Health and Care Innovation EXPO 2016

NHS

Inclusion Health

&

Digital Health

Inclusion Health & Digital Health

Welcome and Introduction

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Addressing equality and health inequalities

Health Inequalities Analysts NHS England

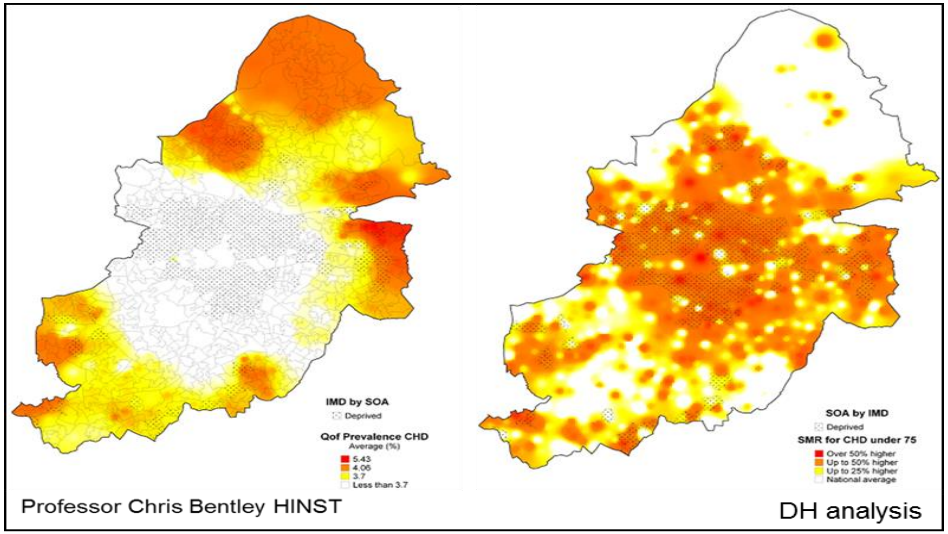
September 2016

People living in deprived areas have poorer health and shorter lives

1. The under 75 mortality rate from CVD, was almost five times higher in the most deprived compared to the least deprived areas
2. The under 75 mortality rate from cancer was over twice as high in the most deprived compared to the least deprived areas
3. The infant mortality rate was over twice as high in the most deprived compared to the least deprived areas

Outcomes framework inequality indicators latest data (2014)

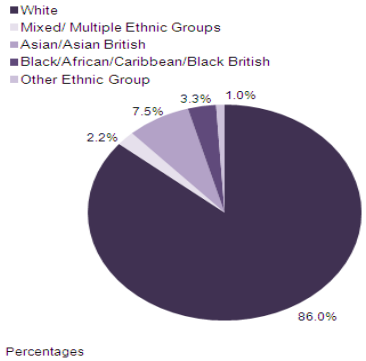
Male Life Expectancy in Birmingham



What about equality?

African– Caribbean population stats:

- 5 times more likely to develop type 2 diabetes
- More likely to have high blood pressure
- Disproportionate representation of men in mental health services
- Harsher treatment from primary & secondary mental health service
- More likely to be diagnosed with a serious mental illness
- Black men are 30% more likely to die from prostate cancer
- Females over 65 have a higher risk of cervical cancer



Ethnic groups- England and Wales, Office of National Statistics, 2011

Research findings

Research shows that health inequalities are associated with various costs, not only to the health system, but to the wider society.

University	Cost of inequalities/Impact on longevity	Source
Centre for Health Economics, York University	• £4.8bn hospital costs • Socioeconomic inequalities result in increased morbidity and decreased life expectancy • Interventions to reduce inequality/improve health in more deprived areas have potential to save money for health systems not only within years but across peoples' entire lifetimes, despite increased costs due to longer life expectancies	Asaria, M., Doran, T., & Cookson, R. (2016). The costs of inequality: whole-population modelling study of lifetime inpatient hospital costs in the English National Health Service by level of neighbourhood deprivation. Journal of epidemiology and community health, jech-2016.
Institute of Health Equity, University College London	• £5.5bn NHS healthcare costs • £31-33 bn productivity losses • £28–32 bn lost taxes and welfare costs • 1.3 to 2.5 million potential years of life lost	Marmot, M., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M., & Geddes, I. (2010). The Marmot review: Fair society, healthy lives. The Strategic Review of Health Inequalities in England Post-2010.
Cass Business School, City University, London	• 5% of British men reaching age 30 live on average to 96 years- 33.3 years longer than the lowest 10% • This gap grew by 1.7 years between 1993, when it was at its narrowest, and 2009. • The longest surviving women reach on average 98.2 years- 31 years more than the lowest • The female gap reached its narrowest in 2005, but has since levelled out.	Mayhew, L, Smith, D. (2016). An investigation into inequalities in adult lifespan

CCG Improvement and Assessment Framework (IAF):

Indicators

106a. Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions and 106b. Inequality in emergency admissions for urgent care sensitive conditions. They are based on those developed by Richard Cookson and Miqdad Asaria from the University of York, as part of the NIHR project (HS&DR: 11/2004/39 - Developing indicators of change in NHS equity performance).

Absolute Gradient of Inequality (AGI)

For each neighbourhood in the country, the rate of emergency admissions for certain conditions per 100,000 population can be calculated. This rate is then standardised to ensure age and sex of the population do not affect the data, enabling national comparison. Computing the differences between these standardised rates in the most and least deprived neighbourhoods provides the AGI for each CCG. This is also referred to as the gradient of the line of best fit (regression line) where emergency admissions data are plotted against deprivation. The AGI describes the difference in emergency admission rates that would be observed between the richest and poorest neighbourhoods in the country if the whole country were as unequal as that CCG. As this measure uses the national range of deprivation, direct comparisons between all CCGs are possible. The greater the AGI value (or the steeper the regression line), the greater the inequality.

Mean

Standardised rates of emergency admissions for each neighbourhood in the country are obtained using the above process. The rates for all neighbourhoods within a CCG can then be summed and divided by the total CCG population to obtain a mean rate for the CCG. The higher the mean, the greater the chance of having such a hospitalisation for people living in the neighbourhoods covered by that CCG.

CCG IAF: Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions – Absolute Gradient

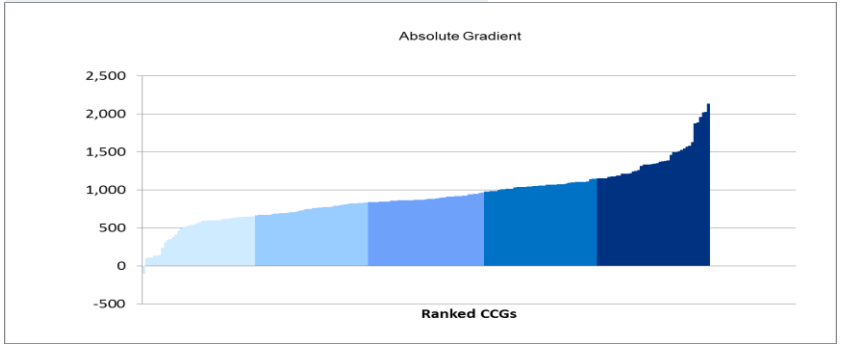
Background

There are large inequalities in the rate of unplanned hospitalisation for chronic ambulatory care sensitive conditions when comparing the most and least deprived areas nationally. A well performing system should minimise this rate. The absolute gradient can be used to measure within-CCG variation and to compare socioeconomic inequalities between CCGs.

