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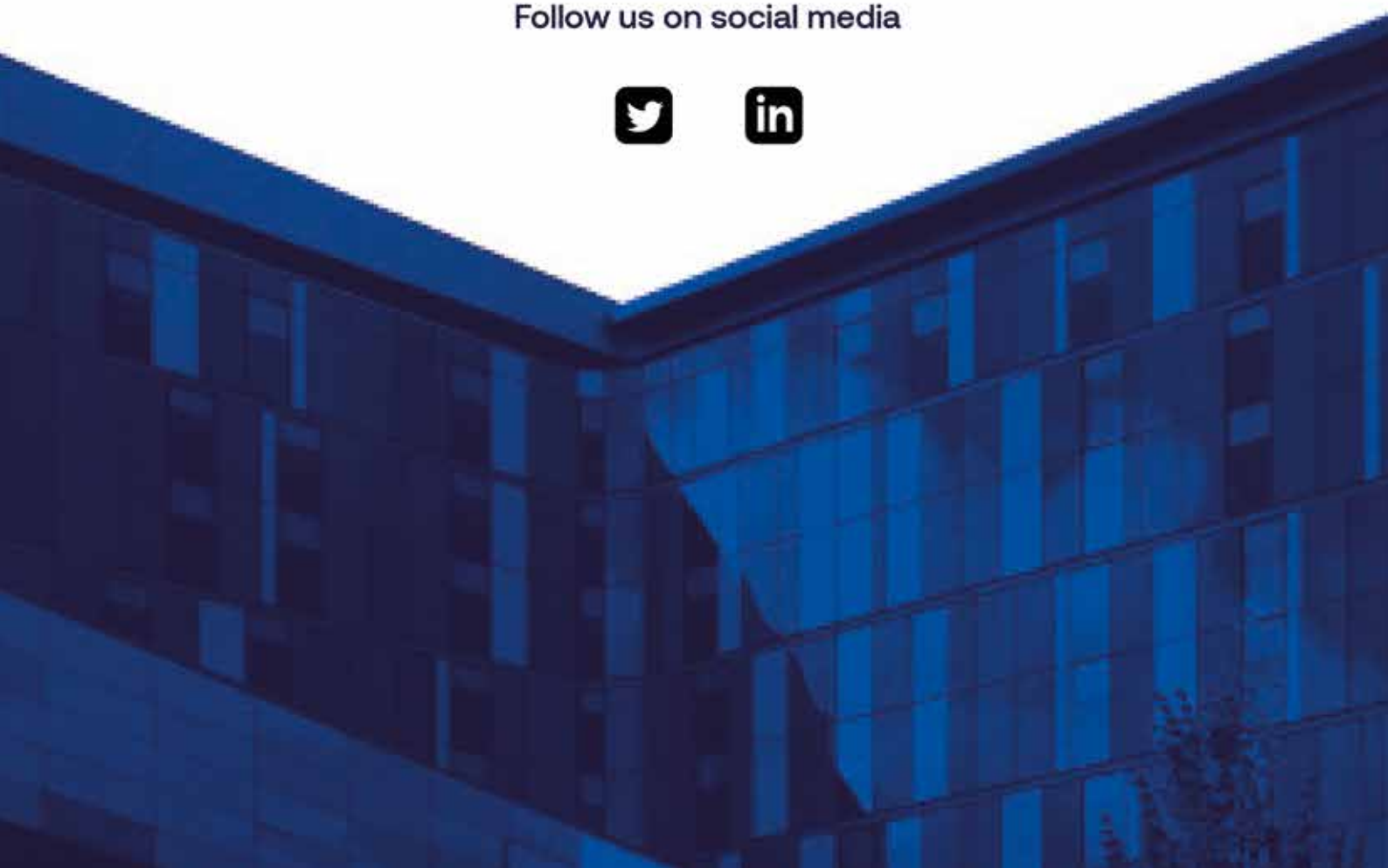

Levelling up

Addressing health inequalities is a priority for health systems. Steve Brown reports on how parts of the service are gearing up for the work and how finance practitioners are getting involved

Health inequalities are nothing new. The most recent figures from the Office for National Statistics showed a 9.4-year gap in life expectancy for men between the least and most deprived areas in England (7.6 years for women). And the gap in healthy life expectancy is closer to 20 years.

