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Primary and Community Care
Development and Innovation Hub
Developing Primary Care in Wales

PRIMARY CARE MEASURES: NATIONAL VARIATION REPORT

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SYNTHESIS AND SUMMARY

SITUATION

The purpose of this national variation report on Primary Care Measures (PCM) is to (1) emphasise variation between and within health boards and (2) signpost to quality improvement options, for Phase 2A measures.

BACKGROUND

Phase 2A measures have been reported via the NWIS Primary Care Information Portal (PCIP) since March 2018. Welsh Government state in WHC (2018) 026 the intention to commence implementation of Phase 2B once there is evidence of routine use of the existing measures by health boards. The Public Health Wales (PHW) Primary Care Division (PCD) proposed, to health board Directors of Primary & Community Care (DPCC), the development of a national report as a means to enhance PCM utility.

ASSESSMENT

A summary of variation between and within health boards in Wales for all Phase 2A Primary Care Measures published on PCIP as at Sep 2018, with the greatest variation (purely in absolute terms) colourised at three levels, is provided in Table 1.

Table 1: Variance dashboard for Primary Care Measures Phase 2A between and within health boards.			
Measure	Inter-LHB variance, by average measure ¹ (blue: 5+ % from ave. or significant)	Largest intra-LHB variance ² (teal: 10+ % variance)	Inter-cluster variance across Wales ³ (olive: 20+ % variance)
Alcohol	7.0%	24.0% (BCUHB)	25.0%
Dental care (adults)	16.4%	—	—
Dental care (children)	18.5%	—	—
Immunisation (childhood): 5-in-1 at 1y	2.7%	6.6% (C&VUHB)	7.4%
Immunisation (childhood): schedule at 4y	7.6%	17.4% (C&VUHB)	23.8%
Immunisation (childhood): MMR2 at 5y	4.4%	13.4% (C&VUHB)	18.2%
Immunisation (childhood): MMR2 at 16y	6.3%	16.3% (C&VUHB)	19.2%
Immunisation (influenza): at risk 6m-64 years	6.0%	13.9% (ABMUHB; ABUHB; BCUHB)	20.3%
Immunisation (influenza): 65+ years	5.6%	15.1% (C&VUHB)	15.2%
Immunisation (influenza): 2-3 years	11.4%	35.5% (C&VUHB)	44.2%
Mat. & CH (breastfeeding)	32.1%	—	—
Mat. & CH (weight)	7.3%	—	—

Screening (AAA)	5.4%	18.3 (C&VUHB)	20.4%
Screening (bowel)	3.5%	20.1% (C&VUHB)	20.1%
Screening (breast)	6.1%	25.3 (C&VUHB)	27.6%
Screening (cervical)	4.0%	18.4% (C&VUHB)	18.7%
Smoking: status change	3.3%	12.7% (C&VUHB)	12.7%
Smoking: support/ treatment	2.4%	6.9% (C&VUHB)	7.0%
Prescribing: cephalosporins	2.75	3.6% (CTUHB)	5.2%
Prescribing: quinolones	0.9%	1.7% (ABMUHB)	2.7%
Circulatory disease: AMI	8.0 per 100,000	—	—
Circulatory disease: all heart disease	21.8 per 100,000	—	—
Circulatory disease: heart failure	2.1 per 100,000	—	—
Circulatory disease: stroke	14.3 per 100,000	—	—
Diabetes	20.1%	42.0% (CTUHB)	56.5%
Dying well: place of death	—	—	—
Dying well: palliative care register	0.3%	—	—
Dementia care: registered dementia	1.3%	2.4% (BCUHB)	3.8%
Dementia care: registered memory impairment	0.5%	1.3% (ABMUHB)	1.5%
Dementia care: prescribed anti-psychotic	1.3%	5.0% (BCUHB)	5.5%
Blood pressure (inequalities)	2.4%	7.3% ⁴	8.6% ⁴
Medication review	11.9%	33.3% (H DUHB)	33.3%
Access: evening opening	5.0%	—	—
Access: weekday opening	45.0%	—	—
Urgent care	—	—	—

Note: (1) Variance at LHB level that is 5% or more from the Welsh average (above, below or in both directions) is shaded blue, as is likely statistical significance for standardised mortality rates (SMRs). (2) Within-LHB variance that exceeds 10% absolute difference is shaded teal. (3) Between-cluster variance that exceeds 20% absolute difference is shaded olive. (4) Excludes C&VUHB due to missing data. Variance thresholds using % are arbitrary for illustrative purposes only, and are not equivalent to confidence intervals, so do not imply statistically significant differences. Abbreviations in column three indicate health boards with the most variance.

The full report identifies key messages relating to each PCM. The **overarching message** is that:

- Averages may obfuscate considerable variation within a health board, or between clusters. Most reporting is presently on the basis of average attainment. Encouragement (or requirement) to routinely report on variance within health boards by cluster is liable to drive focussed quality improvement interventions (i.e. additional support for clusters with lower attainment) that reduce unwarranted variation and improve overall measures of attainment.

When comparing health boards, the measures revealing the most variation (see Table 1) are:

- Dental care access (adults and children)
- **Immunisation against influenza for 2-3 year olds**
- Breastfeeding prevalence
- Circulatory disease mortality rates (all four indicators)
- **Diabetes care**
- **Medication review recording**
- Access to GP practices on weekdays

Within individual health boards, the measures revealing the most variation are:

- Alcohol intake recording
- Childhood immunisation uptake (three of four indicators)
- **Immunisation against influenza** (all three indicators)
- Screening uptake (all four indicators)
- Smoking status change recording
- **Diabetes care**
- **Medication review recording**

Across all clusters in Wales, the measures revealing the most variation are:

- Alcohol intake recording
- Childhood immunisation uptake at age 4 years
- **Immunisation against influenza** (two of three indicators)
- Screening uptake (three of four indicators)
- **Diabetes care**
- **Medication review recording**

From a variance perspective alone, at the levels presently reported/ using existing indicators, the measures with the least discriminatory value are:

- Childhood immunisation 5-in-1 uptake at 1 year
- Prevalence of child overweight and obesity
- Smoking treatment or support offer recording
- Prescribing of non-first line antibiotics (two indicators)
- Entry to the palliative care register
- Dementia care (all three indicators)
- Blood pressure recording
- Access to GP practices during evenings

Measures that this report suggests are problematic and may merit revision are:

- Prescribing of non-first line antibiotics (due to development of the “4Cs” indicator)
- Place of death (due to lack of data reporting on usual residence or preference)
- Blood pressure recording (due to tenuous links to inequality measurement)
- Urgent care (due to inability to draw comparisons between absolute counts)

With regard to quality improvement actions:

- There is a lack of robust improvement action options documented within this report for some measures; substantial further work with stakeholders is needed to address this. Ideally, action options should be mapped to a standardised but flexible quality improvement (QI) approach.
- Heads of Primary Care need encouragement to solicit examples of good local practice in the interest of sharing.

Options for the future development of this report, were it to become a routine output, are:

- Expansion to include Phase 1 PCM (and future PCMs).
- Documentation of overall improvement trend by health board, or reduction in variation within health boards from year-to-year.
- Triangulation of PCM data with other related primary care data, pending improvements in access to primary care data for intelligence/ quality improvement purposes.
- Commissioning NWIS to incorporate the dartboard/ horizon chart as a preferred means of data presentation within the PCIP (if feedback on these devices is sufficiently positive).
- Population of the improvement actions section via a process to create a new stakeholder-accessible database on effective cluster-level interventions and shared good practice, which would also support primary care needs assessment.
- Automated and/ or interactive reporting (e.g. using R and Shiny).

RECOMMENDATIONS

Directors of Primary and Community Care are asked to:

1. Consider **audiences** to whom this report should be disseminated, in its present form, in order to expressly solicit developmental feedback (see section 1.2.3).
2. Consider whether the arbitrary **variance thresholds** chosen here (i.e. within 5% of Welsh average for health boards; 10% within LHB clusters; 20% across all clusters) seem appropriate or whether these should be reset, or alternatively, whether substantial variance is better determined on the basis of 95% confidence intervals (where calculable).
3. Encourage **peer reflection** on possible explanations for reported variation at health board and cluster levels, having understood the report context and limitations (see section 1.5).
4. Identify a process within each health board for delivery of focussed attention to clusters accounting for most variation, with a view to recognising and **sharing learning** from effective practices, and providing **targeted support** to those clusters who would most benefit from adopting more successful ways of working to improve their relative positions.
5. Acknowledge the need for **multiple stakeholders** to contribute improvement actions, support for which may include commissioning evidence mapping where there appears to be a dearth of existing evidence or of well-documented good practice advice.
6. Encourage Heads of Primary Care to identify **good practice examples** in relation to PCMs, utilising this report as a vehicle for sharing learning. Examples might be drawn from QI projects undertaken as part of GMS contract obligations, for example.
7. Consider jointly **prioritising three areas** for quality improvement, given that lower attainment can be readily identified and improvement progress can be monitored at cluster level. Only three measures exhibit wide variation between health boards, within health boards, and across all clusters: (1) immunisation of 2-3 year olds against influenza; (2) diabetes care; and (3) medication review recording.
8. Support the author's conclusion that this report contributes evidence to the emerging need for **additional investment** in QI support within LHB primary care directorates, if unwarranted variation is to be mitigated at scale and pace.

1. INTRODUCTION

1.1 MEASURES & NATIONAL REPORT DEVELOPMENT

A brief synopsis of the Primary Care Measures (PCM) development process culminating in this report is given below:

December 2014	In response to a request from Welsh Government the Directors of Primary & Community Care (DPCC) agreed a Phase 1 set of national primary care quality and delivery measures; these were mapped to the six domains/themes of the NHS Outcomes Framework and Health & Care Standards for Wales.
September 2015	DPCC commissioned Public Health Wales (PHW) to propose a Phase 2 set of measures on the basis of clinical engagement and improved population health outcome focus.
February 2016	From a longlist of 100, a shortlist of 30 candidate Phase 2 PCMs was provided to the DPCC.
July 2016	PHW were asked by the DPCMH to revisit the short list, with a focus on implementation prospects.
May 2017	PHW provided DPCC with a list of Phase 2 PCMs sub-divided as Phase 2A (information is readily accessible; these measures could be realistically implemented within a reasonable/ short timescale) and 2B (information not readily accessible; these measures were deemed important but involve additional challenges to implement).
March 2018	Phase 2A PCMs live on NWIS Primary Care Information Portal (PCIP).
June 2018	PHW Primary Care Division (PCD) received a query from the Wales Audit Office (WAO) asking whether there was any national reporting on PCM, reporting that there was not.
July 2018	Welsh Government state in WHC (2018) 026 the intention to commence implementation of Phase 2B once there is evidence of routine use of the existing measures by health boards.
August 2018	Reflecting on the WHC and earlier WAO query, the PCD proposed to DPCC the development of a national report as a means to enhance PCM utility.
September 2018	PCD shared a mock-up section drafted for the proposed national report on Phase 2A PCMs and are asked to proceed with this work.
December 2018	This PCM national variation report is shared with DPCC.

1.2 REPORT PURPOSE, CONTENTS AND AUDIENCE

1.2.1 PURPOSE

The purpose of this PCM national variation report is to (1) emphasise variation between and within health boards and (2) signpost to quality improvement options, for Phase 2A measures.

The report authors note that:

- **Variation** is a natural phenomenon and can be healthy. For example, it can be a deliberate result of innovation in primary care settings that seeks to test improvements in processes or deliver better care outcomes.
- Variation that is observed (or more precisely, measured) in a healthcare context may be referred to as **inequality**.
- Inequality that is judged to be both *avoidable* and socially *unjust* is termed **inequity**, which is sometimes alternatively described as **unwarranted** variation.
- As this report is intended to emphasise any variation and facilitate quality improvement, it does *not* comment on related performance indicators (targets) where those exist.
- While this report seeks to identify variation, it does *not* postulate what may account for this at individual PCM level. There are many potential reasons for variation—both positive and negative, such as demographic make-up; geography and its effect on access to services; quality improvement activities; programme implementation characteristics; resource constraints; knowledge of best practice; availability of quality improvement expertise; strength of evidence for effective improvement intervention; sustainability-related issues; etc.
- We believe those providing local primary care services are best placed to reflect and consider (within a supportive peer review environment) the relevance of potential explanations for any variation documented by this report.
- Where variation is apparent, the first step should always be to verify the accuracy of the analysis by consulting the original data source; unintended errors are possible in this report.
- We acknowledge that capability and capacity to effect quality improvement action within clusters/ health board primary care directorates is presently constrained.

1.2.2 CONTENTS

Each PCM is treated consistently within the report using the following sub-sections:

- Confirmation of the indicators reported on the Primary Care Information Portal (PCIP), as at September 2018
- Measure context, described in terms of key measure characteristics and key supporting evidence (taken from PHW's *Proposed Primary Care Measures: Phase 2 final report*, May 2017, where applicable); sources of further contextual information are also identified (see grey boxes)
- Comparative analysis, presenting data and narrative on variation between health boards using a “dartboard” and within health boards using a “horizon chart” as described below; key interpretative messages are also provided (see green boxes)
- Improvement actions, incorporating suggestions for potential quality improvement action and examples of good local practice solicited from Heads of Primary Care (see orange boxes)

Note: The improvement actions section is the least developed area of this report, and the report authors acknowledge the need for further refinements here. The decision to separate out actions that might be taken by GP practice cluster members from those more suited to the wider cluster membership is considered. In part, this reflects the present reality that a proportion of clusters across Wales are still largely GP-centric, with low levels of genuine wider stakeholder engagement. It also reflects a perceived need to assist GP practices in fully appreciating the potential contribution of wider stakeholders in driving improvements to person-centred locally-enriched community-based services. Feedback is sought on this approach, as with other aspects of the report, to help ensure it delivers value to our intended audiences.

1.2.3 INTENDED AUDIENCES

We anticipate that this report should be useful to the following audiences:

- Welsh Government for (1) monitoring improvements to the quality of primary care services across Wales; (2) engaging with health boards to explore where wide variation may be unwarranted; and (3) advocating quality improvement proposals put forward in General Medical Service (GMS) contract negotiations that are likely to have a positive impact upon population health.
- Health board Directors of Primary & Community Care, Heads of Primary Care, Associate Medical Directors in Primary Care and cluster development staff who can: (1) liaise with colleagues in other health boards to help disseminate best practice across Wales by sharing approaches taken by their high-attaining clusters; (2) establish business cases for investing in the health board's primary care quality improvement capability and capacity; (3) identify evidence-informed priority actions during the IMTP planning process; and (4) coordinate additional focussed support to clusters who are attaining below the health board average.
- Cluster Leads, members and wider partners, who can benefit from reflective peer review (noting that cluster-specific position is reported on the PCIP) and use these data and improvement options to prioritise quality improvement activities within cluster action plans.
- Local public health teams, who can advise clusters on the programme resources available through Public Health Wales services (e.g. screening, immunisation, etc.) to support and evaluate quality improvement actions.
- Wider stakeholders in primary care quality improvement, such as 1000 Lives Improvement and other public health teams, Health Education and Improvement Wales (HEIW), royal colleges and others, who can enhance the availability of tailored quality improvement resources to help clusters and health boards deliver raised quality and reduced variation at scale and pace.

1.3 HOW TO INTERPRET INCLUDED CHARTS

Charts in this report are generally of two types:

- A *dartboard*, which looks at variation between health boards compared to Wales overall
- A *horizon chart*, which looks at variation within health boards at the cluster level

Please note that the scales on both charts are intended to emphasise variation, and thus magnify the visual impression of any differences in attainment against these quality improvement measures.

1.3.1 EXAMPLE OF VARIATION BY HEALTH BOARD

The dartboard in this example (Fig. 1A) shows the variation proportion of people aged 16+ years with a record of alcohol intake, by health board:

- Uptake for Wales (i.e. national average) is depicted by the green ring
- Those health boards within the ring are above the Wales average, while those outside of it are below
- In keeping with the dartboard metaphor, a high-attaining health board aims to throw a bullseye—or close to it. The closer to the margin of the board a health board is, the further they are from the ideal position. Health boards inside the green line pull the Welsh average up; those outside of the line pull the average down.

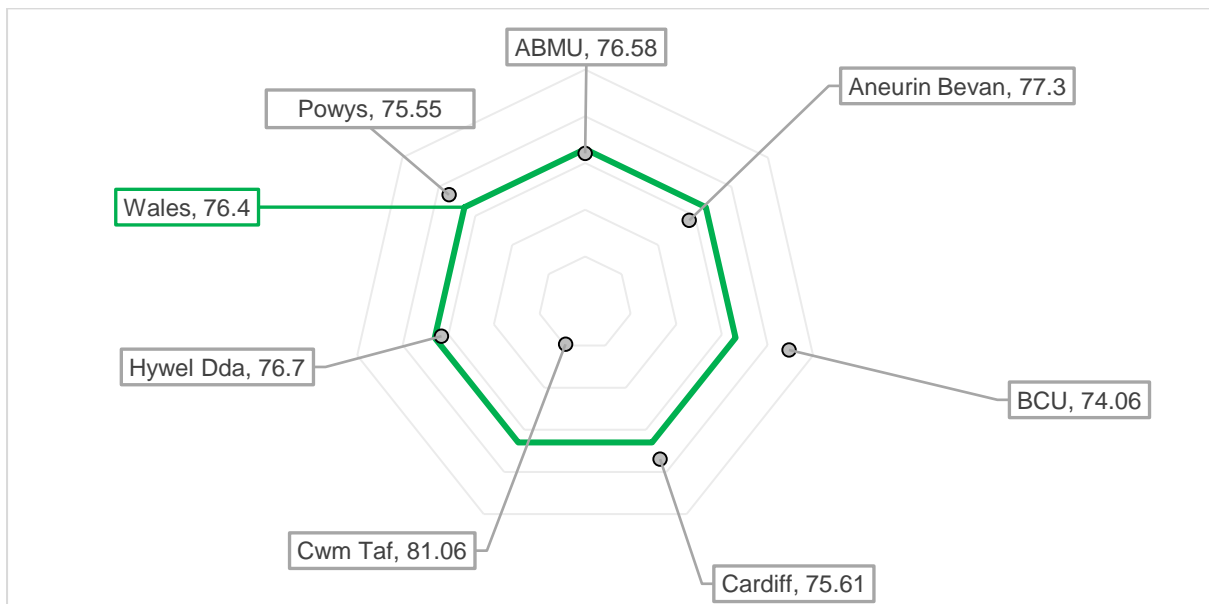


Fig. 1A: Example: Variation in proportion of people aged 16+ years with a record of alcohol intake, by health board, Q3 2017/18 (Source: PCIP, Sep 2018).

1.3.2 EXAMPLE OF VARIATION WITHIN HEALTH BOARDS

The horizon chart in this example (Fig. 1B) shows the variation proportion of people aged 16+ years with a record of alcohol intake, by cluster within each health board:

- Uptake for Wales is depicted by the green horizontal line
- Those health boards with a grey dot above the line are attaining overall above the Wales average; any LHB grey dot underneath the line shows below average overall attainment
- The length of the vertical bar shows cluster-level variation by LHB, from the best-performing (red dot) to least well attaining (blue dot) cluster
- In keeping with the horizon (or altimeter) metaphor, a high-attaining health board (or individual cluster) aims to fly above the horizon. The relative size of the cluster-level variation is depicted by the length of the vertical bar, which should ideally be short and not extend deep below “ground” (the green horizontal line), where it would indicate sub-optimal attainment.

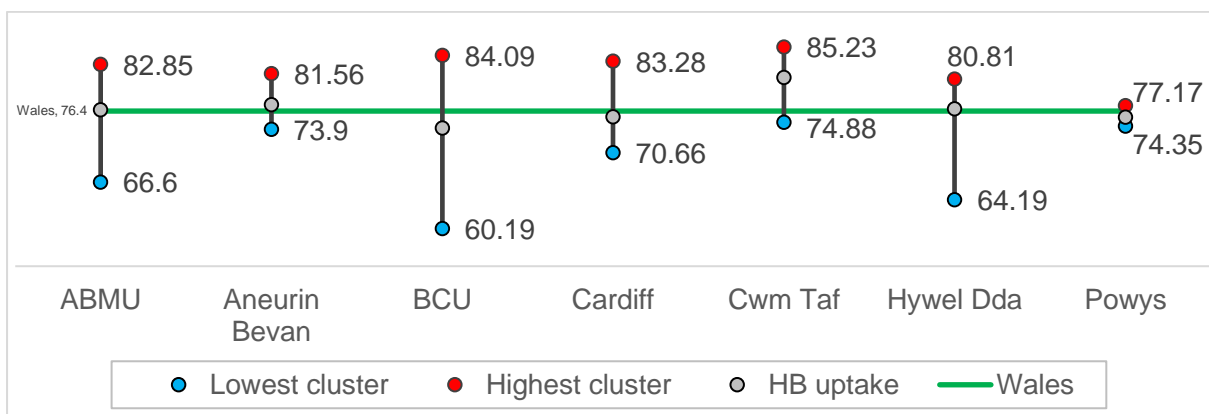


Fig. 1B: Example: Variation in proportion of people aged 16+ years with a record of alcohol intake, by cluster within each health board, Q3 2017/18 (Source: PCIP, Sep 2018).

1.3.3 VARIATION IN IMPROVEMENT TREND

As a baseline/ initial report, time trend information is not available.

1.4 SHARING GOOD PRACTICE

In late September the Heads of Primary Care (HoPC) in all health boards were invited to identify and coordinate the submission local examples of good practice for each PCM.

- The invitation included a report chapter mock-up and abridged list of Phase 2A PCMs, and noted “You may find it helpful to review the tables available on PCIP for your health board and approach clusters that are high-performing with respect to a given Measure, in order to help identify likely good practice. Alternatively, if your health board is performing well compared to Wales overall and with little variation, you may be able to identify an example of a UHB-wide initiative that could account for this position.”
- An online submission form was created using Airtable and this was available to receive submissions until a deadline of the end of October 2018.
- The questions posed in the submission form were as follows:
 - Which Measure is the best fit for the example you are submitting? (select one)
 - Select your health board
 - Q1 - What problem was being addressed?
 - Q2 - What was done to address it?
 - Q3 - Who did it or who can be contacted in the event of any queries?
 - Q4 - How does this evidence good practice? (i.e. how does the solution address the problem outlined in Q1. Please briefly summarize any evaluation outcomes available)
 - Q5 - What key learning can be shared? (i.e. what would you do differently?)
- HoPC were sent a reminder during mid-October, but only two submissions were received from across Wales, with a third submission arriving after the end October deadline.

1.5 HOW TO MAKE BEST USE OF THIS REPORT

Below are a few suggested principles to help you make best use of this report:

- Understand that health board and cluster variation shown in the report is a “best guess” at a single point in time. Variation is more fluid than this snapshot suggests, so measurement at another time point could show a different picture. “Watch and wait” may be an option; a clear trend can be a more powerful inducement to action.
- Promote the report to colleagues as supporting reflective discussion, rather than offering criticism. As noted, not all variation is bad, but where it is wide, this could be a smoke signal to an opportunity for you to decide whether apparent variation around a given measure needs exploring in more depth.
- Don’t feel obliged to prioritise what to tackle first purely on the basis of how wide the variation/ attainment gap is. There are lots of other prioritisation considerations, such as population or health outcome impact; amenability to effective intervention; cost of intervention; need for strategic alignment; professional & public support for change to practice; opportunities for building partnerships; links to performance targets or QI frameworks; etc.
- Work together, as health boards and clusters will often share the same challenges. If you find a way forward, share it. If you need a way forward, ask. Propose joint action: pulling in the same direction increases the likelihood of demonstrating measureable improvement.
- Do provide feedback on this report if you can suggest enhancements that will improve its ability to help you track and respond to potential unwarranted variation—including thoughts on how we might bring consistency to its description and prioritisation going forward.

2. STAYING HEALTHY: ALCOHOL

The Primary Care Information Portal provides data on the following indicator(s):

- % of people aged 16 and over with a record of alcohol intake

2.1 MEASURE CONTEXT

2.1.1 KEY MEASURE CHARACTERISTICS

- Linked national policy or frameworks: *Working together to reduce harm: substance misuse delivery plan 2013-2015*.
- Population health rationale: Alcohol is associated with a significant level of mental and physical morbidity, and is an avoidable cause of premature death and cost to the healthcare system.
- Clinical rationale: Alcohol causes harm.
- Estimated patient/ public perception of topic importance: Moderate alcohol intake is socially acceptable, but excessive alcohol intake is considered to be harmful.
- Identified caveats or limitations: Targeted screening is likely to have more benefit. Recording data is useful, but on its own is not enough.

2.1.2 KEY SUPPORTING EVIDENCE

Public Health Wales Observatory. *Alcohol and health in Wales 2014: Wales profile*. Cardiff: Public Health Wales NHS Trust; 2014. Available [here](#).

- Alcohol remains a major cause of death and illness in Wales. Around 1,500 deaths in Wales are attributable to alcohol each year (4.9% of all deaths). There were around 250 alcohol-specific deaths in males and 140 in females per year in Wales, based on the period 2010-12, and alcoholic liver disease accounts for the majority of these. Mortality rates are higher in Wales than in England. There were 10,200 alcohol specific hospital admissions in Wales in 2012/13. Data from the Welsh Health Survey 2012 (WHS) suggested that 42% of adults drank above guidelines.

Want to know more?



The PHW Observatory host a series of topic pages that bring together information on Observatory products; other key websites; key data sources; key evidence sources; and additional evidence and data sources. The topic page on alcohol can be found [here](#).

2.2 COMPARATIVE ANALYSIS

- Data source: GP clinical systems extracted by Audit+
- Numerator: The number of patients in the denominator population with a record of alcohol intake.
- Denominator: Registered patients aged 16+.

2.2.1 VARIATION BY HEALTH BOARD

Fig. 2A shows the variation in proportion of people aged 16+ years with a record of alcohol intake, by health board. The average Wales attainment for this measure is a recording proportion of 76.4%. Variation in attainment across Wales is 7.0%, ranging from 4.7% above average (CTUHB, 81.1%) to 2.3% below average (BCUHB, 74.1%).

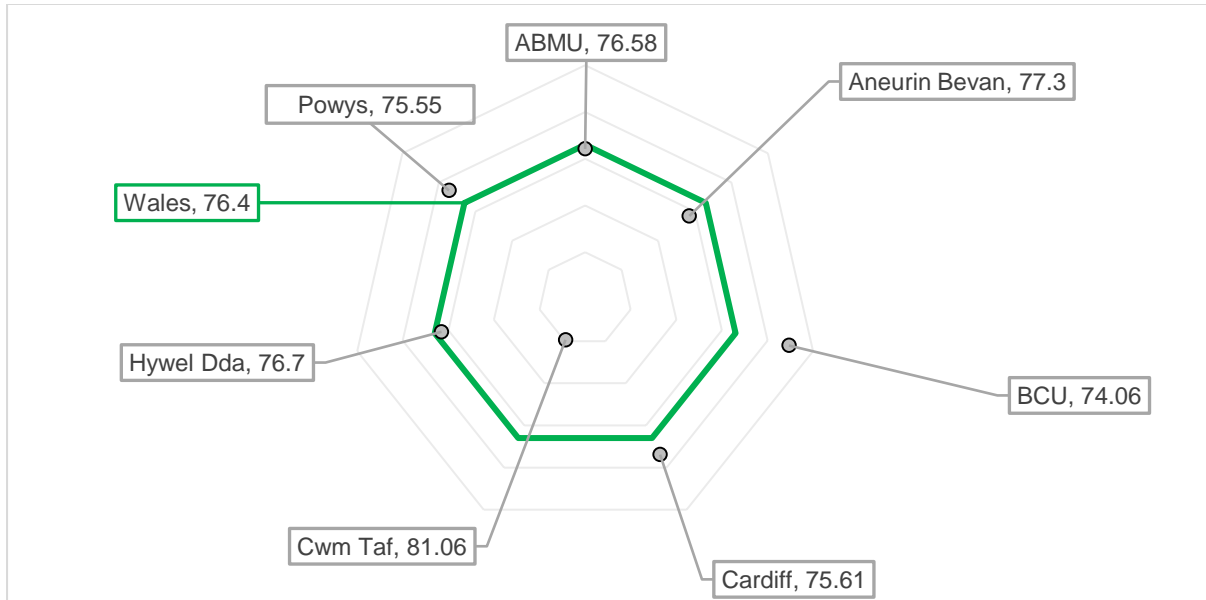


Fig. 2A: Variation in proportion of people aged 16+ years with a record of alcohol intake, by health board, Q3 2017/18 (Source: PCIP, Sep 2018).

2.2.2 VARIATION WITHIN HEALTH BOARDS

Fig. 2B shows the variation in proportion of people aged 16+ years with a record of alcohol intake, by cluster within each health board. Variation in attainment by cluster ranges from as much as 23.9% within BCUHB to as little as 2.8% within PTHB. Variation between the best attaining (CTUHB, 85.2%) and least attaining (BCUHB, 60.2%) cluster across all of Wales is 25.0%.

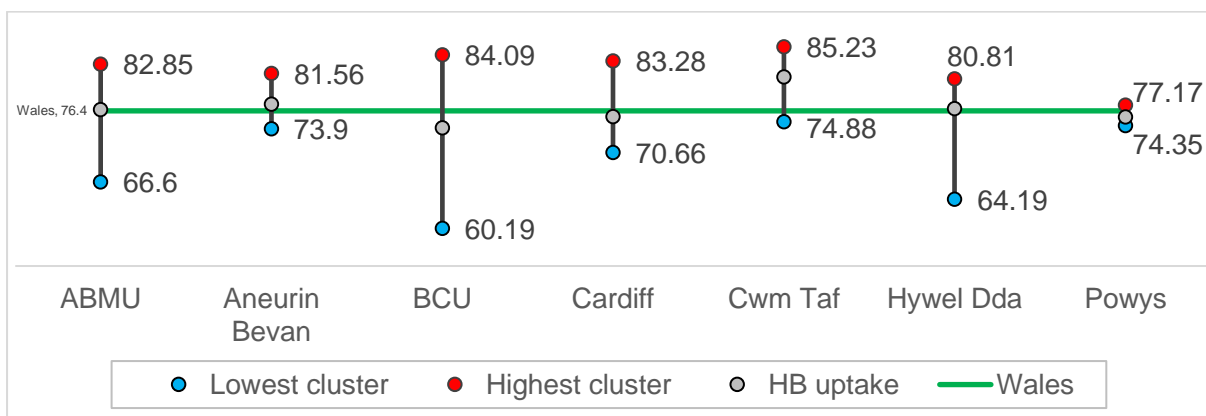


Fig. 2B: Variation in proportion of people aged 16+ years with a record of alcohol intake, by cluster within each health board, Q3 2017/18 (Source: PCIP, Sep 2018).

Key messages

- Overall variation between health boards for recording of alcohol intake is less than 5% either side of the Welsh average.
- Health board averages obfuscate variation within health boards of up to 24%.
- The attainment gap between clusters across Wales is 25%.

2.3 IMPROVEMENT ACTIONS

2.3.1 GP PRACTICE ACTION

Improvement actions potentially suitable for adoption by GP practice cluster members include:

- All appropriate healthcare professionals should be competent to deliver alcohol brief interventions as part of *Making Every Contact Count* [[link](#)]. When working with people who misuse alcohol:
 - Build a trusting relationship.
 - Provide very brief intervention:
 - It can take from 30 seconds to a couple of minutes
 - It is mainly about giving people information, or directing them where to go for further help.
 - It may also include other activities such as raising awareness of risks, or providing encouragement and support for change.
 - It follows an 'ask, advise, assist' structure. For example, very brief advice on alcohol use would involve recording the person's alcohol intake and if of concern advising them to reduce their consumption according to guidelines.
 - Then, depending on the person's response, they may be directed to these services for additional support.
 - Use formal assessment tools to assess the nature and severity of alcohol misuse e.g. AUDIT –C.
 - Provide information appropriate to their level of understanding about the nature and treatment of alcohol misuse to support choice from a range of evidence-based treatments.
 - For service users who typically drink over 15 units of alcohol per day and/or who score 20 or more on the AUDIT, consider offering an assessment for and delivery of a community-based assisted withdrawal, or referral for assessment and management in specialist alcohol services.
 - Encourage families and carers to be involved in the treatment and care of people who misuse alcohol.
- QOF guidance for 2017/18 identified liver disease as a national clinical priority; proposed quality improvement action focussed on management of abnormal liver function tests (see [here](#)). An audit cycle within GP practices is described with the goal “to facilitate appropriate management of abnormal ALT tests and, thereby, more timely diagnosis of patients with liver disease.” The aims were stated as:
 - To reduce the number of repeat liver function tests following an abnormal ALT;
 - To increase appropriate testing following an abnormal ALT;
 - To increase appropriate referrals to hepatology for patients with abnormal ALT indicative of hepatic fibrosis.

2.3.2 WIDER CLUSTER ACTION

Improvement actions potentially suitable for adoption by the wider cluster membership include:

- Raise awareness through routine communication channels, such as email, regular meetings, internal staff briefings and other communications with all relevant partner organisations. Identify things staff can include in their own practice straight away.
- Identify a lead with an interest in the topic to champion and motivate others and to find out any significant issues locally.
- Carry out a baseline assessment against to find out whether there are gaps in current service provision.
- Think about what data will be needed to measure improvement and plan how to collect it. This may also help identify local issues that will slow or prevent implementation.
- Develop a plan, with the steps needed to put the actions into practice. Big, complex changes may take longer to implement, but some may be quick and easy to do. An action plan will help in both cases.
- For very big changes include milestones and a business case, which will set out additional costs, savings and possible areas for disinvestment. A small project group could develop the action plan. The group might include the champion, a senior organisational sponsor, staff involved in the associated services, finance and information professionals.
- Implement the action plan with oversight from the lead and the project group. Big projects may also need project management support.
- Review and monitor how well the action is being implemented through the project group. Share progress with those involved in making improvements, as well as relevant boards and local partners.
- The above national clinical priority QI project required GP practices to:
 - "...participate in a facilitated discussion of the collated data from the baseline and first cycle intervention audits. This will include consideration of how the Cluster Network can support its constituent practices *and other stakeholders* in management of patients with risk factors for liver disease including excess alcohol consumption."

Good practice example

Heads of Primary Care were unable to identify relevant good practice examples of cluster-led quality improvement projects for this report. Readers are encouraged to contact the PHW Primary Care Division with any local examples suitable to share.

References

- NICE. Alcohol-use disorders: prevention, Public health guideline [PH24]: June 2010. <https://www.nice.org.uk/guidance/ph24>
- NICE. Alcohol-use Disorders: The NICE guideline on diagnosis, assessment and management of harmful drinking and alcohol dependence, October 2014: <https://www.nice.org.uk/guidance/cg115/evidence/full-guideline-136423405>
- NICE. Alcohol-use disorders: Diagnosis and clinical management of alcohol-related physical complications, Clinical guideline [CG100] updated: April 2017. <https://www.nice.org.uk/guidance/cg100>
- NICE. Behaviour change: individual approaches, Public health guideline [PH49] January 2014. <https://www.nice.org.uk/guidance/ph49>
- <https://www.nice.org.uk/guidance/ph49/chapter/1-recommendations#recommendation-9-deliver-very-brief-brief-extended-brief-and-high-intensity-behaviour-change>
- The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies, An evidence review, Public Health England, 2016 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/733108/alcohol_public_health_burden_evidence_review_update_2018.pdf

3. STAYING HEALTHY: DENTAL CARE (ADULTS)

The Primary Care Information Portal provides data on the following indicator(s):

- % of adults who accessed dental services at least once every 2 years

3.1 MEASURE CONTEXT

3.1.1 KEY MEASURE CHARACTERISTICS

- Linked national policy or frameworks: NICE guidelines; Oral health and dental services response to Healthier Wales; Primary Care Plan.
- Population health rationale: Regular dental assessment and prevention (primary and secondary) is important for oral health and general health and well-being.
- Clinical rationale: Regular check-up and early detection of oral diseases is likely to avoid costly and invasive procedures (loss of teeth and complex restorations).
- Estimated patient/ public perception of topic importance: Patients understand that regular check-up with intervals based on risks and need is recommended.
- Identified caveats or limitations: Using General Dental Service (GDS) data only, some adults who attend Community Dental Service (CDS) and private dentists will not be picked up. Welsh Government has an action plan for the CDS services in Wales to start using the same data collection system as the GDS from 2019/20 onward.

