Committee: Healthier Communities Panel

Date: 5 September 2018

Agenda item:

Wards: All

Subject: Annual Public Health Report 2018: Tackling health inequalities – progress in closing the gap within Merton

Lead officer: Dagmar Zeuner, Director of Public Health

Lead member: Cllr Tobin Byers, Cabinet Member for Adult Social Care and Health

Contact officer: Samina Sheikh (Principal Public Health Intelligence Specialist) Clarissa Larsen (Health and Wellbeing Board Partnership Manager)

Recommendations:

The Healthier Communities Panel is asked to:

A. Consider and champion the recommendations of the Annual Public Health Report (APHR) 2018 on Health Inequalities.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

There is a statutory duty for the Director of Public Health to produce an independent Annual Public Health Report (APHR) which forms part of the wider Joint Strategic Needs Assessment (JSNA). The purpose of this paper is to share with the Healthier Communities Panel the APHR 2018: *Tackling health inequalities - progress in closing the gap within Merton.*

The report aimed to measure progress in closing the gap of inequalities in Merton. Analysis of the available data showed this was not straight forward. This report therefore seeks to clarify meaning, definitions and measures of health inequalities. It provides analyses of trends over time, proposes measures to monitor future progress and summarises evidence of what works to reduce inequalities, as a resource for councillors, officers and partners.

DETAILS

2. The topic was selected for a number of reasons:

- It is a longstanding aim of the Merton Council and its partners to ‘bridge the gap’ between the east and west of the borough, addressing the disadvantage that some communities face.
- Closing the gap in health inequalities was the overarching aim of the Health and Wellbeing Strategy (HWBS) 2015-2018; and this analysis is central to impact monitoring, and to informing the refresh of the Health and Wellbeing Strategy 2019-2024.
- Analysis and recommendations from this APHR will also inform other strategic work underway in health and social care, including the development of the Local Health and Care Plan, the developing Merton Prevention Framework, and the

development and evaluation of the East Merton model of health and wellbeing centred on the Wilson site.

- There is synergy with the continued focus on health inequalities in London, including the new draft refresh of the Mayor's Health Inequality Strategy.

3. The APHR 2018 aims to provide a reference for officers, partners and residents to understand what we mean by inequalities, specifically health inequalities, but also the underlying drivers of differences in health outcomes between different groups – inequalities in the social determinants of health such as poverty, education and employment.

   The purpose of the APHR 2018 is to inform a shared understanding of where we are now, how far we have come in 'bridging the gap' between the most and least deprived, and how we might best approach and monitor health inequalities in future.

4. The APHR 2018 is split into the following sections:

   Part 1: an overview of what we mean by inequalities, specifically health inequalities; how we measure them; and what we know works to tackle them.

   Part 2: what we know about health inequalities in Merton over time (using a selection of health-specific indicators and others that represent the social determinants of health), and description of the methodology used to analyse the inequality gap.

   Part 3: a summary of what we can learn from this piece of work to take forward into the HWBS refresh and other strategic work.

5. The APHR 2018 is complemented by a Supplementary Data Report with additional graphs and analysis which is also attached to this report.

Key Issues in the Annual Public Health Report

6. We know that there are inequalities between the east and the west of the borough, but this is the first time that we have looked systematically at the scale and trend in inequalities in Merton. This process has shown that it is more complex to monitor health inequalities than it first appears, and has helped identify an approach to more effectively track inequalities going forward.

7. APHR analysis shows that inequalities are evident in every indicator we studied, the vast majority of which show a worse picture in the most deprived areas, as we would expect. Recent supplementary analysis from Public Health England (PHE) reveals that the top three health indicators most strongly associated with deprivation in Merton are emergency hospital admissions; childhood obesity; and hospital stays for alcohol-related harm.

8. These cumulative inequalities – which are evident throughout different life stages and in the environment within which our residents live – contribute to the overarching inequalities in health outcomes that we see in the significant differences in life expectancy of 6.2 years for men and 3.4 years[1] for women between the most and least deprived areas. Inequalities in healthy life expectancy

[1] These figures are from the national 'Slope Index of Inequality' indicator which looks at inequalities in life expectancy at birth between the 10% most and 10% least deprived areas in a borough. Governing Body may be aware that these are different figures for the gap in life expectancy than previously reported, for instance through the JSNA 2013/14 which gave a figure of 9 years for men and 13 years for women. The APHR (Box 3, Chapter 1) gives a detailed explanation of the changes to the data, trend and methodology behind the figures, and why we recommend the use of this Slope Index going forward, as the headline life expectancy indicator.

are even starker, with a difference of 9 years of healthy life between most and least deprived areas.

