OXFORDSHIRE GROWTH BOARD – 29 MARCH 2017

Health Inequalities Commission Report - Paper for consideration

Aim: To inform members of the Growth Board of recommendations from the Health Inequalities Commission report and seek their involvement in taking the recommendations forward.

Context

An independent Health Inequalities Commission for Oxfordshire carried out its work throughout 2016. The report of the Commission was presented by the Chair, Professor Sian Griffiths, to the Health and Wellbeing Board in November 2016 and at a launch event on 1st December to a very wide range of stakeholders.

Prof Griffiths will also present the findings of the Commission to the Growth Board on 29th March 2017.

The Health Inequalities Commissioners were independent members selected from public and voluntary sector organisations and academia. They received written submissions and verbal presentations from a wide range of people and organisations at four public meetings held around Oxfordshire in the winter and spring of 2016. Local data and information on inequalities issues was also presented to the Commissioners supported by access to a wide range of local and national documents, including the Director of Public Health Annual Reports, the Joint Strategic Needs Assessment and data from Public Health England.

The 60 recommendations in the report which are arranged in various themes:

- Five Common Principles
- Cross cutting themes of access to services, housing and homelessness, rurality
- Promoting Healthy Lifestyles
- Life course approach, focussing on Beginning Well, Living Well and Ageing Well.

The Health and Wellbeing Board has received the report and agreed to oversee the next steps of dissemination, implementation of recommendations and evaluation of impact on health inequalities.

The full report and Headline report can be found here:
http://www.oxfordshireccg.nhs.uk/about-us/work-programmes/health-inequalities-commission/health-inequalities-findings/

Why do health inequalities matter?

First and foremost this is an issue of social concern and equity. Health inequalities have an impact on an individual's quality of life, opportunities and outcomes as well as on their communities, creating concerns about community cohesion, community safety and the potential for economic growth.

This is because

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- Oxfordshire has high levels of employment but over 14,000 people claim Employment Support Allowance due to ill health. It is suggested that some of this ill health could be prevented and numbers of economically active people grow.
- There is a correlation between poor educational attainment, low skills levels and poor health outcomes. This is demonstrated in lower school achievement amongst children on free school meals.
- People from more deprived areas of the county are more likely to be ill or disabled in later life, often before retirement age (men from the age of 60, women from the age of 57).They are more likely to die early from preventable causes This may result in more frequent or prolonged sickness absence, early retirement or death in service for people from more disadvantaged backgrounds.
- Long term ill health and disability means increased costs to services including the NHS, DWP and local agencies.
- Poor mental health is associated with greater socioeconomic challenge and both adults and children with mental health problems are more vulnerable to further harm or disadvantage with associated costs, both economically and socially.

Details of the data behind these statements has been set out in Annex A

Inequalities issues in Oxfordshire

The health inequalities express themselves as poorer health and earlier death for some people. These can be

1. People who live in specific geographical areas which are identified as subject to multiple deprivation including health, skills, attainment, income, homelessness, crime (as measured by the Index of Multiple Deprivation 2015).
2. People from some minority ethnic groups.
3. People who have poor access to services e.g. because of rurality, disability, culture or language.

This can be summarised with the following statements:

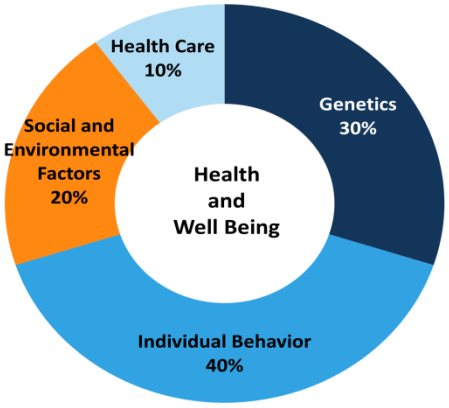
- There is a variation in life expectancy, with people from some more deprived groups or areas living shorter lives on average.
- There is an inequality in the number of years someone can expect to live in good health. Some men and some women who suffer this disadvantage have more years of mental or physical illness or disability before death.
- Analysis of the most common causes of death for people aged under 75 (which are termed “premature deaths”) shows that cancers, heart disease or stroke, liver disease and lung disease account for 77% of these deaths in Oxfordshire.
- Greater emphasis on prevention with changes to healthier lifestyles and access to appropriate healthcare would improve quality of life. For example, according to Cancer Research UK, 4 in 10 cancer cases can be prevented, largely through lifestyle changes. This is applicable to other diseases that kill some people early, such as heart disease and stroke. These changes include

