Closing the gap - Tackling health inequalities in Dudley

DECEMBER 2005

DUDLEY COMMUNITY PARTNERSHIP
achieving together

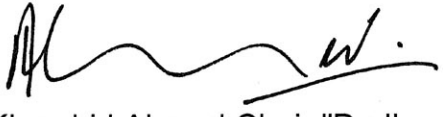
Dudley
Metropolitan Borough Council

Dudley Public Health

Forward

Over the last 70 years health has improved for every section of society. Whilst acknowledging and applauding this fact,behind the headline statement is a much more worrying trend. Whilst overall health has improved, the rate of progress has not been the same for all sections of society. Health improvement amongst the wealthier sections of society has been far more rapid than that of the poorest. The gap today is not only wider than it was 20 years ago, without positive and targeted intervention it will, in all probability, widen even further .A simple, but quite graphical, local demonstration of this is can be seen in relation to a male life expectancy. A man born in Norton today can expect to live 8.5years longer than a man born in Netherton.

This obvious inequality is something that Dudley Community Partnership is committed to addressing. As a strategic body we are determined to tackle issues of inequality wherever they exist. A major part of our work centres around narrowing the gap in service provision, and in terms of service delivery, provides a significant challenge to us all. Whilst detail of our overall strategy is contained within the new community strategy,Vision 2020, this document goes into much greater detail as to our objectives in tackling health inequality. I very much look forward to working with all partners to make this strategy a real focus for change.



Khurshid Ahmed Chair "Dudley Community Partnership"

ENDORSEMENT OF DUDLEY STRATEGIC FRAMEWORK

The Dudley Strategic Framework to reduce health inequalities has been prepared in response to Government directives. The Local Authority, Health and Voluntary Sector jointly endorse the plan.

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(NB. We are grateful to the assistance given by Ian Jeavons, Neighbourhood Renewal Officer, Chief Executive's Directorate, Dudley MBC who retired at the end of December 2004)

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1. INTRODUCTION

1.1. WHAT IS HEALTH INEQUALITY?

Health status and life expectancy are still linked to social circumstances and childhood poverty. Generally, disadvantaged people have worst health, poorer quality of life and an earlier death. These unequal life chances are passed from generation to generation and are both avoidable and unjust. They result from the consequences of 'health inequities', which are '**differences in opportunities'** for different population groups such as:

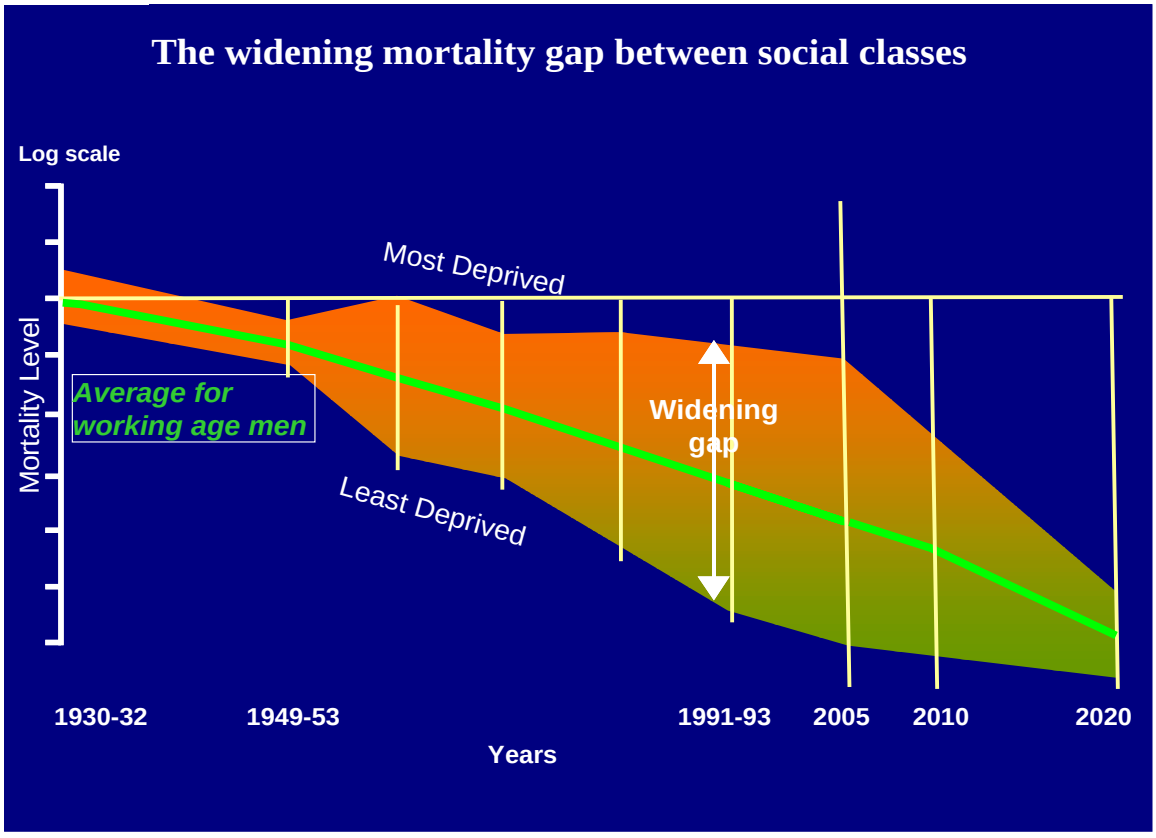
- reduced social and educational opportunities
- fewer material resources
- lifestyle choices constrained by disadvantage
- less healthy work patterns and conditions
- poor housing conditions
- unequal access to, awareness and use of all services, specifically health services.

Health inequalities prevent people from achieving their full potential in life.

1.1.1. The Health Gap

Nationally over the last 70 years health has improved, but health inequalities have widened the gap in health status between the rich and the poor - there is a step gradient in health status that relates principally to poverty. This is illustrated in Figure 1 where this gap is at its widest in 2005. The graph illustrates the target to be achieved by 2020 – to close the gap between the least deprived and most deprived.

Figure 1:



To close this 'health gap' tackling inequalities in health requires us to focus on improving the health of those people who fair worst. This approach does not exclude a whole population approach to improving health, but the intention is to improve the health of the poorest and less healthy fastest. This is not about reducing the health of the more affluent, but is about 'levelling-up' the health status across the borough.

This may mean a redistribution of resources, or a redesign to work differently, or additional investment to target response to the areas of greatest need and reduce barriers to access. The aim is to distribute resources and provision fairly in relation to the health needs of different groups. This is not the same as distributing resources equally, but is about distributing in relation to need.

1.1.2. Who Is Most At Risk?

Certain groups are more at risk of experiencing health inequalities, often referred to as marginal or socially excluded groups and communities. These include:

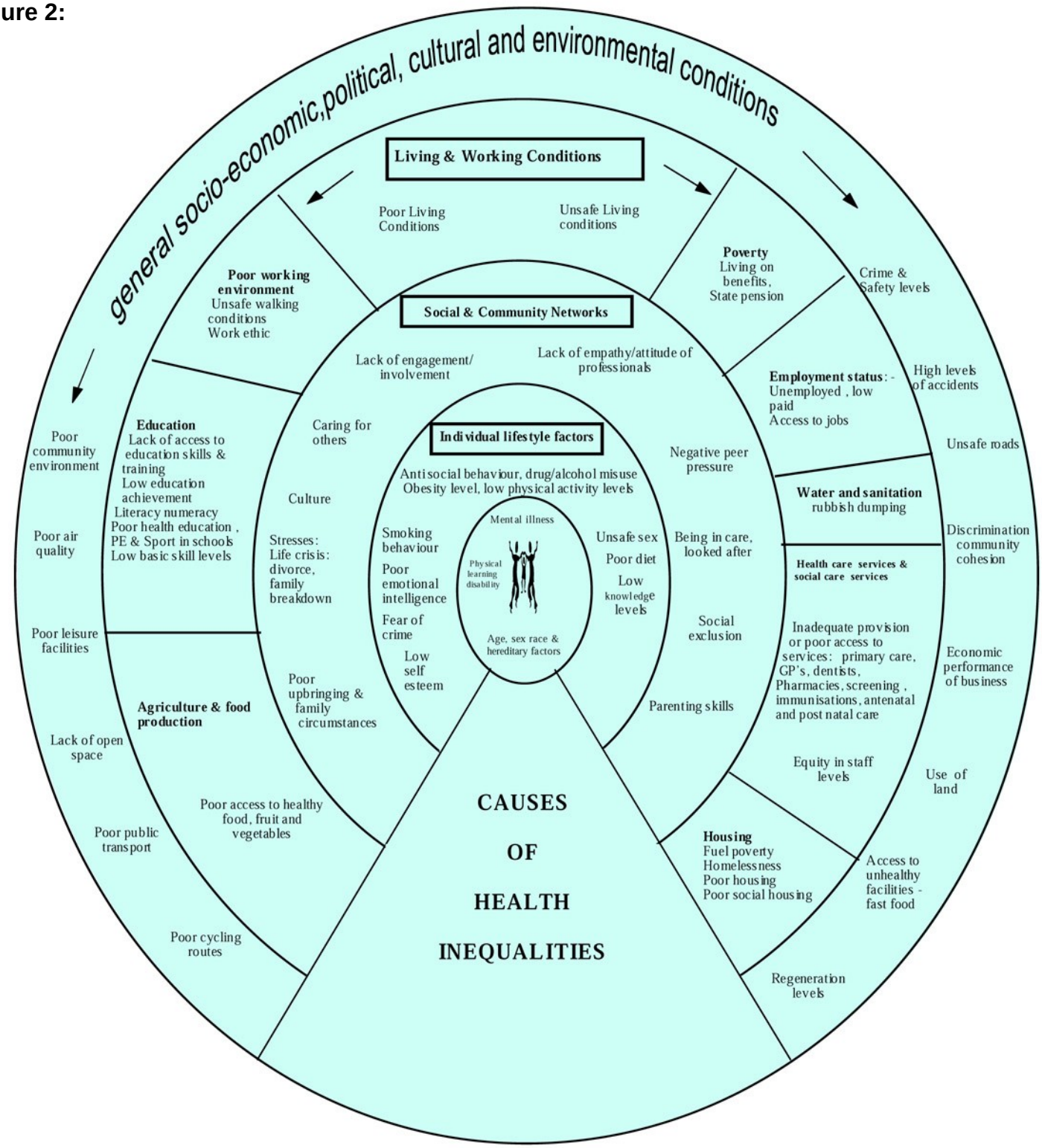
- people with hearing, speech or visual impairments
- people with learning, communication or cognitive difficulties
- people with physical disabilities
- people from black and minority ethnic communities, including newly arrived communities seeking asylum/refuge and travelling communities
- non-english speakers
- mental health service users
- older people
- people who are housebound
- people on benefits or low incomes
- young people
- children who are looked after
- young offenders
- prisoners
- homeless people

This is not a definitive list and may vary depending on the particular strategy, policy or service, but it gives an idea of which communities may need to be targeted to make a real difference to health inequalities. Tackling health inequalities involves targeting either geographical areas of deprivation, or by key vulnerable groups or individuals.

1.1.3. The Underlying Causes

The causes and triggers of health inequalities are highlighted in the diagram below. This diagram illustrates the causes as layers, radiating out from a central point, all of which have the potential to promote or damage health. At the core of the model is the individual, with a set of characteristics – age, sex, and constitutional factors that affect their health, but are fixed. Surrounding this core are layers of influences that can, in theory, be modified:

Figure 2:


general socio-economic,political, cultural and environmental conditions
Living & Working Conditions
Poor Living Conditions
Unsafe Living conditions
Social & Community Networks
Lack of engagement/ involvement
Lack of empathy/attitude of professionals
Individual lifestyle factors
Anti social behaviour, drug/alcohol misuse
Obesity level, low physical activity levels
Mental illness
Physical learning disability
Age, sex race & hereditary factors
Smoking behaviour
Poor emotional intelligence
Fear of crime
Low self esteem
Unsafe sex
Poor diet
Low knowledge levels
Caring for others
Culture
Stresses: Life crisis: divorce, family breakdown
Poor upbringing & family circumstances
Negative peer pressure
Being in care, looked after
Social exclusion
Parenting skills
Poor working environment
Unsafe walking conditions
Work ethic
Education
Lack of access to education skills & training
Low education achievement
Literacy numeracy
Poor health education , PE & Sport in schools
Low basic skill levels
Agriculture & food production
Poverty
Living on benefits, State pension
Employment status: - Unemployed , low paid
Access to jobs
Water and sanitation
rubbish dumping
Health care services & social care services
Inadequate provision or poor access to services: primary care, GP's, dentists, Pharmacies, screening , immunisations, antenatal and post natal care
Equity in staff levels
Housing
Fuel poverty
Homelessness
Poor housing
Poor social housing
Crime & Safety levels
High levels of accidents
Unsafe roads
Discrimination community cohesion
Economic performance of business
Use of land
Access to unhealthy facilities - fast food
Regeneration levels
Poor community environment
Poor air quality
Poor leisure facilities
Lack of open space
Poor public transport
Poor cycling routes
Poor access to healthy food, fruit and vegetables
CAUSES OF HEALTH INEQUALITIES

Individual lifestyle factors:
The knowledge, skills and attitudes of individuals act to develop their health behaviour in a positive or negative way - their lifestyle and self perception.

Social and Community Networks:
Individuals interact with friends, relatives and their immediate community. These social networks and the support they offer can affect an individual's health.

Living and working Conditions:
The environments in which people live and work will affect their health, including their access to essential goods and services, such as health and social services, education, nutritious food, jobs, and adequate housing. Value judgements made by society about people who live in poor environments also have an impact on people's health.

General socio-economic, cultural, political and environmental conditions:
The overall economic, cultural and environmental conditions within society as a whole will impact on a person's health. e.g. the legislative framework such as anti-discrimination, government policy such as transport and the welfare state, and the prevailing culture and attitudes of society.

These causes and influences tend to cluster in deprived neighbourhoods, although not everybody who is at risk lives in a deprived area and not everybody in a deprived area is at risk. This diagram makes it clear that health inequalities cannot be solved through the actions of any one agency alone and that co-ordinated action is required across a broad front to tackle the social, environmental and economic factors underlying health inequalities.

1.2 THE STRATEGY

The Health and Well-being Partnership was tasked with the production of a borough wide strategy to reduce health inequalities in 2004. This was as a response to the government's announcement in 2001 of new national targets to reduce health inequalities. The initial target date for this was 2010. These were incorporated into a single Public Service Agreement target (PSA) to:

'Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth'

As a starting point, a stakeholder's workshop was held in early December 2004 to give as many agencies and services as possible an opportunity to take part in the process (see appendix 1). This was in the context of the development of a new Community Strategy to build stronger communities by 2020 (The Dudley Borough Challenge).

This strategy document is the result of work carried out by contributors on the stakeholder day and following consultations with all relevant agencies and organisations.

In line with the Dudley Borough Challenge, the aim of this strategy is:

'Improving health for everyone, no matter where they live or how much they earn'

Achieving this aim will require action by all services and agencies that have an impact on the economic, environmental and social determinants of health. Whilst working towards an overall improvement in health for the total population, all services will need to contribute to ensuring that the greatest health improvements are achieved among residents who, by virtue of their circumstance, currently carry a disproportionate burden of poor health. **Consequently, tackling health inequalities has to become core business for all agencies and organisations in the borough.**

The timescale of potential impacts is critical:

- The **'2010 agenda'** - action to develop equity in service delivery and support local people to make lifestyle changes will give us early health gain.

- The **'2020 agenda'** will require action to address the underlying determinants of health in order to improve the health of the next generation.

There needs to be a focus on both agendas to achieve sustainable change.

This strategy is focused on how we narrow the health inequalities gap - how we ensure that we improve the health of the poorest at a faster rate than the richest. This will challenge partners to develop ambitious targets and actions to achieve the inequality targets.

The strategy consists of:

- A shared definition of health inequalities
- A framework that provides a set of priorities by which to focus and progress the reduction of health inequalities in the Borough
- A checklist that should be used by all agencies and services in the borough to ensure health inequalities is integrated into their work.

1.3 IMPLEMENTATION OF THE STRATEGY

All agencies have a role to play in tackling health inequalities; hence at a local level the public, voluntary, community and business sectors are all key partners.

