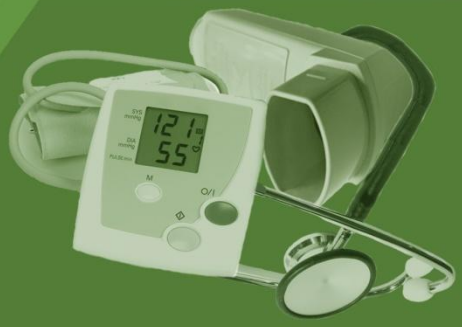
GIG CYMRU NHS WALES

Arsyllfa Iechyd Cyhoeddus Cymru
Public Health Wales Observatory

GP Cluster Profiles:

Abertawe Bro Morgannwg UHB



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.arsyllfaiechydcyhoedduscymru.wales.nhs.uk/clystyrauofeddygonteulu

Project Team

Hugo Cosh, Dr Gareth Davies, Lloyd Evans, Ioan Francis, Martin Holloway (Project Manager), Leon May, Bethan Patterson

Project Board

Nathan Lester, Dr Gareth Davies, Dr Karen Gully, Dr Paul Myers, Dr Jonathan Richards, Dr Kathrin Thomas

Acknowledgements

Thanks to Rhys Powell and Genna Price for providing administrative support

Contact details

Public Health Wales Observatory
14 Cathedral Rd
Cardiff CF11 9LJ

Email: publichealthwalesobservatory@wales.nhs.uk

Contents

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,*[2] 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 Survey[3] 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.[5] 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.[6] The phenomenon known as the *Inverse Care Law,*[7] 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 socio-economic 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.[8] 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 long-term 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 Abertawe Bro Morgannwg University 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 technical guide.

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 eleven clusters operating within the health board, with total list sizes ranging from 30,800 (Upper Valleys) to 73,480 (BayHealth).

Table 1: Number of practices and total list size, GP clusters in ABM UHB, 2012

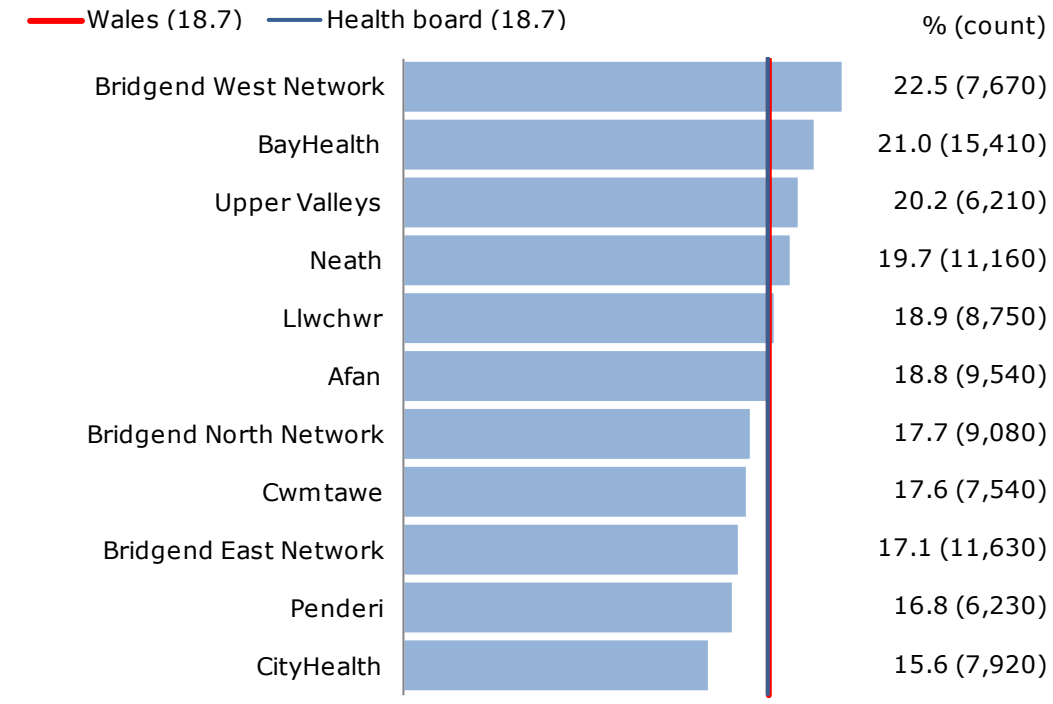
GP cluster	No. of practices	Total list size*
Afan	10	50,820
BayHealth	8	73,480
Bridgend East Network	6	68,130
Bridgend North Network	9	51,250
Bridgend West Network	4	34,100
CityHealth	10	50,870
Cwmtawe	5	42,950
Llwchwr	6	46,250
Neath	8	56,510
Penderi	6	36,990
Upper Valleys	5	30,800
Health Board	**77**	**542,170**
Wales	**474**	**3,174,670**

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

*Rounded to nearest 10 for ease of reading

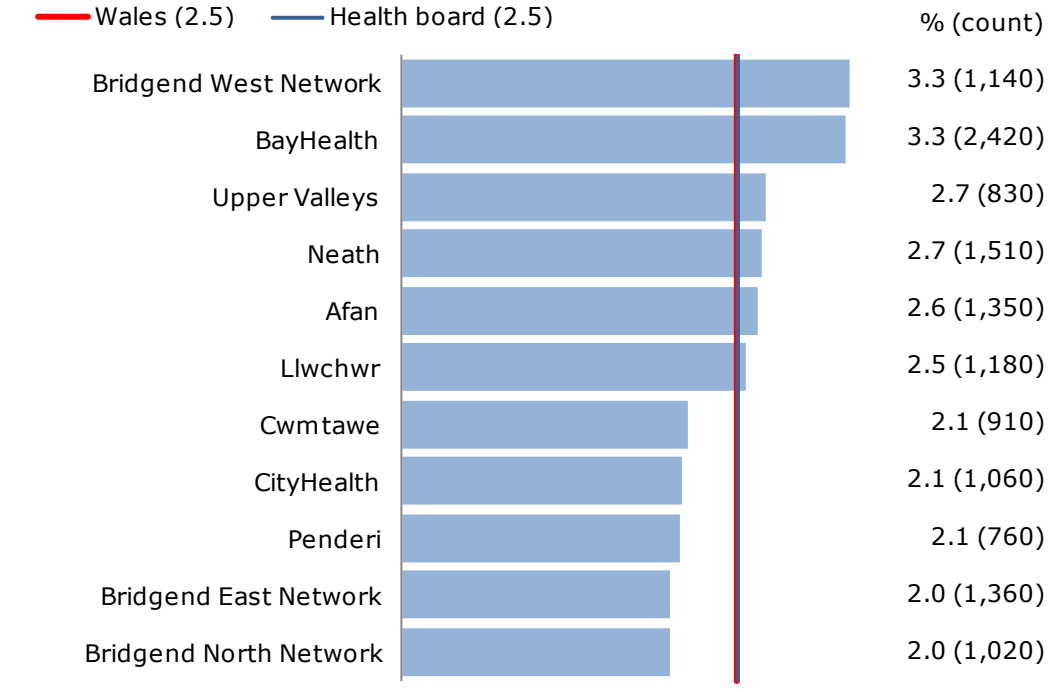
Older people

Figure 1: Percentage of patients aged 65+, GP clusters in ABM UHB, 2012



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

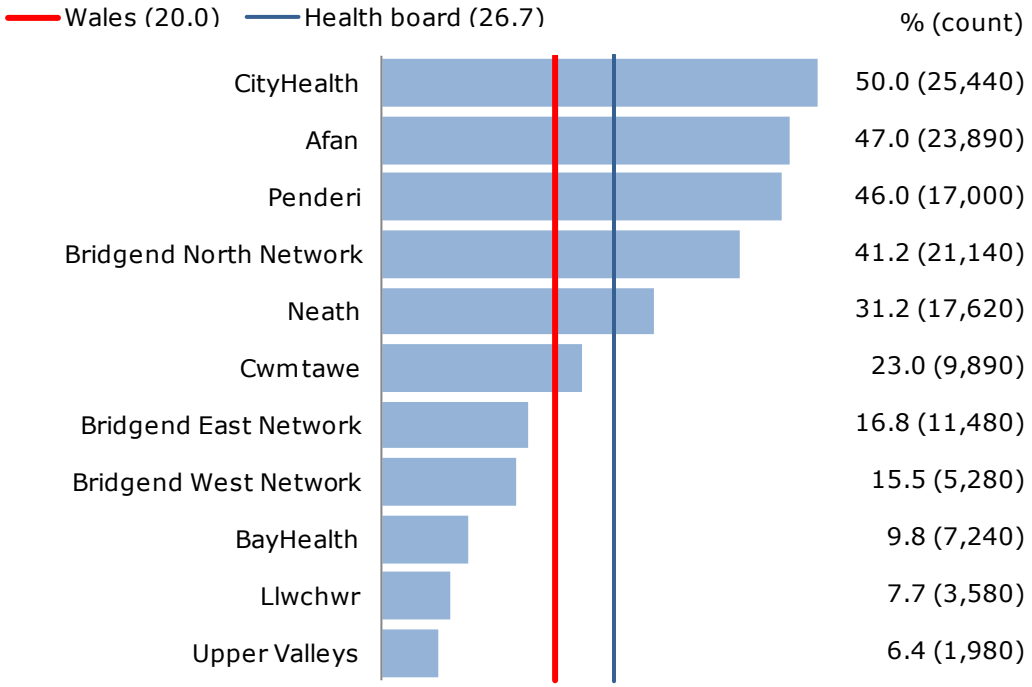
Figure 2: Percentage of patients aged 85+, GP clusters in ABM UHB, 2012



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

Deprivation

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 ABM UHB, 2012

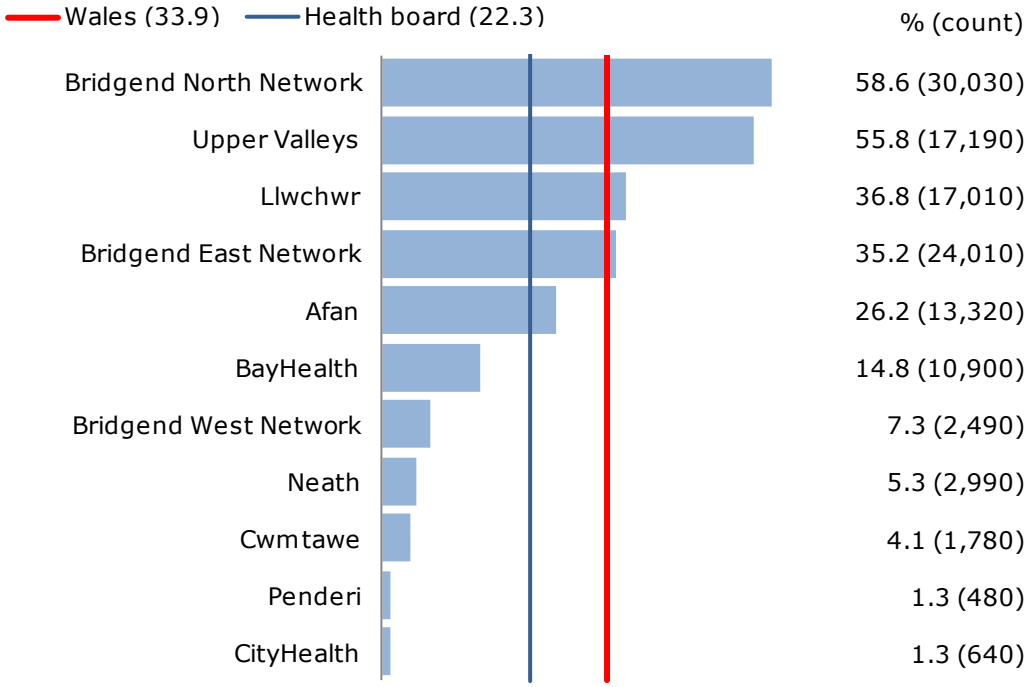


Produced by Public Health Wales Observatory, using WDS (NWIS), WIMD (WG)

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

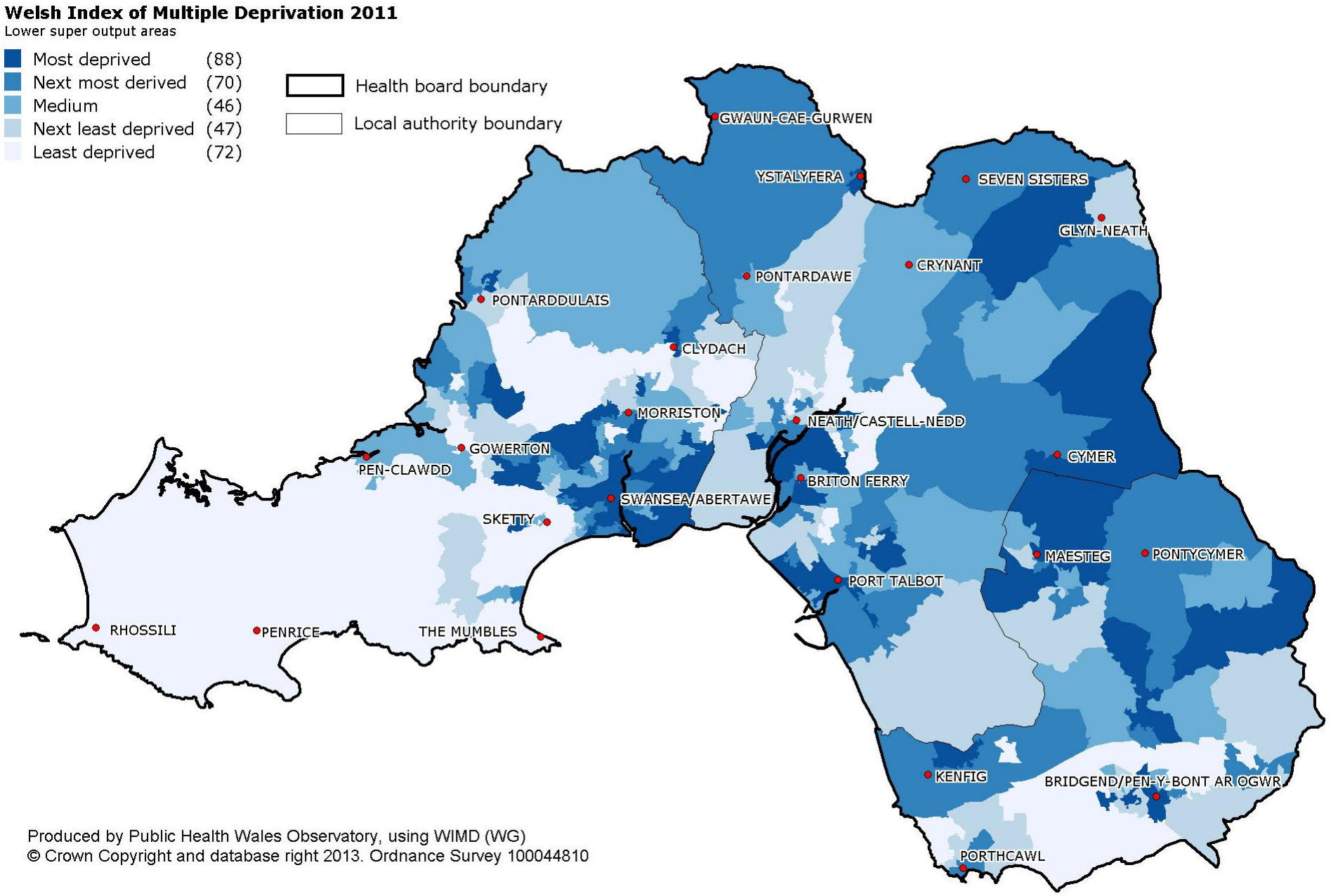
Rurality

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



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 technical guide. 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 are not included for two practices with a total list size of 11,800[‡]. 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 technical guide 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 ABM UHB, 2012

GP cluster	Number of GP cluster patients on register*						
	Asthma	Hypertension	CHD	COPD	Diabetes	Epilepsy	Heart Failure
Afan	3,790	8,530	2,370	1,320	3,400	460	480
BayHealth	4,740	9,200	2,620	1,020	3,120	400	530
Bridgend East Network	4,690	9,690	2,680	1,220	3,610	430	610
Bridgend North Network	3,980	9,060	2,560	1,550	3,280	470	610
Bridgend West Network	2,530	5,780	1,800	720	1,950	260	560
CityHealth	3,500	6,180	1,800	1,100	2,520	330	380
Cwmtawe	2,880	6,050	1,630	710	2,450	360	410
Llwchwr	3,030	5,800	1,480	590	2,060	310	360
Neath	4,470	9,020	2,420	1,230	3,520	480	560
Penderi	2,570	5,380	1,530	850	2,150	330	380
Upper Valleys	2,360	5,460	1,440	820	1,940	240	400
Health Board	**38,540**	**80,140**	**22,330**	**11,120**	**29,990**	**4,080**	**5,270**
Wales	**206,430**	**474,760**	**124,460**	**64,820**	**161,470**	**22,490**	**28,680**

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

*Rounded to nearest 10 for ease of reading

[‡] Rounded to nearest 100 for ease of reading

Table 3 shows the percentage of patients on selected registers in each GP cluster. The data is not age-standardised, 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, GP clusters in ABM UHB, 2012, *to indicate the recorded burden of disease across clusters*

GP cluster	Percentage of GP cluster patients on register						
	Asthma	Hypertension	CHD	COPD	Diabetes	Epilepsy	Heart Failure
Afan	7.5	16.8	4.7	2.6	6.7	0.9	0.9
BayHealth	6.4	12.4	3.5	1.4	4.2	0.5	0.7
Bridgend East Network	6.9	14.2	3.9	1.8	5.3	0.6	0.9
Bridgend North Network	7.7	17.6	5.0	3.0	6.4	0.9	1.2
Bridgend West Network	7.4	17.0	5.3	2.1	5.7	0.8	1.7
CityHealth	7.3	12.8	3.7	2.3	5.2	0.7	0.8
Cwmtawe	6.7	14.1	3.8	1.7	5.7	0.8	0.9
Llwchwr	8.1	15.5	4.0	1.6	5.5	0.8	1.0
Neath	7.9	15.9	4.3	2.2	6.2	0.8	1.0
Penderi	6.8	14.2	4.0	2.3	5.7	0.9	1.0
Upper Valleys	7.7	17.7	4.7	2.6	6.3	0.8	1.3
Health Board	**7.2**	**15.0**	**4.2**	**2.1**	**5.6**	**0.8**	**1.0**
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, GP clusters in ABM UHB, 2012, *to indicate the relative burden of recorded disease across clusters having taken age into account*

GP cluster	Age-standardised percentage of GP cluster patients on register						
	Asthma	Hypertension	CHD	COPD	Diabetes	Epilepsy	Heart Failure
Afan	7.2	12.2	3.0	1.8	5.1	0.8	0.6
BayHealth	6.1	8.2	2.0	0.8	3.0	0.5	0.4
Bridgend East Network	6.6	10.8	2.7	1.3	4.2	0.6	0.6
Bridgend North Network	7.4	13.4	3.4	2.2	4.9	0.8	0.8
Bridgend West Network	7.1	10.6	2.9	1.3	3.8	0.7	0.9
CityHealth	7.1	10.5	2.9	1.9	4.5	0.6	0.6
Cwmtawe	6.4	10.7	2.5	1.2	4.4	0.8	0.6
Llwchwr	7.7	10.9	2.5	1.1	4.1	0.7	0.6
Neath	7.5	10.9	2.6	1.4	4.4	0.8	0.6
Penderi	6.6	11.4	2.9	1.8	4.7	0.8	0.7
Upper Valleys	7.1	11.9	2.8	1.7	4.4	0.7	0.8
Health Board	**6.9**	**10.9**	**2.7**	**1.5**	**4.3**	**0.7**	**0.6**
Wales	**6.4**	**11.1**	**2.6**	**1.4**	**3.9**	**0.7**	**0.6**

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

6 Information for individual GP clusters

In this section, information is provided for each of the GP clusters within ABM UHB 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 technical guide.

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 not age-standardised, 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.

