SHROPSHIRE HEALTH AND WELLBEING BOARD

Meeting Date: 11th November 2021

Paper title: Developing a Health Inequalities Plan for Shropshire

Responsible Officer: Berni Lee, Consultant in Public Health

Email: Berni.lee@shropshire.gov.uk

---

1. Summary

This report sets out how plans to draw together a Health Inequalities Plan for Shropshire will be taken forward based on the Population Health model.

Health inequalities are avoidable, unfair and systematic differences in health between different population groups that develop because of differences in the experiences of different groups, for example in terms of their income, education, or exposure to risks. It is notable that the COVID pandemic has impacted most on populations vulnerable to health inequalities (such as ethnic minority groups) and that inequalities in health have grown wider.

The national Marmot reviews provide evidence in terms of the causes of Health Inequalities and in terms of reducing health inequalities emphasise the importance of providing infants with the 'best start in life' and in improving the socio-economic circumstances in which people grow, live, work and age.

Shropshire's Health Inequalities plan will incorporate Integrated Care System (ICS) and NHS priorities alongside Shropshire specific health improvement/health inequalities priorities, as detailed in the report.

ICS priorities include important programmes of work for example to protect the Shropshire population from COVID and to mitigate the impact of digital exclusion on access to health services. The NHS prevention programmes aimed at reducing obesity and smoking should also have an impact on health inequalities as should transformation programmes in maternity, cardiovascular and cancer care.

A draft structure for the plan illustrates the planned content and level of detail to be included for example, key milestones associated with relevant plans and associated process and outcome measures that can be monitored to illustrate progress in reducing health inequalities.

A Health Inequalities group will meet and will report to the Shropshire Integrated Place Partnership (ShIPP) in agreeing the priorities to be included in the Health

Inequalities plan. The plan should be approved by the H&WBB and ICS Board by April 2022.

2. Recommendations

The Board are asked to:

- Note the content of this report and to suggest any specific areas of concern not specified in the report that should be addressed though the plan.
- Identify any further information required in relation to health inequalities or the plans to address them

3. Report

3.1 Background

In July 2021 the H&WBB received a report summarising some of the key work programmes underway in Shropshire that will help to identify and/or reduce health inequalities across the county. The report included the 'high level' framework that will used to structure the approach to improving population health and reducing health inequalities – the Population Health Model.

Figure 1: Population Health Model

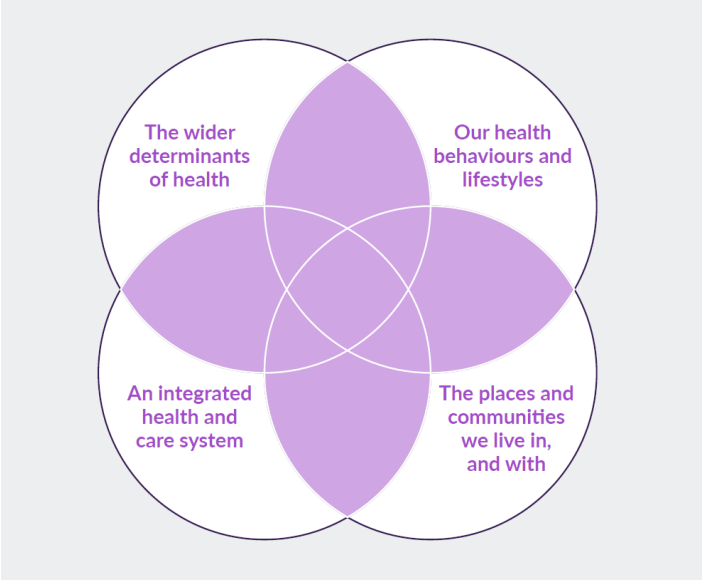


Figure 1 illustrates the key components of the Population Health Model – whereby there are four interconnected pillars/areas for action that need to be addressed to secure health improvement and reduce health inequalities. These are:

1. **The Wider Determinants of Health** - working in partnership to tackle health inequalities through addressing the social determinants of health such as education, employment, income, housing and transport
2. **Health Behaviours and Lifestyles** - aligning and coordinating prevention programmes to maximise impact and reduce barriers to healthy lifestyle choices
3. **The Places and Communities Where we Live** - working with our communities and other partners to co-produce health improvement solutions, based on local needs and assets
4. **An Integrated Care System** - health and social care commissioners and providers working together to commission and deliver services that meet the needs of Shropshire's population.

