ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Bringing together skills, expertise and shared knowledge in UK ambulance services

Strengthening the role of the ambulance sector in reducing health inequalities

Board development session
5th June 2024

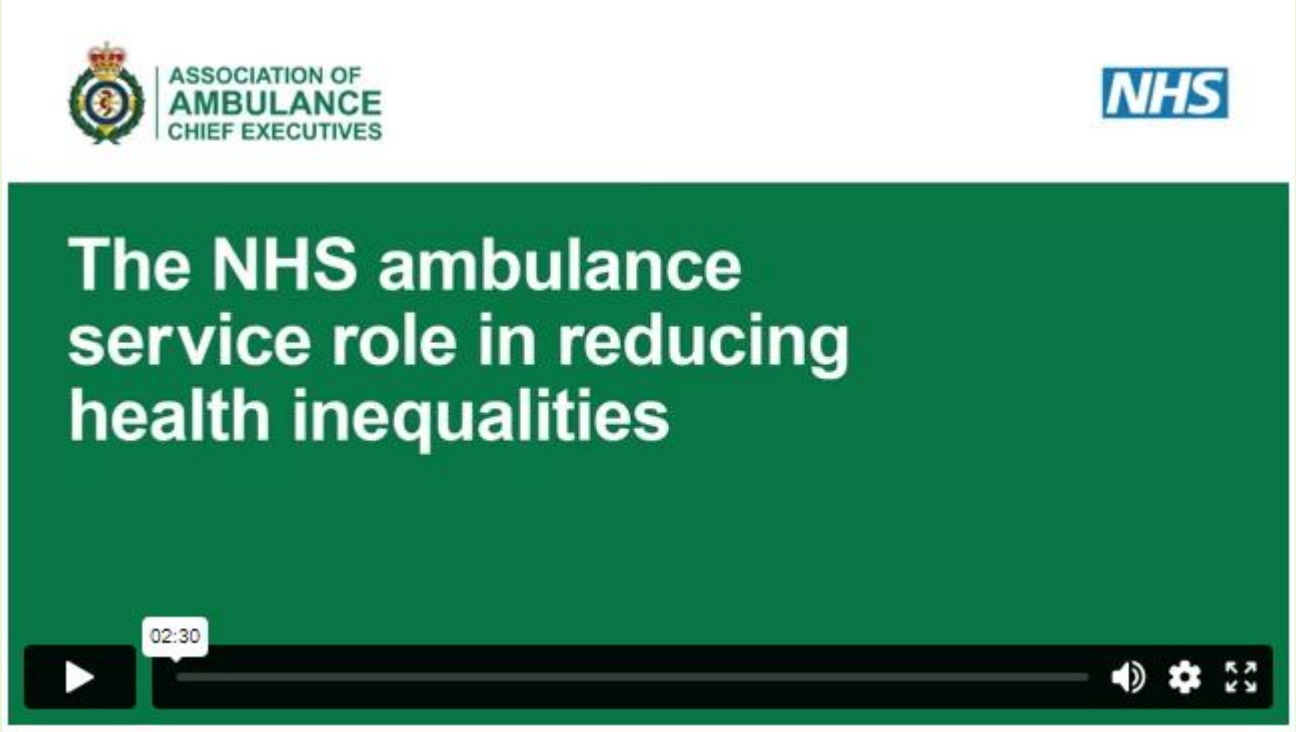
ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Purpose

Recent data shows that:

- **Black women** are **4x more likely** than **white women** to **DIE** in **pregnancy** or **childbirth** in the UK.
- **Women** with a **learning disability** have a **LIFE EXPECTANCY** at birth of **67 years – 17 years less** than women in the general population
- **People experiencing homelessness** are **14x more likely** to **DIE** by **SUICIDE** than those in the general population

The NHS has a role in both **reducing** these healthcare-based inequalities and **mitigating** against the impact of the wider, or social, determinants of health. But **what does this mean** for the ambulance sector **in the context of high demand** and **increasing financial pressures?**



'Click' on the above image to view our short animation describing the role of the ambulance sector in reducing health inequalities.

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Session recording

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Presentation slides

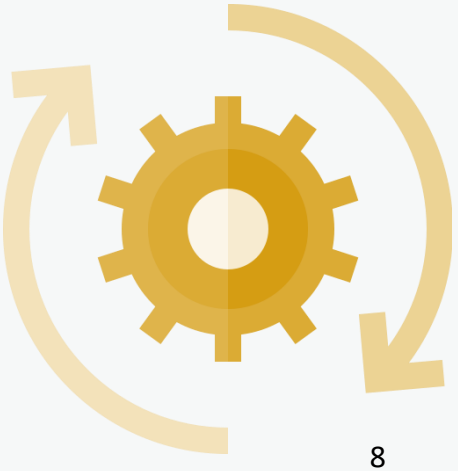
Healthcare inequalities

Ambulance board development day

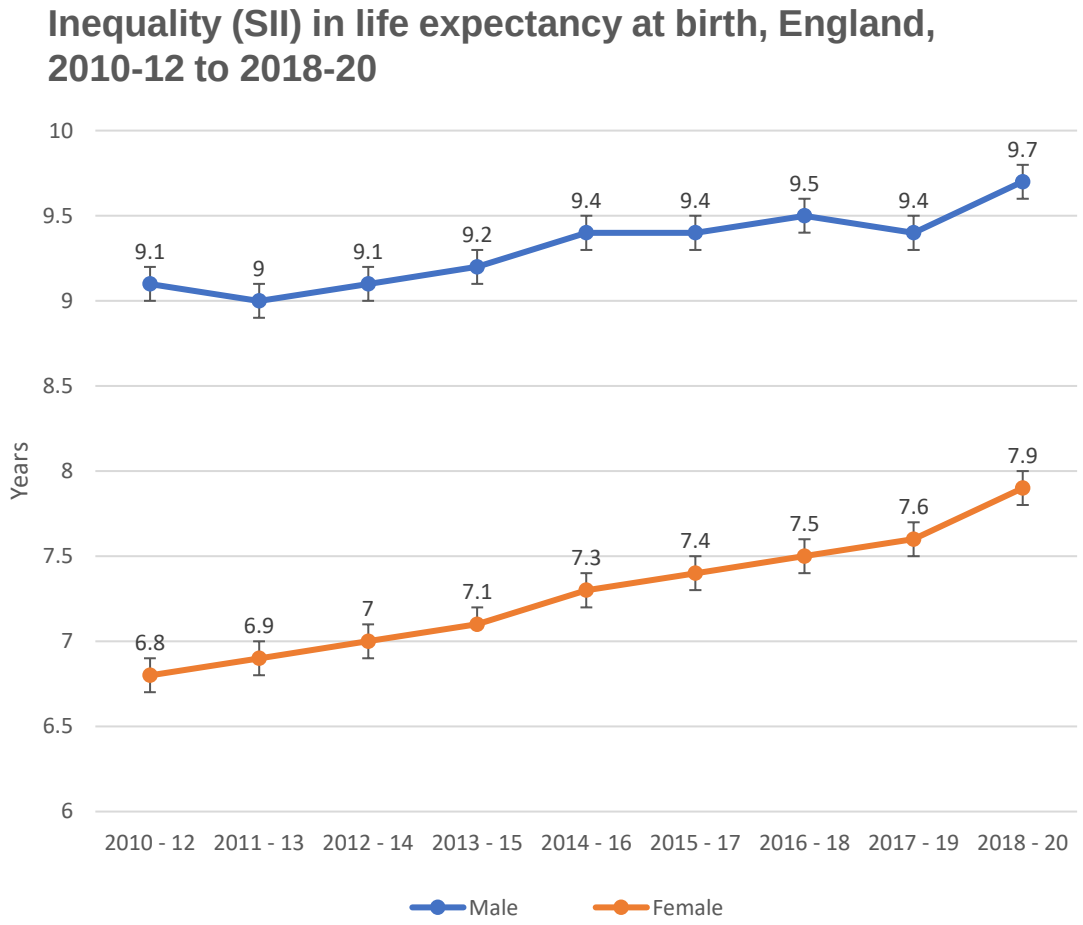
June 2024

Healthcare inequalities improvement programme
england.healthinequalities@nhs.net

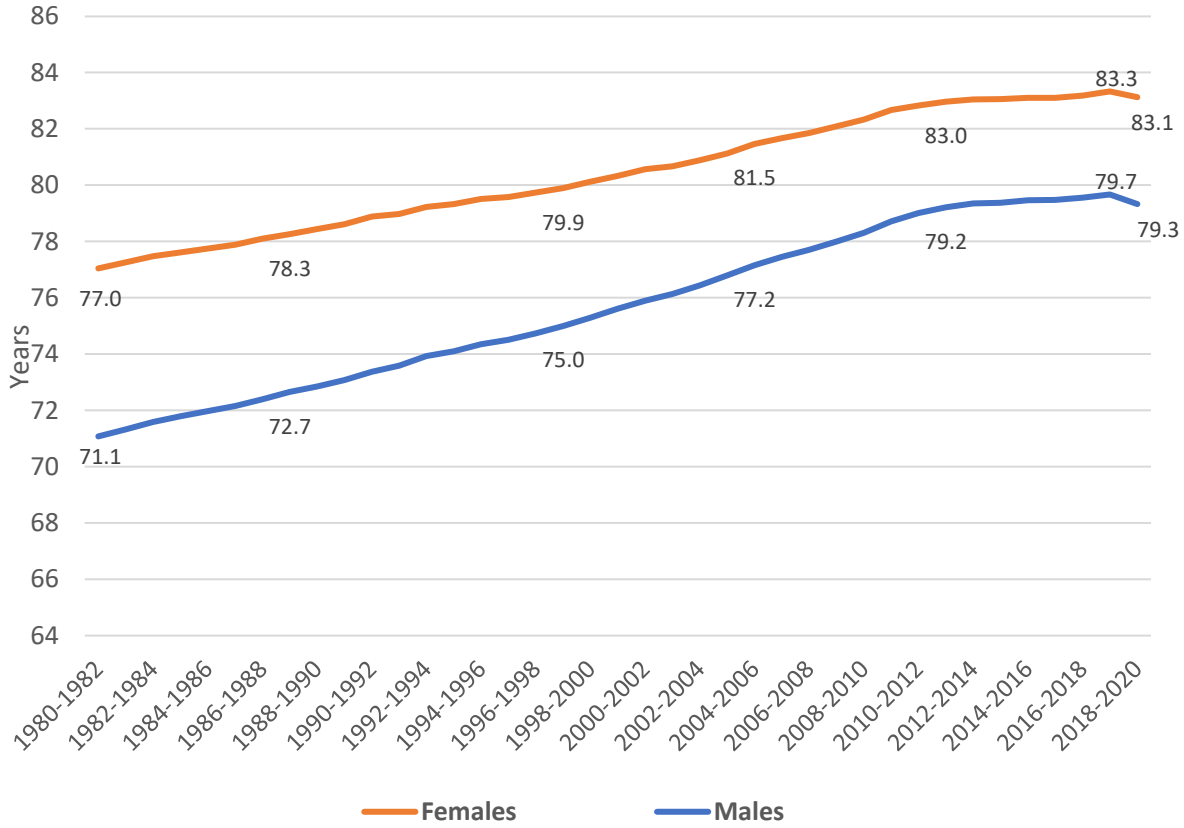
Context: Case for change and policy drivers



Inequalities in life expectancy have been rising since 2010



Improvements in life expectancy have stalled in recent years



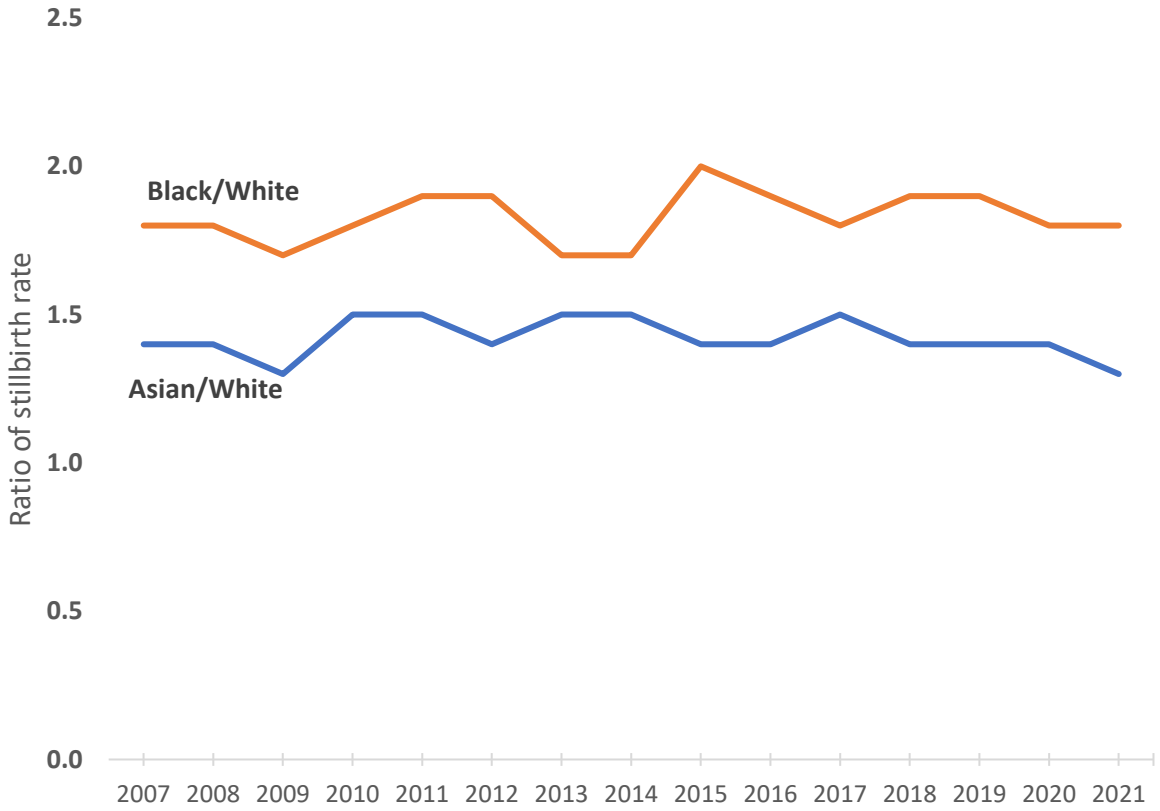
If the gap in life expectancy in 2018-20 between the most and least deprived deciles was closed, in the most deprived areas, males would live almost 10 years longer on average, and females nearly 8 years longer.

