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NHS
North East & North Cumbria

REPORT CLASSIFICATION	✓	CATEGORY OF PAPER	✓
Official	✓	Proposes specific action	✓
Official: Sensitive Commercial		Provides assurance	
Official: Sensitive Personal		For information only	

BOARD MEETING 1 JULY 2022	
Report Title:	**Health Inequalities and Sustainability: a call to action for the North East and North Cumbria Integrated Care System**

Purpose of report

To present an overview of the current health inequalities faced by communities across the North East, and to propose that the Integrated Care Board (ICB) undertakes a review our current coordination arrangements for reducing health inequalities across our system.

To make recommendations to the ICB and ICP for the formation of a multi-agency expert advisory group to drive this work going forward. Such a group would draw on the skills of key partners across our ICS to provide strategic leadership, support, challenge across the system to shape an inequalities strategy for the ICS and ensure the delivery of key local and national priorities.

Key points

Include the following:

- The ICB meets for the first time against the backdrop of persistent health inequalities and a growing cost of living crisis for our communities.
- As a system we have made limited progress in tackling some of these challenges, but the formation of the ICB and ICP presents an opportunity to review current arrangements and galvanise more effective joint action.
- This paper has not been discussed previously.

Risks and issues

- The persistence of health inequalities, and the cost of living crisis, presents a serious risk to the health and wellbeing of all of our communities, and will contribute to the rising demand for health and care services unless we can respond effectively as a system.

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Assurances	
• The proposed review of our system-wide approach to health inequalities will need to be directly accountable to the ICB so that the board is assured that this work is comprehensive and well-designed, with a clear remit and areas of focus.	
Recommendation/Action Required	
Our recommendation is therefore to convene a task and finish group to review our current coordination arrangements for reducing health inequalities across our system, and to make recommendations to the ICB and ICP for the formation of a multi-agency expert advisory group to drive this work going forward. Such a group would draw on the skills of key partners across our ICS to provide strategic leadership, support, challenge across the system to shape an inequalities strategy for the ICS and ensure the delivery of key local and national priorities.	
Sponsor/approving director	Claire Riley, Executive Director of Director of Corporate Governance, Communications and Involvement (Designate)
Report author	Dan Jackson, Director of Governance and Partnerships

Link to ICB corporate aims (please tick all that apply)	
CA1: Improve outcomes in population health and healthcare	✓
CA2: tackle inequalities in outcomes, experience and access	✓
CA3: Enhance productivity and value for money	
CA4: Help the NHS support broader social and economic development	✓

Relevant legal/statutory issues						
Note any relevant Acts, regulations, national guidelines etc						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	✓	**N/A**	
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**	✓	**N/A**	
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**	✓	**N/A**	

Key implications	
Are additional resources required?	The review work proposed in this paper can be carried out within existing resources.

Has there been/does there need to be appropriate clinical involvement?	We will include appropriate clinical representation within the membership of the review group.
Has there been/does there need to be any patient and public involvement?	We will need to ensure the recommendations of this work draws on the insight of our patients and public.
Has there been/does there need to be partner and/or other stakeholder engagement?	Yes, there needs to be multi-sectoral stakeholder engagement in the development of this work.

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Health Inequalities and Sustainability: a call to action for the North East and North Cumbria Integrated Care System

1. Context

1.1 The formation of a statutory Integrated Care Board (ICB) is an exciting milestone in the ongoing development of our integrated care system. But our first board meeting is being held against the backdrop of some stark challenges facing the communities that the ICB is proud to serve. Inflation in the UK has just hit a 40-year high of nine per cent, and the cost of household utilities alone rose by an average of £700 in April. A cost-of-living crisis and rising levels of fuel poverty will put enormous pressure on the health and wellbeing of families across the North East and North Cumbria who were already living with the impact of the covid-19 pandemic and the ongoing challenges faced by the regional economy.

1.2 Our covid-19 experience showed us that inequalities in health and their causes run deep through our society and through how people access, experience and receive care from the NHS. This is why it is crucial that we embed NHS England and NHS Improvement's 'Core20plus5' approach to health inequalities – a focus on 20 per cent of the population in the lowest deprivation quintile alongside a focus on other local inequalities and the five clinical priorities in the NHS Long Term Plan – and why there needs to be a mix of patience and impatience in seeing it through – recognising some things will take time to work but understanding that many have waited a long time to receive truly equitable health care.

1.3 Given the size and scale and influence of our ICB, alongside it's spending power and reach into our communities, we have the tools at our disposal to tackle what is clearly the biggest collective challenge our communities have ever faced.

2. Changing demands on health systems

2.1 Our ICS is being developed in the context of rapidly changing demand. The nature of how and where care is provided is never static - whether that is in hospitals, community settings, or GP surgeries. For example, many operations and treatments that would previously have needed long recovery in bed are now routine, done in a day, and carried out in local hospitals, or primary care settings.

