Inclusive Recovery: A Population health approach

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NHS

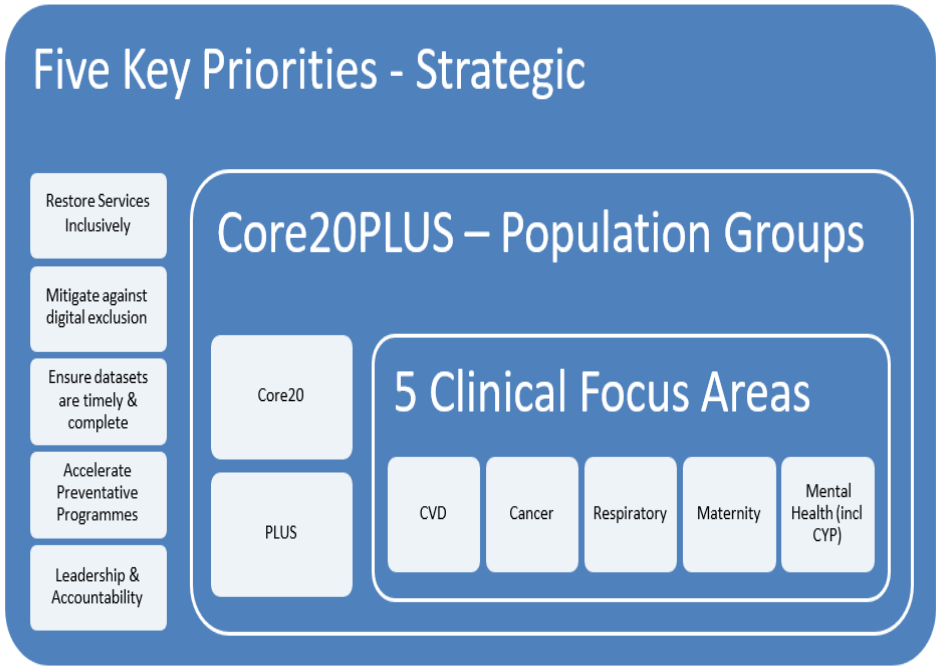
UK Health Security Agency

NHS England and NHS Improvement

Context

- COVID has highlighted the urgent need to prevent and manage ill health in groups that experience health inequalities
- Health services have changed radically and rapidly in response to the Covid pandemic. Services were redesigned to manage anticipated surges in Covid cases and associated risks
- Access to planned acute care, diagnostics, outpatient care and planned surgery are now significant concerns.
- Pre-existing disparities in access, experience, and outcomes, have been exacerbated by the pandemic
- Priority to restore services inclusively using local data/intelligence

Health Inequalities Improvement programme (Core20PLUS5)