This framework will be used to structure Shropshire's Health Inequality plan as described below.

Health inequalities are avoidable, unfair and systematic differences in health between different population groups. It is well recognised that health inequalities exist across a range of dimensions including the nine protected characteristics of the Equality Act 2010, socio-economic status, geographic deprivation, or being part of a vulnerable or Inclusion Health group. Health inequalities may be driven by:

- different experiences of the wider determinants of health, such as the environment, income or housing
- differences in health behaviours or other risk factors, such as smoking, diet and physical activity levels
- differences in psychosocial factors, such as social networks and self-esteem
- unequal access to or experience of health services.

It is important to note that smoking has been identified as the single largest driver of health inequalities in England. One study found that smoking accounted for a third of the difference in death rates between the lowest and highest socioeconomic groups. In addition it has been identified that 50% of the deaths among people with Serious Mental Illness (SMI) are due to tobacco related illnesses. Tobacco control and smoking cessation services thus make a vital contribution in reducing health inequalities.

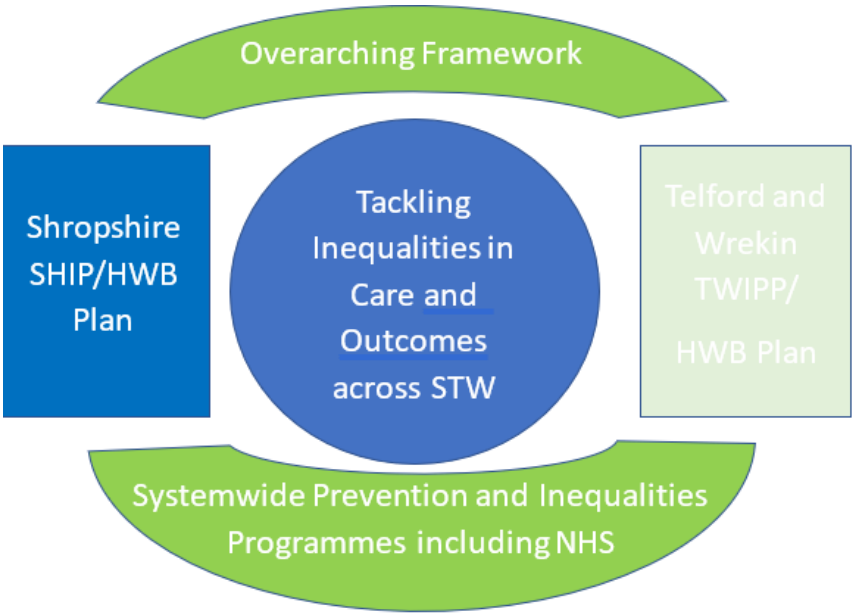
It is further recognised that the pandemic has impacted on health and wellbeing in far reaching ways, reinforcing existing health inequalities.

The national Marmot reviews provide a comprehensive evidence base for action in reducing health inequalities. The reports emphasise the importance of providing infants with the 'best start in life' and in improving the socio-economic circumstances in which people grow, live, work and age. The evidence indicates that health inequalities present across a social gradient, with those living in the most deprived areas having the worst outcomes. As such proportionate universalism is recommended whereby actions are universal, but with a scale and intensity that is proportionate to the level of disadvantage. 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.

3.2 Progressing a Comprehensive ICS Health Inequalities Plan

Work to draw together a comprehensive Health Inequalities plan for the Integrated Care System (ICS) is being led through a sub-group of the ICS Board - the Population Health Board. The Population Health Board will draw together system-wide priorities for reducing health inequalities, including those specified for local action by the NHS. Figure 2 illustrates how local plans to reduce health inequalities sit within the overall system framework.

Figure 2 – Reducing Health Inequalities Through System-Wide and Local Plans



Sub-groups of the Population Health Board have been convened to focus action in key areas, as follows:

- Population Health Management
- Economic Regeneration
- Climate Change

Brief details of the work of these groups are included in appendix 1.

