By: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

Andrew Scott-Clark, Director of Public Health

To: Adult Social Care and Health Cabinet Committee

Date: 1st May 2015

Subject: Update on Addressing Health Inequalities in Kent

Classification: Unrestricted

Pathways: This is the first committee to consider this report

Electoral division: All

Summary:
Reducing health inequalities is fundamental to the delivery of the whole health improvement programme, and thus all commissioning across the system needs to be aimed at not only improving health and wellbeing, but also to reduce differences across and within communities.

Whilst populations across all quintiles are living longer, the data analysis suggests that the gap in life expectancy across most deprived and least deprived during 2006-2014 has not reduced. Thus requiring ongoing concerted effort and a systematic approach across the entire health and care system, with all partners having a role to play in addressing this.

Collectively the Kent Health and Wellbeing Board and local Health and Wellbeing Boards provide opportunities for CCGs and District / Borough Councils to work collaboratively to reduce health inequalities. To effectively address health inequalities it is intended that Public Health commissioning is aligned with commissioning of services across other parts of the system. As a result of this collective effort we aim to ensure that addressing health inequalities is embedded in both commissioning and provision of services to improve the population's health and wellbeing outcomes. Public Health is in the process of developing its strategic delivery plan in line with Council's commissioning priorities. During 2015-16 Public Health will work with partners to design models of services that are easily accessible and targeted to reduce health inequalities.

Recommendations:
Adult Social Care and Health Cabinet Committee Members are asked to:

a) Note the progress made to date in addressing health inequalities across Kent.
b) Support work by the Public Health team and partnership groups (including Local Health and Wellbeing Boards) at local level in designing commissioning models for future provision of public health services at a local level.
c) Support collaborative working between agencies such as the district authorities, police and health in promoting policy initiatives to reduce harm from issues such as alcohol and smoking.

d) Support work at policy level, such as in influencing spatial planning, licensing, housing etc to address health inequalities and promote health and wellbeing in all local policies.

1 Introduction

1.1 Health Inequalities are avoidable variations in the health status of groups and individuals and are a complex issue. Inequalities are ultimately measured by Life Expectancy at Birth, All Age All-Cause Mortality (AAACM) rates and a range of shorter-term performance indicators set by the Public Health Outcomes Framework, along with measuring slope index of inequalities and healthy life expectancy. There is evidence that populations in areas with high deprivation experience higher death rates and more burden of ill health during their life time, compared to those in areas with low deprivation (Marmot strategic review, 2010).

1.2 This paper provides an update to the Adult Social Care and Health Cabinet Committee, on progress regarding how Kent is addressing health inequalities.

1.3 In 2012 Kent produced an action plan "Mind the Gap, Building bridges to better health for all" to address health inequalities, which was agreed by the full Council in March 2012 and an update provided in January 2014. This strategy ends this year and a new strategy will be developed.

1.4 The plan illustrates a range of actions and initiatives undertaken by Kent County Council (KCC) and partners to address the wider social determinants of health inequalities across Kent. It demonstrates the contribution that district councils, community enterprises, voluntary sector and other statutory agencies make to improve healthy lifestyles and promote mental and emotional wellbeing among the Kent population, particularly in deprived communities and to the most vulnerable in society.

2. Measureable indicators of health inequalities

2.1 Life expectancy at the time of birth

This is a measure of health inequalities and refers to the average number of years a newborn is expected to live if mortality patterns at the time of its birth remain constant in the future. Populations across all quintiles are living longer; however, recent trend lines do not appear to show any convergence between the quintiles within the sexes. In fact the life expectancy gap between most deprived and least deprived has very slightly increased during 2006-2014 (figure1).

However, the table shows that when 2006-08 is compared with 2012-14, life expectancy for <u>males</u> is improving at a greater rate in the most deprived quintile: over this period, life expectancy in the worst quintile increased by 2.5%, whereas for the least deprived this was 1.5%. For females, there is no difference between the two quintiles: both increased by 1.3% (table 1).

