Gloucestershire Health and Wellbeing Board

Report Title	Health Inequalities in Gloucestershire – COVID-19 and Beyond
Item for decision or information?	Information and decision
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Organisation	Gloucestershire County Council

Key Issues:

COVID-19 has exposed the deep inequalities in health and life chances that exist between different population groups and areas of the country. In July 2020 the Board committed to a number of projects to better understand and take action to mitigate these impacts, with an initial focus on Black, Asian and Minority Ethnic (BAME) communities.

Meanwhile, the Board has signed off the Gloucestershire Joint Health and Wellbeing Strategy (2019-2030), which commits to embedding action on health inequalities across each of its seven priorities.

The purpose of this paper is to take stock of where we are in tackling health inequalities in Gloucestershire; to update the Board on progress against key areas of work; and to identify potential gaps and propose a way forward.

The paper will conclude that, while some work-streams have been unable to progress as planned during the COVID-19 pandemic, there are many examples of good practice being taken forward. The paper also highlights the opportunity and necessity to bring these strands together into a more coherent approach and makes recommendations on how this could be moved forward.

Recommendations to Board:

The Board is invited to:

1. Consider the developing programme of work on health inequalities, including opportunities and recommendations to strengthen this work
2. Support the recommendation to convene a Health Inequalities Panel to steer this agenda, supported by the Contain Outbreak Management Fund (COMF) health inequalities posts
3. Comment on the draft principles for an anchor institutions approach in Gloucestershire.

Financial/Resource Implications:

None identified

Health Inequalities in Gloucestershire – COVID-19 and Beyond

1. Introduction

1.1 This paper provides a follow up to the paper entitled *'COVID-19 reset: Focusing on inequalities and the role of anchor institutions'*, which was presented to the Board in July 2020. It will update the Board on the developing programme of work on health inequalities in Gloucestershire, including the anchor institutions project, to inform a discussion on:

a) The wider strategic context and approach for understanding and addressing health inequalities in Gloucestershire
b) To agree next steps for taking this agenda forward.

2. Health inequalities

2.1 The background information on health inequalities was presented to the Board in July 2020 so will not be repeated in here detail. However, it is worth a reminder that, immediately before the COVID-19 pandemic, 'The Marmot Review 10 Years On' reported that health was in decline and inequalities were widening[1]. The review welcomes efforts made by local authorities and communities to tackle the social determinants of health but emphasises the need for more effective action to tackle these drivers and to further embed proportionate universalism (universal policies with effort proportionate to need) across our business.

2.2 Shortly after the publication of this report the COVID-19 pandemic both highlighted and exacerbated the health inequalities that already existed in our society. We outlined in July the differential impacts of the virus itself on different population groups. In addition, the long-term impacts of COVID-19 control measures on education, employment and the economy are also likely to be felt disproportionately by different groups in society, both now and over years to come. Other likely impacts include social isolation, mental health issues (anxiety and depression), increased alcohol consumption, obesity and domestic abuse.

2.3 The Board has already acknowledged the imperative to take steps to mitigate impacts and the opportunity to 'build back differently'. Section 3 below provides an update on key areas of activity.

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[1] Institute of Health Equity http://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on/the-marmot-review-10-years-on-executive-summary.pdf

Health Inequalities in Gloucestershire

2.4 The PHE Health Inequalities Dashboard provides information to monitor progress on reducing health inequalities through 19 key indicators. It measures trends in each indicator since a baseline period, with longer term data provided where available. A snapshot of the current position in Gloucestershire, compared to baseline data from up to ten years ago, is given in Appendix 1.

2.5 The picture in Gloucestershire is one of 'no significant change or modest improvement' across the majority of indicators. The notable exception is for obesity and severe obesity among reception-age children, with the 2019-20 data suggesting significantly greater prevalence compared to 2015-16. However, this data must be interpreted with caution because the number of children participating in the programme in 2019-20 was below levels required for a robust sample (owing to school closures due to COVID-19).

2.6 Further analysis of the available data across these indicators is recommended including:

- Inclusion of 2020-21 data when this becomes available to start to understand the impact of COVID-19 across these indicators
- Benchmarking against comparator areas.

2.7 Meanwhile, a rapid health needs assessment has been undertaken to summarise the immediate impact of COVID-19 on health and health inequalities and to start to understand the wider and potential longer-term impacts. A summary of this work will be included in the Health Inequalities Toolkit outlined in section 3 below.

3. Update on key areas of work aiming to address health inequalities

3.1 This section provides an update of key work-streams of particular relevance to the Board. It does not intend to cover all of the good work that is going on to address health inequalities in Gloucestershire.

