Divisions Affected - All

PEOPLE OVERVIEW AND SCRUTINY COMMITTEE
11 November 2021

Health Inequalities

Report by Corporate Director of Public Health & Wellbeing

RECOMMENDATION

1. **The Committee is RECOMMENDED to**

   (a) note the background information provided on health inequality in Oxfordshire

   (b) note activity currently underway and consider implications for the Committee's future programme of work

Executive Summary

2. The purpose of this briefing is to provide the People Overview and Scrutiny Committee with background information on health inequality to provide context for future agenda items and inform the development of the scrutiny work programme.

Scrutiny Guidance

3. In order to assist the People OSC, key background data and information about local health inequalities is available for review via the following links;
   - Director of Public Health Annual Report – This is the key underpinning document regarding local inequalities in health
   - Oxfordshire Joint Strategic Needs Assessment (JSNA) – Provides a very detailed look at a broad range of data to understand health status and need locally
   - Interactive Inequalities Dashboard - Is an interactive tool that shows some key data from the JSNA specific to health inequalities
   - Banbury Ruscote ward profile- Is provided as an example of ward profiles in development that are referenced in this paper.

4. This agenda is intended to operate as follows at the People OSC Meeting:
   i. Background to the issue of health inequalities
   ii. Outlining the tiered approach to addressing inequalities that is used locally

iii. The data on current health inequalities in Oxfordshire
iv. A summary of how COVID-19 has impacted on health inequalities
v. Priority areas for action by partners
vi. Proposed next steps
vii. Question and answer session with Cabinet Member for Public Health and Equality and relevant Officers

Oxfordshire Health Inequalities

Background

5. Health inequalities are best defined as "unfair and avoidable differences in health across the population, and between different groups within society". The causes of health inequality are complex, and a range of factors can be involved. These include;

i. Age, sex, race DNA and other personal biological features
ii. Individual lifestyle factors
iii. Social and community networks
iv. Living and working conditions across the life-course
v. Availability and access to relevant health and care services

6. It is important partners within Oxfordshire seek to address health inequalities. This is not only because of the rationale from a social justice perspective but because of the impact on families, community and the cost to the local economy and public services of such inequalities. Initiatives that effectively address health inequalities will reduce demand on services as more people live in good health for longer.

7. Due to the broad range of determinants of health that exist, action to improve health and wellbeing requires a very broad approach. This is spread across the functions of the Council, our partners and the wider community. The determinant of health range from the built environment, to community resilience, from clean air to access to medical services, from good education and housing in childhood to access to care support in older age. In our areas that experience the greatest health inequality we often see several of these determinants being less favourable and clustering together causing the health inequality. Effective action therefore requires holistic and coordinated action across the Council and with many other partner organisations. As well as commissioning specific preventative services, the Council's role is to provide system's leadership and to convene partners and the community to address inequality.

8. Some activity needs to be delivered at very local, place based, level while others must be at scale, some actions produce more immediate results, while others will only demonstrate benefit in several years or even decades time. All actions fit into one of three tiers and this tiered approach is fundamental in bringing cohesion to our approach to talking inequalities in Oxfordshire.

A tiered approach to tackling Health Inequalities

9. The tiered approach to addressing health inequalities is a continuum from quite "downstream" actions that aim to minimise the impact of established diseases or needs (tier 1) to "upstream" interventions that seek to address the underlying causes of ill health and health inequalities. Action from a range of partners is need at all tiers to make a positive impact. A fuller explanation of each tier is as follows:

10. Tier 1- or tertiary prevention- addresses inequalities where disease or care needs are already established and seeks to optimise treatment and self-management to minimise the impact. For example, Adult Social Care teams taking a strength-based/community asset-based approach when someone needs support to maintain their independence at home or Primary Care teams proactively supporting good blood pressure management. In both examples, the need for this is typically greater in some of our ethnic minority or more deprived communities. A lot of the actions within this tier sit with colleagues in the NHS and in collaboration with OCC's adult social care services.

