



GPCLUSTER PROFILES:

Cwm Taf HB



A **technical guide** explaining the data sources and methods used in this profile, plus **interactive spreadsheets** providing the data in charts and tables, are available at:

www.publichealthwalesobservatory.wales.nhs.uk/gpclusters

www.arsvllfaiechvdcvhoedduscvmru.wales.nhs.uk/clvstvrauofeddvgonteulu

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1 Background and aim

Together for Health,¹ the strategy for health care in Wales, places primary and community services at the heart of health care delivery. The strategy emphasises the importance of prevention, early diagnosis and high quality services, with patient feedback as a key driver for continuous service improvement.

This approach progresses the vision described in *Setting the Direction*,² the Primary and Community Services Strategic Delivery Programme. This identified the key role for primary care services in creating a more sustainable health and social care model for the future, with less reliance on institutional forms of care.

A key element of this service model is locality networking, where local services work collaboratively to inform service planning and are responsible for delivery within a population of 30,000 to 50,000 patients. Health boards in Wales have worked with general practitioners (GPs) to identify groupings known officially as GP clusters. GPs in the clusters play a key role in supporting the ongoing work of a locality network (in some areas these are known as neighbourhood networks). GP clusters are charged with working together and with partners to meet local need. This has been made possible by the Quality and Outcomes Framework Quality and Productivity approach, enabling GPs and their teams to review the care of their own patients and work with cluster colleagues to understand and improve local systems of care.

Access to high quality information is essential to ensure that this developing agenda can proceed with pace. These profiles aim to support GP clusters by providing information on a number of key indicators in relation to their registered populations. They are designed to provide an overview of key characteristics allowing comparison with other clusters in their health board and Wales. Section 2 provides further information together with a rationale for the inclusion of each indicator.

2 Indicators

The 'reach' of the cluster

This term is used to refer to the cluster's geographical coverage in terms of where registered patients reside. Clusters do not have specific geographical confines, however the cluster needs to work in partnership with other health and social care agencies as described in *Setting the Direction*, who are confined to administrative, geographical boundaries such as a local authority or health board. Understanding the reach of the cluster will reveal the extent to which the combined registered population is drawn from across these administrative boundaries. This in turn will help the cluster decide who it may need to establish partnerships with. The profiles include a 'reach map' for each cluster showing the percentage of the population in each lower super output area (LSOA) registered with practices in the cluster. In some rural areas, LSOAs may be geographically large, meaning that the reach of the cluster may appear wider than it actually is.

Age and sex breakdown

The age and sex composition of the cluster's patients is an important determinant of the level of need for health care. Older persons are disproportionately affected by chronic conditions. The Welsh Health Survey³ reported that 82 per cent of respondents aged 65 years and over suffered from a chronic condition, of whom 54 per cent suffered from two or more. If current trends continue the number of people living with chronic conditions will continue to increase in the future, with people living longer and developing more than one

chronic condition.⁴ The profiles include a breakdown of the cluster's patients by age and sex, comparing the cluster with the health board average.

Deprivation

The link between deprivation and poor health is well recognised. People in the most deprived areas have higher levels of mental illness, hearing and sight problems, and long-term conditions, particularly chronic respiratory diseases, cardiovascular diseases and arthritis. The Public Health Wales Observatory has reported that healthy life expectancy in males is 19 years lower in the most deprived areas of Wales compared with the least deprived areas; in females the gap is 18 years. The phenomenon known as the *Inverse Care Law*, where the provision of care is inversely related to population need, has been shown to compound these inequities. It is therefore important to bear in mind the socioeconomic characteristics of the cluster's patients when considering the planning and delivery of primary care. For each cluster the profiles show the proportion of its patients who reside in each fifth of deprivation as measured by the Welsh Index of Multiple Deprivation 2011.

Rurality

Population age structures in rural areas are older and often this is compounded by outward migration of younger people and inward migration of older people. Current projections indicate that the increase in the proportion of older people will be greater in rural areas. This will have a significant impact on local service needs and support systems across health and social care. As well as having an older age structure, the population in rural areas is by definition more dispersed leading to difficulties in respect of access to, or the provision of, services. In addition, primary care services are presented with challenges in respect of integrating the services provided for the individual, some of which are NHS based with the remainder emanating from local government. Travelling distances for health and social care staff limit time spent engaged in direct patient contact. This creates tensions between outreach services, which aim to deliver greater access for patients, and centralisation of services which deliver maximum patient contact. The profiles include summary information using the Office for National Statistics (ONS) rural/urban definition and a modelled private transport based travel time analysis based on distance to registered main practice.

Burden of chronic disease

The Welsh Government has reported that managing and treating people with chronic conditions is placing increasing pressures on the National Health Service (NHS) and other public services.⁴ This is particularly true of GP and hospital services, where there is an impact on emergency admissions, length of stay in hospital, quality of patient care and waiting times across the board.

The Welsh Government has quantified the extent of chronic conditions on the population in Wales:4

- one third of adults in Wales (an estimated 800,000) reported having at least one chronic condition;
- of people aged over 65 in Wales, two thirds reported having at least one chronic condition, and one third had multiple chronic conditions; and
- over three-quarters of people aged over 85 in Wales reported having a limiting longterm illness.

If current trends continue, the number of people living with chronic conditions will increase with people living longer and developing more than one chronic condition.

Those conditions with high numbers of emergency admissions across Wales that could be reduced through enhanced community care include:⁹

- chronic obstructive pulmonary disease, asthma, chest infections;
- angina, heart failure, hypertension;
- epilepsy, convulsions; and
- diabetes with complications.

The profiles include information on the recorded burden of disease for a modified set of conditions based on data quality and availability:

- chronic obstructive pulmonary disease;
- asthma;
- · coronary heart disease;
- heart failure;
- hypertension;
- epilepsy; and
- diabetes.

3 Guide to using the GP cluster profile

The summary (section 5) provides an overview of the GP clusters within Cwm Taf Health Board, in terms of their demographic characteristics and chronic condition registers.

For more detailed information see section 6, where each of the GP clusters is covered individually. A brief guide to interpreting this information is provided at the beginning of the section.

Details of the methods used to produce the information within this profile can be found in the <u>technical quide</u>.

It should be noted that GP clusters do not have physical boundaries since they are based on grouped practice lists rather than grouped residential areas. As a result, information produced for GP clusters cannot directly be compared to information produced for geographically-based boundaries such as local authorities or super output areas.

4 Your feedback and future work

This is the first time that demographic and chronic condition indicators have been presented at the GP cluster level and it is envisaged that ongoing work will be required to support these new entities. In order to assist with this the Observatory would like to gather views on this product as it is recognised that it may stimulate further ideas from the users on what information would support the GP clusters.

Feedback may be left via the Observatory Inbox: publichealthwalesobservatory@wales.nhs.uk

Later in the summer (2013) with the help of project board members, we aim to undertake an evaluation of the profiles. Feedback from users working in health boards and in primary care will be crucial.

5 Summary

5.1 Demographic characteristics of clusters

Table 1 shows that there are eight clusters operating within the health board, with total list sizes ranging from 20,820 (South Cynon) to 56,690 (South Taf Ely).

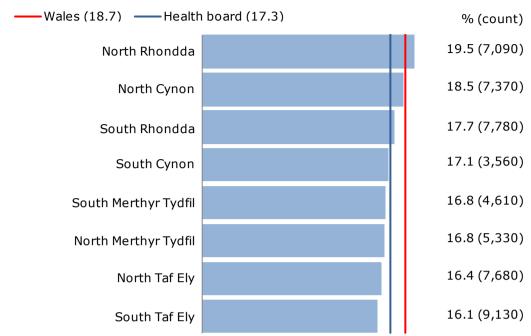
Table 1: Number of practices and total list size, GP clusters in Cwm Taf HB, 2012

GP cluster	No. of practices	Total list size*
North Cynon	6	39,760
North Merthyr Tydfil	5	31,780
North Rhondda	7	36,420
North Taf Ely	5	46,740
South Cynon	6	20,820
South Merthyr Tydfil	6	27,400
South Rhondda	8	44,080
South Taf Ely	5	56,690
Health Board	48	303,700
Wales	474	3,174,670

^{*}Rounded to nearest 10 for ease of reading

Older people

Figure 1: Percentage of patients aged 65+, GP clusters in Cwm Taf HB, 2012



Produced by Public Health Wales Observatory, using WDS (NWIS)

Figure 2: Percentage of patients aged 85+, GP clusters in Cwm Taf HB, 2012

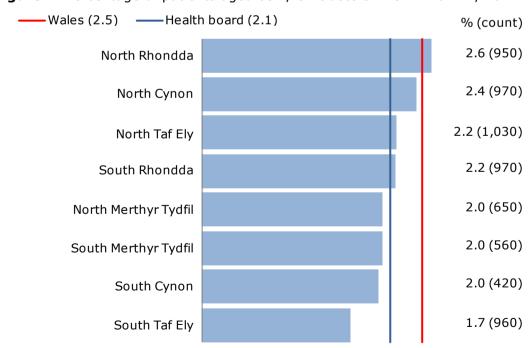
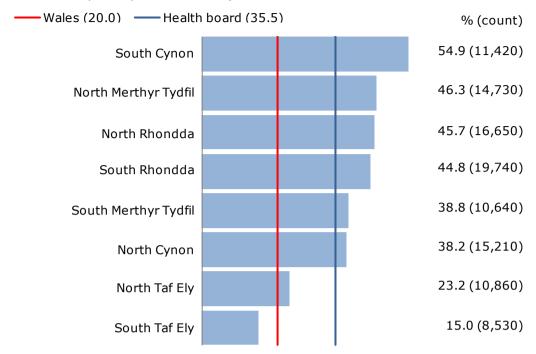


Figure 3: Percentage of patients living in the most deprived fifth of areas in Wales (using Welsh Index of Multiple Deprivation 2011), GP clusters in Cwm Taf HB, 2012

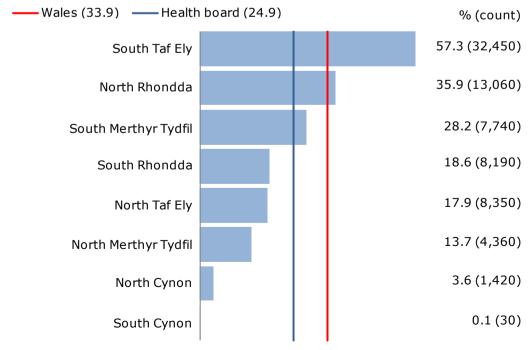


Produced by Public Health Wales Observatory, using WDS (NWIS), WIMD (WG)

Deprivation in the resident population across the health board is shown at LSOA level in figure 5.

