Reducing Health Inequalities : System, Scale and Sustainability

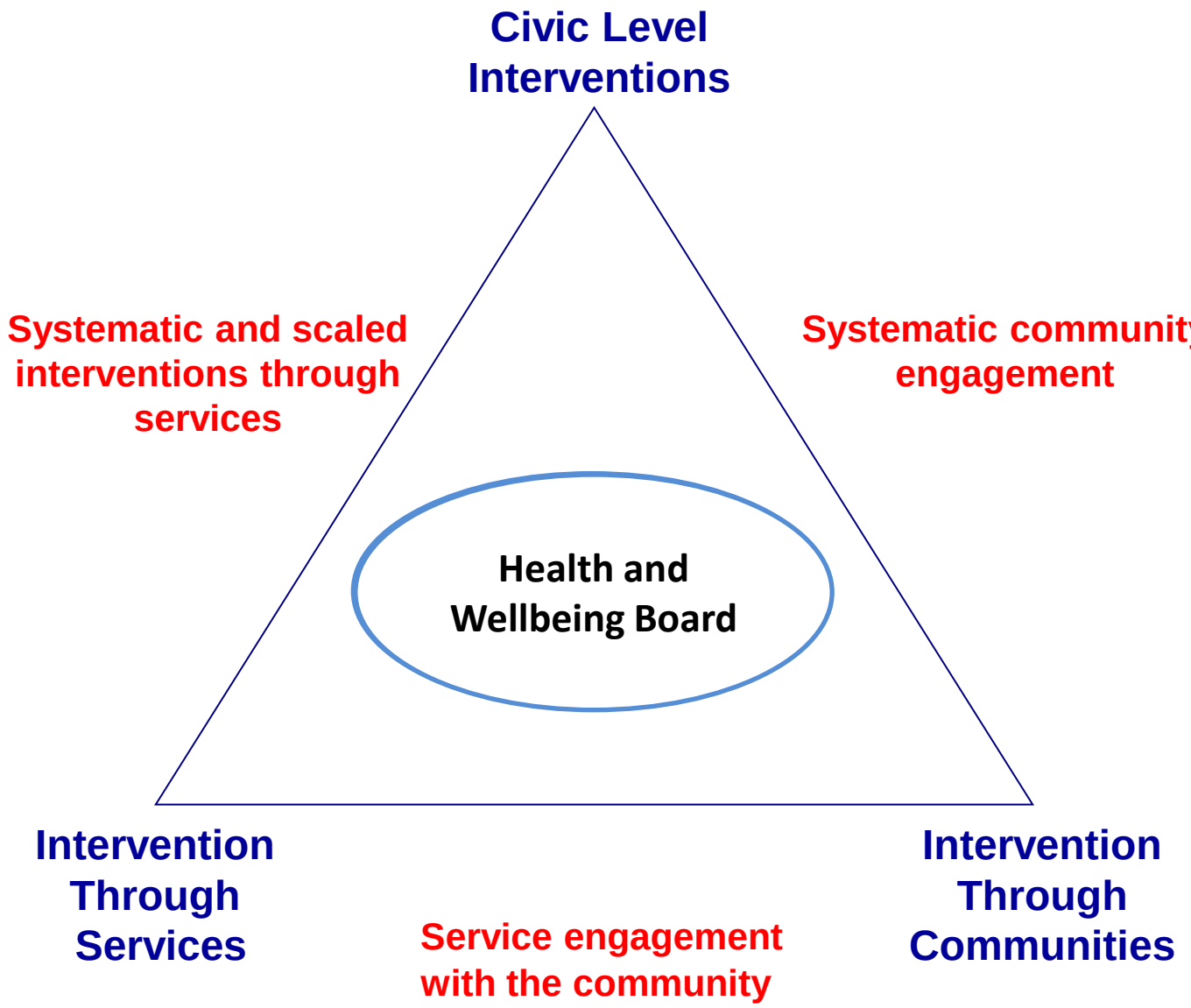
Points of Focus

Professor Chris Bentley
Chris.bentley19@gmail.com

Public Health England

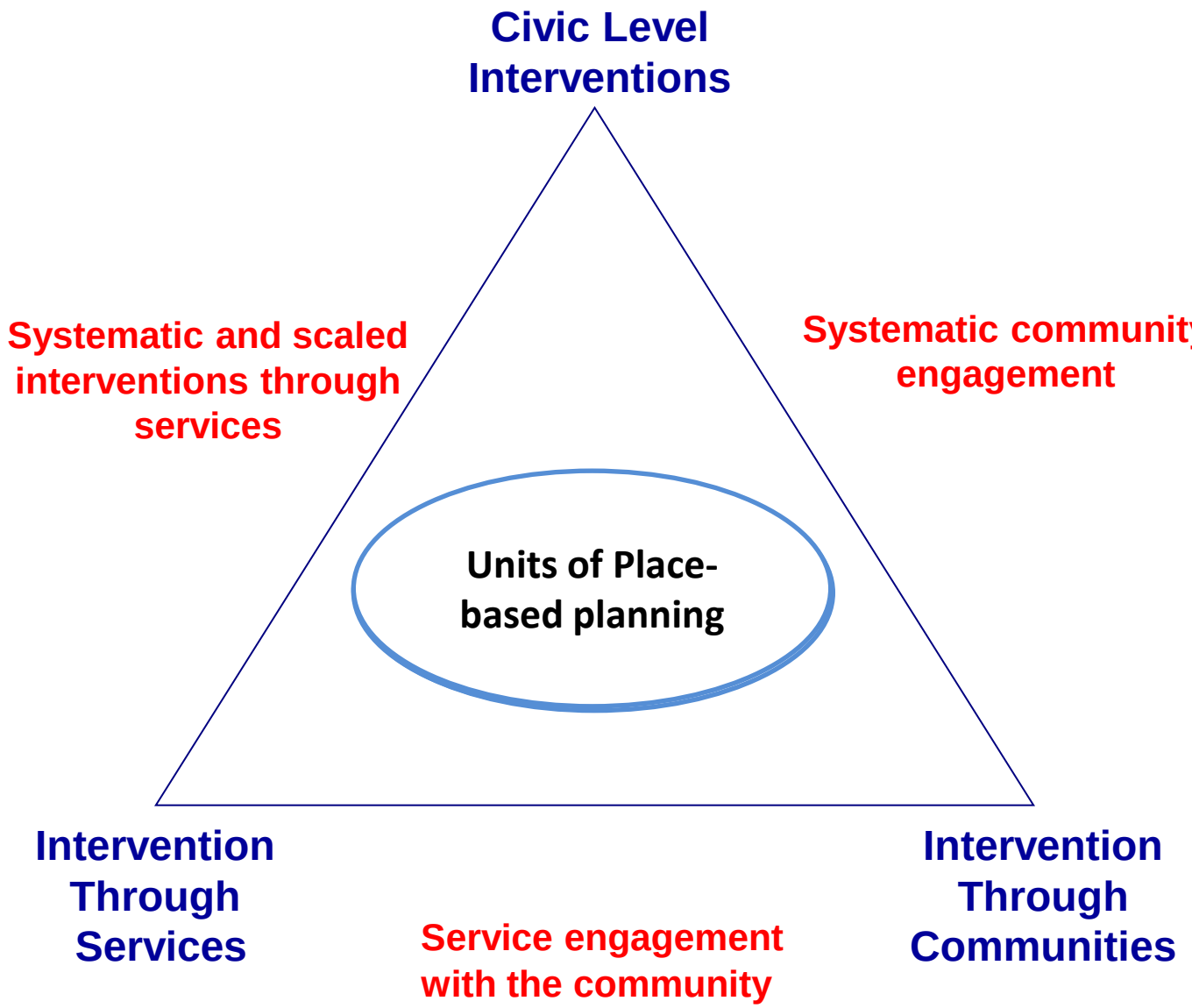
Protecting and improving the nation's health

