NHS
Leeds
Clinical Commissioning Group

Health Inequalities

Our Framework for Action

March 2020

Health Inequalities
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1. Introduction

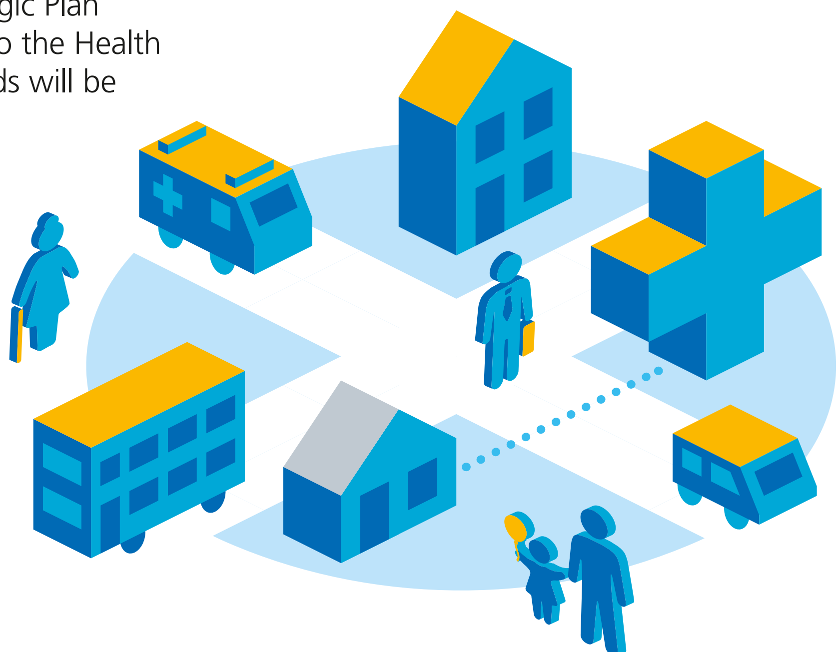
For many years, the NHS has worked with partners to tackle health inequalities. Indeed, CCGs, like PCTs before them, have a legal duty to respond to inequalities in the health of their populations, both in terms of access to services and outcomes on life expectancy. For most of the 20th Century, the life expectancy and health experience between the least healthy people in society and the healthiest has narrowed, largely due to the impact of the economy, public health initiatives and the availability of high quality care for all delivered through the NHS.

However, in more recent times this gap is widening. There is significant speculation about why this is happening, though there is evidence that the changing nature of communities, immigration, the increasing wealth of the healthiest and, most significantly, the impact of austerity have all contributed[1]. So the challenge to respond to health inequalities and meet our legal duty has never been greater.

But in Leeds, it is not just a legal duty that drives us. We set out in our Strategic Plan (July 2018) how we will respond to the Health and Wellbeing ambition that 'Leeds will be a healthy and caring city for people of all ages where people who are the poorest improve their health the fastest'. This included committing to focusing resources to deliver better outcomes for people's health and well-being and to reduce health inequalities across our city.

This framework for action describes how the CCG will use its £1.3bn resource to drive the changes needed to realise this aim. As a CCG it is our duty to ensure the best possible return for the resources we are entrusted with on behalf of the people of Leeds. We define value as securing a reduction in health inequalities and delivery of the best possible outcomes, alongside procuring the highest quality services at the best possible price.

This framework also sets out how the CCG will use its position as a major statutory body to influence the wider determinants of health and our partners in ways which more positively impact on the inequalities faced by the poorest people in the city.



[1] www.health.org.uk/publications/reports/the-marmot-review-10-years-on

2. National context

There is a growing sense that the NHS (commissioners and providers) needs to work with partners to address the health inequalities faced by local people. The Long Term Plan Implementation Guidance (June 2019) sets out the following -

'Over the next five and ten years the NHS will progressively increase its focus on prevention and ensure that inequalities reduction is at the centre of all our plans.'

... and that -

'The Government's Prevention Green Paper (published in July 2019[2]) provides further opportunities for the NHS and Government to go further, faster, in prevention and inequality reduction and will feed into future iterations of system plans.'

The Plan also describes how the NHS needs to support wider social goals through employment, work to tackle climate change and to maximise its contribution to social value as 'anchor institutions'.

As more collaborative approaches emerge across providers, with more provider-led service re-design undertaken across organisations, there will be a growing emphasis for providers to not just respond to the people who present, but to ensure that services reach out and meet the needs of all people. CCGs will need to ensure this proactive approach is strengthened, setting outcomes which result in improved health and services for the most disadvantaged communities and groups.