System-level change – working in partnership

3.2 The Joint Health and Wellbeing Strategy (2019-2030) is the key strategic driver for the work on health inequalities in Gloucestershire. Alongside this the NHS Long Term Plan (LTP) provides the overarching framework for the work of the Integrated Care System (ICS) on prevention and health inequalities. Both Health and Wellbeing and ICS Boards have committed to embedding action on health inequalities across their strategic priorities.

3.3 The relationships between health inequalities and the Health and Wellbeing strategic priorities in the wake of the COVID-19 pandemic are complex. This point is illustrated using the healthy weight priority:

- **Healthy Weight** – prior to the pandemic children living in the most deprived neigbourhoods were already twice as likely to be affected by obesity as those living in the least deprived areas. We would expect children from families facing the greatest challenges prior to the pandemic to be disproportionately affected by the social and economic impacts of lockdown including: loss of income, school closure, reduced opportunities for exercise (e.g. the Daily Mile), impact on mental health and wellbeing, social isolation and so on. We do not yet have the evidence to support or challenge this hypothesis but early data from adults affected by severe obesity suggest disparities; around third report significant weight gain over the last year and a third have been able to lose weight.

3.4 Recognising that poor outcomes in health result from a complex interaction and accumulation of factors over time, the longer-term impacts will need to be worked through, for each GHWB and LTP priority, during the COVID-19 recovery period and beyond.

3.5 While some work under the GHWB strategic priorities has been progressed during the pandemic, the principal focus over the last year has been on the *immediate* needs of vulnerable groups e.g. through the work of community resilience and mental heath cells. Unfortunately, much of the longer-term planning and development work has been paused but will be resumed during recovery.

Health Inequalities Toolkit

3.5 A key enabler for this work is the Gloucestershire Health Inequalities Toolkit. This resource aims to support a more structured and evidence-based approach to understanding and taking action against the underlying causes of health inequality at population-level; enabling services, organisations and partnerships to break down their high-level ambitions into specific objectives and preventive actions.

3.6 The Toolkit will include both *enabling* and *directive* elements. It distils a number of key tools from the overwhelming range available into a practical guide to help local bodies understand where there is inequality and then identify key actions they can take to address this. A number of these tools will be tested locally over forthcoming weeks with support from the public health team and will then be refined and simplified so that they are more accessible for others to use independently (See Table 1).

Table 1: Health Inequalities Tools and Case Studies

Tool	Purpose of the Tool	Case Study (Lead Orgs)
Health Equity Audit (HEA)	To identify how fairly resources are distributed across different groups	Healthy Lifestyles Service (HLS) (Public Health with HLS provider)
Health Equity Assessment (HEAT) Tool	A lighter weight alternative to the HEA tool, which also helps to identify mitigating actions	Carers offer (GCC commissioners with carers providers)
Health Impact Assessment	Used prospectively to predict health consequences for different groups of a proposed change	Planning and health (Public Health with County and District Council planners)
Social Return on Investment (SROI)	Identifies and attempts to put a value on the wider benefits of an intervention or programme	No Child Left Behind Programme (Pubic Heath with Cheltenham Borough Council)
Intervention Effectiveness / Decay Model	Systematically uses data to assess the effectiveness of a patient pathway for different groups of the population	Respiratory CPG (COPD) and cancer (CCG with Public Health)
Place-based tool	A joined-up approach that considers the 'place', not just individual issues, in recognition of the multiple causes of health inequalities	Gloucester City (specifics tbc) (CCG / Integrated Locality Partnership with Public Health)

3.7 The more directive elements of the Toolkit will include specific evidence –based recommendations or 'calls to action' for different sectors and 'levels' within the system; outlining what role they can play in contributing to reducing health inequalities across the priorities of the Gloucestershire Health and Wellbeing Strategy and NHS Long Term Plan; and across other evidence-based interventions within Public Health England's 'menu of interventions' for tackling health inequalities.

3.8 A first draft of the Toolkit will be available in pdf format at the end of March. This will continue to be developed and refined as the case studies are implemented over forthcoming weeks and months. Future iterations of the Toolkit will include straightforward explanations and practical examples of other tools and approaches including: Population Health Management (PHM); Heath Equity in All Policies; and community engagement and development approaches.

Vaccine Equity

3.9 Our principal area of focus on health inequalities since January has been the COVID-19 Vaccinations Equity Programme. This work is being progressed by a multiagency group, chaired by Paul Roberts (Chief Executive of Gloucestershire Health and Care NHS Foundation Trust). The purpose is to support equitable uptake of COVID-19 vaccinations across the population of Gloucestershire; both critical for helping to mitigate against COVID-19 related health inequalities and protecting the wider community from the virus.

