Primary Care Needs Assessment tool: indicator review

Google Chrome is advised to ensure this page displays/ functions as intended.

ⓘ You are now reviewing the PCNA indicator(s) for: **Population**

ⓘ **Caution**: The information on this page is provided for testing purposes and may be subject to amendment. It may contain errors or not be fully reflective of consensus public health advice or relevant services, therefore should only be used with care.

Strategic context

ⓘ Consider the national strategic context for prioritising improvement action in this area (in conjunction with your health board's IMTP and Regional Partnership Board's Area Plan):

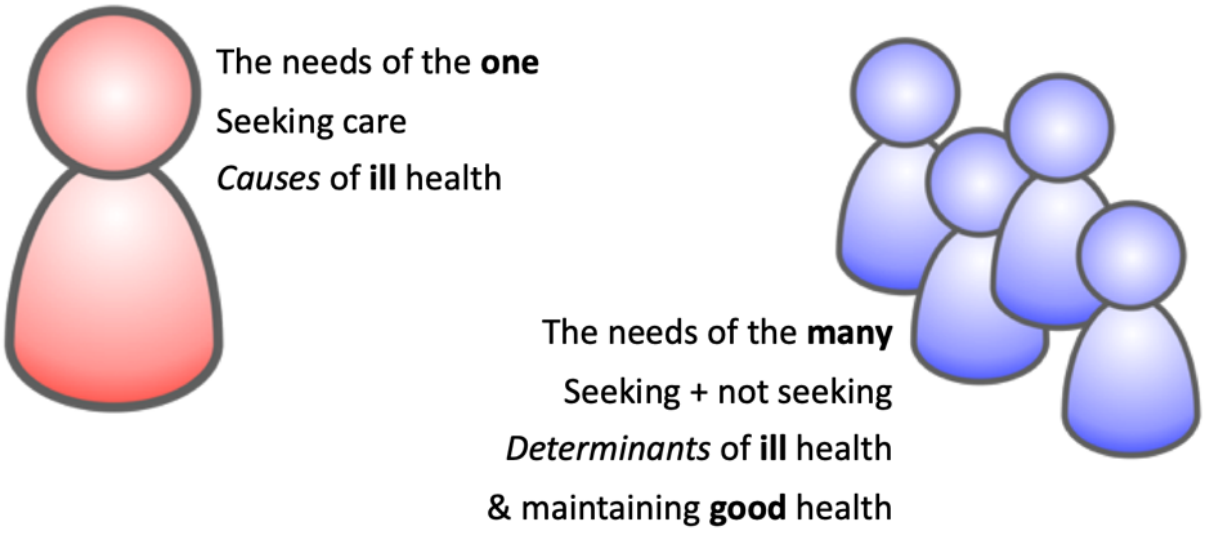
- Demography describes how a population is made up in terms of characteristics such as age, sex and ethnicity. It may also look at characteristics such as all-cause mortality rate, fertility rate, relative deprivation by small area geography (see POP-003) and overarching measures of (and inequalities in) population health status, such as life expectancy (see POP-002).
- Population size and age banding are major influences on demand for health and social care services, hence local service planning should reflect local population characteristics (as well as care needs). Pilot work in Cwm Taf highlights that multi-morbidity is more relevant than age as the key driver of cost.
- Population estimates based on residence vary from those based on GP registration for a variety of reasons (link); analysis carried out in England shows excess GP registrations compared to resident population projection for working aged people (link). Furthermore, clusters in Wales are not geographic units, whereas the Lower Layer Super Output Area (LSOAs) upon which resident population estimates are based are—so there will never be full concordance.

▼ ⓘ Tell me about: Needs

- In the context of needs assessment, **need** can be thought of as "capacity to benefit" from, rather than **demand** for or **supply** of, health and well-being services. The ideal is a situation in which need, demand and supply are balanced.
- Meeting the health and well-being needs of **individuals** is different from planning to meet the health and well-being needs of **populations**, as the needs of an individual may differ from those of the local population in which they live.
- Providing clinical care involves an important advocacy role in which the needs of the individual