3.1.1 KEY SUPPORTING EVIDENCE

Key source: National Institute for Health and Care Excellence. *Oral health: local authorities and partners*. PH55. London: NICE; 2014. Available [here](#).

- This NICE guidance emphasises the importance of oral health to general health and wellbeing. Oral diseases are also associated with heart disease, diabetes complications, rheumatoid arthritis and pregnancy complications. Dental caries are one of the most common oral health problems in the UK. There is a socioeconomic gradient in oral health. The prevalence of dental caries tends to be higher in areas with greater levels of deprivation

Want to know more?



The PHW Dental Public Health team host a page linking to oral health data and information [here](#). Information about oral health improvement activities relevant to adults in Wales is located [here](#).

3.2 COMPARATIVE ANALYSIS

- Data source: NHS Business Services Authority and ONS mid-year population estimates
- Numerator: The number of adults treated by NHS primary dental care services in the last 24 months
- Denominator: ONS mid-year population estimates for adults

- Caveat: It is important to note that the denominator refers to the number of adults attending Dental Care services in each LHB, regardless of where they live

3.2.1 VARIATION BY HEALTH BOARD

Fig. 3A shows the variation in proportion of adults who accessed dental care at least once during the previous 24 months, by health board. The average Wales attainment for this measure is an access proportion of 51.5%. Variation in attainment across Wales is 16.4%, ranging from 6.6% above average (ABMUHB, 58.0%) to 9.8% below average (HDUHB, 41.7%).

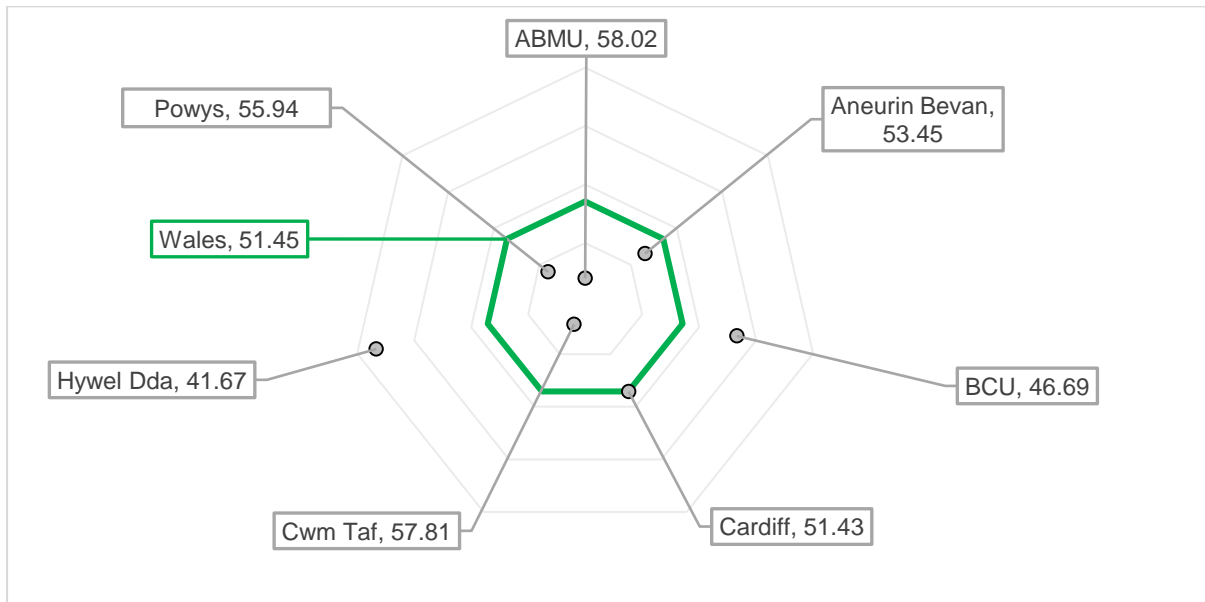


Fig. 3A: Variation in proportion of adults who accessed dental care at least once during the previous 24 months, by health board, 2016/17 (Source: PCIP, Sep 2018).

3.2.2 VARIATION WITHIN HEALTH BOARDS

These data are not reported at cluster level.

Key messages

- Overall variation between health boards for access to adult dental services exceeds 5% either side of the Welsh average.

3.3 IMPROVEMENT ACTIONS

3.3.1 GP PRACTICE ACTION

Improvement actions potentially suitable for adoption by GP practice cluster members include:

- Development of actions required (e.g. What is the oral health status of all vulnerable patient groups and patients with chronic diseases, including cancer? What proportion of patients visiting my practice are for dental/ oral health problems?)

3.3.2 WIDER CLUSTER ACTION

Improvement actions potentially suitable for adoption by the wider cluster membership include:

- Improve understanding of local primary care dental services (General Dental Services and Community Dental Services) and contractual framework for the GDS.
- Work with the health board and their dental services in the neighbourhood to improve dental access for those who cannot access NHS dental care, starting with those who are at risk of dental diseases but have not had an oral health assessment in previous 24 months.
- Work with the health board to pilot dental care pathway between GMS and other primary, community and social care services and NHS dental services in the neighbourhood and integrate oral health into existing care packages (e.g. redirection of urgent dental care patients to local dental practices; referral for dental assessment and treatment on diagnosis of dementia; dental assessment and treatment of different patient groups/ patients with risk factors who have not had any oral health assessment in the previous 24 months; inclusion of oral health in care packages for older people and vulnerable groups; etc.)

Good practice example

Heads of Primary Care were unable to identify relevant good practice examples of cluster-led quality improvement projects for this report. Readers are encouraged to contact the PHW Primary Care Division with any local examples suitable to share.

References

- NICE. Dental checks: intervals between oral health reviews. Clinical guideline [CG19]. Published date: October 2004. <https://www.nice.org.uk/guidance/cg19>

4. STAYING HEALTHY: DENTAL CARE (CHILDREN)

The Primary Care Information Portal provides data on the following indicator(s):

- % of children who accessed dental services at least once a year

4.1 MEASURE CONTEXT

4.1.1 KEY MEASURE CHARACTERISTICS

- Linked national policy or frameworks: Oral Health and Dental Services Response to Healthier Wales; Primary Care Plan.
- Population health rationale: Oral health in children is important for general health and wellbeing and maintaining good oral health for their whole life course. Prevention actions through a targeted national oral health improvement programme, Designed to Smile, needs to be augmented by delivery of preventive interventions through the dental service settings.
- Clinical rationale: Oral health monitoring and access is important to ensure children receive practice-based prevention and avoid dental extraction under general anaesthetic.
- Estimated patient/ public perception of topic importance: It is assumed that parents and public know that access to dental services including GDS for children is free, and regular dental check-up supports parental effort of oral hygiene at home. Tooth decay, if picked up early, can avoid more invasive procedures.
- Identified caveats or limitations: Children who go to the Community Dental Service (CDS) will not be picked up by NWIS primary care portal, but most now are encouraged to go to the General Dental Service (GDS). From 2019/20, CDS will start using the same data submission system as the GDS.

4.1.2 KEY SUPPORTING EVIDENCE

National Institute for Health and Care Excellence. Oral health: local authorities and partners. PH55. London: NICE; 2014. Available [here](#).

- This NICE guidance emphasises the importance of oral health to general health and wellbeing. Oral diseases are also associated with heart disease, diabetes complications, rheumatoid arthritis and pregnancy complications. Dental caries are one of the most common oral health problems in the UK. There is a socioeconomic gradient in oral health. The prevalence of dental caries tends to be higher in areas with greater levels of deprivation.

Cooper AM *et al.* *Primary school-based behavioural interventions for preventing caries.* Cochrane Database Syst Rev 2013, Issue 5. Art. No.: CD009378. Doi: 10.1002/14651858.CD009378.pub2. Available [here](#).

- This Cochrane systematic review reports dental caries as a debilitating condition that can cause a child to suffer pain and if left untreated possible further complications including sepsis and poor general health and well-being, affecting young children's body weight and growth. Social functioning including self-expression and communication may also be affected since poor oral hygiene is associated with unhygienic and undesirable lifestyles and with severe deprivation.

Delivering Better Oral Health: An Evidence Based Toolkit. Available [here](#).

- This toolkit published by Public Health England with support from the British Association for Study of Community Dentistry (BASCD) summarises preventive interventions and evidence base dental practices should deliver.

Want to know more?



The PHW Dental Public Health team host a page linking to oral health data and information [here](#). Information about *Designed to Smile* (D2S) and other oral health improvement information relevant to children in Wales is located [here](#).

4.2 COMPARATIVE ANALYSIS

- Data source: NHS Business Services Authority and ONS mid-year population estimates
- Numerator: The number of children treated by NHS primary dental care services in the last 12 months
- Denominator: ONS mid-year population estimates for children
- Caveat: It is important to note that the [numerator] refers to the number of children attending Dental Care services in each LHB, regardless of where they live

4.2.1 VARIATION BY HEALTH BOARD

Fig. 4A shows the variation in proportion of children who accessed General Dental Services in the previous 12 months, by health board. The average Wales attainment for this measure is an access proportion of 59.5%. Variation in attainment across Wales is 18.5%, ranging from 9.3% above average (ABMUHB, 68.8%) to 9.2% below average (CTUHB, 50.3%).

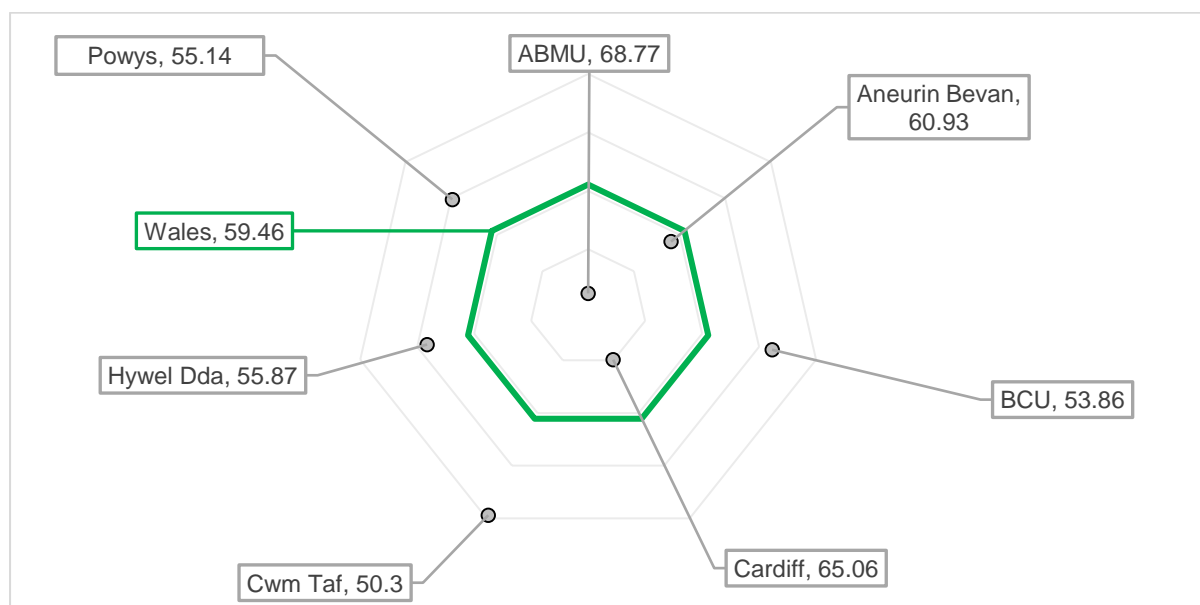


Fig. 4A: Variation in proportion of children who accessed General Dental Services in the previous 12 months, by health board, 2016/17 (Source: PCIP, Sep 2018).

4.2.2 VARIATION WITHIN HEALTH BOARDS

These data are not reported at cluster level.

Key messages

- Overall variation between health boards for access to child dental services exceeds 5% either side of the Welsh average.

4.3 IMPROVEMENT ACTIONS

4.3.1 GP PRACTICE ACTION

Improvement actions potentially suitable for adoption by GP practice cluster members include:

- Development of actions required.

4.3.2 WIDER CLUSTER ACTION

Improvement actions potentially suitable for adoption by the wider cluster membership include:

- Understand local dental services and how they are commissioned and provided.
- Ensure local nurseries and primary schools have taken up the offer of the *Designed to Smile* programme delivered by the local Community Dental Service (D2S is targeted to schools and nurseries located in the three most deprived quintiles).
- Work with the health board and their dental services in the neighbourhood to improve dental access for those who cannot access NHS dental care, starting with those who have not had an oral health assessment in previous 24 months.
- Pilot dental care pathway between GMS and other primary, community and social care services and NHS dental services in the neighbourhood (e.g. referral of children by health visiting service to a dental nurse/ therapist-led clinic in a dental practice for primary prevention).

Good practice example

Heads of Primary Care were unable to identify relevant good practice examples of cluster-led quality improvement projects for this report. Readers are encouraged to contact the PHW Primary Care Division with any local examples suitable to share.

References

- NICE. Dental checks: intervals between oral health reviews. Clinical guideline [CG19]. Published date: October 2004. <https://www.nice.org.uk/guidance/cg19>

5. STAYING HEALTHY: IMMUNISATION (CHILDHOOD)

The Primary Care Information Portal provides data on the following indicator(s):

- The uptake of the 5 in 1 vaccination for babies at one year: Diphtheria, Tetanus, Pertussis, Polio & Hib disease (Haemophilus influenza type b)
- Uptake of scheduled childhood vaccinations at age 4: Children who are up to date with immunisations by age 4 years – Diphtheria, Tetanus, Pertussis, & Polio
- Uptake of MMR2 at 5 years: % of children completed 1st dose reported in children reaching 2nd birthday, completed 2nd dose reported in children reaching 5th birthday
- Uptake of MMR2 at 16 years: % of children aged 16 who have received the agreed vaccination schedule

5.1 MEASURE CONTEXT

5.1.1 KEY MEASURE CHARACTERISTICS

- Linked national policy or frameworks: Public Health Outcome Framework (PHOF); NHS Delivery Framework; NHS Outcomes Framework.
- Population health rationale: The role of vaccinations in preventing communicable disease is well established.
- Clinical rationale: Vaccinations reduce personal and community risk of acquiring infectious disease.
- Estimated patient/ public perception of topic importance: Generally positive.
- Identified caveats or limitations: Query private school students living in Wales but immunised in England. Query whether all immunisations are centrally recorded for Welsh residents.

5.1.2 KEY SUPPORTING EVIDENCE

World Health Organization. *Immunization*. [Online]. Available [here](#).

- The World Health Organization estimates that 3 million lives are saved every year worldwide through immunisation. Illnesses such as diphtheria and tetanus are now rare because of immunisation. Polio was declared eliminated in Europe in 2002 through immunisation but the threat of other diseases such as measles and meningitis is still present in the UK today.

Public Health England. Immunity and how vaccines work: the green book: chapter 1. In Salisbury D, Ramsay M. Eds. *The Green Book: Immunisation against infectious disease*. London: Public Health England; 2013. [online] Available [here](#).

- The Green Book (UK guidance on immunisation for health professionals) notes that whilst the primary aim of immunisation is to protect the individual receiving a vaccine, vaccinated individuals are less likely to be a source of infection for others reducing the risk of infection for unvaccinated individuals. When vaccine coverage is sufficient to induce a high level of population immunity (herd immunity) infections can be eliminated. However, diseases could return if high coverage is not maintained.

Want to know more?



The PHW Vaccine Preventable Disease Programme (VPDP) host a page containing information about immunisation and vaccines [here](#); the childhood schedule for Wales is listed [here](#). Uptake data on childhood immunisation in Wales by health board are recorded in COVER (Coverage of Vaccination Evaluation Rapidly) reports, available [here](#). The PHW intranet site, available to healthcare staff, provides access to detailed COVER statistics including cluster and GP practice-level data, available [here](#).

5.2 COMPARATIVE ANALYSIS

- Data source: National Community Child Health Database (NCCHD)
- Numerator: The number of children where uptake conforms with the 4 indicators above
- Denominator: The number of children in each relevant age group
- Comments: Please note that the clusters reported are in accordance with those reported upon by PHW Screening Services

5.2.1 VARIATION BY HEALTH BOARD

Fig. 5A shows the variation in uptake proportion of the 5-in-1 vaccination at one year, by health board. The average Wales attainment for this measure is an uptake proportion of 96.5%. Variation in attainment across Wales is 2.7%, ranging from 1.5% above average (CTUHB, 98.0%) to 1.23% below average (H DUHB, 95.3%).

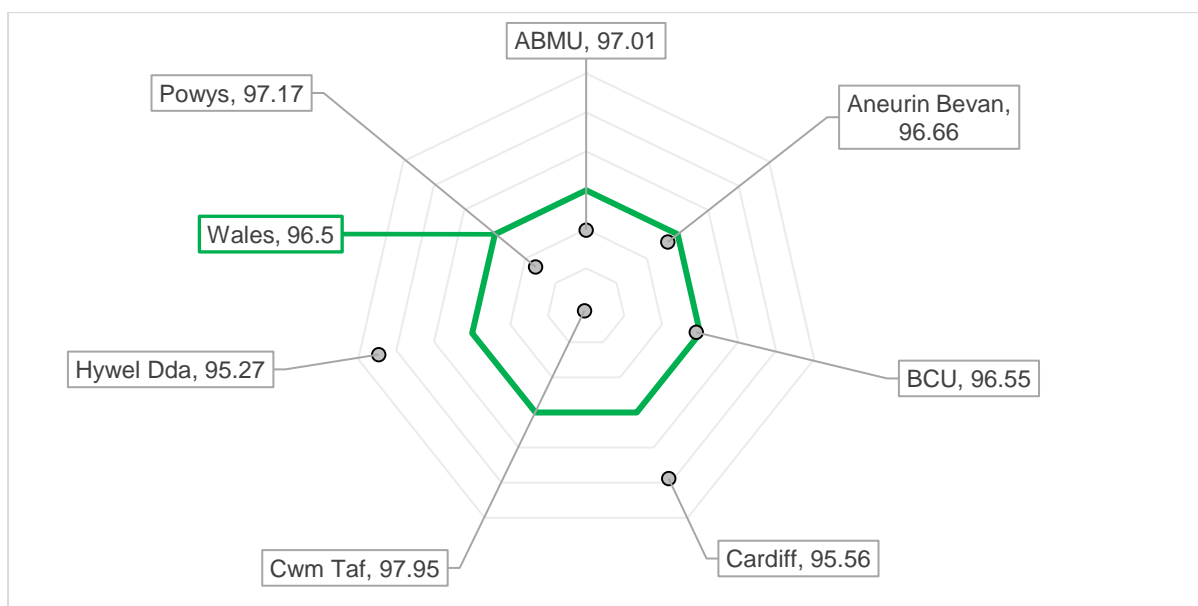


Fig. 5A: Variation in uptake proportion of the 5-in-1 vaccination at one year, by health board, 2016/17 (Source: PCIP, Sep 2018).

Fig. 5B shows the variation in uptake proportion of the scheduled childhood vaccinations at age 4, by health board. The average Wales attainment for this measure is an uptake proportion of 85.2%. Variation in attainment across Wales is 7.6%, ranging from 3.7% above average (BCUHB, 88.9%) to 3.9% below average (ABUHB, 81.2%).

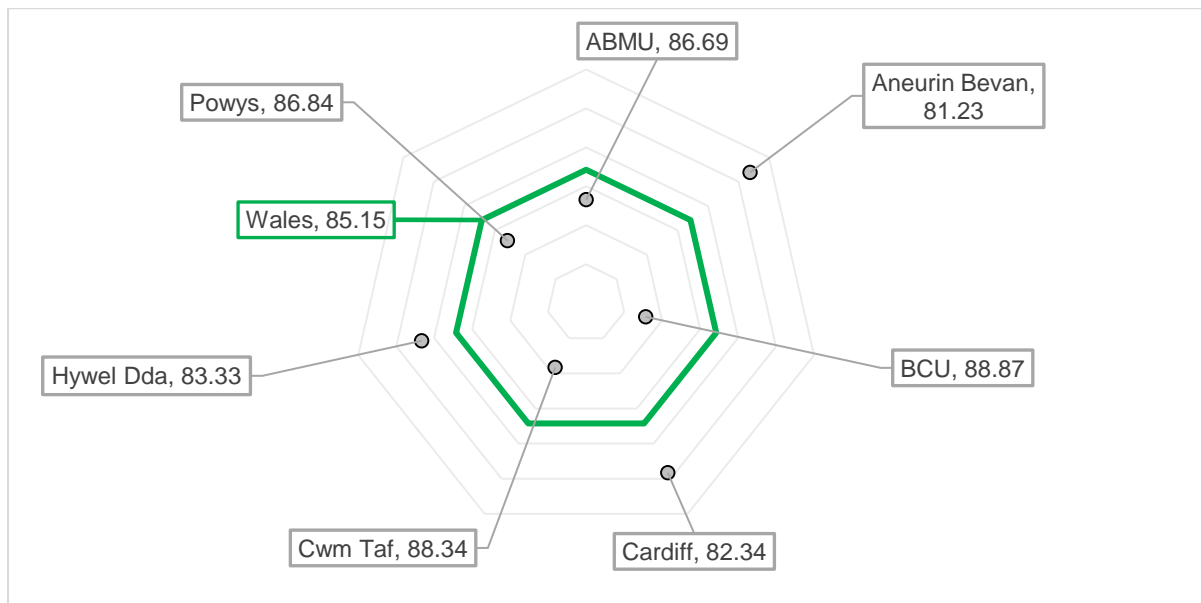


Fig. 5B: Variation in uptake proportion of the scheduled childhood vaccinations at age 4, by health board, 2016/17 (Source: PCIP, Sep 2018).

Fig. 5C shows the variation in uptake proportion of children receiving two doses of MMR vaccination by age 5, by health board. The average Wales attainment for this measure is an uptake proportion of 90.8%. Variation in attainment across Wales is 4.4%, ranging from 2.1% above average (CTUHB, 92.9%) to 2.4% below average (C&VUHB, 88.5%).

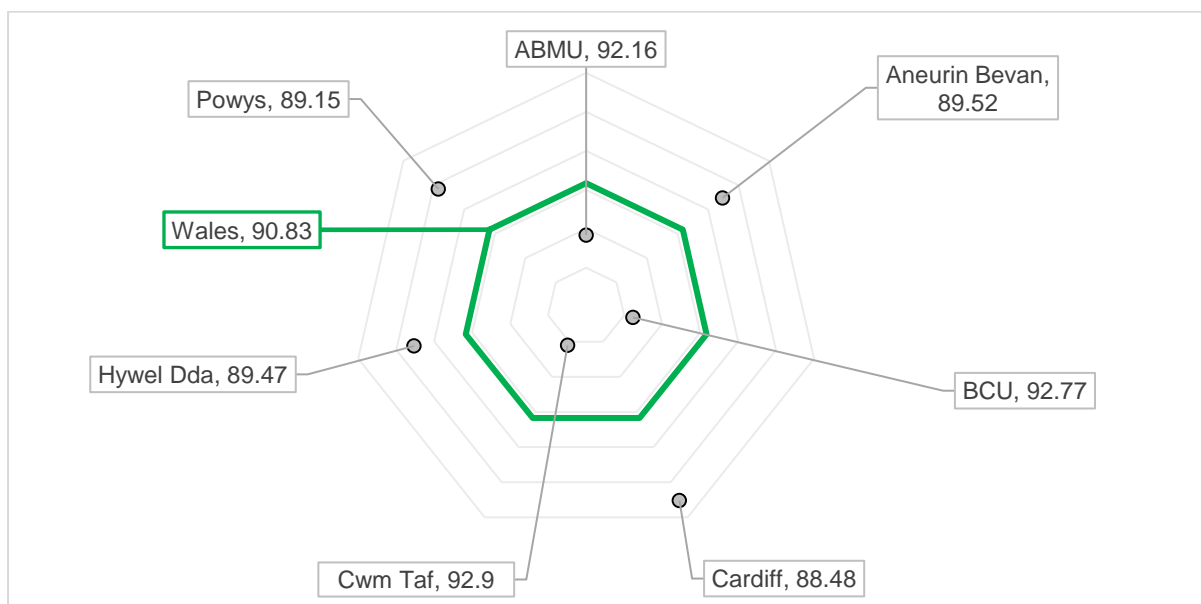


Fig. 5C: Variation in uptake proportion of children receiving two doses of MMR vaccination by age 5, by health board, 2016/17 (Source: PCIP, Sep 2018).

Fig. 5D shows the variation in uptake proportion of children receiving two doses of MMR vaccination by age 16, by health board. The average Wales attainment for this measure is an uptake proportion of 89.2%. Variation in attainment across Wales is 6.3%, ranging from 2.0% above average (BCUHB, 91.2%) to 4.3% below average (PHTB, 84.9%).

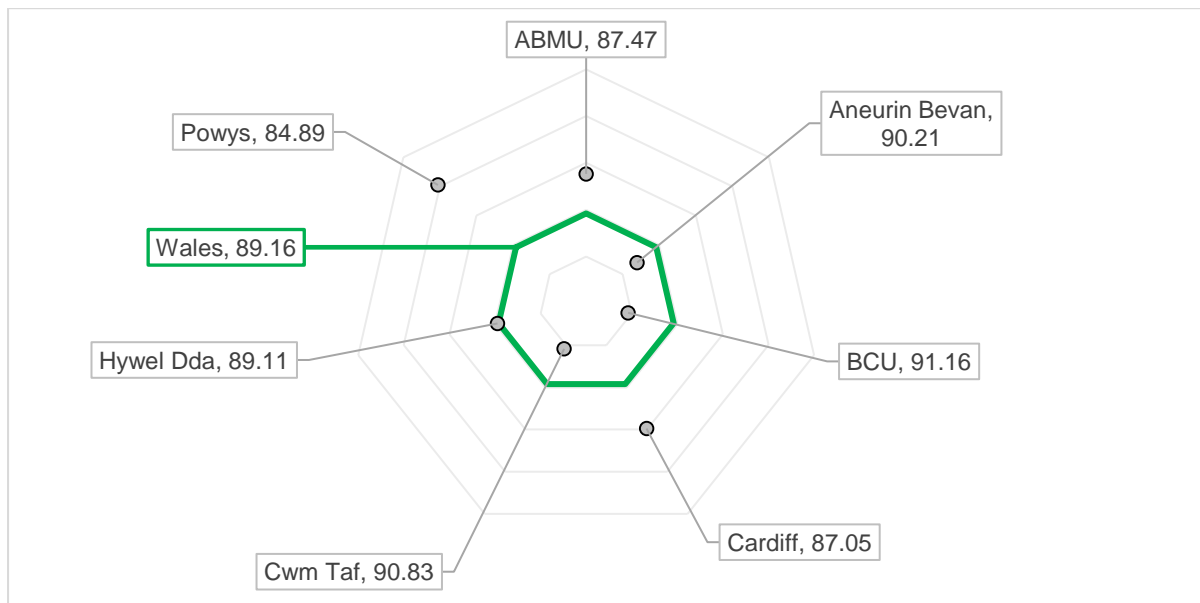


Fig. 5D: Variation in uptake proportion of children receiving two doses of MMR vaccination by age 16, by health board, 2016/17 (Source: PCIP, Sep 2018).

5.2.2 VARIATION WITHIN HEALTH BOARDS

Fig. 5E shows the variation in uptake proportion of the 5-in-1 vaccination at one year, by cluster within each health board. Variation in attainment by cluster ranges from as much as 6.6% within C&VUHB to as little as 1.2% within PHTB. Variation between the best attaining (ABUHB, 99.2%) and least attaining (C&VUHB, 91.8%) cluster across all of Wales is 7.4%.

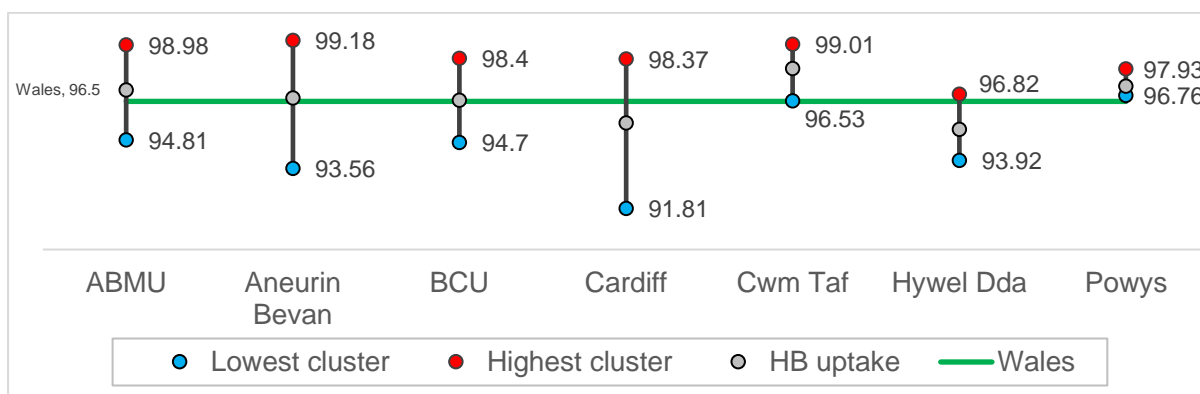


Fig. 5E: Variation in uptake proportion of the 5-in-1 vaccination at one year, by cluster within each health board, 2016/17 (Source: PCIP, Sep 2018).

Fig. 5F shows the variation in uptake proportion of the scheduled childhood vaccinations at age 4, by cluster within each health board. Variation in attainment by cluster ranges from as much as 17.4% within C&VUHB to as little as 4.0% within PTHB. Variation between the best attaining (BCUHB, 94.7%) and least attaining (C&VUHB, 71.0%) cluster across all of Wales is 23.8%.

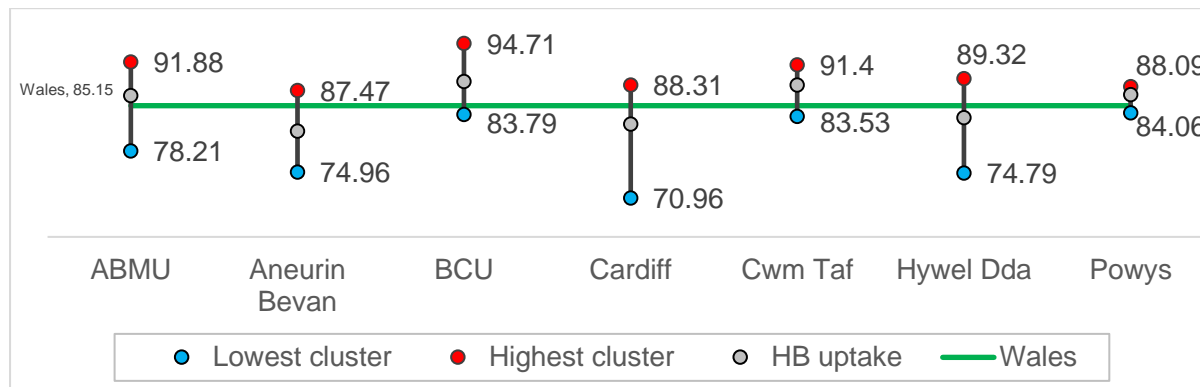


Fig. 5F: Variation in uptake proportion of the scheduled childhood vaccinations at age 4, by cluster within each health board, 2016/17 (Source: PCIP, Sep 2018).

Fig. 5G shows the variation in uptake proportion of children receiving two doses of MMR vaccination by age 5, by cluster within each health board. Variation in attainment by cluster ranges from as much as 13.4% within C&VUHB to as little as 3.2% within PTHB. Variation between the best attaining (ABMUHB, 96.7%) and least attaining (C&VUHB, 78.5%) cluster across all of Wales is 18.2%.

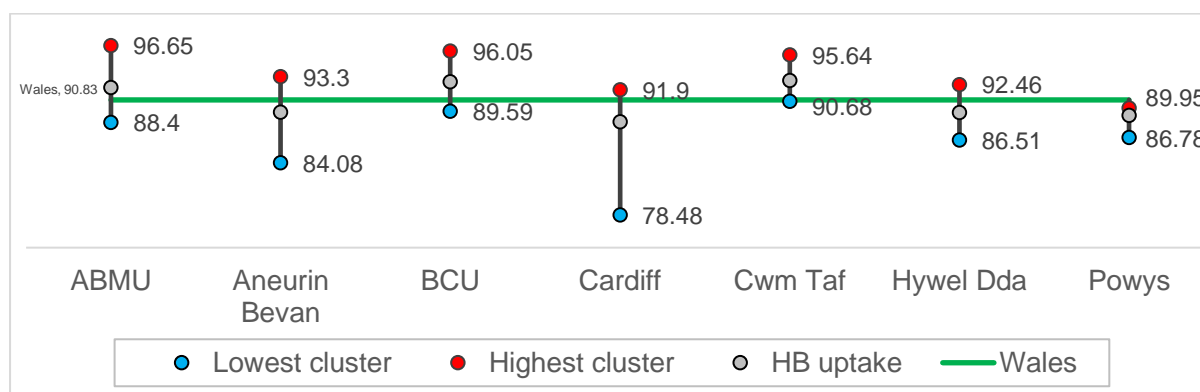


Fig. 5G: Variation in uptake proportion of children receiving two doses of MMR vaccination by age 5, by cluster within each health board, 2016/17 (Source: PCIP, Sep 2018).

Fig. 5H shows the variation in uptake proportion of children receiving two doses of MMR vaccination by age 16, by cluster within each health board. Variation in attainment by cluster ranges from as much as 16.3% within C&VUHB to as little as 2.9% within PTHB. Variation between the best attaining (BCUHB, 95.4%) and least attaining (C&VUHB, 76.3%) cluster across all of Wales is 19.2%.

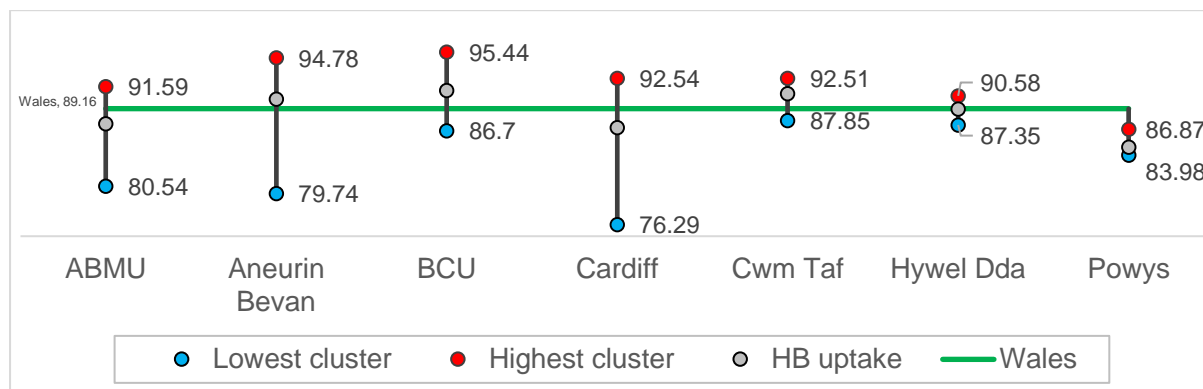


Fig. 5H: Variation in uptake proportion of children receiving two doses of MMR vaccination by age 16, by cluster within each health board, 2016/17 (Source: PCIP, Sep 2018).

