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Coventry and Warwickshire
Integrated Care System

Health Inequalities Strategic Plan

2022-27

Contents

Coventry and Warwickshire Health Inequalities Strategic Plan 2022-27

Introduction

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. This 5-year Health Inequalities Strategic Plan sets out how we are going to reduce health inequalities in Coventry and Warwickshire, taking account of the delivery of key elements of the NHS Long Term Plan and the NHS five priority actions for reducing health inequalities as set out in the March 2021 guidance.[1] Given the size and complexity of the system, this strategic plan by necessity only takes a snapshot of current progress in a very dynamic system, which is strengthening its inequalities focus day-by-day.

The overarching aim of this strategic plan is to set out how the health and care sector – spearheaded by the ICS structure but comprising the full range of organisations and partnership boards – will directly influence and deliver improvements in health outcomes, and reduce health inequalities experienced by the population of Coventry and Warwickshire. We will do this by:

- Embedding action to tackle inequalities at both strategic and operational levels as part of our core ICS work
- Recognising that health inequalities can only be reduced by a system-wide approach to population health – and using our influence to achieve positive alignment with strategies and activities linked to the wider determinants of health
- Identifying specifically how the NHS can contribute, in terms of health service delivery and working in partnership with the wider system.

The specifics included in this strategic plan are an indication of work underway rather than the entirety of it: the work underway is far broader than can easily be captured here.

Our system

The Coventry and Warwickshire System has a number of layers of strategic and operational footprints, including 6 local authorities (1 unitary authority; 1 two-tier authority with 5 district and borough councils); 2 care collaboratives; 4 Places, and 21 Primary Care Networks.

Each Place has a 'Place Partnership' of partners representing the relevant system layers, which comes together to act in concert to consider resources and data & intelligence, and shape systemic progress, including on inequalities. This Place model seeks to ensure that we reap the benefits of operating at the highest system level, whilst taking account of the

[1] Hyperlink - (Report template - NHSI website (england.nhs.uk)

variations in population health need. Our 4 Places are: Coventry; Warwickshire North; Rugby; and South Warwickshire.

With a history of combining effort across Health and Wellbeing Boards and the recent merger of the three Clinical Commissioning Groups into one, our system already understands the opportunities to better direct our resources to maximise benefit. The relationships already in established mean that dialogue on systemwide challenges is our norm. We intend to use the focus given by the formation of the ICS as an accelerant to progress.

A brief picture of health inequalities in Coventry and Warwickshire

In Coventry, residents whose health outcomes suggest the greatest degree of inequality tend to live in the central north-east and north-east of the city - in areas such as Hillfields, Wood End and Foleshill. In Warwickshire, residents with lower health outcomes tend to live in the north of the county - in Nuneaton and Bedworth, and North Warwickshire. In both cases, there are notable pockets of health inequality outside these areas.

Coventry is an urban local authority area, while Warwickshire is largely rural, with a series of urban centres across the five districts and boroughs. Inequality and deprivation look and feel slightly different across our 4 Places, but there are strong similarities of characteristic between those people most likely to experience health inequalities.

Health inequalities can be caused by many factors including household income, quality of housing, protected characteristics, geographical influences and specific vulnerabilities such as homelessness. Detailed information on health inequalities can be found in the Coventry[2] and Warwickshire[3] Joint Strategic Needs Assessments, and the Coventry[4] and Warwickshire[5] Director of Public Health annual reports.

Inset 1 contains a brief overview of inequality in life expectancy in Coventry and Warwickshire.

[2] https://www.coventry.gov.uk/facts-coventry/joint-strategic-needs-assessment-jsna

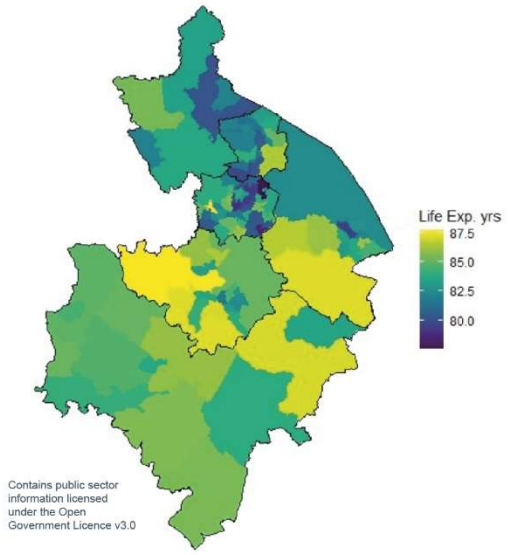
[3] https://www.warwickshire.gov.uk/joint-strategic-needs-assessments-1

[4] https://www.coventry.gov.uk/downloads/download/2984/director_of_public_healths_annual_reports

[5] https://www.warwickshire.gov.uk/publichealthannualreport

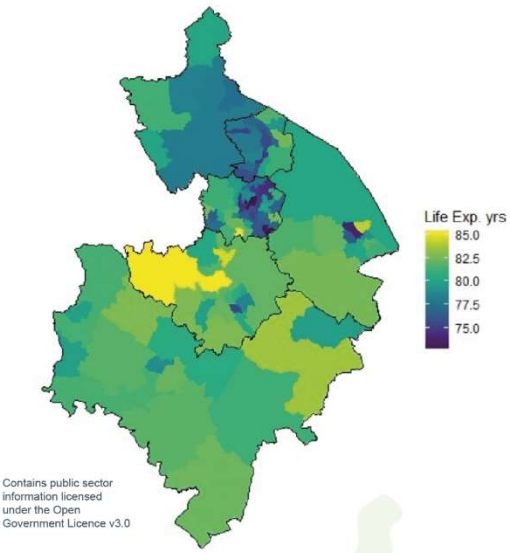
Life Expectancy in C&W (Female)

MSOA Life expectancy, dat sourced from Fingertips for 2015-2019



Life Expectancy in C&W (Male)

MSOA Life expectancy, dat sourced from Fingertips for 2015-2019



These maps of Coventry and Warwickshire show life expectancy at birth for females (left) and males (right). Life expectancy is the average length of time people live. Lighter colours (yellow, pale green) show higher life expectancy, and darker colours (dark green, blue) show lower life expectancy. At Middle Super Output Area (MSOA) data on life expectancy is available for the years 2015-19.

Data on life expectancy at a national level, and for Coventry and Warwickshire local authorities, is available for the year 2018-20. The national average life expectancy for females is 83.1 years. The national average for males is 79.4 years.

Female national average life expectancy

83.1 years

Male national average life expectancy

74.9 years

Females in Coventry

The highest life expectancy is for females living in Allesley Green and Lower Eastern Green, at **87.7 years**.

The lowest life expectancy is for females living in Henley Green and Wood End, at **77.5 years**.

Average life expectancy **82.0**

Males in Coventry

The highest life expectancy is for males living in Finham Park, at **85.3 years.**

The lowest life expectancy is for males living in Foleshill East, at **72.8 years.**

Average life expectancy **76.1**

Females in Warwickshire

Females in Warwickshire. The highest life expectancy is for females living in Stratford-on-Avon district, at **85 years**.

The lowest life expectancy is for females living in Nuneaton and Bedworth borough, at **77.3 years**.

Average life expectancy **83.4**

Males in Warwickshire

The highest life expectancy is for males living in Stratford-on-Avon district, at **81.4 years.**

The lowest life expectancy is for males living in Nuneaton and Bedworth borough at **77.3 years.**

Average life expectancy **79.7**

There is a link between health inequalities and deprivation. In Coventry, 26% (96,654) of residents live in the 20% most deprived areas of the country. In Warwickshire 6.6% (38,067) of residents live in the 20% most deprived areas of the country This varies across the county from 0.5% in South Place, 3.8% in Rugby Place to 16.7% in North Place (Population figures based on 2019 LSOA Mid-Year Estimates from ONS). Overall, people living in Coventry have significantly lower life expectancy than the England average.

Evidence collated in the Coventry and Warwickshire Covid-19 Health Impact Assessment (July 2020) suggests that the Covid-19 pandemic has had a negative impact on deprivation, life expectancy, and access to services. Concerns about financial security and homelessness have increased, alongside concerns for infants, children and young people, particularly where there are known physical and mental health conditions.

Our Strategic Principles

Coventry and Warwickshire ICS agreed the following eight principles at the January 2022 meeting of the shadow Integrated Care Board (ICB).

Principle 1: Addressing inequalities is core to and not peripheral to the work of Coventry and Warwickshire ICS

The Coventry and Warwickshire Integrated Care System (C&W ICS) has four core aims:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Ensure productivity and value for money
- Help the NHS support broader social and economic developments

Reducing inequalities is both a stated and a cross-cutting aim, recognising that we can only improve population health, ensure value for money, and contribute to local social and economic development by tackling health inequalities in the broadest sense.

We have undertaken a large programme of Board- and partnership-level engagement on health inequalities (Appendix 5) to secure and stabilise alignment of priorities, and place this agenda at the heart of local planning. Our upper-tier local authority partners in Coventry and Warwickshire have already recognised health inequalities within the core priority themes of their new strategic plans.

Principle 2: Based on the King's Fund model of population health

The King's Fund model of population health is used as the basis of both the Coventry and Warwickshire Health and Wellbeing Strategies and associated workstreams.

Application of the King's Fund model to our health inequalities strategic plan underlines our recognition that health inequalities can only be reduced by taking a holistic approach to what we do, and how we use the significant influence of system partners as levers for progress.

This health inequalities strategic plan sits predominantly in the 'Integrated Health and Care System' quadrant, to maximise benefit to NHS partners in progressing this agenda, but still links into the working of the wider system to ensure we capitalise on overlaps.

