The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Meeting:	Board of Directors (in Public)		
Meeting Date:	6 October 2020	**Agenda item:**	16
Report Title:	Health Inequalities – COVID-19 response / Phase 3 system plan		
Author:	Carly West-Burnham, Director of Strategy		
Executive Sponsor:	Caroline Shaw, CEO		

Implications

Link to key strategic objectives
[highlight which KSO(s) this recommendation aims to support]

KSO1	KSO2	KSO3	KSO4	KSO5	KSO6
Safe and compassionate care	*Modernise hospital and estate*	*Staff engagement*	*Partnership working, clinical and financial sustainability*	***Healthy lives staff and patients***	*Investing in our staff*

Board assurance framework	Supporting our patients and staff to improve health and clinical outcomes is articulated in Strategic Objective 5 within our Corporate Strategy. The BAF updates are received and reviewed within the Quality Committee and the Senior Leadership team.	
Significant risk register	No significant risks aligned	
	Y/N	If Yes state impact/ implications and mitigation
Quality		
Legal and regulatory		
Financial		

Assurance route

Previously considered by:	

Executive summary

Action required: *[highlight **one** only]*	Approval	**Information**	Discussion	Assurance	Review

Purpose of the report:	The purpose of this paper is to provide the Board with an overview of the diversity of West Norfolk, the current position in relation to health inequalities and the system plan to address issues in this area, aligned to the Phase 3 COVID-19 recovery work.
Recommendation:	The Board is asked to note the work which is being undertaken to date in relation to health inequalities and for a further update on progress to be brought back to the Board in March 2021.
Acronyms	

Background

Within the Trust's Corporate Strategy, we have a clear objective in relation to supporting our patients to improve health and clinical outcomes (SO5.) As an organisation, we recognise the key role which we must play in improving the health and economic wellbeing of the communities we serve and will do so by working alongside our local partners to ensure that we are promoting health priorities for all patients.

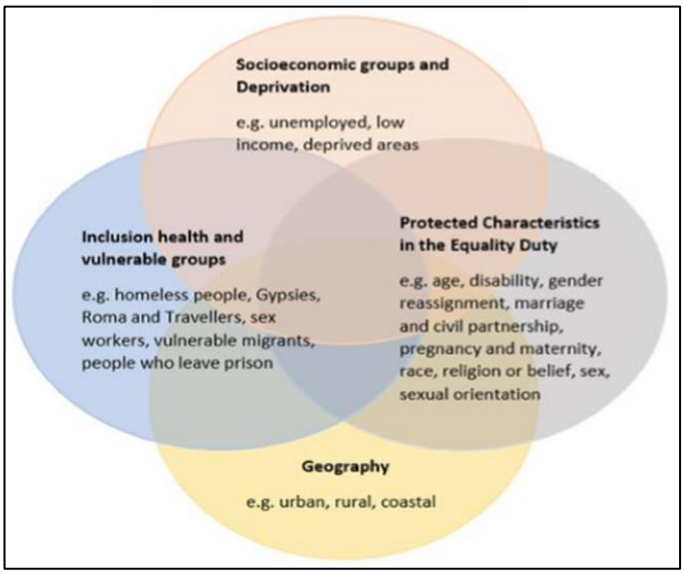
The Chief Executive Officer of the Trust has recently been appointed at the SRO for Health Inequalities across Norfolk and Waveney.

Definition of health inequalities

When we refer to health inequalities, we are referring to avoidable, unfair and systematic differences in health between different groups of peoples.

Health inequalities are ultimately about differences in the status of people's health, but the term is also commonly used to refer to differences in the care that people receive and the opportunities that they have to lead healthy lives, both of which can contribute to their health status. Health inequalities can therefore involve differences in[1];

- health status, for example, life expectancy and prevalence of health conditions
- access to care, for example, availability of treatments
- quality and experience of care, for example, levels of patient satisfaction
- behavioural risks to health, for example, smoking rates
- wider determinants of health, for example, quality of housing.



