THREE YEAR

INTEGRATED MEDIUM TERM PLAN

2019 – 2022 Final January 2019

Local Annexes: Book A1

Local Population Health Needs and Challenges

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf University Health Board

1 INTRODUCTION 3

2 POPULATION HEALTH 3

2.1 DEMOGRAPHY OF OUR POPULATION 3
2.2 A VIEW OF KEY POPULATION HEALTH CHALLENGES 3

3 A FRAMEWORK FOR IMPROVING POPULATION HEALTH 4

3.1 SYSTEM-WIDE APPROACH TO WELLBEING 4
3.2 THE WELL-BEING OF FUTURE GENERATIONS ACT 6

1 INTRODUCTION

The ultimate aim of healthcare is to improve Population Health. Healthcare systems generally achieve improvement in population health by three important sequential and cyclical steps:

- Properly planning healthcare for populations based on good understanding of how illness, health and their determinants are distributed in those populations,
- Delivering good quality, evidence-based healthcare services to individuals from those populations, and
- Monitoring their structures, processes and outcomes of care to ensure that these are improving for everyone and that the distribution of the improvement is equitable (fair, proportional to need)

We view population health as *"the health outcomes of a group of individuals, including the distribution of such outcomes within the group"* (Kindig & Stoddart, 2003). Public Health - a different but closely related concept to Population Health - is *"the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society"* (Acheson 1988). While public health is instrumental to improving population health, it is not the only means. There are equally effective instruments such as healthcare at all levels - primary, secondary, community and tertiary. Current consensus is that healthcare contributes a modest 15-20% to overall population health but this is possibly an underestimation derived from research on non-integrated health systems. The integrated healthcare system in Wales potentially offers greater capacity for healthcare to influence population health.

A key thrust of our Plan is therefore about actualising the potential for our healthcare system to drive sustainable improvements our population health, both directly and through leveraging public health, local partnerships and enabling policy and legislation (such as the Well-being of Future Generations Act). This chapter sets out a framework with which we will enable the Health Board's Directorates make a practical and measurable contribution continually to improving Population Health. This framework incorporates the emerging strategy for population health – the *"System-wide Approach to Improving Wellbeing"* – and the sustainable development principles of the Well-being of Future Generations Act (2015).

2 POPULATION HEALTH

2.1 DEMOGRAPHY OF OUR POPULATION

The resident population of Merthyr Tydfil, Rhondda Cynon Taf and Bridgend is estimated to be 441,293 (StatsWales 2016). An overall population increase of 1.2% is projected by 2026, increasing to 2.1% by 2036 when compared to the StatsWales mid-year population estimates for 2016.

The 65 to 84 and 85+ age groups are projected to have the largest increase by 2036, when an estimated one in four people in Wales will be aged 65 and over.

These projections will have significant implications for the way in which we design and provide health (and increasingly integrated health & social care) services. With an increasing population and especially an increasing older population it is even more important that we support our population to live long and healthy lives, free from the limiting effects of multiple chronic conditions.

2.2 A VIEW OF KEY POPULATION HEALTH CHALLENGES

The status of our population health will not be rehearsed in detail in this document. Much work already has been undertaken to inform understanding of the health and wellbeing of our residents and the data can be accessed using the following links:

- Cwm Taf Population Needs Assessment (2017).
- Cwm Taf Well-Being Assessment (2017).
- Bridgend PSB Assessment of Local Well-Being (2017).

The most widely used indicators of population health are life expectancy at birth and health life expectancy at birth as well as their distribution by deprivation. Our life expectancy and healthy life expectancy at birth (2010 - 2014) have improved since the previous report (2005-2009), and the inequality gap between the most and least

deprived has narrowed across both parameters. This is very positive and has not been seen in other parts of Wales. However:

- We still have the lowest life expectancy (76.6 years men, 80.9 years women) and healthy life expectancy (61.2 years men, 62.6 years women) of all Health Boards in Wales.
- The inequality gap (difference between the most and least deprived) for life expectancy is 7.4 years for men and 3.7 years for women. This is not as big a gap as in some other parts of Wales, but instead reflects the extent of deprivation across the area. The gap for healthy life expectancy is 14.8 years for men and 15.0 years for women.

