From:	Dan Watkins - Cabinet Member for Adult Social Care and Public Health
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To:	Health Reform and Public Health Cabinet Committee 23 January 2024
Subject:	**Health Inequalities – An overview on the differences in the wider determinants of health and health outcomes across Kent.**
Classification:	Unrestricted
Past Pathway:	None
Future Pathway:	None

Summary: This report provides an overview of the concepts currently used to describe health inequalities and what kind of inequalities can be observed in Kent.

Recommendation(s): The Health Reform and Public Health Cabinet Committee is asked to **CONSIDER** and **COMMENT** on the content of this report.

1.   Introduction

1.1   The purpose of this report is to provide an overview of the current concepts and principles on health inequalities as well as patterns which can be observed in Kent. Health inequalities are disparities in health outcomes and underlying determinants which exist between different population groups.

1.2   Health inequalities are avoidable, unfair, and systematic differences in health between different groups of people. Health inequalities, encompass variations in health status, life expectancy, and the prevalence of diseases among different socioeconomic groups, gender, age, ethnicity, disability, and geographic locations. Disparities are often rooted in wider determinants such as education, employment, income, and housing as well as factors like emotional wellbeing and social connectedness or isolation.

1.3   There is currently a renewed focus nationally and across all major health organisations in the UK to address health inequalities. The identification and reduction of inequalities are key themes of the Kent and Medway Integrated Care Strategy.

2.   Key principles

2.1   Wider Determinants of Health

2.1.1   The health of a population is closely linked to the social gradient that can be observed. More deprived communities have poorer health outcomes overall.

Wider determinants of health are root causes for health outcomes and can be used as enablers for overall health and wellbeing for individuals and communities if addressed systematically. They include factors such as education, employment, income, housing, access to green spaces, air quality (the environment), as well as crime rates, and social inclusion. For example, secure and decent housing is a key requirement for a person's health and wellbeing throughout their life.

2.2 Intersectionality

2.2.1 It is important to acknowledge that individuals and groups in our community often experience multiple forms of disadvantage at the same time, requiring a nuanced and tailored as well as a joined-up approach across systems. As an example, homelessness, mental ill health, and drug use often coincide and can lead to repeated episodes of ill health, hospital admissions, and encounters with the justice system. It has been estimated, that preventing homelessness for one year would result in a reduction in public expenditure of £9,266 per person, through costs otherwise resulting from a much higher than typical contact with the NHS, mental health services and criminal justice system.

2.3 Proportionate Universalism

2.3.1 Proportionate Universalism takes account of the observation that it is more effective to apply key interventions universally across a population with specific approaches and intensity to certain groups with higher levels of need. It requires an approach where interventions are proportionate to the level of disadvantage, with a focus on areas and groups with higher levels of need or certain risk factors. For example, giving every child the best start in life aims at reducing the social gradient and by doing so reducing health inequalities as well as health outcomes for every individual child.

2.4 Inclusion Health Groups

2.4.1 Inclusion health describes population groups who are socially excluded, who typically experience multiple overlapping risk factors for poor health and are often not accounted for in electronic records. These groups include the homeless and rough sleepers, vulnerable migrants, sex workers, Gypsy, Roma, and Traveller, victims of modern slavery, people who are in prison or contact with the criminal justice system, and people with drug and alcohol dependence and other socially excluded groups.

3. What can be observed in Kent?

3.1 The following chapters describe the variation of some wider determinants of health and health outcomes that can be observed across Kent.

3.2. Geographical variation, Indices of Deprivation

3.2.1 Last updated in 2019, the Indices of Multiple Deprivation (IMD) is a measure of area level relative deprivation of the 32,844 neighbourhood areas known as Lower Super Output Areas in England[1]. Areas are ranked according to indicators in seven domains: income, employment, education, health, crime,

barriers to housing and services and living environment[1]. To simplify the ranking, deprivation deciles have been created. Each small area is divided into 10 equal groups ranging from the most deprived 10% (IMD decile 1) of small areas nationally, to the least deprived 10% (IMD decile 10).

3.2.2　The map below (figure 1) highlights the pattern of deprivation across Kent and Medway. The most deprived areas are darker, and the least deprived areas are lighter. The highest levels of deprivation can be seen mainly in the coastal regions with some urban areas having high levels of deprivation also.

Figure 1: IMD decile in Kent and Medway, LSOA
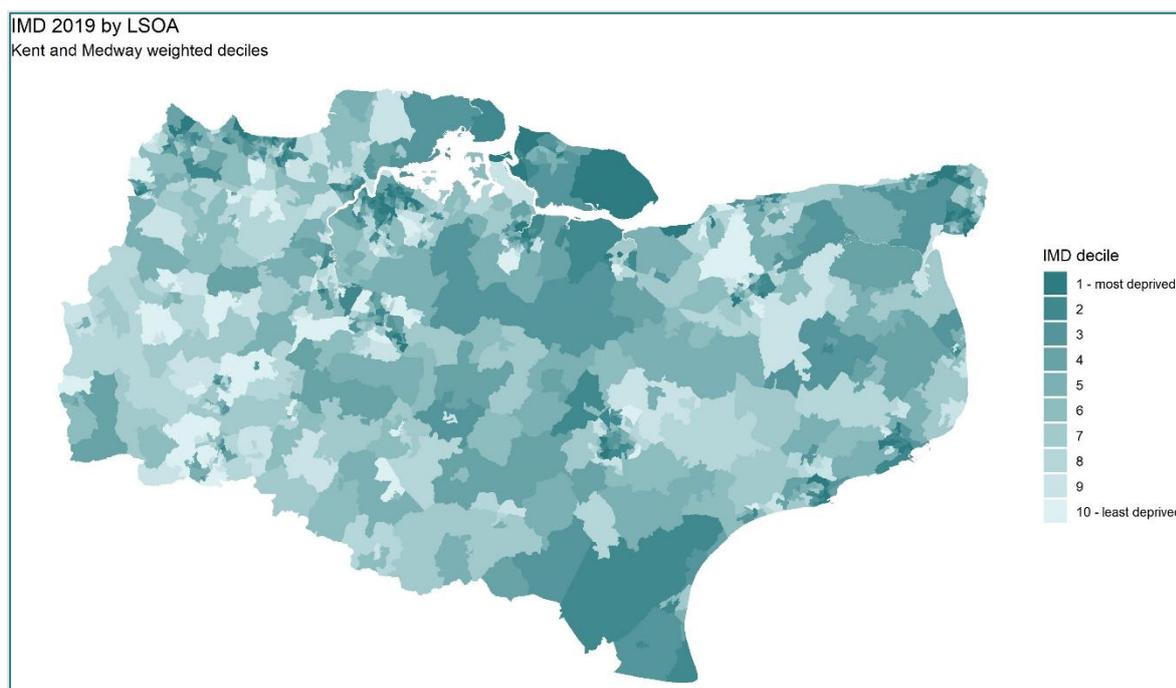
3.3　**Variation in the wider determinants of health**

Employment rates

3.3.1　In March 2023, the average percentage of the Kent population aged 16 to 64 claiming job seekers allowance or other unemployment related benefits was 3.3%, lower than the national average of 3.8%. However, this differs significantly across the districts from 5.7% in Thanet to 2% in Sevenoaks.