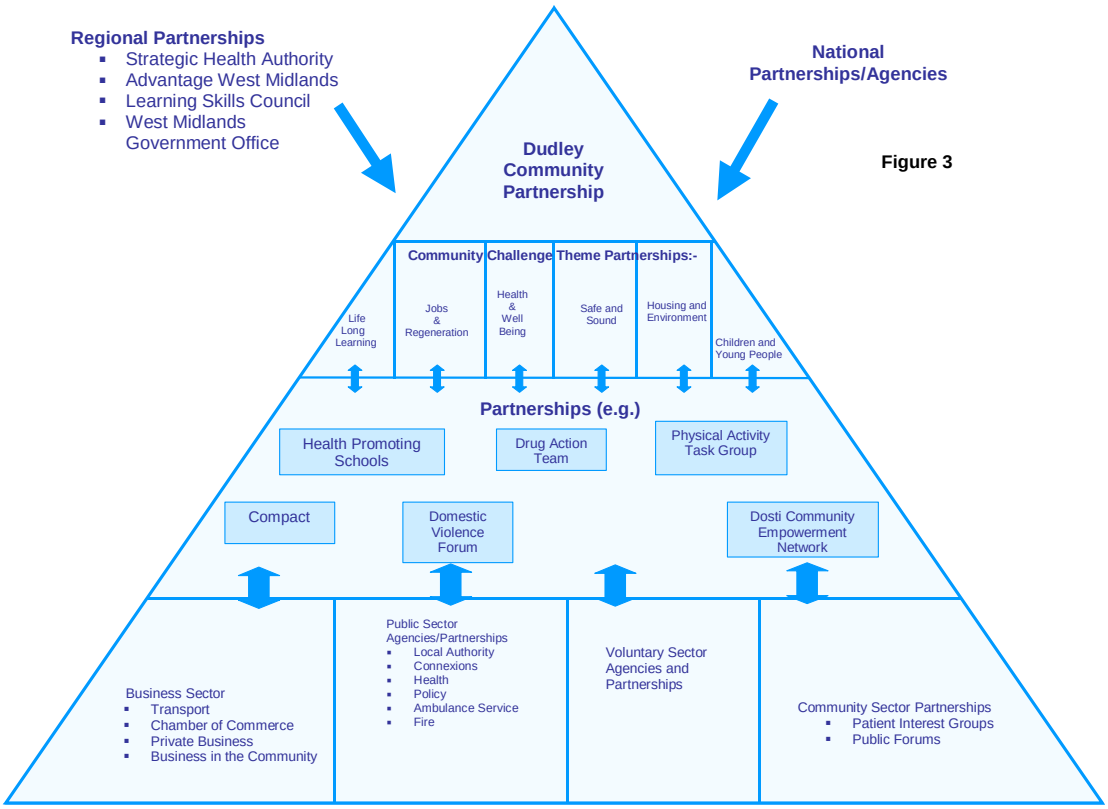


Figure 3

Figure 3, although not exhaustive, gives a flavour of the layers of partnership that need to be involved in the implementation of the strategy, all of which link into the overarching Dudley Community Partnership.

To achieve this, key actions will need to be integrated into existing relevant work plans and policies. There are many local policies/strategies/action plans that result from the national and regional policy context and local priorities. Some of these have a direct and major impact on health inequalities and others contribute in a smaller way, but they all have a role to play.

The strategy 'adds value' by providing a borough focus on tackling health inequalities and a tool to co-ordinate and prioritise targets related to health inequalities. Implementation of this strategic plan will ensure that health inequalities issues are integrated into all relevant local plans and strategies.

2. STRATEGIC CONTEXT

2.1 THE NATIONAL CONTEXT- 2010 AGENDA

The government has expressed its commitment to reducing health inequalities and set a number of national targets for inclusion in the strategies and plans across most government departments.

In July 2003 *Tackling Health Inequalities: A Programme for Action* was published by the Department of Health, which laid the foundation for achieving the PSA target of reducing inequalities in health outcomes by 10% by 2010. It set two more detailed objectives:

- **Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between manual groups and the population as a whole**

- **Starting with local authorities, by 2010, to reduce by at least 10% the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole**

It identified 12 national headline indicators, by which local programmes will be monitored:

- Access to primary care
- Accidents
- Child poverty
- Diet – 5 a day
- Education
- Homelessness
- Housing
- Influenza vaccinations
- PE and school sport
- Smoking prevalence
- Teenage conceptions
- Mortality from the major killer diseases

It also identified the evidence-based key actions most likely to have the greatest impact on reducing health inequalities in the long-term:

- Improvements in early years support for children and families
- Improved social housing and reduced fuel poverty among vulnerable populations
- Improved educational attainment and skills development amongst disadvantaged populations
- Improved access to public services in disadvantaged communities
- Reduced unemployment and improved income levels amongst the poorest communities.

Key interventions to close the life-expectancy gap include:

- Reducing smoking in manual social groups
- Preventing and managing other risks for CHD and cancer such as poor diet, physical inactivity, obesity and high blood pressure through effective primary care and public health interventions- especially targeted at the over 50s
- Improving environmental health including housing conditions by tackling cold and dampness and reducing accidents at home and on the road

Key interventions to close the infant mortality gap include:

- Improving the quality and accessibility of antenatal care and early years support in disadvantaged areas
- Reducing smoking and improving nutrition in pregnancy and early years, including increasing breastfeeding
- Preventing teenage pregnancy and supporting teenage parents
- Improving housing conditions for children in disadvantaged areas

2.2 THE LOCAL CONTEXT- 2020 AGENDA

As part of the Local Strategic Partnership's Borough Challenge, a vision for Dudley has emerged based on the views of the people who live and work in the Borough. This vision encompasses the concept of building stronger communities over the next 15 years:

A strong community is a place where all people are happy to live:
'It has decent housing and a clean environment and it is safe, prosperous, attractive, vibrant and harmonious. In a strong community people would not be disadvantaged by where they live, their culture or social background, their age, gender, or how much money they earn'

Tackling health inequalities is fundamental to achieving this vision, and creating stronger communities where people:

☺ are healthy and prosperous
☺ take an interest in where they live and others they are involved with
☺ know their neighbours and are tolerant of people different to themselves
☺ help and support one another through friendship and shared activities
☺ work together and take pride in their community
☺ keep an eye on elders living there and look out for children
☺ make use of the facilities in their areas, particularly the green spaces
☺ do not live under endless pressure from the stresses of life
☺ have opportunities to access worthwhile jobs
☺ provide positive role models for each other
☺ have self-determination and feel that they have some control over their lives
☺ are able to affect decisions about delivery of local services
☺ know they have a place in their community
☺ have a good idea about what is on offer from service providers, and how to access those services
☺ have pride in their environment, don't drop litter and keep tidy gardens

As a means of building stronger communities, the Dudley Borough Challenge has identified 6 key themes,

- making Dudley a safe and peaceful place to live
- promoting good health and well-being for all
- creating a prosperous and attractive borough
- promoting individual and community learning
- safeguarding and improving our environment
- celebrating our heritage and the diversity of local culture

All of these themes will play an important part in tackling health inequalities across the borough. Each theme is led by a thematic partnership with representation from all key partners across the borough. Health inequalities is a cross-cutting issue and reduction of inequalities will therefore only be achieved by action across all the theme groups.

These themes are also important because of the contribution made in Dudley by people using services themselves, carers, public sector agencies such as the Primary Care Trusts, the Council Directorates (Adult, Community and Housing, Children's Services and Urban Environment), the Voluntary and Community Sector. The challenge is for these agencies and individuals to be able to work together even better to address health inequalities.

2.3 THE CURRENT HEALTH INEQUALITIES STATUS IN DUDLEY

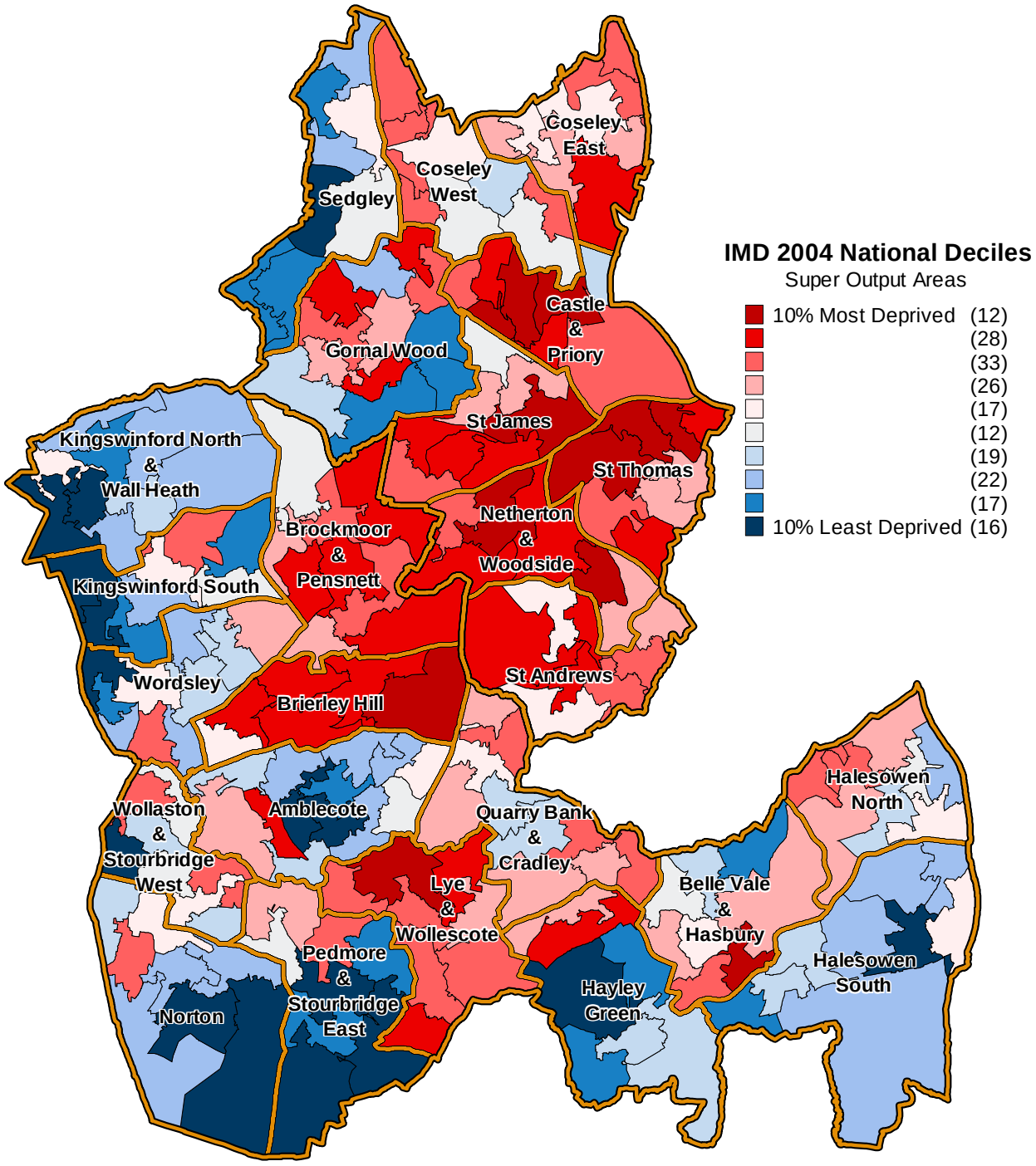
This section provides a summary picture of Dudley in relation to the causes of health inequalities and key targets. Further information can be found in Appendix 2. It includes Dudley's position in relation to the key national targets and indicators set by the government. The key findings are:

2.3.1 Deprivation Levels:

The index of multiple deprivation (IMD 2004) provides an aggregate score for deprivation based on a range of weighted determinants including income deprivation; crime; the living environment - indoors and outdoors; housing and services - barriers, education, skills and training deprivation for children and adults; health deprivation; disability and employment. It gives a picture of which key areas are experiencing such multi-faceted causes of poverty, to a very detailed 'super-output' level which is a small area of about 1000 people based on realistic neighbourhoods.

In Dudley Figure 4 identifies 12 areas with a total population of about 18,000 as among the most deprived 10% of people in the country. These areas largely fall into the following wards: Netherton and Woodside, Castle and Priory, St Thomas, St Andrews, Brierley Hill, Lye and Wollescote, St James, Brockmoor and Pensnett, Coseley East and Quarry Bank and Cradley. However there are also large pockets of deprivation in other wards.

Figure 4 - 2004 Index of Multiple Deprivation
Super Output Area National Deciles



Source: Office for the Deputy Prime Minister, Indices of Deprivation 2004

2.3.2 Key Indicators:

Key Vulnerable Groups

Although over the whole of Dudley the black and minority ethnic (BME) population is relatively small at 6.3%, certain wards have very high numbers and these tend to be

the poorest wards (Appendix 2 Figure 1). These include St Thomas, which has the highest population comprising of 25%, St James, Netherton and Woodside, Brockmoor and Pensnett, Lye and Wollescote and Halesowen North. However this masks the detail of which ethnic groups live in these areas. For example the highest concentration of the Indian community is around Dudley town centre – 55% in one super output area. The Pakistani community is concentrated around Dudley town, Brierley Hill and Lye. These differences are reflected in the different religions in these areas.

Local needs assessments within the Lye and Netherton and Woodside wards, show that marginalised communities such as black and minority ethnic and deprived communities **experience difficulties in accessing health services**. The reasons include: access issues such as poor public transport and availability of suitable appointments; communication issues such as language barriers, low service awareness and staff attitudes; lack of confidence in using services and, service provision such as the need for more local services and health checks/prevention advice/signposting.

High proportions of pensioners living alone are again found within the most deprived wards, however other key wards such as Wollaston and Stourbridge West and Norton also contain high numbers (Appendix 2 Figure 2).

At 5.3% in Dudley, the number of permanently sick and disabled people of working age is the same as England, but the variation across the wards in Dudley, ranges from the 6.5% in the most deprived wards to 2% in the least deprived wards (Appendix 2 Figure 3).

Dudley has seen a reduction in unemployment from 4.8% in 2000 to 3.7% in 2005, with the number of long-term unemployed also having fallen from 30% to 21%. However, Figure 5 highlights that the level of unemployment is not consistent across the borough, again reflecting the deprivation distribution (Appendix 2 Figure 4). Specific groups e.g. BME, people with disabilities also have higher than average unemployment levels. Additionally the average male full-time earnings are the lowest in the West Midlands urban area reflecting a low skill, low wage economy in Dudley.

Figure 6 shows the number of people without qualifications by ward, which can be seen to match the deprivation distribution, and is as high as 52% in key deprived wards.

Figures 7 and 8 shows that the distribution by ward of **adult literacy and numeracy** are very similar with a high percentage of people with poor literacy and numeracy in St. Thomas (34% and 39%), Castle and Priory (34% and 39%) Lye and Wollescote (31% and 34%) and Brierley Hill (30% and 34%).

