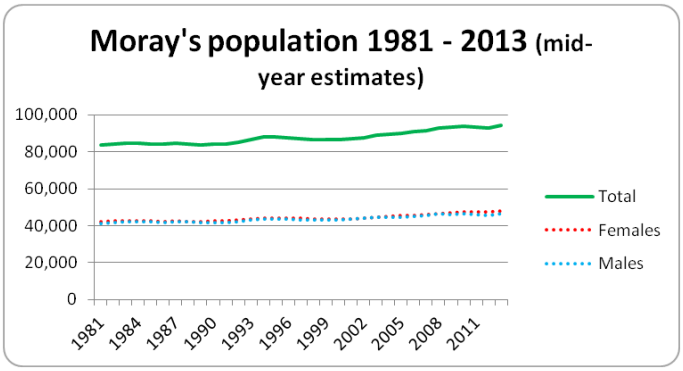
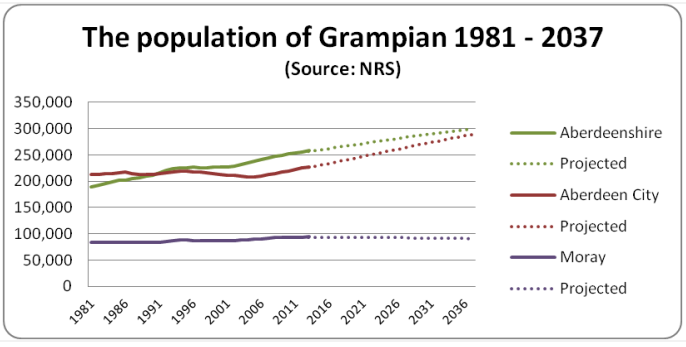


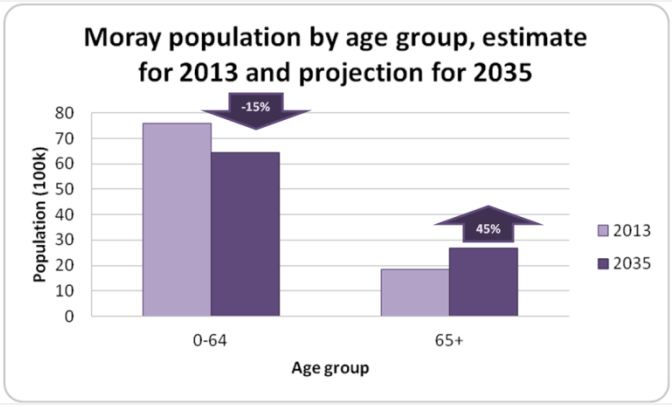
FIGURE 1.4
...with population growth over the next two decades predicted to continue...

Source: National Records of Scotland



Population

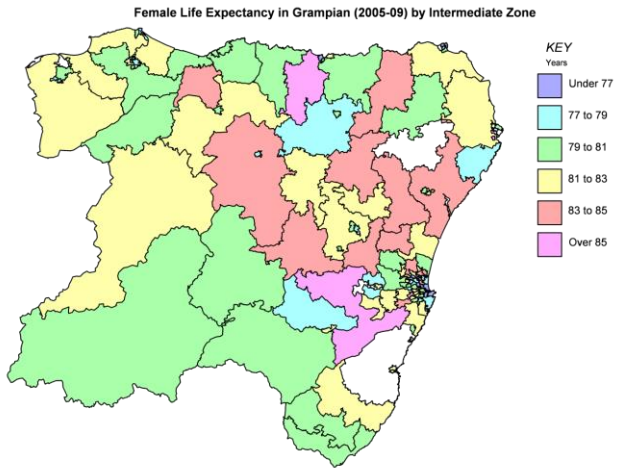
FIGURE 1.5
...primarily predicted to occur in the population aged 65 and over

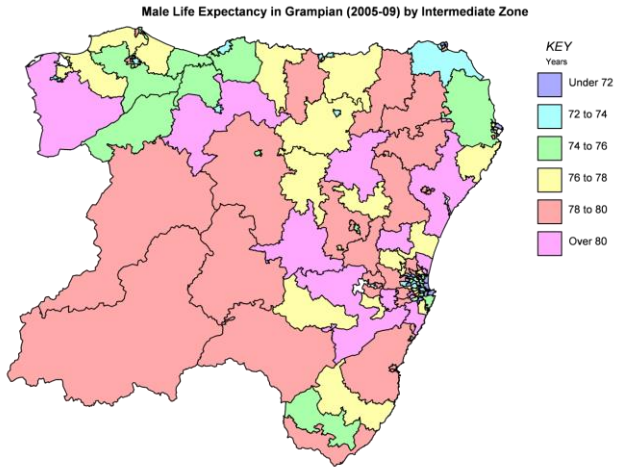


...the population impact of ageing can be seen in a Scotland-level interactive excel file from National Records of Scotland ...

FIGURE 1.6

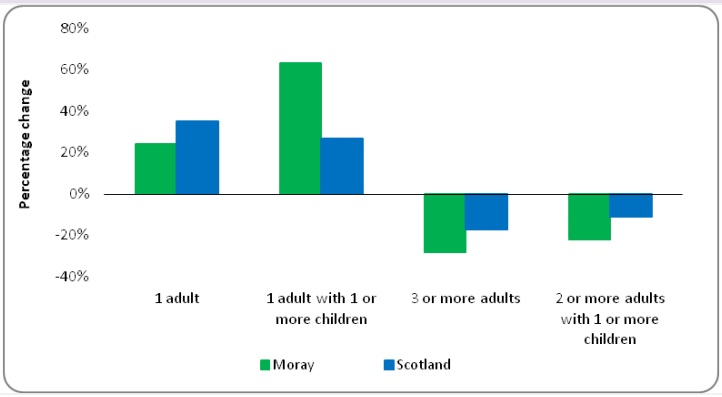
...though life expectancy has not risen equally for all people...





Source: Health Intelligence Public Health Compendium

FIGURE 1.7
Household composition is also predicted to change over the same period, towards greater numbers of single adult and single parent households



Source: NRS Council Profiles

FIGURE 1.8 Ethnic composition (2011)
Source: NHSG Health Intelligence Health & Wellbeing Compendium

	Caucasian						Asian					African/Caribbean		Other	
	Scottish	Other British	Irish	Gypsy/Traveller	Polish	Other	Pakistani, Pakistani British/Scottish	Indian, Indian British/Scottish	Bangladeshi/ Bangladeshi British/Scottish	Chinese, Chinese British/Scottish	Other	African	Caribbean/Black	Mixed or Multiple ethnicity	Other ethnic groups
Moray	78%	18%	0.5%	0.1%	1.1%	1.6%	0.2%	0.1%	0%	0.2%	0.2%	0.1%	0.1%	0.2%	0.1%
Scotland	84%	7.9%	1.0%	0.1%	1.2%	1.9%	0.9%	0.6%	0.1%	0.6%	0.4%	0.6%	0.1%	0.4%	0.3%

Determinants

What are the things that make life meaningful, provide a sense of wellbeing, and keep people healthy? In short, what kind of lifestyles do people choose to live, and how well do their circumstances empower those choices?

A consideration of these questions, amongst others, informed initial consideration of the nine national outcomes for integration (appendix 1).

One suggestion is that individuals, communities, and the organisations that serve them, must be **resilient** to life's challenges

resilient culture
...a resilient community is one that has a collectively held belief in [its] ability to adapt and thrive in spite of adversity (GCPH, 2014,p.11)

resilient economy
...prosperity [is] an ability to flourish in ways that incorporate meaning, purpose and participation in society... (GCPH, 2014,p.13)

resilient governance
...planners should...create the circumstances whereby community members are in a position to be active in helping finding solutions to problems and challenges (GCPH, 2014,p.14)

resilient infrastructure
...unequal distribution [of infrastructure] is associated with inequalities in health within societies (GCPH, 2014,p.15)

Determinants of health therefore include lifestyles and behavioural choices...

- e.g. where to live, what to eat, how much to drink, whether to smoke, whether to exercise

...but also the contexts that enable and empower individuals and communities to make healthy choices...

- e.g. cost and income; time; availability; cultural norms; demands, stress, and perceived control

Since 2004 the Scottish Index of Multiple Deprivation (SIMD) has measured communities standing in a number of domains including Employment, Income, Health, Education, Skills, and Training, Geographic Access to Services, Crime, and Housing. Such domains are the

foundations upon which resilient communities are built.

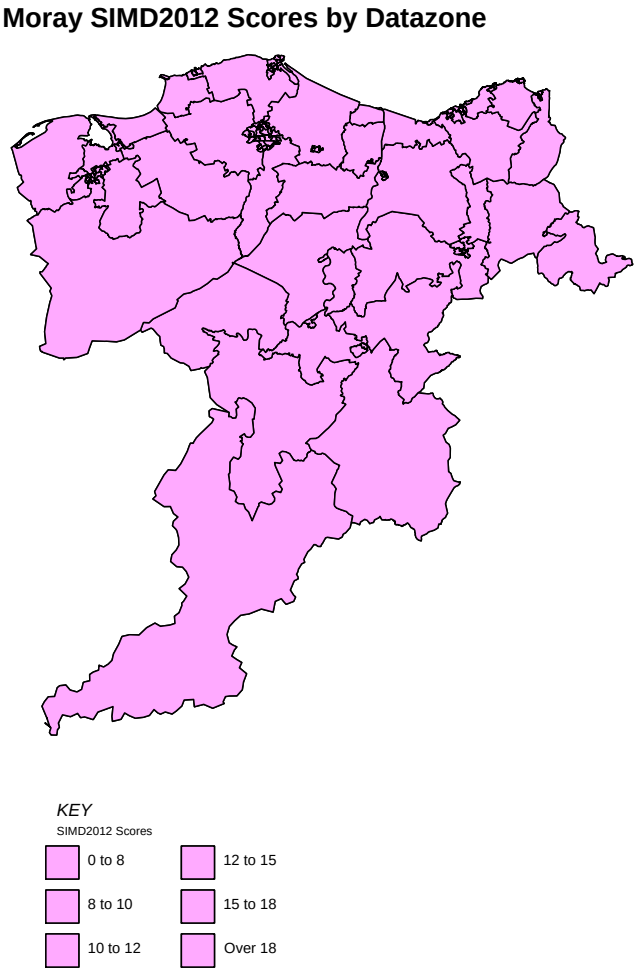
There are 116 SIMD datazones in Moray

- each datazone has a total SIMD score; the higher the score the higher the rank; the datazone with the highest score is the most deprived, and is ranked in position 1
- One eighth (12%) of the population of Moray live in datazones that are amongst the 40% most deprived in Scotland
- Half (48%) of the population in Moray live in datazones that are amongst the 40% least deprived in Scotland

FIGURE 2.1 Moray's population 2012

	National SIMD quintile (1=most deprived)					
	1	2	3	4	5	**TOTAL**
Females	544	5601	18605	16849	5715	47314
Males	561	4893	17730	16323	6089	45596
Persons	**1105**	**10494**	**36335**	**33172**	**11804**	**92910**

FIGURE 2.2 Datazones (SIMD scores increase with measure of multiple deprivation)



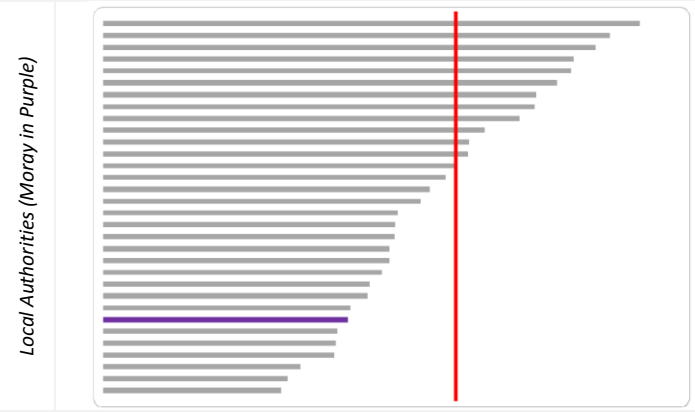
Determinants

Determinants

FIGURE 2.3 Employment

8% unemployment (national average 12%)

