**Health inequalities – service action planning tool**

1. **How can you identify health inequalities relating to your service or area of work?**

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| 1. **What sources can you access?** | * [**https://www.nationalwoundcarestrategy.net/wp-content/uploads/2021/11/20200909\_NWCSP-HIA\_final.pdf**](https://www.nationalwoundcarestrategy.net/wp-content/uploads/2021/11/20200909_NWCSP-HIA_final.pdf) * Podiatry homeless service data * Self-care audit |
| 1. **What other information could be requested or captured?** | * Understanding ~2% of referrals who do not attend initial assessment * Visibility of any drivers of inequality in concordance and outcomes (e.g. healing rates) * Insights from SMSR surveys and other feedback from substance misuse population * Data on distribution of demand and outcome variation by locality * Data on lymphoedema + inequality |
| 1. **Where and when can you review and discuss the information?** | * Monthly pathway group |

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| Examples of sources to consider |
| * External data and analysis (national and local) * PHE health profiles * RightCare * Condition/service specific tools, frameworks and benchmarking reports * Joint Strategic Needs Assessment * PCN PHM profiles * Breakdowns of service activity/KPI/experience/4Cs data (by geography, protected characteristic, other groups) * Qualitative feedback from relevant communities * Data on service users access and communication needs * Surveys, focus groups, consultation with community groups (direct or through partners) * Data on service users social economic and environmental conditions * Coded holistic assessment * Via tools e.g. Outcome Star * MECC referrals * Partner data * Practitioner/ colleague insights |

1. **Which inequalities are of most concern**

What do we know about differences in access and outcomes for your service or area of work, and about what causes or contributes to this?

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|  |  | | **a. According to the evidence you have in your service, which populations face the biggest inequalities?** | | | **b. What does the evidence say about possible drivers or contributing factors?** |
|  |  | | Face greatest inequalities in access or outcomes (✓) | Not sure - needs investigation (✓) | Any specific sub-group, locality or outcomes affected? |
| **Protected characteristics** | | Age | **✓** |  | Concordance/healing rates? | * Research suggests that **older patients with multiple conditions** are at an increased risk of impaired cognitive function, and subsequently may be **less likely to successfully adopt a self-management approach** |
| Sex |  |  |  |  |
| Race | **✓** |  |  | * Skin tone + pressure ulcers (carers information to identify early intervention)- work at national level – changing education packages |
| Religion or belief |  |  |  |  |
| Disability | **✓** |  |  | * Mobility and access to clinic (housebound provision slight delay) |
| Sexual orientation |  |  |  |  |
| Gender reassignment |  |  |  |  |
| Pregnancy and maternity |  |  |  |  |
| Marriage and civil partnership |  |  |  |  |
| **Socio-economic** | | **People impacted by individual socio-economic factors**  **e.g.**   * Income * Employment * Education status * Other | **✓** |  |  | * Patients’ **engagement with self-management** are thought to be influenced by their capacity, responsibility, and motivation, with all three factors adversely impacted by socioeconomic deprivation, compounded by mental health aspect. * **Health literacy** to understand and adopt lifestyle changes to ease symptoms of underlying conditions to help prevent recurrence – diet etc. * Some patient cohorts may **struggle to access a clinical setting on a frequent basis**, due to issues such as complex comorbidities, transport, cost, or mobility. Patients who are socio-economically disadvantaged are more likely to have chronic conditions. * Variation in **formal and informal support at home** that contributes to outcomes (e.g. social networks, informal care, use of attendance allowance) or support to access clinics |
| **Geographic** | | **People living in certain geographies**  e.g.   * Areas of higher deprivation * Coastal or rural communities * Areas with fewer amenities or transport links | **✓** | **✓** | East Riding  Rate of access to clinics | * Some patient cohorts may struggle to **access a clinical setting** on a frequent basis, due to issues such as transport. There is evidence of this in differential rates of clinic attendance in Hull and east Riding. * **Risk factors** behind such conditions include age, smoking, lack of physical activity, stress, and unhealthy eating habits (Anderson, 2008; Ashrani et al., 2009; NHS, 2017) – higher prevalence in some areas. * Lack of in area **Lymphoedema service provision** in east Riding appears to be linked to more patients presenting to lower leg pathway with secondary problems |
| **Vulnerable + health inclusion groups** | | People experiencing homelessness |  |  |  |  |
| People experiencing substance dependence | **✓** |  | Substance misuse population, assessment DNA rates |  |
| Vulnerable migrants |  |  |  |  |
| Gypsy, Roma and Traveller communities |  |  |  |  |
| Sex workers |  |  |  |  |
| People in justice system | **✓** |  | Prison population |  |
| Victims of modern slavery |  |  |  |  |
| People with serious mental illness | **✓** |  |  |  |
| Other |  |  |  |  |

