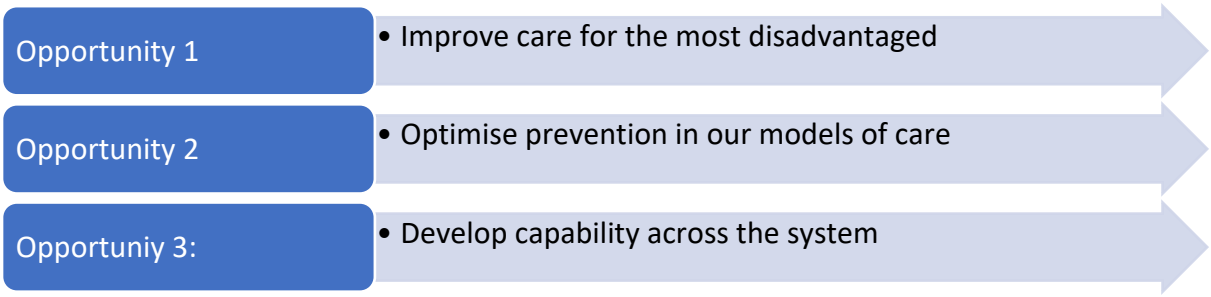
NHS
Lancashire and South Cumbria
Integrated Care Board

Health Inequalities & Prevention Plan, 2024-25

Health outcomes for people living in Lancashire and South Cumbria are significantly worse compared to the national average. There are also significant health inequalities between most and least deprived areas within Lancashire and South Cumbria.

The ICB has a comprehensive approach to reduce health inequalities through improving access, experience, and outcomes with a particular focus on making the greatest improvement, fastest for people who face the greatest barriers to good health. The ICB has also developed a much clearer focus on prevention programmes including the agreement and implementation of the new LSC Tobacco-free strategy.

As an ICB we face a significant financial deficit however the population health approach is recognised as being a key enabler for the System Transformation and Recovery Programme. This document has been drafted by colleagues working in several ICB teams to confirm the plans they are taking forward in relation to health inequalities and prevention. In driving the focus on delivering system balance, we have summarised our priorities into three key opportunities for our system in 24/25:



We will continue to:

- Work with our partners and with communities to tackle the wider determinants of health (the diverse range of social, economic, and environmental factors which impact on people's health).
- Improve support to enable people to make positive health and wellbeing choices.
- Improve detection and diagnosis of illness sooner (eg improving access to health checks and screening for those communities where uptake is low and working with the Cancer Alliance to improve early diagnosis of cancer)
- Ensure that people receive the right evidence-based care keep them well and to avoid unnecessary exacerbations (eg ensuring that people with hypertension receive the right treatment)
- Work with providers in primary care and in trusts to improve equity of access, experience and outcomes for those with a particular focus on the clinical priorities set out in Core20plus5 (for example working with the Provider Collaborative Elective Recovery Health Inequalities Group to understand and support work to target areas of unwarranted variation)

We continue to work in partnership with our colleagues in primary care, trusts, the Provider Collaborative, partnerships in each of our places, local government, the wider public sector, the VCFSE partners, local employers and the people and communities we serve. Place-based working is a focus on how we work and we will continue to nurture and invest in relationships with Public Health and other partners to optimise the opportunities that place-based working can provide.

The plans to address health inequalities and increase prevention are woven throughout many sections of the ICB's Operational Plan 24/25, however for ease of reference we have summarised key Core20plus5 and strategic priorities in Appendix 1. Further detail is provided in Appendix 2 and the Cancer Plans are in Appendix 3.

System-wide work led directly by the Population Health Team is summarised in Appendix 4.
Place-based Population health team themes of work is summarised in Appendix 5. These are themes that are consistent across all the places.

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19th July 2024

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APPENDIX 1

Summary of 24/25 Plans
National Strategic Priorities for Health Inequalities and Core20plus5

Strategic Priorities

Strengthen leadership, capacity and capability

- Continue rollout of Population Health Academy
- Continue & strengthen leadership roles for prevention and HI
- Continue to embed population health within place partnerships
- Strengthen governance including commencing reporting at Board level of unwarranted variation and strengthening role of PHISG

Restore NHS services inclusively

- Continue to use the Provider Collaborative Elective Recovery HI Steering Group to support and provide mutual challenge to Trusts
- Expand the eligibility of the frailty element of the GP Quality Contract to include over 50s
- UEC Boards in each place to increase focus on Health Inequalities, eg use PHM approaches to improve equity of access
- Develop strategic approach to improve proactive care in areas of greatest need
- Improve equity of access for children including targeted work on dentistry and paediatric audiology & surgery waiting lists

Mitigate against digital exclusion

- Continue commissioning digital health navigators from VCFSE
- Co-design digital Inclusion Strategy
- Produce guidance on procuring public-facing digital services
- Include cohorts at risk of digital exclusion in co-design work

Ensure datasets are complete and timely

- Improve completeness and accuracy of ethnicity coding in primary care for patients with mild-moderate frailty
- Improve ethnicity coding

Accelerate preventative programmes

- Implementation of tobacco strategy
- Delivery of Trust treating tobacco services in all Trusts
- Secure funding for Alcohol Care Teams
- Deliver DWMP target
- Deliver CVD target improvement
- Establish a Screening and Immunisation Oversight Group and work collaboratively to improve rates in areas of lower uptake
- Continue diabetes improvement programme

Core20plus5 adults

Maternity

- Implement data solution for system-wide repository and analysis
- Establish Maternity & Neonatal Insight, Co-production and Engagement Network & improve diversity in representation
- Fully embed tobacco treatment services in all maternity providers
- Continue InHIP project, infant feeding strategy, vaccination in pregnancy & newborn etc

SMI

- Develop a communication strategy and plan to support, inform and educate around the SMI work
- Commission a bespoke service to improve access for those facing greatest barriers to access
- Increase understanding and awareness amongst MH practitioners
- Introduce outreach approaches eg HARI bus
- Improve data sharing so that checks undertaken in secondary care are recorded in primary care
- Commission work to raise awareness in PCNs

Cancer Early Diagnosis

- As per separate Cancer Alliance Plan

Hypertension Case Finding & optimal lipid management

- Deliver 80% Hypertension treatment to target by March 2025
- Increase hypertension case-finding to find the 50% of those with HTN that don't know they have it
- Continue to maintain and improve primary and secondary prevention for high cholesterol
- Deliver the national target of 60% of patients with a QRISK equal orgreater than 20% but no diagnosis of CVD, to begin LLTs.