Picture 1 – Determinants of health inequalities

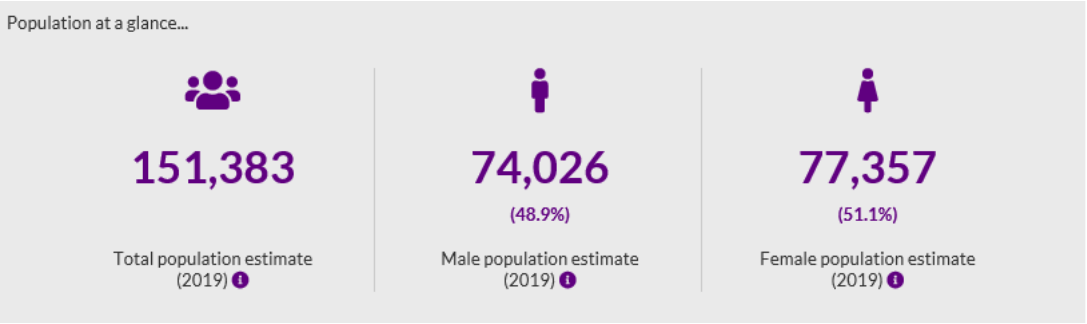
The importance of recognising and acting upon health inequalities has been highlighted in more recent months as a result of the COVID-19 pandemic, but is a recognised priority for the Norfolk and Waveney system as articulated in the Norfolk and Waveney System Plan for Health and Care (2019-24) which identified a "prevention

[1] www.kingsfund.org.uk

priority" focusing on tackling health inequalities and addressing the wider determinants of health.

West Norfolk position

West Norfolk covers a diverse population with a range of diverse needs[2];



Picture 2 – West Norfolk population overview

Picture 3 – West Norfolk deprivation overview

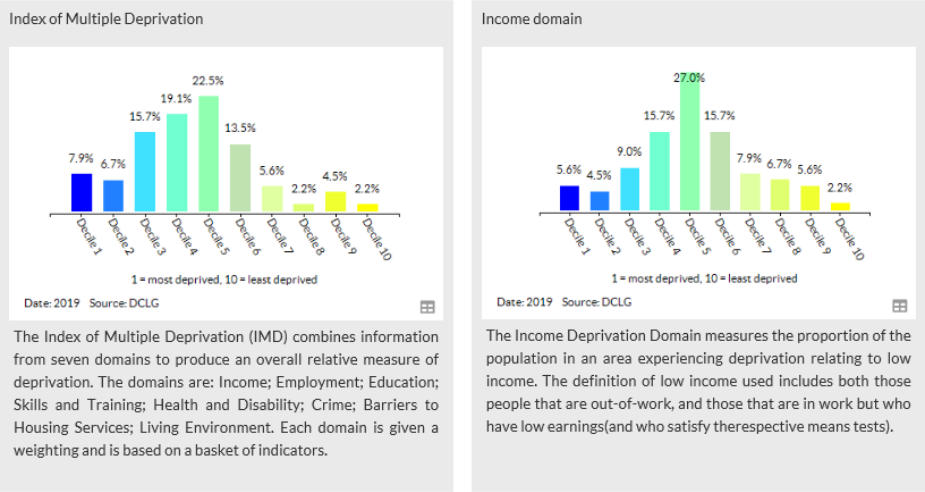
In relation to ensuring a robust understanding of health inequalities, life expectancy must be taken into account. Life expectancy is a key measure of a population's health status. Inequality in life expectancy is therefore one of the foremost measures of health inequality. Life expectancy is closely related to people's socio-economic circumstances. The most common summary measure of these circumstances across a population is deprivation. The index of multiple deprivation is a way of summarising how deprived people are within an area, based on a set of factors that includes their levels of income, employment, education and local levels of crime.

Life expectancy within West Norfolk is shown below[3];

[2] https://www.norfolkinsight.org.uk
[3] https://www.norfolkinsight.org.uk

Picture 4 – West Norfolk Life expectancy

The Index of Multiple Deprivation for West Norfolk is shown below[4];

