GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

State of the Population Report

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Chapter 1: Background

This section outlines some of the core concepts around how the Health Board is, and aims to, approach the design and delivery of our clinical services to meet the needs of our population. It sets out areas of priority and focus, which can be used alongside the supporting information in this report to help clinical services approach planning going forwards.

'A better future for all' - Swansea Bay University Health Board's Population Health Strategy

As part of Swansea Bay University Health Board's (SBUHB's) responsibilities as a population health organisation, the Population Health Strategy 'A better future for All' was approved by Board in March 2023 and sets out the evidence base and overall approach by which the Health Board and its partners will seek to improve the overall health and wellbeing of the local population whilst reducing the gap between our least and most deprived communities. It is based on the Marmot principles and five World Health Organisation (WHO) policy areas as a framework to organise our response to poor health and inequalities in our population (see Figure 1). This Strategy is integrated into SBUHB's Organisational Strategy, with Marmot objectives directly mapping on to Strategic Objective 1: *People of Swansea Bay live healthier, fairer and more prosperous lives*. The actions within it are supported by the Welsh Government's legislative and policy environment, the Future Generations Office, and local partnership efforts. The focus is on prevention and tackling the 'causes of the causes' of ill-health, requiring whole system, multisectoral action and provides an enabling framework to act as a bridge between the evidence base and practical action.

Figure 1: The six Marmot Policy Objectives

Core20Plus5 approach

A key way in which we are focusing our efforts in relation to the health and care system is the Core20plus5 model for targeting action to reduce inequalities. Core20plus5 is an example of an approach to inform priority action to reduce healthcare inequalities at both national and local levels. It aligns closely with Marmot Policy Objective 6 – to strengthen the role and impact of ill-health prevention. The approach includes both adult and child versions and incorporates three aspects: (1) The most deprived 20% of the population (CORE 20); Priority population groups with greater health needs (PLUS); (3) Top five health conditions affecting the population group as a whole (5- FIVE), which in adults include cardiovascular disease, respiratory disease and cancer with smoking as an overarching risk factor across the clinical priority groups, and for children includes asthma, diabetes and epilepsy.

Figure 2: The Core20Plus5 approach

Core20Plus5 in SBUHB

Early cancer diagnosis is a key clinical area of health inequalities. As part of this focused area of work we are investigating differential cancer rates and survival across our population. We have an ongoing commitment to reducing inequities in cancer screening and are working collaboratively with key partners, including the Public Health Wales (PHW) Screening Engagement Team to develop a targeted plan that addresses local inequities in screening participation. We are also engaging to optimise the timeliness and accessibility of screening data. This will enable us to better target interventions and evaluate their impact, ensuring that our efforts are both responsive and evidence-informed.

Another key area of healthcare inequalities is hypertension and cardiovascular disease (CVD). As recent analysis of premature mortality from CVD has shown (detailed later in the report), this is a real area of concern in the SBUHB population. SBUHB has more people dying early from CVD compared to other areas and numbers are increasing. The causes for CVD are multi-factorial and multiple approaches are needed, including early identification of risk factors and management; optimising the management of comorbidities; enabling healthy lifestyle choices; cross-partnership working on the wider determinants of health; and take a 'community by design' approach. There are pilots underway locally and new strategic approaches being developed, alongside support for services that address wider risk factors such as weight management and smoking cessation.

Chronic respiratory disease is an important area in reducing healthcare inequalities in our population. Uptake of vaccination, including against flu and COVID, is central to this. The first SBUHB Annual Health Protection Plan has been approved and sets out how partnership arrangements are now in place to deliver a sustainable, integrated health protection function and strengthen resilience in the system. The partnership response developed during the pandemic is continuing with a focus on increasing uptake and reducing inequity of vaccination

offer and uptake, including through the work of the Vaccine Equity Group. Mental health and wellbeing is another key area that we will be working on over the next few months and a fuller report on mental health and wellbeing needs in SBUHB will be released at a future point.

Smoking cessation is one of the priority areas for SBUHB. As an overarching key approach in the Core20Plus5 evidence-based framework for reducing healthcare inequalities, and a core public health intervention. Integrated 'Help Me Quit' (HMQ) smoking cessation services are supporting people in the community to access stop smoking support in a variety of methods including face to face, online, or telephone. Help Me Quit in Hospital and Maternal Smoking Cessation 'Help Me Quit for Baby' programmes are also operational in the Health Board, though ongoing funding is uncertain. Our current focus is on highlighting the importance of smoking cessation services and raising awareness of the need to ensure sustainability of our services, attempting to address funding uncertainty and staff retention.

Another core public health focus is a whole systems approach to healthy weight. Working across the five PSBs in the region a collective agreement has been reached to focus on access to food (availability and affordability) as a collaborative priority for system-wide action. A vision of 'a sustainable and resilient food system and nutritious food for all' will guide the regional systems approach moving forward. In addition, SBUHB has a range of weight management services available for both adults and children and young people. However, there are challenges around the limited capacity of the Level 2 weight management services compared to demand and unlike other Health Boards in Wales, SBUHB does not have a substantively funded Level 3 service, with a limited digital offer funded through Welsh Government grant funding. There is work happening across the Health Board on developing the Adult Weight Management Pathway but the lack of substantive funding identified for its development is an ongoing cause for concern.

Community by Design (Delivering Integrated Care)

The 'Community by Design' approach will "support the transformation of delivery of care through fully integrated systems thinking", Whilst developed by the Strategic Programme for Primary Care, it is an approach for all clinical services across secondary, community, and primary care to work together to identify opportunities where services may be delivered in a different way to best meet the needs of our population, ensure health/clinical pathways optimise resources for the best outcomes and experience for service users, and prioritise hospital-based care for complex or escalating need.

The vision around accelerating progress with delivery of Integrated Health Services for and in our communities includes that: people and staff will be able to easily navigate care pathways, appointments are timely, delivered in the right setting and appropriate to the need of the patient, staff well-being is enhanced, and that prevention and use of data to inform services are embedded.

Equity and Health Impact Assessments

Changes to services for our population will need to consider the impact on different people, including those with protected characteristics and with different vulnerabilities. The Health Impact Assessment (Wales) Regulations 2025 aim to embed health equity at the heart of public decision making, and must be carried out by a public body when it proposes a decision o a strategic nature (Regulation 3). The impact assessments align with the wider Marmot objectives, SBUHB Population Health Strategy, and wider organisational and Welsh Government objectives to strengthen health equity across services, and will support clinical services in applying a population health lends to ensure that the services do not have any unintended consequences whilst meeting the needs of our people.

Duty of Quality

The Duty of Quality sets out standards for clinical services, outlining that any service should align with: Safe, Timely, Effective (evidence-based to deliver what is needed for our patients), Efficient (optimising productivity and cost-effectiveness), Equitable, and Person-centred.

How this report supports the Clinical Service Plans

Clinical service plans are key documents that set out healthcare organisation's priorities and strategic direction for clinical services. They define the profile of a health service over a set period, considering its capability and capacity at an organisational level and provide guidance for priorities and envisaged models of care. This resource aims to support the clinical services when developing these plans. It is part of a larger piece of work by SBUHB to develop a Clinical Strategic Plan which encompasses understanding the status of the local population, horizon scanning for the future, modelling of demand and capacity of services, and the development of strategic models of care. Alongside this resource we are developing a standardised process for clinical service planning including tools for service-led integrated health assessments.

Chapter 2: What we know about our population

Sources of information on the health needs of the population

A health need is assumed to exist when there is an effective and acceptable intervention for a health issue, or the potential for health gain - 'capacity to benefit'. This can be difficult to assess but is influenced by several factors including the epidemiology of the illness, the effectiveness of interventions, and the resources available to meet the various needs of the population. This

is different to demand, where people may feel that they have a 'need' and request a service, but in fact the service would not add any value. There is a balance between need, demand, and supply of clinical services. In clinical services planning, it is important to have a clear picture of true need, including where there is unmet need, as well as being aware of where services may be delivering some activity which isn't needed.

Needs Assessments are tools to help others understand the needs of populations and groups, with a particular focus on where there are gaps and unmet need. Needs Assessments are therefore an important source of data underpinning clinical service planning. They follow a systematic method of identifying the health and healthcare needs of a population to inform change. There are several health and care assessment and planning footprints in Wales for which needs assessments are carried out, many of which are required through legislation and are delivered through a range of different mechanisms and partners. These needs assessments (including health needs assessments, population needs assessments, and well-being assessments – see Box 1) help provide information on the health needs of the population of Swansea and NPT, relevant to clinical services.

Broadly, needs assessments are developed based on geographical areas, or specific services/sub-populations of interest.

Geographical based needs assessments:

- ARCH Health Needs Assessment (2023)
- Population Needs Assessment 2022-27 – West Glamorgan Regional Partnership
- Swansea Public Services Board Assessment of local wellbeing (2022)
- Neath Port Talbot Public Service Board Wellbeing Assessment (2022)

Service/sub-population based needs assessments:

- SBUHB Pharmaceutical Needs Assessment (2021)
- Swansea HMP Health Needs Assessment (2024)

Box 1: Definitions of types of needs assessments

Health needs assessment = a systematic method of identifying the health needs of a specified population, including the identification of unmet health needs, and prioritising, using evidence-based methodology and a partnership approach, the actions to address this unmet need equitably, including specifying how these actions will be monitored and evaluated.

Population Needs assessment = another systematic method of identifying the needs of a specific group of people but has a broader focus than a HNA, encompassing the overall well-being of a population, including health but also encompassing health, social, economic, cultural and environmental factors.

Joint Strategic Needs Assessments (England) = A type of systematic needs assessment of both the health and wellbeing needs of a local population. These are mandatory for local authorities and NHS trusts to collaboratively produce in England under the Health and Social Care Act 2012.

Wellbeing assessment = a systematic process used to understand the overall wellbeing needs of a specific population beyond the physical health. Focuses more on the social, economic, cultural and well-being of a population. Often a term used interchangeably with a population needs assessment however, population needs assessments haven more of a focus on needs with reference to health and social services, whereas wellbeing needs assessments focus more broadly on understanding the factors that contribute to the overall wellbeing of a population, beyond health and social services.

Key findings from recent Needs Assessments for the population of SBUHB

We undertook a review of needs assessments published for the SBUHB population over the last 10 years so that we could summarise the key findings across them and identify gaps in our understanding of the health needs of the local population. The approach used mixed methodology and involved reviewing local and national strategy and policy documents to identify key themes, priorities and emerging health challenges for our local population and services. Semi-structured interviews were also conducted with key individuals within SBUHB and external organisations involved in developing the HNAs, to gain additional information on potential health need knowledge gaps and clinical service priorities. By including a range of data and perspectives we were able to gain a more holistic understanding of the health needs of the SBUHB population.

Key findings included that SBUHB has a growing population and an increasingly diverse demographic landscape. The population continues to age, there is an increasing proportion of individuals from ethnic minority groups living in the area, an increasing population of Welsh speakers, and there remains a substantial student, children and young people presence. The

population of SBUHB is experiencing a reduced life expectancy compared to the Welsh average, coupled with a decreasing healthy life expectancy, particularly impacting women and those from lower socioeconomic backgrounds reflecting growing inequalities in health outcomes within the population.

The population of SBUHB has a higher diabetes death rate than the Wales average, and increasing rates of obesity, particularly among children, are a growing concern, with 8.2% of adults having a BMI of 35+ and 27.2% of children aged 4-5 being overweight or obese. CVD, especially in Neath Port Talbot, contribute significantly to premature mortality, with higher than Wales stroke and cardiovascular death rates. Respiratory disease deaths are also notably higher in Neath Port Talbot, despite higher prevalence of conditions like COPD and asthma in other regions. Furthermore, Neath Port Talbot has the highest admission rate for musculoskeletal conditions in the ARCH region. Cancer survival rates, particularly for colorectal cancer, are also below the Welsh average. Although data at a community level is sparse in published HNAs, mental health conditions are prevalent, with SBUHB having the highest prevalence rate in Wales.

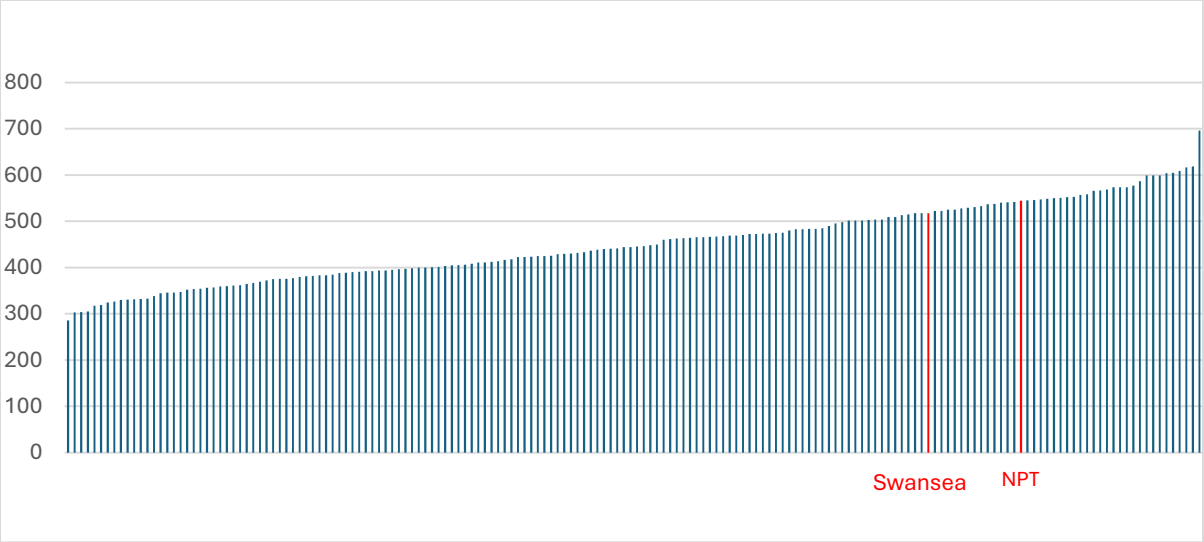
Health behaviours, such as smoking, alcohol consumption, and physical inactivity, contribute to these negative health outcomes, with significant differences observed across the socioeconomic gradient. Social determinants, including poverty, limited digital access among older adults, and housing conditions, further compound these issues. Inequalities in health outcomes are further exacerbated by the differences in health outcomes experienced by specific population groups whose health needs remain largely under-explored in published HNAs.

