Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

Bristol Health and Wellbeing Board

Impact of COVID-19 and lockdown on health inequalities and steps that need to be taken to address this in the Bristol, North Somerset and South Gloucestershire (BNSSG) health system

1. Purpose

The purpose of this paper is to:

- inform the Health and Wellbeing Board of Healthier Together's current understanding of the impact that COVID-19 has had on health inequalities
- inform the Health and Wellbeing Board of actions that are being considered to address these either at a partnership level or more specifically interventions in healthcare in Bristol, North Somerset and South Gloucestershire
- ask the Health and Wellbeing Board to consider how it would like to have an ongoing relationship with the BNSSG Population Health, Prevention and Inequalities Group

2. Impact of COVID-19 and lockdown on health inequalities

2.1 The Healthier Together Executive Group has used the following documents to help to understand the impact of COVID-19 and lockdown on health inequalities:

- Disparities in the risk and outcomes of COVID-19, Public Health England June 2020
- Beyond the data: Understanding the impact of COVID-19 on BAME groups, Public Health England June 2020
- Local Action on Health Inequalities, Public Health England 2018
- Bristol City Council – Response to UK Parliament Call to Evidence Coronavirus (Covid-19) and the impact on people with protected characteristics
- South Gloucestershire Council Briefing
- Placed-based approaches for reducing health inequalities: foreword and executive summary, Public Health England, July 2019

This is In addition to the data included to describe health inequalities in the Healthier Together 5 Year Plan.

2.2 The following has been taken verbatim from slides presented at a recent South Gloucestershire Council Health and Wellbeing Board about the impact of COVID-19:

- "Whilst COVID-19 was initially seen as 'the great leveller' and a virus that "did not discriminate", it is now clear that the direct and indirect effects of the disease have not been felt equally across society.

- People who live in more deprived areas have higher diagnosis and death rates compared to less deprived areas.
- Hospitalisation and death disproportionally affect some groups including older people, men, low-paid workers, and people from Black, Asian, and Minority Ethnic groups.
- Risk factors for COVID-19 more prevalent amongst these groups may include: poor housing, occupations which do not provide opportunities to work from home, unstable work conditions and incomes, stress, comorbidities such as high blood pressure, diabetes, obesity, and existing heart/lung disease.
- Care Quality Commission and ONS report on COVID-19 and people with Learning Disability: mortality increase of 134% in recent months compared to baseline.
- In addition there will be considerable social and economic consequences, and effects on mental and physical health, arising from lockdown measures. Those "shielding" may be at especially high risk.
- Possible longer term impacts on children who were not able to attend school and/or who had limited access to home learning (inequalities in e.g. digital access, family capacity to support)."

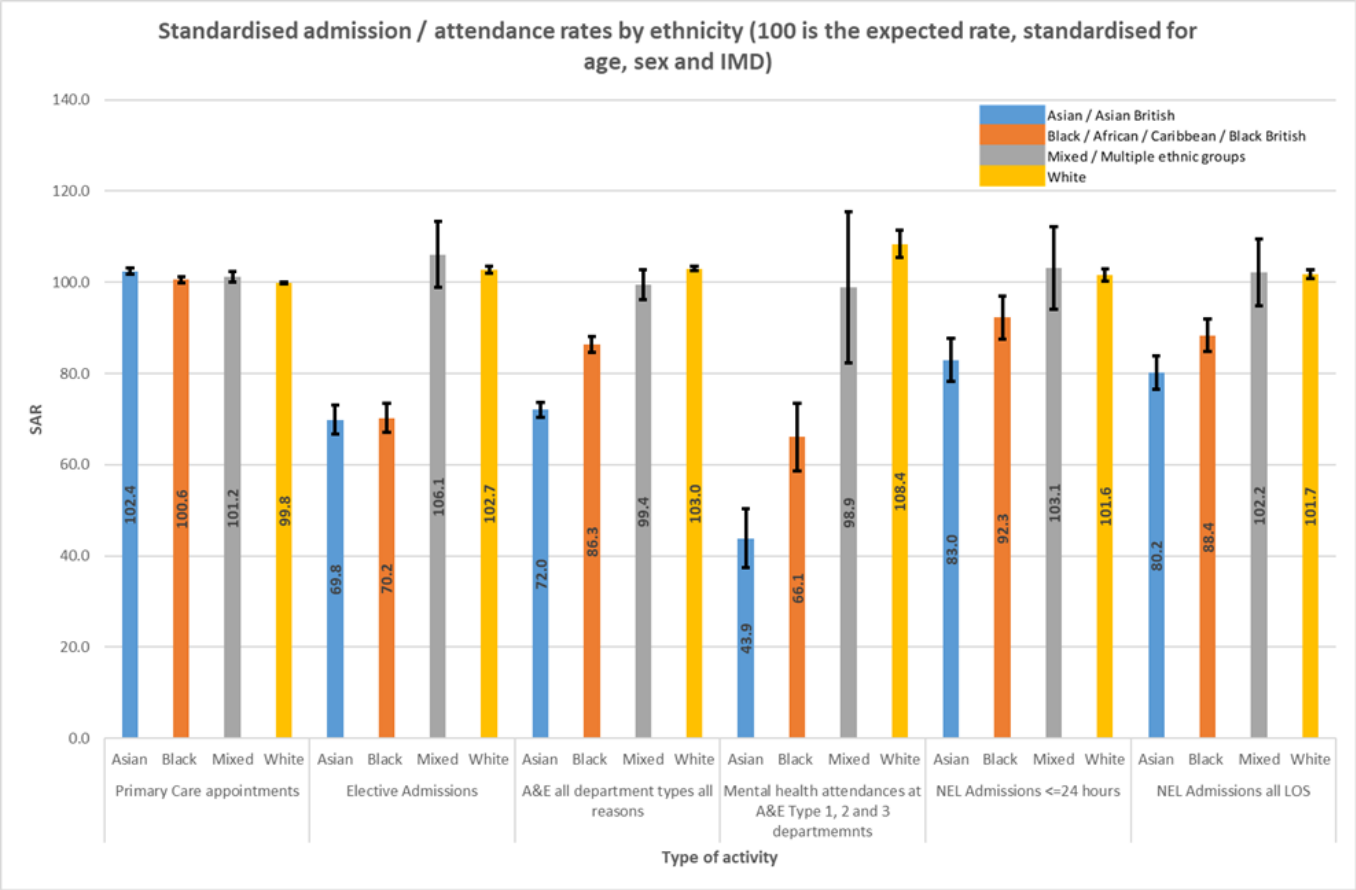
2.3 In terms of deprivation and poverty, in many instances lockdown will have made people's situation worse. Those whose income is low or precarious are more likely to have had their work reduced as they are more likely to be working in parts of the economy which had to shut down or which put them at greater risk of becoming infected with COVID-19 which would in turn affect their ability to work. The Kings Fund report, 'Tackling Poverty: Making More of the NHS in England' draws the following conclusions about the impact of poverty on access to and experience of health:

- Despite the presence of exemptions and grants, many people struggle to pay prescription charges, and travel and other costs can be prohibitive for those with, or with family members with, severe disabilities
- For some groups more likely to be in poverty – such as black and minority ethnic groups – access to primary care services is overall good, but access to other services such as dentistry, and acute care, is less so. Actual experience of care can be worse, even though access is greater
- For some core conditions we know that the NHS can do better, particularly in terms of its support for families at risk of or experiencing child poverty, those with mental health problems and those with long-term conditions – often the same people. This has implications for these people's presence in the workforce, where economic inactivity is a significant risk for poverty.

2.4 In BNSSG, 52% of registered patients do not have ethnicity recorded. The following therefore comes with a health warning to the validity of subsequent analysis.

In terms of understanding access to primary and secondary ("acute") care before COVID-19, Figure 1 shows activity for people who live in BNSSG by point of delivery in 2019/20 by different ethnic groups (95% confidence interval bars are shown).

Figure 1



Independent of age, sex and deprivation (IMD), which will account for some of the possible differences in underlying case-mix (comorbidities), Figure 1 shows significant and large differences in patterns of activity among different ethnic groups, dependent on the point of delivery. Apart from in primary care, where activity was very similar among the groups, Asian and Black populations experienced lower levels of activity across all points of acute sector delivery. In most cases there is a high level of statistical significance in the differences and therefore this is not a chance finding. This might be a result of bias, for example if the missing ethnicity data is predominantly from deprived White populations who don't use health services very often then the White group may appear to be higher users of healthcare. This wouldn't explain however, why primary care usage appears to be equitable where secondary care usage does not.

We have done some analysis on acute hospital activity levels comparing April and May last year to April and May this year. This helps to understand changes

in activity during lockdown. There has not yet been BNSSG specific analysis on community or primary care activity.

Figure 2 describes the percentage change in activity by broad ethnic category between April and May 2019 and April and May 2020. It shows a mixed picture, with the White group generally being the least affected but not always.

Figure 2 Ethnic category percentage change in acute hospital activity

A&E attendances, all types

Ethnicity	April and May 19/20	April and May 20/21	% change
Asian / Asian British	1,165	543	-53.4%
Black / African / Caribbean / Black British	1,588	681	-57.1%
Mixed / Multiple ethnic groups	561	251	-55.3%
White	25,183	11,665	-53.7%
Unknown	32,455	13,080	-59.7%
Total	60,952	26,220	-57.0%

Non elective admissions, all lengths of stay

Ethnicity	April and May 19/20	April and May 20/21	% change
Asian / Asian British	314	193	-38.5%
Black / African / Caribbean / Black British	392	243	-38.0%
Mixed / Multiple ethnic groups	137	69	-49.6%
White	7,266	4,972	-31.6%
Unknown	8,658	4,659	-46.2%
Total	16,767	10,136	-39.5%

Elective admissions, all lengths of stay

Ethnicity	April and May 19/20	April and May 20/21	% change
Asian / Asian British	313	108	-65.5%
Black / African / Caribbean / Black British	282	72	-74.5%
Mixed / Multiple ethnic groups	133	33	-75.2%
White	9,461	2,905	-69.3%
Unknown	7,027	2,062	-70.7%
Total	17,216	5,180	-69.9%

3. What do we need to do?

Note that:

- As a partnership looking at 'place', healthcare partners and the local authorities will want to continue to join up efforts to achieve maximum impact on reducing health inequalities. Currently, the proposals contained in this paper cover health in the main and not the totality of the work of the local authorities or local communities.
- Some of the specific health intervention actions listed may not have had the engagement of those communities affected and may not yet have been co-designed with our local population.
- Although the actions below are described within separate groups, it is obvious that intersectionality (how aspects of a person's social and political identities, e.g. gender, race, class, sexuality, ability, physical appearance, etc. might combine to create unique modes of discrimination and privilege) needs to be considered in our work.