3.3.2　In 2022/2023, the employment rate gap in Kent between individuals aged 16 to 64 with a physical or mental long-term health condition and the overall employment rate was 12.6 percentage points, comparable to the national rate of 10.4.

3.3.4　For those receiving long-term support for a learning disability (aged 18 to 64), the employment rate gap in 2021/2022 was 70.2 percentage points in Kent, closely aligning with the national gap of 70.6.

3.3.5   In 2020/2021, the employment rate gap in Kent for individuals aged 18 to 69 in contact with secondary mental health services on the Care Plan Approach was 66.9 percentage points, similar to the national gap of 66.1.

Crime rates

3.3.6   The total recorded crime rate in Kent (excluding fraud) in the year ending June 2023 was 93.2 per 1,000 of the population (173,230). This is a 5% decrease from June 2022 where the rate was 97.8 (182,689). Of all the local authorities in the Southeast, Kent has the highest rate compared to Hampshire (79.0), Surrey (60.6), Sussex (75.6) and Thames Valley (72.9). The rate in Kent is also higher than the national level at 92.5 per 1,000 of the population. The rate of violence against a person was 40.6 per 1,000 (75,460) with the rate of sexual offences being 3.5 per 1,000 of the population (6,497) in the year ending June 2023.

3.3.7   This is police recorded crime reported in the Crime Survey for England and Wales. Police recorded crime is sensitive to changes in Police operational activity so results should be interpreted with caution[2].

3.3.8   Swale and Thanet are amongst the most deprived areas in Kent, with Sheerness and Margate Central wards having higher rates of crime compared to other areas. The number of recorded crimes increased by 23% in Sheerness between April and September 2023 (688 crimes between April and June compared to 843 crimes between July and September). There was a 10% increase in crime in Margate Central within this same period (665 crimes between April and June compared to 729 crimes between July and September)[3].

Density of fast-food outlets

3.3.9   The term 'fast-food' refers to energy dense meals that are easily and readily available. It includes, but is not limited to, chicken and chip shops, kebab shops and pizza places. Evidence suggests an association between fast food consumption and obesity, with a higher prevalence of obesity existing in more deprived areas[4].

Figure 2: Density of fast-food outlets in Kent, 2017
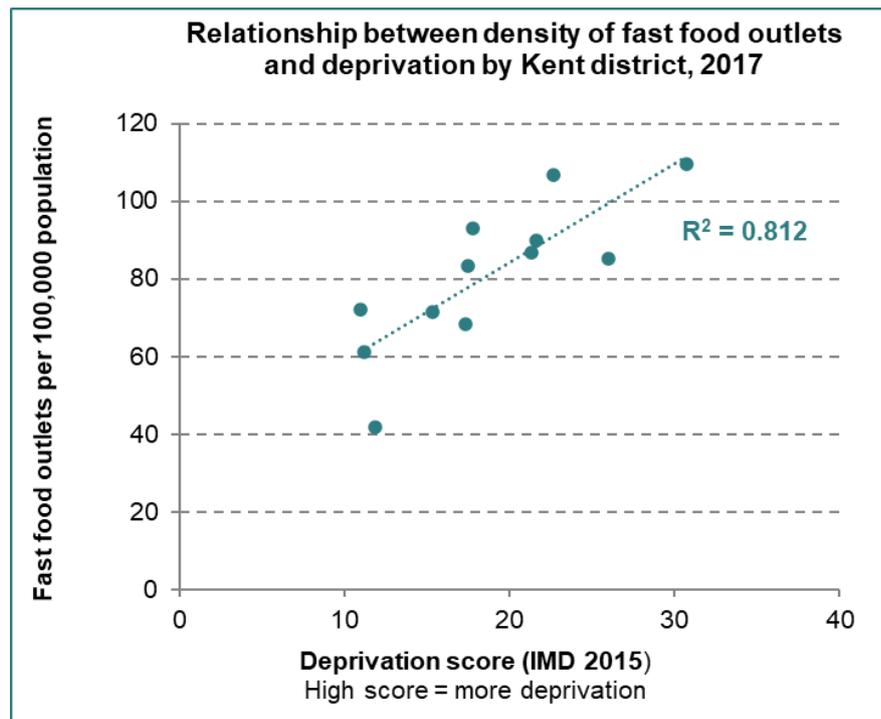
3.3.10   The chart above (figure2) illustrates the correlation between the density of fast-food outlets in Kent districts and area level deprivation[5]. The correlation score is 0.8, a positive correlation, which indicates there is a greater density of fast-food outlets in more deprived areas.

3.3.11   Within Kent, Thanet had the highest number of fast-food outlets, with a rate of 109.7 per 100,000 of the population. Folkestone and Hythe also had a high rate at 106.8 per 100,000 of the population (see figure 3). The most recent Kent annual public health report shows that coastal communities are amongst the most deprived areas in Kent and have worse health outcomes[6]. Factors such as an unhealthy diet can contribute to this problem.

Figure 3: Density of fast-food outlets by Kent district, 2017
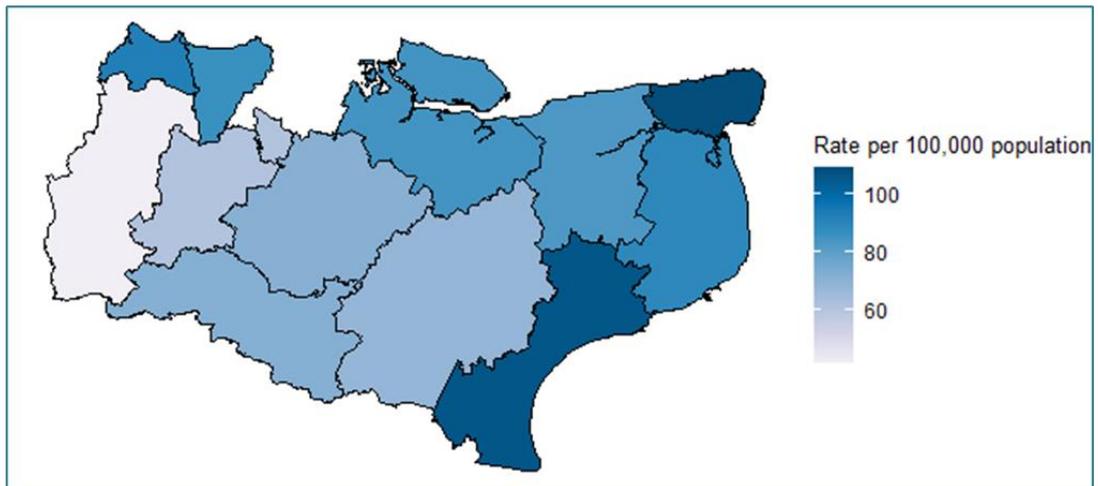
Housing

3.3.12   In the three years to March 2021, the highest rates of overcrowding in England were in Bangladeshi, Arab, black African, and Pakistani households[7]. According to 2021 census data in Kent, areas with the highest proportions of these four ethnic groups also had the highest rates of overcrowding. By district, Dartford and Gravesham had the highest rates of overcrowding.