In terms of **housing,** in 2002 nearly 5,000 private houses in the borough were unfit (4.9% of the stock with 8.4% among BME occupants) and 27% of the social housing

Figure 5 - Long-term Unemployed (2001)
Percentage of People Aged 16-74

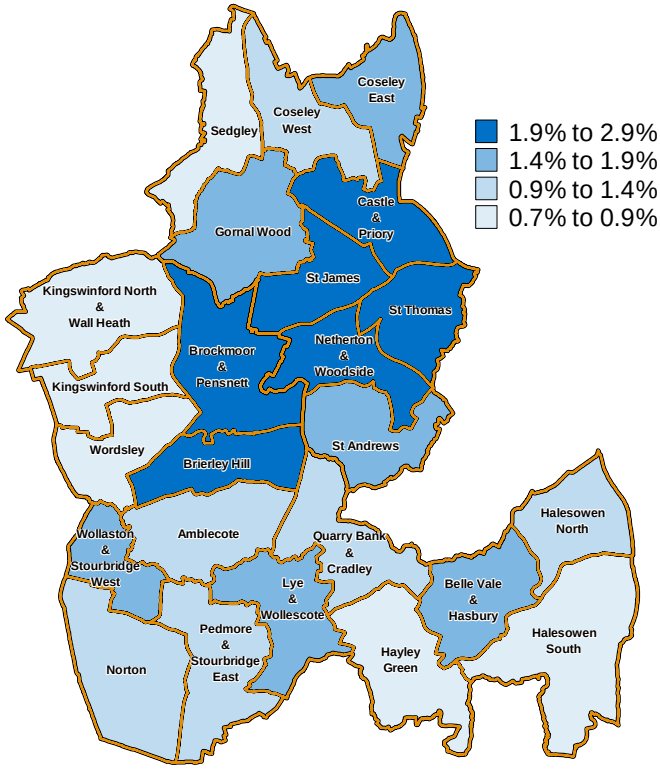


Figure 6 - People Without Qualifications (2001)
Percentage of People Aged 16-74

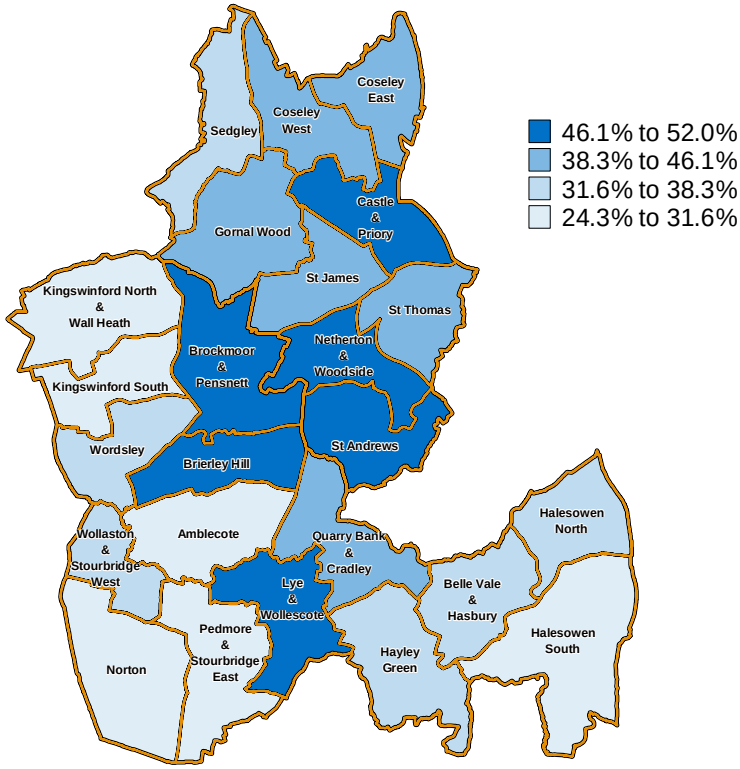


Figure 7 - People With Poor Numeracy (2001)
Percentage of People Aged 16-60

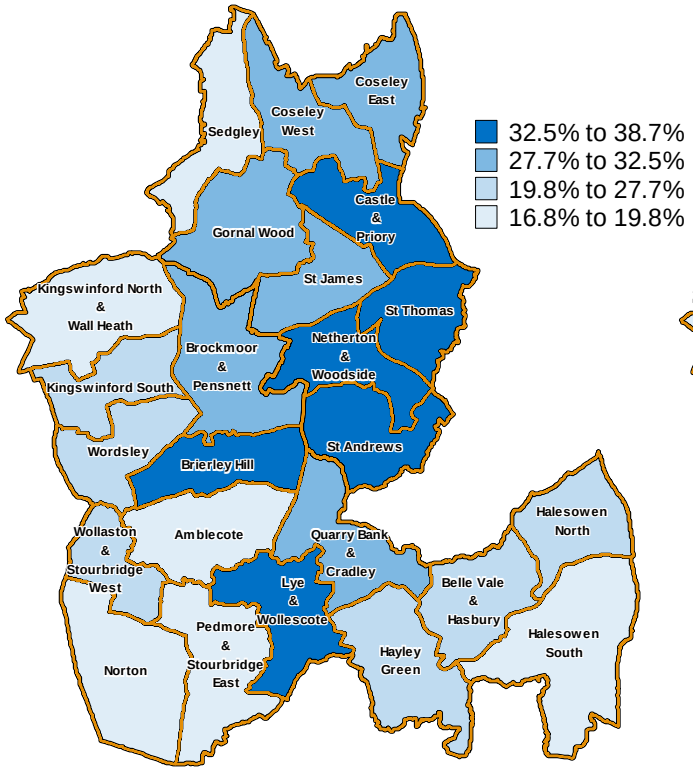
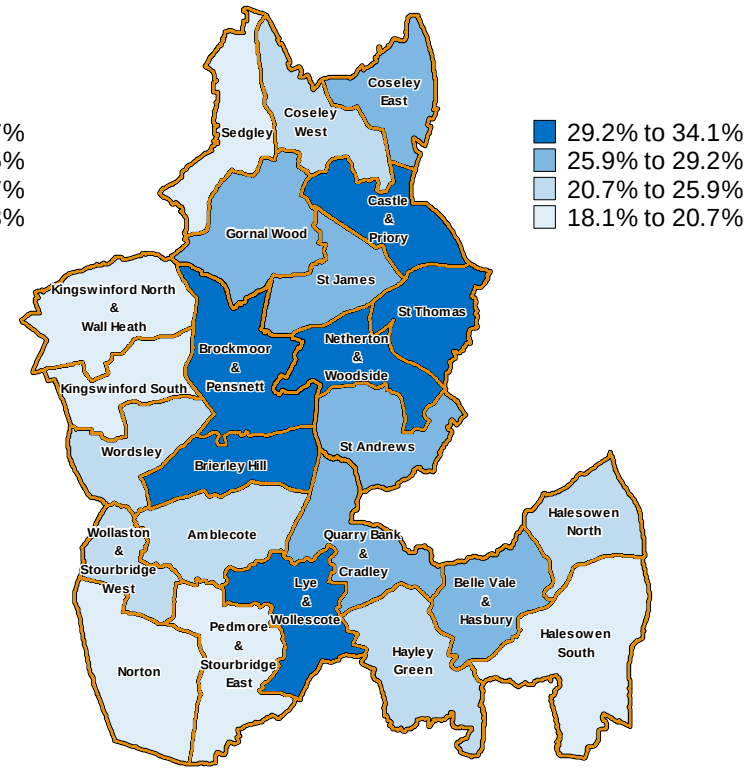


Figure 8 - People With Poor Literacy (2001)
Percentage of People Aged 16-60



Source: 2001 Census

in the borough was statutorily non-decent. There are also a number of homeless people in the borough.

The ID 2004 **Child Poverty** index for Dudley, shows the levels of child poverty concentrating in key wards - Netherton and Woodside, Castle and Priory, St Thomas, Brierley Hill, Lye and Wollescote, St James, Brockmoor and Pensnett, St Andrews, Coseley East and Quarry Bank and Cradley. This matches the deprivation distribution very closely (Appendix 2 Figure 5).

Figures 9 and 10 show Dudley mortality distributions for the 2 major killers- **Coronary Heart Disease (CHD) and Cancers.** CHD tends to follow the deprivation map in its distribution with a few variations in key wards between men and women. With cancer the differences between men and women are more marked, and the association with deprivation much weaker particularly for women. This will be influenced by the incidence of breast cancer, which is one of the few diseases more prevalent among more affluent communities.

Figure 9iii illustrates that reduction in CHD mortality has take place between 1997/99 and 2001/03, and that the level of reduction is greater in the least deprived wards. This illustrates clearly that a gradient in CHD mortality still exists from the most deprived to least deprived wards and although it is very positive to see CHD levels reducing, the gradient has not changed between 1997/99 and 2001/03. This highlights that the gap in health inequalities in relation to CHD mortality has not narrowed and that action is required to produce bigger reductions in CHD mortality in the deprived areas in order to level out the gradient in mortality. (Please note these reductions are not significant in statistical terms.)

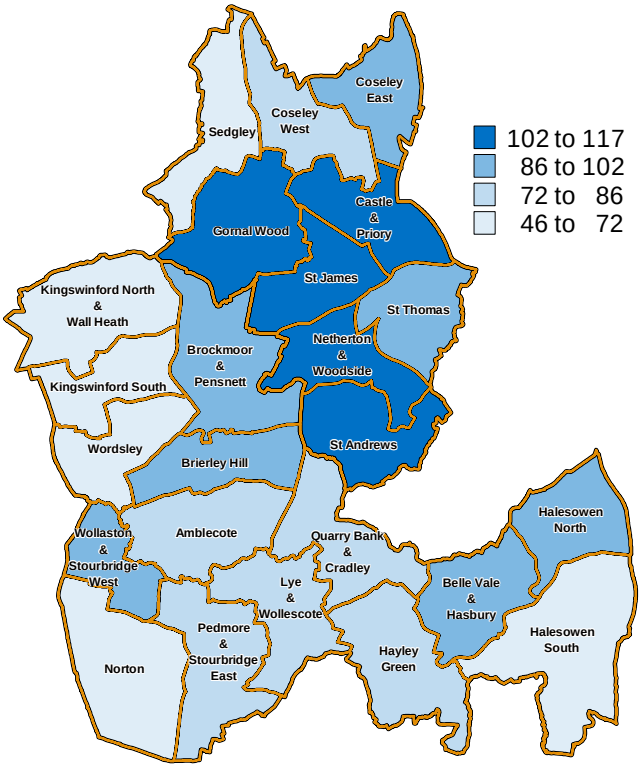
Figure 10iii shows a similar picture for cancer mortality. Although not significant in statistical terms, reductions can be seen across all wards, with no significant change in the gradient for cancer mortality from the most deprived to the least deprived wards.

These patterns of mortality for the major killers are reflected in the ‘all causes’ mortality rates, which show slightly greater mortality reductions between 1997/99 and 2001/3 for the least deprived wards compared to the most deprived wards. (These reductions are not statistically significant.) This is the reverse of what is required to narrow the health inequalities gap (Appendix 2 Figure 6).

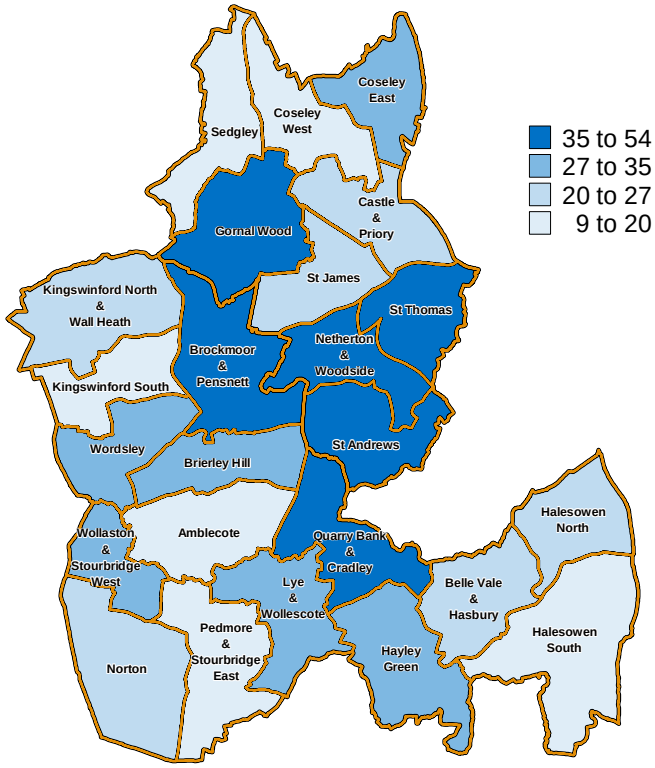
The rate of **teenage conceptions** in Dudley in 2003 was 48.0 per 1000 girls’ aged 15 to 17, a 12.2% decrease from 1998. This rate is now lower than the overall rate for the West Midlands (54.3) though still higher than the rate for England (42.1). However, within Dudley, rates vary by more than 10 times from 10/1000 girls aged 15-17 in Sedgley, to 105 in Castle and Priory and 104 in Brierley Hill. Teenage conception numbers are small, hence there can be more variation at ward level, when trying to identify trends (Appendix 2 Figure 7).

Figure 9 - Coronary Heart Disease Mortality
Directly Standardised Rates per 100,000 Population

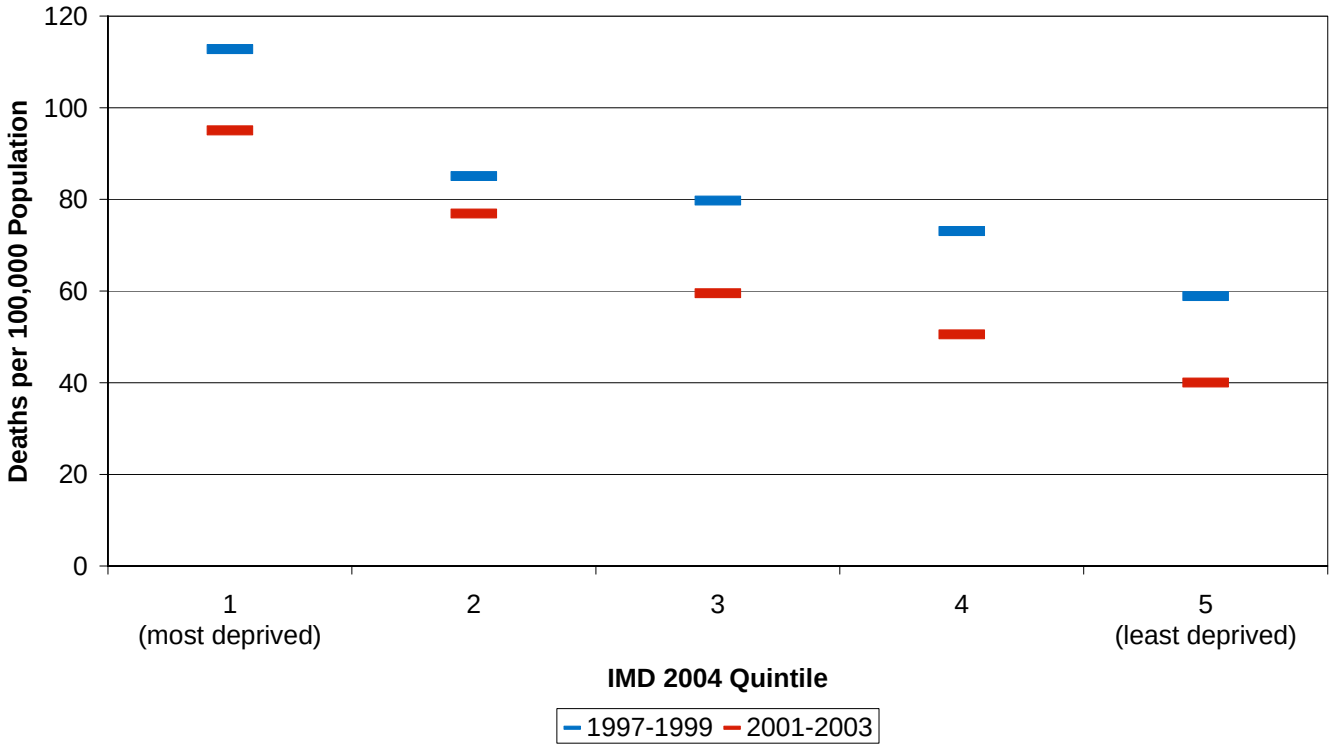
i) Males, under 75 (1999-2003)



ii) Females, under 75 (1999-2003)



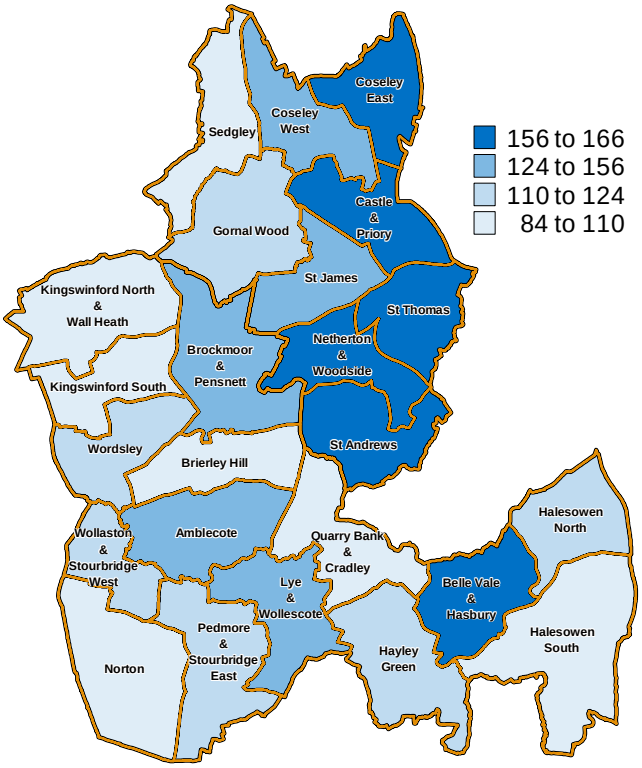
iii) Both sexes, under 75 (1997-1999 & 2001-2003)