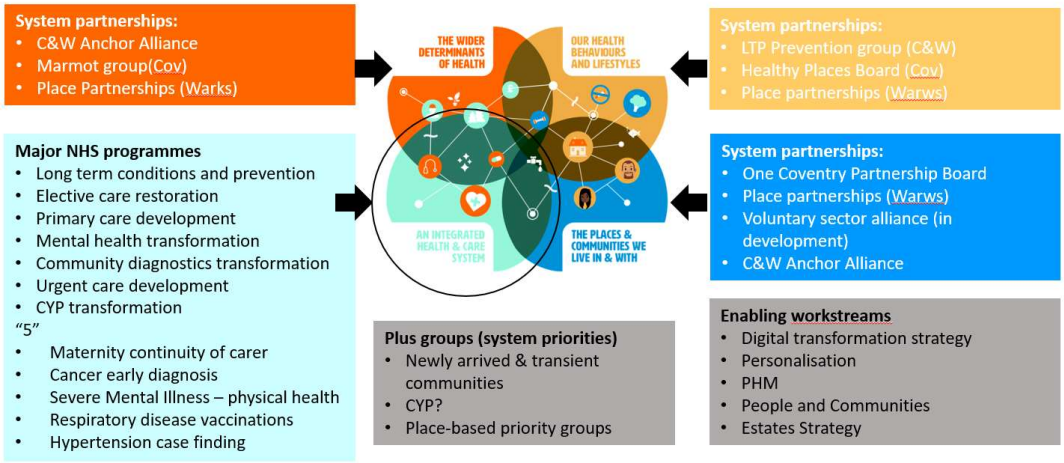


Figure 1: King's Fund model of Population Health, and the Coventry and Warwickshire approach

Principle 3: Built around the Core 20 Plus 5 framework

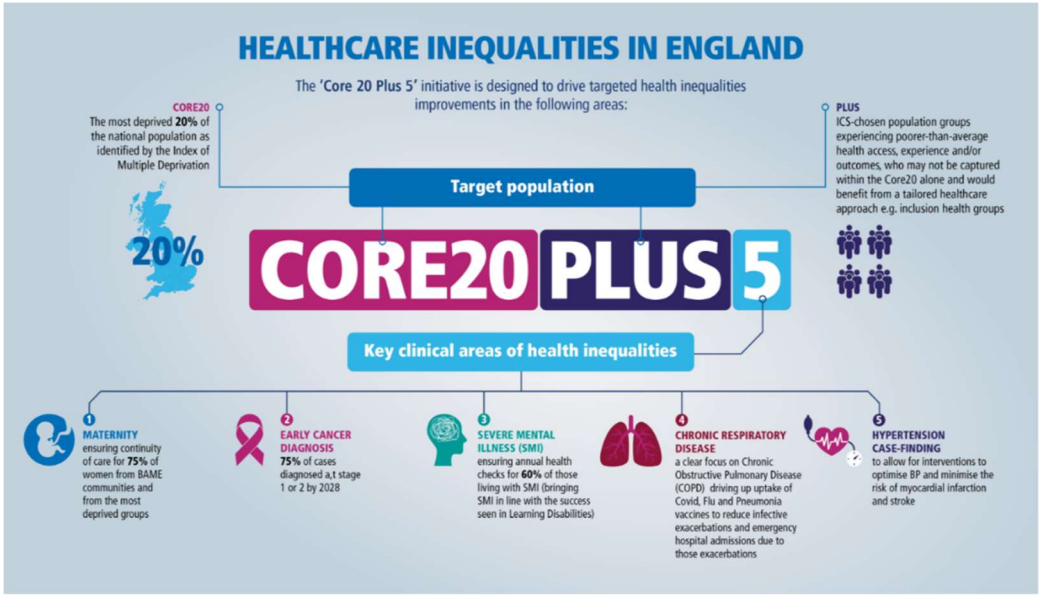


Figure 2: NHS Core 20 Plus 5 model of healthcare inequalities in England

The NHS 'Core 20 Plus 5' model sets out who in our national population are most at risk of experiencing health inequalities, and the clinical areas in which the NHS will focus efforts to reduce inequalities.

For Coventry and Warwickshire, plans are being developed at the various system levels to set out the local approaches that will be taken to improve outcomes for people of all ages, within the operating models in each context or setting, and collectively. Work is underway to confirm the Coventry and Warwickshire 'plus' groups[6], along with the translation of the wider Core20Plus5 model to health inequality work across the system.

Principle 4: Evidence-based approach

Interventions to address inequalities must be evidence-based with meaningful prospects for measurable success; this approach will be consistently applied across all workstreams. Our evidence-based approach applies to both the identification of needs in our local population, and our plans to tackle them. We will also take account of wider system learning, drivers, and influencers to shape the evidence base.

Central to this approach will be the ongoing evolution of our collection and analysis of data and intelligence, and the way we use digital technology. We intend to bring together data from the wider determinants of health datasets with the more traditional health and care data, to dig deeper into the root causes of ill-health. Director of Public Health annual reports and Joint Strategic Needs Assessments (JSNA) are a key vehicle for this, and we have a well-established approach to the production and dissemination of both.

We also take account of the wider national policy agenda as it relates to the population of Coventry and Warwickshire.

[6] See Appendix 1

The Marmot Review – Fair Society, Healthy Lives.[7] Coventry has a long history of collaborative work on inequalities and has had Marmot City status for 10 years. The learning from Marmot and ways of working are embedded locally. This strategy builds on that way of working.

More recently, the government's Levelling Up White Paper[8] adds thematic depth to our evidence base, and potentially offers opportunities to work more holistically with wider partners on connected agendas, with implicit and explicit gains for population health and wellbeing.

We will use the Population Health Management approach to action our evidence base, by connecting evidence into those programmes of work that design and deliver care at all levels in the health system.

We have established close alignment with data and digital colleagues to capitalise on opportunities to strengthen the evidence base.

Principle 5: Encourage innovation

We will encourage and support innovation across the system to reduce health inequalities. This will be accompanied by robust evaluation and rapid dissemination of successful approaches.

Innovation opportunities exist within commissioning, pathway design, organisational processes, service delivery and many other areas. We are already trialling approaches in a range of settings to gather information on scale-up potential to deliver wide system benefit. Two examples of our approach to innovation across the system are set out in Appendix 3: 'Waiting list recovery and health inequality prioritisation tool', and 'Poverty proofing'.

Principle 6: Community co-production

Co-production with our communities will be accelerated within our work to reduce inequalities, creating honest and realistic conversations that result in positive relationships. We have already achieved a shared commitment from system partners to inform our People and Communities Strategy, currently in draft. The Coventry and Warwickshire ICS has convened a system communications and community engagement lead officer group to work together to produce the strategy document. The clear commitment is to putting local voices and experiences at the heart of our processes and decisions. We are anchoring our co-production work in the 'Integrated health and care system' quadrant of the King's Fund model (Figure 1), but noting the overlaps into other quadrants.

We recognise the opportunities and challenges associated with moving towards more flexible and responsive ways of adapting to the needs of our people, but know that this approach is central to the building of sustained trust and engagement with messages and services. Creating the opportunity for people and communities to lead their own approaches to addressing inequalities is a key ambition, recognising that this is how we will meaningfully localise our offers. See Appendix 4 for Community Powered Covid Response case study.

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[7] https://www.local.gov.uk/marmot-review-report-fair-society-healthy-lives

[8] https://levellingup.campaign.gov.uk/?utm_source=Google&utm_medium=Search&utm_campaign=Levelling+Up

Principle 7: Embed inequalities across all ICS work

We will strengthen the “golden thread” of inequalities throughout all our work. To achieve this, we will continue to drive our established approach:

- We have linked with major NHS transformation programmes with the potential to have a significant impact on health inequalities, and have begun to develop health inequalities objectives and measurable deliverables (see table 4 on page 18)
- Action plans are being produced for the “5” clinical areas and the Plus groups, with developing measures for health inequalities (see table 5 on page 23)
- We have begun the roll-out of the Health Equity Assessment Tool (HEAT) throughout the system’s commissioning activity, to embed the reduction of health inequalities as a key element of all service reviews and redesigns.

The Coventry and Warwickshire ICB/S has created officer capacity for Population Health Management, to accelerate the pace at which system-wide and prevention approaches are understood and integrated into strategy and operations. Population Health Management (PHM) is a way of working preventatively to help frontline teams understand current health and care needs and predict what local people will need in the future. Population Health Management particularly focuses on wider determinants that influence health and wellbeing outcomes, including housing, employment and education, and reflects all quadrants of the King’s Fund population health model.

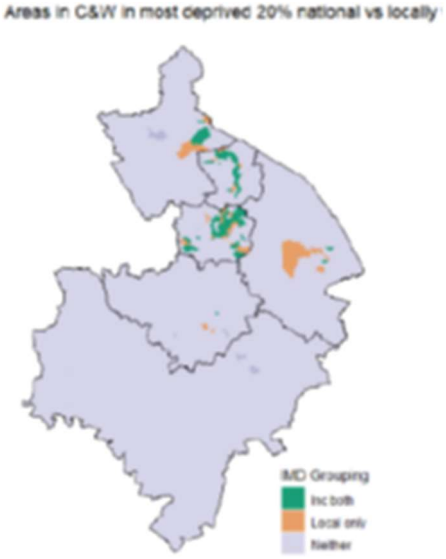
Principle 8: Reducing inequalities is key to decisions on the prioritisation and allocation of resources

A key developing area for the Coventry and Warwickshire ICS is securing a system-wide, service-relevant understanding of how to identify and ‘design out’ health inequalities. We are exploring the best ways of acting on the information we gather from people and communities. We particularly want to learn how people can most easily get access to our services, and what we need to do to offer culturally sensitive and appropriate services. We also want to expand awareness of the cumulative benefits of prioritising and targeting resources to reduce future demand, not just on individual services but on the wider health system.

