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**To: Coventry Health and Wellbeing Board**

**Date: 4<sup>th</sup> April 2022**

**From: Allison Duggal, Director of Public Health and well-being  
Rachel Chapman, Consultant Public Health**

**Title: Coventry & Warwickshire Integrated Care System Health Inequalities Strategic Plan**

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## **1 Purpose of the Note**

- 1.1 The purpose of this paper is to inform the Coventry Health and Wellbeing Board about the progress on the Coventry & Warwickshire Integrated Care System (ICS) Health Inequalities Strategic Plan and provide an opportunity for Board members to make any recommendations or comments as part of the development process.

## **2 Recommendations**

The Health and Wellbeing Board is asked to:

1. Note the requirements for a Coventry and Warwickshire ICS Health Inequalities Strategic Plan;
2. Support the recommended local priority population groups for the strategic plan (covering newly arrived and transient communities and people on long-term sickness benefits);
3. Make any comments and recommendations as part of the development of the plan.

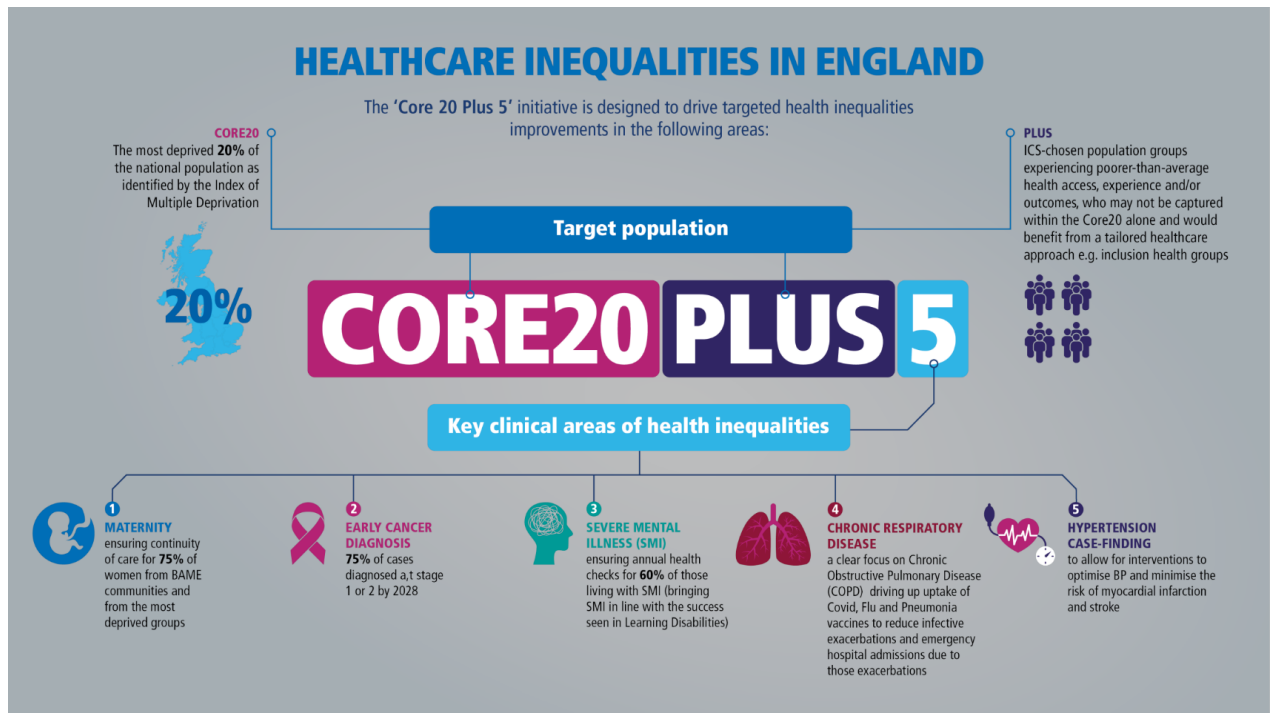
## **3 Information/Background**

- 3.1 The Coventry and Warwickshire Integrated Care System (ICS) is required to provide a 'Health Inequalities Strategic Plan' to NHS England/Improvement by 28<sup>th</sup> April 2022. The plan must set out a locally agreed strategic approach for addressing health inequalities based on a recognised model of health and must include the NHS health inequalities priorities as set out in the NHS Long Term Plan.
- 3.2 The plan should be Place-based and should involve the local Director of Public Health. It has to be owned by decision making bodies within the developing ICS.
- 3.3 A programme of engagement is underway with partners and key NHS workstreams to develop the plan.
- 3.4 The local plan will build on existing work which aims to embed consideration of and action on health inequalities in all that we do and shift how we work with local communities.