Chronic respiratory disease

- Use patient outcomes as a measure to review services
- Identify duplication and opportunities for collaboration with other workstreams across the ICB
- Continue to support pulmonary rehab clinical staff to enable them to target most "at risk" population groups
- Explore digital offer for pulmonary rehab

Core20plus5 CYP

Asthma

- Work with partners in secondary care to eradicate salbutamol weaning plans and replace with Personalised Asthma Action Plans,
- Work with primary care to upskill practitioners & optimise treatment
- Evaluate community champions-led model of asthma education
- Roll out digital passport asthma app
- Deliver education in Family Hubs
- Roll out asthma friendly schools programme
- Collaborate with partners to improve indoor and outdoor air quality

Oral Health

- Identify children on waiting lists for extraction, targeting social disadvantage and ethnic heritages most at risk
- Ensure a targeted approach to improving wait times
- Work alongside public health to deliver supervised toothbrushing and GULP programmes
- Implement a prevention programme related to eradication of tooth decay with dentistry colleagues

Epilepsy

- Ensure all children with a learning disability or autism have access to an epilepsy specialist nurse in the first year of care
- Ensure databases are in place
- Pilot and evaluate a mental health screening tool for CYP
- Ensure robust mechanisms are in place for sodium valproate prescribing to minimise and eradicate harm to future generations

Diabetes

- Address inequalities related to the uptake of diabetes technology to optimise the health outcome:-
  - Targeted education
  - Ensure equity of access to diabetes technology
  - Implementation of NICE technology appraisal relating to Hybrid Closed Loop Technology
- Improve care for children with Type 2 diabetes by:-
  - Evaluating VCFSE pilot undertaking targeted advice to children of south Asian heritage
  - Evaluating pilot working 1:1 with children using a health coach and behaviour change model

Children and Young People's Mental Health

- Improve waiting times by working with partners including mental health support teams, digital access and peer support
- Launch a Blackpool based project to bring NHS, Local Authority, researchers, voluntary and community organisations and residents together to tackle health inequalities with focus on young people's mental health, substance misuse, life-limiting illness, grief and bereavement
- Continuing procurement of digital mental health contract
- Continuing work on Healthy Young Minds Website

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APPENDIX 2

Strategic Priorities	
Restoring NHS services inclusively	**Elective Recovery**
	1) Continue to strengthen the Health Inequalities Steering Group within the Provider Collaborative Elective Recovery Programme with an increased focus on supporting key leads in each Trust in their work, recognising that each Trust is at a different stage of developing this work and has different areas of unwarranted variation. In particular, support Trusts to ensure: a. Understanding of local areas of inequity in access, experience and outcomes b. Effective reporting to Trust Boards and ICB Board regarding inequity c. Alert referrers/commissioners where unwarranted variation in referrals /timeliness of referrals are identified (e.g. late-stage cancer referrals) 2) Refresh programme governance to ensure that improving health equity is a consistent theme throughout Elective Recovery programmes 3) Establish Improvement Collaborative approach to embed and support the work across LSC and exploring the use of IHI methodology to support this 4) Undertake deep dive into the consequences of patient choice and use of independent sector and mutual support to understand impact in terms of equity of access, experience, and outcomes 5) Increase visibility of the work within Trust, Provider Collaborative and ICB comms and help showcase areas of good practice and build an understanding that this is everyone's business
	Primary Care
	1) Expand the eligibility within the Frailty element of the 2024/25 General Practice Quality Contract to include over 50s, recognising that in areas of greater disadvantage a significant proportion of the frail population were being missed by the >65 eligibility criteria. 2) To work with partners to improve vaccination rates in areas of lower uptake (see separate section on vaccination) 3) To continue work through PCNs and practices to improve Hypertension treatment to target (see separate hypertension section) 4) PCN Health Inequalities Clinical Leads to continue local work to improve support for people who are under-served 5) PCNs to continue to improve detection and support for people who may not access routine NHS health checks or may need outreach and inclusion approaches to connect them to the support they need (previously called "Enhanced Health Checks", but re-framed based on learning and feedback in 23/24 to be a broader "Inclusion approach")

	Note the PSED objective on primary care ethnicity coding objective is included under "Ensuring datasets are timely and accurate"
	Urgent and Emergency Care including High Intensity Users
	1) UEC Boards in each place to develop their own local UEC improvement plans, taking into account end to end pathway and responding to population needs, utilising PHM tools and approaches 2) Population Health Place teams supporting local work to reduce unnecessary urgent care demand through:- a. Promoting a focus on tackling health inequalities and identifying trends in increased levels of need for UEC in IMD 1 & 2 neighbourhoods b. Brokering across partner organisations to focus on geographical areas, including priority wards, and other areas that need a focussed approach, to understand the underlying issues our population face c. Understanding the challenges and barriers communities face in accessing wider health and care services looking to address inequity in access and ensure inclusion health groups are accessing timely interventions in the most appropriate setting to meet their individual needs, including considering pathways for high intensity users d. Work to improve equity of access to urgent community response services and reduce cultural barriers to support for people in their own homes, where suitable.
	Children and Young People
	1) Ensure validation of children on waiting lists, with a deeper understanding of the health inequalities affecting the children who are waiting. 2) Targeted work relating to dentistry paediatric audiology waiting lists to reduce the impact on the child's development. 3) Ensure targeted work in relation to children waiting over 65 weeks for surgery
Mitigating against Digital exclusion	1) The ICB digital directorate has commissioned VCFSE providers to support the digital inclusion agenda across primary and secondary care for the past 3-4 years and intends to continue commissioning the support of digital health navigators specifically to mitigate against health inequalities in the deployment of the ICS-wide Patient Engagement Portal. 2) The ICB digital and population health teams will jointly lead the co-design of a LSC Digital Inclusion Strategy with partners from health, care, VSCFE and local authorities (including library services), gleaning on insights from the Have Your Say – Digital Health report published in 2019 and measuring our impact against the recommendations of that report while gaining fresh insights from our local communities. 3) This strategy will embed the principles of the (currently awaiting signoff) LSC Digital and Data Strategy and will support delivery against the National Framework for Inclusive Digital Healthcare (NHS England » Inclusive digital healthcare: a framework for NHS action on digital inclusion).