3. Principles for our approach in Leeds

Our shared Health and Wellbeing vision is that -

'Leeds will be a healthy and caring city for all ages where people who are the poorest improve their health the fastest.'

... is underpinned by the following principle which guides how we work -

'We put people first. We work with people, instead of doing things to them or for them, maximising the assets, strengths and skills of Leeds citizens and our workforce.'

This is essential to our approach in addressing health inequalities in the city. We will fail if we do not work with people in full, as we cannot understand their lives, their motivations, their challenges. And we will fail if we don't recognise the incredible strengths of all communities in the city, and work with people to build from these.

[2] www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s/advancing-our-health-prevention-in-the-2020s-consultation-document

4. What is the local picture of inequalities? Who is affected?

In order to address health inequalities, Leeds has identified the people in the city living in the **10% most deprived areas nationally** as a priority for action. This equates to **224,000 people**, with almost 80% living in the following 7 Local Care Partnerships[3]:

- Harehills
- Chapeltown
- Middleton
- Burmantofts and Richmond Hill
- Beeston
- Seacroft
- Armley

There is a wealth of information about the differences in health experienced by this group of people, with some interesting points to note:

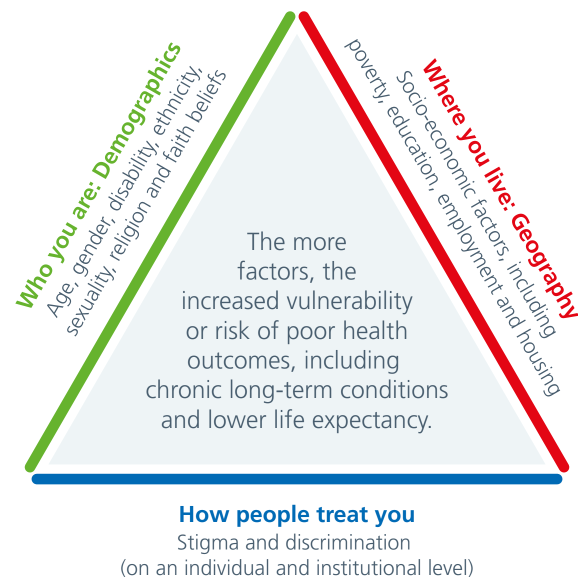
- 25% of people live in 'deprived Leeds'
- 28% of preventable life years lost are for people living in these areas.

Cancer, **CVD** and **respiratory** still account for the most deaths for people living in 'deprived Leeds'. In addition there are a number of particular outliers in these areas in terms of causes of avoidable death for example, **infections**, **maternal infant health** and **neurological illnesses**.

In addition to geographic inequalities, we also need to consider the challenges faced by **marginalised and vulnerable groups of people** as there is significant evidence that vulnerable and marginalised groups have significantly **worse health outcomes** than the general population.

Vulnerable and marginalised populations reside in all geographical areas, deprived and more affluent, however there is increased impact for people who are also living in deprivation.

Figure 1 below describes how vulnerability combines the protected characteristics with the factors relating to where you live and how you are treated within society.



Vulnerable and marginalised populations include **people from black and minority ethnic groups, Gypsies and Travellers, the unemployed, looked after children, the homeless, people living with learning disabilities and people living with severe mental illness**.

And whilst these two categories (geographic and vulnerable groups) are useful to help to shape our work, they are not exhaustive and we cannot ignore other groups/areas of the city given that the health outcomes in Leeds as a whole are often poorer than those of England.

[3] Local Care Partnerships (LCPs) are the long term Leeds vision for integrated community services. Starting with Primary Care Networks, LCPs will build to include all organisations in a local area that can work with people to address heath and care, and the wider determinants of health

5. Key Factors that lead to health inequalities

Figure 2 below frames the key factors that lead to health inequalities:
(Source: Human ecology model of a settlement, Barton and Grant, 2006)

It is estimated that only 20% of health outcomes result from clinical interventions with the remaining 80% driven by healthy lifestyle factors; wider determinants of health, such as social networks and environmental factors

How to tackle health inequalities

Given the above, it is clear that we need to address health inequalities at three levels -

A: Wider Determinants:
Actions to improve 'the causes of the causes' such as increasing access to good work, improving skills, housing and the provision and quality of green space and other public spaces and Best Start initiatives.