Figure 1

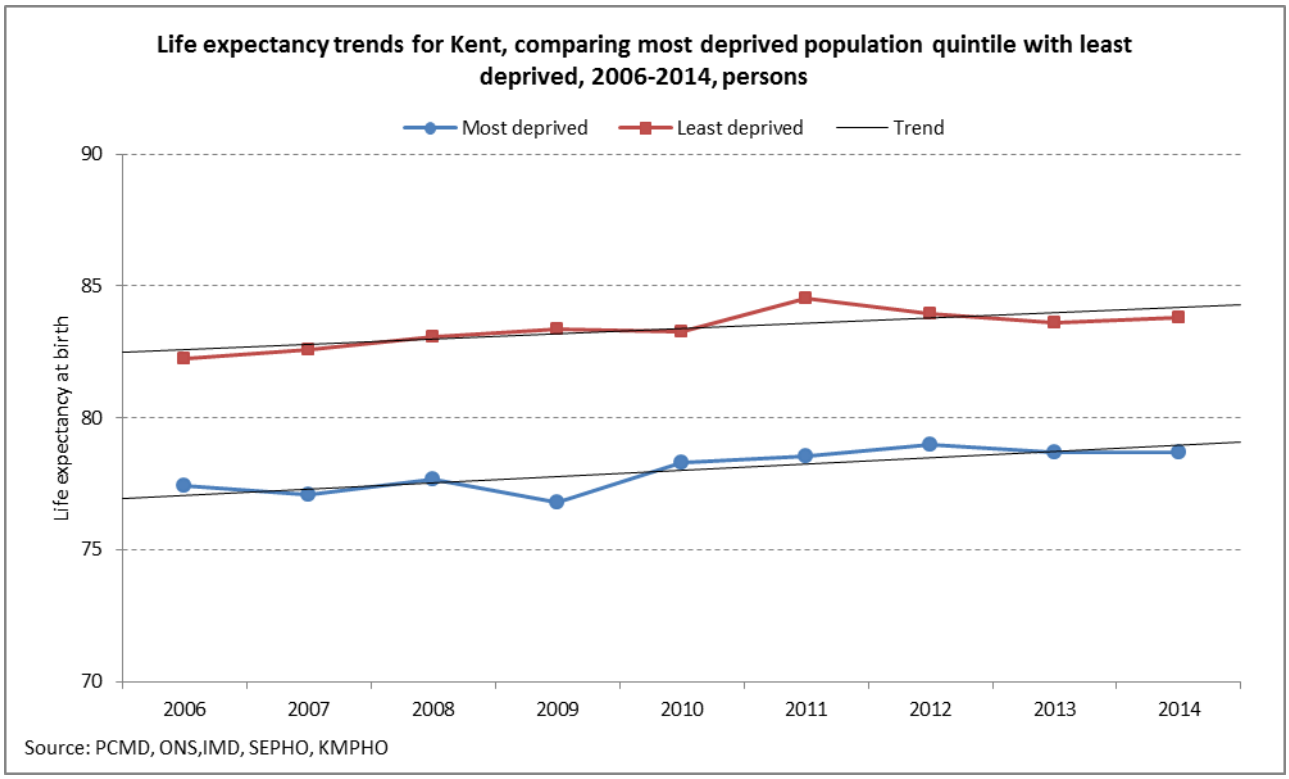


Table 1: Life expectancy at birth for areas in Kent by deprivation status comparing 2006-08 with 2012-14

	Life expectancy at birth (years)								
	Male		Female		Persons		Period percentage change		
Population	2006-08	2012-14	2006-08	2012-14	2006-08	2012-14	Male	Female	Persons
Most deprived (Q1)	74.6	76.5	80.0	81.0	77.4	78.8	2.5	1.3	1.8
Q2	78.4	79.0	82.5	83.6	80.5	81.3	0.8	1.3	1.0
Q3	79.3	80.1	82.1	83.3	80.7	81.8	1.1	1.5	1.3
Q4	80.2	81.1	83.2	84.1	81.7	82.6	1.2	1.0	1.1
Least deprived (Q5)	81.3	82.5	83.9	85.0	82.6	83.8	1.5	1.3	1.4
Kent	**78.8**	**79.9**	**82.4**	**83.4**	**80.6**	**81.7**	**1.4**	**1.3**	**1.3**

Source: PCMD, ONS,IMD, SEPHO, KMPHO

2.2 Routinely monitored indicators

At its meeting in January 2014, the members of the Adult Social Care Cabinet Committee agreed that health inequalities would be measured against agreed indicators. Table 2 summarises these indicators and Kent's current performance against these.