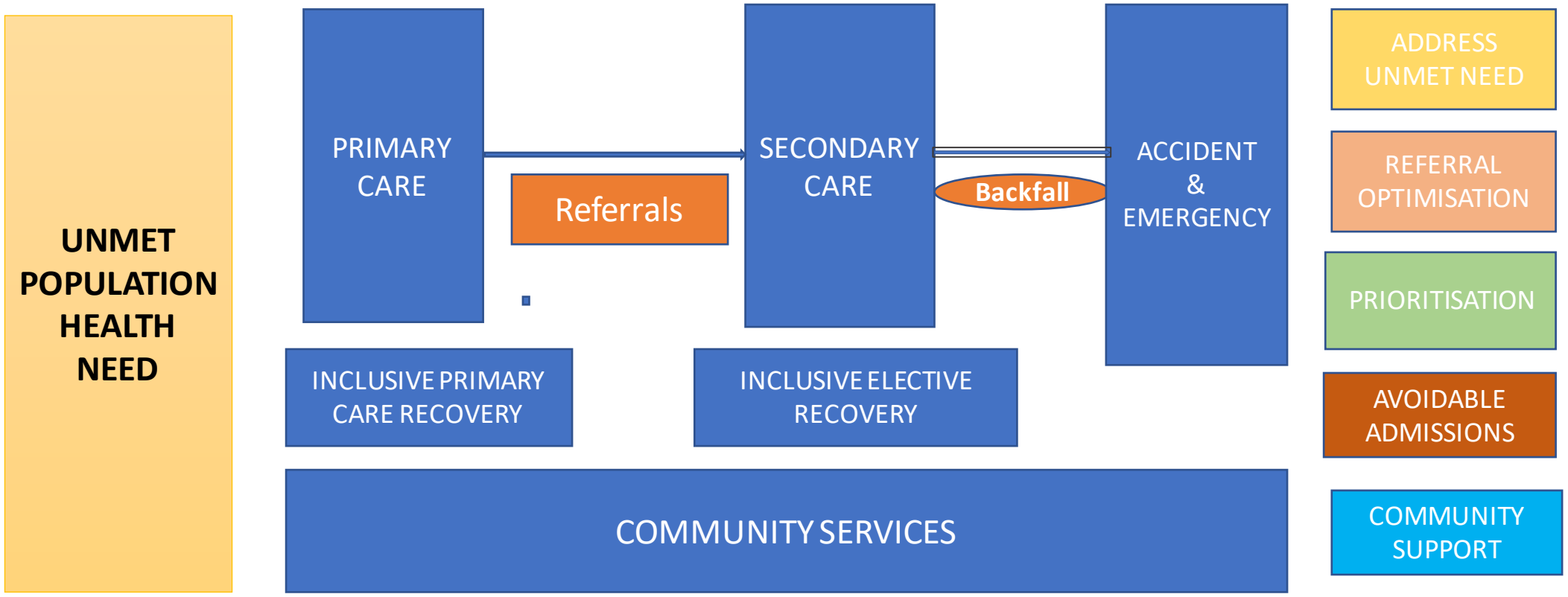


Drivers of demand

- **Increased need and demand for services post COVID**
  - increased mental health issues in children and adults
- **Increased unmet need**
  - reluctance for people to access health and care services
  - reduction in capacity in non-covid-19 services at the peak of the epidemic
- **Significant restraints placed on the capacity due to Covid-19**
  - Reduced staffing and bed capacity during COVID
- **Disproportionate impact on disadvantaged groups**
  - Vulnerable population, inclusion groups
  - Issues with access and acceptability of services

- **Patients' willingness to present at primary care**
- **their ability to get an appointment**
- **GPs willingness to refer to secondary care**
- **willingness of patients to take up hospital appointments**
- **Morbidity & mortality while waiting**
- **Hospital staffing levels**
- **Diagnostics, bed & theatre capacity**

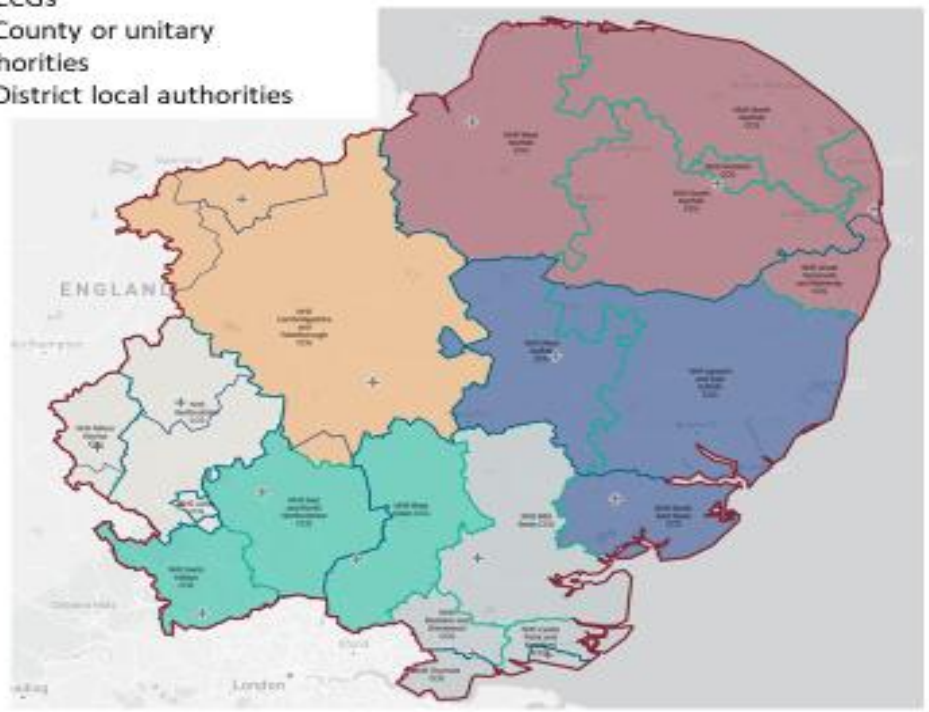
END TO END CARE



Where we are in the EOE?

East of England

6 Integrated Care Systems
14 CCGs
12 County or unitary authorities
46 District local authorities



The East of England is home to 6.269 million people, a population that is bigger than Scotland

The population is forecast to grow by 7.4% (470'k) over the next two decades.

Much of the projected growth will be in older age groups. By 2043, 25.6% of the East of England population are projected to be aged over 65 years.

