Kent Surrey Sussex
Academic Health Science
Network

Next Level

Next level: unlocking the power of health and care innovation for all

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WHO

People who often experience **the best that care has to offer**

People who are **under-represented or seldom heard**

People not **benefiting from innovation**

People not **engaged with traditional services**

What is inequality?

The phenomenon of unequal and/or unjust distribution of resources or opportunities among members of a given society.

In health and care

- It builds in unacceptable unfairness.
- Health is a luxury priority, not available to many citizens in KSS who live chaotic lives and have more immediate and conflicting priorities.

Problem statement

Inequality means some citizens with health and care challenges are less able to flourish.

How do we ensure our work, from local projects to national network programmes, reduces the disadvantage some groups of citizens experience?

NHS

REDUCING HEALTHCARE INEQUALITIES

The **Core20PLUS5** approach is designed to support Integrated Care Systems to drive targeted action in health inequalities improvement

CORE20
The most deprived **20%** of the national population as identified by the Index of Multiple Deprivation

Target population

CORE20 PLUS 5

PLUS
ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups

Key clinical areas of health inequalities

1 **MATERNITY**
ensuring continuity of care for **75%** of women from BAME communities and from the most deprived groups

2 **SEVERE MENTAL ILLNESS (SMI)**
ensuring annual health checks for **60%** of those living with SMI (bringing SMI in line with the success seen in Learning Disabilities)

3 **CHRONIC RESPIRATORY DISEASE**
a clear focus on Chronic Obstructive Pulmonary Disease (COPD), driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations

4 **EARLY CANCER DIAGNOSIS**
75% of cases diagnosed at stage 1 or 2 by 2028

5 **HYPERTENSION CASE-FINDING**
to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke

CORE20+5: what does this mean at ICS, or at place, or at neighbourhood level?

- Do you know your population?
- Have you engaged with them as experts and partners?
- Have you co-created solutions against the current barriers?

Vision:

Clinical leaders and **clinical networks** doing the above, plus population **health information**, working with willing **partners** to **deliver better outcomes**.

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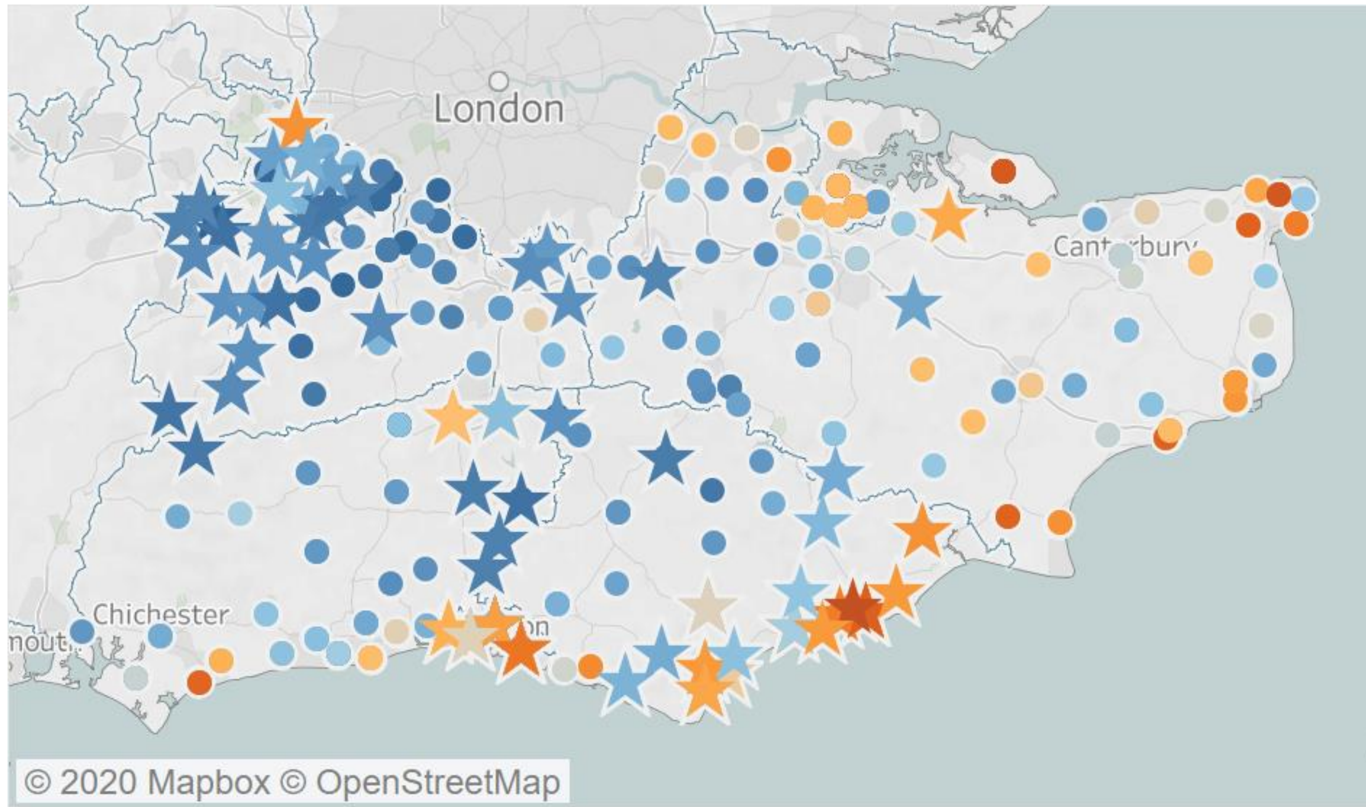
What is our approach?

