KENT AND MEDWAY
JOINT HEALTH AND WELLBEING BOARD

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Feedback from the Health Inequalities Workshop held on June 10 2021 and Next Steps

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Summary
This report sets out the key findings from the Health Inequalities workshop held on the 10 June 2021 and proposes the next steps in the development of a Health Inequalities Action Plan for Kent and Medway Integrated Care System for approval by the Kent and Medway Joint Health and Wellbeing Board.

1. Introduction

1.1 On 17th September 2020 the Kent and Medway Joint Health and Wellbeing Board (The Joint Board) agreed to hold a development session about the emerging impact of Covid 19 and the wider health inequalities found in Kent and Medway. The development session took place on June 10th, 2021 and included the members of The Joint Board and the members of the Integrated Care System Partnership Board, bringing together the widest leadership of the Kent and Medway Integrated Care System for the first time.

1.2 The session was used as 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. It was agreed that the System would develop agreed priorities out of the learning from that day and with further analysis and consideration.

1.3 This paper sets out next steps to consider our priorities. A Kent and Medway health inequalities action plan will then be developed to reflect areas of focus agreed by the Board and the wider system.

2. Background

2.1 As was set out in the paper on 17th September 2020 Covid 19 has impacted on our citizens and our workforce in ways that are becoming clearer. Certain populations have been affected more than others, such as people from black and minority ethnic backgrounds. Other issues are also known to have a

bearing on health inequalities. These include gender and age. People with underlying health conditions, for example diabetes, asthma and cardiovascular disease are known to have experienced worse physical and emotional outcomes during the pandemic. What is clear is that the wider determinates, poverty, housing conditions, job insecurity and worklessness, have played a pivotal role in terms of increasing inequalities during the pandemic. Some people are facing job loss, debt and homelessness, whilst others are facing new or more serious mental health illness. Our workforce has been tremendous in responding to the demands of the pandemic, but has faced traumatic and challenging events, particularly our front line health and social care staff. So, whilst there have always been health inequalities in Kent and Medway, the effect of Covid-19 will be to exacerbate and increase the inequalities experienced by our population.

2.2 Covid 19 response measures have also led to some services being stepped down. We know that latent demand has developed in the population. This could lead to poorer health outcomes as a result of delayed cancer screening, loss of herd immunity and an increase in vaccine preventable diseases arising from a reduction in population coverage of routine child and adult vaccination programmes. There will likely be an effect associated with the postponement of elective care procedures, or through people not accessing routine primary care for fear of visiting their GP during the pandemic.

2.3 Health inequalities are caused by much more than an individual's actions or access to traditional health care. Green spaces; social activities; education and employment opportunities; healthy food; good housing and transport services all play a hugely important role, and all have been disrupted by the pandemic.

2.4 The Kent and Medway Joint Health and Wellbeing Board remains in the unique position of having a wide partnership membership. Its purpose includes promoting health integration and supporting partners to address health inequalities.

2.5 In light of this the Joint Board agreed to take the broadest view of its purpose and to place an unrelenting focus on health inequalities. This includes more focus on children and young people, those with a learning disability, autism or mental health problems and those environmental and lifestyle factors (the wider determinants of health- such as housing, employment and education) that have the greatest impact on health outcomes.

On 17 September 2020 the Joint Board agreed to:

i. 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.

ii. hold a development session to better understand the emerging impact of Covid-19 and the wider health inequalities found in Kent and Medway to inform the plan. This took place on June 10th 2021.

iii. the Executive Director of Strategy and Population Health for Kent and Medway CCG being the lead officer for this work on behalf of the Joint Board, informed by the Public Health Directors of both Medway and Kent.

3 Outcomes of the Workshop: Key Findings

3.1 The content of the workshop set out the current headlines about Health Inequalities in Kent and Medway. Health inequalities are caused by many factors, most of which are beyond the gift of the individual to change.
COVID has shone a light on health inequalities and made them worse, but health inequalities will not simply disappear once COVID is over. Potentially, inequality gaps will widen as we emerge from the epidemic, with disadvantaged communities having disproportionately suffered from its impact.

