Our Approach to tackling Health Inequalities

Health Scrutiny
28th June 2022

Introduction

- This slide deck presents a summary of work to date, current system thinking and our opportunities in the context of the ICS system

- The slide deck will act as a **'discussion starter'** with the aim it mobilises a long term, integrated, structured and coordinated approach to tackling health inequalities.

- This presentation has been socialised through a number of our partnership forums for discussion and supplemented by individual and team conversations. A condensed version of this deck was taken to the Trafford Locality Board in March and fully supported.

- The slide deck will explore a number of themes and areas of work with the hope it:
  - Clarifies our understanding of health inequalities
  - Ensures we understand our current approaches and the key work programmes of each of our partners in reducing health inequalities
  - Captures the learning from previous work and in particular responding to the Covid pandemic
  - Helps us understand our opportunities within the emerging ICS system
  - Clarifies our known risks and challenges
  - Presents us with a clear set of next steps and actions

Background and Context

- **Historical work to tackle inequalities**
  - ❑ A long term commitment through organisational and Trafford system wide strategy to tackle inequalities reinforced by our more recent work, specifically the ambition laid out in the Trafford Together Locality Plan
- **Partnership working**
  - ❑ Built on our agreed behaviours, values and principles which is a foundation of all our Trafford groups, forums, boards and committees
- **Relevant strategies**
  - ❑ Ensuring our strategies are developed in sync where required – delivery aspects of relevant strategies remain visible in our partnership forums
- **H&SC integration**
  - ❑ Using learning from previous integration approaches across health and social care to form the basis of our future models
- **Governance**
  - ❑ Building from the strength of our current partnership governance namely the Locality Board, Provider Collaborative Board and Clinical and Practitioner Senate
- **Data and Intelligence**
  - ❑ Understanding the available data and intelligence and acting upon it together. Understanding our current Business Intelligence functions and capacity as we transition to the GM ICS arrangements
- **Opportunities that ICS creation presents us with**
  - ❑ An opportunity to capitalise on new governance arrangements, shared stewardship of the 'Trafford pound', new ways of working, building on the principle of subsidiarity whilst capitalising on scaling up
- **Challenges and risks**
  - ❑ Evolving governance arrangements at both GM and locality level, operating models and associated 'critical path' components for an effective 'Day 1'

Our Trafford, Our Future

Vision

Trafford – where all our residents, communities & businesses prosper

Outcomes

All our residents will have access to quality learning, training and jobs

All our communities will be happy healthy and safe

All our businesses and town centres will be supported to recover and flourish for the benefit of everyone

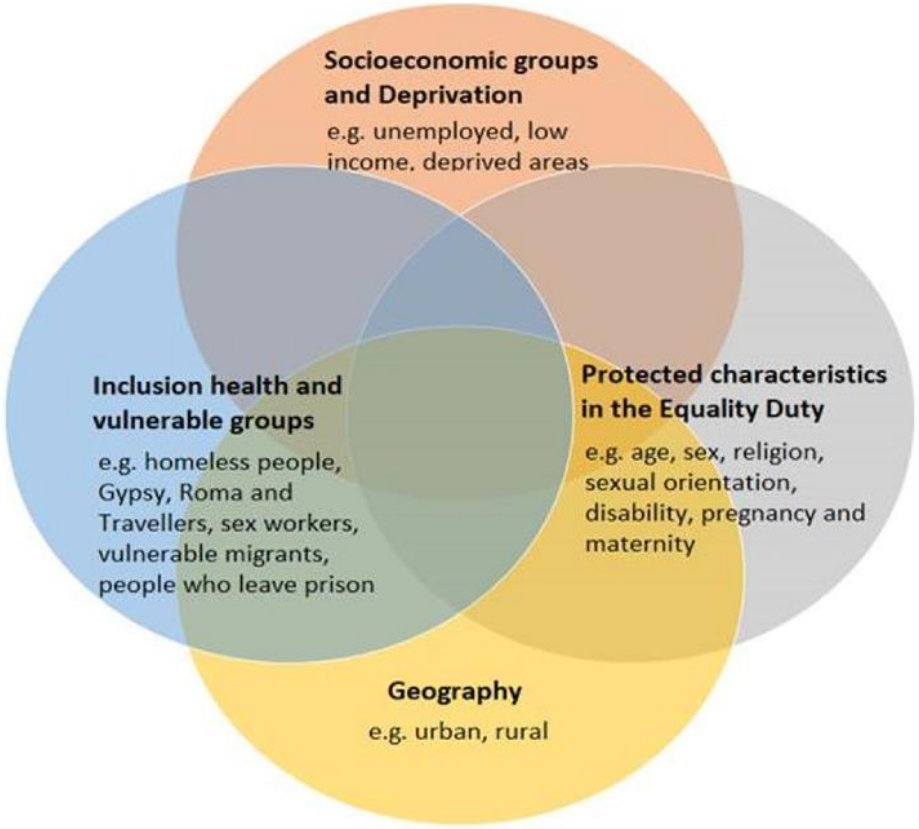
Priorities

- Reducing health inequalities
- Supporting people out of poverty
- Addressing our climate crisis

'Better health, Better jobs, Greener future'

What are health inequalities?

- **Health inequalities are avoidable and systematic differences in health between different groups of people**



- The pandemic has exposed and exacerbated inequalities
- Inequalities damage lives, and are bad for everyone in society not just those at the bottom of the social gradient
- Unfair distribution of power and resources creates avoidable health inequalities
- Social, economic, and environmental factors, as well as political and cultural factors, constitute the 'social determinants of health' which drive health inequalities

What we know……..

- Trafford has 4 neighbourhoods: North, South Central and West

- Trafford is arranged into 5 Primary Care Networks (PCNs). Across the five networks the levels of deprivation vary with the North and West more deprived than Sale Central, South or Altrincham Health Alliance.

- This is illustrated by the map below. People who live in the most deprived areas tend to have a lower healthy life expectancy than those living in the least deprived areas, with those in the most deprived areas more at risk of certain health conditions. These inequalities are largely preventable.

