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| | **Agenda Item: 20** |
| **Report to:** | **Birmingham Health & Wellbeing Board** |
| **Date:** | **30 November 2021** |
| **TITLE:** | **ICS INEQUALITIES WORK PROGRAMME - UPDATE** |
| **Organisation** | **Birmingham & Solihull Integrated Care System** |
| **Presenting Officer** | **Information** |

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| **Report Type:** | **Information** |

| **1.** | **Purpose:** |
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| 1.1 | The purpose of the report is to provide an update for the Health & Wellbeing Board on the work of the Birmingham & Solihull ICS Inequalities Programme. |

| **2.** | **Implications:** | |
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| BHWB Strategy Priorities | Childhood Obesity | |
| | Health Inequalities | Yes |
| Joint Strategic Needs Assessment | | Yes |
| Creating a Healthy Food City | | |
| Creating a Mentally Healthy City | | |
| Creating an Active City | | |
| Creating a City without Inequality | | Yes |
| Health Protection | | |

| **3.** | **Recommendation** |
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| 3.1 | This report provides an overview for the ICS Inequalities Programme Board of the work of the programme to date and planned next steps. |
| 3.2 | The Board is recommended to: |
| 3.2.1 | NOTE the programme report. |
| 3.2.2 | ADVISE the programme team on priorities for next steps. |

**4. Report Body**

## INTRODUCTION

This report provides an overview of the work of the ICS Inequalities Programme as at November 2021. It also provides a programme update for the Birmingham and Solihull Health & Wellbeing Boards.

## THE INEQUALITIES PROGRAMME

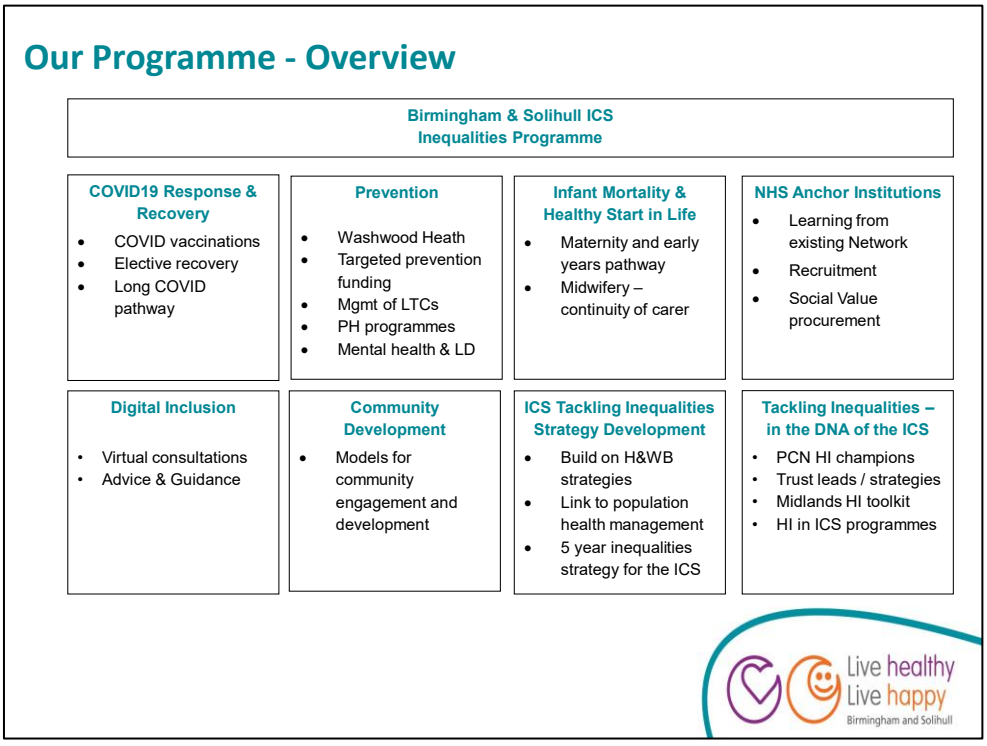
We have set our purpose as putting action to tackle inequalities and the impact of inequalities on health and life chances at the heart of the work of our system.