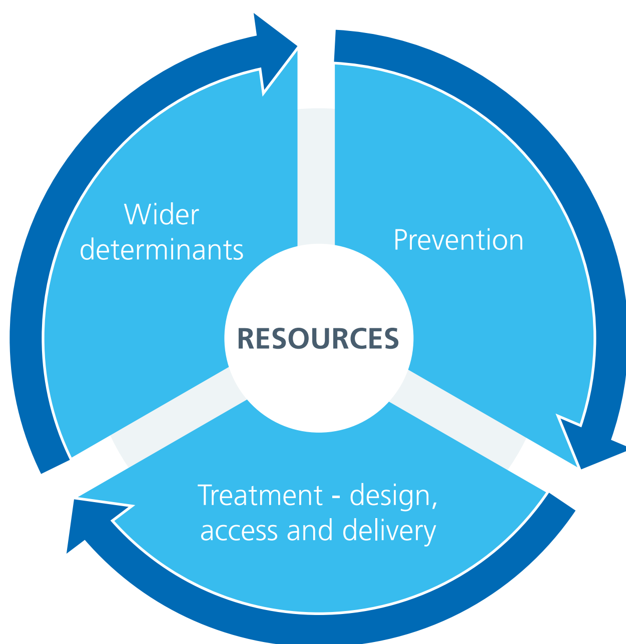
B: Prevention:
Actions to reduce the causes, such as improving healthy lifestyles - (stopping smoking, a healthy diet and reducing harmful alcohol use and increasing physical activity).

C: Access to effective Treatment, Care and Support:
Actions to improve the provision of and access to healthcare and the types of interventions planned for all - for example ensuring health literacy is supportive; ensuring there are health inequalities impacts for all commissioned services.

6. Our Framework for action

Our overarching approach will be to facilitate key stakeholders to collaborate to improve quality, problem solve together and share collective outcomes with a view to moving care upstream and implementing innovative solutions to addressing health inequalities.

Figure 3 below describes the three elements outlined above and sets out principles for how we use our resources (people, time and money) to take action to address inequalities



For each specific element described in Figure 3 above, we will take the following actions:

Wider Determinants

We will work with partners to ensure that the work of the CCG delivers a wider social impact, including on the **employment** of local people, **housing (e.g fuel poverty)**, **air pollution and transport**, all of which disproportionately affect the poorest in society.

We will ensure that our **estates planning** and investment optimises the health effects of the built environment, and will always look for and take opportunities to **co-ordinate resources** with partners to maximise impact.

Prevention

We will work with Public Health colleagues to ensure that the **NHS maximises its contribution to prevention** through the contracts we have with providers. This will include building preventive approaches into pathways, and ensuring that NHS staff have access to prevention and wellbeing services.

We will support **investment in evidence based prevention** services where we know this will improve health outcomes, and will **focus this investment** in the most deprived areas of the city and with marginalised and vulnerable groups. This should include :

- Smoking cessation
- Schemes to promote increased physical activity
- Best Start programmes
- Other wellbeing schemes which address mental health
- Targeted prevention programmes which promote healthy ageing, and which support people known to be at high risk of developing long term physical and mental health conditions

Treatment - Service

We need to take a stronger approach to service design, access and delivery to tackle health inequalities, in particular for those conditions which people from vulnerable groups or the poorest parts of the city are dying of earlier, including cancer, CVD, respiratory disease, etc.

For new services:

We will start with the question how does this **reduce health inequalities** when commissioning or redesigning services (rather than just thinking about how a new services doesn't increase health inequalities). In all cases we will consider disproportionate funding services targeted in specific areas and at specific groups where appropriate.

We will identify the people who currently have the poorest outcomes and ensure that their **voices are central** to how the new services are commissioned, with a **much stronger emphasis on co-production**.

We will increasingly work through **Local Care Partnerships (with particular emphasis on those supporting people in the most deprived areas)**, supporting a locally driven **population health management** approach to service redesign.

We will build in **performance measures** to all new contracts to ensure that outcomes for people currently experiencing the poorest health are improved.

For existing services:

We will develop **key measures** to assess how well services are performing in the poorest areas of the city and with the most vulnerable groups

We recognise that these functions will increasingly be vested in providers; our role as a CCG will be to ensure that the right skills and approaches are transferred in order to ensure that provision reaches out and meets the needs of all people in the community, in particular those facing disadvantage.

Treatment - Access

We will ensure that services are delivered in ways which **optimises access for people from disadvantaged groups**. This included considering **geography, transport, buildings; health literacy and digital inclusion**.