Table 2

Indicator	Current Status	Direction of travel
Reduction in the under -75 mortality rate from Cancer considered preventable (rate per 100,000).	2011-13 78.2	↑ gradual decrease from 2001-03 at 93.4
Reduction in the under -75 mortality rate from Respiratory Disease considered preventable (rate per 100,000).	2011-13 16.7	↔ overall little movement since 2001-03 although has decreased from 18.5 but not in a linear fashion
Increase in the proportion of people receiving NHS Health Checks of the Target number to be invited (proxy for under -75 mortality).	Q1 to Q3 14/15 46.6%	↑ An increase from 24.3% on the same time period in 2013/14
Increase in the number of people quitting smoking via smoking cessation services (number, proxy for under -75 mortality)	Q1 to Q3 14/15 3,008 people quitting at 4-weeks	↓ A decrease from the same period last year. Q1-Q3 13/14 was 4,478
Increasing Breastfeeding initiation rates	2013/14 71.3%	↔ overall little movement but a decrease from 72.5% in 2011/12
Increasing Breastfeeding continuance 6 – 8 weeks	2012/13 40.8%	No published figures to compare due to data validation concerns
Reduction in the number of pregnant women who smoke at time of delivery.	2013/14 13.0%	↑ A decrease from 16.8% in 2010/11

3. Addressing health inequalities through tobacco control

Smoking is still the main contributory cause of premature mortality and the greatest influence on health inequalities. Kent has invested nearly £3.3 million in tobacco control initiatives. As a result in quarter three of 2014-15 3,008 quits were achieved of 5,882 (51%) of those set.

Smoking prevalence rates are continuing to decline, nationally and across Kent (table 3). The National estimate for smoking prevalence is 18.4% and Kent is slightly above the national average at 19%.

Table 3:

Adult Smoking Prevalence	2011	2012	2013
England	20%	19.5%	18.4%
Kent	20.1%	20.9%	19%

Source: PHE Local Tobacco Control Profiles, March 2015

In Kent the highest smoking prevalence exists in the most deprived areas with a 28.4% smoking prevalence among routine and manual workers (table 4). People in routine and manual jobs are twice as likely to smoke as those in managerial and professional roles.

Additionally, manual and routine workers are less likely to quit smoking abruptly or access quit smoking services. Kent is currently exploring harm reduction (cut down to quit) programmes, which may be more effective targeted to these subgroups.

Table 4:

Routine & Manual Worker Smoking Prevalence	2012	2013
England	29.7%	28.6%
Kent	31.3%	28.4%

Source: PHE Local Tobacco Control Profiles, March 2015

Similarly, some women who smoke in pregnancy find it challenging to quit smoking and smoking status at time of delivery rates in Kent are 13% against a national average of 12% (table 5 and figure 2). Although we are RAG red, we are decreasing and have decreased the gap between Kent and National.

The Kent Babyclear programme operates a support programme to assist pregnant smokers quit smoking but is currently experiencing a high number of referrals being lost to service before agreeing to set a quit date. Although the reasons for this are still being explored it is apparent that some women are not ready to quit abruptly and without a harm reduction programme in place, are unable to be supported through the existing commissioned service.

Kent is also a pilot for a national smoking in pregnancy programme called ‘Baby Be Smokefree’, which is looking to reduce smoking in pregnancy amongst teenage pregnant women who smoke.

