HFMA briefing
March 2024

Commissioning to reduce health inequalities: the role of finance

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Introduction

The Healthcare Financial Management Association (HFMA) is working on a range of outputs to help finance staff to support their organisations and systems to reduce health inequalities.

This briefing explores how NHS finance staff can contribute to commissioning approaches which help reduce health inequalities. It sets out the direction of travel, explains the importance of population health management, and looks at the skills and expertise that finance staff can bring to this space. The briefing builds on previous publications focusing on the role of finance in reducing health inequalities,[1] establishing the case for change,[2] the funding available,[3] business cases,[4] financial incentives[5] and examples of good practice within finance teams.[6]

A key change is that commissioners are increasingly using population health management to understand and meet their populations' needs. By using population health management techniques to explore the data, commissioners can better understand how different groups access and experience care, how their outcomes vary, and what factors are driving ill-health. From here, they can explore new models of care designed to reduce health inequalities, meet the needs of under-served groups and prevent the onset or exacerbation of long-term health conditions.

This briefing is structured around the pillars of NHS England's population health management approach of 'know', 'connect' and 'prevent', looking at how finance staff can contribute over the course of the commissioning cycle.

The commissioning landscape

The role of an NHS commissioner is to organise care and negotiate agreements with service providers to meet the health needs of the local population. Commissioners focus on service quality, aiming to achieve the following within available funds:

- improved health outcomes
- reduced health inequalities
- improved provider quality
- increased productivity.

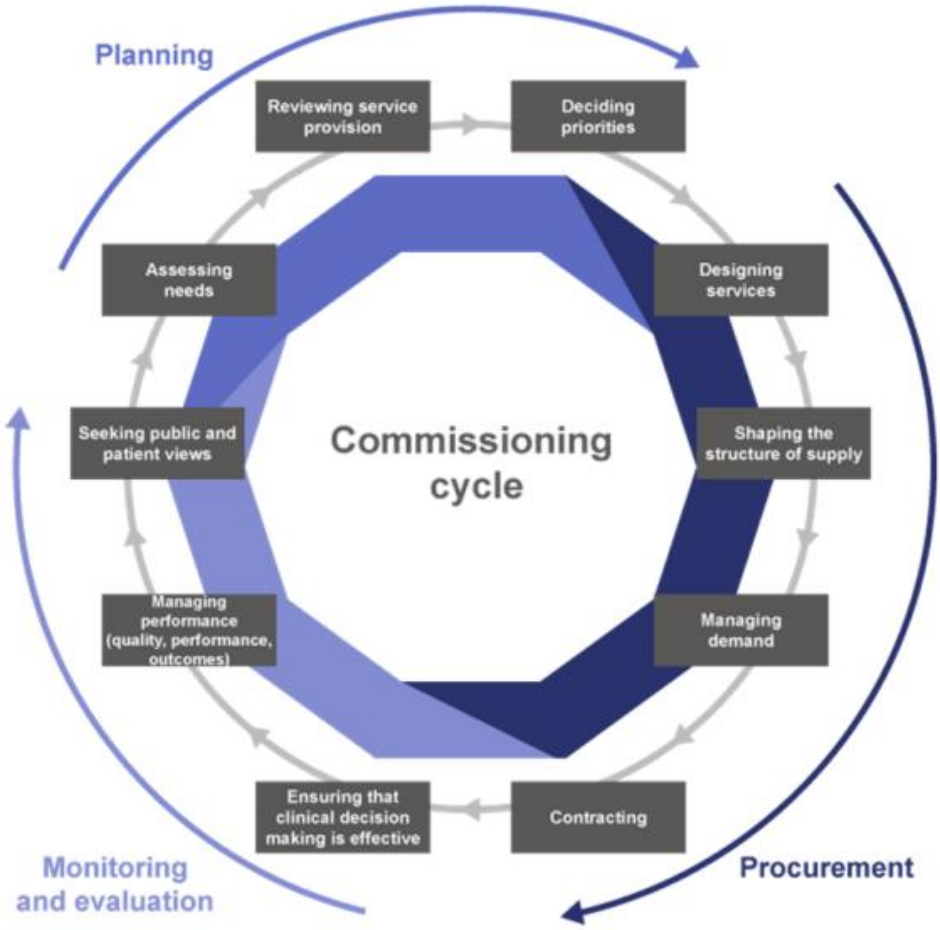
Given that demand for healthcare always exceeds the level of funds available, commissioners must make difficult choices on what to prioritise. To do this, they work to understand local needs, while also reviewing existing services and the way they're run to ensure they are achieving best value. As a result, not all NHS services are available everywhere in the same way.