- More information on to this can be found within our [Joint Strategic Needs Assessment]

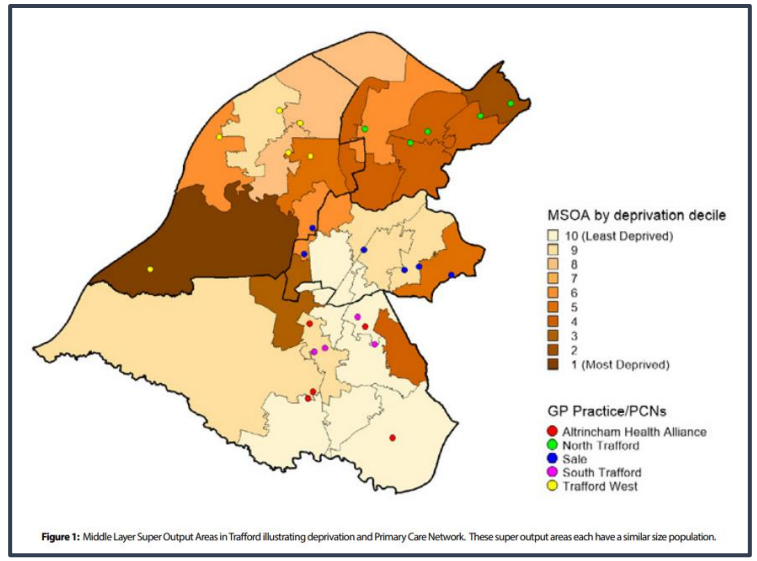
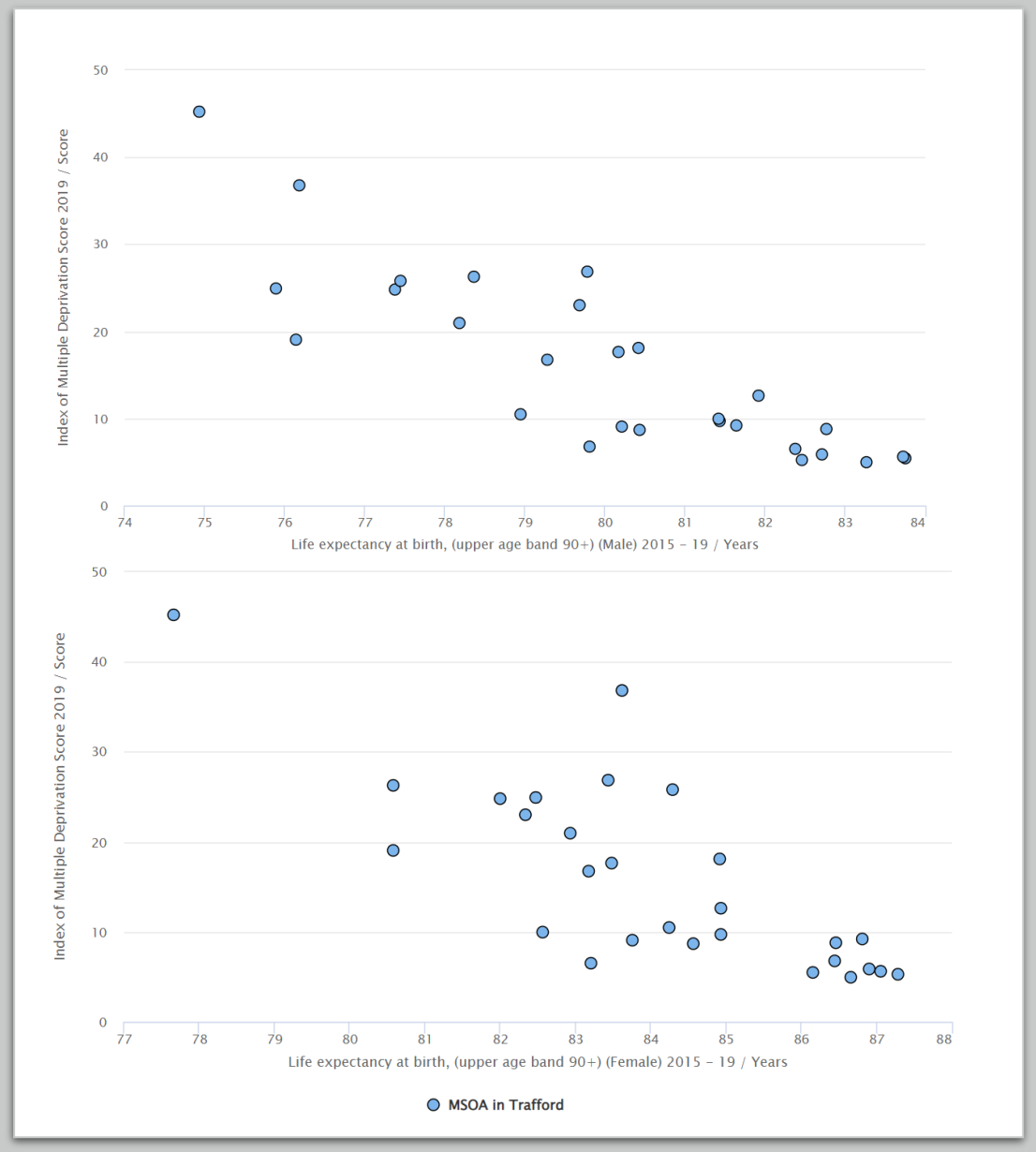


Figure 1: Middle Layer Super Output Areas in Trafford illustrating deprivation and Primary Care Network. These super output areas each have a similar size population.

Trafford's Health Inequalities – What is unique about Trafford?

- Whilst **life expectancy** in Trafford is generally good compared to Greater Manchester and nationally, we have stark inequalities *within* the borough on this measure as shown in the scattergrams for Trafford males (top) and females (bottom) – our more deprived communities have much lower life expectancy than our most affluent areas.
- **Healthy Life Expectancy (HLE)** is also a significant area of concern. HLE is an estimate of the number of years a person is expected to live in 'good' health.
- Data for Trafford for 2018-2020 shows:
  - Healthy life expectancy at birth for males is 66.3 years and higher (statistically significant) than the average of 63.1 for England.
  - Healthy life expectancy at birth for females is 66.9 years and higher (statistically significant) than the average of 63.9 for England.
- HLE is a good pointer to the population's general health and gives an idea of the population's need for health and social care services.
- To improve HLE, we must focus on **preventing poor health and on promoting wellbeing**, as this will reduce health and social care costs, and enhance resilience, employment and social outcomes.



Health Inequalities

Learning from Covid – Widening Inequalities

- As we emerge from the pandemic, we need to refocus on those risk factors that contribute to inequalities in either healthy life expectancy or life expectancy.

- Within Trafford, we know that some of the biggest impacts will be made by reducing smoking, alcohol use, physical inactivity, and obesity and by improving mental health amongst the population. In Trafford, diseases associated with these risk factors contribute to most of the difference (76.9% in men and 73.6% women aged 40-79 years old) in life expectancy between the top and bottom quintile, that is, between the twenty percent most deprived and twenty percent least deprived of the population.

- Reducing these inequalities across Trafford will improve quality of life, reduce service demand, improve health outcomes, and create a fairer, healthy, economically flourishing environment.

- It has got a lot harder for many people to stay physically and mentally healthy during the pandemic. As an example, alcohol specific mortality increased by over 50% in Trafford between 2019 and 2020 (compared with a 19% increase nationally). We need to understand whether these changes will remain as life returns to normal, and to consider how to tackle them if so.

- We know that Covid-19 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.

