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**PARTNERS' PRIORITY PROGRAMME**

**Health Inequalities Assessment Report**

**NIHR CLAHRC NWC Health Inequalities Assessment Toolkit (HIAT) version 3**

All outline and full proposals that want support from NIHR CLAHRC NWC need to include a health inequalities assessment report. The steering board will use this report to decide whether a proposal 'fits' with our objective: to make sure that everything we do has the potential to reduce health inequalities and their causes.

In the form below, we ask you to briefly outline your response to each section of the HIAT toolkit. In particular, we would like you to specify any change you have made to your planned activity as a result of your assessment, or explain why you feel changes are not necessary.

You should use the toolkit with the members of the public involved in your activity. Please briefly outline how you have involved them or explain why you did not involve them at this stage.

**1. Name of your project evaluating the impact of Liverpool Community Care Teams**

**2. Theme of your project**

*Partners Priority Programme: Integrated care CIG B New Pathways and Services*

**3. Who was involved in the assessment (include relevant members of the public)? If you did not involve the public, please say why not.**

When the conception of the Healthy Liverpool Community Model was borne, extensive public engagement was carried out in two phases. One being a general conversation about the principles underlying the community programme and the second was in more detail regarding the community care team model, to ensure patient views have been built in

The new community model of care aims to make the most of the city's assets to deliver the best care and support to improve health and wellbeing. It involves a shift away from the emphasis on hospital care to prevention of illness, supporting self-care and providing integrated, person

centered care closer to people's homes. The new approach will address both the social and clinical issues affecting health in our communities and the role of families and carers.

Two waves of engagement activity was undertaken, the first wave during summer 2015 engaged with over 2,5000 people through community engagement events and 2,566 people undertaking paper or on line services. Community engagement partners commissioned to collect information from a wide variety of community members including people from minority groups and those with protected characteristics. During this first wave participants were informed about the community services priority and what it meant. It asked them about their support of the CCGs intention to prioritising that more care is provide within the community as opposed to hospitals. By encouraging GPs to identify those at risk of developing long term conditions and support them to stay well, manage their health conditions as well as working with community teams to help patients to remain in their own homes. 92% of survey respondents felt that this was the right thing to do to prioritise care outside of hospital.

In the second wave of engagement between January and March 2016 a total of 1,090 respondents completed online of paper based survey and 2,069 participants took part in a variety of engagement activities with ten engagement partners.

The majority of respondents who completed the GP survey were resident within Liverpool (95% of those who provided a valid postcode). Almost one half of respondents completed a survey distributed by Praxis (commissioned to promote the survey), 27% completed the survey online and 24% completed paper version.

The most common age group of respondents was between 45-64 years old (35% of respondents who provided an age. The majority of respondents were white British (72%) and 9% were black African.

Sixty two per cent of respondents were female and only 8 (1%) of respondents stated their current gender was not the same as the identity assigned at birth. The majority of respondents (92%) stated they were heterosexual with a minority stating they were gay or lesbian (n=20; 2%) or bisexual (n=12; Almost two thirds of respondents reported having a religion or belief (63%) with the most common religions being Christianity (76%) and Islam (14%).

Over two thirds of survey respondents (70%) stated that they did not have a disability. Respondents were asked to tick which disabilities they had, the most common were physical disability (n=149) and long-term illness that affects their daily activity (n=127)

Respondents were also asked if they fell into a number of life circumstances; 378 respondents were working full time, 299 were parents, 297 had a long term condition and 253 were aged over 65.

Engagement activities revealed that people generally had good awareness of the wider issues which affect health and wellbeing and the social determinants of health. For example, those

who participated in the Life Circumstances discussion suggested lifestyle, stress and social connections as very important influences on health. Those who completed the Life Circumstances survey indicated that physical activity, group activities and hobbies, affordable/healthy eating and finance and debt advice were all important types of support that could help people stay healthy.

Almost all (93%) of Life Circumstances survey respondents felt it would be helpful or very helpful for the GP to refer them for wider support, particularly to help address some of the wider issues that affect health such as lifestyle (diet and exercise), poverty financial issues, social exclusion and loneliness and housing. It was also suggested that it would reduce mental and psychological ill-health, reduce the reliance on medication and save the NHS money. Discussion groups agreed and felt this was particularly important for people who would not actively seek out support. Some felt this would depend on the relationship they had with their GP

For most participants the GP is still the face of the NHS and the service people use most often and will choose first in most circumstances.

Some respondents in discussion groups admitted they had resorted to A&E or hospital because it was easier than waiting for a GP appointment.

Although people were receptive to receiving care in the community, almost all respondents felt it was important specialist medical teams collaborate and connect to other services that can support them.

Discussion groups raised concerns regarding the effectiveness and organisation of this system, particularly in terms of ensuring continuity of care.

People felt that if they were supported within a community venue, 'communication and coordination between the different specialists' was vital, followed by 'specialists supporting GPs and their community care teams to understand their needs better'.

It was recommended from this engagement work that Pilot schemes for GPs to refer patients for additional support for the wider issues that can influence health such as debt, social support, diet, exercise, loneliness/isolation, housing etc. and also that People with long term conditions need further support for their mental health and the wider social impacts of their conditions.

(Full engagement report and summaries are available for reference)

At this stage it has not been necessary/appropriate to include patient advisors in the development of the outcomes framework as we have been led by providers. However, in the longer term our intention is to engage with residents in the development of evaluation measures for patient experience of Community Care Teams. The Liverpool CCG engagement team are supporting the process of engagement and co-production of patient experience evaluation measures. The Health Inequalities Assessment of this proposal was conducted by the evaluation project team.