[ScotPHO health profiles 2014 – data from 2010]

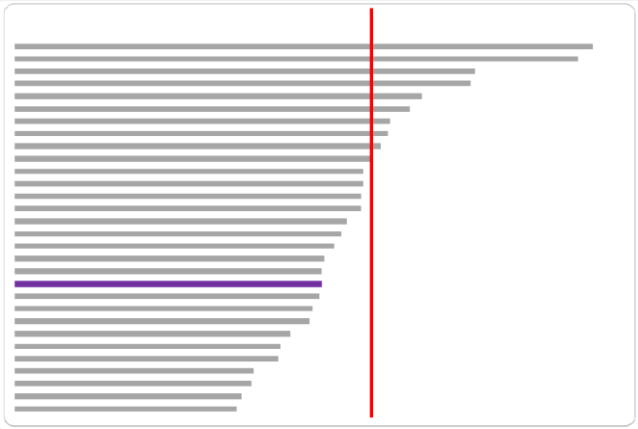


% unemployed (average marked in red)

FIGURE 2.4 Education, Skills, and Training

13% of adults have 'low or no qualifications' (national average 15%)

[ScotPHO health profiles 2014 – data from 2010]

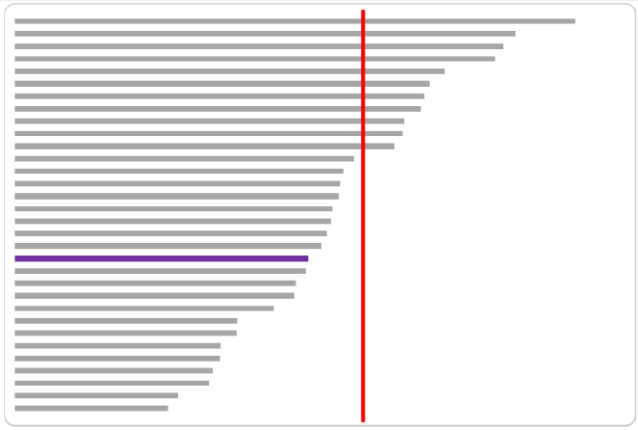


% adults with low or no qualifications (average marked in red)

FIGURE 2.5 Crime

34 recorded crimes per 1,000 population (national average 41 per 1,000)

[ScotPHO health profiles 2014 – data from 2010/11]

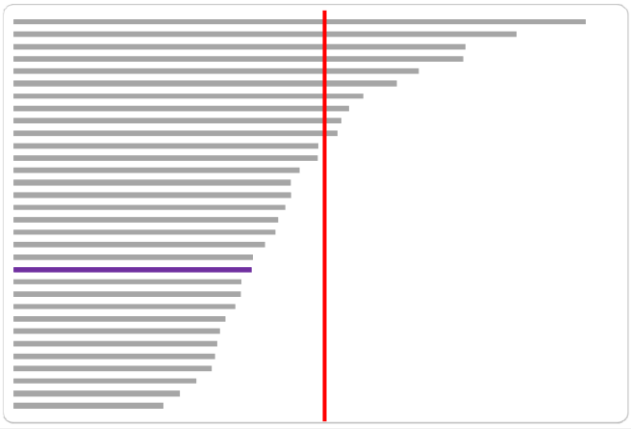


Crimes per 1,000 population (average marked in red)

FIGURE 2.6 Housing

1% of households assessed as homeless (national average 1.3%)

[ScotPHO health profiles 2014 – data from 2012/13]



Determinants

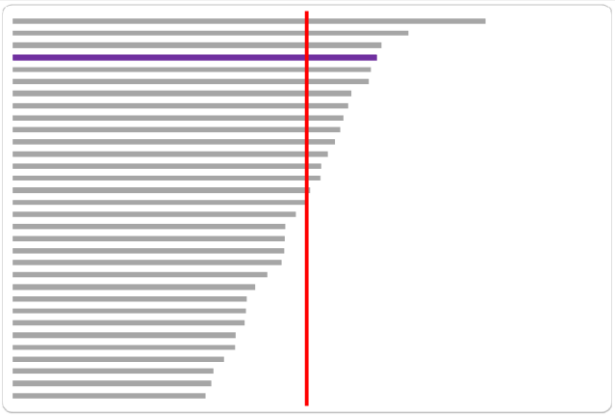
% households homeless (average marked in red)

FIGURE 2.7 Suicides

Five-year rate of 19 per 100,000 (national average 15 per 100,000)

[ScotPHO health profiles 2014 – data from 2008 through 2012 inclusive]

Local Authorities (Moray in Purple)



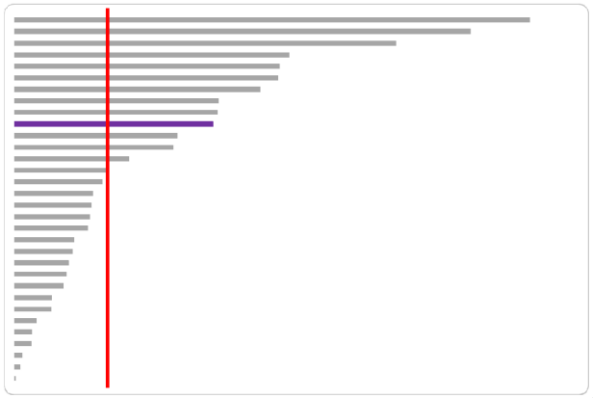
Five-year age-sex standardised rate per 100,000

FIGURE 2.8 Rural deprivation

32% of the population live in Scotland's 15% most 'access deprived' datazones (national average 15%)

[ScotPHO health profiles 2014 – data from 2010]

Local Authorities (Moray in Purple)



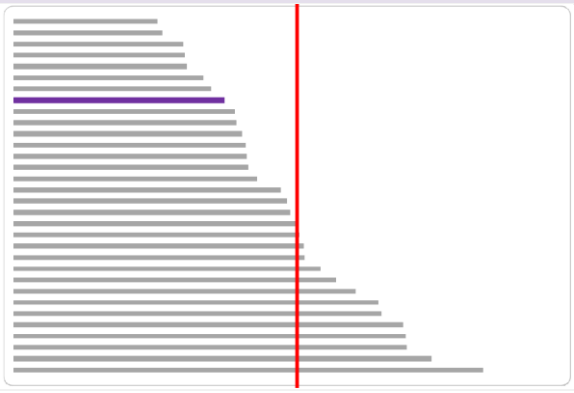
% of population living in 'access deprived' datazones (average marked in red)

FIGURE 2.9 Income deprivation

10% of households experience income deprivation (national average 13%)

[ScotPHO health profiles 2014 - data from 2010]

Local Authorities (Moray in Purple)



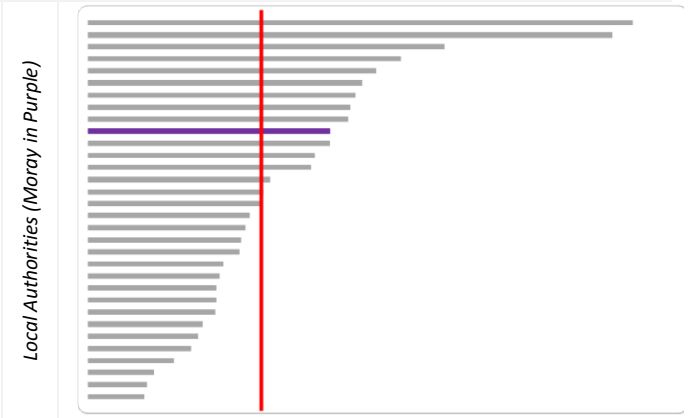
% of population spending >20% of household income on fuel (average marked in red)

Determinants

FIGURE 2.10 Fuel poverty

10% of households report spending >20% of household income on fuel (national average 7%)

[ScotPHO health profiles 2014 - data from 2010-2012]

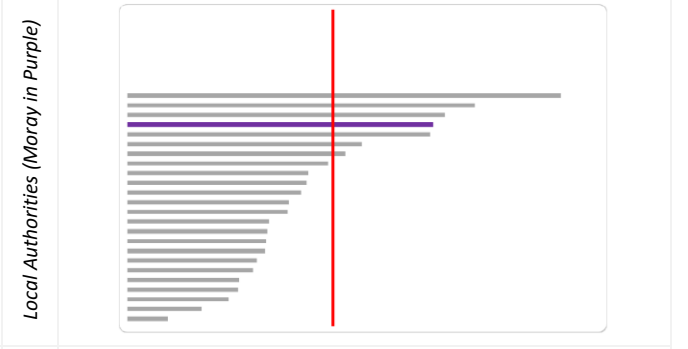


% of population spending >20% of household income on fuel (average marked in red)

Figure 2.11 Active Travel to Work

23% report active travel to work (national average 16%

(ScotPHO health profiles 2014 - data from 2012; 8 LA no data]*)*

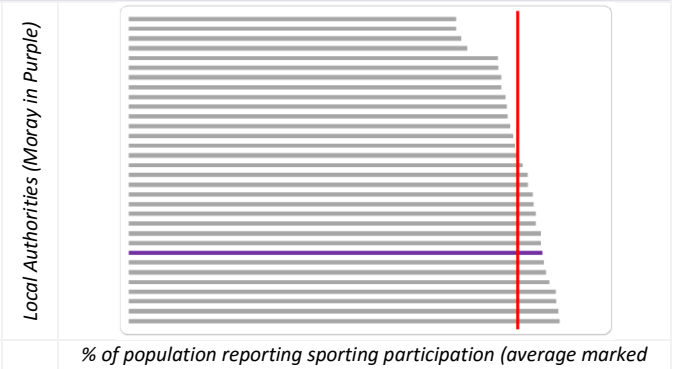


% of popn reporting active travel to work (average marked in red)

FIGURE 2.12 Sporting participation

79% reporting sporting participation (national average 74%)

[ScotPHO health profiles 2014 - data from 2012]



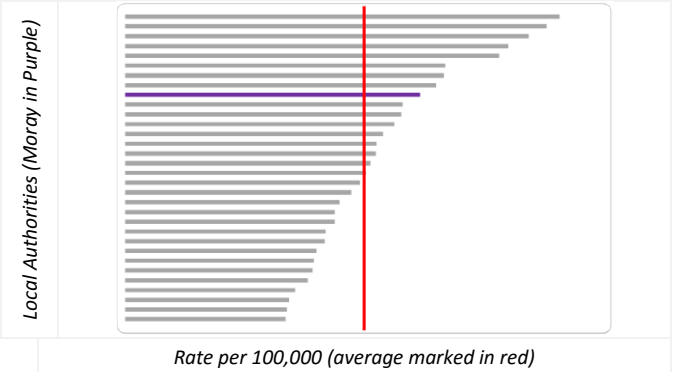
% of population reporting sporting participation (average marked in red)

FIGURE 2.13 Road traffic casualties

A high rate of road traffic casualties

74 casualties per 100,000 (national average 60)

[ScotPHO health profiles 2014 – age-sex standardised rates from 2010-2012]



Rate per 100,000 (average marked in red)

Determinants

FIGURE 2.14 Obesity

- 9,580 people recorded on GP registers as having obesity in Moray
- Moray prevalence 10.5%
- Scotland prevalence 8%
- Prevalence by GP practice varies three-fold, 6% to 18%

[Source: www.isdscotland.org/qof; data 2013/14]

