HEALTH INEQUALITIES

Delivering the shift to prevention

March 2025

NHS Providers

Agenda

Welcome and introduction
Facilitated by Claire Helm

Presentation from Cathy Morgan
Cathy Morgan – director of secondary prevention, Department for Health and Social care

Presentation from Ian Ashworth
Ian Ashworth - Director of population health, Cheshire and Merseyside Integrated Care Board

Panel Q&A
Facilitated by Claire Helm

Breakout discussion

Breakout feedback/Final reflections
Facilitated by Claire Helm

Summary and close

Close of event

Housekeeping

- Please note, this Chatham house rule applies
- Please keep your camera on wherever possible
- If you lose connection, please re-join using the link in your joining instructions or email health.inequalities@nhsproviders.org
- Please ensure your microphone is muted during presentations to minimise background noise
- We will come to questions during the panel Q&A
- Please feel free to use the chat box to ask questions
- If you would like to ask a question audibly, please use the raise hand function during the Q&A section and we will bring you in
- Any unanswered questions will be taken away and answered after the event
- You will receive a link to an evaluation form at the end of the day, please take the time to complete it, we really do appreciate your feedback.

Department of Health & Social Care

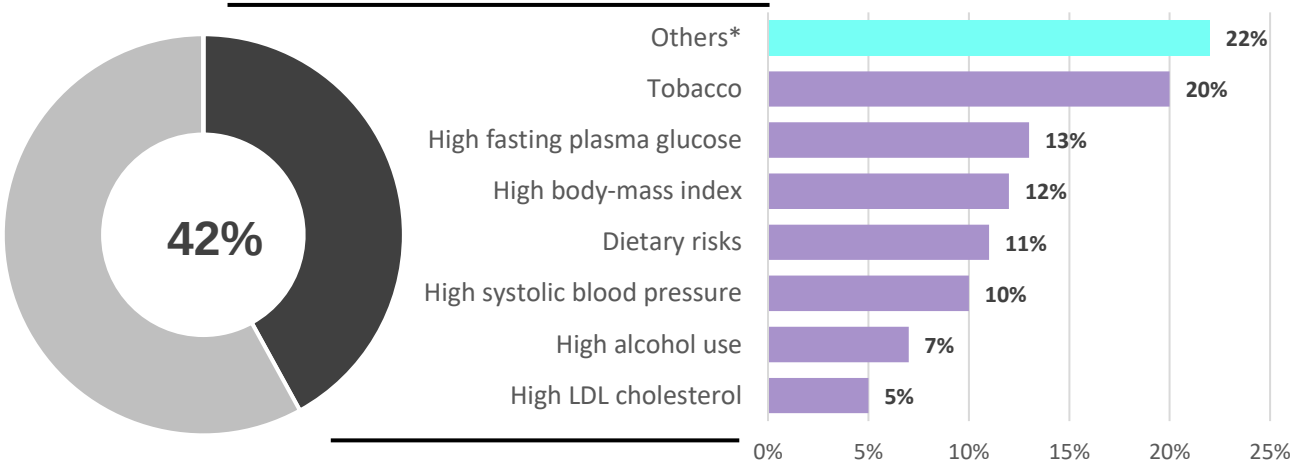
NHS Providers - Prevention

Cathy Morgan

25 March 25

Preventing disease is entirely possible and there is a huge potential for impact

Nearly half (42%) of our ill health and early death can be **linked to factors we can control and possibly even prevent** - diet, high blood pressure, tobacco and alcohol are the top behavioural risk factors



This means that **if we get prevention right, we can make a real difference** to the burden of disease in this country and help close the gap in Healthy Life Expectancy

Prevention is key to delivering the Health Mission

Mission

TO BUILD A HEALTH AND SOCIAL CARE SYSTEM FIT FOR THE FUTURE

Mission outcome

To shorten the amount of time people spend in poor health: reducing health inequalities, driving economic growth, and ultimately improving the financial sustainability of the health and care system

Shifts

(1) Hospital to home

(2) Analogue to digital

(3) Treatment to prevention

And will impact other missions too

Growth

Shortening the time spent in ill-health contributes to reducing economic inactivity. Support growth in the **life sciences sector** and **place-based growth** through the role of the NHS as an anchor institution.

