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Dear Member

KENT AND MEDWAY JOINT HEALTH AND WELLBEING BOARD - TUESDAY, 7 DECEMBER 2021

I am now able to enclose, for consideration at next Tuesday, 7 December 2021 meeting of the Kent and Medway Joint Health and Wellbeing Board, the following report(s) that were unavailable when the agenda was printed.

Agenda Item No

8 **Health Inequalities Strategic Action Plan (Pages 1 - 10)**

Yours sincerely

Benjamin Watts
General Counsel

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KENT AND MEDWAY
JOINT HEALTH AND WELLBEING BOARD

7 DECEMBER 2021

HEALTH INEQUALITIES STRATEGIC ACTION PLAN: INFORMING THE PRIORITY AREAS FOR ACTION

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Summary

This discussion paper asks the Kent and Medway Joint Health and Wellbeing Board to consider the proposed priority areas for the health inequalities strategic action plan based on output from recent system-wide workshops, the Population Health Management Development Programme and national NHS CORE20PLUS5 initiative. It also asks the Joint Board to agree that local communities must be involved in the co-design and delivery of the strategic action plan.

1. Introduction

1.1. On 17 September 2020 the Joint Board agreed to develop a plan to publicly set out its vision, strategic aims, and ambitions regarding how the partnership could work together to tackle those areas of health inequalities identified as priorities for the system.

1.2. Since this meeting in September 2020:

- A half day health inequalities development session was held on 10 June 2021 to highlight the issues facing Kent and Medway and looked at how other health and care systems in the country had responded to their health inequalities challenges.
- The Population Health Management Development Programme was launched on 19 July 2021 and is now in its 20th week of delivery.
- An Integrated Care System (ICS) Partnership Board workshop was held on 14 September 2021, focusing on the level of ambition for the four core purposes of our ICS, two of which are Improving Population Health and Healthcare and Tackling Unequal Outcomes and Access.
- The NHS CORE20PLUS5 approach was launched on 1 November 2021 designed to support Integrated Care Systems to drive targeted action on health inequalities

1.3. These programmes, initiatives and workshops have separately highlighted areas of inequality on which a strategic action plan for Kent and Medway could initially focus. This discussion paper summarises these areas and draws out

emerging themes, on which the proposed priorities for action for the system-wide plan could be based.

2. Background

2.1. The purpose of Kent and Medway Joint Health and Wellbeing Board includes promoting health integration and supporting partners to address health inequalities. Considering this, the Joint Board agreed to take the broadest view of its purpose and to place an unrelenting focus on health inequalities.

2.2. Not all the solutions to tackling health inequalities are in the hands of local public sector organisations. National approaches and legislation are also needed to deal with income and benefits, planning and infrastructure, air quality and emissions, food quality and sugar content. Members of the Joint Board were therefore keen that the priorities of the health inequalities strategic plan were focussed on addressing inequalities that could be delivered successfully at a local level and tackled collectively with the engagement of all system partners.

2.3. The breadth and complexity of the health inequalities faced in Kent and Medway can often appear daunting, particularly given the exacerbation of inequalities in the wake of the COVID-19 pandemic, with the main challenge being to identify and prioritise a clear starting point. A key message from the speakers at the 10 June 2021 development session, and also echoed in the feedback from system leaders, was to **select a small number of umbrella priorities that stakeholders can work on together quickly,** using this as a foundation on which to build future joint action.

2.4. This strategic action plan aims to identify areas for collective, system-wide action on health inequalities. It also aims to complement organisational health inequalities plans; system partners would be expected to continue to embed the reduction of health inequalities in the development and delivery of their services.

3. Informing the priority areas for action

3.1. <u>Health Inequalities Development Session – 10 June 2021</u>

3.1.1. This session provided an introduction to the issues facing Kent and Medway and looked at how other areas in the Country had responded to health inequalities through a system wide approach. This was one of the first times that senior leaders from across Kent and Medway had come together in a single forum to discuss health inequalities. The output from the session was summarised in a report to the Joint Board in September 2021.

