

onenorthern**devon**

OND STRATEGY DEVELOPMENT

HEALTH INEQUALITIES GROUP

4 MAY 2024

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Purpose of this briefing

- To propose a different approach to tackling health inequalities
- To consider whether the best approach, given our resources, is to:
 - to align under a common cause
 - for that cause to be important everyone
 - for the whole workforce to have a role
- To propose that this common cause is the top 20% most deprived people in their service
- That reducing inequality in this group benefits all

Request for agreement

- For OND's Health Inequalities Team to work up this strategic approach to reducing inequality by focussing on our 20% most deprived service users

Why are we suggesting a different approach?

- OND's Health Inequalities team held a development session on 4th May to review and refresh OND's 2020 Reducing Inequalities Strategy.
- The review included a SWOT analysis of the current situation with regard to the strategy and its impact on population-level health inequalities (see next slide)

The image shows a document titled "one northern devon" with the subtitle "10 Year Quality of Life Strategy – 2020-2030". At the top, there is a row of logos for various partners including NHS Devon, Northern Devon Healthcare, Devon County Council, Devon Partnership, Natural Devon, Devon & Cornwall Police, PETROC, and NDVS. Below the title, the document lists three pillars: "Safe, Clean, Sustainable Places", "Health & Wellbeing", and "Economy, Employment & Skills". The "VISION" section states: "One Northern Devon's Strategy covers a 10 year period starting in 2020, the year that saw a global pandemic transform the way we live and work. By bringing together our full range of partners in a united purpose, we can mitigate the threats and challenges brought about by the crisis and use every opportunity and advantage we have in Northern Devon to design a way of life that is fairer for all." It further states: "Our vision is that people in Northern Devon live happy and healthy lives in safe, clean and connected communities where people are supportive of one another and aspirations are achieved through equal access to the best education & employment, whilst living in decent homes and enjoying our world-class natural environment".

Who are we?
One Northern Devon is a partnership of public services, businesses, voluntary & community groups

What do we do?
We collaborate together, influence policy & work over the long term to improve the quality of life, protect our shared natural environment and address local inequality

Why do we exist?
We exist because concerted, systematic action is needed across multiple fronts to address the causes of health & social inequalities. We need to work as ONE system to tackle complex, multifaceted factors involved

Our strength:
Our strength is in being able to bring organisations and communities together to change things for the better

Our approach:
Collaboration is key - there are things we can only do and problems we can only solve if we work together.

We create positive change by:

- Empowering communities
- Working together to improve services
- Challenging each other to work in a way that benefits us all
- Acting as a collective voice for Northern Devon
- Attracting new resources to Northern Devon

Assessment of our current approach to tackling health inequity (has the 2020 Strategy been a success?)

Our reach was limited - we benefit too few people (not enough to make an impact on population health equity)

Our approach has (mostly) not stuck - organisations have not adapted their service offering to take account of inequalities

There were too many priorities, we were spread too thinly and we weren't able to all align behind a single initiative. The majority of our combined workforce was not involved and there is an unequal distribution of resources from within the partnership.

None of our systems or policies help us put resources into prevention (addressing the needs of people who experience the worst outcomes, reducing and preventing risks and the risk conditions) which is essential for effective spend of resources.

OND is a mature partnership with strong relationships that understands health equity

We have a solid community infrastructure

We have a growing evidence base, a tried & tested approach and strong track record of delivery.

Some of our work has scaled and spread (such as our One Communities and Flow programme)

Our strategy focused on our collective priorities & showed progress could be made. Partners have developed an understanding of how issues manifest in each organisation.



We have cross sector & organisational partners willing to engage.

We have the data

We understand the need

We have a set of principles that have been co-designed across system partners

We already work as individual organisations and in partnership with those most at risk of the worst outcomes

We paper over the cracks, using short term interventions both as public services & with VCSE partners.

We don't use the funding to pump-prime systemic change

Inequalities are increasing in our community. As well as the personal cost, this impacts all our services

We all struggle to adequately support people with wide-ranging, multi-factorial needs. Resources are increasingly spent on fewer, more complex people (failure demand).

