APPENDIX A

LEICESTER, LEICESTERSHIRE AND RUTLAND SYSTEM HEALTH INEQUALITIES FRAMEWORK

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

Contents

Foreword

Health inequalities across Leicester, Leicestershire and Rutland (LLR) are stark. A boy born today in the most deprived area of LLR could be expected to die up to 8.7 years earlier than a boy born in the least deprived area. The difference in the proportion of a person's life lived in good health is even more marked – again, with those from less affluent areas spending a greater proportion of their (often shorter) lives in poor health compared to people from more affluent parts of our area. In acknowledging this, we also must accept that the above facts refer only to the extreme poles of what is a distribution of effects throughout the whole population. This is not an issue affecting only the least affluent in our community. Health inequalities affect almost everyone living in LLR to some degree and therefore it will be the business of everyone in our system to take action to reduce these unfair and avoidable differences in health outcomes.

We have known about health inequalities for a long time now and individual partners have been making efforts to reduce them. The COVID-19 pandemic has laid out in stark focus the depth of the inequalities that exist and the devastating impacts they can have on our families and communities. As we come together in LLR as an Integrated Care System, one of our central roles and duties is to implement the evidence-based actions needed to increase health equity in our society and reduce or eliminate health inequality. We want the people of LLR to be healthier with everyone having a fair chance to live a long life in good health. This is why we will aim to "level up" services and funding, rather than take anything away from areas where outcomes are already good.

This framework sets out how we plan to take action, both collectively and through specific organisations to positively impact not just the direct causes, but the "causes of the causes" of these differences. Some work, therefore, will fall to the NHS to do, some mainly to other partners such as local authorities or other public sector bodies, and some to joint working at system, place or neighbourhood. Often this is not something one organisation can do on their own – it requires the system to work together to act as anchor institutions – using their collective resources and working with the voluntary and community sector to make a difference.

We are delighted that this document reflects the pooling of ambitions and contributions from a very wide range of partners in LLR. The onus now on all of us is to play our part in turning ambition into effective action. We know that can only happen if we listen to local people and work with the strengths and assets we have as a basis for a fairer and healthier future for us all.

2. 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 acrossLLR
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.

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 thesebenefits.
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]

[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.

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)

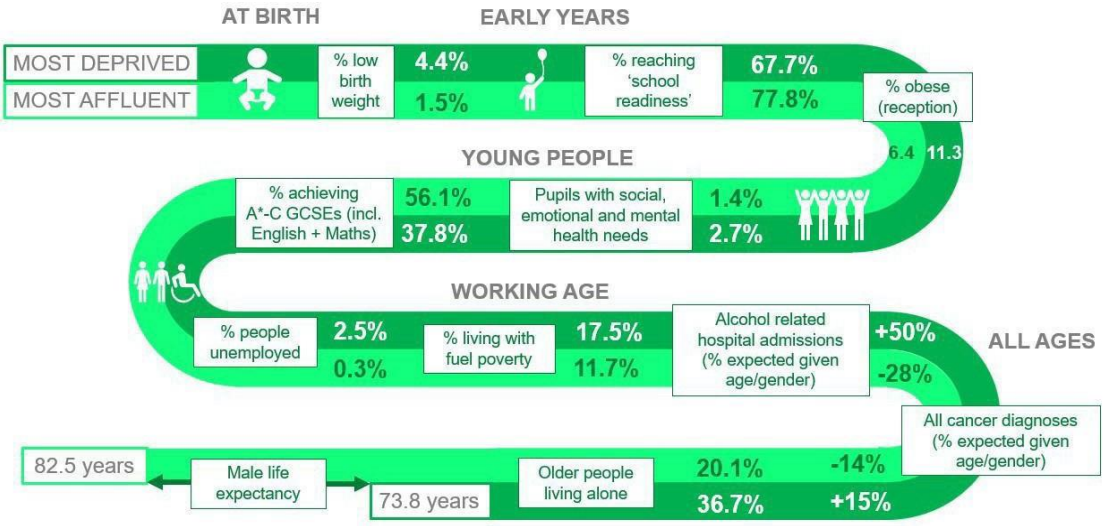
Figure 1 shows, on the top line, four people of different sizes all trying to cycle the same size of bicycle. One person in a wheelchair cannot use the bicycle at all. The second line shows each person happily using a bicycle correctly sized or adapted for their needs.

