Birmingham and Solihull Integrated Care System Reducing Health Inequalities Strategy

FORWARD

Birmingham and Solihull Integrated Care System is the “new kid on the block” in terms of having an approach around tackling health inequalities, working in partnership with the NHS family, local authorities, the wider community, and the public. This Health Inequality Strategy in many ways is nothing new. Previous NHS reorganisations have developed similar strategies in the past, looking at key priorities around the wider terms of health, looking at access to health inequalities looking at workforce, looking at equality. What is different about this strategy is the context that we're living in Britain. This is the second anniversary year of the murder of George Floyd and the resurgence of Black Lives Matter, highlighting inequalities not only affecting particularly Black people around the globe, but also inequalities affecting racialised communities in Britain as well. There's been a call for action that we need to tackle inequalities in society, racial discrimination, and structural racism.

Birmingham and Solihull, like many other organisations in the public sector, are going through a process of reflection, contemplation, and engagement, and looking at the issues how it can become an anti- racist organisation and ensure that the public resources that we have, the workforce that we support, has an impact on improving health inequalities for all.

The impact of COVID-19 and the pandemic has been another wake-up call for the NHS, for local authorities and the wider community exposing issues around intersectionality and gender, race, faith age, disability, and sexual orientation. It's quite clear that we must learn from key lessons of how we dealt with and responded to the pandemic in terms of policies around wellbeing, mental health, its impact on Black and racialised communities, older people, and young people. It's quite clear that we cannot revert to previous ways of commissioning, the ways that we deliver services and the way that we talk to engage with the public regarding their needs.

This has been further highlighted and intensified by the increase, the cost-of-living crisis that we're currently facing. This again has an impact on our approach around attacking health inequalities and the wider determinants of health, such as poverty, housing, education, and employment opportunities.

Finally, we are also facing climate emergency which has major implications for those who live and work in Birmingham and Solihull. The green agenda or the sustainable agenda is critical. It's important that as an Integrated Care System working with a whole range of NHS providers, in partnership with local government, primary care, third sector and faith groups, that we need to have a sustainable approach around tackling health inequalities in terms of the stakes that we have and how they're used and maximised effectively, how we

deploy our resources in the community and particularly looking at the opportunities and benefits of digital in the context of new ways of engaging with the public.

The NHS is a key anchor institution in Birmingham and Solihull. If you can look at the whole NHS family together, we are one of the biggest employers in Birmingham and Solihull. Our footprints and impact and opportunity around regeneration and development is critical for our estate planning, through the workforce development and our recruitment strategies, and it's important that we engage with community organisations in partnership at a neighbourhood level. This requires a new approach to community dialogue, community engagement and to ensure there is transparency and accountability in how we do our business in terms of health inequalities.

In many ways this strategy, which will be updated regularly and will be a live document is something for all of us to embrace, that there is clear ownership across all aspects of life in Birmingham and Solihull. We need to ensure that no one has been left behind in our approach and that is why we develop a call-to-action pledge with all stakeholders that reflects our commitment, drive, and determination to

- Tackling the key priorities in this strategy
- Clear commitment to anti-racism and inclusion supported by our Equality, Diversity and Inclusion plans and targets
- Clear commitment to a sustainable green agenda
- Commitment to community engagement, coproduction and dialogue with patients, services users, and citizens as anchor institution and major employer

Finally, we hope that this strategy and the wider work that we are doing as Birmingham and Solihull ICS, in terms of developing a future ten-year master plan will lay the foundations of a new approach and a clear commitment that we are committed to tackling health inequalities and structural racism. If we get this right this strategy ultimately everyone in Birmingham and Solihull will benefit and have an improved quality of life.

Professor Patrick Vernon OBE
Chair of Health Inequalities Board
Non-Executive Director for Inequalities

Introduction

We have the biggest opportunity in a generation for the most radical overhaul in the way health and care services are delivered in Birmingham and Solihull.

In shifting to a new way of working, the greatest collective impact we can make on the lives of the citizens we serve is to ensure that improving health outcomes and closing inequality is hard-wired into every plan we make, every investment we agree and every decision we take.

Whilst tackling the determinants of poor health, improving outcomes and closing inequality has always been at the heart of health and care, it hasn't always been core business: that will change under the new operating model being designed for Birmingham and Solihull Integrated Health System.

