

WHO GETS HOSPICE CARE?

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Changing demographics at Ardgowan Hospice, 2019–2024

BACKGROUND

Ardgowan Hospice has undergone significant change since 2019, with a new management team, medical staffing and initiatives designed to widen access to palliative care. To evaluate impact, full-year patient data from 2019 and 2024 was compared across inpatient and community services, analysing patient diagnosis, age, deprivation (SIMD), and ethnicity against local demographics.

The majority of deaths in Scottish hospices and specialist palliative care units continue to be due to cancer (86.7% in 2022/23).

By 2040, the number of people dying in Scotland with palliative care needs is projected to be 12% higher than 2021, with heart disease, dementia and reno-vascular disease the main drivers(1).

In Inverclyde, the leading cause of death in 2023 was ischaemic heart disease and dementia for males and females, respectively(2).



In Inverclyde, the population >75 years old is projected to increase 55% by 2043(3), suggesting the need to plan for a higher demand of palliative care services in the area, but also to consider the increased complexity of multi-morbidity in an ageing population.



44% of Inverclyde postcodes were amongst the most deprived 20% of data zones in Scotland (SIMD 1)(3), with people in the most deprived quintile more likely to die in hospital and less likely to die in a hospice or palliative care unit than those in the least deprived quintile.

OBJECTIVES

To analyse changes in patient demographics between 2019 and 2024 against local demographics to understand whether a new management team, medical staffing and initiatives designed to widen access to palliative care have been successful.

To consider the challenges / resources required to meet the needs of the Inverclyde population going forward.

METHOD

Full-year patient data, across inpatient and community services, for 2019 and 2024 was obtained from the electronic patient records system (Crosscare) and anonymised.

Demographic data was analysed, including: primary diagnosis; age of patient; deprivation and patient ethnicity (where available).

Deprivation was measured using the Scottish Index of Multiple Deprivation (SIMD). It is a relative measure of deprivation across 'data zones' (small geographical areas) in Scotland. Patient postcodes were matched to their SIMD quintile: postcodes in SIMD 1 lie in approximately the most deprived 20% of areas, whereas those in SIMD 5 lie in the least deprived 20%.

Demographic data for Inverclyde was obtained from the 'Inverclyde Council Strategic Needs Assessment' and used to compare against hospice demographics and identify future care needs.

RESULTS & DISCUSSION

Between 2019 and 2024:



Patient numbers increased by 21% in the community, and 29% in inpatient services.



Cancer remained the most common diagnosis across both settings.



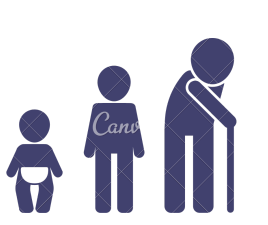
Community referrals for non-malignant diagnoses rose by 14%.



The proportion of hospice inpatients with non-malignant diagnoses remained low; 4% in 2019 and 6% in 2024.



Patients from SIMD 1 were the most frequently represented across both settings.



The majority of inpatients are >65 years across both years and settings.