Source: Office for National Statistics (ONS) Annual Deaths Extract
Office for National Statistics (ONS) Mid-Year Population Estimates

Figure 10 - Cancer Mortality
Directly Standardised Rates per 100,000 Population

i) Males, under 75 (1999-2003)



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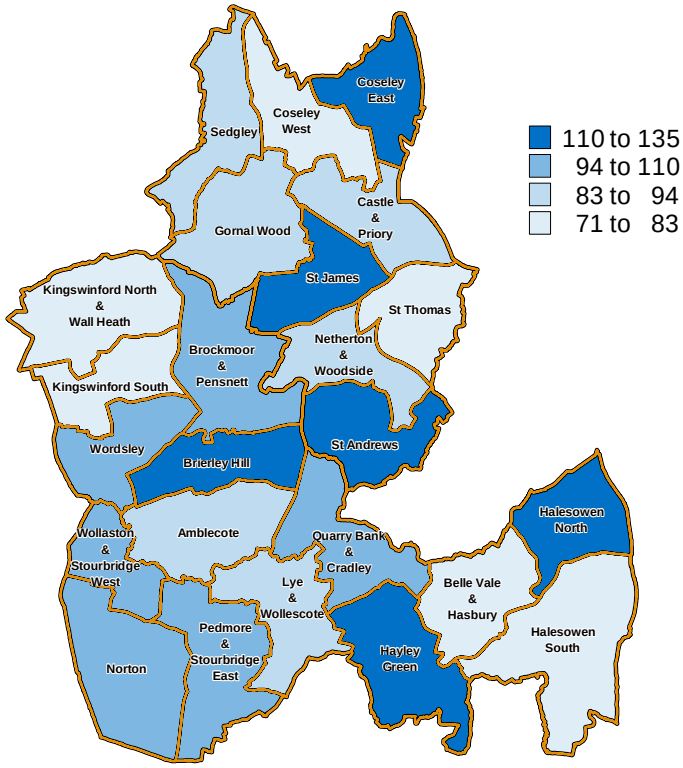

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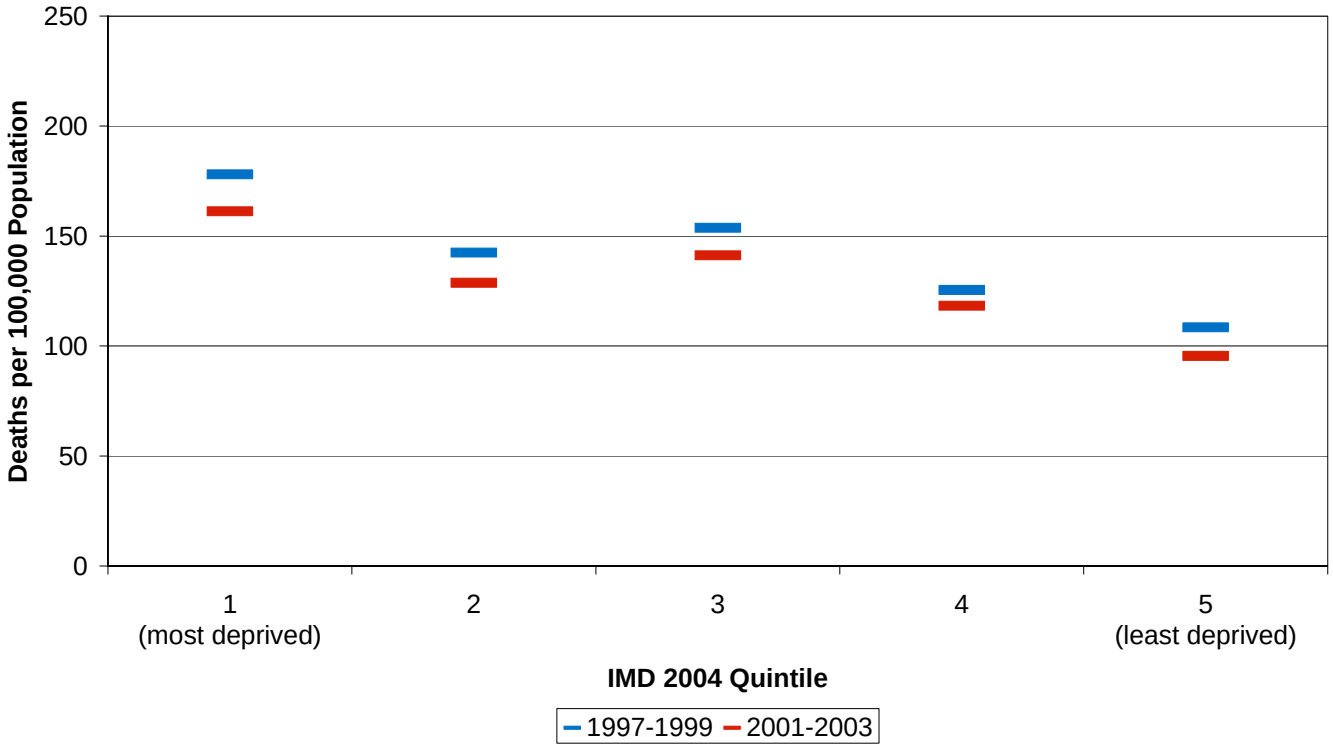
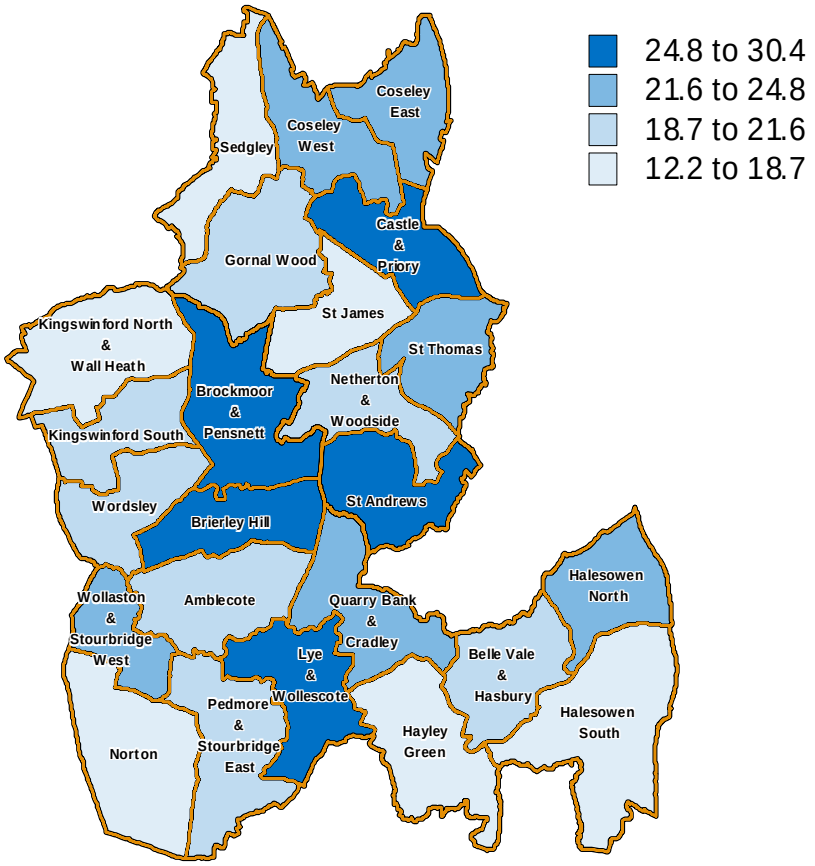


Source: Office for National Statistics (ONS) Annual Deaths Extract
Office for National Statistics (ONS) Mid-Year Population Estimates

Figure 11 highlights the prevalence of smoking by ward within the Borough, which broadly follows the patterns of deprivation. Comparisons to the ward rates in 1992 (from the adult lifestyle survey 1992) show that there has been significant reductions in the levels of smoking across all wards, hence the gradient in smoking levels from the most deprived to the least deprived wards still exists and has not been narrowed (Appendix 2 Figure 8).

Figure 11 - Percentage of Current Smokers



Source: Dudley Health Survey 2004

2.3.3 Headline Targets

Infant mortality has fallen in Dudley as it has nationally, and the rate of decrease has been higher than other areas, meaning that infant mortality is now **lower** than national and regional levels. Comparisons from 1997/99 to 2001/03 levels across the wards shows much larger decreases within the more deprived wards compared to the least deprived in the Borough. The 20% most deprived wards saw a fall of 38.6% (not statistically significant) and the next most deprived 20% of wards, a 69% reduction, which is statistically significant. This is an extremely positive finding, showing a levelling-up of the infant mortality gradient, and suggesting that key interventions such as SureStart are beginning to have an impact (Appendix 2 Figure 9).

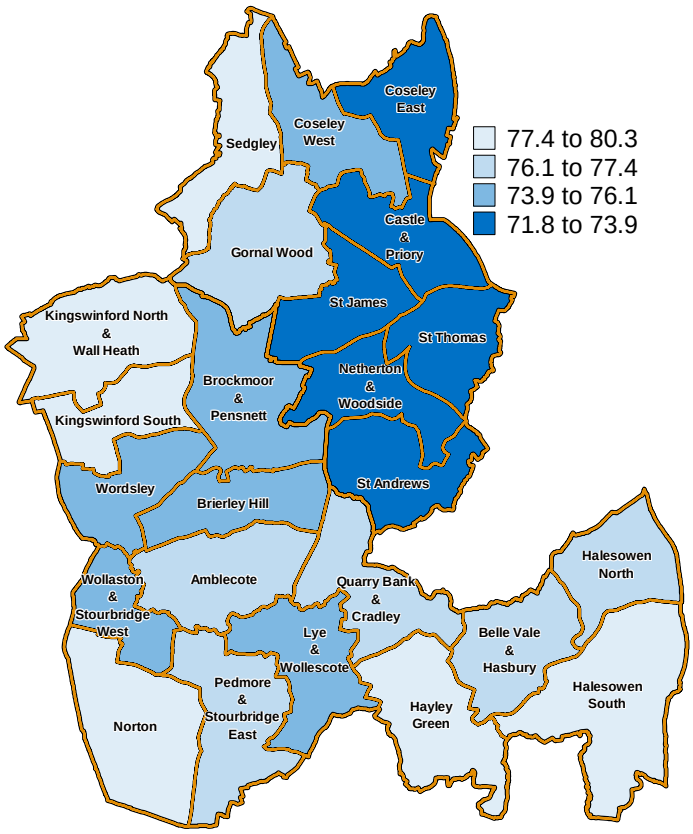
However, infant mortality numbers are very small at ward level, and **low birth weight** can be used as a proxy for infant mortality at ward level, as the numbers are larger, providing a more sensitive measure. Low birth weight gives the proportion of babies born weighing

below 2.5kg and there is a strong association between birth weight and adverse health outcomes. Low birth weight in Dudley continues to show a variation that matches deprivation across wards from 5% of babies born in Hayley Green to over 11% in St Thomas. This shows there is still targeted work required within deprived wards (Appendix 2 Figure 10)

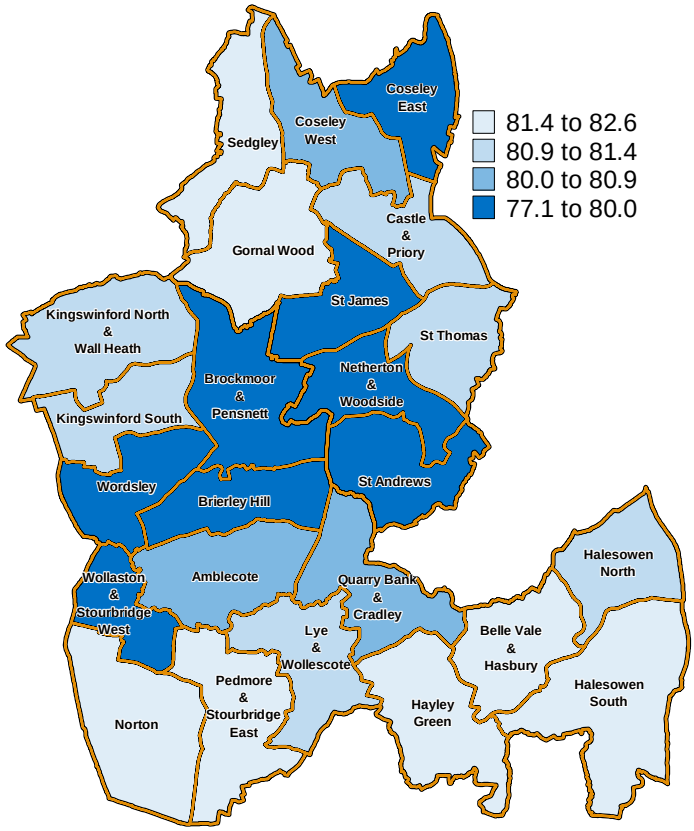
Life expectancy for Dudley overall is similar to the national average for men and women and has risen in line with the national average over the last 20 years. However, Figure 12 shows that life expectancy also follows the deprivation distribution. The least deprived 20% of wards have a life expectancy 10% higher for men and 5% higher for women than the 20% most deprived wards. For example, men in Netherton can expect to live 8.5 years less than men in Norton. Differences also exist between the sexes. Men in Castle and Priory can expect to live 8.5 years less than women in the same ward (Appendix 2 Figure 11). Comparisons between 1997/9 and 2001/3 across the wards shows that the rise in life expectancy in recent years in Dudley for men is mostly due to increases in the least deprived wards, and specifically highlights that no increases have occurred for men in the most deprived 20% of wards (not statistically significant). Thus for men, the health inequalities gradient for life expectancy has widened. For women, recent improvements in life expectancy are much smaller than for men, and have occurred across deprived and affluent wards alike (Appendix 2 Figure 12i and ii)

Figure 12 - Life Expectancy at Birth

i) Males (2000-2002)



ii) Females (2000-2002)



Source: Office for National Statistics (ONS) Annual Deaths Extract
Office for National Statistics (ONS) Mid-Year Population Estimates

2.4 SUMMARY AND RECOMMENDATIONS

In summary, there are significant health inequalities within Dudley. A review of the headline targets suggest that the health inequalities gap for life expectancy is widening, especially for men, although some levelling-up is suggested for infant mortality. In addition, a review of the key indicators shows familiar patterns of deprivation with the same deprived wards experiencing multiple causes of health inequalities, including low levels of literacy, numeracy and educational attainment, higher prevalence of smoking, teenage conceptions and unhealthy lifestyles, higher levels of poverty, child poverty, unemployment, low pay, poor housing and barriers to accessing services.