Covid-19 has pushed health inequalities even further into the spotlight. There has never been such a focus on addressing these issues as there is now.

The pandemic's unequal impact on the population is well documented. Although old age has been the biggest risk factor, the virus has hit deprived areas and some ethnic groupings harder.

A Public Health England report in 2020 said that among confirmed Covid cases, people of Bangladeshi ethnicity had around twice the risk of death compared with white British people. And those with Chinese, Indian, Pakistani, other Asian, black Caribbean and other black ethnicity had between a 10% and 50% higher risk of death than people who define themselves as white British.

There were also more hospitalisations and higher death rates in the most deprived areas. Waiting lists have grown more rapidly in these places – and they could also have larger numbers of the millions of 'missing' patients who didn't come forward for treatment during the past 18 months.

All of this has helped to put addressing health inequalities at the top of the agenda.

The planning guidance for the second half of the current year in England made this absolutely clear, restating the five priority areas for tackling health inequalities:

- Restore services inclusively
- Mitigate against digital exclusion
- Ensure datasets are complete and timely
- Accelerate preventative programmes for those at greatest risk of poor health outcomes
- Strengthen leadership and accountability.

The virus has hit some ethnic groupings harder. There were also more hospitalisations and higher death rates in the most deprived areas

NHS contribution

While many factors driving health inequalities are outside the direct responsibility of the healthcare sector, a paper to an NHS England and NHS Improvement board meeting this year said the NHS could contribute in three ways. First, it could influence multi-agency actions to address social determinants. Second, as a 'significant economic actor in its own right', its actions as an employer, purchaser and local anchor institution can help to moderate inequalities. Third, it can tackle inequalities in healthcare provision – disparities in access to services, patient experience and outcomes.

As director of the health inequalities improvement team at NHS England and NHS Improvement, Bola Owolabi has been central to this increased focus on health inequalities.

She believes data holds the key to addressing inequalities – you need to see the problem before you can address it. But this means looking at data broken down to the right level.

'It is now hardwired into the operational planning guidance that boards will disaggregate data by deprivation and ethnicity going forward, so we can actually see what lies under the bonnet,' she told a recent HFMA conference.

She believes the Covid vaccine campaign stresses the importance of getting beneath the headline data. According to uptake data in January 2021, 82% of the over-80s had had their first jab. But within that, uptake among black Africans was just 38%, for Pakistanis 44%

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and for those living in the 20% most deprived communities 45%. It was being able to view the data in this way that enabled problems to be spotted and improvements made to target specific populations for improved uptake.

Addressing health inequalities could require prioritisation of specific groups within existing budgets or it could lead to increased costs as the service responds to previously unmet demand. That appears challenging given tight finances and a daunting backlog of activity.

Dr Owolabi wants the service to focus on the costs of doing nothing. The original Marmot review estimated that direct treatment costs in England associated with inequality amounted to £5.5bn a year. Productivity losses were put at £31bn-£33bn, with lost taxes and higher welfare payments costing between £20bn and £32bn a year.

'People from the most deprived areas have lower life expectancy and yet the per capita cost of healthcare in these areas due to emergency admissions, long-term conditions and prolonged length of stay in hospital means a higher healthcare cost in their fewer years of life compared with affluent areas,' she says.

The human cost also makes for difficult reading. '27.2% of mortality from cardiovascular disease under the age of 75 is among people in the 20% most deprived communities,' Dr Owolabi adds.

'And 41.5% of avoidable mortality from chronic respiratory disease is again represented in that 20% most deprived.

