Understanding your Population

GP's at Deep End
Lunch and Learn 22/2/24

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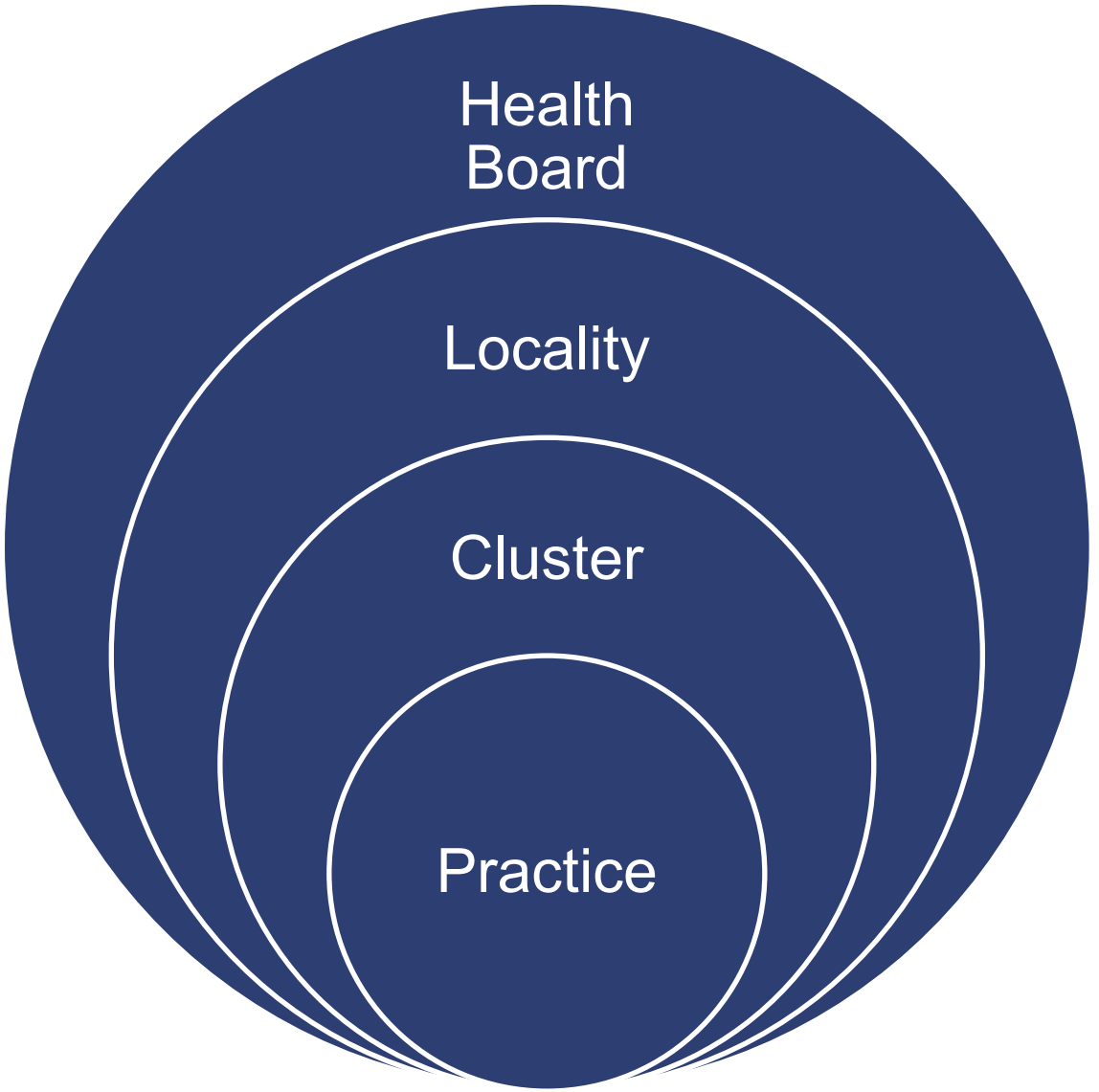
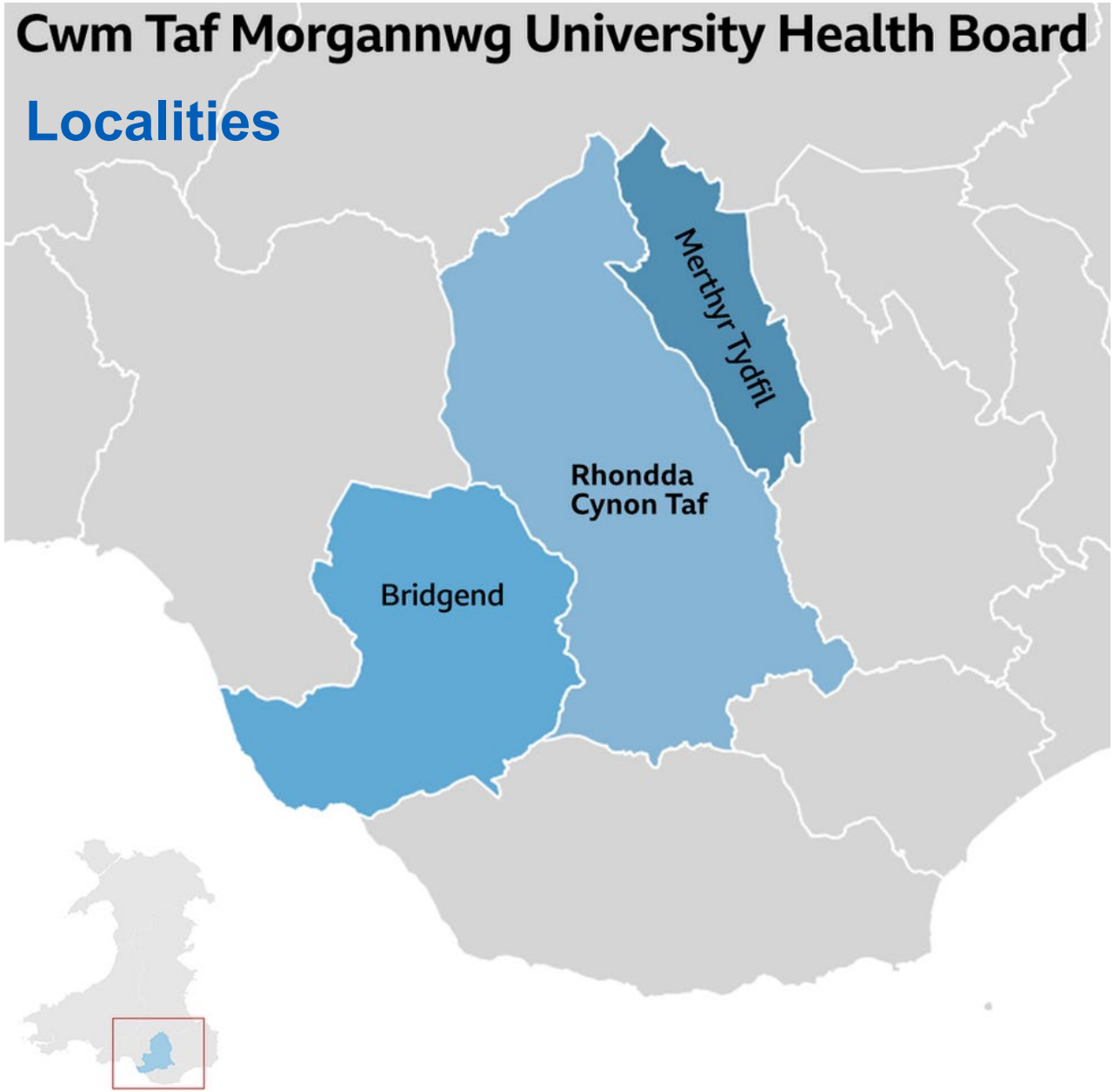
Content

- Your population
- Planning - use of data and intelligence
- Population Health Management