Growing evidence indicates that in the first three years of life, a host of biological (e.g., malnutrition, infectious disease) and psychosocial (e.g., maltreatment, witnessing violence, extreme poverty) hazards can affect a child's developmental trajectory and lead to increased risk of adverse physical and psychological health conditions. Such impacts can be observed across multiple systems, affecting cardiovascular, immune, metabolic, and brain health, and may extend far beyond childhood, affecting life course health

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. This is demonstrated within the case studies provided in appendices 1 and 2. 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.

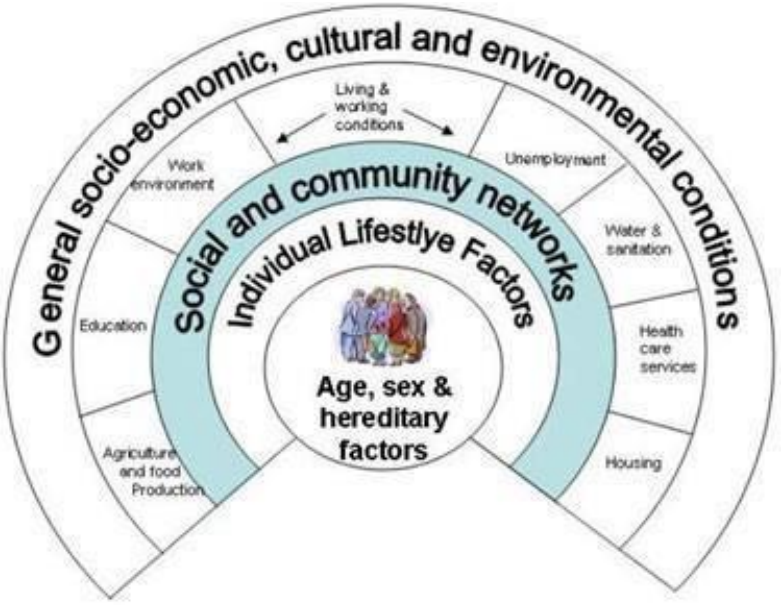
This graphic shows two parallel curving lines – the top line showing the outcomes for those from the most deprived areas in LLR. The bottom line shows the outcomes for those born in the most affluent areas. Small text boxes show differences in life expectancy, school readiness, academic attainment, employment, 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 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. We will explore the possibility of having our principles of approach and programme of actions at system level in LLR recognised as aligning to the principles embodied in the work of Professor Michael Marmot – and that we may, in time, seek be recognised formally as a "Marmot System".

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

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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]

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. In addition we will seek to maximise the value of our collective spending on the local economy.

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.

Principle 7

We will use data and insight – both quantitative 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.

[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]

[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 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 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 even 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 1,001 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 care for Black and Asian women and those from deprivedneighbourhoods)
5. Strengthen leadership and accountability

[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]

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.
The 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 by30.11.21
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 andpoverty
- 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 systempartners.

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 by30.10.21
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 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

9. References

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10. Appendices

1. Case study on health inequalities - Professor Azhar Faroogi

Introduction of new technology to improve care in diabetes

The prescribing of Freestyle Libre (FSL) - a case study in health inequalities of service delivery.

Diabetes is one of the most common chronic disorders affecting nearly 5 million people in the UK.

It is a significantly more common condition in people of low socioeconomic status and in BME groups

Diabetes is a costly condition, not only in financial terms (consuming more than 10% of the NHS budget), but also in terms or mortality and morbidity. Sufferers lose several years of life and the condition is the biggest cause of acquired blindness, renal failure and amputations.

The evidence that good control of blood glucose improves outcomes for patients and reduces NHS costs is overwhelming.

Freestyle Libre is a new technology, known as flash glucose monitoring which allows patients to monitor in real time their blood glucose using a skin patch and a small handheld sensor. It avoids multiple lancet jabs and time-consuming use of glucose strips and machines.

The technology is approved by NICE for patients with Type 1 diabetes who normally would test multiple times a day and is likely soon to be extended to patients with type 2 diabetes on insulin and other groups deemed high risk of hypoglycaemia. There is a significant cost of around £500 per patient per year.

The real-world impact of this technology has shown significant improvements in blood glucose levels reduced hospital admissions and paramedic call outs, less severe hypoglycaemia and improved overall blood glucose control.

