KNOWSLEY HEALTH INEQUALITIES POLICY FRAMEWORK

1. INTRODUCTION

Knowsley has made significant progress in reducing health inequalities within the borough (internally) and is becoming much closer to the national average[1] (external) for many health indicators. In addition, Knowsley has been performing better than average in reaching many of the national health inequalities targets[2]. However, despite these improvements, overall rates of death, cancer and heart disease and strokes are all higher than the national rates, and in some cases such as respiratory disease are widening.

Furthermore, for some diseases there are still large differences to those of our statistical neighbours and internal inequalities are still marked. The Knowsley population are more likely to smoke, drink alcohol and be obese than the rest of the North West and this largely explains the high rates of cancers, respiratory and heart disease.

National and local policies are currently undergoing great change. This framework has been developed to reflect those changes and enable the development of appropriate actions to effectively address health inequalities in Knowsley in the future. In particular, the policy framework will reflect upon the findings of the Marmot Strategic Review into Health Inequalities. The key change being the need for a shift in policy direction from improving people's lives to helping people improve their own lives. It will introduce the need for a new approach focusing on creating conditions to reduce health inequalities through developing people, power and places.

Reducing health inequalities requires a coordinated local effort by local government, the NHS, the voluntary sector, the private sector and local communities, as well as national action on social, economic and health policies.

2. PURPOSE OF POLICY FRAMEWORK

The policy framework will be used to inform and shape policies and strategies developed by key partners in Knowsley including the NHS, Clinical Commissioning Group (CCG) and Local Authority. It will be utilised with partners to develop agreed, shared actions that will effectively bring about improved health and wellbeing and reduced health inequalities in the borough. The aspiration behind the policy framework is to raise levels of health in Knowsley to be at least the average levels of health experienced in England.

3. WHAT ARE HEALTH INEQUALITIES?

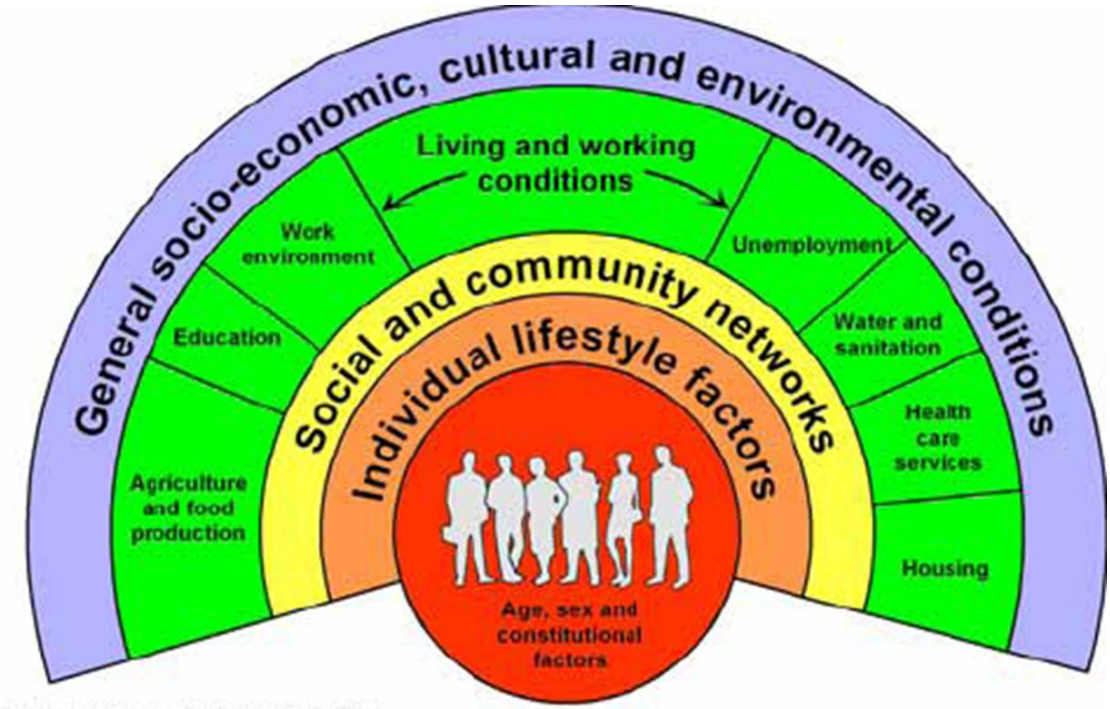
[1] Knowsley Council and NHS Knowsley (2009). *Health for All in Knowsley A Strategic Framework for Improving Health and Reducing Health Inequalities in Knowsley*. Knowsley: NHS Knowsley.