Reducing Health Inequalities: System, Scale and Sustainability



Producing Percentage Change at Population Level

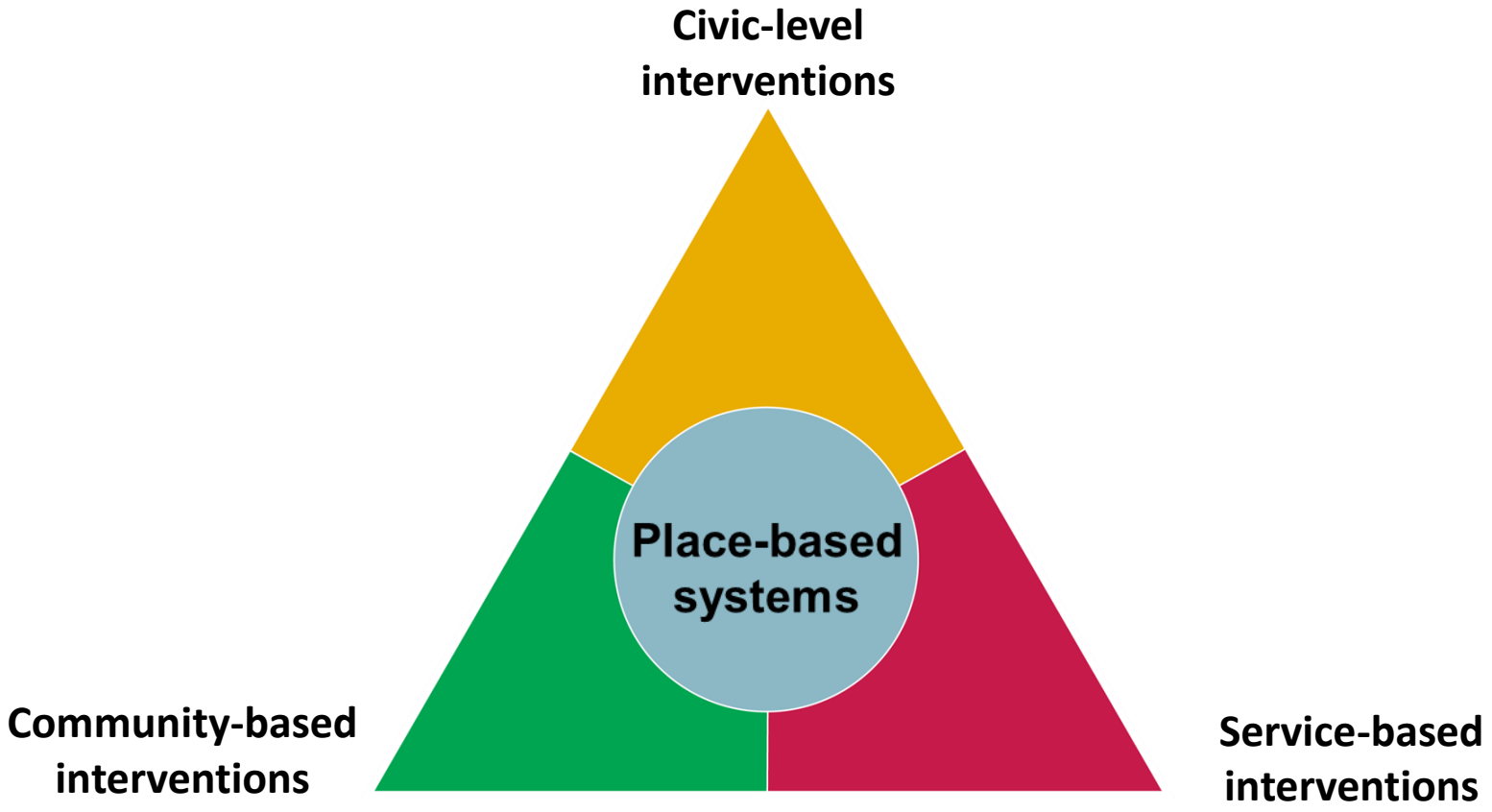
C. Bentley 2007

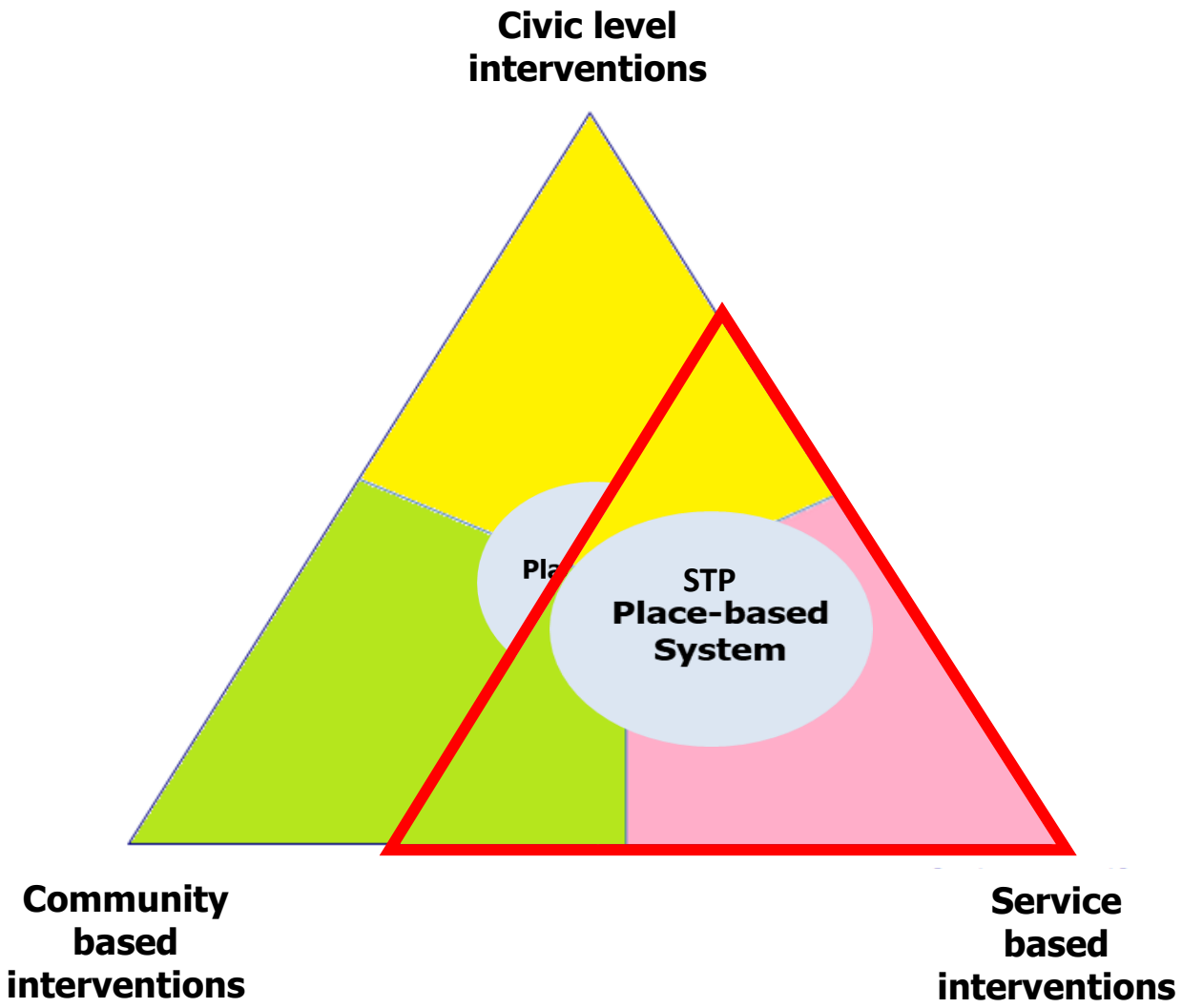


Producing Percentage Change at Population Level

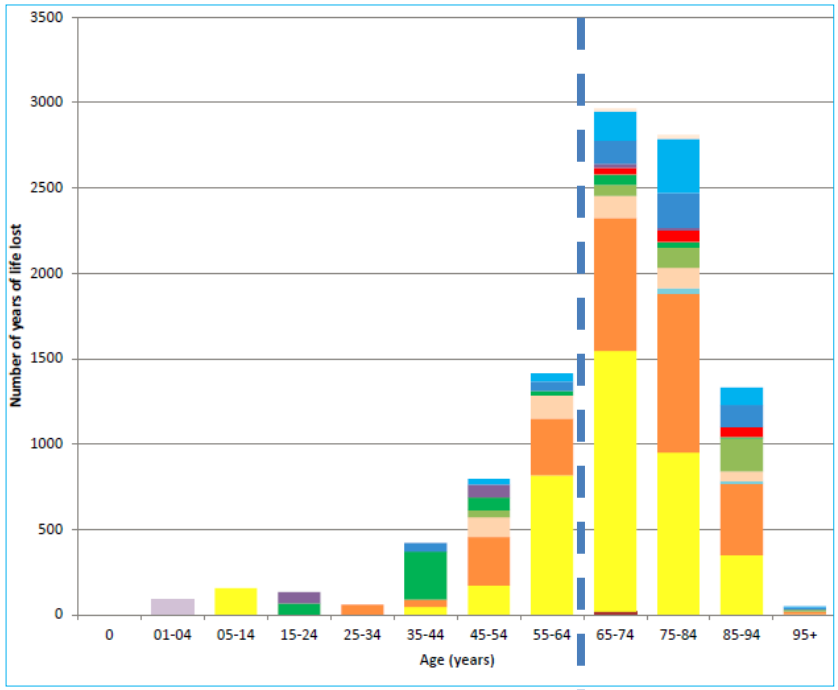
C. Bentley 2007

Population Intervention Triangle

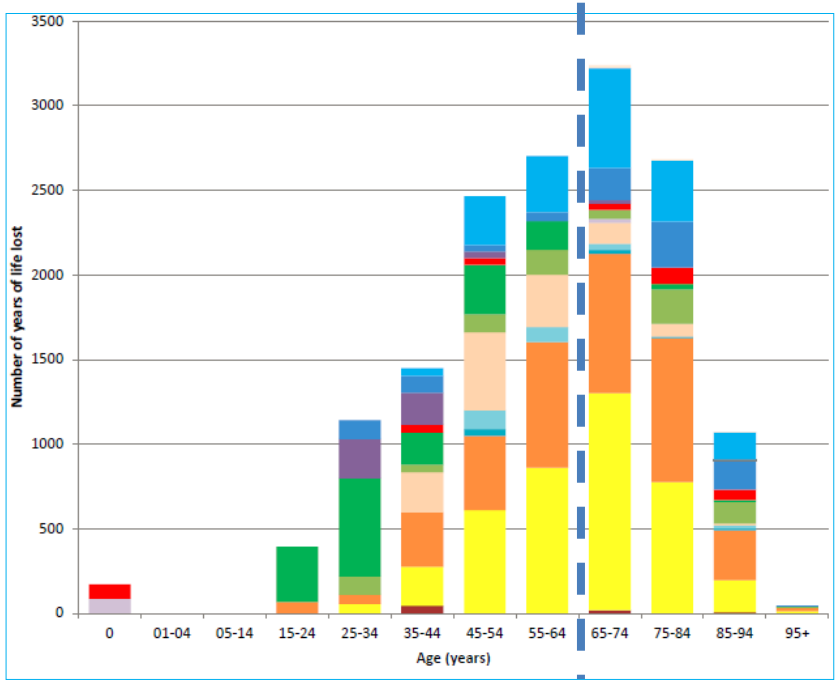




The Population Intervention Triangle (Bentley 2017)



MALE YLL
20% LEAST DEPRIVED LSOAs
(2011-2015)



MALE YLL
20% MOST DEPRIVED LSOAs
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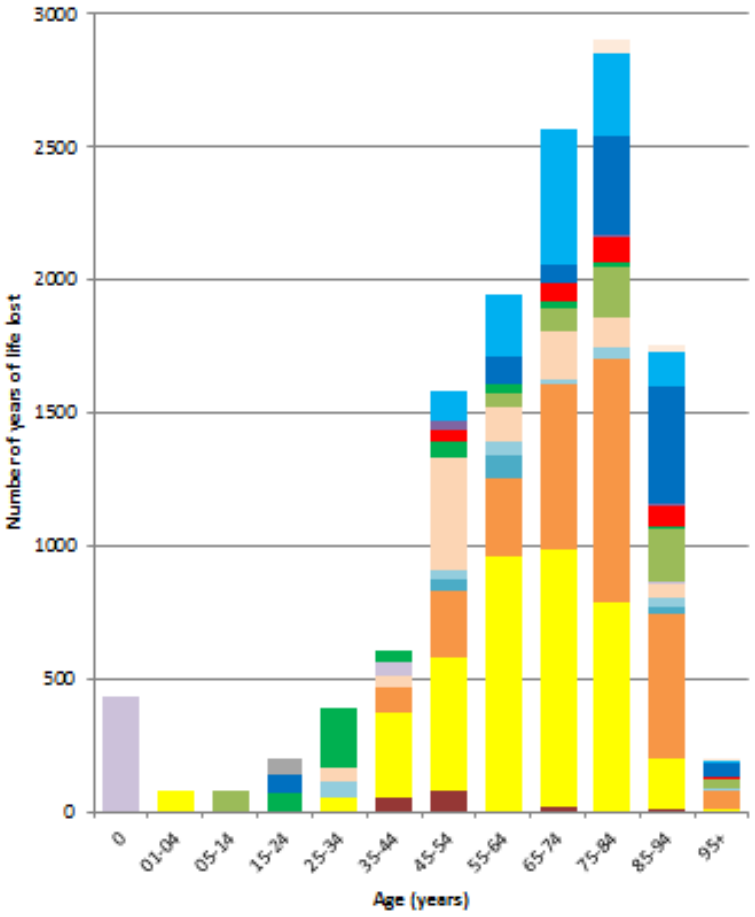
FEMALE YLL
20% MOST DEPRIVED LSOAs (NL)
(2011-2015)



FEMALE YLL
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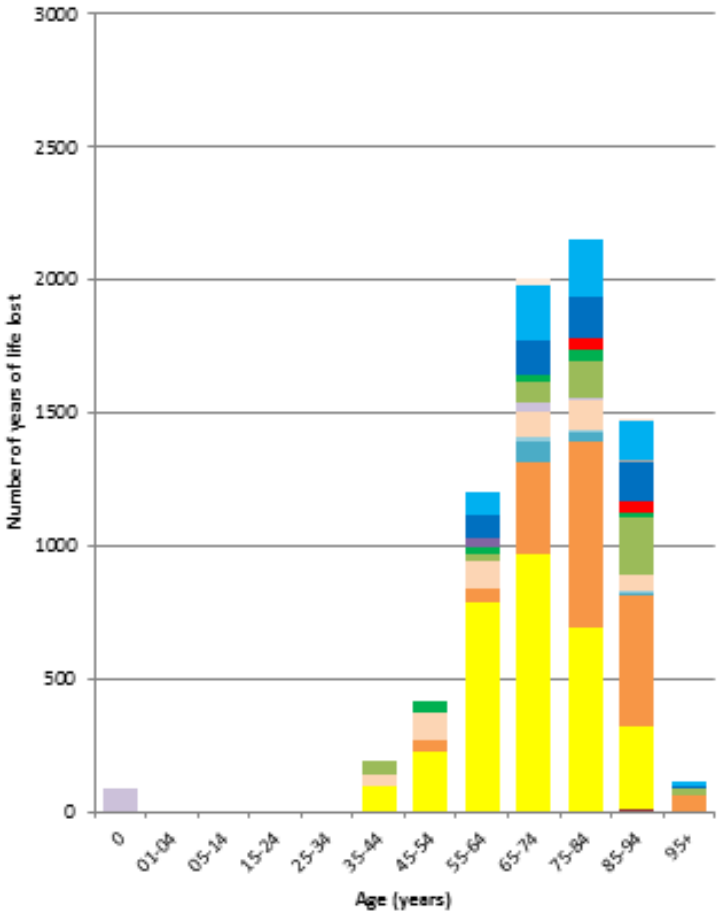
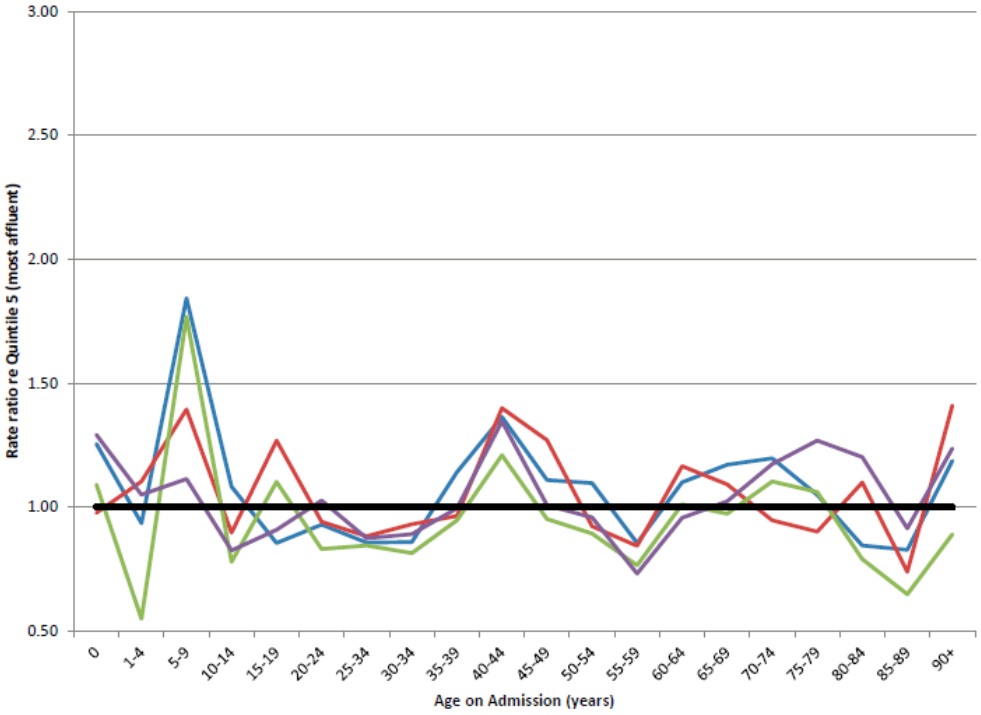
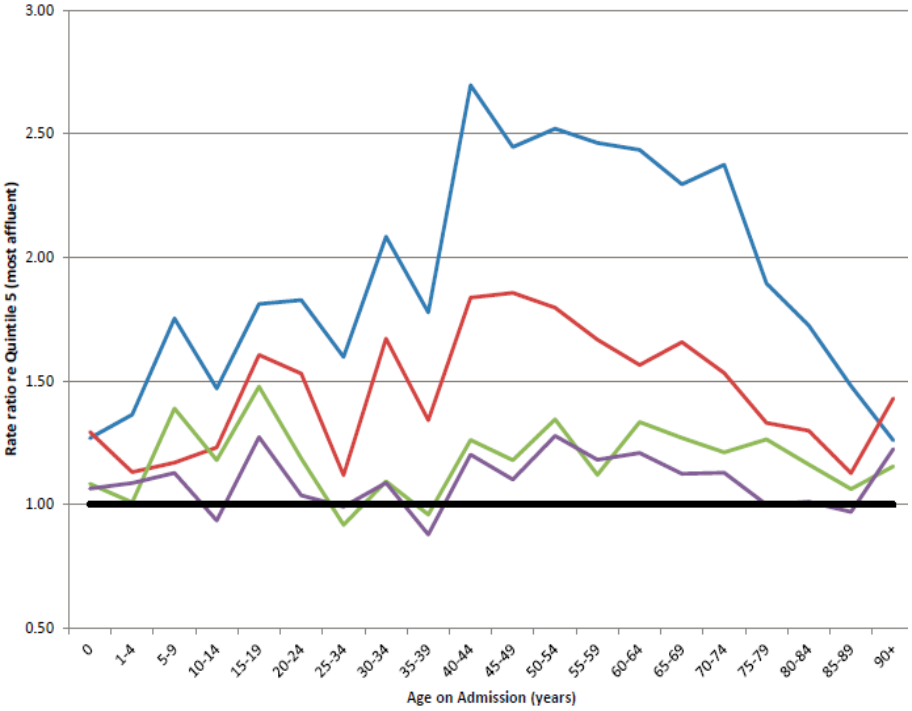