Conclusion of review

- The review concluded that our interventions are beneficial but we struggle to scale them to the extent that they can make a population impact. Therefore a different approach is needed if we are to address this issue that is:
 - Unfair
 - Avoidable
 - Negatively impacting all of us (individuals, communities and services)
- If we are to make an impact on health inequalities, we ALL need to be aligned behind a common vision which explains why this is our business and what we can do
- Staff at all levels of need to know what they can do to play their part in reaching that vision.
- Our recommendation is that each organisation has a particular focus on their 20% most deprived service users.
- We believe this strategy will help us learn, be service-led and guide collective action that will have a much greater chance of reducing the inequality gap between those living in the most and least deprived parts of Northern Devon.

Why does it make sense to have a focus on the 20% most deprived?

Health inequalities in 2040: current and projected patterns of illness - REAL Centre Insight report • April 2024 KEY FINDINGS

Increasing economic prosperity requires a healthy working-age population. But the UK has some of the deepest economic and health inequalities among developed countries – our report shows without change, these inequalities are set to continue at significant cost to our health and prosperity.

Double the rate of Major illness

14.6% of people aged 20-69 have major illness in the most deprived areas - more than double that of the least deprived (6.3%)

Major illness 10 years earlier

People in the 10% most deprived areas can expect to develop major illness 10 years earlier than people in the 10% least deprived

Working age population

80% of the predicted increase in the number of working-age people living with major illness will be concentrated in more deprived areas (deciles 1–5).

Economic consequences

The earlier onset & greater prevalence of major illness among the working-age population in more deprived areas has significant implications for labour supply, prospects for economic growth and regional inequalities

Long-term collective effort required

Action focused on risk factors linked to major illness is essential but insufficient. Making progress also requires long-term effort across government & the economy to address the underlying causes of health inequality, such as poor housing, low income & insecure employment.

Conclusions

This report shows that **health inequalities** ...if current trends ..continue ... in the next two decades... **will have major implications for economic growth, the quality of people's lives and health services.**

To move the dial, the government needs to help people to live longer healthier lives through improving access to the building blocks of good health. This will require cross-government action on a wide range of policy areas including prevention and the wider determinants, **targeted in the most deprived areas.**

This kind of change takes time to deliver. In the meantime **the NHS and other public services need to deliver effective care in the right areas** to support health as an asset, enhance wellbeing and promote economic growth.

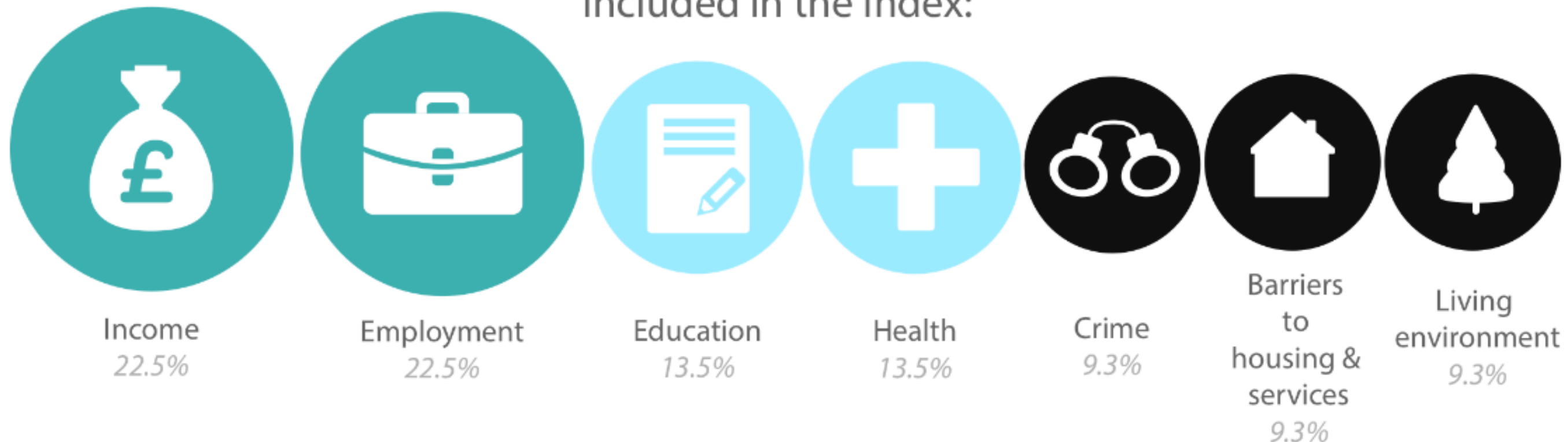
As well as the physical & mental health impacts for individuals (young people will have higher rates of inactivity, depression & obesity, poor education attainment & low social mobility), alongside the economic & productivity costs for our area, there are financial consequences for each of our services, such as:

- increased NHS costs - disease management, drug spend, hospital admissions
- increased council costs - housing, ASBO, litter
- increased hopelessness, violence, crime
- increased import of labour, businesses leave as skills are not local

It is also logical to have a special focus on the most deprived 20% as these are the people the data has identified as being the least well-served by our individual services and therefore our efforts will help these ones benefit from our services in a way that those in least deprived areas are able to.

7 domains of deprivation

included in the Index:



EQUALITY:

Everyone gets the same—regardless if it's needed or right for them.



EQUITY:

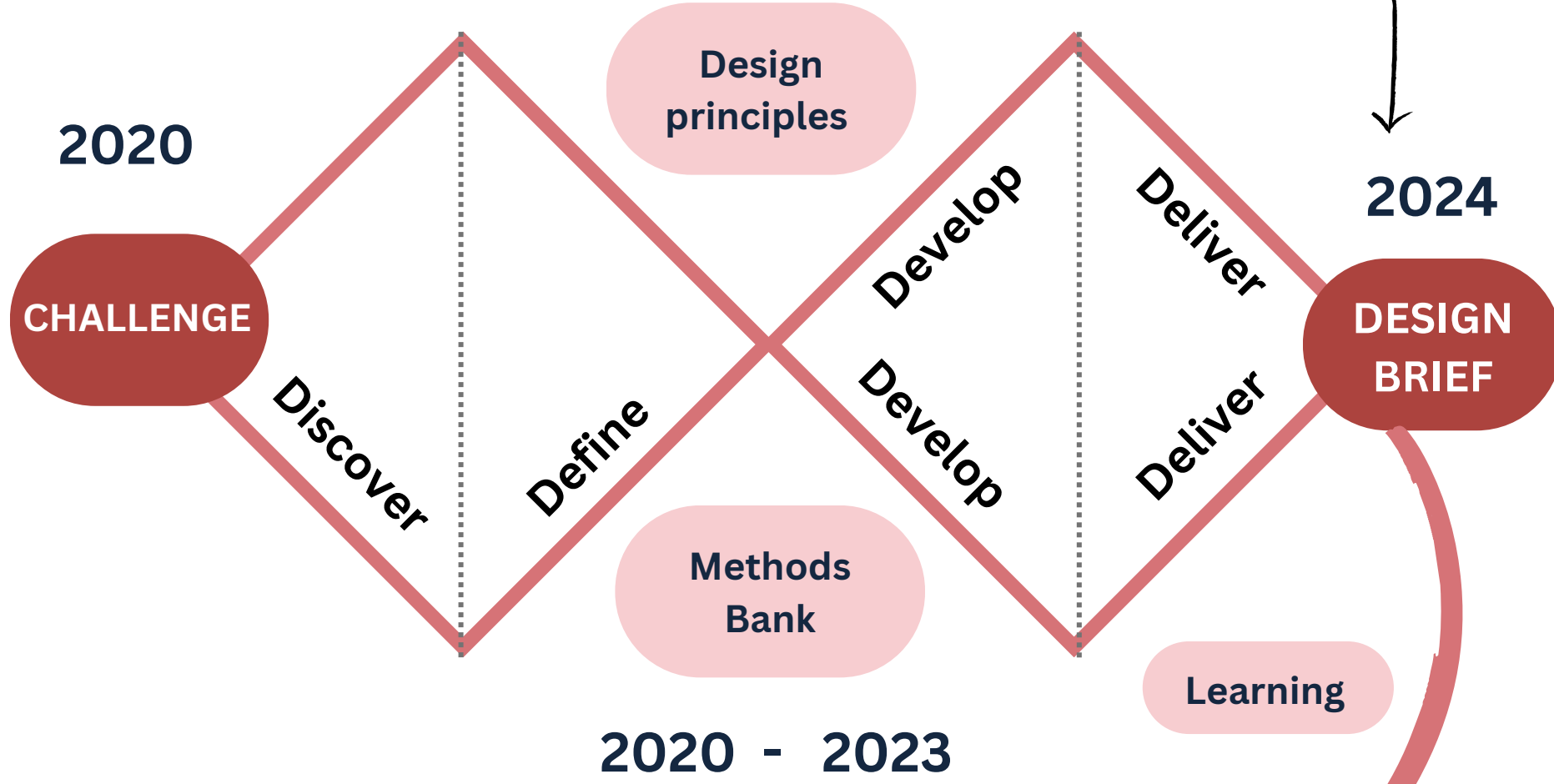
Everyone gets what they need—understanding the barriers, circumstances, and conditions.