Opportunity

Contribution to **early years and child health** and improving the health of children and young people through better support. Joint work on health in schools and on skills.

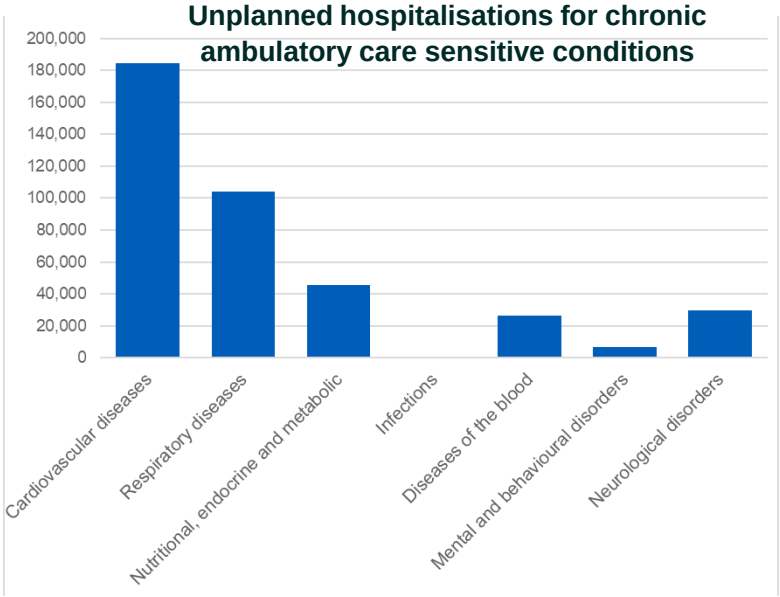
Safer Streets

Improving mental health care provision and contribution to reducing violence against women and girls and crime prevention. Joint work on substance abuse and alcohol.

Clean Energy

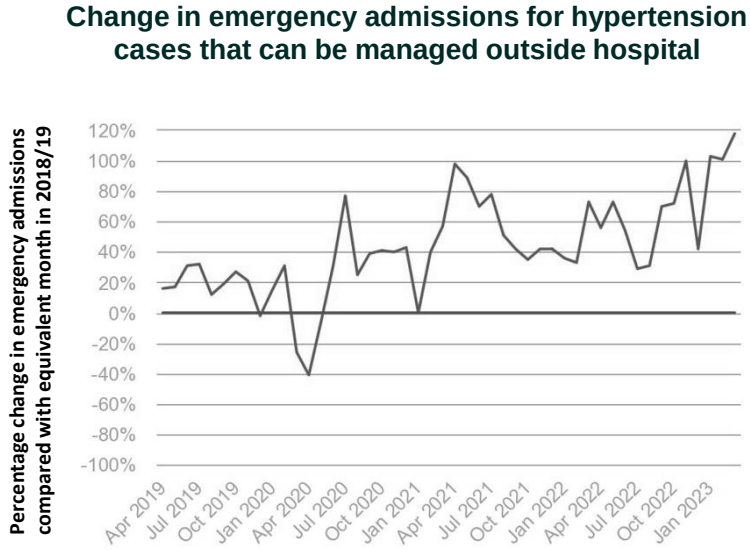
Action on air pollution, where interventions can support both health improvement and decarbonisation. The NHS can also reduce emissions through its role as an anchor institution.

But failure to manage preventable conditions may exacerbate pressure on operational delivery



Source: NHS Digital, NHS Outcomes Framework

- CVD and respiratory diseases are the leading causes of emergency admissions for chronic ambulatory care sensitive conditions.
- Strong demographic bias in terms of who gets admitted to hospital.



- Analysis of data on ambulatory care sensitive conditions by the Nuffield Trust shows that in March 2023 emergency admissions for hypertension had increased by 118% compared with a 2018/19 baseline.

