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Addressing Health inequalities

JHOSC meeting 12 March 2021

Summary

This paper provides an overview of our work to reduce health inequalities covering:

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1. Context

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Inequalities in NCL's population has driven marked differences in health outcomes for different groups in population – and this worsened since 2010 & in pandemic:

'Health inequalities' are avoidable, unfair and systematic differences in health between different groups

Worsening Health Inequalities: Marmot Review 10 years On & Related Reports suggest:

*"Inequalities in health arise because of **inequalities in society** – in conditions in which people are born, grow, live, work & age"*

"The last decade has been marked by deteriorating health and widening inequalities"

"Why do we treat people then discharge them back to the conditions that made them sick?" (Marmot 2015)

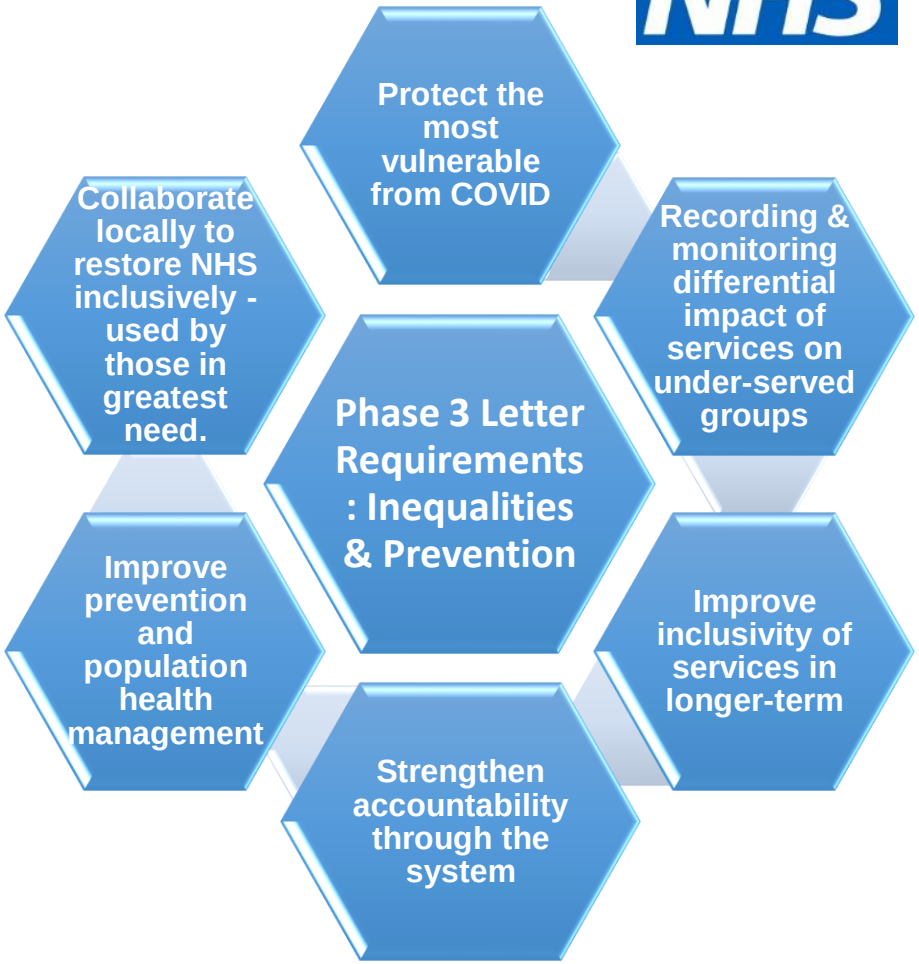
Black Lives Matter and Health Inequalities: People from BAME groups in the UK are **more likely to**:

- Be diagnosed with mental health problems & admitted to MH hospital;
- Experience a poor outcome from treatment or to disengage from MH services.
- Be affected by biological weathering

Impact of COVID-19:

National Policy Institute: People and places in London most vulnerable to COVID -19 (Sept 2020) *"The economic & housing indicators show…the risks are highest in five Boroughs [including] **Haringey and Enfield."***

PHE Beyond the Data: *"It is clear…COVID-19 did not create health inequalities, but **rather exposed and exacerbated longstanding inequalities affecting BAME groups**"*



The 3rd Phase of NHS Response to COVID has included a specific focus on Inequalities & Prevention

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1. National expectations

PHE report *Beyond the Data*	Eight Urgent Actions	Inclusion and monitoring
• Mandate ethnicity data collection • Community Participatory Research • Improve access, experience and outcomes • Culturally competent risk assessments • Fund health prevention and education • Health promotion • Reduce inequalities caused by wider determinants	• Protect the vulnerable • Restore services inclusively • Develop digitally enabled pathways that are inclusive • Accelerate prevention pathways • Prioritise mental health • Leadership and accountability • Improve datasets • Improve local collaboration	• Restore services inclusively - monthly NHS reporting will include measures of performance in relation to patients from the **most deprived 20% and BAME** • Monitoring will compare service use and outcomes across **emergency, outpatient** and **elective care**, including Cancer referrals and waiting time activity • **Challenge: how do we ensure this looks at the general population not just those 'in the system'…?**

2. NCL Clinical Commissioning Group: Aims

To ensure a continued focus across the work of the CCG we established the Communities portfolio and programme in late 2020. The team works across all Boroughs and with partners and is in place to:

- Work with partners to operationalise NCL CCG commitment to health inequalities
- Reduce variation in access, outcomes and experience across NCL
- Identify the highest priority needs to address in order to achieve this – including a review of the traditional understanding of 'need'
- Develop projects and cases for interventions that would reduce health inequalities
- Help shape decision making processes and funding arrangements to drive and enable a more equitable approach
- Spread a culture where health inequalities is at the top of everyone's agenda and an integral part of everyone's role
- Add value to work of Borough Partnerships by leveraging the benefits of NCL CCG and ICS working to focus areas of greatest need within each of the five Boroughs.

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2. Link to borough partnership – inequality priorities

Each ICP has its own priorities and approach to addressing inequalities, coproduced with local authorities, residents and partners. **All partnerships** have a current focus on COVID Vaccine uptake with shared learning & common challenges.

Borough	*Examples* of current priorities and plans to address health inequalities
Camden	• Collaborative working between public-sector, voluntary sector and community groups to tackle inequalities
	• Evidence-based approach to expand and develop locality-based facilities to ensure solutions more equitable
	• Implementing multiagency plan to vaccinate 1,500 homeless residents and asylum seekers in the borough
Islington	Joint work across the ICP to understand and address the short and longer term impact of COVID: • The disproportionate impact of COVID across the Borough's population; • The impact on the mental health of the population as a whole; • The life chances of young people - particularly in terms of education, training and employment
Enfield	• Implementing a project to address inequalities associated with childhood obesity
	• Healthwatch commissioned report into health inequalities with focus on Eastern European communities
	• Joint working on inequalities between Council and CCG – exploring improved opportunities on housing
Barnet	• Inequalities workstream includes equitable same-day access to health services
	• Improving equitable access, outcomes and experience in paediatrics and in mental health
	• Multiagency approach to address inequalities in vaccine take-up with community partners
Haringey	• Multi-agency programme for tackling racism/inequality across multiple health and social aspects of opportunity
	• NHS NCL Charities bid with Enfield to tackle inequalities in mental health, long COVD and digital inclusion
	• Approach to address inequalities in vaccine take-up co-led by CCG & Public Health with community partners

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3. Impact to date

3i. Funding

- **£150K** for Community Participatory Research into families with childhood obesity, supported by Enfield Council contribution of **£250K (Fenton recommendation)**
- **£670K (£1.14m over 2 years)** NHS Charities bid – joint bid across the Haringey & Enfield partnerships focusing on : disproportionate health outcomes for young black males, post Covid and community champions and digital inclusion (**Fenton recommendations being applied as part of process**)
- **£282K** for Hypertension and Diabetes models – health inequalities focus
- **£200k** Shared Outcomes Fund to support homeless health/hospital discharge

