Agenda Item No: 8(a)

Health Inequalities: Report from the Integrated Care Board

To:	Adults and Health Committee
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Electoral division(s):	All

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1. Background

1.1. Health inequalities in England refer to the systematic, avoidable, and unfair differences in health that exist between different groups of people or populations. There are many kinds of health inequality, and many ways in which the term is used, but generally, health inequalities arise from the unequal distribution of social, environmental, and economic conditions within societies which can significantly impact an individual's overall health and wellbeing.

1.2. Inequalities in health reflect the inequalities in society at large and are closely related to personal and socio-economic factors, such as income, education, housing, gender, age, ethnicity, disability, geography and social inclusion. Image 1 has been adapted from the Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute's County Health Rankins Model which shows the various influences on population health and health outcomes.

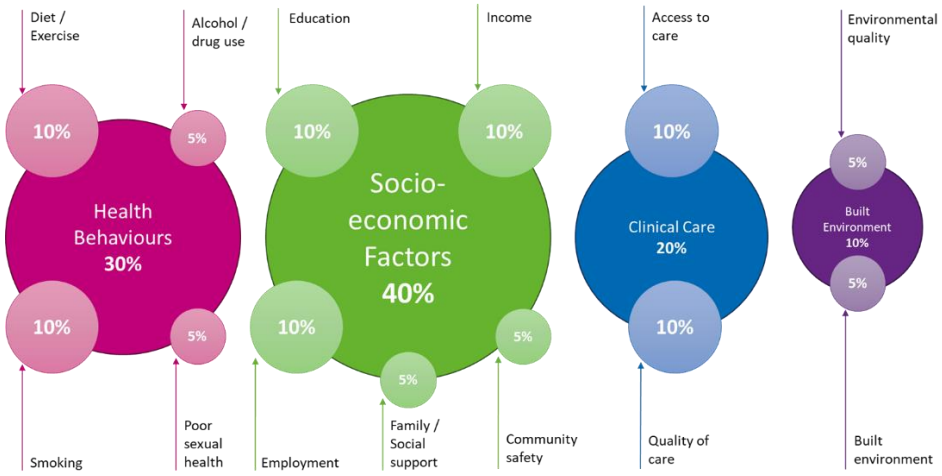

Image 1: Influences on health outcomes

1.3. 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. In England, there is a systematic relationship between deprivation and life expectancy, also known as the inequality gradient.

1.4. Since the early 20th Century, life expectancy in England has risen significantly due to advancements in healthcare, sanitation, and living conditions. In 1900, life expectancy was approximately 45 years for men and 49 for women. By the 21st Century, these figures had increased to over 79 years for men and 83 years for women.

1.5. However, since 2011 improvements in mortality rates have slowed, causing life expectancy gains to stall. In the years between 2011 and 2019, life expectancy at birth in England has been increasing at a slower rate than in previous decades. In recent years however, improvements in life expectancy have stalled and have started to decline, most notably for women living in the most deprived 10 per cent of areas of the country.

1.6. In 2017–19, women living in the least-deprived 10 per cent of areas could, at birth, expect to live to 86.4 years old, whereas women in the most-deprived 10 per cent of areas could expect to live to 78.7 years: a gap in life expectancy of almost 8 years. For men, this gap was even

wider, with a difference of 9.4 years between those in the least-deprived 10 per cent of areas (83.5 years) and the most-deprived 10 per cent of areas (74.1 years).

1.7. About one-third of the inequalities in life expectancy, between the most and least deprived decile of areas, are caused by higher mortality rates from heart and respiratory disease, and lung cancer in the most deprived areas. These conditions are exacerbated by risk factors such as smoking and obesity, rates of which are higher among more deprived groups, but are, more importantly, largely preventable.

1.8. Inequalities in life expectancy have been exacerbated by the Covid-19 pandemic. The gap in life expectancy between the local authorities in England with the highest and lowest life expectancy was 7.4 years in 2017–19 and it grew to 8.7 years in 2020–22.

1.9. Another indicator of health inequality is healthy life expectancy at birth. This is defined as being an estimate of the average number of years that would be lived in a state of 'good general health' by babies born in a given time period, given mortality levels at each age and the level of good health at each age for that time period. Healthy life expectancy in England in 2020-22 was lower than in 2011-13, falling by 0.8 years in males and 1.2 years in females during that time. So not only has life expectancy stalled, but males and females spend more years in poor health.

1.10. For the three aggregated years 2020–22, although male life expectancy in England was 78.8 years, average healthy male life expectancy was only 62.4 years (i.e., 16.4 of those years (21 per cent) would have been spent in poor health). Female life expectancy was 82.8 years, of which 20.1 years (24 per cent) would have been spent in poor health. Therefore, although females live an average of four years longer than males, they spend a higher proportion and more years of their lives in poor health.

1.11. Despite it seemingly being a healthy place to live, we know that significant inequalities in life expectancy and healthy life expectancy exist across Cambridgeshire and Peterborough. Despite female and male life expectancy in Cambridgeshire being persistently higher than in Peterborough, inequalities in Cambridgeshire exist at both district and ward levels.

