Primary Care Needs Assessment tool: indicator review

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ⓘ **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.

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

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):

- Avoidable deaths result from causes considered avoidable (in principle) in the presence of timely and effective healthcare or public health interventions (acknowledging not every death from that cause could have been averted). Avoidable mortality rates are consistently highest in the most deprived local areas in Wales; almost 352 deaths per 100,000 males and almost 235 deaths per 100,000 females could have been avoided in Wales, had mortality rates in the least deprived areas prevailed in the most deprived areas (ONS 2018; link).
- The inverse care law (Hart 1971) states that the availability of good medical care tends to vary inversely with the need for it in the population served. The Inverse Care Law (ICL) Programme, established in the South Wales valleys, aims to increase ascertainment of people with or at risk of cardiovascular disease and cancer and supports them to make healthy behaviour changes.
- In *Understanding pressures in general practice* (2016; link) The King's Fund identify deprivation as a cause of pressure on general practice, noting its relationship with higher prevalence of long-term conditions.

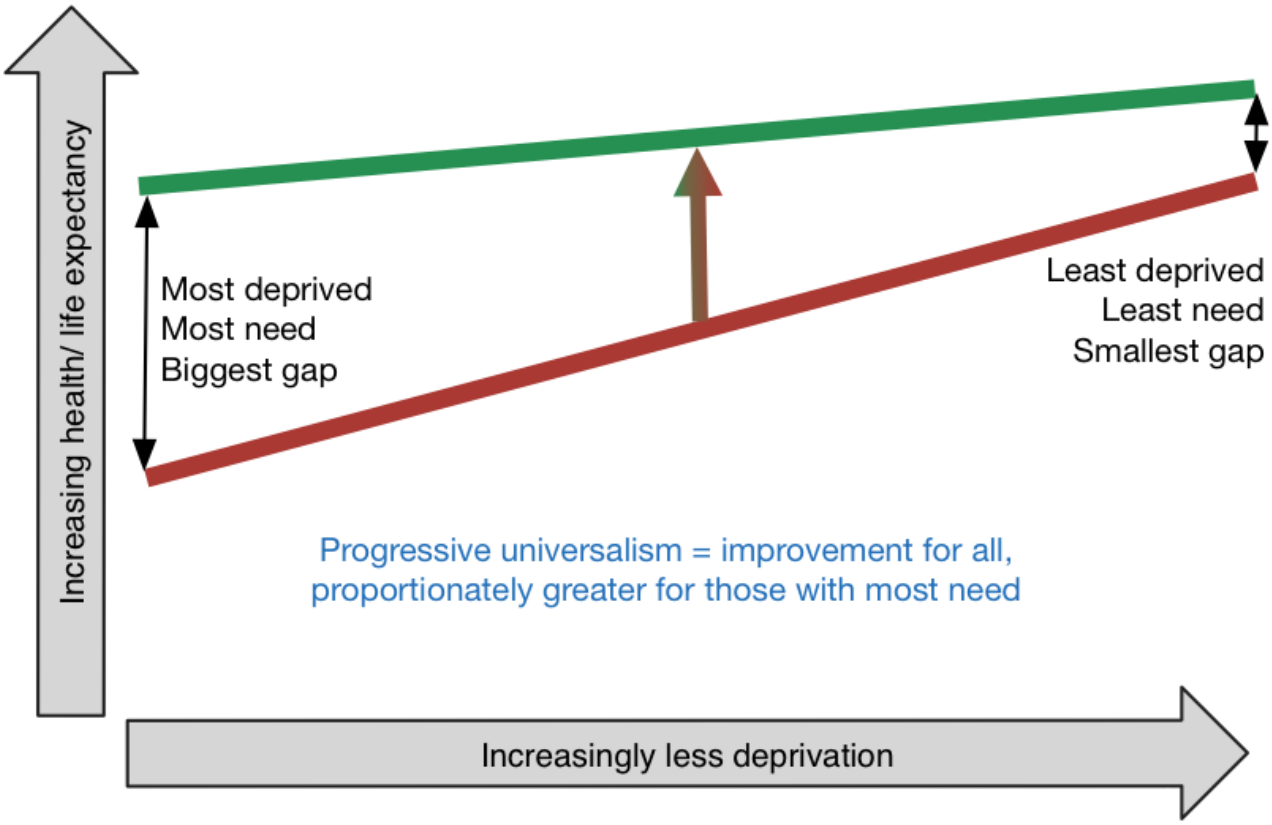
▼ ⓘ Tell me about: Deprivation

- Deprivation is a **relative** measure of the **lack of** access to multi-dimensional information, opportunities and material living conditions to meet needs in small neighbourhood areas.
- The official indicator for estimating deprivation used in Wales is the Welsh Index of Multiple Deprivation (WIMD), which includes the eight dimensions (**domains**) of income; employment; health; education; access to services; community safety; physical environment; and housing. Each domain comprises various indicators and contributes a weighted value to an overall WIMD score; these scores cannot be compared absolutely, over time or with areas from outside of Wales.

- The neighbourhoods are defined by **lower super output areas** (LSOAs).
- LSOAs are ranked nationally, from highest to lowest by deprivation score, and then split into five equal bands (**quintiles**), ranging from least deprived to most deprived fifth. Quintiles are often illustrated by overlaying them on a map e.g. by health board area, as here (PHW 2015).
- It is important to note that aggregation causes obfuscation: in areas of lower deprivation (not equivalent to "affluence") there can be pockets of higher deprivation, and in areas of higher deprivation there are can be pockets of lower deprivation.
- Deprivation, as with life expectancy and healthy life expectancy (LE and HLE; see POP-002), is used in the measurement of inequalities. Whereas LE and HLE are proxy measures for overarching health outcomes, deprivation is commonly used more broadly—as a dimension of equity of access to services (e.g. the most deprived communities typically have the lowest uptake of screening); of equity in health outcomes (e.g. the gap HLE reduces as deprivation decreases); and to measure the distribution of opportunity to access the determinants of health (see WDH-001; WHD-002; WHD-003).

▼ ⓘ Tell me about: Progressive universalism