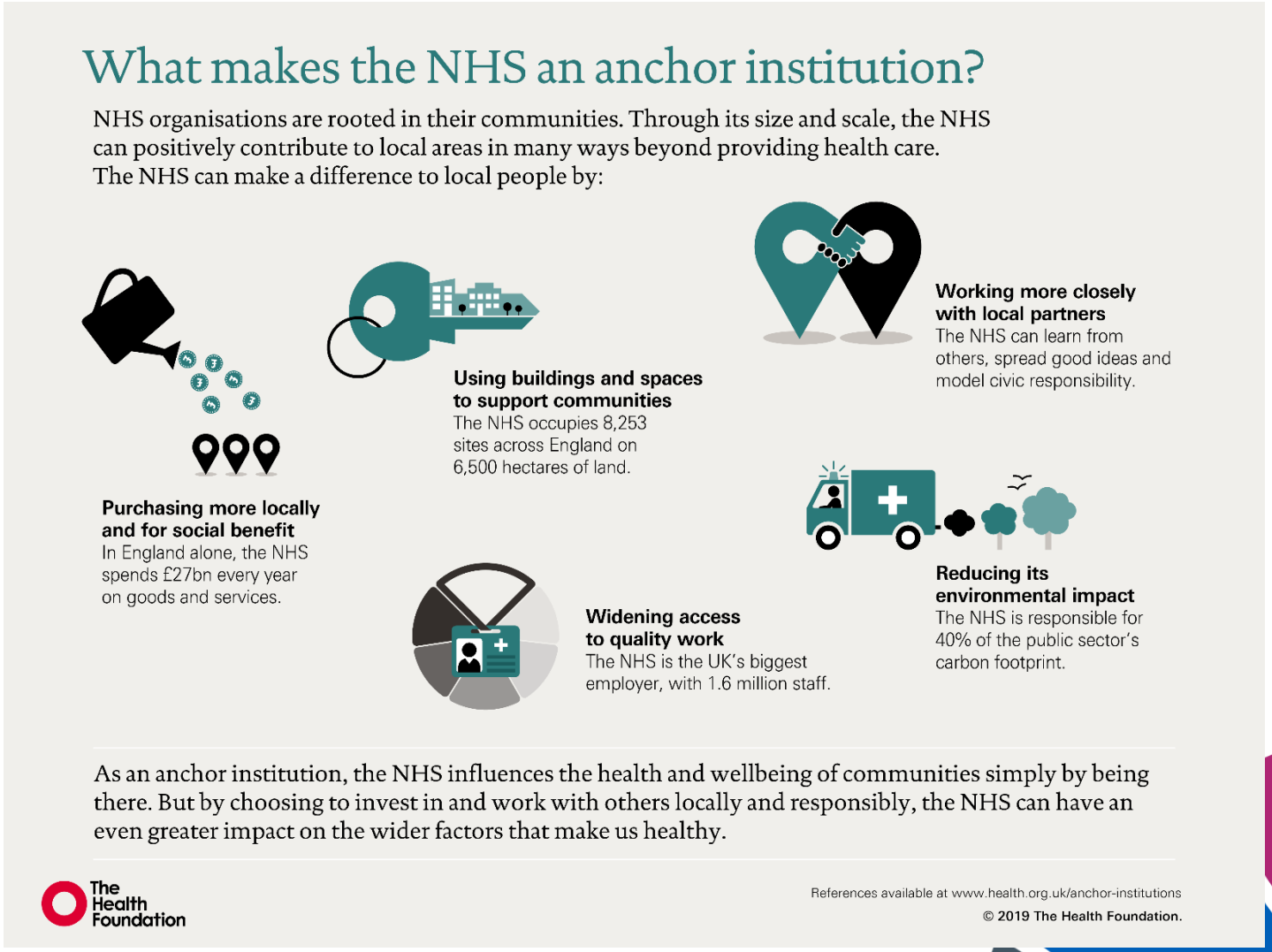
3ii. Strategic Planning

- Team recruited and **work programme developed** based on NCL priorities and NHSE 8 urgent actions
- Development of **NCL Map of Need** to underpin proportionate universalism/resource distribution aspiration.
- Contributing thinking to the emerging **Population Health approach** – driving the shift to a resource distribution approach more explicitly aligned to areas of need and inequality within communities
- Stocktake of **Anchor Institution** approaches across NCL organisations to inform principles and expectations including commitment to leveraging additional social value and to NCL communities and partnership working to address areas of greatest need.
- **Benchmarking and baselining Care Home support models** – moving towards more equitable provision

3iii Anchor Institutions – developing and embedding in NCL

Anchor institutions are big and locally rooted organisations like councils, further education colleges, universities, hospitals and big businesses with local headquarters. Anchors get their name because they are unlikely to relocate given their connection to the local population.

Recognising that the decisions the NHS takes can have an impact in areas of deprivation and contribute to our NHS Long Term Plan and local ambitions to address inequalities.



3.iii Anchor institutions – examples of local work

North Mid purchased Christmas fruit baskets from a Haringey based organisation. The Haringey based organisation aims to reduce food poverty. Now looking for the organisation to provide food stall at the hospital.

Islington care and health academy – structured programme to increase local employment into GP practices

Royal Free used a personal protective equipment (PPE) factory in Haringey during first phase of covid. Gowns are also washable (up to 50 washes).

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3.iv. Digital exclusion and inclusion defined

Digital exclusion occurs when people and groups in society are unable to exploit the benefits from technologies including the internet or devices. At an individual level, digital exclusion is a combination of a number of contributing factors reflecting an individuals' access to, use and engagement with digital technology.

The gap between those who are excluded and those who are able benefit from technology is known as the **digital divide.**

Digital inclusion is an approach for overcoming the barriers to opportunity, access, knowledge and skills for using technology (Gann 2018).

Quantification of digital exclusion and inclusion would require an agreed criteria for NCL. We know from local work that there are differences in local definitions. [see next slide]

** Digital technology and health inequalities: a scoping review; NHS Wales (source)

Health inequalities and disadvantaged groups – factors likely to contribute to digital exclusion:

- Different income groups or socioeconomic classes
- Different ethnic and racial groups
- People living with disabilities and others
- People who live in different geographic areas, like urban and rural areas
- Different levels of deprivation
- People with differing sexuality and sexual behaviours
- Homeless people and the rest of the population.
- Asylum seekers and migrant workers

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3.iv. Digital exclusion and inclusion defined

Example: Haringey digital inclusion project

- Healthwatch Haringey's Lessons from Lockdown report, from August 2020 includes residents' feelings around digital access and inclusion.

- In response, Haringey Primary Care team is leading on a digital inclusion project in collaboration with primary care, Whittington Health, NMUH, Barnet, Enfield and Haringey Mental Health Trust, Haringey Council and Public Voice. This reports via the Borough Partnership.

- The project involves providing support to enable and empower local residents to access health services digitally by providing training, building confidence and in some cases loaning devices (such as mobile phones). They are also looking at setting up community based hubs, such as in libraries, where residents can access online consultations privately. Digital access and inclusion was also a recurring feedback theme at a public meeting in November 2020.

- Feedback relating to digital inclusion include themes such as:
  - Some concerns around privacy and confidentiality
  - Lack of confidence in using new technology, support should be provided when introducing new technology
  - Concerns that move to digital could increase health inequalities particularly for older people

- Healthwatch Haringey have also been commissioned to support primary care networks in Haringey with their communications and engagement. This involves supporting practices developing Patient Participation Groups to ensure a more diverse group of patients can feed back into service development. This includes supporting them to use digital platforms to involve patients.

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3.v. Health inequalities and Covid-19 vaccination

In order to support us to address differential uptake across communities:

All CCG teams and Borough Partnerships are currently focused on maximising uptake of the COVID vaccine and in doing so building relationships with communities and group within and addressing long standing health inequalities in access, experience and outcome

Boroughs are provided with “real time” information about uptake from Healtheintent – by ethnicity, deprivation/ward, age, gender and first language spoken.

This is enabling each borough to modify and maximise engagement and communication to local needs.

Examples include:

- Communities “myth-busting” webinar - Enfield
- Diverse vaccinators reflecting community – Camden
- Vaccination in faith settings – Haringey
- Videos of Mayor and different communities being vaccinated – Islington
- Co-delivery with Hatzola Jewish Ambulance Service – Barnet

Further information in the appendix about the approaches being taken locally.

3.v. Health inequalities and Covid-19 vaccination

To support us to address inclusion health we are:

Working with Borough leads, primary care, public health and UCLH Find and Treat to develop programme to ensure vaccination uptake from underserved populations including people experiencing homelessness, asylum seekers, and traveller communities.

Links to wider focus on the health of these populations and is informing pan-London work/offer.

Key element is preparing people and accommodation providers to support programme – including provision of vaccination to front line staff.

This includes peer developed leaflets, webinars led by clinical lead and pre-visits.

We are working with peer and lived experience groups to inform engagement approaches.

Data is being collected to monitor uptake which will be reviewed ongoing through the NCL Vaccine Board. This will continue to inform planning and development of programme.

Considering innovative approaches to certain population groups – eg Vaxi Taxi and Doctors of the World.

Key link to wider health inequalities and support beyond covid vaccination.

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3.v. Supporting vaccination for people with Learning disabilities and autism spectrum disorder

24th Feb JCVI amended the criteria for Priority Group 6 to include all adults with LD, including those with 'mild to moderate' needs. Carers are also to be prioritised as part of priority 6. In addition to this, NCL CCG has taken the decision to also provide access to the vaccine for people with Autism, aged 16+. In NCL we have also taken the following actions:

- Identifying eligible individuals by cross-referencing LD team service user lists with GP registration data
- Identifying most vulnerable/high needs individuals known to services, particularly those who are known to struggle with vaccinations as learned through the flu vaccination
- Providing easy read information and advice about the vaccine
- Identifying those who may not have capacity to make a decision about the vaccine
- Developing processes to support people w/LD who are needle-phobic. Needle desensitisation work will need to be delivered in advance for this group.
- Developing advice for marshals/ volunteers at vaccination centres - for recognising hidden disabilities (Barnet)
- Identifying opportunities to provide reasonable adjustments that support vaccine delivery, e.g. Enfield have reached agreement with BEH to use a space within Chase Farm hospital as a LD vaccination hub, which supports adjustments such as longer appointment times and sensory needs (e.g. quiet space).
- Clinical staff within local teams are receiving vaccine training, enabling them to support PCNs with delivering vaccines to people with LD, utilising their expertise of working with this cohort, and being able to adjust their approach so care is personalised. In many cases, locally trained LD colleagues will also know the individual being vaccinated, and this will provide further reassurance to individuals. In Islington, support is also being provided to residents to book vaccine appointments and arrange transport.
- Liaising with carers groups to share vaccine information, run Q&A sessions and encouraging carers to register their caring status with their GP, to ensure they are included within priority group 6.

4. Next steps

- Health inequalities will widen and the cost to the system will increase if we don't intervene to support improved outcomes and reduce variation so we need a disproportionate focus on areas of highest need
- We are looking at ways of working and opportunities to apply data and insight to identify need and address it (population health) via local and system-wide interventions e.g. building relationships with communities; developing our insights; scoping a system investment fund for health inequalities

5. Appendices

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Core pillars of NCL Inequalities approach