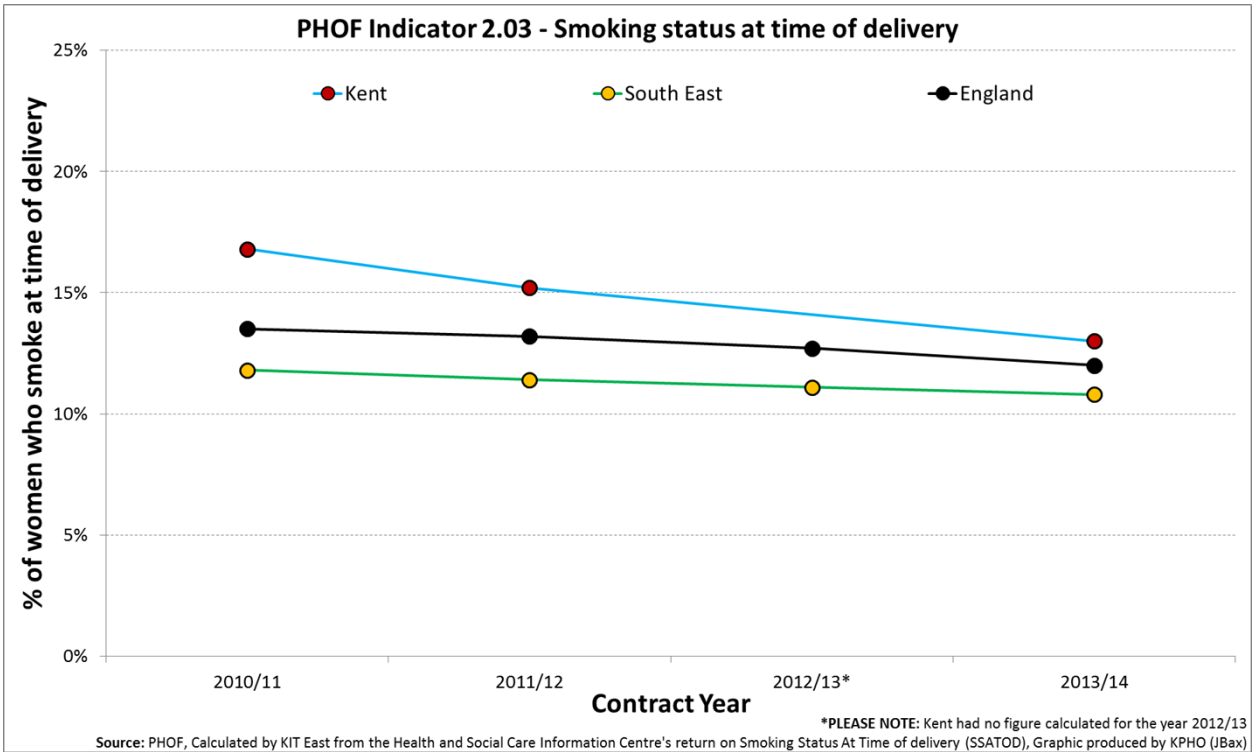
Additionally Kent has also implemented Family Nurse Partnership which is a family support programme, working with young families in most vulnerable communities to reduce smoking prevalence along with offering support in other areas, (further information in section 7.3).

Table 5: Smoking at the time of delivery

	2010/11	2011/12	2012/13	2013/14
Kent	16.8%	15.2%	*	13.0%
South East	11.8%	11.4%	11.1%	10.8%
England	13.5	13.2	12.7%	12.0%

* Poor data quality - not suitable for publication
Source: PHOF

Figure 2



4. Improving mental health services to address health inequalities

Improving mental health and wellbeing is an essential component for addressing health inequalities. Currently, primary care community link workers provide early intervention support to individuals with mental health distress to help them access community resources and to promote social inclusion. During 2014-15, Public Health has worked closely with colleagues from Social Care and Clinical Commissioning Groups to develop the Mental Health core offer of support and the new service will commence from April 2016. This is a priority programme and a leading example of a cross system approach. Public health is focussed on both the promotion of wellbeing, and effective early intervention. This will include a holistic wrap around primary care service to support those with greatest need living in Kent communities. The model needs to sit outside of secondary mental health services to ensure that there is no role dilution. It will form a key part of an integrated pathway across the voluntary sector, primary care mental health and social care and include public health initiatives to ensure there is appropriate, equitable, timely and cost effective interventions for vulnerable people in the community.

5 Front line action at district level

5.1 In 2013-14, additional resources were made available to assist district councils with the improved targeting and effective management of health inequalities programmes. Programmes submitted by districts were assessed using the impact assessment tool and funding was provided to deliver the actions identified from the screening toolkit.

5.2 Though the action plans were varied across Kent districts, the focus however, was given to outcomes related to ‘Give every child the best start in life’. The summary of their focus is outlined in table 6 with further details in Appendix 1.

