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Population health and health inequalities

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Overview

- What Are Health Inequalities?
- NCA's Approach to Tackling Inequalities
- Looking ahead – plan for 25/26
- Partnership working
- Discussion & Reflections

What are health inequalities?

- Health inequalities are unfair and avoidable differences in health between groups of people.
- They affect how long people live, how healthy they are, and the care they receive.
- As a Trust, we serve diverse and often disadvantaged communities, so tackling these inequalities is central to delivering better care and outcomes for everyone.
- Improving population health is a key priority for the NCA:
  - Included in Vision 10 as a core strategic objective
  - In the NCA Annual Plan
  - Supported by the Population Health & Health Inequalities (PHHI) programme
- And it's a legal duty – NHS organisations are required to consider health inequalities under the Health and Care Act 2022

Examples of health inequalities

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- Health inequalities are **unjust and avoidable** differences in people's health across the population and between specific groups
- The kind of life a person is born into, where they live, the environment they grow up in and where they go to school and work will shape their lives, impact their lifestyle choices, and in turn, influence their physical and mental health.

Homelessness
44
Years in the median age at death (compared to 83 for females and 86 for males in England 2016-2018)

Deprivation
51.4
Years is the healthy life expectancy for women born in the most deprived areas, compared to 71.2 years in the least deprived areas

Asylum Seekers
61
Per cent are likely to experience serious mental distress. 5x more likely to have mental health needs than general population

Ethnicity
257
COVID-19 deaths per 100,000 population (age standardised) in Black men compared to 70 in White men in the first wave of COVID-19

Mental illness
390
Per cent excess mortality (aged <75) in people with serious mental illnesses

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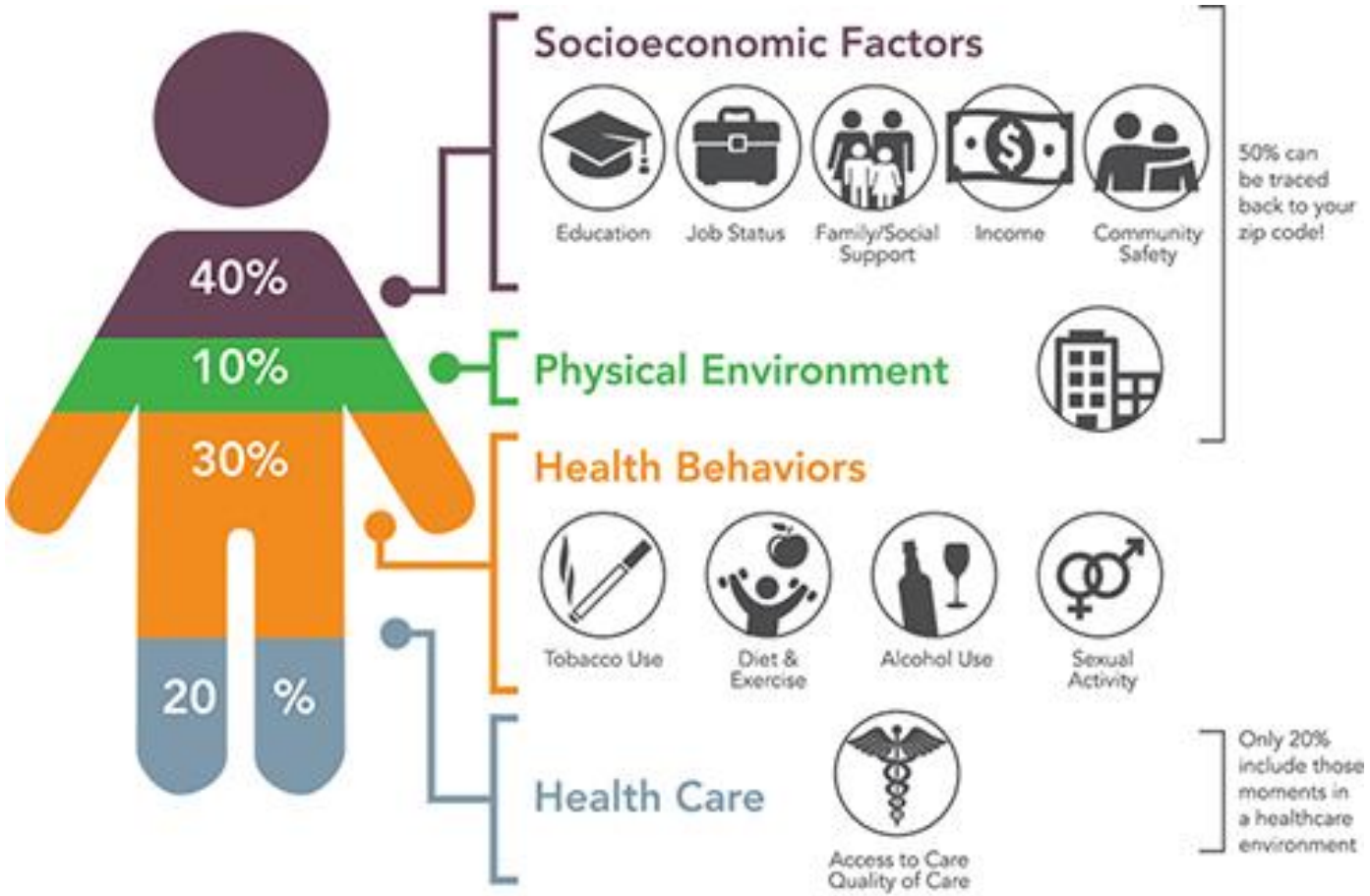
Sources: Kings Fund – Health Inequalities in a nutshell; PHE - Disparities in risk and outcomes of COVID-19; OHID Fingertips tool