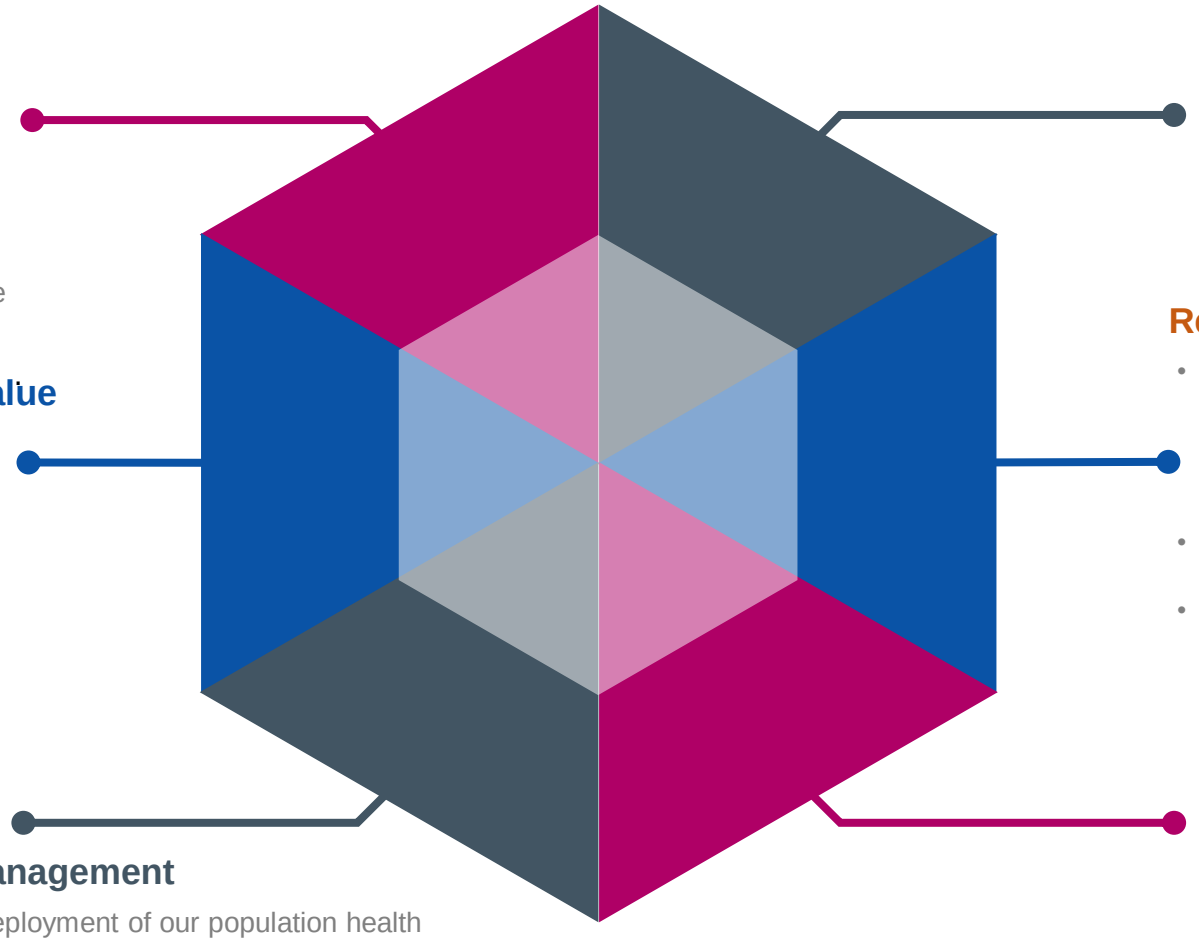
Race and ethnic inequalities

- We will approach all our deliberations on inequalities by applying this lens
- We will build on the strengths of our diverse communities, including local faith leaders
- Through our community engagement plans, we will ensure that BAME communities have the opportunity to engage in the development of strategies, plans and services, including those where English is not their first language

Anchor organisations and social value

We will support our communities by working as a network of anchor organisations, embedding social value:

- Looking at how we can use more of our levers to address factors that contribute to health inequalities
- Capitalise on public sector organisations as employers, with a focus on lower paid staff, many of whom live locally
- Ensure that we are making full use of apprenticeships and other employment opportunities



Population health management

- Continuing with the deployment of our population health management system, HealtheIntent, which will enable the systematic use of data to improve access to services for different equalities groups, vulnerable individuals and populations, as well as improvements in the quality of care

A strengths-based approach

- We will build on individual and community strengths to improve health
- North Central London has a very large voluntary and community sector, as well as business assets that we will work with to address inequalities
- This means ensuring we have a highly networked community with “neighbourliness” / citizenship at its heart

Resource distribution to tackle inequalities

- **Addressing health and care inequalities will be a criterion in reviewing and evaluating future investments, including how we support longer term gains (e.g. for children)**
- **Marmot principle of “proportionate universalism” will be applied**
- **We will achieve parity of esteem between resourcing mental health and physical health services and prevention**

Prevention & early intervention

- We will review our prevention and early intervention plans to ensure we are making the biggest impact in the shortest time. Particular areas of focus likely to be: mental health, smoking, cardiovascular risk, alcohol, overweight and obesity

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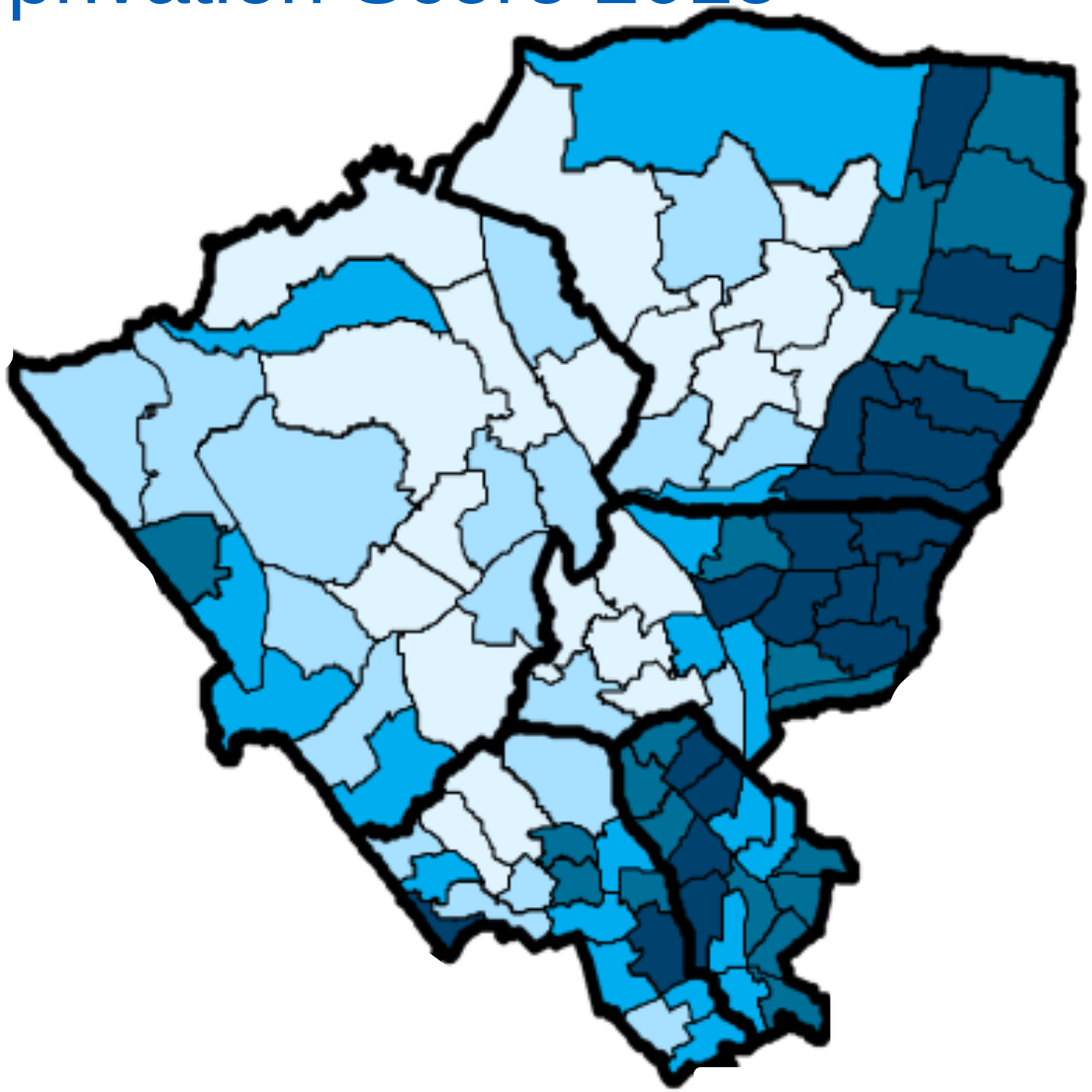
Maps of need across NCL

Index of Multiple Deprivation Score 2015

NCL Top 20%

Ward	Borough	IMD
Northumberland Park	Haringey	52.6
Edmonton Green	Enfield	47.0
White Hart Lane	Haringey	45.9
Tottenham Green	Haringey	43.6
Finsbury Park	Islington	42.4
Tottenham Hale	Haringey	41.5
Bruce Grove	Haringey	40.2
Upper Edmonton	Enfield	39.2
St Pancras and Somers	Camden	38.6
Noel Park	Haringey	38.3
Turkey Street	Enfield	38.2
Lower Edmonton	Enfield	37.1
Ponders End	Enfield	36.5
West Green	Haringey	36.3
Kilburn	Camden	36.0
Holloway	Islington	35.5
Caledonian	Islington	35.5
Tollington	Islington	35.3
Haselbury	Enfield	34.8



Should we look at this from a **ward / needs level** rather than borough level?

The colours on the map show different quintiles across NCL. Darker colours indicate the wards with higher levels of deprivation, based on the IMD deprivation score.

Indicator values range from 9.5 to 52.6.

