



**REDUCING HEALTH
INEQUALITIES THROUGH
NEW MODELS OF CARE:
A RESOURCE FOR NEW CARE MODELS**

UCL INSTITUTE OF HEALTH EQUITY

The Institute is led by Professor Sir Michael Marmot and seeks to increase health equity through action on the social determinants of health. The Institute continues to build on previous work to tackle inequalities in health, including the Commission on Social Determinants of Health, *Fair Society, Healthy Lives* (The Marmot Review) and the *Review of Social Determinants and the Health Divide for the WHO European Region*. The Institute has published widely including evidence reviews, practice resources and data analysis for England and internationally.

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UCL Institute of Health Equity (2018)

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ABOUT THIS REPORT

This report was commissioned by NHS England and developed in collaboration with the vanguards and the new care models team. It provides an analysis of the opportunities for new models of care and place-based health systems to improve health and reduce health inequalities. Building on experience of vanguards across England, it explores levers and mechanisms for embedding a population health-based system and proposes ways of developing new levers and incentives for developing sustainable, effective approaches to reducing health inequalities. The report also assesses potential risks for health inequalities and suggests ways of mitigating those risks.

We would like to thank all those who contributed to the development of this report, including:

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Thanks also go to **Geraint Lewis**, Chief Data Officer, NHS England for his comments and input on an earlier version of this report.

The work was reviewed by NHSE, who supplied feedback prior to publication.

Responsibility for views expressed here and for any errors rests with the authors alone.

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COVER PHOTOGRAPH: West Midlands Fire Service Photographic 2018

1. INTRODUCTION	6
1A Health inequalities in England	7
Figure 1: Life expectancy and disability-free life expectancy, males, based on 2011 Census	7
Figure 2: Life expectancy and disability-free life expectancy, females based on 2011 Census	8
Figure 3: Relative contributions of factors to health	9
Box 1: Examples of Inequalities in access to health services experienced by people with protected characteristics and by health inclusion groups	10
1B Health system approach	11
Box 2: A health system based on prevention and health equity	11
1C New models of care as a health system approach	12
New Care Models, vanguards and developing an equity-based health system approach	13
Figure 4: Health system: strategic, system and resource levers for vanguards	13
Methodology	14
Who this work is for	14
2. MAXIMISING OPPORTUNITIES FOR REDUCING HEALTH INEQUALITIES THROUGH NEW MODELS OF CARE	15
2A Strategic levers	16
2Ai Organisational Culture and Leadership	16
2Aii Equality and health inequality impact analysis	18
2Aiii Evaluations for health inequalities	21
Figure 5: Key functions of process evaluations and relationships among them	21
2B System levers	23
2Bi The Social Value Act For procurement and contracting services	23
Figure 6: Social value and improved health outcomes	25
2Bii Using social prescribing to create action on social determinants	25
2C Resource levers for integrated and shared systems	27
2Ci Sharing, linking and integration of INFORMATION	28
2Cii Collaborations for service delivery	31
2Ciii Equitable access to services	34
3. CONCLUSIONS AND RECOMMENDATIONS	39
4. FUTURE DEVELOPMENTS	42
References	43



1. Introduction

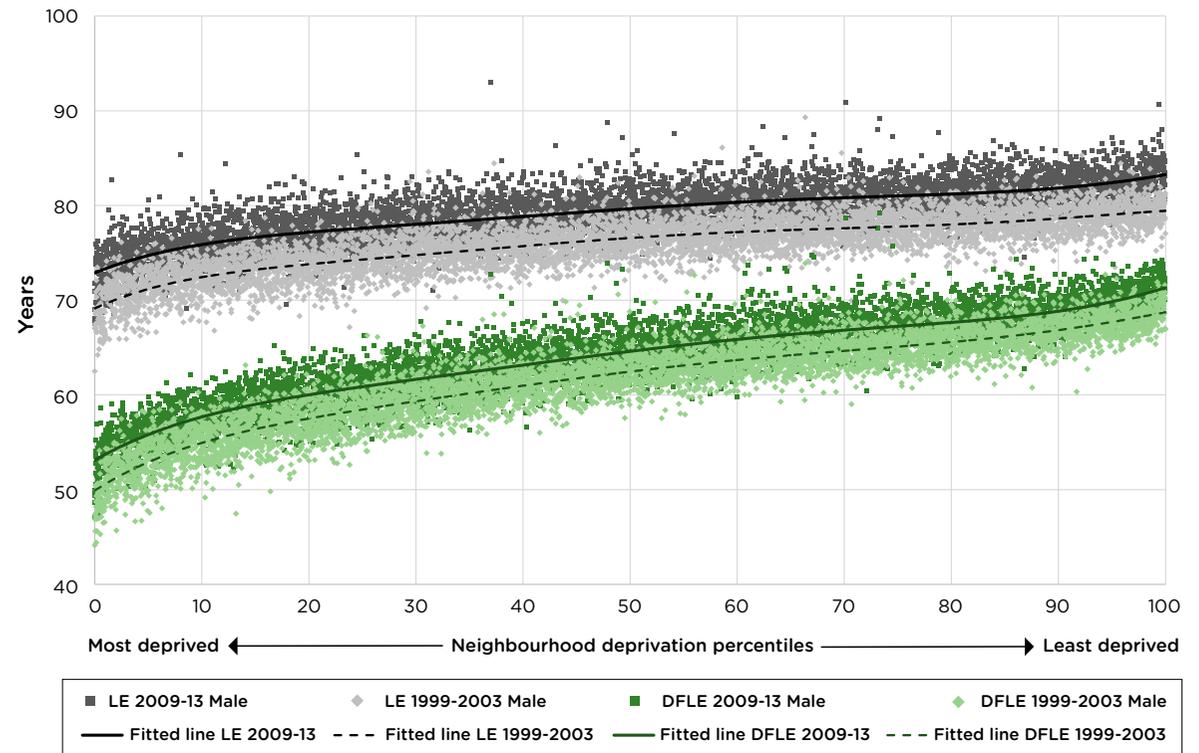
This report assesses the potential and opportunities for new care models to drive a health system that focusses on population health, reduces health inequalities and takes action on the wider determinants of health. If new models of care can capitalise on the opportunities in the new system and deliver these approaches, then overall improvements to health, reductions in health inequalities and reductions in demand for health care services should result. However, currently there is only partial uptake of the available opportunities through existing mechanisms. As such there is scope to further develop action on health inequalities which this report intends to support.

In scoping work and in discussion with vanguards and NHS England (NHSE), the Institute of Health Equity (IHE) has identified key mechanisms available in the new models of care system that offer opportunities to embed health equity-centred approaches, but only if they are utilised and developed effectively. The work has also identified potential risks for health inequalities and differing levels of prioritisation to reduce health inequalities in a variety of new models of care.

1A HEALTH INEQUALITIES IN ENGLAND

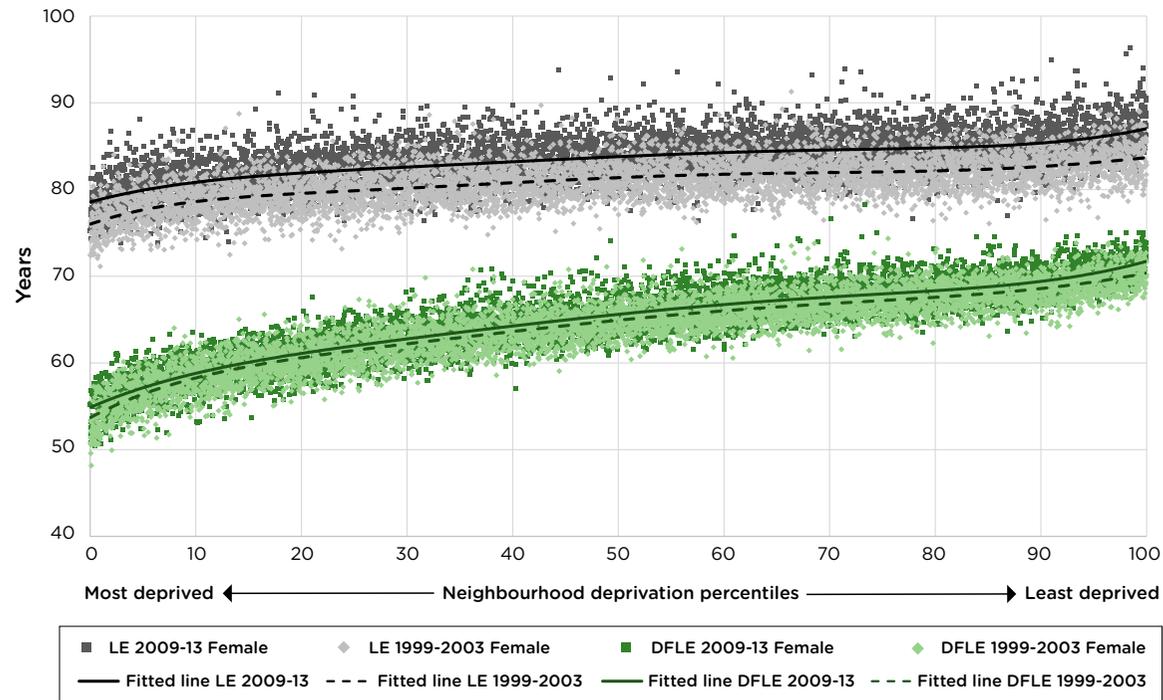
There are clear and persistent health inequalities across England. **The Marmot Review**, *Fair Society, Healthy Lives*, (1) published in 2010, described that people with lower socioeconomic status have worse health outcomes and shorter life expectancy than those higher up the socioeconomic scale. The updated data (2015) (2) shows clear inequalities in life expectancy and disability-free life expectancy (how long a person can expect to live without a life-limiting disability) for men and women in England. Both life expectancy and disability-free life expectancy are closely related to level of neighbourhood deprivation. This is depicted for men in Figure 1 and women in Figure 2.

FIGURE 1: LIFE EXPECTANCY AND DISABILITY-FREE LIFE EXPECTANCY, MALES, BASED ON 2011 CENSUS



¹The Marmot Indicators provide information to local authorities on an annual basis about health inequalities and social determinants. There are a range of indicators at local authority level and at smaller area level within local authorities. The data is related to socioeconomic status and other social and economic domains to describe how health relates to area deprivation and social status.

FIGURE 2: LIFE EXPECTANCY AND DISABILITY-FREE LIFE EXPECTANCY, FEMALES BASED ON 2011 CENSUS

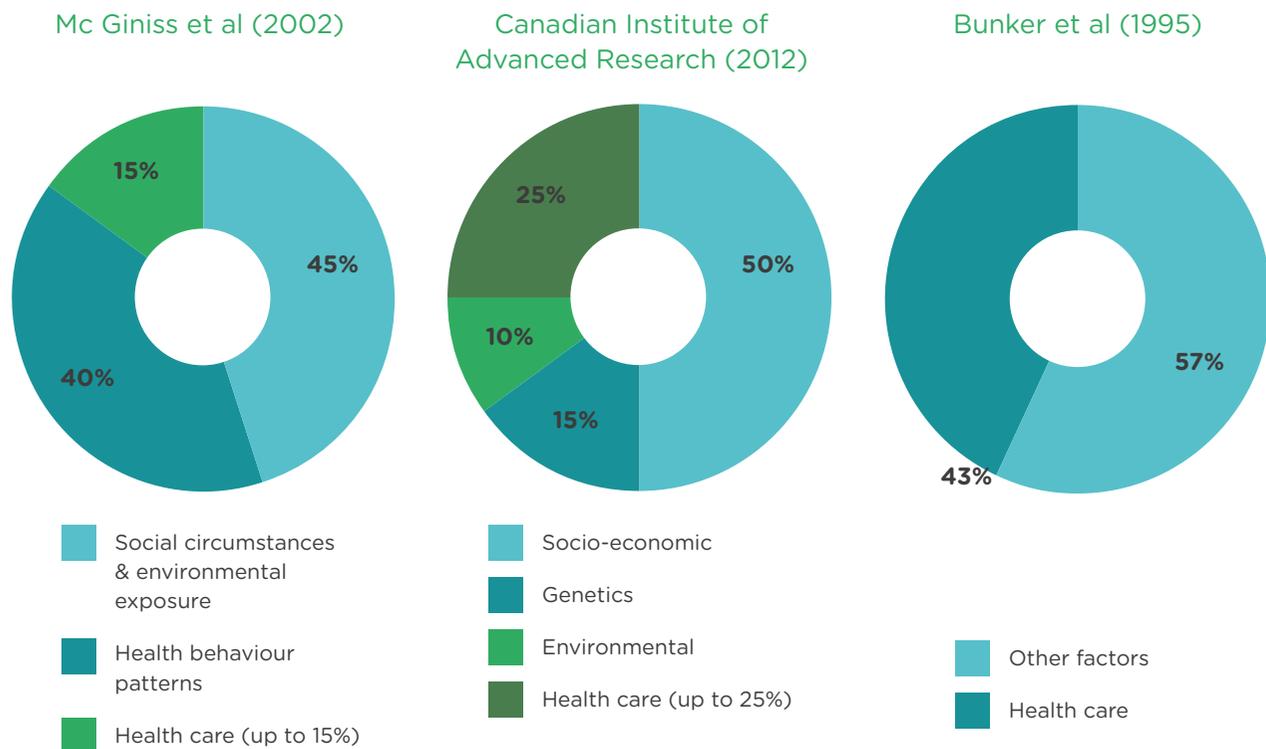


There is a clear social class gradient in both life expectancy and disability-free life expectancy and for a wide range of other health outcomes. This gradient has clear implications for the National Health Service: it is not just the poorest or most excluded who are at risk of poor health outcomes, but everyone below the very top, at least to some extent. Clearly the risks are higher for a person the further down they are on the social gradient, so approaches that are universal but proportionate to need are required in order to raise and flatten the social class gradient and in turn to reduce inequalities in health.