- Plotting deprivation quintiles against measures of access to or outcomes from healthcare often shows a correlation, with worse access/ outcomes associated with higher levels of area deprivation.
- On a chart (see below) such a correlation may be visible as a sloping line, referred to as the **slope of inequality**. The degree of slope depends upon the heterogeneity of socio-economic variables in the local population; this slope and any change in slope over time can be measured.
- With reference to the figure below, a reduction in inequalities/ inequity from the start of measurement (red line) to a recent measurement (green line) would involve both a) universal health status improvement and b) a progressive reduction in difference. Together, these changes constitute proportionate or **progressive universalism**.
- Universal status improvement means there is benefit seen in every deprivation quintile, the common goal of a "one size fits all" service model—but this may belie that "equal" is not the same as "equitable" (see POP-002).
- A progressive reduction in difference means that the status gap between the least and most deprived quintile has declined—hopefully as the designed consequence of a service model that has been tweaked to provide greater attention where it is needed most.



STEP B Improvement actions for GP practice cluster members

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

▼ **Apply progressive universalism when designing healthcare interventions**

- Local access to good quality primary care should be universal (i.e. available to all). However, people from deprived communities do not need the "same" level of access as those from less deprived areas. Targeted interventions should be tailored to make additional provisions in support of improved access and outcomes, proportionate to higher levels of need, in deprived community areas.

STEP C Improvement actions for wider cluster members

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

▼ **Apply progressive universalism when tackling the determinants of health**

- Local access to opportunities for a good quality education (WDH-001), healthy and warm homes (WHD-002) and to health-enabling employment (WHD-003) should be universal (i.e. available to all). However, people from deprived communities do not need the "same" level of access as those from less deprived areas. Targeted interventions should be tailored to make additional provisions in support of improved access and outcomes, proportionate to higher levels of need, in deprived community areas.

▼ **Mitigate the effects of deprivation on health in rural areas**

- *Health and wellbeing in rural areas* (LGA & PHE 2017; link) notes both sparsity and rurality appear to affect poverty levels and consequently the health of people in rural areas. Health risks, some of which that could be a focus for intervention, include changing population patterns; infrastructure; digital access and exclusion; air quality; access to health and related services; lack of community support, isolation and social exclusion; housing and fuel poverty (see WHD-002); and employment and unemployment (see WHD-003).

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:

Type here

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:

Type here

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.