1.12. As image 2 shows, there are considerable variations in both male and female life expectancies at birth across Cambridgeshire. Life expectancy at birth is higher than the England average in all districts except for in Fenland, which is significantly lower than the England average for both male and females. Life expectancy at birth for both males and females is highest in South Cambridgeshire.

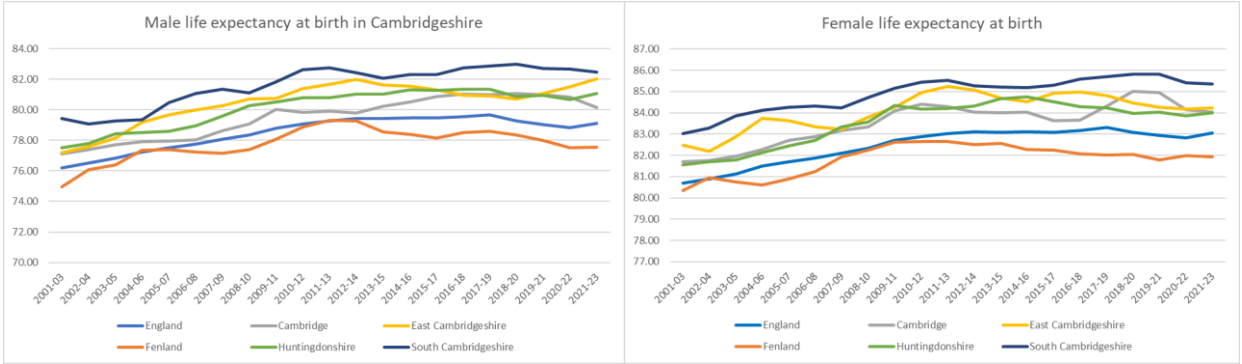

Image 2: Male and female life expectancy at birth across Cambridgeshire Districts

1.13. In terms of healthy life expectancy, for both males and females, Peterborough's healthy life expectancy at birth is lower than Cambridgeshire and lower than the England average (significantly lower than England for females). However, according to data from the Office for Health Improvement and Disparities' Public health profiles 2018-20, for men across Cambridgeshire, the percentage of years spent not in good health is 20.8 per cent which is slightly worse than the England average of 20.6 per cent. For females in Cambridgeshire, the percentage of years spent not in good health is 19.8 per cent which is better than the England average of 23.2 per cent. Healthy life expectancy data not available at lower tier local authority level.

1.14. Healthy life expectancy has fluctuated over the years for which data is available, but overall has not improved over the last decade for either males or females. If district-level data was available, we would expect to see considerable variations within Cambridgeshire in the same way that we have seen for standard life expectancy.

1.15. These trends follow the broader conclusions that both life expectancy and healthy life expectancy at birth are lowest for those people living in more deprived areas. Which means that those living in the more deprived areas not only tend to die earlier, but also spend a greater proportion of their lives in poor health.

1.16. Between 50-60 per cent of the gap in life expectancy between the most and least deprived quintiles of Cambridgeshire is due to circulatory conditions, cancer and respiratory conditions (OHID Segment Tool: Segment Tool).

1.17. The Marmot Review into health inequalities in England entitled 'Fair Society, Healthy Lives,' published 11 February 2010, provides an evidence-based strategy to address the social determinants of health, i.e., the conditions in which people are born, grow, live, work and age, and which all contribute to the health inequalities which have been described.

1.18. According to a report by the Institute of Health Equity entitled Health Inequalities, Lives Cut Short (January 2024), between 2011 and 2019, 890,000 people died earlier than they would have done if they had lived in areas with the same age and sex specific death rates as the least deprived area quintile.

1.19. The report adds further weight to two previous reports published by the Institute of Health Equity in 2020 regarding health inequalities (Health Equity in England: The Marmot Review 10 years On and the COVID-19 Marmot Review) and makes a strong argument that most of our health is determined by our social circumstances, with the NHS accounting for approximately 20 per cent of population health, as previously highlighted in Image 1.

1.20. Tackling health inequalities and improving the health for those groups who typically experience the worst outcomes therefore requires significant collaboration. When local partners (the NHS, councils, voluntary sector and others) work together, they can create better services based on local need and is a fundamental reason for the creation of ICSs. This is vital in terms of addressing the multiple factors that contribute to health inequalities and the disparities we see in terms of life expectancy and healthy life expectancy across Cambridgeshire and the wider ICS.

1.21. The remainder of this paper provides an overview of NHS Cambridge and Peterborough ICB's role in tackling health inequalities, and the alignment to NHS England's five key priorities and Core20PLUS5 approach.

2. Main Issues

2.1. Cambridgeshire and Peterborough (C&P) ICB's overarching ambition is to increase the number of years people live in good health and reduce premature mortality. To achieve this, there has been a renewed focus on primary and secondary prevention, partnership working to address the root causes of health inequalities and promoting population health management approaches.

