HEALTH SCRUTINY COMMITTEE

24 SEPTEMBER 2015

STRATEGIC RESPONSE TO REDUCING HEALTH INEQUALITIES IN THE CITY

1. Purpose

1.1 Nottingham City faces significant health inequalities. The Public Health team, within Nottingham City Council, are continually working with colleagues and partners via a community wide approach to improve the health outcomes of residents.

2. Action required

2.1 The Committee is asked to scrutinise the local strategic approach to tackling health inequalities within the city and recommend ways to ensure Nottingham City Council is responding as robustly as possible to improving the health of the local population. The Interim Director of Public Health will outline how Nottingham City Council is working to address the health inequalities within the city. Activity to reduce health inequalities uses an asset based approach which engages communities.
The report will also consider the health profiling data available; distinguish between equity and equality and identify what future collective actions are required to reduce health inequalities.

3. Background information: Health and Wellbeing in Nottingham

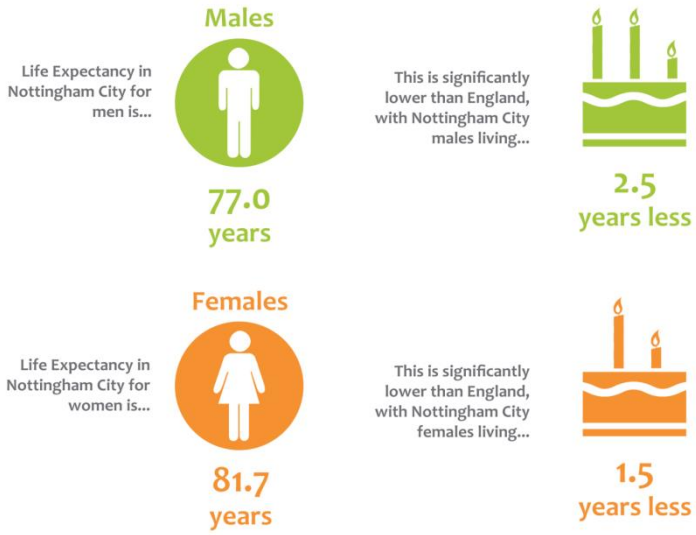
3.1 Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups (World Health Organisation). Some health inequalities are attributable to susceptibility to disease or health behaviours, whilst others are attributable to the external environment and are mainly outside the control of the individuals concerned. As such health inequalities can be described as, avoidable, unjust and unfair.

3.2 Diverse factors can impact on health inequality including age, gender, ethnicity, where individuals live and work and family and community relationships. Existing physical and mental health conditions can also influence health inequality. For example people with diabetes are two to three times more likely to have depression than the general population (The Kings Fund).

3.3 The most obvious health inequality is differences in life expectancy. Across England, people living in deprived neighbourhoods die earlier than those living in more affluent areas and spend more of their lives living with disability.

3.4 In Nottingham, life expectancy over the last 10 years has continued to increase with males living an additional 4 years and females an extra 3.1 years[1]. This increase over the last 10 years is greater than the England average and thus the inequalities gap is closing[2]. Nonetheless, as Figure 1 highlights, there is still a significant difference in life expectancy in Nottingham compared to England average.

Figure 1: Life expectancy in Nottingham City



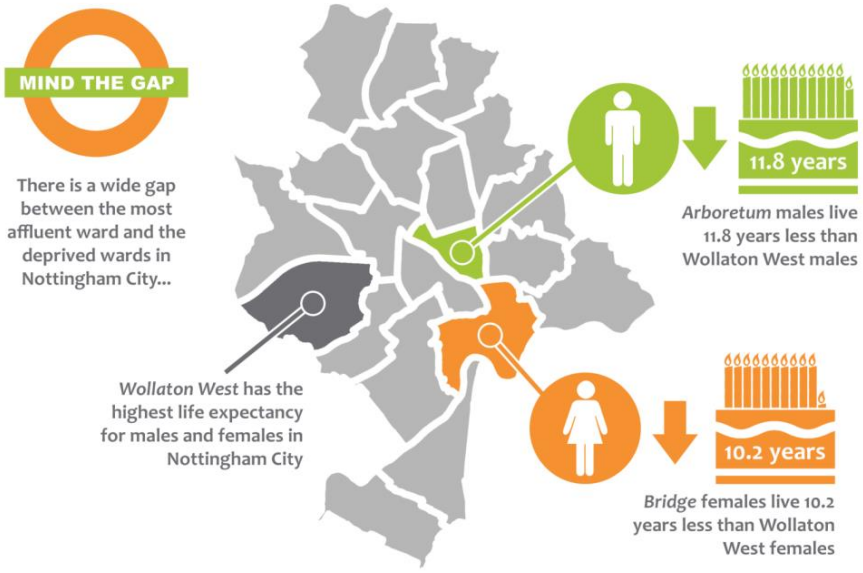
3.5 There is a clear and persisting link between deprivation and social circumstances on the one hand, and life expectancy and mortality on the other. Nottingham's comparatively low life expectancy is directly related to its high levels of deprivation. Reducing inequalities in socio-economic circumstances and opportunity, particularly education and income, will reduce mortality and increase life expectancy in more deprived areas.

