Bath and North East Somerset, Swindon and Wiltshire Partnership

Working together for your health and care

BSW Inequalities Strategy

2021-2024

May 2022

Version control

Version	Date		Initials
Final	12/05/2022	Version 3.2 approved as final at PHCG 11/05/22	HSJ
3.2	11/04/2022	Updated following additional review inc. maternity lead	HSJ
3.1	05/04/2022	Updated following review with SRO Health Inequalities and CYP lead	HSJ
3	18/03/2022	Updated following feedback from ISG 04/03/22 and PHCG 09/03/22	HSJ
2	Feb 2022	Updated following feedback up to 09/02/22	HSJ
1	Jan 2022		HSJ

Contents

Vision

To work in partnership to tackle inequalities across the life course to ensure that every resident of Bath, North East Somerset, Swindon, and Wiltshire can live longer, healthier, happier lives.

What we committed to delivering against the following phases:

Phase 1

- To make inequality everybody's business through awareness raising, training and engagement with partners and communities

Phase 2

To tackle healthcare related inequalities by:

- Implementing the NHS Five Key Priorities

    1. Restore service inclusively
    2. Mitigate against digital exclusion
    3. Ensure datasets are timely and complete
    4. Accelerate preventative programmes
    5. Leadership and accountability.

- Implementing the *Core20PLUS5* programme. The programme focusses on the core 20% of most deprived areas PLUS communities at higher risk of inequality (e.g. those with black, Asian and minority ethnic backgrounds) focussing initially in five clinical areas:

    1. CVD
    2. Maternity
    3. Respiratory
    4. Cancer
    5. Mental Health (including. children and young people)

Phase 3

To focus on prevention, social, economic and environmental factors (known as 'wider determinants')

- To establish Anchor institution status at BSWs three hospitals
- To publish three place-based Joint Strategic Needs Assessments for BANES, Swindon and Wiltshire
- To establish local priorities that address public health and the social, economic, and environmental factors most affecting inequalities at place
- To plan and enable progress on prevention where outcomes will take longer to see
- Tackle life course obesity using a whole systems approach
- Tackle inequality linked to smoking using a whole systems approach

What will success look like?

Making Inequalities everybody's business

- All staff, partners, and communities to understand inequality and how we seek to address this in BSW

Tackling healthcare inequalities

- Work with commissioners and service providers to ensure robust and up-to-date data across the system on where inequalities are, and clear plans on how close the inequality gaps to offer exceptional quality healthcare for all through equitable access, excellent experience, and optimal outcomes

- Achieving the Core20PLUS5 targets to reduce the inequality gaps identified in the five clinical areas

Tackling inequality by addressing social, economic, and environmental factors

- Establish and harness the potential of local anchor Institutions in our three acute hospitals and mental health trust to deliver positive change across all domains of anchor influence including employment, procurement, and environmental impact

- Halt and reverse obesity prevalence in children and adults across BSW

- Reduce smoking prevalence across BSW, with targeted focus on routine and manual occupations and smoking in pregnancy

- Demonstrate action on inequalities that spans from system to place through joined up strategy and planning

The BSW Inequalities Strategy aims to provide a framework for system activity to reduce health inequalities. The strategy has been developed from key guidance and policy relating to reducing healthcare inequalities, as well as recognising the need for close partnership working with colleagues at a place level to address wider determinants of health. This strategy aims to address inequalities across the life course, to include pregnancy, children and young people, adults and into old age.

Action on health inequalities requires improving the lives of those with the worst health outcomes, fastest.

What are health inequalities?

Health Inequalities are *unfair* and *avoidable* differences in health across the population, and between different groups within society. (The King's Fund, 2020). They arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health, and wellbeing.

Health inequalities have been documented between population groups across at least four dimensions, as illustrated in figure 1 below. It is important to note that these are overlapping dimensions with people often falling into various combinations of these categories.

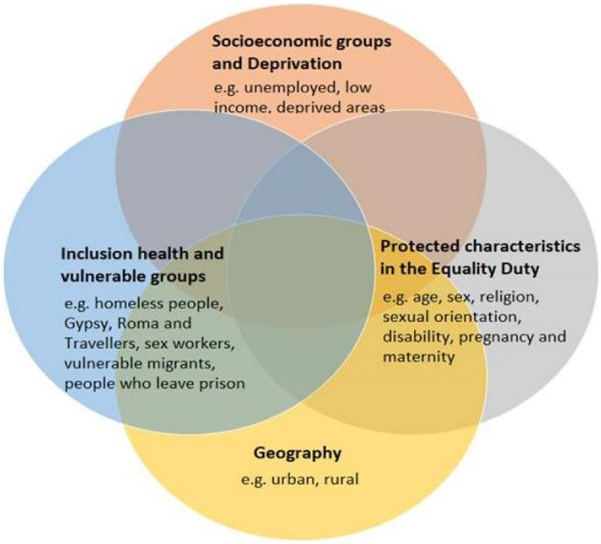


Figure 1 taken from: Health Equity Assessment Tool (HEAT): executive summary - GOV.UK (www.gov.uk)

Examples of the characteristics of people/communities in each of these groups are below (this is not an exhaustive list):

- Socio-economic status and deprivation: e.g. unemployed, low income, people living in deprived areas (e.g. poor housing, poor education and/or unemployment)
- Protected characteristics: e.g. age, sex, race, sexual orientation, disability
- Vulnerable groups of society or 'inclusion health' groups: e.g. vulnerable. migrants; Gypsy, Roma and Traveller communities; rough sleepers and homeless people; and sex workers
- Geography: e.g. urban, rural.

Inclusion Health Groups: Inclusion Health has been used to define a number of groups of people who are not usually well provided for by healthcare services, and have poorer access, experiences and health outcomes. The definition covers people who are homeless and rough sleepers, vulnerable migrants (refugees and asylum seekers), sex workers, and those from the Gypsy, Roma and Traveller communities.

Protected Groups: The protected characteristics covered by the Equality Act 2010 are: age, disability, gender reassignment, marriage and civil partnership (but only in respect of eliminating unlawful discrimination), pregnancy and maternity, race—this includes ethnic or national origins, colour or nationality, religion or belief—this includes lack of belief, sex, sexual orientation

People living in deprived areas: Evidence says that people living in our most deprived areas face the worse health inequalities in relation to health access, experiences and outcomes. When we talk about deprived areas, in relation to geography, this means we are working to address inequalities in urban and rurally deprived areas of England.

Health inequalities can involve differences in:

- 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

This strategy aims to address the unfair and avoidable differences in health by focusing on groups that suffer the greatest inequalities and those with the poorest health outcomes. This typically highlights deprivation and ethnicity as the most influential indicators of inequalities. The BSW Inequalities strategy takes this focus, rather than looking more broadly at all disadvantaged groups (e.g. across all protected characteristics). This is addressed through BSW Equality, Diversity, and Inclusion work, which ensures policies and measures meet the diverse needs of our service, population, and workforce, ensuring that none are placed at a disadvantage over others.

Children and Young People

Inequality affects people of all ages; however, there are some stages of the life-course at which inequality can have a particularly significant impact (Understanding Inequalities, 2022). Children and young people are often more affected by, and subject to, inequality than adults and they are often the least able to defend themselves against it. The impact of inequalities experienced in childhood can have a long-term effect across the life-course.

Intersectionality

Multiple sources of inequality produce intersectional identities which are affected by several discriminations and disadvantages. For example, more deprived areas have on average nine times less access to green space, higher concentrations of fast-food outlets and more limited availability of affordable healthy food than less deprived areas (The King's Fund, 2020).

Healthcare inequality

Healthcare inequality relates specifically to unfair and avoidable differences in how different groups access and experience *healthcare*, and the resulting outcomes. Health inequalities span across

several domains of influence, from the individual through to much wider social and economic conditions, as shown in figure 2. Healthcare inequalities have a narrower focus and are defined by the conditions which can be influenced more directly by healthcare services and the NHS.

Social, economic, and environmental factors

Our health is shaped by a complex interaction between many factors. These include the quality of health and care services, individual behaviours, the places and communities in which people live and wider determinants such as education, housing and access to green space. Health inequalities arise because of systematic variations in these factors across a population.

Sometimes referred to as the *wider determinants of health,* the social, economic, and environmental conditions in which people live that have an impact on health. They include income, education, access to green space and healthy food, the work people do and the homes they live in.

Inequalities in these factors are inter-related: disadvantages are concentrated in particular parts of the population and can be mutually reinforcing. Lower socio-economic groups, for example, tend to have a higher prevalence of risky health behaviours, worse access to care and less opportunity to lead healthy lives.

The interactions between different kinds of inequality, and the factors that drive them, is often complex and multidirectional. People can find it more difficult to move away from unhealthy behaviours if they are worse off in terms of a range of wider determinants of health. Access to green space, on the other hand, seems to weaken the relationship between income and health status in a complex way. We can influence health in other ways for example by improving air quality, improving the built and natural environment, access to work, education and skills, having quality housing and living conditions, access to benefits and addressing justice health.

Adapted from: Williams, Buck and Babalola (2020).

Figure 2: Dahlgren, G. and Whitehead, M. (1993) Tackling inequalities in health: what can we learn from what has been tried?

What are the consequences of these health inequalities?