3.10 To date the Group has reviewed the evidence on COVID-19 vaccine hesitancy, and what works in encouraging and enabling vaccine uptake, and is working to an action plan under the key themes of 'Confidence, Convenience and Complacency'. This evidence is being supplemented with local data on vaccine uptake across

different population groups, local insight research and learning from engagement activities. A range are activities are underway, or being scoped, including action to support reasonable adjustments to address barriers to access; targeted communications and engagement events and 'pop-up clinics' and roving vaccination approached. Initial priority groups include BAME communities, people who are homeless, people with a learning disability, asylum seekers and the wider health and care workforce. A 'test and learn' approach will ensure the programme adapts effectively within the Gloucestershire Mass Vaccination Programme timelines.

Place-based action on health inequalities

3.11 The ICS Board has appointed Paul Roberts, Chief Executive of Gloucestershire Health and Care NHS Foundation Trust to lead on the work to embed action on health inequalities across the NHS Long Term plan and during recovery. The key themes under this plan are 'engagement', 'interventions' and 'workforce'. The work under the ICS plan includes developing a 'place-based approach' to better understand and address health inequalities in Gloucester City. This work being led by the Clinical Commissioning Group with a multiagency sponsoring group the first scoping and the first meeting of the for this plan was held in February.

Organisation-level change

Anchor Institutions

3.12 The Board pledged to adopt an 'anchor institution' (AI) approach as a key part of its plan to address health inequalities, initially focusing on tackling health inequalities post-COVID-19 among BAME communities. The AI approach capitalises on the significant leverage of organisations such as local authorities, the NHS and educational institutions as employers, purchasers, land and asset owners and community leaders.

Initial steps were to:

- Develop a set of principles to support a shared understanding among anchor institutions of what anchor institutions in Gloucestershire are, and what could be done to support the local economy
- Collate a baseline of current anchor institution activity in the county
- Develop an agreed way forward for building on this.

3.13 Draft principles for anchor institutions in Gloucestershire, which have been developed in consultation with representatives from the relevant organisations are given in Appendix 2.

3.14 It has not been possible to progress the other objectives as far as intended due to the ongoing focus on COVID-19 response during the second wave. However, the mapping is underway and it is clear that there are many excellent examples of anchor institution activity already happening in Gloucestershire, though they are not usually badged as such. There is considerable enthusiasm for this approach from

NHS and other local organisations and examples identified so far include policies and initiatives around employment and training, inclusive economic growth, social value and leadership.

3.15 We are also working with Cheltenham Borough Council on a project to evaluate part of the No Child Left Behind programme. We are adapting the 'long version' of the Social Return on Investment (SROI) tool to develop a more pragmatic approach to support organisations to identify the social value delivered through their activities as they develop their role as anchor institutions. This activity should be completed in April.

3.16 Next steps are to complete the mapping exercise and reconvene the Task and Finish group to develop an agreed way forward for building on this work.

Community-led Change

3.17 There is a wealth of community-led and community-level action on health inequalities in Gloucestershire and this section does not attempt to do justice to this work. Key initiatives include the *Healthy Communities Together* (Kings Fund) programme (which is being presented as a separate agenda item), and the work started last year following evidence of the disproportionate impact of COVID-19 on Black, Asian and Minority Ethnic (BAME) groups.

Understanding the Impact of COVID-19 on BAME groups

3.18 In May 2020 a BAME Task and Finish group was established to respond to emerging evidence of impact of COVID-19 on people from BAME backgrounds and later to take forward the recommendations in the 2020 Director of Public Health Annual Report.

3.19 With membership across organisations and communities, the group set out to:

- **Tackle, reduce and prevent** the further impact of COVID-19 on BAME communities in Gloucestershire
- **Connect and collaborate** with BAME communities, groups and partner organisations
- **Gather an understanding** of the views, issues, experiences, concerns and needs of the impact of COVID-19 on local BAME communities

3.19 An initial intelligence gathering exercise identified:

- **Barriers** to understanding and adhering to the available guidance
- Widespread COVID-19 related **rumours and misinformation**
- **Mistrust of public sector** services including hesitancy around uptake of COVID-19 vaccines

3.20 The group has progressed or developed the following:

- An 'Information and resources for BAME Communities' webpage on the GCC website, which includes clear, consistent information about COVID-19 and support available, including translated versions
- Building relationships with Gloucestershire's BAME communities
- A Community Champions network in Gloucester City (with a focus on Barton and Tredworth), who are disseminating accurate information within their communities
- Co-production of the Barton and Tredworth COVID-19 Prevention Plan, with Gloucester City Council
- An understanding of how organisations are undertaking culturally responsive COVID-19 risk assessments for staff from BAME backgrounds
- A range of engagement activities to better understand the potential barriers to the uptake of the COVID-19 vaccination and to design communications and other activities to help address these barriers.