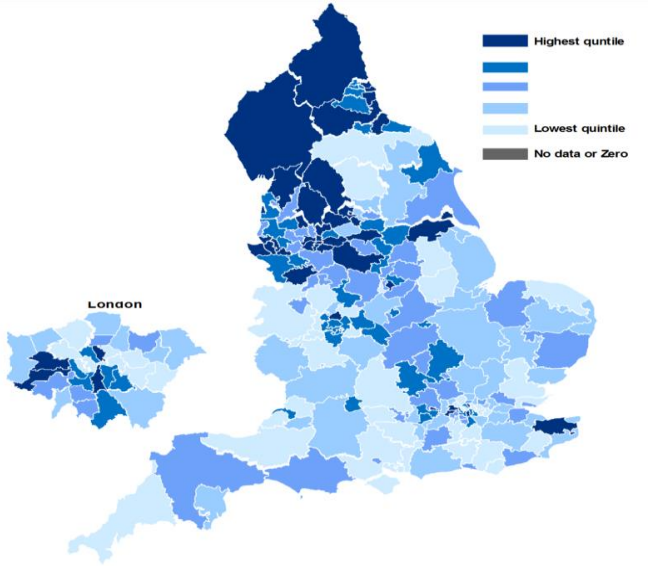
Key lines of enquiry

Larger differences of emergency admissions have been identified in the north. Have CCGs identified any local barriers that cause more unplanned hospitalisation?

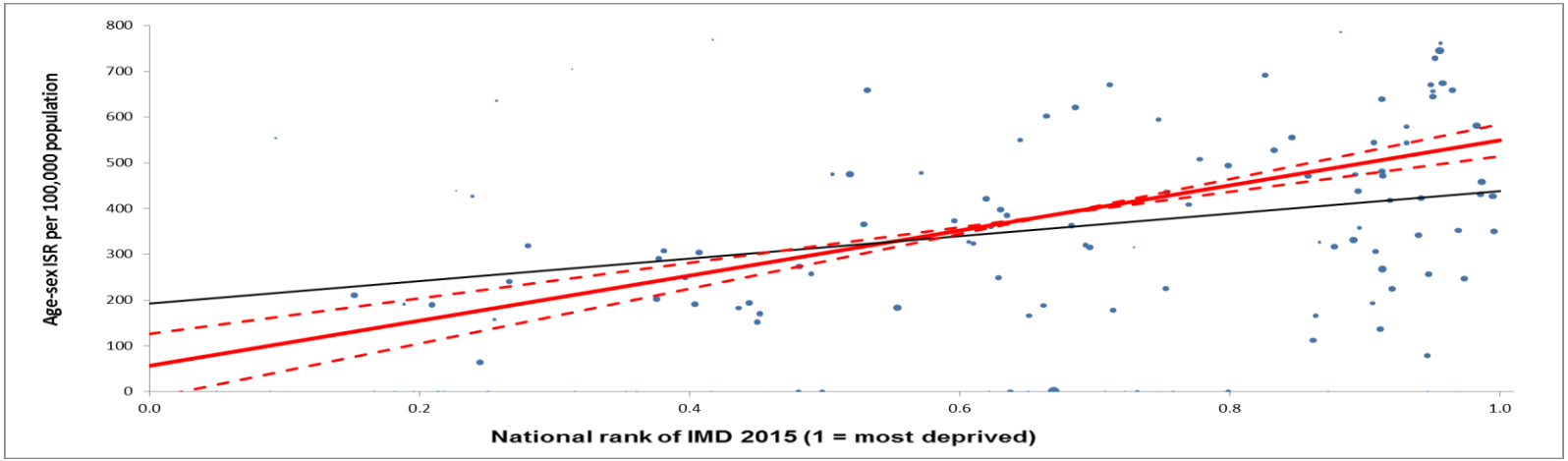
CCGs with large absolute gradient		Region
Central Manchester CCG	2,133	North
Islington CCG	1,958	London
Canterbury and Coastal CCG	1,329	South
CCGs with small absolute gradient		
City and Hackney CCG	-102	London
Fareham and Gosport CCG	109	South
Wyre Forest CCG	341	Midlands



Click here to see interactive heat map online



Right Care example: absolute gradient of inequality South Manchester CCG Avoidable Emergency Admissions for Cardiovascular Disease – bubble chart



Bubbles plotted represent Lower Super Output Areas (LSOAs). Bubbles vary in size in proportion to the population of LSOAs. Nationally there are about 33k LSOAs with an average population of around 2k. Some LSOAs are split over more than one CCG.

The steeper the slope the greater the level of health inequality e.g. a steep slope might mean greater inequality in the rate of avoidable emergency admissions.

The red line is a line of best fit for the CCG, the dotted red lines show 95% confidence intervals sloped lines, the black line shows the national slope.

If the shallowest dotted red line is steeper than the black line, inequality in the CCG is statistically significantly higher than the national level of inequality.

If the shallowest dotted red line slopes upward, then inequality in the CCG is statistically significant.

For Cardiovascular disease in South Manchester there would seem to be a significant difference in rates of avoidable emergence admissions for the most deprived compared with the least deprived.

Right Care Proposed Analysis for Autumn

To develop CCG level analysis / tools on health inequalities for the Autumn Right Care pack on Long Term Conditions

On deprivation and avoidable emergency admissions

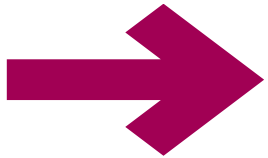
- For CCGs an LSOA absolute gradient of inequality for comparison with the national LSOA absolute gradient of inequality.
- An LSOA level tool so that CCGs can identify LSOAs where there is high deprivation and high rates of avoidable emergency admissions.
- National deciles applied at CCG level for the CCG Improvement and Assessment Framework (IAF) and Outcomes Framework (OF) inequality indicators, comparing CCG rates of avoidable emergency admissions with national rates for these deciles

On protected characteristics comparisons of rates of avoidable emergency admissions for CCG IAF and OF inequality indicators at CCG level with rates at national levels

Where possible the above analyses by Long Term Condition

Right care might then be used to impact upon CCG IAF and OF national indicators of inequality

Annex: Other Key Analyses



Protected characteristics

-These are individuals' characteristics protected by the Equality Act of 2010. Any of these characteristics can increase the chance of health inequalities.