Table 6: Key focus from projects carried out within districts:

Districts	Key focus of projects of individual districts	Current status of programmes
Ashford	Plans to focus on reducing and alleviating child poverty.	Completed
Canterbury	Key focus was on reducing self-harm behaviours in young people	Completed
Dartford	Dartford's was varied but mostly focused on (a) giving every child the best start in life (b)education (c) employment opportunities (d) healthy and sustainable communities	Yet to commence
Dover	Dover and Shepway's outcome message was on (a) inactivity (b) achieving healthy weight by tackling overweight & obesity (c) reducing alcohol (d) smoking	Ongoing
Gravesham	Gravesham's focused on young adults from age 16 (or age 14 through the Gillick competence) to encourage (a) healthy weight by reducing obesity (b) learning disabilities and mental health through 6 ways to wellbeing.	Ongoing
Maidstone	Maidstone – focused on their priorities (a) Give every child the best start in life (pregnancy and early years), (b) children and families, (c) NEETs/employment and skills (d) healthy workplaces (e) healthy weight (f) self-harm (g) Excess winter deaths (h) falls prevention (i) alcohol	Completed and have now raised further funding for next financial year 2015/2016
Sevenoaks	Sevenoaks - (a) rural inaccessibility, (b) drug and alcohol (c) children and families (d) healthy places / communities	Due to complete in March 2015
Shepway	Dover and Shepway - focused on (a) inactivity (b) achieving healthy weight by tackling overweight & obesity (c) reducing alcohol (d) smoking	still ongoing
Swale	Continuation of previous projects such as 'Beats and Breathe' with support from Public Health	
Thanet	Thanet – (a) risk taking behaviours in young people (b) ethnic communities (c) LGBT needs for service development (d) learning disabilities and mental health	Completed
TMBC	Tonbridge and Malling – (a) pregnancy and early years (b) risk taking behaviours in young people (c) healthy workplaces (d) children and families in poverty	Completed
T Wells	Tonbridge Wells – (a) Excess winter deaths (b) self-harm reduction (c) Healthy weight (adult & child obesity reduction) (d) reduction in smoking in young people	Ongoing

6 Front line action at CCG level

It is a statutory duty of the CCGs to reduce health inequalities. Some examples of work that is being undertaken to address health inequalities at a local level are:

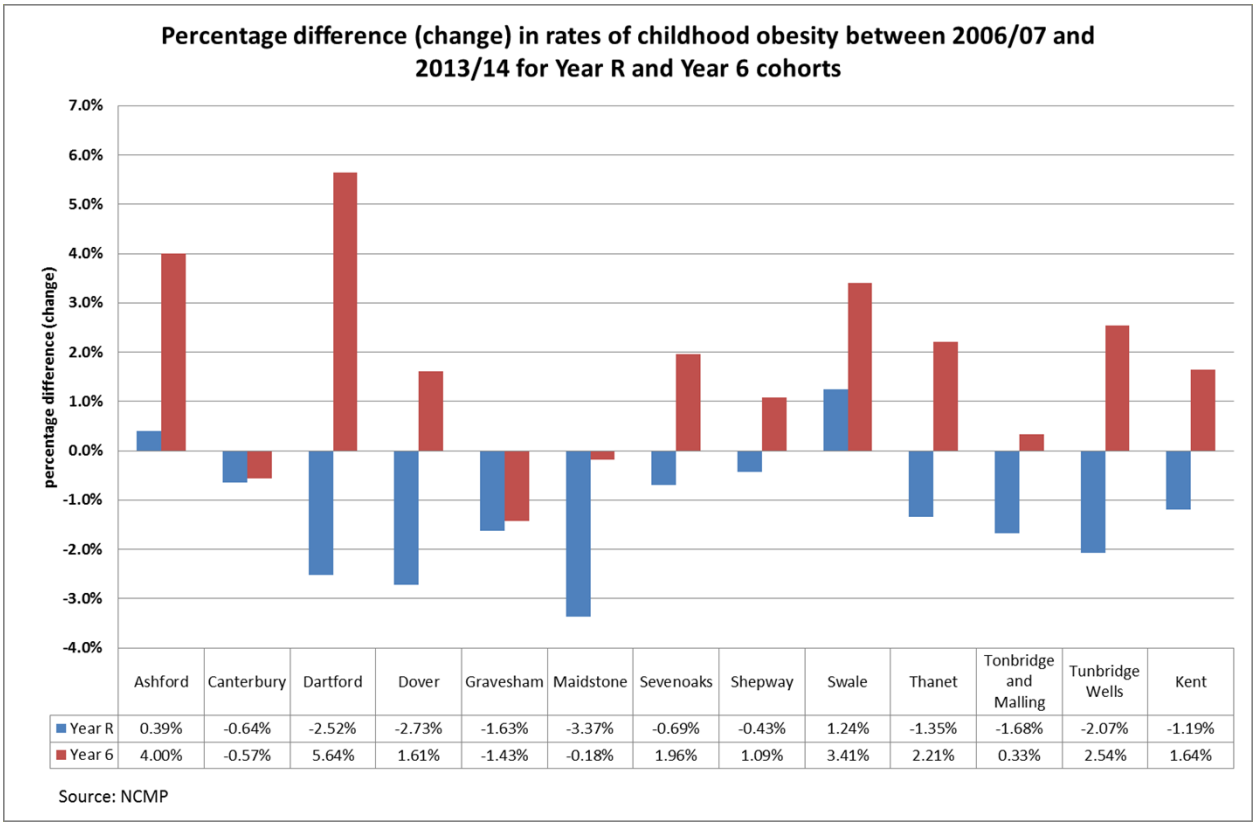
- tackling variations in treatment e.g. atrial fibrillation and stroke
- prioritising support and prevention in the most deprived areas by targeting health trainers
- developing integrated care pathways such as Chronic Obstructive Pulmonary Disease, including prevention and stop smoking
- working with partners across the system to address public health issues such as obesity, breastfeeding, mental health and tobacco control
- working with colleagues to set up local substance misuse steering group and work across all agencies to reduce crime and improve health outcomes
- proactive case-finding (identification) within the General Practice population of vulnerable groups and the undertaking of opportunistic brief advice using the guidance, treatment and referral pathways within the Alcohol Integrated Care Pathway (AICP)
- using community development approaches through programmes such as Margate Task Force and proactively work with local communities in addressing factors that affect health outcomes such as housing, substance misuse etc.

