



**Report of:** Tim Ryley (Chief Executive, NHS Leeds CCG)

**Report to:** Leeds Health and Wellbeing Board

**Date:** 30<sup>th</sup> September 2020

**Subject:** Going further with integration: Working in Partnership to Tackle Health Inequalities

|  |   |  |
|--|---|--|
| Are specific geographical areas affected?<br>If relevant, name(s) of area(s):  | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No |
| Are there implications for equality and diversity and cohesion and integration?  | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No            |
| Is the decision eligible for call-In?  | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No |
| Does the report contain confidential or exempt information?<br>If relevant, access to information procedure rule number:<br>Appendix number: | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No |

## Summary of main issues

The Leeds Health and Wellbeing Strategy has a focus on reducing health inequalities and has a bold ambition that people who are the poorest improve their health the fastest. NHS Leeds CCG are committed to playing their part to deliver this ambition.

A key driver behind the Shaping Our Future process is to create the conditions to go further, faster on reducing health inequalities.

The COVID-19 pandemic of 2020 has heightened awareness of existing health inequalities and the most disadvantaged appear to have been disproportionately affected. There is currently considerable focus on addressing health inequalities within the Leeds health and care system. This presents a significant opportunity to take direct action and to work in partnership with others to ensure a greater impact.

The NHS Leeds CCG Health Inequalities Framework for Action was developed during 2019 and approved at the CCG governing body meeting on 20<sup>th</sup> May 2020.

This ambitious framework sets out four **investment principles** which set the guide for implementation. **Significant investment** will be focussed in **four key areas** in order to make an impact.

Of particular interest to the Leeds Health and Wellbeing Board are the ambitions to devolve resources to tackle health inequalities through Local Care Partnerships and to further develop mechanisms for joint investment in shared priorities around the prevention agenda.

A partnership group called the 'Tackling Health Inequalities Group' (THIG) has also recently been formed to explore where greater impact can be made by working together. Emerging themes are access, proactive personalised care and community-led approaches.

## **Recommendations**

The Health and Wellbeing Board is asked to:

- Note the direction of travel being progressed across the city on reducing health inequalities and in particular the CCG's health inequalities framework and Tackling Health Inequalities Group.

## **1. Purpose of this report**

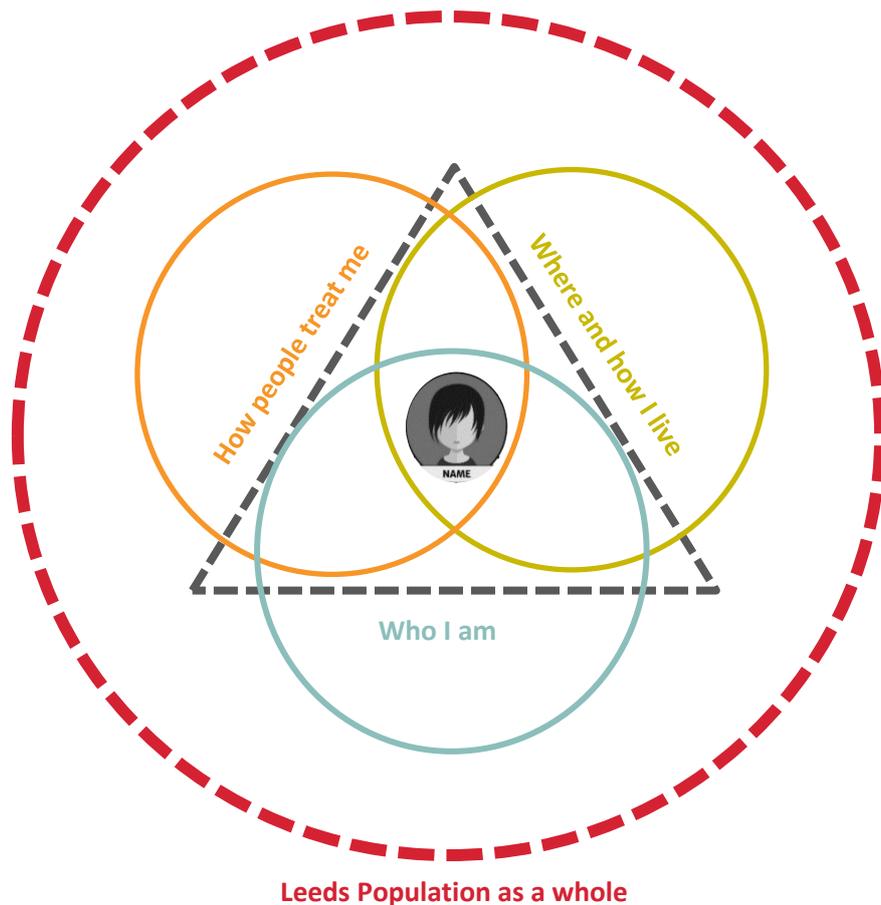
- 1.1 The purpose of this report is to set out, in the context of the Shaping Our Future (see item 10), the process for the NHS Leeds CCG Health Inequalities framework (see Appendix). It also introduces the work of the new Tackling Health Inequalities Group (THIG) and its emerging priorities.

