Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Scene Setter Paper
What can Sheffield CCG do to take action on health inequalities?

Governing Body meeting

24 May 2018

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Purpose of Paper

This paper aims to:

- Provide some clarity on what we mean by health inequalities
- Update Governing Body on the work of the Health Inequalities Steering Group and to highlight some of the areas of support/future work that were identified by GP's and VCS colleagues during a series of round table events
- Highlight areas of current work including Universal Credit roll out and the Deep End Patient Involvement Panel
- Propose some areas of future focus for the CCG in relation to its work to tackle health inequalities in Sheffield

Key Issues

- Health inequalities have a significant impact on people, on the economy and on demand for our health and care services
- We are committed as a CCG to reducing health inequalities in Sheffield; we need a clear and joined up approach to doing this
- We need to be clear on what we mean by inequalities and the part that we play in it.
- We have a Health Inequalities Strategy that is being refreshed
- Significant work has been done via the Health Inequalities Steering Group with the Sheffield Deep End practices that needs to be recognised as part of our future action plan
- There good examples of commissioning work that recognise inequalities and set out to address them, but should we be doing this at greater scale?
- We have some clear ambitions for the next year in relation to targeted investment via a range of mechanisms.
- We have a commitment to support our staff to have ,meaningful engagement with our communities

We need to agree as a Governing Body how we use our collective influence to tackle some of the wider determinants of health

Is your report for Approval / Consideration / Noting

This paper is for consideration

Recommendations / Action Required by Governing Body

The Governing Body is asked to:

- Note the call for a greater focus on the needs and interests of people who experience socio-economic disadvantage or those in Inclusion Health groups given the comparatively weak legislative focus
- Consider how the CCG can respond to the areas of focus for the future suggested/highlighted in the paper
- Note and support the ongoing work described in this paper and the future opportunities.
- Agree to request a more detailed action plan to be produced jointly by the CCG, local authority and voluntary and community sector that sets out potential short and medium term actions that will be taken to address this agenda. This should align to the refresh of the Sheffield Health Inequalities Strategy (due September)

Governing Body Assurance Framework

Which of the CCG's objectives does this paper support?

- To improve patient experience and access to care
- To improve the quality and equality of healthcare in Sheffield
- To work with Sheffield City Council to continue to reduce health inequalities in Sheffield
- To ensure there is a sustainable, affordable healthcare system in Sheffield

Are there any Resource Implications (including Financial, Staffing etc.)?

No

Have you carried out an Equality Impact Assessment and is it attached?

No, not required

Have you involved patients, carers and the public in the preparation of the report?

Not relevant at this stage.

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1. Overview

Many of the indicators for health inequalities in Sheffield do not make for comfortable reading with at best little change in health outcomes and in some case concerning evidence that health inequalities are growing.

People who experience health inequalities are more likely to have a shorter life expectancy and to live a longer period of their lives in poor health and to be unwell with chronic health conditions at an earlier age than people in better economic circumstances.

Of course, the most significant impact of health inequalities is that experienced directly by people who are more likely to spend a large part of their adult lives being unwell. Further, there is an economic impact on the NHS where there is a direct cost on NHS services in particular due to the demand for health services to support people through up to half a life time of chronic illnesses.

Health inequalities also affect the socio-economic success of our city with people less likely to live productive working lives. Finally health inequalities impacts on the cohesion of the city and our ambitions to ensure that it is a fair and equal place to live.

More recently Sheffield CCG has been increasingly concerned to give a greater focus to this agenda - recognising that national measures and strategies are by themselves unlikely to be sufficient to address this issue and that more should and can be done in Sheffield.

This paper seeks to “set the scene” for this agenda in order to lay the foundations for further action in this area.

2. What are health inequalities?

Despite the fact that the term health inequalities is used a great deal in NHS meetings and strategies there is a surprising lack of clarity about what we actually mean. Recently the NHS England Board considered this issue. In discussions Professor John Newton (Director of Health Improvement, PHE) suggested that it is important to be clear about three separate issues;

- **Inequality** - there are groups of people who experience significant inequality for long periods or for the whole of their lives. A characteristic is financial insecurity - NHS England uses the term economic deprivation. For a range of reasons - one of which is availability of cheap housing there are parts of any city where there are a high proportion of people who are on low incomes, working in impermanent jobs that can often involve anti-social hours.