Source: Public health profiles - OHID (phe.org.uk)

In addition to reducing social gradient-based health inequalities, we must tackle stark inequalities experienced by specific groups, including….

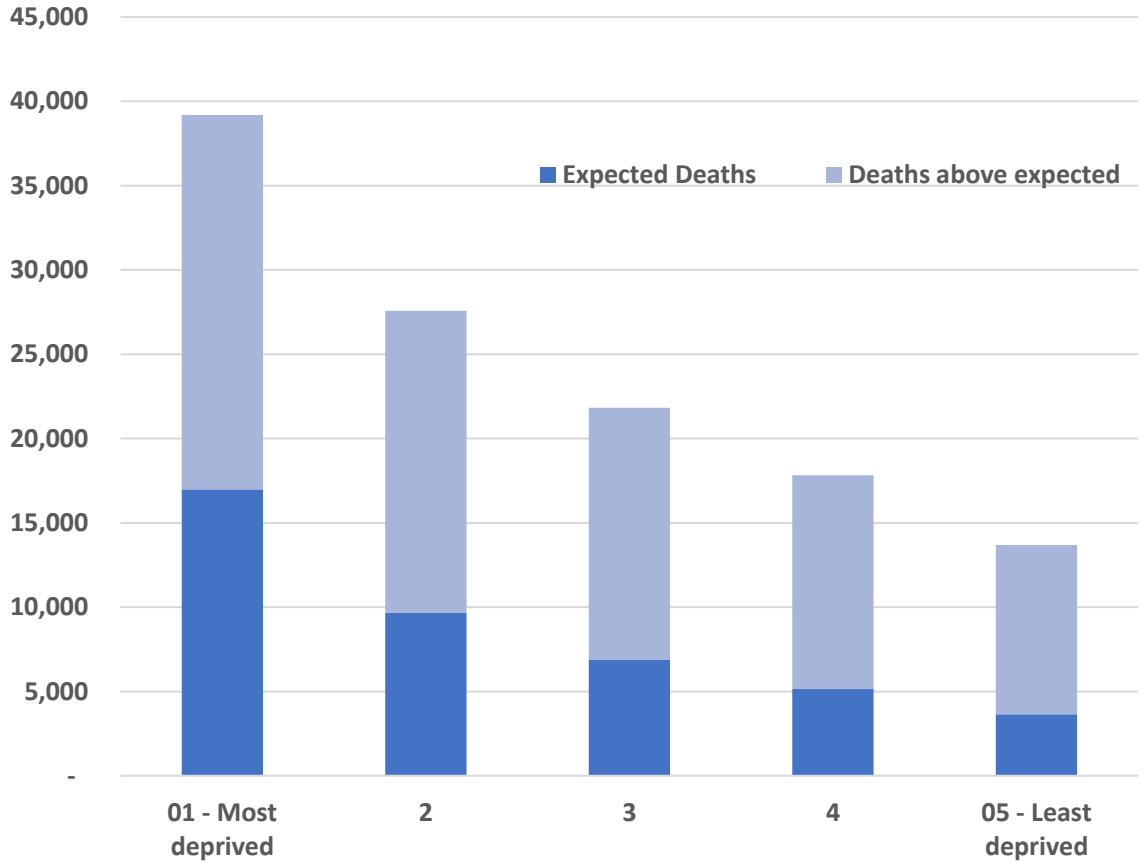
Disparities in maternity outcomes for Black and Asian mothers and babies

Ratio to White stillbirth rates: Black and Asian babies, England, 2007-2021



Premature mortality among people with SMI

Difference between observed and expected deaths for people with severe mental illness (SMI), England, 2018-2020



Note: Data is not standardised by age or deprivation

Source: Birth characteristics - Office for National Statistics (ons.gov.uk)

The role of the NHS in tackling health inequalities

Health inequalities are systematic, unfair and avoidable differences in health across the population, and between different groups within society.

They arise because of differences in the conditions in which we are born, grow, live, work and age. These conditions influence how we think, feel and act and can affect both our physical and mental health and wellbeing.

Healthcare inequalities are part of wider inequalities and relate to inequalities in the access people have to health services and in their experiences of and outcomes from healthcare.

Tackling inequalities in outcomes, experience and access is one of the four key purposes of ICSs.

NHS England's Healthcare Inequalities Improvement Programme's vision is for the NHS to deliver "exceptional quality healthcare for all, ensuring equitable access, excellent experience and optimal outcomes".

There are several contextual drivers to strengthen the NHS approach to health inequalities

Levelling up

Mission 7 of the White Paper: **"***By 2030, the gap in healthy life expectancy between local areas where it is highest and lowest will have narrowed, and by 2035 HLE will rise by five years.***"**

Health and Care Act 2022

NHSE/ICBs' duty to have due regard to the need to reducing inequalities in access to health services and outcomes achieved. NHSE must publish a Statement about Information on Inequalities.

NHS Mandate

NHSE should support ***"****…ICSs to tackle inequalities in access to healthcare at a local level; to fulfil their legal duties on health inequalities, including the delivery of five strategic priorities for system action on health inequalities; and to embed the Core20PLUS5 approach"…*

NHS Long Term Plan

The LTP set out a series of commitments to address health inequalities across the NHS to help moderate growth in demand for healthcare services.

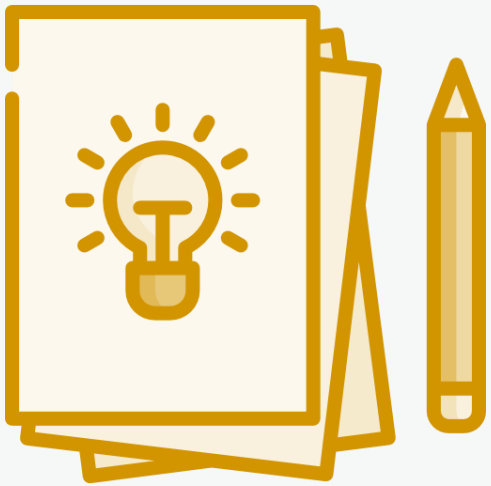
NHS Oversight Framework

Preventing ill health and reducing health inequalities is one of the five themes of the Oversight Framework, with the expectation of supporting metrics to guide delivery.

Joint Forward Plans and ICS strategies

Tackling inequalities in outcomes, experience and and access is one of the purposes of an ICS. ICS strategies and JFPs allow systems to set their local ambitions and strategic actions for tackling inequalities.

Creating change: A cultural shift



Our vision to is achieve exceptional quality healthcare for all through equitable access, excellent experience and optimal outcomes

To do this, we need to make several cultural shifts among NHS leaders.

Shift from	Move to
Health inequalities on the 'too difficult' pile; believing change is someone else's responsibility	Focusing on the things we can do within our spheres of influence Identifying practical steps we can all take in our work
Tick box, late-stage consideration of inequalities issues	Ongoing, proactive consideration of inequalities throughout programmes of work, particularly when faced with choices or decisions
Only describing the problem	Creating solutions through innovation and quality improvement
General statements of ambition	Explicit strategies, action plans and deliverables; demonstrable impact

There are many general opportunities to create change and reduce health inequalities

Improving pathways and interventions	• Designing services and pathways to suit underserved groups by default • Trying out approaches to tailor and target services to better serve specific groups e.g., through targeted case-finding
Working with specific groups or communities	• Developing effective and meaningful ways work in partnership with communities to design and improve services
Integration and multi-agency working	• Partnership working with local government, the VCSE and other partners, including business to develop whole-system approaches and address 'upstream issues'
Improvements to data; maximising research and evidence	• Collecting and analysing routine data needed to reveal inequalities • Community participatory research; co-designing and co-producing research with people from diverse backgrounds ensuring that studies include enough people from underserved groups to draw meaningful conclusions about them
Resource allocation	• Making the most of all resources, distributing capacity and money to support equity; estimating the real costs of failing to address health inequalities
Digital	• Identifying where digital will help to better meet preferences of specific groups • Delivering actions to improve digital inclusion, and support groups who will need non-digital routes to support
Governance and accountability	• Ensuring that discussion about inequalities are built into governance conversations • Commissioning provision with specificity about requirements to tackle inequalities
Anchor institutions	• Using leverage and optimising impact to act as an anchor institution.

To support our vision, we have set five strategic priorities with associated support and initiatives

Vision
Exceptional quality healthcare for all through equitable access, excellent experience and optimal outcomes

1: Restore services inclusively
Supporting major recovery plans

- Primary care
  e.g. GP contract, QOF, INTs
- Elective care
  e.g. actions for boards, case studies
- UEC
  Rollout HIU services
- Inclusion health framework

2: Mitigate against digital exclusion

- Digital inclusion framework

3: Ensure datasets are complete and timely

- Ethnicity coding improvements
- Data dashboard and tools

4: Accelerate preventative programmes

- Core20PLUS5 adult & CYP frameworks
- Core20PLUS change agents: *Ambassadors and Connectors*
- Core20PLUS Accelerator sites
- Innovation for healthcare inequalities programme (InHIP)

5: Strengthen leadership and accountability

- Broad learning offer and resources
- Funding (inequalities/ unmet need adjustment)
- NHS as an anchor institution

Our priorities for health inequalities are set out in priorities and operational planning guidance. They have been recurrent since 2021/22 and we expect them to be in place for at least five years (to 2025/26) to enable ICBs to put in place strategic actions through joint forward plans.

