Office for Health Improvement & Disparities

Reducing health inequalities within diagnostic services

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Office for Health Improvement and Disparities

What I plan to cover

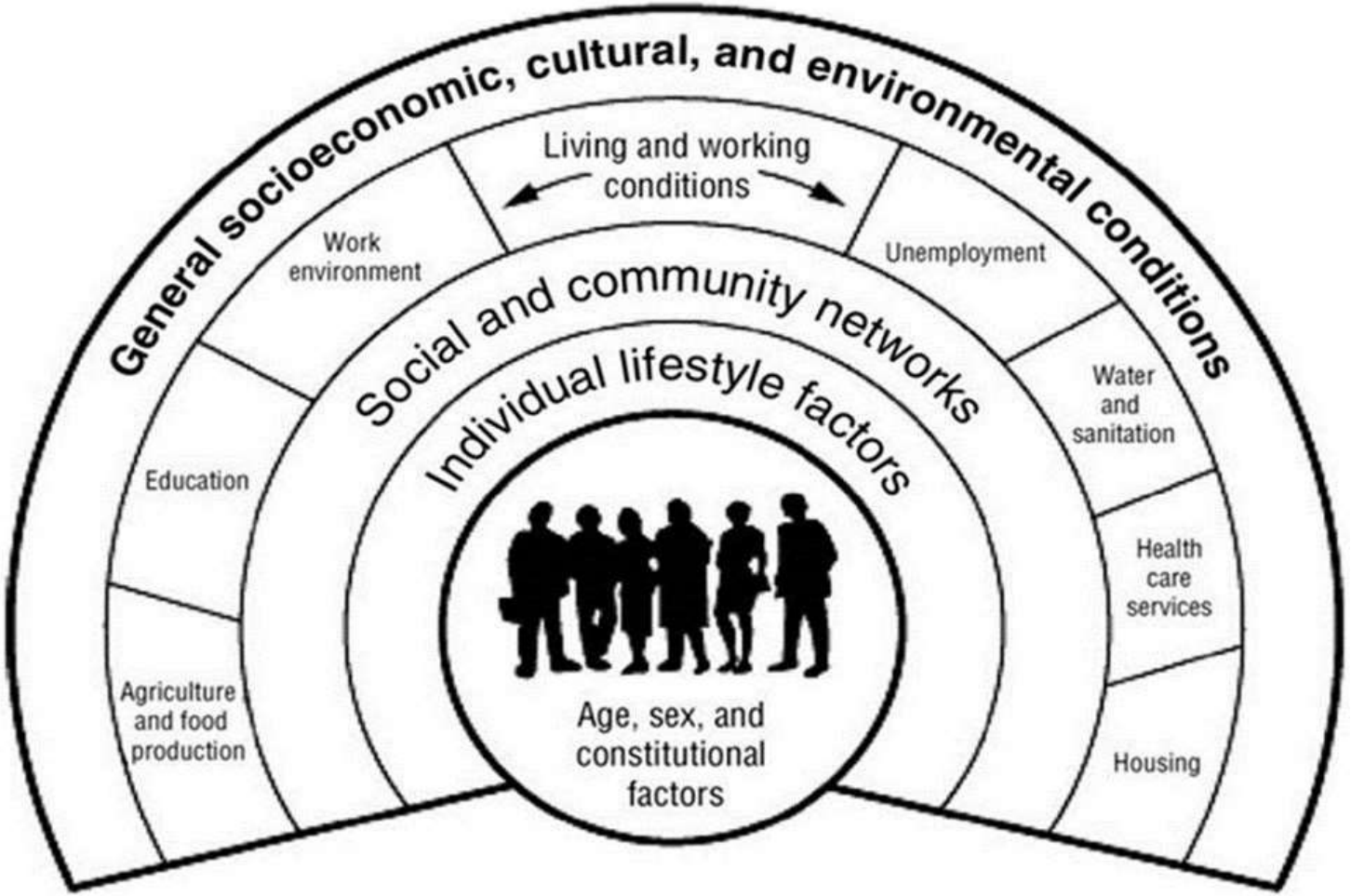
- What health inequalities are
- Why health inequalities exist
- Who experiences health inequalities
- Approach to reducing health inequalities within the NHS
- What can be done within diagnostic services to reduce health inequalities
- Tools and resources

Health inequalities definition

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

Health inequalities are sometimes referred to as the wider determinants of health or social determinants of health

Health inequalities have many drivers, but also present many opportunities to intervene



Source: Dahlgren and Whitehead, 1991

Between which groups might health inequalities exist?

- **Socio-economic status and deprivation: e.g. unemployed, low income, people living in deprived areas (e.g. poor housing, poor education and/or unemployment)**

- **Protected characteristics: e.g. age, sex, race, sexual orientation, disability**

- **Vulnerable groups of society, or 'inclusion health' groups: e.g. vulnerable. migrants; Gypsy, Roma and Traveller communities; rough sleepers and homeless people; and sex workers**

- **Geography: e.g. urban, rural**

Why is it important?