7. Addressing health inequalities in younger years

7.1 Childhood obesity

Childhood obesity particularly in Year R, is another area that has seen a percentage change at a population level in Kent. However, for children in Year 6 the majority of the districts have seen an increase (figure 3).

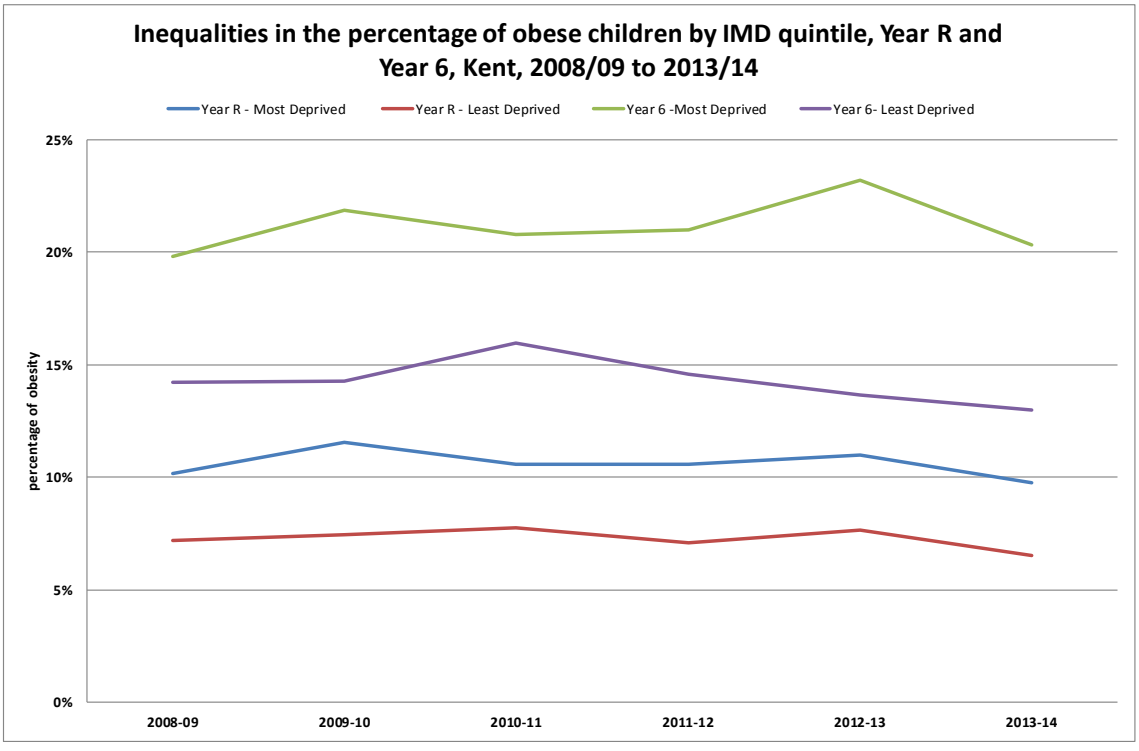
Figure 3



	Ashford	Canterbury	Dartford	Dover	Gravesham	Maidstone	Sevenoaks	Shepway	Swale	Thanet	Tonbridge and Malling	Tunbridge Wells	Kent
Year R	0.39%	-0.64%	-2.52%	-2.73%	-1.63%	-3.37%	-0.69%	-0.43%	1.24%	-1.35%	-1.68%	-2.07%	-1.19%
Year 6	4.00%	-0.57%	5.64%	1.61%	-1.43%	-0.18%	1.96%	1.09%	3.41%	2.21%	0.33%	2.54%	1.64%

When the gap between least and most deprived is considered over the last six years the analysis suggests that for Year R the gap has not increased whereas for Year 6 it has slightly increased (5.6% -7.3%) (figure 4).

Figure 4



Work is being undertaken at district level to address childhood obesity.

7.2 In October, Public Health will inherit the commissioning of Health Visiting from NHS England. Health visitors have a crucial role in the early years of a child's development providing ongoing support for all children and families. This provides an opportunity to impact on health inequalities by ensuring there is an enhanced focus on increasing breastfeeding, reducing childhood obesity and improving maternal mental health.

7.3 The Family Nurse Partnership (FNP) is a nurse led, evidence based, preventative programme offered to vulnerable young parents having their first baby under the age of 20. The offer of intense support over the first two and half years for the most vulnerable young people (offer to the family where possible) is vital in reducing and addressing health inequalities over both the short and long term.

7.4 Emotional wellbeing is recognised as having a crucial influence on children and young people's life chances and their ability to achieve positive outcomes across a range of domains, including educational engagement and attainment, social inclusion and physical health. Kent County Council, with its partners, has published Emotional Health and Wellbeing strategy that focuses on early help and support at the right time in the right place. This will support a series of actions in addressing health inequalities for children and young people.

8 Addressing health inequalities through housing