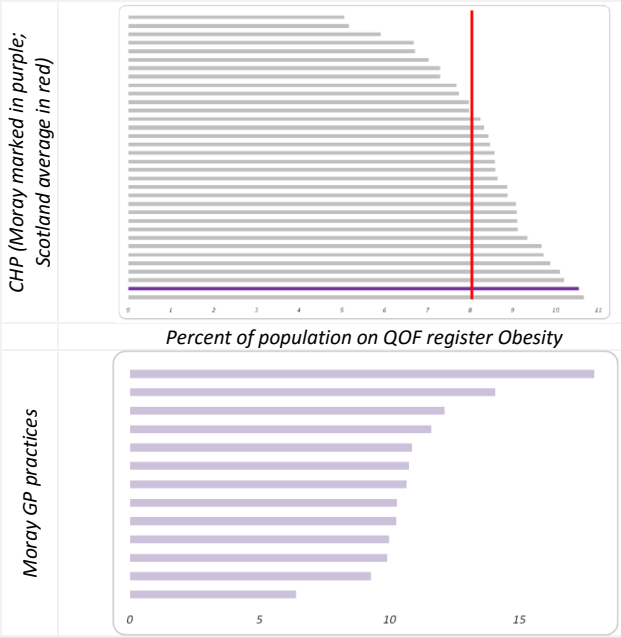


Figure 2.15 Alcohol-related deaths

20 alcohol-related deaths per 100,000 (national average 25)

[ScotPHO health profiles 2014 - data from 2011]

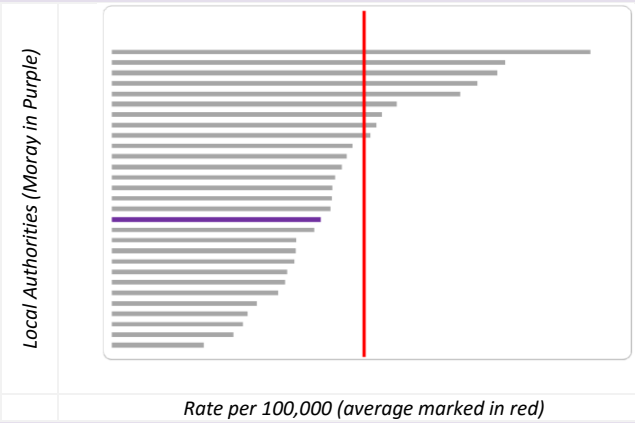


FIGURE 2.16 Smoking prevalence

Average smoking prevalence

over one in five adults (23%) smoke (national average 23%)

[ScotPHO health profiles 2014 – data from 2012 and 2013 inclusive]

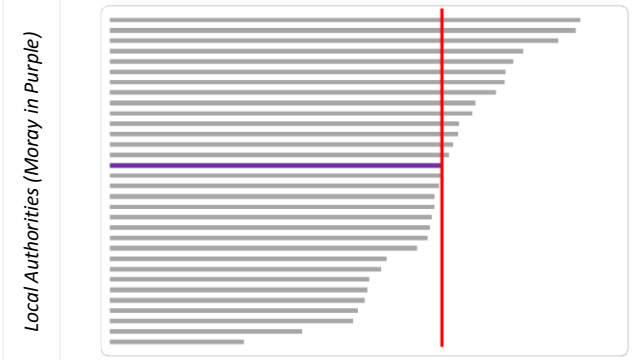
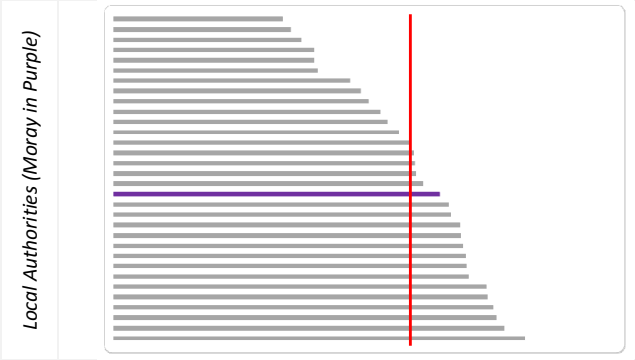
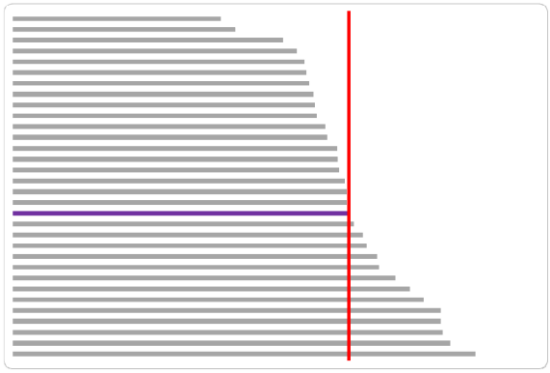


FIGURE 2.17 Smoking in pregnancy – prevalence at booking by SIMD quintile

[ScotPHO health profiles 2014 – data 2010 through 2012 inclusive]



Determinants

		Prevalence of smoking at booking appointments
FIGURE 2.18 Childhood dental decay *45% of primary 7 children have no signs of decay (national average 45%)* [ScotPHO health profiles 2014 – data from 2012/13]	*Local Authorities (Moray in Purple)*	 *% of primary school children with no tooth decay (average marked in red)*

See also
Grampian Alcohol & Illicit Drugs Needs Assessment
PH Health & Wellbeing Compendium

Health Status

GP practices maintain registers of specified conditions as part of the Quality and Outcomes Framework of the General Medical Services Contract (hence 'QOF registers'). While not providing a complete and accurate measure of population prevalence, they are nonetheless helpful in assessing the burden of disease seen by primary care services.

Patients registered with a GP (% of population) in 2013/14 [Source: www.isdscotland.org/qof]	**89,327 (95%)**

Notes
1. The number of patients with each condition do not sum, as some patients will be on more than one QOF register
2. Primary Care QOF registers should not be relied upon to provide a complete picture of the disease prevalence within communities, as a range of variables influence patient inclusion on registers
3. The graphs show Moray CHP crude % prevalence compared to the other 33 Community Health Partnerships in Scotland; and the range of % prevalence for each condition across Moray's 35 GP practices
4. Further detailed explanation can be found here

FIGURE 3.1
Primary Care QOF Registers in Moray

Condition	Number of patients	Prevalence
Hypertension	13,502	15%
Obesity	9,580	11%
Asthma	5,407	6%
Diabetes	4,994	5%
Hypothyroidism	4,898	5%
CHD (Coronary Heart Disease)	3,929	4%
Depression: New diagnosis of depression	3,210	4%
CKD (Chronic Kidney Disease)	2,970	3%
Stroke & Transient Ischaemic Attack (TIA)	2,023	2%
Cancer	1,895	2%
Atrial Fibrillation	1,614	2%
COPD (Chronic Obstructive Pulmonary Disease)	1,546	2%
Heart Failure	821	1%
Peripheral Arterial Disease	783	1%
Dementia	744	1%
Mental Health	717	1%
Rheumatoid arthritis	712	1%
Epilepsy	619	1%
Learning Disabilities	402	0.4%
Osteoporosis	177	0.2%
Palliative Care	176	0.2%

[Source: www.isdscotland.org/qof; data 2013/14]
Numbers cannot be summed as patients may be registered on more than one register

FIGURE 3.2 Hypertension

- 13,502 patients recorded as having hypertension in Moray
- Moray prevalence 14.8%
- Scotland prevalence 13.9%
- Prevalence by GP practice is 11% to 21%

[Source: www.isdscotland.org/qof; data 2013/14]

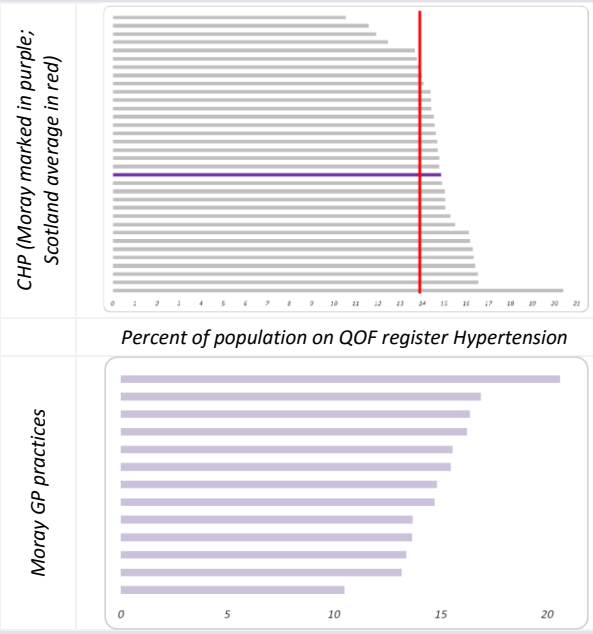


FIGURE 3.3 Asthma

- 5,407 patients recorded as having asthma in Moray
- Moray prevalence 5.9%
- Scottish prevalence 6.1%
- Prevalence by GP practice is 5% to 8%

[Source: www.isdscotland.org/qof; data 2013/14]

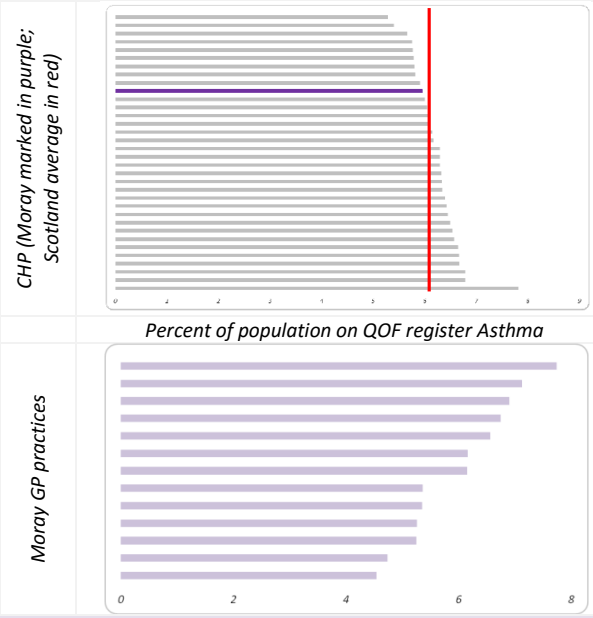
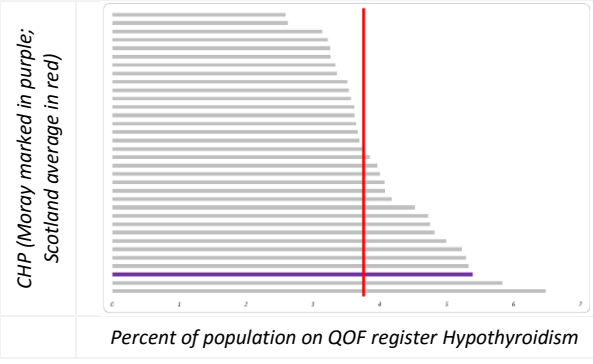


FIGURE 3.4 Hypothyroidism

- 4,898 patients recorded as having hypothyroidism in Moray
- Moray prevalence 5.4%
- Scottish prevalence 3.8%



- Prevalence by GP practice is 5% to 7%

[Source: www.isdscotland.org/qof; data 2013/14]

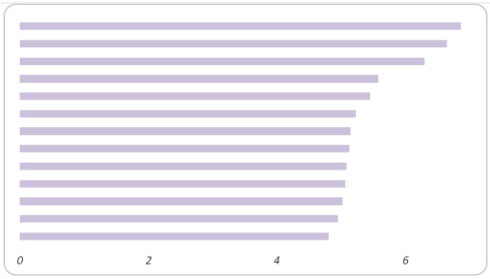
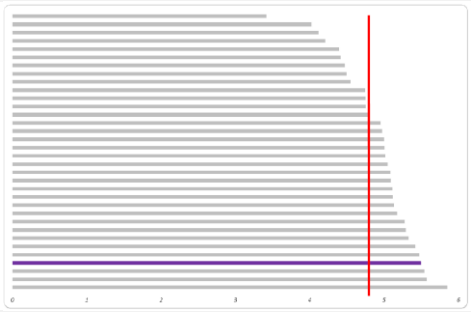


