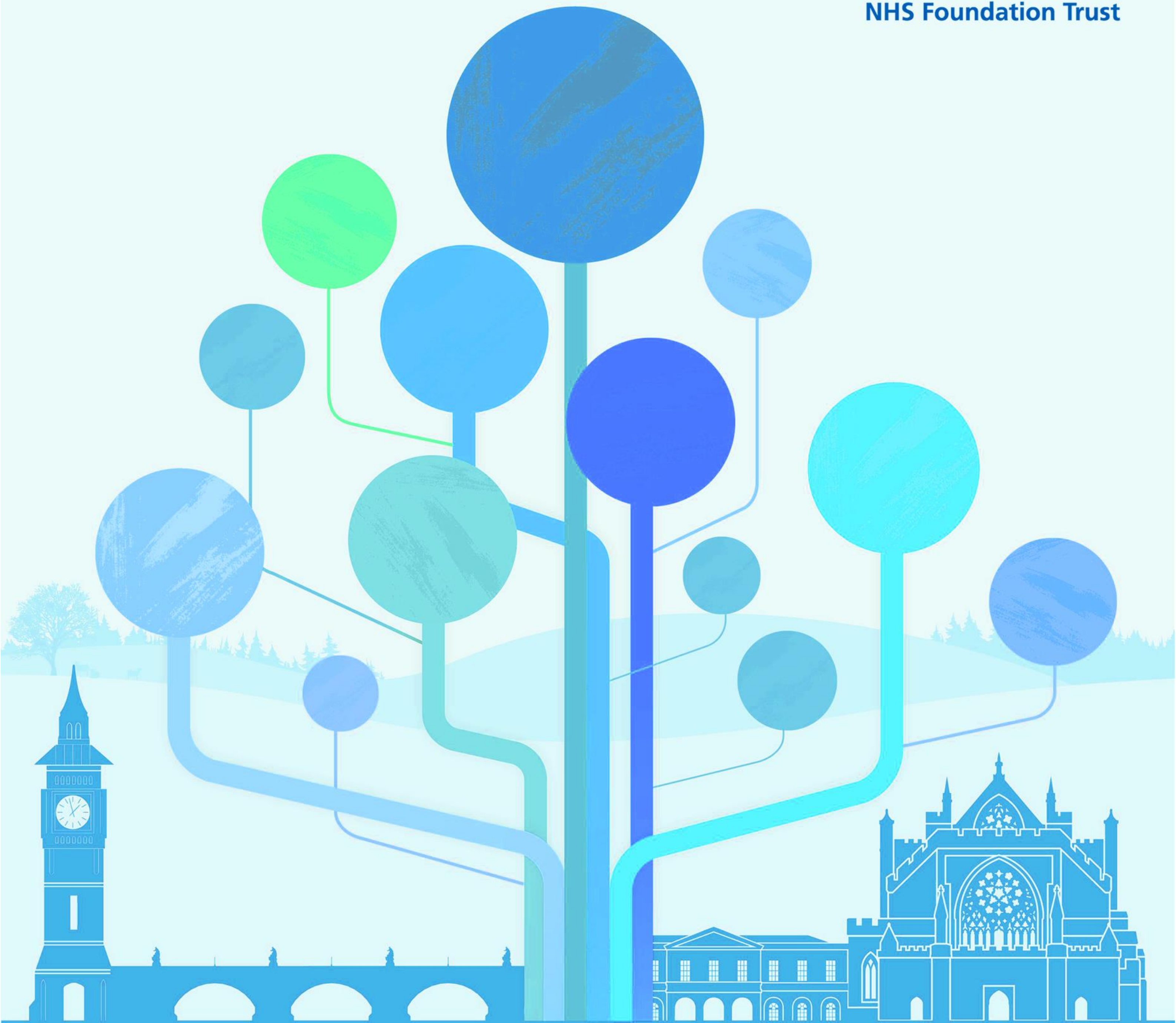

Health inequalities Strategy

2024-2029

January 2024

"In England, health is getting worse for people living in more deprived districts and regions, health inequalities are increasing and, for the population as a whole, health is declining. In particular, lives for people towards the bottom of the social hierarchy have been made more difficult."

Professor Sir Michael Marmot, "Health equity in England: The Marmot Review 10 years on", 2021

"Prevention, population health management and tackling health inequalities are not a distraction from the immediate priorities: indeed, they are the key to sustainable solutions to those immediate performance challenges".

"There will never be a perfect time to shift the dial toward focusing more on preventative services and interventions. It is easy to argue - especially in the current climate of financial constraints and performance issues - that addressing these issues should be something we consider when the current pressures have died down. But that has always been the case."

"The truth is, unless we make the change, the continual focus on improving flow through acute hospitals will simply channel more and more of an older and increasingly unhealthy population into acute hospitals, which will never be large or efficient enough to cope."

The Hewitt Review: an independent review of integrated care systems, 2022

Health inequalities strategy 2024-29

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1. Introduction

Welcome to the first Health Inequalities strategy developed by the Royal Devon, which is an enabling strategy of our Better Together strategy.

Chronic, persistent and unacceptable health inequalities result in poorer health, reduced quality of life, higher costs of care and early death for many people. Marginalised and deprived populations experience health outcomes far worse than the general population. They experience exclusion from services, and economic and social marginalisation.

This strategy has been developed in a context of a twin-demic of Covid recovery and cost of living poverty crisis as well as an NHS challenged to address the imbalance of supply and demand for care. There is a growing body of national policy and evidence suggesting NHS providers have a key role in tackling health inequalities.

The Royal Devon University Healthcare NHS Foundation Trust's health inequalities strategy outlines the evidence-based and partnership contribution we can make as an NHS provider to tackling health inequalities.

To ensure our approach is rooted in the needs of our local community and our Trust priorities we have organised our work on tackling health inequalities into three areas: Royal Devon as a healthcare provider; Royal Devon as a partner; and Royal Devon as an anchor institution.

As a healthcare provider we will adapt our services to ensure inclusion and support the Trust's clinical strategy's intention to shift to targeted, preventative interventions to support better health and reduced health inequalities; we will work with partners on the wider determinants of health; and as an anchor institution within our communities, we will use our capabilities and economies of scale to positively influence people's lives through our employment of 16,000 people and our procurement policies as well as the way we deliver care.

This strategic approach enables a framework to align the multiple initiatives across the Trust which influence health inequalities, such as research and development, sustainability, workforce and digital. And, importantly, our methodology is one which starts with asking people to describe the issue in their own words so that the data gathering, solution and activities remain focused on solving the right problem.

This strategy has the following vision and objectives:

Health inequalities vision:

Reducing health inequalities through involvement, insight and partnerships

Health inequalities objectives:

Royal Devon will

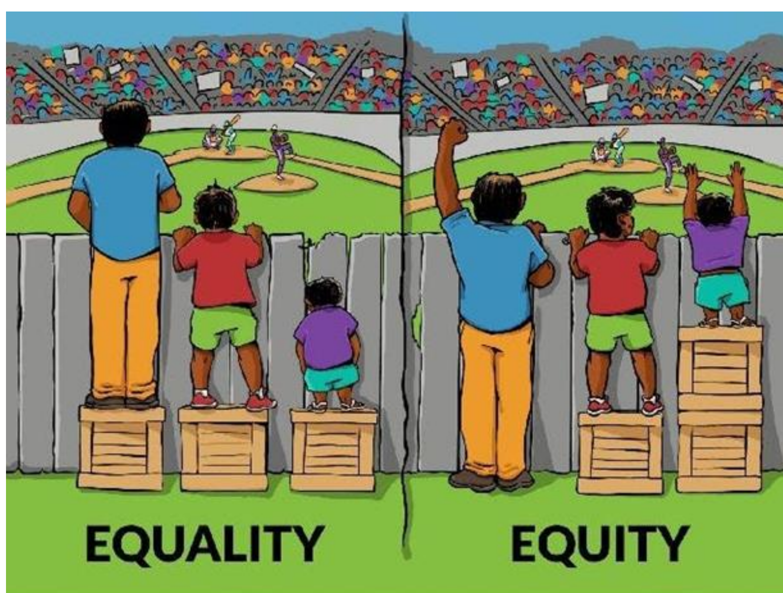
- Use its role as a **provider of healthcare** to reduce health inequalities
- Use its role as a **partner** to reduce health inequalities
- Use its role as an **anchor institution** to reduce health inequalities

2. Definitions

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, and work and which influence our opportunities for good mental and physical health.