3.3.13   9.7% of houses in Kent are fuel poor compared to 8.6% in the south-east and 13.4% in England[8]. Coastal towns tend to have the highest rates of fuel poverty, however rates in Canterbury are among the highest in Kent. Areas in Kent with higher rates of private rented and social housing are associated with higher rates of fuel poverty.

3.3.14   Overcrowding and fuel poverty both follow a deprivation gradient in Kent such that the most deprived areas tend to have the highest rates, and least deprived areas tend to have the lowest rates.

3.3.15   The average monthly rent for privately rented properties in Kent is highest in districts of Sevenoaks, Dartford and Tonbridge and Malling. Sevenoaks has the highest average monthly rent – 40% above the Kent average[9].

Green space and air quality

3.3.16   The charity 'Fields in trust' has produced a Green Space Index, designed to illustrate how well individuals are served by local parks and green spaces[10]. The chart below (figure 4) shows the total green space provision per person by district, reported in square meters. The Green Space Index is compiled using the Ordinance Survey Open Greenspace product. The typologies which are within the Index are Bowling Greens; Other Sports Facilities; Play Spaces; Playing Fields; Public Parks or Gardens; and Tennis Courts. Typologies that are excluded are Allotments & Community Growing Spaces; Cemeteries; Religious Grounds; and Golf Courses.

Figure 4: Green space provision per person, Kent district, 2023

Total Green Space Provision per Person (sqm), District, 2023

Source: Fields in Trust (http://fieldsintrust.org/green-space-index), prepared by KPHO (LS), Dec 23
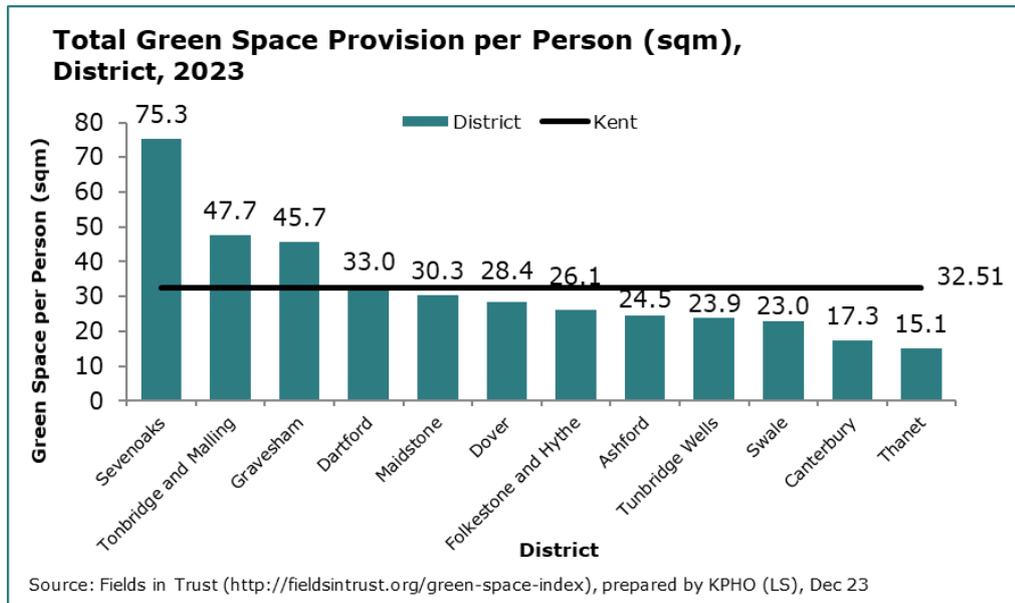
3.3.17 Thanet ranks as the most deprived district in Kent, Tunbridge Wells ranks as the least deprived district in Kent. Tonbridge and Malling and Sevenoaks are ranked 2nd and 3rd least deprived respectively and Swale is ranked 2nd most deprived district.

3.3.18 Only Sevenoaks, Tonbridge and Malling and Gravesham met the 'Fields in Trust' minimum stand of green space provision using their Green Space Index. This index analyses the provision of parks, play and outdoor sport facilities per 1,000 people.

3.3.19 The map below (Figure 5) shows the level of Nitrogen Dioxide (NO2) by Lower Super Output Area (LSOA) from DEFRA. Higher levels of NO2 can be seen in Northwest Kent towards London. Nitrogen dioxide is a gaseous air pollutant produced by road traffic and other fossil fuel combustion processes. It contributes to the formation and modification of other air pollutants, such as ozone and particulate matter, and to acid rain. Nitrogen dioxide is known to cause pulmonary oedema, an accumulation of excessive fluid in the lungs. It can irritate airways and aggravate respiratory diseases. Nitrogen dioxide is one of six widespread air pollutants that have national air quality standards to limit them in the outdoor air[11].

**Figure 5: Map of the level of Nitrogen Dioxide by LSOA, 2019**
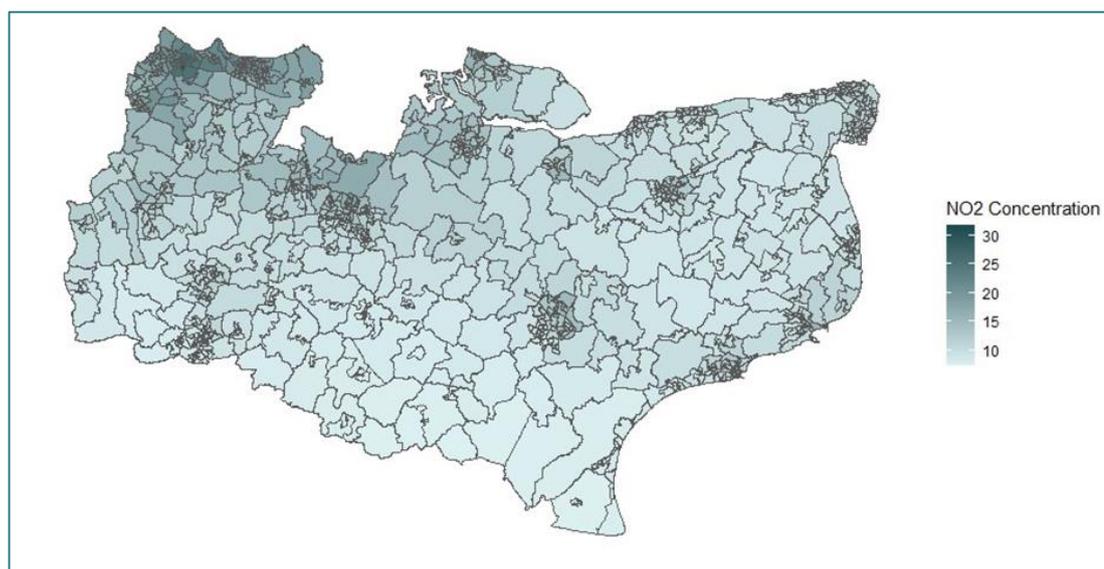
3.3.20 The map below (figure 6) shows the level of Particulate Matter (PM10) by Lower Super Output Area (LSOA) from DEFRA. Higher levels of PM can be seen in North Kent with lower levels to the South and Coastal Areas. Particulate matter (PM) comprises inhalable particles with various compositions, including sulphate, nitrates, ammonia, and others. PM is categorized by size, with PM2.5 and PM10 being most relevant for health in regulatory contexts. Coarse particles primarily originate from sources like pollen, sea spray, and wind-blown dust, while finer particles (PM2.5) come from both primary (combustion) and secondary (chemical reactions) sources. Indoor PM sources include combustion of polluting fuels, cooking, and heating, while outdoor sources encompass traffic, industrial activities, and more. Health risks associated with PM10 and PM2.5 include cardiovascular, cerebrovascular, and respiratory impacts, with both short-term and long-term exposures linked to morbidity, mortality, adverse perinatal outcomes, and lung cancer, as classified by WHO's International Agency for Research on Cancer (IARC). PM is a key indicator for assessing health effects of air pollution[11].