Commissioning is a continuous process with many different elements, broadly grouped into three key phases: planning, procurement, and monitoring and evaluation. **Figure 1** sets out the main elements in the commissioning cycle, with more detail available in the commissioning chapter of the HFMA's *Introductory guide to finance*.[7]

Most commissioning in the NHS in England is carried out by integrated care boards (ICBs), in accordance with the Health and Care Act 2022. Commissioning for some services is carried out centrally by NHS England, and some commissioning is carried out jointly, for instance when ICBs and local authorities work together through pooled budgets.

[1] HFMA, *The role of the NHS finance function in addressing health inequalities*, July 2021
[2] HFMA, *Health inequalities: establishing the case for change*, May 2023
[3] HFMA, *Resources and funding to reduce health inequalities*, July 2023
[4] HFMA, *Considering health inequalities in business cases*, December 2023
[5] HFMA, *Using financial incentives to tackle health inequalities*, January 2024
[6] HFMA, *How finance teams are helping to reduce health inequalities*, September 2023
[7] HFMA, *Introductory guide to NHS finance*, updated January 2023

Figure 1: The commissioning cycle



Source: HFMA, *Introductory guide to NHS finance*, updated January 2024

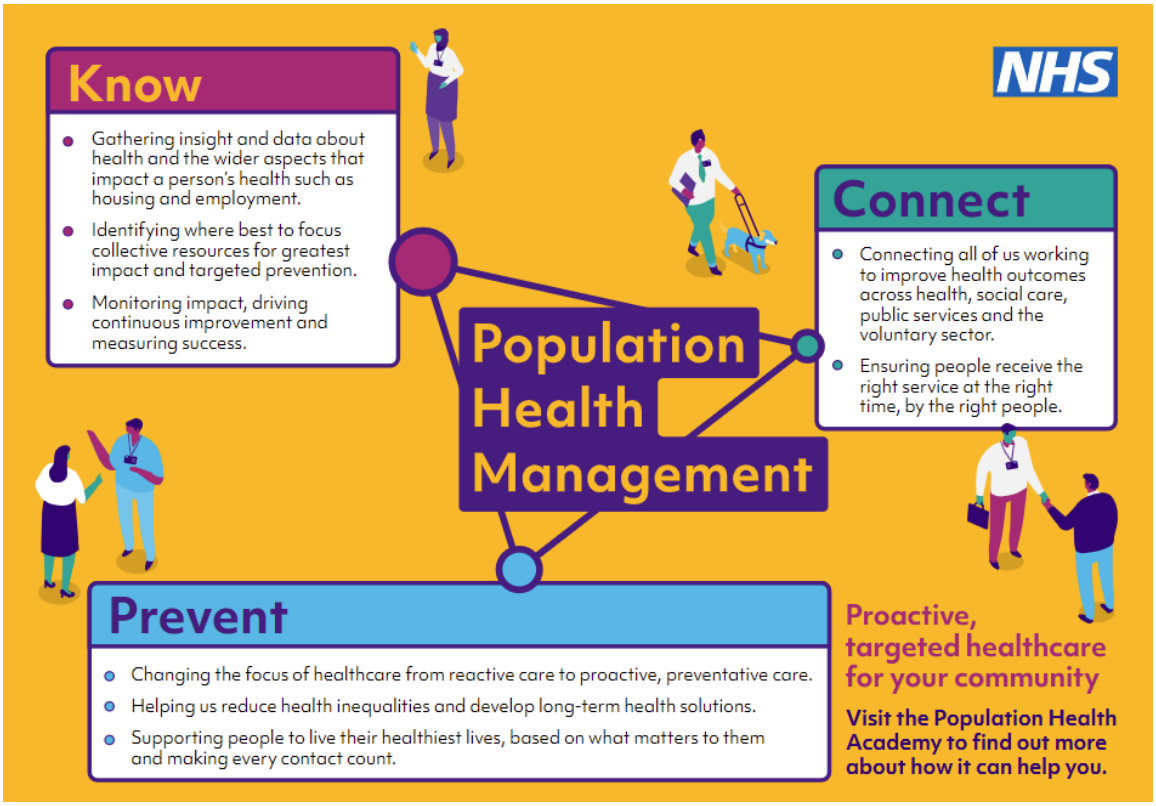
Commissioning is undergoing a period of change. Part of this change is on the technicalities of who does what, with NHS England handing over commissioning of pharmaceutical, dental, general ophthalmic and selected specialised services to ICBs.[8] And part of the change is on the different approaches people are taking to commissioning, with a stronger focus on population health management. This briefing focuses on the second part – on how finance staff can feed into these new approaches to help address health inequalities.

