Health Inequalities and the business of place-based working

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Why is addressing health inequities a priority?

- **It is a moral imperative concerning social justice:** The issue should be of great importance to a caring and compassionate service.

- **Because it is a legal requirement:** Legal responsibilities on the NHS through the Health and Social Care Act (2012) placed responsibilities on CCGs (amongst others) to ‘demonstrably take account of inequalities in access to and outcomes of health care’.

- **Because it makes good business sense:** The burden of ill health and disability, as well as premature mortality, is disproportionately focussed on the most deprived populations.

- These sections of society are least equipped and resourced to make best and most appropriate use of services.

- If the ‘unmet need’ for preventive services and those for early detection and management is not addressed in those at greatest risk, a large part of the growing burden (and cost) of disability, loss of independence and premature mortality will persist.

- **Because the Long Term Plan says so!:** All local health systems will be expected to set out in 2019 how they will reduce health inequalities by 2023/24 and 2028/29
Well being and Health

Physiological risks
- High blood pressure
- High cholesterol
- Stress hormones
- Anxiety/depression

Behavioural risks
- Smoking
- Poor diet
- Lack of activity
- Substance abuse

Psycho-social risks:
- Isolation
- Lack of social support
- Poor social networks
- Low self-esteem
- High self-blame
- Low perceived power
- Loss of meaning/purpose of life

Risk conditions – e.g.:
- Poverty
- Low social status
- Poor educational attainment
- Unemployment
- Vulnerable housing
- Dangerous environments
- Discrimination
- Steep power hierarchy
- Gaps/weaknesses in services and support

After Ronald Labonte
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Individual
Family
Community

Bentley 2018
“People do not ‘choose’ obesity or diabetes or cancer. *(Many)* have just been overwhelmed by a toxic environment.” *(After S. Capewell Nov. 2018)*
After Ronald Labonte

**Well being and Health**

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**Health Seeking Behaviour**
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Assets for recovery and care

Bentley 2018
Life Expectancy

Source: PCMD, prepared by KPHO (RK), Nov 2015

Life Expectancy at Birth

Deprivation Decile in Kent (1 = most deprived)

Men  Women
% Not achieving school-readiness

Source: KCC MIU, prepared by KPHO (RK), Dec 2015
Out of work benefits is defined as all those aged 16-64 who are jobseekers, claiming ESA & Incapacity benefits, lone parents claiming Income Support and others on income related benefits.
Overcrowded Accommodation

Source: Census, prepared by KPHO (RK), Dec 2015

% With Occupancy Rating of -2 or Less

Deprivation Decile in Kent (1 = most deprived)
Crime Rate

Crime Rate (per 100,000 population)

Deprivation Decile in Kent (1 = most deprived)

Source: Data.police.uk, prepared by KPHO (RK), Dec 2015
Smoking
Modelled Prevalence

Source: Experian, prepared by KPHO (RK), Dec 2015
Alcohol-related deaths are defined as ICD10: F10, G31.2, G62.1, I42.6, K29.2, K70, K73, K74, K86.0, X45, X65, Y15 (National Statistics)
The relationship between 4 multiple lifestyle risks and mortality (Smoking; Excessive use of alcohol; Fruit and vegetable consumption; Physical exercise)

People with no qualifications 5 times more likely to have all 4 risk behaviours than those with high level qualifications
MALE Years of Life Lost
20% LEAST DEPRIVED LSOAs (NL) (2011-2015)

MALE Years of Life Lost
20% MOST DEPRIVED LSOAs (NL) (2011-2015)
Burden of disease by quintile of deprivation (East Midlands)
Burden of disease by quintile of deprivation (East Midlands)

vii. Cirrhosis

- Quintile 5 (least deprived)
- Quintile 4
- Quintile 3
- Quintile 2
- Quintile 1 (most deprived)

YLD due to cirrhosis per 100,000 population

v. Chronic respiratory disease

- Quintile 5 (least deprived)
- Quintile 4
- Quintile 3
- Quintile 2
- Quintile 1 (most deprived)

