CityCare
Community Health Services

# Health Inequalities Framework

**Autumn 2024**

**Our values** Kindness | Respect | Trust | Honesty

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# Introduction

Health inequalities are differences in health across the population, and between different groups in society, that are systematic, unfair and avoidable. They are caused by the conditions in which we are born, live, work and grow. These conditions influence our opportunities for good mental and physical health.

The health of people in Nottingham is generally worse than the England average. Both life expectancy and healthy life expectancy for men and women in Nottingham are much lower than the England average.

Health inequalities have been documented across at least four dimensions: Socio-economic; geography; specific characteristics (for example sex, ethnicity, disability); and socially excluded/vulnerable groups (for example homeless people).

Approaches have been published at national (for example, Core20Plus5) and local (Joint Strategic Needs Assessment) level to inform initiatives to reduce healthcare inequalities. Action on health inequalities requires improving the lives of those with the worst health outcomes, fastest.

CityCare's approach recognises the need to address health inequalities at four levels, and highlights two areas in particular (access to care, and quality and experience) in which it can take the lead).

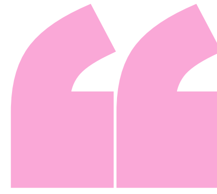
This framework aims to guide services on where and how they can develop initiatives to prevent and respond to the health inequalities which many communities experience. It is intended to encourage teams at all levels in the organisation to collaborate to improve quality, problem solve together and share collective outcomes with a view to implementing innovative solutions to addressing health inequalities.

# National context

The circumstances in which we live (the wider determinants of health) shape our health. Good health is vital for prosperity, allowing people to play an active role at work and in their communities.

There are, however, stark inequalities in the health of communities around the country. The pandemic spotlighted these inequalities, with people from the poorest areas suffering disproportionately from COVID-19.

In the decade before the pandemic, life expectancy improvements had stalled, health inequalities were large and growing – between different parts of the UK, and between the most and least deprived areas. In England, there is a 19-year gap in healthy life expectancy (whether we experience health conditions or diseases that impact how long we live in good health) between the most and least affluent areas of the country, with people in the most deprived neighbourhoods, certain ethnic minority and inclusion health groups getting multiple long-term health conditions 10 to 15 years earlier than the least deprived communities, spending more years in ill health and dying sooner.



In England, there is a 19-year gap in healthy life expectancy (whether we experience health conditions or diseases that impact how long we live in good health) between the most and least affluent areas

# Key factors that lead to health inequalities

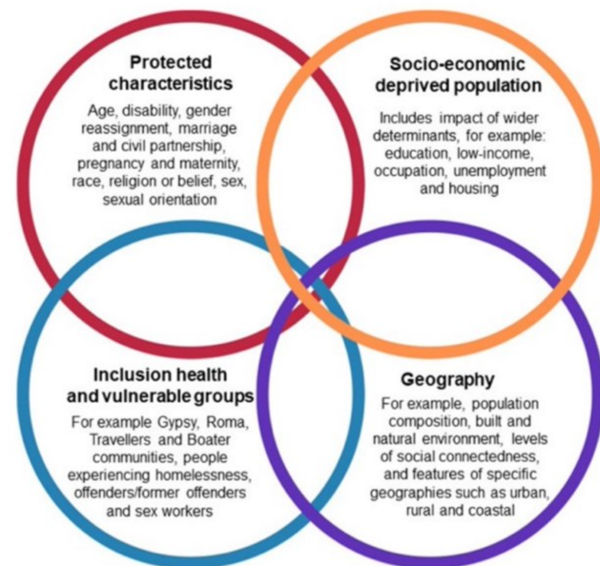
Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing.

**Socio-economic status and deprivation** – for example, unemployment, low income, living in a deprived area, and factors associated with this, such as poor housing.

**Geography** – the characteristics of the place where we live, such as population composition, built and natural environment, levels of social connectedness, and features of specific geographies such as urban, rural, and coastal can impact on an individual's experience of socio-economic deprivation.