## **2. Background information**

- 2.1 The Leeds Health and Wellbeing Strategy has a focus on reducing health inequalities and has a bold ambition that people who are the poorest improve their health the fastest. NHS Leeds CCG are committed to playing their part to deliver this ambition.
- 2.2 People in Leeds with disadvantage are at greater risk of experiencing health inequalities. The gap between the most and least affluent is widening.
- 2.3 The issues surrounding health inequalities have been exposed and brought into sharp focus during the COVID-19 pandemic, but it is not a set of problems that can be solved in the short term, the real solution will require a long term commitment.
- 2.4 Creating the conditions to go further, faster on health inequalities is a key driver behind the Shaping Our Future programme.
- 2.5 The NHS Leeds CCG Health Inequalities Framework for Action was developed during 2019 and approved at the CCG governing body meeting on 20<sup>th</sup> May 2020.
- 2.6 During the COVID-19 pandemic, there has been an increased focus on health inequalities as the most disadvantaged appeared to be disproportionately affected.
- 2.7 Partly in response to this, the THIG which includes representatives from all partner organisations was established. This group has a remit to identify and take action on areas where we can make a greater impact on health inequalities by working in partnership.

## **3. Main issues**

- 3.1 People in the Leeds population who live in the least affluent areas, who belong to vulnerable groups, who are marginalised and experience discrimination are at risk of experiencing health inequalities. These are well known issues and the diagram below illustrates how multiple factors of disadvantage can lead to a greater risk of health inequalities.



- 3.2 The way that health inequalities are demonstrated is by measuring the gap in life expectancy between the least and the most disadvantaged. In Leeds this gap is up to nine years and has widened in recent years.
- 3.3 As well as measuring life expectancy itself, healthy life expectancy is also important and is a key part of the city's approach to tackling health inequalities.
- 3.4 NHS Leeds CCG are committed to playing their part in reducing health inequalities and have recently developed and signed off an ambitious health inequalities framework describing our ambition and commitment.
- 3.5 The framework sets out the four following **investment principles**.
- a) Investment will be devolved to Local Care Partnership (LCP) level using the principle of proportionate universalism<sup>1</sup> to tackle health inequalities at a local level with local solutions.
  - b) Resources (e.g back-fill, facilitation etc) to support groups of clinicians and partners to redesign disease pathways across providers and sectors with a view to moving investment upstream.

<sup>1</sup> Proportionate universalism is the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need. Services are therefore universally available, not only for the most disadvantaged, and are able to respond to the level of presenting need.

- c) Investment for joint commissioning with Leeds City Council around key shared priorities.
- d) Funding for direct and sustainable commissioning of third sector organisations to enable bespoke focussed work with vulnerable and marginalised groups.

3.6 The CCG are seeking to implement the framework as soon as possible and this will be done in several ways:

- Rapid action will be taken during 2020/21, drawing on existing opportunities.
- A process will be developed for more systematic implementation from next year.
- Delivery of the Health Inequalities Framework will be systematised within the operating model of the CCG developed as part of Shaping Our Future.

3.7 Investment in-year has been identified to support schemes that support:

- Ongoing health and wellbeing out-reach for the homeless population
- Mental Health for BAME groups
- Support for carers of people with severe mental illness
- 3 schemes that involve resources being devolved to LCPs to take locally identified action on health inequalities.

3.8 There is a need to begin planning now for a more systematic and strategic approach in coming years with a sustained commitment to investment in the context of Shaping Our Future.

3.9 Work is underway to plan for implementation across the following four years with a budgetary commitment attached. Options being explored include the creation of dedicated budgets to deploy as below and/or require existing service commissioners to identify opportunities for shifting resources, or both.