3.1 As a partnership, consider and act on recommendations from existing reports

In terms of **BAME groups**, the Public Health England reports 'Beyond the data: Understanding the impact of COVID-19 on BAME groups' and 'Local Action on Health Inequalities' contain a number of recommendations that the Healthier Together will want to consider as a whole partnership. 'Beyond the data: Understanding the impact of COVID-19 on BAME groups' concludes,

"Throughout the stakeholder engagement exercise, it was both clearly and consistently expressed that without explicit consideration of ethnicity, racism and structural disadvantage in our responses to COVID-19 and tackling health inequalities there is a risk of partial understanding of the processes producing poor health outcomes and ineffective intervention."

The recommendations in both reports have been extracted verbatim and are shown below.

2018 PHE report

"A number of important messages have been identified to support better focus on ethnicity within action on health inequalities:

Mainstreaming ethnicity: Without explicit consideration of ethnicity within health inequalities work there is a risk of partial understanding of the processes producing poor health outcomes and ineffective intervention.

Influencing decision-makers and role of senior leadership: Progress on ethnic health inequalities has been slow and the need for senior leadership on this agenda has been repeatedly highlighted.

Data collection, analysis and reporting: Gaps in data collection must be filled and there must be more consistent analysis and reporting of data on ethnicity, health and healthcare so that there is adequate understanding of local needs and the extent to which they are being met by policies and services.

Action on the wider social and economic determinants of health may exacerbate ethnic health inequalities unless it adequately takes into account the ethnic patterning in residential, income, educational and occupational profiles.

Tackling racism and ethnic discrimination: The central role of racism must be acknowledged, understood and addressed. There is an urgent need to build the evidence base around effective action.

Commissioning of culturally sensitive health promotion interventions: Interventions need to work with cultural and religious understandings and values while recognising intra-group diversity and avoiding stereotyping.

Improving access, experiences and outcomes of health services: Actions at organisational level include: regular equity audits; use of Health Impact Assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff; sustained workforce development and employment practices; trust-building dialogue with service users

Engagement with minority ethnic groups: Across all areas of activity, the meaningful engagement and involvement of minority ethnic communities, patients, clinical staff and people is central to understanding needs and producing appropriate and effective responses or shaping services. A concerted effort is required by public and private sector employers and service providers.

Making use of evidence: The evidence base to inform policy and practice remains limited but more can be done to mobilise the available evidence and to document and evaluate promising local practice both locally and nationally."

2020 PHE report

"1. Mandate comprehensive and quality **ethnicity data collection and recording** as part of routine NHS and social care data collection systems, including the mandatory collection of ethnicity data at death certification, and ensure that data are readily available to local health and care partners to inform actions to mitigate the impact of COVID-19 on BAME communities.

2. Support **community participatory research**, in which researchers and community stakeholders engage as equal partners in all steps of the research

process, to understand the social, cultural, structural, economic, religious, and commercial determinants of COVID-19 in BAME communities, and to develop readily implementable and scalable programmes to reduce risk and improve health outcomes.

3. Improve **access, experiences and outcomes of NHS, local government and integrated care systems commissioned services** by BAME communities including: regular equity audits; use of health impact assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff at all levels; sustained workforce development and employment practices; trust-building dialogue with service users.

4. Accelerate the development of **culturally competent occupational risk assessment tools** that can be employed in a variety of occupational settings and used to reduce the risk of employee's exposure to and acquisition of COVID-19, especially for key workers working with a large cross section of the general public or in contact with those infected with COVID-19.

5. Fund, develop and implement **culturally competent COVID-19 education and prevention campaigns**, working in partnership with local BAME and faith communities to reinforce individual and household risk reduction strategies; rebuild trust with and uptake of routine clinical services; reinforce messages on early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability.

6. Accelerate efforts to **target culturally competent health promotion and disease prevention programmes** for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective management of chronic conditions including diabetes, hypertension and asthma.

7. Ensure **that COVID-19 recovery strategies actively reduce inequalities caused by the wider determinants** of health to create long term sustainable change. Fully funded, sustained and meaningful approaches to tackling ethnic inequalities must be prioritised.

In terms of **learning disabilities**, in response to the recommendations of the Confidential Inquiry into the premature deaths of people with learning disabilities (CIPOLD), the Learning Disabilities Mortality Review (LeDeR) programme has been established. Its aim is support improvements in the quality of health and social care service delivery for people with learning disabilities and to help reduce premature mortality and health inequalities for people with learning disabilities (see health interventions below).