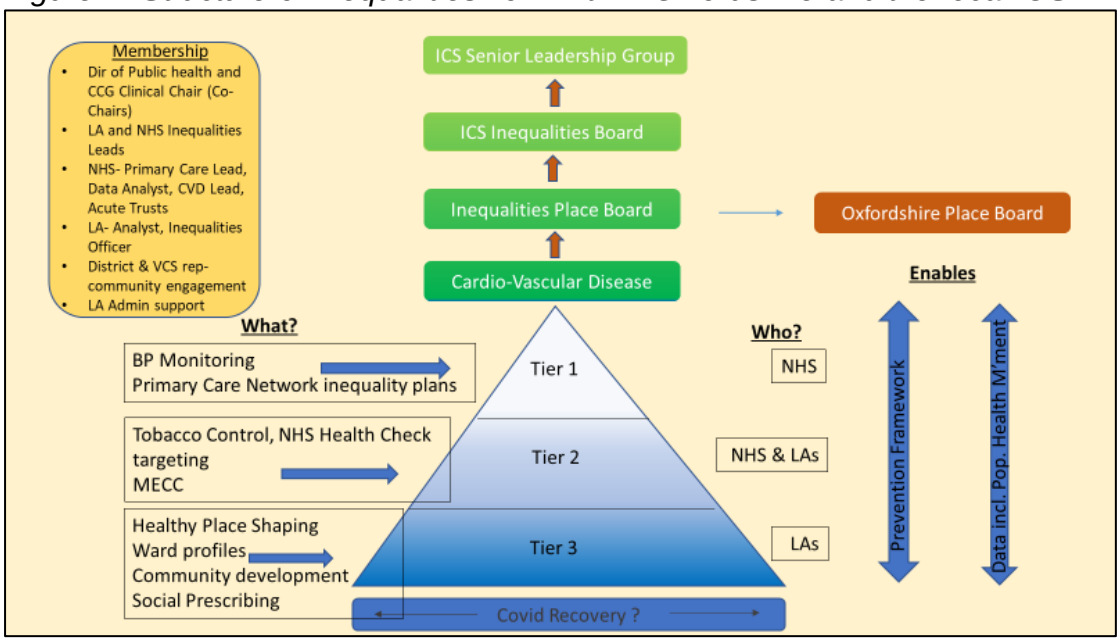
11. Tier 2- or secondary prevention- addresses inequalities where a disease is in earliest stages or a disease risk factor can be addressed before it causes problems. For example, social care colleagues signposting to physical activity support for someone who has started to lose mobility at home and is at risk of falls. Or within the NHS, screening people for undiagnosed or early-stage Cardio-Vascular Disease (CVD) via the NHS Health Check Programme or supporting people with nicotine addiction to be tobacco free. In these areas we know residents from the most deprived communities in Oxfordshire are most likely to smoke or have CVD undiagnosed or diagnosed late. Many of the actions in this tier are led by OCC's public health team and includes a mixture of commissioning and partnership working.

12. Tier 3 or primary prevention- addresses inequalities by tackling the causes of unequal disease prevalence or care needs and the drivers of less healthy behaviours. For example, providing access to green space, supporting active travel and building community resilience are important initiatives because they are strong determinants of health and across the county they vary quite considerably. Place-shaping, community building and supporting the most vulnerable is core to the work of local authorities, both at County and City and District levels, and so teams across councils are engaged in work which ultimately contributes to primary prevention.

    Within these tiers of action, OCC's connection with the community and voluntary sector (VCS) is of great importance. This includes the grant funding the council makes to VCS groups, the VCS infrastructure contract and the partnership working we are engaged with alongside City and District partners through community forums such as Health and Wellbeing Partnerships in Oxford City and the Brighter Futures initiative in Banbury. Adult social care teams also work closely with the VCS in delivering some of the Oxfordshire Way work programme including the empowering communities initiatives.