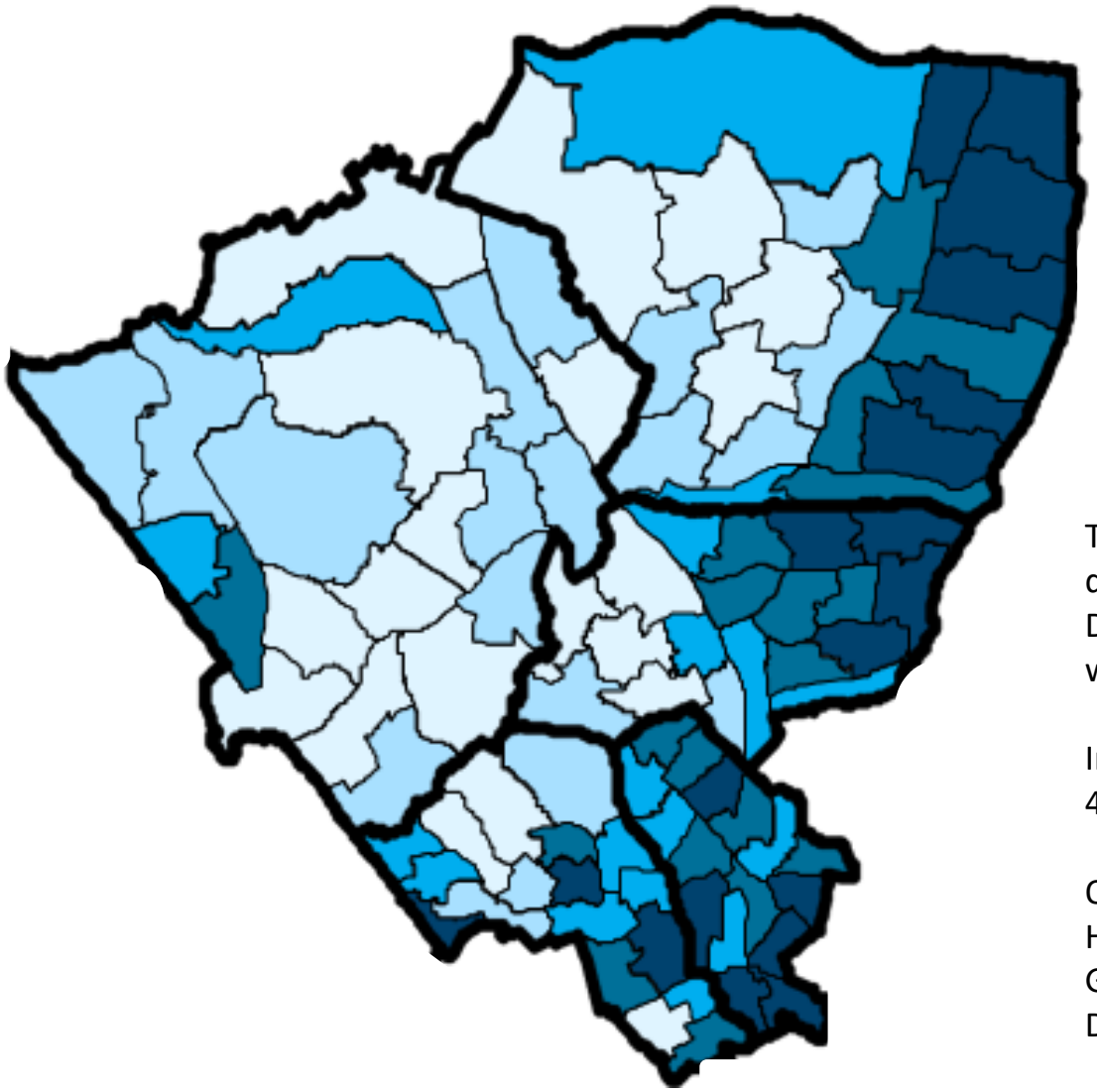
Original Data Source: Ministry of Housing, Communities and Local Government, Index of Multiple Deprivation 2015

Source for all data: PHE Fingertips https://fingertips.phe.org.uk/profile/local-health/

Child Poverty, English Indices of Deprivation 2015, IDACI

NCL Top 20%

Ward	Borough	IDACI
Bunhill	Islington	44.6
St Pancras and Somers Town	Camden	43.3
Kilburn	Camden	42.9
Turkey Street	Enfield	42.8
Enfield Lock	Enfield	42.5
White Hart Lane	Haringey	42.3
Lower Edmonton	Enfield	42.3
Northumberland Park	Haringey	42.1
Tottenham Hale	Haringey	41.7
Caledonian	Islington	40.9
Finsbury Park	Islington	40.8
Edmonton Green	Enfield	40.4
Haverstock	Camden	40.3
Enfield Highway	Enfield	40.1
Clerkenwell	Islington	38.3
St Peter's	Islington	37.9
Tottenham Green	Haringey	37.8
Canonbury	Islington	37.7
Ponders End	Enfield	37.0



The colours on the map show different quintiles across NCL. Darker colours indicate the wards with higher levels of child poverty.

Indicator values range from 5.1 to 44.6.

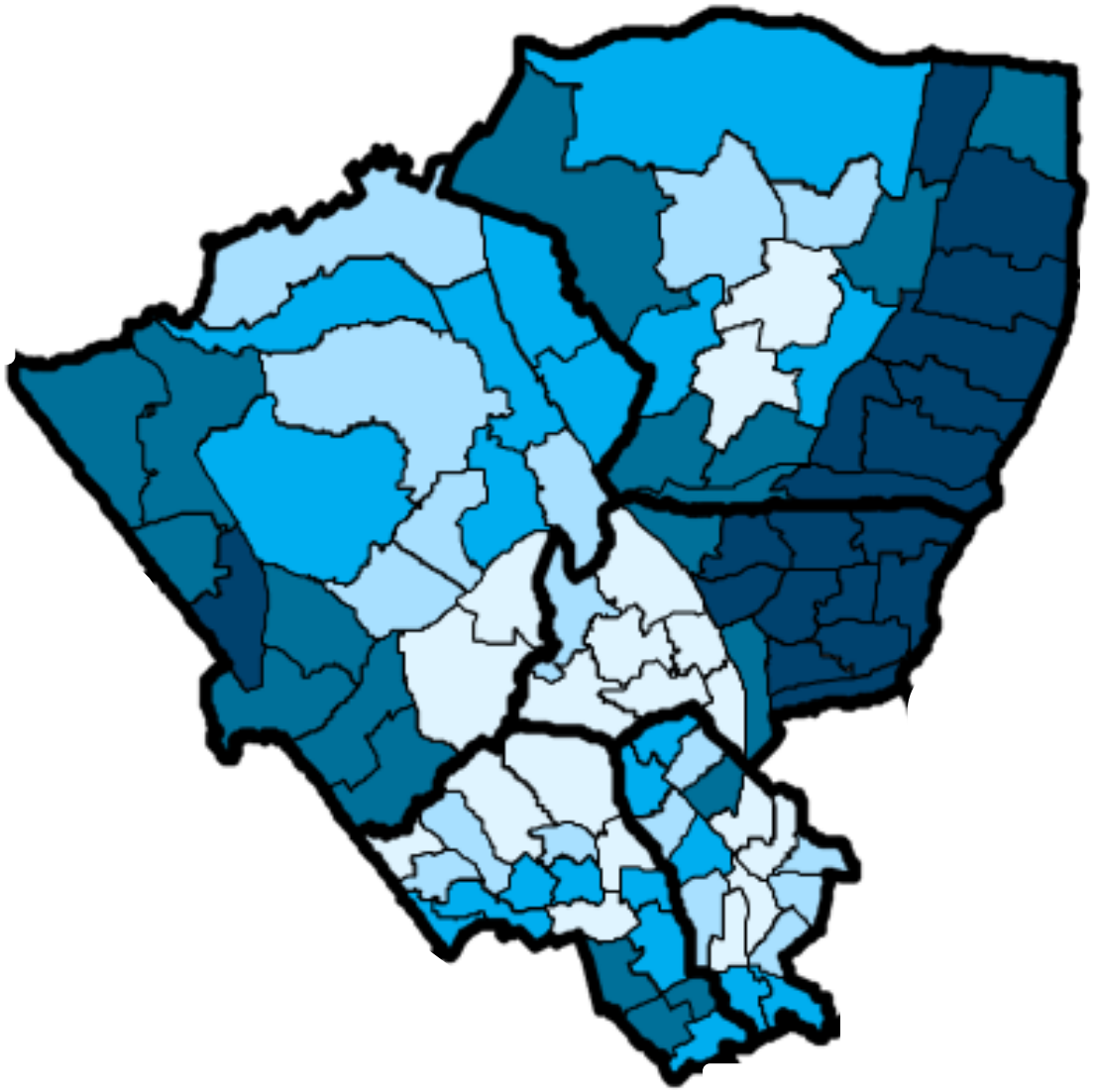
Original Data Source: Ministry of Housing, Communities and Local Government, English Indices of Deprivation 2015

Source for all data: PHE Fingertips https://fingertips.phe.org.uk/profile/local-health/

Fuel poverty

NCL Top 20%

Ward	Borough	%
Bruce Grove	Haringey	18.4
Noel Park	Haringey	18.1
St Ann's	Haringey	17.1
Woodside	Haringey	16.7
White Hart Lane	Haringey	16.4
Tottenham Hale	Haringey	15.9
West Green	Haringey	15.6
Tottenham Green	Haringey	15.3
Seven Sisters	Haringey	15.0
Northumberland Park	Haringey	14.6
Haselbury	Enfield	14.6
Lower Edmonton	Enfield	14.6
Upper Edmonton	Enfield	14.1
Jubilee	Enfield	13.4
Ponders End	Enfield	13.3
Colindale	Barnet	13.2
Edmonton Green	Enfield	13.2
Enfield Highway	Enfield	13.2
Turkey Street	Enfield	13.1



The colours on the map show different quintiles across NCL. Darker colours indicate the wards with higher proportions of households estimated to be fuel poor.

Indicator values range from 6.4% to 18.4%.

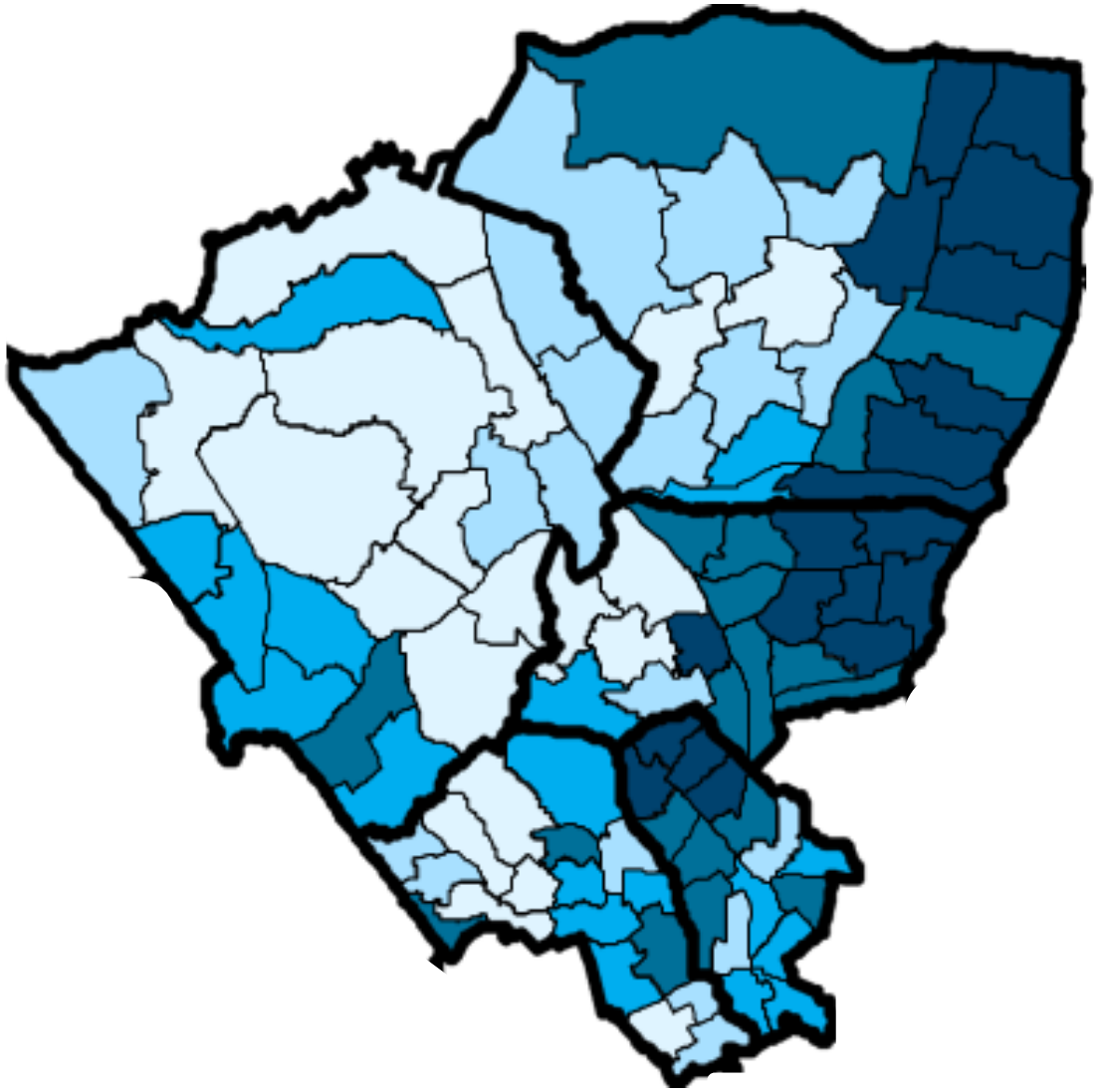
Original Data Source: Department for Business, Energy and Industrial Strategy – modelled estimates (2016). A household is considered to be fuel poor if they have required fuel costs that are above average and, if they were to spend that amount, they would be left with a residual income below the official poverty line.