Resources related to data on health inequalities - link to PDF

Many studies have described how it is not healthcare that influences health the most, but social and economic factors. The Marmot Review (2010), and other reviews of evidence, described that most of the drivers of ill health relate to social, economic, environmental, cultural and political factors that lie outside the immediate remit of the healthcare system, as described in Figure 3 below.

FIGURE 3: RELATIVE CONTRIBUTIONS OF FACTORS TO HEALTH



Source: *The Kings Fund: Broader determinants of health. Future trends. (3)*

The Marmot Review (2010) made recommendations for action, for national and local government and other sectors, in six priority areas, all of which lie outside the healthcare sector:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill health prevention

Since the Marmot Review (2010), IHE has analysed opportunities for the healthcare sector and health professionals to make significant impacts on health through action on social determinants. Its report *Working for Health Equity (4)* includes practical actions that the healthcare workforce could take to have a positive impact on social determinants. That report also outlined actions that healthcare organisations can take, in terms of advocacy, commissioning and employment practices, for instance. This report now builds on the analysis and proposals in *Working for Health Equity*, outlining specific actions for new models of care.

In addition to population-wide health inequalities related to socioeconomic status, there are also clear inequalities experienced by particular groups. Box 1 outlines some of the inequalities related to groups identified under equalities legislation (5) and through the health inclusion definitions. (6, 7)

BOX 1: EXAMPLES OF INEQUALITIES IN ACCESS TO HEALTH SERVICES EXPERIENCED BY PEOPLE WITH PROTECTED CHARACTERISTICS AND BY HEALTH INCLUSION GROUPS

Young people: There is evidence of service gaps for young people reaching adulthood, resulting in a drop in engagement at this time, particularly for those with complex needs. (8, 9) Young people with ADHD and autism can find it especially difficult to transition to adult mental health services that do not offer services for their conditions. (10)

Disabled people: Transport, cost and long waiting lists have been identified as barriers to equal access for disabled people. (11) People with learning disabilities face particular barriers. Breast screening, and contraceptive advice, smear tests are significantly lower for people with learning disabilities than in the general population. (12) (13)

Black and minority ethnic (BME) groups, including Gypsy and Traveller communities: Compared with the general population, some BME groups have much less access to healthcare services. (14) Pakistani, Bangladeshi and Indian groups report significantly lower levels of satisfaction, particularly in relation to prompt access, involvement and choice. (15) Gypsy and traveller communities face substantial barriers and have some of the lowest rates of healthcare access. (16) Discrimination, lack of cultural awareness, exclusion from emergency treatment and temporary registration at GP surgeries, (17, 18) having no fixed address, literacy and language barriers, and a lack of familiarity with NHS systems, can also create substantial barriers. (19, 20)

Religion and belief: Belief systems can influence attitudes to reproductive medicine, abortion, contraception and neonatal care, in addition to views on dying, death and the afterlife. This can influence attitudes towards healthcare. (21) The religious beliefs of people are not always assessed or taken into account during care planning or when people attend healthcare settings. This can be considered a form of indirect discrimination and can have a negative impact on diagnosis and treatment, in addition to causing distress for patients and their families. (21) Up to a fifth of people with religious beliefs believe that people from religious minority groups have less favourable treatment in a variety of settings including local hospitals. These views are more likely to be held by Muslims. (22)

Lesbian, gay, bisexual and transgender communities: LGBT groups report bullying and discrimination is often unchallenged in healthcare settings, and that there is a lack of understanding of LGBT health concerns across vital health and social care services. Equality and diversity training for staff on the health needs of lesbian, gay and bisexual people is lacking (23) There is also a lack of cultural competence and understanding of trans or non-binary issues, and unsympathetic approaches to care. (24, 25) This can create a barrier to accessing services (24) and negative physical and mental health outcomes for transgender people. (26)

People with alcohol and substance misuse needs: In England, 4 per cent of people between the ages of 16 and 65 years are dependent on alcohol and 26 per cent of adults consume alcohol in a way that is harmful to their health. (27) However, only 6 per cent of people dependent on alcohol access treatment for their condition. (27) Stigmatisation and discrimination experienced by people who are dependent on alcohol or other substances have resulted in individuals not being accepted on to practice lists and an inability to access medical care for conditions not related to their substance misuse. (28)

Asylum seekers and refugees: Difficulty in accessing healthcare by these groups has been reported due to lack of awareness of entitlement, difficulties registering and accessing primary and community healthcare services, and language and literacy issues. (29) Data on country of origin for incidence of sexually transmitted diseases is not routinely collected (apart from HIV), preventing targeting of preventative and other services. (30) (31). Over two thirds of NHS primary care trusts in London have been shown to provide the wrong information to GPs regarding the registration of asylum seekers. (32)

Carers: At least 70 per cent of carers come into contact with the health service, but health professionals identify only one in 10 carers, and for GPs the percentage is just 7 per cent. (33) This can result in carers feeling marginalised and overlooked and 66 per cent of carers feel that healthcare professionals do not highlight and refer to the most relevant information and support for carers. (34) (35) Evidence also suggests that there is a lack of recognition of the caring role and the needs and issues related to caring within the health service. Failure to provide flexible appointment times, in addition to costs, waiting times, and transport and car parking difficulties, prevent carers from attending to their own health needs. (35)

Resources related to inequities in access to services and outcomes for specific groups - [link to PDF](#)

1B HEALTH SYSTEM APPROACH

While many of the levers to improve health and reduce health inequalities lie outside the remit and ambit of healthcare services, there are significant opportunities for healthcare organisations to do far more to improve population health and reduce inequalities in health. NHS England is giving increasing attention to the issues including commissioning this report and as an example a recent board report ([link to pdf](#)). Healthcare services must integrate with other sectors to form place-based health systems that influence wider community, social and economic drivers of health – in addition to providing equitable access to treatments. Without these types of approaches there will be new and further risks for health inequalities. Integrated Care Systems provide opportunities for developing health system approaches.

There are a number of steps to achieving this type of health system as described in Box 2.

“ To ensure better health for populations and better distributions of health demands a refocus on health rather than on preventing specific diseases. Investing in ill health prevention, can, if implemented effectively, improve health and life expectancy as well as reduce spending over the long term. ”

*Making a difference in tough times:
Coventry City: a Marmot City, Coventry City Council, 2015*

http://www.coventry.gov.uk/info/176/policy/2457/coventry_a_marmot_city

Resources related to development of health system approaches - [link to PDF](#)

BOX 2: A HEALTH SYSTEM BASED ON PREVENTION AND HEALTH EQUITY

A health system based on prevention and health equity requires the following:

- **Focus on preventing ill health and supporting good health as well as treating ill health** - this involves moving from reactive services that focus solely on treatment for people who are already ill towards services that work to improve the conditions in which people live, which in turn will improve their health.
- **Focus on place** - which supports a focus on small areas, and seeks to influence the environment and social and economic conditions of the place in order to improve the health of residents, especially for the most disadvantaged areas.
- **Cross-sector collaboration** - reducing health inequalities requires close collaborations between multiple organisations and sectors reaching beyond health care, public health and social care. These may include, for instance, housing, early years services, and training and education, all of which profoundly influence health.
- **Focus on population health** - in order to improve health and reduce inequalities it is important to understand local population health and health risks for groups and areas. This requires health assessments that include the broader social and economic drivers of health as well as a focus on and inclusion of particular communities that are at risk of poor health.
- **Action on the social determinants of health as well as medical treatment** - there is much that health professionals and healthcare organisations can do to take action on social, economic and environmental factors that would significantly drive improvements to health outcomes and health inequalities.
- **Development of proportionate universal approaches** - designing interventions and strategies that respond to local health risk and need requires additional resources and actions for more deprived communities and areas. Approaches that focus on improving health equity may look quite different to those that focus only on improving average population health, as they are responsive to those with the greatest levels of need and the highest risks of poor health.

1C NEW MODELS OF CARE AS A HEALTH SYSTEM APPROACH

In recent years the NHS has increased its focus on improving health and reducing health inequalities by acting on the social and economic drivers of poor health. This has been accelerated by the NHS's Five Year Forward View (NHS England, 2014), (36) which states the need for greater emphasis and action on improving population health and reducing health inequalities, aligning broadly with the principles we set out in Box 2. Achieving this would be beneficial for the whole population, but there must be particular focus and support for the most excluded and disadvantaged. Improving population health and reducing health inequalities would also reduce demand on health and social care services at a time when both services are under intense financial and demand pressures.

Development of New Care Models has a stated focus on:

- Partnerships and collaborations between different sectors
- Delivery of prevention services and provision of a range of services outside core medical services
- Improving health and health equity

New Care Models have been put into operation at the local level through partnerships of organisation, these are known as vanguards. Since 2015 local area vanguards have been testing delivering of new ways of working and Integrated Care Systems are further developing these approaches.

While there are opportunities for the New Care Model programme to embed a health system based on prevention and greater health equity, this will not be realised without strategic implementation approaches that focus on reducing health inequalities and seek to understand and influence the broad social and economic drivers of health inequalities.

“ *If the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.*

While the health service certainly can't do everything that's needed by itself, it can and should now become a more activist agent of health-related social change. That's why we will lead where possible, or advocate when appropriate, a range of new approaches to improving health and wellbeing.

”

The NHS's Five Year Forward View, 2014

<https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

Given all the pressures and demands on the healthcare system, the focus on broader socioeconomic factors and health inequalities, can be lost in the drive for greater efficiency and demands for investments in healthcare facilities and personnel: this must be avoided.

Resources related to development New Care Models - link to PDF.

