RACE EQUALITY

Welcome

Race Equality and Health Inequalities: Backlog recovery and impact on ethic minorities

April 2023

NHSProviders

Agenda

Welcome and introduction
Facilitated by chair

Presentation from Kiran Patel + Q&A
Professor Kiran Patel – chief medical officer, deputy CEO and consultant cardiologist, University Hospitals Coventry and Warwickshire NHS Trust

Presentation from Ruw Abeyratne + Q&A
Dr. Ruw Abeyratne – director of health equality and inclusion, University Hospitals of Leicester NHS Trust

Panel Q&A
Facilitated by chair

Summary and close
Facilitated by chair

Close of event

Housekeeping

- Please note, this event is being recorded
- Please keep your camera on wherever possible
- If you lose connection, please re-join using the link in your joining instructions or email race.equality@nhsproviders.org
- Please ensure your microphone is muted during presentations to minimise background noise
- We will come to questions after each speaker
- Please feel free to use the chat box for questions and sharing examples of what has delivered sustained progress in your organisation
- If you would like to ask a question audibly, please use the raise hand function during the Q&A section and we will bring you in
- Any unanswered questions will be taken away and answered after the event
- You will receive a link to an evaluation form at the end of the day, please take the time to complete it, we really do appreciate your feedback.

Getting to the HEARRT of Inequalities

Prof Kiran Patel
Cardiologist, Chief Medical Officer, Deputy CEO

Inequalities in health are worse then inequalities in illness

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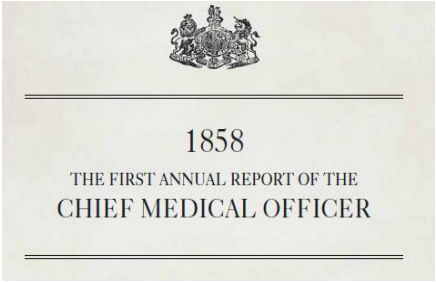
- Unfair and avoidable disparities in health based between different groups within society.

  - Social class
  - Race
  - Gender

Dahlgren G, Whitehead M (1993)



- 1980 Black report
- 1998 Acheson report 39 recommendations
- 1999 Saving lives, our healthier nation
- 2000 NHS Plan
- 2002 Cross cutting review
- 2003 Tackling Health Inequalities: A programme for action
- 2004 Wanless report
- 2004 Choosing Health
- 2006 Health Challenge England
- 2006 Our health, our care, our say
- 2008 Health Inequalities: progress and next steps
- 2009 Tackling health inequalities: 10 yrs on report
- 2010 Marmot review

Markers of inequality

- ACEs
- Qualifications and educational attainment
- Self harm admissions
- Drug abuse
- Alcohol abuse

- Loneliness
- Mental wellbeing
- Antidepressants

- Physical health issues

- Work
    - increased hours
    - zero hours
    - higher sickness rates
    - Lower productivity

Education : a powerful weapon against HI (Harry Burns, CMO for Scotland 2005)

HI for the most deprived

- Access inequity
    - Elective
    - Urgent e.g. dental, CVD
- Delayed diagnoses
    - Cancer
    - DM…
- Disruption of care

Bravery: in action or inaction?