3.6 Within the city, distribution of deprivation contributes to inequalities in life expectancy between wards. Nonetheless, the gap, particularly in relation to males, continues to reduce.

[1]Life expectancy is the number of years that a person can expect to live on average in a given population and is a commonly used summary measure of population level health. Source: ONS 2011-13 data extracted from Public Health Outcomes Framework tool compared to 2001-03

[2] Over the same period male life expectancy increased 3.2 years for males and females 2.4 years across England as a whole

Figure 2: Differences in life expectancy in Nottingham City



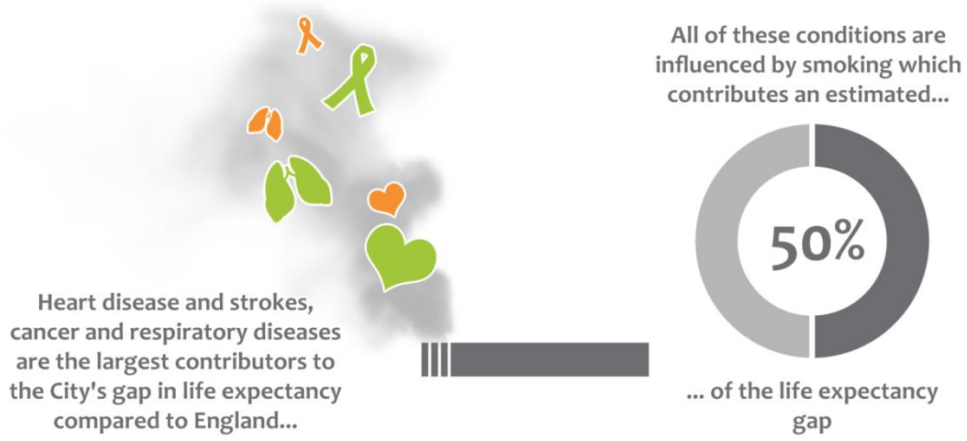
3.7 Assessment of life expectancy across Nottingham, comparing the most deprived areas to the least, by Lower Super Output Area (LSOA), shows that the gap has reduced by 2.8 years for males and 0.5 years for females over the last nine years[3]. Historically, men have experienced greater inequalities within the city but this has improved significantly. Thus the difference in life expectancy, based on LSOAs, between the most and least deprived areas is 8 years for males and females.

3.8 Historically, there have always been differences in life expectancy by socioeconomic group. Reasons for this include affluent groups having better living conditions, nutrition and access to healthcare than more economically deprived groups. These differences persist today. The Marmot review[4] described a comprehensive picture of unfair distribution of health and length of life in England, with a finely graded relationship between the socioeconomic characteristics of the area in which people live and life expectancy.

3.9 The largest contributors to the gap in life expectancy in Nottingham, compared to the England average, are circulatory disease (heart disease and strokes), cancer and respiratory diseases[5] which account for 60% of the gap. Furthermore, all of these conditions are influenced by smoking, which contributes to an estimated 50% of the life expectancy gap.