Figure 6: Map of the level of Particulate Matter (PM10) by LSOA, 2019
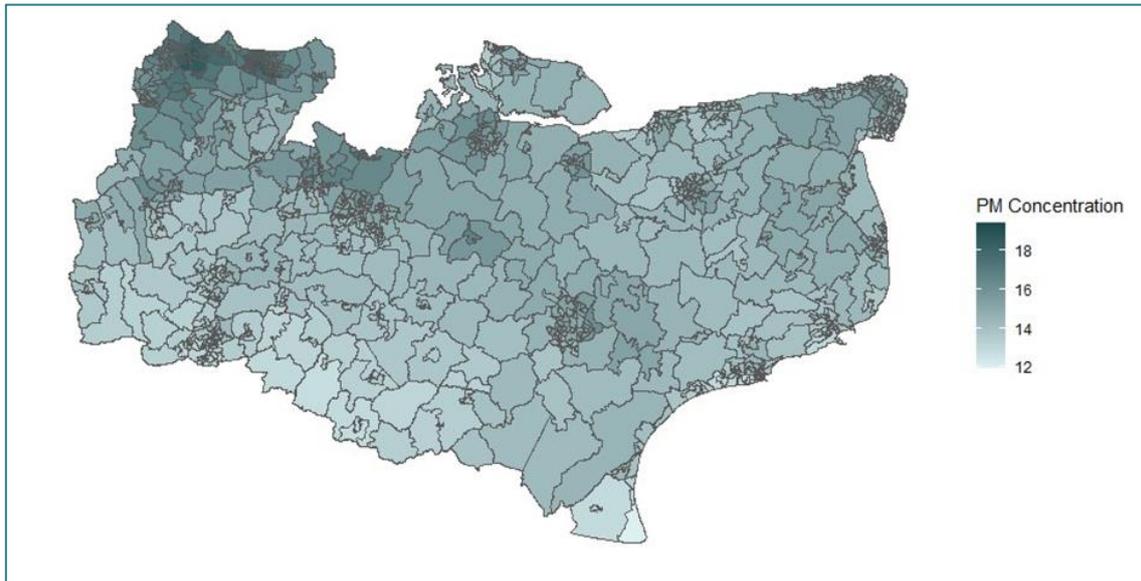
3.3.21 The map below (figure 7) shows the level of Sulphur Dioxide (SO2) by Lower Super Output Area (LSOA) from DEFRA. Higher levels of SO2 can be seen in North-West Kent towards London. Sulphur dioxide (SO2) is a colourless gas that is readily soluble in water. It is predominantly derived from the combustion of fossil fuels for domestic heating, industries and power generation. Exposure to SO2 is associated with asthma hospital admissions and emergency admissions[11].

Figure 7: Map of the level of Sulphur Dioxide by LSOA, 2019
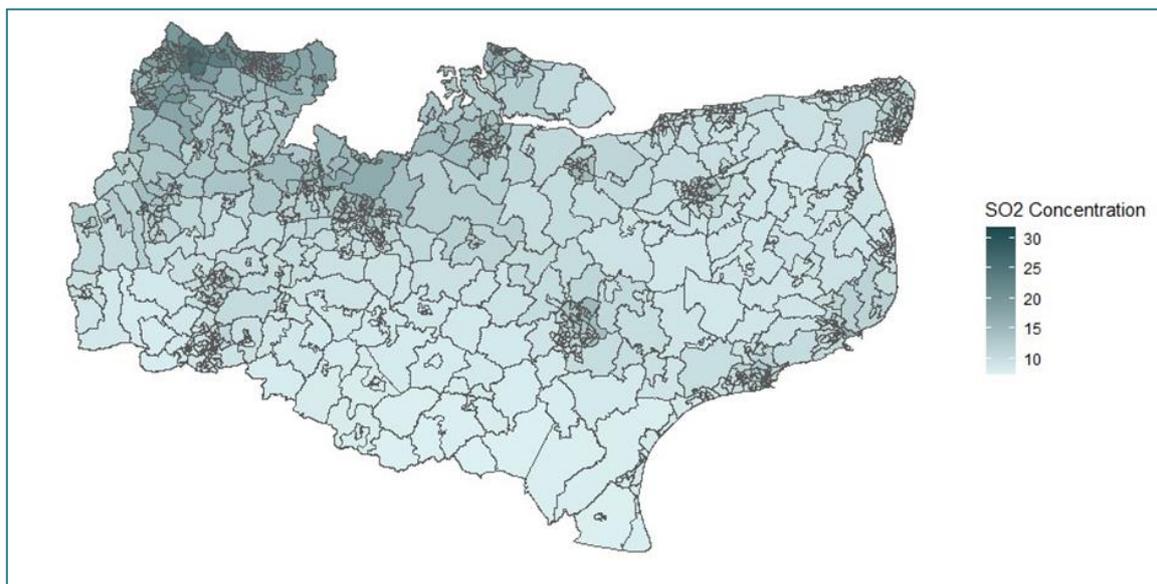
Education

3.3.22   Approximately 22.2% of children in Kent were eligible for free school meals (FSM) in 2022/2023. Children who were eligible for FSM had about twice as many school absences in the year 2021/2022 than those who were not eligible for FSM (12.3% and 6.6% respectively)[12]. More worryingly, 3.7% of children eligible for FSM were severely absent in the same year (absent more than 50% of possible sessions) compared to non-eligible children (0.9% severely absent)[12].

3.3.23   The rates of persistent absence (more than 10% of possible sessions missed) varied significantly by ethnicity in 2022/2023. The highest rates of absences were seen in children with ethnicities Traveller of Irish Heritage (75%) and Gypsy Roma (69%). That is, 75% of children who are Travellers of Irish Heritage are absent for more than 10% of the school year. For children with Black African and Any Other Asian Background ethnicities, the rates were much lower at 11.8% and 16.6% respectively[12].