Population health management approaches to commissioning are more concerned with understanding and meeting population needs than they are with the transactional side of procurement and contract management. This calls on commissioners to work closely with providers, local authorities and other partners to agree priorities and design services.[9] To put this into practice, NHS England is encouraging ICBs to collaborate with their system partners across small geographies known as 'places' (with populations of around 250,000 to 500,000 people). A key principle is that decisions should be taken as close to local communities as possible, and at a larger scale where there are demonstrable benefits or where co-ordination across places adds value.[10]

[8] NHS England, *NHS England commissioning functions for delegation to integrated care systems*, updated December 2023
[9] The King's Fund, *What is commissioning and how is it changing?*, updated July 2023
[10] NHS England, *Thriving places*, September 2021

NHS England explains that population health management is a way of working based around three pillars (know, connect, prevent) as shown in **Figure 2**. Improving health inequalities is a central aim of population health management, with NHS England saying that 'it actively helps to reduce health inequalities and offers proactive, personalised, and preventative healthcare for every community'.[11]

Figure 2: Population health management



Source: NHS England, *Population Health Academy*, November 2023

The role of finance

Finance teams have valuable skills which can support commissioners as they seek to understand and meet the needs of their populations.

Know

The most important contributions that finance teams can make are in the 'know' pillar of NHS England's population health management approach. This feeds into the planning, and monitoring and evaluation phases of the commissioning cycle.

Using data to understand a population's needs

Finance teams should support the use of good quality data throughout the commissioning process such that commissioners can make decisions based on the best available knowledge. This means advocating for an evidence-based approach, including the use of national tools and templates such as the *Healthcare inequalities improvement dashboard* and associated tools,[12] Fingertips,[13] and the *Health equality assessment tool*.[14]

[11] NHS England, *Population health management communication assets*, November 2023. NHS England also provides e-learning on population health management.
[12] NHS England, *Healthcare inequalities improvement dashboard*. The dashboard shows data on the five priority areas for narrowing health inequalities in the 2021-22 planning guidance, and the five clinical areas in NHS England's Core20PLUS5 approach, broken down by ethnicity and deprivation decile. There are three associated tools available through the same link: (1) the priority neighbourhoods for unplanned hospitalisations dashboard; (2) the actionable insights tool; and (3) the primary care networks dashboard.
[13] Office for Health Inequalities and Disparities, *Fingertips*, updated December 2023
[14] Public Health England, *Health Equity Assessment Tool (HEAT)*, updated May 2021

In addition to using national data, finance colleagues are well-placed to bring together local data, triangulating information on costs, workforce, activity and outcomes. Providers have built up these skills in their costing teams, and some are proactively considering health inequalities. The costing team at Barts Health NHS Trust has for instance created a health inequalities dashboard which combines patient level costing data with data on ethnicity, deprivation and wider determinants of health such as air pollution and access to green space. Such information can help commissioners and clinicians to understand their population's needs.