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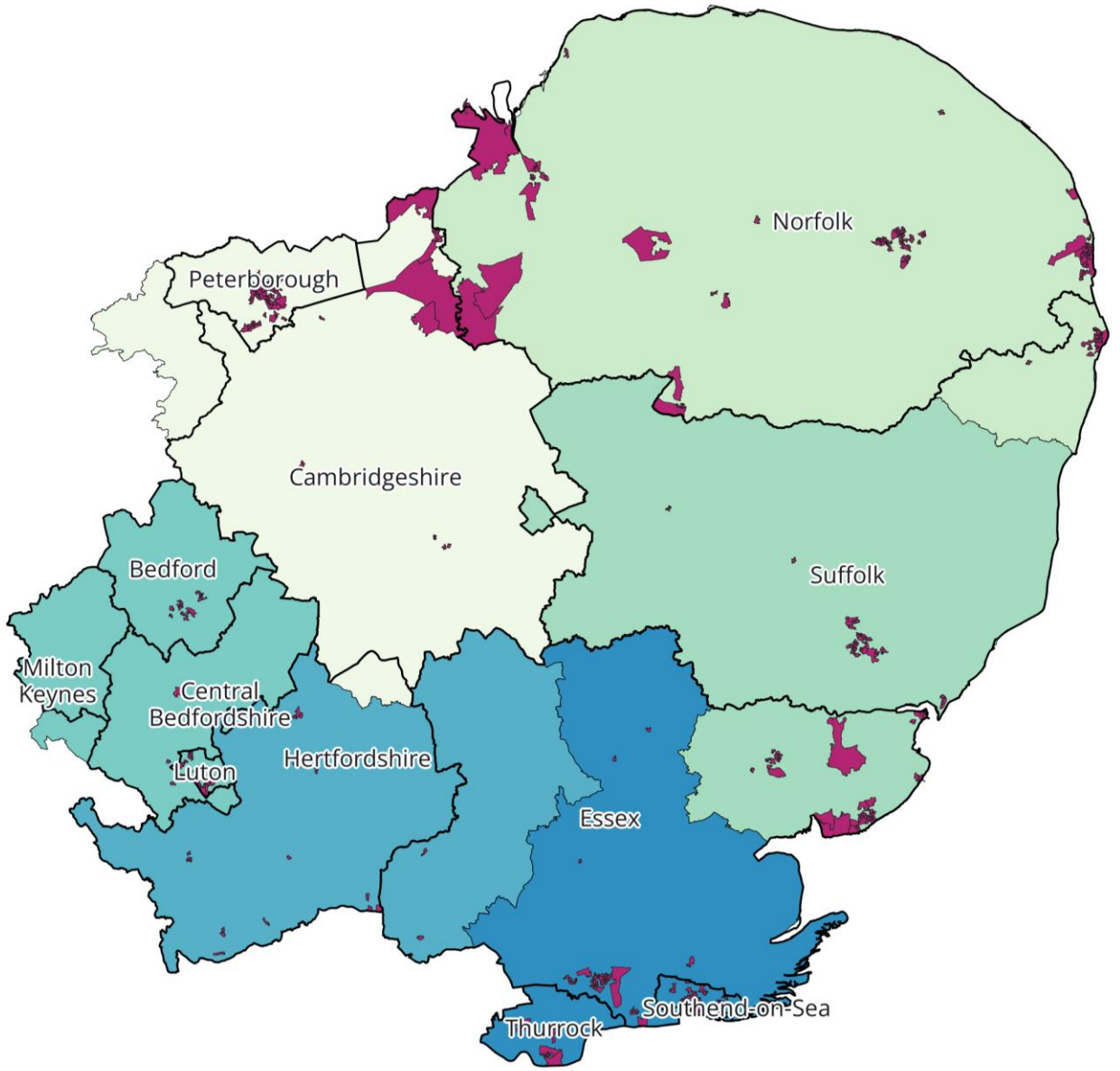
East of England ICS with Upper Tier Local Authority Boundaries

UTLA name (2019)	IMD - Average score	IMD - Rank
Peterborough	27.8	40
Luton	25.9	54
Southend-on-Sea	22.4	76
Norfolk	21.2	84
Thurrock	20.9	85
Bedford	18.9	96
Suffolk	18.5	101
Milton Keynes	18.0	107
Essex	17.0	111
Cambridgeshire	13.9	132
Hertfordshire	12.7	134
Central Bedfordshire	12.2	137