In our Inception Framework published in February this year, we committed to working with our citizens, health and care providers, and voluntary & community organisations to create a 10-year Master Plan which will not only be ambitious in the long-term aspirations it sets to reduce inequality but will guide our decision-making in the short and medium-term.

We are already broadening our scope to look beyond traditional *performance* measures and starting to measure the *outcomes* of decisions: not just 'are we hitting our targets?' but 'are the lives of citizens being improved?'

We are shifting decision-making as close to neighbourhood level as possible, recognising that what might have impact in one part of our system won't necessarily be a priority in another.

In creating Integrated Neighbourhood Teams we will co-locate health and care services and give them the tools and support needed to design an approach to health and care that enables them to make a difference to the lives of the citizens they serve.

And we will use the Fairer Futures Fund not just to bring those teams together to design new ways of working, but to support local organisations and community groups to go even further in the work they are already doing to improve outcomes and reduce inequalities in our communities today.

Understanding the scale of the challenge and the value we can bring

The journey toward meeting those ambitions starts now, underpinned by a sense of urgency about what we have deliver, not least because Birmingham and Solihull have the largest proportion of citizens living in deprivation compared to any other health and care system in England.

Beneath the headline inequalities, such as men born in Birmingham live on average 3 years less than the average for England whilst in Solihull they live on average 0.5 years more, there are a number of inequality gaps that need further investigation.

Within Birmingham there is a **ten-year gap** in the estimated life expectancy of a boy born in Castle Vale compared to one born in Sutton Mere Green, similarly within Solihull girls

born in Chelmsley Wood are expected to live 9.5 years shorter lives than those born in St. Alphege.

Not only are people living in the poorest neighbourhoods in Birmingham and Solihull dying a decade earlier than those living in the most well-off neighbourhoods, but they are spending almost 2 decades (17 years on average) of their shorter lives in ill health.

Headline Metrics	Birmingham	Solihull	West Midlands	England
Life Expectancy at birth (2018-20)				
Male	75.8	79.1	77.6	78.7
Female	80.5	83.1	81.8	82.6
Healthy Life Expectancy at birth (2018-20)				
Male	59.2	67.4	61.9	63.1
Female	60.2	65.7	62.6	63.9
Inequality in Life Expectancy at birth (2018-20) i.e. gap between those in the richest and the poorest areas				
Male	9.5	11.6	10.1	9.7
Female	6.2	10.1	7.9	7.9

These lost years of life are mainly down to diseases that can be prevented and can be treated.

Although there are differences between Solihull and Birmingham communities both places see specific communities dying younger than they should from diseases such as heart disease, lung disease and infant mortality, things that can be prevented or if diagnosed early and managed well do not lead to chronic disease and premature death.

Inequalities exist between communities of place, often reflecting poverty and deprivation as the headline but this sits on top of inequalities between communities of identity e.g. different ethnic groups, LGBTQ+ communities, and communities of experience e.g. homeless populations, veterans, migrants and carers.

Birmingham and Solihull ICS have the largest proportion of citizens living in deprivation of any ICS in England. Both local and national work has demonstrated that we have to go deeper than geographical boundaries to understand inequality and recognise that we cannot just deliver generic ‘one size fits all’ solutions.

These inequalities in life expectancy and in healthy life expectancy reflect the opportunity to make a difference. **Dying younger because of your household income, your ethnicity, or because you experience becoming homeless or have caring responsibilities, is not inevitable and it is not acceptable.**

The COVID-19 Pandemic has highlighted the significant risk around the burden of disease affecting our communities. COVID-19 highlighted existing inequalities and their impact –

our poorest areas, disabled communities and some of our Black, Asian and minority ethnic communities have been hardest hit. These are also the communities who will be among those hardest hit by post-pandemic increases in the cost of living, which is causing hardship to even those previously considered 'comfortable'.

By commissioners and providers of health and social care services working together, working differently, and working closely with our communities, we can make a real difference.

The pandemic demonstrated the importance of us working together as a system to respond to challenges and importantly about the way we can work with communities to co-create solutions and overcome the reality of the barriers. We recognise that while health and social care is a part of the solution, individual health is a result of a wider range of factors including quality of education, employment, housing as well as connection to community and social networks or the damaging impact of discrimination such as racism. Many of these elements are actively being addressed by the two local Health and Wellbeing Boards and we have a key role as an ICS contributing to action in these spaces as employers and as an important space for making every contact count for citizens.