Causes of health inequalities



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Source: Institute for Clinical Systems Improvement - Going beyond walls: Solving complex problems (October 2014)

	Bury	Oldham	Rochdale	Salford	England
Population	193,851 65+: 35,448 (18%)	242,089 65+: 38,614 (16%)	223,773 65+: 36,867 (16.5%)	269,923 65+: 35,924 (13.3%)	56,490,048 65+: 10,401,301 (18.4%)
Population living in most deprived IMD quintile	23.8%	51.5%	46.7%	51.7%	20%
Single-person households	30.8%	29.4%	30.6%	34%	30.1%
Ethnicity	White – 82.9% Asian – 10.6% Black – 1.9% Mixed – 2.6% Other – 1.9%	White – 68.1% Asian – 24.6% Black – 3.4% Mixed – 2.5% Other – 1.4%	White – 74% Asian – 18.5% Black – 3.5% Mixed – 2.4% Other – 1.6%	White – 82.3% Asian – 5.5% Black – 6.1% Mixed – 3.1% Other – 2.9%	White – 81% Asian – 9.6% Black – 4.2% Mixed – 3.0% Other – 2.2%
English as main language (households)	92.3%	86.6%	88.2%	87%	89.3%
Economic activity (residents aged 16+)	Employed – 57.2% Unemployed – 3.2%	Employed – 52.5% Unemployed – 4.1%	Employed – 54% Unemployed – 3.8%	Employed – 58.8% Unemployed – 4.7%	Employed – 57.4% Unemployed – 3.5%
Economic inactivity (due to ill health)	39.7% (4.7%)	43.3% (5.6%)	42.2% (5.9%)	36.5% (5.6%)	39.1% (4.1%)
Education – no formal qualifications	18.5%	24.7%	23.2%	19.7%	18.1%
Self-rated health bad or very bad	5.5%	6.2%	6.2%	6%	5.2%
Long term health problem/disability	25.6%	23.9%	24.9%	24.7%	24.1%

Source: ONS - 2021 Census

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NCA approach

Where are we now & examples of delivery

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Improving **Population Health** in all our places, working with Partners

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Evidenced outcomes

Working with academic partners to evaluate our work and show impact on population health

Systematic implementation

Widespread scale up and spread throughout the NCA

Building capacity & capability

Health inequalities training across the NCA
Develop programme management team

Data & Intelligence

Embedding health inequalities measurement & tracking changes over time

Leadership

Executive lead for health inequalities & public health consultant as clinical lead

