DUDLEY HEALTH INEQUALITIES STRATEGY 2010

EXECUTIVE SUMMARY

(DRAFT - SUBJECT TO CABINET APPROVAL)

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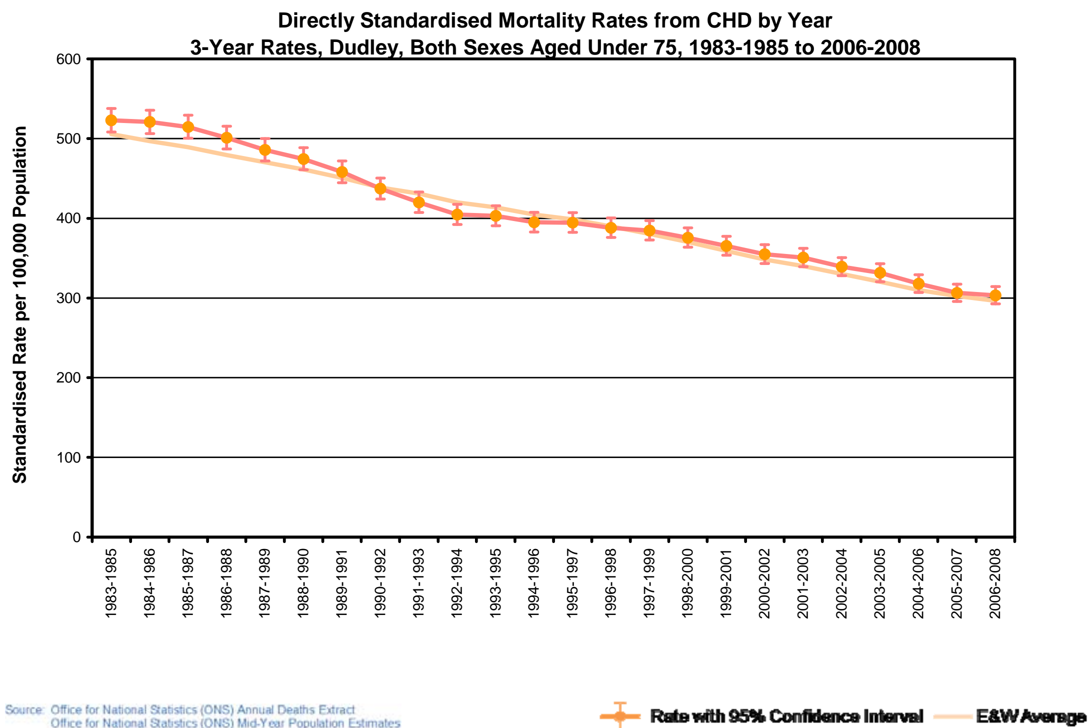
BACKGROUND

This strategy replaces and builds on the previous strategy to tackle health inequalities in Dudley, ‘Closing the Gap – Tackling Health Inequalities in Dudley’ (Dudley MBC/PCT 2005). In the five years since the strategy was written we have seen mortality rates from the main contributory diseases all reduce slowly and life expectancy for Dudley residents has increased from 75.7 years for men and 80.3 years for women in 2003 to 80.3 years for men and 81.9 for women by 2008.