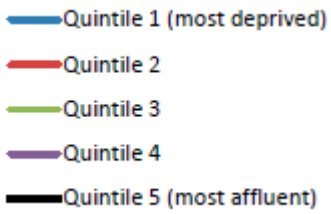
NORTH LINCOLNSHIRE HOSPITAL ADMISSION RATES RELATIVE TO 20% MOST AFFLUENT NATIONAL LSOAs

Elective admissions



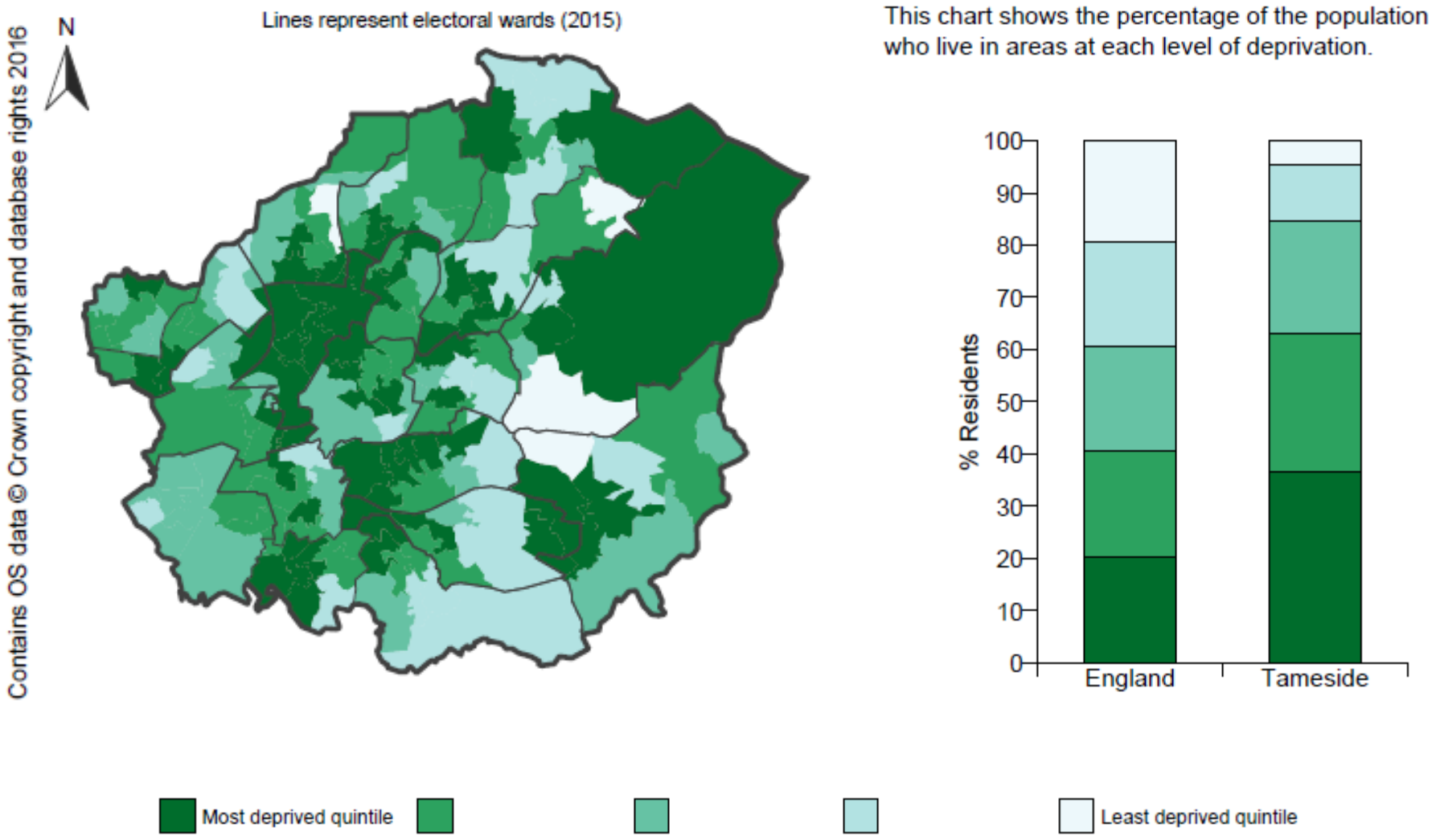
Emergency admissions



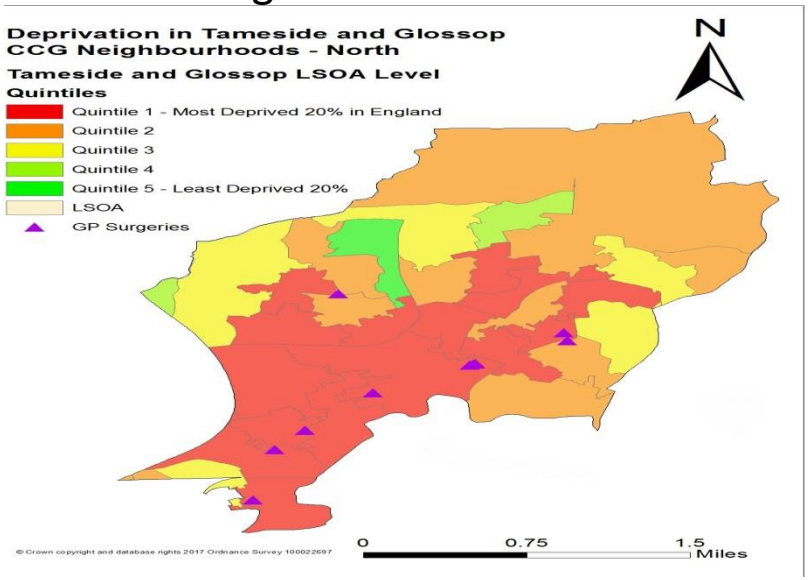


1. Map, and share ownership of the need for graduated input by socio-economic circumstance

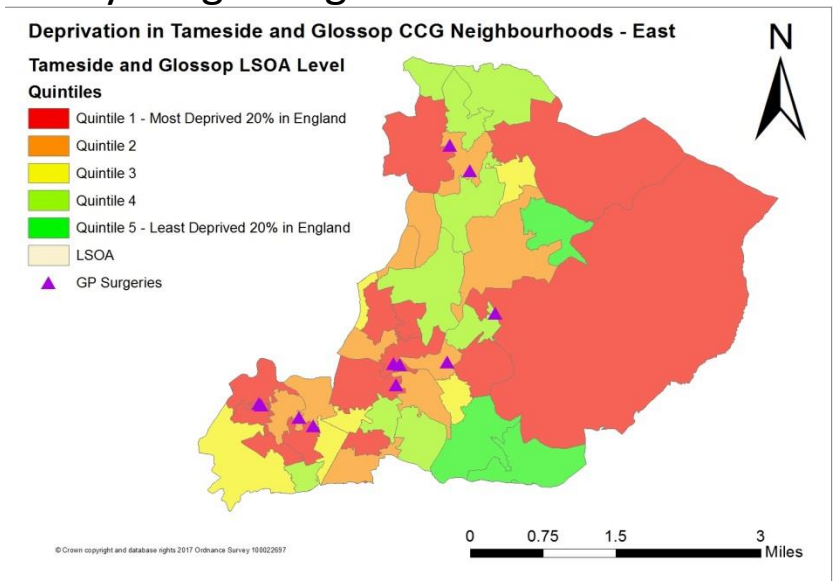
Tameside deprivation distribution based on England quintiles (20% segments)