3.10 Such budgets would be deployed in the following ways:

3.10.1 A budget to be devolved to LCPs with at least a three year commitment. Proportionate Universalism to be applied so that the seven most deprived LCPs receive a greater proportion. Actions would be developed locally against a set of criteria which would also support local leadership development and partnerships to form. They could include:

- Progression on the LCP maturity matrix
- Use of Population Health Management Techniques to identify areas of focus
- Local commissioning with third sector organisations and other partners
- Alignment with Community Committee agendas and local Asset Based Community Development schemes
- Impact on health inequalities in local area

3.10.2 There is a need to develop a more formal mechanism of agreeing joint priorities and investment with Leeds City Council to accelerate the impact and

effectiveness of actions focussed around prevention, which could include; smoking cessation; physical activity; Best Start; mental wellbeing; healthy ageing.

- 3.10.3 To work towards our investment principle to support a more sustainable third sector an element of the budget could be identified for third sector organisations with at least a four year commitment to support the sector to work with marginalised and vulnerable communities to increase inclusion and access to health services.
- 3.11 Health inequalities cannot be addressed by one organisation alone and the CCG recognises that much of the work to reduce health inequalities will be led by others in the city and is committed to working in partnership where it makes sense to do so.
- 3.12 For example, the Leeds Health and Care Partnership Executive Group (PEG) has recently established the Tackling Health Inequalities Group (THIG). This Group is formed of representatives from all major stakeholders for public health, health and care organisations in Leeds. The THIG is a functioning, citywide multi-organisational forum that ensures Leeds has a systematic approach and co-ordinated action to tackling Health Inequality issues in our city.
- 3.13 This group does not replace or replicate existing work, but seeks to make best use of it to drive collective improvement. As such, THIG members feed in from organisations, projects, board and groups, work across health and care, Third Sector and grant giving organisations, drive action in the system and work collaboratively to achieve positive change for Leeds. THIG has identified several areas of focus including access, proactive, personalised care and promoting community-led approaches. The Health and Wellbeing Board (HWB) holds strategic oversight.

#### **4. Health and Wellbeing Board governance**

##### **4.1 Consultation, engagement and hearing citizen voice**

- 4.1.1 NHS Leeds CCG recently commissioned Qa Research to carry out a piece of insight work on the principle of proportionate universalism<sup>2</sup>. The outcome of this detailed piece of work will be used to design and develop engagement messages as the principle is applied. In terms of the principle that includes devolving resources to LCPs inclusion of the citizen voice will be a key criteria for release of resources.
- 4.1.2 A communications and engagement plan is being developed taking the Qa work into account and phase one of this plan will be delivered during October 2020 to March 2021 to launch the CCG Framework.

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<sup>2</sup> Proportionate universalism is the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need. Services are therefore universally available, not only for the most disadvantaged, and are able to respond to the level of presenting need.

## **4.2 Equality and diversity / cohesion and integration**

4.2.1 Equality groups are integral to this work and people with protected characteristics are at the heart of the model that guides the identification of people who are most at risk of experiencing health inequalities.

4.2.2 Further opportunities exist by building links the Communities of Interest work which has been led by Forum Central, Health Watch, VAL and the council's Communities Team. The Communities of Interest Network was established to understand the compound nature of the social and economic inequality in Leeds directly related to COVID-19 but plans to continue to operate. The network is made up of key partners who provide specialist support to the city's diverse communities. The members of this network have a wide reach into communities of interest some of whom have not traditionally engaged with mainstream service providers and organisations. These specialist organisations have a trusted relationship with the communities of interest.

## **4.3 Resources and value for money**

4.3.1 Addressing health inequalities is a key strategic objective that guides use of resources and sits alongside value for money principles. Whether a scheme or project addresses health inequalities is a key factor in decision making on resource utilisation.

## **4.4 Legal Implications, access to information and call In**

4.4.1 There are no legal, access to information or call in implications from this report.

## **4.5 Risk management**

4.5.1 Risks relating to each piece of work highlighted is managed by relevant organisations and boards/groups as part of their risk management procedures as well as NHS Leeds CCG.

## **5. Conclusions**

5.1 The CCG Health Inequalities Framework demonstrates our commitment to taking direct action and working with others to address health inequalities in Leeds. The Shaping Our Future Process will create the conditions for us to be able to deliver on these commitments, to go further, faster and make a real impact.

5.2 In particular, the innovative investment principle which promises that we will devolve resources to LCPs to take direct action on health inequalities aligns strongly with the Health and Wellbeing Strategy's ambition to promote community-led approaches to problem solving and empower citizens to take action.

## **6. Recommendations**

The Health and Wellbeing Board is asked to:

- Note the direction of travel being progressed across the city on reducing health inequalities and in particular the CCG's health inequalities framework and Tackling Health Inequalities Group.