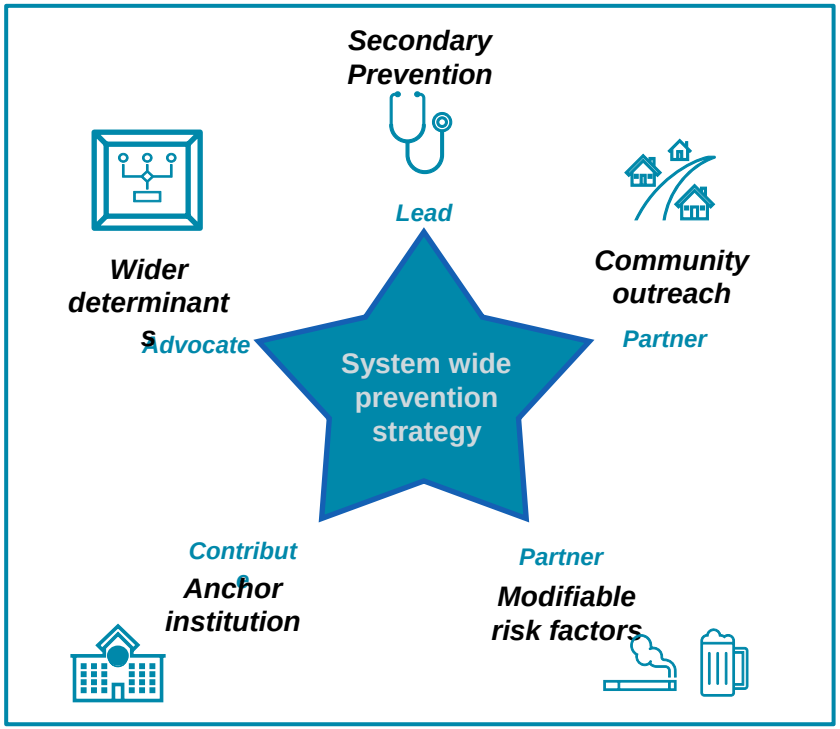
The NHS is uniquely placed to lead on secondary prevention, but needs to do so in the context of the overall system strategy

The NHS can play a **stronger role in prevention**

This needs to sit **alongside and align with a broader system wide strategy** for prevention and tackling wider determinants

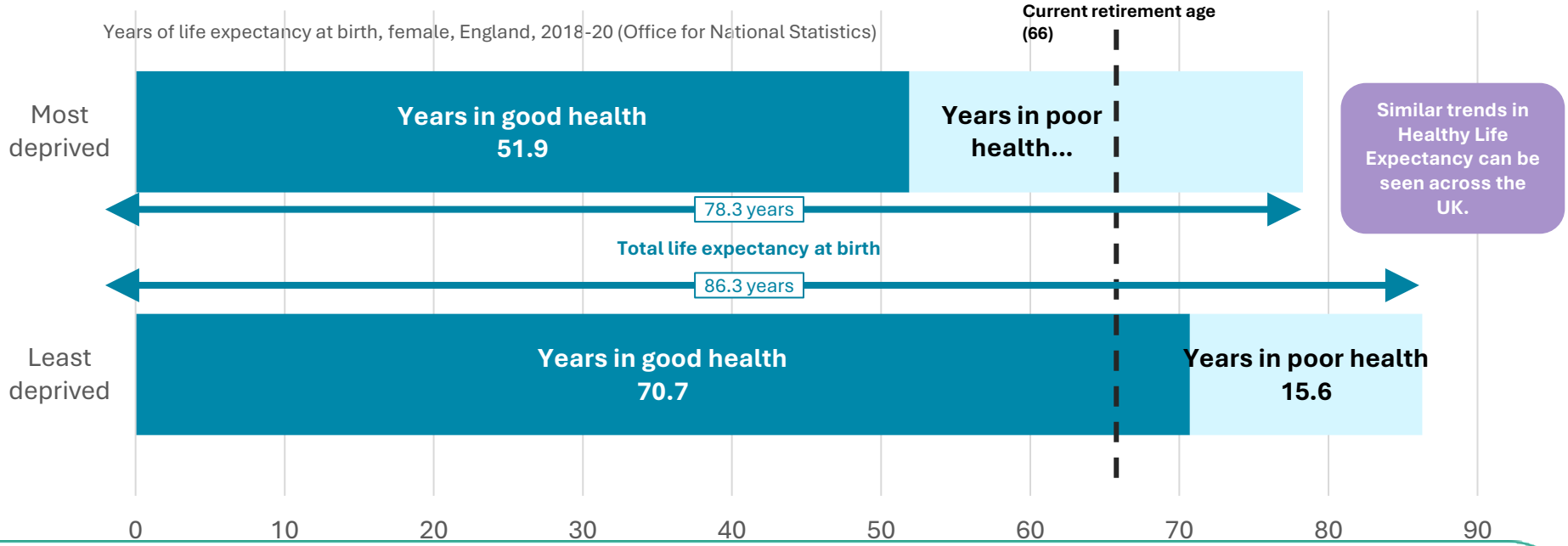
The NHS role in prevention:

- Uniquely placed to lead action on secondary prevention – e.g. ABC for CVD prevention;
- Expanding role, alongside local government, to address modifiable risk factors;
- Working with local government and VCS partners to improve outreach to under-served communities;
- Advocating for and supporting action on wider determinants (but not necessarily funding);
- Contributing to social and economic development as we deliver healthcare - an anchor institution



And will also need to consider health inequalities

People in the richest areas live around a decade longer and have around two decades more in good health. Action on primary and secondary prevention, particularly for underserved groups and those in deprived areas, will help reduce such inequalities and shorten the period of life spent in ill-health. But *how* this is done is important as it can inadvertently worsen inequalities. Interventions should aim for 'proportionate universalism,' the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need.



How can secondary care providers contribute to prevention?

- Being proactive about identifying and referring for risk factors
- Supporting our staff to make changes to reduce risk factors for disease
- Improving the management of multiple LTCs
- Being a good anchor institution, and signpost people to support for wider determinants of health
- Building analysis and attention to inequalities into business as usual

The 10 Year Health Plan is being developed and some emerging themes from our working groups in relation to prevention are…

increased patient agency, empowering people to better manage their own health, and incentivising the system to prioritise this

maximising the use of technology, including expansion of the NHS app to support increased patient control and choice, and maximising use of shared data for both patients and staff

a more equal partnership between clinicians and patients, enabling a fundamentally different and modern relationship between citizens and health services

an expanded role of the VCSE in service delivery, to support a genuine shift of services, resources and workforce out of hospital and into the community

delivering equity as a reality, increasing our focus on the most deprived areas where we know health inequalities are greatest, and involving organisations from a wide range of communities to better meet patient needs

Population Health & NHS Prevention Pledge

NHS
Cheshire and Merseyside

25th March 20225

NHS Providers, Health Inequalities: Delivering the shift to prevention

Prof. Ian Ashworth, Director of Population Health

Population Health

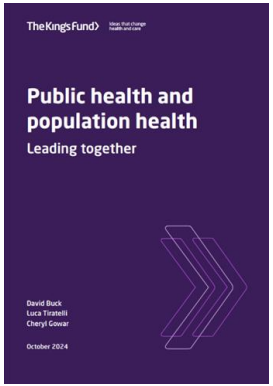
NHS
Cheshire and Merseyside

Our unique approach to system leadership in Cheshire and Merseyside was recognised by the Kings Fund in their recent report Public Health and Population Health: Leading Together.

The Champs collaborative network of the nine Local Authority Directors of Public Health, working alongside NHS Cheshire and Merseyside is a national exemplar of distributed and shared leadership, we have created a unified approach to prevention and tackling heath inequalities.

This has been further supported by the financial commitment made by NHS Cheshire and Merseyside into the Population Health Programme and our Health and Care Partnership Plan.

