Better health for all

A framework to reduce health inequalities in Leicester, Leicestershire and Rutland

What are health inequalities?

Health inequalities are avoidable and unfair differences in health between different groups of people. Health inequalities concern not only people's health but the differences in care they receive and the opportunities they have to lead healthy lives.

Those living in the most disadvantaged areas often have poorer health, as do some ethnic minority groups and vulnerable/socially excluded people. These inequalities are due to many factors, such as income, education and the general conditions in which people are living. In addition, the most disadvantaged are not only more likely to get ill, but less likely to access services when they are ill.

Health inequalities have been made worse by the Covid-19 pandemic, which has hit hardest the groups who already do not have the best health. The rate of people dying from the virus has been higher in more deprived areas and among some ethnic minority communities and people with disabilities. People in crowded housing, on low wages, unstable or frontline work have experienced a greater impact from Covid-19.

There are always going to be differences in health, some are unavoidable, due to people's age or genetics, but many differences in health are avoidable, unjust and unfair – it is these that we are concerned about and that this framework seeks to address.

What does it mean for local people?

Health inequalities across Leicester, Leicestershire and Rutland (LLR) are stark*. A boy born today in our most deprived area could be expected to die up to nearly nine years earlier than a boy born in the least deprived area*. Furthermore, people from less affluent areas will be spending a greater proportion of their (often shorter) lives in poor health compared to people from more affluent parts of our area.

What will this framework seek to achieve?

We want local people to be healthier, with everyone having a fair chance to live a long life in good health. This is why we will aim to 'level up' services and funding, rather than take anything away from areas where outcomes are already good.

This framework sets out how local organisations will plan to take action to not only affect the causes of these health inequalities but the 'causes of these causes'.

Health and wellbeing is not just the concern of the NHS. The health and wellbeing of people is an asset to individuals, to communities, and to wider society. Good mental and physical health is a basic precondition for people to take an active role in family, community and work life. The NHS, local authorities and other public bodies all have a part to play. Often, it will involve a number of different organisations working together to improve all the things that can affect someone's health. Locally, we have set up an integrated care system (ICS) which brings organisations together to ensure better partnership working, and improvements in people's health and care. By listening and responding to local people, we will achieve a fairer and healthier future for us all.

What does equity look like?

'Health inequalities' is the commonly used term, however we are actually referring to 'health equity and inequities'. 'Equality' means treating everyone the same or providing everyone with the same resource, whereas 'equity' means providing services relative to need. We can show what this looks like in the illustration below. Figure one shows, on the top line, four people of different sizes all trying to cycle the same size of bicycle. One person in a wheelchair cannot use the bicycle at all. The second line shows each person happily using a bicycle correctly sized or adapted for their needs.

Figure one: Representation of equality and equity using adapted bicycle example. Source: Reproduced with authorisation from Robert Wood Johnson Foundation (Better Bike Share, 2017)

Inequalities can be seen as being present from birth, through someone's early years and into later life. At each stage this can result in relatively poorer mental and physical health. This can be shown in a tale of two babies in figure two below. While we must recognise that no outcome is set in stone, the story aims to illustrate the different opportunities and difficulties that two babies might encounter throughout their life. This graphic shows two parallel curving lines – the top line showing outcomes for those from the most deprived areas in LLR. The bottom line shows the outcomes for those born in the most affluent areas.

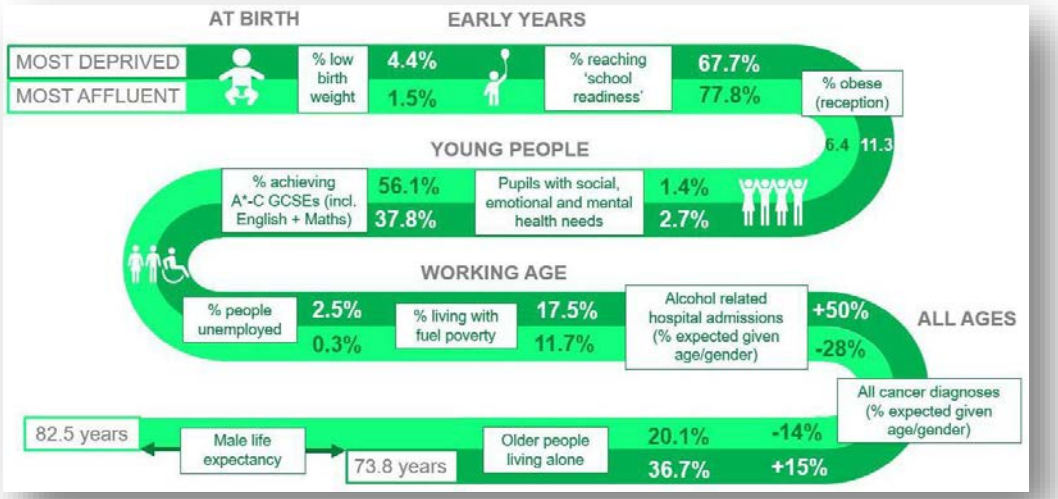

Figure two: Difference in health indicators between the most and least deprived local areas of LLR. Source: PHE Fingertips

What is 'health'?