'If you look at maternity,' she continues, '[the Mbrrace-UK report shows that] black women are four times more likely to die in childbirth or in the year following birth and Asian women are two times more likely. That is the cost of doing nothing.'

The challenge for many health systems will be knowing where to start. The response from NHS England and NHS Improvement is a new programme called Core20plus5.

This calls for systems to focus efforts and energy differentially on those 20% most deprived communities, plus other population groups experiencing poorer than average healthcare access, experience or outcomes, such as ethnic minority communities, as identified by local population health data.

There is also an emphasis on five key clinical areas of health inequalities:

- Early cancer diagnosis
- Hypertension case finding
- Chronic respiratory disease
- Annual health checks for people with serious mental illness
- Continuity of maternity carer plans.

This will be supported by a health inequalities improvement dashboard, which will enable systems to measure, monitor and gain insight to make improvements to narrow health inequalities.

It covers the five priority areas in the 2021/22 planning guidance, as well as the five clinical areas in the Core20plus5 approach. By providing data by ethnicity and deprivation, the dashboard will enable the NHS to take concerted action to improve health inequalities.

LLR initiative

One system putting its money where its mouth is on addressing health inequalities is Leicester, Leicestershire and Rutland (LLR). The three constituent clinical commissioning groups have introduced a general practice funding formula that better reflects health inequalities across the system.

'I'm sure that if you look at every system strategy, it would talk about a left shift,' says the CCGs' chief finance officer, Nicci Briggs. 'Yet when you look at everyone's finances, you continue to see massive growth in secondary care and lower growth in community and primary care.'

She says the new local approach addresses concerns with the national Carr-Hill practice funding formula, which has been used relatively unchanged since 2004.

'The two largest elements in the Carr-Hill formula are age and gender, so you get more funding if your population is older. But the areas with the most deprivation have a lower life expectancy,' Ms Briggs says. 'That is just a fact.'

In response, the CCGs have adopted the Johns Hopkins Adjusted Clinical Group (ACG) system. This population health analytics tool enables systems to develop an in-depth understanding of population characteristics.

It has already been successfully used in Sweden to support a more equitable reimbursement system for primary care.

The LLR system has used this greater understanding to develop its own capitation formula, with weightings for a wider range of issues that reflect population needs.

For example, it takes account of communication issues. If a practice serves a larger community of people for whom English is not their first language, consultations may take longer.

This might mean fewer people are seen overall or that more practitioners are needed to deliver the same level of service. And that should be reflected in practice funding.

The Carr-Hill formula does adjust for factors outside of age and gender – for example, morbidity and mortality, number of care home residents and list turnover.

However, Ms Briggs says the difference is that the LLR approach takes its data from the system's own patients, while the existing national formula simply applies national percentages. 'And when [the national approach] is divided up at practice level, it doesn't necessarily result in more payments to those practices that have high- and multi-morbidity,' she adds.

The new formula is potentially redistributive – 29 practices were shown to be 10% away from target funding when comparing the new model with existing funding. And eight were more than 15% away from target.

Following wide-ranging consultation, the LLR system implemented its new approach in July on a 'no losers' basis.

Protecting practice income in this way encouraged support for the change among the GP community but did require extra investment. However, this only amounted to £3m.

'Leicestershire is a £1.7bn health economy,' says Ms Briggs. 'This isn't huge in overall terms, but it has led to some practices receiving a 20% increase – showing just how underfunded they were.'

The local funding model does not cover all practice income – quality and outcomes framework payments, premises costs and dispensing monies are all excluded.

However, it does dictate the distribution of more than two-thirds of the system's £180m primary care budget across 133 practices.