3.3.24   Reading, writing and maths (RWM) standards provide an insight into academic performance in children. Across Kent, there is considerable inequality in the proportion of pupils who achieve an 'expected' standard in RWM at KS2 level. For each district, schools can be divided by disadvantage status into "disadvantaged" and "not known to be disadvantaged." For disadvantaged schools, the proportion of children meeting the expected standard ranges across districts from 34% to 48%, and from 62% to 70% in the non-disadvantaged schools. The districts which have the best performing, non-disadvantaged schools also have the largest attainment gaps between disadvantaged/non-disadvantaged schools. Namely Sevenoaks, Canterbury, Tonbridge and Malling and Tunbridge Wells where the differences in the proportion of children achieving the expected standard for RWM are 35%, 34%, 33% and 33% respectively. This compares to Gravesham, Folkestone and Hythe and Thanet where the differences in attainment are 21%[12]. (See figure 8)

Figure 8: Percentage difference in children meeting expected RWM standards, Kent districts, 2021/2022

Difference in proportion of children meeting the expected KS2 RWM standards in disadvantaged and non-disadvantaged schools in Kent districts in 2021/22
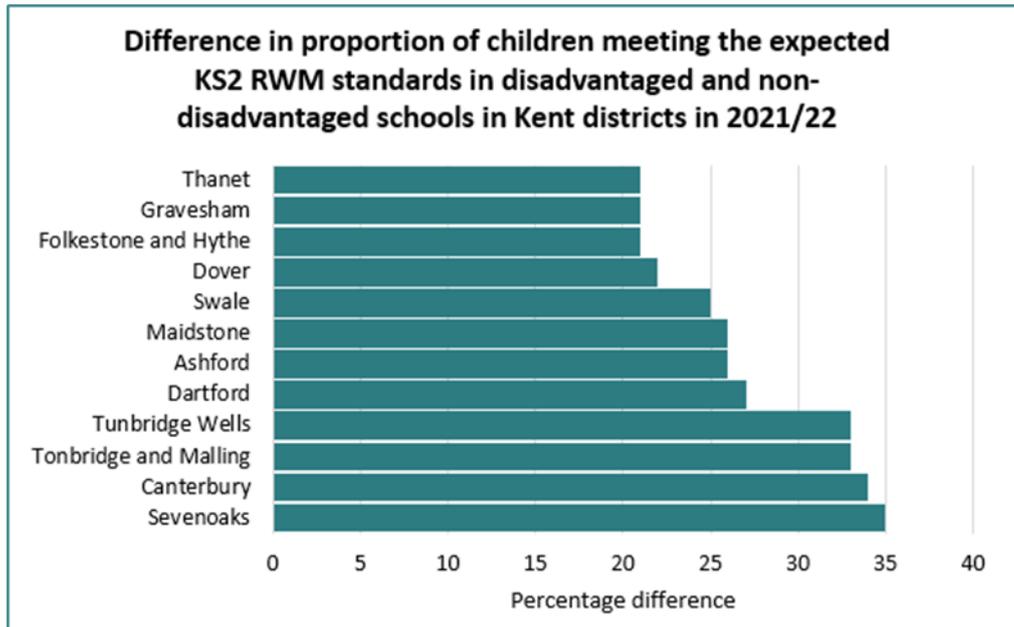
3.4 Differences in health outcomes

Life expectancy at birth

3.4.1 **Males**: From 2016 to 2020, the average life expectancy at birth for males in Kent was 79.7 years, slightly higher than the national average of 79.5 years in England. To gauge the disparity in life expectancy at birth across the county, the Slope Index of Inequality was used. This index measures how much life expectancy varies with deprivation, representing the range in years of life expectancy across the social gradient from most to least deprived. For males in Kent from 2018 to 2020, the Slope Index of Inequality was 7.8 years, compared to 9.7 years for England as a whole.

3.4.2 **Females**: From 2016 to 2020, the average life expectancy at birth for females in Kent was 83.3 years, slightly surpassing the national average of 83.2 years in England. The Slope Index of Inequality for females in Kent during 2018 to 2020 was 5.6 years compared to 7.9 years for England as a whole.

Healthy life expectancy

3.4.3 Healthy life expectancy shows the years a person can expect to live in good health, rather than a disability or in poor health (see table 1).

3.4.4 Over the past decade, the healthy life expectancy for males in Kent has shown a slight increase. In contrast, the healthy life expectancy for females has declined during the same period. The available data doesn't explain this trend, prompting the need for further investigation.

Table 1: Healthy life expectancy in males and females in Kent and England 2010 to 2020

| Period	Males		Females	
	Kent	England	Kent	England
2010 to 12	63.3	63.2	66.4	64.0
2011 to 13	62.9	63.2	65.8	63.8
2012 to 14	63.6	63.4	64.5	63.9
2013 to 15	63.7	63.4	65.4	64.1
2014 to 16	64.1	63.3	65.1	63.8
2015 to 17	64.2	63.4	64.0	63.8
2016 to 18	63.8	63.4	64.9	63.9
2017 to 19	63.8	63.2	64.6	63.5
2018 to 20	64.6	63.1	63.6	63.9

Excess weight

3.4.5   Excess weight is a term used to categorise obesity and being overweight. The National Child Measurement Programme (NCMP) measures children at ages 4 to 5 (reception/ year R) and ages 10 to 11 (year 6).

3.4.6   The percentage of children living in the most deprived areas, between the ages of 4 to 5 with excess weight was almost double that of children living in the least deprived areas. In 2020/2021, 34.3% of children living in the most deprived areas were found to have excess weight compared to 19.5% in the least deprived areas, this decreased to 26% and 16.5% respectively in 2021/2022[13].

3.4.7   Within Kent, Thanet had the highest prevalence of children in year R with excess weight at 24.3%, surpassing the Kent average of 21.3%. Dover and Gravesham also had a high prevalence with 23.3% and 23.2% respectively. Sevenoaks had the lowest at 17.6%, 2021/2022. However, most districts showed an improvement in lowering excess weight in this year group, compared to the previous year[14]. (See figure 9)