We have also previously adopted two guiding principles as an ICS for our work on inequalities. These are:

1. reducing health inequalities and workforce inequalities is mainstream activity that is core to, and not peripheral to, the work of health and social care;

2. interventions to address inequalities must be evidence-based with meaningful prospects for measurable success.

At this stage our programme has identified eight priorities for action.




## POPULATION HEALTH MANAGEMENT

Work to set out a model for Population Health Management in our ICS and to set a strategy for its development is closely connected to the work of the Inequalities Programme. A PHM programme board has been established and

the Strategy Unit have been commissioned to pull together all our existing work in this area and support us to share our PHM approach.

As part of this work we have agreed we will "learn by doing" by identifying a small number of priorities for initial work to develop a Population Health Management approach practice. Possible priorities for this work are all closely linked to work on Inequalities and include:

- infant mortality and health start to life;
- a long-term condition for example diabetes;
- vaccination and immunisations;
- elective recovery.

We aim to bring an initial programme scope and proposed approach to PHM to the ICS Board in December for formal approval.

## PROGRESS WITH PRIORITIES

The next section of this report provides an overview of progress and planned next steps for each of the eight priorities within the ICS Inequalities programme.

### PRIORITY 1
### COVID19 RESPONSE & RECOVERY

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| **Objective** | This priority aims to support our COVID19 response and recovery work to ensure we are contributing to reducing inequalities. We have focused on: vaccinations, elective recovery and the Long COVID pathway. |
| **Issues and Progress** | **Vaccinations**<br>• COVID19 vaccination coverage (2 doses) is at 65% in Birmingham and 82% in Solihull. NHS staff uptake in BSol trusts is between 80% and 87% but 3 of 5 trusts are in the lowest 15 trusts for uptake nationally.<br>• Vaccination uptake is strongly affected by deprivation and ethnicity and much work has been done by the NHS, Birmingham city council and Solihull MBC with our communities to support increased uptake.<br>**Elective Recovery**<br>• The national GP dataset contains ethnicity data for 82% of our patients, this rises to 93% when HES data is included. We continue to work to understand this position by trust and type of activity.<br>• We have analysed waiting lists by ethnicity and deprivation and in both cases the waiting list reflects the population we |

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| | serve. We see an average time on the waiting list of 35 weeks for those in the bottom IMD decile and 37 weeks for those in the least deprived. Initial analysis suggests a similar position for ethnicity.<br><br>• Referrals to secondary care have recovered fastest for PCNs serving our least deprived communities and this effect is particularly strong in use of digital routes such as Advice & Guidance.<br><br>**Long COVID**<br><br>• We have received referrals, activity and waiting lists for the Long COVID pathway. 60% of assessments are for female patients, 42% are from the most deprived 20% using IMD and 40% are aged 65 – 74. Ethnicity is recorded for 73% of assessments and where ethnicity is known 56% of patients are White. These characteristics broadly fit those indicated in Public Health modelling of demand for this pathway.<br><br>• Just under 1,000 patients are waiting for a Long COVID assessment and this number has stabilised recently. There are further waits following assessment for community therapies for people referred on. |
| **Next Steps** | **Vaccinations**<br><br>• Agree with the Vaccinations & Immunisations board how the Inequalities Board best supports their work.<br><br>**Elective Recovery**<br>• Understand and improve ethnicity coding by trust and by point of delivery (e.g. outpatients, electives).<br><br>• Finalise ethnicity analysis of the waiting list and review waiting list data monthly.<br><br>• Coordinate our approach to self-care advice and support for patients waiting a long time for treatment.<br><br>**Long COVID**<br><br>• Undertake further work with the BCHC Long COVID pathway team to track uptake across communities. |