Average IMD
England: 22.9
EoE: 19.1



151 UTLA

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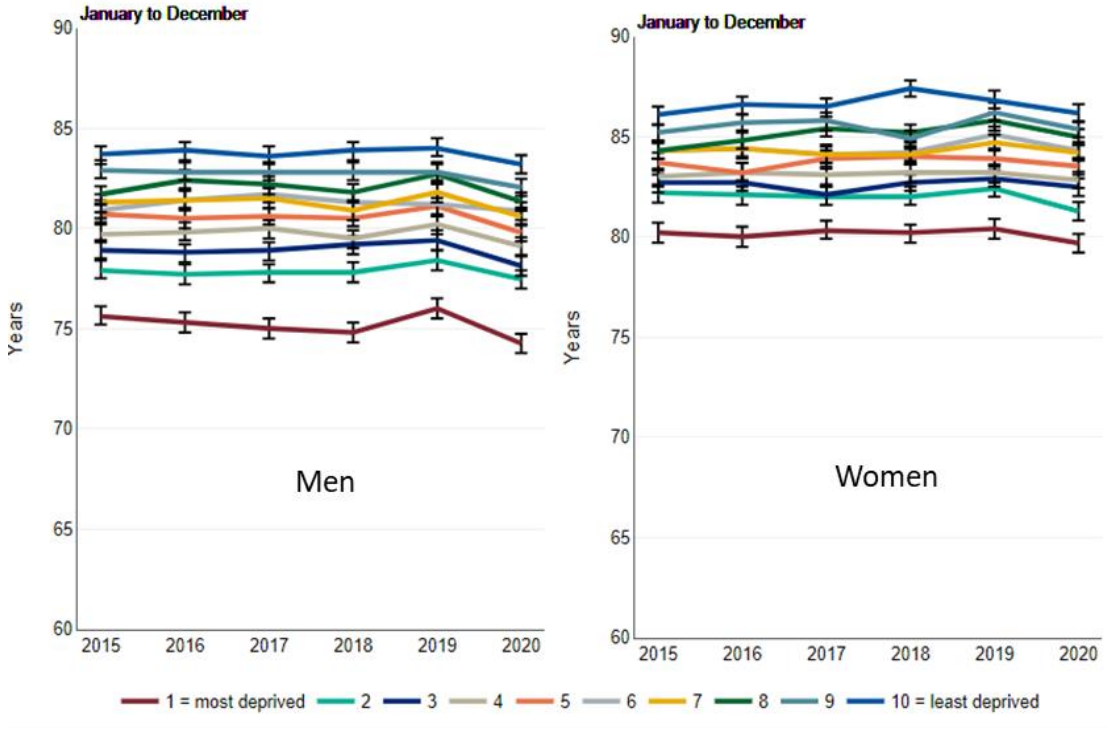
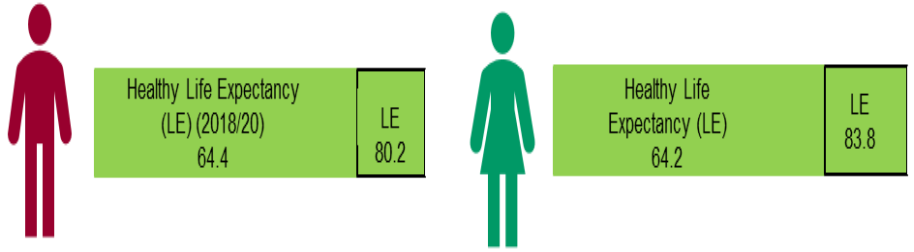
English indices of deprivation 2019 - GOV.UK (www.gov.uk)

Life expectancy by deprivation



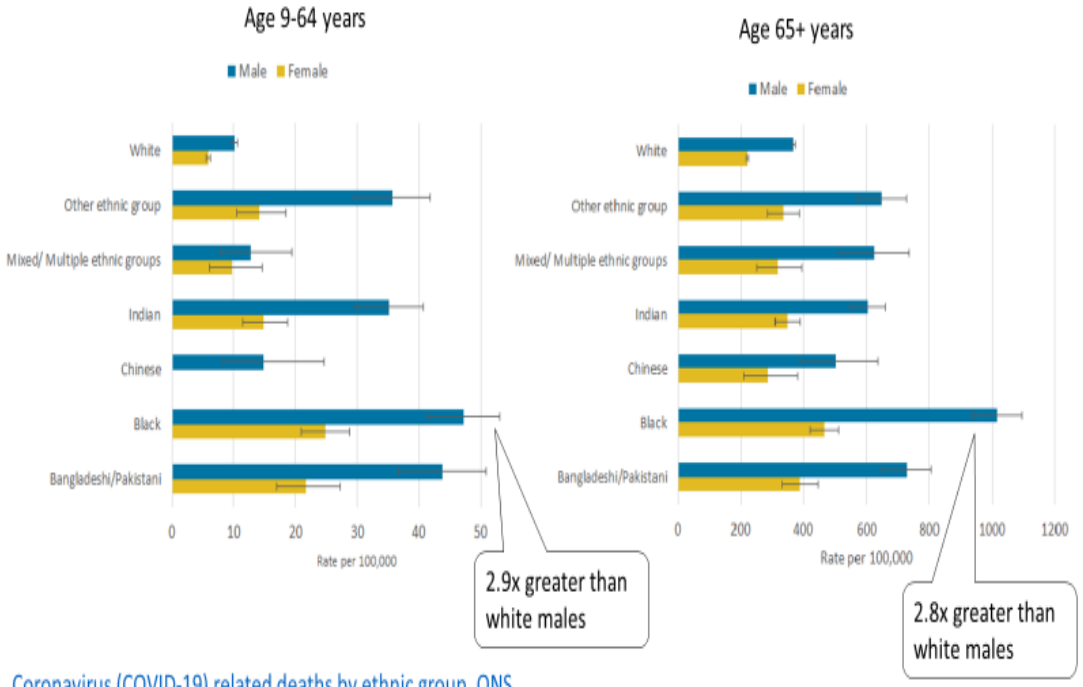
Life expectancy at birth for men and women in the East of England by deprivation decile