The report '*Fair Society, Healthy Lives'* (Marmot, 2010) highlighted health inequality in England, and the consequences on the health and wellbeing of the population. Key findings include:

- People living in the poorest neighbourhoods in England will on average die seven years earlier than people living in the richest neighbourhoods

- People living in poorer areas not only die sooner, but spend more of their lives with disability - an average total difference of 17 years
- The Review highlights the social gradient of health inequalities - put simply, the lower one's social and economic status, the poorer one's health is likely to be
- Health inequalities arise from a complex interaction of many factors - housing, income, education, social isolation, disability - all of which are strongly affected by one's economic and social status
- Health inequalities are largely preventable. Not only is there a strong social justice case for addressing health inequalities, there is also a pressing economic case. It is estimated that the annual cost of health inequalities is between £36 billion to £40 billion through lost taxes, welfare payments and costs to the NHS
- Action on health inequalities requires action across all the social determinants of health, including education, occupation, income, home and community
- Early childhood is a critical time for development of later life outcomes, including health. Less positive experiences early in life, particularly experiences of adversity, relate closely to many negative long-term outcomes: poverty, unemployment, homelessness, unhealthy behaviours, and poor mental and physical health (Marmot, 2010, p. 17)

Evidence shows that the Covid-19 pandemic has exacerbated existing health inequalities. The 2020 update to the original 2010 Marmot report highlights those outcomes have got worse for those already suffering from inequalities in health. For example, ten years on:

- people can expect to spend more of their lives in poor health
- improvements to life expectancy have stalled, and declined for the poorest 10% of women
- the health gap has grown between wealthy and deprived areas
- relative child poverty has worsened, living in a household with less than 60 percent of median income, after housing costs will increase from 30 percent to 36.6 percent in 2021 in the UK (Marmot, 2010, p. 17)
- place matters – living in a deprived area of the North East is worse for your health than living in a similarly deprived area in London, to the extent that life expectancy is nearly five years less.

In addition to the effect on health and wellbeing and social injustice of these inequalities, there is an economic and societal cost to the widening gaps between population groups. For example:

- The extra costs to the NHS of health inequalities have been estimated as £4.8 billion a year from the greater use of hospitals by people in deprived areas alone.
- Health inequalities reduce employment and productivity - which has a cost for the national and local economies
- The burden of ill health and disability, as well as premature mortality, is disproportionately focussed on the most deprived populations. These sections of society are least equipped and resourced to make best and most appropriate use of services. If the ‘unmet need’ for preventive services and those for early detection and management is not addressed in those at greatest risk, a large part of the growing burden and cost will persist (NHS, 2018)
- It is also a legal requirement to take account of inequalities under the Health and Social Care Act (2012)
- The impact of inequality in childhood can last a lifetime and what happens during early years (starting in the womb) has lifelong effects and greatly influences health and well-being outcomes for adults

Inequalities in BSW

Demographics

Bath and North East Somerset, Swindon and Wiltshire has a combined population of around 923,000 people (BSW System Intelligence Report, 2021). Life expectancy across the three areas varies from 73 years to 91 years according to sex and geographical location.

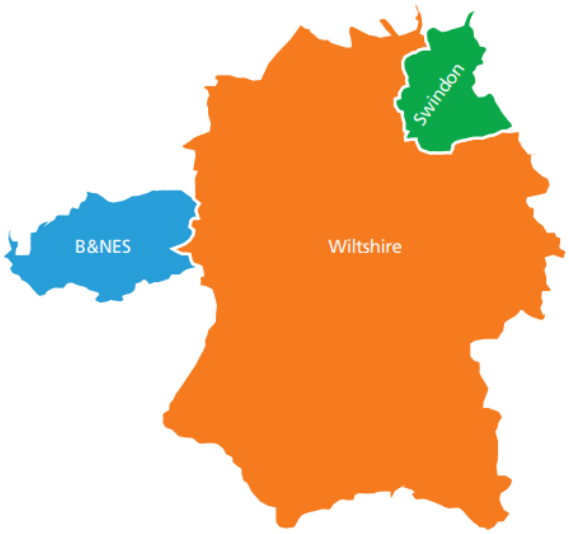


Figure 3 Map of Bath and North East Somerset, Swindon and Wiltshire taken from 'Our plan for health and care 2020-2024', BSW Partnership (2020)

Figure 4-6 (taken from *BSW system Intelligence Report*; BSW, 2021) highlights population sizes, breakdown by age group, life expectancy, healthy life expectancy, and inequality in life expectancy.

Inequality in life expectancy is represented by the slope index of inequality (SII), which is based on statistical analysis of how much life expectancy varies with area deprivation. The SII represents the range in years of life expectancy across the social gradient from most to least deprived.

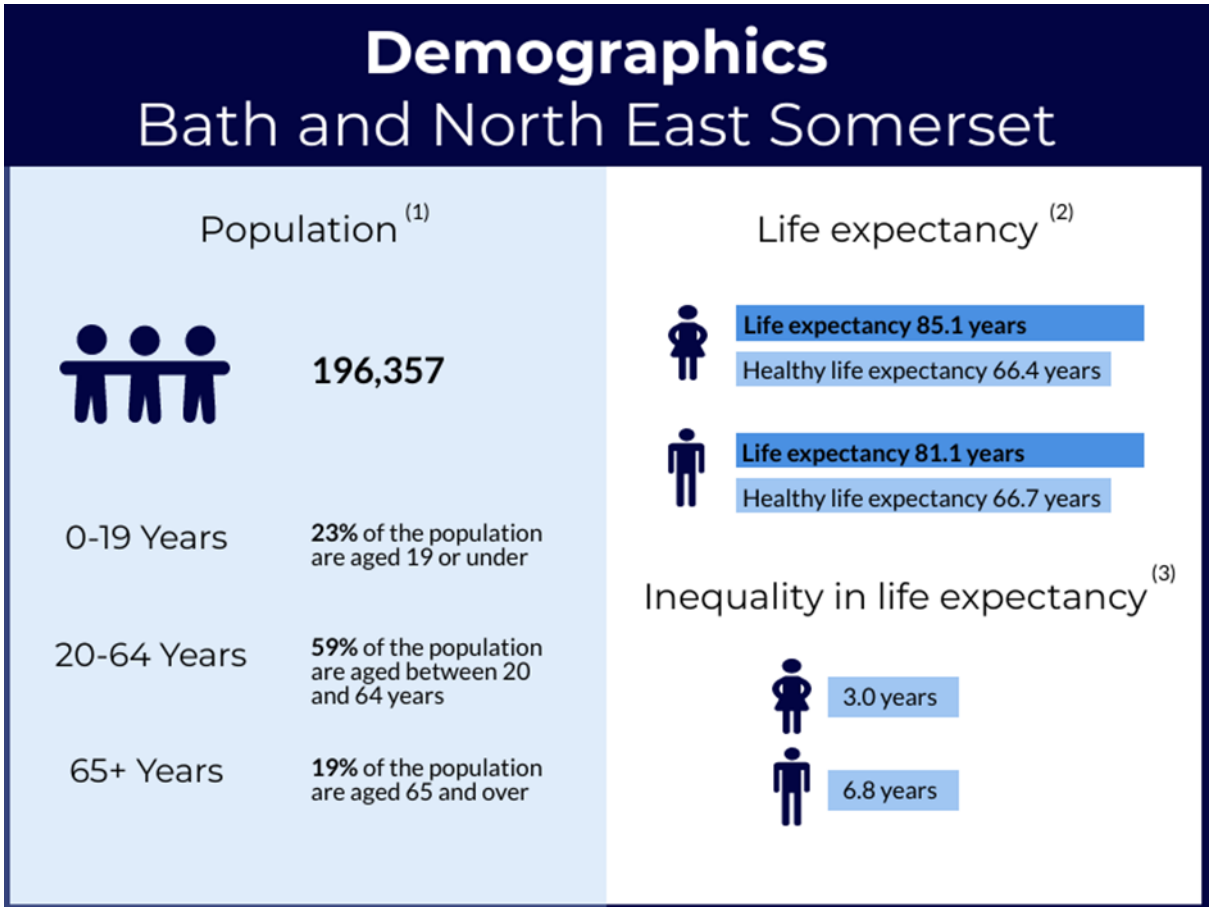


Figure 4 Demographics BANES (BSW Partnership, 2021)

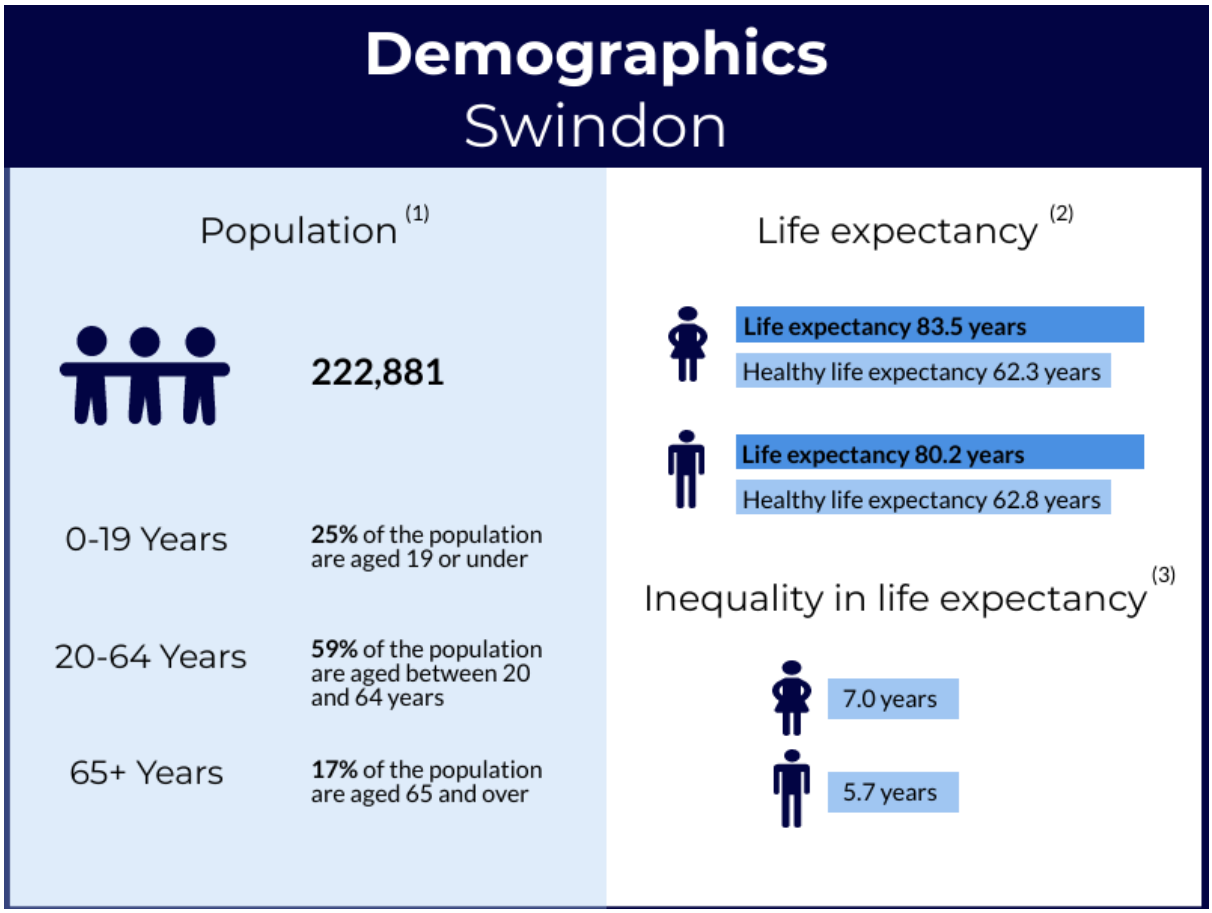


Figure 5 Demographics Swindon (BSW Partnership, 2021)