2 Forrest D (2010). Much Achieved: More To Do. Reducing Health Inequalities in Knowsley. A review and position statement. Knowsley: Knowsley NHS and Knowsley MBC.

Health inequalities can be defined as “the differences in health status or in the distribution of health determinants between different population groups”. This relates to the quality of people’s lives and also how long they live.

The health gap between socioeconomic groups cannot simply be explained by ‘bad’ health behaviours in the lower social classes and poorer access to services, although they do play an important part. The gap is caused by social and economic inequalities in the conditions in which people are born, grow, live, work and age and the drivers that give rise to them, which are inequities in power, money and resources (Marmot, 2010)[3]. Figure 1 shows the factors that influence health and wellbeing.

Figure 1 The factors that influence health and wellbeing



Dahlgren and Whitehead (1991) Determinants of Health Model

This shows that there are multiple factors that affect health and wellbeing. These factors are not independent and so to improve health it is not simply enough to address one factor. For example, good education can lead to better health but likewise being healthy can lead to better education. In addition, education influences employment prospects and wellbeing but also influences social and community networks.

Therefore reducing health inequalities requires local action by local government, the NHS, the voluntary sector, the private sector and local communities, as well as national action on social, economic and health policies.

4. HEALTH INEQUALITIES IN KNOWSLEY

[3] Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England post-2010. http://www.marmotreview.org/

Knowsley is one of the most deprived boroughs in the country and has very significant health inequalities to address.

Overall, the Index of Deprivation for 2010 positions Knowsley as the 5th most deprived in the country, with 43% of people in Knowsley living in communities classed as being within the 10% most deprived in England.

Knowsley has made significant progress in reducing health inequalities and is becoming much closer to the national average. The latest health statistics (2008 - 10) show the significant improvements made since 1995-97 (13 years):

- Overall death rates down 29%
- Inequalities gap in deaths down 41%
- CVD deaths down 52%, gap reduced by 52%
- Cancer deaths down 28%, gap reduced by 43%
- Respiratory disease down 14%, gap reduced by 5%

There have also been significant improvements in the key contributing factors to health inequalities including improvements in educational attainment and reductions in crime.

- Over the last 5 years, the percentage of children achieving 5 GCSE's A* to C (incl. English & Maths), has increased by 12.5%.
- Crime is falling, there were over 6600 less recorded crimes in 2010/2011 compared with 4 years ago, a reduction of 40% over this period.

4.1 Comparisons to England

Despite these achievements, Knowsley residents still suffer from health inequalities compared to the England average. For example;

- Overall deaths remain 22% higher than the England rate
- Cancer deaths remains at 29% higher than the England rate
- CVD death rates are 37% higher than the England rate
- Respiratory disease death rates are 89% higher than the England rate
- Educational attainment – 38% of pupils achieved 5 GCSEs grade A to C (incl. English and Maths) compared to 55.3% in England (2009/10)
- Employment - 61.9% of the working age population are employed compared to an employment rate of 70.3% in Great Britain.
- 32% of children live in poverty compared to an England average of 21% (2009 figures).
- Breast feeding rates at 6-8 weeks are 16.7% in Knowsley compared to 46.5% nationally.
- There are more 16-18 year olds not in Education, Employment or Training (NEET) than nationally (11% compared to 7% in England)
- Almost a third of Knowsley adults are smokers, compared to around a fifth of adults nationally.