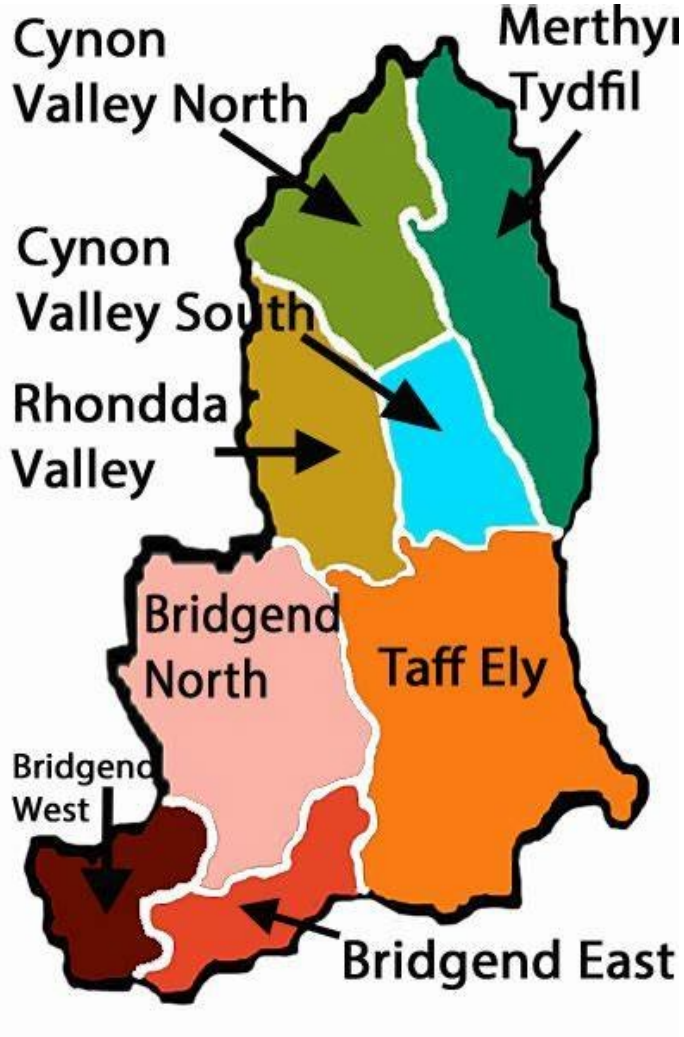
Your Population

Population of interest

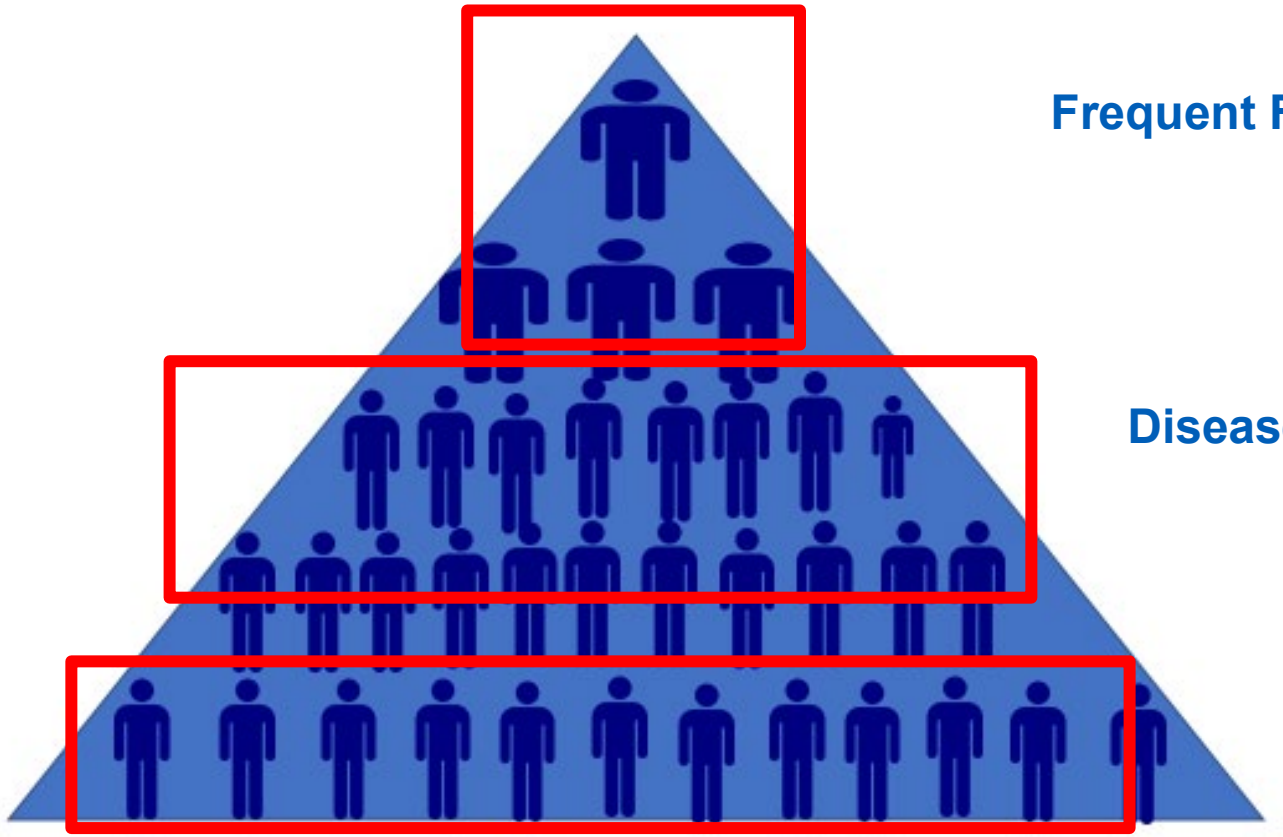




Primary Care Clusters



How well do you know your practice population?



Frequent Flyers

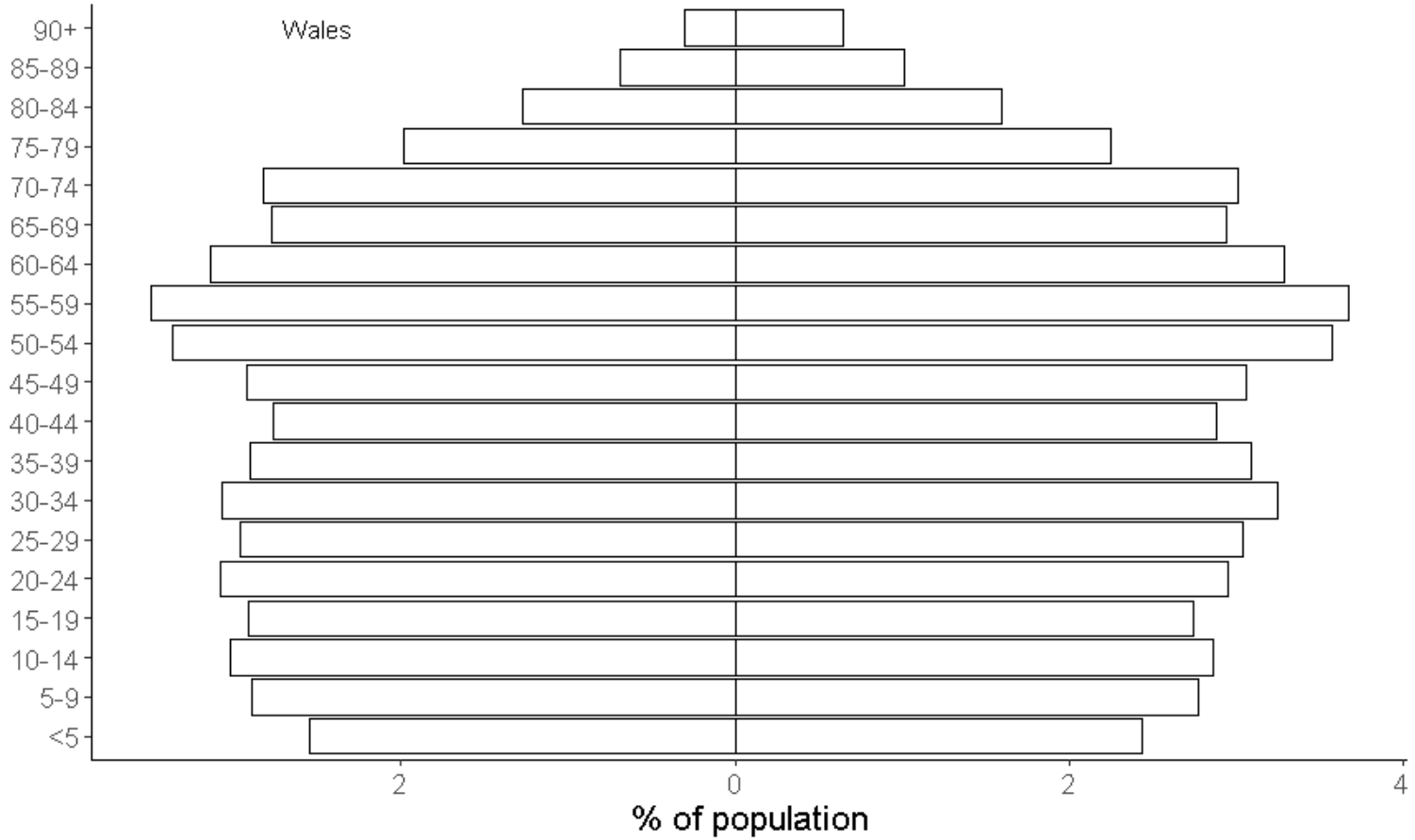
Disease Registers

Well population

What might we want to know about our population?

