System Health Inequalities Framework

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Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	X
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	
Noting	For noting without the need for discussion	

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
CMG Board (specify which CMG)		
Executive Board		
Trust Board Committee		
Trust Board		

Executive Summary

"Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies." (NHS England).

In September 2020 the Board considered a paper "Understanding Health Inequalities", (Wightman 3/9/2020), which concluded:

'Bevan's original vision for the NHS that it would meet the needs of everyone, be free at the point of delivery and be based on clinical need, not ability to pay has stood the test of time. However, it does not follow that because the NHS is freely available to all that 'all' have equal access or indeed outcomes. Access in itself is determined by amongst other things, a person's sense of right and entitlement and if that sense is diminished as a result of socioeconomic factors and lived experience then access cannot be equitable. Recognising this and seeking to understand where inequalities exist in a planned and systematic way has to inform the planning of our services and the wider health system. That work starts now'.

In recent months a coalition of senior LLR NHS leaders, Local Authority colleagues, Public Health experts, and representatives from Health Watch have met to draft an LLR system Health Inequalities Framework. The framework is intended as a clear call to action by the system.

It sets out key principles to inform our approach to this work and a series of high-level facilitative actions at system level that the partners are committed to delivering. The framework confirms that it will be for the "Places" in LLR to undertake their needs assessments, and co-produce with local people, the local priorities and action plans to reduce the impact of health inequality. This draft framework is presented here for discussion about how the principles and actions laid out in the framework could inform the work of this board to reduce inequity in access to and outcomes from our services.

Questions

1. Does the Board support the approach outlined in the Framework?

Conclusion

The Framework sets out a manifesto for how all partners in Leicester, Leicestershire and Rutland, (LLR) have a role to play in tackling inequity and describes short, medium and longer term actions that will ultimately improve healthy life expectancy for all our citizens. This is not a 1 or 2 year program, genuine 'levelling up' will take time, effort and consistent focus. It is significant that at the same time that our LLR system was finalising this framework NHSE/I published their '2021/22 Priorities and Operational Planning Guidance' and within that guidance was the following:

"Systems are required to demonstrate that plans for elective recovery will:

• Use waiting list data (pre and during pandemic), including for clinically prioritised cohorts, to identify disparities in relation to the bottom 20% by Index of Multiple Deprivation (IMD) and black and minority ethnic populations

• Prioritise service delivery by taking account of the bottom 20% by IMD and black and minority ethnic populations for patients on the waiting list and not on the waiting list, including through proactive case finding

• Use system performance frameworks to measure access, experience and outcomes for black and minority ethnic populations and those in the bottom 20% of IMD scores

• Evaluate the impact of elective recovery plans on addressing pre-pandemic and pandemic-related disparities in waiting lists, including for clinically prioritised cohorts

• Demonstrate how the ICS's SRO for health inequalities will work with the Board and partner organisations to use local population data to identify the needs of communities experiencing inequalities in access, experience and outcomes and ensure that performance reporting allows monitoring of progress in addressing these inequalities".

The significance of the approach set out above should not be underestimated and both the system response and the UHL specific response will be the subject of a future Board discussion.

For Reference:
This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures	Not applicable
Improved Cancer pathways	Yes
Streamlined emergency care	Not applicable
Better care pathways	Yes
Ward accreditation	Not applicable

2. Supporting priorities:

People strategy implementation	Yes
Investment in sustainable Estate and reconfiguration	Not applicable
e-Hospital	Not applicable
Embedded research, training and education	Yes
Embed innovation in recovery and renewal	Yes
Sustainable finances	Not applicable

Equality Impact Assessment and Patient and Public Involvement considerations:

- What was the outcome of your Equality Impact Assessment (EIA)? The EIA is in the course of being completed while this document is in draft form.
- **Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required**. Engagement with patients and the public on the priorities and plans for reducing health Inequalities will be undertaken by Health and Care partnerships and Health and Wellbeing Boards at place level in due course as these bodies are closest to the local communities and best placed to undertake this engagement

- **How did the outcome of the EIA influence your Patient and Public Involvement?** N/A
- If an EIA was not carried out, what was the rationale for this decision? An EIA on the LLR Health Inequalities Framework is underway to help inform the final version.

3. Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	**Select (X)**	**Risk Description:**
Strategic: Does this link to a ***Principal Risk*** on the BAF?		
Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register		
New Risk identified in paper: What ***type*** and ***description***?		
None		

4. Scheduled date for the **next paper** on this topic: [date] or [TBC]

5. Executive Summaries should not exceed **5 sides** [My paper does/does not comply]

LEICESTER, LEICESTERSHIRE AND RUTLAND SYSTEM HEALTH INEQUALITIES FRAMEWORK

Version: Draft 10.3
Date: April 2021

Date	Version	Status	Author	Notes
December 2020	Initial	Early Draft	Mark Pierce and Steve McCue	For consideration: Reducing health inequalities across LLR – Task & Finish Group on 11/12/20 LLR Population Health Management Advisory Group on 15/12/20
January 2021	Version 5	Draft	Mark Pierce and Steve McCue	For consideration: Reducing health inequalities across LLR – Task & Finish Group on 07/01/21 LLR CCGs Governing Body meetings in common (confidential) on 12/01/21 Clinical Executive on 14/01/21 LLR NHS System Executive on 19/01/21
February 2021	Version 7	Draft	Mark Pierce Steve McCue, Viv Robbins, Jo Atkinson, Aloma Onyemah and Lucy Wilson	For consideration: Reducing health inequalities across LLR – Task & Finish Group on 04/02/21
February 2021	Version 9	Draft	Mark Pierce Steve McCue, Viv Robbins, Jo Atkinson, Aloma Onyemah and Lucy Wilson	For consideration: Reducing health inequalities across LLR – Task & Finish Group on 18/02/21
March 2021	Version 10.1	Draft	Mark Pierce Steve McCue, Viv Robbins, Jo Atkinson, Aloma Onyemah and Lucy Wilson	For consideration: Reducing health inequalities across LLR – Task & Finish Group on 04/03/21 LLR CCGs Governing Body meetings in common (confidential) on 09/03/21 LLR Alliance Leadership Group 23.03.21 Leicester City and Leicestershire County Health & Wellbeing Boards 25.03.21 LLR Clinical Executive 08.04.21
April 2021	10.2	Draft	Steve McCue, Mark Pierce	Additions following feedback from various forums across LLR

Leicester, Leicestershire and Rutland (LLR) System Health Inequalities Framework

Contents

1. Purpose 1
2. Introduction 2
3. What are health inequalities? 2
4. Inequalities vs equity 3
5. What is health? 4
6. How I can find out more about health inequalities in LLR? 6
7. Principles 7
8. System actions 11
8.1. Introduction 11
8.2. Strategic System Actions 12
9. References 15

Foreword to be included by ICS Chair – Sarah to arrange

1. Purpose

The aim of the Leicester, Leicestershire, and Rutland (LLR) Health Inequalities Framework is to improve healthy life expectancy across LLR, by reducing health inequalities across the system. The purpose of this Framework is therefore to:

1.1. Provide a system mandate for action to address health inequalities across LLR
1.2. Establish a collective understanding of the terms ‘Inequality’, ‘Inequity’ and ‘Prevention’ in relation to population health, across all parts of the LLR Integrated Care System (ICS)
1.3. Strengthen a whole system collaborative approach to reduce (and remove entirely where possible) avoidable unfairness in people’s health and wellbeing in LLR
1.4. Establish the high-level principles of how LLR ICS partners will approach the work of reducing health inequity at system level
1.5. Recognise the framework will be implemented and agreed at system level, with much operational, political and community action taking place at ‘place’ and ‘neighbourhood’ level[1] . It is the systems’ minimum ask of Place in relation to reducing health inequalities.
1.6. Set out some key actions that can be delivered at system level with support through the ICS, with recognition that some actions will be primarily for individual organisations e.g. the NHS or the Local Authority however many requiring partners to work together.

[1] LLR is divided into three “Places”; Leicester City, Leicestershire County and Rutland County, all of which align to upper tier local authority boundaries. Within each ‘Place’ smaller geographic areas known as ‘Neighbourhoods’ (also known by other terms such as ‘districts’ or ‘communities’) are used.