Figure 9: Prevalence of excess weight in children in year R by district in Kent, 2021/22
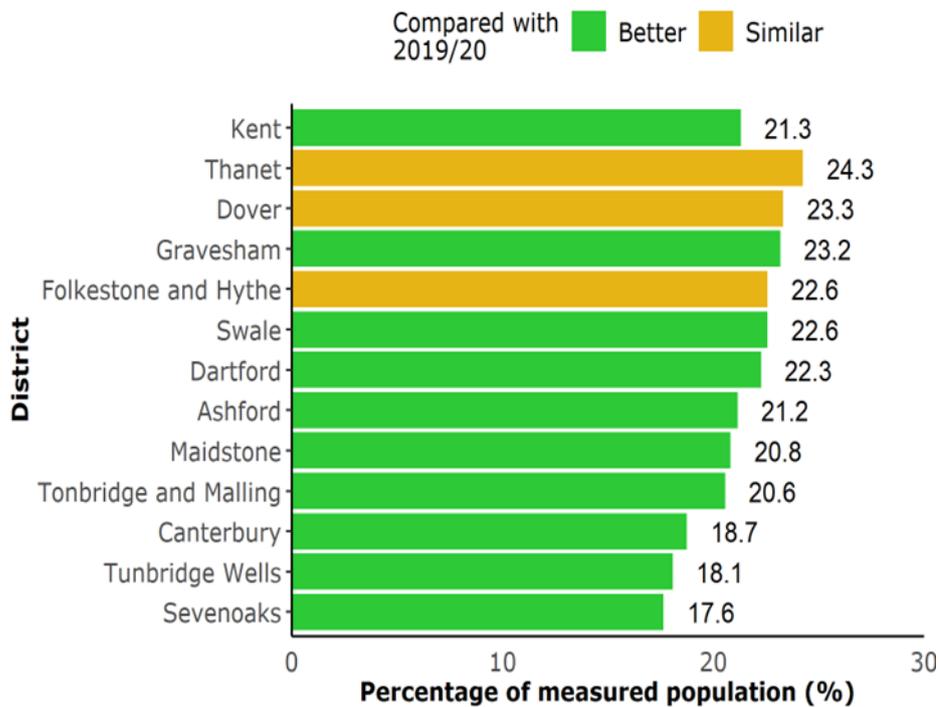
3.4.8   The prevalence of excess weight in Kent in children in year 6 (figure 10) increased in 2021/2022 compared to the previous year (35.8% compared to 34.6%). At 41.7%, Gravesham had the highest prevalence of children with excess weight, followed by Dartford at 40.1%. The prevalence was lowest in Tunbridge Wells (28.1%)[14].

Figure 10: Prevalence of excess weight in children in year 6 by district in Kent, 2021/22
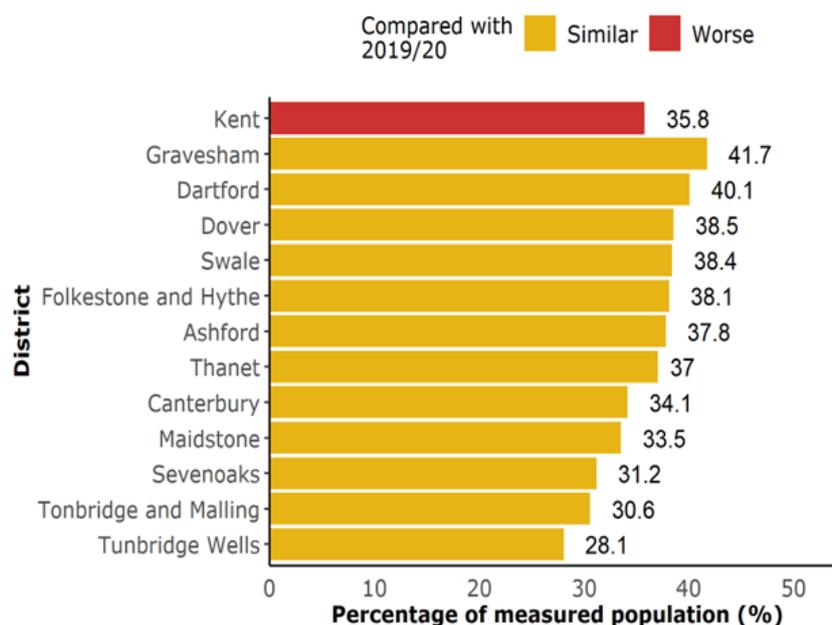
Child obesity

3.4.9   The table (table 2) below shows the prevalence of obesity amongst children in reception. The prevalence of obesity is highest amongst children of Black ethnicity with 20.6% of children being classified as obese in 2020/2021. This is 75% higher than the proportion of children classified as obese amongst the Asian and Mixed ethnic groups (9.5 in 2021/2022) and the White ethnic group (9.4% in 2021/2022). The prevalence of obesity amongst children of Black ethnicity decreased to 16.5% in 2021/2022. Children of White ethnicity had the lowest prevalence of obesity in year R[14].

Table 2: Prevalence of obesity in children in Year R by ethnic group, 2017 to 2022, Kent

Ethnic group	Proportion obese %				
	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022
Asian	7.6	9.3	11.6	15.7	9.5
Black	12.5	16.1	14.6	20.6	16.5
Mixed	8.7	10.5	9.1	14.8	9.5
White	8.3	10.3	10.3	13.5	9.4

3.4.10   Children in year R, living in the most deprived areas were found to be more than twice as likely to be obese when compared to children living in the least deprived areas in both 2020/2021 (most deprived - 20%; least deprived - 7.2%) and 2021/2022 (most deprived – 12.9%; least deprived – 6.4%). A similar trend can be seen for children in year 6, with the prevalence of obesity being 30.4% amongst children in the most deprived areas compared to 13.2% in the least deprived areas in 2021/2022[14].

Chronic Obstructive Pulmonary Disease (COPD) admissions by deprivation

3.4.11   Emergency hospital admissions for chronic obstructive pulmonary disease (COPD) in Kent's most deprived communities are approximately four times higher than the least deprived. Over the past five years to 2022/2023 admission rates have been relatively stable in the least deprived but have reduced by around a third in the most deprived, thereby reducing the deprivation inequality[15].

3.4.12   The rates in the most deprived areas are proportionately much higher, 127% above the Kent average compared to the least deprived areas which is 55% below the Kent average[15].

Premature mortality in mental health

3.4.13   Based on data from 2018 to 2020[16] in Kent, people with severe mental illness (SMI) were around 4 times more likely to die prematurely than those who do not have SMI. Between the periods 2015 to 2017 and 2018 to 2020,

premature mortality in adults with SMI has increased by around 14% to 101 per 100,000. This value for Kent is higher than the south-east region but similar to England. Males with SMI in Kent have a 50% higher rate of premature mortality compared to females with SMI.

Alcoholic liver disease mortality

3.4.14   The mortality rate from alcoholic liver disease was 9.5 per 100,000 in Kent in 2022. This rate has increased from 4.9 per 100,000 since 2018. There is a marked difference between the mortality rates of those who live in an area in the 10% most deprived and 10% least deprived areas of Kent. Those in the most deprived decile have almost 4 times the rate of mortality at 24.6 per 100,000, compared to 6.3 per 100,000 in the least deprived decile[17].

Respiratory disease mortality under 75

3.4.15   Respiratory disease mortality under 75 rates varied significantly across Kent districts in 2022. Dover has the highest mortality rate at 46 per 100,000, followed by Folkestone and Hythe (40). Tonbridge and Malling have the lowest mortality rate at 19 per 100,000, and the overall Kent rate was 29.9 per 100,000. Those in the most deprived decile had 4 times the mortality rate of those in the least deprived decile (65 and 16 per 100,000 respectively)[17].

