HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Report subject	**Health inequalities – background briefing**
Meeting date	15 January 2024
Status	Public Report
Executive summary	This briefing is to help Committee inform its future work programme. Especially how health and care services respond to reducing inequalities in health. Health inequalities are avoidable and unjust differences in health between groups of people. They are unjust because they don't happen by chance. This means we can change them. There may be specific causes, such as lack of access to services, or timely diagnosis of disease. Or wider social factors such as income, education, housing or environmental factors. BCP council has a statutory duty to assess and respond to health inequalities. So do our NHS organisations and partners in the integrated care system. This paper gives an overview of what we know about health inequalities in BCP Council. It considers different approaches to how to reduce them. It takes stock of local progress, and it highlights areas that Committee may wish to review in the future.
Recommendations	**It is RECOMMENDED that:** (a) Councillors are invited to comment on the content of this briefing. (b) To note the local work developing in response to health inequalities.

	(c) To consider what areas or opportunities for scrutiny Committee includes in its forward plan around progress in tackling inequalities in health.
Reason for recommendations	To enable Members to understand the main inequalities arising in health and social care and be able to ask strategic questions of ICS partners to assess progress in reducing them.

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Corporate Director	Jillian Kay, Corporate Director for Wellbeing
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Wards	All wards
Classification	For Update and Information

Background

1.1. Health inequalities are avoidable and unjust differences in health that arise between groups of people. The reason they are considered avoidable and unjust is because they do not arise because of underlying biological differences. They arise because of variations in access to services and support, variations in risk behaviours such as smoking, alcohol use and poor diet, and variations in the drivers of poor outcomes and health. This includes wider social issues such as living standards, education, job, housing and environment.

1.2. Public health measures that are used to measure health inequalities at the population level include life expectancy and healthy life expectancy. Life expectancy calculates the average age that someone born today can be expected to live; healthy life expectancy calculates the length of time someone born today can expect to live free from disease or disability.

1.3. Both of these measures vary:

- Between upper tier local authority areas in England
- Within BCP Council – i.e. between wards
- When comparing areas using classifications that measure deprivation, such as the Index of Multiple Deprivation 2019.

1.4. There are also numerous examples of where health outcome, access to services or experience of health and care vary, depending on characteristics including gender, age, ethnic background or race, sexual identity, level of income or education, job classification and many other factors. A comprehensive summary of health inequalities was developed for BCP Council in 2021 – most of the issues will have stayed the same, if not worsened since the pandemic.[1]

1.5. The main organisations responsible for the integrated care system locally have legal duties to identify and reduce inequalities in health. This includes NHS organisations, via the The Health and Social Care Act (2021), Equality Act (2010), and NHS Planning Guidance. And upper tier local authorities through the Equality Act (2010), and the legal duty to improve the health of local populations, and reduce differences in health outcomes between them. The primary purpose of Health and Wellbeing Boards, which are statutory committees of local authorities, is to 'improve the health and wellbeing of people in their area, reduce health inequalities, and promote the integration of services'.[2]

1.6. Integrated care systems were formally given 4 objectives on their establishment in 2022 – 2 of them relate directly to inequalities. One focuses on the role of treatment in health inequalities (tackle inequalities in outcomes, experience and access) and the second focuses on the wider impact of social conditions in inequality (help the NHS support broader social and economic development).

1.7. This report provides a high level update on current and recent work to identify and address health inequalities in BCP Council and the ICS.

BCP Council Health and Wellbeing Board

[1] Health inequalities in BCP Nov 2021 FINAL (bcpcouncil.gov.uk)
[2] Health and Social Care Act 2012.

2.1 The Board agreed its strategy in September 2020, which set three high-level priorities:

- Engaging with and empowering communities of highest need to improve healthy life expectancy;
- Set priorities to accelerate work promoting healthy lives and wellbeing;
- Provide governance and support to our partners, prioritising the delivery of key partnership outcomes.

2.2 As a forum for strategic leadership the Board has championed and overseen some important work on inequalities including the access to food partnership (food security), mobilising community organisations and volunteers through the Together We Can approach during the pandemic; and endorsing the establishment of a Poverty Truth Commission for the BCP Council area. It has also championed the importance of access to quality green space to improve health and wellbeing, with a view to increasing access in communities less likely to live close to these areas, through the Green Heart Parks initiative.

2.3 The Board is also responsible for publishing a joint strategic needs assessment each year, which informs its strategy, and also system strategies like the Integrated Care Strategy, Working Better Together. The report on inequalities formed part of the previous JSNA work in support of priority 1.

2.4 The Health and Wellbeing Board strategy, and joint strategic needs assessment was used during 2022 to inform the first Integrated Care Strategy. The HWB highlighted variation in access to support for mental health in children and young people, how well hypertension is identified and managed to reduce risk of strokes, and prevention of falls in older people as three key health issues to be addressed.

NHS Dorset Integrated Care Board and system work

2.5 Action on Health inequalities has been overseen by the Health Inequalities Group (HIG) - a sub-group of System Executive Group. The Dorset ICP strategy also recognises the importance of creating equity or 'fairness' in access, outcomes and experience for local people.