Our measurement of population health through life expectancy and its distribution reflects a focus on generic health and wellbeing but we are also interested in disease-specific indicators such as the 'emergency admissions for a basket of eight chronic conditions indicator. In addition, we track population prevalence and trends in risk factors (such as alcohol use, smoking, physical inactivity and poor diets) that impact future health. This is important because current health status measured by life expectancy and disease-specific indicators does not capture the health effects of such risk factors, which do not cause symptoms today but may do so in the future.

In developing a view of the most significant challenges facing population health and wellbeing, we have taken account of factors such as: magnitude of impact, numbers of people affected, short- to medium-term projected trends and availability of opportunities to redress. The list could therefore be longer but the following are major health and wellbeing challenges which the healthcare system could tackle both directly and in partnership:

- Frailty – associated with an ageing population.
- Obesity/overweight.
- Inequalities in health outcomes.
- Loss of wellbeing (mental health).

Further details can be found in **Chapter 3 of the IMTP**.

3 A FRAMEWORK FOR IMPROVING POPULATION HEALTH

Improving population health will depend on how successfully we tackle the afore-mentioned priority challenges, maintaining continued increase in life expectancy and healthy life expectancy at birth and narrowing the gap between groups. For our population healthcare system, the foundations for achieving these improvements will involve planning, delivering and monitoring of good quality care (safe, patient-centred, efficient, effective, equitable and timely) in partnership with our communities and partners.

The two pillars of population health improvement through population healthcare are:

- System-wide Approach to Improving Wellbeing.
- The Well-being of Future Generations.

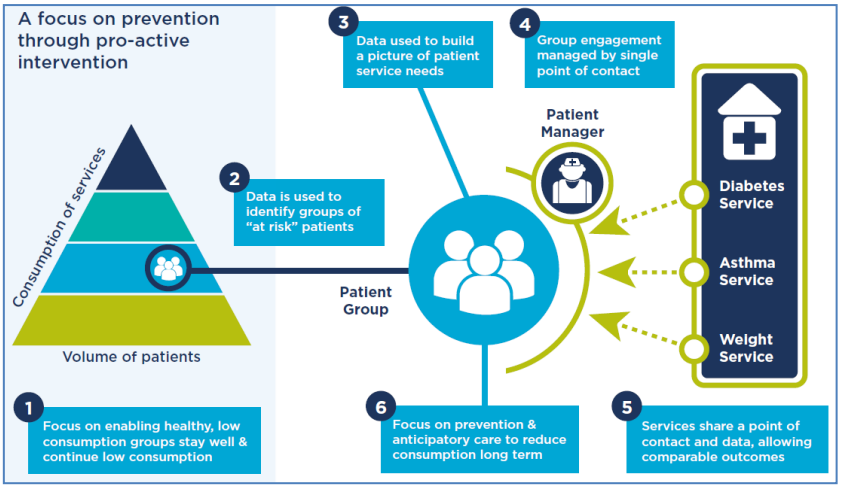
Figure 1 - A framework for improving population health in Cwm Taf through healthcare

3.1 SYSTEM-WIDE APPROACH TO WELLBEING

Health care services traditionally have been developed to help those who are unwell. As a consequence most healthcare services are focused in primary care (which accounts for about 90% of health care interactions) and

hospital bed-based care (which accounts for majority of the remaining care). These services can be reactive and service-centric (largely structured after the specialisms of medicine). We are beginning to explore the opportunities to further develop our population healthcare system into one that is more preventative and person-centric, and which considers the needs of the broader population, not just of those presenting for care.