- Demographics (Age, sex)
- Area Deprivation
- Life expectancy/ Healthy Life Expectancy
- Chronic conditions – prevalence and management
- Lifestyles, Immunisation Status, Screening status
- Social Determinants e.g. education, housing
- Inequalities
- Community / Patient perspectives and Lived Experience

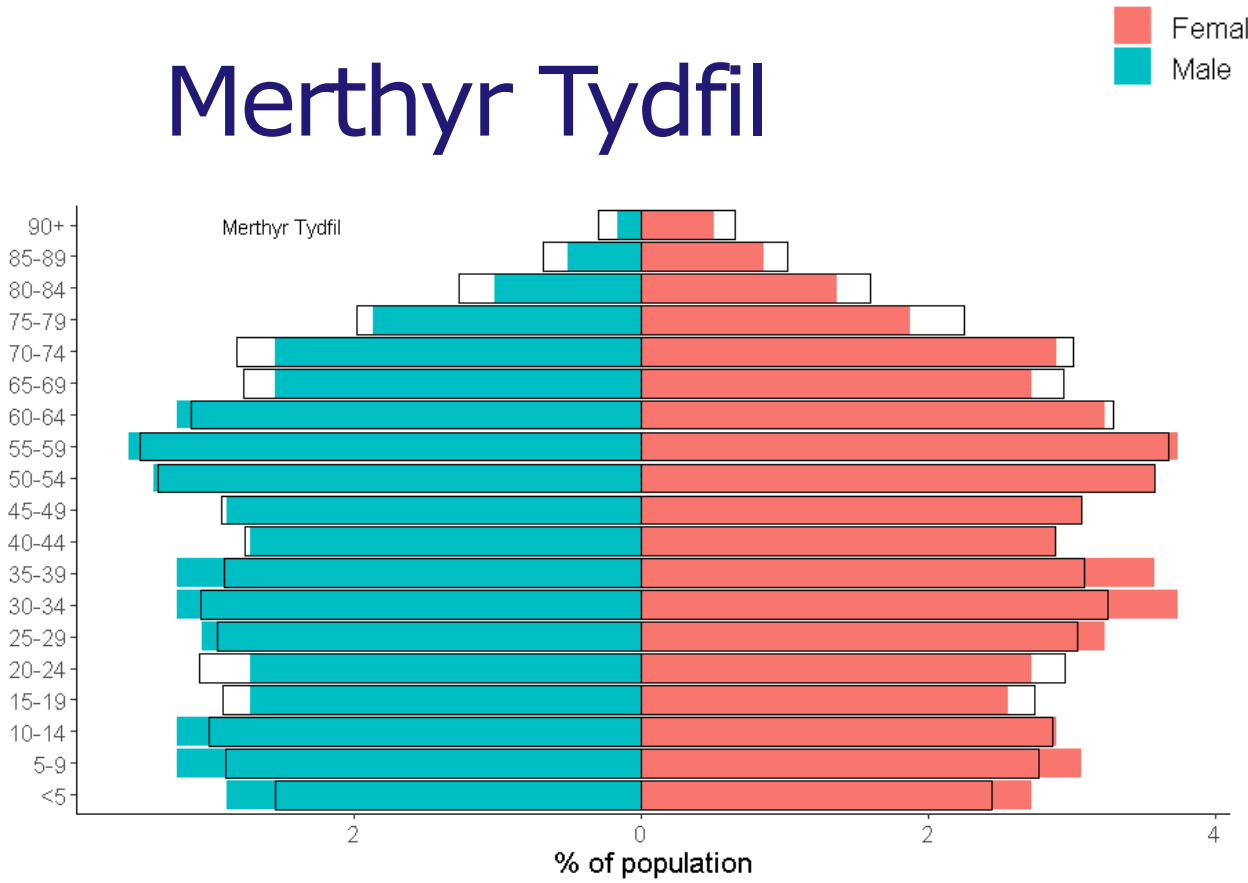
Population of Wales



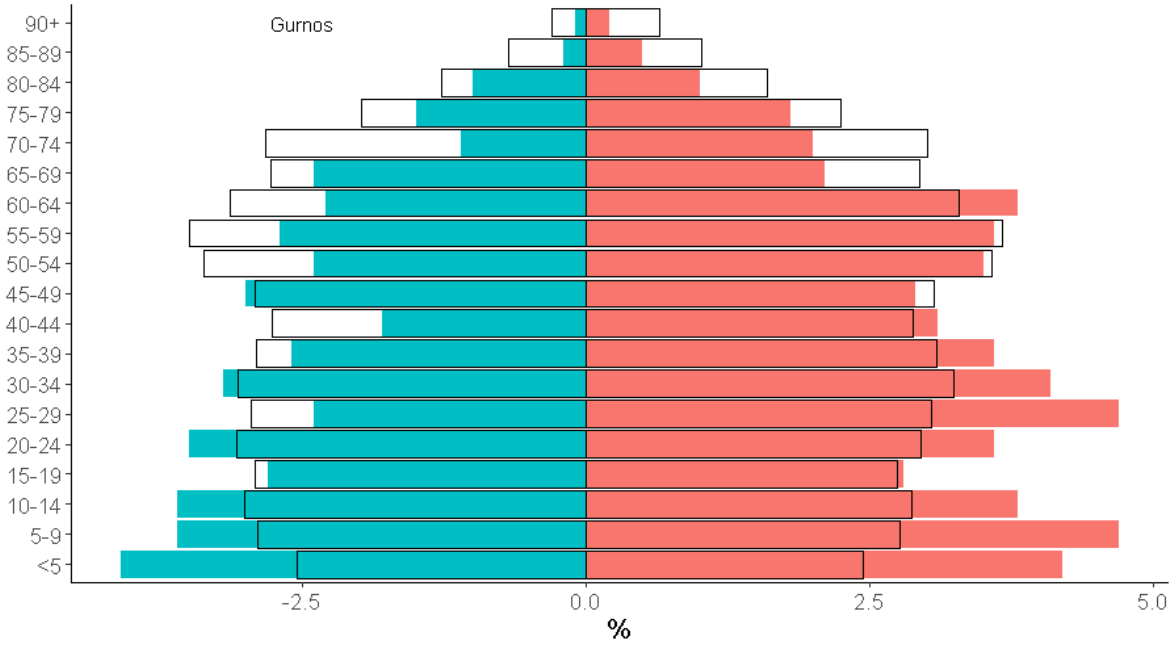
ONS, Census 2021 data

Population of

Merthyr Tydfil



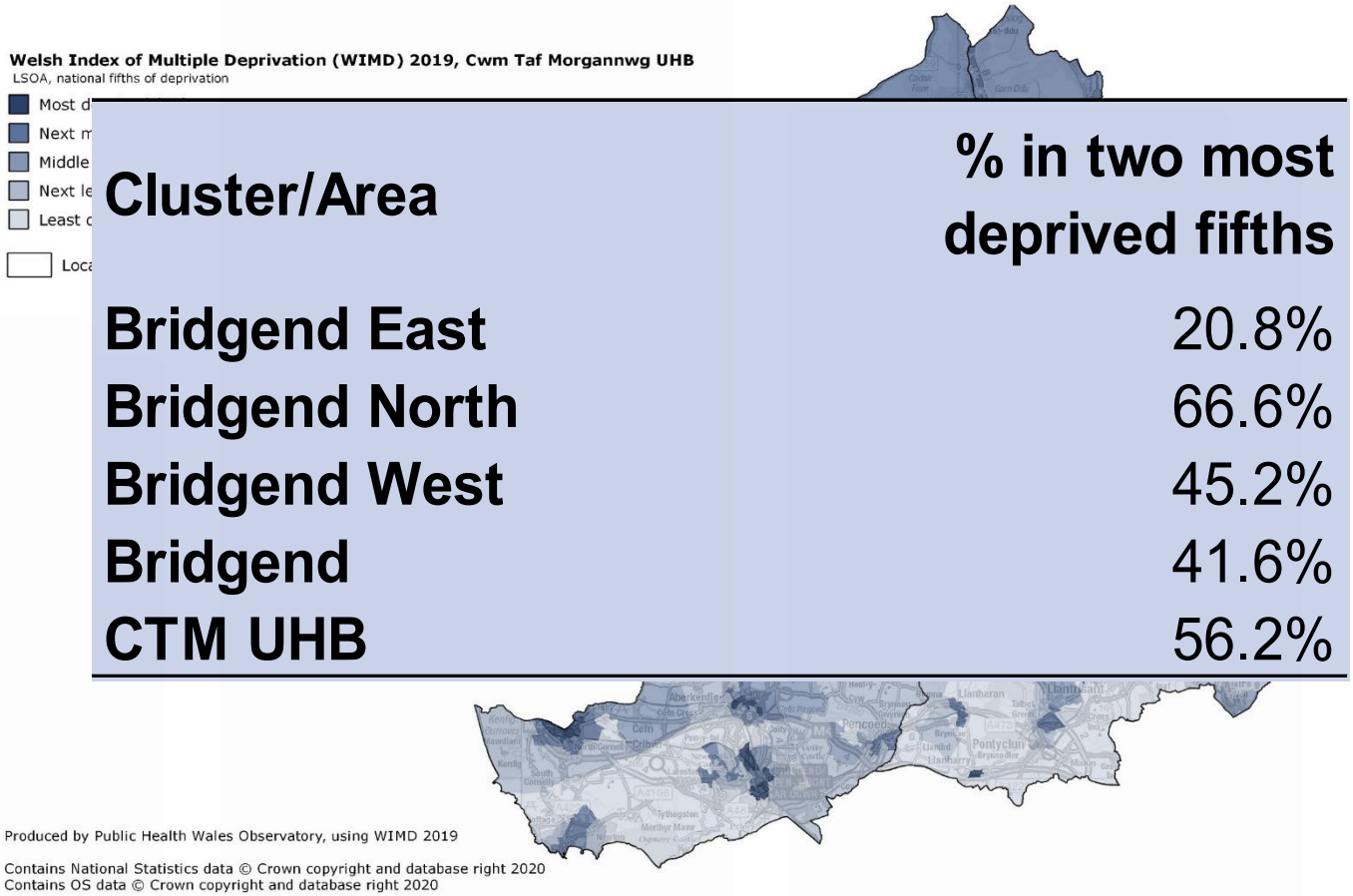
Gurnos



ONS, Census 2021 data, Small area estimates 2020

Deprivation

Local Authority /Area[1]	% in two most deprived fifths
Bridgend	41.6%
Merthyr Tydfil	67.9%
Rhondda Cynon Taf	62.7%
CTM UHB	**56.2%**