- **Age** *e.g. those 70 and over make up half of diagnosed cancer cases*
- **Disability** *e.g. those with a LD have a greater chance of mortality from respiratory disease*
- **Gender** *e.g. men typically develop heart disease 10 years earlier than women*
- **Gender reassignment** *e.g. Poor access to health care services experienced by trans people*
- **Marriage and civil partnership** ***e.g. Married people live longer than unmarried people***
- **Pregnancy and maternity** ***e.g. Teenage pregnancy can affect education and employment***
- **Race** *e.g. South Asian and black minorities have a greater chance of type 2 diabetes*
- **Religion or belief** *e.g. increased discrimination in Muslims results in poorer overall health*
- **Sexual orientation** *e.g. higher prevalence of attempted suicide in the gay and lesbian population*

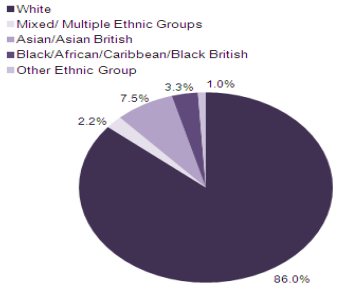
Cancer and racial inequalities

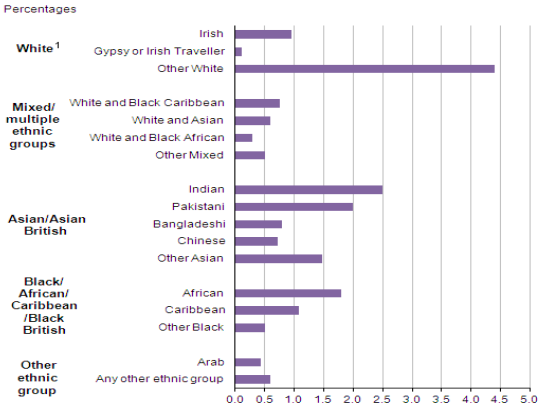
UK ethnicity breakdown

Although White is the majority ethnicity group (86% reported), there are increasing numbers of people identifying with minority ethnic groups

London is the most ethnically diverse area across English regions- above average proportions for most ethnic minorities

Indian is the next largest ethnic group followed by Pakistani





Ethnic groups- England and Wales, Office of National Statistics, 2011

Access to services

Researchers suggest 2 main groups of factors that cause inequalities in access:

- Personal factors
  - Cultural differences- response and attitude to health care services can differ
  - Language and literacy
  - Lack of knowledge on health services
- Organisational factors
  - Differential need- risk profiles of different population groups need to be taken into account
  - Location
  - Staff training- staff may have skills in dealing with diversity appropriately which can create barriers

Cancer and racial inequalities contd.

Patient experience

Access to culturally relevant information flagged as an issue amongst BME groups

Ethnic minority patients report lower levels of satisfaction and poor experiences with cancer care

End of life care

Less awareness and uptake of palliative care and at home services is an issue for minority groups

Could be due to a lack of referrals, knowledge, poor communication and location

Those from BME minorities are less likely to complete advance care planning documents and more likely to want active treatment

Deprivation

Overall incidence and mortality are higher in the more deprived area- this has not improved over time

Exceptions include incidence of female breast cancer highest in the least deprived decile- is this related to age?

Challenges

There is limited evidence on the extent of cancer inequalities

There are gaps in available data for analysis

Particularly poor data on prevalence and survival

Some cancer data is outdated

Ethnicity data is categorised in different ways depending on the source- disparities between HES and ONS

Priorities and available data

NHSE Business Priorities	Available Data	Analysis
(1) Improving the quality of care and access to cancer treatment	Cancer waiting times (NHS England statistics) *https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/* Cancer register (CCG, regional & national level, HSCIC) *http://www.hscic.gov.uk/searchcatalogue?productid=19196&q=cancer&sort=Relevance&size=10&page=1#top* - Cancer survival rates *http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/datasets/cancersurvivalratescancersurvivalinenglandadultsdiagnosed*	-Which population groups are more prone to certain types of cancer and why -After diagnosis how is treatment being followed up - Difference in cancer survival rates between different population groups
(2) Upgrading the quality of care and access to mental health and dementia services	-Field tool available on HES -Mental health statistics *http://www.hscic.gov.uk/catalogue/PUB20943*	-Bed days for different population groups i.e. variation by age or ethnicity - Link between mental health and deprivation (using IMD)
(3) Transforming care for people with learning disabilities	-Field tool available on HES - Learning disability statistics (HSCIC) *http://www.hscic.gov.uk/catalogue/PUB20824*	-Bed days for different population groups i.e. variation by age or ethnicity
(4) Tackling obesity and preventing diabetes	-HES avoidable emergency admissions data -Diabetes register (HSCIC) *http://www.hscic.gov.uk/searchcatalogue?productid=19196&q=cancer&sort=Relevance&size=10&page=1#top*	-Avoidable emergency admissions for related conditions i.e. T2DM, CVD - Which areas have higher relative registers- which inequalities could this relate to
(5) Strengthening primary care services	-GP survey data (protected characteristics) *https://www.england.nhs.uk/statistics/category/statistics/gp-patient-survey /* QOF data (various conditions) *http://www.hscic.gov.uk/catalogue/PUB18887* GP practices registered populations *http://www.hscic.gov.uk/searchcatalogue?productid=20718&topics=2%2fPrimary+care+services%2fGeneral+practice%2fGP+registered+population&sort=Relevance&size=10&page=1#top* -HES avoidable emergency admissions data	-Looking at what causes inequality in patient experience; which groups have poor access to primary care services - The link between avoidable emergency admissions to poor access of primary care services, due to protected characteristics/socio-economic factors
(6) Redesigning urgent and emergency care services	-HES avoidable emergency admissions data	-Find out what drives inequality based on patient charateristics and socio-economic status- link admission condition to area deprivation sore
(7) Providing timely access to high quality elective care	-Elective care waiting times (consultant-led referral, NHSE Statistics) *https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/* --Cancelled elective operations *https://www.england.nhs.uk/statistics/statistical-work-areas/cancelled-elective-operations/*	- Look at population groups experience higher waiting times - Access to maternity services based on population groups
(8) Ensuring high quality and affordable specialised care	- Innovation scorecard data? *http://www.hscic.gov.uk/article/7101/Innovation-Scorecard*	- Inequalities in access to medicines & specialised treatments between CCGs/LSOAs - Comparison between like CCGs (Right care)
(9)Transforming commissioning	- maternity & breastfeeding data *https://www.england.nhs.uk/statistics/statistical-work-areas/maternity-and-breastfeeding/* - Maternity service statistics (HSCIC) *http://www.hscic.gov.uk/maternityandchildren/maternityreports*	- Access to maternity services based on population groups - Ties in analysis from previous priorities to reduce inequalities- look at health outcomes across different CCGs for key disease areas
(10) Controlling costs and enabling change	-HES avoidable emergency admissions data - Innovation scorecard data?*http://www.hscic.gov.uk/article/7101/Innovation-Scorecard* -GP survey data *https://www.england.nhs.uk/statistics/category/statistics/gp-patient-survey/* - Friends and family test data *https://www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/* - NHS staff survey *http://www.nhsstaffsurveys.com/Page/1010/Home/NHS-Staff-Survey-2015/*	- Right care analysis supported with avoidable emergency admissions - Uptake of innovation across the country (CCG, national, regional level) -Analysis of patient experience from different population groups -Workforce experience baesd on protected characteristics

Protected characteristics and NHS England priorities

			Protected Characteristics									Deprivation
			Age	Disability	Gender reassignment	Marriage & civil partnership	Pregnancy and maternity	Race	Religion or belief	Sex	Sexual orientation	
		Inequality Indicators from outcomes framework	1a.i, 1b.i, 1b.ii, 2, 2.3.i, 1.4, 4.4.i	4a.i	2.3.i, 4a.i, 4.4.i	3a	1.6i, 4.4i	1.1, 1.4, 2, 3a, 4a.i, 4.4.i	2	1a.i, 1b.i, 1b.ii, 1.4, 2	2, 3a, 4a.i, 4.4.i	All indicators
NHS Business Plan Priorities	1. Improving the quality of care and access to cancer treatment	1.4	■		■	■		■		■	■	■
	2. Upgrading the quality of care and access to mental health and dementia services	2.3.i	■		■			■		■	■	■
	3. Transforming care for people with learning disabilities	2.3i, 3a	■									■
	4. Tackling obesity and preventing diabetes	1.1, 2.3.i	■			■		■		■		■
	5. Strengthening primary care services	1.6.i, 2, 2.3.i, 4a.i, 4.4.i	■	■	■			■			■	■
	6. Redesigning urgent and emergency care services	2.3.i, 3a	■			■		■		■		■
	7. Providing timely access to high quality elective care	1.6.i										■
	8. Ensuring high quality and affordable specialised care											■
	9. Transforming commissioning		■					■				■
	10. Controlling costs and enabling change	3a	■	■				■	■	■	■	■