## PRIORITY 2
## PREVENTION

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| **Objective** | This priority aims to bring together work on prevention and on the management of long-term conditions across the NHS and local authority partners in the ICS to deliver maximum impact for the people of Birmingham and Solihull. |
| **Issues and Progress** | • We have established an ICS Prevention Board that is chaired by Ruth Tennant and that will lead this agenda for us. We are working with the ICS to agree programme management to support this board. This will seek to bring together the established work on prevention programmes led by Public Heath with NHS-led work on long term conditions to maximum effect.<br><br>• We are progressing work to establish a prototype for PCN-level engagement working with GPs in Washwood Heath and concentrating on diabetes. We are also exploring how we can contribute to plans for the community health and social care partnership in Kingshurst in Solihull.<br><br>• We have secured £200k from the national Targeted Prevention Fund as part of a joint bid with BCWB ICS to work with communities to improve access to preventative services.<br><br>• We have submitted our plans for reducing tobacco dependency for NHS inpatients. This starts with work to led by BUMP for maternity services. A pilot for smoking cessation support for adult inpatients will being at QEH with roll out across all our inpatients services over the next 12 – 24 months.<br><br>• We have reviewed progress with physical heath checks for people with a learning disability. Overall the ICS meets the national standard for completion of these checks but we plan to explore further what this means in practice for people with a learning disability in Birmingham and Solihull. |
| **Next Steps** | • Fully established the ICS Prevention Board (reporting to the Inequalities Board) and agree it scope and resources.<br><br>• Use the work in Washwood Heath to develop a model that can be used more widely across the ICS.<br><br>• Successfully deliver the Targeted Prevention Fund proposal.<br><br>• Take forward the “deep dive” into the impact of physical heath checks for people living with a learning disability. |

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| | • Scope the issues relating to the prevention of mental ill-health and agree how this should be taken forward within the ICS. |

## PRIORITY 3
## INFANT MORTALITY & HEALTHY START IN LIFE

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| **Objective** | This priority aims to ensure that the ICS plays a full part in reducing infant mortality and ensuring that children have a heathy start in life across Birmingham and Solihull. |
| **Issues and Progress** | • Birmingham has a long-standing high infant mortality rate (7.0 deaths per 1,000 live births) while Solihull's (4.8 deaths per 1,000 live births) is closer to the national average (3.8). Birmingham City Council has established a taskforce to tackle infant mortality and Solihull has a priority to improve support to families in the first 1,000 days of life.<br>• A review of ethnicity coding in maternity services has identified significant variation between the hospitals serving the ICS that is being followed up with the trusts involved.<br>• BUMP (Local Maternity & Neonatal Services Network) is undertaking the national LMNS equity audit to identify areas for further work.<br>• Continuity of midwife is identified as national priority for the NHS work to reduce inequalities and is being progressed through BUMP. |
| **Next Steps** | • Scope the work already underway led by the two local authorities and agree how the ICS can best support the delivery of improved outcomes in this area.<br>• Ensure that we understand how the range of groups working on these issues fit together in way that adds values and avoids duplication.<br>• Agree inequalities objectives for early years services working with the Birmingham Children's Partnership and BUMP and Birmingham Forward Steps and with Solihull Together partners. |

## PRIORITY 4
## NHS ANCHOR INSTITUTIONS

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| **Objective** | This priority aims to agree and support the delivery of an "anchor institution" approach for the partners in the ICS to provide improved opportunities for people in the communities we serve. NB This work will be developed jointly with the ICS People Board. |
| **Issues and Progress** | • There are existing examples of "anchor institution" approaches to recruitment and procurement across the partners in the ICS including, for example.<br>• We have bid for additional resources to support an Anchor Institution Network for all of the NHS organisations in the ICS.<br>• An initial discussion at our October board meeting has identified a number of areas for us pursue including building on the local recruitment ambition already set by the People Board, looking at how we use the agreed ICS Social Value procurement policy and exploring a Living Wage commitment for the employers in the ICS.<br>• We have been working with the ICS Estates programme to agree how we can jointly support local health and social care hubs that are fully embedded within the communities they serve. |
| **Next Steps** | • Progress the plan to establish an Anchor Institution Network for all the NHS organisations in the ICS.<br>• Develop an ICS framework for an Anchor Institution that can be used by the organisations in the ICS as a basis for their work in this area<br>• Explore what it will mean for the organisations in the ICS to make a Living Wage commitment. |