Health has been defined as: "a state of wellbeing with physical, cultural, psychosocial, economic and spiritual attributes, not simply the absence of illness." We are using this definition of health in assessing health inequalities. Our work is also based on a 'social model' of the factors that can influence someone's health. This is shown in figure three below. It shows that everything but age, sex and hereditary factors can be modified in terms of factors that can influence an individual's health.

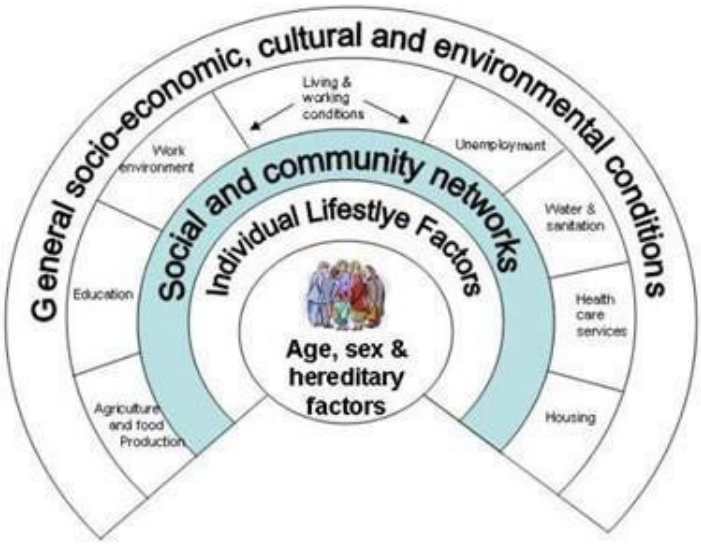

Figure three: A social model of health. Source: The World Health Organisation

Things like education, housing, transport and clean air are often known as ‘wider determinants of health’. They can also be seen as the ‘causes of causes’ which we mentioned earlier. It shows the importance of the NHS working with local authorities and other organisations who can influence these factors.

Our principles for reducing health inequalities

Our work in this area will be guided by the following principles:

Principle 1

Reducing health inequalities is a key factor in all work caried out within the ICS – it is everyone’s business. Reducing health inequalities and improving health equity should run through all our work, at all levels, as a ‘golden thread’. Appropriate training and support will be given to enable people to think and act in ways that reduce health inequity.

Principle 2

We will use data and insight to better understand local health inequalities and how they affect people. We will draw upon the best evidence to take action to reduce inequalities and to evaluate the impact of our services. This is known as ‘population health management’. Where services are failing to reduce inequity, or (by accident) are increasing it, the services will be adjusted or changed completely.

Principle 3

We will prioritise prevention, helping prevent or lessen the impact of illness. This is important in improving health equity as the burden of disease is borne unfairly by those who are more deprived, marginalised or in a minority. Primary prevention includes a focus on and increased investment in reducing inequalities in lifestyle risk factors (such as smoking, diet, exercise or alcohol consumption), mental wellbeing, housing, income, education, working conditions and the wider environment. In these areas, it is critical that the NHS works effectively with local authority partners.

Principle 4

A focus on gaining a fair balance between mental and physical health - reducing inequalities in mental health will be prioritised to the same extent as reducing inequalities in physical health.

Principle 5

Local public sector organisations will seek to reduce health inequalities through offering ‘social value’. This approach includes efforts to make the workforce more representative of the local population. We will use mentoring, reverse mentoring and apprenticeships to improve opportunities for under-represented groups, support people from less affluent backgrounds to establish a career in the public sector, and seek to tackle racism and prejudice in society. In

addition, we will seek to maximise the value of our collective spending on the local economy.

Principle 6

Investment in services will be proportionate to the needs of people using those services. This means that although there will be a universal offer of services to all, we will vary the provision of services in response to differences in need within, and between, groups of people. In this way we will look to 'level up' the way that services are offered and outcomes achieved.

Principle 7

We will draw on the strengths of communities and individuals to reduce health inequality and inequity. Our services will aim to focus on 'what matters to people' rather than focusing on 'what is the matter' with them. We will listen to local people with lived experience to shape local priorities and redesign services. As part of strengthening resilience in communities we will work to improve health literacy – the skills, knowledge and understanding that people have to make use of available information and access local services.

