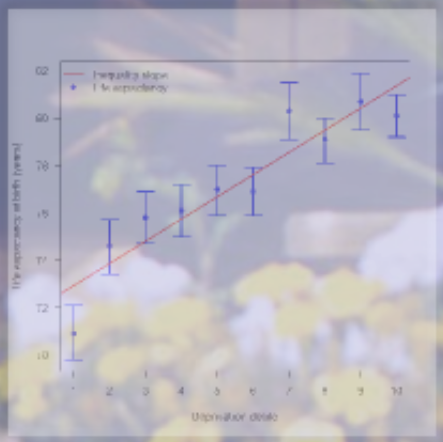
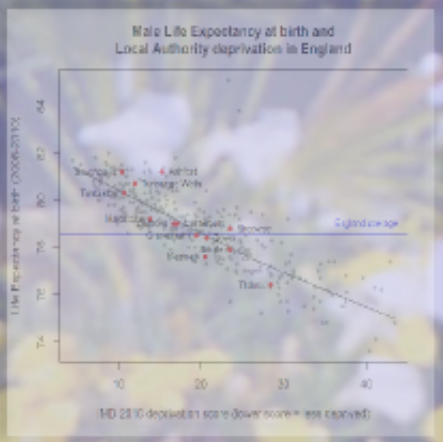
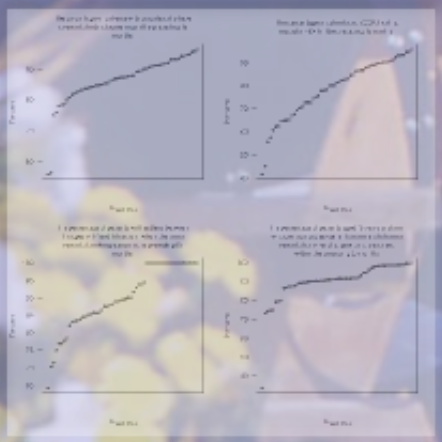
Health Inequalities Review

Prepared by a Task Group of the Health and Adult Social Care Overview and Scrutiny Committee

April 2014







Medway Council

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1. FOREWORD

1.1. On behalf of the Health and Adult Social Care Overview and Scrutiny Committee the Task Group is pleased to present the Health Inequalities scrutiny review, with its associated recommendations for Medway Council's Cabinet. The particular focus of this review was Health Inequalities across Medway wards and how to direct investment where it is most needed.

1.2. Reducing Health Inequalities is one of the five strategic themes in the Joint Health and Wellbeing Strategy for Medway 2012 – 2017. Within Medway the difference in life expectancy between the ten per cent most and least deprived in the population is 9.4 years for men and four years for women. The Strategy highlights the moral imperative to tackle health inequalities as well as the good business argument to do so. Taking action through tackling the wider determinants of health, lifestyle factors and improved health and social care to reduce health inequalities will result in reduced costs for the health and social care system.

1.3. Ambitions in the Joint Health and Wellbeing Strategy are to continue to improve our understanding of who experiences health inequality and to be able to tackle it effectively. This Task Group is recommending a set of principles which it hopes will assist the Council, other system leaders and partner organisations to ensure that health impact is assessed where appropriate and that where provision is available to all, resources and effort are being directed according to need to tackle health inequalities.

1.4. The Task Group is also recommending a range of actions to embed an understanding of health inequalities in Medway, achieve buy-in to the commitment in the Joint HWB Strategy to reducing health inequalities and to ensure advice is available on the range of mechanisms, which can have effective impact in this area. The Task Group has taken evidence which shows that action is already underway across a range of services to deliver this approach. For example NHS Health Checks, Action For Families and work underway in the Early Years Service.

1.5. The Task Group hopes these recommendations will deliver an increase in the pace with which we can reduce health inequalities and improve the lives of Medway residents. The Task Group hopes that this review will help to inform the work on the Health and Wellbeing Board's health inequalities stream.

1.6. We would like to place on record our thanks to all those who participated in the review.

Cllr Wildey (Chairman)

Councillor Adrian Gulvin

Councillor Wendy Purdy

Councillor Julie Shaw

Councillor Diana Smith

2. EXECUTIVE SUMMARY

2.1. At a meeting of Business Support Overview and Scrutiny Committee on 3 April 2013 the programme of in-depth scrutiny reviews was agreed.

2.2. The terms of reference, as set out below, were agreed by the Task Group at its first meeting along with the scoping of the review.

Terms of reference

2.3. The Task Group agreed the following terms of reference for the review:

- To review and understand health inequalities across Medway wards
- To consider how to direct investment where it is most needed, including consideration of the application of proportionate universalism[1] as a concept
- To review two areas of service delivery to illustrate the key issues, for example smoking cessation and primary care
- To recommend a set of principles to assist the Council and partners to direct investment where it is most needed in terms of tackling health inequalities

Conduct of work

2.4. Prior to undertaking any evidence gathering the Task Group received a comprehensive briefing from the Director of Public Health and the Senior Public Health Intelligence Manager on the topic. Details of this briefing can be found in chapter 6 of this review.

2.5. A series of meetings then took place with a cross section of service managers working for the Council and key stakeholders, to establish successful standards of working across Medway. This included speaking to officers working in Early Years, Housing, Planning, Leisure, Public Health and Medway Action for Families. This was supported by some additional written submissions and desktop research. Evidence was also taken from colleagues in the NHS, in particular NHS Kent and Medway

[1] Extract from Marmot Review Report:
("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")

Local Area Team (the local arm of NHS England), the NHS Medway Clinical Commissioning Group and Medway Community Healthcare.

2.6. A summary of the evidence given can be found in Appendix 3 to this review.

2.7. A Diversity Impact Assessment considering the recommendations is attached as Appendix 1.

2.8. The review was supported by:

Dr Alison Barnett, Director of Public Health
Dr David Whiting, Senior Public Health Intelligence Manager
Rosie Gunstone, Democratic Services Officer
Rachael Horner, Health Inequalities Manager

Outcomes of the review

2.9 The following summarises the main findings of the review under a number of theme headings which lead to a set of three principles:

Wider determinants

In order to take forward its concern in relation to minimising the impact of wider determinants on health inequalities the Task Group is recommending some targeted work with landlords, residents and partners to ensure minimum legal housing standards are maintained, along with robust enforcement action being taken where they are not. A further recommendation relates to the potential for Public Health to work with Planning in the development of the Medway Local Plan and to work more closely with Housing and Licensing.

Access to primary care

In order to address variation in practice in local primary care a recommendation is put forward for NHS England (Kent and Medway Local Area Team) and NHS Medway CCG to investigate inequity in access and outcomes at GP practices in Medway and report back to the Health and Wellbeing Board on plans to address this issue.

Alcohol, smoking and workplace health

The Task Group's proposals in relation to alcohol, smoking and workplace health relate to the Council's leadership role as one of the largest employers in Medway. The proposals recommend developing good practice around workforce health

issues and suggest the expansion of work with local businesses in this regard within the framework of the Public Health Department's 'A Better Medway' services.

Engagement and outreach

In the light of a number of examples of barriers to people engaging with services, causing inequalities, the Task Group is proposing a strand within the Health and Wellbeing Board engagement plan relating to barriers to the uptake of services and that feedback be used to target further work to address health inequalities across Medway.

Examples of proportionate universalism

In the light of good practice which came forward as part of the evidence on this review in relation to examples of proportionate universalism, the Task Group is keen for Public Health to explore the development of a framework to enable the application of proportionate universalism approaches in a structured way in the planning and delivery of all services.

Evaluation and review to identify and address gaps

The Task Group, in an attempt to address gaps in services, has put forward a suggestion that the Health and Wellbeing Board identify where health equity audits may be of assistance in addressing health inequalities.

Health impact assessment

The Task Group is suggesting the Director of Regeneration, Community and Culture and Director of Public Health should develop a protocol to ensure that sufficient attention if paid to maximising opportunities to address health inequalities at an early point in the planning of local services and service redesign. This could potentially use a health impact assessment tool.

Principles to direct investment

The Task Group is recommending the adoption of three key principles to assist the Council and partners to direct investment to where it is most needed in terms of tackling health inequalities in Medway:

Principle 1: Actively seek ways of working in partnership across teams and agencies to tackle health inequalities and direct resources

Principle 2: Assess the impact of investment decisions on health inequalities before decisions are made

Principle 3: Review and evaluate how equitable services are, e.g. through health equity audit, and adjust service delivery to address any health inequalities found

3. BACKGROUND

Introduction

3.1. At a meeting of Business Support Overview and Scrutiny Committee on 3 April 2013 the programme of in-depth scrutiny reviews was agreed.

3.2. The following text sets out the rationale for the review which was considered at that meeting:

Reason for review

In Medway, in 2006-2010 there was an inequality in life expectancy between the 10% most and least deprived of the population of 9.4 years for men and 4 years for women. Within Medway in the same time period there was a 7-year gap in life expectancy between Gillingham North with an average life expectancy of 74 years and Hempstead and Wigmore with an average life expectancy of 81 years.

National/local context

Nationally, the Marmot Review into Health Inequalities 2010 highlighted the importance of the wider determinants of health in reducing health inequalities. It brought together national and international evidence on what works in health inequalities to make six main policy recommendations. These are focused around; giving every child the best start in life, good education and employment, ensuring a healthy standard of living for all, creating and designing healthy and sustainable places and communities and strengthening the role of ill health prevention. To successfully impact on health inequalities requires action across all the Marmot policy areas and Medway Council and its partners have a key role to play in delivering these recommendations.

The six principles, from the Marmot review, to address the wider determinants and reduce health inequalities are as follows:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention

Medway's Joint Health and Wellbeing Strategy 2012-17 has identified reducing health inequalities as one of its main priority areas and so has also been identified as a significant issue in Medway.

Performance indicators

Long-term national indicators: life expectancy and healthy life expectancy, Short-term indicators would be selected depending on specific issues and actions identified.

Public feedback/interest in issue

Reducing health inequalities was confirmed by stakeholders as one of the key themes for Medway's Joint Health and Wellbeing Strategy 2012-17.

3.3. On 20 August 2013 the Health and Adult Social Care Overview and Scrutiny Committee agreed that a Member task be set up on the basis of 3:1:1. The membership was agreed as follows:

Councillors Wildey, Adrian Gulvin, Purdy, Shaw and Smith.

Terms of reference

3.4. At the first meeting of the Task Group the following terms of reference were agreed:

- To review and understand health inequalities across Medway wards
- To consider how to direct investment where it is most needed including consideration of the application of proportionate universalism* as a concept
- To review two areas of service delivery to highlight the key issues – for example smoking cessation and primary care
- To recommend a set of principles to assist the Council and partners to direct investment where it is most needed in terms of tackling health inequalities

*Extract from Marmot Review Report:

("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")

4. SETTING THE CONTEXT

4.1. Legal framework, Council duties, obligations and accountabilities

4.1.1. The following section sets out a summary of the council's duties to reduce health inequalities. This duty is set out in detail in the Public Health Outcomes Framework 2013-2016 Part 3.

4.1.2. The Health and Social Care Act 2012 provides the legal framework for the council's duties in respect of its public health functions. The council has a duty under section 12 of The Health and Social care Act 2012 to take such steps as it considers appropriate to improve the health of people in its area. In addition, the act places a duty on local authorities to reduce health inequalities in its area through the discharge of The Director of Public Health's duties.

4.1.3. In particular section 31 of The Health and Social Care Act 2012, inserts a new section 73B into the NHS Act 2006, which gives the Secretary of State the power to publish guidance to which the local authority must have regard when exercising its public health functions. The Council must have regard to documents published by the secretary of state, which includes the Department of Health's Public Health Outcomes Framework.

4.1.4. The Public Health Outcomes Framework 2013-2016 focuses on the respective roles of local government, the NHS and their delivery of improved well-being outcomes for the people and communities they serve. The prime purpose of the Public Health Outcomes Framework is to reduce health inequalities in addition to those with Protected Characteristics under The Equality Act 2010. Part 3 of the Public Health Outcomes Framework provides guidance on impact assessments and equalities impact assessment. In addition to the duties under The Health and Social Care Act 2012, the Council also has a general duty under the Equality Act 2010 to take appropriate action to reduce health inequality for those with a protected characteristic.

4.1.5. Consideration of this process is by way of Joint Strategic Needs Assessment and the Council's Joint Health and Well Being Strategy under the Health and Social Care Act 2012.

4.1.6. The Council also has the power under The Local Government Act 2000 and The Localism Act 2011 to do whatever is required to improve the well-being of the inhabitants of its area.

4.2. National and local picture

In the 1960's a long-term study of the health of civil servants -the Whitehall Study- was begun. Whitehall 1 and Whitehall 2 cohort studies found a strong association between grade levels of civil servant employment and mortality rates. Men in the lowest grades had a mortality rate three times higher than that of men in the highest grades. A key cause was noted as cardiovascular disease.

In light of this, the government of the 1970's asked Sir Douglas Black to chair an expert commission to investigate health inequalities. The Black report subsequently published in 1980 found not only that health inequalities existed but that they were fundamentally caused by economic inequalities.

This was followed in 1998 by publication of the Acheson report of the Independent Inquiry into Inequalities in Health. Again, recommendations for action were across the board including for agriculture, housing, transport and others. Relevant recommendations were:

- "[That there] should be a duty of partnership between the NHS Executive and regional government to ensure that effective local partnerships are established between health, local authorities and other agencies and that joint programmes to address health inequalities are in place and monitored.

- [that] as part of health impact assessment, all policies likely to have a direct or indirect effect on health should be evaluated in terms of their impact on health inequalities, and should be formulated in such a way that by favouring the less well off they will, wherever possible, reduce such inequalities." [i]

In 2005, the Commission on Social Determinants of Health was set up by the World Health Organization (WHO) to "marshal the evidence on what can be done to promote health equity, and to foster a global movement to achieve it".[ii] In 2008 it published the report *Closing the Gap in a Generation*. The report made explicit the extent of the impact of non-health determinants of ill health – the wider or "social" determinants of health and these remain the greatest challenge for those wishing to address health inequalities.