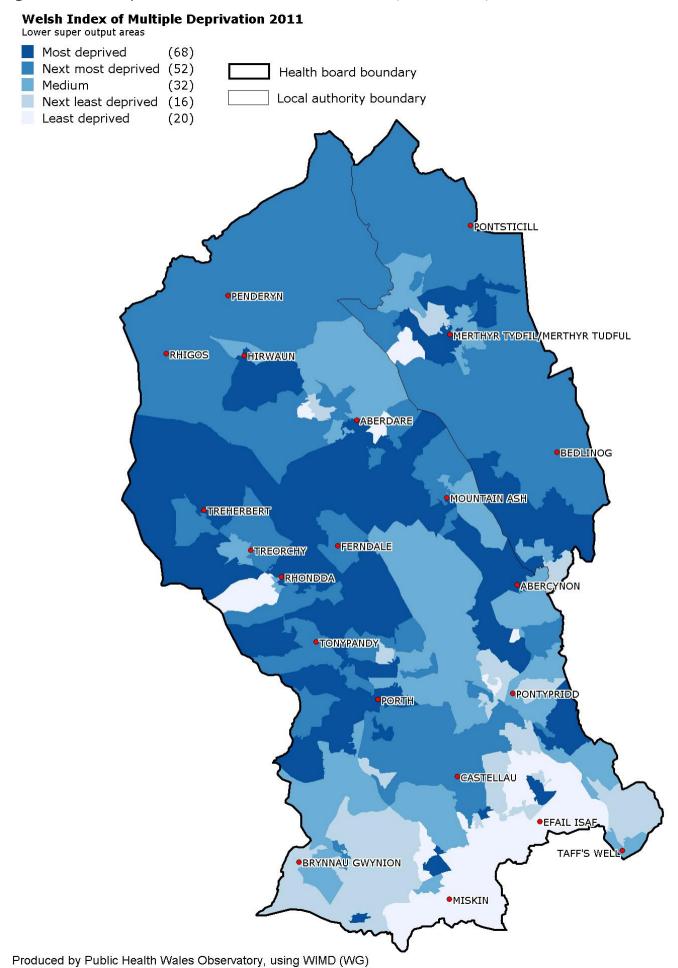
Rurality

Figure 4: Percentage of patients living in areas classified as rural (using 2004 Office for National Statistics definition), GP clusters in Cwm Taf HB, 2012



Produced by Public Health Wales Observatory, using WDS (NWIS), rural/urban classification 2004 (ONS)

Figure 5: LSOA deprivation fifths within health board area, WIMD 2011, all residents



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5.2 Chronic condition registers

Tables 2 to 4 use data from the Audit+ data repository to show the chronic condition registers within GP clusters across the health board. Data is submitted to Audit+ on a voluntary basis and only three practices in Wales have opted out of installing the Audit + software. For more information on this see the <u>technical guide</u>. There are some technical and organisational issues that mean that we have not been able to collect data from all practices even if the software is installed. On average, the repository receives around a 90 percent return rate from all the practices that have installed Audit+. The composition of practices submitting data does vary from submission to submission. Within this health board, data is included for all practices. This data source is only used to support the disease burden sections.

It should be noted that these figures can only report on cases of those conditions which have been diagnosed and recorded. For example, there will be a certain number of undiagnosed cases of diabetes or hypertension within all practice populations. This has two key implications:

- The information presented is more likely to underestimate than overestimate the 'true' prevalence of the conditions within the GP cluster.
- A higher number of patients on the register may reflect greater efforts on the behalf of GPs within the cluster to identify patients with the condition.

The <u>technical guide</u> provides further information about the strengths and weaknesses of Audit+ data.

Table 2 shows the actual number of patients on selected chronic condition registers. This information, together with the percentage of patients on each register (see table 3), is clearly useful for service planning purposes.

Table 2: Number of patients on selected chronic condition registers, GP clusters in Cwm Taf HB, 2012

-		Number of GP cluster patients on register*									
GP cluster	Asthma	Hypertension	CHD	COPD	Diabetes	Epilepsy	Heart Failure				
North Cynon	2,470	7,170	1,770	1,210	2,220	350	460				
North Merthyr Tydfil	1,830	5,450	1,450	1,060	1,620	290	360				
North Rhondda	2,150	6,980	1,800	1,060	2,090	330	280				
North Taf Ely	2,970	7,140	1,810	1,010	2,430	380	380				
South Cynon	1,260	3,950	900	840	1,220	180	310				
South Merthyr Tydfil	1,740	4,520	960	720	1,350	200	190				
South Rhondda	2,860	8,350	2,010	1,240	2,430	460	350				
South Taf Ely	3,550	7,330	1,970	930	2,660	390	350				
Health Board	18,820	50,890	12,680	8,060	16,020	2,580	2,660				
Wales	206,430	474,760	124,460	64,820	161,470	22,490	28,680				

^{*}Rounded to nearest 10 for ease of reading

Table 3 shows the percentage of patients on selected registers in each GP cluster. The data is <u>not age-standardised</u>, so clusters with higher proportions of older patients would be expected to have higher percentages of patients with conditions associated with old age. The data therefore shows the recorded burden of disease within each cluster, without taking the age profiles of different clusters into account.

Table 3: Percentage of patients on selected chronic condition registers, Cwm Taf HB, 2012, <u>to</u> indicate the recorded burden of disease across clusters

	Percentage of GP cluster patients on register									
GP cluster	Asthma	Hypertension	CHD	COPD	Diabetes	Epilepsy	Heart Failure			
North Cynon	6.2	18.0	4.4	3.0	5.6	0.9	1.2			
North Merthyr Tydfil	5.8	17.1	4.6	3.3	5.1	0.9	1.1			
North Rhondda	5.9	19.1	4.9	2.9	5.7	0.9	0.8			
North Taf Ely	6.3	15.1	3.8	2.1	5.1	0.8	0.8			
South Cynon	6.0	18.9	4.3	4.0	5.8	0.9	1.5			
South Merthyr Tydfil	6.3	16.5	3.5	2.6	4.9	0.7	0.7			
South Rhondda	6.5	18.9	4.5	2.8	5.5	1.1	0.8			
South Taf Ely	6.3	12.9	3.5	1.6	4.7	0.7	0.6			
Health Board	6.2	16.7	4.2	2.6	5.3	8.0	0.9			
Wales	6.7	15.3	4.0	2.1	5.2	0.7	0.9			

Produced by Public Health Wales Observatory, using Audit+ (NWIS)

Table 4 shows the age-standardised percentage of patients on selected registers in each GP cluster. This enables comparisons of recorded disease burden to be made across GP clusters having taken their different age profiles into account.

Table 4: Age-standardised percentage of patients on selected chronic condition registers , Cwm Taf HB, 2012, <u>to indicate the relative burden of recorded disease across clusters having taken age into account</u>

	Age-standardised percentage of GP cluster patients on register										
GP cluster	Asthma	Hypertension	CHD	COPD	Diabetes	Epilepsy	Heart Failure				
North Cynon	6.0	13.3	3.0	2.1	4.2	0.8	0.7				
North Merthyr Tydfil	5.6	13.5	3.4	2.5	4.1	0.9	8.0				
North Rhondda	5.6	13.8	3.2	1.9	4.3	0.8	0.4				
North Taf Ely	6.1	12.2	2.8	1.6	4.3	0.8	0.5				
South Cynon	6.0	15.0	3.2	3.0	4.7	0.8	1.0				
South Merthyr Tydfil	6.2	12.8	2.5	2.0	4.0	0.7	0.5				
South Rhondda	6.2	14.6	3.2	2.0	4.3	1.0	0.5				
South Taf Ely	6.1	10.1	2.6	1.2	3.8	0.6	0.4				
Health Board	6.0	12.9	2.9	1.9	4.2	8.0	0.6				
Wales	6.4	11.1	2.6	1.4	3.9	0.7	0.6				

6 Information for individual GP clusters

In this section, information is provided for each of the GP clusters within Cwm Taf HB in turn. Details of the methods used to produce this information, along with visual guides to interpretation of charts/maps, can be found in the <u>technical guide</u>.

Notes for interpretation

Geographical 'reach' maps

The areas shaded on the map are called 'Lower Super Output Areas' (LSOAs). These are geographically-defined areas used to show statistical information, with an average population of around 1,500. Each LSOA is shaded according to the percentage of its population that is registered with the GP cluster in question. In some rural areas, LSOAs may be geographically large, meaning that the reach of the cluster may appear wider than it actually is.

Age/sex breakdown

The horizontal bars show the percentage of patients within each age/sex category. The shaded element shows the GP cluster percentage, with the outline providing the comparative health board percentages.

• Deprivation charts

The horizontal bars show the percentage of patients within each deprivation fifth, along with the actual number of people in brackets.

The vertical dotted lines show the comparative percentage of the overall health board registered population within each fifth.

Rurality charts

The horizontal bars show the percentage of patients within each rural/urban category, along with the actual number of people in brackets.

The vertical dotted lines show the comparative percentage of the overall health board registered population within each category.