FIGURE 3.5 Diabetes

- 4,994 patients recorded as having diabetes in Moray
- Moray prevalence 6%
- Scottish prevalence 5%



Percent of population on QOF register Diabetes

- Prevalence by GP pr practice is 5% to 7%

[Source: www.isdscotland.org/qof; data 2013/14]

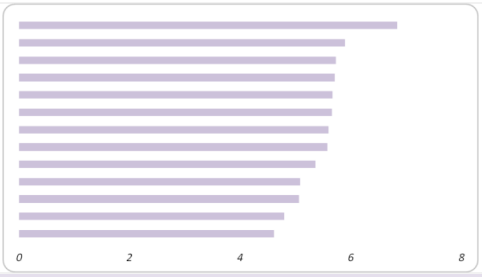
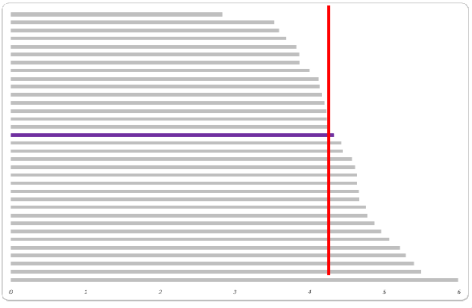


FIGURE 3.6 CHD

- 3,929 patients recorded as having CHD in Moray
- Moray prevalence 4.3%
- Scottish prevalence 4.3%



Percent of population on QOF register CHD

- Prevalence by GP practice is 2% to 5%

[Source: www.isdscotland.org/qof; data 2013/14]

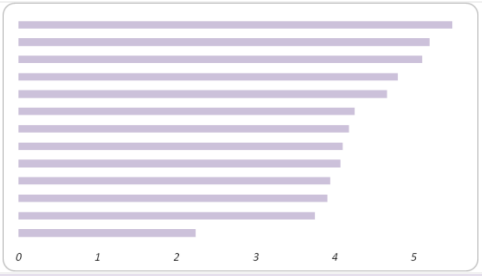
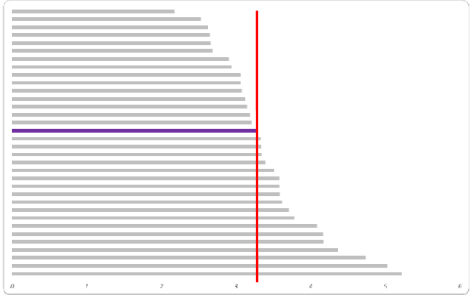


FIGURE 3.7 CKD

- 2,970 patients recorded as having CKD in Moray
- Moray prevalence 3.3%
- Scottish prevalence 3.2%



Health Status

- Prevalence by GP practice is 1% to 5%

[Source: www.isdscotland.org/qof; data 2013/14]

Percent of population on QOF register CKD

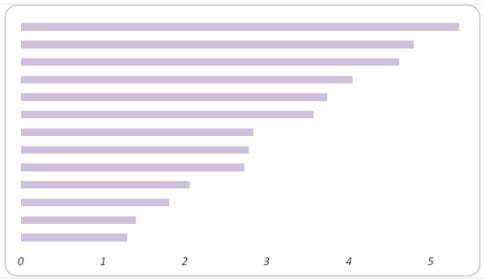
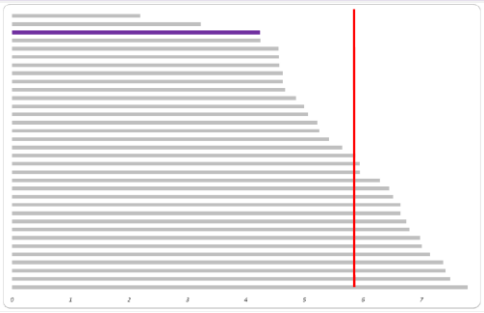


FIGURE 3.8 Depression (new diagnoses)

- 3,210 patients recorded as having a new diagnosis of depression in Moray
- Moray prevalence 4.2%
- Scottish prevalence 5.8%



Percent of population on QOF register New Depression

- Prevalence by GP practice is 1% to 8%

[Source: www.isdscotland.org/qof; data 2013/14]

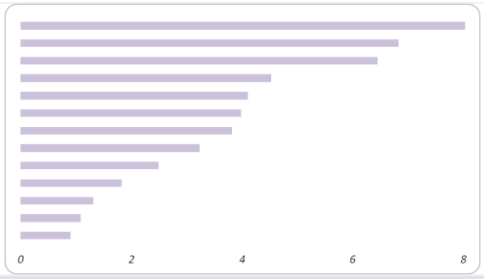
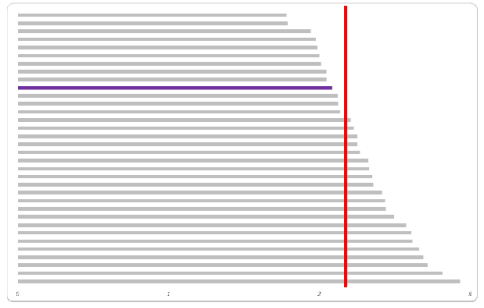


FIGURE 3.9 Cancer

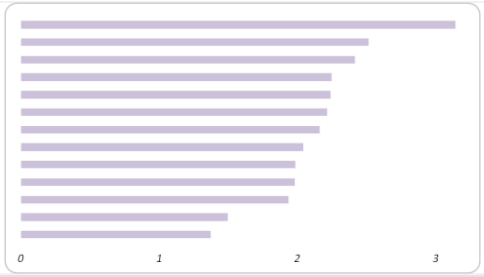
- 1,895 patients recorded as having cancer in Moray
- Moray prevalence 2.1%
- Scottish prevalence 2.2%



Percent of population on QOF register Cancer

- Prevalence by GP practice is 1% to 3%

[Source: www.isdscotland.org/qof; data 2013/14]



Health Status

FIGURE 3.10 Stroke & Transient Ischaemic Attack (TIA)

- 2,023patients recorded as having stroke or TIA in Moray
- Moray prevalence 2.22%
- Scottish prevalence 2.16%
- Prevalence by GP practice is 1% to 3%

[Source: www.isdscotland.org/qof; data 2013/14]

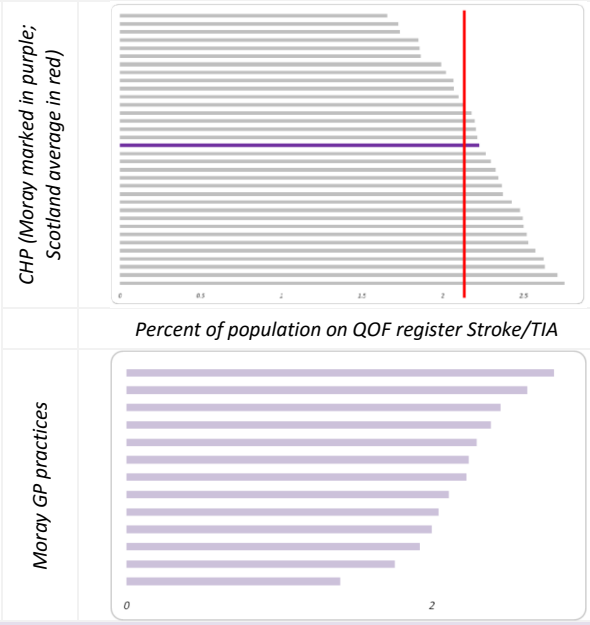


FIGURE 3.11 Atrial Fibrillation

- 1,614 patients recorded as having AF in Moray
- Moray prevalence 1.8%
- Scottish prevalence 1.6%
- Prevalence by GP practice is 1% to 3%

[Source: www.isdscotland.org/qof; data 2013/14]

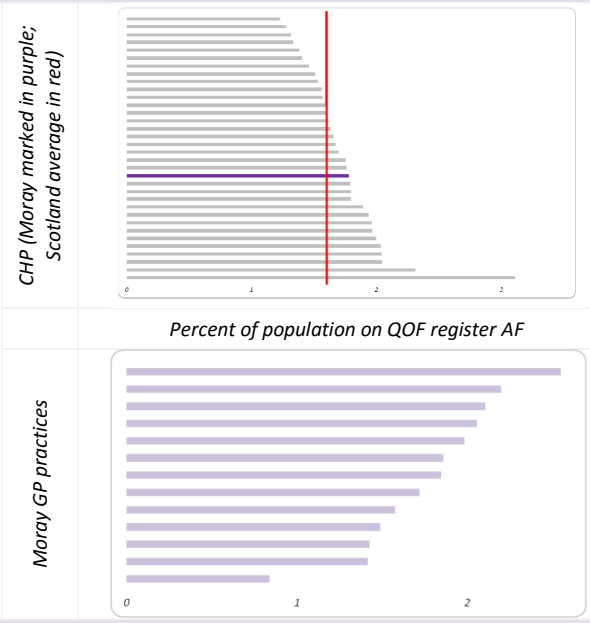
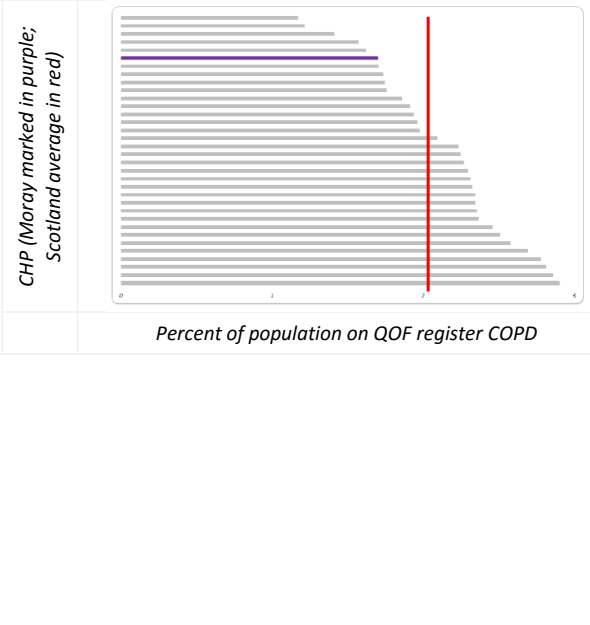


FIGURE 3.12 COPD

- 1,546 patients recorded as having COPD in Moray
- Moray prevalence 1.7%
- Scottish prevalence 2.2%



- Prevalence by GP practice is 1% to 3%

[Source: www.isdscotland.org/qof; data 2013/14]

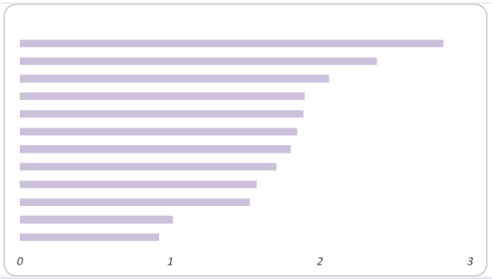
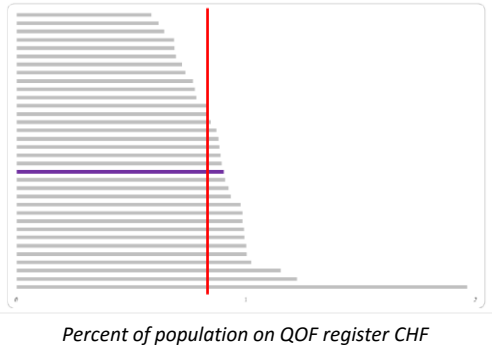


FIGURE 3.13 Heart Failure

- 821 patients recorded as having heart failure in Moray
- Moray prevalence 0.9%
- Scottish prevalence 0.8%



- Prevalence by GP practice is 0.5% to 1.2%

[Source: www.isdscotland.org/qof; data 2013/14]