Tackling all areas of health inequality is a demanding and crowded agenda requiring a co-ordination of partner actions and prioritisation of action in order to have a meaningful impact within finite resources. On this basis, key action areas have been identified in Section 3 to provide a strategic framework for action, and have been prioritised based on:

- The national evidence on key action areas likely to have the greatest long-term impact on health inequalities
- The national evidence on key action areas likely to provide ‘ big wins’ and have the greatest impact in the short to medium term.
- The local picture of need in Dudley
- Views expressed by the community during the Dudley Borough Challenge process

3. STRATEGIC FRAMEWORK FOR REDUCING HEALTH INEQUALITIES

3.1 STRATEGIC PRIORITIES

This framework focuses on narrowing the health inequalities gap, that is, it aims to achieve greater health improvements in the least healthy and often poorest population groups in Dudley. In order to meet the challenge to reduce health inequalities in a planned and sustainable way across the LSP partners, 3 priorities have been identified for action in Dudley based on the national evidence for what works, the local picture of need in Dudley and the views expressed by the community during the Dudley Borough Challenge process:

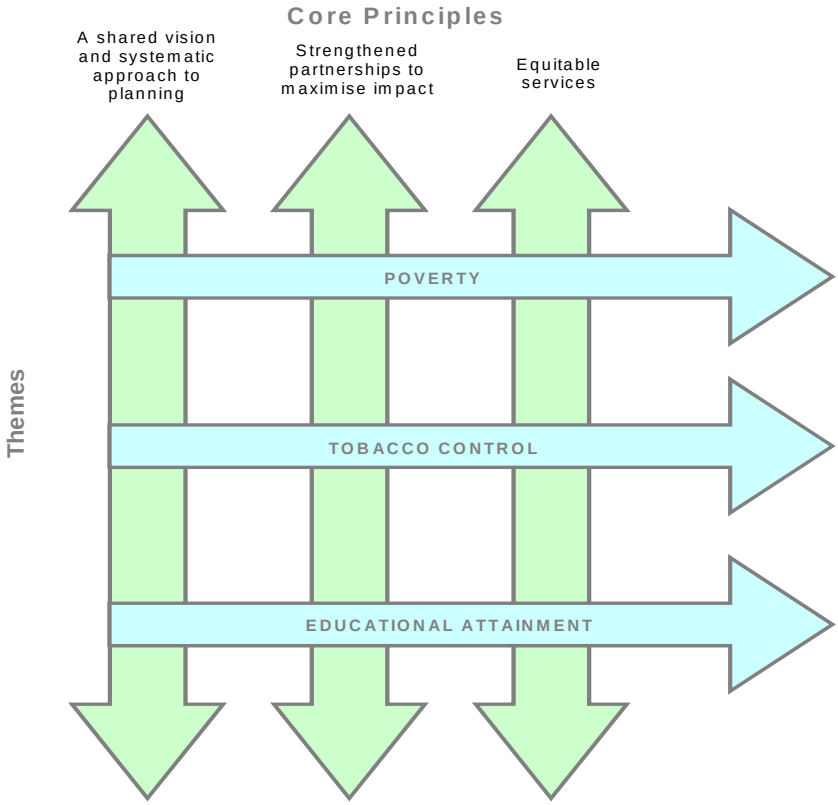
- **Reduce Poverty**
- **Tobacco Control**
- **Increase Educational Attainment**

In addition to these, 3 core principles have been identified that underpin achievement of the priorities:

- **A Shared Vision - A Systematic Approach To Planning**
- **Strengthened Partnerships To Maximise Impact**
- **Equitable Services**

This provides a framework for action:

Figure 13



3.1.1. Reduce Poverty:

Develop a joint anti-poverty action plan that maximises the potential for all agencies to reduce poverty, to include:

- Reduce homelessness
- Increase access to supported and adequate social and private housing among vulnerable groups
- Reduce fuel poverty among vulnerable groups
- Increase employment opportunities through welfare-to-work schemes
- Increase the uptake of eligible benefits
- Regenerate deprived neighbourhoods to improve local environments and access to services and facilities
- Re-orientate job creation from low-skilled, low paid jobs, to higher skilled, higher paid jobs

3.1.2. Tobacco Control

Support and implement a 'smoke free generation' programme in Dudley with a focus on deprived areas. This will involve a 6 strand approach:-

- Reduce exposure to second hand smoke
- Reduce tobacco promotion by enforcing legislation
- Ensure compliance with relevant tobacco regulation legislation
- Reduce availability and supply of illegal tobacco products
- Build stop smoking services, focussing on deprived areas and vulnerable groups; pregnancy and the early years
- Develop a local media programme

3.1.3. Improve Educational Attainment

Action to increase the educational attainment, aspirations and life skills of adults, children and young people in deprived areas and of key vulnerable groups through the implementation of Every Child Matters:

- Implement the Children's Centres programme
- Implement the Extended Schools programme
- Further develop the Health Promoting School Programme
- Focus on parenting skills and family support networks
- Focus on key vulnerable children e.g. looked after children, teenage mothers

3.1.4. A Shared Vision – A Systematic Approach To Planning

Our existing ways of working and patterns of service delivery have delivered significant health improvements but have failed to halt the increase in health inequalities. This is not surprising since our primary aim has been health improvement. In order to deliver the same level of success in reducing health inequalities as we have to improving health, health inequalities must be mainstreamed and be given equal status alongside health improvement in everything

we do. In practice this will mean that any organisation, service or activity that has health improvement as one of its aims should also have reducing health inequalities as one of its aims at the same level. This principle needs to be progressively built into key plans and into all new plans, strategies and frameworks. This requires all agencies and professionals, at all levels, to have understanding and ownership of the rationale for tackling health inequalities and the action needed.

Delivering actions that reduce health inequalities will be challenging. More of the same will not achieve a reduction. Services need to be provided differently and new services need to be provided. In order for it to happen, where new relevant resources are available, the basic premise of this framework is that it should be preferentially allocated to targeted health inequality work. This will ensure the resources contribute both to reducing inequalities and improving the overall population health. There will never be sufficient new resources to solve health inequalities, so the use of existing resources more effectively (in health inequality terms) is also crucial. Existing resource allocations need to account for the fact that achieving change in deprived areas requires a disproportionate application of resources. This is because, firstly, there is greater need and secondly, achieving change in these communities requires a disproportionate amount of resources for the same level of outcome.

In summary there needs to be:

- A planning and performance framework for health inequalities as an integral part of the LSP with clear lines of accountability across all LSP partnership themes.
- Joint training at all organisational levels to develop knowledge, understanding and skills
- Development and application of a ‘checklist’ for auditing and assessing the inclusion of health inequalities in all strategies, policies and services (see Section 4)
- A commitment to prioritise the resourcing of health inequality work

3.1.5. Strengthened Partnerships To Maximise Impact

Strengthening partnership arrangements to maximise the potential for tackling health inequalities, both in terms of delivery and impact, is critical to success. This could include:

- Greater co-ordination of borough strategies
- Additional ability to link relevant and overlapping themes
- Integrated workforces
- Pooled budgets
- Joint priority areas for action
- Joint intelligence systems
- Joint consultation and involvement processes

3.1.6 Equitable Services

A commitment to focus on addressing the equity of service provision across agencies, with all mainstream services:

- Identifying inequalities and addressing them
- Addressing barriers to accessing and using services experienced by vulnerable groups and people living in deprived areas.
- Targeting services to areas of greatest need, vulnerable groups and deprived areas
- Allocating resources disproportionately, based on need
- Being responsive to diverse needs e.g. providing additional support to access services where needed
- Providing localised community services
- Involving communities in the design and delivery of services
- Aligning facilities with public transport and transport alternatives in deprived areas

The implementation of the proposed checklist for auditing health inequalities (see Section 4) will assist services in achieving this principle.

3.2. OUTCOMES, TARGETS AND ACTION PLANNING

The strategic framework outlined in 3.1, challenges partners to develop ambitious targets and actions to implement the priorities and narrow the health inequalities gap.

From the stakeholder event, a number of actions were identified, and these form the basis of a draft action plan that provides a starting point from which thematic partnership groups will develop action plans. Thematic workshops will take place between November 2005 and February 2006 to help facilitate the process, and help partners address both theme and cross theme issues. Resultant action plans will be evidence based and will have community input in their design.

The action plans must take on board the core principles identified in the framework and must be capable of making a significant contribution to targeted reduction of health inequalities. They must also be evidence-based, demonstrate the application of new resources or the bending of existing resources to target health inequalities and make specific provision to involve communities and or front-line workers in their design.

Additionally, training is proposed for all agencies and professionals to facilitate a shared understanding of how to reduce health inequalities and implement the checklist for developing equitable policy and services (Section 4).

3.3. Performance Management

In order to assess our progress over time we will put in place a performance monitoring framework with key outcomes and targets being set against the action planning process. The Health and Wellbeing Partnership reporting on to the wider Dudley Community Partnership will monitor performance.

The stakeholder workshop, and national guidance, identified a number of key targets and outcomes and these form the basis of a draft performance framework, which will be used as a starting point. A template for assessing performance against the

implementation of the health inequalities checklist in Section 4 is also to be developed and agreed for March 2006.

The targets and outcomes selected need to fit the following criteria:

- Be a measure for a key action area required to reduce health inequalities in Dudley's strategic framework
- Be routinely published and available as a measure at ward level, and for different population groups including deprivation quintiles
- Be updated preferably at yearly intervals, but at least at 5-yearly intervals
- Be robust enough to detect changes over time
- If it is not routinely published, the data to calculate it are routinely collected at Local Authority or PCT level

4. MAINSTREAMING THE REDUCTION OF HEALTH INEQUALITIES

4.1. HEALTH INEQUALITIES CHECKLIST FOR STRATEGIES AND PLANS

Agencies and organisations need to ensure that the reduction of health inequalities is an integral part of all their strategies and plans. This checklist is designed to assist in the development of these strategies by highlighting some of the issues that need to be considered in relation to health inequalities**.**

Key Actions		**Yes/No**
1	Does the strategy or policy make specific reference to reducing health inequalities?	
2	Is there evidence to illustrate the inequality?	
3	Are all relevant partners engaged in the process?	
4	Is there a named person with lead responsibility?	
5	Is there a national or local target set? Has a monitoring or evaluation process been established?	

Background Information

1. Reference to Health Inequalities

- Does the strategy or plan make specific reference to reducing health inequalities?
- Will the strategy or plan have a negative or positive impact on the health of deprived communities or key vulnerable groups?
- What and how will it contribute to reducing health inequalities?
- Have specific actions been identified to address health inequality rather than just identifying the problems?

2. Is there evidence to illustrate the inequality?

- Has a baseline been established?
    - What is the current position?
    - Is there a need to carry out a health impact assessment or health equity audit?
- Is there a greater need in certain groups or areas?
- Does the strategy or policy highlight this?
- What type of inequality is it?
    - Service provision – the provision of services maybe unfairly distributed, and not based on need
    - Access to services – services may be inaccessible to some groups in society
    - Service use – lack of awareness of service or poor uptake with certain groups
    - Health/illness – different illness and death rates for people from different social or ethnic groups, age and gender.

3. Are all relevant partners engaged in the process?

- Is there representation from all involved groups i.e. staff, statutory organisations, voluntary sector and users?
- Do they all attend regular meetings?
- Do they have a shared understanding of the issues?
- Are they committed to the implementation of the strategy or plan?

4. Is there a named person with lead responsibility for the plan or strategy?

- Do they have a clear remit?
- Do they have the support of all involved partners?
- Do they have a clear understanding of the Health Inequalities Strategy?

5. Is there a national or local inequalities target set relating to this strategy or plan?

- How will progress towards targets be monitored?
- How will you know if health inequalities have been reduced?
- How will the impact of the strategy on health inequalities be monitored and evaluated?

4.2. HEALTH INEQUALITIES CHECKLIST FOR SERVICES

Reducing health inequalities is not about taking services away from more affluent areas or groups. It is about being flexible enough in service delivery terms to meet the different needs people have in accessing and using services. It is about breaking down barriers, offering additional or different support and providing services differently to prevent exclusion of the most vulnerable groups in our borough.

This checklist has been designed to ensure that issues contributing to the reduction of health inequalities can be automatically built into the planning and redesign of services across all agencies and organisations in the borough.

Actions **Does the service take into account the following factors?**	**Yes/No**
1. Evidence of need – baseline monitoring data	
2. Accessibility	
3. User-friendliness	
4. Information about the service	
5. Users' views	
6. Staff understanding of health inequality issues	
7. Groups with special needs	

Explanatory Notes

These notes have been produced to help with the completion of the checklist, and pose a range of questions that should be considered when planning or redesigning a service to ensure that it is delivered on an equitable basis.

1. Evidence of Need / Baseline Monitoring Data

Are there particular groups that are vulnerable and at risk? Are there groups you would expect to be using your service more frequently because they have greater needs? Collection of monitoring data on ethnicity, gender and postcode (for geographical, area) will allow simple health equity audits to be conducted, for example, baseline data can be analysed to see if key vulnerable groups or geographical areas are using the service at the level expected.

Is there a system in place to enable the identification of health inequality e.g. health equity audits, reviews of data on service use or satisfaction surveys by different groups and communities or needs assessment processes?

Are there monitoring systems in place such as ethnicity monitoring data, gender, age, postcode and DNAs (Did Not Attends)?

Does this information highlight particular geographical areas of deprivation and need?

What other evidence is available to prove that there is a need?

- clients' views
- professionals' perceptions based on profiles, experience of working with client group, discussions with clients
- health trends, research showing the disease levels or health needs of particular groups of people

2. Accessibility

This is not just about where the service is based, but also links to a range of factors which act as 'hidden' barriers such as the attitude of the service

Physical

- Is the service in walking distance?
- How near is the service to the client group?
- What facilities are in place to take the service to the housebound?
- Is there adequate, low cost public transport available to ensure access?
- Are there adequate facilities for the disabled, such as disabled access, induction loops?
- Flexible opening times e.g. taking account of how these link with local public transport arrangements

Hidden barriers to access:

- Awareness of services and how to use them
- Information on services, how to get to them, how to contact them and what to expect.
- Treatment and care episodes in different languages and formats to cover different literacy levels and visual impairments
- Some communities don't feel confident in accessing and using services. This may be due to previous bad experiences, unfamiliarity or fear. So we need to go to them:
    - by utilising venues in the community where people feel more at ease
    - by providing additional support to bridge the gap between services and communities e.g. through link workers in mental health and schools
    - by building capacity in the community to understand services
    - through providing services differently – e.g. community development mental health workers for BME communities
    - working to break down barriers within communities e.g. perceptions of mental health and mental health services

NB. DNAs are a useful way of auditing accessibility and use. The people having difficulty accessing the service, and therefore not attending, are usually those with the greatest need. DNAs can be monitored in a number of ways, such as by

postcode, ethnicity and age, to identify if inequalities exist. A different model of service delivery may help reach these particular groups.

3. User friendliness

- How easy is it to contact the service?
- Are the opening times and appointment systems flexible enough to facilitate access? Do they fit in with local transport timetables? Do they fit in with people who work, or have children at school?
- How pleasant is the physical environment e.g. reception, waiting areas, consulting rooms? Are facilities available e.g. chairs, toilet, children's area?

4. Information about service

- Is information provided to help individuals use the service effectively?
- Is health advice supported with material that can be taken away to reinforce the messages?
- Is information provided in an appropriate form i.e. different languages, written, verbal?

5. Users' Views

- Is there a common working routine to ask for users' views?
- Is the service modified as a result of feedback from users?
- Are communities, individuals and patients involved in the ongoing development of the service (especially from excluded or hard to reach groups)?

6. Staff understanding of health inequality issues

- Are staff trained and aware of the equality and diversity agenda i.e. needs of different groups, difficulties people have in using services?
- Do they have a friendly, non judgemental attitude towards clients?

7. Needs of specific users' groups

- Is there provision for interpreting and language support?
- Is there flexibility to offer longer appointments for people with learning disability and mental health problems?
- Are there crèche facilities for parents with young children?

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6. GLOSSARY

- **BTCV** British Trust for Conservation Volunteers.

- **CHD** Coronary Heart Disease.

- **Community Plan/Community Strategy**
  Under the Local Government Act 2000 all local authorities are required to work in partnership with the community, businesses, the voluntary sector and other public sector partners to develop a long-term strategy to promote the social, economic and environmental well being of their local communities.

- **DCP**
  Dudley Community Partnership: The Local Strategic Partnership for Dudley (see LSP).

- **DCVS** Dudley Council for Voluntary Services.

- **DNA** Did not attend.

- **Dosti** Dudley's Local Community Empowerment Network.

- **Early Years Plans**
  All local areas are required to agree a multi-agency strategy encompassing health, social, educational and leisure services, provided by statutory, voluntary and private sector, which aims to provide an holistic approach to addressing the needs of pre-school children.

- **Health Act 1999**
  Introduced closer partnership arrangements between health and local government than was previously permitted by legislation. The three new types of arrangement are pooled budgets, lead commissioning and integrated provision. They can include a wide range of health and local authority functions, including social services, housing, transport, leisure and library services.

- **Health and Social Care Act 2001**
  Introduces the concept of Care Trusts. NHS bodies largely based on Primary Care Trusts, to provide both health care and social care delegated by local authorities. The Act also gives the role of scrutinising local health services to local authorities. The possibility of Public Private Partnerships to provide health services and infrastructure is greatly extended.

- **Health Inequalities**
  Are differences in health experiences and outcome between different population groups, which occur as a consequence of differences in social and educational opportunities, financial resources health behaviour, work patterns and conditions, housing conditions and unequal access to all services, specifically health services.

- **Health Inequity**
  Differences in opportunity for different population groups which result in unequal life chances, access to health services, nutritious food, adequate housing. These can lead to health inequalities.

- **Learning and Skills Councils**
  These are the 46 local arms of the National Learning and Skills Council established to oversee post-16 education and provision of training.

