By:	Graham Gibbens, Cabinet Member, Adult Social Care and Public Health Andrew Scott-Clark, Director of Public Health
To:	Adult Social Care and Health Cabinet Committee
Date:	11th September 2015
Subject:	Future Direction for "Mind The Gap: Reducing health inequalities in Kent"
Classification:	Unrestricted
Pathways:	This is the first committee to consider this report
Electoral Division:	All

Summary

Health Inequalities remains an issue for the population of Kent and particularly the populations living in the most deprived decile where life expectancy step changes down for both men and women.

Whilst the gap in life expectancy has narrowed for men, it is widening for women and this appears to be driven by rising rates of COPD and lung cancer mortality.

The current Mind the Gap focused upon the Marmot objectives and although these continue to be relevant for reducing health inequalities, any new Kent plan must focus upon the places and communities the most deprived population with the lowest life expectancies of Kent live.

Measurement of deprivation is being updated in late September and analysis and stock take will be based upon the areas identified using IMD 2015.

This means a full new plan based upon the impending publication and local review take will not be ready until early in the new year

Recommendation:

Members of the committee are asked to comment on the proposed direction of travel and time scales for developing a new health inequalities plan for Kent.

1. Introduction

1.1 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.

1.2 The national vision is to improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest which is measured through two key targets in the Public Health Outcomes Framework:

Outcome 1: Increased healthy life expectancy

This takes into account the quality of health as well as the length of life measure and uses a self-reported health assessment, applied to life expectancy.

Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities.

1.3 In 2012 Kent County Council adopted the Kent Health Inequalities Action Plan titled "Mind the Gap Building Bridges to better health for all".

Mind the gap was built upon the six key policy objectives derived from the work of Sir Michael Marmot entitled "Fair Society, Equal Lives" published in 2010.

The policy objectives are as follows:

- Give every child the best start in life
- Enable all children young people and adults to maximise their capabilities and have control over their lives
- 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

1.4 Those policy objectives are still as relevant today as they were when published in 2010. However just using these policy objectives without providing a greater geographical focus on the communities suffering the worst health and lowest life expectancy, and planning over an unrealistic time period will not in themselves reduce health inequalities significantly.

1.5 Since the approval and publication of Mind the Gap, some significant structural changes have been made in the health and social care sector, not least being the move in April 2013 of the responsibility for Public Health to upper tier local authorities as a result of implementation of the Health and Social Care Act

1.6 This report provides a summary update on the progress made in reducing health inequalities and proposes some principles for the future direction and focus of our reducing inequalities work.

2. Progress

2.1 The standard way of measuring health inequalities is to measure differences in life expectancy. The population is divided into ten equal groups (deciles) based on the Index of Multiple Deprivation (IMD 2010) and then looking at average life expectancy for each decile. This is achieved by building up populations from Lower Layer Super Output Areas, ranking them on the basis of IMD score and finding the average life expectancy for each of the ten groups. Life expectancy is then plotted against the most deprived to least deprived decile and the steepness of the slope represents the inequality of life expectancy that is related to deprivation in the population being studied. The actual gap in life expectancy is taken as the difference between the least and most deprived on the line of best fit.

2.2 It is obvious over the last two years that Public Health analysis has been at both decile level and quintile level, both of which are valid but give very different answers in terms of the difference in years of life expectancy. All future analysis of health inequalities based on life expectancy will be done at the decile level, not quintile.

2.3 Analysis of the current Kent picture of health inequalities using the methodology described in paragraph 2.1 above shows:

- 7.1 life expectancy gap for men
- 5.1 life expectancy gap for women.

This is based on pooled data for 2011-2013 as can be seen in the Charts in Figure 1 Life Expectancy gap in Kent 2011-2013.on the following page.