3.3 ICS-wide Health Inequality Priorities

Following the evidence demonstrating that COVID has widened health inequalities NHS England (NHSE) commissioned a national advisory group to recommend how best to increase the scale and pace of action to tackle health inequalities. The priorities identified have been further refined producing the following five objectives:

- Maximise equitable uptake of COVID and Flu vaccinations
- Restore NHS services inclusively
- Develop digitally enabled care pathways in ways which increase inclusion
- Accelerate delivery of:
    - preventative programmes which proactively engage those at risk of poor health outcomes (see below)
    - Long-term condition management programmes
    - Annual health checks for those with a Learning Disability (LD) or with Serious Mental Illness (SMI)
    - Continuity of carer for at least 35% of maternity bookings
- Strengthen leadership and accountability
- Ensure datasets are complete and timely

The preventative programmes include:

- **Obesity** – including the introduction of a digital weight management service in primary care, expansion of the diabetes prevention programme and taking action to improve NHS premises such that they support healthy lifestyles
- **Tobacco Dependency Treatment** – with patients being assessed and offered smoking cessation services (counselling and treatments to manage addiction) in acute, maternity and mental health settings
- **Tackling alcohol addiction** – through the introduction of Alcohol Care Teams
- **Tackling air pollution** – for example through decreasing 'business miles' and increasing the use of 'virtual' meetings

3.4 NHS LTP

The NHSE priorities listed above build on the commitments made in the NHS Long-Term Plan (LTP) which has strengthened the NHS focus on prevention and on the imperative to reduce health inequalities. The LTP incorporates the delivery of a number of transformation programmes that have the potential to make a significant contribution in reducing inequalities. These include:

- Maternity transformation – with increased roll-out of 'continuity of carer' and a reduction in smoking in pregnancy
- Cancer and Cardiovascular Disease transformation – with increased opportunity for early diagnosis and treatment
- Diabetes prevention – with earlier identification and the provision of expert support

There is also a focus on improving children's health, respiratory health and mental health. These developments present significant opportunities for reducing health inequalities.

3.5 Development of an Integrated Assessment Framework

One of the early actions being taken forward by the Population Health Board is the development of an integrated assessment framework aimed at ensuring that all future plans, strategies or policies that are developed by partners across the ICS are considered in the context of their impact on factors including heath, wellbeing and health inequalities. Further details are included in appendix 2. Through such a process there will be an explicit and consistent approach to considering the impact of all mainstream service developments on health inequalities (and other factors) such that maximal impact in securing a reduction in health inequalities over time can be achieved.

3.6 Developing a Comprehensive Shropshire Health Inequalities Plan

A group has been convened to take forward Shropshire's plan that will be based on:

- ICS (system wide) health inequality priorities
- Shropshire H&WBB priorities as expressed through Health and Wellbeing Strategy and relevant Shropshire Council priorities
- Local NHS transformation programmes (including PCN plans) with particular relevance to reducing health inequalities.

In tackling the complex issues that underlie health inequalities there is a need to recognise the importance of understanding problems from the perspective of those with 'lived experience' of the issue and adopting a 'whole system approach' built on complex systems theory (i.e. simplistic approaches ('sticking plasters') are not effective solutions to complex problems). Other principles that will underpin action include:

- Intelligence led identification of problems and evidence-based solutions
- Community centred action – co-producing solutions building on local assets working with individuals and community and voluntary sector partners
- Based on equitable targeting of resources
- Built on place-based collaboration

The intention of the plan is not to duplicate existing work programmes but to draw together current plans aimed at reducing health inequalities, seek to strengthen the plans, in particular through identifying synergies between them, to identify and address any gaps in support or provision and to enable monitoring of progress towards a reduction in health inequalities.