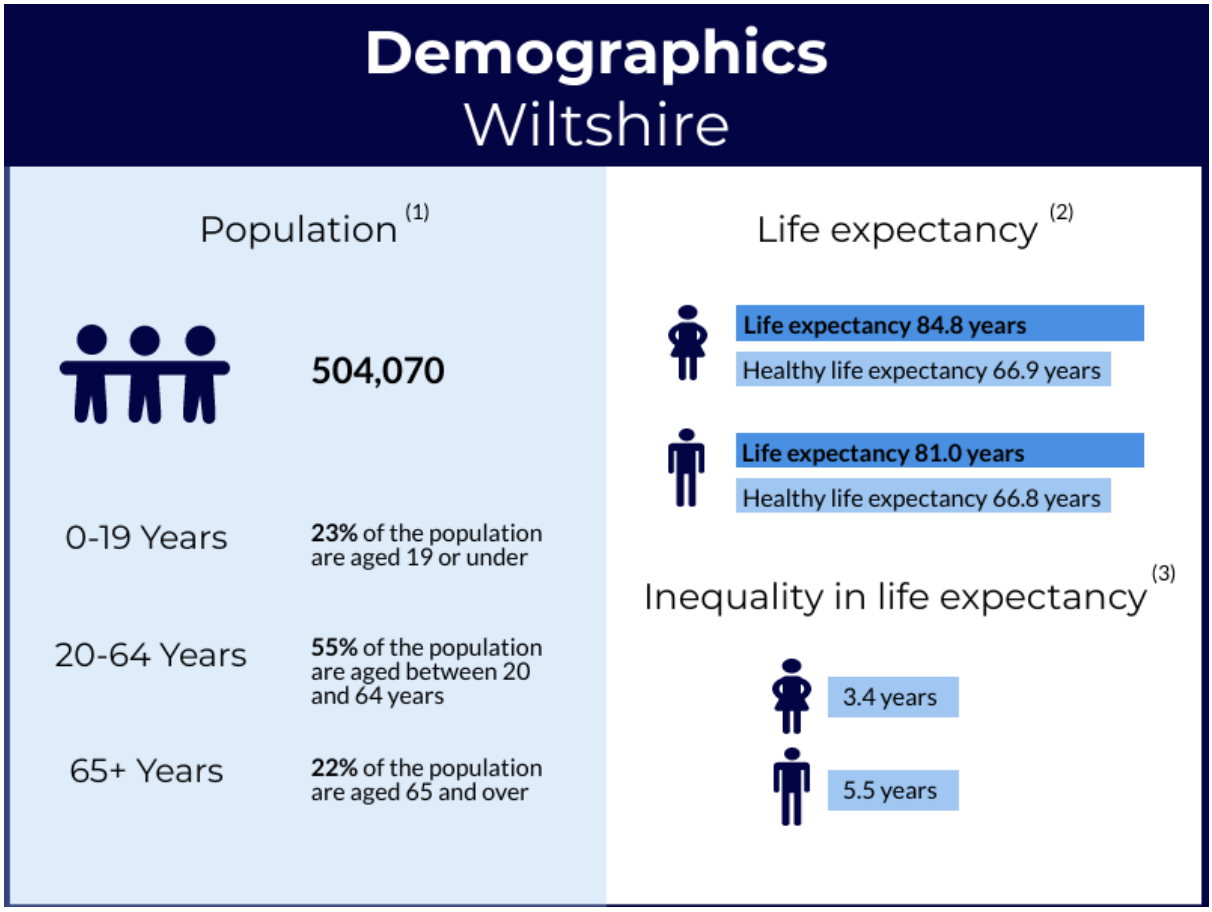


Figure 6 Demographics Wiltshire (BSW Partnership, 2021)

In BANES and Wiltshire, and nationally, the social gradient in life expectancy is steeper for males. In Swindon, however, the social gradient in life expectancy is steeper for females.

There are further variations in life expectancy between neighbourhoods in BSW. For example, a female in Bathavon South, BANES, can expect to live for 91 years, whereas a male from Trowbridge Central, Wiltshire, can expect to live for 73 years (BSW Partnership, 2021).

Deprivation

People living in deprived areas on average have poorer health and shorter lives. Research shows that socioeconomic inequalities result in increased morbidity and decreased life expectancy. The UCL Institute of Health Equity estimates 1.3 to 2.5 million potential years of life lost annually due to inequalities (Marmot, 2010). Males living in the most deprived tenth of areas can expect to live 9 fewer years compared with the least deprived tenth, and females can expect to live 7 fewer years (Public Health England, 2017).

What defines whether an area is a deprived area is based on a number of characteristics included in the Index of Multiple Deprivation (IMD) – Income Deprivation, Employment Deprivation; Education, Skills and Training Deprivation; Health Deprivation and Disability; Crime; Barriers to Housing and Services; Living Environment Deprivation.

According to the IMD (2019), Bath, North East Somerset, Swindon, and Wiltshire remains one of the least deprived parts in the country. However, this overall average masks pockets of deep deprivation and inequality within each area, including two neighbourhoods within the most deprived 10% nationally. Swindon has a higher level of deprivation compared to Wiltshire and Bath and North

East Somerset. See appendix two for detailed breakdown of deprivation by neighbourhood across BSW.

Quintiles: Best | Worst | Not applicable

Recent trends: – Could not be calculated | No significant change | Increasing | Decreasing

Deprivation score (IMD 2019) 2019 — Score

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	21.7	-	-
South West region	–	-	18.2	-	-
Torbay	–	-	28.1	-	-
Plymouth	–	-	26.6	-	-
Bristol	–	-	26.4	-	-
Cornwall	–	-	23.1	-	-
Swindon	–	-	18.6	-	-
Somerset	–	-	18.6	-	-
Bournemouth, Christchurch and Poole	–	-	18.2	-	-
Devon	–	-	16.6	-	-
North Somerset	–	-	15.8	-	-
Dorset	–	-	15.7	-	-
Gloucestershire	–	-	14.9	-	-
Wiltshire	–	-	13.4	-	-
Isles of Scilly	–	-	12.0	-	-
Bath and North East Somerset	–	-	11.7	-	-
South Gloucestershire	–	-	11.7	-	-

Table 1: Office for Health Improvement & Disparities (2022).

As there is variation in deprivation across the South West region, there is also variation within the local authorities as exemplified here across the wards in Swindon.

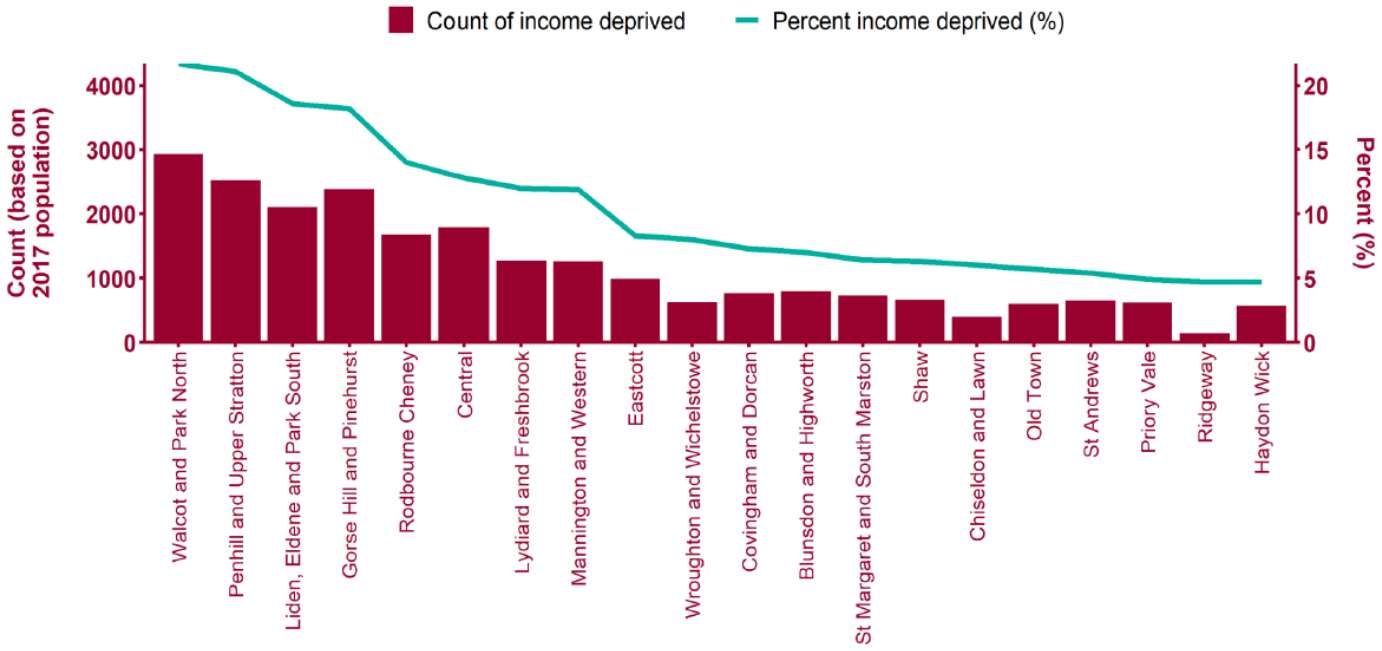


Figure 7 Income deprivation by ward in Swindon (IMD, 2019; taken from presentation by Maddern and Arulrajah, 2021)

During the pandemic there have been disproportionate deaths from COVID-19 between those living in the most deprived areas and those living in the least deprived areas. These mirror higher mortality due to other causes, in line with social gradient (Dodge and Owolabi, 2021).

