**From** Graham Gibbens, Cabinet Member for Social Care and Public Health

Andrew Scott-Clark, Director of Public Health

**To**: Kent Health and Wellbeing Board

**Date**: 20th July 2016

**Subject**: Progress on Outcome Two of the Kent Joint Health and Wellbeing Strategy
Progress and future plans to reduce health inequalities in Kent.


**Summary:**
This report provides an overview on Outcome 2 of the Kent Health and Wellbeing Strategy and sets on the analysis, and plans for the future Kent Mind the Gap Action Plan aimed at reducing health inequalities.

Generally, the indicators relating to Outcome 2 are positive with and retain a green or amber status. There are a range of factors that have contributed to the improvements that include an increase in the prescribing of anti-hypertensive medication. There is still scope to improve. For example, there is a need to increase the proportion of people receiving a NHS Health Check of the eligible population.

Health needs in Kent are disproportionately greater in the most deprived populations. Closing the 'health gap' will require a faster improvement in health in these areas. Thus we will need to take a much greater place based systematic approach where we better engage these communities at a local level, make local plans (based on natural local communities) which aim to improve place based health through population, service and community based approaches


**Recommendation:**
The Kent Health and Wellbeing Board is asked to comment on progress made on key indicators reflecting progress in Outcome Two of the Kent Joint Health and Wellbeing Board Strategy and to support greater local Clinical Commissioning Group oversight for the NHS Health Check programme, particularly in encouraging practices where there is no engagement in delivery of the programme.

The Kent Health and Wellbeing Board is asked to CONSIDER, COMMENT and AGREE the following:

- The renewed approach to reducing health inequalities in Kent
- That Local Health and Wellbeing Boards take a place based approach and for local plans to encompass population, service and community development based approaches.
- That regular reporting of progress is shared with the Kent Health and Wellbeing Board
- That Kent Health and Wellbeing Board takes an overview on county wide progress

1.1 The Kent Health and Wellbeing Strategy sets out a vision "to improve health outcomes, deliver better coordinated quality care, improve the public's experience of integrated health and social care services, and ensure that the individual is involved and at the heart of everything we do".

1.2 The strategy identifies five outcomes

1.2.1 Every child has the best start in life
1.2.2 Effective prevention of ill health by people taking greater responsibility for their health and wellbeing
1.2.3 The quality of life for people with long term conditions is enhanced and they have access to good quality care and support
1.2.4 People with mental ill health issues are supported to live well
1.2.5 People with dementia are assessed and treated earlier

1.3 This paper updates progress made around outcome 2, and additionally reviews progress made in reducing health inequalities in the Kent population.

## 2. Performance in comparison to the Target/England average

2.1 Table 1 shows a range of indicators from national dataset to measure progress related to outcome 2. Generally, the results are positive with the majority of indicators being green (Target has been achieved or exceeded, or is better when compared to National).

2.2 There has been improved direction of travel in:

- Increases in life expectancy
- Increasing male healthy life expectancy
- Reducing the slope index for health inequalities for females
- Increasing the proportion of people quitting having set a quit date with smoking cessation services
- Reduced alcohol related admissions to hospital
- Reducing the rates of deaths attributable to smoking persons aged 35+,
- Reducing the under-75 mortality rate from cancer considered preventable
- Reducing the under-75 mortality rate from respiratory disease considered preventable and
- Reducing the under-75 mortality rate from cardiovascular disease considered preventable.

2.3 There has been a decline in the direction of travel for the following indicators:

- Increasing healthy life expectancy for females, (in effect healthy life expectancy has declined in females)
- Reducing the slope index for health inequalities for males (in effect the health inequality gap for males has become marginally worse)
- Increasing the proportion of people receiving a NHS Health Check of the eligible population and

- increasing the proportion of eligible women screened adequately in the breast cancer screening programme (in effect the proportion has got marginally worse)

All indicators with a decline in the direction of travel are above the target with the exception of increasing the proportion of people receiving a NHS Health Check of the eligible population.

2.4. Kent County Council took on the commissioning responsibility for the NHS Health Check programme from April 2013. Since this time, over 115,000 checks have been delivered, whilst over 280,000 of the eligible Kent population have been invited to have an NHS Health Check. Performance on overall uptake of checks as a proportion of invites issued has remained constant over the past two years at 42%. The decline in the actual number of checks completed is therefore likely to be the result of fewer invites needing to be issued in 2016/17 and the increasing capacity constraints in primary care. Public Health continues to work with Kent Community Healthcare Foundation Trust (KCHFT) in order to improve uptake. CCG support for encouraging further local uptake rates is sought.