2.2. To help measure the whole system's success in keeping the population well and reducing illness, the Cambridgeshire and Peterborough ICS Outcomes Framework has been developed. Hosted on the Cambridgeshire and Peterborough Insight website, the framework has been developed based on the overarching aims of the Health & Wellbeing Integrated Care Strategy, supports the evolution and delivery of the ICB's Joint Forward Plan, and helps guide the development of place-based partnership delivery plans. One of the ambitions of the Outcomes Framework is to monitor several healthcare inequality metrics. These metrics will evolve to help identify disparities in health outcomes through the lenses of deprivation, ethnicity and other protected characteristics.

2.3. NHS Cambridgeshire and Peterborough ICB is committed to driving tackling health inequalities and as part of our Joint Forward Plan set out an ambitious approach to tackling healthcare inequalities in terms of access, experience and outcomes by focusing on the key strategic priorities set by NHS England and embedding the Core20PLUS5 approach. The plan set out the following:

- Ensure reducing health inequalities is a priority for everyone and embedding a 'Core20PLUS' approach.
- Be informed by our data and wider insights and be evidence-led in our approaches.
- Promote healthy lifestyles and behaviours and increase access to early intervention services.
- Improve access to healthcare services for vulnerable and marginalised populations.
- Improve the quality of care and patient experience across the ICS.
- Work with local people and communities to better understand the challenges they experience and coproduce solutions that best meet their needs.

2.4. To deliver these objectives, the ICB refreshed its health inequalities governance through the establishment of the Population Health Improvement (PHI) Board, which brings together the ICB's prevention, population health management and health inequalities programmes. The PHI Board is currently co-chaired by the Deputy Chief Executive of the ICB and the Acting Director of Public Health for Cambridgeshire.

2.5. To ensure the ICB discharges its statutory duty to have regard to the need to reduce inequalities and to ensure effective co-ordination of the healthcare inequalities agenda, the ICB has also established a system-wide Healthcare Inequalities Strategic Oversight Group (HISOG), with further sub-groups including a NHS Provider Health Inequalities group and a PCN Health Inequalities leads network. These sub-groups have been established to ensure

strategic alignment, serve as collaborative forums, help identify opportunities for partnership working, and to share best practice across the system,

2.6. The HISOG, managed by a central team within the ICB's Strategic Commissioning Unit and co-chaired by both ICB and Public Health representatives, is responsible for coordinating and driving action across NHS providers and wider ICS partners in relation to the five strategic priorities and delivery against the Core20PLUS5 approach as described earlier.

2.7. In January 2024, the PHI Board approved the recommendations to align the Cambridgeshire and Peterborough healthcare inequalities programme to NHSE's strategic priorities and embedding a Core20PLUS5 approach. These are summarised below:

2.8. <u>NHSE England's Strategic Priorities:</u>

2.8.1. Restore NHS services inclusively: pre-existing disparities in access, experience and outcomes have been exacerbated by the Covid pandemic. Systems are asked to utilise and monitor data efficiently, delineated by ethnicity, deprivation and other protected characteristics.

2.8.2. Mitigate against digital exclusion: systems are asked to offer face-to-face care to those unable to use remote services and to conduct analysis of who is accessing services and by what means, broken down by relevant protected characteristics and health inclusion groups.

2.8.3. Ensure datasets are complete and timely: systems are asked to improve the collection and recording of ethnicity data across primary care, outpatients, A&E, mental health, community services and specialised commissioning.

2.8.4. Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes: systems are asked to focus on the ongoing management of long-term conditions; improving the percentage of annual health checks for people with a learning disability and those with serious mental health; and implementation of continuity of carer for women from Black, Asian and other minority ethnic groups.

2.8.5. Strengthen leadership and accountability: systems are asked to identify named leads for tackling health inequalities and increase access to training and support.

2.9. <u>Core20PLUS5 approach:</u>

The approach offers a multi-year focused delivery approach to enable prioritisation of energies and resources in the delivery of NHS commitments to tackle health inequalities.

The approach defines a target population – the 'Core20PLUS' – and identifies '5' clinical areas requiring accelerated improvement:

'Core20': The most deprived 20 per cent of the national population as identified by the national Index of Multiple Deprivation (IMD).

'PLUS': ICS-determined population groups experiencing poorer than average health access, experience and outcomes, but not captured in the 'Core20' alone. This should be based on population health data at a local ICS-level

'5': The final part sets out five clinical areas of focus for adults:

1. Maternity – ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups.
2. Severe mental illness (SMI) – ensuring annual physical health checks for people with SMI to at least nationally set targets.
3. Chronic respiratory disease – a focus on Chronic Obstructive Pulmonary Disease driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.
4. Hypertension case-finding and optimal management and lipid optimal management – to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.
5. Cancer Screening – to ensure 75 per cent of cases are diagnosed at stage 1 or 2 by 2028.

2.10. Smoking cessation has also been included as a cross-cutting priority for the Core20PLUS5 approach to tackling healthcare inequalities given that it remains the single greatest cause of preventable death. Generally, in Cambridgeshire, rates of conditions and deaths attributed to smoking are generally below the England rate, whilst Peterborough's rates are above. That said, smoking accounts for approximately half of the difference in life expectancy between the most and lead affluent communities in England with the gap in smoking prevalence between the most and least deprived areas increasing each year. The evidence clearly shows that stopping smoking is most effective in preventing poor health outcomes.