For commissioners working at a system level, it's important not just to focus on data from the acute sector (which is more readily available), but to draw in data from across the health and care service. In Wales, by working with the University of Swansea, Welsh Health Specialised Services and the NHS Wales Executive were able to draw in primary care data and analyse care pathways for cardiovascular interventions. The study team found that deprivation was a key driver of cost variation, with people in areas of high deprivation less likely to access proactive care and elective interventions, and more likely to need emergency interventions and admission to hospital.[15] As a next step, the team is now looking to test the safety and efficacy of a triaging system used for cardiac referrals, which aims to improve access to proactive care in West Wales.

There is a vast amount of data available and endless possibilities for analysis. When building the evidence base on health inequalities, it is helpful for finance teams to focus their efforts on national and local priorities. Nationally, they might focus on priorities in NHS England's Core20PLUS5 approach, as set out in **Figure 3**.[16] And locally, they might focus on priorities in the joint strategic needs assessment (JSNA).

Figure 3: Core20PLUS5 and its implications for data analysis

Concept	Meaning	Data implications
Core20	The most deprived 20% of the national population	This is defined by the national Index of Multiple Deprivation (IMD). It is broken down into lower super output areas (LSOAs), which are geographic areas in which approximately 1,500 people live. The IMD is usually expressed in deciles, with decile 1 being the most deprived and decile 10 being the least deprived. Core20 is made up of people living in deciles 1 and 2. IMD information and analysis is available on NHS England's health inequalities improvement dashboard.[12] Commissioners carrying out their own analysis may prefer to use the raw data, which they can access from the Office for National Statistics.[17] Core20 is the most deprived 20% of the national population, not the local population. Some systems (such as Birmingham and Solihull) will find that significantly more than 20% of their population falls under Core20, and some significantly less (such as Surrey Heartlands).

[15] Davies G et al., *Cardiac interventions in Wales: a comparison of benefits between NHS Wales specialties*, February 2024

[16] NHS England, *Core20PLUS5 (adults) – an approach to reducing healthcare inequalities*, 2021; NHS England, *Core20PLUS5 – an approach to reducing health inequalities for children and young people*, 2021

[17] Office for National Statistics, *English indices of deprivation 2019*, September 2019; Office for National Statistics, *Lookup: postcode to lower layer super output area 2019*, updated February 2023. Commissioners can use these two data sources to assign patients an IMD decile based on their postcode.

<table>
<tr>
<td>PLUS</td>
<td>Population groups identified at a local level as experiencing health inequalities, who would benefit from a tailored healthcare approach</td>
<td>PLUS population groups are agreed at a system level and should be included in the system's integrated care strategy and the ICB's joint forward plan.

PLUS population groups might include:

• specific ethnic minority communities
• coastal communities (where there may be small areas of high deprivation hidden among relative affluence)
• people with a learning disability and autistic people
• people with multiple long-term health conditions
• people with protected characteristics
• 'inclusion health groups' of people who experience social exclusion (for instance vulnerable migrants, sex workers, people in contact with the justice system, victims of modern slavery, people who are homeless, people experiencing drug and alcohol dependency, and people from Gypsy, Roma and Traveller communities).