What do we mean by equity?

- **Equity** is an ethical concept and has its origins in concepts of social justice and fairness
- In the context of social justice, equity refers to the **fair and just distribution of resources, power, and opportunities**. It is often contrasted with equality, which refers to the equal treatment of all people, regardless of their circumstances.
- Equity is important because it ensures that **everyone has the opportunity to succeed**. When people have equal opportunities, they are more likely to reach their full potential. This can lead to a more just and prosperous society for everyone.

Where we are in our design process



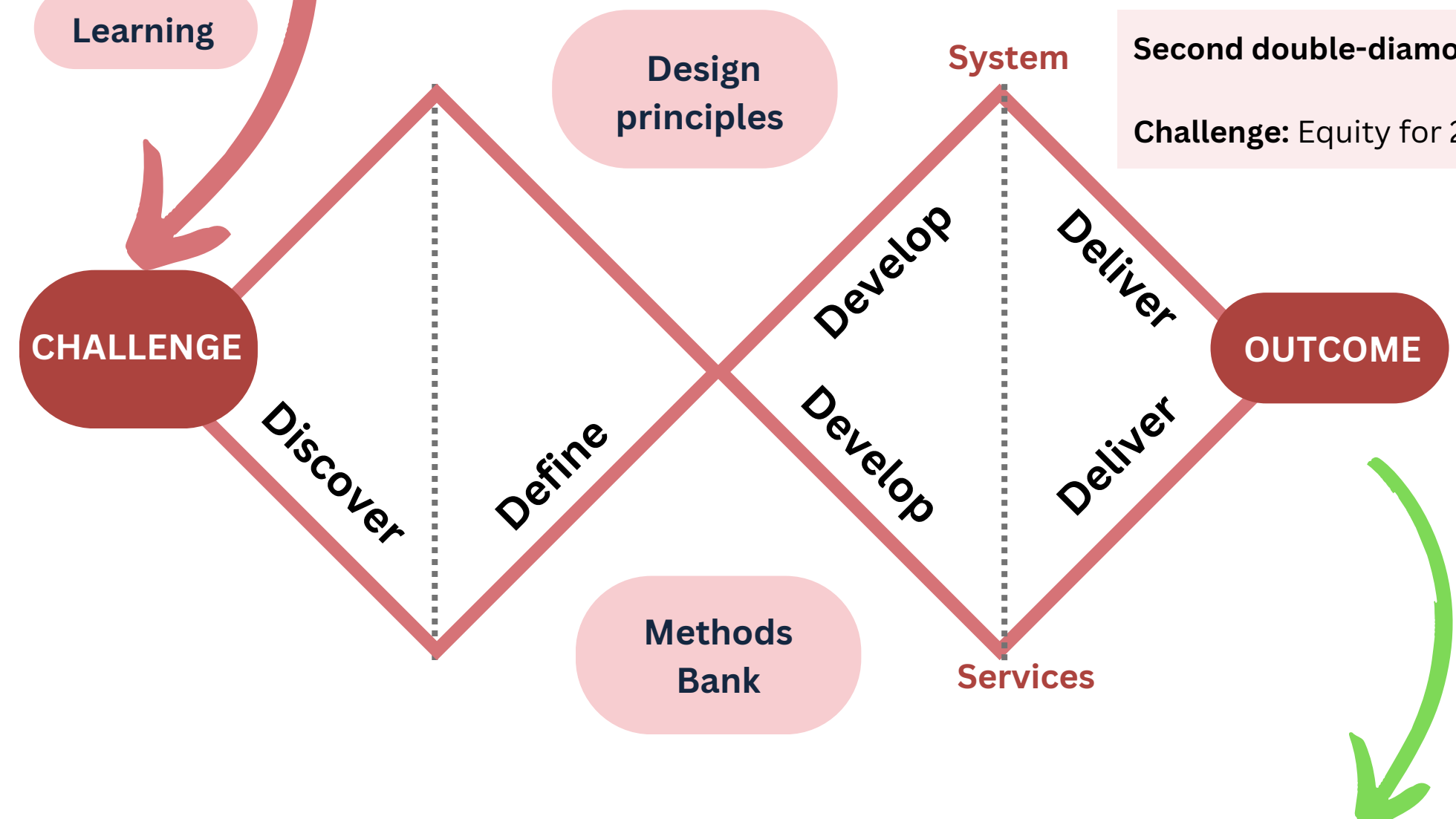
First double-diamond phase (2020 - 2024)