Inclusion health is a term favoured by public health and Devon County Council to describe a policy agenda that aims to redress the extreme health and social inequities among the most vulnerable and marginalised in a community.

Equality means treating everyone the same or providing everyone with the same resource, whereas equity means providing services relative to need.



Most health inequality strategies recognise that reducing the steepness of the social gradient in health involves actions which are universal, but with a scale and intensity matched to the level of disadvantage: this is known as **proportionate universalism**.

Wider determinants Wider determinants are a diverse range of social, economic and environmental factors which impact on people's health. Such factors are influenced by the local, national and international distribution of power and resources which shape the conditions of daily life. They determine the extent to which different individuals have the physical, social and personal resources to identify and achieve goals, meet their needs and deal with changes to their circumstances.

The wider determinants of health are interlinked: for example, someone who is unemployed may be more likely to live in poorer quality housing with less access to green space and less access to fresh, healthy food. This means some groups and communities are more likely to experience poorer health than the general population. These groups are also more likely to experience challenges in accessing care.

Core 20+5 is an approach designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement. There is a version for adults and children. **Core20** is the most deprived 20% of the population as measured by the index of multiple deprivation; **Plus** are those ICS-chosen groups experiencing poorer than average health access and/or outcomes who may not be captured within the Core20 and who would benefit from tailored healthcare approaches i.e. inclusion health groups; 5 refer to the key clinical areas of health inequalities.

For adults they are **maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension** with smoking cessation recognised as a common positive intervention for all. For children the **5** are **asthma, diabetes, epilepsy, oral health and mental health**. Devon is using Core20+5 to segment the population to prioritise attention and resources. See appendix A for the Core20+5 explainer).

3. Strategic context and evidence base

3.1 Clinical data on health inequalities and impact on NHS demand

Health inequalities have always existed but the evidence from multiple sources indicates they are worsening. In both the 2020 Health Equity Study, authored by Sir Michael Marmot, and the evidence base to the NHS England major conditions strategy (2023) there is confirmation that improvement in life expectancy has stalled and the deprivation gap in life expectancy is widening and driven by preventable and manageable disease. 42% of the burden of poor health is attributable to modifiable risk factors (see figure 1).

The Covid-19 pandemic exacerbated inequality and highlighted the unequal impact of the disease on different population groups, some of whom were not previously thought to be an at-risk group. The success of specific strategies to target homeless people and ethnic minorities with vaccination support are examples where adapting the service delivery model makes a positive difference to people's health and wellbeing.

The current UK 'cost-of-living crisis' is further worsening the socio-economic inequalities that drive many health disparities. The disease groups in figure 1 contain many of the areas where this strategy and the community services element of the clinical strategy (see section 3.4) overlap and where joint prevention strategies and targeting approaches will be effective.

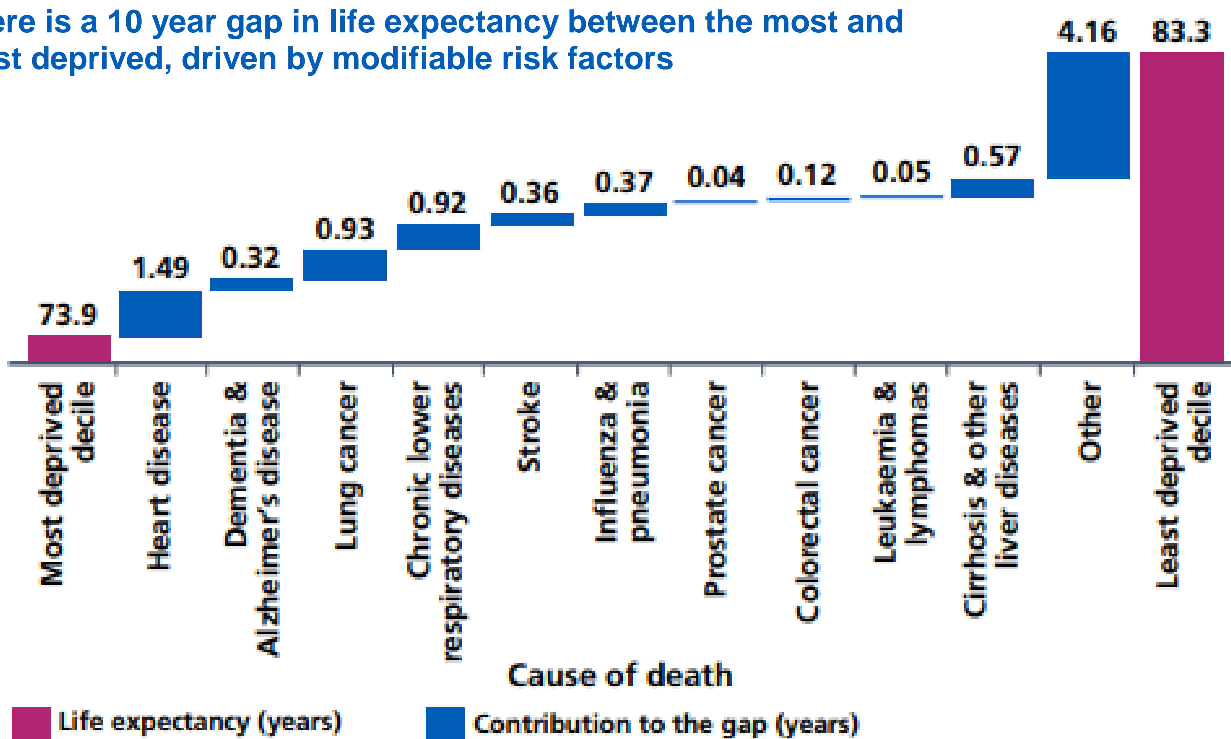
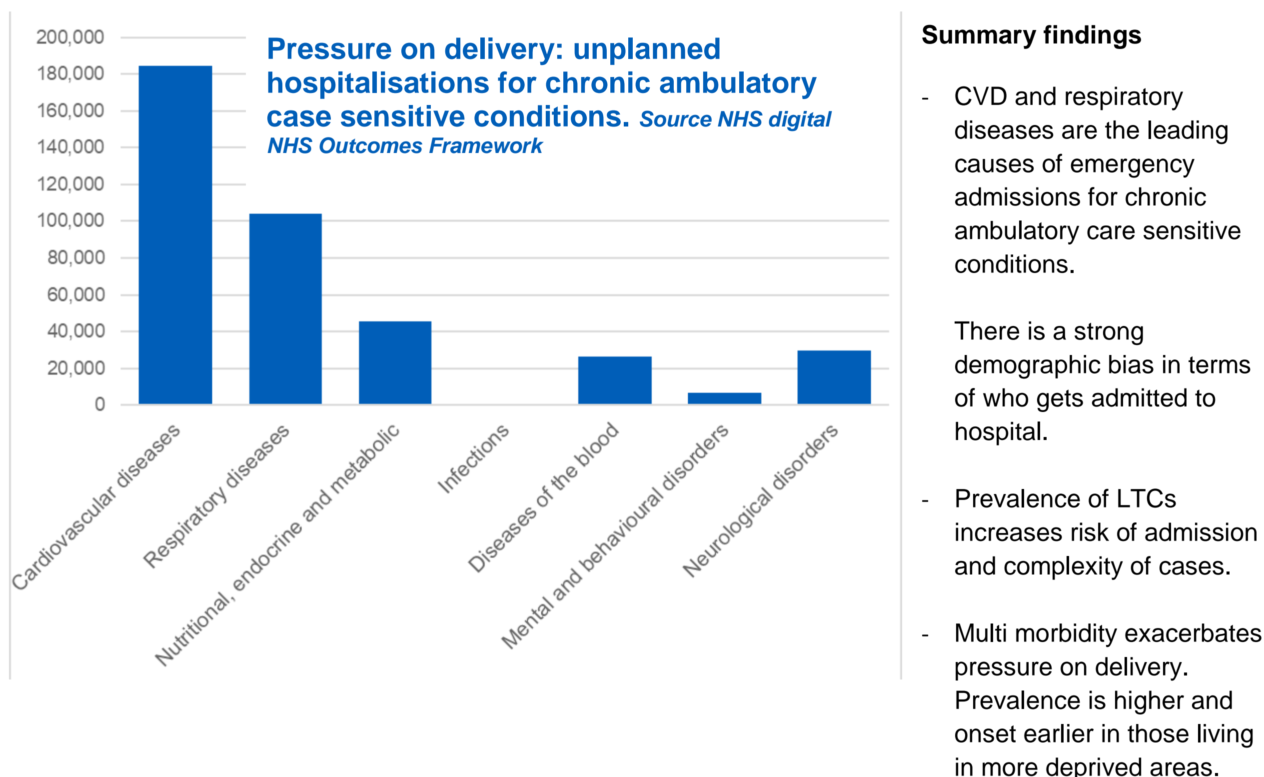