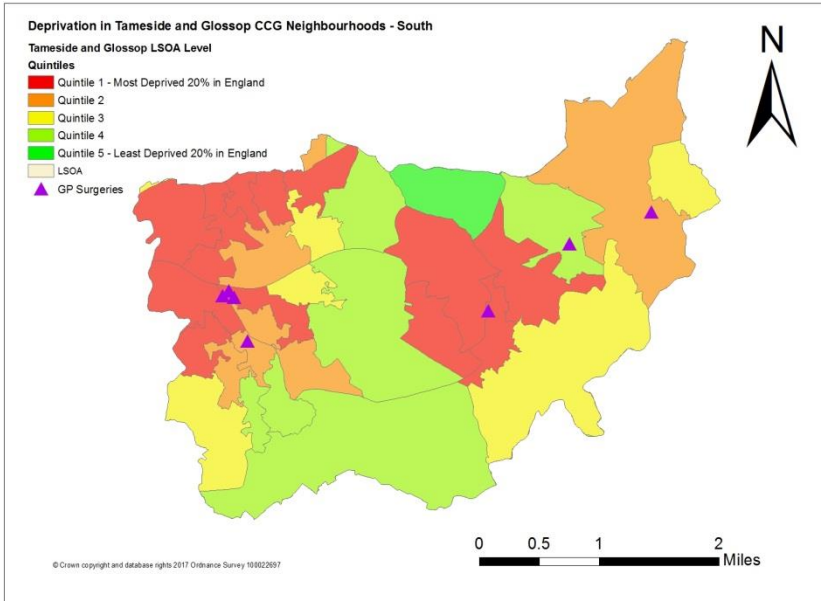
Ashton Neighbourhood



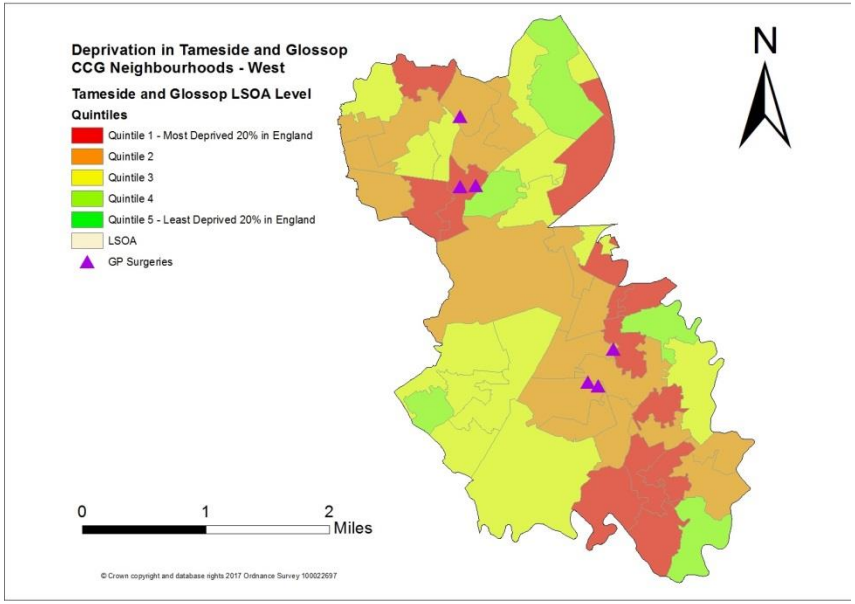
Stalybridge Neighbourhood



Hyde Neighbourhood



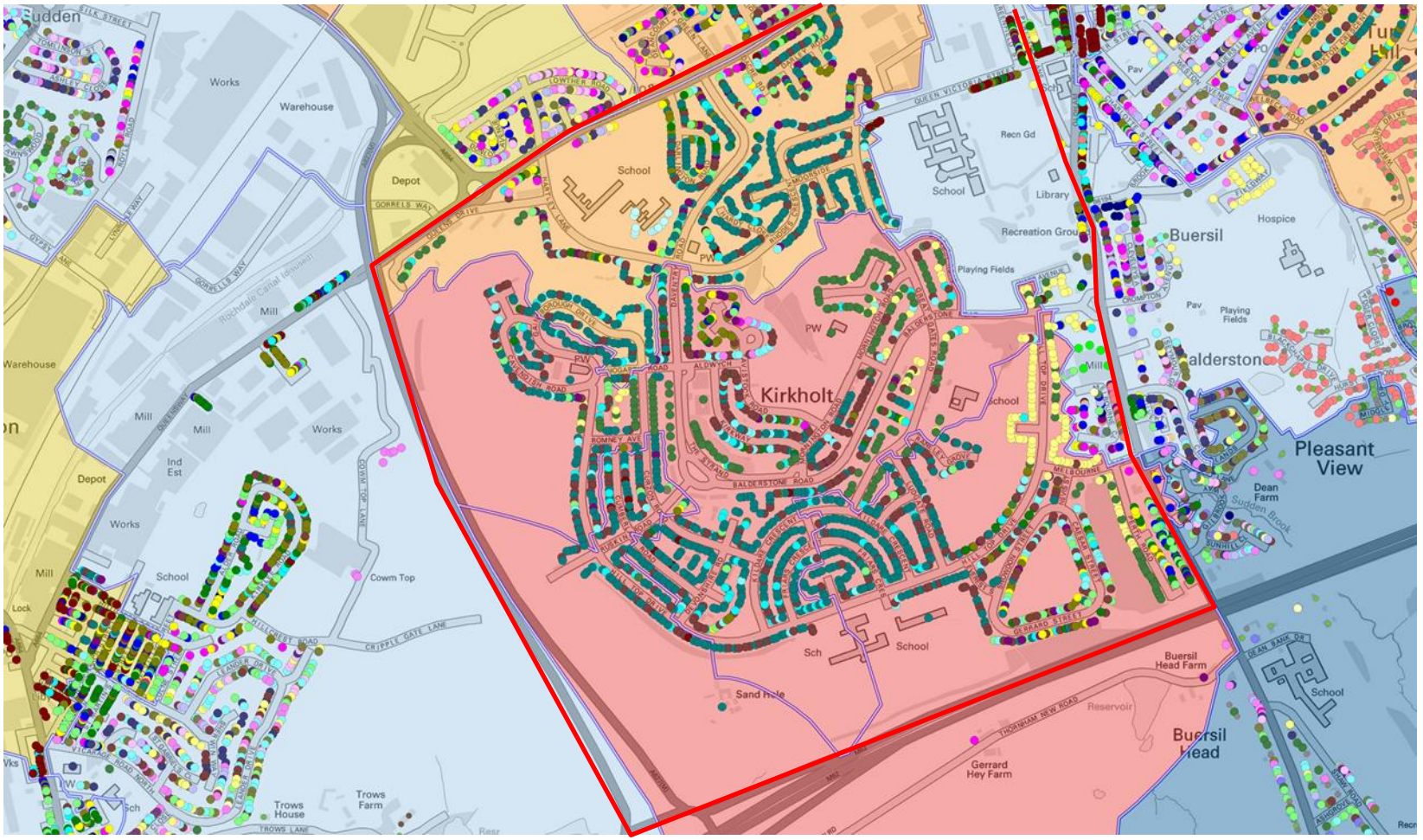
Denton Neighbourhood

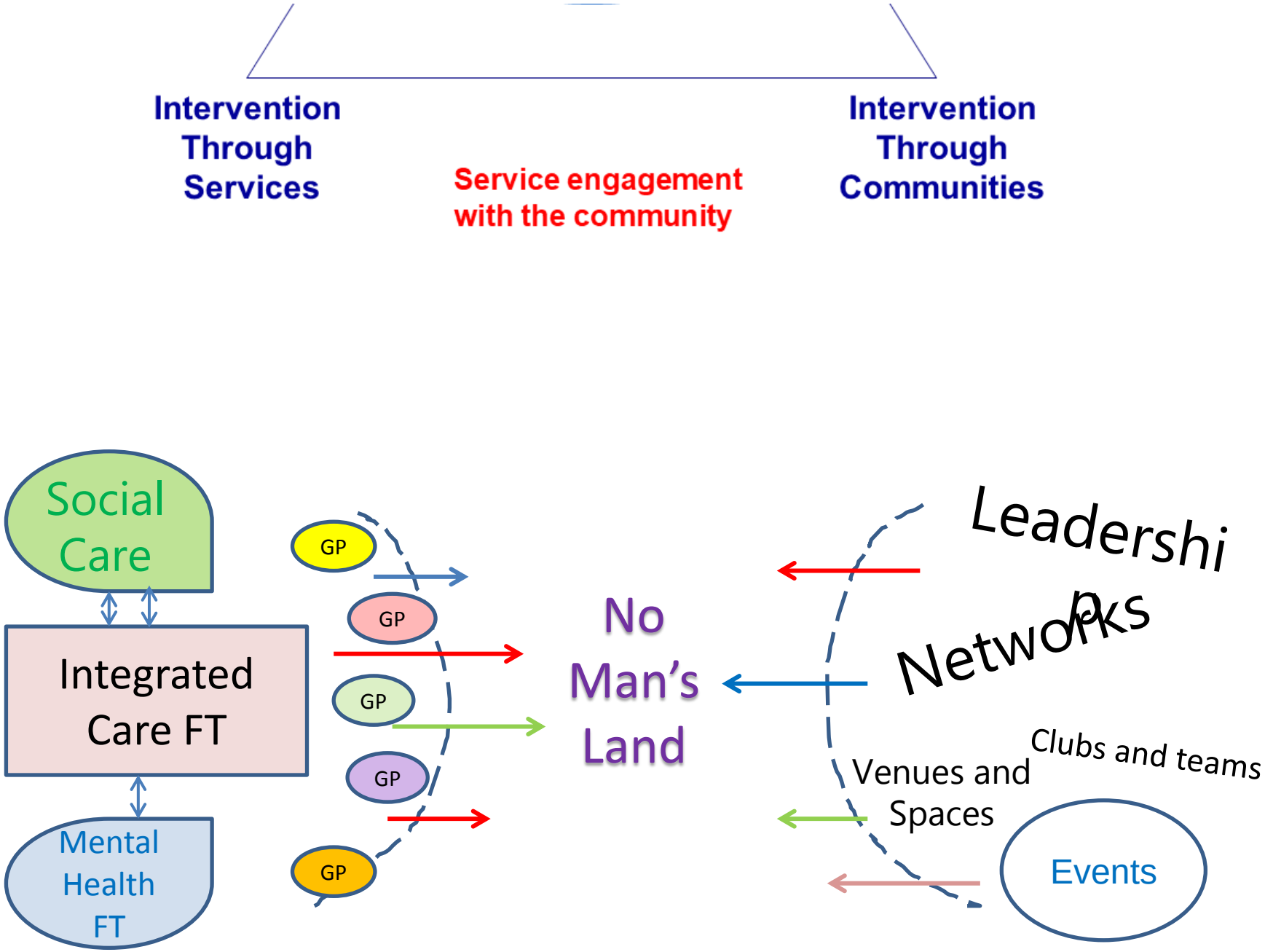


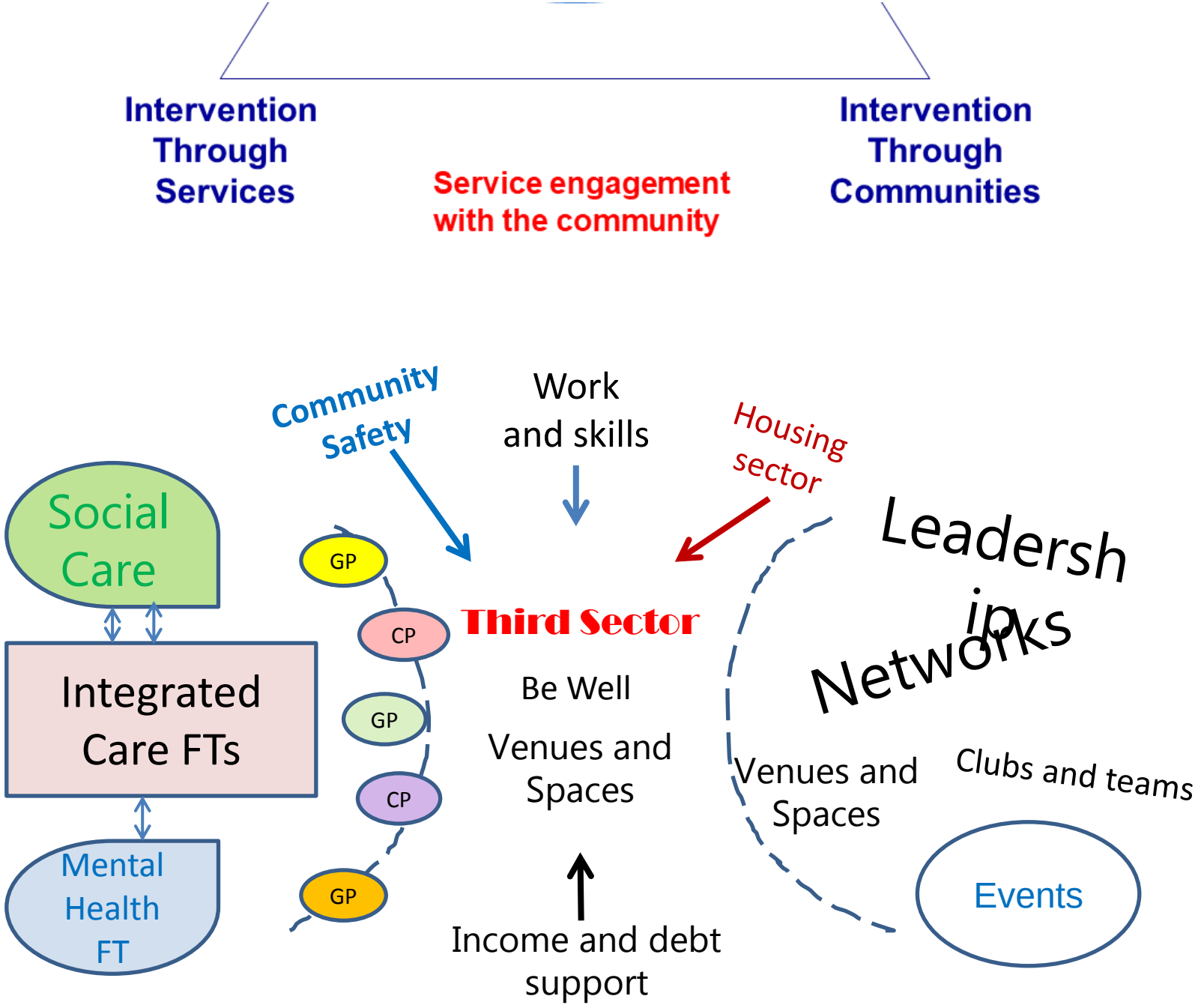
Jacqui Dorman. Tameside PHI

2. Systematically identify key assets to support co-operative development of ‘No Man’s Land’ with target communities, starting with national quintile 1.

Define Natural Community (e.g.Kirkholt, Rochdale)




Intervention Through Services
Service engagement with the community
Intervention Through Communities
Social Care
Integrated Care FT
Mental Health FT
GP
GP
GP
GP
GP
No Man's Land
Leadership
Networks
Clubs and teams
Venues and Spaces
Events


Intervention Through Services
Service engagement with the community
Intervention Through Communities
Community Safety
Work and skills
Housing sector
Social Care
Integrated Care FTs
Mental Health FT
GP
CP
GP
CP
GP
Third Sector
Be Well
Venues and Spaces
Income and debt support
Leadership in Networks
Venues and Spaces
Clubs and teams
Events

Asset mapping

Profiles should emphasise a stocktake of assets (alongside deficits and barriers), identifying key organisations, associations and individuals: who they are, and what they have.

- Local leaders
- Community infrastructures
- Community venues
- Significant local focussed sectoral initiatives

Mapped readily available data –

- Health care facilities e.g. GP Practices, Pharmacies
- Community Centres and Children's Centres
- Key localised assets of public sector partners

3. Define clear lines of governance for each priority objective:
    - where decisions are taken;
    - who is accountable (overall, not piecemeal) for reporting to the leadership (where?) for progress;
    - system plan for communication.

Leadership; Partnership; Vision and Strategy

STP Vision and Strategies

JSNA + HWB Strategy

Turning the Curve

Locality Plan

ICFT Plans

Care Together

LA Corporate Plan

Transformation Programme

CCG Plans +

Health Inequalities Plan

GP Plans

GP Plans

GP Plans

GP Plans

Neighbourhood Plans

Action Together

4. For practical, outcomes-based working, identify credible SMART targets and milestones for key objectives. Base on knowledge of evidence based interventions and their likely dimensions of change in given timescales.