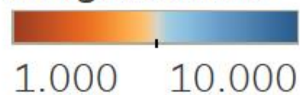
Let’s Talk Crawley

- In parallel… KSS AHSN commissioned a research exercise employing ethnographic methods to complement the *Let’s Talk Crawley* and build in additional insights on the dreams and ambitions of local Crawley residents to improve their lives and make their communities more resilient. A series of discussion guides were developed to prompt and guide conversations with the general public, business leaders and community & patient groups.

- a ‘healthy person’ is able to carry out their day-to-day activities without any challenges and/or with ease, and to be able and motivated to look after themself. Most participants described health holistically - in terms of being able to carry out one’s aspirations and interests, quality of life, as well as linking it to mental, emotional and spiritual wellbeing. (community and neighbourhood, and worthwhile, fulfilling work strong contributors).
- access to primary care and to mental health services (including for dementia)… very vulnerable people who can’t ‘fight’ to get heard, treated or monitored, which then falls on to the responsibility of others to shoulder creating additional strain.

Geographical spread of PINCER in Kent, Surrey and Sussex



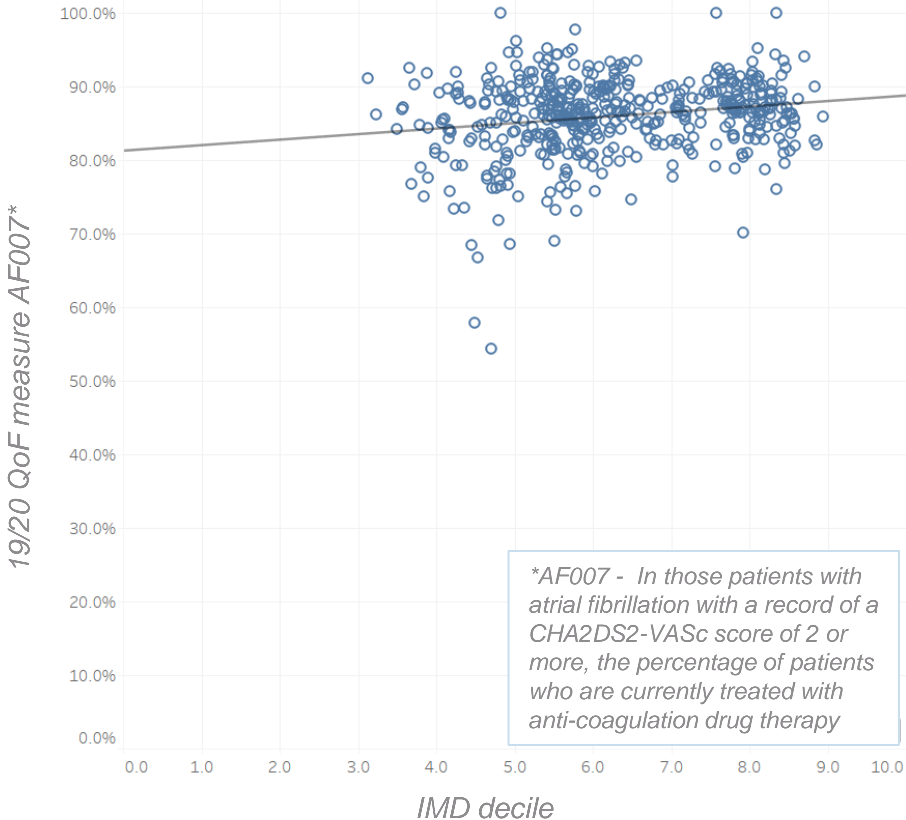


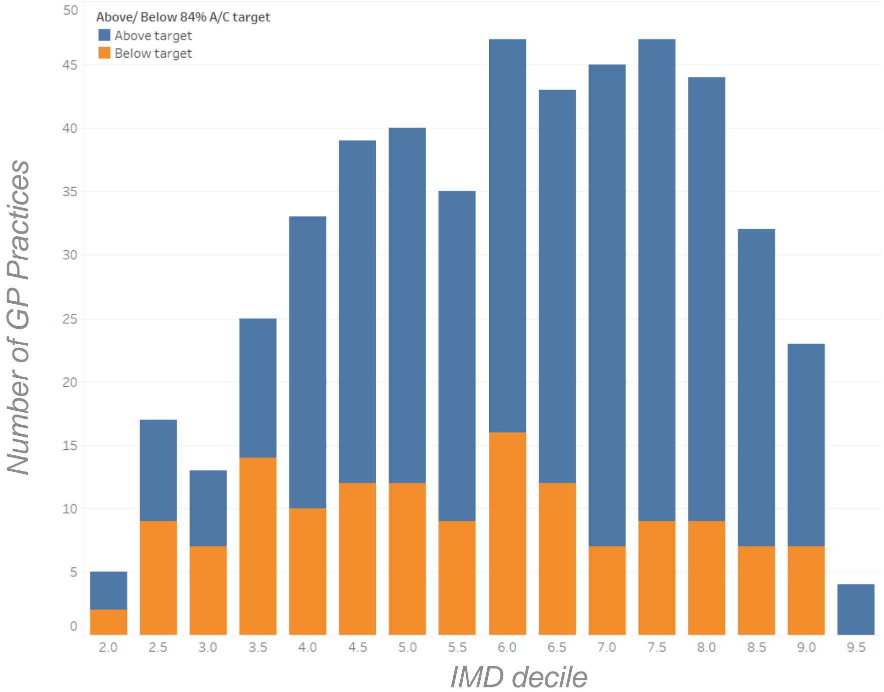
