Response ID ANON-U5DP-ABQ2-4

Submitted to Core20PLUS5
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1 Have you read the 'Core20PLUS5 Online Engage Survey - supporting document'?

Yes

2 Which of the following best describes you?

I have a particular interest in health inequalities – non NHS (including local government, public health, Department of Health and Social Care)

Other::

3 Considering the 'Core20' part of the approach outlined in the supporting document, what are your thoughts on the following statements?

Considering the 'Core20' part of the approach outlined in the supporting document, what are your thoughts on the following statements? - A focus on the nationally most deprived 20% is a good approach to tackling health inequalities:
Strongly agree

Considering the 'Core20' part of the approach outlined in the supporting document, what are your thoughts on the following statements? - Identifying the 20% most deprived will provide ICSs with direction & focus in improving health inequalities:
Strongly agree

Considering the 'Core20' part of the approach outlined in the supporting document, what are your thoughts on the following statements? - The 'Core20' approach will be straightforward to apply:
Neither

4 Please use this space to provide further context to the answers you have given to Q3 on the 'Core20' part of the approach:

Please use this space to provide further context to the answers you have given to Q3 on the 'Core20' part of the approach::

The unequal health outcomes experienced by the most deprived 20% create significant burdens on both the NHS and the wider economy. It is right that they should be the focus of targeted action. However, focus is needed to ensure that the NHS and ICS take action in areas where they can most directly influence health outcomes but that this focus is not confined to healthcare access. Among the biggest drivers of poor health outcomes in this population are risk factors such as smoking, harmful alcohol consumption and obesity. Tackling these is in line with aspirations of the NHS Long Term Plan and will be necessary to achieve the stated goal of improved health outcomes. We strongly welcome the commitment to further define high impact actions in partnership with local systems but would urge NHSE to also engage with stakeholders and members of the Smokefree Action Coalition, Obesity Health Alliance and Alcohol Health Alliance to identify the high impact evidence-based activity that can be undertaken by ICSs to really drive changed health outcomes for the most deprived 20%. Smoking is the first risk factor listed on NHSE's menu of evidence-based interventions and approaches for addressing and reducing health inequalities (https://www.england.nhs.uk/ltphimenu/). If the focus is solely on access to healthcare or the limited number of clinical actions currently listed in the document this will be a missed opportunity.

5 Considering the 'PLUS' element of the approach outlined in the supporting document, what are your thoughts on the following statements?

Considering the 'PLUS' element of the approach outlined in the supporting document, what are your thoughts on the following statements? - I understand which population groups fit into the 'PLUS' element of the framework:
Neither

Considering the 'PLUS' element of the approach outlined in the supporting document, what are your thoughts on the following statements? - My ICS will need support to identify their 'PLUS' groups:
Neither

Considering the 'PLUS' element of the approach outlined in the supporting document, what are your thoughts on the following statements? - I would benefit from additional training to identify and respond to the sensitive and cultural needs of 'PLUS' groups:
Neither

Considering the 'PLUS' element of the approach outlined in the supporting document, what are your thoughts on the following statements? - The 'PLUS' element of the framework will enable local flexibility:
Neither

Considering the 'PLUS' element of the approach outlined in the supporting document, what are your thoughts on the following statements? - Partnerships established through the COVID-19 vaccination roll-out can be built on to identify and respond to the healthcare needs of the 'PLUS' groups:
Agree

Considering the 'PLUS' element of the approach outlined in the supporting document, what are your thoughts on the following statements? - This approach will positively impact inclusion health groups:

Neither

Considering the ‘PLUS’ element of the approach outlined in the supporting document, what are your thoughts on the following statements? - The ‘PLUS’ element of the approach is straightforward to apply:
Neither

6 Please use this space to provide further context to the answers you have given to Q5 on the ‘PLUS’ part of the approach.

Please use this space to provide further context to the answers you have given to Q5 on the ‘PLUS’ part of the approach.:

Smoking remains a leading cause of health inequalities in England and key driver of inequalities faced by many inclusion health groups (e.g. people experiencing homelessness, people with multi-morbidities, drug and alcohol dependent groups, people in contact with the justice system, LGBT people etc). Smoking is also the largest risk factor relating to the CORE20PLUS approach and should be given greater consideration within or alongside the CORE20PLUS model. Failure to do so risks delivering insufficient progress on health inequalities and many of the metrics outlined across the model, as outlined further in response to question 13.

The pandemic drove real progress in outreach to some high need populations too often neglected by public health action, in particular the homeless population. The ‘everybody in’ initiative necessitated rapid action to manage smoking behaviours in settings where these were dangerous or prohibited. A great deal was learnt and relationships were built through this process with clear opportunities to maintain momentum in the future.

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7 Considering the five focus clinical areas outlined in the supporting document, what are your thoughts on the following statements?

Considering the five focus clinical areas outlined in the supporting document, what are your thoughts on the following statements? - I understand how the five focus clinical areas have been identified:
Disagree

Considering the five focus clinical areas outlined in the supporting document, what are your thoughts on the following statements? - I agree that the five focus areas identified are the right place to start in reducing health inequalities:
Disagree

Considering the five focus clinical areas outlined in the supporting document, what are your thoughts on the following statements? - Application of the ‘Core20PLUS’ approach should lead to improvements in the five clinical areas in the target populations:
Neither

Considering the five focus clinical areas outlined in the supporting document, what are your thoughts on the following statements? - The five focus areas should be adapted as progress is made:
Strongly agree

Considering the five focus clinical areas outlined in the supporting document, what are your thoughts on the following statements? - I understand how ICSs can apply the Core20PLUS approach to these five focus areas:
Neither

8 Please use this space to provide further context to the answers you have given to Q7 on the five focus clinical areas:

Please use this space to provide further context to the answers you have given to Q7 on the five focus clinical areas::

We’re unclear on the development process for choosing the five clinical areas. We are also unclear on what applying the CORE20PLUS approach to the five focus areas means in practice. See response to Q13 for further explanation.

9 Considering the whole Core20PLUS5 approach, what are your thoughts on the following statements?

Considering the whole Core20PLUS5 approach, what are your thoughts on the following statements? - The Core20PLUS5 approach is clear and understandable:
Agree

Considering the whole Core20PLUS5 approach, what are your thoughts on the following statements? - I understand my role in Core20PLUS5:
Neither

Considering the whole Core20PLUS5 approach, what are your thoughts on the following statements? - I understand how to integrate Core20PLUS5 with my own existing priority areas:
Neither

Considering the whole Core20PLUS5 approach, what are your thoughts on the following statements? - I am confident that if applied across all ICSs, the Core20PLUS5 approach will lead to reductions in health inequalities:
Neither

10 Overall, how useful an approach is ‘Core20PLUS5’ in helping NHS systems to reduce health inequalities?

Somewhat useful,

11 In your opinion, what support from the national Health Inequalities Improvement team would help ICSs the most to reduce health inequalities through application of the Core20PLUS5 framework?

In your opinion, what support from the national Health Inequalities Improvement team would help ICSs the most to reduce health inequalities through application of the Core20PLUS5 framework? - Support in identifying their 'Core20PLUS' populations and their specific healthcare needs:
2

In your opinion, what support from the national Health Inequalities Improvement team would help ICSs the most to reduce health inequalities through application of the Core20PLUS5 framework? - Support and advice on working in partnership with people and communities who are being targeted through this approach:
6

In your opinion, what support from the national Health Inequalities Improvement team would help ICSs the most to reduce health inequalities through application of the Core20PLUS5 framework? - Support with data including collection, analysis or access:
4

In your opinion, what support from the national Health Inequalities Improvement team would help ICSs the most to reduce health inequalities through application of the Core20PLUS5 framework? - Provide platforms, networks and other opportunities for sharing learning and best practice:
3

In your opinion, what support from the national Health Inequalities Improvement team would help ICSs the most to reduce health inequalities through application of the Core20PLUS5 framework? - Recommended interventions to reach target populations:
1

In your opinion, what support from the national Health Inequalities Improvement team would help ICSs the most to reduce health inequalities through application of the Core20PLUS5 framework? - Provide Health Inequalities training for NHS professionals:
5

12 Use this space to share any other suggestions for what support ICSs will need to successfully apply the Core20PLUS5 approach:

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To secure change this needs to be clearly linked to ICS requirements as set out in the planning guidance. This must encompass requirements to involve all system stakeholders in identifying a strategy for addressing health inequalities, including local government. Much of the information and expertise needed to successfully identify, target and support populations with the highest need at a local level already exists within local authorities and the Office for Health Improvement and Disparities. ICSs should draw on these resources rather than unnecessarily duplicating them. For example, local Joint Strategic Needs Assessments at local authority level are likely to provide much of the granularity needed to identify at need populations and the risk factors driving poor health.

ICSs are likely to require support in identifying areas for high impact action and developing approaches to tackle these. There is good case for focusing on areas like tobacco where there is:
- Strong evidence of impact and need within the target population
- Clear evidence on the action that will change health outcomes
- Wider benefits to health and the economy (for example, through increased household income)
- Good fit with existing action within the NHS Long Term Plan

ICSs may also need support in developing approaches that speak to the whole system, not just single aspects of delivery. In the case of tobacco, action is needed in all healthcare settings with a particular gap present around primary care delivery. In addition, there is a strong evidence base for action outside of treatment settings to drive behaviour change, particularly in relation to communications campaigns and enforcement activity.

Stakeholders such as ASH and other members of the Smokefree Action Coalition are likely to be in a good position to support the development of implementation resources and would be happy to provide further support.

13 Use this space to share any other comments on the Core20PLUS5 approach:

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Overall, the CORE20PLUS5 approach is a strong way of bringing together partners to focus on those at greatest risk of poor health outcomes. The focus on five key clinical areas of health inequalities is welcome and, as outlined in the document, this focus can bring traction to efforts to reduce health inequalities.

However, there is a danger that this guidance suggests there are only 5 actions ICSs need to take to tackle health inequalities, none of which address more upstream causes of inequality. One of the simplest and most effective ways for ICSs to have greatest impact on the health outcomes of the most deprived 20% is to take action on the biggest drivers of ill health.

Smoking is the single biggest cause of preventable death and illness in England and a leading cause of health inequalities. As such, it is the largest risk factor for population groups and the 5 clinical priorities outlined in the CORE20PLUS5 model. Smoking is linked to almost every indicator of disadvantage with a clear gradient evident: the more disadvantaged you are the more likely you are to smoke.

Smoking is a leading or major risk factor for each of the five key clinical areas:

• Maternity, where smoking in pregnancy remains a leading cause of poor outcomes for both mother and child.
• Severe mental illness, where smoking is the largest contributor to reduced life expectancy.
• COPD, for which 80% of deaths are caused by smoking.
• Cancer, for which smoking is the greatest preventable cause.
• Hypertension, for which smoking is a risk factor. Those with hypertension are at far greater risk of morbidity and mortality if they also smoke.

The prioritisation of action on tobacco should not be left to the local discretion of ICSs when it is a pre-requisite for improved outcomes for many of the populations and priorities the CORE20PLUS5 model targets. Given the emerging nature of ICSs and their broad remit, their role in addressing smoking should be clearly set out to avoid it being overlooked.

Prioritising smoking through the CORE20PLUS5 model is also key to ensuring commitments already made through the NHS Long Term Plan to address health inequalities are supported and complimented. On smoking, the Long Term Plan committed to:

• Ensure that, by 2023/24, all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services;
• adapt this model for expectant mothers and their partners, with a new smoke-free pregnancy pathway including focused sessions and treatments; and
• launch a new universal smoking cessation offer as part of specialist mental health services for long-term users of specialist mental health services and in learning disability services.

If fully implemented, these commitments will deliver significant progress in improving the health of the nation, preventing illness, and reducing inequalities. These commitments will specifically deliver improved outcomes for populations and clinical areas prioritised by the CORE20PLUS5 model. The CORE20PLUS5 model must include action on smoking to support the Long Term Plan's action on inequalities and ensure maximum value and efficiency is delivered by the NHS as a whole.

There is significant level of existing and planned activity in relation to tackling smoking, but this is not necessarily being joined up across systems. However, there are strong case studies of areas with a pre-existing regional infrastructure on tobacco, particularly the North East and Greater Manchester. The action to address smoking through the NHS Long Term Plan will treat smokers in the health care system. To maximise the impact of NHS tobacco dependence services, links are needed into the community treatment being delivered by local authorities and primary care. However, the broader context also matters. Treatment programme will have better outcomes if complimented by the broader population level action shown to have the biggest impact on smoking rates, most importantly mass media campaigns and action on illicit tobacco.

Ensuring co-ordination across the treatment pathway and getting best value through wider population level measures demands co-ordination, investment at sub-regional or regional level, and the engagement of many stakeholders in the system. ICSs appear very well placed to play this role alongside local authority public health teams. But they are unlikely to do so without direction.

There is a strong existing evidence base for tackling smoking on a larger footprint. The economies of scale enable regional tobacco control teams to run behaviour change campaigns, work with partners to tackle illicit tobacco, develop smoking policy than can be adopted across regions and make the case for evidence-based national policy change.

ICSs already financially support regional tobacco control approaches in Greater Manchester, the North East and Yorkshire and the Humber, where local authorities also provide funding. These three regions with established regional tobacco control approaches are areas with the greatest percentage point prevalence reduction in smoking over the past decade. However, more could be done in these regions and much more could be done in other parts of the country.

ICSs are extremely well placed to support this large-scale work because they cover larger footprints, have dedicated funding streams for reducing health inequalities and can make links with clinical teams and services. ICSs should be encouraged to work with local authorities on the right geographical footprint to support regional or subregional tobacco control. Regional tobacco control teams can be based in local authorities, NHS trusts or other organisations as best fits local circumstances.

ASH and the University of Nottingham will shortly be publishing research into regional tobacco control that involved interviews with NHSE and ICS participants and would be happy to share the final report in the coming weeks.

14 If you are interested in staying informed about further engagement opportunities around NHS England and NHS Improvement's approach for reducing health inequalities, please provide your name, job title, organisation and email address:

Name::
Robbie

Job title::
Senior Policy Officer

Organisation::
Action on Smoking and Health (ASH)

Email address::
robbie.titmarsh@ash.org.uk