People with learning disabilities

63

years is the median age at death (compared to 82 and 86 for males and females in England 2018–20)

Homeless men

45

years is the mean age at death (43 years for homeless women)

LGBTIQ+

52%

have experienced depression, compared with 16% in the general population

Black people

6.6

infant deaths per 1,000 live births, more than double the mortality rate among white infants

Gypsy or Irish Travellers

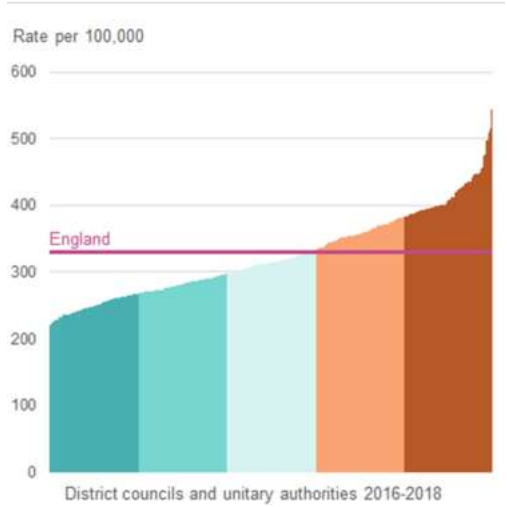
12.5%

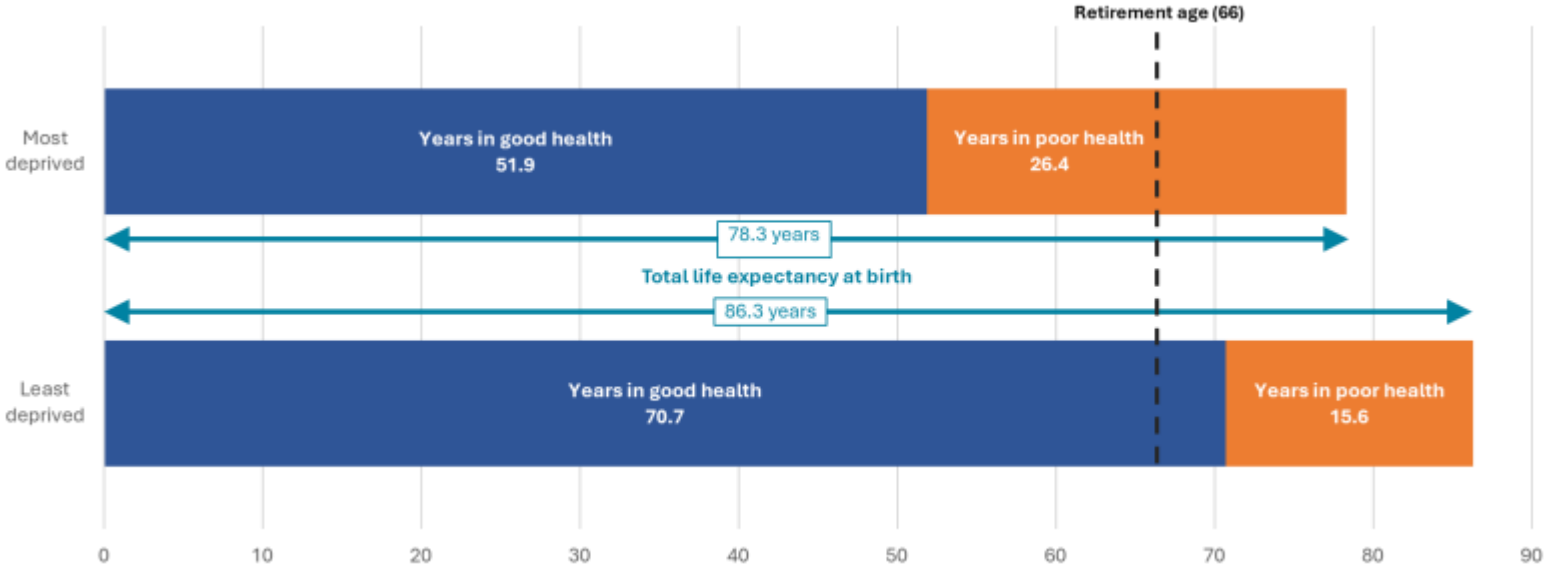
report being in bad or very bad health, more than double the general population