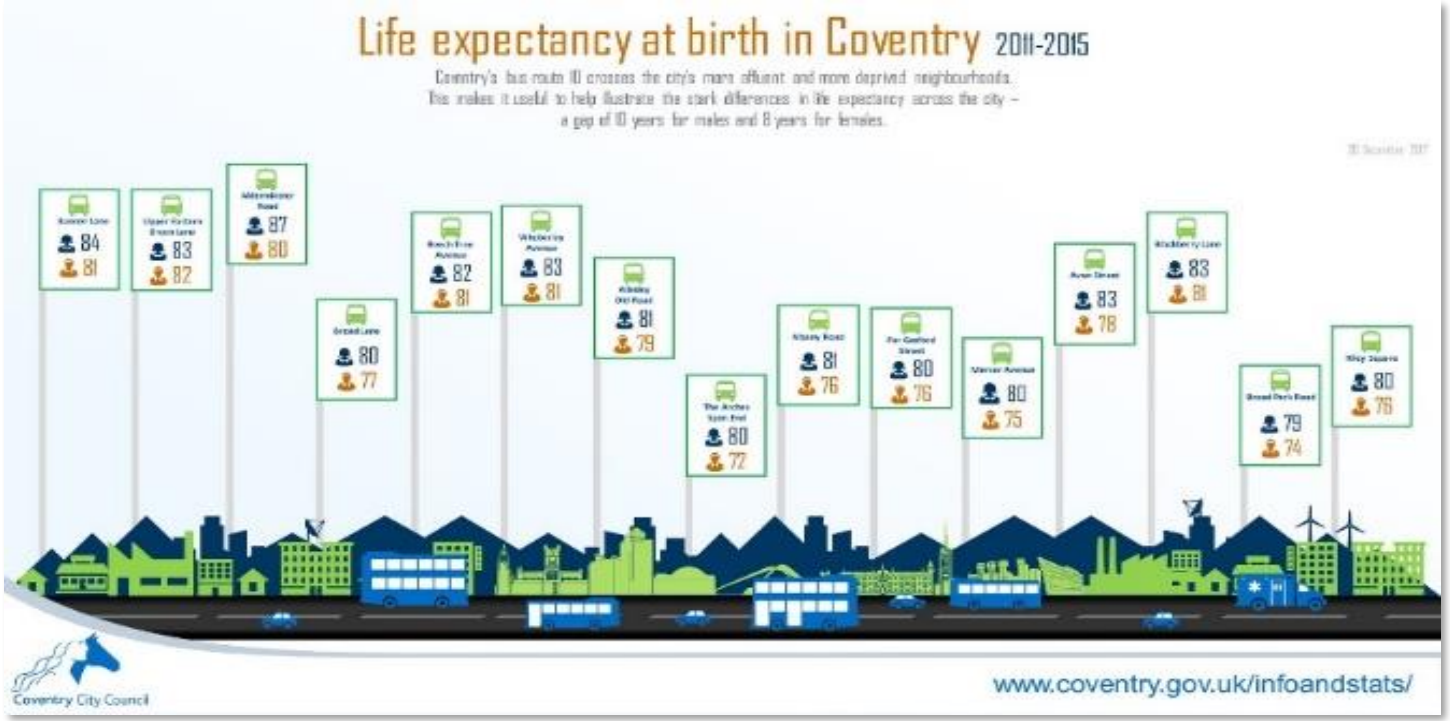
- Centralisation vs devolution
    - Power to fund and deliver public services
    - e.g. Greater Manchester had an impact on HI with devolution
    - BUT ; USA has also devolved but has greater HI!
- Austerity – hits the vulnerable hardest
- Market regulation
    - Income from tobacco & fast food challenges public health
    - Liberalism vs nanny state
- Accountability deficit

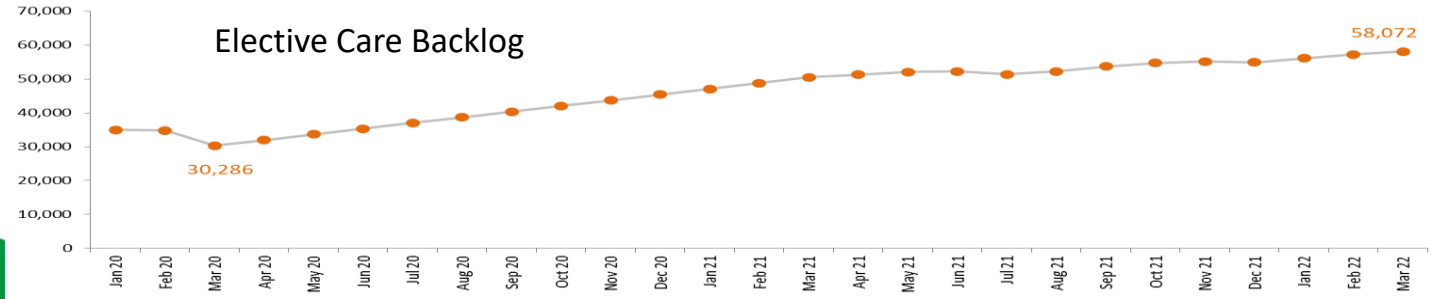
How to think about HI

- See health as an asset
    - Level up health and prosperity……within a generation
- Seeing illness as a cost in isolation…….a failure of H&SC or civil society?
- Healthy places
    - Access to green space
    - Access to services
    - Crime
    - Economic and working conditions
    - Living conditions

The challenge

- Combatting health inequalities at a local level
- The role of integrated care systems
- Prevention initiatives
- Addressing risk factors for poor health outcomes
- Use of population health methods
- Accessibility of local services





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NHS Priority: to reduce health inequalities

1. **Restore** NHS services inclusively
2. **Mitigate** digital exclusion
3. **Ensure** datasets are complete and timely
4. **Accelerate** preventative programmes that proactively engage those at greatest risk of poor health outcomes
5. **Strengthen** leadership and accountability