NHSE planning guidance - Healthcare inequalities

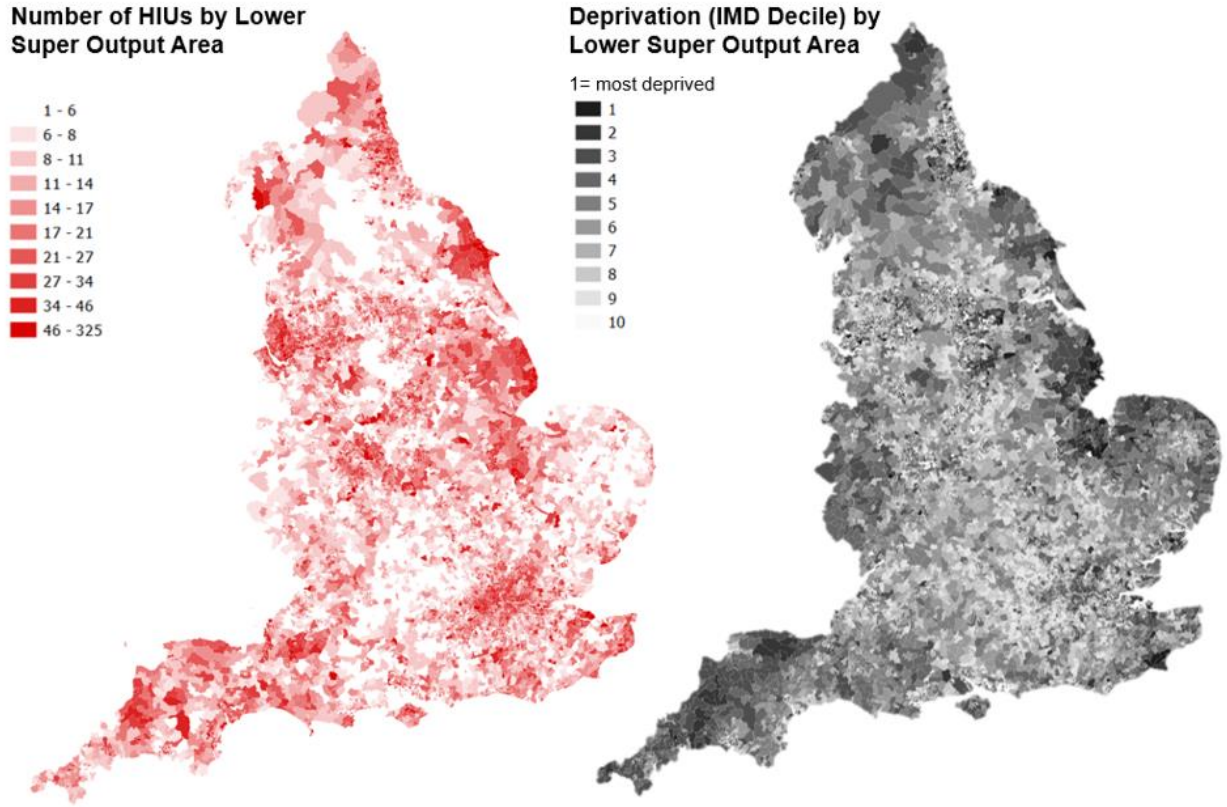
Key messages set out in planning guidance continue to be relevant

Key line included in the 2024/25 priorities and operational planning guidance:

Funding is provided through core ICB allocations to support the delivery of system plans developed with public health, local authority, VCSE and other partners. The formula includes an adjustment to weight resources to areas with higher avoidable mortality, and the £200m of additional funding allocated for health inequalities was made recurrent in 2023/24. ICBs are expected to demonstrate how they are using this funding to target areas of highest need and premature morbidity and mortality in line with the Core20PLUS5 approach and in collaboration with primary care and VCSE colleagues.

UEC High Intensity Use is associated with Health Inequalities

- HIUs are split roughly equally between men and women with almost one third of HIUs aged 20-40
- **20% of HIUs live in areas in the most deprived band (IMD band 1 of 10).**
- HIUs are over a third more likely to live alone than the general population
- HIUs are at least 25% more likely to move than the general population - A crucial point is the 7th visit to A&E when an HIU is more likely to be one for more than a year
- HIUs aged 30-50 mortality rates are elevated by 7.5 times compared to the average population
- HIUs who attend 16 times a year, remain an HIU for multiple years



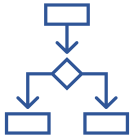
Sources: HES data benchmarked against ONS data. **KB**

Obligations about health inequalities introduced by the Health and Care 2022

General changes

Persons rather than patients (i.e. an emphasis on inclusive access)

Joint forward plan not annual plan



Regard to likely effects of the decisions in the exercise of functions

This is in relation to the **triple aims***:*

(a) the health and wellbeing of the people of England

(b) the quality of services provided to individuals

(c) efficiency and sustainability in relation to the use of resources by relevant bodies for the purposes of the health service in England.

Health inequalities legal duties: new duties on ICBs and Trusts

ICBs

- **Duty on health inequalities**: ‘Each integrated care board must, in the exercise of its functions, have regard to the need to— (a) reduce inequalities between persons with respect to their ability to **access health services**, and (b) reduce inequalities between persons with respect to the **outcomes achieved** for them by the provision of health services.’
- **Quality of service** duty, which includes addressing health inequalities
- Duty to **promote integration** where this would reduce inequalities in access to services or outcomes achieved
- Duties on several other areas which require consideration of health inequalities – in making wider decisions, **planning, performance reporting**, publishing certain reports and plans, **annual reports and forward planning**
- **Annual assessment** of performance by NHS England on how well the ICB has discharged its functions in relation to a range of matters including reducing health inequalities, improving quality of service, and public involvement and consultation.

Trusts and Foundation Trusts

Have regard to wider effects of decisions in relation to the health and wellbeing of people and the quality of services provided to individuals including in relation to inequalities (s. 26A).

Note: in addition to the health inequalities duties, the **public sector equality duty (PSED)** applies to NHS bodies in relation to both functions and workforce and prescribes characteristics to be considered (i.e. protected characteristics).

NHS England will be publishing a reference document on the two sets of duties, which will replace the 2015 Guidance for NHS commissioners on equality and health inequalities legal duties

New duties on information about inequalities

New requirements to publish inequalities data for ICBs, Trusts and Foundation Trusts

- **NHS England must publish a statement** about use of information on inequalities in access and outcomes, setting out the powers available to bodies to **collect, analyse and publish** such information, and views about how the powers should be exercised (s. 13SA).
- **NHS bodies should publish annual reports** describing the extent to which NHS England steers on inequalities information have been addressed

The opportunity

This is a lever to **drive more complete and better-quality data collection** and **increase transparency** on progress tackling health inequalities in the long run

How information about inequalities should be used

Understanding general healthcare needs

Adopt a population health management approach, underpinned by working with people and communities

Build from Joint Strategic Needs Assessments

Understanding healthcare access, experience and outcomes

Collate, analyse and publish information set out on the Statement.

- small number of already available indicators
- disaggregated by a limited number of variables where available (mainly age, sex, ethnicity, deprivation)

Publication within or alongside annual reports

Accessible format

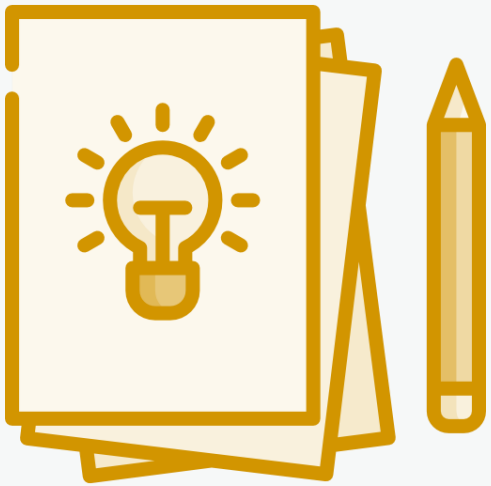
Distil key messages and explain what the data is saying

Informing service improvements and reductions in healthcare inequalities

Use data to inform service improvements, e.g. through changes to resource allocation

Encouraged to collect, analyse (and publish) other information

Role and opportunities for the board



Health Inequalities – Role of Leadership & Leaders

[Ambulance Services helping to reduce Health Inequalities - aace.org.uk]

Actions to consider: The five priorities for healthcare inequalities improvements

These were originally set out in March 2021 priorities and operational planning guidance and continue in the latest planning guidance.

Priority 1: Restoring NHS services inclusively:

- How is the ambulance service working with their local acute trusts in relation to HIU service?
- How can the ambulance service support the HIU service?
- What does the clinical pathway look like for those frequent attenders to A&E?
- How can the service embed our core domains for action on inclusion health set out in the inclusion health framework?

Priority 2: Mitigating against 'digital exclusion':

- NHS 111, telephone options – how can the ambulance service ensure the principles of the NHS digital inclusion framework are embedded in how the service operates?

Priority 3: Ensuring datasets are complete and timely:

- LAS, making demonstrable progress, practice on ethnicity coding - what is the current picture on ethnicity coding across services, what additional support is needed?
- What examples are there already on data and links to public health, and population health? What do we already know about the populations you serve?

Priority 4: Accelerating preventative programmes:

- Core20PLUS5 adults, CYP – implications for the Consensus Statement mapping?
- What are the opportunities for Making Every contact Count? What opportunities arise e.g. BP checks, lipids checked, learning from the Fire Service safe and well checks, falls prevention, links to VCSE and social prescribing link workers?

Priority 5:Strengthening leadership and accountability:

- Named exec lead in place?
- Production of HI plan by the end of June

Thank You

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We have provided, and continue to develop a range of resources and support to inform action on our strategic priorities and the Core20PLUS5 approach

Structured programmes

- Core20PLUS Connectors
- Core20PLUS Ambassadors
- Health Inequalities Finance Fellows
- School4Change Agents

Facilitated networks

- Emerging leaders network
- Health inequalities forum (SROs)
- Health inequalities network (clinicians)

Frameworks and guidance

- Statement on information on inequalities
- Framework for NHS action on digital inclusion
- Framework for NHS action on inclusion health

Accessible E-Learning

- Core20PLUS5 modules
- Health inequalities and inclusion health intro
- Sickle Cell Disease
- Finance eLearning
- Intersectionality (March 24)

Tools and resources

- Innovation for health inequalities (InHIP) toolkit
- NHS Providers support package
- NHS Confed leadership toolkit
- NHSE place based allocation tool
- HFMA ICB finance and health inequalities toolkit
- Tackling inequalities in access, experience and outcomes: actionable insights
- Healthcare Inequalities Improvement Dashboard and supporting data tools
- Core20PLUS5 handbook
- Leadership resources, including elective care case studies, board performance reporting deep dive, High Intensity Use HIU resources
- Health inequalities: improving accountability in the NHS

FutureNHS

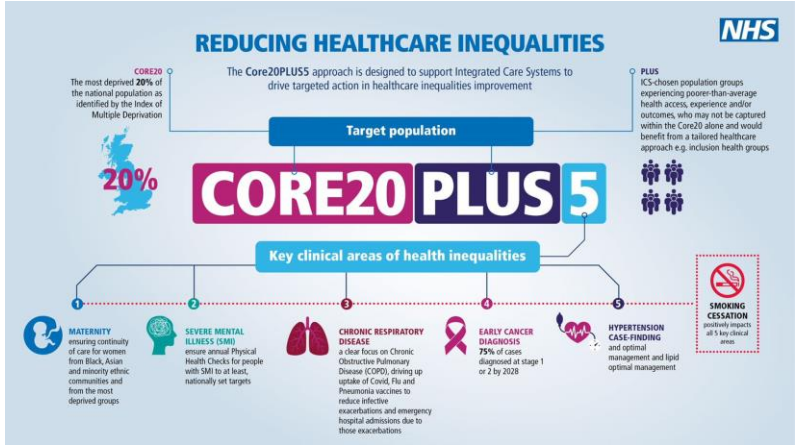
Healthcare Inequalities Improvement Programme NHS Futures Pages

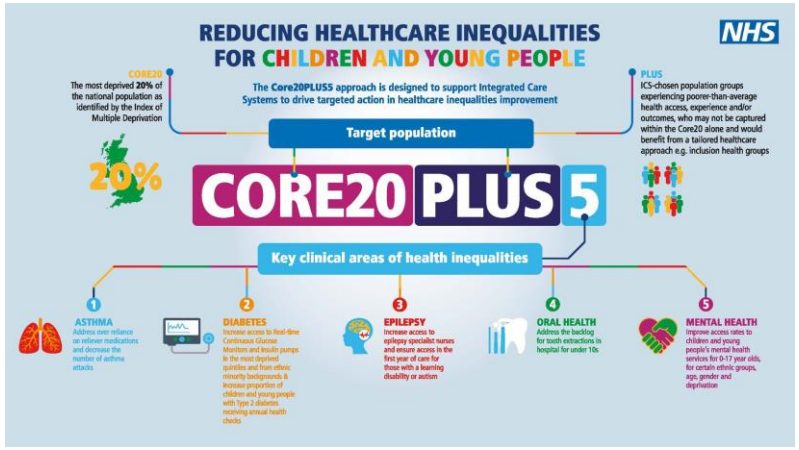
The Core20PLUS5 approach

Core20PLUS5 adults: We introduced the Core20PLUS5 as a framework to support systems to focus on clinical priorities where the NHS can address the social gradient in the most common cause of death, and stark inequalities faced by other groups.