	4) Supporting this strategy, the digital directorate will produce guidance for teams and services on considerations when procuring patient/public facing digital services, to ensure risks are mitigated and products meet the requirements and needs of those who will use them. 5) We will utilise the Population Health Management tools currently available in LSC, as well as any available trust intelligence, to help identify those cohorts or individuals at increased risk of digital exclusion, in order to include them in any co-design work and support them to become digitally activated. 6) We will investigate the need for a Digital Inclusion Impact Assessment process for use by any service of programme that seeks to implement digital solutions to healthcare problems to ensure that no elements of our populations are excluded.
Ensuring datasets are complete and timely	1) ICB Business Intelligence continue to participate in work being coordinated by NHS England North West Region team that has a focus on improving ethnicity recording. 2) To improve completeness and accuracy of ethnicity coding in primary care for patients assessed as having mild-moderate frailty. This will enable us to understand frailty in different ethnic groups, to map need and to tailor services to better reflect needs. The objectives for 24/25 are:- a. to have completed an audit of completeness and accuracy by December 2024, to provide a baseline for future improvement for patients within the assessed frailty cohorts. b. aspiration of 80% having up to date and accurate ethnicity coding for those patients who have received a frailty review by March 2025 (PSED objective) 3) Establish routine reporting in line with NHS E Legal Statement on Health Inequalities reporting, which includes regular reporting of metrics by ethnic category.
Accelerating preventative programmes	**Alcohol Care Teams**
	1) Work is underway to secure an agreement to commission the two existing ACTs (ELHT and BTH) recurrently from April 2024 (dependent on commissioning decision). Providing this is agreed, work during 24/25 will be: - a. To establish substantive posts in the teams. b. To address findings of the Peer Review when published (BTH) c. Continue strengthening pathways into community services 2) If agreed in principle as a commissioning intention, develop a business case and 3-year phased investment plan to roll out ACT provision across hospital sites in LSC including inpatient MH sites.
	Tobacco
	1) Ensure inpatient acute and maternity treating tobacco dependency services are delivering against national model, submitting data and meeting agreed national targets

	2)Ensure full implementation of the Inpatient Mental Health treating tobacco dependency service at LSCFT according to national model, including data submission and supporting research at national level 3) Work with partners to: a. Support delivery of the NHS aspects of the Smoke Free Lancashire & South Cumbria Strategy b. Deliver system-wide tobacco free campaign to increase the reach, representation, receptivity, and accessibility of smoking cessation messages. c. Ensure robust referral pathways into community services 4) Establish a ICB Treating Tobacco Dependency Dashboard to link data from the national dashboard with the latest fingertips, NHS activity and patient outcome data to demonstrate the impact (phase 1) and incorporate LA TTD service data and Advanced Pharmacy offer data (Phase 2). 5) Use PHM approaches to identify wards that would benefit from a targeted smoke free offer and work with service providers, public health, and place-based population health leads to introduce targeted interventions to these areas. 6) Identify efficiency savings in TTD services based on standardisation of services and centralised processes. Including centralised NRT procurement, shared specialist service roles across Trusts, joint Tobacco and Alcohol teams 7) Implement national projects within LSC including roll out of digital NHS staff offer, E-incentive scheme for pregnant women, trial of use of vapes as a quit aid (Swap to Stop).
	Weight Management
	1) Map weight management services to understand equity of access (NHS & LA commissioned services) in order to ensure access to services (including addressing known gaps in access to Tier 4 service) 2) Use data to target areas of most need to provide additional behaviour change support for people with characteristics that suggest they may be less likely to complete behavioural and lifestyle change programmes to reduce and manage their weight 3) Support the continued roll out of DWMP programme across primary care (target is 4205 people across LSC for 24/25)
	HIV & Emergency Department Blood Born Virus Screening
	1) In accordance with the HIV action plan 2025: work to deliver 80% reduction in HIV diagnosis 2) Ensure that the aims of the Fast Track City initiative are achieved. 3) Improve access to HIV Care in looking at the current HIV workforce- make a case to increase staffing to ensure that we can provide outreach. 4) Implement HIV support for those in South Cumbria. 5) Increase nursing hours in the North to ensure greater accessibility to HIV Care.
	Diabetes

	1) Have a stronger focus on 'patient' and citizen voice, including among those who find it harder to engage with services. 2) Review of GP quality contract. 3) Recovery of 9 key diabetes process in place. 4) Roll out of consistent Structured Education Programme (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) to improve self-management and patient control over their diabetes. 5) Roll out of Oviva service for Type 2 Diabetics to improve self-management.
	Screening
	1) Consider establishment of a LSC Screening and Immunisation Oversight Group to strenthen LSC oversight 2) Work with NHSE Public Health commissioning team, primary care and place teams and Local Authority colleagues to improve uptake, with particular focus on areas of lowest uptake 3) Work with Cancer Alliance colleagues to ensure alignment with Early Diagnosis plans
	Vaccinations – covid 1) Spring covid vaccination program will be running from April 2024 to June 2024. 2) Planning will continue for the Winter 24/25 covid programme. 3) The transition of section 7A to the ICB is due to take place in 2025/26, therefore planning and preparing for the transition will take place throughout 24/25.
	Vaccinations – other
	1) Work with NHSE Public Health commissioning team, primary care and place teams and Local Authority colleagues to improve uptake, with particular focus on areas of lowest uptake 2) Continue focused activity to improve uptake of MMR vaccine 3) Prepare for delegation of commissioning responsibility to the ICB in April 2025
	Learning Disabilities and Autism
	1) Work in partnership with system partners and experts by experience to improve access to universal services with a focus on reasonable adjustments. 2) To deliver learning disability and autism awareness training, providing a Learning Disability & Autism champion model of support infrastructure. 3) Upskill community services and work with place-based teams and hospital trusts to address and action local priorities, with the ambition to improve and standardise access to equitable services across the LSC footprint.
	CVD