- 9 year difference in average life expectancy for men living in the most and least deprived parts of the region. For women, there is a 6.5 year difference
- on average, men in the East of England can expect to spend 16 years of their life in poor health, for women the equivalent figure is 20 years



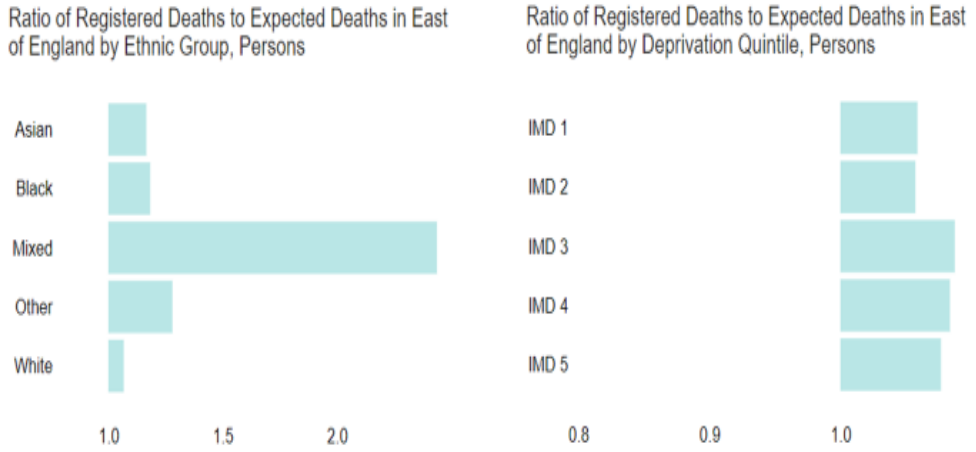
Impact of COVID

Age-standardised Mortality Rates from Covid-19 by Ethnicity, England and Wales, Mar-May 2020



Coronavirus (COVID-19) related deaths by ethnic group, ONS

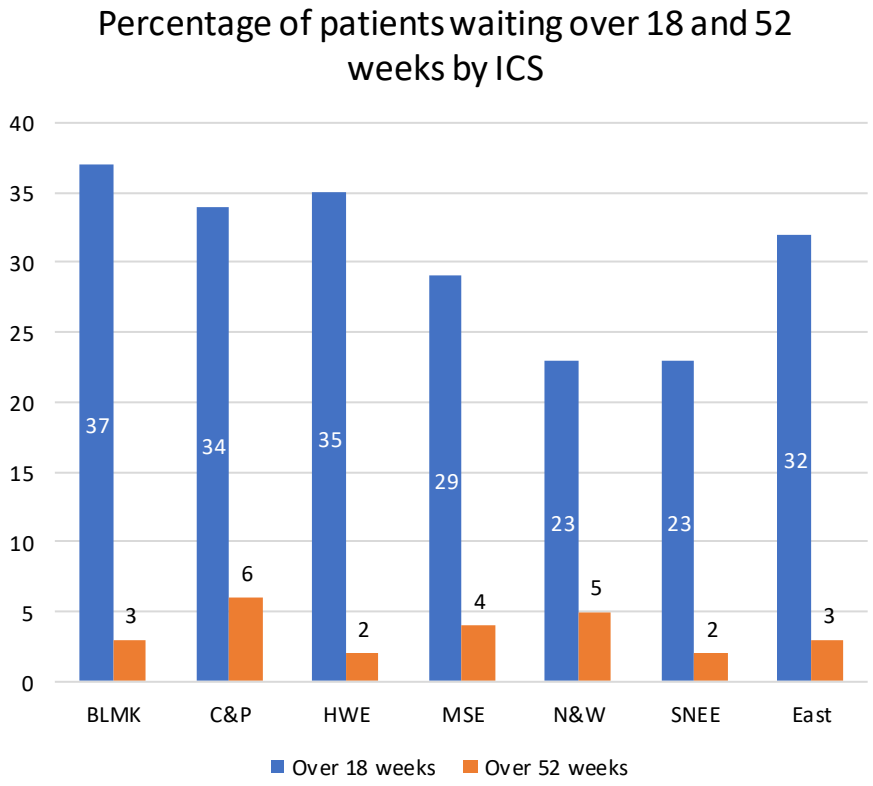
Excess Mortality Ratio due to Covid-19 in East of England, Mar 2020 to May 2022



