Public Report
Health Select Commission

Committee Name and Date of Committee Meeting
Health Select Commission – 24 November 2021

Report Title
Prevention-led systems

Is this a Key Decision and has it been included on the Forward Plan?
No

Strategic Director Approving Submission of the Report
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Ward(s) Affected
Borough-wide

Report Summary
This report outlines some of the key challenges and opportunities in Rotherham in relation to the prevention agenda. It also provides an update on activity taking place to produce a Prevention and Health Inequalities Strategy for Rotherham, providing an opportunity for Health Select Commission to feed into the development of this strategy.

Recommendations

1. That Health Select Commission provide comments and contribute towards the development of a prevention and health inequalities strategy for Rotherham.

2. That Health Select Commission consider how this developing area of strategy should be reflected in future scrutiny activity.

List of Appendices Included
Appendix 1 Equality Analysis – Form A

Background Papers
None

Consideration by any other Council Committee, Scrutiny or Advisory Panel
No

Council Approval Required
No

Exempt from the Press and Public
No

1. Background

1.1 This report outlines some of the key challenges and opportunities in Rotherham in relation to the prevention agenda. It also provides an update on activity taking place to produce a Prevention and Health Inequalities Strategy for Rotherham, providing an opportunity for Health Select Commission to feed into the development of this strategy.

1.2 What is prevention and why is it important?

1.3 Prevention is about promoting good health and wellbeing and stopping illnesses from escalating further – enabling people to live happy and healthy lives for longer.

1.4 Prevention activity is typically broken down into three categories:

- *Primary prevention* – Taking action to reduce the incidence of disease within the population before the disease occurs.
- *Secondary prevention* – Reducing the impact of a disease, by detecting and treating it as early as possible in its course.
- *Tertiary prevention* – Reducing the negative impact of established disease, aiming to minimise the impact of disease on life quality and life expectancy.

1.5 Focussing on prevention has benefits for the individual, but also for the sustainability of the health and social care system. The population is ageing, and across the UK, advances in life expectancy over the last century have not been matched by improvements in 'healthy life expectancy' – (or the years an individual lives in good health.) This means that people are living for longer periods in poor health and spending more years in the 'window of need', contributing towards demand pressures for health and social care.

1.6 Linked to this, there is a strong economic case for prevention. Ill-health amongst working age people costs the UK economy approximately £100 billion per year. A systematic review of cost-effectiveness evidence produced to support the development of public health guidance at the National Institute of Health and Clinical Excellence (NICE) found that most public health interventions reviewed were cost-effective. (Owen et al., 2018) Another review found an estimated median return on investment from public health interventions of 14.3 to 1. (Masters et al., 2017)

1.7 Evidence shows that there are often opportunities to delay or prevent the onset ill-health, alleviating pressure within the system and improving health outcomes in the longer term. For example:

- 95% of liver disease is attributable to three preventable causes – alcohol, obesity, and viral hepatitis

- 90% of first heart attacks are related to 1 of 9 modifiable factors
- 80% of diabetes spend is treating avoidable illness and complications
- Two thirds of premature deaths could be avoided through improved prevention, early detection, and better treatment
- 42% of cancers in the UK are preventable
- 17% of deaths in adults over 35 are attributable to smoking

1.8 Prevention also has an important role to play in addressing health inequalities. This is because there is a steep social gradient in healthy life expectancy, with those living in the most deprived communities living in ill-health for a longer proportion of their life than those in more affluent communities.

1.9 **What is a prevention-led system?**

1.10 A prevention-led health and social care system is one that is taking a systematic approach to prevention across organisations to maximise impact. This requires a focus on preventing the onset of disease (primary prevention), as well as preventing the progression and impacts of the disease (secondary and tertiary prevention) through equitable access to early intervention with high quality treatment and care.

1.11 Developing a prevention-led system includes ensuring that prevention is embedded in our approach to:

- Leadership and governance
- Commissioning and delivery of services
- Staff wellbeing
- Sustainability and corporate social responsibility

1.12 Another underpinning principle of a prevention-led system is the concept of 'proportionate universalism', as outlined in the Marmot Review. This research identified a clear social gradient in health in England, whereby the lower an individual's social and economic status, the poorer their health is likely to be. Based on this finding, the report recommended that in order to reduce health inequalities and the burden of ill-health, 'actions must be universal, but with a scale and intensity that is proportionate to the degree of need.'

2. Key Issues

2.1 **Rotherham context**

2.1 Healthy life expectancy at birth in Rotherham is significantly below the national average. Males can expect to live 58.3 years in good health (compared with an England average of 63.2) and females can expect to live 58.9 years in good health (compared with an England average of 63.5.) (2017-19 data)

2.2 There are also considerable inequalities in healthy life expectancy across the

borough. Men in the most deprived areas of Rotherham can expect to live an average of 52.3 healthy years, compared with 70.7 healthy years for those living in the least deprived communities. In comparison, women in the most deprived areas of Rotherham can expect to live an average of 51.4 healthy years compared with 71.2 years for those in the least deprived areas. (2017-2019 data)

2.3 Additionally, Rotherham is significantly worse than the national average for preventable mortality for several conditions. This includes cardiovascular disease, cancer, and respiratory disease. (2017-19 data)

2.4 The Global Burden of Disease Study 2019 shows that behavioural, metabolic, and environmental risk factors significantly contribute to disability-adjusted life years (DALYs)* in the borough.

**(Disability-adjusted life years refers to the number of years lost due to ill-health, disability, or early death.)*

2.5 For example, the following table sets out the five leading causes, which between them contribute over 25% of DALYs in Rotherham and the estimated percentage of DALYs which were attributable to risk.

Condition	**% risk factor attribution**	**% of total DALYs in Rotherham**
Ischemic heart disease	94.87%	8.9%
Tracheal, bronchus and lung cancer	86.5%	5.03%
Stroke	83.18%	3.69%
Chronic obstructive pulmonary disease	72.9%	5.04%
Lower back pain	41.73%	4.5%

2.6 The risk factors that are driving DALYs and premature mortality in Rotherham are largely amenable to prevention. The top ten risk factors associated with DALYs in Rotherham are: smoking; high blood glucose; diet; high BMI; high blood pressure; high cholesterol; alcohol use; occupational risk; cold homes; and air quality. These risk factors are also drivers of health inequalities and are associated with socioeconomic deprivation.

2.7 This evidence indicates that focussing on prevention in Rotherham could have a considerable impact on improving health outcomes, reducing demand for services, and reducing health inequalities.

2.7 **National policy context**

2.8 In addition to this local evidence, there is also a national policy imperative to take a prevention-led approach. The NHS Long Term Plan (2019) committed to ‘more NHS action on prevention and health inequalities’ which was subsequently reinforced by the prevention green paper. (2019)

2.9 More recently, as part of the recovery from the COVID-19 pandemic, the NHS operational planning guidance (2021) outlined five strategic actions to prevent and manage ill-health in groups that experience health inequalities:

1. Restoring NHS services inclusively
2. Mitigating digital exclusion
3. Ensuring datasets are complete and timely
4. Accelerating preventative programmes that proactively engage those at greatest risk of poor health outcomes
5. Strengthening leadership and accountability

2.10 The NHS has also set out a Core20 Plus 5 strategy to reduce healthcare inequalities. This will focus on the most deprived 20% of the national population (36% of the Rotherham population live in the 20% most deprived areas), plus any locally identified priority groups, and delivery across the following five key clinical areas:

1. Maternity – ensuring continuity of care for 75% of women from BAME communities and the most deprived groups
2. Severe Mental Illness – ensuring annual health checks for 60% of those living with SMI
3. Chronic Respiratory Disease – a clear focus on COPD, driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions
4. Early Cancer Diagnosis – 75% of cases diagnosed at stage 1 or 2 by 2028
5. Hypertension Case Finding – to allow for interventions to optimise blood pressure and minimise the risk of MI and stroke

2.11 In addition to a policy drive within the NHS around inequalities, there is also a broader focus nationally on tackling socioeconomic inequality and the wider determinants of health. The Government is set to publish a Levelling Up White Paper in 2021, which will seek to address inequalities by improving living standards, grow the private sector, improve health, education and policing, strengthen communities and local leadership and restore pride in place. Additionally, the Office for Health Improvement and Disparities has been established with a clear remit around addressing inequalities in health and wellbeing.

2.12 Ensuring that our approach to prevention is systematic would support us in responding to these national policy drives at a local level. It would also support in the delivery of our local policy objectives set out in core strategies, such as the Health and Wellbeing Strategy.

2.13 **Developing a prevention-led system in Rotherham**

2.14 Informed by the evidence and national policy drivers, it has been agreed that a Prevention and Health Inequalities Strategy and Action Plan will be produced for Rotherham. To develop this, the Prevention and Health Inequalities Enabler Group has been established.

2.15 The Prevention and Health Inequalities Enabler Group is part of the Integrated Care Partnership (ICP) Place Board governance arrangements and supports the delivery of the ICP Place Plan. The group is comprised of all partners across the ICP, including the Council, the CCG, The Rotherham Hospital NHS Foundation Trust, Rotherham Doncaster and South Humber NHS Foundation Trust, Voluntary Action Rotherham, and the Rotherham GP Federation. The group feeds into the Place Board, as well as having a direct line to the Health and Wellbeing Board.

2.16 Regular meetings of the group have now been established. At the meeting on 15th November, the group discussed and agreed six priorities for the strategy:

1. Develop the prevention pathway to reduce the harms from smoking, obesity and alcohol and support healthy ageing
2. Support the prevention and early diagnosis of chronic conditions (including mental health conditions)
3. Tackle clinical variation and promote equity of access and care for underserved groups
4. Harness partners' collective roles as anchor institutions to address health inequalities
5. Strengthen our understanding of health inequalities through data and intelligence
6. Advocate for prevention across the system

2.17 All activity will be underpinned by the principle of proportionate universalism, with a universal offer accompanied by a more targeted approach for those in need.

2.18 The next stage will be to develop the strategy based around these six priority areas. The strategy will be accompanied by an action plan, which will include clear milestones and KPIs. The timescale for developing this strategy and plan is included in this briefing note from 5.1.

2.19 Additionally, as a Council we will develop an internal plan outlining our contribution to the partnership strategy, ensuring prevention is embedded across everything we do. This will build on the commitment to prevention that is being set out in the new Council Plan and will include reviewing the way prevention features in our commissioning activity, building on our 'making every contact count' approach and focussing on the wider determinants of health.

2.20 In terms of holding the whole system accountable for driving the prevention agenda, Health Select Commission plays a leading role. As outlined in the recommendations, further discussion would be welcomed regarding how committee members would like to engage with the programme as it develops.

3. Options considered and recommended proposal

3.1 Informed by evidence around the benefit of prevention to individuals,

communities and the health and social care system, it has been agreed that a Prevention and Health Inequalities Strategy and Action Plan is developed for Rotherham.

3.2 This programme of work is at a very early stage, and this report seeks to consult with Health Select Commission on its development. It also seeks to understand how committee members would wish to engage with the programme in the future.

3.3 The recommendations are:

- That Health Select Commission provide comments and contribute towards the development of a prevention and health inequalities strategy for Rotherham.

- That Health Select Commission consider how this developing area of strategy should be reflected in future scrutiny activity.

4. Consultation on proposal

4.1 This report seeks to consult with Health Select Commission on the development of the strategy. One of the recommendations is for committee members to provide comments on the development of the strategy.

4.2 Partners have been closely involved with the development of the draft priorities through the Place Partnership structures and will continue to contribute towards the production of the strategy and action plan. Wider stakeholder engagement will also take place as appropriate to inform this work.

5. Timetable and Accountability for Implementing this Decision

5.1 Following engagement with Health Select Commission regarding prevention priorities, work will take place to develop the strategy and action plan. A high-level timetable is outlined below.

Action	**Timescale**
Development of the strategy and action plan, including identification of milestones and KPIs	November 2021 – January 2022
Programme priorities will be considered by the ICP Place Board	1st December 2022
Draft partnership strategy and action plan presented back to the Prevention and Health Inequalities Enabler Group	January 2022
Final partnership strategy and action plan approved	April 2022

6. Financial and Procurement Advice and Implications

6.1 As outlined in the report, developing Rotherham's prevention strategy could have significant financial benefits in the longer-term, particularly with regards to stemming the demand for health and social care services. However, there are no direct or immediate financial or procurement implications arising from this report.

7. Legal Advice and Implications

7.1 There are no direct legal implications arising from this report.

8. Human Resources Advice and Implications

8.1 Whilst the programme will include a focus on staff wellbeing across the partnership, there are no direct HR or staffing implications arising from this report.

9. Implications for Children and Young People and Vulnerable Adults

9.1 The strategy will include interventions focussed on reducing the burden of ill-health for children and young people and vulnerable adults.

10. Equalities and Human Rights Advice and Implications

10.1 This programme is directly focussed on reducing health inequalities and this report has outlined the implications of socioeconomic deprivation on ill-health. However, health inequalities are multi-factorial and socioeconomic deprivation often intersects with other dimensions of inequality, such as protected characteristics, geographical factors (e.g., rural communities) and other vulnerabilities (e.g., those with severe mental illness.) This can lead to multiple disadvantage.

10.2 Taking an evidence-based approach and following the principles of proportionate universalism, the programme will identify where a targeted approach may be required to benefit specific cohorts. An understanding around multiple disadvantage will be integral to the development of the strategy and action plan.

10.3 A 'Part A' Equality Analysis form has been appended to the briefing and a full equality analysis will be undertaken as part of the development of the strategy.

11. Implications for CO_2 Emissions and Climate Change

11.1 Climate change has implications for health inequalities and developing our approach to sustainability across health and social care will underpin the programme.

12. Implications for Partners

12.1 This work is being driven by the ICP Prevention and Health Inequalities Enabler Group and is jointly owned by partners.

13. Risks and Mitigation

13.1 Monthly meetings of the ICP Prevention and Health Inequalities Enabler Group are in place, where risks will be monitored and escalated if required. The Enabler Group will report into the Place Board and to the Health and Wellbeing Board, supporting public accountability and assuring that risks to the programme objectives are managed appropriately.

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