2. Introduction

2.1. Health and wellbeing is not just the concern of the NHS. The health and wellbeing of people is an asset to individuals, to communities, and to wider society. Good mental and physical health is a basic precondition for people to take an active role in family, community and work life. Although there is growing concern about stalling life expectancy, the existing wide inequalities in health outcomes tend to be overlooked. Improving healthy life expectancy enables people to live in better health for longer. Ensuring they can contribute to society. A workforce that remains fit, healthy and working for longer can contribute to a productive economy and decrease the costs of supporting an ageing society. However, health inequalities undermine these benefits.

2.2. Health inequalities can be found along a social gradient, with those living in the most deprived areas having the worst outcomes. Inequalities can be found even within areas that might be regarded as affluent. Therefore, using a 'levelling up' approach will have an impact on the majority of the population. Evidence shows that having a more equitable society benefits the whole population, not just those living in the most deprived areas or currently experiencing the worst outcomes. [1] [2] [3] [4]

3. What are health inequalities?

"*Health inequalities are the* ***preventable, unfair and unjust differences*** *in health status between groups, populations or individuals that* ***arise from the unequal distribution of social, environmental and economic*** *conditions within societies*" (NHS England) [5]

3.1. Those living in the most disadvantaged areas often have poorer health outcomes, as do some ethnic minority groups and vulnerable/socially excluded people. These inequalities are due to a combination of factors including income, education and the general conditions in which people are living. In addition, the most disadvantaged are not only more likely to get ill, but less likely to access services when they are ill. This is known as the inverse care law.

3.2. Health inequalities have been further exposed by the Covid-19 pandemic, which has taken a disproportionate toll on groups already facing the worst health outcomes. The mortality rate from the virus in the most deprived areas has been more than double that of the least deprived. In addition, some ethnic minority communities and people with disabilities have seen significantly higher Covid-19 mortality rates than the rest of the population. The economic and social consequences of measures to contain the virus have worsened these inequalities further, with people in crowded housing, on low wage, unstable and frontline work experiencing a greater burden and transmission of the virus.

3.3. There are always going to be differences in health, some are unavoidable e.g. as result of age or genetics but many differences in health are avoidable, unjust and unfair – it is these that we are concerned about and that this framework seeks to address. [2] [6] [7]

4. Inequalities vs equity

4.1. "Health inequalities" is the commonly used term, however we are actually referring to **health equity and inequities.** Therefore, the terms are used interchangeably within this document and in the LLR system.

4.2. **Equality** means treating everyone the same/providing everyone with the same resource, whereas **Equity** means providing services relative to need. This will mean some *warranted* variation in services for different groups (see Figure 1).

4.3. It is important to note the difference in terminology between this work and those stated in the Equality Act 2010, although the terms relate to the same concept of equity. The Equality Act defines specific protected characteristics that require explicit consideration in any decision-making process, but this framework recognises the importance of identifying vulnerable groups that are not well reflected within these definitions (such as homeless people or those with caring responsibilities).

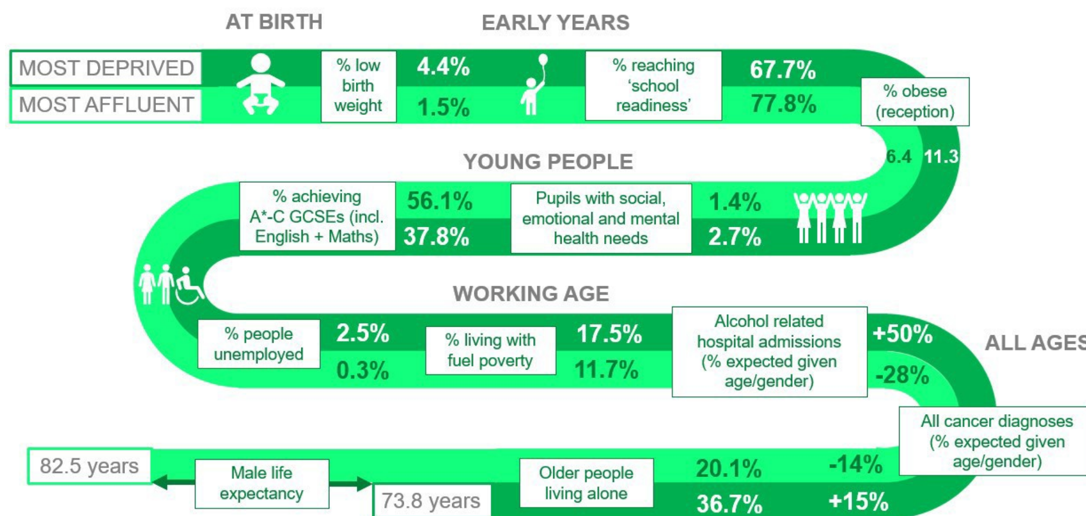
Figure 1: Representation of equality and equity using adapted bicycle example

Source: Reproduced with authorisation from Robert Wood Johnson Foundation (Better Bike Share, 2017)

This illustration above shows, on the top line, four people of different sizes all trying to cycle the same size of bicycle. One person in a wheelchair cannot use the bicycle at all. The second line shows each person happily using a bicycle correctly sized or adapted for their needs.