Source: Kings Fund

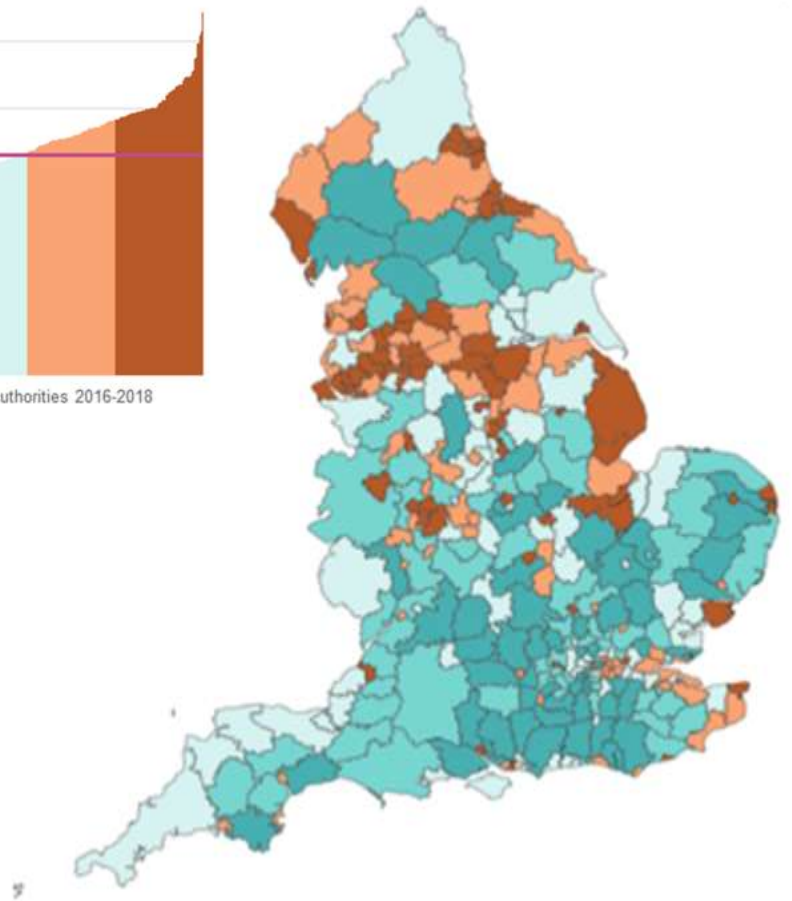
Deprivation and geographical differences

There are inequalities in the proportion of our lives spent in ill health as well as in life expectancy between the most and least deprived





Years of life expectancy at birth, female, England, 2018-20[1]



Under 75 year mortality (2016-18)

Sources: ONS, OHID

The economic cost of health inequalities

Health Inequalities were estimated to cost the NHS an extra £4.8 billion a year

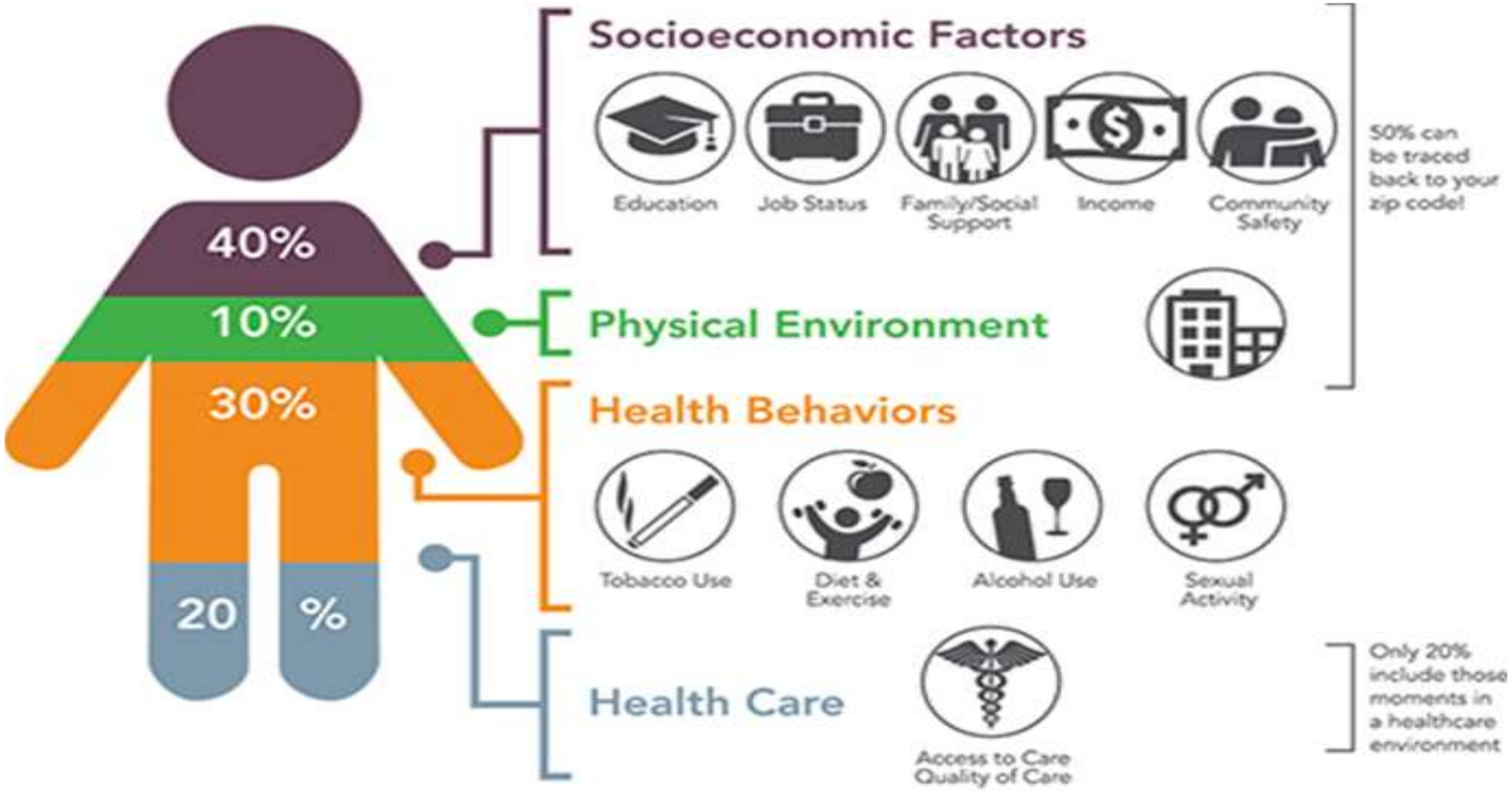
Estimated that health inequalities cost society £31 billion in lost production