The overarching recommendations from this report were:

- To improve daily living conditions
- To tackle the inequitable distribution of power, money and resources
- To measure and understand the problem and assess the impact of action

A primary measure of health inequality is life expectancy at birth. Medway has a slightly lower life expectancy at birth than the national average with 78.2 years for men compared to 78.9 years nationally. Similarly, for women life expectancy at birth is 82.1 years in Medway compared to 82.9 nationally.

However, in Medway the range in years of life expectancy between most and least deprived deciles is 5.1 years for females and 7.5 years for males demonstrating that there are inequalities at work that need addressing[iii].

Overall in the last 50 years (1960-2010) the average life span has increased by around 10 years for a man and 8 years for a woman.[1]

[i] List of Recommendations, Independent Inquiry into Inequalities in Health Report, The Stationary Office, 1998, accessed on internet on 26th February 2014 at: http://www.archive.official-documents.co.uk/document/doh/ih/contents.htm

[ii] CSDH (2008). *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health.* Geneva, World Health Organization

[iii] Public Health England Segmenting life expectancy gaps by cause of death, January 2014, accessed on internet at http://www.lho.org.uk/LHO_Topics/Analytic_Tools/Segment/TheSegmentTool.aspx

[1] Source: http://www.ons.gov.uk/ons/rel/mortality-ageing/mortality-in-england-and-wales/average-life-span/rpt-average-life-span.html [Accessed 2014-03-21]

5. METHODOLOGY

5.1. At the first meeting of the Task Group held on 15 October 2013, Members determined the scope of the review as set out in Appendix 2.

Rationale for the review

The rationale for undertaking the review was on the basis of the fact that reducing health inequalities is a national and local priority and a key theme within Medway's Joint Health and Wellbeing Strategy. Reducing health inequalities leads to increased productivity and a reduction in demand on health and social care services.

Terms of reference

5.2. The Task Group agreed the following terms of reference for the review:

- To review and understand health inequalities across Medway wards
- To consider how to direct investment where it is most needed including consideration of the application of proportionate universalism* as a concept
- To review two areas of service delivery to highlight the key issues –for example smoking cessation and primary care
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*Extract from Marmot Review Report:
("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")

5.3. The Task Group considered and set a number of key lines of enquiry including:

a) an initial briefing for Members
b) to consider taking evidence from experts on health inequalities/proportionate universalism
c) identify any successful approaches to tackling health inequalities across wards in other local authority areas/abroad
d) examine case studies, for example smoking cessation and primary care services

5.4 At the second meeting of the Task Group the Public Health Intelligence Manager set out a briefing on the topic of health inequalities in Medway and the principles of proportionate universalism. The content of that briefing is set out in the next chapter 6 entitled Objective Evidence.

5.5. Overleaf is a table setting out the timeline of the work of the Task Group.

Health Inequalities – across Medway wards

Date	Members in attendance	Other attendees	Purpose
15 October 2013	Councillors Wildey, Adrian Gulvin, Purdy, Shaw and Smith	Dr Alison Barnett, Director of Public Health Dr David Whiting, Senior Public Health Intelligence Manager Rosie Gunstone, Democratic Services Officer	To scope the review and agree terms of reference
13 November 2013	Councillors Adrian Gulvin, Purdy, Shaw and Smith	Dr Alison Barnett, Director of Public Health Dr David Whiting, Senior Public Health Intelligence Manager Rosie Gunstone, Democratic Services Officer	To receive a briefing on the review topic
18 November 2013	Councillor Wildey	Dr David Whiting, Senior Public Health Intelligence Manager Rosie Gunstone, Democratic Services Officer	To receive a briefing on the review topic (as Cllr Wildey had been unable to attend on 13 November 2013)
20 November 2013	Councillors Wildey, Adrian Gulvin, Purdy, Shaw and Smith	Dr Alison Barnett, Director of Public Health Dr David Whiting, Senior Public Health Intelligence Manager Rosie Gunstone, Democratic Services Officer Kerri-Anne Collins, Public Health Julia Thomas, Public Health	(a) to confirm key lines of enquiry and agree suggested questions for witnesses (b) to take evidence from Public Health officers working on the stop smoking campaign and Healthchecks and Chlamydia screening
17 December 2013	Councillors Wildey, Adrian Gulvin, Purdy, Shaw and Smith	Dr Alison Barnett, Director of Public Health Dr David Whiting, Senior Public Health Intelligence Manager Rosie Gunstone, Democratic Services Officer Mark Holmes, Early Years Strategy Manager, Children and Adults Bob Dimond, Head of Sport, Leisure and Tourism, Regeneration, Community and Culture Catherine Smith, Development Policy and Engagement Manager, Regeneration, Community and Culture	To take evidence from selected service managers within the Council in relation to early years work, sport and leisure and planning and development on their perception of proportionate universalism and whether they target resources to specific areas
17 January 2014	Councillors Wildey, Adrian Gulvin, Purdy,Shaw and Smith	Dr David Whiting, Senior Public Health Intelligence Manager Rosie Gunstone, Democratic Services Officer Rachael Horner, Health Inequalities Manager Sam Halter, Health Programme Manager, Medway Community Healthcare Claire Robson, YOT Health Manager Hayley Ince, Specialist Health Visitor Diane Butler, Health Visitor Scott Elliott, Project Manager, Supporting Healthy Weight, Public Health Matt Gough, Housing	To take evidence from Medway Community Healthcare, Housing and Public Health in relation to the review

Date	Members in attendance	Other attendees	Purpose
3 February 2014	Councillors Wildey, Adrian Gulvin, Purdy, Shaw and Smith	Rachael Horner, Health Inequalities Manager Rosie Gunstone, Democratic Services Officer Andy Willetts, Service Manager, Medway Action for Families Felicity Cox, Area Director, NHS Kent and Medway Local Area Team Stephen Ingram, Head of Primary Care, NHS Kent and Medway Local Area Team	To take evidence from the Service Manager, Medway Action for Families, and the representatives from the NHS Kent and Medway Local Area Team particularly in relation to primary care services in Medway
13 February 2014	Councillors Wildey, Adrian Gulvin, Purdy, Shaw and Smith	Dr David Whiting, Senior Public Health Intelligence Manager Rachael Horner, Health Inequalities Manager Julie Keith, Head of Democratic Services Aelish Geldenhuys, Senior Public Health Manager Dr Peter Green, Chief Clinical Officer, NHS Medway Clinical Commissioning Group	To take evidence in relation to alcohol and substance misuse and to find out how NHS Medway CCG are tackling their duty to reduce health inequalities

5.6. In addition the Task Group was given the following documentation as background reading for the review:

- Medway's Joint Health and Wellbeing Strategy http://www.medway.gov.uk/pdf/health%20and%20Well-being%20StrategyFINAL.pdf

- Medway's Health Profile 2013

  http://www.apho.org.uk/resource/item.aspx?RID=127193

- HM Government ' Healthy Lives, Healthy People' – Our Strategy of public health in England https://www.gov.uk/government/publications/healthy-lives-healthy-people-our-strategy-for-public-health-in-england

- If you could do one thing – nine local actions to reduce health inequalities – January 2014 from the British Academy for the humanities and social sciences

  https://www.britac.ac.uk/policy/Health_Inequalities.cfm

Health Inequalities – across Medway wards

- Promoting action on health inequalities – working together to improve the quality of life in West Sussex 2012-2017

  http://www.westsussex.nhs.uk/professionals-health-inequalities

- Reducing the Strength campaign – Suffolk – produced by Suffolk Public Health Team

- Guide to Alcohol for Local Councillors published by Alcohol Concern

  http://www.alcoholconcern.org.uk/media-centre/news/guide-to-alcohol-for-councillors

- Universal and targeted approaches to Health Equity – National Collaborating Centre for Determinants of Health

  http://nccdh.ca/images/uploads/Approaches_EN_Final.pdf

- Fair Society, Healthy Lives (Marmot review) February 2010

  http://www.local.gov.uk/web/guest/health/-/journal_content/56/10180/3510094/ARTICLE

- Equality and Access Group Annual Report
  http://www.medway.gov.uk/workandjobs/equalopportunities.aspx

6. OBJECTIVE EVIDENCE

On 15 October 2013 the Task Group was given a briefing on the national picture in relation to health inequalities and the Marmot review by the Director of Public Health and the Senior Public Health Intelligence Manager.

On 13 November 2013 the Task Group was then given a more detailed briefing by the same officers on the local picture with regards to health inequalities and the principle of proportionate universalism. Building on the questions raised during the evidence sessions additional desktop research was conducted. The content of the briefings and the additional desktop research are summarised below.

National picture

What are health inequalities?

Health inequalities can be defined as:

> *Differences in health status or in the distribution of health determinants between different population groups.*

Typically the focus is on reducing health inequalities, which are preventable or unfair. Differences in life expectancy and healthy life expectancy between different groups are key indicators of health inequalities.

The preventable factor highlighted nationally as being most important in reducing health inequalities is socio-economic status. The best way of measuring socio-economic status in the UK is to use the “index of multiple deprivation.”

What is health inequity and how does it relate to health inequality?

Health inequality is a measure of differences in health outcomes. Health equity relates to the fairness of the difference. A simple way of illustrating the difference is to consider a group of 20 people and 20 tablets of aspirin. If all 20 people are given one aspirin, then the aspirin has been distributed equally (there is no inequality). However, if half of the group have a headache and all of the aspirin is given to them, then the aspirin has been distributed equitably because it has been given to those who need it (there is no inequity). Similarly, with access to GPs, for example, we would expect that those who are sick and need to see a GP would see a GP, while those who are healthy and do not need to see a GP will not. This would mean that use of a GP is equitable, not equal. Generally we want to see equal outcomes (e.g. life expectancy, or quality of life) and to achieve this requires equitable access to and use of services.

Index of Multiple Deprivation (IMD)

The index of multiple deprivation (IMD) combines the following factors to create a deprivation score for an area.

- income deprivation;
- employment deprivation;
- health deprivation and disability;
- education deprivation;
- crime deprivation;
- barriers to housing and services deprivation;
- and living environment deprivation

The index of multiple deprivation is often divided by quintiles into five groups of equal size, or by deciles into 10 groups of equal size, and the health outcomes in these different groups are compared.

Inequalities in life expectancy

Using the index of multiple deprivation it is possible to calculate the deprivation score for each local authority and consider this with respect to the life expectancy of each local authority. In the figure below every dot represents a local authority. There is a clear gradient, with less deprived local authorities (on the left) having longer life expectancies. This is seen not only across England, but also within Kent and Medway. For example, Sevenoaks is less deprived than Medway and the average life expectancy is almost four years higher.

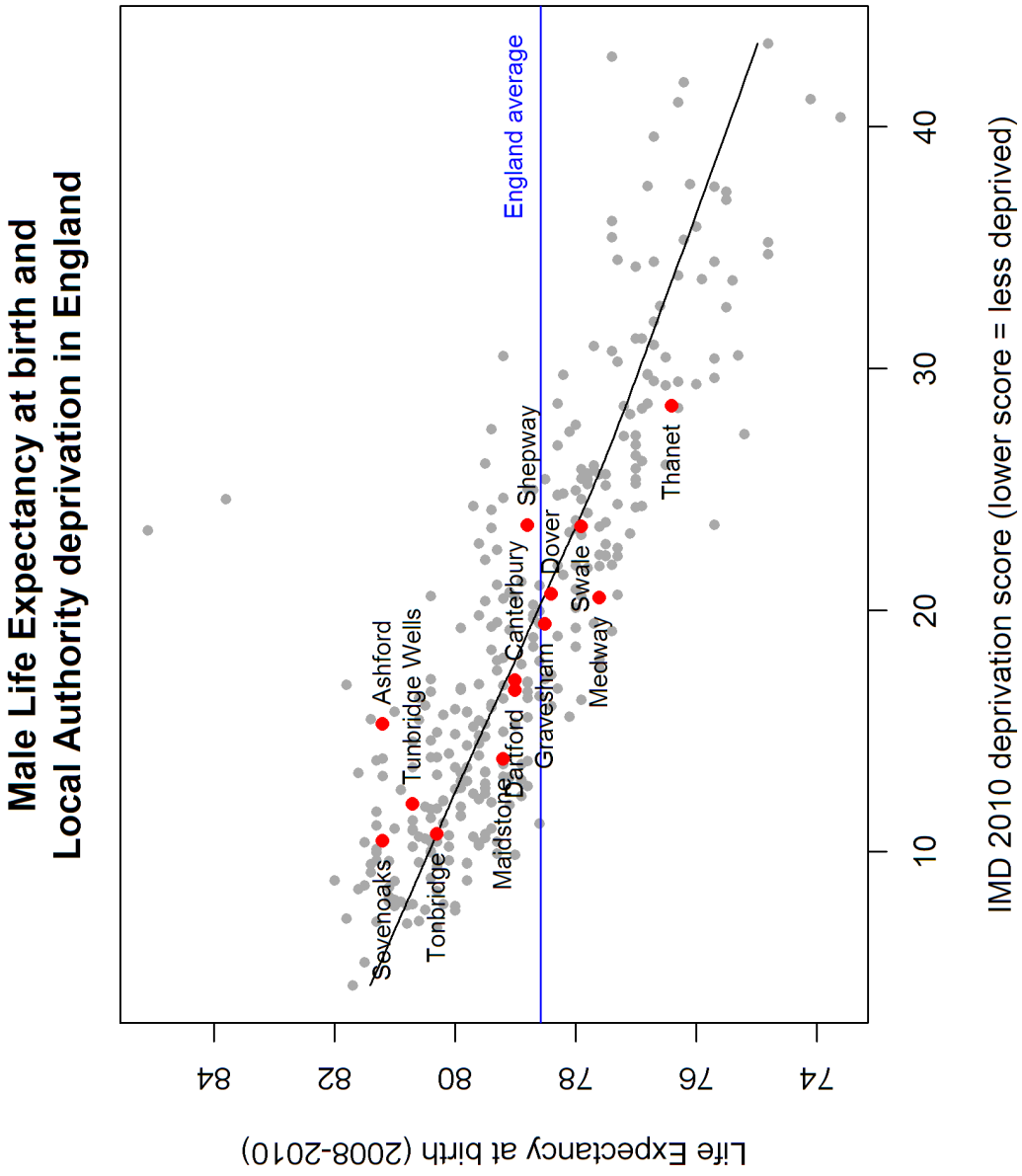

Figure 1 Local authority deprivation and life expectancy

The Policy Rainbow

In 1991 Dalgren and Whitehead[1] developed the 'Policy Rainbow', which describes the layers of influence on an individual's potential for health.