- Alcohol related hospital admissions in Knowsley are over 60% higher than the England rate
- Smoking at time of delivery is 22% in Knowsley compared to 13% in England.
- In Knowsley 23.4% of households are living in fuel poverty, compared to an England average of 21%,

4.2 Comparisons to statistical neighbours

The differences in the health and wellbeing outcomes can also be observed against statistical neighbours. Knowsley's statistical neighbours are Middlesbrough, Kingston-Upon-Hull, St Helens and Halton who all have similar characteristics as Knowsley allowing direct comparisons to be made.

Historically on most of the high level indicators such as cancer, cardiovascular disease (heart disease and strokes) and respiratory disease deaths, Knowsley has had higher rates than statistical neighbours. However, with the exception of respiratory disease, Knowsley has been narrowing the gap and performing better. Indeed, for cancer and cardiovascular disease (heart disease and strokes) the rates are now comparable, with negligible difference to statistical neighbours.

4.3 Internal health Inequalities (gap within the borough)

Internal health inequalities that exist with differences between the most deprived areas of the borough and the least deprived. Differences can be measured between the 50% most deprived and the 50% least deprived. This is calculated through the Index of Multiple Deprivation which is a national measure which based upon particularly indicators provides a deprivation score. Unless otherwise stated, when the difference between the most and the least deprived is quoted in this policy this is the measure used. However, in addition, differences can be observed to show inequalities between wards.

Overall, males live 9.1 years longer in least deprived areas compared to those living in the most deprived areas in the borough. For females there is an 8.6 year gap between those living in the most and least deprived areas of the borough.

- The life expectancy gap between the most and least deprived is 4.7 years for Males and is 3.7 years for females.

- For all causes of mortality, the difference between the most and least deprived is 216 deaths per 100,000 population

- For Cardiovascular disease, the difference between the most and least deprived is 50 deaths per 100,000 population

- For cancer, the difference between the most and least deprived is 68 deaths per 100,000 population

- For respiratory disease, the difference between the most and least deprived is 40 deaths per 100,000 population.

- In 2009, smoking prevalence varies dramatically across Knowsley, with the smoking rates being over double in the most deprived wards than the least deprived.

- When analysis of breastfeeding initiation was analysed by electoral ward in 2007/08 the rate ranged from 11.8% to 51.4%

5. CHANGING POLICY CONTEXT

In 2009, Knowsley published a strategic framework for Reducing Health Inequalities, entitled 'Health for All in Knowsley' (NHS Knowsley/ Knowsley MBC, 2009). This strategic framework was based upon policy thinking at the time and reflected upon the progress made in reducing health inequalities in Knowsley.

Since its publication, there have been major shifts in policy direction and evidence on what should be implemented to reduce health inequalities.

One of the main policy drivers for this framework is the Marmot Review, Fair Society, Healthy Lives (Marmot, 2010). This was the biggest review of health inequalities since the Acheson report in 1998 which emphasised the persistent nature of health inequalities in England and suggested that efforts should be made to tackle the social gradient in health. However, focusing solely on the disadvantaged will not reduce the gradient sufficiently. Marmot introduces the concept of 'proportionate universalism' where actions must be universal, but with a scale and intensity that is proportional to the level of deprivation. It identified a number of policy areas that will have the greatest impact on reducing health inequalities.

These strategic priorities identified were:

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

By setting out the strategic priorities like this, Marmot also draws attention to the underlying causes of disease ('causes of the causes') which are the social determinants of ill health.