These factors (or domains) are complex and interact with each other to benefit or disadvantage people or groups, leading to differences in health outcomes. Individuals fall into more than one category and, subsequently, may experience multiple drivers of poor health at the same time.

**Vulnerable or inclusion health groups** – for example, vulnerable migrants, Gypsy, Roma, Irish Traveller and Boater communities, people experiencing homelessness, offenders or former offenders, and sex workers.




**Protected characteristics under the Equality Act 2010** – for example, Individuals who belong to one of the 9 protected characteristics, which are: age, sex, race, sexual orientation, marriage or civil partnership, pregnancy and maternity, gender reassignment, religion or belief, and disability, and as a result may be treated differently within their communities and society in general, leading to a feeling of exclusion or isolation.

# National approach

### Core20PLUS5

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the Core20PLUS – and identifies 5 focus clinical areas requiring accelerated improvement.

The 20 refers to the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.

PLUS population groups are identified at a local level. Populations often include ethnic minority communities; people with a learning disability and autistic people; people with multiple long-term health conditions; inclusion health groups, such as people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

There are five clinical areas of focus which require accelerated improvement. Governance for these five focus areas sits with national programmes; national and regional teams coordinate activity across local systems to achieve national aims. These are:

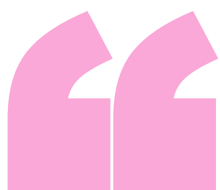
- Maternity
- Severe mental illness
- Chronic respiratory disease
- Early cancer diagnosis
- Hypertension case-finding and optimal management and lipid optimal management.

### Core20PLUS5 (Children)

Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort and identifies 5 focus clinical areas requiring accelerated improvement.

The five areas of focus are part of wider actions for Integrated Care Board and Integrated Care Partnerships to achieve system change and improve care for children and young people. They are:

- Asthma
- Diabetes
- Epilepsy
- Oral health
- Mental health.



Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level

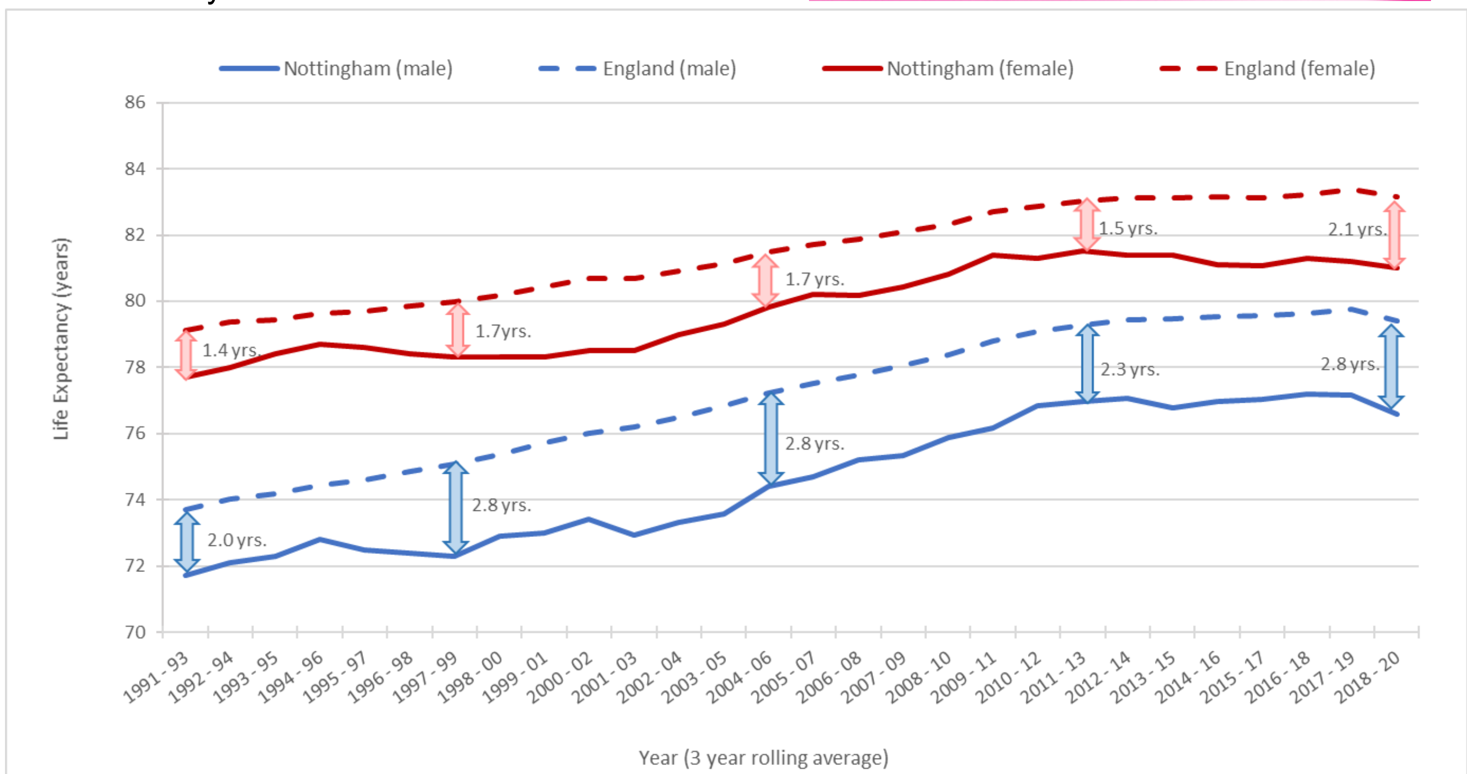
# Local context

Overall, the health of people in Nottingham is generally worse than the England average. This can be clearly seen when comparing life expectancy and healthy life expectancy in Nottingham to other parts of the country.

**Life expectancy**

Nottingham's life expectancy for men is currently ranked 138th out of 150 local authorities in England and 134th for women.

A baby boy born in Nottingham today has a life expectancy of 76.6 years, compared to an England average of 79.4 years. Life expectancy for women in Nottingham is slightly higher at 81 years, but this is also significantly lower than the England average of 83.1 years.



# Local context

**Healthy life expectancy**

Healthy life expectancy, the length of time that an individual can expect to live without poor health or disability, is also significantly lower in Nottingham.

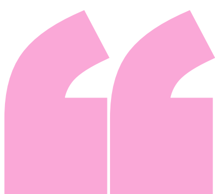
The City is ranked 139th of 150 local authorities for men and 143rd for women.

In Nottingham, healthy life expectancy is 56.4 years for men, this is the third lowest of any local authority area in England, and for women it is even lower at 55.6 years, which is the second lowest of any local authority area in England. This means that in Nottingham on average a woman can expect to spend almost a third of her life in poor health.

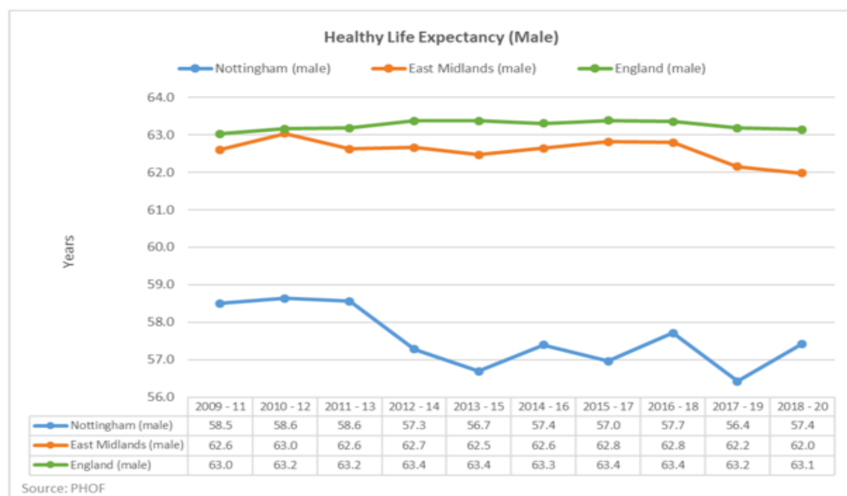
This has significant consequences for individuals, communities and services.