And getting the health and social care part right can make a huge difference to people's health and wellbeing from prevention through early detection, treatment, and care to supporting death with dignity at the end of life.

A range of connected factors drive inequality in health outcomes in Birmingham and Solihull.

- **Deprivation**. Around 50% of the population of the ICS are amongst the 20% worst off people nationally (the "Core20"); 94 percent of the most deprived areas of the ICS are in Birmingham, and 6 per cent are in Solihull.

- **Ethnicity**. Around 45% of the people of Birmingham and around 15% in Solihull are from Black, Asian and minority ethnic groups. Many (though not all) of these communities live in the most deprived neighbourhoods, and additionally suffer the impact of structural racism, worsening already poor outcomes related to poverty. We recognise the variation in access and outcomes between different ethnicities . This includes Black women being 4 times likely to die in childbirth and Asian women being twice as likely to die in childbirth or first year of delivery. Pakistani communities are largest ethnic minority group in the ICS, but experience some of the worst health outcomes. Black and African Caribbean communities are the second largest ethnic grouping. People from Gypsy and Traveller Groups are a small minority but have very poor health outcomes. White groups also include a range of ethnicities such as English, Irish, Polish, with their own unique experiences. Evidence shows they are more likely to be impacted by issues related to alcohol and tobacco, and white men have a disproportionately high suicide rate.

- **Children**. We have the largest population of children and young people in the country. Having the youngest population should mean fewer health challenges. However one in three children in our system – over 130,000 children in Birmingham, and over 30,000 children in Solihull - live in poverty and we have some of the highest rates of infant mortality in the country. Studies have shown that adverse experiences in early years have life-long impacts which can entrench generational inequality. Conversely, intervening positively in early years has the biggest impact in improving life chances including healthy outcomes.

- **Long Term Conditions**. Our system has high numbers of people living with long term conditions and outcomes that vary significantly. We perform worse than the England average on many of the factors that drive good health. The biggest 'killer' in our system is circulatory disease (CVD), followed by respiratory disease (COPD) and cancer. High prevalence of preventable diabetes in our system contributes to these diseases and their impact.

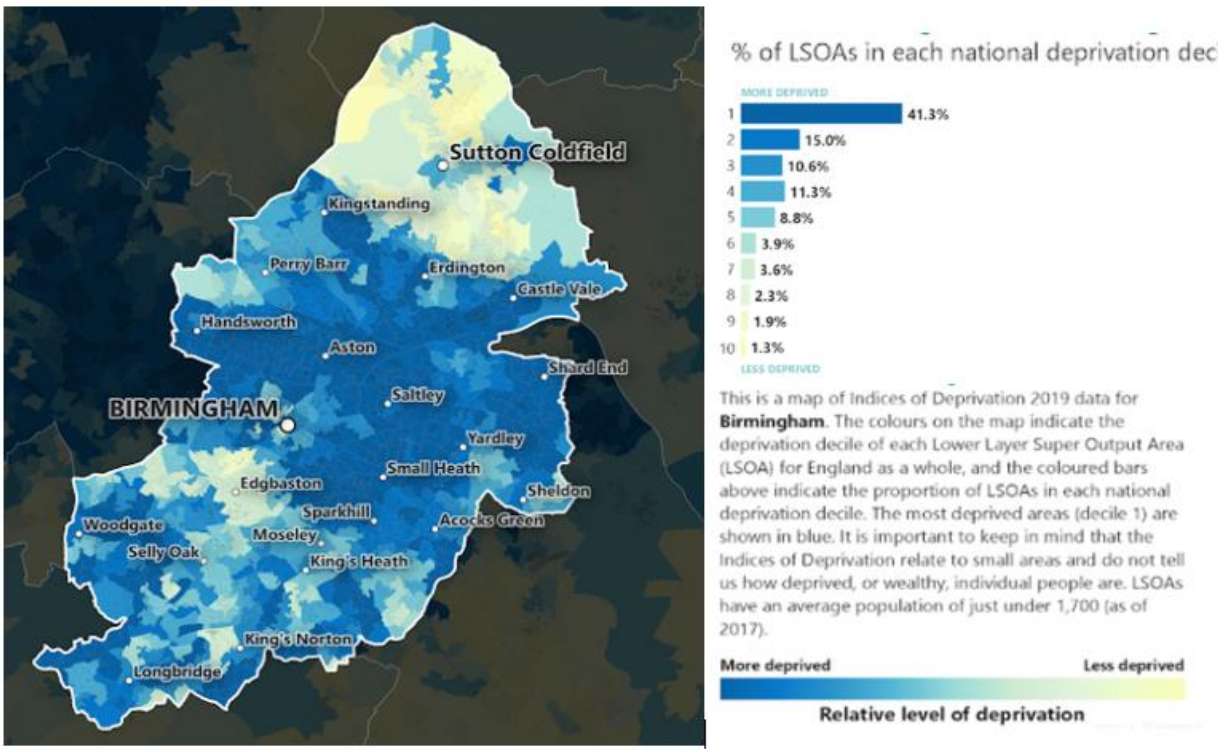
- **Mental Health & Learning Disabilities**. Outcomes for people with mental illness and learning disabilities are worse than outcomes for the population as a whole. On average people with serious mental illness or a learning disability die 15-20 years earlier than those without. Not because these conditions are killers, but due to treatable physical conditions not being diagnosed or treated appropriately.