In continuing to work towards this ambition, we have set out a series of actions that will take us forward:

- Include information on the impact of health inequalities in decision-making processes - particularly relating to resource allocation – to support financial and operational prioritisation
- Provide advice and guidance to support increased understanding across our services and staff teams
- Make the inclusion of health inequalities information the norm in key decision documents
- Develop and implement a strategic prioritisation framework based on the work of the STAR group (link)
- Shift resources to target population groups demonstrating the greatest need to achieve equity in outcomes, taking a gradient approach known as proportionate universalism.

The Coventry and Warwickshire approach to Core20Plus5



'**Core 20**' refers to the people living in the 20% most deprived areas in England. The total population of Coventry and Warwickshire is 949,000 people. 14% (135,000) of our residents live in the green areas identified as within the top 20% areas of deprivation in England. This proportion varies by place, with the highest - 26% of the Coventry Place population - coming within the defined cohort, and the lowest - 0.5% of the South Warwickshire Place - population, within it.

The orange colour denotes those areas that fall into the 20% most deprived areas of the Coventry and Warwickshire footprint. These areas are part of our local focus on addressing health inequalities across our system footprint.

Figure 3: Map showing the areas in Coventry and Warwickshire featuring in the most deprived 20% nationally, and locally.

'**Plus'** refers to additional groups of people chosen by the Coventry and Warwickshire ICS for targeted intervention, because our data on service access and outcomes tells us either that access and outcomes are below other population groups, or because our data on them is very limited, and we need to increase our understanding of their health outcomes. To identify these groups, we have used local and national evidence on risk factors, uptake of routine and preventative health services, and a range of health outcomes such as life expectancy. We have also accounted for themes emerging from place-based JSNAs completed in 2018-19, and intelligence on local COVID impacts (identified in COVID health impact assessments and local surveys in 2020 and 2021[9]).

Our draft 'Plus' Groups

We are currently undertaking work to identify Plus groups that are not covered off by any of the other main themes of the programme model. Our early thinking is as follows:

Coventry and Warwickshire-wide ICS 'Plus' groups

- Transient communities (people experiencing homelessness, gypsies, travellers and boaters, newly arrived communities including refugees and asylum seekers, and guests from Ukraine)

Coventry Place 'Plus' group

- People on long term sickness benefit

DRAFT Warwickshire Place 'Plus' groups for years 1-3

- Disabled people, particularly with a sensory and/or developmental disability

[9] Need hyperlinks

- People with physical and mental health needs and conditions with poor transport access to local services
- People in minority ethnic heritage groups experiencing comparatively poor health

A summary of the rationale for choosing each of these groups is included in Appendix 1. 'Plus' priority groups will be kept under review annually for the life of the strategic plan.

'**5**' refers to the 5 clinical areas identified by NHS England as their target services in which to reduce health inequalities (shown in Figure 2). Our preliminary data to benchmark Coventry and Warwickshire performance for our 'Core 20 Plus' groups are shown in Appendix 2.

NHS Operating Plan Priority Actions on Health Inequalities

Figure 4 – Coventry and Warwickshire's delivery 'plan on a page'

There are five priority areas in the NHS Operating Plan that we have mapped against our activity and ambitions for reducing health inequalities. These are summarised in headline form in Table 1, with some additional information featuring in later parts of this strategic plan. Many other aligned activities are underway.

Priority Action	Our evolving local approach
1. Restore NHS services inclusively	• Produce and deliver Elective Recovery Plans (see delivery plan 1) • Widescale implementation of the waiting list prioritisation tool • Use of Population Health Management 'HealtheIntent' platform and techniques
2. Mitigate against 'digital exclusion'	• Deliver the Digital Transformation Strategy (see delivery plan 4) • Analyse uptake of face to face and digital services by protected characteristics and IMD, and link learning to service and process planning • Strengthen links with other local work on digital inclusion in communities
3. Ensure datasets are complete and timely	• Complete research project to understand barriers to capturing accurate ethnicity data • Improve data quality and create 'single version of the truth' through implementation of HealtheIntent digital PHM platform • Embed regular reporting of inequalities data to Boards within ICS governance arrangements
4. Accelerate preventative programmes	• Implement our NHS Long Term Plan prevention programmes • Continue our long-term conditions work programme • Continue to extend the Wellbeing for Life programme • Embed and sustain the Thrive at Work workplace wellbeing programme in the business sector
5. Strengthen leadership and accountability	• Create 'Inequalities Senior Responsible Owner' roles in each core system organisation • Maintain regular meetings of Board Leads for health inequalities • Maintain System-wide Health inequalities Task Group

Table 1: NHS operating plan priority actions and our local Health Inequalities Strategic Plan approach

Enabling workstreams

The type of system working required to deliver progress on health inequalities means that we are mindful of other channels of activity with overlapping interests. We are already working through the best ways to secure and embed proactive work arrangements with the following 'enablers' – and in many cases are already substantially aligned. Again, many other aligned activities are underway but not referenced.

Enabling workstream	Noted synergies with Health Inequalities Strategic Plan
Digital transformation strategy	• Opportunity to bring together information on the wider determinants of health with a person's clinical data • Potential to predict populations at risk, and implement proactive management approaches to prevent disease / progression • Opportunity to mitigate against health inequalities by offering support in different ways, such as remote consultations and monitoring • Collaboration opportunity for the system to increase digital literacy and access in the population
Personalisation	• Align the 'choice and control' aspects of care planning and delivery with health inequalities approaches • Align with 'strengths-based' thinking and approaches, and greater influence of individuals over the type and format of services and support they value the most • Opportunity to reflect personalised care approaches aligned to the 'health inequalities' narrative in Elective Recovery Plans
Population health management	• Cross-reference the learning from insight and intelligence on health inequalities through a virtual 'Decision Support Unit' • Opportunity to improve data quality on factors which result in health inequalities (such as ethnicity, sexual orientation, and disabilities) • Understand the gaps and ways to fill these • Consider "impactability" in terms of reducing health inequalities • Procurement of the HealtheIntent digital platform • Accelerating PHM in action at PCN and Place level through the national PHM development programme, and the Place Population Health Development Programme.

	• Developing a PHM Roadmap (by mid-June) which will set out plans for how to scale and sustain PHM.
People and Communities	• Opportunity to overlap the engagement strategy and co-production approaches with the health inequalities agenda • Strengthens and builds the community and voluntary sector • Enable an asset-based approach to thinking and doing activity
Estates Strategy	To follow
Health in All Policies	• Produce a collaborative, evidence-based approach to improving health by incorporating health considerations into decision-making across sectors and policy areas • Stabilise connections between service areas and cross-cutting issues such as health
People strategy	To follow

Table 2: Enabling workstreams and their synergy with the Health Inequalities Strategic Plan

We have also recognised the importance of system and partnership Boards, and the opportunity to influence the conversations and decisions made at them which can advance the health inequalities agenda. In particular the Coventry Health and Wellbeing Board and Strategy [10] , the Warwickshire Health and Wellbeing Board and Strategy[11], and the Joint Place Forum[12] provide very visible platforms on which to shape and strengthen our work, securing highly influential buy-in.

Digital transformation strategy and health inequalities

Concurrent with work on this Health Inequalities strategic plan, Coventry & Warwickshire is shaping a digital transformation strategy, and an open dialogue has been established to capitalise on alignment opportunities. We believe that the digital transformation strategy is a key mechanism for delivering against digital exclusion, and to that end we have taken an active role in strengthening the linkages to tackling health inequalities.

Our specific observations to the digital transformation strategy group on alignment with health inequalities are summarised here:

[10] https://www.coventry.gov.uk/health-wellbeing/coventry-health-wellbeing-strategy

[11] https://www.warwickshire.gov.uk/healthandwellbeingstrategy

[12] https://www.coventry.gov.uk/downloads/download/5184/coventry_and_warwickshire_health_and_wellbeing_concordat_2018

- **Digital and Data Enablers** – we support the inclusion of digital skills and the resourcing of an ICS digital inclusion programme as a key enabler in the strategy. We have suggested that this could be strengthened by also leveraging additional innovation and resources to maximise digital inclusion, access and aspiration. We have alerted colleagues to the existing work of Coventry City Council and Warwickshire County Council on this agenda, and have recommended collaboration, and links into technology, broadband (ref. https://www.cswbroadband.org.uk/) and digital skills development initiatives. We have further recommended a multi-agency, cross-sector digital inclusion programme in the short-term priorities.

- **Population Health Management and data.** We have endorsed the digital transformation strategy commitment to enhance and embed PHM capabilities in order to achieve reduced inequalities in outcomes and experiences, as well as the ambition to create a single source of truth for ICS data. This aligns with this strategic plan's core principle, to take an evidence-based approach. We aspire to meaningfully bring together data from the wider determinants of health datasets with the more traditional health and care data, to dig deeper into the root causes of ill-health. The implementation of the Digital Transformation Strategy is a key opportunity to strengthen the evidence base about the needs of our population, and especially those who experience inequalities. This includes opportunities to improve the quality of recorded data about those with protected characteristics, and those in our 'Core20Plus' groups. We have asked for a a commitment to recording and analysing uptake of face to face and digital services by protected characteristics and deprivation, and link learning to service and process planning.