Whitehead further described these factors as those that are:

1) fixed (core non-modifiable factors), such as age, sex and genetics; and
2) a set of potentially modifiable factors expressed as a series of layers of influence including:
   2a) personal lifestyle

   2b) the physical and social environment and

   2c) wider socio-economic, cultural and environment conditions

This policy rainbow demonstrates that there are factors operating at different levels that influence the health of an individual, and that to improve health there has to be a partnership between the individual and society: individuals make personal choices, but societal factors influence the range of choices available and the ease with which healthy choices can be made.

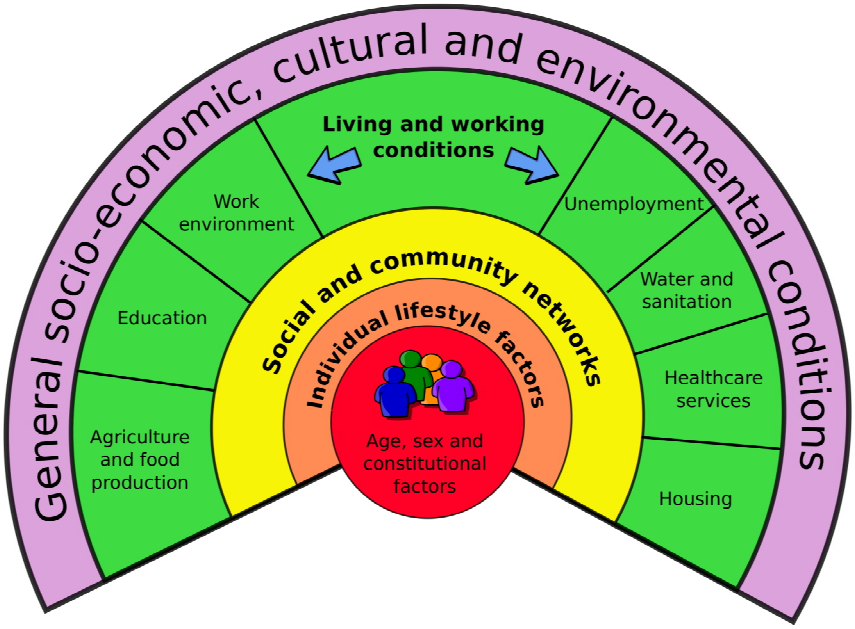

Figure 2 Policy Rainbow

[1] Dahlgren G, Whitehead M 1991. *Policies and Strategies to Promote Social Equity in Health.* Stockholm, Institute of Futures Studies

Marmot objectives and proportionate universalism

In 2010 the report 'Fair Society, Healthy Lives' led by Sir Michael Marmot, was published. This report provided more evidence for the role of social determinants in health inequalities in the UK and included six principles to address these determinants and to reduce health inequalities.

1) Give every child the best start in life
2) Enable all children, young people and adults to maximise their capabilities and have control over their lives
3) Create fair employment and good work for all
4) Ensure a healthy standard of living for all
5) Create and develop healthy and sustainable places and communities
6) Strengthen the role and impact of ill-health prevention

To address health inequalities the report noted 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.*

The term "proportionate universalism" has been difficult for some people to understand and the UCL Institute for Health Equity is now using the term "socially graded". The following figure is designed to demonstrate the concept of proportionate universalism. The first plot (a) shows a typical gradient in health outcome, with outcomes getting worse as deprivation increases. The second plot (b) demonstrates the effect of focusing effort to reduce inequalities only on the most deprived. When successful it raises this end of the curve, but has minimal effect on the rest of the community.

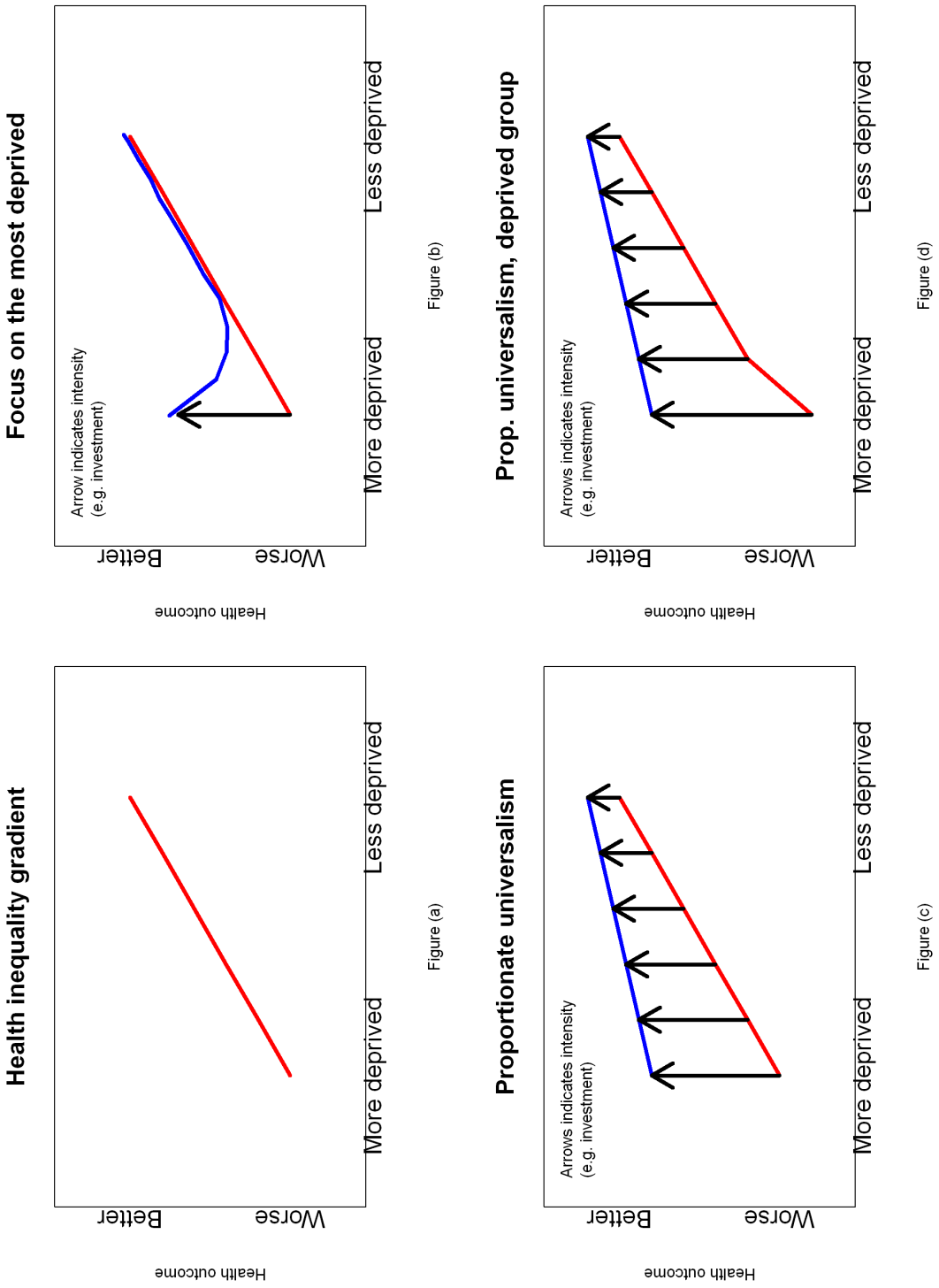

Figure 3 Illustration of proportionate universalism

The third plot (c) demonstrates proportionate universalism. Here effort is applied along the whole gradient, with **a scale and intensity that is proportionate to the level of disadvantage**. In this way the whole of the community benefits, and inequalities are reduced. Plot (d) demonstrates that proportionate universalism is appropriate even if the gradient is not smooth.

The ultimate aim of proportionate universalism is to equalise the ***outcomes***, not the ***inputs***. The type of input needed may be different in different groups.

Examples of proportionate universalism in practice

The Institute of Health Equity provides examples of interventions and programmes classified as being "socially graded"[2]. One example is GP systems of referral to exercise and to other services. In these examples other services (e.g. employment, housing, financial, debt and benefits advice) are placed within GP surgeries where possible. An example is Firefighters in the community, delivered jointly by Fire Services, housing services, social services, NHS services, and energy efficiency improvement schemes. In this example home visits are made to address health and safety and fire safety, including health and safety education on smoking and alcohol links to home fires, and road safety. Referral is also provided to other services and including provision of physical activity services. As a result there is evidence of reduction in fires and accidents in the homes[3].

Medway picture

The following sections show some of the inequalities that are seen in Medway.

Life expectancy by ward

Figure 4 shows that the distribution of life expectancy by ward in Medway has several important features. The first is inequality by geography: wards listed on the left have lower life expectancy than wards on the right. There is also inequality by sex, with women consistently having higher life expectancy than men, with the gap much larger in the wards with the lowest life expectancy. For men 'external causes' (accidents and suicide) have a notable effect, largely because such deaths often occur in young men.

In Medway the range in years of life expectancy between most and least deprived deciles is 5.1 years for females and 7.5 years for males demonstrating that there are inequalities at work that need addressing.[4]

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[2] http://www.instituteofhealthequity.org/report-finder-results?Location=UK&Themes=&Keywords=Socially+Graded

[3] http://www.instituteofhealthequity.org/projects/firefighters-in-the-community

[4] Public Health England Segmenting life expectancy gaps by cause of death, January 2014, access on internet at http://www.lho.org.uk/LHO Topic/Analytic Tools/Segment/The SegmentTool.aspx

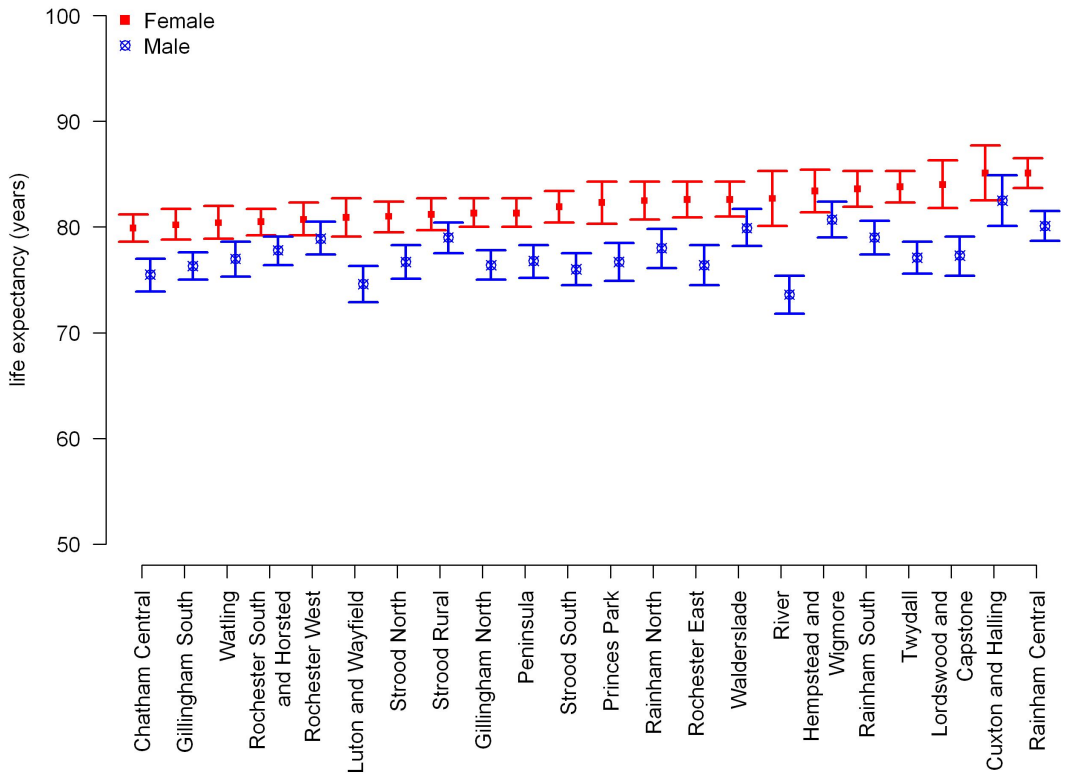


Figure 4 Life expectancy by ward (2008—2012)

Distribution of deprivation within wards

The figure above shows that there is a gradient in life expectancy by ward, and generally the more deprived wards have lower life expectancies. Wards are not, however, completely homogeneous and there is variation in deprivation within wards.

This next figure shows the distribution of deprivation within wards. The wards are sorted with the most deprived ward overall bottom-left, and the least deprived ward top-right. Within each ward the index of multiple deprivation is divided by quintiles and this shows that there are pockets of deprivation within many of the wards in Medway. The most deprived 20% bar is indicated by 1 along the bottom of each panel, and the least deprived 20% bar is indicated by the number 5.