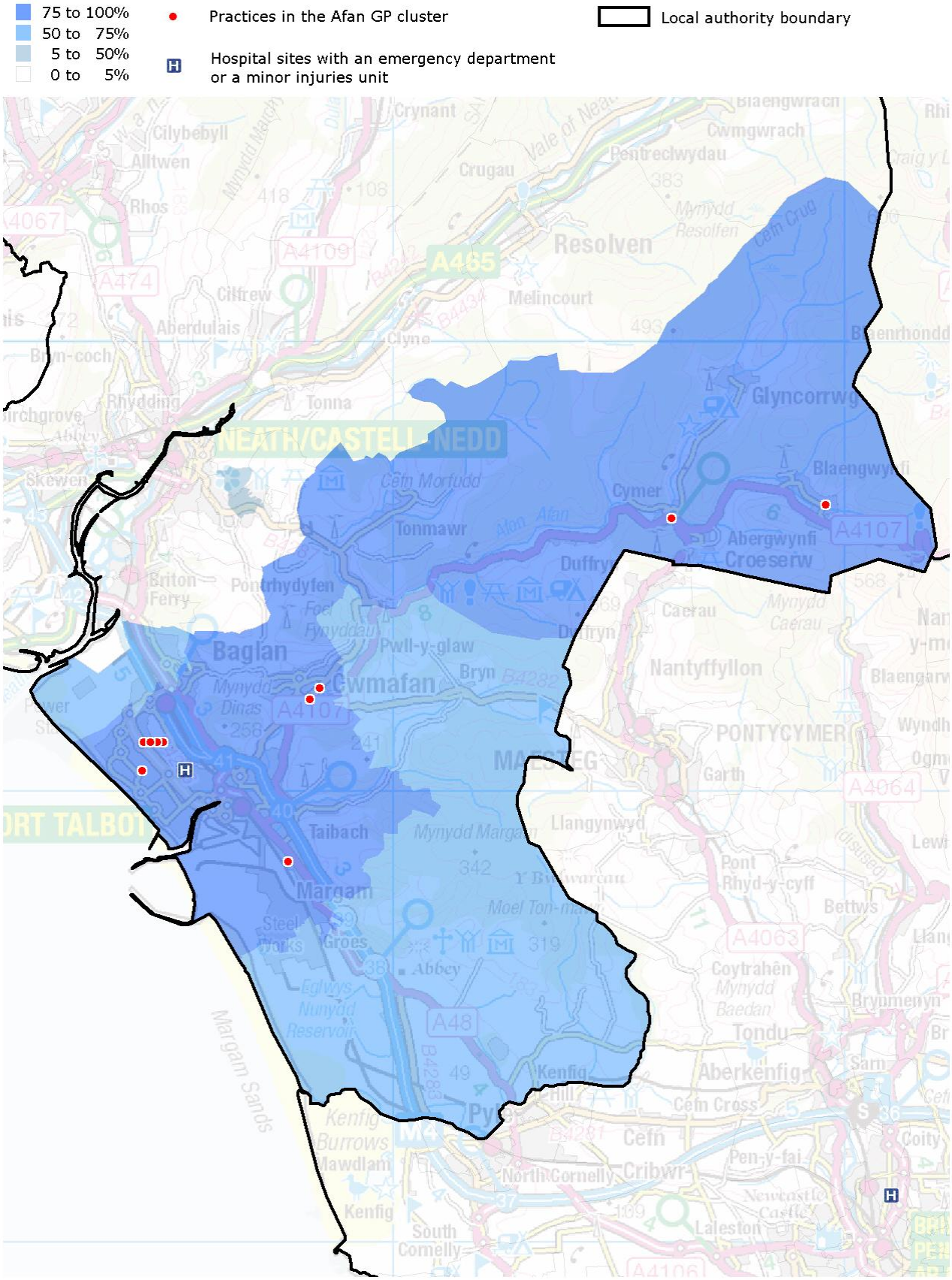
  2. Adjusted recorded burden of disease

     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 Afan

Geographical 'reach' map

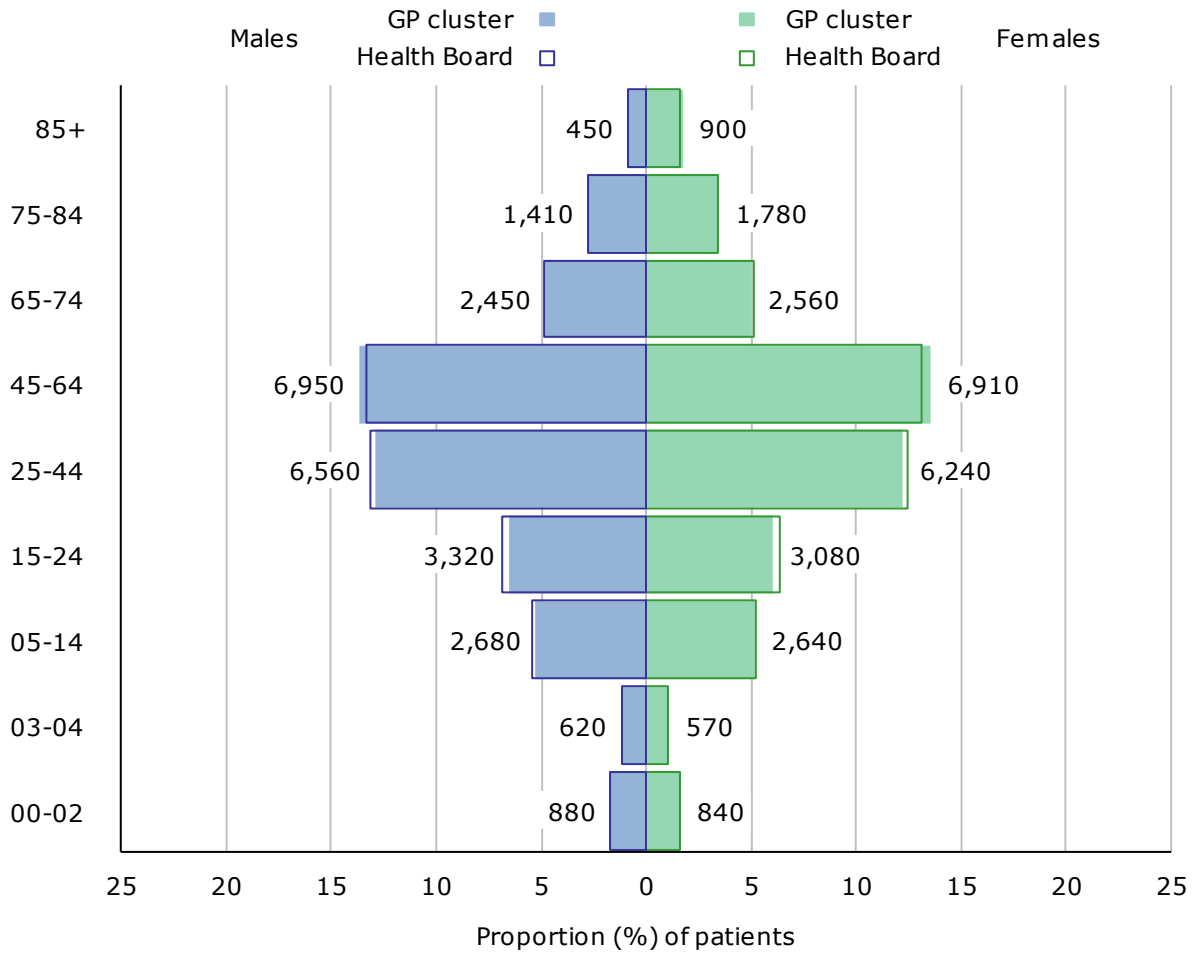
Figure 6: Percentage of population registered with practices in the Afan GP cluster, 2012



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

Age/sex breakdown of population

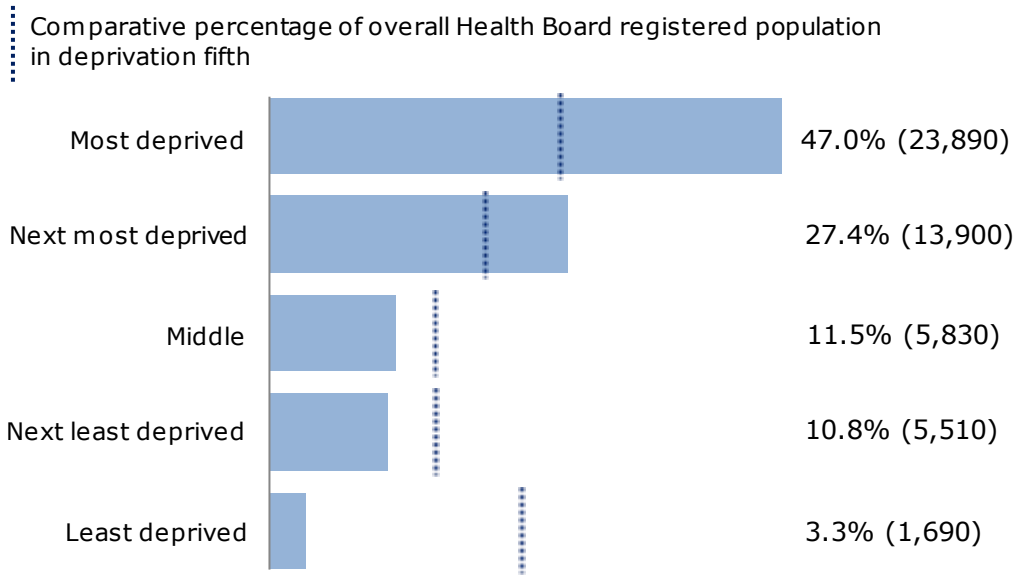
Figure 7: Percentage of patients by age and sex (with actual GP cluster counts shown next to bars), showing Afan GP cluster and ABM UHB for comparison, 2012



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

Deprivation

Figure 8: Percentage of patients (with count in brackets) by deprivation fifth in Afan GP cluster, showing ABM UHB for comparison, 2012



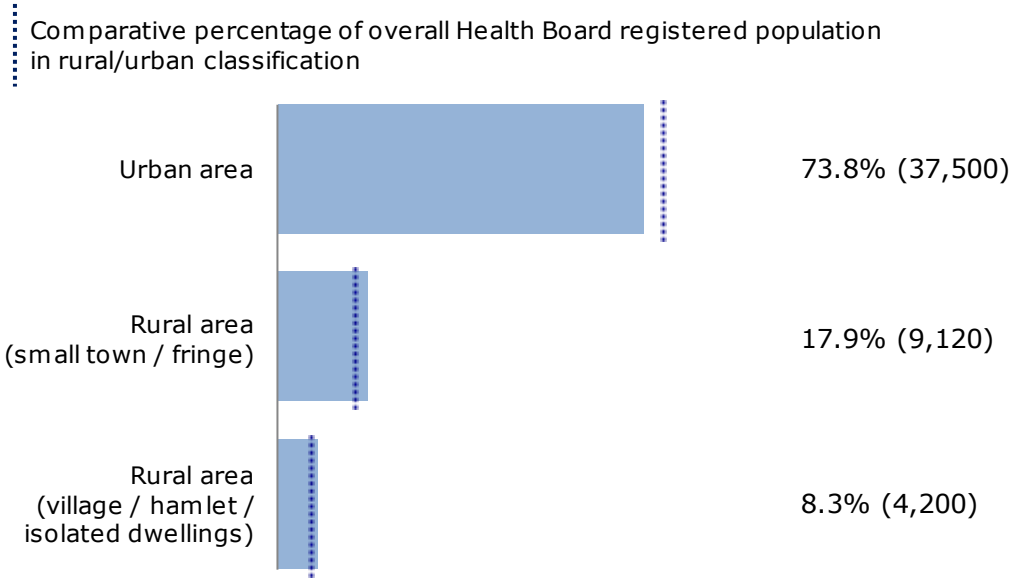
Produced by Public Health Wales Observatory, using WDS (NWIS), WIMD (WG)

N.B. Chart omits <5 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 Afan GP cluster, showing ABM UHB for comparison, 2012



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

N.B. Chart omits <5 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 Afan GP cluster

Time band (Minutes)	Number registered	Percentage
Less than 5	18,350	36.1
5 or more, less than 10	24,460	48.1
10 or more, less than 15	5,850	11.5
15 and over	2,160	4.3
*Unmatched postcode	<5	-
Total†	**50,820**	

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

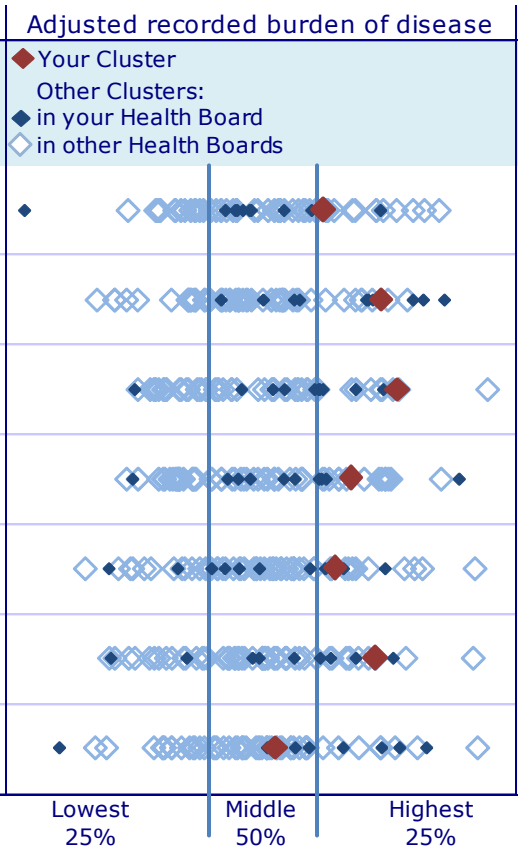
*Postcode could not be matched to an area of residence and therefore could not be classified or drivetime was not available

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

Chronic condition registers

Figure 10: Recorded and adjusted recorded burden of disease in Afan GP cluster, showing other GP clusters in ABM UHB and Wales for comparison, 2012

Indicator	Recorded burden of disease: Your Cluster: count	Your Cluster: %	Other Clusters in your Health Board: min %	Other Clusters in your Health Board: max %	Health Board %	Wales %
Hypertension	8,530	16.8	12.4	17.7	15.0	15.3
Asthma	3,790	7.5	6.4	8.1	7.2	6.7
Diabetes	3,400	6.7	4.2	6.7	5.6	5.2
CHD	2,370	4.7	3.5	5.3	4.2	4.0
COPD	1,320	2.6	1.4	3.0	2.1	2.1
Epilepsy	460	0.9	0.5	0.9	0.8	0.7
Heart Failure	480	0.9	0.7	1.7	1.0	0.9



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

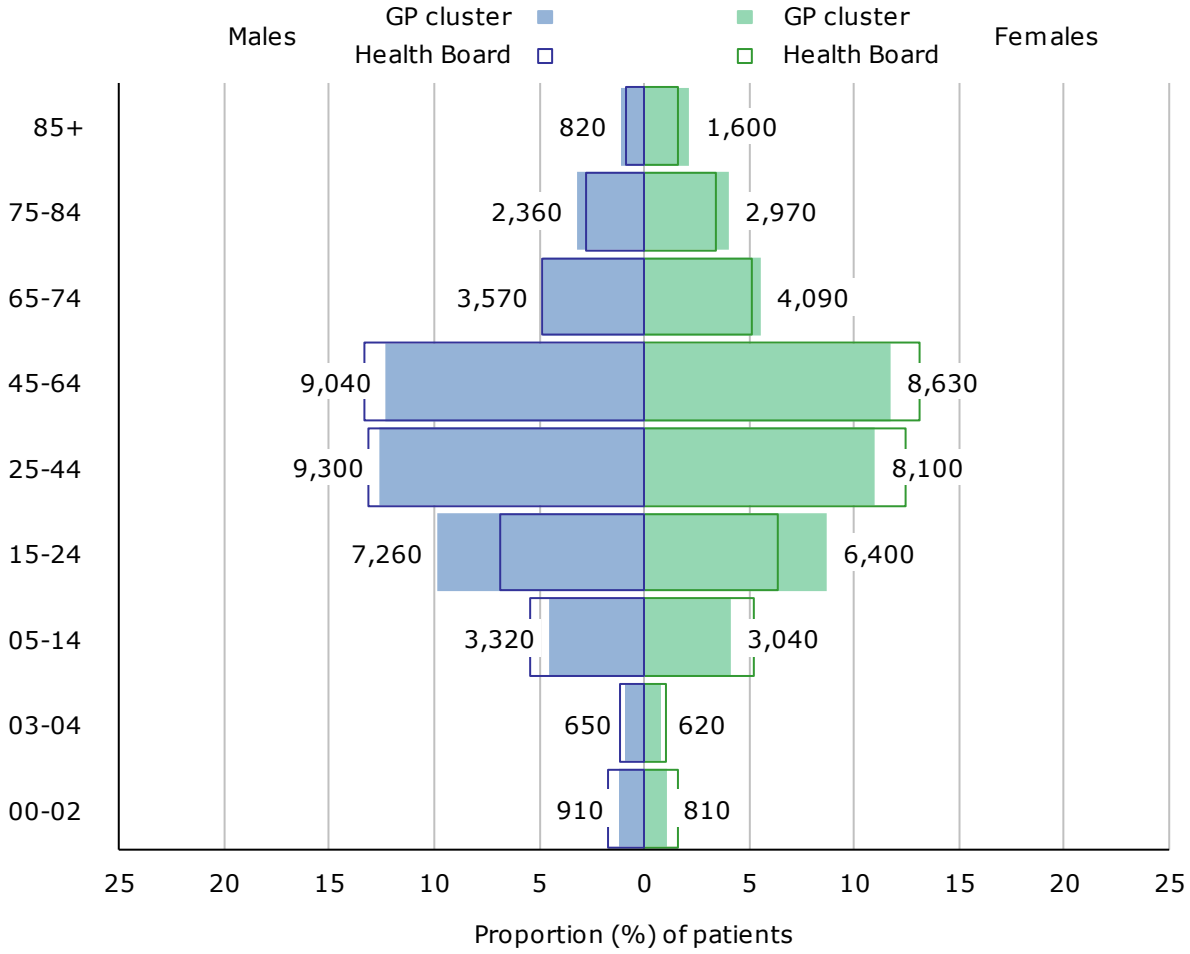
6.2 BayHealth

Geographical 'reach' map

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

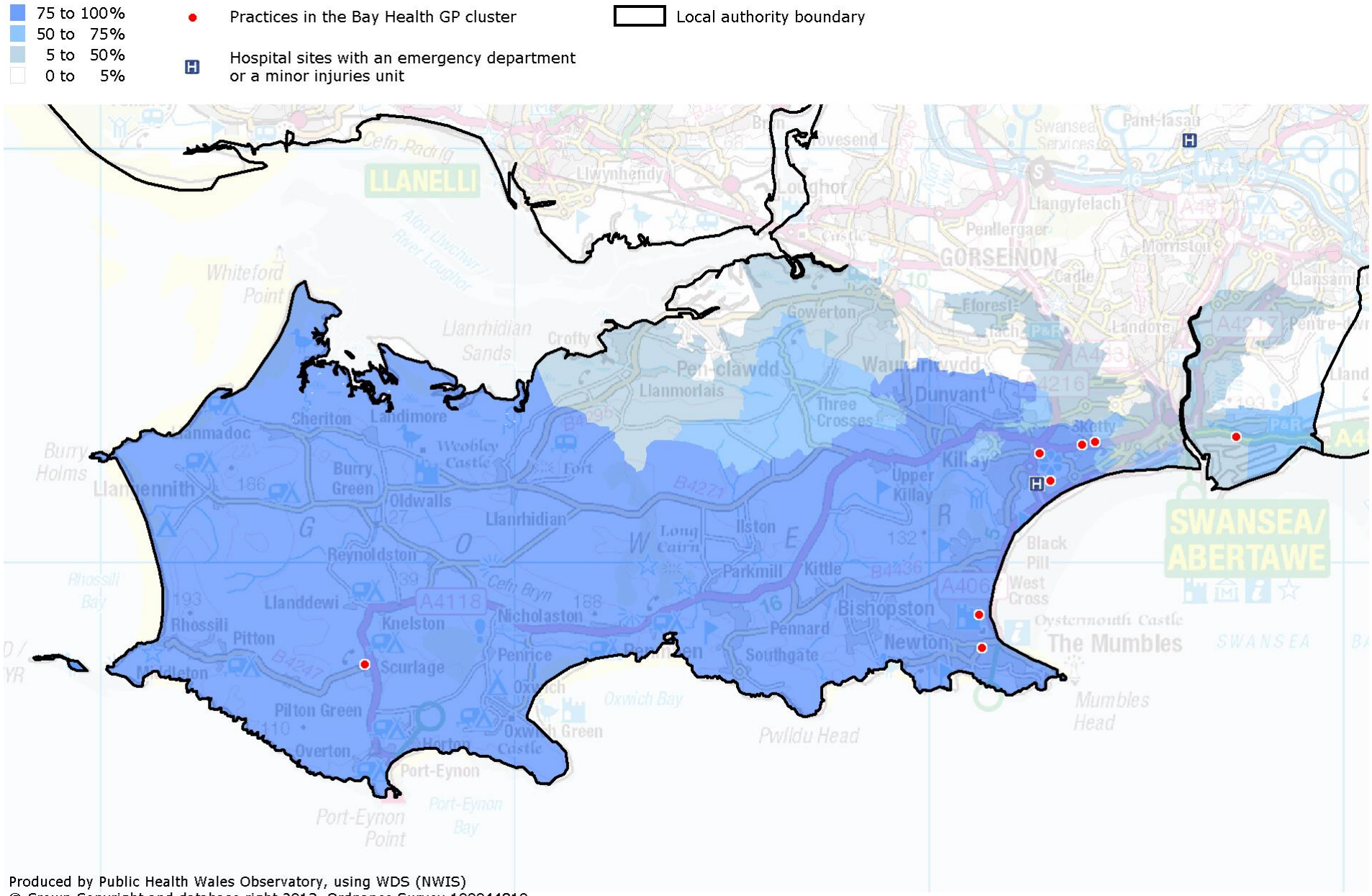
Age/sex breakdown of population

Figure 11: Percentage of patients by age and sex (with actual GP cluster counts shown next to bars), showing BayHealth GP cluster and ABM UHB for comparison, 2012



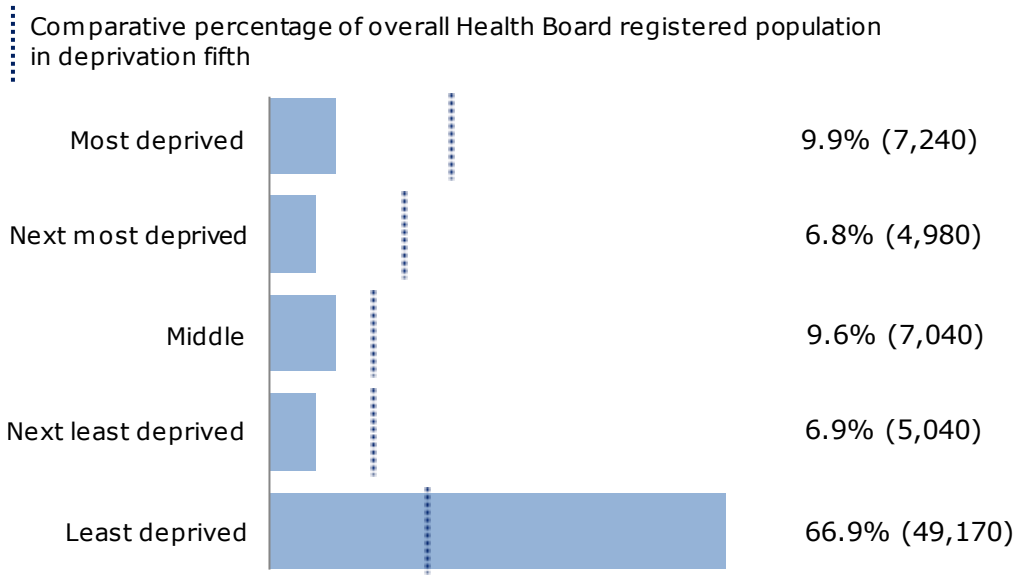
Produced by Public Health Wales Observatory, using WDS (NWIS)

Figure 12: Percentage of population registered with practices in the BayHealth GP cluster, 2012



Deprivation

Figure 13: Percentage of patients (with count in brackets) by deprivation fifth in BayHealth GP cluster, showing ABM UHB for comparison, 2012