- **Virtual health and care.** We have welcomed the commitment to a virtual health and care platform, and the priority to enhance and scale our capabilities to monitor and interact with more citizens and patients virtually, offering remote monitoring support to everyone living in Coventry and Warwickshire with a chronic long-term condition or in a high-risk group (developed to support the PCN Investment and Impact Fund schemes for patients living in their own home with a long-term condition). We see this as a real opportunity to reduce health inequalities if implemented with appropriate mitigation to ensure inclusion.

- **Outcomes delivered for our citizens.** We are aware of funding that has been secured to engage with communities on the draft Digital Transformation Strategy and test whether it is aspirational enough for those experiencing digital poverty. We have specifically asked that careful consideration is given to how the digital transformation strategy group obtains the views of those experiencing digital poverty, to ensure that a genuine community co-production approach is taken and there are honest and realistic conversations with those experiencing inequalities.

- **Personalised care.** We have noted an opportunity to expand the thinking on personalised care and the way the digital transformation strategy can help achieve this (including approaches such as shared decision making, supported self-management, personalised care and support plans, social prescribing and community support, enabling choice and personal health budgets). This will improve informed choice-making on health and wellbeing. We have noted the opportunity to improve health care experience and outcomes, reduce pressure on the system and provide value for money.

- **Health and Wellbeing.** We have recommended to the digital transformation strategy group that it could expand its ‘health and care’ narrative to ‘health and wellbeing’, to target wider wellbeing issues (ie. emotionally resilient, physically active, socially connected, economically active), and use the King’s Fund model for population health (including wider determinants, the place and community we live in, and health behaviours) as the framework.

- **System and Place.** We have suggested there is a need to strengthen the connection with the emerging Care Collaboratives and to ensure that the Digital Transformation Strategy works both at a system and place level.

- **Terminology.** We have recommended alignment with language used in other plans, specific to the way ethnic minority groups are referred to, and personalised care is described.

- **HEAT Tool.** We have recommended the digital transformation strategy group undertakes a full assessment of the health equality impacts of the Strategy using the Health Equity Assessment Tool (HEAT) throughout the system’s commissioning activity, to embed the reduction of health inequalities as a key element of all service reviews and redesigns.

Governance

We have thought carefully about governance, given the critical importance of progressing work to reduce health inequalities. The Coventry and Warwickshire governance approach is described in Figure 5.

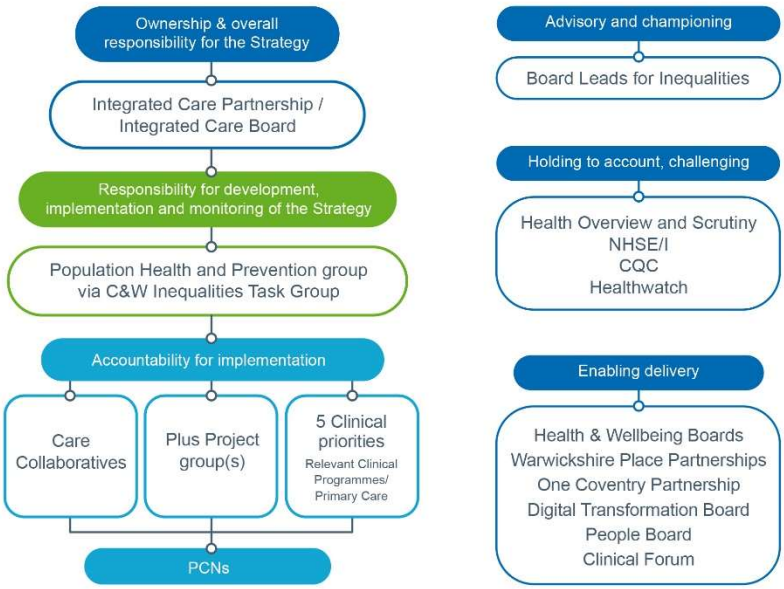


Figure 5: The Coventry and Warwickshire ICS governance model for the Health Inequalities Strategic Plan

Assurance Framework

The strategic plan and its supporting programmes will be monitored and measured by the ICS through a range of appropriate metrics; including where possible, qualitative information.

Across the system there are already a number of performance, monitoring and assurance dashboards and measures including the national requirements through the NHS Constitution, System Oversight Framework and the long term plan as well as all the local priorities. As the ICS develops there is a need to ensure alignment and consistency across the system. The delivery plans within the strategy provide a number of proposed and illustrative measurements, some of which are already routinely monitored and others not yet established. The assurance framework will evolve through a phased approach and will encompass both delivery and developmental metrics. The focus will be on both current and historical performance (where available) and will aim to identify patterns and changes including evidence of improvement in reducing variation and inequalities. Its aim will also be to develop early warning metrics to identify deterioration or programmes of work that may need revisiting or tailoring to the population's needs to enable transformation.

The monitoring framework for the strategic plan will be developed to align with, and complement, existing frameworks and metrics within the system. Key to this is ensuring that we have a single version of the truth and clarity on definitions, data-sources. As a principle, we will avoid duplication of effort and ensure that any locally developed measures are clearly defined to ensure the reporting of a 'single version of the truth'. For example the measures relating to uptake rates or access to services for Long Terms Conditions or elective recovery will be carefully designed with the leads for those areas to ensure that the parameters are appropriate and clearly documented such as agreeing the data sources, parameters such as diagnosis and procedure codes that are relevant for condition sensitive measures and identifying the appropriate population figures for the calculation of activity rates.

The Business Intelligence and Performance and Assurance teams will be working together collaboratively in developing and co-designing this framework along with support and input from colleagues and partners across Coventry and Warwickshire.

Linking Health Inequalities and Coventry and Warwickshire ICS delivery plans

Major inequalities work Programmes	Health inequalities strategic plan priorities	Links to Core20Plus5 groups	Key deliverables in Year 1	Measurement
Long term conditions and prevention	Ensure equitable access, experience and outcomes for Core20+5 groups and ethnic minorities	Core20 (5) Hypertension case finding	Implement LTP smoking programme Provision of Spirometry across system Restoration to 2019 achievement of diabetes annual review and 3 treatment targets	Uptake and success rates by IMD and ethnicity Increase prevalence and reduction in waiting lists Number and % of people achieving all 8 care processes, the number and % of people achieving all 3 treatment targets from primary care data sets
Elective care restoration	Restore elective care services more quickly for Core20 (as per C&W Elective Care Recovery Plan)	Core20	IMD PTL to be implemented and monitored weekly to ensure effective elective care delivery aligned to Core20. Implementation of the elective care prioritisation tool via identification of above at specialty level. Develop pro-active case finding along whole patient pathways through collaborative	Access, experience and outcomes for Core20 and ethnic minority groups Review of average waiting times by speciality and IMD. OP metrics to be reviewed by IMD to determine any opportunities for our population including:

			Place based reviews and whole system engagement including local authority. Equality and health inequalities impact assessment to be completed. Exploration of elective pathways aligned to our ICS 5 strategic objectives including, COPD and Diabetes. Further review of access by IMD on specific pathways such as Urology and ENT due to identification of variation on access times within these specialties. Use of transformational opportunities to target Core20 and priority groups specifically OP transformation and use of A&G, PIFU and Virtual appointments. Ensure effective use of current capacity through engagement with patient populations linked to IMD.	- DNA rates - PIFU uptake in set areas - Use of virtual

			Ensuring effective communication and transport links alongside use of 'digital first' approach can be achieved across whole ICS aligned to HI analysis. Exploration of pre-habilitation on elective pathways. Collaborative working with public health to identify areas of opportunity for prevention across our ICS linked to inequalities.	
Primary care development	Priorities as set out in the Primary Care Delivery Plan (see appendix 6) We will monitor progress in terms of inequalities across our PCNs. If we need to prioritise resources for support then these will be given to areas covering the CORE20 first.	All (as set out in Primary Care Delivery Plan in appendix 6)	As set out in Primary Care Delivery Plan in appendix 6	As set out in Primary Care Delivery Plan in appendix 6
Mental health transformation (Adults and Childrens)	Embed action on health inequalities into the transformation, including greater co-production with those with lower rates of access or poorer	(5) SMI – physical health (Plus) Support for transient communities inc. homelessness and newly arrived communities	Increase co-production with people with lived experience Improve engagement with Core20+ groups. Increase roll-	Recruited people with lived experience of MH challenges from priority population groups % coverage of annual health checks with SMI

	outcomes in response to the C&W MH JSNA (2021)	Core 20	out of Annual Physical Health Checks for people with SMI	
Community diagnostics transformation	Increase access for Core 20 & priority population groups Working with the Cancer Alliances, delivery of the LTP ambitions for cancer diagnosis	(5) Cancer early diagnosis Core 20	Development and mobilisation of our CDC across our ICS to ensure increased access for Core20+ groups. Use of transformational opportunities to target Core20 and priority groups. Ensure effective use of current capacity through engagement with patient populations linked to IMD. Ensuring effective communication for all patients specifically Transient and newly arrived communities. Ensure effective transport links via collaboration with LA and aligned to mutual aid opportunities. Use of 'digital first' approach can be achieved across whole ICS aligned to HI analysis and potential groups a	Review access by IMD for patients on diagnostic pathways. Measure delivery of CDC increase in capacity against IMD. Staging data completion Delivery of 28 day faster diagnosis standard