13. The emerging overarching structure of the health inequalities work within the Oxfordshire "place" within the Buckinghamshire Oxfordshire and Berkshire West Integrated Care System (BOB ICS) is summarised below, using Cardio-Vascular Disease as an example of how the tiered approach described approve fits within it. This aims to bring closer working with NHS colleagues to take forward initiatives that require a joined-up approach with the NHS.

Figure 1- Structure of Inequalities work within Oxfordshire and the local ICS



10 Wards with greatest health inequality

14. Despite being an affluent and healthy county overall, Oxfordshire comprises of 10 wards which are within the 20% most socio-economically deprived in the country. This is detailed in the Director of Public Health Annual Report and the Oxfordshire Joint Strategic Needs Assessment. The details around such inequalities are described more fully in these documents, but in summary the difference in life expectancy between the most and least deprived neighbourhoods is 11 years, whilst the difference in healthy life expectancy (how long you can expect to live without an impactful long-term condition or disability) is often even greater. There is more than a 5-fold difference in preventable mortality between the same areas.

15. The 10 wards which are among the 20% most deprived in the country and experience the greatest health inequalities are as follows;

i. Abingdon Caldecott
ii. Banbury Cross and Neithrop
iii. Banbury Grimsbury and Hightown
iv. Banbury Ruscote
v. Barton and Sandhills
vi. Blackbird Leys
vii. Carfax
viii. Littlemore
ix. Northfield Brook

x. Rose Hill and Iffley

16. The data pack in Appendix 2 presents the latest information available on the inequalities in Oxfordshire. It shows that whilst there may be little variation from Oxfordshire and England averages (red and black lines) at a District or City level, there is significant variation at a ward level. The data also highlights, for a range of different measures of health inequality, how commonly these "top 10" wards appear as those with the worst outcome in the county. The cumulative impact of these poor outcomes across the life-course is what leads to the reduced life expectancy and healthy life expectancy noted above. While focus on the most deprived geographical inequality is important, significant inequality exists between different groups within the community, within and beyond the most deprived areas.

Covid impacts and lessons learned

17. It is clear that the COVID-19 pandemic has had a major impact on all residents of Oxfordshire in some form. To understand the impact and organise our response, we can categorise this impact as:

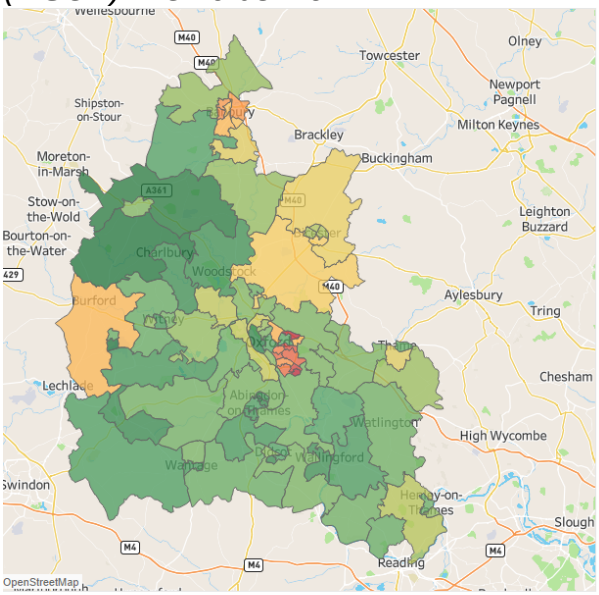
- Direct COVID related through COVID infection, illness and in some cases death – this is the impact we have clearest data on

- The indirect health impact of COVID, for example through increased prevalence of mental ill-health, periods of inactivity or limitations on access to health care delaying diagnosis and treatment – data is emerging about these impacts locally and nationally

- The wider impacts of COVID which will have long term health consequences, for example educational outcomes and loss of employment - these are the longest-term impacts for which data is limited

18. By the end of October 2021, more than 75,000 people have tested positive within the county showing that the direct impact has been seen across the County. However, we know that the direct impact of the pandemic has not been felt equally. The map below in figure 2 shows that cases have been more prevalent within the urban parts of Oxfordshire and in the areas with the highest level of socio-economic deprivation.