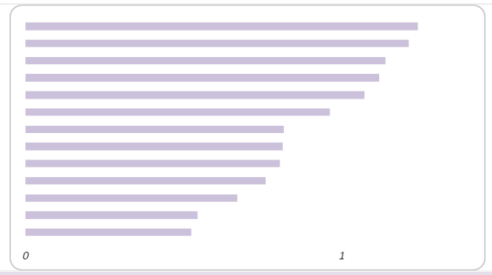
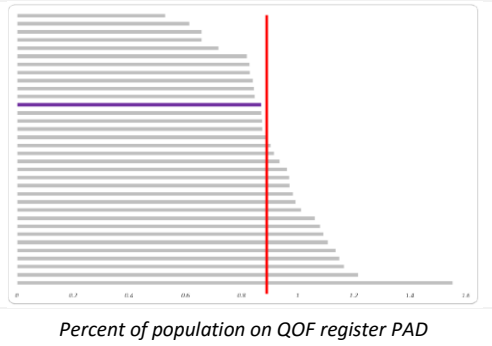


FIGURE 3.14 Peripheral Arterial Disease

- 783 patients recorded as having PAD in Moray
- Moray prevalence 0.9%
- Scottish prevalence 0.9%



- Prevalence by GP practice is 0.7% to 1.2%

[Source: www.isdscotland.org/qof; data 2013/14]

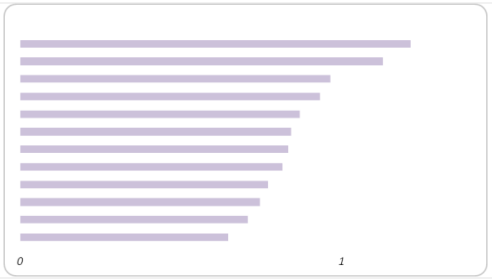
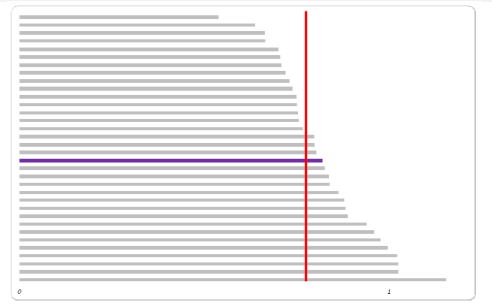


FIGURE 3.15 Dementia

- 744 patients recorded as having cancer in Moray
- Moray prevalence 0.8%
- Scottish prevalence 0.8%



- Prevalence by GP practice is 0.4% to 1.1%

[Source: www.isdscotland.org/qof; data 2013/14]

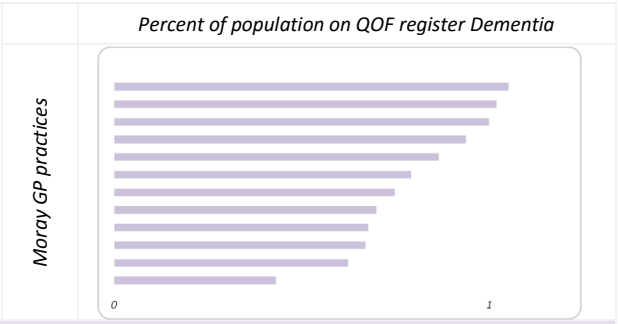


FIGURE 3.16 Epilepsy

- 619 patients recorded as having epilepsy in Moray
- Moray prevalence 0.7%
- Scottish prevalence 0.8%
- Prevalence by GP practice is 0.4% to 1%

[Source: www.isdscotland.org/qof; data 2013/14]

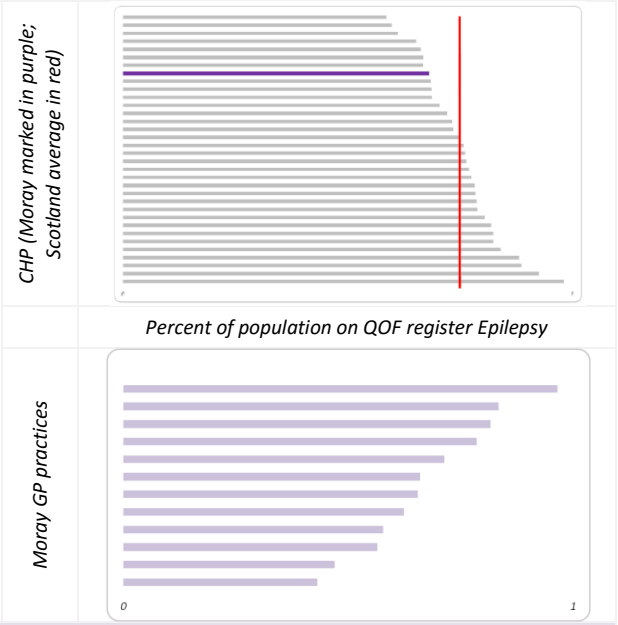
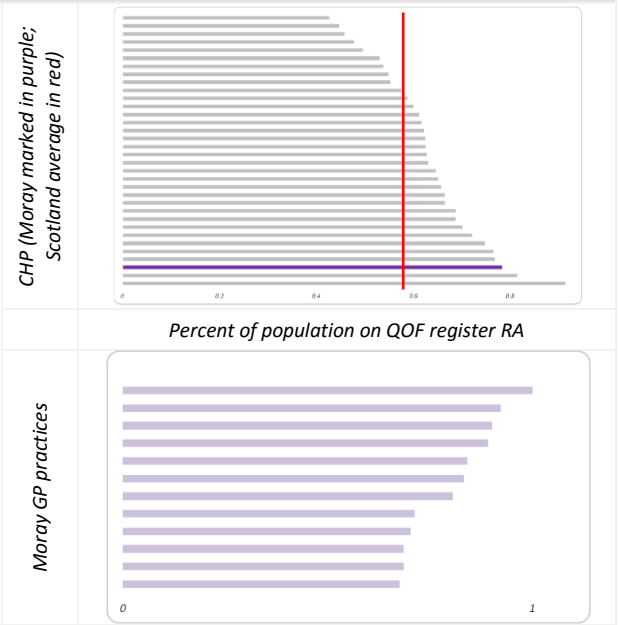


FIGURE 3.17 Rheumatoid arthritis

- 712 patients recorded as having RA in Moray
- Moray prevalence 0.8%
- Scottish prevalence 0.6%
- Prevalence by GP practice is 0.7% to 1%

[Source: www.isdscotland.org/qof; data 2013/14]



Health Status

FIGURE 3.18 Mental Health

- 717 patients recorded as having a mental health diagnosis in Moray
- Moray prevalence 0.8%
- Scottish prevalence 0.9%
- Prevalence by GP practice is 0.6% to 1.1%

[Source: www.isdscotland.org/qof; data 2013/14]

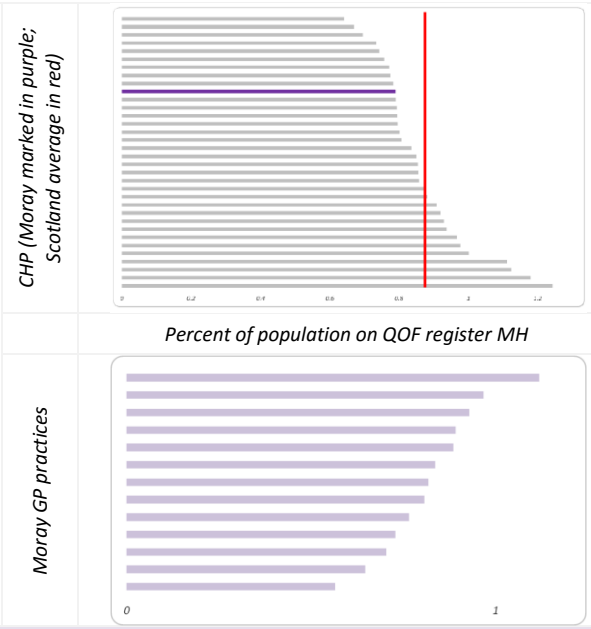


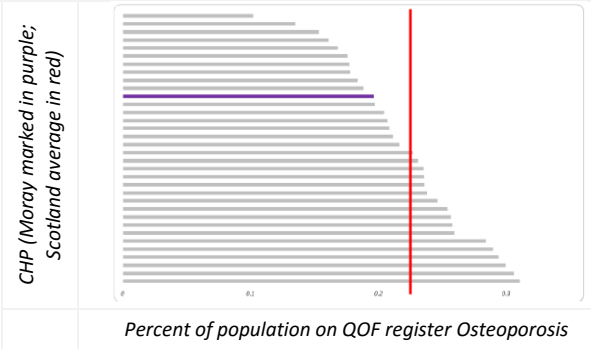
FIGURE 3.19 Learning Disabilities

- 402 patients recorded as having learning disability in Moray
- Moray prevalence 0.4%
- Scottish prevalence 0.5%
- Prevalence by GP practice is 0.2% to 0.9%

[Source: www.isdscotland.org/qof; data 2013/14]

FIGURE 3.20 Osteoporosis

- 177 patients recorded as having osteoporosis in Moray
- Moray prevalence 0.2%
- Scottish prevalence 0.2%



- Prevalence by GP practices is 0.1% to 0.4%

[Source: www.isdscotland.org/qof; data 2013/14]

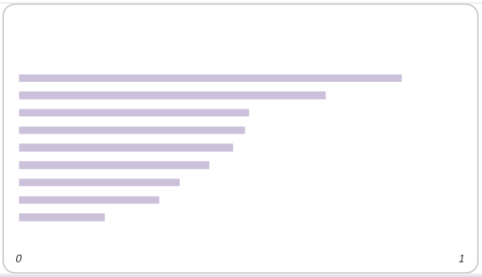
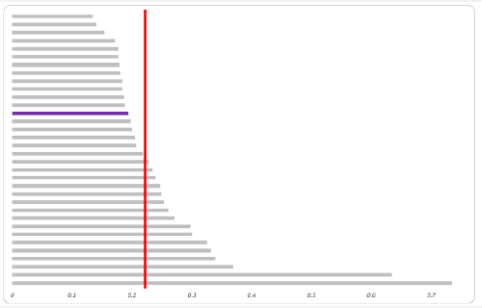


FIGURE 3.21 Palliative Care

- 176 patients recorded on palliative care registers in Moray in 2013/14
- Moray prevalence 0.2%
- Scottish prevalence 0.2%



- Prevalence by GP practices is 0.1% to 0.4%

[Source: www.isdscotland.org/qof; data 2013/14]

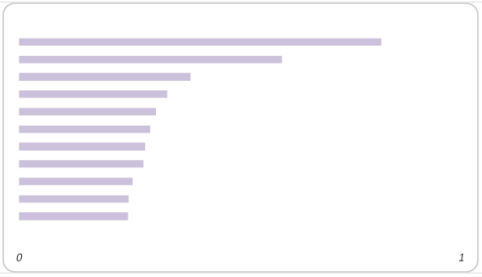


FIGURE 3.22 Rates of disability and ill health are higher in more deprived communities

Compared to the Grampian average:

- % fewer people in the least deprived quintile have no reported health condition
- % more people in the most deprived quintile have a physical disability or mental health condition

Health Status

Acute Hospital Emergency (Non-Elective) Admission Rates (2009 – 2013)

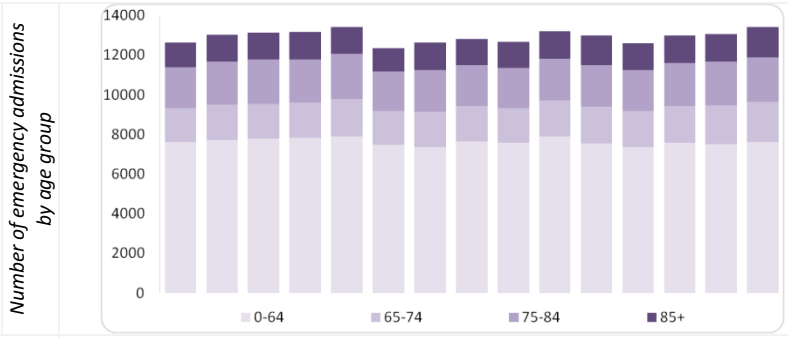
[Source: NHS Grampian Health Intelligence – SMR01 data 2009 through 2013 inclusive]