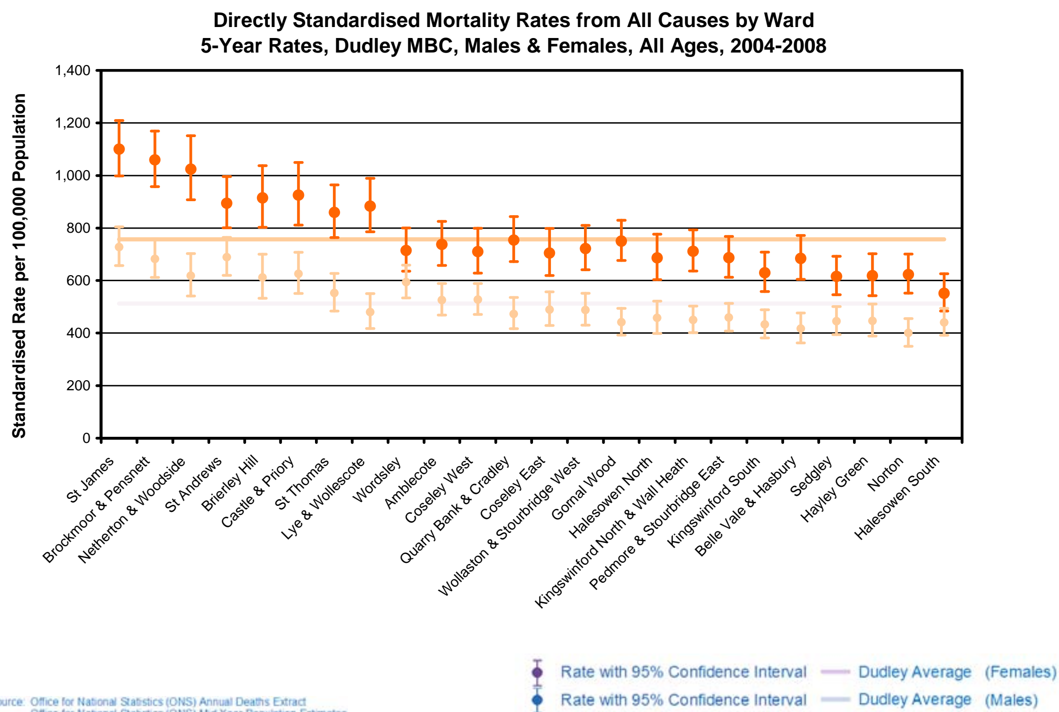
However the gap in life expectancy for the most affluent residents in the borough compared with those living in the poorest areas still persists. There are also gender differences associated with health inequalities and males bear the bigger burden of morbidity from disease and premature death.

The previous strategy set a target based on a national Public Service Agreement to;

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

It is not possible to say whether we have achieved this target yet, since 2010 data is not available. However the gap is no longer widening at the same rate.

Life expectancy for the whole population has improved, but the gap between the national average and the spearhead authorities (the most deprived Local Authorities) has widened by 7% for men and 14% for women since 1995-97.Life expectancy for the whole population in England is now 77.9 years for men and 82.0 years for women. Life expectancy in Dudley is improving, but there are still significant differences across the borough



Whilst it is pleasing to see the reduction in premature mortality the inequalities gap is still very evident and it is for this very powerful reason that this strategy seeks to address the social determinants of health as well as focusing on improving the health of the most deprived populations within the borough.

STRATEGIC PRIORITIES

The 2005 strategy identified three key priorities:

- Reduce poverty
- Tobacco control
- Increase educational attainment

There were three principles that underpinned the delivery of the strategy:

- A systematic approach to planning
- Strengthened partnerships to maximise planning
- Providing equitable services:

Significant progress has been made against the three key priorities with some actions achieved and some progress made against others. The notable successes have been in tobacco control with the introduction of the smoking ban in public places and the effectiveness of the local quit smoking services. Educational attainment has also improved over the last five years with 76% of pupils achieving grades A to C in 2010, compared with 56% in 2006. Improvements have also been seen in housing, reducing fuel poverty and the regeneration of deprived neighbourhoods, all of which have contributed to the reduction in health inequalities.

The challenge for the refreshed strategy is to build on this foundation in a very different economic environment and ensure that we continue to implement plans that support the health and economic well being of the most vulnerable groups in the borough.

In July 2009 the Department of Heath's Health Inequalities National Support Team visited Dudley to assess our performance in reducing health inequalities. Their report was very favourable in a number of areas, particularly partnership, strategic vision and community engagement. However they did identify five key priority actions for Dudley.

- Strengthening leadership for health and health inequalities across the partnership and particularly within the Local Authority and Acute Trust
- Improving the quality and capacity of primary care
- Refreshing the Health Inequalities Strategy, developing detailed delivery plans and agreeing a common frame of reference for monitoring progress on addressing health inequalities.
- The continued market development of the voluntary, community and faith sector.
- The simplification of neighbourhood community engagement structures.