Source for all data: PHE Fingertips https://fingertips.phe.org.uk/profile/local-health/

% of working age population claiming out of work benefit

NCL Top 20%

Ward	Borough	%
Northumberland Park	Haringey	5.1
Ponders End	Enfield	3.5
Edmonton Green	Enfield	3.5
Bruce Grove	Haringey	3.4
Hornsey	Haringey	3.3
Lower Edmonton	Enfield	3.1
Tollington	Islington	3.0
Tottenham Green	Haringey	3.0
White Hart Lane	Haringey	2.9
Tottenham Hale	Haringey	2.9
West Green	Haringey	2.9
Finsbury Park	Islington	2.9
Hillrise	Islington	2.7
Turkey Street	Enfield	2.7
Enfield Highway	Enfield	2.7
Upper Edmonton	Enfield	2.6
Southbury	Enfield	2.6
Enfield Lock	Enfield	2.6
Junction	Islington	2.5



The colours on the map show different quintiles across NCL. Darker colours indicate the wards with higher proportions of the population claiming out of work benefit.

Indicator values range from 0.5% to 5.1%.

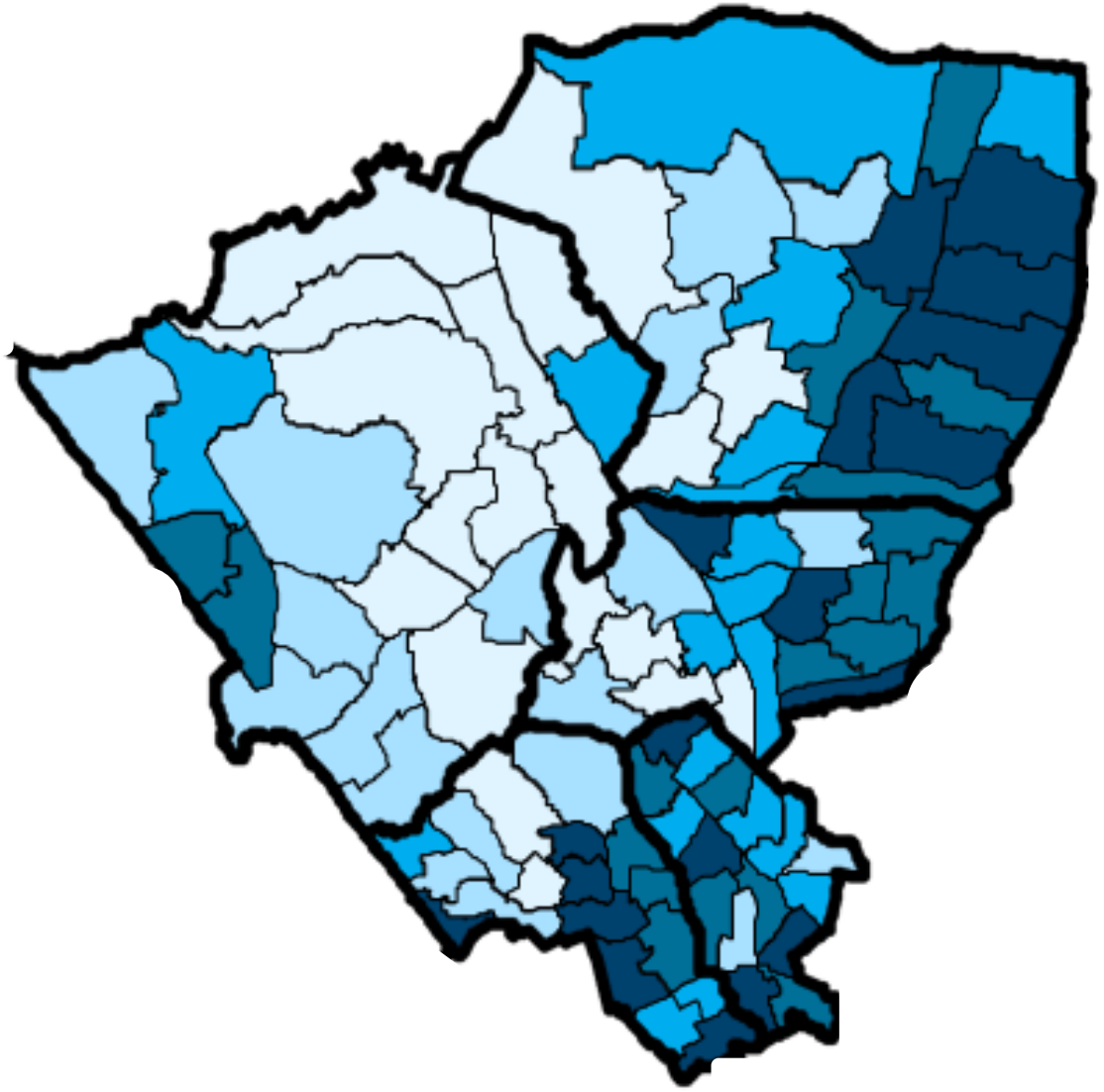
Original Data Source: NOMIS Labour Market Statistics (2017/18)

Source for all data: PHE Fingertips https://fingertips.phe.org.uk/profile/local-health/

Child Development at age 5 (%)

NCL Bottom 20%

Ward	Borough	%
Jubilee	Enfield	54.5
Southbury	Enfield	54.5
Holloway	Islington	54.1
Gospel Oak	Camden	53.9
St Peter's	Islington	53.4
West Green	Haringey	53.1
Bounds Green	Haringey	52.6
Clerkenwell	Islington	51.9
Ponders End	Enfield	51.8
Hillrise	Islington	51.6
Haselbury	Enfield	51.4
Haverstock	Camden	50.7
Seven Sisters	Haringey	50.4
Holborn and Covent Garden	Camden	50.3
Enfield Highway	Enfield	50.3
Camden Town with Primrose Hill	Camden	48.8
Kilburn	Camden	48.7
Edmonton Green	Enfield	48.4
Regent's Park	Camden	47.0



The colours on the map show different quintiles across NCL. Darker colours indicate the wards with lower proportions of children achieving a good level of development at age 5.

Indicator values range from 47.0% to 76.0%.

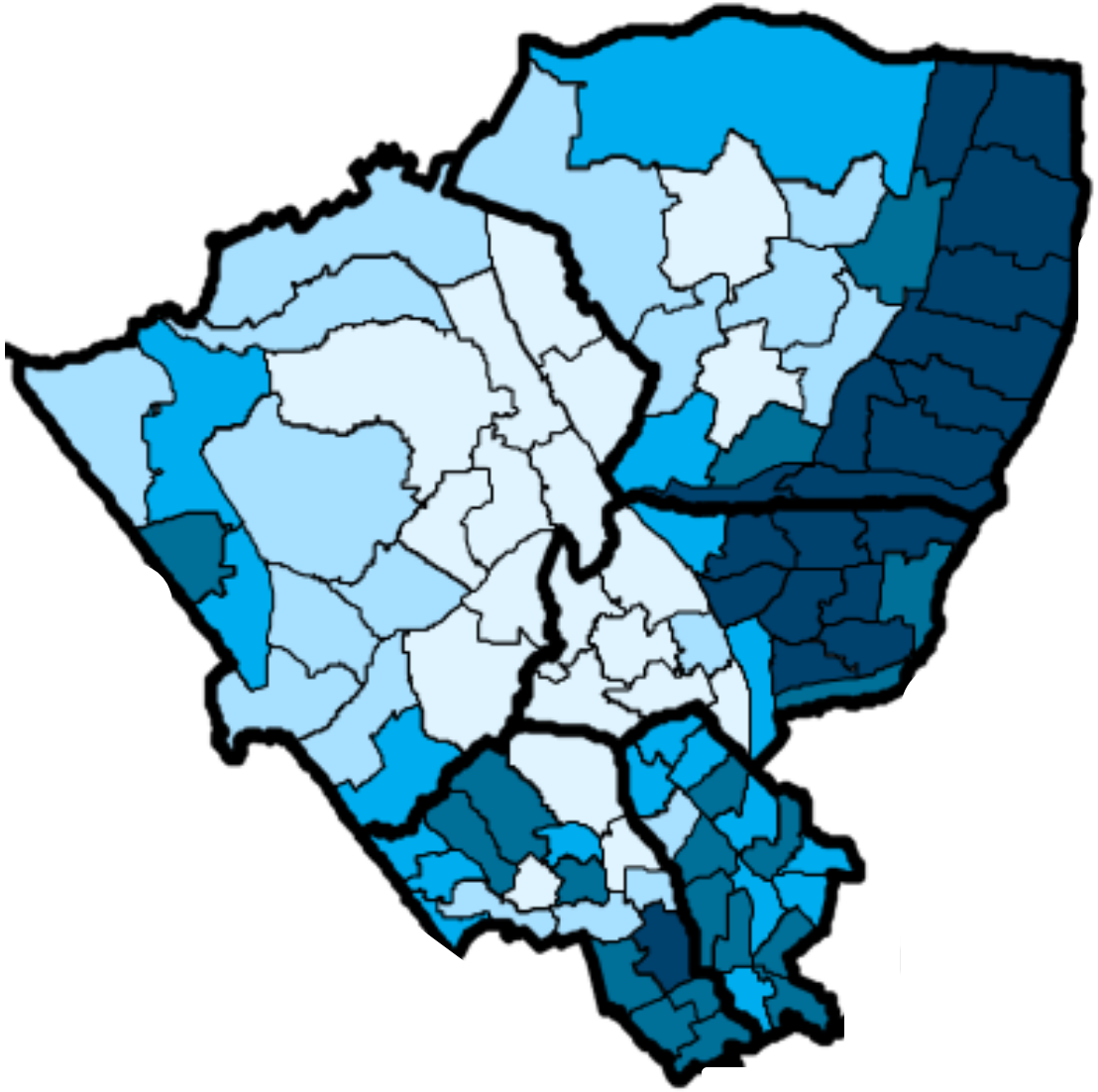
Original Data Source: Department for Education, EYFS Profile 2013/14.