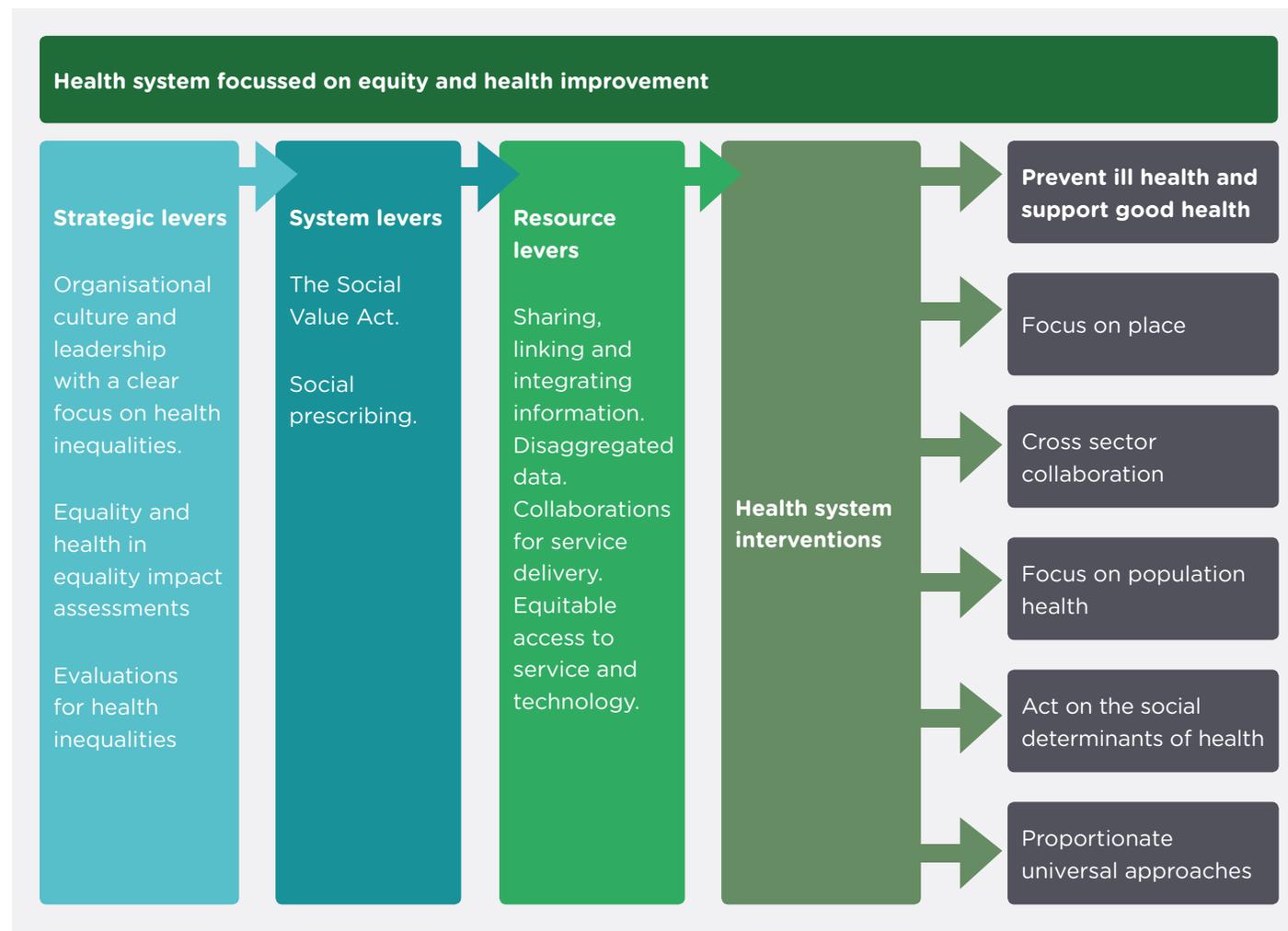
Outside the New Care Models programme, there are already some promising approaches towards improving health inequalities by shaping the conditions in which people live, as well as their treatment needs. Examples include, **Barts and the London NHS Trust**, **Great Chapel Street, London**, and **Coventry, A Marmot City**. More detailed information can be found on these case studies by clicking on the linked names above.

NEW CARE MODELS, VANGUARDS AND DEVELOPING AN EQUITY-BASED HEALTH SYSTEM APPROACH

The New Care Models programme, and latterly the move towards Sustainability and Transformation partnerships and integrated care systems, provides opportunities to embed elements of a health system approach (see Box 2) that delivers population health, a focus on prevention and reductions in health inequalities. Figure 4 below, developed for this report, describes the strategic, system, and resource levers that are available to vanguards.

It outlines how together they could contribute to the development of a health system focused on equity and health improvement.

FIGURE 4: HEALTH SYSTEM: STRATEGIC, SYSTEM AND RESOURCE LEVELS FOR VANGUARDS



Source: Authors

The figure is not intended to describe a comprehensive health system approach that is appropriate for all organisations at national and local level. The figure, and analysis in the report which corresponds to it, are based on discussions with local vanguards and with NHS England's New Care Models team and are informed by the IHE's previous work and expertise. It would be appropriate for other organisations to consider other elements and levers that are relevant to their organisations and context.

The strategic, system, and resource levers that are available to vanguards and that would support the development of a health system approach designed to reduce population health inequalities are explored in Section 2. It expands on each of the elements detailed in Figure 4 above

These are explored through analysis of elements of strategic levers, (Section 2A), system levers (Section 2B), resource levers (Section 2C) and health service interventions (Section 2D) which are available to New Care Models. The concluding analysis (Section 3) makes recommendations for action that are suitable for vanguards to develop using the levers described. Taken together, the approach and recommendations will support the building of a local health system (Figure 4), with capacity to reduce health inequalities in local areas.

METHODOLOGY

The scope of the work was developed following discussions between IHE and NHS England. Issues that either had the potential to reduce, or improve health inequalities were identified and these became the focus of subsequent analysis and discussions with local areas.

At the request of NHS England two site visits, were conducted at Dudley, and the City of Manchester. These sites were selected because they represent areas with differing types of populations and health inequality profiles, that were making particular efforts to prioritise and embed approaches to health equity and were at different stages of developing the approaches.

Discussions with the sites led to further refinement of the scope and further discussions with NHS England's new care models team, including leads in evaluation, technology, workforce and leadership, impact studies, enhanced health in care homes (EHCH) and primary and acute care systems (PACs). At the next stage, seven vanguards were selected for phone interviews. The sites were a mixture of multispecialty community providers, PACs and EHCH vanguards in the following geographical areas: Dudley MCP; City of Manchester MCP; South Hants Better Local Care (Hampshire) MCP; Morecambe Bay PACs; East Lancashire EHCH; Sutton Clinical Commissioning Group Homes of Care EHCH; Encompass MCP; Tower Hamlets Together MCP; and My Life a Full Life (Isle of Wight) PACs.

The aim of the semi-structured interviews was to increase understanding of:

- Vanguards' view of risks and opportunities related to tackling health inequalities
- What vanguards are doing in relation to health inequalities, particularly around the areas identified in earlier discussions
- Opportunities and barriers to further work on health inequalities within the existing healthcare system.

Notes were made from all conversations and these were analysed and drawn on to inform the approach and material covered in this report. There are quotes from the interviews throughout the text; these have been anonymised.

IHE also drew upon published work (including its own previous work) and grey literature, from NHSE, think tanks, international evidence and literature relating to New Care Models, population health and integrated health systems, as well as approaches to health equity, practical tools, and evidence of action for health systems to reduce health inequalities. This resource material is linked to throughout the text.

WHO THIS WORK IS FOR

This work is intended to influence and support efforts to reduce health inequalities in the design and delivery of new care models and other newly established place-based health systems such as integrated care systems (ICSs) and sustainability and transformation partnerships (STPs).

The work and associated outputs aim to inform:

- Vanguard leads
- Public health teams
- Contracting and commissioning teams
- NHSE account managers and leadership
- Other stakeholders including think tanks, academics, and the broader NHS system

2. Maximising opportunities for reducing health inequalities through new models of care

This section describes the key levers and mechanisms available within the new care models system that would support the development of a health system approach. It follows the structure of figure 4 above and draws on discussions with vanguards and new models of care leads.

2A STRATEGIC LEVERS

Strategic levers can help drive organisational focus on population health and health equity. Nationally a strategic focus on population and health equity can foster and support new care models to focus on the development of an equitable population health system. NHS England's Five Year Forward View, for instance, contains elements of a national strategic focus on equitable, population health system approaches, put into operation through local vanguards. It is critical that local strategic levers are also developed and embedded.

Many strategies within public health and healthcare have a stated focus on health inequalities, but translating that into delivery of services and approaches is challenging and other actions and issues are frequently prioritised. This section describes how a strategic focus on health inequalities can be embedded by vanguards, and potentially other health systems, through practical actions supported by utilisation of available levers, specifically:

2Ai Organisational culture and leadership

2Aii Meeting the provisions of health inequality and equality legislation and undertaking Equality and Health Inequality Analysis

2Aiii Design and implementation of evaluations

2AI ORGANISATIONAL CULTURE AND LEADERSHIP

This report outlines some of the available mechanisms through which approaches to health equity could be embedded into new care models. Doing this would at least partly contribute to the development of an equity-focussed health system. In order to foster and sustain focus and action on population health and inequalities, within a rapidly changing organisational and financial context, there needs to be strong leadership to develop, commit to and sustain focus and action on health inequalities.

There are several elements to successful organisational culture and leadership on health inequalities:

1. Top leadership prioritisation – chief executives or equivalent
2. Top to bottom organisational capacity, good will and enthusiasm for taking action on health inequalities
3. Systems and structures for collaboration between different levels of the organisation and across organisations
4. Focusing on and involving excluded groups in the design and delivery of action on health inequalities
5. Supporting and developing multi-sector partnerships, for interventions with a focus on health inequalities through action on social and economic drivers of poor health
6. Improving public and patient engagement in activities to deliver greater health equity

One of the benefits of new care models is that there is opportunity for greater organisational cohesion and functioning between the broad range of partners involved, which should, in theory, foster cohesion and clear strategic direction that focuses on health inequalities. It is important that relationships between organisations, and individuals involved, are supported and given time to mature as effective partnerships often rely on excellent organisational and individual working relationships. Equally important are the enthusiasm, commitment and common vision of those working in roles below the leadership team, including those delivering services.

Allied to the relationships are the technical elements to support the opportunity to deliver large-scale efforts to improve population health with an overarching framework, driven by a shared outcomes framework that supports action on the social determinants and reducing inequalities. These elements are discussed further in this report.

SUCCESSFUL LEADERSHIP ON HEALTH EQUITY: EVIDENCE FROM CANADA

The Canadian Council on Social Determinants of Health conducted an enquiry of successful leaders on health equity in Canada and cite the following criteria for successful leadership on health equity.

Organisational support: Elements include budgets, human resources strategies, high quality data collection, and adherence to external policies and standards. This policy commitment to health equity can be seen throughout supportive organisations, reflected in a clearly articulated vision that is aligned with health equity values and in measurable programme goals and outcomes.

Bridging organisational activity with community action: Organisations must pay attention to external community capacity. Effective leadership to address social determinants of health links organisational activities with community action, establishes partnerships and builds relationships, and moves public health roles into the community.

Professional competency: The people interviewed for the project were selected because they were known as leaders who effectively address social determinants of health and health equity. These individuals described credible leadership as involving the development of the necessary knowledge, skills, and attitudes to understand issues associated with social determinants of health and health equity.

<http://ccsdh.ca/about-ccsdh/>

Source: *What contributes to successful Public Health Leadership for Health Equity? An Appreciative Inquiry* (2013), National Collaborating Council for Social Determinants of Health.

http://nccd.ca/images/uploads/Appreciative_Inquiry_Full_En.pdf

While some of the leadership in vanguards may have some of the elements needed for health equity, it was made clear during discussions, and leadership teams acknowledged, that there are gaps in knowledge, capacity, skills, resources and organisational support to facilitate the required leadership. IHE has advocated for greater focus on health inequalities and social determinants in the following areas, which are critical for developing leadership and action on health equity: workforce education and training; work with individuals and communities; NHS organisations; working in partnership and workforce as advocates.

Resources related to governance and leadership for health equity - link to PDF.

2Aii Equality and health inequality impact analysis

One of the ways for new models of care to meet the obligations of equality and inequalities legislation and ensure a focus on health inequalities is to complete an 'Equality and Health Inequalities Analysis' (EHIA). Conducting an EHIA helps organisations to understand the adverse or positive impacts of system and service design and delivery on health inequalities for particular groups. The EHIA forms are available locally from clinical commissioning groups (CCGs) and NHS provider organisations that also use them to commission and develop services.

Equality and Health Inequalities Analysis enables new care models to focus on the needs and health inequalities experienced by specific groups covered under the Equality Act 2010 and Health Inequality duties specified by the Health and Social Care Act 2012 (see boxes below). The analyses can support the necessary strategic approach and the commissioning, delivery and planning of services required for successful action on promoting equality and reducing health inequalities. This includes engaging with different groups and providing tailored, more accessible services.