Cluster/Area	% in two most deprived fifths
Bridgend East	20.8%
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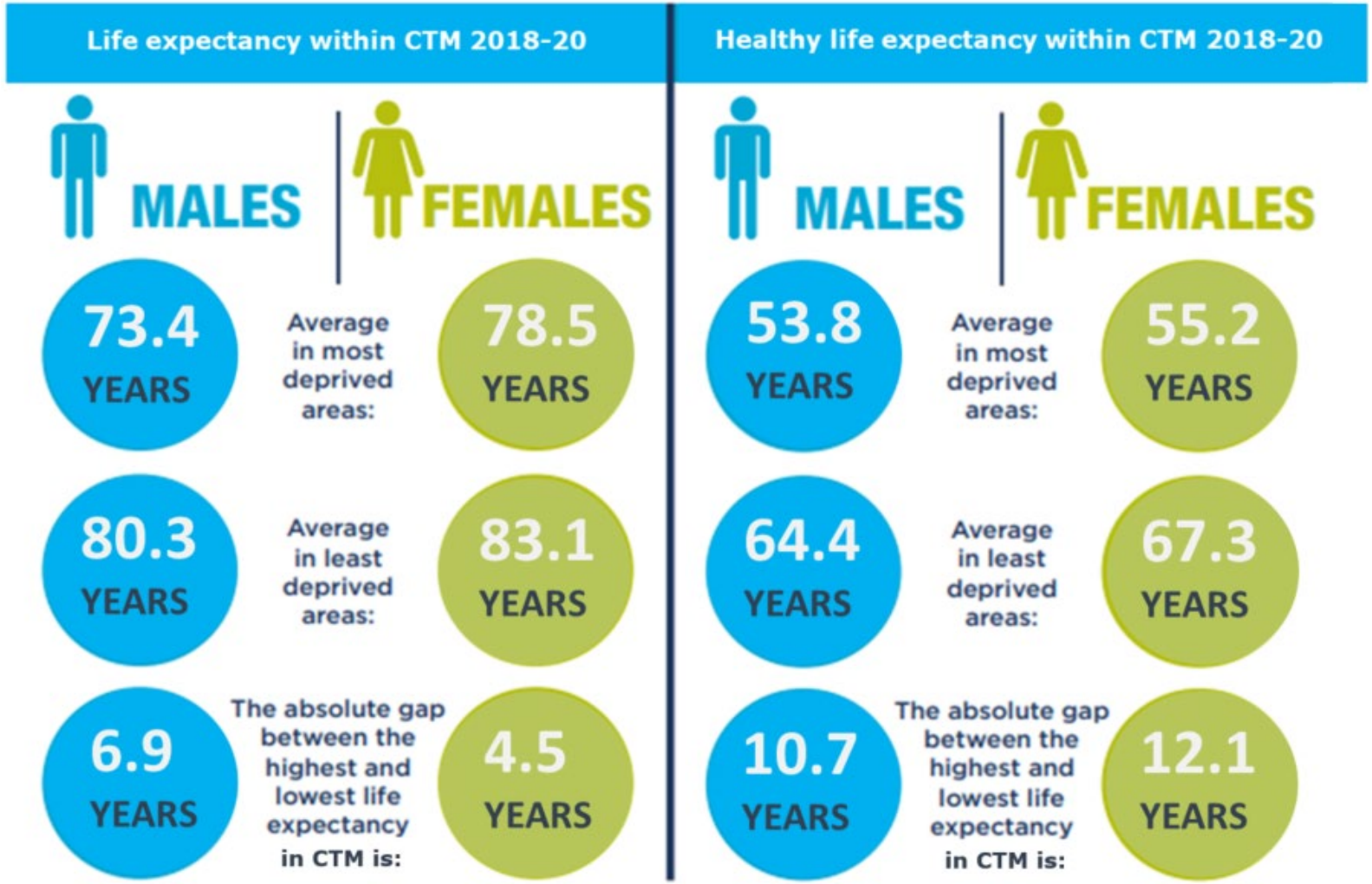
[1] Using data from the CTM UHB Population Segmentation dataset, 2021/22. 48/49 CTM practices included; [2] Deprivation Map produced by CTM LPHT using the Welsh Index of Multiple Deprivation (WIMD) map for Rhondda Cynon Tad, WIMD is available at wimd.gov.wales.

Inequality in Outcomes

Covid-19



National Survey for Wales

cwmtafmorgannwg.wales

Lifestyles and behaviours

% of adults who reported eating 5 or more portions of fruit & vegatables the previous day

Merthyr Tydfil: 15.1%
CTM: 21.6%
Wales: 24.3%

% of adults who reported being active for at least 150 minutes the previous week

Merthyr Tydfil: 39.6%
CTM: 41.7%
Wales: 53.2%

% of adults who reported being a current smoker

Merthyr Tydfil: 22.7%
CTM: 18.6%
Wales: 17.4%

Overweight and Obesity

Childhood overweight & obese (2018/19)[1]

Merthyr Tydfil: 35.4%

CTM UHB: 29.3%

Wales: 27.0%

Adult overweight and obese (2018/19 and 2019/20)[2]

Merthyr Tydfil: 62.4%

CTM UHB: 63.6%

Wales: 59.9%

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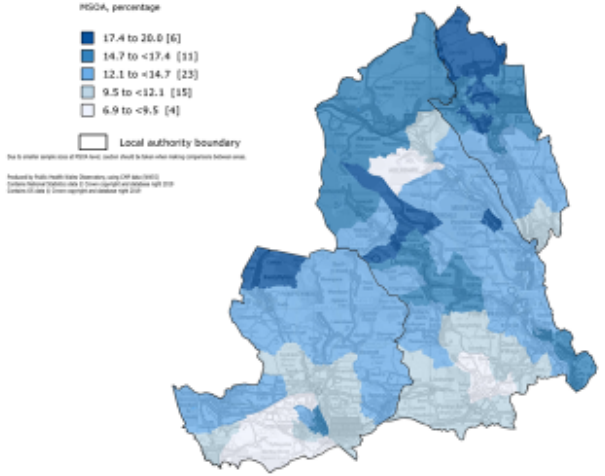
Percentage of children aged 4 to 5 years who are obese, Cwm Taf Morgannwg UHB, Child Measurement Programme for Wales 2013/14 - 2017/18



[1] Childhood overweight and obesity uses Child Measurement Program data 2021 (NWIS); [2] Adult overweight and obesity uses National Survey for Wales data 2020 (Welsh Government); [3] Map covers 5 years of data 2013/14-2017/18 and includes the percentage of children aged 4 to 5 years who are obese only.

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Infectious disease prevention

	Merthyr Tydfil	CTM UHB	Wales
Covid – 19 First Dose Administered	**80.3%**	84.28%	
Influenza Vaccination[2] in Children (2 and 3 year olds)	**38.7%**	40.8%	40.9%
MMR[3] (age 16)	**94.6% (MMR1) 93% (MMR2)**	96.6% (MMR1) 94% (MMR2)	94.7% (MMR1) 91.6% (MMR2)
Childhood vaccination[3] (up to date by age 4)	**84.8%**	86.1%	84.7%

([2]IVOR Tables; [3]COVER data – July-Sept 2023)

Cancer Incidence Rates

Cancer Incidence rates (per 100,000 population) 2017/2019[1]				
	Bowel	**Female Breast**	**Lung**	**Prostate**
Merthyr Tydfil	**79.4**	**123.9**	**105.9**	**224.1**
CTM UHB	77.4	164.7	92.4	223.4
Wales	74.1	165.0	77.1	194.4

Cancer Screening uptake

Screening rates 2019/2020[2]			
	Bowel	**Female Breast**	**Cervical**
Merthyr Tydfil	**59.1%**	**70.8%**	**70.5%**
CTM UHB	62.1%	73.3%	72.6%
Wales	61.5%	76.1%	73.2%
National Target	Not set	85%	85%

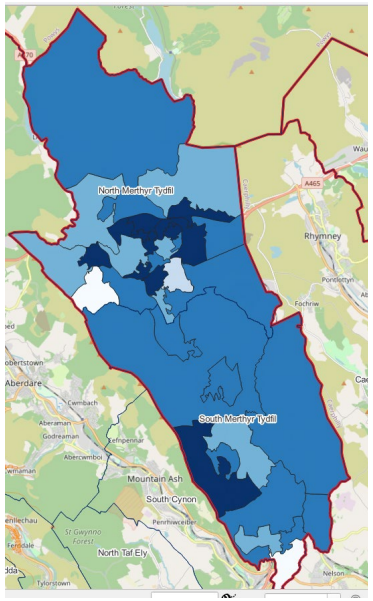
[1] Using National Statistics data for cancer incidence, produced by the Welsh Cancer Intelligence and Surveillance Unit (2022); [2] Public Health Wales NHS Trust (2021) Screening Programmes Statistical Reports [online]. phw.nhs.wales/services-and-teams/screening/. Accessed on: 21/06/2022

Clinical risk and chronic conditions[1]

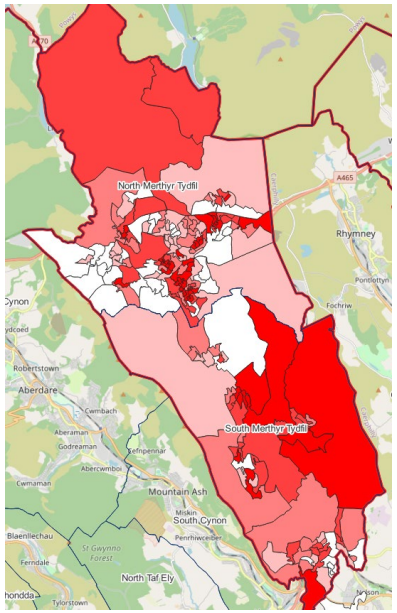
	Merthyr North	Merthyr South	Merthyr Tydfil	CTM UHB
Average Number of Chronic Conditions	1.64	1.22	1.46	1.45
Anxiety/ Depression	21.4%	18.5%	20.1%	20.1%
Asthma	11.9%	11.1%	11.6%	12.8%
COPD	3.5%	2.1%	2.9%	2.7%
Hypertension	17.9%	15.4%	16.8%	16.9%
Diabetes	7.5%	6.6%	7.1%	7.1%

[1] Chronic conditions based on coded diagnosis in primary and secondary care data between 2001 and Feb 2022 using Johns Hopkins ACG system (results similar to QOF coding) and record-linked data from the SAIL databank. 48 out of 49 practices included in CTM.