2.5 The latest available data for the Stop Smoking Service shows that the service exceeded the 'quit-rate' target of 52% with a rate of 55%. For 2015/16, there were 6,236 Kent residents that set a quit date with 3,417 successfully quitting smoking via the service. Of the 3,417 residents who were successful in stopping smoking, 947 were from routine and manual occupations, 308 had never worked or had been unemployed for more than one year and 199 were home carers (unpaid).

2.6 Mortality rates are decreasing across all groups. This is a significant success for our population across all groups in society. A wide range of factors will have influenced the reduction in mortality rates, not least better disease detection and better treatments.

2.7 There is no change in the direction of travel in the proportion of adults with excess weight, but this was due to no previous status being reported in the Public Health Outcomes Framework for this indicator. It is based on a synthetic estimate measured via the Active People Survey between 2012 and 2014. The reported estimate for Kent is not significantly different from that for England.

**Table 1: Range of indicators relating to outcome 2 of Kent Health and Wellbeing Strategy**

| Indicator Description | Target | Previous status 2011-2013 | Recent status 2012-2014 | DoT | Recent time period |
|---|---|---|---|---|---|
| **2.1 Increasing life expectancy at birth (PHOF):** | | | | | |
| Male (years) | 79.5 (national) | 79.9 (g) | 80.1 (g) | ⇧ | 2012-14 |
| Female (years) | 83.2 | 83.6 (g) | 83.6 (g) | ⇔ | 2012-14 |

| Indicator Description | Target | Previous status 2011-2013 | Recent status 2012-2014 | DoT | Recent time period |
|---|---|---|---|---|---|
| | (national) | | | | |
| **2.2 Increasing healthy life expectancy (PHOF):** | | | | | |
| Male (years) | 63.4 (national) | 62.8 (a) | 63.7 (a) | ⇧ | 2012-14 |
| Female (years) | 64.0 (national) | 66.4 (g) | 65.0 (a) | ⇩ | 2012-14 |
| **2.3 Reducing the slope index for health inequalities (PHOF):** | | | | | |
| Male (years) | 9.1 (national) | 7.1 | 7.4 | ⇩ | 2012-14 |
| Female (years) | 6.2 (national) | 5.1 | 4.4 | ⇧ | 2012-14 |
| **2.4** Reducing the proportion of adults with excess weight (PHOF) | 64.6% (national) | - | 65.1% (a) | - | 2012-14 |
| **2.5** Increasing the proportion of people quitting having set a quit date with smoking cessation services (Public Health) | 52% | 54% (g) | 55% (g) | ⇧ | 2015/16 |
| **2.6** Increasing the proportion of people receiving a NHS Health Check of the eligible population (Public Health) | 50% full year | 51% (g) | 43% (a) | ⇩ | 2015/16 |
| **2.7** Reducing alcohol related admissions to hospital (per 100,000. PHOF) | 645 (national) | 565 (g) | 551 (g) | ⇧ | 2013/14 |
| **2.8** Increasing the proportion of eligible women screened adequately in the breast cancer screening programme (PHOF) | 75.4% (national) | 77.6% (g) | 77.0% (g) | ⇩ | 2015 |
| **2.9** Increasing the proportion of eligible women screened adequately in the cervical cancer screening programme (PHOF) | 73.5% (national) | 77.1% (g) | 77.1% (g) | ⇔ | 2015 |
| **2.10** Reducing the rates of deaths attributable to smoking persons aged 35+ (rate per 100,000. Estimated. Local Tobacco Control Profiles) | 274.8 (national) | 272.6 (g) | 266.7 (g) | ⇧ | 2012-14 |
| **2.11** Reducing the under-75 mortality rate from cancer considered preventable (rate per 100,000. PHOF) | 83.0 (national) | 79.3 (g) | 78.4 (g) | ⇧ | 2012-14 |
| **2.12** Reducing the under-75 mortality rate from respiratory disease considered preventable (rate per 100,000. PHOF) | 17.8 (national) | 16.7 (a) | 16.5 (a) | ⇧ | 2012-14 |
| **2.13** Reducing the under-75 mortality rate from cardiovascular disease considered preventable (rate per 100,000. PHOF) | 49.2 (national) | 49.3 (a) | 46.0 (g) | ⇧ | 2012-14 |

**Key to KPI Ratings used**

| | |
|---|---|
| **GREEN** | Target has been achieved or exceeded, or in comparison to National |
| **AMBER** | Performance was at an acceptable level within the target or in comparison to National |
| **RED** | Performance is below an acceptable level, or in comparison to National |
| ⇧ | Performance has improved relative to the previous period |

| | |
|---|---|
| ⇩ | Performance has worsened relative to the previous period |
| ⇔ | Performance has remained the same relative to the previous period |

## 3. Health Inequalities

### Introduction

3.1 Health Inequalities are differences in health outcomes between people or groups due to social, geographical, biological or other factors. These differences have a huge impact, because they result in people who are worst off, experiencing poorer health and shorter lives.