Chronic condition registers tables/charts

There are two sections to this graphic:

1. Actual recorded burden of disease

This is the percentage of the GP cluster's patients who are on the chronic condition registers. These numbers are <u>not age-standardised</u>, so clusters with higher proportions of older people would be expected to have higher percentages of people with conditions associated with old age. The data therefore shows the actual recorded burden of disease within each cluster, rather than the relative level of disease across clusters.

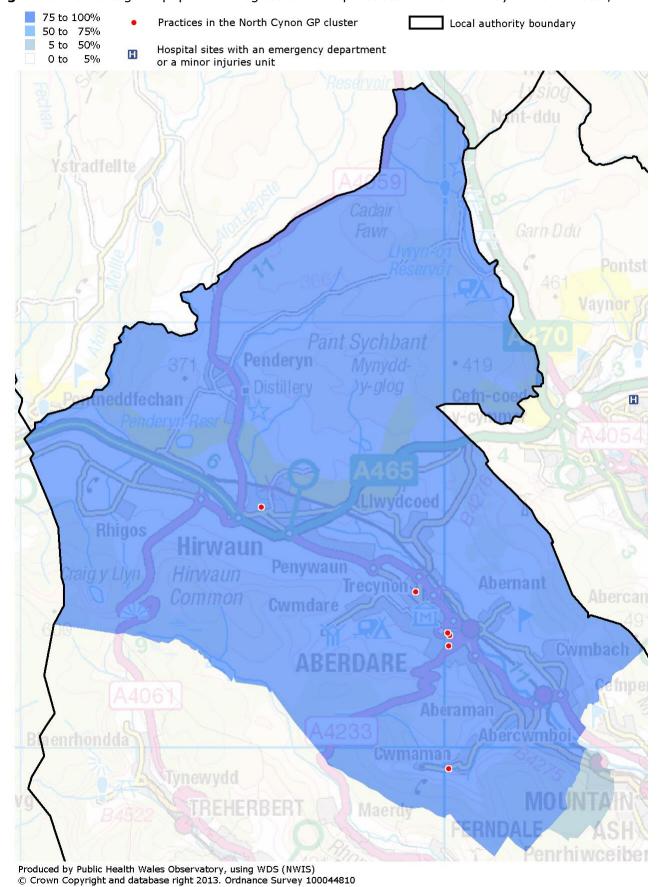
2. Adjusted recorded burden of disease

This shows the variation of GP cluster values for each condition after standardisation, to adjust for different age structures, and normalisation to allow plotting of different conditions on a single scale. As such it is not possible to make magnitude comparisons between conditions, for this the actual age-standardised rates can be seen in table 4. Within a particular condition, the chart shows whether the cluster is higher or lower than its peers and also whether it is in the middle 50 per cent of values in Wales.

6.1 North Cynon

Geographical 'reach' map

Figure 6: Percentage of population registered with practices in the North Cynon GP cluster, 2012



Age/sex breakdown of population

Figure 7: Percentage of patients by age and sex (with actual GP cluster counts shown next to bars), showing North Cynon GP cluster and Cwm Taf HB for comparison, 2012

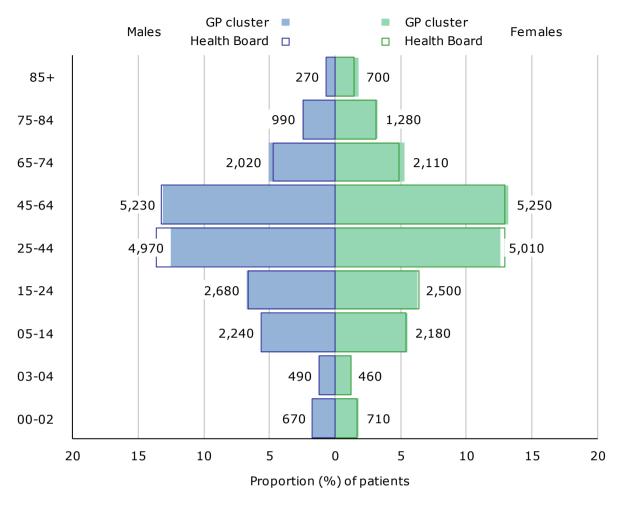
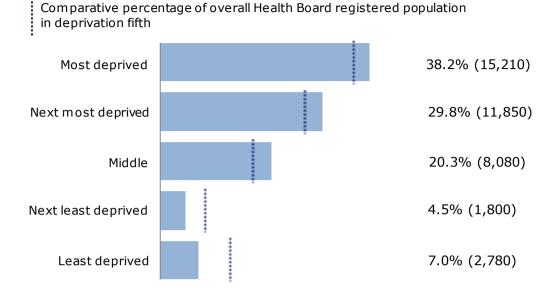


Figure 8: Percentage of patients (with count in brackets) by deprivation fifth in North Cynon GP cluster, showing Cwm Taf HB for comparison, 2012



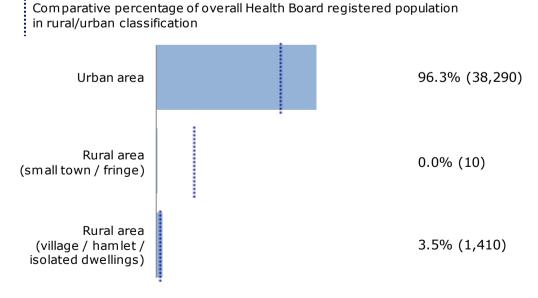
Produced by Public Health Wales Observatory, using WDS (NWIS), WIMD (WG)

N.B. Chart omits 50 patients with postcodes that could not be matched to an area of residence and therefore could not be classified

Rurality

i) Office for National Statistics rural/urban classification

Figure 9: Percentage of patients (with count in brackets) by rural/urban classification in North Cynon GP cluster, showing Cwm Taf HB for comparison, 2012



Produced by Public Health Wales Observatory, using WDS (NWIS), 2004 rural/urban definition (ONS)

N.B. Chart omits 50 patients with postcodes that could not be matched to an area of residence and therefore could not be classified

ii) Time taken to drive to registered practice

Table 5: Modelled percentage of patients living within specified driving times to their registered main practice in North Cynon GP cluster

Time band (Minutes)	Number registered	Percentage
Less than 5	14,360	36.1
5 or more, less than 10	16,680	41.9
10 or more, less than 15	6,000	15.1
15 and over	2,680	6.7
*Unmatched postcode	50	0.1
Total†	39,760	

Produced by Public Health Wales Observatory, using WDS (NWIS), MapInfo Drivetime

Chronic condition registers

Figure 10: Recorded and adjusted recorded burden of disease in North Cynon GP cluster, showing other GP clusters in Cwm Taf HB and Wales for comparison, 2012

					•	•				
		Rec	orded burd	len of disea	Adjusted records	ed burd	den of disea	ise		
Indicator	Your Cluster:		Other Clusters in your Health Board: Board		Health Board	Wales	◆Your Cluster Other Clusters:			
Indicator	count	%	min %	max %	%	%	♠ in your Health Boa♦ in other Health Boa			
Hypertension	7,170	18.0	12.9	19.1	16.7	15.3	♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦	(19)(1)(E)	*** ***	
Asthma	2,470	6.2	5.8	6.5	6.2	6.7	◇◆◇ ◇●●			
Diabetes	2,220	5.6	4.7	5.8	5.3	5.2	◇@ 300	XX 93 0	> € 680>	\Q
CHD	1,770	4.4	3.5	4.9	4.2	4.0	(S)(E)(S)	********	○● ○● •<	>
COPD	1,210	3.0	1.6	4.0	2.6	2.1	◇ <333 ><3 30 0		©⊕ ◆><>	•
Epilepsy	350	0.9	0.7	1.1	0.8	0.7	OCCESSES	•(•:(3)	****	•
Heart Failure	460	1.2	0.6	1.5	0.9	0.9	♦ ♦ ♦ ♦		○○◆◆○ ◇	•
Produced by Pu	blic Health	Wales O	bservatory,	using Audit-	+ (NWIS)			Middle 50%	Highes 25%	

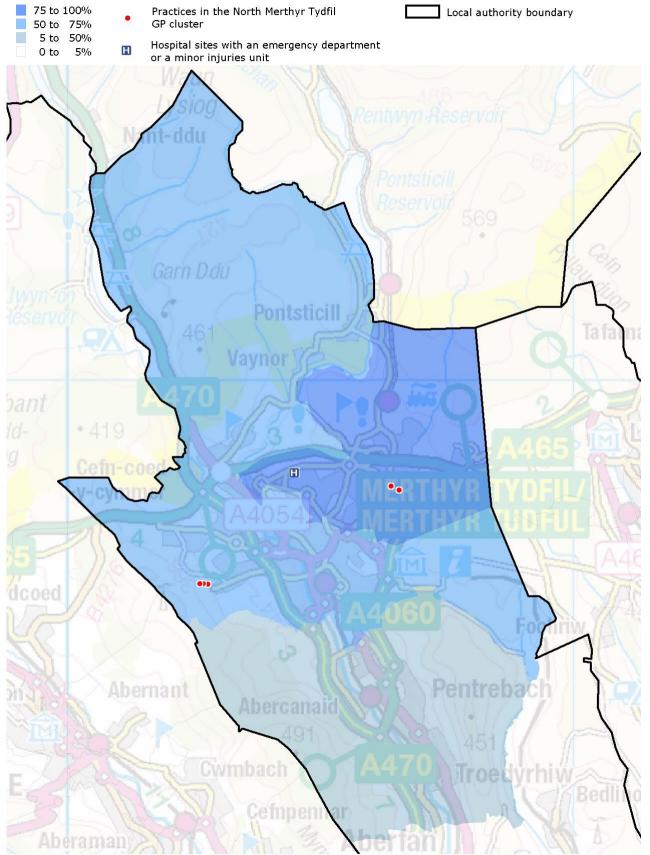
^{*}Postcode could not be matched to an area of residence and therefore could not be classified or drivetime was not available