[3] Slope index of inequality in life expectancy at birth within English local authorities measures the range in years of life expectancy across the social gradient (based on deprivation at Local Super Output Level) within the city, from most to least deprived. Source: ONS 2011-13 data extracted from Public Health Outcomes Framework tool. Data not available for 2001-03
[4] UCL (2010), Fair Society Health Lives: The Marmot Review
[5] Largely related to Chronic Obstructive Pulmonary Disease

Figure 3: Contributors to the differences in life expectancy

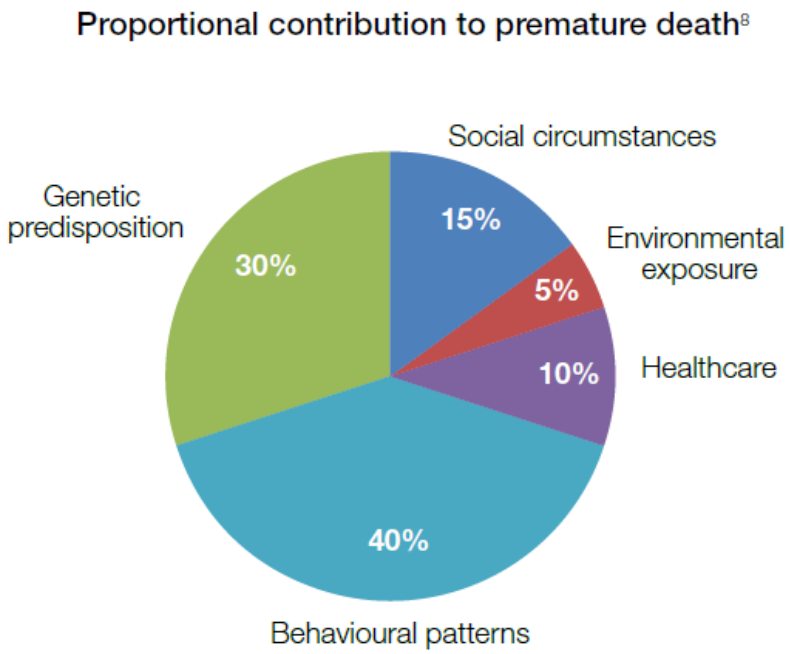


3.10 Smoking, harmful use of alcohol, physical inactivity and poor diet are key lifestyle factors which contribute to the 'big killers'. These have been identified and their contribution to 'disability adjusted life years[6]' calculated for the UK, in the global burden of disease study (Lancet, 2013). Additionally, the proportional contribution of behavioural, or 'lifestyle', factors, compared to genetic predisposition, social circumstances, environmental exposure or healthcare are shown in figure 1, below. Thus, lifestyle factors make up the greatest proportion explaining 40% of premature deaths. However, that is not the whole story with wider determinants, including social circumstances and environmental exposure, also accounting for 20%.

3.11 Interventions to increase life expectancy and reduce health inequality should recognise the difference between equity and equality. Using smoking cessation services as an example, equality is offering a service to all residents of Nottingham city. Equity is tailoring those services to promote access by those with greatest need, including offering more smoking cessation sessions in areas of deprivation and/or providing resources in different languages and formats.

[6] WHO definition of DALY: One DALY can be thought of as one lost year of "healthy" life. The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability

Figure 4: Proportional contribution to premature death. Source: McGinnis et al, in PHE (2014)[7]



4. A Life Course Approach to Reducing Health Inequalities

A range of evidence-based interventions are implemented to tackle inequalities across the city. The following highlights some of the current work using the Marmot framework.

4.1 Give every child the best start in life

4.1.1 **Health inequalities and children's susceptibility**

Health inequalities are responsible for considerable levels of reduced length and quality of life in the United Kingdom. Children are amongst the most vulnerable sections of society. As such, they are greatly affected by the outcomes of any social and economic deterioration surrounding them. These inequalities mean poorer health, reduced quality of life and an overall shorter life expectancy for many. Children are susceptible throughout their life course; from before birth and all the way through their crucial developmental, preschool and school years.

4.1.2 **Importance of early life and development**

There is mounting evidence that shows the benefits and cost effectiveness of focusing on the development and health of infants and children. The vital importance of early life, both in its own right and for promoting future life chances is evident. Children's early physical and emotional development will eventually help determine educational and social progress, employment prospects and physical, social and

[7] PHE (2014) From evidence into action: opportunities to protect and improve the nation's health.

mental health outcomes. The best possible health underpins a child's or young person's ability to flourish, stay safe and achieve as they grow up; and lifestyles and habits established during childhood, influence a person's health throughout their life. The need to ensure all children within Nottingham get the support they need to obtain the best start in life is clear.