3.2 This section of the report provides an update on the public health analysis carried out following publication of the new national Index of Multiple Deprivation (2015) and sets out a proposed action plan.

## 4 Findings

4.1 Whilst mortality rates in Kent have been falling over the last decade for all populations in Kent, the gap in all age, all-cause mortality rates between the most and least deprived communities has remained constant. This gap is also consistent nationally where the Office of National Statistics recently reported a persistent fixed gap in life expectancy across England as a whole.

4.2 Our findings show that the most deprived populations have disproportionately worse life expectancy and the highest premature mortality rates signalling that if we are to begin to narrow the health inequalities gap, we need to understand exactly where and who these populations are.

4.3 Analysis of the causes of premature deaths in the most deprived population's show cancers, cardiovascular, respiratory and gastro-intestinal diseases account for the majority of the cause.

4.4 The populations that show the highest rates of all age, all-cause mortality and premature mortality are identified by segmenting Kent's population based on Lower Layer Super Outputs Areas (LSOAs). LSOAs are typically a population of about 1,500 people, and no smaller than 1000 people. LSOAs allow the reporting of small area statistics. Kent is made up of 880 LSOAs and thus the bottom decile is made up of 88 LSOAs

The geographical spreads of these 88 LSOAs is as follows:

| | |
|---|---|
| Ashford District: | 4 |
| Canterbury District | 7 |
| Dartford District | 4 |
| Dover District | 11 |
| Gravesham District | 7 |
| Maidstone District | 5 |
| Sevenoaks District | 2 |

| | |
|---|---|
| Shepway District | 8 |
| Swale District | 16 |
| Thanet District | 24 |

4.5 Further analysis of the 88 LSOAs and applying a segmentation tool known as MOSAIC shows that these populations have very different social characteristics and thus demonstrates that there will need to be multiple and differing approaches to improving life expectancy and reducing premature mortality.

4.6 However, a number of common themes are also evident in the analysis as follows:

- *Young people*: In general, the most deprived areas in Kent feature a high proportion of young adults. This is significant, as evidence shows that early choices and behaviours have lasting effects on life chances, and the health impacts of deprivation accumulate in individuals throughout their lives.

- *Children*: There should be a focus on child health and education, to provide opportunities to these children to break the cycle of deprivation. Even by the age of 3, there is a marked inequality gradient in childhood development which will impact on outcomes throughout life.

- *Education/Employment/Housing:* The big challenges in many of these communities are not health problems, but rather socioeconomic problems: education, employment, and housing. Any long term strategy to address health inequalities must address these issues. Housing in particular is a defining issue for some local areas.

- *Churn:* A number of areas are subject to high levels of 'transiency' i.e. people moving in and out of the area (churn). What this suggests is that efforts to tackle deprivation should not focus solely on individuals or households because those who do graduate through such programmes are likely to move away from the area, and be replaced by other young, struggling, individuals. Rather, there should be concurrent efforts to regenerate local communities themselves as physical, social and cultural spaces. This area-based approach will have an enduring impact on the health and wellbeing of local populations, however transiently they may live there.

4.7 Analysis of other social indicators such as school readiness, GCSE attainment, crime rates, over crowded accommodation and living environment shows exactly the same pattern of inequality, in fact some of the gradients are not linear, but rather curved which shows a disproportionate effect in the most deprived deciles. For example alcohol related premature mortality is six times higher in the most deprived decile than it is in the most affluent decile.

## 5 Actions Required

***5.1 Reducing health inequalities requires a much more systematic, place based and disproportionate approach with a focus on those LSOAs identified above, as reducing health inequalities will require the health of these local populations to improve faster than the rest of the population.***

5.2 It will also require a range of interventions and programmes that aim to deliver improved outcomes in the short, medium and long term. For example improving detection and optimising treatment for disease, particularly those diseases associated with premature mortality will provide short term (0-5year) outcomes, whereas lifestyle interventions such as stop smoking have medium term (0-10year) outcomes and modifying social determinants of health may well have longer term (0-15year) outcomes.