In order to understand this, **we will** continuously **review access levels** to services to ensure that current arrangements do not further disadvantage people experiencing the poorest health.

Treatment - Delivery

Proactive Preventative Care

Key to addressing health inequalities will be the early identification of people at risk of or in the early stages of illnesses. We will continue to strengthen our Quality Improvement Scheme in General Practice so that people are identified and supported to manage their condition at the earliest possible stage, but with a greater focus on practices working in the most deprived areas. This will also include far greater focus on ensuring that people with Learning Disabilities and Mental Health issues and carers have health checks with appropriate care and support plans.

Pathway Improvement

We will support an approach to care and disease pathway improvement (e.g. diabetes) that focusses on bringing together key clinicians and professionals across primary, community and secondary care.

There will be an emphasis on problem solving, quality improvement and developing shared objectives with a view to making a greater impact on deprived communities. This will be underpinned by a **population health management approach**.

Local Care Partnerships

Our key vehicle for tackling health inequalities are the Local Care Partnerships, especially those serving the most deprived areas. LCPs bring together health, social care, local community/voluntary organisations and local people to design services responsive to the local community.

There are 18 LCPs in the city, with 7 covering the majority of those communities living in the most deprived areas. And we have supported their development by investing in leadership and empowering them through the development of population health management skills. We see that they will increasingly be the footprint for the delivery of integrated services, and will take on more 'commissioning' responsibilities - that is designing and delivering services to meet improved health outcomes.

Our LCPs will now be underpinned by Primary Care Networks (PCNs), thus strengthening their ability to come together and deliver change. These new arrangements give us a great opportunity to support the redesign of services in a way which meets more local needs and so helps to address health inequalities, and we will ensure this is maximised.

A Stronger Partnership with 3rd Sector Organisations

We will act to ensure that the strong, vibrant and diverse third sector of community and voluntary organisations continues to be at the heart of care and support services being provided in the city. This will include investment and support so that as well as being key providers of services, our third sector organisations are actively contributing to and informing the development of health and care services across the city and in local communities. This will have a particular emphasis on the role of the third sector in supporting people in the most vulnerable groups and living complex lives in areas of deprivation.

7. Using our resources

As part of our duty to secure value described in section 1 we will focus our resources to address health inequalities:

We will have a targeted approach, applying the principle of 'proportionate universalism'[4]:

There is an existing agreed scheme to reinvest Primary Medical Services (PMS) monies in general practice in Leeds. For an agreed set of outcomes relating to health inequalities a formula has been agreed using proportionate universalism to target investment. This has been developed using the 'Car-Hill' formula (widely accepted as not adequately reflecting additional input needed for primary prevention associated with deprivation levels) and adding in ethnicity as a way to reflect deprivation. This scheme could be further developed and built upon to have more of an emphasis on deprivation and vulnerable groups. A core principle would be that actions and interventions would be decided at PCN/ LCP level, but with outcomes set that required a focus on deprivation and vulnerable groups.

We will focus our investment in areas that deliver greater prevention across disease pathways

We will reprofile investment across disease pathways so that we allow the greatest opportunity for prevention. As we implement the approach outlined in this framework and our 'Left-Shift Blueprint' plan this will mean differential investment in services that aim to prevent and proactively manage disease, which will receive a greater proportion of investment in the future, and services designed to treat the consequences of disease.

Not only will this contribute to addressing health inequalities and lead to an improved quality of life for more of our people, it will also represent better use of resources for our health and care system.

We will have a partnership approach to prevention and wider determinants of health:

The lead for most areas of prevention and wider determinants is held by Leeds City Council. Where the CCG and Leeds City Council agree on a set of shared priorities there could be joint investment and actions in a number of areas that directly affect health services e.g. housing, drug and alcohol, employment, poverty etc.

This could be approached using existing forums (e.g. Integrated Commissioning Executive - ICE) to agree priorities.

Learning can be drawn from the way that Children's work is organised in Leeds. Using a population approach means that commissioners from health and other parts of the system are able to agree and work towards joint priorities and 'obsessions' through the Children and Young People Board at which all stakeholders are represented. This population approach could be extended to the other population segment agreed as part of the population outcomes work.