## **7. Background documents**

7.1 None.

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**How does this help reduce health inequalities in Leeds?**

The focus of this paper and the CCG health inequalities framework is to demonstrate commitment and action towards reducing health inequalities.

**How does this help create a high quality health and care system?**

The overarching aim of Shaping Our Future and the health inequalities framework is to create the conditions for a high quality health and care system.

**How does this help to have a financially sustainable health and care system?**

The focus of this work is not to create a sustainable health and care system however implementation of this framework will need to be done within the context of overall resources.

**Future challenges or opportunities**

- Work is in progress to identify significant resources to implement this framework.
- COVID-19 has significantly highlighted existing health inequalities and there is a risk that these may have been widened during the pandemic – we will need to monitor the emerging situation as we move forward.

| <b>Priorities of the Leeds Health and Wellbeing Strategy 2016-21</b> |   |
|--|---|
| A Child Friendly City and the best start in life                     | ✓ |
| An Age Friendly City where people age well                           | ✓ |
| Strong, engaged and well-connected communities                       | ✓ |
| Housing and the environment enable all people of Leeds to be healthy |   |
| A strong economy with quality, local jobs                            |   |
| Get more people, more physically active, more often                  |   |
| Maximise the benefits of information and technology                  |   |
| A stronger focus on prevention                                       | ✓ |
| Support self-care, with more people managing their own conditions    | ✓ |
| Promote mental and physical health equally                           |   |
| A valued, well trained and supported workforce                       |   |
| The best care, in the right place, at the right time                 | ✓ |

# Health Inequalities

## Our Framework for Action

March 2020



# Health Inequalities

## Our Framework for Action

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# 1. Introduction

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For many years, the NHS has worked with partners to tackle health inequalities. Indeed, CCGs, like PCTs before them, have a legal duty to respond to inequalities in the health of their populations, both in terms of access to services and outcomes on life expectancy. For most of the 20th Century, the life expectancy and health experience between the least healthy people in society and the healthiest has narrowed, largely due to the impact of the economy, public health initiatives and the availability of high quality care for all delivered through the NHS.

However, in more recent times this gap is widening. There is significant speculation about why this is happening, though there is evidence that the changing nature of communities, immigration, the increasing wealth of the healthiest and, most significantly, the impact of austerity have all contributed<sup>1</sup>. So the challenge to respond to health inequalities and meet our legal duty has never been greater.

But in Leeds, it is not just a legal duty that drives us. We set out in our Strategic Plan (July 2018) how we will respond to the Health and Wellbeing ambition that 'Leeds will be

a healthy and caring city for people of all ages where people who are the poorest improve their health the fastest'. This included committing to focusing resources to deliver better outcomes for people's health and well-being and to reduce health inequalities across our city.

This framework for action describes how the CCG will use its £1.3bn resource to drive the changes needed to realise this aim. As a CCG it is our duty to ensure the best possible return for the resources we are entrusted with on behalf of the people of Leeds. We define value as securing a reduction in health inequalities and delivery of the best possible outcomes, alongside procuring the highest quality services at the best possible price.

This framework also sets out how the CCG will use its position as a major statutory body to influence the wider determinants of health and our partners in ways which more positively impact on the inequalities faced by the poorest people in the city.



<sup>1</sup> [www.health.org.uk/publications/reports/the-marmot-review-10-years-on](http://www.health.org.uk/publications/reports/the-marmot-review-10-years-on)

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## 2. National context

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There is a growing sense that the NHS (commissioners and providers) needs to work with partners to address the health inequalities faced by local people. The Long Term Plan Implementation Guidance (June 2019) sets out the following -

*'Over the next five and ten years the NHS will progressively increase its focus on prevention and ensure that inequalities reduction is at the centre of all our plans.'*

... and that -

*'The Government's Prevention Green Paper (published in July 2019<sup>2</sup>) provides further opportunities for the NHS and Government to go further, faster, in prevention and inequality reduction and will feed into future iterations of system plans.'*

The Plan also describes how the NHS needs to support wider social goals through employment, work to tackle climate change and to maximise its contribution to social value as 'anchor institutions'.

As more collaborative approaches emerge across providers, with more provider-led service re-design undertaken across organisations, there will be a growing emphasis for providers to not just respond to the people who present, but to ensure that services reach out and meet the needs of all people. CCGs will need to ensure this proactive approach is strengthened, setting outcomes which result in improved health and services for the most disadvantaged communities and groups.