	1) Creation and dissemination of 3-pronged coaching and support offer through PCNs, Cardiac Network and HINWC 2) Develop and implement 3 year training and education plan based on CVD Learning needs assessment currently underway 3) Continual data interrogation into HI around CVD, monthly/quarterly reporting on improvements and decreasing the gap 4) Provide HI expertise to end-to-end pathway discussions for LTCs 5) Update and future promotion of Healthy Hearts web page 6) Continued weekly input into the GP newsletter and PCN/primary care events **AF** 1) Continue to maintain and improve AF detection & management as outlined within the Transforming CVD Prevention, Detection & Management Strategy (led through Stroke Prevention workstream) 2) Work towards the 2029 Long Term Plan ambitions of a. Diagnose 90% of people estimated to have AF (QOF) b. Treat with anti-coagulation 90% of those with AF identified as high risk (CVDP002AF) 3) Improve access to detection devices within the community at population-led settings, 4) Use MECC approach to incorporate AF within BP check 5) Awareness raising across healthcare organisations, especially where diagnosis is very low. **Chronic Kidney Disease (CKD)**: 1. Roll out larger pilot of CKD-SPAN program assisting primary care practices in CKD case finding and validation of CKD registers. Aiming for 95% agreement in participating practices. 2. As part of CKD-SPAN, reducing duplication from targeted blood and urine testing. Aiming for >90% eGFR testing and >65% uACR testing of CKD patients in year 1 of participating practices. 3. Rolling out NICE recommended Kidney Failure Risk Equation routine reporting and accompanying education package starting with Central Lancs>Morecambe bay>Blackpool>East Lancs by end of 2025. **Hypertension & Cholesterol** *(covered below in Core20plus5 section)*
Leadership & Accountability – capacity and capability	1) Increase the number of people trained and supported to play their part across the wider NHS system in LSC including: a. continuing to deliver the Population Health Leadership Academy, with the introduction of new “Senior leaders” and “Emerging Leaders” programmes b. continued masterclasses for graduates of the leadership programme c. the expansion of communities of practice including supporting the Core20plus5 workstreams and the “Health Inequality Ambassadors” d. Review the way we deliver personalised care training and build it into the strategic workforce approach

	2) Recruit to the agreed new CVD/LTCs prevention role to lead workstream to connect prevention and detection across LTCs 3) Continue to commission clinical leadership roles in PCNs 4) Continue strengthening the role of population health within place based partnerships
Leadership & Accountability - governance, accountability and assurance	1) Commence reporting at Board level of unwarranted variation and Core20plus5 metrics with the first report against the new national metrics due to be available in April 2024 2) Review the Prevention and Health Inequalities Steering Group including strengthening the governance and reporting arrangements, increasing Trust, Provider Collaborative and Primary Care representation and continuing to evolve the close working with the Public Health Collaborative 3) Increase the use of a health equity weighted funding formula 4) Develop a business case for the ICB to increase expenditure on prevention and inequalities for future years, including strengthening work on return on investment
Inclusion health	**Workforce and EDI** 1) Set up People and Culture Steering Group within the ICB to ensure that the ICB enables colleagues to feel supported in their work and to have a consistently inclusive and compassionate culture. 2) Continue work on embedding EHIIRA policy across ICB including specialist training resources. 3) Follow the plan set out in in ICS Belonging Plan 2023-2028 4) Setting up ICB staff networks for dedicated and inclusive spaces to allow staff to support each other, raise awareness, and influence meaningful change in the workplace. 5) All staff to have yearly health and wellbeing conversations as part of their appraisal, and training for managers on how to have these effectively if needed. **Service** 6) Support the development of local primary care teams to continue to move towards more inclusive health approaches that enable those with greatest need to access services, this includes: a. Working in collaboration with LA commissioners to prioritise health equity in calling people forward for standard NHS health checks and offering further support (i.e. social prescribing and further screening) where appropriate using the Enhanced Health Check templates where helpful.

	b. Actively pursuing inclusion approaches and working with key community partners, to meet people with greater need where they are and 'plugging' in support offers with the aim of providing immediate assistance and breaking down barriers to people accessing services in a more standard way long term 7) By March 2025 to have used the 2021 census data to map the LGBTQ population for Lancashire and South Cumbria and to understand the correlation with Core20plus populations. *(PSED objective)*
Core20plus5 Adults	
Maternity	**Enablers** 1) Implement data solution for system-wide repository and analysis to inform health needs analysis, intervention planning and evaluation of impact 2) Establishment of the Maternity & Neonatal Insight, Co-production and Engagement (ICE) Network. 3) By March 2025, to demonstrate that maternity and neonatal insight, co-production and engagement (ICE) activity is focused on service users and their families who are representative of the diversity of the local (maternity) population. This will support delivery of "Intervention 6: ensure the MVPs in your LMS reflect the ethnic diversity of the local population, in line with NICE QS167". This will be demonstrated through: a. Development and implementation of a robust, system-wide data collection tool for ICE activity b. Updated population health needs analysis of the maternity population which will include population demographics *c.* Delivery of targeted ICE activity with identified cohorts and communities *(PSED objective)* 4) Link with wider Maternity (and Neonatal) workforce workstreams to ensure equity is a golden thread and that the equity requirements for workforce are addressed including WRES
	Projects 1) InHiP – Increasing in community literacy regarding pre-eclampsia and screening / Insight work with communities regarding development of enhanced continuity of carer teams 2) Smoke-free Pregnancy – To fully embed the in-house treating tobacco dependency service in all four maternity provider Trusts & Insight work in identified communities regarding smoking and vaping during pregnancy 3) Infant Feeding – Ratification of the new Infant Feeding Strategy by the ICB & Action Plan commenced in all localities 4) Vaccination in pregnancy and newborn – Fully operationalise in-house vaccination services for pregnant women and newborns 5) Personalised Care and Support Plans to be in place and fit for purpose for all women 6) Maternal Medicine Network – Robust data capture and reporting for ethnicity and IMDD 7) Inclusion of consideration of Ethnicity, culture and language as part of Serious Incident Reviews – using PSIRF

	8) Development and commencement of the Workforce Equality Action Plan
Physical health checks for those with SMI	1) The development of a communication strategy and plan to work with key organisations and people to support, educate and inform around the PH SMI work. 2) Commissioning a bespoke service which will work with the hardest to reach patients to try and encourage their participation in receiving a health check. 3) Consider training and education opportunities to improve knowledge within organisations in contact with the targeted group (local authorities, VCFSE organisations, pharmacies etc). 4) Work to improve engagement with the MH practitioners (ARRS roles) and promote the checks and their importance. 5) Determine where we can utilise other services across the patch to deliver checks e.g. HARI's bus (health checks in community settings; Remote digital PH SMI checks; population health Enhanced Health Checks. 6) Investigate different approaches to working with people to ensure they access their checks. For example, using a video approach for patients which provides information on what their check means for them and practical information about their check. 7) Work to improve data sharing between secondary & primary care to improve reporting on checks undertaken by them and enable recording in primary care. 8) External communication and engagement organisation commission to work with PCNs to raise awareness of performance (previously undertaken in other MH areas including suicide awareness and talking therapies with some success). 9) PLT (Central) & Blackpool Service PMI (BTH) – review of legacy services commissioned in some CCG areas to provide additional checks for this patient group.
Cancer early diagnosis	The submitted Cancer Alliance plans include detailed plans for early diagnosis and reducing health inequalities – to avoid duplication it is attached as Appendix 2
Hypertension case finding and optimal management and lipid	**Hypertension** 1. Improve on 70% of patients on the hypertension register being treated to target, aiming for 77% by March 25 (target of 80% by March 2029), with plan for all places/sub divisions to be over 72% (Covid recovery) and decrease the variation of the data 2. Increase case finding utilising HI data and National materials to find the 50% of those with HTN that don't know they have it.

optimal management	3. Support Primary Care to follow-up on 400k+ patients who have a recorded high BP reading on EMIS but no follow up investigation recorded **Cholesterol** 1. Continue to maintain and improve Primary Prevention of high cholesterol as outlined within the LSC Transforming CVD Prevention, Detection & Management Strategy 2. Continue to maintain and improve Secondary Prevention: STF funding pilot (evaluate and grow), Lab reporting project to support Primary Care interventions, End to End pathway 3. Work towards the national (& LTP ambition) of 60% of patients who have a QRISK equal to or greater than 20%, but no diagnosis of CVD, to begin LLTs (CVDP003CHOL) (NB threshold may drop to 10%, thereby significantly increasing the target number), including:- a. Easier access to cholesterol detection devices within the community at population led settings b. MECC approach with BP check c. awareness raising across general public d. Work at Place and at system level e. Improve rates of NHS HC in community, GP and workplace (should bids be successful), f. Mythbusting statins across L&SC (misinformation more prevalent in differing localities) g. Medicines Optimisation work around prescribing in lipid management (details TBC) 4. Build injectables model that supports the patient, as well as working well for primary and secondary care 5. Familial Hypercholesterolemia (FH): a. Publication of Amgen benchmarking findings/Pathway creation and implementation b. Focus on improving access to FH services c. FH training across the board for healthcare professionals d. HI audit around FH access, diagnosis rates & genetic testing
Chronic respiratory disease (driving up covid, flu and pneumonia vaccination rates)	1) Use patient outcomes as a measure to review services offered. 2) Consider the patient journey when designing, implementing and evaluating services 3) Understanding multiple duplication in teams across the ICB and how there can bAsthmae more collaboration across workstreams. 4) Continue to consider the impact of long covid and the role of respiratory services in this. 5) Continue to support pulmonary rehabilitation clinical staff to enable them to target patients from the most ‘at risk’ population groups. 6) Explore digital offer for Pulmonary Rehab which will improve data capture and support alternative access options for those that may prefer remote coaching.
Core20plus5 – Children and Young People	

Asthma	1) Working to address the over reliance of reliever medications and reduce asthma attacks. 2) Data relating to acute admissions for asthma exacerbations highlights that over 50% of these are for children living in the areas of highest social deprivation. To address this the children's team are working with partners in secondary care to eradicate salbutamol weaning plans and replace these with Personalised Asthma Action Plans, further ensuring asthma attacks are treated according to severity, thereby reducing salbutamol toxicity. 3) Working with partners across Primary Care to upskill practitioners and ensure optimisation of asthma treatment for all children. 4) Evaluation of the community champions led model of asthma education and self-empowerment with our most vulnerable communities. 5) Roll out the digital passport asthma app to promote self-empowerment and optimal management for all children and families. 6) Working at a priority ward level to deliver education in Family Hubs to self-empower and reach our underserved communities. 7) Roll out of the asthma friendly school programme to ensure all children have a Personalised Asthma Action plan and access to an emergency inhaler in school. 8) We will collaborate with our partner agencies to improve indoor & outdoor air quality with a particular focus on smoking, vaping & housing conditions. These include collaborating with schools to achieve Asthma Friendly Status.
Complications of Excess Weight	1) Work on a system wide action plan to improve care and outcomes for children with excess weight. 2) To devise a training programme with LA colleagues in order to upskill our workforce regarding how to have a compassionate, often emotive discussion with children and families. 3) Link local authority VCFSE and health pathways together to maximise access to services for children and young people. Endeavour to find a simple solution for health care professionals to easily signpost families in need of this support. 4) Maximise any opportunities arising from the NCMP screening programme, signposting children and families to targeted support in their own community 5) Continue the PASTA and GULP programmes across local authority areas. 6) Ensure a safeguarding pathway is in place to provide targeted help for children in need.
Oral Health	1) Identification of children on waiting lists for dental extractions, targeting inequalities relating to deciles of social deprivation and different ethnic heritages 2) Ensure a targeted approach to improving the wait times for these extractions. 3) Work alongside public health colleagues to deliver supervised toothbrushing and GULP programmes. 4) Implement (subject to agreed funding) a prevention programme related to eradication of tooth decay with dentistry colleagues.
Diabetes	1) Addressing inequalities related to uptake of diabetes technology in order to optimise the health outcome of the CYP by:

	a. Ensure targeted education and work with children from different heritages and every social background have access to diabetes technology. b. Implementation of the NICE Technology Appraisal relating to Hybrid Closed Loop Technology 2) Improve Care for children with Type 2 diabetes by: a. Evaluating the VCFSE pilot undertaking targeted help advice to children of South Asian heritage. b. Evaluating the pilot working 1-1 with children using a health coach and behaviour change model to intervention.
Epilepsy	1) Ensuring that all children with a learning disability or autism have access to an Epilepsy Specialist Nurse in the first year of care 2) Ensuring databases are in place to record this information, with targeted support to ensure children are seen by an ESN. 3) Pilot and evaluate a mental health screening tool for CYP to ensure they receive early interventions where needed. 4) Ensure robust mechanisms are in place for sodium valproate prescribing to minimize and eradicate harm to future generations of children.
Children and Young people's Mental Health	1) Improving waiting times for young people with mental health problems within the ICB by working with partner organisations to enable young people to have access to mental health services. Partners include mental health support teams, digital access and peer support. 2) Launching a Blackpool based project that will bring the NHS, local authorities, researchers, voluntary and community organisations and residents together to tackle health inequalities. It will focus in particular on mental health, including: a. young people's mental health b. substance misuse c. life-limiting illness, grief and bereavement 3) Continuing the ongoing process of procurement for a digital mental health contract for young people. 4) Continuing to work with partners and stake holders to ensure our "Healthy Young Minds" website is informative and useful for young people, carers and parents throughout Lancashire and South Cumbria.
Children with medical complexities	1) Implement a commissioning framework for the neurodisability pathway to target current health inequalities and existing long waits for support and treatment. This will include pre and post assessment support to ensure families receive the most appropriate level of help at the earliest opportunity 2) Implement special school nursing and continence frameworks to help to optimise the life chances and outcomes for children with medical complexities. 3) Ensure access to personal health budgets to maximise lifestyle opportunities and positive experiences for children

Cancer Alliance Early Diagnosis and Health Inequalities Plan (*excerpt from Cancer Alliance Plan*)

4.1 Working with ICBs to improve rates of Early Diagnosis

In Lancashire and South Cumbria ICB, we consistently have a lower proportion of patients presenting at early stage than nationally and compared to some of our ICB peer groups. Our current staging data taken from the RCRD data set (Stage 1 and Stage 2) performance is 56.3% v 58.6% nationally.