How was this technology rolled out?

The prescribing of FSL has been via secondary care to eligible patients who have an education session to allow them to use this technology.

The sessions which include an online module is in English.

As with all new technologies and treatments, patients learn about the availability of this via media and friends and those most empowered, clearly would know about it first. The patient benefit is not only in improved diabetes control but also the avoidance of painful finger pricks and the ‘Ferrari ‘or ‘latest iPhone’ effect of having new technology on show.

Therefore, it was entirely predictable that the most articulate, informed, and persuasive patients would be in a position to demand this technology and persuade their health care professional they are eligible and would benefit.

The criteria of existing multiple testing and the education package also favours English speakers, literate patients and those already empowered in looking after their condition, all of which make it less likely that people form deprived backgrounds would either push for this technology or be prioritised for it.

What has been the health inequality?
Given the above, it was entirely predictable that the inverse care law would apply in the supply of this important therapeutic intervention.

Data in Leicester Leicestershire and Rutland shows that in the bottom quintile of deprivation, Type I patients had a 29% chance of receiving this technology, compared to 39% of the top (least deprived) quintile (data from Abbot pharmaceuticals).

With respect to BME populations, practices with the most BME percentage by quintile, only 14% of type 1 patients received FSL, compared to 38% in those practices in the quintile with the fewest BME %.

Why has this happened?
It is interesting that this data was produced by the pharma company Abbot, who in effect, whistle blew the problem.

The local NHS service provider had no idea of this health inequality and in fact denied it was occurring.

There was no consideration of health inequalities in the introduction of this technology nor monitoring of uptake by deprivation or socioeconomic status.
Despite the data, little has changed on the provision of this technology to date.

Lessons to be learnt
It is important that a full equity impact assessment is done when all new technology (or therapies) are introduced.

It is important that monitoring of uptake by socioeconomic status and BME status as well as other characteristics is undertaken, and data reported and shared.

It is important to consider if specialist only provision will worsen health inequalities. Most type 1 patients (60%) and the vast majority of type 2 diabetics (95%) receive care only in general practice.

It is likely that appropriate primary care provision will improve wider access to this intervention.

Language is likely to be a significant barrier in addressing health inequalities in particular when a mandatory education package is only available in English.
Specific thought, investment and planning needs to take place to reverse this inequality of provision of FSL.

2. Case study on health inequalities – Dr Abbas Tejani

Samantha

Samantha is a 39-year-old single mother of three young children who live with her. She works at a local retail outlet on a 'zero hours' contract and is paid the minimum wage. Due to the unpredictable nature of her work, she has never attended for cervical screening as she struggles to book a convenient time. A few months ago, she noticed some spotting in between her periods and after intercourse. Initially she was a bit worried, but a close friend advised her not to worry, that she had something similar once and everything was fine.

A few weeks later Samantha began to experience worsening pelvic pain radiating through to her back. She attended the out-of-hours service who prescribed simple analgesics but after a while, the pain became too much to bear so she took sickness absence from work and presented to her GP, who also enquired about periods and Samantha admitted that she had been spotting for a number of weeks but thought that this was normal.

A vaginal examination carried out by the GP revealed a sinister looking cervix and hospital assessment on the 2-week-wait pathway confirmed an advanced cervical squamous cell carcinoma.

Over the subsequent weeks Samantha has had a vast number of appointments to discuss treatment options, starting chemotherapy and pre-operative assessment for surgery. This has meant that Samantha has had to leave her job and apply for benefits. Cashflow has become a big obstacle, as she needs to organise childcare whilst she attends the hospital, the steroids she is given after chemotherapy stimulate her appetite and so she is consuming more food, and parking at the hospital is also very expensive. Samantha is considering selling her car to help pay for childcare and household bills as this is the only way she can afford to continue going through treatment. She is also struggling with symptoms of depression owing to the concerns about her health, as well as the wellbeing of her family, and she sees no light at the end of the tunnel.