Ethnicity

Ethnicity also has a large and complex effect on health. In England, inequality is experienced when comparing ethnic minority groups and those from white ethnic groups, and between different ethnic minority groups (Robertson et al., 2021). The infographic below (figure 8) highlights just some of the stark health inequalities related to ethnicity in the UK.

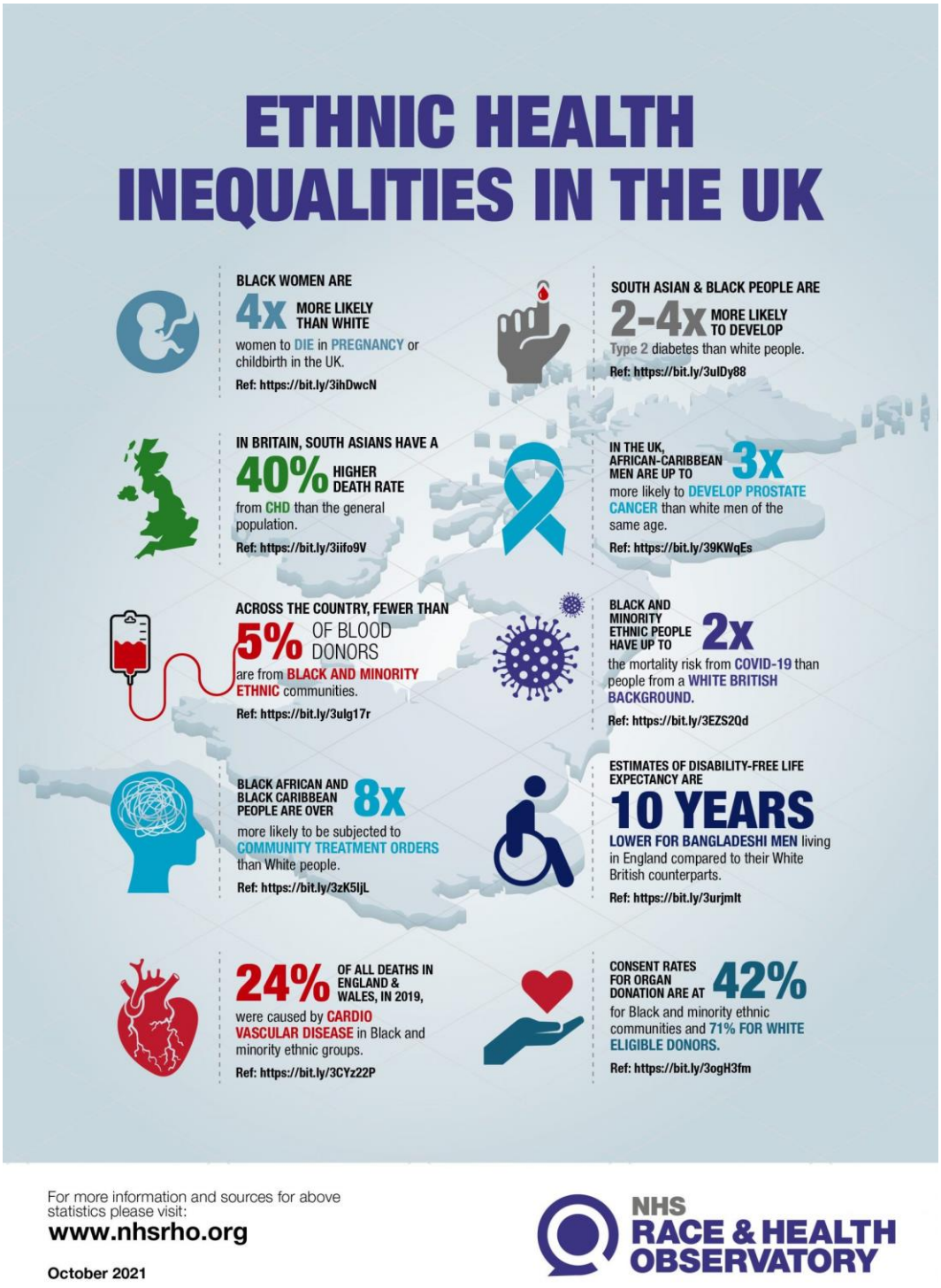


Figure 8 Taken from NHS - Race and Health Observatory (2021)

Nationally, the Covid-19 pandemic has had a disproportionate impact on ethnic minority communities, who have experienced higher infection and mortality rates than the white population.

Geography, deprivation, occupation, living arrangements and health conditions such as CVD and diabetes accounted for a large proportion, but not all, of the excess mortality risk of Covid-19 in ethnic minority groups (Raleigh and Holmes, 2021). It is important to understand the distribution of different ethnic groups across BSW as health outcomes, attitudes and beliefs, as well as health service accessibility and usage can vary.

There are approximately 100,000 people from Black and Minority Ethnic (BME) communities living in BSW (ONS, 2017). Swindon has significantly more residents from a black and ethnic minority group: 10.2% in Swindon, compared to 5.4% in BANES and 3.4% in Wiltshire (ONS, 2011). In BANES and Wiltshire, 'All other white' group is the largest ethnic group after 'White British', whereas in Swindon it is 'Asian/Asian British'.

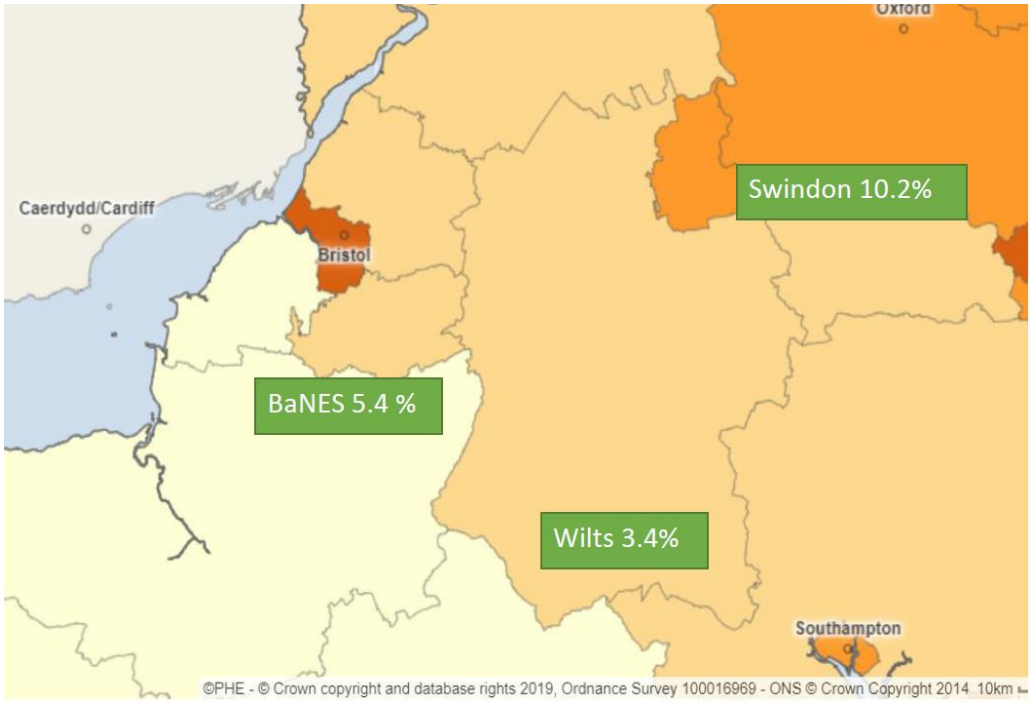


Figure 9 BSW Black and Ethnic Minority Population, 2011

Preventable risk factors

Although inequalities are broad and intersectional, it is clear there is strong evidence that people from socio-economically deprived populations and certain ethnic minority groups experience poorer health than the rest of the population, so it is particularly important to focus preventative services on these groups.

Ill health and premature mortality is considered preventable if, in the light of the understanding of the determinants of health at the time of death, all or most deaths from the underlying cause (subject to age limits if appropriate) could potentially be avoided by public health interventions in the broadest sense.

Smoking is the single largest driver of health disparities between the most and least affluent quintiles. Obesity is the next biggest preventable risk factor and obesity in children has seen a major increase during the pandemic, especially in the least well off (NHS, 2022). In BSW, this is supported by figure 10, showing the contribution to the gap in life expectancy in the most and least deprived groups by broad cause of death.