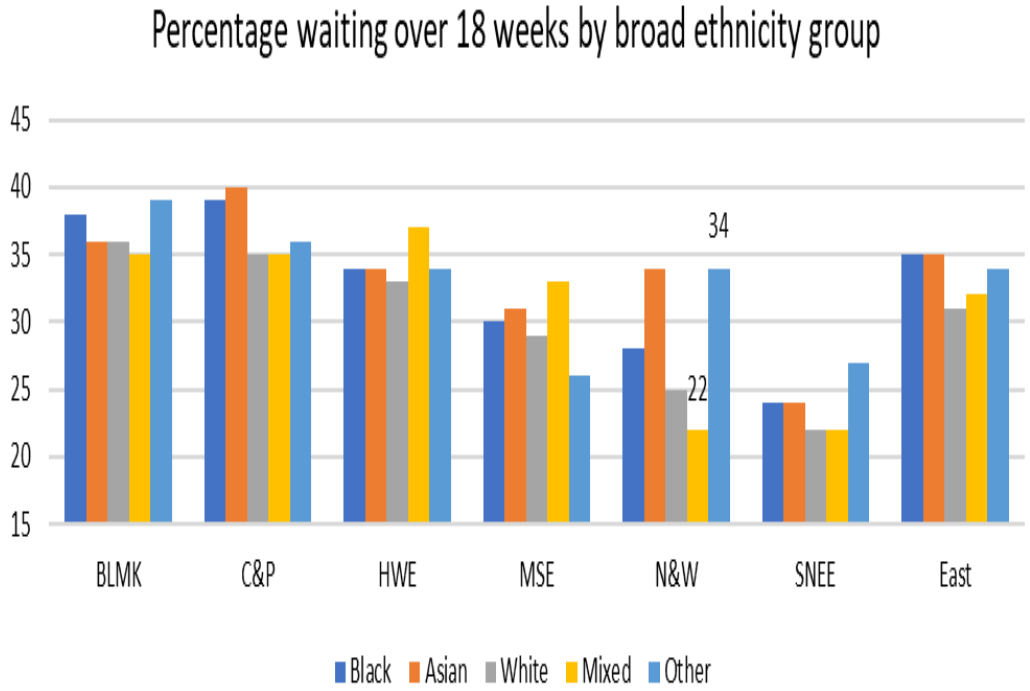
Excess mortality in England and English regions - GOV.UK (www.gov.uk)

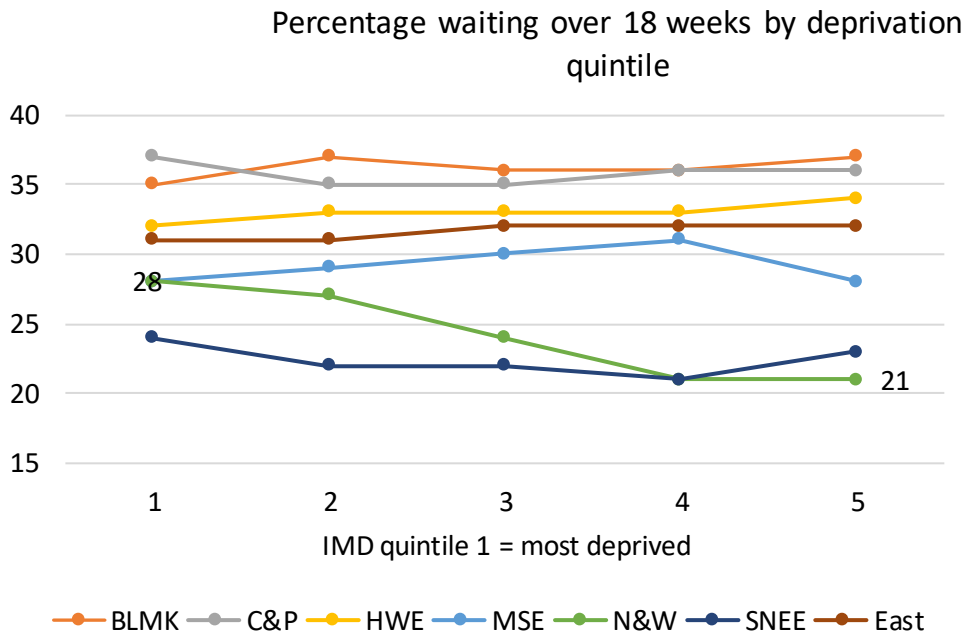
Waiting list data

- **698,420** pathways recorded on the waiting list in the East of England. Despite some data missing, the **waiting list is increasing week on week**.
- **41.6% of pathways** in EoE have been waiting for **18 full weeks or longer**, **and 5.4% have been waiting for 52 full weeks or longer.**
- There is **clear variation between systems and providers** e.g % of waiting lists waiting over **18 weeks** range from **21.4%** at Royal Papworth, up to **49.9%** at Norfolk and Norwich Hospital and % **waiting over 52 weeks** ranges from **0%** at Royal Papworth, up to **7.4%** at Princess Alexandra Hospital.