Bernard

Bernard is a 60-year-old man who works as a CEO of a successful multinational company that was founded by his grandfather and father. He owns holiday homes in Spain and Italy and enjoys flying to France for dinner on Friday night. Bernard is very fit for his age and suffers with no medical conditions or symptoms. He has private medical insurance and receives a routine medical check-up every six months. He attended his latest check-up on Monday morning and at 5pm on the same day, he received a call from the private clinic to advise that his PSA was mildly elevated. He was booked in to see a private urologist the following morning and at this appointment, a TRUS biopsy was taken. On Thursday, he received the results that he had the early stages of prostate cancer and he commenced hormonal injection therapy on Friday.

As the CEO, he can take off as much time from work as needed and has no financial concerns. Should his health deteriorate, Bernard can rest assured in the knowledge that he has a lucrative income protection plan, multiple assets he can liquidate, an enviable pension pot and no outstanding debts or mortgages.

Critique of cases

We have taken an example of two patients who live only 20 minutes apart, one in a deprived area and another in one of the most affluent parts of the UK. We know from the Marmot Review 2010 that people living in the poorest neighbourhoods in England will die seven years earlier than those living in the richest neighbourhoods. In addition, not only do those living in poorer areas die sooner, they also spend on average 17 years more of their lives living with disability. Health inequalities arise from a complex combination of factors, including housing, income, education, social isolation and disability. Health inequalities are largely preventable, and it is estimated they cost the UK £36-40 billion annually.

We know that disadvantage starts before birth and accumulates throughout life. Sir Michael Marmot summarised six key recommendations to reduce health inequalities as part of his review, including:

1. Giving every child the best start in life
2. Enabling all children, young people and adults to maximise their capabilities and have control over their lives
3. Creating fair employment and good work for all
4. Ensuring a healthy standard of living for all
5. Creating and developing sustainable places and communities
6. Strengthening the role and impact of ill-health prevention.

With this in mind, we can understand why Samantha and Bernard's experiences were so different. Samantha was born into a single-parent household and has four other siblings. Her mother worked in a low-paid manual job and education was not a focus in her childhood, nor through adolescence. She left school at the age of 16 years-old and has worked manual jobs earning minimum wage for most of her life. Her social network includes people from similar backgrounds with variable healthcare beliefs.

By contrast, Bernard was born into a wealthy two-parent family and has one other sibling. He received private education throughout both primary and secondary school, as well as a personal tutor during exam season. Bernard attended university and completed both undergraduate and postgraduate degrees and has worked for the family business for all his working life. He has a good understanding of his body and health, and a lot of his close friends are doctors, which gives him an opportunity to understand more about Medicine and to seek friendly medical advice.

Samantha faced several barriers in seeking help early, which Bernard did not. Neither Samantha, nor her friend, understood the significance of her symptoms and she received false reassurance. Samantha worked in an unpredictable environment and so could never pre-book a smear test Monday to Friday 09.00-17.00. Samantha has also struggled to pay parking expenses to attend hospital appointments.
Samantha could have been served better by promoting important warning symptoms of cervical cancer, as well as providing smear test appointments outside of core working hours (for example, evenings and weekends). The removal of/support with costs such as parking charges in hospital car parks would have reduced the financial strain her treatment has placed on her whole family. Living in an integrated care system with health inequalities at the heart of decision-making will mean that children like Samantha can be identified and supported earlier on in, and throughout, life.

Midlands and Lancashire
Commissioning Support Unit

Stage 1 Equality, Health Inequality Impact and Risk Assessment

- **Title of Assessment:**
  Leicester, Leicestershire & Rutland (LLR) Health Inequalities Framework 2021 - 2024

- **Person Responsible:**
  Steve McCue, Senior Strategic Development Manager, LLR CCGs
  Mark Pierce, Head of Population Health Management, LLR CCGs

- **Service Area:**
  Strategy & Planning Directorate, LLR CCGs

- **Overview of proposal, policy, service etc:**

Health inequalities across Leicester, Leicestershire, and Rutland (LLR) are stark. A boy born today in the most deprived area of LLR could be expected to die up to 8.7 years earlier than a boy born in the least deprived area. The difference in the proportion of a person's life lived in good health is even more marked – again, with those from less affluent areas spending a greater proportion of their (often shorter) lives in poor health compared to people from more affluent parts of our area. In acknowledging this, we also must accept that the above facts refer only to the extreme poles of what is a distribution of effects throughout the whole population. This is not an issue affecting only the least affluent in our community. Health inequalities affect almost everyone living in LLR to some degree and therefore it will be the business of everyone in our system to take action to reduce these unfair and avoidable differences in health outcomes.