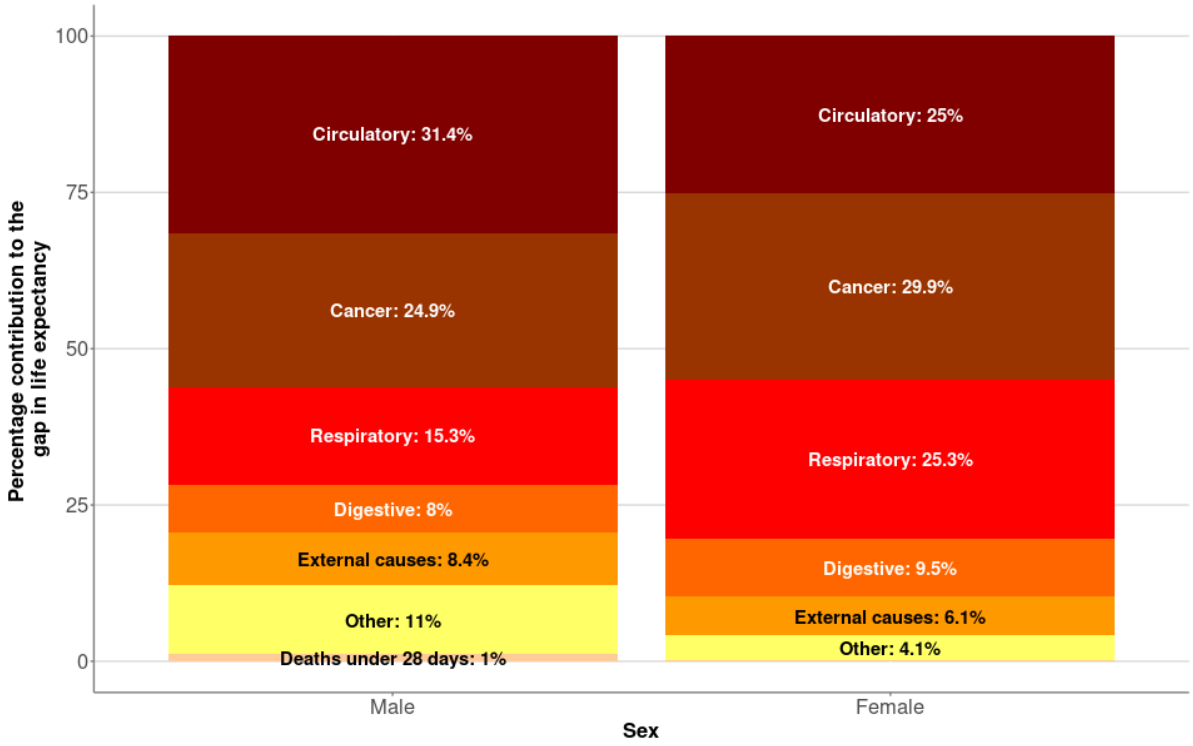


Figure 10 Scarf chart showing the breakdown of the life expectancy gap between the most deprived quintile and least deprived quintile of Bath and North East Somerset, Swindon and Wiltshire, by broad cause of death, 2015-17.

Smoking

Smoking is the leading cause of preventable illness and premature death in England, with about half of all lifelong smokers dying prematurely, losing on average around 10 years of life (Public Health England, 2019). There are around 128,000 smokers in BSW. This has increased since 2019, due to population growth and a slight increase in smoking prevalence in BANES and Wiltshire (BSW Partnership, 2021).

The decline in smoking prevalence in the last few decades has been more prominent in affluent groups, meaning that inequalities in smoking prevalence have widened (Mackenbach, 2011). Smoking is a key mediator of the effect of socioeconomic deprivation on mortality and therefore an important driver of health inequalities.

Smoking Prevalence in adults (18+) - current smokers (APS) 2019

Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	-	6,144,703	13.9	13.6	14.1
South West region	-	633,500	14.0	13.3	14.7
Plymouth	-	38,738	18.5	15.8	21.2
Bristol	-	66,358	18.0	15.2	20.7
Cornwall	-	69,931	15.2	12.6	17.7
Torbay	-	16,590	15.0	12.6	17.3
Wiltshire	-	57,527	14.6	12.2	17.0
Somerset	-	64,912	14.4	11.8	17.0
Bournemouth, Christchurch and Poole	-	44,330	13.9	11.8	15.9
Devon	-	88,461	13.5	11.2	15.7
Swindon	-	22,505	13.1	10.7	15.5
Bath and North East Somerset	-	20,484	13.0	10.5	15.6
Gloucestershire	-	65,858	13.0	10.7	15.2
North Somerset	-	19,276	11.3	9.0	13.5
South Gloucestershire	-	25,299	11.2	8.8	13.6
Dorset	-	31,530	10.1	7.8	12.5
Isles of Scilly	-	.	.	.	.

Table 2 Office for Health Improvement & Disparities (2022).

In all three local authority areas, the prevalence of smoking for people in routine and manual occupations is over double the prevalence for people in managerial and professional occupations. In BANES and Wiltshire, over a quarter of routine and manual workers are current smokers.

In all three local authority areas, the prevalence of smoking for people in social housing is over four times the prevalence for people who own their home outright. Smoking inequalities by housing tenure are greatest in Swindon, where 40% of people who rent from a local authority or housing association are current smokers, compared with 6% of people who own their house outright.

Taken from BSW Partnership 'NHS Long Term Plan - internal intelligence briefing' 2021.

Obesity

Obesity does not affect all groups equally, it increases with age, and is more common in middle aged adults, people with low incomes, some BME groups and people with mental health issues, learning or physical disabilities (Batterham, 2020).

For children and adults, obesity and poor diet are linked with type 2 diabetes, high blood pressure, high cholesterol, and increased risk of respiratory, musculoskeletal, and liver diseases.

Increasingly, children with obesity are being diagnosed with a range of health conditions previously seen almost exclusively among adults. Obesity in childhood can also result in serious psychological difficulties (Childhood Obesity Foundation, 2014). In the *NHS Long Term Plan*, the UK Government has pledged to halve childhood obesity and significantly reduce the gap in obesity between children from the most and least deprived areas by 2030 (NHS England, 2019).

People with obesity are also at increased risk of certain cancers, including being three times more likely to develop colon cancer (NHS, 2019). The risk of developing type 2 diabetes is up to six times higher in certain Black, Asian and Minority Ethnic (BAME) groups.

Around two-thirds of adults in Swindon and Wiltshire live with excess weight or obesity, which is similar to the national average. BANES is significantly below the national average for overweight or obesity, but still over half of adults are affected.

Percentage of adults (aged 18+) classified as overweight or obese 2019/20

Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	62.8	62.6	63.0
South West region	–	-	62.0	61.2	62.8
Plymouth	–	-	67.5	63.0	72.0
Torbay	–	-	67.0	62.3	71.4
Swindon	–	-	66.1	61.7	70.6
South Gloucestershire	–	-	66.0	61.5	70.5
Dorset	–	-	65.9	61.1	70.4
Cornwall	–	-	65.9	61.4	70.5
Wiltshire	–	-	63.9	59.3	68.5
Somerset	–	-	62.5	60.2	64.8
Bournemouth, Christchurch and Poole	–	-	62.2	57.4	66.7
Gloucestershire	–	-	61.4	59.5	63.3
North Somerset	–	-	60.5	55.7	65.1
Devon	–	-	59.3	57.7	60.9
Bristol	–	-	57.3	55.0	59.7
Bath and North East Somerset	–	-	55.4	50.8	60.0
Isles of Scilly	–	-	52.5	44.7	60.2

Table 3 Office for Health Improvement & Disparities (2022).

The BSW Inequalities Strategy

The BSW Inequalities Strategy offers a framework to build a foundation for our shared understanding of health inequalities as a system, bringing together existing strategy and local data and intelligence and focusing this on the CORE20PLUS5 population.

Core framework that formed this strategy:

- NHS Health Inequalities Improvement Programme Policy Drivers
- NHS Long Term Plan – Chapter 2
- Covid Pandemic Phase 3 Letter – Eight Urgent Actions
- NHSE/I 21/22 Operational/Implementation Planning Guidance – 5 Key Priorities
- NHS 2021/'22 (Q1&2) Health Inequalities Priorities for Systems and Providers Health Inequalities Improvement
- NHS England » 2022/23 priorities and operational planning guidance
- Healthcare Inequalities 2022/23 Planning Guidance Advisory Note February 2022
- Health Equity in England: The Marmot Review 10 Years On - The Health Foundation
- NHS Race and Health Observatory: Supporting named leads for health inequalities on NHS boards
- Building healthier communities: the role of the NHS as an anchor institution - The Health Foundation

NHS Strategic priorities

COVID-19 has highlighted the urgent need to prevent and manage ill health in groups that experience health inequalities, as outlined in the NHS Long Term Plan. To help achieve this, NHS England and NHS Improvement issued guidance as part of its 'phase 3' response to the COVID-19 pandemic, setting out eight urgent actions for tackling health inequalities.

Systems were asked to focus on five priority areas in the first half of 2021/22, distilled from the eight actions. The 2022/23 NHS guidance outlines a requirement to continue efforts to implement the five priority areas as set out in March 2021 guidance.

Figure 11: The NHS Five Priorities (national)

Priority 1: Restore NHS services inclusively

At national level, the decline in access amongst some groups during the first wave of the pandemic broadly recovered in later months. Insight work has, however, highlighted that in some cases pre-existing disparities in access, experience, and outcomes, have been exacerbated by the pandemic. It is therefore critical that systems use their data to plan the inclusive restoration of services, guided by local evidence. This approach should be informed by NHS performance reports that are delineated by ethnicity and deprivation, as evidence suggests these are the areas where heath inequalities have widened during the pandemic.

Priority 2: Mitigate against digital exclusion

Systems are asked to ensure that:

- providers offer face-to-face care to patients who cannot use remote services
- more complete data collection is carried out, to identify who is accessing face-to-face, telephone, or video consultations, broken down by relevant protected characteristic and health inclusion groups
- they take account of their assessment of the impact of digital consultation channels on patient access.

Priority 3: Ensure datasets are complete and timely

Systems are asked to continue to improve the collection and recording of ethnicity data across primary care, outpatients, A&E, mental health, community services, and specialised commissioning. NHS England and NHS Improvement will support the improvement of data collection across all settings, including through the development of the Health Inequalities Improvement Dashboard, which will contain expanded datasets where there is currently a relative scarcity of intelligence, e.g. for people experiencing post- COVID syndrome.