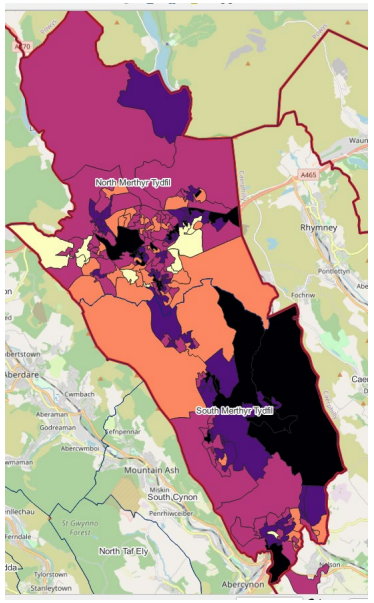
Inequalities: energy use and housing quality



Deprivation by LSOA



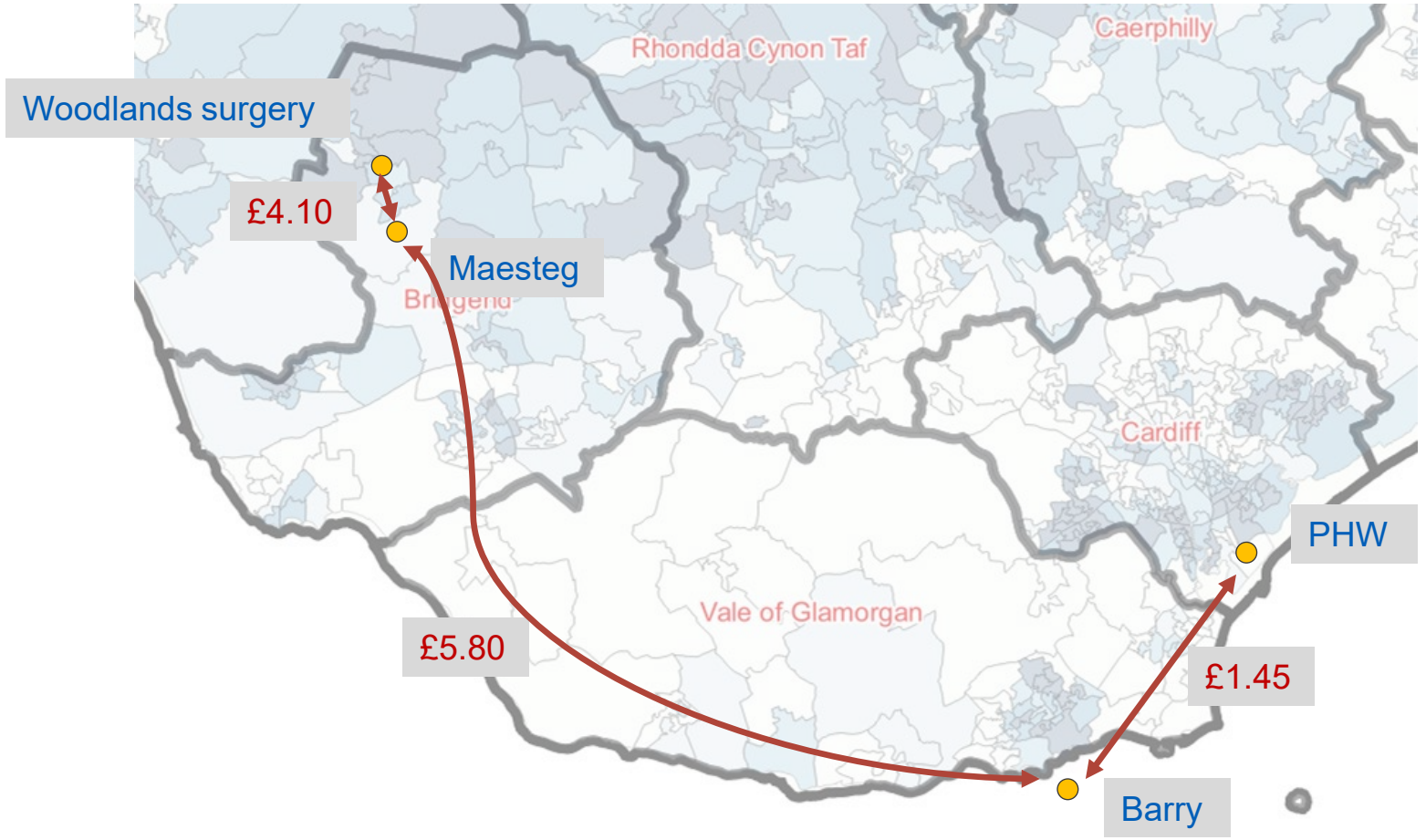
Energy usage by Output area



Difference between current and potential use

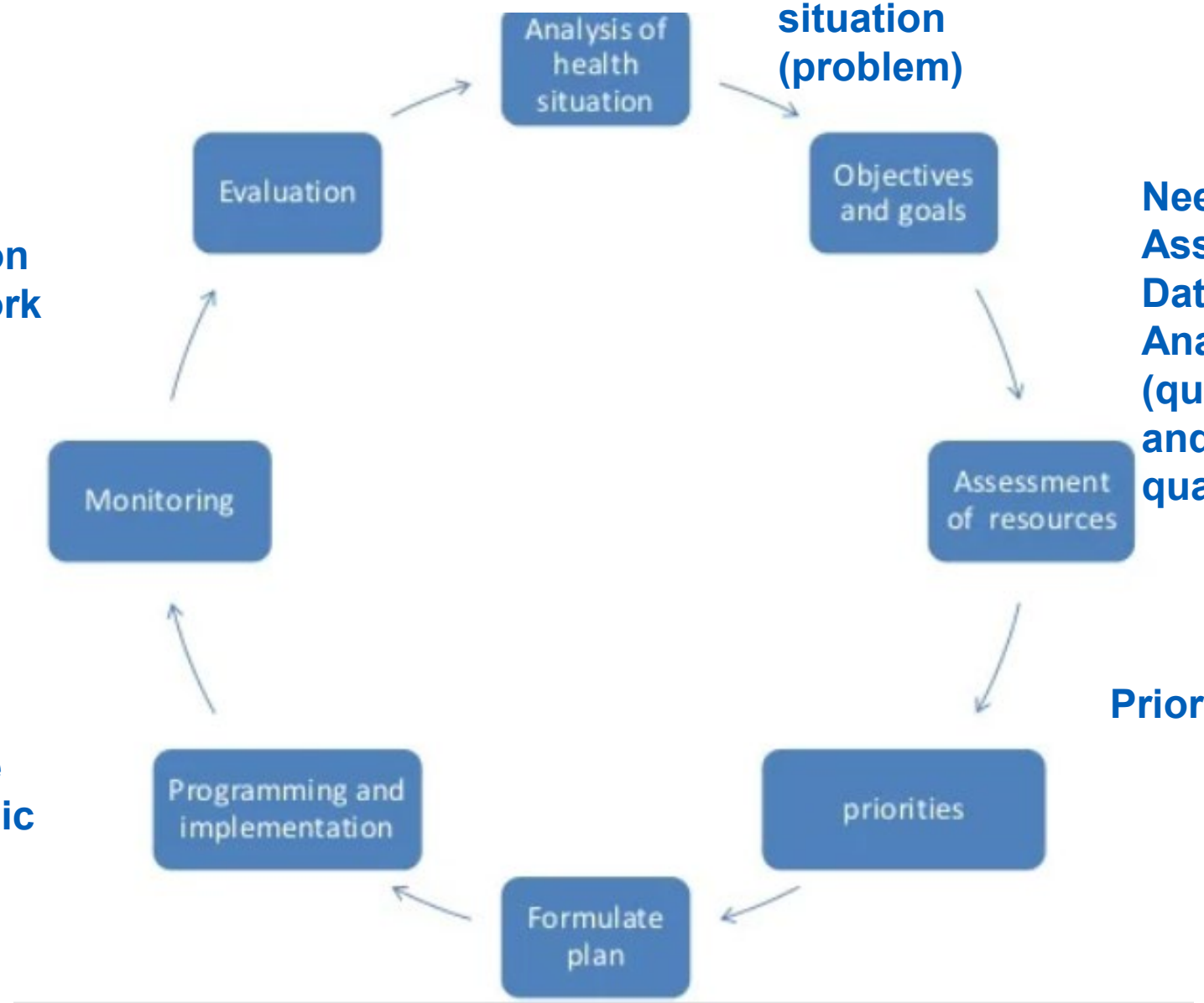
Deprivation, energy usage and potential energy usage reduction,
Welsh Index of Multiple Deprivation 2019 and Bridgend, Nov 2022 EPC data.
Darker shading = higher value in each case

Inequalities: transport



Planning and Use of data and Intelligence

Planning Cycle



Identify the situation (problem)