Core20PLUS5 children and young people: Similarly focuses on inequalities in disease areas where the NHS can make a specific contribution that will complement the work of wider partners

Core20PLUS5 ecosystem
The Core20PLUS5 approach is supported by people – both professionals and those with lived experience – appointed to help to encourage change





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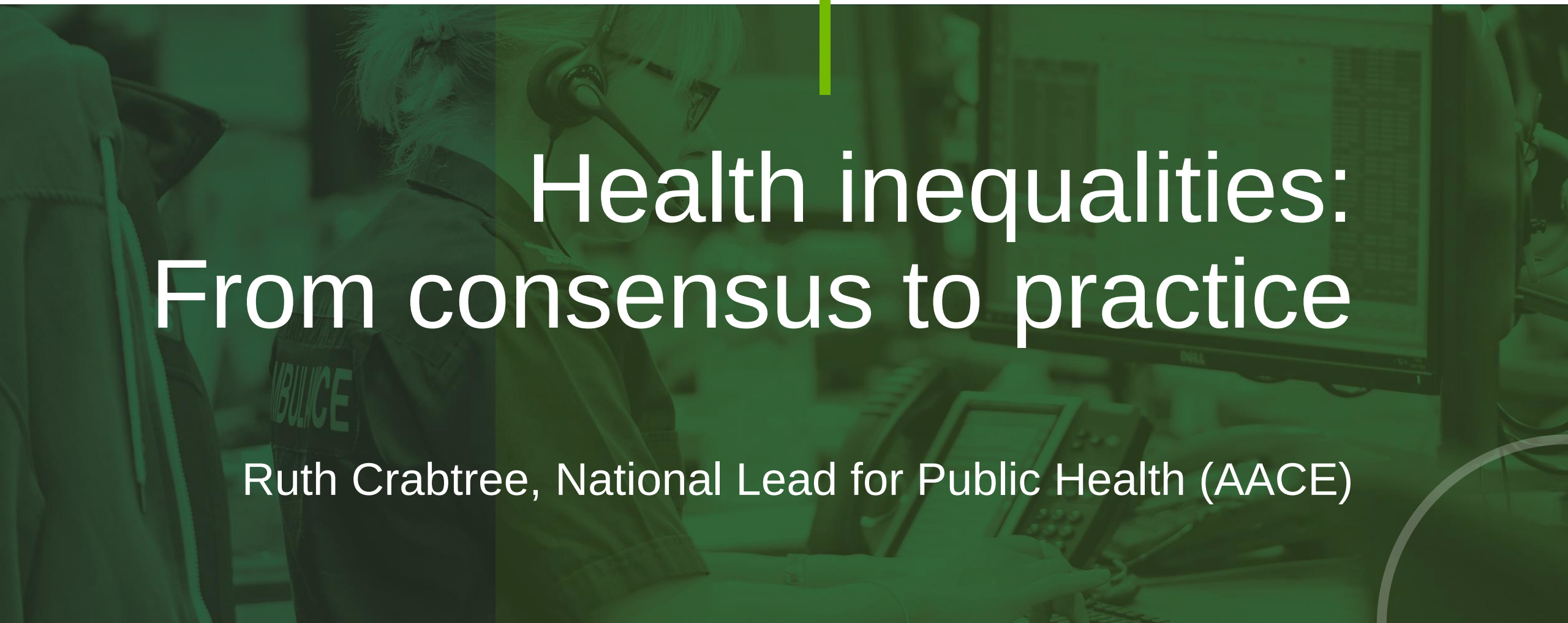
Bringing together skills, expertise and shared knowledge in UK ambulance services



Health inequalities: From consensus to practice

Ruth Crabtree, National Lead for Public Health (AACE)

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National consensus statement

Bringing together skills, expertise and shared knowledge in UK ambulance services

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What does this mean in practice?

This framework maps the core purposes of Integrated Care Systems to the key areas of focus for the ambulance sector in terms of reducing health inequalities together with the organisational enablers that will support this approach to be embedded.

ICS core purposes	Improve outcomes in population health and healthcare inequalities	Tackle inequalities in outcomes, experience and access	Enhance productivity and value for money	Help the NHS support broader social and economic development	
Key areas of focus for the ambulance sector	Reducing inequalities in healthcare access, experience, and outcomes delivered by the ambulance service		Reducing inequalities in the social determinants of health, enhancing the role of the ambulance service as an anchor organisation		
Enablers at Trust level	Systems partnerships	Data, insight, evidence & evaluation	Strategic leadership & accountability	Building public health capacity & capability	
Key supporting public health approaches	Population approach	Data & evidence	Prevention focus	Wider determinants & a focus on reducing inequalities	Collaborative partnership approach

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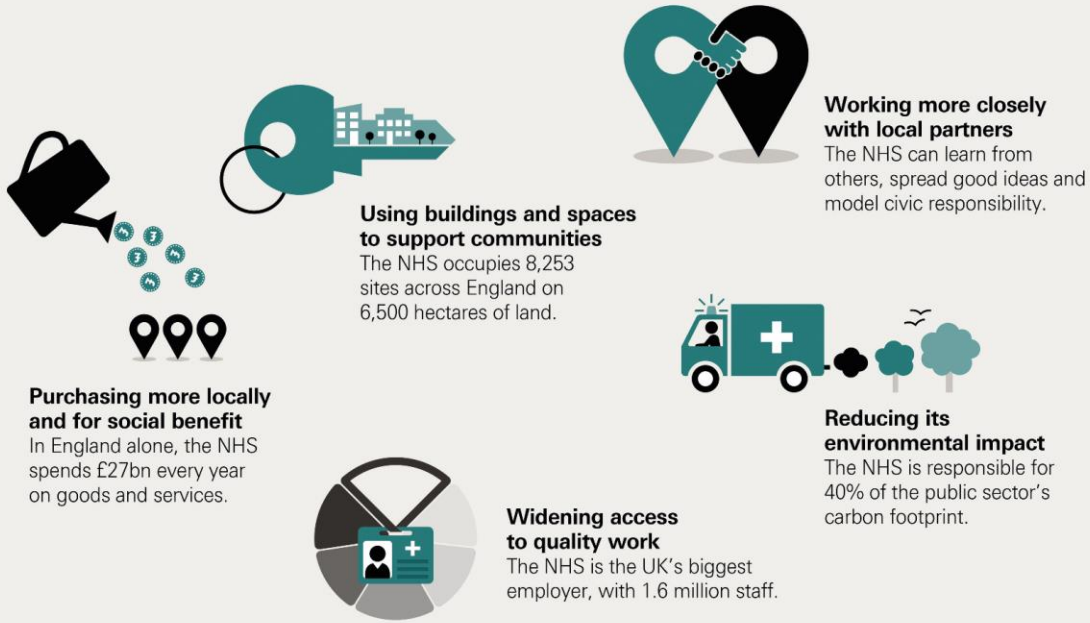
Reducing inequalities in the social determinants of health

What makes the NHS an anchor institution?

NHS organisations are rooted in their communities. Through its size and scale, the NHS can positively contribute to local areas in many ways beyond providing health care. The NHS can make a difference to local people by:



Working more closely with local partners
The NHS can learn from others, spread good ideas and model civic responsibility.

Using buildings and spaces to support communities
The NHS occupies 8,253 sites across England on 6,500 hectares of land.

Purchasing more locally and for social benefit
In England alone, the NHS spends £27bn every year on goods and services.

Reducing its environmental impact
The NHS is responsible for 40% of the public sector's carbon footprint.

Widening access to quality work
The NHS is the UK's biggest employer, with 1.6 million staff.

As an anchor institution, the NHS influences the health and wellbeing of communities simply by being there. But by choosing to invest in and work with others locally and responsibly, the NHS can have an even greater impact on the wider factors that make us healthy.

The Health Foundation

References available at www.health.org.uk/anchor-institutions

What makes the NHS an anchor institution?

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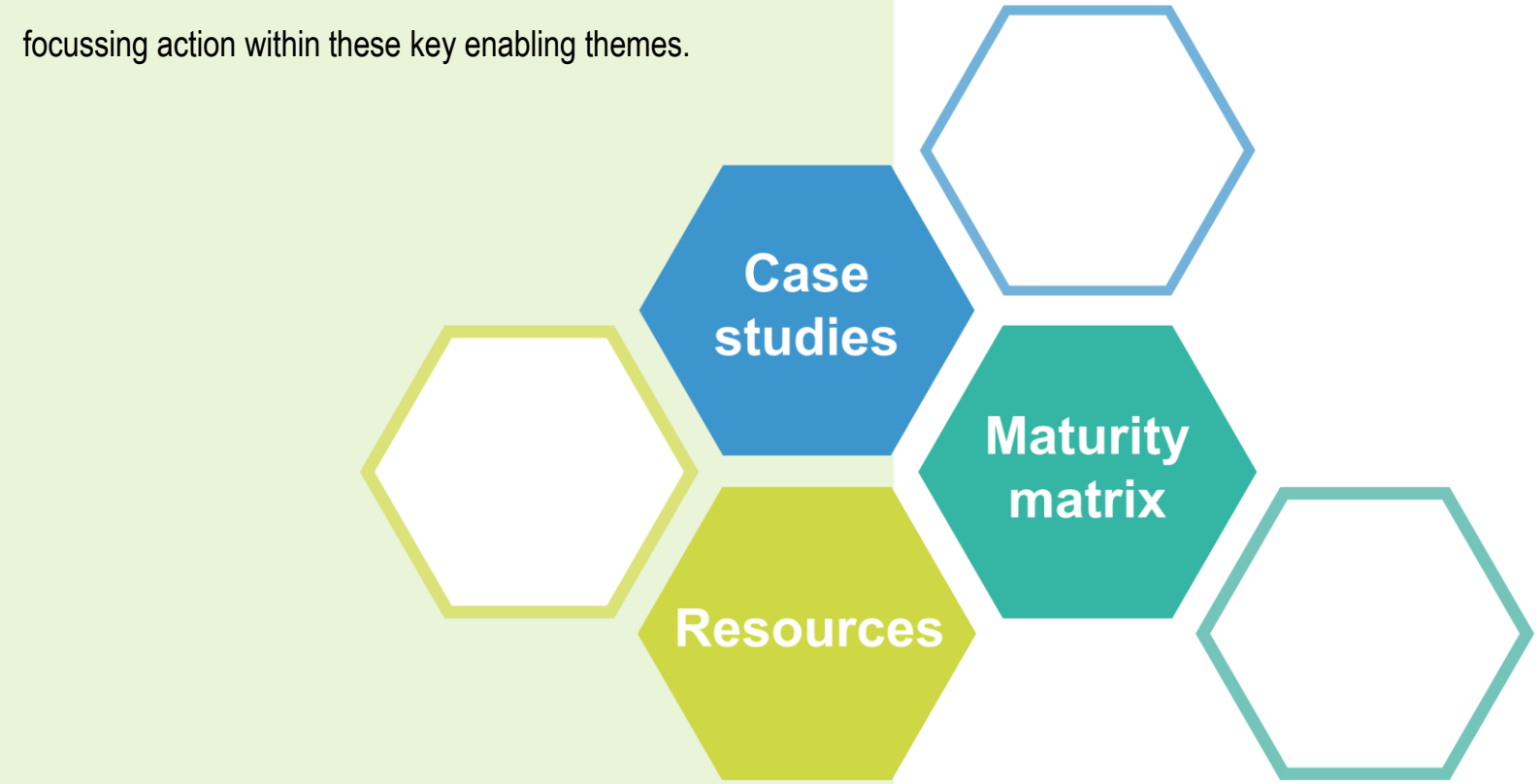
Developing the enablers

As outlined, a series of enablers have been identified that will support the embedding of approaches to reducing health inequalities into the culture of ambulance service working practices.

The key enablers that support organisations to reduce health inequalities are:

- Building public health capacity and capability
- Data insight, evidence and evaluation
- Strategic leadership and accountability
- Systems partnerships

The implementation toolkit looks at each of these in detail and provides practical resources to assist Trusts in guiding and focussing action within these key enabling themes.