2.2 Patients now have access to a wider range of treatment, using new technology, techniques and medicines, and provided by a changing workforce who have new skills and expertise. Positive outcomes have increased, with more people living longer and healthier lives, often as a result of personalised support for long-term conditions and more successful treatment for serious illness or injury.

2.3 How we manage the increasing number of frail elderly people in our population, often with multiple cognitive and medical issues, and complex social needs, including balancing provision between social care in residential and community settings, is a growing challenge. This group present a challenge to both social care and health, which manifests as increased and unmet need in the community with

repeated and prolonged episodes of hospitalisation that may not always be appropriate.

2.4 We need to get much better at sustaining health and well-being among older people and if they do become unwell, ensuring that we can optimise their recovery. Spending less time in hospital is better for patients' recovery and we know most people prefer to be cared for at home if possible. New technologies and ways of working allow this to happen more easily, which also means a greater need for social care and community health services to be coordinated, and new approaches to prevention and wellbeing, patient-centred care and integration of services across all health settings.

2.5 We are also home to some of the most rural and isolated communities in England, alongside densely populated urban areas in the former industrial heartlands. While technological developments and new delivery models will help us to deliver equitable care across a varied range of urban, coastal and rural areas, meeting these challenges will mean working smarter as an integrated health and care system to deliver outstanding care and the best possible outcomes for our local communities.

3. The challenge of poor health outcomes in the North East and North Cumbria

3.1 Across our ICS area we are proud of our high quality and frequently high performing public health, health and care services. We have a strong recent legacy of innovation and partnership working that yielded reductions in some aspects of health inequalities such as teenage pregnancies, smoking prevalence, and mortality from cardiovascular disease. Yet whilst the quality of some of our health and care services has been amongst the best in the country we are still not making fast enough improvements in improving the overall health of our population, driving much of the pressure that health and social services struggle to manage, so we know things need to change.

3.2 Despite relatively small pockets of prosperity, much of the poor health in the North East and North Cumbria is driven by a century of declining prosperity, and the difficult economic transition that followed the demise of the heavy industries that once dominated this region. This means that life expectancy is much lower here than in the rest of England, where the averages are 79.6 for men and 83.1 for women, compared to 77.9 and 81.6 respectively in our region.

3.3 These averages mask the variation and inequalities that exist within the region with some communities having a reversal of the life expectancy gains experienced by others. One third of our GP registered population live in the 20% most deprived areas and over 50% in 30% most deprived areas. This is why focusing on the 20% most deprived communities as required by the Core20Plus5 will require significant effort and resources, because such poverty across our ICS translates into greater demand from our most deprived communities for urgent and emergency care health services.

3.4 Furthermore, healthy life expectancy (HLE) in the North East and North Cumbria is way behind the rest of the country with significant variation within our ICS. Indeed, closer analysis reveals that 9 of the 13 local authorities within NECN ICS have an average HLE, for both men and women, of under 60. In the entire south of England including London, there are only 4 out of 67 such authorities.

3.5 The North East has the highest levels of preventable mortality in the county – 23% higher than the national average (182 per 100,000 nationally – 223 per 100,000 in the North East and North Cumbria). Our cancer rates are higher than any other English region (78.0 per 100,000 nationally – 92.8 per 100,000 in the North East and North Cumbria); we have the second highest rates of cardio-vascular disease and liver disease in the country, and our rates of respiratory disease are 42% higher than the national average.

3.6 Men in our region spend almost a quarter of their lives in ill health (20.3% England average – 23.6% in the North East and North Cumbria), and women spend over a quarter of their lives not in 'good health' (23.3% England average – 26% in the North East). The frailty of our elderly population is also a major challenge, with hospital admissions due to falls and hip fractures in people aged 65+ significantly higher than the England average.

3.7 Many of our persistent health challenges can be attributed to tobacco, alcohol and the use of opioids. Indeed, deaths from drug misuse are the highest in the country combined with one of the worst rates of successful completion from drug treatment. Alcohol and drug misuse are risk factors for violence, and Hospital admissions for alcohol related conditions are significantly higher in the North East where 1 in 5 adults are estimated to binge drink, higher than the national average, and increasing the risk of alcohol related harm. 15% of our population are current smokers, significantly higher than the England average, with over 326,000 estimated smokers in the region. Over 33,000 hospital admissions were estimated to be attributable to smoking in 2019/20, and premature births that are linked to smoking are higher than the national average.

3.8 This must also be seen alongside the climate crisis, for approximately 30% of preventable deaths in England are due to non-communicable diseases specifically attributed to air pollution. By tackling air pollution Integrated Care Systems can help reduce health inequalities in communities across the region. Our providers are doing much to tackle air pollution from travel by promoting digital consultations, active travel, and electric transport (public, shared and private), as well as mass tree planting on their estates. Some of our Trusts are even exploring the use of drones to transport medical specimens. Many of these activities will also save time and money for the NHS and patients, and the ICS is supporting the Clean Air Hospital Framework to share best practice.