Non-elective admissions to acute hospital (nearest thousand; column %) (ISD IRF data)				
Age group	**Patients**	**Episodes**	**Bed days**	**Cost (£m)**
<18	1,100 (20%)	1,500 (13%)	3,200 (5%)	£4 (12%)
18-64	2,200 (40%)	4,200 (37%)	15,800 (25%)	£8 (29%)
65+	2,200 (40%	5,800 (50%)	45,400 (70%)	£17 (59%)
TOTALS	5,500 (100%)	11,500 (100%)	64,400 (100%)	£29 (100%)

FIGURE 3.23
Health Intelligence provide regular update reports against **236 indicators** through **routine scorecards**

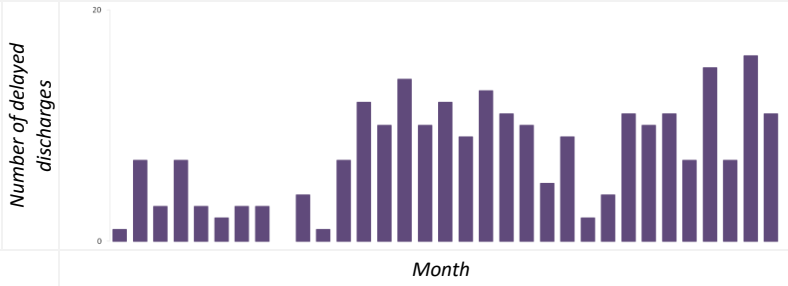
Number of emergency admissions in Grampian

[Source: NHSG Health Intelligence USC at-a-glance Scorecard December 2014 – data June 2011 through December 2014]



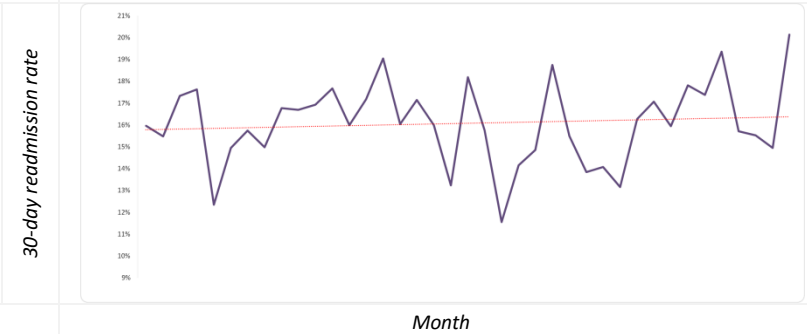
Total number of delayed discharges in Moray

[data June 2011 through December 2014]



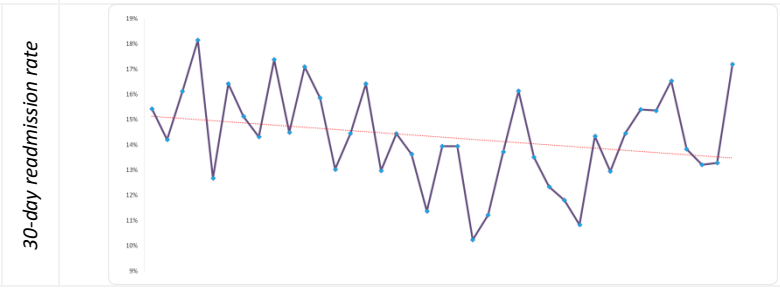
Moray CHP 30-day readmission rates (reported monthly)

[data April 2011 through June 2014]



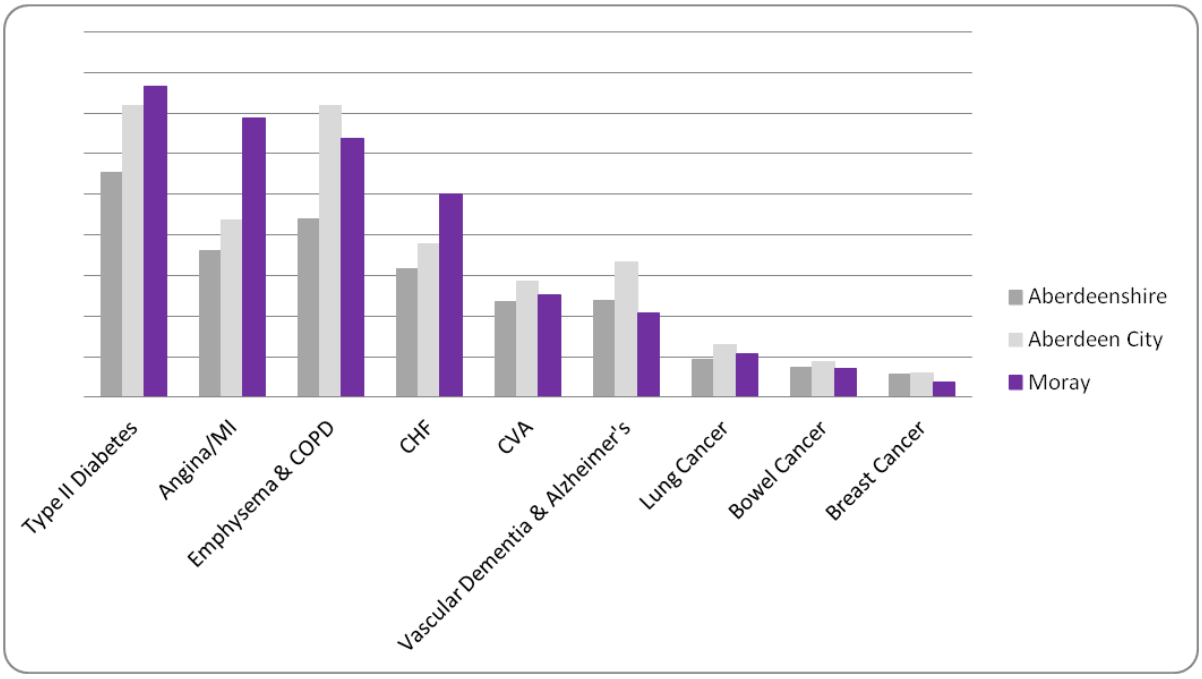
Dr Gray's 30-day readmission rates (reported monthly)

[data April 2011 through June 2014]



	Month

FIGURE 3.24 Emergency Acute admission rates per 100,000 population by specified condition



Emergency admissions for type 2 diabetes, angina/MI, and congestive heart failure are higher than elsewhere in Grampian

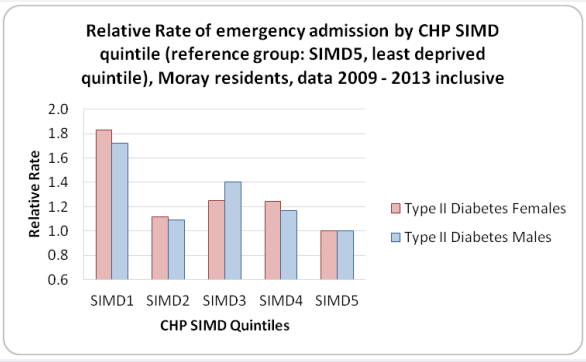
FIGURE 3.25 Emergency (non-elective) Acute admissions, Relative Rates by CHP SIMD quintiles

Type II diabetes (T2D)

Compared to least deprived population quintile (SIMD5), there is a 70% (♂) to 80% (♀) increased risk of emergency admission for people with T2D from the most deprived quintile (SIMD1)

	SIMD1	SIMD2	SIMD3	SIMD4	SIMD5
Females	1.8	1.1	1.3	1.2	1.0
Males	1.7	1.1	1.4	1.2	1.0

[Source: NHSG Health Intelligence SMR01 data]

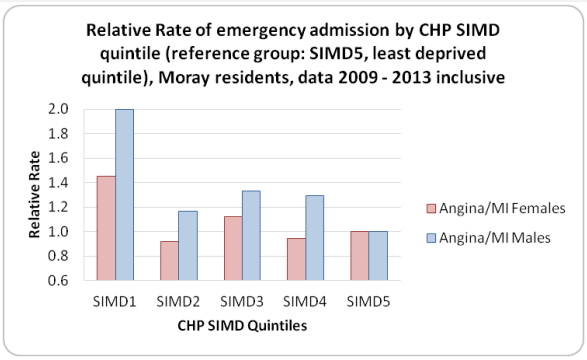


Angina or myocardial infarction (MI)

Compared to least deprived population quintile (SIMD5), there is a 100% (♂) to 40% (♀) increased risk of emergency admission for people with angina or MI from the most deprived quintile (SIMD1)

	SIMD1	SIMD2	SIMD3	SIMD4	SIMD5
Females	1.4	0.9	1.1	0.9	1.0
Males	2.0	1.2	1.3	1.3	1.0

[Source: NHSG Health Intelligence SMR01 data]

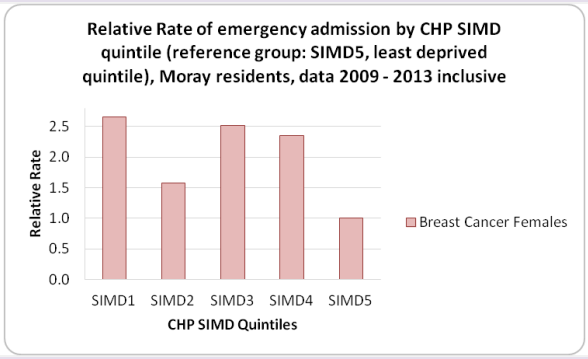


Breast Cancer

Compared to least deprived population quintile (SIMD5), there is a 170% increased risk of emergency admission for women with breast cancer from the middle deprivation quintile (SIMD3)

	SIMD1	SIMD2	SIMD3	SIMD4	SIMD5
Females	2.7	1.6	2.5	2.4	1.0

[Source: NHSG Health Intelligence SMR01 data]

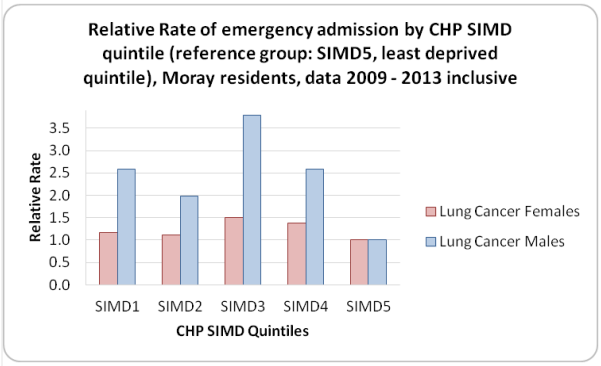


Lung Cancer

Compared to least deprived population quintile (SIMD5), there is a 20% (♀) to 160% (♂) increased risk of emergency admission for people with lung cancer from the most deprived quintile (SIMD1) [though note the greatest increased risk is 280% for men in the middle quintile]

	SIMD1	SIMD2	SIMD3	SIMD4	SIMD5
Females	1.2	1.1	1.5	1.4	1.0
Males	2.6	2.0	3.8	2.6	1.0

[Source: NHSG Health Intelligence SMR01 data]

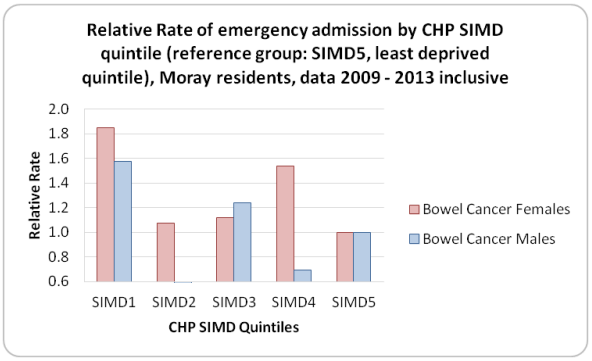


Bowel Cancer

Compared to least deprived population quintile (SIMD5), there is a 60% (♂) to 80% (♀) increased risk of emergency admission for people with bowel cancer from the most deprived quintile (SIMD1)