It is well evidenced that the condition and location of housing has a strong bearing on health inequalities. In response to addressing housing related health inequalities the Kent Housing Group and the Joint Policy and Planning Board for Housing have produced a separate action plan, focussing on housing issues referred to as 'Think Housing First', which has been recognised by DCLG. The plan seeks to take strategic actions to:

- reduce homelessness
- provide affordable housing provision
- tackle cold and hazardous housing
- promote safe and accessible housing
- promote referral schemes

Each of the priorities have tangible, measurable objectives to improve access to primary health care, falls prevention services and promote smoke free homes. Projects are also underway to improve staff skills to engage with the population, to provide interventions for supporting behaviour change.

9 Conclusion

9. 1 Evidence suggests that addressing health inequalities requires a systematic approach across the entire health and care system with all partners having a role to play. NHS England and CCGs are collectively responsible for commissioning health services that can make a difference to the early deaths in the 'at risk'

groups. Kent County Council and District / Borough Councils have responsibility for commissioning services that affect health outcomes. Collectively the Kent Health and Wellbeing Board and local Health and Wellbeing Boards provide opportunities for CCGs and District / Borough Councils to work collaboratively to reduce health inequalities. Members have a real understanding of the issues that matter to their local communities and can play a pivotal role in influencing partners to address health inequalities.

9.2 Each of Kent's district authorities have demonstrated a commitment to reducing health inequalities and developed a local plan to address health inequalities. This needs ongoing implementation and monitoring.

9.3 Public Health is in the process of developing its strategic delivery plan in line with Council's commissioning priorities. The delivery plan will be structured into three areas for improved outcomes, namely: starting well, living well and ageing well. The opportunity presented by the transfer of Health Visitors into the local authority, and the end of most of the major contracts for many of adult healthy lifestyle services will allow for application of the strategic principles and reshape the service design and commissioning.