- Discovery: we looked at public health & other data sources; engaged communities, front line workers & leaders to understand the problem from multiple perspectives
- Held two multi-sector workshops to consider the findings & co-produce health equity design principles
- Defined key priority areas
- Developed a work programme to reduce inequalities in those areas using the principles
- Delivered a series of tests, pilots and programmes of work

Key learning: interventions are beneficial at an individual level but are limited in population reach. Programmes like the One Communities and Flow have stronger potential for impact as infrastructure has been developed around these programmes.

OND Health Inequalities Double Diamond Design Process using:

The Design Council’s Double Diamond “Framework for Innovation helps organisations across the globe tackle some of the most complex, social, economic and environmental problems”



Second double-diamond phase: 2024 - 2026

Challenge: Equity for 20% most deprived

Outline process for whole system focus on 20% most deprived

This approach still starts with the person, rather than the area of focus. By identifying individuals most at risk of poor outcomes, and gaining partner commitment to a more equitable service.

Second double-diamond phase: 2024 - 2026
 Challenge: Equity for 20% most deprived



DESIGN BRIEF

Design principles

- System agreement
- Whole system alignment to focus on an agreed target group
- Service identification of target group

Methods Bank

CORE 20%

Identify services 20% which may be:

- service users within their 20% most deprived service geography
- 20% most deprived service users (from other data)
- 20% most deprived communities

CHALLENGE

Barriers

Are there barriers to those in the target group accessing your service in an equitable way?

Discover

Define

Mitigations

How could our organisations prioritise people in these groups to reduce their risk?

Shared learning

System Solutions

Develop

Service Solutions

Services

System

Develop

Deliver

Deliver

Can we improve our collaborative response now and in the long-term (prevention)?

OUTCOME

Organisations providing equitable service delivery to reduce the inequality gap

Worked example - Healthcare

Theory of change

IDENTIFY

Patient population segmented to identify high risk cohorts

Individual patient level:

Individual patient health inequality risk will be identified.

Patient cohort level:

Patient population will be segmented into risk cohorts.

DEFINE

Discrepancies in experience, outcomes and access investigated

Individual patient level:

Enhanced personalised care approaches adopted (needs, strengths, circumstances, risks)

Patient cohort level:

Baseline discrepancies will be defined

DEVELOP

Pathways of care developed that actively aim to reduce inequalities

Individual patient level:

Pathways may include multi-agency approaches & interventions to address (non-medical) social risk factors

Patient cohort level:

Patient cohorts identified for potential early interventions.

Problem

- Health Inequalities are avoidable, unfair & systematic differences in health between different groups of people. They involve differences in health status, access to care, quality & experience of care, behavioural risks to health & wider determinants of health.
- People who experience multiple disadvantage are more likely to have difficulty accessing healthcare, have lower quality and experience of care and worse health outcomes.
- Health inequalities exist throughout society but often go hidden as they are not routinely monitored and can therefore not be addressed.
- Unless we can identify those most at risk of inequity, we can't provide a more equitable service.
- As well as ensuring patients receive equitable healthcare, we need to connect them with support with issues such as housing, debt, loneliness & transport.

Aims

To improve the health outcomes of those most at risk of health inequalities both at individual patient and patient cohort level by:

- identifying those at risk
- ensuring equity of access, quality and experience for those identified
- connecting them to the support available to address their social risk factors

To deliver the RDUH Health Inequalities strategy and legal obligations

We will

Use Epic's native Social Drivers of Health (SDriversOH) measures to capture individual patient data to provide:

- 1) high level population data to highlight risk factors for health and healthcare outcomes due to health inequalities to enable improved service design, planning
- 2) patient level data to identify those at risk due to increased social drivers