EHIA templates also available on request from:
england.eandhi@nhs.net

THE HEALTH AND SOCIAL CARE ACT 2012

The Health and Social Care Act 2012 places legal duties on NHS England to 'have regard to the need to reduce inequalities' between patients in access to, and outcomes from, healthcare services and in ensuring that services are delivered in an integrated way. Having regard means that health inequalities must be taken into account properly and seriously during decision-making processes, or exercising functions.

CCGs have duties to:

- Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved
- Exercise their functions with a view to securing that health services are provided in an integrated way, and are integrated with health-related and social care services, where they consider that this would improve quality, reduce inequalities in access to those services or reduce inequalities in the outcomes achieved
- Include in an annual commissioning plan an explanation of how they propose to discharge their duty to have regard to the need to reduce inequalities
- Include in an annual report an assessment of how effectively they discharged their duty to have regard to the need to reduce inequalities

NHS England has duties to:

- Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved
- Exercise its functions with a view to securing that health services are provided in an integrated way, and are integrated with health-related and social care services, where it considers that this would improve quality, reduce inequalities in access to those services or reduce inequalities in the outcomes achieved; Include in an annual business plan an explanation of how it proposes to discharge its duty to have regard to the need to reduce inequalities
- Include in an annual report an assessment of how effectively it discharged its duty to have regard to the need to reduce inequalities
- Conduct an annual assessment of CCGs, including an assessment of how well each CCG has discharged their duty to have regard to the need to reduce inequalities, and publish a summary of the result

The Act does not define specific groups covered by the legislation, and all patients are covered. (37)

Importantly, the Act makes it possible to focus on:

- The social class gradient in health (as shown in Figures 1 and 2) and therefore the impact of socioeconomic status on health
- Health inequalities experienced by some of the most excluded groups, as identified by the National Inclusion Health Programme and discussed in Box 1, Section 1.

THE PUBLIC SECTOR EQUALITY DUTY

The Public Sector Equality Duty, as set out in the Equality Act 2010, requires public authorities to have 'due regard' to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share protected characteristics and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

Protected characteristics covered by the Act include age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Health inclusion groups include:

Alcohol/ drug misusers; asylum seekers/refugees; carers, ex-service personnel/veterans; those who experienced female genital mutilation; Gypsies, Roma and Travellers; homeless people and rough sleepers; those who have experienced human trafficking or modern slavery; sex workers; trans people and other members of the non-binary community.

Inequalities in health, and disability-free life expectancy for men and women, were summarised in 1A. **Annex 1** describes inequalities in health for especially excluded groups who are at risk of particularly poor health outcomes. It also describes health inequalities across the life course and provides a list of relevant resources.

WHAT IS ASSESSED IN AN EQUALITY AND HEALTH INEQUALITIES ANALYSIS (EHIA) AND WHAT ARE THE BENEFITS?

EHIAs provide a range of questions to assess likely impacts of new models of care on health inequalities and equalities issues.

The analysis involves assessing local equality and health inequality information and the results of any engagement to understand the impact (or potential impact) of policies, practices or decisions on people with different protected characteristics and those with lower socioeconomic status who are at greater risk of poor health outcomes. The analysis should be an integral part of policy development and decision-making, which involves considering whether a policy or practice could be revised or delivered in a different way to better advance equality, reduce inequality or foster good relations.

If completed and responded to effectively, EHIAs can ensure new models of care develop action to reduce health inequalities, following intentions set out in the *NHS Five Year Forward View*. Using Equality and Health Inequality Analysis can ensure that new models of care have:

- A full understanding of inequalities experienced by particular groups in their area
- A full understanding of likely impacts (positive and negative) on health of particular groups as a result of service and intervention redesign
- Better involvement of excluded groups and communities in the design and delivery of services and approaches, so that they better meet their health and other needs
- Strategic direction and implementation that meet the legal duties set out in the Health and Social Care Act 2012, and the Equality Act 2010, increasing the likelihood of reducing individual and population-level health inequalities and moving towards a health system approach (see Figure 4 above).

It is important to note that NHS commissioning and provider organisations who host the Vanguard/New Care Models work should continue to be mindful of their legal duties under the Equality Act 2010 and, if they are commissioners, the Health and Social Care Act 2012, to pay regard to reduce inequalities between patients in access to, and outcomes from healthcare services and to plan the integration of services where this will help reduce inequalities.

Completing Equality and Health Inequalities Assessments (EHIA's) is a useful process to follow in order to understand and evidence inequalities and to plan for the reduction of those inequalities. The EHIA process helps Vanguards to mitigate against any potential negative impact as a result of their work on specific population groups who evidence shows experience some of the greatest inequalities. This process would help target services to those most at risk of ill health and poor outcomes. In addition, EHIA's provide a robust mechanism to demonstrate how duties have been considered in the commissioning, design and delivery of those services. EHIA's present an excellent opportunity to further understand, prioritise and embed action to reduce health inequalities and support health inclusion groups and those with protected characteristics.

THE EQUALITY DELIVERY SYSTEM 2 (EDS2)

EDS 2 is a generic tool designed for both NHS commissioners and NHS providers. It is designed to help NHS organisations, in discussion with local partners, including local people and NHS staff, to review and improve their performance for people with characteristics protected by the Equality Act 2010.

At the heart of EDS2 is a set of outcomes covering patient care, access and experience, working environments and leadership. NHS commissioners may analyse their performance against these outcomes for each group afforded protection under the Equality Act 2010, plus Inclusion Health groups (i.e. refugees, asylum seekers, homeless, and sex industry workers). Ideally this should be done in discussion with local stakeholders including patients, communities and staff, and using the best available evidence.

EDS2 has four goals:

1. Improve the services they provide for their local communities;
2. Improve the experiences of people using the services;
3. Consider reducing health inequalities in their locality; and
4. Provide better working environments, free of discrimination, for those who work in the NHS.

A desktop review of NHS organisations in 2014 showed that those organisations that were implementing EDS2 were more likely to be meeting the specific duties of the Public Sector Equality Duty (PSED) (i.e. to have published their corporate equality duties/objectives and equality information in a timely and meaningful way).

EDS2 supports NHS organisations to ensure system alignment with the following:

- NHS Standard Contract
- CCG Assurance Framework
- Care Quality Commission's inspection regime - well led domain.
- NHS trusts' planning guidance for NHS Boards (NHS Improvement)

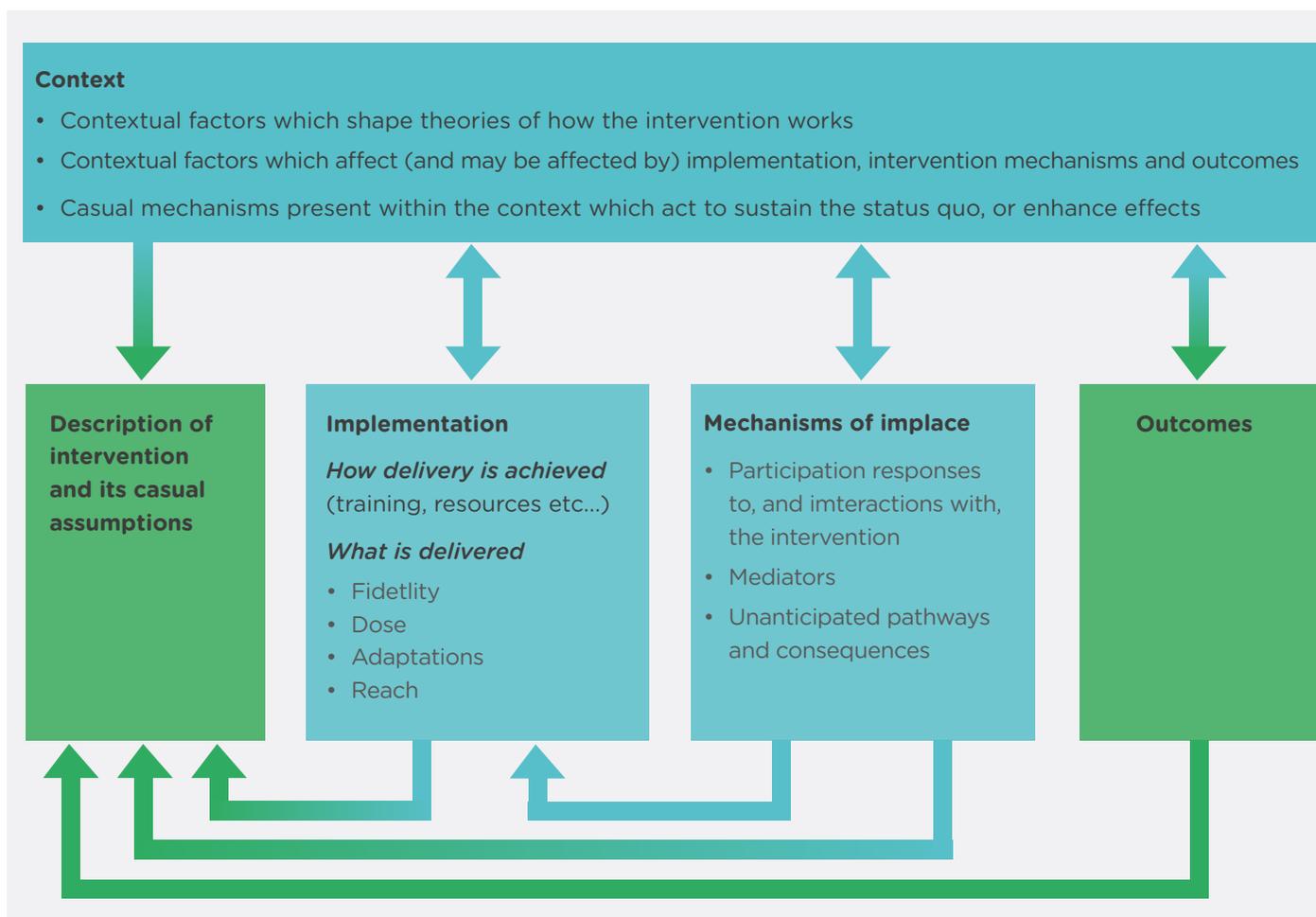
Resources related to health inequalities and equalities duties and guides to promoting equality and reducing inequalities for specific groups - [link to PDF](#).

2Aiii Evaluations for health inequalities

It is well understood that the piloting of new policies and practices in health services requires meticulous evaluation of processes, outcomes and impact. This includes new care models, which are being evaluated as a national programme and also at local, vanguard level.

The main factors to be considered in process evaluation are summarised in UK Medical Research Council (MRC) guidance on process evaluation of complex interventions, shown in Figure 5.

FIGURE 5: KEY FUNCTIONS OF PROCESS EVALUATIONS AND RELATIONSHIPS AMONG THEM



Note: Blue boxes represent components of process evaluation, which are informed by the causal assumptions of the intervention, and inform the interpretation of outcomes.

Source: Moore G, Audrey S, Barker M, Bond L, Bonell C, Hardeman W, Moore L, O’Cathain A, Tinati T, Wright D, Baird J (2015) *Process evaluation of complex interventions: Medical Research Council guidance.* (38)

<https://www.mrc.ac.uk/documents/pdf/mrc-phsrn-process-evaluation-guidance-final/>

The inequality duties in the Health and Social Care Act 2012 require CCGs and NHS England to have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved. To meet these obligations, they need to include an explanation of how they propose to discharge these duties in their annual plans and their annual reports need to include an assessment of how effectively they have discharged them.

In the development of the multispecialty community provider (MCP) framework (39) NHS England indicates that it has given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not. It also indicates that it has given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and the need to ensure services are provided in an integrated way where this might reduce health inequalities.

In the evaluation of vanguards, it would be possible to include rigorous assessments of these equality and inequality statements at both local and national levels. As shown in Figure 5, this includes both design – the causal assumptions concerning the effect of the ‘intervention’ on those with disadvantage and protected characteristics – and implementation. For example, in terms of reach: is access to services appropriate to social and clinical need? Are any of the groups with protected characteristics adversely affected by the implementation? Do mechanisms for impact result in unanticipated pathways for disadvantaged groups or those with protected characteristics, either more or less advantageously than anticipated? Are data available for monitoring

the distribution of outcomes and impact, to identify differential effects of the intervention across the social gradient or among those with protected characteristics?

