chcp

Excellence • Compassion • Expertise

Health Inequalities Strategy

November 2022

Contents

What do we mean by health inequalities

Health inequalities are avoidable, unfair and systemic differences in health between groups of people or communities.

Inequalities of what?

This can involve differences in outcomes and in known contributing factors to health:

- **Health status** e.g. life expectancy and prevalence of health conditions
- **Access to care** and non-clinical services e.g. availability or waiting times for treatments, take-up of services, access to information
- **Quality and experience of care**, e.g. levels of patient satisfaction, feeling involved
- **Behavioural risks** to health, e.g. smoking rates
- **Mental wellbeing** and exposure to stressors and adversities (or protective factors)
- **Social economic and environmental conditions** that are 'wider determinants' of health e.g. housing quality, community life, discrimination

Inequalities between who?

Differences can be found between people grouped by:

- **Socio-economic factors** e.g. people's individual income, employment or education status
- **Geography** e.g. living in areas of higher deprivation, coastal or rural communities, or areas with fewer amenities or transport links
- **Specific characteristics protected in law** e.g. ethnicity, disability, LGBTQI+
- **Socially excluded or vulnerable groups** e.g. people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery

How we developed the strategy

Review of where we are today

- Document review, stakeholder interviews
- Tested with working group

Defining vision and aims

- Workshop with wider working group

Develop detailed recommendations to close the gap

- Input from key stakeholders
- Designing service-specific actions plans

Strategy

- Test with working group
- Test with staff network forums

Purpose and key aims

Common purpose and key aims

Our purpose:

To ensure people in our localities who are more likely to face worse health outcomes get the community health services that they need and are connected to the clinical, social and environmental resources that enable them to have better health outcomes.

Aims of the strategy:

As services and locality-based teams:

- Ensure that we reach and engage everyone who most needs our services in a way that works for them
- Maximise use of each interaction to understand the person as a whole and address the wider factors contributing to their health

As an organisation:

- Ensure our system partners know about the health inequalities we identify through our services and recognise the opportunities to address these
- Use all our activities to address service access and wellbeing for those in our communities who are most likely to experience worse health outcomes.

Focus of the strategy:

Our strategy reflects a service-led approach in order to:

- Make tangible improvements to services, specifically for those who face inequalities – e.g. down to clinic timetables
- Start where we can have the greatest influence i.e. as a service provider
- Make consideration of health inequalities part of everyone's day-to-day business

Guiding principles

Guiding principles – learning, planning and review

To achieve these aims, our approach to inequalities will be underpinned by reflection, learning and sharing what we know about health inequalities:

- Ensure we know who is not accessing our services, as well as who is
- Recognise the impact of social and economic status, as well as demographic groups
- Look for evidence of differences in access, experiences and outcomes from care – inviting feedback or scrutiny from our service users, teams and partners, even if data is unavailable
- Persist and be creative with co-production – seeking and listening to diverse voices in our service design and development and working with communities on solution – make sure we've heard directly from people involved what needs to change
- Escalate or challenge where contractual or reporting limitations or obligations get in the way of what is needed
- Continue to monitor the impact of our actions on outcomes

Guiding principles – service-level action

Reach and engage everyone who most needs our services, in a way that works for them:

- Deliver services to the maximum extent 'where people are' and when they are available
- Open up access as far as possible e.g. do people need to take action to get an appointment?
- Challenge ourselves to maximise people's choices, skills and support networks – this may mean rethinking who delivers care and how
- Ask what causes people to miss an appointment or not take-up an intervention or support and how can we address these
- Think beyond what makes the service better for everyone - addressing inequalities may mean some groups need more than others

Seek to understand and address wider factors contributing to the person's health:

- Look beyond the presenting need
- Ask if there are other CHCP services you can promote or link to
- Look beyond healthcare and respond to the social and environmental factors shaping individual's health where we find them, linking individuals to the things that can help

Guiding principles – organisation-level action

- Focus our reinvestment and put more of our resources and efforts where we see opportunities to improve service access and wellbeing for those in our communities who are most likely to experience worse health outcome

- Proactively identify how our activities as a workforce developer, employer, local business and VCS incubator, procurer of goods and services, estates and environment manager can be directed to supporting these priorities

- Share evidence about who is waiting for treatment, who is not being referred to prompt action from partners