Geographical spread of PINCER, layered with weighted average Index of Multiple Deprivation 2019 decile per practice

Note: Decile 1 is the most deprived, Decile 10 is the least deprived.

2019/20 Atrial Fibrillation anticoagulation rate

This scatter plot suggests that there is a statistically significant correlation between the A/C rate and IMD Decile (P<0.0001). However, the effect size is small suggesting a 0.75% increase in A/C rate per IMD Decile





This histogram shows the number of practices per IMD Decile and are colour coded to show those above and below the national target of 84%.
27.5% of practices involved with KSS AHSN are below the A/C target which compares favourably with those not involved at 29.2%. Nationally 23.9% of practices are below target.

Learning

- Retrospective analysis showed little (inadvertent) difference across IMD for two national programmes.
- Unable to look at other traditional areas of inequality.
- Unable to describe who benefited (and who didn't) from either programme.
- From Alivecor, learned/confirmed that cannot infer benefit from deployment.

Unknown ethnicity

- Maternity 11%
- Cancer clinics attendance 20+%
- 52 week waiters 30+%

Data from an acute NHS Trust, June 2021

Integrated Stroke Delivery Network: Health Inequalities Pre-workshop survey

38%

had low/low-medium knowledge of the kinds of **health inequalities that exist locally**.