3.21 The group has identified the following challenges and opportunities:

- Gaps in the BAME voluntary and community sector (VCS) and the need to build capacity in the sector
- The need for health promotion and disease prevention programmes addressing prevalent risk factors (diabetes, hypertension, obesity, physical activity) better tailored to the needs of BAME communities
- Ensure COVID-19 recovery plans actively reduce inequalities caused by the wider determinants of health to create sustainable change for BAME communities.

4. Joining it up

4.1 The Joint Strategic Needs Assessment (JSNA) and Gloucestershire Health and Wellbeing Strategy are the preeminent frameworks for understanding and addressing local health inequalities in the county. However, inclusion, equity and equality are themes across a plethora of other local strategies and plans, all of which emphasise the importance of taking a partnership approach that recognises and builds on local strengths and works alongside communities.

4.2 This picture is inevitably messy, as it is for all so-called 'wicked issues'. However, within this 'messiness' having a coherent narrative and approach to delivering on these commitments is essential to ensure that we are joined-up and effective. The Public Health England (PHE) guidance on place-based approaches for reducing health inequalities includes a checklist, which has informed the recommendations below.

4.3 We propose that the Board convenes a small stakeholder 'Panel' to steer this agenda, and to provide oversight, challenge and support to key cross-cutting work-streams. It is proposed that the Panel reports directly to the Board and utilises the

Enabling Active Communities-Individuals (EAC-I) Board as a stakeholder reference group.

The responsibilities of the Health Inequalities Panel would include:

- Developing a clear narrative to describe our approach for understanding and addressing health inequalities
- Working out how we will meaningfully involve communities in shaping, delivering and evaluating this work
- System oversight to understand the balance of work across the wider determinants of health and other areas and identify key gaps and opportunities
- Oversight of the developing anchor institutions approach and Health Inequalities Toolkit
- Supporting future development of the Joint Strategic Needs Assessment (JSNA), ensuring that community assets are given the same prominence to needs and are routinely considered as part of planning
- Further development of the rapid COVID-19 health needs assessment to better understand the longer-term impacts and opportunities arising from COVID-19
- Clarification of the relationship between the GHWB and ICS in relation to addressing health inequalities
- Establish a shared health inequalities dashboard (building on the PHE dashboard) and an approach for monitoring, review and reflection ('plan, do, study, act')
- Develop a plan for evaluation and sharing the learning
- Identify opportunities for increasing awareness across the system of how action on health inequalities is fundamental to other priorities and for embedding across all our business
- Feed into workforce development plans relevant to health inequalities including embedding cultural competency training.

4.5 Some dedicated capacity is needed for this work to move forward at the pace required to embed the lessons from the pandemic during the recovery period and beyond. Funding has been allocated from the COVID-19 Contain Outbreak Management Fund (COMF) for two fixed term (two year) posts (a Programme Manager and Facilitator), working to the Director of Public Health.

5. Recommendations to the Health and Wellbeing Board

1. To note the developing programme of work on health inequalities, including opportunities and recommendations to strengthen this work
2. To support the recommendation to convene a Health Inequalities Panel to steer this agenda, supported by the COMF health inequalities posts
3. To comment on the draft principles for an anchor institutions approach in Gloucestershire.

Appendix 1: Health Inequalities Dashboard for Gloucestershire

↑ significantly better → no significant change ↓ significantly worse →no significance calculated / not available

Table 2: Trends in Indicators of Health Inequality in Gloucestershire (Extract from Public Health England's Health Inequalities Dashboard 06/03/2021)

Domain	Indicator	Group	Measure	Baseline period	Baseline value	Reporting period	Reporting value	Absolute change	Trend
Overarching indicators	Life expectancy at birth (males)		Value	2011-13	79.8	2017-19	80.6	0.8	↑
		LSOA deprivation deciles	Slope index of inequality	2011-13	7.6	2017-19	7.6	0.0	→
	Life expectancy at birth (females)		Value	2011-13	83.7	2017-19	84.0	0.3	↑
		LSOA deprivation deciles	Slope index of inequality	2011-13	6.1	2017-19	5.4	-0.7	↓
	Healthy life expectancy at birth (males)		Value	2011-13	63.3	2016-18	68.1	4.8	↑
	Healthy life expectancy at birth (females)			2011-13	66.2	2016-18	67.2	1.0	↑
Wider determinants	Children in absolute low income families (under 16s)		Value	2014-15	13.7	2018-19	10.4	-3.3	↓
	Children in relative low income families (under 16s)		Value	2014-15	13.9	2018-19	12.7	-1.2	↓
	School readiness: % of children not achieving a good level of development		Value	2012-13	48.0	2018-19	28.1	-19.9	↓
		FSM status	Relative gap	2012-13	1.5	2018-19	1.8	0.3	↑
		FSM status	Relative gap	2012-13	20.7	2018-19	21.5	0.8	↑
	16-17 year olds not in education, employment of training (NEET) or whose activity is not known		Value	2016	7.4	2019	3.5	-3.9	↓
	Gap in the employment rate between those with a long term health condition (LTC) and the overall employment rate	LTC and overall employment	Absolute gap	2013-14	9.8	2019-20	10.4	0.6	↑