Figure 1: Patient numbers by diagnosis

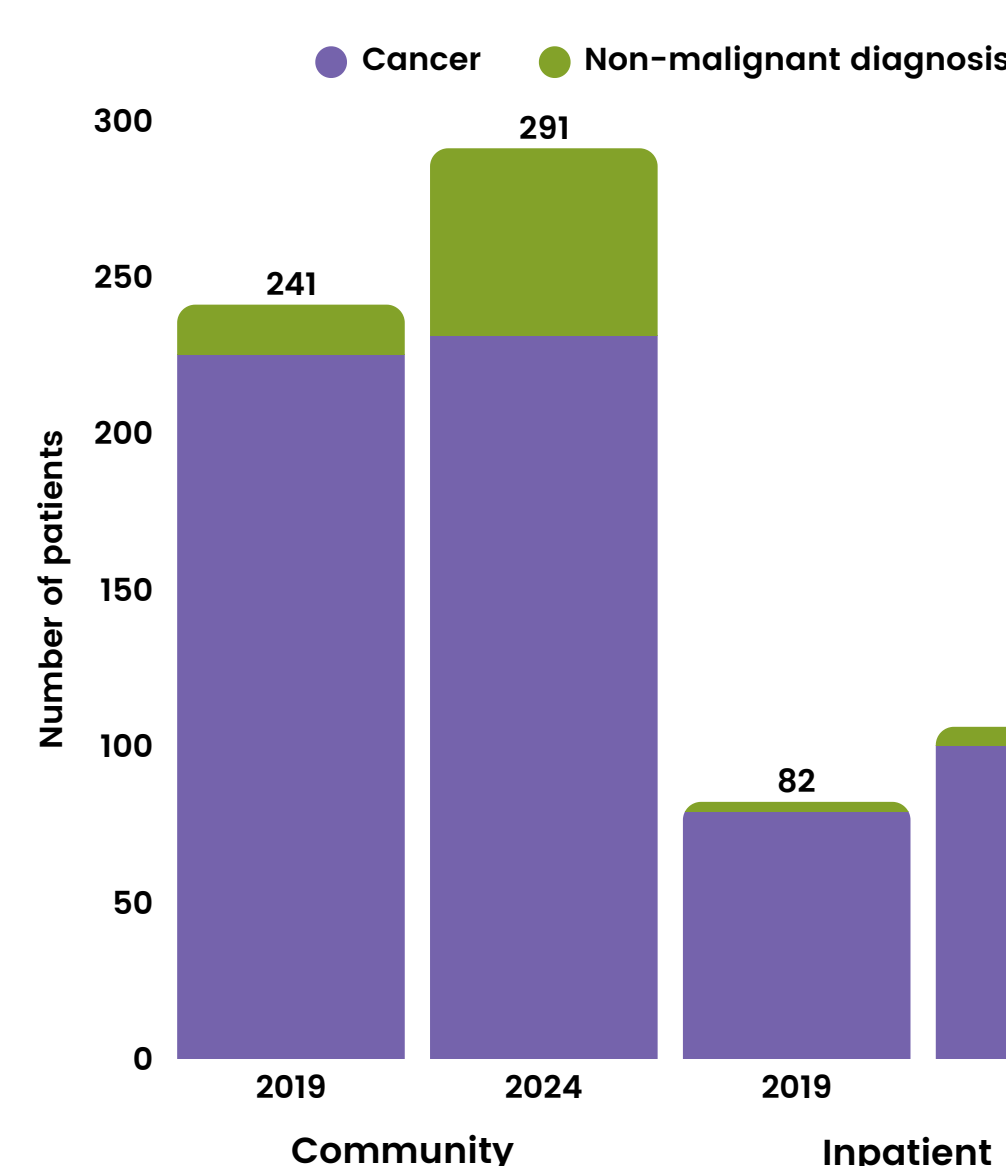


Figure 3: Patient split by SIMD quintile (% of total)

