Suffolk and
North East Essex
Integrated Care Board

Joint Forward Plan 2023 – 2028

5.2 Health inequalities

5.2.1 Why is this important for people in Suffolk and north east Essex?

Health inequalities are unfair and avoidable differences in health and wellbeing across the population, and between different groups within society. These inequalities are evident for people living in SNEE.

There is a life expectancy gap between individuals born in the most deprived communities in SNEE and those in the least deprived. The difference in average life expectancy is 7.4 years in men and 5.9 years in women[20]. This has increased over time, showing that health inequalities are widening.

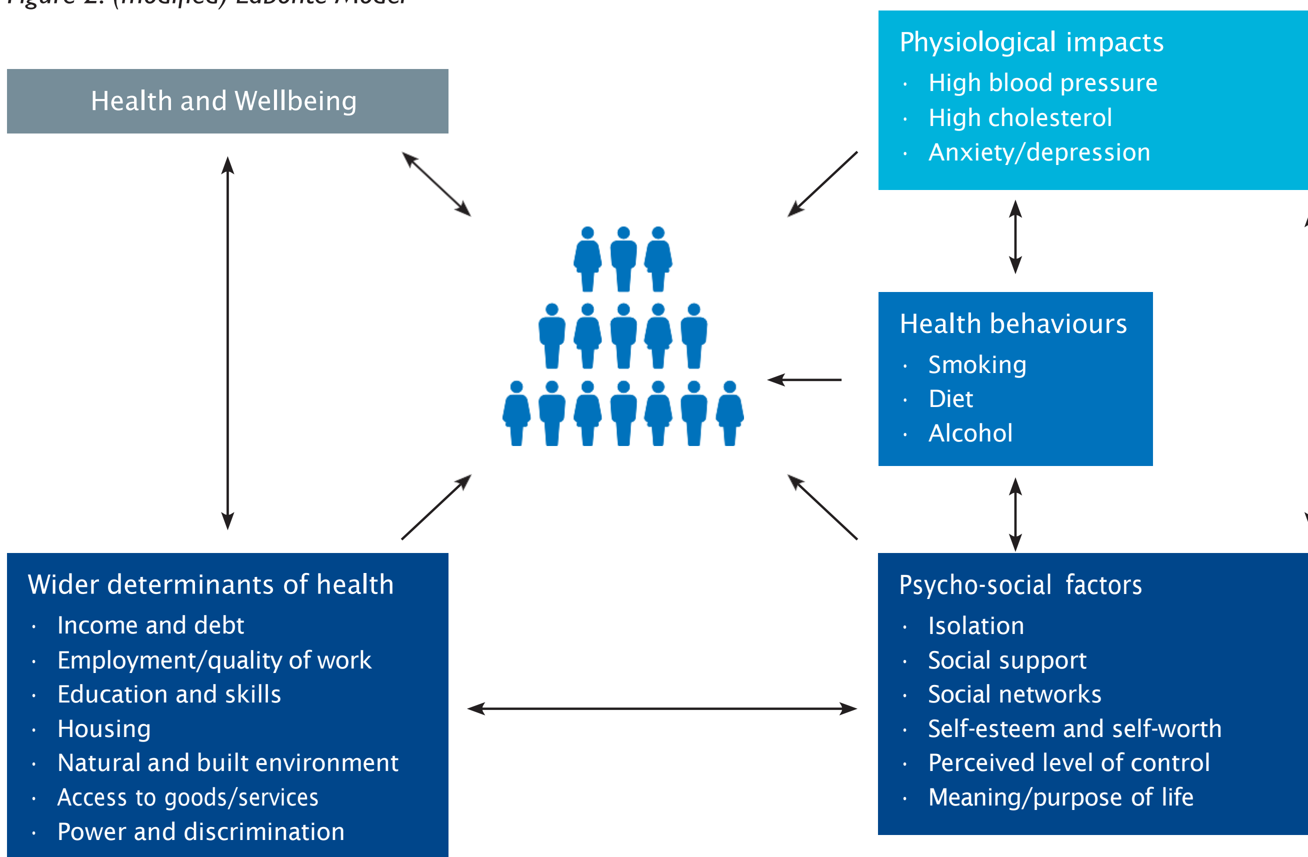
Health inequalities have also been documented between population groups across the four dimensions below:

- Protected characteristics outlined in the Equality Act (2010) e.g., age, gender, race, sexual orientation, and disability
- Socio-economic status and deprivation e.g., unemployment, low income, living in a deprived area, poor housing, and poor education
- Vulnerable groups in society (inclusion health groups) e.g., homeless people, Gypsy, Roma, and Traveller communities, vulnerable migrants and sex workers
- Geography e.g., rural or urban areas

Addressing health inequalities therefore is a key priority for the SNEE ICB. Understanding the causes and drivers of health inequalities and identifying opportunities for action across the ICS will help us do this effectively.

The modified Labonte Model (fig 2) illustrates how a broad and complex range of factors drive health inequalities. Effective action to address these will require us to adopt a population health approach. This aims to improve physical and mental health outcomes across the population, while reducing health inequalities. It takes into consideration the wider factors that influence these outcomes and recognises the need to work with communities and across partner agencies.

Figure 2: (modified) Labonte Model



[20] Source: https://www.gov.uk/government/publications/health-inequalities-place-based-approaches-to-reduce-inequalities/place-based-approaches-for-reducing-health-inequalities-main-report

5.2.2 What do we know about people's local experiences?

Across SNEE, different causes of death contribute to the difference in life expectancy between our most deprived and least deprived communities. Leading causes of death include circulatory conditions, cancer and respiratory conditions. Several underlying risk factors are implicated in their causation, e.g., tobacco, high body mass index, diabetes, dietary risks, high blood pressure and alcohol. Focused action to tackle these risk factors will not only prevent people from developing these conditions but will also reduce health inequalities. A system-wide focus on prevention, targeting areas where we have the strongest evidence for inequalities, is therefore important.

A draft of the JFP was shared on the online platform LetsTalkSNEE in January 2023 to gather feedback on key aspects of the document. Findings included:

- the need to address health inequalities in dental and oral health for marginalised groups
- 50% of respondents said that *"understanding women's health inequalities"* was the most important action for the SNEE ICB. The remaining 50% were focused on the *"development of a programme of analytics"* in this field. All respondents felt that a reduction in inequalities was the most important measure for women's health
- 100% of respondents said that *"high quality care and reduced health inequalities"* was the most important action for ME and Chronic Fatigue Syndrome

Reducing health inequalities was also a core ambition identified by Healthwatch Suffolk in the development of the SNEE ICS strategy.

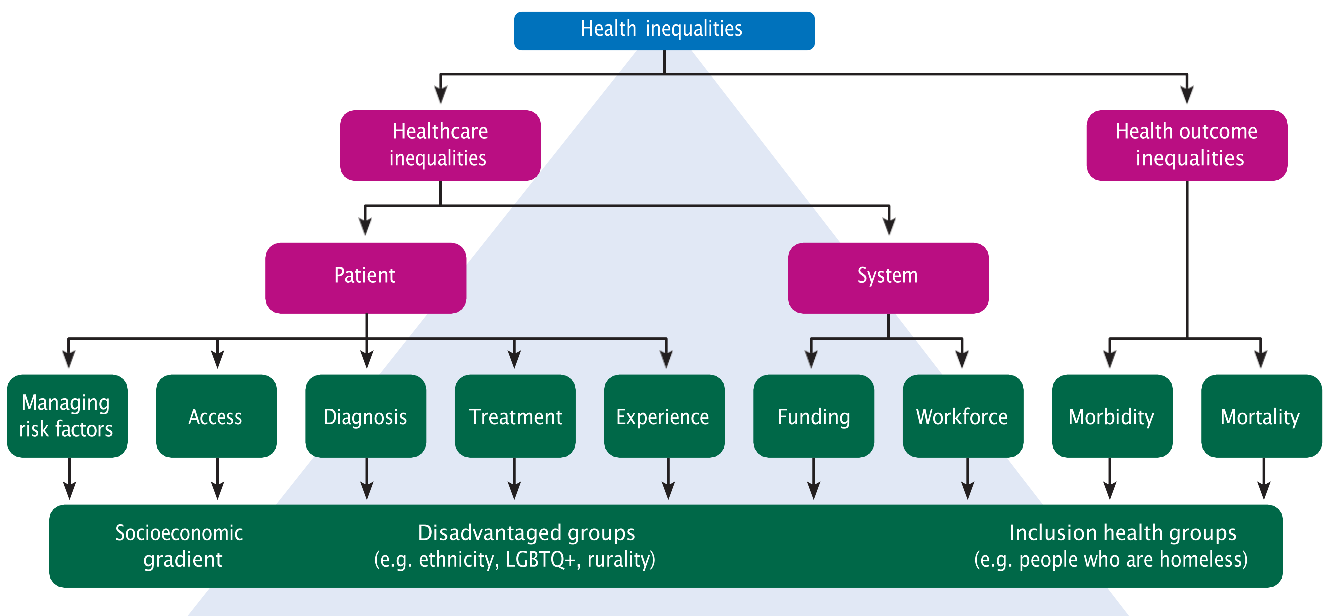
5.2.3 How do we plan to make a difference?