Key messages

- Averaged uptake proportion between health boards for all four selected childhood immunisation indicators is less than 5% either side of the Welsh average
- Health board averages obfuscate variation within individual health boards of up to 17%.
- The attainment gap between clusters across Wales is wide beyond the first year of the immunisation schedule, at up to 24%.

5.3 IMPROVEMENT ACTIONS

5.3.1 GP PRACTICE ACTION

Improvement actions potentially suitable for adoption by GP practice cluster members include:

- A synopsis of NICE guidance PH21 on reducing difference in immunisation uptake in under 19s is provided in a PHOF evidence summary [\[link\]](#) (the PDF has been copy protected by the Observatory Evidence Service, so content cannot be reproduced here).

5.3.2 WIDER CLUSTER ACTION

Improvement actions potentially suitable for adoption by the wider cluster membership include:

- Enhanced COVER data [\[link\]](#) presents childhood immunisation uptake rates, for health board and at GP cluster level for additional ages to enable health boards and clusters to estimate uptake figures that will be reported in future national quarterly COVER reports and take steps to increase uptake, or improve local data quality if necessary.
- Audit against agreed national standards [\[link\]](#) that aim to provide consistency in the administrative and data collection procedures associated with routine childhood immunisation across Wales e.g. completion of scheduled and unscheduled immunisation computer returns to CHIS.

- All Wales Health Visitor good practice guidelines for the follow up of preschool children who are outstanding routine immunisation [\[link\]](#)
- A School Nursing Framework for Wales [\[link\]](#) includes a set of immunisation standards for school age children in Wales (Appendix 3) that aim to ensure consistency in the provision of immunisation services for school age children, improve immunisation uptakes and reduce inequalities [Welsh Government, 2017].

Good practice example (submitted by Cardiff & Vale UHB)

What problem was being addressed? Immunisations and health promotion within the BME community.

What was done to address it? Health fair at local mosque and cultural centre.

How does this evidence good practice? GP-led health fair which promotes the importance of immunisations and a healthy lifestyle to the BME community.

What key learning can be shared? Well publicised annual health fair which promotes uptake of immunisations and healthy lifestyles to the BME community.

Who did it or who can be contacted in the event of any queries? Dr Amir Ghanghro at St. David's Court Surgery.

References

- NICE. Immunisations: reducing differences in uptake in under 19s. Public health guideline [PH21]. Published date: September 2009. Last updated: September 2017. <https://www.nice.org.uk/guidance/PH21>
- Public Health Wales. Evidence summary: Vaccination rates at age 4: PHOF indicator 30. <http://www.publichealthwalesobservatory.wales.nhs.uk/phofevidence>

6. STAYING HEALTHY: IMMUNISATION (INFLUENZA)

The Primary Care Information Portal provides data on the following indicator(s):

- % patients immunised who are identified at risk aged 6m-64 years
- % patients immunised over 65 years of age
- % patients immunised aged 2 [or] 3 years

6.1 MEASURE CONTEXT

6.1.1 KEY MEASURE CHARACTERISTICS

- Linked national policy or frameworks: ~~Public Health Outcomes Framework (PHOF)~~; Making Every Contact Count (MECC).
- Population health rationale: Vaccination of 'at risk' groups is consistent with national policy to reduce winter pressures and prevent avoidable hospital admissions.
- Clinical rationale: To reduce personal risk of morbidity and mortality and minimise transmission to other vulnerable persons.
- Estimated patient/ public perception of topic importance: Generally well accepted.
- Identified caveats or limitations: There is a small proportion who have had vaccine administered by providers other than General Medical Practices.

6.1.2 KEY SUPPORTING EVIDENCE

Public Health England. Influenza, the green book: chapter 19. In Salisbury D, Ramsay M. Eds. *The Green Book: Immunisation against infectious disease*. London: Public Health England; 2013. [online] Available [here](#).

- The Green Book (UK guidance on immunisation for health professionals) reports that influenza immunisation has been recommended in the UK since the late 1960s, with the aim of directly protecting those in clinical risk groups who are at a higher risk of influenza associated morbidity and mortality. In 2000, the policy was extended to include all people aged 65 years or over (see later for age definition). The list of conditions that constitute a clinical risk group where influenza vaccine is indicated are reviewed regularly by the Joint Committee on Vaccination and Immunisation (JCVI).

Want to know more?



The PHW Vaccine Preventable Disease Programme (VPDP) host a page containing information about immunisation and vaccines [here](#); an influenza-specific page is [here](#). The PHW VPDP intranet site, available to healthcare staff, provides access to current and previous flu season statistics via IVOR (Influenza Vaccine Online Reporting), including data at the cluster and GP practice level, available [here](#).

6.2 COMPARATIVE ANALYSIS

- Data source: GP clinical systems
- Numerator: Not stated
- Denominator: Not stated
- Caveat: The denominator includes those who would have been exception reported in QOF. The reports to be included in the portal will be updated on an annual basis and will report on the flu season which is between September and April of each financial year
- Comment: Please note that the clusters reported are in accordance with those reported upon by PHW Screening Services

6.2.1 VARIATION BY HEALTH BOARD

Fig. 6A shows the variation in uptake proportion of patients vaccinated against influenza who are identified at risk aged 6m-64 years, by health board. The average Wales attainment for this measure is an uptake proportion of 46.9%. Variation in attainment across Wales is 6.0%, ranging from 2.8% above average (ABUHB, 49.7%) to 3.2% below average (ABMUHB, 43.7%).

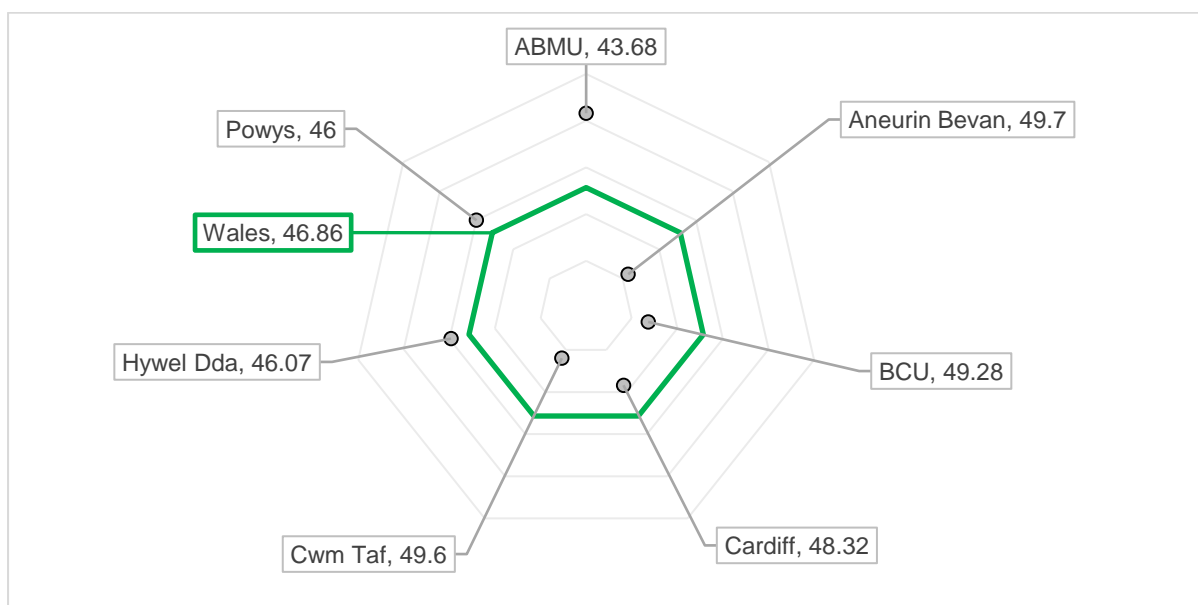


Fig. 6A: Variation in uptake proportion of patients vaccinated against influenza who are identified at risk aged 6m-64 years, by health board, 2016/17 (Source: PCIP, Sep 2018).

Fig. 6B shows the variation in uptake proportion of patients vaccinated against influenza who are 65+ years, by health board. The average Wales attainment for this measure is an uptake proportion of 66.7%. Variation in attainment across Wales is 5.6%, ranging from 2.3% above average (C&VUHB, 69.0%) to 3.1% below average (HDUHB, 63.4%).

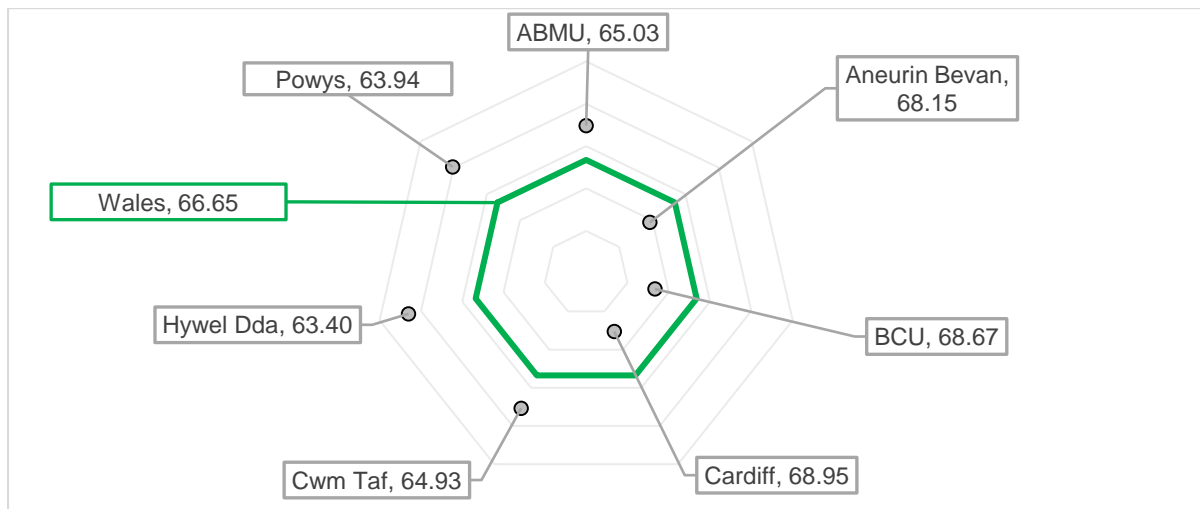


Fig. 6B: Variation in uptake proportion of patients vaccinated against influenza who are 65+ years, by health board, 2016/17 (Source: PCIP, Sep 2018).

Fig. 6C shows the variation in uptake proportion of patients vaccinated against influenza who are aged 2 and 3 years, by health board. The average Wales attainment for this measure is an uptake proportion of 45.3%. Variation in attainment across Wales is 11.4%, ranging from 4.5% above average (BCUHB, 49.7%) to 6.9% below average (HDUHB, 38.3%).

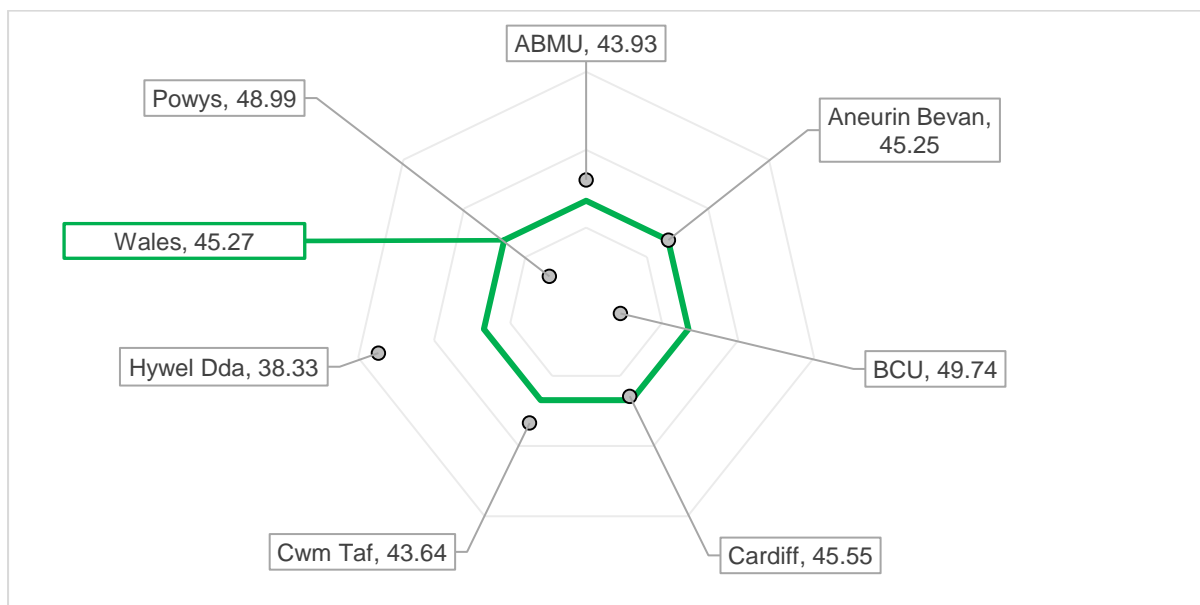


Fig. 6C: Variation in uptake proportion of patients vaccinated against influenza who are aged 2 and 3 years, by health board, 2016/17 (Source: PCIP, Sep 2018).

6.2.2 VARIATION WITHIN HEALTH BOARDS

Fig. 6D shows the variation in uptake proportion of patients vaccinated against influenza who are identified at risk aged 6m-64 years, by cluster within each health board. Variation in attainment by cluster ranges from as much as 13.9% within ABMUHB, ABUHB and BCUHB to as little as 3.0% within PTHB. Variation between the best attaining (BCUHB, 56.4%) and least attaining (ABMUHB, 36.2%) cluster across all of Wales is 20.3%.

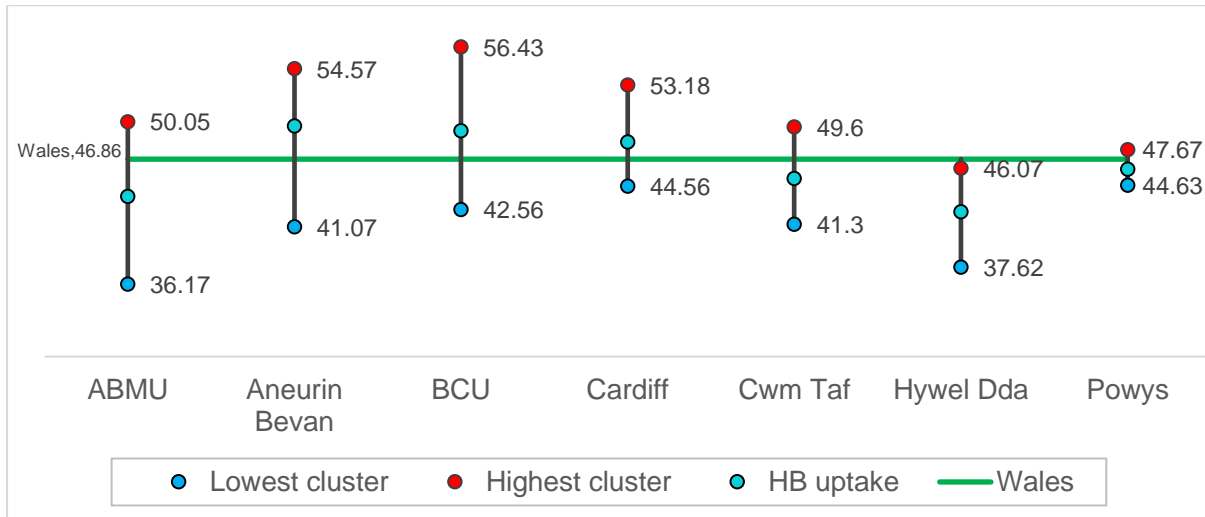


Fig. 6D: Variation in uptake proportion of patients vaccinated against influenza who are identified at risk aged 6m-64 years, by cluster within each health board, 2016/17 (Source: PCIP, Sep 2018).

Fig. 6E shows the variation in uptake proportion of patients vaccinated against influenza who are 65+ years, by cluster within each health board. Variation in attainment by cluster ranges from as much as 15.1% within C&VUHB to as little as 1.2% within PTHB. Variation between the best attaining (C&VUHB, 73.8%) and least attaining (HDUHB, 58.6%) cluster across all of Wales is 15.2%.

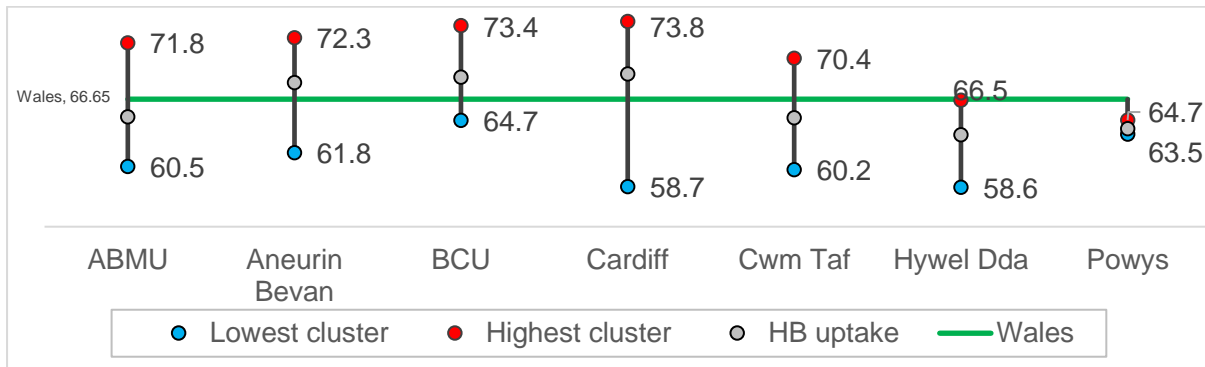


Fig. 6E: Variation in uptake proportion of patients vaccinated against influenza who are 65+ years, by cluster within each health board, 2016/17 (Source: PCIP, Sep 2018).

Fig. 6F shows the variation in uptake proportion of patients vaccinated against influenza who are aged 2 and 3 years, by cluster within each health board. Variation in attainment by cluster ranges from as much as 35.6% within C&VUHB to as little as 14.4% within PTHB. Variation between the best attaining (ABUHB, 65.6%) and least attaining (C&VUHB, 21.3%) cluster across all of Wales is 44.2%.

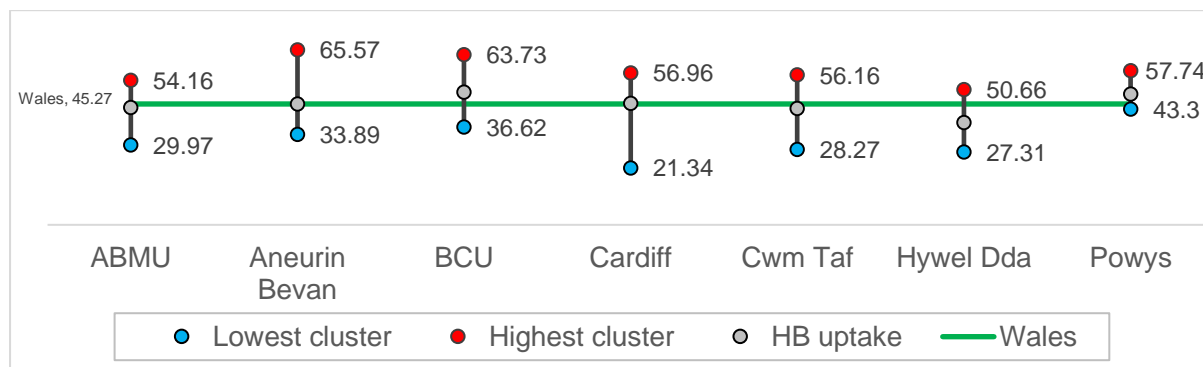


Fig. 6F: Variation in uptake proportion of patients vaccinated against influenza who are aged 2 and 3 years, by cluster within each health board, 2016/17 (Source: PCIP, Sep 2018).

Key messages

- Averaged uptake proportion between health boards for two influenza immunisation indicators is less than 5% either side of the Welsh average, although it exceeds 5% for immunisation of 2 and 3 year olds.
- Health board averages obfuscate variation within individual health boards of up to 36%.
- The attainment gap between clusters across Wales is wide across two of the three indicators, both of which exceed 20% variance.

6.3 IMPROVEMENT ACTIONS

6.3.1 GP PRACTICE ACTION

Improvement actions potentially suitable for adoption by GP practice cluster members include:

- Evidenced-based information to support primary care flu campaigns is available [here](#) & [here](#).
- Reports from previous PHW Cluster Support Schemes are available [here](#).
- *A good practice guide for flu campaign planning in primary care clusters* (VPDP 2018) collates experience across Wales and provides evidence of several general practice factors that can have a positive influence on flu vaccine uptake, helping to protect more staff and patients—whilst also generating income for the practice.
 - Top tips (see doc for detail) are that Early collaborative planning is important; Leadership is key; Sharing information helps; Learn together; and Supporting each other makes a difference
 - Ways you may support each general practice:
 - Highlight the Good practice guide for general practice
 - Encourage practices and community pharmacies to work together on their flu plans
 - Encourage them to plan the campaign at a team meeting early in the year

- Encourage them to engage with a wide group of healthcare workers in their planning: Midwives can help actively encourage pregnant women to get their vaccine; Care home staff may actively encourage residents and staff to get their vaccine
- Require/request an end of season practice flu report [\[link\]](#)
- Actively encourage all general practice staff to complete FluOne – Information for all health and social care staff [\[link\]](#)
- Remind them of appropriate training opportunities for clinical staff [\[link\]](#)
- Encourage them to offer flu vaccine to staff with direct patient contact as a priority
- Remind practices they are required to invite eligible individuals to have their flu vaccine and that it makes a difference to vaccine uptake.
- Encourage them to utilise different formats of invitation and signpost to resources that will help such as template invitation letters in a range of minority languages [\[link\]](#)
- Remind them on the importance of recording timely accurate data and the benefits of data cleansing
- Advise on the benefits of accessing their [IVOR data](#), and show them how to do it.
- Signpost to key resources such as posters, leaflets, stickers etc. at publichealthwales.org/health-information-resources
- Encourage opportunistic immunisation
- Remind them how they are doing with [flu vaccine uptake](#) on a regular basis
- Support ordering adequate supplies of appropriate vaccines in a timely way
- Public Health Wales FluTwo e-Learning module is a clinical update on flu and flu vaccination suitable for all healthcare professionals, and is available [here](#).
- A new CPD Module has been added to CPD Resources for General Practitioners. 'Influenza Vaccine' has been created for Primary Care practitioners and is available [here](#). Created by Public Health Wales in conjunction with Hywel Dda University Health Board, it's a guide to encouraging your patients to get vaccinated.

6.3.2 WIDER CLUSTER ACTION

Improvement actions potentially suitable for adoption by the wider cluster membership include:

- Ways you may support each community pharmacy (from *A good practice guide for flu campaign planning in primary care clusters*, VPDP 2018):
 - Encourage community pharmacies and practices to work together on their plans
 - Encourage community pharmacies to promote the benefits of flu vaccination to eligible groups
 - Actively encourage all community pharmacy staff to complete FluOne – Information for all health and social care staff [\[link\]](#)
 - Remind of appropriate training opportunities for clinical staff [\[link\]](#)
 - Encourage them to offer flu vaccine to staff with direct patient contact as a priority
 - Advise on timely data cleansing and accurate recording
 - Signpost to resources such as posters at publichealthwales.org/health-information-resources
 - Encourage opportunistic reminding of individuals who are eligible for a flu vaccine
 - Support ordering adequate supplies of appropriate vaccines in a timely way

- Ways you may support other healthcare providers locally (from *A good practice guide for flu campaign planning in primary care clusters*, VPDP 2018):
 - Encourage dental surgeries and opticians to promote the benefits of flu vaccination to eligible groups
 - Share Guidance on Fighting Flu in Dental Practice with local dental surgeries [\[link\]](#)
 - Encourage care homes to promote the benefits of flu vaccination to eligible groups
 - Share resources specific to care homes with them (this includes a good practice guide) [\[link\]](#)
 - Actively encourage all dental surgeries, optician and care home staff to complete FluOne – Information for all health and social care staff [\[link\]](#)
 - Signpost to key resources such as posters, leaflets, stickers [\[link\]](#)

Good practice example

Heads of Primary Care were unable to identify relevant good practice examples of cluster-led quality improvement projects for this report. Readers are encouraged to contact the PHW Primary Care Division with any local examples suitable to share.

References

- Flu vaccination: increasing uptake. NICE guideline [NG103]. Published date: August 2018. <https://www.nice.org.uk/guidance/ng103>
- Dexter LJ, Teare MD, Dexter M, et al Strategies to increase influenza vaccination rates: outcomes of a nationwide cross-sectional survey of UK general practice *BMJ Open* 2012;2:e000851. doi: 10.1136/bmjopen-2011-000851 [\[link\]](#)
- Kassianos G, Blank P, Falup-Pecurariu O, Kuchar E, Kyncl J, Ortiz De Lejarazu R, Nitsch-Osuch A, Van Essen GA. Influenza vaccination: key facts for general practitioners in Europe—a synthesis by European experts based on national guidelines and best practices in the United Kingdom and the Netherlands. *Drugs in Context* 2016; 5: 212293. DOI: 10.7573/dic.212293 [\[link\]](#)

7. STAYING HEALTHY: MATERNITY & CHILD HEALTH (BREASTFEEDING)

The Primary Care Information Portal provides data on the following indicator(s):

- % of babies exclusively breastfed at 10 days following birth

7.1 MEASURE CONTEXT

7.1.1 KEY MEASURE CHARACTERISTICS

- Linked national policy or frameworks: Early years programme.
- Population health rationale: Breastfeeding has long-term benefits which persist into adulthood.
- Clinical rationale: Breastfeeding reduces neonatal infections.
- Estimated patient/ public perception of topic importance: Breast is best, but not necessarily convenient.
- Identified caveats or limitations: 6-8 weeks would be more reflective of persistence in breastfeeding, but it isn't currently recorded in a standard format.

7.1.2 KEY SUPPORTING EVIDENCE

Note: The following source was identified when searching for evidence of breastfeeding at 6-8 weeks, not specifically at 10 days. While the health visitor records at 6-8 weeks, the existing PHOF indicator is for 10 days (PHOF technical [guide](#) and PHOF [Tool](#) contain breastfeeding at 10 days).

Victora CG, et al. *Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect*. Lancet 2016; 387(10017):475-490. Available [here](#).

- The authors of this review of systematic reviews and meta-analyses conclude that children who are breastfed for longer periods have lower infectious morbidity and mortality, fewer dental malocclusions, and higher intelligence than those who are not breastfed; the evidence suggests that greater benefits accrue with increasing duration of breastfeeding; growing evidence suggests that breastfeeding might protect against overweight and diabetes later in life. The review authors also conclude that breastfeeding benefits mothers; it can prevent breast cancer, and might reduce the risk of diabetes and ovarian cancer.

Want to know more?



The PHW Observatory host a series of topic pages that bring together information on Observatory products; other key websites; key data sources; key evidence sources; and additional evidence and data sources. The topic page on maternal & child health is [here](#).

Breastfeeding data are available from StatsWales (Welsh Government) [here](#).

7.2 COMPARATIVE ANALYSIS

- Data source: Public Health Outcomes Framework: National Community Child Health Database (NCCHD); Welsh Index of Multiple Deprivation (WIMD) 2014, Welsh Government (WG); Rural/urban classifications (2011), Office for National Statistics (ONS)
- Numerator: The number of babies exclusively breastfed at 10 days following birth
- Denominator: All live births where breastfeeding status is recorded

7.2.1 VARIATION BY HEALTH BOARD

Fig. 7A shows the variation in proportion of babies exclusively breastfed at 10 days following birth, by health board. The average Wales attainment for this measure is a breastfeeding proportion of 33.8%. Variation in attainment across Wales is 32.1%, ranging from 19.6% above average (PTHB, 53.3%) to 12.5% below average (CTUHB, 21.2%).

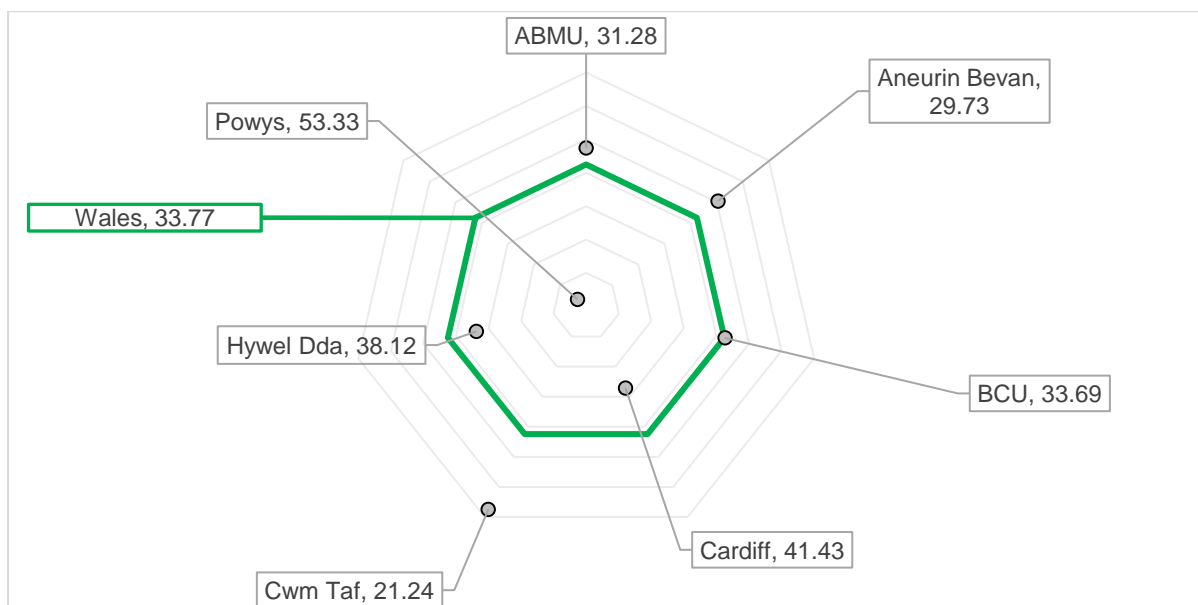


Fig. 7A: Variation in proportion of babies exclusively breastfed at 10 days following birth, by health board, 2016 (Source: PCIP, Sep 2018).

7.2.2 VARIATION WITHIN HEALTH BOARDS

These data are not reported at cluster level.

Key messages

- Overall variation between health boards for exclusive breastfeeding at 10 days exceeds 5% either side of the Welsh average.

7.3 IMPROVEMENT ACTIONS

7.3.1 GP PRACTICE ACTION

Improvement actions potentially suitable for adoption by GP practice cluster members include:

- Encourage persistence with breast feeding:
 - The risk of being overweight or obese is increased by nutrition in the early years of life. Being bottle-fed, early weaning and rapid growth in the first year of life are all associated with increased risk of obesity and overweight in children.
 - Around 59% of mothers initiated breastfeeding in 2016 in Wales. There is variation in breastfeeding initiation rates by maternal age with less than a third of mothers aged under 16 initiating breastfeeding compared to three quarters of mothers aged 45+.

7.3.2 WIDER CLUSTER ACTION

Improvement actions potentially suitable for adoption by the wider cluster membership include:

- In relation to NICE guidance on maternal and child nutrition:
 - Recommendation 9: Midwives, obstetricians, GPs and health visitors:
 - Midwives and health visitors should ensure pregnant women and their partners are offered breastfeeding information, education and support on an individual or group basis. This should be provided by someone trained in breastfeeding management and should be delivered in a setting and style that best meets the woman's needs.
 - During individual antenatal consultations GPs, obstetricians and midwives should encourage breastfeeding. They should pay particular attention to the needs of women who are least likely to breastfeed (for example, young women, those who have low educational achievement and those from disadvantaged groups).
 - A midwife or health visitor trained in breastfeeding management should provide an informal group session in the last trimester of pregnancy. This should focus on how to breastfeed effectively by covering feeding position and how to attach the baby correctly.
 - Recommendation 10: Midwives, health visitors, midwifery and health visitor support workers:
 - Ensure a mother can demonstrate how to position and attach the baby to the breast and can identify signs that the baby is feeding well. This should be achieved (and be documented) before she leaves hospital or the birth centre (or before the midwife leaves the mother after a home birth).
 - Provide continuing and proactive breastfeeding support at home, recording all advice in the mother's hand held records.
 - Provide contact details for local voluntary organisations that can offer ongoing support to complement NHS breastfeeding services.
 - Advise mothers that a healthy diet is important for everyone and that they do not need to modify their diet to breastfeed.
 - Do not provide written materials in isolation but use them to reinforce face to face advice about breastfeeding.
 - Recommendation 12: Midwives, health visitors, paediatric nurses, nurses working in special care baby and neonatal units, and nursery nurses:
 - Show all breastfeeding mothers how to hand express breast milk.

- Advise mothers that expressed milk can be stored for: up to 5 days in the main part of a fridge, at 4°C or lower; up to 2 weeks in the freezer compartment of a fridge; up to 6 months in a domestic freezer, at minus 18°C or lower.
- Advise mothers who wish to store expressed breast milk for less than 5 days that the fridge preserves its properties more effectively than freezing.
- Advise mothers who freeze their expressed breast milk to defrost it in the fridge and not to re-freeze it once thawed. Advise them never to use a microwave oven to warm or defrost breast milk.
- Recommendation 13: NHS trusts responsible for maternity care and GP surgeries and community health centres:
 - NHS trusts should train link workers who speak the mother's first language to provide information and support on breastfeeding, use of infant formula, weaning and healthy eating.
 - Where link workers are not available, ensure women whose first language is not English have access to interpreting services and information in a format and language they can understand.
 - NHS trusts should encourage women from minority ethnic communities whose first language is not English to train as breastfeeding peer supporters.
- Recommendation 14: GPs, midwives, health visitors and pharmacists:
 - Midwives should ensure mothers who choose to use infant formula are shown how to make up a feed before leaving hospital or the birth centre (or before the mother is left after a home birth). This advice should follow the most recent guidance from the DH ('Guide to bottle feeding' 2011).
 - Avoid promoting or advertising infant or follow on formula. Do not display, distribute or use product samples, leaflets, posters, charts, educational or other materials and equipment produced or donated by infant formula, bottle and teat manufacturers.

Good practice example

Heads of Primary Care were unable to identify relevant good practice examples of cluster-led quality improvement projects for this report. Readers are encouraged to contact the PHW Primary Care Division with any local examples suitable to share.

References

- NICE guidance - Maternal and child nutrition, Public health guideline [PH11] Published date: March 2008 Last updated: November 2014.
- The Unicef Baby Friendly Initiative provides standards, guidance and resources to support breastfeeding. We understand this resource is under currently review. <https://www.unicef.org.uk/babyfriendly/call-to-action-campaign-update-becoming-breastfeeding-friendly-project/>

8. STAYING HEALTHY: MATERNITY & CHILD HEALTH (WEIGHT)

The Primary Care Information Portal provides data on the following indicator(s):

- % of 4-5 year olds classified as overweight or obese, defined by the Child Measurement Programme (BMI calculation)

8.1 MEASURE CONTEXT

8.1.1 KEY MEASURE CHARACTERISTICS

- Linked national policy or frameworks: Staying healthy: Reduction in morbidity caused by obesity; Wellbeing of Future Generations; Public Health Outcomes Framework; MECC; Early Years Outcomes Framework.
- Population health rationale: There is good evidence that an obese child is more likely to become an obese adult, with an increased risk of developing diabetes.
- Clinical rationale: Overweight children are more prone to develop chronic conditions and may be socially disadvantaged.
- Estimated patient/ public perception of topic importance: This is a complex area with a need to strike a balance between avoidance of body-shaming and the normalisation of being overweight.
- Identified caveats or limitations: These are measurements at two points in a child's development, rather than a trend. Primary care practitioners have a role in the context of a system-wide approach. Currently, the Child Measurement Programme (CMP) in Wales measures once at age 4-5 years; no second measurement currently collected as per England (10-11 years). CMP considered measurement at age 8-9 years in line with other European countries, as more meaningful than 10-11 years due to confounding factors such as puberty.