A tale of two babies illustrates our story of inequalities in LLR (see Figure 2). It is vital to recognise that no outcome is set in stone. However, the story aims to illustrate the potential variation in the opportunities and difficulties two babies might encounter throughout their life based on the circumstances into which they are born.

It highlights a demonstrable bias in the way our current systems are set up to benefit, to a greater extent, those in more affluent circumstances. With determination and collaborative effort, we can reduce this injustice. *Figure 2: Difference in health indicators between the most and least deprived local areas of LLR, over the life course*



Source: PHE Fingertips [8]
Notes: Most deprived area data reflects inner City areas such as Braunston Park and Rowley Fields. Most affluent area data reflects areas such as Market Harborough-Logan and Market Harborough-Welland However there will be further hidden inequalities within each place for example within Rutland the most deprived ward is Greetham. Where small area data is not available local authority-level has been used.

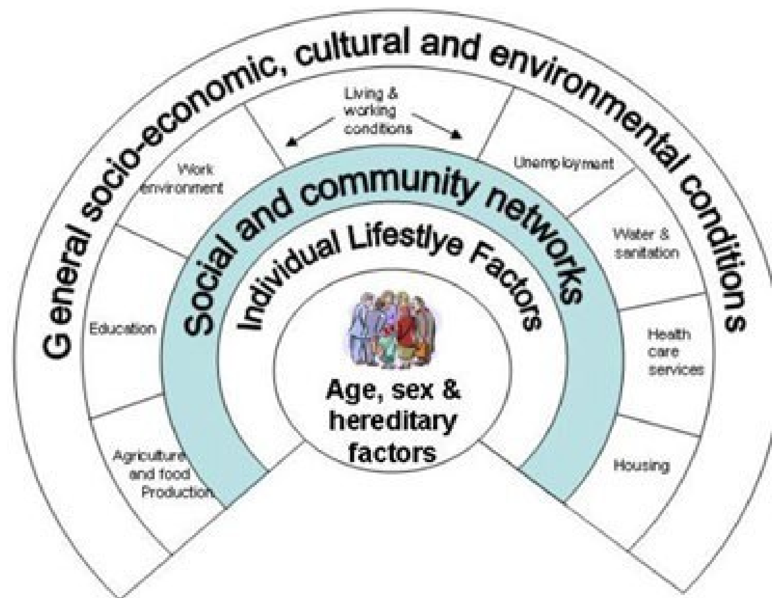
This graphic shows two parallel curving lines – the top line showing the outcomes for those from the most deprived areas in LLR. The bottom line shows the outcomes for those born in the most affluent areas. Small text boxes show differences in life expectancy, school readiness, academic attainment, employment, fuel poverty, alcohol-related hospital admissions, cancer prevalence and numbers living alone as people's lives progress.

5. What is health?

5.1. Once we define health, we can understand why reducing health inequalities is a key piece of work for all partners within the ICS. Health is understood as; *"a state of wellbeing with physical, cultural, psychosocial, economic and spiritual attributes, not simply the absence of illness"* (Marks, 2005) [9]

5.2. This framework recognises the above definition of health and the interconnected relationship between the elements of this definition. The work also adopts a social model of health influences, outlined in Figure 3 below. The social model of health identifies all but age, sex and hereditary factors as modifiable to change and therefore lying within the scope of this work, particularly in relation to primary prevention.

Figure 3: A Social Model of Health, Dahlgren & Whitehead (1991)



Source: The World Health Organisation. [6]
This illustration shows a series of five concentric rings representing, from the centre outwards: age, sex and hereditary factors, Individual lifestyle factors, social and community networks and general socio-economic, cultural and environmental factors – all of which contribute to determining health outcomes.