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## 3. Principles for our approach in Leeds

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Our shared Health and Wellbeing vision is that -

*'Leeds will be a healthy and caring city for all ages where people who are the poorest improve their health the fastest.'*

... is underpinned by the following principle which guides how we work -

*'We put people first. We work with people, instead of doing things to them or for them, maximising the assets, strengths and skills of Leeds citizens and our workforce.'*

This is essential to our approach in addressing health inequalities in the city. We will fail if we do not work with people in full, as we cannot understand their lives, their motivations, their challenges. And we will fail if we don't recognise the incredible strengths of all communities in the city, and work with people to build from these.



<sup>2</sup> [www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s/advancing-our-health-prevention-in-the-2020s-consultation-document](http://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s/advancing-our-health-prevention-in-the-2020s-consultation-document)

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## 4. What is the local picture of inequalities? Who is affected?

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In order to address health inequalities, Leeds has identified the people in the city living in the **10% most deprived areas nationally** as a priority for action. This equates to **224,000 people**, with almost 80% living in the following 7 Local Care Partnerships<sup>3</sup>:

- Harehills
- Chapeltown
- Middleton
- Burmantofts and Richmond Hill
- Beeston
- Seacroft
- Armley

There is a wealth of information about the differences in health experienced by this group of people, with some interesting points to note:

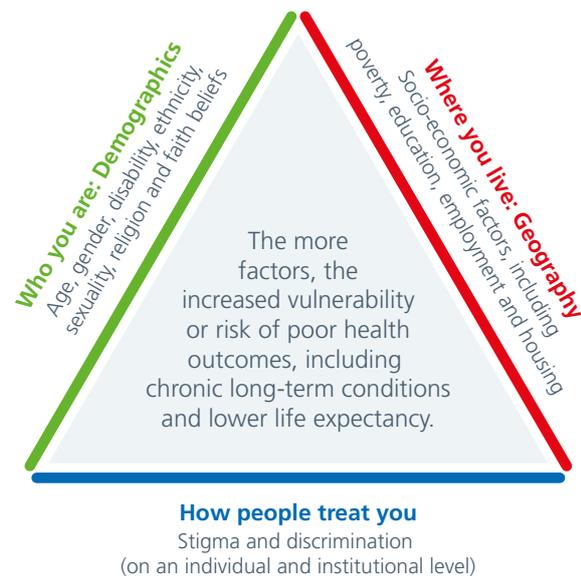
- 25% of people live in 'deprived Leeds'
- 28% of preventable life years lost are for people living in these areas.

**Cancer, CVD and respiratory** still account for the most deaths for people living in 'deprived Leeds'. In addition there are a number of particular outliers in these areas in terms of causes of avoidable death for example, **infections, maternal infant and neurological illnesses**.

In addition to geographic inequalities, we also need to consider the challenges faced by **marginalised and vulnerable groups of people** as there is significant evidence that vulnerable and marginalised groups have significantly **worse health outcomes** than the general population.

Vulnerable and marginalised populations reside in all geographical areas, deprived and more affluent, however there is increased impact for people who are also living in deprivation.

Figure 1 below describes how vulnerability combines the protected characteristics with the factors relating to where you live and how you are treated within society.



Vulnerable and marginalised populations include **people from black and minority ethnic groups, Gypsies and Travellers, the unemployed, homeless, looked after children, the homeless, people living with learning disabilities and people living with severe mental illness**.

And whilst these two categories (geographic and vulnerable groups) are useful to help to shape our work, they are not exhaustive and we cannot ignore other groups/areas of the city given that the health outcomes in Leeds as a whole are often poorer than those of England.

<sup>3</sup> Local Care Partnerships (LCPs) are the long term Leeds vision for integrated community services. Starting with Primary Care Networks, LCPs will build to include all organisations in a local area that can work with people to address health and care, and the wider determinants of health

## 5. Key Factors that lead to health inequalities

Figure 2 below frames the key factors that lead to health inequalities:  
 (Source: *Human ecology model of a settlement*, Barton and Grant, 2006)



It is estimated that only 20% of health outcomes result from clinical interventions with the remaining 80% driven by healthy lifestyle factors; wider determinants of health, such as social networks and environmental factors

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## How to tackle health inequalities

Given the above, it is clear that we need to address health inequalities at three levels -

### **A: Wider Determinants:**

Actions to improve 'the causes of the causes' such as increasing access to good work, improving skills, housing and the provision and quality of green space and other public spaces and Best Start initiatives.

### **B: Prevention:**

Actions to reduce the causes, such as improving healthy lifestyles - (stopping smoking, a healthy diet and reducing harmful alcohol use and increasing physical activity).