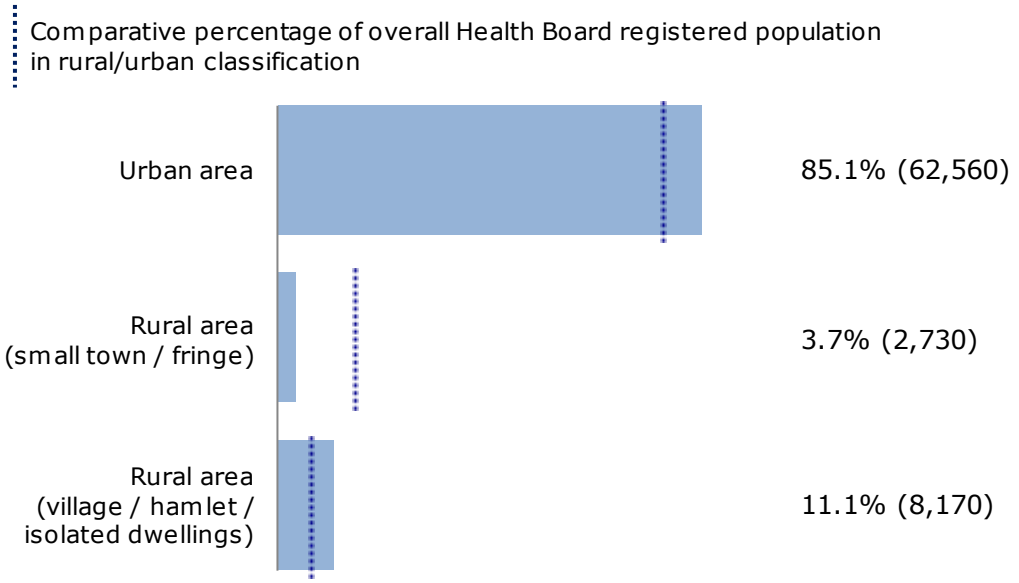
Produced by Public Health Wales Observatory, using WDS (NWIS), WIMD (WG)

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 14: Percentage of patients (with count in brackets) by rural/urban classification in BayHealth GP cluster, showing ABM UHB for comparison, 2012



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

N.B. Chart omits 20 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 6: Modelled percentage of patients living within specified driving times to their registered main practice in BayHealth GP cluster

Time band (Minutes)	Number registered	Percentage
Less than 5	20,250	27.6
5 or more, less than 10	30,060	40.9
10 or more, less than 15	14,140	19.2
15 and over	9,020	12.3
*Unmatched postcode	20	0.0
Total†	**73,480**	

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

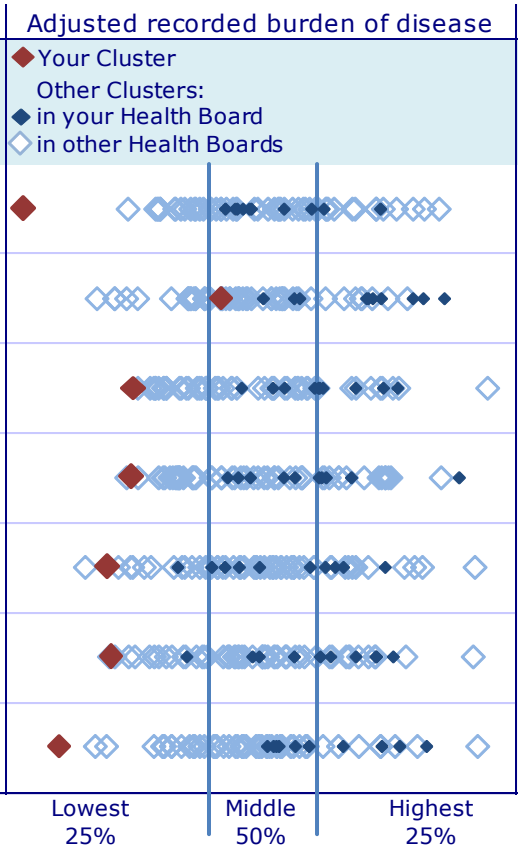
*Postcode could not be matched to an area of residence and therefore could not be classified or drivetime was not available

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

Chronic condition registers

Figure 15: Recorded and adjusted recorded burden of disease in BayHealth GP cluster, showing other GP clusters in ABM UHB and Wales for comparison, 2012

Indicator	Recorded burden of disease: Your Cluster: count	Your Cluster: %	Other Clusters in your Health Board: min %	Other Clusters in your Health Board: max %	Health Board %	Wales %
Hypertension	9,200	12.4	12.4	17.7	15.0	15.3
Asthma	4,740	6.4	6.4	8.1	7.2	6.7
Diabetes	3,120	4.2	4.2	6.7	5.6	5.2
CHD	2,620	3.5	3.5	5.3	4.2	4.0
COPD	1,020	1.4	1.4	3.0	2.1	2.1
Epilepsy	400	0.5	0.5	0.9	0.8	0.7
Heart Failure	530	0.7	0.7	1.7	1.0	0.9



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

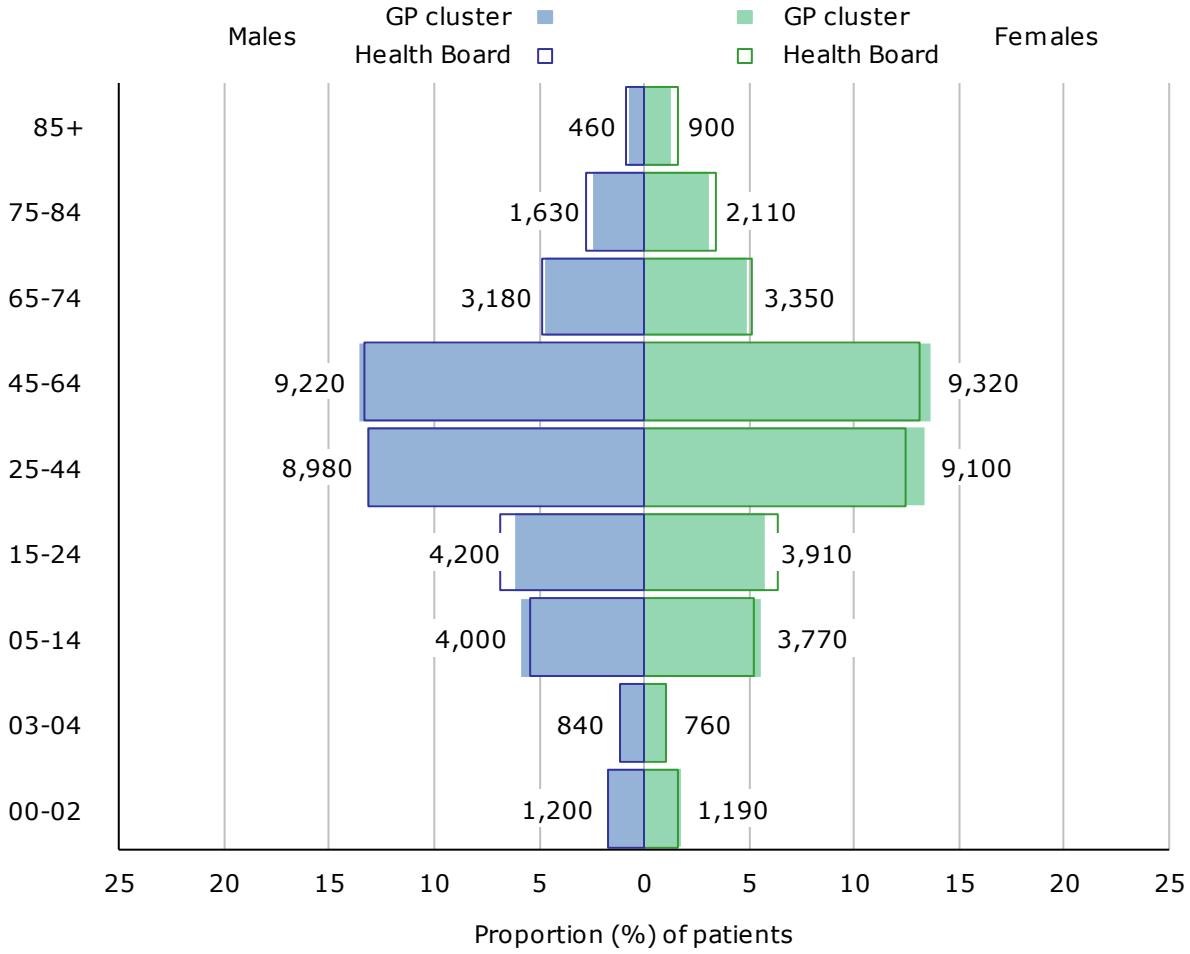
6.3 Bridgend East Network

Geographical 'reach' map

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

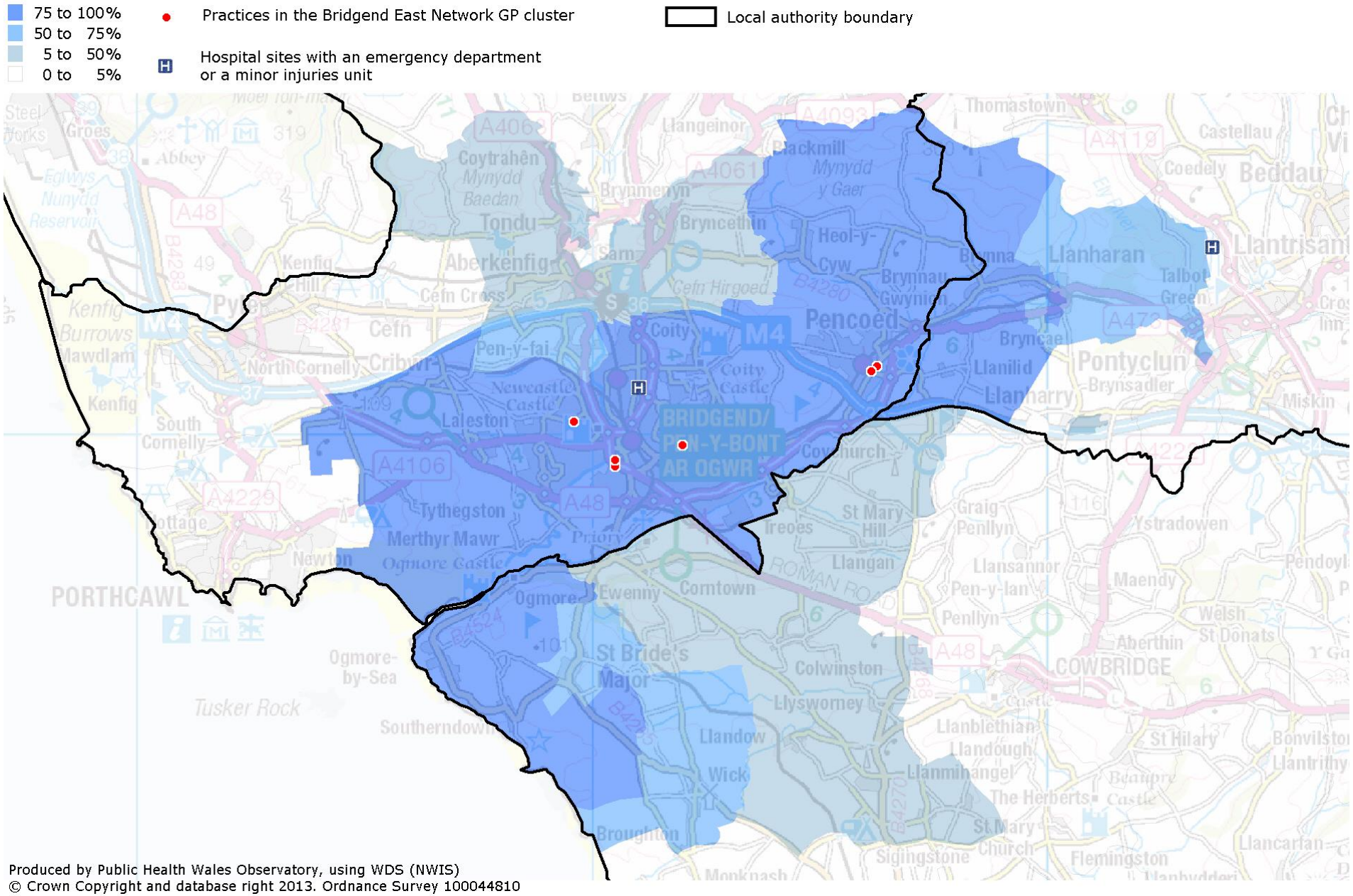
Age/sex breakdown of population

Figure 16: Percentage of patients by age and sex (with actual GP cluster counts shown next to bars), showing Bridgend East Network GP cluster and ABM UHB for comparison, 2012



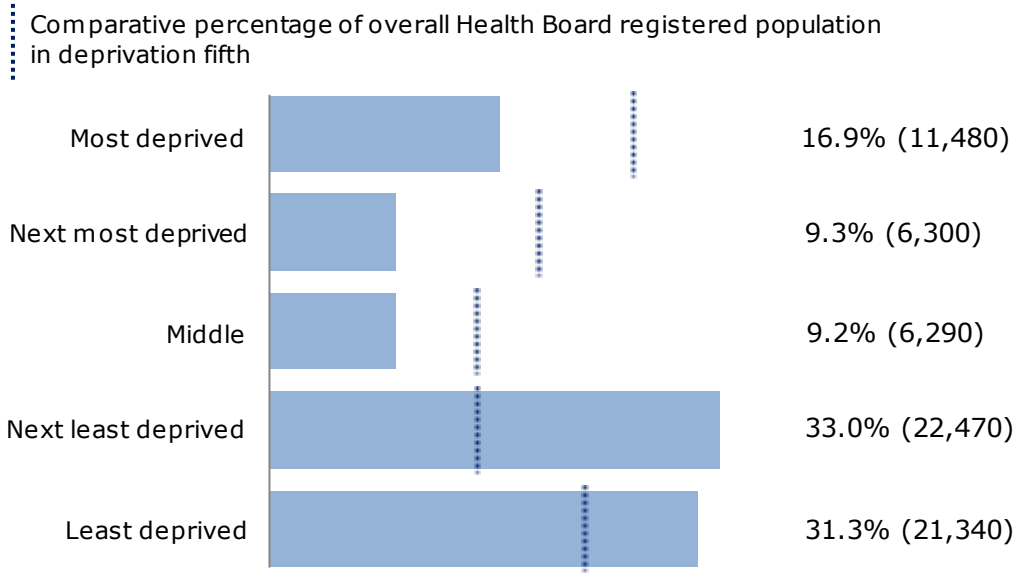
Produced by Public Health Wales Observatory, using WDS (NWIS)

Figure 17: Percentage of population registered with practices in the Bridgend East Network GP cluster, 2012



Deprivation

Figure 18: Percentage of patients (with count in brackets) by deprivation fifth in Bridgend East Network GP cluster, showing ABM UHB for comparison, 2012



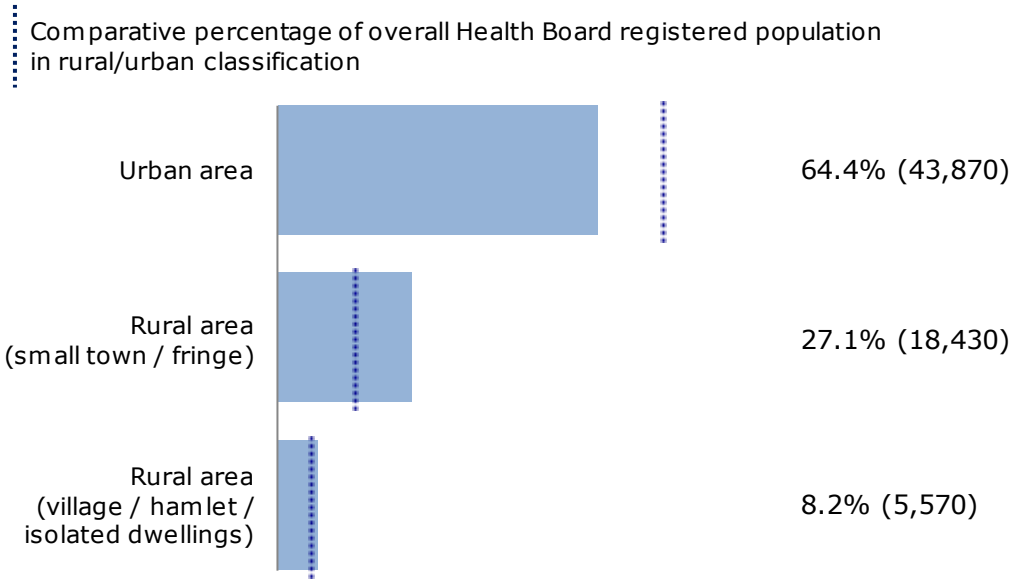
Produced by Public Health Wales Observatory, using WDS (NWIS), WIMD (WG)

N.B. Chart omits 250 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 19: Percentage of patients (with count in brackets) by rural/urban classification in Bridgend East Network GP cluster, showing ABM UHB for comparison, 2012



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

N.B. Chart omits 250 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 Bridgend East Network GP cluster

Time band (Minutes)	Number registered	Percentage
Less than 5	17,130	25.1
5 or more, less than 10	35,350	51.9
10 or more, less than 15	14,220	20.9
15 and over	1,180	1.7
*Unmatched postcode	250	0.4
Total†	**68,130**	

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

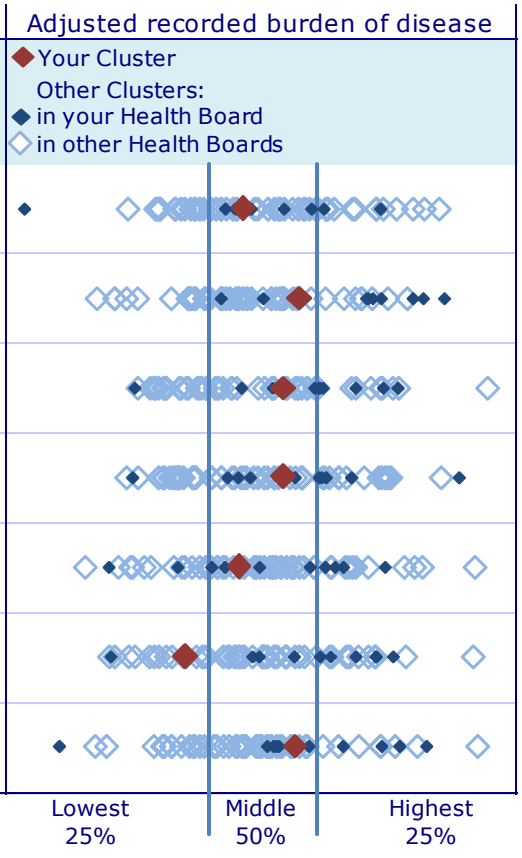
*Postcode could not be matched to an area of residence and therefore could not be classified or drivetime was not available

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

Chronic condition registers

Figure 20: Recorded and adjusted recorded burden of disease in Bridgend East Network GP cluster, showing other GP clusters in ABM UHB and Wales for comparison, 2012

Indicator	Recorded burden of disease: Your Cluster: count	Your Cluster: %	Other Clusters in your Health Board: min %	Other Clusters in your Health Board: max %	Health Board %	Wales %
Hypertension	9,690	14.2	12.4	17.7	15.0	15.3
Asthma	4,690	6.9	6.4	8.1	7.2	6.7
Diabetes	3,610	5.3	4.2	6.7	5.6	5.2
CHD	2,680	3.9	3.5	5.3	4.2	4.0
COPD	1,220	1.8	1.4	3.0	2.1	2.1
Epilepsy	430	0.6	0.5	0.9	0.8	0.7
Heart Failure	610	0.9	0.7	1.7	1.0	0.9