**4. Please summarize the results of your assessment under the section headings. For each stage, highlight the changes to your activity as a result of the assessment. If you did not make any changes, please give your reasons why.**

<p>What are the health inequalities that influence (d) or create (d) the problem being addressed by your project?</p>	<p>Evidence from the Centre For Health Economics clearly highlights how inequalities impact health outcomes and use of hospital services. Nearly half of emergency admissions arise from social inequality. Social inequality is associated with more than 158,000 preventable emergence hospitalisations in England and nearly 38,000 deaths from treatable conditions across England.</p> <p>People living in the most deprived fifth of neighbourhoods in England suffer nearly two and half times as many preventable emergency hospitalisations, compared to the least deprived neighbourhoods*.</p> <p>The reasons for this difference in admissions could be attributed to a range of factors. For example evidence has shown there is a higher prevalence of long term and ambulatory care sensitive conditions in more deprived areas. † There is also evidence of the</p>
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\* Centre For Health Economics Policy and Research Briefing January 2016 Health Inequality and the A and E crisis

† Tian, Y. Dixon, A. Gao, H. Fund (2012). Emergency hospital admissions for ambulatory care-sensitive conditions: identifying the potential for reductions. [online] Available at [https://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/data-briefing-emergency-hospital-admissions-for-ambulatory-care-sensitive-conditions-apr-2012.pdf](https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/data-briefing-emergency-hospital-admissions-for-ambulatory-care-sensitive-conditions-apr-2012.pdf) [Accessed 27th October]

	<p>higher prevalence of unhealthy lifestyle behaviours such as smoking and low fruit and vegetable consumption in more deprived populations<sup>‡</sup>.</p> <p>Marmot has also presented evidence on the impact of social determinants on health. Poorer people are more likely to live in more deprived neighbourhoods which are more likely to have social and environmental characteristics that can be a risk to health such as poor housing, higher rates of crime, poorer air quality, a lack of green spaces and places that are safe to engage in physical activity. Marmot concluded that social determinants have persistent and complex relationships and multiple disadvantages compound to produce significantly worse physical and mental health and wellbeing<sup>§</sup>.</p>
<p>How will your proposed work tackle the socio-economic causes of the inequalities in health you have identified as relevant?</p>	<p>The aim of Community Care Teams is to provide person centred care planning and support for patients (proactively and reactively) to ensure that services work together where possible to improve health and wellbeing, improved independence and minimise unnecessary hospital admissions.</p> <p>The purpose of the evaluation of the CCTs across Liverpool is to assess whether the interventions that they provide successfully impact on the outcomes measures. It is also to ensure that the CCG and Care Providers direct the right amount of resource at those who need it the most, therefore impacting on health inequality across Liverpool by improve access for resources to those most in need.</p> <p>The evaluation framework reflects the need to collect outcomes across the city, but also at a neighbourhood level to identify the</p>

<sup>‡</sup> Lakshman R, Mcconville A, How S (2011) 'Association between area-level socioeconomic deprivation and a cluster of behavioural risk factors; Cross-sectional, population based study. Journal of Public Health vol33 (2) pp234-45

<sup>§</sup> Fair society healthy lives. The Marmot Review Strategic review of health inequalities in England post 2010

	<p>impact of this work in areas with varying socio-economic needs. The outcomes data will be disaggregated by indicators of disadvantage whenever possible to show if inequalities have widened or improved and who will have benefited most from proactive care.</p> <p>The routine data that is collected during a proactive care visit Community Care Team members use the Generic Assessment Tool and Evaluation (GATE) form, as a way to identify client needs and to collect information relevant to all services once. The GATE will be used by neighbourhood Community Care Teams to identify any patient needs that could be supported by local community services that support poor physical and mental health amongst people living in disadvantaged neighbourhoods.</p> <p>The information collated through the GATE will provide a detailed picture of the comorbidities and needs within each neighbourhood as well as the use of health and social care services. Ultimately, evaluation findings will be used to shape and improve the delivery of future services and to target provider resources based on neighbourhood need.</p>
<p>How will you make sure that your evaluation and monitoring shows the effect of your activity on health inequalities and their causes?</p>	<p>As a minimum the outcomes data will be disaggregated by indicators of disadvantage whenever possible to neighbourhood level</p> <p>When the full project goes live baseline data will be collated to ascertain if there has been a change in hospital based activity (A&amp;E attendances, hospital admissions) activity from a socio economic view, including GIS maps displaying the current 50-90% risk. More importantly, a snapshot will be taken at 6 and 12 months to understand if there has been any change in risk score by IMD and causality. The team will review findings from the snapshots to assess if it is feasible to improve any aspect of the intervention.</p> <p>Additionally participants and the number of people who declined proactive care will be monitored by GP Practice/Neighbourhood to understand if there is an unmet need. Conversely, if resources allow, qualitative research may be used to follow up those who have declined to find out their perceptions about need, barriers to receive services and utilization of health services</p>

What wider effect  
might your activity  
have on health  
inequalities and their  
causes and how can  
this be delivered?

The work has potential to increase understanding of socioeconomic inequalities in health within neighbourhood community care teams, local provider organisations and partner organisations.

It also has the potential to make a case for action to address the social determinants of health within specific neighbourhoods and to advocate for changes in service provision based on this evidence.

However this initiative has the potential to 'widen inequalities' if not monitored effectively in terms of workforce resource allocation and the number of declines for proactive care by neighbourhood.