Champs Public Health Collaborative



Our Population Health Programme

NHS
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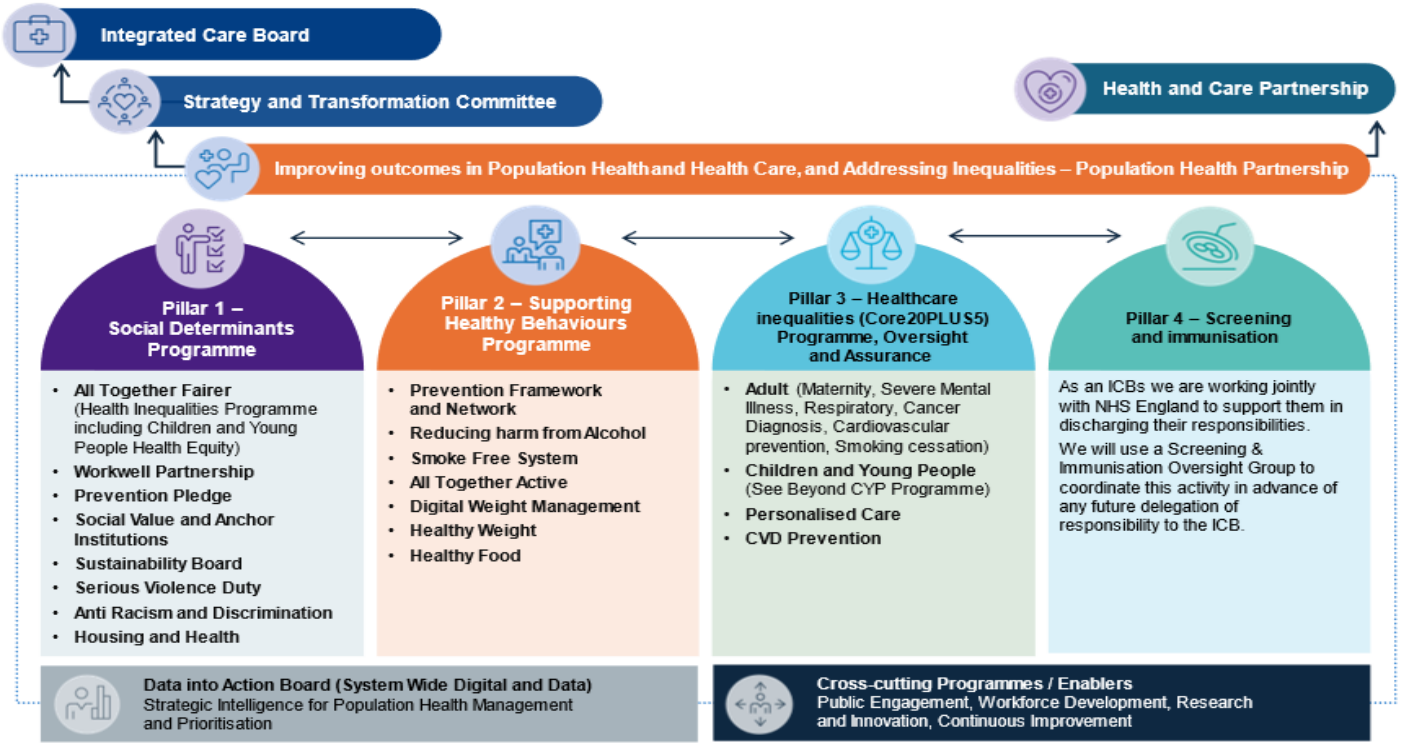
Our Core Strategies – Population Health and Addressing Inequalities



Pillar 1:

- This describes how we will deliver AllTogether Fairer: Our Health and Care Partnership Delivery Plan.

Pillar 2:

- Supports healthy behaviours is built around a number of priority prevention programmes.

Pillar 3:

- Outlines our Core20PLUS5 priorities and Personalised Care approach for Adults and Children and Young People. We have a dedicated Children and Young People Committee with a structured delivery plan.
- The C&M CVD Prevention Group will bring together partners to agree our approach to preventing CVD with a focus on improving identification and management of hypertension and lipid management; collectively agreeing what we do once and do well and the metrics we will use to measure success.

Pillar 4:

- This programme will support the NHS England delegation expected by April 2026.

What is the NHS Prevention Pledge?

Part of All Together Fairer programme addressing health inequalities through Marmot Principles.

Programme aim: To support adoption of a cross-cutting prevention framework by NHS Provider Trusts, embedding prevention of ill health & equitable access to healthcare within governance and service delivery.