2.11. Five separate clinical priority areas have also been identified for children and young people (CYP), which are: asthma, diabetes, epilepsy, oral health, mental health.

2.12. For Cambridgeshire and Peterborough, 62 Lower Super Output Areas (LSOAs) are in the 20 per cent most deprived nationally; 46 are in Peterborough, while 11 are in Fenland. 13 per cent of the Cambridgeshire and Peterborough registered population live within the 20 per cent most deprived areas with the geographical distribution varying considerably: 95 per cent (107,000) living in the north of the ICS footprint, compared with 5 per cent (5,000) in the south.

2.13. Examples of 'PLUS' groups within Cambridgeshire and Peterborough include, and this is not an exhaustive list:

- Gypsy, Roma, and Travellers (GRT) is an umbrella term to describe people from a range of ethnicities who face similar challenges in terms of access to healthcare and the outcomes they receive. GRT is one of the largest ethnic minority groups with approximately 7000+ living within the ICS footprint. GRT populations have a life expectancy 10-12 years less than that of the non-traveller population.
- There are approximately 1,500-1,700 people who are homeless within Cambridgeshire and Peterborough with the average age of death for those experiencing homelessness being 45 for men and 43 for women. Population growth, combined with increasing housing costs and lack of affordable housing is one of the possible reasons for increasing homelessness issues. People who rough sleep, because of their lack of secure accommodation and often co-existing health issues or other vulnerabilities, represent the most disadvantaged groups in society. The average life expectancy for those experiencing homelessness is 45 for men and 43 for women.

- Cambridgeshire and Peterborough has a large transient migrant population, with influxes of migrant workers predominantly from Eastern Europe, most markedly in the Fenland and Peterborough areas. Language barriers, cultural differences and health literacy are identified as being key drivers of inequalities amongst such migrant and broader ethnic minority populations.

2.14. The following sections highlight some of the key work programmes and initiatives to address healthcare inequalities. For ease, a summary table can be found at Appendix A to show alignment to NHSE's strategic priorities and Core20PLUS5 approach.

2.15. Prevention

As outlined previously, cardiovascular disease (CVD) is one of the major contributors to the life expectancy difference between the most and least deprived areas within Cambridgeshire, contributing to almost 25 per cent of the gap in women (Office for Health Improvement and Disparities: Segment Tool). The 'Your Healthier Future' (YHF) programme, launched by the ICB in conjunction with the Cambridgeshire and Peterborough public health teams, launched a 2-year programme which targets key clinical and behavioural risks associated with CVD. The programme risk stratifies people with a high or increasing risk of a major adverse cardiovascular events and enables GP practices to better support patients and reduce premature mortality.

2.16. The programme has five elements which focus on:

- Lipid detection and optimisation: identify and treat at-risk patient groups with high cholesterol – launched July 2024
- NHS health checks: improve uptake of NHS health checks to better identify CVD risk factors and maximise secondary prevention measures – anticipated to launch January 2025
- Hypertension Detect: identify patients with or at risk of high blood pressure – launched November 2024
- Hypertension Perfect: optimise treatment for patients with known high blood pressure – launched November 2024
- BMI and personalised care: improve quality of information practices hold to identify patients at risk and who will benefit from future support – due to launch February 2025.

2.17. The Lipid Detection and Optimisation pathway has resulted in those practices which utilise the enhanced support from Eclipse, a population health management tool, initiating more than twice as many patients onto lipid lowering therapies in the period since the start of the programme. The data for the hypertension pathways are currently in development.

2.18. Initial data shows the programme is having a positive impact upon Core20PLUS groups. In terms of deprivation, responses to the contacts made by Eclipse are broadly equitable across all deprivation deciles. However, once contact is made, those from the most deprived two deciles (Core20) are more likely to take up a lipid lowering therapy than those from other deciles. In terms of ethnic minority patient groups, mental health and learning disability groups, early results show the YHF programme is achieving proportionately higher uptake rates for lipid lowering therapies, directly contributing to delivering better outcomes for Core20PLUS populations through preventative measures.

2.19. Further work and analysis are being undertaken following the development of a new minimum data set for the established pathways which will report in greater detail the impact of the programmes respect of both outcomes and inequalities.

2.20. In 2025/26, we will extend the YHF approach to identify and support further patients with reversible risk. This is likely to focus on optimising patients with several long-term conditions (multi-morbidity) because the evidence suggests this will have the greatest impact on preventing serious illness and helping patients avoid admission to hospital.

2.21. In addition, and in line with the strategic priorities to tackle health inequalities, the primary care based annual physical health check team continue to deliver the enhanced 12-point Serious Mental Illness (SMI) annual physical health checks across Cambridgeshire and Peterborough. Although there are some areas where the 6-point SMI annual physical health check is available, work is ongoing to ensure equity across the system.