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Take home messages

- The sector has more to learn
- Find out what is happening in your Trust – are you challenging your organisations to think differently?
- Use your maturity matrix results to identify other areas in which you can develop

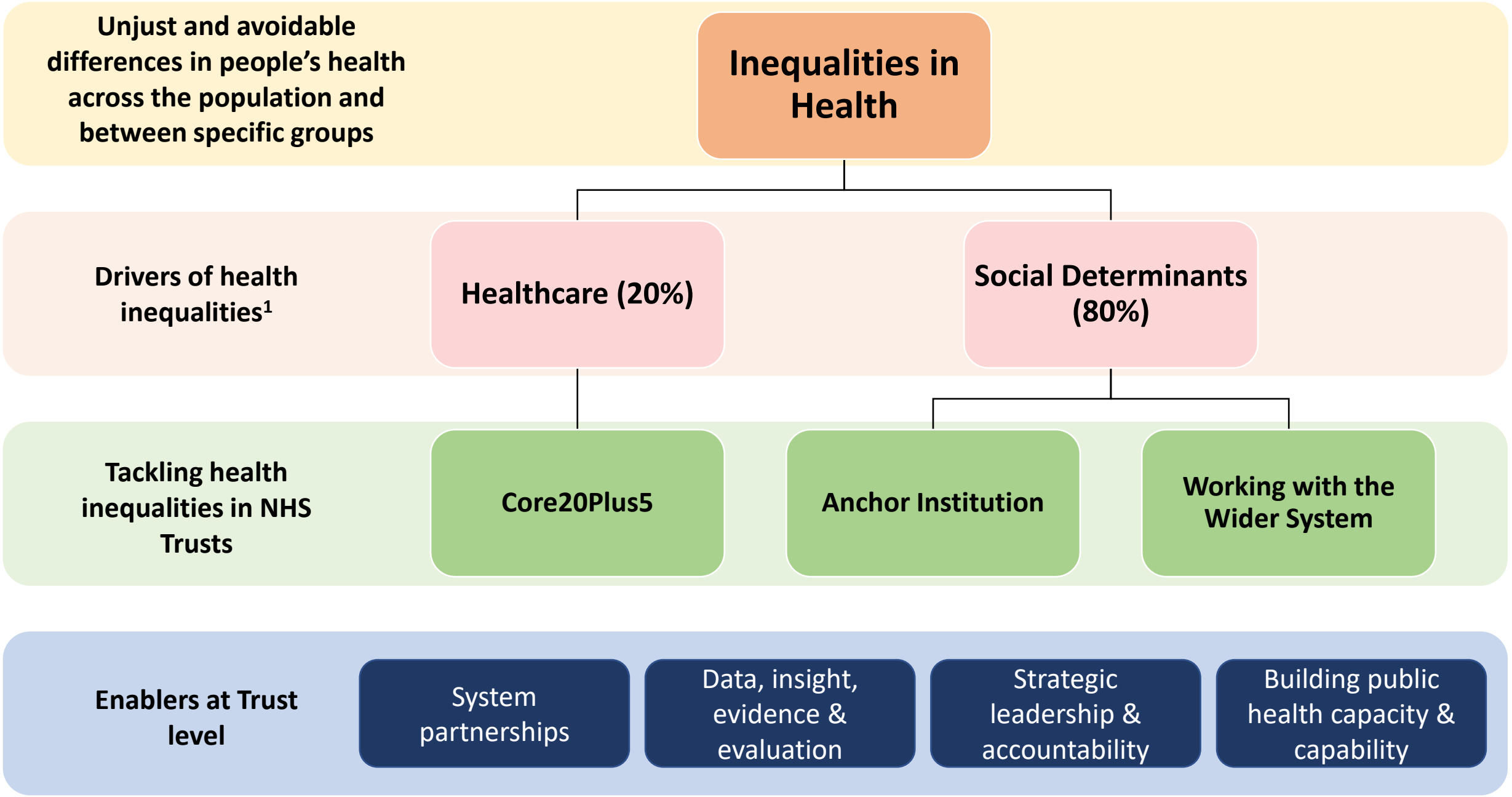
The role of Ambulance Trusts in tackling health inequalities

Rachael McKeown
Policy Advisor (Health inequalities)
NHS Providers

Christine Camacho
Public Health Registrar
Northern Care Alliance NHS FT

Overview

- Setting the scene
- Reducing health inequalities – a guide for NHS trust board members
- What does good look like
- Reflections from NHS Providers

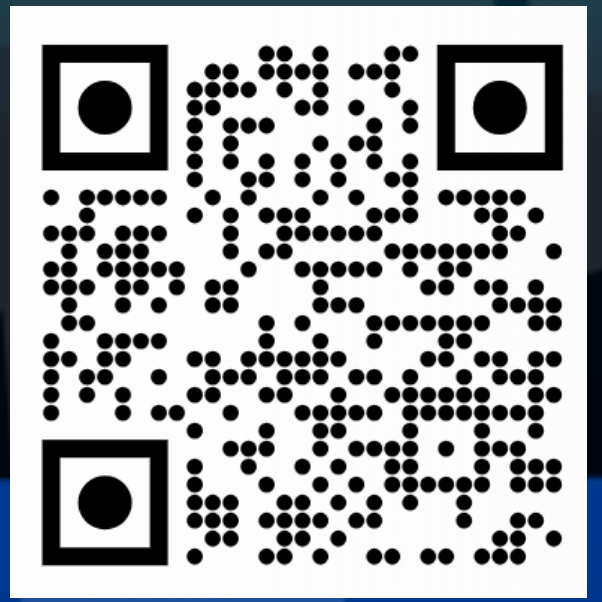


1. Source: Institute for Clinical Systems Improvement – Going Beyond Walls: Solving Complex Problems (2014)

Why is this an important issue for ambulance trusts?

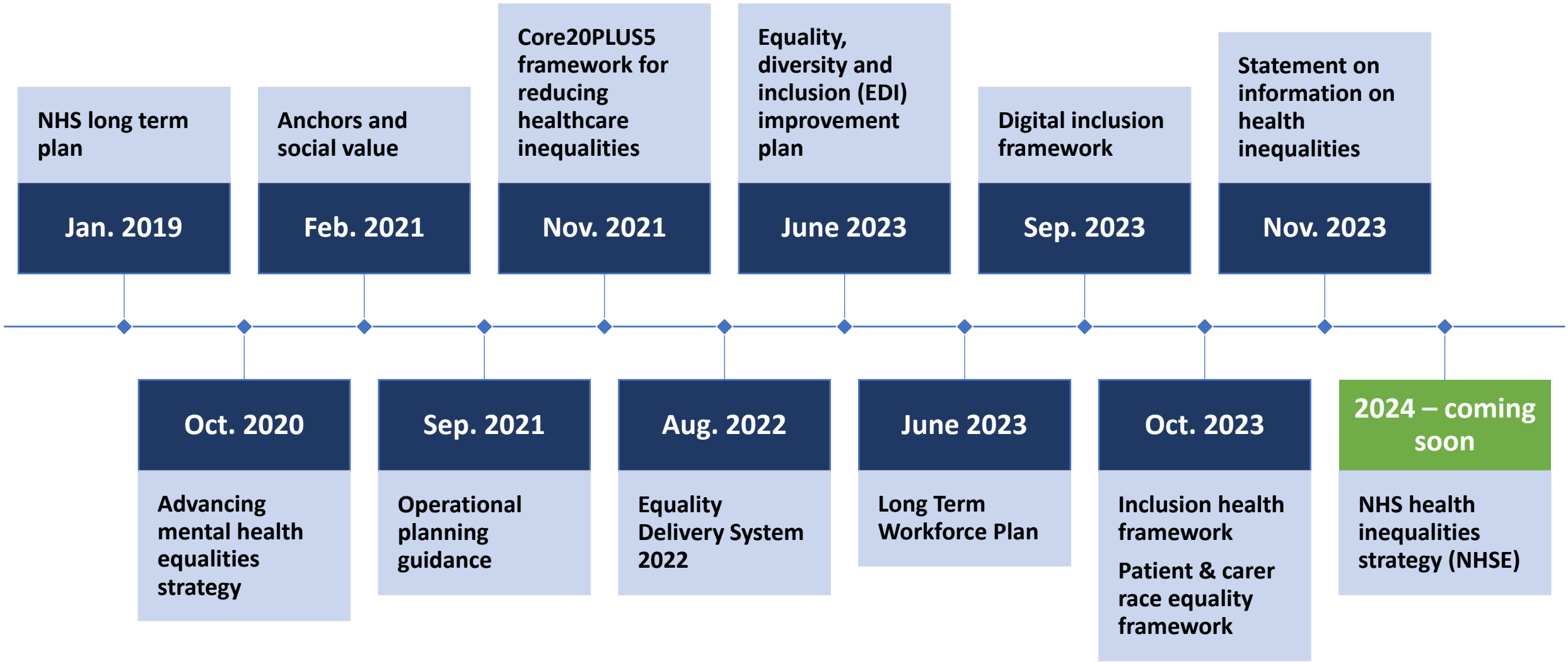
- Trusts have a legal duty to consider health inequalities
- Reducing health inequalities is a leadership expectation for board members
- Access, experience and outcomes are variable, its within our gift to improve this. Moral obligation.
- Enabler to achieving the triple aim by improving operational and financial performance, patient safety and experience.
- Opportunity to prevent further ill health, particularly for those who primarily use urgent and emergency care to manage health.
- Larger anchor organisations – preventing ill health in the longer term.

REDUCING HEALTH INEQUALITIES: A GUIDE FOR NHS TRUST BOARD MEMBERS



March 2024

Health inequalities policy & guidance

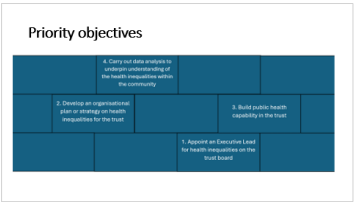


What is the guide?

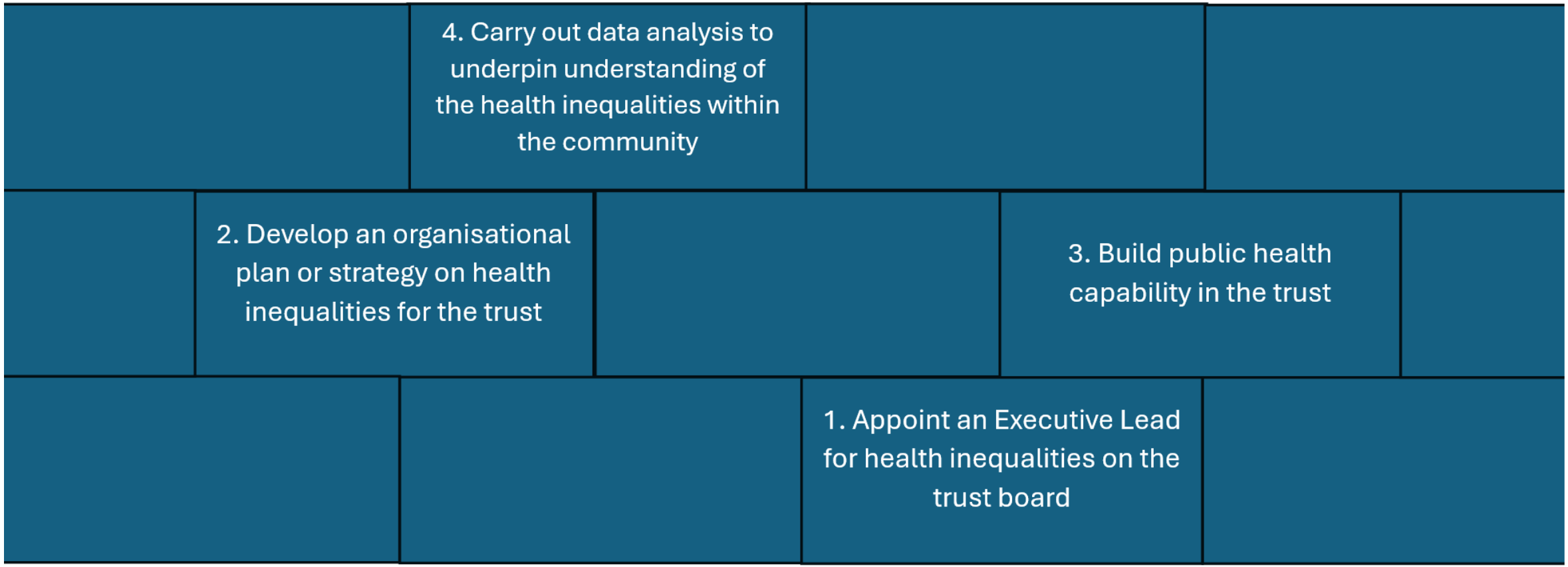
- Outlines roles and responsibilities for NHS board members in addressing health inequalities
- Aim is to enable an environment that promotes tackling inequalities as business as usual within NHS trusts
- Provides a range of different actions that can be taken across portfolio areas of the trust board
- Includes a self-assessment tool
- Objectives are drawn from NHS England policy, guidance and good practice from the sector

Objectives

- Suggested objectives for NHS Trust board members to use to inform their workplans on tackling health inequalities.
- Trusts will be at different stages of maturity in relation to their health inequalities work.
- Board composition and executive portfolios will vary across Trusts.
- Objectives have been grouped into indicative areas of responsibility, but this is not intended to be prescriptive.
- SMART measures of progress should be defined for each chosen objective.
- 79 objectives in total to select from



Priority objectives



Ensure the board receives annual training on health inequalities, with priority for the board member appointed as executive lead for health inequalities. Training should be refreshed, as relevant, and provided in induction processes.

Develop opportunities and systems to encourage and enable staff to develop public health expertise across a range of roles.

Ensure opportunities are identified to invest in services that will prevent and mitigate healthcare inequalities and realise longer term benefits.

Work with the communications lead to review trust communications with patients (such as leaflets and letters) in response to the health literacy and digital literacy levels of your patient population. Refresh and update communications

Ensure all frontline staff have training and development opportunities in ‘Making Every Contact Count’. Training should be refreshed, as relevant.