Between £20 and £32 billion a year in lost tax revenue and benefit payments

NHS cost per person is 22% higher in most deprived neighbourhoods

Source: Place-based approaches for reducing health inequalities: main report - GOV.UK (www.gov.uk)

Causes and impact of health inequalities



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

REDUCING HEALTHCARE INEQUALITIES

NHS

The **Core20PLUS5** approach is designed to support Integrated Care Systems to drive targeted action in health inequalities improvement

CORE20
The most deprived **20%** of the national population as identified by the Index of Multiple Deprivation

PLUS
ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups

Target population

CORE20PLUS5

Key clinical areas of health inequalities

1. **MATERNITY**
ensuring continuity of care for **75%** of women from BAME communities and from the most deprived groups

2. **SEVERE MENTAL ILLNESS (SMI)**
ensuring annual health checks for **60%** of those living with SMI (bringing SMI in line with the success seen in Learning Disabilities)

3. **CHRONIC RESPIRATORY DISEASE**
a clear focus on Chronic Obstructive Pulmonary Disease (COPD), driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations

4. **EARLY CANCER DIAGNOSIS**
75% of cases diagnosed at stage 1 or 2 by 2028

5. **HYPERTENSION CASE-FINDING**
and optimal management and lipid optimal management

SMOKING CESSATION
positively impacts all 5 key clinical areas

REDUCING HEALTHCARE INEQUALITIES FOR CHILDREN AND YOUNG PEOPLE

NHS

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Target population

CORE20 PLUS 5

Key clinical areas of health inequalities

1. **ASTHMA**
Address over reliance on reliever medications and decrease the number of asthma attacks

2. **DIABETES**
Increase access to Real-time Continuous Glucose Monitors and insulin pumps in the most deprived quintiles and from ethnic minority backgrounds & increase proportion of children and young people with Type 2 diabetes receiving annual health checks

3. **EPILEPSY**
Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism

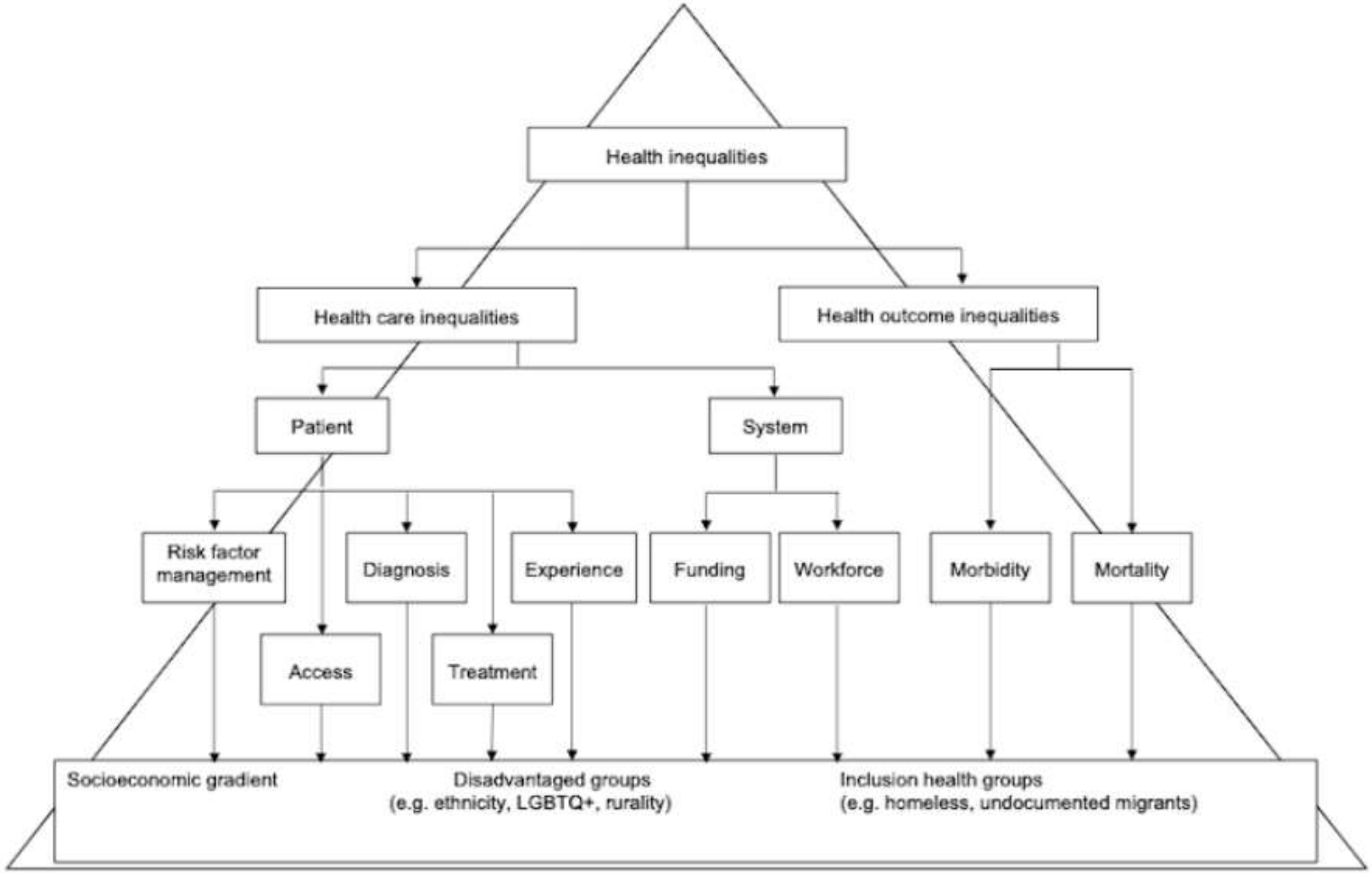
4. **ORAL HEALTH**
Address the backlog for tooth extractions in hospital for under 10s