EDITORIALS

Check for updates

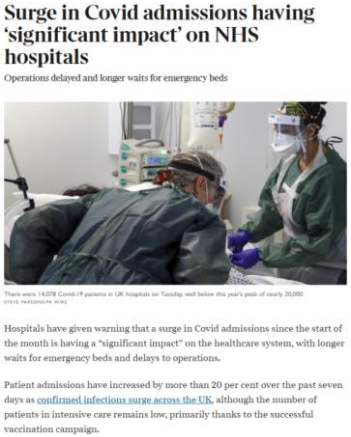
Ensuring an equitable recovery for the NHS

Health leaders must seize this historic opportunity to level up

Kiran Patel,[1] Rachel Chapman,[1] Raj Gill,[2] Justine Richards[1]

The effect of the pandemic on non-covid related healthcare is only now starting to be felt by patients and healthcare systems. At least 4.5 million people are estimated to be waiting for elective care in the

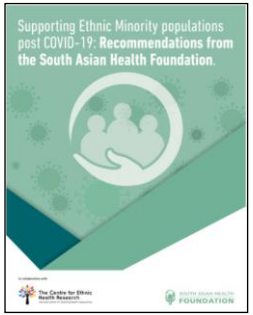
in more affluent areas.[8] NHS waiting lists must swell with more needful patients, even at a time of substantial backlog, if we are to reduce inequalities. We must not accept a system that increases waiting


Surge in Covid admissions having 'significant impact' on NHS hospitals

Operations delayed and longer waits for emergency beds

Hospitals have given warning that a surge in Covid admissions since the start of the month is having a "significant impact" on the healthcare system, with longer waits for emergency beds and delays to operations.

Patient admissions have increased by more than 20 per cent over the past seven days as confirmed infections surge across the UK, although the number of patients in intensive care remains low, primarily thanks to the successful vaccination campaign.



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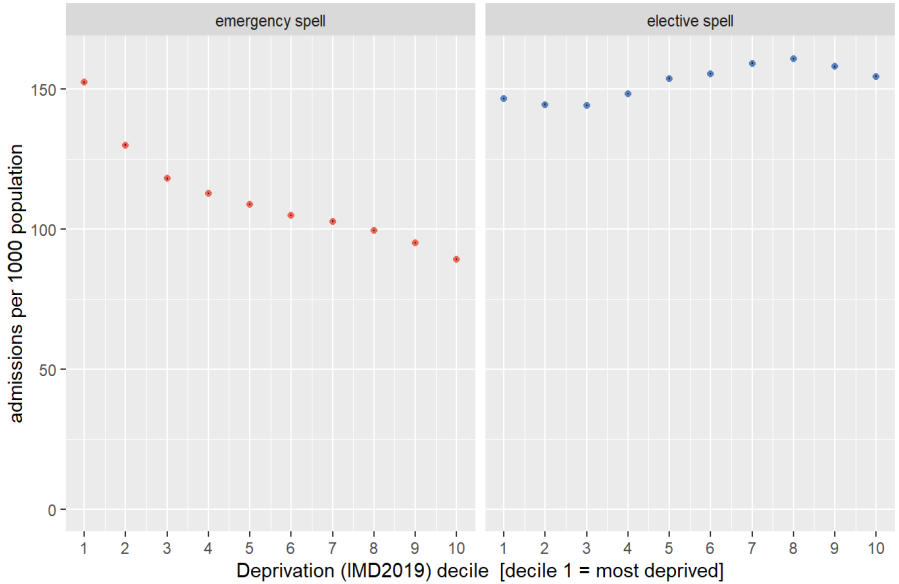
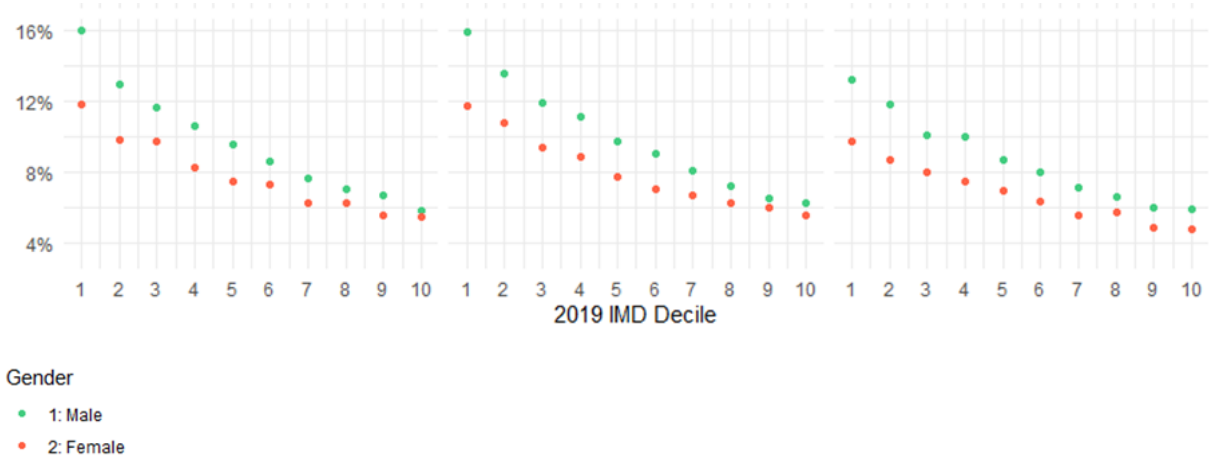
Elective and Emergency Admissions by Deprivation