43% reported a medium knowledge level.

56%

had low/low-medium knowledge of **how inequalities can be addressed locally**.

38% reported a medium knowledge level.

69%

agree/strongly agree **that patient experience is positive and there is good communication with patients.**

57% agree/strongly agree that we are good at adapting to different needs

56%

had low/low-medium knowledge of the **drivers of inequalities in people who've had a stroke.**

69%

had low/low-medium knowledge of **where to access national and local resources on how to address health inequalities.**

100%

agreed, when considering how to address health inequalities, **more needs to be done to reach underserved communities**

'Which communities/group of people worry you the most with regards to health inequalities in the stroke pathway' → (in score order) carers, BAME groups, those living in rural areas, refugees, working age adults

Integrated Stroke Delivery Network: Health Inequalities Post-workshop feedback

After completing the workshop 100% of respondents reported an improved knowledge of:

- **The different kinds of health inequalities that exist locally**
  (Pre workshop score: 2.69/5, post workshop score 3.71/5)
- **How inequalities can be addressed locally**
  (Pre workshop score: 2.38/5, post workshop score 3.71/5)
- **Knowing where to access national / local resources on how to address inequalities**
  (Pre workshop score: 2.13/5, post workshop score 3.14/5)
- **Drivers of inequalities in people who've have a stroke**
  (Pre workshop score: 2.38/5, post workshop score 3.57/5)

All respondents reported that the workshop

- **helped to increase their knowledge of health inequalities**
- **helped to increase their understanding of health inequalities experienced in the stroke pathway**
- **provided them with enough information to go back to their teams and discuss how to progress work on this area**

Really keen to explore further practice examples of where/how our services have met the inequalities gap

In a future workshop I'd like to know how to address some of the inequalities that were identified such as reaching groups who don't access health care