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| Examples of drivers or contributing factors to consider |
| * Social economic and environmental conditions e.g. housing quality, community life, discrimination * Mental wellbeing and exposure to stressors and adversities (or protective factors) * Behavioural risks e.g. smoking * Service take-up, availability, ease of access and information (and access to non-health services) * Differences in quality or experience of care e.g. feeling involved, satisfaction |

1. **Action plan**

What specific actions can you take to affect these inequalities?

|  | **Identified inequality** | **Actions to understand, address and monitor this inequality** | **Lead** | **Timing** | **Next steps** |
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| 1 | Outcomes for substance misuse population linked with engagement with initial assessment and concordance with treatment | **In place:**   * Design pathway with ReNew | **-** | **-** | **-** |
| Test pathway with Renew/CGL Lived Experience community |  |  |  |
| Capture learning from podiatry homeless pathway |  |  |  |
| Implement new pathway with Renew including Shared Care route and co-location | Kerry C |  |  |
| Multi-agency working and Shared Care with Renew | Kerry C |  |  |
| Test drop-in clinics for those who struggle to manage appointments (including homeless, mental health) |  |  |  |
| Increase flexibility of service in other ways? |  |  |  |
| Identify strategies for activation of patients with capacity but reluctance to engage |  |  |  |
| 2 | Geographic variation in access to clinics | **In place:**   * Streamlined and simplified pathway, reduces variation in treatment delay between Places/Localities * Changes to pathways for referral to vascular services, podiatry, and dermatology provide a clearer route and encourage earlier patient referral to such services * Options for home visits (same treatment guidelines) and variety of clinic locations | **-** | **-** | - |
| Review demand, access, and outcomes by area |  |  | Caseload, staffing review |
| Test extended hours (enabling family/carer attendance) |  | Q3 2022/23 (Oct) |  |
| Work with CCG/ YAS to improve social care transport provision e.g. increasing volunteers and their flexibility |  |  | Identify who could coordinate this centrally |
| 3 | Suitability of health and service information for patients with lower literacy or other languages | Gather SMSR feedback |  |  | Complete |
| Identify and adopt materials produced by national strategy group/ patient engagement network |  |  | Meeting 13/7 |
| Scope content and format for any additional or locally-tailored information for patients with lower levels of health literacies, disabilities, or first languages |  |  | Brief accessible information officer |
| User testing/ participation in development of any local materials |  |  |  |
| 4 | Capability and personal support needed to benefit from self-care models   * Older isolated patients * Adverse impacts of socioeconomic deprivation and mental health | **In place:**   * Time taken to support patient activation and information – noted in patient feedback * Motivational interviewing training for B6 delivering new model | - | - | - |
| Perform self-care audit to understand barriers/ why it fails and enablers |  | Q2 2022/23 | Propose for next audit round |
| To be defined following audit – may address social/personal support, health literary/education and empowerment |  |  |  |
| Compile existing self-care resources and identify any patient education gaps |  |  |  |
| Access to weight management and ICC? |  |  |  |
| Inclusive approach to Leg Club Model Leg club model (volunteer-led) to be developed - a social care model of wound care provision may help reduce feelings of social isolation and negative mood through interaction with other local individuals with lower limb wounds (White, 2016) | Industry partners | 2023 |  |
| 5 | Higher rates of complication/leaking legs in east Riding linked to lack of access to lymphoedema care | Capture and present data to make the case for preventive provision – initially for garment costs |  |  | CCG meeting 14/7  Escalate/ PMO support for business case |
|  | Project management | Incorporate workstreams to service development plan |  |  |  |