Indicators on Equality and Health Inequalities

New CCG Improvement and Assessment Framework Indicators – the aim is to increase these further in the coming year

- 106a Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions
- 106b Inequality in emergency admissions for urgent care sensitive conditions

Current outcomes framework indicators

Preventing people from dying prematurely

- 1a.i: Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare
- 1bi Life expectancy at 75 males
- 1bii Life expectancy at 75 females
- 1.1 Under 75 mortality rate from cardiovascular disease
- 1.4 Under 75 mortality rate from cancer
- 1.6.i Infant mortality

Enhancing quality of life for people with long-term conditions

- 2 Health-related quality of life for people with long-term conditions
- 2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions

Helping people to recover from episodes of ill health or following injury

- 3a Emergency admissions for acute conditions that should not usually require hospital admission

Ensuring that people have a positive experience of care

Health inequalities: people living in deprived areas have poorer health

Outcomes framework inequality indicators latest data (2014) show

Preventing people from dying prematurely

- **The under 75 mortality rate from CVD, was almost five times higher in the most deprived compared to the least deprived areas**
- **The under 75 mortality rate from cancer was over twice as high in the most deprived compared to the least deprived areas**
- **The infant mortality rate was over twice as high in the most deprived compared to the least deprived areas**

Enhancing quality of life for people with long-term conditions

- **Unplanned hospitalisation for chronic ambulatory care sensitive conditions is four times as high in the most deprived areas compared to the least deprived areas**

Helping people to recover from episodes of ill health or following injury

- **Emergency admissions for acute conditions that should not usually require hospital admission are over twice as high in the most deprived areas compared to the least deprived areas**

Ensuring that people have a positive experience of care

- **For the proportion of people who report their experience of GP services as very good or fairly good, there has been an increase in the gap between areas of high deprivation and low deprivation**

How are things changing?

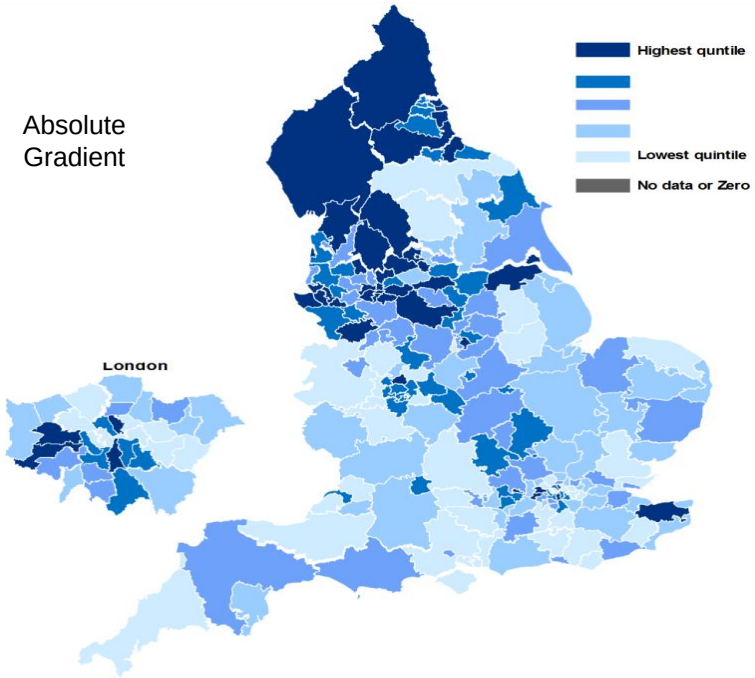
- **Infant mortality by deprivation has narrowed. The greatest gains in reducing infant mortality have been seen amongst the most deprived cohort of the population.**
- **The under 75 mortality rate from CVD by area deprivation (NB since overall CVD mortality has been reducing, the effect has been to increase the relative ratio)**

- **However, for people who report their experience of GP services as 'very good' or 'fairly good' there has been an increase in the gap (https://gp-patient.co.uk/):**
  - between areas of high and low deprivation,
  - between white British people and other ethnic groups,
  - between heterosexuals and people of other sexual orientation and
  - between older and younger people

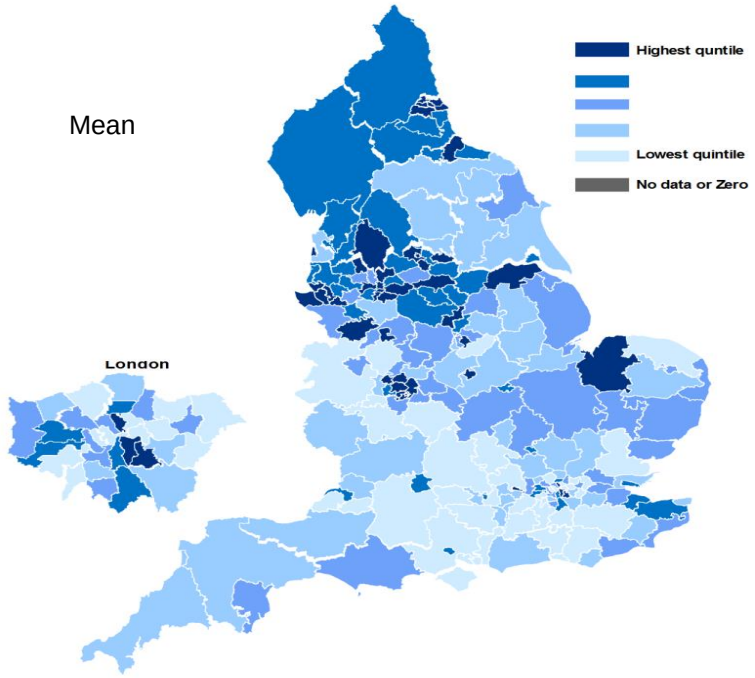
IAF: Comparison of Absolute Gradient and Mean for inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions

Ideally, a CCG will have both a low absolute gradient and a low mean. That is a low rate of avoidable emergency admissions for the CCG as a whole with little variation by area of deprivation. Comparison of heat maps enables identification of areas where this is not the case; for example, a low mean but large absolute gradient suggests a low rate of avoidable emergency admissions for the CCG as a whole but variation by area of deprivation within the CCG.

Absolute Gradient



Mean



Right Care Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions (105a in IAF, 2.3i in OF IHIE)

Select CCG		Aylesbury Vale				
CCG Code		10Y				

		2.3i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages) (emergency admissions)				
		Emergency Admissions per 100k CCG registered population			CCG Emergency Admissions	Population
IMD 2015 Decile		CCG (IAS)	National (IAS)	% Difference		
Most deprived decile	1	0	1,423	-100%	0	10
	2	989	1,123	-12%	47	5,580
	3	1,296	963	34%	113	10,925
	4	1,042	836	25%	74	9,125
	5	943	759	24%	81	11,217
	6	635	681	-7%	77	11,668
	7	476	623	-24%	133	30,191
	8	467	582	-20%	154	29,765
	9	479	525	-9%	205	40,247
Least deprived decile	10	356	458	-22%	233	59,289
	All	531	773	-31%	1,117	208,017

Deciles represent a national list of 33k Lower Super Output Areas ranked by deprivation score split into10 groups. (the average LSOA population is 2k). Some LSOAs are split over more than one CCG.