YLD due to chronic respiratory disease per 100,000 population
people in deprived circumstances have the same prevalence of multi-morbidity as more affluent patients who were 10 – 15 years older
HOSPITAL ADMISSION RATES
RELATIVE TO 20% MOST AFFLUENT NATIONAL LSOAs

Elective admissions
National Quintiles of Deprivation - Distribution in Croydon
Equality and Health Inequalities Pack

NHS Croydon CCG
December 2018

Email for enquiries: england.eandhi@nhs.net
Unplanned Hospitalisations for Chronic Ambulatory Care Sensitive Conditions and Urgent Care Sensitive Conditions for 2016/17

Priority Wards

*Age-sex standardised

NHS Croydon CCG

Priority Wards

NHS RightCare
Priority Wards for Inequality for your CCG

Up to 20 priority wards, with at least 50 hospitalisations, for your CCG are listed below. The final column shows the opportunity for saved hospitalisations if your CCG had no inequality. This is the number of hospitalisations that would be saved if expected rates for priority wards moved to the expected rate at median deprivation*.

<table>
<thead>
<tr>
<th>Rank</th>
<th>2015 ward</th>
<th>Population</th>
<th>Unplanned hospitalisations per 100,000 population**</th>
<th>Unplanned hospitalisations</th>
<th>Opportunity for saved hospitalisations, if your CCG had no inequality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Selhurst</td>
<td>20,644</td>
<td>3,553</td>
<td>571</td>
<td>82</td>
</tr>
<tr>
<td>2</td>
<td>Broad Green</td>
<td>22,039</td>
<td>3,642</td>
<td>558</td>
<td>76</td>
</tr>
<tr>
<td>3</td>
<td>Waddon</td>
<td>18,542</td>
<td>3,426</td>
<td>549</td>
<td>40</td>
</tr>
<tr>
<td>4</td>
<td>Bensham Manor</td>
<td>18,485</td>
<td>3,343</td>
<td>492</td>
<td>32</td>
</tr>
<tr>
<td>5</td>
<td>New Addington</td>
<td>11,696</td>
<td>4,296</td>
<td>437</td>
<td>57</td>
</tr>
<tr>
<td>6</td>
<td>Fieldway</td>
<td>12,888</td>
<td>3,833</td>
<td>375</td>
<td>66</td>
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<tr>
<td>Total</td>
<td></td>
<td>104,294</td>
<td></td>
<td>2,982</td>
<td>354</td>
</tr>
</tbody>
</table>
### Top 10 Conditions for Inequality in all Priority Wards for your CCG

<table>
<thead>
<tr>
<th>Condition</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain in throat and chest</td>
<td>490</td>
</tr>
<tr>
<td>Abdominal and pelvic pain</td>
<td>428</td>
</tr>
<tr>
<td>Other disorders of urinary system</td>
<td>328</td>
</tr>
<tr>
<td>Asthma</td>
<td>232</td>
</tr>
<tr>
<td>Other chronic obstructive pulmonary disease</td>
<td>212</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>105</td>
</tr>
<tr>
<td>Heart failure</td>
<td>102</td>
</tr>
<tr>
<td>Atrial fibrillation and flutter</td>
<td>81</td>
</tr>
<tr>
<td>Superficial injury of head</td>
<td>83</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>78</td>
</tr>
<tr>
<td>Other</td>
<td>843</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,982</strong></td>
</tr>
</tbody>
</table>

**Opportunity for saved hospitalisations, if your CCG had no inequality** 354
In each priority ward:

- What is the quality, accessibility and service outcomes of primary care?
- How does the population use services and how is it supported to do so?
Community-centred interventions

Service-based interventions

Civic-level interventions

Place-based planning
Closer working with the community?

Community

Mental Health FT

Integrated Care FT

Social Care

Leadership

Networks

Venues and Spaces

Clubs and teams

No Man’s Land

Events
Mapping the ‘toxic’ priority communities
Closer working with the community?