			Ensure Cancer staging data is complete and determine Core20 opportunities and position.	
Urgent care development	Increase access to alternatives to ED. Improve discharge processes associated with deconditioning. Reduce admission and attendances for high intensity users linked to Core 20 +5	Core 20+5 supporting access closer to home and alternatives especially linked to long term conditions, transient newly arrived populations	Increase alternative to ED closer to home Offer targeted support to high intensity users and transient and newly arrived populations Strengthen links to access to elective care and high users of UEC services with reference to vulnerable groups e.g. those at risk of suicide	Suite of alternates to ED in place Reduction in high intensity users Targeted offer for transient and newly arrived populations
Children and Young people transformation – physical health	Ensure equitable access, experience and outcomes for Core20+5 groups and ethnic minorities	Core 20 Black and Minority Ethnic Groups	Increase engagement & co-production with CYP with long-term conditions; hear views first-hand about access, experience and outcomes	Commission 3rd sector to undertake co-production / engagement with CYP; increase voice of the child and inform mapping and benchmarking work
Maternity	The Equity and equality Guidance for local maternity systems, Sept 21, set out the key aims and requirements of LMNS's to reduce health inequalities There are two aims relating to equity and equality for maternity and neonatal care are to improve:	(5) prioritisation of the implementation of MCoC with the most deprived neighbourhoods and those with higher numbers of Black, Asian and mixed ethnicity women	Re-submit their Equality and Equality analyses by 31 May 2022. Submission of Equity and Equality action plans (Phase 2) to Regional teams by 30 Sept 2022	% of births to mothers from ethnic minority groups % of mothers receiving continuity of carer % of low birth weight by ethnicity and deprivation

	• equity for mothers and babies from Black, Asian and Mixed ethnic groups and those living in the most deprived areas • race equality for staff	(Core &Plus) improve equity and equality in maternity and neonatal care, aligned to the five priorities set out with the Equity and Equality guidance for LMNS's	After which, key milestones and measurements to be added inc. management of change process with staff, mapping how areas will be divided into team, how many staff needed to support. Consideration for all by deprivation, BAME, vulnerability	% of Smoking at time of delivery by deprivation and ethnicity % of stillbirths to mother from ethnic minorities % of stillbirths to mother by deprivation % of neonatal deaths from ethnic minorities % of neonatal deaths by deprivation

Table 4 – Major NHS transformation programmes, and our health inequalities measures

This table provides an overview of activity underway. We note that there is much more not included.

Five clinical areas	Health inequalities strategic plan priorities	Explicit reference to Core20+ groups	Key deliverables in yr 1	Measurement (by deprivation and ethnicity where possible)
Maternity - ensuring continuity of care (MCoC) for 75% of women from BAME communities and most deprived groups	Development and implementation of Midwifery continuity of carer as the default model of care by March 2024 prioritising those most likely to experience poor outcomes	Include Core20 group Specific consideration of transient and newly arrived communities Prioritise the rollout of MCoC teams to the most deprived neighbourhoods and those with higher numbers of	Each provider to submit a plan for the rollout of MCoC including quarterly trajectories by June 2022	% of births to mothers from ethnic minority groups % of mothers receiving continuity of carer % of low birth weight by ethnicity and deprivation

	Ensure that this model delivers improved outcomes for women, and babies	Black, Asian and mixed ethnicity women		% of Smoking at time of delivery by deprivation and ethnicity % of stillbirths to mother from ethnic minorities
Early Cancer Diagnosis – 75% of cases diagnosed at stage 1 or 2 by 2028	Working with cancer alliances, delivery of LTP ambitions for cancer through delivering actions to tackle inequalities for specific patient groups	75% target to be achieved for Core20 group and ethnic minority groups	Health equity audit of current late cancer diagnoses	Overall % of cancers diagnoses at stage 1 & 2 % of people invited for & attending cancer screening programmes
Severe Mental Illness – ensuring annual health checks for 60% of those living with SMI	Ensure CORE20+5 groups are included within annual health checks programme	Target to be achieved for Core20 group and ethnic minority groups Specific consideration of transient and newly arrived communities	Aligned with wider plans for increasing health checks	% of practices/PCNs implementing HCA model for SMI Health Checks % of people with SMI offered a health check & % attending
Chronic Respiratory Disease – a clear focus on COPD, driving uptake of vaccines to reduce exacerbations and emergency hospital admissions	Priorities as set out in the Primary Care Delivery Plan (see appendix 6)	Core20 4) Chronic Respiratory Disease	As set out in the Primary Care Delivery Plan (see appendix 6)	As set out in the Primary Care Delivery Plan (see appendix 6)

Hypertension Case Finding – to allow for interventions to optimise BP and minimise myocardial infarction and stroke	Priorities as set out in the Primary Care Delivery Plan (see appendix 6)	CORE 20 (5) Hypertension Case Finding	As set out in the Primary Care Delivery Plan (see appendix 6)	As set out in the Primary Care Delivery Plan (see appendix 6)

Table 5 - '5' clinical areas, and our health inequalities measures

Whilst all work programmes will need to demonstrate key deliverables related to the Core20, focus on Plus may only be applicable to a few. Recognising that our Plus groups are inclusion health populations and some may be from marginalised communities, we are also looking at specific deliverables around these groups. More detailed rationales can be found in Appendix 1.

Plus Groups		**Health inequalities strategic plan priorities**	**Key deliverables in Yr 1**	**Measurement**
Transient and newly arrived communities (C&W)	People who are homeless	• Access to health services • Secondary care pathways	• Implement the findings of the Pathway reviews in the Provider Trusts	• Reduced A&E attendance • Reduced emergency admissions • Reduced re-admissions
	Gypsies, travellers and boaters	• Access to health promoting and screening services		
	Refugees, asylum seekers and guests from Ukraine	• Access to good information regarding entitlements to health service provision	• Develop NHS-led governance arrangements for considering the needs of these groups	Access, experience and outcomes for physical and mental health services

	• Access to appropriate specialist mental health and therapeutic services • Sustainable primary care support • Ensure appropriate cultural competency among health services	• Review of translation services • Review of access to specialist mental health services • Review primary care access and support	
People on long term sickness benefit (Coventry)	• Increased opportunities for employment, training and volunteering • Pathways to wider support services	• Develop links between primary care and the Job Shop • Develop a Return to Work employment offer through our Anchor Institutions	• referrals to job shop • number of recruitments of individuals with > 6 months on sickness benefit
DRAFT -Disabled people, particularly with a sensory and/or developmental disability (Warwickshire)	• Access to health services • Access to good information regarding entitlements to health service provision • Pathways to wider support services	• Not year 1 - Complete review into discrete cohorts with a view to planning action for future years	Not year 1 - Access, experience and outcomes for physical and mental health services
DRAFT - People with physical and mental health needs and conditions with poor transport access to local services (Warwickshire)	• Access to health services • Access to good information regarding entitlements to health service provision • Pathways to wider support services	• Develop clear definition of this cohort using blended data and analytics incorporating new Census data • Understand transport issues and options to improve service access	• Population group identified and segmented • Recommendations produced on service access opportunities -

DRAFT - People in minority ethnic heritage groups experiencing comparatively poor health (Warwickshire)	• Access to health services • Access to good information regarding entitlements to health service provision • Pathways to wider support services • Ensure appropriate cultural competency among health services	• Not year 1 - Complete review into discrete cohorts with a view to planning action for future years	Not year 1 - Access, experience and outcomes for physical and mental health services

Table 6 - Coventry and Warwickshire "Plus" groups, and our health inequalities measures

Monitoring the strategic plan

Implementation of the strategic plan will be monitored through each of the programmes detailed in the delivery plans (Tables 4 and 5). In addition, we will develop an inequalities dashboard, based on the national dashboard (*current indicators shown in italics*) with additional measures to look at the short- and longer-term impact of the strategy on health inequalities. Table 7 offers some examples of ways in which we might seek to shape the measurement of aspects of the wider system work. This is a developing area of work, and we have begun the process to develop an aligned monitoring and assurance plan to fit within the system programme framework.

	Examples of possible measures within ICS inequality – deprivation, ethnic group, plus groups (where possible)
Risk factors	Obesity prevalence adults Excess weight –children Breastfeeding prevalence Smoking rates and quit rates
Access to and use of services	Rate of avoidable hospital admissions all ages Rate of emergency admissions all ages Rates of ED attendances and emergency admissions 0-4y GP experience and GP booking ratings Secondary care DNA rates Digital exclusion- Outpatient attendances occurring virtually Patients Waiting Over 18 or Over 52 Weeks Size and Shape of Waiting List by Weeks Waiting COVID-19 Vaccine Uptake
Diagnostics	Rate of angiography hospital admissions Uptake of screening programmes
Treatment	% type 2 diabetes who meet all 3 NDA treatment targets % hypertension with bp 150/90 Proportion of patients with a serious mental illness (SMI) who received a complete physical health check Percentage of registered learning disabilities patients who received an annual health check.
Outcomes	Life expectancy male/female Rate of preventable mortality Rate of mortality amenable to healthcare

	<75 mortality: CVD, cancer, respiratory

Table 7 – Example potential measures for monitoring progress on health inequalities

Appendices

Appendix 1: Detail on "Plus" groups

Coventry and Warwickshire ICS is working to identified Plus groups at the System and Place levels. The information in this appendix explains our evolving thinking in greater detail.

Coventry and Warwickshire-wide ICS 'Plus' group

- Transient communities (people experiencing homelessness, gypsies, travellers and boaters, newly arrived communities including refugees, asylum seekers and guests from Ukraine)

Coventry Place 'Plus' group

- People on long term sickness benefit

Warwickshire Place DRAFT 'Plus' groups

- Disabled people, particularly with a sensory and/or developmental disability
- People with physical and mental health needs and conditions with poor transport access to local services
- People in minority ethnic heritage groups experiencing comparatively poor health

The Warwickshire Plus groups are currently in draft form, with work being done across the Places to more fully explore the data, intelligence, and the way the wider system can respond. The intention is to select one Warwickshire Plus group per year on which to focus resource and activity, with the other Plus groups being picked up in future years. A review of Plus groups will take place annually to check continued prioritisation in the context of updated and improved data quality.