8.1.2 KEY SUPPORTING EVIDENCE

Public Health England. 2016. *Health risks of childhood obesity*. [Online]. Available [here](#).

- The National Obesity Observatory (now Public Health England) have summarised evidence on the possible health risks associated with childhood obesity. These include; type 2 diabetes; asthma; obstructive sleep apnoea; increased cardiovascular risk factors; risk of mental ill health and musculoskeletal problems

Want to know more?



The PHW Observatory host a series of topic pages that bring together information on Observatory products; other key websites; key data sources; key evidence sources; and additional evidence and data sources. The topic page on maternal & child health is [here](#), while the topic page on obesity is [here](#). There are related topic pages on healthy eating ([here](#)) and on physical activity ([here](#)). Information about the Child Measurement Programme for Wales, including annual reports, can be found [here](#).

8.2 COMPARATIVE ANALYSIS

- Data source: Child Health Measurement Programme
- Numerator: All children aged 4-5 who are overweight or obese on BMI criteria
- Denominator: All children aged 4-5 who are eligible for measurement according to CMP criteria
- Caveat: These data are only available to HB. Currently, the Child Measurement Programme in Wales measures once at age 4-5 years; no second measurement currently collected as per England (10-11 years)

8.2.1 VARIATION BY HEALTH BOARD

Fig. 8A shows the variation in proportion of 4-5 year olds classified as overweight or obese, by health board. The average Wales attainment for this measure is a recording proportion of 26.2%. Variation in attainment across Wales is 7.3%, ranging from 2.6% above average (CTUHB, 28.8%) to 4.7% below average (C&VUHB, 21.5%).

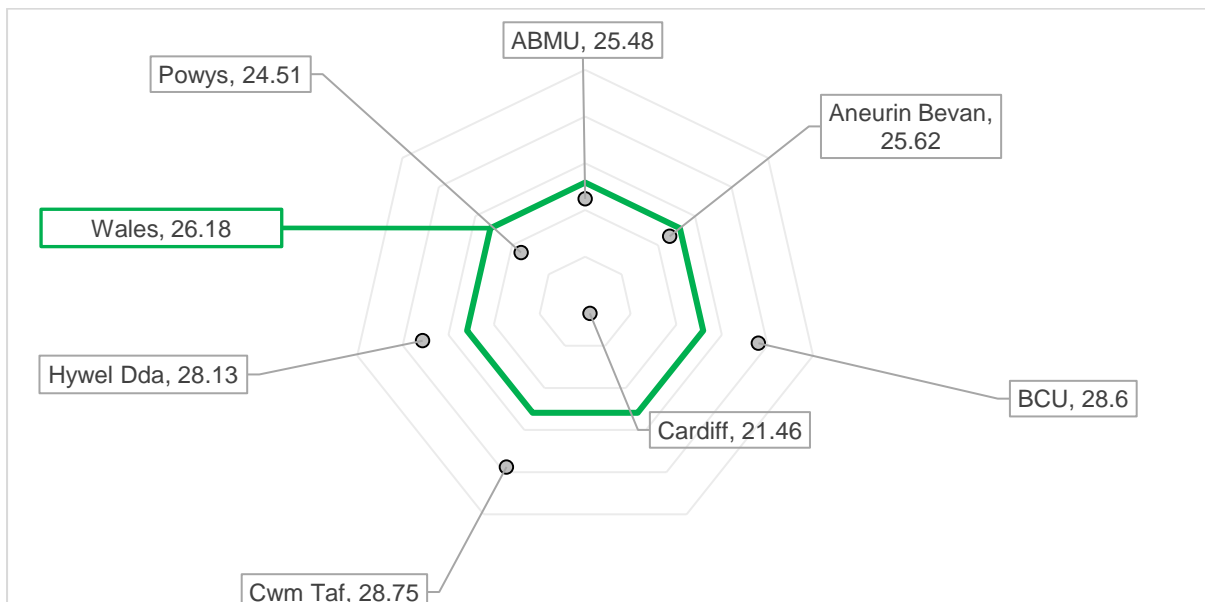


Fig. 8A: Variation in proportion of 4-5 year olds classified as overweight or obese, by health board, 2015/16 (Source: PCIP, Sep 2018).

8.2.2 VARIATION WITHIN HEALTH BOARDS

These data are not reported at cluster level.

Key messages

- Overall variation between health boards for prevalence of child overweight and obesity is less than 5% either side of the Welsh average.

8.3 IMPROVEMENT ACTIONS

8.3.1 GP PRACTICE ACTION

Improvement actions potentially suitable for adoption by GP practice cluster members include:

- Evidenced-based information to support primary care work on overweight and obesity for children under 5 years is available from the *Every Child 10 Steps to a Healthy Weight Programme* [website](#). Health professionals can promote the following advice:
 - Step 1: If you are planning to start a family, aim to be a healthy weight. If you as parents are a healthy weight your child is more likely to be a healthy weight too.
 - Step 2: Avoid gaining too much weight during pregnancy. Pregnancy isn't a good time to try to lose weight but making sure that you gain weight within recommended levels is a good idea for your health and that of your baby.
 - Step 3: Breastfeed your baby. Babies who are breastfed are more likely to be a healthy weight by the time they start school.
 - Step 4: Wait for six months before starting solid foods. Babies who are given solid food too soon are more likely to be overweight. In the first six months of their life, babies get all the nutrients they need from breast milk or infant formula.
 - Step 5: Help your baby to grow steadily. Babies who grow rapidly in the first year of life are more likely to be overweight when they are school age.
 - Step 6: Give children and toddlers opportunities to play outdoors every day. Children who play outdoors every day are more likely to be a healthy weight.
 - Step 7: Keep screen time below two hours a day. Children who spend less than two hours a day looking at a screen, including a phone, tablet, computer or TV, are more likely to be a healthy weight.
 - Step 8: Give your children fruit and vegetables every day. Fruit and vegetables are full of vitamins, minerals and fibre which all help to keep your child healthy.
 - Step 9: Make sure your child gets enough sleep. Regularly getting enough sleep will help your child stay a healthy weight.
 - Step 10: Stick to drinking water and milk. Drinks with no added sugar mean healthier teeth and a healthier weight.
- Primary care professionals can support parents to recognise whether their child is a healthy weight or overweight. Raising the issue of a child's weight with parents is an important first step in parents changing behaviours:
 - In Wales, insight work done in 2016, to inform 10 Steps to a Healthy Weight for Every Child, found limited parental recognition of public concern or awareness if a child aged 0-5 years was above a healthy weight and found that the language used to describe weight at this age can include more positive sounding phrases like tall for age, big boned etc.
 - The 10 Steps to a Healthy Weight Baseline Survey found that while parents estimated the level of overweight or obesity to be slightly higher than measured rates (26% in the CMP 2016) only 4% identified that their child was overweight.
 - The conclusion drawn from this is that parents find it hard to recognise whether their child is a healthy weight and may be less willing to accept that they are overweight or obese when this is identified.

8.3.2 WIDER CLUSTER ACTION

Improvement actions potentially suitable for adoption by the wider cluster membership include:

- Encourage persistence with breast feeding:
 - The risk of being overweight or obese is increased by nutrition in the early years of life. Being bottle-fed, early weaning and rapid growth in the first year of life are all associated with increased risk of obesity and overweight in children.
 - Around 59% of mothers initiated breastfeeding in 2016 in Wales. There is variation in breastfeeding initiation rates by maternal age with less than a third of mothers aged under 16 initiating breastfeeding compared to three quarters of mothers aged 45+.

Good practice example

Heads of Primary Care were unable to identify relevant good practice examples of cluster-led quality improvement projects for this report. Readers are encouraged to contact the PHW Primary Care Division with any local examples suitable to share.

References

- Phillips CJ et al. Assessing the costs to the NHS associated with alcohol and obesity in Wales. Social research. Number 20. Cardiff: Welsh Assembly Government; 2011. Available at: <https://gov.wales/statistics-and-research/assessing-costs-nhs-associated-alcohol-obesity/?lang=en>
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- Public Health Wales NHS Trust. Child Measurement Programme for Wales Report 2016/17. [Online]. 2018. Available at: <http://www.wales.nhs.uk/sitesplus/888/page/67795>
- Obesity prevention. Clinical guideline [CG43] Published date: December 2006 Last updated: March 2015 <https://www.nice.org.uk/guidance/cg43>
- Obesity in children and young people: prevention and lifestyle weight management programmes. Quality standard [QS94] Published date: July 2015 <https://www.nice.org.uk/guidance/qs94>

9. STAYING HEALTHY: SCREENING (AAA)

The Primary Care Information Portal provides data on the following indicator(s):

- % uptake of AAA screening

9.1 MEASURE CONTEXT

9.1.1 KEY MEASURE CHARACTERISTICS

- Linked national policy or frameworks: Staying Healthy: Prevention; Reduction in premature mortality from the major causes of death; Effective screening services; Health checks; PHOF.
- Population health rationale: AAA is a major non-communicable disease concern and early detection and intervention may reduce this burden.
- Clinical rationale: Early intervention reduces morbidity and improves patient outcomes.
- Estimated patient/ public perception of topic importance: Public perception of screening programmes is positive.
- Identified caveats or limitations: Screening has the potential to cause harm. Not wholly influenced by primary care.

9.1.2 KEY SUPPORTING EVIDENCE

Public Health England. *The UK NSC recommendation on Abdominal Aortic Aneurysm screening in men over 65*. London: Public Health England; 2009. Available [here](#).

- This reports that a systematic population screening programme recommended in 2009¹ was largely based on the results of a Medical Research Council trial of screening for Abdominal Aortic Aneurysm [AAA] which showed that in a research setting, involving five vascular surgical services in England, screening men for AAA resulted in a decline in mortality from ruptured aneurysm.

Cosford, PA; Leng, GC & Thomas, J. *Screening for Abdominal Aortic Aneurysm*. Cochrane Database Syst Rev 2007, Issue 2. Art. No.: CD002945. Doi: 10.1002/14651858.CD002945.pub2. Available [here](#).

- Authors of this Cochrane Review covering a number of controlled trials including the MRC trial concluded there is evidence of a significant reduction in mortality from AAA in men aged 65-79 years following ultrasound screening.

Want to know more?



Information about the Wales Abdominal Aortic Aneurysm (AAA) Screening Programme is available [here](#), including statistical reports [here](#). Information on the programme for healthcare professionals is available on the NHS Wales intranet [here](#).

¹ Ashton, HA *et al*. The Multicentre Aneurysm Screening Study (MASS) into the effect of abdominal aortic aneurysm screening on mortality in men: a randomised controlled trial. *Lancet* 2002; 360(9345):1531-1539.

9.2 COMPARATIVE ANALYSIS

- Data source: AAA Screening Wales
- Numerator: Eligible men resident in Wales aged 65 years that attended for screening in the time period
- Denominator: Number of eligible men resident in Wales aged 65 that were invited within the time period
- Comment: Please note that the clusters reported are in accordance with those reported upon by PHW Screening Services

9.2.1 VARIATION BY HEALTH BOARD

Fig. 9A shows the variation in uptake proportion for AAA screening, by health board. The average Wales attainment for this measure is an uptake proportion of 80.8%. Variation in attainment across Wales is 5.4%, ranging from 2.4% above average (Cwm Taf, 83.2%) to 3.1% below average (C&VUHB, 77.7%).

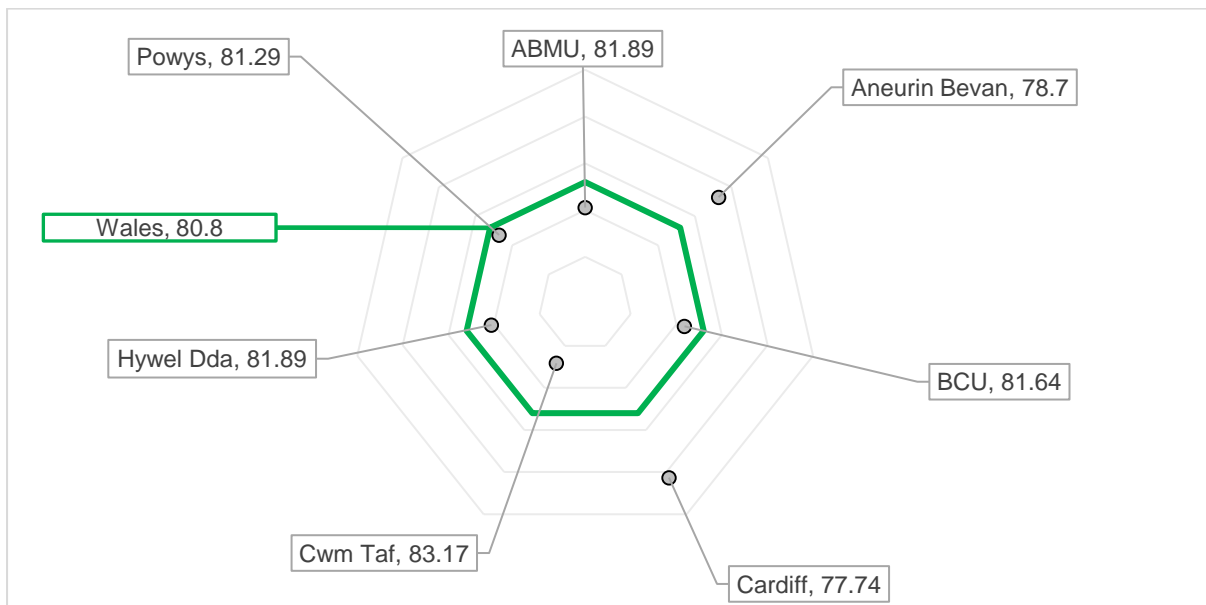


Fig. 9A: Variation in uptake proportion for AAA screening, by health board, 2016/17 (Source: PCIP, Sep 2018).

9.2.2 VARIATION WITHIN HEALTH BOARDS

Fig. 9B shows the variation in uptake proportion for AAA screening, by cluster within each health board. Variation in attainment by cluster ranges from as much as 18.3% within C&VUHB to as little as 7.1% within HDUHB. Variation between the best attaining (ABMUHB, 86.8%) and least attaining (C&VUHB, 66.4%) cluster across all of Wales is 20.4%.

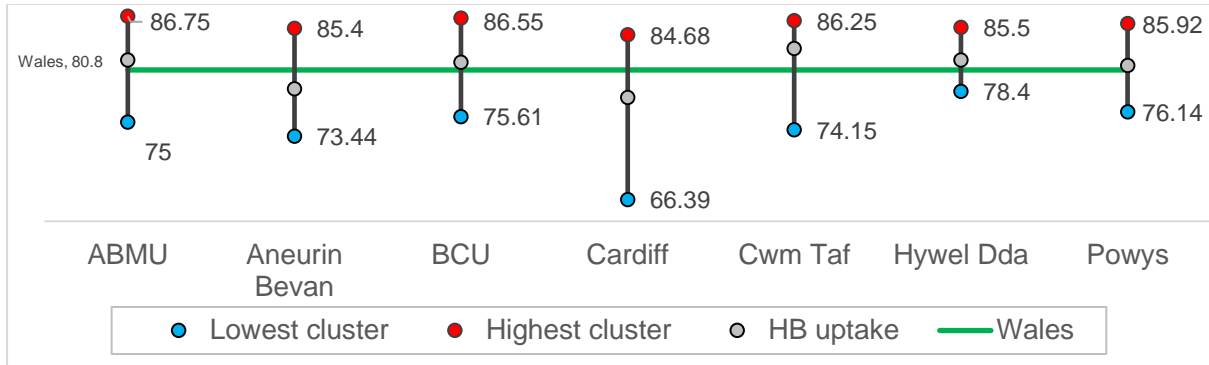


Fig. 9B: Variation in uptake proportion for AAA screening, by cluster within each health board, 2016/17 (Source: PCIP, Sep 2018).

Key messages

- Overall variation between health boards for uptake of AAA screening is less than 5% either side of the Welsh average.
- Health board averages obfuscate variation within health boards of up to 18.3%.
- The attainment gap between clusters across Wales is 20.4%.

9.3 IMPROVEMENT ACTIONS

9.3.1 GP PRACTICE ACTION

Improvement actions potentially suitable for adoption by GP practice cluster members include:

- Development of actions required.

9.3.2 WIDER CLUSTER ACTION

Improvement actions potentially suitable for adoption by the wider cluster membership include:

- Development of actions required.

Good practice example

Heads of Primary Care were unable to identify relevant good practice examples of cluster-led quality improvement projects for this report. Readers are encouraged to contact the PHW Primary Care Division with any local examples suitable to share.

10. STAYING HEALTHY: SCREENING (BOWEL)

The Primary Care Information Portal provides data on the following indicator(s):

- % uptake of bowel screening

10.1 MEASURE CONTEXT

10.1.1 KEY MEASURE CHARACTERISTICS

- Linked national policy or frameworks: Staying Healthy: Prevention; Reduction in premature mortality from the major causes of death; Effective screening services; Health checks; PHOF.
- Population health rationale: Bowel cancer is a major non-communicable disease concern and early detection and intervention may reduce this burden.
- Clinical rationale: Early intervention reduces morbidity and improves patient outcomes.
- Estimated patient/ public perception of topic importance: Public perception of screening programmes is positive.
- Identified caveats or limitations: Screening has the potential to cause harm. Not wholly influenced by primary care.

10.1.2 KEY SUPPORTING EVIDENCE

National Institute for Health and Care Excellence. *Bowel Screening. Clinical Knowledge Summary*. London: NICE; 2014. Available [here](#).

- This NICE CKS reports that bowel cancer is a significant public health problem causing 16,000 deaths a year in the UK. Bowel cancer may be detected at an asymptomatic stage through screening. Early treatment of bowel cancer leads to better outcomes and may reduce bowel cancer mortality by approximately 16%. Bowel screening has been shown to reduce the incidence of bowel cancer in a screened population.

Want to know more?



Information about Bowel Screening Wales is available [here](#), including statistical reports [here](#). Information on the programme for healthcare professionals is available on the NHS Wales intranet [here](#). Data on cancer incidence (including stage at diagnosis), mortality and survival rates can be found on the Welsh Cancer Intelligence and Surveillance Unit (WCISU) website [here](#).

10.2 COMPARATIVE ANALYSIS

- Data source: Bowel Screening Wales
- Numerator: Number of eligible men and women resident in Wales aged 60-74 years who responded to their invitation and the bowel screening programme received a used test kit within six months of their invitation
- Denominator: Number of eligible men and women resident in Wales aged 60-74 that were invited within the time period

- Comment: Please note that the clusters reported are in accordance with those reported upon by PHW Screening Services

10.2.1 VARIATION BY HEALTH BOARD

Fig. 10A shows the variation in uptake proportion for bowel screening, by health board. The average Wales attainment for this measure is an uptake proportion of 53.4%. Variation in attainment across Wales is 3.5%, ranging from 1.7% above average (PTHB, 55.1%) to 1.8% below average (C&VUHB, 51.5%).

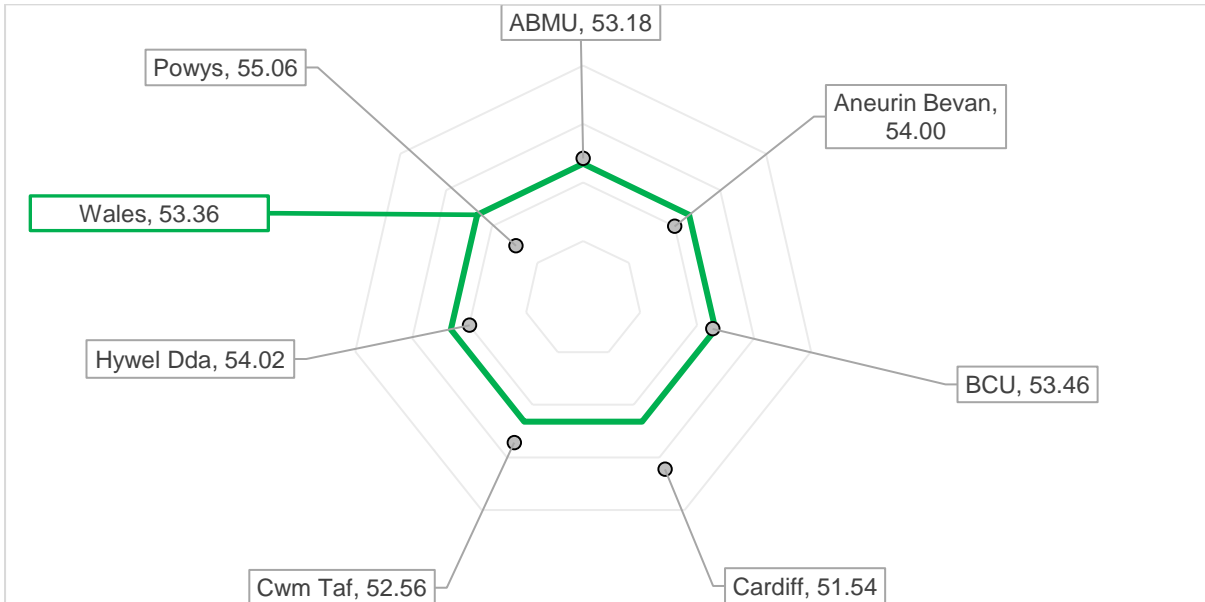


Fig. 10A: Variation in uptake proportion for bowel screening, by health board, 2016/17 (Source: PCIP, Sep 2018).

10.2.2 VARIATION WITHIN HEALTH BOARDS

Fig. 9B shows the variation in uptake proportion for bowel screening, by cluster within each health board. Variation in attainment by cluster ranges from as much as 20.1% within C&VUHB to as little as 0.4% within PTHB. Variation between the best attaining (C&VUHB, 58.9%) and least attaining (C&VUHB, 38.8%) cluster across all of Wales is 20.1%.

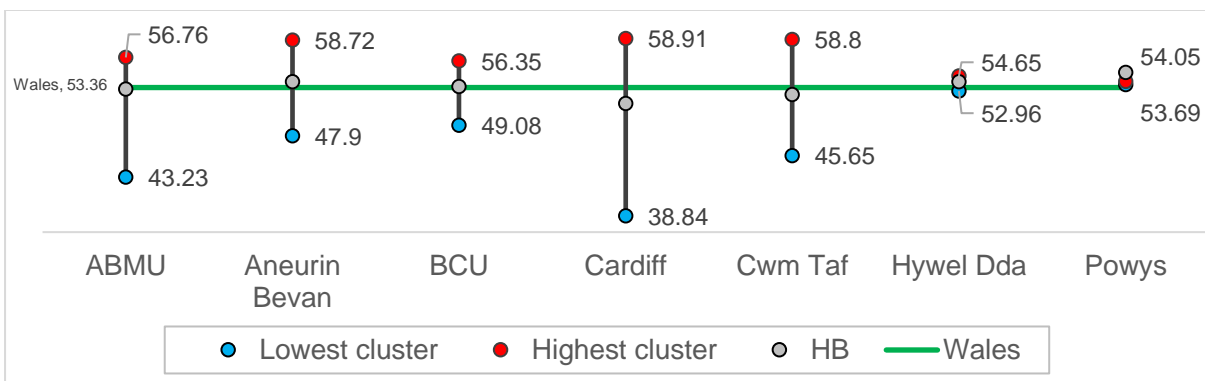


Fig. 10A: Variation in uptake proportion for bowel screening, by cluster within each health board, 2016/17 (Source: PCIP, Sep 2018).

Key messages

- Overall variation between health boards for uptake of bowel screening is less than 5% either side of the Welsh average.
- Health board averages obfuscate variation within health boards of up to 20%.
- The attainment gap between clusters across Wales is 20% (in this case, the best and least attaining clusters are within the same health board).

10.3 IMPROVEMENT ACTIONS

10.3.1 GP PRACTICE ACTION

Improvement actions potentially suitable for adoption by GP practice cluster members include:

- Interventions to increase bowel screening uptake (Cancer Research UK, Macmillan, NHS England August 2017) identified for GP practices are:
 - The role of GP Practices in supporting screening participation should be promoted:
 - GPs and their practice staff have a key role to play in providing details about the BCSP and, in particular, discussing the pros and cons of screening with patients so they are able to make an informed choice to participate. Having helpful healthcare messages displayed in the practice to alert people to bowel screening or discussed opportunistically during a routine visit are encouraged. These messages should highlight; the benefits of screening, that the risk of developing bowel cancer increases with age, and that if bowel cancer is diagnosed earlier, treatment can be more successful, and longer term survival improved.
 - The Royal College of General Practitioners has developed a 30-minute online bowel cancer screening course which highlights the importance of the GP's role in the BCSP [\[link\]](#).
 - Encouraging positive dialogue and communication:
 - ACE recommends having conversations with patients as key to resolving some of the barriers and influencing positive participation. Directly targeting segments of a practice population dominated by ethnic minority groupings and providing access to interpreters to overcome language and translation issues, are considered really important. The conversations should provide a reason to talk about screening positively.
 - Re-engaging patients for colonoscopy following positive screening test:
 - Patients who test positive at gFOBt are normally offered a colonoscopy investigation at their local screening centre. There is variation in numbers of patients who fail to attend their colonoscopy appointment (the average rate is 20%). Recognising that for some of these patients, colonoscopy may not be the next appropriate investigation, ACE recommends, given the high risk element of significant pathology findings in this patient cohort, they are a particular group that GPs should actively seek to re-engage with.

10.3.2 WIDER CLUSTER ACTION

Improvement actions potentially suitable for adoption by the wider cluster membership include:

- Development of partnership actions required.

Good practice example (submitted by Cardiff & Vale UHB)

What problem was being addressed? Bowel Screening and health promotion in the BME community.

What was done to address it? GP-led health fair within local mosques and cultural centres.

How does this evidence good practice? Raise awareness within the BME community of the importance of screening and healthy lifestyles.

What key learning can be shared? Increase awareness through a series of well publicised, coordinated health fairs which promote screening and health promotion to the BME community.

Who did it or who can be contacted in the event of any queries? Dr Amir Ghanghro at St. David's Court Surgery.

References

- Engaging primary care in bowel screening GP good practice guide Wales version
https://www.cancerresearchuk.org/sites/default/files/wales_gp_workbook_2017_final_pdf.pdf
- Interventions to increase bowel screening uptake, Cancer Research UK, Macmillan, NHS England August 2017.
https://www.cancerresearchuk.org/sites/default/files/interventions_to_increase_bowel_screening_uptake_v1.0_exec_summary.pdf

11. STAYING HEALTHY: SCREENING (BREAST)

The Primary Care Information Portal provides data on the following indicator(s):

- % uptake of breast screening

11.1 MEASURE CONTEXT

This indicator is not described within PHW's *Proposed Primary Care Measures: Phase 2* final report (May 2017) or related documentation.

Want to know more?



Information about Breast Test Wales is available [here](#), including statistical reports [here](#). Information on the programme for healthcare professionals is available on the NHS Wales intranet [here](#). Data on cancer incidence (including stage at diagnosis), mortality and survival rates can be found on the Welsh Cancer Intelligence and Surveillance Unit (WCISU) website [here](#).

11.2 COMPARATIVE ANALYSIS

- Data source: Breast Test Wales
- Numerator: Number of eligible women resident in Wales age 50-70 years who responded to their invitation for screening and attended within six months of their original invitation
- Denominator: Number of eligible women resident in Wales aged 50-70 years that were invited within the time period
- Comment: Please note that the clusters reported are in accordance with those reported upon by PHW Screening Services

11.2.1 VARIATION BY HEALTH BOARD

Fig. 11A shows the variation in uptake proportion for breast screening, by health board. The average Wales attainment for this measure is an uptake proportion of 73.1%. Variation in attainment across Wales is 6.1%, ranging from 3.2% above average (PTHB, 76.3%) to 2.9% below average (C&VUHB, 70.2%).

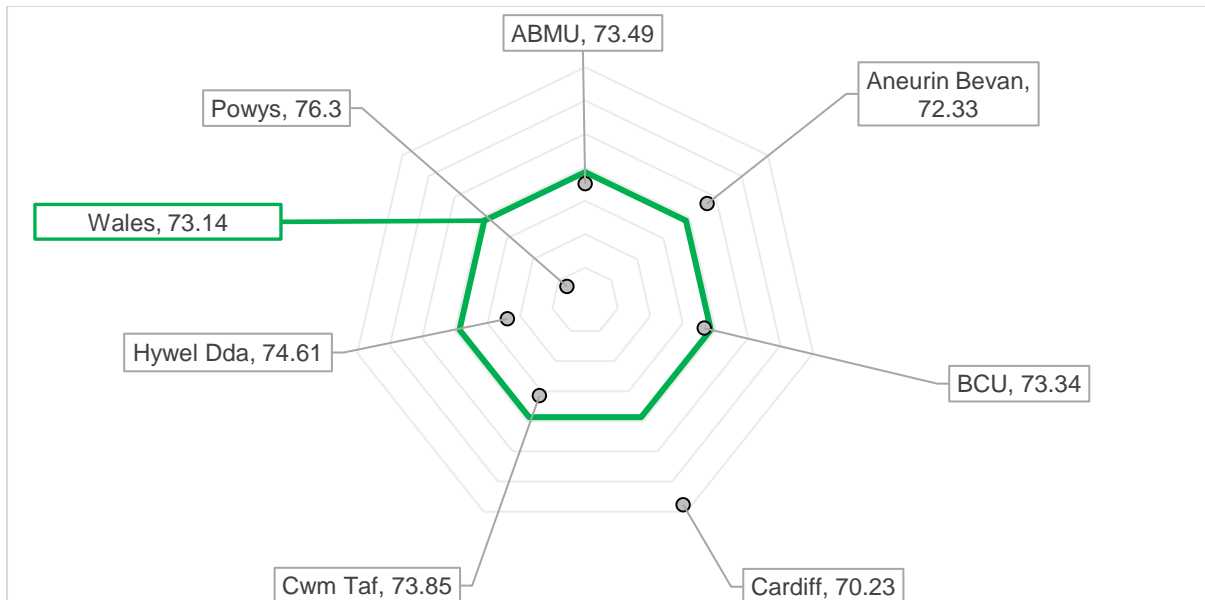


Fig. 11A: Variation in uptake proportion for breast screening, by health board, latest round as at Nov 2017 (Source: PCIP, Sep 2018).

11.2.2 VARIATION WITHIN HEALTH BOARDS

Fig. 11B shows the variation in uptake proportion for breast screening, by cluster within each health board. Variation in attainment by cluster ranges from as much as 25.3% within C&VUHB to as little as 3.2% within PTHB. Variation between the best attaining (BCUHB, 79.0%) and least attaining (C&VUHB, 51.4%) cluster across all of Wales is 27.6%.

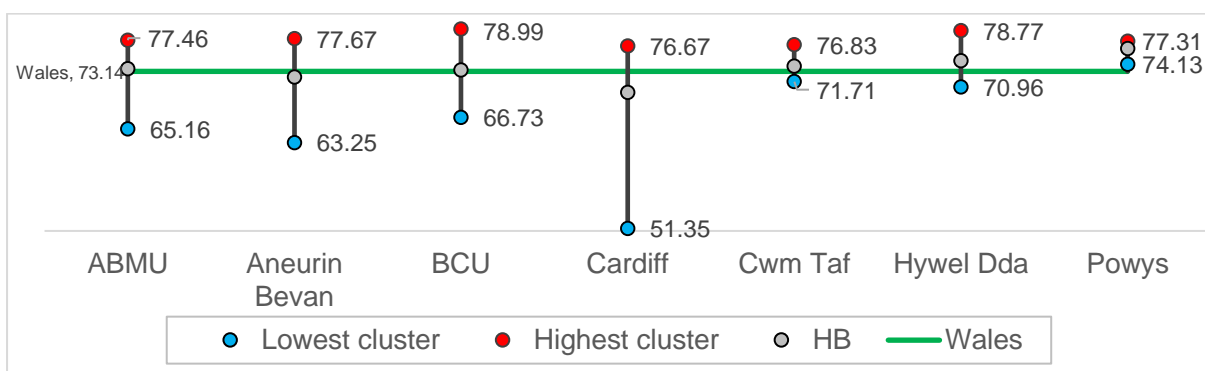


Fig. 11B: Variation in uptake proportion for breast screening, by cluster within each health board, latest round as at Nov 2017 (Source: PCIP, Sep 2018).

Key messages

- Overall variation between health boards for uptake of breast screening is less than 5% either side of the Welsh average.
- Health board averages obfuscate variation within health boards of up to 25%.
- The attainment gap between clusters across Wales is 28%.

11.3 IMPROVEMENT ACTIONS

11.3.1 GP PRACTICE ACTION

Improvement actions potentially suitable for adoption by GP practice cluster members include:

- Development of actions required.

11.3.2 WIDER CLUSTER ACTION

Improvement actions potentially suitable for adoption by the wider cluster membership include:

- Development of partnership actions required.

Good practice example

Heads of Primary Care were unable to identify relevant good practice examples of cluster-led quality improvement projects for this report. Readers are encouraged to contact the PHW Primary Care Division with any local examples suitable to share.

12. STAYING HEALTHY: SCREENING (CERVICAL)

The Primary Care Information Portal provides data on the following indicator(s):

- % uptake of cervical screening

12.1 MEASURE CONTEXT

This indicator is not described within PHW's *Proposed Primary Care Measures: Phase 2* final report (May 2017) or related documentation.

Want to know more?



Information about Cervical Screening Wales is available [here](#), including statistical reports [here](#). Information on the programme for healthcare professionals is available on the NHS Wales intranet [here](#). Data on cancer incidence (including stage at diagnosis), mortality and survival rates can be found on the Welsh Cancer Intelligence and Surveillance Unit (WCISU) website [here](#).

12.2 COMPARATIVE ANALYSIS

- Data source: Cervical Screening Wales
- Numerator: Number of eligible women resident in Wales aged 25-64 years who attended their invitation for cervical screening and had an adequate test result issued within the last 5 years
- Denominator: Number of eligible women resident in Wales aged 25 -64 years that were invited with the time period
- Comment: Please note that the clusters reported are in accordance with those reported upon by PHW Screening Services

12.2.1 VARIATION BY HEALTH BOARD

Fig. 12A shows the variation in uptake proportion for AAA screening, by health board. The average Wales attainment for this measure is an uptake proportion of 77.0%. Variation in attainment across Wales is 4.0%, ranging from 2.4% above average (PHTB, 79.5%) to 1.5% below average (HDUHB, 75.5%).