Effective action to address health inequalities in SNEE will require a coordinated and whole-system approach, with targeted prevention work using PHM as an enabler.

PHM data will help the system to identify areas of focus and individuals or communities for targeted interventions. Linked datasets will provide insight into current and future population needs, allow targeted action to prevent ill health and reduce health inequalities, and enable the delivery of better coordinated care and better use of scarce resources. It will enable us to move from data to action and have much greater impact than could be achieved previously.

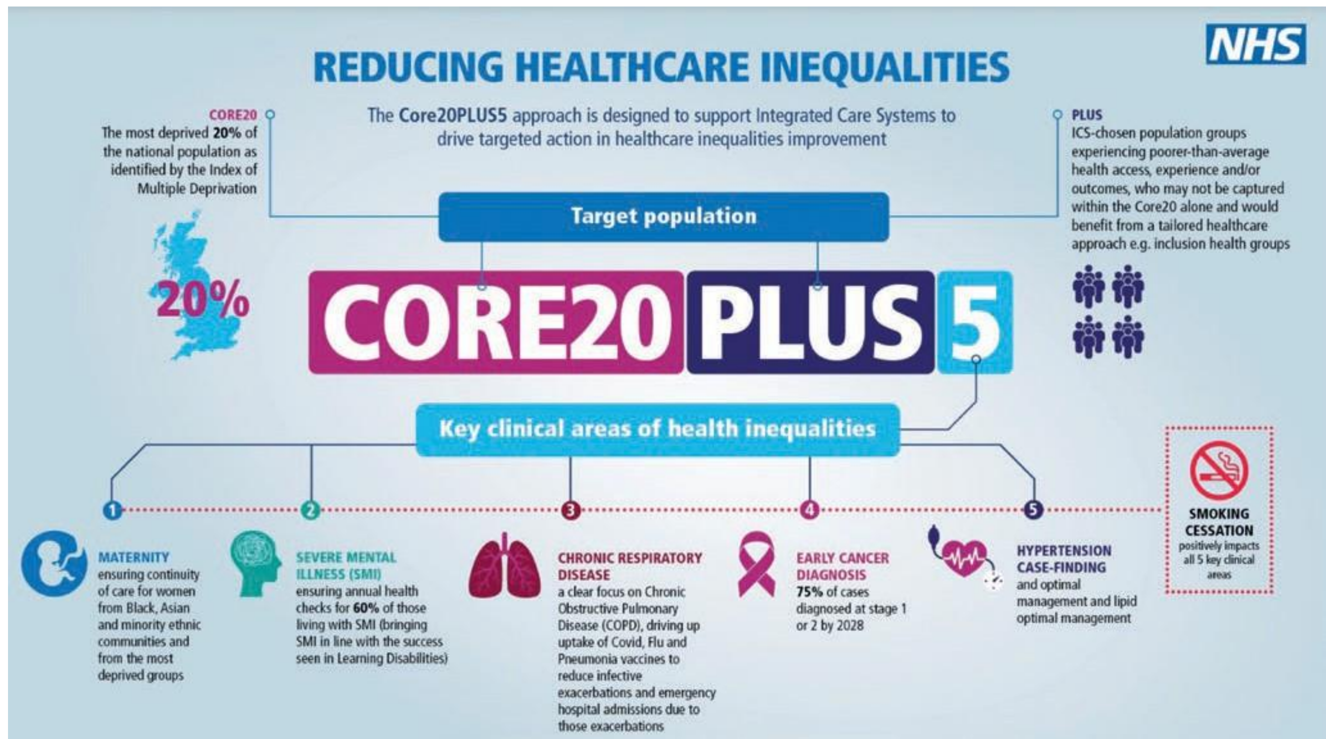
Figure 3 provides a useful framework for consideration by health and care organisations across SNEE. It illustrates key areas for action across the spectrum of health and care. These include, for example, the distribution of health system resources like funding and workforce, looking at the access to, quality and experience of services, and major drivers of morbidity and mortality and their underlying risk factors.

