Systematically Addressing Health Inequalities
This booklet describes the diagnostic model used by the Health Inequalities National Support Team to identify at a local level what specific interventions are needed to improve service outcomes and highlights the key lessons learned from visits undertaken to date since the team's inception in January 2007.
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1. Introduction to the National Support Team

The National Support Team (NST) for Health Inequalities was set up in 2007 to provide support to local areas focusing principally on the life expectancy element of the 2010 Public Service Agreement (PSA) target – to reduce by at least 10% the gap between the fifth of areas with the worst health and deprivation indicators (Spearhead areas) and the population as a whole.

The team uses a diagnostic model to help local areas identify the key interventions they can implement in order to succeed. The three categories of intervention are:

- population health;
- personal health; and
- community health.

The team then helps local areas identify interventions that can improve service outcomes and how local populations can use and be supported to use those services.

This briefing outlines the key components of the model and highlights some of the lessons learned by the team since its inception.

BACKGROUND

The Public Health NSTs were first set up in February 2006 with the creation of the Sexual Health NST focusing on the 2008 target to provide 100% access to all genito-urinary medicine clinics within 48 hours. Subsequent NSTs to support 2010 targets on tobacco control and teenage pregnancy were set up late in 2006 and early 2007 alongside the Health Inequalities NST. A further NST focusing on childhood obesity began in September 2007.

To date, the NSTs have undertaken over 150 visits to local areas, providing intensive, tailored support to primary care trusts (PCTs) and their partners to deliver against public health priorities. The NSTs have produced a number of High Impact Change guides, communication tools and good practice publications to enable shared learning across England. Each NST also provides follow-up support to areas through the provision of ongoing support, interim management, social marketing training and visioning events.

Currently, the NSTs are engaging in a number of regional events to market and share learning with Government Office and strategic health authority (SHA) colleagues, PCT and local authority chief executives and directors of public health directly.
2. Ten major lessons learned to date

The following list encapsulates some of the major lessons learned by the NST for Health Inequalities, after considering the good practice and identified gaps in delivery across the Spearhead communities visited in the last 15 months.

Make vision and strategy clear: Take a strategic, evidence-based approach – know your inequalities gaps, and what conditions are responsible. Look right across the patch and consider the drivers, and which organisations have the levers to address them. Consider demographic and other future changes. Develop strategy that addresses issues in the short term (up to 2010), the medium term (involving lifestyle approaches) and the longer term (including the wider determinants).

Extend leadership and engagement: Lead from the top with chief executives, directors of finance, commissioning and primary care, and clinical leadership playing their part. Public health can play a leading role, but cannot deliver this alone. Non-executive members of PCT boards and elected members of councils should have informed ownership and nominated champions.

Make partnership work: Ensure that partnerships are effective at the level of executive/non-executive members, but also among middle management and frontline staff. Each organisation should agree priorities, explicitly share leadership and responsibility, and contribute to concerted action. Support infrastructure development within organisations in the voluntary, community and faith (VCF) sector to enhance their potential contribution as strategic partners.

Get system and scale right: Turn effective personal health and community health interventions into population-level interventions by addressing ad hoc and patchy delivery. Develop systematic, focused action plans detailing the whole trail, through to targets and outcomes. Aim to ‘demystify’ how change will be achieved. Scale action to the size of the problem, modelling the numbers where possible.

Adjust workforce: Consider and address the workforce implications of industrial-scale programmes, eg register management, taking into account the necessary scale of activity and balancing skill mix to obtain cost-effective, sustainable systems.

Strengthen primary care: Ensure that the quality and quantity of primary care available in disadvantaged areas meets need and is well organised. Strongly challenge practices causing concern, to ensure that there is pressure to
improve them, and they remain under ongoing scrutiny. Proactive development and support should be available both generally – eg strengthening practice management – and for the specific priorities of managing cardiovascular disease, diabetes and chronic obstructive pulmonary disease programmes. Capitalise on strong performers in the same Practice Based Commissioning alliance to show the way.

**Find the missing thousands:**
Be proactive in seeking out people who already have disease or are at high risk but are accessing services sub-optimally or not at all. Use prevalence models to identify gaps between expected and actual numbers on registers (eg Quality and Outcomes Framework (QOF), Cancer Registers). Pursue them systematically through practice records, and by outreach into communities.

**Capitalise on community engagement:**
Support local authority partners in the development of neighbourhood and community infrastructures to engage residents, particularly those ‘seldom seen, seldom heard’ in services. Use to ensure that services are responsive to needs, but also to help motivate and support appropriate health-seeking behaviour. Establish effective links with frontline services, utilising the potential of VCF sector agencies as valuable catalysts for dialogue, mutual understanding and empowerment.