Believable Targets

Specific

Measurable

Attainable

Relevant

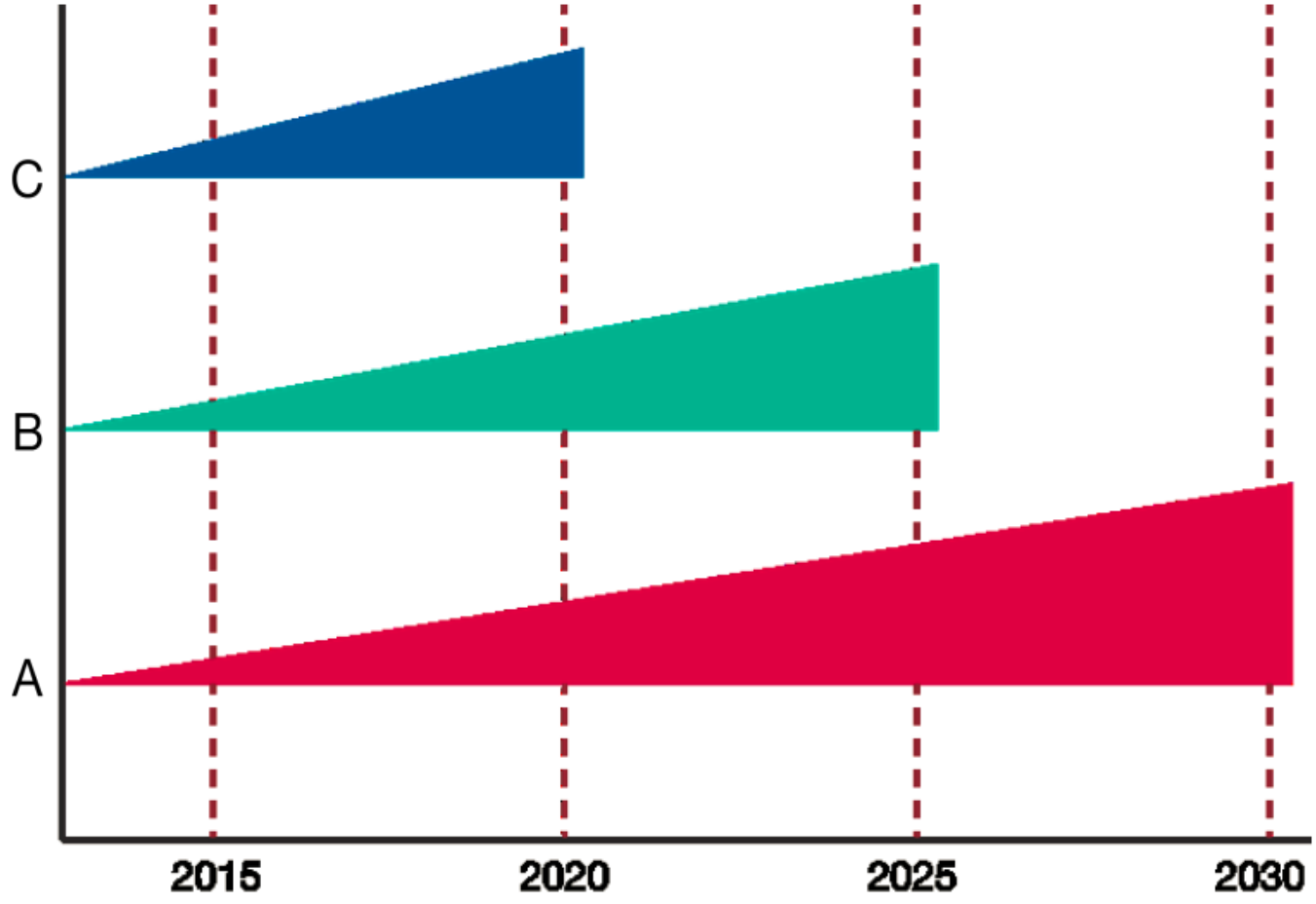
Timely

Time needed to deliver outcomes from different intervention types

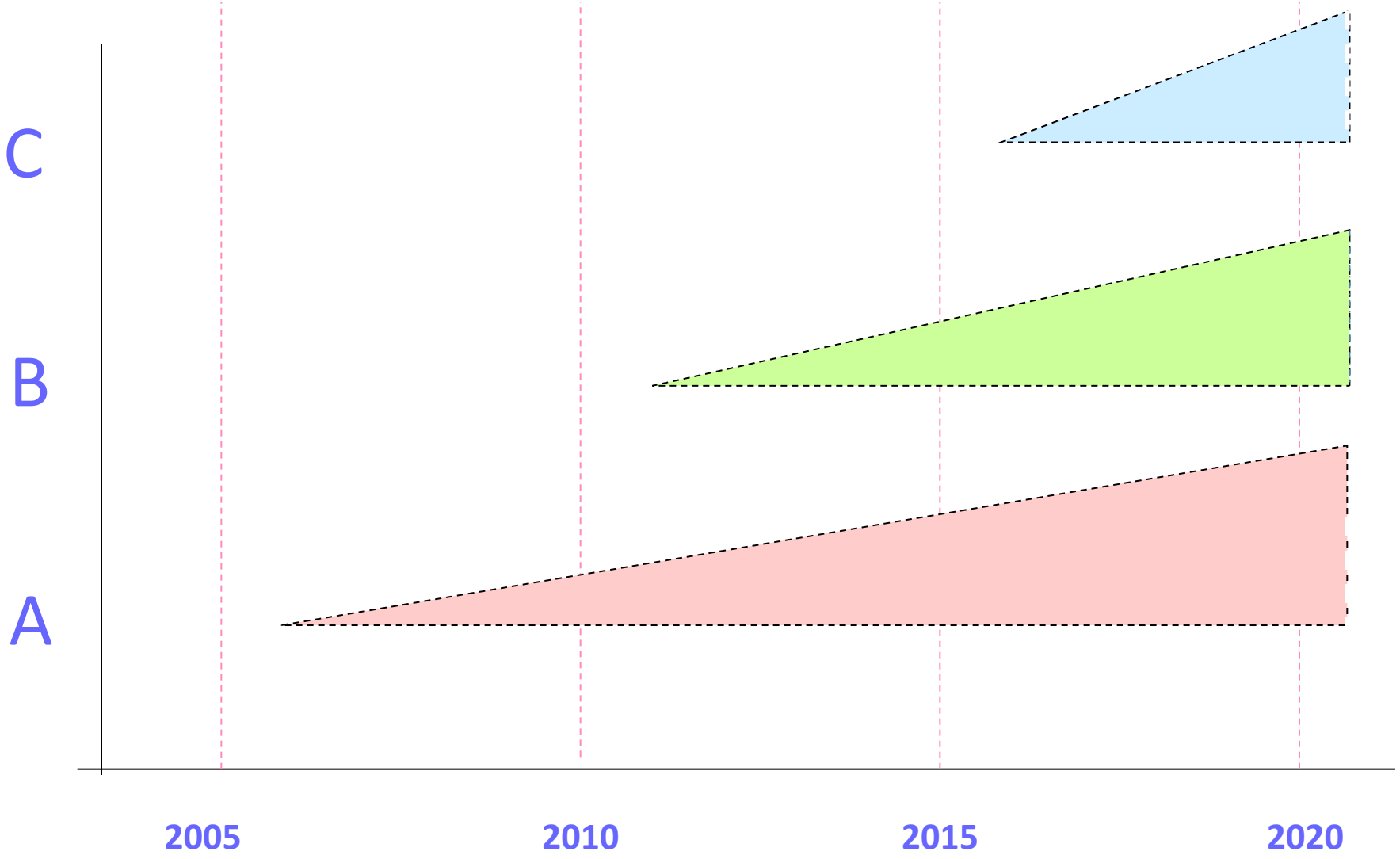
Substantial impact in 3-5 years: manage hypertension: CHD; diabets; cancer

Substantial impact 8-10 years: tobacco; alcohol harm; obesity management

Substantial impact in 12-15 years: work and skills: reduce poverty: housing

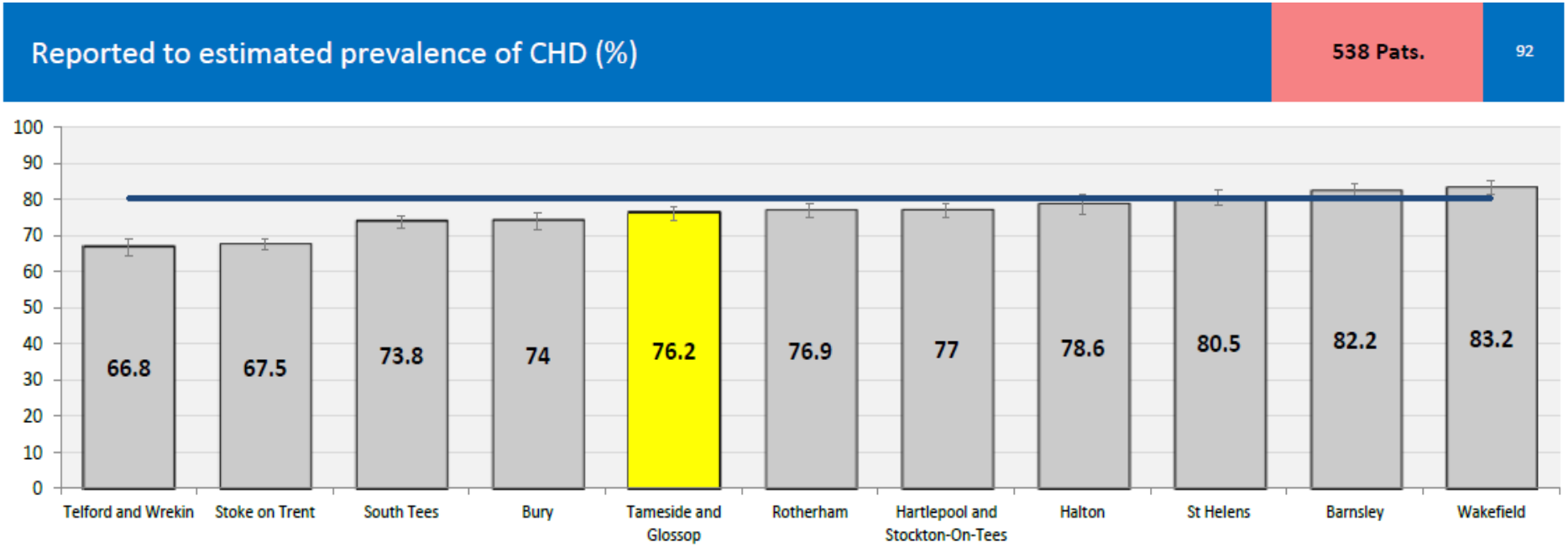


Gestation from Input to Outcome

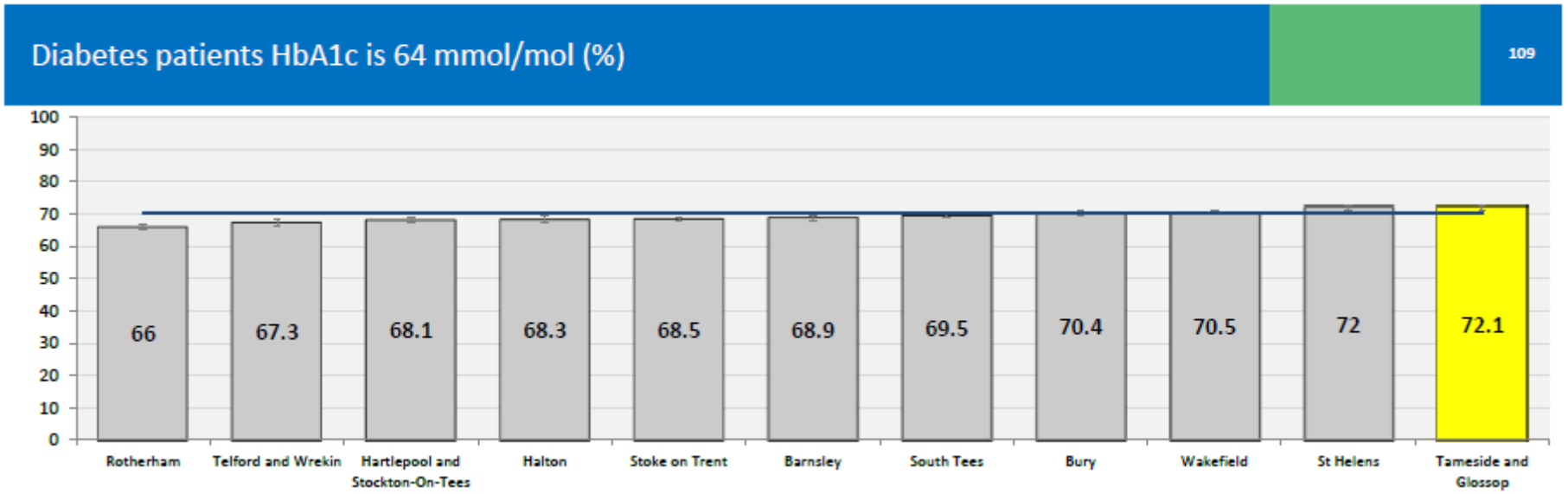


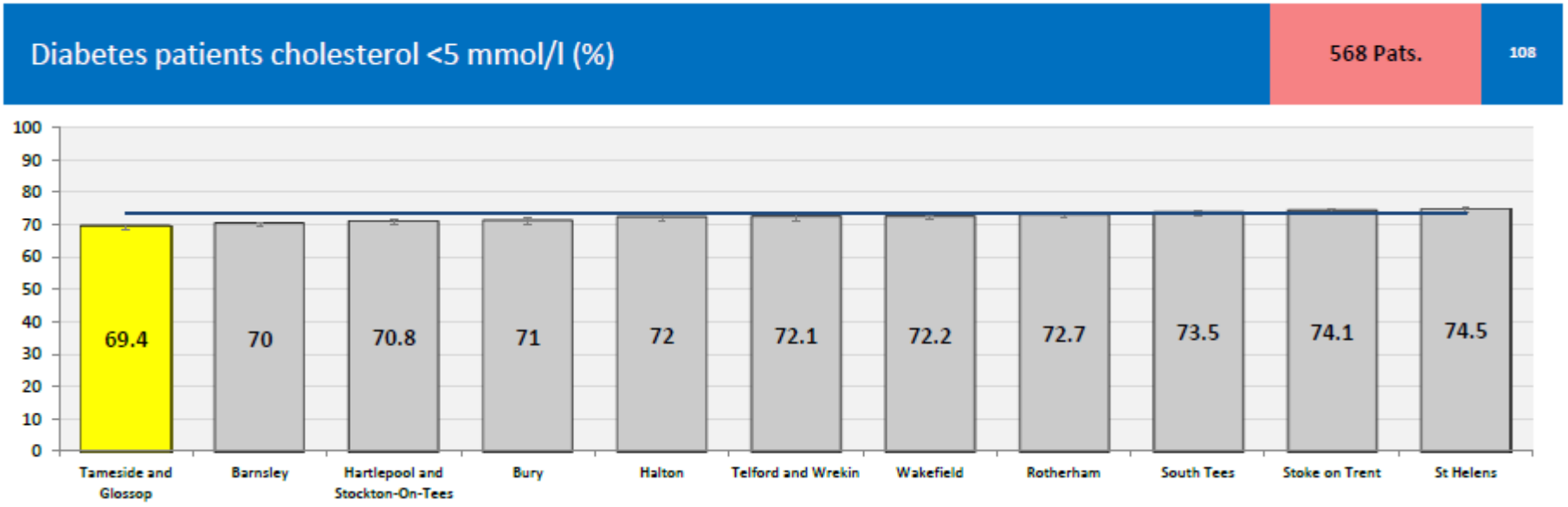
5. Focus programmes on components best able to deliver percentage change at population level in the given timeframe: set milestones