Figure 2 - Population healthcare shifting from reactive, service-centric to preventative, patient-centric care



As shown in Figure 3, this involves a different way of looking at groups of people in our population, using analyses of the data we hold to group them by their needs rather than exclusively by their disease condition. It effectively means that individuals with different disease conditions could have similar needs and vice-versa. Evidence based anticipatory care plans that address the holistic needs of these patient groups are then developed with a view always to reducing healthcare utilisation and promoting independence and wellbeing. This approach requires weaving together and into practice five principles which are described below:

(a) Prudent healthcare. The philosophy of prudent healthcare involves (a) co-production of health with patients (e.g. promoting self-care), (b) caring for people with the greatest needs first (equity), (c) doing only what is needed and doing no harm, and (d) identifying and tackling unwarranted variation. In practice, translating this set of values or philosophy into practice will require clinical directorates to consider how they intend to understand the equity profile of their services, identify and tackle unwarranted variation in the processes and outcomes of their services, nurture self-management[1] and patient choice, and deliver safe care.

(b) Quadruple aim. This articulates the four population healthcare system aims of improving population health and its distribution, improving patient experience through delivery of good quality care, reducing per capita cost of health, and taking measures to enrich the wellbeing, capability and engagement of staff. These aims are interdependent and all equally important. In practice, translating this principle into practice will require clinical directorates to consider how they intend to identify appropriate population health and clinical indices of the outcomes (not just outputs or processes) of their services, measure and monitor these alongside the costs of these services. Reducing per capita cost of care is impossible to achieve without a systematic clinic-level monitoring of population outcomes, clinical outcomes and cost of service provision. It is also vital for directorates as well as the UHB as a whole to demonstrate its commitment to enriching staff wellbeing such as encouraging and facilitating staff to take up flu vaccinations, to become wellbeing champions and to make '1 Small Change' to improve their health and well-being.

(c) Equitable healthcare. Equity simply means 'fairness'. This in turn means 'access or supply or use that is proportional to need'. Equitable care is a key component of good quality care. It is enshrined in Prudent

[1] Many people in Cwm Taf have one or more long-term conditions and the numbers are likely to increase even further. People with long-term conditions are the most frequent users of our healthcare services, generally accounting for 50 per cent of all GP appointments and 70 per cent of all inpatient bed days. We know that around 75% of people with long-term conditions can be supported to manage their own condition and at the heart of the chronic disease management model we are keen to promote in Cwm Taf is the informed, empowered patient with access to continuous self-management support.

Healthcare too. Some people describe it using the terminology of 'universal proportionalism', which means 'everybody gets healthcare but by measure of their health deficit'. This crucial domain of quality healthcare simply requires us as a population healthcare system to ensure that each clinical service/directorate has mechanisms to assure itself and the Board that it understands how both access to and outcomes of the services it delivers are distributed to our population by the equity dimensions of geography, socioeconomic deprivation, age, gender and ethnicity.

(d) Prevention. The system-wide approach articulates the 'fully-engaged scenario' of Derek Wanless paper to the UK government over a decade ago. It states simply that we can only secure and sustain improvements in population health if prevention is everyone's actual business. As a population healthcare system, we have a significant role to play in prevention and health promotion. First, GPs see each of their patients, on average, three to four times per year. Many of these contacts are for minor, self-limiting problems. GPs, therefore, have many excellent opportunities each year to discuss healthy living with the patients and for the early detection of illness (RCGP 2007). But it's not just GPs. By virtue of being hospitalised, patients have healthcare needs (that may or may not be related to any current lifestyle issues) and as such may be receptive to improving their own health. This opportunity means that frontline healthcare workers are in a key position, with support, to promote healthy lifestyles and contribute to public health goals directly. In practice, translating the principle of prevention into practice will require clinical directorates to consider how they ensure, in accordance with the WHO Standards for Health Promotion in Hospitals[2], that their healthcare professionals, in partnership with patients, systematically assess needs for health promotion activities. Such health promotion would aim to identify patients at risk for disease and/or those with early stage disease, with the aim of averting disease onset (primary prevention) or limiting progression of disease (secondary prevention).