- Advocate for the needs of those who are most likely to have poor outcomes and ask for the funding/ resources/support to meet these before turning away – whether internally, from external funders or for other services

Roadmap and key actions

Key activities roadmap

Driving action against each strategic aim

Build shared understanding

with communication, training and engagement on what we mean by health inequalities, why action is needed and what this means in practice

Develop business intelligence

To increase the visibility of variation in access, outcome indicators, experience and resource allocation and understand the impact of our actions

Support each service to create action plans

With tools and support to design, implements and evaluate these

Reframe our approach to acting on wider determinants of health

With clearer goals and responsibilities and an improved and more flexible information/recording solution

Harness citizen engagement

By capturing and sharing co-production best practice, building strategic links with community engagement groups and piloting innovative engagement methods

Position CHCP to work through our wider systems

Collate and use intelligence from our frontline to influence system plans, including gaps in our data. Also, linking with neighbourhood-based action to show the impact we can have

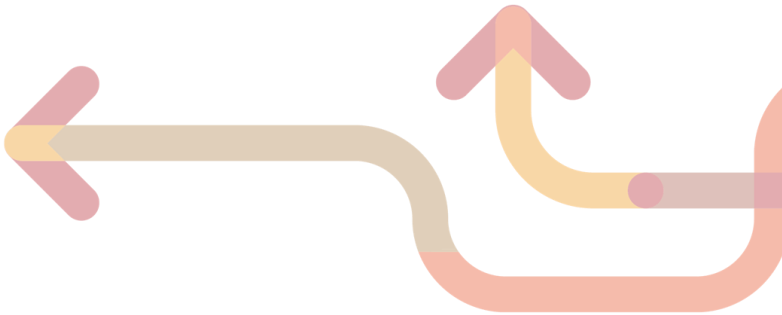
Maximise local resources and assets

By defining and focusing on the most critical gaps for our patients, and harnessing our full range of activities and influence to address shared priorities

Embed leadership and assurance for health inequalities

In business as usual – with clear responsibilities, routine reporting and review

Build shared understanding



Objectives

- Develop shared understanding of what we mean by inequalities, CHCP's aims and principles and what they mean in practice
- Promote service/practitioner level ownership and action
- Engage colleagues in identifying shared priorities

Key actions:

- Continue to **iterate the strategy** with input from colleagues. This may require a specific mechanism or channel to routinely feedback ideas and issues.
- Sustained **programme of communications** about what CHCP means by health inequalities, why action is needed and guidance on what this means in practice, based on what resonates with colleagues. For example we will use questions, stories and worked examples to illustrate each principle.
  - Initially this could build on planned conversations with colleagues about the cost of living crisis, to discuss health inequalities in tangible terms and explore what support for 'wider determinants of health' looks like on ground.
- Integrate population health management and inequalities into the organisation's **learning and development, and quality agenda** for all colleagues to increase awareness, highlight data/ insights and share best practice. To include **specific training** (in line with the approach to EDI awareness).
- **Leadership initiate conversations with services/functions individually** about inequalities linked to business and action planning.

Develop business intelligence on inequalities

Objectives

- Enable CHCP to identify inequalities by increasing visibility of variation in access, outcome indicators and resource allocation
- Enable services to assess and prioritise inequalities and monitor the impact of action plans
- Provide evidence to enable CHCP to advocate for resources/ cross-system action

Key actions:

- Progressively build **core demographic breakdowns** as standard into KPI reports for key access and outcome metrics.
  - Initially this would include IMD quintiles or Core20 (and potentially gender, age or geography). Data for other 'plus' groups to be incorporated as improved data recording and sharing are pursued.
  - Utilise this analysis (alongside population measures) to offer a dashboard view of demand and access across services/over time within key population groups. E.g. Barts Outpatient Equity Dashboard.
- Report on variation between key demographics within CHCP's **standard quality/ experience measures** such as 4cs and patient survey. Invite agency proposals for how the annual patient survey can draw out diverse experiences of care (particularly through more granular reporting).
- Add **specific BI resource for inequalities action planning and evaluation.** This would be used to investigate inequalities, create new routine measures for monitoring and evaluation, and enable retrospective review of impacts of service changes.
- More systematically **capture, flag and quantify** needs and gaps in relation to the **wider determinants of health**, in line with the overarching approach to this workstream.