**‘Raise the bar’ on target achievement:**
Currently, performance targets often have ceilings of 70–80%. This may reduce incentives to address the patients who are harder to reach, those with more complex problems or those with greater levels of personal or contextual problems. Develop a strong QOF exemptions strategy to ensure that vulnerable patients are not removed from target registers before significant efforts have been made to achieve good outcomes, despite the complexity and resource this might involve. Follow this with systematic validation of the records.

**Utilise population health intelligence:**
Ensure that there is adequate capacity and capability to generate population health information and intelligence in real time and on a business footing to drive programmes. This should be networked internally (eg linking public health, primary care, prescribing and commissioning data) and externally (eg linking with local strategic partnership systems, population health intelligence networks and public health observatories). Analytical output should be disseminated and ‘marketed’ widely to stakeholders.
3. Hitting population-level targets

Achieving percentage change at population level can be pursued in three main ways (Figure 1):

**Population health level**
- Direct input at population level through legislation, regulation, taxation, mass media etc (eg preventing smoking in enclosed public spaces).

**Personal health level**
- Applying effective personal health interventions (eg cholesterol management with statins, affordable warmth) systematically, and at a scale such that improvements add up to population-level change.

**Community health level**
- Engaging, developing and empowering communities effectively and systematically enough that resulting health-improving and health-seeking behaviours lead to percentage change at population level.

**IMPROVING SYSTEMS**

Achieving improvement in health inequalities through a combination of these factors will depend on ‘the organised efforts of society’ at four points in the population health triangle as shown in Figure 1. Lessons learned by the NST related to each of these are summarised in the boxes below.

A. The whole must be driven by committed leadership fostering engagement, effective local strategic partnership, and a locally owned, coherent vision and strategy (Box A).

B. Interventions must be provided effectively with system and scale by frontline services proactively pursuing health outcomes (Box B).

C. Community development should be addressed in a systematic way, rather than ad hoc, targeting engagement and support to the weakest and least capable of responding alone (Box C).

D. A range of processes should connect frontline services into the heart of communities, reaching out to ‘seldom seen, seldom heard’ groups and individuals (Box D).
The NST has seen excellent examples of ‘seamless’ partnership working between local authorities and PCTs, with cross-representation on boards, joint meetings of executive teams and members/non-executive members, and jointly funded posts.

Joint director of public health posts work best where there are resources available for support to the post in both the PCT and the local authority, and governance arrangements are clear.

In many areas, PCTs are being relied on to deliver health agendas, as the health ‘directorate’ of the local authority, because health inequalities do not appear in local authority corporate plans.

Chief executives, boards and all directorates need to have joint responsibility for the health inequalities agenda. Public health will have a major role but cannot deliver on its own.

There is a need for a detailed strategy or action plan that shows how the 2010 PSA inequalities targets will be achieved.

The public health analytical resource needs to be integrated into the mainstream corporate intelligence of both the PCT and the local authority, if it is to help drive the ‘core business’ of addressing health improvement targets.
Systematically Addressing Health Inequalities

Systematic and scaled interventions by frontline services

- Primary care will need to play a central role if the 2010 target is to be achieved. Organisational capacity and capability may need to be addressed in some practices if they are to work more effectively on this agenda.
- PCTs are working on ambitious reconfiguration and estates strategies, often in conjunction with primary care modernisation plans, but many of these will not have produced substantial change before 2010.
- PCTs find great difficulty in ‘moving on’ GPs found to be no longer up to the task.
- The best performing PCTs are providing tailored developmental support to improve underperforming but remediable practices.
- Most PCTs visited now have a good analysis of their inequalities gap. This is put to best use when modelling numbers to derive necessary system and scale in programmes if targets are to be met.
- Some commissioners are exploring a ‘health gain schedule’ as part of all contract specifications to make the prevention agenda part of the business of all frontline staff. This is systematic about training, brief interventions, referral pathways and performance monitoring, and should, at least, cover smoking, alcohol problems and obesity.
LESSONS LEARNED BY THE NATIONAL SUPPORT TEAM FOR HEALTH INEQUALITIES