(e) Value-based healthcare. In common parlance, 'value' implies benefit or utility in relation to cost. So value-based healthcare is healthcare that seeks to return the maximum utility or outcome for patients and healthcare funders for each unit pound spent. It goes without saying that the outcomes must be those that are valued by patients (thus the need to co-produce health with patients) and not just by the health system. The means or care processes by which those outcomes are achieved must not be limited by specialism or care setting (e.g. primary care, secondary) but must relate to the full care cycle that resolves the patient's health deficit. Finally, the care processes must be costed so that the simple value equation of outcome/cost can be generated both at individual patient and population levels. In practice, translating the principle of value-based healthcare into practice will require clinical directorates to consider how they (1) defining categories of their patient populations clustered by similarity of need irrespective of underlying disease, e.g. identifying all patients with frailty, (2) deliver care that is seamless and integrated across primary, secondary and community care and consistent with evidence-based care plans for those groups of patients (3) measure systematically the cost and outcomes of the care they deliver (including Patient-Reported Outcome and Experience Measures). For patient groups with ambulatory care-sensitive conditions[3], this will include setting out plans to manage these conditions, with the intended outcomes monitored over time.

3.2 THE WELL-BEING OF FUTURE GENERATIONS ACT

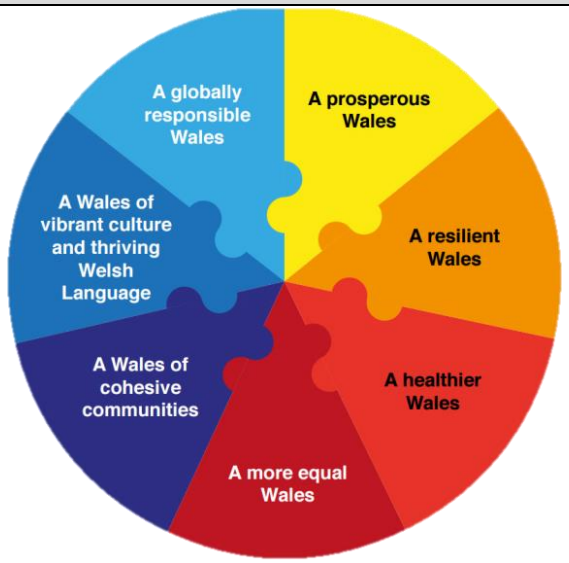
The Well-Being of Future Generations (Wales) Act 2015 provides an opportunity to champion the protection and improvement of public health and reduce inequalities over the short, medium and long term in local Well-being Plans across Wales.

The Health Board has a single Public Service Board and is a statutory partner on the Board. It aims to articulate the vision of our area in 25 years' time. This is supported through well-being assessments to identify the steps to getting there, using the five year Well-being Plans and the best evidence. The Act requires the Public Service Board to think more about the long term, work better with people and communities and each other, look to prevent problems and take a more joined-up approach.

[2] http://www.euro.who.int/__data/assets/pdf_file/0006/99762/e82490.pdf

[3] Ambulatory care-sensitive (ACS) conditions are chronic conditions for which it is possible to prevent acute exacerbations and reduce the need for hospital admission through active management, such as vaccination; better self-management, disease management or case management; or lifestyle interventions. Examples include congestive heart failure, diabetes, asthma, angina, epilepsy and hypertension.

This is an opportunity to see health in the context of the wider determinants of health alongside the importance of employment, environment, economy, education, workplace and home. It fits very well with the seven well-being goals of a more prosperous, globally responsible, resilient, healthier and more equal Wales with cohesive communities, a vibrant culture and thriving Welsh language. Implementation of the seven well-being goals is to be supported by five ways of working:

Seven well-being goals for Wales	**Five** ways of working
	Long-term
	Collaboration
	Integration
	Involvement
	Prevention

The emphasis of the Act is on the principle of sustainable development i.e. to ensure the needs of the present are met without compromising the ability of future generations to meet their own needs. This can be demonstrated by working in the following five ways:

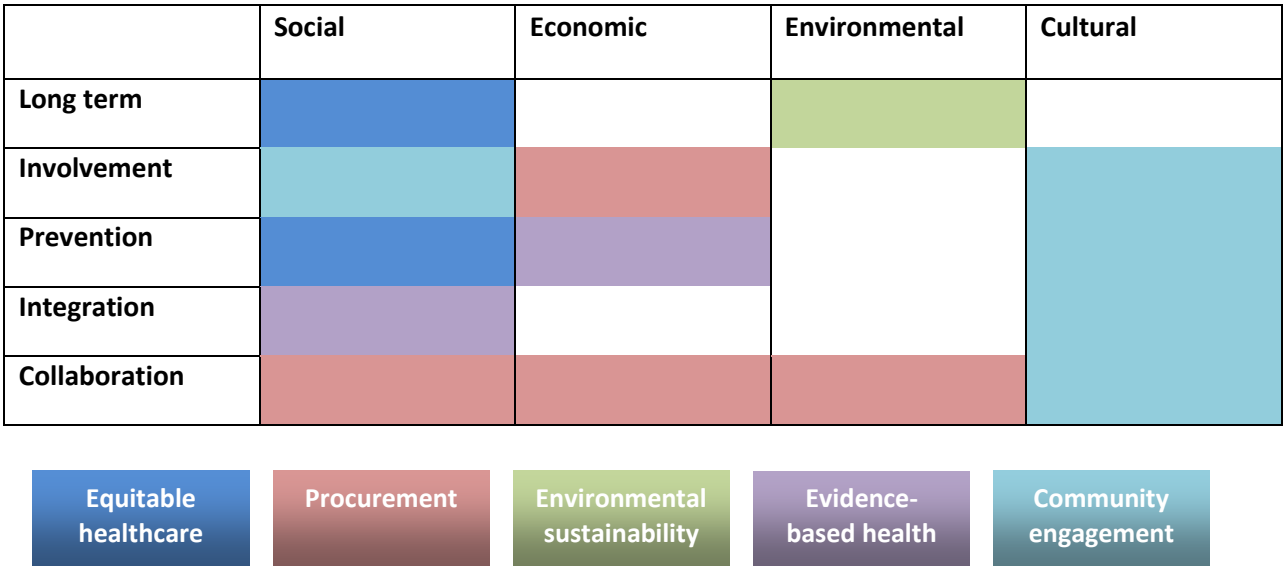
- Long term – balancing short term need while safeguarding the ability to meet long term needs.
- Prevention – preventing problems occurring or getting worse.
- Integration – how well-being objectives impact on well-being goals, the Health Board's objectives and the objectives of other public bodies.
- Collaboration – to meet well-being objectives.
- Involvement – involving people.

Directorates are required to demonstrate how they are implementing, or plan to implement the seven well-being goals and five ways of working. Essentially, they are expected to set out actions under the sustainable development principles by which they will achieve the goals of the Act. To enable directorates do this, we have set out five action-oriented principles that are a practical interpretation of the 'five ways of working' in the context of our population healthcare system and developed the accompanying grid below to illustrate the links across the principles and the goals of the Act.

1. **Equitable healthcare.** Key to sustainable development is equity of access to healthcare. This has already been described in a previous paragraph. Best practice suggests health equity audits (not just clinical audits) and perhaps an equity dashboard are possible ways of developing a culture of focus on healthcare equity.
2. **Procurement.** This is about a sustainable local economy and what our role could be in making sure every pound goes as far as possible in returning social and economic value. Again, the potential of the NHS to exemplify sustainable local procurement is significant and this is very clearly measurable.
3. **Environmental sustainability**. This is about recognising that the economy and clinical interactions occur in the context of a physical environment which they interact with in complex ways. So the ongoing work on reducing our organisational carbon footprint is great and needs to encompass low carbon buildings, low carbon journeys and low carbon procurement.

4. **Evidence based health**. This is about responsible use of sound science, value-based health and prudent healthcare. NICE guidelines provide a rich source of evidence-based guidelines and we should explore how much more we could do to promote this practice.
5. **Community engagement**. This is about breaking down barriers between our services and our communities. It does not imply that there are definitely barriers but the work we are already doing and proposing to do on conversations with our communities exemplifies this very well and we should aim to demonstrate this at service/directorate levels.

Figure 3 - Illustrating links across five ways of working', wellbeing goals and sustainable development principles as applied in Cwm Taf population healthcare context



For more detail please see the UHB's Director of Public Health Annual Report