There have also been wider government policy changes that will have an impact on health inequalities. In particular is the role of 'building more resilient communities', which encourages people to take more control over their own lives, rely less on public services and help other people. This could be a really positive change in our society, but could also have the unintended consequence of leaving the most

vulnerable at risk of further inequities in health and social care. In addition, the Localism Bill which strengthens the powers of local government provides a major shift in policy direction. It reduces top down bureaucratic central government control and advocates devolution to the local level. This means that Councils have a greater opportunity to decide upon priorities and freedom to focus more on commissioning based approaches, redefining demand for services and involving a greater number of residents in shaping the services they receive.

The other major policy shift has been reflected in the White Paper, *Liberating the NHS* (Great Britain, DH, 2010), which sets out radical change for the way in which NHS services will be commissioned and delivered in the future. By 2013 the responsibility for improving health and wellbeing and reducing health inequalities will be transferred to Local Authorities along with delivering some other Public Health functions. Locally, the NW Directors of Public Health have put wellbeing at the heart of tackling health inequalities. Their report[4], states that, there will be no lasting reduction in inequalities unless we create the conditions across local communities that support wellbeing and enable people to live well (figure 2).

6. A NEW APPROACH TO REDUCING HEALTH INEQUALITIES

Based upon the changing policy context and emerging evidence on the effectiveness of strategies to reduce health inequalities it is clear that a different approach is needed. The figure below shows the key changes in approach;

Figure 2. The new approach to reducing health inequalities

The New Approach: Key Points
1. A universal population approach to improve the health for all 2. A life course focus with a particular emphasis on early years. 3. Enhance assets within the community rather than just dealing with deficits (needs) 4. A shift in policy direction from 'improving people's lives' to 'helping people improve their own lives' (where appropriate). 5. To effectively reduce health inequalities and improve wellbeing there needs to be a focus on the concept of People, Power and Places.

A population approach is needed to drive up health and wellbeing outcomes in the Borough rather than targeting those most in need. This type of approach aims to improve the health of the entire population and to reduce health inequities among all

[4] Living Well Across Local Communities: prioritising wellbeing to reduce inequalities, NHS NW, 2011

population groups. However, the new approach needs to focus on the life course, with a particular emphasis on early years development. It is acknowledged that such a focus will require a long term view and commitment. However, in the long-run, evidence indicates that a focus on early years development will have a greater impact upon reducing inequalities, be more cost effective and produce better outcomes. A life course approach which focuses upon common themes at different stages of life will produce the biggest impact on a population level. Rather than targeting the whole population with many different topic based health initiatives and messages (e.g. obesity, smoking, Cardiovascular disease etc.), it is more appropriate for local health and wellbeing services to, in the main, align to the life-course approach. This will enable the development of population level interventions to change behaviour, by addressing the underlying causes of disease and illness rather than focus on the end outcomes. The life course categories could include, for example: maternal and early years; children; young people and families; middle age and older age.

There is also a need to recognise and enhance the assets within the community rather than dealing with the deficits. An asset based approach to reducing health inequalities will better equip partners to work with the community to achieve more effective and sustainable outcomes. In addition, people need to be enabled to take control of their own lives and remain independent for as long as possible.

Reflecting on Marmot's objectives, it is clear that to improve health and reduce health inequalities requires a partnership approach between the local authority, NHS, voluntary, third sector and the community. Indeed, improving health needs to continue to be everybody's business.

In principle, Marmot can be summarised as improving three key constructs, people, places and power.

People

A focus on people and relationships is key to reducing inequalities across the Borough. Particularly important is supporting early years development to give every child the best start in life including ensuring high quality maternity services, parenting programs, childcare and early years education to meet needs across the social gradient.

Case Study: Breastfeeding

As well as protecting babies from infection, studies also link breastfeeding to higher IQ and a reduced risk of childhood obesity, and for the mother, increased protection from breast and ovarian cancer. The Peer Support Service in Knowsley aims to provide support to women during the antenatal and postnatal periods, in order to target a more intensive care pathway to women less likely to breastfeed.

Peer support helps mums like Carol, who gave birth to a boy in September 2011. Although a normal delivery, Carol's baby had lost 13.5% of his birth weight prior to being discharged from hospital. Carol and her baby were soon thriving after she followed the breastfeeding advice and support given by her peer supporter during regular home visits and over the phone.

The positive start in life needs to be followed on across the life course to enable people to maintain a good quality of life. This should be supported by the availability of good quality public services that encourage and promote emotional, physical and mental development throughout a person's life.

Key to this is prevention and early detection and intervention, especially those conditions that are most strongly linked to health inequalities.

Case Study: 'Knowsley at Heart' Health Checks Programme

Knowsley at Heart is supported by Knowsley Health and Wellbeing Partnership, an enterprise which is using the combined force and expertise of Knowsley Council and Knowsley PCT, along with key third sector partners, to tackle health inequalities in the borough.

The 'Knowsley at Heart' Health Checks programme offers a free, quick and easy health test and lifestyle assessment in GP and other community settings. In Knowsley last year, more than 1400 people undertook a health check. The programme was also estimated to have identified more than 50 people with diabetes and 135 with kidney disease, resulted in more than 150 people being referred to stop smoking services and motivated more than 100 people to increase their physical activity levels.

A number of local residents who have survived a heart attack or stroke have welcomed the health checks. One patient from Prescot said:

"I was in hospital for a long time after my heart problems and it took me a long time to get my confidence back when I left hospital. It's great that people can get these checks before they get sick and they won't ever have to go through what I did, Just get checked out!"

Places (environments)

The places in which people live need to be of high quality. This includes the availability of high quality housing and access to open and green spaces across the social gradient. Planning, transport, housing, environmental and health systems need to be fully integrated to address the social determinants of health in each area.

Case Study: Community Energy Saving Programme Project

In partnership with British Gas, Knowsley Council secured funding from the Community Energy Saving Programme (CESP) to make improvements to eligible homes across the Borough. Home owners could benefit from up to £10,000 of improvements to their property, making homes more energy efficient and helping residents to potentially reduce their energy bills by up to 40%.

Mr and Mrs Clarke from Stockbridge Village registered with the Programme and had a survey of their home undertaken which concluded that they would receive a brand new A-rated boiler, new radiator valves and external wall insulation. Mrs Clarke commented:

"We couldn't believe it… we were delighted! Our house was a really cold house… we had to boil the kettle for hot water… I've had some health problems and the cold didn't help but now I really feel the benefit, I'm much more comfortable!"

This is key to creating health promoting environments which make the decision to adopt healthy lifestyles easier. Places also need to effectively serve the communities who live there. Barriers need to be removed to enable community participation and action and reduce social isolation, particularly in older people.

Case Study: Knowsley's Older People's Olympics

Knowsley's Older People's Olympics aims to give older people the chance to have fun, meet new friends and stay active and improve their health & wellbeing.

There is a wide range of activities on offer ranging from badminton, table tennis, draughts, Connect 4, darts, dominoes and netball/football shoot outs to boccia bowls, welly throwing, scrabble and interactive electric games.

One participant commented that *"it makes everyone competitive…it's a great way to get people active!"*

Power

Feeling empowered is important to tackling health inequalities across the social gradient. Active engagement with individuals and communities is key to people feeling able to influence local decisions and services and empowered to adopt healthier lifestyles and engage with services to improve wellbeing.

Case Study: Family Nurse Partnership

Laura* was 16 years old, 12 weeks pregnant and still at school when she first enrolled with the Family Nurse Partnership (FNP) programme. At the time she was living with her partner, a heavy drinker and cannabis user who also had a history of domestic violence. Laura stopped drinking when she became pregnant, but continued to smoke heavily.