healthy eating, giving up smoking, moderating alcohol intake and increasing levels of physical activity. Nearly a fifth of the local population are inactive (that means they do less than 30 minutes of physical activity a week) and great gains in population health could be made by helping that group in particular to increase their activity levels.

The various impacts of determinants of health have been summarized in the diagram below

Figure 1

Impact of Different Factors on Risk of Premature Death

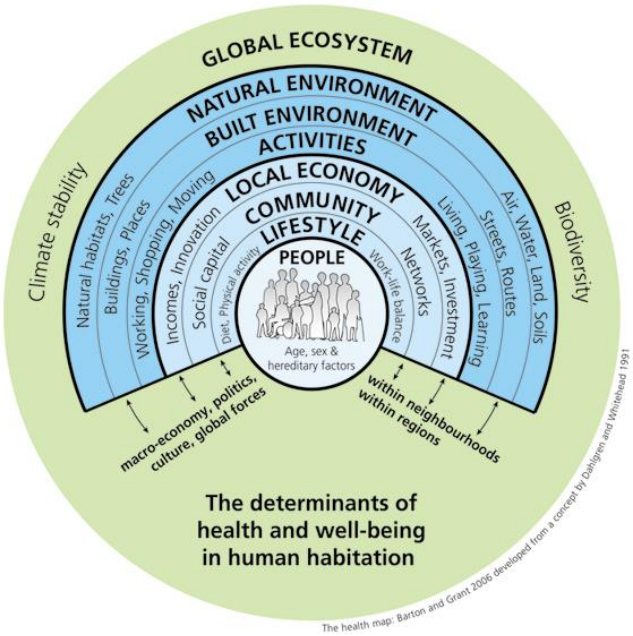


SOURCE: Schroeder, SA. (2007). We Can Do Better — Improving the Health of the American People. *NEJM*. 357:1221-8.

Source: http://kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

The Future Health of Oxfordshire

As the report from the Health Inequalities Commission emphasises, the solution to levelling up health inequalities is not simple and does not just mean making health services better. Many of the determinants of poor health (as illustrated in the diagram below) are beyond the immediate influence of individuals or single organisations but can be improved by local or national action. These include education, housing, transport, leisure services, employment, skills and removing barriers to services, including behaviour change. Some of these factors have been the focus of local programmes in recent years.



What more can be done?

1. Prevention of ill health, particularly for the groups of people who are currently facing poor health outcomes, is a major feature of the Commission report. Some of the recommendations call for more focus on prevention initiatives such as increasing physical activity or reducing alcohol consumption, while others address the wider social determinants of health set out in the diagram above. Recommendations call for guarantees that the proportion of public money being spent on prevention should be maintained or increased .

2. Several recommendations are specific to increasing the numbers of people regularly participating in physical activity. The evidence is clear that this is an important way to improve health outcomes and there are great gains to be made, particularly in focussing on people who are currently inactive. A major bid is currently being prepared by Oxfordshire Sport and Physical Activity (OxSPA) to secure money to focus on reducing Health Inequalities through participation in physical activity. The Expression of Interest has recently been presented to the Health and Wellbeing Board for endorsement. The focus is on enabling people who are currently inactive to find appropriate ways to do more and then to share and embed learning to make this a sustainable change for whole sections of the population. Members of the Growth Board are asked to support this bid as an immediate first step in responding to the Health Inequalities Commission report.

3. Some of the work to respond to recommendations from the Health Inequalities Report will be carried out through adjustments to existing systems and processes in the public sector e.g. commissioning, amending current contracts and developing work to focus on known inequalities. This will be overseen by the Health and Wellbeing Board and will mainly cover the health and social care system.