2.6 NHS Dorset developed its Joint Forward Plan based on the integrated care strategy, and this identifies that working in partnership to tackle inequalities, improve productivity and value for money, and support social and economic development is at the heart of their plans and strategies.

2.7 Specific objectives in the NHS Forward Plan include commitments to:

- Improve the lives of 100,000 people impacted by poor mental health.

- Prevent 55,000 children from becoming overweight by 2040.
- Outcome 3 has a specific focus on health inequalities through its ambition to reduce the gap in life expectancy between most and least deprived areas from 19 years to 15 years by 2043.
- Increase the percentage of older people living well and independently in Dorset.
- Add 100,000 healthy life years to the people of Dorset by 2033.

2.8 NHS Dorset receives £2,128,000 annual funding for health inequalities. This is being used to recruit and fund a core team to support ICB duties and co-ordinate system shared priorities. It will also provide for extra capacity where required, and to pay for transformation test and learn projects and programmes to deliver health inequalities priorities agreed through the Health Inequalities Group.

Approaches to reducing inequalities

2.9 Many studies and national reports have highlighted patterns and approaches to tackling inequalities. This includes the link between poverty, overcrowding and infectious diseases identified during Victorian times; the 'inverse care law',[3] the uneven distribution of ill-health and premature death in The Black Report (1980).

2.10 More recently Professor Sir Michael Marmot undertook a major review for Government in 2010, *Fair Society, Healthy Lives.* Six policy objectives were identified to guide interventions.[4] The policy objectives were aimed at tackling social and environmental factors, ranging from best start in life, to strengthening the impact of ill health prevention. Some of these policy objectives align with social and economic development issues like access to high quality work and fairer pay.

2.11 But when it comes to the role of health and care services, perhaps the most important concept was that to reduce inequalities it is important to act proportionately across the whole social gradient of health. This means not singling out groups and treating them differently, but making adjustments in how services are provided to increase engagement, improve access, outcomes and experience – using proportionately more resource in those most affected. In practice, a mix of civic-led interventions, service interventions and strengthening of community interventions will be required in any place-based approach.

[3] Julian Tudor Hart 1971. The observation that good health and care is usually most accessible to those least in need,

[4] Fair Society Healthy Lives full report (parliament.uk)

2.12 Civic interventions might include work to tackle poor housing, improve employment prospects and local social mobility working with learning and skills providers. Service interventions include for example the work the NHS is engaged in understanding access to care, experience and outcomes for people identified in the most deprived areas, plus selected disadvantaged groups (CORE 20 Plus 5 programme). Community interventions include the Poverty Truth Commission, Together We Can, Access to Food partnership, and other ways of investing to boost community resilience.

3. Upcoming opportunities for scrutiny

3.5 Committee is asked to note this briefing report on health inequalities. The report provides an overview of a complex area. Scrutiny will play an important role in supporting how the system focuses to reduce health inequalities. The following points suggest areas for consideration.

3.6 For service-based work – can we measure reduction in the current variation?

- in access to services for preventive interventions like vaccination and screening, smoking cessation, and health behaviour change?
- in how well chronic diseases like circulatory disease and cancer are treated?
- are some groups waiting longer for access to elective care? Is this improving? Are some groups affected more by the long waits (for example their mental health, or impact on being able to work).

3.7 What will the refreshed Health and Wellbeing Board Strategy say about strategic priorities to reduce inequalities in health? Are there sufficiently clear and measurable actions for partners?

3.8 What has been the impact of some of the community-led work, such as Poverty Truth Commission, or the community infrastructure organisations like CAN and its contribution to the new wellbeing hubs?

4 Summary of financial implications

4.1 Health inequalities introduce greater cost into health and care systems. By not tackling the gap in healthy life expectancy, more people will be living for longer with preventable conditions that will increase demand and cost. NHS Dorset has received an allocation for health inequalities work. Understanding how this funding has benefited and improved outcomes will be important learning for future resource allocation.

Summary of legal implications

5.1 Councils and NHS organisations both had duties on them to identify and tackle health inequalities, as does the Integrated Care System.

Summary of human resources implications

6.1 None specific. Work to tackle health inequalities should not be considered as a stand-alone set of projects or programmes – ideally adjustments in how services are commissioned and provided should be business as usual, and not requiring additional special capacity.

Summary of environmental impact

7.1 There are no negative environmental impacts associated with this work.

Summary of public health implications

8.1 Tackling health inequalities helps Councils fulfil their legal duties around public health. Health gains will be greatest by targeting adjustments to populations with the greatest needs.

Summary of equality implications

9.1 Health inequalities affect some protected characteristics covered by the Equality Act, such as age, gender, race and sexual orientation. Ideally work to tackle health inequality aims for equity, not equality – equity is the concept of providing a level playing field recognising that in some instances adjustments need to be made to boost access, experience and outcomes.

Summary of risk assessment

10.1 The risk of not tackling inequalities in health is poorer access, experience and outcomes for some sections of our local population. This will lead to greater demand and cost to health and care providers. It also impacts on quality of life and length of life for people.

Background papers

Health inequalities in BCP Council

JSNA narrative summary