| Examples of action areas to consider | | | | |
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| Learning, analysis and planning | Improving access and experience of care | Addressing social factors in outcomes from care | Long term actions e.g. acting on causes/ preventing ill health | Coordinating, monitoring and reviewing progress |
| * Capture feedback and design solutions with communities * Identify partners e.g. community organisations * Perform audit * Request data analysis | * Delivery location and hours * Accessible information and communication (inc digital) * Ease of navigation including tailored pathways, direct or walk-in access * Who provides care and how are they trained or informed * Proportionate availability / resourcing of services * Proactive outreach/ case finding * Maximising individual choice and control | * Personalised care [[1]](#footnote-1)– especially for those most excluded * Facilitate access to resources to address stressors and healthy behaviours * Increase availability of services/resources * Increase provision/ availability of community-centred interventions | * Targeted prevention activity e.g. awareness raising * Sharing knowledge, skills and resources in the community (e.g. offering training, volunteering, space) * Promoting preventive interventions to CHCP colleagues and system partners * Advocating for relevant investment in prevention * Maximising local economic and social wellbeing through employment, workforce development, estates, procurement choices | * Setting up a dedicated inequalities working group or steering group * Incorporating actions to existing service improvement plans and team meetings * Keeping relevant groups, committees or stakeholders informed about the plans and their progress * Setting up an evaluation of the outcomes/impact * Setting up ongoing reporting on outcomes/ key metrics (e.g. as part of existing operational reports) |

1. **How can you monitor and evaluate the effect of action taken?**

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|  | **Health inequality identified** | **What measures or indicators can you use?**  Can be qualitative or quantitative | **Data collection (how? how often?)** | **Reporting + review of metrics (where? how often?)** |
| **1** | Outcomes for substance misuse population | Rate of assessment attendance (SU population) – before/after | Manual tracking | Pathway group monthly? |
| Rate of concordance (SU population) – reduced differential with wider caseload | Capture SU on record? |  |
| **2** | Geographic variation in access to clinics |  |  |  |
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| **3** | Health and service information | Patient feedback? | Survey/interview? |  |
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| **4** | Benefit from self-care models | Frequency/themes in barriers to self-care | Self-care audit (pre-post) |  |
| Variation in healing rates/ other outcomes by IMD/age/mental health status |  |  |
| Attendance at Leg Club by IMD vs profile for overall service |  |  |
| **5** | Lymphoedema inequity | Variance in rate of presentation with complications E Riding v Hull |  | Report to pathway group |
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1. **What do you need from others to implement the plan?**

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|  | **Required support or changes** |
| **Data, analysis or reporting** | * TBC once assessed what measures can be captured manually |
| **Specialist advice or support** | * Accessible Information Officer **–** gap analysis and plan for local patient information |
| **Changes to contract obligations, resources or KPIs** |  |
| **Awareness or change in the local health system or other public services** | * PMO support to make inequalities case for Lymphoedema provision or escalation of issue, potentially via ICS |
| **Links with existing services** | * Anticipated need for venues and local volunteer groups to support leg club model |
| **New or expanded resources in the community** | * Engagement to expand YAS patient transport |
| **Other** |  |

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| Examples of support |
| * Data, analysis or reporting * Specialist project support e.g. accessible communication, community engagement * Service contractual changes e.g. updates to KPIs * Awareness or change in the local health system or other public services e.g. changes to how services work together or how resources are distributed across the system * Links with existing services e.g. CHCP services, social prescribing, community organisations * New or expanded resources in the community e.g. digital social prescribing, health coaching, volunteer/peer-based programmes, transport solutions |

1. E.g. Gathering information about the whole person, Planning and coordinating with colleagues and multi-agency partners, Team members are empowered to respond to ‘what matters’ to people, Participate in or instigate collaborations with other neighbourhood partners [↑](#footnote-ref-1)