Agenda item: 9

Strategic Approach to Tackling Inequalities in Derbyshire

Introduction

As part of the World Class Commissioning Strategy, the PCT has committed to reducing health inequalities in Derbyshire. This commitment is to:

- Reduce the mortality gap between the most deprived 20% and the average by 3% percent over 5 years
- Reduce the strength of association between deprivation and mortality by 20% over five years.

This is in addition to existing PSA targets to increase life expectancy, reduce under 75 deaths from circulatory disease, cancer and suicide and 'spearhead' inequalities targets.

The purpose of this paper is to share with the PCT and with our partners the strategic approach to tackling inequalities across Derbyshire.

This paper will describe:

- The framework for tackling health inequalities.
- Highlight the importance of both delivering uniform access to high quality services
- And the need to work with partners in local communities to engage them in raising aspirations and to tackle the wider determinants and root causes of ill health.

This paper will also introduce some of the challenges in both measuring health inequalities across Derbyshire and the limitations of available information to target our efforts. It will also describe the limitations of evidence in predicting the health outcome benefits of our investment and our work both within the NHS and with our partners.

This paper thus sets the context within which we must deliver our World Class Commissioning Strategic Plan inequalities targets and introduces the Board to the key concepts and challenges that we face.

Background

The PCT has been working with a wide range of partners in a variety of ways to improve health and tackling inequalities. The Board is already aware of:

- The PCTs work to implement the Choosing Health White Paper and invest in the key Choosing Health topic areas.
- Investment from the inequalities allocation for 2008/9.
- The PCTs work in partnership at District and Borough LSP level to tackle health and well-being priorities identified through these local partnerships (and the Board has received a series of reports on this successful work).
- Work through the Derbyshire County Local Strategic Partnership (Derbyshire Partnership Forum) and the Local Area Agreement Boards to improve health and well-being in Derbyshire (and the Board has adopted the Local Area Agreement). A new Derbyshire Sustainable Community Strategy which will have a focus on inequalities is under development.

- Particular work in the Bolsover Spearhead area which has built on a record of excellent joint working, further informed by the National Support Team visit earlier in 2008.
- Work across the PCT to drive-up the quality of NHS services and to improve equitable access and utilisation of high quality NHS care.

The challenge that the PCT now faces is to deliver its ambitious inequalities reduction target laid out in the Word Class Commissioning Strategy. This is on a background of challenging economic circumstances but builds on some excellent partnerships and matrix working both within the PCT and with its key partners.

Progress towards reducing health inequalities is performance managed through the Choosing Health and Inequalities Programme Board which reports both to the Statutory Partnership for Health and Wellbeing LAA Board and the Resource Oversight Committee. However, reducing inequalities is integral to all the work of the PCT and all Programme Boards and planning, commissioning, and quality work includes reducing inequalities.

Framework for Tackling Health Inequalities in Derbyshire

The purpose of the framework is to logically guide our investment and efforts to deliver the Word Class Commissioning inequalities objectives. However, applying this framework should enable us to go beyond just these inequality targets which are focussed on reducing premature mortality and improving the mortality outcomes of more deprived populations. In addition, using this framework we should also seek to achieve:

- Raised health aspirations in the population.
- An increase in disability free years of life.
- An improvement in health of our ageing population as an ever increasing proportion of our population will be elderly.

Target Populations

- Derbyshire wide –All organisations strive to ensure that people where ever they live have access to the best quality services. This drive for quality often points to the need for remedial action where standards are not being achieved and people are not receiving the services to meet their need. This commitment cuts across all programme and service areas, with the realisation that to achieve equitable access to services for the more vulnerable communities/ population groups, additional action and resources may be needed.

  This focus on the provision of universal services utilises tools such as Health Equity Audits and impact assessments to assess whether resources are equitably distributed to populations and utilised when weighted for deprivation and need. This underpins the PCTs equity “Fairshare” approach to practice based commissioning.