Source for all data: PHE Fingertips https://fingertips.phe.org.uk/profile/local-health/

Obese children Year 6, three year average

NCL Top 20%

Ward	Borough	%
White Hart Lane	Haringey	32.1
St Pancras and Somers Town	Camden	30.9
West Green	Haringey	30.9
Enfield Lock	Enfield	30.1
Lower Edmonton	Enfield	30.1
Northumberland Park	Haringey	30.0
Haselbury	Enfield	29.7
St Ann's	Haringey	29.5
Noel Park	Haringey	29.3
Ponders End	Enfield	29.2
Tottenham Green	Haringey	29.1
Edmonton Green	Enfield	28.9
Jubilee	Enfield	28.8
Woodside	Haringey	28.8
Upper Edmonton	Enfield	28.6
Turkey Street	Enfield	28.6
Bruce Grove	Haringey	28.6
Enfield Highway	Enfield	27.9



The colours on the map show different quintiles across NCL. Darker colours indicate the wards with higher proportions of obese Year 6 children.

Indicator values range from 9.0% to 32.1%.

Original Data Source: National Child Measurement Programme, 2015/16 – 2017/18

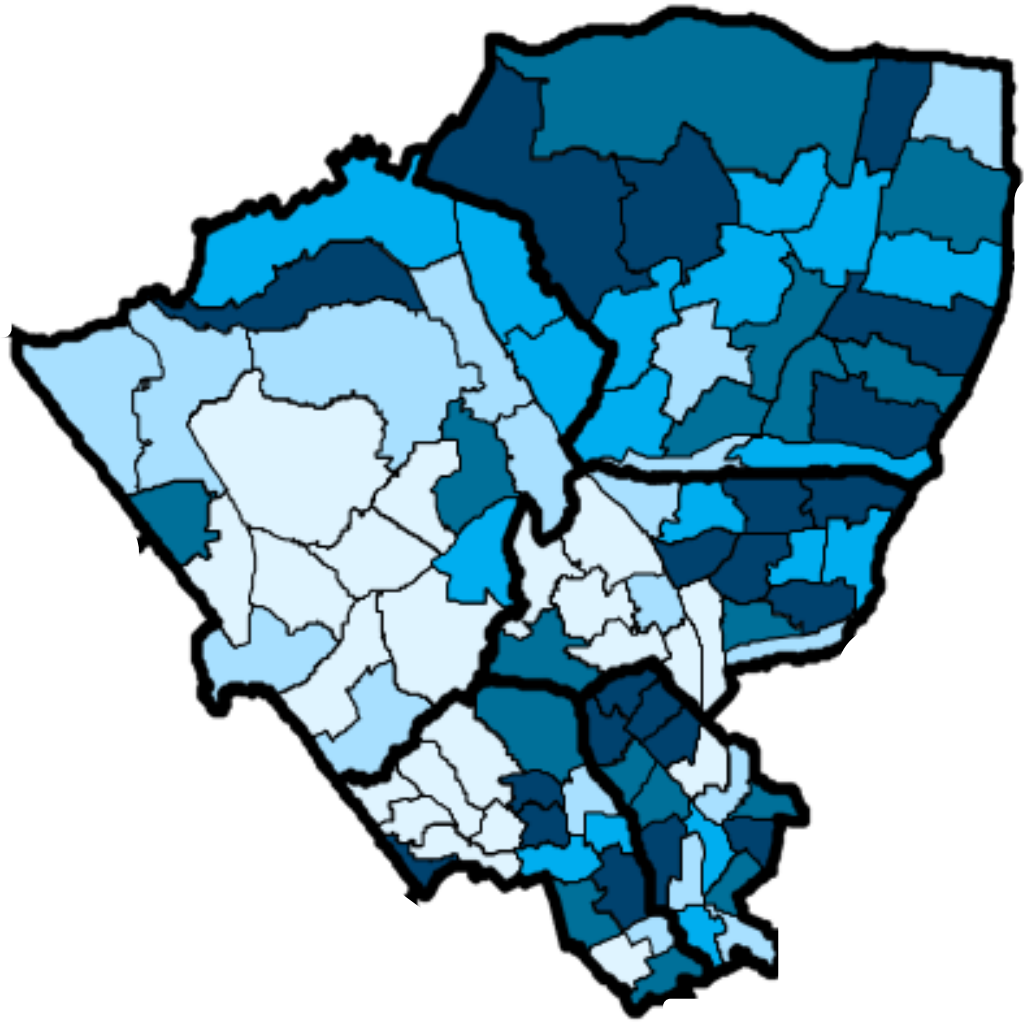
Source for all data: PHE Fingertips https://fingertips.phe.org.uk/profile/local-health/

Percentage of people who reported having a limiting long-term illness or disability

NCL Top 20%

Ward	Borough	%
Kilburn	Camden	18.5
St Pancras and Somers Town	Camden	18.4
Gospel Oak	Camden	18.2
Haverstock	Camden	18.1
Finsbury Park	Islington	17.6
Caledonian	Islington	17.5
White Hart Lane	Haringey	17.4
Hillrise	Islington	17.3
Underhill	Barnet	17.2
Canonbury	Islington	17.2
Turkey Street	Enfield	17.1
Noel Park	Haringey	17.0
Tollington	Islington	17.0
Junction	Islington	16.8
Northumberland Park	Haringey	16.7
Edmonton Green	Enfield	16.6
Jubilee	Enfield	16.5
Tottenham Green	Haringey	16.4
West Green	Haringey	16.3

Source for all data: PHE Fingertips https://fingertips.phe.org.uk/profile/local-health/



The colours on the map show different quintiles across NCL. Darker colours indicate the wards with higher proportions of their population who report having a limiting long-term illness or disability.

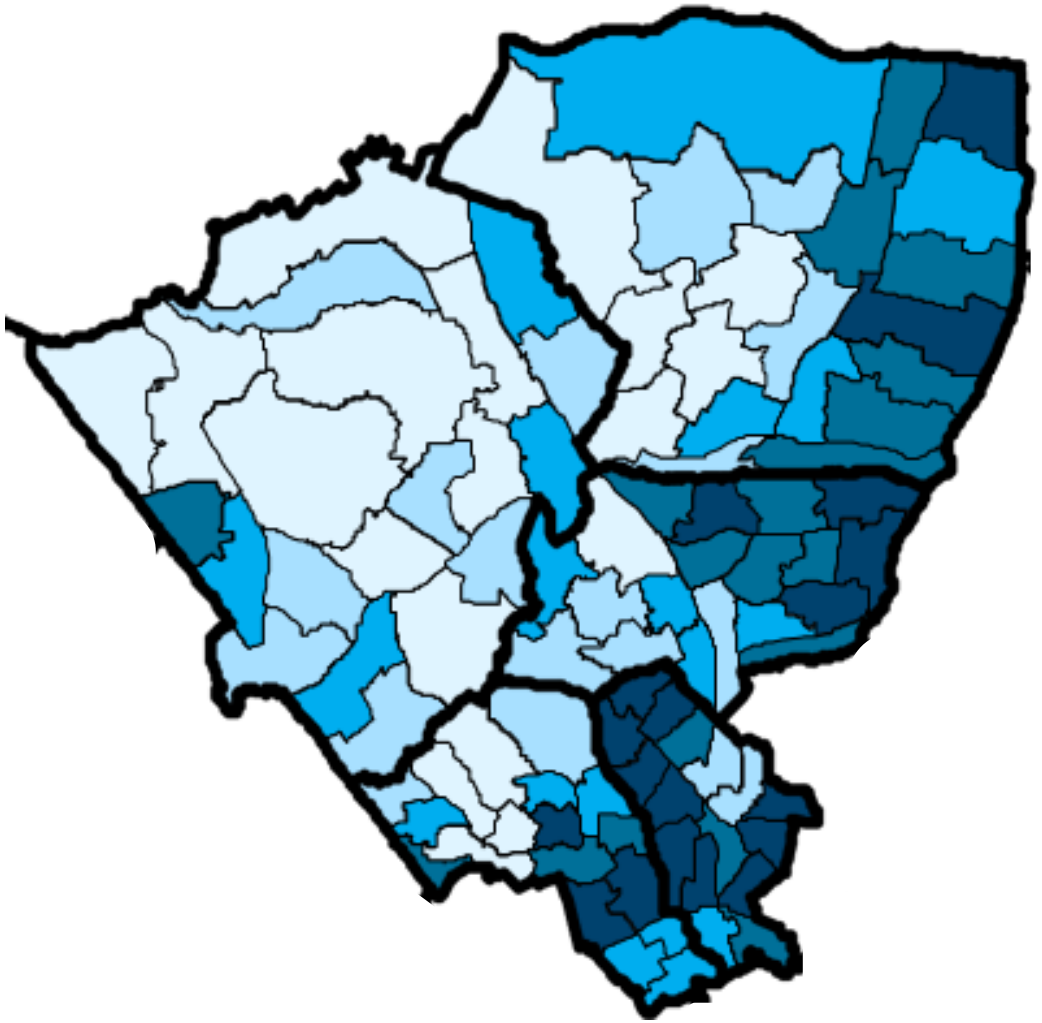
Indicator values range from 9.4% to 18.5%.