3.2 Third Phase of NHS Response to COVID

On 31 July 2020, NHS England issued a letter that describes the priorities and the requirements for the third phase of the NHS response to COVID-19. This covers the remainder of 2020/21. There is a focus on action on inequalities and prevention. The letter describes this further as,

"We are asking you to work collaboratively with your local communities and partners to take urgent action to increase the scale and pace of progress of reducing health inequalities, and regularly assess this progress. Recommended urgent actions have been developed by an expert national advisory group and these will be published shortly. They include:

• Protect the most vulnerable from Covid, with enhanced analysis and community engagement, to mitigate the risks associated with relevant protected characteristics and social and economic conditions; and better engage those communities who need most support.

• Restore NHS services inclusively, so that they are used by those in greatest need. This will be guided by new, core performance monitoring of service use and outcomes among those from the most deprived neighbourhoods and from Black and Asian communities, by 31 October. Develop digitally enabled care pathways in ways which increase inclusion, including reviewing who is using new primary, outpatient and mental health digitally enabled care pathways by 31 March.

• Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes. This should include more accessible flu vaccinations, the better targeting of long-term condition prevention and management programmes, obesity reduction programmes including self-referral to the NHS Diabetes Prevention Programme, health checks for people with learning disabilities, and increasing the continuity of maternity carers including for BAME women and those in high risk groups.

• Strengthen leadership and accountability, with a named executive Board member responsible for tackling inequalities in place in September in every NHS organisation. Each NHS board to publish an action plan showing how over the next five years its board and senior staffing will in percentage terms at least match the overall BAME composition of its overall workforce, or its local community, whichever is the higher.

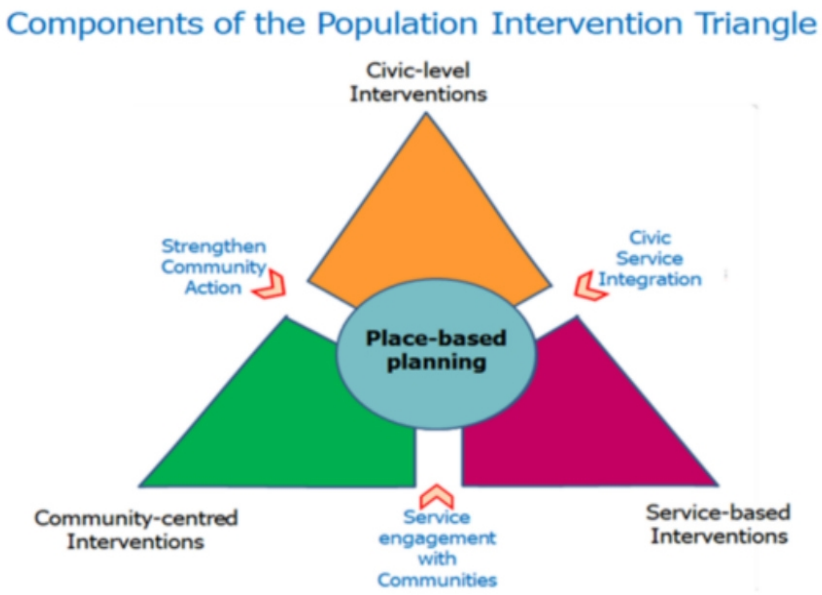
• Ensure datasets are complete and timely, to underpin an understanding of and response to inequalities. All NHS organisations should proactively review and ensure the completeness of patient ethnicity data by no later 31 December, with general practice prioritising those groups at significant risk of Covid19 from 1 September."

Final Phase 3 plans are due by 21 September 2020. All Healthier Together partners have been and continue to work on the writing the Bristol, North Somerset and South Gloucestershire Phase 3 plan and ensuring that the plan is carried out.

3.3 BNSSG Population Health, Prevention and Inequalities Group

This has been set up to direct and move towards whole system tackling of socio-economic and health inequalities. Figure 4 below describes what is needed to improve population outcomes.

Figure 4 Components of the Population Intervention Triangle



Figures 5 and 6 demonstrate the health service and public health aspect of this.

Figure 5 Components of 'Implementation Decay'