Our target is to improve stage shift by 2.5% this year which would put us in line with current National performance. In the next three years we will be looking at improving performance to build upon this to achieve the national target of 75% by 2028.

Too many of our population are being diagnosed late, and individuals facing the greatest we fall behind in many other categories, most significantly in Upper GI, Oesophageal and Prostate. We are also below the national average in Colorectal, Lung, Haematological and Urological excluding Prostate.

Screening

We reviewed screening uptake across breast, cervical and bowel. We are failing significantly on breast and cervical uptake across Lancashire & South Cumbria.

Based on June 2023 data breast screening uptake (age 50 – 70) our current position is 70.4% against a national target of 80%. England average is 66.6%. We intend to increase coverage by 2.5% to 72.9%

Based on June 2023 data cervical screening coverage (age 25-49) our current position is 67.7%, England average is 67%. We intend to increase coverage by 2.5% to 70.2%

Based on June 2023 data our bowel screening uptake is currently 69.8% England average is 70.3%. We need to maintain and improve our currently rates.

4.2 Screening

Deliverables	• **Work with NHSE Regional Public Health Commissioning Teams and local partners to develop and deliver plans to increase uptake and coverage of the NHS breast cancer, bowel cancer and cervical screening programmes.** • **Work with Regional public health and local authority commissioners to develop and deliver plans jointly with local system partners to encourage the uptake of HPV vaccination in the catch-up cohorts.**

We will use data and insights to identify and understand cancer health inequalities across Lancashire and South Cumbria in relation to all screening programmes. We will use Core20Plus5 approaches to tackle health inequalities, working with a wide range of partners at system and at place in order to make the greatest impact.

HPV:

As current commissioner of NHS Cancer Screening Programmes – bowel, breast and cervical - and the HPV vaccination programme, NHS England North West's priorities are to:

- Work strategically in collaboration with system partners - ICBs, Cancer Alliances and Local Authorities and PCNS - to promote uptake of the HPV vaccine and participation in cancer screening maximising national and local resources/assets, improve access, uptake and coverage and address unwarranted variation
- Continue to ensure delivery of high-quality cancer screening services and HPV vaccinations (as part of the school aged immunisation programme) that are accessible to the eligible population
- Work with system partners and screening providers to develop and implement targeted approaches to increase uptake across the footprint within the school age immunisation service for HPV vaccine and all cancer screening programmes safely with a continued focus on reducing health inequalities
- Work with the North West HPV screening laboratory to ensure turnaround times are consistently met for continued high levels of activity in the cervical screening programme
- Ensure continued delivery of the HPV vaccine to the eligible population with a particular focus on areas of low uptake

Screening:

Work with ICBs to ensure workforce capacity is in place to support both screening, diagnostic capacity, and symptomatic pathways across Breast, LGI and gynae pathways. Within LSC we have particular pressures within our Endoscopy services, we will ensure that work close with our diagnostic partners to ensure that we have sufficient capacity in place.

- to be able to deliver national priorities and programme changes in the bowel, breast and cervical screening programmes
- Continue to work with providers and the Screening Quality Assurance Service (SQAS) to ensure programme standards are maintained in order to deliver safe and high quality services
- Work with bowel screening programmes to implement Years 4 of Age Extension for 50 & 52 year olds, continue to integrate individuals with Lynch Syndrome into the programme
- Work with breast screening providers to ensure that venues for mobile screening sites meet the needs of the eligible population
- Develop longer term strategies to support forward planning in collaboration with system partners, incorporating national changes and guidance focusing on all screening programmes, but utilising a phased approach to ensure the quality and safety of programmes can be maintained
- Support Programmes to explore the potential to pilot national planned programme changes including lowering the FIT threshold (bowel). (See FIT 3.3 further details)

4.3 Timely Presentation

Deliverables	• **Set out Timely Presentation objectives, informed by data and insights, with a particular focus on the most disadvantaged 20% .**

	• **Deliver programme of campaigns, community engagement and partnership activity to increase symptom knowledge and encourage earlier presentation, which link where appropriate to national Help Us Help You campaigns.** • **Establish metrics to measure achievement of objectives and review tracking regularly.**

Communication and Engagement

Our communication and engagement approach will focus upon planning, developing and delivering externally-facing behavioural change campaigns to:

- increase uptake of bowel, breast and cervical screening among our population
- encourage timely presentation for a small number of high-priority tumour types in locations where outcomes are currently worst

This will be delivered in coordination with national campaigns and awareness months and through working with the Early Diagnosis Steering Group which oversees the timely presentation projects that we are investing in this year. These projects will be delivered through utilising Core20Plus5 approaches including outreach work specifically in disadvantaged communities and with health inclusion groups.

Patient and public involvement with relevant individuals and/or groups will be carried out to inform the development of communications and engagement initiatives.

Local Data

We have reviewed our staging and screening data and as sited above we are focusing our projects on where our focus needs to be on the most disadvantaged 20% and health inclusion groups.

We will use data and insights to identify and understand cancer health inequalities across Lancashire and South Cumbria in relation to timely presentation. We will use Core20Plus5 approaches to tackle health inequalities, working with a wide range of partners at system and at place in order to make the greatest impact.

4.4 Primary Care Pathways

Deliverables	• **Work with Primary Care Networks (PCNs) and other primary care stakeholders as required, to outline a clear set of actions and milestones to improve referral practice for bowel, lung and one other tumour site as determined locally, supporting delivery of the early cancer diagnosis requirements in the PCN DES** • **Provide local insights and input into the development of resources to support Cancer Alliances to implement local incentive schemes for primary care**

We have several projects focused at a PCN level. These projects are supporting improvements to screening uptake, symptom awareness and case finding.

We will continue with the development and piloting of the Clinical Decision Support Tool

We will continue with the development of the PCN Dashboard to support primary care colleagues with data content that support them in Early Diagnosis and Screening.

We will continue to develop the GP intranet signposting Primary Care colleagues to Early Diagnosis resources.

We have provided funding to establish 6 Band 4 Cancer Champions that will work with targeted PCN's supporting Early Diagnosis and Screening. They will work closely with the GP Cancer Leads enabling & facilitating sharing of good practice.

PCN Clinical Support

The Cancer Alliance Primary Care Director and the three (1 vacancy) GP Cancer Leads will provide a pivotal role to support early diagnosis working with PCN's across the patch. Whilst we have a vacancy in South Cumbria (Morecambe Bay) for a GP Cancer Lead, we have mitigated this through our investment in Morecambe Bay Primary Care Collaborative and will have clinical leadership in the area whilst this programme is operating.

Primary Care Education

We will work with our Education Team to support a rolling programme of education and awareness around Early Diagnosis aimed at our primary care colleagues.

Details on Health Inequalities

We will use data and insights to identify and understand cancer health inequalities across Lancashire and South Cumbria in relation to primary care pathways. We will use Core20Plus5 approaches to tackle health inequalities, working with a wide range of partners at system and at place in order to make the greatest impact. We will also work with PCNs via their Health Inequalities Clinical Leads to target those areas with specific cancer health inequality challenges.

4.5 Early Diagnosis Initiatives (Innovation)

Deliverable	**Identify, fund, support, evaluate and share learnings from early diagnosis initiatives with a particular focus on the tumour sites with the highest volume of late-stage diagnoses in your area and deprived groups with lower rates of early diagnosis.**

Innovation- (*the following are responses to specific NHSE questions as required in the plan***)**

1. The L&SC cancer alliance are currently delivering the Open call 2 Cytoprime 2 project.

2. As mentioned in earlier diagnosis section – locally working on innovations including Decision Clinical support tools to aid referral practice. Further detail section 4.4. We are also continuing through transitional funding to support the delivery of capsule sponge and CCE delivery to aid diagnostic capacity (FDS), further detail section 6.
3. The L&SC cancer alliance continues to work with the NW health innovation network and we now have a very strong working relationship, we meet monthly and plans for 24/25 include a joint piece of work with the NW health innovation agency and C&M cancer alliance. The proposed plan is for us to provide to the NW health Innovation agency a list of our priority areas and they will do a horizon scan piece of work and then develop an innovation show case for representatives from both cancer alliances to attend, matching us with innovation companies who provide innovate approaches in our priority areas. We also work with the NW health innovation agency on some of the PPIE elements of our projects and plans are in place to continue this on projects in 24/25.
4. **Horizon Scanning :Dragons Den Initiative 24/25-** In 23/24 we ran a successful dragon's den initiative- developing an application proforma and guidance, scoring matrix and held a clinical panel review. We had an overwhelming response with over 19 bids from a number of stakeholder partners including commercial / NHS/charity sector. We funded four local innovation projects-- Genexus a lung sampling pilot in secondary care, the IOAT project a- To introduce the Internation Ovarian Tumour Analysis principles and ADNEX model- assists with differentiating between benign and malignant ovarian tumours in secondary care, a cervical screening self-booking pilot at a GP practice and the development of a primary care pancreatic cancer toolkit for primary care. We intend to run this initiative again in 24/25, with plans being for a communications and engagement piece to go out in Q1(with an increased budget due to last years success) and for successful applications to be awarded in Q2- for projects to commence. As with last year's initiative all pilots will have to provide monthly/quarterly highlight reports with an evaluation after 12 months.
   SBRI bid for Open Call 3- We are currently working with Medtronic and Corporate health on a CCE in primary care bid for SBRI Innovation Open call 3. This will be a collaborative approach with lots of learning from previous successful SBRI partnerships.

Benchmarking: We will continue to work closely with the other Innovation leads from across the UK. Attending and inputting into the innovation community of practice monthly meeting and linking in with innovation colleagues to share learning and knowledge

4.6 Health Inequalities

Deliverables	• **Cancer Alliance to develop, resource and deliver a clear workplan to ensure rates of early diagnosis improve in the most deprived areas by at least as much as in the least deprived areas.** • **Cancer Alliances to use data resources and apply a Core20PLUS5 lens (i.e. looking at deprivation, protected characteristics and inclusion health groups) to embed health inequalities approaches across all programmes of work.**

Working with partners across our system and building on our learning from the IHI Core20Plus5 Collaborative programme, we will work towards embedding a health inequalities focus across all areas of the cancer alliance. This will be year 1 of a 3-year programme to establish, develop, and embed a health inequalities improvement approach.

Our work will utilise the Core20Plus5 framework and a variety of improvement methodologies to embed a culture of continuous improvement and learning across LSC Cancer Alliance and among our system partners in relation to reducing cancer health inequalities.

In particular, this work will be a key enabler to driving towards the Core20Plus5 target of 75% of cancers diagnosed at stage 1 and stage 2 by 2028, and to ensuring that we reduce health inequalities while working towards that target.

Our priorities in 24/25 will be:

- Support the development and delivery of the programme of Early Diagnosis, Screening, and Timely Presentation projects to ensure that they apply a health inequalities focus across their work, linking with partners at place to understand and reach their communities and to meet health inclusion needs.
- Create and share health inequalities learning and improvement approaches such as case studies, bitesize learning, and training/skills development sessions to embed a continuous improvement culture across the Cancer Alliance and our partners in relation to tackling health inequalities. We will utilise the expertise and resources already developed by colleagues across LSCICB and in other cancer alliances, such as Cheshire & Mersey.
- Ensure that we use relevant data and insights to help us to understand cancer health inequalities across Lancashire and South Cumbria and to inform planning and prioritisation.

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APPENDIX 4

Population Health Team - System-wide priorities

Description	Priorities 24/25
1. Strengthen leadership and accountability	1.1 Increase the number of people trained and supported to play their part across the wider NHS system in LSC including:- - continuing to deliver the Population Health Leadership Academy, with the introduction of new "Senior leaders" and "Emerging Leaders" programmes - continued masterclasses for graduates of the leadership programme - the expansion of communities of practice including supporting the Core20plus5 workstreams and the "Health Inequality Ambassadors" 1.2 Commence reporting at Board level of unwarranted variation and Core20plus5 metrics with the first report against the new national metrics due to be available in April 2024 1.3 Strengthen the governance, visibility and reporting arrangements, increasing the alignment with Trusts, the Provider Collaborative, Primary Care and continuing to evolve the close working with the Public Health Collaborative 1.4 Increase the use of a health equity weighted funding formula 1.5 Make moves towards understanding current spend on prevention and establish plans to increase expenditure on prevention for future years 1.6 Improve datasets, in particular ethnicity coding, across all services and sectors of the NHS 1.7 Review the way we deliver personalised care training and build it into the strategic workforce approach
2. Demonstrate a relentless focus on driving equity for our Core20plus populations in the identified clinical areas (adults and children)	2.1 Increase the use of Population Health Management (PHM) and improvement approaches within the Core20plus5 clinical workstreams 2.2 Plan for (and deliver where possible) more joined up, place-based approaches co-produced with Core20plus populations for the things that matter to them 2.4 Take action to avoid people being disadvantaged by the growth of digital access to healthcare
3 Improve detection and management of people who have long term conditions with a particular focus on people in core20plus populations	3.1 Establish a new post to coordinate prevention activities with a particular focus on coronary vascular disease (CVD) and Long term Conditions aiming to:- - improve compliance with treatment guidelines, particularly in terms of hypertension and lipids, continuing the approach taken in 23/24 and increasing the focus on providing targeted support to the areas with the greatest health inequalities - Increase the coordination of campaigns and support for patients (self-management) 3.2 Continue the review of social prescribing in order to resolve historical variations in provision and develop a clear LSC-wide approach