Scale of challenge in Birmingham and Solihull

The picture of the scale of poverty and diversity of communities in Birmingham and Solihull is quite striking.

Deprivation in Birmingham

Large parts of Birmingham in the West, East and South are characterised by the poorest neighbourhoods (dark blue) in England.



Source: English Indices of Deprivation 2019 - Maps - Google Drive

Figure 1: Populations for the Birmingham Localities by Lower Super Output Area (LSOA) and Index of Multiple Deprivation 2019 (IMD 2019) decile.

Deprivation in Solihull

Parts of North and West of Solihull (dark blue) also have some of the poorest neighbourhoods.

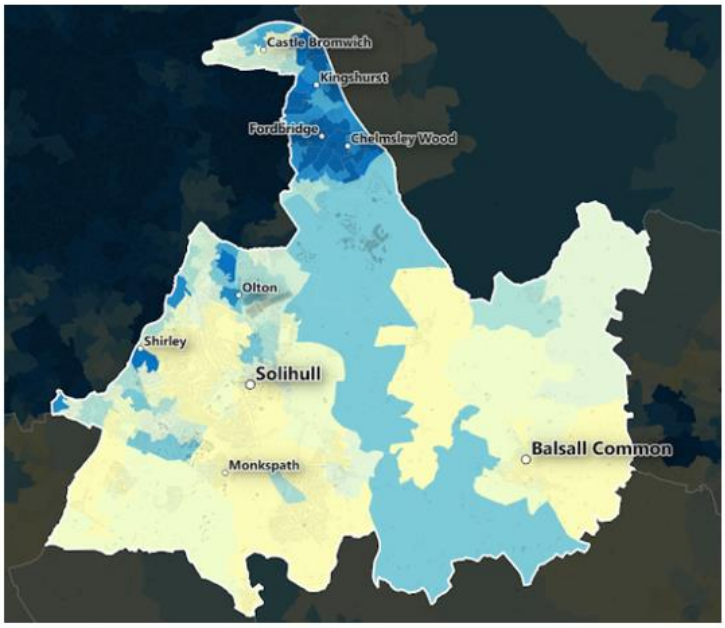


Figure 2: Populations for the Solihull Localities by Lower Super Output Area (LSOA) and Index of Multiple Deprivation 2019 (IMD 2019) decile.

‘Ethnic Minority’ Communities are ‘majority’ communities in many parts of BSol ICS (Over 70% in 3 Birmingham constituencies and 20% in Solihull) *Source: Midland & Lancashire CSU John O Neill