Similar deciles are used nationally in relation to monitoring OF Indicators for Health Inequality progress

This indicator is also in the CCG IAF, progress will be measured using the absolute gradient of inequality.

The above table shows national deciles applied to Aylesbry Vale CCG and compares rates of emergency admission for these deciles in the CCG with rates for the same decile nationally.

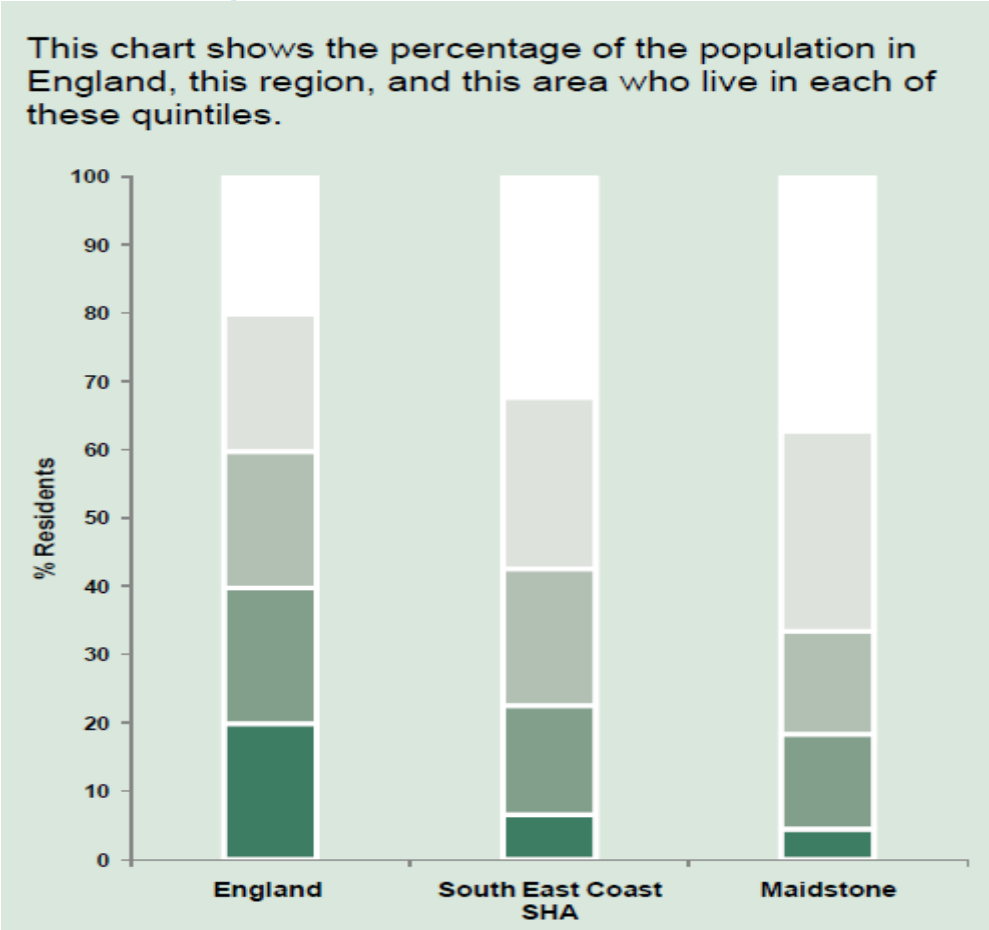
Note there are very few people in the most deprived decile in Aylesbry Vale CCG

If all CCGs aim to address deciles where rates are high compared to national rates, Right Care could have impact on both CCG IAF and national indicators

National quintiles applied regionally and to an area

Maidstone
Index of Multiple Deprivation (IMD)

% of residents from each English quintile



Logic Model on current work to further develop the NHS England Equality and Health Inequalities (EHI) Capability building Programme

1.Aims: Strengthen good practice in promoting equality and reducing health inequalities across NHS England's priority areas

- Build knowledge and understanding of the Public Sector Equality Duty and Health Inequalities Duties.
- Mainstream promoting equality and reducing health inequalities across NHS England's priority area policies and programmes.
- Ensure Robust Equality and Health Inequalities Impact Analyses feed into the development of policies
- Develop EHI Champions network to share good practice and support others in EHIA work

2.Offer to NHS E

- Inputs: Staff time
- Activities: Advanced Capability Training delivered to circa 30 senior staff by March 2017; One day capability development sessions for 200 staff by March 2018, starting in July 2016; EHIA 'surgeries' and webinars July 2016- March 2020.
- Screening tool and EQIA template
- Outputs: Trained staff, EHIAs inform better policy formulation

3.Behaviour changes sought

- Changes: Cultural change in NHSE so that equalities and health inequalities are mainstreamed as a matter of course during policy development

4.What is needed to help desired behaviour changes happen?

- Understand the baseline. Know what good looks like. Gain traction for improvement. NHSE, CCGs, Providers identify patterns in inequality and make targeted interventions to address these
- E.g. ***Potentially through the CCG assessment framework and Right Care Programme. Through recruitment and performance management***

5.Impacts/Benefits: Reduced inequality, more equitable health service, more productive health service and economy

6.Tracking progress: CCG Assessment Framework Indicators, Outcomes Framework Indicators, NHSE staff surveys

7.Links: ?

Health and Care Innovation EXPO 2016

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Everyone has Lived Experience….

- Our focus is upon the Lived Experience of people with protected characteristics and / or with multiple disadvantage.
- We have personal experience of destitution, homelessness, asylum Seeking, addiction, prison healthcare, gang and gun crime and recovery.
- We are working with Devolution Greater Manchester to ensure that 'people like us' can find themselves more easily in local NHS strategies and in commissioning proposals, including those with protected characteristics such as BME, lesbian, gay and trans gender communities.
- We work with the EDC to ensure that those who are socially excluded and live in challenged circumstances get a fair deal from the NHS.

Stark Inequalities and 'Inclusion Health' groups

Gypsy and Traveller communities have lowest life expectancy of any ethnic group in UK, high maternal and infant mortality rates; low child immunization levels, high rates of mental illness, suicides, diabetes and heart disease.

Homeless people are over 9 x more likely to commit suicide than general population.

Two-thirds of refugees & asylum seekers suffer on anxiety or depression and PTSD is underdiagnosed.

The average age of death of a rough sleepers is 30 years earlier than average population.

(Sources: DH Ministerial working group 2012, Crisis 2012, Faculty of Public Health, 2008)

Inclusion Health

is about supporting those who are 'excluded' in society and 'marginalised' from mainstream services.

- **'Inclusion Health Groups' are not usually best served by healthcare services, and have significantly poorer health outcomes.**
- **Traditional definitions cover people who are homeless, vulnerable migrants (refugees and asylum seekers), sex workers, and those from the Traveller community (including Gypsies and Roma)**
- **Our definition of those in scope is kept under constant and regular review.**

Expo 2015

Quotations about Exclusion

It happens to us:

Invisibility , marginalisation , denial of access to care.