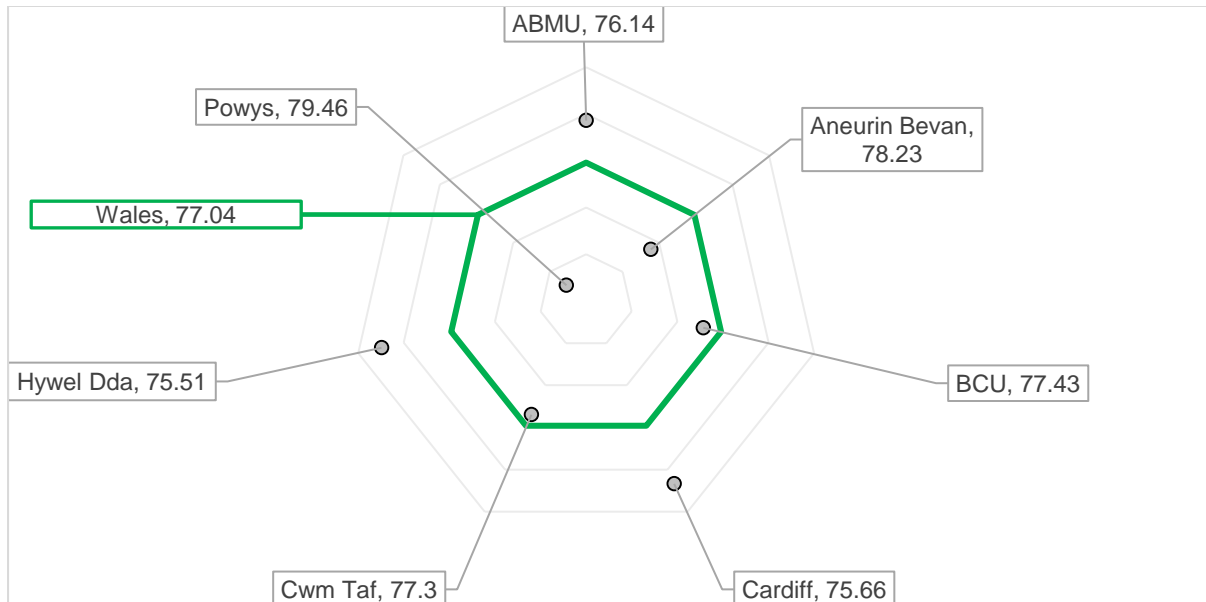


Fig. 12A: Variation in uptake proportion for cervical screening, by health board, 5-year coverage as at Apr 2017 (Source: PCIP, Sep 2018).

12.2.2 VARIATION WITHIN HEALTH BOARDS

Fig. 12B shows the variation in uptake proportion for cervical screening, by cluster within each health board. Variation in attainment by cluster ranges from as much as 18.4% within C&VUHB to as little as 0.7% within PHTB. Variation between the best attaining (ABUHB, 82.6%) and least attaining (C&VUHB, 64.0%) cluster across all of Wales is 18.7%.

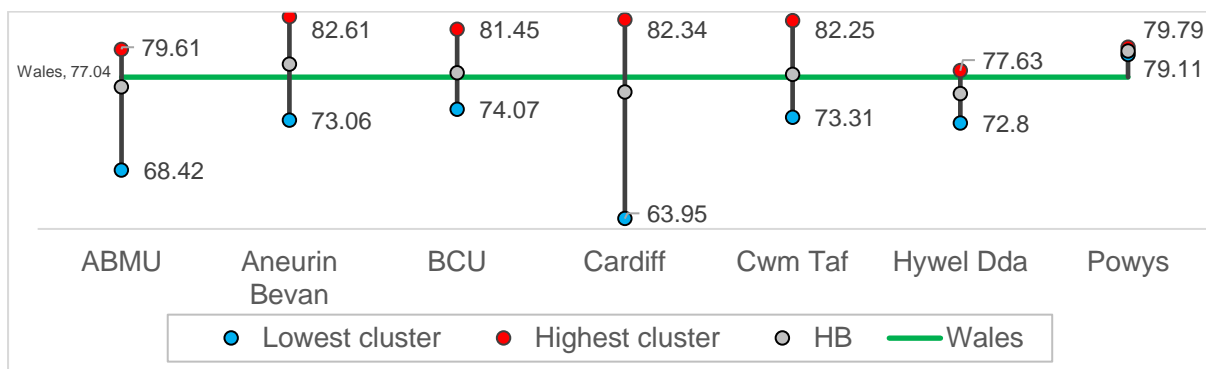


Fig. 12B: Variation in uptake proportion for cervical screening, by cluster within each health board, 5-year coverage as at Apr 2017 (Source: PCIP, Sep 2018).

Key messages

- Overall variation between health boards for uptake of cervical screening is less than 5% either side of the Welsh average.
- Health board averages obfuscate variation within health boards of up to 18%.
- The attainment gap between clusters across Wales is 19%.

12.3 IMPROVEMENT ACTIONS

12.3.1 GP PRACTICE ACTION

Improvement actions potentially suitable for adoption by GP practice cluster members include:

- Development of actions required.

12.3.2 WIDER CLUSTER ACTION

Improvement actions potentially suitable for adoption by the wider cluster membership include:

- Development of partnership actions required.

Good practice example

Heads of Primary Care were unable to identify relevant good practice examples of cluster-led quality improvement projects for this report. Readers are encouraged to contact the PHW Primary Care Division with any local examples suitable to share.

References

- Cervical screening evidence and resources: https://www.cancerresearchuk.org/health-professional/screening/evidence-on-increasing-cervical-screening-uptake#cervical_increase0

13. STAYING HEALTHY: SMOKING

The Primary Care Information Portal provides data on the following indicator(s):

- % of people recorded as smokers in GP clinical records, whose most recent smoking status change is to non-smoker or ex-smoker within the last 5 years
- % of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months (SMOK004)

13.1 MEASURE CONTEXT

These two exact indicators are not described within PHW's *Proposed Primary Care Measures: Phase 2* final report (May 2017) or related documentation.

13.1.1 KEY MEASURE CHARACTERISTICS

Note: The following characteristics were recorded for a very similar proposed indicator: "The proportion of people recorded as smokers in GP clinical records, whose most recent smoking status change is to non-smoker or ex-smoker within the last *24 months*".

- Linked national policy or frameworks: PHOF.
- Population health rationale: The benefits of smoking cessation unquestionable, however the difficulty in measuring long-term effectiveness of interventions has been established.
- Clinical rationale: Reduced morbidity and mortality from a range of smoking-related conditions. The importance of individualised smoking cessation advice appears critical to success.
- Estimated patient/ public perception of topic importance: Recent policy changes have helped shift opinion towards seeing smoking as a public health issue.
- Identified caveats or limitations: Follow-up smoking status changes aren't consistently recorded. Those who successfully change status outside of GP will not be captured. Systems may need to be set up to improve communication between cessation services.

13.1.2 KEY SUPPORTING EVIDENCE

Public Health Wales Observatory, Welsh Government. Tobacco and health in Wales. Cardiff: Public Health Wales NHS Trust / Welsh Government; 2012. Available [here](#).

- This reports that smoking is estimated to be the cause of around 30 per cent of the total inequality in deaths rates between the most and least deprived areas in Wales. It is the greatest single cause of avoidable mortality in people aged over 35 and causes nearly one in five of all deaths. Smoking is estimated to cause around 27,700 hospital admissions each year in Wales placing a considerable burden on the health service.

Want to know more?



The PHW Observatory host a series of topic pages that bring together information on Observatory products; other key websites; key data sources; key evidence sources; and additional evidence and data sources. The topic page on smoking can be found [here](#). Information about Help Me Quit programme in Wales can be found [here](#).

13.2 COMPARATIVE ANALYSIS

For % of people recorded as smokers in GP clinical records, whose most recent smoking status change is to non-smoker or ex-smoker within the last 5 years:

- Data source: GP clinical systems extracted by Audit +
- Numerator: The number of patients in the denominator population where the most recent recorded status is 'ex' or 'non-smoker' within the last 5 years
- Denominator: The number of registered patients over the age of 15 with a status of 'smoker' recorded within the last 5 years

For % of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months (SMOK004):

- Data source: Quality and Outcomes Framework (QOF)
- Numerator: Number of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months
- Denominator: Number of patients aged 15 and over who were recorded as current smokers

13.2.1 VARIATION BY HEALTH BOARD

Fig. 13A shows the variation in proportion of people recorded as smokers in GP clinical records, whose most recent smoking status change is to non-smoker or ex-smoker within the last 5 years, by health board. The average Wales attainment for this measure is a recording proportion of 20.4%. Variation in attainment across Wales is 3.3%, ranging from 2.7% above average (PTHB, 23.0%) to 0.7% below average (CTUHB & ABMUHB, 19.7%).

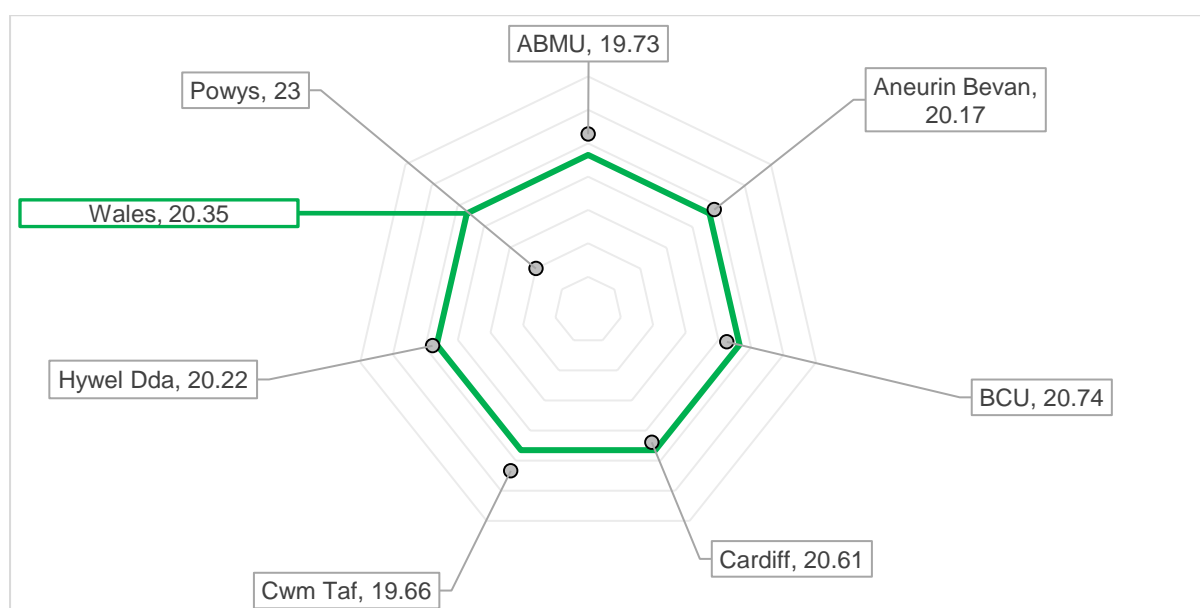


Fig. 13A: Variation in proportion of people recorded as smokers in GP clinical records, whose most recent smoking status change is to non-smoker or ex-smoker within the last 5 years, by health board, Q3 2017/18 (Source: PCIP, Sep 2018).

Fig. 13B shows the variation in proportion of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months, by health board. The average Wales attainment for this measure is a recording proportion of 83.7%. Variation in attainment across Wales is 2.4%, ranging from 1.7% above average (PTHB, 85.4%) to 0.7% below average (CTUHB, 83.0%).

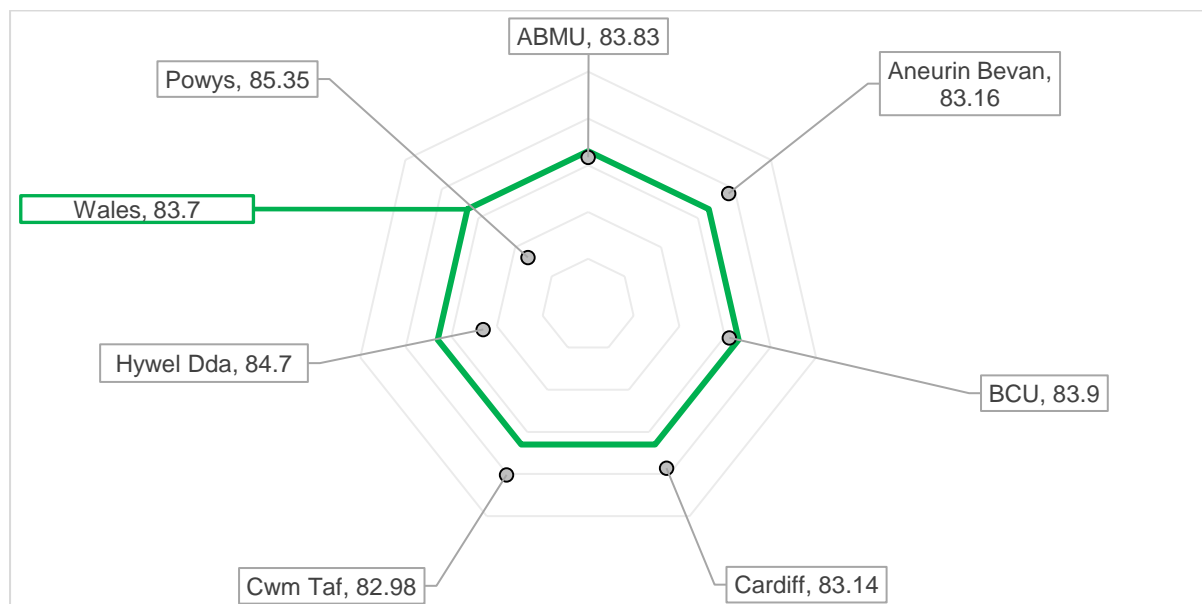


Fig. 13B: Variation in proportion of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months, by health board, 2016/16 (Source: PCIP, Sep 2018).

13.2.2 VARIATION WITHIN HEALTH BOARDS

Fig. 13C shows the variation in proportion of people recorded as smokers in GP clinical records, whose most recent smoking status change is to non-smoker or ex-smoker within the last 5 years, by cluster within each health board. Variation in attainment by cluster ranges from as much as 12.7% within C&VUHB to as little as 2.3% within CTUHB. Variation between the best attaining (C&VUHB, 27.6%) and least attaining (C&VUHB, 15.0%) cluster across all of Wales is 12.7%.

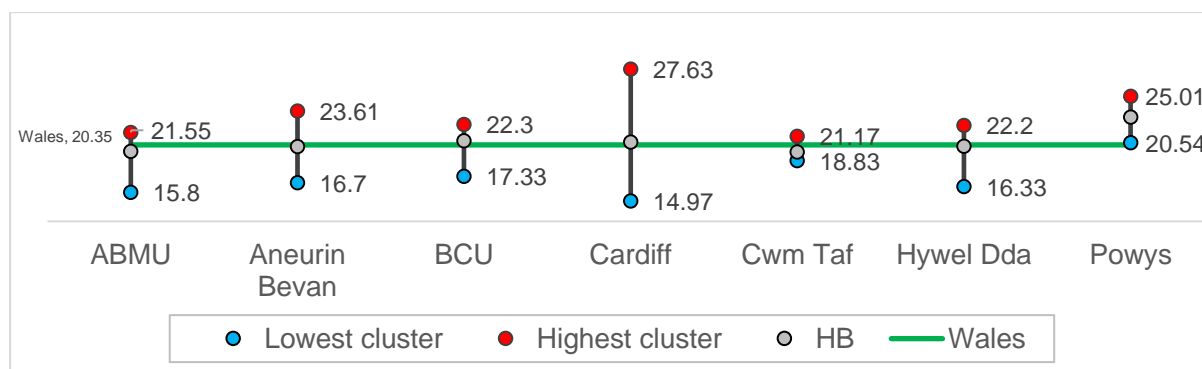


Fig. 13C: Variation in proportion of people recorded as smokers in GP clinical records, whose most recent smoking status change is to non-smoker or ex-smoker within the last 5 years, by cluster within each health board, Q3 2017/18 (Source: PCIP, Sep 2018).

Fig. 13D shows the variation in proportion of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months, by cluster within each health board. Variation in attainment by cluster ranges from as much as 6.9% within C&VUHB to as little as 2.5% within PTHB. Variation between the best attaining (HDUHB, 87.5%) and least attaining (C&VUHB, 80.5%) cluster across all of Wales is 7.0%.

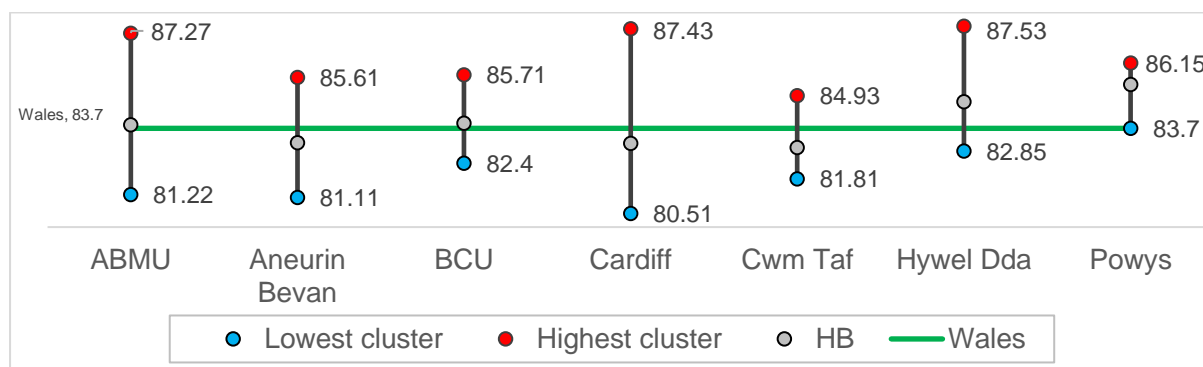


Fig. 13D: Variation in proportion of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months, by cluster within each health board, 2016/16 (Source: PCIP, Sep 2018).

Key messages

- Overall variation between health boards for recording of smoking status change or of a support/ treatment offer is less than 5% either side of the Welsh average.
- Health board averages obfuscate variation within health boards of up to 13% for recording of smoking status.

13.3 IMPROVEMENT ACTIONS

13.3.1 GP PRACTICE ACTION

Improvement actions potentially suitable for adoption by GP practice cluster members include:

- All appropriate healthcare professionals should be competent to deliver brief interventions as part of *Making Every Contact Count* [\[link\]](#).
- Ask, Advise, Act as below in relation to *Help Me Quit*

13.3.2 WIDER CLUSTER ACTION

Improvement actions potentially suitable for adoption by the wider cluster membership include:

- From the PHNC MECC [website](#), clusters could consider the fundamental concepts of MECC:
 - NHS Wales employs 70,000 staff in Wales, both clinical and non-clinical, all of whom could promote health messages. The potential reach into our population is therefore significant. This number would increase markedly if employees of partner organisations are also included.
 - The opportunistic use of routine client/patient contact as a vehicle for delivering messages in response to identified prompts in an effective way.

- Keeping it simple in terms of messages.
- Staff empowerment.
- People at different stages of behaviour change require different information and different approaches to delivering that information to more effectively support change.
- The opportunities to deliver MECC within their role differ by professional group - the support needs to be tailored to that to maximise impact.
- Information for health professionals can be accessed via the *Help Me Quit* workforce development website and completing the registration [[link](#)].
 - Ask: establish and record status (non-smoker, ex-smoker, smoker)
 - Advise: “The best way to quit is with NHS stop smoking support”
 - Act: Motivate and refer – to Help Me Quit
- What advice should smokers be given?
 - The best way to quit smoking is with free NHS stop smoking support offered through Help Me Quit.
 - NHS stop smoking services offer smokers the greatest chances of success by providing: Structured, tailored and expert support; Carbon monoxide monitoring-for-motivation; Access to free licensed stop smoking medication
 - Smokers are four times more likely to successfully quit smoking with NHS stop smoking support, than going it alone.
- Smokers can get support directly by:
 - Calling: 0800 085 2219, or
 - Texting: HMQ to 80818 (to get a call-back), or
 - Visiting: www.helpmequit.wales/quit-now to request a call-back
- Professionals should refer smokers by:
 - Using existing referral routes such as the web-based referral platform: Quit Manager, or
 - Telephone Help Me Quit (with client permission): 0800 085 2219
 - Using the professional referral short-form: www.helpmequit.wales/professional-referrer/
- What else can we do?:
 - Display posters and contact-cards (print and/or digital).
 - Asking about smoking status can trigger a quit attempt, referring increases the likelihood of success.
- Contact helpmequit@wales.nhs.uk for anything smoking cessation related.

Good practice example (submitted by Betsi Cadwaladr LPHT)

What problem was being addressed? Proactive method of recruiting smokers within primary care.

What was done to address it? BCUHB Public Health Team, Stop Smoking Wales and primary care colleagues have been working collectively to explore the role of GP practices in supporting smokers to quit smoking. Smokers in the pilot practices were contacted by letter to attend a stop smoking information session.

How does this evidence good practice? The evaluation of the pilot project demonstrated that a proactive approach to recruiting smokers to available smoking cessation services makes a significant difference to smokers accessing information and support.

What key learning can be shared? Whilst it was encouraging to see different age groups booking appointments with Stop Smoking Wales, more than half (77.5%) were over 45 years old. Methods for attracting younger age groups will be explored further in rolling out the project. The second phase implementation will commence from January 2019.

Who did it or who can be contacted in the event of any queries? Volunteer GP Practices across North Wales. Project Lead/ report available from: Fatima.sayed@wales.nhs.uk.

References

- Stop smoking interventions and services, NICE guideline [NG92] Published date: March 2018
- <https://www.nice.org.uk/guidance/ng92/chapter/Recommendations>
- Behaviour change: individual approaches, Public health guideline [PH49] Published date: January 2014. <https://www.nice.org.uk/guidance/ph49/chapter/1-recommendations#recommendation-9-deliver-very-brief-brief-extended-brief-and-high-intensity-behaviour-change-interventions>
- Public Health England. Health matters: stopping smoking - what works? Published 25 September 2018. <https://www.gov.uk/government/publications/health-matters-stopping-smoking-what-works/health-matters-stopping-smoking-what-works>

14. SAFE CARE: PRESCRIBING

The Primary Care Information Portal provides data on the following indicator(s):

- Cephalosporin items as % of all antibacterial items prescribed
- Quinolone items as a % of all antibacterial items prescribed

Note: PCIP includes a third indicator, “Antibiotic prescribing”, which as of this report, holds no data.

14.1 MEASURE CONTEXT

These two exact indicators are not described within PHW’s *Proposed Primary Care Measures: Phase 2* final report (May 2017) or related documentation.

Note: We understand that these indicators have been superseded by new 4Cs antimicrobials indicator from AWMSG (co-amoxiclav, cephalosporins, fluoroquinolones and clindamycin), and that NWIS did not have permission to report these data as of September 2018. We understand it is anticipated that PCM reporting will be brought in line with the indicators used in the Delivery Framework.

14.1.1 KEY MEASURE CHARACTERISTICS

Note: The following characteristics were recorded for a broadly similar proposed indicator: “Number of dispensed items for antibiotics per 1000 STAR-PUs”.

- Linked national policy or frameworks: All Wales Medicines Strategy Group’s National Prescribing Indicators.
- Population health rationale: Antimicrobial resistance is a global concern that may result in lack of available treatments for some infectious diseases.
- Clinical rationale: Antibiotics can treat some bacterial infections.
- Estimated patient/ public perception of topic importance: Antibiotics are an effective treatment for a variety of infections. Limited awareness of the wider picture drives demand that may not always be appropriate.
- Identified caveats or limitations: There are inherent difficulties in measuring appropriateness. A certain level of prescribing will always be appropriate.

14.1.2 KEY SUPPORTING EVIDENCE

National Institute for Health and Care Excellence. *Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use*. NG15. London: NICE; 2015. Available [here](#).

- This NICE medicines and prescribing centre report undertaken to inform NICE guidance 15 cites the following reports:

Public Health England. *English surveillance programme for antimicrobial utilisation and resistance (ESPAUR) 2010 to 2014*. London: Public Health England; 2015. Available [here](#).

- This report produced in 2015 highlighted an overall increase in the rate of antibiotic resistant infections. It also noted that the number of individuals with antibiotic resistant infections had increased substantially in the previous five years. The report states that ‘antibiotics are unlike other drugs used in medicine, as the more we use them the less effective they become. This is because overuse gives resistant bacteria a greater chance to survive and spread.’ The report states that ‘antibiotic prescribing has increased in England year on year’ and that

although there is variability across England for antimicrobial resistance and antimicrobial prescribing, 'frequently areas with high prescribing also have high resistance'.

World Health Organization. *Antimicrobial resistance: global report on surveillance*. Geneva: World Health Organization; 2014. Available [here](#).

- States that 'AMR develops when a microorganism (bacteria, fungus, virus or parasite) no longer responds to a drug to which it was originally sensitive. This means that standard treatments no longer work; infections are harder or impossible to control; the risk of the spread of infection to others is increased; illness and hospital stays are prolonged, with added economic and social costs; and the risk of death is greater—in some cases, twice that of patients who have infections caused by non-resistant bacteria.'

National Institute of Health and Care Excellence. *Antibiotic prescribing – especially broad spectrum antibiotics*. KTT9, London: NICE; 2015. Available [here](#).

- This Key therapeutic topic (KTT9) reports that to help prevent the development of resistance it is important to only prescribe antibiotics when they are necessary, and not for self-limiting mild infections such as colds and most coughs, sinusitis, earache and sore throats.

Want to know more?



PHW are currently developing a new website for the joint Healthcare Associated Infection, Antimicrobial Resistance & Prescribing Programme (HARP). Reports on healthcare-associated infection in Wales can be found on the Welsh Healthcare Associated Infection Programme (WHAIP) website [here](#), with reports on antibiotic resistance available [here](#). Antimicrobial awareness resources can be found [here](#).

14.2 COMPARATIVE ANALYSIS

- Data source: National Prescribing Indicators available via the NHS Shared Services Partnership
- Numerator: The number of cephalosporin/ quinolone items prescribed
- Denominator: The total number of antibacterial items prescribed

Note: On the PCIP the charts for quinilones and cephalosporins are both labelled "cephalosporin", so there is some uncertainty as to which chart belongs to which drug. Data provided within health boards includes "unidentified" clusters for both indicators.

14.2.1 VARIATION BY HEALTH BOARD

Fig. 14A shows the variation in proportion of cephalosporin items as % of all antibacterial items prescribed, by health board. The average Wales attainment for this measure is a prescribing proportion of 2.9%. Variation in attainment across Wales is 2.7%, ranging from 1.6% above average (CTUHB, 4.5%) to 1.1% below average (ABUHB, 1.8%).

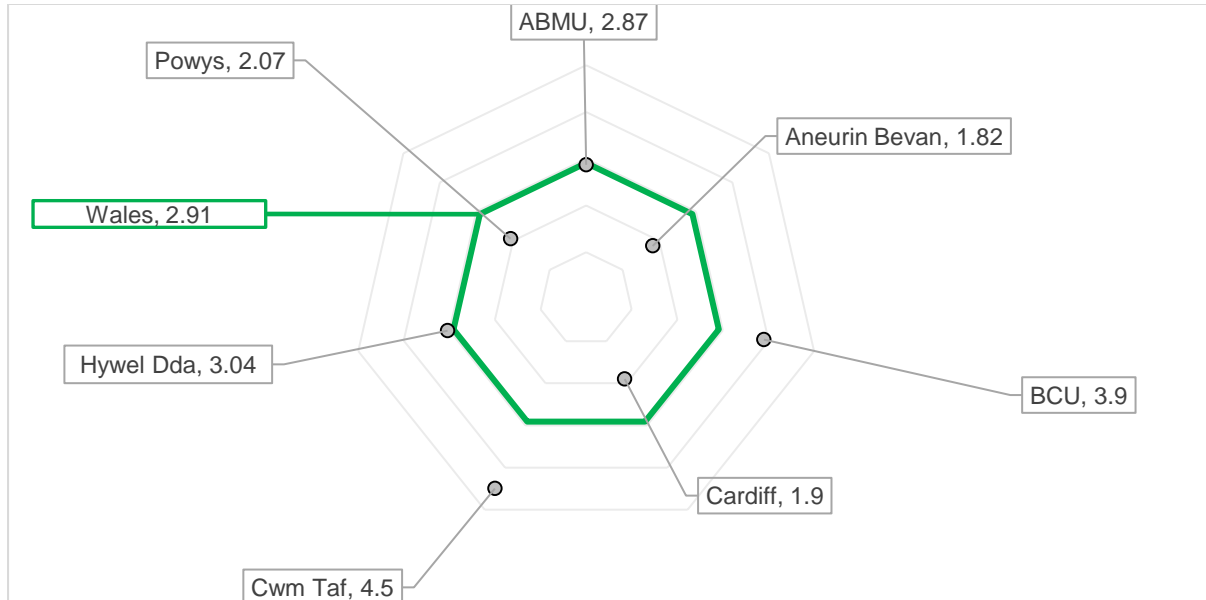


Fig. 14A: Variation in proportion of cephalosporin items as % of all antibacterial items prescribed, by health board, Q3 2017/18 (Source: PCIP, Sep 2018).

Fig. 14B shows the variation in proportion of quinolone items as % of all antibacterial items prescribed, by health board. The average Wales attainment for this measure is a prescribing proportion of 2.2%. Variation in attainment across Wales is 0.9%, ranging from 0.3% above average (BCUHB, 2.5%) to 0.6% below average (ABUHB, 1.6%).

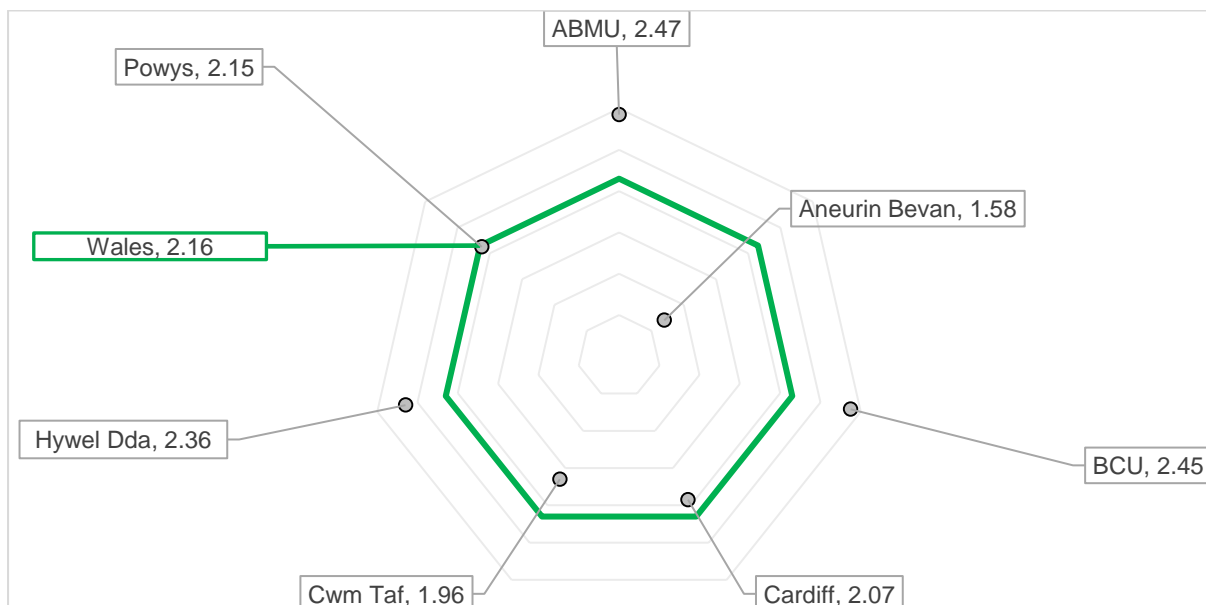


Fig. 14B: Variation in proportion of quinolone items as % of all antibacterial items prescribed, by health board, Q2 2017/18 (Source: PCIP, Sep 2018).

14.2.2 VARIATION WITHIN HEALTH BOARDS

Fig. 14C shows the variation of cephalosporin items as % of all antibacterial items prescribed, by cluster within each health board. Variation in attainment by cluster ranges from as much as 3.6% within CTUHB to as little as 0.6% within C&VUHB. Variation between the best attaining (PTHB, 1.1%) and least attaining (CTUHB, 6.3%) cluster across all of Wales is 5.2%.

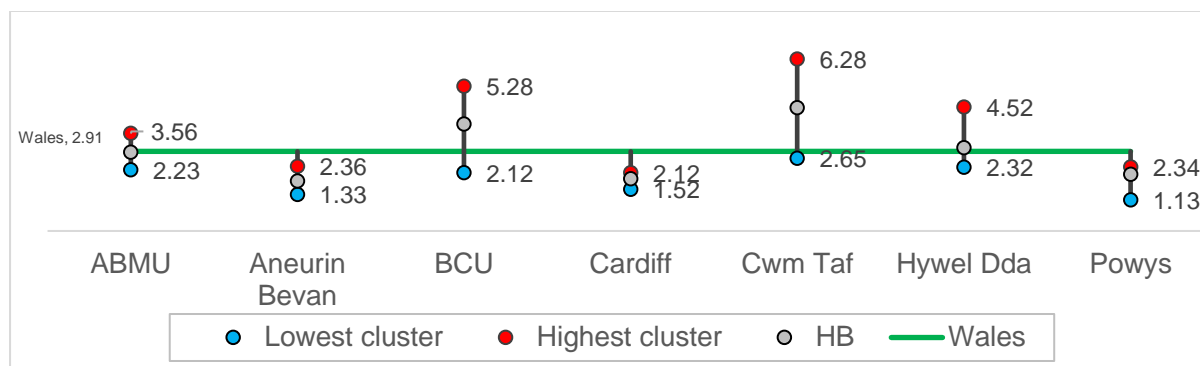


Fig. 14C: Variation in proportion of cephalosporin items as % of all antibacterial items prescribed, by cluster within each health board, Q3 2017/18 (Source: PCIP, Sep 2018).

Fig. 14D shows the variation of quinolone items as % of all antibacterial items prescribed, by cluster within each health board. Variation in attainment by cluster ranges from as much as 1.7% within ABMUHB to as little as 1.0% within C&VUHB. Variation between the best attaining (ABUHB, 1.1%) and least attaining (ABMUHB, 3.7%) cluster across all of Wales is 2.7%.

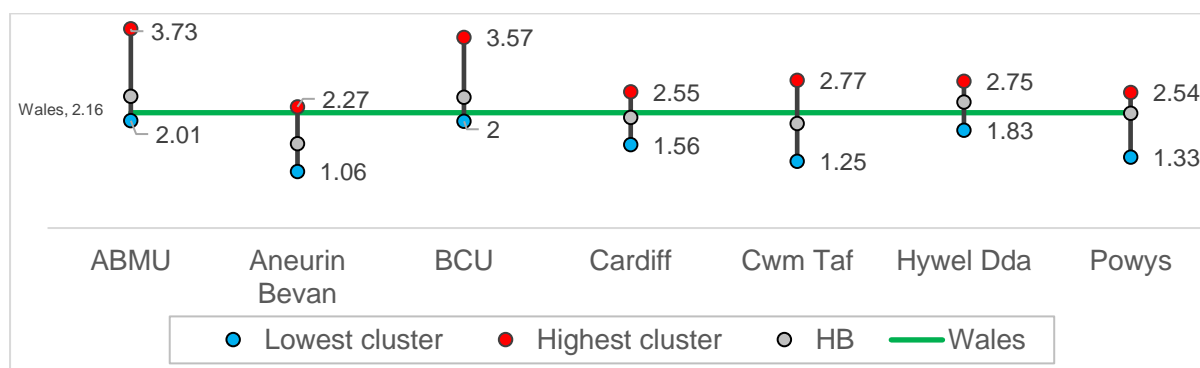


Fig. 14D: Variation in proportion of quinolone items as % of all antibacterial items prescribed, by cluster within each health board, Q2 2017/18 (Source: PCIP, Sep 2018).

Key messages

- Overall variation between health boards for prescribing of these antibiotics is less than 5% either side of the Welsh average
- There is relatively little variation within health boards or between clusters for this measure.