	SIMD1	SIMD2	SIMD3	SIMD4	SIMD5
Females	1.8	1.1	1.1	1.5	1.0
Males	1.6	0.3	1.2	0.7	1.0

[Source: NHSG Health Intelligence SMR01 data]

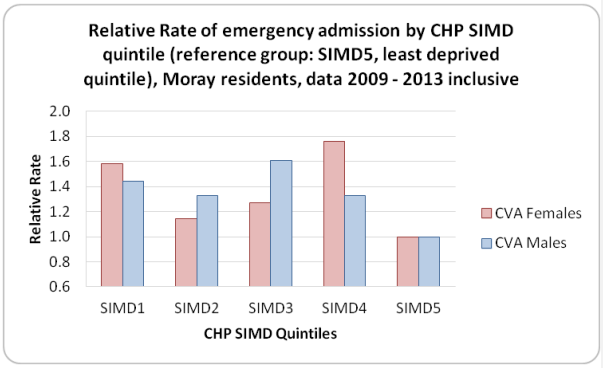


Cerebrovascular Accident (Stroke)

Compared to least deprived population quintile (SIMD5), there is a 40% (♂) to 60% (♀) increased risk of emergency admission for people with stroke from the most deprived quintile (SIMD1)

	SIMD1	SIMD2	SIMD3	SIMD4	SIMD5
Females	1.6	1.1	1.3	1.8	1.0
Males	1.4	1.3	1.6	1.3	1.0

[Source: NHSG Health Intelligence SMR01 data]

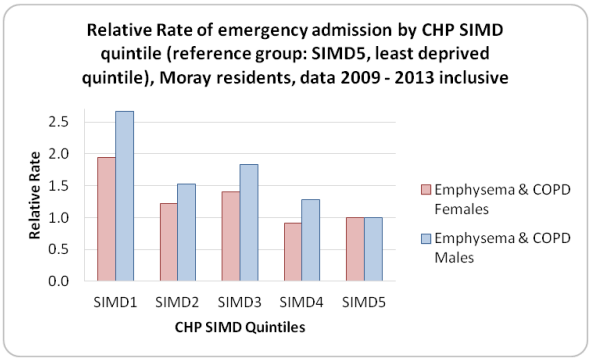


Emphysema & Chronic Obstructive Airways Disease (COPD)

Compared to least deprived population quintile (SIMD5), there is a 90% (♀) to 170% (♂)increased risk of emergency admission for people with COPD from the most deprived quintile (SIMD1)

	SIMD1	SIMD2	SIMD3	SIMD4	SIMD5
Females	1.9	1.2	1.4	0.9	1.0
Males	2.7	1.5	1.8	1.3	1.0

[Source: NHSG Health Intelligence SMR01 data]

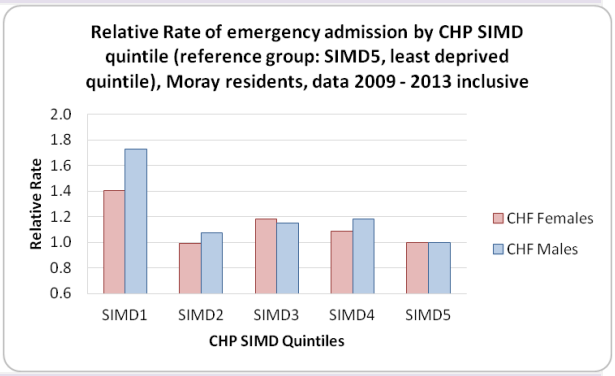


Congestive Heart Failure (CHF)

Compared to least deprived population quintile (SIMD5), there is a 40% (♀)to 70% (♂)increased risk of emergency admission for people with CHF from the most deprived quintile (SIMD1)

	SIMD1	SIMD2	SIMD3	SIMD4	SIMD5
Females	1.4	1.0	1.2	1.1	1.0
Males	1.7	1.1	1.1	1.2	1.0

[Source: NHSG Health Intelligence SMR01 data]



Vascular Dementia & Alzheimer's Disease

Compared to least deprived population quintile (SIMD5), there is a 10% (♀) to 90% (♂) increased risk of emergency admission for people with dementia from the most deprived quintile (SIMD1)

	SIMD1	SIMD2	SIMD3	SIMD4	SIMD5
Females	1.1	0.9	0.8	1.7	1.0
Males	1.9	1.3	1.0	1.8	1.0

[Source: NHSG Health Intelligence SMR01 data]

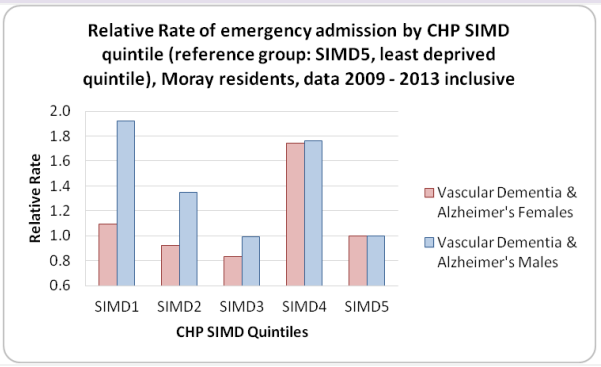
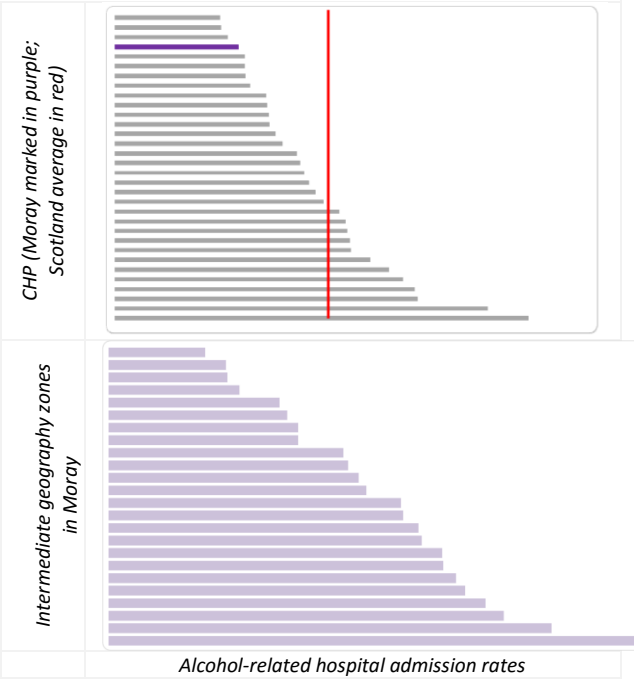


FIGURE 3.26

Alcohol-related acute hospital admission rates



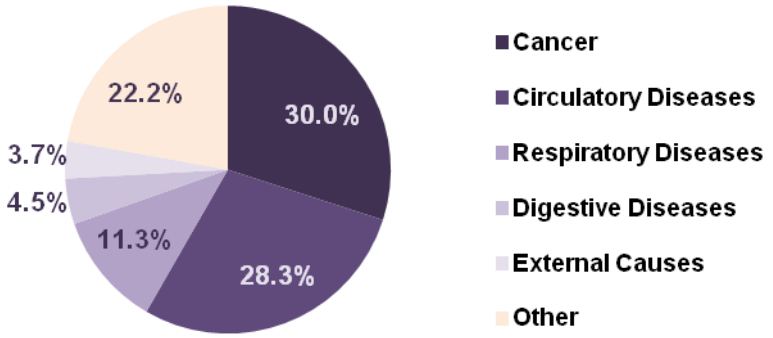
Moray has one of the lowest alcohol-related acute admission rates in Scotland...

...but with marked variation across communities in Moray

[Source: NHS Grampian Health Intelligence – SMR01 data 2008/09 through 2013/14 inclusive]

FIGURE 3.27 Cause of death in Moray (2013)

Females



Males

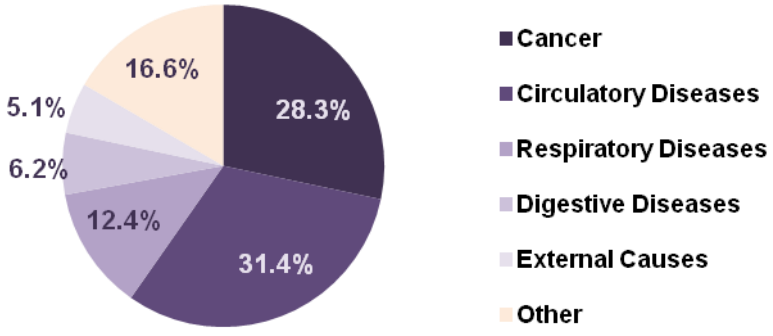
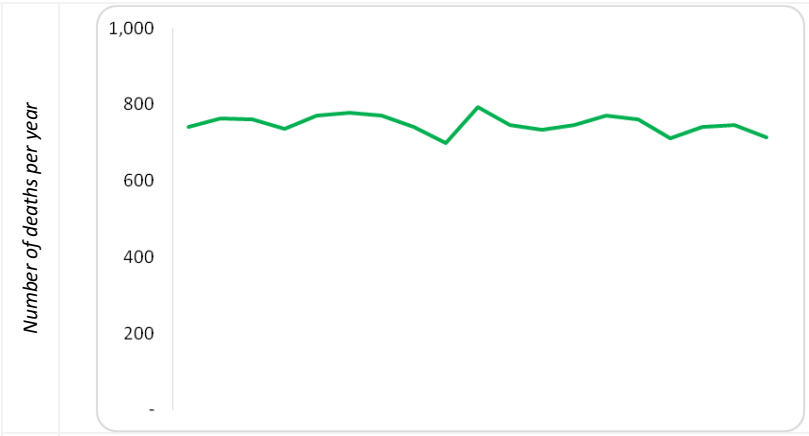


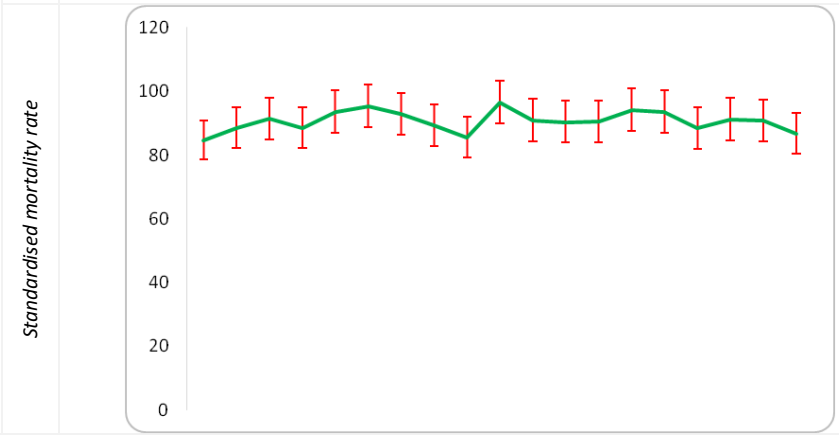
FIGURE 3.28 Premature cancer deaths in Grampian

Annual average 749 deaths from cancer before age 75...