A draft structure for the plan is included in appendix 3 and the plan should be completed and approved by April 2022. The plan will be built around the four Population Health pillars with the Marmot Principles mapped across as follows:

Wider Determinants	**Healthy Behaviours and Lifestyles**	**Healthy places and communities**	**Integrated Health and Care**
Marmot: (i) Create fair employment (ii) Ensure healthy living standard	*Marmot: (iii) CYP and adults – maximise capability and control (iv.a) strengthen Ill-health prevention (lifestyles)*	*Marmot: (v) Create healthy and sustainable places and communities*	*Marmot: (vi) Give every child the best start in life (iv.b) strengthen Ill-health prevention (transformation/disease programmes)*

The key ICS/NHS priorities are stated in section 3.3 above and there is considerable cross-over with many of Shropshire's local priorities (e.g. Health weight and mental illness). As the Shropshire group being convened to agree the Health Inequalities plan is yet to meet the final list of priorities has not been confirmed however additional priorities (either H&WBB or wider council) are included in the tables in appendix 3

In the context of the strong evidence linking smoking to health inequalities consideration needs to be given to the priority afforded to smoking from a Shropshire perspective – particularly in the context of the NHS Tobacco Dependency Treatment programme whereby smokers will be identified and supported by the NHS (for eg. following an emergency admission) with the need for on-going follow-up in the community.

3.7 Performance Measure

The ShIPP has agreed some interim inequalities performance measures to be monitored through the review of performance in relation to the Health and Wellbeing Strategy priorities. These are included in appendix 4.

3.8 Emerging Areas of Focus

In recent discussions with NHS partners the concept of focusing on the 'Core 20% + 5' in tackling health inequalities has emerged, although further clarity is required. It is understood to mean a focus on prioritising:

- Those living in the 20% most deprived Lower Super Output Areas (LSOAs)
- The following 5 ambitions – (i) Continuity of carer for maternity care (ii) Reducing chronic respiratory disease (iii) Hypertension case finding (iv) Increasing health checks among those with SMI (v) Early diagnosis of cancer through screening/early referral
- Plus locally defined priorities relevant to local inequalities (for example rurality or the health of ethnic minority groups)

Alongside this Primary Care Network (PCN) planning guidance indicates the need to reduce health inequalities through hypertension case finding and to tackle neighbourhood inequalities through identifying a local inequalities issue and co-producing a solution with the affected community. Working in partnership will be important in achieving these objectives.

3.9 Next Steps

The Health Inequalities group will meet and will report to the ShIPP in agreeing the priorities and level of detail to be included in the plan – for example as shown in the table shown in appendix 2. ShIPP will also support the group in agreeing the metrics to be used in monitoring progress in reducing health inequalities.

4. Risk assessment and opportunities appraisal

(NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)

Health inequalities are not always evident. It can be difficult – particularly in rural areas – to identify individuals vulnerable to health inequalities and as such there is a risk that all needs will be identified and/or met.

5. Financial implications

There are no immediate financial implications related to this report, however if gaps in services are identified in reviewing our response to health inequalities there could be financial implications in the future

6. Climate Change Appraisal

The work on Health Inequalities includes a review of the collective response of the ICS in tackling climate change and as such a positive impact in reducing the carbon footprint might be anticipated.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder) or your organisational lead e.g. Exec lead or Non-Exec/Clinical Lead

Cllr. Simon Jones Portfolio Holder for Adult Social Care and Public Health
Appendices Appendix 1 Subgroups of the Population Health Board Appendix 2 Development of an Integrated Assessment Framework Appendix 3 Draft Structure for Shropshire's Health Inequalities Plan Appendix 4 Inequalities Targets Associated with Health and Wellbeing Priorities

Appendix 1

Sub-groups of the Population Health Board

Population Health Management group

The aim of the Population Health Management programme is to use all data, evidence, and insight in a systematic way to better understand, plan, deliver and ultimately improve population health and care whilst making best use of all available resources.

The work stream has two elements - infrastructure to deliver a population health management approach including analytic capability and creating an "engine room" for data, to provide a rich evidence base to support programmes of work and secondly to provide the evidence to support prioritisation. Through this work more targeted interventions to address health inequalities can be developed.

Economic Regeneration group

There are recognised links between employment; economic prosperity and better health outcomes and a wide range of strategies and programmes are already in place aimed at driving economic growth, attracting investment, supporting the physical & digital infrastructure, as well as delivering skills training. Through post-COVID programmes of 'Recovery, Reset & Reform' links between economic growth & health have strengthened but there are recognised opportunities to embed this further.