Develop business intelligence on inequalities

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Key actions:

- Establish a coordinated and strategic approach to **linking with Population Health Management teams to address gaps in data**. This may include:
  - Access to more granular population health analytics and benchmarks/baselines for service analysis.
  - Influencing the recording and sharing of priority demographic (protected characteristics) data within primary care. CHCP's own practices could model the benefits of improved demographic data quality/sharing.
  - In cases where shared information is not available, CHCP may need to revisit the case for local collection of demographics/health inclusion status that are critical to specific service action plans.

Harness citizen engagement

Objectives

- Provide precise and robust insights about what needs to change/ what good looks like from the perspective of those affected
- Build foundations for partnership working on inequalities

Key actions:

- Map and ensure there is **strategic link with all local citizen engagement and community development programmes/channels** for key population groups/ geographic communities (including those in development e.g. ICB Citizen Engagement Group).
  - This includes establishing ownership for relationship management and establishing how services and functions can access insights and consult with these groups.
  - Assess whether new or dedicated community development groups are required – seeking to commission these collaboratively/via the ICS.
- **Capture and disseminate best practice** for co-production related to inequalities – including consideration of the scope of co-production (what questions we are asking).
- Consult on what support or tools services need in order to execute effective and sustained co-production.
- Identify and **pilot creative methods of engagement** with services that have struggled to elicit representative input from key population groups – aligned to service action planning. This may require external specialist support.

Support each service to create action plans

Objectives

- Encourage and enable each service or locality-based team to identify the most pertinent inequalities issues, take steps to address these and actively highlight where assistance or coordination with others is needed

Key actions:

- **Facilitate development of an action plan** on inequalities by each service area that promotes co-design of services and pathways to improve inclusivity:
  - Disseminate and maintain a **toolkit** that prompts key considerations, captures co-production best practice and offer ideas and insights from other services.
  - In order to gather initial momentum, assign (a group of) **facilitator**(s) who understand the principles, process and expectations to work service-by service with operational managers to devise, capture and kick-off plans.
  - Coordinate access to **specialist advice and input** aligned to the service-by-service action planning process ensuring there is a clear escalation route when external support is needed.
- **Encourage more immediate action** across all services, based on available insights and intelligence – by asking **each service to identify in business plans two tangible and achievable commitments** to reduce inequalities.