5. **MENTAL HEALTH**
Improve access rates to children and young people's mental health services for 0-17 year olds, for certain ethnic groups, age, gender and deprivation

Reducing health inequalities within diagnostic services

What contribution can you make

Unpacking Health Inequalities

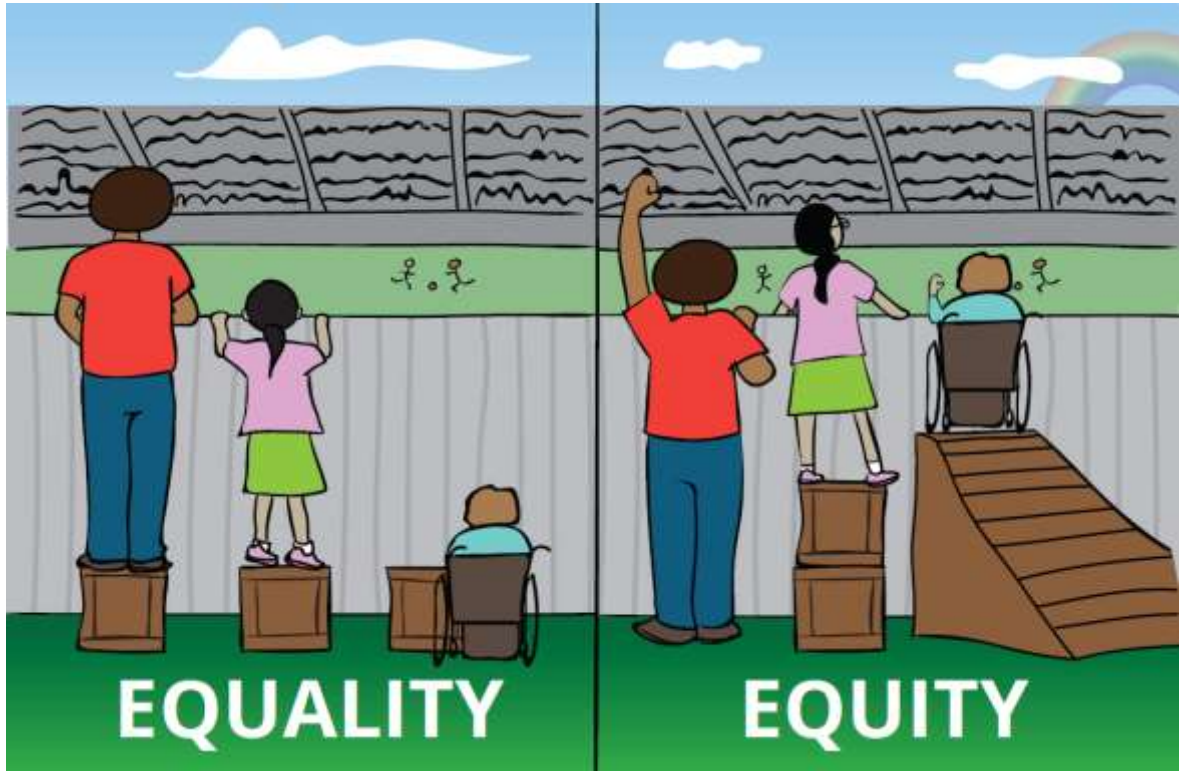


Areas of focus related to patient care

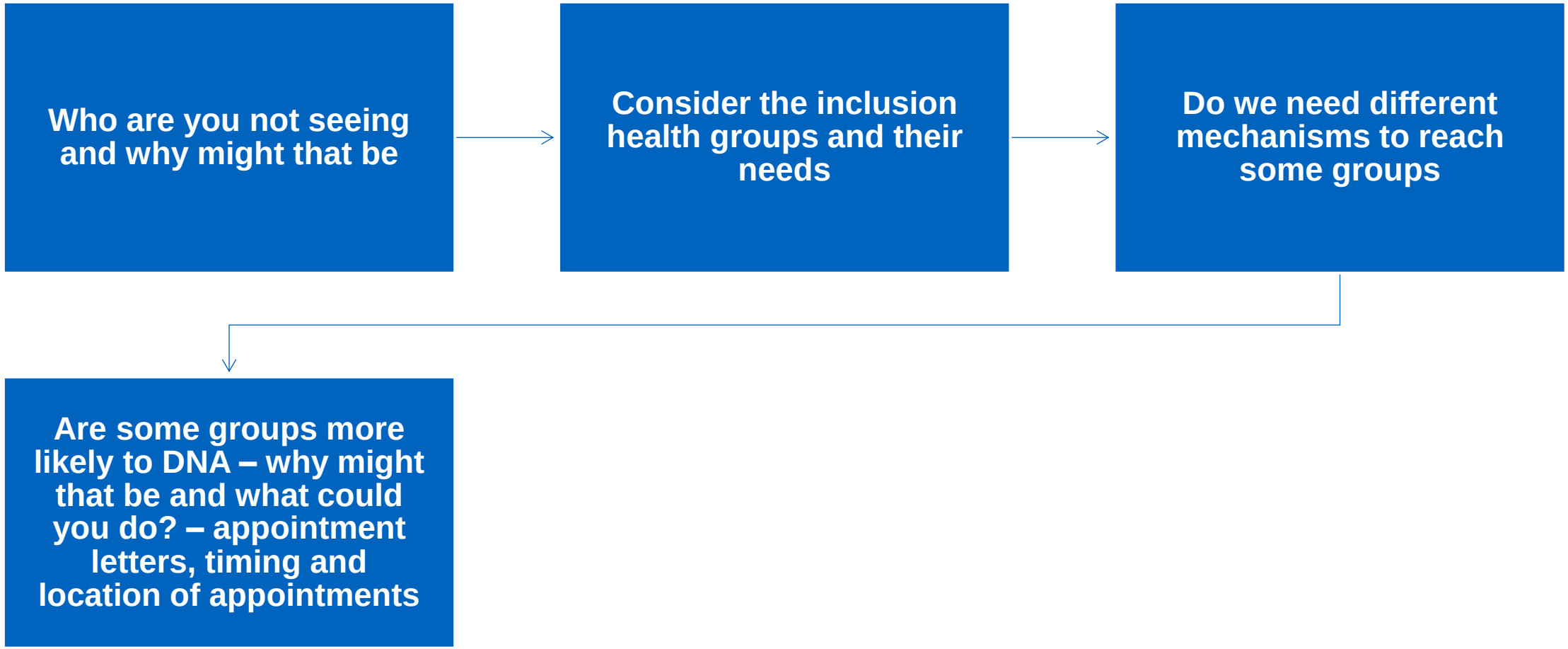
Equity of access

Equity of experience

Equity of outcome



Equity of access



Equity of experience

Does everyone understand the process – easy to read information, access to interpreters

Cultural sensitivities

Accessibility for people with disabilities

Equity of outcomes

Impact of skin tone on the results of some diagnostic tests

CLINICAL PERSPECTIVE | ARTICLES IN PRESS

Structural racism in radiation induced skin reaction toxicity scoring

Naman Julka-Anderson

Published: October 11, 2023 • DOI: https://doi.org/10.1016/j.jmir.2023.09.021

Abstract