Systematic community engagement

- All PCTs and local authorities should have joint systems for reaching vulnerable patients at highest risk, who may be demotivated and not in meaningful contact with services. These systems should be of sufficient scale to make a difference.
- In many areas, community engagement has responded to communities that already have good levels of social capital, and are well placed to bid and compete for funds. Funding regimes need to ensure that disadvantaged communities with the lowest social capital are empowered to secure resources sustainably.
- Each locality needs a coherent structure for community engagement, preferably using natural neighbourhoods as the building blocks. For example, in larger boroughs neighbourhood management may function at three levels: 1) borough-wide, with themed connectivity, eg ethnic minority; 2) intermediate locality reflecting organisational structures; and 3) the neighbourhood itself.
- A comprehensive engagement system is needed to interact not only with community groups but also with socially excluded individuals and families, eg through health trainers, community ambassadors and community health educators.
- Segmentation, as part of ‘bespoke’ social marketing analysis, is beginning to offer scope for developing intelligence-led ‘customer access strategies’.

Frontline service engagement with the community

- Many local areas have large proportions of the population that are ‘seldom seen, seldom heard’. This can be addressed through the systematic use of practice registers and outreach staff to draw people into services.
- Strategies for outreach to excluded individuals should focus on peer training, eg health trainers, health advocates, community ambassadors. Outreach strategies need to be targeted, and scaled up appropriately in order to have an impact across whole communities.
- The NHS workforce, working to connect with communities – eg community development workers, health trainers – should be fully integrated with other services and central to strategic development. Best practice integrates them effectively with other frontline community-based staff and programmes (eg tobacco, diabetes, affordable warmth).
- The VCF sector has great potential to bridge across from service into community, provided the sector is supported to develop its infrastructure to function at a strategic level and becomes integral to local commissioning.
OPTIMAL POPULATION-LEVEL IMPACT FROM INDIVIDUAL INTERVENTIONS

Moving from projects to programmes

- To achieve an impact at population level, systems of delivery need to move from being project based to being programme based. The NST has established a set of criteria by which to achieve this (see Panel 1).

Panel 1: Key points for achieving percentage change in population health

Programme characteristics will include being:

- **evidence based** – concentrate on interventions where research findings and professional consensus are strongest;
- **outcomes orientated** – with measurements locally relevant and locally owned;
- **systematically applied** – not depending on exceptional circumstances and exceptional champions;
- **scaled up appropriately** – ‘industrial-scale’ processes require different thinking to small ‘bench experiments’;
- **appropriately resourced** – refocus on core budgets and services rather than short bursts of project funding; and
- **persistent** – continue for the long haul, capitalising on, but not dependent on, fads, fashion and policy priorities.
4. Lead time for achieving outcomes

Figure 2: Lead time for achieving outcomes

For 2010, only a specific set of interventions will impact in time. It is important to concentrate on these in the short term (A).

BUT that does not mean neglecting completely interventions with a medium- (B) or longer-term (C) gestation period.

Quite a number of the short-term interventions will also pay benefits in the medium term, eg tobacco control, physical exercise (B).

Many of the developments necessary to deliver with the right levels of system and scale in the short term will be necessary to deliver long-term objectives (eg strengthening primary care delivery, systematic community engagement) (C).
5. The National Support Team for Health Inequalities ‘Christmas tree’ diagnostic

- This diagnostic model identifies those factors which will determine whether a given intervention will achieve its best possible outcomes in a given population.

- Figure 3 contains 13 components.
  - Those factors under **Challenge to providers** determine whether the services delivering the intervention will produce the optimal service outcomes.
  - However, best outcomes at population level, including maximum health gain with minimal health inequalities, will not be achieved without attention to **Population focus**. These factors determine how the population will use, and be supported to use, the available services.
  - Factors shown in the middle of Figure 3 influence how commissioners and their providers will balance and co-ordinate need and supply.

- Much central policy guidance has focused on service outcomes (right-hand side of Figure 3). Little attention has been given to the factors (left-hand side of Figure 3) that will bring most influence to bear on inequalities in access and outcomes.

(The following numbered paragraphs correspond to the numbered components of Figure 3.)
Figure 3: Commissioning healthcare for best outcomes

**Population focus**
- 10. Supported self-management
- 9. Responsive services
- 7. Expressed demand
- 6. Known population-health needs
- 8. Equitable resourcing

**Challenge to providers**
- 5. Engaging the public
- 4. Accessibility
- 2. Local service effectiveness

**Optimal population outcome**
- 13. Networks, leadership and co-ordination

**12. Balanced service portfolio**
- 11. Adequate service volumes

**CHALLENGE TO PROVIDERS**

1. **Known intervention efficacy**
The health community should work to ensure that services are set up and maintained on the basis of best current knowledge of the efficacy of interventions and national guidance.