[†]Total does not include counts of <5, totals may not match due to rounding

6.2 North Merthyr Tydfil

Geographical 'reach' map

Figure 11: Percentage of population registered with practices in the North Merthyr Tydfil GP cluster, 2012



Age/sex breakdown of population

Figure 12: Percentage of patients by age and sex (with actual GP cluster counts shown next to bars), showing North Merthyr Tydfil GP cluster and Cwm Taf HB for comparison, 2012

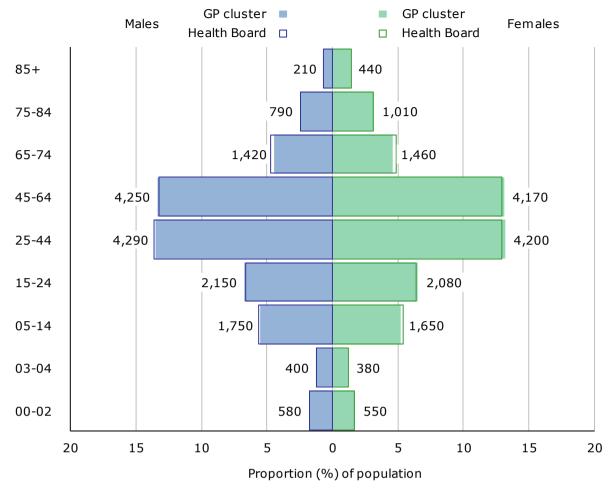
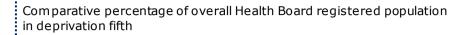
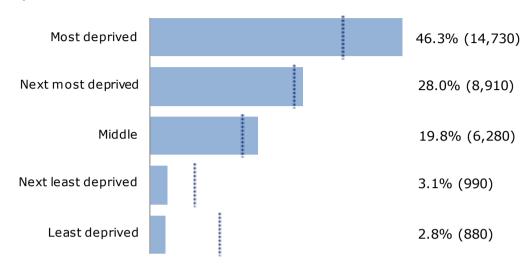


Figure 13: Percentage of patients (with count in brackets) by deprivation fifth in North Merthyr Tydfil GP cluster, showing Cwm Taf HB for comparison, 2012

Produced by Public Health Wales Observatory, using WDS (NWIS), WIMD (WG)

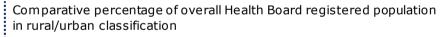


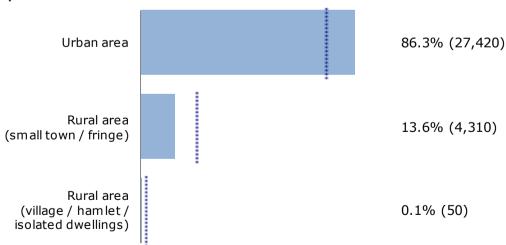


Rurality

i) Office for National Statistics rural/urban classification

Figure 14: Percentage of patients (with count in brackets) by rural/urban classification in North Merthyr Tydfil GP cluster, showing Cwm Taf HB for comparison, 2012





Produced by Public Health Wales Observatory, using WDS (NWIS), 2004 rural/urban definition (ONS)

ii) Time taken to drive to registered practice

Table 6: Modelled percentage of patients living within specified driving times to their registered main practice in North Merthyr Tydfil GP cluster

Time band (Minutes)	Number registered	Percentage
Less than 5	9,900	31.1
5 or more, less than 10	17,400	54.7
10 or more, less than 15	4,370	13.7
15 and over	120	0.4
*Unmatched postcode	-	-
Total†	31,780	

Produced by Public Health Wales Observatory, using WDS (NWIS), MapInfo Drivetime

Chronic condition registers

Figure 15: Recorded and adjusted recorded burden of disease in North Merthyr Tydfil GP cluster, showing other GP clusters in Cwm Taf HB and Wales for comparison, 2012

		Rec	orded burd	len of disea	Adjusted recorded burden of disease		
Indicator	Your Cluster:				Health Board	Wales	◆ Your Cluster Other Clusters:
2ndicator	count	%	min %	max %	%	%	♦ in your Health Board in other Health Boards
Hypertension	5,450	17.1	12.9	19.1	16.7	15.3	
Asthma	1,830	5.8	5.8	6.5	6.2	6.7	
Diabetes	1,620	5.1	4.7	5.8	5.3	5.2	○000000000000000000000000000000000000
CHD	1,450	4.6	3.5	4.9	4.2	4.0	
COPD	1,060	3.3	1.6	4.0	2.6	2.1	
Epilepsy	290	0.9	0.7	1.1	0.8	0.7	◆ ○<8888 (*********************************
Heart Failure	360	1.1	0.6	1.5	0.9	0.9	
Produced by Pul	olic Health	Wales O	bservatory,	using Audit-	+ (NWIS)		Lowest Middle Highest 25% 50% 25%

^{*}Postcode could not be matched to an area of residence and therefore could not be classified or drivetime was not available

[†]Total does not include counts of <5, totals may not match due to rounding

6.3 North Rhondda

Geographical 'reach' map

The map fits better on a landscape page and has therefore been inserted on the next page.

Age/sex breakdown of population

Figure 16: Percentage of patients by age and sex (with actual GP cluster counts shown next to bars), showing North Rhondda GP cluster and Cwm Taf HB for comparison, 2012

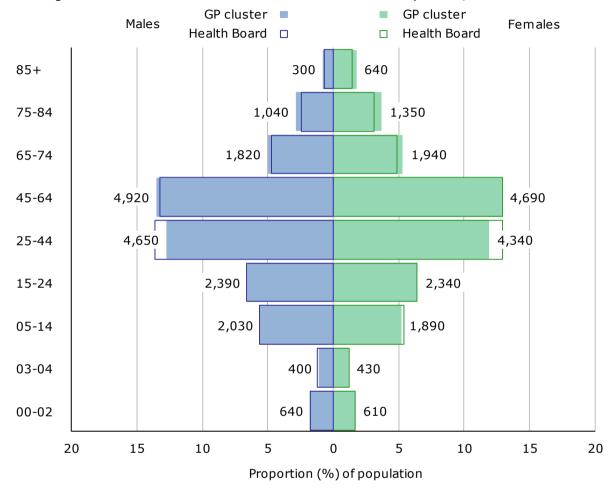


Figure 17: Percentage of population registered with practices in the North Rhondda GP cluster, 2012

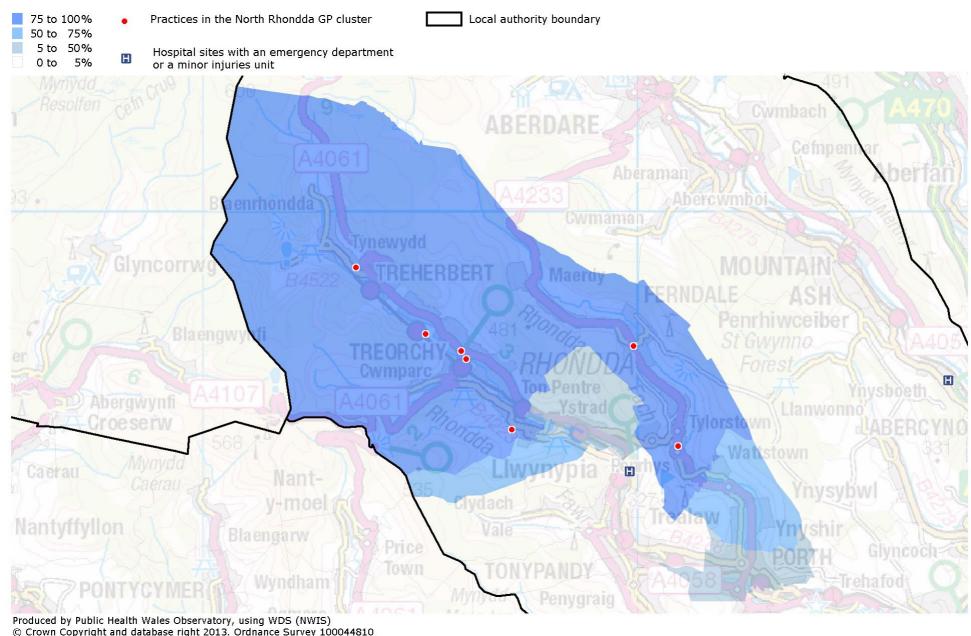
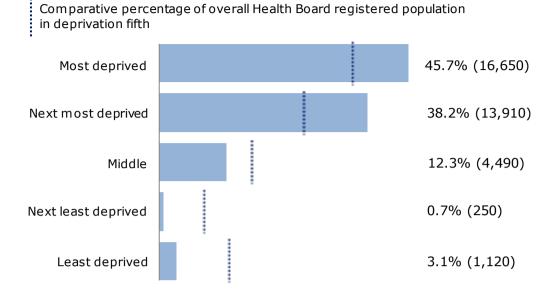


Figure 18: Percentage of patients (with count in brackets) by deprivation fifth in North Rhondda GP cluster, showing Cwm Taf HB for comparison, 2012



Produced by Public Health Wales Observatory, using WDS (NWIS), WIMD (WG)

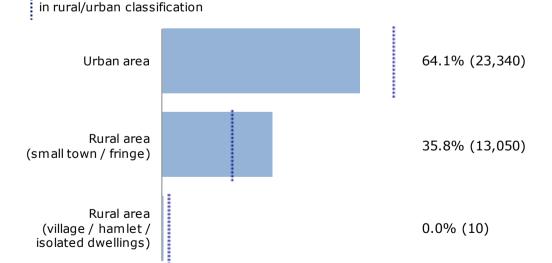
N.B. Chart omits 20 patients with postcodes that could not be matched to an area of residence and therefore could not be classified

Rurality

i) Office for National Statistics rural/urban classification

Comparative percentage of overall Health Board registered population

Figure 19: Percentage of patients (with count in brackets) by rural/urban classification in North Rhondda GP cluster, showing Cwm Taf HB for comparison, 2012