Even within Nottingham there are inequalities in life expectancy and healthy life expectancy.

Life expectancy is 8.4 years lower for men and 8.6 years lower for women in the most deprived areas of Nottingham than in the least deprived areas of the city.

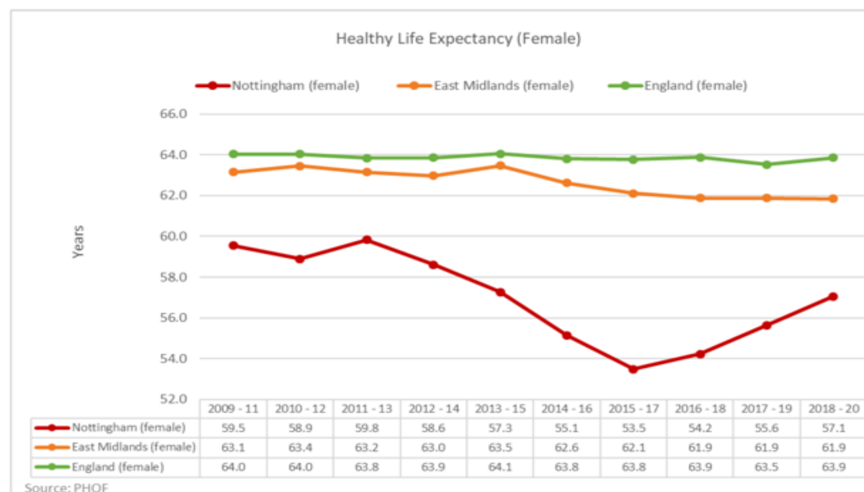


In Nottingham, healthy life expectancy is just 56.4 years for men...and for women it is even lower at 55.6




| | 2009 - 11 | 2010 - 12 | 2011 - 13 | 2012 - 14 | 2013 - 15 | 2014 - 16 | 2015 - 17 | 2016 - 18 | 2017 - 19 | 2018 - 20 |
|---|---|---|---|---|---|---|---|---|---|---|
| Nottingham (male) | 58.5 | 58.6 | 58.6 | 57.3 | 56.7 | 57.4 | 57.0 | 57.7 | 56.4 | 57.4 |
| East Midlands (male) | 62.6 | 63.0 | 62.6 | 62.7 | 62.5 | 62.6 | 62.8 | 62.8 | 62.2 | 62.0 |
| England (male) | 63.0 | 63.2 | 63.2 | 63.4 | 63.4 | 63.3 | 63.4 | 63.4 | 63.2 | 63.1 |

Source: PHOF




| | 2009 - 11 | 2010 - 12 | 2011 - 13 | 2012 - 14 | 2013 - 15 | 2014 - 16 | 2015 - 17 | 2016 - 18 | 2017 - 19 | 2018 - 20 |
|---|---|---|---|---|---|---|---|---|---|---|
| Nottingham (female) | 59.5 | 58.9 | 59.8 | 58.6 | 57.3 | 55.1 | 53.5 | 54.2 | 55.6 | 57.1 |
| East Midlands (female) | 63.1 | 63.4 | 63.2 | 63.0 | 63.5 | 62.6 | 62.1 | 61.9 | 61.9 | 61.9 |
| England (female) | 64.0 | 64.0 | 63.8 | 63.9 | 64.1 | 63.8 | 63.8 | 63.9 | 63.5 | 63.9 |

Source: PHOF

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## Causes of death

Risk factors which sit behind the causes of death include a range of interrelated factors, such as where we live, the work we do and the behaviours we engage in – all of which have an impact on the biological condition of our body, and subsequently our mental and physical health and wellbeing.