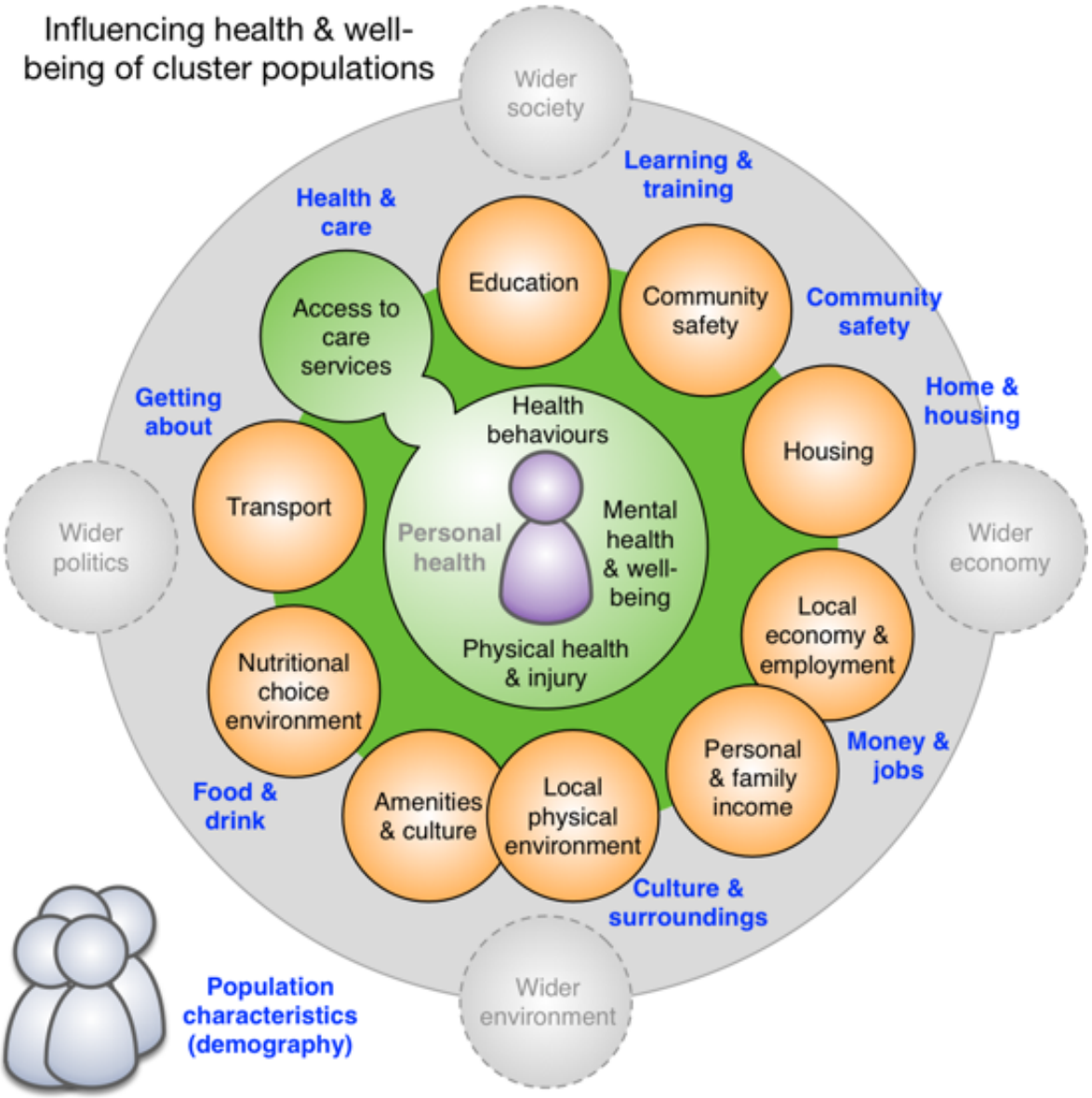
patient in front of the clinician are paramount. Care is most often given only to those who seek it, and attention tends to focus on addressing what are perceived to be the directly-attributable causes of that patient's state of ill health.

- Planning for the care of populations requires taking account of much broader needs, some of which may be rarely encountered within a typical clinical consultation—or so prevalent that they are not the primary reason for attendance, and may be overlooked. As not all of the population actively seek care, it involves reaching segments who have needs that may be hidden. Emphasis is given to understanding and influencing what determines the health of populations (see determinants, below) in terms of both what makes groups of people ill *and* what keeps them well.



▼ ⓘ Tell me about: Determinants of health

- The **determinants** of health are broader, population-level influences on health and well-being (as opposed to the **causes** of ill health, which tend to be visible on an individual basis).
- The **wider** determinants of health are often described as the 'causes of the causes'—they generally reflect national conditions (grey in the diagram below) and include the broad economic, social, environmental and political factors that ultimately determine the health of whole populations.
- It can be helpful to describe **intermediate** determinants of health—these are the things that can be more readily influenced or modified through partnership action at local authority or health board level (orange in the diagram).
- Personal health status (influenced by health behaviours, mental health and well-being, physical health and injury) is closely linked to access to health and care services—a relationship shown in green in the diagram—but also to other intermediate determinants.
- Clusters should appreciate how other influences shape health and care on their patch, because the **unjust distribution** of determinants of health (e.g. by deprivation; see POP-003) is manifest as inequality in outcomes (e.g. gap in life/ healthy life expectancy; see POP-002).



STEP B

Improvement actions for GP practice cluster members

ⓘ Consider which of the following actions could be taken forward:

▼ **Consider the service planning implications of current basic demographics**

- Public Health Wales have very limited access to primary care data; the PCNA tool cannot provide a comprehensive demographic breakdown of registered population by cluster.
- Aggregate GP practice lists for a combined picture of the cluster age and sex profile.
- Anticipate current demand for local health and care services by making assumptions based upon the resident population profile, as outlined below under wider cluster actions.