Systems should also implement mandatory ethnicity data reporting in primary care, to enable demographic data to be linked with other datasets and support an integrated approach to performance monitoring for improvement.

Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes

Uptake of the COVID and flu vaccination has increased significantly across all groups, but inequality has also widened, particularly by deprivation and ethnicity. Systems and providers should take a culturally competent approach to increasing vaccination uptake in groups that had a lower uptake than the overall average as of March 2021. Preventative programmes and proactive health management for groups at greatest risk of poor health outcomes should be accelerated, as set out in the main 2021/22 planning guidance, including:

- Ongoing management of long-term conditions
- Annual health checks for people with a learning disability
- Annual health checks for people with serious mental illness
- In maternity care, implementing continuity of carer for at least 35% of women, with the proportion of Black and Asian women and those from the most deprived neighbourhoods meeting and preferably exceeding the proportion in the population.

Priority 5: Strengthen leadership and accountability

Supporting PCN, ICS and Provider health inequalities SROs to access training and wider support offer, including utilising the Health Inequalities Leadership Framework, developed by the NHS Confederation.

Core20PLUS5 – An approach to reducing health inequalities

Core20PLUS5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

Core20

The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.

PLUS

- Integrated Care System (ICS)-determined population groups experiencing poorer than average health access, experience and/or outcomes, but not captured in the 'Core20' alone. This should be based on ICS population health data.

- Inclusion health groups can include: ethnic minority communities, coastal communities, people with multi-morbidities, protected characteristic groups, people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

- In BSW, the 'PLUS' population was defined at place using public health data to determine which population groups were experiencing the worst health outcomes in addition to the 'Core20'. These are:

    - BANES: **Socially excluded groups, migrants, vulnerable children, rural communities**
    - Swindon: **Black, Asian, and minority ethnic communities**
    - Wiltshire: **routine and manual workers**, specifically those in minority groups (e.g. polish speakers). This is due to higher smoking prevalence. For example, latest data from 2019 showed 27.9% of smokers in this occupation group for Wiltshire compared with 23.2% nationally. This is also in support of the evidence that smoking is the main driver of inequalities and ties into prevention. With a significant predicted growth in older population of Wiltshire, tackling working age now has more potential long term benefit for the health and social care system.

'5'

The final part sets out five clinical areas of focus. Governance for these five focus areas sits with national programmes; national and regional teams coordinate local systems to achieve national aims.

1. **Maternity:** ensuring continuity of care for 75% of women from Black, Asian and minority ethnic communities and from the most deprived groups.

2. **Severe mental illness (SMI):** ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).

3. **Chronic respiratory disease**: a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.

4. **Early cancer diagnosis:** 75% of cases diagnosed at stage 1 or 2 by 2028.

5. **Hypertension case-finding**: to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

The clinical areas have been funnelled directly from the NHS LTP commitments on tackling health inequalities in addition to Global Burden of Disease data and Public Health England contributions. National data shows Cardiovascular Disease, Chronic Respiratory Disease (in particular COPD) and Cancer as the biggest contributors to the gap in life expectancy between the most and least deprived populations. Furthermore, the NHS LTP has highlighted maternity services and annual health checks for SMI as key areas of wide inequitable disparities.

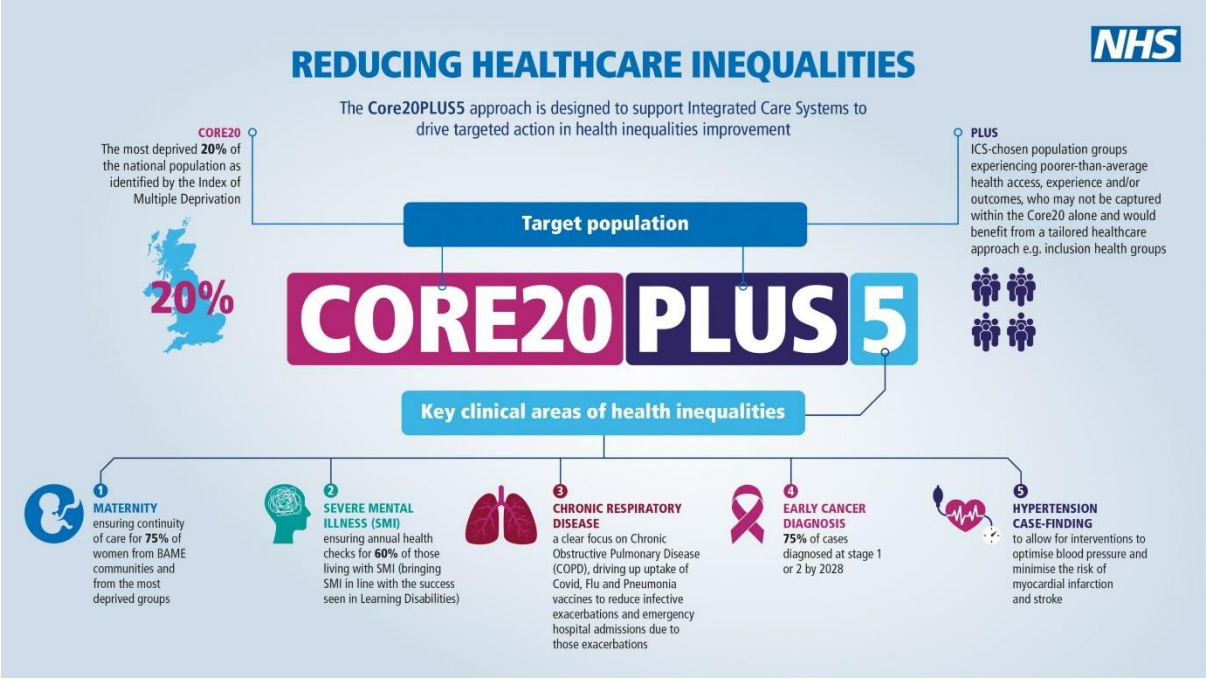


Figure 12 taken from: NHS England » Core20PLUS5 – An approach to reducing health inequalities

Prevention

Tertiary prevention	Softening the impact of an ongoing illness or injury that has lasting effects. This is done by helping people manage long-term, often-complex health problems and injuries (e.g. chronic diseases, permanent impairments) in order to improve as much as possible their ability to function, their quality of life and their life expectancy.
Secondary Prevention	Systematically detecting the early stages of disease and intervening before full symptoms develop – for example, prescribing statins to reduce cholesterol and taking measures to reduce high blood pressure.
Primary Prevention	Taking action to reduce the incidence of disease and health problems within the population, either through universal measures that reduce lifestyle risks and their causes or by targeting high-risk groups.
Wider determinants	These are the social, economic or environmental factors affecting health, such as housing, employment, education, or parks and green spaces.

Figure 13 Definitions of prevention, adapted from: Prevention | Local Government Association

Healthcare represents an important driver to reduce overall health inequalities, but this strategy seeks to encompass the broader role of prevention and the wider determinants of health. To support progress on this, BSW will also include action that take a broader view of prevention. These additional areas will be determined as data supporting this strategy from the updated BSW Joint Strategic Needs Assessments (JSNA) are published in 2022-2023, and form phase two of implementation planning.

Whilst this data will refine work needed to target on prevention and the wider determinants of health, this strategy will focus on **smoking** and **obesity** as key areas for prevention.

Anchor Institutions

Anchor institutions are "*large, public-sector organisations that are unlikely to relocate and have a significant stake in a geographical area*" (The Health Foundation, 2019). The size, scale and reach of the NHS means it influences the health and wellbeing of communities simply by being there.

In addition to its core purpose of delivering health care services, the NHS has the potential to influence the conditions in which people live, learn, work and age (The Health Foundation, 2019). We know that health care itself has a limited impact on the health of our communities and therefore on addressing health inequalities.

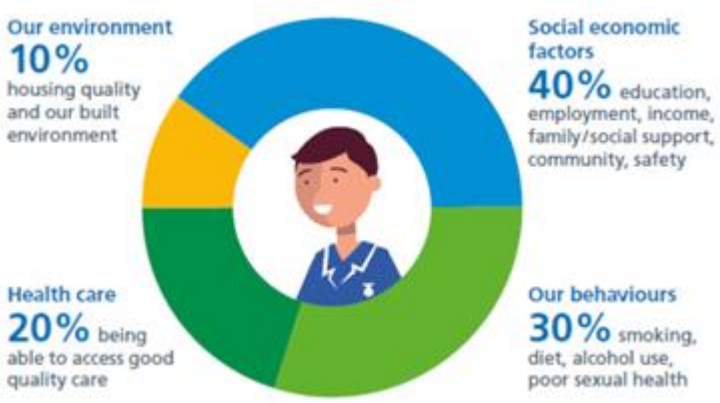


Figure 14 Adapted from University of Wisconsin Population Health Institute. County Health Rankings Key Findings 2014

However, as an employer of 1.4 million people, with an annual budget of £114 billion in 2018/19, the health service creates social value in local communities. Some NHS organisations are the largest local employer or procurer of services at place.

The infographic below (figure 15; The Health Foundation, 2019) indicates some of the ways in which NHS organisations in particular can leverage greater social value from our activities. The term anchor institution reflects that these organisations are rooted in their 'place', unlikely to move and therefore able to align their long term plans with the interests of their local communities in a way other entities cannot. Anchor institutions are large, non-profit local organisations that can choose to use their resources differently in order to drive greater health and wellbeing, and in a targeted way to address health inequalities through tackling some of the wider determinants of health. Specifically in BSW these are likely to be hospitals and universities or colleges, noting that the implications of the widening gaps in healthy life expectancy place an even greater impetus on hospitals to adopt these approaches. This can be done collectively with local authority or educational partners at ICA level or across the ICS as an NHS collaboration.