If interventions are being employed to have an impact at population level, clear levels of evidence are required, avoiding interventions where there is doubt or lack of consensus.

The Health Inequalities Toolkit (ref) provides support to such analysis, with breakdown from national level mirrored on a local basis. Emphasis will then need to be placed on how to extend the interventions effectively to all those who can benefit.

2. **Local service effectiveness**
Service providers should maintain consistent high standards of local effectiveness through education and training. This should be driven
by integrated systems of professional and organisational governance and audit. Figure 4 shows that, in this PCT, only about 40% of patients on the practice diabetes registers have their blood sugars controlled to the target level. This data should be owned by primary and secondary care providers, as well as commissioners, as action plans are developed, implemented and monitored to identify poor performance and develop recovery plans.

3. Cost-effectiveness
If interventions are to impact on the whole population, it is necessary to ensure that they are delivered in the most cost-effective manner, in order to ensure that the programme is affordable and sustainable. Good practice investigation has linked costs to outcomes, e.g., diabetes prescribing costs set against success of controlling blood sugar. High-cost, poor-outcome practices are now being ‘buddied’ with low-cost, high-outcome practices to prompt beneficial change.

Figure 4: DM 6 – Percentage of patients whose haemoglobin A1C was ≤7.4 (measured in the last 15 months)
4. Accessibility
Bringing services closer to patients and communities may substantially improve uptake, presentation and utilisation. Patient pathways should be designed with this in mind. However, service reconfiguration, Care Closer to Home and Practice Based Commissioning initiatives need to balance this with issues around effectiveness and cost-effectiveness for optimum overall impact.

5. Engaging the public and patients
Delivery systems for interventions should be based around, and directly respond to, the needs and wants of the person, rather than the person having to fit around the needs of the service. Patient and community inputs should be drawn in systematically, not as a tokenistic add-on, and ongoing dialogue should be established.

Efforts should be made to engage ‘seldom seen, seldom heard’ elements of the population, not just the usual suspects. Segmentation of the consulted population should be used where possible, applying social marketing principles, so as to define targeted ‘customer access strategies’.

POPULATION FOCUS
6. Known population health needs
Most Spearhead PCTs (using the Health Inequalities Toolkit) have carried out an appraisal of the main components of mortality that contribute to their mortality gap. The analysis is extended in most cases to ward level, and in many cases to neighbourhood/super output area level, so as not to miss pockets of deprivation and excess mortality.

However:

- some areas could benefit from improved ethnic monitoring;
- it is important to have consistent methods to calculate mortality trends to avoid mistakes in interpretation;
- the rate of seasonal excess deaths could be significant in some areas so routine monitoring could be helpful; and
- Cancer Networks may benefit from having a population focus so as to cover issues such as late presentation and low intervention rates.

A number of Spearhead areas have used their analysis to model which interventions will be necessary, and to what scale, if the 2010 PSA target is to be reached. These areas have produced the most realistic delivery plans as a result.
7. Expressed demand
Many people with important health needs fail to present with them to service, including those with chronic problems – many of whom will present too late (heart attack, lung cancer). This is particularly true of those in deprived circumstances, who have many competing needs, those with chaotic lifestyles, those with personal challenges (low IQ, poor literacy, low expectation) and those from different cultures.

Chronic diseases require management and unless patients are identified, either with high risk or established disease, and registered they will not benefit from interventions such as primary and secondary prevention.

Figure 5 shows that, in this PCT, there is a considerable gap between the number of patients registered, and an estimate of how many would be expected. There are good examples now of PCTs that have managed to close these gaps, particularly for coronary heart disease patients, by addressing factors in Panel 2.
LESSONS LEARNED BY THE NATIONAL SUPPORT TEAM FOR HEALTH INEQUALITIES

Panel 2: Identifying patients not yet registered with target diseases

Reasons why appropriate patients are not appearing on registers include:
- they have been diagnosed, but missed off the register;
- they have been identified as possible, but without confirmed diagnosis;
- they attend the practice, but the issue has not been raised;
- they rarely, if ever, attend the practice; or
- they are not registered with a practice.

Studies have identified reasons why patients do not present, eg with angina, including:
- geographical, eg distance from practice, complex journey;
- user-unfriendly service access: frosty, bureaucratic reception; cultural/interpreter problems; appointment systems; access delays; unlinked out-of-hours;
- community knowledge, understanding, beliefs and expectation: about condition, services, life; and
- personal beliefs and skills: demotivation, low expectations, low self-confidence, poor literacy, low-IQ etc.

Corrective strategies are needed to explore each of these elements systematically.