Crude rate per 1000 population – England 2018



Spilsbury et al, Midlands and Lancs CSU, 2016

NHS service inequalities – OP DNAs



Analysis done by Coventry and Warwickshire CCG BI Team, 2022

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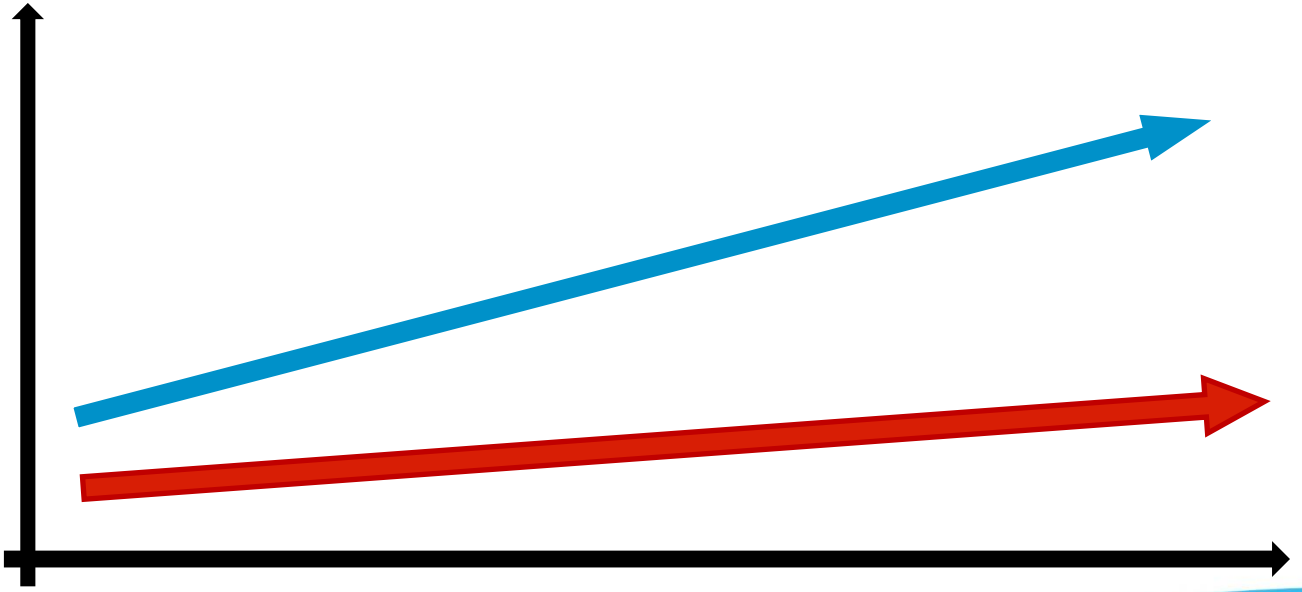
Inequalities in Health



Guarding against inequality throughout the care pathway

Who are we missing?

- Proactive case finding
- Early referral

How do we ensure timely access?

- Prioritisation of waiting lists
- Active waiting
- Poverty proofing
- DNA management

Which patients are more likely to have poor experience/outcomes?

- Lifestyle referrals
- Social prescribing
- Wider determinants
- Health literacy
- Prevention in all pathways

Restoration using PHM

1. How do we ensure that restoration **doesn't increase** inequalities?

2. How can restoration **help** to reduce inequalities?

Delivering further value:

- Prevention at scale
- Urgent and emergency care: reduced demand

Voluntary health screening tool
accessed by QR code to help identify how University Hospitals Coventry and Warwickshire NHS Trust can support your health and well being.