Work with system partners to ensure the trust has pathways to engage with communities and local voluntary, community and social enterprise (VCSE) sector organisations.

Establish programmes to improve access to employment for those from deprived areas, underrepresented ethnic minority groups, those with protected characteristics and/or inclusion health groups in your trust.

Self-assessment tool

Percentage	Maturity Rating
0	Not started
1-24	Emerging
25-49	Developing
50-74	Maturing
75-100	Thriving

Health Inequalities Self-Assessment Tool

1 - Building public health capacity & capability		
1	Has your board received training and/or development on health inequalities?	○ Yes ○ No ○ Partial
2	Does your trust deliver regular training to all staff groups on health inequalities?	○ Yes ○ No ○ Partial
3	Has your trust delivered any quality improvement work or change programmes related to health inequalities?	○ Yes ○ No ○ Partial
4	Does your trust employ public health specialist staff and is the wider workforce encouraged to develop public health expertise?	○ Yes ○ No ○ Partial

Score & maturity rating for each domain

- Building public health capacity & capability
- Data, insight, evidence & evaluation
- Strategic leadership & accountability
- System partnerships

Emerging | Developing | Maturing | Thriving

Bespoke set of suggested objectives based on responses and maturity ratings

Self-assessment 2023/24

Theme	Score	Percentage Complete	Maturity Level
1 - Building public health capacity & capability	3	38%	Developing
2 - Data, insight, evidence and evaluation	5	36%	Developing
3 - Strategic leadership & accountability	9	50%	Maturing
4 - System partnerships	7	70%	Maturing

Plan 2024/25

Build public health capacity and capability

- All Board members to receive health inequalities training in 2024/25
- Public health consultant in post
- Introduction to health inequalities included in trust induction/EDI mandatory training

Strategic leadership and accountability

- Health inequalities implementation plan agreed by board
- Population health and health equity sub-committee re-established

Population health data, insight and intelligence

- Routine reporting at Board meetings of performance and outcomes data by ethnicity & deprivation
- Develop local metrics to monitor progress in addressing health inequalities over time

What does good look like?

Leadership

- The board has collective responsibility for championing and overseeing the reduction of health inequalities.
- Executive lead for health inequalities champions the agenda across the organisation.
- Executive lead is linked into broader system working on health inequalities
- The executive lead should be aware of regional and national work on health inequalities.

Strategy

- Overall commitment to reducing health inequalities in trust's organisational strategy
- Health inequalities in all major trust strategies, recognising that this is core business for the trust.
- Specific strategy or plan on health inequalities.
- Practical delivery plans and governance structures should be in place to support implementation.
- Clear actions and outcome measures.

Data, insight, evidence & evaluation

- EPRs should be optimised for population health analysis
- Data analysts have relevant training in population health.
- Data routinely available by deprivation, age, ethnicity and other relevant protected characteristics.
- Frontline staff understand the importance of accurately collecting and recording demographic data.
- The organisation able to demonstrate marked progress in data quality and completion, especially around ethnicity recording.

Building public health capacity & capability

- Public health team within the trust
- Dedicated resource on health inequalities, prevention, and health promotion
- Clinical staff have the knowledge and confidence to use data to better understand their services and address health inequalities.
- Opportunities for role development and progression
- Identifying training needs among the workforce and facilitating the training and learning for other staff members.

Reflections from NHS Providers

Rachael McKeown, Policy Advisor (Health Inequalities)

Questions, comments…

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Rachael McKeown

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Understanding the impact of health inequalities on our patients, our communities and our ambulance service

Verity Bellamy, Senior Public Health Analyst
Lewis Etoria, Senior Community Engagement Manager
Lesley Butterworth, Head of Nursing & Patient Experience

What is population health management?

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Using ambulance data for Population Health Management

NHS Yorkshire Ambulance Service NHS Trust

- PHM aims to:
  - shift from reactive to proactive, preventative care
  - use qualitative and quantitative data and insights to identify local ‘at risk’ cohorts and create the evidence base for the targeted action needed
  - can be used to target/examine health inequalities
  - means using a different approach and different skill sets, rather than following the way services have traditionally worked
  - driven by need and **not** by existing services

Why is ambulance data important for PHM?

NHS Yorkshire Ambulance Service NHS Trust

The missing link

Mental health, drugs, alcohol, self-harm, violence, suicide attempts…

Inclusion health groups e.g. homeless population

Primary care (QOF)

Ambulance data

A&E (ECDS)

Inpatient (HES & SUS)

In 2023 dealt with almost 800,000 patients

Over a third are not conveyed to hospital (288,000)

The missing link - mental health

Only convey 38% of mental health calls (31,000 in 2023 only seen by YAS)

Recorded prevalence

54,000 common mental health disorders QOF (2022/23)

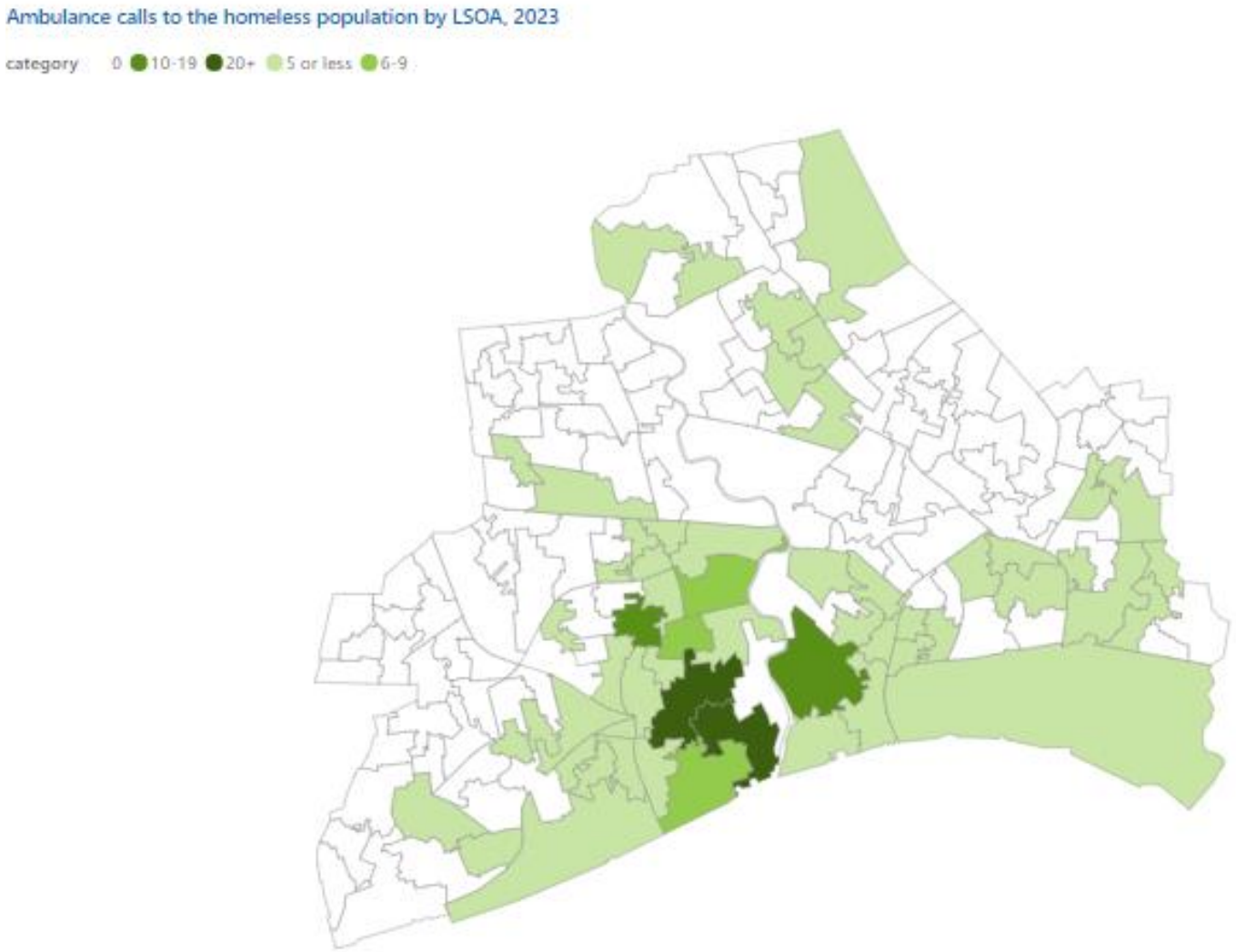
→

Ambulance calls

50,000 calls flagged as mental health (2023)

The missing link - PLUS populations

Yorkshire Ambulance Service NHS Trust



Policy drivers

- NHS England statement on inequalities
  - Sets out the information that in NHS England's view NHS Bodies should collect, analyse and publish as part of addressing inequalities
  - Are to be disaggregated by age, sex, deprivation and ethnicity.
  - **Are not currently relevant to the ambulance sector**

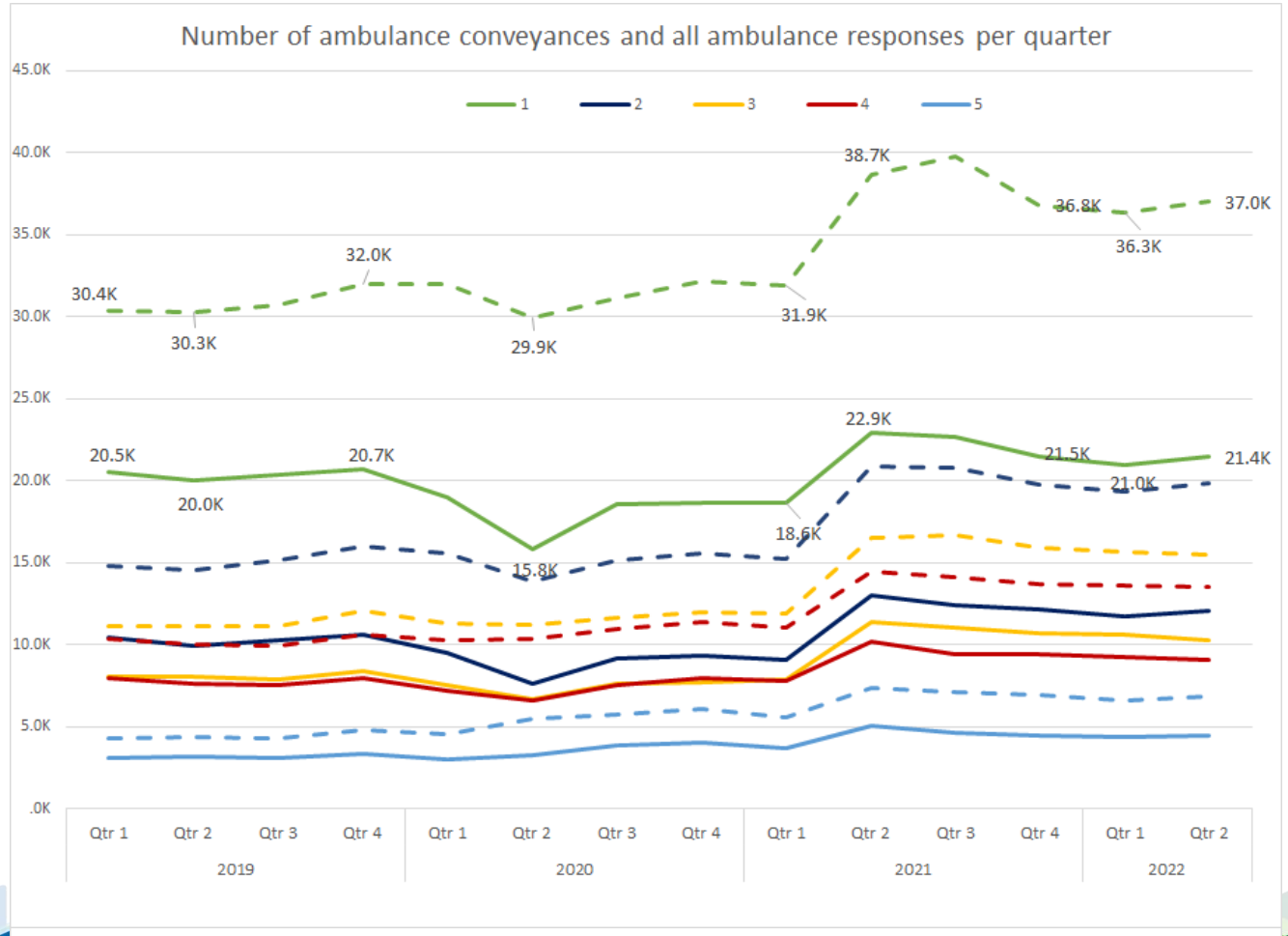
- Draft ICB Capability Assessment proposals
  - PHM is a core thread throughout
  - Use of population level data triangulated with community insights & patient voice to proactively identify & target most 'at risk' in local communities
  - System-wide, multi-disciplinary intelligence

<u>Significant opportunities to influence and support nationally and locally</u>

What could the ambulance sector do?