Racially motivated biases are often implicit and can go unnoticed, especially if *your* normal is white and adjustments are required to cater for 'others.' Current consent forms and grading tools within radiotherapy are not inclusive of all skin tones. This commentary highlights gaps in care within radiation induced skin reactions (RISR) assessment for people of colour. Healthcare professionals and patients are directed to look for visual cues such as redness for RISR, but this is not always visible on people with pigmented skin. Their skin may go darker than their normal or changes across the colour spectrum. The lack of understanding of these fundamental differences are leading to people of colour being oppressed through structural racism and racialised myths. Using inclusive terminology will allow for moving away from the current view of healthcare that white skin is the norm. People of colour deserve more than are currently offered in RISR toxicity assessment.

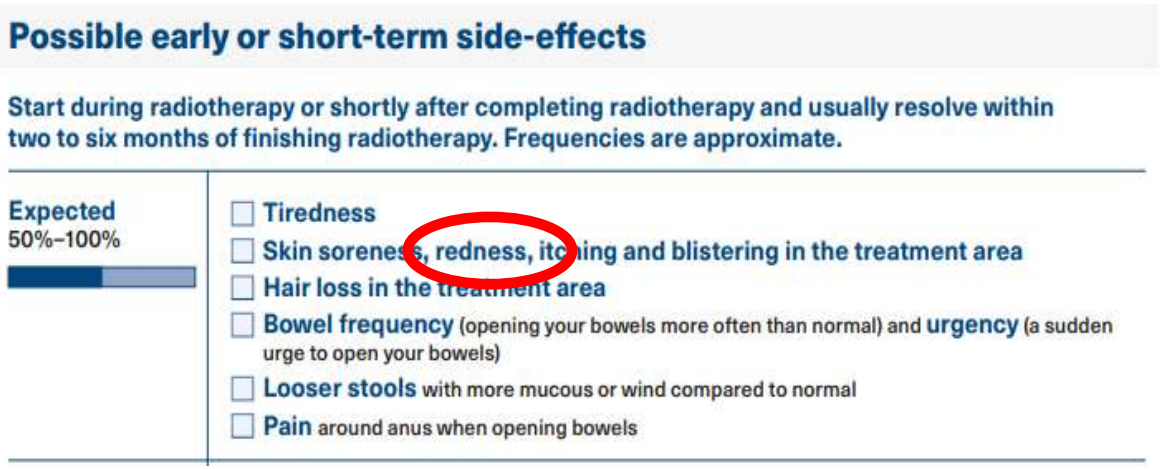
Consent Forms

Possible early or short-term side-effects

Start during radiotherapy or shortly after completing radiotherapy and usually resolve within two to six months of finishing radiotherapy. Frequencies are approximate.