9. In terms of trend in inequalities in Merton, the picture is mixed. There are some success stories, for instance the reducing gap between the most and least deprived areas in life expectancy for women, in school readiness, and in the proportion of the economically active population claiming Jobseeker's Allowance, and the apparent reduction in the Child Poverty gap. However, the majority of indicators either show the inequality gap to be stable over time, to be increasing, or to be reducing for the 'wrong' reasons (for instance because the situation for those in more affluent areas appears to be worsening whilst that for those in the more deprived areas remains stable, narrowing the gap). It is evident from this analysis that inequalities in Merton are intransigent, and we need to keep them under review over a longer time frame.

Recommendations

10. The analysis confirms that health inequalities are persistent, complex and difficult to shift. In order to make progress, we have to actively and systematically target them through a long-term, multi-sectoral approach, across all partners. If we take our eye off the ball, health inequalities are likely to increase. Therefore we need to continuously monitor progress and review our approach over time.

Recommendations for tackling health inequalities in Merton:

11. In order to reduce the steepness of the social gradient in health outcomes, a 'proportionate universalism' approach should be adopted, meaning that population-wide action is vital, but that universal interventions should be undertaken with a scale and intensity that is proportionate to the level of disadvantage. Action needs to be taken across the whole life course so that all Merton residents can start well, live well and age well.

12. Whilst recognising the role of personal prevention approaches to improve health (e.g. support for individuals to stop smoking), the evidence shows that we need to rebalance our efforts towards population level prevention. This recognises both the increased cost-effectiveness of interventions at population level compared to personal level interventions, and the evidence of increased impact on health inequalities.

13. Approaches must be underpinned by participatory decision-making and co-design, empowering individuals and communities.

Recommendations for monitoring health inequalities in Merton:

14. A standardised methodology should be used across Merton to be able to effectively monitor inequalities and progress. We recommend that the methodology set out in the attached APHR Part 2.2 is adopted across the Council and Merton Partnership.

15. We need to be realistic about timescales in which we can expect changes to the inequality gaps in Merton. Different types of interventions will take different amounts of time to demonstrate impact. When setting targets, we need to be explicit about the timescales within which we expect to see changes in metrics, and that these timeframes are likely to differ from local and national political cycles, requiring coordinated action over time. This is discussed in more detail in the APHR Part 1.

16. Because some of the longer term health outcomes will take time to address, when developing a set of indicators to monitor progress through strategies such as the current Health and Wellbeing Strategy or the NHS's Local Health and Care Plan (covering 3-5 year time periods), it will be important to consider an underpinning logic model or theory of change. This can include shorter term 'proxy' measures that can help to suggest if change is occurring in the right direction. This is discussed in more detail in the APHR, Part 3.

17. The summary indicator table in APHR Part 5 highlights some of the indicators we think would be most useful. This includes measures of inequalities in life expectancy, deprivation, education, employment (taking into account the changes to benefits with the introduction of Universal Credit by 2020), and a selection of key healthy lifestyle and disease indicators for children and adults.

18. Merton Public Health will feed back to PHE about the availability of sub-borough indicator data in easy to use formats, to inform their ongoing support to public health teams. We will also respond to the Government's consultation on Universal Credit metrics, to ensure data supports monitoring of inequalities over time.

19. ALTERNATIVE OPTIONS

None

20. CONSULTATION UNDERTAKEN OR PROPOSED

The APHR will be disseminated through officers, members and partners.

21. TIMETABLE

The APHR was taken to the Health and Wellbeing Board, MCCG Governing Body and Cabinet. It is now being designed and is due to be published in September 2018 as part of the Merton JSNA website.

We also plan to produce an accessible, simple summary of highlights from the Annual Public Health Report in infographic, easy read format and share this widely.

22. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

None for the purpose of this report. Implementation of the recommendations of the APHR is based on delivery within existing resources by changing ways of working of the Council and partners rather than new investment.

23. LEGAL AND STATUTORY IMPLICATIONS

Producing an independent APHR is a statutory duty of the Director of Public Health.

24. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

The APHR focuses on health inequalities – with analysis of the current picture of inequalities in Merton, and recommendations on how to monitor them and how to address them in Merton.

It aims to support LBM to deliver its Public Sector Equality Duty obligations under the Equality Act 2010, which means that we need to pay due regard to equality and inclusion issues in all of our decision making.

25. CRIME AND DISORDER IMPLICATIONS

None

26. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

None

APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

APHR 2018: Tackling health inequalities – progress in closing the gap within Merton

APHR 2018: Supplementary Data Report

BACKGROUND PAPERS

None

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