Where the principal aim of the policy change is not directly related to a specific dimension of inequality, paying attention to inequality and equality dimensions is complex. As well as the process guidance described above, more general guidance is available on dealing with the complications of this complexity. (40)

Similarly, to the extent that the principal intended effect of many vanguards is not the reduction of inequalities or delivering benefits to groups with protected characteristics, the evaluation of any unintended consequences on disadvantaged groups or those with protected characteristics can draw on the guidance for evaluating natural experiments. These are evaluations carried out, for example, in situations where a change has taken place in policy or practice and specific unintended consequences are evaluated to see if they can be ascribed or correlated with the change that took place. A classic example quoted of this technique is the estimation of the reduction in suicide rates that resulted from the introduction of natural gas in homes. More directly relevant here is the evaluation of policy changes that cannot be implemented as randomised control trials. Guidance is available on the evaluation of natural experiments. (41)

Another approach adopted in assessing whether or not a policy differentially affects particular social groups is the evaluation design developed for Sure Start children’s centres. This study is more appropriate for vanguards than other evaluation methodologies. A key element of the Sure Start evaluation design was the development of a study (the Millennium Cohort Study) to assess what had happened to the same

social groups in a control group. While this approach is not practical in assessing vanguard pilots, the principle of identifying control groups with known social and/or protected characteristics has value in evaluating the inequality dimensions of the relevant policy and service changes. In this context, the methodologies used in evaluating Sure Start provide useful lessons for vanguards.

NHS England published its strategy for the evaluation of new care models’ vanguards in 2016. This identified the need to evaluate ‘the quality and equality of care that patients receive’ but did not go any further in drawing attention to equality or inequality duties or to the methods described above to quantify the impact of specific models in meeting these duties. This relatively broad guidance was in part due to the need to allow vanguards flexibility to shape their evaluations to local need and context. A specific issue was that vanguards typically introduced several innovative changes together, making it difficult to ascertain the impact of each one. (42) The evaluations themselves were commissioned and conducted locally. Many focused on using a ‘realist’ approach that emphasised ‘context-mechanism-outcome’ as well as indicators of impact. (43)

The Department of Health has commissioned a summative national evaluation. This will use the techniques described above to evaluate health inequality and equity impacts. This is likely to shed light on potential and actual impacts on disadvantaged areas, excluded communities and on the social class gradient in health. (42, Paragraph 8.2)

Resources related to relevant evaluations and methodologies - link to PDF.

2B SYSTEM LEVERS

As outlined in Section 2A there are some opportunities for reducing health inequalities within new care models, given a reasonably strong national strategic focus, and strong leadership committed to doing so. However, these opportunities will not be realised without effective incentives and levers embedded within the overall national and local health and care system. There are mechanisms available in new care models that can support embedding approaches that incentivise action on health inequalities.

These include:

2Bi The Social Value Act for procurement and contracting of services

2Bii Social prescribing for action on social determinants of health

2Bi THE SOCIAL VALUE ACT FOR PROCUREMENT AND CONTRACTING SERVICES

In January 2013 the Social Value Act came into force for England and Wales. The Act states that for public bodies procuring service contracts over a certain threshold (currently £111,676 for central government bodies and £172,514 for other bodies), the authority must consider: 'a) how what is being proposed to be procured might improve the economic, social and environmental wellbeing of the relevant area, and b) how, in conducting the process of procurement, it might act with a view to securing that improvement.' (44)

DEFINING SOCIAL VALUE

Within the Social Value Act, social value is defined broadly as improvements in economic, social and environmental wellbeing. This means the wider public benefits that result from decisions around who receives the contract, how they deliver it, and what impact this will have on local populations. Social Enterprise UK states in its guide to social value, 'Social value asks the question: "If £1 is spent on the delivery of services, can that same £1 be used to also produce a wider benefit to the community?"'

The ambition of social value is to obtain the best value from public spending and to ensure public sector commissioners consider and support the economic, social and environmental wellbeing of communities and individuals through service contracts. Reduced funding increases the need to maximise social value per pound spent in local areas. (45) Focusing on social value means examining how to broaden the impact of spending beyond just the services being procured and ensure contributions to the economic, social and environmental wellbeing of communities.

As social determinants of health approaches describe, improving economic, social and environmental wellbeing of communities will also improve health – and reduce health inequalities. (45) The Social Value Act therefore

holds important implications and possibilities for procurement of healthcare services. The Institute of Health Equity publication **Using the Social Value Act to reduce health inequalities in England through action on the social determinants of health** provides clear information on how, when and why to use the Social Value Act to reduce health inequalities through contracting.

Social value contracting is still relatively underdeveloped within the NHS, even though it is a legal requirement. Only 13 per cent of CCGs were able in recent research to evidence active use of the Act. (46) Most services are procured on the basis of the value and quality of the service alone - rather than on the broader social, environmental and economic impacts to the local community. It is unusual to find social value stipulations built into contracts or specified in the tendering process. When it is built into the tendering process, the weighting for social value is often low. (46)

However, there are examples in healthcare procurement and in other public service procurement where social value approaches have had a positive impact on local economic, social and environmental wellbeing. For example, Coventry's Health and Wellbeing Strategy for 2016–2019 includes how the city will use social value in its contracting with organisations to encourage recruitment of local people, apprenticeships and training opportunities, paying the living wage, support for the most vulnerable people, and promotion of environmental, social and economic sustainability. (47)

Knowsley Council social value framework, Halton clinical commissioning group, and City and Hackney clinical commissioning groups all provide examples of how social value can be used in procurement of services. More information on these examples can be found by clicking

on the linked names above or on the **Social Value Hub**, and in the Institute of Health Equity publication, *Using the Social Value Act to reduce health inequalities in England through action on the social determinants of health*.

Despite positive opportunities, there are challenges in achieving social value commissioning of healthcare services, including the following.

- The Social Value Act is not widely known about in NHS organisations. Commissioners are often not trained, nor required, to factor social value into tender processes as the focus is on improving efficiency and value for money.
- Different stakeholders have differing interpretations of what social value can mean. (48)
- Action can often be limited to contracting with voluntary, community and social enterprise (VCSE) organisations, acting on employment measures and keeping the supply chain local. (45)
- Capacity building is needed to support providers to understand how to deliver social value. (45)
- The ongoing management of large, recurring contracts is often seen as a way of improving services, rather than redesigning or commissioning new services with built-in social value considerations. (46)
- Social value is difficult to measure and monitor. This can prevent organisations from taking action at all, or from appropriately measuring the impact of action to implement social value. (45)

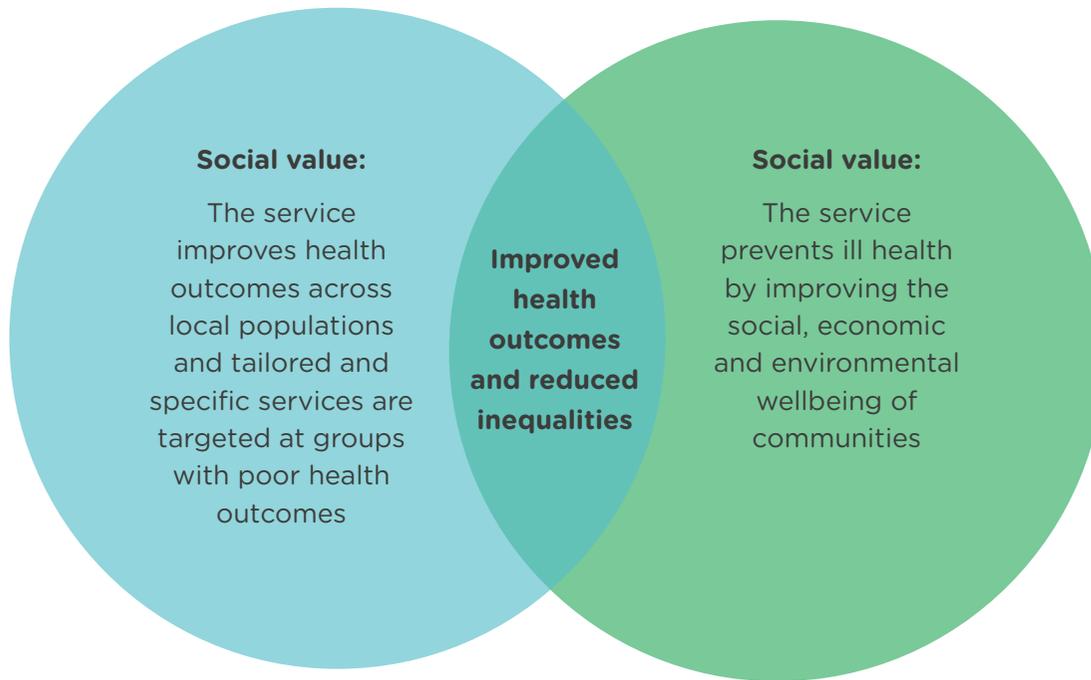
There is a need to define, agree, and take action on securing social value from vanguards' procurement of services. However, this should be done based on the circumstances and needs of local communities.

The broadness of the definition of social value within the Social Value Act means that commissioners, in collaboration with local populations, can define social value according to local needs and assets, as well as organisational priorities, strategies and policies. (45) This process will enable commissioners to embed action to improve the social determinants of health while obtaining the best value for money and better service delivery to reduce local health inequalities. (45)

Social value approaches can also improve access to services, including health and social care services, for deprived communities. This may help offset the risk of the 'inverse care law' and differential access to services.

Figure 6 below demonstrates how developing, and agreeing, a meaning of value that is centred on the individual or community, while embedding social value into procurement, can improve health outcomes locally.

FIGURE 6: SOCIAL VALUE AND IMPROVED HEALTH OUTCOMES



[Resources related to social value contracting - link to PDF.](#)

2Bii Using social prescribing to create action on social determinants

Broadly speaking, social prescribing can be described as ‘a mechanism for linking patients’ and their carers ‘with non-medical sources of support within the community’. (50) Social prescribing is often used to access an alternative treatment for a specific health issue, such as a group that promotes physical activity to address obesity. Social prescribing can also address the social determinants of health, for example through housing or debt advice. Other examples include parenting support programmes, employment and training support, and befriending schemes to address social isolation and loneliness. As such, social prescribing fits well with the equity-focussed health system approach outlined in Section 1, and facilitates action on social and economic factors that influence health.

Social prescribing is most often implemented either through a GP or other health service professional using a directory of community services to which they can directly refer, or through use of a link worker or referral agent, linking patients to a range of community services.

A number of evaluations (50) have noted multiple positive outcomes for patients accessing social prescribing schemes. These include:

- Improved self-esteem and confidence
- Greater sense of control and empowerment
- Improvements in psychological or mental wellbeing, including reduction in symptoms of anxiety and depression
- Improvements in physical health and health behaviours
- Improved knowledge and skills
- Improved social connectivity (50)

Health services including general practice have also reported:

- Reduced numbers of visits to the GP and other health professionals or primary or secondary care services
- Increased ability to take a holistic approach to treating patients
- Improved engagement with 'hard-to-reach' patients (50)

One pilot evaluation (51) found that in-patient admissions reduced by up to 21 per cent, A&E attendances by up to 20 per cent, and out-patient attendances by 21 per cent. A further financial return on investment evaluation has found a return of 50 pence on every pound spent and potential NHS cost reductions of £415,000 in the first year of the pilot. There are also social return on investment benefits including an improved and more sustainable voluntary sector, increased community wellbeing, and increased take-up of welfare benefits. (51)

Social prescribing offers a clear opportunity for vanguard sites to provide a way to refer patients to community-based services that complement traditional medical interventions, reduce demand on more costly services, and broaden, diversify and integrate services for patients, particularly those with complex needs. (50) Social prescribing has the potential to address some of the social determinants of ill health, and health inequalities, enabling new care models to address the social gradient in health and reduce health inequalities. Additionally, social prescribing, if commissioned and implemented effectively has the potential to support health services and general practices to meet their duties under the Social Value Act, demonstrated by Dudley, City of Manchester, South Hants, Whitstable, East Lancashire, Isle of Wight,

Social prescribing has yet to be scaled up across NHS organisations, including vanguards although most have some social prescribing and NHSE have a social prescribing team to support this across the health system. To date much of social prescribing has focused on alternative interventions for mental health rather than interventions that impact on the wider determinants of health, such as poor housing, poverty, and poor quality work. This type of social prescribing, alongside social prescribing of interventions for mental health, could support reductions in inequalities.