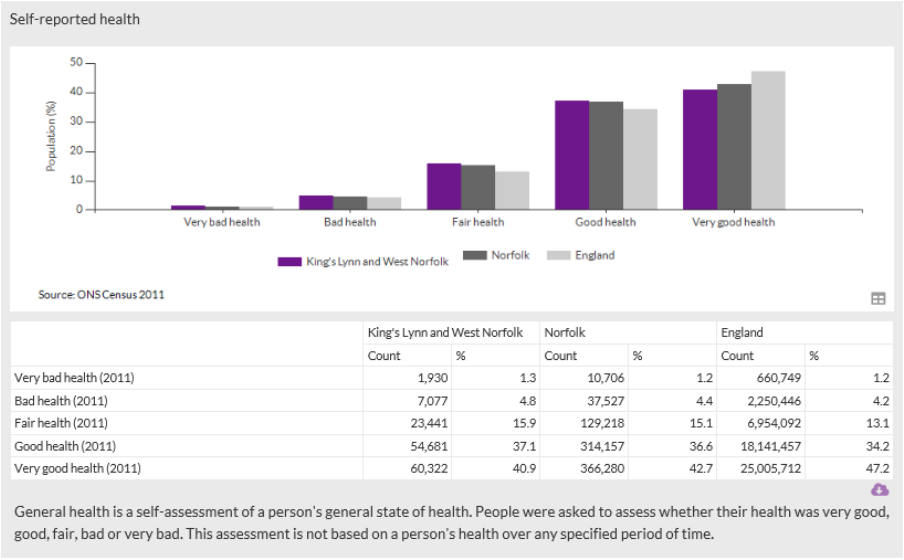


Picture 5 – West Norfolk Index of Multiple Deprivation

Another key measure of health inequality is how much time people spend in good health over the course of their lives, given how crucial good health is to wider quality of life and people's ability to do the things that they value.

Two important measures of the amount of time that people spend in good health are 'healthy life expectancy' and 'disability-free life expectancy.'

Within West Norfolk patient's self-reported health outcomes are as below;



	King's Lynn and West Norfolk		Norfolk		England	
	Count	%	Count	%	Count	%
Very bad health (2011)	1,930	1.3	10,706	1.2	660,749	1.2
Bad health (2011)	7,077	4.8	37,527	4.4	2,250,446	4.2
Fair health (2011)	23,441	15.9	129,218	15.1	6,954,092	13.1
Good health (2011)	54,681	37.1	314,157	36.6	18,141,457	34.2
Very good health (2011)	60,322	40.9	366,280	42.7	25,005,712	47.2

Picture 6 – West Norfolk self-reported health outcomes

[4] https://www.norfolkinsight.org.uk

Alongside this, we can see that the below data in relation to mortality rates from causes considered preventable for those under 75 shown the West Norfolk is higher that the Norfolk average for Cardiovascular and Respiratory diseases.

	King's Lynn and West Norfolk		Norfolk		England	
	Count	Per 100,000	Count	Per 100,000	Count	Per 100,000
Under 75 mortality rate from cancer considered preventable (2016 - 18)	349	71.5	1,948	70.6	108,817	76.3
Under 75 mortality rate from cardiovascular diseases considered preventable (2016 - 18)	215	44.1	1,115	40.3	64,530	45.3
Under 75 mortality rate from liver disease considered preventable (2016 - 18)	52	11.3	340	13.1	23,438	16.3
Under 75 mortality rate from respiratory disease considered preventable (2016 - 18)	113	22	466	16.2	27,186	19.2

Picture 7 – West Norfolk mortality rate from causes considered preventable

COVID-19

Prior to the pandemic the *N&W Health and Wellbeing Strategy (2018-2022)* recognised the necessity to coordinate our shared efforts across partners to address inequality and improve health outcomes*; "Working together we will use our resources in the most effective way to prioritise prevention and support to the most vulnerable. Key priorities are prioritising prevention and tackling inequalities in communities".*

Covid-19 has had a disproportionate impact on our patients and local communities who live with some of the greatest levels of need and health inequality and for some, the pandemic has further amplified existing inequalities.[5]

Figure 1 below highlights the range of factors which are associated with COVID-19 transmission and mortality.