3.2 In summary the workshop highlighted that:

a) Living in a deprived area negatively affects your health and wellbeing:
- If you live in the most deprived ward in Kent you are likely to die before someone who lives in the least deprived. In the most extreme case, there is a 25-year age gap between the average age of death for the least deprived and most deprived in our area.
- You are more likely to go into hospital as an emergency case if you live in a poorer ward. For example, there are more emergency admissions for chronic obstructive pulmonary disease and stroke for people in more deprived areas.
- You are more likely to have more than one thing wrong with you i.e. Diabetes AND high blood pressure if you live in a more deprived area.
- As deprivation increases school examination attainment decreases. Children from poorer areas receive far lower grades than those in less deprived areas.
- If you live in a deprived area, you were more likely than those living in more affluent areas to die from Covid

b) However not all inequality is related to poverty:

- If you have a mental illness, you are more likely than the general population to have a physical illness and to die younger.
- If you grow up and have experienced more than 4 adverse childhood events- such as parental separation, any kind of mental or physical abuse or experienced mental health problems - you are more likely as an adult to go on to use drugs, become involved in violence or go to jail than a child who has had no or fewer adverse experiences.
- The increase in mortality compared to before COVID was greater in people who were from Black and Asian minority ethnic backgrounds.

- If you eat a poor diet, smoke or drink too much alcohol or take drugs you are more likely to develop a preventable illness and your long-term health and wellbeing will be severely affected.

3.3 The workshop emphasised that life chances of individuals are severely impacted by the inequalities they face in their lives. Tackling the root causes of inequality is the right thing to do for any public sector organisation involved in serving, supporting and championing their communities. However, it will also provide wider benefits not just to the individuals affected but to wider society as there is an economic burden to be borne, not only in the costs of health and social care but also in years of working life lost to ill health and disability.

3.4 It must be recognised that not all the solutions to tackling inequalities are in the hands of local public sector organisations. National approaches are also needed to deal with income and benefits, planning and infrastructure, air quality and emissions, food quality and sugar content etc. But there is no doubt that there are opportunities through the power of our wider partnership to do more together and to focus unrelentingly on the things we can change to tackle d disadvantage in our community.

3.5 Reflections from system leaders on the event

a) Leadership

- Leadership is vital, however it has to be system wide and all recognised as equal partners to ensure this works well in order to ensure the best outcomes

- We need a sustained commitment to this and we must use our span of influence

- Deciding where to put resource is key. We need to be clear and confident in what we want to achieve.

- We need to challenge ingrained adverse culture and understand the importance of place-based context and know and act on how people could be empowered.

- Involving the local community is a key part of a number of the key points we have raised today.

- Find one small thing that we can do together (with thought and based on data) and DO IT!

- Focus on staff inequalities as much as community inequalities.

b) Areas of Priority for system working

- Collectively driving cultural change and holding each other to account.

- Using and understanding our own data and developing it to give us better access across the whole system.

- Focus on mental health and multi-morbidity

- We know the interventions that work, we need to do them at scale. The selection of interventions and how they are implemented needs to be worked out within the community.

- Our leadership needs to be aligned across all levels – we need to commit to that alignment and hold each other to account.

- We need to both enable local pilots with multiple partners including voluntary sector, while building in the right enablers to scale things across the whole system – can't do one without the other.

- Get together as leaders around the shared purpose more often and trigger the conversations in our own organisations.

- We need to build health inequalities into our agenda and take a more integrated, proactive approach to our business to incorporate action to address health inequalities.

4. Next steps

a) To capitalise on the energy and motivation expressed by those senior leaders who attended the workshop.

b) To feed the outputs and views from the health inequalities workshop into the population health management (PHM) programme to develop a system wide understanding of the leadership required to make the best of this learning and development programme opportunity.

c) To support the new programme of work that launched on 22 July 2021 looking at PHM and how, as a system we understand and plan health and care services for our communities. This is a 22 week externally supported programme which works with each tier of the system to link local data, build analytical skills to find at risk cohorts and design and deliver new models of care. The aim of the programme is to accelerate changes to care delivery to achieve better outcomes and experiences for selected populations and secure the skills to spread the approach to other cohorts. Please see Appendix 1 for the structure of the PHM programme and the priority cohorts identified.

   This is a whole system programme, and the Directors of Public Health from Kent and Medway are joint chairs of the Kent and Medway Population Health and Prevention Group. The programme is being managed by the Strategy and Population Health Team in the CCG and local authority officers as well as Members are engaged in the programme.

d) It is important that the learning from this programme influences the priority setting for the Health Inequalities Action Plan and the two link together to provide a coherent strategic approach for joint planning and working going forward.

5. Recommendations

The Joint Board is asked to agree to receiving a discussion paper at the December meeting of the Joint Health and Wellbeing Board that sets out the learning from the PHM programme and the proposed priority areas for the health inequalities action plan to focus on

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Appendices
Appendix 1 – PHM 22 week programme structure & priority cohorts