  In Derbyshire, this approach also includes the work on the World Class Commissioning inequalities priorities to: improve cardiovascular disease risk assessment and management of patient identified at being at risk, increase breast feeding and reduce childhood obesity. The focus is on ensuring

equitable and universal access to high quality services. Deprivation is associated with higher risk of cardiovascular disease, lower rates of breast feeding and higher rates of obesity. Therefore this work will lead to a reduction in the strength of association between deprivation and mortality providing the interventions are utilised equitably, that is in proportion to need.

- Targeted Approach - The framework also leads us to focus particular action at those in the most deprived 20% of the Derbyshire population based on super-output areas. This geographical focus on the 97,000 people living in the identified areas (see Map in Appendix A), does not include all those people in the most deprived 20% of the population. However, work elsewhere suggests that this approach captures approximately 2/3rds of this population. It is also the case that some "communities of interest / vulnerable groups", such as those with learning disability, mental health problems, people experiencing rural poverty, homeless people etc may not be captured through this geographical focus. However, these populations are largely concentrated in the geographically most deprived areas. In addition, the framework does guide us to prioritise some of our work towards these vulnerable groups and some of our existing investment already targets these groups.

  Whilst we will be focussing on the most deprived 20%, the geographical distribution of these populations, mostly down the eastern boarder of the County, and in close proximity to population in the next most deprived quintile, will mean that there will be some significant spill-over into these communities. However, it is necessary to target and prioritise our work to the most deprived 20% in order that we can achieve some real and tangible change. As part of this approach we will also need to obtain more detailed population profiling to identify the age, distribution and number of households within the target areas.

The Framework

The framework summarises our interventions into six areas:

- Healthy Pregnancy and Early Childhood
- Children and Young People
- Access to Health Rated Services
- Tackling the Major Killers
- Strengthening Disadvantaged and Vulnerable Individuals in Communities
- Wider Determinants of Health

These are underpinned by supporting systems such as information and analysis, workforce development and organisational development.

These six categories are required in order to work with our partners in a structured and logical manner. However, we have also simplified the framework in order to summarise our investment and the six can be distilled into three areas for this purpose:

- Healthy Pregnancy, Early Childhood, Children and Young People
- Access to Health Rated Services and Tackling the Major Killers
- Strengthening Disadvantaged and Vulnerable Individuals and Communities and addressing the Wider Determinants of Health.

The Universal Approach for Driving Up Access and Quality
The PCT is already committed to redistribution of resources as part of its overall strategic approach to tackling inequalities and improving outcomes. A good example is the work that has commenced on supporting general practices that are most distant from their equity budget position. For those practices under equity, there are two issues to address:

- In some practices, ensure investment is used to raise the quality of services provided to the most disadvantaged communities (rather than simply buying in more acute provision).
- Encouraging development proposals from localities and clusters of practices, informed by local knowledge of inequalities, to reflect need in that area. This inequalities framework should guide this investment and will encourage better links with local strategic partnerships and community strategies.

There are many other examples in which the PCT works to improve access including; promoting uptake of cancer screening, expert patient programmes, health equity audit of 4 week smoking quitters, planned health equity audit for stroke and dementia care, the Health Trainers Programme, development of general practices in underserved deprived areas and many others.

Targeted Approach on the Most Deprived 20% and Vulnerable Groups
This framework is intended to inform not only the work of the PCT but also other partners at local and county level. Many of the communities identified in the most deprived 20% will also be communities identified as a priority by the County Council and by District and Borough's. It will be important that we are pragmatic in working with our partners on commonly identified communities, even if this does not capture every single geographical area that we have identified. However, taking advantage of shared priorities with partners will give us the greatest chances of achieving real change and success for these communities. This framework should inform the work of the county statutory partnership for health and wellbeing and the health 'themes' within the district and borough Local Strategic Partnerships.

A challenge for all partners serving disadvantaged communities is to identify appropriate mechanisms for coordination to maximise impact on inequalities. The governments' "New Deal for Communities" was an attempt at joining it up at a very local level. We face the challenge of coordination without the funding that the New Deal for Communities offered. Rather, this raises the challenge to work more effectively as partners to use the resources already in the system for maximum impact.