People with LIVED EXPERIENCE of social exclusion in healthcare,

“Nothing about us without us!”

- **You can't design services for groups of people whose lives , needs , assets and health issues are an ‘unknown’**
- **You can't speak in your own language and assume it's universal – whether that be the language of professionals, the language of acronyms, or the English language...**

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NHS

Expo 2015 Pledge

We will co-produce leaflets to tackle denial of access to healthcare for Inclusion Health groups, commencing with a bespoke leaflet with and for asylum seekers and refugees.

What is the NHS doing to tackle health inequalities for Inclusion Health group?

Inclusion Health groups experience poorer health outcomes and worse health care than the general population. These poorer health outcomes can contribute to reduced life expectancy and reduced healthy life expectancy, which directly translates to increased costs for the health and social care sector and the wider public sector and impacts on the contribution these groups can made to society.

Access to Primary care –new registration guidelines

Patient Standard Operating Principles for Primary Medical Care (General Practice) November 2015

https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/11/pat-reg-sop-pmc-gp.pdf

Patient facing leaflets for all Inclusion Health groups under development, via the EDC Inclusion Health quick wins programme.

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Devolution Principles that aim to Tackle Exclusion

NHS

1. A new relationship between public services and communities that enables shared decision making, voice, genuine co-production and joint delivery of services. Do with, not to.

2. An asset based approach that recognises and builds on the strengths of individuals, families and our communities rather than focussing on the deficits.

3. A Behaviour change in our communities that builds independence and supports residents to be in control

4. A place-based approach that redefines services and places individuals, families, communities at the heart

5. A stronger prioritisation of well being, prevention and early intervention

6. An approach that supports the development of new investment and resourcing models..

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Working to tackle healthcare and digital exclusion

NHS

- NHS England Digital Technology Strategy
- NHS England Asylum Health National pilot
- Devolution for Greater Manchester priorities

Working to ensure that patient voice, lived experience, co-production and co-design are central to ensuring that those people facing the worst inequalities are given particular support so they are not excluded from access to healthcare and are not digitally excluded from NHS Choices and digital information about NHS services.

Key Aims of the NHS England National Asylum Health Pilot in Greater Manchester

- Asylum seeker led –enabling positive change
- High quality, appropriate healthcare for asylum seekers
- Clear, accessible information about asylum health
- Implementation of the new registration guidelines - Help to register
- Good access to appropriate services - wrap around volunteer support- health buddies, mentors, people to help us navigate the system, write letters
- Co-designing the service model and co designing training for staff including GPs and receptionists
- Building and sharing learning - bringing the lived experience of asylum seekers together with the expertise of the healthcare professionals to enhance healthcare and tackle inequalities in asylum health

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CONSULTATION SESSION

NHS

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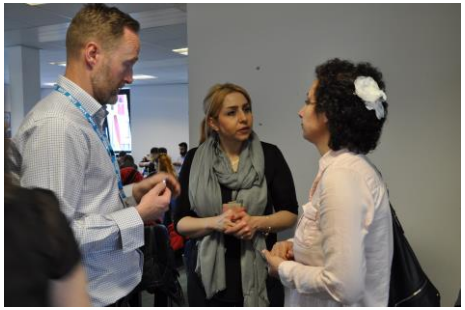
ASYLUM SEEKERS HEALTH OPEN EVENT

NHS



www.expo.nhs.uk | @ExpoNHS | #Expo16NHS

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Patient Facing Leaflets

NHS

Leaflet developed by and for asylum seekers explaining *how to register with a doctor (GP)*, your rights to registration with a note to the GP Practice asking for them to assist in registering the person in accordance with the new guidelines.

Message to the GP Practice

Thank you for helping to register this patient. We hope the patient was able to show you relevant documents. NHS Guidelines say 'If a patient cannot produce any supportive documentation but states that they reside within the practice boundary then practices should accept the registration'.

There is no regulatory requirement to prove identity, address, immigration status or an NHS number in order to register as a patient and no contractual requirement for GPs to request this.

All asylum seekers and refugees and those who are homeless, overseas visitors, whether lawfully in the UK or not, are eligible to register with a GP practice even if they are not eligible for Secondary Care (hospital care) services.

The patient MUST be registered on application unless the practice has reasonable grounds to decline.

GP practices have limited grounds on which they can turn down an application and these are; if

•The commissioner has agreed that they can close their list to new patients.

•The patient lives outside the practice boundary.

If you require further information or advice, please contact your local NHS England primary care commissioning team.

Please refer to the NHS England Guidance on Patient Registration:
Patient Registration Standard Operating Principles for Primary Medical Care (GP), November 2015:
http://tinyurl.com/ouolmkc

If you cannot register this patient, please identify the reasons from the list below and sign and date the form so the patient is informed

A: Our list is closed to new patients as from (date) ☐

B: The patient states that they live outside the practice boundary and we do not offer an enhanced registration service. ☐

C: We cannot register the patient due to other reasons as stated below: ☐

Name:
Date:

How to register with a doctor (GP)

What is a GP?
A GP is a local, family doctor. You need to register with a GP as soon as you can when you arrive in England so you can see the doctor when you are sick.

Does it cost?

There is no charge to register with a GP in England. Once you are registered, there is also no charge to see your GP. If your GP decide that you need medicine, you will receive a prescription. To get your medicine, take the prescription to any pharmacy. If you have been issued with a HC2 certificate, you will not be charged for the medicine. You should show this to the staff at the pharmacy and also tick the correct box on your prescription. You may need to fill in a HC1 form to get HC2 certificate.
If you want more information about the HC2 you can contact Help with the Health Cost on 0300 330 1343.

If you need to see a GP but have difficulty speaking or understanding English, tell the staff at the GP surgery. They will be able to arrange an interpreter. You will not be charged for this

Do I need ID to register?

It is ideal to provide ID but you CAN register if you do not have these documents.

Finding a doctor:

Before you register, contact the GP to confirm that it covers the address where you are living or staying temporarily.

You can register with any GP your local area as long as they have space for new patients.

- Ask Friends
- Ask at the library
- Ask local organisations such as: Schools, Mosques, Temples, and Churches
- Ask a support worker
- Ask your housing case worker
- Look on NHS Choice:

http://tinyurl.com/jcby7mr

Register with a Doctor:

Ask to register at the doctors' reception. Show this leaflet and they ask you to fill in a registration form. Get help with form if needed and return it to the GP reception.

Help with filling in the form

Local organisations that support asylum seekers and refugees may be able to help you fill in the GMS 1 form or local registration form:

REFUGEE ACTION

BritishRedCross

REFUGEE COUNCIL

If you can't get help, tell the GP receptionist. Ask them to book an interpreter who can help you fill in the form so you can register.

- You can ask to see a woman doctor if you prefer, if the GP has a female doctor. You can ask for a female chaperone.
- You can expect to be treated politely and with dignity.
- The GP and staff can expect you to treat them politely.
- You can ask for help if you feel they don't understand your needs.
- You can ask to discuss your health issues and personal details in a quiet and confidential place.
- Your details should always be kept confidential and safe by the doctor.

Help if you are refused registration

Ask the GP reception to write the reason why they cannot register you in the box overleaf. You cannot be refused registration because you don't have proof of address, ID or because of your immigration statues. If the GP already has too many patients they can refuse to register you. In this instance they must explain why in writing. If this happens you, or a helper, can get advice on how to access GP services.