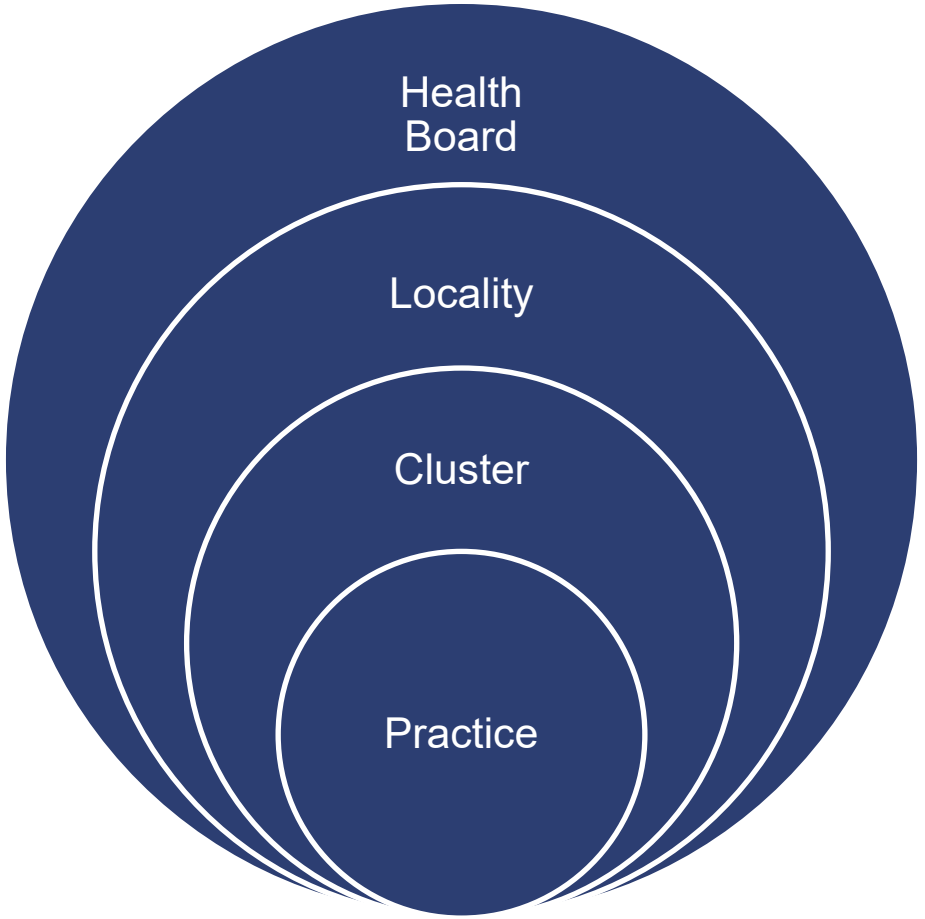
Needs Assessment; Data and Analyses (quantitative and qualitative

Prioritisation

Evidence base, logic model

Evaluation Framework

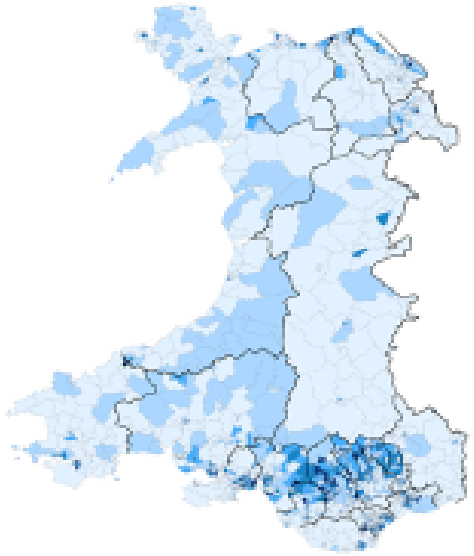
Planning takes place at all levels, but what data is available……



Considerations

- Data granularity
- Registered vs resident population
- Estimates
- Time Period
- Survey data

Office National Statistics Small area Data



3.1 million
people
in Wales

1,909
small areas
Lower-layer Super Output Areas (LSOAs)

Between 1,000 and 3,000 people
in each small area

Sources of Data

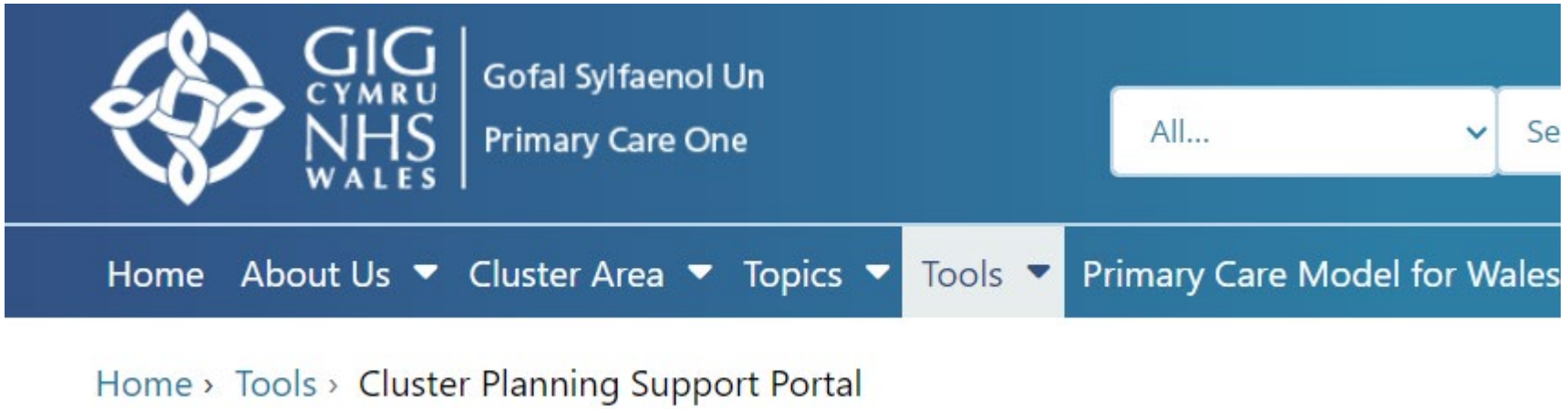
Practice Data
Clinical system, Audit+, Prescribing Data

Primary Care Information Portal

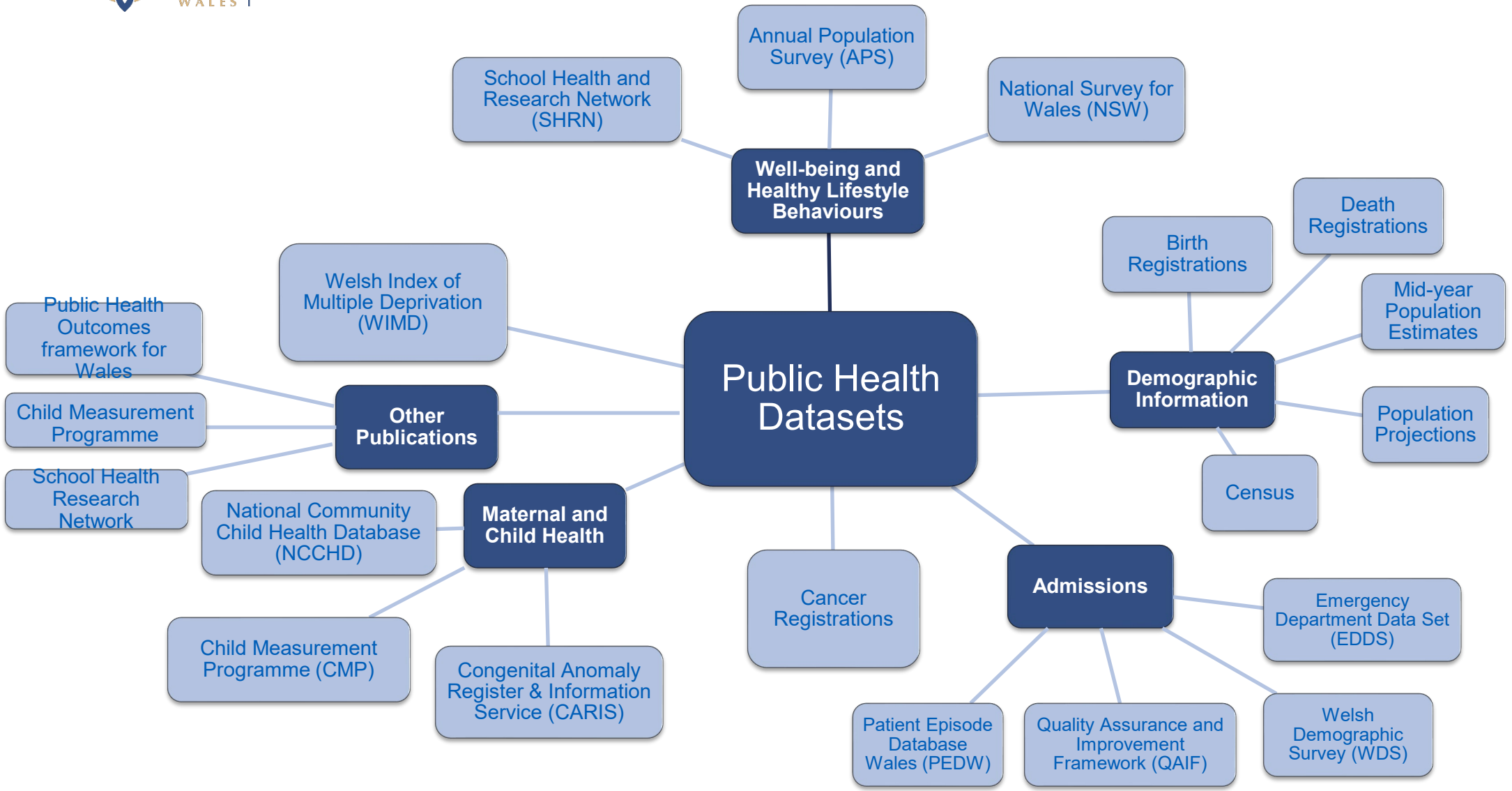
Health Board
Primary Care Team, Cluster Manager, Public Health Team