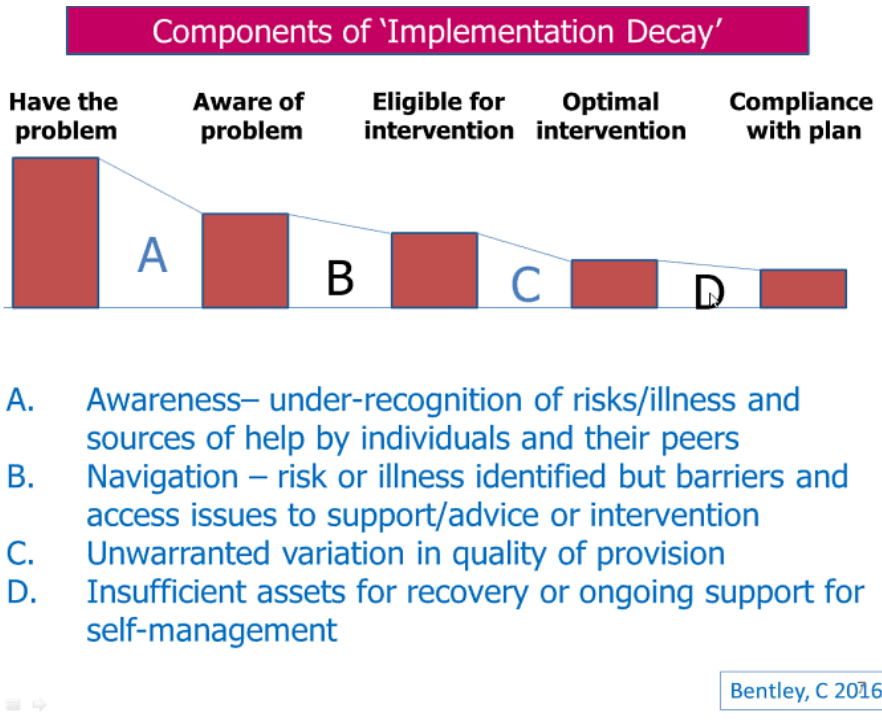
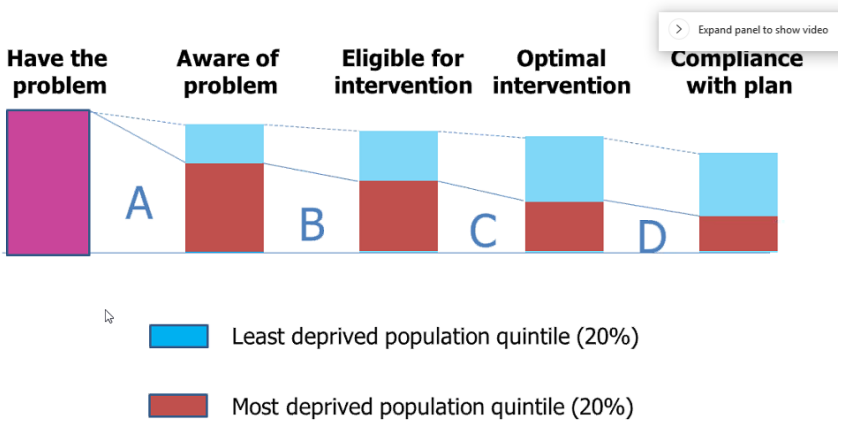


Figure 5 shows that there is a difference (reduction) in the number of people who have a particular health issue, e.g. angina, renal disease, glaucoma, diabetic retinopathy, and the subsequent number who comply with a plan to manage that issue. Ideally, within people's autonomy about choices they make about their own health, the majority of people with a problem would be enacting the plan to help with that problem. However, of those who have actually have a problem, the under-recognition of risks/illness means that only some are aware that they have a problem. Once people are aware of the problem, barriers and access issues to get support/advice or an intervention mean that only some become "eligible" for that support/advice or intervention. Of those that do access help, unwarranted variation in the help that they do or do not receive means that only some get 'optimal' care. Of those who do receive optimal care only some have sufficient assets for recovery or support for self management.

Figure 6 Components of 'Implementation Decay' by deprivation



Bentley,C 2019

Figure 6 shows that this difference (reduction) in the number of people who have a particular health issue and the subsequent number who 'comply' with a plan to manage that issue is even greater for the most deprived population quintile. Fewer are aware that they have a problem. The barriers and access issues that they encounter mean that fewer become 'eligible' for support/advice or an intervention. A smaller proportion still receives optimal care and fewer have the sufficient assets for recovery or support for self management. Therefore, while the wider determinants of health have a significant impact on health inequalities, all healthcare services themselves also have a significant impact on health inequalities.

The Population Health, Prevention and Inequalities Group is currently made up of the Directors of Public Health, the Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG CCG) Medical Director Clinical Effectiveness and the inequalities clinical lead at the CCG. It will also have a

representative from the provider organisations in the Healthier Together partnership. It will lead the work on:

1. Updating the BNSSG picture of population need in light of COVID-19 (with links to Population Health Management and Insights)
2. Producing a BNSSG Population Outcomes Framework
3. Identifying asks of the system to enable and influence a system-wide focus on population health, prevention and inequalities

The work will learn from approaches that have been taken elsewhere, such as NHS Scotland http://www.healthscotland.scot/, and adapt them for BNSSG use. The group will also want to consider how the recommendations in the Public Health England (and inevitably other) reports can be turned into interventions that will help to achieve population health outcomes in line with the framework being developed. This may involve directing a gap analysis.

How does the Health and Wellbeing Board want to develop an ongoing relationship with the BNSSG Population Health, Prevention and Inequalities Group?

3.4 Equality and inequality impact assessments

These have been completed for the group's involved in the response to COVID-19, i.e. the cells. Furthermore, an equality and inequality impact assessment will be done on the BNSSG NHS Phase 3 planning submission which will be made at end of July / beginning of August to understand the cumulative effect of the plan on health inequalities.