### **C: Access to effective Treatment, Care and Support:**

Actions to improve the provision of and access to healthcare and the types of interventions planned for all - for example ensuring health literacy is supportive; ensuring there are health inequalities impacts for all commissioned services.



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## 6. Our Framework for action

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Our overarching approach will be to facilitate key stakeholders to collaborate to improve quality, problem solve together and share collective outcomes with a view to moving care upstream and implementing innovative solutions to addressing health inequalities.

Figure 3 below describes the three elements outlined above and sets out principles for how we use our resources (people, time and money) to take action to address inequalities



For each specific element described in Figure 3 above, we will take the following actions:

### Wider Determinants

**We will work with partners** to ensure that the work of the CCG delivers a wider social impact, including on the **employment** of local people, **housing (e.g fuel poverty)**, **air pollution and transport**, all of which disproportionately affect the poorest in society.

**We will** ensure that our **estates planning** and investment optimises the health effects of the built environment, and will always look for and take opportunities to **co-ordinate resources** with partners to maximise impact.

### Prevention

**We will work with Public Health** colleagues to ensure that the **NHS maximises its contribution to prevention** through the contracts we have with providers. This will include building preventive approaches into pathways, and ensuring that NHS staff have access to prevention and wellbeing services.

**We will** support **investment in evidence based prevention** services where we know this will improve health outcomes, and will **focus this investment** in the most deprived areas of the city and with marginalised and vulnerable groups. This should include :

- Smoking cessation
- Schemes to promote increased physical activity
- Best Start programmes
- Other wellbeing schemes which address mental health
- Targeted prevention programmes which promote healthy ageing, and which support people known to be at high risk of developing long term physical and mental health conditions

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## Treatment - Service

We need to take a stronger approach to service design, access and delivery to tackle health inequalities, in particular for those conditions which people from vulnerable groups or the poorest parts of the city are dying of earlier, including cancer, CVD, respiratory disease, etc.

### For new services:

**We will** start with the question how does this **reduce health inequalities** when commissioning or redesigning services (rather than just thinking about how a new services doesn't increase health inequalities). In all cases we will consider disproportionate funding services targeted in specific areas and at specific groups where appropriate.

**We will** identify the people who currently have the poorest outcomes and ensure that their **voices are central** to how the new services are commissioned, with a **much stronger emphasis on co-production**.

**We will** increasingly work through **Local Care Partnerships (with particular emphasis on those supporting people in the most deprived areas)**, supporting a locally driven **population health management** approach to service redesign.

**We will** build in **performance measures** to all new contracts to ensure that outcomes for people currently experiencing the poorest health are improved.

### For existing services:

**We will** develop **key measures** to assess how well services are performing in the poorest areas of the city and with the most vulnerable groups

We recognise that these functions will increasingly be vested in providers; our role as a CCG will be to ensure that the right skills and approaches are transferred in order to

ensure that provision reaches out and meets the needs of all people in the community, in particular those facing disadvantage.

## Treatment - Access

**We will** ensure that services are delivered in ways which **optimises access for people from disadvantaged groups**. This included considering **geography, transport, buildings; health literacy and digital inclusion**.

In order to understand this, **we will** continuously **review access levels** to services to ensure that current arrangements do not further disadvantage people experiencing the poorest health.

## Treatment - Delivery

### Proactive Preventative Care

Key to addressing health inequalities will be the early identification of people at risk of or in the early stages of illnesses. We will continue to strengthen our Quality Improvement Scheme in General Practice so that people are identified and supported to manage their condition at the earliest possible stage, but with a greater focus on practices working in the most deprived areas. This will also include far greater focus on ensuring that people with Learning Disabilities and Mental Health issues and carers have health checks with appropriate care and support plans.

### Pathway Improvement

We will support an approach to care and disease pathway improvement (e.g. diabetes) that focusses on bringing together key clinicians and professionals across primary, community and secondary care.

There will be an emphasis on problem solving, quality improvement and developing shared objectives with a view to making a greater impact on deprived communities. This will be underpinned by a **population health management approach**.

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### Local Care Partnerships

Our key vehicle for tackling health inequalities are the Local Care Partnerships, especially those serving the most deprived areas. LCPs bring together health, social care, local community/voluntary organisations and local people to design services responsive to the local community.

There are 18 LCPs in the city, with 7 covering the majority of those communities living in the most deprived areas. And we have supported their development by investing in leadership and empowering them through the development of population health management skills. We see that they will increasingly be the footprint for the delivery of integrated services, and will take on more 'commissioning' responsibilities - that is designing and delivering services to meet improved health outcomes.