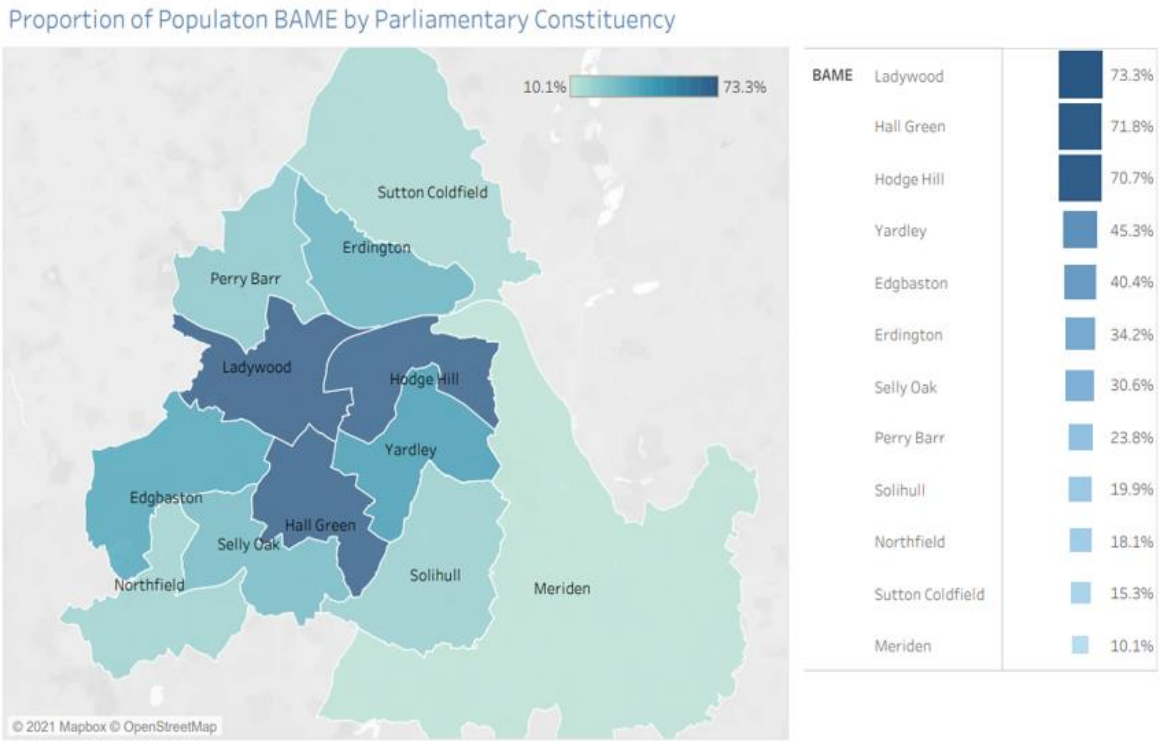


Figure 3: Proportion of population BAME by Parliamentary Constituency

Ethnicity in Birmingham and Solihull

Ethnicity can be broken down into sub-sets as shown in Figures 5 and 6 below.
These pie charts show the variation within the 'BAME' and 'White' categories. This Census 2021 data will allow us to map population changes and reflect on how our population has grown over the last ten years. This will help us focus on the areas of greatest need within our population groups.