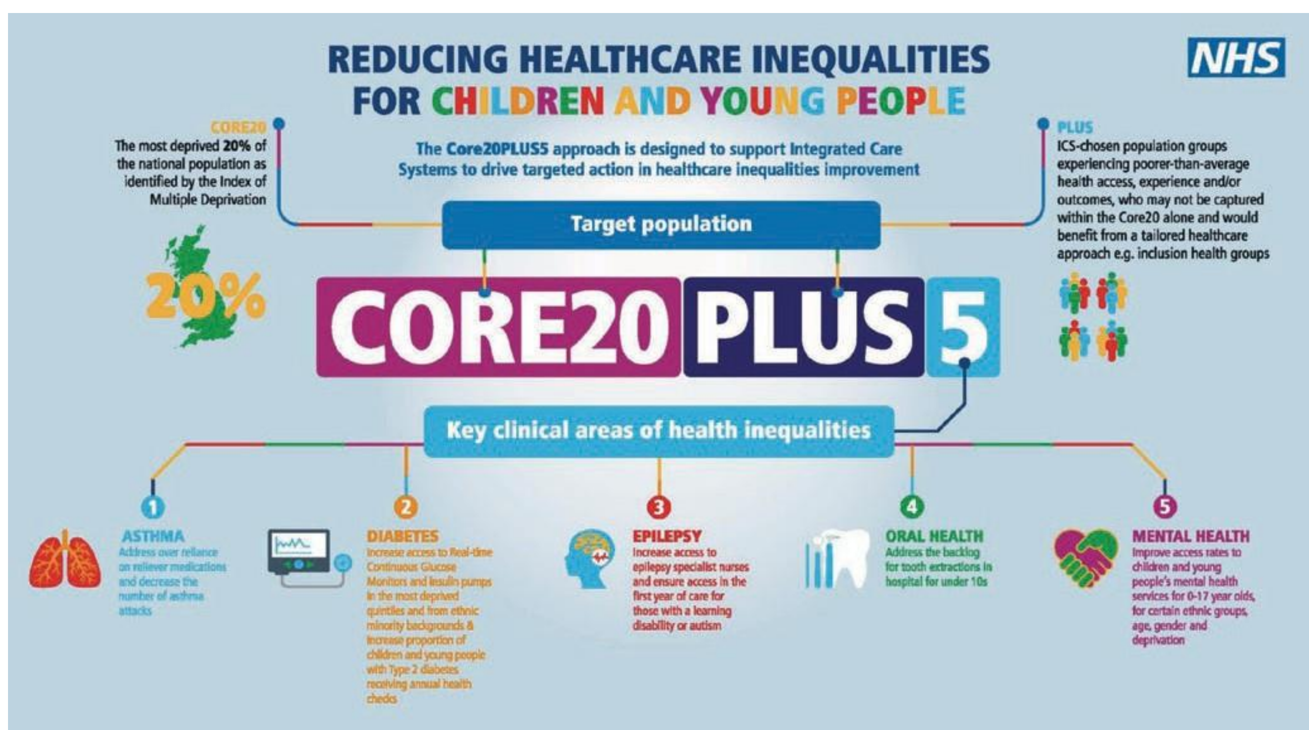
Figure 3: Framework for Health Inequalities



The Core20PLUS5 framework is an NHSE national approach to help ICSs reduce health inequalities, as shown in the below infographics:

Figure 4: Infographics for the Core20Plus5 Approach





Core20 Across SNEE, 2019 Index of Multiple Deprivation (IMD) data showed that:

- 12.5% of LSOAs in SNEE fall into the 20% most deprived areas, as identified by national IMD data, including the Brooklands and Broadway areas of Jaywick which are the most deprived LSOAs in the country
- 116,673 people in SNEE living in the 20% most deprived areas nationally, of which the majority live in Tendring and Ipswich

PLUS populations – across SNEE these groups have been identified as:

- people from minority ethnic communities
- coastal communities
- rural communities
- people and groups facing the sharpest health inequalities (groups at risk of disadvantage or "inclusion" health groups) e.g., migrants, travellers, those who are homeless, those in prison and sex workers
- people with learning disabilities and/or autism
- people with more than one health condition

Five – Clinical focus areas including:

- **Maternity:** see Section 5.4 for further information
- **Severe Mental Illness (SMI):** this is covered in more detail in Section 5.5, *Feel Well*
- **Chronic Respiratory Disease:** please see Section 5.7 (5.7.3.5 – 5.7.3.7) for further details on respiratory ambitions of the SNEE ICB
- **Early Cancer Diagnosis:** our plans for Cancer are detailed in Section 5.7.3.3
- **Hypertension Case-Finding and optimal management and lipid optimal management:** further information on stroke and stroke rehab is available in Section 5.7.3.8

In addition, NHSE has more recently published an equivalent Core20PLUS5 for children and young people. Further details are provided in Section 5.4.

Our work on health inequalities will be informed by seven key areas.

1. **Reducing health inequalities by levelling up is core business for everybody**

- Delivery of a continued programme of training and resources to ensure we all understand health inequity and how to reduce it
- Health Inequality Impact Assessments and associated principles embedded across ICB planning, design and delivery of services
- Health inequalities as a core consideration across all governance structures and reporting e.g. board papers, performance frameworks

2. **We will match resources to need:**

- inequalities will be included in investment and prioritisation decisions
- financial and staffing resources will be shifted (proportionate universalism) to where the need is

3. **We are data informed and evidence based as we are:**

- driven by PHM, JSNA and Health Equity Audits
- focused on data quality and completeness of data

4. **We do this work through community centred approaches and coproduction enabled by:**

- building on community capacity to act together
- focusing on enhancing individuals' capabilities to provide advice, information and support or organise activities around health and wellbeing in their or other communities
- communities and local services working together at all stages of planning cycle, from identifying needs through to implementation and evaluation
- connecting people to community resources, practical help, group activities and volunteering opportunities to meet health needs and increase social participation

5. **We target our efforts through a Core20PLUS5 and prevention frame:**

- focusing on the Core 20% most deprived population and PLUS groups
- preventing and managing those conditions which are the biggest drivers of health inequalities (secondary prevention)
- targeting behavioural risk factors (primary prevention)

6. **We use our position as Community Anchors to tackle the 'causes of the causes' through:**

- maximising social value
- sharing our assets with our communities
- recruiting a diverse workforce that is inclusive and representative of the local population

7. **Our services and communication are digitally inclusive:**

- providing reliable easy-to-understand health information in accessible formats for all people and communities

These priorities will be overseen by the newly formed Health Inequalities and Prevention Committee (HIPC) chaired by the Suffolk Director of Public Health to provide a focal point and strategic leadership on reducing health inequalities and embedding prevention across the ICB.

Reducing variation in performance will be a key priority across the JFP, with a particular focus on reducing health inequalities among the population living within the 20% most deprived areas and disadvantaged groups, in line with NHSE's Core20PLUS5 strategy. Within the first year of the JFP, the HIPC will define the SNEE ICB's approach to reducing health inequalities and the specific targets for performance indicators. However, an overall aim of the committee is to reduce the number of deaths in under 75s considered preventable, prioritising a reduction in inequalities in our most deprived areas and amongst disadvantaged groups by 2028.

In addition, current system-wide actions are being taken to address health inequalities, themed around five priority areas:

- Restoring NHS services inclusively
- Mitigating against digital exclusion by providing equitable options through digital and non-digital routes, whilst understanding that some people prefer not to use technology
- Ensuring datasets are complete and timely
- Accelerating preventative programmes that proactively engage those at greatest risk of poor health outcomes (including Core20PLUS5 approach)
- Strengthening leadership and accountability

Please see Appendix 4 for a more detailed plan on the above five areas.

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