Suicide

3.4.16   The mortality rate from suicide and undetermined injury in those aged 10 years old and over was 11.9 per 100,000 in Kent in 2022. Across districts this ranged from 17 per 100,000 in Swale to 7.1 per 100,000 in Sevenoaks, however due to low absolute numbers, none of the differences between districts are statistically significant. Those in the 10% most deprived areas of Kent had higher rates of suicide than those in the least deprived decile (16.8 per 100,000 and 10.0 per 100,000 respectively)[18]. Perhaps the most striking inequality in suicide rates is that between males and females. 17.9 per 100,000 males took their lives in Kent compared to 5.8 per 100,000 females in the period 2019-2021[19].

Depression prevalence

3.4.17   In 2022/2023, the prevalence of depression in those aged 18+ in Kent was 15.5%, higher than the national prevalence of 13.2%. There are differences between districts in Kent, with Thanet having a significantly higher prevalence than all other districts at 17.6%, and Gravesham having the lowest prevalence at 11.7%. The most recent analysis by deprivation level was in 2020/21. This showed there was a 4.7% difference in the prevalence of depression between those who are in the 10% most deprived and 10% least deprived areas in Kent (16.7% and 12.0% respectively)[20].

3.4.18 In recent years depression in Kent has increased at a faster rate than in other nearby counties and since 2013, there are approximately 130,000 additional people living with depression[20].

Figure 11: Depression prevalence in Kent and neighbouring areas

Prevalence of depression in Kent and neighbouring counties
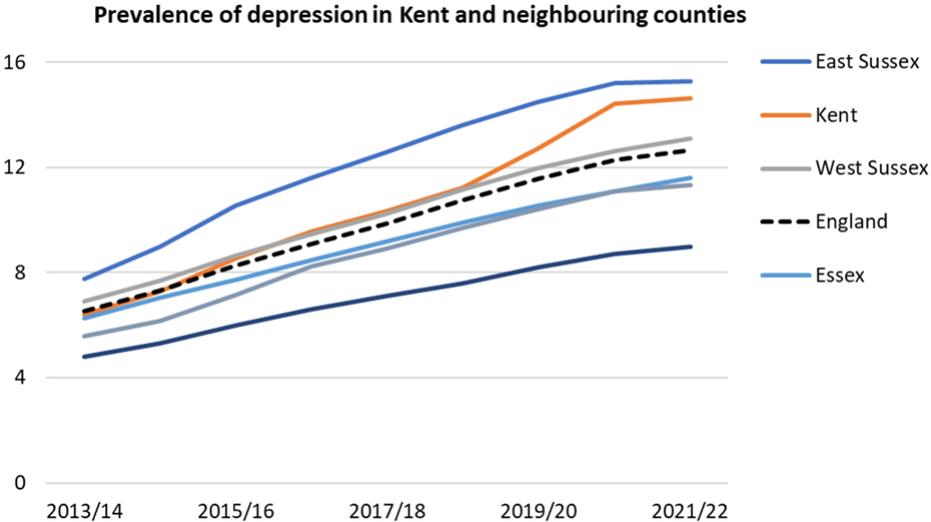
Smoking prevalence

3.4.19 In Kent, there are an estimated 144,128 adult smokers, equal to 11.6% of the adult population (18 years +). Since 2011, there has been an 8.6% decline in smoking prevalence and 85,113 fewer smokers. Kent's prevalence is slightly lower than the England rate (12.7%) which has seen a 7.1% decrease since 2011[21]. (see figure 12)

Figure 12 Smoking prevalence in adults aged 18+, 2011 to 2022

Source: QOF, NHS Digital, prepared by KPHO (LS), September 2023
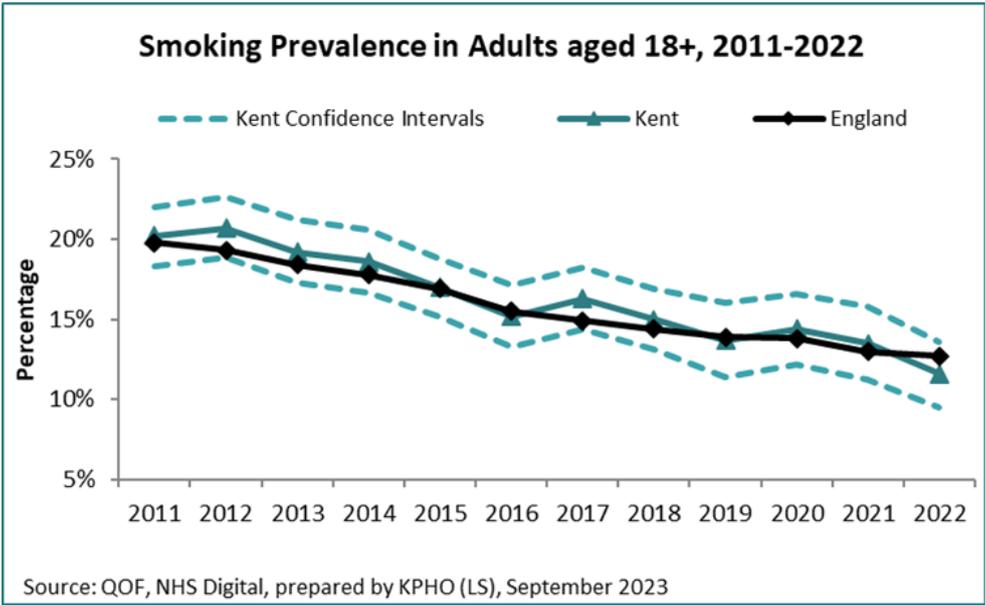
3.4.20 There is significant variation in smoking prevalence at district level[22], reflecting higher rates in areas of deprivation and among routine and manual workers, where people are likely to be heavy smokers with high nicotine dependency. (see table 3)

Table 3: Estimated Smoking Prevalence (Kent Districts)

Area	Smoking prevalence (%)	Estimated number of current smokers
Folkestone and Hythe	18.9%	17,399
Sevenoaks	15.3%	14,382
Ashford	13.6%	13,721
Thanet	12.8%	14,293
Dartford	12.0%	10,254
Dover	11.8%	11,239
Tunbridge Wells	11.3%	10,375
Canterbury	11.2%	15,322
Swale	11.1%	12,952
Gravesham	8.3%	6,751
Maidstone	7.8%	10,489
Tonbridge and Malling	6.7%	6,838
Kent	**11.6%**	**144,128**
England	**12.7%**	**5,614,225**

3.4.21 In 2022, the lowest smoking prevalence was in Tonbridge and Malling (6.7%) and Maidstone (7.8%). Folkestone and Hythe (18.9%) and Sevenoaks (15.3%) currently have the highest smoking rates, but levels fluctuate year on year, depending on survey response rates so annual figures alone should not be regarded as accurate indicators of smoking prevalence. The high prevalence rate for Sevenoaks in 2022 is likely due to be the low survey response rate rather than an increase in smoking rates. Thanet, Swale and Dover districts have had higher smoking rates over time, commensurate with more areas of higher deprivation[22].

