Appendix 2

Health Inequalities

“Health inequalities are not inevitable and can be significantly reduced… avoidable health inequalities are unfair and putting them right is a matter of social justice”

Michael Marmot
Fair Society, Healthy Lives: The Marmot Review. London; 2010.

What are health inequalities?

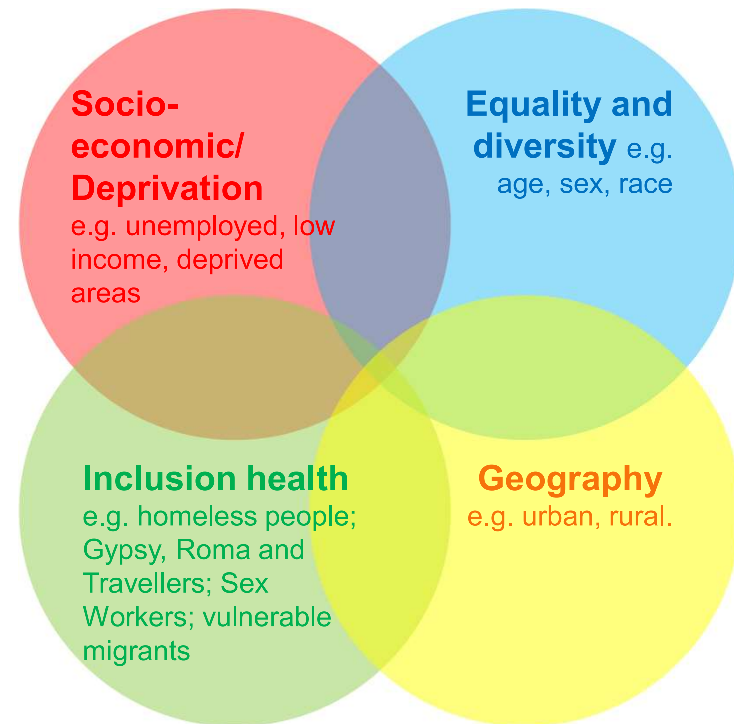
Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society.

Health inequalities arise because of the conditions in which we are **born, grow, live, work and age**. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing.

Health inequalities have been documented between population groups across at least four dimensions, as illustrated to the right.

Action on health inequalities requires improving the lives of those with the worst health outcomes, fastest.

Dimensions of health inequalities



Health Inequalities in Herefordshire

Health inequalities across Herefordshire

- Health inequalities are unfair and avoidable differences in health across the population and between different groups of people
- A range of individual characteristics and societal factors have been identified as contributing to health inequalities, including deprivation, vulnerable groups, protected characteristics or where people live
- Males born in most deprived areas can expect to live 5.4 years less, and females 4.0 years less, than those in least deprived areas
- People living in the most deprived areas within the Herefordshire were 1.5 times more likely to die with COVID-19 than those living in the least deprived areas[1]

What are we doing?

Our main strategies to tackle HI

Health & Wellbeing Strategy

Core Priorities
- Best Start in Life
- Good Mental Wellbeing across the Lifetime

Health Inequalities Strategy

Core Priorities
- Rurally Dispersed
- Travelling Communities
- Unregistered Individuals

The Vision	Herefordshire residents are resilient; lead fulfilling lives; are emotionally and physically healthy and feel safe and secure.		
The Challenge	Requires inequalities in health outcomes between different groups of people to be reduced. This necessitates a mix of short, medium and long term action including upon the wider determinants.		
We will focus on	Reducing health inequalities across the population, particularly within:		
	Rurally dispersed	Travelling Community	Unregistered individuals
To do this we will	Work in partnership to develop local solutions, using national frameworks and best practice, which encourage and empower people of all ages and abilities to reduce inequalities and improve health and wellbeing; focusing on;		
1.	Engaging healthcare professionals to improve digital and health literacy		
2.	Empower and support workforces to understand and deliver equitable services that reduce inequalities and address workforce inequality and training needs		
3.	Reaching communities to work in partnership to reduce inequalities		

Core20+5

- Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level.

- Capture all the great work already happening in different PCNs

- Use data to inform our interventions. Evaluate and share what works and what doesn't.

- Room for growth, but start simple

- Identify proportion of overall county IMD 1 reside in each PCN
- Identify PCN most deprived 20% and highlight using Geographic Information System (GIS)

HEALTHCARE INEQUALITIES IN ENGLAND

The 'Core 20 Plus 5' initiative is designed to drive targeted health inequalities improvements in the following areas:

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. **EARLY CANCER DIAGNOSIS** **75%** of cases diagnosed a,t stage 1 or 2 by 2028
3. **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)
4. **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
5. **HYPERTENSION CASE-FINDING** to allow for interventions to optimise BP and minimise the risk of myocardial infarction and stroke

Plus groups will be locally determined based on H&W strategy & HI Strategy:
-Rurality
-Unregistered
-Gypsy, Roma traveller communities
-Best start to life
-Good mental health throughout life

- The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading
- Diabetes: QOF prevalence (17year +)
- Uptake of NHS health checks

- Smoking status at time of delivery
- Breastfeeding prevalence at 6-8 weeks

- The proportion of women eligible for Cervical screening aged 25-49 years that an adequate cervical screening test has been performed in the previous 3 years and 6 months
- Bowel cancer screening uptake

- The percentage of patients diagnosed with dementia whose care plan has been reviewed in the preceding 12 months
- The percentage of patients aged 18 or over with a new diagnosis of depression
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months

- The percentage of patients with COPD on the register, who have had a review in the preceding 12 months
- The percentage of patients with COPD and Medical Research Council (MRC) dyspnoea scale ≥3 at any time in the preceding 12 months
- Smoking : The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months

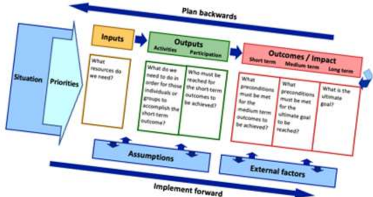
Flow of HI work

PCN HI Leads & PH

Identify Gaps informed by data

[Microsoft Power BI]

Plan intervention using evidence



Monitor, evaluation & share

Place HIPP→ 1HP & System HIPP

PCN's priorities for 24/25

Hypertension

19.91% (national prevalence
14.42% - 18.53% Herefordshire)

- Tenbury : 22.07% prevalence (2109 patients)
- 77.30% (2676) of patients aged 45-79, with hypertension and BP in last 12months is >= 130/80 or less

Continue with group sessions in Tenbury for those patients diagnosed with Hypertension in the last 12months.

Review of the programme underway to sense check outcomes, benefits and agree plan for 2024/2025 onwards.

Cervical Screening

Uptake in Cervical Screening: aged 24-64yrs

- 29.52% (3576 patients) not had their cervical screening
- Outlier practices Kington [33.84%] and Tenbury [31.11%]
- 35% No cervical screening in IMD 1

Practices using HeroHealth to offer patients a direct online booking of an appointment in the evening or weekend via EA

Review data in 6months time, has this improved uptake.

If not, look at Wellbeing Team support with telephone calls to patients to understand the barriers to accessing an appointment

Smoking Cessation: 11.71% prevalence (13.30% national, 12.06% Herefordshire)

- Although below the national prevalence, Ryeland are at 15.15% (2898 patients), and the trend shows this is increasing, and there are a couple of IMD1 areas of deprivation within Leominster.

Working collaboratively between PCN Wellbeing Team and Healthy Lifestyle Team, to increase the uptake in offer to stop smoking via

Training for Wellbeing Team re HLT 'quick questions' and resources

HLT targetted outreach to be agreed after further analysis of the data