[5] https://www.doctorsoftheworld.org.uk/wp-content/uploads/2020/05/covid19-brief-rna-report.pdf

Figure 1. Factors associated with COVID-19 transmission and mortality

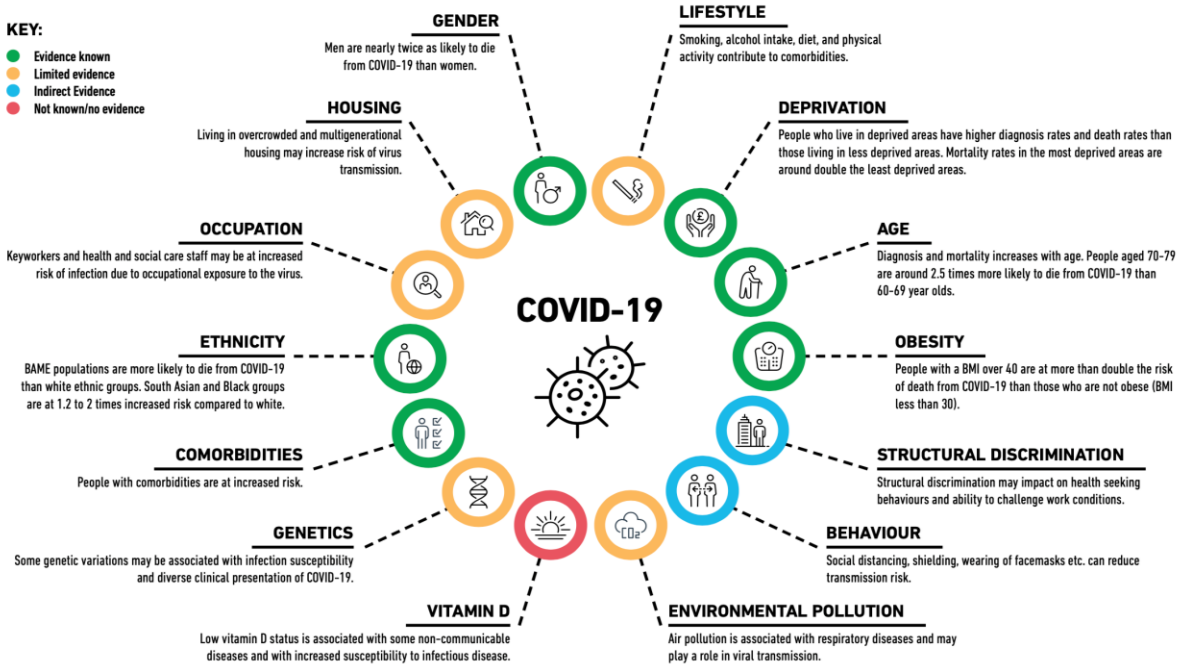


Figure 1 – Factors associated with COVID-19 transmission and mortality

The national guidance on implementing the Phase 3 Covid-19 recovery plans set out eight urgent actions to be taken by health and social care systems to address health inequalities;

1. Protect the most vulnerable from COVID-19, with enhanced analysis and community engagement, to mitigate the risks associated with relevant protected characteristics and social and economic conditions; and better engage those communities who need most support.

2. Restore NHS services inclusively, so that they are used by those in greatest need. This will be guided by new, core performance monitoring of service use and outcomes among those from the most deprived neighbourhoods and from Black and Asian communities, by 31 October.

3. Develop digitally enabled care pathways in ways which increase inclusion, including reviewing who is using new primary, outpatient and mental health digitally enabled care pathways by 31 March.

4. Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes; including more accessible flu vaccinations, better targeting of long-term condition prevention and management programmes such as obesity reduction programmes, health checks for people with learning disabilities, and increasing the continuity of maternity carers.

5. Particularly support those who suffer mental ill health, as society and the NHS recover from COVID-19, underpinned by more robust data collection and monitoring by 31 December.

6. Strengthen leadership and accountability, with a named executive board member responsible for tackling inequalities in place in September in every NHS organisation, alongside action to increase the diversity of senior leaders.

7. Ensure datasets are complete and timely, to underpin an understanding of and response to inequalities. All NHS organisations should proactively review and ensure the completeness of patient ethnicity data by no later than 31 December, with general practice prioritising those groups at significant risk of COVID-19 from 1 September.

8. Collaborate locally in planning and delivering action to address health inequalities, including incorporating in plans for restoring critical services by 21 September; better listening to communities and strengthening local accountability; deepening partnerships with local authorities and the voluntary and community sector; and maintaining a continual focus on implementation of these actions, resources and impact, including a full report by 31 March.

