Primary Care Needs Assessment tool: indicator review

Google Chrome is advised to ensure this page displays/ functions as intended.

ⓘ You are now reviewing the PCNA indicator(s) for: **Life expectancy/ healthy life expectancy**

ⓘ **Caution**: The information on this page is provided for testing purposes and may be subject to amendment. It may contain errors or not be fully reflective of consensus public health advice or relevant services, therefore should only be used with care.

Strategic context

ⓘ Consider the national strategic context for prioritising improvement action in this area (in conjunction with your health board's IMTP and Regional Partnership Board's Area Plan):

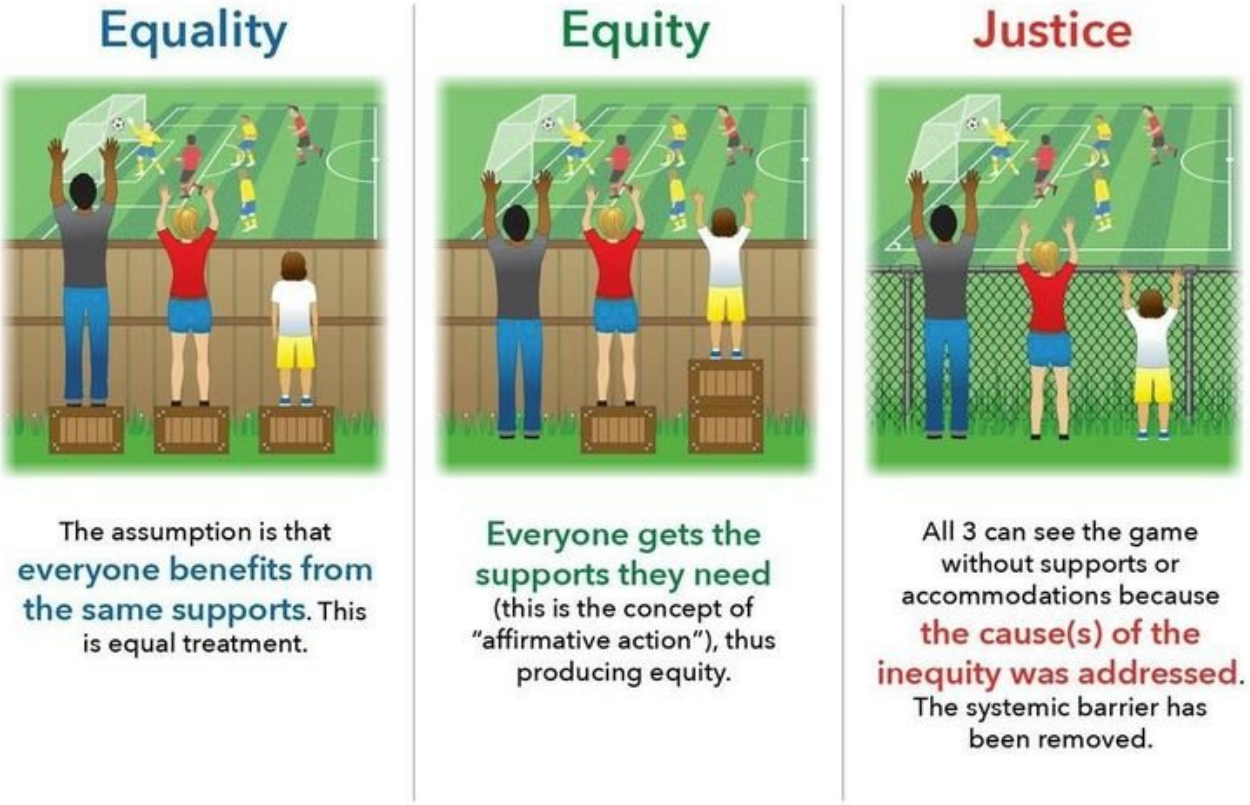
- Life expectancy (LE) refers to the average number of years an individual of a given age is expected to live if current age-specific mortality rates continue to apply.
- Health life expectancy (HLE) refers to the average number of years an individual of a given age is expected to live in good health, if current age-specific mortality rates continue to apply.
- *A healthier Wales* (Welsh Government 2018; link) notes large differences in healthy life expectancy, even for people who live in communities within a few miles of each other; it declares reducing inequality (with focus on prevention and health improvement) as key to sustainable development, wellness and well-being for future generations of the people of Wales.
- Gaps in LE and HLE (e.g. by sex and/ or deprivation status) are typically used, among other measures, as an overarching indication of health inequalities that can be monitored over time to assess the effectiveness of improvement actions.