5.3. The wider determinants of health are a diverse range of social, economic and environmental factors which influence people's mental and physical health. Systematic variation in these factors constitutes social inequality, an important driver of health inequalities. On a whole population level, improving the wider determinants of health (the "causes of the causes") will have a much greater effect on reducing inequities in health compared to NHS interventions alone. Local Authorities, rather than the NHS, have influence and responsibility over some of the wider determinants such as education, housing, transport, clean air, licensing of food and alcohol outlets etc.

5.4. Local Authorities also have a key role in terms of fostering economic opportunity which is reflected in the supply and quality of jobs available in an area.

5.5. We can also see from Figure 3 that communities themselves are vital partners for the ICS members as we work together to drive down health inequalities– in terms of articulating lived experience of health inequalities and helping us co-produce solutions.

5.6. It's important to note that as an individual's health declines, the relative impact of NHS services on future health and life expectancy increases. By taking a preventative approach (working equally across primary, secondary and tertiary levels of intervention2) to delay and reduce the need for NHS treatment

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[2] Primary prevention - Taking action to reduce the incidence of disease and health problems, through universal or targeted measures that reduce lifestyle risks and their causes

Secondary prevention - Systematically detecting the early stages of disease and intervening before full symptoms develop (e.g. taking measures to reduce high blood pressure).

Tertiary prevention - Helping people to manage the impact of ongoing illness or injury (e.g. chronic diseases, permanent impairments) to improve as much as possible their ability to function, their quality of life and their life expectancy. [12] [22]

services the increasing demands on the health service and care services can be managed appropriately. [1] [10] [11] [12]

5.7. The Long-Term Plan sets out commitments for action that the NHS itself will take to improve prevention. It does so while recognising that a comprehensive approach to preventing ill-health also depends on action that only companies, communities, and national government can take to tackle wider threats to health, and ensure health is hardwired into social and economic policy.

6. How I can find out more about health inequalities in LLR?

6.1. A detailed analysis of local demographic and health data demonstrating the extent of inequality is available through local JSNA (Joint Strategic Needs Assessment) reports produced by each Public Health Team. Local JSNA's are available via the following organisational links:
Leicester City:
https://www.leicester.gov.uk/your-council/policies-plans-and-strategies/public-health/data-reports-information/jsna/

Leicestershire:
https://www.lsr-online.org/leicestershire-2018-2021-jsna.html

Rutland:
https://www.rutland.gov.uk/my-services/health-and-family/health-and-nhs/joint-strategic-needs-assessment/

Leicester, Leicestershire, and Rutland Integrated Care System Principles of Approach to Reducing Health Inequalities

7. Principles

As an ICS we are committed to acting to reduce health inequalities across LLR. Our work in this area will be guided by the following set of principles.

Principle 1

Reducing Health inequalities is a key factor in all work conducted within the ICS – it is *everyone's* business. Reducing health inequalities and improving health equity should run through all work programmes at all levels as a "golden thread" from system to place to neighbourhood. Appropriate training and support will be given to enable people to think and act in ways that lead to reductions in health inequity.

Principle 2

The Integrated Care System (ICS) will adopt a Population Health Management[3] and balanced approach to Prevention (across all three tiers[2]) as core principles for their work together in order to reduce health inequalities. Prevention is key to managing future demand for health and care services. Prevention is also essential

[3] Population Health Management approach involves the effective use of routinely collected data to provide meaningful insights on the population being served. This approach allows for proactive care planning by understanding the role of wider determinants of health and making best use of collective resources to improve the health of the population now and in the future. [3]

for improving health equity as the burden of disease is borne unfairly by those who are more deprived, marginalised or in a minority.

Principle 3

A focus on prevention, including tackling the wider determinants of health. Primary prevention includes a focus on and increased investment in reducing inequalities in lifestyle risk factors (smoking, diet, exercise, alcohol consumption etc.), mental wellbeing, housing, income, education, working conditions and the wider environment. The Integrated Care System will also provide stronger foundations for the NHS and other partners to work with local government and voluntary sector partners on the broader agenda of prevention and health inequalities. Action by the NHS is a complement to, but cannot be a substitute for, the important role for local government. In addition to its wider responsibilities for planning, education, housing, social care and economic development, in recent years it has also become responsible for funding and commissioning preventive health services, including smoking cessation, drug and alcohol services, sexual health, and early years support for children such as school nursing and health visitors. Partners will move from reactive services towards a model embodying active population health management.