Figure 2- Cumulative case rate of COVID-19 per Medium Super Output Area (MSOA) in Oxfordshire



MSOA long name	Cases	Rate per 1000..
Barton	1,188	17,140
Greater Leys	1,063	17,101
Blackbird Leys	929	16,236
Churchill	1,133	15,855
Cowley North	2,052	15,278
Iffley Fields	757	15,170
Littlemore & Rose Hill	1,467	14,995
East Central Oxford	1,533	14,458
Banbury Ruscote	1,176	13,914
Cowley South & Iffley	1,263	13,787
Banbury Hardwick	1,126	13,663
Banbury Grimsbury	1,611	13,580
Marston	796	12,960
Risinghurst & Sandhills	958	12,857
Banbury Easington	1,080	12,857
Burford & Brize Norton	782	12,818
Banbury Neithrop	746	12,685
Banbury Calthorpe	641	12,618
Islip, Arncott & Chesterton	1,469	12,400
Bicester South	979	12,391
Kidlington South	680	12,257
Caversfield, Ambrosden & Fringford	1,240	12,207
Bodicote, Adderbury & Bloxham	1,175	12,080
Thame South	872	12,066
Wolvercote & Cutteslowe	664	11,847
Botley & Kennington	1,187	11,726
Hanborough & Cassington	732	11,636
Shiplake & Binfield Heath	710	11,446

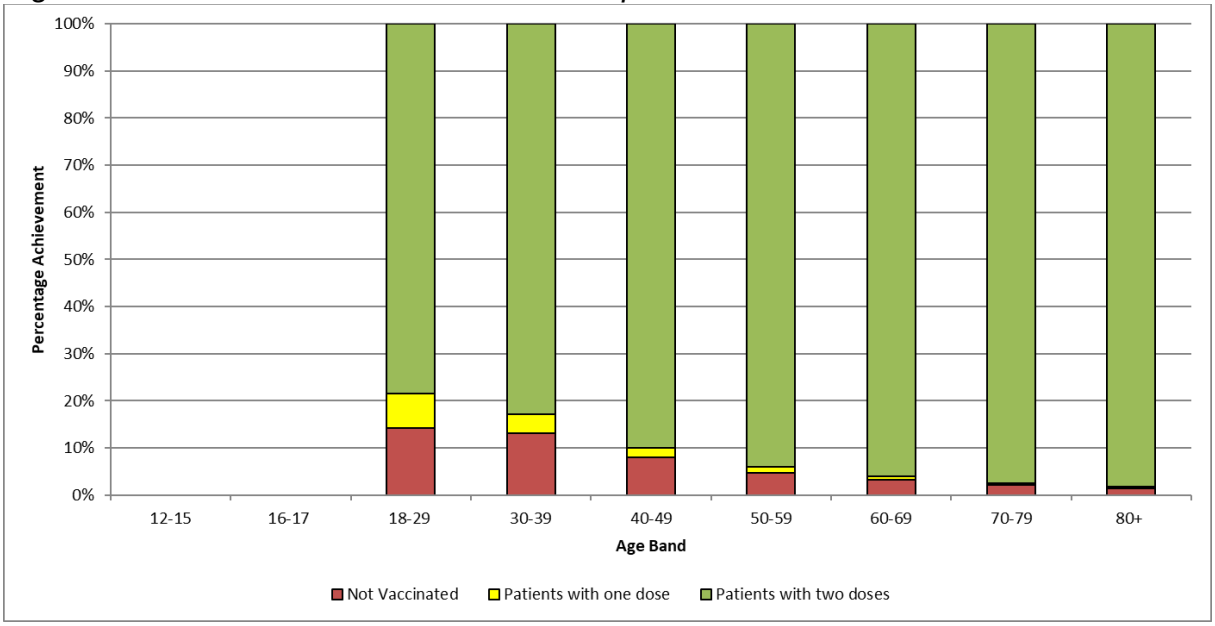
NB- only MSOAs with highest prevalence listed in table on right