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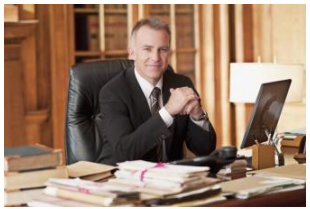
The Problem: Waiting lists fuel inequality

William from Warwick



GP at first symptoms
No co-morbidities
Prehab

Waiting List Time 18 weeks

WFH + supported return
Full recovery
No impact on family

Norman from Nuneaton

GP when can't work
Smoker, diabetes, HTN
Can't attend prehab

Waiting List Time 18 weeks

Late stage surgery
Poor recovery
Loses job
Depression
Increased healthcare cost

Additional Factors Impacting Healthcare Outcomes

Within the existing categories are numerous patients, with many conflicting underlying health issues, and a range of social and demographic indicators including socio economic status, occupation, geographical location and protected characteristics

Current Factors for Booking Order			
Clinical Priority		Time on the Waiting List	
Additional Factors Impacting Healthcare			
Patients Age	Underlying Health Issues	Readmission Rates	Deprivation Score
Emergency Admissions	Cancer Diagnosis or Referral	Breaches to the Clinical Priority	Shielded Patient
Mental Health Issues	Previous Cancellations	Previous DNAs impacting Wait	Many more…

Everybody receives NHS Constitutional Standards

What information do we have now?

Avatar – Trauma & Orthopaedics

Patient A

- Waiting for Total Prosthetic Replacement of Knee Joint
- Priority 3
- Waited 15 Weeks

Patient B

- Waiting for Total Prosthetic Replacement of Knee Joint
- Priority 3
- Waited 47 Weeks

In this example, we would book Patient B, as they have waited longer

What additional information can the tool give us?

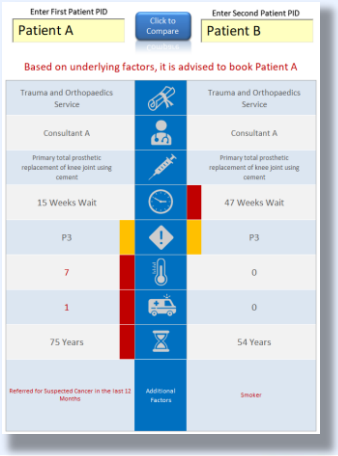
Avatar – Trauma & Orthopaedics

Patient A

- 75 Years Old
- 7 Comorbidities
- Has been referred separately to another service for suspected Cancer
- Recently came into A&E after a fall
- Has breached their clinical priority
- Lives in a deprived area

Patient B

- 54 Years Old
- Smoker



Now who ?

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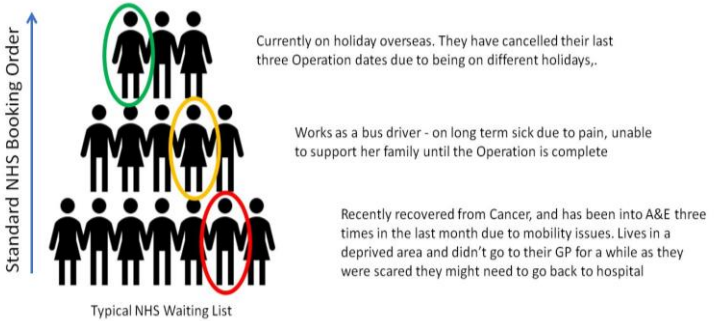
Patients Waiting for a Hip Replacement

Clinical Priority Level 3



Waiting List Generator

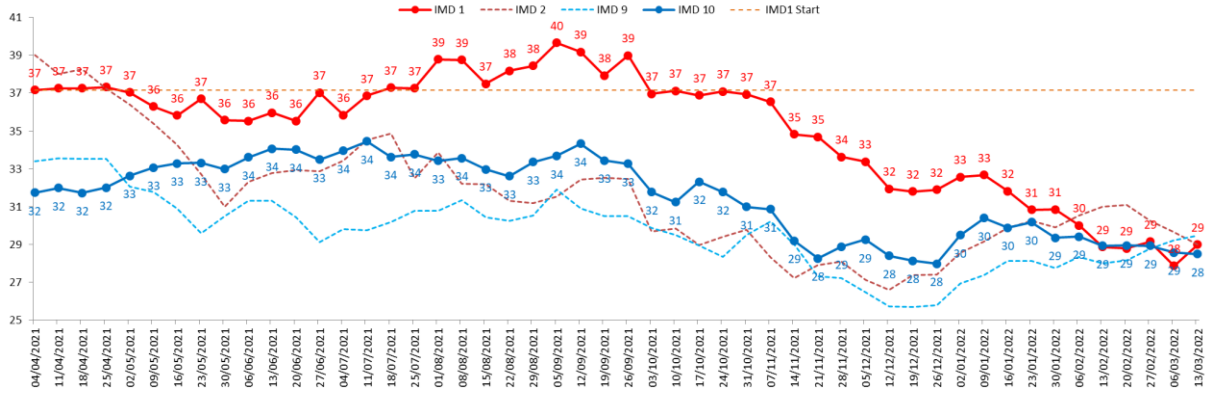
Using the weighting system within the Priority Tool we can apply the same process for comparing two patients to the entire Waiting List.
This is done on a Specialty, or even Procedure basis, to ensure a like for like comparison