Doctor of the World Clinical advice line:
020 75157534
(Mon-Fri 10am-12 midday)
Outside of this time please email:
clinic@doctorsoftheworld.org.uk
Please see www.doctorsoftheworlds.org.uk for alternative formats.

You can make a complaint

By email: England.contactus@nhs.net (for the attention of the complaints manager in subject line)

By post: NHS England, P.O Box 16738, Redditch,B97 9PT

By phone: 0300 311 2233 (Telephone Interpreter Service Available)

FOR FURTHER INFORMATION

You may be able to get help and advice from your local Citizens Advice
www.citizensadvice.org.uk or your local Health watch 0300 068 3000
www.healthwatch.co.uk

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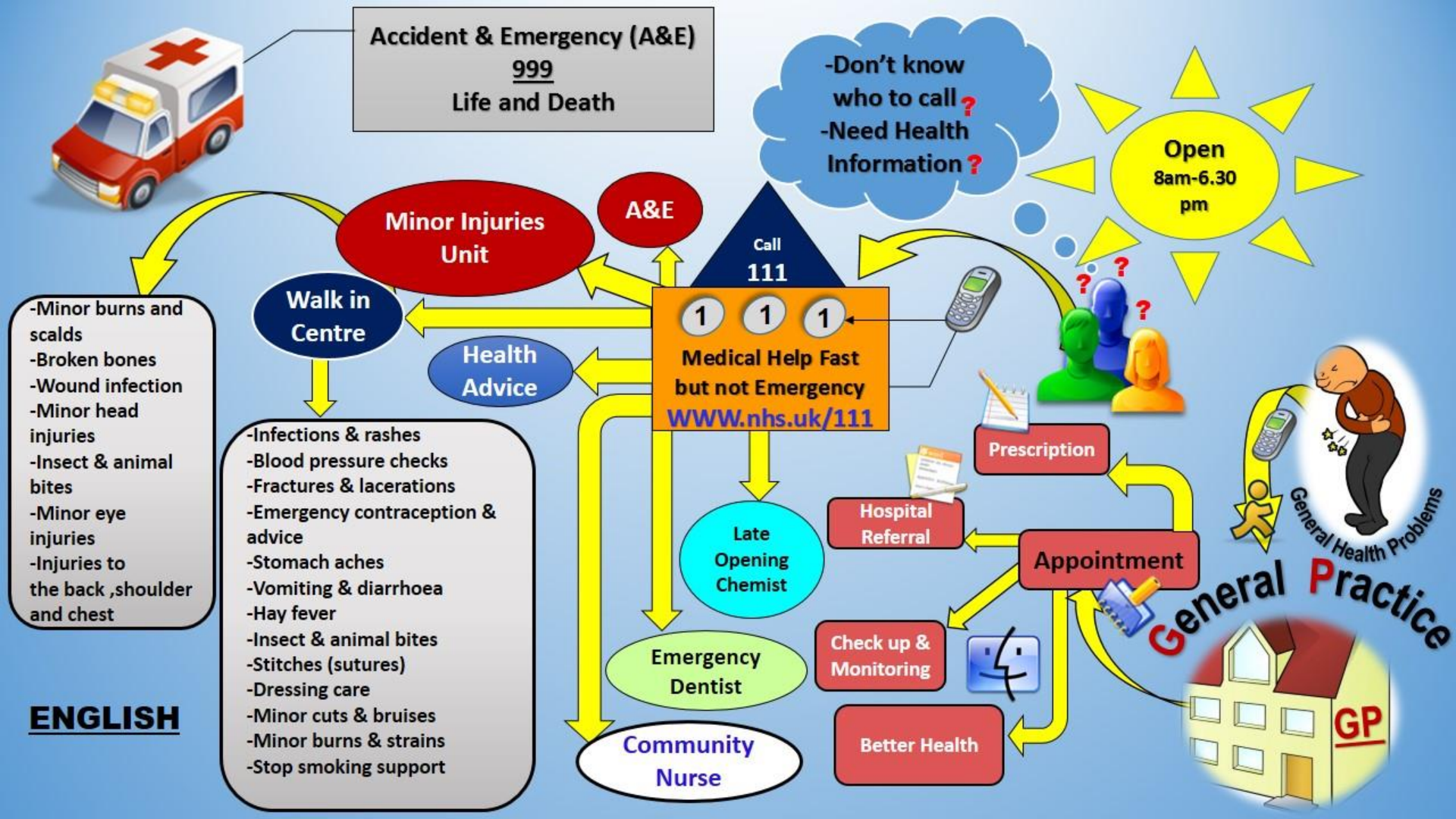
Further leaflets developed by and for asylum seekers

NHS

How to use NHS services, Night and Day


Accident & Emergency (A&E)
999
Life and Death
-Don't know who to call?
-Need Health Information?
Open 8am-6.30 pm
Minor Injuries Unit
A&E
Call 111
Walk in Centre
Health Advice
1 1 1
Medical Help Fast but not Emergency
WWW.nhs.uk/111
-Minor burns and scalds
-Broken bones
-Wound infection
-Minor head injuries
-Insect & animal bites
-Minor eye injuries
-Injuries to the back ,shoulder and chest
-Infections & rashes
-Blood pressure checks
-Fractures & lacerations
-Emergency contraception & advice
-Stomach aches
-Vomiting & diarrhoea
-Hay fever
-Insect & animal bites
-Stitches (sutures)
-Dressing care
-Minor cuts & bruises
-Minor burns & strains
-Stop smoking support
Prescription
Hospital Referral
Late Opening Chemist
Appointment
Emergency Dentist
Check up & Monitoring
Community Nurse
Better Health
General Health Problems
General Practice
GP
ENGLISH

HOW TO USE NHS SERVICES

Open
6.30pm-8am

-If you or someone you know is unwell when your doctor's surgery is closed and you feel it can't wait until it re-opens.

Accident & Emergency (A&E)
999
Life and Death

Call
111

1 1 1
Medical Help Fast
but not Emergency
WWW.nhs.uk/111

Out of Hour
Service

Out of Hour
GP

ENGLISH

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NHS

NHS Digital Programme

Helen Rowntree, Programme Director – NHS Choices and widening digital participation

September 2016

What's the problem we need to solve?

- 12.6m adults (23%) in UK lack basic digital skills & 5.3m (11%) have never used the internet,
- Those who lack digital skills or access are likely to be older, have disabilities, lower income & education,
- Correlation between digital exclusion, wider social disadvantage & health inequalities,
- Health & care services, information, & opportunities for participation are increasingly delivered digitally,
- We need to take positive steps to ensure that those who most need health & care services are not left behind in the digital revolution,

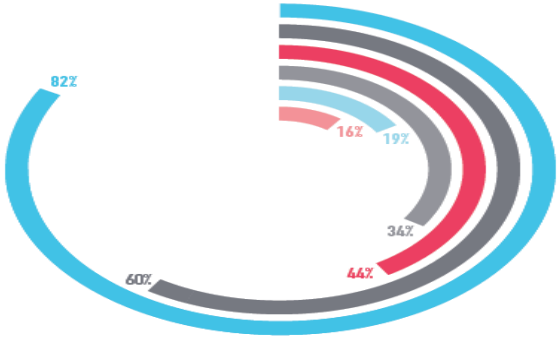
What have we done already?