Prevention Pledge underpinned by **14 core commitments** on cross-cutting prevention themes:

- Reduction of Non-Communicable Disease risk factors (e.g. healthier catering offer; smokefree sites & TTD; active travel)
- Using continuous improvement techniques to embed & monitor prevention
- Taking a MECC approach & building prevention into workforce development
- Working with partners at place to address health inequalities & equitable access to healthcare
- Staff health & wellbeing programmes
- Prioritising positive mental health and wellbeing for patients, visitors and staff
- www.preventionpledge.org.uk

Adopting the Pledge & support

- **Process:** Trusts required to adopt minimum of **6-7 of the 14 core** commitments in first **12 months**; work towards **all 14 commitments** required by end of **24 months**
- Agree **board level commitment on** adoption of the Pledge to signal organisational commitment
- Identification of **executive sponsor(s)** e.g. clinical champion and/or NED
- Trusts required to evidence impact through an **'action tracker' with associated KPIs** that are aligned to the 14 commitments; action tracker **reports required every 6 months.**
- Trusts are supported through quarterly '**community of practice**' meetings to share current practices and develop new partnerships; also supported through a suite of guidance materials.
- **All 16 trusts in Cheshire & Merseyside have now fully adopted the NHS Prevention Pledge.**

Liverpool University Hospitals NHS FT:
What has the NHS Prevention Pledge supported?

Liverpool University Hospitals NHS Foundation Trust

CURE treating tobacco dependency outcomes/activity

- **23% inpatient quit rate based upon a 4 week quit – 23/24**
- **Led the staff offer for C&M and had a 20% quit rate for staff**
- Identified as a national exemplar service
- Supported local Trusts to start an inpatient smoking cessation service
- **Hub & spoke model with other Liverpool trusts:** rolled out inpatient service at Walton, Clatterbridge and supporting Women's acute inpatients
- Funding received from CMCA for a pre-op service
- Joint 'live well work well' events for staff with Liverpool Heart & Chest Hospital (LHCH)
- Community outreach for 'know your numbers week' in collaboration with Liverpool City Council and LHCH

Warrington & Halton Teaching Hospitals NHS FT:
What has the NHS Prevention Pledge supported?

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Establishment of Health Inequalities Focus Group

- Provide expert advice on how to further embed health inequalities into the work of the Trust and ensure that the right data is used to inform how the Trust tackles health inequalities, both at local and organisational level.
- Carry out a gap analysis using the recently published NHS Providers Health Inequalities Self-Assessment Tool (health-inequality-tool.net) framework for consideration by the Trust Executive and Board. This will help the Trust to demonstrate annual progress towards reducing health inequalities, with progress and metrics reported in the annual statement.
- Ensure line managers and service leads are equipped with the knowledge, skills and capabilities to meet the requirements of the Trust.
- Development/delivery / oversight / assurance of Health Inequalities Priorities work plan
- Ensure compliance with Trust's legal duty to consider health inequalities under the Health and Care Act (2022) and relevant national guidance.

How else can our NHS Trusts support delivery of Pillar 2?

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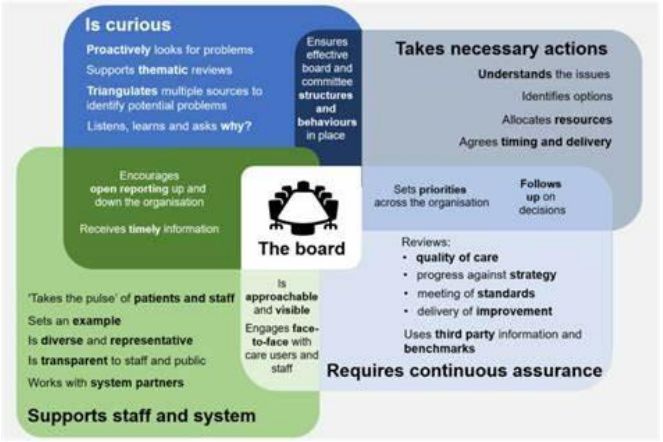
- Create a health promoting environment across all your sites where the healthy choice is the easy choice.
- Provide strong system leadership to support all staff, patients and visitors to remain smokefree.
- Support staff, visitors and patients to actively travel to your sites and remain active when on site.
- Adopt a food and drink retail policy that provides access to healthy and affordable food and drink for staff, visitors and patients.
- Workforce and Patient wellbeing: Kindtoyourmind.org

How else can NHS Trusts Support delivery of Pillar 3?