‘Missing’ patients with Coronary Heart Disease

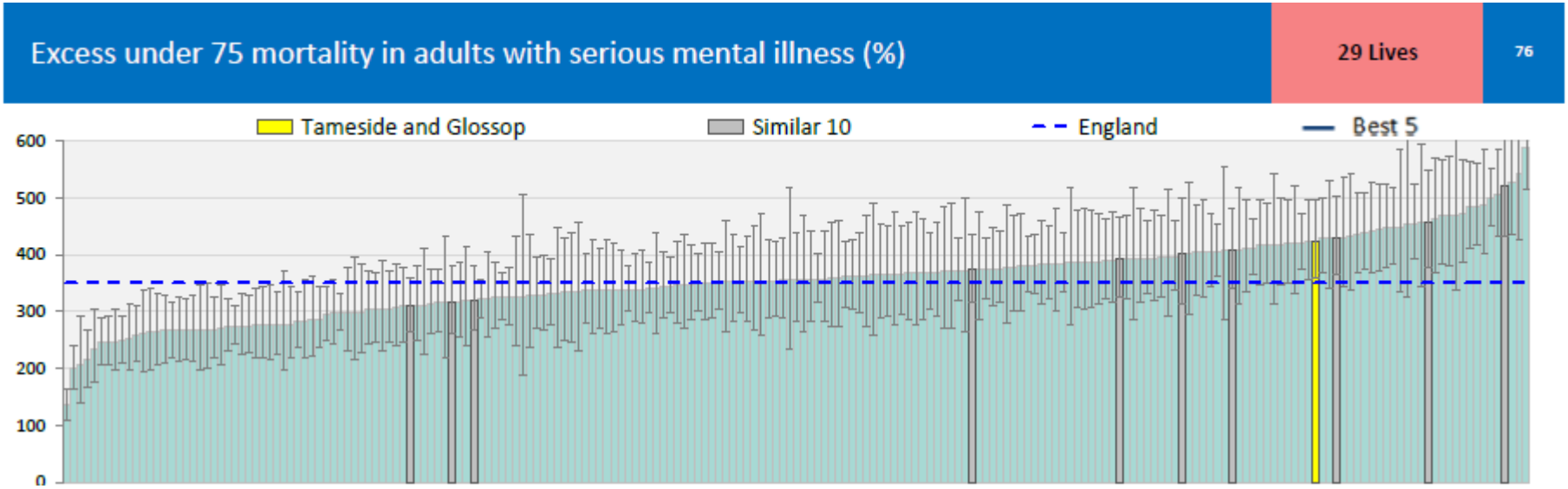


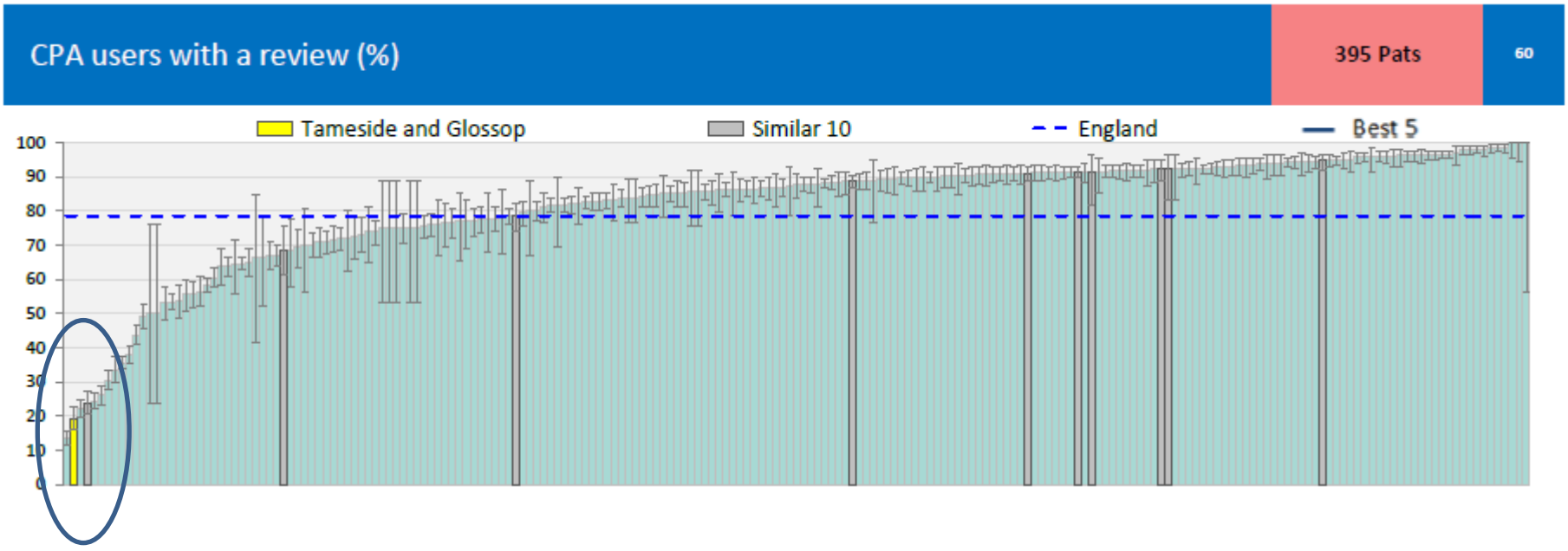
Focus of diabetes treatment not CVD protective





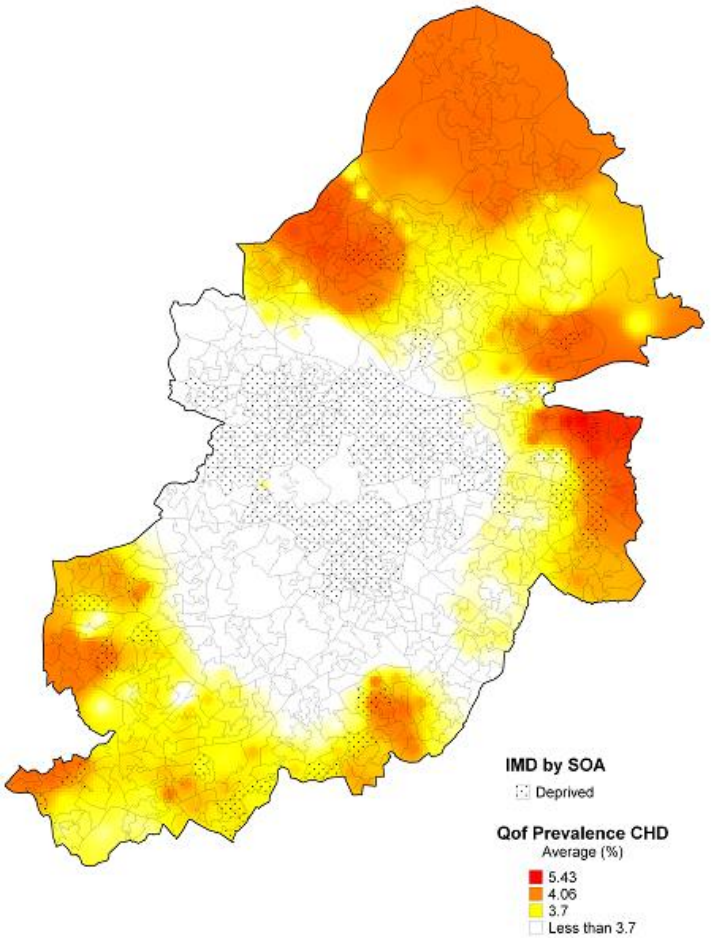
Physical health of people with serious mental illness

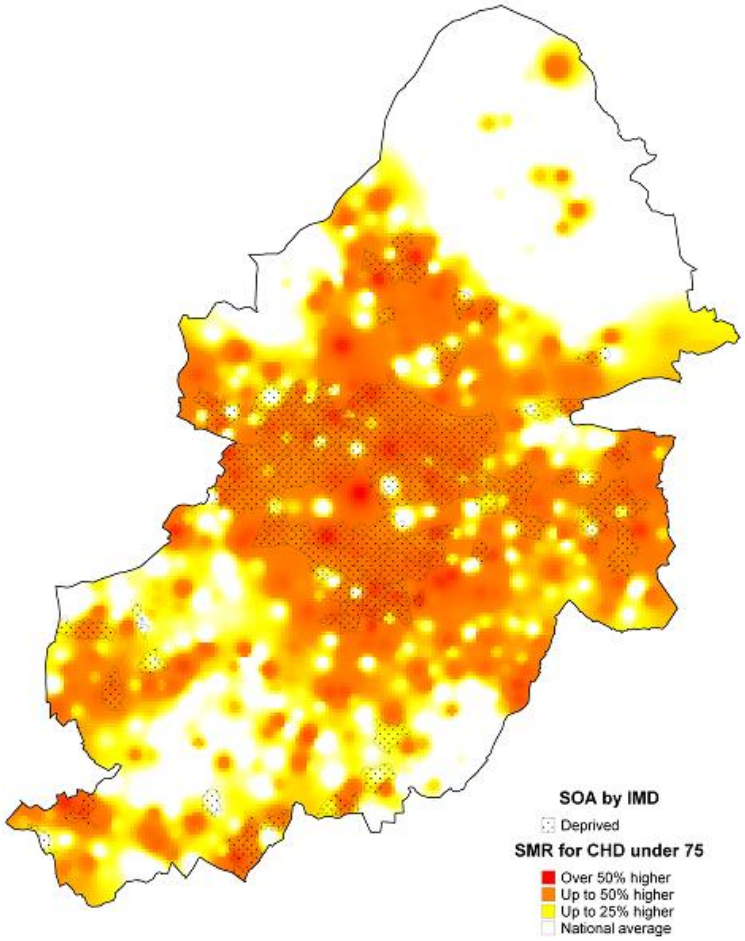




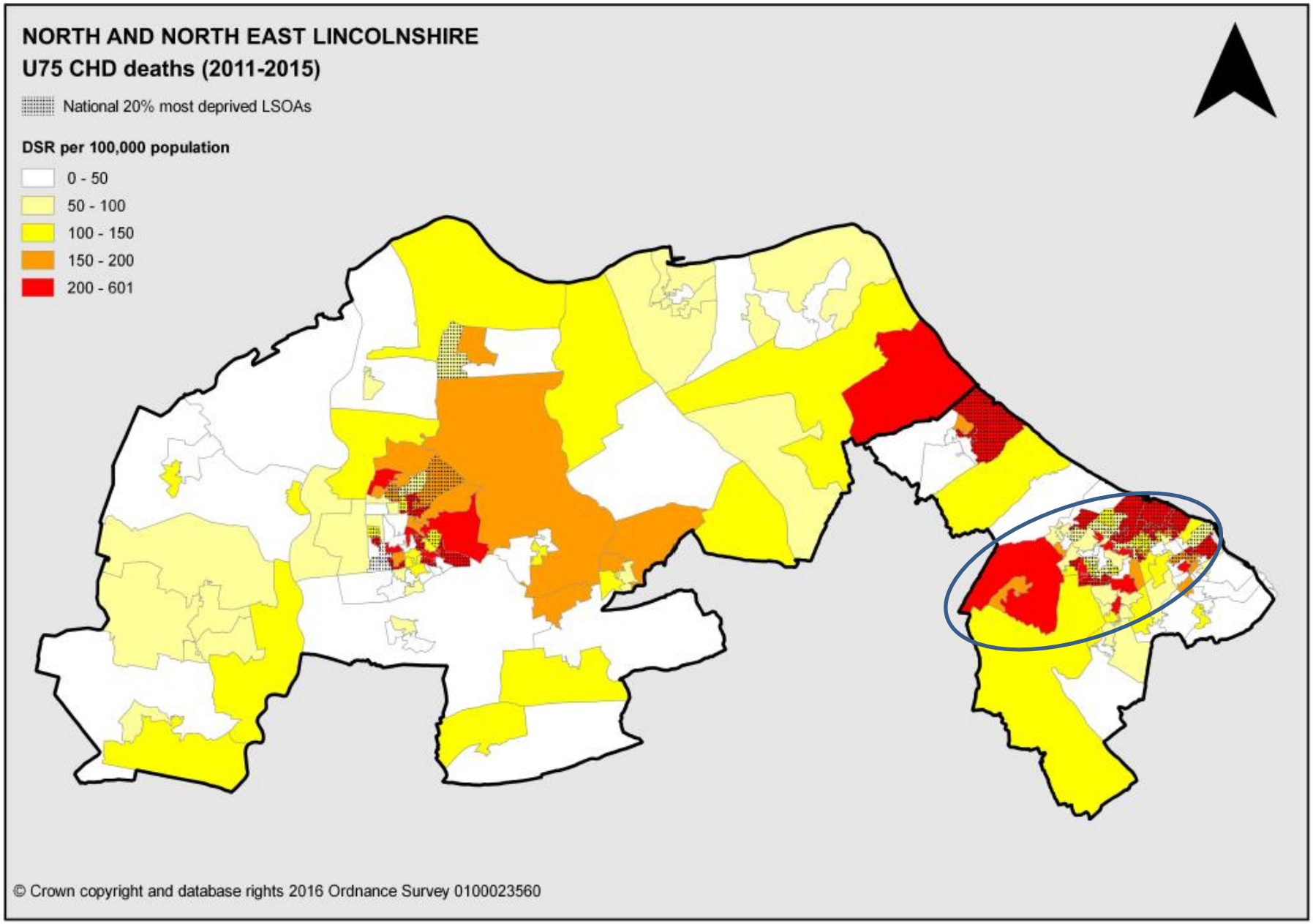
6. Systematically engage partners, with defined roles, to find and engage missing beneficiaries and reduce Intervention Decay in key programmes