More than a quarter of the population of Nottingham is under the age of twenty. There are an estimated 20,000 infants aged 0-4 years and 57,200 children and young people aged 5-19 years resident in the City. The number of births has risen considerably in recent years and is likely to continue to do so. The projected population (age 0-19 years) in 2020 is 78,500. In 2011, 30.3% of births were to mothers born outside of the UK, more than double the percentage in 2001 (14.5%). 44% of school children are from a black or minority ethnic group.

4.1.3 **Deprivation and the wider determinants of child health**

Deprivation strongly influences children's health outcomes throughout all aspects of their development. Poor maternal health and lifestyle choices, premature labour, low birth weight and social / physical developmental problems are strongly associated with higher levels of poverty and worse health outcomes. Successful early emotional, physical and social developments are essential to enhance a child's future ability to form positive relationships, improve their educational attainment and achieve good health. Research shows, if children fall behind in these aspects of development during their first year they will continue to do so throughout the rest of their preschool and school education.

Nottingham's level of child poverty is worse than the England average with almost 19,000 (35.2%) children aged less than 16 years living in poverty. Nottingham's children fare worse on a range of wider determinants of health than children in England as a whole.

Deprivation also negatively impacts on a child's health through: their parent's age, level of education, whether they are unemployed and in good health, the environment they live in, housing quality, choice of nursery/schools, opportunities for social interaction and the quality of services accessed such as transport, leisure, libraries, shops, health and social care.

4.1.4 **Early childhood and education**

The foundations of a healthy and fulfilled adult life are laid in childhood and adolescence. For example, up to 79 per cent of obese adolescents remain obese in adulthood, and adolescents who binge drink are 50 per cent more likely to be dependent on alcohol or misusing other substances when they reach the age of 30. Failure to meet the health needs of children and young people would be costly in the long term; in both health and economic terms.

Health is crucially linked with education. Good health and emotional wellbeing are associated with improved attendance and attainment at school, which in turn lead to improved employment opportunities. An evidence-based approach using prevention and early intervention would reduce costs to society and to health, education and

wider children's services in the long term. The Healthy Child Programme (HCP) sets out the good practice framework for prevention and early intervention services for children and young people to promote optimal health and wellbeing.

4.1.5 **Reducing Health inequalities**

Reducing health inequalities and improving health and social outcomes for children are not easy to address. The evidence clearly shows that any one agency on its own will not have sufficient impact to guarantee a reduction in the gap currently observed between populations. The examples of current services and strategies within this paper specifically focusing on reducing inequalities illustrate that actions need to be executed in partnership with all agencies involved in the wider causes and outcomes of child health inequalities.

This requires a high level strategic understanding and commitment from everyone to secure a coordinated approach. Public Health will continue to support services and strategies by persuading and influencing a wide range of partner agencies to make certain the reduction in child health inequalities is high on everyone's agenda.

'*Reducing health inequalities, improving health and social outcomes for children and young people in Nottingham City is everyone's business.'*

5. Create Fair Employment and Good Work for All

"The social conditions in which people live and work can help create or destroy their health. Lack of income, inappropriate housing, unsafe workplaces and lack of access to health care systems are some of the social determinants of health leading to inequalities"(WHO, 2004)

5.1 Being in employment is associated with better health whilst being unemployed contributes to poor health. There are strong links between unemployment and poorer physical and mental health resulting in an increased use of medication, health and care services including higher hospital admission rates.

5.2 The nature of employment can reinforce or minimise health inequalities. 'Good jobs', that is jobs that pay fairly, offer opportunities for development, policies that enable work/life balance and a range of support services, including occupational health, are more likely to have 'healthy' employees who are able to stay in work even if they experience ill-health.

5.3 The local Fit for Work programme aims to support 1100 people, over 3 years, to remain in work or begin working. The programme has been particularly successful in supporting citizens who experience mental ill-health to return to work following sickness absence. Supporting citizens who are long-term claimants of Employment Support Allowance (ESA) to return to work has been more challenging but the numbers of citizens finding employment is on the increase.