Produced by Public Health Wales Observatory, using WDS (NWIS), 2004 rural/urban definition (ONS)

N.B. Chart omits 20 registered patients with postcodes that could not be matched to an area of residence and therefore could not be classified

ii) Time taken to drive to registered practice

Table 7: Modelled percentage of patients living within specified driving times to their registered main practice in North Rhondda GP cluster

Time band (Minutes)	Number registered	Percentage
Less than 5	14,850	40.8
5 or more, less than 10	14,760	40.5
10 or more, less than 15	5,710	15.7
15 and over	1,090	3.0
*Unmatched postcode	20	0.0
Total†	36,420	

Produced by Public Health Wales Observatory, using WDS (NWIS), MapInfo Drivetime $\,$

Chronic condition registers

Figure 20: Recorded and adjusted recorded burden of disease in North Rhondda GP cluster, showing other GP clusters in Cwm Taf HB and Wales for comparison, 2012

		Rec	orded burd	len of disea	Adjusted recorded burden of disease		
Indicator	Your Cluster:				Health Board	Wales	◆ Your Cluster Other Clusters:
21101100101	count	%	min %	max %	%	%	♦ in your Health Board in other Health Boards
Hypertension	6,980	19.1	12.9	19.1	16.7	15.3	
Asthma	2,150	5.9	5.8	6.5	6.2	6.7	
Diabetes	2,090	5.7	4.7	5.8	5.3	5.2	◇@@@@******* > ◆<@©
CHD	1,800	4.9	3.5	4.9	4.2	4.0	≪ ◆ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★
COPD	1,060	2.9	1.6	4.0	2.6	2.1	
Epilepsy	330	0.9	0.7	1.1	0.8	0.7	◆ ○<
Heart Failure	280	0.8	0.6	1.5	0.9	0.9	♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦
Produced by Pul	blic Health	Wales O	bservatory,	using Audit-	+ (NWIS)		Lowest Middle Highest 25% 50% 25%

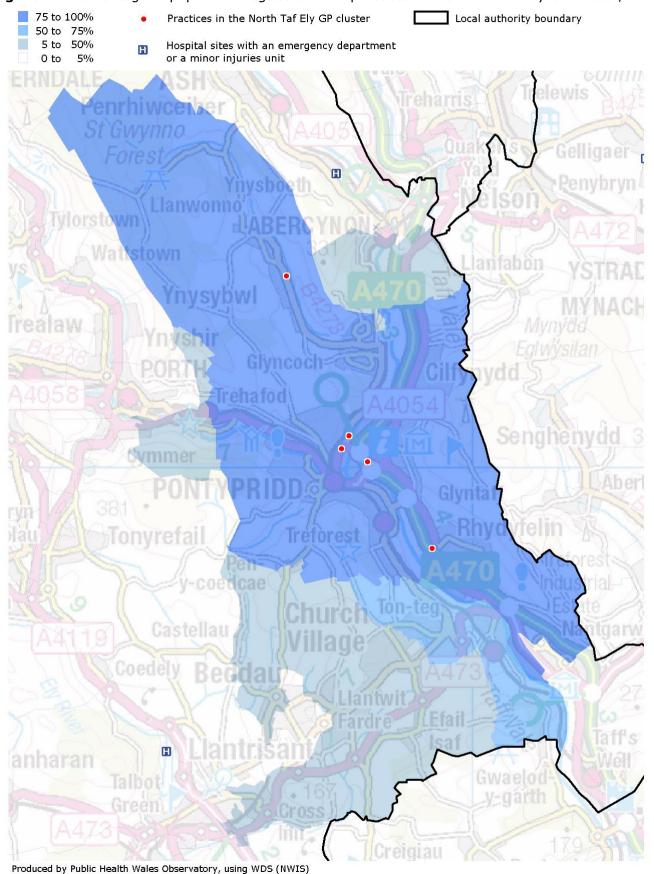
^{*}Postcode could not be matched to an area of residence and therefore could not be classified or drivetime was not available

[†]Total does not include counts of <5, totals may not match due to rounding

6.4 North Taf Ely

Geographical 'reach' map

Figure 21: Percentage of population registered with practices in the North Taf Ely GP cluster, 2012



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Age/sex breakdown of population

Figure 22: Percentage of patients by age and sex (with actual GP cluster counts shown next to bars), showing North Taf Ely GP cluster and Cwm Taf HB for comparison, 2012

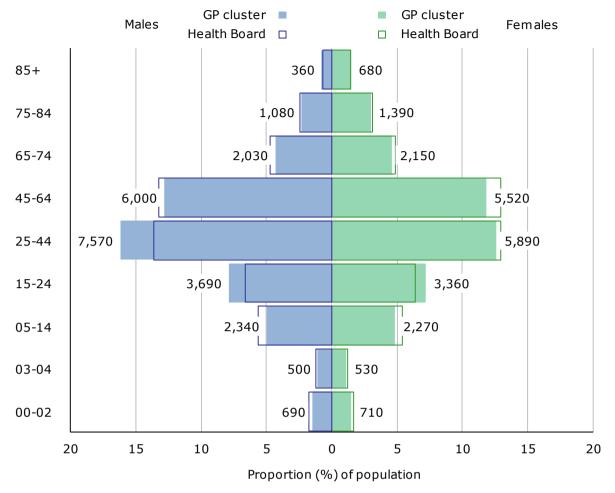
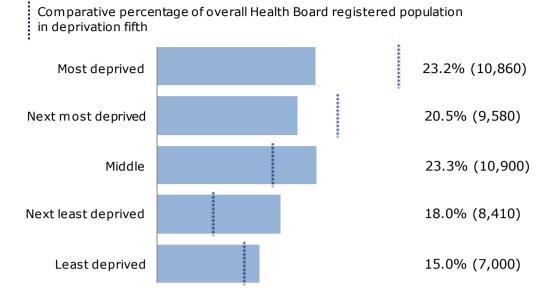


Figure 23: Percentage of patients (with count in brackets) by deprivation fifth in North Taf Ely GP cluster, showing Cwm Taf HB for comparison, 2012

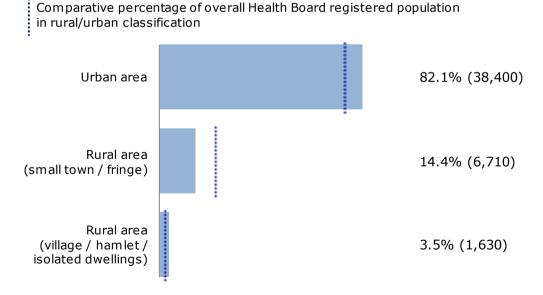


Produced by Public Health Wales Observatory, using WDS (NWIS), WIMD (WG)

Rurality

i) Office for National Statistics rural/urban classification

Figure 24: Percentage of patients (with count in brackets) by rural/urban classification in North Taf Ely GP cluster, showing Cwm Taf HB for comparison, 2012



Produced by Public Health Wales Observatory, using WDS (NWIS), 2004 rural/urban definition (ONS)

ii) Time taken to drive to registered practice

Table 8: Modelled percentage of patients living within specified driving times to their registered main practice in North Taf Ely GP cluster

Time band (Minutes)	Number registered	Percentage
Less than 5	15,810	33.8
5 or more, less than 10	19,470	41.6
10 or more, less than 15	7,680	16.4
15 and over	3,790	8.1
*Unmatched postcode	-	-
Total†	46,740	

Produced by Public Health Wales Observatory, using WDS (NWIS), MapInfo Drivetime

Chronic condition registers

Figure 25: Recorded and adjusted recorded burden of disease in North Taf Ely GP cluster, showing other GP clusters in Cwm Taf HB and Wales for comparison, 2012

		Recorded burden of disease Adjusted recorded burden of disease										
Indicator	Your Cluster:		Other Clusters in your Health Board:		Health Board	Wales	◆ Your Cluster Other Clusters:					
	count	%	min %	max %	%	%	♦ in your Health Board ○ in other Health Boards					
Hypertension	7,140	15.1	12.9	19.1	16.7	15.3						
Asthma	2,970	6.3	5.8	6.5	6.2	6.7						
Diabetes	2,430	5.1	4.7	5.8	5.3	5.2	○000000000000000000000000000000000000					
CHD	1,810	3.8	3.5	4.9	4.2	4.0						
COPD	1,010	2.1	1.6	4.0	2.6	2.1						
Epilepsy	380	0.8	0.7	1.1	0.8	0.7	◆3000000000000000000000000000000000000					
Heart Failure	380	0.8	0.6	1.5	0.9	0.9						
Produced by Pul	blic Health	Wales O	bservatory,	using Audit	+ (NWIS)		Lowest Middle Highest 25% 50% 25%					

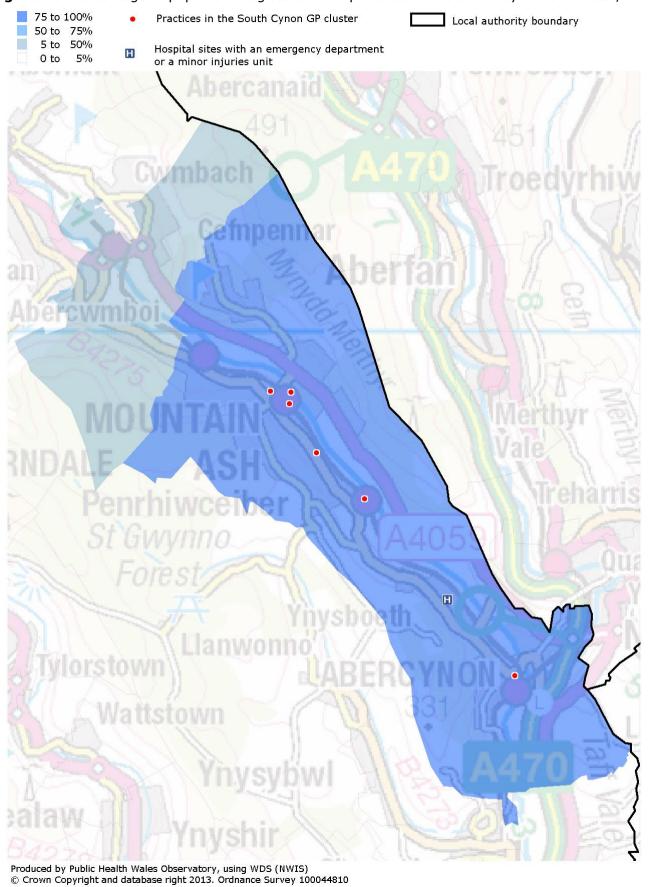
^{*}Postcode could not be matched to an area of residence and therefore could not be classified or drivetime was not available