4. How we are tackling health inequalities

4.1 We have already included specific actions to address health inequalities have been included within each section of our strategic five year plan. We have developed a confirm and challenge process for health inequalities to support our ICS priority

workstreams to place health inequalities front and centre of their approaches and workplans. This utilises a checklist aligned to the national Health Inequalities 'Well Led Framework', Core20Plus5 and the NHS Providers Board assurance toolkit for health inequalities.

4.2 Our Directors of Public Health and their teams play a key role both within local authorities at place and across our ICS, with representation on our ICB itself, and by steering the work of our Prevention Board. Their work sits alongside the additional capacity we have put in place across the NHS system with one example being the recruitment of Trust-based Consultants in Public Health roles to provide specialist leadership, support, and challenge for local NHS providers and across the organisations. As well as providing public health leadership within NHS organisations, they also work closely with the Association of Directors of Public Health network which is a key forum within our ICS area.

4.3 We have developed several ICS priority area performance dashboards that proactively identify areas of high deprivation, BAME, age-sex adjustment etc that reflect of utilise the national and regional heath inequalities tools to monitor progress and delivery, and to understand specific geographical challenges. These sit within an overarching compendium of health inequalities dashboards.

4.4 We are proactively supporting our Primary Care Networks to adopt a population health management approach to identify their priority population groups. Using analysis and insight to understand specific demographical challenges in need and access across specific groups to enable targeted delivery models tailored to anticipated shortfalls. Reasonable adjustments are made to how services are promoted, delivered, and evaluated to accommodate these vulnerable groups, considering where personalised care approaches can be beneficial.

4.5 Our 'RAIDR' health intelligence tool (developed locally by NECS, our care system support provider) underpins our approach to population health management using advanced analytical techniques which link and aggregate data to provide comprehensive cohort analysis. RAIDR is currently under development to create a new cardio-vascular disease prevention tool, providing high level information on our population profiles.

4.6 These tools are helping us to understand our Core 20 and supporting condition specific analysis such as that for respiratory conditions, expanding our knowledge in relation to the 'Plus 5'. We have also developed ‘Axiom’, our data system providing access to a wide variety of health, care and other data to health and care staff for planning, redesign, operational reporting and for population health management.

4.7 We have excellent examples where Trusts are starting to include the Index of Multiple Deprivation (IMD) quintile in several key data sets and reports, to monitor performance of services including the development of the ICS Preparing Well Dashboard to support elective recovery which will be rolled out across the ICS. Development and implementation of additional indicators to monitor inclusiveness of restoration plans using indicators of vulnerability and or disadvantage

(performance indicators are being developed for monthly NHS reporting to include deprivation (patients from the 20% most deprived neighbourhoods) and ethnicity.

4.8 Our North East and North Cumbria 'Deep End programme' focuses predominantly on the 'Core 20 Plus' and is a key priority area across the ICS area due to levels of deprivation. The Deep End programme has developed a population health management approach to consider the impact of health inequalities on health resource utilisation. This is being shared nationally as an influence to primary care payment algorithms.

4.9 Directed through the Health Inequalities Advisory Group work continues to identify our 'plus' communities. We are currently developing specific profiles for severe mental illness, learning disabilities, BAME, carers, substance misuse, homeless, Gypsy, Roma and Traveller communities, asylum seekers and refugees. Consideration to an understanding of 'double jeopardy', intersection of medical and social factors and multiple vulnerabilities is being given supported by the population health analytics and infrastructure where possible.

5. A call to further action

5.1 Although there are reasons to be optimistic for our ICS area, not least through the determined efforts of our local and combined authorities, as well as the education and business sectors, which has led to well-performing schools, increasing skill levels, and strengths in tech, digital, pharmaceuticals and life sciences, energy and offshore, and major employment in financial and professional business services sectors.

5.2 We also have world class universities and research and development capacity, with over 100,000 students and expertise that supports our industrial strengths. Alongside this we have an incredible diversity of natural, environmental, heritage and cultural assets – spanning city, coast and countryside. To achieve our ambitions, we must make the most of these unique assets and opportunities, while addressing our challenges and move us further towards a low-unemployment, high-wage economy.

5.3 But as an ICB we must be clear-eyed about the challenges our communities face, and tenacious in the pursuit of improved outcomes, using the leverage that our size, reach and spending power can bring to the table. We know that treating the symptoms of poor health is no substitute for tackling their cause.