The full findings of our collation of information from HNAs in Swansea and NPT, relevant to planning healthcare services, can be found in Appendix A.

Premature and avoidable mortality for key chronic conditions in SBUHB

SBUHB has a significantly higher rate of preventable mortality than the Welsh average and premature mortality (from any cause) is also particularly high in Neath Port Talbot (NPT) compared to other Local Authorities (LAs) across England and Wales. It is in the highest 20% of LAs and compared to other LAs in Wales it is 4th highest. Recent analysis by the ONS shows that people in NPT are almost twice as likely to die prematurely compared to some regions in England.

Figure 3: All cause premature mortality rates across 172 Local Authorities in England and Wales, per 100,000 person-years at risk



For diseases of the circulatory system specifically, treatable mortality and preventable mortality in SBUHB are significantly higher than the Wales average. Broken down to LA level, Swansea in particular has significantly higher treatable mortality for diseases of the circulatory system than the Wales average. Both Swansea and NPT have significantly higher preventable mortality for diseases of the circulatory system than the Wales average. Avoidable mortality from diseases of the circulatory system has been increasing in SBUHB, and across Wales, since 2017/19 and is now significantly higher than it was.

Premature mortality from cardiovascular disease is also high in NPT, and particularly high in Swansea, compared to other LAs in England and Wales. NPT is in the highest 20% of LAs, while Swansea is in the highest 5% of LAs across England and Wales. Swansea is also in the highest 10% of LAs in Wales. People in NPT and Swansea were more than twice as likely to die prematurely due to CVD compared to some regions in England. Premature mortality rates from CVD are also increasing in SBUHB.

Figure 4: All cause premature mortality from CVD across 172 Local Authorities in England and Wales, per 100,000 person-years at risk

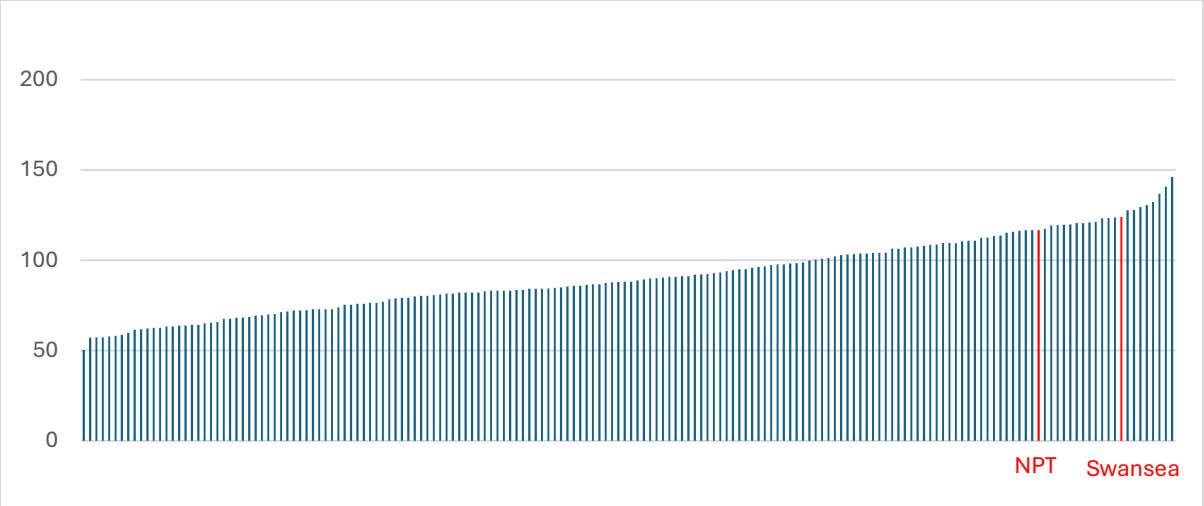
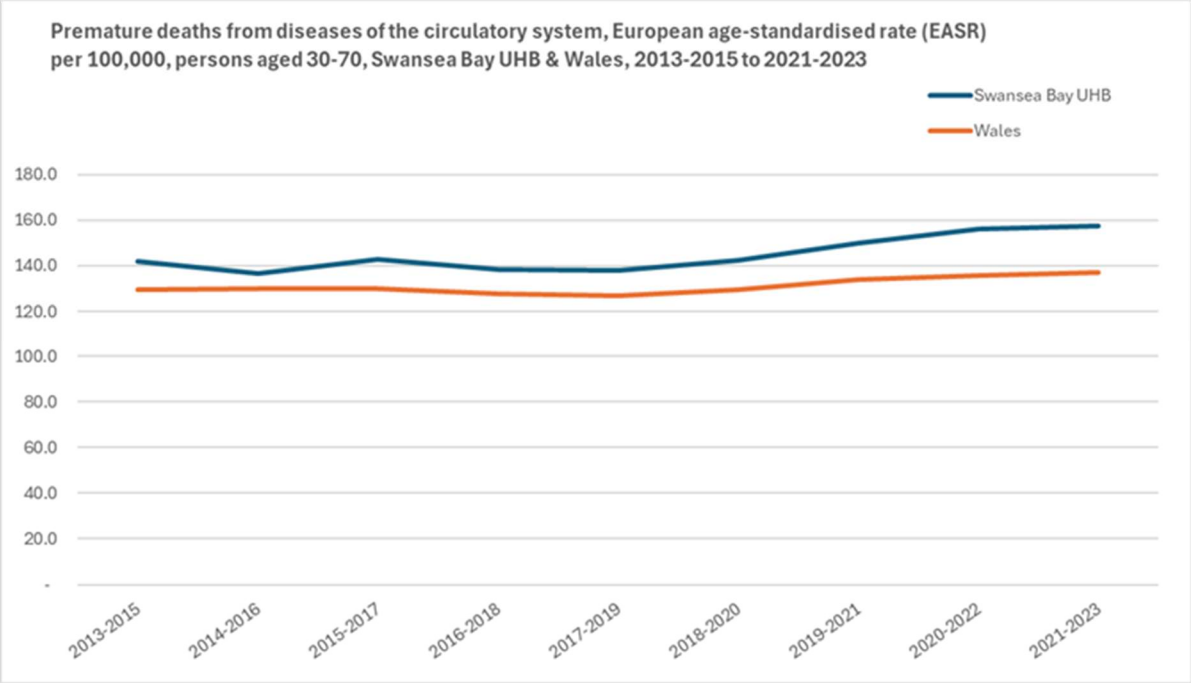


Figure 5: Premature mortality from CVD in SBUHB and Wales, per 100,000 persons



Box 2: Premature mortality versus preventable and treatable mortality

Premature mortality are deaths in adults that occur before someone reaches their 70th or 75th birthday (sources vary). These can be deaths from any cause or deaths from a particular condition such as cancer or diabetes.

Preventable mortality refers to deaths that can be avoided through effective public health and primary prevention interventions. Preventable mortality is a measure of how effective a primary preventative intervention is and the actions that are designed by the health sector to reduce the incidence of disease and injury. *Treatable mortality* refers to deaths that can be avoided through effective and timely healthcare interventions, including secondary prevention and treatment of disease. Preventable and treatable mortality are important measures in clinical service planning because they can suggest specific areas where preventative and treatment systems are falling short, allowing us to target improvement in our services.

Changes in the population structure

It is estimated that around 389,600 people live in SBUHB (based on 2023 data). Around 63% of the population live in Swansea LA and 37% in NPT. The average population density of the city and county of Swansea is 653 people per sq. km (2020 estimate), the fifth highest of the 22 LA areas in Wales (average: 153 people per Community Area: 13 sq. km). However, the population is not evenly distributed across the county, with most people living within the urban city area and the surrounding settlements to the north, including Morriston, Clydach, Gorseinon and Pontarddulais**.** These contrast with the sparsely populated rural areas of the Gower and northern Lliw area. Both Mawr and Gower wards have a population density of 32 people per sq. km, the lowest in the county. Within NPT (88%) individuals live in the urban areas within the county, even though 30.5% of the county has an urban environment.

Figure 6: Population density in SBUHB Local Cluster Collaboratives

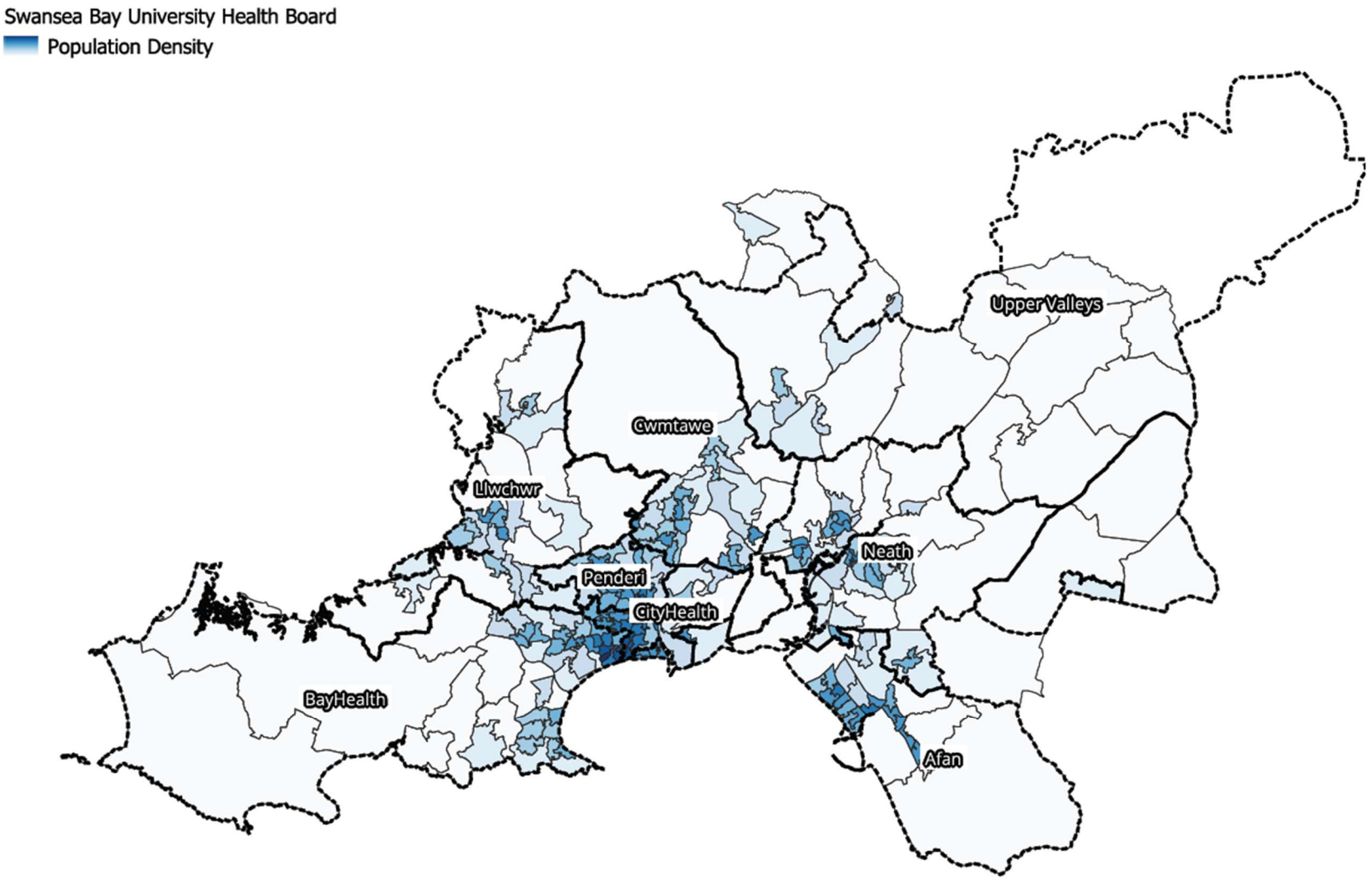


Figure 7: Distribution of rural and urban areas in SBUHB Local Cluster Collaboratives