Figure 1: NHS England health inequality analysis, 2023

The demand presenting to the NHS has led policy leaders to examine the impact of health inequality and deprivation on admissions to hospital. Figure 2 shows the correlation between emergency admissions for hypertension, respiratory and mental health. Those three conditions are three of the five identified in Core 20+5 as being more prevalent in deprived communities.

This data indicates an evidence base for prioritising the areas to target based on the known impact on demand from certain disease groups.



Summary findings

- CVD and respiratory diseases are the leading causes of emergency admissions for chronic ambulatory care sensitive conditions.

  There is a strong demographic bias in terms of who gets admitted to hospital.

- Prevalence of LTCs increases risk of admission and complexity of cases.

- Multi morbidity exacerbates pressure on delivery. Prevalence is higher and onset earlier in those living in more deprived areas.

Figure 2: Failure to manage preventable conditions may exacerbate pressure on operational delivery. Nuffield Trust analysis of ambulatory care sensitive conditions and admissions, 2022

Royal Devon's catchment has a North and South seaboard and the Chief Medical Officer's report in 2021 highlights the substantially higher burden of physical and mental health conditions in coastal communities. The report highlights four main points, which resonate with local leaders and communities in Devon:

1. *"older, retired citizens – who have more and increasing health problems – often settle in coastal regions but without the same access to healthcare as urban inland areas. In smaller seaside towns, 31% of the resident population was aged 65 years or over in 2019, compared to just 22% in smaller non-coastal towns*
2. *difficulties in attracting NHS and social care staff to peripheral areas is a common issue. The report found coastal communities have 14.6% fewer postgraduate medical trainees, 15% fewer consultants and 7.4% fewer nurses per patient than the national average, despite higher healthcare needs*
3. *an oversupply of guest housing has led to houses in multiple occupation (HMOs) which lead to concentrations of deprivation and ill health. Directors of public health and local government leaders raise concerns about the challenges of poor quality but cheap HMOs,*

encouraging the migration of vulnerable people from elsewhere in the UK, often with multiple and complex health needs, into coastal towns

4. *the sea is a benefit but also a barrier: attracting NHS and social care staff to peripheral areas is harder, catchment areas for health services are artificially foreshortened and transport is often limited, in turn limiting job opportunities. The least wealthy often have the worst health outcomes."*

3.2 National policy context

Reducing health inequalities is one of the main priorities of the NHS Long-Term Plan, refreshed in the NHS at 75 update in 2023. The Health and Care Act 2022 enshrines this priority in legislation by stating that addressing health inequalities in outcomes, experience and access is one of the four core aims of an integrated care board (ICB).

In response to the continuing rise of chronic ill-health, NHS policy (NHS@75 report) shifts the focus to the following:

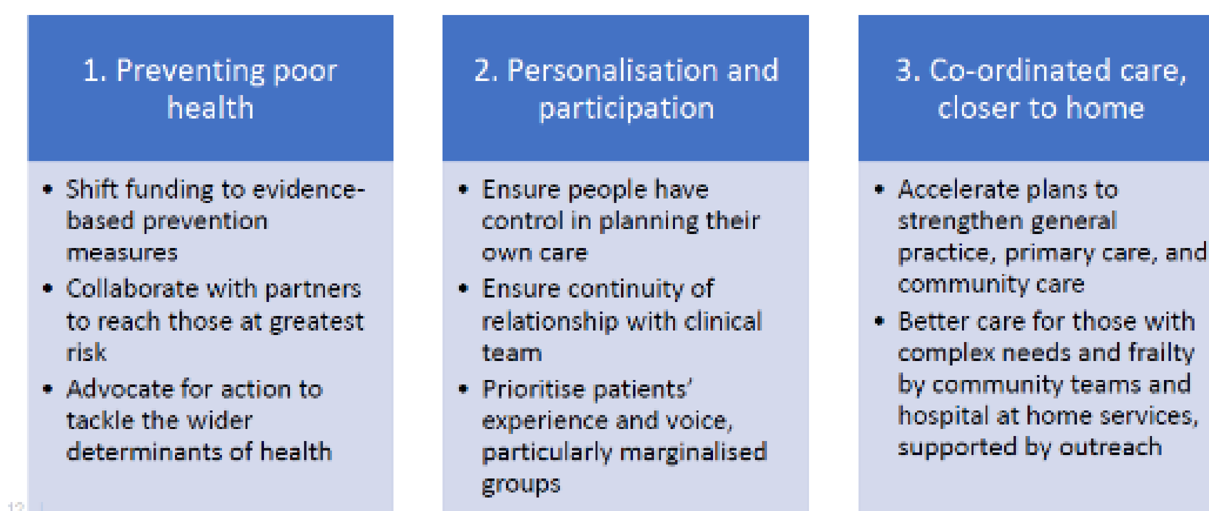


Figure 3: summary of the NHS&75 report, 2023

The NHS Long-Term Plans have signalled the intent to focus on health inequality, inclusion and prevention with the operating plans committing to ring-fenced budgets for prevention allocated to each ICS. This policy draws from the evidence that focusing upstream on modifiable behaviours means more people living longer in better health, which reduces the costs of that care. There is a risk that in a NOF 4 ICS, this ringfenced investment may be stalled- however, section 5 sets out the economic case for this investment.

The NHS England Health Inequality statement, published in 2023 sets out the responsibilities of NHS providers. To fulfil duties of service provision in ways which comply with the NHS Act 2022, Royal Devon is required to:

- Understand healthcare needs including by adopting population health management approaches, underpinned by working with people and communities.
- Understand health access, experience and outcomes including by collecting, analysing and publishing information on health inequalities set out in the Statement.

- Publish information on health inequalities within or alongside annual reports in an accessible format.

- Use data to inform action including as outlined in the Statement.

Trust Boards are expected to use health inequality data to inform strategy development, policy options review, resource allocation, service redesign, service delivery decisions and service evaluations. These obligations are included in the delivery plan supporting this strategy (section 5).

3.3 Financial case for prevention and health inequalities

The Healthcare Financial Management Association report 'Health Inequalities: establishing the case for change' from May 2023 draws together the evidence indicating that inequalities in health can drive demand for NHS services. Avoidable differences between population groups can impact the prevalence of conditions, and the ability and willingness of people to seek treatment prior to crisis and care costs increase the less planned the care.

At a time of intense demand on the NHS, significant financial pressure, and critical workforce shortages often means providers favouring a response to the immediate presenting problem rather than thinking about the long-term repeat presentations.

It is therefore an explicit medium-term aim of this strategy to have developed a business case for investing in targeting health inequality as a way of reducing demand on our NHS services (see section 5).