Principle 4

A focus on parity of esteem between mental and physical health - reducing inequalities in mental health will be prioritised to the same extent as reducing inequalities in physical health.

Principle 5

Public sector ICS partners will act as 'anchor institutions'[4]in LLR to promote health equity and reduce health inequalities through offering "social value". This approach includes supporting the system workforce to be more representative of the demography of the LLR population. We will use mentoring, reverse mentoring and apprenticeships to improve opportunities for under-represented groups, improve awareness and sensitivity to issues of racism and prejudice and support people from less affluent backgrounds to establish a career in the public sector.

Principle 6

Investment in services will be proportionate to the needs (the ability to benefit) the people using those services (the principle of "proportionate universalism"). This means that although there will be a universal offer of services to all, there will be justifiable variation in services in response to differences in need within and between groups of people. Where we find variation in services that appears not to be justified by the variation in need, we will act to "level up" the way the services are offered, and outcomes achieved. While levelling up is generally a good thing, levelling down is not. So, applying focus and resources in one area and targeting those resources to make them most effective will be appropriate, however, diverting those resources from somewhere they were also needed in order to improve health outcomes will not be.

[4] "Anchor institutions are large, public sector organisations that are called such because they are unlikely to relocate and have a significant stake in a geographical area – they are effectively 'anchored' in their surrounding community. They have sizeable assets that can be used to support local community wealth building and development, through procurement and spending power, workforce and training, and buildings and land". [21

Principle 7

We will use data and insight – both qualitative and qualitative - to better understand the health inequalities that exist in LLR and how they affect people. We will draw upon the best evidence to select and implement effective action to reduce inequalities and to evaluate the impact of our services. Where services are failing to reduce inequity, or (by accident) are increasing it, the services will be adjusted or changed completely.

Principle 8

We will draw on the assets and strengths of communities and individuals to reduce health inequality and inequity. Our services will always try to listen to what really matters to people rather than focusing solely on "what is the matter" with them. We will listen to the voices of local people with lived experience to shape local priorities and redesign services. We believe in the ability of people to develop effective solutions that meet the needs of themselves and other people in their community. As part of strengthening resilience in communities we will work to improve health literacy. Strategies to improve health literacy are important empowerment tools which have the potential to reduce health inequalities. The term"Health literacy" describes the skills (language, literacy and numeracy), knowledge, understanding and confidence to access, understand, evaluate, use and navigate health and social care information and services.

Principle 9

The "**Health and Equity in all Policies**" approach[55] will help foster the process of ensuring the health and health equity perspectives are a core part of the ICS way of doing its business. This is particularly important on the wider determinants of health such as housing, education, employment etc.

Principle 10

We will take effective action at key points of the life course ("from the cradle to the grave") dependent on need to reduce health inequality and inequity. This means a specific focus on giving children the best start in life, prevention of ill health (including primary prevention), the promotion of wellbeing and resilience as key principles of our work. This approach will also address the intergenerational cycle of health inequalities across LLR**. As part of our life course approach, we recognise the fundamental importance of the first 1001 days of a child's life in determining their future chances of reaching a healthy old age**. We will increase our collective work to deliver better outcomes for both children and parents during this key period.

Principle 11

Accountability for delivering on system wide health inequalities will be an ICS system accountability. However, we acknowledge that upper tier local authorities have a statutory duty to reduce health inequalities at the place level. Governance of system level principles and actions will be via the Health and Care Partnership. Governance of place–based plans and strategies will be via Health and Wellbeing

[5] "Health in All Policies is an approach on health-related rights and obligations. It improves accountability of policymakers for health impacts at all levels of policymaking. It includes an emphasis on the consequences of public policies on health systems, determinants of health, and well-being. It also contributes to sustainable development". [22] [12]

Boards. Governance of plans and actions at footprints beneath place level will be agreed between local partners using the most appropriate structures consistent with effective representation and oversight.

Much of the implementation of programmes to reduce health inequalities will occur at place. Within the requirements of system, places will be expected to influence the priorities for their populations. This is about understanding the population, how factors such as education, economy, housing, health etc. are impacting on local communities and ensuring local engagement and co-production of any strategies or plans. The challenge is partners coming together to understand that impact, prioritising and developing programmes in collaboration with local communities (particularly communities who are most deprived and disadvantaged) is essential to strengthen community resilience and adverse social circumstances.