3.4.22 Smoking rates are higher in lower socio-economic groups causing greater health inequalities. In 2022, 1 in 4 people in routine and manual occupations in Kent were smokers (24.5%), higher than the England average (22.5%) (OHID, 2022). Smoking rates among this group have declined in Kent since 2017[23] (see figure 13).

Figure 13: Smoking prevalence by occupation in adults in Kent, 2011 to 2022

Smoking Prevalence in Adults Aged 18+/18-64, General Population Vs Routine and Manual Occupations, 2011-2022

Source: Annual Popultion Survey, Fingertips, prepared by KPHO (LS), September 2023
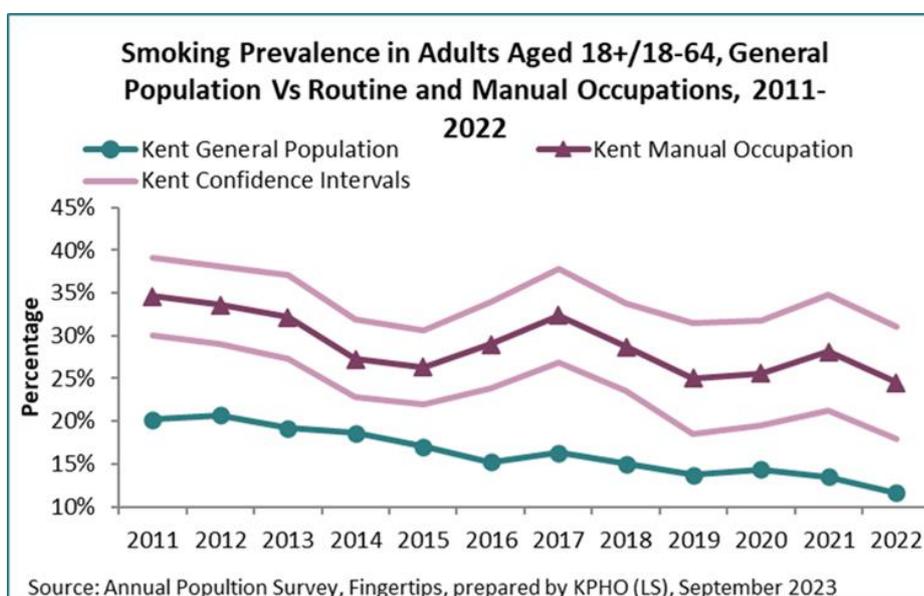
4.   Approaches to reduce inequalities

4.1   NHS England and Integrated Care Boards (ICBs) have a legal duty to have regard to reducing inequalities associated with access to and outcomes from NHS services. This means that health inequalities must be properly and seriously considered when making decisions or exercising functions, including balancing those needs against any other challenging factors. ICBs and NHS trusts must also provide annual narrative for progress to address inequalities.

The Core20 PLUS5 programme

4.2   Core20PLUS5 is a national NHS England approach to support the reduction of healthcare inequalities at both national and system level. The approach identifies 5 focus clinical areas requiring accelerated improvement, maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension. The approach, which initially focussed on healthcare inequalities experienced by adults, has now been adapted to apply to children and young people.

4.3   **Core20:** The most deprived 20% of the population as identified by the Index of Multiple Deprivation are being targeted with an attempt to reduce inequalities in healthcare outcomes in the 5 focus clinical areas.

4.4   **PLUS5:** PLUS population groups are being identified at a local level by each Integrated Care System. They include ethnic minority communities; people with a learning disability and autistic people; people with multiple long-term health conditions; other groups that share protected characteristics as defined by the Equality Act 2010; groups experiencing social exclusion (Inclusion health groups), and coastal communities.

Figure 14: NHS England's Core20plus5 (adults) – an approach to reducing healthcare inequalities
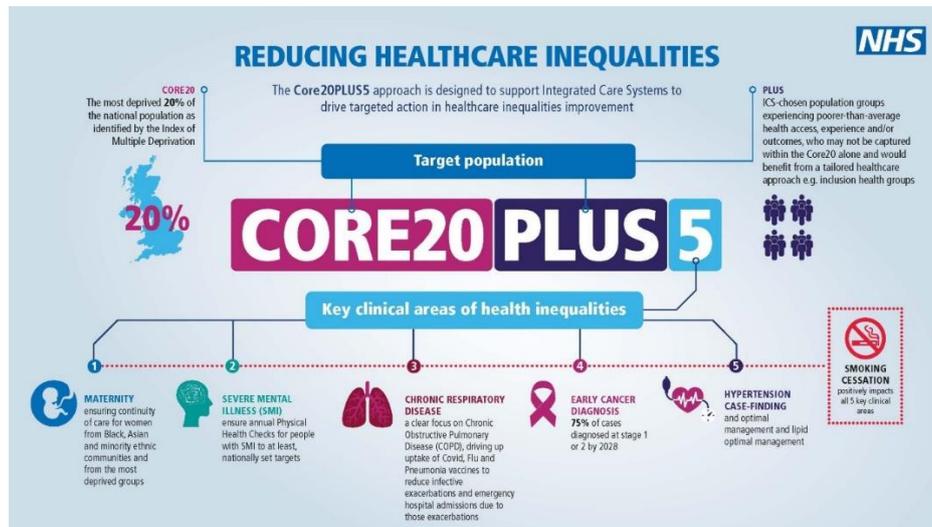
The National Framework for NHS Action on Inclusion Health

4.5   The national framework for NHS - action on inclusion health was published in October 2023 (see figure 14). It is intended to support systems to plan, develop and improve health services to meet the needs of people in inclusion health groups. The framework is based on five principles for action on inclusion health, outlining actions to address issues which are common across inclusion health groups. The framework focuses on the role that the NHS plays in improving healthcare, highlighting the importance of working in partnership across sectors and with other members of the Integrated Care System.

4.6   Inclusion health describes population groups who are socially excluded, who typically experience multiple overlapping risk factors for poor health and are often not accounted for in electronic records. This includes people who experience homelessness, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, those with drug and alcohol dependence and victims of modern slavery but can also include other socially excluded groups.

4.7   In December 2023, The Office of Health Improvement and Disparities Southeast published an overview of available data and published evidence for Kent and Medway ICS.

5.   Conclusion

5.1   Health inequalities often have their root causes in wider determinants of health and are linked to deprivation. There has recently been a renewed focus on reducing inequalities which is one of the key themes in the Kent and Medway Integrated Care Strategy. Reducing inequalities in health and wellbeing will require improved data collection and the ability to describe inequalities in our local area as well as joint-up action across all organisations under the umbrella of the Integrated Care Strategy.

6.   Recommendation

6.1   Recommendation(s): The Health Reform and Public Health Cabinet
         Committee is asked to **CONSIDER** and **COMMENT** the content of this report.

7.   Background Documents

https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5

NHS England » A national framework for NHS – action on inclusion health

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