▼ ⓘ Tell me about: Inequality and inequity

- **Variation** is a natural phenomenon and can be healthy. For example, it can be a deliberate result of innovation in primary care settings that seeks to test improvements in processes or deliver better care outcomes.
- Variation that is observed (or more precisely, measured) in a healthcare context may be referred to as **inequality** (inequalities exist in other contexts too, most notably in relation to the determinants of health; see WDH-001, WDH-002, WDH-003).
- Inequality that is judged to be both avoidable and socially unjust is termed **inequity**, which in healthcare is sometimes alternatively described as **unwarranted** variation.

- Delivering equality involves the same treatment irrespective of need, whereas equity is a form of justice that provides fair treatment, proportionate to need; another form of justice is "liberation"—negating any requirement for ongoing adjustment via removal or reduction of a universal barrier (see graphic: unknown illustrator, after an original by Froehle).

- See also POP-003, which includes an explanation of **progressive universalism** as an objective when reducing health inequalities, using the example of life expectancy and deprivation status.



STEP B

Improvement actions for GP practice cluster members

ⓘ Consider which of the following actions could be taken forward:

▼ **Reduce inequalities through provision of equity-informed clinical care**

- LE and HLE estimates are not available based on registration with a GP; however, appropriate care delivered via primary care professionals can have a role in helping to reduce them.

- *Tackling inequalities in general practice* (The King's Fund 2010; link) suggests the role of GPs in tackling inequalities includes tackling the conditions that cause illness; ensuring equitable access to GP practice services; acting to reduce rather than exacerbate inequalities; adopting a generalist

approach to service provision; acting as an advocate for patients and connecting them with local services; being aware of the needs of vulnerable groups; and taking a population-focussed view of the community (while balancing the patient perspective with population health goals).

▼ **Reduce inequalities through emphasis on the determinants of health**

- *Doctors for health equity* (WMA 2018; link) refers to a growing body of evidence that doctors working at all levels can impact health inequity through action on the social determinants.
- The WMA report calls on doctors to incorporate the social determinants of health into their everyday practice and broader societal roles and provides a large number of suggestions for action, covering education and training; monitoring and evaluation; working with individuals and communities; as employers, managers and commissioners; working in partnership; and as advocates.

▼ **Ensure awareness and implementation of NICE quality standards**

- *Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups*. Quality standard [QS167] (Published date: May 2018) sets out six quality statements, any of which could form a focus for collective local improvement action. This quality standard covers promoting health and preventing premature mortality among black, Asian and other minority ethnic groups. It is relevant to all age groups and all settings.

Improvement actions for wider cluster members

ⓘ Consider which of the following actions could be taken forward:

▼ **Monitor time trends in local area LE and HLE gaps**

- LE and HLE estimates are available at health board and local authority level and may be a useful proxy indicator for monitoring the longer-term effectiveness of local collaborative action to reduce inequalities.

▼ **Reduce inequalities through proactive community engagement**

- NICE define community engagement as "a range of approaches to maximise the involvement of local communities in local initiatives to improve their health and wellbeing and reduce health inequalities. This includes: needs assessment, community development, planning, design,

development, delivery and evaluation." (see NG44, below).

- *Tackling inequalities in general practice* (The King's Fund 2010; link) notes that many of the recommendations about the role of GPs in tackling health inequalities are about engaging with community development [engagement]—something many will have little experience of. The wider cluster membership may be better positioned to support GP practices in this activity.

- *Health and wellbeing: a guide to community-centred approaches* (PHE 2015; link) outlines a 'family of approaches' for evidence-based community-centred approaches to health and well-being.

▼ Learn from evaluation of inverse care law programmes

- *Building a healthier Wales* (Feb 2019) describes the importance of learning from evaluation of the inverse care law programmes underway in Aneurin Bevan and Cwm Taf UHBs, to ensure that wider implementation maximises population outcomes; delivers value for money; utilises quality improvement techniques in order to minimise the decay between identification and optimal management; and adopts minimum standards and a minimum data set.

▼ Improve the sustainability of primary care to increase attention on inequalities

- *Health inequalities* (RCGP 2015; link) states that, at the heart of the community, general practice has a pivotal role to play in combatting the causes of health inequalities and dealing with their effects. The report states this role requires the means to undertake both proactive and reactive care, supported by a wider integrated health and social care system, but identifies sustainability and other constraints that inhibit this ambition. RCGP advocate six supporting actions:

- 1. As part of measures to increase the overall size of the GP workforce, put in place incentives to attract more GPs to currently under-doctored areas, ensuring that there is sufficient GP workforce capacity in areas where patient need is highest.

