Example data cards

Four categories of information

A *Healthcare – both unequally **accessed** and fundamentally different for poor people*

B *Primary care today – are we **medicalising poverty**? Is this the best use of our resources and a wise way of spending the money?*

C ***Rationing** – Who is forgotten? Are we looking honestly at the reality of rationing of services? Examples from Children and Young People and the vaccine programme*

D *Questions to answer*

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Example data cards

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A1

There is both unequal and different care for poorer people

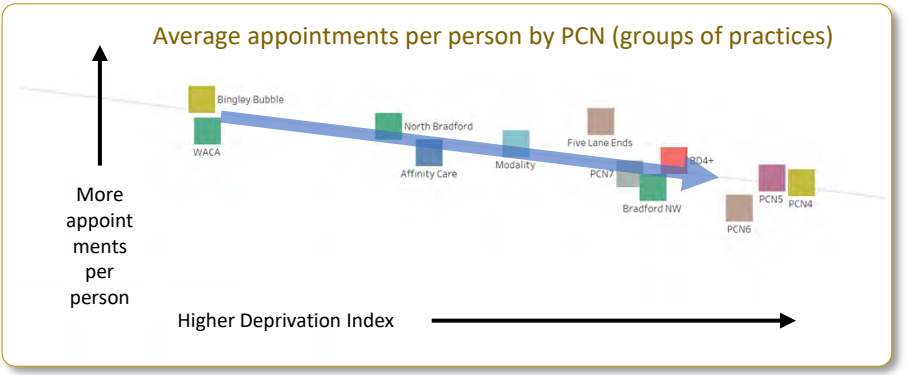
The primary care we provide is fundamentally different in in poorer areas.

For a poor population who may have huge challenges in their lives, primary care is:

(a) harder to access (fewer appointments)

(b) And less preventative (lower screening levels, less planned admissions).

Data example: fewer appts available per person in poorer areas



** Data not currently provided in Hastings*

A2

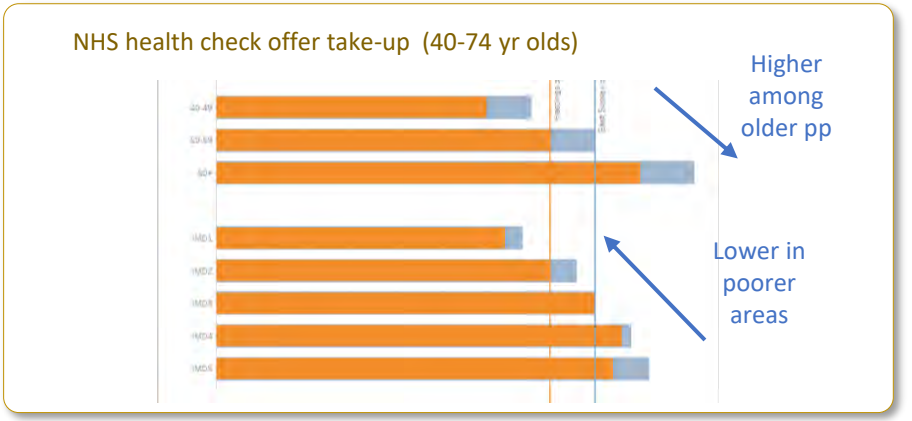
A flat offer is unequal

Equal inputs produce unequal outputs. Counterintuitively the same offer to everyone generates more inequality.

"Fair" is not fair

Data example: NHS health checks demonstrate this. A similar offer made to all people aged 40-74 shows different take-up rates by age, gender, ethnicity and poverty/deprivation.

Data example : different take-up rates for a common offer



A5

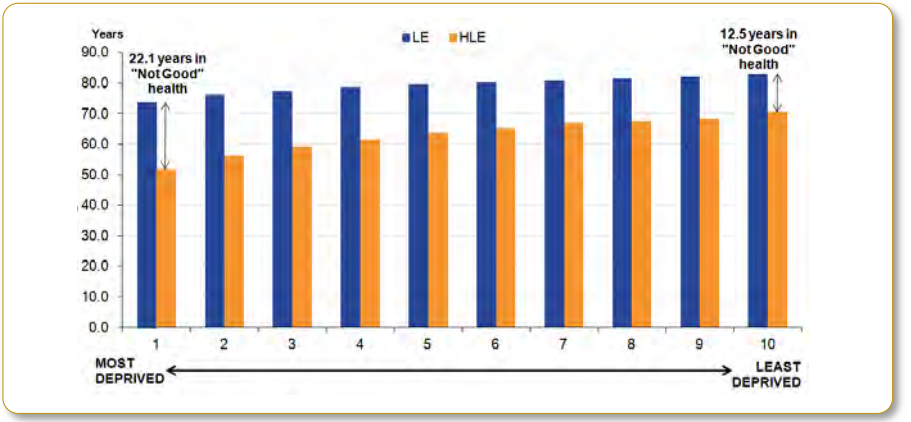
The life expectancy gap for people who are poor has not narrowed

Poor people live shorter lives by 5 to 10 years. And they also spend a much shorter number of years in good health.