The top 10 causes of death in Nottingham City are:

1: Ischaemic heart disease
2: COPD
3: Stroke
4: Lung cancer
5: Lower respiratory infections
6: Alzheimer's disease
7: Colorectal cancer
8: Breast cancer
9: Prostate cancer
10: Cirrhosis

Top 10 risk factors leading to poor health and death in Nottingham City are:

1: Tobacco
2: High body mass index
3: High fasting plasma glucose
4: Dietary risks
5: High systolic blood pressure
6: Alcohol use
7: High LDL cholesterol
8: Occupational risks
9: Drug use
10: Child and maternal malnutrition

# Local context

### Children and Young People

Nottingham has a higher proportion of younger people than the national average, which is partly due to the high number of students. Full-time students account for approximately 1 in 8 of the population.

The proportion of children is lower than the England average, although not for the under-4s.

This suggests that although birth rates are comparatively high, a high proportion of children leave the city before starting school.

As Nottingham is one of the 20% most deprived districts/unitary authorities in England, 29.5% (17,555) children live in low-income families, compared to 17.0% in England as a whole.

The prevalence of obesity among children in Year 6 is 26% in Nottingham, compared to 21% in England. Levels of teenage pregnancy, GCSE attainment (average attainment 8 score), breastfeeding and smoking in pregnancy are worse than the England average.

The rate of conceptions in women aged under 18 (per 1,000 females aged 15-17) in Nottingham is 24.9 compared to 16.7 in England.

**Child health**

| Indicator | Age | Period | Count | Value (Local) | Value (Region) | Value (England) | Change from previous |
|---|---|---|---|---|---|---|---|
| 18 Teenage conception rate | <18 yrs | 2017 | 126 | 26.5 | 17.5 | 17.8 | ↓ |
| 19 Percentage of smoking during pregnancy | All ages | 2018/19 | 618 | 15.9 | 14.0 ^ | 10.6 | ↓ |
| 20 Percentage of breastfeeding initiation | All ages | 2016/17 | 3148 | 72.4 | 69.7 | 74.5 | ↑ |
| 21 Infant mortality rate | <1 yr | 2016 - 18 | 56 | 4.55 | 4.04 | 3.93 | ↑ |
| 22 Year 6: Prevalence of obesity (including severe obesity) | 10-11 yrs | 2018/19 | 817 | 23.2 | 19.7 | 20.2 | ↓ |

**Key**

Significance compared to goal / England average:

| | | | |
|---|---|---|---|
| Significantly worse | Significantly lower | ↑ Increasing / Getting worse | ↑ Increasing / Getting better |
| Not significantly different | Significantly higher | ↓ Decreasing / Getting worse | ↓ Decreasing / Getting better |
| Significantly better | Significance not tested | ↑ Increasing | ↓ Decreasing |
| | | ↑ Increasing (not significant) | ↓ Decreasing (not significant) |
| | | – Could not be calculated | → No significant change |

# Local approach

**Joint Strategic Needs Assessment (JSNA)**

Nottingham City's Joint Strategic Needs Assessment (JSNA) is an assessment of the current and future health and social care needs of its people. The aim of a JSNA is to improve the health and wellbeing of the local community and reduce inequalities for all ages by ensuring commissioned services reflect need. It is used to help determine what actions local authorities, the NHS and other partners need to take to meet health and social care needs and to address the wider determinants that impact on health and wellbeing.

The areas of focus highlighted in the JSNA are:

- Pregnancy
- Air quality and health
- Demography
- Smoking and tobacco control
- Severe Multiple Disadvantage (SMD)
- Housing

**Nottingham Joint Health and Wellbeing Strategy**

The Nottingham City Joint Health and Wellbeing strategy[1] sets out the vision and ambitions for making Nottingham City a happier and healthier place to live. Having considered the main causes of death and ill-health and the ineven distribution of health between the most and least deprived communities, four priority areas were identified that have an important impact on the health and wellbeing of the population of Nottingham:

- Smoking and tobacco control,
- Eating and moving for good health,
- Severe Multiple Disadvantage (SMD)
- Financial wellbeing.

[1] https://www.nottinghamcity.gov.uk/media/gd0fxokf/nottingham-city-joint-health-and-wellbeing-strategy-2022-25.pdf

# CityCare approach

Given the above, it is clear that CityCare needs to address health inequalities at four levels:

**Wider determinants:** Actions to improve "the causes of the causes", such as increasing access to good work, improving skills, housing and the provision and quality of green space and other public spaces, and best-start initiatives.