2.22. The 12-point model continues to be considered a best practice approach and is recognised nationally as offering best practice for patients. At the end of 23-24, Cambridgeshire and Peterborough had an 80 per cent uptake rate in SMI annual physical health checks, which is ahead of the target (60 per cent) and performance last year. This equates to 5541 AHC completed in 23-24.

2.23. Across Cambridgeshire and Peterborough, the NHS Treating Tobacco Dependency programme, an NHS Long Term Plan prevention programme and a cross-cutting priority of the Core20PLUS5 approach, has resulted in new smoke-free pathways being established in all acute and mental health inpatient hospitals and maternity units. Since commencement of the pathways in 2023, provider data up to end of Q2 2024/25 reported a total of 2,334 smokers having been identified and referred to in-house specialist stop smoking services; 950 people having initially setting a quit date; and 532 (56 per cent) having quit smoking as measured by the standard 28-day quit target.

2.24. In July 2024, the ICB approved the request to utilise a proportion of the health inequalities funding allocated to the ICB to expand the treating tobacco dependency programme given the overwhelming evidence which demonstrates the positive impact it has on tackling health inequalities, preventing ill health, and the wider socio-economic benefits. The additional funding will support further development of the existing pathways whilst also seeking new opportunities to expand smoking cessation pathways in outpatient and emergency departments, whilst strengthening the discharge pathways into community stop smoking services.

2.25. <u>Elective Waits</u>

In April this year, the ICB conducted an analysis of the elective waiting times which was presented at both the Planned Care Board and HISOG. The analysis examined waiting times for patients based on ethnicity, age and deprivation levels. It showed that waiting times are disproportionately longer for different ethnic groups, particularly for those waiting over 52 and 62 weeks. In addition, as levels of deprivation increase, so do average waiting times. It must be noted that waiting lists are managed on clinical risk. Other systems have explored management of waiting lists through other methods which C&P ICS continue to monitor, but to date these have not been very successful. Since the report was completed in April 2024, the over 52 week waiting list has reduced from 10,188 people waiting over 52 weeks to 5,442

(Dec 2024). Since receiving the report further work has been undertaken on the data quality at all providers and the ICB plans to re-run the data to assess impact and determine further actions to be undertaken.

2.26. Patients under the age of 18 experience longer waiting times compared to older groups. Furthermore, elective admission rates for children from the most deprived quintile were found to be statistically comparable to those from the least deprived quintile for both genders in the 2022/23 period. Whilst average waiting times for males and females are similar, a high percentage of males face waits exceeding 52 and 62 weeks. CYP waiting times are a national priority. For Cambridgeshire and Peterborough ICS, Ear, Nose and Throat (ENT) remains the highest risk with Ophthalmology in the North also challenged. Both North West Anglia NHS Foundation Trust (NWAFT) and Cambridge University Hospitals NHS Foundation Trust (CUHFT) have been working collectively on solutions which has included CUHFT Ophthalmologist providing additional clinics at NWAFT. Overall, waiting times for CYP have reduced since April 2024 by 2-3 weeks, but this remains a key focus for the system.

2.27. The elective wait analysis is also being replicated at the provider level to help identify disparities in speciality pathways. In addition, further analysis of Did Not Attend (DNA) rates in outpatients is planned in 2025/26 to identify disparities and help identify opportunities to address these.

2.28. <u>Cancer Screening</u>

Increasing the number of cancers identified at stage 1 or 2 to 75% through earlier diagnosis is a key priority for C&P ICS. Two key programmes are supporting this work 1) Targeted Lung Health Checks 2) Cervical Screening – Neighbourhood programmes.

2.29. Lung cancer remains the biggest cancer killer across the UK, with more than one in five cancer deaths (21%) attributed to lung cancer. People diagnosed at the earliest stage are nearly 20 times more likely to survive for five years than those whose cancer is caught late; however evidence suggest that less than a third of lung cancers are diagnosed at either stage one or two when treatment with a curative intent is more likely. Targeted Lung Health Checks (TLHC) is a national screening programme delivered by local systems to identify lung cancer at stage 1 or 2. The programme is targeted at populations where there are high levels of smoking, deprivation and poor lung cancer outcomes. The roll out of TLHC is due to start in March 2025 across C&P ICS starting in the North with full roll out by 2028/29 to all in scope across C& P ICS.

2.30. C&P ICS cervical screening uptake is below the national target of 80% and below the national average. For the ages 25-49 in Q4 23/24 C&P uptake was 65.38% with the national coverage of 67.59%. For the ages of 50-64 C&P uptake was 74.88% with the national position at 75.18%. Working with North and South Place, additional Cancer Alliance funding has been identified to deliver targeted work through the integrated neighbourhood teams. Different approaches are being taken based on the preference of place. North Place is focusing on practices with low uptake for both age cohorts and supporting practices to contact and engage with individuals. South Place is utilising their community events to promote the benefits of screening while also aligning to other funding streams such as the establishment of Women's Health Hubs.