Life expectancy difference from highest decile of deprivation area to lowest:

Female: 86 years drops to 79 years (**7 year gap**)
Male: 83 years drops to 74 years (**9 year gap**)

Data : Life expectancy (LE) and healthy life expectancy (HLE) gaps



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A

Healthcare – both unequally accessed and fundamentally different for poor people

B

*Primary care today – are we **medicalising poverty**? Is this the best use of our resources and a wise way of spending the money?*

C

Rationing – Who is forgotten? Are we honestly looking at the reality of rationing of services? Examples from Children and Young People and the vaccine

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Questions to start conversations

B1a

20% of next year's GP appointments are already booked

The people who see GPs frequently **year after year** are effectively 'pre-booked' next year too, taking up 20% of future GP appointments

This is just 4% of patients. That's a whole GP used up full-time for a medium-sized practice on 200-200 pp).

Data example: a year's GP appointments - 20% to long-term regular attenders

NEXT year's appointments with the GP

*Source: Hastings GP practice 2021 appts

1. **NON-ATTENDERS** (30-40% of list)

   It is so busy, it's difficult to for us to think about pro-active care *"If you don't call us we won't call you"*

2. **'Normal' ATTENDERS?**

   Will represent half of the GP time and cover a known spectrum of demand

3. **NEW FREQUENT ATTENDERS (new, episodic, short-term)**

   The challenge is efficient, rapid identification, diagnosis and support

4. **PRE-BOOKED Long-term regular attenders**

   We already know who they are and how often they will come. **A&E overlap** is high also. Often low **continuity** of care and **failure demand** is common

   Not just complex clinical care for old people. They cover a **very wide range** of different segments by age and concerns including many young and working age people with no existing LTC labels

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B1b

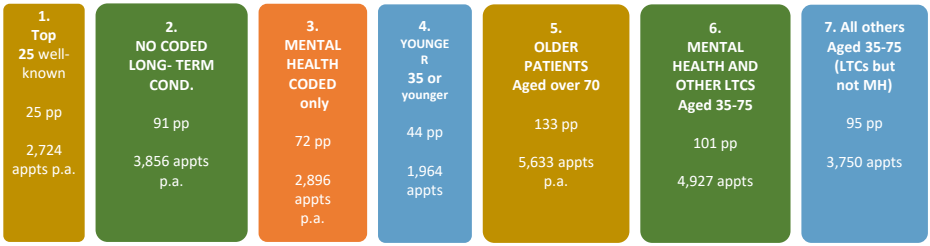
Your long-term regulars are not who you think they are

They are just a few hundred people but up to a quarter of all GP appointments, but they are mostly NOT well-known to the practice.

Every practice's group is different:

- They are often bouncing around between all staff members and not really being "picked up"
- So there is often a lack of consistency or long-view in their care
- Stereotypes and language like 'frequent flyers" are inaccurate and very unhelpful.
- They are all ages and very mixed in their needs. They may be … chronic pain sufferers … and/or young … and/or neurodiverse … and/or suffering from health anxiety … and in challenging social or family circumstances.
- These patients are very receptive to trying different support approaches to break the cycle

Data example: long-term attender cohorts, a large practice



a) REVIEW AND RETHINK

Reviewing of a small sample, what can we learn?

- *Past/Present/Future thinking*

b) NEW STARTS

- *Long MDT reboot appt? Active navigation? Continuity? ARRS roles usage, social links? …many options*