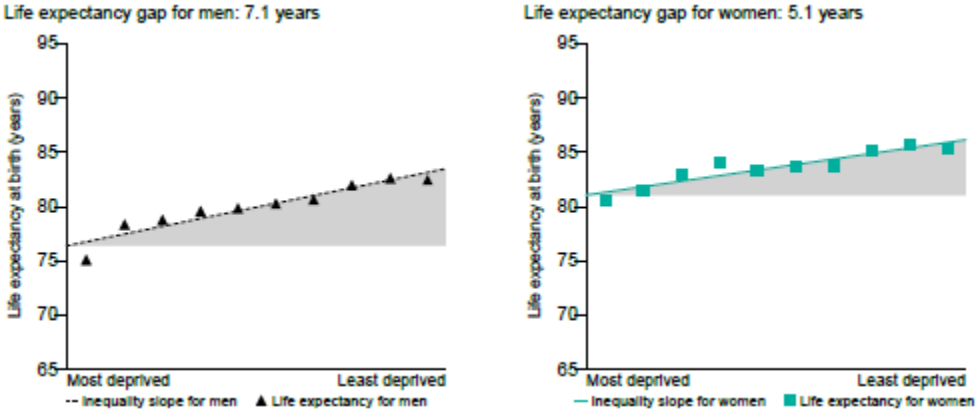


Figure 1 Life Expectancy gap in Kent 2011-2013.

2.4 It is quite clear that people living in the most deprived decile are experiencing the poorest health outcomes and the shortest lives in Kent, in fact so poor and so short the indicator is not included in the line of best fit for the other nine deciles of life expectancy, particularly for men, but this is also true for women. There is also a clear step down between the 9th decile and the lowest decile.

2.5 This decile therefore must be the focus of Kent's future inequalities work and requires a joined up disproportionate response to reduce the disparity.

2.6 Since 2011 in Kent, the trend for health inequalities in men has generally been decreasing over the last five years.

For women in Kent over the same time period the trend has changed from reducing to more recently increasing and overall the gap in life expectancy has increased between the least and most deprived female population in the last five years

Data Years	Life Expectancy Gap – Males years	Life Expectancy Gap – Females years
2007-2009	8.1	5
2008-2010	8.2	4.5
2009-2011	8.2	4.5
2010-2012	7.1	4.8
2011-2013	7.1	5.1

2.7 An analysis of what is driving the increasing trend for the recent widening of the gap for women suggests an increasing upward trend in mortality rates in women from chronic obstructive pulmonary disease (COPD) and a recent rise in mortality rates in women aged under 75 due to lung cancer.

2.8 Smoking rates are strongly associated with both lung cancer and COPD and we also know the smoking rates also account for about half of the inequality gap.

3. Future Direction

3.1 Currently all analysis of deprivation is based on the Index of Multiple Deprivation (IMD) 2010. This is a full five years out of date and also is based

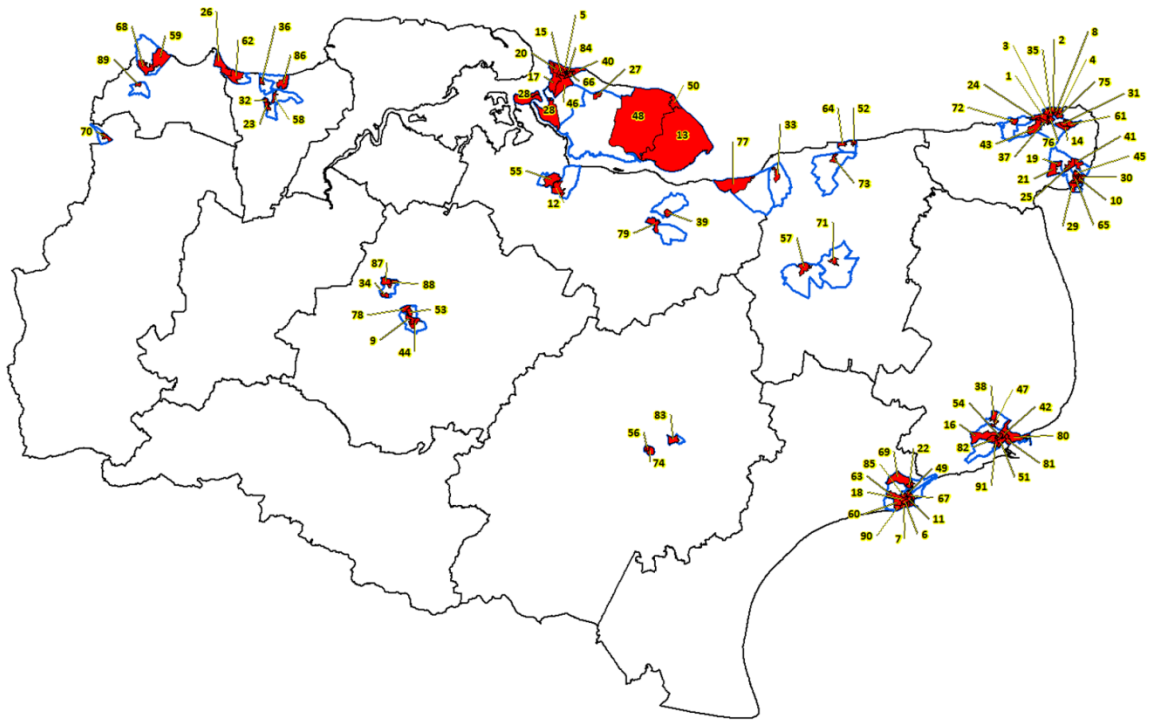
on census population information collected in 2001.