Principle 12

Actions will be undertaken at the most appropriate level of the ICS where they can be most effectively owned and delivered. Governance of different types of action will be determined in some cases by how statutory responsibility devolves from central government. Housing, education, and licensing rest with Local Authorities for example, while commissioning responsibility for most hospital services will lie with the local CCGs and their successors.

Principle 13

Digital Inclusion: There is significant potential for the transformation of health care through better and widespread use of digital technologies. Digital technologies are integral to many of the changes envisaged in the NHS long-term plan. However, it will also be important to take steps to prevent digital technologies entrenching or widening health inequalities. This means understanding and addressing the issue of digital exclusion and seeking to use technologies to address the health needs of groups hit hardest by inequalities - while, at the same time, ensuring that there remains the alternative of face-to-face offers for people for whom a solely digital or remote care offer would be exclude some people – often those already disadvantaged in society.

High level system actions to reduce health inequalities in Leicester, Leicestershire and Rutland

8. System actions

8.1. Introduction

We can see that health inequalities are the result of a complex range of interrelated causes – and “the causes of those causes”. In some cases, actions will be primarily in the hands of one partner. In other cases, reducing inequity will require close collaboration between several organisations across the system. The ICS partners are committed to taking action at all levels:

- System level – across the whole LLR area
- Place level – across the area covered by our Upper Tier Local Authorities (Leicester City Council, Leicestershire County Council, Rutland County Council) and led by Health and Wellbeing Boards
- Neighbourhood or locality level – smaller (though locally meaningful) populations within the wider Upper Tier boundaries.

At each of these levels the partners within the ICS – not just the NHS and the Local Authority, but the voluntary and community sectors too – will come together to plan in

ever finer detail the actions they are going to take, individually and collectively, to reduce health inequity.
Medium to long term priorities will be determined at place level and are likely to include;

1. A focus on the first 1,000 days of life. Events and outcomes during this period often determine outcomes across the whole life course. Action will be determined by the needs of each place.
2. Improving healthy life expectancy through early intervention and prevention including actions relating to the wider determinants of health. Actions will be determined by the needs of each place.
3. Using the lived experiences of people to inform our plans and actions.
4. Each organisation having an executive nominated lead for health inequalities who will be responsible for driving this agenda forward in their own organisation
5. A SMART approach to delivering actions at Place

In the shorter term, specifically Q1 & Q2 2021, there are five priority areas for health inequalities. While these initially are described as priorities for the NHS in Q1 and 2, they are likely to remain of longer-term saliency, and in fact, are relevant to the whole ICS and not just the NHS:

1. Restore NHS services inclusively
2. Mitigate against digital exclusion
3. Ensure data sets are complete and timely
4. Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes (management of long-term conditions, annual health checks for people with learning disabilities/serious mental illness, continuity of maternity carer for Black and Asian women and those from deprived neighbourhoods)
5. Strengthen leadership and accountability

The actions below are high level system actions we will work on together because they will support effective work to increase health equity at all levels of the ICS or because they represent important health inequities faced to some degree in all parts of the system.
More detailed plans on action to reduce health inequity will be agreed at place level. The development, delivery and evaluation of place led plans will be led by Directors of Public Health and Health and Wellbeing Boards. The plans will be based on local data and intelligence – qualitative and quantitative – derived from Public health, Local authority services, the NHS, other public sector partners, and communities themselves.

The most detailed implementation plans and actions will be developed by partners working together at a very local level (Neighbourhood or locality level). Multi-Disciplinary Team working, the sharing of information and engagement of individuals and communities around their assets and strengths will ensure that action is direct, person-centred and sensitive to feedback and revision from the integrated teams and the people those teams serve.

8.2. Strategic System Actions

Action 1

Places will be expected to translate the system level principles to their specific populations in the most appropriate way that meets their local needs. This is likely to take an approach encompassing the wider determinants of health, acknowledging that much of this work happens at this level.

Action 2

We will agree a proportionate universalism approach to investment decisions across the ICS. This would allow actions to be universal, but with a scale and intensity that is proportionate to the level of disadvantage. ICS organisations will create a financial framework for addressing health inequalities with agreed investment in transformation of priority areas and investment based on need.