We have known about health inequalities for a long time now and individual partners have been making efforts to reduce them. The COVID-19 pandemic has laid out in stark focus the depth of the inequalities that exist and the devastating impacts they can have on our families and communities. As we come together in LLR as an Integrated Care System, one of our central roles and duties is to implement the evidence-based actions needed to increase health equity in our society and reduce or eliminate health inequality. We want the people of LLR to be healthier with everyone having a fair chance to live a long life in good health. Therefore, we will aim to "level up" services and funding, rather than take anything away from areas where outcomes are already good.

The Leicester, Leicestershire and Rutland (LLR) Health Inequalities Framework sets out how we plan to take action, both collectively and through specific organisations to positively impact not just the direct causes, but the "causes of the causes" of these differences. Some work, therefore, will fall to the NHS to do, some mainly to other partners such as local authorities or other public sector bodies, and some to joint working at system, place or neighbourhood. Often this is not something one organisation can do on their own – it requires the system to work together to act as anchor institutions – using

their collective resources and working with the voluntary and community sector to make a difference.

The aim of the 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:

- Provide a system mandate for action to address health inequalities across LLR
- 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)
- Strengthen a whole system collaborative approach to reduce (and remove entirely where possible) avoidable unfairness in people's health and wellbeing in LLR
- Establish the high-level principles of how LLR ICS partners will approach the work of reducing health inequity at system level
- 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. It is the systems' minimum ask of Place in relation to reducing health inequalities.
- Set out some key actions that can be delivered at system level with support through the Integrated Care System (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.

Midlands and Lancashire
Commissioning Support Unit

Equality, Health Inequality Impact and Risk Assessment

Section one: equality impact

For each question, please answer **Yes** or **No**, and provide a brief rationale for your answer.

1. Will this (decision / proposal / change) affect / impact on people in any way? (e.g. population, patients, carers, staff)?
   Yes - The aim of the LLR Health Inequalities Framework is to improve healthy life expectancy for people across LLR, by reducing health inequalities across the system. 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. 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. Is this decision or change part of a transformation programme or commissioning / decommissioning review?
   Yes. The development of the LLR Health Inequalities Framework is part of the transformation work to create the LLR Integrated Care System (LLR ICS). This involves bringing a range of system partners together to collaborate on implementing a wide programme of interconnected transformation in the commissioning and provision of a range of public and voluntary services to improve the lives of the residents of LLR. The framework principles and its proposed system-wide actions will ensure that the development of an ICS is underpinned by a commitment that future changes to services will be undertaken with a central aim of reducing health inequalities and increasing health equity.

3. Is this a decision that may change or potentially change the delivery of a service / activity or introduce a charge?
   Yes – Under the principles of this framework, future Investment in services will be proportionate to the needs (the ability to benefit) of 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 using these services. 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.

4. Will this (decision / proposal / change) potentially reduce the availability of a service or activity or product (e.g. prescriptions)?
No - 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. Proposals or decisions about specific services are not within the remit of this framework and will be made by identified responsible bodies within a specialist sphere. The framework proposes principles which are intended to support decision-making bodies reach conclusions about proposed changes to any services that keep the needs of traditionally underserved groups at the centre of these processes. 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 even finer detail the actions they are going to take, individually and collectively, to reduce health inequity

5. Is this a review of a policy, procedure, protocol or strategy?
No – The LLR Health Inequalities Framework is a first strategic approach to guide reducing health inequalities across LLR. 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.

6. Is this (decision / proposal / change) about improving access or delivery of a service?

   Yes - 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 from the integrated teams and the people those teams serve.

7. Will this (decision / proposal / change) potentially negatively impact groups covered by the Equality Act and other vulnerable groups?
   No

8. Will this (decision / proposal / change) affect Employees or levels of training for those who will be delivering the service?
   Yes – All decision makers within the ICS will have training and development to gain expertise, skills, insight and understanding of health inequity and how to reduce it, specifically;

   - ***Health Inequity and Inequality training will be mandatory for all executive decision makers in each organisation***
   - ***We will work with local and regional partners to develop appropriate and robust training packages relevant to roles***

9. Will this (decision / proposal / change) have any **positive** effect / impact in reducing health inequalities?
   Yes - The aim of the LLR Health Inequalities Framework is to improve healthy life expectancy for people across LLR, by driving action on evidence-based approaches to reducing health inequalities across the system

10. Will this (decision / proposal / change) have any **negative** effect / impact on health inequalities?
    No

Section two: equality risk

For each question, please answer **Yes** or **No**, and provide a brief rationale for your answer.