Expected
50%–100%

- ☐ Tiredness
- ☐ Skin redness, irritation, itching, flaking, peeling, scaling and dryness in the treatment area
- ☐ The skin may scab over several times
- ☐ Skin breakdown in the treatment area – for example oozing, weeping, scabbing and/or bleeding
- ☐ Hair thinning or loss in radiotherapy area

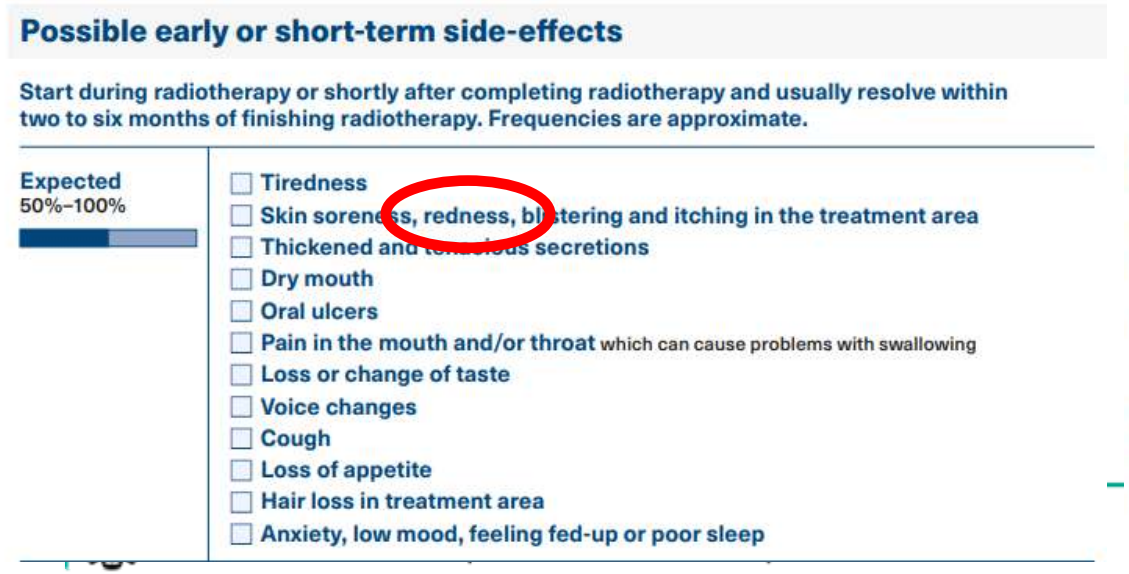


Possible early or short-term side-effects

Start during radiotherapy or shortly after completing radiotherapy and usually resolve within two to six months of finishing radiotherapy. Frequencies are approximate.

Expected
50%–100%

- ☐ Tiredness
- ☐ Skin soreness, redness, itching and blistering in the treatment area
- ☐ Hair loss in the treatment area
- ☐ Bowel frequency (opening your bowels more often than normal) and urgency (a sudden urge to open your bowels)
- ☐ Looser stools with more mucous or wind compared to normal
- ☐ Pain around anus when opening bowels



Possible early or short-term side-effects

Start during radiotherapy or shortly after completing radiotherapy and usually resolve within two to six months of finishing radiotherapy. Frequencies are approximate.

Expected
50%–100%

- ☐ Tiredness
- ☐ Skin soreness, redness, blistering and itching in the treatment area
- ☐ Thickened and tenacious secretions
- ☐ Dry mouth
- ☐ Oral ulcers
- ☐ Pain in the mouth and/or throat which can cause problems with swallowing
- ☐ Loss or change of taste
- ☐ Voice changes
- ☐ Cough
- ☐ Loss of appetite
- ☐ Hair loss in treatment area
- ☐ Anxiety, low mood, feeling fed-up or poor sleep

Possible early/short-term side-effects

Start during radiotherapy or shortly after completing radiotherapy and usually resolve within two to six months of finishing radiotherapy. Frequencies are approximate.

Expected
50%–100%

- ☐ Tiredness
- ☐ Temporary hair loss in treatment area

Common
10%–50%

- ☐ Skin soreness, redness and itching in the treatment area

Common
10%–50%

☐ **Skin soreness, itching, blistering and colour changes in treatment area**
– redness in white skin tones and subtle darkness, yellow/purple/grey appearance in brown and black skin tones

1 Erythema (redness) non-blanching or persistent blanching	2 Erythema to Maroon - non-blanching or persistent blanching	3. Maroon discolouration	4. Purple or Maroon discolouration	5. Purple discolouration or Hyperpigmentation (skin darker than surrounding area)	6. Hyperpig-mentation (skin darker than surrounding area)

Skin Tone Tool (adapted from Ho & Robinson, 2015)- Wounds UK (2021) Best Practice Statement: Addressing skin tone bias in wound care: assessing signs and symptoms in people with dark skin tones. Wounds UK, London.