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

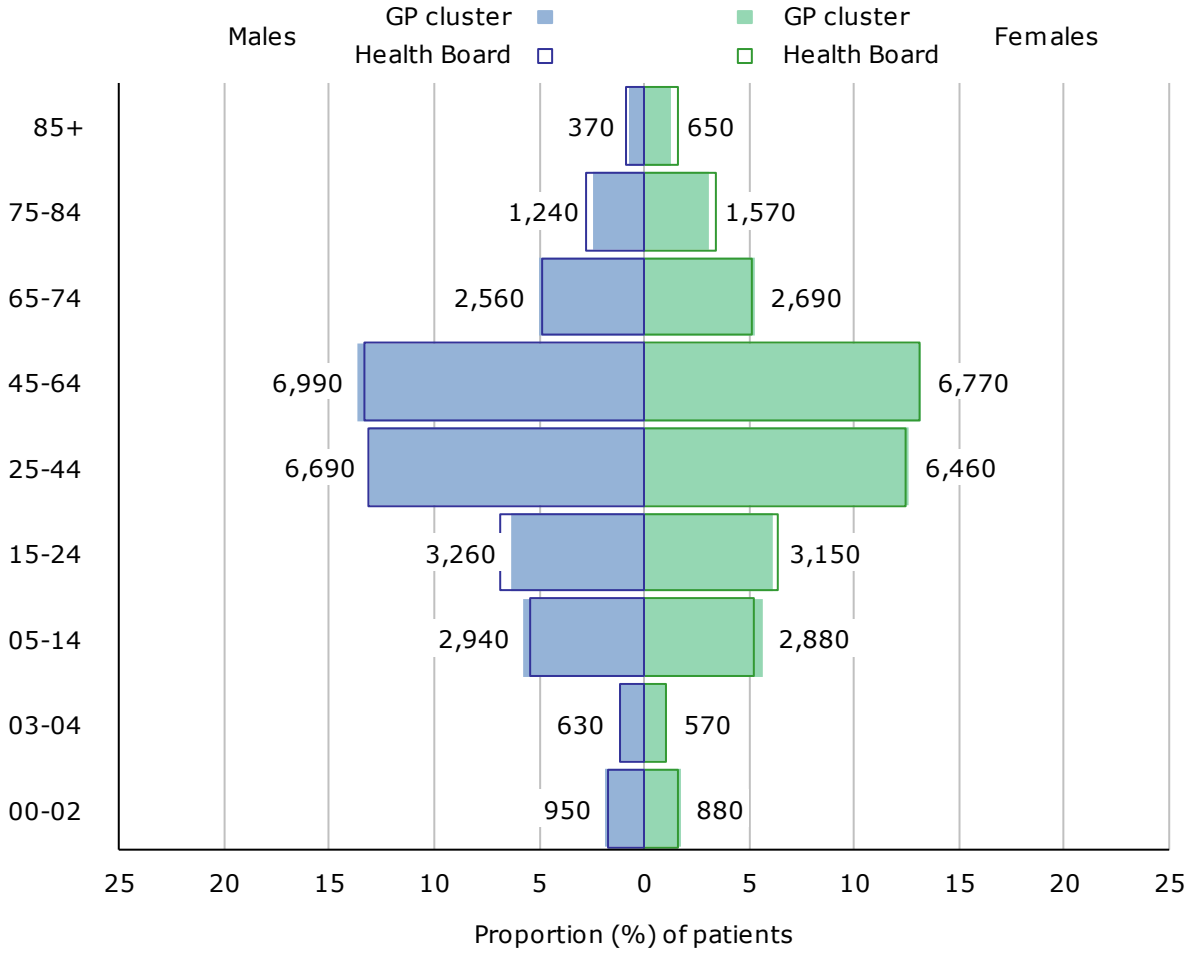
6.4 Bridgend North Network

Geographical 'reach' map

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

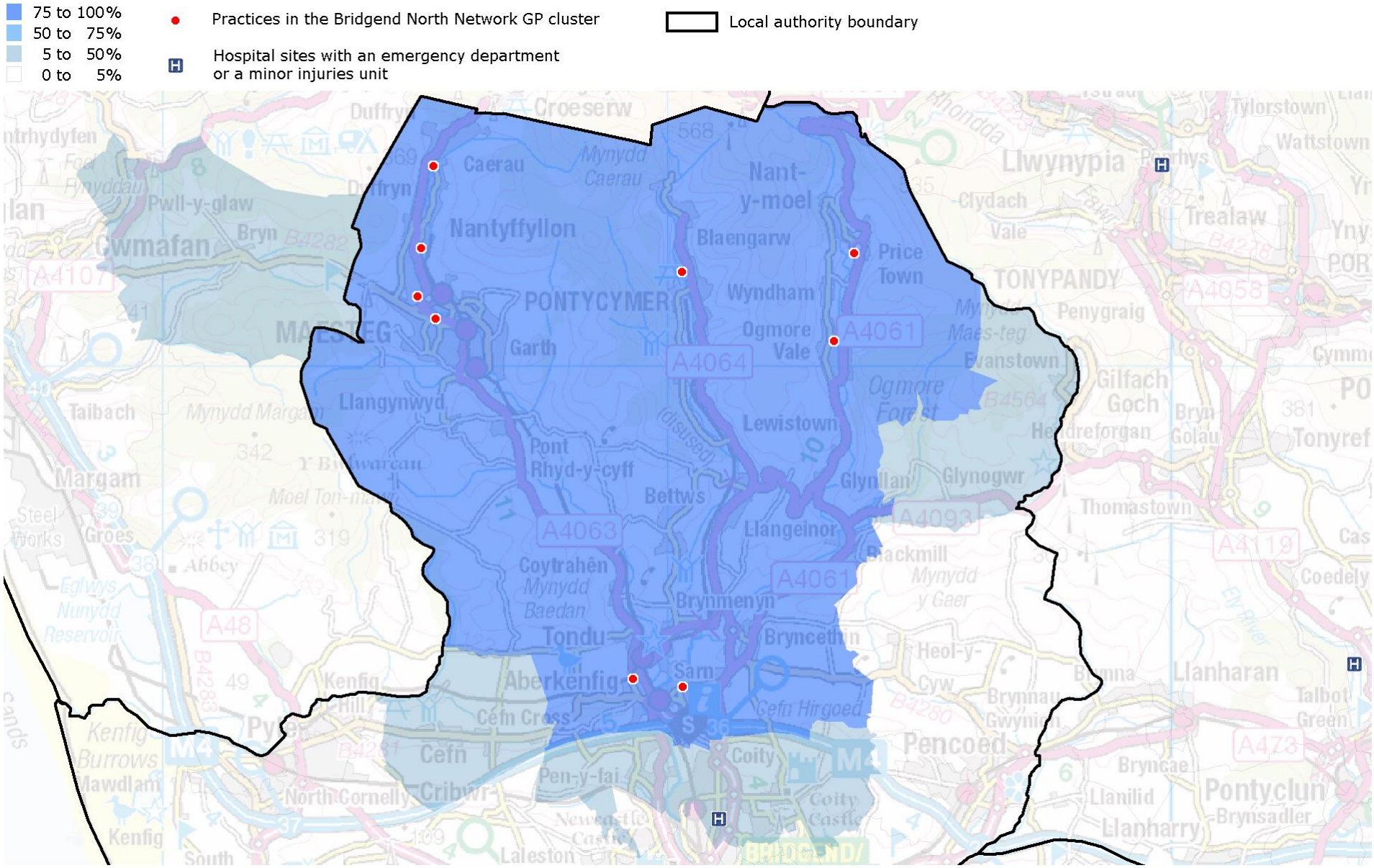
Age/sex breakdown of population

Figure 21: Percentage of patients by age and sex (with actual GP cluster counts shown next to bars), showing Bridgend North Network GP cluster and ABM UHB for comparison, 2012



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

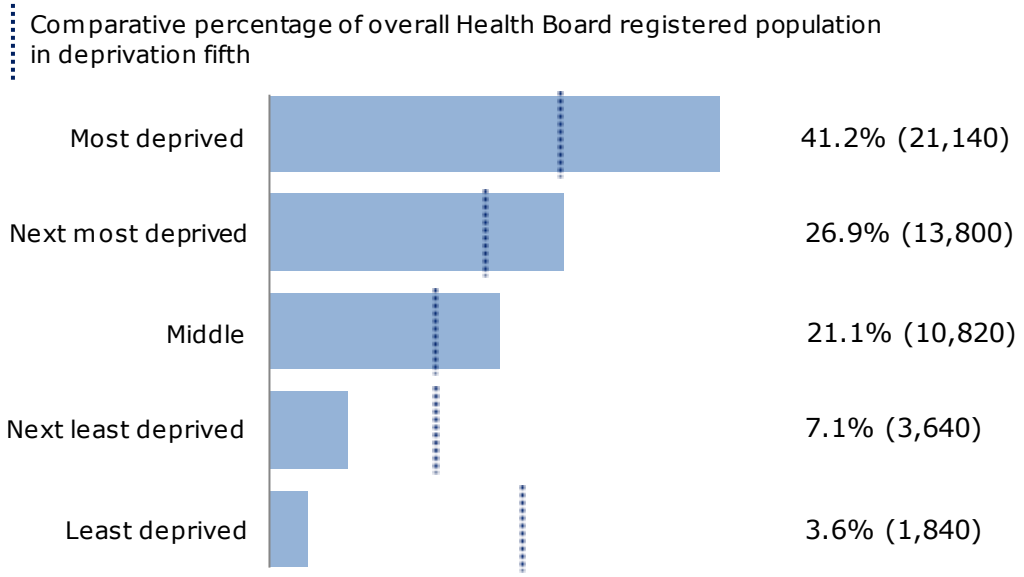
Figure 22: Percentage of population registered with practices in the Bridgend North Network GP cluster, 2012



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

Deprivation

Figure 23: Percentage of patients (with count in brackets) by deprivation fifth in Bridgend North Network GP cluster, showing ABM UHB for comparison, 2012



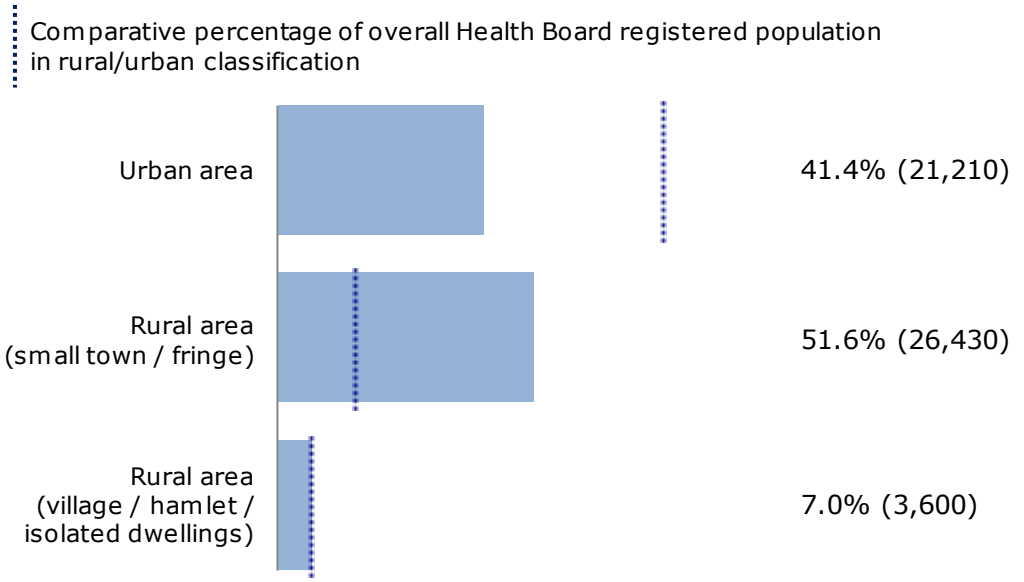
Produced by Public Health Wales Observatory, using WDS (NWIS), WIMD (WG)

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 24: Percentage of patients (with count in brackets) by rural/urban classification in Bridgend North Network GP cluster, showing ABM UHB for comparison, 2012



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

N.B. Chart omits 10 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 8: Modelled percentage of patients living within specified driving times to their registered main practice in Bridgend North Network GP cluster

Time band (Minutes)	Number registered	Percentage
Less than 5	21,700	42.3
5 or more, less than 10	23,440	45.7
10 or more, less than 15	5,260	10.3
15 and over	840	1.6
*Unmatched postcode	10	0.0
Total†	**51,250**	

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

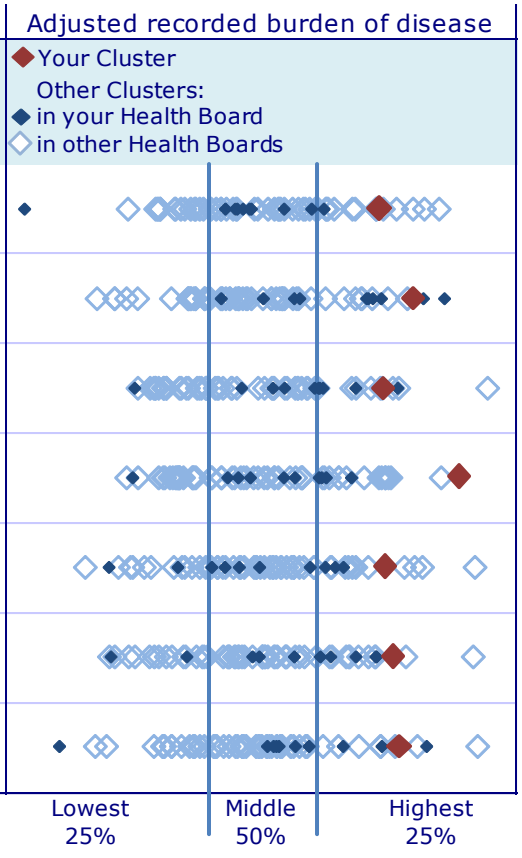
*Postcode could not be matched to an area of residence and therefore could not be classified or drivetime was not available

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

Chronic condition registers

Figure 25: Recorded and adjusted recorded burden of disease in Bridgend North Network GP cluster, showing other GP clusters in ABM UHB and Wales for comparison, 2012

Indicator	Recorded burden of disease: Your Cluster: count	Your Cluster: %	Other Clusters in your Health Board: min %	Other Clusters in your Health Board: max %	Health Board %	Wales %
Hypertension	9,060	17.6	12.4	17.7	15.0	15.3
Asthma	3,980	7.7	6.4	8.1	7.2	6.7
Diabetes	3,280	6.4	4.2	6.7	5.6	5.2
CHD	2,560	5.0	3.5	5.3	4.2	4.0
COPD	1,550	3.0	1.4	3.0	2.1	2.1
Epilepsy	470	0.9	0.5	0.9	0.8	0.7
Heart Failure	610	1.2	0.7	1.7	1.0	0.9

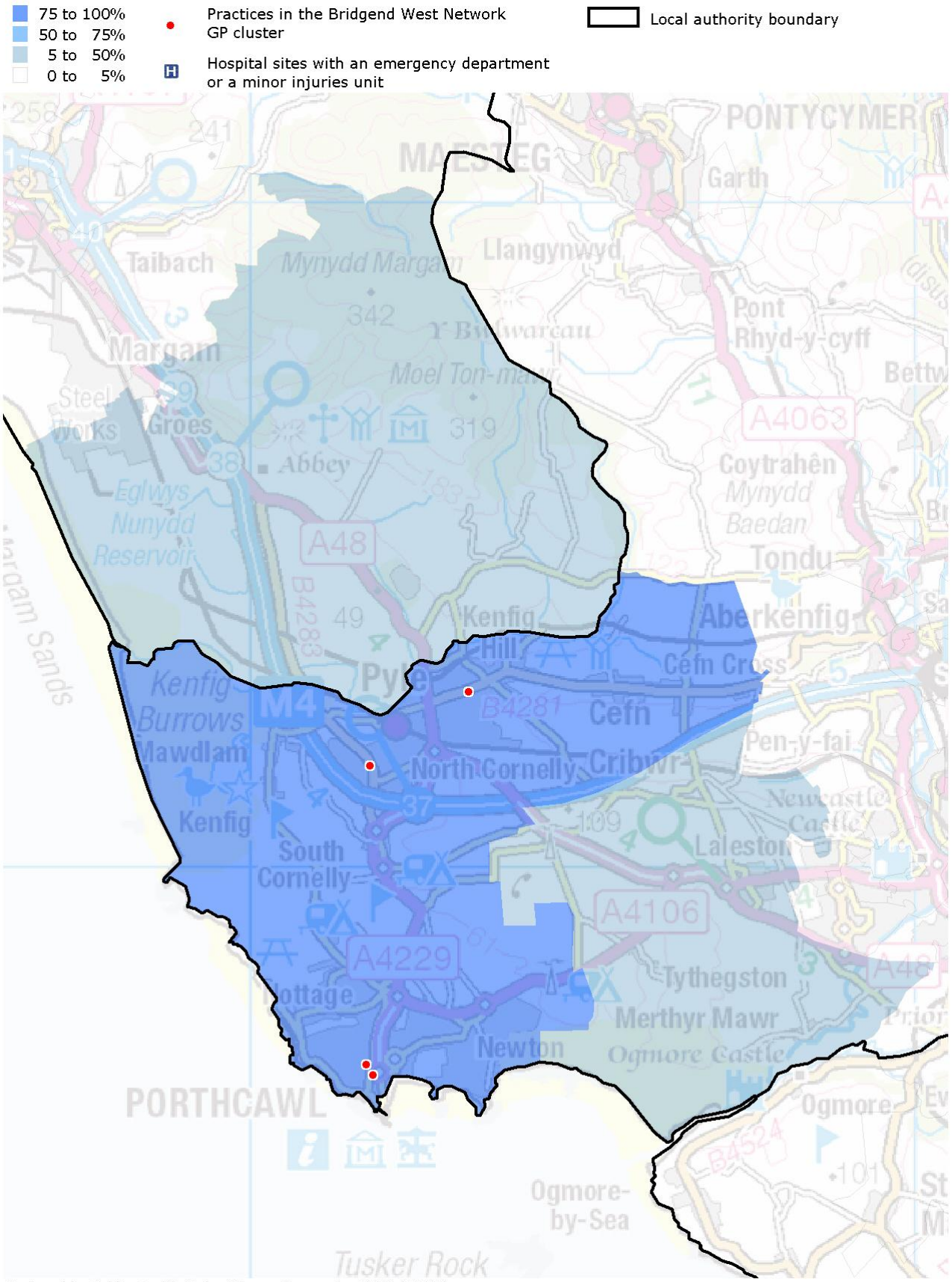


Produced by Public Health Wales Observatory, using Audit+ (NWIS)

6.5 Bridgend West Network

Geographical 'reach' map

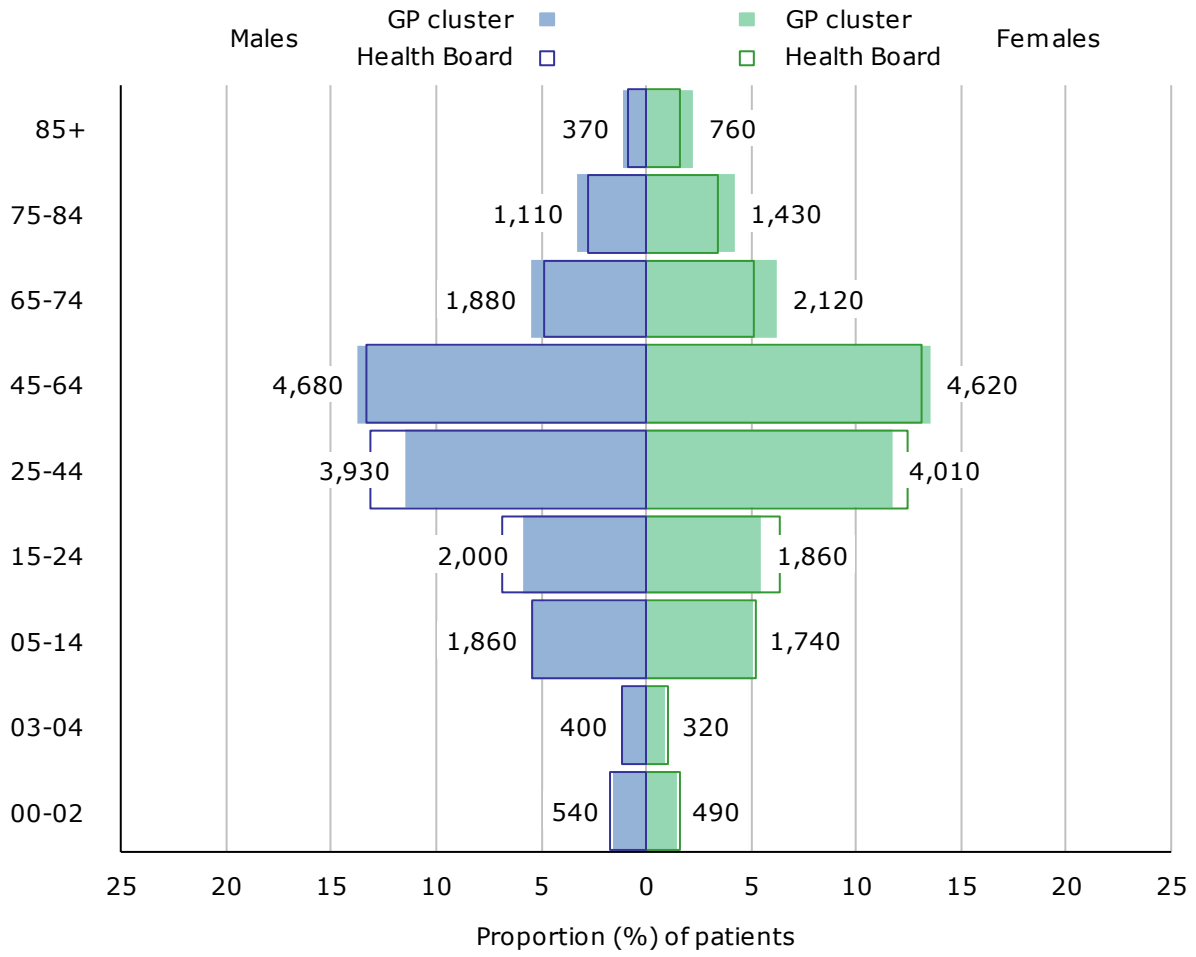
Figure 26: Percentage of population registered with practices in the Bridgend West Network GP cluster, 2012



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

Age/sex breakdown of population

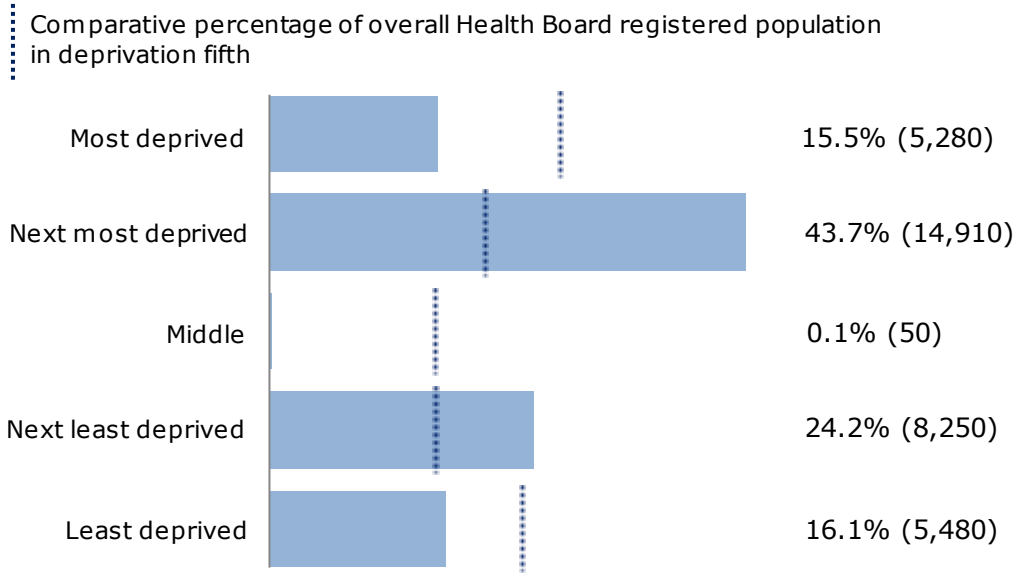
Figure 27: Percentage of patients by age and sex (with actual GP cluster counts shown next to bars), showing Bridgend West Network GP cluster and ABM UHB for comparison, 2012



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

Deprivation

Figure 28: Percentage of patients (with count in brackets) by deprivation fifth in Bridgend West Network GP cluster, showing ABM UHB for comparison, 2012



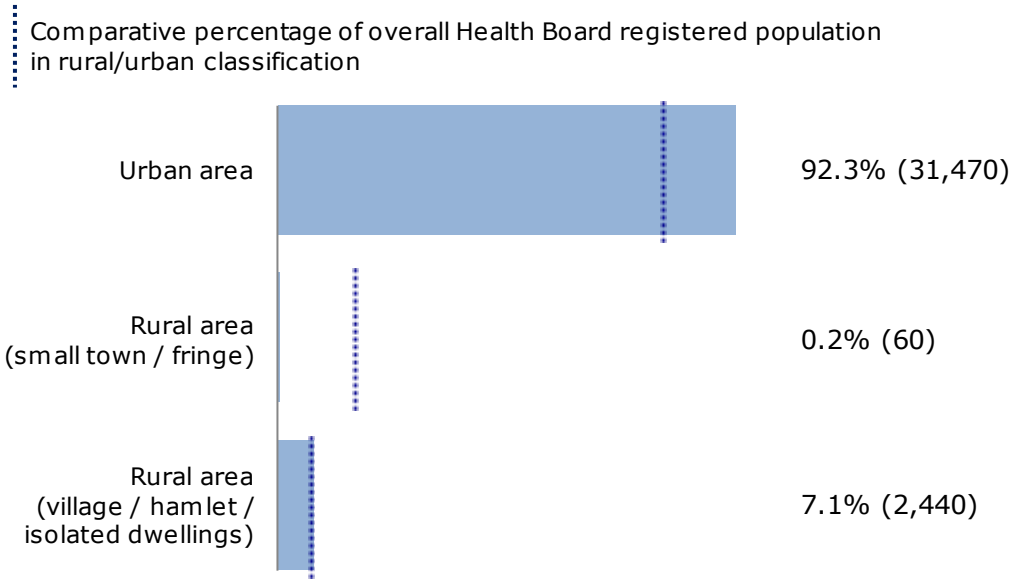
Produced by Public Health Wales Observatory, using WDS (NWIS), WIMD (WG)

N.B. Chart omits 130 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 Bridgend West Network GP cluster, showing ABM UHB for comparison, 2012