These recommendations, and other specific recommendations relating to priority actions known to have a significant impact on reducing health inequalities, have been taken into account in the development of the refreshed strategy. They have been summarised as high level actions in the

delivery plan, together with the outcomes and indicators that will be used to monitor progress.

Whilst this strategy has been in development a key report was released and a number of important policy changes have taken place that will impact on how health inequalities will be addressed in the future. Firstly the Marmot Review, Fair Society, Healthy Lives (DH 2010) was released in February 2010. This review emphasised the persistent nature of health inequalities in England and suggested that efforts should be made to tackle the social gradient in health, but focusing solely on the disadvantaged will not reduce the gradient sufficiently. Marmot introduces the concept of 'proportionate universalism' where actions must be universal, but with a scale and intensity that is proportionate to the level of deprivation. He identifies a number of policy areas that will have the greatest impact on reducing health inequalities and these have been adapted as the key strategic aims of this strategy.

STRATEGIC AIMS

❖ **Give every child the best start in life**
❖ **Create fair employment and good work for all**
❖ **Ensure healthy standard of living for all**
❖ **Create and develop healthy and sustainable places and communities**
❖ **Strengthen the role and impact of ill health prevention**

The first policy change that impacts on health inequalities is the role of the 'Big Society', which encourages people to take more control over their own lives, rely less on the state and help other people. This could be a really positive change in our society, but could also have the unintended consequence of leaving the most vulnerable at risk of further inequities in health and social care.

The other major policy shift has been reflected in the White Paper, ' Liberating the NHS' (DH 2010), which sets out radical change for the way in which NHS services will be commissioned and delivered in the future. The responsibility for improving health and wellbeing and reducing health inequalities will be transferred to Local Authorities along with delivering some other Public Health functions.

<u>LEADERSHIP AND PARTNERSHIP</u>

In the midst of these changes we need to safeguard the strong partnerships developed with people living in local communities in Dudley. Long before

statutory requirements like the Duty to Involve came into being, public and voluntary sector agencies in Dudley have been working alongside local communities to ensure that people can affect decision making, influence change in the delivery of health and social services, gain experience and skills which may lead to a better quality of life for them and their families, and take ownership of their own health improvement. This work has been built on trusting relationships, which takes time to develop. An increasing focus on market-driven, cost-efficient models of service delivery brings an inevitable tension in keeping local people at the forefront of our thoughts and our plans. In this climate we need to work particularly hard at valuing and sustaining these relationships and ensuring they continue to be based on trust, respect, empathy and reciprocity.

GIVE EVERY CHILD THE BEST START IN LIFE

While data systems exist to look at progress, at a population level, on immunisation, breast feeding, and attainment at reception year of primary school, there are no systems which enable the full picture to be obtained of the developmental progress of our children in the vital early years. Equally, the systems for tracking fidelity to the Healthy Child Programme and fidelity to important formal manual-based parenting programmes are not well developed.. Undoubtedly, each individual child's progress is recorded in a health, education, children's centre record or parenting programme database but the systems to extract this and examine progress across the child population as a whole or for disadvantaged sub-groups of the population is not always there. This is a priority for development. It is not a small job and will require time to implement. Nevertheless, we will not be able to assess whether our interventions in early years are producing the outcomes we desire if we do not have systems to allow us to view progress.

It has not been possible in the timescale for production of this strategy to amass data on the relative spend on children in the early years versus spend on the school years and the adolescent years in Dudley. Marmot acknowledged that this is not wholly possible at national level either. However, it should be possible to at least reproduce for Dudley an analysis of the type presented in the national data in the Marmot Report, Fair Society, Healthy Lives (The Marmot Review 2010). It is recommended that investment in school and adolescent years should be examined to see if there is any way in which efficiency can be improved to release resource to be invested in the vital early years.