Original Data Source: ONS Census 2011

Deaths from causes considered preventable, all ages, standardised mortality ratio

NCL Top 20%

Ward	Borough	SMR
St Pancras and Somers Town	Camden	144.7
Northumberland Park	Haringey	140.0
Junction	Islington	137.5
Mildmay	Islington	128.4
Tottenham Green	Haringey	127.6
Barnsbury	Islington	125.0
Tottenham Hale	Haringey	123.0
Caledonian	Islington	120.8
St Peter's	Islington	120.8
Tollington	Islington	119.7
Hillrise	Islington	119.3
Holloway	Islington	116.6
Woodside	Haringey	116.2
Jubilee	Enfield	112.1
Canonbury	Islington	111.5
St George's	Islington	110.1
Enfield Lock	Enfield	109.3
Haverstock	Camden	107.6
Regent's Park	Camden	107.4



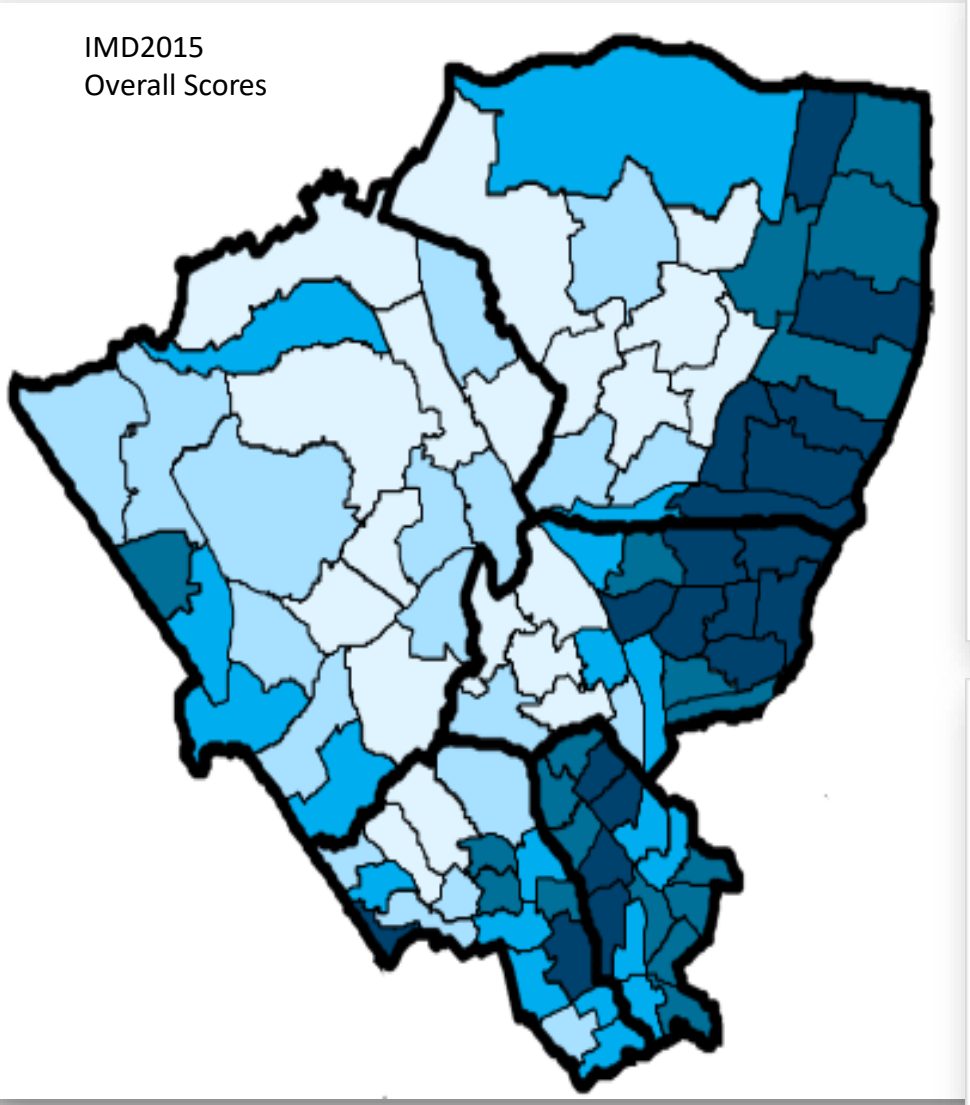
The colours on the map show different quintiles across NCL. Darker colours indicate the wards with higher rates of deaths from causes considered preventable.

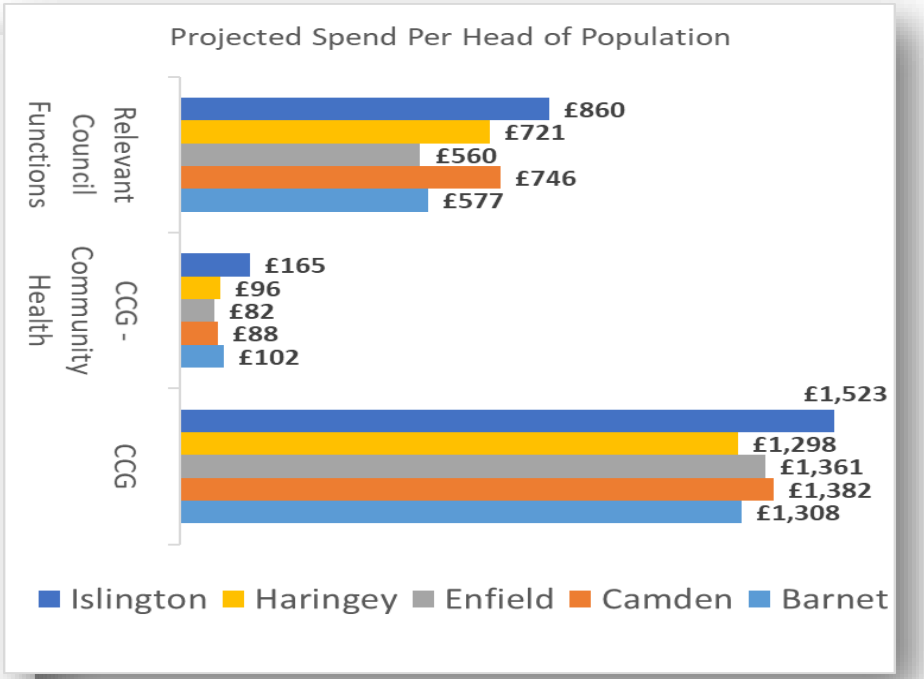
Indicator values range from 38.6 to 144.7.

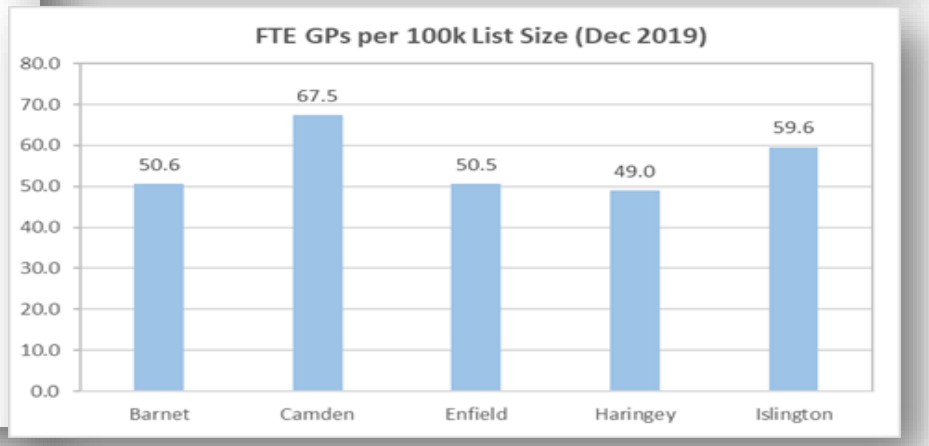
Original Data Source: ONS; Public Health England Annual Mortality Extracts 2013-17.
Preventable mortality refers to causes of death where all or most deaths could potentially be prevented by public health interventions in the broadest sense (subject to age limits if appropriate).

Source for all data: PHE Fingertips https://fingertips.phe.org.uk/profile/local-health/

CURRENT RESOURCE ALLOCATION – DEPRIVATION AS AN EXAMPLE (resources are insufficiently focused on populations – they are focused on institutions….)







Resources are NOT disproportionately focused on areas of greatest need

This leads to a 'double jeopardy':

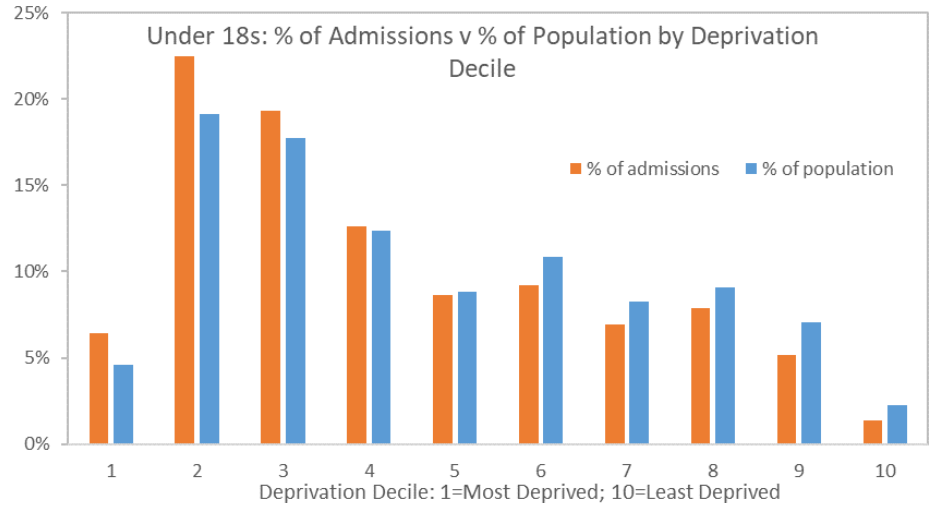
- Wards with marked deprivation are more likely to need community interventions
- If these aren't sufficiently well resourced, then residents may need more intensive interventions later – e.g. increased hospitalisation.
- Result is % available for community investment becomes less in more deprived areas