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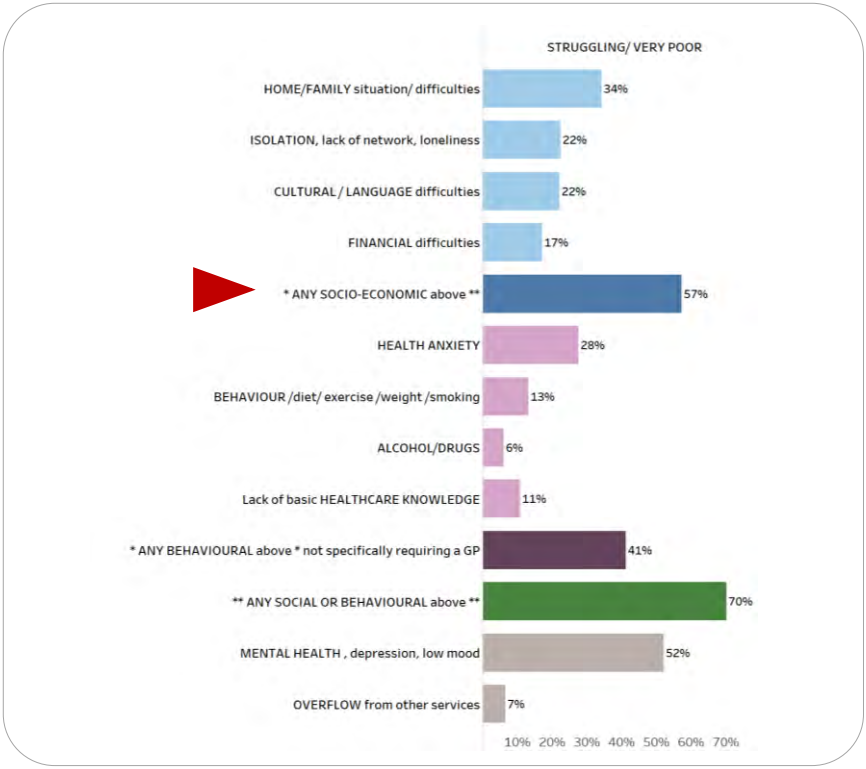
B2

At least a quarter of doctor appointments in general practice are significantly driven by social context

This rises to 60% of appointments for people with a turbulent life context.

Data example: GP audit of non-medical factors contributing to their appointments – below shown among patients with a turbulent life context



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B4

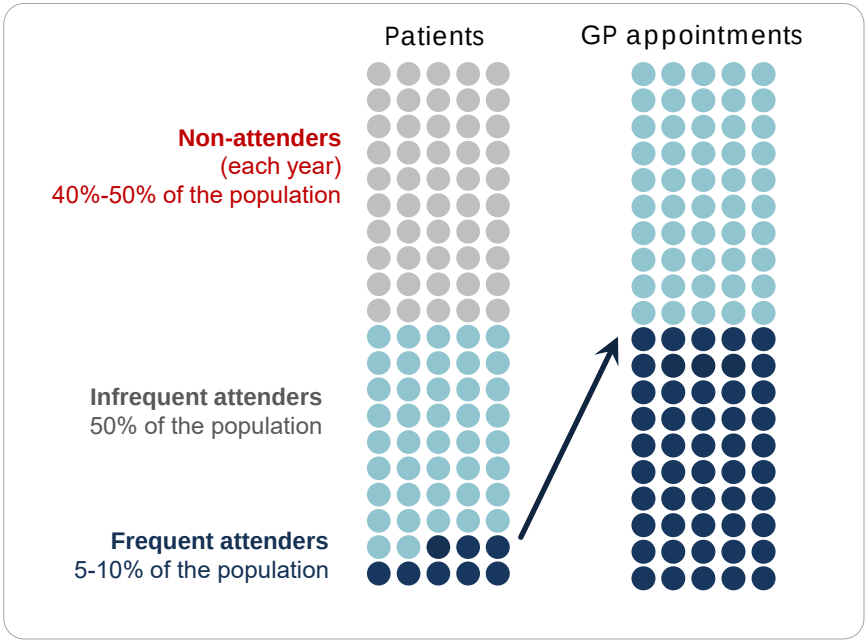
Reactive care is unequal

In a frantic world, primary care generally waits for people to come to it and then responds.

GP appointments skew to a small portion of the population every year with little left over for proactive work.

40 - 50% of people registered at a practice won't come in a given year - and a quarter or more haven't been heard from for 3-4 years, possibly longer.

Data example : patient vs appointment 'skew'
(aggregated across 25 practices)



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D *Questions to start conversations*

C1

Mental health waits for young people are extreme

CAMHS referrals are up very significantly post Covid.

EXAMPLE

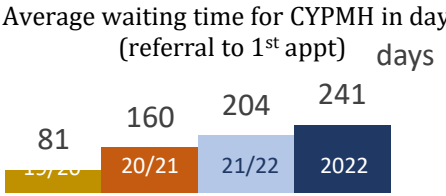
- Wait for first appointment = 8 months (one region)
- Over 500 people waiting over 6 months (another region)

The wait for **neurodiversity assessment** in xxxx can be just short of 2 years. **This isn't a wait, it's "life on hold".**

Referrals in one area have increased over 70% in the last 2 years.

Neurodiversity: Over 4,500 young people were waiting for an Autism and/or ADHD diagnosis in xxx recently and some services have seen up to an **80% increase in referrals over the last 2 years**.