- **Local Agenda 21 Plans**
  Arising from the Earth Summit in 1992, all local authorities were encouraged to work with community representatives to adopt a development strategy built on the principles of social, economic and environmental sustainability.

- **Local Government Act 2000**
  Received Royal Assent in July 2000 and gives councils a new power to promote the economic, social and environmental well being of their local communities. Councils will be required to produce a community strategy, in partnership with businesses, communities, voluntary groups and other public sector organisations, which identifies long-term targets and action to improve the local area.

- **Local Strategic Partnerships (LSP)**
  Bring together public, private, and voluntary and community sectors to provide a single overarching local framework within which action to improve the quality of life for local people is co-ordinated.

- **Public Service Agreements (PSAs)**
  The Government has set Public Service Agreements, which are specific targets for service improvement for every government department. Starting from April 2001, local authorities will be able to bid for more money by agreeing to set local service improvement targets that go beyond existing Best Value Performance Indicators.

- **Health Inequalities Targets**
  Measurable objectives for reducing health inequalities across the country, as specified in the Performance and Planning Framework (PPF) for which responsibility for delivery lies with local health and social care agencies.

- **IMD (2004) Index of Multiple Deprivation:**
  This provides an aggregate score for deprivation based on a range of weighted determinants including income deprivation; crime; the living environment – indoors and outdoors; housing and services – barriers, education, skills and training deprivation for children and adults; health deprivation; disability and employment.

- **National Plan for the NHS**
  The Government's programme for spending the funding for health announced in the Comprehensive Spending Review in July 2000. It has been followed up by a series of government policy and guidance papers giving more detail on how money is to be allocated within certain priority areas, e.g. staffing in the health service, health inequalities, patient consultation, cancer, dentistry, pharmacy services.

- **National Service Frameworks (NSFs)**
  A series of documents giving specific government guidance to both health and local government in a number of key areas of joint working between health and local government, e.g. NSFs for Older People, Mental Health and CHD.

- **SureStart**
  Is an area-based government led initiative in the 250 most deprived neighbourhoods, for children under four and their families. SureStart aims to secure social, educational and health improvement by supporting, developing and creating innovative local services in partnership with local people.

- **Super Output Area**
  A small geographical area of about 1000 people based on realistic neighbourhoods

- **Neighbourhood Management**
  A way of encouraging stakeholders to work with service providers to improve the quality of services delivered in deprived neighbourhoods**.**

APPENDIX 1: STAKEHOLDER EVENT

As part of the strategy development process, a stakeholder event was held on the 1st December 2004, to ensure involvement and ownership of all key partners.

An external consultant led the event and the programme included:

Introduction and Purpose
Developing the framework
Scoping the strategy
Aims
Informing the strategy
Vision
Current activity
Evidence base
Rationalisation

The event was designed to achieve maximum involvement and the outcomes were used to develop the strategy, draft action plans and a draft performance framework.

An editorial team was appointed at the event to draft and co-ordinate the development of the strategy.

The process identified the existence of many excellent projects and services across all agencies contributing to the reduction of health inequalities (see appendix 3).

List of Delegates:

DELEGATE LIST		
Robert	Bacon	Chief Executive, Beacon & Castle PCT
Richard	Baines	Senior Environmental Consultant, Black Country Housing & Communication
Jean	Brayshay	Head of Resources & Partnership, Dudley MBC
Richard	Coverdale	Director of Health Strategy, Commissioning & Modernisation, Beacon & Castle PCT
Linda	Cropper	Commissioning Manager, Beacon & Castle PCT
Jenny	Darby	Health Visitor, Dudley South PCT
Paul	Farenden	Chief Executive, DGoH
John	Freeman	Director of Education & Lifelong Learning, Dudley MBC
Dennis	Hodson	Director, Dudley Community Partnership
Karen	Holden	Chief Executive, CAB
Sue	Holmyard	Assistant Director of Development of Environmental Protection, Dudley MBC
Sue	Hurley	District Business Development Manager, Job Centre Plus
Hilary	Jackson	Acting Assistant Director of Business Services, Dudley MBC
Mark	James	Local Services Delivery Manager, Dudley & Wolverhampton, Pension Scheme
Ian	Jeavons	Neighbourhood Renewal Co-ordinator, Dudley MBC
Helen	Kew	Early Years & Care Manager, Dudley MBC
Chris	Knight	Director of Clinical Services/Lead for Inequality, DGoH

Duncan	Lowndes	Assistant Director of Culture & Community Services, Dudley MBC
Susan	McGavin	Head of Priority Neighbourhood Initiative, Dudley MBC
Sharon	Menghini	Assistant Director Access & Inclusion, Dudley MBC
Allan	Miles	Dudley Federation Tenant & Residents Association
Anne-Marie	Morris	Strategic Lead-Learning Disability & Children's Services, Beacon & Castle PCT
Aldo	Mussi	Dudley South PCT Patient & Public Involvement Forum
Claire	Old	Director of Quality (Nurse Lead), Beacon & Castle PCT
Philip	Osbourne	Dudley Learning Partnership
Cindy	Peek	Assistant Director Community Education & Development, Dudley MBC
Chris	Potter	Chief Executive, Dudley South PCT
Carol	Richardson	General Manager – Learning Disabilities, Dudley PCT
Kenneth	Rodney	Director, Dudley Racial Council
Ron	Sims	Assistant Director House, Dudley MBC
John	Stringer	Director of Housing, Dudley MBC
Geoff	Thomas	Head of Policy, Dudley MBC
Alan	Torbet	Director of Organisational Development & Communications, Dudley South PCT
Kathy	Vilton	Director of Modernisation, Lead Nurse/Deputy Chief Executive, Dudley South PCT
Linda	Warren	Director of Social Services, Dudley MBC
Michelle	Wellsbury	Health Visitor, Beacon & Castle PCT
Les	Williams	Director of Performance Review DGoH
Andy	Wright	Strategic Policy & Information Manager, Dudley MBC
Jenny	Yardley	Action for Disabled people and Carers ADC

APPENDIX 2: CURRENT HEALTH INEQUALITIES STATUS IN DUDLEY

Figure 1 - Black & Minority Ethnic (2001) Communities. Percentage of Total Population

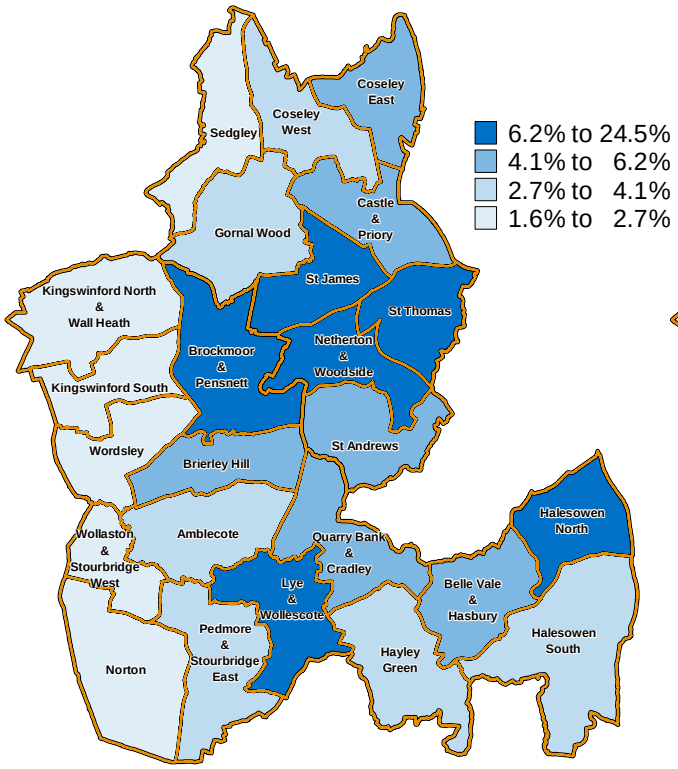


Figure 2 - Pensioners Living Alone (2001) Percentage of All Pensioners

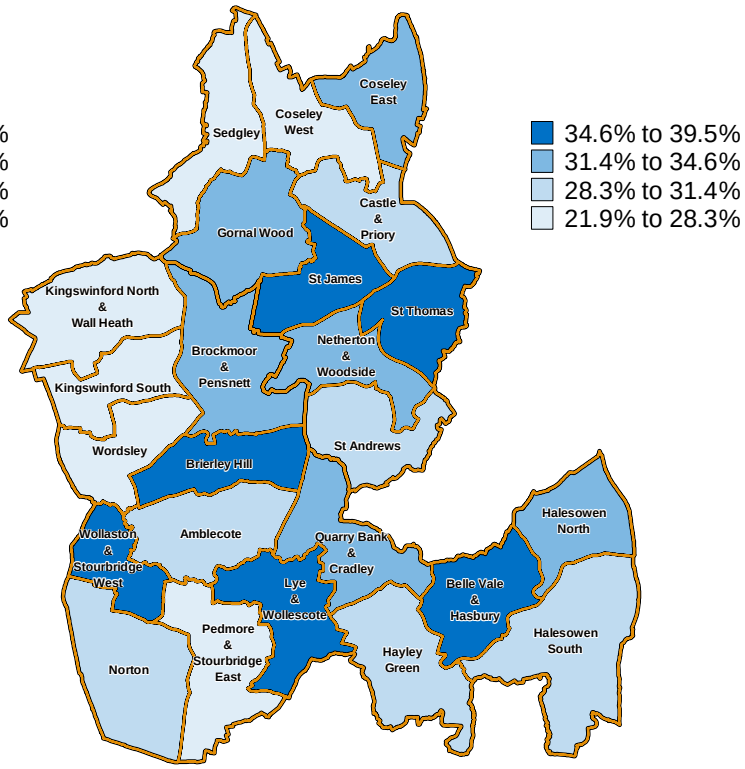
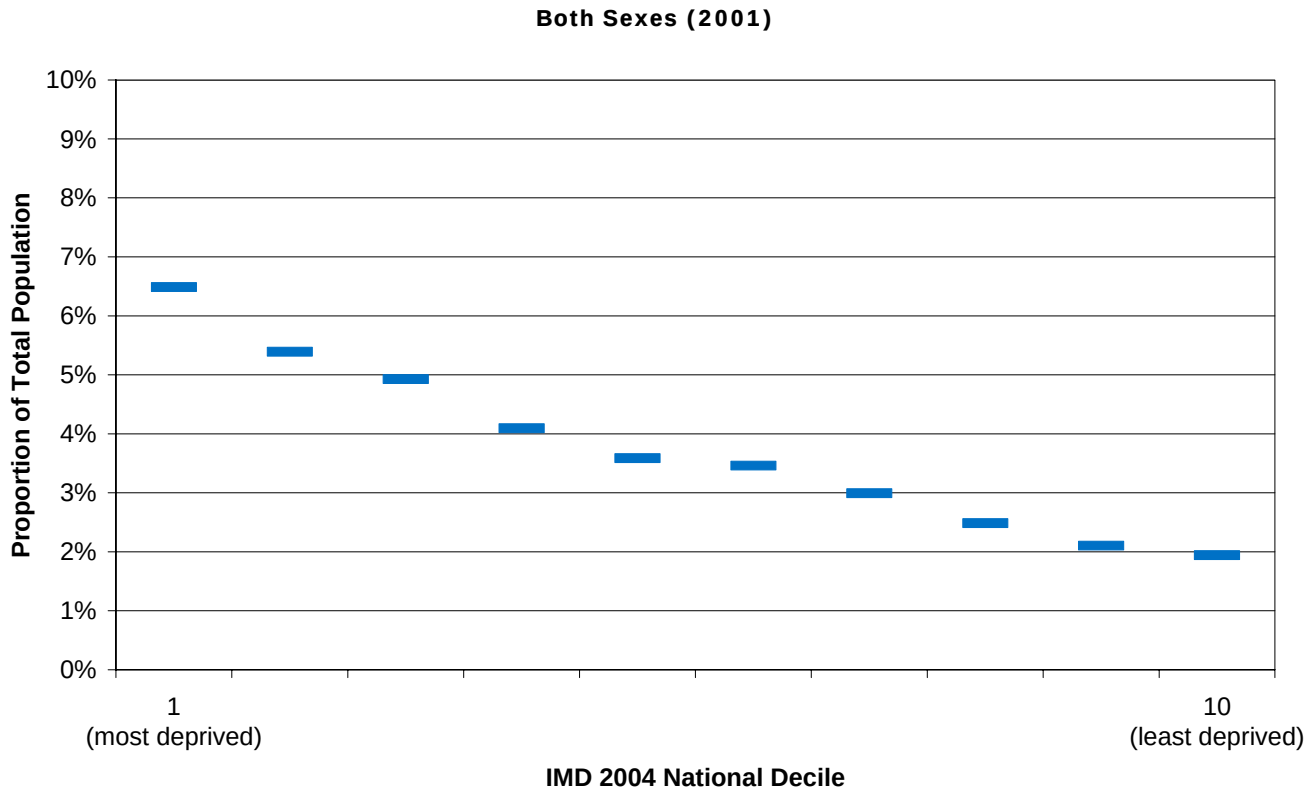
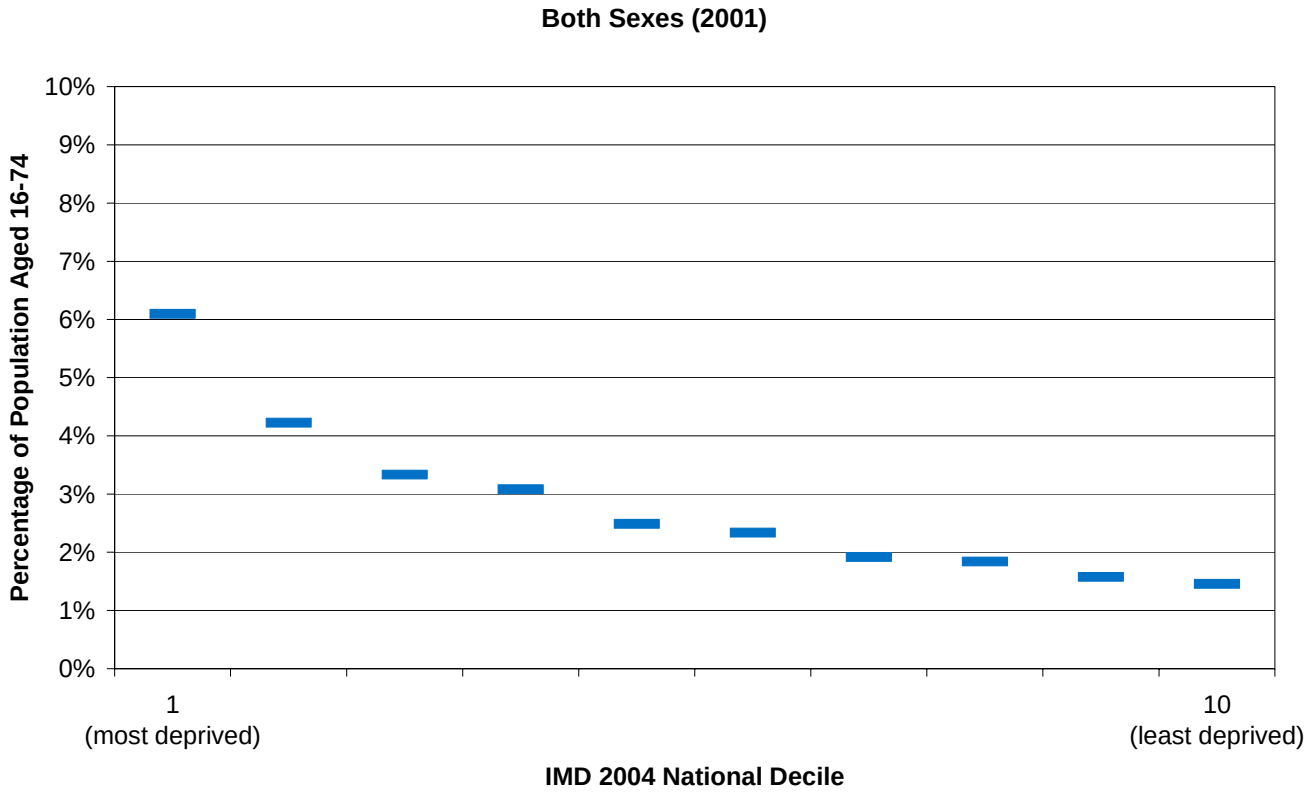