It is intended that 2015-16 is one of development and change for the services commissioned by Public Health, during which we will work with our partners to design models of services that are easily accessible and targeted to reduce health inequalities.

9.4 To effectively address health inequalities it is intended that Public Health commissioning is aligned with commissioning of services across other parts of the system. As a result of this collective effort we aim to ensure that addressing health inequalities is embedded both in commissioning and provision of services and improve population's health and wellbeing outcomes.

10 Recommendations:

Adult Social Care and Health Cabinet Committee Members are asked to:

a) Note the progress made to date in addressing health inequalities across Kent.
b) Support work by the Public Health team and partnership groups (including Local Health and Wellbeing Boards) at local level in designing commissioning models for future provision of public health services at a local level.
c) Support collaborative working between agencies such as the district authorities, police and health in promoting policy initiatives to reduce harm from issues such as alcohol and smoking.
d) Support work at policy level, such as in influencing spatial planning, licensing, housing etc to address health inequalities and promote health and wellbeing in all local policies.

Background documents: None

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Appendix 1

Local details can be provided on individual pilots

Ashford District Council

Active Travel: focused on encouraging primary aged children and their parents to make use of active travel methods to and from schools.
Self-Harm Programme: focused to address the rise in issues of self-harm and mental health issues amongst young people.

Canterbury District Council

Focus on reducing self-harm behaviours in young people. This was called The Mind and Body Programme, which is a multi-component risk reduction programme for young people who are vulnerable to risk taking behaviours.

Dartford District Council

Focus on priority action of 'reduce the gap in health inequalities across the social gradient for priority public health issues'.

Dover District Council

Dover district council had an agreed South Kent Coast Health and Wellbeing strategy which highlighted health inequalities in health as part of its action plan. To tackle HI within a project, it was decided to focus on promoting walking as an effective intervention in tackling inactivity whilst supporting weight reduction.

Gravesham District Council

The focus of Gravesham District Council was on reducing the gap in the health status between the deprived and non-deprived communities, with the aim of improving health in deprived communities sooner to reduce gap in the life expectancy. The focus of programmes was healthy weight with maintenance of 5-10% body weight loss among overweight or obese adults from age 16 (or 14 if deemed appropriate through the Gillick Competence) and over and improving men's health.

Maidstone District Council

The funding in Maidstone was used for a programme aimed to reduce the number of young people between the ages of 16 and 25 who are Not in Education and in Training (NEET). The programme focused on engaging young parents in the programme with the aim at identifying what the barriers were for them to engage in training and education.

Sevenoaks District Council

Sevenoaks district council invested the HI funds into a project focused on healthy eating with focus being on fathers. The project was designed to engage with fathers across the

district, offering them the opportunity to spend quality time with their children whilst learning about healthy living through cookery classes. The main aim of the project was to improve confidence and skills in the preparation of a healthy meal on a small budget and looking at healthy weight, healthy lunch boxes, healthy snacks, and healthy meals in general.

Shepway District Council

Shepway District Councils have an agreed South Kent Coast Health and Wellbeing Strategy, which highlights inequalities in health outcomes in its action plan.

Tackling Inactivity
Reducing overweight and obesity
Reducing alcohol consumption
Reducing the numbers of people who smoke – particularly in Shepway

Shepway – Promoting healthy eating and cooking in priority primary schools, focus on exploring healthy eating and diet and confidence to cook in Primary Schools

Thanet District Council

The programme awarded the HI funds from PH to the Smoking Cessation outreach work in Thanet.

The aim of this project is to undertake outreach work with the diverse communities in the Cliftonville West ward in Thanet.

Tonbridge and Malling District Council

The funding was used for '**Counterweight'** a healthy weight management programme and supporting initiatives: **'Cook & Eat'** NHS Health Checks and Wellbeing Checks (for those not eligible for HC). One additional programme of **'Headspace'** a mental health programme for men has been funded to try and increase the uptake of men onto the weight management programme both at the MIND centre and the community programmes.

Tunbridge Wells District Council

The programme focused on Adult Healthy Weight and had specific target on three particular groups:

- people with learning disabilities (Move, Eat, Grow)
- pregnant women (Healthy Mums, Healthy Bumps)
- men (Man up, Shape up)