3.5 Expert review/challenge/scrutiny group

The chief executives of the Healthier Together partner organisations requested that an expert group, made up of people from the BNSSG community, be set up to provide scrutiny of the work and decisions of Healthier Together in relation to inequalities. The Healthier Together Partnership Board, whose members are the chief executives and chairs of the partners and the chairs of the three Health and Wellbeing Boards, will consider what is needed to make this effective before setting this group up.

What does the Health and Wellbeing Board think would make this BNSSG-wide expert review/challenge/scrutiny group effective?

3.6 Use population health management and intelligence insights

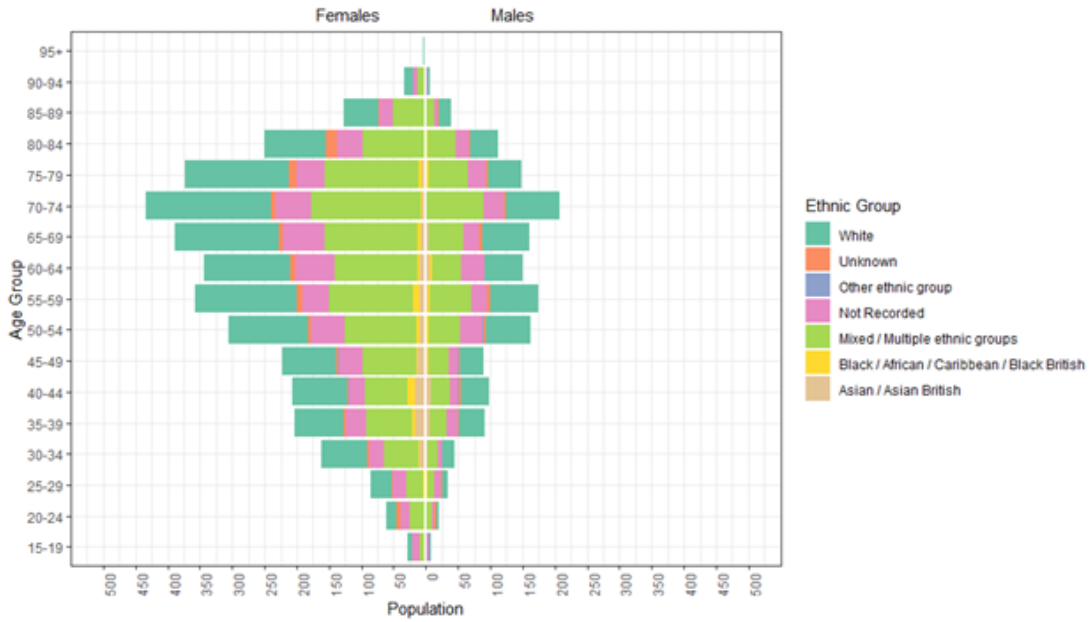
The manipulation and analyses of data and the information we get from our communities and other sources should be used to monitor health inequalities. It should be used to help understand where we need to target changes and also as a way to monitor what effect changes and interventions have had on health inequalities. Work has started on this "observatory" and below are examples of analysis that is being done.

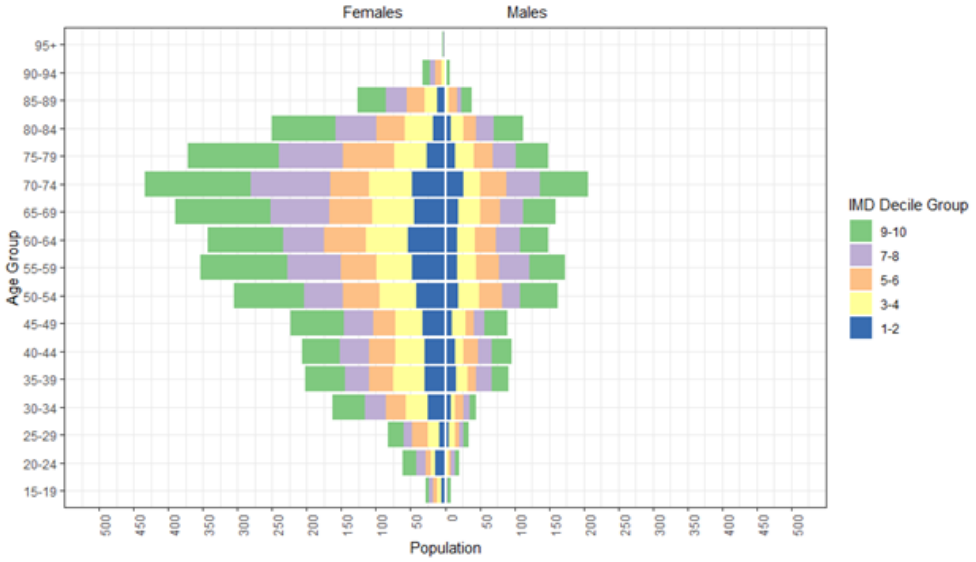
Example 1

We are developing a population view of the rheumatology outpatient lists using the system wide dataset. The aim of this is to help prioritise and manage the list in order to improve overall outcomes and reduce health inequalities. Together with the three hospital rheumatology leads we have identified the list of factors we believe are most important in understanding the population through equity and risk management lenses, such as ethnicity, deprivation (IMD 1 = most deprived), age, respiratory comorbidities, multimorbidity and polypharmacy.