4. Other work will be further developed in the voluntary and community sector, building on strong work already being delivered. This may need ongoing support, for example, through small pump priming grants. Members of the Growth Board

are asked to consider how a local Innovation Fund can be established by all partners and to make a first contribution of £2000 from each organisation represented on the Board. Further discussions can then take place on what level of contribution organisations could be asked to make in the future, based on outcomes from the early work.

Recent examples of success of this type of Innovation Fund have been reported from the Bicester and Barton Healthy New Town programmes. These small grants, often of just a few hundred pounds, are being used to build up good networks of local activities which will improve social cohesion and wellbeing. This is establishing what is known as "social prescribing" – where good health outcomes can be achieved by non-medical prescribing of activities such as walking, joining a local lunch club or attending a reminiscence session, for example. External funding could also be sought and good examples of this in the Districts include Go Active Gold and Active Women which have tackled both mental and physical issues and behaviour change by bringing people together at exercise based activities.

5. Better data which can be shared is needed to identify poor outcomes and to monitor the effectiveness of work to address them. This is sometimes limited by the lack of information being collected by services, or a failure to use the information effectively. For example better targeting of services can be planned by carrying out Equity Audits or measuring how successful a campaign has been beyond numbers of attendees. Several recommendations in the report relate to this issue and it is suggested that, as a first step, there should be a scoping exercise to define a practical approach and identify priority areas for action.

6. The Health Inequalities Commission received submissions from a wide range of individuals and organisations on specific topics, such as income maximisation, mental health, minority ethnic community concerns, housing, loneliness, fuel poverty, food banks and transport. There are specific recommendations on all these issues (and others) and the route to implementing these recommendations will need further discussion and joined up action across organisations and sectors. Members of the Growth Board are asked to pledge their support in taking this work forward as it is clear that a partnership approach is needed if change is to be made and sustained.

7. All agencies are urged to adopt the approach of Health in All Policies and to work effectively together.

Proposal to the members of the Growth Board

As part of the dissemination of the Health Inequalities Commission report, the Health Improvement Board (HIB) held a workshop in December 2016. It was agreed that a number of the recommendations could be taken forward through the work they are already overseeing but, in addition, the members of the HIB were keen to inform and engage Leaders in the discussion. They agreed to bring this information to the Growth Board.

In response to the presentation from Professor Griffiths:

1. Members of the Growth Board are asked to accept the recommendations and report of the Health Inequalities Commission and support the implementation of recommendations within and between their organisations as appropriate.

2. Members of the Growth Board are asked to endorse and support Oxfordshire Sport and Physical Activity in their bid to Sport England for money to tackle health inequalities in Oxfordshire.

3. Members of the Growth Board are asked to consider how a local Innovation Fund can be established by all partners and to offer a small contribution of £2000 each to get the fund started.

4. Members of the Growth Board are asked to consider and support further action which will facilitate implementation of the recommendations and enable review and reporting progress on a regular basis.