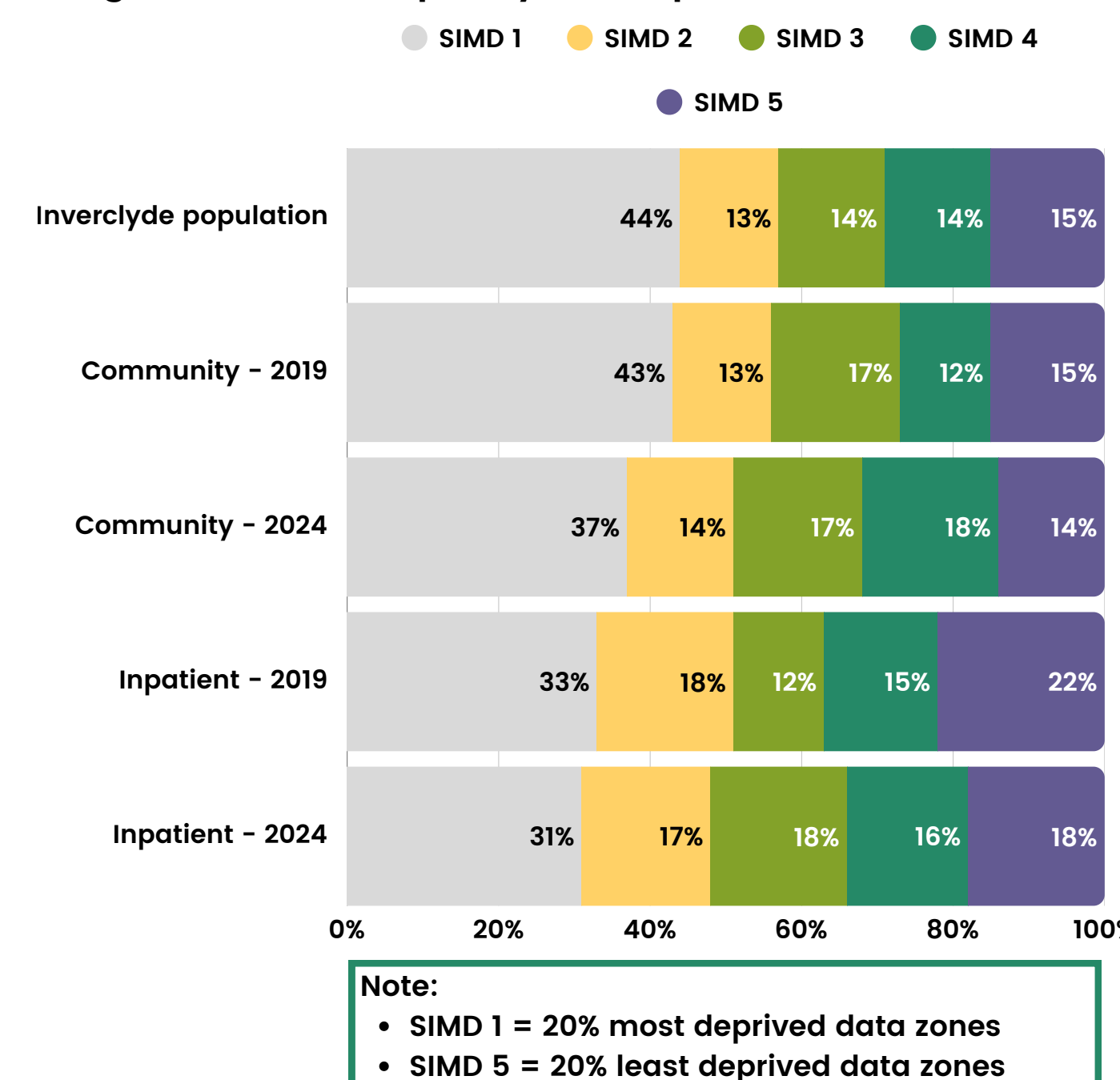
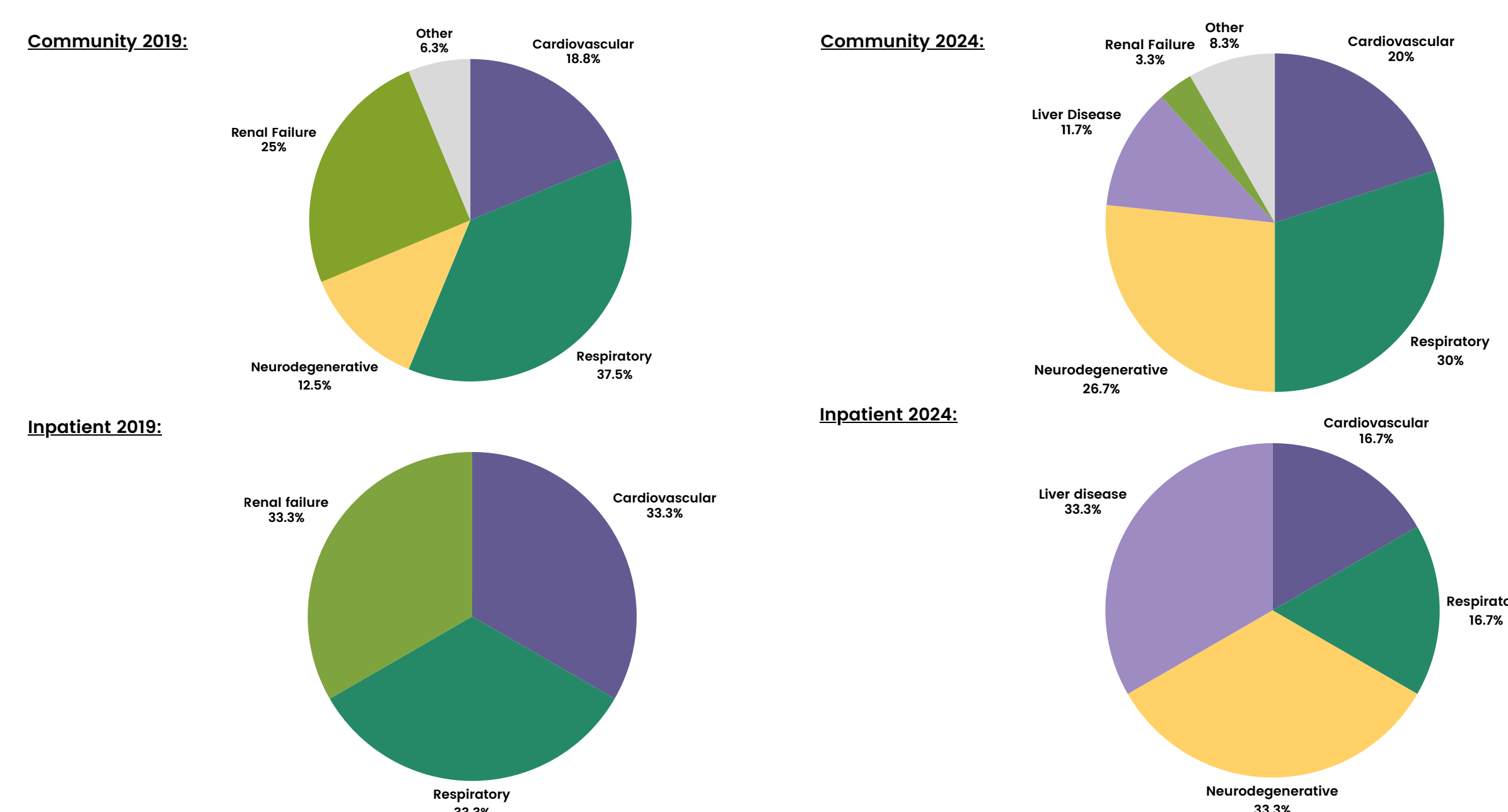