StatsWales
Workforce, population, prescribing

Public Health Wales
Primary Care Cluster Dashboard, Profiles, Cancer Stats, Misc Publications



Wider datasets available to use



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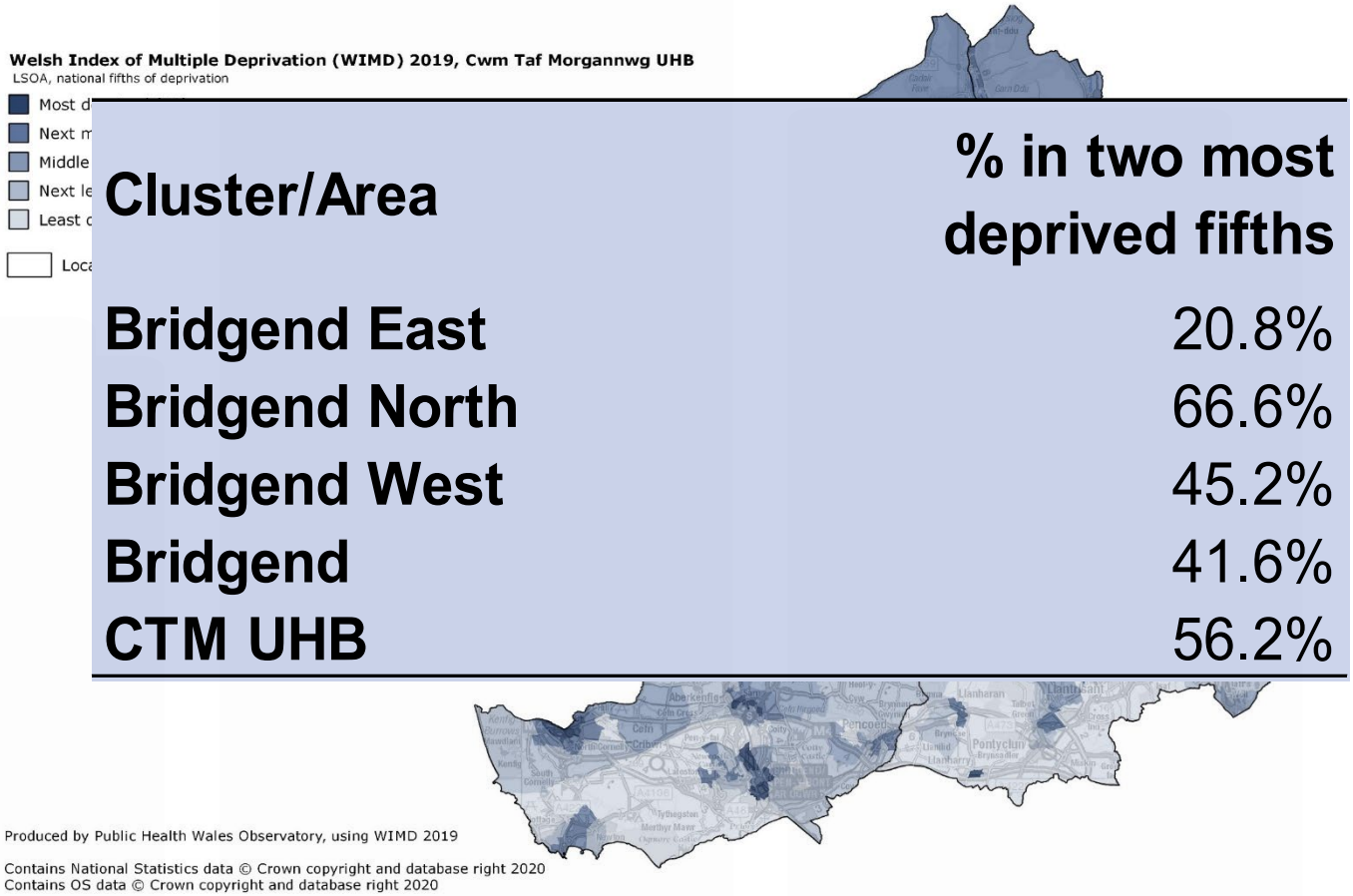

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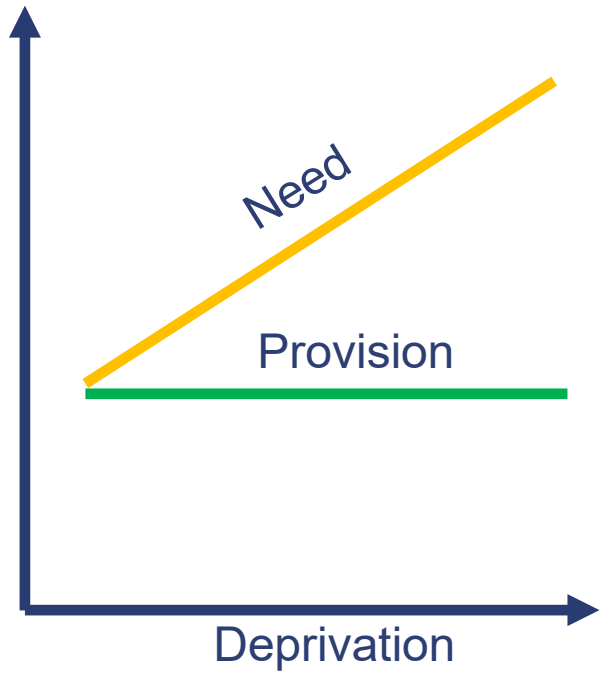
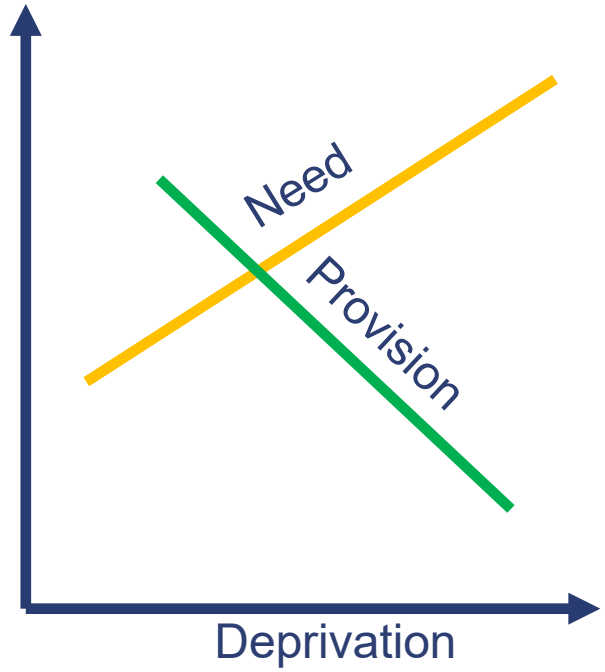
Deprivation and Service Provision

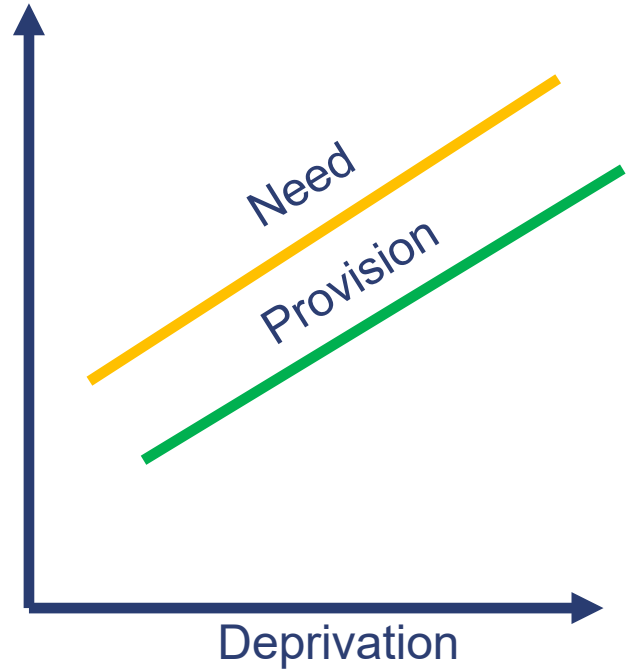
Equality, inverse care and proportionate universalism



Equality



Inverse care law



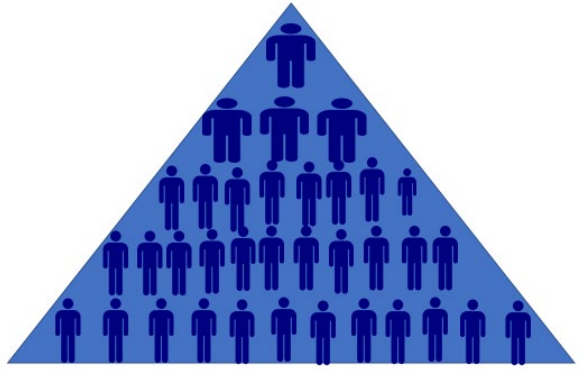
Proportionate universalism

Population Health Management

Definitions

Public Health

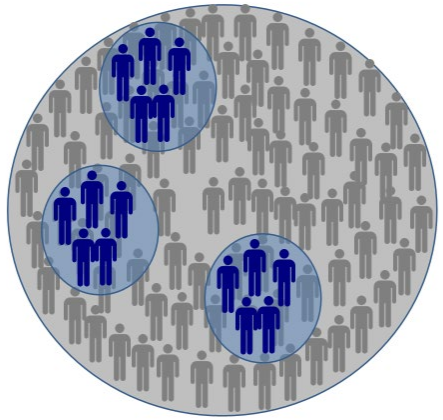
Is the science and art of preventing disease, prolonging life and promoting health and wellbeing, through the organised efforts of society.