- Similarly we know that social isolation has impacted on people's mental health and for older people the pandemic has resulted in less opportunities to exercise

Existing Approaches – What good looks like

- Agreed focus for Primary Care Quality Improvement since Q4 2020
- Incorporates key strategic priorities – JSNA, planning guidance
- Aligns to key transformation work streams eg: Mental Health/Cancer
- Timeframe and outcomes align with Trafford Locality Plan up to 2024
- Built around 5 key themes: Data, Long Term Conditions, SMI/LD Annual Health Checks, Screening and Vaccinations and Access
- High level measurement framework in place
- Good progress during 21/22 (Year 1)
- Built around collaborative partnerships with others outside of CCG
- Plan under review for 22/23 priorities which will incorporate current guidance and a local level Core20plus5 approach
- Current Governance via Primary Care Quality Assurance Group (PCQAG) and Primary Care Commissioning Committee (PCCC)

Existing Approaches – What good looks like

Case Study: Community Model

A sustainable and well supported VCFSE sector including volunteering coordination and support

Access to skills and jobs, giving people financial security and enough income to live well

Access to information and advice for everyone, and support for those that need it

Good quality data and intelligence shared at neighbourhood level from a variety of sources

Community-based services and activities designed with local people to meet their needs

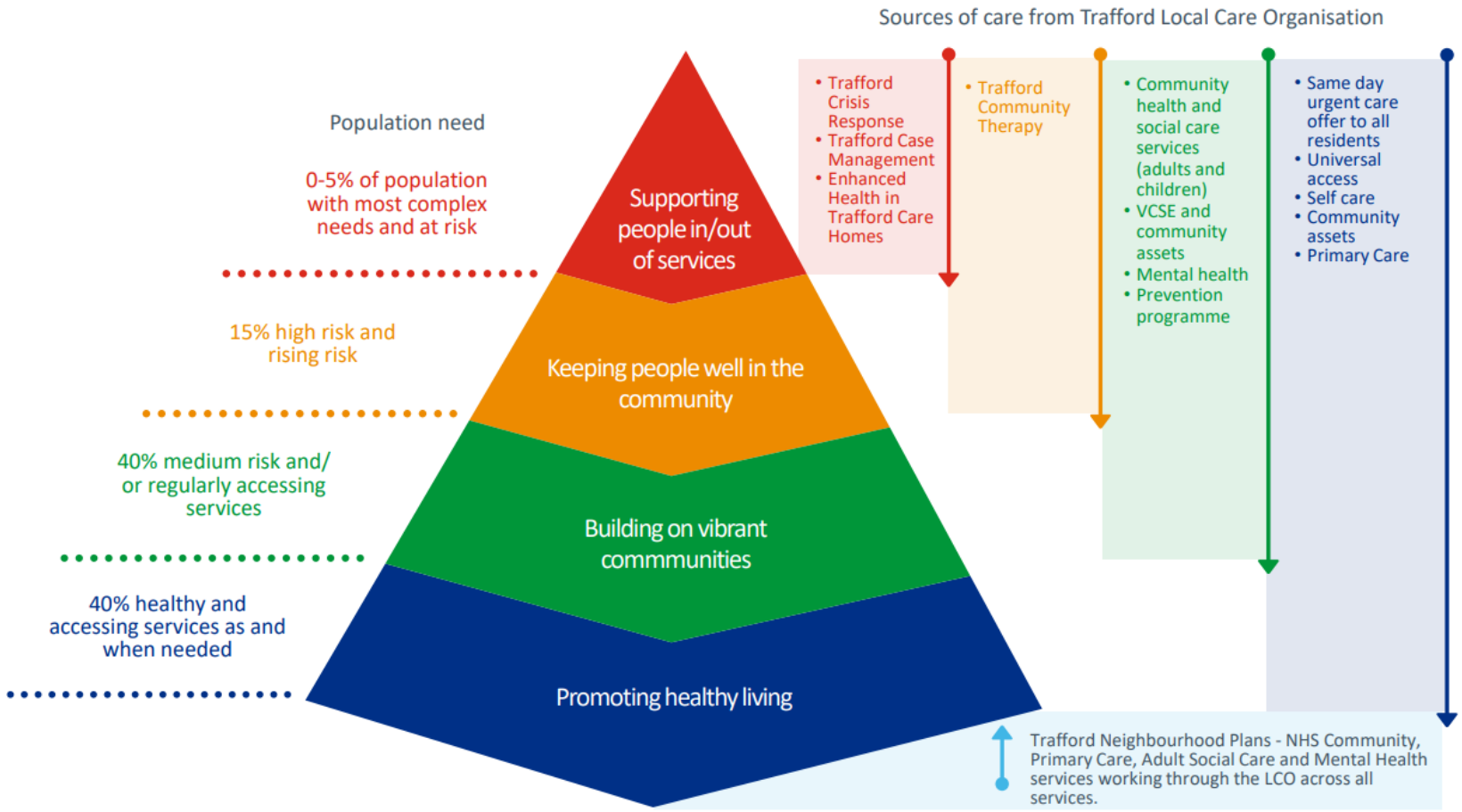
Healthy homes, quality outdoor spaces and safe, connected communities

Schools, colleges, early years settings and community groups that support children and young people to flourish

Local employers engaged to create inclusive, equitable economies that maximise the Trafford pound while reducing carbon