3.2 The Department for Communities and Local Government (DCLG) is currently updating the indices of deprivation, including the Index of Multiple Deprivation (IMD). The indices of multiple deprivation 2015 are likely to be published in late September 2015. Whilst we don't expect an updated IMD to radically change the geographical areas we classify in the lowest decile, any plan should use the most contemporary information and data available.

3.3 As described previously, the population associated with the most deprived decile are suffering the poorest health outcomes and have the lowest average life expectancy. Our focus must be on identifying exactly who and where these populations are and focusing a much greater and coordinated response with these communities; a disproportionate response.

3.3 Analysis using the IMD 2010 shows the populations to be in the areas identified in the map below

Map showing the 91 LSOAs which form the most deprived decile in Kent based on the 2010 Indices of Multiple Deprivation



3.4 Preliminary analysis using IMD 2010 also shows that life expectancy within the 91 lowest deciles varies between each LLSOA and development of the new plan will prioritise which areas in Kent to focus on.

3.5 Moving to a more place based approach will also require local areas to be more joined up and focused on gaining local health improvements and outcomes that will influence life expectancy over the short, medium and long term

3.6 This new placed based approach should have three main components and plans to improve life expectancy and should be joined up and co-ordinated

across the various local public sector organisations The three components include:

1. The Health Service response.
2. The partnership response.
3. Working with local communities in the target areas

3.7 The Health Service response reflects the current variation in delivery of health services to populations in the lowest decile of multiple deprivation. For each area we will need to analyse what are the key causes of premature mortality for people in the lowest decile, how many people that relates to, how many people and what are the key, evidence based interventions required to reduce premature mortality.

3.8 The partnership response will need to look more broadly at the wider determinants of health, for example local economic regeneration, employment, quality of housing, educational attainment and focus on enhancing delivery through working together.

3.9 The third component is about the local communities themselves and how we collectively work with these communities to enhance social capital and cohesion build on local community assets to enhance local outcomes.

3.10 There will therefore be the expectation that local areas will develop local agreed plans in order to focus effort into local places and communities.

3.11 Paragraph 3.4 described the variation in life expectancy for those people living with the 91 lowest deciles. Joined up and coordinated action is already taking place in some areas and it is not the intention of this placed based approach to stop supporting those areas, rather it is to provide focus upon the areas which continue to do less well.

4.0 Timescales

4.1 The new IMD 2015 will not be published until late September and we therefore envisage a draft plan to come back early in the new year

4.2 Timescales are envisaged as follows:

June, July, August 2015	Planning our approach
September 2015	Cabinet Committee paper on approach
September to December 2015	Review and analysis based on IMD 2015.
Draft new plan to this Committee prior to key decision to adopt approach	January 2016.

5.0 Conclusion

5.1 Health Inequalities remains an issue for the population of Kent and particularly the populations living in the most deprived decile where life expectancy step changes down for both men and women.

5.2 Whilst the gap in life expectancy has narrowed for men, it is widening for women and this appears to be driven by rising rates of COPD and lung cancer mortality.

5.3 The current Mind the Gap focused upon the Marmot objectives and although these continue to be relevant for reducing health inequalities, any new Kent plan must focus upon the places and communities the most deprived population of Kent live.

5.4 Measurement of deprivation is being updated in late September and analysis and a detailed analysis and review will be based upon the areas identified using IMD 2015.

5.5 This means a full new plan based upon the impending review and analysis will not be ready until early in the new year

6.0 Recommendation

Members of the committee are asked to comment on the proposed direction of travel and time scales for developing a new health inequalities plan for Kent.

Background documents

"Mind the Gap Building Bridges to Better Health for All"
http://www.kent.gov.uk/__data/assets/pdf_file/0008/14777/Mind-the-Gap-Building-bridges-to-better-health-for-all.pdf

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