Serving a population which has more healthy years in retirement age will reduce the complexity and volume of healthcare need, providing the return on investment of interventions. Marmot links poor health to loss of economic productivity and higher welfare spend which creates the alignment to wider health and wealth policies across national and inter-governmental policy. Levelling Up and Local Government policies, as expressed via Local Plans, increasingly recognise the link between health, housing, skills, employment, crime, environment and the need for commitment from all partners to tackle these root causes of deprivation to ensure the health and wealth of a local area.

Making the case for longer term change to tackle health inequalities during a period of extreme pressure for the NHS, with short term recovery targets, is challenging. For this reason the workplan supporting delivery of this strategy recognises the need to target areas using the available evidence base; approach in ways with proven benefit and in partnership with the communities impacted. The evaluation which demonstrates impact will underpin delivery. This evidence is crucial to develop effective partnerships, maintain stakeholder buy-in and make the business case for sustainable funding.

3.4 RDUH strategy: Better Together

The Better Together strategy was developed to support the integration of two Trusts following the creation of the Royal Devon in 2022. The Better Together strategy has a mission that signals a clear shift towards preventing ill health through targeted intervention: "*Working together to help you to stay healthy and to care for you expertly and compassionately when you are not*".

One of the key drivers of the merger rationale was to address health inequalities across North and East Devon and to ensure access to healthcare and outcomes were equitable.

As described within the 'Collaboration and Partnership' strategic objective, the Trust is committed to being a collaborative partner with patients and stakeholders as well as with other providers, primary care, the ICS, local government, wider public services and the voluntary sector and using our combined expertise and data to make decisions that address health inequalities. Working in partnership is central to reducing health inequalities. Only 20% of someone's health is directly influenced by the NHS, the greatest influence is from someone's socio-economic context and influencing these wider determinants requires effective partnerships.

The clinical strategy (pictured in the graphic) has six objectives which this strategy will support.

Clinical strategy theme	Health inequality strategy response
Transforming patient experience through innovation and technology	We will use our digital capability to improve access to specialist healthcare for marginalised groups – for example through wearables and diagnostics in community settings.
Investing in our people so they can achieve their full potential	As an anchor institution and the largest employer in Devon, the NHS has the resources to significantly improve the health outcomes of our employees through training, development and fulfilment.
Strengthening our cancer services	A health inequalities approach to cancer would emphasis the need to target certain communities and demographics to reduce late diagnosis. There is a link between late diagnosis and health inequality/deprivation.
Reducing our waiting times	Equitably. There is a national link between deprivation and longer waiting times. The Health Inequalities board report and annual statement will demonstrate the extent to which we are managing this risk.
Delivering excellence through networks and partnerships	The entire basis of this strategy is one of encouraging a multi-agency effort involving central government, the NHS and local government working in close partnership, harnessing the contribution of the voluntary, statutory and private sectors to have the greatest impact in tackling health inequalities.
Stabilising acute services in North Devon	This objective is important to ensuring the continued access to local acute services to the population of Northern Devon, which has pockets of extreme deprivation and barriers to access.

Also within the Trust's clinical strategy is a commitment to develop the capacity and capability of our community services. This includes improved discharge pathways as well as supporting a range of physical or digital interventions delivered either directly or by partners that build wellness and independence. As well as improving health outcomes overall and delivering better value for money for the taxpayer, this form of early intervention helps to break the cycle of services not meeting people's needs and disadvantaged citizens experiencing worse health outcomes. A key area of overlap between this strategy and the community service element of the clinical strategy is presented in figure 4.

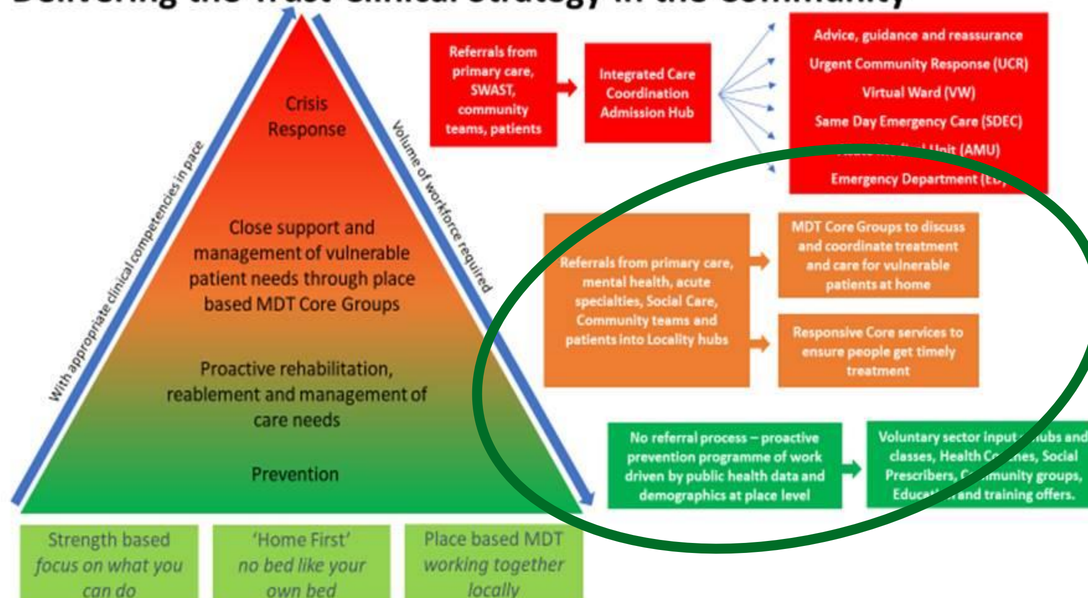


Figure 4: Showing the link between the RDUH clinical strategy: community services and the Health Inequality strategy

4. Health inequalities data

In recent years the depth of data and analytical capabilities have significantly increased in recognition that narrowing the inequality gap requires better data and insight. There are four main categories of data which will be accessed to support delivery of this strategy, working with our local care partnerships.

- **Population Health** data (called population health management) joins up data across local health and care partners and enables population segmentation and risk stratification. This gives practitioners insight into the holistic needs of different population groups and the drivers of health inequalities. Partners can identify a local 'at risk' cohort and create the evidence base for the targeted action needed. PHM means using data, evidence and knowledge in all forms to create local intelligence that aids decision-making.

- **National data platforms**. NHS England has invested in several data platforms to support the use of data in guiding local decisions to reduce the health inequality gap. The health inequalities improvement dashboard focuses on Core20+5 data and is contained within NHS National Data Platform (the Foundry) which identifies significant health inequalities statistical analysis and suggests actionable insights.

- **Local data capabilities**. The RDUH's EPIC electronic patient record has the functionality to record and report risk factors for health and healthcare inequalities across our acute and community patient caseload. It's health determinant tool also has the analytical power to combine data sets to indicate trends and patient cohorts. There are clear opportunities to use this data to inform and prioritise our health inequalities work as well as to collaborate on further research with partners.

- Our police, council and charity partners also collect data for example on anti-social behaviour, place of safety; housing supply, fuel poverty, evictions and housing standards; and gaps in community resilience respectively. Data sharing agreement to enable the overlay with health data will guide and target the interventions to reduce health inequalities and enable effective partnership working.

- **Neighbourhood qualitative data**. We will take concerted steps to understand the lived experience of people who are impacted by health inequalities. It is only be listening to the lived experience that services can understand how they must adapt their provision models to mitigate disadvantage and deprivation.

4.2 The data on health inequalities in North and East Devon

The following snapshots of East and North Devon show the type of data that will be commonly used to stratify risk, segment the population and plan interventions.