Coventry and Warwickshire-wide Plus group

'**Transient communities'** covers a number of population groups and communities of interest.

There has been an unprecedented rise in numbers, pre- and in-pandemic, and Coventry hosts numbers well in excess of other regional authorities. In 2018 a comprehensive needs assessment[13] was undertaken for our refugee and asylum seeker/migrant communities and their needs in Coventry. Whilst a similar needs assessment has not as yet been conducted for the population group in Warwickshire, there is a recognition of some significant overlap in terms of needs identified.

With a significant increase in population size there are huge opportunities to influence the health of these communities directly through healthcare, and indirectly through wider determinants such as housing, education and employment. We have many gaps in our services: mental health service provision; access to appropriately resourced primary care (including access to mainstream primary care when refugees need to be moved from specialist practice provision (Coventry)); and wider access issues related to poor translation

[13] https://www.coventry.gov.uk/downloads/download/5281/migrant_needs_assessment

services across the patch. The Meridien Centre (specialist primary care) is currently managing its largest ever list with additional space being provided temporarily, but this impact is spreading into other primary care setting also. There is a huge amount of opportunity for change and for levelling up in terms of what we could and should provide for these communities. Action to support these communities will support newly arrived communities and migrant communities more broadly also, with ethnic inequality being critical to consider, in terms of the interplay with socio-economic deprivation.

Transient communities – Gypsies and Travellers

Gypsies and Travellers have the poorest self-reported health outcomes of all ethnic groups. National research suggests life expectancy is reduced by 10-12 years compared to the settled community and remain one of the most socially excluded groups within the UK. Higher infant mortality rates contribute to this gap in life expectancy and cause significant distress to individuals, families and communities. Such inequalities arise due to a range of factors including discrimination, poor accommodation, poor health literacy, a lack of trust in health providers and barriers in accessing health services. In the 2011 Census, 58,000 people identified themselves as Gypsy or Irish Travellers across England and Wales with 494 in Warwickshire (0.1% of the resident population). It is believed the number is a lot higher (3,500-4,200) as a large proportion of this group may not have participated in the Census.

Based on findings from a [local health needs survey https://api.warwickshire.gov.uk/documents/WCCC-630-1310] (40 G&Ts in 2015), priorities are around:

- Access to material related to health, in particular around healthy lifestyles and behaviours due to high rates of smoking (62% said they do not read anything related to health because they cannot read)
- Access to appropriate mental health services (67% of interviewees said that either themselves of someone in the family has experienced a mental health problem)

Transient Communities - Boaters

Warwickshire has an extensive network of waterways, with 19 rivers crossing the County and 4 canals in the 'Warwickshire Ring'[4]. Whilst these waterways are popular tourist attractions it must be remembered that they also provide a home to a number of Liveaboard Boaters. A 2019 survey highlighted health inequalities experienced by Liveaboard Boaters. The study based on responses from 356 Boaters found 88% were registered with a GP and 52% with a dentist, whilst 37% had experienced being wrongly refused registration at GP surgeries and dentists. Access to routine appointments is poorer for Boaters than the general population, with 50% of Boaters rating their experience of getting an appointment as "Fairly" or "Very Good" compared to the general population. Screening uptake appointments is also poorer, with only 64% of Boaters having received an invitation letter for Cervical or Breast Screening when they should have and only 53% had received an invitation for Bowel Cancer when they should have.[1]

Local data on access and uptake of health services, and subsequent outcomes for this population is not currently available due to gaps in data recording and reporting systems.

Transient communities – people who are experiencing homelessness

In 2020/21, 9 in every 1,000 households (2,257 in total) were owed a duty under the Homelessness Reduction Act in Warwickshire. In Coventry, this figure was 16.6 per 1,000 households (2,503 in total).[i] It is recognised that homeless populations have significantly worse physical and emotional health outcomes compared to the general population. The following factors should be considered:

- Reduced life expectancy
- Physical health and accelerated ageing
- Mental health and alcohol & drug use
- Autism and learning disability

People experiencing homelessness may have additional challenges in their experience and outcomes.

Coventry Plus group

People on long-term sickness benefit

The 2010 Marmot Review concluded that being in good employment is usually protective of health while unemployment, particularly long-term unemployment, contributes significantly to poor health. However, being in work is not an automatic step towards good health and wellbeing; employment can also be detrimental to health and wellbeing and a poor quality or stressful job can be more detrimental to health than being unemployed. Unemployment and poor quality work are major drivers of inequalities in physical and mental health.

The period covered by employment usually encompasses the longest segment of people's lives: approximately 40 to 50 years. It also often covers the years when people are raising families, and as such is a particularly important period for the transmission of inequities to the next generation.

https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on

People who are long-term unemployed have a lower life expectancy and experience worse health than those in work. Employment is one of the most important determinants of physical and mental health.

https://www.coventry.gov.uk/downloads/file/31254/director_of_public_health_report_2019_-_bridging_the_gap

There are approximately 14,600 people in Coventry who are on long term sickness benefit.

Warwickshire Plus Group(s)

Warwickshire intends to progress work against 3 identified Plus groups in consecutive years, subject to an annual review based on improved data quality.

People with physical and mental health needs and conditions with poor transport access to local services

Rural isolation is a significant area of concern for Warwickshire given our geography, and the proportion of older people experiencing it (although this is not solely an older people's issue). Around 99,000 people in Warwickshire live in the most deprived fifth of the population when using the "Barriers to Housing and Services" domain (IMD2019), compared to around 38,000 in the most deprived fifth when using the combined IMD Score. Many people living in a rural areas live in strong communities with good support mechanisms, but for those who don't the combination of social and rural isolation can have a significant impact on health and wellbeing[14].

Marginalised groups[15] and older people[16] in rural areas are at higher risk of social exclusion and isolation[17]. Infrastructure challenges, including transport and broadband, can present barriers to accessing services either in person or remotely.

Age UK highlight 5 key areas for action when addressing inequalities experienced by older people in rural communities, although they have common features for people of all ages:

- Loneliness and social isolation
- The digital divide
- Lack of support networks among people who move to rural communities
- Gaps in public transport provision
- Gaps in support for carers and people living with dementia

Not year 1 - People in minority ethnic heritage groups experiencing comparatively poor health

Not year 1 - Disabled people, particularly with a sensory and/or developmental disability

[14] https://journals.sagepub.com/doi/10.1177/1745691614568352
[15] https://www.gov.uk/government/publications/health-inequalities-in-ageing-in-rural-and-coastal-areas
[16] https://www.ageuk.org.uk/our-impact/policy-research/ageing-in-coastal-and-rural-communities/

[17] *https://www.campaigntoendloneliness.org/threat-to-health/*

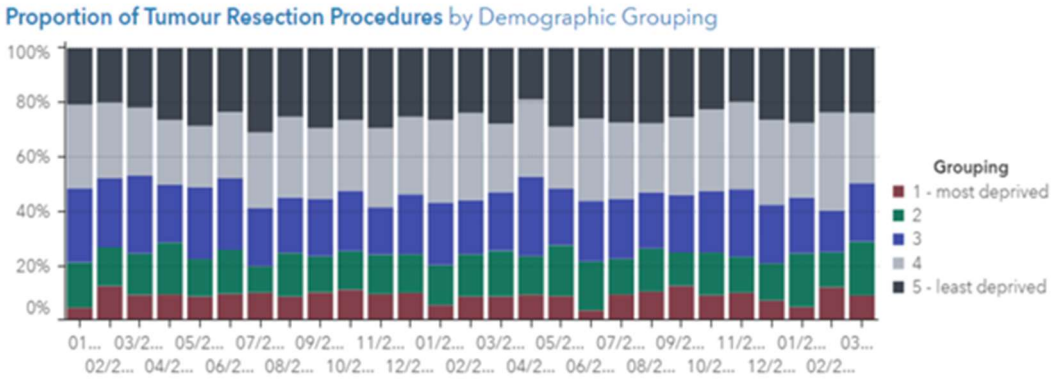
Appendix 2: Local intelligence on the “5” clinical areas

Early Cancer Diagnosis

In Coventry and Warwickshire CCG from 2017-2019 52.7% of cancers were diagnosed at stage 1 & 2. Completeness of data in terms of ethnicity by stages has been highlighted as a potential gap to address in future data collections.

The proportion of tumour resection procedures in the 3 Acute Trusts in C&W from most deprived areas were comparatively lower than those from least deprived areas.

Figure 1 Cancer staging by deprivation in 3 Acute Trusts in C&W



Maternity

Nationally Maternal mortality rates among Asian women were twice as high than in White women, and four times higher in Black women compared to White. Continuity of carer work has paused and therefore currently no data in C&W.