VISION 10 strategy

Sets direction on improving population health and reducing health inequalities

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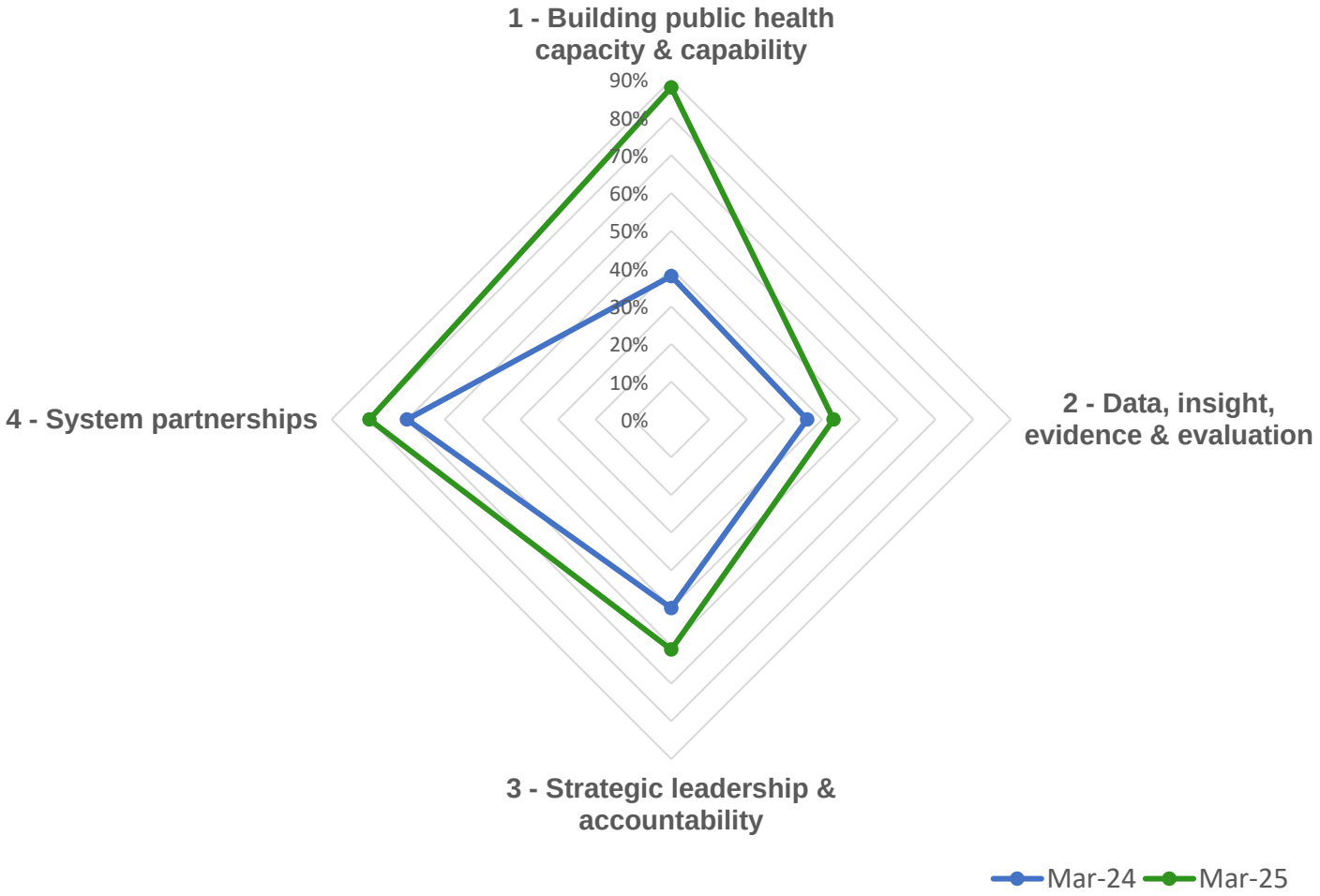
Health inequalities self-assessment



Theme	March 2024	March 2025
1 - Building public health capacity & capability	Developing	Thriving
2 - Data, insight, evidence & evaluation	Developing	Developing
3 - Strategic leadership & accountability	Maturing	Maturing
4 - System partnerships	Maturing	Maturing

Gestational Diabetes in South Asian women

NHS RACE & HEALTH OBSERVATORY
Breaking barriers for better health

44 women tested **41 or above** when HbA1c tested

4 women tested **48 or above** when HbA1c tested

24 women diagnosed with GDM – 1 with Type 2 Diabetes

Outcomes of our change process of offering HbA1c testing at booking for South Asian women, for earlier identification of and intervention for GDM. HbA1c testing will not impact our outcome measure, but we decided to adopt into our Trust process as we were seeing positive outcomes for some women.