14.3 IMPROVEMENT ACTIONS

14.3.1 GP PRACTICE ACTION

Improvement actions potentially suitable for adoption by GP practice cluster members include:

- The All Wales Medicines Strategy Group has published guidelines and resources to support improvements in antimicrobial prescribing in practice:
 - Primary Care Anti-microbial Guidelines [\[link\]](#)
 - CEPP National Audit, Focus on Antibiotic Prescribing , March 2013 [\[link\]](#)
 - There are a number of antimicrobial indicators identified as National Prescribing Indicators which pick up antibiotic prescribing [\[link\]](#)
- The Royal College of GPs have developed and published a toolkit for use in primary care to improve antimicrobial prescribing. TARGET stands for: Treat Antibiotics Responsibly, Guidance, Education, Tools. The toolkit helps influence prescribers' and patients' personal attitudes, social norms and perceived barriers to optimal antibiotic prescribing. It includes a range of resources that can each be used to support prescribers' and patients' responsible antibiotic use, helping to fulfil CPD and revalidation requirements [\[link\]](#).
- NICE QS121 advised that:
 - Service providers (such as GP practices, health centres, pharmacies, community services) ensure that systems are in place for people with a self-limiting condition to receive advice about self-management and the adverse consequences of overusing antimicrobials.
 - Prescribers in primary care (such as GPs, nurses and pharmacists) ensure that they provide people with a self-limiting condition with advice on self-management and the adverse consequences of overusing antimicrobials.
 - Service providers (such as GP practices, health centres, pharmacies) ensure that systems are in place to allow back-up (delayed) antimicrobial prescribing if there is uncertainty about whether a condition is self-limiting or is likely to deteriorate.
 - Prescribers in primary care (such as GPs, nurses, pharmacists) can use back up (delayed) antimicrobial prescribing if there is uncertainty about whether a condition is self-limiting or is likely to deteriorate.
 - Service providers (such as hospitals, walk in centres, GP practices, health centres, dental care providers, pharmacies, community services) monitor standards of record keeping to check that clinical indication, dose and duration of treatment are documented when antimicrobials are prescribed.
 - Prescribers document in patients' clinical records the clinical indication, dose and duration of treatment when they prescribe antimicrobials.
 - Service providers (such as hospitals, GP practices, walk in centres, dental practices, pharmacies, community health services) ensure that systems are in place for individuals and teams responsible for antimicrobial stewardship within the service to monitor data and provide feedback on prescribing at prescriber, team, organisation and commissioner level. The frequency and specific content of the feedback should be agreed locally between commissioners and service providers.
 - Prescribers receive feedback on their individual antimicrobial prescribing practice and the antimicrobial prescribing practice of their team, organisation and commissioning group from individuals and teams responsible for antimicrobial stewardship within the organisation.

14.3.2 WIDER CLUSTER ACTION

Improvement actions potentially suitable for adoption by the wider cluster membership include:

- Many of the above resources will also apply to non-medical prescribers, such as independent prescriber pharmacists or allied health professionals.

Good practice example

Heads of Primary Care were unable to identify relevant good practice examples of cluster-led quality improvement projects for this report. Readers are encouraged to contact the PHW Primary Care Division with any local examples suitable to share.

References

- Public Health Wales, Healthcare Associated Infection, Antimicrobial Resistance & Prescribing Programme (HARP team). Antibacterial Usage in Primary Care In Wales 2013/14 - 2017/18. <http://www.wales.nhs.uk/sitesplus/documents/888/Antibacterial%20Usage%20in%20Primary%20Care%20in%20Wales%202013-2017%20%28financial%20years%29.pdf>
- NICE. Antimicrobial stewardship: Quality standard [QS121]. Published date: April 2016. <https://www.nice.org.uk/guidance/QS121>

15. EFFECTIVE CARE: CIRCULATORY DISEASE

The Primary Care Information Portal provides data on the following indicator(s):

- Acute myocardial infarction 3-year rolling SMR per 100,000 population under 75 years of age
- All heart disease 3-year rolling SMR per 100,000 population under 75 years of age
- Heart failure 3-year rolling SMR per 100,000 population under 75 years of age
- Stroke 3-year rolling SMR per 100,000 population (all ages)

15.1 MEASURE CONTEXT

15.1.1 KEY MEASURE CHARACTERISTICS

- Linked national policy or frameworks: Cardiovascular Delivery Plan; Stroke Delivery Plan.
- Population health rationale: Premature mortality from cardiovascular disease is experienced disproportionately among deprived populations, although the need for prevention is universal. It's a leading cause of mortality.
- Clinical rationale: Good preventive care reduces death rate in people under 75.
- Estimated patient/ public perception of topic importance: While the risk factors are widely appreciated, making changes to reduce them is a challenge.
- Identified caveats or limitations: Reducing mortality from heart disease is also the role of public health and secondary care.

15.1.2 KEY SUPPORTING EVIDENCE

Welsh Government. *Health Statistics Wales*. Cardiff: Welsh Government; 2016. Available [here](#).

- This report states that in 2013 the highest causes of death in Wales remained diseases of the circulatory system (29 per cent), cancer (neoplasms) (28 per cent) and diseases of the respiratory system (15 per cent).

Townsend N et al. *Cardiovascular disease statistics*, 2015. British Heart Foundation: London; 2015. Available [here](#).

- This report states that one quarter of premature deaths in men and around 17 per cent of premature deaths in women were from cardiovascular disease (CVD) in 2014. In total that year, there were over 41,000 premature deaths from CVD in the UK.

National Institute for Health and Care Excellence. *Cardiovascular disease prevention*. PH25. London: NICE; 2010. Available [here](#).

- This NICE Public Health Guidance states that changes in cardiovascular disease (CVD) risk factors can be brought about by intervening at the population and individual level. Interventions focused on changing an individual's behaviour are important and are supported by a range of existing NICE guidance. Addressing diet, physical inactivity, smoking and excessive alcohol consumption to reduce CVD will also help reduce a wide range of other chronic conditions. This includes many of the other main causes of death and illness in England such as type 2 diabetes and many common cancers.

Want to know more?



The PHW Observatory host a series of topic pages that bring together information on Observatory products; other key websites; key data sources; key evidence sources; and additional evidence and data sources. The topic page on cardiovascular disease is [here](#).

15.2 COMPARATIVE ANALYSIS

- Data source: Health Maps Wales
- Numerator: The number of deaths from each of the following causes: all heart disease; acute myocardial infarction; heart failure; stroke
- Denominator: The population aged under 75 years (all ages for stroke)

Note: All charts for these measures are incorrectly labelled as percentage (vertical axis) on the PCIP.

15.2.1 VARIATION BY HEALTH BOARD

Fig. 15A shows the variation in acute myocardial infarction 3-year rolling SMR per 100,000 population under 75 years of age, by health board. The average Wales rate for this measure is 18.3 deaths per 100,000. Variation in mortality across Wales is 8.0 per 100,000, ranging from 3.0 per 100,000 above average (BCUHB, 21.3 per 100,000 [95% CI: 19.4-23.4]) to 5.0 per 100,000 below average (HDUHB, 13.3 per 100,000 [95% CI: 11.3-15.5]). As the 95% confidence intervals for these highest and lowest rates (not shown in Fig. 15A) do not overlap, this SMR difference is likely to be statistically significant.

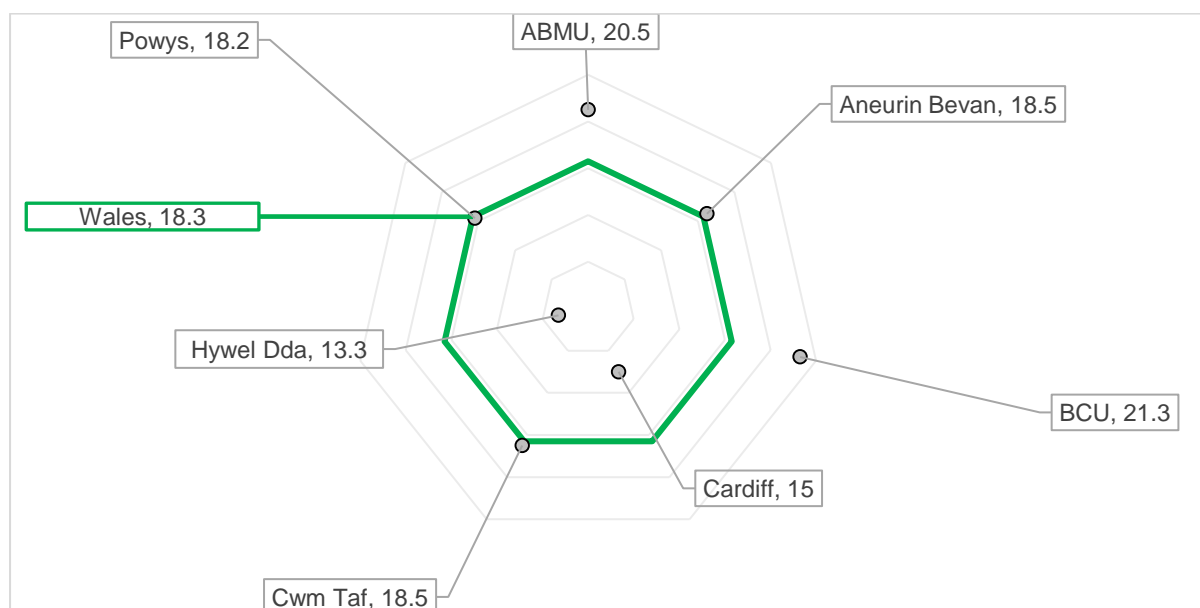


Fig. 15A: Variation in acute myocardial infarction 3-year rolling SMR per 100,000 population under 75 years of age, by health board, 2014-2016 (Source: PCIP, Sep 2018).

Fig. 15B shows the variation in all heart disease 3-year rolling SMR per 100,000 population under 75 years of age, by health board. The average Wales rate for this measure is 62.3 deaths per 100,000. Variation in mortality across Wales is 21.8 per 100,000, ranging from 10.0 per 100,000 above average (CTUHB, 72.3 per 100,000 [95% CI: 66.5-78.5]) to 11.8 per 100,000 below average (C&VUHB, 50.5 per 100,000 [95% CI: 46.4-55.0]). As the 95% confidence intervals for these highest and lowest rates (not shown in Fig. 15B) do not overlap, this SMR difference is likely to be statistically significant.

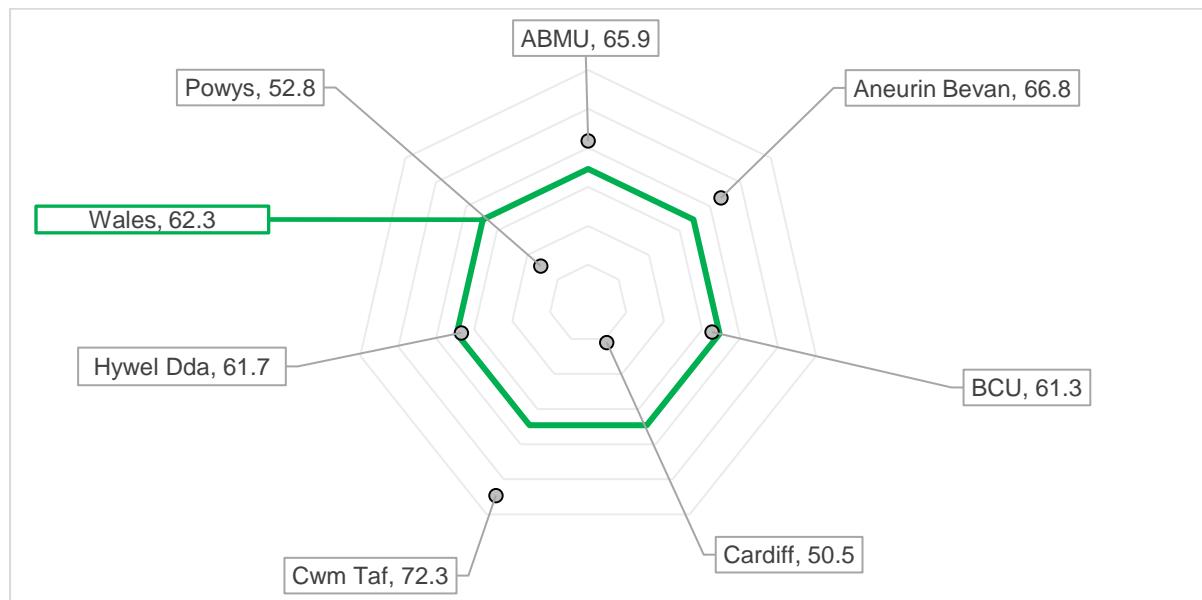


Fig. 15B: Variation in all heart disease 3-year rolling SMR per 100,000 population under 75 years of age, by health board, 2014-2016 (Source: PCIP, Sep 2018).

Fig. 15C shows the variation in heart failure 3-year rolling SMR per 100,000 population under 75 years of age, by health board. The average Wales rate for this measure is 1.1 deaths per 100,000. Variation in mortality across Wales is 2.1 per 100,000, ranging from 1 per 100,000 above average (ABUHB, 2.1 per 100,000 [95% CI: 1.4-2.9]) to 1.1 per 100,000 below average (ABMUHB, 0 per 100,000 [95% CI: 0.2-1.1]). As the 95% confidence intervals for these highest and lowest rates (not shown in Fig. 15C) do not overlap, this SMR difference is likely to be statistically significant.

Note: Five health boards are reported to have an SMR of 0.0 per 100,000; all have 95% confidence intervals that do not straddle 0, so it is assumed this does not mean there were no deaths due to heart failure within the three-year period and likewise it does not mean no data were reported; these SMRs must therefore reflect rounding.

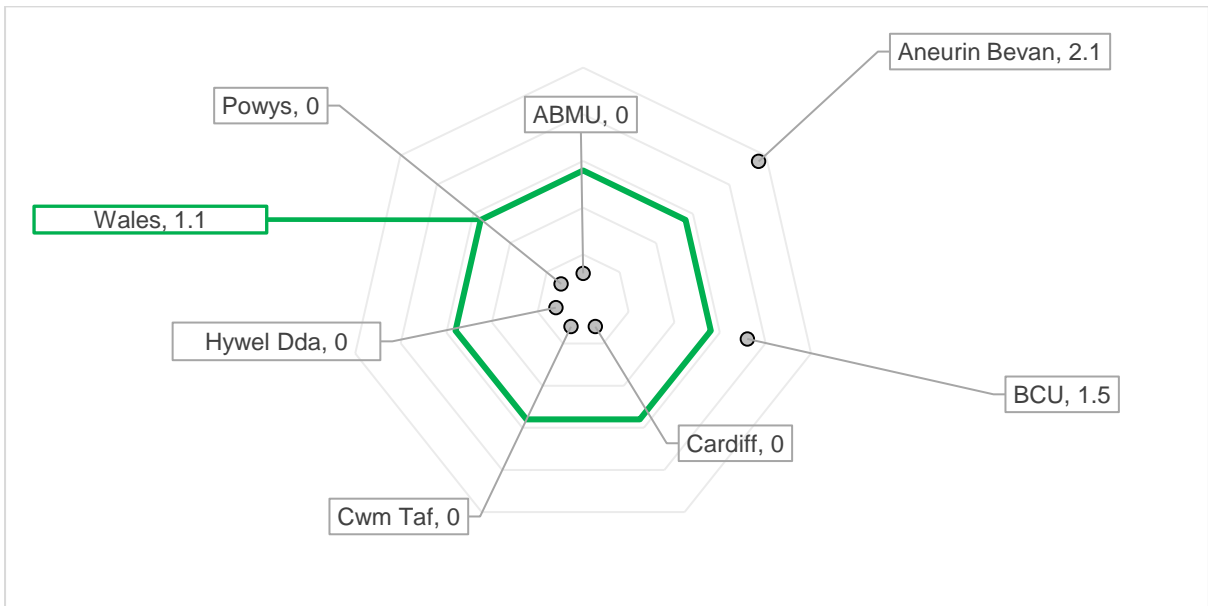


Fig. 15C: Variation in heart failure 3-year rolling SMR per 100,000 population under 75 years of age, by health board, 2014-2016 (Source: PCIP, Sep 2018).

Fig. 15D shows the variation in stroke 3-year rolling SMR per 100,000 population (all ages), by health board. The average Wales rate for this measure is 70.6 deaths per 100,000. Variation in mortality across Wales is 14.3 per 100,000, ranging from 6.2 per 100,000 above average (CTUHB, 76.8 per 100,000 [95% CI: 70.8-83.2]) to 8.1 per 100,000 below average (C&VUHB, 62.5 per 100,000 [95% CI: 58.1-67.2]). As the 95% confidence intervals for these highest and lowest rates (not shown in Fig. 15D) do not overlap, this SMR difference is likely to be statistically significant.

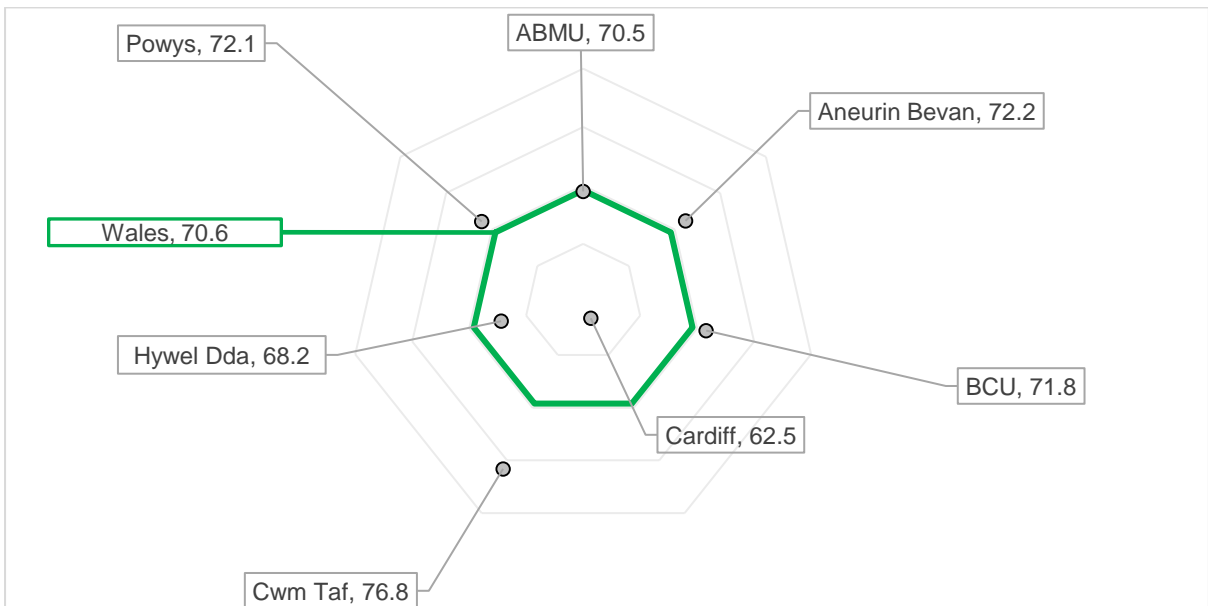


Fig. 15D: Variation in stroke 3-year rolling SMR per 100,000 population (all ages), by health board, 2014-2016 (Source: PCIP, Sep 2018).

15.2.2 VARIATION WITHIN HEALTH BOARDS

These data are not reported at cluster level.

Key messages

- There is likely to be statistically significant variation between health boards in premature mortality due to acute myocardial infarction, all heart disease, and heart failure.
- There is likely to be statistically significant variation between health boards in all-age mortality due to stroke.

15.3 IMPROVEMENT ACTIONS

15.3.1 GP PRACTICE ACTION

Improvement actions potentially suitable for adoption by GP practice cluster members include:

- Manage risk factors to prevent CVD and to mitigate established disease:
 - Behavioural risk factors:
 - Increase provision of advice and signposting to support for smoking cessation; see section 13 of this report: Smoking
 - Increase provision of advice and signposting to support for reducing inactivity; see NICE Encouraging people to be physically active, [here](#).
 - Increase provision of advice and signposting to support for healthy eating; see NICE *Recommendations about diet for primary care and community health services*, [here](#).
 - Increase provision of advice and signposting to support for substance misuse; see section 2 of this report: Alcohol.
 - Clinical risk factors:
 - Improve detection and management of high blood pressure; see section 19 of this report: Inequalities (BP); see NICE [CG127](#)
 - Improve detection and management of high cholesterol; see NICE [CG181](#)
 - Improve detection and management of raised fasting glucose; see section 16 of this report: Diabetes; see NICE *Managing cardiovascular risk in adults with type 1 diabetes*, [here](#).
 - Improve recording and management of overweight and obesity.
- In addition to the above risk factors, to reduce risk of (first or repeat) stroke:
 - Atrial fibrillation (AF) should be treated in accordance with NICE guideline [CG180](#).
- Manage CVD in accordance with clinical guidelines:
 - Acute coronary syndromes should be managed in accordance with NICE guidelines and quality standards (references below):
 - Cardiovascular disease prevention (PH25)
 - Cardiovascular disease: risk assessment and reduction, including lipid modification (CG181)
 - Chest pain of recent onset: assessment and diagnosis (CG95)
 - Myocardial infarction: cardiac rehabilitation and prevention of further cardiovascular disease (CG172)
 - Acute coronary syndromes in adults (QS68)
 - Cardiovascular risk assessment and lipid modification (QS100)

- Secondary prevention after a myocardial infarction (QS99)
- Heart failure should be managed in accordance with NICE guidelines and quality standards (references below):
 - Acute heart failure: diagnosis and management (CG187)
 - Chronic heart failure in adults: diagnosis and management (NG106)
 - Acute heart failure (QS103)
 - Chronic heart failure in adults (QS9)
- Stable angina should be managed in accordance with NICE guidelines and quality standards (references below):
 - Cardiovascular disease: risk assessment and reduction, including lipid modification (CG181)
 - Stable angina: management (CG126)
 - Cardiovascular risk assessment and lipid modification (QS100)
 - Stable angina (QS21)
- Stroke and transient ischaemic attack (TIA) should be managed in accordance with NICE guidelines and quality standards (references below):
 - Cardiovascular disease prevention (PH25)
 - Cardiovascular disease: risk assessment and reduction, including lipid modification (CG181)
 - Stroke and transient ischaemic attack in over 16s: diagnosis and initial management (CG68)
 - Stroke rehabilitation in adults (CG162)
 - Cardiovascular risk assessment and lipid modification (QS100)
 - Stroke in adults (QS2)

15.3.2 WIDER CLUSTER ACTION

Improvement actions potentially suitable for adoption by the wider cluster membership include:

- Development of partnership actions required.

Good practice example

Heads of Primary Care were unable to identify relevant good practice examples of cluster-led quality improvement projects for this report. Readers are encouraged to contact the PHW Primary Care Division with any local examples suitable to share.

References

- NICE. Atrial fibrillation: management. Clinical guideline [CG180]. Published date: June 2014. Last updated: August 2014. <https://www.nice.org.uk/guidance/cg180>
- NICE. Cardiovascular disease prevention. Public health guideline [PH25]. Published date: June 2010. <https://www.nice.org.uk/guidance/ph25>
- NICE. Cardiovascular disease: risk assessment and reduction, including lipid modification. Clinical guideline [CG181]. Published date: July 2014. Last updated: September 2016. <https://www.nice.org.uk/guidance/cg181>
- NICE. Chest pain of recent onset: assessment and diagnosis. Clinical guideline [CG95]. Published date: March 2010. Last updated: November 2016. <https://www.nice.org.uk/guidance/cg95>
- NICE. Myocardial infarction: cardiac rehabilitation and prevention of further cardiovascular disease. Clinical guideline [CG172]. Published date: November 2013. <https://www.nice.org.uk/guidance/cg172>
- NICE. Acute coronary syndromes in adults. Quality standard [QS68]. Published date: September 2014. <https://www.nice.org.uk/guidance/qs68>
- NICE. Cardiovascular risk assessment and lipid modification. Quality standard [QS100]. Published date: September 2015. <https://www.nice.org.uk/guidance/qs100>

- NICE. Secondary prevention after a myocardial infarction. Quality standard [QS99]. Published date: September 2015. <https://www.nice.org.uk/guidance/qs99>
- NICE. Acute heart failure: diagnosis and management. Clinical guideline [CG187]. Published date: October 2014. <https://www.nice.org.uk/guidance/cg187>
- NICE. Chronic heart failure in adults: diagnosis and management. NICE guideline [NG106]. Published date: September 2018. <https://www.nice.org.uk/guidance/ng106>
- NICE. Acute heart failure. Quality standard [QS103]. Published date: December 2015. <https://www.nice.org.uk/guidance/qs103>
- NICE. Chronic heart failure in adults. Quality standard [QS9]. Published date: June 2011. Last updated: September 2018. <https://www.nice.org.uk/guidance/qs9>
- NICE. Stable angina: management. Clinical guideline [CG126]. Published date: July 2011. Last updated: August 2016. <https://www.nice.org.uk/guidance/cg126>
- NICE. Stable angina. Quality standard [QS21]. Published date: August 2012. Last updated: February 2017. <https://www.nice.org.uk/guidance/qs21>
- NICE. Stroke and transient ischaemic attack in over 16s: diagnosis and initial management. Clinical guideline [CG68]. Published date: July 2008. Last updated: March 2017. <https://www.nice.org.uk/guidance/cg68>
- NICE. Stroke rehabilitation in adults. Clinical guideline [CG162]. Published date: June 2013. <https://www.nice.org.uk/guidance/cg162>
- NICE. Stroke in adults. Quality standard [QS2]. Published date: June 2010. Last updated: April 2016. <https://www.nice.org.uk/guidance/qs2>

16. EFFECTIVE CARE: DIABETES

The Primary Care Information Portal provides data on the following indicator(s):

- % of people with diabetes who have received all National Diabetes Audit key care processes

16.1 MEASURE CONTEXT

16.1.1 KEY MEASURE CHARACTERISTICS

- Linked national policy or frameworks: NICE diabetes guidelines, Diabetes Delivery Plan for Wales 2016-2020, Compliance with the key care processes (KPI).²
- Population health rationale: Routine measurement of key care indicators improves diabetes outcomes at population level.
- Clinical rationale: Routine measurement of key care indicators improves diabetes outcomes at an individual level.
- Estimated patient/ public perception of topic importance: The public appreciate that poorly managed diabetes can have very significant complications.
- Identified caveats or limitations: Some patients with Type 1 diabetes will be largely managed in secondary care.

16.1.2 KEY SUPPORTING EVIDENCE

National Institute for Health and Care Excellence. *Type 1 diabetes in adults: diagnosis and management*. NG17. London: NICE; 2015. Available [here](#).

- This clinical guideline reports that over years, type 1 diabetes causes tissue damage which, if not detected and managed early, can result in disability: blindness, kidney failure and foot ulceration leading to amputation, as well as premature heart disease, stroke and death. The risk of all of these complications is greatly reduced by treatment that keeps circulating glucose levels to as near normal as possible, reducing tissue damage. Disability from complications that are not avoided can often be prevented by early detection and active management.
- At present there is no cure. Having type 1 diabetes typically reduces life expectancy in the UK by 11-14 years. Risk of death is 135% higher than for people without diabetes of the same age. Most of the deaths are due to chronic complications, although death in acute hypoglycaemia or diabetic ketoacidosis may occur. Rates of diabetic ketoacidosis appear to be increasing in the UK. There has also been an increase in the number of people with type 1 diabetes needing treatment for end-stage kidney disease.

National Institute for Health and Care Excellence. *Type 2 diabetes in adults: management*. NG28. London: NICE; 2015. Available [here](#).

- This clinical guideline update reports that in 2013, over 3.2 million adults were diagnosed with diabetes, with prevalence rates of 6% and 6.7% in England and Wales respectively. It is estimated that about 90% of adults currently diagnosed with diabetes have type 2 diabetes. It is estimated that diabetes account for approximately 15 to 16% of deaths in England, with life

² Key Care processes currently in the NDA for Wales: HbA1C; blood pressure; cholesterol; serum creatinine; urine albumin; foot surveillance; BMI; smoking. Retinopathy screening is undertaken by a national screening service outside of primary care.

expectancy for people with type 2 diabetes reduced by an average of up to 10 years. Type 2 diabetes is notable for the increased cardiovascular risk that it carries: coronary artery disease (leading to heart attacks, angina); peripheral artery disease (leg claudication, gangrene); and carotid artery disease (strokes, dementia). In addition, prolonged hyperglycaemia can lead to irreversible microvascular complications such as diabetic retinopathy, nephropathy and neuropathy (resulting in amputation, painful symptoms, erectile dysfunction and other problems).

- Multiple vascular risk factors and wide-ranging complications make diabetes care complex and time-consuming, and many areas of healthcare services must be involved for optimal management. Necessary lifestyle changes, the complexities and possible side effects of therapy make patient education and self-management important aspects of diabetes care.

Want to know more?



The PHW Observatory host a series of topic pages that bring together information on Observatory products; other key websites; key data sources; key evidence sources; and additional evidence and data sources. There is not currently a topic page on diabetes, but there are related topic pages on obesity ([here](#)), healthy eating ([here](#)) and physical activity ([here](#)).

Diabetes statistics and resources can be found [here](#).

16.2 COMPARATIVE ANALYSIS

- Data source: National Diabetes Audit - Care Processes
- Numerator: The number of people with diabetes who have received all National Diabetes Audit key care processes
- Denominator: All patients diagnosed with diabetes (Type 1 and 2)

16.2.1 VARIATION BY HEALTH BOARD

Fig. 16A shows the variation in proportion of people with diabetes who have received all National Diabetes Audit key care processes, by health board. The average Wales attainment for this measure is a recording proportion of 45.2%. Variation in attainment across Wales is 20.1%, ranging from 10.3% above average (PHTB, 55.6%) to 9.8% below average (BCUHB, 35.4%).

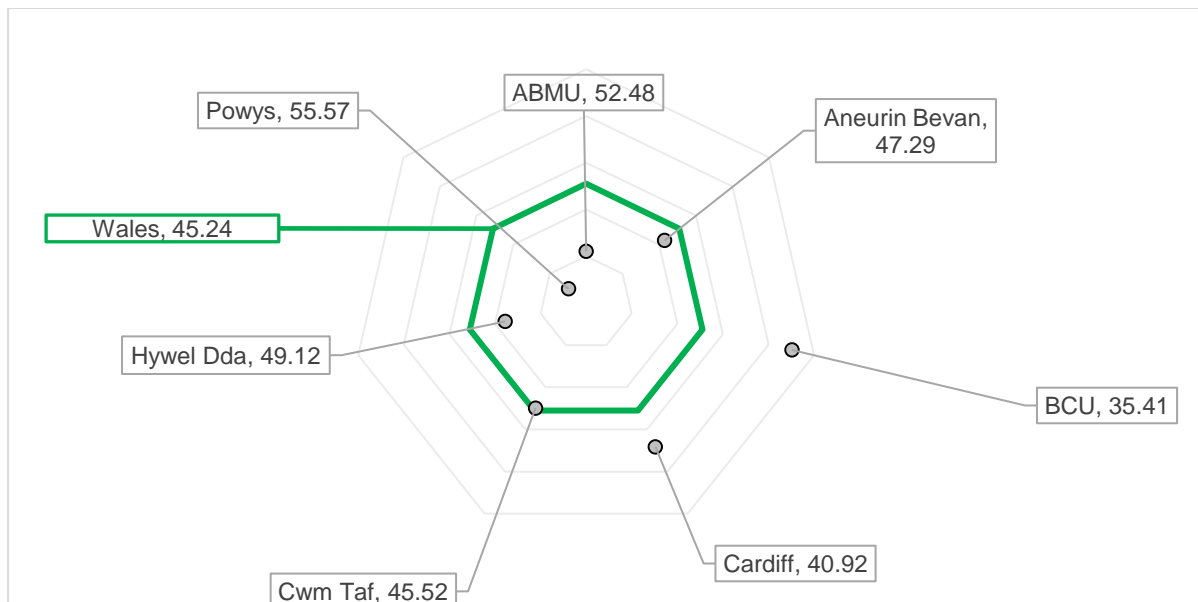


Fig. 16A: Variation in proportion of people with diabetes who have received all National Diabetes Audit key care processes, by health board, 2016/17 (Source: PCIP, Sep 2018).

16.2.2 VARIATION WITHIN HEALTH BOARDS

Fig. 16B shows the variation in proportion of people with diabetes who have received all National Diabetes Audit key care processes, by cluster within each health board. Variation in attainment by cluster ranges from as much as 42.0% within CTUHB to as little as 4.0% within PHTB. Variation between the best attaining (ABUHB, 72.1%) and least attaining (CTUHB, 15.7%) cluster across all of Wales is 56.5%.

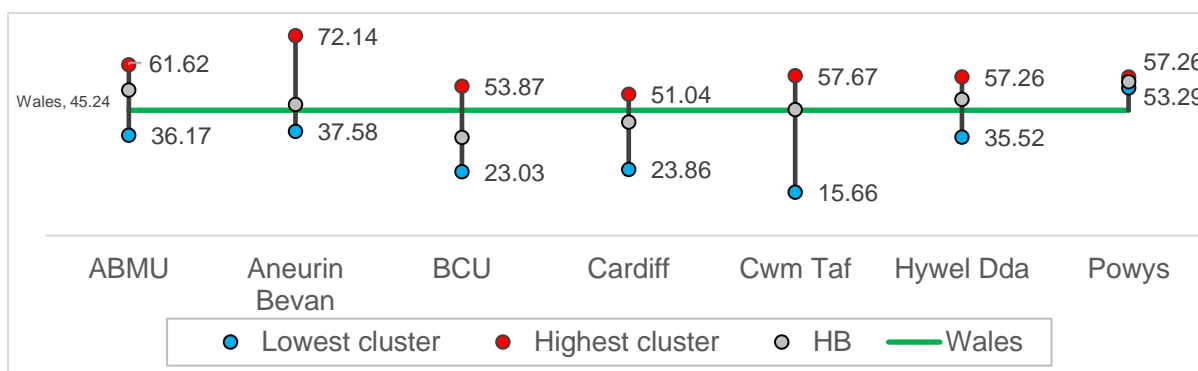


Fig. 16B: Variation in proportion of people with diabetes who have received all National Diabetes Audit key care processes, by cluster within each health board, 2016/17 (Source: PCIP, Sep 2018).

Key messages

- Overall variation between health boards for receipt of all NDA care processes exceeds 5% either side of the Welsh average.
- Health board averages obfuscate variation within health boards of up to 42%.
- The attainment gap between clusters across Wales is 57%.

16.3 IMPROVEMENT ACTIONS

16.3.1 GP PRACTICE ACTION

Improvement actions potentially suitable for adoption by GP practice cluster members include:

- Development of actions required.

16.3.2 WIDER CLUSTER ACTION

Improvement actions potentially suitable for adoption by the wider cluster membership include:

- Development of partnership actions required.

Good practice example

Heads of Primary Care were unable to identify relevant good practice examples of cluster-led quality improvement projects for this report. Readers are encouraged to contact the PHW Primary Care Division with any local examples suitable to share.

17. EFFECTIVE CARE: DYING WELL

The Primary Care Information Portal provides data on the following indicator(s):

- % of patients dying in usual place of residence
- % of patients on the palliative care register, as a proportion of patients on the practice register

17.1 MEASURE CONTEXT

These exact indicators are not described within PHW's *Proposed Primary Care Measures: Phase 2* final report (May 2017) or related documentation.

17.1.1 KEY MEASURE CHARACTERISTICS

Note: The following characteristics were recorded for a related indicator: "Percentage of palliative care patients dying in place of preference". This was recommended by PHW for Phase 2B development (information not readily accessible; these measures were deemed important but involve additional challenges to implement).

- Linked national policy or frameworks: End of Life Care Delivery Plan. NHS Outcomes Framework.
- Population health rationale: Supports living and dying well.
- Clinical rationale: Deliver fast, effective, patient-centred care in the most appropriate setting.
- Estimated patient/ public perception of topic importance: Reduce the distress of terminal illness for the patient and their family.
- Identified caveats or limitations: Not all preferences are recorded yet; potential data quality issue.