NHS Yorkshire Ambulance Service NHS Trust

- Use PHM to try to understand how health inequalities impacts what we do



What could the ambulance sector do?

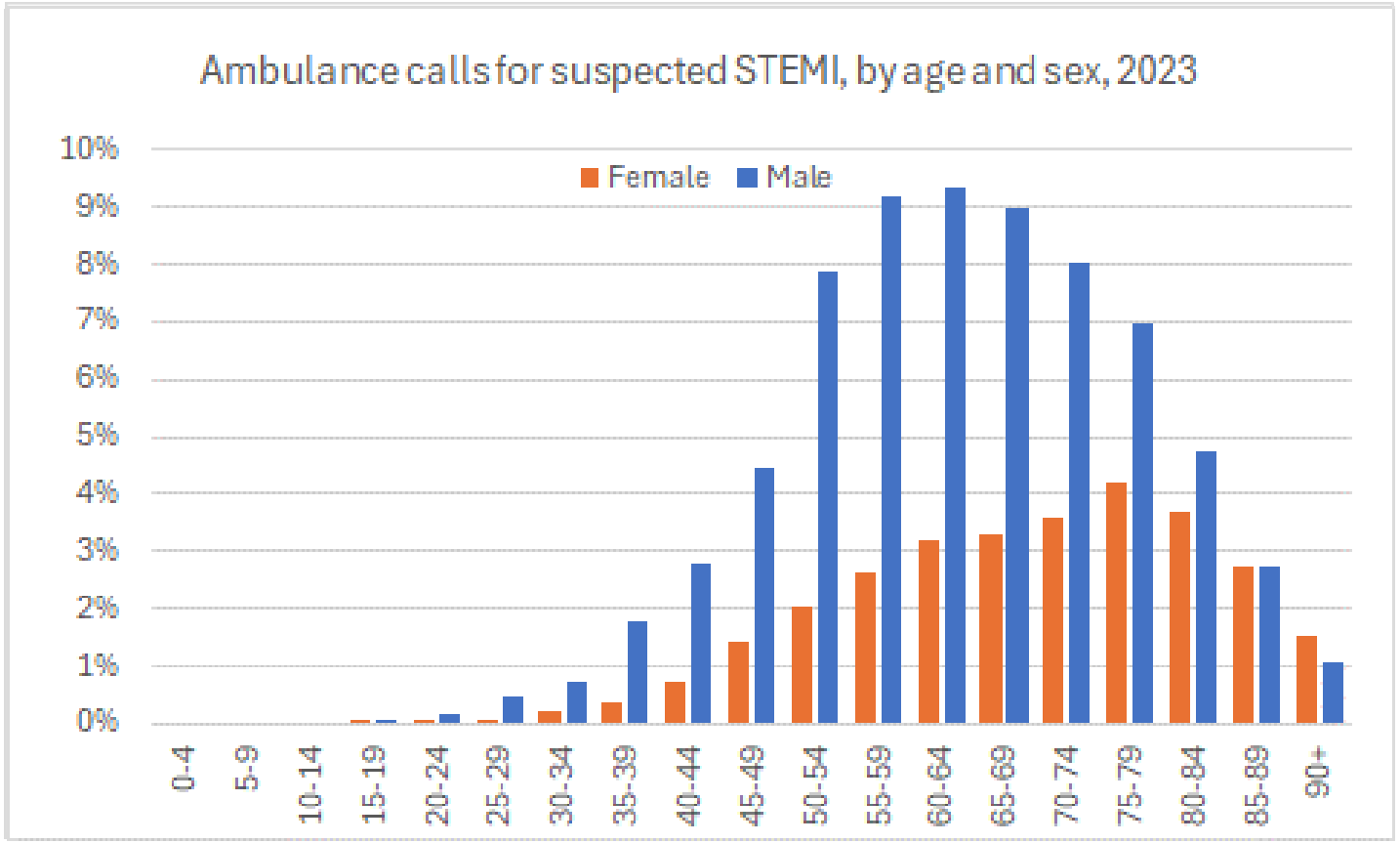
NHS Yorkshire Ambulance Service NHS Trust

- Use it as a lever to improve data quality

Ethnicity	Count	Proportion
Blank or unknown	334501	52.2%
White British	280387	43.8%
Asian British Pakistani	8169	1.3%
White - any other background	5329	0.8%
Other Ethnic Group	4308	0.7%
White Irish	1693	0.3%
Asian British Indian	1328	0.2%
Black British African	1127	0.2%
Mixed - any other mixed background	779	0.1%
Asian British - other background	663	0.1%
Black British Caribbean	644	0.1%
Black British - any other background	426	0.1%
Mixed White and Black Caribbean	419	0.1%
Asian British Bangladeshi	308	0.0%
Other Ethnic Group - Chinese	280	0.0%
Mixed White and Asian	264	0.0%
Mixed White and Black African	224	0.0%

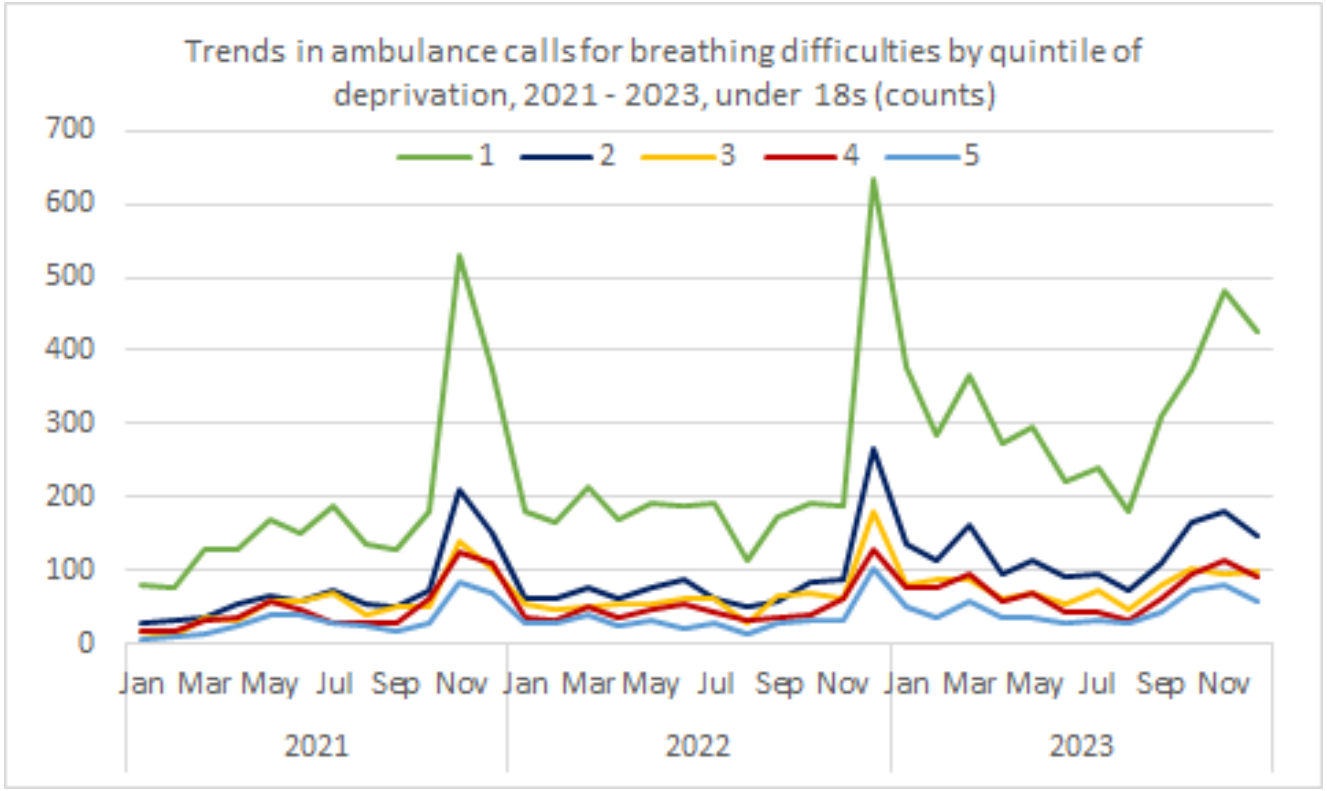
- Over half of our ethnicity field is currently blank or unknown
- This almost certainly masks inequalities in our population

By age and sex



Two thirds of calls for STEMI were for males (69%) and only 30% to females. The average age for an ambulance attendance for STEMI in males is younger (63) than females (69).

By deprivation



Rate of ambulance attendances for breathing problems in the most deprived group is more than 2.5 times that in the least deprived. Overall, about 45% of calls were from the most deprived quintile.

Respiratory repeat calls in the most deprived group

Number of calls	Number of patients
20+	9
10-19	39
9	9
8	17
7	24
6	38
5	66
4	94
3	255
2	782
1	4054

- There were 48 patients in the most deprived group who had had more than 10 ambulance calls between 2022 and 2023 for respiratory conditions
- These ‘high intensity users’ accounted for over 1000 calls over 2 years
- If we estimate each ambulance call costs £250 the estimated cost of these calls is over £250,000

So what?

- What can PHM inform within the ambulance service?
  - How & where we prioritise/target our work to have the biggest impact on health inequalities in a challenging financial environment
  - How we utilise our operational resource more effectively e.g. the positioning of Specialist Paramedics in Urgent Care to manage deterioration in respiratory conditions
  - A data-led approach to Patient/Community Engagement
  - New insights into learning from deaths

- The ambulance service is only part of the solution – <u>we must feed this information back to the wider system</u>

Turning data into insight & intelligence

- **Data** for the *what*, **patient & community engagement** for the *how* and *why*
- To understand the why and how of the impact, we need to talk to the people impacted
- This means very targeted engagement, based on gathering *insight from experience*
- It means engaging communities with common impacts, needs and barriers and not just individual patients
- For Inclusion Health groups this may mean dropping the greens and the expertise and working through the VCSE
- **We need to accept we don't know what we are going to hear and be willing to respond to what we do hear**

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Engaging rough sleepers in Hull

Engagement to understand a vulnerable population

Getting started

- We wanted to engage communities with complex needs who are likely to have different needs and experiences, but we didn't know where to start
- Limited ambulance data on service use by population group and no baseline of engagement to go on
- We worked with ICB colleagues across Yorkshire to see which population to start with
- Anecdotal feedback on ambulance calls in Hull to rough sleepers
- Data analysis indicated a small number of individuals with many repeat calls

Why this project and why this area?

- Homelessness - health outcomes; barriers to access; complex needs; emergency care use
- Little insight on ambulance service use by people at risk of rough sleeping
- Good links with agencies on the ground through the Changing Futures programme

Our approach

Voices of the street;

Exploring homeless experiences of Yorkshire Ambulance service NHS Trust

A findings report

healthwatch Kingston upon Hull

Produced in partnership with:

YORKSHIRE AMBULANCE SERVICE CHARITY

NHS Yorkshire Ambulance Service NHS Trust

- Commission VCSE
- Work with agencies on the ground
- Engage rough sleepers, our staff and local agencies
- Embed lived experience
- Focus on people's stories
- Experience of all YAS services

Who we spoke to

- Healthwatch Hull commissioned and linked with agencies on the ground
- 3 people with lived experience involved from outset
- 78 people experiencing homelessness
- 70 YAS staff
- 28 stakeholders

What do we know that we didn't know before?