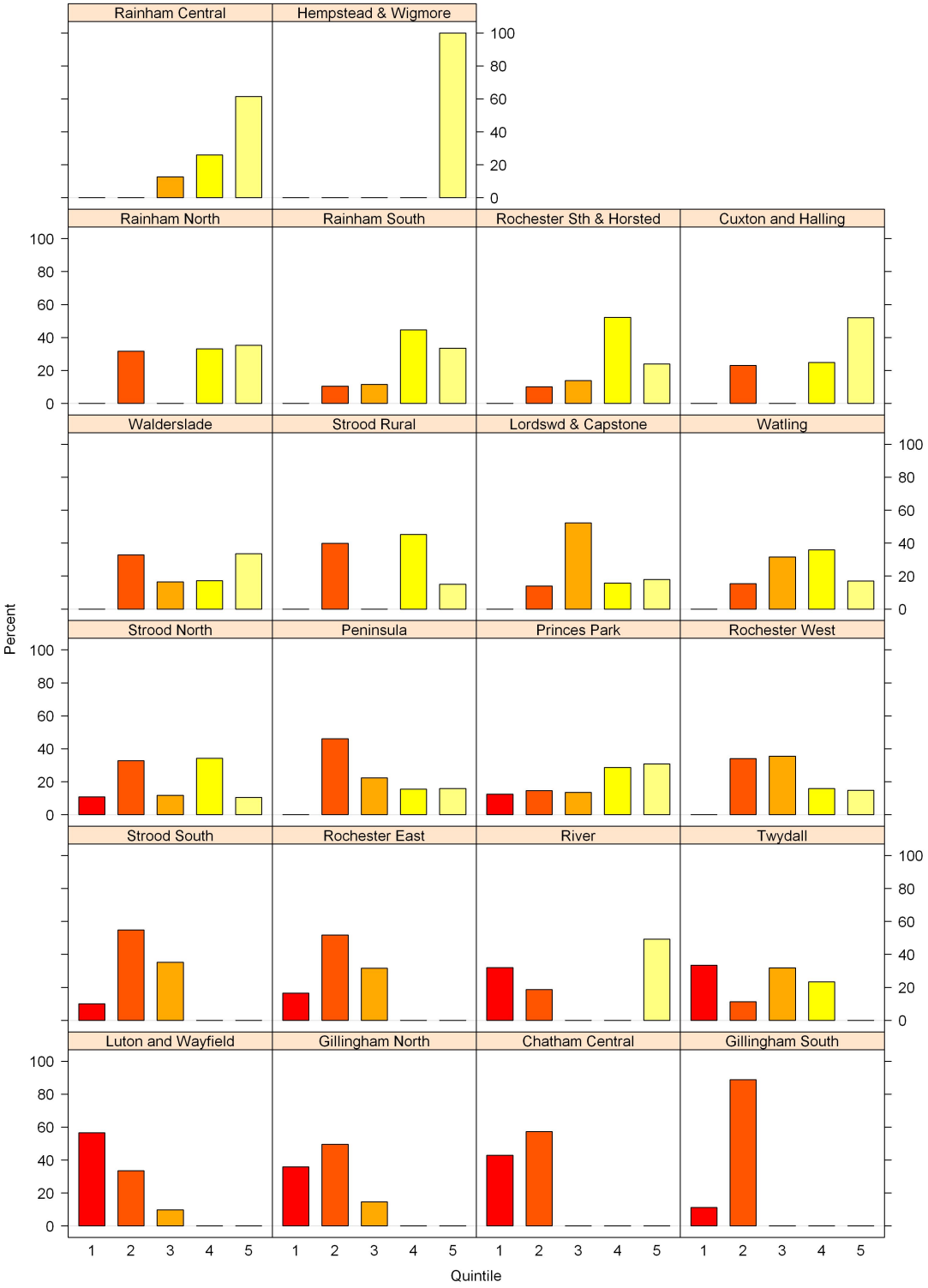


Figure 5 Distribution of the number of people by deprivation group in wards in Medway (IMD 2010)

Life expectancy by deprivation

Instead of dividing the data by geographical areas (wards) life expectancy can be calculated for divisions of deprivation, dividing deprivation values by deciles into 10 groups of 10% (bottom 10%, up to top 10%). Plotting life expectancy against deprivation group we see a strong gradient, with much lower life expectancy in those in the most deprived 10%. This gradient shows that inequalities are not confined to “the poorest of the poor” but through the entire range of deprivation values in Medway.

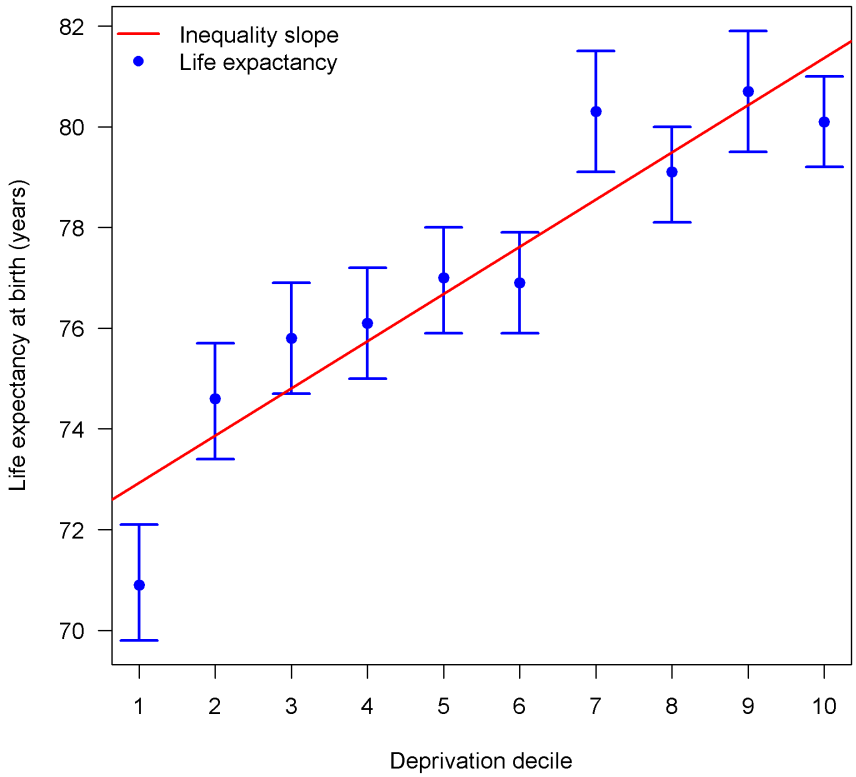


Figure 6 Life expectancy in men by deprivation group (Medway PCT, 2006—2010)

Inequalities in deaths from heart disease

As well as gradients in life expectancy there are gradients in cause-specific mortality rates. The next figure shows death rates from heart disease (cardiovascular disease) in Medway. Again deprivation is on the x-axis, along the bottom, with the most deprived 20% on the left, and the least deprived 20% on the right.

There is a clear gradient, with the most deprived 20% having the highest mortality rate, about double that in the least deprived 20%. The gradient

shows that it is not only important to consider the most deprived, it is also important to address the inequality along the gradient.

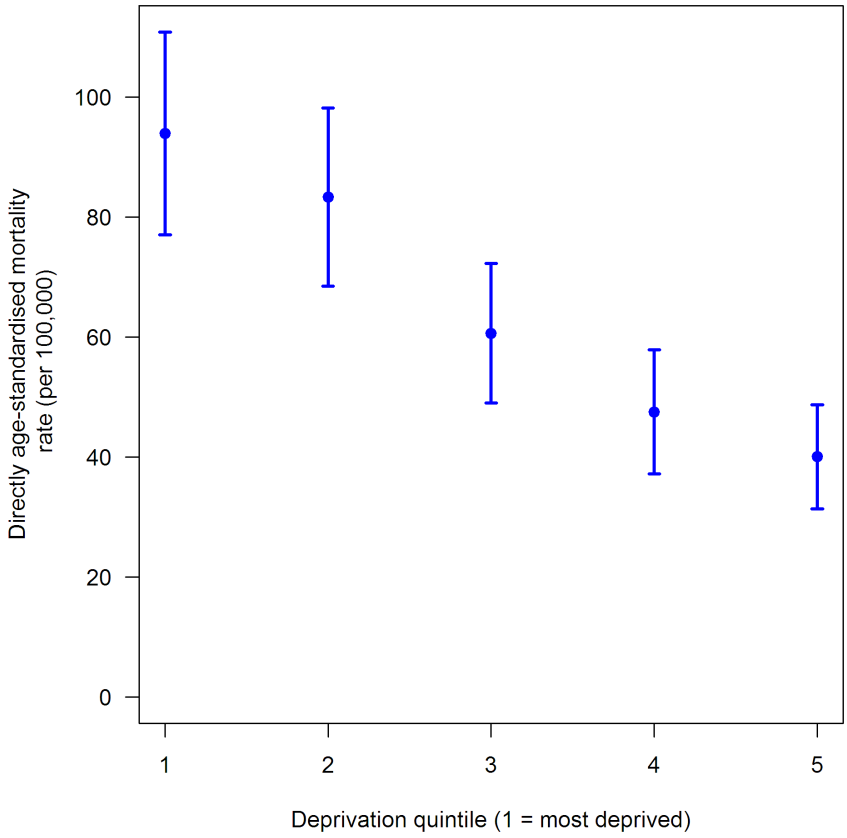
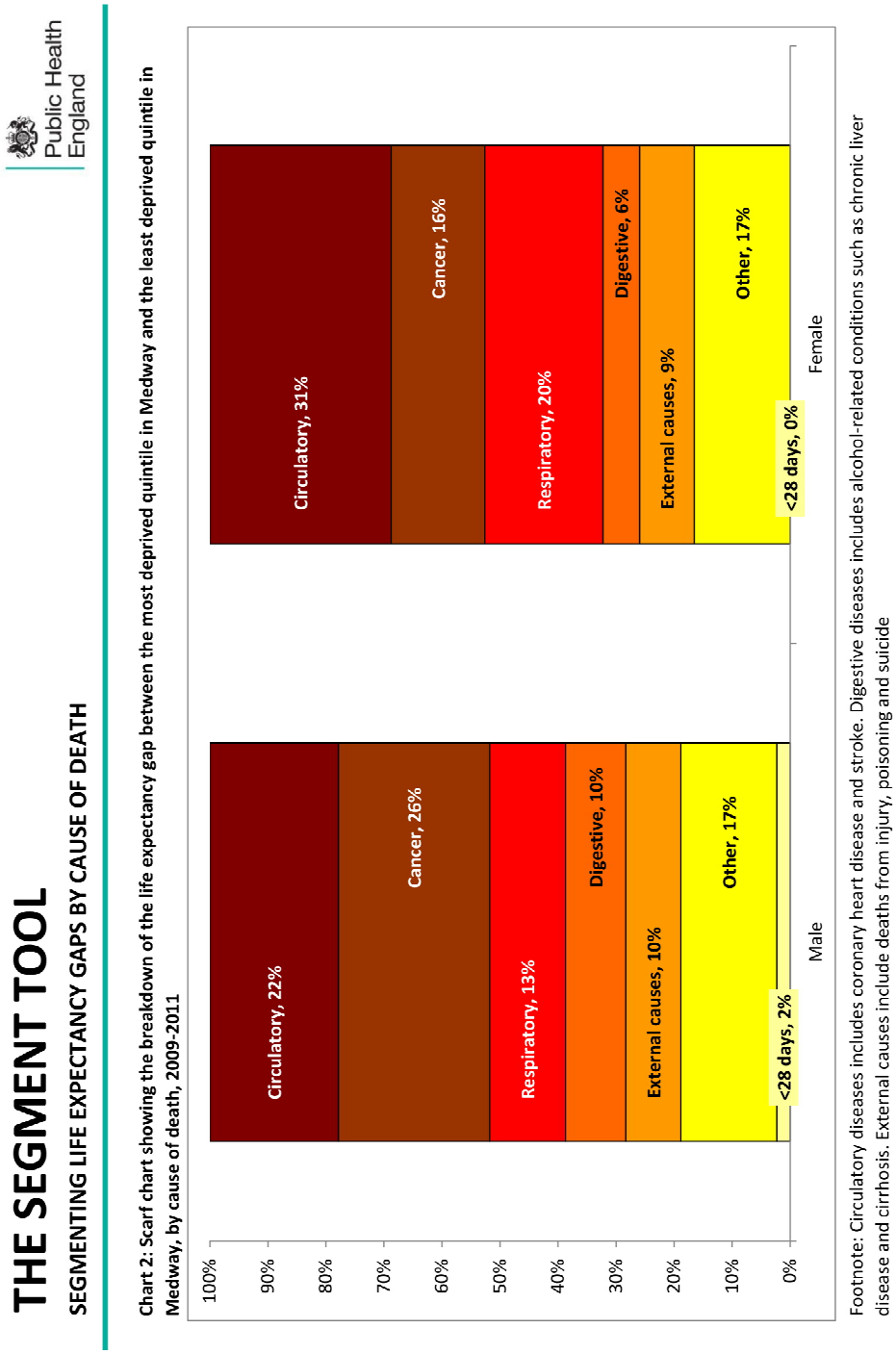


Figure 7 Cardio-vascular disease mortality rate in men in Medway UA by deprivation group (2010—2012)

Main causes of death that lead to inequalities in life expectancy

The main causes of death that are responsible for the difference in life expectancy between the least and most deprived people in Medway are shown in the next figure. The main causes are circulatory (e.g. heart disease), cancer and respiratory disease. If outcomes for these conditions were improved in the more deprived people in Medway their life expectancy would be similar to that in the least deprived group. Cancer is particularly important for men, and circulatory disease and respiratory disease are particularly important for women. These immediate (proximate) causes will be related to so-called lifestyle factors, such as smoking, diet or physical activity.



Source: London Knowledge and Intelligence Team, Public Health England[5]

Figure 8 Life expectancy gap in Medway by cause of death

[5] http://www.lho.org.uk/LHO_Topics/Analytic_Tools/Segment/TheSegmentTool.aspx

Variation in outcomes in GP practices

Inequalities in the uptake or delivery of GP services are likely to result in inequalities in health outcomes. Many services relating primarily to long-term conditions that are delivered by GPs are monitored through the Quality and Outcomes Framework (QOF). Variations are seen in outcomes in GP practices across the country, and in Medway. The figure below shows the variation in GP performance in Medway for four measures from the quality and outcomes framework using the most recent published data (for the year 2012/13). Each dot represents a GP practice. Note that the plots do not start at zero on the vertical axis as they have been drawn to accentuate and highlight differences.