Our LCPs will now be underpinned by Primary Care Networks (PCNs), thus strengthening their ability to come together and deliver change. These new arrangements give us a great opportunity to support the redesign of services in a way which meets more local needs and so helps to address health inequalities, and we will ensure this is maximised.

### A Stronger Partnership with 3rd Sector Organisations

We will act to ensure that the strong, vibrant and diverse third sector of community and voluntary organisations continues to be at the heart of care and support services being provided in the city. This will include investment and support so that as well as being key providers of services, our third sector organisations are actively contributing to and informing the development of health and care services across the city and in local communities. This will have a particular emphasis on the role of the third sector in supporting people in the most vulnerable groups and living complex lives in areas of deprivation.



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## 7. Using our resources

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As part of our duty to secure value described in section 1 we will focus our resources to address health inequalities:

### **We will have a targeted approach, applying the principle of 'proportionate universalism'<sup>4</sup>:**

There is an existing agreed scheme to reinvest Primary Medical Services (PMS) monies in general practice in Leeds. For an agreed set of outcomes relating to health inequalities a formula has been agreed using proportionate universalism to target investment. This has been developed using the 'Car-Hill' formula (widely accepted as not adequately reflecting additional input needed for primary prevention associated with deprivation levels) and adding in ethnicity as a way to reflect deprivation. This scheme could be further developed and built upon to have more of an emphasis on deprivation and vulnerable groups. A core principle would be that actions and interventions would be decided at PCN/ LCP level, but with outcomes set that required a focus on deprivation and vulnerable groups.

### **We will focus our investment in areas that deliver greater prevention across disease pathways**

We will reprofile investment across disease pathways so that we allow the greatest opportunity for prevention. As we implement the approach outlined in this framework and our 'Left-Shift Blueprint' plan this will mean differential investment in services that aim to prevent and proactively manage disease, which will receive a greater proportion of investment in the future, and services designed to treat the consequences of disease.

Not only will this contribute to addressing health inequalities and lead to an improved quality of life for more of our people, it will also represent better use of resources for our health and care system.

### **We will have a partnership approach to prevention and wider determinants of health:**

The lead for most areas of prevention and wider determinants is held by Leeds City Council. Where the CCG and Leeds City Council agree on a set of shared priorities there could be joint investment and actions in a number of areas that directly affect health services e.g. housing, drug and alcohol, employment, poverty etc.

This could be approached using existing forums (e.g. Integrated Commissioning Executive - ICE) to agree priorities.

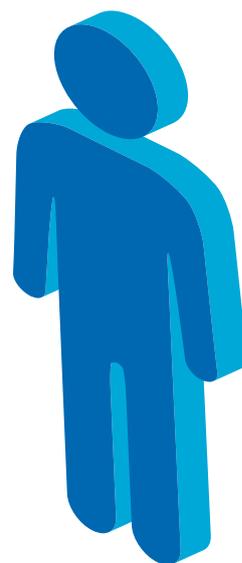
Learning can be drawn from the way that Children's work is organised in Leeds. Using a population approach means that commissioners from health and other parts of the system are able to agree and work towards joint priorities and 'obsessions' through the Children and Young People Board at which all stakeholders are represented. This population approach could be extended to the other population segment agreed as part of the population outcomes work.

<sup>4</sup> "Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a **scale and intensity** that is **proportionate** to the **level of disadvantage**. We call this **proportionate universalism**." The Marmot Review, 2010

**We will invest in third sector sustainably where there is evidence that this is an effective approach:**

We know that partnerships with the local third sector are crucial in reaching vulnerable and marginalised groups, who may be very small, hidden and will be hard to reach. We are reliant on a sustainable third sector if we want to reach these groups and address the health inequalities that they experience.

Where there is evidence that partnering with third sector organisations will have an impact on reducing health inequalities, we will strengthen our contracting arrangements ensuring that these organisations are able to sustain their vital, work with specific groups.



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## 8. What could this look like in practice?

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There are many ways that these principles could be applied in our work. Here are two examples of how this strategy could work in practice.