New Order	Original Order	Patient Number	Wait Time	OPCS Code	PrimaryProcedureDesc
1	200	Patient0200	56.7	W401	Primary total prosthetic replacement of kn
2	342	Patient0342	36.3	W371	Primary total prosthetic replacement of hip
3	66	Patient066	23.7	W401	Primary total prosthetic replacement of kn
4	13	Patient013	70.9	W403	Revision of total prosthetic replacement of
5	38	Patient038	36.4	W401	Primary total prosthetic replacement of kn
6	54	Patient054	28.6	W371	Primary total prosthetic replacement of hip
7	100	Patient0100	12.4	W371	Primary total prosthetic replacement of hip
8	119	Patient0119	90.7	W401	Primary total prosthetic replacement of kn
9	124	Patient0124	87.3	W401	Primary total prosthetic replacement of kn
10	126	Patient0126	85.1	W401	Primary total prosthetic replacement of kn

Here, this patient was original number 200 on the list. Based on their underlying conditions, they are now next to be booked

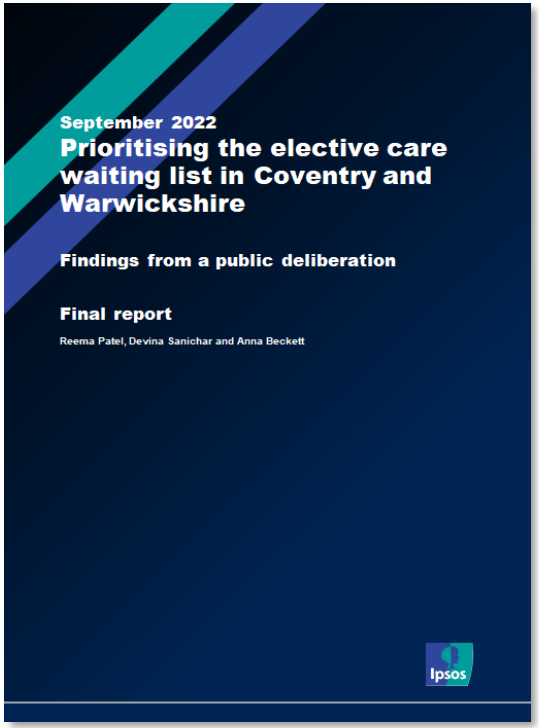
Trauma & Orthopaedics

Inpatients – T&O Average Wait Time (Weeks) – narrowing the gap



For T&O the most deprived (IMD 1) have reduced from 37 weeks to 29 weeks wait on average (a reduction of 8 weeks). During the same period the least deprived (IMD 10) reduced from 32 weeks to 28 weeks – a reduction of 4 weeks.

Public Engagement: IPSOS



- “My dad needed a knee replacement, didn’t get it, fell it and broke his hip. Has fallen again and broken his ribs. Has had pneumonia four times. If he had his knee done, it wouldn’t have happened.”
- “All of these people should have the same right to be assisted at the same time. None of them are more important than others. Their condition should be the only factor, not social aspects.”
- “If people are suffering more than others, those people should go first. You are reducing suffering for those people. I certainly see advantages.”
- “We’re trying to solve problems that aren’t medical ones in a way. We’re looking at balancing out people who are living in deprived areas and things like that and is that for the NHS to do or is it for the government to do?”
- “Life isn't fair, but I think it is a moral obligation as a human being to even out those odds where necessary, if possible.”

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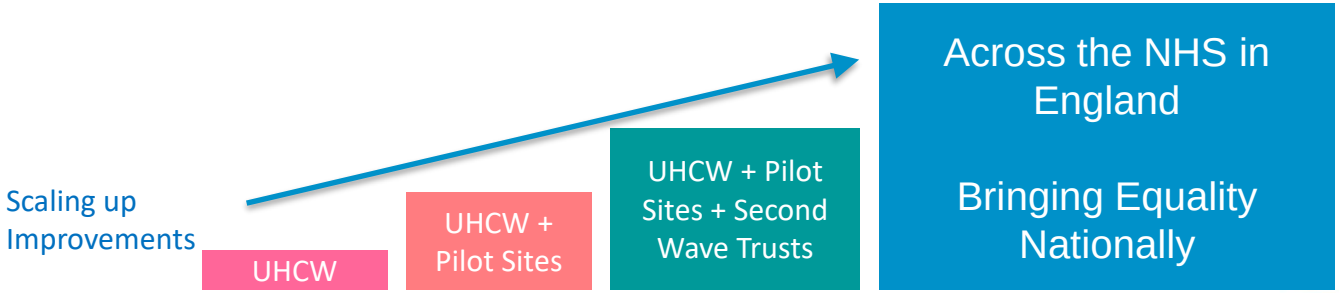
Adoption and Diffusion at Scale