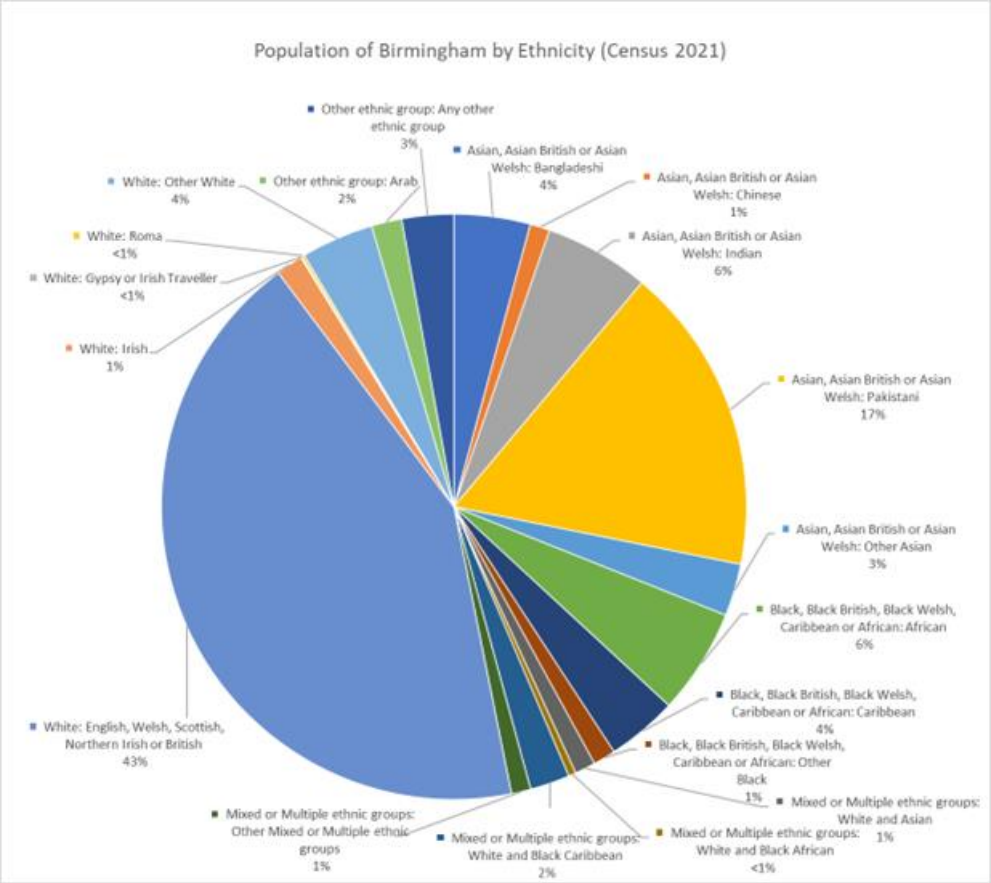


Figure 5: Ethnicity breakdown of Birmingham Population

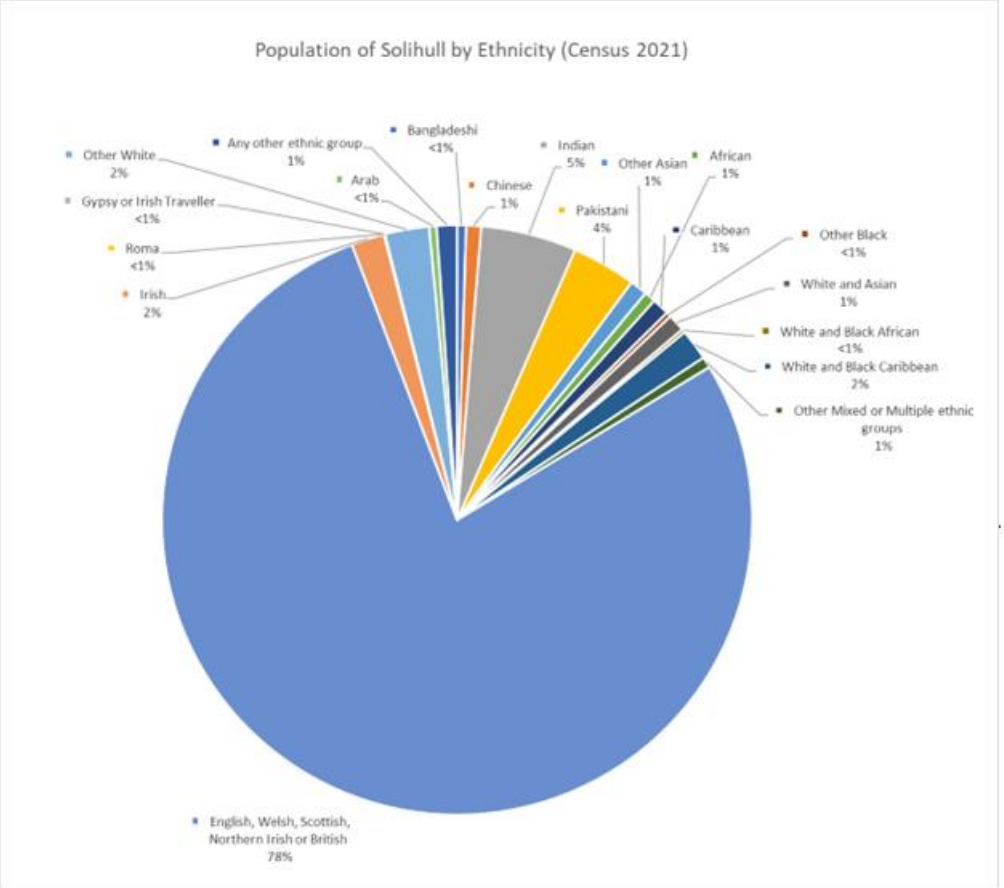


Figure 6: Ethnicity breakdown of Solihull Population

What do we want to achieve?

Over the next ten years our ambition is to visibly and meaningfully reduce the gap in healthy life expectancy for citizens in Birmingham and Solihull.

The National Core20Plus5 framework sets out the national expectations for tackling health inequalities. It reflects the importance of understanding these gaps and differences better, being clear about priorities and taking evidence-based action at different levels of the ICS.