There is recognition of the role of ICS partners in driving economic prosperity, alongside the Councils. Through working with the ICS those leading economic development will be better able to target activities to benefit health/reduce health inequalities and to monitor agreed indicators (health outcomes) reflecting the impact of economic strategies on health/health inequalities

Climate Change subgroup

Climate change has well described impacts on health and is associated with factors such as:

- poor air quality, impacting on respiratory and cardiovascular health – particularly affecting those living in more deprived communities
- extreme weather events (for example leading to flooding)
- change in exposure to pests/new diseases

Shropshire Council declared a climate emergency in May 2019 and adopted a comprehensive climate strategy and action plan in December 2020. Through working jointly with ICS partners, including commissioned services, the intention is to further reduce the carbon footprint across the county.

Appendix 2

Development of an Integrated Assessment Framework

The work to develop an integrated assessment framework is at an early stage but provisional discussions indicate that the framework will include consideration of the following factors:

- Health, wellbeing and health inequalities
- Quality (e.g. client or patient experience)
- Social inclusion/vulnerable groups (e.g. the homeless or those experiencing addiction)
- Equality – in the context of those with 'protected characteristics' (eg. gender, race or disability)
- Sustainability/climate change (e.g. impacts on air quality or flood risk)
- Economic impacts (e.g. proposals that could lead to increased opportunities to develop skills/work opportunities for the local population)

A process will be developed to ensure the assessments are robust but also proportionate in the context of the specific development in question. Through such a process there will be an explicit and consistent approach to considering the impact of all mainstream service developments on health inequalities (and other factors) such that maximal impact in securing a reduction in health inequalities over time can be achieved.

Appendix 3

DRAFT

Structure for Health Inequalities Plan

Context

(i)Data illustrating HIs across Shropshire (II) Rural inequalities (iii) Marmot (iv) NHS programmes (v)Underpinning principles (vi) Governance through Pop Health Board/ShIPP and H&WWB

Plan is not intended to re-iterate existing plans – just reference existing work plan and key inequality aspects/targets

There may be the case for adding some additional plans – e.g. LAC do badly in terms of academic achievement (also are they getting annual health checks?). We also fall behind in terms of 2/2.5 years development and HV assessments and academic achievement FSM vs non-FSM pupils etc. Perhaps these things will be picked up in the C&YP strategy??

Structure

Use population health model – map Marmot priorities across domains – allocate existing relevant programmes across Pop Health Domains – as follows:

Table 1: Mapping Health Inequality Programme Areas Against Population Health Domains

Wider Determinants	**Healthy Behaviours and Lifestyles**	**Healthy places and communities**	**Integrated Health and Care**
Marmot: (i) Create fair employment (ii) Ensure healthy living standard	*Marmot: (iii) CYP and adults – maximise capability and control (iv.a) strengthen Ill-health prevention (lifestyles)*	*Marmot: (i)v Create healthy and sustainable places and communities*	*Marmot: (vi) Give every child the best start in life (iv.b) strengthen Ill-health prevention (transformation/disease programmes)*
Health Inequalities Work Programmes			
Health in all polices	Smoking/tobacco dependency treatment (incorporating NHS must do)	Rural inequalities (anything particular?)	
Integrated health assessment	Healthy weight (incorporating NHS must do)	JSNA place based process	Population Health Management
Economic strategy	Physical Activity	Air Quality/climate change	Leadership and accountability for HIs
Thrive at work	Alcohol	Health contribution to Core Plan	Data sets complete and timely
Reduce NEETs	Drug/substance misuse		Personalisation (include SP)
Employment MH/LD	Reduce school exclusions		Mental Health (bereavement & Suicide)
Reduce Food Insecurity	Reduce inequalities in academic achievement		SMI
Housing	Trauma informed approaches		LD
Fuel poverty			Complex need
			Maternity Transformation
			Cancer
			Diabetes

			CVD (Incl PCN HI plans for hypertension/AF)
			COVID//Flu vaccination
			Restore NHS services inclusively
			Inclusive digital pathways
			Whole System Approach – Shaping Places learning programme