19. The data pack in Appendix 2 shows the same cumulative case rate over the course of the pandemic but segmented by age, gender, ethnicity and deprivation. It is clear from page 1 that younger populations have had greater infection rates, although the more serious outcome of hospitalisation and death is more common in older age. More females than males have tested positive, although this may reflect patterns of access to testing than true prevalence. Overall mortality has been higher in men than women.

20. There has been a clear difference in the impact of COVID-19 between different ethnic groups. Although the local data on page 2 shows the greatest count of cases is within British residents this is because they are the largest ethnic group in the county. The mortality rate at different points in the pandemic has shown up to a 4-fold increase in mortality between Black African and some Asian ethnicities when compared to white British. The graph on table 3 shows that at a small neighbourhood level (referred to as a Lower Super Output Area or LSOA) the case rate has been 1.5 times greater in more socio-economically deprived communities compare to the least deprived.

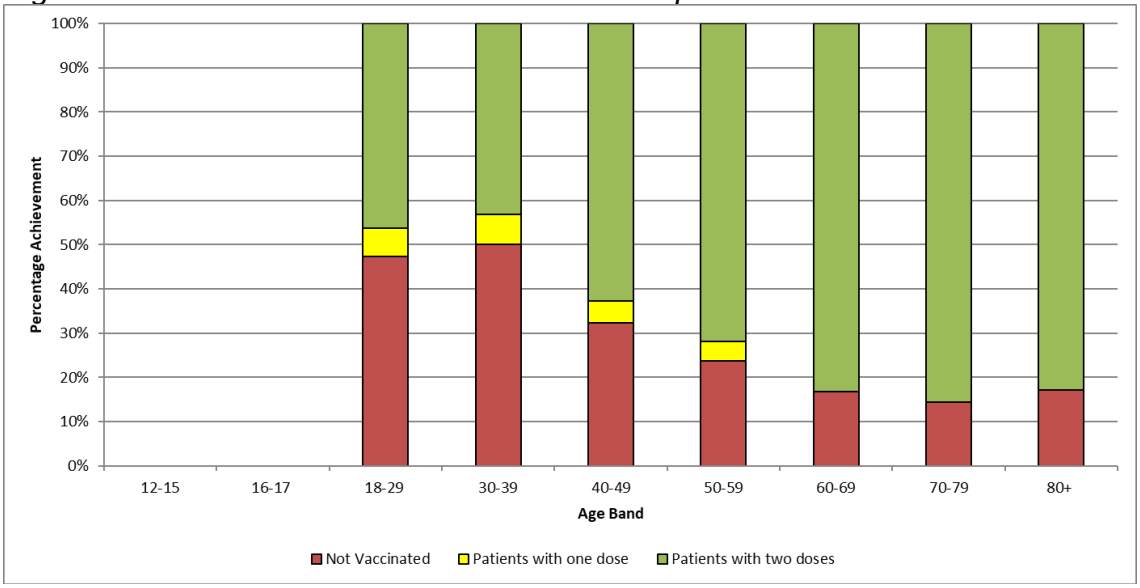
21. Vaccination inequalities have been present before the national vaccination programme had started, with some Black ethnic groups reporting 2-3 times the level of vaccine hesitancy than other ethnic groups. This hesitancy is present within vaccination uptake data in figure 3a and 3b below that shows difference in uptake between White British and African Caribbean residents as an example of the difference seen locally.