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

N.B. Chart omits 130 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 Bridgend West Network GP cluster

Time band (Minutes)	Number registered	Percentage
Less than 5	14,720	43.2
5 or more, less than 10	17,230	50.5
10 or more, less than 15	1,920	5.6
15 and over	90	0.3
*Unmatched postcode	130	0.4
Total†	**34,100**	

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

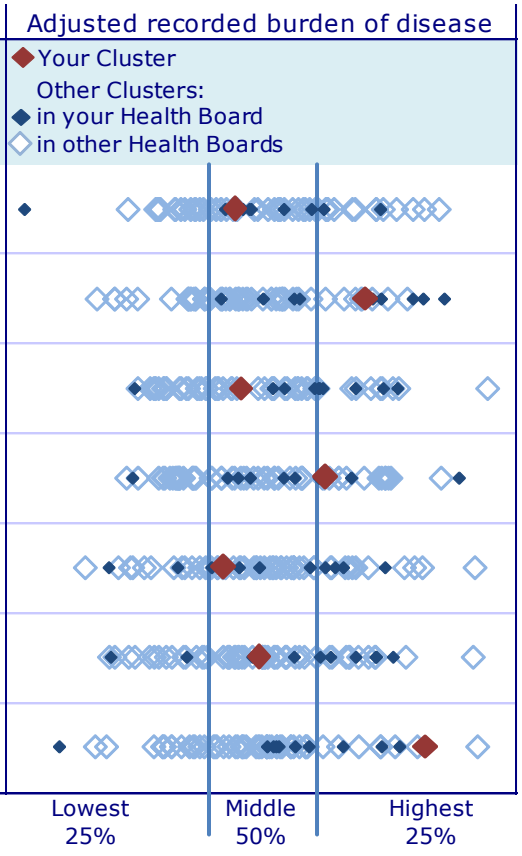
*Postcode could not be matched to an area of residence and therefore could not be classified or drivetime was not available

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

Chronic condition registers

Figure 30: Recorded and adjusted recorded burden of disease in Bridgend West Network GP cluster, showing other GP clusters in ABM UHB and Wales for comparison, 2012

Indicator	Recorded burden of disease: Your Cluster: count	Your Cluster: %	Other Clusters in your Health Board: min %	Other Clusters in your Health Board: max %	Health Board %	Wales %
Hypertension	5,780	17.0	12.4	17.7	15.0	15.3
Asthma	2,530	7.4	6.4	8.1	7.2	6.7
Diabetes	1,950	5.7	4.2	6.7	5.6	5.2
CHD	1,800	5.3	3.5	5.3	4.2	4.0
COPD	720	2.1	1.4	3.0	2.1	2.1
Epilepsy	260	0.8	0.5	0.9	0.8	0.7
Heart Failure	560	1.7	0.7	1.7	1.0	0.9



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

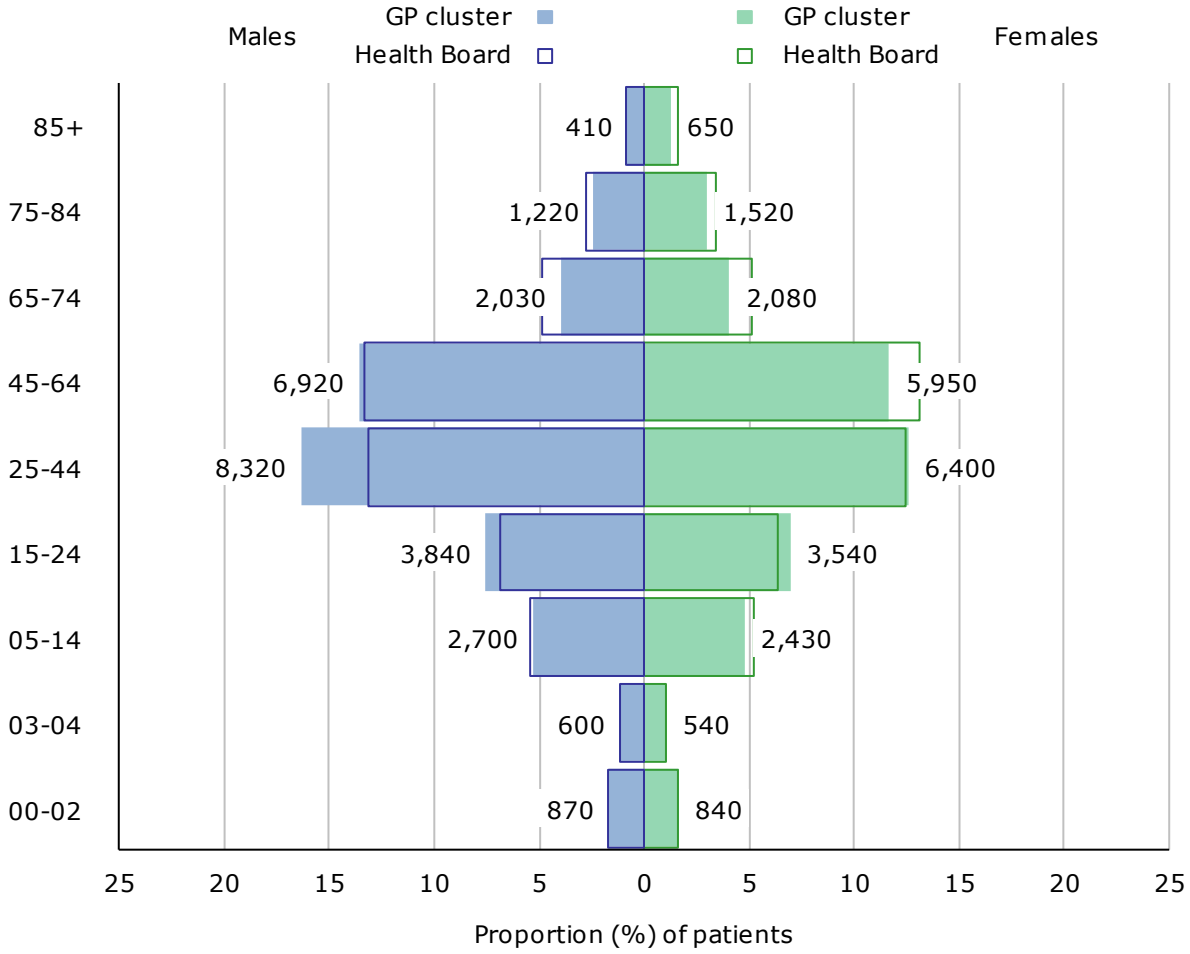
6.6 CityHealth

Geographical 'reach' map

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

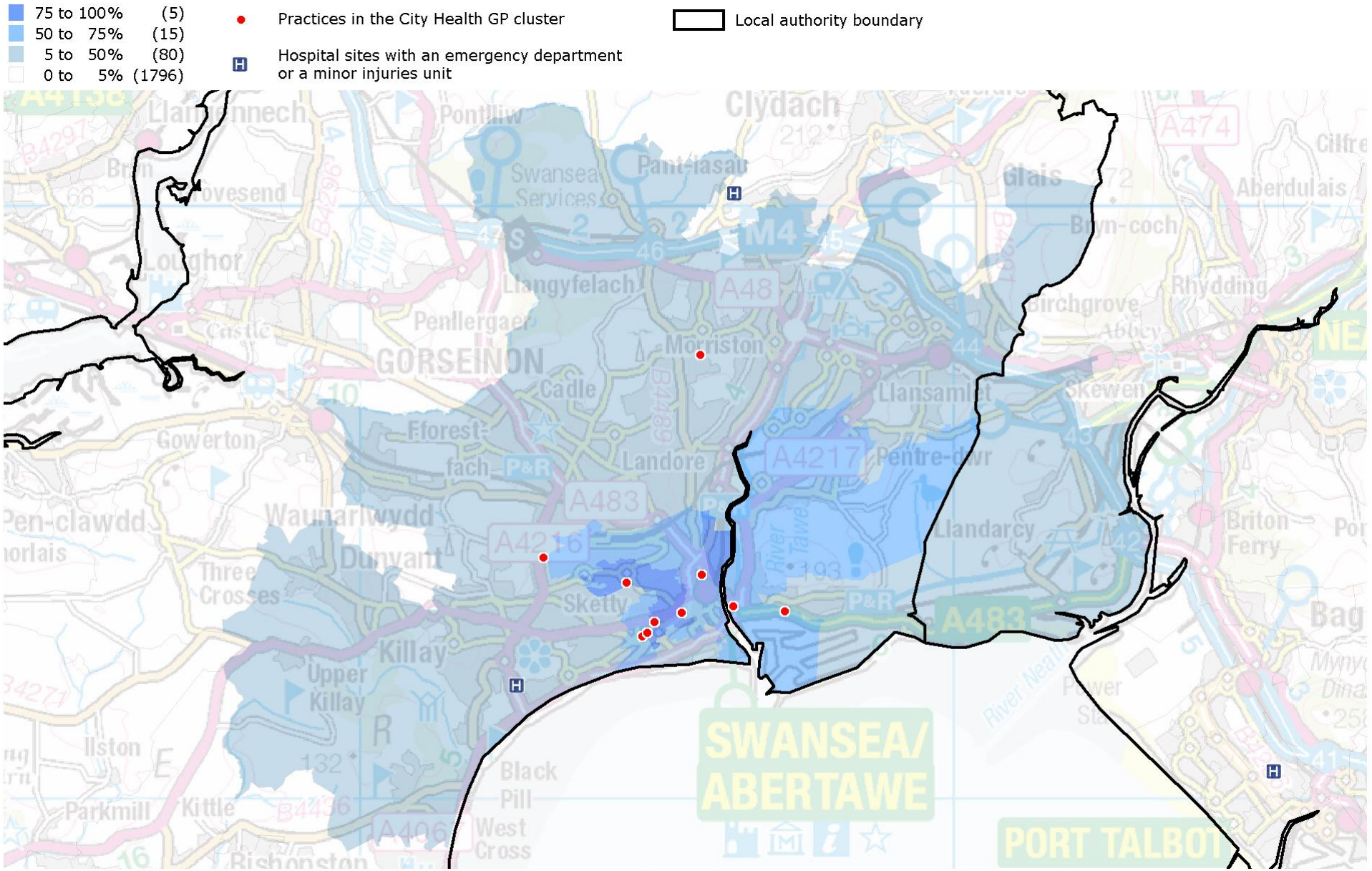
Age/sex breakdown of population

Figure 31: Percentage of patients by age and sex (with actual GP cluster counts shown next to bars), showing CityHealth GP cluster and ABM UHB for comparison, 2012



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

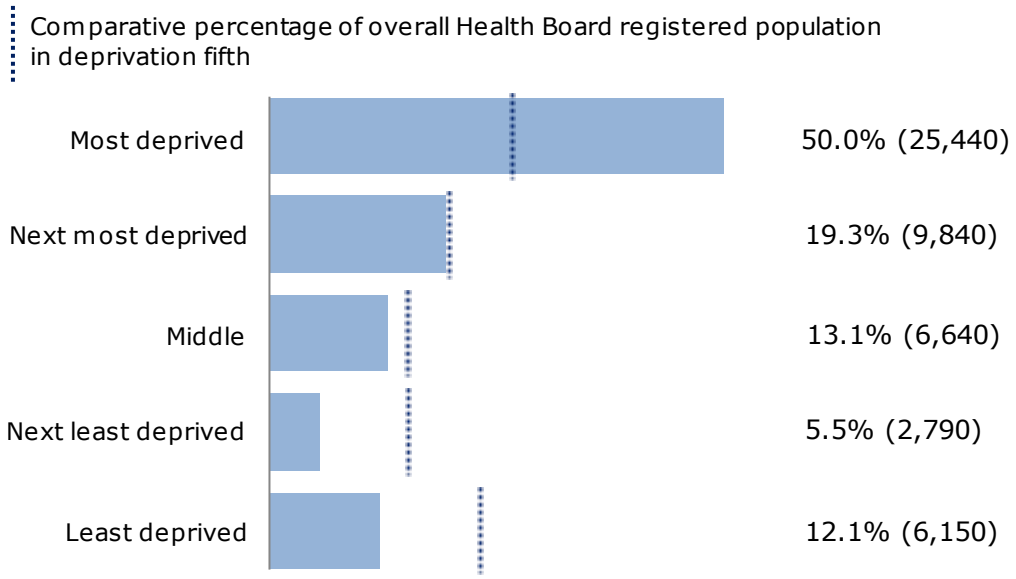
Figure 32: Percentage of population registered with practices in the CityHealth GP cluster, 2012



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

Deprivation

Figure 33: Percentage of patients (with count in brackets) by deprivation fifth in CityHealth GP cluster, showing ABM UHB for comparison, 2012



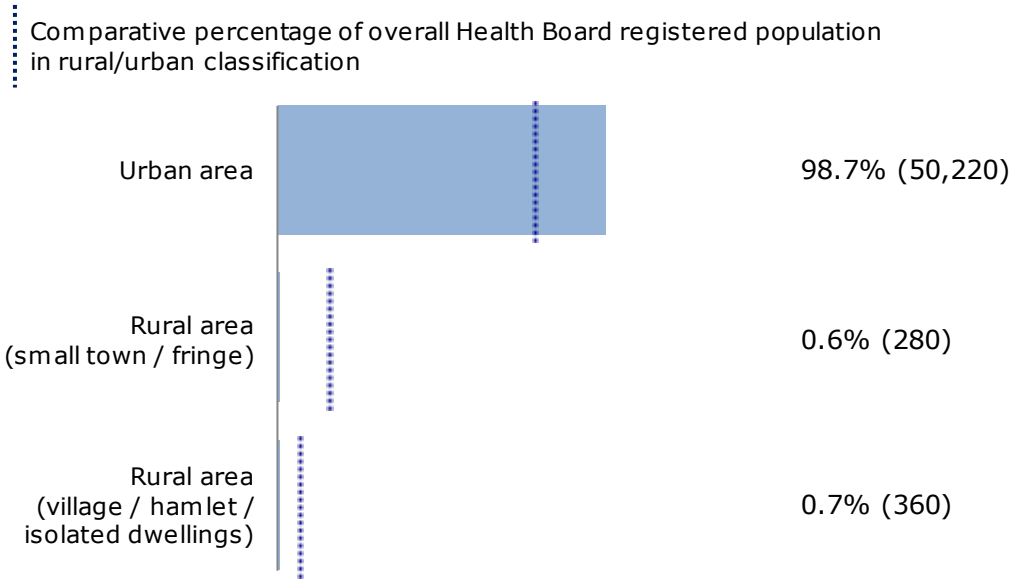
Produced by Public Health Wales Observatory, using WDS (NWIS), WIMD (WG)

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 34: Percentage of patients (with count in brackets) by rural/urban classification in CityHealth GP cluster, showing ABM UHB for comparison, 2012



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

N.B. Chart omits 20 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 10: Modelled percentage of patients living within specified driving times to their registered main practice in CityHealth GP cluster

Time band (Minutes)	Number registered	Percentage
Less than 5	11,800	23.2
5 or more, less than 10	19,570	38.5
10 or more, less than 15	13,670	26.9
15 and over	5,820	11.4
*Unmatched postcode	20	0.0
Total†	**50,870**	

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

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

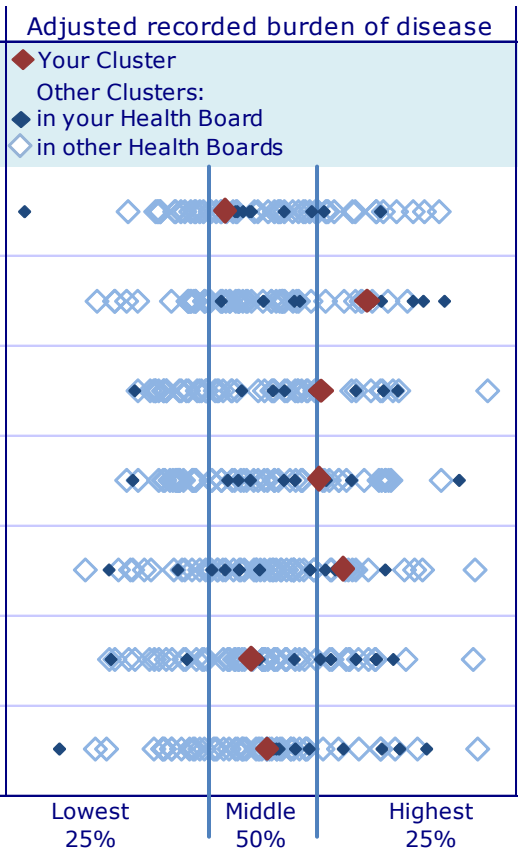
†Total does not include counts of <5, totals may not match due to rounding

Chronic condition registers

Within this cluster data is missing for one practice with a list size of 3,000‡.

Figure 35: Recorded and adjusted recorded burden of disease in CityHealth GP cluster, showing other GP clusters in ABM UHB and Wales for comparison, 2012

Indicator	Recorded burden of disease: Your Cluster: count	Your Cluster: %	Other Clusters in your Health Board: min %	Other Clusters in your Health Board: max %	Health Board %	Wales %
Hypertension	6,180	12.8	12.4	17.7	15.0	15.3
Asthma	3,500	7.3	6.4	8.1	7.2	6.7
Diabetes	2,520	5.2	4.2	6.7	5.6	5.2
CHD	1,800	3.7	3.5	5.3	4.2	4.0
COPD	1,100	2.3	1.4	3.0	2.1	2.1
Epilepsy	330	0.7	0.5	0.9	0.8	0.7
Heart Failure	380	0.8	0.7	1.7	1.0	0.9



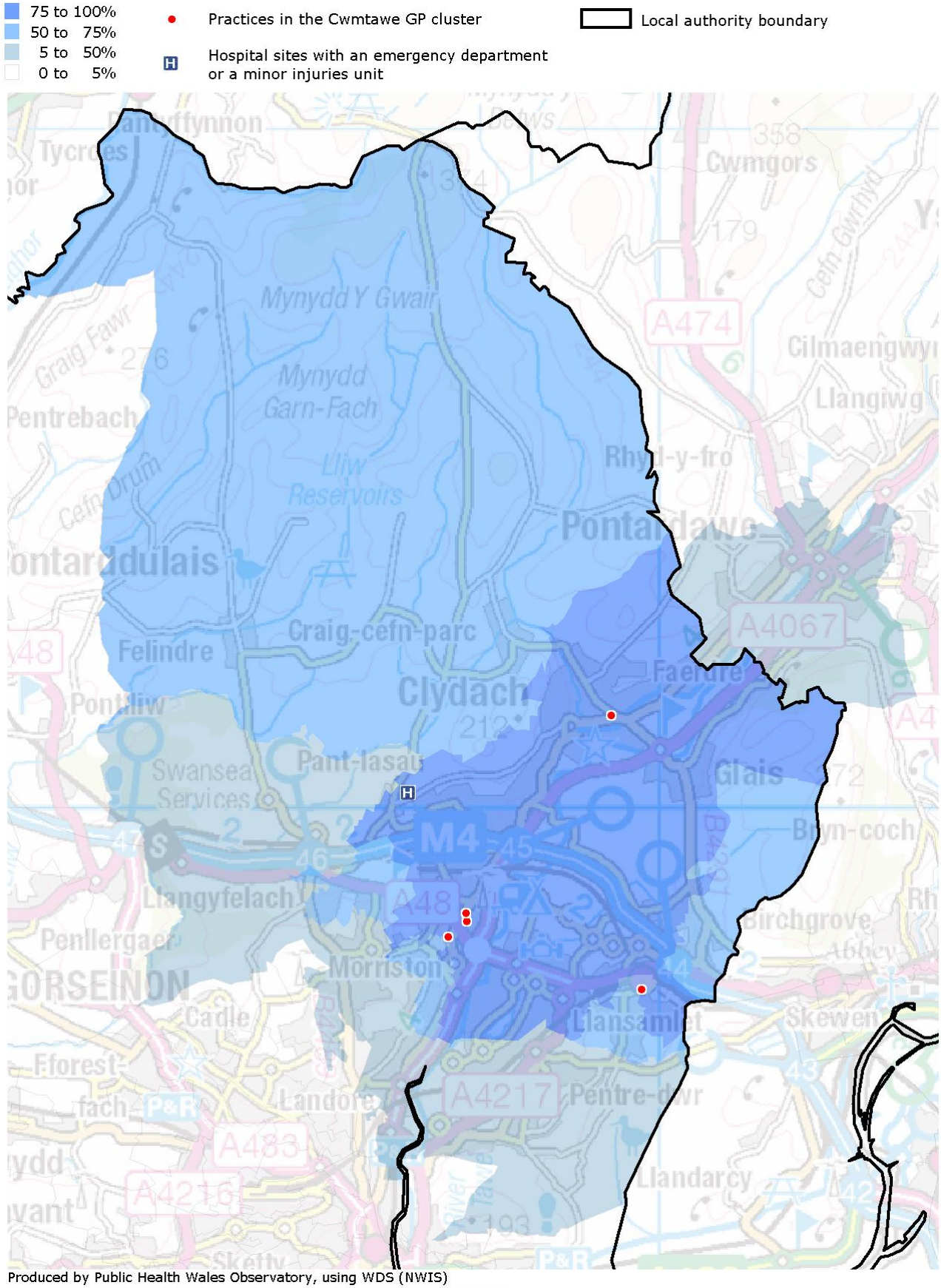
Produced by Public Health Wales Observatory, using Audit+ (NWIS)