There is a growing body of evidence on the impact that long term economic deprivation has on people and communities. We know that the experience of financial and social exclusion can lead to a lack of “sense of coherence” a feeling of alienation and a greater likelihood of poor mental health.

- **Inclusion Health** - there are small populations of people who may be more likely to experience inequality. One of the characteristics of this group is impermanence and transience. It includes populations such as Street Sex workers, Substance misusers, Homeless People, People in Prison and Gipsy and Traveller communities.

- **Equality** - there are a range of legislative requirements to ensure that particular groups of people are not discriminated against. These groups of people with ‘protected characteristics’ are those who have often experienced some form of discrimination because of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation

We suggest that while there is a legislative requirement to take account of the needs and interests of people with protected characteristics, the legislative focus on those who experience socio-economic disadvantage or those in Inclusion Health groups is much weaker.

This is the area where Sheffield CCG needs to and can take a greater focus; inequality and inclusion health.

3. What is going on?

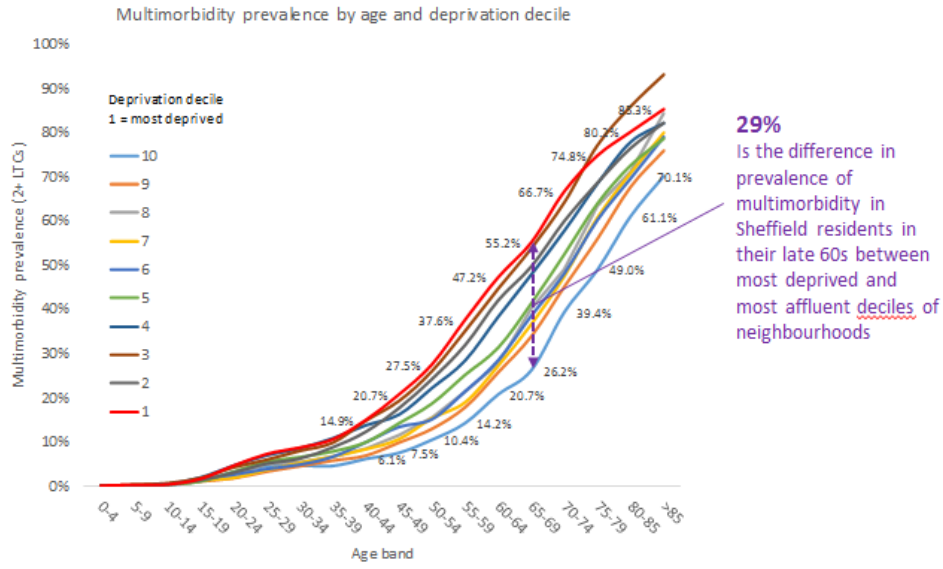
We are increasingly familiar with the bus route analogy to describe the difference in life expectancy in places. In Sheffield we used the 83 bus route which showed an 8 year difference in male life expectancy of (83.7 years in Ecclesall to 75.6 years in Firth Park) to support the work of the Fairness Commission in 2013

However, there is a growing view that this lens is inadequate when trying to understand health inequality. The work of Sir Michael Marmot’s Institute of Health Equity highlights the relationship between the experience economic inequality and the likelihood of experiencing chronic ill health (with associated co-morbidities) at an earlier age. As Figure 1 shows people on low incomes are far more likely to be chronically unwell before retirement age unlike those who are wealthier.

Figure 1

Not only do people living in more deprived areas develop ill health earlier, they also develop co-morbidity earlier. Although multi-morbidity is a citywide issue that is driving demand for healthcare, people living in more deprived areas develop multi-morbidity decades before people living in more affluent areas dispelling the myth that it is solely age driving morbidity prevalence. Local data in Figure 2 demonstrates that 55.2% of people living in the most deprived decile in Sheffield have developed multimorbidity by their late 60's compared to 26.2% of those living in the most affluent areas of the city.