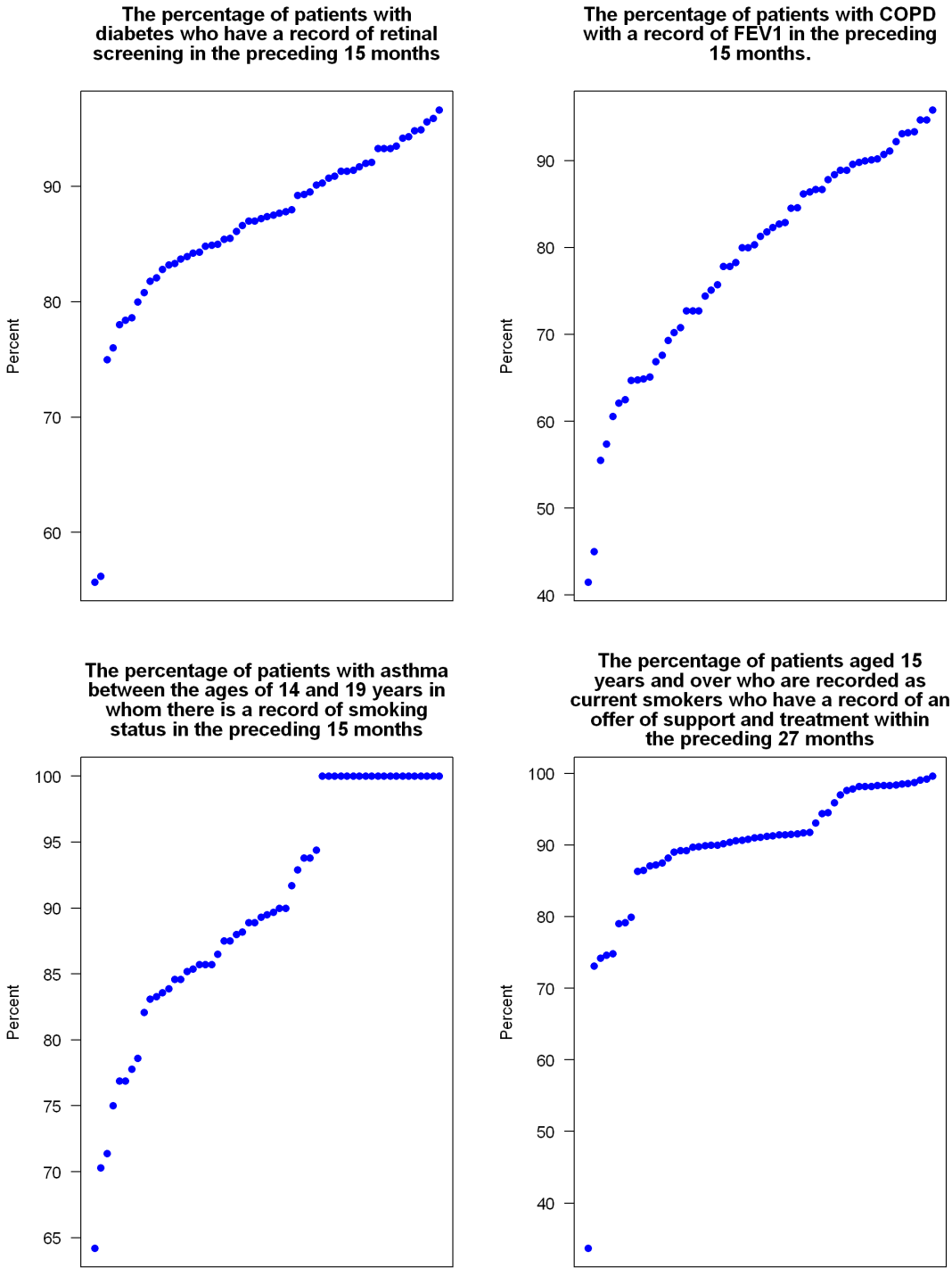


Figure 9 Examples of inequalities in quality and outcomes framework indicators in Medway GP practices (each dot is a practice).
Note that the y-axis is different in each plot to emphasise the inequalities

Addressing health inequalities in Medway

Health equity audit (HEA) is an approach that has been used since the early 1990s in public health to actively seek inequities in the use of health-related services. Broadly health equity audits involve three steps:

1) Systematically reviewing inequities in the causes of ill health, and in access to effective services and their outcomes, for a defined population
2) Ensuring that action required is agreed and incorporated into local plans, services and practice
3) Evaluating the impact of the actions on reducing inequity

Medway Public Health Directorate has performed a number of health equity audits and two examples were given to the task group, one for NHS Health Checks and the other for the Stop Smoking Service.

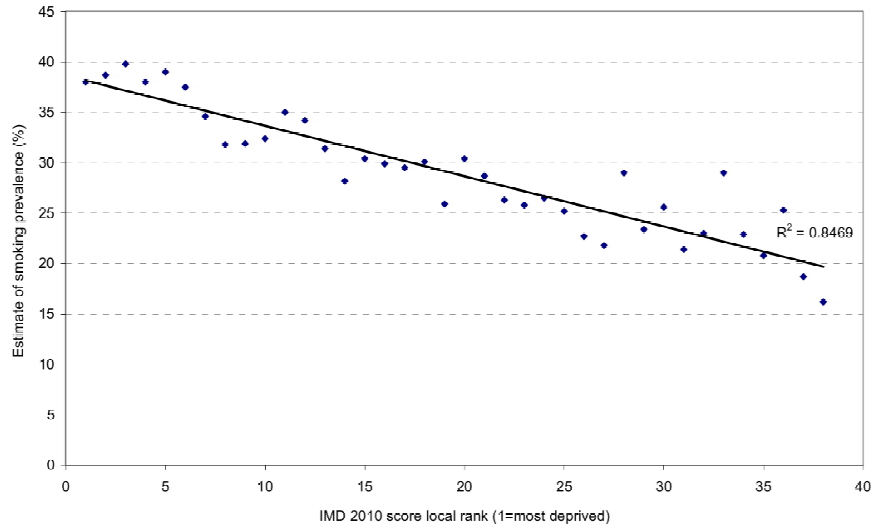
NHS Health Checks is a national programme that is available people who have not been identified as having cardiovascular disorders or diabetes and aged 40-74 over a 5 year period. The health equity audit identified sub-groups of the population who were less likely than others to use the service: those from certain wards, men, those aged 40-54 years and those who were from a black or minority ethnic group. As a result of this health equity audit an out-reach service was established that had a payment structure that rewarded the service provider more for performing checks on people from these under-represented groups. As a result the number of people from these groups who have had a health check has increased.

The Stop Smoking Service has run for many years in Medway and according to the National Institute for Health and Care Excellence (NICE) return-on-investment tool the savings are now greater than the costs of running the service. A health equity audit was performed in 2009 and the service was adjusted, for example by hiring staff who speak specific languages, to ensure that use of the service matched the need in the population (see Figure 10). A second health equity audit is currently underway.

As well as the legal duties the council has to address health inequalities, there are good economic reasons to do so, which are illustrated well by smoking. It is estimated that in Medway the total annual cost to society of smoking is £79.5 million. The majority of this (£64.4 million) is made up of lost output due to early death and lost productivity, e.g. from smoking-related sick days, and other factors[6], and the remaining £15.6 million is NHS costs.

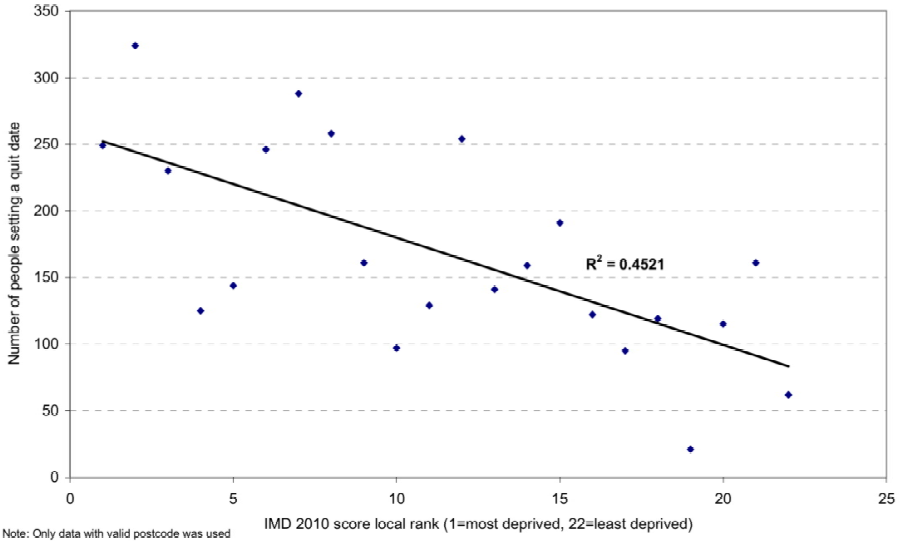
[6] http://ash.org.uk/localtoolkit/docs/Reckoner.xls

Scatterplot of IMD 2010 rank versus estimate of smoking prevalence 2003-05 by MSOA



Sources: Deprivation scores for MSOAs calculated from unweighted averages of LLSOA scores from DCLG IMD 2010; Smoking prevalence from ONS, 2007.

Scatterplot of number of people setting a quit date versus IMD 2010 rank at ward level



Note: Only data with valid postcode was used

Sources: Deprivation rank calculated at ward level from DCLG IMD 2010; People setting quit date from S3 Manager, Medway Stop Smoking Service

Figure 10 Plots showing the distribution of smoking prevalence and the distribution of the number of people setting a quit date by deprivation. These plots show that the service is equitable with respect to deprivation.

7. CONCLUSION AND RECOMMENDATIONS

7.1. The evidence collected during the review (see Appendix 3) can be summarised in a number of key themes, leading to a set of three principles.

Wider determinants

The Health Visitors and the Medway Action for Families service spoke about competing priorities in people's lives such that engaging with health services is not seen as a priority in comparison with other issues such as housing, poverty (food or fuel bills) or the probation/criminal justice system.

The Service Manager for Medway Action for Families and the Early Years Strategy Manager, Children and Adults referred to a wide range of influences on health inequalities including but not limited to: social isolation, socio-economic deprivation status and geographical area, young parents, maternal mental health and attachment, post-natal depression, domestic abuse, ethnic group, maternal nutrition status, and parental health. The testimony stressed the critical impact that these risk factors can have both in determining the health of the child and the lifelong health of the adult-to-be. They cited as an example the critical development of an individual's neurological pathways during these formative years and the impact this has on an adult's lifespan. Children's services emphasised the importance of picking up all issues that affect a child's health as soon as possible – including poor housing, and domestic abuse. They also referenced the important impact of the built environment, for example where fear of antisocial behaviour from teenagers or fouling by dogs deters families from using local parks for physical exercise.

The Chief Clinical Officer's (Medway CCG) testimony explained how epigenetics can result in influences in one generation being carried across to future generations, thereby emphasising the importance of intervening in early years to prevent problems not only in the current generation but also in the next.

The Planning team referenced the increased likelihood of poor housing affecting low income families. The Medway Action for Families service and the Health Visitors also stated the importance of housing in relation to health inequalities. They also referenced other issues that impact on families such as pest control, the usefulness of the benefits advice centre at the Pentagon, the projects that enable families to get back into training or work like Care to Learn or the Family Nurse Partnership. There was a strong emphasis from frontline service that solutions need to be holistic.

The Housing team gave evidence to illustrate some of the problems that are faced by those in more deprived areas (no hot water, no heating, insecure accommodation). They also stated that landlords are willing to offer only

minimum standards of accommodation in their rented properties due to prior experiences of abuse of the property or non-payment of rent.

Further research also indicates that the high cost of maintaining a property (rent, mortgage, fuel costs) reduces the disposable income available to families, which in turn impacts on their standard of living[1]. The Housing team also commented that minimum standards of housing have risen over the years, and as they have done so health has improved in those who are more disadvantaged.

With the primary importance that Housing, Planning and Licensing issues hold in determining the well-being of families and their children, it is felt that the Council should target its concern on minimising the impact of these wider determinants of health inequalities.

Recommendation 1:

That Cabinet tasks the Council to continue to work with landlords, developers, partners and residents to aspire to raise housing standards. Where it is apparent that the legal standards are not being met to seek a resolution to those issues in line with the Council's Housing Enforcement Policy.

Recommendation 2:

That Cabinet tasks the Director of Public Health to engage with the Director of Regeneration, Community and Culture to inform the development of the Medway Local Plan and establish a joint officer project group to ensure that the local plan maximises the opportunity to improve the wider determinants of health through planning.

Recommendation 3:

That the Cabinet tasks the Director of Public Health to continue to engage with Licensing Officers to maximise the opportunity to improve the wider determinants of health through licensing, building on the partnership working to date between Public Health, Licensing and other departments and agencies to provide ongoing messages to licensees and the public on public safety and public health issues.

[1] The impact of the economic downturn and policy changes on health inequalities in London, UCL Institute of Health Equity, June 2012, accessed on internet at: http://www.instituteofhealthequity.org/projects/demographics-finance-and-policy-london-2011-15-effects-on-housing-employment-and-income-and-strategies-to-reduce-health-inequalities/the-impact-of-the-economic-downturn-and-policy-changes-on-health-inequalities-in-london-full-report

Access to primary care

The information received from the NHS England Local Area Team referred to variation in mortality figures and life expectancy rates (also shown in the objective evidence given at the start of the review) and stated that access to GP services and quality of care were being looked at. They also indicated that data suggest that single-handed practices find it harder to deliver outcomes often because the GP is managing a large number of patients and doesn't have all services available in the practice. They informed the Task Group that some CCGs are looking at working in networks to allow different specialisms across the different practices. Other CCGs have looked at defining their own local GP contract to augment the national core contract.

The Chief Clinical Officer from the CCG explained that NHS England is responsible for in hours primary care contracts and manages in accordance with the national Primary Care Contracts. CCGs do have the responsibility for commissioning out of hours primary medical services, which locally the CCG does through MedOCC.

CCGs have a huge part to play in driving up the quality of primary medical care but the performance management of core contractual issues rests with NHS England. However, they can commission additional services not necessarily exclusive to GPs, which act as local enhancements to the main GP contracts.

In addition, the national contracts are not always specific around detailed service requirements. As such, contractually it is often difficult to hold practice to account. They may be providing services that are felt to be short of meeting need but still contractually compliant. In these circumstances we have to work through exerting influence and, in particular, peer pressure to address any service shortfall.

The Task Group noted the variations in the quality and outcomes of care at GP practices in Medway and was keen to receive further updates on how it is being addressed.

Recommendation 4:

That Cabinet asks NHS England (Kent and Medway Local Area Team) to work with NHS Medway Clinical Commissioning Group (CCG) to investigate inequity[2] in access and outcomes at GP practices and report back to the Health and Wellbeing Board with its plan to address the issue.

[2] see definition of inequity in section 6

Alcohol, smoking and workplace health

The Task Group heard evidence that the problems presented by alcohol consumption are throughout society and that they may present differently in different groups, e.g. workers versus unemployed people, or those in manual versus professional jobs, and may be hidden. The Task Group also heard that current methods for judging alcohol intake could be difficult for people to understand.

The Task Group asked about the health impact of the increase in the number of people drinking at home. The Senior Public Health Manager responsible for Alcohol and Substance Misuse agreed that some socio-economic groups were more likely to consume alcohol at home, but stated that evidence shows that those from the more deprived wards are more likely to be admitted to hospital with alcohol related conditions and other health issues. She emphasised the importance of applying the concept of proportionate universalism by targeting everyone with the key messages about alcohol misuse and focussing more active interventions on those most likely to experience harm.

The Task Group considered the Guide to Alcohol for Local Councillors published by Alcohol Concern and noted that Medway Council has already begun to implement seven of the 10 items on the action list in the document. The Task Group discussed the opportunity for Medway Council to lead by example in working with partners to address alcohol issues in the workplace (item number 8 on the action list).

The guide suggests the need to ensure, current policies, which incorporate alcohol, in this case the drug and alcohol policy, adopted by the council, reflect current best practice. This point is particularly pertinent as the council now has a responsibility to promote workplace health and prior to advice being given to external organisations re policies the council should ensure its own is as close to gold standard as possible and leads other by its example. Naturally any policy change would need to be conducted in full consultation with internal and external partners including unions, Employment Matters Committee and others.

Recommendation 5:

That Cabinet acknowledges that as a large employer Medway Council plays an important leadership role in reducing health inequalities. As such the implementation of workplace health initiatives are welcomed, and it is suggested that the drug and alcohol policy for the Medway Council workforce is refreshed covering all types of workers.

The Task Group heard from the Stop Smoking Service that every day 365 people die from a smoking-related disease, which it is the leading cause of avoidable premature death and is strongly associated with health inequalities. Having been running for a number of years, the Stop Smoking service

decided to profile the equity of access to the services across Medway and therefore undertook a Health Equity Audit. A number of areas that would benefit from specific action were identified as far as health inequalities were concerned. These related to smoking in pregnancy, manual workers and people from black and minority ethnic backgrounds.

The Task Group heard examples of two successful models of service implementation. Firstly, using service "graduates" to train or support others and, secondly, that group work is popular with service users as it provides a support network for those trying to quit.

The Task Group also heard from the NHS Health Checks programme that there are inequalities in the update of the national cardiovascular screening NHS Health Checks, with lower uptake in those who are male, aged between 40-55 years and those from black or minority ethnic communities.

The Task Group felt that, as the Council itself can play a leadership role, so can other workplaces and in so doing they can act as facilitators/ enablers ensuring that their workers have easy access to health promotion services.

Recommendation 6:

That Cabinet asks the Director of Regeneration, Community and Culture and the Director of Public Health to expand and build on work with local businesses to support them to implement workplace health initiatives within the framework of the Public Health Department's "A Better Medway" services.

Engagement and outreach

The Task Group heard evidence of examples of barriers to people engaging with services, which may cause health inequalities. These barriers took many forms.

The Stop Smoking team and the NHS Health Checks team took proactive action to determine areas or groups where the services were not being taken up by conducting Health Equity Audits. Once these target groups were identified, they were able to commission or develop additional services to fill these gaps and had thus discovered that those groups had previously not been aware of the service. The Public Health team also described how the analysis of the data captured by the Exercise Referral service showed that although success rates were good across all Medway wards, more in-depth analysis showed a lower success rate in those individuals with mental health needs. The service is currently engaging with partners and patients in order to better serve this population.

The lack of awareness of the consequences of not accessing a service was reported by both the Medway Action for Families team and the Health Visitors. These frontline services stated that some populations don't access some services due to a perceived fear or stigma attached to doing so. The Health Visitors mentioned that some parents in more affluent areas don't seek assistance as they believe it will be perceived negatively by their peers, believing that their peers expect them to know how to be good parents. The Medway Action for Families service stated that some parents don't access some NHS services because they are afraid that this might trigger intervention by social services. The Task Group felt that engagement with these services needs to be reviewed and outreach services explored to allow all populations to feel comfortable with accessing the services.

The Healthwatch Medway team spoke of the inaccessibility of existing information to less health literate groups. They referenced "hidden" information – not knowing where to look for it, not knowing what an organisation does, difficulties with terminology, people with limited or no access to computers, and people whose primary communication medium is social media.

The Health Visitors and Children Services spoke about problems with information sharing and the risk of services working in silos and the problems caused by mismatched technology. Medway Action for Families spoke about the extent to which this risk was mitigated by strong partnership working.

Given the many different types of barriers to uptake of services that exist and the inequalities of access to services that this can mask, more work is needed to understand how the Council and other providers can best adjust how they provide services to ensure effective and full participation by all eligible groups in offered services.

Recommendation 7:

That Cabinet:

(a) asks the Health and Wellbeing Board to engage with members of the public and seek views on barriers to uptake of services – whether they be Council, NHS or volunteer – in the development and implementation of the Health and Wellbeing Board engagement plan in the next 12 months; and

(b) that the findings of this engagement exercise should be used to programme and target further work to address health inequalities with Council service managers, NHS colleagues and the voluntary sector.

Examples of proportionate universalism

Many of the services that submitted evidence regarding their work in addressing health inequalities are universal with targeted support: services that are national in origin (children's services, Sure Start centres, health visiting, NHS health checks, smoking cessation) and then tailored to local or individual use.

The Task Group heard that Sure Start centres are available to all and every Medway household is within pram-pushing distance of one of the 19 centres. This evidence demonstrated two levels of targeting: initially allocating resources in proportion to the need at area-level, then within each Centre the health visitor can signpost individual families to the interventions that they need. Evidence was presented demonstrating that the work done over the last ten years has resulted in an overall increase in the level of school-readiness of all Medway children. The Task Group noted that this application of proportionate universalism has resulted in raising standards for the whole population.

The Health Visitors provided evidence to the Task Group regarding the health visitor programme saying that it is structured into four tiers: community, universal, universal partnership and universal partnership plus. Families move between the packages as their needs dictate. The Health Visitors programme is an evidence-based national programme and is structured according to the principles of proportionate universalism. It has a service delivery model that delivers universal care with greater support provided to those families that require it.

The Task Group noted that the application of proportionate universalism is a nationally recognised and evidence-based approach and that there are some examples of where Medway Council and partners are delivering services in a manner that is consistent with proportionate universalism.

Recommendation 8:

That Cabinet notes that one mechanism for providing services to reduce health inequalities, consistent with proportionate universalism, is to provide a universal service with targeted support where appropriate, and asks Public Health to investigate developing a framework to enable the application of proportionate universalism approaches in a structured way in the planning and delivery of all services.

Evaluation and review to identify and address gaps

The Task Group heard evidence from several of the services showing how they had gathered information to more accurately develop their services and achieve their goals.

The Smoking Cessation team and the NHS Health Checks team in Public Health showed how they had used Health Equity Audits to reduce inequalities in the use of their services. The Public Health Tipping the Balance programme had analysed its data to establish that it successfully covered every ward in Medway, however, for those people who also had a mental health problem the program success rate was lower. Using this information the team is working on enhancing the service to address the needs of this group more appropriately.

The Task Group heard from the Stop Smoking service that they had conducted a Health Equity Audit and was able to identify groups such as pregnant women, which required special measures and is taking forward specific work in these areas. The Medway NHS Health Checks programme highlighted groups that were not accessing the service as frequently as expected: males between 40-55 years, from certain wards, and people from black or minority ethnic groups. The Health Checks team has commissioned outreach services to reach this population, with the outreach contract priced to incentivise inclusion of these under-represented groups.

The Sure Start Centres are audited for compliance on an annual basis, through a Local Service Agreement. The Council conducts quarterly review meetings to ensure that they are fully supported in complying with the standards thereby ensuring a minimum standard of quality available to all.

The Head of Sport, Leisure and Tourism from Regeneration, Community and Culture (RCC) gave evidence indicating that they are conducting research to investigate barriers to the uptake of sporting activities. He explained that RCC take a blanket approach to encouraging people to take more exercise focussing on mass participation events and getting people through the door. They rely on Public Health to identify and target hard to reach groups.

The Task Group noted that health equity audit is an established formal approach used in Public Health to reduce health inequalities, and that there are some similar approaches taken elsewhere in the Council. In addition to the Task Group noted that formal application of health equity audit more widely across the council and services commissioned by the CCG should be considered.

Recommendation 9:

That Cabinet asks:

(a) The Health and Wellbeing Board to identify where health equity audits may help to determine action that would reduce health inequalities across council services and those commissioned by the CCG and NHS England (Kent and Medway Local Area Team); and

(b) that the Public Health department then provides support or leads on conducting those which are determined to be the highest priority by the Health and Wellbeing Board.

Health impact assessment

The planning team spoke about the difficulty of making an impact on what was already built and the need for a health impact analysis on planning and design standards. They also indicated that they would find an evidence-based strategic healthy living policy a useful tool that could be adopted by all stakeholders (including transport, housing and regeneration) and used to inform planning new developments and enable partnership working on shared goals.

The planning team described some of their recent successes, for example the positive effect the village/community transport service has had on older people's wellbeing. They also mentioned the local policy guidance note that is being developed to discourage unhealthy hot food takeaways close to schools.

The Task Group heard that more positive outcomes could be achieved if public health was taken into account during the planning stages. The Regeneration, Community and Culture (RCC) team put forward evidence that demonstrates the benefits of evaluating the impact on health being undertaken prior to new development, citing Capstone Park as a good example. RCC also cited not including a jogging loop around the Great Lines Heritage Park as an example of a missed opportunity to provide a much needed facility at minimum cost that may have been identified with greater consideration of public health.

Both RCC and Public Health referenced the need to achieve shared goals on an increasingly restricted budget. The Council, the CCG and the Health and Wellbeing Board all have statutory duties to promote partnership working, meet the needs of the community and reduce inequalities as well as provide accountability for the planning of local services and service redesign.

The Task Group concluded that there may be some merit in introducing into the standard template for reports to Council, Cabinet and other Member level decision making bodies an analysis of health impact where any new policy or service development is proposed with recommendations on how resources should be directed where most needed. The Task Group felt that more immediately a protocol should be determined between the Director of Regeneration, Community and Culture and the Director of Public Health in the light of guidance just issued by the Department for Communities and Local Government relating to close working between planning and public health in relation to identifying health inequalities at an early stage.

Recommendation 10:

That the Cabinet tasks the Director of Regeneration, Community and Culture and Director of Public Health to work together to develop a protocol for dealing with any future planning developments in Medway that may have a significant impact on the health and wellbeing of the local population. (This is to enable the Director of Public Health's comments to be considered as a material consideration in the determination of those applications).

Principles to direct investment

The Terms of Reference for the review included asking the Task Group "to recommend a set of principles to assist the Council and partners to direct investment where it is most needed in terms of tackling health inequalities". Having reviewed the evidence gathered from service-providers within and outside of Medway Council the Task Group determined the three principles below.

Recommendation 11:

That Cabinet recommends the following three principles to assist the Council and partners, where relevant, to direct investment where it is most needed in order to tackle health inequalities:

Principle 1: Actively seek ways of working in partnership across teams and agencies to tackle health inequalities and direct resources

Principle 2: Assess the impact of investment decisions on health inequalities before decisions are made

Principle 3: Review and evaluate how equitable services are, e.g. through health equity audit, and adjust service delivery to address any inequalities found.

Appendix 1

Diversity Impact Assessment: Screening Form

Directorate Health Inequalities Task Group, Health and Adult Social Care Overview and Scrutiny Committee	**Name of Function or Policy or Major Service Change** Health Inequalities – across Medway wards – how to direct investment to where it is most needed	
Officer responsible for assessment David Whiting	Date of assessment 16/12/2013	New or existing? New

Defining what is being assessed		
1. Briefly describe the purpose and objectives	• To review and understand Health Inequalities across Medway wards • To consider how to direct investment where it is most needed including consideration of the application of proportionate universalism as a concept • To illustrate health inequalities and proportionate universalism using two areas of service delivery to highlight the key issues – e.g. smoking cessation and access to primary care • To recommend a set of principles to assist the Council and partners to direct investment where it is most needed in terms of tackling health inequalities	
2. Who is intended to benefit, and in what way?	The review is intended to benefit groups of people who have poorer health outcomes by establishing a set of principles for the council and partners to follow to reduce health inequalities	
3. What outcomes are wanted?	A set of principles to assist the Council and partners to direct investment where it is most needed in terms of tackling health inequalities	
4. What factors/forces could contribute/detract from the outcomes?	Contribute All partners work together to apply the principles and reduce health inequalities	Detract If one or more parties declines or delays implementation of the recommendations
5. Who are the main stakeholders?	Medway Council, Health and Well-being Board, Medway CCG, NHE England (Kent and Medway Local Area Team), other council partners	

6. Who implements this and who is responsible?	Medway Council and partners

Assessing impact		
7. Are there concerns that there <u>could</u> be a differential impact due to *racial/ethnic groups*?	YES NO	Brief statement of main issue No. This review actively aims to reduce inequalities
What evidence exists for this?		
8. Are there concerns that there <u>could</u> be a differential impact due to *disability*?	YES NO	Brief statement of main issue No. This review actively aims to reduce inequalities
What evidence exists for this?		
9. Are there concerns that there <u>could</u> be a differential impact due to *gender*?	YES NO	Brief statement of main issue No. This review actively aims to reduce inequalities
What evidence exists for this?		
10. Are there concerns there <u>could</u> be a differential impact due to *sexual orientation*?	YES NO	Brief statement of main issue No. This review actively aims to reduce inequalities
What evidence exists for this?		
11. Are there concerns there <u>could</u> be a have a differential impact due to *religion or belief*?	YES NO	Brief statement of main issue No. This review actively aims to reduce inequalities
What evidence exists for this?		
12. Are there concerns there <u>could</u> be a differential impact due to people's *age*?	YES NO	Brief statement of main issue No. This review actively aims to reduce inequalities
What evidence exists for this?		
13. Are there concerns that there <u>could</u> be a differential impact due to *being trans-gendered or transsexual*?	YES NO	Brief statement of main issue No. This review actively aims to reduce inequalities
What evidence exists for this?		

