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

Andrew Scott-Clark, Director of Public Health

To: Adult Social Care and Health Cabinet Committee – 12 July 2016

Subject: Mind the Gap - Health Inequalities Action Plan for Kent 2016

Decision Non-Key

Classification: Unrestricted

Past Pathway of Paper: This is the first committee

Future Pathway of Paper: A summary will be shared at the July Kent Health and Wellbeing Board.

Electoral Division: All

Summary: This report updates the committee on analysis and progress on developing the next Mind the Gap Reducing Health Inequalities Action plan for the county. The health inequalities gap has not narrowed since 2006. This report identifies the populations across Kent who shows the worst health outcomes and describes the mapping analysis and actions required at local level in order to reduce health inequalities in the future. This work continues to supported by Professor Chris Bentley (former national lead for the Health Inequalities National Service Team).

Recommendation(s):

The Adult Social Care and Health Cabinet Committee is asked to **CONSIDER**, **COMMENT ON** and **ENDORSE** the analysis and progress in developing the next 'Mind the Gap' 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 Adult Social Care and Health Cabinet Committee in September last year considered the future direction for "Mind the Gap: Reducing Health Inequalities in Kent" and endorsed the proposed direction for development of a new Kent Inequalities Action Plan.

1.3 This 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.

2. Findings

2.1 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.

2.2 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.

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

2.4 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

2.5 The geographical spreads of these 88 LSOAs is as follows:

2.5.1	Ashford District:	4
2.5.2	Canterbury District	7
2.5.3	Dartford District	4
2.5.4	Dover District	11
2.5.5	Gravesham District	7
2.5.6	Maidstone District	5
2.5.7	Sevenoaks District	2
2.5.8	Shepway District	8
2.5.9	Swale District	16
2.5.10	Thanet District	24

2.6 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.

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

2.7.1 *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.

2.7.2 *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.

2.7.3 *Education/Employment/Housing:* The big challenges in many of these communities are not health problems, but rather socio-economic 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.

2.7.4 *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.

2.8 Analysis of other social indicators such as school readiness, GCSE Attainment, crime rates, overcrowded 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.

3. Action Plans

3.1 Reducing health inequalities requires a much more systematic, place-based and disproportionate approach with a focus on those LSOAs identified above.

3.2 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.

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

3.3.1 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”.

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

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

3.4 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.

3.5 Community development can be carried out systematically in the deprived areas 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’:-

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

3.5.2 *Defining communities*: The next step is to define how communities define themselves, geographically and in a socio-cultural sense.

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

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

3.5.5 *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.

3.5.6 *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.

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

3.5.8 *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.

3.5.9 *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 ongoing,structured gathering and collation of local intelligence of community infrastructures.

3.5.10 *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.

3.6 Public Health are currently working with local partners in each district highlighted above as having LSOAs in the most deprived decile in order to ensure we have accurately defined local communities and have mapped local assets.

3.7 Our 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.

4. Legal implications

4.1 None identified.

5. Equalities implications

5.1 This action plan is designed to reduce inequalities within and between communities. It is expected the equality impact assessments will be carried out on each local plan.

6. Other corporate implications

6.1 As described above, the wider determinants of health impact on other services and areas of the County Council, and importantly of public, private and local voluntary sectors

7. Governance

7.1 As this is primarily about health inequalities, and a place-based approach, the oversight of local plans should be managed through local Health and Wellbeing Boards and Local Children's Partnership Groups.

7.2 Oversight at a Kent strategic level will be managed at the Kent Health and Wellbeing Board; reducing health inequalities remains part of the Kent Joint

Health and Wellbeing Strategy.

8. Conclusions

8.1 Health Inequalities result from a wide variety of determinants: the conditions in which we are born, grow, live, work and age. Addressing these health inequalities is a key policy focus at the local, national and global level.

8.2 Since Kent's 2012 Strategy 'Mind the Gap', Kent has shown progress in some health outcomes, and Kent as a whole scores above the England average on a number of indicators. However, inequalities continue to exist within and between Kent communities, and there is a persistent gap in mortality rates between the most and least deprived.

8.3 Steep gradients exist across a range of health and social indicators in Kent, and the very worst outcomes are found in the most deprived decile. These inequalities carry through to life expectancy and premature mortality, with steeper gradients in men than in women.

8.4 The most significant causes of death (in both men and women) that are driving these inequalities are cardiovascular disease, respiratory disease and gastro-intestinal disease. In the main these diseases are preventable through earlier detection, behavioural modification and optimal risk management.

8.5 There are four different 'types' of deprivation within the most deprived decile. These populations have been mapped geographically in Kent. Granular analysis over small areas provides insights into the challenges facing local communities.

8.6 Moving forward, the priorities to tackle health inequalities in Kent should be to focus on these most deprived decile areas. Preventative interventions should focus on early identification and management of health risks in these traditionally hard-to-reach populations.

8.7 The health system is moving towards a place-based approach to improving health outcomes through the NHS five year forward view and local Sustainability and Transformation plans. Recognising area inequalities is a key part of this. Community initiatives (often already existing in some form) present opportunities to engage, though this is not currently systematic or at-scale. The Chris Bentley ten-step plan helps us to work towards this aim.

8.8 Public Health are currently working with local partners in each district highlighted above (para 2.5) as having LSOAs in the most deprived decile in order to ensure we have accurately defined local communities and have mapped local assets.

9. Next steps

9.1 Local plans (based on natural local communities) will be developed which aim to improve place-based health through population, service and community-based approaches.

9.2 These plans will be reported back to this committee by January 2017.

10. Recommendation:

10.1 The Adult Social Care and Health Cabinet Committee is asked to **CONSIDER**, **COMMENT ON** and **ENDORSE** the analysis and progress in developing the next 'Mind the Gap' for Kent.

11 Background Documents

11.1 Kent Public Health Annual Report 2015
http://www.kpho.org.uk/__data/assets/pdf_file/0005/57407/Final-Public-Health-Annual-Report-2015.pdf

11.2 Future Direction for "Mind The Gap: Reducing health inequalities in Kent Report to the September 2015 Adult Social Care and Health Cabinet Committee.
"https://democracy.kent.gov.uk/documents/s59510/C2%20-%20Mind%20the%20Gap%20final.pdf

12 Contact details

Report Author:
Name and job title Andrew Scott-Clark
Telephone number 03000416659
Email address andrew.scott-clark@kent.gov.uk