5.4 Employers have a valuable role to play in promoting good physical and mental health including stress management. A survey of the support for employees offered by the organisations represented on the Health and Wellbeing board has been undertaken with the aim of encouraging all organisations to develop as exemplar employers with specific regard to mental health.

6. Create and Develop Healthy and Sustainable Places and Communities

Nottingham City has an excellent reputation for innovative sustainable development and health through the work of the Nottingham Health Action Team and respective action groups.

6.1 'Food' - The Food Health and Environment action group developed the Food Initiatives Group, and commissioned the Nottingham Food Health and Environment Strategy with a small grants fund to target scarce resources at supporting people on low income, in Nottingham's communities, to procure and consume healthy sustainable food at low cost and supported Nottingham University Hospitals Trust in achieving Gold Food for Life status.

The Food for Life Partnership has been commissioned to support a whole school approach to food. This is improving access to healthy and nutritious foods in 40 schools, in areas of disadvantage in Nottingham, which is helping to transform the food culture and tackle diet inequalities across the population.

6.2 'Transport' - The Transport and Health Initiatives Group developed the Ridewise "cycling with confidence" service which provides the Cycling for Health Service[8].

6.3 'Warmth' - The Affordable Warmth Action Group developed the Healthy Housing Referral Service[9] and supported the eradication of fuel poverty by developing systems for reducing housing running costs and increasing personal finance for fuel payments.

Energy efficiency measures and renewable energy installation are targeted towards the homes of vulnerable people.

6.4 'Air quality' - Improving local air quality and reducing our impact on climate change by reducing carbon equivalent emissions across the partnership.

6.5 Contributing to a reduction in avoidable injuries, accidents and falls and improving security in the homes of vulnerable people.

[8] http://www.ridewise.org.uk/ride/index.php

[9] http://www.nottenergy.com/projects/domestic/greater_nottingham_healthy_housing_service/.

7. Strengthen the role and impact of ill-health prevention

7.1 The city council commissions a range of services to enable adults to access behaviour change support to reduce lifestyle risk factors for long term conditions such as cardiovascular disease and cancer. These services include the New Leaf Stop Smoking Service and the Healthy Change Lifestyle Referral hub which supports citizens to set goals to improve their health and supports their referral into other physical activity, healthy eating, weight management and other commissioned services and opportunities using a client centred tailored approach.

7.2 Each of the public health commissioned services has a service specification which sets out the requirements of the services. The aim is that these services are accessed by citizens who are most at risk of dying early from long term conditions or who have a higher prevalence of the given risk factor, e.g. smoking, thus the principle of proportionate universalism is reflected in the service specification[10].

This is achieved through the inclusion of targeted, service level targets. For example not just the proportion of smokers who quit smoking but additional proportional 'smoking quitter' targets for 'at risk groups' such as people with mental health problems, pregnant women and people from routine and manual groups.

8. **Next Steps**

8.1 Use data and information, including the JSNA, to inform commissioning that reduces health inequality. For example, data suggests that citizens living in more deprived areas of Nottingham city are less likely to access sexual health services. This understanding has informed the new, integrated sexual health service specification for 2016 onwards.

8.2 Work in partnership with the CCG to commission services that reduce health inequality through effective targeting of service provision to those with greatest need. For example, recently commissioned mental health training targets frontline staff working with the most disadvantaged who are more likely to experience mental ill-health.

8.3 Monitor and evaluate service use to inform local action to reduce health inequality. For example, a planned health equity audit of breast cancer screening will aim to identify variation in uptake of screening.

8.4 Support citizens who may be adversely affected by budget cuts mitigating, where possible, widening health inequality[11].

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[10] The Marmot Review identifies that *"Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism."*

[11] Colin Monkton's work on mitigating the combined impacts of budget cuts

8.5 Ensure health inequalities are specifically considered in the refresh of the Health and Wellbeing strategy.

9. List of attached information

None

10. Background papers, other than published works or those disclosing exempt or confidential information

None

11. Published documents referred to in compiling this report

- Department of Health (2015) The Healthy Child Programme. https://www.gov.uk/government/publications/healthy-child-programme-pregnancy-and-the-first-5-years-of-life
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- World Health Organisation (2015) Glossary of Terms http://www.who.int/hia/about/glos/en/index1.html

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