Existing Approaches – What good looks like

Case Study: Community Model

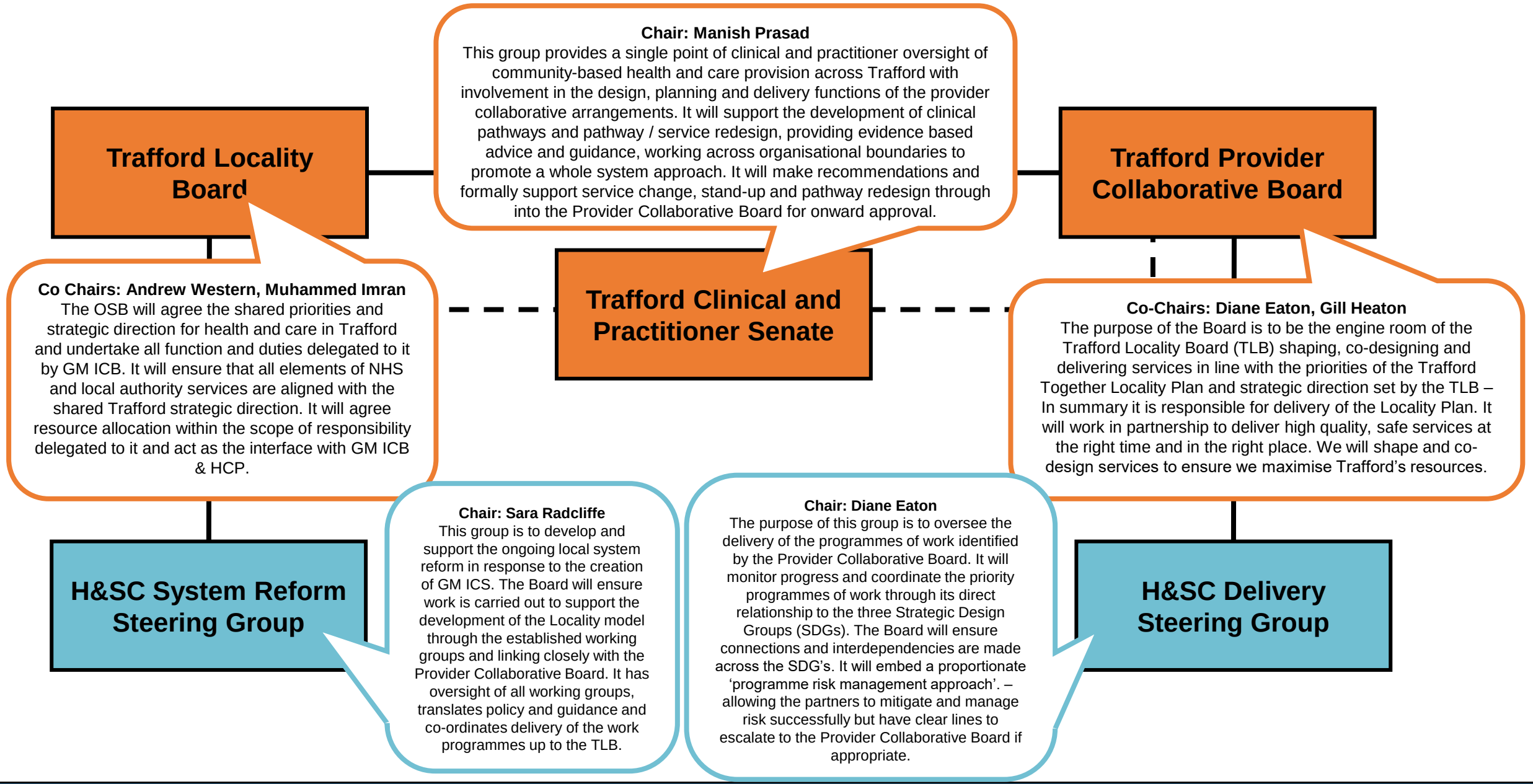


Existing Governance, Roles and Responsibilities

A number of existing Trafford governance groups have an active role in tackling health inequalities…….

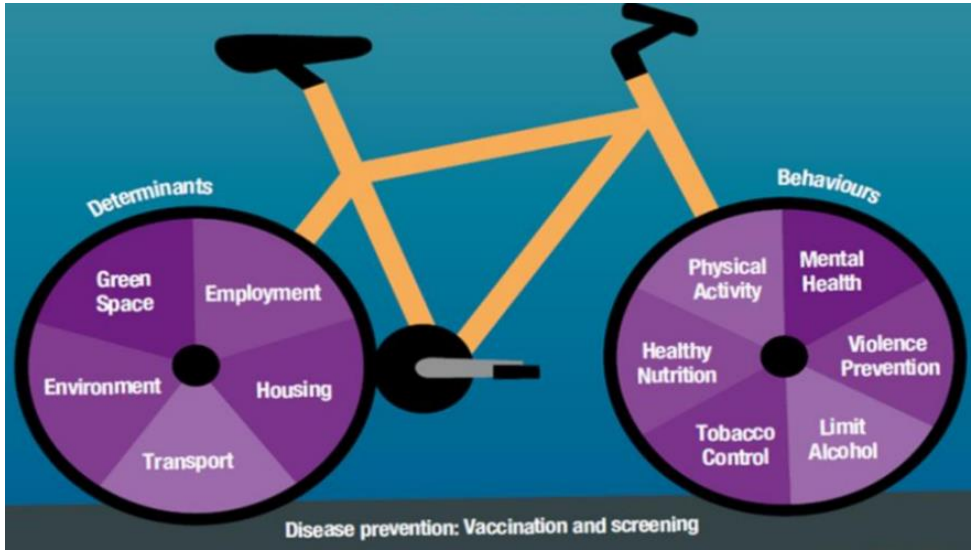
Trafford Health and Wellbeing Board	**Trafford Locality Board**	**Trafford Provider Collaborative Board**
Trafford Clinical and Practitioner Senate	**Trafford Partnership Board**	**Trafford Inclusive Economy Board**
Trafford Council Equality Group	**Trafford CCG Equality Group**	**Council Staff Groups / CCG Staff Groups**

The governance diagram overleaf describes the pertinent new H&SC governance in Trafford including how the key governance forums connect, their purpose and the current leadership arrangements


Chair: Manish Prasad
This group provides a single point of clinical and practitioner oversight of community-based health and care provision across Trafford with involvement in the design, planning and delivery functions of the provider collaborative arrangements. It will support the development of clinical pathways and pathway / service redesign, providing evidence based advice and guidance, working across organisational boundaries to promote a whole system approach. It will make recommendations and formally support service change, stand-up and pathway redesign through into the Provider Collaborative Board for onward approval.
Trafford Locality Board
Trafford Provider Collaborative Board
Trafford Clinical and Practitioner Senate
Co Chairs: Andrew Western, Muhammed Imran
The OSB will agree the shared priorities and strategic direction for health and care in Trafford and undertake all function and duties delegated to it by GM ICB. It will ensure that all elements of NHS and local authority services are aligned with the shared Trafford strategic direction. It will agree resource allocation within the scope of responsibility delegated to it and act as the interface with GM ICB & HCP.
Co-Chairs: Diane Eaton, Gill Heaton
The purpose of the Board is to be the engine room of the Trafford Locality Board (TLB) shaping, co-designing and delivering services in line with the priorities of the Trafford Together Locality Plan and strategic direction set by the TLB – In summary it is responsible for delivery of the Locality Plan. It will work in partnership to deliver high quality, safe services at the right time and in the right place. We will shape and co-design services to ensure we maximise Trafford's resources.
H&SC System Reform Steering Group
Chair: Sara Radcliffe
This group is to develop and support the ongoing local system reform in response to the creation of GM ICS. The Board will ensure work is carried out to support the development of the Locality model through the established working groups and linking closely with the Provider Collaborative Board. It has oversight of all working groups, translates policy and guidance and co-ordinates delivery of the work programmes up to the TLB.
Chair: Diane Eaton
The purpose of this group is to oversee the delivery of the programmes of work identified by the Provider Collaborative Board. It will monitor progress and coordinate the priority programmes of work through its direct relationship to the three Strategic Design Groups (SDGs). The Board will ensure connections and interdependencies are made across the SDG's. It will embed a proportionate 'programme risk management approach'. – allowing the partners to mitigate and manage risk successfully but have clear lines to escalate to the Provider Collaborative Board if appropriate.
H&SC Delivery Steering Group