Improving Male Life Expectancy in Birmingham

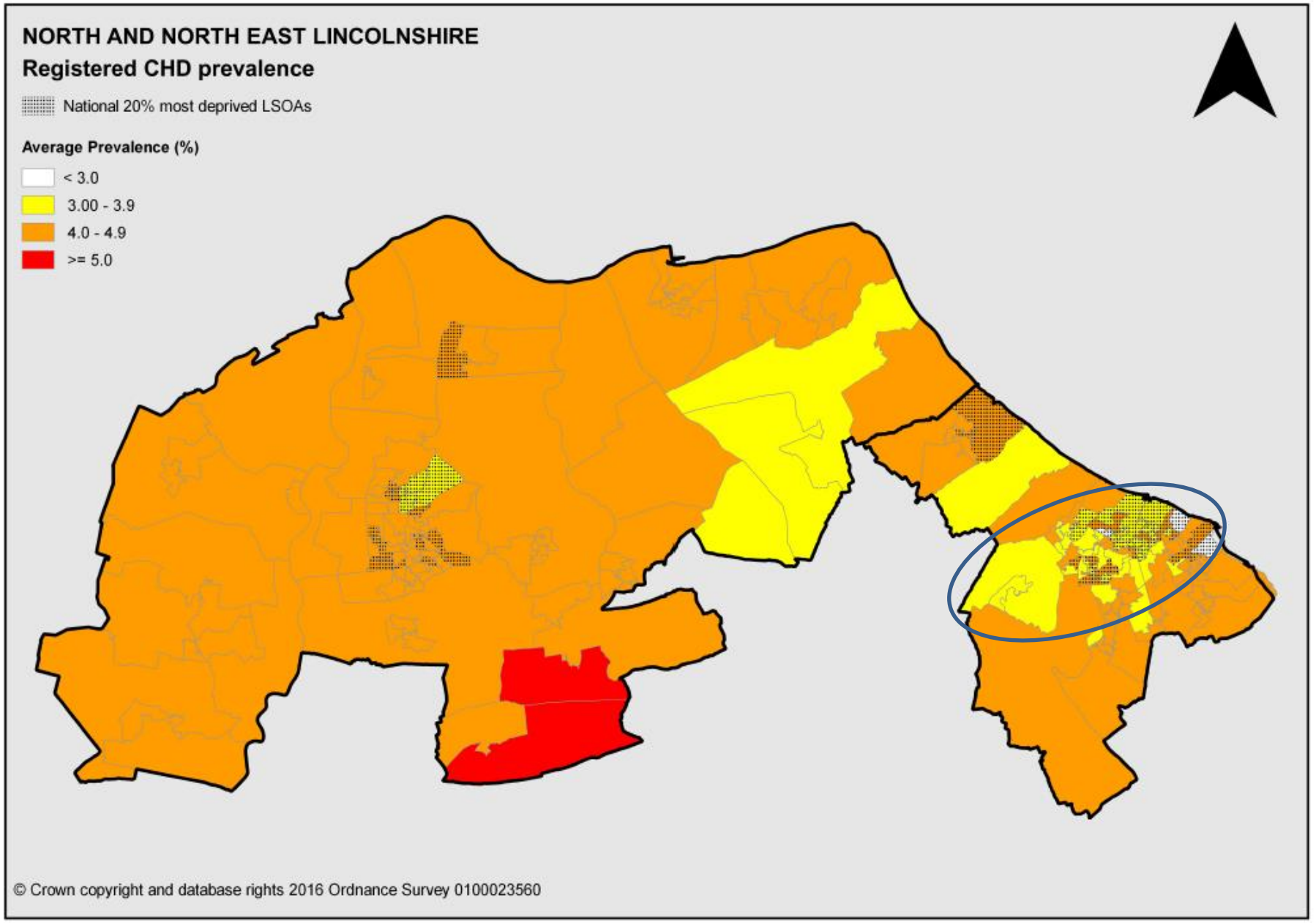




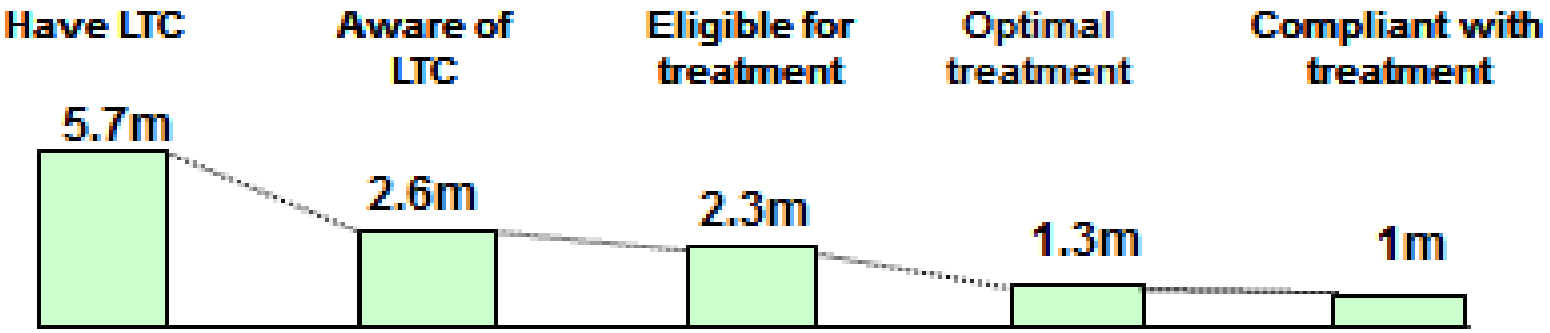
Coronary Heart Disease Standardised Death Rate



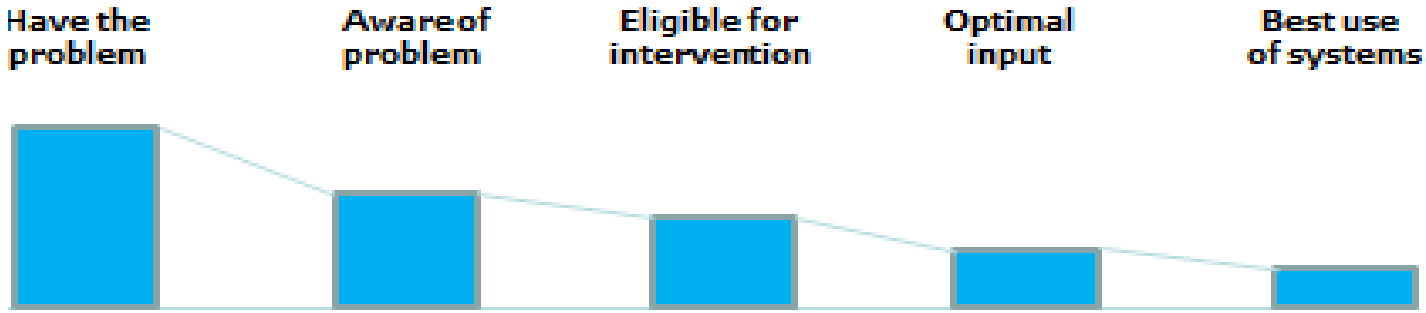
Coronary Heart Disease GP Register Prevalence



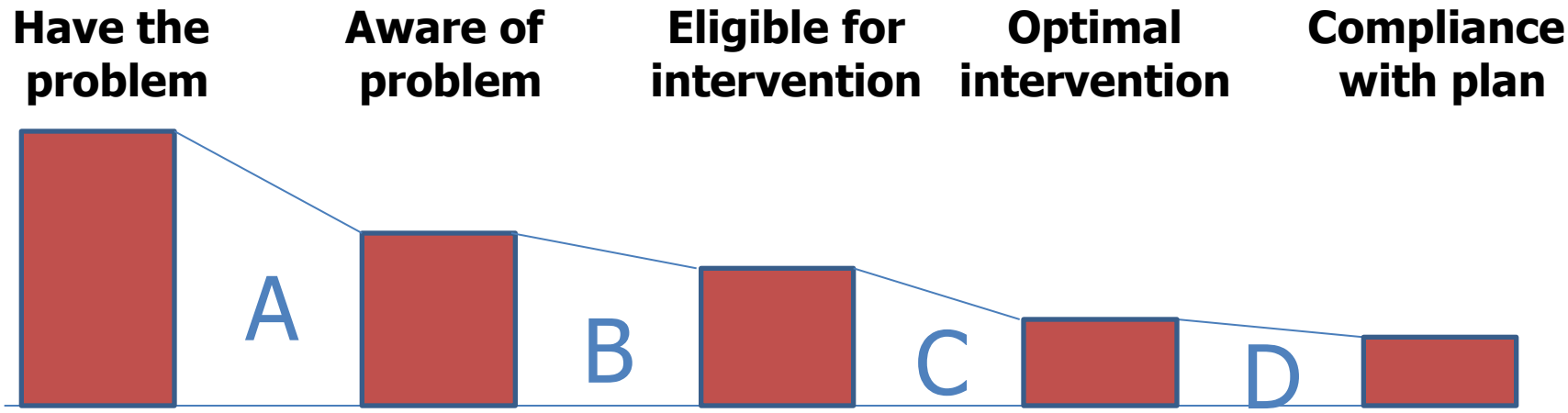
Coronary Heart Disease



Cold Damp Housing



Components of Unmet Need



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

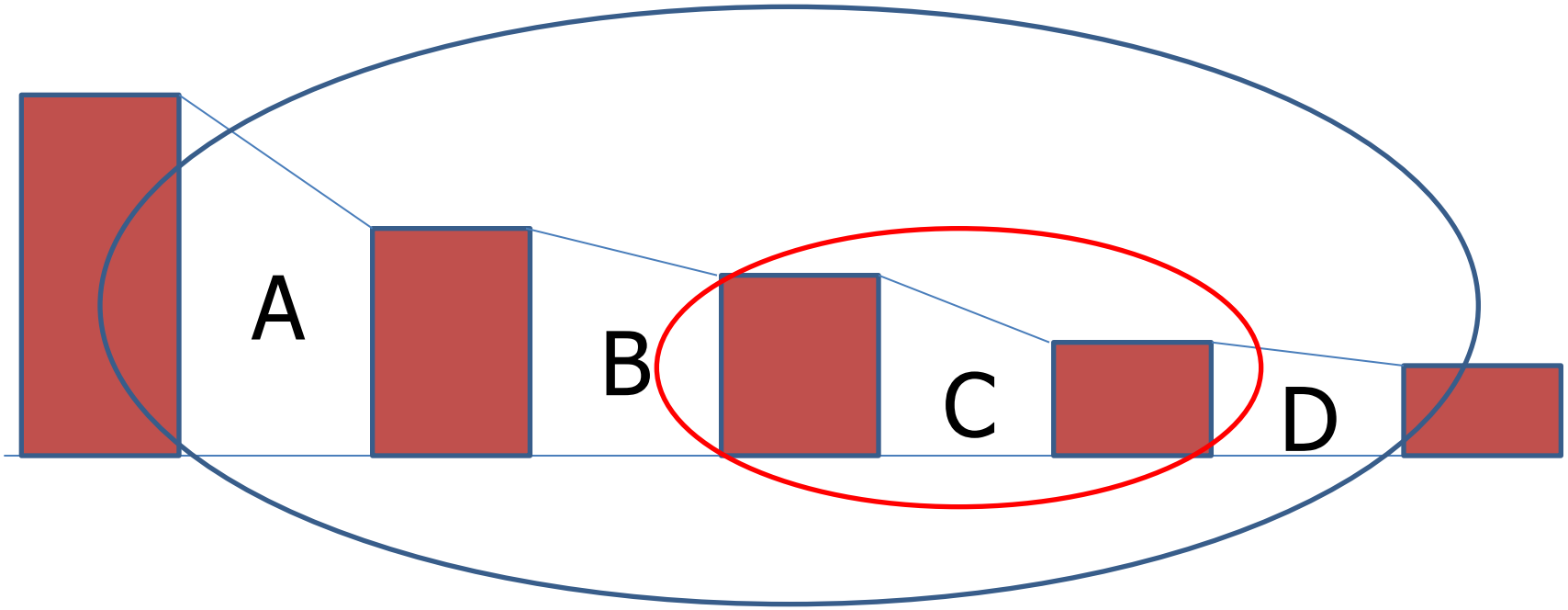
Bentley, C 2016

Collaboration to address 'implementation decay'