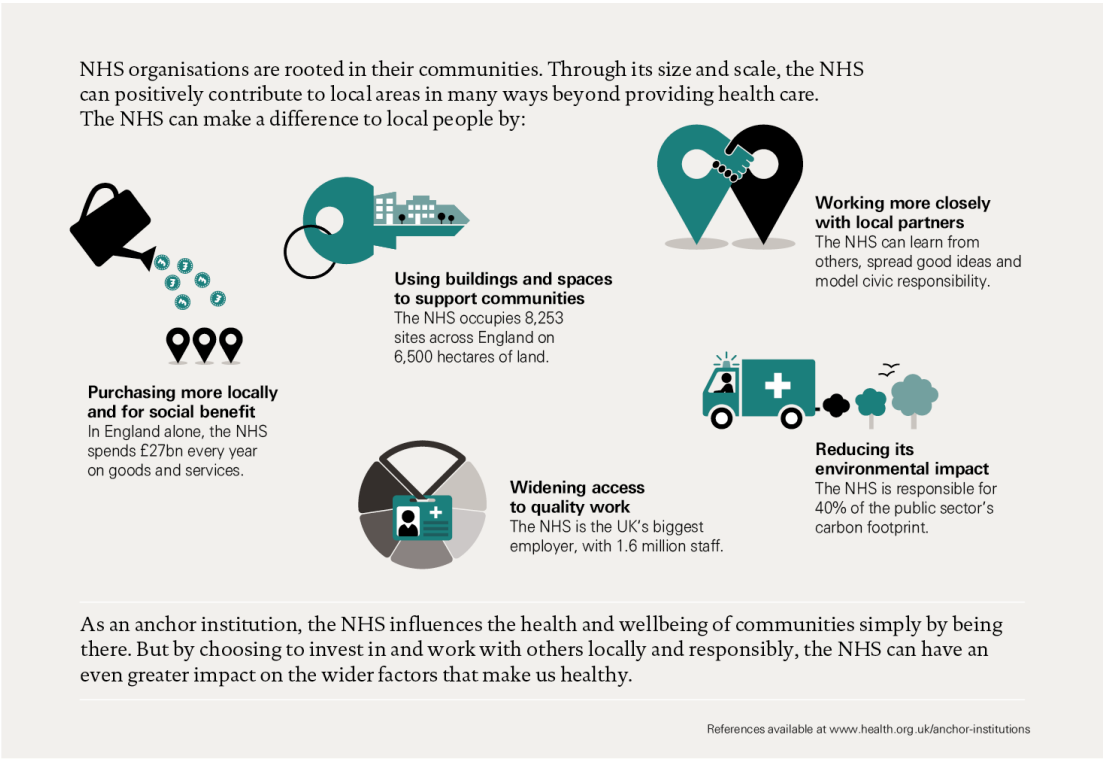


Figure 15 Image taken from: Building healthier communities: the role of the NHS as an anchor institution, The Health Foundation (2019).

The NHS Long Term Plan (2019) sets out the ambition to work with sites across the country to identify more of this good practice that can be adopted across England. The BSW Inequalities strategy includes the target to form anchor institutions as a lever to support change in the wider determinants of health. The example below shows how hospitals or health systems in the US, as anchor institutions have sought to improve community health.

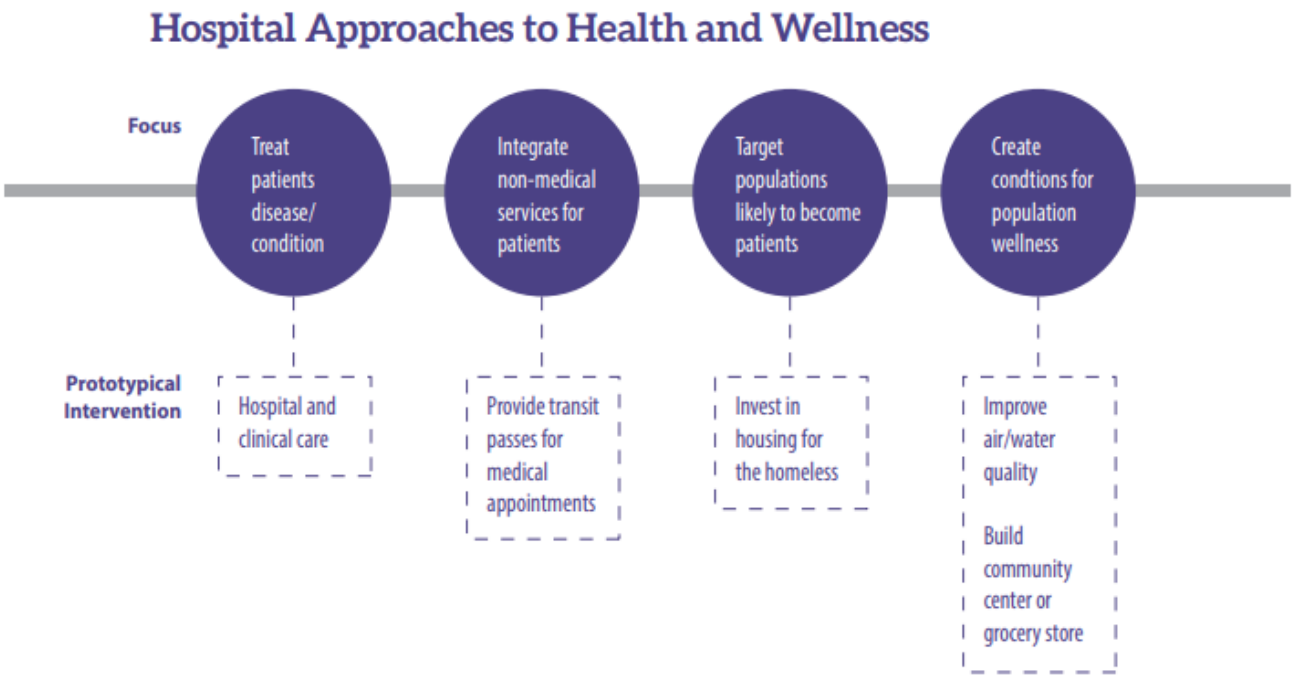


Image adapted from Robin Hacke, et al, "Improving Community Health by Strengthening Community Investment: Roles for Hospitals and Health Systems."[2]

Figure 16 (referenced above)

Domains of anchor influence

The Health Foundation (2019) identifies five ways in which NHS organisations act as anchor institutions:

- employment
- procurement and commissioning for social value
- use of capital and estates
- environmental sustainability
- as a partner in a place

Setting targets and measuring progress

Arising from the five NHS priorities and the CORE20PLUS5 approach, there are a set of defined targets to deliver. There are specific metrics arising from these targets to measure how we progress against them (see appendix 2). Each phase of the strategy will have an implementation plan developed to refine detailed action plans, metrics, and reporting.

How we will deliver

Targets for this strategy have been identified over key themes: awareness raising; healthcare inequality and the Core20PLUS5; and prevention and wider determinants.

Figure 17 Three phases of the BSW Inequalities Strategy - summary

The BSW Inequalities Strategy will be delivered in three phases from 2021-2024:

Figure 18 Three phases of the BSW Inequalities Strategy

Implementation

Implementation, development, and evaluation of the inequalities strategy and action plan will be driven by the BSW Inequalities strategy group. This group will include members from across the system including local authority, public health, local commissioned services, and Avon and Wiltshire Partnership Trust.

Working in partnership, an implementation plan will be developed for each phase which will detail specific objectives, timelines, and the identified lead organisation. Building on existing work, detailed action plans will be in place for each work area. Various groups, including task and finish groups and local communities will be involved in the implementation of the strategy.

Governance

This strategy is governed by the Population Health and Care group through the Inequalities Strategy Group which will monitor an action plan.

Not all interventions will be directly under the governance of the inequalities strategy as they will report through their own governance arrangements. However, bringing the contributions together under the BSW Inequalities Strategy will ensure coherence and progress of action. There will also be a need that the inequalities agenda and strategy is linked to other allied strategies and vice versa.

References

Batterham, R. (2020). *Health Inequalities and Obesity.* [online] RCP London. Available at: https://www.rcplondon.ac.uk/news/health-inequalities-and-obesity. [Accessed 1 Mar. 2022].

BSW Partnership. (2020). *Our plan for health and care.* [online] Available at: https://bswpartnership.nhs.uk/wp-content/uploads/BSW-Our-Plan-for-Health-and-Care-2020-2024-full-version.pdf [Accessed 1 Mar. 2022].

BSW Partnership. (2021). *NHS Long Term Plan - internal intelligence briefing: November 2021*. Unpublished.

Childhood Obesity Foundation. (2014). *What is Childhood Obesity? Who is at Risk?* [online] Available at: https://childhoodobesityfoundation.ca/what-is-childhood-obesity/. [Accessed 11 Apr. 2022].

Dodge, I. and Owolabi, B. (2021). *NHS England and NHS Improvement Board meetings held in common NHS England and NHS Improvement.* [online] Available at: https://www.england.nhs.uk/wp-content/uploads/2021/06/240621-board-meeting-item-9-tackling-inequalities-in-nhs-care.pdf. [Accessed 1 Mar. 2022].

Health Foundation. (2019). *Building healthier communities: the role of the NHS as an anchor institution*. [online] Available at: https://reader.health.org.uk/building-healthier-communities [Accessed 22 Feb. 2022].

Mackenbach, J.P. (2011). *What would happen to health inequalities if smoking were eliminated?* BMJ, 342(jun28 1), pp.d3460–d3460.

Maddern, S. and Arulrajah, J. (2021) *Overview of Health Inequalities across BSW*. Presentation September 2021.

Marmot, M. (2010). *Fair Society, Healthy Lives The Marmot Review.* [online] Available at: https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf. [Accessed 22 Feb. 2022].

NHS. (2018). *Equality and Health Inequalities Pack NHS Swindon CCG*. [online] Available at: https://www.england.nhs.uk/wp-content/uploads/2018/12/ehircp-sw-swindon-ccg-dec18.pdf [Accessed 22 Feb. 2022].

NHS. (2019). *The NHS as an "anchor institution."* [online] NHS Long Term Plan. Available at: https://www.longtermplan.nhs.uk/online-version/appendix/the-nhs-as-an-anchor-institution/ [Accessed 22 Feb. 2022].