17.1.2 KEY SUPPORTING EVIDENCE

Ali M et al. *The importance of identifying preferred place of death*. BMJ Support Palliat Care. [Epub ahead of print] 2015. Available [here](#).

- No synopsis provided.

Want to know more?

We are not aware of statistical or information resources concerning preferred place of death in Wales. If you know of such resources, please advise the report authors of them.

17.2 COMPARATIVE ANALYSIS

For % of patients dying in usual place of residence:

- Data source: Office for National Statistics (ONS)
- Numerator: Number of deaths for each place of occurrence
- Denominator: Total number of deaths

For % of patients on the palliative care register, as a proportion of patients on the practice register:

- Data source: Quality and Outcomes Framework (QOF)
- Numerator: The contractor establishes and maintains a register of all patients in need of palliative care/ support irrespective of age (PC001)
- Denominator: Not stated

17.2.1 VARIATION BY HEALTH BOARD

Fig. 17A is reproduced from PCIP and shows the variation in proportion of deaths by place of occurrence, by health board. As these data correspond to neither the measure description (deaths by usual residence) nor the original intent (deaths by place of preference), no meaningful analysis is possible.

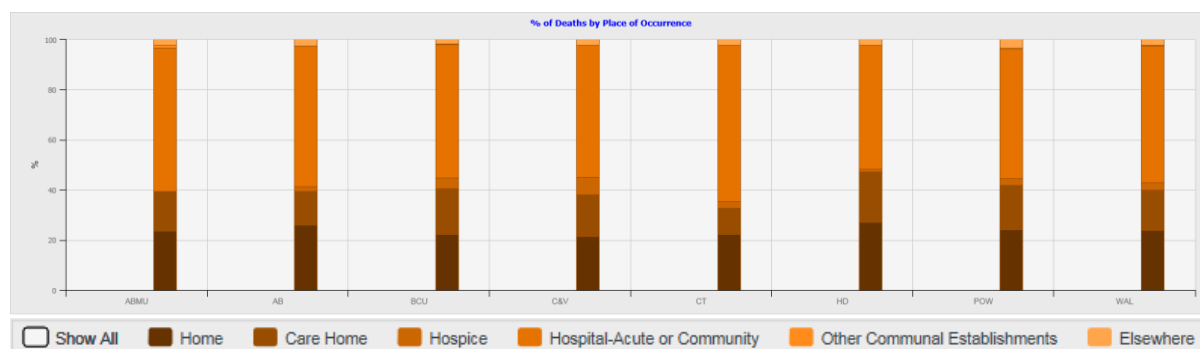


Fig. 17A: Variation in proportion of deaths by place of occurrence, by health board, 2015 (Source: PCIP, Sep 2018).

Fig. 17B shows the variation in proportion patients on the palliative care register, by health board. The average Wales attainment for this measure is a recording proportion of 0.3%. Variation in attainment across Wales is 0.3%, ranging from 0.1% above average (PHTB, 0.4%) to 0.1% below average (C&VUHB, 0.2%).

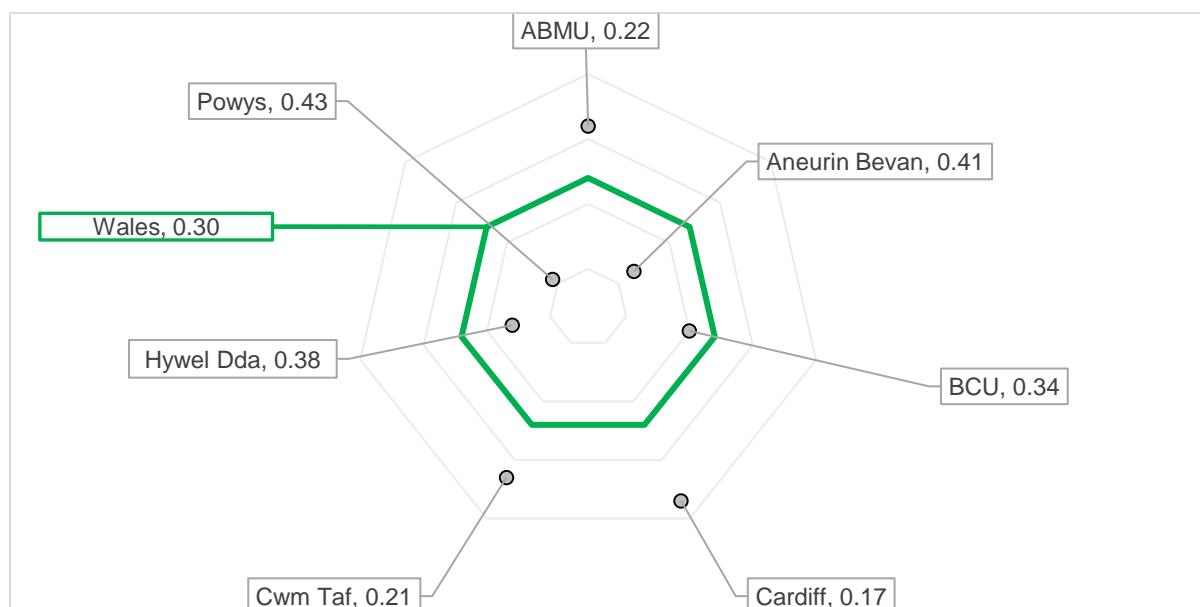
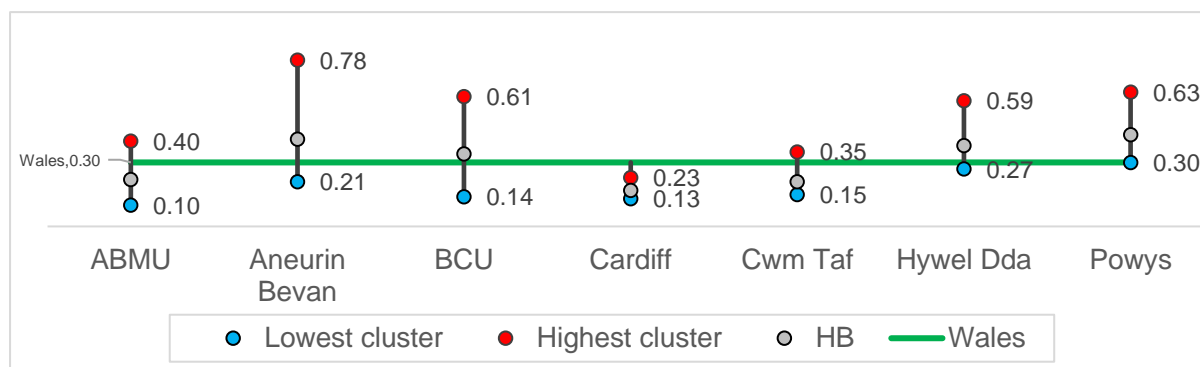


Fig. 17A: Variation in proportion of patients on the palliative care register, by health board, 2015/16 (Source: PCIP, Sep 2018).

17.2.2 VARIATION WITHIN HEALTH BOARDS

These data are not reported at cluster level.



Key messages

- Overall variation between health boards for entry to the palliative care register is less than 5% either side of the Welsh average.

17.3 IMPROVEMENT ACTIONS

17.3.1 GP PRACTICE ACTION

Improvement actions potentially suitable for adoption by GP practice cluster members include:

- MacMillan Cancer Support produce a *Top tips guide to supportive and palliative care meetings* [[link](#)]. The following top tips are offered (with expanded detail relevant to the above indicators):
 - Top tip 1: Regularly remind your team why they have supportive and palliative care meetings
 - ‘Branding’ the meetings as supportive and ensuring the name of your register includes the term ‘supportive’ can make earlier conversations easier.
 - Top tip 2: Prepare for the meetings
 - Top tip 3: Identify patients for the supportive and palliative care register
 - Aim for early identification of patients in the last years of life – this is especially important for people with dementia.
 - Use existing predictor tools e.g. GSF Proactive Information Guidance (PIG 2017), Supportive and Palliative Care Indicators Tool (SPICT), Primary Care Electronic Frailty Index (eFI).
 - Encourage everyone in the team in all settings to ask ‘Would I be surprised if this patient died in the next 12 months?’ (the surprise question).
 - Use other information – e.g. hospital phone calls or specialist letters, patients own concerns, patient’s choice e.g. patient with advanced chronic kidney disease who chooses not to have dialysis, carer concerns, other staff

concerns (care home/nursing home, district nurses, community matrons etc.), frequent unplanned admissions to hospital, use of out of hours services (OOHS).

- Discuss with the patient and gain consent to them being added to the supportive and palliative care register, explain the benefits such as the ability to share electronic information.
- Top tip 4: Prioritise patients according to need
 - Discuss all deaths since the last meeting including deaths of patients who were not on the register and sudden or unexpected deaths – consider bereavement care needs.
- Top tip 5: Run an effective meeting
 - Plan the meeting; use the agenda as a tool, e.g. New patients to the register
- Top tip 6: Significant event analysis
 - Review outcomes for patients: Patients who died in hospital – was this the preferred place of death? If not, could the admission have been prevented?
 - Patients not on the register who died – could they have been identified?
- Top tip 7: Continuity and coordination of care
 - Record actions from the meeting in a coded manner suitable for sharing: Admin – updating register, alerts, OOHS notifications, maintenance of register
- Top tip 8: Communicate
 - With patient and family/ carers – use every opportunity to discuss wishes and preferences for future care and check consent to share information is given.
- Top tip 9: Maintain your register
 - This can be done outside of the regular meeting – establish a smaller key team e.g. administrator, lead GP, practice nurse, district nurse or other key person.
 - Add new patients identified as being in last years of life.
 - Remove patients (those who have died or moved to another practice).
 - Move patients according to their needs/ changing health status e.g. now actively dying (amber to red), increasing decline (green to amber).
 - Add new important statements e.g. now has DNACPR order, change in preferred place of care.
- Top tip 10: Reinforce positivity whenever possible

17.3.2 WIDER CLUSTER ACTION

Improvement actions potentially suitable for adoption by the wider cluster membership include:

- Development of actions required

Good practice example

Heads of Primary Care were unable to identify relevant good practice examples of cluster-led quality improvement projects for this report. Readers are encouraged to contact the PHW Primary Care Division with any local examples suitable to share.

References

- MacMillan Cancer Support. Top tips guide to supportive and palliative care meetings. https://www.macmillan.org.uk/images/top-tips-supportive-and-palliative-care-meetings_tcm9-315966.pdf
- NICE guidance CSG4 – Improving supportive and palliative care for adults with cancer <https://www.nice.org.uk/guidance/csg4>

18. INDIVIDUAL CARE: DEMENTIA CARE

The Primary Care Information Portal provides data on the following indicator(s):

- % of over 65 registered as having dementia with their GP practice
- % of over 65 registered as having memory impairment
- % of people with dementia prescribed anti-psychotic medication

18.1 MEASURE CONTEXT

18.1.1 KEY MEASURE CHARACTERISTICS

For registration activity:

- Linked national policy or frameworks: Mental health Delivery Plan.
- Population health rationale: Dementia and the associated care requirements are forecast to place an increasing burden on health and social care systems.
- Clinical rationale: Recognition of the condition facilitates access to appropriate management and care.
- Estimated patient/ public perception of topic importance: Fear of dementia and challenging for family with respect to care arrangements.
- Identified caveats or limitations: Awaiting strategic dementia plan.

For prescribing activity:

- Linked national policy or frameworks: Dementia Delivery Plan.
- Population health rationale: Dementia is significant problem in an aging population.
- Clinical rationale: Anti-psychotics are potentially more harmful than beneficial in this group.
- Estimated patient/ public perception of topic importance: Agitated people with dementia are a source of distress. Anti-psychotics might be seen as an easy answer by carers.
- Identified caveats or limitations: Not all preferences are recorded yet; potential data quality issue.

18.1.2 KEY SUPPORTING EVIDENCE

World Health Organization. 2016. *Dementia Fact sheet*. [Online]. Available [here](#).

- Reports that Dementia is one of the major causes of disability and dependency among older people worldwide and it has physical, psychological, social and economical impact on caregivers, families and society.

Office for National Statistics. *Statistical bulletin: Deaths registered in England and Wales (Series DR)*: 2015. Newport: Office for National Statistics; 2016. Available [here](#).

- Reports that Dementia and Alzheimer disease became the leading cause of death in England and Wales in 2015 accounting for 11.6% of all deaths registered.

Prince M et al. *The global prevalence of dementia: A systematic review & meta-analysis*. *Alzheimer's & Dementia* 2013; 9:63-75. Available [here](#).

- In this study the authors provide a systematic review of the global literature on the prevalence of dementia (1980–2009) and meta-analysis to estimate the prevalence and numbers of those

affected, aged >60 years in 21 Global Burden of Disease regions. Review authors report that age-standardized prevalence for those aged >60 years varied in a narrow band, 5%–7% in most world regions, with a higher prevalence in Latin America (8.5%), and a distinctively lower prevalence in the four sub-Saharan African regions (2%–4%). It was estimated that 35.6 million people lived with dementia worldwide in 2010, with numbers expected to almost double every 20 years, to 65.7 million in 2030 and 115.4 million in 2050. In 2010, 58% of all people with dementia lived in countries with low or middle incomes, with this proportion anticipated to rise to 63% in 2030 and 71% in 2050.

National Institute for Health and Care Excellence. *Dementia: supporting people with dementia and their carers in health and social care*. CG42. London: NICE; 2016. Available [here](#).

- Recommends that primary healthcare staff should consider referring people who show signs of mild cognitive impairment (MCI) for assessment by memory assessment services to aid early identification of dementia, because more than 50% of people with MCI later develop dementia. Memory assessment services that identify people with MCI (including those without memory impairment, which may be absent in the earlier stages of non Alzheimer's dementias) should offer follow up to monitor cognitive decline and other signs of possible dementia in order to plan care at an early stage.

NHS Choices. 2015. *Behind the headlines 'Antipsychotics used on people with no mental illness diagnosis'* [Online]. Available [here](#).

- Synopsis not provided.

NHS Choices. 2009. *Behind the headlines 'Antipsychotic use in dementia'* [Online]. Available [here](#).

- The report found that the current approach to treating the psychological and behavioural symptoms of dementia appears to be largely based on the use of antipsychotics. It also found that the evidence regarding the use of antipsychotics in people with dementia is complex, sometimes contradictory and contains gaps. Due to the gaps in the evidence, any conclusions need to be drawn cautiously.
- The report concluded that, overall, the evidence suggests that antipsychotics appear to have only a limited positive effect in treating these symptoms and cause significant harm to people with dementia. However, it also said that some people with dementia do benefit from antipsychotics and there are likely to be specific subgroups of people with dementia who benefit, such as those with severe symptoms. It said this has not yet been tested in rigorous trials.

National Institute for Health and Care Excellence. *Dementia: supporting people with dementia and their carers in health and social care*. CG42. London: NICE; 2016. Available [here](#).

- Under Pharmacological interventions for non-cognitive symptoms and behaviour that challenges in people with dementia it states:
 - People with Alzheimer's disease, vascular dementia or mixed dementias with mild to moderate non cognitive symptoms should not be prescribed antipsychotic drugs because of the possible increased risk of cerebrovascular adverse events and death.
 - People with DLB with mild to moderate non cognitive symptoms, should not be prescribed antipsychotic drugs, because they are at particular risk of severe adverse reactions.
 - People with Alzheimer's disease, vascular dementia, mixed dementias or DLB with severe non-cognitive symptoms (psychosis and/or agitated behaviour causing

significant distress) may be offered treatment with an antipsychotic drug after the following criteria have been met:

- There should be a full discussion with the person with dementia and/or carers about the possible benefits and risks of treatment. In particular, cerebrovascular risk factors should be assessed and the possible increased risk of stroke/transient ischaemic attack and possible adverse effects on cognition discussed.
 - Changes in cognition should be assessed and recorded at regular intervals. Alternative medication should be considered if necessary.
 - Target symptoms should be identified, quantified and documented.
 - Changes in target symptoms should be assessed and recorded at regular intervals.
 - The effect of comorbid conditions, such as depression, should be considered.
 - The choice of antipsychotic should be made after an individual risk-benefit analysis.
 - The dose should be low initially and then titrated upwards.
 - Treatment should be time limited and regularly reviewed (every 3 months or according to clinical need).
 - For people with DLB, healthcare professionals should monitor carefully for the emergence of severe untoward reactions, particularly neuroleptic sensitivity reactions (which manifest as the development or worsening of severe extrapyramidal features after treatment in the accepted dose range or acute and severe physical deterioration following prescription of antipsychotic drugs for which there is no other apparent cause).
- Healthcare professionals who use medication in the management of violence, aggression and extreme agitation in people with dementia should:
 - Be trained in the correct use of drugs for behavioural control, specifically benzodiazepines and antipsychotics.
 - Understand the cardiorespiratory effects of the acute administration of benzodiazepines and antipsychotics and the need to titrate dosage to effect.

NICE *Low-dose antipsychotics in people with dementia*, Key therapeutic topic [KTT7] Published date: January 2015 states:

- There are currently no medicines optimisation key therapeutic topic (MO KTT) prescribing comparators for this topic. The development of a suitable comparator is currently being explored by the NHS England Medicines Optimisation Intelligence Group. The National dementia and antipsychotic prescribing audit from 2012 suggests that there has been an encouraging overall reduction in the proportion of people with dementia being prescribed antipsychotics in recent years. See the National Dementia and Antipsychotic Prescribing Audit [website](#) for more details.

Want to know more?



The PHW Observatory host a series of topic pages that bring together information on Observatory products; other key websites; key data sources; key evidence sources; and additional evidence and data sources. The topic page on mental health can be found [here](#), although references to dementia specifically are limited.

18.2 COMPARATIVE ANALYSIS

For % of over 65 registered as having dementia with their GP practice and % of over 65 registered as having memory impairment:

- Data source: GP clinical systems extracted by Audit+
- Numerator: The number of patients in the denominator with a Read code of dementia, or memory impairment only
- Denominator: Registered patients aged 65 years and over

For % of people with dementia prescribed anti-psychotic medication:

- Data source: GP clinical systems extracted by Audit+
- Numerator: The number of patients in the denominator population that are currently prescribed anti-psychotic medication (6 month QOF drug rule to apply)
- Denominator: The number of registered patients aged 65+ with a Read code of dementia

18.2.1 VARIATION BY HEALTH BOARD

Fig. 18A shows the variation in proportion of people over 65 registered as having dementia with their GP practice, by health board. The average Wales attainment for this measure is a recording proportion of 3.0%. Variation in attainment across Wales is 1.3%, ranging from 0.8% above average (C&VUHB, 3.8%) to 0.5% below average (H DUHB, 2.5%).

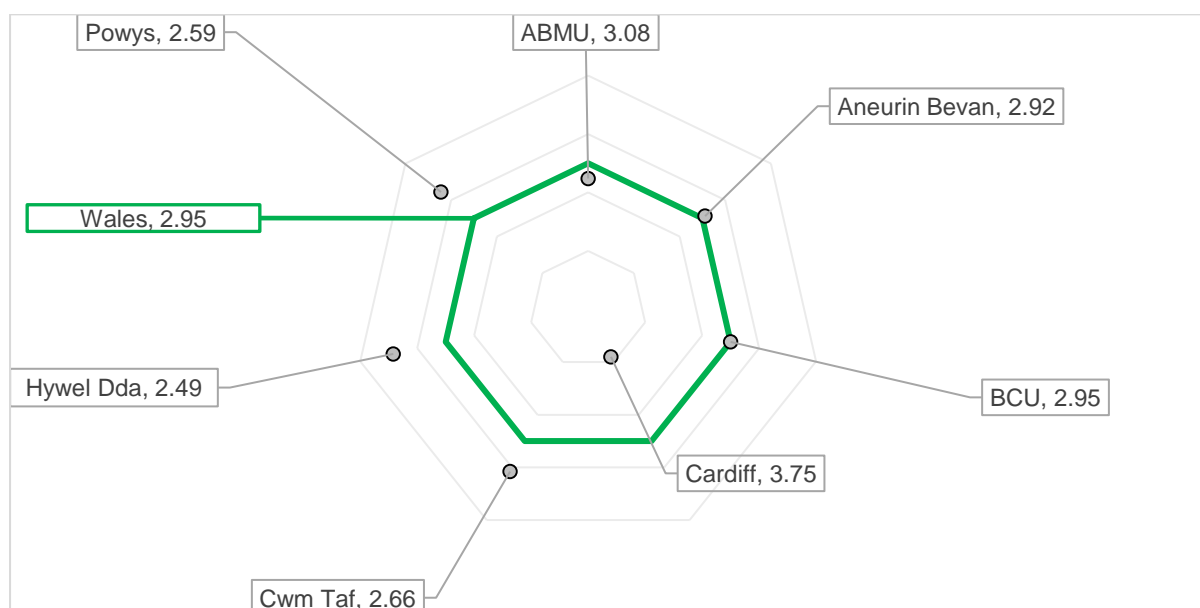


Fig. 18A: Variation in proportion of people over 65 registered as having dementia with their GP practice, by health board, Q3 2017/18 (Source: PCIP, Sep 2018).

Fig. 18B shows the variation in proportion of people over 65 registered as having memory impairment with their GP practice, by health board. The average Wales attainment for this measure is a recording proportion of 0.7%. Variation in attainment across Wales is 0.5%, ranging from 0.1% above average (BCUUBH & C&VUHB, 0.7%) to 0.4% below average (CTUHB, 0.3%).

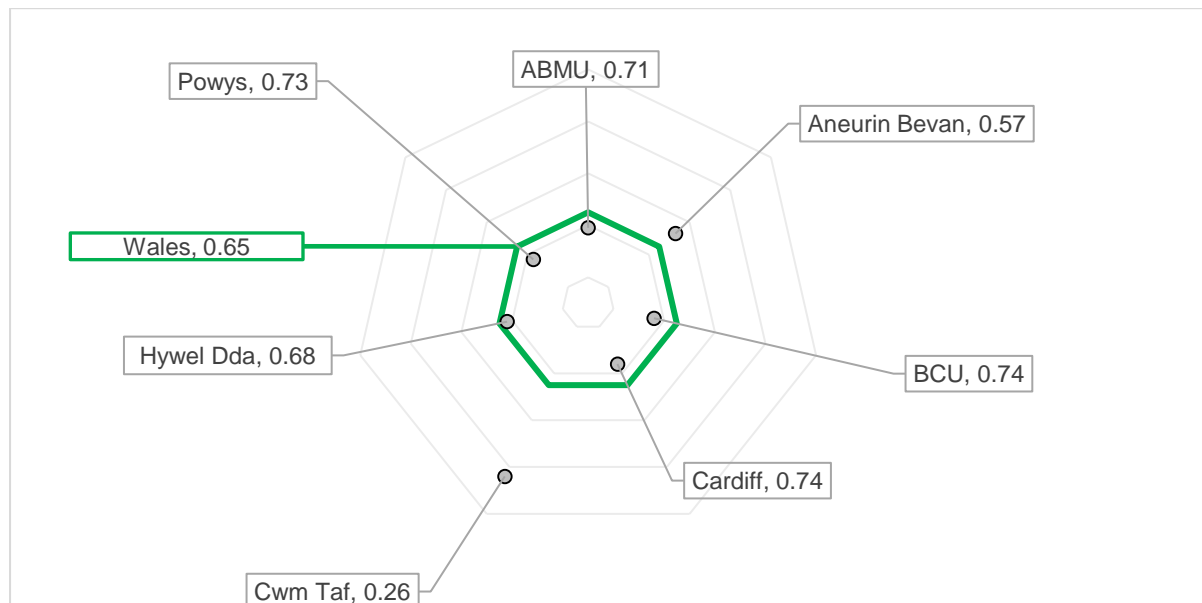


Fig. 18B: Variation in proportion of people over 65 registered as having memory impairment with their GP practice, by health board, Q3 2017/18 (Source: PCIP, Sep 2018).

Fig. 18C shows the variation in proportion of people with dementia prescribed anti-psychotic medication, by health board. The average Wales attainment for this measure is a recording proportion of 1.8%. Variation in attainment across Wales is 1.3%, ranging from 0.8% above average (PTHB, 1.0%) to 0.5% below average (ABMUHB, 2.3%).

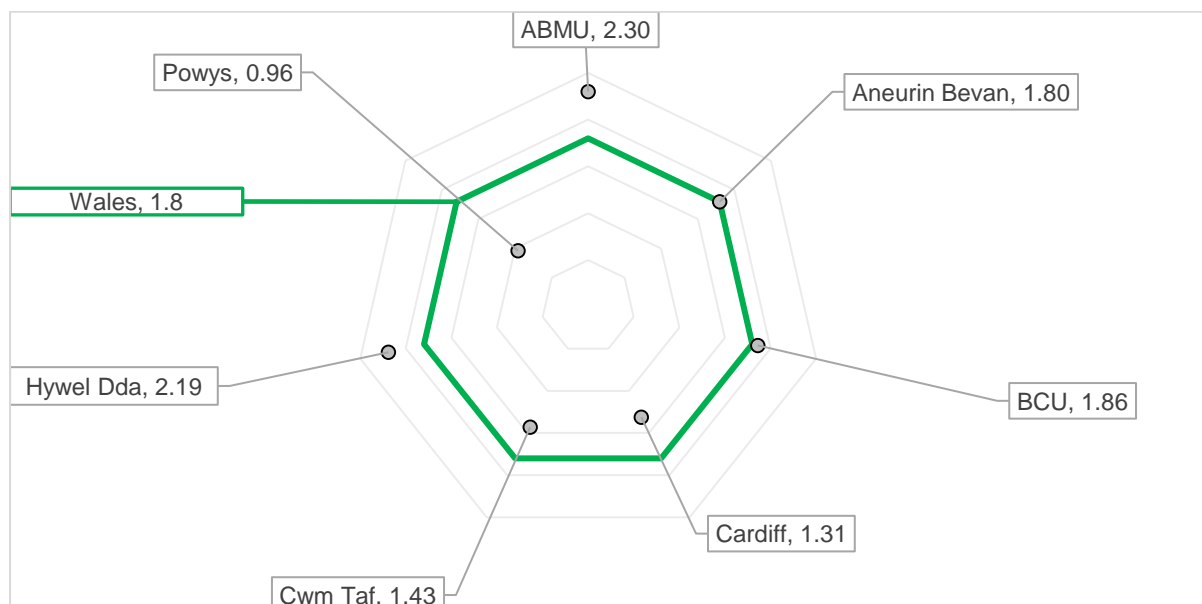


Fig. 18C: Variation in proportion of people with dementia prescribed anti-psychotic medication, by health board, Q3 2017/18 (Source: PCIP, Sep 2018).

18.2.2 VARIATION WITHIN HEALTH BOARDS

Fig. 18D shows the variation in proportion of people over 65 registered as having dementia with their GP practice, by cluster within each health board. Variation in attainment by cluster ranges from as much as 2.4% within BCUHB to as little as 0.7% within HDUHB. Variation between the best attaining (CTUHB, 1.5%) and least attaining (C&VUHB, 5.2%) cluster across all of Wales is 3.8%.

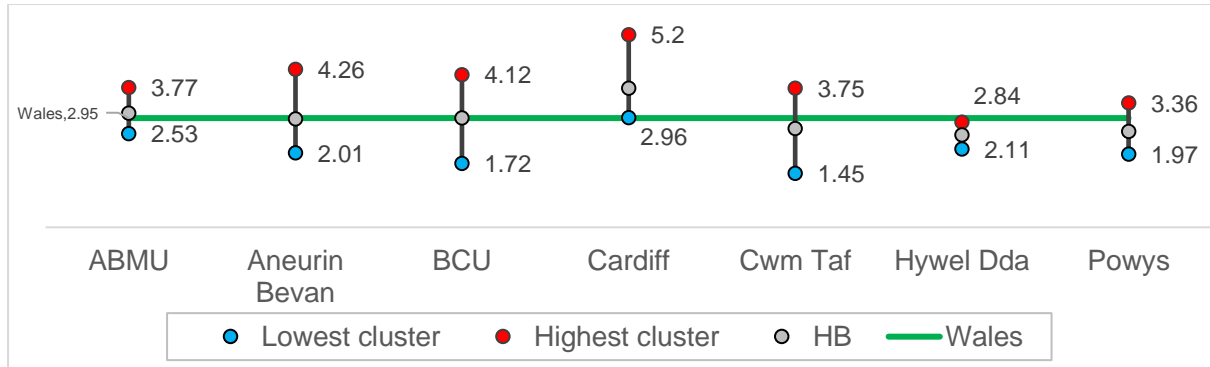


Fig. 18D: Variation in proportion of people over 65 registered as having dementia with their GP practice, by cluster within each health board, Q3 2017/18 (Source: PCIP, Sep 2018).

Fig. 18E shows the variation in proportion of people over 65 registered as having memory impairment with their GP practice, by cluster within each health board. Variation in attainment by cluster ranges from as much as 1.3% within ABMUHB to as little as 0.2% within CTUHB. Variation between the best attaining (ABMUHB, 1.6%) and least attaining (CTUHB, 0.2%) cluster across all of Wales is 1.5%.

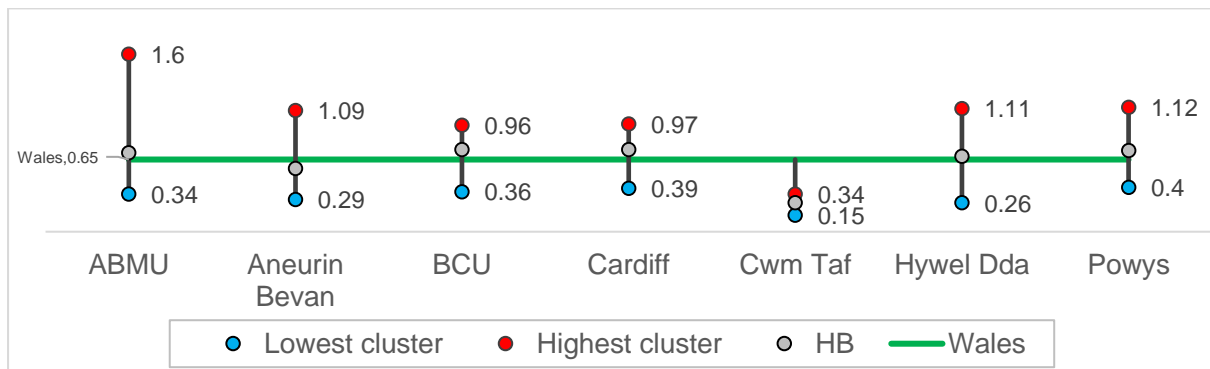


Fig. 18E: Variation in proportion of people over 65 registered as having memory impairment with their GP practice, by cluster within each health board, Q3 2017/18 (Source: PCIP, Sep 2018).

Fig. 18F shows the variation in proportion of people with dementia prescribed anti-psychotic medication, by cluster within each health board. Variation in attainment by cluster ranges from as much as 5.0% within BCUHB to as little as 1.1% within HDUHB & PTHB. Variation between the best attaining (ABMUHB & CTUHB, 0.0%) and least attaining (BCUHB, 5.5%) cluster across all of Wales is 5.5%.

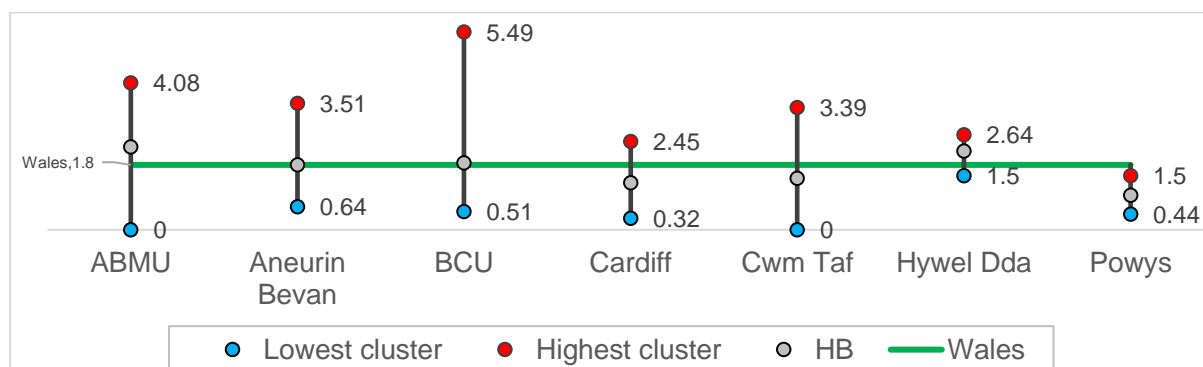


Fig. 18F: Variation in proportion of people with dementia prescribed anti-psychotic medication, by cluster within each health board, Q3 2017/18 (Source: PCIP, Sep 2018).

Key messages

- Overall variation between health boards for entry to the dementia register, for recording of memory impairment, and for anti-psychotic prescription is less than 5% either side of the Welsh average.
- Variation within health boards and between clusters across Wales is relatively slight.

18.3 IMPROVEMENT ACTIONS

18.3.1 GP PRACTICE ACTION

Improvement actions potentially suitable for adoption by GP practice cluster members include:

- QOF guidance for 2017/18 identified dementia as a national clinical priority; proposed quality improvement action focussed on using one or more of three Quality Improvement Toolkits (see [here](#)). Practices are asked to self-assess and discuss QI plans for:
 - Dementia Management in Primary Care – Quality Improvement Toolkit (Public Health Wales October 2013) (Toolkit 1);
 - Recognition, Assessment and Referral of Suspected Dementia in Primary Care – Quality Improvement Toolkit (Public Health Wales October 2013) (Toolkit 2);
 - “End of Life Care Review” Case Review Audit (Public Health Wales January 2013) (Toolkit 3).

18.3.2 WIDER CLUSTER ACTION

Improvement actions potentially suitable for adoption by the wider cluster membership include:

- The above national clinical priority QI project required GP practices to:
 - “Discuss the shared practice Quality Improvement Plans for dementia care with the other practices [*sic*—no reason for limitation to GP practice stakeholders] in a cluster meeting”;
 - “Develop a *Cluster* Quality Improvement Plan for dementia care”;
 - “Include this plan in the Cluster Report”;
 - “Review the actions within the plan regularly to ensure progress is made to achieving them”.
- Good practice in dementia care is the subject of an information resource from Social Care Wales, *Dementia resource for care professionals*. This contains essential information, case studies, data, and research findings; this is available [here](#).

Good practice example

Heads of Primary Care were unable to identify relevant good practice examples of cluster-led quality improvement projects for this report. Readers are encouraged to contact the PHW Primary Care Division with any local examples suitable to share.

References

- Dementia: assessment, management and support for people living with dementia and their carers. NICE guideline [NG97] Published date: June 2018.
<https://www.nice.org.uk/guidance/ng97/chapter/Recommendations#pharmacological-interventions-for-dementia>

19. INDIVIDUAL CARE: BLOOD PRESSURE

The Primary Care Information Portal provides data on the following indicator(s):

- % of patients aged 50 or over who have a record of blood pressure in the preceding 5 years (BP001W)

19.1 MEASURE CONTEXT

This indicator is not described within PHW's *Proposed Primary Care Measures: Phase 2* final report (May 2017) or related documentation.

Want to know more?



The PHW Observatory host a series of topic pages that bring together information on Observatory products; other key websites; key data sources; key evidence sources; and additional evidence and data sources. The topic page on inequalities and inequities can be found [here](#), with data on hypertension available from the cardiovascular disease topic page [here](#).

19.2 COMPARATIVE ANALYSIS

- Data source: Quality and Outcomes Framework (QOF)
- Numerator: Number of patients aged 50 or over who have a GP record of blood pressure in the preceding 5 years
- Denominator: Number of patients aged 50 or over who had a GP record of blood pressure at any point (i.e. not necessarily in the preceding five years)

Note: No C&VUHB cluster-level data are reported on PCIP for this indicator.