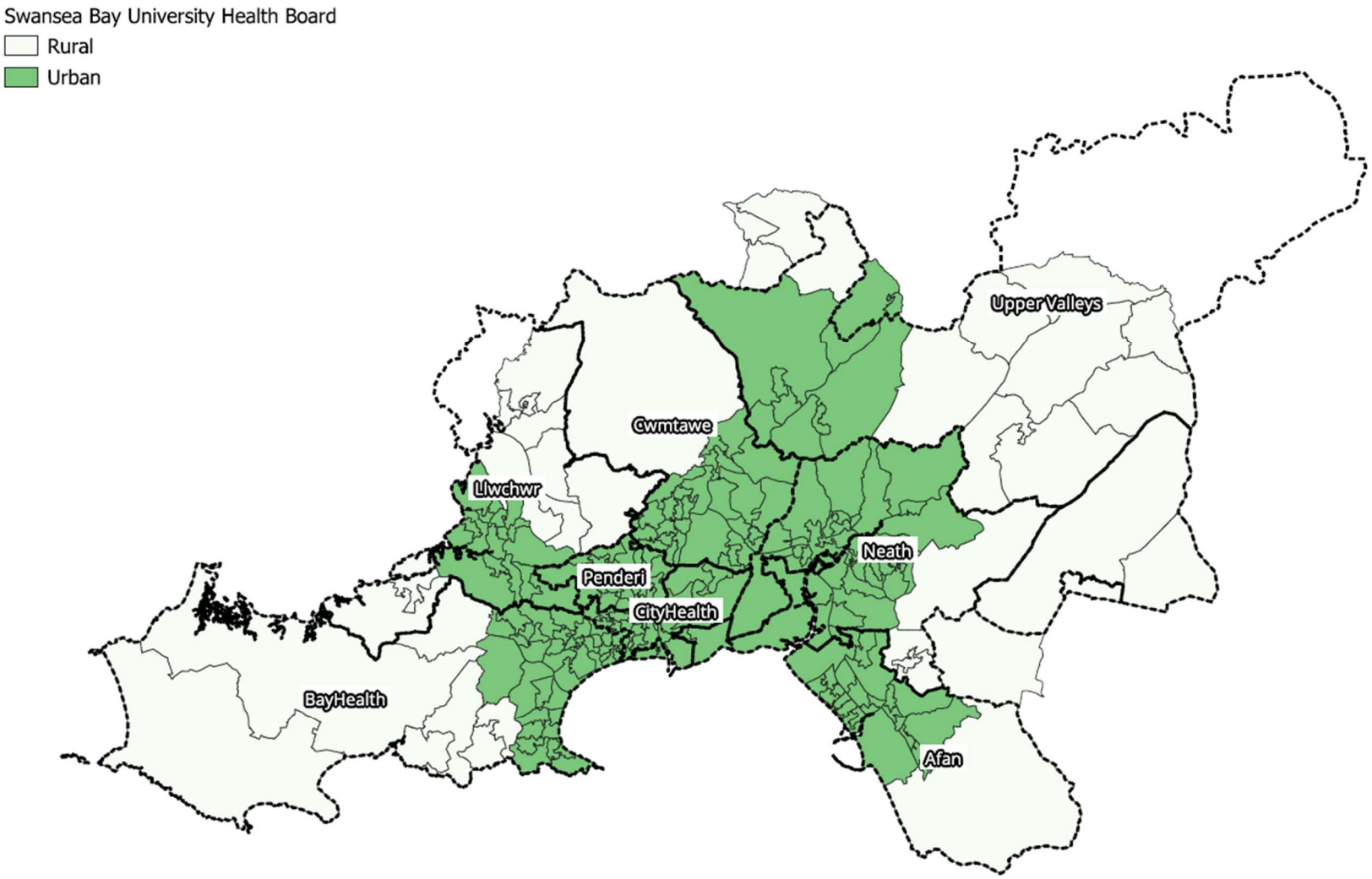
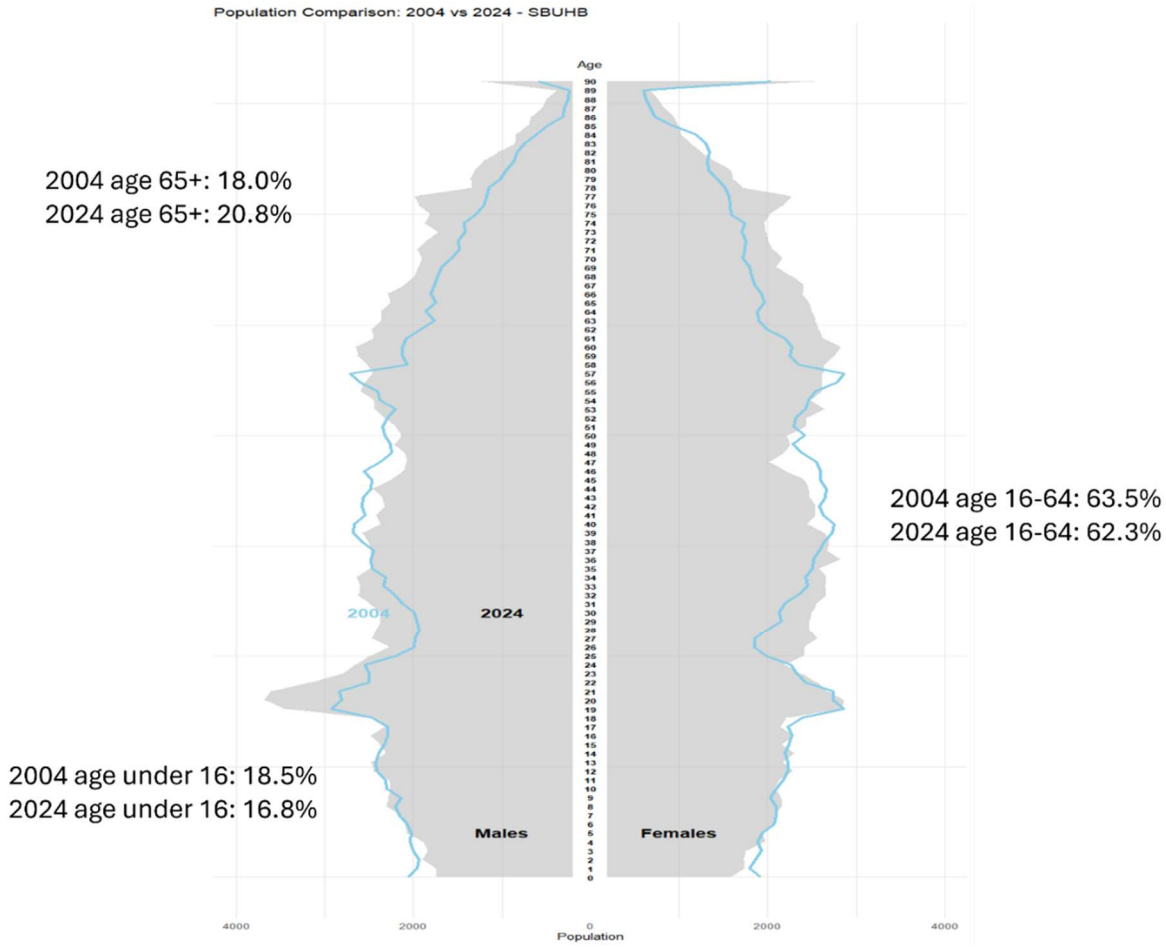


Figure 8: SBUHB population age structure in 2004 and 2024



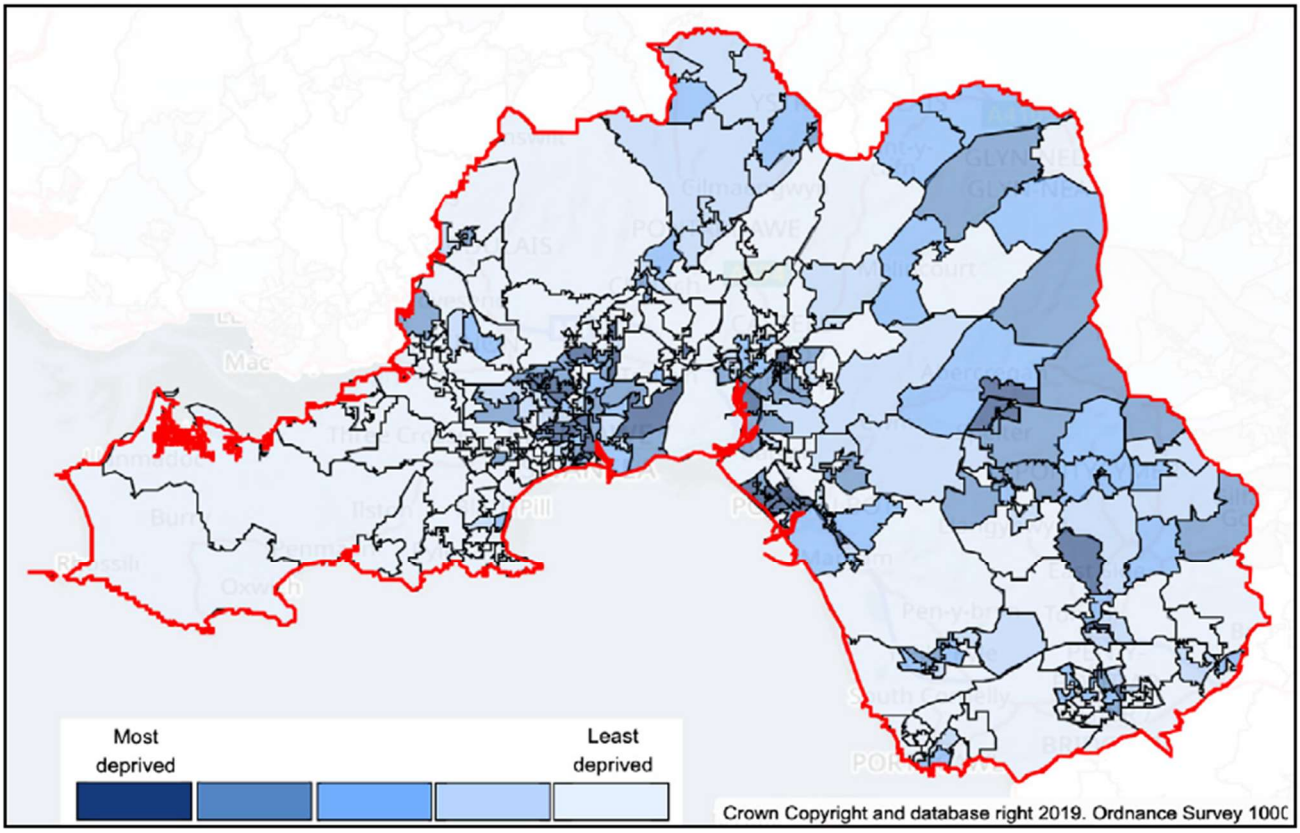
Approximately 60% of the current population are of working-age (16-64) and 20% are over 65. Swansea has a lower proportion of children (aged 0-15), at 16.9%, than both Wales (17.8%) and the UK (19.0%). There are differences between NPT and Swansea – Swansea has a large spike in the population cohorts aged between 19-22 years, in part associated with students at Swansea's universities. Welsh Government's latest trend-based population projections suggest that between 2018 and 2041 Swansea's population will grow by 7.0% to 263,600 and NPT's population will increase by 5.8% to 151,210. This means an additional 25,400 people living in SBUHB by 2041.

Importantly, as is the case with the rest of Wales, SBUHB has an ageing population, with a rising proportion of those aged 65+, while the younger age group (0-15) is declining. Persons aged 75+ are projected to increase from 40,800 persons in 2025 to 46,300 persons in 2035, a growth of 13%. The main reason for this is long-term improvements in mortality rates (reflected in people living longer) and the ageing of certain population cohorts. NPT has one of the highest proportions of elderly residents. The largest increase in the elderly population is projected to be in the Neath and Port Talbot areas, and to a lesser extent in the Pontardawe area.

Inequalities in health arise because of inequalities in society and the conditions in which people are born, grow, live, work, age – leading to differential levels of vulnerabilities. To change this we need to act on what we term the 'root' causes - the basic building blocks for health such as

good education, good quality housing, fair work, money and resources, the social fabric of our communities and our surroundings. Without these, our health and wellbeing are affected, leading to ill-health that is avoidable and unfair. SBUHB has relatively more deprived communities than average for Wales with over a quarter of our communities falling into the most deprived category. The areas of deprivation are particularly focused in urban parts of Swansea, NPT and the upper valley communities.

Figure 9: map of deprivation in SBUHB



Swansea has the highest proportion of ethnic minority groups across the region at 8.6% of the population. NPT and Carmarthenshire have lower ethnic diversity, with over 95% of the population identifying as White British.

Life expectancy and healthy life expectancy

Life expectancy in SBUHB has increased over the long term, partially contributing to the aging population as described above. However, these long-term improvements have slightly reversed in recent years. The latest ONS figures on average life expectancy at birth (for 2021-23) now

stand at 77.0 years for males in SBUHB and 81.6 years for females, similar to that for Wales as a whole. Eight years previously, i.e. 2013-15, life expectancy in SBUHB was 77.8 years for males and 81.9 years for females.