Dudley has no structured intensive home visiting service, such as that delivered within a Family Nurse Partnership Programme, though intensive family support is being delivered through childrens social care, childrens centres and the Family Intervention Programme to some of the Borough's most disadvantaged families. A further nurse based programme is essential for some families. Any investment released from other areas for early years should be channelled into the commissioning of a Family Nurse Partnership

Programme for families on a defined set of eligibility criteria, with a clear means of auditing outcomes.

The structured approach to implementation of formal parenting programmes set out in Dudley's Parenting and Family Learning Strategy (Dudley Children's trust 2009) should continue but with full tracking of adherence to eligibility criteria which ensure that those who need them most get them. Impact in terms of outcome measures must be tracked.

Undoubtedly, productivity would be improved and potentially some resource released, if there was more formal integrated working between the Health Visiting service the midwifery service and the Children's Centres, particularly between the outreach workers and Health Visitors.

Ensuring that paid parental leave is available for workers within Dudley may not be within the compass of the statutory agencies to deliver, but all statutory agencies should ensure that their own policies embrace this and economic regeneration initiatives should promote this.

Pre and immediately post-natal periods are crucial for a child's development and the improvements required in the antenatal care service are highlighted in Dudley's complementary Infant Mortality Reduction Action Plan. The action plan must be implemented in full.

Child care for working mothers with children aged 2 – 5 years can be extremely beneficial but may not be benign if the child care is of a poor quality. Children who experience high quality early years childcare provision are well placed to achieve better outcomes in school and beyond and develop better social emotional and cognitive abilities necessary for lifelong learning. Independent inspection data identifies that 81% of childcare providers in Dudley have achieved good or outstanding grade. Quality assurance of the child care provision in Dudley remains a high priority

CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL

Maximising fair employment for all in Dudley has the potential for making a major contribution to a reduction in inequality of health outcomes. Dudley is currently developing a local economic strategy, designed to develop the local economy and maximize employment. It will be important for this strategy to focus not only on total jobs gained but also on attracting high quality jobs for Dudley people to access. The full set of measures to achieve this is being set out in the Dudley Local Economic Strategy and is not repeated here. For maximum impact on reducing health inequalities Dudley needs to:

- Ensure that data systems for tracking the impact of economic strategy initiatives use a consistent approach to assessment across the social gradient.

- Ensure that public and private sector employers adhere to equality guidance and legislation.

- Develop means of implementing guidance on stress management and the effective promotion of wellbeing and physical and mental health at work, both for public sector and private sector employees.

- Consider the potential for incentivising employers to adapt jobs to provide suitable employment for lone parents, carers and people with physical mental health problems.

- Ensure that Dudley participates to the maximum in any available well evidenced active labour market programmes

ENSURE A HEALTHY STANDARD OF LIVING FOR ALL

As things stand, the extent to which all people in Dudley will have disposable income which provides sufficient for them to have a standard of living for a healthy life is very dependent on national policies adopted by central governments. In particular, the extent to which central governments are prepared to shift the taxation system towards being more progressive; the extent to which welfare policy initiatives are designed to remove the ' cliff edge' and the extent to which measures are implemented to ensure full take up of entitlement to state benefits.

In the meantime, all public service agencies in Dudley should be ensuring that those eligible and entitled to benefit are receiving it.

It is a legal requirement for the Dudley MBC to produce a strategy to reduce child and family poverty and the key actions for poverty reduction in Dudley are contained in that document and are not reproduced within the strategy. The Child and Family Poverty Reduction Strategy must be implemented in full.

CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

The creation of healthy, sustainable places and communities combined with the mitigation of climate change can have an impact in reducing health inequalities. Good policies will include plans to increase opportunities for walking and recreation in green spaces, sporting and cultural facilities complementing strategies to reduce obesity and increase physical activity which contribute to improved mental and physical health.