2.31. Ethnicity Coding

Evaluation of GP ethnicity coding completeness carried out in June 2024 showed that ethnicity coding completeness has improved across GP practices by 8 percentage points from 88 per cent completeness in July 2022 to 96 per cent completeness in June 2024. In addition, the percentage of patients coded as Black, Asian or any other ethnic minority group has increased from 13 per cent to 16 per cent. Similar work is now taking place within the hospital providers to improve disparities in ethnicity completeness rates and inconsistencies in which the data has been coded. For example, at Cambridgeshire and Peterborough NHS Foundation Trust (CPFT), the Performance and Analytics oversaw a project to improve ethnicity recording which resulted in a reduction of 'not stated' ethnicity coding from 18 per cent to less than 5 per cent.

2.32. High intensity use programme

The Cambridgeshire and Peterborough high intensity use (HIU) programme has been designed to effectively identify and manage those who utilise healthcare services more frequently to reduce demand and help increase capacity across the system.

2.33. High intensity use of services is linked to health inequalities, with those attending most frequently generally low in numbers, but their impact on the wider health system is significant. In Cambridgeshire & Peterborough (C&P) approx. 110 individuals (0.01 per cent of the total population) attended A&E departments in the system 20 or more times in a 12-month period between March 2023 and February 2024. This resulted in 2,004 A&E attendances (1.3 per cent of the overall total).

2.34. Over the same period, patients attending A&E 5 or more times represented less than 0.5 per cent of the registered population in C&P but accounted for more than 1 in 10 (11.8 per cent) of A&E attendances, with a total of 17,652 attendances.

2.35. Previous work carried out by the British Red Cross to explore high intensity use has generally shown those who attend A&E most frequently are people living in the most deprived communities; are more likely to be admitted to hospital than people who attend less frequently; have poorer physical and mental health; and experience poorer than average health outcomes despite the high use of services.

2.36. Utilising funding from the health inequalities allocation and the Better Care Fund, supported through the Cambridgeshire and Peterborough Health and Wellbeing Board, the ICB has established a two-tiered HIU programme as follows:

- Tier 1: A specialist service focusing on people who are already high users of urgent and emergency NHS services, particularly focusing on those who have attended A&E 10 or more times in the previous 12-months; and
- Tier 2: A targeted service focusing on those people identified by general practice and Integrated Neighbourhood teams who are at increasing risk of utilising A&E services, and/or being admitted to a hospital bed in the future.

2.37. Both approaches centre on a model that offers a more proactive and personalised approach to addressing high or increasing use of services, working with partners to understand the gaps in service use, current gaps in care and support, and explore opportunities for care and support to be better coordinated through pathway transformation and personalised care

approaches. The model acknowledges that no single organisation or system partner can do this alone.

2.38. The Tier 1 Service, which is being delivered in partnership with Cambridgeshire County Council, commenced in October 2024. The team is hosted within the Council's Communities Service Directorate and works across the ICS footprint with a lead aligned to both North and South Place. The service has been initially funded for 18-months with the specific aim of reducing A&E attendances, non-elective hospital admissions, 999 and 111 calls, and ambulance conveyances within the selected cohort.

2.39. Despite only recently launching, the service is already having a profound impact on the lives of those who are being supported by the approach with key trends emerging:

- A&E attendances are reducing – individuals' reliance on emergency services as they build trust and resilience and are connected to community-based support.
- Mental health is a core issue – many referrals to the HIU service involve long-term mental health challenges compounded by addiction, social isolation, or trauma.
- Relational support is key – tailored, non-judgemental support helps individuals navigate complex systems without feeling stigmatised.
- Collaborative working – the HIU link workers break down silos between health, social care and community services
- Boundaries build trust – clear, consistent boundaries allow the team to deliver high levels of support while promoting independence.

2.40. The Tier 2 HIU service, which has been operational since November 2023, has resulted in the development of approximately 5,000 personalised care plans for those individuals identified by staff working within primary care and across integrated neighbourhoods requiring proactive support to manage conditions and to reduce the reliance on urgent and emergency care. An analysis of the impacts the Tier 2 service is having is currently underway with the final report available in April 2025.

2.41. <u>Children and young people (CYP)</u>

In response to the Core20PLUS5 CYP priorities, the ICB appointed a clinical lead in April 2024 to deliver the national bundle of care for CYP epilepsy. The bundle focuses on:

1) Addressing variation in care between epilepsy services,
2) Supporting mental health and wellbeing of CYP with epilepsy,
3) Improving referrals into tertiary services,
4) Improving transition from paediatric to adult epilepsy services.

2.42. There will also be a focus on ensuring that the local epilepsy12, a national clinical audit system, data is maintained and kept up to date. This data is key to identifying local variation in CYP epilepsy care and benchmarking both regionally and nationally. Additionally, CUH is hosting Psychology Adding Value in Epilepsy Pilot (PAVES), which links into a key delivery requirement of the national bundle of care.

2.43. The delivery of the CYP national pilot and CYP national asthma bundle of care has been hosted by Cambridgeshire Community Services (CCS) since April 2023. The strategic clinical leadership of this sits under CUH. To date, the team have worked with ICB practices based in areas of higher deprivation and with poorer asthma outcomes. Through the pilot work and

the delivery of the national bundle, the team are covering the areas of clinical focus outlined within the Core20PLUS5 approach which aims to address reliance on reliever medications and decrease the number of asthma attacks. In addition, a respiratory physio community clinic has been established to address the need of CYP with complex chest conditions / complex disabilities to prevent frequent admission to hospital with chest infections.