Note: These data are poorly suited to measurement of inequalities. Inequalities are typically assessed in relation to variance in access to healthcare or care outcomes with sub-analysis according to characteristics such as age, sex, ethnicity, deprivation status, etc.

19.2.1 VARIATION BY HEALTH BOARD

Fig. 19A shows the variation in proportion of patients aged 50 or over who have a record of blood pressure in the preceding 5 years, by health board. The average Wales attainment for this measure is a recording proportion of 91.0%. Variation in attainment across Wales is 2.4%, ranging from 1.6% above average (CTUHB, 92.6%) to 0.8% below average (HDUHB, 90.2%).

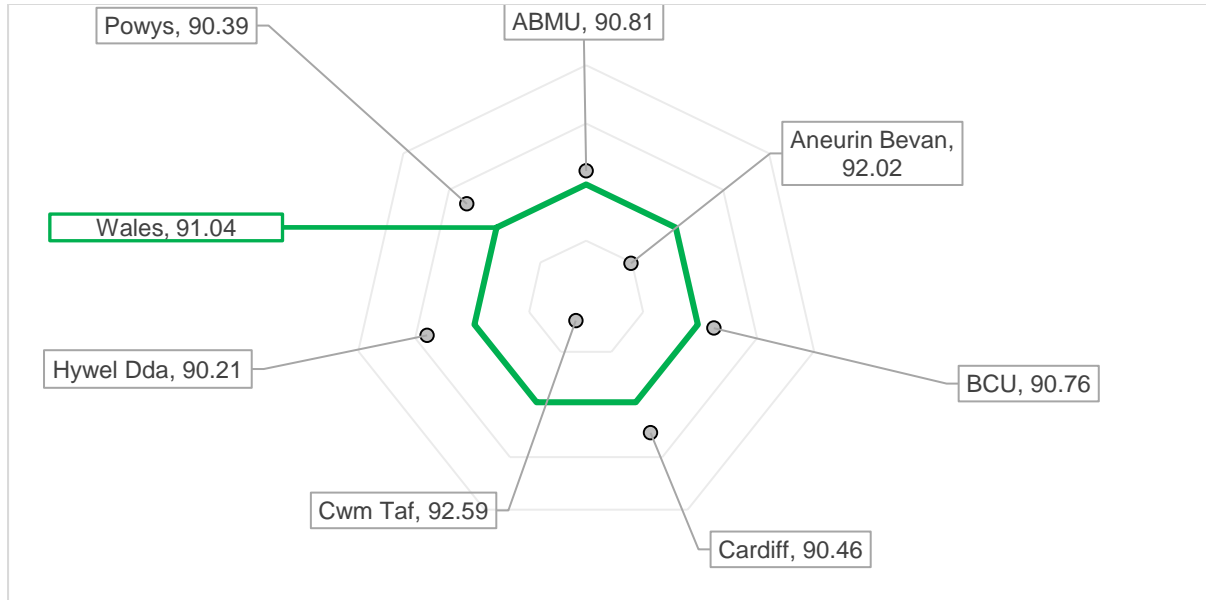


Fig. 19A: Variation in proportion of patients aged 50 or over who have a record of blood pressure in the preceding 5 years, by health board, 2015/16 (Source: PCIP, Sep 2018).

19.2.2 VARIATION WITHIN HEALTH BOARDS

Fig. 19B shows the variation in proportion of patients aged 50 or over who have a record of blood pressure in the preceding 5 years, by cluster within each health board. Variation in attainment by cluster ranges from as much as 7.3% within ABMUHB to as little as 0.8% within PTHB (excluding C&VUHB, the data for which is unknown). Variation between the best attaining (CTUHB, 95.1%) and least attaining (ABMUHB, 86.4%) cluster across all of Wales is 8.6%.

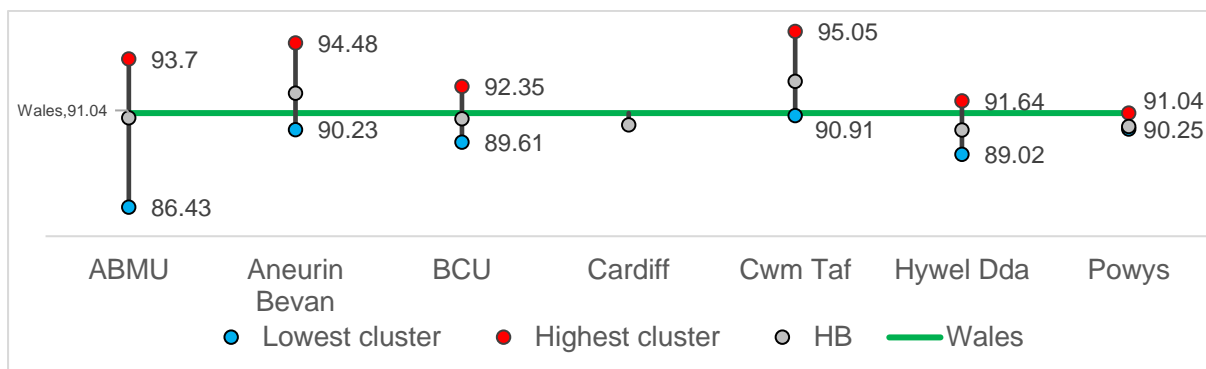


Fig. 19B: Variation in proportion of patients aged 50 or over who have a record of blood pressure in the preceding 5 years, by cluster within each health board, 2015/16 (Source: PCIP, Sep 2018).

Key messages

- Overall variation between health boards for recording of blood pressure is less than 5% either side of the Welsh average.
- Variation within health boards and between clusters across Wales is relatively slight.
- It is difficult to consider this metric as a good health inequalities indicator.

19.3 IMPROVEMENT ACTIONS

19.3.1 GP PRACTICE ACTION

Improvement actions potentially suitable for adoption by GP practice cluster members include:

- Hypertension should be treated in accordance with NICE guideline [CG127](#).
- Behavioural risk reduction is also beneficial to lowering BP (BMJ [2016;355:i5719](#)):
 - Diet rich in fruits, vegetables, and low-fat dairy with reduced fat intake: 8-14 mmHg decrease in systolic BP
 - Regular aerobic activity at least 30 minutes a day: 4-9 mmHg
 - No more than 2400 mg (ideally 1600 mg) of sodium daily: 2-8 mmHg
 - Max 2 oz ethanol/ day (men) 1 oz ethanol/ day (women): 2-4 mmHg
 - Achieve/ maintain BMI of 18.5-24.9: 3 mmHg per 4-8% bodyweight reduction.
- A 3 g reduction in daily salt intake (a reasonably conservative estimate of what could be achieved) would reduce systolic blood pressure by approximately 2 mmHg (NICE [PH25](#), 2010).
- BHF Cymru advise that, in relation to *detection* of high blood pressure, GP practices can:
 - Audit practice records to identify people with high BP recordings who do not have a hypertension code. To prioritise, consider starting with those with readings above 150/90mmHg.
 - Increase opportunistic blood pressure testing in the practice:
 - Think BP in routine consultations.
 - Make blood pressure testing routine in all nurse led-clinics such as asthma, COPD, diabetes, weight management, smoking cessation, as well as other local enhanced service clinics – prompt by adding to templates.
 - Take the opportunity to promote community BP campaigns. Please note patient may present with a BP record from these events.
 - If a reading is high, always offer ambulatory or, when appropriate, home blood pressure monitoring in order to confirm a diagnosis of high BP and always include assessment of lifetime cardiovascular risk as part of the diagnosis.
 - Promote high standards in BP measurement, including machine calibration, signposting patients and staff to resources on high blood pressure and self-testing through NHS Choices.
- BHF Cymru advise that, in relation to *management* of high blood pressure, GP practices can:
 - Audit practice records to identify individuals with poor control of high BP - focus first on people under 85 years with BP above 140/90 who are not on a three-drug combination.
 - Use shared decision making resources to help the individual make informed decisions about behaviour change and drug treatment.
 - Agree BP treatment targets with patients as part of shared management plan, taking account of comorbidity, adverse effects and patient preference.

- Offer therapy according to NICE/BIHS guidelines and have a clear protocol to ensure regular review and intensification of therapy to maintain BP targets.
- Make BP testing routine in nurse-led clinics and ensure that identification of poor BP control is the responsibility of all clinicians.
- When blood pressure is above target always ask about adherence to treatment.
- Advise patients of the option to buy clinically validated blood pressure machines advised by the British and Irish Hypertension Society and provide advice on how they can monitor their own blood pressure.
- Explore use of remote monitoring via telehealth or blood pressure apps.

19.3.2 WIDER CLUSTER ACTION

Improvement actions potentially suitable for adoption by the wider cluster membership include:

- PHE's High blood pressure: [action plan](#) provides evidence-based advice for partners including local government and the health system on how to effectively identify, treat and prevent hypertension.
- BHF Cymru advise that, in relation to *detection* of high blood pressure, health boards and [primary care] clusters can:
 - Examine the level of variation in the numbers of people with high blood pressure between [primary care] clusters and practices.
 - Adopt quality improvement methods to support all practices to identify people with high blood pressure.
 - Work with partners to promote public awareness of blood pressure and opportunities for testing and self-testing.
 - Promote access to ambulatory blood pressure monitoring.
 - Consider partnership opportunities with community pharmacists and community BP campaigns to offer blood pressure checking.
 - Consider supporting practices to have self-test BP stations in the waiting room.
- BHF Cymru advise that, in relation to *management* of high blood pressure, health boards and [primary care] clusters can:
 - Use local data where it is available to estimate how many people with high BP are controlled to the NICE/ BIHS guidelines.
 - Examine the level of variation in achievement rates between practices.
 - Adopt quality improvement methods to support all practices to perform as well as the top quartile in high BP.
 - Expand adherence support by community pharmacists as part of medicine review service.
 - Consider the role of community pharmacists to support BP monitoring and treatment optimisation.
 - Support practices to evaluate emerging technologies that can help patients and clinicians to monitor and manage high BP.
 - Promote and support opportunities for educational activities for GPs, nurses, health care assistants and patients.

Good practice example

Heads of Primary Care were unable to identify relevant good practice examples of cluster-led quality improvement projects for this report. Readers are encouraged to contact the PHW Primary Care Division with any local examples suitable to share.

References

- NICE. Hypertension in adults: diagnosis and management. Clinical guideline [CG127]. Published date: August 2011. Last updated: November 2016. <https://www.nice.org.uk/guidance/cg127>
- Viera Anthony J, Hawes Emily M. Management of mild hypertension in adults BMJ 2016; 355 :i5719. <https://www.bmj.com/content/355/bmj.i5719>
- Cardiovascular disease prevention. Public health guideline [PH25]. Published date: June 2010. <https://www.nice.org.uk/guidance/ph25>
- Public Health England. High blood pressure: action plan: Evidence-based advice for partners including local government and the health system on how to effectively identify, treat and prevent high blood pressure (hypertension). Published 18 November 2014. Last updated 9 January 2018. <https://www.gov.uk/government/publications/high-blood-pressure-action-plan>
- British Heart Foundation Cymru. High blood Pressure: How can we do better? Published Feb 2018. <https://www.bhf.org.uk/for-professionals/healthcare-professionals/commissioning-and-services/service-innovation/bp-how-can-we-do-better>

20. INDIVIDUAL CARE: MEDICATION REVIEW

The Primary Care Information Portal provides data on the following indicator(s):

- A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed 4 or more repeat medicines (MED007W)

20.1 MEASURE CONTEXT

This indicator is not described within PHW's *Proposed Primary Care Measures: Phase 2* final report (May 2017) or related documentation.

Want to know more?

National standards for medication reviews in Wales are currently under development, overseen by the All Wales Medicines Strategy Group (AWMSG). The strategy, which includes a recommendation to "Implement a nationally agreed, multi-professional standard for medicine reviews" by 2020 (3.2), is available [here](#).

20.2 COMPARATIVE ANALYSIS

- Data source: Quality and Outcomes Framework (QOF)
- Numerator: A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed four or more repeat medicines (MED007W)
- Denominator: Not stated

20.2.1 VARIATION BY HEALTH BOARD

Fig. 20A shows the variation in proportion of medication reviews recorded in the notes in the preceding 15 months for all patients being prescribed 4 or more repeat medicines, by health board. The average Wales attainment for this measure is a recording proportion of 93.8%. Variation in attainment across Wales is 11.9%, ranging from 6.2% above average (Powys, 100%) to 5.7% below average (ABUHB, 88.1%).

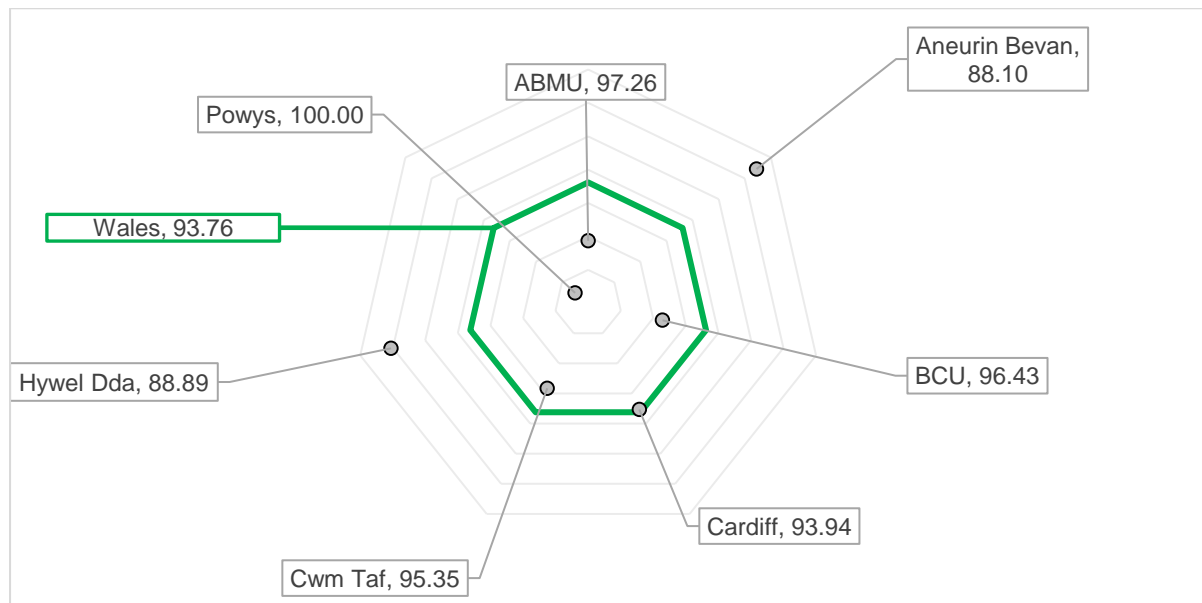


Fig. 20A: Variation in proportion of medication reviews recorded in the notes in the preceding 15 months for all patients being prescribed 4 or more repeat medicines, by health board, 2015/16 (Source: PCIP, Sep 2018).

20.2.2 VARIATION WITHIN HEALTH BOARDS

Fig. 20B shows the variation in proportion of medication reviews recorded in the notes in the preceding 15 months for all patients being prescribed 4 or more repeat medicines, by cluster within each health board. Variation in attainment by cluster ranges from as much as 33.3% within HDUHB to as little as 0.0% within PTHB. Variation between the best attaining (all health boards, 100%) and least attaining (H DUHB, 66.7%) cluster across all of Wales is 33.3%.

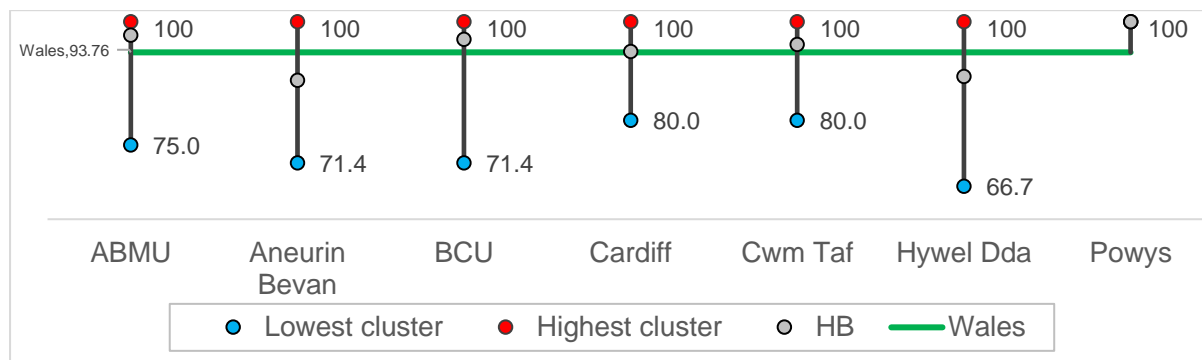


Fig. 20B: Variation in proportion of medication reviews recorded in the notes in the preceding 15 months for all patients being prescribed 4 or more repeat medicines, by cluster within each health board, 2015/16 (Source: PCIP, Sep 2018).

Key messages

- Overall variation between health boards for recording of medication reviews exceeds 5% either side of the Welsh average.
- Health board averages obfuscate variation within health boards of up to 33%.
- The attainment gap between clusters across Wales is 33%.

20.3 IMPROVEMENT ACTIONS

20.3.1 GP PRACTICE ACTION

Improvement actions potentially suitable for adoption by GP practice cluster members include:

- NICE (2015) advice is to consider carrying out a structured medication review for some groups of people when a clear purpose for the review has been identified. These groups may include:
 - adults, children and young people taking multiple medicines (polypharmacy)
 - adults, children and young people with chronic or long term conditions
 - older people.
- NICE (2015) advice is that organisations should determine locally the most appropriate health professional to carry out a structured medication review, based on their knowledge and skills, including all of the following:
 - technical knowledge of processes for managing medicines
 - therapeutic knowledge on medicines use
 - effective communication skills.
- NICE (2015) advice is that during a structured medication review, take into account:
 - the person's, and their family members or carers where appropriate, views and understanding about their medicines
 - the person's, and their family members' or carers' where appropriate, concerns, questions or problems with the medicines
 - all prescribed, over-the-counter and complementary medicines that the person is taking or using, and what these are for
 - how safe the medicines are, how well they work for the person, how appropriate they are, and whether their use is in line with national guidance
 - whether the person has had or has any risk factors for developing adverse drug reactions (report adverse drug reactions in line with the yellow card scheme)
 - any monitoring that is needed.

20.3.2 WIDER CLUSTER ACTION

Improvement actions potentially suitable for adoption by the wider cluster membership include:

- NICE (2015) advice is that medication review may be led, for example, by a pharmacist or by an appropriate health professional who is part of a multidisciplinary team.
- In relation to medication reviews carried out with care home partners, WeMeReC provide the following tips for clusters around organisation of care:
 - A lead GP for each care home in the practice area. This could be organised at local or "cluster" level.

- A nominated clinical pharmacist having overall oversight for medicines use in the care home.
- Putting in place adequate staff training and suitable protocols.
- Involving the resident and their family in the medicine optimisation process, as much as possible.
- Assume that a resident can take and look after their medicines themselves (self-administer) unless a risk assessment has indicated otherwise.
- Remote access to the medical record, use of electronic administration systems, use of barcodes.
- A clear process for reporting medicines-related safeguarding incidents under local safeguarding processes, and to the appropriate regulator.
- Adherence aids such as monitored dosage boxes or 'pill organisers' are widely used in care homes. They may be inflexible in this setting and careful administration of medicines by trained staff (nurses in nursing homes) may be preferable.
- In relation to medication reviews carried out with care home partners, WeMeReC provide the following tips for clusters around prescribing and reviewing medication:
 - Regular review of the use and accuracy of medication administration records (MAR charts), particularly when transferred between care settings, e.g. on discharge from hospital.
 - Clear instructions on how and when the medicine should be used, particularly for 'as required' or variable dose medicines.
 - Monitoring of omitted doses and ordering systems. Checking for waste.
 - Timing of medication administration to prevent interruption, e.g. not at meal times.
 - Regular, appropriate monitoring of patients on specific higher-risk medicines (such as ACE inhibitors and angiotensin II receptor blockers), including blood tests.
 - All medication to be regularly reviewed by a pharmacist.

Good practice example

Heads of Primary Care were unable to identify relevant good practice examples of cluster-led quality improvement projects for this report. Readers are encouraged to contact the PHW Primary Care Division with any local examples suitable to share.

References

- NICE. Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes, 2015 (NG5) 2015. <https://www.nice.org.uk/guidance/ng5>
- WeMeReC – Optimising medicines use in care homes. <https://www.wemerec.org/Documents/Bulletins/optimisingmed2016online.pdf>

21. TIMELY CARE: ACCESS

The Primary Care Information Portal provides data on the following indicator(s):

- % GP practices offering appointments between 5pm & 6:30pm at least 2 nights per week
- % GP practices open during daily core hours or within one hour of the daily core hours Monday to Friday

21.1 MEASURE CONTEXT

The rationale for selection of these indicators is not described within PHW's *Proposed Primary Care Measures: Phase 2* final report (May 2017) or related documentation.

21.1.1 KEY MEASURE CHARACTERISTICS

Note: The following characteristics were recorded for a related indicator: "Numbers of people answering *I am able to consult the primary health care practitioner of my choice within a reasonable and convenient timeframe*". This was recommended by PHW for Phase 2B development (information not readily accessible; these measures were deemed important but involve additional challenges to implement).

- Linked national policy or frameworks: Public perspective: Awareness of local health services: involvement and information. Choose Well. Primary Care Plan
- Population health rationale: Improved autonomy leads to better population health outcomes.
- Clinical rationale: Patient experience is important to the concept of clinical excellence (Darzi). Appropriate use of clinician time.
- Estimated patient/ public perception of topic importance: Fits with Choose Well (making right choice) & Welsh Government prudent public concept. Improved access to appropriate care.
- Identified caveats or limitations: Survey methodology/ inconsistency. Requires validation [not applicable to the above alternative indicators].

21.1.2 KEY SUPPORTING EVIDENCE

National Institute for Health and Care Excellence. *Patient experience in adult NHS services: Improving the experience of care for people using adult NHS services: patient experience in generic terms*. CG138. London: NICE; 2012. Available [here](#).

- There are eight Picker Principles of patient-centred care. These are the seven dimensions outlined by Gerteis *et al* (1993)³ with an eighth dimension 'access to care' added.
- 'Access to care' is described as follows:
 - Patients need to know they can access care when it is needed
 - Attention must also be given to time spent waiting for admission or time between admission and allocation to a bed in a ward

³ Gerteis M et al. *Through the patient's eyes: understanding and promoting patient-centered care*. San Francisco: Jossey-Bass; 1993.

- Specific comment regarding ambulatory care is made by Picker:
 - Access to the location of hospitals, clinics and physician offices
 - Availability of transportation
 - Ease of scheduling appointments
 - Availability of appointments when needed
 - Accessibility to specialists or specialty services when a referral is made
 - Clear instructions provided on when and how to get referrals

Want to know more?

Statistical analyses on GP access in Wales are published by Welsh Government and are available [here](#).

21.2 COMPARATIVE ANALYSIS

- Data source: Knowledge & Analytical Services, Welsh Government
- Numerator: “Measures are currently being defined”
- Denominator: “Measures are currently being defined”

21.2.1 VARIATION BY HEALTH BOARD

Fig. 21A shows the variation in proportion of GP practices offering appointments between 1700h & 1830h at least 2 nights per week, by health board. The average Wales attainment for this measure is an opening proportion of 97.0%. Variation in attainment across Wales is 5.0%, ranging from 3.0% above average (ABUHB, CTUHB & PTHB, 100%) to 2.0% below average (ABMUHB, 95.0%).

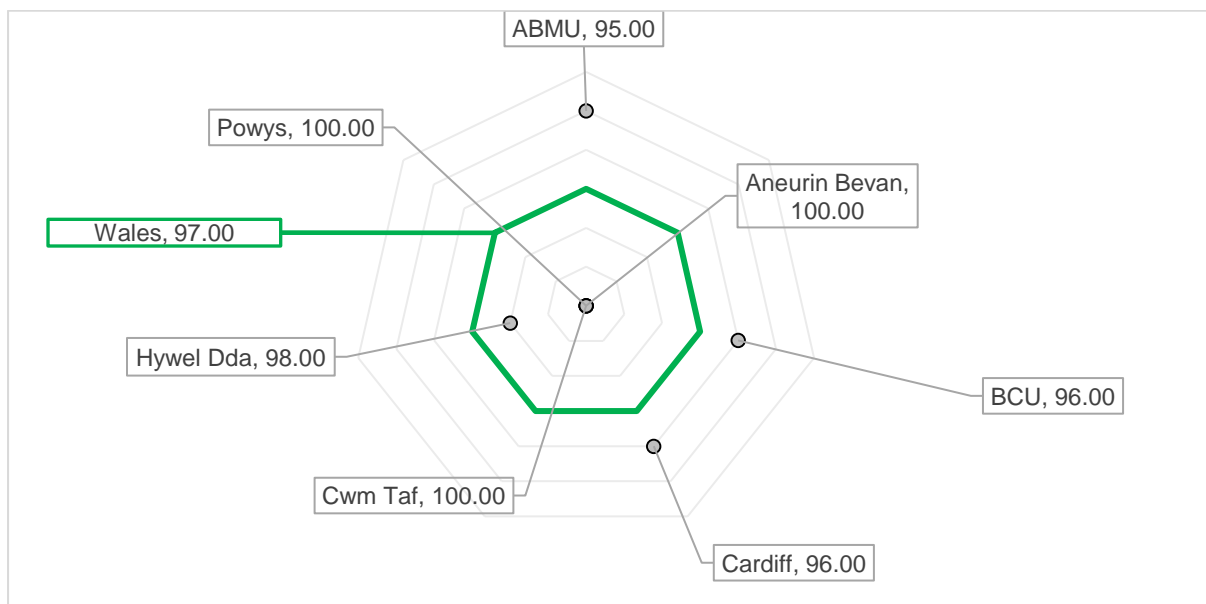


Fig. 2A: Variation in proportion of GP practices offering appointments between 1700h & 1830h at least 2 nights per week, by health board, 2016 (Source: PCIP, Sep 2018).

Fig. 21B shows the variation in proportion of GP practices open during daily core hours or within one hour of the daily core hours Monday to Friday, by health board. The average Wales attainment for this measure is an opening proportion of 50.0%. Variation in attainment across Wales is 45.0%, ranging from 29% above average (ABUHB, 79.0%) to 16% below average (BCUHB, 34.0%).

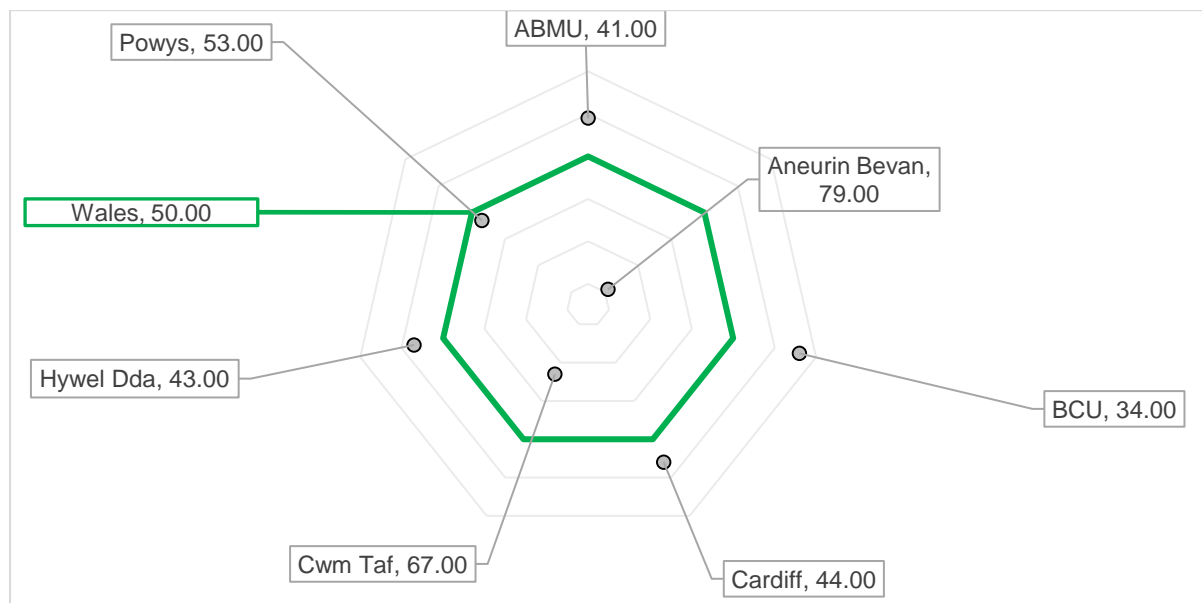


Fig. 21B: Variation in proportion of GP practices open during daily core hours or within one hour of the daily core hours Monday to Friday, by health board, 2016 (Source: PCIP, Sep 2018).

21.2.2 VARIATION WITHIN HEALTH BOARDS

These data are not reported at cluster level.

Key messages

- Overall variation between health boards for evening opening is less than 5% either side of the Welsh average; for weekday opening, variation exceeds 5% both sides of the Welsh average.

21.3 IMPROVEMENT ACTIONS

21.3.1 GP PRACTICE ACTION

Improvement actions potentially suitable for adoption by GP practice cluster members include:

- Development of actions required.

21.3.2 WIDER CLUSTER ACTION

Improvement actions potentially suitable for adoption by the wider cluster membership include:

- Development of partnership actions required.

Good practice example

Heads of Primary Care were unable to identify relevant good practice examples of cluster-led quality improvement projects for this report. Readers are encouraged to contact the PHW Primary Care Division with any local examples suitable to share.

22. TIMELY CARE: URGENT CARE

The Primary Care Information Portal provides data on the following indicator(s):

- Count of emergency admissions/ readmissions per month for Alzheimer’s disease
- Count of emergency admissions/ readmissions per month for atrial fibrillation
- Count of emergency admissions/ readmissions per month for “cardiovascular”
- Count of emergency admissions/ readmissions per month for CVA
- Count of emergency admissions/ readmissions per month for diabetes
- Count of emergency admissions/ readmissions per month for “musculoskeletal”
- Count of emergency admissions/ readmissions per month for “neurological”
- Count of emergency admissions/ readmissions per month for “respiratory”

22.1 MEASURE CONTEXT

The rationale for selection of these indicators is not described within PHW’s *Proposed Primary Care Measures: Phase 2* final report (May 2017) or related documentation.

22.1.1 KEY MEASURE CHARACTERISTICS

Note: The following characteristics were recorded for a related indicator: “Percentage of patients with long term conditions who have an unscheduled emergency admissions arising from that condition”. These conditions were specified (based on *High impact changes 2011*) as: COPD; asthma; heart failure; epilepsy; and diabetes complications⁴.

- Linked national policy or frameworks: National delivery plans.
- Population health rationale: Appropriate management of chronic conditions prevents deterioration and avoidable resource use.
- Clinical rationale: Appropriate treatment prevents complications.
- Estimated patient/ public perception of topic importance: Patients prefer care closer to home.
- Identified caveats or limitations: Read coding issues will need resolving so it recognises this measures relates to acute exacerbations/ episodes of pre-existing chronic conditions.

22.1.2 KEY SUPPORTING EVIDENCE

Tian Y, Dixon A, Gao, H. *Data briefing: emergency hospital admissions for ambulatory care sensitive conditions*. London: The Kings Fund; 2012. Available [here](#).

- This King’s fund data briefing states that Ambulatory Care Sensitive Conditions (ACSC) are conditions for which effective management and treatment should prevent admission to hospital. They can be classified as: chronic conditions, where effective care can prevent flare-ups; acute conditions, where early intervention can prevent more serious progression; and

⁴ *High impact changes 2011* looked at 8 conditions. (1) COPD: included - if managed well and treated appropriately should help avoid severe acute exacerbations; (2) Asthma: included - if managed well and treated appropriately should help avoid severe acute exacerbations; (3) Coronary heart disease: not included – can’t differentiate poorly controlled severe angina/ MI; (4) Heart failure: included - if managed well and treated appropriately should help avoid severe acute exacerbations. (5) Hypertension: not included – the number of admissions for control of BP (i.e. hypertension alone) is low as compared with conditions associated with hypertension; (6) Epilepsy: included - if managed well and treated appropriately should help avoid admissions for uncontrolled epilepsy (status epilepticus); (7) Diabetes: included (complications to be defined); (8) Chest infections: not included – not a long term condition unless associated with COPD.

preventable conditions, where immunisation and other interventions can prevent illness (Ham et al 2010).

- High levels of admissions for ACSCs often indicate poor co-ordination between the different elements of the health care system, in particular between primary and secondary care. An emergency admission for an ACSC is a sign of the poor overall quality of care, even if the ACSC episode itself is managed well. The wide variation of emergency hospital admissions for ACSCs implies that they, and the associated costs for commissioners, can be reduced.

Page A et al. *Atlas of Avoidable Hospitalisations in Australia: ambulatory care-sensitive conditions*. Adelaide: PHIDU, University of Adelaide; 2007. Available [here](#).

- This report states that ACSC can be used as an indicator to assess the adequacy, efficiency and quality of primary health care within the broader health system. Analyses at the area level may assist as a tool to monitor need; as a performance indicator of variations in access to, or the quality of, primary care; or in allocating limited resources among communities. Admissions for these conditions can be avoided in three ways. Firstly, for conditions that are usually preventable through immunisation, disease can be prevented almost entirely. Secondly, diseases or conditions that can lead to rapid onset of problems, such as dehydration and gastroenteritis, can be treated. Thirdly, chronic conditions, such as congestive heart failure, can be managed to prevent or reduce the severity of acute flare-ups to avoid hospitalisation.

Want to know more?



The PHW Observatory published an interactive atlas of variation in unscheduled care in 2014; this is available [here](#). This includes summary emergency admissions statistics, but without sub-analysis by long-term (chronic) condition groupings.

22.2 COMPARATIVE ANALYSIS

It would be inappropriate to draw comparisons between non-standardised counts of monthly admissions or readmissions. No variation analyses have therefore been conducted for this measure.

Key messages

- Non-standardised counts of monthly admissions or readmissions cannot be legitimately compared.

22.3 IMPROVEMENT ACTIONS

22.3.1 GP PRACTICE ACTION

Improvement actions potentially suitable for adoption by GP practice cluster members include:

- QOF guidance for 2017/18 identified COPD as a national clinical priority; proposed quality improvement action focussed on the national COPD audit finding that there should be better coding and recording of COPD consultations, prescribing and referrals (see [here](#)). Activity to attain this was proposed as follows:
 - GP practices to reflect on their national COPD audit report;
 - Review of spirometry results for those on the practice COPD register to ensure accurate coding of results;
 - Collation of practice-level data on % correct/ incorrect diagnoses and reflective themes.

22.3.2 WIDER CLUSTER ACTION

Improvement actions potentially suitable for adoption by the wider cluster membership include:

- The above national clinical priority QI project required GP practices to:
 - Ensure data were “discussed at cluster level together with review of QOF data extraction and other allied issues relating to the whole COPD pathway to identify further *actions required across whole pathway*”.

Good practice example

Heads of Primary Care were unable to identify relevant good practice examples of cluster-led quality improvement projects for this report. Readers are encouraged to contact the PHW Primary Care Division with any local examples suitable to share.

23. ACKNOWLEDGEMENTS

This report was prepared by Dr Bruce McKenzie, Consultant in Public Health Medicine; Harvey Carman, Senior Health Intelligence Analyst; Sian Evans, Consultant in Public Health; and Dr Siôn Edwards, General Practice Advisor, all of Public Health Wales, Primary Care Division. Contributions to improvement action options were gratefully received from a number of PHW teams, as were the small number of good practice examples submitted via Heads of Primary Care. Key supporting evidence synopses in the measure context sections were provided by the PHW Observatory Evidence Service.