The priorities for Dudley are:

Increase opportunities for active travel across the social gradient

Maintain access and quality of open and green spaces across the social gradient

Continue to improve the energy efficiency of housing and reducing fuel poverty

Support locally developed and evidence based community regeneration programmes that reduce barriers to community participation and reduce social isolation

STRENGTHEN THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

Most of the NHS budget is spent on treating illnesses which in many cases are preventable. It is estimated that approximately 4% of the national NHS budget is spent on prevention and in times of economic pressure it is often the health improvement programmes that suffer because of the more immediate need to treat people who are ill. The evidence base for prevention is better developed in some areas than others; indeed the pubic health benefits for immunisation programmes and screening programmes are well established and there is strong evidence to support the prescribing of statins for lowering cholesterol and for the use for blood pressure lowering medication in the treatment of heart disease.

Interventions that rely on changing the behaviour of populations are also known to work, but they take a long time to become established and their impact may not be able to be measured for many years. The action plans for reducing mortality from cardio-vascular disease, cancer, chronic obstructive pulmonary disease, which are the three biggest causes of mortality in Dudley, are supported by actions that include primary and secondary prevention measures. Separate plans to reduce alcohol and tobacco consumption are included because of their known impact on mortality rates.

Actions for Secondary Prevention Cardiovascular Disease

1. Reduction in the gaps between actual and expected prevalence for the key vascular diseases via
    - The implementation of NHS health checks, to ensure a high uptake from those who are most at risk and more unlikely to take up a health check e.g. men, minority ethnic communities and low income groups. Targeted promotions, out-reach services and case-finding especially in relation to hypertension should be part of this response.
    - Investigate practice outliers with low levels of prevalence for the CHD and stroke registers

2. Variation in performance across practices for treatment outcomes: Investigate performance for practice outliers starting with blood pressure and cholesterol management
3. Develop an on-going programme of health equity audits supported by the incorporation of a health equity element into all planned primary care/service audits. E.g. medicines management audits, service reviews, improved ethnicity monitoring across primary care/ community services.
4. Put strategies in place to increase referrals to LRMS for those on practice registers and improve outcomes for patients from deprived areas.

Develop and implement a self care strategy as part of the long term conditions strategy so there is a menu of quality assured options for all newly diagnosed vascular patients.

Actions for Acute CHD

The NST identifies a number of priority areas for action and this section draws on those in conjunction with the main findings from the Health Needs Assessment:

- Introduce public awareness campaigns with a targeted approach to groups with higher needs; over 65s, minority ethnic groups, women and deprived areas. Health care professionals should take every opportunity to advise all patients with, or at high risk of, vascular disease to call 999 should they experience unexplained chest pain.
- Continue to embed delivery of expanded services for acute MI diagnostics and revascularisation and review the equity of provision in a further 5 years time.
- Investigate reasons for 'no procedures' being undertaken with the PPCI service
- Repeat the cardiac rehabilitation equity audit with larger numbers to establish a fuller picture and implement recommendations made from this. This should include a review of DNAs and DNRs for cardiac rehabilitation and the establishment of routine procedure to follow-up these groups.

Actions for Acute Stroke/Transient Ischaemic Attacks

The NST identified a number of priority areas for action:

- Continue FAST awareness programmes with an emphasis on segmentation and use of social marketing to ensure the message reaches all communities, to include the development of targeted campaigns for minority ethnic groups and the over 65s
- Continue implementation of current stroke/TIA workstreams to increase speed of access to diagnostics and treatment to meet the national targets set out in the accelerating stroke improvement programme in all cases, specifically:
- If any metrics remain significantly below target, consider equity auditing to compare demographics of patients receiving optimum versus not optimum care.
- Audit GP TIA referrals data for consistency
- Review GP practice performance for outlying practices in relation to admissions data

Actions for COPD

Although the HINST did not hold a specific workshop on COPD when they visited us, they have since produced a series of recommendations on delivering better management of COPD based on the experiences of the

Spearhead PCTs. These recommendations have been reviewed and concur with the COPD pathway that is implemented in Dudley.