Finance teams should find out the PLUS population groups in their local system and explore ways of disaggregating existing data to learn about these groups' health outcomes, experiences and access to care.</td>
</tr>
<tr>
<td>5</td>
<td>Key clinical areas of health inequalities which require accelerated progress

(Called '5' because there are 5 key clinical areas for adults and 5 key clinical areas for children and young people.)</td>
<td>Most of the key clinical areas have specific aims, which will determine what data should be collected and analysed. These are as follows:

For adults

<table>
<tr><td>(1) Maternity</td><td>• ensure continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups</td></tr>
<tr><td>(2) Severe mental illness</td><td>• provide annual physical health checks for people with severe mental illness</td></tr>
<tr><td>(3) Chronic respiratory disease</td><td>• increase uptake of COVID, flu and pneumonia vaccines</td></tr>
<tr><td>(4) Early cancer diagnosis</td><td>• increase diagnosis at stage 1 or 2</td></tr>
<tr><td colspan="2">(5) Hypertension case finding and optimal management and lipid optimal management</td></tr>
<tr><td colspan="2">Smoking cessation positively impacts on all five key clinical areas</td></tr>
</table>

For children

<table>
<tr><td>(1) Asthma</td><td>• reduce over-reliance on reliever medication
• reduce the number of asthma attacks</td></tr>
<tr><td>(2) Diabetes</td><td>• increase access to real-time continuous glucose monitors and insulin pumps for people in the most deprived quintiles and from ethnic minority backgrounds
• increase proportion of those with Type 2 diabetes receiving recommended NICE care processes</td></tr>
<tr><td>(3) Epilepsy</td><td>• increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism</td></tr>
<tr><td>(4) Oral health</td><td>• address the backlog for tooth extractions in hospital for under 10s</td></tr>
<tr><td>(5) Mental health</td><td>• improve access rates to mental health services for 0-17 year olds, for certain ethnic groups, age, gender and deprivation</td></tr>
</table>
</td>
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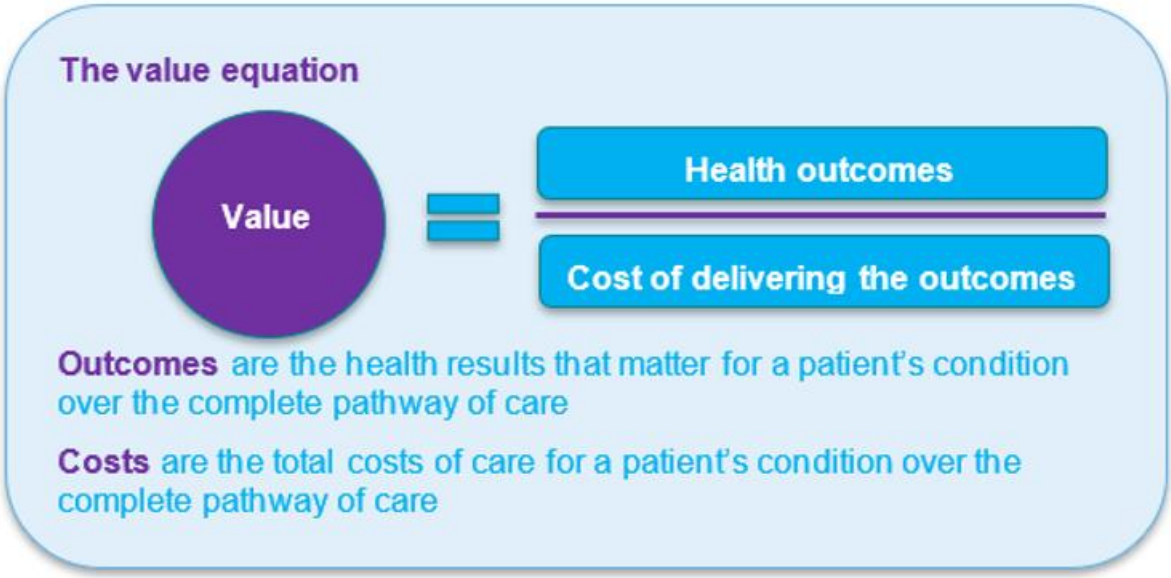
Measuring value

Part of the 'know' pillar of NHS England's population health management approach is on identifying where best to focus resources to achieve the greatest impact. The concept of value is important here, and finance teams have a key role in pushing this forward. Value-based healthcare is about maximising the outcomes which matter to people at the lowest possible cost, as shown by the value equation in **Figure 4**.