[†]Total does not include counts of <5, totals may not match due to rounding

6.5 South Cynon

Geographical 'reach' map

Figure 26: Percentage of population registered with practices in the South Cynon GP cluster, 2012



Age/sex breakdown of population

Figure 27: Percentage of patients by age and sex (with actual GP cluster counts shown next to bars), showing South Cynon GP cluster and Cwm Taf HB for comparison, 2012

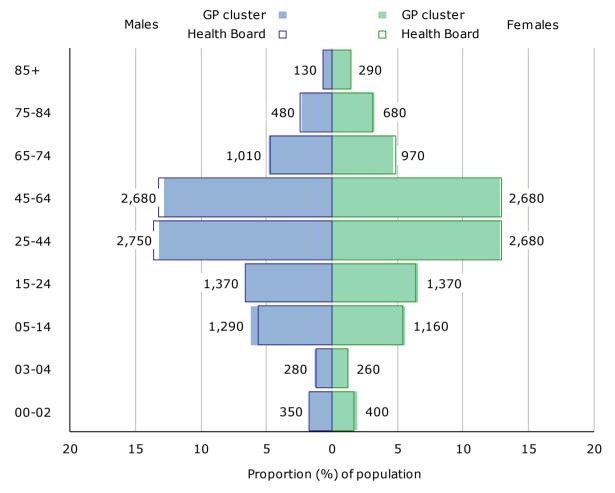
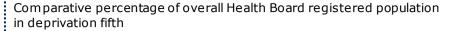
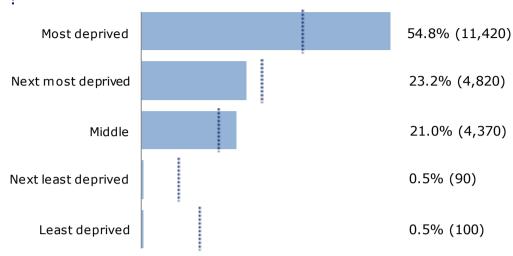


Figure 28: Percentage of patients (with count in brackets) by deprivation fifth in South Cynon GP cluster, showing Cwm Taf HB for comparison, 2012





Produced by Public Health Wales Observatory, using WDS (NWIS), WIMD (WG)

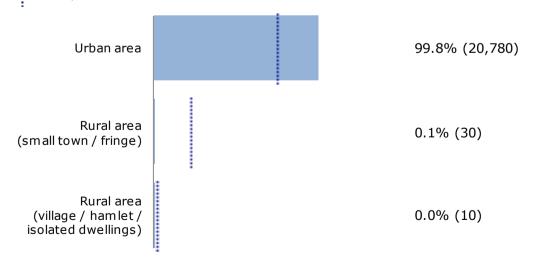
N.B. Chart omits 20 patients with postcodes that could not be matched to an area of residence and therefore could not be classified

Rurality

i) Office for National Statistics rural/urban classification

Figure 29: Percentage of patients (with count in brackets) by rural/urban classification in South Cynon GP cluster, showing Cwm Taf HB for comparison, 2012

Comparative percentage of overall Health Board registered population in rural/urban classification



Produced by Public Health Wales Observatory, using WDS (NWIS), 2004 rural/urban definition (ONS)

N.B. Chart omits 20 registered patients with postcodes that could not be matched to an area of residence and therefore could not be classified

ii) Time taken to drive to registered practice

Table 9: Modelled percentage of patients living within specified driving times to their registered main practice in South Cynon GP cluster

Time band (Minutes)	Number registered	Percentage
Less than 5	10,350	49.7
5 or more, less than 10	8,880	42.7
10 or more, less than 15	1,070	5.1
15 and over	510	2.4
*Unmatched postcode	20	0.1
Total†	20,820	

Produced by Public Health Wales Observatory, using WDS (NWIS), MapInfo Drivetime

Chronic condition registers

Figure 30: Recorded and adjusted recorded burden of disease in South Cynon GP cluster, showing other GP clusters in Cwm Taf HB and Wales for comparison, 2012

		Rec	orded burd	len of disea	ase		Adjusted record	ded burd	den of disease
Indicator	Your Cl	uster:	Other Clusters in your Health Board:		Health Board	Wales	◆Your Cluster Other Clusters:		
	count	%	min %	max %	%	%	♠ in your Health B♦ in other Health E		
Hypertension	3,950	18.9	12.9	19.1	16.7	15.3			◎♦♦• ◇• ♦
Asthma	1,260	6.0	5.8	6.5	6.2	6.7	◇•◇ ◇•		
Diabetes	1,220	5.8	4.7	5.8	5.3	5.2	00000		> ◆ 636>
CHD	900	4.3	3.5	4.9	4.2	4.0	(3) (883)		3963♦ •◇
COPD	840	4.0	1.6	4.0	2.6	2.1	◇< \$3\$> € \$100 \$100 \$100 \$100 \$100 \$100 \$100 \$100		∞• ♦
Epilepsy	180	0.9	0.7	1.1	0.8	0.7	◆○0 0000	(*(* (*)))	*G * *
Heart Failure	310	1.5	0.6	1.5	0.9	0.9	◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊		30+€0⊗ ◆
Produced by Pu	blic Health	Wales O	bservatory,	using Audit-	+ (NWIS)		Lowest 25%	Middle 50%	Highest 25%

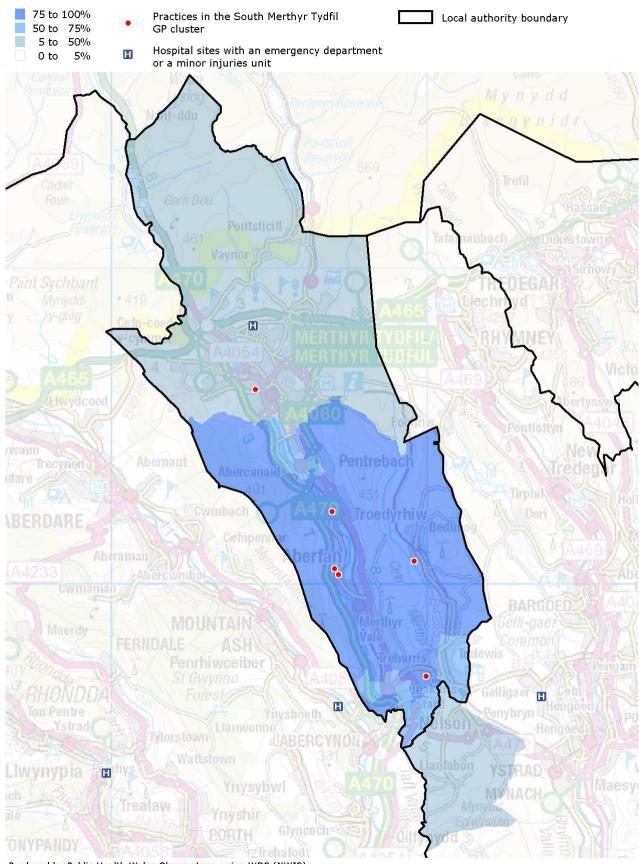
^{*}Postcode could not be matched to an area of residence and therefore could not be classified or drivetime was not available

[†]Total does not include counts of <5, totals may not match due to rounding

6.6 South Merthyr Tydfil

Geographical 'reach' map

Figure 31: Percentage of population registered with practices in the South Merthyr Tydfil GP cluster, 2012



Age/sex breakdown of population

Figure 32: Percentage of patients by age and sex (with actual GP cluster counts shown next to bars), showing South Merthyr Tydfil GP cluster and Cwm Taf HB for comparison, 2012

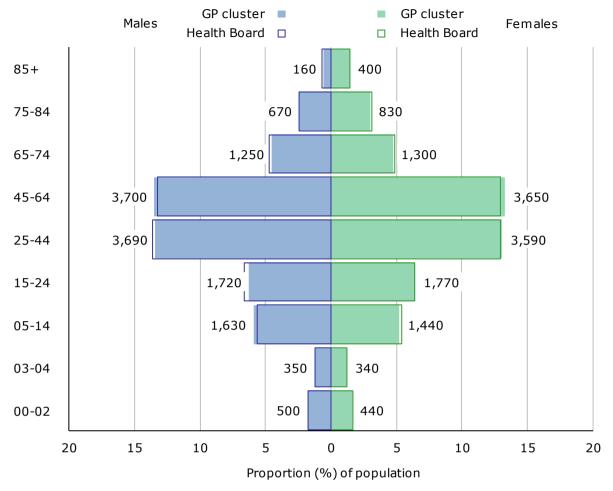
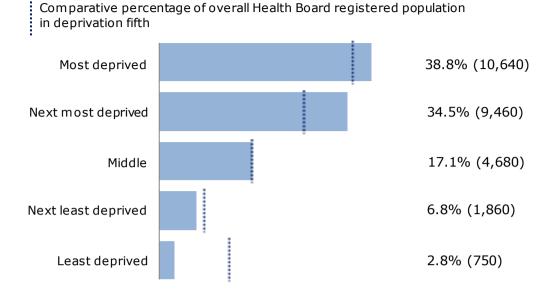


Figure 33: Percentage of patients (with count in brackets) by deprivation fifth in South Merthyr Tydfil GP cluster, showing Cwm Taf HB for comparison, 2012