The local priorities for development are:-

- As part of the National COPD Strategy and to increase prevalence numbers in Dudley a 'Missing Millions' (previously undiagnosed COPD) pilot that has commenced: Audit of 800 patients via GP surgeries, community pharmacists, Dudley Stop Smoking
- Implement the new NICE guidelines for COPD Mild, Moderate, Severe and Very Severe
- There is an application via SHA End of life workforce projects for an end of life care lead/nurse for COPD
- There is a concerted focus to improve under diagnosis and increase prevalence of asthma in Dudley via an education and training programme. There will also be actions to reduce the numbers of recurrent admissions with asthma

Actions for tobacco control

The NST identified a number of priority areas for action an action plan has been developed to be included ensure that they will form part of the tobacco control programme. The recommendations have been outlined in conjunction with current local action & priorities:
Strategic approach to Tobacco Control is best co-ordinated by an effective multi-agency partnership:

- Continued strong senior level support & leadership for TC agenda
- Review role of Tobacco Action Group (TAG)
- TAG continued accountability to DCP via the H&WP
- Refresh the Tobacco Strategy & action plan in line with new National Strategy
- Development of advocacy role of the Alliance around SHS & Illicit tobacco

Further develop an evidenced based & proactive approach to illicit tobacco

- Plan local priorities

The PCT, Acute Trust, LA & other partners should explore ways in which data can be collected & shared to improve local intelligence on key areas e.g. smoking in pregnancy, illicit tobacco, under age sales
Intention to commission EH to carry out additional smokefree compliance checks in routine & manual workplaces to include illicit tobacco & stop smoking information
There would be a benefit in developing a programme of ongoing test purchasing to explore the issue of supply of tobacco to young people
The early adoption of DH Stop Smoking in Secondary Care toolkit provides an opportunity to ensure effective care pathways are in place for smokers – this will impact on the key contributors to tackling health inequalities.

- This would also provide an opportunity to ensure a formally agreed care pathway for smoking in pregnancy to be used by all staff.

The DH Stop Smoking Interventions in Primary Care toolkit is rolled out to ensure strengthened infrastructure for quality brief interventions.
All tobacco control initiatives will require senior level support and agreement between Primary and Secondary Care organisations to ensure a seamless quality service for clients.
It will be beneficial to have Varenicline as a first line smoking cessation medication

Actions for alcohol harm reduction

The national health inequalities team have identified four key actions that will impact on health inequalities and result in both short term and longer term health gains through:

- Tackling underage/illegal alcohol consumption and encourage the industry to promote responsible drinking
- Combating crime related disorder
- Raising awareness of, and educating about, safe and sensible drinking
- Facilitate identification of at risk individuals and enabling access to alcohol treatment services which are consistent with national standards

Actions to reduce cancer inequalities:

- Promote healthier lifestyles
- Raise awareness of cancer symptoms
- Reduce cancer waits all patients
- Enhance quality and timeliness of information
- Provide financial and psychological support

IMPLEMENTING THE HEALTH INEQUALITIES STRATEGY

Such a broad ranging strategy can only be achieved by a whole range of partners working together in a co-ordinated and planned way. The strategy brings together many individual action plans that are already being delivered through existing multi-agency partnerships.

The progress on reducing health inequalities is currently overseen by the Health Improvement Modernisation Management Team (HIMMT) which reports to the Health and Wellbeing Board, which in turn reports to Dudley Community Partnership. Independent scrutiny of the strategy is done by the Health Overview and Scrutiny Committee. It is likely that these structures will change in the future and a newly structured Health and Wellbeing Board will take responsibility for monitoring health improvement plans and reducing health inequalities.

There are important roles for all statutory agencies. Local Authority directorates, including Adult Social Care, Children's Services, Environmental Health and Housing will take a lead role in delivery of the strategic aims and the Local Authority will ensure the involvement of the new GP Commissioning Cluster in implementing the strategy when its new public health role becomes functional. The prevention role of the Foundation Trust needs to be developed as they become the providers of some community health services and the work on developing the role of the third sector needs to be advanced. As part of the Big Society vision the role of community champions, volunteers and Health Trainers will become more prominent over time.

The role for Community Engagement and consultation will remain an important feature in delivering this strategy and will influence the priorities and future direction of the work. The development of the strategy has been informed by a comprehensive joint strategic needs assessment.