Although social prescribing provides a clear opportunity for new care models to address the wider determinants of health, there are challenges that need to be addressed in order for it to be successfully funded, implemented and upscaled to have a broad and long-term impact.

Recommendations:

- Ensure a clear definition and understanding of the meaning and processes of social prescribing that is specific to local area need and available resources. Be clear what social prescribing is not, i.e. it is not referring to alternative therapies that may conflict with GP advice and care. (52)
- Strengthen the focus on the broader determinants of health and the services that address them, in addition to complementary services that enhance traditional medical models.
- Provide sufficient funding through service level agreements that enables the co-production of longer-term social prescribing services, with good quality independent evaluation. This will enable GPs and other health service providers to develop confidence in social prescribing and community schemes. (52, 53)
- Focus on the elements of the social prescribing process that enable individualisation and responsiveness to the needs of different groups of patients and providers. This focus should clearly prioritise understanding of how to maximise uptake from groups who are more vulnerable to health inequalities and where geography, cost and anxiety can prevent successful engagement. (52)
- Address issues of data sharing across the NHS, social care and voluntary sector organisations. (48) There are successful examples of this (see subsections 2Ci and 2Cii).
- Develop clear infrastructure that supports social prescribing, including job descriptions, career pathways, and professional regulation frameworks for embedding new workers in general practice, including physician assistants and administrative support workers. (53)

Resources related to social prescribing - link to PDF.

2C RESOURCE LEVERS FOR INTEGRATED AND SHARED SYSTEMS

Cross-sector joint working and social and economic interventions are important mechanisms for creating a health system focussed on health equity. This section explores some of the resources and processes that can be used to reduce health inequalities through integration of systems and more effective sharing of resources. It looks first at sharing, linking and integrating information with a number of case studies to illustrate the different types of linkage that are being undertaken and their benefits, then looks at collaborations for service delivery and finally at equitable access to services.

2Ci Sharing, linking and integrating information

Sharing, linking and integrating information from different parts of the care sector provides an improved picture of the patient pathway, facilitating greater attention to early intervention, improved identification of patients with complex needs and facilitates more accurate needs-based finance models. Going beyond this, the linkage of information on wider social, economic and environmental conditions to health utilisation and outcome data provides information about the drivers of health inequalities. This can provide knowledge to use resources across sectors on early interventions that reduce inequalities and help prevent the development of some more complex health needs. Where this type of linkage is carried out, or at least analysed, at small area level it can help to provide a localised focus to address health needs, inequalities and their causes. In this way, the commissioning of services and development of inter-sectoral partnerships can be undertaken with a clear focus on improving health and reducing health inequalities.

These processes are broken down and described further below

2Cii Collaborations for service delivery

Secondly, the section explores the need for service collaborations which support development of an integrated health system focussing on equity. Service collaborations need to be supported by a workforce that has knowledge and capacity to take action on broader social and economic factors, with a focus on disadvantaged and excluded communities in local areas.

- 1) Partnerships
- 2) Multi-disciplinary teams
- 3) Workforce

Section 2Ciii Equitable access to services

An integrated health system can support improved access to health, social care, and other services, particularly for communities who are currently experiencing worse access. Two particular issues were highlighted to us during discussions with vanguards and NHSE; access to health care and other services for care home residents and the uses of new technologies. These are described in sections 2Ciii 1, 2 respectively.

2Ci SHARING, LINKING AND INTEGRATION OF INFORMATION

2Ci 1 Data Integration

Integrated health system partnerships require shared information about the population in the area covered by the partnership. The Health and Social Care (Safety and Quality) Act 2015 placed a legal duty on health and adult social care bodies to share information where this facilitates care for an individual. (54) The extent to which this duty requires and/or facilitates sharing of data from different care settings (including social care) and for different purposes is discussed in the Information Governance Alliance (IGA) document, Duty to Share. (54) At its most basic, the duty is to share information about an individual that is held by a health or adult social care commissioner or provider to facilitate the provision to the individual of health services or adult social care in the individual's best interests. (55) This duty to share does not extend to non-direct care purposes.

“ *The information that is normally shared to support direct care will be confidential personal information and the purpose will clearly facilitate the provision of care so the information must be shared where it is lawful to do so. This means that individuals need to be informed about the proposed sharing and that some form of consent is required. For most types of direct care (where it would be unlikely that an individual would be surprised by the sharing and hasn't objected) this consent can be implied.* ”

**Duty to Share,
Information Governance Alliance (2015)**

Where this data include information that is collected by NHS organisations, it would normally include NHS number, and there are software tools for GPs use, available for purchase through CCGs to facilitate meeting this duty. They can be acquired through GP Systems of Choice (GPSoC), a contractual framework to supply IT systems and services to GP practices and associated organisations in England (56).

While the sharing of data relating to clinical and social care status of the patient is an essential requirement of the Act, if it is solely undertaken to help provide direct care, there is also a need to take account of social need which may or may not be identified through NHS systems (those containing NHS number as an identifier). Duties related to fair access to care and equality of outcomes are also met by linking data that differentiates population groups (e.g. ethnicity, disability, gender, socioeconomic group) by their access to care services and the health outcomes experienced following that care. However, some of these characteristics, either on their own or in combination, are sufficiently specific to one person that they can make people identifiable. The inclusion of outcomes to these characteristics makes identifiability even more likely. In these instances, compliance with the Data Protection Act 1998 and (from May 2018) the General Data Protection Regulation (GDPR) (Regulation (EU) 2016/679) is essential, recognising, in particular, that many of the protected characteristics and outcomes are classified as 'Sensitive Personal Data' and that arrangements need to be put in place to make it easy for people to opt out of having their data shared. NHS Digital is developing a new system to support the national data opt out which will give patients more control over how their personally identifiable data is used. The system will let patients exercise their right to make an informed choice about whether or not their personally identifiable data is only used for their individual care and treatment or also shared for research and planning purposes.

Two key pieces of relevant legislation are the equality duties in the Equality Act 2010 and inequality duties in the Health and Social Care Act 2012. Neither of these Acts includes an explicit duty to share data. However, in situations where there is general agreement that it is clear from the Act that a power or duty conferred can only be carried out by using linked personal data, data can be shared. This is only likely to be the case where the data are used to ensure the equitable delivery of direct care to an individual.

In deciding whether linkage of identifiable data can be undertaken, it is also important to consider who will be doing the linkage. Where care data is linked information previously submitted to and processed by NHS Digital, it can be linked by NHS Digital, under its powers, subject to approval by the Independent Group Advising on the Release of Data (IGARD). However, linkage of identifiable data processed solely within the CCG and/or local authority requires additional permissions to ensure that linkage is within the law and takes place within an approved secure setting.

Linkage for these purposes therefore requires explicit justification and, where necessary, these approvals. In all cases where linkage cannot be undertaken using de-personalised data, approval will usually require a mechanism for obtaining subject consent. One-to-one engagement with individual patients or clients would include a facility

to easily withdraw consent, but this is difficult to achieve at a population level. To help resolve this problem, the Duty to Share document identifies what can be done.

“ *Health and adult social care commissioners and providers, including those contracted to provide services, need to consider the circumstances where information can be lawfully shared and the information that might facilitate the provision of health services and adult social care.*

There are several different types of information. Effectively anonymised information can be shared lawfully and so where this might facilitate care it must be shared. Where information is associated with an identifiable individual (personal information) then the individual concerned should be informed about the proposed sharing for it to be lawful. Where the information is confidential personal information it is also necessary to have the individual's consent or some other legal basis for meeting the requirements of confidentiality. (54). ”

**Duty to Share,
Information Governance Alliance (2015)**

The quote above highlights the importance of mounting an effective patient and public engagement exercise. This is particularly important when NHS data are to be linked to non-NHS data on the wider determinants of health - such as that held by local authorities. Much of this additional data will be from services that are not related to clients' health care, for example data relating to the property in which they live, such as housing conditions and energy efficiency. Achieving public engagement requires a clear narrative on the impact of wider determinants on health and wellbeing. The support of local leaders, including councillors and mayors, for work to assess this impact is essential. This requires clear messages on the value of linkage and the use of depersonalised data.

Linked and integrated data-sets, available at neighbourhood level, are an important first step in developing a population health system that assists with equality and inequality duties by, as described in Figure 4 above, focusing on place, equity and population health. Some of this information may be held on NHS systems, in which case sharing can be achieved through the software tools described above. But other information will be from non-NHS sources and will therefore require additional governance arrangements and software.

Integrated data-sets support greater understanding of the relationships between wider social determinants, health outcomes and healthcare need and utilisation at small area level. This information can be used by vanguards and others to inform planning and commissioning of services. This will ensure that:

1. More resources are channelled into services where they are needed most ('proportionate universal' services). Integrated data-sets at small area level will undoubtedly show inequalities between neighbourhoods in health care use, health outcomes and in social determinants. This will enable better targeting of universal and other services, to areas and people where they are most needed.
2. Service planning and delivery supports action on the social determinants. The integrated and linked data-sets will show at small area level the relationships between particular social determinants of health (informed by local authority data) and health and healthcare. Integrated data-sets should therefore be used in planning and supporting services that improve conditions in the social determinants, which will lead to improvements in health, reductions in health inequalities and reductions in avoidable healthcare utilisation.

To inform strategy, commissioning and practice and the development of a preventative, equity-focussed place-based health system, data-sets are needed that incorporate: social and economic drivers of health and health inequalities and clinical information, including data from health and social care, public health and local authorities and other services, such as housing and environment.

The next subsections explore how the sharing of information and linked and integrated data-sets are being developed. They also describe how they can assist in: improving population health and wellbeing, improving modelling of funding services by establishing a more complete picture of cost and need, and reducing inequalities in order to inform strategic direction, commissioning and resource allocation.

2Ci 2) Sharing Data

In some vanguards the data-sharing facilities are relatively developed – at least, between GP practices and in some areas between ambulance and acute trusts as well. For instance, in Dudley, all GP practices use the same clinical records system, and a data-sharing agreement between the local authority and each practice allows public health senior analysts to analyse de-personalised primary care summary records in order to better assess health needs across the borough and prioritise interventions. As well as supporting enhanced population health and social determinants analyses, shared data for individuals allows more appropriate care and health promotion activities tailored to the needs of the individual.

These types of shared data systems facilitate focus on population health and can be built into outcomes frameworks for contractual purposes. One MCP vanguard pointed out that shared data, outlining social and health risk profiles, can also facilitate understanding on how to push and stretch the outcomes framework to incentivise reductions of health inequalities. **NHS South, Central & West Commissioning Support Unit** has linked patient register information with utilisation of services information to identify opportunities for early intervention. More details can be found by clicking on the named link.

“Partnerships need to be multi-agency and some teams with a strategic lens [need] to look at the health data for each neighbourhood and plan accordingly.”

MCP Vanguard

2Ci 3) Linkage of data

New and innovative approaches to risk stratification are critical to vanguards' ability to focus on social determinants of health. It is essential to move away from viewing individual and population risk solely as clinical and therefore it is necessary to build social risk factors into risk profiling.

“Social risk profiling: we need risk stratification combining NHS-level data and high-risk population data to provide a combined predictive model; for example, integrating NHS data with the adult social care lists with sociological data built in – for instance, deprivation by area, some ethnicity data, combining all these elements.”

MCP Vanguard

“Risk profiling – we are starting to build in social risks. Risk stratification is based on NHS-level data and mapping the high-risk population. For example, 65 is a poor health age threshold for us. We also need to co-manage data from multiple sources – e.g. adverse childhood experiences. There are confidentiality issues which are difficult to manage – but there needs to be a cultural shift. We need to find a way of linking data that satisfies GP confidentiality and enables social risk profiling.”

Vanguard lead

“Information governance is a big problem in all of this – with the risk stratification in the models – we can't get wider determinants into the system.”

There are issues about data and how that is now going to impact in some areas – that is a big barrier. Having population data is vitally important. Some areas are looking at how that can be resolved.”