Figure 2



A further challenge that we face is that the traditional response of NHS services has been to focus on responding to physical chronic health problems with solutions that focus on directly addressing the persons presenting physical health conditions such as Chronic Obstructive Pulmonary Disease or Diabetes.

This approach has tended to lead to a siloed approach to responding to health inequalities with individual secondary health services trying to develop actions for cancer, pregnancy etc. rather than recognising that it is the experience of inequality that is shared across the population whatever clinical condition they may be presenting with.

4. Health Inequalities Steering Group

The Sheffield 'Alliance of the Willing' project – overseen by the Health Inequalities Steering Group at Sheffield CCG – has brought together a cadre of GPs and VCS organisations to start a dialogue around the good practice already within the city to address health inequalities. Loosely following the principle of a social movement, the project aims to support committed organisations and individuals delivering services in the most deprived areas of the city to;

- come together, share existing good practice and experience of working collaboratively to address local health inequalities
- provide a forum for learning and developing a shared agenda for change from the grass roots that will inform and influence the development of city wide strategies including the primary care strategy amongst others.

Since 2016 the Steering Group has overseen two main strands of work

- Research undertaken by Leeds Beckett University that captured existing collaborative work between general practice and VCS organisations in Sheffield to address health inequalities in order to inform the development of future local health and care services in the city.
- Convened a series of 3 round table events that provided an opportunity for GPs and their local VCS colleagues to come together and identify the challenges faced in tackling health inequalities at a neighbourhood level and set out recommendations for further action that is required to make progress in this area.

The first roundtable discussion generated enthusiasm for a grassroots cadre of practitioners involved in tackling health inequalities in Sheffield. A number of priorities and actions were agreed, whether undertaken as 'Sheffield Deep End' or under another name, some of which are highlighted below:

- Language and literacy - in the socio-economically deprived communities in which GPs and VCS organisations are operating a significant proportion of patients speak English as a second language or struggle with written English. Interpreters can be used (typically by GPs) but can be time consuming.
- *There is a need for a 'Deep End' group in Sheffield*– It was agreed that those in the field – GPs, VCS organisations, and other health care professionals – need to identify common problems and solutions. One collective voice, based on collective experience, needs to speak to commissioners about what primary care services should look like to address health inequalities across the city. A core function of the Sheffield Deep End group should be to provide a forum for greater understanding and collaboration between VCS and general practice.
- *'Unequal resources for unequal need'* – Primary care services in the city are based on a one-size-fits-all model. This undermines GPs' ability to effectively tackle health inequalities. It was agreed that addressing health inequalities in Sheffield will require a new approach; "unequal resources for unequal need" should be the new mantra
- *Unconditional care* – the overarching aim of those looking to address health inequalities in deprived communities in Sheffield should be to provide

unconditional, personalised continuity of care. How can this way of working be supported and enabled at system level?

- *Evidence and data* – There is a need for better data about workload, attendance rates, income and need across healthcare providers. Professional experience and stories are to be collated to capture the Sheffield Deep End's perception on specific issues.
- *Link workers* –GP's value having a designated point of contact that they can refer patients to who can connect their patients into the services offered by the VCS.

With regard to training and development for practitioners working in deprived areas, the following was highlighted by attendees:

- *Induction Programme* - Practices working in deprived communities 'at the deep end' in Sheffield felt they needed greater awareness of local communities and required the skills to work with local VCS organisations. To address this need, an induction programme about the community for new members of staff was suggested as well as the opportunity for GP staff to sit in with non-clinical practitioners, such as health trainers, community support workers and VCS organisations, to learn more about their practice.
- *Cultural awareness training* - GP staff require cultural and local awareness training in order to help them understand patients 'holistically'. This includes awareness of ethnic diversity as well as cultural differences within 'white British' communities. Examples include cultural perceptions of illness which lead to concordance and fatalism. Such understanding might help GP staff when dealing with erstwhile 'difficult patients'.
- *Welfare rights and benefits system* - GP staff expressed a need for more knowledge of the benefits/social security and asylum and immigration systems. It was agreed that GP staff should only need to be sufficiently understanding of these systems in order to effectively signpost patients.
- Soft Skills training - Clinicians expressed a particular CPD need around 'soft skills' to develop relations and work in partnership with other (non-clinical) organisations. Senior GPs and administrators also need more training around the future 'architecture' of general practice, such as what federating means.
- *Wider practice team training* - Non-clinical staff in general practice need to be upskilled to be 'navigators'; to be aware of, and make referrals to, VCS organisations. However, whether patients would accept such information from non-clinical staff was questioned.
- *Research* - General practice staff working in deprived communities were generally concerned with identifying 'what works' in addressing the health needs of their patients. In official guidelines most evidence is disease focussed and not about health inequalities and research is rarely conducted in deprived communities. The 'best practice' described in such documents is often not achievable in deprived communities and so clinicians at the deep end often have to extrapolate information to suit their needs. More accessible dissemination of research knowledge would be favoured and podcasts, a bi-weekly email of 'deep end' relevant research, or TED Talks style videos were suggested as possible ideas.

Since the round table events were delivered, the Health Inequalities Steering Group has supported the delivery of a multiagency Roma-Slovak Health workshop that brought together practitioners from health, local authority and VCS and aimed to give participants:

1. A better understanding of the community and their experiences of health and healthcare in Sheffield
2. An opportunity to share experiences and insights with other professionals and consider how we can work better together within the current system.
3. An opportunity to think about what the system could do better to support both the community and the health and social care teams in their work.

In response to the findings of the workshop, the HISG will input into the development of new arrivals health pack and support its dissemination across general practices in the city.

In response to the expressed need for more information about the welfare, benefits and immigration systems the HISG is also working with the Universal Credit Partnership Group in the Council to ensure that GPs are ready for the roll out of Universal Credit from November 2018 which will have a significant impact on patients, particularly those living in areas of social disadvantage.

The HISG has also offered to support 'The Deep End Patient involvement Panel' which is one aspect of the work of the 'Deep End Yorkshire and Humber Group', which has been set up and is led by GPs from the region (Walton et al 2017).[1] The patient panel is hosted by Whitehouse Surgery in the most deprived area of Sheffield and aims to involve patients at all stages of research. The Deep End movement in Yorkshire and Humber also runs educational events relevant to GPs working in the most deprived areas and is strongly influencing undergraduate and post-graduate education.

5. Examples of Our Commissioning Approach to Date

We have undertaken a range of commissioning activities that recognise our population inequalities and support a more targeted approach to reducing them, or rather investing in need. Examples include:

- Development and maturity of neighbourhoods – allows neighbourhoods to identify specific issues within their neighbourhood, develop a plan to improve access to e.g. mental health services, social care closer to home

- Person-centred, asset based approaches enables us to focus on those who are less well activated (low skills, knowledge and confidence)

- Social investment on COPD and frailty – development of social investment business cases in 18/19

- LTC and multi-morbidity prevention work

- Diabetes prevention programme delivered in multiple languages including exploring with NHSE possibility of commissioned course for people with LD

- Development of DESMOND for BAME cohorts (who currently do not access DESMOND)

[1] Walton L, Ratcliffe T, Jackson BE, Patterson D. Mining for Deep End GPs: a group forged with steel in Yorkshire and Humber. Br J Gen Pract. 2017 Jan 1;67(654):36-7.

- Stroke pathway redesign

- Connecting LTC services with access to IAPT wellbeing

- Improving access to respiratory services for people with substance misuse issues as part of IPC programme

- Improving access to pulmonary rehabilitation

- Engagement activities trying to ensure people who are seldom heard have a voice

6. Future focus on Health Inequalities

If Sheffield CCG is to have a strong focus on health inequalities we need to lead a programme of work that will include the following:

- working on an explicit programme of work that supports primary care neighbourhoods working in economically disadvantaged communities (Sheffield's "Deep End Practices") to develop integrated services that respond to the wicked issues of co-morbidities, financial insecurity and poor mental health. Central to this is to ensure that there is a consistent approach to working with local communities and the community anchor organisations that are based there.
- using our neighbourhood model to differentially invest in geographical areas where there is inequality – needs to be supported by real-time access to neighbourhood intelligence and predictive analytics functions for health and social care. There are some good examples of where this has been done by our local authority colleagues and we are committed to developing a joint approach.
- Through PAM and person-centred approaches we will invest disproportionately in those who have the lowest activation levels, which will target our services at those with greatest need and where there will be greatest impact on health outcomes. This will be supported by Integrated Personal Commissioning and Personal Health Budgets, where usual commissioned services do not meet their needs.
- We know that one of the things that has great impact is connection with our communities through meaningful engagement. We will be strengthening our approach to this via the implementation of our Volunteering Strategy (developed by Voluntary Action Sheffield), getting staff into the heart of communities and having real conversations.
- We will focus on integration of physical and mental health and on the inequalities for those with Learning Disabilities. Championing a city wide mental health strategy that recognises the impact of health inequality on mental health and sets out actions to address this. Have an agreement at a city level about what we mean by health inequalities AND recognise that this means focussing on particular geographies and populations recognising that while discrimination is completely unacceptable, there will be many people with protected characteristics who do not experience any form of economic deprivation and inequality.
- Realise the CCG's commitment to differential resourcing, or the Marmot principle of proportionate universalism made as part of the citywide Health Inequalities Action Plan. Whatever mechanisms are used the need is to focus the greatest resources where need is highest, and not disinvest as it is more expensive improving outcomes in the populations with most need.

- The CCG is an important anchor organisation with the potential to impact hugely on the development of inclusive growth in the city. It should use the levers and mechanisms it has to tackle inequality through local procurement and supporting learning and work through its employment practices to maximise its social value.
- Place an emphasis on treating and preventing early onset of chronic comorbidities, moving away from a focus on the “high risk, top of triangle”, virtual ward, etc. towards more person centred approaches, managing risk not individual conditions with increased resources and capacity invested in prevention and delaying the onset and development of further morbidity in patients.
- Recognise financial insecurity and problematic debt as a determinant of health – not only as a risk factor contributing to the development of poor mental and physical health but also as a contributing factor in a person’s ability to engage in optimal self-care ‘activation’, condition management and subsequent recovery, and support investment in it as part of good primary care management for those populations most vulnerable to financial insecurity. E.g. integration of debt and welfare advice with primary care especially for those referred to IAPT for common mental health disorders.
- Recognise that the NHS cannot do this on its own – only 20% of health outcomes result from clinical interventions with the remaining 80% driven by wider determinants of health. It will be essential that the CCG commits to an inclusive approach that includes the wider functions of local government, the third sector, business and social enterprise, housing providers, education and other services.
- Routinely conduct Health Equity Audits on major work programmes

7. Role of the CCG

The Health and Social Care Act 2012 introduced a new duty on the Secretary of State, NHS England and clinical commissioning groups to ‘have regard to the need to reduce inequalities’ in access to care and outcomes of care.

As a CCG we can undertake specific activities as described above, as well as recognise our role as an anchor organisation in employing a diverse workforce and supporting stable employment. But we also have an influencing role with our partners and with MPs. We need to use our significant system influence and the voices of our members to ensure the wider determinants of health are prioritised, with an immediate example being Air Quality. We need to describe and coordinate our approach to this.

8. Recommendations

The Governing Body is asked to:

- Note the call for a greater focus on the needs and interests of people who experience socio-economic disadvantage or those in Inclusion Health groups given the comparatively weak legislative focus

- Consider how the CCG can respond to the areas of focus for the future suggested/highlighted in the paper

- Note and support the ongoing work described in this paper and the future opportunities.

- Requested a more detailed action plan to be produced jointly by the CCG, local authority and voluntary and community sector that sets out potential short and

medium term actions that will be taken to address this agenda. This should align to the refresh of the Sheffield Health Inequalities Strategy (due September)

Paper prepared by Joanna Rutter, Health Improvement Principal

On behalf of the Health Inequalities Steering Group

May 2018