The figures below show what two of the lists look like by deprivation and ethnicity. As a result, rheumatology lists might be managed differently such that groups at high risk from complications, e.g. people with respiratory complications might be followed up with a greater intensity than those at lower risk. While this might happen on a case by case basis currently, it is not planned for at a population level and there is no systematic mapping of outcomes to these groups.

It also appears that the lists might be less deprived that we might expect, given what we know about the association between deprivation and health. This means we need to explore further to see whether this might be an effect of less deprived populations not reaching secondary care. The intention is to combine this work with the electronic measurement of patient reported outcomes measures (PROMS).

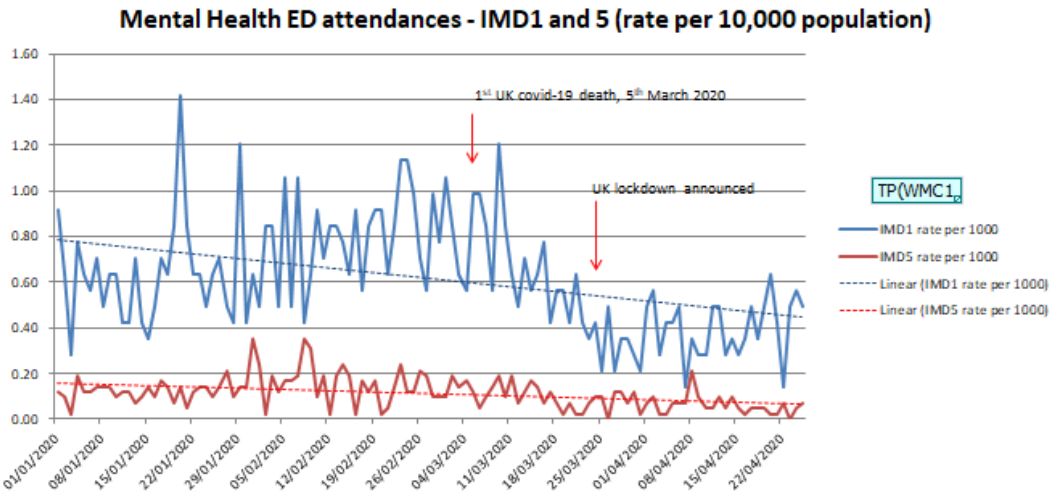




Example 2

The following graph suggests that access to Emergency Departments for those presenting with mental health issues has been most disrupted for the most deprived (discounting the point that Emergency Departments may not been the place that best meets the needs of this cohort of people). This information supplements the information the Mental Health Cell is getting from service users involved in its work.

More deprived = more likely to attend ED with a mental health problem; access most disrupted for most deprived



Index of multiple deprivation
IMD1 = Most deprived 20% of the county
IMD5 = Least deprived 20%

Who are the people in deprived populations who attend ED with MH problems? Do they interact with their GP? Would they benefit from targeted intervention?

3.7 Interventions in healthcare in BNSSG

It is important to recognise that there are areas of existing work in BNSSG to address health inequalities. For example, the Healthier Together Primary Care Strategy talks specifically about actions to be taken and the Cardiovascular Disease Programme's hypertension work is focussing only on those with poor outcomes. We also need to consider the opportunities to allocate resources in support of reducing inequalities.

We now have recommendations from national reviews/reports and the requirements set out in the Phase 3 planning letter which Healthier Together needs to respond to in a way the builds on the work that partners have already been doing. There are some local ideas that need to be scoped and tested further.

1. **Engagement with our communities** There have already been actions taken to respond to feedback and recommendations about how we are communicating COVID-19 related information to those parts of our communities who may have had poorer access to that information and with whom trust needs to be established. For example, the work with the Community Access Support Service (CASS) in Bristol on providing culturally and linguistically appropriate public health communications. Given the further work that will need to happen in terms of engaging people from our communities in the interventions being designed and proposed, the opportunities for doing this jointly across partners is being pursued.

   Providers of services, Healthwatch and other groups may have already gone out to particular population groups in order to understand the cultural appropriateness of services and improvements that are needed; some of the more practical aspects of service delivery, e.g. the format and language of appointment letters or service discharge summaries and; how the attitudes of staff impact on their experience of health and care. As the Healthier Together partnership we need to ensure that we don't repeat those exercises where they have already been done.

2. **Prioritising care and resources for people with poorer outcomes both for COVID-19 and non COVID-19**. For outcomes related to BAME groups and COVID-19, the Healthier Together Partnership will need to consider how taking this approach will help enact or respond the implementation of many of the recommendations in the Public Health England report 'Beyond the data: Understanding the impact of COVID-19 on BAME groups'. For example, accelerating efforts to target culturally competent health promotion and disease prevention programmes for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective

management of chronic conditions including diabetes, hypertension and asthma may mean targeting allocating more of our resources to this and less to something else.