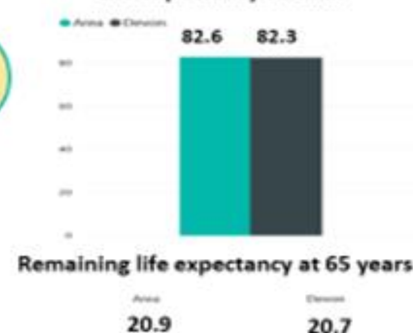
Eastern Local Care Partnership: Selected data

Indices of Multiple Deprivation

Selected IMD indicators

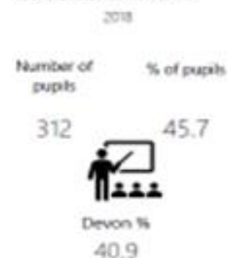
Preventable deaths

Life expectancy at birth



Child poverty

GSCE attainment



Houses classified as fuel poor %

Lifestyle behaviours %

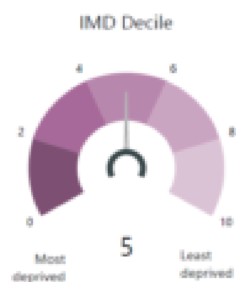
Car Ownership

Source: JSNA/2021 Census

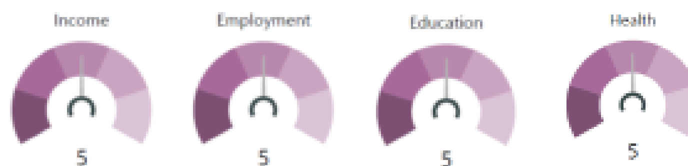
Whilst these are a narrow selection of data, the comparison between North and East reveals stark comparative differences between health outcomes, particularly in child poverty, educational attainment, fuel poverty and car ownership, which have implications for Devon in addressing health inequalities.

Northern Local Care Partnership: Selected data

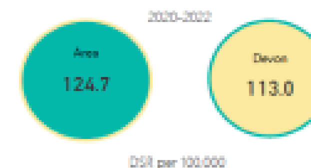
Indices of Multiple Deprivation



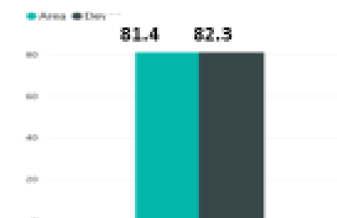
Selected IMD indicators



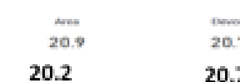
Preventable deaths



Life expectancy at birth

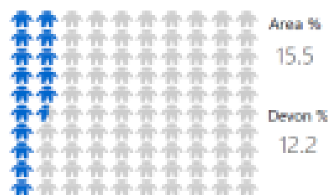


Remaining life expectancy at 65 years

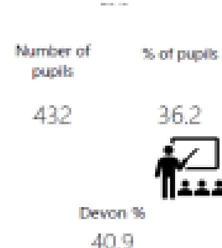


20.2 20.7

Child poverty

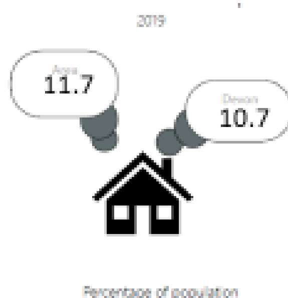


GSCE attainment



Houses classified as fuel poor %

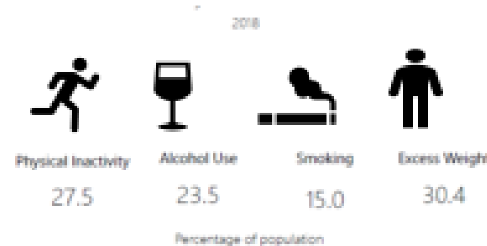
2019



Percentage of population

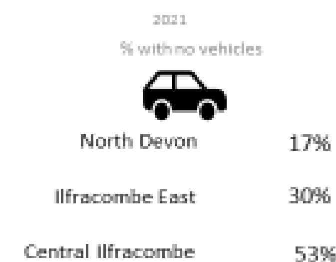
Lifestyle behaviours %

2018



Car Ownership

2021



Source: JSNA/2021 Census

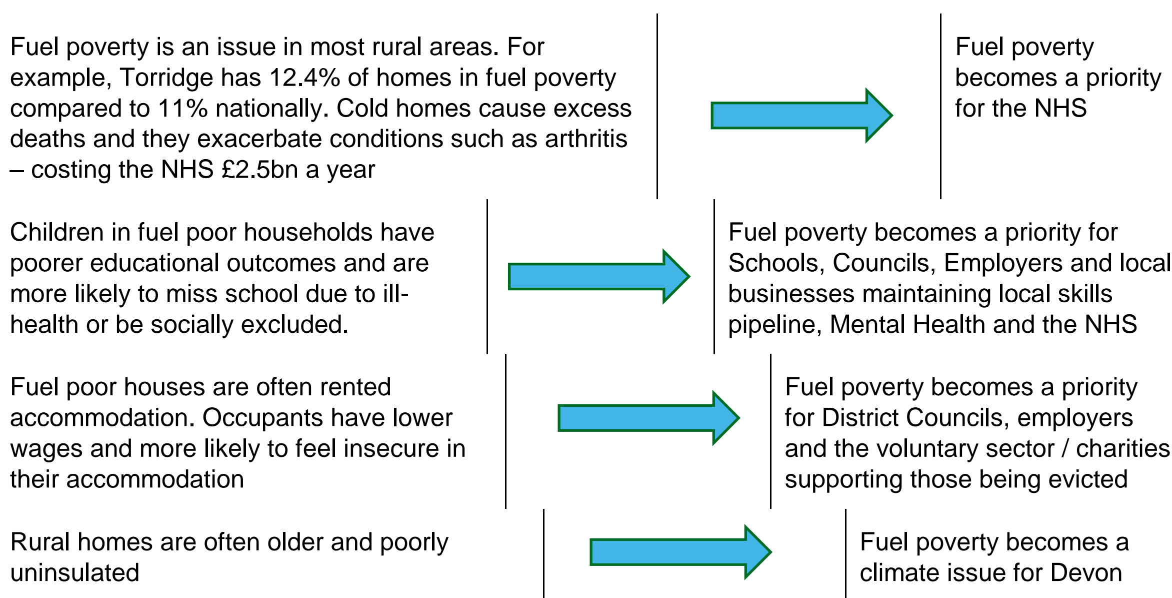
4.3 Using the data on health inequalities in North and East Devon

There is no shortage of data and often the key challenge is translating knowledge into meaningful action and impact, particularly when tackling the wider determinants of health requires an alignment of the priorities of all partners.

However, as the fuel poverty case study below shows, health inequalities are structural, multi-factorial and influence the service delivery of most public sector organisations. The approach summarised below is expanded in section 6.

A. Understanding the impact of fuel poverty and aligning priorities

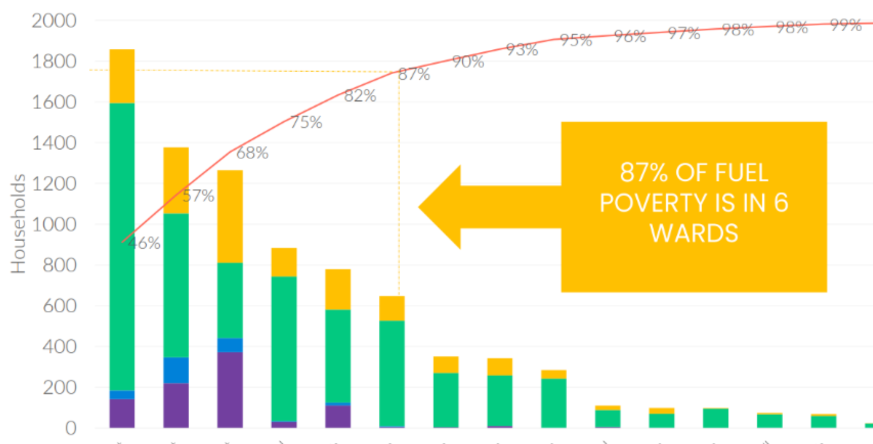
The table below shows how partners articulate the impact health inequalities is having on their service delivery and outcomes.