1995 to 2013

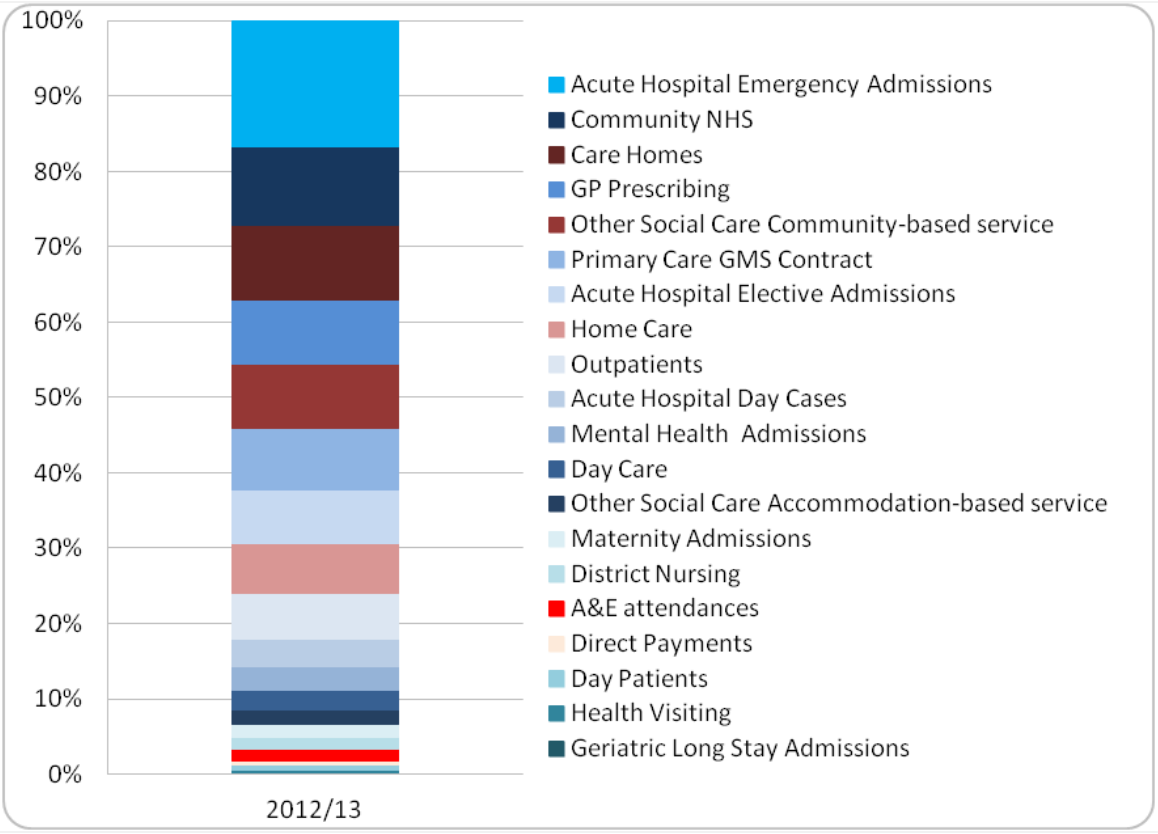
...while the standardised rate shows premature cancer deaths to be less than or equal to the Scottish average over the same period



Source: ISD Cancer Statistics (data 1995 – 2013)

Health Services

FIGURE 4 The total NHS & Social Care costs for Moray residents in 2012/13 was £172m



Sector	£million (%) 2012/13
Acute Hospital Emergency Admissions	£29 (17%)
Community Health - other	£18 (11%)
Care Homes	£17 (10%)
GP Prescribing	£15 (9%)
Other-Community-based service	£15 (9%)
Primary Care GMS Contract	£14 (8%)
Acute Hospital Elective Admissions	£12 (7%)
Home Care	£11 (7%)
Outpatients	£11 (6%)
Acute Hospital Day Cases	£6 (4%)
Mental Health Admissions	£5 (3%)
Day Care	£4 (<3%)
Other-Accommodation-based service	£3 (<2%)
Maternity Admissions	£3 (<2%)
District Nursing	£3 (<2%)
A&E attendances	£3 (<2%)
Direct Payments	£1 (<1%)
Day Patients	£1 (<1%)
Health Visiting	£1 (<1%)
Geriatric Long Stay Admissions	<£0.01 (<0.1%)

FIGURE 4.3
High Resource Individuals

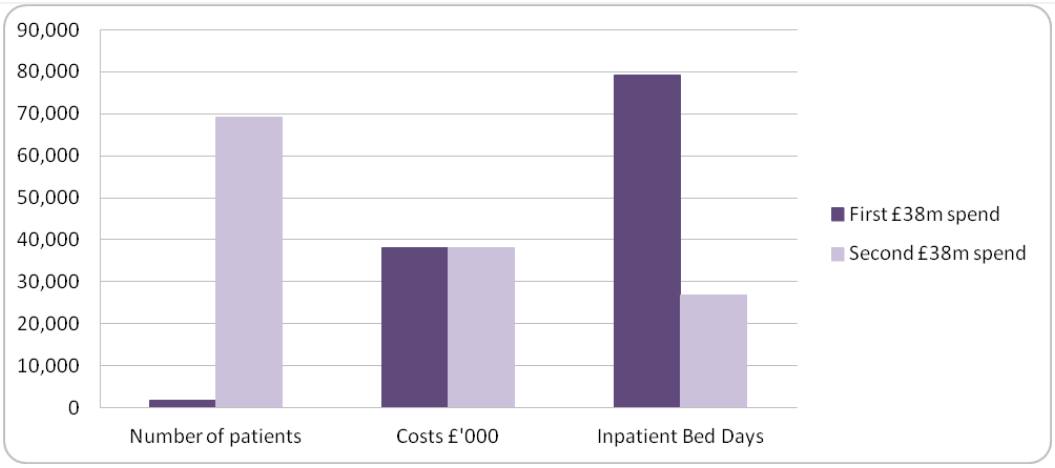
ISD are able to provide individually-attributable data for NHS spend (social care spend is not currently available at this level).

In 2012/13 two-thirds (63%) of NHS spending was individually attributable to patients through the community health index (CHI) system. In Moray around 71,000 patients had individually-attributable NHS cost data. Ranking these individuals by total cost allows the list to be split such that 50% of costs are contained in each half.

The upper half of the list contained 1,811 individuals, who required half of the individually-identifiable spend (£38m), and three quarters (75%) of bed days (79,249). ISD refers to these patients as "high resource individuals" (HRI).

The lower half of the list contained the remaining 69,294 individuals, who also required half of the individually-identified spend (£38m), and one quarter of bed days (26,720).

Thus **approximately 2.5% of Moray's NHS patients required at least one third (32%) of total NHS costs** (and possibly more, as an unknown proportion of the non-individually attributable costs could also be for services required by these patients), and **three quarters of all inpatient bed days**.



Number of patients and respective NHS costs and bed days, in the two groups each requiring 50% of individually-attributable data

Appendix 1 Questions for Integration Boards to ask their Populations

Health and social care boards are now responsible for ensuring the provision of all community health services (e.g. GP services, district nursing, mental health services), social care services (e.g. home care, respite care), and some emergency hospital services. Boards are also responsible for improving the health of their populations and helping people to avoid illness and disability.

Are any of the following suggestions contentious? What do you understand each suggestion to mean? For which population groups do the suggestions have most relevance for (by geographical location, by age group, by health condition)?

As well as ensuring service provision to those who are ill or disabled, health and social care boards should invest time, money and effort in:

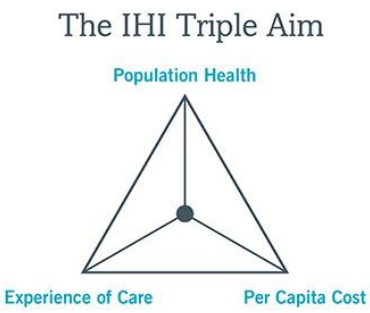
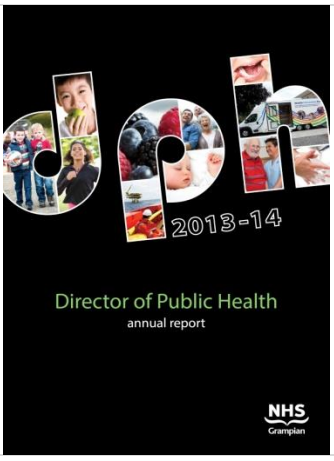
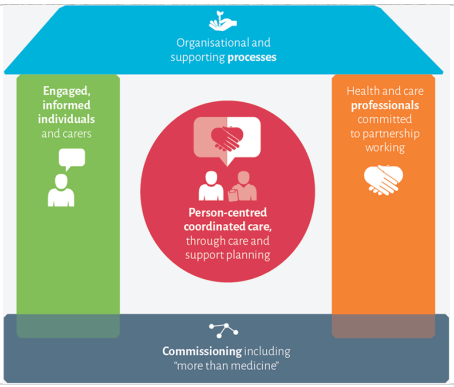
- improving health and preventing illness and disability by reducing inequalities in the wider social conditions that affect our health
- ensuring that citizens and communities are able to be involved in Board's decision-making
- strengthening existing community assets and resources that can help local people with their needs
- promoting and supporting independence, self-efficacy and self-reliance
- helping people to care for their own health
- helping people to be as independent as possible in managing their long-term health conditions
- thinking ahead and planning, rather than reacting only once people are ill
- making sure that people are only admitted to hospital when that is the best place to be
- supporting third sector organisations to help local people with their needs
- making it easier for people to contribute to helping others in their communities
- giving recognition to people for helping others in their communities
- supporting those who are unpaid carers to look after their own health

Appendix 2 Relevant Extant Strategies & Plans

Source	Strategy/policy document
Moray Council	• Moray Joint Commissioning Strategy for Older People 2013-2023[43] • Moray Single Outcome Agreement 2013-2023[44] highlights early years, employment, equity, independence, carers, safety, and community resilience • Moray Local Community Planning Strategic Assessments
Moray Alcohol & Drug Partnership	• Moray[45] Alcohol & Drug Partnership Strategy
NHS Grampian	• NHS Grampian primary and secondary care modernisation programmes informed by the Health Fit 2020 strategic vision[46] • NHS Grampian Dental Plan 2020[47] • DPH Annual Report 2012 and 2013/14 • NHS Grampian's Health Traffic Lights[48]
National	• Health Scotland *Best preventative investments in Scotland*[49] • Scottish Public Health Observatory *Informing Investment to reduce health Inequalities*[50] • *Caring together, The Carers' Strategy for Scotland, 2010 -2015*[51] • Healthcare Improvement Scotland (2014) *Report on the review of the quality of care at Aberdeen Royal Infirmary* [52] • SSSC workforce development[53]

[43] www.Moray.gov.uk/about/departments/JointCommissioningStrategyforOlderPeople.pdf
[44] www.ourMoray.org.uk/images/media/docs/soa/FinalMoraySOA2013-2023.pdf
[45] www.Morayadp.org.uk/docs/Moray_ADP_Strategy_-_Healthier_Happier_Safer.pdf
[46] www.nhsgrampian.org/grampianfoi/files/Item_1_2020_Vision.pdf
[47] www.hi-netgrampian.org/hinet/file/8477/item05.1DentalPlanFinalv7.doc
[48] www.nhsgrampian/traffic lights
[49] www.healthscotland.com/documents/24575.aspx
[50] www.scotpho.org.uk/comparative-health/health-inequalities-tools/intervention-tools/informing-investment-to-reduce-health-inequalities-iii
[51] www.scotland.gov.uk/Publications/2010/07/23153304/0
[52] www.healthcareimprovementscotland.org/our_work/governance_and_assurance/programme_resources/ari_review.aspx
[53] www.sssc.uk.com/workforce-development

Appendix 3 Suggested Further Reading

The King's Fund	The King's Fund report *Improving the Public's Health* The King's Fund report *Transforming our health care system* King's Fund report *Making our health and care systems fit for an ageing population*
	The Triple Aim model for health systems Referenced in the Scottish Government's Route map to the 2020 vision
	NHS Grampian Director of Public Health Report 2013/14
	Grampian Substance Misuse Health Needs Assessment
HSJ | serco COMMISSION on HOSPITAL CARE for FRAIL OLDER PEOPLE	Commission on Hospital Care for Frail Older People: Report
	House of Care model