Our ambition is significant and will require action across the whole system by everyone in every space, every day. Activity at every level of our new system – be it at system-level, Place Boards, localities, integrated neighbourhood teams – will be driven by a data-led approach reducing inequality and improving outcomes.

We want to be clear about where health and social care should and can lead effective change, where we should be active contributors to action led by others and where we need to be part of social and political movements of change.

We will start to do this by focussing our Integrated Care System on six system-wide priorities. Alongside this each part of our system will focus additional activity on what matters most to citizens in their area at Place, locality and neighbourhood level.

We have identified our six system priorities based on:

- factors that drive poor healthy life expectancy for our citizens;

- priorities of the Birmingham Health & Wellbeing board;
- priorities of the Solihull Inequalities strategy;
- patients waiting longer for diagnostics and surgery;
- opportunities for improvement identified in the Birmingham & Lewisham Black African and Caribbean Health Inequalities Review (BLACHIR);
- lessons learnt from the way in which COVID-19 hit hardest those who were already worst off; and
- national “Core20plus5” priorities for reducing inequalities.

These priorities draw on significant existing consultation in both Birmingham and Solihull in creating their strategies for population health and the engagement activities of the clinical commissioning groups that preceded the ICS formation.

Our six system priorities will be focused on those populations who experience the greatest inequalities in outcomes at each layer of the ICS. In addressing each of these priorities we will focus on people in our most deprived communities and people from Black, Asian and minority ethnic backgrounds who are often those experiencing worst outcomes currently.

The six priorities are:

1. **Maternity Care & Infant Mortality.** Improve the experience and outcomes for mothers, parents, and babies and reduce the number of infants who die before their first birthday

2. **Better Start for our Children.** Improve the health of children from our most deprived communities by supporting them to get the best start in life, focusing first on increasing uptake of vaccination and improving school readiness.

3. **Better Prevention, Detection & Treatment of Major Diseases.** Improve the prevention, early detection and treatment of the diseases that drive early mortality for people, focusing first on reducing waiting lists for diagnosis and surgery, cardiovascular disease, respiratory disease, cancer screening, diabetes and addressing the backlog of elective treatment.
4. **Better Outcomes for People with Mental Illness.** Improve the experience and outcomes for people living with serious mental illness and improve their health and wellbeing to achieve their potential in life.
5. **Better Outcomes for People with Disabilities including Learning Disability.** Improve the experience and outcomes for people living with a disability across the life course, starting with a focus on learning disability and autism.

6. **Improved Outcomes for Inclusion Health Groups.** Improve health and care outcomes for our most vulnerable citizens in inclusion health groups including new migrants, refugees and asylum seekers, homeless people, people with substance misuse difficulties, women, people experiencing racial disparity and LGBTQIAplus.

As we have developed this strategy it has become clear that here are some areas where we need further work to establish relevant indicators and develop our understanding of the impact of inequality in a more granular way, such as experience and outcomes for people who draw on social care and we will continue to work towards during our first year of implementation.

In tackling these six priorities and in taking forward our work on inequalities, we have also made a commitment as a system and at place to respond to the opportunities for action

set out in local plans, strategies and needs assessments. Most significantly as an ICS we are committed to supporting delivery of the Birmingham Health & Wellbeing board strategy and the Solihull Council Inequalities Strategy.

This includes in the first five years responding to:

- Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR)
- Birmingham Annual Director of Public Health Report 2019/20 'Complex Lives, Fulfilling Futures'
- Solihull Director of Public Health Annual Report 2020/21 'Counting the Cost of Covid' and Birmingham DPH Annual Report 2020/21 'The Year I Stopped Dancing'
- Birmingham Deep Dive Reports in health inequalities affecting
  - Veterans (2020)
  - Learning difficulties and Autism (2022)
  - Physical Impairment (2022)
  - Sex Workers (2022)
- Solihull Deep Dive Needs Assessments
- Health and Social Care Act 2022
- Equality Act 2010

How will we deliver improvement?

We will only deliver our ambition to tackle inequalities and contribute to the ICS objective to increase life expectancy if we work together as a system at every level of the partnership and truly make every contact with citizens and between staff count.

Reducing inequalities will be at the heart of all our work at place, in localities and in neighbourhoods. It will also be central to all our system-wide programmes and to the work of our provider collaboratives and each of our provider organisations.

We acknowledge that offering the same service to everyone – a 'one size fits all approach' – whilst appearing to be 'fair', has in fact resulted in unequal access, experience and outcomes for many of our citizens. That is why we are building a system that is more flexible to be able to offer tailored approaches which match the requirements of all our citizens.

To support our system to deliver on our priorities we will build a new way of working together based on the following six building blocks:

1. **Insight & Impact.** We will use data to identify the drivers and consequences of inequality, set priorities and to track the impact of the changes we are making. We are committed to using the data we have access to effectively and addressing the gaps in our knowledge and understanding proactively.

2. **Pathway Improvement.** We will audit our services to identify areas where existing pathways are widening inequalities, including waiting lists for hospital appointments and surgery and GP access. We shall support service improvement methods that enable us to utilise research and development and test innovations and new approaches in the way we deliver health and care working with patients and communities and then deliver these at scale across our system where they demonstrate benefit.

3. **Targeting our Prevention Programmes.** We will work with our prevention programmes (including alcohol, smoking, physical activity, nutrition) to ensure that they support our focus on the communities who currently experience the worst health. We will deliver these in a culturally appropriate way co-designed with citizens and embed prevention properly at every level of our system and in every pathway.

4. **Working with Communities.** We recognise that our citizens are experts in their own situation. We will work closely with communities to co-design solutions to the challenges they face that will support us to deliver our priorities. Through this work we will also address some of the structural discrimination and distrust and build culturally safe approaches with communities. In working with communities we recognise and will seek to support the potential for voluntary and community sector organisation to act as "Anchor organisations" adding significant value to the communities they serve.

5. **Supporting Health Literacy.** We will work across the system with citizens to build health literacy, increasing individual understanding of health and wellbeing and how to navigate the system to get support appropriately when it is needed.

6. **Anchor Institutions.** We will use the full potential of our health and care providers as an "Anchor Institution" to address wider determinants of health such as poverty and living environment. We are committing to supporting partners in their efforts, but also to leading the way ourselves. For example, by prioritising procuring locally, ensuring we pay all our own staff a Real Living Wage, and increasing the opportunity for and employing people from our most deprived communities. This will lift not only lift individuals and families directly, but also the neighbourhoods they live in, as they can spend more on local businesses contributing to a virtuous cycle of wealth creation in poorer neighbourhoods.

Measuring success

We recognise that further work is needed to establish our dashboard of indicators that will allow us to monitor progress and see the clear links between actions at different layers of the system, contributing to the overall objective to reduce health inequalities.

The ICS outcomes framework will include clear outcomes around health inequalities and our six priority areas. This will be supported by a dashboard of measurable indicators for each of the six priority areas, which will allow us to measure impact and progress from a citizen level to a community and ultimately to the population level impact across the ICS.

What next?

Firstly, we will support and ensure the ambition that reducing health inequalities and improving health outcomes for our citizens is hard-wired into how the new Integrated Care System works.

Data will be at the heart of making this possible. To support this, we will establish the mechanisms needed to both collect appropriate data and to act on it appropriately. We will standardise what we know works well and build on what is already strong. A Reducing Health Inequalities Committee of the Integrated Care Board will be tasked with setting

system priorities for reducing inequalities, ensuring we understand what the data is telling us, ensuring that our whole system is accountable for reducing inequalities and supporting innovation and new ways of working.

But we cannot expect to be able to design the most effective system on our own: if it was that easy, we wouldn't be facing the kind of challenges we do today. That's why we will engage widely with the citizens and communities we serve – as well as those who deliver health and care services in our system – to manage the challenge of delivering something new without destabilising the parts that are working well.

We recognise that any change requires embracing some risk. Especially with the sharing of power and resources. But we are committed to living our values and supporting each other with courage and resilience.

To this end, we will review how we can use existing opportunities such as the Fairer Futures Fund to support communities to address and tackle health inequalities at a local level; working with them, learning from each other, and working together to build a better approach to improving health outcomes.

We will produce an initial action plan for the next 1-2 years that will set out the specific action we will take to (a) progress our service priorities and (b) establish our new way of working in practice, although we might expect that plan to change and adapt as we work with communities, health and care professionals and the wider system to develop and improve our approach.

This strategy has been presented and approved at the ICS Health Inequalities Board on 14 July 2022 and ICB board on 8 August 2022.