2.44. A CYP Diabetes GIRFT visit was undertaken earlier this year which identifies key areas for improvement that are being actioned in relation to transitions particularly. In addition, a tertiary service has been established at CUH for supporting and managing CYP with excess weight which could lead to future co-morbidities.

2.45. CYP mental health remains a priority for the ICB to ensure children are ready to enter education and exit, prepared for the next phase of their lives. With the prevalence of issues affecting children and young people's mental health increasing, a central approach being taken to address health inequalities in access to mental health services is through the embedding of co-produced quality improvement initiatives, with a commitment to listen to, discuss and act on the voices of young children, young people and their families. The Cambridgeshire and Peterborough Children and Young People's Mental Health strategy identified the following key priorities:

- Improving access and equity to emotional wellbeing and mental health help and treatment for 0-25 year olds
- Targeting children and young people who are at increased risk of developing mental health issues
- Improve the safety and experience of young people transitioning from children's services to adult mental health services.

2.46. As part of the CYP MH strategy, the 'Keyworker collaborative' (hosted by two third sector organisations) is a programme designed to prioritise children and young people who are living with Learning Disability and/or Autism who have other complex behaviour or mental health needs that could increase risk of hospitalisation. The keyworker function includes:

- support to remain in their local communities
- support during inpatient admission, to help avoid longer than stays than needed
- reduce risk of re-admission
- resettlement into their communities.
- dynamic process of early identification and linked to the Dynamic Support Register

Keyworkers help develop self-advocacy and empowerment and encourage children and young people/adults to actively engage in planning for their future.

2.47. The Access & Inequalities Vaccine Project seeks to improve uptake of childhood and respiratory immunisations in Cambridgeshire and Peterborough. Focusing specifically on Core20PLUS population groups, which have particularly low vaccine uptake, the project provides additional opportunities for these population groups to take up the offer of a vaccination. This includes supporting GP practices with low uptake rates and organising pop-up community clinics to target specific populations. The project commenced in July 2024 and a total of 1072 additional vaccinations were given in Q2 of 2024/25, across 7 different sites. Sites included GP practices situated in deprived areas, asylum seeker accommodation and

university campuses. The project was initially funded for 12 months but will now continue until June 2026 because of additional funding into the project.

2.48. Impact assessment process

In their NHSE-commissioned report on Reducing Health Inequalities through New Models of Care, the Institute of Health Equity recommended that Health Inequalities Impact Assessments (HIIAs) are undertaken as an integral part of policy development and decision making to reduce health inequalities.

2.49. In September 2024, a new consolidated two-stage impact assessment process was implemented across the ICB which will be overseen by the Strategic Commissioning Unit. The updated process ensures compliance with the ICB's statutory duty under both the Health Care Act 2012 and the Public Sector Equality Duty 2011 to evaluate the impacts of its decisions, while embedding the need to assess the impact in relation to equality and health inequalities and those population groups most at risk of experiencing health inequalities.

2.50. Embedding a robust health inequality impact assessment process, one of the recommendations included in the Cambridgeshire and Peterborough Health Inequality Strategy, ensures that all proposals that seeks ICB funding, decommissioning or transformation of services, are accompanied by a robust impact assessment. The process has been designed after many months of collaboration with internal and external stakeholders to assure the safety, quality and fairness of the services that the ICB commissions.

2.51. Inclusion Health

Inclusion health is an umbrella term used to describe people who are socially excluded, who typically experience multiple interacting risk factors for poor health, such as stigma, discrimination, poverty, violence, and complex trauma. People in inclusion health groups tend to have poor experiences of healthcare services because of barriers created by service design. These negative experiences can lead to people in inclusion health groups avoiding future contact with NHS services and being least likely to receive healthcare despite have high needs. This can result in significantly poorer health outcomes and earlier death among people in inclusion health groups compared with the general population.

2.52. In November 2023, NHS England published a national inclusion health framework to help meet the healthcare needs of people in inclusion health groups. Cambridgeshire & Peterborough ICB was successful in an EoI process to be a part of the second wave of the national Inclusion Health Learning Programme in partnership with Pathway, Groundswell and NHS England. Seven systems were chosen from a total of 22 ICSs who applied. Six learning sessions took place throughout Q1 2024/25 with representation from across Cambridgeshire and Peterborough ICS including the ICB, North/South Care Partnerships, local authorities, public health and the VCSE sector.

2.53. At the end of June 2024, and building on the inclusion health learning programme, C&P ICB held a system wide Knowledge Sharing Event to highlight examples of initiatives already in place to address health inequalities amongst inclusion health groups; to share the outcomes of the recent homeless health needs audit; and to facilitate discussions around the new inclusion health framework published by NHSE. The event was attended by more than 80 people with representation from across the system including from primary care, secondary

care, local authority, public health, and the voluntary sector. The feedback from the event was overwhelmingly positive.

