

HEALTH AND WELLBEING BOARD

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MEDWAY CCG's 'QUANTIFIABLE LEVELS OF AMBITION' TO REDUCE HEALTH INEQUALITIES

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Summary

CCGs are required to work with local government partners to set and share in 2015/16 quantifiable levels of ambition to reduce local health and healthcare inequalities and improve outcomes for health and wellbeing. This document describes the rationale for the approach that Medway CCG and Medway Council's Directorate of Public Health have taken to define quantifiable levels of ambition for Medway. The Health and Wellbeing Board is asked to consider this report.

1. Budget and Policy Framework

- 1.1 Medway Council and Medway Clinical Commissioning Group both have a duty to reduce health inequalities.
- 1.2 One of the five strategic themes of the Joint Health and Wellbeing Strategy is to reduce health inequalities.

2. Background

- 2.1 The document *NHS Forward View Into Action: Planning for 2015/16* states: "Clinical Commissioning Groups (CCGs) should work with local government partners to set and share in 2015/16 quantifiable levels of ambition to reduce local health and healthcare inequalities and improve outcomes for health and wellbeing."
- 2.2 Health inequalities are defined as differences in health status or in the distribution of health determinants between different population groups. Some differences may be impossible or unethical to address, however, many are preventable. As well as the moral imperative to tackle inequalities there is a good business argument to do so. More emergency hospital admissions or more years spent with a long-term illness mean greater costs for health and

social care systems, and therefore reducing inequalities in health will reduce costs to the health and social care economy.

- 2.3 Health inequalities may exist across a number of domains, for example by geographic area, by level of deprivation, GP practice, gender, age.
- 2.4 The CCG is already undertaking a number of actions to reduce health inequalities across a number of areas and the CCG's Equality and Diversity Group has helped develop the CCG's approach to addressing Health Inequalities, with regard to existing legislation and the NHS Equality Delivery System (EDS2).
- 2.5 Prior to the publication of this document, however, the CCG has not committed to measurable ambitions for reducing health inequalities.

3. Options

- 3.1 In the development of this document the options considered included attempting to completely eradicate all health inequalities; focussing on the most deprived quintile; focussing on only one kind of health inequality; focussing on a number of priority health problems; and taking a proportionate approach.

4. Advice and analysis

- 4.1 The document advises focussing on a number of priority health problems, considering a range of domains of health inequalities, and taking a proportionate approach to reducing health inequalities.
- 4.2 It is not realistic to aim to completely eradicate all health inequalities within the life of the CCG strategic plan, so the proposed approach is to narrow the gap between each group and the next by 50%. So, for example, if there are three groups, A, B, and C, that currently achieve 70%, 50% and 40% success respectively for a given measure, the quantifiable level of ambition will be to halve the gap from A to B from 20% to 10%, and from B to C from 10% to 5%. This implies action across all groups, with proportionately more effort required in the worst groups, that will result in a reduction in the slope of health inequalities.
- 4.3 The attached document will be used by the CCG to inform the development of the next strategic plan.

5. Engagement activity

- 5.1 No engagement activity has been undertaken for this document.

6. Risk management

- 6.1. No specific risks arise from this report.

7. Consultation

- 7.1. The CCG Governing Body was consulted in the development of the document.

8. Financial implications

8.1 This document will be used to inform the development of the next CCG strategy and as such will have general rather than specific financial implications for Medway CCG.

8.2 There are no financial implications for Medway Council.

9. Legal implications

9.1 No legal implications arise from this document.

10. Recommendation

10.1. The Health and Wellbeing Board is asked to consider and comment on this proposal.

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Appendix 1 - MEDWAY CCG HEALTH INEQUALITIES: Quantifiable levels of ambition

Background papers

None

MEDWAY CCG HEALTH INEQUALITIES

Quantifiable levels of ambition

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1 Introduction

This document describes health inequalities in Medway and sets out opportunities for developing a strategy to address them in the context of implementing the *NHS Five Year Forward View*.⁽¹⁾

Clinical commissioning groups (CCGs) have a statutory duty to reduce health inequalities. It is expected (and outlined in the Health and Social Care Act 2012⁽²⁾) that in all commissioning activities CCGs will have regard to meeting legal duties on health inequalities, including to reduce inequalities between patients in access to health services and in the outcomes achieved.

The *NHS Forward View Into Action: Planning for 2015/16* states: “Clinical Commissioning Groups (CCGs) should work with local government partners to set and share in 2015/16 *quantifiable levels of ambition* to reduce local health and healthcare inequalities and improve outcomes for health and wellbeing.”⁽³⁾ Also, a review of health inequalities in Medway led by members of Medway Council recommended that Medway CCG develops a plan to address health inequalities.⁽⁴⁾

Health inequalities are defined as differences in health status or in the distribution of health determinants between different population groups.⁽⁵⁾ Some differences may be impossible or unethical to address, however, many are preventable and these preventable differences in health access and outcomes are what is referred to as “health inequalities”. As well as the moral imperative to tackle inequalities there is a good business argument to do so. More emergency hospital admissions or more years spent with a long-term illness mean greater costs for health and social care systems, and therefore reducing inequalities in health will reduce costs to the health and social care economy.

1.1 Commissioning for prevention

At Medway CCG we recognise our role in reducing health inequalities in terms of both outcomes and access to services, and have placed prevention and health improvement at the heart of our strategic plan:

- We have been working to reduce health inequalities for children, to improve outcomes for children with long term conditions and secure access to high quality and safe maternity services.
- We are coordinating health and social care response with primary care to deliver more accessible and responsive services for vulnerable and older people to the end of their lives.
- We have committed to narrow the gap in health outcomes between those with and those without a mental health condition; improve access to children and adult mental health services and develop a primary care led response to supporting people in the community.
- We are working to embed a systematic approach to ensuring the early identification of those >15yrs at risk of ill health or harm; through greater self-awareness and management and improved access to specialist diagnosis and advice.
- In the area of urgent and emergency care we continue to work to deliver a health and social care coordinated response to preventing unnecessary acute hospital admissions and reducing demand at A&E whilst securing rapid high quality access to emergency care for those who need it.

The CCG is also committed to delivering its duties in line with the Equality Act 2010, and to meet the Public Sector Equality Duty. The CCG's Equality and Diversity Group has helped develop the CCG's approach to addressing Health Inequalities, with regard to existing legislation and the NHS Equality Delivery System (EDS2).

Reducing health inequalities is key to delivering a sustainable health economy in Medway, and as a CCG we are working with our partners in Primary, Community and Secondary Care to ensure that inequalities are identified and addressed, and when a person comes into contact with a health service that no opportunity is missed to improve their outcomes and to prevent future ill-health. We are using technology to identify people who will benefit from such an intervention, and to ensure that different sectors communicate this information effectively.

In 2016/17 and beyond the CCG is focussing on identifying and addressing variation in outcome, access, and experience measures in Primary Care. Practices

will be supported in identifying actions to reduce variation and inequality across the Medway population.

Prior to the publication of this document, however, the CCG has not committed to measurable ambitions for reducing health inequalities. These have been chosen based on the available evidence and with a focus on the areas which we have identified as the most important in delivering a healthier Medway.

These measures are detailed in section 5.3, along with high level delivery plans which outline how we intend to achieve the ambitions.

2 Health inequalities in Medway

Health inequalities occur in many different forms; there may be differences between geographic locations, e.g. between one local authority and another, or between one ward and another. There may also be differences between population groups, such as between males and females, or people from different ethnic groups. These are illustrated below.

2.1 Geographic inequalities and deprivation

The Index of Multiple Deprivation (IMD) is a composite measure of deprivation and because there are many associations between deprivation and poorer health outcomes it can be used to anticipate where poor health outcomes are more likely to occur. IMD consists of:

- income deprivation;
- employment deprivation;
- health deprivation and disability;
- education deprivation;
- crime deprivation;
- barriers to housing and services deprivation; and
- living environment deprivation.

The distribution of deprivation in Medway is shown in the map in Figure 1.

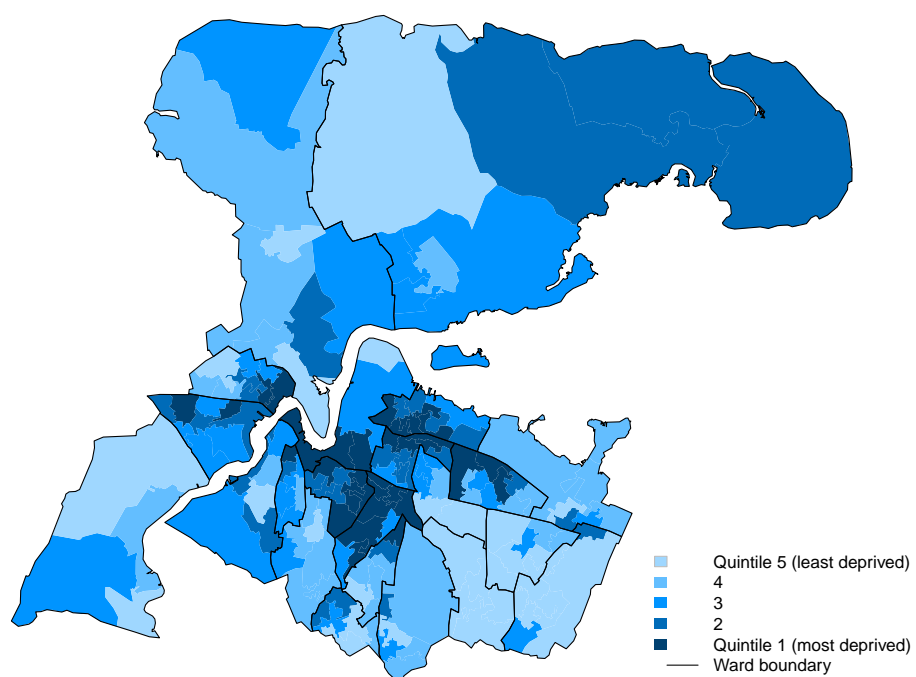


Figure 1
Areas of deprivation in Medway as measured by Index of Multiple Deprivation (IMD).

Source: Department for Communities and Local Government.

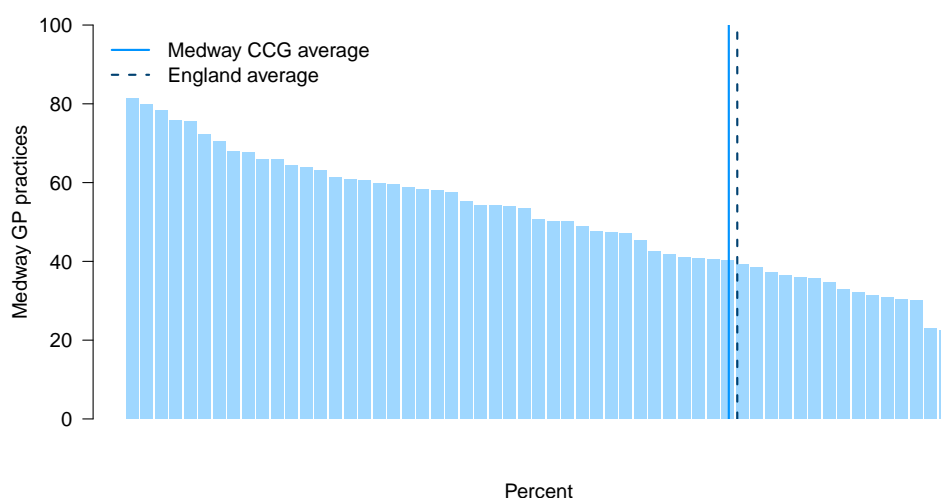


Figure 2

Percentage of GP survey respondents who saw/spoke to nurse or GP same or next day, 2013/14.

Source: Department of Health, GP patient survey.

2.2 Inequality in access to healthcare

As well as inequalities in health outcomes there can also be inequalities in access to effective and appropriate healthcare. Most people are registered with GP practices but there will be different levels of “health literacy” that prompt people to be aware of the help and support that they could seek there. There are also discrepancies in the availability of care. For example, Figure 2 shows Medway practices ranked by the percentage of respondents in the GP Survey who indicated that they had same- or next-day access to a nurse or GP. Overall Medway is similar to the national average, however within Medway there is considerable variation (22.5–81.2%).

Once accessed, the care that is provided needs to be appropriate for the population and the quality of the care provided needs to meet standards consistently. For example, circulatory disease is one of the top three contributory conditions for excess deaths in Medway (compared to England) for both men and women, and hypertension is a key risk factor for cardiovascular disease. Figure 3 shows the estimated modelled prevalence for hypertension in Medway practices. It shows that the expected prevalence ranges from 12.5% to 31.4%, with an average of 23% indicating different levels of need of the different populations regarding hypertension.

Figure 4 shows the reported prevalence of hypertension for Medway practices which shows an average of about 14% and ranging from 6.86–25.9%. Individual

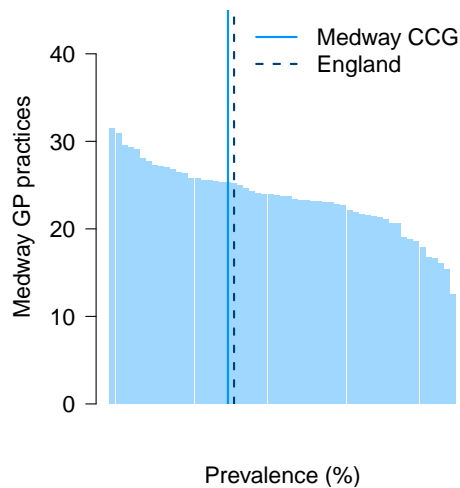


Figure 3
Modelled hypertension prevalence in Medway practices.
Source: ERPHO.

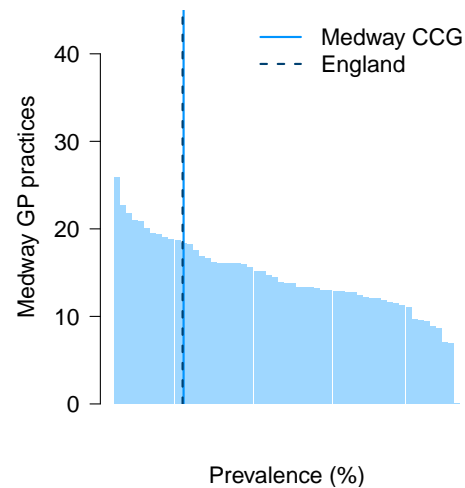


Figure 4
QOF-reported prevalence of hypertension in Medway practices.
Source: QOF 2013/14.

practices have different levels of discrepancy between the modelled and the reported numbers of people with hypertension; however, caution must be taken in ascribing this differential performance at practice level as there will be uncertainty in the modelled estimates at practice level.

There is also a section of the population that is not registered with GP services who will have poorer access to healthcare services. There is little data available on the amount or types of need in unregistered populations, however, unregistered patients are often prisoners, asylum seekers, military personnel, and homeless people and are likely to have particular needs.

It is important to consider the health needs of this population. One study demonstrated “that [in 2009/10] the health service needs of and associated costs by unregistered populations are important issues for health care commissioners at national and local levels in England.” (6)

2.3 Inequalities by population groups

The Equality Act (2010) defines groups with *protected characteristics* which provide another lens with which to view health inequalities and examples of known health inequalities in these groups are given below.

Table 1

Broad age distribution in Medway.
Source: ONS mid-2014 population estimates.

Age (years)	Medway	England
0–19	69,626	12,907,331
20–64	162,569	31,871,579
65–74	24,018	5,162,873
75+	17,802	4,374,835
Total	274,015	54,316,618

2.3.1 Age

Overall, Medway has a younger population than the South East or England (Table 1). Young people are at risk of a number of wider determinants of health that are associated with poor health outcomes either while young or later in life, such as teenage pregnancy, unemployment, insecure housing, poor quality housing, lone parenthood, mental health issues, binge drinking, chlamydia and other sexually-transmitted infections, poor diet, and bullying and harassment.(7)

Older people are more likely to suffer from social isolation, loss of mobility, deterioration in physical health, deterioration in income, and loss of family and friends. They are also less able to recuperate from episodes of ill-health.(8)

2.3.2 Gender

There are slightly more men in Medway up to the age of 45–49 years when the position levels out, and then reverses. Women are in the majority for all age groups above 75.

Men have consistently lower life expectancies than women and the drivers of premature death (in Medway compared to England) vary between the two. Cancer causes two thirds of the excess deaths in Medway males; for women, it causes only one third, with mental and behavioural conditions and digestive conditions also making significant contributions.(9)

2.3.3 Transgender

Data on transgender people are limited, however, based on estimates, Medway would expect to have around 68 residents who would be in their reassigned gender or undergoing the process of having their gender reassigned.

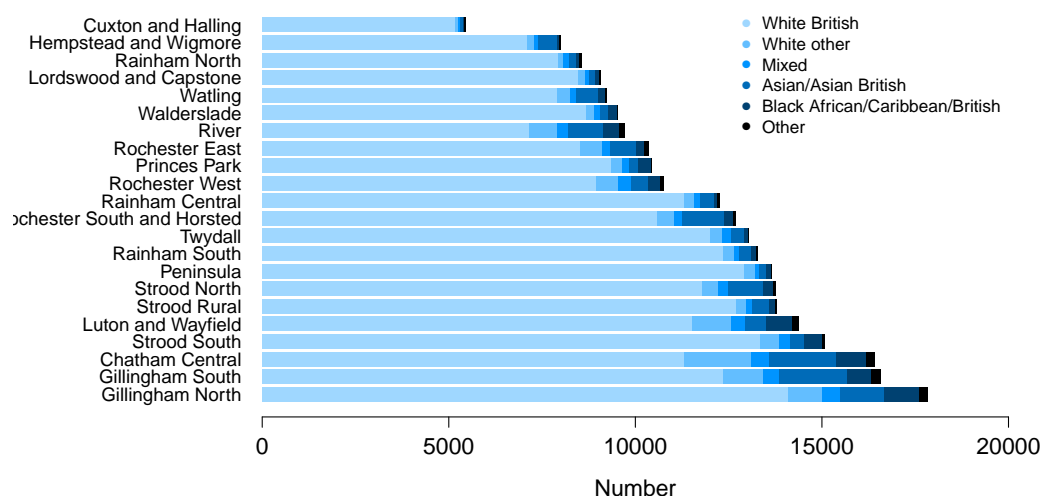


Figure 5
Number of people in Medway wards by ethnic group.
Source: ONS

Although this represents a small section of the community, transgender people can face significant inequalities throughout all spheres of life impacting negatively on their health outcomes and at cost to the healthcare system.

2.3.4 Ethnicity

Medway is becoming more ethnically diverse, although it is still less diverse than England as a whole. In 2011 Black and Minority Ethnic (BME) communities made up 10.4% of Medway's population, up from 5.4% of the population in 2001. These communities are predominantly in the most deprived wards (Figures 5 and 6).

There are biological differences between ethnic groups that affect their risk of certain health outcomes, e.g. people of Asian origin have higher risk of diabetes and cardiovascular disease for a given body-mass index. In addition the wider determinants of health are unequally distributed across different ethnic groups. This means that there are significant differences in use of health services and health outcomes with more negative outcomes seen in ethnic minorities. For example, a recent Health Equity Audit of Maternity Services in Medway found that "women from white-other, black or Asian ethnic groups... are significantly more likely to access antenatal services after, not only the 10 week ideal national standard, but also after the maximum recommendation of 12 weeks and 6 days." (10)

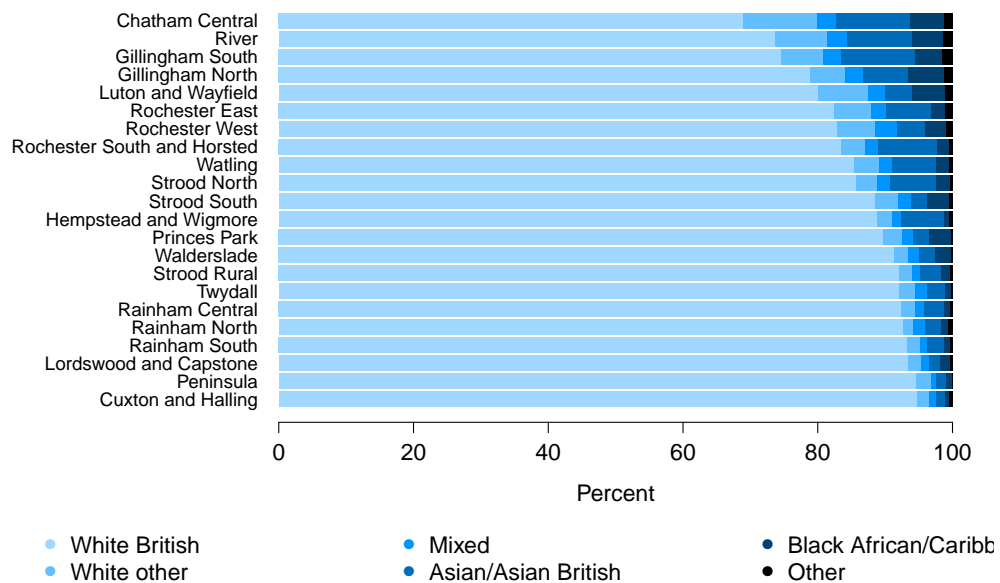


Figure 6
Percentage of people in Medway wards by ethnic group.
Source: ONS

2.3.5 Disability

There is no single measure of disability, however the 2011 Census asked people if they had a Limiting Long-Term Illness (LLTI) and in Medway 16.4% of residents indicated, roughly 43,300 people, that they have a LLTI.

As of March 2014, there were 1,928 people registered blind, partially sighted, deaf or hard of hearing in Medway. There were also 4,350 requests for a parking Blue Badge.

In 2013/14, there were 529 clients with a physical or learning disability in residential and nursing care, and a further 1,754 receiving community-based services.

People with learning disabilities have poorer health outcomes, much of which is attributable to barriers in accessing effective healthcare. It is important for healthcare commissioners and providers to remedy this, as a matter of social justice, legal prudence and efficient healthcare provision.

People with a disability or LLTI are more likely to experience unemployment, poverty, social exclusion, all of which contribute to negative health outcomes as well as premature death.⁽¹¹⁾

2.3.6 Sexual orientation

Estimates of Medway's Lesbian, Gay, Bi-sexual and Trans (LGBT) population vary from 1.5% (approximately 4,000 people) to 5–7% (13–19,000 people).

Data on health service use and health outcomes for this group of people are limited; however, it is known that this group has increased risks of negative health outcomes. For example, LGBT groups face greater levels of mental health issues, bullying, harassment and discrimination, barriers to access to healthcare services, higher smoking rates, lower screening rates, and higher domestic abuse rates.⁽¹²⁾ These factors contribute to higher rates of negative health outcomes; for example, LGBT groups have a greater risk of cardiovascular disease (CVD) in part due to the increased use of tobacco, alcohol and drugs among this population.⁽¹³⁾

2.3.7 Religion/belief

The majority of residents in Medway state they are part of the Christian religion (57.8%), a fall of 14 percentage points since the 2001 Census. The second largest group indicate that they have no religion (29.9%), an increase of 13 percentage points.

Muslims represent the next largest religious group, up from one percent to two percent. Sikh, Hindu, Buddhist, Jewish and all other religions are a much smaller proportion of the population.

As with ethnicity, the wider determinants of health are unequally distributed across different religious groups resulting in varying health outcomes. For example, a 2013 Scottish review of religion and evidence of equality outcomes found that: Muslims and Sikhs are most likely to have no qualifications; Muslims and Buddhists are the most likely to have low income; Jewish people are more represented in higher income brackets; Roman Catholics are over-represented in living in deprived areas; Hindus have the best self-reported health; and Muslims and Catholics have lower-than-average participation in sports.⁽¹⁴⁾

3 Drivers of health inequality

3.1 Drivers of inequality in life expectancy

In 2011–13, life expectancy at birth in both males and females in Medway was significantly lower than the national average. Within Medway, the gap in life expectancy between the most and the least deprived deciles of Medway's population is 5.8 years for males and 4.8 years for females. People in Medway's more deprived communities have higher rates of death than those in more affluent communities.

Table 2

Life expectancy at birth in males and females in Medway and England (2011–13).

	Males	Females
Medway	78.8	82.5
National	79.4	83.1

Table 3

Key risk factors for greatest causes of preventable mortality in Medway

Condition	Circulatory	Cancer	COPD ^a	Liver disease
Smoking	X	X	X	
Obesity	X	X		X
Alcohol		X		X
Poor diet	X	X		
Physical inactivity	X			
High blood pressure	X			
Air pollution ^c	X	X	X	

^a Chronic obstructive pulmonary disease

As shown in Figure 7, three main causes (circulatory disease, respiratory disease and cancer) account for 60% of the difference in life expectancy between the least and most deprived communities in Medway in males and 75% of the difference in females. Addressing these conditions in more deprived communities will have an impact on the life expectancy of these groups and reduce inequalities in life expectancy.

3.2 Drivers of inequality in lifestyle risk factors

Table 3 summarises the key modifiable risk factors for the diseases which cause the greatest amount of preventable mortality in Medway.

3.3 Smoking

Smoking is the main cause of preventable death in the UK. Smoking prevalence rates in Medway are highest in people in routine and manual employment, lone

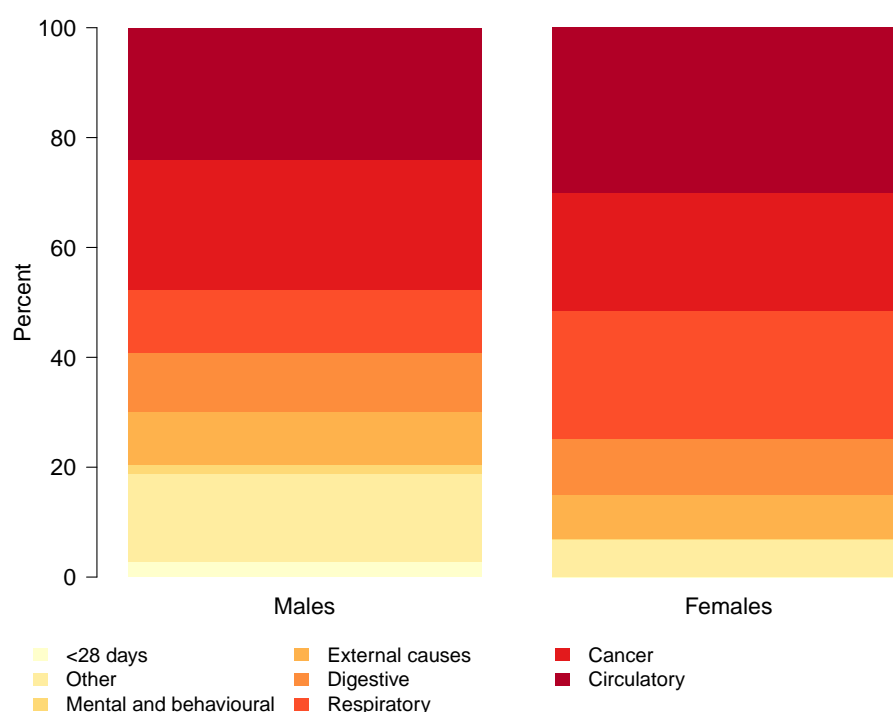


Figure 7

Breakdown of the life expectancy gap between the most deprived quintile and least deprived quintile in Medway, by broad cause of death, 2010–2012.

Source: Public Health England, January 2015.

parents in receipt of benefits, people on low income, Irish and Bangladeshi men, and younger people age 20–34. Furthermore, Medway has a high rate of pregnant women who smoke, and younger mothers who are more likely to smoke throughout pregnancy. Offenders, military staff and people with mental health needs also have extremely high smoking rates.(15)

3.4 Excess weight and physical inactivity

Being overweight or obese is associated with increased risk of cardiovascular disease, diabetes and some cancers and other health problems. It is also associated with poor mental health in adults, and stigma and bullying in childhood.

The prevalence of overweight and obesity has increased across all communities, demonstrating that the whole population is at risk. Some sectors of the population, however, are more at risk of developing obesity or its complications and this contributes to inequalities in health. Obesity prevalence is influenced by age, ethnicity and deprivation.(16)

Poor diet and lack of physical activity are the main risk factors for obesity which synthetic modelling estimates affects approximately 30% of adults in Medway.

3.5 Childhood obesity

Rates of overweight and obesity in children in Medway, as measured by the National Child Measurement Programme, have decreased over the last five years and are now the same as or below the national average. However, there is a range of obesity rates across Medway. Obesity in children in reception year varies by electoral ward from 5.9% to 12.3%, with the majority of wards over 9%. For children in year 6, rates of obesity by ward range from 9.9% to 22.1% with all but two wards over 15.9%.(17)

3.6 Alcohol

Alcohol is now one of the leading causes of preventable death in people aged 15–49 years. The most deprived fifth of the population of the country suffers two to three times greater loss of life attributable to alcohol.(18)

Evidence consistently shows that men consume more alcohol than women. However, drinking varies greatly across age and socio-economic group, resulting in a complex picture of alcohol consumption and alcohol-related harm across gender.

High risk groups in Medway are: men aged over 35 who work in an unskilled or manual field or are unemployed; men and women living in the most deprived

areas; offenders; and people with mental health needs. In addition, there are higher levels of alcohol misuse among LGBT groups.(19)

In 2015, the Blue Light group estimated there are 250 treatment resistant drinkers in Medway, costing combined health, social care, local authority and criminal services £12,973,714 per annum.

4 Wider determinants of health

NHS England has estimated that only 15–20% of the inequality in life expectancy can be influenced by health care interventions.(20) Hence in fulfilling its role in addressing health inequalities, the health care system must understand the wider context for its policies as well as the impact and effectiveness of its own actions.

4.1 Child poverty

Children in relative poverty are more likely to be materially deprived and more likely to have low levels of health and well-being. In 2012, a significantly greater proportion of children were living in poverty in Medway (20.2%) than the England (18.6%) and regional (13.6%) averages.(21) Gillingham South, Gillingham North, Luton and Wayfield, and Chatham Central have the highest levels of child poverty (30–37%). However, as can be seen in Figure 8, over half of Medway's wards have 1 in 5 or more children living in poverty.(22)

4.2 School readiness

Ensuring that children are school-ready and able to participate and engage with school life has the potential to make considerable savings in public expenditure by reducing the costs of educational under-achievement, smoking and substance abuse, teenage pregnancy, behavioural issues, justice system costs, unemployment and the negative health outcomes which are associated with all of the above.(23, 24)

There are three dimensions that must work in tandem to ensure school readiness: individual children, their families and their schools—the third will not be discussed in this context. A school-ready family is one that has ensured that the child has received antenatal visits, breast-feeding and early stimulation behaviours for newborns and infants as these are early indicators of parenting practices that promote the learning and development of children.(25)

A school-ready child is one that has achieved a good level of development defined as achieving the expected level within the three prime areas of learning (communication and language, physical development and personal, social and

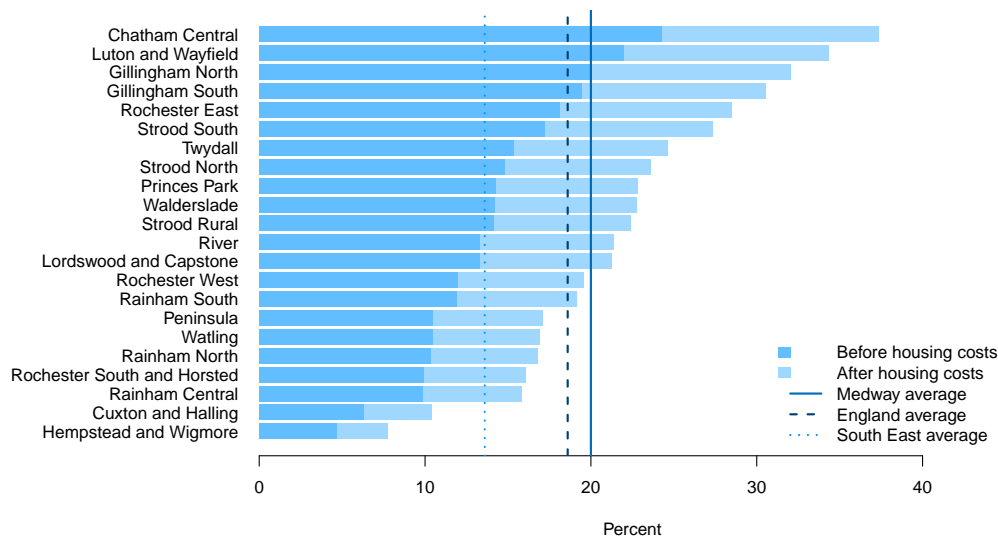


Figure 8
 Children in poverty in Medway by electoral ward, Oct–Dec 2013.
 Source: Centre for Research in Social Policy, 2014

emotional development) and the early learning goals in the specific areas of mathematics and literacy.

For Medway in 2013/14, 64.48% of five-year olds achieved a good level of development, which is better than the national average. Within this however, there will be variations in levels of achievement as national data shows that girls out-perform boys, there are ethnic differences in levels of achievement, and children eligible for Free School Meals (FSM) or with Special Educational Needs (SEN) perform at much lower levels.^(26, 27) In Medway for 2013/14, the percentage of pupils achieving a good level of development ranged across schools from 28% to 90%, with 51 out of 65 schools achieving 60% or over.

4.3 Not in education, employment or training (NEET)

Young people aged 16–18 years not in education, employment or training (NEET) reflects skill development during school years and indicates those at greater risk of a range of negative outcomes, including poor health.

In May 2015, in Medway, 7.16% of 16–18 year olds were identified as NEET. This is significantly worse than the national average and has been increasing since 2014.⁽²⁸⁾ Across Medway the picture varies widely, ranging from 1.64% in Hempstead to 15.12% in Luton and Wayfield.

The likelihood of a young person being NEET is closely linked to other vul-

nerabilities. Three-quarters of teenaged parents are NEET, as are one third of young carers, one third of young people with substance abuse issues, nearly half of young people leaving care, and nearly half of young people supervised by the Youth Offending Team (YOT).⁽²⁹⁾

4.4 Fuel poverty

Older people, children, disabled people and those with long-term conditions are particularly vulnerable to the health effects of living in cold, damp homes.

In 2012 8.6% (9,143) of households in Medway were estimated to be fuel-poor, lower than England overall. The current economic situation is likely to increase the risk of fuel poverty.

4.5 Decent Homes Standard

Good quality housing can enhance health just as low quality housing can aggravate or cause ill-health. Housing has been linked to major long-term conditions such as heart disease, stroke, mental illness, respiratory disease, arthritis and accidents. People who spend most of their time at home, for example older people, are particularly at risk of negative health outcomes from low quality housing.

Rates of non-decent homes are highest in the private rented sector. However, because owner-occupation is by far the most common form of tenure, it still accounts for two-thirds of all non-decent homes.

In Medway (Q2 2014/15) 99.7% of all registered providers, including social housing and Council-owned properties, met or exceeded the Decent Homes Standard.

4.6 Unemployment

There is a very strong connection between unemployment and poor health. Reduced income and economic activity leads to a reduced living standard, cold homes, poor diet, less social activity, over-crowding, and behavioural issues. Unemployment can trigger distress, anxiety and depression, reduced social integration, low self-esteem, mental health problems, health problems for children, and increased lifestyle risk.

There is a strong social gradient to unemployment. It is associated with lower levels of education, disabilities and mental ill health, caring responsibilities, being a lone parent, young people, older people, and some ethnic minorities.

Medway unemployment rates (Jul 14–Jun 15) for both men (8.2%) and women (8.7%) are higher than the national average (men 5.8%; women 5.4%).

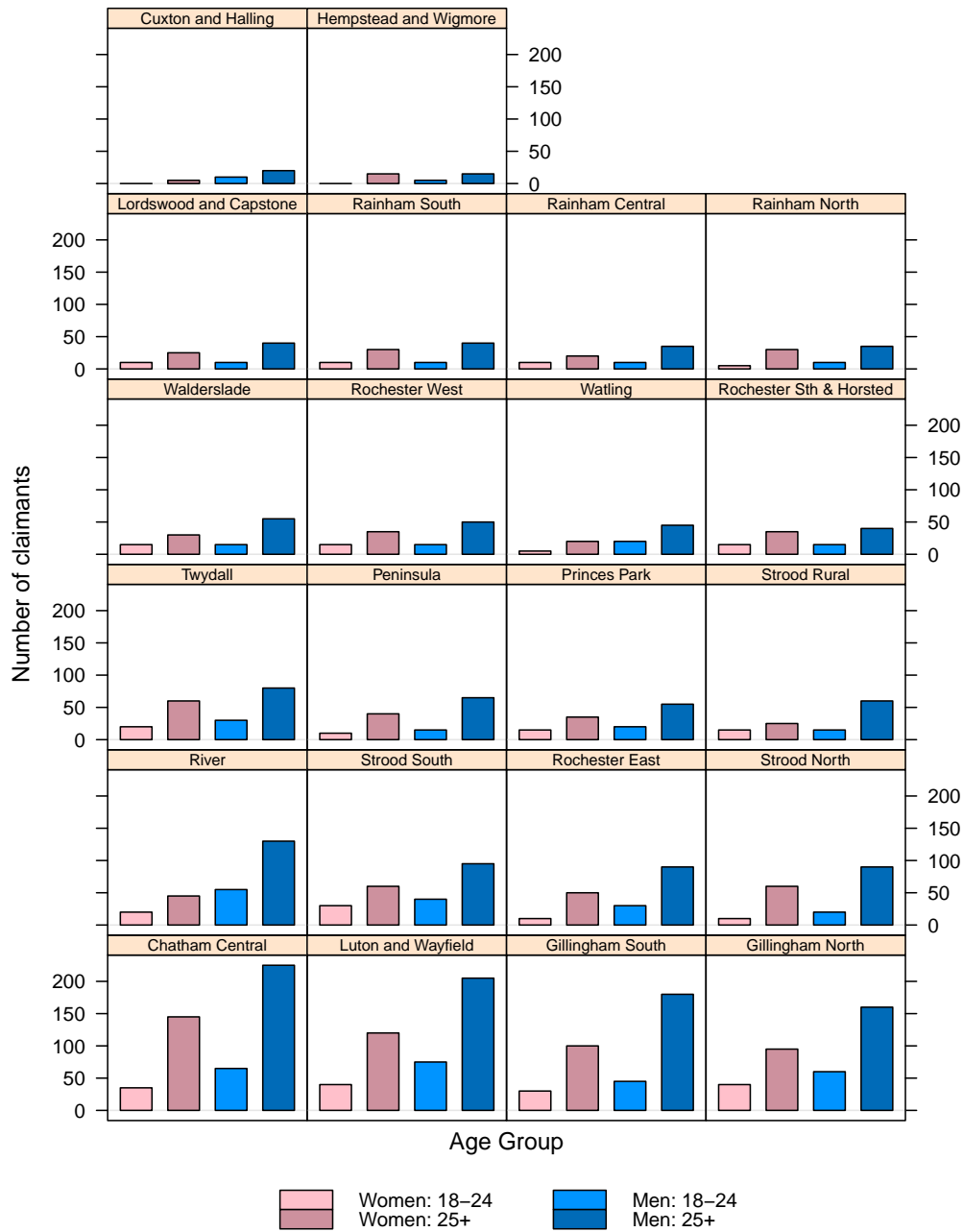


Figure 9
 Number of jobseekers allowance claimants by age by Medway electoral ward,
 May 2015.
 Source: NOMIS.

In Medway, people economically inactive because they are long-term sick rose to around 25% in 2009 and has remained at that level since then.(30)

Figure 9 shows the range of numbers of jobseekers by ward in Medway for men and women.

5 Quantifiable levels of ambition to reduce health inequalities

5.1 Overview of the approach taken

The illustration of health inequalities in the previous sections was used to frame the approach to develop locally quantifiable levels of ambition.

To decide what would be the most appropriate “quantifiable levels of ambition to reduce health inequalities” for Medway CCG a number of measures that align with the CCG’s strategic priorities, the NHS Outcomes Framework and the CCG outcomes Framework were examined by geographical area (deprivation), GP locality group, individual GP practices, and the protected characteristics, where data were available. It was recognised that it would not be possible in every case to completely eliminate health inequalities, and a pragmatic approach was taken to determine quantifiable levels of ambition to reduce the slope of health inequalities in a way that would be meaningful and feasible.

Broadly the aim is to reduce the gap from one group to the next by 50% over the next five years. This approach is illustrated in Figure 10 which shows indirectly-standardised unplanned hospitalisation for chronic ambulatory care sensitive conditions (in adults) for the seven CCG locality groups. The first plot (i) shows the rate for each locality group in the natural order; (ii) shows the same data plotted in ascending order. This shows the clear gradient, with locality group 7 having the lowest rates, and locality group 1 having the second lowest. Plot (iii) shows the quantifiable level of ambition to reduce health inequalities in this measure. The gap between groups 7 and 1 has been halved, as has the gap between 1 and 3; and so on. The resulting slope is shallower, indicating that the overall health inequalities would be reduced in a proportionate manner.

These proposed standardised rates were then used to calculate the reduction in the number of admissions for this measure for each locality group, as shown in Table 4. This was performed for each indicator across each domain (IMD, locality groups, GP practices, protected characteristics) and the results were reviewed by the CCG governing body.

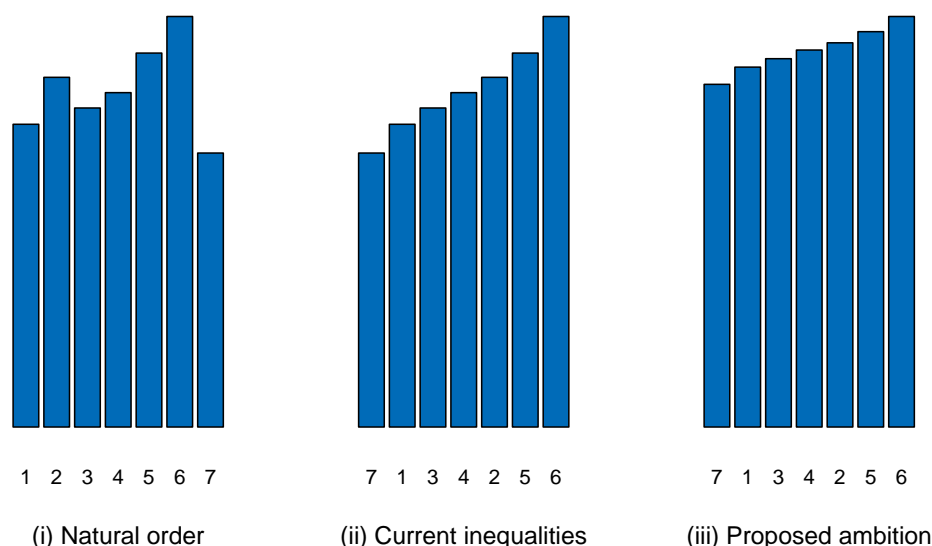


Figure 10

Distribution of indirectly-standardised unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) by locality group, 1 April 2009 to 31 March 2014 (5 years).

NOTE: As these are indirectly-standardised rates values should not be compared directly from one plot to the next. When indirectly-standardised rates are calculated they are based on the total number of events for the whole population in Medway, so when the number of events changes, e.g. as a result of reducing health inequalities, the population reference value changes. This means that it appears that the rates of admissions for Group 7 is higher in plot (iii) than it is in plot (ii), but the actual rate is lower. The important point is that the slope is shallower.

Table 4

Quantified levels of ambition to reduce inequalities in unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) by locality group

Locality group	Ambition
1	156 fewer admissions per year (from 1171 to 1015)
2	109 fewer admissions per year (from 1004 to 895)
3	53 fewer admissions per year (from 894 to 841)
4	155 fewer admissions per year (from 826 to 671)
5	209 fewer admissions per year (from 1534 to 1325)
6	338 fewer admissions per year (from 1693 to 1355)
7	17 fewer admissions per year (from 1343 to 1326)

5.2 Selected levels of ambition to reduce health inequalities

The following areas were selected by the CCG governing body:

- Complications associated with diabetes including emergency admission for diabetic ketoacidosis and lower limb amputation;
- Good blood glucose control in people with diabetes;
- Good blood pressure control in people with diabetes;
- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adult);
- Ratio of recorded COPD prevalence to expected prevalence 2011/12;
- Smoking rates in people with severe mental illness;
- Smoking in people with diabetes;
- Cholesterol in people with diabetes;
- Smoking, all patients.

The health inequalities and proposed quantifiable levels of ambition for these health outcomes are illustrated in Appendix 1. As described previously, the aim is to achieve these proposed levels within five years. For a number of these health outcomes good data are available from QOF or Audit+; however, in many cases there is little information available for health outcomes in the protected groups, e.g. transgender people, and possible actions may include systematically collecting this information.

5.3 High-level delivery plan

Plans for delivery of the identified levels of ambition will be worked on in 2016/17. However the CCG Governing Body has described at a high level the next steps needed, and these are outlined below:

5.3.1 Diabetes Measures

- Complications associated with diabetes
- Good blood glucose control in people with diabetes
- Good blood pressure control in people with diabetes
- Cholesterol in people with diabetes

The CCG will be working with GP practices to highlight and address variation in these areas. Patient structured education is being promoted to patients which offers advice and support to assist them in managing their conditions and how to make lifestyle changes especially with diet that will benefit the patient.

Two diabetes specialist nurses will be providing support and training to Practices in Medway. Practices will be identified by the Audit Plus system which require support in achieving the NICE care processes:

- HbA_{1c}
- Blood Pressure
- Cholesterol
- Serum Creatinine
- Urine Albumin c
- Foot Surveillance
- Body-mass index (BMI)
- Smoking

5.4 Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adult)

This measure covers emergency admissions in those aged 18+ where the primary diagnosis is one of a number of long-term conditions which should not normally require hospitalisation. These conditions include, for example, diabetes, convulsions and epilepsy, and high blood pressure.

The CCG has been working with community nursing services, social care, the voluntary sector and GP practices to offer better and more integrated support for patients with long term conditions who are at risk of attending hospital as

an emergency. Seven Local Care Teams have been set up around clusters of GP practices where services can wrap around primary care and offer multidisciplinary support to the at risk population.

In 2016/17 we will be further developing these plans to ensure that variation in outcomes is reduced and that support is consistent, effective, and efficient.

5.4.1 Ratio of Recorded COPD prevalence to expected prevalence

We know that in Medway there is variation in the identification of patients COPD. In 2015/16 the CCG has been working with practices to ensure that all patients with COPD receive a diagnosis and appropriate management. This work will continue in 2016/17 as part of wider efforts to address clinical variation in primary care. We are also working with GPs, Medway NHS Foundation Trust and Medway Community Healthcare to improve management and support of COPD patients outside of hospital.

5.4.2 Smoking Measures

- Smoking rates in people with severe Mental Illness;
- Smoking in people with diabetes;
- Smoking, all patients.

Whilst smoking prevention remains the overall responsibility of Medway Council's Public Health Team, we recognise the responsibility of the CCG in supporting health partners to make every contact count in identifying smoking status and signposting patients to services who can help them quit. The effectiveness of brief interventions in primary care is well-evidenced,⁽³¹⁾ and we will continue to develop ways in which we can use technology to make this a straightforward process for Health Professionals in Medway. We will also identify and support GP practices or other providers who require more help in this area.

5.5 Future Developments

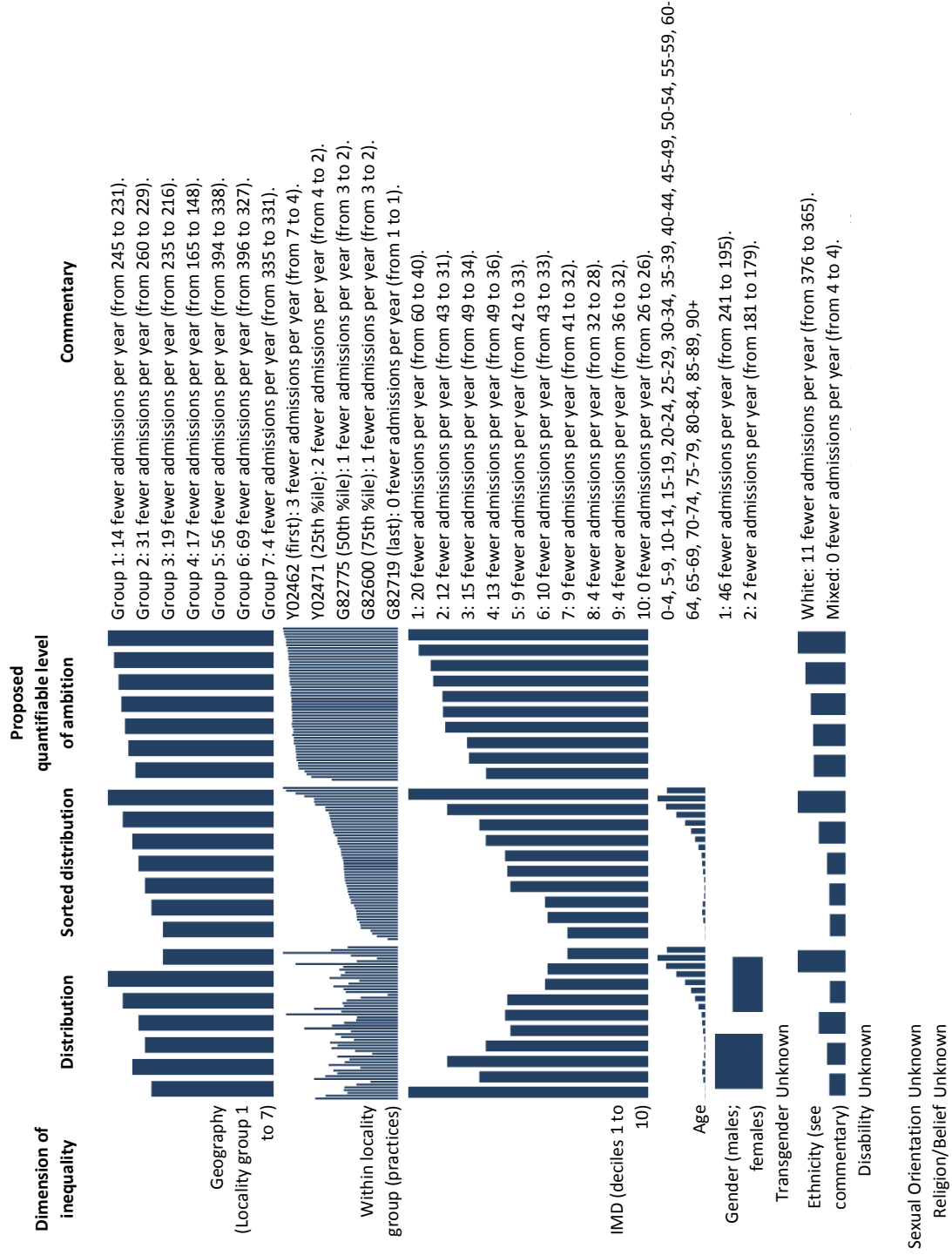
Having established five-year ambitions for reducing health inequalities, the CCG and Medway Public Health will develop in 2016/17 annual measures to track progress towards the achievement of those ambitions.

We will also seek to develop measures and ambitions in the areas of body weight and alcohol intake, which are important in reducing risk of a number of illnesses including Diabetes, Heart Disease, Cancer and Dementia.

6 Appendix 1

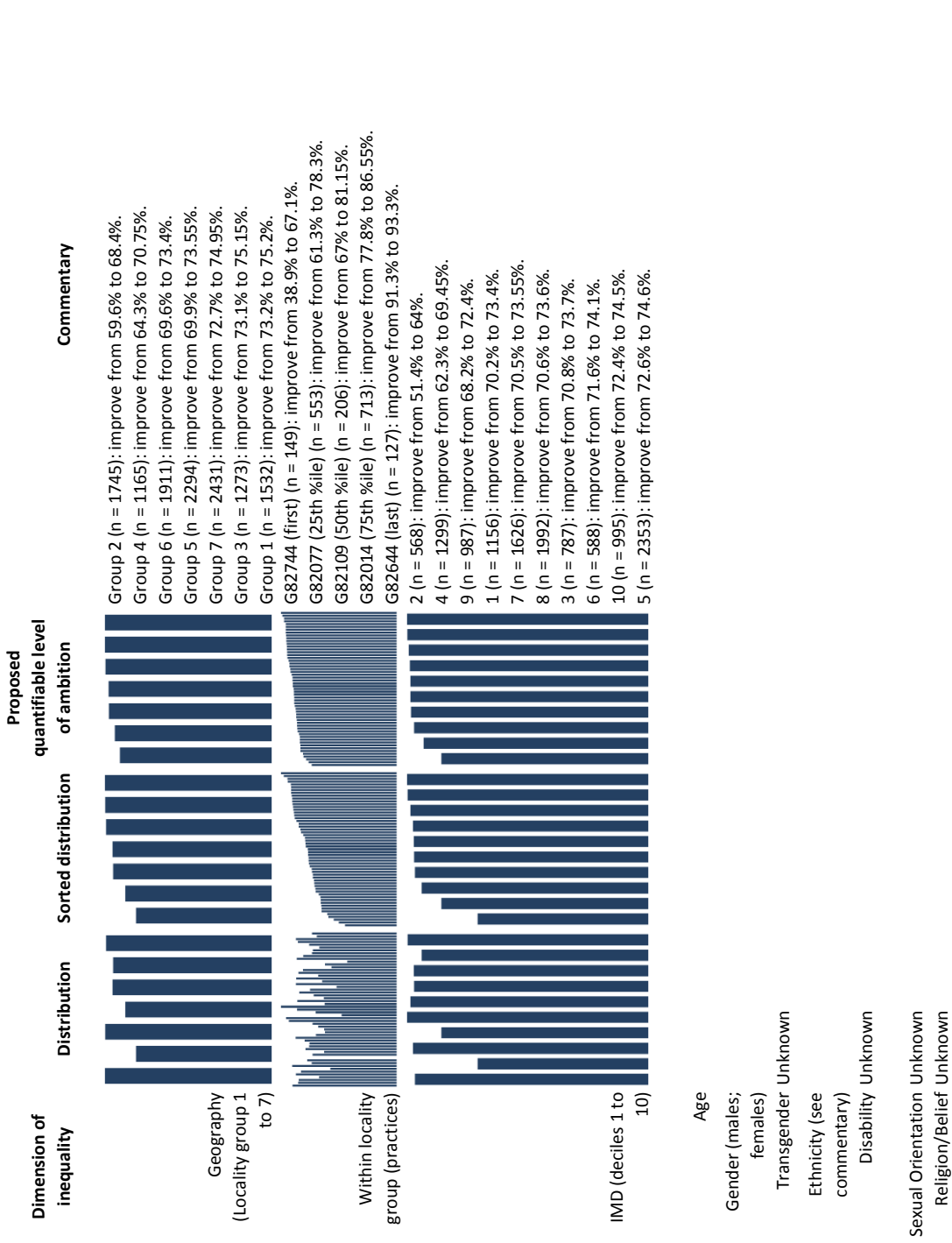
The following pages demonstrate the health inequalities in the selected areas viewed through the domains discussed above. Taking this approach will help to ensure that the CCG addresses these health inequalities from multiple perspectives and will help to reduce the risk of addressing one domain leading to increased inequalities in another domain.

Complications associated with diabetes incl. emergency admission for diabetic ketoacidosis and lower limb amputation



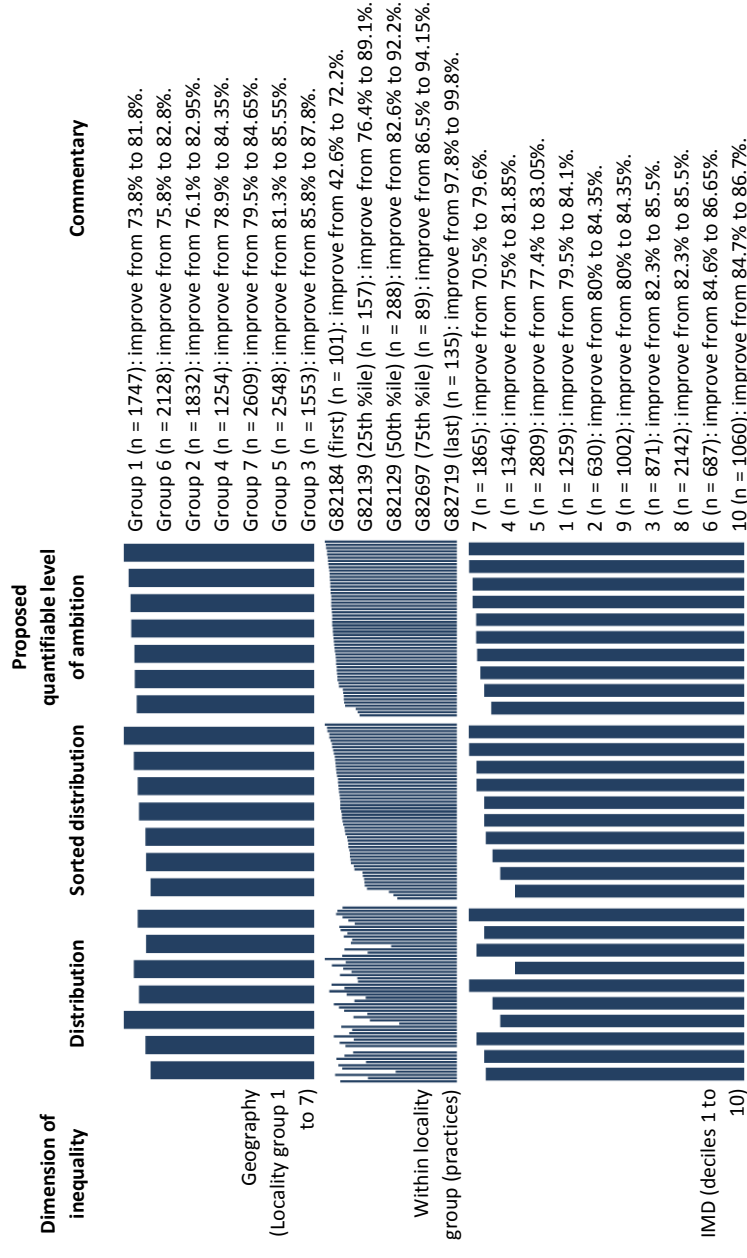
Sources: SUS admissions, PCS practice populations, ONS mid-year population estimates
Date range: 01 Apr 2009 to 31 Mar 2014 (5 years)
Description: Proxy indicator based on National Diabetes Audit indicator definition. Elective and Emergency admissions where Diabetes is recorded in any diagnosis position and primary diagnosis is one of Ketoacidosis, Angina, Acute MI, Heart failure or Diabetic retinopathy. Also count procedures for lower limb amputation and kidney transplant.

Good blood glucose control in people with diabetes



Sources: QoF, PCS practice populations
Date range: 01 Apr 2013 to 31 Mar 2014 (1 year)
Description: Proxy indicator based on QoF definition, which uses NICE 2010 guidelines. Percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mm/Hg or less.

Good blood pressure control in people with diabetes



Age

Gender (males;
females)

Transgender Unknown

Ethnicity (see
commentary)

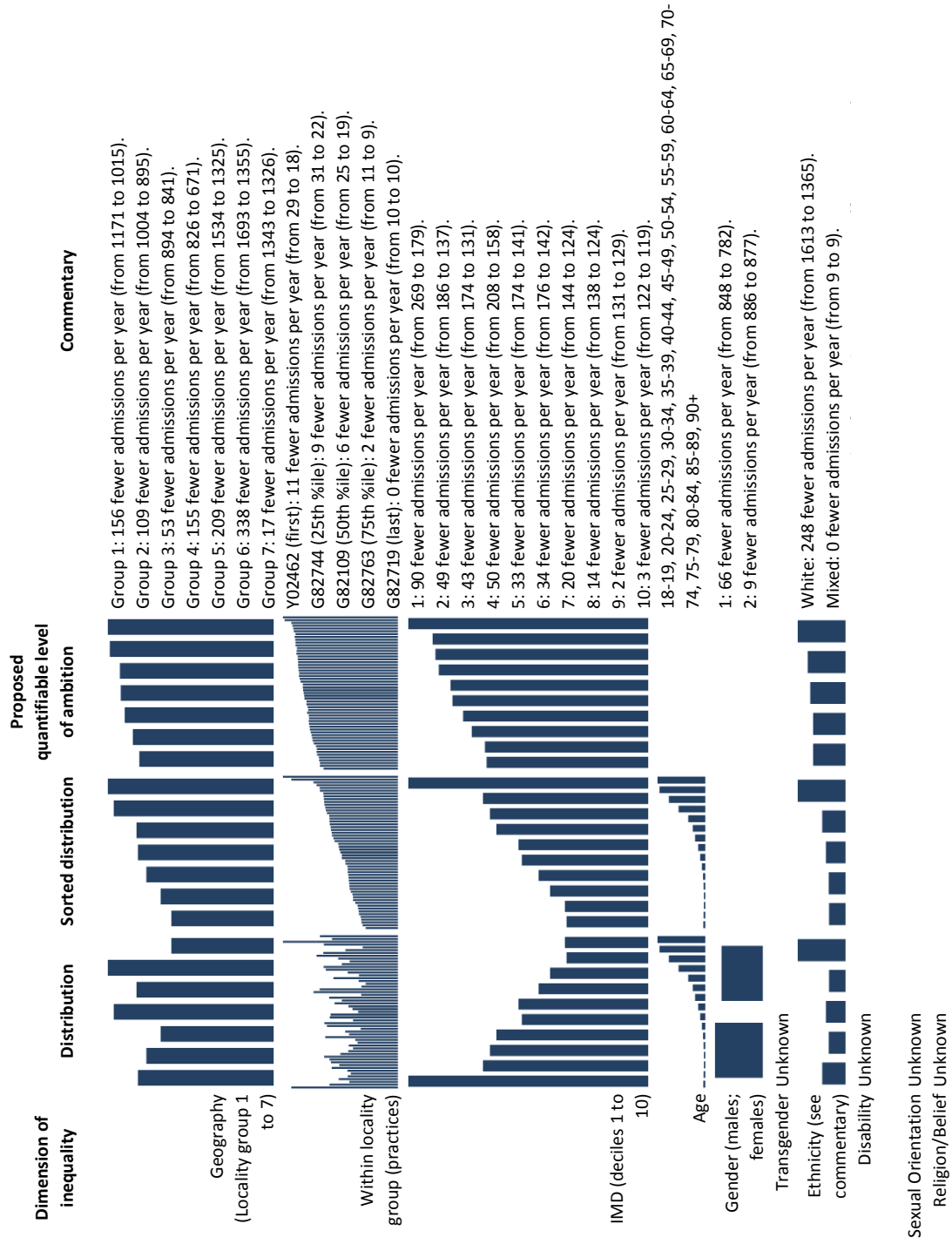
Disability Unknown

Sexual Orientation Unknown

Religion/Belief Unknown

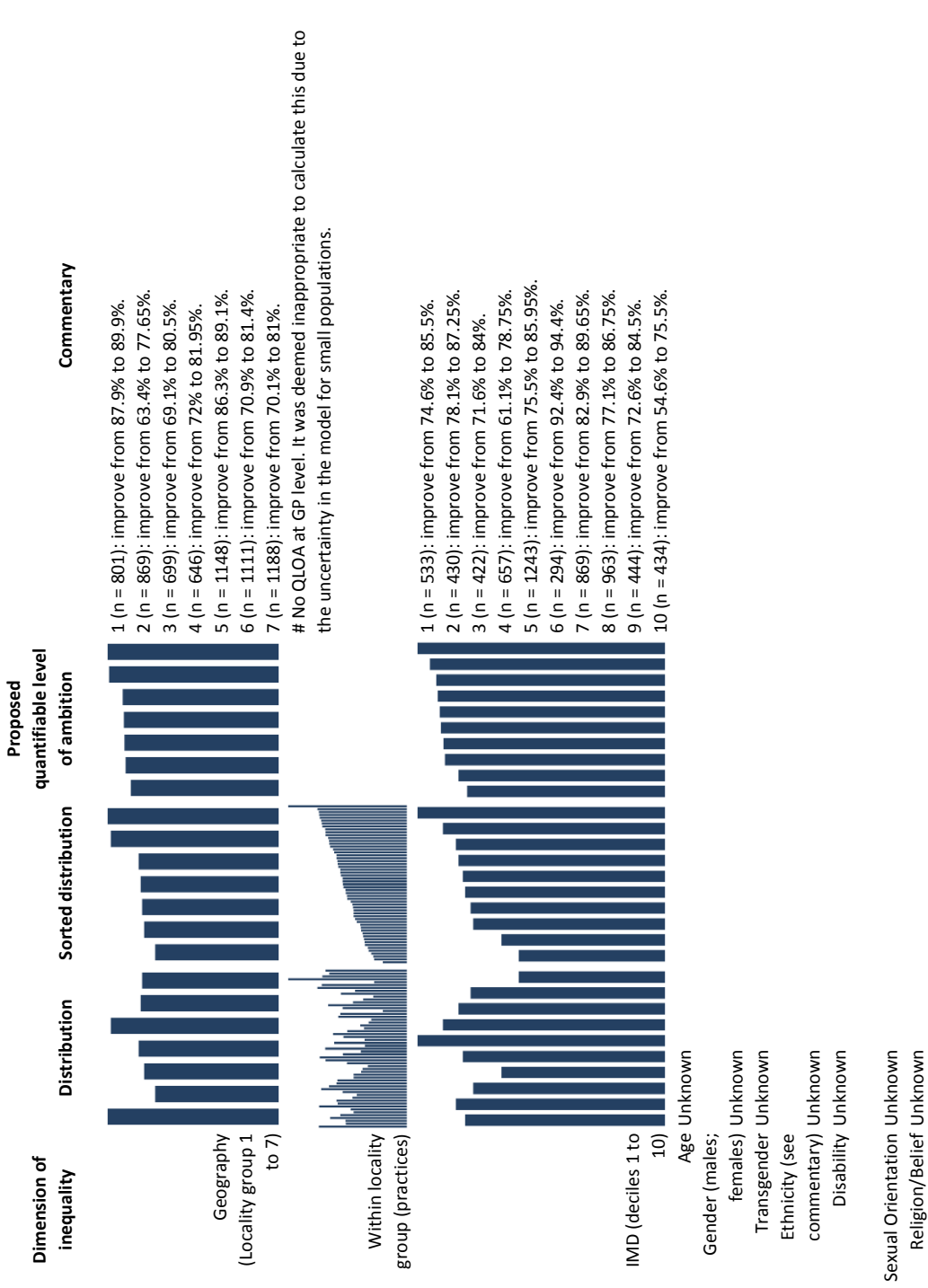
Sources: QoF, PCS practice populations
Date range: 01 Apr 2013 to 31 Mar 2014 (1 year)
Description: Proxy indicator based on QoF definition, which uses NICE 2010 guidelines. Percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c was 59 mmol/mol or less in the preceding 12 months.

Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adult)



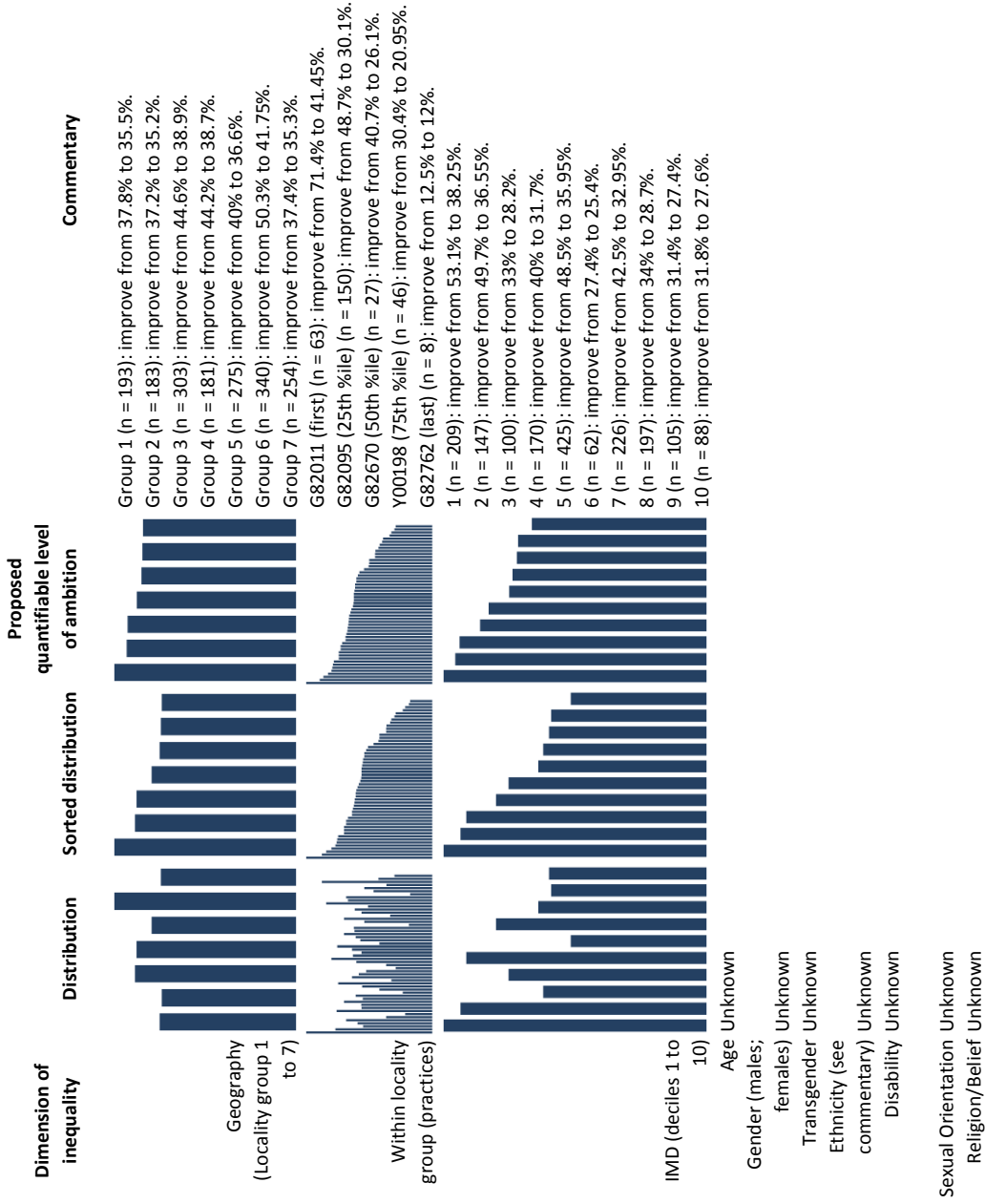
Sources: SUS admissions, PCS practice populations, ONS mid-year population estimates
Date range: 01 Apr 2009 to 31 Mar 2014 (5 years)
Description: Applied definition for NHS OF 2.3i: Emergency admissions in those aged 18+ where primary diagnosis is one of a number of long-term conditions which should not normally require hospitalisation. These conditions include, for example, diabetes, convulsions and epilepsy, and high blood pressure.

Ratio of recorded COPD prevalence to expected prevalence 2011/12



Sources: SUS admissions, PCDs practice populations, ONS mid-year population estimates
Date range: 01 Apr 2009 to 31 Mar 2014 (5 years)
Description: Proxy indicator based on National Diabetes Audit indicator definition. Elective and Emergency admissions where Diabetes is recorded in any diagnosis position and primary diagnosis is one of Ketoacidosis, