Health Equity Commission.

Bay Health and Care Partners' Evidence.

Bay Health and Care Partners Evidence Submission for HEC.

1. Executive Summary

This document summarises the Bay Health and Care Partners' evidence regarding health inequalities for submission to the Health Equity Commission Panel. The evidence collation was overseen by a Morecambe Bay steering group. Local partnerships were asked to respond to the questions posed by the Health Equity Commission, and the themes of that feedback are summarised in this document.

Bay Health and Care Partners (BHCP) is located in Morecambe Bay and is one of the five Place Based Partnerships (PBP) in Lancashire and South Cumbria Integrated Care Partnership (ISC ICP). It covers a relatively large geographical area with a relatively small population living in a range of urban, rural and coastal communities. This has a significant impact of the location and delivery of services, requiring multiple sites and a reliance on the local transport infrastructure to deliver care to the local population.

BHCP has made a commitment to improving population health through the reduction of health inequalities and has a local accountability structure to oversee this through a Population Health Strategy Group. There are established district and neighbourhood level partnerships that lead the delivery of action to support local communities.

Local Health Inequalities.

Communities living in Morecambe Bay experience many health inequalities, as evidenced by the data and feedback included in this evidence. There are two main areas of disadvantage in Barrow and Morecambe, and these areas also have the poorest health outcomes. There is a 12-year difference in life expectancy between the most and least disadvantaged wards in Barrow-in-Furness and Lancaster. The rate of premature mortality is almost twice as high in the most disadvantaged decile of Morecambe Bay, compared to the least disadvantaged and the inequality gap is widening year on year and has been exacerbated by COVID-19.

There are inequalities in a range of social and health outcomes within Morecambe Bay, Cumbria and Lancashire. One of the most notable was the data in relation to school readiness, which shows that Lancashire and Cumbria have a lower level of school readiness in children eligible for free school meals compared to the national average and Blackpool and Blackburn-with-Darwen. A whole system approach to providing support in early years is needed to help protect future generations from disadvantage and poor health.

COVID-19 has had a huge impact on local communities and has particularly affected South Lakeland district, which had the highest level of furlough nationally and a significant increase in applications for free school meals. South Lakeland has hidden inequality, mainly manifesting through poor quality housing.

The inequalities in healthcare are of a similar pattern to those evidenced nationally. People living within the most disadvantaged communities have higher rates of attendance at A&E and emergency admission to hospital. In contrast, people living in the most disadvantaged communities have lower rates of elective admissions. The areas with the highest rates of premature mortality due to cancer are also the areas with lower rates of access to cancer related elective care. Communities with the highest healthcare need are not receiving the care when and where they need it. Different ways of

working, sustained community conversations, shared decision-making and additional support is needed for these communities.

There are a range of priorities to reduce health inequalities at place and neighbourhood level. From a social determinants' perspective, local feedback indicates that reducing poverty is a priority action to reduce health inequalities. Anchor institutions are an essential intervention that are within local control and can achieve co-benefits for climate change, community assets and future employment. Outside local control, national influence to increase national minimum/living wage, welfare payments and public sector funding are also important.

Early years should be an area of focus across Morecambe Bay. The data shows that in Cumbria and Lancashire, a lower percentage of children eligible for free school meals are ready for school. There are healthcare inequalities in access to maternity and some paediatric services for families living in the most disadvantaged areas. There are also inequalities in relation to babies being born at full term with low birth weight. Good physical, cognitive and language development is essential in protecting the next generation from health inequalities.

Childhood poor mental health and obesity are important priorities to support children and young people to reach their potential. Inequalities in these areas may have been exacerbated during the pandemic, with children and young people missing prolonged periods of school, experiencing isolation and in some cases 'hibernating' at home. Action on mental health and obesity should take a full life-course approach.

From a healthcare perspective, it is important to shift the balance of inequality to increase elective care for the most disadvantaged communities. This can be achieved through pro-active identification and optimum management o ill-health, and through targeted vaccination and screening programmes to support communities at risk from health inequalities.

The local priorities for Morecambe Bay are summarised below, with a focus on supporting and improving outcomes for communities living in the areas of highest local disadvantage.

- Support a reduction in poverty
- Prioritise investment and support for early years, particularly during pregnancy and the first year of life and for the most disadvantaged communities
- Improve mental health and reduce obesity across the life-course in the most disadvantaged communities
- Reduce the rate of attendance and admission to emergency care for the most disadvantaged communities
- Reduce the rate of premature mortality in the most disadvantaged communities and reducing the gap in life-expectancy

Local feedback.

Engagement with local partnerships has illustrated the following themes as being important in addressing health inequalities.

To build more support for reducing health inequalities:

- Increased funding and allocation based on health need and deprivation

- Strategic alignment and accountability
- Community development and a social movement for health
- Integrated plans for action with agreed shared priorities
- Improved data collection with explicit focus on health inequalities integrated across organisations
- Emphasis on co-benefits so that action has multiple positive outcomes for communities, especially in relation to climate change
- Evidence of what works
- National influence

To strengthen local partnerships:

- Sharing data to emphasise the importance of reducing health inequalities and generate a shared sense of responsibility and moral duty
- Dedicated time to generate and agree shared priorities to be included in an integrated plan for action
- Integrated funding to ensure that funds are allocated to meet need and ensure the emphasis on prevention
- Improve commissioning for CVSFE to improve sustainability
- Community development and a social movement for health based on genuine asset-based community development
- Use of tools for health equity to ensure that reducing health inequalities is a golden thread throughout the system

To reduce barriers to action:

- The organisational complexity of Morecambe Bay, namely the two County Councils with different social care, 0-19 and public health offers plus two providers of community children's health services, results in a wide range of partners trying to work together in the context of different strategic and delivery priorities.
- The geography of Morecambe Bay makes service delivery a challenge and relatively expensive due to the location of and number of sites. Access in terms of the local travel infrastructure is important in considering health inequalities.
- The reduction in local public sector funding, the short-term funding of CVFSE and the need for greater focus on the allocation of funding to reflect disadvantage
- A lack of integrated, granular data to illustrate health inequalities, that is accessible to all. A lack of capacity to analyse data proactively and reactively to have a better understanding of health inequalities
- Services are not designed to meet the needs of communities and can be provided in the wrong way, at the wrong time in the wrong place.
- Recruitment of staff is difficult, particularly in the isolated area of Furness and more socially disadvantaged areas. These recruitment challenges affect all partners and adds to the challenge of developing sustained relationships and integration.

Support from the Health Equity Commission.

Based on the local feedback from partnerships, the following support is requested from the HEC to make reducing health inequalities the number one priority.

- **Improve system oversight and accountability**
- **Develop a shared set of priorities and outcomes with identified strategic responsibility**
- **Provide evidence of how to implement interventions to reduce health inequalities in the short, medium and long-term.**

The action required by the HEC to achieve these three priority areas are described below.

Funding.

The Commission is asked to:

- Provide guidance on how to effectively influence national policy in relation to public sector funding and healthy public policy.
- Advocate the need to explicitly consider community deprivation and health outcomes when allocating funding.
- Ensure that the system allocates sufficient funding to early years. With the current financial pressures and widening health inequalities, it is essential that early child health and development are prioritised. This is evidenced by the data regarding inequalities in access to healthcare and lower than average school readiness in children eligible for free school meals in Cumbria and Lancashire.
- Influence the local integration of funding to re-assign resource to population health and prevention to reduce the demand for urgent, acute and expensive healthcare.
- Emphasise the value of CVSFE and advocate for the need to increase and sustain financial support through a commissioning model that supports collaboration and sustainability.

Strategic alignment and accountability

The Commission is asked to:

- Provide the mandate and sense of urgency to develop integrated plans to reduce health inequalities. These plans will be complex, working across system, place and neighbourhoods. Ensure that the process of developing these raises the priority of health inequalities, improves relationships and creates a sense of shared ownership.
- Acknowledge the system and transformational leadership required to address Health Inequalities as a whole system across our complex organisational and geographical landscape.
- Identify the over-arching shared priorities and outcome measures across the life-course and the three spheres of prevention.
- Describe evidence-based interventions that can be implemented at system, place and neighbourhood.
- Outline which partnership is best placed to drive it forward: Integrated Care Board/integrated care partnership/provider collaborative/health and wellbeing boards/strategic thematic partnerships/place-based partnerships/PCNs/ICCs.

- Agree on a structure of true accountability for the delivery of the statutory duty of reducing health inequalities, so that it is of equivalent importance to maintaining financial balance. Ensure that this system includes genuine and robust accountability to local communities.
- Provide a set of tools to facilitate the consideration of health inequalities in every partnership, workstream, organisation, staff team and community. These tools will be agreed across the system to enable a shared approach to integrating action on health inequalities into every decision that is taken regarding. These tools will support joint decision making across the system.

Geography

The Commission is asked to:

- Provide guidance on how to work differently across two County Councils, specifically in relation to local authorities and health services agreeing a coterminous footprint to work within for children and maternity services.

Data

The Commission is asked to:

- Acknowledge the importance of data as an enabler in creating a moral duty and sense of urgency to address health inequalities. This includes both qualitative and quantitative date, with qualitative data being essential to understand lived experience and consider what will work best for local communities.
- Ensure that routine data collection must make explicit the differential impact of service delivery on access, experience and outcomes across different communities at a neighbourhood level.
- Facilitate the development of integrated data sets across organisations to enable an understanding of the spectrum of health inequalities, whilst also reducing the duplication of multiple services/organisations undertaking the same analysis.
- Prioritise the need for research and evaluation, emphasising the importance of considering the gradient of inequality when evaluating action. Research and evaluation should make explicit the impact on different communities and any contribution to narrowing health inequalities.
- Develop an infographic that contains the important messages regarding health inequality and local action, to create a consistent and simple message to promote the importance of addressing health inequalities.

Community engagement

The Commission is asked to:

- Provide guidance on how to include and support people with lived experience and members of local communities onto strategic decision-making partnerships. Build the understanding of how these meetings need to adapt to ensure that the essence of the community voice is maintained, rather than 'institutionalising' them.

- Advocate for trust in hyper-local action by involving the community in strategic planning and delivery at a local level.

Evidence and co-benefits

The Commission is asked to:

- Provide evidence on 'how' to make a difference to health inequalities by outlining what works to specifically support people living in more disadvantaged areas, from different ethnicities and other communities that experience inequalities.
- Provide the evidence of what works in relation to achieving proportionate universalism, taking a neuroscience informed approach to child development and integrated action to prioritise and support good cognitive, linguistic and social development.
- Focus on the co-benefits by emphasising the shared benefits of reducing health inequalities on the local economy, recovery and resilience and very importantly climate change.
- Advocate that all action is based on a culture of kindness, supporting staff to make a difference but providing rest, care and compassion.
- Propose realistic timelines for action, outcomes and evaluation and advocate to funders that funding duration reflect these as a minimum.

Anchor institutions, local businesses and the economy.

The Commission is asked to:

- Emphasise the importance of partner organisations behaving as exemplar employers providing sustainable and ethical local assets, achieving net zero, paying the living wage, ensuring opportunities for young people and employing people with long term conditions.

2. Introduction

This document provides a summary of the evidence for the Health Equity Commission. A local steering group was established to oversee the process and multiple local partnerships and organisations have contributed to this document. The document provides feedback to the questions posed by the Institute of Health Equity:

Identify the key health inequalities in your area. What would you like to emphasise or highlight?

What are your localities priorities to reduce health inequalities?

What are your area's priorities to reduce health inequalities?

Tell us about work/projects/strategies in your area that have had the most positive impacts on health inequalities?

What support do you need to make a step change in addressing health inequalities?

How would you strengthen local partnerships with stakeholders who impact on health in our region eg. business, community groups, public services and local authorities?

What barriers have prevented you from making a difference in your area?

How can we make health inequalities our number 1 priority?

Section three provides some background information regarding Bay Health and Care Partners to provide some context to the Place Based Partnership. Section four outlines the key health inequalities in Morecambe Bay, providing a summary of social and health inequalities. Section five outlines the local priorities to address health inequalities and section six describes some examples of local action. Section seven outlines the support that is needed to make a step change in local action and section eight considers how local partnerships can be strengthened. Section nine discusses the local barriers to action and section ten outlines the support required from the HEC.

3. Background

3.1 Bay Health and Care Partners (Morecambe Bay Place Based Partnership).

Bay Health and Care Partners (BHCP) Placed-Based Partnership (formally Integrated Care Partnership or ICP) brings together local NHS organisations, councils and voluntary, community, faith and social enterprise (VCFSE) organisations. It aims to ensure the voices of people living in Morecambe Bay are at the heart of decision making to ensure the right health, social care and public health services are built for the future.

BHCP is focused on integrating care and addressing health inequalities for people and communities across Morecambe Bay. The partnership aims to improve outcomes and quality of care by delivering services more sustainably through joint resources including staff, services and money.

Bay Health and Care Partners is made up of a range of local health and social care services working together across North Lancashire, South Cumbria and Furness. The Partners are:

- University Hospitals of Morecambe Bay NHS Foundation Trust
- NHS Morecambe Bay Clinical Commissioning Group (CCG)
- Lancashire and South Cumbria NHS Foundation Trust
- Morecambe Bay Primary Care Collaborative
- Cumbria County Council
- Lancashire County Council

- Lancaster City Council
- Barrow Borough Council
- South Lakeland District Council
- Lancaster Council for Voluntary Service (CVS)
- Cumbria Council for Voluntary Service (CVS)

In addition, the following organisations work closely with Bay Health and Care Partners:

- North Cumbria Integrated Care NHS Foundation Trust
- North West Ambulance Service NHS Trust

3.2 The geography Morecambe Bay.

The geography of Morecambe Bay encompasses the districts of Barrow-in Furness, Lancaster and South Lakeland. The flow of the population around the edges of Morecambe Bay means that the Bay also encompasses parts of Copeland district (i.e. Millom and surrounding area) and some of Craven (i.e. Bentham and Ingleton). Morecambe Bay contains the city of Lancaster, large towns including Morecambe, Barrow-in-Furness and Kendal, and then a range of smaller towns, villages and many hamlets in rural parts of the Lancashire and South Lakeland areas.

Figure 1. Map showing the boundaries of Morecambe Bay

Although Morecambe Bay covers a large geographical area the population largely (approximately 62%) resides in the larger towns of Morecambe, Kendal, Ulverston and Lancaster city itself; a further 22% are living in smaller towns and the remaining 16% scattered across the more rural areas.

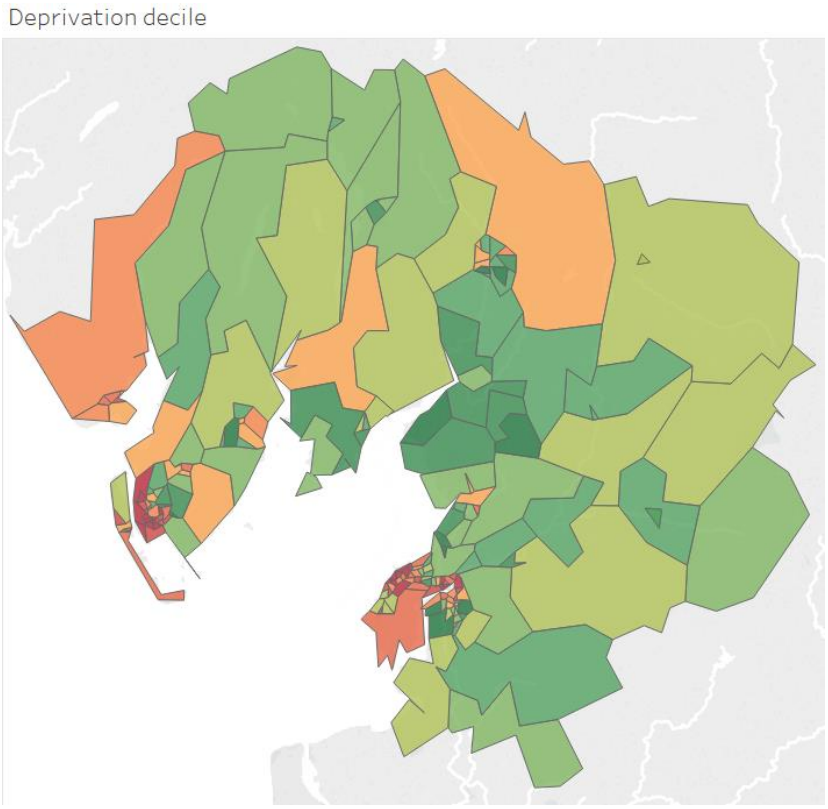
Morecambe Bay covers a total area of 310 square kilometres and much of the area is challenged by its rurality and poor transport links. The distances across the Bay and the spread of healthcare

services across the three localities are challenging. Morecambe Bay is dissected by the M6, a main tourist route into the Lake District national park and surrounding areas.

Morecambe Bay is within the top 30 CCGs nationally for population size and the square miles coverage. When working within the Place Based Partnership and wider Integrated Care Partnership of Lancashire and South Cumbria, the Bay needs to consider the challenges of a large geographical footprint with relatively low population density with a combination of urban, rural and coastal communities. A recent visit from the Chief Medical Officer highlighted the health challenges of coastal communities, with Morecambe being included in the report but with parallel challenges in Barrow-in-Furness (Appendix 1). When seeking to create and sustain effective and efficient services and partnerships, the ICP and specifically the Bay requires a different response than if there was a population dense system.

Morecambe Bay has two main areas of disadvantage clustered around Barrow-in-Furness and Morecambe (as illustrated in Fig. 2). The data showing local health inequalities in Section four will highlight that these same areas experience some of the poorest health outcomes. However, it is important to note that South Lakeland, although relatively less disadvantaged, also has areas and groups of people that experience disadvantage and challenge associated with rurality, including poverty and housing. These areas have been severely impacted by COVID-19.

Figure 2. Deprivation (IMD2019) in Morecambe Bay at ward level.



3.3 Bay Health and Care Partners Population Health Team

BHCP identified population health as a priority some years ago, recognising that it is only by focusing on health inequalities, prevention and early intervention that the local health and care system can become sustainable. As part of this approach, BHCP has spear-headed a different way of working including establishing Integrated Care Communities and appointing a clinical lead for Population Health.

This involved support for the establishment of the Morecambe Bay Poverty Truth Commission (http://www.morecambebaypovertytruthcommission.org.uk/) and the promotion of the Art of Hosting approach to facilitate conversations with our local communities. Further details of the training provided to local community groups and individuals and community conversations held can be found at http://lovemorecambebay.co.uk/.

Subsequently, a small Population Health Team was established to support specific projects and to working in partnership with key stakeholders and local communities across Morecambe Bay to improve the health of the population and to tackle health inequalities. The BHCP Population Health Strategic Group has oversight of the range of work delivered by multiple partners across the local system. The Strategic Group is accountable to BHCP Leadership Team and has close links with district Health and Wellbeing Partnerships. At a neighbourhood level, Integrated Care Communities (ICCs) and Primary Care Networks are the delivery agents for population health and action on health inequalities, with links into.

In March 2021, BHCP Leadership Team approved a 'COVID-19 Phase Three Recovery Strategy for Health Inequalities (21-23)' (Appendix 2), which sets outs BHCP's response to the planning guidance in relation to health inequalities. This highlights the level of local inequality in healthcare, which is particularly relevant given the need to recover from the impact of COVID-19. The ambition is to develop a full PBP plan to reducing health inequalities from 2024.

3.4 Integrated Care Communities (ICCs).

BHCP established ICCs to work in close partnership with the VCSFE sector and local communities promote and develop a population health approach on the ground. ICCs are made up of teams of health and care workers, voluntary organisations and wider partners who are working together to improve physical and mental health outcomes, promote wellbeing, reduce health inequalities and focus on wider determinants of health across the population in Morecambe Bay. The focus of ICCs is to ensure that people are supported to improve their own health and wellbeing and that when people are ill or need support, they receive the best possible joined-up care. The ICCs empower people to take an active role in their health and wellbeing and support them to manage their conditions at home.

In Morecambe Bay there are eight ICCs which have been created to help bring together local health and care organisations. These are Barrow and Millom, Bay (covering Heysham and Morecambe), Carnforth, East (covering Bentham, Kirkby Lonsdale and Sedbergh), Grange and Lakes (covering Ambleside, Grange-over-Sands and Windermere), Kendal, Lancaster and Mid Furness. Each ICC employs both a Clinical Lead and a Development Lead.

Fig 3. Map of ICCs in Morecambe Bay.

ICCs have been instrumental in developing local partnerships, some consisting of over 100 organisations, to support the local community. They work very closely across public, private and CVFSE organisations to share information, identify priorities, have conversations with communities and develop locally-led interventions to reduce health inequalities.

The ICCs are broadly co-terminus with the newer Primary Care Network (PCN) footprints, with some exceptions. PCNs are the building blocks for the delivery of the NHS Long Term Plan and have responsibilities in relation to reducing health inequalities as part of a Direct Enhanced Service. BHCP are working with PCNs and ICCs to maximise delivery to provide integration at a neighbourhood level and work with communities to improve health outcomes.

3.5 Primary Care Networks

The eight PCNs in Morecambe Bay were established in July 2019. They are Barrow and Millom PCN, Bay PCN (covering Heysham and Morecambe), Carnforth and Milnthorpe PCN, Grange and Lakes PCN (covering Ambleside, Grange-over-Sands and Windermere), Kendal PCN, Lancaster PCN, Mid Furness PCN and Western Dales PCN (covering Bentham, Kirkby Lonsdale and Sedbergh). The footprints of the PCNs are broadly co-terminus with those of the previously established Integrated Care Communities, although the Carnforth and Milnthorpe PCN overlaps with East ICC and the majority of the area covered by East ICC (excluding Milnthorpe and surrounds) is covered by the Western Dales PCN.

The majority of PCNs across Morecambe Bay have recently been involved in an NHSE/Morecambe Bay CCG funded project to engage with local people who experience poorer health outcomes to identify their priorities and to work towards co-producing solutions with key stakeholders. Cohorts selected by PCNs – with the support of ICCs - included adults with learning disabilities living in the

community, young people aged 16-24, migrant workers working in the hospitality industry, rural communities experiencing poverty and members of disadvantaged communities at risk of identified ill-health issues (e.g. depression, obesity etc.).

Work has also been undertaken – as part of a wider piece of work at ICS level - to map data about deprivation and ethnicity against PCNs. The results by PCN are shown in the figures below. The PCNs with the greatest percentage of their population in the first quintile of the Indices of Multiple Deprivation (IMD) are Barrow and Millom PCN, Bay PCN (covering Morecambe and Heysham) and Lancaster PCN. Western Dales is the PCN with the least disadvantaged population in the whole ICS footprint when considering the first quintile of IMD. However, local intelligence shows that it – like many areas in rural South Lakeland - has local pockets of disadvantage which can be hidden when considering a less granular dataset. Further work is currently underway to map the seven underlying domains of the Index of Multiple Deprivation against PCNs and it is anticipated that this will provide further insights.

A figure showing ethnicity (i.e. percentage of population who are not classified as White British to allow the inclusion of the Gypsy Roma Traveller Community (where identified) and other White non-British Groups). The ethnicity data is based on a limited dataset sourced from the GP Patient Survey July 2020 and must be interpreted with caution.

Figure 4. Indices of Multiple Deprivation (IMD 2019) by Primary Care Network (PCN) in Morecambe Bay showing the percentage of the population in the 1st quintile (20% most disadvantaged).

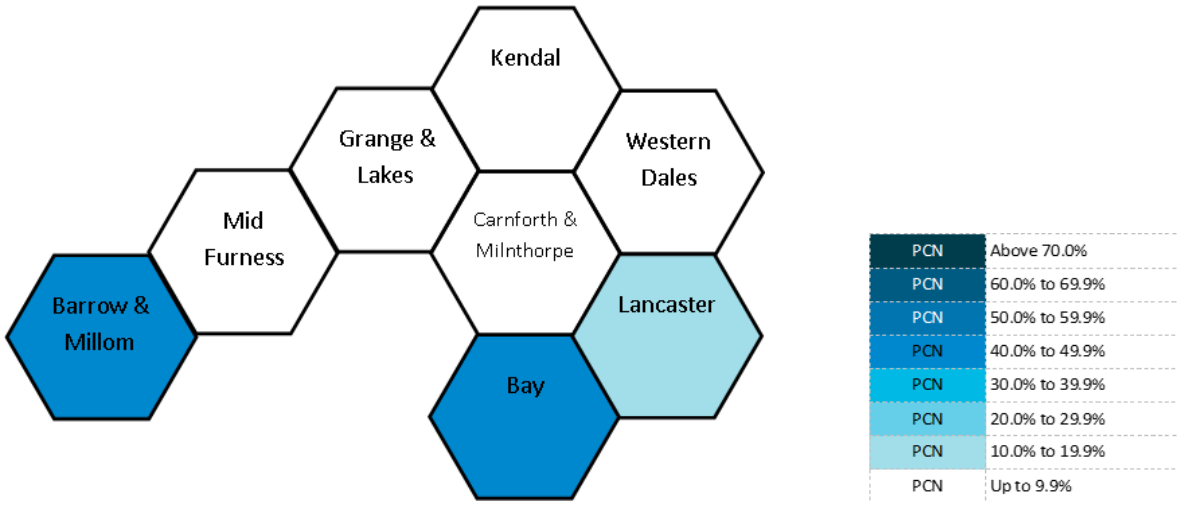
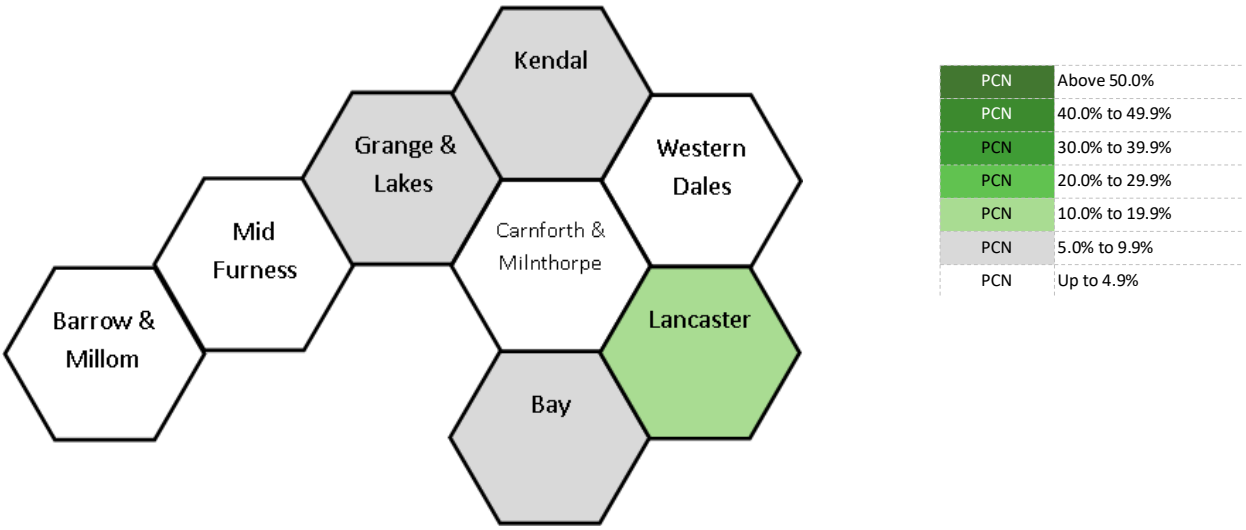


Figure 5. Ethnicity (% of population who are not classified as White British) by Primary Care Network (PCN) in Morecambe Bay.



3.6 Local process for HEC evidence collation.

A Morecambe Bay Health Equity Commission Steering Group was established to oversee the collation of the evidence for the submission. Invites were extended to members of the Population Health Strategy Group and other colleagues who expressed an interest in the process. The questions were shared with a range of partnerships across Morecambe Bay to get feedback, including:

- District Health and Wellbeing Boards
- Local Resilience Forums
- Integrated Care Communities
- Community Voluntary Sector
- Integrated Care Partnerships

Partnerships were asked to focus on how integration can improve local action to reduce health inequalities, with a focus on:

- social inequalities that drive health inequalities, such as poverty, education and housing,
- inequalities in risk factors, such as obesity and tobacco use
- inequalities in healthcare access and outcomes.

Partnerships were also asked to consider the life-course when responding to the questions.

The responses were compiled and analysed for themes, which are reflected in the evidence below.

4. The local picture of health inequalities.

This section reflects on the data received from IHE and expands upon this to illustrate the local understanding of inequalities. This builds upon a Morecambe Bay needs assessment, which was undertaken in 2019 (Appendix 3).

4.1 Institute for Health Equity Data-pack.

4.1.1 Life expectancy.

BHCP is familiar with the inequalities in life expectancy across Morecambe Bay and the aim of the Population Health Approach is to reduce the gap in life expectancy across Morecambe Bay by 50%. It is notable that in Barrow-in-Furness, only a minority of wards have a life expectancy that exceeds that of the national average. The 12 years difference in life expectancy between the most disadvantaged and least disadvantaged wards in Lancaster and Barrow-in-Furness is a sobering statistic. However, it is positive to note that the inequality experienced by people living in South Lakeland and Cumbria as a whole is smaller to that experienced in areas elsewhere within the ICP.

BHCP have additional insight into the inequalities between district areas in Morecambe Bay. Figures 6 and 7 highlight the inequalities in life expectancy experienced by people living along the 555 and X6 bus routes in Morecambe Bay.

Figure 6. Inequalities in life expectancy along the 555 bus route from Lancaster to Grasmere (compiled 2019)

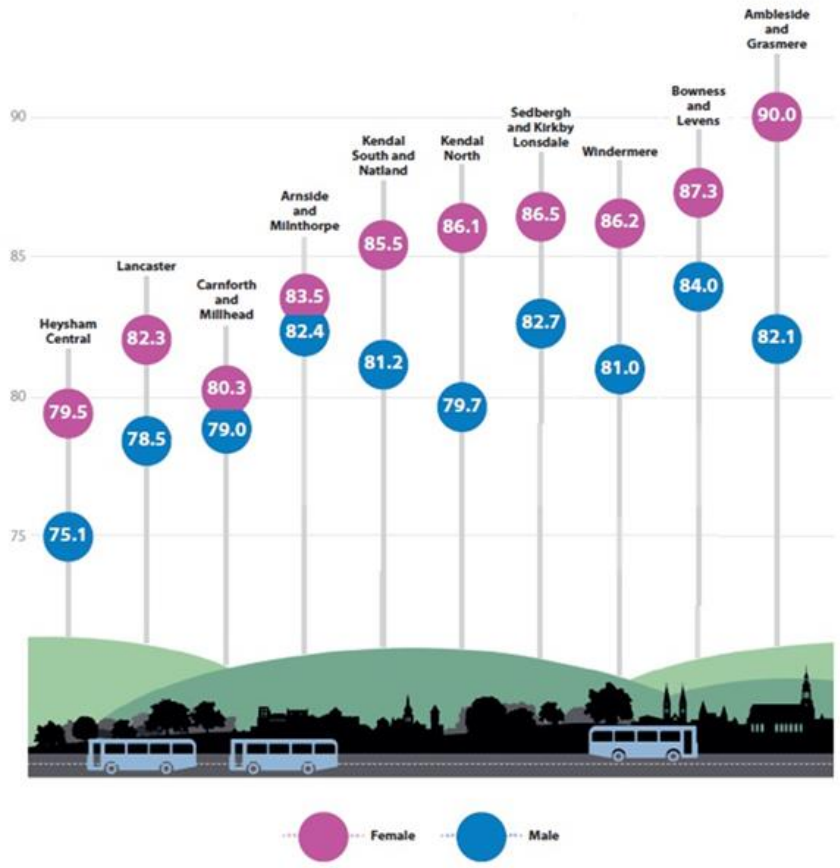
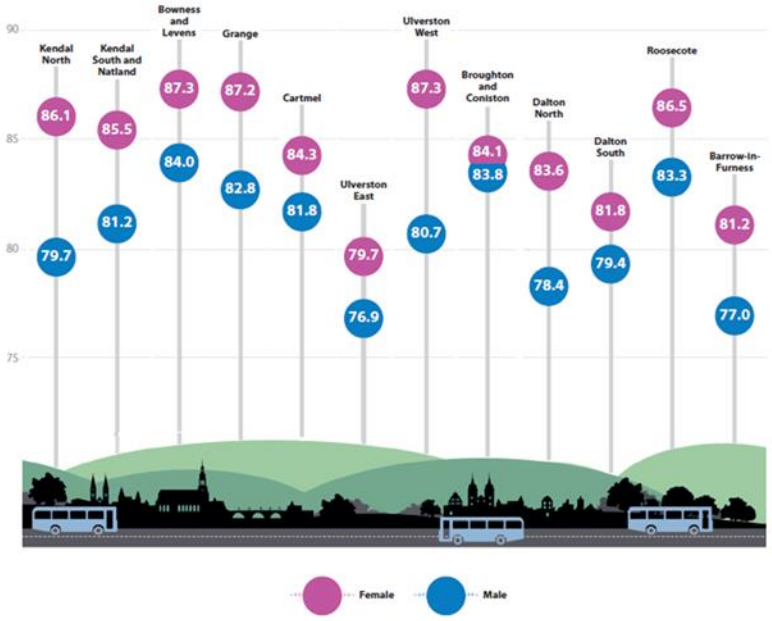


Figure 7 Inequalities in life expectancy along the X6 bus route from Kendal to Barrow (compiled 2019)

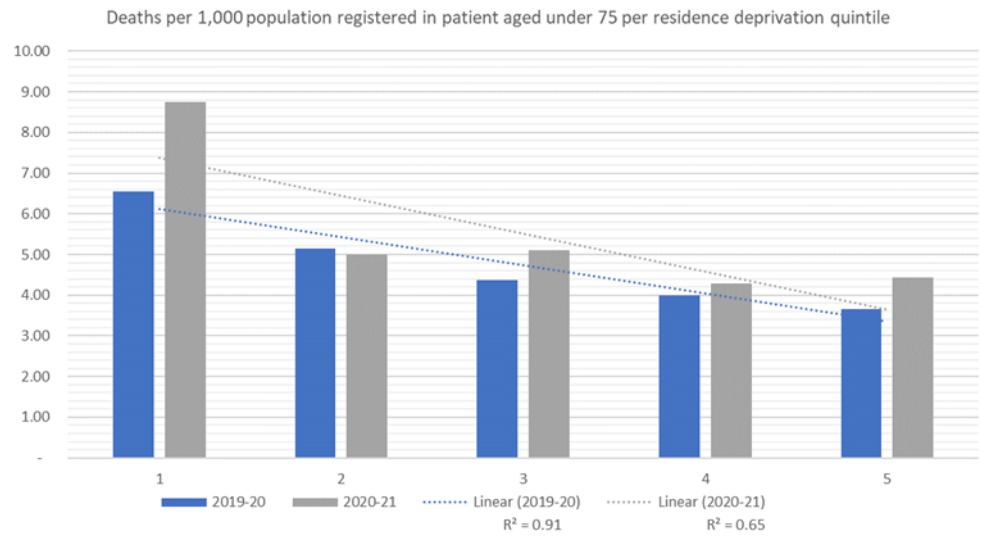


4.1.2 COVID-19.

Nationally and locally, the most disadvantaged communities have been disproportionately affected by COVID-19, with rates of infection and sadly mortality being higher in the communities with the highest levels of Index of Multiple Deprivation. Barrow-in-Furness has been particularly affected by mortality due to COVID-19, and this is likely to be associated with existing higher levels of morbidity associated with deprivation and disadvantage.

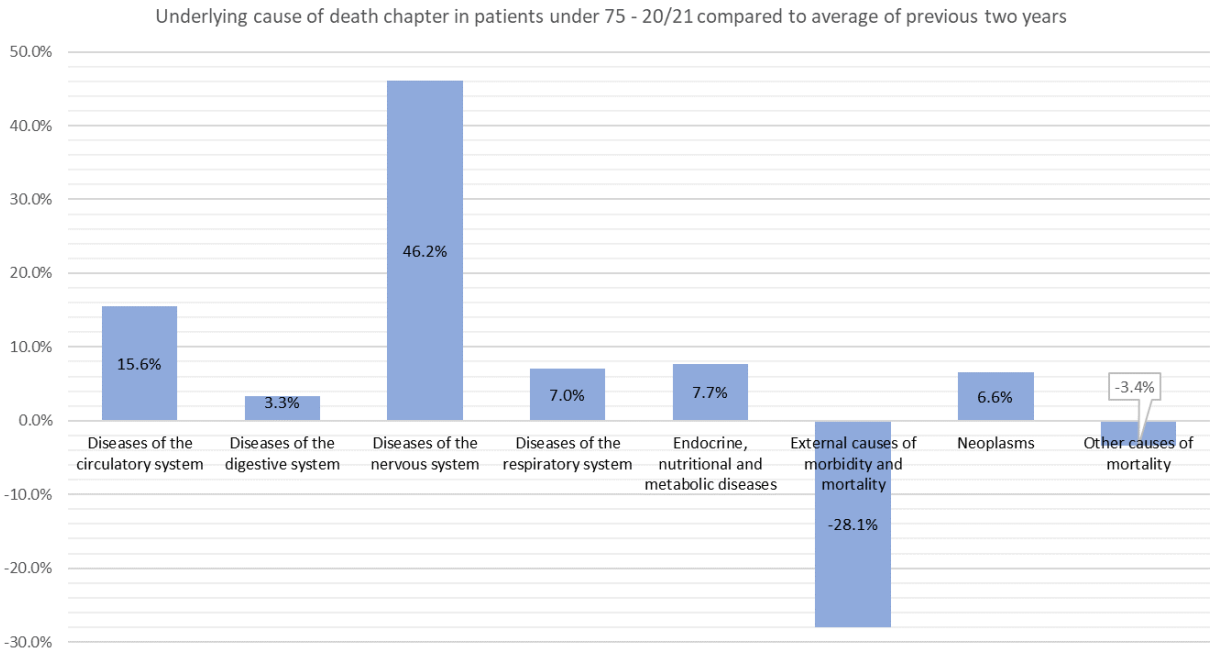
BHCP have undertaken local analysis to explore the impact of COVID-19 on premature mortality and health inequalities. This analysis has shown that there were existing inequalities in premature mortality in Morecambe Bay, with the most disadvantaged communities having the highest rates of mortality, but also that the inequality in premature mortality has widened during the pandemic, with the mortality rate in the most disadvantaged communities increasing more than that in the least disadvantaged communities (fig. 8).

Figure 8 Deaths per 1000 registered population aged under 75 by deprivation quintile



The large proportion of this premature mortality was directly due to COVID-19 but mortality was also due to other causes (Fig 9). The increase in mortality due to the nervous system was largest, but the number of patients within this category was small. What is notable is the reduction in external causes of mortality, which is an area in Morecambe Bay where we know that there are inequalities.

Figure 9 Underlying cause of death chapter in patients under 75 years.



4.1.3 Health

This data will be expanded upon in section 4.2. However, the notable points are:

- Pre-term births and low birth weight of term babies are highest in Lancaster, and higher than the national average. The widest inequalities in low birth weight is in South Lakeland, with a 11% gap in the pooled percentage between Kendal West and Bowness and Levens.
- All districts have lower than the national average rates of smoking during pregnancy.
- Emergency admissions for intentional self-harm are higher in Barrow-in-Furness compared to the other local districts and the national average. There is also a high level of inequality within Barrow-in-Furness, with a ratio of 79 in Roosecote and 465 in Hindpool. The rate of suicide in Barrow-in-Furness is approximately twice that of the national average. Ulverston East in South Lakeland has a high ratio compared to the rest of the South Lakeland wards.
- Barrow-in-Furness has higher levels of admissions caused by unintentional and deliberate injuries to children aged 0-14 and young people aged 15-25 years, compared to the national average. Lancaster and South Lakeland also have higher levels of admissions in children aged 0-14 years.

4.1.4 Give every child the best start in life.

Lancashire and Cumbria have a lower percentage of amongst children eligible free school meals and all other children ready for school, when compared to the national average and figures for Blackpool and Blackburn. There has been some improvement for Cumbria for pupils reaching the expected standard in Key Stage 2. It is notable that Cumbria has a high level of first-time entrants to the criminal justice system.

4.1.5 Enable all children, young people and adults to maximise their capabilities and have control over their lives.

Barrow-in-Furness and Lancaster have lower average attainment 8 score compared to the national average for children who are eligible for free school meals. In Lancaster, all other pupils achieve an attainment score similar to that of the national average, but in Barrow-in-Furness this attainment score is lower than the national average. Barrow-in-Furness also has higher levels of pupil absence. Lancaster and Barrow-in-Furness both have under 18s conceptions rates that are higher than the national average.

It is important to note the health inequalities experienced by the most vulnerable children in society, namely those with special educational needs and disabilities (SEND) and children looked after. A joint strategic needs assessment is underway for children with SEND, and there is a dedicated health partnership that aims to provide support to Children Looked After (Annual Report available in Appendix 4)

4.1.6 Create fair employment and good work for all.

Unemployment levels across Morecambe Bay are lower than the national average. Barrow-in-Furness has the highest gap in the employment rate between people with a long-term condition and the overall employment rate.

Although low unemployment is important, so too is the quality of work. The minimum income standard[1] developed by the Joseph Rowntree Association, calculates that the minimum income for a single person to meet basic needs is £20,400, which is higher than an income of £17,400 for someone working full-time on the National Living Wage. A couple with two children will need to earn £32,200 to achieve the minimum income standard, which will require both parents to work full-time, which is difficult to achieve due to the high costs of child-care.

South Lakeland, the least disadvantaged area in Morecambe Bay, has seen the highest furlough rate in the country, with over 20% of all eligible jobs subject to furlough. In addition, 49% of all eligible workers applied for the Self-Employment Income Support Scheme. South Lakeland has been greatly affected by the pandemic due to the district's reliance on hospitality and tourism.

4.1.7 Ensure a healthy standard of living for all.

1 in 7 children in Barrow-in-Furness live in absolute poverty (before housing costs) and this rises further when including housing costs. In Barrow-in-Furness, 31% of children are living in absolute poverty, 30% in Lancaster and 25% in South Lakeland.

The new Universal Credit value (with the removal of the £20) means that a family with two children will receive less than half the amount that they require to achieve the minimum standard[1]. Poor welfare and employment policies have meant that people living in Morecambe Bay are living in poverty and accumulating high levels of debt[2], which is having a negative impact on their mental and physical health (Appendix 5.)

Food bank utilisation indicates the level of food poverty in Morecambe Bay. Nationally and locally, demand for food banks increased during the first stage of the pandemic have decreased since Jan 2020. A local food bank in Lancaster is providing on average food to 900 people a month. Since January 2021, the food bank has provided food to 3,200 children and 5,500 adults; approximately 45% of referrals made to the food back are for families in crisis.

There are two health partnerships across Morecambe Bay focussing on the health needs of the homeless and other vulnerable populations that experience health inequalities. This partnership has fed back that discharge pathways are well established, but there are inequalities in relation to mental health and substance misuse support, and poor access to dental, eye and foot care. Lower GP registration for the homeless population continues to produce health inequalities, although work is ongoing to address this.

4.1.8 Create and develop healthy and sustainable places and communities.

People living in South Lakeland experience lower levels of loneliness and violent offences compared to the national average and the other districts. South Lakeland has the longest distance to travel to reach a park or green space, and all areas have lower levels of sustainable travel compared to the national average.

[1] A Minimum Income Standard for the United Kingdom in 2021 | JRF

[2] http://www.northlancashirecab.org.uk/Docs/An%20Income%20To%20Live%20By%202021.pdf

All districts in Morecambe Bay have a higher percentage of households that experience fuel poverty compared to the national average. In South Lakeland, there are 10,360 dwellings with category 1 hazards (HHSRS) in the private housing sector, half of which are due to excess cold, which is significantly higher than the national average. There are 9,948 (24.9%) households in the private sector in fuel poverty (above the national average of 21%). There are significant numbers of hard-to-treat solid wall pre-1919 dwellings and off mains gas dwellings. 16.4% of the District's housing stock is in the lowest energy performance certificate (EPC) bands (F and G). There are 6,123 households in fuel poverty in South Lakeland.

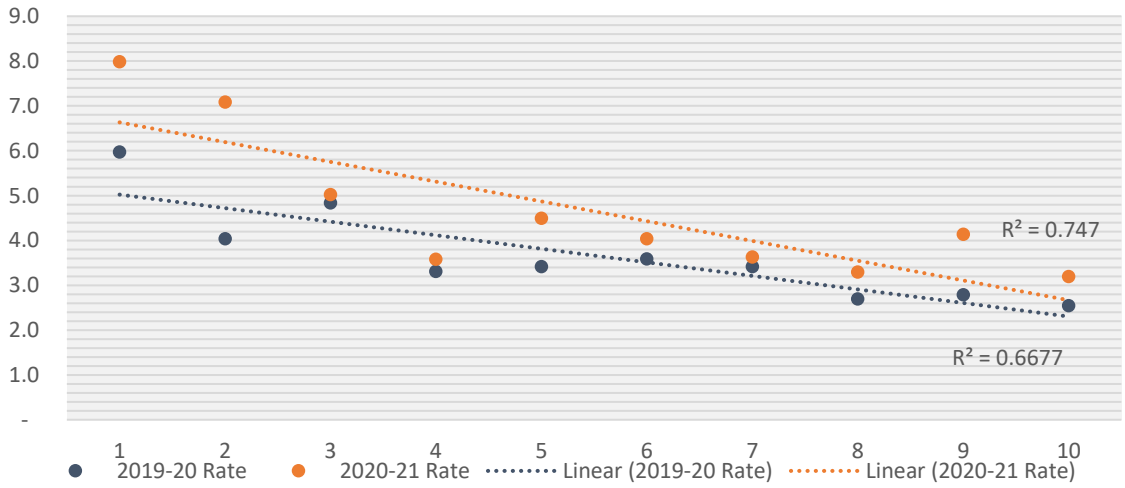
4.2 Local inequalities in healthcare.

COVID-19 has increased the focus on health inequalities in healthcare, with a requirement to consider inequalities when recovering services and to reduce inequalities in outcomes, access and experience. The following data outlines local healthcare inequalities in Morecambe Bay.

4.2.1 Inequalities in outcomes.

Fig. 10 shows the rate of premature mortality (deaths in people aged under 75) across Morecambe Bay and how this differs based on deprivation deciles. The important measures in relation to health inequalities are R^2, which gives a value of how much the outcome changes for each deprivation decile, and Slope Index of Inequality (SII), which shows the difference (gap) in the outcome between the least and most disadvantaged communities in Morecambe Bay. These measure of health inequality support prioritisation of work and provide a baseline from which to measure progress.

Figure 10 Premature mortality in Morecambe Bay (rate per 1000) by deprivation decile (2019-2021)

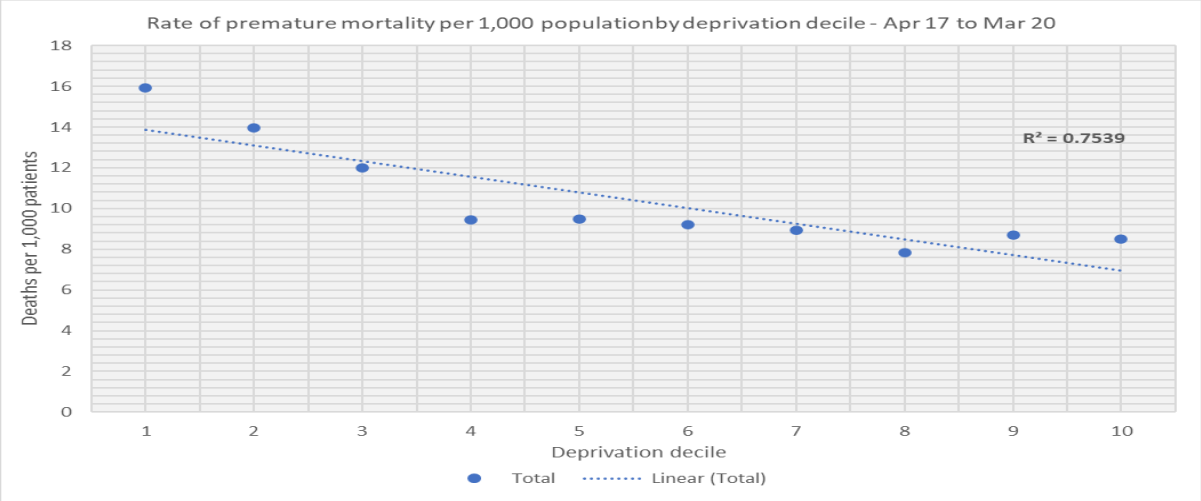


In 2019-20, the rate of premature mortality in Morecambe Bay was 3.7 per 1,000 compared to 4.6 per 1,000 in 2020-2021. R^2 increased showing that deprivation was a more important contributor to premature mortality. The SII increased from 2.7 per 1000 to 4.0 per 1000, indicating that there are an additional 4 deaths per 1000 population per year in Morecambe Bay's most disadvantaged communities compared to the least disadvantaged. This shows that the rate of premature mortality has increased during the COVID pandemic and that this increase has been higher in the most disadvantaged communities. The average rate of premature mortality across Morecambe Bay in

2020-21 was 4.6 per 1000. Comparing this to the difference (4.0 per 1000) between the most and least disadvantaged deciles illustrates the scale of local inequalities in premature mortality.

Fig. 11 shows the rate of premature mortality in Morecambe Bay during the last 3 years. The association with deprivation remains strong and there were an additional 7.4 deaths per 1000 in the most disadvantaged decile compared to the least disadvantaged.

Figure 11. Premature mortality in Morecambe Bay (rate per 1000) by deprivation decile (2017-2021)



The gap in premature mortality between the least and most disadvantaged has increased substantially since 2017-18, when it was 1.5 per 1000. A focus on halting this rate of increase is essential. If the rate of premature mortality in the three most disadvantaged deciles was reduced to the Morecambe Bay average (10.3 per 1,000), then over 110 premature deaths per year could be prevented across Morecambe Bay.

Fig. 12 illustrates the health conditions that cause the highest inequality in premature mortality in Morecambe Bay, namely respiratory disease, circulatory disease, cancer and external causes of morbidity and mortality (which includes intentional self-harm and drug-use).

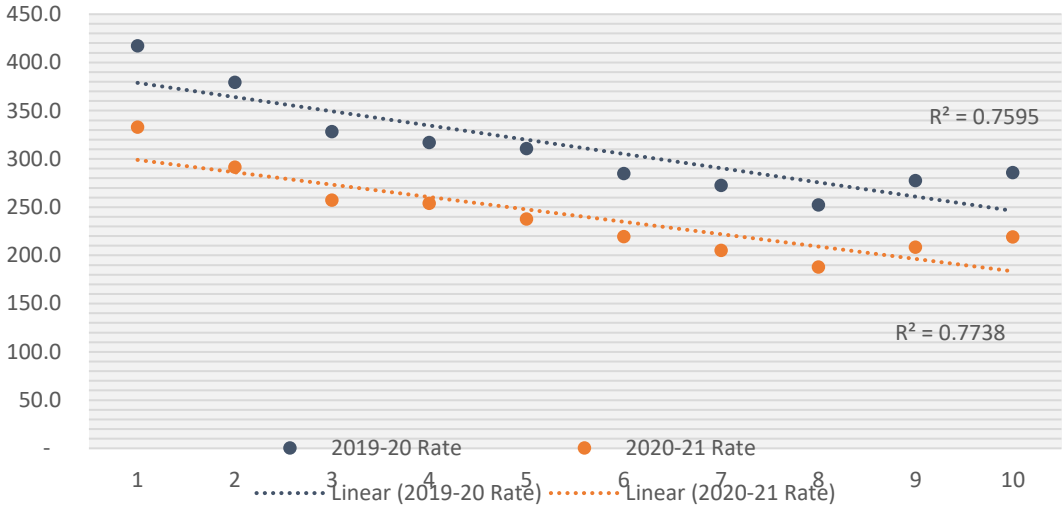
Figure 12. Inequalities in premature mortality by ICD10 chapter.

Underlying cause ICD10 Chapter	Trend	Difference in rate per 1,000 between most affluant and most deprived	R^2
Neoplasms		1.32	0.6239268
Diseases of the circulatory system		1.74	0.7004001
Diseases of the respiratory system		1.92	0.869789
Diseases of the digestive system		0.86	0.6321674
External causes of morbidity and mortality		1.27	0.718776
Diseases of the nervous system		-0.28	0.3272172
Endocrine, nutritional and metabolic diseases		0.24	0.5026179
Mental and behavioural disorders		0.03	0.0423061
Certain infectious and parasitic diseases		0.17	0.3426702

4.2.2 Inequalities in access to services.

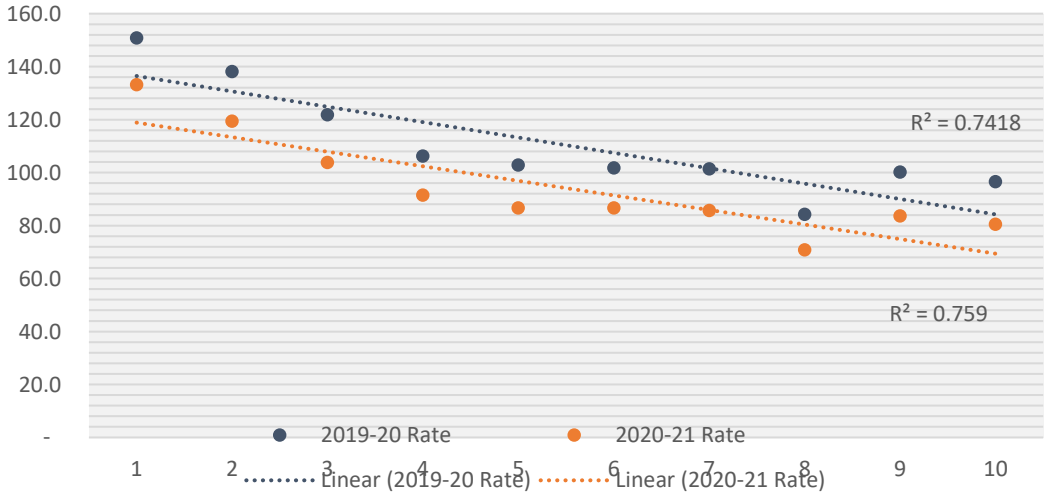
Figs. 13 and 14 show inequalities in access to urgent care, illustrating that patients living in the most disadvantaged decile attend A&E more often and have a higher rate of non-elective admissions.

Figure 13. Attendance at A&E across Morecambe Bay (rate per 1000) by deprivation decile (2019-2021)



In 2020-21, there were 417 A&E attendances per 1,000 in patients living in the most disadvantaged areas (decile 1) compared to 286 per 1,000 for those living in the least disadvantaged decile (decile 10). If the rate of A&E attendance in patients living in the areas that are 20% most disadvantaged was reduced to the Morecambe Bay average, then 6,000 A&E attendances could be avoided.

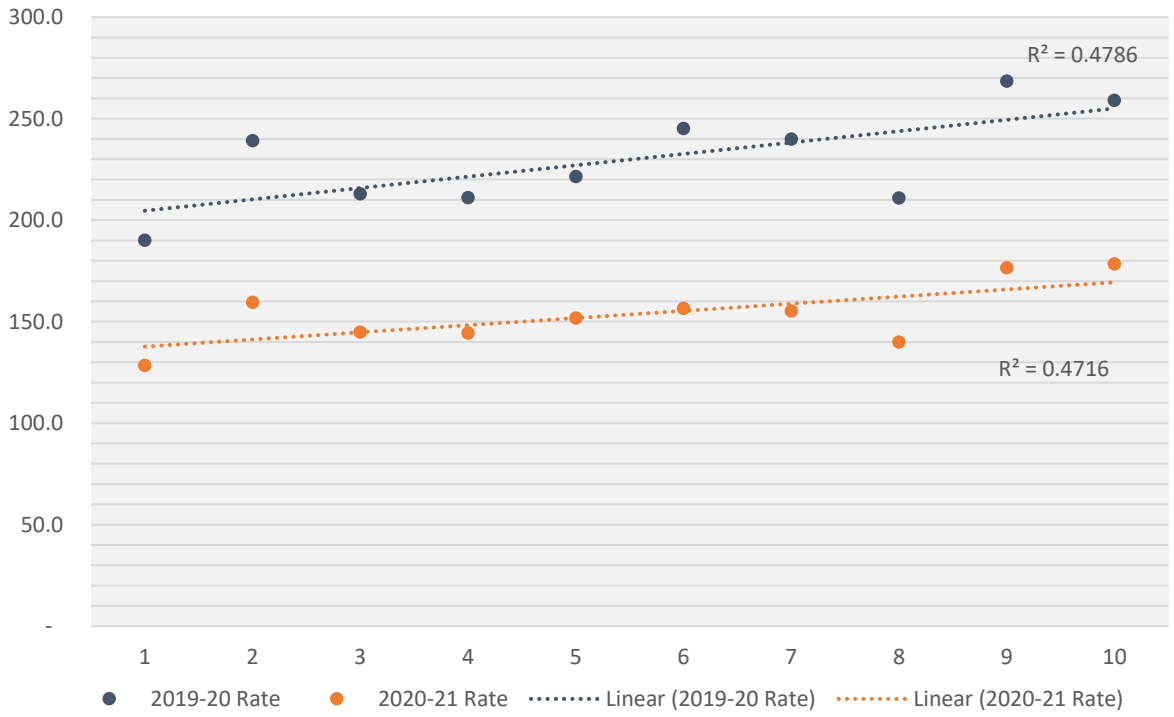
Figure 14. Non-elective admissions in Morecambe Bay (rate per 1000) by deprivation decile.



There were 151 emergency admissions per 1,000 people living in the most disadvantaged decile in 2019-20, compared to 97 per 1,000 in the most affluent decile. If the rate of emergency admissions in patients from the 30% most disadvantaged areas was reduced to the Morecambe Bay average, there is the potential to avoid over 2,700 emergency admissions per year. The conditions that saw highest inequalities (absolute gradient) in emergency admissions include diseases of childhood and neonates (even when weighting to population aged <19) and diseases of the respiratory system. Within diseases of childhood and neonates, the largest inequalities are seen in paediatric respiratory disorders, paediatric gastroenterology disorders and paediatric infectious diseases. Other conditions which saw high relative inequality include obstetrics and female reproductive system and assisted reproduction.

The inequality in elective admissions is shown in Fig. 15 and illustrates that the rate of admissions to elective care is lower in the most disadvantaged communities compared to the least disadvantaged.

Figure 15 Elective admissions (rate per 1000) in Morecambe Bay by deprivation decile.



Patients living in the most disadvantaged decile are less likely to have an elective admission (including daycase) than the Morecambe Bay average, with 190 elective admissions per 1,000 registered patients seen in 19-20, compared to 259 per 1,000 in the least disadvantaged decile. If patients living within the most disadvantaged decile were to have an elective admission rate similar to the Morecambe Bay average, there would be nearly 1,400 additional elective admissions amongst this cohort of the population (accounts for 11% of overall CCG population). Patients living in the most disadvantaged decile have the lowest elective admission rates for haematology, chemotherapy, radiotherapy & specialist palliative care category when compared to elective admissions in the least disadvantaged. The inequalities in elective care admissions are the opposite

to the inequalities in A&E attendance and non-elective admissions, indicating that patients living in the most disadvantaged communities are not receiving the care that they need.

The relationship between deprivation and the rate of attended outpatient appointments for Morecambe Bay patients is not a strong one. While those in the most disadvantaged 10% of areas have a lower rate than the Morecambe Bay average, those in the next disadvantaged 10% of areas have a higher rate than the average. However, there is a strong relationship with those in areas of higher deprivation attending fewer outpatient appointments in physiotherapy, audiology and oral surgery, while attending more appointments in paediatrics, midwife services and obstetrics.

Targeted proactive case finding, optimal management of conditions and pathway design with health inequalities at the fore will all contribute to a reduction in inequalities in elective and non-elective care by increasing support and access. This approach will also contribute to improved outcomes for the patients, which can contribute to reduced healthcare demand.

4.2.3 Inequalities in morbidity.

Working age adults in the 10% most disadvantaged areas have on average 0.61 long term conditions, while in the 10% least disadvantaged this reduces to 0.38. On average, patients living in the 30% most disadvantaged areas have more long-term conditions than the Morecambe Bay average. This is a similar pattern to that observed in premature mortality. If the average number of long-term conditions in patients living in the most disadvantaged areas could be reduced to the Morecambe Bay average, then there would be nearly 7,000 fewer long-term conditions. The prevalence of long-term conditions within these areas can be reduced by addressing social inequalities and reducing the prevalence of risk factors such as obesity, high alcohol consumption and tobacco use.

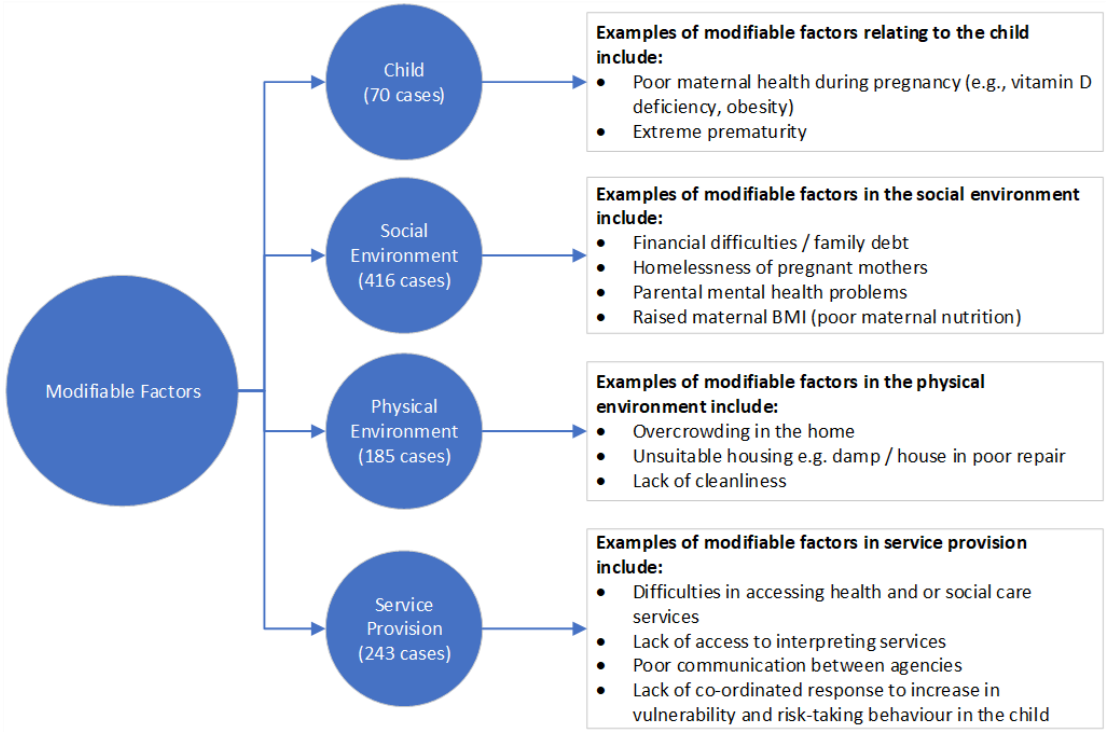
Depression is by far the most common long-term condition amongst this age group and also has the highest level of inequality. While COPD has much lower prevalence, it has a higher rate of relative inequality, with 24.4 patients in every 1,000 having this recorded in the most disadvantaged areas, and only 4.1 per 1,000 in the most affluent areas. Other long-term conditions with either absolute or relative inequality include mental health conditions, epilepsy, learning disability, diabetes and peripheral arterial disease

4.2.4 Inequalities experienced by children and young people.

Reducing health inequalities in children and young people is essential in supporting them to reach their potential to live a long and healthy life.

National research into inequalities in child mortality has shown that the rate of child mortality increases by 10% for every decile of deprivation. If these inequalities were removed, there is the potential to avoid 700 child deaths a year nationally. This research has shown that housing, service integration and communication, poverty and maternity factors, amongst others, contribute to child mortality (Fig. 16).

Figure 16. Modifiable factors contributing to child mortality (England, 2019-2020).



Locally, there are inequalities in access to maternity and paediatric services. Appointment rates for midwifery, obstetrics and paediatric services are higher in more disadvantaged communities. There are higher rates of non-elective admissions for paediatric respiratory, gastrointestinal and infectious diseases for children living in the most disadvantaged areas. The evidence illustrates how important maternal health, the first year of life and the first 1001 days are to child health outcomes[3]. Improving maternal outcomes, peri-natal mental health and reducing the risk of adverse child experiences should be priorities. A focus on maternity and early years to improve child outcomes is important.

At a national level, an area of notable health inequality is in childhood obesity, where young people aged under 18 years have a Body Mass Index of over 30. Given the disproportionate impact of COVID-19 on more disadvantaged communities, the mental health of children and young people should be a priority.

4.2.5 Summary of health inequalities by conditions with highest inequalities in premature mortality.

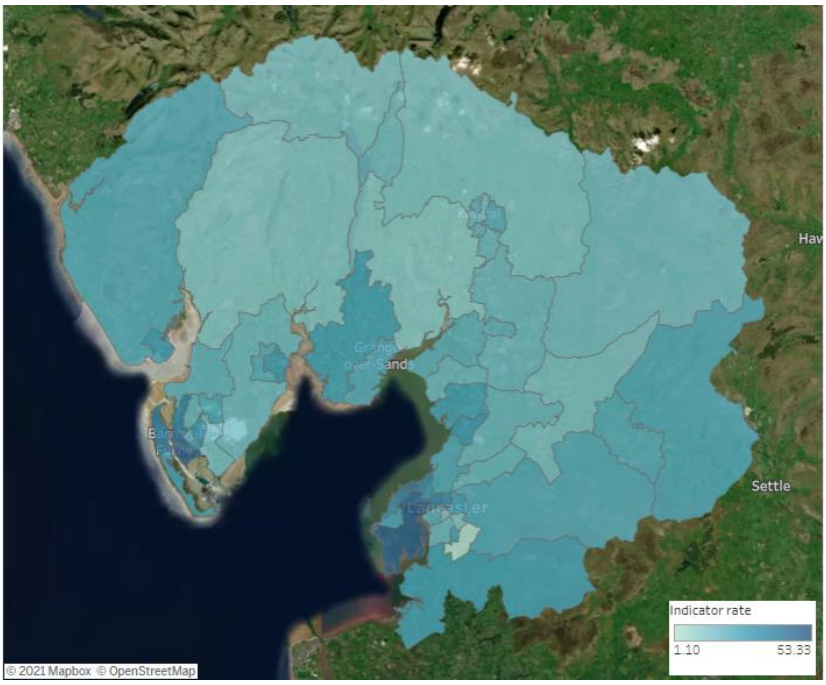
4.2.5.1 Respiratory

There is a higher rate of premature mortality caused by respiratory conditions in more disadvantaged areas than in more affluent areas. There is a high relative inequality for those who have COPD, and high emergency admission rates for respiratory diseases and paediatric respiratory diseases amongst patients from the more disadvantaged areas. Previous analysis also shows that

[3] https://www.parliament.uk/globalassets/documents/fair-society-healthy-lives-full-report.pdf

patients from more disadvantaged areas are less likely to receive their annual flu vaccination than those from more affluent areas. The map (Fig. 17) shows prevalence of COPD in Morecambe Bay patients by electoral ward. This shows that some of the priority wards for this condition are Barrow Island and Hindpool in Barrow-in-Furness, and Westgate and Overton near Heysham.

Figure 17 Map of prevalence (rate per 1,000) of COPD by ward in Morecambe Bay.



When comparing the prevalence rates for asthma, the priority wards appear to be Barrow Island, Westgate and Overton. The priority wards for when looking at respiratory and housing issues as an indicator are Barrow Island, Hindpool and Central (Barrow).

4.2.5.2 Circulatory disease

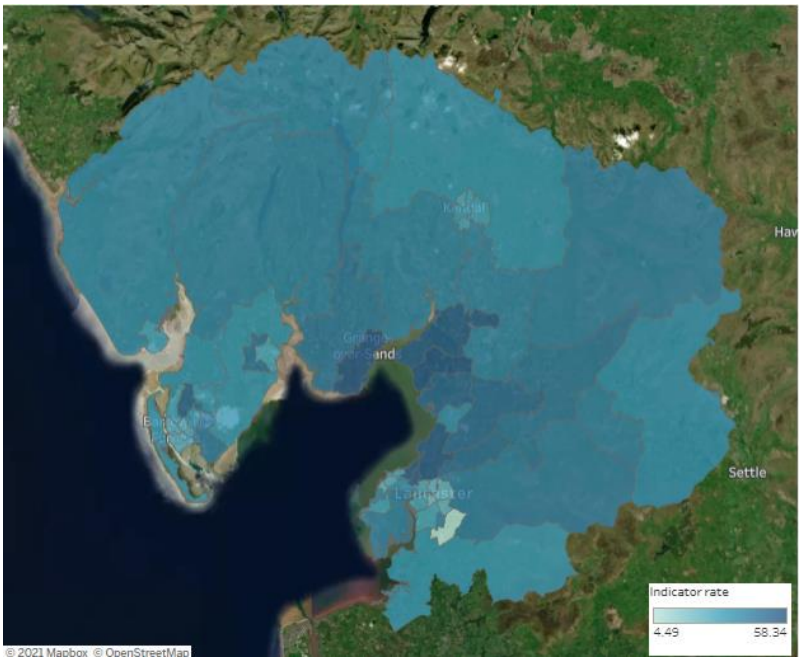
There is high inequality in premature mortality caused by circulatory diseases and also high levels of inequality for patients diagnosed with peripheral arterial disease and diabetes as well as higher risk factor rates such as diet, smoking and alcohol intake. Data collection regarding prevalence of risk factors can be improved, so it is difficult to draw conclusions locally. However, national data shows that risk factors increase with increasing deprivation. The electoral wards that have the highest rates of premature mortality caused by diseases of the circulatory system are Barrow Island and Hindpool and Central in Barrow-in-Furness, and Overton near Heysham. The greatest prevalence rates for diabetes are seen in Overton and Westgate, with the same two wards also being outliers for peripheral artery disease. The wards of Overton and Westgate also have comparatively high rates of hypertension amongst adults aged 19 to 64, as do Heysham Central and Heysham North.

4.2.5.3 Cancer

There are high levels of inequality in premature deaths due to cancer but there are much fewer elective admissions for haematology, chemotherapy, radiotherapy & specialist palliative care for

patients from more disadvantaged areas. Recorded diagnosis of cancer in primary care (Fig. 18) shows a positive correlation with deprivation (i.e. higher prevalence in more affluent areas), but premature mortality from neoplasms show a negative correlation.

Figure 18 Map of cancer prevalence (rate per 1000) in Morecambe Bay.



The electoral ward of Cartmel ward has the highest rate of premature mortality caused by neoplasms, with the next highest rates being seen in Westgate, Barrow Island, Carnforth & Millhead and Central (Barrow). However, while these wards have the highest rates of premature mortality caused by neoplasms, Table 1 suggests that these wards can rank relatively low for elective admissions for haematology, chemotherapy, radiotherapy & specialist palliative care

Table 1 Summary of inequalities in access and outcomes for cancer.

	CCG rank		
Ward	Premature mortality caused by neoplasms	Elective admissions for haem, chemo, radiotherapy & specialist palliative care	Ave deprivation decile (1 = most deprived, 10 = least deprived)
Cartmel	1	16	7
Westgate Ward	2	44	2.4
Barrow Island Ward	3	56	1.5
Carnforth & Millhead Ward	4	20	5.6
Central Ward	5	66	1

While all wards in Table 1 rank highly for premature mortality, it is clear that the wards with higher average deprivation rank lower for elective admissions in this area. Central (Barrow) as a ward has an average deprivation decile of 1, meaning this area is within the 10% most disadvantaged nationally, and the rate of elective admissions as a ward ranks 66 out of 70 (for Morecambe Bay), while having the 5th highest premature mortality rate.

4.2.6 External causes

There are high rates of premature deaths due to external causes (chiefly intentional self-harm and drug use) in patients from areas of high deprivation. There are also higher rates of depression and mental health issues from these patients living in the same areas. The wards with the highest rate of premature mortality due to external causes are Barrow Island, Cartmel, Hindpool and Furness Peninsula. The prevalence of recorded mental health conditions by ward shows particularly high rates in Poulton, Central (Barrow), Hindpool and Barrow Island.

4.2.7 Impact of COVID-19

Feedback from local partnerships paints a worrying picture in relation to health inequalities in the context of the pandemic. The lockdowns during 2020/21 exacerbated the pressure that local families were already experiencing in relation to the social inequalities that drive health inequalities. Job insecurity has increased, leading to an increase in access to food banks and applications for free school meals across Morecambe Bay. Families have become increasingly isolated, affecting mental health across the life-course. Drug and alcohol consumption have been heightened during the pandemic.

Local research by HealthWatch on the impact of coronavirus in Millom[4] has highlighted that the respondents were anxious for the future, often specifically around the economic impact of the lockdown and its ultimate negative affect on the UK population. Respondents raised concerns about the financial impact of job losses, being furloughed and the possibilities of losing a business or state benefits. The lockdown forced many households to spend significantly more time together than previously, which resulted with many struggling to maintain harmony within the household, especially those households with young children, or children who have learning difficulties and/or autism. But there were others who became hugely reliant on other people and lost their independence as a consequence of the lockdown. Furthermore, there was a rise (from the initial weeks) in the number of people reporting that they were finding it difficult to look after vulnerable individuals (including elderly relatives). In relation to the impact on the LGBTQ community, the research found that LGBT people were at more risk of abuse and discrimination than the general population and they were also more likely to report barriers to accessing healthcare. It found that many gender identity services had suspended their services and gender confirmation surgeries (which can involve a wait of many years) had been cancelled or postponed as a result of the pandemic. A report into the implications of Covid-19 for LGBTQ youth mental health and suicide prevention found that there were risks for some LGBTQ people who have been forced to quarantine with family members who may not be accepting of them. Being at home with family can also be difficult for people who have not yet come 'out'. These findings were supported by the research conducted by Lancashire LGBT. Calls to the UK LGBTQ+ helpline 'Switchboard' had increased by 20% over the lockdown period.

Children living in the most disadvantaged areas are more likely to have experienced infection and sadly bereavement of a family member or friend due to the high case and mortality figures. A

[4] https://healthwatchcumbria.co.uk/wp-content/uploads/2020/10/The-impact-of-the-coronavirus-on-Millom-August-2020-final-version.pdf

pattern of increasing mental health problems, substance misuse and self-harm in children and young people is becoming evident. Some families have 'hibernated' during lockdown with reduced physical activity and stimulation. Some schools provide low level support and there are waiting lists for children with more complex issues.

Education has been impacted, with children in the most disadvantaged areas being affected most. There are concerns for children who do not meet the threshold for an Education Health and Care Plan, or the Pupil Premium, but who are experiencing disadvantage and for whom there is insufficient funding to provide the needed additional support. A growing number of children have been withdrawn from mainstream education for Elective Home Education, in order to avoid penalties for non-attendance due to multiple COVID-related reasons.

The role of Adverse Childhood Experiences is well evidenced[5] and the experiences of the most vulnerable children in Morecambe Bay may have been exacerbated during the pandemic.

5. Locality/area priorities to reduce health inequalities.

This section describes the feedback from local partnerships in relation to local priorities.

5.1 All age population.

"Being 'healthy' isn't just about the absence of disease and longevity of life...art, beauty, spirituality, nature and community are part of what makes us human, supports purpose and keeps us alive. When people are struggling to feed themselves, how can they begin to consider these other needs and prioritise health?

There is a local emergency in that some adults and children don't have enough food to eat, enough money to heat their home, are living in unsuitable conditions or don't have a home at all. Basic need is not always being met and people die earlier than they would if things were different.

There is isolation and exclusion within our community and those who are already at risk of being marginalised are at a greater risk of isolation and loneliness - isolation is used as a punishment because it is effective at breaking people. Prioritising connection, belonging and growing this through communities maximising our local environmental, art and cultural and other community assets will help build an infrastructure that supports recovery from trauma, addiction, impact of isolation, can provide support to manage ongoing issues and improve quality of life.

There are multiple interventions to 'tackle' the symptoms of inequalities supporting management of conditions, raising awareness and early detection but there are societal and cultural barriers that can mean these interventions serve to fight fires that continue to be fuelled at source."

Source: Bay ICC

[5] https://www.sciencedirect.com/science/article/abs/pii/S1751722217302913

The data in Section 4 shows the scale of local health inequalities, and none of this data is new, there has been a modern awareness of health inequalities since the 1980s. The challenge is to take action to make a difference to the sobering data above. There is an awareness that reducing health inequalities is everyone's responsibility and therefore there are a raft of priorities across different organisations, different localities and different parts of the system.

Bay Health and Care Partners contribute to a range of cross-system strategies, including the Cumbria COVID Recovery Strategy, the Health and Wellbeing Strategy and the Joint Public Health Strategy. The actions and outcomes included in these strategies are summarised in Appendix 5.

In addition, there are local documents for Barrow-in-Furness and Morecambe that illustrate the local picture and the priority areas to address to reduce health inequalities (Appendix 6 and 7), and also data on the health needs of specific communities, such as the Gypsy, Roma and Traveller community (Appendix 8.)

The high-level priority for Bay Health and Care Partners is to reduce the gap in healthy life expectancy by 50% by 2029. Given the widening of inequalities in relation to premature mortality, there is also a system priority to reduce the rate of premature mortality in the most disadvantaged communities.

There are three key areas that will contribute to these priorities from a shorter-term healthcare perspective, which have been developed from the data above:

- Shifting the pattern of inequality present in non-elective and elective care, particularly focussing on the areas outlined in section 3.
- Taking a preventative approach to increase vaccination uptake, access to screening, health checks and public health services, particularly focussing on areas with highest premature mortality.
- Prioritising support to young people regarding healthcare in maternity and early years, weight management and mental health support.

Community engagement through community conversations, the Poverty Truth Commissions and the Morecambe Bay Curriculum will ensure that the needs of community are centre stage. Partnerships with organisations involved in authentic conversations with the public will ensure that the public are empowered to participate in local decisions, whilst supporting community development.

To protect the future health of generations, and improve outcomes for working age adults, strong partnership working with the public and private sector to progress Anchor Institutions is essential. A focus on providing well paid, high quality employment, staff health and wellbeing, local assets and sustainable organisations will support the local population to improve living standards and health outcomes.

Poverty is a major driver for health inequalities, leading to poor quality housing, poor diets and contributing to adverse child experiences. It can cause social isolation as people cannot afford to participate in social activities, and this can have a negative impact on mental health. A combination of poor health and poverty requires holistic support from Place Based Partnerships, to consider the

entire person and their environment as well as chronic and acute health events. Neighbourhood partnerships are essential to ensure holistic support for the people that need it the most.

5.2 Children and Young People

The first 1001 days are a pivotal time to provide support to achieve maximum benefit across the life-course. Children's experiences in pregnancy and the first two years of life influence their development, learning, earning, physical and mental health outcomes across their whole lives. There are many positive developments locally, but there is limited cohesiveness across the system on how each element fits together. There is a need for a clearer understanding of the accessibility and impact of services (maternity, health visiting, SLC, Children Centres) for the hardest to reach families. **'The best start for life: a vision for the 1,001 critical days'** starts with the needs of the baby and describes 6 action areas designed to help make things easier for parents and carers that need to applied across Morecambe Bay. Proportionate universalism should be used to develop a Child and Family hub to ensure that those that need support the most achieve it. An important step to achieving this will be a review of all commissioned services to understand reach and accessibility. It is important to note that recent reductions in the Public Health grant have reduced service delivery, but the local reorganisations for NHS and LA bodies may provide an opportunity to undertake this work as part of the change process.

Demand for mental health support has increased as a result of COVID. Anxiety continues to be the highest reason for referral to all services. Cases are becoming more complex with increases in other areas of need, for example levels of pupil de-motivation and emotional based school avoidance (EBSA), eating disorders/disordered eating. The increased demand is placing targeted and specialist mental health support services under increased pressure, which in turn is having a knock-on effect on early intervention services, resulting in those that need the service not receiving it and those children and families who struggle to access services withdrawing further. There is a need to support the early identification of children and young people who may be struggling but are identified under another heading ie. behaviour/SEND or are 'flying under the radar' due to inability to engage. All schools and colleges should have access to Mental Health Support Teams in schools. The national strategy is to achieve provision in 50% of school but feedback from schools and families shows that the whole school approach and ability to provide interventions in schools as well as supporting staff and families is working well. Collaboration with strategic education partnerships to support schools in providing support for children in relation to mental health and substance misuse, understanding the reasons for withdrawals for education and advocating for local assets to be developed to improve the experience of learning, for example Earnse Bay, will support early intervention. However, there needs to be an increase in capacity across the system to enable the prioritisation of prevention and early identification. The voice of children and their families need to be heard to understand the reasons why people are not accessing services, or disengaging, so that services can be delivered in ways the meet the greatest need.

The National Child Measurement Programme (NCMP) rates across Morecambe Bay are higher than the England average for both Reception and Year 6. There has not been a robust children's healthy

weight pathway in place for a significant number of years. The lack of a clear, needs led support offer has become more apparent through NCMP and latterly as a result of covid. Currently when a child is identified as overweight or very overweight, there is very limited evidence-based support available. NCMP rates link directly with poverty and deprivation and addressing this is dependent on a system wide and community approach to tackle health inequalities. A 'Think Family' needs led, strength-based approach, with a clear whole system pathway that incorporates Early Help, is needed to ensure that the wider needs of a family are identified and addressed to help them access the support offered. This can include providing support to families to access the local green and blue assets of Morecambe Bay.

6. Local action that has had an impact on health inequalities.

Below is a selection of case studies of work that has had an impact on health inequalities. This is not full list but a selection of projects that were shared as part of the evidence collation, which provide insight into the work underway across Morecambe Bay.

6.1 All age population

"In Bay ICC, we have made efforts to invest in local organisations that already work with our population outside of statutory services and promote community development. So far in 2021 through ICC & PCN collaborative investment £26,000.00 has been directly invested into local organisations. The funding panel comprised local groups and representatives from our community who were directly involved in decision making for this fund. 15 local organisations received small amounts of funding to deliver local support. Whilst this was a well-received initiative the value of funds requested via the applications was almost double the available fund and decision making was hard because almost every application demonstrated how they could support our population and strengthen the community. This fund is not enough to support the locality and funding again is short term. Monitoring for all 'projects' is very light touch as Bay wanted to ensure that the funds went on delivery and change not checking up that it is happening as there is local trust that the VCFSE know what they are doing and do it well.

This has some impact on the inequality between statutory and VCFSE sector as partners in delivering initiatives to improve health equity and has furthered a collaborative approach in our locality as it is a demonstration of local health partners confidence in and understanding of the vital importance of the VCFSE to make a positive and sustainable impact on reducing health inequalities. In some way however, this initiative furthers a power imbalance in terms of the fund holders and bidders, the haves and the have nots. "

Source: Bay ICC.

"The work of the Health and Wellbeing Partnership in using funds available to target support to meet local health inequality priorities. The group takes time to look at applications for funding and makes decisions based on local need, ensuring that funding is allocated to projects that will offer a range of benefits to all age ranges. This is an important group using local professionals to allocate support to local priorities. The local overview of the allocation of the funding ensures that available funds are used across the needs of the community and not just in one particular area. this approach takes away the funding decisions sometimes made by national charities / funding bodies to fund the shiny new projects, so supporting organisations to sustain locally important pieces of work which can demonstrate impact. More of this please."

Source: Furness Strategic Education Partnership.

"During the previous 18 months of the Covid 19 pandemic we have worked with a range of organisations including health, Barrow Borough Council, Cumbria County Council and third sector partners to develop and effective approach to support families and individuals adversely affected by the pandemic. We have been involved in a number of key strategies to develop appropriate services to meet the needs of the local community. From the beginning of the pandemic Bram Longstaffe Community Hub was the named Covid Resilience Hub for Barrow Island and Central wards. Throughout the pandemic we have supported families and individuals affected by food poverty though delivery of food parcels and hot daily meals to ensure families and individuals were able to feed themselves, through this service we were also able to support parents and individuals who were isolating with their mental health and some of these people were not seeing anybody and were extremely lonely. We have also supported individuals and families who were facing fuel poverty ensuring they were able to heat their property, through working with key partners such as the Well we were able to support individuals and parents that may have been affected by drug and alcohol problems. Due to the area that we work in which has a high percentage of high rise accommodation filled with families with young children which due to the pandemic had a negative effect on the mental health and social skills, we developed holiday programmes where these isolated and vulnerable children could attend free of charge a structured and fun programme where they could expand their social networks, build their confidence and receive a hot lunch."

Source: Bram Longstaffe Community Hub

Morecambe Bay Poverty Truth Commission began with a start-up group of locally interested people in the Lancaster City Council area the late autumn of 2016. A development worker was appointed in August 2017 with seed funding from the Joseph Rowntree Foundation and Seedbed.

Throughout the following year a group of local citizens with lived experience of poverty began to meet together and shared their stories with each other. They decided who from positions of civic leadership locally they would like to share their stories with and these were invited to the formal launch of the commission in July 2018.

Staff from Morecambe Bay CCG were involved in establishing the Morecambe Bay Poverty Truth Commission, contributed funding and attended to launch event. Several senior members of Bay Health and Care Partnership staff were invited to serve as civic commissioners in the first round.

Further details of the development of the Morecambe Bay Poverty Truth Commission can be found at here and a report on reflections and learning from the first round of the Poverty Truth Commission can be found at here.

Morecambe Bay CCG has recently provided additional funding through its Population Health Innovation Fund (PHIF) to employ a development worker for round two of the Morecambe Bay Poverty Truth Commission.

This next round of work - building on a successful first round that has brought about system change in the district – will ensure that people with lived experience of poverty are involved in policy, pathways and service development to support increased awareness of the impact of poverty. It will also help ensure that the impact of the first round is continued and to further develop new roles to support the most vulnerable in our community.

The need to include the voice of lived experience and the Poverty Truth Commissions key theme "Nothing about us, without us, is for us" is one of the central planks of the population health approach developed and adopted by Bay Health and Care Partners.

Source: Population Health Strategy Group.

"We are moving, all the time, towards listening to people as much as we can, and ensuring that we are providing services that are designed or influenced by people with lived experience. The Poverty Truth Commission (MBPTC) has had a huge impact on the way in which many services have developed in this area and we intend to continue this work into the future. Our CEO is a civic commissioner on the MBPTC. We have two projects - Let's Be Friends, and the Citizens' Representative work, both of which have come directly from the Poverty Truth Commission. They were designed by people with lived-experience and they have companionship and wellbeing at their heart - treating the whole person and not just a collection of problems.

Citizens Advice North Lancashire, in partnership with the local NHS and the Morecambe Bay Poverty Truth Commission, has recently appointed a Citizens' Representative. The role is to support clients who are vulnerable and have complex needs to improve their health and wellbeing. Referrals come from GPs, social workers, MacMillan, Lancaster City Council, our own service and other partners. This post is able to work on a longer-term basis to establish positive working relationships with clients and improve their welfare, keeping them away from crisis and front line emergency services such as A&E or reliance on a GP for welfare issues"

Source: Citizens Advice North Lancashire.

"The Morecambe Bay Funding Formula was developed in an attempt to allocate resources using a methodology which would better reflect the inequalities faced by local communities. It is understood that this is the first time that any element of a Clinical Commissioning Group (CCG) budget has been allocated to place an additional emphasis on inequalities.

Morecambe Bay CCG has utilised a component of its Programme Allocation to fund Population Health interventions. This Population Health budget is being allocated using a locally designed formula, The Morecambe Bay Funding Formula, which is 50% based on the Carr-Hill formula and 50% based on the proportion of the population living in the 20% most disadvantaged areas. This money is provided to district Health and Wellbeing Partnerships by the Bay Health and Care Partners' Population Health Strategic Group (PHSG), with a requirement that the funds are used for asset-based community development to reduce health inequalities in priority areas identified by the PHSG. A total of £250K was invested in 2020/21 and £500K in 2021/22. An example evaluation of the impact of this funding can be found in Appendix 9.

The locally developed Morecambe Bay Funding Formula (MBFF) has highlighted the stark funding differences between allocation based on Carr-Hill compared to our funding model that includes deprivation. The first iteration of the MBFF was based entirely on the proportion of the population living in the most disadvantaged areas. Applying our initial iteration increased the allocation in one district by 82% and decreased it in another by 98%, a significant difference.

IMD does not capture all inequality and the district with the greatest reduction was also a district with high furlough rates and increasing free school meals uptake due to the pandemic, which would not be reflected by the 2019 measure of IMD. The formula of 50% Carr-Hill and 50% IMD was agreed

to reflect the local range of deprivation and to acknowledge the impact that COVID-19 has had on communities.

The Morecambe Bay Funding Formula has subsequently been adopted for use in the Lancashire and South Cumbria Health and Care Partnership Population Health Operation Model (PHOM) to allocate population health funds in selected work streams at a Place Based Partnership and/or Primary Care Network level. This application of the Morecambe Bay Funding Formula will be evaluated with academic partners to measure the short, medium and long-term impact on health inequalities.

The use of the Morecambe Bay Funding Formula is also being discussed as a possible method of allocating other small health budgets in other operational areas across the Lancashire and South Cumbria Health and Care Partnership"

Source: Population Health Strategy Group

"The Engagement and Health Inequalities project worked closely with Primary Care Networks (PCNs), Integrated Care Communities (ICCs), local VCSFE organisations and local communities to identify and explore the impact of health inequalities within our neighbourhoods across Morecambe Bay.

The first phase of the work was funded by NHSE/I and by Morecambe Bay CCG. Working closely with Business Intelligence colleagues, local teams – supported by staff from the Population Health Team – segmented their population on the basis of deprivation, protected characteristics or membership of a vulnerable group to select a target cohort with which to engage. The following cohorts were selected:

- Families in Ulverston East
- Migrant workers in the hospitality sector in Grange and Lakes
- Young people aged 16-24 years old in Kendal
- Rural poverty in Western Dales
- Families in the Highfields Estate in Carnforth
- Women aged 25-64 in Skerton, Lancaster
- Adults with learning disabilities living in the community in Morecambe.

The next phase of the work involved Co:Create (www.wearecocreate.com/) working closely with the local teams to undertake a stakeholder and asset mapping exercise and an engagement planning exercise. These activities had to be conducted virtually, using a variety of online tools, due to the pandemic restrictions. Wherever possible members of the local community and/or target community were involved in the planning process which brought realism and greater insight into the engagement planning process.

The engagement work was carried out during lockdown in the period February to May 2021. This precluded the use of a number of different engagement methodologies and meant that face to face engagement could only happen in restricted environments (e.g. schools and colleges). The questions asked in the engagement were broad and focussed on what helped people stay health and well and what acted as a barrier. The sample size was not critical as it was recognised that even a small response can give meaningful insight into the challenges faced by a community.

The local teams then undertook thematic analysis of the results of the engagement and identified key themes to feed back to the participants and other stakeholders[6].

Morecambe bay CCG subsequently provided funding for a second phase of work involving the co-production of solutions to the issues identified with clinical staff, local VCSFE organisations and members of the local community or target cohort. Seventeen volunteer facilitators were recruited and trained in techniques for planning and delivering co-production workshops virtually or face to face. It is anticipated that co-production workshops will be held with selected cohorts in November/December 2021, although the pressure on primary care and on the voluntary sector due to the ongoing pandemic is creating uncertainty around the planned timescales.

A detailed training pack – including videos, templates and workbooks – has been produced and circulated widely. It provides information on various engagement techniques (including surveys, online workshops and cultural probes) and on how to plan and facilitate co-production workshops. A group of people in health, the voluntary sector and from local communities have been trained in these techniques and will form a resource to undertake similar work on health inequalities across Morecambe Bay in the future."

Source: Morecambe Bay CCG

Bay Health and Care Partners are working closely with partner organisations to develop the Bay wide Anchor Collaborative. The Anchor Collaborative will support organisations across Morecambe Bay to make a difference to local people by widening access to quality work, purchasing and Commissioning for social benefit, using buildings and spaces to support communities, reducing environmental impact, working closely with local partners and reducing inequalities.

In order to support organisations to embed anchor practices, a Morecambe Bay Anchor Charter has been produced. This can be used by organisations to self-evaluate their anchor status, identify cross cutting opportunities to embed anchor practices and measure progress over time. A locally produced scoring system can be used by individual organisations to demonstrate their commitment as an anchor organisation.

Organisations signed up to the collaborative include; Morecambe Bay CCG; University Hospitals Morecambe Bay NHS Foundation Trust; Barrow Borough Council; South Lakeland District Council, Lancaster District Council, Lancaster University, Lancaster and Morecambe College, EDF energy, and BAE Systems. Other organisations that are engaged and taking the steps to become formal partners include Lancashire County Council, Cumbria County Council, University of Cumbria, Furness collage, Kendal Collage and Lancaster CVS. Conversations with Cumbria CVS are being planned.

A local Anchor Collaborative Steering Group has been established and the associated monthly meetings provide a space for champions to provide updates on their organisational anchor practices, share learning across organisations and identify common areas for development and aid partnership working.

All organisations within the Morecambe Bay Anchor Collaborative are currently using the Morecambe Bay Anchor Charter to self-evaluate their individual anchor status and also to inform the development of cross organisational objectives for all of the organisations within the Collaborative.

[6] https://www.wearecocreate.com/what-we-do/our-services/research-analysis-evaluation/research-and-evaluation-reports/

Once a set of key anchor objectives and outcome measures have been co-produced by the group, champions will take these through their internal organisational channels for approval. Once approval is obtained organisations will support one another towards reaching these co-produced targets.

Source: Anchor Collaborative

6.2 Children and Young People.

Love Barrow Families.

The Love Barrow Families (LBF) pilot project started in 2013 and was funded from both the Troubled Families Programme and Lankelly Chase, a community interest company.

The aim was to allocate one key professional who would work with families holistically to address multiple and complex issues such as mental health, education/worklessness, abuse, substance misuse, behaviour problems and parenting. The intervention methods were informed by the Dynamic Maturation Model of Attachment.

Funding for the project ended in March 2018 although the scheme has continued.

What is working well?

- There is a whole family approach to address pervasive issues.
- The qualitative feedback and perceptions of impact from both families and LBF professionals has been very positive. Trusting relationships have been built with previously "hard to engage" families.
- It has inspired families to start contributing to their community and help other families.
- It has contributed to a reduction in the use of statutory services for these families (see the independent evaluation by Northumbria University included in the Appendix 10).

Mental Health Support in Schools.

Mental Health Support Teams (MHST) have been set up nationally as part of the 2017 green paper response to children and young people's mental health difficulties. MHST are primarily based in schools or colleges. Each team supports a school age population of approximately 8000 children and young people. Each team represents a long term investment of £360,000 per year.

In the main, the MHSTs are intended to support children and young people who would benefit from support for mental health and wellbeing needs that would not reach the threshold to be a 'diagnosable mental health' problem. The support will help prevent more serious problems developing by providing children and young people with low intensity support for mild/moderate difficulties, focusing particularly on low mood, anxiety, and behavioural difficulties.

Mental Health Support Teams are intended to:

- Deliver evidence-based interventions for mild to moderate mental health and emotional wellbeing needs

- Support senior mental health leads in education settings to develop and introduce their whole-school or whole-college approach to mental health and emotional wellbeing
- Provide timely advice to staff and liaising with external specialist services so that children and young people can get the right support and remain in education.

The existing two MHSTs within Morecambe Bay cover the Barrow Peninsular High Schools and the Morecambe and Heysham school system with the new third team to be mobilised in September 2022 expected to cover High Schools across the Morecambe Bay footprint. Once the third team has been mobilised all special schools in Morecambe Bay will have access to MHST support.

The current 2 teams are supporting between 120 and 130 children and young people each per quarter with evidence-based interventions for mild to moderate mental health and emotional wellbeing needs.

During the winter of 2020-21, Morecambe Bay funded the provision of community mental health drop-in sessions for young people. These were provided in Morecambe, Lancaster, Kendal and Barrow by different community groups and were intended to give young people a space to speak through any anxieties or concerns before they became overwhelming, and provide a safe space for any young person who felt themselves to be in crisis or needing immediate help. Feedback from the providers has been that for those accessing the offer, the experience has been a positive support to them:

Quote from Drop-Zone, Barrow: "The NHS funding has enabled us to provide support in a proactive way. We have been able to put provision in place which is relevant to each young person who accessed our service. It supports us putting something in place immediately instead of phone calls and referral being talked about when somebody is struggling. Often this can put young people off. They feel comfortable in our environment and the majority have relationships with us already so can be honest and open. We are all mental health first aid trained so can offer appropriate and tailored support."

Quote from a young person using the service offered via Stanleys: "I feel comfortable talking to you at Stanleys because it feels like you actually listen and don't judge me."

7. Support required to make a step change in addressing health inequalities

This section outlines that support needed to make a step-change in how Bay Health and Care Partners' can address health inequalities. It is important to note that during the process of collecting evidence for the Commission, there was a sense of frustration that evidence of health inequalities has been well acknowledged for decades and yet they are still present in society today. There was consensus that things need to be done differently, that organisations and individuals must hold each other to account in taking action to address inequalities and that the voice of communities must be the driving force behind local action. There was an acceptance that there is local action that can make a difference and that there is a commitment to maximise this, but also that national and regional policy and investment is needed to maximise what can be achieved locally.

7.1 All age population

A strong and recurring theme in the feedback was the need for increased funding. The data presented here has clearly illustrated that the Inverse Care Law is still evident in how services are delivered, despite the seminal paper being published 50 years ago. At a national level, the allocation of funding to primary care does not explicitly take into account deprivation[7] and is unlikely to reduce inequalities[8], yet the delivery of the NHS' commitment to reduce health inequalities, Core20PLUS5[9], is very much based within community and primary care. Given the commitment to target support to the 20% most disadvantaged communities, it is logical that funding should be prioritised in those areas, and evidence has shown that increasing investment into the most disadvantaged communities can reduce inequalities in outcomes amenable to healthcare[10]. However, NHS funding is the tip of the iceberg when addressing health inequalities. Reductions in local authority funding, including social care and public health funding, has been associated with additional mortality (2013/14)[11]. Increased investment into the NHS and local authorities, plus an emphasis on allocating funds to address the inverse care law, will be supportive in reducing health inequalities.

There is a need for improved national investment to support the most disadvantaged communities, but also a requirement for local systems to make funding decisions that take into account health inequalities when allocating resources, similar to the approach in the Morecambe Bay Funding Formula. There is an imperative to acknowledge the role of the Community, Voluntary and Faith and Social Enterprise partners and adequately fund the support that they provide to local communities. This funding needs to be of sufficient value and sustainable; the reliance of CVFSE on short term funding is destabilising, affecting staff, community trust and impact.

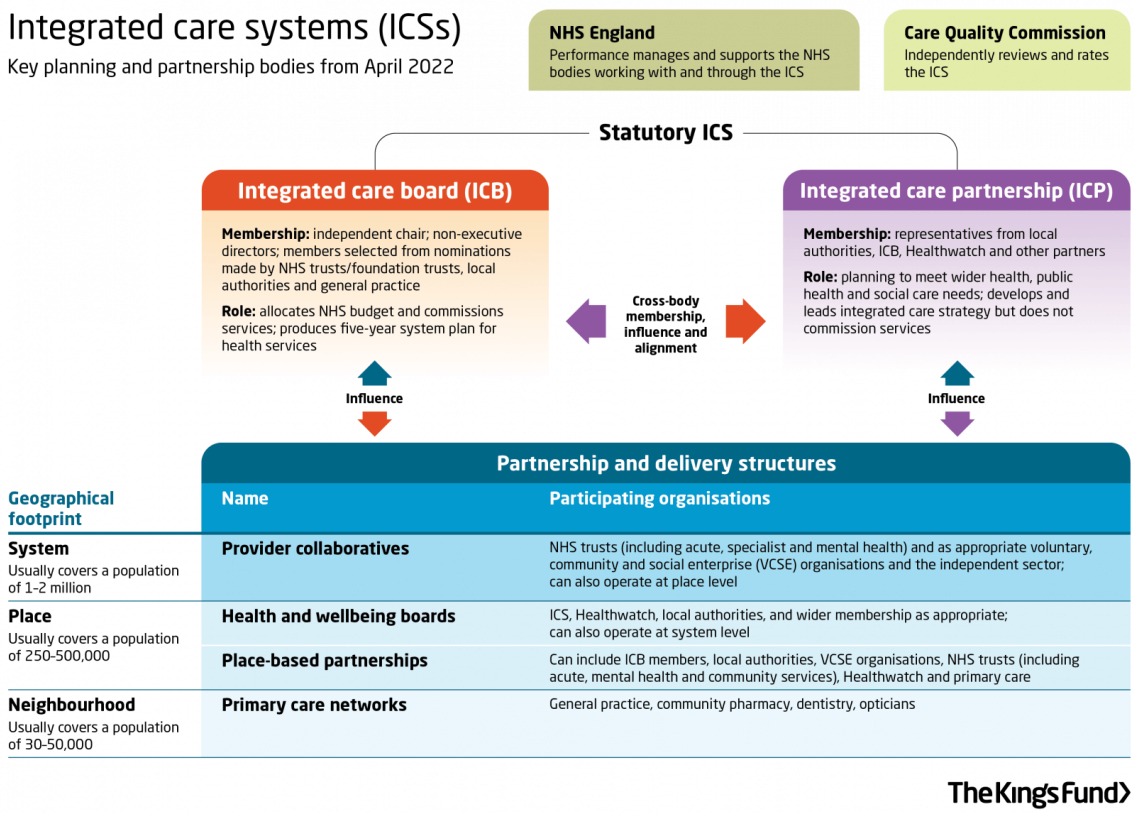
The impact of funding on health inequalities needs to be explicit. This requires a step change in data collection at a local, regional and national level, including analysis at sub-population level so that there is commitment to visualising inequalities, understanding the impact of local action and ensuring that delivery supports the communities experiencing the poorest health outcomes. This data must be timely, longitudinal and as local as the sample size allows. It should be integrated between local partners, enabling oversight of social, behavioural and health inequalities across the life-course. This data can inform needs-based funding allocation and support the evaluation of the impact of multiple interventions across the system.

There needs to be greater strategic alignment in local action to address health inequalities. The formation of ICSs (ICPs) in April 2022 is an opportunity to emphasise the importance of local action to reduce health inequalities. However, the geographical scale and potential complexity of the system risks reducing the potential benefits. There needs to be a shared understanding across the system of the importance of reducing health inequalities, and a commitment to a set of explicitly equity-based priorities, with agreement for where the responsibility for oversight and action sits

[7] https://www.bma.org.uk/advice-and-support/gp-practices/funding-and-contracts/global-sum-allocation-formula
[8] https://bjgp.org/content/69/685/e546
[9] https://www.england.nhs.uk/wp-content/uploads/2021/06/240621-board-meeting-item-9-tackling-inequalities-in-nhs-care.pdf
[10] https://www.england.nhs.uk/wp-content/uploads/2021/06/240621-board-meeting-item-9-tackling-inequalities-in-nhs-care.pdf
[11] https://bmjopen.bmj.com/content/11/10/e046417

across the structure (Fig. 19), based on the geographical size of the areas and the representation and scope of the Board, Partnership or Network. The dedicated dataset discussed above will support the process to agree and monitor the priorities, as will guidance from local communities.

Figure 19. Illustration of planning and partnership bodies from April 2022[12]



There is a need to continue to learn from and grow with local communities. Community engagement and building a social movement for health are local priorities and are working well. However, there is a need to continue to progress this and to further build two-way conversations with communities, including greater representation from communities in strategic decision-making partnerships. This will require new ways of working to ensure that community members can be actively involved in conversations and decision-making processes.

The integration of services is essential in addressing health inequalities. The complex nature of health inequalities over time and across social and health factors requires the provision of holistic support to communities, which can only be achieved through joint working. An emphasis on building relationships and understanding cultures is essential to build trust and shared ways of working to support communities. This is particularly relevant to Bay Health and Care Partners given the local geographical complexities and the multitude of organisations working across Morecambe Bay.

[12] https://www.kingsfund.org.uk/audio-video/integrated-care-systems-health-and-care-bill

Understanding the co-benefits of action to reduce health inequalities and the climate emergency will support joint action to achieve the biggest impact. The effects of climate change will disproportionately affect the communities that experience health inequalities, and these communities may also be disproportionately affected interventions to address climate change.

7.2 Children and young people.

A joint strategic plan to reduce health inequalities for children and young people across all partners needs to be developed. The plan needs to put an end to working in silos and clearly identify how integration will make a difference to the areas of work within our sphere of control (rather than focusing on the things that are undoubtedly major issue but are outside of our local control e.g. changes to universal credit, taxes etc.). The plan needs to be backed up by joined up data, joint health and equity impact assessments of any commissioning changes and a clear accountability framework that enables challenge of any disinvestment decisions or planning decisions that will have a negative impact on health inequalities for children and young people. The plan should be shared across planning departments, housing teams, health, social care, educational providers, child-care providers and many others - and most importantly our communities.

Services need to be mobilised to work differently with families who are experience the most need but are least likely to benefit from the way services are currently provided. Evidence is that these families are most likely to DNA or cancel appointments and where there are gaps in services these families are least likely to complain or mediate to get what they need. Services should be needs led and not service driven. Service data is required to inform the system which sub-populations are underrepresented in services, and services need to actively reach out to find these families rather than waiting for referrals. Work with families must be more joined up, based on engagement with the families and communities – more like Hilary Cottam's "Radical Help" approach and the approach used by Love Barrow Families. This doesn't necessarily need more resource in the long term as it would remove the current "failure demand".

There is significant evidence regarding the scale of inequalities experienced by children and young people and what can make a difference, but less about *how* local partnerships can alter what is within their control to make an impact on specific sub-populations. At a time when resources are stretched to provide support to children presenting with significant needs, the evidence to guide the implementation of proportionate universalism is essential. The return on investment for early years is well evidenced, but information on how resources can be used to target key stages of neurodevelopment is less clear. The importance of good cognitive, linguistic and social development is clear, but again, it is less clear how local partnerships can work together to support this, particularly within the most disadvantaged families. Mapping of investment across all partners supporting children and young people may inform decisions about shifting resource to early years and local partnerships will need committed leadership to advocate for evidence-based resource allocation to early years development.

Communities and families need to be empowered through work using more strength-based approaches and appreciative enquiry to understand what would make a difference. The VCFSE sector, who work with families and communities at a local level and know and understand their needs, needs investment to develop asset-based approaches at really local level, for example ward or estate. For example, supporting local activity classes and youth groups, food hubs, creating community led action. Increased, more sustainable funding should be available to the VCFSE organisations to facilitate this support.

Local partners need to lobby nationally to influence policy decisions in relation to welfare and public spending, to ensure that the most vulnerable are protected. It is important to align this approach with other areas across the UK to ensure a strong voice and consistent, effective messages.

8. Strengthening local partnerships with stakeholders who impact on health in our region eg. business, community groups, public services and local authorities

This section describes the feedback regarding how to strengthen local partnerships to take further action to reduce health inequalities.

8.1 All age population

Sharing local data that makes explicit the impact of health inequalities on local communities and the factors that drive these inequalities will be useful in developing a moral and business rationale for the importance of reducing inequalities. The data illustrating the role of education, employment and housing is important to raise awareness of the cross-sector role in addressing inequalities. Analysis to demonstrate the impact of reducing these inequalities can highlight the benefits of reducing inequalities.

Dedicated time to identify shared priorities, understand differing cultures and language and agree governance and accountability for action can support action at a system and a place level. At a neighbourhood level, the models of the integrated care communities and primary care networks are essential to ensuring that holistic support is provided at a hyper-local level. This requires hyper-local leadership, excellent relationships and regular meetings to ensure shared understanding of what is available for the local community with the moto of ‘find one of us, find all of us’, which is more than ‘making every contact count’ (NHS health behaviour change or ‘making every contact count plus’ (local government support around debt, housing etc) it is about making every community connection help to create belonging and reduce marginalisation.

More sustainable funding for CVFSE will reduce competition and the opportunity cost of time spent seeking funding to maintain grass roots support for communities. Continuing to work with the VCFSE to understand the experiences and needs of local communities, working towards authentic community voice in strategic decisions will devolve more power to community partnerships.

There needs to be a change in strategic thinking to empower the agenda from the top and stop funding different groups within the community that have no connectivity between each other. Connectivity that is real and evidence based rather than window dressing needs to be developed. Ways of measuring need and impact across the spectrum is needed – from public sector down to individuals living in the community so that there is a common understanding and participation in our common goal – improved health.

There is a necessity to fully fund things that don't have health in the title (things that are not necessarily called health projects) but back this up with solid, meaningful and accessible evaluation of health needs and outcomes. It is important to identify clinical health as distinct from ‘wellbeing’ which has largely become a catch-all term for funding work indistinguishable from day-to-day community work.

Developing a local plan to reduce health inequalities, which highlights a small number of key priorities with outcome measures over time, but with local delivery to enable hyper local action to

reflect community needs and the data intelligence to see what is working and scale up as appropriate. These outcomes need to be co-produced with local communities and partnerships to ensure that there is shared ownership and commitment to delivery. Reducing health inequalities will not be achieved by single interventions, it requires multiple interventions, targeting different components of health inequalities (the causes of the causes, the health risk factors and the population who is already unwell) across the life-course. This needs to be strategic to ensure oversight and coverage in terms of the need, geography and population, but hyperlocal to ensure that it makes a difference to people on the ground. Celebrate what works to reinforce the benefits of partnership working.

8.2 Children and Young People

There is a need to work differently with families so that solutions are developed with not for communities. "Art of Hosting" approaches should be used to hold conversations to genuinely understand and get to know people across the whole system and in the communities themselves – and start to jointly come up with some solutions. There has been some amazing work done during Covid to support people and work differently (schools providing laptops, communities working together, neighbours supporting each other, homeless families being rehoused at a pace unheard of before, etc. etc.). This energy and passions needs to be harnessed to help build a more equitable childhood for all our young people and to develop a shared vision and plan of how we will make Lancashire and Cumbria the best place for them to be born, grow and learn.

A joint strategic plan across all partners that encompasses a shared vision, co-produced principles that direct action to address health inequalities, shared outcomes (across the whole area – not differing by geography), shared data, shared methods of evaluation, shared impact assessments against which we evaluate our plan and possibly a charter that all partners sign up to. The plan needs to be based on the co-production of priorities and solutions with families and communities, for example the plan could include agreeing a priority around children's weight and then co-producing delivery with communities and local organisations including those commissioning and providing school meals, those with vending machines, planners, Health Visitors, local businesses, community centres providing cooking classes and activity sessions etc.

It is critical that people working in a local area know each other to enable them to work in an integrated manner to support families. Currently professionals do not know each other and often do not know who does what and how to access help. Very local partnership arrangements need to be strengthened so that professionals and VCFSE sectors work together in either actual or virtual hubs – networking together to provide more appropriate and accessible support for families and making it clearer for everyone how to access support. Family Hubs may be an option for achieving this but are currently being developed in silos. These hubs need to work in communities using an asset-based approach, a way of working together that is most critical in our areas of highest deprivation. Priority areas can be identified based on deprivation and a join plan can be developed for family hubs within these areas (like Sure Start centres used to be).

Schools are the places children spend much of their time and yet the local system is so complex that schools do not know how to access help and support. The system needs to focus on providing what families and schools need, where they need it, and make it much simpler to navigate so that people know where to go to get help and so that services don't work in silos (part of this is making sure that services are not commissioned to work in silos). We also need to ensure that responsibility in the

layers of education is delegated so issues can be resolved in a more efficient manner rather than waiting for senior approval.

The local structure for partnerships needs to be clarified to ensure information sharing and clear guidance on routes for appropriate escalation. A good example is the district Children's Trust Partnerships in Cumbria, which feed up to the Children's Trust Partnership. In Lancaster and Morecambe there is the Children and Young People Multi-Agency Forum. A next step may be to develop a structure to strengthen 2-way communication and engagement from local, through to district, through to a Morecambe Bay-wide partnership group for children and young people. Currently there is a Morecambe Bay Children and Maternity Steering Group, which is predominantly health focused and could be made more representative by including representatives from the local district-based partnerships.

Clearer understanding is needed of where the "Team Around the Schools" fits with these groups. Both Lancashire and Cumbria have a Team around the School approach, but the issue is the availability of services to support schools/settings. The services need additional capacity to be able to wrap around schools, whilst having the staff to attend partnerships to build relationships.

Investment is required to develop data systems to support better joint working between commissioners and providers of children's services. Data professionals need to focus on analysing joined up data about health inequalities for children to help local understanding what is working well and where things can be done differently. A dedicated resource for children and young people is require as data is often focussed on adults. This capacity will work across the partner organisations involved in children's services to develop the data to help answer the challenging questions that needs to be explored. This data needs to be shared with all partners, with analysis as to its meaning, recommendations for action and training to enable services to delve deeper into areas of interest.

Specific pledges should be built into the Anchor Charter to reflect how organisations will work to support families, children and young people – for example paying a living wage to apprentices or employers finding other ways to attract young people into work. There is the possibility to work with schools to develop a school's anchor charter – or something similar –including two-way commitments about how schools will be supported as well as about what they pledge to do

A system for undertaking health equity assessments jointly across partners will enable accountability within partnerships for decisions taken to development/re-commission/decommission/planning decision impacts on health equity for children

9. The barriers preventing a local difference in health inequalities

9.1 All age population

There are many national barriers to making a difference, such as funding patters and changes to welfare policy, which can be felt most harshly by people who are already experiencing disadvantage. There is a crisis in terms of the impact on the community and the people who work to support it are often 'putting out fires' caused by the systemic nature of inequality – it doesn't always feel like it is within our control to change things.

One of the biggest challenges in Morecambe Bay is the geography, which results in a number of boundary issues when considering the number of different organisations who are part of Bay Health and Care Partners or who operate across the Morecambe Bay footprint.

Morecambe Bay is one of 5 Place-based Partnerships (formerly Integrated Care Partnerships) in the Lancashire and South Cumbria Integrated care partnership (formerly the Integrated Care System).

The key partners who have responsibilities for the delivery of various services across the Morecambe Bay footprint include:

- 3 county councils (Cumbria, Lancashire and North Yorkshire)
- 3 Local Enterprise Partnerships (CLEP, Lancashire Enterprise Partnership and York and North Yorkshire Local Enterprise Partnership)
- 3 county constabularies (Cumbria Constabulary, Lancashire Constabulary and North Yorkshire Police)
- 3 Fire and Rescue Services (Cumbria Fire and Rescue Services, Lancashire Fire and Rescue Service and North Yorkshire Fire and Rescue Services)
- 4 NHS Trust (Lancashire and South Cumbria Foundation Trust, North west Ambulance Service NHS Trust, NCIC, and University Hospitals of Morecambe Bay NHS Foundation Trust)
- 5 district councils (Lancaster City Council in Lancashire, Craven District Council in North Yorkshire and Barrow Borough Council, Copeland Borough Council and South Lakeland District Council in Cumbria)
- 3 Further Education Colleges (Furness College, Kendal College and Lancaster and Morecambe College)
- 2 Councils for Voluntary Service (Cumbria CVS and Lancaster District CVS)
- the Lancaster and South Cumbria Economic Region
- Morecambe Bay Clinical Commissioning Group
- Morecambe Bay Primary Care Collaborative
- 1 Local Medical Committee
- 1 GP Provider Alliance
- 8 Integrated Care Communities
- 8 Primary Care Networks

The Partnership as a whole has little interaction with organisations in North Yorkshire apart from Craven District Council and the local voluntary sector organisations in North Craven.

The situation will be further complicated in April 2023 when Local Government Reorganisation is finalised in both Cumbria and North Yorkshire. North Yorkshire will become a single unitary authority and Cumbria will be reorganised into two unitary authorities, namely East Cumbria (i.e. Barrow Borough Council, Eden District Council and South Lakeland District) and West Cumbria (Allerdale Borough Council, Carlisle City Council and Copeland Borough Council).

The boundaries of the proposed East Cumbria unitary authority will not be co-terminus with those Morecambe Bay due to the inclusion of Eden District. Eden district is currently within the boundaries of North Cumbria CCG and will form part of the North East and North Cumbria ICS after April 2022.

The shadow authorities for the proposed East Cumbria and West Cumbria unitary authorities will come into being in April 2022. This will happen at the same time that the NHS reorganisation proposed in the Health and care Bill 2021 is scheduled to be implemented.

Morecambe Bay will the only Place-based Partnership within the Lancashire and South Cumbria ICP that will be impacted directly by the Local Government Reorganisation. However, there will also be an impact – although potentially lesser due to the lack of county boundaries involved – on the North Cumbria Place-based Partnership which will form part of the North East and North Cumbria ICS.

The organisational and geographical complexity of Morecambe Bay can lead to large amounts of time spent attending duplicate meetings and is can be challenging in terms of achieving consensus to drive work forward. This can lead to a perception that the systems and processes are built for institutions rather than the people that they serve, disempowering staff and meaning communities need to navigate complex systems and service pathways, telling their story multiple times and completing multiple forms. However, there is a shared commitment that to 'do nothing' is not an option and a focus on driving integration with simpler services provision to meet local need is essential.

There are multiple local funding streams that have been reduced over recent years, impacting significantly of the level of support available for communities and negatively impacting on prevention and early intervention. CVFSE have been essential in reducing the gaps within this support, but that has been achieved within the context of reduced funding available for the sector. All these factors exacerbate challenges in providing support for people now, but also will be potentially widen inequalities for the future.

9.2 Children and Young People.

Recent reductions in the Local Authority budgets and the subsequent impact on service delivery models for Children Centres, Early Help and 0-19 Healthy Child Programme Services has had a significant impact on integrated working and co-location good practice. People are working really hard and feel worn down and over-stretched. Even delivering core services feels difficult and services come under pressure for waiting times, performance etc. There is no energy or time left to be curious about those who are not presenting on waiting lists or are not asking for help, probably the most vulnerable residents and patients. Some people have become so disillusioned with public services that they have given up trying to access support. Staff feel like they spend their time firefighting rather than seeing the larger issues that affect the care for women and their families. VCFSE often provide support where statutory organisations cannot but they are constantly having to apply for short term funding to stay afloat and consequently have to re-focus onto where the funding is.

The range of local commissioner and provider organisations has an impact on service delivery. There are two County Councils providing services in Morecambe Bay, resulting in differing social services, public health and 0-19 service offers. There are also two providers delivering children's services. One example of the impact of this is illustrated in Table 2, which shows some analysis of children and young people's use of Hospice provision at Derian House. Although these services are in theory available equally for children and young people across the whole of Lancashire and South Cumbria, in reality the average hours/person for Lancashire and South Cumbria is 28/hrs, whereas for Morecambe Bay it was 17.5 hrs and even less for South Cumbria. The hospice has now put in place dedicated nurse time to address this inequity and understand the need in South Cumbria.

Table 2 Service provision across Lancashire and South Cumbria for hospice provision and Derian House.

Hospice activity vs need

	MBCCG usage & need
Current Derian House no. CYP	42
Current estimated Derian & Jigsaw	44
Predicted CYP need	49
Current hours at Derian	735
Current estimated Derian & Jigsaw	765
Predicted hours needed	1378
Average hours/person for ICS	28hrs/person
Average hours/person for MBCCG	17.5hrs/person

There is a lack of data regarding children and young people. It is difficult to get data on many children's services (it often feels there is much more focus on adult services and things that are higher profile nationally – e.g. waiting times). It is even harder to get data about community provision and especially at a local level. It is therefore virtually impossible to try to join up data at a local level across services to understand what is really happening for a particular school or community. There is a desperate need for more capacity in terms of data and integrated systems that can be mined for local level data.

There is an expectation that people come to services and as such there is not enough effort dedicated to working with communities to understand their issues and what can make a difference for them. For example, VCFSE partners describe how providing free activities in local community centres attracts people and then additional provision such as nutrition and cookery sessions can begin. Services need to be available when people need them – often this might be outside of 9-5. Ideally there would be a local hub that children, young people or families could access 24/7. Our CVS partner described it as needing to put a scaffolding around our communities and around the front-line professionals like PCSOs, community centre volunteers and housing officers who work in them because at the moment they see the problems but they do not know where they can go to for help. The impact of rurality can be significant, with a lack of access to services, educational opportunities, cultural activities, social isolation and poor housing – all of which can contribute to health inequalities but can be hidden within the usual data.

There are challenges around workforce recruitment and retention (in particular in areas of higher deprivation and areas that are more isolated). This leads to constant changes in roles which interrupts relationship building, leads to staff having to focus on the most time-critical, basic work and means services cannot work efficiently due to constantly inducting and training people. When this effect is multiplied across multiple partner organisations it makes it virtually impossible for people to sustain the networks of contacts and relationships that enable good support for families. This can lead to the

duplication of projects and commissioned services as there is a lack of consistent integration and therefore wasted resources.

There are cohorts of the local population who are severely disadvantaged e.g. children and young people with learning disabilities and/or autism. There is not the funding to provide robust services to meet their needs which leads to escalation of need, considerable impact on the young person's health, wellbeing and life-chances, family breakdown and sometimes high-cost placements often out of area. Some families fight to get what they need for their child despite the gaps in service, but this only increases the health inequalities as it is often the more educated and affluent families who fight hard enough to get support.

There is an expectation that people can change their behaviours. Services may be commissioned to support a reduction in risk factors, such as obesity, smoking prevalence, but these will be most effective when the impact that wider determinants have on people's behaviours is understood and addressed. Our most challenged communities often have the most off-licences, the most fast-food takeaways and the least access to cheap health food. There is a need to work across the entire health, care and wellbeing system to understand and address the factors that contribute to health inequalities.

10. Making health inequalities our number 1 priority

This evidence has illustrated that there is local commitment to address health inequalities and that there are barriers preventing the action that should be taken. Many of the people contributing to this evidence have been working to reduce health inequalities over many years. It is essential that this Health Equity Commission supports and informs local action to make a true improvement to the lives of Morecambe Bay's most vulnerable communities.

This section outlines how the HEC can support Morecambe Bay in making that difference. There are three areas of support that the HEC should prioritise:

- Improving system oversight and accountability
- Developing a shared set of priorities and outcomes with identified strategic responsibility
- Providing evidence of how to implement interventions to reduce health inequalities in the short, medium and long-term.

The action required by the HEC to achieve these three priority areas are described below.

Funding.

The Commission is asked to:

Provide guidance on how to effectively influence national policy in relation to public sector funding and healthy public policy.

Advocate the need to explicitly consider community deprivation and health outcomes when allocating funding.

Influence the system to ensure that sufficient funding is allocated to early years. With the current financial pressures and widening health inequalities, it is essential that early child health and development are prioritised. This is evidenced by the data regarding inequalities in access to

healthcare and lower than average school readiness in children eligible for free school meals in Cumbria and Lancashire.

Influence the local integration of funding to re-assign resource to population health and prevention to reduce the demand for urgent, acute and expensive healthcare.

Emphasise the value of CVSFE and advocate for the need to increase and sustain financial support.

Strategic alignment and accountability

The Commission is asked to:

Provide the mandate and sense of urgency to develop integrated plans to reduce health inequalities. These plans will be complex, working across system, place and neighbourhoods. Ensure that the process of developing these raises the priority of health inequalities, improves relationships and creates a sense of shared ownership.

Acknowledge the system and transformational leadership required to address Health Inequalities as a whole system across our complex organisational and geographical landscape.

Identify the over-arching shared priorities and outcome measures across the life-course and the three spheres of prevention.

Describe evidence-based interventions that can be implemented at system, place and neighbourhood.

Outline which partnership is best placed to drive it forward: Integrated Care Board/integrated care partnership/provider collaborative/health and wellbeing boards/strategic thematic partnerships/place-based partnerships/PCNs/ICCs.

Agree on a structure of true accountability for the delivery of the statutory duty of reducing health inequalities, so that it is of equivalent importance to maintaining financial balance. Ensure that this system includes accountability to local communities.

Provide a set of tools to facilitate the consideration of health inequalities in every partnership, workstream, organisation, staff team and community. These tools will be agreed across the system to enable a shared approach to integrating action on health inequalities into every decision that is taken regarding. These tools will support joint decision making across the system.

Geography

Provide guidance on how to work differently across two County Councils, specifically in relation to local authorities and health services agreeing a coterminous footprint to work within for children and maternity services.

Data

The Commission is asked to:

Acknowledge the importance of data as an enabler in creating a moral duty and sense of urgency to address health inequalities. This includes both qualitative and quantitative date, with qualitative

data being essential to understand lived experience and consider what will work best for local communities.

Ensure that routine data collection must make explicit the differential impact of service delivery on access, experience and outcomes across different communities at a neighbourhood level.

Facilitate the development of integrated data sets across organisations to enable an understanding of the spectrum of health inequalities, whilst also reducing the duplication of multiple services/organisations undertaking the same analysis.

Prioritise the need for research and evaluation, emphasising the importance of considering the gradient of inequality when evaluating action. Research and evaluation should make explicit the impact on different communities and any contribution to narrowing health inequalities.

Develop an infographic that contains the important messages regarding health inequality and local action, to create a consistent and simple message to promote the importance of addressing health inequalities.

Community engagement

The Commission is asked to:

Provide guidance on how to include and support people with lived experience and members of local communities onto strategic decision-making partnerships. Build the understanding of how these meetings need to adapt to ensure that the essence of the community voice is maintained, rather than 'institutionalising' them.

Advocate for trust in hyper-local action by involving the community in strategic planning and delivery at a local level.

Evidence and co-benefits

The Commission is asked to:

Provide evidence on 'how' to make a difference to health inequalities by outlining what works to specifically support people living in more disadvantaged areas, from different ethnicities and other communities that experience inequalities.

Provide the evidence of what works in relation to achieving proportionate universalism, taking a neuroscience informed approach to child development and integrated action to prioritise and support good cognitive, linguistic and social development.

Focus on the co-benefits by emphasising the shared benefits of reducing health inequalities on the local economy, recovery and resilience and very importantly climate change.

Advocate that all action is based on a culture of kindness, supporting staff to make a difference but providing rest, care and compassion.

Propose realistic timelines for action, outcomes and evaluation and advocate to funders that funding duration reflect these as a minimum.

Anchor institutions, local businesses and the economy.

The Commission is asked to:

Emphasise the importance of partner organisations behaving as exemplar employers providing sustainable and ethical local assets, achieving net zero, paying the living wage, ensuring opportunities for young people and employing people with long term conditions.

Appendix 1. Morecambe Bay Needs Assessment (2019)

MB Health Needs Assessment_2019.pdf

Appendix 2. COVID-19 Phase 3 Recovery Strategy for Health Inequalities (21-23)

Phase 3 Recovery Strategy for Health In

Appendix 3. Children Looked After Annual Report.

Children Looked After annual report 2(

Appendix 4. An Income to Live By.

An Income To Live By FINAL_Lancaster.pdf

Appendix 5. All Themes in one Table.

All themes - in one table by partnershipC

Appendix 6. Furness Needs Opportunities and Challenges (2021)

Furness Needs Opportunities and Ch

Appendix 7. CMO Report: Health in Coastal Towns.

CMO_report_Health_in_Coastal_Towns_202

Appendix 8. Gypsy, Roma and Traveller Health Report

GRT health Report for Cancercare 22.9.2

Appendix 9. Lancaster District evaluation of Population Health Investment Fund.

LDCVS PHF Evaluation final.pdf

Appendix 10. Love Barrow Families Evaluation

LBF final full report - Northumbria Universi

Love Barrow Families - Oversight, key issues