LMNS completed a C&W Equity & equality analysis in 2021, key finding included:

- women of mixed race were particularly at risk of poorer outcomes in a number of areas. instrumental delivery.
- women from BAME backgrounds were more likely to live in deprived areas and had a significantly higher proportion lower birth weight and premature babies

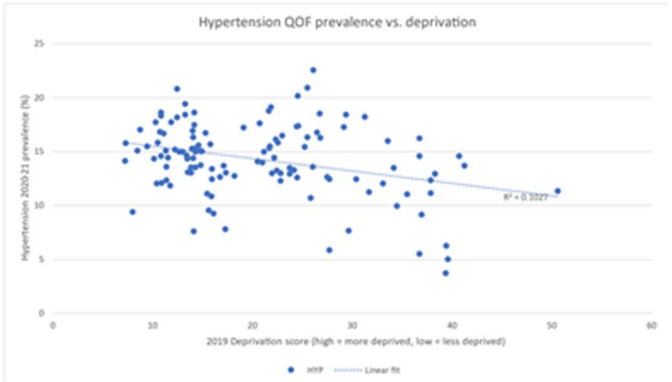
The recent C&W Joint Strategic Needs Assessment for adults mental health & wellbeing highlighted some key inequalities experienced by those with SMI:

- **1 in 3 people** experiencing a mental health problem are able to access the support they need.
- Those experiencing SMI die, on average, **15–20 years earlier** than the general population & are over 3 times as likely to attend A&E
- **85% of older people** with depression receive no NHS support
- **Black adults are the least likely** ethnic group to report being in receipt of medication for mental health*

Current data from 2020/21 Q4 shows a 10.6% uptake of annual health checks across C&W. (Coventry & Rugby CCG: 11.0%, South Warks: 13%, Wark North 4.8%)

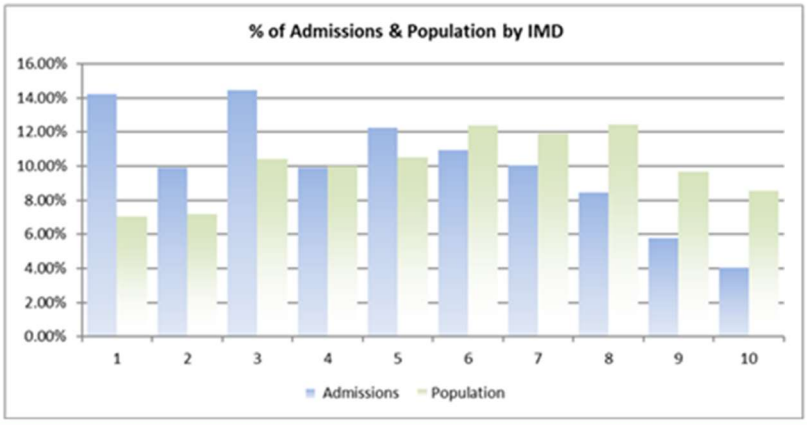
Hypertension Case-Finding and Target to Treat

The graph below shows hypertension prevalence using by primary care Quality and Outcomes Framework (QOF) by deprivation in C&W. There was an inverse relationship observed, the linear best fit (r -0.32) showed a weak, negative correlation, or a slightly lower prevalence of hypertension with higher deprivation. These data need more exploration as this difference could be due to differing age structures or poorer access to services between areas. Risk factors for hypertension also need to be taken into account.



Chronic Respiratory Disease

2019/20 data shows 7.03% of the population live in IMD 1, but 14.2% of COPD admissions are for this group, conversely, 8.52% of the population live in the least deprived decile and they account for just 4.07 % of the COPD admissions.



Appendix 3

Examples of innovation in the Coventry and Warwickshire integrated care system

Clinical prioritisation health equity tool

University Hospitals Coventry & Warwickshire NHS Trust (UHCW) have developed a clinical prioritisation health equity tool to prioritise waiting lists based on wider clinical and social needs. The tool is designed to be used across whole waiting lists to reduce health inequality developing or widening because of conventional waiting list management, so has an impact at a population level. Factors which contribute to health inequalities are built into the tool as part of the prioritisation algorithm. The target population can be defined locally by any inequalities variable that is included in patient management systems e.g. IMD score, ethnicity, protected characteristics, geography etc. This can be customised by clinical specialty to reflect the needs of their specific population group. The tool can be used to add weightings to anyone within the Core20PLUS5 group, as well as broader measures of health inequalities. Conventional use of waiting list management by time of wait alone risks increasing inequality and this tool enables all patients to benefit from NHS constitutional standards, yet within that, aims to reduce health inequality by clinically prioritising care based upon objective, evidence-based drivers of clinical outcome. Furthermore, it can impact the drivers of health inequality by enabling the social determinants of health to be factored into scheduling care for patients. A key strength of the tool is its flexibility - it can be used more broadly across the system for any priority clinical condition or population group who experience health inequalities by including the relevant measures. All clinical areas can be accommodated, and the tool enables population health management via impact at individual level.

Poverty Proofing

Warwickshire County Council is working with ‘Children North East’, the originators of the Poverty Proofing programme approach, as part of its wider strategy on tackling social inequalities. The programme was first run in schools in the North East, with the aim to reduce stigma and remove barriers to learning, and to assist schools in exploring the most effective way to spend pupil premium allocation.

The Poverty Proofing approach is holistic, encompassing:

- A review of local policies, practices, systems and structures through the lens of poverty
- A clear and individualised understanding of the local context and community
- Keeping the voice of those with lived experience of poverty at the heart of all interventions

We are taking the Poverty Proofing approach and transplanting it into four pilot sites in hospital trusts, and the local authority. The pilot encompasses training for professionals, gathering an understanding of the organisational and local context, consulting and listening to individuals who access or don’t access the services provided, and using the evidence gathered to inform decision making. A further review of subsequent practice changes will take place a year later.

Appendix 4 – Community engagement and co-production case study

Community Powered Covid Response

In response to the restrictions of the first lockdown in March 2020, and the resulting urgent need to support vulnerable and isolated people, many communities formed local support groups, providing food and essential household items, transport, prescription deliveries, and mental health support including befriending services. The resulting informal network of some 300 groups across Warwickshire provided a lifeline to many people, but also a means of community engagement for the ICS. This widespread mobilisation is a lesson to public agencies in the ability of communities to recognise their own priorities and challenges, to act with pace in designing services, and to deliver services with high levels of efficiency. Outside of the pressure of a pandemic, this reinforces the value of coproducing services to ensure focus on the correct priorities, good design and efficient delivery.

Appendix 5 – Health Inequalities Strategic Plan engagement activity

We continue to work to an engagement programme, not only to influence the shape of the Health Inequalities strategic Plan, but also to help us shape other system strategies being developed in this timeframe. See Table 3, below.

Engagement activity	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Key Boards						
Warwickshire Health and Wellbeing Board						
Coventry Health and Wellbeing Board						
Warwickshire Place Partnership - North						
Warwickshire Place Partnership - Rugby						
Warwickshire Place Partnership - South						
Coventry Overview and Scrutiny Committee						
Warwickshire Adult's and Communities Overview and Scrutiny Committee						
Coventry Marmot Group						
Shadow Integrated Care Board						
Digital Transformation Board						
Board Leads for Inequalities						
Population Health and Prevention						
Place (?) Executive Group (PEG)						
Cancer Board						
Coventry and Warwickshire Clinical Forum						
Anchor Development Group						
Coventry and Warwickshire Place Forum						
Coventry SCRUCO						
One Coventry Partnership						
George Eliot Hospital Trust Development Board						
University Hospital Coventry and Warwickshire Board						

South Warwickshire Foundation Trust Board						
Coventry and Warwickshire Partnership Trust Board						
Integrated Care Partnership Development Session						
Coventry Primary Care Development Group						
Warwickshire North Members Engagement (Primary Care)						
Rugby Members Engagement (Primary Care)						
Warwickshire Care Collaborative Development Board						
South Warwickshire Members Engagement (Primary Care)						
Warwickshire Corporate Board						
Other engagement discussions						
Personalisation						
Elective delivery leads						
Primary care delivery group						
Mental health transformation leads						
Children and young people physical and mental health leads						
NHS England/Improvement						
Inequalities Task Group						
CORE20+5 NHS Programme Leads						

Key

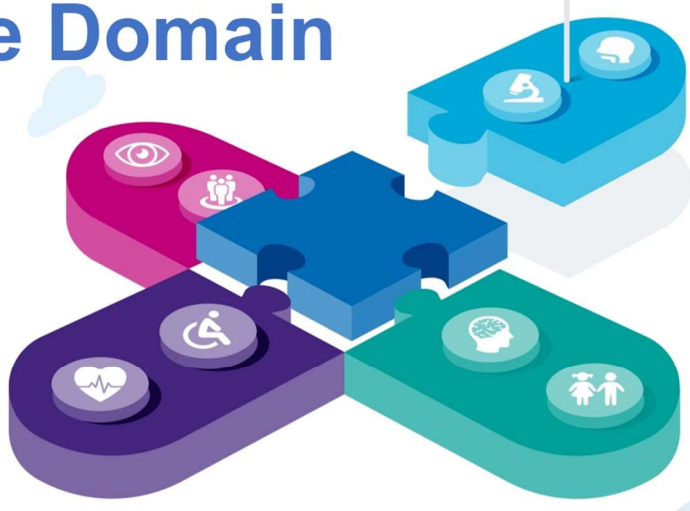
	System engagement
	Coventry engagement
	Warwickshire engagement
	NHS Provider Engagement

NHS
Coventry and Warwickshire
Clinical Commissioning Group

C&W Health Inequalities Strategic Plan – Delivery Plan for Primary Care Domain

| 29 March 2022

*** NB. Key deliverables and metrics to be developed further/refined following publication of 2022/23 primary medical care services contract documentation, including Network DES Contract Specification, PCN service specifications, QOF guidance etc.*