Lead service

Place-based partners

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

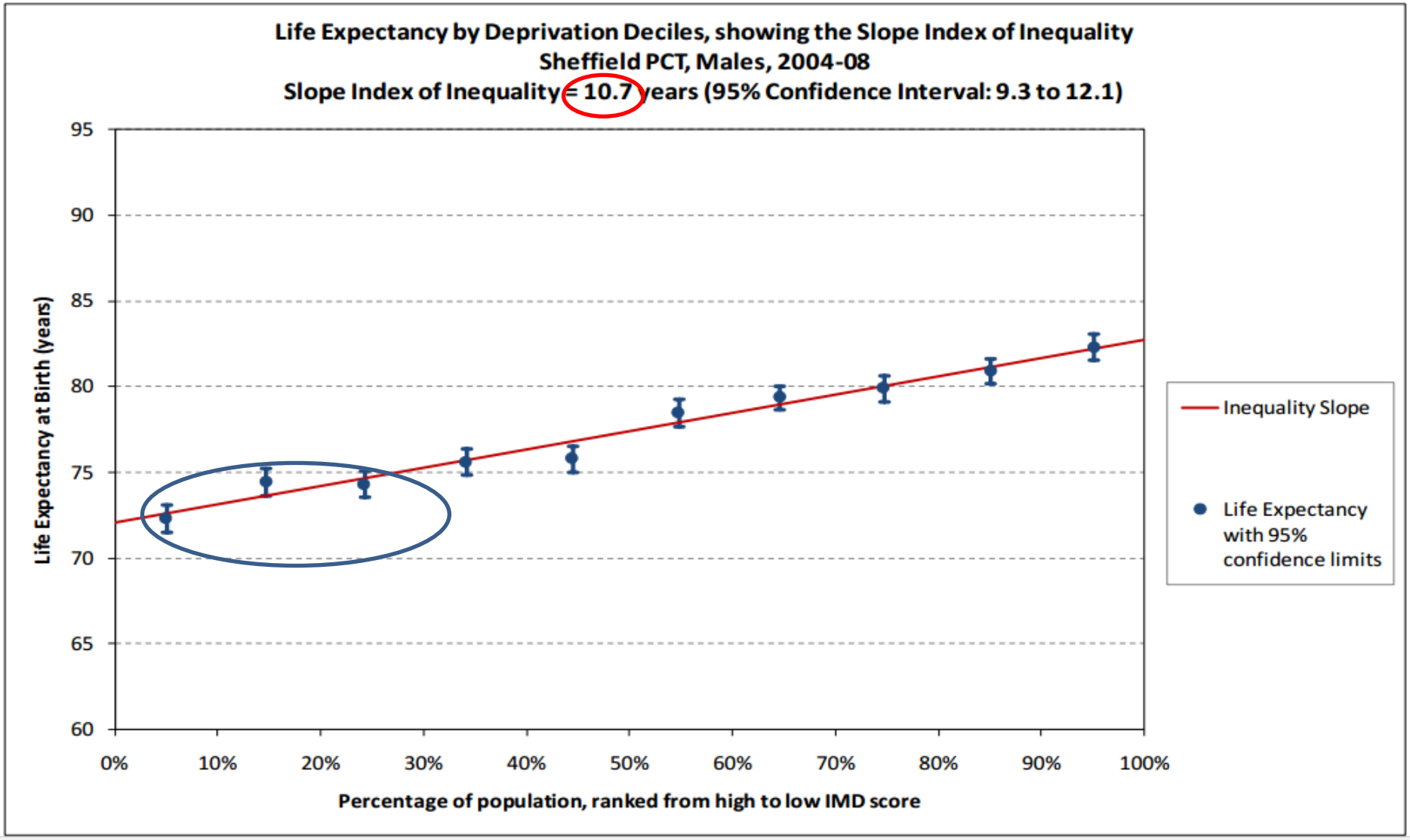


Chris Bentley 2012

Key Actions to Consider

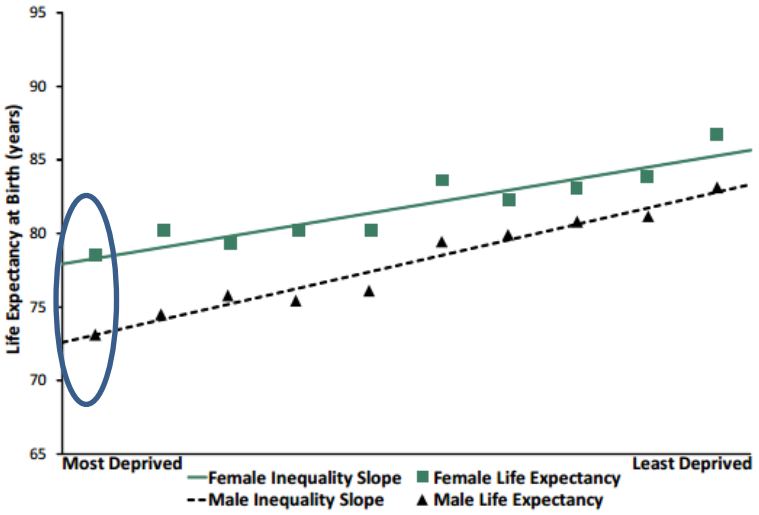
1. Map need for graduated input
2. Jointly bridge ‘No Man’s Land’ with target communities
3. Define clear lines of governance for each priority objective
4. Develop credible SMART targets for key objectives
5. Focus programmes on components able to make greatest population level change within timescales
6. Partners work together to reduce Intervention Decay in key areas

Sheffield: slope index of inequality



Sheffield: slope index of inequality

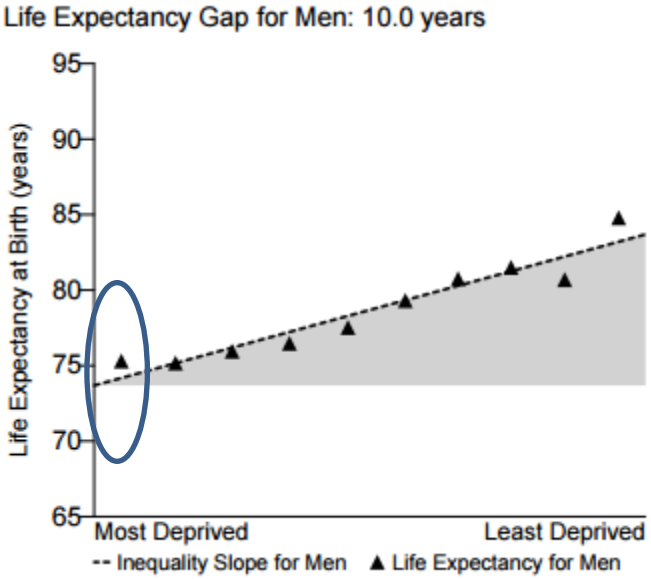
2013

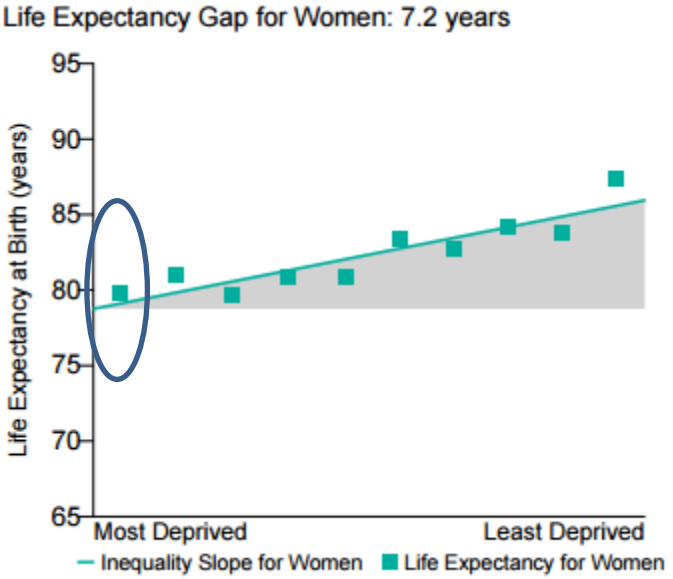


Life Expectancy gap Women 7.7

Life Expectancy gap Men 10.7

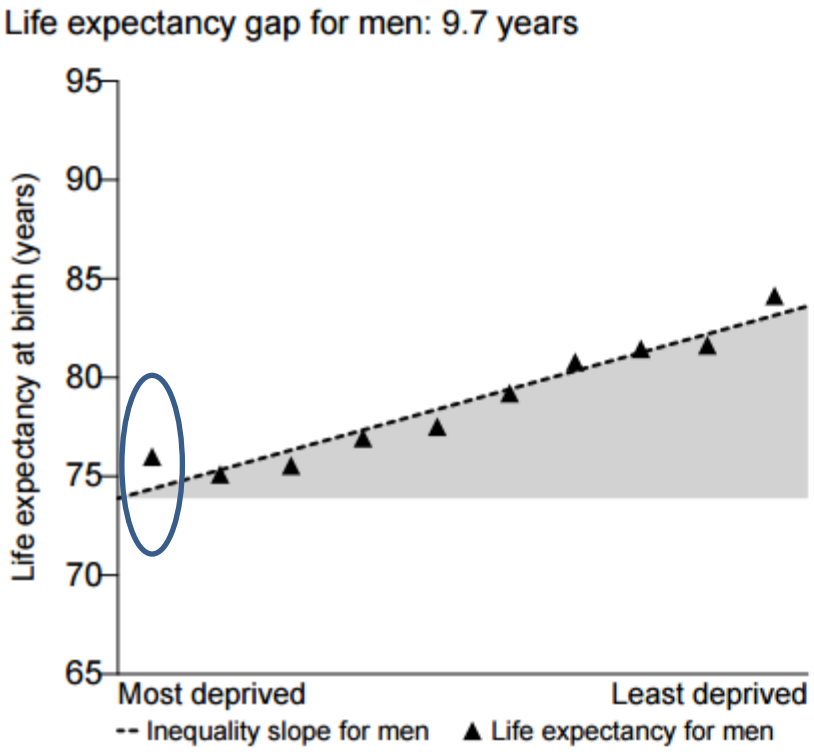
2014

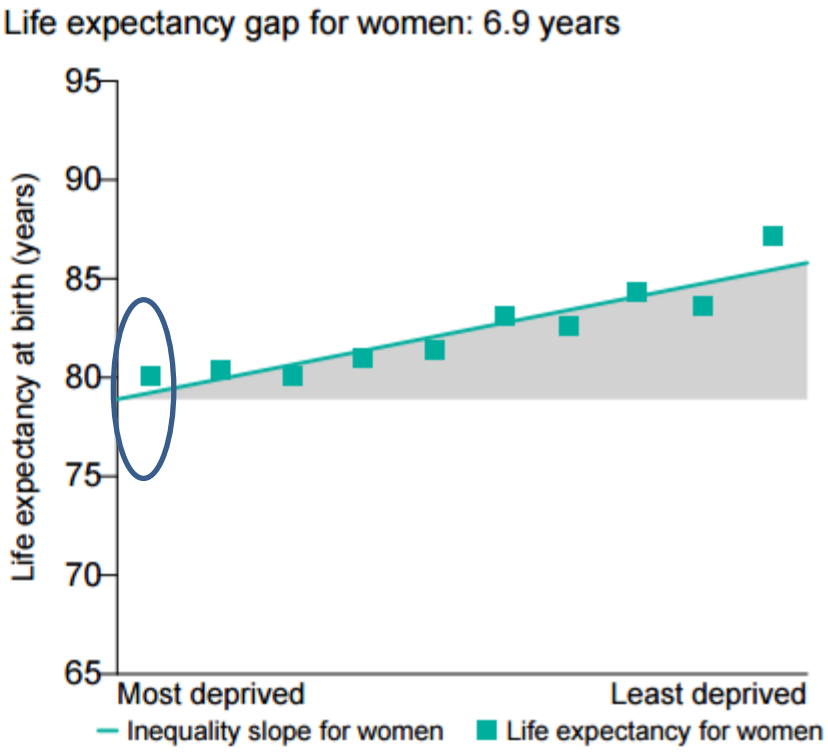




Sheffield: slope index of inequality

2015

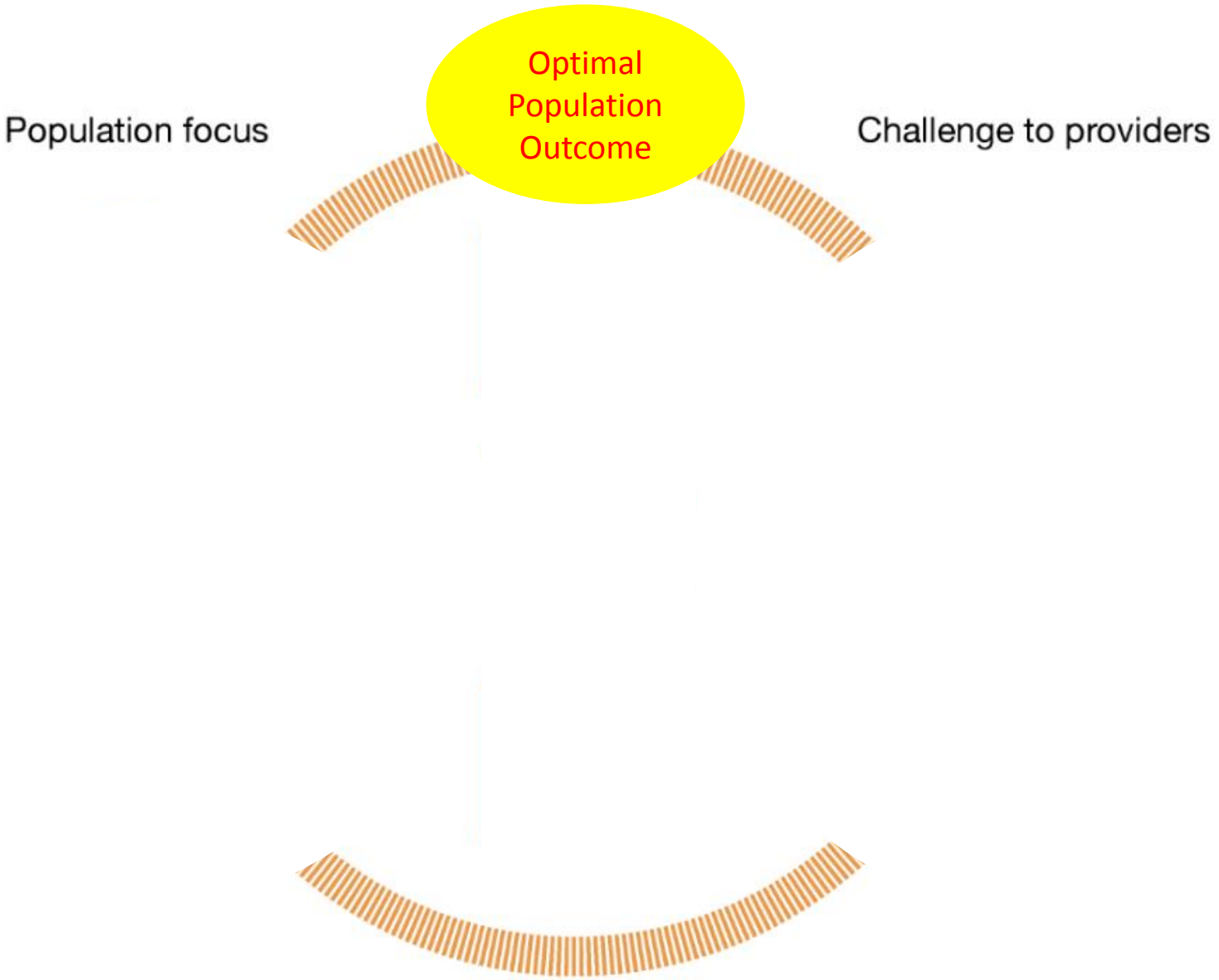




Sheffield Intervention Decay (A+B+C+D) Strategy

A	B	D
• Resilient communities • Active citizenship and health literacy • Healthy Community Programme (stress; healthy eating; debt) • Altogether better Health Champions • Social capital and connectivity with 'seldom seen' residents • Single point of access advice and support channels	• Sheffield Wellbeing consortium • Health Champions + Practice Health Champions • Advocates • Front-line services: ➢ No-wrong door ➢ Reduced handoffs ➢ Shared key workers ➢ Data-sharing ➢ Outreach and community venues • Single point of access advice and support channels	• Practice health champions • Social prescribing • Co-ordinated voluntary services support • Healthy Community Programme • Health Champions

Population Outcomes Through Services (POTS) Framework



Population Outcomes Through Services (POTS) Framework