"My sister-in-law was diabetic, but was not diagnosed until the GTT. I am glad to see the test done early as all the women in the family have had diabetes in pregnancy."
- currently pregnant at the NCA.

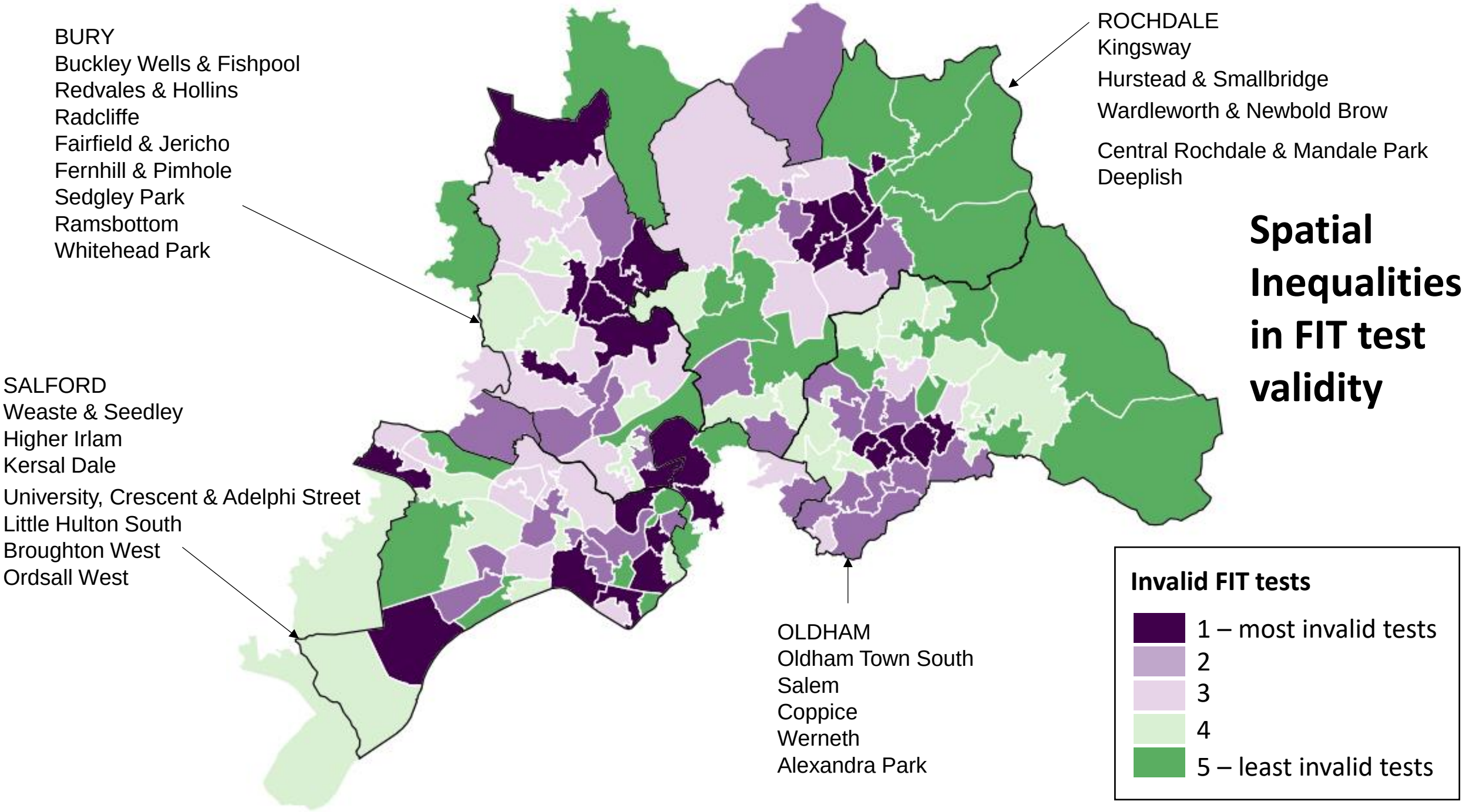
"Earlier HbA1c testing means we can advise women on diet and exercise early. We aim for our women to have cultural-specific resources." - **Community Engagement Midwife**