## **4 Progress to date**

- 4.1 A programme of engagement with partners and key NHS workstreams is currently underway to shape the Strategic Plan and ensure the approach takes into account the needs and inequalities within Coventry.
- 4.2 In January 2022 the shadow Integrated Care Board (ICB) agreed 8 principles for the plan:
- Addressing Inequalities is core to and not peripheral to the work of the C&W ICS
  - Strategic Plan will be based on the King’s Fund model of Population Health
  - Built around the Core20+5 health inequalities framework
  - Evidence-based approach
  - Encourage innovation
  - Community co-production
  - Embed reducing health inequalities across all ICS work
  - Reducing inequalities is key to decisions on the prioritisation and allocation of resources
- 4.3 The King’s Fund model of Population Health includes the impact of the wider determinants, individual behaviours, places and communities as well as health and care on people’s health. It is already embedded as an approach within our system, it is well recognised by partners and is the basis for the Health and Wellbeing Strategies for both Coventry and Warwickshire. Use of this model prompts the system to consider the breadth of influences on inequalities and to act beyond the health and care domain to achieve sustainable impacts.
- 4.1 The Core20+5 framework has been developed by NHSE/I to support the reduction of health inequalities at a system level. It is composed of 3 parts:
- “Core20”: the 20% most deprived areas as defined by Index of Multiple Deprivation nationally.
  - “Plus”: these are specific groups identified locally who experience poorer than average health outcomes but may not be captured within the Core20. For Coventry and Warwickshire these are proposed to be transient and newly arrived populations, includes homeless, gypsies and travellers, boaters, refugees and asylum seekers. In addition, for Coventry, people who are on long term sickness benefit will be considered as a Plus group.
  - “Five” Key clinical areas of health inequality:
    - **Maternity:** continuity of care for women from Black and Minority Ethnic (BAME) communities in the most deprived areas
    - **Early Cancer Diagnosis:** 75% of cancers diagnosed at Stage 1 or 2 by 2028
    - **Severe Mental Illness (SMI):** annual health checks for 60% of those living with SMI
    - **Chronic Respiratory Disease:** a focus on Chronic Obstructive Respiratory Disease (COPD), driving up uptake of COVID, Flu and Pneumonia vaccinations
    - **Hypertension Case-Finding:** to allow for interventions to optimise blood pressure (BP) and minimise the risk of myocardial infarctions and stroke.

This framework does not preclude consideration of other groups experiencing health inequalities but provides a focus for concerted system-wide efforts.



4.2 The 5 clinical areas have been selected due to existing inequalities and with Cancer, Circulatory and Respiratory illness being the biggest killers. Action in these areas is vital for having an impact on health outcomes for all population groups.

4.3 Maternity has been included following findings from the national Confidential Enquiries into Maternal Deaths and Morbidity which found maternal mortality rates among Asian women were twice as high than in White women, and four times higher in Black women compared to White.

4.4 People living with a SMI are a national priority due to the gap in life expectancy for this cohort, which is 15-20 years lower than the general population and largely due to physical health conditions.

4.5 The 5 clinical priorities are primarily focused on secondary and tertiary prevention approaches (identifying significant risk factors or early signs of disease in order to intervene and prevent further ill-health, or preventing exacerbation of existing illnesses). Such approaches are likely to provide swifter return on investment for local systems than primary prevention approaches, however for longer-term and sustained impacts on health inequalities applying primary prevention to reduce the prevalence of risk factors is required.

4.6 Broader partnership activity is required to promote healthy behaviours, address inequalities in the wider determinants of health and create healthy environments in which residents live, work and play within is required in order to harness longer-term improvements in health equity.