[4] *"Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a* ***scale and intensity*** *that is* ***proportionate*** *to the* ***level of disadvantage****. We call this proportionate universalism."*

The Marmot Review, 2010

We will invest in third sector sustainably where there is evidence that this is an effective approach:

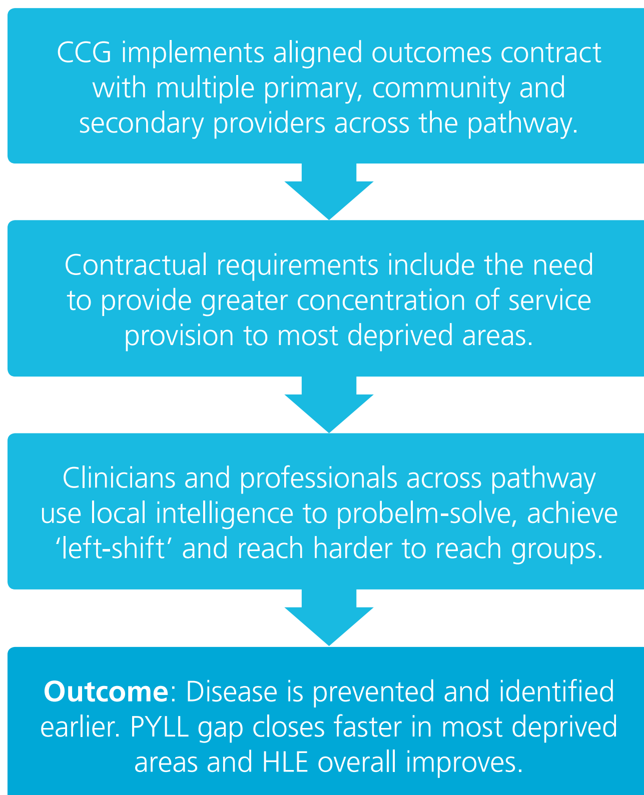
We know that partnerships with the local third sector are crucial in reaching vulnerable and marginalised groups, who may be very small, hidden and will be hard to reach. We are reliant on a sustainable third sector if we want to reach these groups and address the health inequalities that they experience.

Where there is evidence that partnering with third sector organisations will have an impact on reducing health inequalities, we will strengthen our contracting arrangements ensuring that these organisations are able to sustain their vital, work with specific groups.

8. What could this look like in practice?

There are many ways that these principles could be applied in our work.
Here are two examples of how this strategy could work in practice.

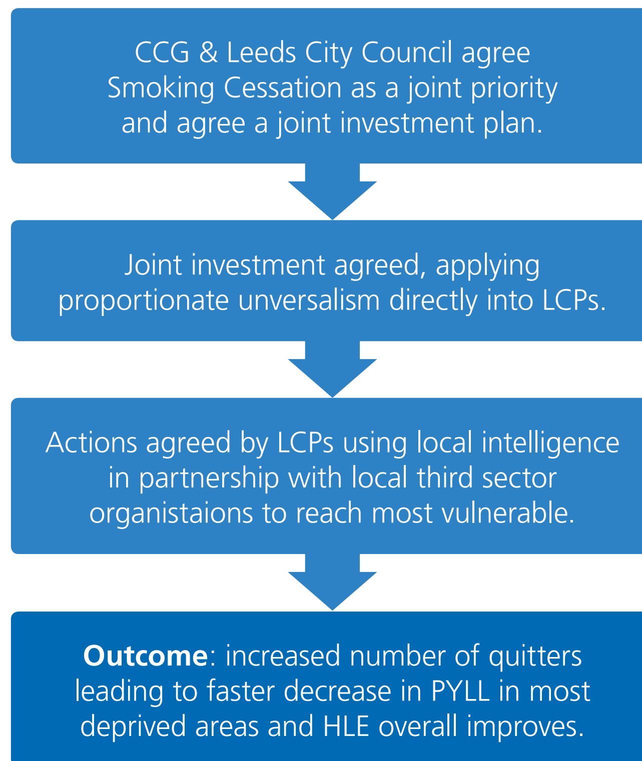
a) Diabetes Pathway



So as a commissioner, we will ensure that our contracts promote provider responsibility for addressing health inequalities, bringing clinicians from across primary and secondary care together to design services which respond effectively to more local needs. We will also ensure that contracts engineer providers to work together across care pathways, and to bring in community/3rd sector organisations in delivery to help with addressing inequalities.

This will be reflected in how we work as a CCG going forward, with a more strategic approach to commissioning and a bigger role in supporting integration of services across providers. This is being described in the 'Shaping Our Future' programme.

b) Smoking Cessation



So as a commissioner, we will work with Public Health colleagues to invest in additional preventive services which enable improved health outcomes for deprived and disadvantaged groups of people.