Figure 3 - Proportion Of People Who Are Permanently Sick Or Disabled



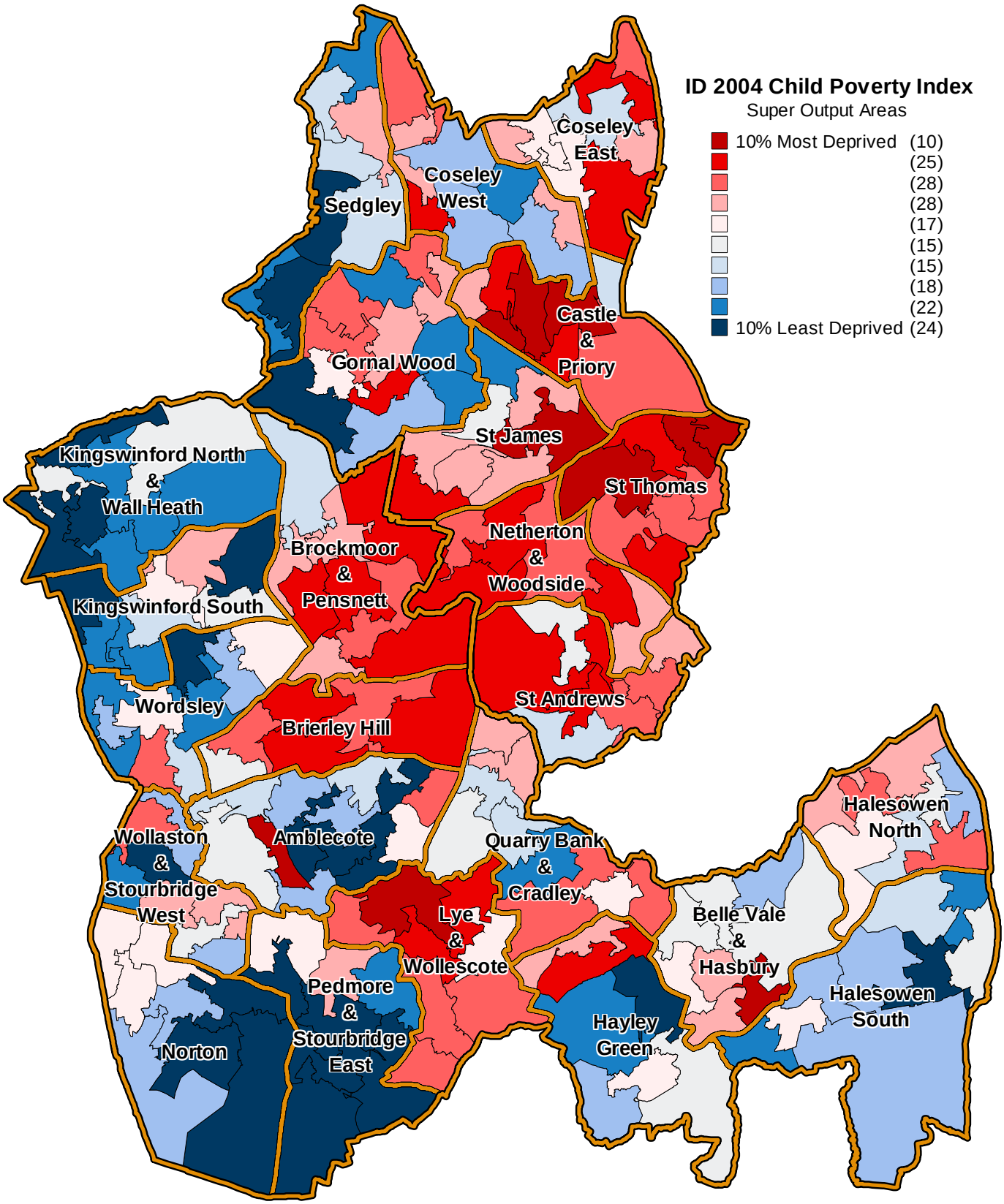
Source: 2001 Census

Figure 4 – Proportion Of People Aged 16-74 Who Are Unemployed



Source: 2001 Census

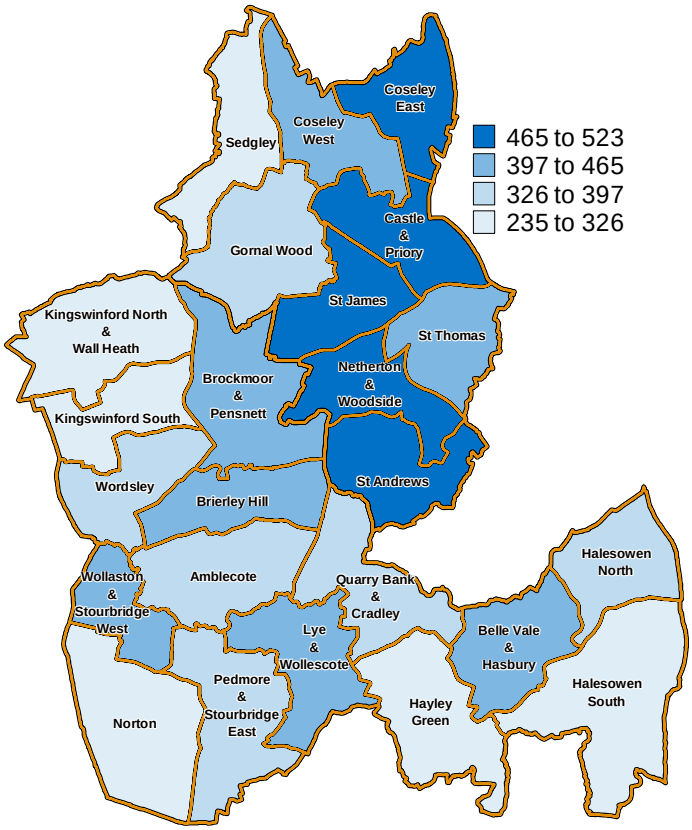
Figure 5 - 2004 Child Poverty Index
Super Output Area National Deciles



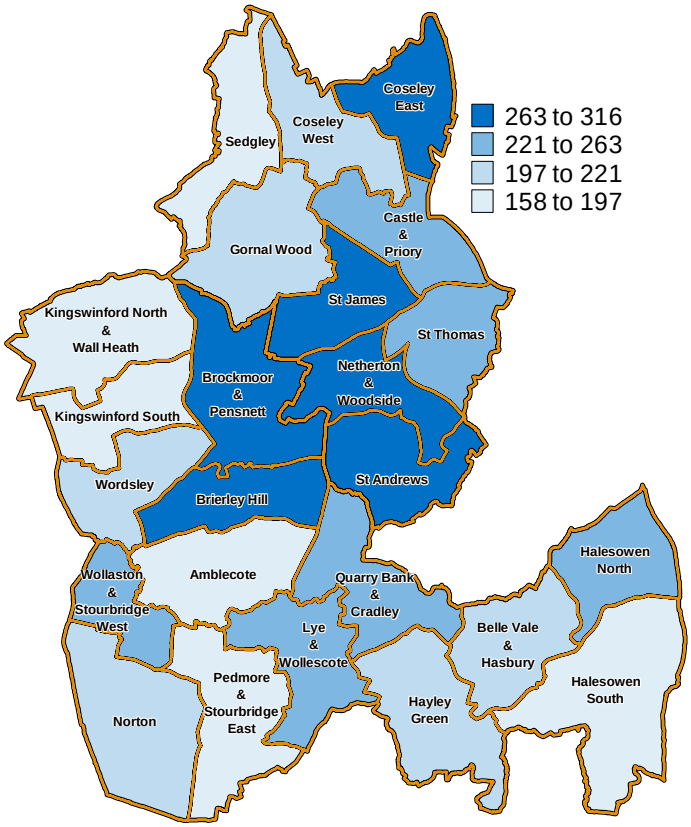
Source: Office for the Deputy Prime Minister, Indices of Deprivation 2004

Figure 6 - All Cause Mortality
Directly Standardised Rates per 100,000 Population

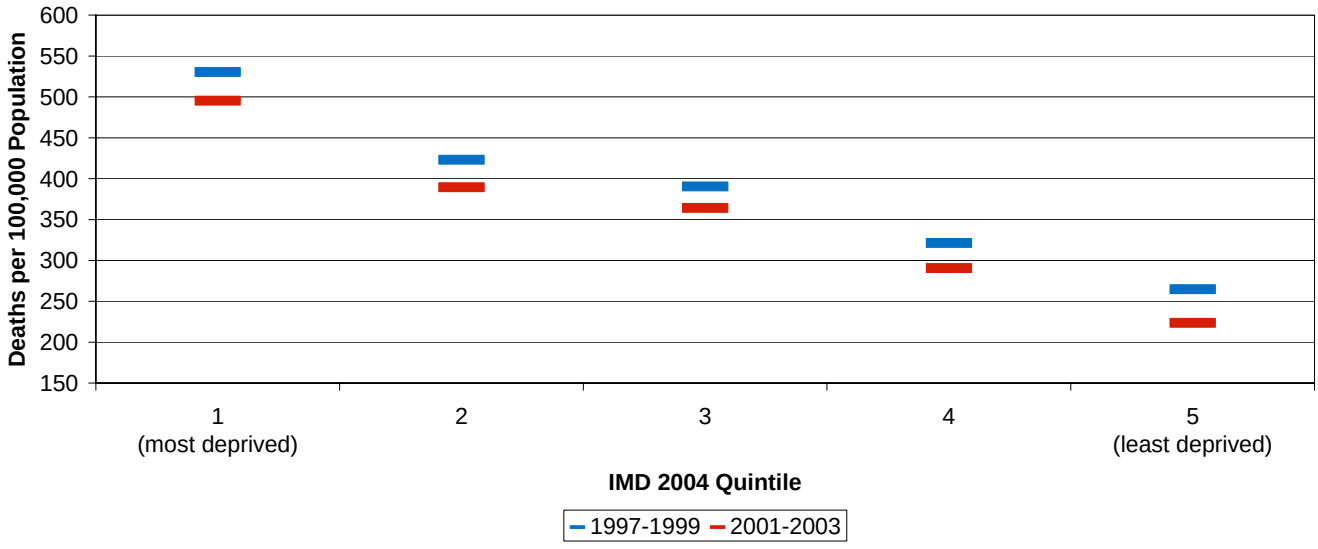
i) Males, under 75 (1999-2003)



ii) Females, under 75 (1999-2003)



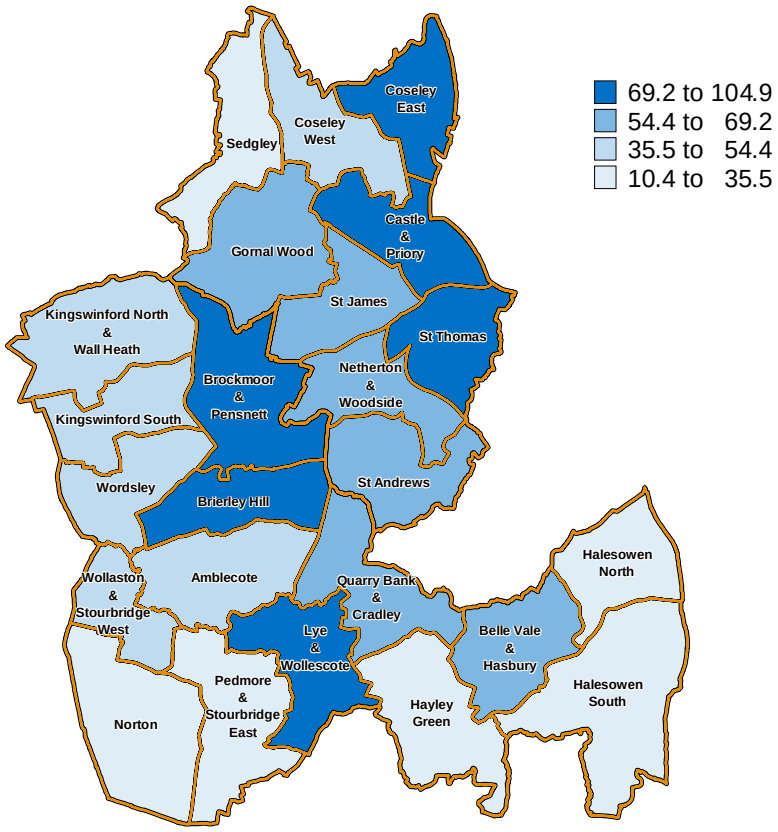
iii) Both sexes, under 75 (1997-1999 & 2001-2003)



Source: Office for National Statistics (ONS) Annual Deaths Extract
Office for National Statistics (ONS) Mid-Year Population Estimates

Figure 7 - Teenage Pregnancy

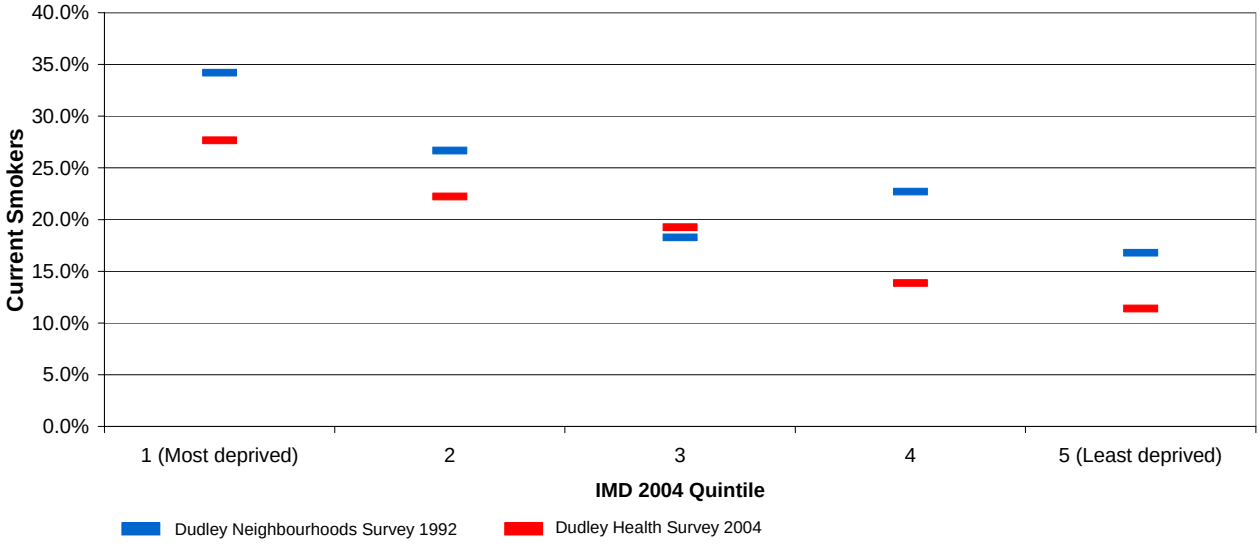
Under 18 Conceptions (2000-2002)
Conceptions per 1,000 girls aged 15-17



Source: Department of Health, Teenage Pregnancy Unit

Figure 8 - Smoking Prevalence

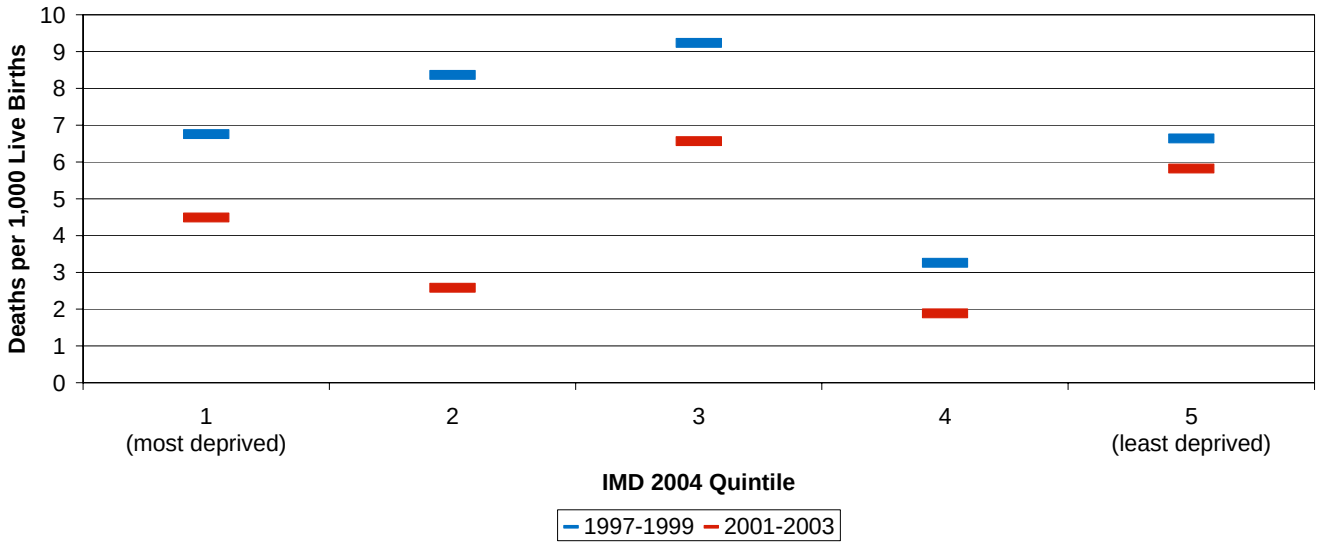
ii) Current Smoker prevalence (1992, 2004)