3.1.2. Inequalities in health outcomes across several areas were highlighted and discussed during the session and in breakout groups, including:

People with mental health conditions

- Long-term conditions are more common in people with mental health conditions than in those without. Within Kent and Medway, there is

double the risk of three or more long-term conditions in people experiencing mental health conditions
- People with severe mental disorders tend to die earlier than the general population. There is a 10-to-25-year life expectancy reduction in people with severe mental disorders

People with multiple long-term conditions
- People in the most deprived 10% have multiple morbidities equivalent to people 10 years older in the least deprived decile.
- People with multiple long-term conditions require additional and more complex health and care services, which also makes it more difficult for those people to manage their own condition

Children experiencing adverse childhood experiences (ACEs)
- Children exposed to four or more ACEs have a significantly increased likelihood of developing health harming behaviours in adolescence and into adult life
- Children experiencing four or more ACEs are also more likely to be diagnosed with a major illness (e.g. cancer, stoke, diabetes CVD) in later life

People living in deprived areas
- There is a 25-year age gap between the average age of death for the least deprived and most deprived populations in our area
- Children from poorer areas receive far lower exam grades than those in less deprived areas
- There are more emergency admissions for many diseases including chronic obstructive pulmonary disease and stroke for people in more deprived areas

3.2. Population Health Management Development Programme

3.2.1. This 22-week programme aims to develop Population Health Management knowledge and capability, working with each tier of the Kent and Medway system to link local data and build analytical skills to identify at risk cohorts and design and deliver new models of care.

3.2.2. Launched on 19 July 2021, the programme is now in its 20th week. Integrated care partnerships (ICPs) and primary care networks (PCNs) participating in the programme have selected their cohorts and are designing and implementing their interventions.

3.2.3. Table 1 below shows that across the cohorts selected:
- Five included a focus on **obesity**
- Four included a focus on people with **diabetes** or at risk of diabetes which has strong links to obesity.
- Four included a focus on people with **mental health conditions and wellbeing**, including depression and anxiety
- Three focussed on **areas of highest deprivation** where all of the above are more prevalent.

3.2.4. Other selection criteria included people with three or more co-morbidities, asthma, hypertension, people who are housebound or are smokers. One

ICP cohort is focussed exclusively on children and young people (0-19 years)

Table 1: PHM Development Programme - Selected Cohorts

ICP / PCN	Cohort details	Cohort size
Medway & Swale ICP	Children between the age of 5-19, with asthma or diabetes from the 2 highest deprivation deciles	1,250
East Kent ICP	Diabetics in the Chronic Segment, with Depression, live in highly deprived areas, and have an additional 3 or more co-morbidities	727
ABC PCN (West Kent)	Aged 10-59 yrs, obese with depression and live in highly deprived areas	107
Dover Town PCN (East Kent)	Aged 40-69 yrs, who are obese, hypertensive with depression with mid-level complexity across all deprivation scales	131
Garden City PCN (DGS)	Aged 40-60 yrs, obese with anxiety and smokers across all deprivation levels	137
Medway Central PCN (Medway & Swale)	Aged 20-39, obese and hypertensive across all deprivation levels. Target those at risk of diabetes (pre-diabetic)	166
Ramsgate PCN (East Kent)	All age-groups, with diabetes and housebound; all levels of complexity and deprivation	118

3.2.5. Feedback from each of the action learning sets is being collated to inform how we spread and sustain the Population Health Management approach across Kent and Medway. The feedback will also guide the rollout of the next phase of the Kent and Medway PHM programme provisionally planned to start in May 2022.

3.3. <u>ICS Partnership Board System Workshop – 17 September 2021</u>

3.3.1. A system-wide workshop was held on 14 September 2021 focusing on the level of ambition for the four core purposes of our integrated care system (ICS). Also considered were the behaviours senior leaders need to build on personally and at neighbourhood, place, and system level to deliver integrated working. The four purposes are below, two of which focus on population health and tackling inequality in access and outcomes. It was agreed that the outputs from this workshop session should inform the development of the health inequalities strategic plan.

ICS Four Core Purposes			
Improving Population Health and Healthcare	**Tacking Unequal Outcomes and Access**	Enhancing Productivity and Value for Money	Supporting Broader Social and Economic Development

3.3.2. Some of the current health inequalities challenges highlighted by system leaders included:

- **People with mental health conditions:** Mental health outcomes need to have parity with physical health outcomes. Children's mental health is a challenge for the system, poor outcomes are linked to poor access and this needs to be recognised

- **Disadvantaged communities:** The same communities are often repeatedly disadvantaged.