Principle 8

We will ensure that all plans and policies put forward by the ICS partners take into account issues of health equity. This is particularly important in relation to the wider factors that can affect people's health such as housing, education or employment.

Principle 9

We will take effective action during the key points of a person's life to help reduce health inequality and inequity. This means a specific focus on giving children the best start in life, prevention of ill health and the promotion of wellbeing and resilience.

Principle 10

The ICS is accountable for delivering on health inequalities across the local health and care system. We acknowledge that organisations within the ICS also have a statutory duty to reduce health inequalities. The work required to reduce health inequalities will tend to take place at a 'place' (or local neighbourhood) level. These places will need to be responsive to the particular needs of local people.

Principle 11

Actions will be undertaken at the most appropriate level of the ICS where they can be most effectively owned and delivered. This will tend to be determined by the relevant statutory responsibilities of the partner organisations. Housing, education, and licensing rest with local authorities, for example, while commissioning responsibility for most health services sits with the local NHS clinical commissioning groups and their successors.

Principle 12

There is significant potential to improve people's health through better and more widespread use of digital technologies. Digital technologies are integral to many of the changes envisaged in the NHS Long Term Plan. However, it will also be important to take steps to prevent digital technologies entrenching or widening health inequalities. This means understanding and addressing the issue of digital exclusion and ensuring that people can still receive face-to-face services where required.

Taking steps to reduce health inequalities

Actions to address health inequalities will need to take place at different levels:

- System level - across the whole LLR area
- Place level - across the area covered by the upper tier local authorities (Leicester City Council, Leicestershire County Council, Rutland County Council) and led by Health and Wellbeing Boards
- Neighbourhood or locality level – smaller (though locally meaningful) populations within the wider upper tier boundaries.

Medium to long term priorities will be determined at place level and are likely to include:

1. A focus on the first 1,001 days of life. Events and people's health during this period often determine outcomes across the whole of someone's life
2. Improving healthy life expectancy through early intervention and prevention. This will include actions relating to the other factors that can affect someone's health such as education or job opportunities
3. Using the lived experiences of people to inform our plans and actions
4. Each organisation having their own executive lead for health inequalities who will be responsible for driving this agenda forward
5. An approach which is smart, measurable, achievable, realistic and timed (SMART).

Shorter term goals are to:

1. Restore NHS services inclusively (following the impact of Covid-19)
2. Mitigate against digital exclusion
3. Ensure that our data is accurate and providing the necessary insights
4. Accelerate preventative programmes that engage those at greatest risk of poor health (management of long-term conditions, annual health checks for people with learning disabilities/serious mental illness, continuity of maternity care for BME women and those from deprived neighbourhoods)
5. Strengthen leadership and accountability.

Strategic actions to reduce health inequalities at the ICS level

Action 1

Places will be expected to apply the principles, outlined in this framework, to their specific populations, in the most appropriate way, that meets their local needs. This is likely to embrace the various factors that can affect people's health (as shown in figure three).

Action 2

The ICS will make investment decisions for people across LLR that reflect the various needs of different communities. In this way, actions can be universal, but adjusted and made proportionate to the level of disadvantage. The aim of reducing health inequalities will be a high priority. Specifically, we will develop a new strategic long-term model of primary care (GP practice) funding, distribution and investment. This will 'level up' funding based on population need rather than historical allocation.

Action 3

We will establish a defined resource to review health inequalities at this strategic level. This will be a virtual partnership between the NHS, local authorities and local universities. An enhanced ability to process and analyse data will support a better understanding of inequity across the area. We will gather and share best practice in effective interventions and provide teaching and training to all levels of staff in undertaking health equity audits. We will facilitate local research. Public health teams will deliver, with partners, the health inequalities support function at a place and neighbourhood level. Specifically, a proposal for the establishment of an LLR health inequality resource will be presented to the system executive by the end of September 2021.

Action 4

All decision makers within the ICS will have expertise, skills, insight and understanding of health inequity and how to reduce it. Specifically, health inequity and inequality training will be mandatory for all executive decision makers in each organisation by the end of November 2021. We will work with local and regional partners to develop appropriate and robust training packages relevant to roles.

Action 5

Partner organisations will work together to understand the impact of Covid-19 on health inequalities across LLR, to allow effective and equitable recovery after the pandemic. We will be looking to:

- Identify groups and communities, across all ages and across protected characteristics, which have been most affected by the pandemic as a result of pre-existing vulnerabilities and disadvantages
- Undertake proportionate additional work to ensure vaccine uptake is equitable
- Include consideration of the role of the wider determinants of health, such as

education, employment, housing and poverty
- Promote equal support for mental and physical health to those groups worst affected by the pandemic and the consequences of lockdown.