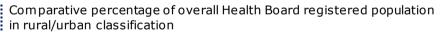
Produced by Public Health Wales Observatory, using WDS (NWIS), WIMD (WG)

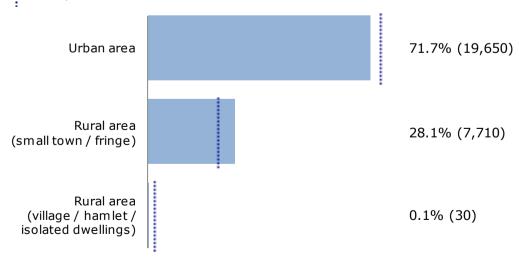
N.B. Chart omits 10 patients with postcodes that could not be matched to an area of residence and therefore could not be classified

Rurality

i) Office for National Statistics rural/urban classification

Figure 34: Percentage of patients (with count in brackets) by rural/urban classification in South Merthyr Tydfil GP cluster, showing Cwm Taf HB for comparison, 2012





Produced by Public Health Wales Observatory, using WDS (NWIS), 2004 rural/urban definition (ONS)

N.B. Chart omits 10 registered patients with postcodes that could not be matched to an area c residence and therefore could not be classified

ii) Time taken to drive to registered practice

Table 10: Modelled percentage of patients living within specified driving times to their registered main practice in South Merthyr Tydfil GP cluster

Time band (Minutes)	Number registered	Percentage
Less than 5	8,530	31.1
5 or more, less than 10	13,680	49.9
10 or more, less than 15	3,140	11.4
15 and over	2,040	7.4
*Unmatched postcode	10	0.0
Total†	27,400	

Produced by Public Health Wales Observatory, using WDS (NWIS), MapInfo Drivetime

Chronic condition registers

Figure 35: Recorded and adjusted recorded burden of disease in South Merthyr Tydfil GP cluster, showing other GP clusters in Cwm Taf HB and Wales for comparison, 2012

3						•	•	
		Rec	orded burd	en of disea	ase		Adjusted recorded burden of d	isease
Indicator	Your Cl	uster:		Other Clusters in your Health Board:		Wales	◆ Your Cluster Other Clusters:	
	count	%	min %	max %	%	%	♦ in your Health Board ○ in other Health Boards	
Hypertension	4,520	16.5	12.9	19.1	16.7	15.3		>••
Asthma	1,740	6.3	5.8	6.5	6.2	6.7		>>>
Diabetes	1,350	4.9	4.7	5.8	5.3	5.2	◇@@@@⊕ ⊘ € ©>	\Q
CHD	960	3.5	3.5	4.9	4.2	4.0		•♦
COPD	720	2.6	1.6	4.0	2.6	2.1	◇◇◇◇◇◇	* *
Epilepsy	200	0.7	0.7	1.1	0.8	0.7	◆ > C C C C C C C C C C	•
Heart Failure	190	0.7	0.6	1.5	0.9	0.9	♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦	♦
Produced by Pu	blic Health	Wales O	bservatory,	using Audit-	+ (NWIS)			ghest 25%

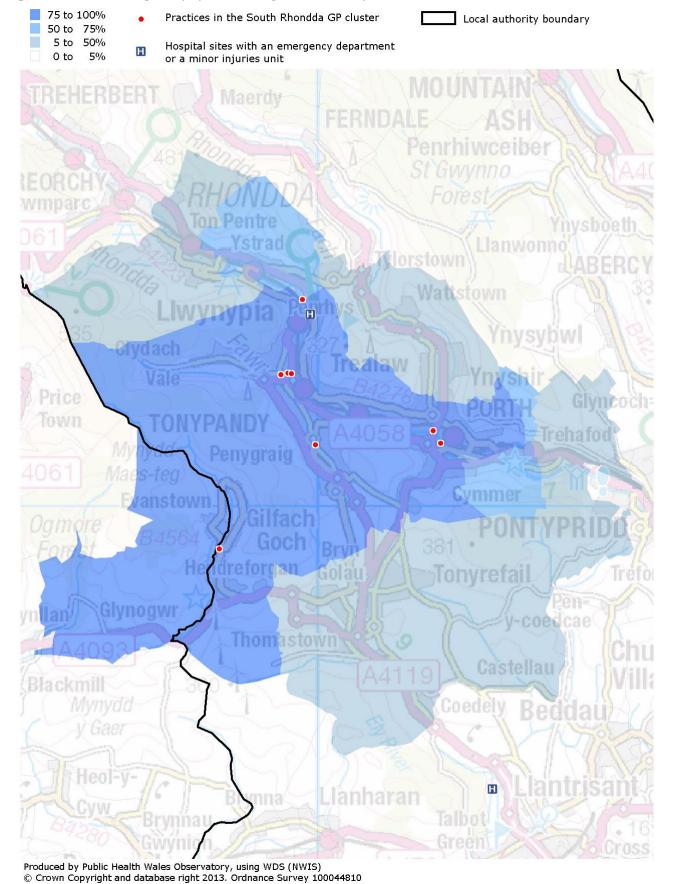
^{*}Postcode could not be matched to an area of residence and therefore could not be classified or drivetime was not available

[†]Total does not include counts of <5, totals may not match due to rounding

6.7 South Rhondda

Geographical 'reach' map

Figure 36: Percentage of population registered with practices in the South Rhondda GP cluster, 2012



Age/sex breakdown of population

Figure 37: Percentage of patients by age and sex (with actual GP cluster counts shown next to bars), showing South Rhondda GP cluster and Cwm Taf HB for comparison, 2012

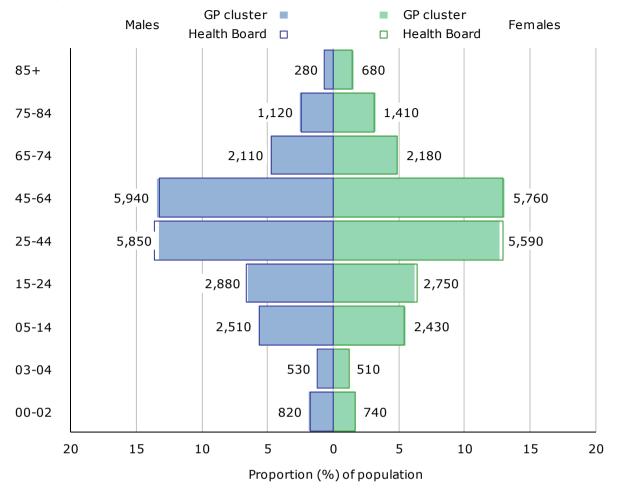
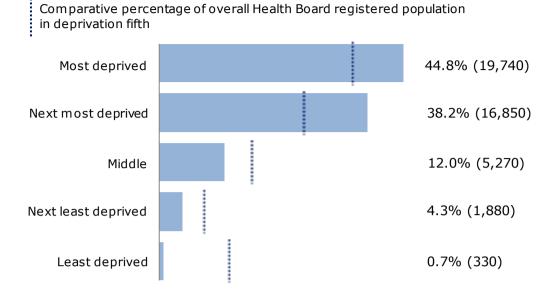


Figure 38: Percentage of patients (with count in brackets) by deprivation fifth in South Rhondda GP cluster, showing Cwm Taf HB for comparison, 2012



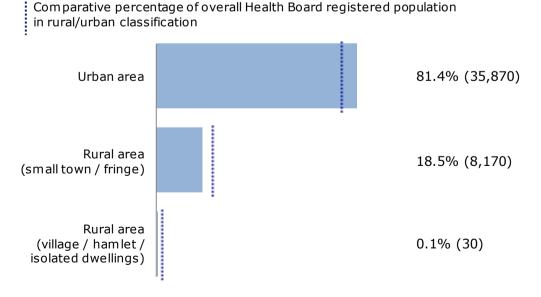
Produced by Public Health Wales Observatory, using WDS (NWIS), WIMD (WG)

N.B. Chart omits 20 patients with postcodes that could not be matched to an area of residence and therefore could not be classified

Rurality

i) Office for National Statistics rural/urban classification

Figure 39: Percentage of patients (with count in brackets) by rural/urban classification in South Rhondda GP cluster, showing Cwm Taf HB for comparison, 2012



Produced by Public Health Wales Observatory, using WDS (NWIS), 2004 rural/urban definition (ONS)

N.B. Chart omits 20 registered patients with postcodes that could not be matched to an area of residence and therefore could not be classified

ii) Time taken to drive to registered practice

Table 11: Modelled percentage of patients living within specified driving times to their registered main practice in South Rhondda GP cluster

Time band (Minutes)	Number registered	Percentage
Less than 5	20,280	46.0
5 or more, less than 10	16,370	37.1
10 or more, less than 15	6,250	14.2
15 and over	1,160	2.6
*Unmatched postcode	20	0.0
Total†	44,080	

Produced by Public Health Wales Observatory, using WDS (NWIS), MapInfo Drivetime

Chronic condition registers

Figure 40: Recorded and adjusted recorded burden of disease in South Rhondda GP cluster, showing other GP clusters in Cwm Taf HB and Wales for comparison, 2012

					•	•				
		Rec	orded burd	len of disea	ase		Adjusted recor	ded burd	den of disea	ise
Indicator	Your Cl	uster:	Other Clusters in your Health Board:		Health Board	Wales	◆ Your Cluster Other Clusters:			
	count	%	min %	max %	%	%	♠ in your Health B♦ in other Health B			
Hypertension	8,350	18.9	12.9	19.1	16.7	15.3			*****	
Asthma	2,860	6.5	5.8	6.5	6.2	6.7	◇•◇ ◇•			
Diabetes	2,430	5.5	4.7	5.8	5.3	5.2	<00000	E900000	> ◆ 38\$	 \tau \tau \tau \tau \tau \tau \tau \tau
CHD	2,010	4.5	3.5	4.9	4.2	4.0	(()		3000⊕ • <	>
COPD	1,240	2.8	1.6	4.0	2.6	2.1	◇ ≪30> € 88		(3)	•
Epilepsy	460	1.1	0.7	1.1	0.8	0.7	COGSS		106340	♦
Heart Failure	350	0.8	0.6	1.5	0.9	0.9	♦ ♦ ♦		◇◇◆◆◇ ◇	•
Produced by Pu	blic Health	Wales O	bservatory,	using Audit-	+ (NWIS)		Lowest 25%	Middle 50%	Highes 25%	