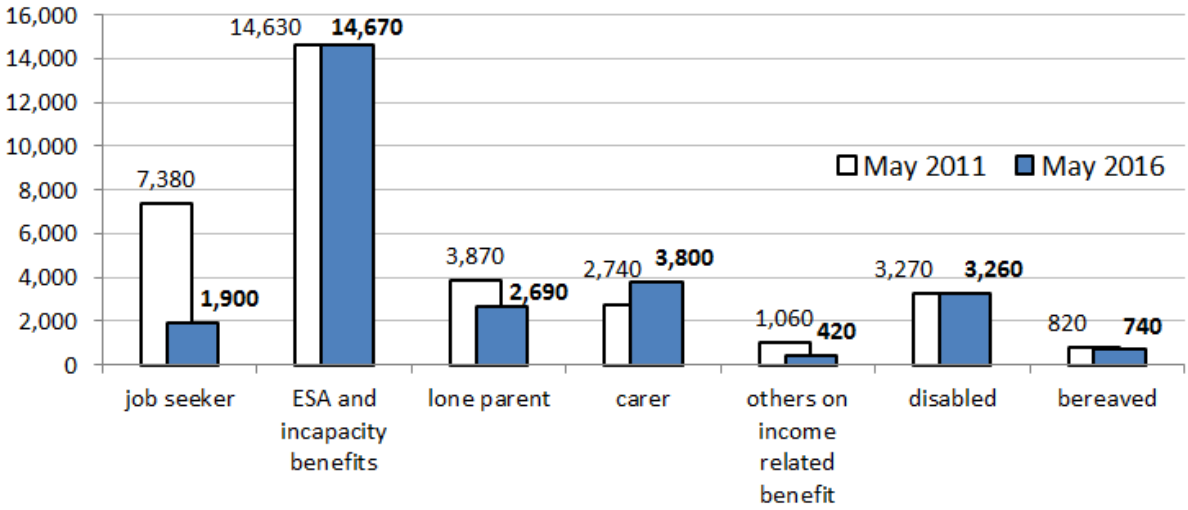
Dr Joe McManners
Cllr Anna Badcock

Annex A

Benefits claimants

As of May 2016 there was a total of **27,480** working age benefits claimants in Oxfordshire of which over half (14,670, 53%) were claiming Employment and Support Allowance and Incapacity benefits.
The number of people claiming ESA has remained at a similar level to the number of claimants in May 2011. The number of people claiming job seeker benefits, and others on income related benefits, have each dropped significantly.

Figure 32 Working age benefits claimants in Oxfordshire May 2016 (vs May 2011)



Source: DWP from nomis; claimants aged 16-64

Annex B Healthy Life Expectancy

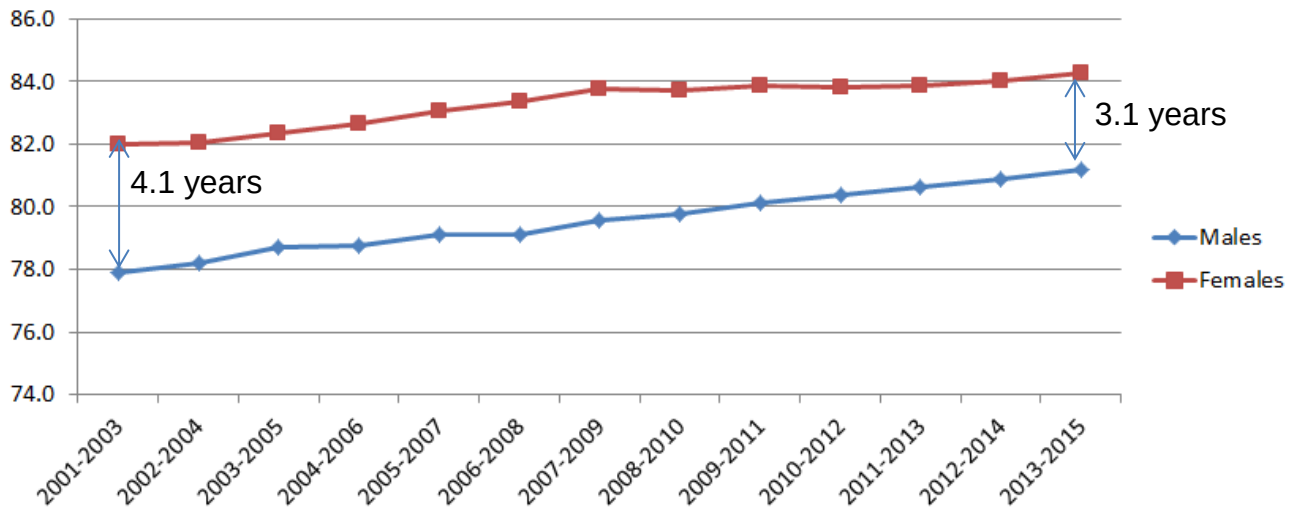
Life expectancy

The most recent set of 3 year life expectancy data shows that, between 2012-14 and 2013-15, life expectancy for males and females in Oxfordshire each increased.

- Male life expectancy increased from 80.9 to 81.2 (+0.3 years)
- Female life expectancy increased from 84.0 to 84.3 (+0.3 years)

Between 2001-03 and 2013-15, the gap between male and female life expectancy decreased from 4.1 years to 3.1 years.