Figure 10: Life expectancy in SBUHB from 2011 to 2023

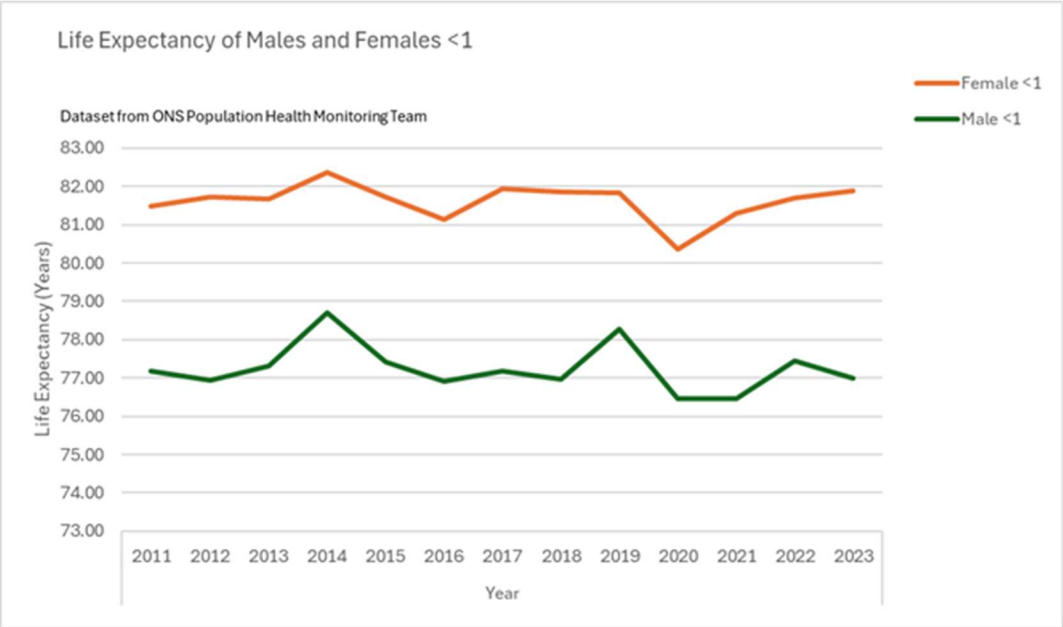
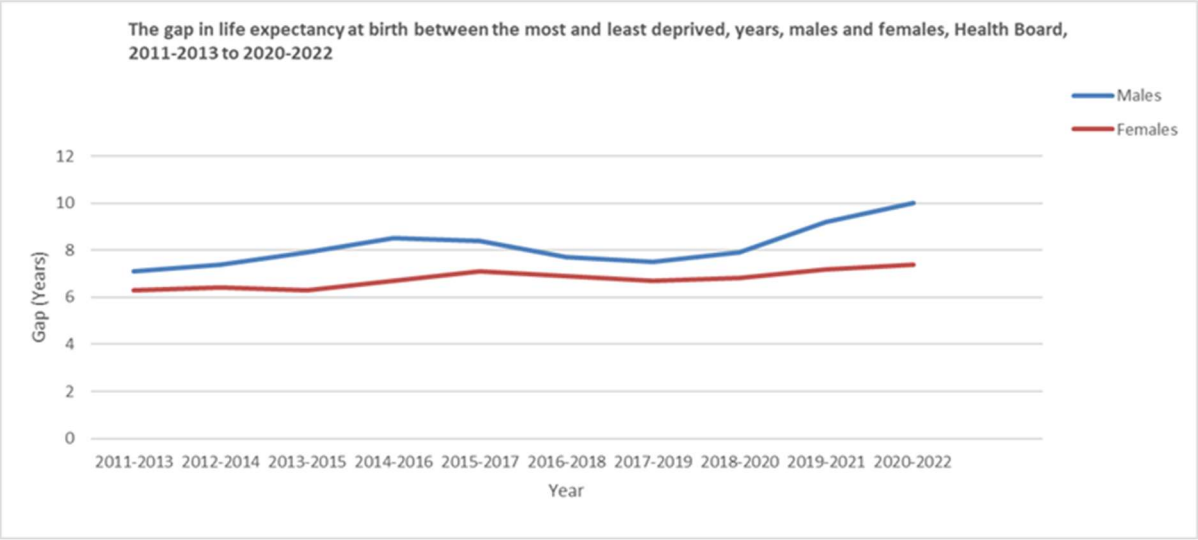


Figure 11: Gap in life expectancy between those living in the most and least deprived areas in SBUHB over time



The gap in life expectancy at birth between the most and least deprived in the SBUHB population is 10.0 years for males and 7.4 years for females (2020-22). This has shown an increasing trend over the last 10 years from only 7.1 and 6.3 years in 2011-13 for males and females respectively. The gap in healthy life expectancy at birth between the most and least deprived in the SBUHB population is bigger at 14.6 years for males and 19.9 years for females

(2020-22). The recent reductions in healthy life expectancy, particularly the increasing inequalities seen in gender and socioeconomic status, are an increasing cause for concern. These haven't been explored in the current HNAs, these trends will affect how many years of life individuals in SBUHB spend in ill health, and inequalities locally.

Figure 12: Healthy life expectancy at birth in SBUHB over time

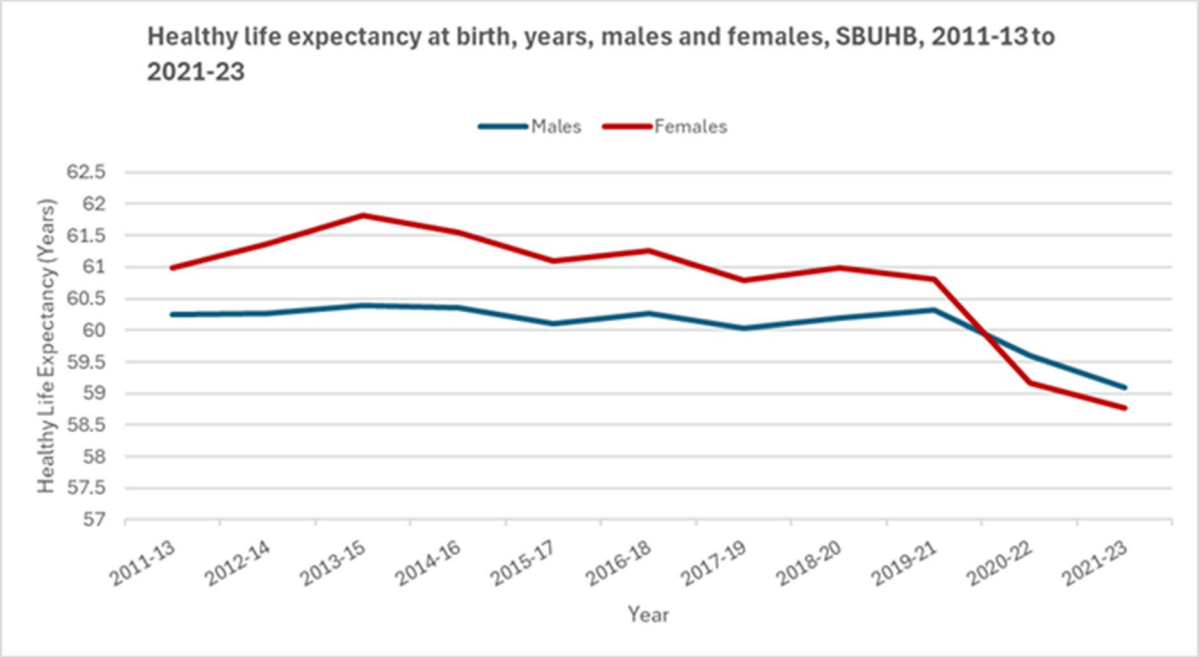
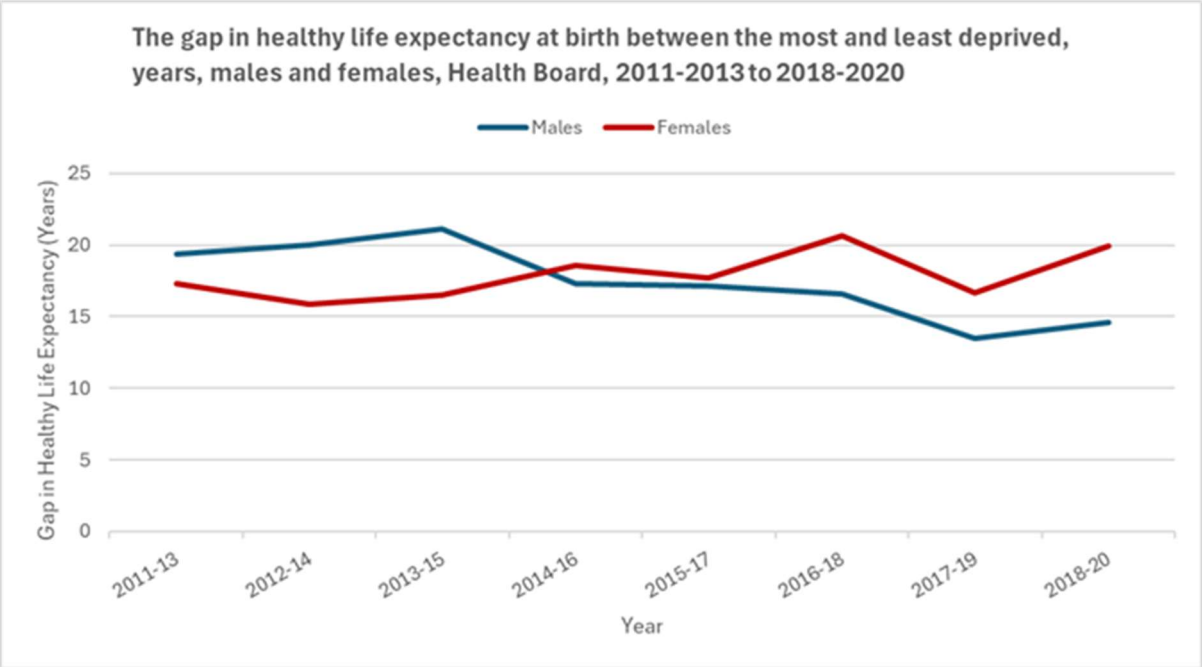


Figure 13: Gap in healthy life expectancy between those living in the most and least deprived areas in SBUHB over time



The number of people aged 65 years and over who live alone in England and Wales saw a 14.6% increase from 2011 and 2021 (between censuses) – reaching 3.3 million. Though the proportion

of the population aged 65 and over who were living alone decreased from 31.5% in 2011 to 30.1% in 2021. Applying these changes to the population of SBUHB, suggests that from 2011 to 2021 there would have been an increase of around 4,500 additional people aged 65 years and over who were living alone.

Key chronic conditions

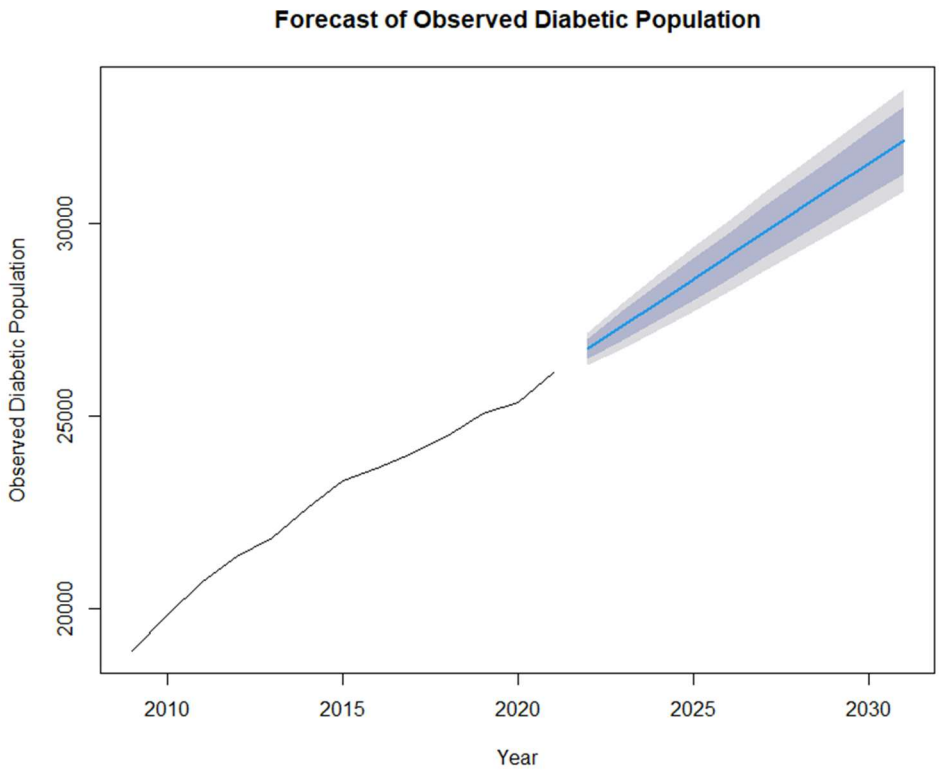
With an ageing population an increase in the prevalence of some health conditions and healthcare need is inevitable and the more proactive we are in planning for these the better we will be able to meet them in future. There are also many health needs that are increasing but are avoidable if we focus on preventing them before they develop. Projections of long-term conditions (LTCs) trends in Wales, suggest that some conditions will increase faster than we would expect based on an ageing population alone. These include: atrial fibrillation, dementia, heart failure, chronic obstructive pulmonary disease, osteoporosis, chronic heart disease (CHD), inflammatory bowel disease, peripheral vascular disease, asthma, hypertension, anxiety disorders, and diabetes. Focusing on prevention and tackling the social determinants of health can mitigate the trajectory of many LTCs, including CHD, atrial fibrillation, stroke, some cancers, type 2 diabetes, and many mental health conditions.

Diabetes

The prevalence of all types of diabetes in SBUHB is 7.8%. Since 2009/10 the number of adults aged 17 years or older living with diabetes in Wales has increased by 40% (to 2021/22). If current trends continue it is estimated that around 1 in 11 adults will be living with diabetes in Wales. If this is the same in SBUHB as for Wales as a whole, we can expect around an additional 8,000 adults to be living with diabetes by 2035/36.

In SBUHB the death rate (16 deaths per 100,000) has increased by an extra 3.6 deaths per 100,000 population since 2016-2018. SBUHB has a higher diabetes death rate than Wales (13.3 death per 100,000) and was the highest Health Board in Wales death rate of diabetes in both the 2018-2020 and the 2019-2021 time period (ARCH).