Impact		Priority
Fuel poverty is an issue in most rural areas. For example, Torridge has 12.4% of homes in fuel poverty compared to 11% nationally. Cold homes cause excess deaths and they exacerbate conditions such as arthritis – costing the NHS £2.5bn a year	→	Fuel poverty becomes a priority for the NHS
Children in fuel poor households have poorer educational outcomes and are more likely to miss school due to ill-health or be socially excluded.	→	Fuel poverty becomes a priority for Schools, Councils, Employers and local businesses maintaining local skills pipeline, Mental Health and the NHS
Fuel poor houses are often rented accommodation. Occupants have lower wages and more likely to feel insecure in their accommodation	→	Fuel poverty becomes a priority for District Councils, employers and the voluntary sector / charities supporting those being evicted
Rural homes are often older and poorly uninsulated	→	Fuel poverty becomes a climate issue for Devon

B. Identifying those impacted

Segment the population and gather all available data on each segment, i.e. low income, private rental, health conditions and use partner data if appropriate, i.e. from Energy Saving Trust, EPC ratings, Dept of Work and Pensions.



C. Stratify data and agree priorities

Share and use the data to stratify the population and agree priorities.

D. Act!

Locate and discuss the impacts with the target population. Agree interventions. Do the interventions and evaluate impact with partners and people.

5. The Royal Devon's role in tackling health inequalities

The Royal Devon's role in tackling health inequalities is in three objectives:

- As a provider of care
- As a partner
- As an anchor institution

This section explains how the Trust will convert its strategic intent into a series of deliverables for each objective. This is summarised on the 'Strategy on a Page' overleaf.

5.1 RDUH as a provider of healthcare tackling health inequalities

Objective	Development work: Year 1	Work programme: Year 2 onwards	Outcomes
Use our role as a **healthcare provider** to reduce health inequalities	*As per NHSE Statement…..* • **Understand healthcare needs**. Develop data capabilities: EPIC, PHM, One Devon Dataset, JNSA. Alongside community and partner engagement • **Understand health access**, experience & outcomes • **Collect, analyse and publish** health inequalities information at Board (biannual recovery report and NHSE HI statement) • **Publish** information on HI in annual report • **Use** data/evidence to inform action	• RDUH Core 20+5 delivery programme launched in CVD and diabetes • EPIC-PHM etc combined dataset • Elective recovery – HI input to outpatient transformation, digital inclusion, virtual/remote care delivery • Urgent care recovery – HI input to high intensity users (+High Flow), social prescribing and community connectors • Maturity of personalised care, make every contact count, value-based care and effective	**More years in better health (QALY + SHMI)** **North and East service integration levels up**

Year 1 will focus on building the evidence base. RDUH has the capability through its data analytics and highly-skilled, multi-professional clinical teams who are in contact with 100,000s of patients to risk stratify and understand the needs of its patient population. There is a robust evidence base behind 'make every contact count' to indicate the positive influence clinicians have on the healthy wellbeing behaviours of patients. Whilst it is recognised that asking about lifestyle issues such as alcohol intake and smoking takes time and adds more of a data collection burden for clinicians, the utility of the data and the impact of the conversation on the patient can be profound.

For Year 2, by using the data collected, Royal Devon can then begin to mitigate some of this inequity. Having achieved a dataset, the population groups can be segmented and targeted for a differential approach to care provision that meets their needs.

With improved data and targeted investment from the ICB and NHS grants, we will also begin to explore the priority areas of Core20+5, elective recovery and urgent and emergency care.

Health inequalities strategy on a page

Vision	Objective	Development work: Year 1	Work programme: Year 2 onwards	Outcomes
Reduce health inequalities through involvement, insight and partnership working	Use our role as a **healthcare provider** to reduce health inequalities	As per NHSE Statement…. • **Understand healthcare needs**. Develop data capabilities: EPIC, PHM, One Devon Dataset, JNSA. Alongside community and partner engagement • **Understand health access**, experience & outcomes • **Collect, analyse and publish** health inequalities information at Board (biannual recovery report and NHSE HI statement) • **Publish** information on HI in annual report • **Use** data/evidence to inform action	• RDUH Core 20+5 delivery programme launched for both adults and children - targeting CVD and diabetes • EPIC-PHM etc combined dataset • Elective recovery – HI input to outpatient transformation, digital inclusion, virtual/remote care delivery • Urgent care recovery – HI input to high intensity users (+High Flow), social prescribing and community connectors • Maturity in make every contact count, value-based care and effective interventions as NHS	**More years in better health (QALY + SHMI)** **North and East service integration levels up**
	Use our role as a **partner** to reduce health inequalities	• Participate in strong **One Northern Devon** partnership and contribute resources and effort to a shared prevention workplan • Support the development of **One Eastern Devon** to same partnership model as OND • Support maturity of **LCPs** as the ICS delegates more functions to local place level • Support delivery of the RDUH community strategy, particularly prevention • Establish DPIAs with partners to enable joint action	• Pursue joint prevention, regeneration and Levelling Up partnership initiatives • **North** - focus on local priorities: mental health, fuel poverty, high intensity user, social prescribing, homelessness, cost of living • **East** - focus on local priorities: mental health, loneliness, homelessness • Partner economic case for health inequality improvement programmes	**Services have adapted to people's needs** **Improved health outcomes** **& Reduced cost of delivery**
	Use our role as an **anchor institution** to reduce health inequalities	• Map all the health inequality opportunities and activities across RDUH functions i.e. apprenticeships (social mobility), Green Plan, Digital, Estates, Finance and Procurement and clinical models of care delivery • Publish progress in line with the NHSE statement and equality legislation	• Secure sustainable funding for health inequalities improvement initiatives • Benchmark the health inequality anchor activities with cost/benefit analysis • RDUH and District Council Local Plan alignment	**RDUH has net +ve impact on the socio-economic health and wealth of Devon**

5.2 RDUH working in partnership to tackle health inequalities

Objective	Development work: Year 1	Work programme: Year 2 onwards	Outcomes
Use our role as a **partner** to reduce health inequalities	• Participate in strong **One Northern Devon** partnership and contribute resources and effort to a shared prevention workplan • Support the development of **One Eastern Devon** to same partnership model as OND • Support maturity of **LCPs** as the ICS delegates more functions to local place level • Support delivery of the **clinical strategy, particularly community services and prevention** • Establish DPIAs with partners to enable joint action	• Pursue joint prevention, regeneration and Levelling Up partnership initiatives • **North -** focus on local priorities: mental health, fuel poverty, high intensity user, social prescribing, homelessness, cost of living • **East: -** focus on local priorities: mental health, loneliness, homelessness • Partner economic case for health inequality improvement programmes	**Services have adapted to people's needs** **Improved health outcomes** **& Reduced cost of delivery**

The establishment of the ICSs and place-based partnerships (local care partnerships) in legislation offers RDUH an opportunity to accelerate efforts to tackle heath inequalities given the mandate set out in the legislation and in NHSE guidance.

In addition we are a founding member of the One Northern Devon partnership board which takes membership from all local partners and has agreed a programme of work aimed at tackling local health inequality priorities. This approach is being replicated with One Eastern Devon and we will continue to take on a leadership role within all these partnership fora going forward.

This objective also defines RDUH's role in supporting delivery of the programmes within Devon's Joint Forward Plan and the Local Care Partnership workplans (North and East). The alignment between the ICS's Joint Forward Plan and RDUH's Better Together strategy is contained in appendix B.

5.3 RDUH as an anchor institution

Objective	Development work: Year 1	Work programme: Year 2 onwards	Outcomes
Use our role as an **anchor institution** to reduce health inequalities	• Map all the health inequality opportunities and activities across RDUH functions i.e apprenticeships (social mobility), Green Plan, Digital, Estates, Finance and Procurement and clinical models of care delivery • Publish progress in line with the NHSE statement and equality legislation	• Secure sustainable funding for health inequalities improvement initiatives • Benchmark the health inequality anchor activities with cost/benefit analysis • RDUH and stakeholder alignment, i.e. District Council Local Plans	**RDUH has net +ve impact on the socio-economic health and wealth of Devon**

Employing a 16,000 strong professionally diverse workforce; caring for 600,000+ local residents; and spending £1billion on the provision of healthcare makes the Royal Devon an anchor institution within the community of Devon (see figure 6).