GP vanguards

“The social and healthcare integrator model – risk stratification in primary care – there is a tool looking at frailty and complex conditions highlighting people who need more support and MDTs and integrator locality teams. Care home needs to be included in that cohort and not excluded from it.”

EHCH vanguard manager

A number of case studies illustrate the way in which successively more challenging linkage has been undertaken to meet or facilitate meeting the duties described above. More details can be found by clicking on the following links: [Kent Integrated Dataset](#), [North West London Collaboration](#) and [Tower Hamlets Together Going beyond the sole use of NHS data](#) (linked on the basis of patients' NHS numbers) to a data-set that includes data from social care and more than one commissioning group requires significantly greater record linkage. It also requires significantly greater attention to information governance arrangements, to underpin the use of the data set - beyond direct patient care. (57) [A guidance document based on the Tower Hamlets Whole Systems Dataset Project can be found by clicking here.](#)

[Resources related to sharing and linking data - link to PDF.](#)

2Cii Collaborations for service delivery

Closer integration between health services and a wide range of services has long been called for by those advocating for improvements in health inequalities and action on social determinants. Integration of multiple services has benefits to individual patients and also supports area-based approaches to planning and delivering healthcare and health improvement for those areas and communities where it is most needed. The flexibilities, and in some cases requirements, within new care models to partner with other services and organisations have potential to help reduce health inequalities through action on the social determinants. However, integration without focus on the most excluded and deprived areas will not maximise the potential of new models of care to reduce health inequalities.

While new care models have a strong focus on integration, partnerships and multidisciplinary teams, there are risks to the operationalisation of this integrated approach. In practice, there are multiple organisational and systemic barriers to the delivery of integrated partnerships:

- Different organisational targets, outcomes frameworks, budgets, organisational cultures and professional practices
- Different geographies and populations
- Different data and information systems which are not shared
- Time and resource pressures
- Working within specific organisations in specific areas rather than across systems

Vanguards can at least partially offset these risks through some of the mechanisms outlined in this report, the vanguards we spoke with had some elements of the approaches we have outlined in this report. However, even if these were fully developed in new care models approaches, there are still significant organisational and workforce barriers to integrated systems. Vanguards can look beyond integration with social care and public health services, to explore how they can work with other public services and voluntary and community sectors. All the vanguards we spoke to had partnerships with community and voluntary sectors.

This subsection assesses how vanguards can develop further integration and how this can help support action to reduce health inequalities and improve social, as well as medical, outcomes. It discusses which mechanisms support new models of care to develop service integration and outlines some of the barriers to doing this. The subsection focuses on three important arenas for action for collaboration that were outlined to us during discussions with vanguards:

- 1) Partnerships
- 2) Multi-disciplinary teams
- 3) Workforce

2Cii 1) Partnerships

In all cases strategic focus on integration should be supported by collaborative partnerships between services that broadly influence health outcomes, including organisations with remit outside healthcare services, including housing, education, social care, public health, community services and primary care. Partnerships between organisations should have the ambition to support improved social, economic and environmental conditions for those with greatest need and translate them into better health outcomes for these people and places. These types of partnerships are critical to the functioning of new care models and are necessary for underpinning integrated health systems and successful approaches to health inequalities through action on social determinants.

“ The MCP will enable partnerships with a range of services including the community and voluntary sector and Hampshire County Council. They know the area – so can provide a range of prevention services such as housing and working with people who are having trouble with finance, employment.

Spatial planning and housing and multi-disciplinary teams work in small teams in small neighbourhoods and we are planning on moving children’s services onto school premises. ”

Vanguard

In order to successfully tackle health inequalities, vanguards must understand and develop services for areas with particularly poor health and social outcomes, focussing on the most deprived areas, with delivery of appropriate services to meet need and reduce health risks – social risk as well as clinical risk. More disadvantaged areas require more resources and support in order to improve social and health outcomes: as outlined in Section 1, partnerships must be geared to deliver proportionate universal approaches.

“ Relationships with other services are critically important, including social care and housing. This is potentially a large area which can be integrated into locality-based services. ”

MCP Vanguard

“ Advice services can be tailored to local geography. We know what people in our area need. Greater clinical involvement in social care and other services will benefit. There are ways of incentivising action on social need through integrated care. For instance, the council need to build more sports facilities in the north of the borough. The MCP would be a vessel to influence facility with procurement. ”

MCP GP

There are a number of key mechanisms that need to be in place in order to ensure effective partnerships between multiple organisations. Without these, the potential for developing effective systems for health equity will be lost. The mechanisms are available in the system, but are often not drawn on or developed to sufficient scale by vanguards.

2Ciii 2) Multi-disciplinary Teams

In vanguards, partnerships manifest in workforces from different organisations collaborating in multi-disciplinary teams (MDTs). MDTs are critical to the integration of services and the provision of appropriate services focussed on ill health prevention and reducing inequalities. They are the means through which people can access a full range of services and have their social, health and treatment needs assessed, coordinated and managed. To fully maximise potential to impact on health inequalities, MDTs must also seek to improve population health, assessing area health outcomes and needs, and responding by intervening in areas of greatest deprivation in upstream and proactive ways. This is particularly important for deprived areas, as well as excluded and marginalised population groups, for whom outcomes are likely to be particularly poor.

“ Core members of the MDT are GPs, social workers, Macmillan nurses and other nurses, and social prescribers. But additionally, we will have community and voluntary services to provide locality link workers – aligned to the five geographic areas and to attend all the MDT meetings. ”

MCP Vanguard

However, there are clear limitations in some areas around the collaborations within MDTs and also the range of partners involved.

“ We need to encourage partners to use the information to facilitate collaborative working. The difficulty is that you have organisations empire building and not truly collaborating.

We have a motivation to engage with corporate and the Local Economic Partnership to get people back into work. We work with the CCG alongside the council but we are not paying proper attention to the LEP to achieve that. We need to build links with organisations responsible for local economies. ”

Vanguard leads

2Cii 3) Workforce

In order to achieve effective broad-based partnerships, it is important that the workforce, particularly the healthcare workforce, supports activities that improve social and economic conditions and are aligned to work in geographic areas and with communities where need is highest.

“ [We aim to] focus skills and people around the neighbourhood, in neighbourhood teams. These are small enough to connect but also to be strategic – every professional is part of that neighbourhood team – that is the new workforce approach.

[Areas] are beginning to use more information and data to understand health inequalities, using population data, for instance. Some areas are understanding areas of need and now they understand that the workforce isn't aligned to that. [It] comes back to contracts and commissioning the workforce – it is generally using a standard contract, in the past, a fixed contract – but that can mean that staff are not properly aligned with areas that need more. ”

MCP vanguards

Contracts with staff need to have flexibilities built in to allow weighting for areas with higher need, and high levels of deprivation.

“ Financial incentives? If you have more money for poorer areas do staff move from other areas? But we need to ensure quality in all areas. There is a concern about staff moving – affluent areas take staff from less affluent areas and vice versa. This creates turnover problems. If you have surplus/extra capacity in an area, do we allow capacity to work across boundaries rather than physically moving?

How do you change particular locality teams or GP teams? How do you get them to flex across a wider area? How do you use your community voluntary sector and third sector? How do you de-medicalise some of the resource allocation – to include the community voluntary sector as part of your broader workforce? ”

Workforce lead, NHSE

Given the focus on integration through partnerships and MDTs consisting of multi-sector teams, there are opportunities for a new type of workforce to be involved in delivery of care, and given the focus of this report, in the delivery of action on social and economic drivers of health.

“ *There are new opportunities for the workforce – some new roles (clinical pharmacists, local area coordinators) are on boundaries of organisations. We need to encourage them to think more creatively about the use of these roles.*

There should be close collaboration between workforces, so that MDTs seek out referrals from police or housing sectors, rather than waiting for people to turn up through the door. ”

Workforce lead, NHSE

Resources related to workforce roles and organisational development - link to PDF.

2Ciii Equitable access to services

While the NHS is still assessed as the most equitable healthcare system in the world, (58) there are inequalities in access to many services and inequalities in experience and outcomes. As described in Section 1, inequitable access to healthcare services is not the most significant driver of inequalities in health, but there are inequities for particular groups, mostly those who are already at risk of poor health (see Box 1 above). These inequities are particularly significant for excluded groups, those with lower socioeconomic status, those with pre-existing and multiple long-term conditions, and for some older people, especially those who live in care homes.

Two particular issues were highlighted to us during discussions with vanguards and NHSE which this section addresses: firstly we focus on access to primary care and community services for older people living in care homes, describing some of the barriers to access, and care homes. This analysis will help to assess if new models of care in care homes are likely to reduce risk of inequalities in access to services for care home residents, and pinpoint where further opportunities for action may exist.

Secondly, possible opportunities and risks to health inequalities through expanded use of technology in health are explored.

2Ciii 1) Care homes access to primary care services

This section examines how the provision of current primary, community health and other services meets the needs of older people and residents in care homes. It analyses areas where there are inequalities in access to and quality of services. This section also draws on interviews with managers delivering enhanced care in care homes through the new vanguard programme, to help establish potential risks and opportunities for addressing inequalities.

In the UK 405,000 older people (aged 65-plus) live in care homes. (59) The majority of people living in residential care homes have complex healthcare needs, with long-term functional dependency and frailty. (60) Around 75 to 80 per cent of people in care homes have some form of cognitive impairment and poor mental health including depression is common. (60) A high proportion of people under the age of 65 living in care homes have learning disabilities. (59) The ability to support mental and physical health for residents depends on health services that reflect these needs. Residents also require access to primary and community health services that are at least the same as those available to people living in their own homes, and preferably with enhanced access given the complexity of their needs.

Current care home provision

NHS long-stay hospital beds have reduced by 80 per cent and GPs are now responsible for older residents who would have previously been cared for by hospital specialists. (61) Medical treatment can be difficult for GPs to deliver under existing time and resource constraints and without specialist training, such as geriatric medical care. (60)

Standard GP services that are available to the rest of the population are often not sufficiently accessible to care home residents. (62) (60) Missing services and gaps in health and other care in care homes include: basic care, issues around risk, safety and safeguarding and non-adherence to national standards, reviews of medication, care planning, primary care services, rehabilitation after acute illness, speech therapy and specialist mental health support. (62) (63) A lack of sufficient end-of-life and palliative care also presents problems. Lack of training of care home staff and gaps in their knowledge can result in older people being admitted and staying in hospital at the end of life, rather than staying in the familiar and often more comfortable surroundings of their care home. (62)

Community and voluntary support services that provide important preventative services, such as befriending schemes or opportunities to volunteer and interact with the local community, are also often inaccessible to those in residential accommodation.

“ *People in care homes often don't meet the eligibility criteria for voluntary sector services and so can be excluded.* ”

Vanguard programme lead

These issues can result in poorer health outcomes and increased admission to hospital, including Accident and Emergency departments. Out-of-hours services are often unable to access the right information for appropriate care planning, and this can exacerbate existing health conditions. (60)

Care home quality drivers

There are stark inequalities in the geographic distribution of care homes that offer care that is either 'inadequate' or 'needs improving'. This is found at a regional and local authority level. The North West is the worst performing region in England and has the smallest number of 'satisfactory' care homes, along with the local authority areas of Stockport, Salford, Tameside, Manchester, and Kensington and Chelsea. (61) Stockport, Salford, Tameside, and Manchester are all in the 10 per cent most deprived local authority areas in the country. Staff training, recruitment and retention and lack of appropriate support systems for improving inadequate or struggling care home services are all issues that impact on quality of care and health outcomes. (64) (62)

Inequalities in access to good quality care can also be seen in relation to equality and health inclusion groups, as identified in Section 2A. Qualitative studies have reported a lack of awareness around the cultural needs of BME groups, including Gypsy and Traveller communities, and around the needs of LGBT groups, including knowledge of the importance of relationships. These issues are particularly important for ensuring good quality, personalised end-of-life care (65) and supporting mental health. The needs of older people with visual impairment and hearing loss can sometimes be missed, too. (66)

Opportunities for enhanced health in care homes (EHCH)

There are clearly inequalities in access and quality of services for people living in residential care homes. However, opportunities exist to address inequalities through the enhanced health in care homes programme.