11. To reach your (decision / proposal / change) have you considered any information / supporting documents?
    Yes – 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/

12. Have you engaged or consulted with people or stakeholders / staff that may be affected by the (decision / proposal / change)?
Yes – Multiple partners have been involved in the production of the LLR Health Inequalities Framework to include LLR CCGs,(including Independent Lay members) Public Health, Clinicians, and Leicester/Leicestershire and Rutland Healthwatch.

13. Have you taken specialist advice in regard to impacts of the (decision / proposal / change)?
Yes – the production of the LLR Health Inequalities Framework has been clinically led with managerial support. Equality, Diversity and Inclusion Leads from University Hospitals of Leicester and Leicestershire Partnership Trust have been part of the document drafting group advising on issues of equity and equality. Public Health Consultants from city, county and Public Health England have reviewed and drafted the framework's health equity position.

14. Have you considered how this can address and eliminate discrimination, harassment and victimisation?
Yes - Reducing Health inequalities for everybody, including those with protected characteristics, is identified in the framework as a key component in all the work undertaken 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. The framework identifies Appropriate training and support to enable people to think and act in ways that lead to reductions in health inequity as one of the key system actions.

15. Have you considered how this can help to address inequality issues to enable all groups to access services?
Yes – as above and the framework identifies that undertaking health Equity Audits and using the LLR Inclusive Decision Making Framework will be required at the outset of service redesign work by Design Groups.

16. Have you considered how this can help foster good relations and community cohesion within communities?
Yes – The LLR Health Inequality Framework explicitly states "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." It refers to our intention to draw upon the positive community engagement arising during the COVID pandemic as a template of how to create inclusive and positive involvement of all communities in pursuing common goals.

17. Can you address or minimise any negative impacts that may represent an equality risk?
Yes - Where specific actions / projects will be undertaken by the LLR Health Inequalities Support Unit or Task and Finish Group, an EHIIRA will be undertaken to identify potential unintended adverse consequences and mitigate those risks.

Most of the actions proposed in the framework will be delivered by either LLR Design Groups or by individual organisations who will undertake Health Equity Audits or EIIHRs to identify risk and mitigations of any negative impacts related to those individual pieces of work. The framework sets out the expectation that the LLR Inclusive Decision-Making Framework and health Equity audits are the process to be used to capture any potential or actual negative impacts and our responses.

18. Will your decision reports be available to the public?
    Yes - The Health Equity Audits and EIIHRs for individual projects or service redesigns will all be in the public domain

Section three: human rights impact

For each question, please answer **Yes** or **No**, and provide a brief rationale for your answer.

19. Is there any concern that Article 2: Right to life may be breached?
    No

20. Is there any concern that Article 3: Right not to be treated in an inhuman or degrading way may be breached?
    No

21. Is there any concern that Article 5: Right to liberty may be breached?
    No

22. Is there any concern that Article 6: Right to a fair trial or hearing (this includes right to fair assessment, interview or investigation) may be breached?
    No

23. Is there any concern that Article 8: Right to respect for private and family life may be breached?
    No

24. Is there any concern that Article 9: Right to freedom of thought, conscience and religion may be breached? E.g. right to participate (individually or as a group) religion / belief
    No

25. Is there any concern that Article 10: Right to freedom of expression may be breached? E.g. concern that people won't be able to have opinions and express their views on their own or in a group
    No

26. Is there any concern that Article 14: Right not to be discriminated against in relation to any human rights, may be breached?
No

27. Is there any concern the obligation to protect human rights may be breached? E.g. concern that systems, processes and monitoring will not identify human rights breaches.
No

Section four: Assessment Comments

28. Further comments from individual / team drafting this assessment:
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 – and will reference the principles and high-level facilitative actions identified in this framework.

- Stage 1 Assessment / Approval comments from MLCSU Equality and Inclusion Business Partner:

The policy has been quality assured, and I am happy that this provides a rigorous assessment of the LLR Health Inequalities Framework.

Shaun Cropper E&I Business Partner MLCSU 28/05/21

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