NHS anticipates that any allocation of transformation and development funds being used to support the ICS will have reducing health inequalities as a high priority.

Specifically:

The NHS in LLR will develop and agree a new strategic long-term model of primary care funding distribution and investment to "level up" funding based on population need rather than historical allocation**.** This strategy will not destabilise local primary care.

Action 3

The ICS will establish a defined LLR resource to review health inequalities at the system level. This will be a virtual partnership between the NHS, the local authorities and local universities. It will aim to make available an enhanced capacity and capability for data processing and analysis to support a better understanding of inequity across LLR. It will gather and share best practice in effective interventions, it will provide teaching and training to all levels of staff in undertaking health equity audits. It will facilitate local research. It is acknowledged that Public Health teams will deliver, with partners, the health inequalities support function at a place and neighbourhood level.

Specifically:

a) Proposal for establishment of an LLR health inequality specified resource to be presented to System Executive by 30.09.21

Action 4

All decision makers within the ICS will have expertise, skills, insight and understanding of health inequity and how to reduce it.

Specifically:

a) Health Inequity and Inequality training will be mandatory for all executive decision makers in each organisation by 30.11 21
b) We will work with local and regional partners to develop appropriate and robust training packages relevant to roles.

Action 5

System partners will work together to understand the full effect of the COVID-19 pandemic on health inequalities across LLR, to allow effective and equitable recovery after the pandemic. Whilst the specific programmes, metrics and evaluations will be agreed at place level for the most part, the LLR system will be looking to understand and encourage action around the following points:

- Identifying those communities and groups of all ages and across protected characteristics which have been most affected through the pandemic as a result of pre-existing vulnerabilities and disadvantages
- Undertake proportionate additional work to ensure vaccine uptake is equitable
- Ensuring a primary prevention focus to recovery that considers the wider determinants of health and causes of the causes including education, employment, housing and poverty
- Promote parity of esteem between the importance of both mental and physical health to those groups worst affected by the pandemic and the consequences of lockdown.

Action 6

All partners will work to improve the completeness and consistency of their data to enable a better understanding of health inequity at all levels of the ICS. This predominantly relates to the collection of data on 'protected characteristics' under the Equality Act. The aim is to most appropriately reflect population need including levels of deprivation, vulnerability and the experience of different groups (including the use of qualitative methods).

Specifically:

(a) Key partner organisations to develop an action plan for having ethnicity, accessibility and communication needs of their population appropriately coded in records by 30.07.21

(b) We will risk stratify our population using combined data sets to identify vulnerable groups and individuals to offer proactive, holistic care through Integrated Neighbourhood Teams involving a variety of system partners.

Action 7

The ICS will support the creation of health equity dashboards at place and system-level using agreed metrics to establish baseline information on health inequity and ensure systems are in place to measure progress appropriately. These dashboards at each level will help ensure accountability against our plans and targets to remove or reduce health inequity through all the work we do.

Specifically:

a) Each organisation will have adopted a standard health equity audit tool for completion at the planning phase of each project by 30.10.21

b) Training in undertaking these audits and common corrective actions that can be implemented to reduce inequity will be mandatory for relevant staff in each organisation – confirmation to System Executive by 30.10.21

c) Each Place in the LLR system will have a health equity dashboard with agreed metrics and benchmarked baseline performance by 30.10.21

Action 8

A form of Health Equity Audit (HEA) will be undertaken for projects delivered at all levels of commissioning, service redesign and evaluation within the ICS. These will occur at the planning stage of project work, at a scale that reflects a proportionate approach to work being conducted. Action to reduce health inequity will be taken based on audit findings (at a minimum considering the protected characteristics of the Equality Act 2010) will appropriate reviews planned where necessary.

Action 9

The ICS will develop an action plan, which develops the potential of the NHS and other partners to lead by example and act as an anchor institutions to drive change around a preventative approach and reducing health inequalities that focuses on what the collective LLR public sector can do in the areas of work opportunities, use of buildings and purchasing by 1.7 2021

How will we know if this work is succeeding across LLR? If this framework is successful in driving effective action, we expect to see the following outcomes;

- A reduction in health inequities
- An increase in healthy life expectancy
- A reduction in premature mortality
- A workforce that is representative of the LLR population
- Population reported outcomes

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