I will be talking to my team about what information we feel we need

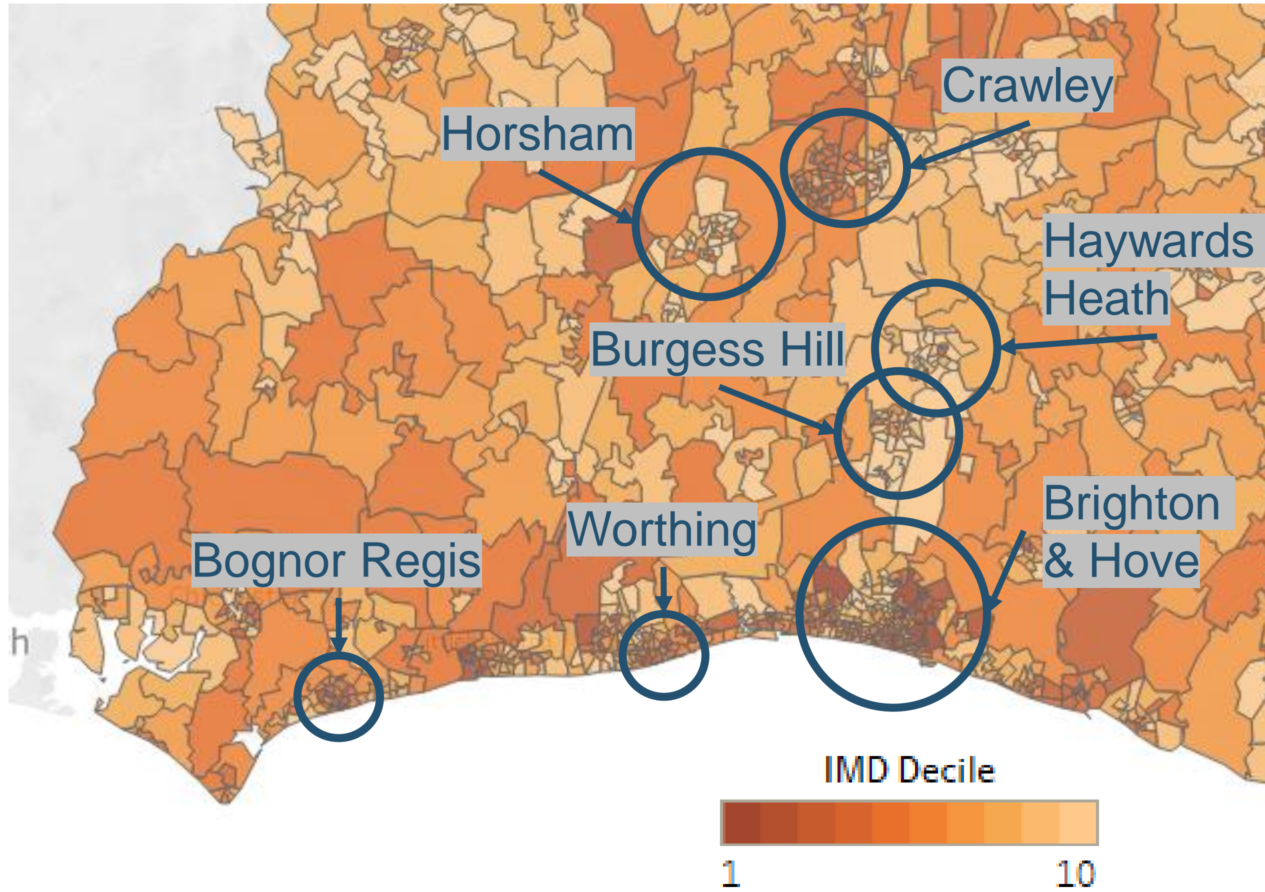
The conversation needs to continue

ARC KSS

- Co-designed information leaflets with Nepali people (not translation of English leaflets). Wide uptake in UK and also in Nepal.
- Needs articulation for children and young people leaving care, co-designed at front line of service delivery/ receipt.
- Several projects looking at acceptability and success of remote intervention (memory assessment, CBT).

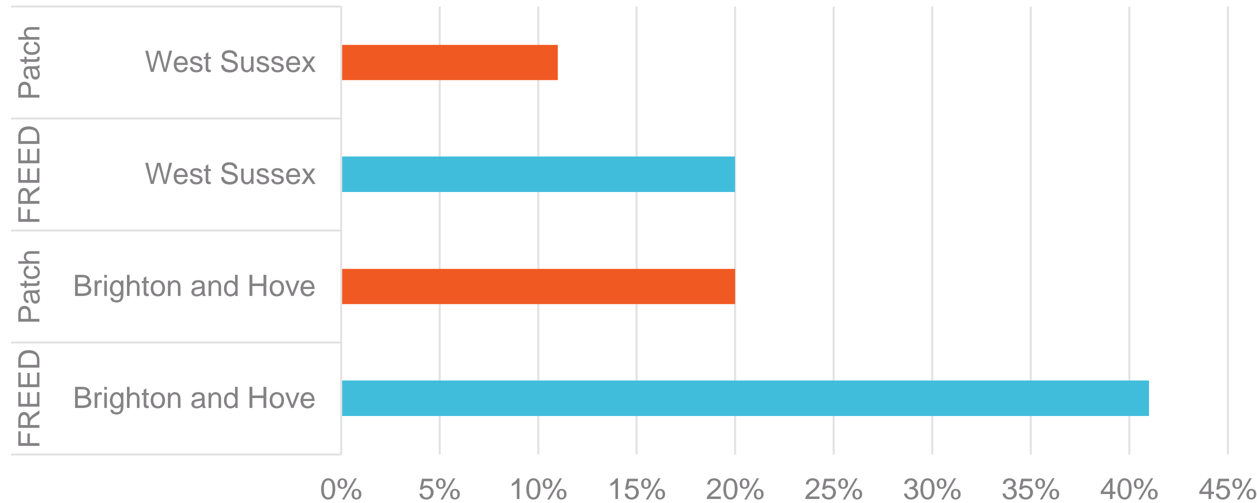
FREED - Geography & Deprivation

IMD map from KSS dashboard



Patch	Patients Referred
Brighton & Hove	37
Horsham	11
HH/Burgess Hill	7
Crawley	5
Bognor Regis	4
Worthing	4
Chichester/Arundel	3
Burgess Hill	2
Littlehampton	2
Shoreham/Lancing	2
Chichester	1
East Grinsted	1
Emsworth	1
Lancing	1
Steyning	1