8. Equitable resourcing
Few Spearhead communities visited by the NST have made much progress in moving from historical to needs-based funding. This is critical if health inequalities are to be addressed. Achieving equitable outcomes with individuals from deprived circumstances costs disproportionate amounts for delivery and support (eg it is three times more costly to support someone quitting smoking who is from an ethnic minority than a white Caucasian).

9. Responsive services
When patients express demand and present for service appropriately, and with resources targeted and available, services should respond actively to channel them effectively to interventions they will benefit from. This should happen regardless of entry point chosen. Patients should receive culturally sensitive help to navigate to the relevant service, and should be followed up to ensure arrival and engagement.
Traditionally referred to as the ‘inverse care law’, it was usual for areas with most need to have access to the least effective frontline services. This has been due to a combination of pressure of need, inability to attract high-calibre staff into deprived areas, under-resourcing and poor facilities.

Figure 6 shows the situation in one PCT, where a significant number of practices have been unable to claim large numbers of their non-clinical points in QOF. This may be an indication that these practices have poor capacity and capability for organisation and management. Such practices will be ill equipped to provide the responsive and supportive services required by patients in more deprived circumstances.

The NST has identified exceptions as being potentially a mechanism whereby the system is driving the inequalities gap wider (variable levels by practice are shown in Figure 7). It currently allows many of the most complex,
Figure 7: Percentage of patients with last measured cholesterol ≤ 5 mmol/l (measured in the last 15 months)

vulnerable and least amenable patients to be excluded from assessment of disease management. In some areas, for example, housebound patients have been exempted.

As a minimum, the NST recommends that all PCTs develop an exceptions strategy as part of their validation. This tightens up on criteria and their application. For example, they would include a failsafe mechanism to ensure that there is sensitive follow-up of vulnerable patients before excluding them for missing appointments on three occasions.

10. Supported self-management
Patients with, for example, diabetes, hypertension and coronary heart disease can end up on a complicated array of medication, which can be challenging for anyone to manage. This is particularly so where there is low IQ, poor educational attainment and literacy, chaotic lifestyle, or cultural and
language issues, and targeted support will be necessary.

It may be necessary to commission interventions such as structured education programmes, to provide more cover in a way that is good enough for purpose, rather than trying to maintain excellence for a few. An alternative workforce, of educationalists, may be able to produce the bulk of the programme, reducing the time commitment of specialist clinical professionals.

Segmentation of the delivery options, rather than a one-size-fits-all approach, has proven beneficial. This has reduced waiting lists and drop-out rates for example in pulmonary rehabilitation programmes.

**BALANCE AND CO-ORDINATION**

**11. Adequate service volumes**

**12. Balanced service portfolio**

Paying attention to the way the population uses services and supporting them to do so will drive up demand for services. It may be possible to model the expected increases, in which case services should be commissioned appropriately. Waiting lists may particularly disbenefit some disadvantaged patients. Similarly, bottlenecks in service may increase fallout of vulnerable patients who may not manage setbacks well, so attention must be paid to patient pathways.

**13. Networks, leadership and co-ordination**

Balancing all the many complex factors that influence whether an intervention is delivered efficiently and effectively through service, and that the population is supported to access and utilise the service appropriately, requires leadership and co-ordination. This will be a major role for the commissioners, but also for networks engaging local providers.
6. Conclusions and next steps

The theoretical delivery framework described above, outlining the practical steps that can be taken to hit health inequalities targets, has been used by the NST as the basis of its diagnostics.

The ‘Christmas tree’ framework has been used to develop a series of detailed workbooks, which are the basis of focus group work during NST visits. Current workbooks include:

- cardiovascular disease;
- diabetes;
- cancer;
- tobacco control;
- infant mortality; and
- seasonal excess deaths.

Workbooks for chronic obstructive pulmonary disease and alcohol are under development.

NST support visits focus equally on identifying strengths and good practice and making tailored recommendations on how to address gaps in planning and delivery.

Feedback following visits has been extremely positive and return visits after six months have in each case shown very substantial changes to planning and delivery in line with key recommendations.

The NST is examining methods for highlighting and sharing good practice both in ways that are tailored to local health communities, and in more generalised formats for policy makers at SHA/regional and national level.

Consideration is being given to the possibility of extending offers of visits to all Spearhead communities.

Benefits of the lessons learned will be extended to non-Spearhead communities that are addressing local inequalities gaps, initially through a series of regional and sub-regional learning events.

The NST for Health Inequalities believes that current gaps can be substantially reduced if attention is paid to delivery of effective interventions as systematically as possible and to the appropriate scale.