Table 2. Key Details of Wider Determinant Health Inequality Programmes (To be Completed – once framework is finalised)

Population Health Domain: Wider Determinants					
Plan/ Development	**Health Inequalities Dimension**	**Lead organisation/ individual/governance**	**Key milestones**	**Key process measures**	**Key outcome measures**
Health in all polices	Ensure that developments approved by Shropshire Council (housing, employment, environment etc) consider the health impacts and impacts on health inequalities prior to approval	Organisation: Shropshire Council Lead officer: Sue Lloyd Governance: Health and Wellbeing Board			
Integrated health assessment	Ensure that developments approved across the ICS use a standardised approach to assessing the health impacts and impacts on health inequalities prior to approval	Organisation: ICS Lead officer: Edna Boampong Governance: Population Health Board			
Economic strategy					
Thrive at work					
Reduce school exclusions	No explicit plan I am aware of ATM				
Reduce NEETs	No explicit plan I am aware of ATM				
Employment MH/LD	No explicit plan I am aware of ATM				
Reduce Food Insecurity					

Table 3. Key Details of 'Healthy Behaviours and Lifestyles' Health Inequality Programmes (To be Completed – once framework is finalised)

Population Health Domain: Healthy Behaviours and Lifestyles					
Plan/ Development	**Health Inequalities Dimension**	**Lead organisation/ individual/governance**	**Key milestones**	**Key process measures**	**Key outcome measures**
Smoking/tobacco dependency treatment (Incl NHS must do)	Smoking is the biggest single driver of His and 50% of all deaths among those with SMI are tobacco related. Tobacco Dependency Treatment is a key NHS LTP commitment	Organisation Shropshire Council – Tobacco Control Lead officer: Berni Lee Governance: Health and Wellbeing Board Organisation: ICS - Tobacco Dependency Treatment Lead officer: Tracey Jones Governance: ICS Board			
Healthy weight (Incl NHS must do)					
Physical Activity					
Alcohol					
Drug/substance misuse					
Trauma informed approaches					

To be added: **Tables 4 Healthy places and communities and Table 5 Integrated Health and Care**

Appendix 4

Inequality Targets Associated with H&WB Priorities

Key Priority name	Key indicator description and rating	Additional Outcome Indicators	Process Indicators
Workforce	Average weekly earnings	Unemployment rate (all)	Number of buisnesses signed up to 'thrive at work'
	B05 16-17 year olds not in education employment or training (NEET) whose activity is not known	Unemployment rate those with Learing Disability	
	Make Every Contact Count (MECC) training. Numbers of staff trained.	Unemployment rate those with Mental Illness	
	Workforce who works together to improve access to the right services at the right time	In-work poverty rate	
Mental Health	E09b Excess under 75 mortality rate in adults with Severe Mental Illness (SMI)	% of those on SMI register receiving annual health check	Number of staff trained under 'Trauma informed workforce' programme
	School pupils with social, emotional and mental health needs, % of pupils with social, emotional and mental health needs		Delivery of key priorities within Community Mental Health Transformation programme
			Number of Shropshire schools accessing national 'Senior mental health lead training' programme
Children and Young People	C08a Child development. % achieving a good level of development at 2 - 2 1/2 years	Educational attainment FSM vs Non-FSM status	Roll-out of C&YP SP pilot in SW Shropshire
	C03b Child development. % achieving the expected level in communication skills at 2 - 2 1/2 years	% Children Looked After with annual health plan review	Implementation/roll-out of ACE programme (is this staff training first??)
	C03c Child development. % achieving the expected level in personal-social skills at 2 - 2 1/2 years		
	Children in Care		

Healthy weight and physical activity	*C16* The percentage of adults who are overweight and obese	*Reception and Year 6 NCMP (by deprivation)*	*Healthy weight strategy developed/agreed*
	C03a Obesity in early pregnancy		Recruitment to tier 2 weight management posts
	C22 Estimated diabetes diagnosis rate for people aged 17+		Establish delivery of Shaping Places Healthy Lives programme
	C03c Smoking in early pregnancy		Number of referals to Diabetes Prevention Programme
			Number of practices providing access to NHS DigitalWeight Managment Programme