## 5 Health Inequalities in Coventry

5.1 Coventry suffers from high levels of deprivation, with 26% of residents living in areas in the 20% most deprived in England. This equates to 96,654 of the city's residents living in the most deprived areas. As a Local Authority area, men and women in Coventry experience

significantly lower life expectancy than the England average. Whilst there are pockets of deprivation in all parts of the city, the areas with the highest levels of deprivation and lowest life expectancy are in the central and north-east of the city, with pockets in the south west and south east.

- 5.2 Health outcomes also vary between population groups. Key groups experiencing health inequalities, and recommended as local priority population groups were identified from local and national evidence, the impact of the Covid19 pandemic and discussion with partners.
- 5.3 **Transient communities – Refugees/Migrants:** Coventry has a long history of welcoming refugees and asylum seekers to the city. However, due to the recent international situation, exacerbated by COVID-19, Coventry and Warwickshire have seen an unprecedented rise in numbers.
- 5.4 **Asylum seekers:** In April 2019 there were 569 asylum seekers accommodated in Coventry under the Home Office Asylum Dispersal arrangements. The latest figures (December 2021) show this number has risen to 2055 – 1592 in Serco run accommodation and 527 in initial accommodation (3 x local hotels). This is an increase of 361% and is unprecedented locally and regionally.
- 5.5 **Refugees:** With regard to resettled refugees, both Coventry and Warwickshire are welcoming refugees from both Syria and Afghanistan among other countries. Alongside the 36 Syrian families who were originally being supported in Warwickshire, Warwickshire have made a pledge to resettle an additional 63 families between April 2021 and April 2025 (through UK resettlement and Afghan programmes). In Coventry, we have 968 existing Syrian, Yemeni, Iraqi, Sudanese and Afghan refugees currently in the city, with a further 121 Afghans arriving into the city over the course of 2021. In addition to the asylum seeker hotels outlined above, there is a further hotel in the city housing Afghan refugees who are seeing out their quarantine period before moving out of the city.
- 5.6 Asylum seekers and refugees can have complex health needs. Common health challenges can include: poorly controlled chronic health conditions; untreated infectious diseases or missing vaccinations; poor mental health related to previous trauma and/or to isolation as a newly arrived resident; and women may have additional need ante- or post-natally, associated with late presentation to healthcare, previous trauma, malnutrition or poverty. Despite these health needs there is no evidence of a disproportionate use of healthcare resources. In fact asylum seeker and refugees often face barriers accessing services whilst also facing barriers to accessing services, including language and cultural barriers along with a lack of understanding of UK health systems
- 5.7 **Gypsies/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 with 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, 57,680 people identified themselves as Gypsy or Irish Travellers across England and Wales, with 151 in Coventry (0.05% of the resident population).

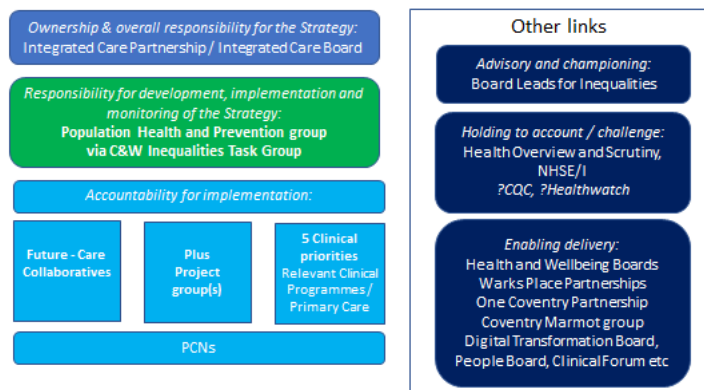
- 5.8 **People who are experiencing homelessness:** In 2020/21, 16.6 per 1,000 households (2,503 in total) were owed a duty under the Homelessness Reduction Act in Coventry. It is recognised that homeless populations have significantly worse physical and emotional health outcomes compared to the general 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
- 5.9 The physical and mental health impacts of being homeless, as well as barriers to accessing services, including digital exclusion, contribute towards premature mortality for this cohort.
- 5.10 **People on long-term sickness benefits:** 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.
- 5.11 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. There are approximately 14,600 people in Coventry who are on long term sickness benefit.