## PRIORITY 5
## DIGITAL INCLUSION

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| **Objective** | This priority aims to ensure that moves to digitally delivered services and digitally supported care pathways are developed in a way that reduces rather than widens inequality in access to services. |
| **Issues and Progress** | • Work has already been undertaken on digital inclusion by many of the organisations within the ICS on an individual basis e.g. BCHC have worked with patients on their move to remote |

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| | consultations in many pathways, both local authorities have led work on digital inclusion with their communities.<br><br>• A review of the use of remote consultations by the NHS providers in the ICS has shown relatively high levels of satisfaction with this model of delivery amongst those who have used it.<br><br>• We also however have evidence of differential uptake of digital services amongst different groups. As notes in priority 1, Advice & Guidance uptake has been fastest in PCN serving more affluent areas and work by UHB has shown that older and more deprived patients are those least likely to use the digital portal to access information about their care.<br><br>• A joint workshop between representatives of the ICS Digital Enablement Group and the Inequalities Board is arranged for 11th November. |
| **Next Steps** | • Agree the objectives for this priority and how they will be best taken forward following the workshop on 11th November. |

## PRIORITY 6
## COMMUNITY DEVELOPMENT

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| **Objective** | This priority aims to develop a model for community engagement and development that can be used to drive our work on inequalities and be used by the organisations in the ICS. |
| **Issues and Progress** | • The Inequalities has held an initial discussion including representatives of a number of community organisations (e.g. Citizen's UK) to start our thinking about how best to develop a community and engagement approach for the ICS.<br><br>• It is recognised that this work will be best taken forward in conjunction with the work of the ICS on place, locality and neighbourhoods.<br><br>• The Inequalities Board has asked a small group to develop this thinking further and report to a future board meeting. |
| **Next Steps** | • We will agree how to progress this priority in light of the outcome of the working group. |

## PRIORITY 7
## ICS INEQUALITIES STRATEGY DEVELOPMENT

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| **Objective** | This priority aims to develop a 5 years strategy for reducing inequalities and their impact on health outcomes across the ICS. |
| **Issues and Progress** | • Our plan commits us to the development of a 5 years strategy for reducing inequalities and their impact on health by April 2022. This is consistent with the national expectations of ICS's from the NHS.<br>• We have discussed our approach to an "inequalities mission statement" or "charter" at our October board meeting. The "charter" approach is one of the recommendations from the NHS Midlands Inequalities Toolkit.<br>• Our November board meeting will review the national "Core20plus5" inequalities strategy and its impact on our local priorities.<br>• The Birmingham Health & Wellbeing Board strategy that is currently out for consultation and Solihull Council's draft Inequalities Strategy will be important building blocks in our work.<br>• We have had some initial discussions with the BCWB ICS about their approach to inequalities and areas where we can learn from each other as neighbouring systems.<br>• We have a broad approach for the development of our strategy including a board development day to be held towards the end of January 2022.<br>• The inequalities strategy will link to the ICS approach to Population Health Management. With the support of the Strategy Unit and using national support from NHSE/I we are developing the ICS PHM model alongside this work. |
| **Next Steps** | • Board development day in January 2022.<br>• Five years inequalities strategy for the ICS to be developed for approval in April 2022. |