- 2. As part of a wider rebalancing of resources towards general practice, direct more NHS funding into GP and wider primary care services in those areas where health inequalities are currently worst.

- 3. Ensure that the process of piloting and delivering new models of care integrated around patients in each of the four nations of the UK serves to tackle, rather than exacerbate, health inequalities.

- 4. Create a supportive environment for GPs and their teams to take a more proactive population-based approach to preventing ill health in their communities, working with other professionals to tackle the underlying causes of health inequalities. However, this cannot be taken forward without an increase in workforce capacity and resources, and must be led by GPs and other professionals from the bottom-up, rather than through imposing top-down interventions.

- 5. Focus on incentivising ways of working that promote continuity of care in areas where patients would benefit most from a continuous therapeutic relationship with their GP—particularly areas where a high number of patients are living with multiple morbidities.

- 6. Fund outreach programmes to help often excluded groups such as those with mental health

problems, learning disabilities and the homeless to access general practice.

▼ **Ensure awareness and implementation of NICE guidance/ quality standards**

- *Community engagement: improving health and wellbeing and reducing health inequalities*. NICE guideline [NG44] (Published date: March 2016) includes recommendations suitable for a broad audience. This guideline covers community engagement approaches to reduce health inequalities, ensure health and well-being initiatives are effective and help local authorities and health bodies meet their statutory obligations.

- *Community engagement: improving health and wellbeing*. Quality standard [QS148] (Published date: March 2017) sets out four quality statements, any of which could form a focus for collective local improvement action. This quality standard covers community engagement approaches to improve health and wellbeing and reduce health inequalities, and initiatives to change behaviours that harm people's health. This includes building on the strengths and capabilities of communities, helping them to identify their needs and working with them to design and deliver initiatives and improve equity.

- *Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups*. Quality standard [QS167] (Published date: May 2018) sets out six quality statements, any of which could form a focus for collective local improvement action. This quality standard covers promoting health and preventing premature mortality among black, Asian and other minority ethnic groups. It is relevant to all age groups and all settings.

▼ **Use levers to reduce inequality when implementing new models of care**

- *Reducing health inequalities through new models of care: a resource for new care models* (IHE 2018; link) recommends a number of strategic, system and resource levers (detailed in the report) to reduce inequality:

- Strategic levers comprise organisational culture and leadership with a clear focus on health inequalities; equality and health inequalities (EHI) impact analysis; and evaluations for health inequalities.

- System levers comprise contract design and the Social Value Act (2012); and social prescribing.

- Resource levers comprise sharing, linking and integrating information; collaborations for service delivery partnerships; multi-disciplinary teams; workforce; equitable access to services—care homes; and equitable access to services—technology.

What is happening in Wales?

ⓘ Consider whether shared learning/ local experience might guide your own implementation of the evidence:

▼ **Placeholder project description**

- *What problem was being addressed?* Placeholder.
- *What was done to address it?* Placeholder.
- *How does this evidence good practice?* Placeholder.
- *What key learning can be shared?* Placeholder.
- *Who did it or who can be contacted in the event of queries?* Placeholder.

ⓘ Have something to share? Please let us know here.

ⓘ **Caution**: Any text entered into the following sections will not be saved if you navigate away from this page, or close the browser window before selecting PRINT.

What do you know about community views on this?

ⓘ Consider any relevant citizen/ community voice information (e.g. from surveys, complaints, engagement events, or your health board's well-being or population needs assessments). Summarise this into the following box:

What assets or partnership opportunities can you identify?

ⓘ Consider any relevant local assets or potential partner organisations that might facilitate co-production. Summarise this into the following box:

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STEP G Do you need more data before making a decision?

ⓘ If relevant, consider any additional data (or information) requirements that might ensure a more informed decision on determining action. Summarise this into the following box:

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STEP H What is your provisional decision?

ⓘ Having reviewed indicator data on local needs and considered evidence-informed quality improvement options, please record initial thoughts on proposed actions. You may also wish to record related thoughts around potential service models, capacity requirements, workforce development or financial considerations. Ideally, discuss these with both the wider cluster and with your local public health team (LPHT). Summarise your proposals for action into the following box:

Type here

ⓘ Now PRINT this page (e.g. to PDF) so you have a record of your entries (Steps E-H). You may then close the Print view browser window and return to the PCNA workbook to review another indicator.