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Primary Care	Health inequalities Strategic Plan Priorities	Links to Core20Plus5 Groups	Key Deliverables in Year 1 **	Measurement **
	(1) Continued focus on Primary Care Network (PCN) development and specifically the delivery of the five, nationally identified, areas of focus for PCNs for 2022/23, recognising the role that each local PCN will play in our system as a key vehicle for reducing health inequalities; including through an increasing focus on prevention, early intervention, personalisation and population health management, in line with the NHS Long Term Plan (NHS LTP). We will monitor progress in terms of inequalities across our PCNs. If we need to prioritise resources for support then these will be given to areas covering the CORE20 first.			
	PCN Focus Area 1: Improving prevention and tackling health inequalities in the delivery of primary care.	Core20 2) Early Cancer Diagnosis 4) Chronic Respiratory Disease (Flu Vaccinations) 5) Hypertension Case-Finding	Requirements of relevant national PCN service specifications: - Tackling Neighbourhood Inequalities; - Cardiovascular disease prevention and diagnosis; - Early Cancer Diagnosis; - Personalised Care.	As per national Investment and Impact Fund, including progress towards the delivery of national ambitions for: - Learning Disability Health Checks; - Flu vaccinations to at-risk groups, including chronic respiratory disease; - Closing the hypertension diagnosis gap; - Personalised care interventions e.g. social prescribing. More complete recording of ethnicity in patient records
	PCN Focus Area 2: Support improved patient outcomes in the community through proactive primary care.	Core20 4) Chronic Respiratory Disease	Requirements of relevant national PCN service specifications: - Tackling Neighbourhood Inequalities; - Anticipatory Care; - Enhanced Health in Care Homes; - Personalised Care.	As per national Investment and Impact Fund, including: - Mitigation of emergency admissions for patients with a subset of Ambulatory Care Sensitive Conditions including COPD; - Continued expansion of social prescribing services, in line with NHS LTP ambitions.
	PCN Focus Area 3: Supporting improved patient access to primary care services through increasing and optimising capacity, addressing variation and spreading good practice.	Core20 4) Chronic Respiratory Disease	Planning requirements relating to (April-October 2022) and requirements of (from October 2022) new national PCN Enhanced Access service specification. Requirements of Quality Outcomes Framework (QOF) Quality Improvement domain (NB. optimising access will be one of two areas of focus in 2022/23). Maintain surge capacity, administration hub and respiratory monitoring local schemes (legacy of Winter Access Fund). Develop portfolio of business cases based on local Winter Access Fund schemes to ensure readiness in case of other funding opportunities.	As per national Investment and Impact Fund, including: - Making use of GP Patient Survey results for practices in the PCN to identify patient groups experiencing inequalities in their experience of access to general practice, and developing and implementing plans plan to improve access for these groups.

Primary Care	Health inequalities Strategic Plan Priorities	Links to Core20Plus5 Groups	Key Deliverables in Year 1 **	Measurement **
	Continue to support the development of PCN Clinical Directors so that they are equipped with the skills and knowledge to successfully lead the work and development of local PCNs, and maximise each PCN's impact across the five areas of focus for 2022/23.	All	Plans in place across all local PCNs to deploy PCN leadership and management funding (NB. funding incorporates adjustment for unmet need in areas of higher deprivation).	See above rows.
	Continue to support capability building and accelerate take up of population health management by PCNs to enable a locally driven/responsive, intelligence-led population health management approach to patient care/service redesign, in turn reducing health inequalities.	Core20	Requirements of relevant national PCN service specifications: - Tackling Neighbourhood Inequalities; - Anticipatory Care; - Personalised Care. Other deliverables per Wave 3 Population Health Management Development Programme?	
	(2) Local GP practices to deliver the requirements of the national Quality Outcomes Framework (QOF) driving effective, proactive interventions in relation to long term condition management and recognising the national consensus that evidence-based care provided via QOF continues to be important in minimising health inequalities and securing the best outcomes for people living with long term conditions. We will monitor progress in terms of inequalities across our PCNs. If we need to prioritise resources for support then these will be given to areas covering the CORE20 first.			
	GP practices to restore QOF delivery in line with national guidance and local prioritisation.	Core 20 4) Chronic Respiratory Disease 5) Hypertension Case-Finding	Requirements of relevant clinical domains including: - Atrial Fibrillation; - Hypertension; - Chronic Obstructive Pulmonary Disease (COPD).	As per national QOF guidance.
	(3) Local GP practices to continue to restore services inclusively, in line with the locally developed and agreed prioritisation framework. We will monitor progress in terms of inequalities across our PCNs. If we need to prioritise resources for support then these will be given to areas covering the CORE20 first.			
	GP practices to continue to maximise uptake of annual Learning Disability and Severe Mental Illness (SMI) health checks	Core 20 3) Severe Mental Illness	Requirements of relevant QOF clinical domain: - Learning Disabilities; - Mental Health. Requirements of Learning Disabilities Health Checks Scheme as per national Directed Enhanced Services Directions. Maintain enhanced local arrangements and funding in relation to both cohorts of health checks.	Progress towards the delivery of national ambitions for: - Learning Disability Health Checks; - SMI Health Checks..

*** To be developed further/refined following publication of 2022/23 contract documentation, including Network DES Contract Specification, PCN service specifications, QOF guidance etc.*

Primary Care	Health inequalities Strategic Plan Priorities	Links to Core20Plus5 Groups	Key Deliverables in Year 1 **	Measurement **
	GP Practices to continue to maximise uptake of Seasonal Flu and Pneumonia vaccines, including a focus on people living with COPD.	Core20 4) Chronic Respiratory Disease	Requirements of core primary medical care services contract (Pneumonia) and Enhanced Service Specification (Seasonal Flu). Re. Cohort 6, CCG Performance and Delivery Team to link backing data to look at COPD specifically and highlight areas of low uptake. Information to be shared with general practice via CCG Primary Care Team (Heads of Primary Care). CCG to continue to participate in the Coventry & Warwickshire Flu and Covid Vaccination Steering Group – strategic approaches/activities re. health inequalities reduction to be developed through this Group, based on learning from the Covid Vaccination Programme.	TBC
	PCNs to continue to play a role in the delivery of uninterrupted Covid-19 vaccinations for the period to September 2022, including a focus on Cohort 6 ('at risk' cohort). NB. Cohort 6 includes people living with COPD.	Core20 4) Chronic Respiratory Disease	Requirements of national guidance (*Next steps for the NHS COVID-19 Vaccination Programme planning and delivery*, 23 February 2022). As above re. backing data and Steering Group.	TBC
	(4) Continue to support the local response to national Resettlement Schemes. We will monitor progress in terms of inequalities across our PCNs. If we need to prioritise resources for support then these will be given to areas covering the CORE20 first.			
	As above	Core 20	CCG Primary Care Team to engage with any working/project groups convened by Coventry City Council or Warwickshire County Council to ensure that arrangements are in place to enable beneficiaries of relevant Schemes to access general practice services in line with national guidance. CCG Primary Care Team to maintain routine contract management arrangements in respect of services commissioned through GP Federation/individual practices which support the registration of and respond to the needs of relevant groups.	TBC

Primary Care	Health inequalities Strategic Plan Priorities	Links to Core20Plus5 Groups	Key Deliverables in Year 1	Measurement **
	(5) Continued focus on delivery of the Coventry and Warwickshire Primary Care Workforce Plan and associated schemes, including monitoring of schemes for equitable uptake across the four Places (targeted approaches to be implemented, engaging general practice leaders at Place, where any inequity is identified). We will monitor progress in terms of inequalities across our PCNs. If we need to prioritise resources for support then these will be given to areas covering the CORE20 first.			
	Continue to focus on local implementation of the national Additional Roles Reimbursement Scheme (ARRS) in order to both: - Increase capacity in general practice and support access improvement; - Support social prescriber recruitment; and - Drive the development of multi-disciplinary teams (MDT) which will create the foundations for more integrated out of hospital care at both PCN and Place levels which in turn, and in line with national guidance, will be an integral part of solutions to key system challenges including health inequalities.	All	Deliver trajectories agreed with NHSE/I at PCN level, based on NHSE/I funding allocations. Coventry and Warwickshire Training Hub to maintain support offer, including ambassadors to champion ARRS roles and support those recruited. CCG Primary Care Team to maintain engagement with the Midlands Region Workforce and Retention Working Group.	Progress against agreed trajectories. As per national Investment and Impact Fund: - Continued expansion of social prescribing services, in line with NHS LTP ambitions.
	Explored all avenues to recruit and retain an MDT workforce in areas of deprivation, including by targeting international recruitment and Tier 2 Visa applications to these areas.	All	Appoint a Training Hub lead in this area, to encourage placements and apprenticeships and look to support practices to become training practices.	TBC
	Continue to participate in the Trailblazer Deprivation Fellowship Scheme.	All	2 Fellows recruited.	See previous column.
	(6) Continue to support general practice, as a sector, to build its influence and participation at all levels of the Coventry and Warwickshire Integrated Care System (Place, Care Collaborative and System) so that (amongst other impacts); **- Local GP practices and PCNs are able to shape and inform the strategic direction and priorities of the Integrated Care Board and the Integrated Care Partnership to reflect both total population need and population diversity at a local level;** **- Local GP practices act as key partners within collaborative working arrangements/partnerships at geographical levels below system (Care Collaboratives, Place Partnerships) recognising that, in line with key national policy documents, these partnership entities will be critical in driving service redesign in a way which delivers more integrated out of hospital care; improving population health; and tackling health inequalities.** **We will monitor progress in terms of inequalities across our PCNs. If we need to prioritise resources for support then these will be given to areas covering the CORE20 first.**			
	CCG Primary Care Team to continue to facilitate the development of the Coventry and Warwickshire Primary Care Collaborative.	All	Coventry and Warwickshire Primary Care Collaborative established and meeting regularly.	See previous column.