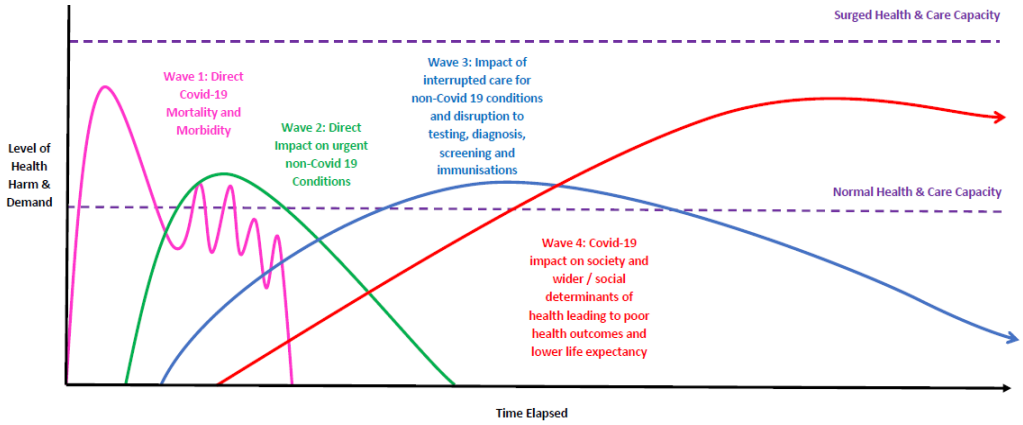
Norfolk and Waveney system response

The 8 urgent actions have formed an integral part of the system's Phase 3 recovery response.

As a wider health and social care system, the importance of both accelerating and enhancing plans to tackle inequality are recognised, alongside the need to adopt targeted action prioritising individuals, groups and communities who are most vulnerable.

To inform the development of the system approach to recovery, the figure below illustrates the likely impact of the pandemic over time, with each differing wave requiring tailored recovery planning.

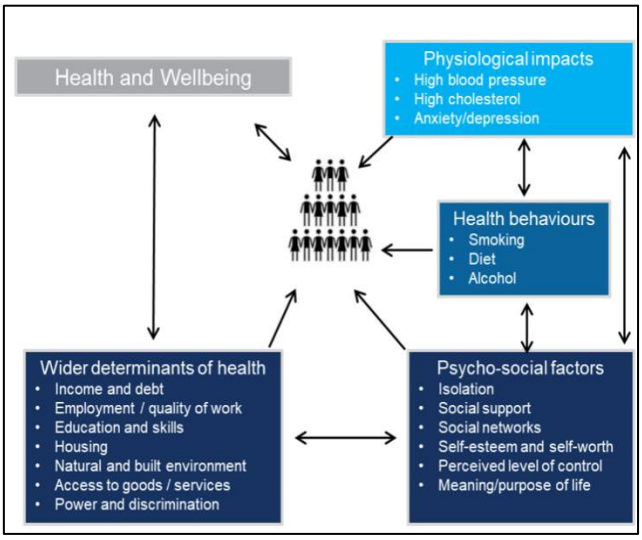
In particular, this graph highlights the stark need to develop short, medium and longer-term recovery plans for those groups most adversely affected by the pandemic and at greatest risk of disadvantage.



Graph 1 – likely impact of the COVID pandemic over time

The Labonte Framework (below) acknowledges the differing factors impacting upon health, where they stem from and how they interact. This framework supports the system's shared understanding of why our Covid-19 recovery planning to address

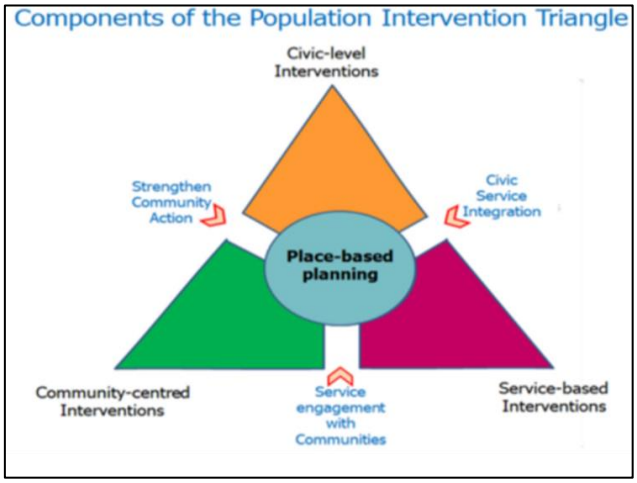
inequality must focus at a 'Place' level to ensure that the benefits of an effective 'whole-system' response are fully realised.