Data example : CYPMH waiting to 1st appt in one region:

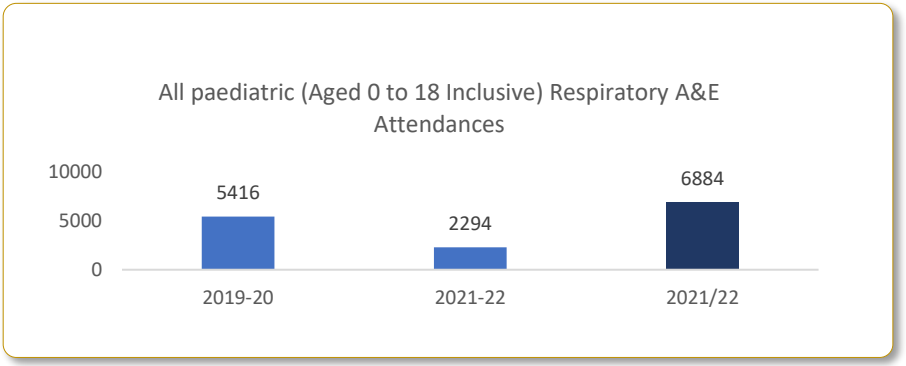


C4

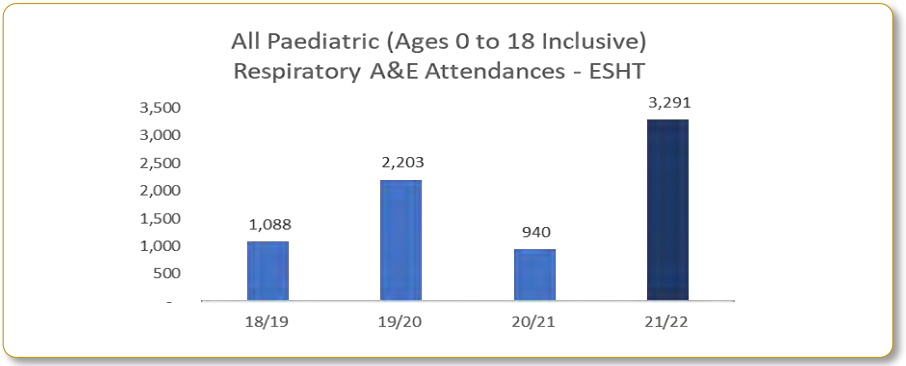
Young people are accessing A&E more frequently

There is growth in children and young people attending A&E

Data example 1 : **0-18 A&E respiratory attendances +30%**



Data example 2 : **0-18 A&E respiratory attendances +40%**



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C6

A triple impact on primary care in poorer areas

1. Appointments are already skewed to a **small proportion of patients** (true for all practices)

AND

2. There are proportionately **less GPs** and les GP time available in poorer areas

AND

3. **Funding allocation may be lower** as it is weighted more by demographics than by complexity or deprivation levels

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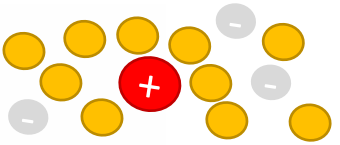
D1



ADD A NEW SERVICE … OR TAKE SOME AWAY?

When services aren't joined up or missing, do we tend to try and fix things by ADDING a new service

But do we need to also we think about TAKING AWAY, SIMPLIFYING OR COMBINING services too?

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D2

THE NEXT GENERATION

How do we focus on preventing the NEXT GENERATION from being medicalised?

- If it's too late - or at least very hard - to change the current generation as they have had years of behaviour built into the system, then …
- **How do we work with the NEXT generation to fundamentally change their relationship with healthcare?**
- How do we support tough GP conversations? And coordinate other support. How could this work?

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D3

IS A NEW MODEL OF CARE NEEDED?

The traditional model of Primary Care (GPs in one place, building relationships with a stable population) is challenged by not enough GPs and an often transient or dis-engaged population then …

What's the NEW MODEL OF PRIMARY CARE that doesn't assume that we can recruit enough GPs and that people stay in the same place, or come to us all the time?

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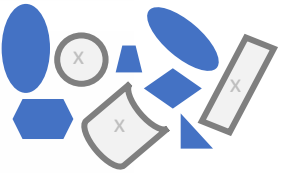
D7



WHAT IS A GP APPOINTMENT FOR?

What if it's covering a lot more than we expected?

Are there things it should it NOT cover?

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D9

Do we need to GET OUT THERE?

Is there too much ***"Don't call us... and we won't call you"*** today in our services?

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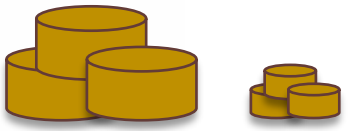
D10



HOW CAN WE BETTER DISTRIBUTE FUNDING?

To those areas that get less.

In areas where flat funding today produces inequality?

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D12

PEOPLE DON'T WAIT EQUALLY

Waiting isn't fair

What about waiting list adjustments?

If people who are poorer wait harder what can we do?

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