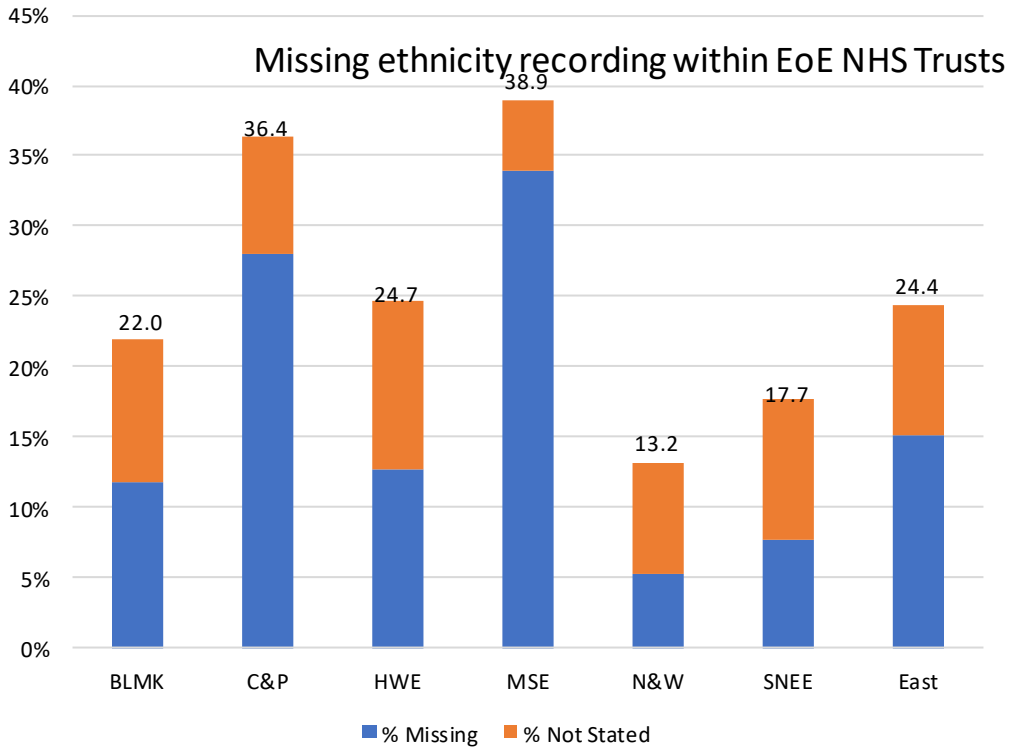
Waiting list by ethnicity and deprivation