NHS (2020). *Treating and preventing ill health*. [online] NHS Long Term Plan. Available at: https://www.longtermplan.nhs.uk/areas-of-work/prevention/treating-and-preventing-ill-health/. [Accessed 03 Mar. 2022].

NHS. (2022). *2022/23 priorities and operational planning guidance.* [online] Available at: https://www.england.nhs.uk/wp-content/uploads/2022/02/20211223-B1160-2022-23-priorities-and-operational-planning-guidance-v3.2.pdf [Accessed 22 Feb. 2022].

NHS England (2019). *The NHS Long Term Plan*. [online] NHS. Available at: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf. [Accessed 11 Apr. 2022].

NHS - Race and Health Observatory. (2021). *Ethnic Health Inequalities in the UK.* [online] Available at: https://www.nhsrho.org/publications/ethnic-health-inequalities-in-the-uk/ [Accessed 1 Mar. 2022].

Office for Health Improvement & Disparities (2022). *Public health profiles - OHID.* [online] Phe.org.uk. Available at:

- https://fingertips.phe.org.uk/search/IMD%202019#page/9/gid/1/pat/6/par/E12000009/ati/402/are/E06000022/iid/93553/age/1/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0 (IMD) [Accessed 22 Feb. 2022].
- https://fingertips.phe.org.uk/search/smoking#page/3/gid/1/pat/6/par/E12000009/ati/402/are/E06000022/iid/92443/age/168/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1(Smoking) [Accessed 22 Feb. 2022]
- https://fingertips.phe.org.uk/search/excess%20weight#page/3/gid/1/pat/6/par/E12000009/ati/402/are/E06000022/iid/93088/age/168/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1 (Obesity)

ONS (2017). *UK Population 2017 - Office for National Statistics.* [online] Available at: https://www.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfoi/ukpopulation2017. [Accessed 22 Feb. 2022].

Public Health England (2017). *Chapter 5: inequality in health.* [online] GOV.UK. Available at: https://www.gov.uk/government/publications/health-profile-for-england/chapter-5-inequality-in-health. [Accessed 1 Mar. 2022].

Public Health England (2019). *Health matters: stopping smoking - what works?* [online] GOV.UK. Available at: https://www.gov.uk/government/publications/health-matters-stopping-smoking-what-works/health-matters-stopping-smoking-what-works. [Accessed 1 Mar. 2022].

Raleigh, V. and Holmes, J. (2021). *The health of people from ethnic minority groups in England*. [online] The King's Fund. Available at: https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england. [Accessed 22 Feb. 2022].

Robertson, R., Williams, E., Buck, D. and Breckwoldt, J. (2021). *Ethnic health inequalities and the NHS Driving progress in a changing system*. [online] Available at: https://www.nhsrho.org/wp-content/uploads/2021/06/Ethnic-Health-Inequalities-Kings-Fund-Report.pdf. [Accessed 1 Mar. 2022].

The King's Fund. (2020). *Health inequalities: our position.* [online] Available at: https://www.kingsfund.org.uk/projects/positions/health-inequalities. [Accessed 22 Feb. 2022].

Understanding Inequalities. (2022). *Age | Understanding Inequalities.* [online] Available at: https://www.understanding-inequalities.ac.uk/research-themes/age [Accessed 05 Apr. 2022].

Williams, E., Buck, D. and Babalola, G. (2020). *What Are Health inequalities?* [online] The King's Fund. Available at: https://www.kingsfund.org.uk/publications/what-are-health-inequalities. [Accessed 22 Feb. 2022].

Appendix 1 - One page summary

Phase 1: Awareness Raising

Phase 2: Healthcare Inequality

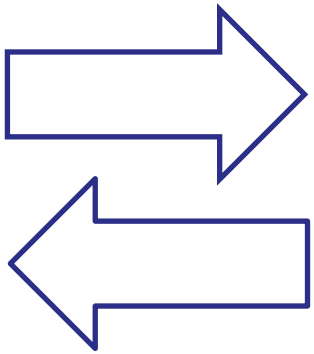
NHS Five Key Priorities

1. Restore service inclusively
2. Mitigate against digital exclusion
3. Ensure datasets are timely and complete
4. Accelerate preventative programmes
5. Leadership and accountability

Core 20 Plus 5

- Core 20% of most deprived areas
- PLUS Groups (defined at place):
  - Black, Asian, and Minority Ethnic groups (Swindon)
  - Routine and Manual workers (Wilts)
  - Socially excluded and vulnerable groups including looked after children and migrants (BANES)
- Five clinical areas

1. CVD
2. Maternity
3. Respiratory
4. Cancer
5. Mental Health (inc. CYP)



Phase 3: Prevention and social, economic, and environmental factors

Priority Areas:

- Anchor institutions
- Publish three place-based Joint Strategic Needs Assessments for BANES, Swindon, and Wiltshire
- Establish local priorities that address public health and the social, economic, and environmental factors most affecting inequalities at place
- Plan and enable progress on prevention where outcomes will take longer to see

Committed areas of focus

- Whole system approach to Obesity
- Whole system approach to Smoking

Cross-cutting themes: Population Health Management (PHM); Equality, Diversity, and Inclusion (EDI); Workforce; Prevention; Personalised care

Appendix 2 – Draft Metrics

Phase		Vision	Metrics	Restore Services Inclusively	Mitigate against digital exclusion	Ensure datasets are timely and complete	Accelerate Preventative Programmes	Leadership and Accountability
1	Making inequalities everybody's business	All staff, partners, and communities to understand inequality and how we seek to address this in BSW	20 sessions delivered by April 2023					✔
			50% increase of staff network trained by April 2024					✔
			Resource library to be available and distributed by **September 2022**					✔
			All staff to have access to Health Inequalities storytelling by **December 2023**					✔
2	Healthcare inequalities and CORE20+5	Work with commissioners and service providers to ensure robust and up-to-date data across the system on where inequalities are, and clear plans on how close the inequality gaps to offer exceptional quality healthcare for all through equitable access, excellent experience, and optimal outcomes	Increased access across the system to data segmented by ethnicity and deprivation (as standard)	✔				
			Performance reports will be broken down by patient ethnicity and IMD quintile, focusing on:	✔				
			Identifying who is accessing different modes of consultation by collecting data on patient age, ethnicity, disability status, condition, IMD quintile		✔			
			Improved data collection on ethnicity across primary care, outpatients, A&E, mental health, community services, specialised commissioning			✔		
			Increased understanding of equity of access, experience and outcomes for priority groups as shown through patient engagement	✔				
			Engagement in digital supported self-management services				✔	
			Continuity of care for 75% of women from BAME communities and most deprived groups	✔			✔	
		Achieving the Core20PLUS5 targets to reduce the inequality gaps identified in the five clinical areas	Annual health checks for 60% of those living with with severe mental illness and learning disabilities	✔			✔	
			Increase in flu and Covid-19 vaccine uptake				✔	
			75% of cancer cases diagnosed at stage 1 or 2 by 2028				✔	
			Increase in hypertension case finding				✔	
			Prevalence of current smokers in BSW				✔	
3	Tackling inequality by addressing social, economic, and environmental factors	Reduce smoking prevalence across BSW, with targeted focus on routine and manual occupations and smoking in pregnancy	Prevelance of current smoking with routine and manual occupations				✔	
			Prevelance of people smoking in pregnancy				✔	
			Proportion of smokers received smoking cessation support within hospital				✔	
			Proportion of pregnant smokers offered support in maternity settings				✔	
			Uptake of lifestyle services– exact metric tbc				✔	
		Halt and reverse of obesity prevalence in children and adults across BSW	Engagement in NDPP				✔	
			Engagement in Digital Weight Management Programme				✔	
			All three acute hospitals in BSW achieve chartered anchor institution status by 2025				✔	✔
		Establishing and harnessing the potential of local anchor Institutions in our three acute hospitals and mental health trust to deliver positive change across all domains of anchor influence including employment, procurement, and environmental impact	Increased number of local hires				✔	✔
			Increased number of apprenticeships				✔	✔
			Increased recruitment representative of local demographic data				✔	✔
			Increased local vs. central spend where possible				✔	✔
			Increased community use of NHS estates				✔	✔
			Increased support for NHS staff to access affordable housing				✔	✔
			Increase in accessible community green space				✔	✔
			Decreased carbon output through improved energy efficiency, increased sustainable travel options				✔	✔
			Reduced waste and water consumption				✔	✔
			Develop and support anchor collaboratives/networks (e.g. AWP, Local authorities, campuses, leisure centres)				✔	✔

Appendix 3 – Decile rankings for domains of deprivation in BSW neighbourhoods

Taken from BSW Partnership. (2021). NHS Long Term Plan - internal intelligence briefing: November 2021. Lower-layer Super Output Areas (LSOA) that are in the most deprived decile nationally (IMD, 2019).

1	= Most deprived decile
2	= 2nd most deprived decile
3	= 3rd most deprived decile

Neighbourhoods (LSOA) in most deprived decile overall	Domain of deprivation						
	Income	Employment	Education	Health & Disability	Crime	Barriers to Housing & Services	Living environment
BANES							
Twerton West	2	1	1	1	2	7	10
Whiteway	1	2	1	2	2	5	9
Swindon							
Penhill East	1	1	1	1	2	7	6
Penhill North	1	1	1	1	1	7	4
Penhill Central	1	1	1	1	1	6	6
Upper Stratton South East	2	1	1	1	3	4	8
Pinehurst West	1	1	1	1	1	5	7
Pinehurst South	2	2	1	2	1	4	6
Park North North	1	2	1	1	2	5	6
Walcot East East	2	2	1	3	1	4	4
Walcot East South West	2	2	2	1	1	5	4
Walcot East North West	1	1	1	2	1	6	4
Park South Central	1	1	1	1	1	7	6
Park South South West	1	1	1	2	3	2	5
Wiltshire							
Studley Green	1	1	1	3	3	5	8