‡ Rounded to nearest 100 for ease of reading

6.7 Cwmtawe

Geographical 'reach' map

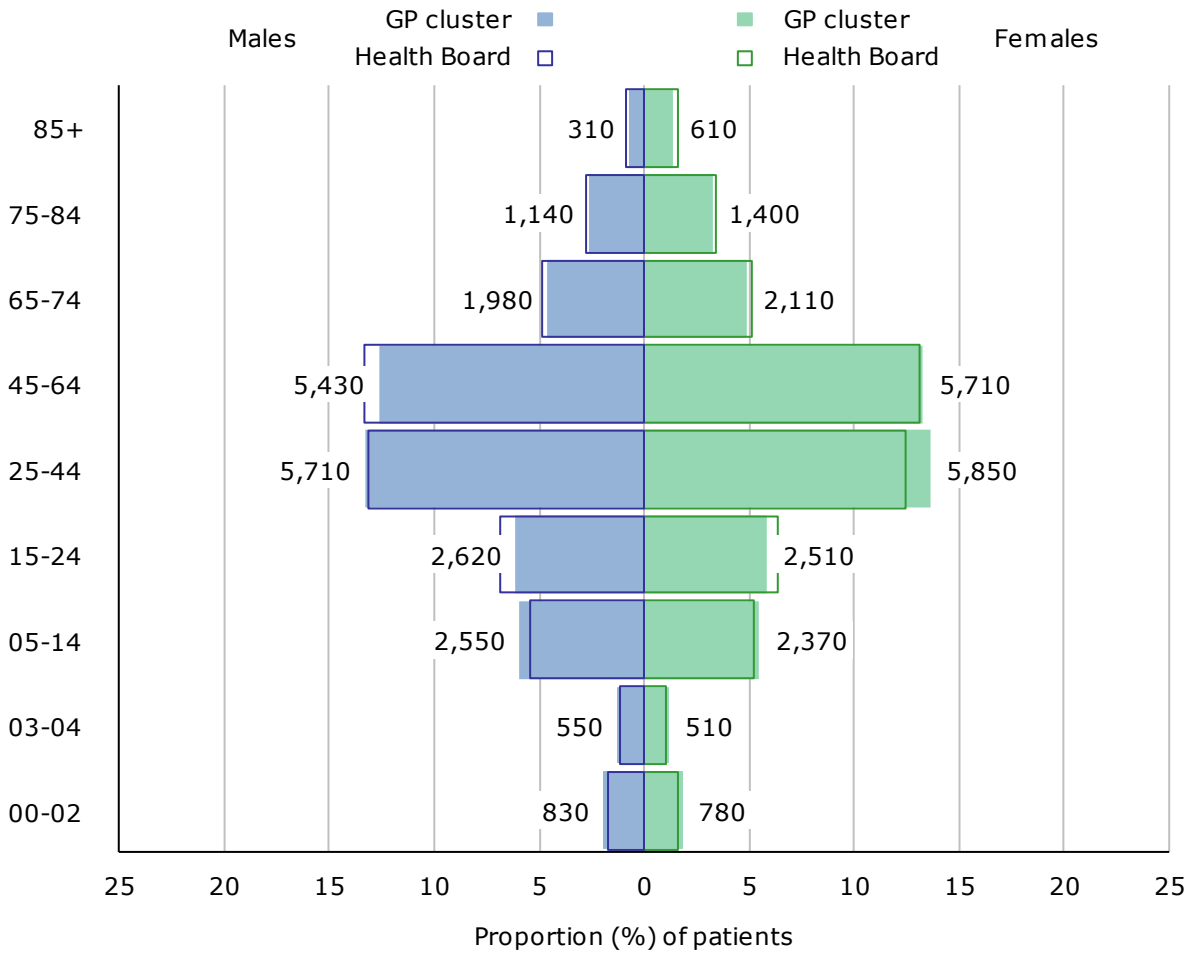
Figure 36: Percentage of population registered with practices in the Cwmtawe GP cluster, 2012



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

Age/sex breakdown of population

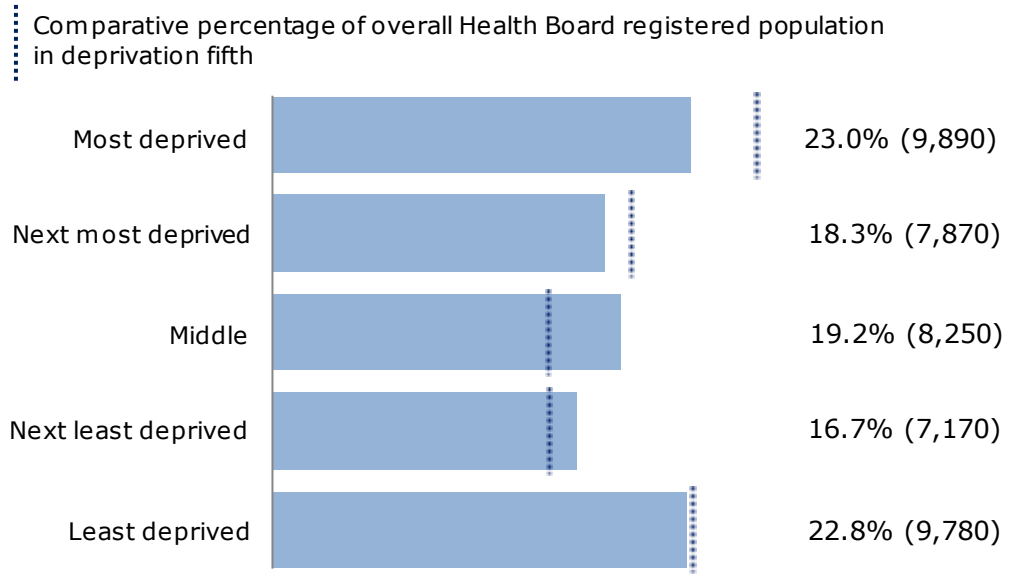
Figure 37: Percentage of patients by age and sex (with actual GP cluster counts shown next to bars), showing Cwmtawe GP cluster and ABM UHB for comparison, 2012



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

Deprivation

Figure 38: Percentage of patients (with count in brackets) by deprivation fifth in Cwmtawe GP cluster, showing ABM UHB for comparison, 2012

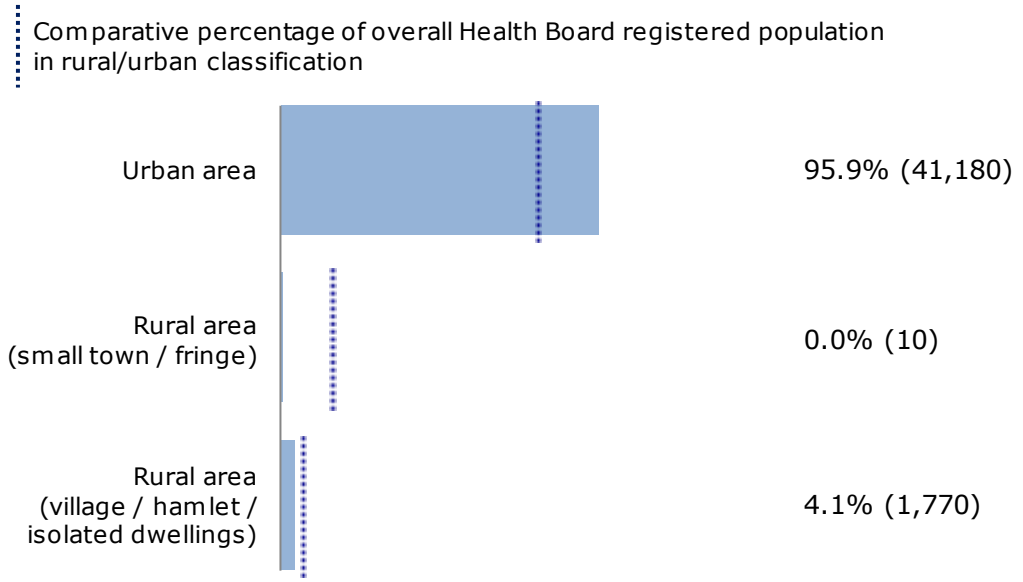


Produced by Public Health Wales Observatory, using WDS (NWIS), WIMD (WG)

Rurality

i) Office for National Statistics rural/urban classification

Figure 39: Percentage of patients (with count in brackets) by rural/urban classification in Cwmtawe GP cluster, showing ABM UHB 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 11: Modelled percentage of patients living within specified driving times to their registered main practice in Cwmtawe GP cluster

Time band (Minutes)	Number registered	Percentage
Less than 5	22,510	52.4
5 or more, less than 10	18,170	42.3
10 or more, less than 15	2,060	4.8
15 and over	220	0.5
*Unmatched postcode	-	-
Total†	**42,950**	

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

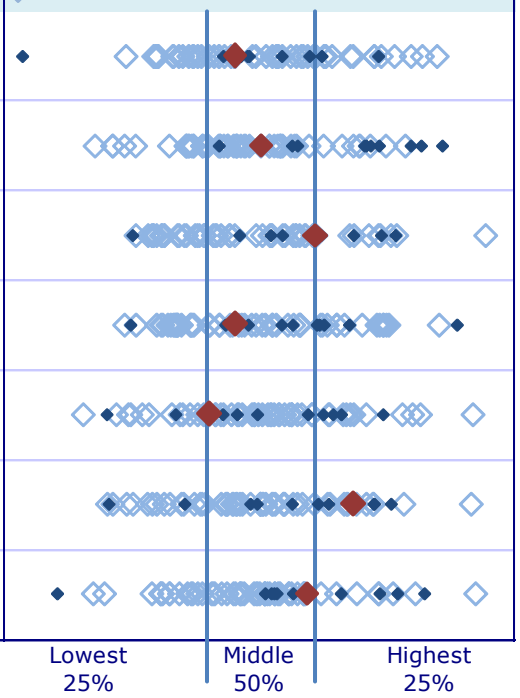
*Postcode could not be matched to an area of residence and therefore could not be classified or drivetime was not available

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

Chronic condition registers

Figure 40: Recorded and adjusted recorded burden of disease in Cwmtawe GP cluster, showing other GP clusters in ABM UHB and Wales for comparison, 2012

Indicator	Recorded burden of disease						Adjusted recorded burden of disease
	Your Cluster:		Other Clusters in your Health Board:		Health Board	Wales	◆ Your Cluster Other Clusters: ◆ in your Health Board ◇ in other Health Boards
	count	%	min %	max %	%	%	
Hypertension	6,050	14.1	12.4	17.7	15.0	15.3	
Asthma	2,880	6.7	6.4	8.1	7.2	6.7	
Diabetes	2,450	5.7	4.2	6.7	5.6	5.2	
CHD	1,630	3.8	3.5	5.3	4.2	4.0	
COPD	710	1.7	1.4	3.0	2.1	2.1	
Epilepsy	360	0.8	0.5	0.9	0.8	0.7	
Heart Failure	410	0.9	0.7	1.7	1.0	0.9	



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

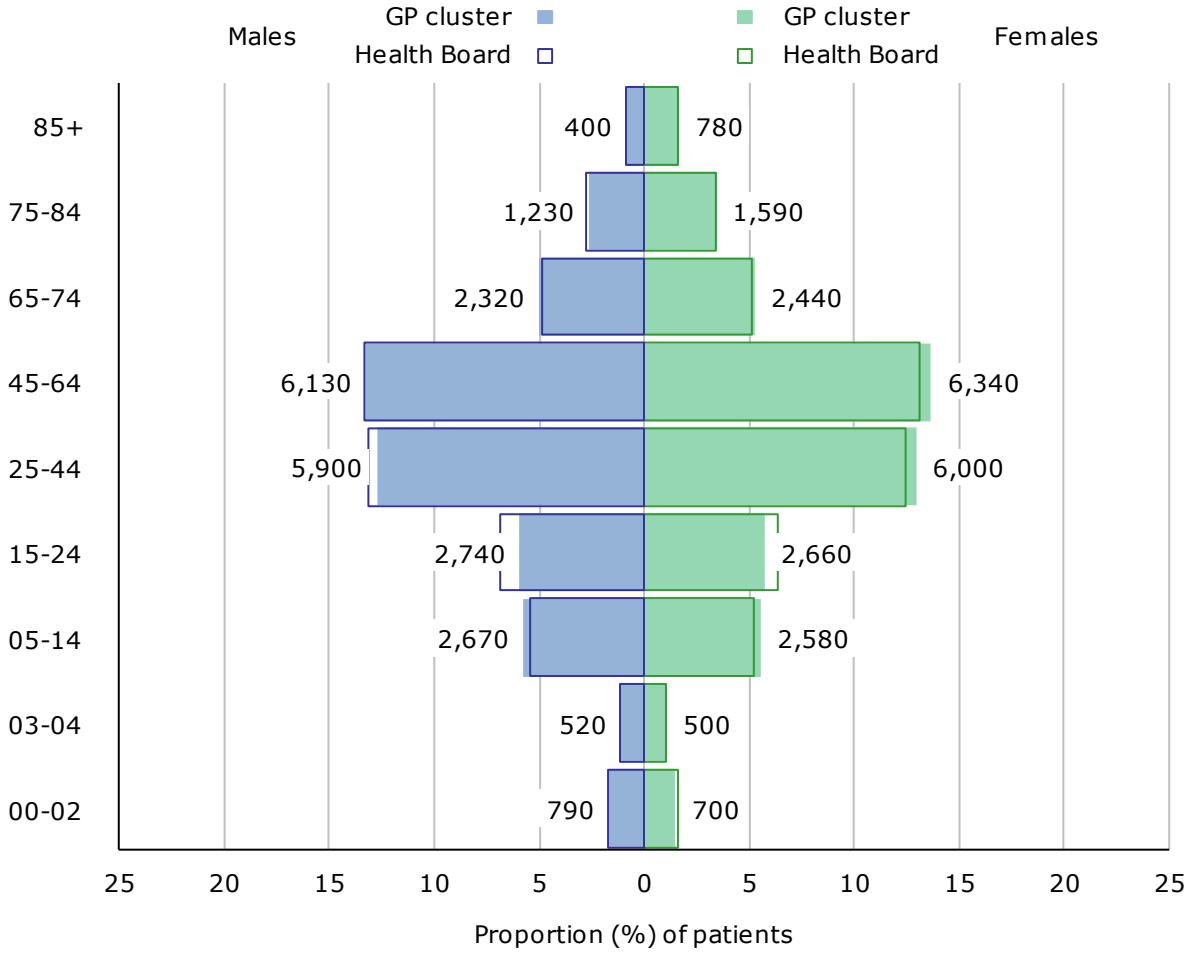
6.8 Llwchwr

Geographical 'reach' map

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

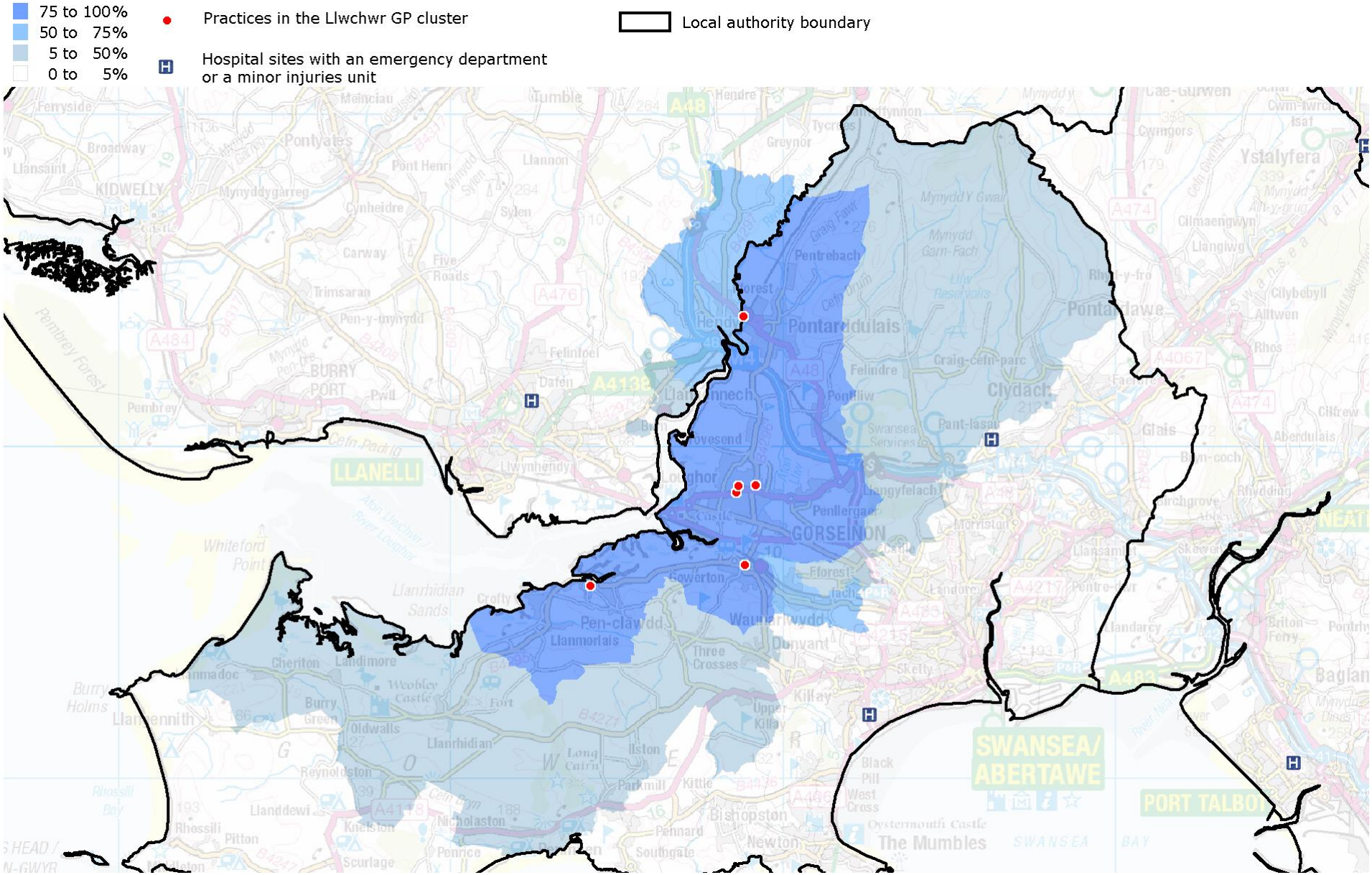
Age/sex breakdown of population

Figure 41: Percentage of patients by age and sex (with actual GP cluster counts shown next to bars), showing Llwchwr GP cluster and ABM UHB for comparison, 2012



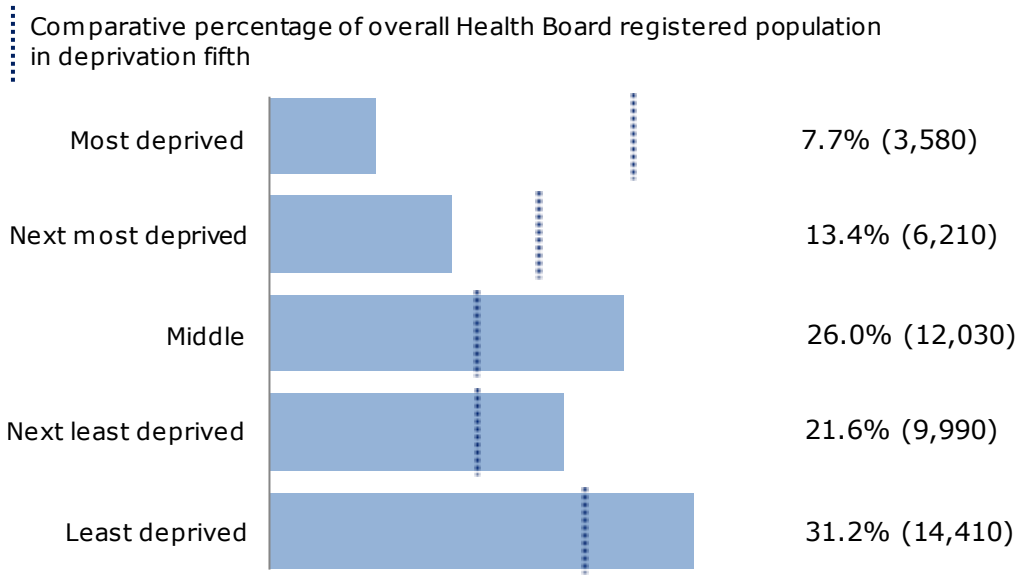
Produced by Public Health Wales Observatory, using WDS (NWIS)

Figure 42: Percentage of population registered with practices in the Llwchwr GP cluster, 2012



Deprivation

Figure 43: Percentage of patients (with count in brackets) by deprivation fifth in Llwchwr GP cluster, showing ABM UHB for comparison, 2012



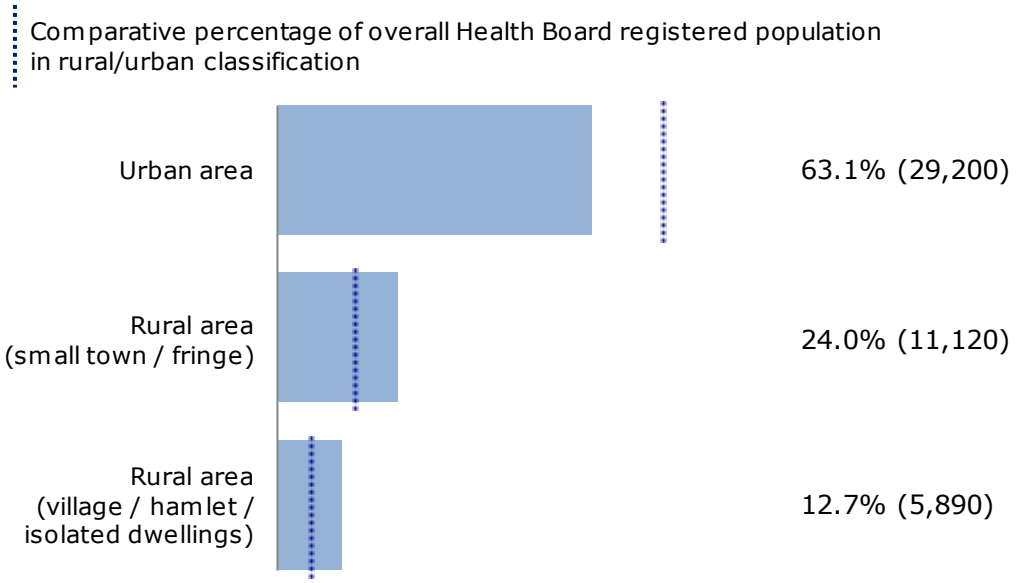
Produced by Public Health Wales Observatory, using WDS (NWIS), WIMD (WG)

N.B. Chart omits 40 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 Llwchwr GP cluster, showing ABM UHB for comparison, 2012



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

N.B. Chart omits 40 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 Llwchwr GP cluster

Time band (Minutes)	Number registered	Percentage
Less than 5	19,850	42.9
5 or more, less than 10	20,720	44.8
10 or more, less than 15	4,660	10.1
15 and over	990	2.1
*Unmatched postcode	40	0.1
Total†	**46,250**	

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

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

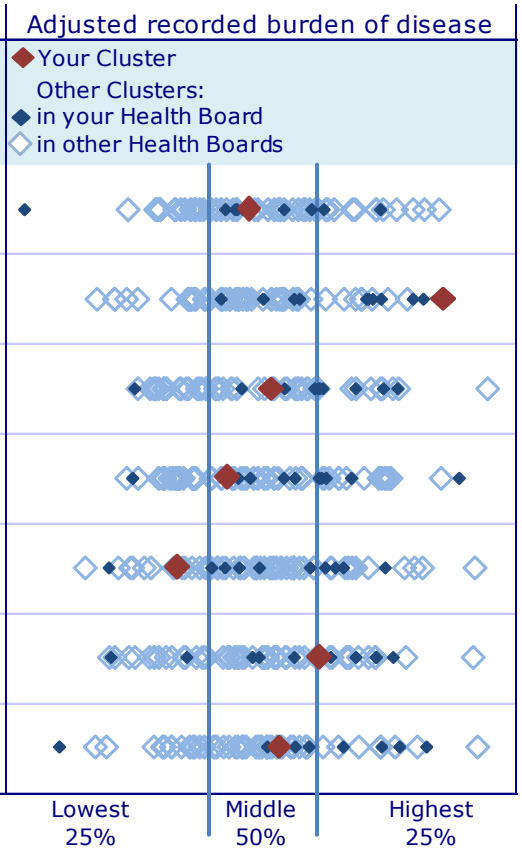
†Total does not include counts of <5, totals may not match due to rounding

Chronic condition registers

Within this cluster data is missing for one practice with a list size of 8,700‡.