Figure 1 Change in life expectancy in Oxfordshire – males and females to 2013-15



Source: ONS, Crown Copyright 2016; Figures are based on the number of deaths registered and mid-year population estimates, aggregated over 3 consecutive years. Note that scale does not start at 0

However, there is variation in life expectancy in Oxfordshire as follows:

Lowest life expectancy for men - 74.7 years (MSOA level 2009-13)
Highest life expectancy for men – 85.6 years (MSOA level 209-13)

This is a gap of 10.9 years between the best and worst areas in Oxfordshire for men.

Lowest life expectancy for women – 77.2 years (MSOA level, 2009-13)
Highest life expectancy for women – 90.8 years (MSOA level, 2009-12)

This is a gap of 13.6 years between the best and worst areas in Oxfordshire for women.

Healthy life expectancies can be used to measure the proportion of life spent in "good" health or the proportion of life spent without disability.

In Oxfordshire, males at birth are expected to spend 84% of their life in good health (compared with 80% in England), for females it is 82% (compared with 78% in England).

Data for Middle Layer Super Output Areas (MSOAs[1]) in Oxfordshire shows geographical differences in the proportion of life spent in good health of between 80% and 89% for males and between 74% and 88% for females. The gap between highest and lowest areas in Oxfordshire is narrower than the gap for the South East region and England as a whole.

Table 1 Proportion of life spent in good health (2009 to 2013)

% life spent in good health	Males			Females		
	lowest MSOA	highest MSOA	Average	lowest MSOA	highest MSOA	Average
Oxfordshire	80.4%	88.6%	84.1%	74.1%	88.1%	82.2%
South East	78.9%	90.2%	82.6%	66.0%	88.4%	80.8%
England	76.9%	90.2%	80.2%	58.0%	88.4%	78.1%

Source: ONS Healthy Life Expectancy at Birth dataset, released Sept 2015; confidence intervals not published for this data (but will apply)

1. Variation in Healthy Life Expectancy for Men

The life expectancy for men in the worst MSOAs is 74.7 years and the best MSOAs is 85.6 years

- If 80.4% of that life is spent in good health then, on average, men in the **worst** MSOA might expect to develop disability or poor health from **the age of 60.**
- If 88.6% of that life is spent in good health then, on average, men in the **best** MSOA might expect to develop disability or poor health from **the age of 75 years 10 months**

2. Variation in Healthy Life Expectancy for Women

The life expectancy for women in the worst MSOA is 77.2 years and the best MSOA is 90.8 years

- If 74.1% of that life is spent in good health then, on average women in the **worst** MSOA might expect to develop disability or poorer health from the **age of 57 years 2 months**
- If 88.1% of that life is spent in good health then, on average women in the best MSOA might expect to develop disability or poorer health from the **age of 80 years**

[1] Middle Layer Super Output areas are a statistical geography. There is a total of 86 MSOAs in Oxfordshire each with an average of 7,900 people.

Premature mortality

In 2014, nearly a quarter of all deaths (23%; 116,489 out of 501,424) in England and Wales were from causes considered potentially avoidable through timely and effective healthcare or public health interventions. Males accounted for approximately 60% of all avoidable deaths.

In Oxfordshire there were 4,399 deaths in people under the age of 75 between 2013 and 2015 (268 per 100,000). Cancer, heart disease and stroke, liver disease and lung disease account for 77% of these deaths.

2013-15	**Number of deaths under 75 years**	**Rate / 100,000**
Cancer	1893	116.9
Heart disease & stroke	872	54.1
Liver disease	231	13.9
Lung disease	376	23.6
	3372	

Common causes of these four diseases can be found in the table below along with possible interventions that would help reduce mortality rates.

Common causes	**Avoidable diseases**	**Interventions**
Smoking Poor diet Alcohol Physical activity High Blood pressure Obesity	Cancer Heart disease & Stroke Lung disease Liver disease	Smoking cessation - primary care and workplace / Prevent uptake in young people / Enforcement of underage sales / Promote healthy eating and exercise (Change4Life) / Healthy eating learning programmes / Delivery of planned care pathways (Let's Get Moving) / Raise awareness / Consider restriction of consumption in public places / Underage sales penalties / Community support for physically active modes of travel (walking and cycling) / Advice on reducing intake of salt and processed food / Campaigns to promote physical activity / Local services to help with weight loss and weight management.