- Widening Digital Participation (WDP): three year NHS England programme 2013-16
- Worked with social enterprise Tinder Foundation to provide national digital skills training programme
- Digitally excluded people engaged through local UK Online Centres in deprived communities

387,470
PEOPLE REACHED TO HELP THEM MANAGE THEIR HEALTH IN THREE YEARS
152,005 reached in the third year

221,941
PEOPLE TRAINED TO USE DIGITAL HEALTH RESOURCES IN THREE YEARS
81,048 trained in the third year

8,138
DIGITAL CHAMPIONS OR VOLUNTEERS TRAINED IN THREE YEARS



REACH OF THE PROGRAMME

The programme has targeted the most vulnerable patients. Of the learners supported by the programme through the Learn My Way platform:

- 82% of learners fall into at least one category of SOCIAL EXCLUSION
- 60% of learners are in receipt of BENEFITS
- 44% of learners are DISABLED
- 34% of learners are UNEMPLOYED
- 19% of learners are AGED 65+
- 16% of learners are from BAME GROUPS

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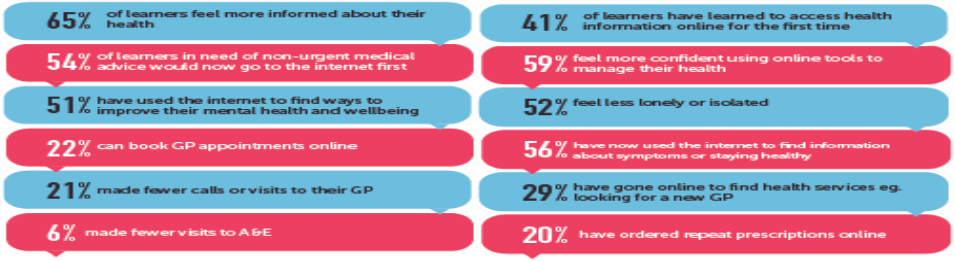
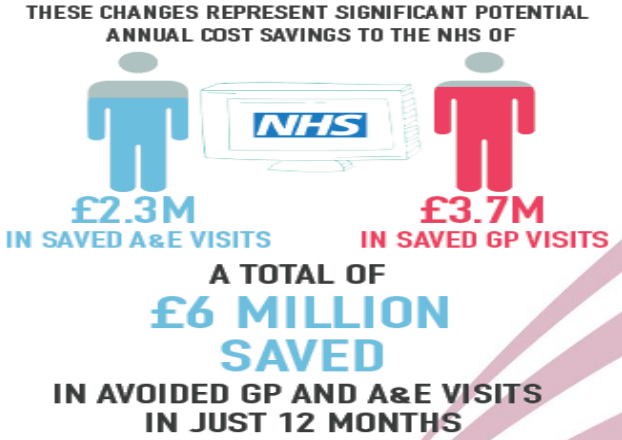
How successful have we been?

NHS

- **Evaluation** over the three year programme using quantitative & qualitative methods
- **Good evidence** of benefits realised for individuals & the health & care system
- **Positive outcomes** include increased confidence, more self care & greater use of online health services





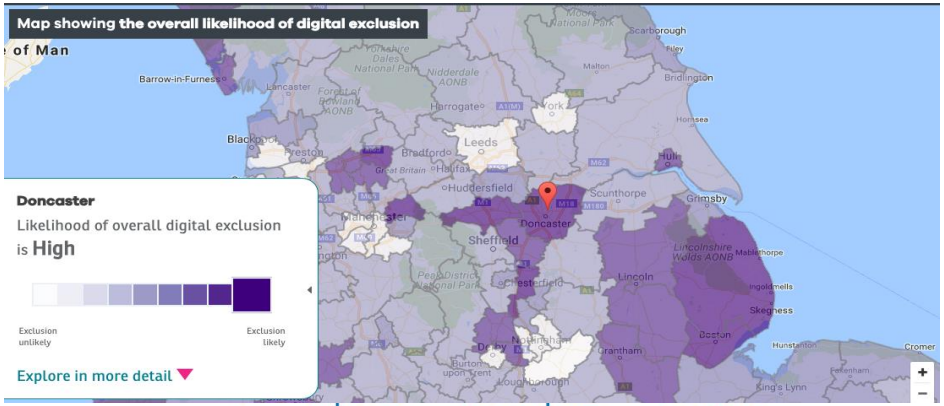
Next phase of the programme

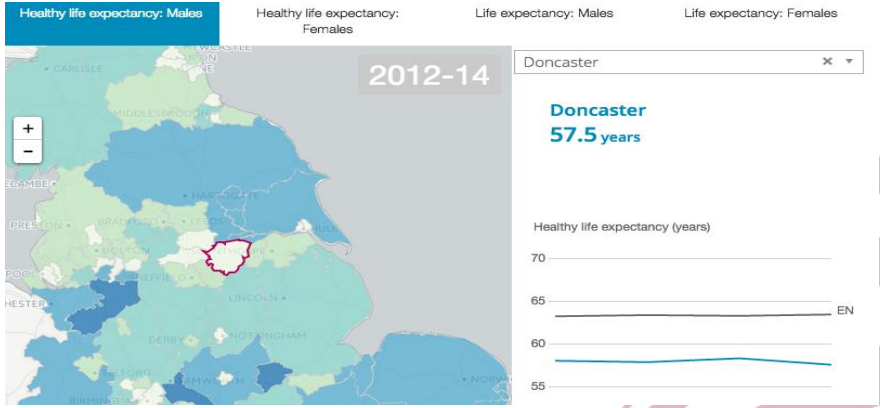
Key objectives for the new programme will be to:

- **Develop models for effective local partnerships for tackling digital exclusion through supporting local pathfinders (16 areas – 4 per Region)**
- **Work with digital delivery teams to ensure that digital health services are inclusive**
- **Create and communicate evidence on how best to support groups which are currently digitally excluded**
- **Build partnerships with other digital engagement initiatives in government, industry & voluntary sector**
- **Embed digital inclusion in NHS systems & processes eg. planning, performance management & incentives**

How will we prioritise our work?

- An evidence based approach
- Data-driven analysis to understand the cross over between digital exclusion and health inequality
- Mapping of digital exclusion heatmaps against indicators of local health inequalities
- The needs of the most digitally excluded will be prioritised – reaching the furthest first





What will success look like?

The outcomes of the programme will include:

- **Number of citizens engaged**
- **Digital skills improved (using GDS digital inclusion scale)**
- **Health & care organisations engaged**
- **Activation of individuals (including decision making & self care)**
- **Impact on frontline services (including increased use of digital services & reduced use of primary or urgent care)**
- **Sustainability of digital inclusion activity at local level (embedding in health & social care commissioning & provision)**

Inspiring Change Manchester

- **Inspiring Change Manchester is led by Shelter and is part of the Big Lottery Fund Fulfilling Lives multiple complex needs programme.**

- **We are a learning programme, testing new ways of addressing multiple needs, for us that means people with a combination of problems related to homelessness, mental health, drugs and alcohol or committing crime.**

- **Empowering and involving people who have experienced multiple needs one of the main elements of the programme. Along with finding new ways of providing joined up, person centred support.**

Expo 2016 Pledge

What are our next steps?

Can we co-produce leaflets and digital material to tackle denial of access to healthcare for people who are homeless and vulnerably housed?

Can we work with Health watch to produce material to tackle denial of access to healthcare for gypsy, travellers and Roma groups?

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Inclusion Health & Digital Health

NHS

Q&A

Session