FREED - Ethnicity



Ethnicity	Average Assessment Wait Time (Days)	% of 48hr Calls on Time
Mixed Ethnicity	29	25%
White - British	24	70%
White - Other	21	67%
Not Stated	27	73%

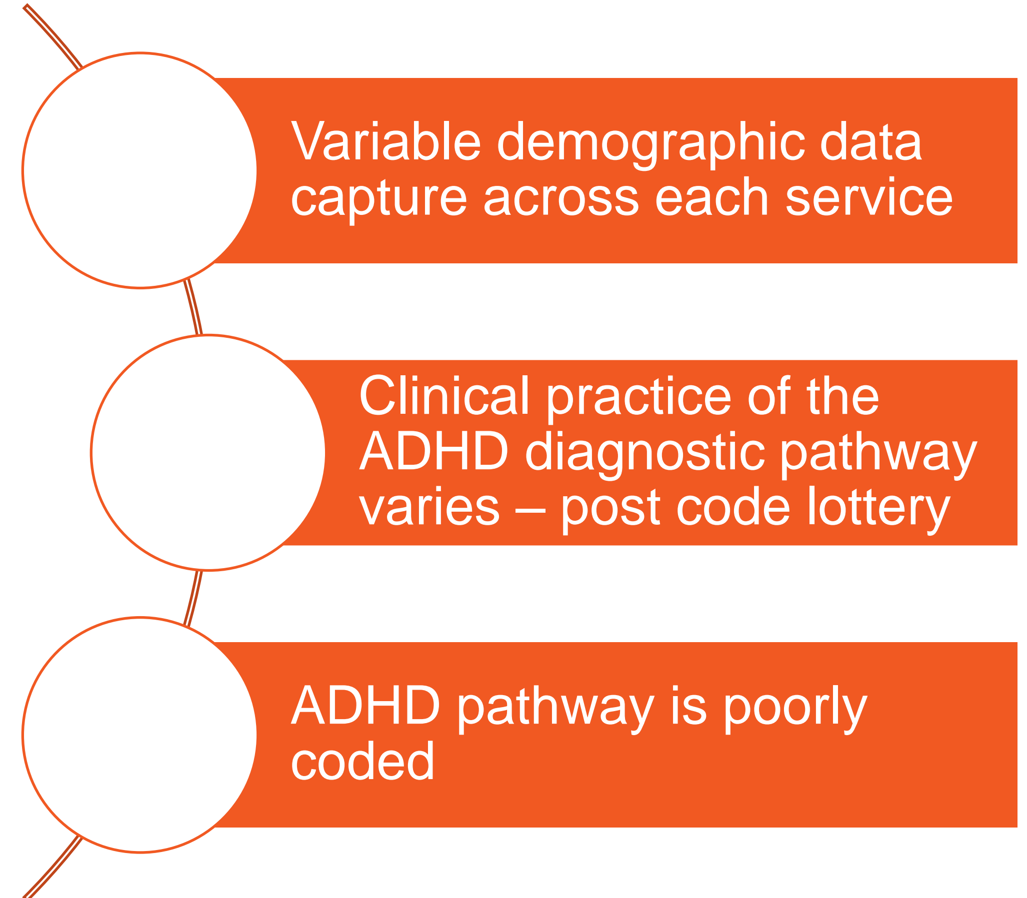
- **Larger proportion of non-white British patients** within the service compared to the areas the patients are from
- **Longer wait times for assessment for mixed ethnicity** patients compared to white British patients
- **Smaller proportion of 48hr calls were made on time for mixed ethnicity** patients compared to other cohorts

Focus ADHD

Purpose: To examine meaningful variation in access, quality of care and outcomes between demographic groups across ADHD services in Kent, Surrey & Sussex