National Scale up of the **HEARTT** System

- Pipeline of 30 NHS Trusts to potentially implementing HEARTT tool across trusts and ICSs

- Potential to contribute data on Deprivation and Wait Times to a central NHS dataset
- Benchmarking across Trusts, systems and populations



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The journey ahead

- Reducing inequalities further – is it the end of RTT as we know it?
- Agile waiting: GPs and patients
- Opening the debate on social value judgements – employment (NHS staff), career status, educational impact

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In the midst of every crisis, lies great opportunity: *Albert Einstein*

Acknowledgments to the HEARRT team at UHCW Prof Kiran Patel, Daniel Hayes, Dr Rachel Chapman, Paul Lipscombe, Prof Harpal Randheva

Thank you

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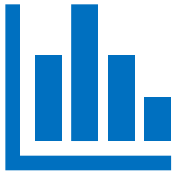
University Hospitals of Leicester NHS Trust

Health Inequalities at UHL

Dr Ruw Abeyratne

Director of Health Equality and Inclusion

Our approach to health equality



Data

Improvement

People

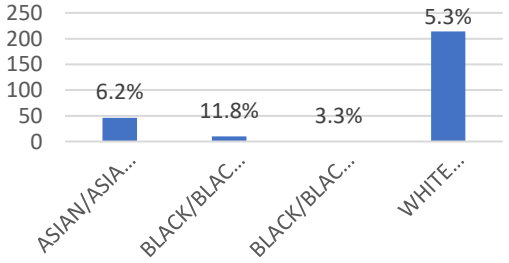
Learning

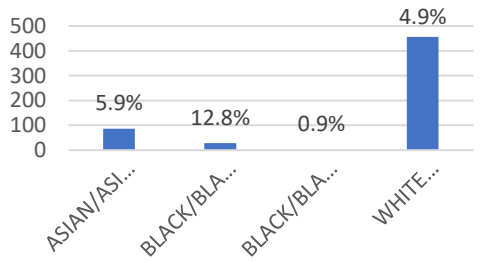
Culture

CORE20 PLUS 5

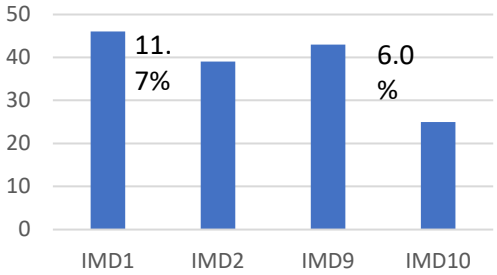
UHL Non-Attendance Pilot

Data: Patients from the most deprived communities and certain ethnic minority groups are more likely to not attend planned care appointments

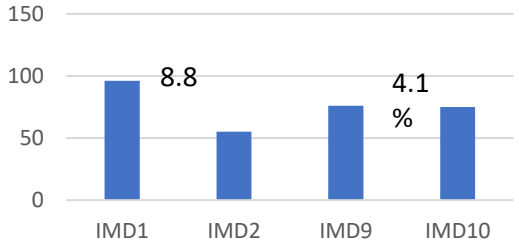




Gynae-oncology



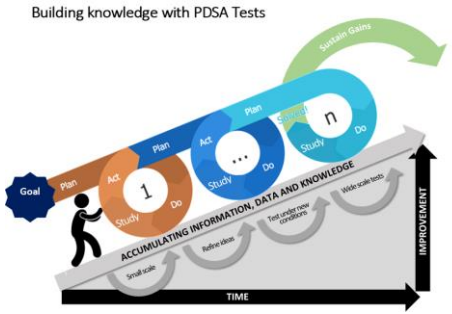
Breast care



UHL Non-Attendance Pilot

Improvement:

- Respiratory only for 3 months
- Contacted patients in IMD 1 areas
  - Reminder of appointment, offer of support
- Non attendance improved from 30-50% to c.8%
  - eliminated the differential in outpatient attendance for the most deprived patients