- **Childhood obesity:** Childhood obesity is high and getting worse and this must be an area of system-wide focus and include work with schools. It was also noted that there is disproportionate number of fast-food outlets in areas of deprivation.

3.4. Core20PLUS5

3.4.1. Launched on 1 November 2021, Core20PLUS5 is a new NHS framework designed to support Integrated Care Systems to drive targeted action in health inequalities improvement. It supports health and care systems to focus their energies and resources on three key areas of inequality:

- **the most deprived 20% of the national population** as identified by the index of multiple deprivation (**CORE20**)

- **the ICS-chosen population groups experiencing poorer than average health access, experience and/or outcomes**, who may not be captured within the CORE20 alone and would benefit from a tailored healthcare approach e.g., ethnic minority communities, inclusion health groups (PLUS)

- five key clinical areas of health inequalities: **maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, hypertension case finding** (5)

3.4.2. Core20PLUS5 will be underpinned by quality improvement approach that builds on existing strengths, incorporates co-production with communities, and includes data driven improvement.

4. Emerging themes and priority areas

4.1. There are two recurrent themes that cut across all the above activities, and as such, should form the initial priority areas for the health inequalities strategic action plan:

- **Mental health conditions and wellbeing**
- **Areas of highest deprivation**

4.2. Mental health

4.2.1. Addressing health inequalities has been a priority in mental health for number of years, as highlighted in the Five Year Forward View for Mental Health and the NHS Long Term Plan. All integrated care systems are expected to set out how they will specifically reduce health inequalities by 2023/24.

4.2.2. Mental health inequalities are often linked with wider cultural and societal disadvantage which impact a person's wellbeing, including (but not limited

to) adverse childhood experiences, stigma, discrimination, and environment, such as housing security. As mental health inequalities are varied and contextual, local health and care partners – NHS, local government, voluntary sector, and other agencies – are ideally positioned to co-produce localised solutions with communities experiencing mental health inequalities.

4.2.3. The Mental Health, Learning Disabilities, and Autism (MHLDA) Improvement Board provides leadership, oversight and partnership working to improve the mental health and mental wellbeing outcomes of the population of Kent & Medway. The MHLDA Board will be considering a paper on mental health inequalities early 2022, which presents an opportunity to engage key stakeholders at an early stage in developing this priority area within the plan.

4.3. Deprivation

4.3.1. Evidence shows that people living in our most deprived areas face worse health inequalities in relation to health access, experiences, and outcomes. Inequalities in health outcomes are underpinned by the wider social determinants of health. This consists of the physical, social, and economic environment in which we live, including education, housing, employment, and income.

4.3.2. There are examples of services developed in particular districts or localities, aimed at delivering services to the most disadvantaged communities. For example, Thanet Multiagency Task Force is a collective of professionals working with people and families with complex issues who struggle to access services through mainstream routes. The Task Force focusses its activities in the more deprived wards within Thanet, such as Cliftonville West and Margate Central.

4.3.3. Some services also commission outreach into deprived communities to improve access and uptake, for example, stop smoking services and NHS Health Checks. A system-wide focus on reducing health inequalities in deprived areas could help tackle the unintended repeated and cumulative disadvantage these communities often experience.

4.4. Given the considerable breadth of the two priority areas, further will now be undertaken to map and understand what programmes of work are already in place, where we may have gaps and where joint action across the system would have the greatest impact. The intention is to use data to understand the impacts in those communities and focus work within those priorities.

5. Involving our communities

5.1. To develop an effective strategic action plan we need to understand the needs of our communities and involve them closely in its design and delivery. Involving our local communities was a key theme running through stakeholders' contributions on 10 June 2021. This message was further amplified at the ICS Partnership Board workshop; one of the stated ambitions of system leaders is to work with our communities to make sure access for all is properly considered and planned for.

5.2. A crucial element of the PHM Development Programme was the engagement of a wide range of stakeholders, including representatives from local voluntary and community groups and patient representatives. Within the System action learning sets, leaders felt that co-production is vital to effective intervention design. However, at Place and PCN level, the programme revealed that capacity and capability in this area remains a gap. Genuinely listening with curiosity to our local communities and engaging them in the design, implementation and evaluation of our health inequalities interventions is also central to the CORE20PLUS5 approach.