At the same time, the new approach has

"It's now hardwired … that boards will disaggregate data by deprivation and ethnicity, so we can actually see what lies under the bonnet"

Bola Owolabi, NHS England and NHS Improvement

Financial contribution

Finance teams have a major part to play in moves to reduce health inequalities. While there is a big push for systems to ensure datasets are complete, finance professionals' jobs will be putting these wide-ranging datasets alongside patient-level cost data – and in future, whole pathway patient-level costs (Plics). They will need to help signpost the inequalities to be addressed, highlight the short- and long-term costs of these inequalities, and understand the costs of reducing them.

It is a huge task, but one that many finance teams are already grappling with. Leeds Teaching Hospitals NHS Trust is one of the more advanced, having developed a Plics population health management analyser to support its population health management approach to improving outcomes (*see Healthcare Finance March 2021, page 30*).

The system enables activity and costs to be analysed by geographical location and levels of deprivation or ethnicity. It also pulls in data about lifestyles – alcohol consumption, smoking, body mass index, diabetes status – although this is based on the trust's own internal data collection and so is not a complete dataset.

Vinod Bassi (pictured), the trust's assistant director of finance, says that initial work turned into a dashboard that supported a Shape up for Surgery initiative. This aims to support improved outcomes by getting patients to adopt different lifestyle choices ahead of surgery.

But word got out about what the finance team could do, and with health inequalities a major priority for the trust, it has been inundated with requests to develop different dashboards.

'We've done an outpatients did-not-attend dashboard to see if there are demographic factors that impact on attendance at clinics,' Mr Bassi says.

'We've also looked at cancer pathway and critical care and we've produced a dashboard for accident and emergency, which, for example, looks at whether people arriving at A&E via different routes – ambulance or walk-in, say – are receiving different responses. And it has helped us to explore the amount of time spent in A&E based on age and ethnicity.'

Mr Bassi says there is massive interest in the trust around population health management and health inequalities. 'There is so much data that you can't fit it all into a one-size-fits-all tool or dashboard, which is why we have so many distinct ones on the go and working with lots of different people at the same time,' he says.

There is a concern that a lot of the work around using data is being taken forward in the provider sector, where arguably there is, in general, better quality activity and cost data.

Some finance managers argue that this initiative should be driven by systems, looking across acute, community and mental health services, as well as primary care and local authorities.

Peter Fry, head of costing and service line reporting at Somerset NHS Foundation Trust – a fully integrated trust delivering acute, community and mental health services – says trusts are having to go 'from zero to 60' on health inequalities.

Building on ideas that other people have implemented – and understanding the mechanics – would help people to get started. So he would also like to see a more structured approach to sharing through case studies and best practice examples.

The Somerset trust has been co-ordinating regular workshops with other provider costing teams to demonstrate that it has mapped deprivation to Plics data. It is also an opportunity to share ideas across teams and get into the detail of data matching and dashboard building. He is keen to expand the group if organisations are interested.

Information governance is an issue that NHS bodies need specific help with. Mr Bassi says there is powerful information in its A&E analyser that ambulance services would be interested in – for patients transported to hospital but released without treatment, would a referral to a different service have been a better solution?

'Our ambulance service is really keen to make use of this, but there are a lot of information governance hurdles that we have to overcome,' he says.

He is not alone. Another finance manager in a recent HFMA discussion about the finance role in health inequalities said his trust could not get direct access to diabetes HBA1C test results it had undertaken for GPs. Instead, it had to access the anonymised data via a university-run database.

Mr Bassi agrees that the Leeds data would be enhanced if it covered the whole patient pathway, including primary care – potentially enabling clinicians to see the patients they aren't reaching, as well as those they are.

Jason Dean, service improvement and costing accountant at Alder Hey Children's NHS Foundation Trust, believes all systems could do with support on this issue.

He says: 'It feels like something that NHS England and NHS Improvement could drive and facilitate the sharing of data between organisations.'

still seen a major simplification in payments – reducing an estimated 80 different payment lines down to around 30, according to Ms Briggs. That brings time savings both at the centre and within practices. In parallel, the system is looking to harmonise primary care services across its health economy, which could require further investment of up to £1.8m.