Approaches considered

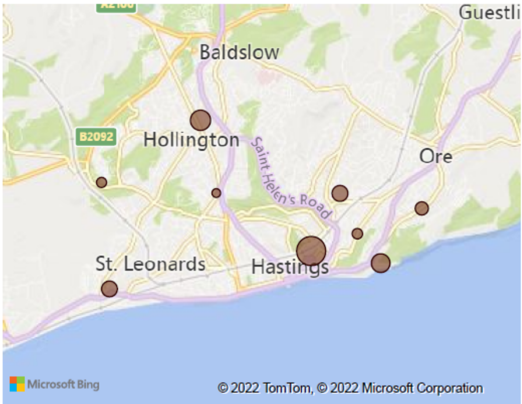
1. Working with local providers to obtain demographic data and ADHD clinical data
2. Utilising national mandatory data collections to observe inequalities



Sussex Integrated Dataset: health checks in SMI

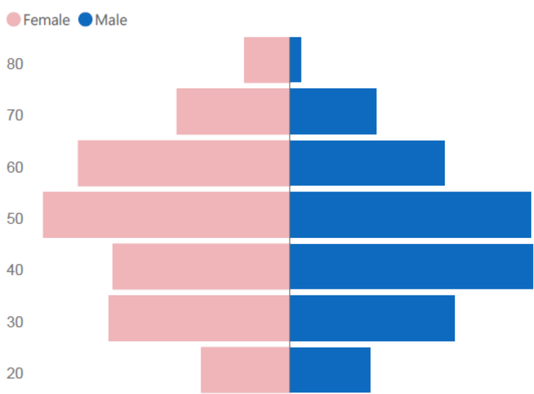
PCN	Practice	Place
Hastings and St Leonards PCN	All	All

SMI Patients by Practice

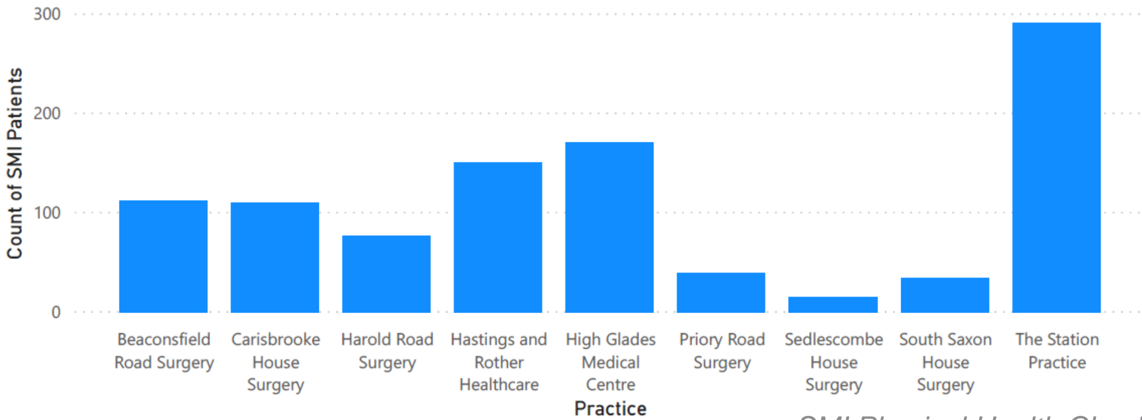


Full Patient List	Of which SMI
107K	999
In remission	**Active SMI**
157	842
Full PHC completed	**Full PHC %**
567	67%

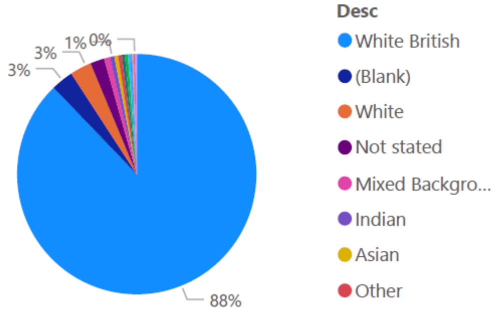
SMI Patients by age and sex



SMI Patients by Practice



SMI Count by ethnicity



SMI Physical Health Checks Dashboard – Sussex Integrated Dataset

Learning

- Better data (and data access) is needed, to understand the challenge and evaluate the success of a variation in approach. This could be prospectively collected, or be drawn from integrated data sets.
- Co-design at the *gemba* is vital.
- Groups are not hard to reach.
- Therefore, outcomes, evaluation, spread and impact of work needs to be designed-in early, not retro-fitted.
- Lack of fairness may be an important hook.

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Q&A