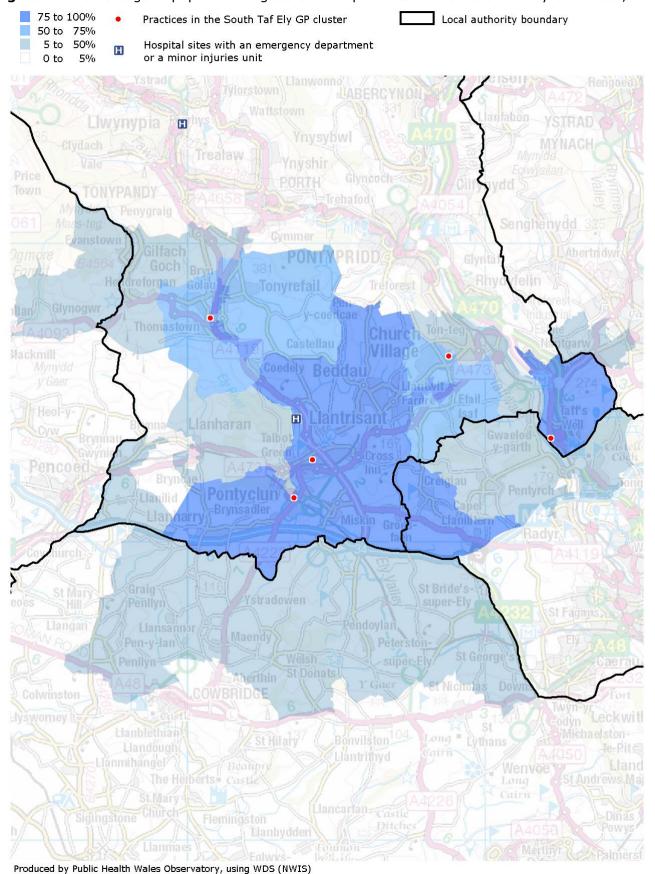
^{*}Postcode could not be matched to an area of residence and therefore could not be classified or drivetime was not available

[†]Total does not include counts of <5, totals may not match due to rounding

6.8 South Taf Ely

Geographical 'reach' map

Figure 41: Percentage of population registered with practices in the South Taf Ely GP cluster, 2012



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Age/sex breakdown of population

Figure 42: Percentage of patients by age and sex (with actual GP cluster counts shown next to bars), showing South Taf Ely GP cluster and Cwm Taf HB for comparison, 2012

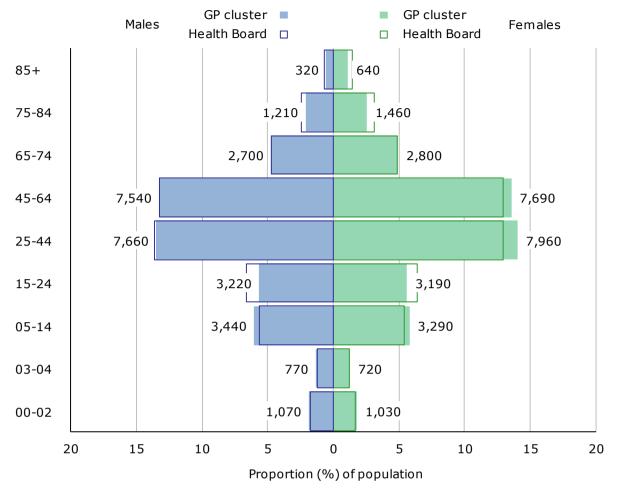
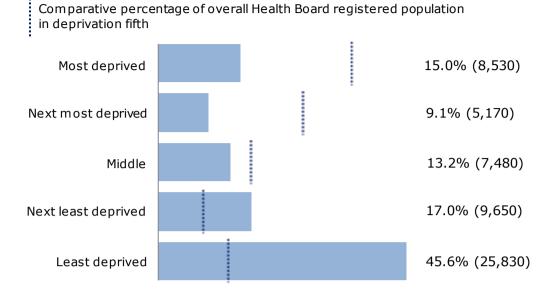


Figure 43: Percentage of patients (with count in brackets) by deprivation fifth in South Taf Ely GP cluster, showing Cwm Taf HB for comparison, 2012



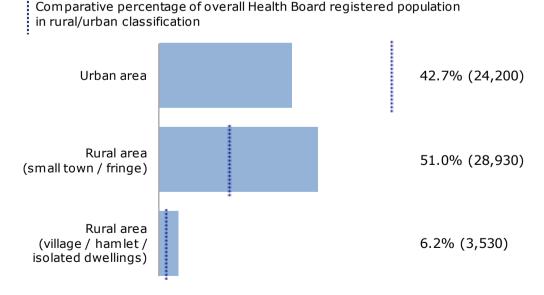
Produced by Public Health Wales Observatory, using WDS (NWIS), WIMD (WG)

N.B. Chart omits 30 patients with postcodes that could not be matched to an area of residence and therefore could not be classified

Rurality

i) Office for National Statistics rural/urban classification

Figure 44: Percentage of patients (with count in brackets) by rural/urban classification in South Taf Ely GP cluster, showing Cwm Taf HB for comparison, 2012



Produced by Public Health Wales Observatory, using WDS (NWIS), 2004 rural/urban definition (ONS)

N.B. Chart omits 30 registered patients with postcodes that could not be matched to an area of residence and therefore could not be classified

ii) Time taken to drive to registered practice

Table 12: Modelled percentage of patients living within specified driving times to their registered main practice in South Taf Ely GP cluster

Time band (Minutes)	Number registered	Percentage
Less than 5	21,560	38.0
5 or more, less than 10	25,950	45.8
10 or more, less than 15	8,490	15.0
15 and over	670	1.2
*Unmatched postcode	30	0.0
Total†	56,690	

Produced by Public Health Wales Observatory, using WDS (NWIS), MapInfo Drivetime

Chronic condition registers

Figure 45: Recorded and adjusted recorded burden of disease in South Taf Ely GP cluster, showing other GP clusters in Cwm Taf HB and Wales for comparison, 2012

		Rec	orded burd	en of disea	ase		Adjusted recor	ded burd	den of disea	ıse
Indicator	Your Cl	uster:	Other Clusters in your Health Board:		Health Board	Wales	◆ Your Cluster Other Clusters:			
	count	%	min %	max %	%	%	♠ in your Health E♦ in other Health			
Hypertension	7,330	12.9	12.9	19.1	16.7	15.3				
Asthma	3,550	6.3	5.8	6.5	6.2	6.7	◇◆◆ ◇●			,
Diabetes	2,660	4.7	4.7	5.8	5.3	5.2	<3@000	B # 000 %	> € 636>	 \tau \tau \tau \tau \tau \tau \tau \tau
CHD	1,970	3.5	3.5	4.9	4.2	4.0			3963@ •<	>
COPD	930	1.6	1.6	4.0	2.6	2.1	◇ < >○○○		(3)+ +<<(>)	•
Epilepsy	390	0.7	0.7	1.1	0.8	0.7	OCCIO	(\$ (\$600)	103200	•
Heart Failure	350	0.6	0.6	1.5	0.9	0.9	◊ ◊ ◊		○○・◆○ ⊗	•
Produced by Pul	blic Health	Wales O	bservatory,	using Audit-	+ (NWIS)		Lowest 25%	Middle 50%	Highe: 25%	

^{*}Postcode could not be matched to an area of residence and therefore could not be classified or drivetime was not available

[†]Total does not include counts of <5, totals may not match due to rounding

7 References

- 1. Welsh Government. *Together for Health. A Five Year Vision for the NHS in Wales*. Cardiff: WG; 2011. Available at: http://wales.gov.uk/docs/dhss/publications/111101togetheren.pdf
- 2. Welsh Government. Setting the Direction. Primary & Community Services Strategic Delivery Programme. Cardiff: WG; 2010. Available at: http://wales.gov.uk/docs/dhss/publications/100727settingthedirectionen.pdf
- 3. Welsh Government. *Welsh Health Survey 2011.* Cardiff: WG; 2012. Available at: http://wales.gov.uk/docs/statistics/2012/120919healthsurvey2011en.pdf
- 4. Welsh Government. *Chronic Conditions*. [Online]. Cardiff: WG; 2006. Available at: http://wales.gov.uk/topics/health/nhswales/majorhealth/chronicconditions/?lang=en
- 5. National Public Health Service for Wales. *Deprivation and Health: A Report by the National Public Health Service for Wales.* Cardiff: NPHS; 2004. Available at: http://www2.nphs.wales.nhs.uk:8080/hiatdocs.nsf/c944d98bdfffc718802570050043d5cd/2eaebe01733430f8802576ea004bc063/\$FILE/Deprivationreport10Dec04.pdf
- 6. Public Health Wales Observatory. *Measuring inequalities 2011: trends in mortality and life expectancy in Wales*. Cardiff: Public Health Wales; 2011. Available at: www.publichealthwalesobservatory.wales.nhs.uk/inequalities
- 7. Hart JT. The Inverse Care Law. Lancet 1971; i:405-12.
- 8. Welsh Government. Rural Health Plan. Improving integrated service delivery across Wales. Cardiff: WG; 2009. Available at: http://wales.gov.uk/docs/dhss/publications/100118ruralhealthplanen.pdf
- 9. Welsh Government. High Impact Service Changes. Delivering high quality, cost-effective care in the Community. Cardiff: WG; 2011. Available at: http://wales.gov.uk/docs/dhss/publications/110216changesen.pdf