"Changing processes may take time to initiate and embed, but long-term benefits include better self-management and a stronger community for our women." - **Staff**

"We have since worked with BadgerNet to ensure 'ethnicity' and 'interpreter' fields are mandatory to better identify patient needs and maintain accurate records." - **Staff**

"I am happy with providing a change to care & treatment. I understand the importance of improving services for South Asian women who are at high risk of Gestational Diabetes. It's easier now, as we know which women are needing the HbA1c test." **- Booking Midwife at our Birth Centre.**

Spatial Inequalities in FIT test validity



NCA as an Anchor Institution

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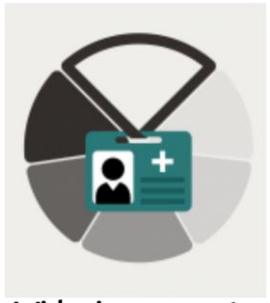

Widening access to quality work

Producing more locally and for social benefit

89.5% of staff reside in GM
(GM Average = 86.4%), highest in GM

41.7% of non-pay spend in local economy
2nd highest in GM (GM Average = 21%)

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Images taken from: Reed S, Göpfert A, Wood S, Allwood D, Warburton W. Building healthier communities: the role of the NHS as an anchor institution. London: The Health Foundation; 2019.

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Looking ahead: Our plan for 25/26

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Population health and health inequalities programme

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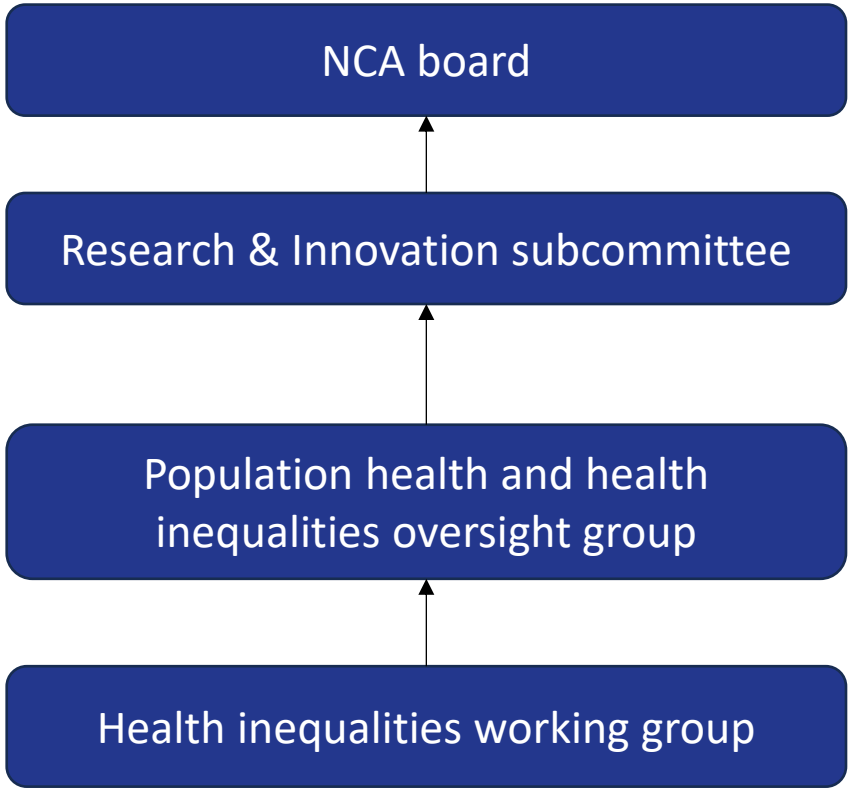