NHS Cheshire and Merseyside

- Embed the use of Population Health Management Tools
  - ➢Waiting list
  - ➢Enhanced Case finding
  - ➢Fuel poverty
  - ➢Complex households
- Understand the demographic profile of your patients and their engagement with your services, remove barriers to access
- Engage with health inclusion groups to understand how you can improve access to services
- NHS CM Contract Schedule 2N Health Inequalities Tool
- NHS Providers Guidance on Health Inequalities
- The Insightful Board Guidance
- NHS England Health Inequalities Duty for all Trusts (Section 13SA NHS Act 2006)



Reducing Diagnostic Healthcare Inequalities

NHS
Cheshire and Merseyside
Acute and Specialist Trust Provider Collaborative

Diagnostic Waiting Times and Activity

- We review waiting times and number of patients receiving each test per 100,000 population (on a weekly basis) to ensure that we drive down health inequalities.
- We have gained agreement from all Trust Chief Operating Officers to operate a mutual aid scheme for diagnostics which allows us to offer patients the chance to be seen in a neighbouring trust if the waiting time is shorter.

Diagnostic Service Locations

- When reviewing service models and opportunities for new sites we use SHAPE atlas modelling to review locations against deprivation indexes, population density information and also travel times.

Adjustments

- Our Diagnostic Delivery Board opens each time with a patient story. One such story told of a patient who was invited to attend for scan but without a stand frame to help her maintain position when not in her wheelchair she was not able to have her procedure.

Do Not Attend Review with Healthwatch

- In July 534 Cheshire and Merseyside patients (just less than 5%) were invited to attend for an endoscopy but didn't attend for their appointment. We are working with all Cheshire and Merseyside Healthwatch's to try and understand what we can do to reduce this figure and ensure that we make it as easy as possible for people to attend for their appointment. Higher Did Not Attend (DNA) rates correlate with areas of deprivation and so we are reviewing our communications and health literacy principles, transport, how we alleviate fears not disruptive to our patient's life commitments such as work or caring.

Diagnosing Asthma and COPD

- Cheshire and Merseyside ICS has the highest respiratory admission rates and deaths in the country. In 2023/24 there were 23,545 C&M admissions for respiratory conditions, and we know that there are at least 20,000 undiagnosed patents in C&M. The CORE20PLUS5 agenda has identified asthma in children and COPD as one of the biggest opportunities for the health inequality gap to be closed. Reviewing invest to save opportunities for spiro and feno tests to be made available for GPs to directly access in all our places with these tests concentrated in areas of deprivation where incidence and prevalence of COPD and asthma are worse due to poor housing, high rates of smoking and poor air quality

How can else NHS Trusts support delivery of Pillar 4?

NHS
Cheshire and Merseyside

- Increase uptake of vaccinations across the healthcare workforce.

- Increase the workforce's understanding of how uptake of vaccinations in the population can impact on NHS demand.

- Enable your workforce to access screening appointments.

NHS
Cheshire and Merseyside

Summary Areas of Focus

1. Statutory responsibility on Health Inequalities.
2. How well do you know your Board is fulfilling this responsibility?
3. How well is the Insightful Board Guidance being used?
4. Working in place or sub region. How is your Board influencing/ influenced by activities and investments happening in Place and neighbourhoods?

HEALTH INEQUALITIES

Panel Q&A

March 2025

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Breakout Discussion

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HEALTH INEQUALITIES

Tell us what you think

Your feedback helps us shape future events.

Please take five minutes to complete our evaluation.

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HEALTH INEQUALITIES

Visit our website

Discover further topics on how to address health inequalities including:

- Anchor institutions
- Partnership and system working
- Approaches for reducing health inequalities
- Embedding prevention

Scan here to access our website

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