Figure 3a- White British residents vaccine uptake in Oxfordshire



NB- single dose vaccination data for 12-17 year olds omitted from this data set as roll-out not complete at the time of reporting

Figure 3b- Black Caribbean residents vaccine uptake in Oxfordshire



22. Ultimately, the greatest impacts of COVID-19 at the population level are not likely to be the direct impacts of COVID-19 but rather caused by the impacts of lockdowns and COVID restrictions on people's health and wellbeing. For example, the impact on there being less access to health services for non-infectious diseases (such as cancer or heart disease), or the wider impact of missed education, financial impacts, job losses, social isolation and reduced mental wellbeing.

23. While data and insight into the longest-term impacts on COVID remain in development, it is clear that those who were already likely to be suffering the most health inequality are also likely to suffer the greatest consequences of

the pandemic. Directly and indirectly, the impact of COVID will have exasperated existing inequalities and must therefore be a significant factor in our long-term planning.

24. While partnership working has always been at the core of public health work in the widest sense, Oxfordshire's COVID response has accelerated and expanded planning and activity at the systems level, focussing on the needs of communities and individuals rather than the specific services of individual organisations. A significant element of the learning from the COVID-19 period will be on how these ways of working can continue to develop and grow to tackle cross-community issues such as health inequality.

Priority areas for action

25. In partnership with key stakeholders, the Public Health team is currently focussing our action on inequalities on the priority areas of; Tobacco Control, Physical Activity and Healthy Weight, and Mental Wellbeing. These three areas have been selected because of the significant contribution they make to premature mortality and morbidity, because there are significant inequalities present within each one and because they are issues that have become all the more important in light of the COVID-19 pandemic.

26. Smoking tobacco is the leading modifiable risk factor for premature mortality and it accounts for over half of the difference in risk of premature death between the most and least deprived social groups.

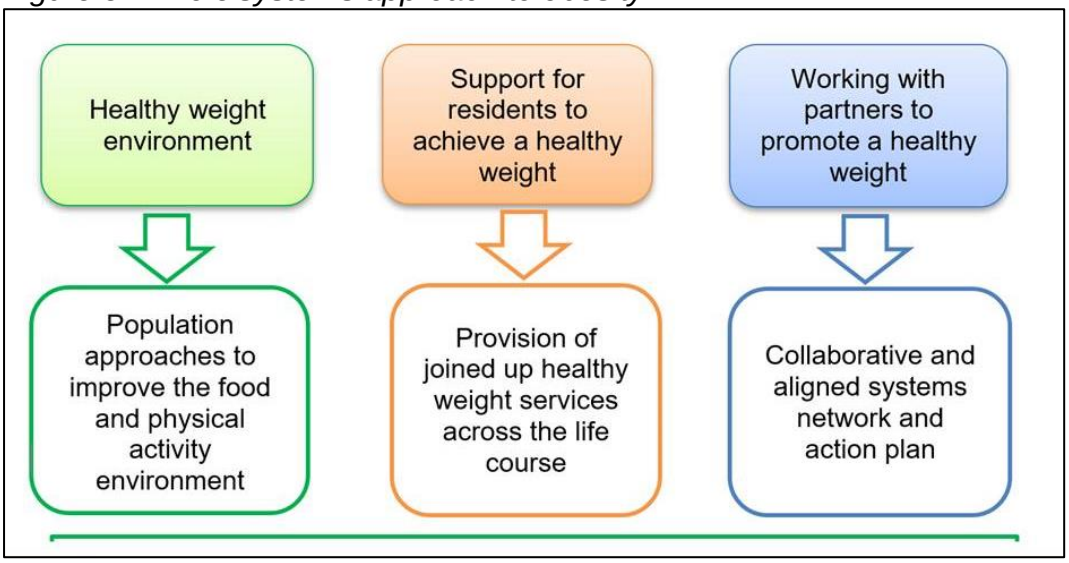
27. In May 2020, County and District Councils across Oxfordshire, as well as local NHS organisations, signed up to a County-wide Tobacco Control Strategy with an ambition for Oxfordshire to be smoke free by 2025 (defined as an overall smoking prevalence of <5%). This is five years earlier than the national target, as outlined in the Government National Tobacco Control Plan for England 2017-22. The Oxfordshire Tobacco Control Strategy has four key pillars for a whole systems approach to local tobacco use: prevention, creating smokefree environments, enforcement, and supporting smokers to quit. The Oxfordshire Tobacco Control Alliance is responsible for delivering the action plan that sits under this strategy. It is an officer-led alliance of organisations signed up to the strategy and regularly reports on its progress to the Oxfordshire Health Improvement Board.