Figure 4: The value equation



Source: Porter, *Value-based healthcare delivery,* 2012

Traditionally, commissioners have been concerned with technical efficiency, by which we mean producing the most possible outputs for the least possible input. Outputs could be measured for instance in the number of GP appointments, operations, or patients staying in hospital. Value-based healthcare asks instead for allocative efficiency, by which we mean getting the best possible health outcomes for the least possible input. Outcomes could be measured for instance in mortality, quality of life, people's social participation, their mood, pain, fatigue and cognitive function. As well as looking at clinical outcomes, it is important to measure value in terms of the outcomes that matter to patients, and measures can be based on patient reporting.

Much of the data that the NHS currently collects is on inputs, processes and outputs rather than outcomes. Shifting to value-based healthcare means doing more to collect and analyse outcomes data. In setting expectations on how services should measure their success, commissioners are a key part of this change. Finance staff can help by advocating for the use of value-based healthcare, by keeping informed of the latest developments and methods for measuring outcomes, and by helping colleagues in their evaluation of specific services and interventions. Suggested outcome measures are available from the International Consortium for Health Outcomes Measurement (ICHOM),[18] and from the Office for Health Improvement and Disparities (OHID).[19]

Many systems are using logic models as a practical tool to help them explain how inputs, activities and outputs will drive the outcomes they are seeking through their change projects. Further guidance is available from the Midlands and Lancashire Commissioning Support Unit (CSU).[20]

The value equation can be applied to different segments of population, helping to guide attention towards health inequalities by exposing differences in outcomes between population groups.

[18] International Consortium for Health Outcomes Measurement, *Patient centered outcomes for health measures*, updated January 2024. These measures cover a wide range of health conditions.
[19] Office for Health Improvement and Disparities, *Public health outcomes framework*. These measures are specific to public health.
[20] Midlands and Lancashire CSU, *Logic model guide*, 2016

Commissioners should aim to address avoidable and unfair differences, and the focus on outcomes helps them to spot gaps in their care pathways and identify those most at risk who would benefit from targeted interventions. Nottingham and Nottinghamshire Integrated Care System (ICS) has for instance used population health management techniques of population segmentation and risk stratification to identify priority cohorts.[21]

It is important to consider that as well as showing what works well, value-based healthcare can reveal what is not working well. Commissioners and finance staff should be looking for opportunities where they can reduce funding for interventions and services which provide poor value, in order to free up resources for the things that work.

One way of doing this is by examining value across a whole pathway. Gloucestershire ICS worked with the Health Economics Unit to understand the pathway for chronic obstructive pulmonary disease (COPD), focusing on the wider determinants of health. [22] It brought stakeholders together and used a technique called socio-technical allocation of resources (STAR) to assess the relative value and cost of different interventions on the pathway. From this analysis, the ICS created a priority list of improvements, which included better use of the virtual ward, more proactive case finding, and increased uptake for an online programme of pulmonary rehabilitation. Each of these improvements should save costs because they reduce the need for more expensive, reactive work elsewhere in the pathway.

Connect

Finance teams can also contribute to the 'connect' pillar of NHS England's population health management approach, helping commissioners to work more closely with providers, local authorities and other partners. This applies throughout the commissioning cycle.