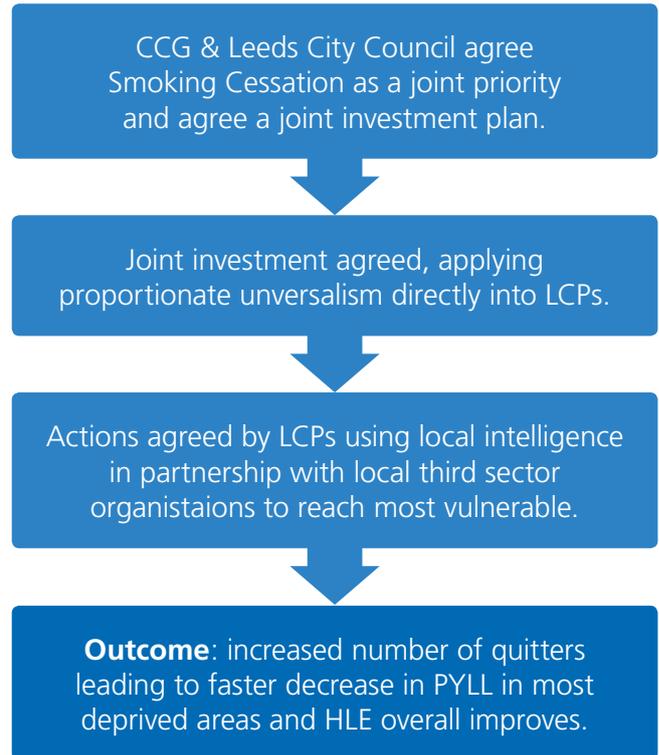
### a) Diabetes Pathway



So as a commissioner, we will ensure that our contracts promote provider responsibility for addressing health inequalities, bringing clinicians from across primary and secondary care together to design services which respond effectively to more local needs. We will also ensure that contracts engineer providers to work together across care pathways, and to bring in community/3rd sector organisations in delivery to help with addressing inequalities.

This will be reflected in how we work as a CCG going forward, with a more strategic approach to commissioning and a bigger role in supporting integration of services across providers. This is being described in the 'Shaping Our Future' programme.

### b) Smoking Cessation



So as a commissioner, we will work with Public Health colleagues to invest in additional preventive services which enable improved health outcomes for deprived and disadvantaged groups of people.

## 9. How will we measure the impact?

Our Health Inequalities outcome focus is on reducing Potential Years Life Lost for conditions amenable to healthcare (PYLL) and Healthy Life Expectancy (HLE)

Our aim is to close the PYLL gap of Leeds compared to the national average as well as increasing overall HLE. Additionally we aim to close the PYLL gap within the most deprived communities faster than the non-deprived areas.

In order to understand progress, a small number of measures which capture the impact of our actions have been developed as part of the 'Left-Shift Blueprint', the CCG's 5-year investment plan.

As part of the CCG's Strategic Plan, we committed to lead action against a number of the Health and Wellbeing Strategy indicators:

There is also a growing emphasis on healthy life expectancy - increasing the number of

years people live in good health, particularly for those from deprived communities and vulnerable groups.

However, we need to work with people to develop outcome measures which matter to them. And we would need to compare progress in the 7 LCPs with the highest number of people living in deprivation, as well as by different vulnerable groups where appropriate and possible.

The measures for this framework will align with the Health Outcomes Ambitions described in the CCG's 'Left-Shift Blueprint', our 5 year strategic commissioning and investment plan. We are working to set specific ambitions for these outcomes which will describe the impact we will make for Leeds as a whole (compared to the national average) as well as within Leeds (to narrow the gap between the 10% most deprived communities and the Leeds average).

This is our proposed measurement framework:

| Measure  | By LCP  | By vulnerable group                                       |
|--|---|---|
| Improve infant mortality and narrow the gap                                | Yes   | Yes   |
| Reduce weight in 10-11 year olds   | Yes   | Yes   |
| Reduce suicide rate  | Yes   | Yes   |
| Reduce PYLL for conditions amenable to healthcare                          | Yes   | Yes   |
| Reduce early rate of early deaths: CVD, cancer, respiratory, liver disease | Yes   | Yes   |
| Reduce mortality for those with LD and SMI                                 | Yes   | Yes   |
| Increase Healthy Life Expectancy   | Data not available at LCP level - citywide aggregate only | Data not available at LCP level - citywide aggregate only |

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The specific measures will be developed over the coming months and years, recognising that developing outcomes which matter to different groups of people will take time.

The metrics will also be built into provider contracts in order that services are continuously shaped for people who have the greatest inequalities and commissioning teams will be held to account for this as part of internal commissioning processes.

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## 10. Conclusion

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NHS Leeds CCG recognises the health inequalities in our city. We also recognise that we can have a significant role to play in addressing these, both in how we work with partners and how we use our commissioning resources.

We know that we are building on great previous work, and we know that it will take time to achieve change. However, we now want to take a more coherent and ambitious approach to tackling health inequalities in order to make a reality of the vision that 'people who are the poorest improve their health the fastest'.





**Leeds**

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