A key part of making this successful will be to engage with local people themselves. We want to share with local communities the information that we have available about their health and well-being and indicate some of the priorities for their particular community. However, it will be important to listen to local people and their particular concerns in order to achieve maximum engagement. This is a complicated area but gaining genuine local ownership both by our

partners and by local people is going to be key in success. Both the PCT and its partners recognise the importance of raising aspirations in order to achieve long-term change for the better.

Measuring Progress

The Board has already seen our work to measure progress in Bolsover. The Board has already received the first of four reports that consider process, proxy and actual health outcomes focussing on cardiovascular disease. Future reports will focus on other areas, such as healthy pregnancy and childhood. Work is ongoing to look at how we will measure performance over the next five years across the whole of Derbyshire, utilising NHS and non NHS data sources. Once again, this is a complicated area with the range of measures available. In due course we will, as part of the delivery plan for tackling health inequalities, propose a set of measures that will help us to understand how health inequalities are changing over time across Derbyshire. It is likely that a bundle of measures will be needed in order to gain an in-depth understanding of our progress particularly within the identified 20% most deprived areas and to take action where progress is too slow.

Estimating the Impact of Investment and Interventions

The evidence base that links investment in interventions to reduce health inequalities and the health outcomes achieved is under-developed. For instance, we are now working with the University of Sheffield to measure the health outcomes from investment and citizen's advice sessions in general practice. There is evidence that this improves mental well-being but we would like better evidence in this area to support our investment. The same is true across many other areas of interventions to improve health and reduce health inequalities. For instance, it is very difficult to model the impact of interventions to increase healthy eating and increased levels of physical activity into final health outcomes. Some interventions, such as medical interventions (eg. simvastatin for reducing cardiac risk) have a stronger evidence base, but making calculations on a population scale remain a challenge. It is important that the PCT and its partners understand the limitations of the degree to which we can accurately model the impact of our interventions on health outcomes. This should not prevent investment and working in areas that we know will lead to improved health outcomes even if we cannot be exact in estimating the impact. What will be important is to be clear about what our investment will deliver, monitoring those outcomes (which may well be process and proxy outcomes) and applying a high degree of rigour to this process. This coupled with well developed monitoring of overall mortality and inequalities will take the PCT as far as is possible in ensuring that we are investing and working effectively to reduce inequalities and improve health.

Next steps

1. Finalise investment plan for the inequalities strand of the PCT Strategy and complete implementation plans
2. Continue to develop bundles of outcome and process measures for each of the policy areas
3. Engage in a wider consultation process via the Statutory Partnership for Health and Wellbeing LAA Board. (A summit is planned in March 09) and with the district Local Strategic Partnerships.

4. Develop and pilot a model of interagency working at local community/neighbourhood level informed by successes and failures of the past.
5. Share the framework with examples of investment possibilities with practices as part of PBC and the move to equitable funding.

Recommendations

The programme boards are asked to:

1. Adopt this strategic approach to tackling inequalities in Derbyshire.
2. Endorse the two pronged approach – equitable access and utilisation of services and targeted 20% approach - working in partnership to strengthen individuals and communities and tackle the underlying determinants of health.
3. Ensure that the inequality agenda as described within the framework is appropriately reflected in the frameworks, programmes, pathways and commissioning specifications developed and implemented by the board.
4. Identify areas of concern within the remit of the board and reflected in the inequalities framework suitable for inclusion in a health equity audit programme.
5. Review the contribution of services/ issues covered by the board to a broader community approach within geographical areas that contribute to the Derbyshire 20% population, and how the board will collaborate with a partnership approach coordinated at LSP/District level.
6. Consider the relationship between the PCT commissioning and PBC cluster configurations for the issues pertinent to the target 20% and other target vulnerable communities.

Steve Pintus
David Black

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