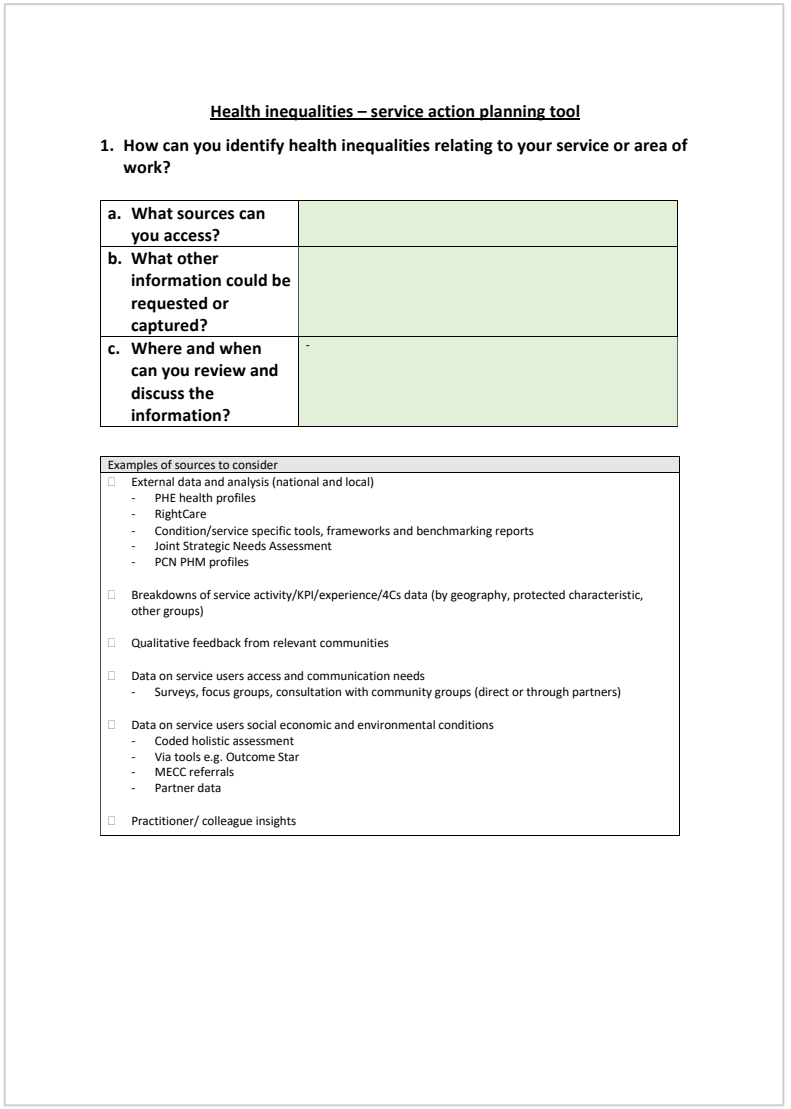
Service action plan tool overview

How can you identify health inequalities relating to your service or area of work?

Which inequalities are of most concern? (groups and drivers)

What is the action plan to understand and address these?

How can you monitor and evaluate the effect of the action taken?



Health inequalities – service action planning tool

1. **How can you identify health inequalities relating to your service or area of work?**

a. What sources can you access?	
b. What other information could be requested or captured?	
c. Where and when can you review and discuss the information?	-

Examples of sources to consider
☐ External data and analysis (national and local) - PHE health profiles - RightCare - Condition/service specific tools, frameworks and benchmarking reports - Joint Strategic Needs Assessment - PCN PHM profiles
☐ Breakdowns of service activity/KPI/experience/4Cs data (by geography, protected characteristic, other groups)
☐ Qualitative feedback from relevant communities
☐ Data on service users access and communication needs - Surveys, focus groups, consultation with community groups (direct or through partners)
☐ Data on service users social economic and environmental conditions - Coded holistic assessment - Via tools e.g. Outcome Star - MECC referrals - Partner data
☐ Practitioner/ colleague insights

Reframe our approach to acting on wider determinants of health

Objectives

- In a practical way, enable services and practitioners to identify and respond to wider factors affecting the health of individuals in relevant population groups – including links with internal resources
- Develop a proportionate way to capture and review action on wider determinants of health to support effective working and investment where it is needed

Key actions:

- Articulate **the strategic direction for CHCP's approach to the wider determinants** of health, specifying its scope, what it should achieve and who is responsible for driving it. Should it focus on lifestyle and behaviour actions, specific actions associated with inequalities (e.g. hypertension case-finding), or include more holistic social prescribing connecting people into support in their communities? Is it restricted to MECC referrals as currently defined and brief interventions or encompass different intensities of intervention?
- Reframe MECC as part of a wider **multi-level approach that promotes and increases the onus on services and practitioners.** With increased emphasis on frontline conversations and the flexibility for practitioners to raise an issue, actively signpost, link directly with other services or via Care Coordination. This would be underpinned by expanded training, enhanced navigation tools/information and service-level reporting.
- Enable practitioners to **prioritise people in groups vulnerable to worse health outcomes** for conversations about the wider determinants of health – e.g. by flagging these on the patient's record. This could make use of locally used risk stratification tools.
- Conduct a scoping exercise to understand what informal 'MECC' activity is happening now and how it is recorded. Consult on options to quantify needs that are identified and actions taken without adding friction to this process e.g. referrals received by relevant services (see St Helens Wellbeing dashboard), structured data items in assessment templates, audit.

Reframe our approach to acting on wider determinants of health

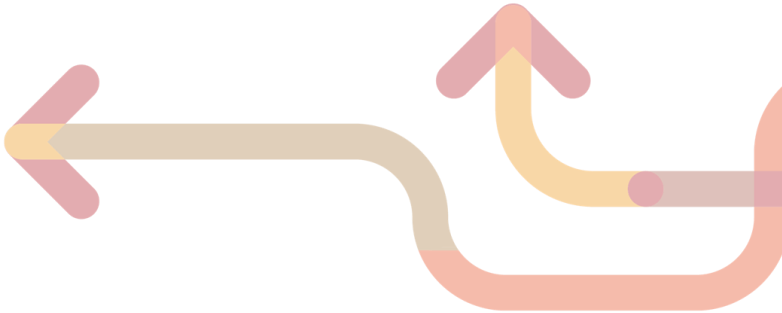
Objectives

- In a practical way, enable services to identify and respond to wider factors affecting the health of individuals in relevant population groups – including links with internal resources
- Develop a proportionate way to capture and review action on wider determinants of health to support effective working and investment where it is needed