**Behavioural risk to health:** Actions to modify behaviours that can impact on morbidity and mortality that are largely preventable; the factors that contribute to illness and premature death. These include stopping smoking, a healthy diet and reducing harmful alcohol use and increasing physical activity.

# CityCare approach

**Access to effective treatment,** care and support: Actions to improve the provision of and access to healthcare and the types of interventions planned for all - for example, ensuring health literacy is supportive; ensuring there are health inequalities impact assessments for all commissioned services.

**Quality and experience of healthcare services:** Actions that improve the experience that a person has of their care, treatment and support is one of the three parts of high-quality care, alongside clinical effectiveness and safety.

**This is summarised here:**

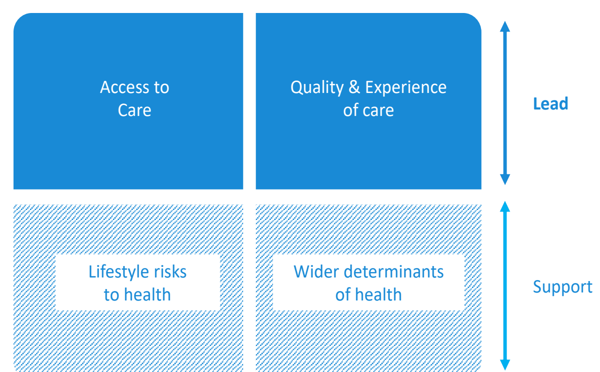
As Nottingham's NHS community care provider, CityCare is in a position to directly impact health inequalities in two of the four strands, namely "access to care" and "quality and experience of care" in the services it is commissioned to deliver.

The organisation can directly influence behavioural risks to health through some of its commissioned services and will work in partnership to support the activities of others in their pursuit of longer-term health and wellbeing,

including, the Integrated Care System, Nottingham City Place-Based Partnership and Nottingham City Council.

In relation to the other strand: wider determinants to health, we hold our own social value aims and will work with others to maximise the impact of these across the city.

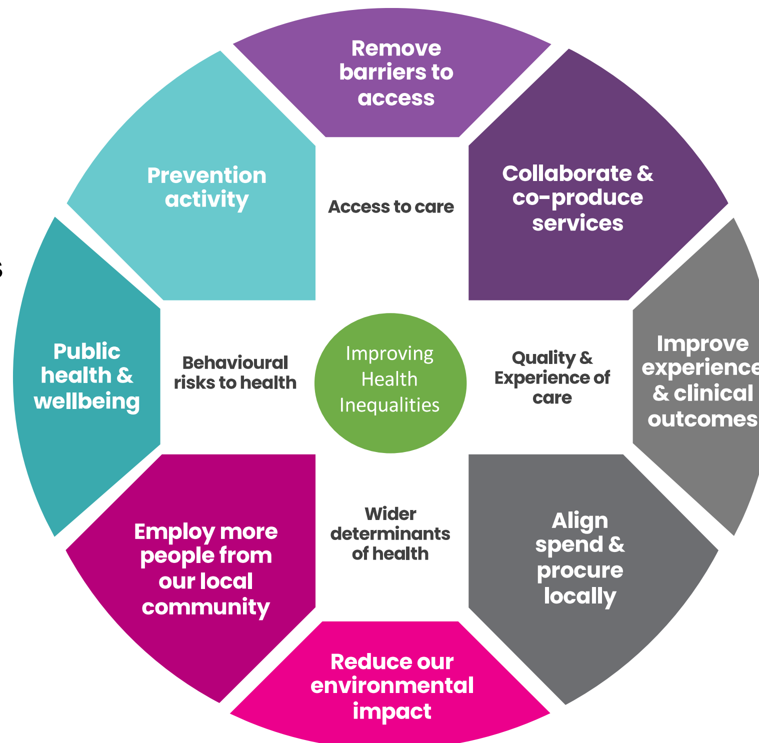
Taking into account where CityCare has the opportunity to lead activities that impact on health inequalities, it should be defined as "avoidable differences in health outcomes between groups or populations caused by unequal access to care and variances in quality and experience of care".