Flen Health
advanced skin healing

Date ____ /____ /____ Patient Initials _____

For single use only www.flenhealth.co.uk

System Inequalities

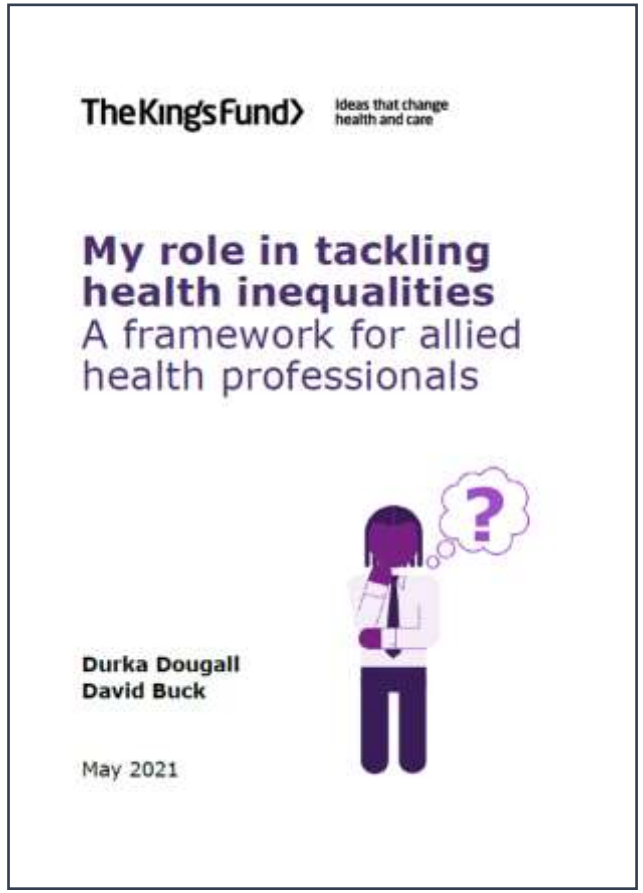
Does the workforce reflect the population?

Equity of access to opportunities / training

Do we allocate our resources based on need?

Related resources

[My role in tackling health inequalities: a framework for allied health professionals | The King's Fund (kingsfund.org.uk)](#) (2021)



What is All Our Health?

- The All Our Health programme is OHID's professional workforce development digital platform and a call to action, supporting public health practice through:
  - **bite-sized e-learning** on critical public health topics to enhance knowledge, confidence and action at individual, community and population level
  - **key evidence** and **data** into practice to stimulate change
  - **signposting** to other trusted sources of information
- Based on insights and research on key barriers to adopting public and population health approaches across the workforce.
- Developed by national topic leads in collaboration with key stakeholders and other interested parties.
- Supports the government's ambition to develop a prevention- first health and care system.
- Supports the NHS Long Term Workforce Plan which committed to ensure that the workforce has the right skills and knowledge to shift care towards prevention and early intervention and reducing health inequalities.
- Complements the Making Every Contact Count (MECC) approach to improving health and wellbeing by providing a broader view of public health that goes beyond individual level interventions.

All Our Health e-learning

- The e-learning is available on the eLearning for Healthcare platform.
- Over thirty different topics across all areas of public health.
- Consistent format answering three key questions + optional knowledge check.
- Plain text, educational resources is available on GOV.UK.
- **Supplementary resources including **NEW** adult social care public health tips e-learning tailored** for the social care sector.

All Our Health:
Health Inequalities e-learning

- A new e-learning module on health inequalities was published in October 2022.
- Promotes a shared understanding of health inequalities and how they can be addressed and complements existing modules on key public health issues.
- Supports the government and NHS priorities on reducing health inequalities.
- Developed in partnership with NHS England, the National Institute for Health and Care Excellence, the Local Government Association and the Social Care Institute for Excellence.
- A national pilot study was conducted early 2022 to test the content and impact of the e-learning.

Office for Health Improvement & Disparities

Guidance

Addressing health inequalities across allied health professional (AHP) services: a guide for AHP system leaders

Published 9 May 2024

https://www.gov.uk/government/publications/addressing-health-inequalities-across-allied-health-professional-ahp-services-a-guide-for-ahp-system-leaders/addressing-health-inequalities-across-allied-health-professional-ahp-services-a-guide-for-ahp-system-leaders

Checklist for action

- ❑ Understand the health needs of our populations, including subsections who have different health care and access needs
- ❑ Act as early as possible to prevent or reduce the need for complex interventions
- ❑ Ensure equity of access to services and appropriate support to enable equity of health outcomes
- ❑ Consider who you aren’t seeing as well as who you are
- ❑ Understand and appreciate the value of diversity of the population and reflect that in the workforce
- ❑ Understand the wider determinants of health and consider referrals to services who can provide wider support
- ❑ Use small scale test and learn to any change

THANK-YOU

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