Key actions:

- **Clarify the process, responsibilities and leadership** for maintaining the DOS, keeping practitioners up to date on services/resources, updating referral pathways with partners and engaging with community development initiatives to build the ecosystem of resources, in order to **expand knowledge of where we can refer in what circumstances.** Assess potential to use GP care navigation tool and take a collaborative approach.
- **Simplify MECC referrals** to the care coordination centre and revisit the platform/ database used so that it facilitates more efficient information-sharing and visibility of the status and outcome of the referrals to service areas. InHealthcare, the Care Navigation Tool or Service-Specific solutions may be considered as options.
- As necessary, engage with commissioners on **reviewing the definition of MECC, quality specification and reporting requirements.** This aims to recognise and facilitate actions within service areas (including those that encourage self-referral) and release care coordination resource to focus on follow-up conversations and increasing links with the ecosystem of support. Other areas evaluating the effectiveness of MECC focus on staff-reported impact of MECC training as key measure.

Maximise local resources and assets



Objectives

- Enhance the resources and assets – whether internal, across the system or in the community – that are most relevant to easing access to our services for disadvantaged groups, and to addressing the wider determinants of their health
- Prioritise core issues for those who need our services and align CHCP strategies to maximise the collective impact of every pound spent – including reinvestment, employment and skill development, volunteering, estates planning and supply chain

Key actions:

- Map and **define the most critical gaps** or opportunities in wider resources (bringing together service, CCC, community and system intelligence) for each place – e.g. transport models, digital prescribing, health coaching, befriending. Establish a process to periodically refresh this list.
- Use CHCP's Social Value strategy to **harness CHCP's activities and influence to specifically build, expand or adapt these resources** and addressing the needs of agreed priority population groups (e.g. Core20Plus). This may include:
  - Aligning (part of) the systems thinking fund specifically to inequalities – with the expectation that all initiatives mitigate potential impact on equality.
  - Aligning key workforce development and inclusion programmes with specific objectives to draw more of the workforce from the population groups CHCP most needs to serve.
  - Overlaying priority issues / population segments to relevant social value measures (e.g. grants, apprenticeships) to increase attention, accountability and partner engagement.

Position CHCP to work through our wider systems

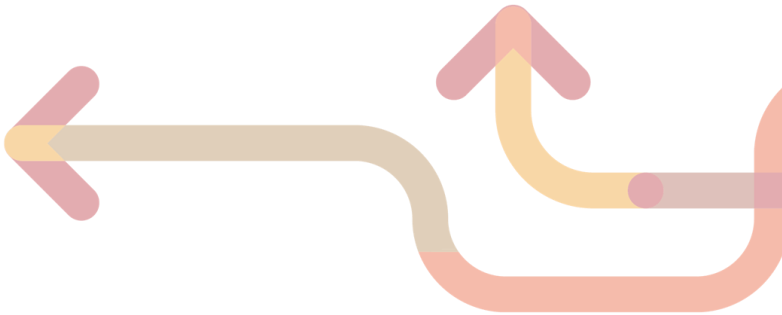
Objectives

- Increase cross-system attention to issues identified by services and advocate for system strategies and resources to address them
- Connect relevant teams with PCN/neighbourhood-based working to support hyper-local action

Key actions:

- **Increase CHCP's profile as a VCSE working in communities** that face worse health outcomes, using this to influence programme priorities and resource allocation.
- **Utilise scoping of ICS and Place-based inequalities work** to put forward key tangible asks aligned with the strategy and service action plans, including incentivising/ promoting data recording and sharing; access to shared citizen engagement resource and insights; and community resource development identified (as identified).
- Coordinate **nominated individuals to participate in all relevant strategic and operational groups,** ensuring they are fully briefed on inequalities intelligence from across service areas and feedback from citizen engagement. Communicate a clear route for escalation of system issues.
- **Model the role that CHCP services can play in neighbourhood-based action.**
  - Assign to the most engaged PCNs in Hull and East Riding: District Nurses to maximise contacts with housebound patients in key population groups + IAPT to develop delivery that is more integrated with local primary care.
  - In the North West, Link Workers tasked to define opportunity for targeting support to deliver on neighbourhood priorities.
  - Advocate for enablers of further integrated working on inequalities through community and primary care interface group, HWWB and Place Boards.