“ *Enhanced health in care homes addresses some of the issues of equity of access to NHS services. But, there are a number of challenges across the whole system in delivering services equally – one is heterogeneity with 16,000 different providers (care homes), 400,000 residents, huge numbers of acute trusts, and CCGs and 10,000s of GPs. So consistency is hard.* ”

EHCH lead, NHSE

Action is needed to ensure that care home residents have access to the same level and quality of services no matter where they are located, and that interventions and activities support social, economic and emotional needs

as well as physical health needs; in short, to increase access to support and services in the community.

Vanguard approaches, with a focus on multi-sector partnerships, can be beneficial to care home residents. Multi-disciplinary teams can open up services that may have not been available or accessed by care homes.

“ *We have tried to open health access and look at other options for supporting the wellbeing of residents. For example, we had a market place of services that provided a whole range of services – interactive computers, physical exercise, to open up awareness of different services available for care homes.* ”

EHCH lead, NHSE

EHCH vanguards are well placed to identify services that care home residents may or may not be accessing. But all reported that there were significant differences, and therefore inequalities, between care homes related to types of services accessed.

“ *There are big differences between care homes in relation to commissioning and accessing services. For instance, some care homes assume they can't access podiatry services; others access them. We need to equalise access between care homes.* ”

EHCH lead, NHSE

One vanguard manager told us that some care homes assumed that voluntary services were not appropriate or accessible for care home residents. In fact, in many cases the voluntary and community sector was able and willing to provide services for care home residents.

“ [There are mixed] assumptions about the eligibility [of care home residents to a range of services] and there are wrong assumptions from both commissioners and providers about what is available to those in care homes. So what it has meant for residents is that they haven't had same levels of access to many services. Some voluntary services have made the assumption that their services are not applicable to residents. We have worked hard to break down the barriers, we think. ”

EHCH programme lead

“ They [NHSE EHCH team] have developed a framework which stipulates what services residents should have access to and this seems to be effective. Evidence shows that there have been improvements in outcomes for service users. ”

EHCH programme lead

There are challenges around access to GPs but also a question as to whether access should always be to the GP. Broader primary care services may be more appropriate. For example, in one area they could provide pharmacy services but not GP services. GPs provide the core elements and pharmacies provide a range of primary care services.

“ In relation to GP provision, it was too expensive to pay for weekly rounds for GPs for every care home. What we have done is develop the role of liaison nurses, who build capacity among care home staff to work with patients proactively to identify healthcare needs and for them to liaise with primary healthcare teams. ”

What has been really positive has been the partnerships and organisations across the organisations – the network of relationships which involves the care homes so they are a valid player. Often the care homes are forgotten about but the vanguard has helped build the relationships. ”

EHCH programme lead

To promote better health outcomes for care home residents a set of recommendations has been developed based on examples of best practice reports covering specific issues for care home residents (referenced in the text), and interviews with care home managers.

RECOMMENDATIONS FOR PROMOTING BETTER HEALTH FOR CARE HOME RESIDENTS

Upskill staff to ensure they have the confidence and skills to support residents' health and wellbeing and work with primary care services to support residents' health proactively, including by:

- Identifying and referring health conditions appropriately
- Having knowledge of associated conditions and appropriate routes of referral to specialist help
- Understanding how psychiatric and physical illness may present differently in patients with learning disabilities
- Being knowledgeable in providing care for residents with dementia and in providing end-of-life care (65)
- Providing inclusive and culturally competent services to all residents, including those from black and minority ethnic groups, those who are LGBT, and other health inclusion groups

Implement comprehensive, multi-disciplinary case management, with trained specialists contributing to care pathways (60)

Make use of community pharmacists and specialist nurses to facilitate better management of medicines and prevention of minor ailments escalating to more serious conditions

Ensure equitable access to primary care homes, including provision of GP services and wider community and mental health services. Levels of access should be equal to those of people not living in care homes. Provision of services should be developed to reduce inequalities within and between care homes

Implement individualised, person-centred models of care, recognising that standard protocols are not always sufficient in addressing the needs of people living in care homes (60)

Focus on the wider determinants of wellbeing, including living environment, social connections, and purposeful activities

Develop multi-disciplinary teams that incorporate a range of partners from different sectors, which involve those able to support social, economic and emotional needs of residents

Build relationships and access services from voluntary sector and community organisations that can provide appropriate preventative services to all care home residents, including befriending schemes, therapeutic services, volunteering and community engagement schemes. These must be appropriate for all residents, including specially focussed support for those from excluded communities and those currently less well served by care home service provision.

Examples of new innovation in enhanced health in care homes can be found by clicking on the following named links: **[EHCH Gateshead, Airedale and Partners Case study: Connecting Care Wakefield District, Better Care for Care Home Residents – East and North Hertfordshire clinical commissioning group](#)**

[Resources related to inequities in access to healthcare services for care home residents - link to PDF](#)

2Ciii 2) New technology: health inequality risks and opportunities

There is a focus within many vanguards on expanding access and developing tools for self-management of health conditions and patient activation using technology. There are clear risks to health inequalities through expanding the use of technology, particularly for groups with limited access to technology and limited willingness or skill to use it. Many people find access to healthcare challenging and would prefer to visit GPs and other services in person. New care models must mitigate risks to access to services resulting from new technology, and provide accessible services that suit everybody. However, there are opportunities for improving access for those who are willing and able to use the technology – particularly for those who find it difficult to physically attend healthcare settings, such as those in rural areas or those with conditions preventing attendance in person.

The new care models programmes are working towards supporting people to take a more active role in their health, healthcare and support, and this requires improved levels of digital literacy.

“*There is some evidence that ‘activated patients’ (ie. those who are technology-literate) reduce demand on services. However, there is a clear risk to more disadvantaged and excluded groups who may find it harder to use tools and engage with traditional services in this way.*”

New models of care programme lead

Performance management for new care models should include ensuring that access is not made more difficult by focussing on virtual access to services, online portals and other access points that require computer literacy, access to computers and even basic literacy. The advice in the ‘implementation matrix’ which is the criteria all vanguards have been working towards, stipulates that consideration must be given to targeting digital services to patients who are in a good position to use them, and that alternatives must be offered to others. The reality of delivering this, however, is dependent on capacity, resources and funding and the effort and impact to do this has been mixed.

“*The digital divide is important – digital health is a new area and will likely bring new inequalities. This has not really been discussed. App developers aren’t aware. We need amelioration strategies – recognising who doesn’t have access and how to keep walk-in appointments.*”

New models of care programme lead

We had discussions in the vanguards about potential negative impacts on equity of access to services, arising from expanded use of technology. This was a clear concern in many vanguards.

“*The way they are driving access poses risks to inequalities. Not everyone is tech savvy; some are even frightened of the phone. The loss of personal contact for deprived patients can have a big impact. Many of them will only see one person, and it has to be that person. They won’t see the benefits of accessing the hub. It will work for a section of people but there is a group of unspoken-for people who don’t have a voice but they are unlabelled so don’t fall into any particular group.*”

Plans involve the use of technology [but] people can’t read and write. This results in loss of personal connection and good relationships. Patients like to see one GP. People find technology difficult and it’s not just the elderly, also the young. Patients ask – Why do we have to go through a central hub?”

MCP GP

Resources related to risks and opportunities to improving access through technology - [link to PDF](#).

3. CONCLUSIONS AND RECOMMENDATIONS

There are clear opportunities through the new care models programme to support development of an effective local health system with a focus on health improvement and reducing health inequalities. However, while there are opportunities, at the time of discussions with vanguards in 2017, these had not been sufficiently capitalised on and there is much greater potential throughout the new care models system to do more to reduce health inequalities. In some areas good progress has already been made, and these provide indications of how the national and local integrated care system could make greater progress. As the system moves towards sustainability and transformation partnerships and integrated care systems, the experiences of the new care models in relation to health inequalities will become highly relevant.

The sections above have described how new care models, and potentially other locally based health systems, can embed approaches to health and health inequality that allow for population wide approaches, that focus on ill health prevention and equity through action on the wider drivers of health. From the experience of vanguards, it is apparent that national and local systems need to be aligned to have a strong strategic focus on health inequalities and all available levers – strategic, system and resource levers – should be deployed to ensure an effective response to health inequalities.

RECOMMENDATIONS

In order for new models of care to develop the mechanisms outlined in the report IHE recommends the following:

Strategic levers	
Organisational culture and leadership with a clear focus on health inequalities	<ul style="list-style-type: none"> Promote equality and address health inequalities at the highest organisational level, including chief executives or equivalent posts. Embed capacity at all levels to promote and address equality and health inequalities
Equality and health inequalities (EHI) impact analysis	<ul style="list-style-type: none"> Ensure EHI analysis is an integral part of policy development and reporting Consider whether a policy or practice could be revised or delivered to advance equality and reduce inequality.
Evaluations for health inequalities	<ul style="list-style-type: none"> Include rigorous assessments of equality and inequality duties, at both local and national levels, ensuring that these cover plans, processes, outcomes and annual reporting

System levers	
Contract design and the Social Value Act (2012)	<ul style="list-style-type: none"> Build capacity locally among all stakeholders to better understand how to deliver and monitor social value. Review all tendering processes, including existing contracts, to establish if they can be redesigned to ensure social value is incorporated Define and agree social value according to local needs and assets, as well as organisational priorities, strategies and policies
Social prescribing	<ul style="list-style-type: none"> Ensure a clear definition and understanding of the meaning and processes of social prescribing that is specific to local area need, available resources and strengthens the focus on the broader determinants of health and the services that address them

Resource levers: integrating and sharing systems

Sharing, linking and integrating information	<ul style="list-style-type: none"> • Use integrated and shared data to provide social and health risk profiles that enable commissioning and outcome frameworks to incentivise reductions in health inequalities and improve equity
Collaborations for service delivery partnerships	<ul style="list-style-type: none"> • Support partnerships between health and other local services with a remit to reduce inequalities and improve equity and health outcomes • Ensure multi-sector partnerships address the drivers of unequal health outcomes • Use the knowledge and expertise within partnerships to influence procurement and tailor services to the local economies, geographies and demographics
Multi-disciplinary team	<ul style="list-style-type: none"> • Ensure multidisciplinary teams have the right mix of partners, including the voluntary sector, to support action on improving social, economic and environmental factors as well as health and social care. • Workforce staff and skills and contracts are focused around social, economic and health needs in local neighbourhoods and ensure this is reflected in the composition of neighbourhood teams.
Workforce	<ul style="list-style-type: none"> • Assess the potential for staff to work across geographical boundaries • Include voluntary sector services, that can work across geographical boundaries, as part of the workforce • Workforce seek out referrals from broader formal and informal partners, including police, fire service, housing
Equitable access to services - care homes	<ul style="list-style-type: none"> • Ensure equitable access to GP services and wider community and mental health services, equivalent to people not living in care homes. • Develop provision of services to reduce inequalities within and between care homes • Build relationships and access services from voluntary sector and community organisations that provide preventative services to all care home residents and are appropriate for all residents, including those from excluded communities and those less well served by care home service provision.
Equitable access to services - technology	<ul style="list-style-type: none"> • Mitigate any assessed impact on inequalities in access and outcomes resulting from virtual access to services, online portals and other access points that require computer literacy • Consider, and mitigate, the impact of loss of personal contacts and trusted relationships for deprived patients and their health outcomes

4. FUTURE DEVELOPMENTS

While the analysis conducted for this report has highlighted opportunities in new care models for embedding a health system approach focused on reducing inequalities, other emerging partnerships such as ICSs, which are based on collaborations within defined geographic areas, have the opportunity to develop and implement these approaches further. It is important to assess how and whether STPs and ICSs are taking forward a health system approach along the lines outlined in Section 1.

Meanwhile, further in-depth work is required to fully assess and analyse the direction and consistency of development of all new care models and integrated care systems in becoming systems focused on health equity. This report has provided initial analysis and recommendations in these areas, but the work mainly relates to vanguards.

The scale of actions needed to tackle inequalities requires greater capacity and resources across the system, including nationally. Local health systems need to be led and supported by a national health system that focuses on prevention and equity – and critically, resources and capacity building need investment to realise this. While we have set out the main levers currently available to begin the process locally, stronger national levers and more resources, that are focussed on equity, need to be in place to drive the whole system.

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