- Some of our services are not accessible to people at risk of rough sleeping (PTS), or are difficult for them to access (111) - despite the engagement showing a need for both services
- Lack of clear pathways for rough sleepers who do not present with a clinical need – taking patients to ED as a place of safety
- Many issues for rough sleepers in ED means they often leave before being seen/treated when they have a clinical need – and we are then called out again
- Most 999 calls are from agencies/bystanders and can be clinical need or general concern
- Reluctance among rough sleepers to go to ED – starting to gain insights into why which will help with staff info/training
- The impact of mental health, complex trauma, alcohol and drugs needs to be understood

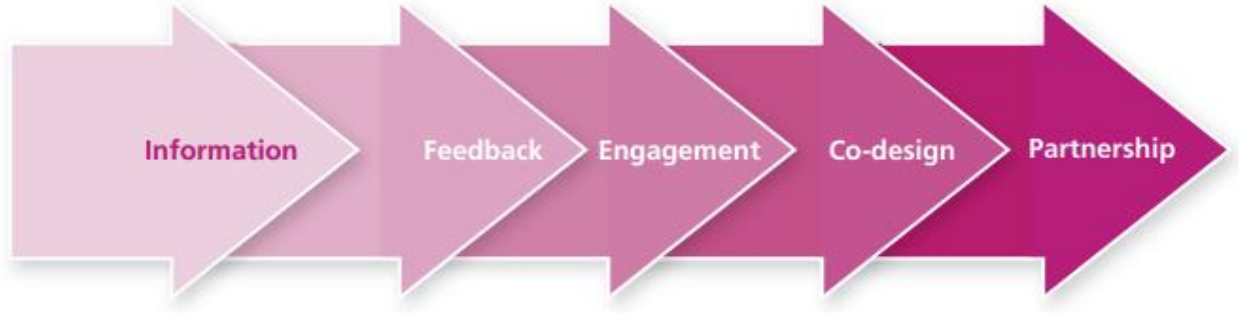
Patient Experience

NHS Yorkshire Ambulance Service NHS Trust

Defining 'experience'	An event or occurrence which leaves an impression on someone. (Oxford dictionaries 2021) In healthcare this would be what the process of receiving care feels like.

Defining 'patient experience'	'Patient experience' is what receiving care feels like not only for patients, but their families and carers to.

How do we capture experience



- Surveys/FFT
- Formal feedback
- Co-design
- Critical Friends Network

Why are complaints important?

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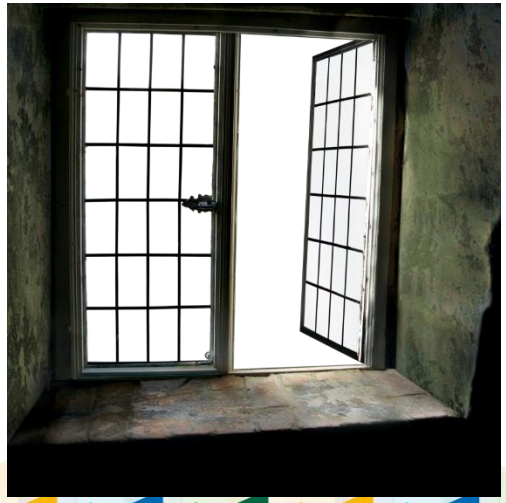
"A health service that does not listen to complaints is unlikely to reflect its patients' needs. One that does will be more likely to detect the early warning signs that something requires correction, to address such issues and to protect others from harmful treatment."

"A complaints system that does not respond flexibly, promptly and effectively to the justifiable concerns of complainants not only allows unacceptable practice to persist, it aggravates the grievance and suffering of the patient and those associated with the complaint, and undermines the public's trust in the service."

Sir Robert Francis, 2013



A new framework for Patient Experience

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Connecting our communities

Actively seeking opportunities to listen to our patients, carers and families about what matters most to them and ensuring that the voices of all our communities are heard e.g. proactive surveying, meetings held in communities

Insight

Utilise and strengthen patient experience data to determine areas for improvement, health inequalities and areas for further engagement. Data should be detailed and provide timely insight in order to make improvements

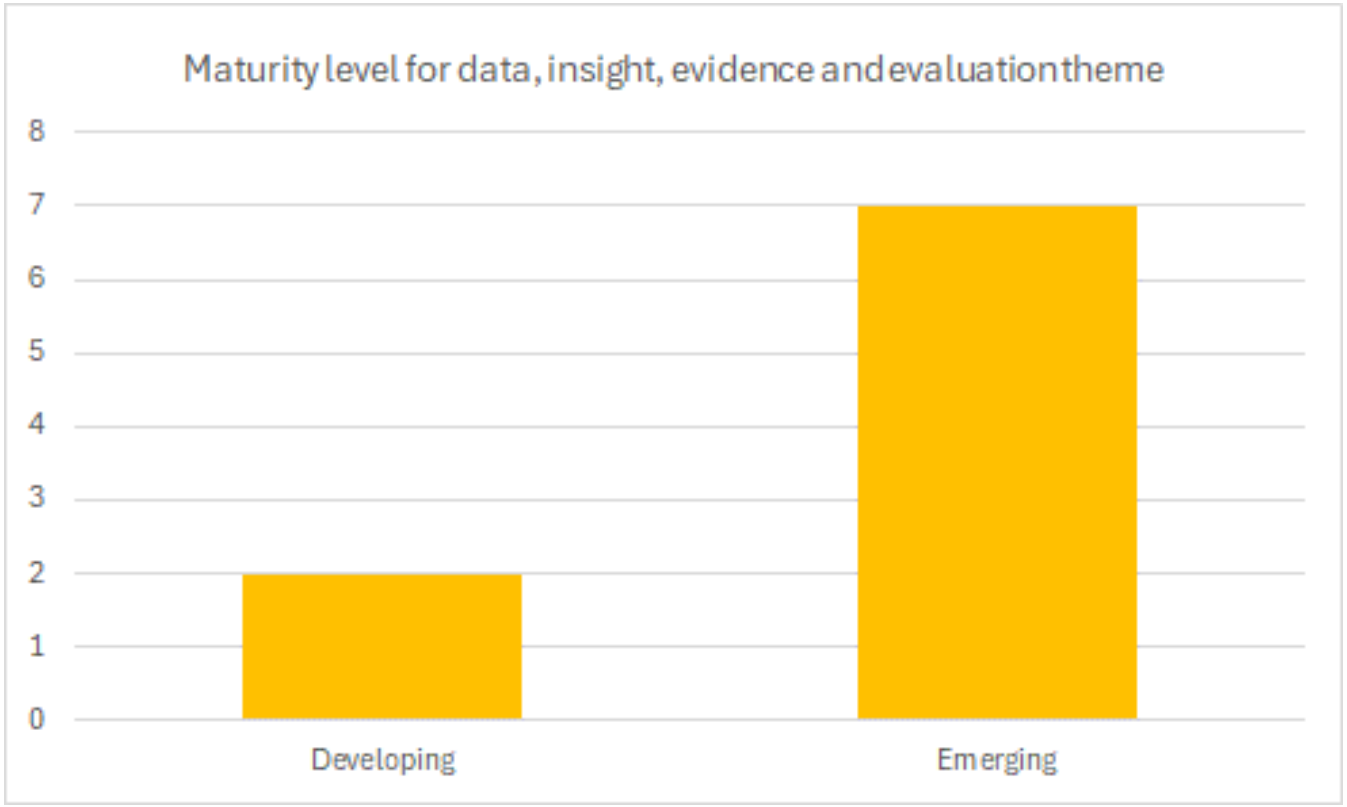
Co-production

Utilising the expertise of patients, carers and families experiences to design, produce and implement improvements to our services e.g. engagement with specialist groups such as people living with learning disabilities, people living with dementia

Integrated Patient Voice

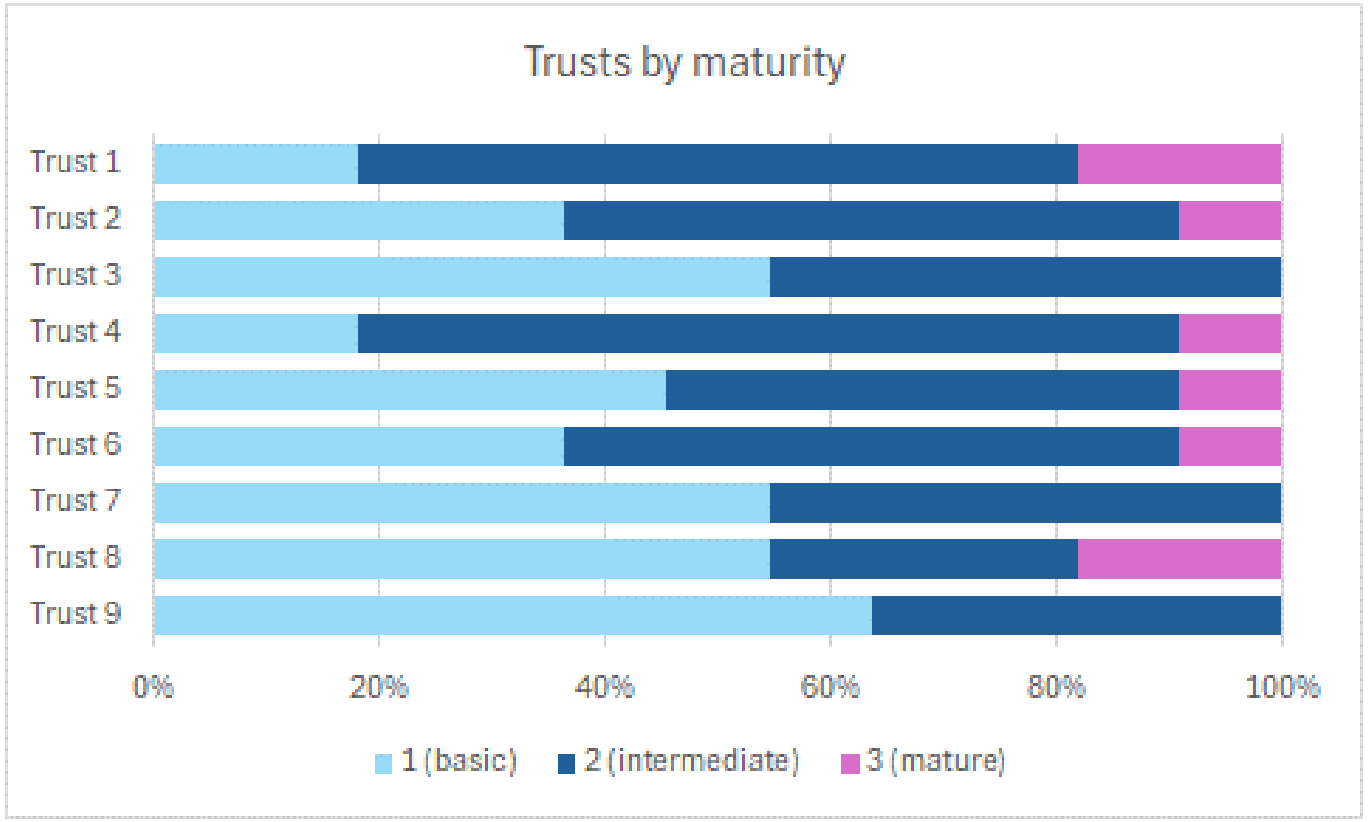
Working in partnership with patients, carers and families to ensure that their voices are represented and heard inside Yorkshire Ambulance Service. The aim is to improve patient experience by learning about people in our communities, listening to and acting on what patients tell us through a number of internal and external forums

Where are we now?



- Overall, the maturity of 7 Trusts was assessed as ‘emerging’
- 2 Trusts assessed as ‘developing’
- No Trusts have as yet reached ‘maturing’ or ‘thriving’

Summary by Trust (anonymised)



- All but three trusts had at least one response rated as ‘mature’
- There is no one Trust that is performing significantly better than the others
- There are pockets of good practice across the sector & a real opportunity to share & learn

What is my role as a Board member?

- The Board has a responsibility to ensure the delivery of high quality, equitable, person-centred care

- In order to make the changes that we say we want to see, we need to do things differently
  - Strategy
  - Re-purposing resource
  - Culture change
  - Authenticity
  - Developing mechanisms by which we truly hold our organisations to account

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Useful resources

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Useful resources

NHS England's National Healthcare Inequalities Improvement Programme

How to embed action on health inequalities into Integrated Care Systems: A practical guide to inform spending on health inequalities by NHS Confederation

Nowhere else to turn: A report exploring high intensity use of Accident and Emergency services by the British Red Cross

How ambulance services are helping to reduce health inequalities

Getting started as a health anchor

NHS Providers' resources on the role of NHS Trusts in reducing health inequalities

Reducing health inequalities: A guide for NHS Trust Board members by NHS Providers

NHS England's Statement on Information on Health Inequalities

Working in partnership with people and communities: Statutory guidance from NHS England

NHS England's patient experience improvement framework

Making patient experience a priority: A long read by the King's Fund

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Next steps

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Next steps

We are keen to keep the conversation going around this topic and would love to hear your views on what would be most helpful. Please email ruth.crabtree@nhs.net or hilary.pillin@aace.org.uk with any thoughts or suggestions.

We are also in conversation with NHS England, NHS Providers, NHS Confederation and the National Ambulance Commissioning Network to consider how they can support this agenda moving forwards.

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Bringing together skills, expertise and shared knowledge in UK ambulance services

If you have any feedback on the session or ideas about how AACE could further support the sector in progressing this agenda please email Ruth Crabtree, National Lead for Public Health (AACE) or Hilary Pillin, UEC Strategy Advisor (AACE).

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