Figure 14: Predicted diabetic population in SBUHB in future



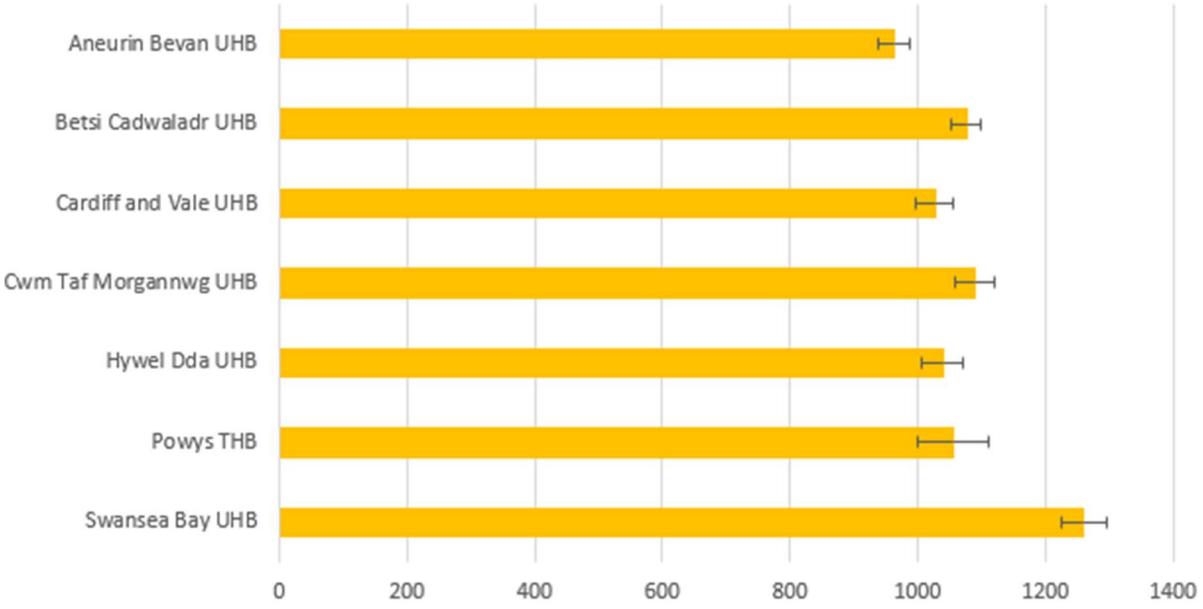
Public Health Wales have published projections and resources on diabetes prevalence in Wales, including information on trends, risk factors and 10-year projections:

Diabetes prevalence – trends, risk factors, and 10-year projection - Public Health Wales

Mental health and wellbeing

The population of SBUHB has a high level of mental health needs - GP registers indicate the highest prevalence of long-term mental disorders in Wales and more people in NPT report a mental health condition than elsewhere in Wales. In 2024, there were around 5,040 individuals on the GP mental health register in SBUHB. There are significant inequalities in mental health and wellbeing outcomes in Wales and in SBUHB linked to age, gender, other population characteristics and socioeconomic inequalities. Comorbidity between physical and mental health conditions is common and projected to increase.

Figure 15: European age-standardised rate of individuals on the mental health register per 100,000 population by Health Board, 2024



Dementia is the second most common mental health problem in older people and 20% of people over 85 years, and 5% over 65 years, have dementia. In SBUHB around 5,607 individuals are registered with dementia which is likely to be an underestimate. Prevalence and incidence projections show that the number of people with dementia will continue to grow, especially in the oldest age group (85 years and over). Social Care Wales projections for the West Glamorgan area indicate a 65% increase in the number of people with dementia by 2040. Dementia is one of the major causes of disability in later life and accounts for 12% of years lived with a disability. Over 10% of deaths in men aged 65 and older and 15% of deaths in women in the same age group are attributable to dementia.

Cancer

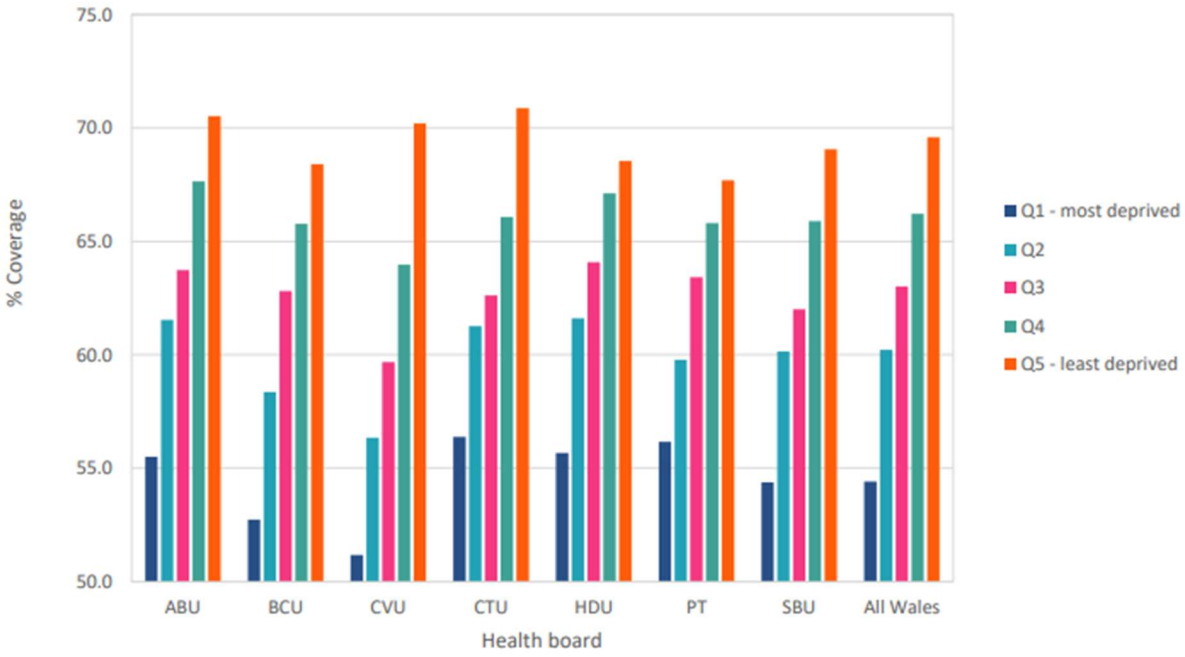
Cancer is the leading cause of death in Wales. Mortality rates are significantly worse for people living in deprived areas and the gap between the most and least deprived is growing. Long-term historic improvement in 5-year net cancer survival has stagnated since the 2014-2018 diagnosis period. This stalling in improvement started before the Covid-19 pandemic and has continued beyond it. By 2035, it is estimated that there will be around 24,000 new cancer cases each year among people living in Wales.

Cancer survival worsens with increasing levels of area deprivation. For the 2017-2021 diagnosis period, 70.1% of people from the least deprived areas in Wales survived to 5 years, compared to 51.8% of people from the most deprived areas. This wide deprivation gap has not widened since diagnosis between 2002-2006. For 5-year net cancer survival, the deprivation inequality gap remains wider in men (21.5% difference) than women (14.9% difference) in the 2017-2021 period.

Engagement in national screening programmes means that people can be offered earlier treatment and have better outcomes. However, inequalities in screening uptake can contribute to widening inequalities in morbidity and mortality in the population. Only around 65% of those invited to bowel

screening in SBUHB in 2022-23 took up their offer – the lowest uptake of any Health Board. There is also inequality in uptake by deprivation, with 72.3% of those living in the least deprived areas of SBUHB taking up screening compared to only 56.9% of those in the most deprived areas. Unstandardised 1-year and 5-year net survival rates for bowel cancer in SBUHB are significantly lower than the Wales average, based on the most recent data (73.7% and 55.5% compared to 74.4% and 58.6% for Wales respectively). Bowel cancer 5-year survival has dropped sharply in men aged <55 years across Wales over the last 9 years (69.9% to 53.3%). A similar trend has been seen in England and Scotland.

Figure 16: Bowel screening uptake by deprivation quintile and health board of residence, 2022-23



Around 12,800 women were screened for breast cancer in SBUHB in 2021/22 – an uptake rate of 72.5%. This was the highest of the Health Boards and higher than the all-Wales average of 70.0%. However, there is still a clear gradient in uptake of breast screening by deprivation across Wales and in SBUHB. Uptake varied from only 63.7% in the most deprived areas of SBUHB to 78.7% in the least deprived areas.

In 2020/21 there was also still a clear gradient in coverage of cervical screening by deprivation quintile in SBUHB and across Wales. Coverage was only 62.9% is the most deprived areas in SBUHB compared to 74.9% in the least deprived areas. Unstandardised 5-year net survival rates for cervical cancer in SBUHB are significantly lower than the Wales average (68.2% compared to 73.1% for Wales), based on the most recent data. However, 1-year survival rates are significantly higher than the Wales average (90.3% compared to 85.9% for Wales).

Following a recommendation by the UK National Screening Committee, SBUHB are preparing to implement a national pathway for lung cancer screening. Currently Unstandardised 10-year and 5-year net survival for lung cancer in SBUHB (9.1% and 16.4%) is lower than the Wales average, based on the most recent figures (10.5% and 16.6% for Wales respectively). However, 1-year survival is higher than the Wales average (41.3% compared to 39.1% for Wales). Health inequalities in lung cancer survival have widened in Wales in recent years due to survival greatly

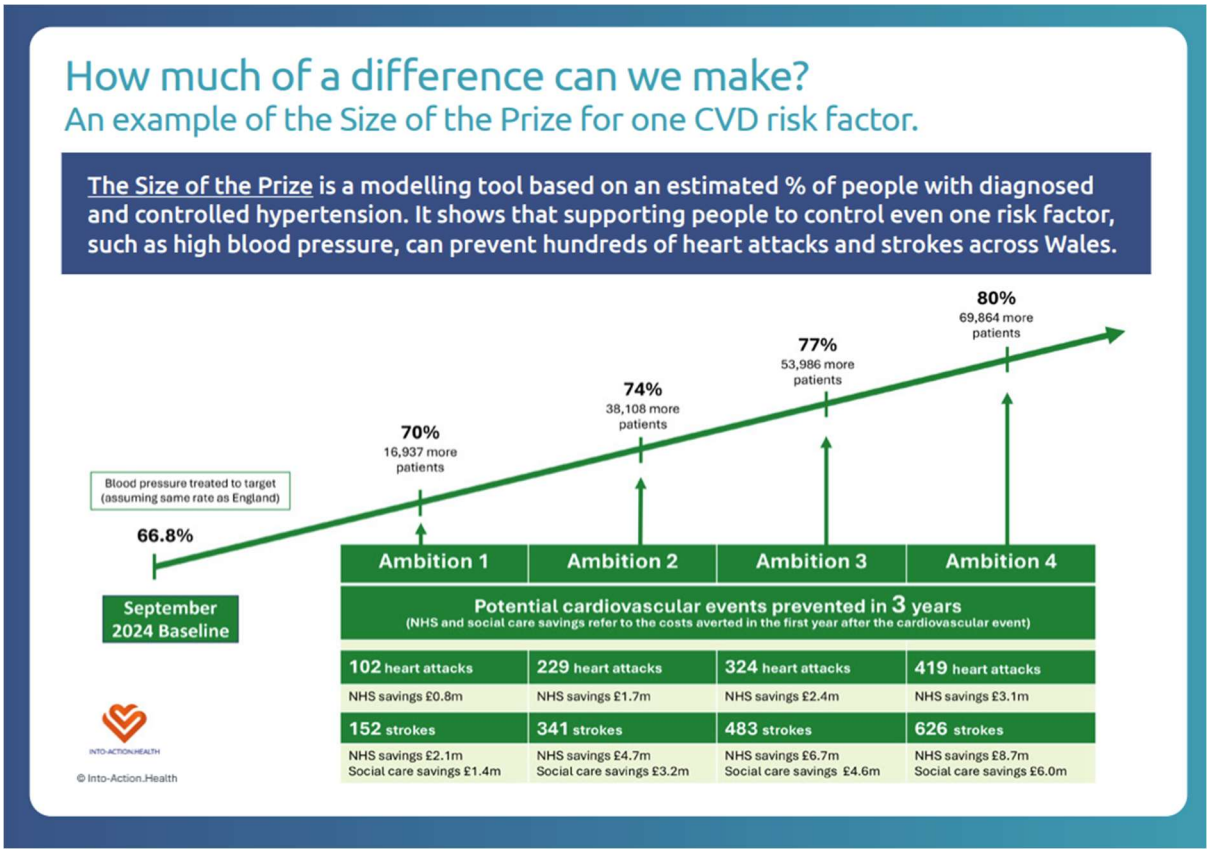
improving in the least deprived areas (from 8% to 15%) but little in the most deprived areas (7% to 9%).

Cardiovascular disease (CVD)

SBUHB has some of the worst outcomes related to CVD mortality across England and Wales. Despite the strong evidence base around modifiable risk factors associated with cardiovascular disease and effective clinical management of these risk factors, there is still a lot more we could do around sub-optimal detection, prevention and treatment to reduce population morbidity and mortality. This is not limited to our health board area and is affected by a variety of factors, but it is worth exploring in greater detail locally.

Co-morbidities associated with cardiovascular disease, and living with the consequence of events such as heart attacks and strokes, has a wide impact on society, healthcare services, and individuals. The estimated healthcare costs in Wales related to heart and circulatory diseases (CVD) was £766.2 million in 2021/22, with wider societal costs of £879.8 million. Prevention and management of cardiovascular risk factors has also been shown to be cost-effective. Modelling has demonstrated that better control of cardiovascular risk factors, including hypertension and cholesterol, can lead to a reduction in potential cardiovascular events (including heart attacks and strokes) over three years, which would lead to significant NHS and social care savings.