[https://www.coventry.gov.uk/downloads/file/31254/director\\_of\\_public\\_health\\_report\\_2019\\_-\\_bridging\\_the\\_gap](https://www.coventry.gov.uk/downloads/file/31254/director_of_public_health_report_2019_-_bridging_the_gap)

## 6 Delivery of the Strategic Plan

- 6.1 The proposed governance arrangements are shown in the diagram (below). Responsibility for delivery of the strategic plan will be through the Integrated Care Partnership and the Integrated Care Board. The Population Health, Inequalities and Prevention system group will oversee development, implementation and monitoring. Delivery will be through the Care Collaboratives, PCNs and specific identified workstreams. National accountability for delivery will be to NHSE/I and local accountability through Health Overview and Scrutiny. The Health and Wellbeing Board has a key role to play in enabling delivery, in particular joining up the healthcare elements with the other quadrants of the Kings Fund model.

## Proposed governance arrangements:

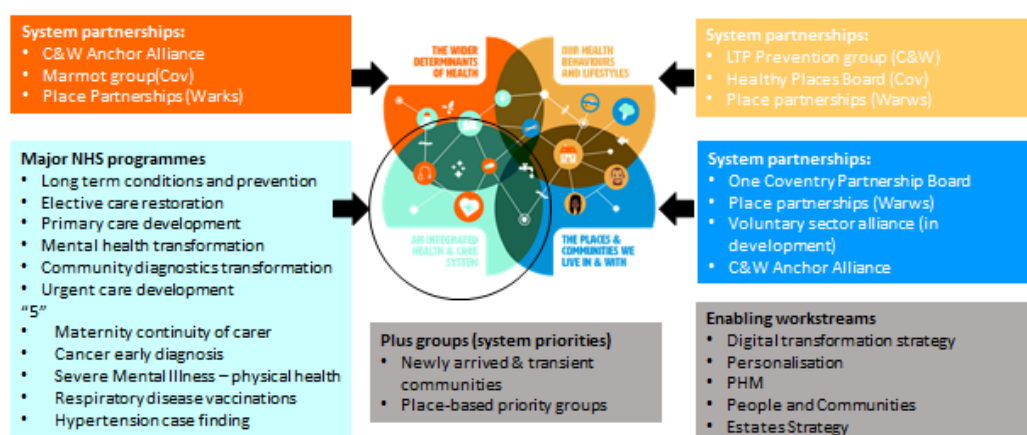


### 6.2 Delivery of the strategic plan will be through a number of workstreams:

- Major NHS transformation programmes eg community diagnostics expansion, mental health transformation, primary care development where the focus will be on the “Core 20” population
- Specific “plus group” workstreams
- “5” key clinical areas
- Enabling workstreams eg System Digital strategy

### 6.3 In addition, the wider work on health inequalities will continue to be delivered through the existing partnership arrangements eg One Coventry partnership, Anchor Alliance, Marmot group. The system-wide approach to health inequalities is summarised in the diagram:

## HI Strategic Plan - system delivery



- 6.4 A monitoring framework based on “access, experience and outcomes” is being developed to measure and monitor change as a result of this strategy

## **7 Next steps and timescales**

- 7.1 A programme of engagement with key partners to further shape the plan based on the Core20+5 model and embedded within our wider population health management approach is taking place between November 2021 to April 2022.
- 7.2 The draft Coventry and Warwickshire Health Inequalities Strategic Plan will be shared with NHS England/Improvement by 31st March 2022, who are expected to provide feedback prior to a final version being adopted locally from the end of April 2022.

## **8 Recommendations**

The Health and Wellbeing Board is asked to:

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### **Report Authors:**

#### **Name and Job Title:**

Rachel Chapman, Consultant Public Health

Robina Nawaz, Policy, Partnerships & Transformation Officer

#### **Contact Details:**

[Rachel.Chapman@uhcw.nhs.uk](mailto:Rachel.Chapman@uhcw.nhs.uk)

[robina.nawaz@coventry.gov.uk](mailto:robina.nawaz@coventry.gov.uk)

#### **Appendices**

None