Supporting partner organisations to get involved

Partnership working is integral to the structure of the NHS, with each system having an integrated care partnership (ICP) that brings together NHS organisations with local authorities and other partners such as those in the voluntary, community and social enterprise (VCSE) sector. NHS England issues statutory guidance on how ICPs should develop integrated care strategies that meet the needs of their population and reduce health inequalities.[23]

While the statutory responsibilities are clear, the day-to-day practicalities and culture of partnership working will vary across the country. Finance is sometimes seen as a barrier to joint working, including on health inequalities. But finance staff often have well-established networks across their organisation and system and can help to identify and overcome barriers. As such, finance colleagues can help to create an environment in which it is easier for commissioners, providers and other partners to work together in the interest of the people they serve.

Place-based partnerships are an important part of the system, and often seen as the best vehicle through which to tackle health inequalities.[24] 'Places' are smaller, relatively self-contained geographies where local people will access most of the health and care services they use – typically with a population of 250,000 to 500,000 people. Some places are further subdivided into 'neighbourhoods', with multi-disciplinary teams that work proactively to improve people's health. A key principle (known as subsidiarity) is that decisions should be taken as close to local communities as possible.[25] To match this decision-making structure, finance staff should expect to offer financial support and expertise at a place and sometimes a neighbourhood level.

Provider collaboratives are another important part of the system, with groups of two or more trusts working across multiple places to help one another and achieve economies of scale. Commissioners can support provider collaboratives as they develop, enabling trusts to work together on complex

[21] Nottingham and Nottinghamshire ICS, *Population health management: an ICS approach*
[22] Health Economics Unit & Midlands and Lancashire CSU, *Smarter spending in population health: using economic principles to set priorities for COPD resource allocation in Gloucestershire ICS*, July 2023
[23] NHS England, *Guidance on the preparation of integrated care strategies*, updated February 2024
[24] HFMA, *Roundtable: the place to be*, September 2023
[25] Local Government Association & NHS England, *Thriving places: guidance on the development of place-based partnerships as part of statutory integrated care systems*, September 2021

issues such as population health and health inequalities, and moving them away from a culture of organisational autonomy and competition. As per the Health and Care Act 2022, all acute and mental health trusts must now be part of a collaborative.[26] They also have the option of inviting other partners to join, including community and ambulance trusts and partners from the VCSE or independent sector.

Partners in the VCSE sector sometimes struggle with the requirements and time commitment needed to take part in an NHS procurement.[27] Provider collaboratives could offer them a less onerous route in, with lead providers able to award small clinical contracts on a sub-contract basis. This could be helpful for work on health inequalities, with VCSE organisations often better able to access seldom-heard groups, and their interventions often demonstrating a good return on investment.

Commissioners can also work more closely with local authorities by setting up pooled budgets under Section 75 of the NHS Act 2006.[28] This is the route through which the better care fund is delivered and can help to bring organisations together under a clear governance structure as they deliver a joint service or pathway. Section 75 arrangements can be administratively complex and are currently only available to NHS bodies and local authorities. However, the Department for Health and Social Care is currently considering ways to simplify the arrangements, and whether section 75 should be extended to a wider range of organisations.[29]

Commissioners may also be able to incentivise services to prioritise work on health inequalities by building financial incentives into their contracts. This is explored in more detail in the HFMA briefing *Using financial incentives to tackle health inequalities*.[5]

Facilitating data sharing

To support a population management approach, it is important that information is shared across the system. Viewing data at an organisational level will not give the whole picture, and is not enough for commissioners to understand the needs of the population. Finance staff can help by being transparent about financial information, for instance on cost and income, and by helping with governance arrangements that facilitate data sharing.

Prevent

Finance teams should be aware of the 'prevent' pillar of NHS England's population health management approach and can help to support and champion work that colleagues are doing in this area. This is particularly relevant in the planning phase of the commissioning cycle.