2.54. As a result of this programme, the ICB hosted an inclusion health knowledge sharing event for ICS partners to help develop a collective understanding of 'inclusion health' and the healthcare inequalities faced from those with lived experience. The event also showcased some of the projects and initiatives already in place which have been implemented to address healthcare inequalities amongst inclusion health groups such as the Wildflowers Project, Changing Futures Programme, and the Peterborough Homeless Health Hub. A new inclusion health network has since been established to maintain momentum in this space and to help facilitate connections across the system.

2.55. In addition, the Homeless Health Needs Audit (HHNA), which was commissioned by the ICB and developed in partnership with Homeless Link, was published in January 2024. The needs audit provides a detailed insight into the health needs of the homeless population within Cambridgeshire and Peterborough to help inform future commissioning decisions. The HHNA uses a survey methodology to assess the health needs of people experiencing homelessness with a total of 228 surveys completed and with the initial support of 60 homelessness service providers.

2.56. <u>Voluntary, Community and Social Enterprise Sector (VCSE)</u>

Significant progress has been made since the ICS VCSE Strategy launched in 2022. Highlights include development and expansion of the Voluntary Sector Network, including the establishment of a clear structure and strategic steering board; launch of the £2million Healthier Future's Fund and two rounds of the ICB/Assura Community Grants Programme; VCSE representation roles on all ICB committees and accountable business units; development of a VCSE data catalogue; approval of a research business case in partnership with Anglia Ruskin University to support the future sustainability and enhancement of our system-wide volunteering workforce; and ICB training and development offers made to the sector.

2.57. In March 2024, the ICB secured funding from NHS England to review the ICS VCSE Strategy and assess relationship maturity using the national VCSE Quality Development Tool. This involved facilitated workshops with diverse VCSE organisations and ICS partners to assess the six development areas and identify opportunities for future action. A broader consultation has since been launched to gather additional feedback. This included a survey, dedicated workshops, and discussions on the action plan at various forums, including North and South Place Partnership Boards, Health Inequalities Strategic Oversight Group, ICB Leadership and Culture Enabling Group, and the system Aligning Support to the VCSE steering group. The final action plan, aligned with the Strategy's four strategic goals, is currently going through the ICB governance for approval.

2.58. Our first Participation and Involvement Network Summit took place in September 2024, attended by over 50 co-production experts from across the system. The purpose was to explore how we further amplify and embed people's voices to lead change and inform decision making, so that co-production becomes common practice. The Network, established by the ICB in December 2023, has since expanded to include over 100 members from a diverse range of sectors and organisations, driven by collective challenges and a desire to collaborate.

2.59. Summary

The Committee is asked to acknowledge the breadth of work associated with the healthcare inequalities programme and the contribution the ICB is making in terms of reducing health inequalities across Cambridgeshire and Peterborough.

The Committee is also asked to acknowledge that tackling health inequalities requires a coordinated approach across system partners that goes beyond the remit of the healthcare inequalities programme, the ICB and the NHS.

3. Source documents

3.1. British Red Cross; Nowhere else to turn: Exploring the high intensity use of accident and emergency services, November 2021 (Nowehere else to turn: Exploring the High Intensity Use of Accident and Emergency Services)

3.2. Cambridgeshire and Peterborough Joint Strategic Needs Assessment 2023 (Cambridgeshire & Peterborough Insight – JSNA 2023)

3.3. Department of Health and Social Care, Fingertips (Fingertips | Department of Health and Social Care)

3.4. Institute of Health Equity; Reducing health inequalities through new models of care: A resource for new care models (reducing-health-inequalities-through-new-models-of-care-a-resource-for-new-care-models.pdf)

3.5. NHS Cambridgeshire and Peterborough ICB Joint Forward Plan 2024-29 (ICB Joint Forward Plan 2024-29)

3.6. NHS England Inclusion Health Framework; Action on inclusion health, October 2023 (NHS England » A national framework for NHS – action on inclusion health)

3.7. NIHR Case Study; How health and care systems can improve ethnicity data collection to help combat inequality, September 2024 (NIHR Case Study)

3.8. The Health Foundation; Interpreting the latest life expectancy data, February 2024 (Interpreting the latest life expectancy data - The Health Foundation)

3.9. The Health Foundation; Life expectancy and health life expectancy at birth by deprivation, January 2022 (Life expectancy and healthy life expectancy at birth by deprivation | The Health Foundation)

3.10. The Kings Fund; Tackling health inequalities: seven priorities for the NHS, September 2024 (Tackling Health Inequalities | Seven Priorities For The NHS | The King's Fund)

3.11. The King Fund; What are health inequalities, June 2022 (What Are Health Inequalities? | The King's Fund)

3.12. The Kings Fund; What is happening to life expectancy in England, April 2024 (What Is Happening To Life Expectancy In England? | The King's Fund)

4. Appendices

Appendix A – Summary table of key health inequality initiatives / programmes and their alignment to NHSE's strategic priorities and Core20PLUS5 approaches