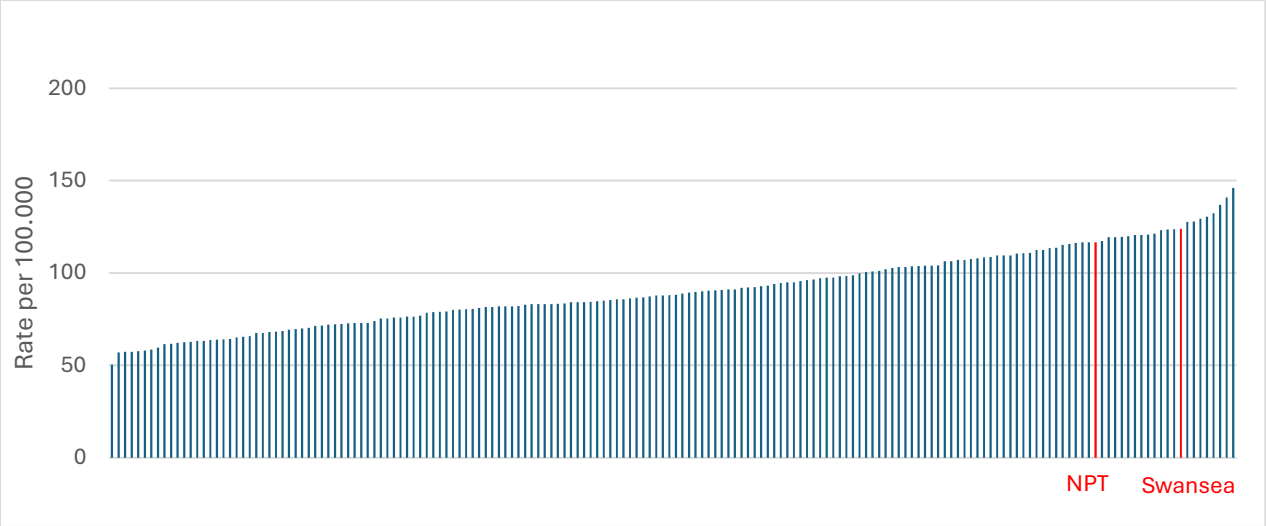
Figure 17: Estimates of the 'size of the prize' for CVD



Source: Public Health Wales. Cardiovascular Disease Prevention Plan for Wales: An 'ABCD Plus' Approach. September 2025. Available online

Swansea and Neath Port Talbot are two of the five local authority areas in Wales with the highest rates of premature mortality from cardiovascular disease in Wales; up to 80% of premature deaths from cardiovascular disease are preventable. Premature mortality from cardiovascular diseases (unadjusted) was 117 per 100,000 in Neath Port Talbot (NPT) (95% CI 103-130 per 100,000) and 124 per 100,000 in Swansea (95% CI 113-135 per 100,000) between March 2021 to December 2023. Of 172 Local Authorities across England and Wales (which ranged from 50 per 100,000 in Richmond upon Thames to 146 per 100,000 in Blackpool), Swansea was ranked 9th highest, and NPT was ranked 22nd highest (Figure 1).

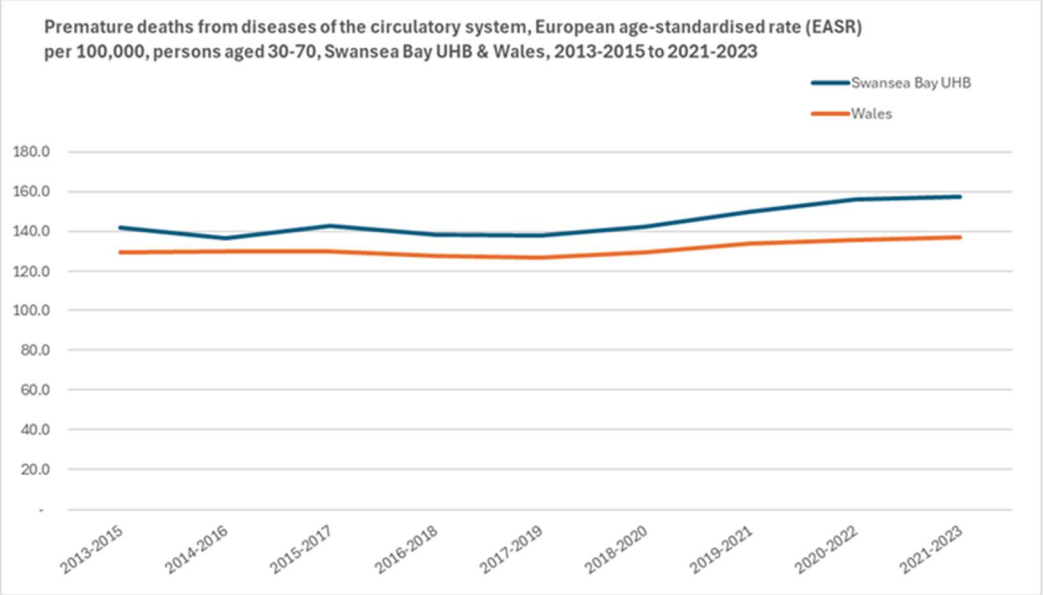
Figure 18: Premature mortality from CVD across 172 Local Authorities in England and Wales, per 100,000 person-years at risk



People living in SBUHB are more than twice as likely to die prematurely due to cardiovascular disease compared to some regions in England. The incidence rate ratios for NPT and Swansea, compared to Richmond upon Thames (with one of the lowest rates), were 2.32 and 2.46 respectively. When ethnicity and being born outside of the UK were taken into account, the incidence rate ratios were 2.23 and 2.38 respectively. When ethnicity, being born outside of the UK, and socioeconomic status were taken into account, the incidence rate ratios were 1.34 and 1.69 respectively. This suggests that a significant amount of the higher incidence in NPT and Swansea may be driven by socioeconomic status.

Trend data from Public Health Wales shows that premature mortality from cardiovascular disease is increasing in SBUHB. There has been an upward trend in the rate of premature deaths from diseases of the circulatory system in SBUHB over the last reported 5 years, from 138 per 100,000 population in 2017-19 to 157 per 100,000 in 2021-23. During the last 2 years, the rate in SBUHB has become statistically significantly higher than the rate for Wales as a whole (157 versus 137 per 100,000 population).

Figure 19: Premature mortality from CVD in SBUHB and Wales, per 100,000 persons



As the causes for cardiovascular disease are multi-factorial, approaches towards preventing the development or the worsening of cardiovascular disease and premature mortality require multiple approaches. These include:

- Early identification of risk factors and management
- Optimising the management of co-morbidities
- Enabling healthy lifestyle choices
- Cross-partnership working on the wider determinants of health, including reducing inequalities
- Taking a 'community by design' approach, ensuring care can be provided where possible in the community setting, utilising hospital-based care only when this is required by more complex or escalating clinical need

These strategies include primary prevention where people are at high risk of developing cardiovascular disease, secondary prevention who already have cardiovascular disease but could reduce ongoing risk, and population-based strategies to lower the average risk of cardiovascular disease in the population.

There are many people living with risk factors for cardiovascular disease in Wales. Within this, there are two key groups. Those who are known to be high-risk, with risk factors already identified, and those who are not yet known. For example, it is estimated that around three-quarters million people in Wales have hypertension, but only 530,000 are known. These cohorts pose different challenges for healthcare. For patients who are known to be high-risk, there is the need to correctly identify them, risk stratify, and ensure they are receiving optimal treatment to achieve control to minimise their risk. For those who are yet to be diagnosed, there are the challenges around how to proactively identify these individuals.

If nothing changes, it is projected that the number of patients with heart failure in Wales will increase by 46% by 2033/34 (from 2023/24). If these projections hold true for the SBUHB population too, this would mean around an additional 2,150 patients with heart failure. The number of patients with atrial fibrillation and hypertension, clinical risk factors for CVD, are

expected to increase by 26% and 7% respectively. This would mean around an additional 2,600 and 3,700 patients in SBUHB respectively.

Multimorbidity

There is projected to be an increase in multimorbidity (patients with 2 or more LTCs) and resulting complexity of need, and in polypharmacy (multiple prescriptions) and secondary care demand across Wales in future. Studies have estimated that the proportion of patients with 4+ LTCs is expected to almost double from 2015 to 2035, and two-thirds of these future patients will have mental ill-health (dementia, depression, cognitive impairment no dementia).

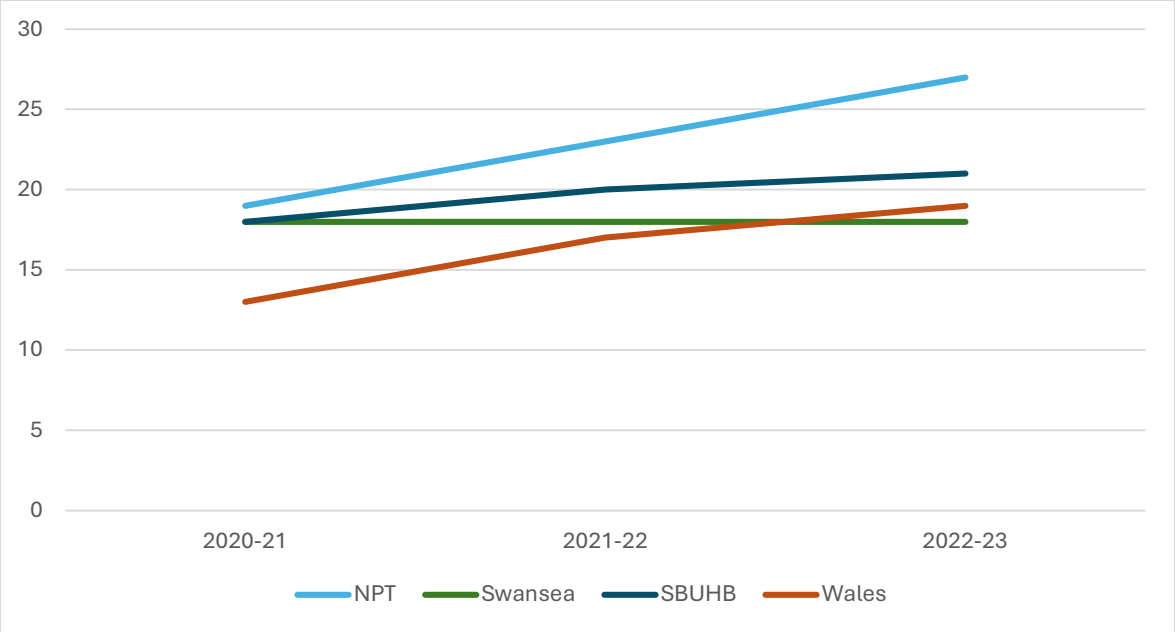
Data on multimorbidity in the population is limited due to challenges linking individual patients across disease registers. We know that 26% of residents in NPT (more than 1 in 4) and 17% of residents in Swansea (around 1 in 6) reported having 2 or more longstanding illnesses in 2022-23. The percentage of residents who report being limited a lot by longstanding illness has also been rising in SBUHB and across Wales over the last 3 years. Though this should be treated with caution as we don't have enough data yet to be sure of trends.

There is still a lot that we don't know about the current and future prevalence of multimorbidity in our population, or the impact that it will have on healthcare services.

Table 1: Percentage of residents reporting longstanding illness (2022-23)

	Any long-standing illnesses	2+ long-standing illnesses
NPT	56%	26%
Swansea	43%	17%
SBUHB	48%	21%
Wales	48%	20%

Figure 20: Percentage of residents who report being limited a lot by longstanding illness



Palliative care needs

With an increasing older population and increases in multimorbidity and chronic illnesses, it is predicted that there will be an increase in need for palliative care services. One study has suggested that all individuals who die from a chronic disease would have benefitted from palliative care. This equates to around 2,950 individuals in SBUHB, increasing to around 3,300 by 2035.

Chapter 3: Key gaps and limitations in existing needs assessments

We undertook a review of needs assessments published for the SBUHB population over the last 10 years so that we could summarise the key findings across them and identify gaps in our understanding of the health needs of the local population. The approach used mixed

methodology and involved reviewing local and national strategy and policy documents to identify key themes, priorities and emerging health challenges for our local population and services. Semi-structured interviews were also conducted with key individuals within SBUHB and external organisations involved in developing the HNAs, to gain additional information on potential health need knowledge gaps and clinical service priorities. By including a range of data and perspectives we were able to gain a more holistic understanding of the health needs of the SBUHB population. However, there were a range of gaps identified in the information included in needs assessments for the SBUHB population.

Demographics and population predictions

Key gaps in existing Needs Assessments that were identified included:

- **Detail on the drivers of population change** over the next 10 years in the SBUHB area was limited in the existing HNAs. In particular, the origin, demographics and healthcare needs of individuals migrating into SBUHB were not explored, despite this being cited as the main driver of population change.
- The **impact of geographical location on access to healthcare services** and transportation within the SBUHB region has not been explored.
- Detailed and up to-date data on the **ethnicity** of the population is lacking in the current HNAs, potentially creating a gap in our understanding of the healthcare needs of ethnic minority groups.
- The current HNAs only provide data on males and females, omitting information on the prevalence and health needs of individuals in the population identifying as **other genders**.

Morbidity and mortality in our population and predicted trends

Key gaps in existing Needs Assessments that were identified included:

- Across all causes of morbidity/mortality, the existing HNA's predominantly focused on disease epidemiology at a secondary care or mortality level, with limited discussion of **community level epidemiology**, intervention effectiveness or cost-effectiveness of clinical services.
- **Drivers of the recent reduction in healthy life expectancy**, particularly the gender and socioeconomic disparities in this, were not explored limiting our understanding of the health needs of the population effected by this reduction.
- The **reasons for the significantly higher preventable and treatable mortality** in SBUHB compared to the Welsh average and neighbouring Health Board's was not explored in the HNAs.
- Whilst 1 in 4 individuals in NPT experience 2 or more longstanding disease (with the Wales average being 1 in 5), the causes, outcomes or healthcare needs associated with **multimorbidity** are not explored in existing HNAs.