28. Data on childhood obesity clearly shows a social gradient which increased with age meaning that children from more deprived areas are more likely to be of unhealthy weight by age 4 when compared to more affluent peers, a difference which then increases 2-3 fold by age 11. Physical inactivity and unhealthy weight levels have worsened during the pandemic in children and adults. Both lower physical activity levels and higher obesity levels are most pronounced in the more deprived communities in Oxfordshire.

29. Obesity is a complex problem with multiple causes. Most interventions to date have focussed on individual behaviour change like improving diet or reducing sedentary behaviour. While these remain important, a system wide

approach, tailored to local need across the life course is required, in line with the national Whole Systems Approach/Obesity Framework. Consequently, in Oxfordshire a similar approach to that utilised for tobacco control, is underway. This involves developing work that addresses 3 inter-related areas of; promoting a healthy weight and preventing obesity, addressing the physical and social environment and providing support to residents to achieve a healthy weight.

Figure 3- Whole systems approach to obesity



30. The importance of mental wellbeing has become increasingly apparent as we have moved through the COVID-19 pandemic and we know that certain population groups have been at a greater risk of experiencing mental ill-health. For the majority of residents of Oxfordshire this does not mean they need specialist mental health services from the NHS, but rather to be supported individually and in their social or community context to care for their mental wellbeing. A Mental Wellbeing Health Needs Assessment has recently been completed and presented to the Health and Wellbeing Board

31. The actions to support this are coordinated by the Prevention Concordat for Better Mental Health. This concordat aims to facilitate local action around preventing mental health problems and promoting good mental health. The concordat is underpinned by an understanding that taking a prevention focused approach to improving the public's mental health is shown to make a valuable contribution to achieving a fairer and more equitable society. The concordat promotes evidence-based planning and commissioning to increase the impact on reducing health inequalities.

32. As noted, health inequality must be tackled across the organisation. As well as consideration being developed with the overall council strategic plan under development, a number of corporate and partnership strategies are in development to address issues that have come to additional prominance during the pandemic, including digital exclusion and access to food. The Digital Inclusion and Food Strategies are being developed in partnership with public sector and VCS partners to collectively address inequalities in day-to-

day life, which can indirectly impact on health, which include access to healthy food and access to training and devices to get online safely and confidently.

33. Revised consideration of the priority of health inequalities will also inform system-level planning for COVID-19 recovery and renewal planning. One part of that is a review of the Health and Wellbeing Strategy for Oxfordshire undertaken by the Health and Wellbeing Board in September 2021. That review concluded that the strategy, although written pre- COVID-19, remains relevant for the county and the priority it gives to health inequalities is an increasingly important focus. Overall system planning also presents an opportunity to influence the wider determinants of health – for example through the development of long-term place-based plans including Oxfordshire 2050 and through the delivery of sector specific recovery programmes such as the Oxfordshire Economic Recovery plan.

Next Steps

34. To take forward effective action to address health inequalities Officers are in the process of taking forward a range of actions. These do not sit with any one team, service or organisation, but rather require partnership working to ensure they are effective. Initiatives being developed include the following list.

35. Establishing a health inequalities board for Oxfordshire. This board will be co-chaired by the Director of Public Health and the NHS Clinical Commissioning Group's Clinical Chair. It will report into the Integrated Care Partnership for our area and initially focus on taking a tiered approach to addressing inequalities in CVD.