The RDUH will use this status to positively impact the local economy, society and economy through:

- purchasing more locally wherever possible
- using social value measures in commissioning and procurement
- ensuring access to work, and making sure that job roles are high quality

- supporting families to live healthy, sustainable lives
- supporting the wider transition to a net zero economy, helping to reduce emissions and improve air quality

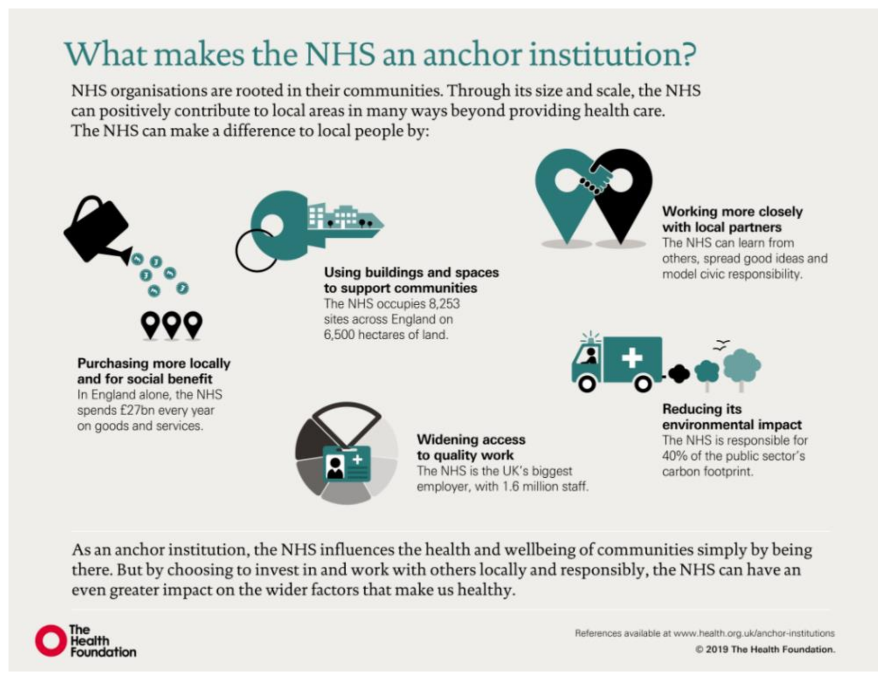


Figure 6: Health Foundation definition of an NHS anchor institution

Anchor institutions also tend to have more corporate professional resources which are essential to supporting partnership work and momentum, i.e. bid writers for grants, accountants, IG specialists for DPIAs, administrators to take meeting minutes and so on. Royal Devon offers these services as contributions when working in partnership.

6. Governance and programme management

The governance of health inequalities work is complex, matrix and system-wide. It also differs across projects and within each of the objectives of this strategy.

Three layers of governance are emerging with the new ICS architecture: initiatives that are implemented at system level (i.e. recovering waiting times equitably, smoking); at place level (i.e. high intensity users); and at person level (i.e. homelessness, apprenticeships).

Each area has its own appropriate governance and reporting structures.

Within the NHS England statement there is an expectation that the Royal Devon quantifies its impacts and publishes its activities to improve health inequality. The following governance structure details the process to support assurance of compliance with the 'statement'.

6.1 Trust governance to support delivery and prioritisation of this strategy

RDUH Board	Approves and monitors delivery of health inequality strategy. Receive bi-annual reports charting progress in delivering the three objectives of this strategy. All reports will align to the requirements of NHS England Health Inequalities statement
Strategic Trust Delivery Group	STDG will receive the report ahead of Board and validate impact, benefit and progress of the activities.
Joint N&E Operational Board	Trust Director members of our OB are also members of each LCP. N&E Devon localised updates will be presented to Ops Board containing update on Local workplans, health inequality projects, prevention, anchor institution activities and relevant grant funded projects.
One Northern Devon / One Eastern Devon	Coalition of willing partners who meet to agree local priorities and programmes across health, economy, environment. Membership of all health bodies, councils, police, fire, business, education, VCSE, third sector.
Strategy and Partnership team	Delivery of a workplan which includes: • RDUH health inequality strategy delivery (and support to community strategy) • One Northern Devon + North LCP workplans • One Eastern Devon + East Devon LCP workplans • ICS workplans i.e. smoking (secondary prevention)

As the Local Care Partnerships develop and take responsibility for more local commissioning functions and decisions, this governance will evolve and in some cases merge with the strong partnership forums already in existence – One Eastern Devon and One Northern Devon.

During this transition the Health Inequalities strategy delivery reports and requirements under the NHSE Health Inequalities statement, i.e. waiting list report by deprivation and ethnicity will report to Trust Delivery Group, relevant sub-committee and Board of Directors.

6.3 Resources to deliver the strategy

Firstly, there is a huge interest in addressing health inequalities amongst our clinicians, and in understanding what our data is telling us. EPIC also gives us a data repository. This dataset coupled with the curiosity of our clinicians is a natural resource that we are able to tap into.

To support this, Royal Devon has a small internal team of health inequality practitioners who support the delivery of this strategy and the One Northern and Eastern Devon workplans. This team maintains the partner relations and community networks which provide the infrastructure and coalitions required and ready to work in partnership on the wider determinants of health.

Investment is also available through our Local Care Partnerships. For example, through securing external grant income, One Northern Devon oversees a budget of between £0.5-£1m, wholly discharged on projects targeted at health inequalities and prevention.

As Integrated Care Boards (ICBs) have a statutory duty to reduce health inequalities, as defined in the Health and Care Act 2022 and are allocated ringfenced funding, we will need to ensure that this duty is maintained.

7. Conclusion

The NHS is uniquely placed to make a strong contribution to reducing health inequalities.

Due to the level of health inequality in our communities and the impact this has on the complexity and demand approaching our NHS services, working with partners on ways to tackle the root causes has become our core business.

We are already mid-flight in delivering this strategy. This strategy condenses all of the data, expertise, research and depth of partner relationships that Royal Devon has invested in over many years. We have generated a positive reputation as a constructive partner who works collectively and shares expertise to address the challenges facing our communities.

This strategy sets out a realistic and achievable framework for RDUH to demonstrate that addressing health inequalities can contribute to resolving some of the demographic, demand and financial challenges facing the NHS.

As society's expectations and demands on the NHS become more complex and intense, this strategy offers a way of meeting those expectations through personalisation, co-production and supporting the empowerment and resilience of local people.