▼ **Consider the service planning implications of future basic demographics**

- Population projections are not available based on registration with a GP.
- Anticipate future demand for local health and care services by making assumptions based upon the resident population profile, as outlined below under wider cluster actions.

▼ **Consider obtaining more advanced cluster population profiles**

- Aggregate GP practice lists for a combined picture of additional population characteristics of local interest. For example, to identify specific groups of vulnerable persons, or others who may benefit from services commissioned or provided at the cluster level.
- Segmentation tools that permit risk stratification (adjusted for case mix) can provide much richer intelligence on care needs and patterns of resource utilisation for particular patient cohorts than is provided through traditional population profiling; such a tool is being evaluated within Cwm Taf UHB.

Improvement actions for wider cluster members

ⓘ Consider which of the following actions could be taken forward:

▼ **Consider the service planning implications of current basic demographics**

- Basic population profiles are available for resident populations (in the PCNA tool initial release, only age banding is provided at health board and local authority level; data are available to LSOA level).
- *Demography 2016* (PHW 2016; link) is based on the 2011 Census (next due 2021) and indicates that in 2014, 1 in 5 Welsh residents were aged over 65 years (20%), 6 in every 10 (62%) were of working age (16 to 64 years) and nearly 1 in 5 (18%) were aged under 16.
- A total population count provides a denominator that can be used with expected incidence rates or prevalence proportions (e.g. if asthma prevalence is 12% in the Welsh population, multiply by cluster list size to estimate total persons with asthma *expected* to need care locally; compare this number with the *measured* count of persons with a coded diagnosis of asthma).
- Population age bands can be used to estimate an expected frequency of health and well-being needs across the life course. For example, the local emphasis may vary between health issues among children (including pregnancy) e.g. exposure to adverse childhood experiences (ACEs); young people e.g. self-harming; people of working age e.g. stress/ anxiety; and among older people e.g. frailty.

- Population counts by sex can help determine the size of target population for planning a sex-specific intervention e.g. breast screening promotion (especially in combination with age band). Sex also helps predict the risk of some health events, such as suicides.
- Population counts by ethnicity can help estimate influences on the overall cluster prevalence of some health conditions (e.g. Is diabetes at the level expected—and if not why not?), gauge potential language requirements and other considerations for ensuring culturally-appropriate access to health information, and are a basis for exploring potential inequalities in access to or outcomes from health care.
- A measure of rurality can help identify a population cohort that experience certain health challenges, such as access to hospital-based services.

▼ **Consider the service planning implications of future basic demographics**

- Demand for healthcare varies over time and in addition to reflecting general population characteristics, it can also reflect changes in condition prevalence or management outcomes. Population projections are widely used in relation to determinants of health, such as housing, transport and education.
- Population projections are available in PCNA for resident populations to local authority level; these use the Census as a baseline and allow for mortality, fertility and migration to predict future demographics. The longer the term of the projection, the less reliable it is likely to be.
- *Demography 2016* (PHW 2016; link) is based on the 2011 Census (next due 2021) and indicates that by 2036 an estimated 1 in 4 people in Wales will be aged 65 and over.
- The King's Fund identify a number of future trends in the English population (link) that may have local relevance: the population is growing; the population is becoming more diverse; more people are living alone; after recent growth, the number of births each year is expected to level off; life expectancy and healthy life expectancy are growing; the population is ageing; after a recent decline, the number of deaths each year is expected to grow; and health inequalities persist.

What is happening in Wales?

ⓘ Consider whether shared learning/ local experience might guide your own implementation of the evidence:

▼ **Placeholder project description**

- *What problem was being addressed?* Placeholder.
- *What was done to address it?* Placeholder.
- *How does this evidence good practice?* Placeholder.

- *What key learning can be shared?* Placeholder.
- *Who did it or who can be contacted in the event of queries?* Placeholder.

ⓘ Have something to share? Please let us know here.

ⓘ **Caution**: Any text entered into the following sections will not be saved if you navigate away from this page, or close the browser window before selecting PRINT.

What do you know about community views on this?

ⓘ Consider any relevant citizen/ community voice information (e.g. from surveys, complaints, engagement events, or your health board's well-being or population needs assessments). Summarise this into the following box:

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What assets or partnership opportunities can you identify?

ⓘ Consider any relevant local assets or potential partner organisations that might facilitate co-production. Summarise this into the following box:

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Do you need more data before making a decision?

ⓘ If relevant, consider any additional data (or information) requirements that might ensure a more informed decision on determining action. Summarise this into the following box:

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What is your provisional decision?

ⓘ Having reviewed indicator data on local needs and considered evidence-informed quality improvement options, please record initial thoughts on proposed actions. You may also wish to record related thoughts around potential service models, capacity requirements, workforce development or financial considerations. Ideally, discuss these with both the wider cluster and with your local public health team (LPHT). Summarise your proposals for action into the following box:

Type here

ⓘ Now PRINT this page (e.g. to PDF) so you have a record of your entries (Steps E-H). You may then close the Print view browser window and return to the PCNA workbook to review another indicator.