36. Tackling inequalities and providing opportunities for everyone in Oxfordshire to achieve their full potential is one of the 9 priorities of the Fair Deal Alliance. Work has commenced to develop the County Council's Strategic Plan to take these priorities forward and Officers will seek to include actions which tackle inequalities in health that sit across the organisation.

37. Our partnership with the Voluntary and Community Sector (VCS) plays a significant role in addressing health inequalities. Cross-organisational work is already underway to develop a VCS Strategy which will underpin our collective commitment to the sector and enable us to work more closely to address the needs of our communities. This work will also support the longer-term vision for the infrastructure provision that supports VCS organisations and volunteers across the county, and will seek to strengthen our commitment to equality, diversity and inclusion through prioritising the needs of our under-represented groups across Oxfordshire

38. To improve inequalities in physical activity levels and un-healthy weight Officers are developing a whole systems approach to obesity. There already is consensus across County and District Councils plan to expand the Families Active and Sporting Together (FAST) initiative which has run successfully in the 3 most deprived wards in Banbury. This will be made available to residents

in the other most deprived wards in the county and to all children in Oxfordshire in receipt of Pupil Premium support. This work will report into the Oxfordshire Health Improvement Board

39. With oversight from the Oxfordshire Health Improvement Board and the new health inequalities board for Oxfordshire, work is now progressing to expand the reach of the Tobacco Control strategy. Officers are working with colleagues in the NHS to galvanise action to support smoking cessation with residents who are in contact with NHS Secondary Care services, especially aiming to reduce smoking prevalence among pregnant women and acute mental health service users.

40. The 2021 Mental Wellbeing Health Needs Assessment has provided a comprehensive picture of mental wellbeing in Oxfordshire and the impacts of COVID-19. This has been presented to the Health and Wellbeing Board and Officers will be taking forward the recommendations within the report to reduce inequalities in this area. This work will be overseen by the Oxfordshire Mental Health Prevention Concordat Partnership Group reporting into the Oxfordshire Health Improvement Board

41. After the publication of the Director of Public Health Annual Report (link above), Officers intended to undertake more detailed ward profiles of the 10 wards with the greatest health inequalities to more fully understand the need in these communities. This involves the collection of further quantitative data but crucially also involves asset mapping with the community and gathering qualitative insight from residents in these areas. This work has been delayed because of the COVID-19 pandemic response work and one profile has been completed so far (Banbury Ruscote). Officers are now moving forward with undertaking more of these profiles to ensure this work is completed.

42. The overall impact of COVID-19 on different communities in Oxfordshire has been described briefly above but is not yet fully understood. As has been highlighted, some ethnic minority groups have borne a greater burden, but we need greater insight into this. We therefore intend, alongside the ward profile insight work, to undertake further impact analysis in this area.

Financial Implications

43. There are no direct financial implications to this report. All projects or services referred to in the report have established and various funding streams. As work is developed and any changes to funding levels is required this is decided via the usual governance process within the relevant service area.

44. The Public Health team hold a small Health Inequalities Fund which has a value of £600k per annum. This is being used to seed fund specific initiatives such as FAST expansion or other cross-cutting work areas such as the ward profile work, which enable a more informed insightful approach to be taken to address health inequalities.

45. The bulk of resources available to tackle health inequalities are of course within service and partner budgets and work programmes. Good intelligence and joined up planning will maximise the impact that existing funding can have to tackle health inequalities from a whole-system perspective.

Legal Implications

46. There are no direct legal implications of this report. The Council's duty under the Equality Act 2010 is supported by the range of work described above and individual projects are required to have Equality Impact Assessments undertaken in the usual way.

Ansaf Azhar
Corporate Director of Public Health and Wellbeing

Annexes:
Appendix 1 Data Pack on latest Health Inequalities Data in Oxfordshire
Appendix 2 Data Pack on Cumulative Cases of COVID-19 in Oxfordshire

Background papers:
Nil

Contact Officer: David Munday, Consultant in Public Health,
David.munday@oxfordshire.gov.uk, 07922 849652

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