Understanding the role of the Health and Wellbeing Board

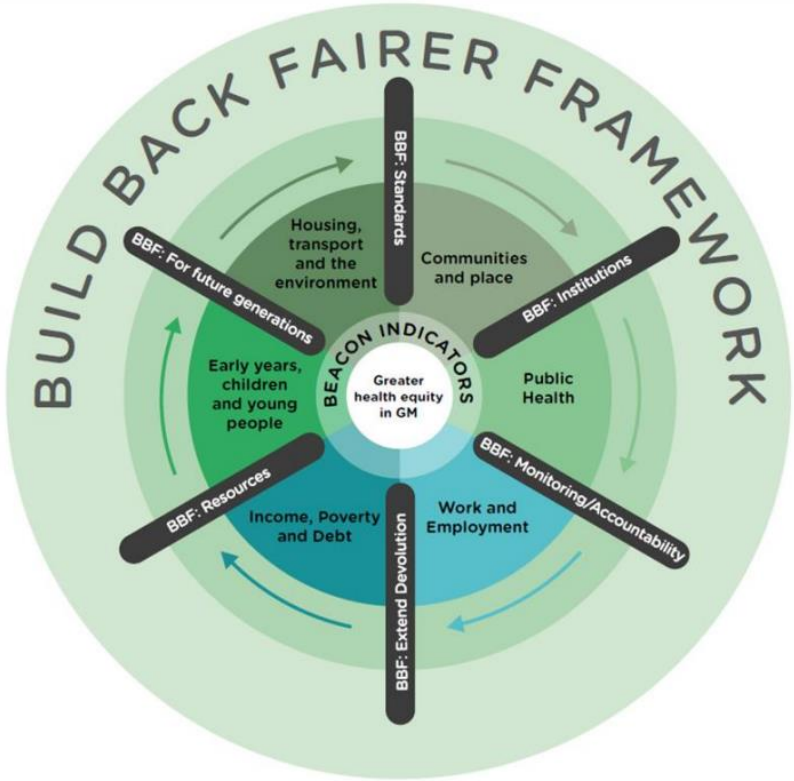
- We have recently completed an LGA review of our Health & Wellbeing Board aiming to agree the Board's purpose and functions in the new integrated health and care landscape.
- This review has enabled us to refresh and strengthen the HWBB, aligning it to place-based partnership arrangements with a focus on prevention and health inequalities, moving away from the current 'treatment' focus.
- The HWBB have agreed that the 2019-29 Health & Wellbeing Strategy remains the key driver for its work, and Board meetings over the next three months will involve a series of deep dives focusing on 5 key priorities set out in the Health & Wellbeing Strategy namely:
    - Physical activity
    - Healthy weight
    - Mental health
    - Alcohol
    - Tobacco



Planning Guidance and Key Strategies

A visual of each of the documents may be more powerful here to show the plethora of relevant strategies and other key documents –
One of the challenges we have in developing a co-ordinated integrated approach to reducing health inequalities is that different partners are working to different planning guidance. Whilst this adds complexity it more than anything requires a structured approach where there is clear accountability and visibility on all the areas of action, leadership and governance

- Trafford Together Locality Plan
- NHS Planning Guidance 22/23
- Trafford Council Corporate Plan 2022/23
- NW ADASS Vision 2030
- Trafford HWBB Strategy
- Trafford VCFSE Strategy
- Trafford Poverty Strategy
- Trafford Social Value Charter
- GM Strategies: Taking Charge 2, People and Communities Engagement Strategy, Marmot, GM Inequalities Commission, etc



Key Strategies example: The Poverty Truth Commission

- An example of activity in the borough relating to the council's corporate priorities of health inequalities and supporting people out of poverty is The Poverty Truth Commission which launched in May 2022.
- The Commission has 20 civic leaders from private, public, voluntary sectors etc and 15 community commissioners who have or are experiencing poverty.
- The Commission will conclude by March 2023 and the report and findings will be ready for summer 2023 and be incorporated into the three year partnership poverty strategy.
- A progress report on Equalities is currently being drafted and will be going to the Council Executive in July. The report will provide a summary of performance against the Council's Corporate Plan and supporting management information for the refreshed priorities, for January to March 2022, Quarter 4

NHS Planning Guidance 2022/23

- GM ICS have responded to the NHS Planning Guidance describing how we will collectively work across the conurbation to tackle our health inequalities
- Locally we have RAG rated our work and approaches against the criteria set out in the table to the right:

System name:	
Introduction - Health Inequalities - Maintain focus on preventing ill-health and tackling health inequalities by redoubling efforts on the five priority areas for tackling health inequalities set out in guidance in March 2021. ICSs will take a lead role in tackling health inequalities, building on the Core20PLUS5 approach introduced in 2021/22 to support the reduction of health inequalities experienced by adults, children and young people, at both the national and system level.	
Please outline priority actions, assumptions, risks, issues and associated mitigation. Please refer to guidance on the five priority areas and Core20PLUS5 approach to support your response.	
Actions	
Assumptions	
Risks, issues and mitigation	

Criteria	RAG
1. Protect the most vulnerable from COVID-19, with enhanced analysis and community engagement, to mitigate the risks associated with relevant protected characteristics and social and economic conditions; and better engage those communities who need most support.	
2. Restore NHS services inclusively, so that they are used by those in greatest need. This will be guided by new, core performance monitoring of service use and outcomes among those from the most deprived neighbourhoods and from Black and Asian communities, by 31 October.	
3. Develop digitally enabled care pathways in ways which increase inclusion, including reviewing who is using new primary, outpatient and mental health digitally enabled care pathways by 31 March.	
4. Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes; including more accessible flu vaccinations, better targeting of long-term condition prevention and management programmes such as obesity reduction programmes, health checks for people with learning disabilities, and increasing the continuity of maternity carers.	
5. Particularly support those who suffer mental ill health, as society and the NHS recover from COVID-19, underpinned by more robust data collection and monitoring by 31 December.	
6. Strengthen leadership and accountability, with a named executive board member responsible for tackling inequalities in place in September in every NHS organisation, alongside action to increase the diversity of senior leaders. Classification: Official 3 | Implementing Phase 3 of the NHS response to the COVID-19 pandemic	
7. Ensure datasets are complete and timely, to underpin an understanding of and response to inequalities. All NHS organisations should proactively review and ensure the completeness of patient ethnicity data by no later than 31 December, with general practice prioritising those groups at significant risk of COVID-19 from 1 September.	
8. Collaborate locally in planning and delivering action to address health inequalities, including incorporating in plans for restoring critical services by 21 September; better listening to communities and strengthening local accountability; deepening partnerships with local authorities and the voluntary and community sector; and maintaining a continual focus on implementation of these actions, resources and impact, including a full report by 31 March.	

REDUCING HEALTHCARE INEQUALITIES

The **Core20PLUS5** approach is designed to support Integrated Care Systems to drive targeted action in health inequalities improvement

CORE20
The most deprived **20%** of the national population as identified by the Index of Multiple Deprivation

Target population

CORE20 PLUS 5

PLUS
ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups

Key clinical areas of health inequalities

1. **MATERNITY**
ensuring continuity of care for **75%** of women from BAME 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

Business Intelligence: Being a data led system

CCG BI Team
* Head of Business Intelligence
** Senior Information Analyst*

Receives national and local datasets via contracts with providers. DSCRO provide pseudonymised data for Commissioning purposes

All data stored in TCCG Data Warehouse

Business Intelligence and reports delivered via Tableau

Supports → All teams within TCCG

Replaced by GMICS from July 2022

Works closely with:
Primary Care Data Quality
Commissioners
Finance
Performance & Quality Team
Public Health
Local Authority BI Team

Risks
Loss of local knowledge
One Size Fits All Approach
Centralisation / loss of response time
Council BI and Public Health are not part of ICS

Opportunities
Pooled BI knowledge & Experience
Efficiencies in processing
Removal of duplication of effort
GM-wide agreements open up new datasets / insight for Trafford Locality

Business Intelligence: Being a data led system

ICS Data & Intelligence Transition Workshops
February – June 22

Workshops attended by Gtr Mcr CCG BI Teams, Public Health, Local Authority, GMHSCP

Prioritising ICB Establishment & Technical Infrastructure and Data Management

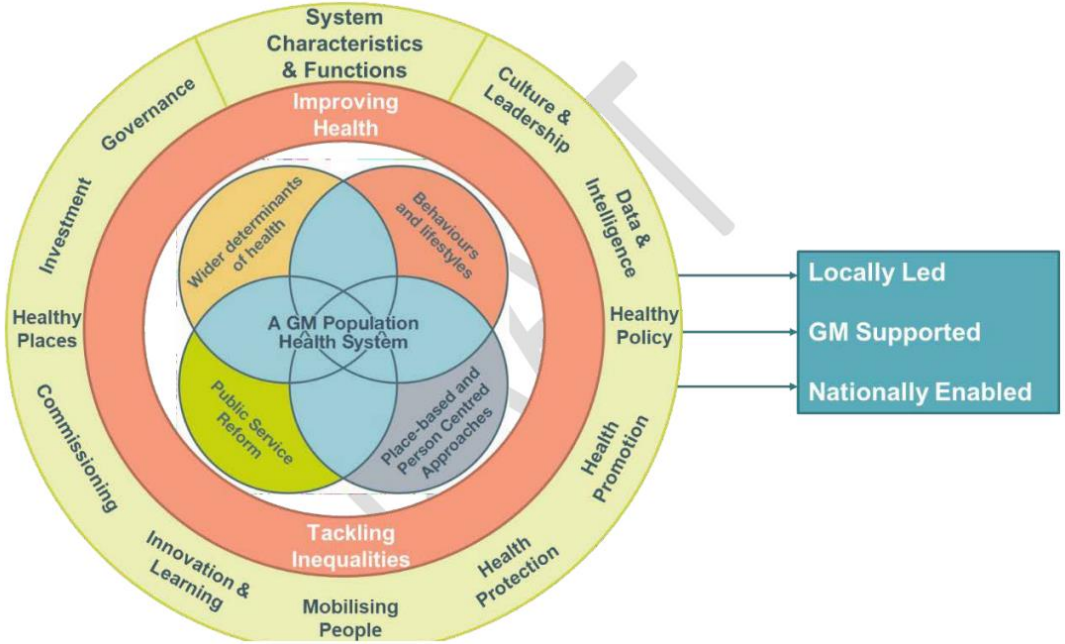
Key Outputs – 7 Task & Finish Workstreams aligned to ICS Intelligence functions and key activities:

ICB Establishment – covering CCG/GMHSCP/GMSS staff transition issues; ICB HR, Finance and Corporate reporting; Governance and links to wider ICS
Technical Infrastructure and Data Management - Infrastructure & Cloud; Data Management (thematic datasets); Direct Care Re-Ident & Interoperable API driven models, TRE
Data Governance – ICS DARS; Novation of DSAs and new DPIAs; Data Access and User management; Sources of Data for Longitudinal Record
Standardisation and methods - Capacity & Demand model; Population Health Management; System PQI Methods; Data Science and Advanced Analytics; Output QA process
Strategic Intelligence -Pop health; System Surveillance; Marmot Beacon Indicators
Mobilisation – Curator Web development & Dissemination; GM Futures Site management; Communications; PMO
ICS Workforce development - Staff development, training and professional registration; AnalystX

Population Health Management

- GM Population Health System Framework – a shared ambition within GM to use our system assets and the opportunities of devolution to significantly improve health and tackle inequalities
  - ❑ Core system characteristics
  - ❑ Conditions & Functions required at a City-Regional Level
  - ❑ **<u>Conditions & Functions required at a locality / neighbourhood level</u>**

- Trafford approach will include:
  - ❑ Culture
  - ❑ Governance
  - ❑ Mobilising and Involving People & Communities
  - ❑ Leadership
  - ❑ Sustainable investment in Population Health
  - ❑ Data, Intelligence, Research and Evaluation
  - ❑ Shaping Healthy Policy & Strategy
  - ❑ Health Protection
  - ❑ Taking action to improve health
  - ❑ Tackling Inequalities
  - ❑ Commissioning for Health & Outcomes
  - ❑ Shaping heathier environments by optimizing the use of regulatory & legislative levers and powers
  - ❑ Promoting Innovation and Learning



Trafford TOGETHER

Trafford Population Health Management

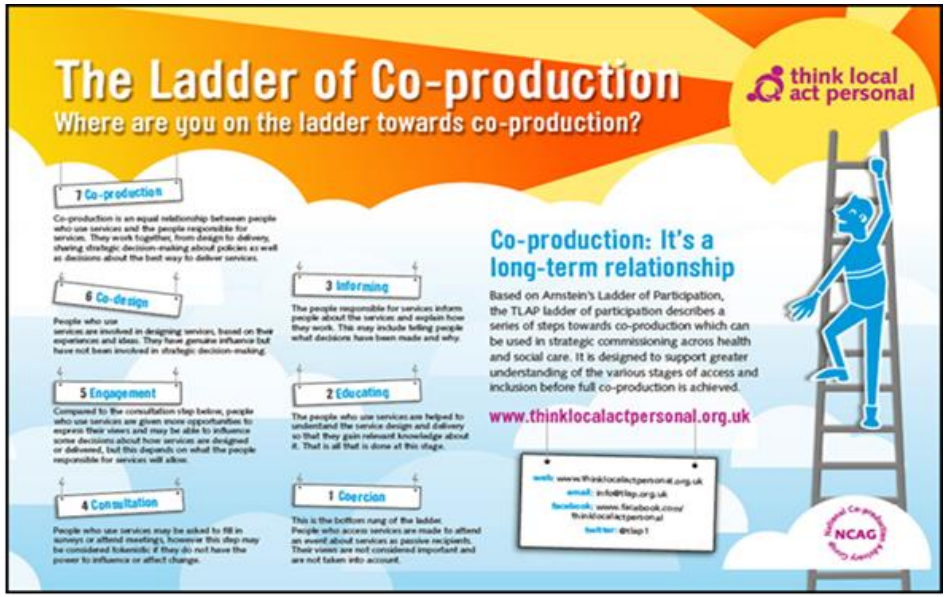
- Key to addressing health inequalities will be the early identification of people at risk of or in the early stages of illnesses.

- We will continue to strengthen our Population Health Approach so that people are identified and supported to manage their condition at the earliest possible stage, with a greater focus on working in the most deprived areas.

- We will increase collaborative delivery at Neighbourhood level (with particular emphasis on those supporting people in the most deprived areas), supporting a locally driven population health management approach through our emergent Neighbourhood Model

- Initially we will focus on ensuring that people with Learning Disabilities and Mental Health issues and carers have health checks with appropriate care and support plans.

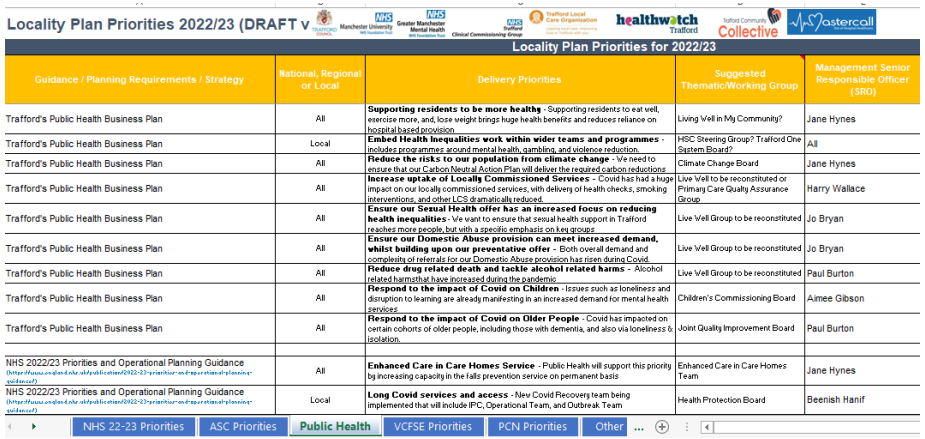
Public and Community Engagement



Our Engagement Methods……

- Public/VCFSE sit on various committees and can influence priorities and decisions
- Healthwatch Trafford representation truly valued by partners
- Established and effective partnership working to plan and co-design with VCFSE and communities
- Community insight via established networks/partners and teams
- Asset Based approaches – Community Hubs, Lets Talk, Asset Mapping

TPCB Prioritisation: Understanding our priorities and impact on reducing health inequalities



Locality Plan Priorities 2022/23 (DRAFT v

Locality Plan Priorities for 2022/23

Guidance / Planning Requirements / Strategy	National, Regional or Local	Delivery Priorities	Suggested Thematic/Working Group	Management Senior Responsible Officer (SRO)
Trafford's Public Health Business Plan	All	**Supporting residents to be more healthy** - Supporting residents to eat well, exercise more, and, lose weight brings huge health benefits and reduces reliance on hospital based provision	Living Well in My Community?	Jane Hynes
Trafford's Public Health Business Plan	Local	**Embed Health Inequalities work within wider teams and programmes** - includes programmes around mental health, gambling, and violence reduction.	HSC Steering Group? Trafford One System Board?	All
Trafford's Public Health Business Plan	All	**Reduce the risks to our population from climate change** - We need to ensure that our Carbon Neutral Action Plan will deliver the required carbon reductions	Climate Change Board	Jane Hynes
Trafford's Public Health Business Plan	All	**Increase uptake of Locally Commissioned Services** - Covid has had a huge impact on our locally commissioned services, with delivery of health checks, smoking interventions, and other LCS dramatically reduced.	Live Well to be reconstituted or Primary Care Quality Assurance Group	Harry Wallace
Trafford's Public Health Business Plan	All	**Ensure our Sexual Health offer has an increased focus on reducing health inequalities** - We want to ensure that sexual health support in Trafford reaches more people, but with a specific emphasis on key groups	Live Well Group to be reconstituted	Jo Bryan
Trafford's Public Health Business Plan	All	**Ensure our Domestic Abuse provision can meet increased demand, whilst building upon our preventative offer** - Both overall demand and complexity of referrals for our Domestic Abuse provision has risen during Covid.	Live Well Group to be reconstituted	Jo Bryan
Trafford's Public Health Business Plan	All	**Reduce drug related death and tackle alcohol related harms** - Alcohol related harms that have increased during the pandemic	Live Well Group to be reconstituted	Paul Burton
Trafford's Public Health Business Plan	All	**Respond to the impact of Covid on Children** - Issues such as loneliness and disruption to learning are already manifesting in an increased demand for mental health services	Children's Commissioning Board	Aimee Gibson
Trafford's Public Health Business Plan	All	**Respond to the impact of Covid on Older People** - Covid has impacted on certain cohorts of older people, including those with dementia, and also via loneliness & isolation.	Joint Quality Improvement Board	Paul Burton
NHS 2022/23 Priorities and Operational Planning Guidance	All	**Enhanced Care in Care Homes Service** - Public Health will support this priority by increasing capacity in the Falls prevention service on permanent basis	Enhanced Care in Care Homes Team	Jane Hynes
NHS 2022/23 Priorities and Operational Planning Guidance	Local	**Long Covid services and access** - New Covid Recovery team being implemented that will include IPC, Operational Team, and Outbreak Team	Health Protection Board	Beenish Hanif

NHS 22-23 Priorities | ASC Priorities | Public Health | VCFSE Priorities | PCN Priorities | Other

- We have been through a process of identifying Locality Plan priorities and the forums these will report into, as well as identifying leads
- Health inequalities have been a key focus in determining our priorities

TPCB In-Scope Priorities

Trafford Provider Collaborative Board

Locality Resilient Discharge to Assess Model — **SSIH** cross-cut with **LWAH**

Implementation of Neighbourhood Model/Anticipatory Care — LWAH cross-cut with LWIMC

TPCB Operational Effectiveness Review Recommendations (TBC)

Opportunities, Challenges & Risks

- **Fragmented analytical capacity** across partners
- Uncertainty on **governance** and other critical path issues
- Local **data sharing issues** – particularly access to primary care data
- Data accessibility issues – particularly with the **multiple separate servers** in operation
- Data Quality
- Data and Intelligence – **Capacity** to deliver against both organisational, sector and partnership priorities
- Embryonic developments of the '**Public and Community Engagement**' model
- Uncertainty surrounding the appointment process and subsequent responsibilities of the **Place Leader**
- A common understanding and **definition of business intelligence** – we mean different things when saying business intelligence
- **Staff development** and 'skilling up' will be required
- **Financial constraints** and available resources
- Interdependencies with **Manchester**
- **Transformation / System Reform 'v' Business As Usual**
- **Holding ourselves to account** – where does progress get reported?
- Transition: Alignment and ways of working of current CCG functions across a **'hub and spoke'** model

Our proposed approach to tackling health inequalities, supported by the Trafford Locality Board: A Framework for action

Review of the Data and Intelligence

- What is our data telling us? Where are our biggest inequalities and what are the causes? What is within our collective gift to do something about the root causes?

Existing Services Review

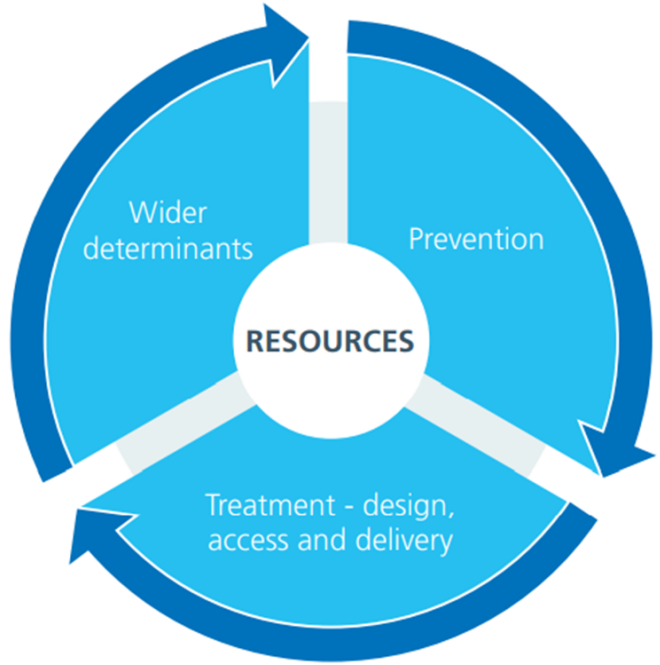
- Are our existing services helping address inequalities? Have we any gaps in service? What services are not having the desired impact? What services need to be more targeted?

Commissioning / Transformation of new services

- Can we embed in governance a process whereby new services must account for a reduction in health inequalities? What are the opportunities of in-sight locality funding and future pooled funding arrangements? Do we need to strengthen the current integrated commissioning approach? How do we influence those services commissioned at GM ICB level?

Tackling Wider Determinants

- How do we use the reach of our partnerships to address the wider determinants? How do we make real connections between complimentary strategies?



Our proposed approach to tackling health inequalities: Design Principles

- We need to take a stronger approach to **service design, access and delivery** to tackle health inequalities, in particular for those conditions which people from vulnerable groups or the poorest parts of the borough are dying of earlier, including cancer, CVD, respiratory disease, etc.
- **For new services:** We will start with the question how does this reduce health inequalities when commissioning or redesigning services (rather than just thinking about how a new services doesn't increase health inequalities).
- In all cases we will consider **disproportionate funding** services targeted in specific areas and at specific groups where appropriate.
- We will identify the people who currently have the poorest outcomes and ensure that their **voices** are central to how the new services are commissioned, with a much stronger emphasis on co-production.
- We will build in **performance measures** to all new contracts to ensure that outcomes for people currently experiencing the poorest health are improved
- We will support an approach to **care and disease pathway improvement** (e.g. diabetes) that focusses on bringing together key clinicians and professionals across primary, community and secondary care, in Trafford Clinical and Practitioner Senate. There will be an emphasis on **problem solving, quality improvement and developing shared objectives** with a view to making a greater impact on deprived communities.
- This will be underpinned by a population health management approach, through a **Neighbourhood Delivery model.**

Next steps agreed at the Trafford Locality Board

- Consider the work that is ongoing in relation to GM ICS and how Trafford can create a clear locally developed view as to how data will be curated, managed, and utilised in a sustainable and resilient way moving forward
- Agreed the outlined ‘framework for action’ approach
- Agreed the ‘design principles’
- Agreed the need for a local formal governance process to identify impact of new projects / programmes (In-Scope) on tackling inequalities
- Agreed ‘leadership’ and the forums to drive the work – pending HWBB review outcome and TPCB Operational Effectiveness Review
- Agreed the requirement for a time limited ‘Data and Intelligence’ forum to drive the business intelligence analytical work moving forward

Any questions or comments?

Appendix:

Prevention: We will work to ensure that the NHS maximises its contribution to prevention through the contracts we have with providers. This will include building preventive approaches into pathways, and ensuring that NHS staff have access to prevention and wellbeing services. Our key behavioural change programmes are:

Key priority	Rationale
Smoking Reducing rates for people with SMI and rates in our wards with higher levels of deprivation.	Whilst adult smoking prevalence in Trafford has been **declining** from 16.4% in 2015 to 9.1% in 2019, and smoking prevalence in routine and manual workers has seen a sharp **decline** from 26.4% in 2018 to 17.4% in 2019. The inequality gap in smoking prevalence between those with and without a long term mental health condition is **widening.** Trafford is significantly worse than the England average and the third highest amongst group of similar authorities for lung cancer registrations. There are wide social inequalities between electoral wards within Trafford in indicators of smoking related harm (e.g. there is a strong trend towards increasing rates of emergency admissions with Chronic Obstructive Pulmonary Disease (COPD) and lung cancer incidence as deprivation increases)
Alcohol Reducing rates for males and residents in our wards with higher levels of deprivation.	Rates of alcohol-related hospital admissions in 2018-2019 have remained **stable** at 601 per 100,000; but **higher** than England average; rates of alcohol-related deaths have **declined** from 55.9 per 100,000 in 2013 to 44.2 per 100,000 in 2018. Premature mortality (deaths under 75 years of age) from liver diseases in Trafford has been **declining** from 22.8 per 100,000 in 2011-2013 to 18.9 per 100,000 in 2017-2019. However rates of alcohol-specific hospital admissions for individuals **under 18 years** of age are 47.6 per 100,000 for 2017/2018-2019/2020 are **higher** than England average. Alcohol related death and hospital admission rates amongst male residents in Trafford are at least twice as high as amongst females. Hospital admissions for alcohol attributable conditions increase as the levels of deprivation increases in Trafford.
Physical Inactivity. Reducing rates **in** adults who are inactive and increase in physical inactivity in Trafford adults with a disability or long term health condition.	About 1 in 5 (19.9%) Trafford adults are inactive (<30 mins a week) **an improvement** (reduction) on 2015/16 baseline44% of Trafford adults with a disability or long term health condition are inactive compared with 18.9% of those without a disability. With individuals in both categories becoming more active, the disability gap has **reduced** to 25.5%. However widening inequalities with increase in overweight/obesity and in physical activity in deprived population groups, black and Asian ethnic groups and males .Continued inequality gap between activity levels of individuals with a disability or long term health condition and the general population.
Obesity: Reducing rates in our BAME community, and wards with high levels of deprivation. Reducing rates in Year 6	Percentage of adults (aged 18+) classified as overweight or obese has seen a **significant drop** (4.7%) from 64% in 2018/19 to 59.3% in 2019/20..Prevalence of overweight (including obesity) in reception has **declined** from 20.2% in 2014/15 to 18.8% in 2019/20. But prevalence of overweight (including obesity) in Year 6 has **increased** from 29.8% in 2014/15 to 32.2% in 2019/20

We will support investment in evidence based prevention services where we know this will improve health outcomes, and will focus this investment in the most deprived areas of the Borough and with marginalised and vulnerable groups. This will also include wellbeing schemes which address mental health, targeted prevention programmes which promote healthy ageing, and which support people known to be at high risk of developing long term physical and mental health condition