- Whilst death rates and admission rates for mental health illness are discussed in the ARCH HNA, **community level data on mental health need**, service provision, and effective interventions are not discussed in the existing HNAS. Inequalities in the burden of mental health between groups were not discussed in detail.
- Rates of overweight and obesity are discussed in existing HNAs but **future trends in overweight and obesity in children** were not. Current service provision, service impact and service need was also unclear from the existing HNAs.
- Although the HNA's identify that SBUHB had the highest death rate of diabetes of all Health Board's in Wales in both the 2018-2020 and the 2019-2021 time period, community level, detailed secondary care level information and provision of care to those with diabetes is not explored in the HNAs, limiting our understanding of the health needs of those with diabetes and the **reasons for the comparatively high rate of diabetes deaths** in the region. Inequalities in the burden of diabetes within the SBUHB population was also not explored in depth in the existing HNAs.
- Prevalence at the primary care level of dementia and death rates are explored in the HNAs but **secondary care level data on dementia** and the specific healthcare needs or healthcare provision provided to those with dementia are not explored in detail in the existing HNAs. Inequalities in the burden of dementia within the SBUHB population was also not explored in depth in the existing HNAs.
- The incidence, impact and healthcare needs of those with **frailty** are not addressed in the existing HNAs.
- Although cardiovascular mortality data is outlined, (with NPT having the 4th highest cardiovascular death rate in Wales in 2022), and community prevalence of ischaemic heart disease hypertension, atrial fibrillation, heart failure and peripheral vascular disease were displayed, specific **reasons for the high cardiovascular mortality rate** were not explored within the HNAs. Secondary care level data, data on disparities in cardiovascular disease prevalence, current healthcare provision, and healthcare service needs were also omitted.
- Comparative mortality data on respiratory disease and primary care level prevalence of COPD and asthma was explored in the exiting HNAs with Neath Port Talbot having the second highest rate (13.7 deaths per 100,000) of deaths due to respiratory disease of all local authorities in Wales and the Afan GP Cluster in SBUHB having the 3rd highest prevalence of asthma or COPD of the sixty-three GP clusters across Wales (2022). However, secondary care level data, primary care level data on other respiratory diseases and detailed mortality data on **respiratory illness** was not captured in the HNAs, nor is information on demographic/socioeconomic disparities. Furthermore, current service provision, and causes of the increased mortality rates were not directly addressed in the HNAs reviewed.
- Secondary care admissions for musculoskeletal disorders were explored in depth in the ARCH HNA. However, other than the prevalence of rheumatoid arthritis and osteoarthritis, **primary care level data on musculoskeletal conditions** was not explored in the HNAs, where the largest burden of disease is likely to be. Current service provision, and disparities in the burden of MSK between demographic/socioeconomic groups was not explored.

- Other than making reference to the aging population and rising diabetes rates resulting in increased vision impairment and diabetic retinopathy in the population, the specific health needs with regards **optical/visual health** need were not explored in the existing HNAs.
- The **dental health needs** or services available to the SBUHB population were not explored at all in the existing HNAS.
- Local data, vulnerable populations and the impact of **antimicrobial resistance** on the population and clinical services provided by SBUHB was not explored in the existing HNAs.
- Like many HNAs, the existing HNAs for the Swansea and NPT region primarily focus on non-communicable disease, reflecting their prominence as the leading causes of morbidity/mortality in the UK and the historical centralisation of **communicable disease** control in Wales (previously mainly managed through PHW). However, the financial burden of treating infectious diseases and complications falls upon the health board. The covid-19 pandemic has highlighted the need to better integrate communicable disease considerations into health service planning and the need to strengthen local health protection responses. Ongoing efforts are underway to enable this but to facilitate this, we need to understand the health needs of those at risk of and living with communicable disease. In particular, vaccination services, while delivered locally, are not discussed in the existing HNAs nor is the impact of antimicrobial resistance on our ability to respond to certain infectious diseases.

Health behaviours

Key gaps in existing Needs Assessments that were identified included:

- A significant gap exists in the HNAs regarding **vaping**, with no information on prevalence, disparities, health impacts, cessation service provision or service needs.
- With regards to **smoking**, prevalence, and health impacts were included in the existing HNAs but **cessation service provision** and need was not explored. Although disparities between socioeconomic groups is explored, recommendations for reducing the disparities between different socioeconomic statuses is not made. Disparities in smoking prevalence/impact between ethnic groups was also not explored.
- Despite a reduction in the proportion of adults drinking **alcohol** above the recommended limits, in the 3-year period 2019-2021 NPT had the highest alcohol-related death rate in Wales with 21.8 deaths per 100,000 population, (5.2 deaths higher than the Wales rate). Provision of and need for **substance misuse** services in NPT was not discussed in the existing HNAS.
- In 2020, Swansea unfortunately had the highest level of **fatal drug poisonings** in Wales, nearly 40% more than any other local authority despite positive engagement rates with substance misuse services and high naloxone distribution rates. The reasons for this and the specific service needs of those who consume illegal drugs were not explored in detail in the existing HNAs.

- Uptake of the HPV vaccine was discussed in the pharmaceutical HNA but uptake and health behaviours with regards to all other **vaccinations** was omitted from the current health needs assessments.
- The uptake of cancer screening was discussed in the ARCH HNA but other national screening uptake was not discussed.
- **Sexual health** behaviours, service provision and need were not discussed in the existing HNAs.

Social determinants of health and creating healthy places

Key gaps in existing Needs Assessments that were identified included:

- **Access to public transport**, availability of walking/cycling paths and the impact of this on health and healthcare utilisation/ service need was not explored in the HNAS.
- **Access to healthcare** (particularly secondary and emergency care) in terms of availability, accessibility, waiting times, health literacy (the ability of the population to navigate the healthcare system) was not explored in the existing HNAs.
- The health impacts of the **mass unemployment event** and the impact on service need was not discussed in the HNAs. However, following the announcement of plans to close two blast furnaces at Tata Steel UK in Port Talbot, a HNA has been commissioned by SBUHB with funding from UK Government as part of the Tata Transition Board work programme and in partnership with NPTCBC and other local stakeholders.
- Although the impact of **climate change** was explored briefly in the existing HNAs, the impact of this on service need or recommendations to account for this are not made in the existing HNAs.
- Lack of spatial data and maps to show the distribution of need across communities and places.

Vulnerable populations

Key gaps in existing Needs Assessments that were identified included:

- The specific health needs of children in their **early years** and of those between early years and school leaving were not thoroughly explored in the existing HNAs.
- Despite women living more years in poor health than men, and healthy life expectancy reducing to a greater extent in women than men, specific causes of this and health needs of **women** across the lifespan were not explored in the HNAs.
- Furthermore the needs of **pregnant women** and access, utilisation of and outcomes regarding maternity services were not explored in the existing HNAs.
- Detailed information on the presence, demographics and specific health needs and health inequalities faced by the following vulnerable groups in the SBUHB area are not explored in the existing HNAS:

- **Ethnic minority groups** – Detailed information on health needs of different groups not given in existing HNAs.
- **Those seeking refuge**.
- Those who are living with a **disability** – the estimated number of people was included but with no discussion of health outcomes, or how the healthcare system affects these outcomes
- Those experiencing **homelessness** in NPT
- **Transient** groups in the SBUHB region e.g. student, the travelling community
- The **LGBQT** community
- Those with **neurodivergence**, though autism was explored in isolation

Learning to support individual clinical service plans development

While utilising existing Needs Assessments has been an effective way to assess health need prior to the publication of the Clinical Service Plans, these Needs Assessments were not conducted specifically to inform clinical services, and therefore have not mapped current service provision. To address this, it's important to map whether the current capacity, capability and structure of clinical services alongside what we know about the population. This would allow for the identification of potential service gaps, redundancies, and areas where service delivery may not be adequately aligned with the identified health needs of the SBUHB population, aiming to inform service improvement and more resource-efficient service-provision. Crucially, it would also allow assessment of service equity given the stark inequalities within our population highlighted in the existing HNAs. It would also allow us to consider how we can take a whole of health system approach to improving population health.

The existing Needs Assessment also lack a review of the effectiveness and cost-effectiveness of current models of clinical care provision. A process for which this information and continued evaluation can be incorporated into clinical service planning and the ongoing assessment of population health need over the course of the next ten years would help to ensure health need assessment can be integrated into a feedback loop that allows measurable improvement of our clinical services. This is essential to enable out clinical services to contribute to improving population health and to ensure the financial sustainability of services by prioritising models of care and services that provide the greatest value and optimise resource utilisation.

Understanding the health needs of our population in a way that allows us to consider how we can meet these health needs through our clinical services is complex. Health needs assessments are tools that can help with this task and, while valuable for understanding basic population demographics, morbidity and mortality, can often be resource intensive to produce be limited by data availability and can struggle to be effectively translated into actionable recommendations for clinical service planning. It is important to meet the evolving health needs of the SBUHB population by developing a continuous process of understanding and meeting health needs using the diverse data sources that are presented in an integrated and accessible way to those running and designing services.

Chapter 4: Opportunities for future approaches to understand health needs

The speed at which new healthcare technologies are being developed is unprecedented. With new technologies, comes new opportunities to detect unmet need and identify those at risk of future healthcare need. This has the potential to lead to an increase in known cases and demand for healthcare. However, it also presents the opportunity to intervene before need escalates, which is often more clinically effective and more cost-effective.

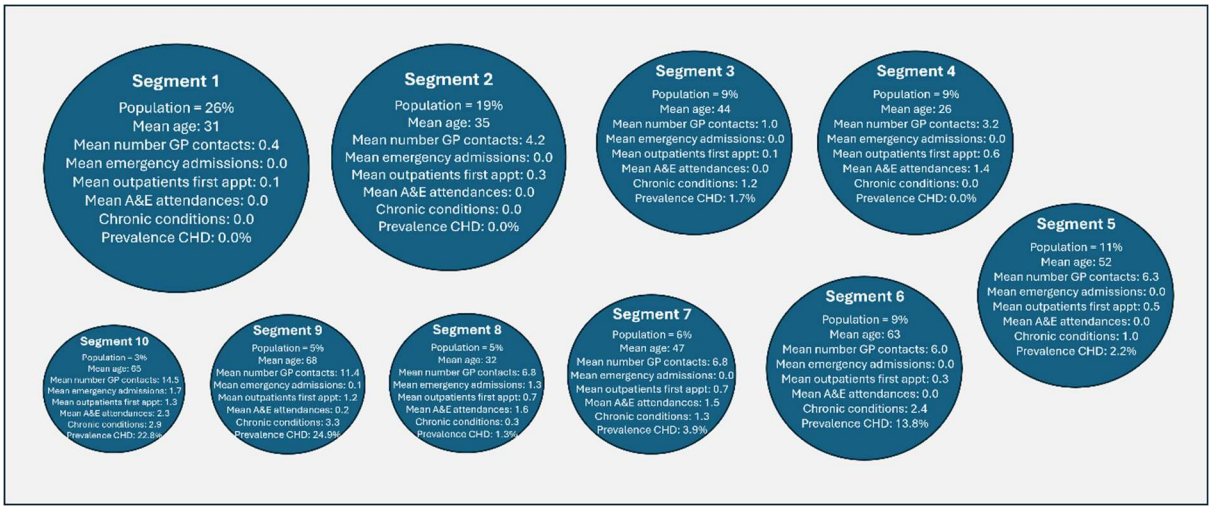
The use of digital tools such as machine learning and AI presents new opportunities to better understand the healthcare needs of the population. For example, it removes any bias from previously held beliefs in who is at risk and identifies similarities between groups of patients that were previously unknown. Particularly if population segmentation using a data-driven approach is used. Advances in risk stratification models, when combined with population segmentation, enable more accurate prediction of current and future demand for healthcare.

Crucially, population health management approaches combine better understanding of need through machine learning approaches with action to tackle those needs. In order to do this, those patients at risk need to be identifiable to healthcare services. One of the greatest challenges to addressing unmet need in the population, and fully utilising these new approaches, is our inability to routinely link patient identifiable data, particularly between primary and secondary care. Use of anonymous linked data in healthcare research has been undertaken for many years in Wales and it is not always clear how the findings have been actioned and used to improve population health. Healthcare organisations have an obligation that when collecting data on the health and risk level of individuals that it is used to support improvements to their health. This cannot be done if we do not know who the individuals are. Wales faces ongoing challenges with sharing of patient identifiable data for improving population health that cannot be tackled by individual healthcare organisations alone.

Case study: Population segmentation and risk stratification in CTMUHB

- Population health management (PHM) is a data-driven approach to improving the health of an entire group of people by proactively identifying health needs, reducing inequalities and coordinating care.
- It is much more than the risk stratification and segmentation tools often used within it. But using these tools, if the data can be accessed, is core foundational component and can offer a practical approach to integrating patient-centred care and population health.
- Segmentation in particular, typically involves grouping populations on the similarity of proxy measures of health need. These groups can then be targeted with more tailored health and care interventions, increasing effectiveness and efficiency of healthcare delivery. Data driven segmentation uses statistical methods to define the segments and is less dependent on assumptions already held which may introduce bias into how we group patients.
- CTMUHB Public Health Team combined primary and secondary care within the SAIL Databank to run a novel segmentation model which combined the degree of multimorbidity of chronic conditions with healthcare utilisation measures. They found 10 key segments in the population with varying levels of risk of future healthcare need.

- Pilot projects are now underway to proactively target these segments and improve patient and population outcomes.



Gartner et al. (2024). How predictive of future healthcare utilisation and mortality is data-driven population segmentation based on healthcare utilisation and chronic condition comorbidity? BMC Public Health 24: 1621. https://doi.org/10.1186/s12889-024-19065-w

The health data landscape is vast, complex and continually increasing. Often the challenge isn't the lack of health data but knowing how to access and interpret it; how to use it to inform policy and practice; ensuring that it is captured accurately and is complete; and ensuring we have the skill sets within our workforce to do this. We are far from making full use of the many existing data sources containing health-related information.

However, there are associated gaps when it comes to data on the wider determinants of health. Despite increasing awareness of the importance of the role of these determinants in population health and the limits to which healthcare provision can address population health challenges. Where the data does exist, it is often held by non-health organisations and cross-sectoral data linkage often proves even more challenging than data linkage between healthcare organisations in Wales. There are also gaps in healthcare data collection when it comes to the some of the most vulnerable groups in the population and where health inequity with the rest of the population is likely to be greatest. For example, ethnic minority groups, those living in poverty, or those with undiagnosed mental ill-health. In many areas of population health, preventative approaches increasingly need to focus on inclusion health groups with more complex needs once the majority of the population have adopted the changes. There is a need to explore new and innovative ways to support vulnerable groups to ensure that no one is left behind and health inequalities increased.

New approaches offer new opportunities to improve population health as they continue to develop. Systems thinking is an approach that views systems with a holistic lens, focusing on how components of systems are interconnected. It has been shown to be useful when applied to health systems as these are complex, adaptive systems that contain a variety of intricately interconnected components. They are dynamic, open systems that change and evolve due to multiple interactions within and across the system, with positive and negative feedback, time

delays and tipping points. The most advanced systems methodologies seek to model in order to identify potential points for intervention and change – with significant potential for improving decision-making in health policy and planning; to better understand the structural complexity of real-world problems. There are now a range of tools and methods to support applying a systems thinking approach for organisations in Wales. And new indexes being developed that capture a more holistic view of population wellbeing.