LLR is also keen to align what it measures with this new funding approach, moving much more towards collecting outcomes rather than inputs and outputs. All practices will be focusing on addressing their own health inequalities. But Ms Briggs says the system will be able to see the correlation between funding and the rate of improvement from the newly established baseline.

Although it may take time for some improvements to show up, the system anticipates several benefits will be realised much more quickly.

'We recognise that a lot of practices with high morbidity and deprivation struggle on lots of the screening programmes,' she says.

More funding for diabetes, smoking cessation and heart health clinics could deliver fast results. Funding could be used to boost communications in key areas or to target services at parts of the community with known health inequalities – a Bangladeshi nurse to run outreach clinics, for example.

In other areas, with high and long-standing vacancies, the increased funding may enable higher wages to be paid to attract practitioners into the city.

There is a long way to go with addressing health inequalities, but LLR is convinced its person-centred approach is a practical step in the right direction.

And the GP practice – which is how most people enter the health system – is the right place to start.

How healthcare partnerships supported Trusts and patients in the pandemic

Kieran Doona, Head of Healthcare and NHS Pharmacy Services at LloydsPharmacy shares his thoughts on how NHS Trusts can leverage partnerships to drive much-needed efficiencies and improve patient outcomes.

The world of healthcare is changing rapidly. The familiar challenges of capacity, cost and quality still exist, but are now compounded by the effects of an increasingly ageing population as well as a rise in people living with long-term conditions.

The pandemic has brought all this into even sharper focus, and in many ways, accelerated the need to provide patients with the option to access treatment and medicines outside the traditional hospital setting.

The NHS is one of the country's most prized assets and is the envy of the rest of the world. In order to ensure it continues to provide quality care for millions of people, it too needs to look at ways to become more efficient.

I'm delighted to be attending this year's HFMA conference and getting to spend some time with like-minded professionals from the world of healthcare. It's also a great opportunity for us to talk about what we're doing at LloydsPharmacy to support NHS Trusts to meet their objectives.

Our proposition is all about delivering expert, patient-centric services that are financially viable and sustainable long-term.

We already work with a number of NHS Trusts across the country to help them drive efficiencies and free up capacity within their hospitals. Our approach involves spending time understanding what the challenges are for each Trust and how we can help. We then work together to develop and deliver effective treatment pathways that take people out of the typical hospital environment and into a more convenient setting – crucially without compromising quality or patient outcomes.

We are incredibly proud to provide outpatient dispensary services for over 48 hospitals across the UK. We've celebrated the ten-year anniversary since we opened our first one in partnership with Royal Liverpool and Broadgreen University Hospitals NHS Trust. This is a well-established service with a track record of helping Trusts to make significant savings.

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During the pandemic, we have also introduced additional new services to reduce pressure on Trusts, free up staff resources and improve the patient experience.

These include allowing patients to collect medicines from their local LloydsPharmacy branch instead of from the hospital. And providing a home delivery service, where we dispense and then deliver direct to patients homes. These innovative new approaches have reduced footfall in hospitals, increased capacity as well as supported patient safety.

Another example of how we're partnering with Trusts is through our LloydsPharmacy Healthcare Centres initiative. This concept is designed to give patients the option to get their treatment closer to home, either at one of our healthcare centres, their local LloydsPharmacy branch or a mobile unit. This in turn frees up resource for Trusts and releases capacity in hospital-based clinics.

As you can see, we're on a mission to become the UK's number one integrated healthcare partner. We want to hear from Trusts that understand the need to become more efficient but are committed to delivering great outcomes for their patients.

Find out how we can help you, go to **lloydspharmacyhs.com** to view Trust and patient case studies. Alternatively contact me directly on **07787 558171** or email **kieran.doona@lloydspharmacy.co.uk** to find out more about our pharmacy services.

*Based on average spend of £8m on outpatient medicines, and analysis of current LloydsPharmacy contracts. This is not indicative or guaranteed. ^This is the average for all patient prescriptions.