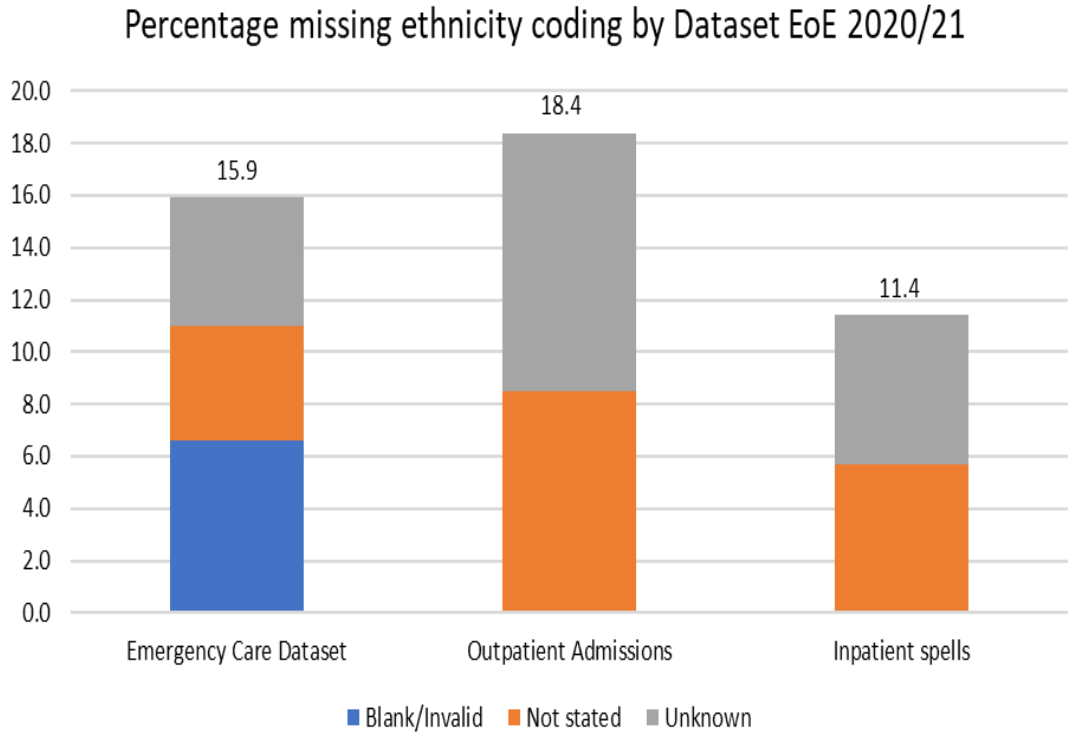




Data quality issues: missing data

- **Data quality issues**: Data completeness, Data accuracy

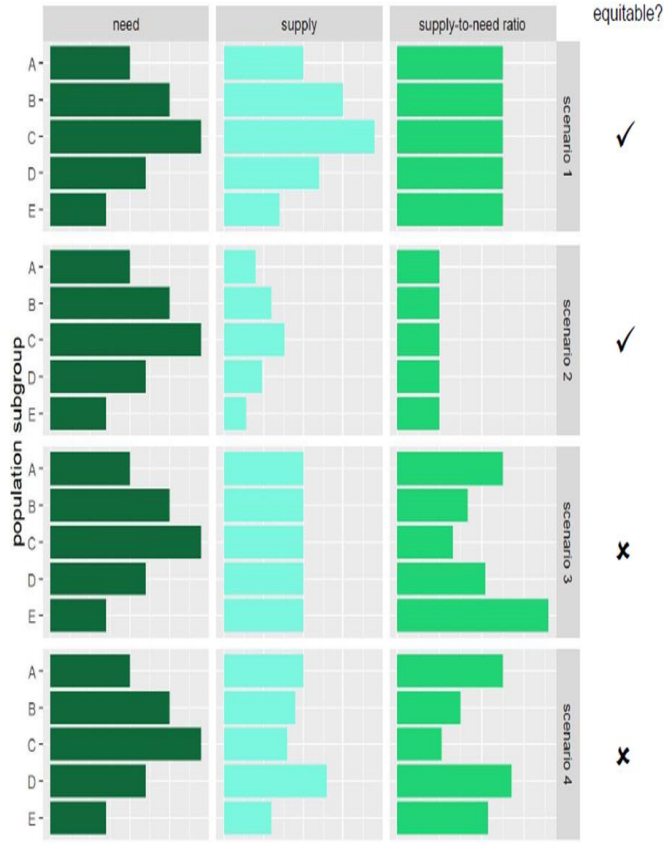




Inclusive recovery: Guiding Principles

- An equitable distribution is one where rates across population subgroups follow the distribution of need, such that a patient with a given level of need in one subgroup has the same chance of accessing a service as their counterparts with a similar level of need in other subgroups.
- **Levelling up:** Levelling-up involves differentially increasing supply to population subgroups by just enough so that all subgroups have supply-to-need ratios equivalent to the population subgroups with the highest supply-to-need ratio at baseline.
- **Levelling down:** The levelling-down route to equity involves differentially reducing supply to population subgroups by just enough so that all subgroups have supply-to-need ratios equal to the population subgroup with the lowest supply-to-need ratio at baseline.
- **Zero sum distribution:** The zero-sum redistribution route to equity sits between the levelling-up and levelling- down scenarios. Total level of activity is preserved, but the activity is redistributed across population subgroups so that all have the same supply-to-need ratios.

Figure 3: Illustrative examples of equitable and inequitable distributions of a service



Inclusive recovery: guiding principles

- Effectively address health needs of population within available health and care resources
- 3 clinical principles
  - **Minimise the harm** at the individual and population level (e.g. time critical care)
  - **Maximise benefit** (e.g. the clinical prioritisation of outcomes)
  - **Limit health inequalities** (e.g. vulnerable groups)
- Consider population risk and clinical risk

	Clinical Risk	Population risk
Minimise harm (Time Critical Care)	• Clinical risk gradient • Time critical clinical pathways	• Population need and demand; trends
Maximise benefit (Prioritisation of outcomes)	• High Impact Clinical Interventions • PoLCE	• Population benefit • Preventable morbidity and mortality
Reduce inequalities (Vulnerable groups)	• Increased clinical risk • Reduced access to services	• Variations in need and demand by population groups • High risk groups

Discussion points

- Recognition: important and urgent area of work, complex, new ways of working
- Engagement with key stakeholders; System wide, collaborative approach; work in progress

Issues to address

- Consensus on approach and framework for recovery- uniform system wide approach? What's the best fit for EoE?
- How do we improve data quality?
- What will good look like? Measures of success
- How well linked is the Inequalities agenda with the elective recovery agenda in systems? What has gone well and what are the challenges?
- What added value can the regional PH team offer?
- Next steps