# Framework for action

Our framework for healthcare inequalities is aimed at guiding services in considering where and how they can develop initiatives to prevent and respond to the health inequalities which many communities experience. It is intended to encourage teams at all levels in the organisation to collaborate to improve quality, problem-solve together and share collective outcomes with a view to implementing innovative solutions to addressing health inequalities.

**Remove barriers to access**: What are the barriers that inhibit access for some people in our community. How can we adjust our approach to remove or overcome barriers for marginalised and vulnerable groups?




**Collaborate and co-produce services**: How can we work in partnership with people in our community to design and deliver services they need and value?

**Experience and outcomes:** How can we work to improve patient satisfaction across our whole community?

**Prevention activity:** How can we support evidence-based prevention services where we know this will improve health outcomes in all patient groups?

**Public health and wellbeing:** What can we do to support the local authority (Nottingham City Council) and the Place Based Partnership to improve the health and wellbeing of the people of Nottingham?

**Align spend and procure locally:** Where can, we buy goods and services from organisations and companies that employ people in the city of Nottingham.

**Reduce our environmental impact.** How can we minimise our impact on the environment while promoting sustainability and environmental awareness at all levels of our organisation?

**Employ more people from our local community:** What development opportunities can we offer to the local community to help people to gain future employment?

The plan will be informed by the Patient and Public Engagement Plan and having a more culturally competent workforce (EDI Strategy).

# Putting into practice

Reducing health inequalities, a core aim of CityCare's strategy, is an integral component of the overall strategic, business and operational plans. It is not a separate list of actions or initiatives. There are a number of channels through which we collate ideas from the organisation to improve health inequalities including:

**Annual business planning exercise:** One of the key topics of discussion with the service teams and a key output from the objectives-setting exercise

**Service transformation:** Embedded within the work led by the transformation team in designing and implementing service delivery enhancements

**New business proposals:** How we will reduce health inequalities will be a key consideration in the development of all new business proposals submitted to our commissioners.

**Corporate actions:** CityCare will review all new legislation, guidance and recommendations to establish whether they present an opportunity to reduce health inequalities across the organisation.

Priority areas for action should be based on health data analysis and community engagement feedback. Schemes will be approved through the annual business planning process, with the health inequalities group having oversight of all the schemes across the organisation for monitoring purposes.

# Measuring the impact

Life expectancy is a key measure of a population's health.

Therefore, inequality in life expectancy is one of the main measures of health inequality. The most common summary measure of this is the Index of Multiple Deprivation.

Another key measure is how much time people spend in good health over the course of their lives. A widely-used measure for this is healthy life expectancy. This estimates time spent in good or very good health, based on how people perceive and report on their general health.

While these long-term outcomes communicate the long-term benefits, they may take years (or even decades) for the measures to change and they are subject to a range of inputs beyond CityCare's sphere of influence.

CityCare will therefore use proxy measures and indicators to establish progress towards these long-term outcomes.

These will be an indirect measure of the desired outcome which is itself strongly correlated to that outcome. These will be agreed when the actions are proposed and will be used to monitor the progress and quality of actions, while also providing feedback and learning opportunities for improving the design and delivery of initiatives.

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# Conclusion

Reducing health inequalities is a core aim of CityCare's strategy and it will become an integral component of business planning, transformation and the development of all new services. This framework outlines the proposed approach to considering and developing new initiatives to prevent and respond to the health inequalities in our communities.

Undoubtedly, as we become more proficient in identifying health inequalities, the number of initiatives will grow.

The impact of these changes will be monitored, reviewed and an overview published on an annual basis.

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# Our mission

Making a difference every day to the health and wellbeing of our communities

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**www.nottinghamcitycare.nhs.uk**

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Nottingham CityCare Partnership CIC is registered as a company limited by guarantee. Company Registration Number: 07548602

**Our values** Kindness | Respect | Trust | Honesty