## PRIORITY 8
## TACKLING INEQUALITIES: IN THE "DNA" OF THE ICS

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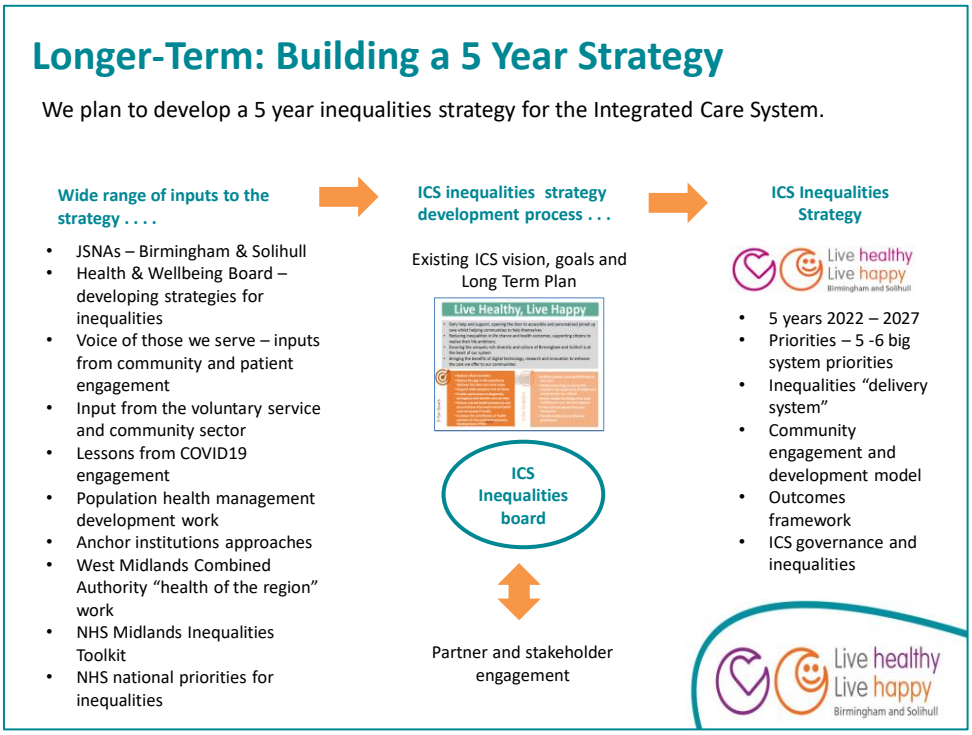
| **Objective** | This priority aims to ensure that tackling inequalities and their impact on health is built into all that the ICS does. |
| **Issues and Progress** | • We have an established ICS Inequalities Board meeting monthly. The Board is chaired by an ICS non-executive director and has an SRO and an ICS Inequalities Lead. We are recruiting to additional programme management posts to support delivery of the programme through 2021 and 2022.<br>• Each of our 36 PCNs has a Health Inequalities Champion and a local health profile to act as a basis for local work to address health inequalities.<br>• Each of our NHS trusts has an executive lead for inequalities represented on the ICS inequalities board. Some of our trusts have existing inequalities strategies for their organisations. We will use part of our November board meeting to start a discussion about the ICS framework for these strategies.<br>• We have an agreed interim outcomes framework for our work on inequalities and will be populating this with data as a next step.<br>• We are linked to the regional and national inequalities networks. |
| **Next Steps** | • In the light of the November board discussion about trust strategies engage with each of the NHS providers to understand their local work on inequalities.<br>• Agree specific inequalities objectives for all the ICS programmes.<br>• Populate the interim outcomes framework and agree arrangements for analytical support for the programme going forward.<br>• Agree the structure for Inequalities, prevention and population health management as part of the Integrated Care Board organisation. |

## ICS INEQUALITIES STRATEGY

As set out above, we are planning to develop a longer-term strategy for the ICS to set out how we will tackle inequalities and their impact on health. We will work on this strategy through January to March with the aim of having a draft for formal consultation from April.

Our approach to the development of this strategy is summarised in the diagram below.




| 5. | Compliance Issues |
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| **5.1** | **HWBB Forum Responsibility and Board Update** |
| 5.1.1 | Creating a City without Inequality |

| **5.2 Management Responsibility** |
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| 5.2.1 Richard Kirby, SRO ICS Inequalities Programme |
| 5.2.2 Salma Yaqoob, ICS Inequalities Programme Lead |

| 6. Risk Analysis | | | |
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| **Identified Risk** | **Likelihood** | **Impact** | **Actions to Manage Risk** |
| That a lack of engagement undermines impact. | Low | High | Engagement workstream within the programme to address this during the first half of 2021/22. |
| That a failure to align work with partners reduces impact. | Medium | High | Engagement with Health & Wellbeing Boards and ongoing work with local authorities and Directors of Public Health. |
| That a failure to commit resources reduces impact. | Medium | High | Commitment from the ICS Board to the work programme and initial support for the programme team. |

| **Appendices** |
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| N/A |

The following people have been involved in the preparation of this board paper:

- Richard Kirby – SRO ICS Inequalities Programme
- Salma Yaqoob – ICS Inequalities Lead