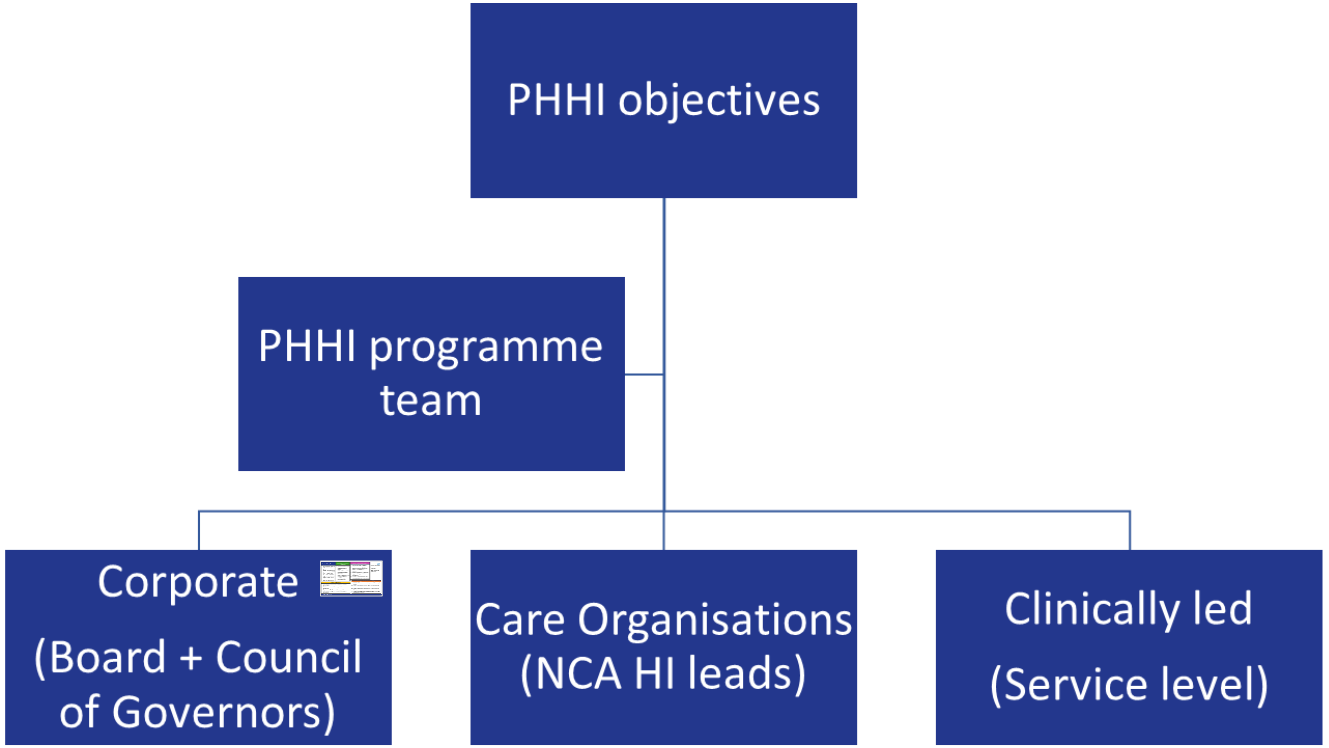

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Service delivery & access

- Reduce waiting times for children and young people
- Embed equity in clinical programmes (e.g. GIRFT)
- Pilot a “Making Every Contact Count” (MECC) approach in one service
- Support return to work and reduce economic inactivity (MSK/spines)

Data, insight, evidence & evaluation

- Improve monitoring of health inequalities metrics
- Build analytic capability to identify and act on disparities
- Explore digital tools (e.g. NHS App) through a health literacy and accessibility lens

Building capacity & capability

- Launch a Population Health for Leaders development programme
- Develop internal programmes to address inequalities in the workforce
- Update Anchor People Strategy to support staff as part of their communities
- Include cultural competence and inclusion in leadership expectations

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25/26 Delivery plan – corporate objectives

System partnerships

- Partner with researchers to evaluate provider-led interventions
- Prioritise procurement from organisations delivering social value
- Support council of Governors to engage with our communities through the membership to support programme

Strategic leadership & accountability

- Maintain robust governance through the PHHI oversight group
- Refresh Vision10 goals to strengthen population health focus
- Include strategic inequality objective in consultant job planning
- Integrate inequalities into clinical governance and quality improvement processes

Strengthening partnerships

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We see the impact of inequality through:

- Emergency admissions for preventable conditions
- Barriers to attending appointments or engaging with care
- Poor housing, financial insecurity, or lack of social support
- Delayed discharge due to unmet community needs

How can we facilitate stronger connections into:

- Housing and homelessness services
- Employment and welfare support
- Early years and education
- Transport to and from healthcare settings
- Community assets: leisure, libraries, social prescribing

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Discussion & reflections