Given the emerging evidence around the combination of diabetes, obesity and ethnicity as a risk factor for COVID-19 severity, we expect the existing diabetes work to be specifically tasked with co-designing how to prioritise preventative and other care for people who have this combination.

In terms of non COVID-19 related care, for all people with poorer outcomes the cost of non-COVID delayed care is greater than for the average person. One way of beginning to prioritise planned care in such a way to reduce health inequalities and improve overall value for our system could be to think about those waiting for care who are at higher risk of having poorer outcomes **in addition to** considering the clinical urgency of everyone waiting for care when scheduling long term condition and other management. Prioritising these groups may have a limited overall impact on waiting times for most people but would improve the situation of some of our highest risk and most vulnerable people.

In all of this, proposals would be expected to have:

- been designed with or sense-checked by the people they affect
- undergone an equality and health inequalities impact assessment

a. **People with learning disabilities (LD)** (1.7% of the BNSSG population) **and autism** to improve their outcomes. The Learning Disabilities and Autism Cell have plans in place to improve the proportion of people who have an annual health check in order to reduce health inequalities and improve outcomes.

b. **People with mental illness.** Some of our worst outcomes are seen among those with serious mental illness (SMI). For people in BNSSG with a SMI diagnosis the change of dying prematurely (before 75 years of age) is 3.5 times that of the general population. The Healthier Together Mental Health Business Case clearly articulates how existing health inequalities will widen further as a result of COVID-19.
    i. Men from Black ethnic groups are nearly three times more likely to be diagnosed with COVID-19 than men from White ethnic groups and local communities report this leading to anxiety, fear, growing distrust of statutory services and worsening levels of mental health.
    ii. The poorest parts of England have experienced higher rates of mortality from COVID-19 than wealthier areas, and they are also likely to be hardest by the economic downturn. People in the lowest socio-economic groups already have worse mental health than those in middle and higher groups, which is likely to be compounded further.

The proposals in the mental health business case focus on proposals focus on those disproportionately affected including people from our Black communities; people affected by trauma and abuse, including refugees, and those living in our areas of greatest deprivation with the accompanying allocation of resources that is needed.

Proposals that are being developed for **initial consideration** at Clinical Cabinet are:

- Ensuring that LD and SMI patients are highlighted on referral letters
- Prioritising access to LD and SMI patients as long term condition management services are restored
- Flagging LD and SMI patients as a priority category when patients are added to waiting lists for clinics or procedures
- Working with primary care to ensure all correspondence and information is communicated in an accessible manner, which encourages and supports patients to continue to access services

c. **People living with higher levels of deprivation** could be another group that is prioritised. We do not currently have a clear understanding of how the full range of BNSSG services are accessed by socio-economic status.

Proposals on prioritising care will be discussed at Healthier Together Clinical Cabinet during the coming weeks. Decisions on any new approaches will be taken through the Healthier Together governance structure as appropriate.

4. Summary

Everyone deserves the same opportunities to lead a healthy life and to access the health and care services they need, no matter where they live or who they are. Closing the heath inequalities gap is one of the biggest challenges we face as a health and care system. There are clear actions we can take across our partnership tackle health inequalities. Our actions should:

- **Be data led.** It is essential that good data is collected and that we have a shared understanding of data sets and other information that are available across the partnership and any barriers to sharing. In addition, the data needs to be regularly reviewed.
- **Focus on partnership**. Reducing inequalities is everyone's business, so actions should be locally relevant and locally owned – and developed and delivered in partnership with agencies and the community.
- **Be measureable**. All actions should have some way of showing their impact. In some cases this may be quantitative with outcomes that can be counted, and others may be qualitative where impact is captured in a narrative way; or a combination of both. This action need to also ensure that we understand both

the impacts on the groups being targeted and on other groups so that we understand any potential unintended consequences as well as planned impact.

- **Be aspirational yet realistic.** We have the opportunity to make real change, and our actions should reflect that aspiration. However, it is important that they are grounded in evidence and within our combined capacity, so we do not set things up to fail. We will need to find a way to challenge ourselves on this.
- **Be open to challenge and evolve.** Actions should reflect our communities – what information tells us about their needs but more importantly what people tell us about what is important to them. All actions should be monitored to make sure they are fit for purpose, and evolve and develop as necessary.
- **Be appropriately resourced and sustainable.** Actions should refocus core budgets and services rather than short bursts of project funding.
- **Be systematically applied and scaled up appropriately.** We should not depend only on exceptional circumstances and exceptional champions, and must remember that "industrial scale" processes require different thinking to small "bench experiments"

5. Recommendations

5.1 Note Healthier Together's current understanding of the impact that COVID-19 has had on health inequalities

5.2 Note the actions that are being considered to address these either at a partnership level or more specifically interventions in healthcare in Bristol, North Somerset and South Gloucestershire

5.3 Consider how the Health and Wellbeing Board wants to develop an ongoing relationship with the BNSSG Population Health, Prevention and Inequalities Group

5.4 Consider what would make a BNSSG-wide expert review/challenge/scrutiny group effective