Source: Dudley Neighbourhoods Survey 1992 and Dudley Health Survey 2004

Figure 9 - Infant Mortality

Both Sexes (1997-1999 & 2001-2003)

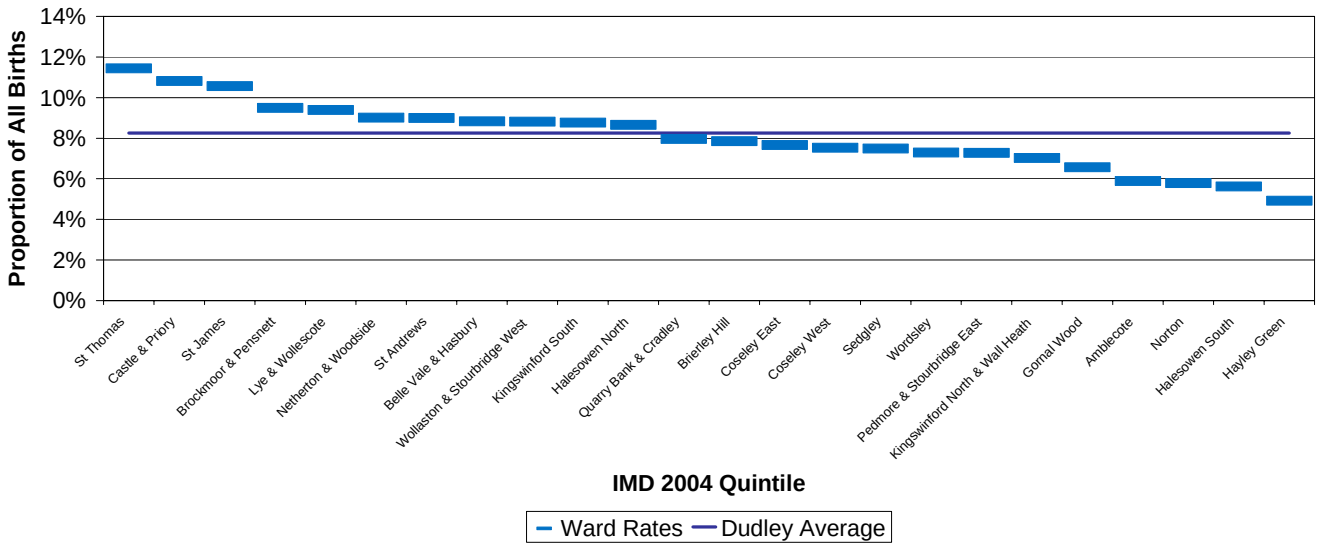


Source: for National Statistics (ONS) Annual Births & Deaths Extracts

Figure 10 – Low Birthweight

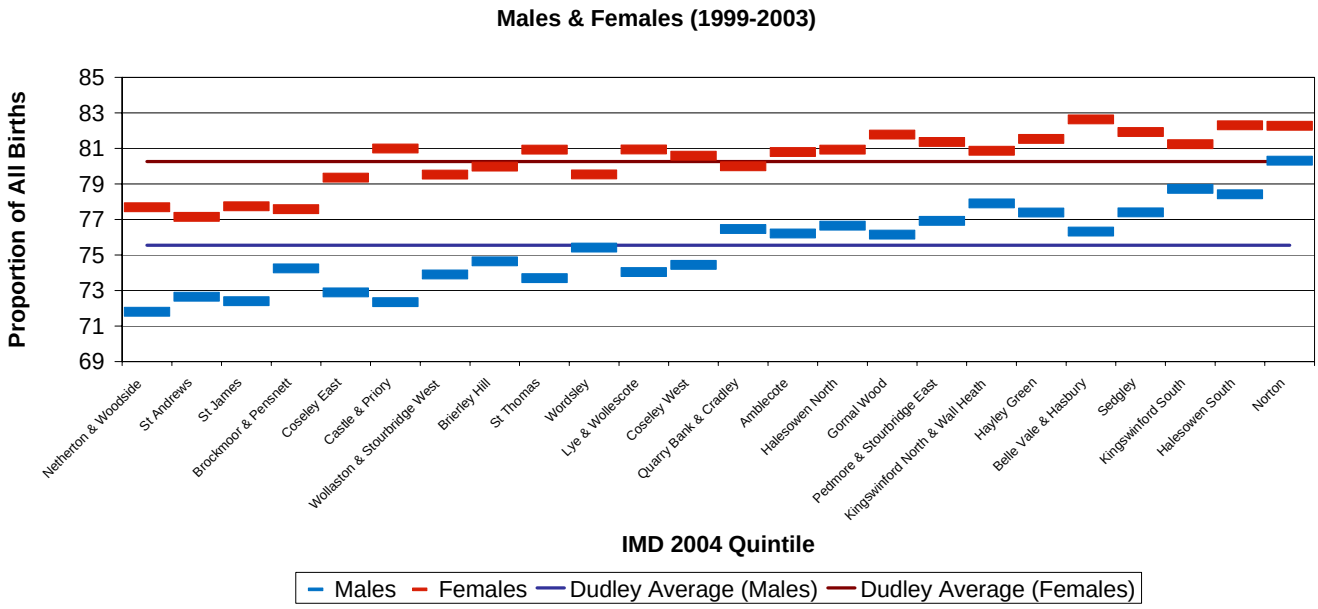
Proportion of all babies born weighing less than 2.5 kg

Both Sexes (1999-2003)



Source: Office for National Statistics (ONS) Annual Deaths Extract
Office for National Statistics (ONS) Mid-Year Population Estimates

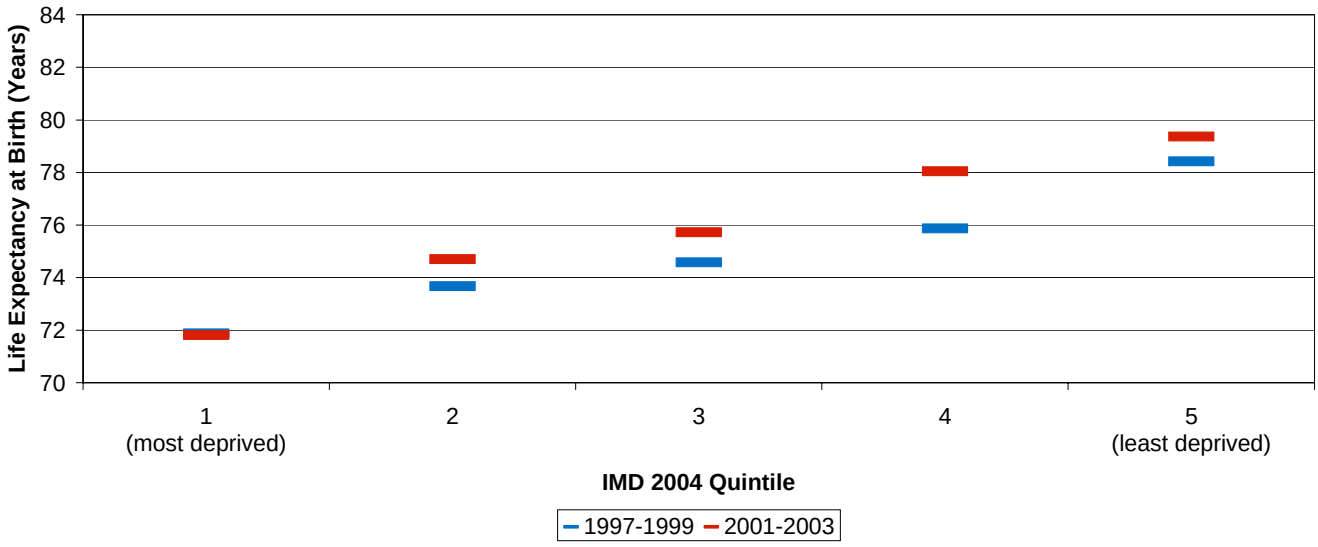
Figure 11 - Life Expectancy at Birth



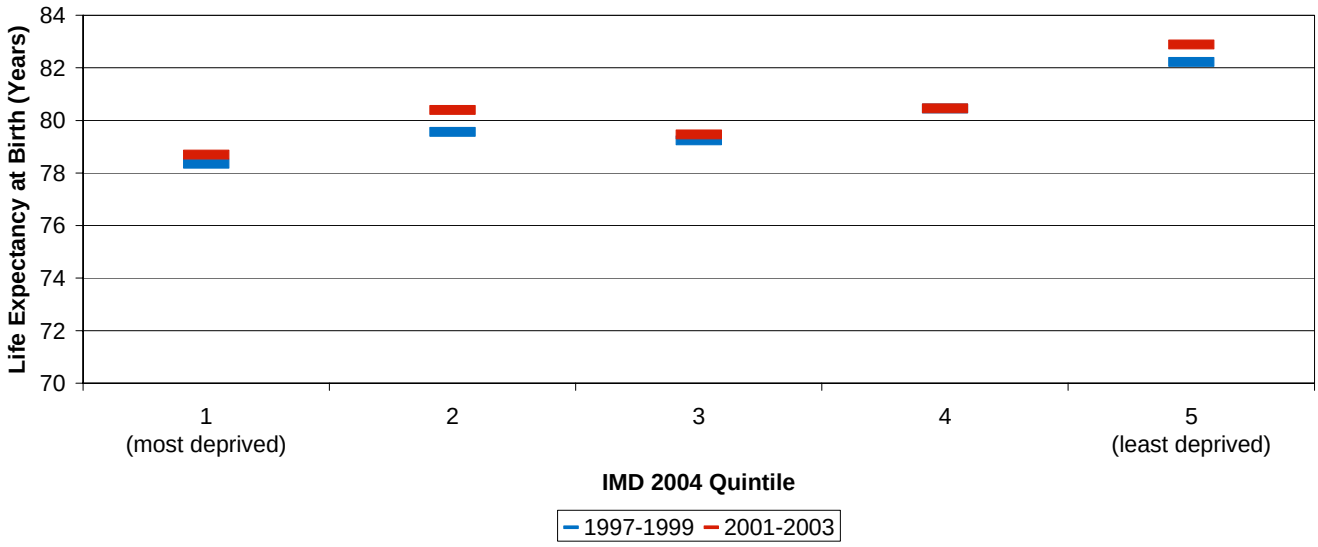
Source: Office for National Statistics (ONS) Annual Deaths Extract
Office for National Statistics (ONS) Mid-Year Population Estimates

Figure 12 - Life Expectancy at Birth

i) Males (1997-1999 & 2001-2003)



ii) Females (1997-1999 & 2001-2003)



Source: Office for National Statistics (ONS) Annual Deaths Extract
Office for National Statistics (ONS) Mid-Year Population Estimates

APPENDIX 3: CURRENT AND PLANNED ACTIVITY CONTRIBUTING TO TACKLING HEALTH INEQUALITIES

(Please note this is not an exhaustive list)

POVERTY

- **Neighbourhood Management** focus on the most deprived areas
- **Housing**: Flatted estates review
- **Benefits uptake and financial support**
    - Citizens Advice Bureau– debt counselling
    - Health Through Warmth programme signposting to reducing fuel poverty
- **Volunteering and employment programmes**
    - Local people for local jobs programme
    - Jobs Club
    - BTCV, Rethink, (for people with mental health problems)
- **Environment in deprived areas:**
    - ***Borough Physical Activity Action Plan***:
        - Make use of all open spaces- transforming open space programme
        - Co-ordinate public transport with good access in deprived areas and links to key facilities e.g. hospitals, GPs, social care
    - ***Local development Schemes (LDS) and local area action plans:***
        - To deliver effective local land-use plans
        - Implementation of Brierley Hill Air Quality Action Plan
    - Fluoridation of Stourbridge Water
    - Community Transport and hospital transport schemes

EDUCATIONAL ATTAINMENT

- 'Plays the Thing' mental health promotion theatre work to reduce barriers to educational opportunities for people with mental health problems
- SureStart Programmes
- Health Promoting School
- Fruit in Schools Programme
- Food and Physical Activity in Schools Programme

EQUITABLE SERVICES AND PROGRAMMES

- Establish 'keyring' initiative for vulnerable people- older people, learning disabilities, less able
- Arrest and referral schemes for drug/substance misuse
- Development of a foster placement programme
- Implementation of the Care Leavers Action Plan
- Development of Looked After Children health team based at Cross Street
- Health awareness work with specific BME community groups
- Implementation of Seesaw palliative care team based at 8 Ednam Road
- Work with carers and carers groups
- Expert Patients Programmes especially in deprived areas and with vulnerable groups
- Establishment of the Priory community pharmacy as a social business

- Implementation of the Teenage Pregnancy Action Plan
- Health Promotion events targeted at specific groups, e.g. 'Keep Me Healthy' for people with a learning disability
- All public authorities having Race Equality Schemes and working towards the equality and diversity agenda

- **Involving communities:**
    - Development of neighbourhood forums and health forums in deprived areas
    - Existing groups and networks to engage with communities- *DCVS / Global Group Link, Dosti, health forums, Forum Support Organisation*
    - Implementation of health needs assessments targeted at deprived areas – Lye, Netherton and Woodside
    - Implementation of Borough Challenge consultation into community plan

PREVENTION: COMMUNITY DEVELOPMENT AND HEALTHY LIFESTYLES:

- ***Borough Physical Activity Action Plan and Leisure And Culture Strategy:***
    - Increase investment in safer routes to school,
    - Cycling and walking initiatives
    - Increase availability and use of school sports facilities by general public
    - Free swimming programme for children to be piloted
    - Mainstream pilot GP exercise referral programme – 'Steps to Health'
    - Map facilities & activities to ensure coverage at local level for <u>all</u> targeting deprived communities

- ***Food For Health Plan For Dudley***
    - Free school meals for all primary schools
    - Developing nutrition standards in early years settings
    - Encouraging cooking lessons in schools
    - Mapping of food 'deserts' to improve local access to fresh produce linked to regeneration of deprived neighbourhoods
    - Dudley Food for Health Award
    - Get Cooking Programme targeted at deprived areas

- ***Borough Obesity Action Plan***
    - Develop a weight control service for adults and children targeted to areas of greatest need
    - Tackling of the obeseogenic environment
    - Promotion of breast feeding particularly in deprived areas

- ***Accident Prevention Strategy - Targeting vulnerable groups***
    - Home safety check audit for homes with children under 5s, including supply and fitting of safety equipment,
    - Over 65s targeted with falls prevention programme

- ***Community Nursing Reviews***
    - Changing front line delivery of health staff to a population perspective
    - Development of the public health role of health visitors, school health advisors and practice nurses

- ***Community Volunteers Programme***
    - Training local volunteers to act as mentors to improve health in deprived areas

- ***Health Promoting Schools Programme***
    - Support for schools in deprived areas
    - Support to schools on equality and diversity issues
    - Promotion of inclusion of children and young people with emotional and behavioural difficulties
    - Emotional literacy programme
    - Personal health and social education: drug and alcohol education, sexual health and relationships education, emotional well-being

- ***Mental Health Promotion Action Plan****:*
    - Proposals for a schools post to further develop positive self esteem and emotional literacy in children targeting schools in deprived areas and key vulnerable groups
    - Proposals to focus of anti-stigma work at key vulnerable groups in the community - BME, deprived areas, older people, young people, unemployed, young offenders

- ***Workwell programme***
    - Health and Safety Week – Asbestos

- ***Community Cohesion Strategy***

- ***Community Safety Strategy***