Long-term approaches and the tools to support embedding them, present opportunities to prevent harms and maximise health and well-being. They also help us to predict and plan for how the future may look for different groups in our population and make sure that no one is left behind. Whole systems approaches to improving health and reducing inequalities are also gaining traction, particularly those with a focus on obesity. Nearly 4 in 5 people who are overweight report having tried to lose weight in the last year. The reality is that most people, most of the time, do not have as much choice over their behaviours as they would like to. They are often trapped by path dependency, whether that path is set by the circumstances of their life or past behaviours, it limits their options and can make it far harder to make healthy choices. Our environments shape the choices that we make every day, so we need to shape our environments to make it easier for people to make healthier choices.

Chapter 5: Implications for clinical services

While this resource aims to support the clinical services when developing their plans, it is recognised that each will service different sub-populations, have different service provision challenges, and different key events on the horizon, such as new technologies in development, that could significantly change service provision and need for some, or all, of their patients. The implications highlighted here are limited to those operating at a large population level that are likely to impact multiple clinical services in some way. Alongside this resource we are developing a standardised process for clinical service planning including tools for service-led integrated health assessments, which will aid more detailed planning by individual services.

Key implications of demographic changes in the population for clinical services

- Population growth is likely to result in increased demand for services in some locations, but not all. Most areas are seeing an aging population with an increase in the health needs associated with this.
- Reductions in populations in some rural areas could lead to the costs of providing services to these populations being spread over smaller numbers of people and increasing the cost per person.
- The pool of potential staff in traditional working age groups may be lower in future.
- The number of people living alone, particularly in older age groups, is likely to increase alongside an increase in their support needs.

Key implications of changes in health needs of the population for clinical services

- Decreasing healthy life expectancy means more people will spend more years of their life in ill-health. This may particularly impact women in future, who are commonly the providers of informal care. This could lead to reductions in support available to patients may mean poorer outcomes and more missed opportunities for early diagnosis.
- The gap in life expectancy between those living in the most and least deprived areas of SBUHB is increasing. This means that the gap in the health outcomes that can be achieved for these patients may also be bigger in future unless action is taken to mitigate health inequalities.
- SBUHB has high levels of preventable mortality and areas of high premature mortality. This suggests there is plenty of opportunity to make a difference to levels of need and demand for healthcare services by targeting upstream and preventative activity.
- There will be increasing numbers of patients with key chronic conditions, in particular, cancer, dementia, diabetes and CVD. Increases in some, or all, of these conditions will result in a need for more facilities to diagnose and treat.
- There are large health inequalities in these key chronic conditions within our population which will impact the health outcomes that can be achieved. And health inequity with other regions, with SBUHB having higher much higher rates of premature mortality for CVD and lower survival for conditions such as bowel cancer than other regions of England and Wales.
- More of those people diagnosed with chronic conditions will have pre-existing health conditions and social care needs when they are diagnosed. They will also be at increased risk of developing other long-term conditions in future.

Implications of new population-level interventions for clinical services

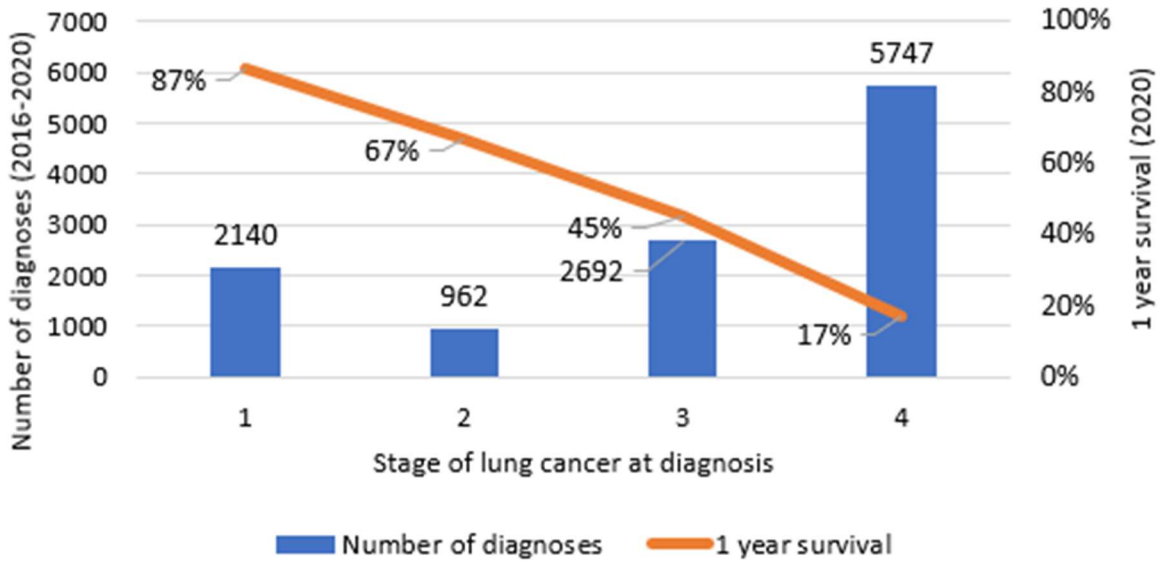
As new population-level initiatives are developed these will impact population health and demand for clinical services in different ways. Where national recommendations to implement new initiatives are made these are typically based on a strong evidence base and offer the opportunity to model the impact on the population and on clinical services. Ongoing horizon scanning for population-level initiatives would enable planning and adaptation by clinical services.

Case study: lung cancer screening

Following a successful pilot of lung cancer screening in the Welsh population, this service is expected to be implemented across Wales by Public Health Wales. The impact of implementing lung cancer screening on the Health Board's downstream clinical services was modelled to help plan for this.

The screening programme is expected to increase the number of patients diagnosed at stage 1 and reduce the number of patients diagnosed at stage 4, leading to better outcomes and chances of survival. In year 5 of implementation, it is estimated that the screening programme will detect 45 lung cancers in SBUHB residents - 13 of these will be additional diagnoses. There will an additional 58 single cancer pathway cases, 58 additional PET scans required, 64 additional lung function tests, and 38 additional CT-guided lung biopsies. An additional 293 smokers are expected to accept support from local Help Me Quit services. There will be an additional 53 patients across South West Wales needing thoracic surgery. Four less patients will chemotherapy and 20 less patients will need palliative radiotherapy.

Figure 21: Number of diagnoses of lung cancer by stage at diagnosis and 1-year survival in Wales, 2016-20



Implications of health inequalities in the population for clinical services

Impacts on health inequality should be an important component in determining the value of investment in, and prioritisation of, clinical services. Any service change risks widening inequity inadvertently increasing the health inequalities in the patient population unless these are identified and mitigated.

Risk of inadvertently increasing health inequalities through prevention activity

Population-level initiatives to improve health outcomes often risk being taken up more by groups within the population who already have greater likelihood of good outcomes. For example, those who are more health literate or have greater health-seeking behaviours are more likely to take up of the offer of a new screening programme. This can make existing health inequalities in the population worse. As clinical service pathways seek to move further

upstream into the preventative space it is important to identify ways in which increases in health inequalities can be prevented or even reduced.

Box: what is proportionate universalism?

The social gradient in health in our population means that often the hardest to reach are the ones that we need to reach the most. Proportionate universalism advocates that health actions should be universal, not targeted, but with a scale and intensity that is proportionate to the level of disadvantage. Targeting specific groups can label those groups and risk stigma, and targeting only those at highest risk often misses much of the problem. Marmot advocates for a proportionate investment of resources into different social groups with different degrees of targeting during implementation, when deciding how those resources should be distributed and in what form. A proportionate investment may be agreed at a policy or strategy level, and when it comes to putting this investment into practice, decisions are made about what programmes and interventions should look like, necessarily including some individuals and excluding others.

Carey et al. (2015). Towards health equity: a framework for the application of proportionate universalism. International Journal for Equity in Health 14: 81. DOI 10.1186/s12939-015-0207-6

Risk of inadvertently introducing health inequalities through inequity in access to healthcare

Conventional waiting lists have been shown to fuel inequalities in populations. This can be through the point of referral, when being listed, whilst on the waiting list, or at the delivery of healthcare. Local policies and procedures can unintentionally disadvantage people living in more deprived areas. For example, through enabling choice, referral management, waiting list prioritisation, or access to aftercare.

Case study: health inequalities in waiting lists

The Strategy Unit at NHS Midlands and Lancashire looked at socio-economic inequalities in access to planned hospital care. They found that in the early and mid-2000s, those living in more deprived areas were, on average getting faster access to elective inpatient activity. Waiting times dramatically improved for all groups in the late 2000s. By 2014, the gradient in waiting times across deprivation quintiles had reversed and those in less deprived areas were receiving faster access to care. They put this down to a number of factors. Firstly, Growth in access to new imaging technologies and screening programmes is slower in more deprived areas, leading to slower growth in interventions following these procedures in those in more deprived areas. Secondly, when access to certain forms of surgery is limited, rates fall more rapidly in the most deprived areas.

NHS Confederation (2021) Tackling health inequalities when reducing the elective backlog. Tackling health inequalities when reducing the elective backlog | NHS Confederation

Mitigating the impact of these changes on clinical services

There are a number of actions that clinical services can take to help mitigate the impact of population changes on healthcare demand and health outcomes. For example:

- Ensure planning of clinical services takes into account changing demographic and health needs in the population accessing the service.
- Plan for systematic ongoing horizon scanning to identify new changes in population need and new interventions that will impact on clinical services in the future.
- Focus on gaining a greater understanding the population needs through data-driven approaches and taking a holistic view of determinants that will impact on the likelihood of improved health outcomes.
- Consider whether clinical services could be widening health inequalities at each stage of the patient's interaction with the service.
- Plan for increasing multimorbidity in the population. For example, raising awareness of the likelihood of other comorbidities in the patient population based on detailed knowledge of the patient population; planning for smooth transition of patients through multiple clinical services; or taking every opportunity to engage patients with preventative services such as Help Me Quit or weight management services.

Future research on the impact of health inequalities on demand for healthcare

There is a lot that is yet to be understood about how the health inequalities present in our population impact on demand for our healthcare services, now and in the future. We are working as part of a regional collaboration with Hywel Dda University Health Board and Public Health Wales to better understand this. Some of the areas that we hope to better understand in future include:

- What is driving the decrease in healthy life expectancy and leading to a greater number of years being spent in ill health, particularly for women in our population.
- How, and if, the increasing numbers of older people living alone impacts on demand for healthcare services. For example, through missed opportunities to diagnose earlier or a lack of informal support in the community.
- What multimorbidity will look like in patients presenting to healthcare, and which patients are at higher risk of other comorbidities in the near future, providing opportunities for preventative action.
- Detailed and up-to-date predictions of the future prevalence of key chronic diseases in our local population.
- Detailed mapping of service provision against deprivation and wider determinants of health within our population.

Appendix A: information relevant to planning healthcare services captured by recent needs assessments in Swansea and NPT

Available upon request.

Appendix B: findings from the review of Needs Assessments in Swansea and NPT that can be used to improve future Needs Assessments

To adequately assess health need and provide a holistic view of healthcare need, HNAs ideally employ a mix of methodologies, including epidemiological, comparative, felt-needs, and corporate approaches. The existing HNAs conducted over the last ten years for the Swansea and NPT region use diverse methodology. For example, the ARCH HNA relies heavily on epidemiological and comparative data, while the Public Service Board (PSB) wellbeing assessments (Neath Port Talbot and Swansea) adopt a more corporate approach. Using information from multiple HNAs therefore has offered a richer understanding of health need, encompassing information on disease prevalence, disparities, local service provision and local expertise and priorities.

However, whilst these HNAs contain a wealth of useful information, they have been developed with diverse aims and objectives by partner organisations, not specifically tailored to provide evidence or recommendations for the SBUHB clinical service plan. Thus, there are some important gaps in the information presented. Overarching limitations, identified from applying the methodology described above, that hinder the existing HNA's ability to effectively inform the SBUHB CSP include:

- **A lack of a review of current clinical service provision**: A comprehensive review of current service provision including infrastructure, workforce capabilities and a comparison against established standards, health board priorities or other local areas, is not included in the existing HNAs. Inequalities in service provision is also not explored. This means that the current capacity and capability of our services is not assessed and thus direct recommendations for addressing service gaps cannot be made from this data.
- **An absence of effectiveness and cost effectiveness data:** Evidence regarding the effectiveness and cost-effectiveness of current or potential models of care are not explored in the existing HNA's limiting the scope of evidence-based recommendations that can be made from the health needs assessments included in this review.
- **Limited community level data**: Community level data on health need is limited with most reported statistics focusing on secondary care level disease statistics or mortality. This limitation impedes our understanding of the true burden of disease in the community, leading to a focus on reactive, hospital-based care rather than proactive, preventative services, which may be more effective and cost-effective for SBUHB.

Qualitative data on patients experiences of the health services is also limited in the existing HNAs.

- **Insufficient analysis of causes of inequalities in health and thus potential solutions:** The epidemiological, comparative and even corporate methodology used in the existing HNAs is primarily descriptive. Potential causes and interactions in identified need are rarely discussed limiting the HNAs ability to inform effective solutions or interventions to address the health need.
- **An absence of prioritisation recommendations**. Recommendations on prioritising need are rarely included.
- **Data availability, timeliness and comparability**: Much of the information collated in the HNAs relies on data publicly available at the time the HNA was conducted which may be outdated and limited, Data and statistics are not always presented in a comparable manner between locations.
- **Limited consideration of interdependencies:** There are multiple interdependencies between different population cohorts and the various elements of health and social care. The descriptive nature of HNAs can mean that the analytical elements needed to understand these interdependencies is not considered, which makes making recommendations on models of integrated care difficult.