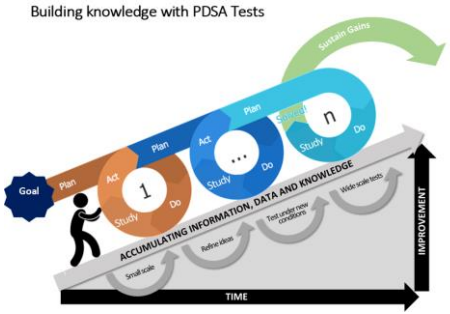


UHL Non-Attendance Pilot

University Hospitals of Leicester NHS Trust

Improvement cont…

- Review Sept 2022:
  - Volunteer feedback: cultural barriers!
  - Challenges: funding, scaling and sustaining
  - Roll out to all specialities
  - All patients with an IMD1 postcode

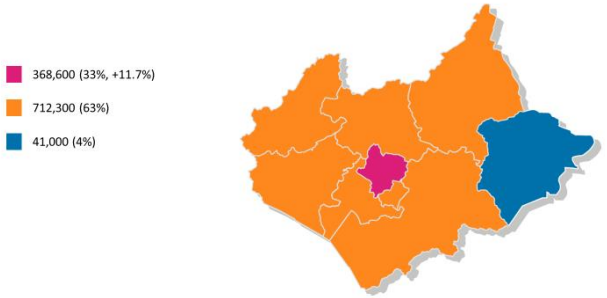


- Review March 2023
  - Most recent results remain very positive: **contacted c.10% vs. not contacted c.16%**
  - Funding secured with plan to scale (e.g. IMD2)
    - Focused work on 2WW pathways, surgical OTDC – linking to other trust priorities and challenges
  - Deep dive into data and responses

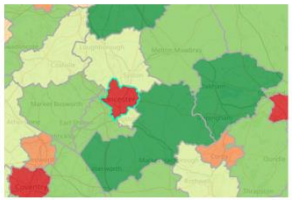
UHL Non-Attendance: from pilot to BAU

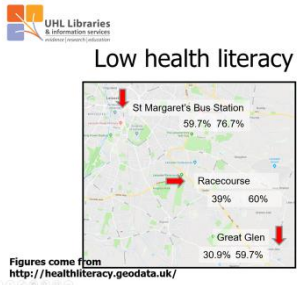
- **People**
  - Who are the people we care for?
  - What are their needs?
  - Community partnerships
    - Trust before co-design and co-delivery e.g. Access to Cancer Services workshops
  - Equity of voice

Local Context – who are the people of LLR?



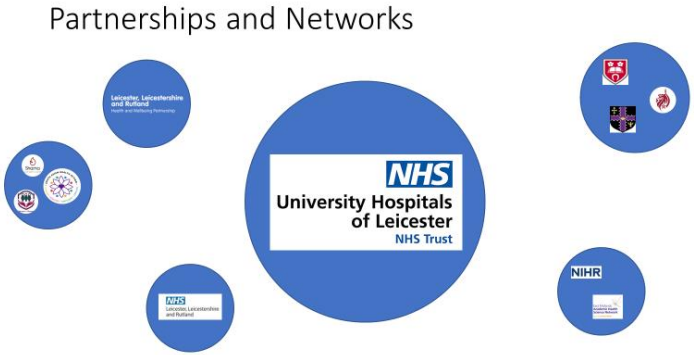
Local Context – Health Literacy





UHL Non-Attendance: from pilot to BAU

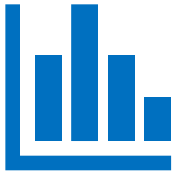
- **Learning**
  - Networks
    - Core20PLUS5 ambassadors, connectors and champions
    - Peer to peer conversations
    - Research and academic partners
  - IHI Pursuing Equity
    - Addressing racial injustice in healthcare
    - Improvement science
    - Strategic direction
    - Accountability



UHL Non-Attendance: from pilot to BAU

- **Culture**
- Challenges: WRES, WDES, Staff survey, F2SU
- Problem: injustice and compassion

Our approach to health equality



Data

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CORE20 PLUS 5

RACE EQUALITY

Book now:

Taking a community driven approach to addressing health inequalities

Thursday 27 April 2023 | virtual event via Zoom

This interactive online event will allow delegates to hear from NHS leaders on solutions-based interventions that have been implemented by trusts to address the needs of underserved communities to improve their health outcomes.

Scan here to access our upcoming events

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RACE EQUALITY

Tell us what you think

Scan here to access
our evaluation

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Visit our website for further information on the Race Equality work:

- Race 2.0 report
- Podcasts
- My journey as a White ally videos
- Blogs
- Previous events and additional resources

Scan here to access our website

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Thank you!

Scan here to access our evaluation

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