Figure 45: Recorded and adjusted recorded burden of disease in Llwchwr GP cluster, showing other GP clusters in ABM UHB and Wales for comparison, 2012

Indicator	Recorded burden of disease: Your Cluster: count	Your Cluster: %	Other Clusters in your Health Board: min %	Other Clusters in your Health Board: max %	Health Board %	Wales %
Hypertension	5,800	15.5	12.4	17.7	15.0	15.3
Asthma	3,030	8.1	6.4	8.1	7.2	6.7
Diabetes	2,060	5.5	4.2	6.7	5.6	5.2
CHD	1,480	4.0	3.5	5.3	4.2	4.0
COPD	590	1.6	1.4	3.0	2.1	2.1
Epilepsy	310	0.8	0.5	0.9	0.8	0.7
Heart Failure	360	1.0	0.7	1.7	1.0	0.9



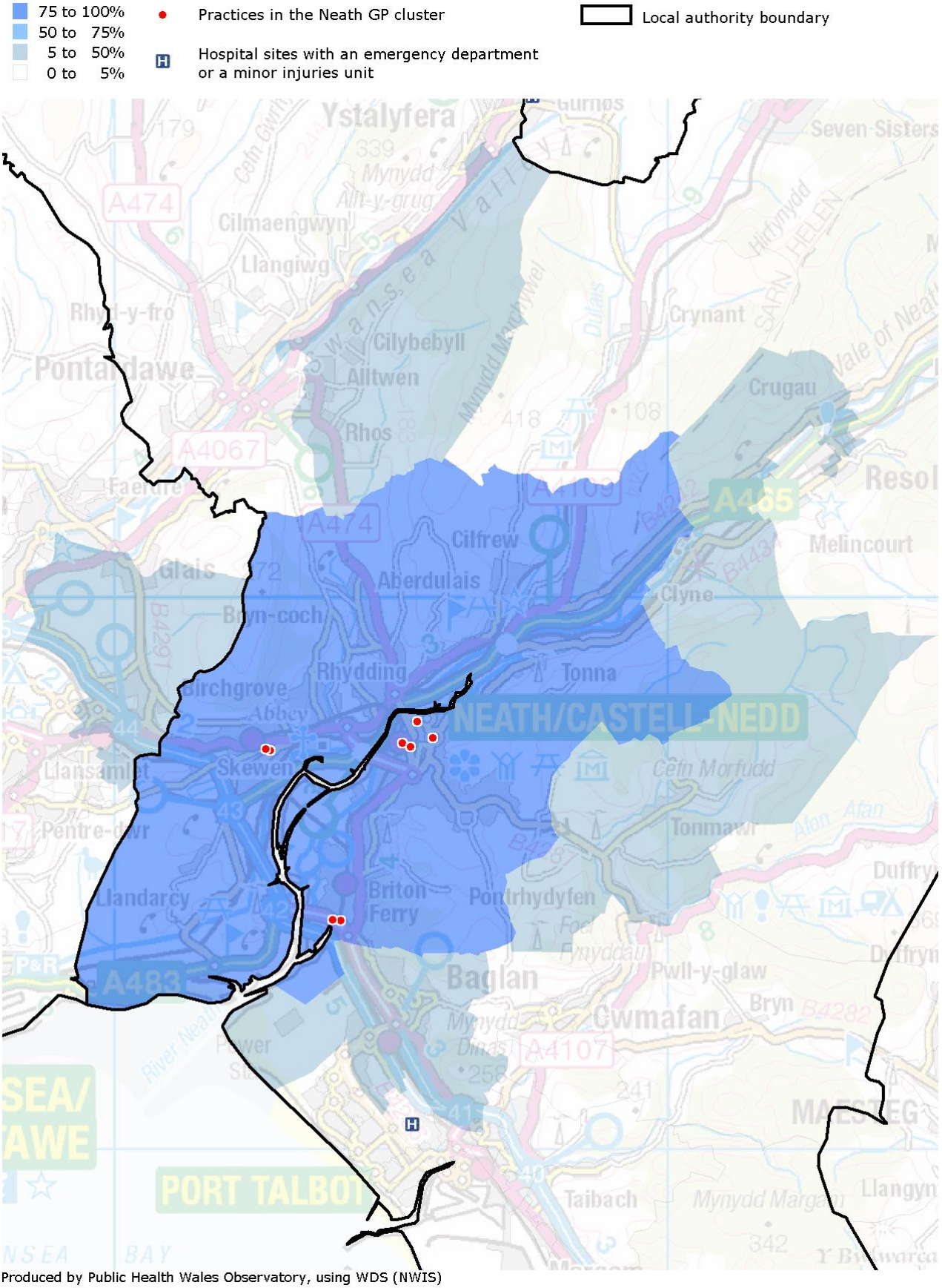
Produced by Public Health Wales Observatory, using Audit+ (NWIS)

‡ Rounded to nearest 100 for ease of reading

6.9 Neath

Geographical 'reach' map

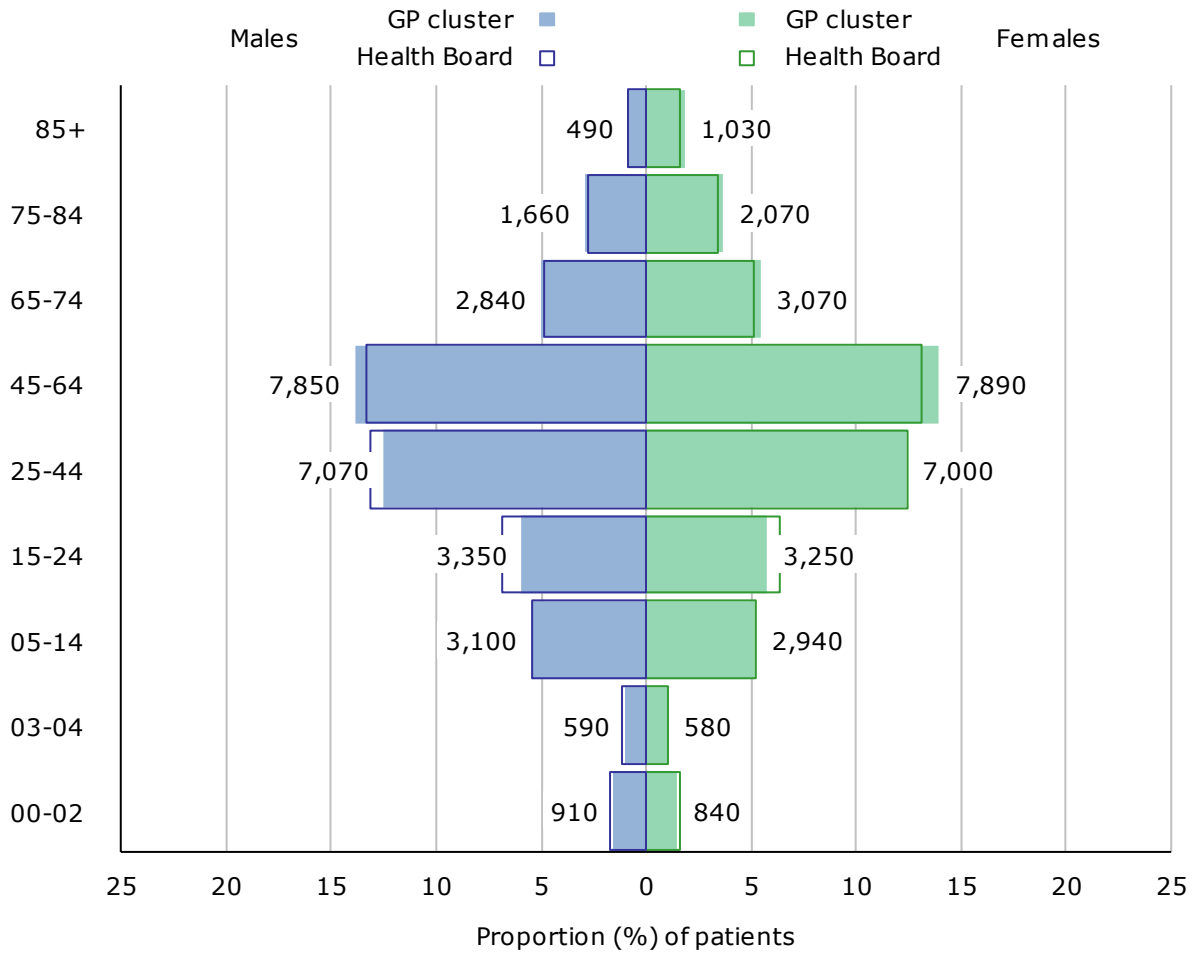
Figure 46: Percentage of population registered with practices in the Neath GP cluster, 2012



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

Age/sex breakdown of population

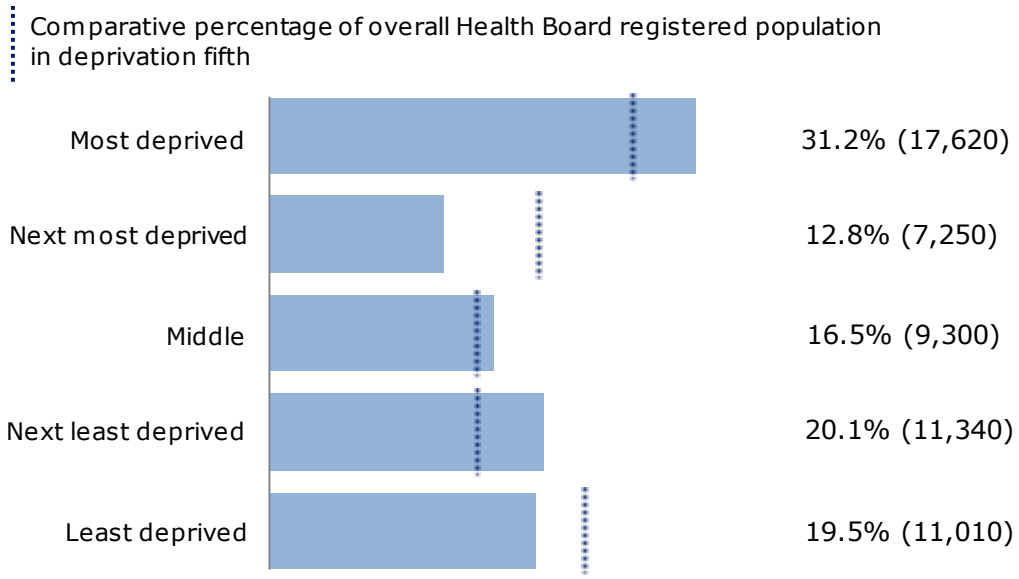
Figure 47: Percentage of patients by age and sex (with actual GP cluster counts shown next to bars), showing Neath GP cluster and ABM UHB for comparison, 2012



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

Deprivation

Figure 48: Percentage of patients (with count in brackets) by deprivation fifth in Neath GP cluster, showing ABM UHB for comparison, 2012



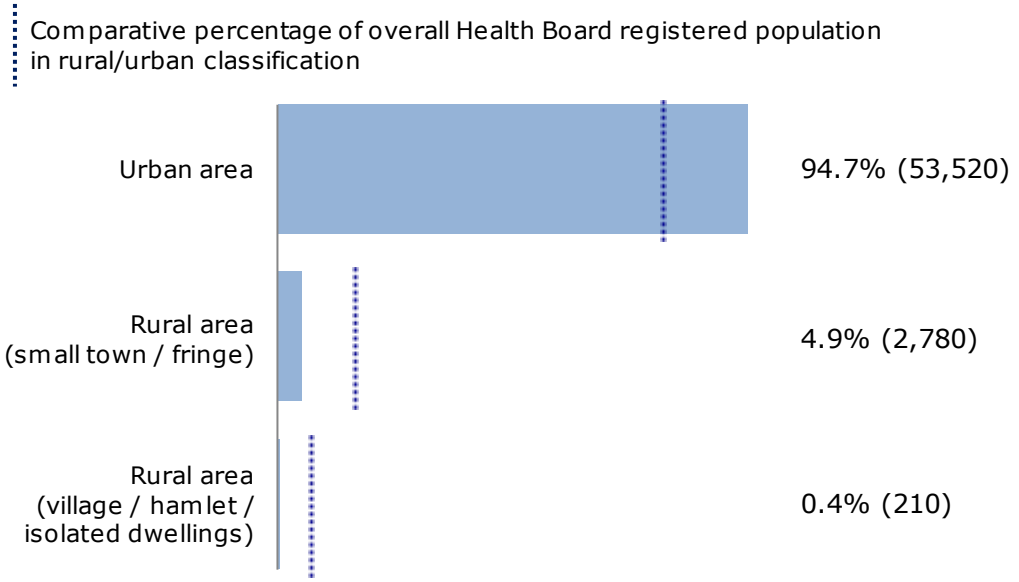
Produced by Public Health Wales Observatory, using WDS (NWIS), WIMD (WG)

N.B. Chart omits <5 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 49: Percentage of patients (with count in brackets) by rural/urban classification in Neath GP cluster, showing ABM UHB for comparison, 2012



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

N.B. Chart omits <5 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 13: Modelled percentage of patients living within specified driving times to their registered main practice in Neath GP cluster

Time band (Minutes)	Number registered	Percentage
Less than 5	14,240	25.2
5 or more, less than 10	29,920	52.9
10 or more, less than 15	9,680	17.1
15 and over	2,660	4.7
*Unmatched postcode	<5	-
Total†	**56,510**	

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

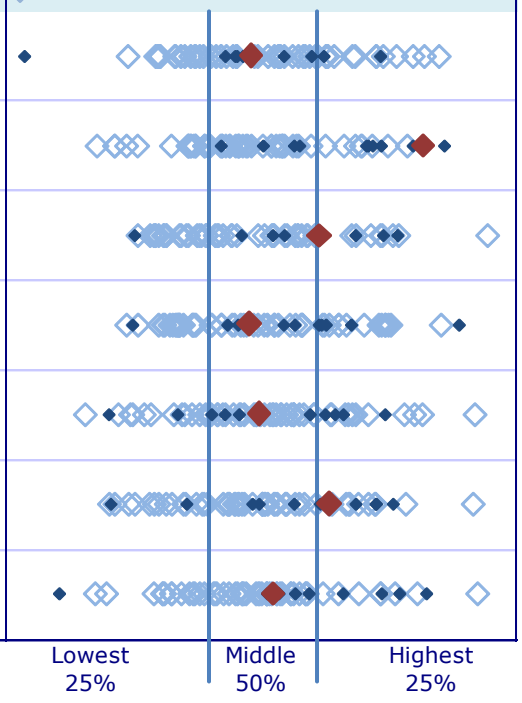
*Postcode could not be matched to an area of residence and therefore could not be classified or drivetime was not available

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

Chronic condition registers

Figure 50: Recorded and adjusted recorded burden of disease in Neath GP cluster, showing other GP clusters in ABM UHB and Wales for comparison, 2012

Indicator	Recorded burden of disease						Adjusted recorded burden of disease
	Your Cluster:		Other Clusters in your Health Board:		Health Board	Wales	◆ Your Cluster Other Clusters: ◆ in your Health Board ◇ in other Health Boards
	count	%	min %	max %	%	%	
Hypertension	9,020	15.9	12.4	17.7	15.0	15.3	
Asthma	4,470	7.9	6.4	8.1	7.2	6.7	
Diabetes	3,520	6.2	4.2	6.7	5.6	5.2	
CHD	2,420	4.3	3.5	5.3	4.2	4.0	
COPD	1,230	2.2	1.4	3.0	2.1	2.1	
Epilepsy	480	0.8	0.5	0.9	0.8	0.7	
Heart Failure	560	1.0	0.7	1.7	1.0	0.9	

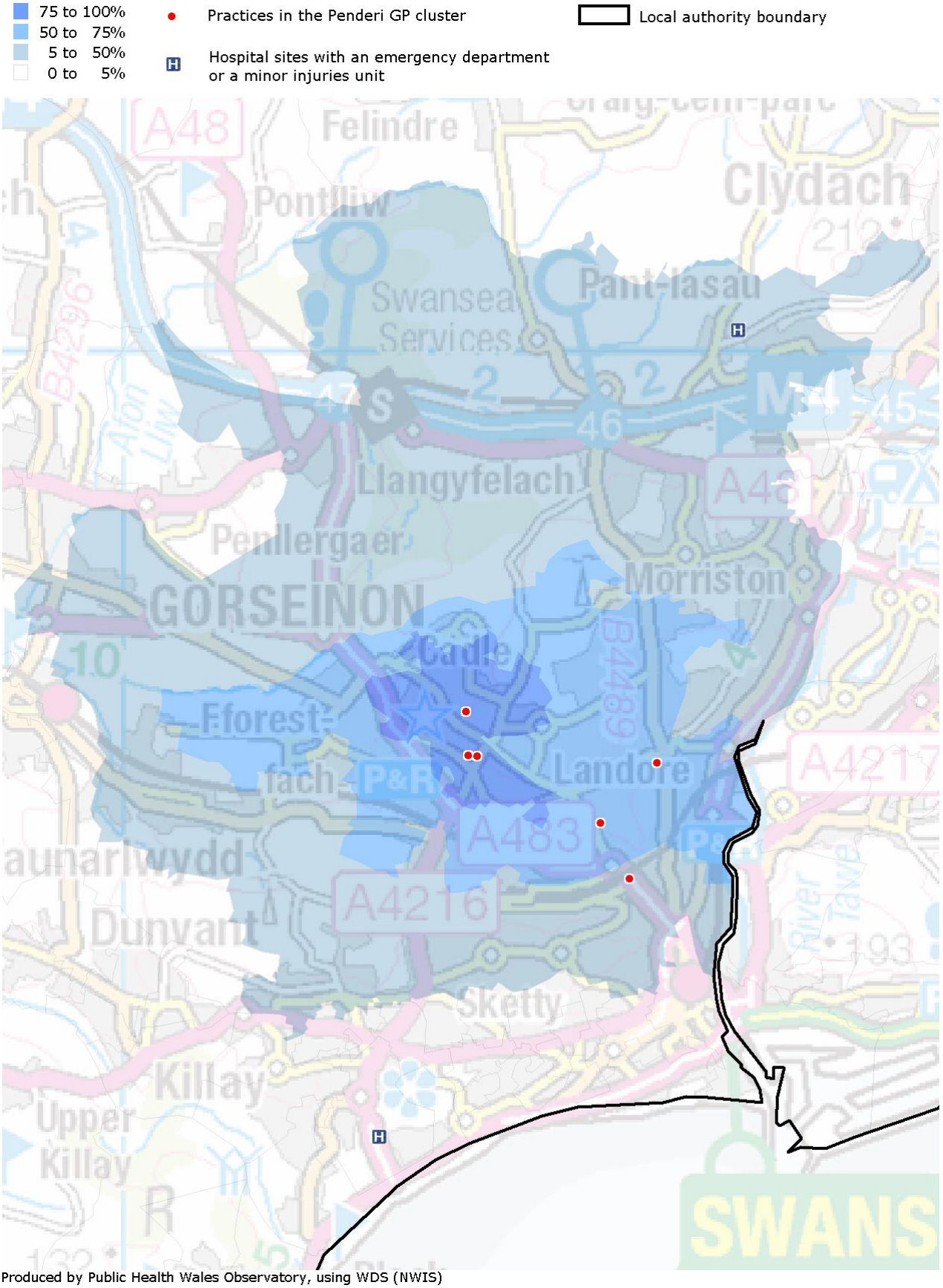


Produced by Public Health Wales Observatory, using Audit+ (NWIS)

6.10 Penderi

Geographical 'reach' map

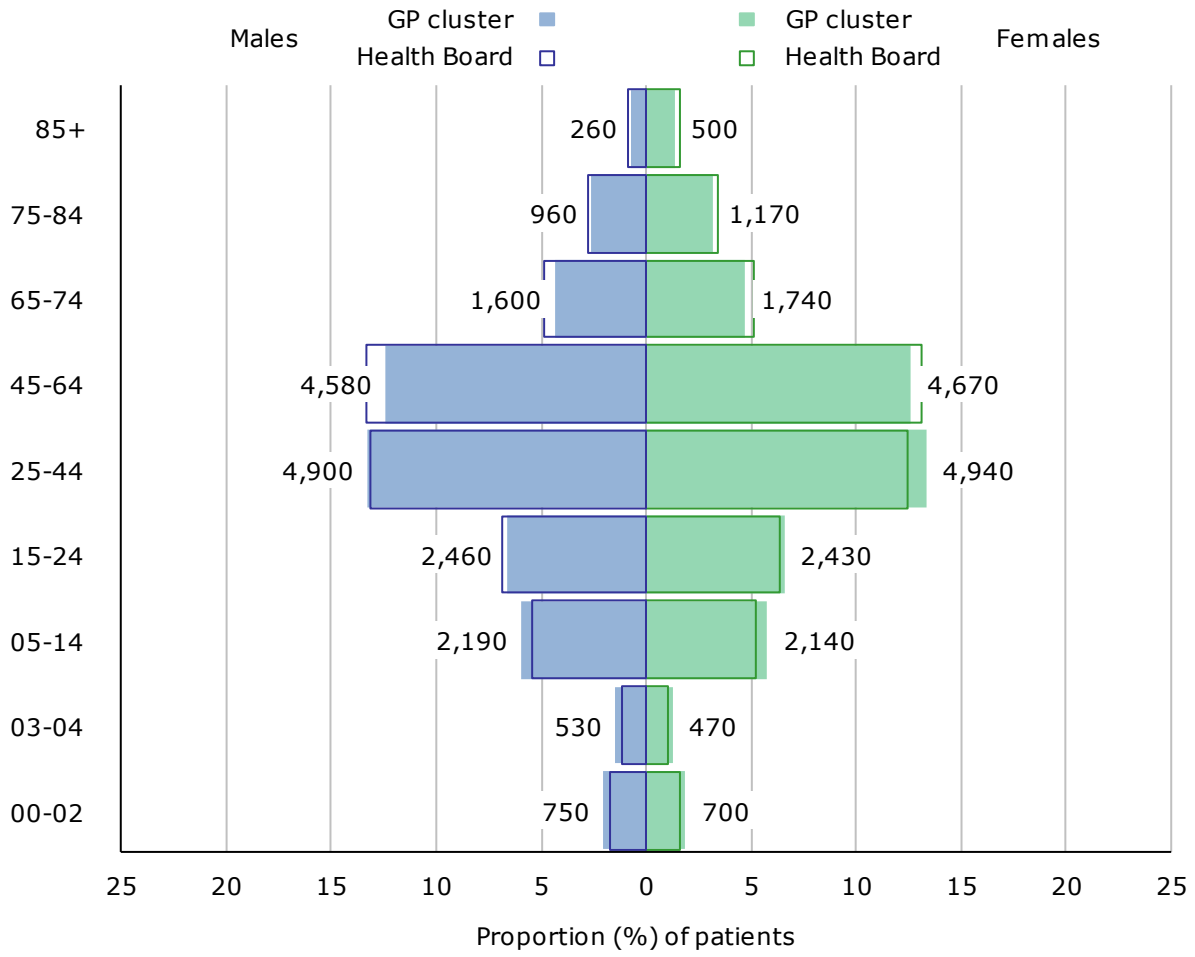
Figure 51: Percentage of population registered with practices in the Penderi GP cluster, 2012