14. Are there any *other* groups that would find it difficult to access/make use of the function (e.g. speakers of other languages; people with caring responsibilities or dependants; those with an offending past; or people living in rural areas)?	YES NO	If yes, which group(s)? No. This review actively aims to reduce inequalities
What evidence exists for this?		
15. Are there concerns there <u>could</u> be a have a differential impact due to *multiple discriminations* (e.g. disability <u>and</u> age)?	YES NO	Brief statement of main issue No. This review actively aims to reduce inequalities
What evidence exists for this?		

Conclusions & recommendation		
16. Could the differential impacts identified in questions 7-15 amount to there being the potential for adverse impact?	YES NO	Brief statement of main issue No. This review actively aims to reduce inequalities
17. Can the adverse impact be justified on the grounds of promoting equality of opportunity for one group? Or another reason?	YES NO	Please explain No. This review actively aims to reduce inequalities
Recommendation to proceed to a full impact assessment? No		
NO	**This function/ policy/ service change complies with the requirements of the legislation and there is evidence to show this is the case.**	
NO, BUT …	**What is required to ensure this complies with the requirements of the legislation? (see DIA Guidance Notes)?**	Minor modifications necessary (e.g. change of 'he' to 'he or she', re-analysis of way routine statistics are reported)
YES	**Give details of key person responsible and target date for carrying out full impact assessment (see DIA Guidance Notes)**	

Action plan to make Minor modifications		
Outcome	**Actions (with date of completion)**	**Officer responsible**

Planning ahead: Reminders for the next review			
Date of next review			
Areas to check at next review (e.g. new census information, new legislation due)			
Is there *another* group (e.g. new communities) that is relevant and ought to be considered next time?			
Signed (completing officer/service manager)		**Date**	
Signed (service manager/Assistant Director)		**Date**	

NB: Remember to list the evidence (i.e. documents and data sources) used

HEALTH INEQUALITIES SCRUTINY REVIEW –SCOPE

Review Name:	Health Inequalities
Review Topic:	Health Inequalities – across Medway wards – how to direct investment to where it is most needed
Lead Committee:	Health and Adult Social Care Overview and Scrutiny Committee
Suggested terms of Reference for discussion with Members:	• To review and understand Health Inequalities across Medway wards • To consider how to direct investment where it is most needed including consideration of the application of proportionate universalism as a concept • To review two areas of service delivery to illustrate the key issues – for example smoking cessation and primary care • To recommend a set of principles to assist the Council and partners to direct investment where it is most needed in terms of tackling health inequalities (Note: Extract from Marmot Review Report: "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.")
Development of key lines of enquiry:	• Initial briefing for Members • Consider taking evidence from experts on health inequalities/PU • Identify any successful approaches to tackling health inequalities across wards in other local authority areas/abroad • Examine smoking cessation and primary care services as case studies
Task Group Members:	Councillors Wildey (Chairman), Purdy, Adrian Gulvin, Shaw and Smith
Officer Support to include Democratic Services Officer:	Dr Barnett, Director of Public Health David Whiting, Senior Public Health Intelligence Manager Rosie Gunstone, Democratic Services Officer

Rationale (key issues and/or reason for doing the review)	Reducing health inequalities is a national and local priority and a key theme within Medway's Joint Health and Wellbeing Strategy. Reducing health inequalities leads to increased productivity and a reduction in demand on health and social care services
Purpose/Objective of Review: **(specify exactly what the review should achieve)**	To develop a set of recommended principles and actions to assist the Council and its Partners to assess future policies, commissioning/ procurement arrangements and service development proposals to maximise the scope for investment where it is most needed across wards in terms of tackling health inequalities.
Experts/models of best practice who might be called as expert witnesses (who to see and when)	
Legal framework	
Relevant Medway policy framework	JSNA and JHWBS
Performance regime: ➢ **How is performance measured?** ➢ **What are current targets and current performance** ➢ **How does Medway compare with other local authorities?**	
Diversity impact assessment needed	
Current risk assessment for this service area	
Evidence sources for documents	
Resource requirements/costs (including officer time, number of meetings, evidence sessions, visits etc)	
Spend per head of population (where applicable)	

Project start date:	October 2013
Draft report deadline:	6 January 2014 (for 28 January HASC)
Meeting frequency:	To be agreed
Route for review:	Health and Adult Social Care O&S Committee either 28 January 2014 or 8 April 2014 then Cabinet either 11 February 2014 or 13 May 2014
Projected completion date:	Mid February latest to allow for the next review on welfare reform to commence

For information relating to this review please contact
Rosie Gunstone, Democratic Services Officer on 01634 332715

Appendix 3

SUMMARY OF TASK GROUP EVIDENCE SESSIONS

Evidence gathered

As set out in the methodology section the Task Group selected a cross section of officers and stakeholders over a range of services to ask an agreed set of questions (see appendix 4) to establish successful standards of working across Medway.

Interviews with Public Health Managers

On 20 November 2013 the Task Group took evidence from two Public Health Managers, one in relation to Healthchecks and Chlamydia screening and the second in relation to the stop smoking campaign. The aim of the evidence was to determine if proportionate universalism was an integral part of the existing work being carried out in those sections and to discover whether there were any gaps in services provided. The areas explored related to what was currently being offered in Medway in relation to these services and where these were specifically targeted. It was explained that while some of the campaigns in public health related to nationally agreed campaigns there was a local adaptation in most cases.

Healthchecks campaign

Members were encouraged to be told of the work, which was being undertaken to tailor this service to specific identified needs, following work being taken forward as part of the Joint Health and Wellbeing Strategy.

The detail given was that as a result of a health equity audit taking place on the service, which identified the fact that the service did not originally match the needs in Medway and that some people from Gillingham North, Gillingham South, Luton and Wayfield, Chatham South and Peninsular were not taking advantage of the healthchecks even though they were eligible. In order to better match the service to needs a company called Solutions for Health was commissioned to undertake outreach work to target males between 40-55 and some from black or minority ethnic communities. The service was procured through the NHS but then transferred to the Council on 1 April and the provider had a financial incentive to find those people who were not accessing the service. By the end of October 2013 the company saw 615 people, 84% of whom were from wards and/or groups previously not attending.

Stop smoking campaign

The delivery of this service was universal in that it was available to all Medway residents. However, it was identified that more targeted work was needed to reach those smoking in pregnancy, manual workers and those from black and minority ethnic backgrounds. Work was ongoing with employers in Medway and also in schools to give support to young people to encourage them to give up smoking. The greatest barrier to the success of the stop smoking campaign appeared to be a lack of awareness - hence increased communication and marketing was key.

On 17 January 2014 a further interview with the Project Manager, Supporting Healthy Weight, from Public Health took place and Members of the Task Group was informed of the measures currently underway in Public Health to target obesity in Medway, which are set out below:

Supporting Healthy Weight

The Task Group explored with the Public Health Project Manager details of the Supporting Healthy Weight programme which is a universal service available in Medway, accessible by referral from a professional in the case of an adult with a Body Mass Index of over 30 and for younger people by self referral or by referral from a health professional. The team of 25 people covering childhood and adult obesity support services had been expanded in 2010 to have four specialist weight management nurses.

In relation to the potential for links between Public Health and the Council's planning and licensing teams, the Task Group welcomed evidence of increased working between Public Health and the Planning section and the aspiration of staff in Public Health of a link to health to be included in the Core Planning Strategy for the first time. The point was also made that in relation to success rates for the healthy weight programme it had been identified that those people who also had a mental health problem were less likely to succeed in reducing their weight through the programme.

In connection with healthy eating generally reference was made to the Medway Diners accreditation and the possibility of extending this to encourage takeaway owners to be accredited for healthier menu options. Reference was also made to the possibility of the Council introducing a Alcohol, smoking and workplace health programme to discourage staff from eating lunches at their desks, bearing in mind the dangers associated with a sedentary lifestyle.

On 13 February 2014 an interview with the Senior Public Health Manager took place and the Task Group was advised that she had responsibility for

programmes relating to tobacco control, child health, sexual health and alcohol and substance misuse.

Substance and alcohol misuse

The Task Group heard that work was underway on alcohol misuse with the aim of reducing harm whilst being consistent with national strategy, which recognises that alcohol consumption is part of the UK culture. A measure of success of the various programmes in Medway would be a reduction in levels of admission to Medway Hospital of people with conditions specifically connected to alcohol misuse and those with related conditions.

Details were given of partnership working – in particular the work of the multi-agency Alcohol Partnership Group to develop a shared pathway for direct referral for treatment. Members were told about work across Medway to increase the number of front line people, such as pharmacists, who are trained in 'Identification and Brief Advice' (IBA), which is a high impact, low cost intervention (for every 8 people experiencing an IBA intervention, 1 person will reduce their alcohol consumption). Alcohol Liaison Staff at Medway Hospital are now targeting patients in A&E and in some specific wards to identify those who may have been admitted more than once with previously undiagnosed alcohol related conditions. Work was also ongoing to evaluate how the Council and other organisations could make better use of licensing powers to tackle alcohol misuse.

The Task Group was advised of a programme piloted in Essex called "Risk Averse" which involved work with year 7 students to screen a range of factors including levels of unsupervised play, alcohol consumption, smoking and parent perception. This provided a base of evidence, with together with intelligence from Head teachers, enabled the cohort most likely to benefit from early intervention to be identified. This would mean the extension of the PHSE curriculum beyond teaching awareness of risk to development of skills and assertiveness to negotiate around the issues and peer pressure.

Other initiatives were mentioned such as an effort to target premises selling high strength, low cost alcohol in Gillingham High Street. This was based on the success of the 'Reducing Strength' campaign, which had been successful in Ipswich where increased levels of enforcement ranging from activity in off-licenses to street drinking had achieved significant impact.

Reference was made to actions being progressed in Medway around the introduction of a by-law on minimum pricing and the introduction of a modern workforce alcohol policy.

Key findings

Alcohol, smoking and workplace health

- The Task Group identified good practice across Public Health, with the use of the Health Equity Audits, and felt that the Council was well placed to encourage other local organisations to consider how they could reduce health inequalities in their work. The possibility of introducing a Council-wide workplace programme to lead the way in encouraging staff to move away from their desks midday, in view of the dangers of a sedentary lifestyle, was mentioned.
- Members expressed interest in the actions recommended by Alcohol Concern for introduction a refreshed workforce alcohol policy
- The Task Group commended the creation of the Alcohol Partnership Group and the strengthened links between Public Health and the organisations involved in licensing
- Members expressed interest in the actions recommended by Alcohol Concern for introduction of a by-law on minimum pricing

Wider determinants

- The possibility of introducing an accreditation scheme for healthier options menus for takeaway restaurants in Medway was put forward
- The Task Group was keen to encourage the inclusion of links in the Core Strategy to health issues
- Building capacity in schools is crucial in terms of early intervention

Examples of proportionate universalism

- The value of a Health Equity Audit in identifying appropriate adjustments to be made to the health check service to target it more specifically to the gaps in provision demonstrated how proportionate universalism could work successfully in providing a universal service but targeted to meet the areas of need.
- The Risk Averse programme in Essex provided a good example of proportionate universalism in practice as it enabled a response proportionate to identified risk levels across schools

Evaluation and review to identify and address gaps

- It was felt that more work needed to be done to identify how to support those people with a mental health problem, also accessing the supporting healthy weight programme, in order to bring about more positive outcomes for them

Interview with Strategy Manager, Early Years

On 17 December 2013 the Task Group discussed with the Strategy Manager, Children and Adults, the work being done in the directorate to support young families.

Early years

The Task Group was informed of health inequalities evident in areas of high deprivation in Medway, which was particularly noticeable in speech and language development. The service response to this was to put more services into those areas. Social isolation also had an impact.

In response to a question about how to apply proportionate universalism to early years he told the Task Group the easiest way to do this was through the 19 Sure Start centres. At some of them there is particular scaled targeted support ie central Chatham, North Gillingham and Central Strood. The amount of resources devoted to those areas could be four times that of support elsewhere. He referred, however, to the need to fill the gaps in relation to the different levels of need in Medway. The success of the targeted support was that it was now possible to see improvements in the health of those children who had taken advantage of support over the past few years.

Key findings:

Principles to direct investment

- The Task Group felt that the good work around parenting skills and addressing speech and language difficulties early on should continue as the results of early intervention seem very positive. The principle of providing such support was universal but it was clear that there needed to be focus on what is most appropriate for each area. For instance the type of support given in more affluent areas needs to be adapted as far as its delivery and content is concerned to appeal rather than detract young parents from coming forward. Classes offered at golf clubs and social clubs for example encouraging networking of young mothers in surroundings where they feel comfortable and free from any perceived stigma.

Interview with Head of Sport, Leisure and Tourism

On 17 December 2013 the Task Group took evidence from the Head of Sport, Leisure and Tourism in relation to areas of his responsibility.

Sport, Leisure and Tourism

Whilst the Task Group found that the area of sport, leisure and tourism was very much focussed on a universal service to encourage people across Medway to take more exercise and participate in sport, leisure and tourism, there had been successful targeted work around the Paralympics and as a result 6 disabled sports clubs were now operating from Medway Park.

In relation to outreach work there was some specific work in schools, work with Hempstead Active Retirement Association and with some villages to start up groups such as netball groups for instance. Work had also just commenced on trying to reach ethnic minority groups to ensure that there were no barriers to them joining in with sport and leisure but this was at an early stage.

Key findings:

Evaluation and review to identify and address gaps

- The Task Group felt that the approach as to how to market healthy exercise and healthy living needed to be done differently to encourage more Medway residents to participate in sport and leisure and also in healthier lifestyles.

Interview with Manager, Development Policy and Engagement

On 17 December 2013 the Task Group discussed with the Manager, Development Policy and Engagement her role within the Council and the areas of focus in her work relating to health inequalities.

Development Policy and Engagement

The Manager explained that she worked in planning policy and as such could not give any specific examples of targeted work, rather her work was in connection with bringing about the best use of space, supporting healthier lifestyles, giving access to greenspaces and making it easier for people to cycle, walk etc.

The only work, which was concentrated in specific areas, related to the village/community transport service available in some areas, which largely worked with older people providing day trips and opportunities for shopping. This in itself had demonstrated great health benefits and reduced social isolation.