Demonstrating the value of preventative care

As set out in the 'prevent' pillar, national policy is directed towards 'changing the focus of healthcare from reactive care to proactive, preventative care'. Prevention was a key priority of both the *NHS long term plan* (2019),[30] and before that the *NHS five year forward view* (2014).[31] It was also a key recommendation in the *Hewitt review*.[32] In practical terms, this means boosting out-of-hospital care (primary and community care), and taking action on key public health issues (smoking, obesity, alcohol, air pollution, antimicrobial resistance and healthcare inequalities).

Finance staff can use the value-based healthcare approach to help demonstrate the value of preventative care (see 'measuring value' section above). They should seek and share examples which evidence the value of specific interventions. It is often assumed that the benefits of preventative work take a long time to materialise, but this is not always the case. For instance, the CURE project for smoking cessation in Greater Manchester modelled that by helping smokers to quit

[26] NHS England, *Working together at scale: guidance on provider collaboratives*, August 2021
[27] NHS England, *A framework for addressing practical barriers to integration of VCSE organisations in integrated care systems,* May 2023
[28] Legislation.gov.uk, National Health Service Act 2006
[29] DHSC, *Review of section 75 arrangements: supporting document* (September 2023)
[30] NHS England, *NHS long term plan*, January 2019
[31] NHS England, *NHS five year forward view*, October 2014
[32] DHSC, *The Hewitt review: an independent review of integrated care systems*, April 2023. This recommended that 'the share of total NHS budgets at ICS level going towards prevention should be increased by at least 1% over the next 5 years'.

it would quickly reduce hospital admissions, saving 30,880 bed days and £9.9m per year.[33] At a smaller scale, a primary care network (PCN) in Warrington introduced an app called 'HealthyYou', through which at-risk patients submitted blood pressure readings to clinicians. By reducing patients' risk of cardiovascular events, the app saved £400k in health and care costs for the first 1,000 patients across three years. The PCN was able to put together a successful business case to roll the app out across the whole ICS.[34]

Drawing on user insight

The 'prevent' pillar talks about supporting people 'based on what matters to them', and to do this, commissioners must seek out and listen to insights from service users.[35] For health inequalities, it's important to consider how to include people from seldom-heard groups. NHS England has produced guidance on how the NHS can better engage with 'inclusion health groups' who are socially-excluded and at greater risk of poor health.[36]

While finance staff may not be directly involved in collecting user insight, they should ask for and expect clinical and operational colleagues to share this information. They should then be prepared to feed user insight into their analysis, combining it with hard data to give a fuller picture. Specific points at which finance staff might have more influence include during the business case process,[4] and when agreeing contracts with providers.[37]

Conclusions

Finance staff have valuable skills which can support commissioners as they seek to understand and meet the needs of their populations. This is part of an emerging population health management approach which aims to reduce health inequalities.

It is important that finance teams have the capacity and capability to help with this work. Specifically, they can contribute by using data to understand a population's needs, measuring value, supporting partner organisations to get involved, facilitating data sharing and drawing on user insight. Commissioning approaches will continue to evolve as integrated care boards become better established and NHS England works on national policy and guidance. Finance teams should keep abreast of developments such that they can support commissioners in their work to reduce health inequalities.

[33] NHS Greater Manchester Cancer Alliance, *CURE project*, updated March 2023
[34] NHS England, *Scaling up a population health management approach using digital technology*, March 2024
[35] NHS England, *ICS implementation guidance on working with people and communities*, September 2021
[36] NHS England, *A national framework for NHS action on inclusion health,* October 2023
[37] Schedule 2N (health inequalities action plan) of the NHS standard contract gives guidance on how providers and commissioners can engage with communities. It is an optional part of the contract which ICBs can use to agree actions and timescales, how to monitor progress and how to measure outcomes on health inequalities.

About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For over 70 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

The HFMA offers a range of qualifications in healthcare business and finance at undergraduate and postgraduate level and can provide a route to an MBA in healthcare finance. The qualifications are delivered through HFMA's Academy which was launched in 2017 and has already established strong learner and alumni networks.

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