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Royal Free approach

While tackling health inequalities has often been regarded as a commissioner or even local authority role, providers also have a big part to play and it will certainly be a big issue for systems.

The Royal Free London NHS Foundation Trust was one of the first trusts to have a public health team in place. Its population health committee publishes an annual report. The 2021 report, *Translating population health: reducing inequalities with every contact,* sets out the trust's aim to embed a 'systematic approach to identify and reduce health inequalities' across the trust. The report highlights a significant gap in life expectancy across the trust's roughly one million population, with a two-year gap even at the borough level.

> **"We have a shared vision – my clinical, procurement, finance and planning colleagues are speaking great public health language"**
>
> **Judith Stanton, Royal Free**

Looking across North Central London as a whole, there is an 11.6-year gap for men (12.3 for women) between the most and least deprived wards. The main causes of the gap are circulatory disease, cancer and respiratory disease.

And again, with differences across the boroughs, on average people are spending their last 15 to 20 years in poor health.

The trust serves a very diverse population, with 150 different languages spoken and about 40% of people black, Asian or from a minority ethnic group.

Judith Stanton, the trust's deputy director of public health, says it has done a lot of work exploring the inequalities that exist in gaining access to services – including the time taken to receive a first outpatient appointment, the time to intervention and rates of non-attendance.

The trust is delivering a programme, driven by health inequalities data, to improve equity of access, reduce health inequalities in targeted specialty areas and reduce the rates of non-attendance. It aims to explore some of the health inequalities that underpin waiting times as well as improve recording of ethnicity data.

There are systemic reasons why patients cannot attend, so the programme will look at improving patient administration processes to communicate more effectively with patients and involve them in making services accessible.

There is still a long way to go, but Dr Stanton insists there is a real opportunity to reduce inequalities and embed equity.

'We all have a shared vision of what we want to do,' she says. 'And my clinical, procurement, finance and planning colleagues are speaking great public health language.'

At the moment, the trust is most familiar with its own service users – and can analyse their use of services by age, gender, deprivation score and ethnicity. But it is also part of the North Central London population health management platform, HealtheIntent, which includes an integrated health and care record.

This means it will gain greater whole-system insight about equity of outcomes, access and experience of the local population, including how health inequalities in groups such as those with serious mental illness, learning disability and multiple disadvantage are playing through.

HealtheIntent will also give the trust the insights to develop its role in population health within the integrated health and care system, including prevention and proactive care.

Fuller picture

Dr Stanton says that, even without this 'full picture', the trust is trying to take a view of its broader population as part of its accelerated recovery programme.

'We are trying to see who we are missing and who we might normally expect to see,' she says. This involves comparing the make-up of the patients being seen with the demographic profile of the communities it serves.

Dr Stanton says the key is to 'build equity in' as the trust looks to address the backlog all trusts face. This includes work on how to take forward the virtual outpatient appointments that rapidly expanded during Covid. It means ensuring patient views are listened to and that the trust doesn't make assumptions about different groups' preferences or abilities.

'If we put in a universal approach, we need to make sure we have considered what the risks might be to inequalities,' she adds.

The trust has done multiple iterations of trust-wide inequality analyses to check that its methodology is robust. It has already identified gaps in average waiting times and length of stay for different groups of patients.

It also aims to improve recording of protected characteristics in order to bolster the validity of future analyses. Initial meetings are taking place with services and key inequality KPIs have been agreed and are about to be embedded in executive and local performance reporting.

'Ultimately we want to put inequality analyses into routine performance reports for each division or directorate,' says Dr Stanton. 'They will own their data and track their performance. They will be able to see their own inequalities, put any required response into action and then monitor the impact.'

Addressing health inequalities will not be achieved overnight. For issues NHS bodies can directly influence, the key will be embedding good practice into everyday processes. That means understanding performance across different groups and ensuring access and provision is matched to their needs.