Smoking was discussed during visits by her Family Nurse, but was not perceived by Laura to be a problem until the nurse encouraged Laura to think about the effects of her smoking on her unborn baby's health. By the time her daughter was born Laura had managed to stop smoking. Laura's daughter is now a year old and Laura has separated from her partner and continues to engage well with the FNP programme. Laura says that over the past 12 months she has grown in confidence.

Feeling empowered and having high levels of self esteem impacts on resilience and enables people to take control of their own lives and health and remain independent for as long as possible.

Case Study: IKAN Project

The 'IKAN' team offers advice and support to Knowsley residents aged over 55 on issues around health, home and personal safety. Services include falls advice, signposting to community activities, home aids and adaptations and a handyman service.

The booklet is a highly valuable resource for older people, helping them to remain independent and providing a 'trusted' source for help. The IKAN team has been particularly successful in accessing and engaging those isolated and living alone, with 78% of individuals reporting that they receive no social services input.

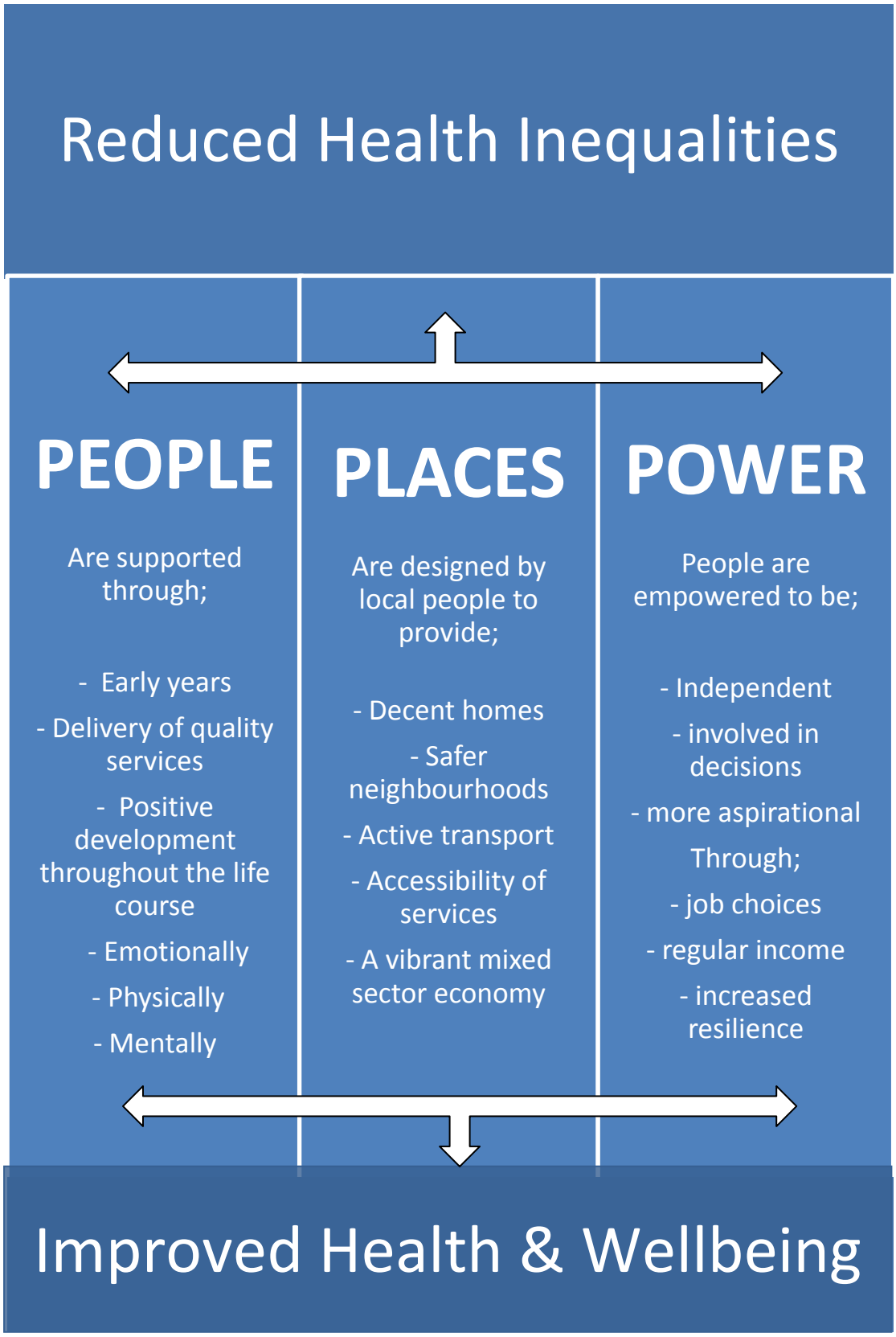
One service user commented:

I'm more confident in myself now, when I'm in on my own… I go in the garden and I have my pendant on me and if I have a fall I know exactly what to do, so I am quite happy".

Marmot suggests that key to this is the availability of good employment as a protector of health. For those who do require services, they should have as much choice and control over these services as possible aided by self-directed support, co-production and recovery-orientated practices.

The conditions required for each of these constructs are detailed in figure 3.

Figure 3. Improving health and reducing health inequalities by putting wellbeing at the heart of people, places and power



Using this construct, wellbeing is the glue that binds people, places and power together. Improving health and reducing health inequalities is everybody's business. Local policies and strategies need to be developed to reflect this shift in policy direction.

7. WHAT DO WE WANT TO ACHIEVE?

The aspiration behind the policy framework is to improve health outcomes at a faster rate than nationally and against our statistical neighbours and to reduce internal inequalities.

Specifically, the health outcomes that we want to achieve are:

- To reduce the gap in Health Inequalities between Knowsley and the England average, with the ultimate aim of being at least as good as the England average

- To improve our performance against our statistical neighbours, with the ultimate aim of becoming the top performer

- Internally, to reduce the health gap between the least deprived quintiles and the most deprived quintiles in the borough.

The overarching measure will be all age all-cause mortality (deaths) but further outcome indicators will be agreed with partners.

8. UNDERPINNING POLICIES AND STRATEGIES

The Joint Health and Wellbeing Strategy is the overarching strategic framework for local health and wellbeing commissioning. This has reducing health inequalities as a key component and reflects this change in policy direction. Furthermore, other key policies and strategies within the NHS, Clinical Commissioning Group (CCG), local authority, and other key partners will help to reduce health inequalities. These policies and strategies should be reviewed and aligned to reflect this policy framework.

The key policies and strategies underpinning this policy framework include;

- Child Poverty
- Economic activity and employment
- Educational attainment
- Community engagement in prevention and self-care
- Social Growth
- Localism
- Behaviour Change

This list is not exhaustive, with all key policies and strategies needing to consider their impact on wellbeing and health inequalities.

9. NEXT STEPS

Once the principles are agreed by key partners, adoption will be sought. The key partners include the NHS, Clinical Commissioning Group and the local authority.

The next steps will be to;

- Seek adoption of the policy framework with the Knowsley Partnership and other key partners
- Promote the Health Inequalities Policy Framework widely and;
- Agree partner actions to deliver the policy framework.

Public health will work with partners to support the implementation of the Framework. This will include supporting the development of evidence and strategy to reduce health inequalities.

The next steps for partners, with support from public health where relevant, will include;

- Partners reviewing existing policies and strategies in the light of this changing policy direction.
- Ensure that emerging and new policies and strategies adopt the approach outlined and consider the impacts of these on health inequalities
- Ensure that commissioning decisions and proposals are health inequality screened and impact assessed
- Commissioned and in-house services conduct regular health equity audits
- Impact on reducing health inequalities should be assessed.
- Develop action plans as necessary to address the approach outlined.