Health improvement	Low birthweight of term babies		Value	2011	2.4	2018	1.9	-0.5	↓
	Reception: prevalence of obesity including severe obesity		Value	2015-16	8.7	2019-20	10.3	1.6	↑
	Year 6: prevalence of obesity including severe obesity		Value	2015-16	17.7	2019-20	19.3	1.6	↑
	Smoking prevalence in adults (18+) – current smokers		Value	2013	18.1	2019	13.0	-5.1	↓
		Routine and manual occupations vs other occupations	Odds ratio: socioeconomic gap	2013	2.8	2019	3.6	0.8	↑
	Admission episodes for alcohol-related conditions		Value	2012-13	655.0	2018-18	673.8	18.8	↑
	Self-reported wellbeing – people with a low satisfaction score		Value	2013-14	5.0	2014-15	5.1	0.1	↓
Health protection	TB incidence (three year average)		Value	2011-13	5.9	2017-19	3.5	-2.4	↓
Healthcare and premature mortality	Infant mortality rate		Value	2011-13	3.4	2017-19	3.1	-0.3	↓
	% 5 year olds with experience of visually obvious dental decay		Value	2011-12	28.0	2018-19	19.5	-8.5	↓
	Under 75 mortality rate from all cardiovascular diseases		Value	2011-13	66.9	2017-19	59.8	-7.1	↓
	Under 75 mortality rate from cancer		Value	2011-13	130.9	2017-19	118.1	-12.8	
	Suicide rate		Value	2011-13	12.9	2017-19	10.2	-2.7	↓

Appendix 2: Anchor Institutions in Gloucestershire – draft principles

Anchor Institutions Principles

Anchor Institutions are organisations that play a significant and recognised role in a locality by making a strategic contribution to the local economy. The anchor institutions approach capitalises on the significant leverage of organisations such as Local Authorities, the NHS and educational institutions as employers, purchasers, holders of physical assets and community leaders. By acting as anchor institutions Health and Wellbeing Board member organisations can play a key role in tackling health inequalities post COVID-19

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Being an anchor institution means that we will work to:

1) Commit to target voluntary, training and employment opportunities for local residents, especially in underrepresented and disadvantaged communities.

   Work experience placements, apprenticeships and internships to build the skills of those furthest from the jobs market.

2) Support staff development and career progression, targeted at groups who are underrepresented in senior positions.

   Mentoring and coaching schemes that are coproduced by groups who are underrepresented in senior positions.

3) Maximise the social, economic and environmental benefits to the local community by being a fair and ethical partner.

   Work with diverse local providers and suppliers where possible, to support the overall sustainability agenda and create a Greener Gloucestershire.

4) Consider the implications for social value in all relevant decision-making processes.

   Ensure there is an aligned social value policy within the organisation, and that it is given significant consideration in procurement exercises.

5) Adhere to the highest ethical standards in our operations and supply chains.

   Ensure systems and procedures are transparent and promote best practice so that employees, local people and local environment are protected.

6) Support local community action and mutual aid groups by being an active community partner, focusing in areas with greater need.

Work collaboratively with local third sector organisations and share resources and expertise to encourage local groups to access available opportunities.

7) Consult with local community groups to co-produce policy solutions.

Establish and maintain positive relationships with community groups and faith leaders, and involve them in decision making processes.

8) Protect the local environment, and minimise negative impacts on places and spaces.

Ensure that environmental consideration is evident in each stage of the supply chain and decision-making process, to maintain quality and access to green spaces.

9) Promote healthy lifestyles and support the health and wellbeing of the community.

Prioritise the health and wellbeing of staff and encourage healthy lifestyle choices in all work.

10) Act as a positive example of ethical and effective leadership to encourage innovation and action across the community.

Encourage leaders to play an active role in the locality, demonstrating best practice in an accessible and visible manner.