5.4 So alongside the delivery of healthcare and the joint work we do with public health colleagues on prevention of avoidable illness, we know that we can make a significant contribution to the regional economy. For the NHS is more than just a healthcare provider; we hold a much wider role in ensuring the economic, social and environmental well-being of all our local communities. With a combined budget of almost £6bn, NHS organisations play a key role as vital ‘anchor institutions’ whose workforce and buying power are hugely significant factors in the local economy.

5.5 Anchor institutions are large organisations that are unlikely to relocate and have a significant stake in their local area. They have sizeable assets that can be used to support their local community's health and wellbeing and tackle health inequalities, for example, through procurement, training, employment, professional development, and buildings and land use. Health and care organisations acting as anchor institutions can have a positive impact on local communities in two main areas: the local economy and the environment. Health and social care organisations can reinvest in their local areas by giving local suppliers greater weight in procurement processes, which in turn can create new employment locally. Legislation, in place since 2013, requires social value (defined as 'economic, social and environmental wellbeing in connection with public services') to be considered in the design of some contracts, and in the NHS, there will be a mandatory 10 per cent weighting for social value in all NHS procurement from 2022.

5.6 We therefore have a huge opportunity to contribute both to improving population health and well-being, whilst also tackling the wider socio-economic determinants of health, including child poverty, substance misuse and economic exclusion, that have such an impact on the communities that we serve. We are already taking positive steps towards increasing employment opportunities for local people in the health and care system, working with schools and colleges so that our young people aren't driven to leave the area to build their careers and increasing volunteering and apprenticeship opportunities to support more local people into work.

5.7 We are also committed to playing our part in tackling climate change and carbon reduction, with many of our Trusts and Local Authorities having already declared a 'climate emergency', in recognition of the benefits both to the environment, and to local people through better air quality and increased access to green space in our communities. As a system we are committed to developing a consistent approach with our partners in the public and voluntary sectors to sustainability, recycling and carbon reduction across all NHS organisations.

6. Responding as a Whole System

6.1 The North East and North Cumbria is home to world class health and public service assets and has shown through our response to pandemic innovation, proactive delivery and the ability to rapidly mobilise as a whole system. Our communities (and the organisations supporting them) have shown resilience, innovation and a sense of togetherness and support, with a focus on vulnerable individuals and communities.

6.2 As a region our we came together in the pandemic to request additional action and make difficult decisions on social restrictions. This allowed us to weather the lockdown with many of our communities showing significantly lower levels of infection than many parts of the country. Strong collaboration between NHS and Local Authority partners allowed us to make good judgements about system capacity, resource allocation and the ways in which we would seek to improve our local arrangements.

6.3 We need to learn from how rapidly we mobilised as a system in response to covid-19, and apply the same principles to how we respond to the endemic challenges of health inequalities, so that the multiple groups working in this field can coalesce and influence more widely the policy decisions made by the Integrated Care Partnership and Integrated Care Board, as well as their constituent organisations, learning from each other for the good of the population and how also we mobilise and play our part as an NHS statutory body.

7. Recommendations

7.1 Across the NENC ICS footprint we are proud of our high quality and frequently high performing health and care services. We have a strong legacy of innovation and partnership working that has delivered reductions in some aspects of health inequalities such as teenage pregnancies, smoking prevalence, and mortality from cardiovascular disease and myocardial infarctions.

7.2 However, despite very good NHS services that remain amongst the best in the country, as well as our strong partnerships, our health outcomes remain poor and our health inequalities within the ICS, and in comparison to the rest of the country, remain stubbornly high. These factors, plus a worsening cost of living crisis, need to catalyse determined joint action across our system.

7.3 We acknowledge that the causes of health inequalities are often driven by the social determinants of health, and action to address these are driven through our 13 Health and Wellbeing Boards. However, we recognise that the NHS is also uniquely placed to address inequalities in access, experience, and outcomes from the population we serve as well as in our contribution to tackle the social determinants of health as anchor institutions.

7.4 We are therefore committed to articulating where the NHS should lead, where we should collaborate or work in partnership with others and where we should advocate for changes to address inequalities.

7.5 We know that our system has the tools to make a significant difference in three broad areas: in policy and strategy, and how we hardwire tackling health inequalities into everything we do, giving our staff the analytical tools they need to make a difference, and target the right individuals and communities; in workforce and recruitment, building on the work of our NHS anchor institutions in each of our communities to support more local people into the health care workforce; and in procurement and sustainability, multiplying the impact our anchor institutions can make as a system, and driving forward an ambitious programme of joint action to help us achieve net zero and a greener NHS.

7.6 Our recommendation is therefore to convene a task and finish group to review our current coordination arrangements for reducing health inequalities across our system, and to make recommendations to the ICB and ICP for the formation of a multi-agency expert advisory group to drive this work going forward. Such a group would draw on the skills of key partners across our ICS to provide strategic

leadership, support, challenge across the system to shape an inequalities strategy for the ICS and ensure the delivery of key local and national priorities.

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