9. How will we measure the impact?

Our Health Inequalities outcome focus is on reducing Potential Years Life Lost for conditions amendable to healthcare (PYLL) and Healthy Life Expectancy (HLE)

Our aim is to close the PYLL gap of Leeds compared to the national average as well as increasing overall HLE. Additional we aim to close the PYLL gap within the most deprived communities faster than the non-deprived areas.

In order to understand progress, a small number of measures which capture the impact of our actions have been developed as part of the 'Left-Shift Blueprint', the CCG's 5-year investment plan.

As part of the CCG's Strategic Plan, we committed to lead action against a number of the Health and Wellbeing Strategy indicators:

There is also a growing emphasis on healthy life expectancy - increasing the number of years people live in good health, particularly for those from deprived communities and vulnerable groups.

However, we need to work with people to develop outcome measures which matter to them. And we would need to compare progress in the 7 LCPs with the highest number of people living in deprivation, as well as by different vulnerable groups where appropriate and possible.

The measures for this framework will align with the Health Outcomes Ambitions described in the CCG's 'Left-Shift Blueprint', our 5 year strategic commissioning and investment plan. We are working to set specific ambitions for these outcomes which will describe the impact we will make for Leeds as a whole (compared to the national average) as well as within Leeds (to narrow the gap between the 10% most deprived communities and the Leeds average).

This is our proposed measurement framework:

Measure	By LCP	By vulnerable group
Improve infant mortality and narrow the gap	Yes	Yes
Reduce weight in 10-11 year olds	Yes	Yes
Reduce suicide rate	Yes	Yes
Reduce PYLL for conditions amendable to healthcare	Yes	Yes
Reduce early rate of early deaths: CVD, cancer, respiratory, liver disease	Yes	Yes
Reduce mortality for those with LD and SMI	Yes	Yes
Increase Healthy Life Expectancy	Data not available at LCP level - citywide aggregate only	Data not available at LCP level - citywide aggregate only

The specific measures will be developed over the coming months and years, recognising that developing outcomes which matter to different groups of people will take time.

The metrics will also be built into provider contracts in order that services are continuously shaped for people who have the greatest inequalities and commissioning teams will be held to account for this as part of internal commissioning processes.

10. Conclusion

NHS Leeds CCG recognises the health inequalities in our city. We also recognise that we can have a significant role to play in addressing these, both in how we work with partners and how we use our commissioning resources.

We know that we are building on great previous work, and we know that it will take time to achieve change. However, we now want to take a more coherent and ambitious approach to tackling health inequalities in order to make a reality of the vision that ‘people who are the poorest improve their health the fastest’.

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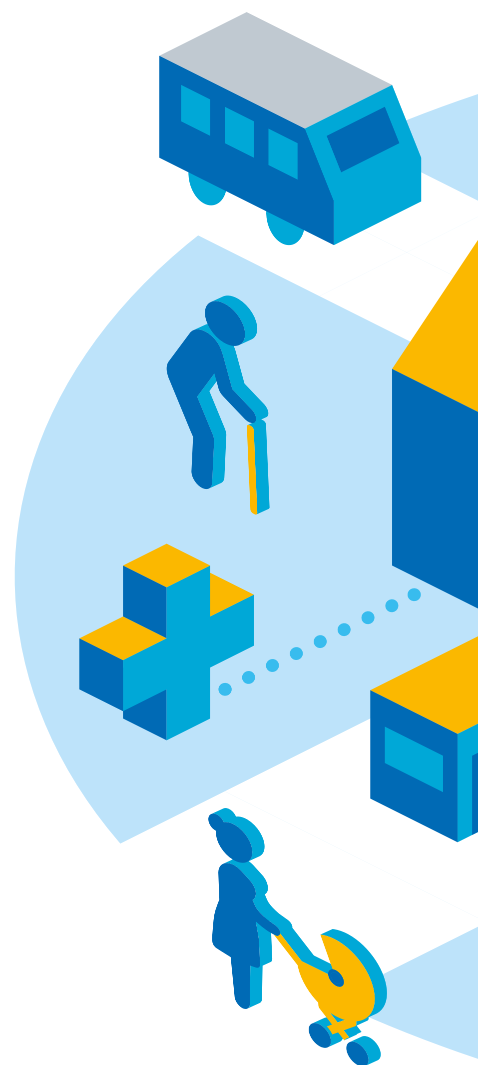

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