In relation to the need to tackle off licences/corner shops selling alcohol to young people she explained that from a planning perspective it was difficult to tackle such shops as they provided much needed support to local people in the provision of other products they sold.

Discussion also took place in relation to the Core Strategy and the possibility of there being an inclusion in that relating to health.

Key findings:

Evaluation and review to identify and address gaps

- The Task Group was keen to find out whether it would be possible for a link to be added to the Core Strategy in relation to health.

Interview with Healthwatch Medway

On 17 January 2014 the Task Group took evidence from the Director, Healthwatch Medway and Community Engagement Officer in relation to their perception of the way that Healthwatch Medway addressed health inequalities.

Healthwatch Medway

The Task Group heard that poor communication was a barrier and that more needed to be done across both health and social care to ensure the following:

- that people know exactly what each service is and what to expect from that service to enable them to measure if the service is delivering successfully what it has set out to do and if not how to complain
- more use needs to be made of social media to get across messages and to help people to find their way through the health and social care system
- terminology needs to be very simple particularly when describing the service and how to access it
- good signposting should be available on health and social care providers websites so that the general public can find their way easily
- it is important to make every contact with people count and that services work together to ensure that this happens

Key findings:

Engagement and outreach:

- The Task Group noted the importance of all organisations across health and social care making sure that information on the services they provide are clearly explained in plain English with good signposting. Each service needs to set out exactly what the public should expect from the service so that they can judge what a good service from that organisation would look like and find it easy to complain where the service has not met that standard.

- The role of Healthwatch Medway in signposting the public to health and social care services was key as far as the Task Group was concerned

- The Task Group considered whether any asset mapping of health related services might be helpful

- Better use could be made of social media and fitting the message to suit the audience

Interview with Housing

On 17 January 2014 the Task Group discussed with the Housing Strategy Manager how his work impacted on health inequalities in Medway.

Housing

It was stated that the housing service was a universal one to address the legal improvements needed to housing provision, access and maintenance rather than to address aspirations. There were, however, some areas of targeted support in the case of vulnerable people who need extra support with finding accommodation or in living independently. He confirmed that while the greatest concentration of homeless people tended to come from the poorer wards/areas of high deprivation, there were still some from the more affluent wards.

Some multi-agency work was being conducted in the All Saints area of Chatham, which mirrored that being undertaken in Margate by their multi-agency task force. This work had so far been working well in identifying a number of issues such as houses in multiple occupation which need to be licensed, benefits issues and health issues. Members also discussed the benefits of social regeneration and how that this had wide reaching benefits. In some areas this had been achieved by generating community involvement through the voluntary sector.

The Task Group was told that often landlords are unprepared to go beyond minimum standards in their properties because of the difficulties they experience if a tenant needs to be evicted, resulting in them having no income from the property for some months. He also stated one of the biggest problems was damp.

It was stated that in general the overall standard of housing had improved over the past years compared to days when there was no central heating, outside toilets etc and the Task Group noted that this had brought about an impact on improving health standards.

Key findings:

Wider determinants

- There was a clear link between standards of housing and quality of health and the example given of rising standards showed how proportionate universalism can work in that improvements in minimum standards had also brought about associated improvements in health

- The Task Group considered whether it would be possible for anything more to do be done to bring about better housing standards

- Consideration was given to the possibility of encouraging community links/voluntary sector engagement in social regeneration to bring about improvements to areas of high deprivation.

Interview with the Service Manager, Medway Action for Families

On 3 February 2014 the Task Group discussed with the Service Manager for Medway Action for Families, the extent to which his work involved health inequalities.

Medway Action for Families programme

The Task Group heard that the Medway Action for Families programme covers all of Medway but the work was mainly based around three particular wards. He made the point that while services for Medway Action for Families were available universally that there were sometimes difficulties for people getting to access them.

In order to access the Medway Action for Families programme the family had to match three criteria: crime and anti social behaviour, educational risk (which includes poor school attendance and exclusions, including pupils in the pupil referral unit) and families on benefits and out of work. The programme is a government-funded one with the aim of transforming lives of Medway Action for Families and getting the children back to school and adults back to work.

The programme operated on a payment by results basis and the national average in the country was 12% payment by results claims, for Medway last year there were 60% claims so the programme was very successful. A partnership, multi-agency, hub had been put together comprising school advisory service, Police, Probation, Youth Offending, Fire, pupil referral unit, family worker, inclusions, Job Centre Plus etc. Consideration was being given to the inclusion of an officer from housing.

The Task Group noted that health equality issues were picked up as part of the Common Assessment Framework (CAF) and he referred to

work he undertook with the Director of Public Health on this. It has also been agreed that a post could be recruited to his service from health. He welcomed the return of public health to the local authority, which he felt was helpful.

There are 127 families in Medway for whom payment by results had been claimed and in order to receive payment there had to be proof of attendance in education being 85% and maintained for a year, and offending had to be reduced by 60% for a year before payment could be claimed. He pointed out that every troubled family costs the system £75,000 compared to £7,500 spent on an average family.

Poor health was a key element to most of the work – he referred to 12-13% of cases with mental health issues, 22% with substance misuse issues and 11% domestic violence. Unknown needs were a worry and a gap. There was a clear need for preventative work to be undertaken although this did not qualify under the programme.

The Task Group was told that every ward in Medway contains a troubled family. The difference tended to be that in the more affluent areas those families were more likely to know how to trigger support than some from the more deprived areas.

Responding to a question about what more could be done he stated that more health outreach work would be helpful or secondment of staff to community teams with a named person perhaps in schools. An identified building in which to house the Medway Action for Families programme would also be of benefit.

Key findings:

Engagement and outreach

- It was acknowledged that every ward in Medway had a troubled family but not all were familiar with how to access services highlighting a need for better communication and engagement

- The benefits of close partnership working in relation to working with Medway Action for Families were acknowledged. The Task Group was keen to assess whether it would be possible to extend the service to more preventative work, including the provision of outreach health workers particularly bearing in mind the saving to the whole system that this might bring about

Evaluation and review to identify and address gaps

- The Task Group noted the request for a building in which to house the Medway Action for Families service partnership hub

Discussions with the NHS

Interview with Medway Community Healthcare

On 17 January 2014 the Task Group took evidence from a number of representatives from Medway Community Healthcare – the Health Programme Manager, the Youth Offending Team Health Manager, a Health Visitor and Specialist Health Visitor and heard about their work.

Health visiting/work with Youth Offenders

The Task Group heard that it would be helpful if all agencies working

with mothers through their pregnancy could work to the same guidelines and training in order to ensure that they could receive a seamless and consistent service. Reference was made to the fact that most of the agencies involved are working to the UNICEF Baby Friendly initiative standards (evidence based standards to improve care and support for pregnant women, new mothers and their families to build strong relationships with and feed and care for their baby). It was stated that although Medway Maritime Hospital women and children's services had signed up to the initiative they had been unable to fulfil the requirements needed to progress it further. This meant that advice given to new mothers was often inconsistent and opportunities missed to encourage and support breastfeeding.

The point was made that information sharing across the agencies was often complex.

Lack of accountability around the Common Assessment Framework (CAF) was also referred to which lead to delay and frustration. It was stated that it was not always clear who would take matters further if one party did not fulfil their obligations. Earlier identification for the need for a CAF would also be helpful.

Reference was made to the usefulness of a breastfeeding/baby care application for a mobile phone which many mothers found helpful. It was stated that the app could be purchased from the iTunes store and was produced by East Coast Community Healthcare. The point was made that for new mothers it was helpful for them to have a point of contact/guidance at any time of the day and night to give guidance and prevent them from giving up on breastfeeding too soon.

The reduction in universal provision of health visitors had lead to some areas with less identified need (ie the more affluent areas) being under served. This was a concern to the service as it was very possible that people in such areas could become isolated and depressed. The view

was expressed that often new mothers were embarrassed to admit they needed help, particularly around depression and parenting skills.

A reduction in people coming forward to have their child immunised was referred to and it was suggested that a further campaign would be helpful.

The usefulness of the benefits advice centre in the Pentagon Centre, Chatham was referenced as this empowered people to get out of financial difficulties.

The impact of imposing a charge on the pest control service was mentioned. The effect of this was that often the problem was not dealt with and the infestation spread to other properties.

Key findings:

Engagement and outreach:

- The benefits of a seamless consistent message for mothers in Medway were obvious and the Task Group was of the opinion more should be done to address this issue
- Further publicity could be done to advise new mothers of the existence of the breastfeeding/baby care applications for mobile phones
- Members were keen to see what could be done to address the information sharing difficulties which seem to be experienced across the different agencies working to the same aim
- A further campaign is needed to encourage mothers to bring forward their children for immunisation even if they have missed the standard timings for these to happen
- More could be learned from the Benefits reform advice programme based in the Pentagon in Chatham to help advise and support those who have got into financial difficulties

Wider determinants

- Further consideration could be given to the charge for pest control service bearing in mind the consequent health problems if the issue is not dealt with

Evaluation and review to identify and address gaps

- It was clear that there are some sections of the community where gaps in provision for young mothers could cause isolation and depression and it would be helpful to investigate how this could be addressed

Discussion with Local Area Team (Kent & Medway)

On 3 February 2014 the Task Group took evidence from the Area Director, NHS Kent and Medway Local Area Team and the Head of Primary Care, NHS Kent and Medway Local Area Team around their duties and responsibilities concerning health inequalities in Medway, particularly relating to primary care.

Local Area Team (LAT)

The Task Group was informed that there are four main contractor groups in commissioning primary care, general practice, dentistry and optical. The Local Area Team role varies across these, with the exception of dentistry where the LAT commissions for the whole pathway. With general practice the LAT holds the contracts for GPs and manages an existing portfolio of contracts, most in perpetuity but in the case of six contracts in Medway these are time limited. In addition to the basic contract a number of other services are commissioned by the LAT. Military health is commissioned on behalf of the South East by Bath, Swindon, Wiltshire and Gloucester Area Team.

The LAT and Clinical Commissioning Group (CCG) share responsibility for the quality of general practice. The Care Quality Commission role is to be extended this year to cover general practice. The LAT role would be one of assurance and the LAT had six members of staff looking after 260 contracts so relied on picking up issues through councils, complaints, and monitoring Twitter feeds for instance.

In relation to access and quality of care it was stated that NHS Medway CCG were trying to get a better understanding of what natural communities exist in Medway and how general practices can support each other through networking. As far as continuity of access is concerned in the area, consideration was being given to the merits of linking GP practices to bring about better access for patients, more opportunities for specialisms to be developed and more sustainability overall.

There was discussion around the proliferation of pharmacies in certain parts of Medway and the lack of them elsewhere. It was pointed out that responsibility for the Pharmaceutical Needs Assessment rested with the local authority and the Health and Wellbeing Board specifically.

It was stated that the NHS Medway CCG were keen to get more involved in the prevention agenda rather than just the traditional reactive service provided by GPs. Discussion took place around the standard GP contract, the content of which appeared to vary across the country, and had been determined locally with some areas providing services such as phlebotomy from each practice as a matter of course.

As far as addressing health inequalities was concerned reference was made to work being undertaken by NHS Medway CCG to try to integrate services and target those people on three or more medications per day as they were the most likely people to require care in an acute setting if their conditions were not managed successfully.

Key findings:

Access to primary care

- It was noted that there was a lack of flexibility over part of the LAT work due to the fact that a large part of it was lead nationally. However there was an opportunity to input to the GP core contract and to encourage more prevention work.

Discussion with NHS Medway Clinical Commissioning Group

On 13 February 2014 the Task Group took evidence from the Chief Clinical Officer, NHS Medway CCG.

NHS Medway CCG

The scope to maximise the 'health gain' from reductions in health inequalities in Medway was mentioned, as there was a clear business case to focus activity on reducing health inequalities to release funding to be spent elsewhere in the system.

In relation to the proven potential for socio-economic factors to influence gene expression (epigenetics) changes that can carry across generations, an improvement in lifestyle factors can prevent these adverse effects being compounded through generations. The Big Lottery Bid which Medway had put in for could bring around $40m over the next 10 year to enable a systematic change to services to provide a preventative approach in pregnancy and early years and reduce the incidence of health and social problems later in life.

In relation to the CCG statutory duty to reduce health inequalities across the range of services it commissions and how the increased emphasis on prevention would play out among GPs and secondary care services, he stated that there was a need to reach out into the more deprived communities in order to breakdown barriers to some people accessing services. More could be done to work together across organisations and communities using multiple channels including social media to reach those who were disempowered or less receptive to key messages. The Health and Wellbeing Board could assist this.

The Task Group was told of work going on locally to establish clear benchmarks across GP practices via data on BMI, smoking cessation

and diabetes and that GPs were generally responsive to initiatives with clear benefits for patients. More action was needed to raise awareness on a persistent and ongoing basis about cancer screening and symptoms with targeting for those in the lower socio-economic groups where the disease was more prevalent. More work was also needed in relation to cardio vascular disease in women in the light of emerging statistics.

Members of the Task Group queried the ease of access to GP services, particularly in relation to new registrations, changing a GP or in cases where delays were experienced in accessing a particular doctor. It was stated that there were no particular issues around changing a GP but there would always be an issue of delays for appointments with the most popular GPs.

Key findings:

Engagement and outreach

- The importance of using multiple channels and agencies to deliver key messages about preventative services was highlighted
- Multi-agency action to tackle negative perception is important. For example the facts about how to change a GP

Structured interview for gathering evidence about health inequalities in Medway Council

Introduction

Start by describing the rationale for the interview.

Questions

Please describe what you understand by health inequalities. (If the interviewee does not know what health inequalities are, or does not understand correctly, take this opportunity to explain the concept so that the next questions are answered in the correct context)	
Can you give an example of an individual experience that you have witnessed or are aware of that illustrates the issue of health inequalities? (Real names or other identifiable information will not be recorded.)	
Have you heard of the Marmot review, "Fair Society Healthy Lives", or the government's response, "Healthy Lives Healthy People"?	
Have you heard of proportionate universalism? If so, what do you understand by this?	
What do you think causes health inequalities in Medway?	
Does your organisation/department/section/team do anything to explicitly reduce health inequalities in Medway? If yes, what do you do?	
Are there other things that your organisation could do to help reduce health inequalities in Medway?	
Are there any barriers that prevent your organisation from reducing health inequalities in Medway?	