Action 6

All partners will work to improve the completeness and consistency of their data to enable a better understanding of health inequity. This mainly relates to data collection on people with 'protected characteristics' under the Equality Act. Specifically, partner organisations will develop an action plan for having ethnicity, accessibility and communication needs of their population appropriately coded in records by the end of July 2021. In addition, we will make better use of our data sets in order to identify vulnerable groups and individuals to offer proactive, holistic care through Integrated Neighbourhood Teams.

Action 7

At the ICS level, we will obtain and use data to help us better understand where we can do more work to reduce health inequity. Specifically, by the end of October 2021, each organisation will have adopted a standard health equity audit tool and put training plans in place to use this tool, so that each 'place' area can compare their performance against other areas.

Action 8

We will undertake health equity audits to identify health inequalities between different population groups. These will be carried out at the planning stage when we commission, redesign or evaluate services. Action to reduce health inequity will be taken based on audit findings (at a minimum considering the protected characteristics of the Equality Act 2010).

Action 9

The NHS and public sector partner organisations within the ICS will seek to reduce health inequalities through seeing what we can do together, especially in the areas of work opportunities, use of buildings and purchasing.

How will we know if this work is succeeding?

If this framework is successful in driving effective action, we expect to see the following outcomes:

- A reduction in health inequities
- An increase in healthy life expectancy
- A reduction in premature mortality
- A workforce that is representative of the local population
- Better use of data.

Health inequalities case study: Introduction of new technology to improve care in diabetes

Case study by Professor Azhar Farooqi

Diabetes is one of the most common chronic disorders affecting nearly five million people in the UK. It is a significantly more common condition in people of low socio-economic status and in BME groups. Diabetes is a costly condition, not only in financial terms (more than 10% of the NHS budget), but also in terms of mortality and morbidity. Sufferers lose several years of life and the condition is the biggest cause of acquired blindness, renal failure and amputations.

The evidence that good control of blood glucose improves outcomes for patients and reduces NHS costs is overwhelming. Freestyle Libre (FSL) is a new technology, known as flash glucose monitoring, which allows patients to monitor in real time their blood glucose using a skin patch and a small handheld sensor. It avoids multiple lancet jabs and time-consuming use of glucose strips and machines.

The technology is approved by NICE for patients with type 1 diabetes who normally would test multiple times a day and is likely soon to be extended to patients with type 2 diabetes on insulin and other groups deemed at high risk of hypoglycaemia.
It costs about £500 per patient per year. The real-world impact of this technology has shown significant improvements in blood glucose levels, reduced hospital admissions and paramedic call-outs, less severe hypoglycaemia and improved overall blood glucose control.

How was this technology rolled out?

The prescribing of FSL has been via secondary (hospital) care to eligible patients who have an education session on how to use it. As with all new technologies and treatments, patients learn about the availability of this via media and friends and those most empowered tend to know about it first. The patient benefit is not only in improved diabetes control but also the avoidance of painful finger pricks. It was entirely predictable that the most articulate, informed and persuasive patients would be in a position to demand this technology and persuade their health care professional they are eligible and would benefit. The criteria of existing multiple testing and the education package also favours English speakers, literate patients and those already empowered in looking after their condition - all of which make it less likely that people form deprived backgrounds would either push for this technology or be prioritised for it.

What has been the health inequality?

Type 1 patients in the most deprived area of Leicester, Leicestershire and Rutland had a 29% chance of receiving this technology, compared to 39% in the least deprived area. Only 14% of type 1 patients received FSL in GP practices with the most BME people in their population, whereas this figure was 38% for the practices with fewest BME people.

Why has this happened?

This data was produced by the pharma company Abbot, who in effect, 'whistle blew' the problem. The local NHS service provider had no idea of this health inequality and in fact denied it was occurring. There was no consideration of health inequalities in the introduction of this technology, nor monitoring of uptake by deprivation or socio-economic status. Despite the data, little has changed on the provision of this technology to date.

Lessons to be learnt

It is important that a full equity impact assessment is carried out when all new technology (or therapies) are introduced. It is important that monitoring of uptake by socio-economic status and BME status, as well as other characteristics, is undertaken, and data reported and shared. It is important to consider if specialist-only provision will worsen health inequalities. Most type 1 patients (60%) and the vast majority of type 2 diabetics (95%) receive care only in general practice. It is likely that appropriate primary care provision will improve wider access to this intervention. Language is likely to be a significant barrier in addressing health inequalities, in particular, when a mandatory education package is only available in English. Specific thought, investment and planning needs to take place to reverse this inequality of provision of FSL.

Where can I find out more?

Public health experts routinely put together assessments of health and health inequalities for local areas. These are known as Joint Strategic Needs Assessments and are available for:

- Leicester City
- Leicestershire
- Rutland