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

Age/sex breakdown of population

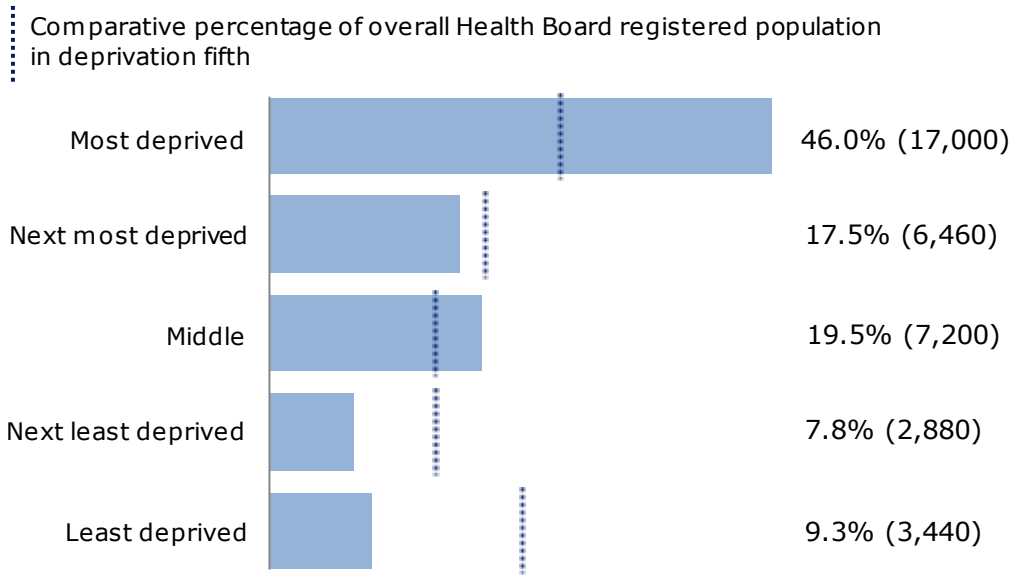
Figure 52: Percentage of patients by age and sex (with actual GP cluster counts shown next to bars), showing Penderi GP cluster and ABM UHB for comparison, 2012



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

Deprivation

Figure 53: Percentage of patients (with count in brackets) by deprivation fifth in Penderi GP cluster, showing ABM UHB for comparison, 2012



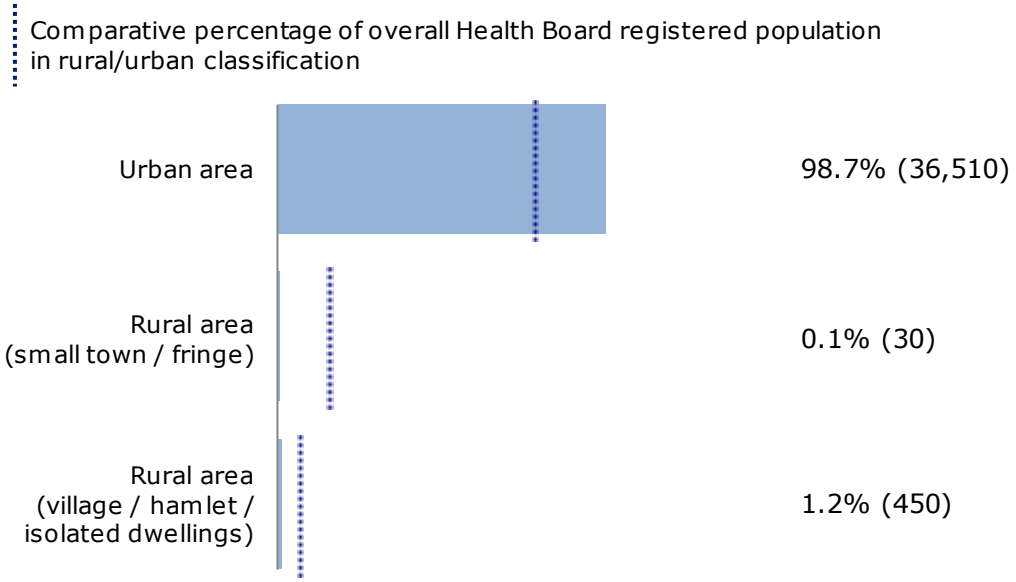
Produced by Public Health Wales Observatory, using WDS (NWIS), WIMD (WG)

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 54: Percentage of patients (with count in brackets) by rural/urban classification in Penderi GP cluster, showing ABM UHB for comparison, 2012



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

N.B. Chart omits 10 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 14: Modelled percentage of patients living within specified driving times to their registered main practice in Penderi GP cluster

Time band (Minutes)	Number registered	Percentage
Less than 5	10,450	28.3
5 or more, less than 10	17,680	47.8
10 or more, less than 15	7,590	20.5
15 and over	1,260	3.4
*Unmatched postcode	10	0.0
Total†	**36,990**	

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

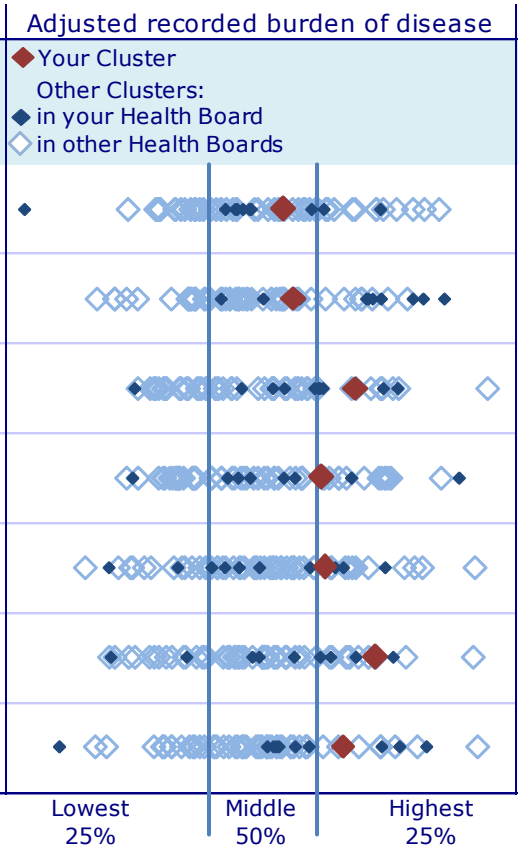
*Postcode could not be matched to an area of residence and therefore could not be classified or drivetime was not available

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

Chronic condition registers

Figure 55: Recorded and adjusted recorded burden of disease in Penderi GP cluster, showing other GP clusters in ABM UHB and Wales for comparison, 2012

Indicator	Recorded burden of disease: Your Cluster: count	Your Cluster: %	Other Clusters in your Health Board: min %	Other Clusters in your Health Board: max %	Health Board %	Wales %
Hypertension	5,380	14.2	12.4	17.7	15.0	15.3
Asthma	2,570	6.8	6.4	8.1	7.2	6.7
Diabetes	2,150	5.7	4.2	6.7	5.6	5.2
CHD	1,530	4.0	3.5	5.3	4.2	4.0
COPD	850	2.3	1.4	3.0	2.1	2.1
Epilepsy	330	0.9	0.5	0.9	0.8	0.7
Heart Failure	380	1.0	0.7	1.7	1.0	0.9



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

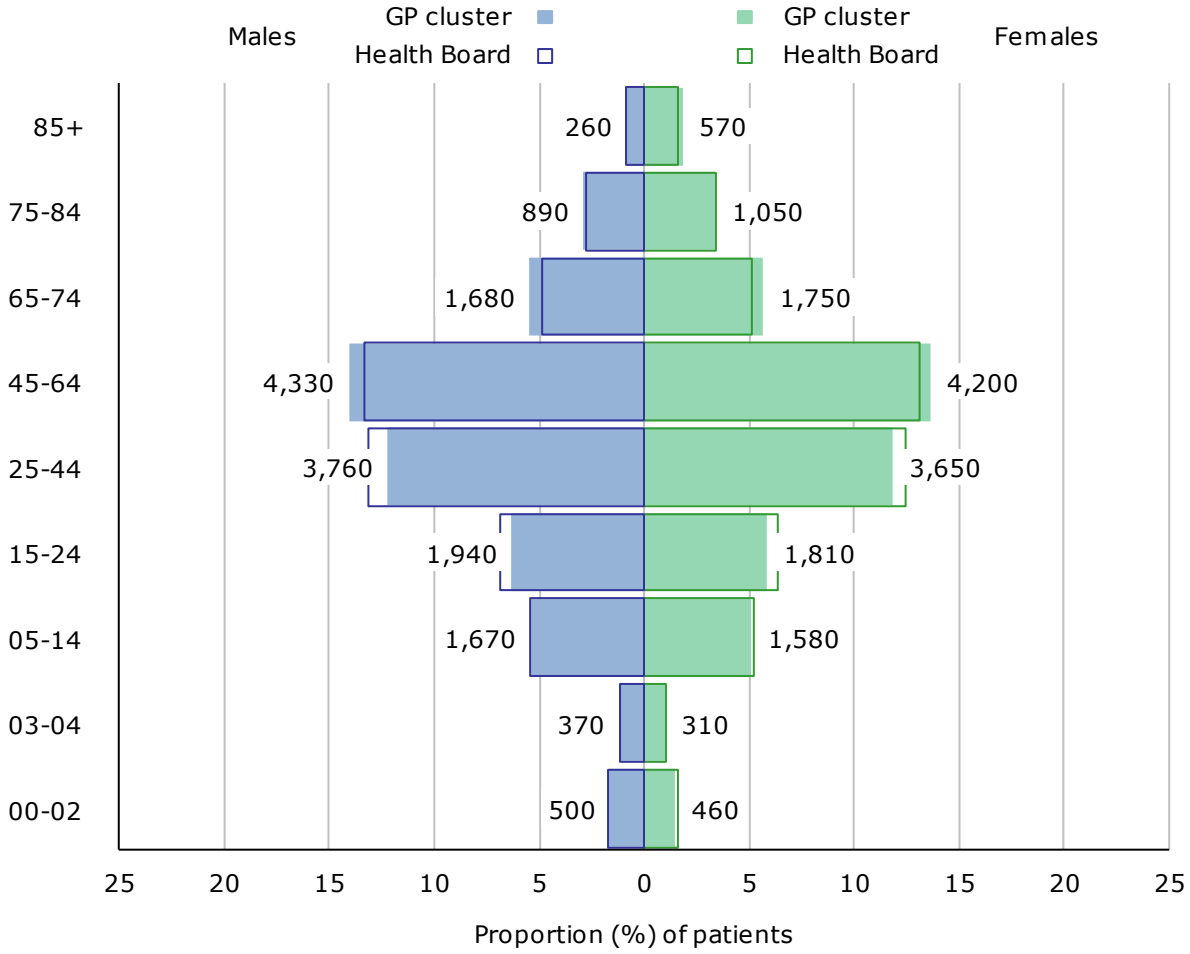
6.11 Upper Valleys

Geographical 'reach' map

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

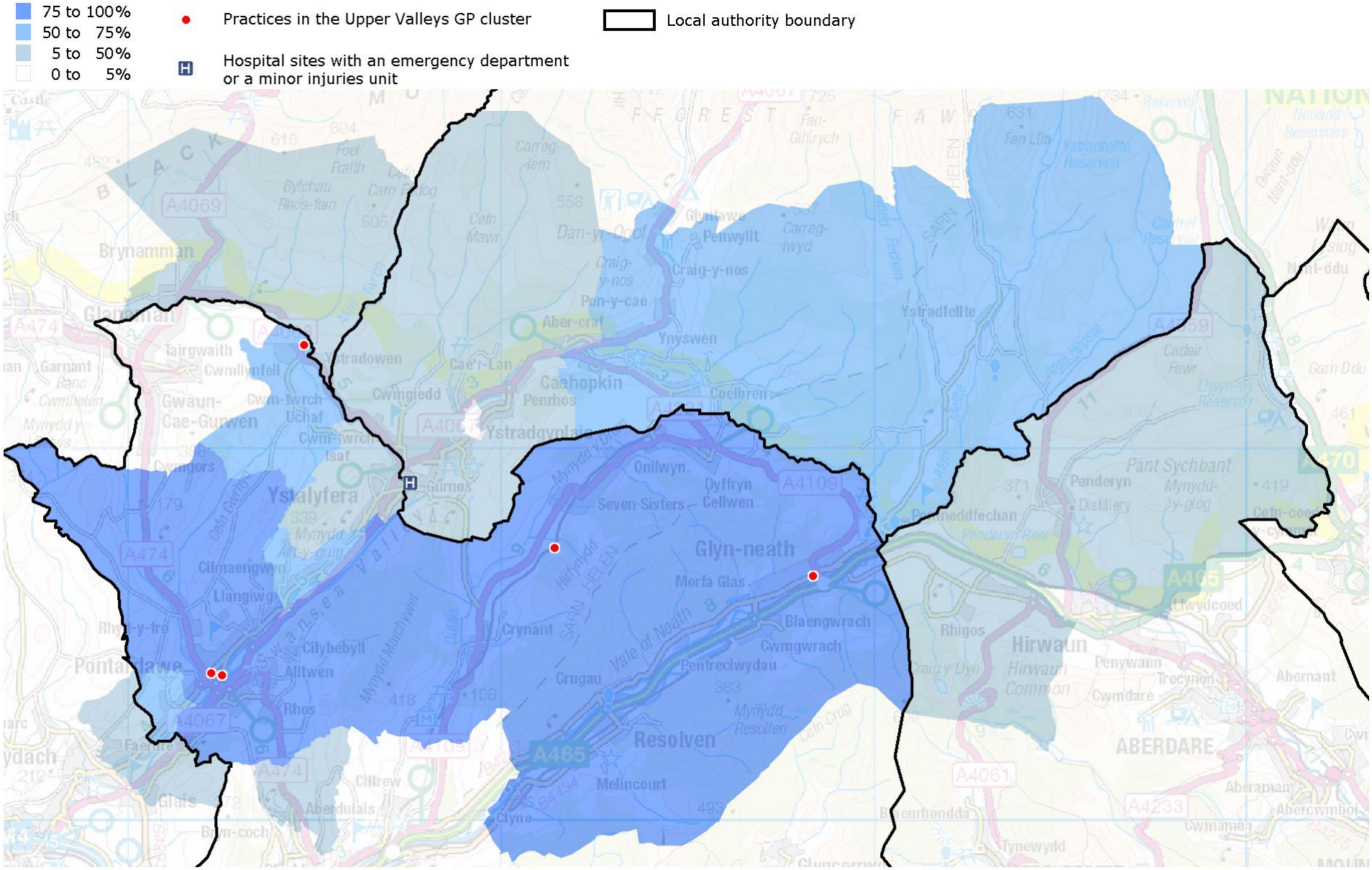
Age/sex breakdown of population

Figure 56: Percentage of patients by age and sex (with actual GP cluster counts shown next to bars), showing Upper Valleys GP cluster and ABM UHB for comparison, 2012



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

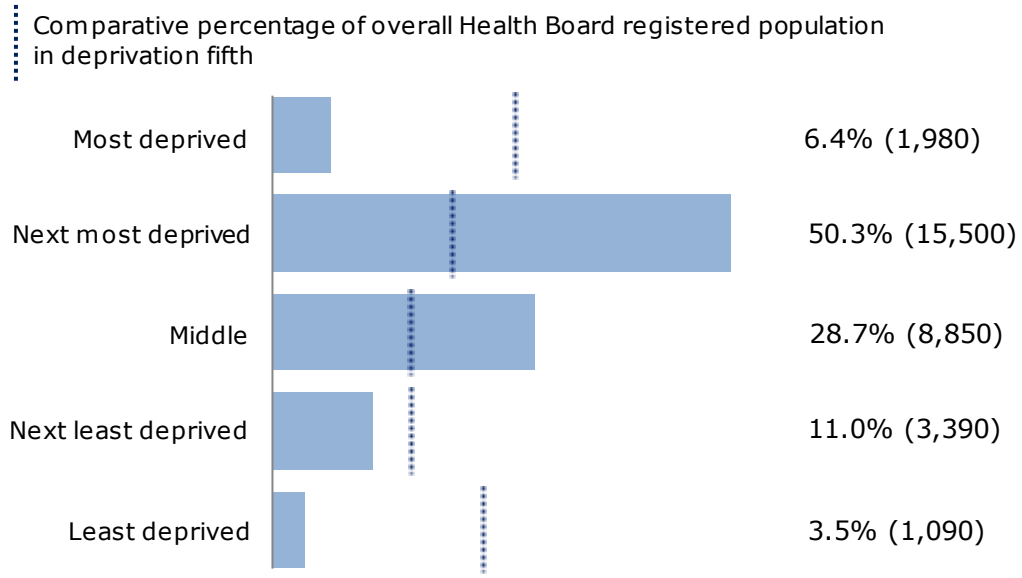
Figure 57: Percentage of population registered with practices in the Upper Valleys GP cluster, 2012



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

Deprivation

Figure 58: Percentage of patients (with count in brackets) by deprivation fifth in Upper Valleys GP cluster, showing ABM UHB for comparison, 2012

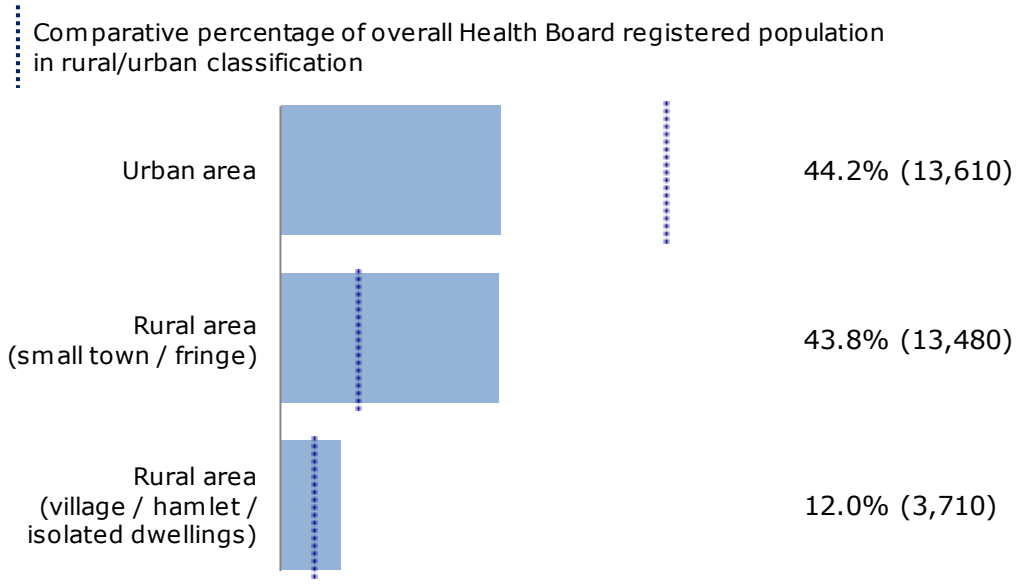


Produced by Public Health Wales Observatory, using WDS (NWIS), WIMD (WG)

Rurality

i) Office for National Statistics rural/urban classification

Figure 59: Percentage of patients (with count in brackets) by rural/urban classification in Upper Valleys GP cluster, showing ABM UHB 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 15: Modelled percentage of patients living within specified driving times to their registered main practice in Upper Valleys GP cluster

Time band (Minutes)	Number registered	Percentage
Less than 5	7,100	23.0
5 or more, less than 10	16,630	54.0
10 or more, less than 15	6,150	20.0
15 and over	930	3.0
*Unmatched postcode	-	-
Total†	**30,800**	

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

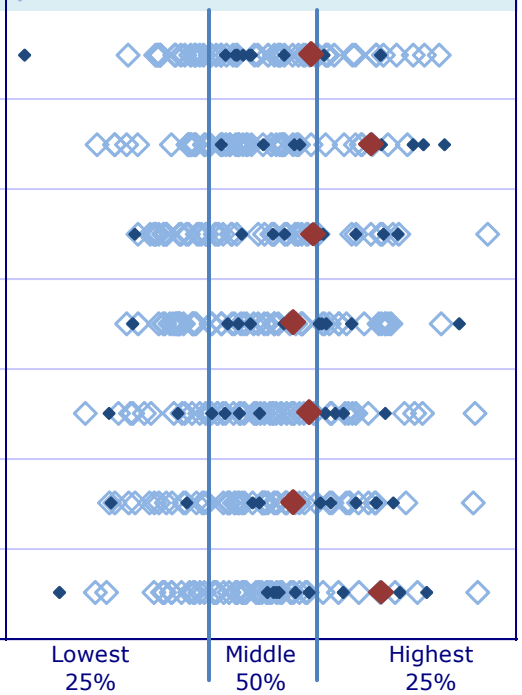
*Postcode could not be matched to an area of residence and therefore could not be classified or drivetime was not available

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

Chronic condition registers

Figure 60: Recorded and adjusted recorded burden of disease in Upper Valleys GP cluster, showing other GP clusters in ABM UHB and Wales for comparison, 2012

Indicator	Recorded burden of disease						Adjusted recorded burden of disease
	Your Cluster:		Other Clusters in your Health Board:		Health Board	Wales	◆ Your Cluster Other Clusters: ◆ in your Health Board ◇ in other Health Boards
	count	%	min %	max %	%	%	
Hypertension	5,460	17.7	12.4	17.7	15.0	15.3	
Asthma	2,360	7.7	6.4	8.1	7.2	6.7	
Diabetes	1,940	6.3	4.2	6.7	5.6	5.2	
CHD	1,440	4.7	3.5	5.3	4.2	4.0	
COPD	820	2.6	1.4	3.0	2.1	2.1	
Epilepsy	240	0.8	0.5	0.9	0.8	0.7	
Heart Failure	400	1.3	0.7	1.7	1.0	0.9	



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

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