Embed leadership and assurance



Objectives

- Clarify ownership and responsibilities at each level for inequalities actions
- Provide visibility of how CHCP is performing on addressing health inequalities and the impact of key changes on inequalities
- Ensure CHCP is accountable for achieving its objectives which contribute towards reducing health inequalities

Key actions:

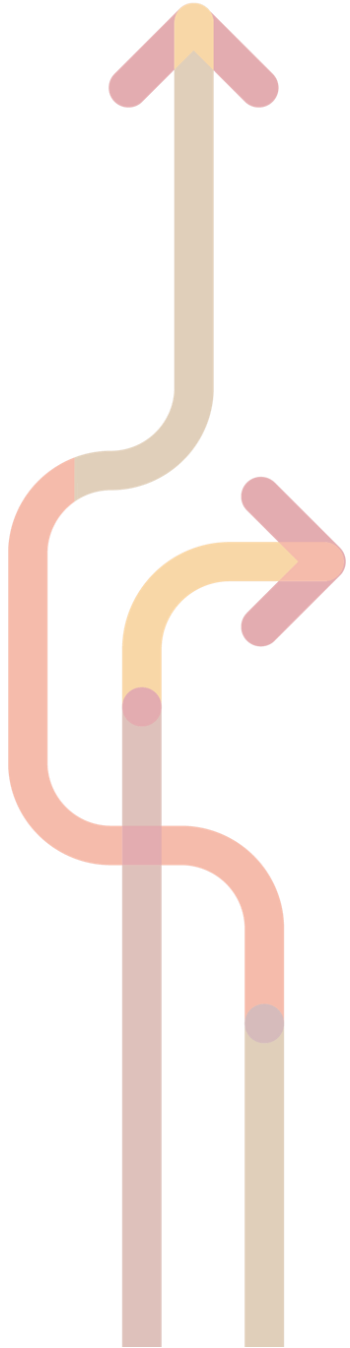
- Establish a **programme structure with senior leadership** to drive implementation of the strategy and provide assurance on delivery of key improvements.
- Create a **framework that 'mainstreams' oversight and responsibilities** for health inequalities – clarifying what is operationally owned and the role of central coordination, support and assurance.
- Formalise ongoing **organisation-wide responsibilities** (within new or existing roles) e.g. leadership for wider determinants of health.
- Articulate and embed **expectations at individual, team and service level** in relation to inequalities aims and principles.
- Design a **routine reporting and oversight framework** that increases visibility of equity within existing management/ governance structures (e.g. business performance committee), supports professional accountability for core activities such as training or AIS compliance, and retrospectively reviews the impact of key service developments (e.g. as part of project management forum benefits tracking).
- Schedule **periodic review/evaluation at organisational level** (e.g. EDS) that draws on external scrutiny and challenge such as peer review and/or community appraisal. Structuring this to focus on a sub-set of services or core activities at a time will enable deeper investigation, including data analysis.

How will we measure success?

Aim	Measures
Ensure that we reach and engage everyone who most needs our services in a way that works for them	• Progress on reducing key gaps in access KPIs by core population groups and on service-defined equity measures • Evidence that services and pathways are designed for inclusion addressing feedback from citizen engagement, patient surveys and 4Cs • Periodic review with peer/ citizen scrutiny demonstrates equity considerations are well-embedded in service design and delivery
Maximise use of each interaction to understand the person as a whole and address the wider factors contributing to their health	• Wider determinants of health data (TBD) demonstrates practitioners routinely responding to wider factors across service areas • Colleague feedback shows practitioners are engaging in conversations with patients identified as most vulnerable and making relevant links • Holistic experiences of care are reflected in feedback from community or patient engagement
Ensure our system partners know about the health inequalities we identify through our services and recognise the opportunities to address these	• Place-based plans reflect priorities and needs identified by CHCP • We are delivering action on inequalities with neighbourhood and Place colleagues and demonstrating collective progress on shared priorities (e.g. Core20Plus5 clinical areas)
Use all our activities to address service access and wellbeing for those in our communities who are most likely to experience worse health outcomes	• Evidence of organisational choices aimed at reducing inequalities • Social value measures (e.g. TOMs) show resources and opportunities are actively targeting key population groups and priority community resources

Next steps

- Test implementation structure/timing
- Investigate resourcing options



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