Picture 8 – Labonte Framework

To further inform the system recovery plans it has been agreed that the PIT model (below) will be adopted, advocating for interventions to be considered at three levels; civic, community and service.

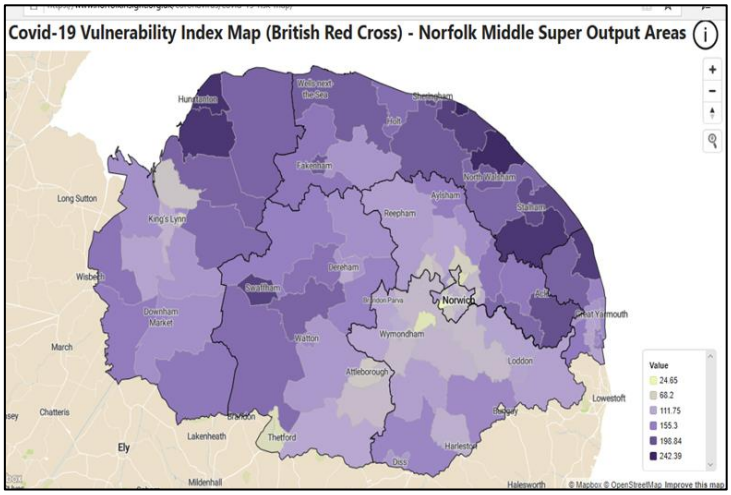
This approach will allow for system wide partner engagement within each Place and within communities, to ensure actions to optimise the opportunity to reduce health inequalities are co-ordinated at both Place and Primary Care Network level.



Picture 9 – Population Intervention Triangle - Model

The system has committed to ensuring that their plans are data-led, adopting an evidence-based approach to underpin the agreed place response. This will ensure that all place partners with an interest in the wellbeing of the citizens of Norfolk and Waveney have a shared understanding of our system and local priorities and who our most vulnerable groups are.

The picture below provides an example of the way in which data has been used to visualise the system population's vulnerability across Norfolk and Suffolk;



Picture 10 – COVID-19 vulnerability index may (British red Cross)

The response of the Trust

The Chief Executive Officer has been appointed as the Norfolk and Waveney system SRO in relation to Health Inequalities and is the identified Board level Champion for the Trust.

In partnership with our Local Delivery Group, the Trust are working collaboratively to ensure that we are prioritising the work which is being undertaken in relation to responding to the eight urgent actions in relation to the management of health inequalities. This work is being replicated across the other areas of the system and co-ordinated by the CCG.

We recognise that there is still work to be done in this area and will be focusing on supporting the delivery of system key priority areas;

- Ensuring plans for protecting communities from COVID-19, such as through communication about reducing risks, is appropriate to all communities
- Rapidly assessing whether some population groups are finding it harder to engage with restored critical services and putting in place measures to better reach out to these groups and reduce any barriers to engagement
- Reducing the variation in flu vaccination rates alongside the overall ambitious targets for increasing vaccination
- Alongside these assessments, ensure data collection on ethnicity and other protected characteristics improves.

In line with national best practice, we will be working with system partners to;

- Ensure that there is a detailed plan in relation to the delivery of the 8 urgent actions
- Develop a health inequality strategy
- Ensure that there is clear governance and accountability for health inequalities across the system

- Agree and implement a Health Inequality Impact Assessment to ensure that there is visibility around the impact of decision-making on disadvantaged health groups
- Ensure that that there is agreement and visibility around the indicators for measuring progress
    - Information from the Lead for Equality and Health Inequalities, NHSEI indicates that the plan will be to assess health inequalities by measuring the "*changes in proportion of activity post-COVID compared with pre-COVID for the most deprived 20% and the BAME community for:*
        - *Elective admissions;*
        - *Emergency admissions;*
        - *Outpatient attendances; and*
        - *Headline cancer referral and waiting times"*

Recommendation

The Board is asked to note the work which is being undertaken to date in relation to health inequalities and for a further update on progress to be brought back to the Board in March 2021.