4	Continue to increase the delivery of national evidence-based prevention programmes	4.1 Implement the programme plan to deliver the LSC Tobacco-free Lancashire and South 4.2 Cumbria Strategy programme plan 4.3 Complete the implementation of the Tobacco Dependency Treatment service for people in inpatient mental health services (commenced delivery in March 2023) 4.4 Dependent on agreement of funding, continue the existing Alcohol Care Treatment (ACT) Services for people attending ELHT and BTH and develop a phased implementation plan to roll out ACTs across other sites 4.5 Support work to improve access to screening & vaccination programmes including:- - Strengthening LSC governance and oversight of Screening and Vaccination - Delivering focussed interventions to increase uptake in areas with the lowest update and poorest outcomes
5	Maximise the use of NHS resources to improve the economic wellbeing and environment in which people live and work	5.1 Support Trusts in their role as anchor organisations 5.2 Continue work to maximise the role the ICB can play as an anchor organisation 5.3 Lead the delivery of the WorkWell programme (dependent on bid being successful)
6	Public Sector Equality Duties (draft)	6.1.1 To demonstrate that insight, co-production and engagement (ICE) activity taking place is focused on maternity and neonatal service users and their families who are representative of the diversity of the local (maternity) population. (In order to deliver "Intervention 6: ensure the MVPs in your LMS reflect the ethnic diversity of the local population, in line with NICE QS167") This will be demonstrated through: ▪ Development and implementation of a robust, system-wide data collection tool for ICE activity ▪ Updated population health needs analysis of the maternity population which will include population demographics ▪ Delivery of targeted ICE activity with identified cohorts and communities 6.1.2 Improving ethnicity coding in primary care for frailty patient cohort, in line with the GP Quality Contract. (We are currently refining the wording to be able to state the current rate of ethnicity coding for the frailty cohort and to state the % improvement we are aiming for) 6.1.3 To have used the 2021 census data to map the LGBTQ population for Lancashire and South Cumbria and to understand the correlation with Core20plus populations

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APPENDIX 5

Population health - Place-based priorities

24/25 plans for addressing health inequalities are specific to each place and are decided in partnership with partners at place. Each place is building on the place-based work that has been undertaken in 23/24, in particular the deep dives in Priority Wards, the work off the Health Inequalities Clinical Leads and the Enhanced Health Checks programme. With the continued evolution of place-based working, the plans for 24/25 are increasingly tailored to for each place, however the following summarises a number of consistent themes across these plans:-

Theme	Priorities 24/25
1. Using intelligence and insight	1.1 Identifying areas of significant variation and opportunity 1.2 Working with business intelligence teams, lived experience and the VCFSE to deeply listen, understand the issues and to develop actionable insights. 1.3 Linking health inequality insights to the strategic goals of the ICB and its partners
2. Ensuring effective partnerships & infrastructure	2.1 Support the development of effective governance and delivery infrastructure to: • enable collaborative decision making around the direction of collective resources based on evidence, data and the voice of the people with the greatest need • draw services into the areas of greatest need, meet people where they are and providing immediate support whilst breaking down barriers to them accessing services in a standard way
3. Applying the Inclusion Framework	2.3 Support the development of local primary care teams (practices/PCNs/ INTs) to continue to move towards more inclusive health approaches that enable those with greatest need to access services, this includes: • Prioritising health equity in calling people forward for standard NHS health checks and offering further support to any they suspect may benefit (i.e. social prescribing and further screening) using the EHC templates where helpful. • Applying inclusion approaches and working with key community partners, to meet people with greater need where they are and 'plugging' in support offers (aligned to the national targets, e.g. Imms and Vaccs, CVD, cancer screening, diabetes etc) alongside social prescribing support. With the aim of providing immediate assistance and breaking down barriers to people accessing services in a more standard way long term
4. Improving coordination of activity to identify and support people in our most disadvantaged	4.1 Help to connect LTC workstreams at place 4.2 Supporting improvements in LTC management in the following: - across CORE20PLUS groups - particularly relating to 'detect' and 'protect' categories - Improved delivery - Improved reach / access - Consolidate year 1 work on CVD followed by respiratory

communities experiencing multiple Long Term Conditions	- Strong partner focus on working with public health to further primary and secondary prevention in NHS community settings
5. Building community power	5.1 We will support and encourage partners across the ICS to work in partnership with people and communities to address known inequities of access, experience and outcomes for those living in our most disadvantaged areas. Initially this will build upon ongoing work with engaged stakeholders and communities in our priority wards across Lancashire and South Cumbria, with potential to expand to wider district council level footprints. We will do this by: • Supporting the deliberative involvement of communities to build consensus on key issues affecting them and make their voice a core component of how we make decisions. This will be achieved through a mix of both formal (such as Poverty Truth Commissions and/or citizens assemblies etc) and less formal approaches. • Working with partners to mobilise community assets which have the potential to support prevention, promote health and reduce inequalities. • Driving a community-powered culture within the ICB and across the wider ICS
6. Reducing unnecessary use of urgent & emergency care	6.1 Promoting a focus on tackling health inequalities and identifying trends in increased levels of need for UEC in IMD 1 & 2 neighbourhoods 6.2 Brokering across partner organisations to focus on geographical areas, including priority wards, and other areas that need a focussed approach, to understand the underlying issues our population face 6.3 Understanding the challenges and barriers communities face in accessing wider health and care services looking to address inequity in access and ensure inclusion health groups are accessing timely interventions in the most appropriate setting to meet their individual needs, including considering pathways for high intensity users 6.4 Work to improve equity of access to urgent community response services and reduce cultural barriers to support for people in their own homes, where suitable.