5.3 Plans also require buy in and action across a wide range of local stakeholders and can be split into three approaches as follows:

- Population approaches which describes the action by policy makers in addressing the wider determinants of health through, for example policy, legislation and regulation and local strategies of “Health in all Policies”.

- Service approaches which describes action by service providers relating to health for example general practice, acute services.

- Community development approaches which describes actions by community groups and local community leaders to build resilience and improve community wellbeing.

5.4 Traditional methods for community development have tended to focus upon prescribing top down solutions to the needs and deficiencies of deprived areas, with poor buy in and engagement of local communities. We are advocating for an asset based community development approach. This approach recognises the inherent assets, skills and capabilities of residents, citizen associations and local institutions and builds upon these in a co-productive way that creates sustainable long term change.

5.5 Community development can be carried out systematically in the deprived areas we have identified in this report. A methodology for systematically engaging communities is found in Chris Bentley’s Ten Point Plan of ‘System and Scale into Community Empowerment’.

- *Prioritisation of areas* : This has already been done by focussing on the most deprived decile LSOAs in Kent

- *Defining communities*: The next step is to define how communities define themselves, geographically and in a sociocultural sense

- *Asset mapping*: We then need to produce a stocktake of the positive resources in place in each community

- *Behaviour of partners*: A multi-agency response requires coordination, such as agreed common ways of working and the sharing of intelligence.

- *Community profiles*: Local profiles involve collating the top-down analysis already conducted with bottom-up views from the ground to construct a recognisable story of place and culture.

- *Community Based Research (CBR):* Local residents can be trained to be involved in assessing needs, barriers and aspirations, and exploring ideas for action. This develops skills, and raises self-esteem, in residents who can go on to become community champions.

- *Neighbourhood Action Plans (NAPS):* Plans for action should be community owned, but could also form the building blocks on which to base local Health and Wellbeing Strategies.

- *Outreach models*: Community empowerment should allow locals to have a say in how and where they receive services from a range of statutory sector and community venues.

- *Community Links Strategy:* There need to be ongoing mechanisms to involve all sections of the community in what services are provided and how they are provided. Solutions should not involve rigid structures, but mechanisms for on-going structured gathering and collation of local intelligence of community infrastructures.

- *Transfer of Service Ownership:* Change will be more sustainable if we transfer power and resources to genuinely empower communities to take more control of things that affect them e.g. through social enterprise.

5.6 Thus, a local three pronged approach which identifies the:

- NHS response
- The partnership response
- The community transformation response

## 6 Local Implementation

6.1 Public Health is currently working with local partners in each district to understand and map the natural communities which encompass the LSOAs outlined previously.

6.2 Concurrently PH are also mapping local community assets and positive local resources, as we recognise that there are currently other local initiatives happening, particularly community transformation initiatives such as “Big Local”, Housing Association initiatives, Community Safety initiatives, or indeed big infrastructure projects such as Ebbsfleet Garden city where the planning footprint includes existing populations in the populations of concern. We must work in a coordinated way and build upon what already exists, rather than “reinventing” local initiatives that are seen to compete or create confusion.

6.3 Our collective aim is to develop a number of local plans (based on natural local communities) which aim to improve place based health through population, service and community based approaches

6.3 As this is primarily about health inequalities and a place based approach, the over sight of local plans should be managed through local Health and Wellbeing Boards and Local children’s partnership groups.

6.4 Oversight at a Kent Strategic level will be managed at the Kent Health and Wellbeing board; as reducing health inequalities remains a priority of the Kent Joint Health and Wellbeing Strategy.

6.5 Local plans will be reported to local Health and Wellbeing Boards and to the Kent Health and Wellbeing Board in the New Year.

**Recommendation:**
The Kent Health and Wellbeing Board is asked to comment on progress made on key indicators reflecting progress in Outcome Two of the Kent Joint Health and Wellbeing Board Strategy and support greater local Clinical Commissioning Group support for the NHS Health Check programme, particularly in practices where there is no engagement with the service.

The Kent Health and Wellbeing Board is asked to **CONSIDER, COMMENT** and **ENDORSE** the following:

- The renewed approach to reducing health inequalities in Kent
- Agree that Local Health and Wellbeing Boards take a place based approach and for local plans to encompass population, service and community development based approaches.
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http://www.kpho.org.uk/__data/assets/pdf_file/0005/57407/Final-Public-Health-Annual-Report-2015.pdf

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