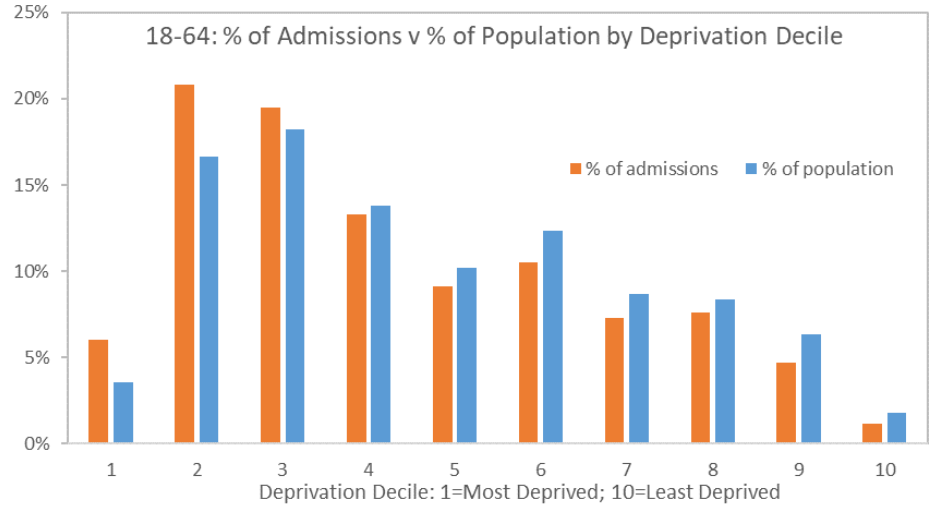
** 'Relevant Council Functions' relates to Revenue Account submission from Councils on children's and adult social care, public health and housing options/homelessness only*

Emergency admissions by deprivation and age

19/20 Emergency Admissions per 1000 Population by IMD2019 Deprivation Decile and Age Group

Deprivation Decile	Under 18	18-64	65-79	80+	Total
1	72	81	289	564	107
2	60	60	203	487	81
3	55	51	185	496	73
4	52	46	173	464	68
5	50	43	156	458	68
6	43	41	143	463	66
7	43	40	123	440	65
8	44	43	124	410	71
9	37	35	101	394	63
10	31	31	81	296	51





- Across all age groups, there is a higher rate of admissions for those living in the most deprived areas of NCL.
- Among adults, admission rates for younger age groups in the most deprived areas are the same or similar to admission rates for older age groups in the least deprived areas (see circled values above).

Sources: Admissions data from SUS; Population data from ONS Mid-2019 Population Estimates

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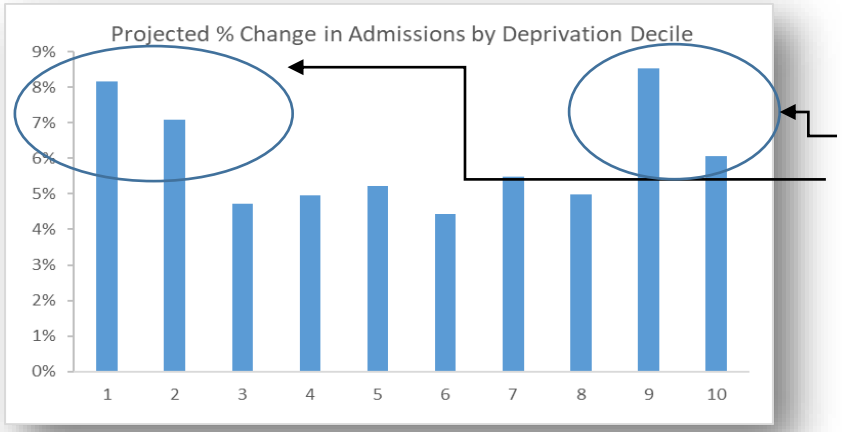
How will this change over the next five years?

NHS

NCL's population will change in 2025 – what will this mean for the pattern of admissions across age groups?

Scenario: 'No Change to Current Pattern of Allocations' and applying deprivation-related & age-specific population projections*

Based on GLA population projections, NCL's population is expected to grow by 2.3% by 2025, slightly lower than the ONS CCG estimates. However, age groups (particularly older people) with the highest expected levels of growth are consistent between two sources.



Using this assumption, it's possible to predict:

- Large older populations often in more affluent areas are expected to see high increases in admissions – this is being driven by an increase of those aged 80+;
- NCL's more deprived areas are likely to see higher rates of growth in admissions - from an already high level;

	% MSOA Population Change	19/20 Emergency Admissions	2025 Projected Admissions	Admissions Change	% Admissions Change	Additional PbR Cost Impact**
Under 18	-1.2%	16,888	16,675	-213	-1.3%	-£290,078
18-64	1.3%	47,518	48,459	941	1.2%	£1,814,929
65-79	14.8%	20,664	23,898	3,234	13.1%	£11,643,280
80+	10.9%	23,101	25,357	2,256	8.5%	£9,468,559
Total	**2.3%**	**108,171**	**114,389**	**6,218**	**5.7%**	**£22,636,689**

Impact of COVID

- Emerging national evidence suggests higher levels of infection, hospitalisation & deaths for people in the most deprived areas – at least twice as high mortality rates in Wave 1 were reported in both BMJ and King's Fund research
- Impact is likely to be further compounded as NCL has a higher proportion of people from black ethnic backgrounds than national position – and this ethnic group known to be disproportionately impacted by COVID, including post-COVID syndrome

It's possible increased costs over next 5 years in terms of NEL admissions are likely to be even higher

Financial impact on a Borough & Trust basis varies, e.g. those Trusts seeing more deprived residents likely to have greater increase – 'double jeopardy'

Sources: *GLA MSOA Population Projections (2018) – projections before impact of Covid; **PbR Cost at 19/20 tariff prices: average admission price per age group: Under 18: £1,359; 18-64: £1,928; 65-79: £3,600; Over 80: £4,198

Imagine that we could address some of the issues we've highlighted about navigation – what difference might it make now and by 2025

Example 1: Reduce the rate of emergency admissions for the population living in the 20% most deprived areas (deciles 1 and 2) to the rate currently experienced by the decile 3 population

2019 Population

	Under 18	18-64	65-79	80+	Total
Total (2019) Population: Deciles 1 and 2	78,728	200,866	21,814	7,993	**309,401**
Number of Admissions: Deciles 1 and 2	4,886	12,757	4,780	4,011	**26,434**
Rate of Admissions per 1000: Deciles 1 and 2	62.1	63.5	219.1	501.8	**85.4**
Rate of Admissions per 1000: Decile 3	55.4	51.1	184.9	495.8	**73.4**
Decile 1/2 Admissions if @ Decile 3 Rate	4,360	10,259	4,033	3,963	**22,615**
Admissions Saved	**526**	**2,498**	**747**	**48**	**3,819**
Admission Cost Saved	**£714,524**	**£4,817,815**	**£2,689,261**	**£200,663**	**£8,422,264**

2025 Population Projection

	Under 18	18-64	65-79	80+	Total
Total (2025) Population: Deciles 1 and 2	81,424	211,559	26,368	8,281	**327,632**
Number of Admissions: Deciles 1 and 2	5,053	13,436	5,778	4,156	**28,423**
Rate of Admissions per 1000: Deciles 1 and 2	62.1	63.5	219.1	501.8	**85.4**
Rate of Admissions per 1000: Decile 3	55.4	51.1	184.9	495.8	**73.4**
Decile 1/2 Admissions if @ Decile 3 Rate	4,509	10,805	4,875	4,106	**24,295**
Admissions Saved	**544**	**2,631**	**903**	**50**	**4,128**
Admission Cost Saved	**£738,995**	**£5,074,280**	**£3,250,641**	**£207,903**	**£9,271,818**

Example 2: Reduce the rate of emergency admissions for the population living in the 40% deprived areas (deciles 1-4) to the rate currently experienced by the decile 5 population

2019 Population

	Under 18	18-64	65-79	80+	Total
Total (2019) Population: Deciles 1-4	178,710	519,487	56,095	20,135	**774,427**
Number of Admissions: Deciles 1-4	10,282	28,330	10,949	9,865	**59,426**
Rate of Admissions per 1000: Deciles 1-4	57.5	54.5	195.2	489.9	**76.7**
Rate of Admissions per 1000: Decile 5	49.8	42.7	156.1	458.3	**67.8**
Decile 1-4 Admissions if @ Decile 5 Rate	8,899	22,183	8,757	9,228	**49,068**
Admissions Saved	**1,383**	**6,147**	**2,192**	**637**	**10,358**
Admission Cost Saved	**£1,878,741**	**£11,853,312**	**£7,889,403**	**£2,674,444**	**£24,295,900**

2025 Population Projections

	Under 18	18-64	65-79	80+	Total
Total (2025) Population: Deciles 1-4	179,382	533,852	66,427	21,435	**801,095**
Number of Admissions: Deciles 1-4	10,321	29,113	12,966	10,502	**62,901**
Rate of Admissions per 1000: Deciles 1-4	57.5	54.5	195.2	489.9	**76.7**
Rate of Admissions per 1000: Decile 5	49.8	42.7	156.1	458.3	**67.8**
Decile 1-4 Admissions if @ Decile 5 Rate	8,933	22,797	10,370	9,824	**51,923**
Admissions Saved	**1,388**	**6,317**	**2,595**	**678**	**10,978**
Admission Cost Saved	**£1,885,805**	**£12,181,074**	**£9,342,550**	**£2,847,075**	**£26,256,505**

MSOA and age-specific population projections used for 2025 population estimate.

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NHS

Anchor areas for development

Environment	Estates	Procurement	Civic behaviour	Employment
Plans and actions which support a greener public sector Commitment and progress to zero carbon	Opening facilities to the community Social impact of new developments	Increasing % of spend with local suppliers & SMEs Enabling local businesses & VCS to bid for NHS contracts Social value in practices	Leadership and partnership with other anchor organisations Offering volunteering for staff and communities	Pathways into careers in health Progression for priority groups Training & apprenticeship schemes