Population Health

Improves the health of an entire population.

It is about improving the physical and mental health outcomes and wellbeing of people, whilst reducing health inequalities within and across the population. It includes action to reduce the occurrence of ill-health, including addressing wider determinants of health, delivering social justice and working with communities.



Population Health Management

Improves population health by data-driven planning and delivery of proactive care to achieve maximum impact for the health and wellbeing of the population.

Linked datasets are used to segment, stratify and model the local 'at risk' and 'rising risk' cohorts that in turn are used to design, target and personalise interventions to deliver proactive care and proportionate universalism to reduce health inequalities.

Value Based Healthcare

Support to build core PHM capabilities

Innovation

Collective action where the health and care system share a cohesive population health approach to working together to improve health and wellbeing.

- **System leadership** with representatives from all parts of the health and care system and strategic partners with a **shared vision** and a **common language**
- Becoming a **population health organisation** from the ground up, ensuring prevention as key to the health of future generations.
- **Population needs prioritised over organisational agendas**: decision-makers are committed to empowering communities through listening, discussing, and working with communities to allocate resource and design care collaboratively
- Using **whole population data** to drive planning to improve the health and wellbeing for the local people now and in the future.

Intelligence

System-wide intelligence capability to understand the needs of the population and generate actionable insight.

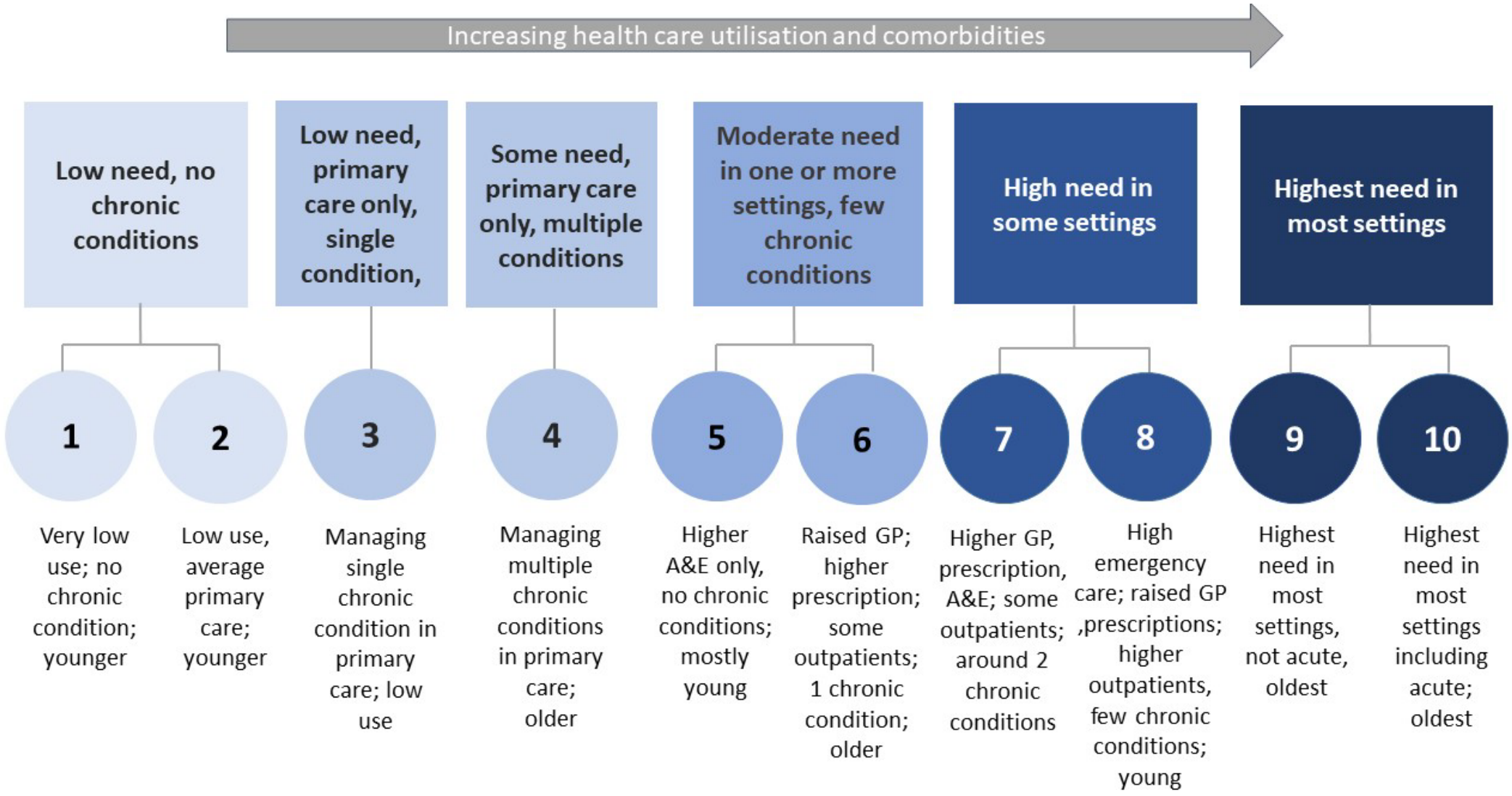
- **Linked, person-level datasets** for the whole population to enable **segmentation, risk stratification**, and high-quality analysis to develop **information for action** (yet a lack of data should not prevent action)
- **Advanced analytical tools** and software, and system-wide multi-disciplinary analytical and improvement teams

Implementation

Using intelligence to inform new service models improve care quality, efficiency, and equity.

- **Building capability and capacity**, growing the expertise in public health, and developing **PHM champions**
- **Data-informed decision making** to drive care coordination and proactive personalised care
- **Co-production**: build capacity for meaningful stakeholder engagement, where the public, patients, and healthcare professionals are involved in decision-making. Ensure lived experiences inform system and intervention design.
- **Focus on prevention and community well-being**, using an asset-based approach, social prescribing, social value projects, and principles of Making Every Contact Count
- Incentives alignment using a **value-based healthcare approach**
- Ongoing **monitoring, evaluation, and improvement** to ensure interventions remain appropriate and are adaptable to changes in the population or overarching context. Impact should be evaluated and learning shared to form a **"learning health system"**

CTM UHB data-driven segments, 2019 baseline



PHM feasibility project: Winter pressure/fuel poverty in Taff Ely cluster

Aim: Improve outcomes for patients at highest risk of adverse effects of fuel poverty this winter

Data: Use combination of clinical records and PSRS data (deprivation data, chronic conditions, segments and risk strata)

Target population: Those who live in areas of highest deprivation in Taff Ely aged over 65 and any of:

- CVD/stroke/TIA,
- respiratory disease (COPD/asthma)
- mental health issues (mild/severe)

- Split into frail/not frail
- Prioritised by risk groups and data-driven segments

Intervention: Proactive phone call and offer of a 'what matters most' conversation. Then referral to appropriate services - frailty or social prescribing service

Evaluation: outcomes include GP contacts, emergency hospital admissions or A&E attendance, patient/staff feedback and evaluation of use of PSRS data

Winter pressure/fuel poverty in Taff Ely cluster – case study 1

Patient A

Identification

- Proactive.
- Segmentation Case-find.
- Identified from 65+ 20% Frailty 3 Conditions list.
- EFI Mild.

Background

- Lives alone
- Worried about the cost of living, has Cancer and many appointments, worried about keeping car to attend appointments
- Worries about being able to afford bills at home.
- States had previous support offered but never been eligible

Care Planning

- Referral to NEST warmer home scheme: supported provided with tips to reduce fuel bills and keeping home warm.
- Blue Badge application information provided
- Information of local warm hubs in community setting. Doesn't feel needs any further intervention at the moment but happy for local information to consider further.

Follow up

- Following input and guidance has reduced fuel bills and has been able to keep car on the road to be able to attend important health appointments, remains independent.
- Has contact details and connections now made for future reference.
- Feels more confident in knowing services are available for help when needed.

Feedback

- Thankful for input, …."making contact with referred services has been very useful. I can still keep my car and attend appointments for my health. And I know where to go in the future if I need anything more"

In Summary - What can we do?

- Understand our population in relation to our issues
  - Scale: CTM? Merthyr Tydfil? North/ South? Practice?
  - Use data effectively
  - Listen to what our communities are telling us
- Develop and enhance partnerships to deliver across the system
  - Understand needs in relation to services
  - Leverage capacity for co-operation
- Target interventions where we have capacity to make a difference
  - Data driven understanding of population risks
  - Development in partnership across system, co-production with community
  - Evaluate, refine and scale

Diolch

Thank You

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