Leadership

Networks

Venues and Spaces

Clubs and teams

Events

No Man's Land

Primary Care Network

Hospital Care

Community

Services
Disease management provided according to evidence-based protocols e.g. NSFs or NICE guidance

CHD

10.2 m

High Risk

Have LTC

Aware of LTC

Eligible for treatment

Optimal treatment

Compliant with treatment

5.7m

2.6m

2.3m

1.3m

1m

NOTE: Figures are for UK. Taken from Harrison W, Marshall T, Singh D & Tennant R “The effectiveness of healthcare systems in the UK – scoping study”; Department of Public Health & Epidemiology and HSMC University of Birmingham, July 2006.
A. **Awareness** - under recognition of risks or illness by individuals and people around them

B. **Navigation** – risk or illness identified but support/advice or intervention not accessible

C. **Inadequacies** in quality of in-service provision

D. **Insufficient assets** for recovery or ongoing support for self-management

*Components of ‘Implementation Decay’*

**Have the problem**
- A

**Aware of problem**
- B

**Eligible for intervention**
- C

**Optimal intervention**
- D

**Compliance with plan**

*Bentley, C 2016*
C + D ‘Sweat the asset’ of disease registers

CCG A

CHD registers

964 people whose BP is not \( \leq 150/90 \)

GP practice range: 4.7% to 18.9%

If all reach level of the best an extra 401 would be treated
A + B Actual versus Expected numbers on disease registers

CCG A CHD

CCG B CHD

Legend:
- Undiagnosed
- Exception
- Target missed
- Target met
‘Awareness’ in disadvantaged communities

- External ‘locus of control’
- Regard poor health as a series of crises
- Seek help in response to specific events
- Warning signs may be downgraded:
  - Lack of positive conception of health; low expectations for self
  - The normalisation of symptoms within deprived communities
  - Fear of being blamed by health professionals
‘Navigation’ issues in disadvantaged communities

• Lack of awareness of service opportunities
• Low self esteem/poor skills (literacy); may not cope with demands of formal systems
• Practicalities: child care; transport
• Inflexibility/costs in work situations
  – OK if ill or crisis event
  – But barrier for ‘optional’ services: Health checks; prevention/health promotion activities
• Appointment systems: keeping track
Self-management support in disadvantaged communities

• Self management support programmes develop: Knowledge; Communication skills; Effective coping skills; Social support; Self-efficacy

• But to be able to benefit need resources already:
  – Informed about existence of such programmes
  – Speak same language as programme leader and other members
  – Sufficiently literate
  – Able to reach location easily
  – Afford costs of participation, or
  – Know how to get reimbursed
Collaboration to address ‘implementation decay’

Have the problem
Aware of problem
Eligible for intervention
Optimal intervention
Compliance with plan

Lead service
Place-based partners

Chris Bentley 2012
## Addressing Intervention Decay in heart disease for rapid impact

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
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<tbody>
<tr>
<td><strong>Social marketing programmes</strong></td>
<td><strong>Partnership</strong></td>
<td><strong>GP</strong></td>
<td><strong>Structured self-management education</strong></td>
</tr>
<tr>
<td>Community based focus to awareness</td>
<td>Frontline Making Every Contact Count (MECC)</td>
<td>Patient register search</td>
<td>Support ↑ completion of cardiac and</td>
</tr>
<tr>
<td>raising</td>
<td>Enhanced focus on target communities: Share No</td>
<td>Flag: opportunistic review</td>
<td>stroke rehab</td>
</tr>
<tr>
<td></td>
<td>Man’s Land</td>
<td>Health Check</td>
<td><strong>Peer support to self-managed care</strong></td>
</tr>
<tr>
<td>Community Champions and Ambassadors</td>
<td>Health Check</td>
<td>‘Hidden’ CHD:</td>
<td><strong>Wrap-around socio-economic support –</strong></td>
</tr>
<tr>
<td></td>
<td>‘No wrong door’ for health queries</td>
<td>• Diabetes</td>
<td><strong>assets for recovery</strong></td>
</tr>
<tr>
<td></td>
<td>Single point of access/helpline</td>
<td>• COPD</td>
<td><strong>Social prescribing</strong></td>
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<tr>
<td></td>
<td>Peer support:</td>
<td>• Severe Mental Illness</td>
<td></td>
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<tr>
<td></td>
<td>• Champions</td>
<td>• Learning Disabled</td>
<td></td>
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<td></td>
<td>• Navigators</td>
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<td></td>
<td>• Advocates</td>
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