5.3. An example of successful co-production is the Kent and Medway COVID-19 Vaccination Inequalities Programme. The national COVID-19 vaccination programme, the largest of its kind in history, continues to be rolled out across the country. In Kent and Medway, this programme has been informed by data collection and analysis to identify population groups where inequalities existed in the uptake of the vaccine. Armed with this intelligence, the programme engaged with local voluntary groups based within those communities to both plan and deliver targeted outreach activities to improve access and uptake within specific population groups, e.g. BAME communities.

5.4. Working with local people to develop and deliver health inequalities interventions is a recurring theme, locally and nationally. Co-production should therefore be a key principle underpinning this action plan and local communities should co-design the plan and its delivery.

6. Leadership for health inequalities

6.1. There is a strong sense across the system that clear, inclusive and accountable leadership is crucial if real progress is to be made on reducing health inequalities across the Kent and Medway health and care system. This was a key theme running through the health inequalities workshop in June 2021; system leaders felt that a collective clarity and confidence was required about what they wanted to jointly achieve, including joint decisions as a system on where to place resources to maximise impact. Partner organisations need to maintain a sustained commitment to this agenda and hold each other to account for their actions in this regard.

6.2. PHM is expected to become an embedded way of working, one that influences and directs priorities. Championing PHM was therefore seen as a key strategic priority including commitment of resources to support PHM spread and sustain across all levels of the system. The importance of building collaborative leadership was also stressed, including the ability for partners to be outcomes-focussed and see beyond their individual organisations to benefit our communities.

6.3. At the ICS Partnership Board workshop, system leaders highlighted the importance of sharing and linking datasets across partner organisations, pointing out that integrated care required integrated data. It was felt that platforms of shared population health data were needed with one agreed version that all partners can see and these data should include wider sectors, such as education, fire and police. The development of population health management and a health inequalities strategic action plan were seen as opportunities to take a ‘positive disruptive’ approach that is different from what has been done before.

6.4. To support system leaders in delivering their ambitions to tackle health inequalities, Health Education England South East, in collaboration with PHE South East have commissioned Professor Sir Michael Marmot's team at the Institute of Health Equity, UCL to deliver a health inequalities programme to support ICSs across the region. Each ICS to nominate a team of 5 senior candidates to participate in the 13-week programme.

6.5. The Population Health and Prevention Group have endorsed the approach outlined within this discussion paper, noting that:

- The plan should support, enable and facilitate local action on health inequalities, pulling together and connecting existing programmes of work. The aim of the strategic action plan is not to coordinate work already in train to harness, add value and share learning;
- We recognise there is a direct relationship between deprivation and health inequalities and therefore the 2 priorities are interlinked.
- There are interventions already being successfully implemented at a local level that could be rolled out at scale. The action plan should highlight and promote these initiatives.

7. Next Steps

a) Subject to the Joint Board views on the proposed priority areas of mental health and wellbeing and deprivation, to begin working with colleagues across system to understand what programmes of work are already in place or in train, where we may have gaps and where joint action across the system would have the greatest impact;

b) Nominated senior leaders and system sponsors to attend the Health Education England commissioned health inequalities programme to support ICSs in the South East to deliver their ambitions to tackle health inequalities, delivered by the Institute of Health Equity;

c) To finalise the population health management roadmap, including the spread and sustain plan and rollout of the next phase of the PHM programme, by April 2022.

8. Recommendations

8.1. The Joint Board is asked to:

i. Consider the proposed priority areas for a system-wide health inequalities strategic action plan, based on output from recent system-wide workshops, the PHM development programme and national CORE20PLUS5 initiative.

ii. Agree that co-production should be a key principle underpinning this action plan and that local communities should be involved in its design and delivery.

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Background papers

- Feedback from the Health Inequalities Workshop held on June 10 2021 and Next Steps, Kent and Medway Joint Health and Wellbeing Board,16/09/2021

- Strategic plan to mitigate the impact of COVID-19 on health inequalities: Progress update, Kent and Medway Joint Health and Wellbeing Board, 10/03/2021

- Proposal to develop a strategic plan to mitigate the impact of COVID-19 on health inequalities, Kent and Medway Joint Health and Wellbeing Board, 17/09/2020

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