Figure 2: % Split of diagnoses within non-malignant total



As per Figure 1, the majority of patients had a diagnosis of cancer, however, community non-malignant referrals have increased by 14%.

Inpatient non-malignant diagnoses remained low: 4% in 2019 and 6% in 2024. Prognostic uncertainty and complex disease trajectories remain key challenges in managing non-malignant diagnoses and determining when palliative care involvement is appropriate.

Figure 2 shows the breakdown of non-malignant diagnoses. Respiratory, cardiovascular and neurodegenerative disease were the most frequently represented (in terms of absolute number) across both years.

Figure 3 shows that access to Ardgowan Hospice services by SIMD quintile was broadly in-line with the population split in Inverclyde. It was noted that the proportion of inpatients from SIMD 1 (2019: 33%, 2024: 31%) was less than the population split (44%). Higher hospital admissions, patient preference and barriers to access are all possible causes.

The majority of patients were >65 years across both years and settings. Notably, 30% of inpatients in 2019 and 2024 were <65 years, with younger patients often presenting with rarer, more aggressive disease, and requiring longer-term palliative care input.

Ethnicity data has not been routinely collected. Improved data collection going forward is necessary to facilitate an accurate comparison with the local demographic.

CONCLUSION & FUTURE CONSIDERATIONS

The results indicate that overall, there has been an increase in patient numbers between 2019 and 2024, and the proportion of non-malignant diagnoses in the community has increased. The patient split by SIMD quintile is broadly in line with the population split and the proportions have remained largely the same across years and settings. Due to limited ethnicity data, we were unable to draw any reliable conclusions.

The number of people requiring palliative care services with non-malignant diagnoses is projected to increase and they are currently underrepresented in Ardgowan Hospice. Are their needs already being met in the community / by specialist services, or do we need to implement strategies to meet the palliative care needs of these patients?

With the elderly population in Inverclyde set to increase, ensuring that Ardgowan Hospice has the capacity to meet the needs of more complex patients with multimorbidities is key.

The proportion of single-adult households in Inverclyde is projected to increase (43% of all households by 2028)(3), which may have implications for the social support available to an ageing population. Consideration should be made as to how this may impact their needs from a palliative care perspective.

Given a higher proportion of inpatients <65 years old, we must ensure that we are flexible in our approach in regards to their care and more adaptable in how we communicate.

It is important that we strive to meet the palliative care needs of the most deprived in our area by continuing initiatives to widen access and work alongside our community partners.

Improved collection of ethnicity data is required in order to fully understand our population, how it is changing and how we can engage with different communities to understand their needs.

REFERENCES

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