Appendix A: NHSE and national evidence base

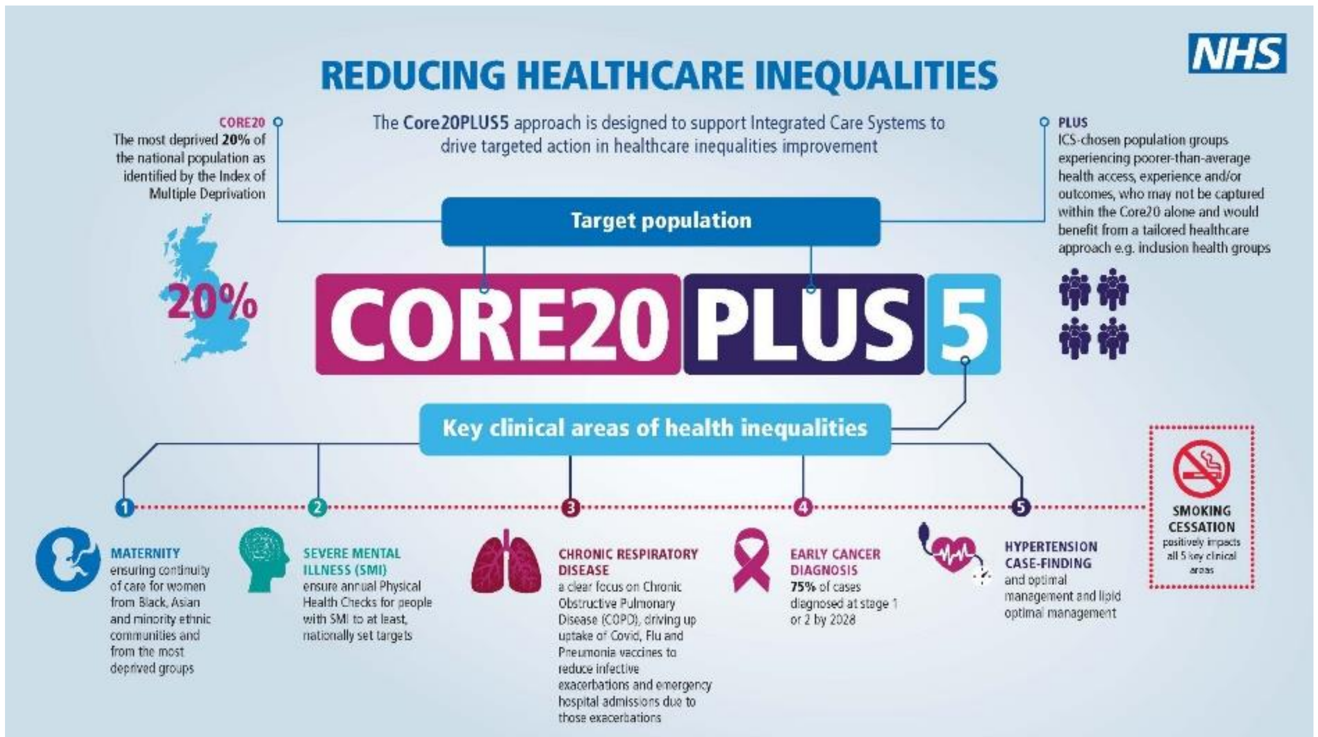
Further reading: the NHSE health inequalities statement and obligations, 2023

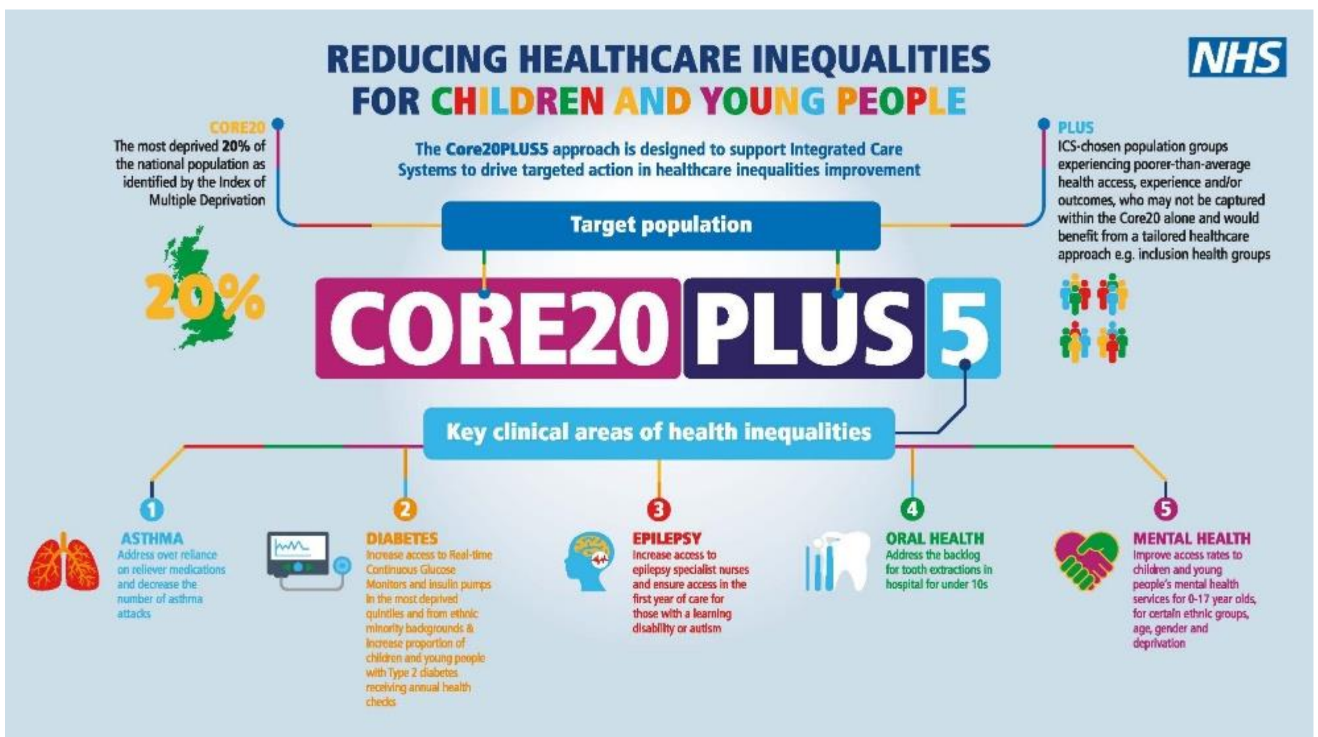
Statutory basis for addressing health inequalities

The NHS is mandated to consider health inequalities as a result of its legal duties and the regulatory framework in which it operates.

- The Equality Act 2010 legally protects people from discrimination in the workplace and in wider society.
- Public Sector Equality Duty (s.149 Equality Act 2010)
- Social Value Act 2013
- The right of everyone to the highest attainable standard of physical and mental health has been recognised formally in the UK since 1976 when the Government approved the International Covenant on Economic, Social and Cultural Rights (ICESCR).
- Health and Care Act 2022 committed to reduce inequalities between patients with respect to their ability to access health services, and the outcomes
- The Care Quality Commission's (CQC) strategy (2021) outlines a commitment to supporting and enabling health and care providers and wider systems to reduce health inequalities within services and the wider population, for the first time.
- NHS England and NHS Improvement's *System oversight framework 2021/22* onwards, commenced the ICS focus on improving population health and tackling unequal access, experience and outcomes.
- 2023 NHS England statement on health inequalities NHS England » NHS England's statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006)
- Core20+5 (overleaf)

Core20+5 for adults and children





Appendix B: Strategic alignment

The alignment between the ICS's Joint Forward Plan and RDUH's Better Together strategy

ICS delivery programme	Better Together strategic objective • **C**ollaboration and Partnership • **A** great place to work • **R**ecovering for the future • **E**xcellence and Innovation	RDUH enabling strategy
Acute service sustainability	C A R E	Clinical strategy Digital strategy People strategy Finance strategy
Housing	C	Health inequalities strategy
Community development and learning	C	Health inequalities strategy
Employment	C A	People strategy Health inequalities strategy
Health protection	E	Clinical strategy
Suicide prevention	C	Health inequalities strategy
Primary and community care	C	Clinical strategy Health inequalities strategy
Mental Health, Learning Disability and Neurodiversity	C R	Clinical strategy Health inequalities strategy
Children and young people	R E	Clinical strategy Health inequalities strategy

ICS enabling programme	Better Together strategic objective	RDUH enabling strategy
Climate Change	C A R E	Green Plan Estates strategy Digital strategy Clinical strategy
Population health	C R E	Clinical strategy Transformation strategy Health inequalities strategy

		Digital strategy Data strategy
System development	C	Better Together Transformation strategy Digital strategy
Workforce	A R	People strategy
Digital and data	C A R E	Digital strategy Data strategy Clinical strategy
Estates and infrastructure	A R E	Estates strategy Green Plan Clinical strategy Digital strategy
Finance	R	Finance strategy Transformation strategy
Communities and involvement	C R	Health inequalities strategy Digital strategy Clinical strategy (+ communications, engagement and marketing strategy)
Research, innovation and improvement	R E	Digital strategy Transformation strategy Green Plan
Equality, diversity and inclusion	C A	People strategy Digital strategy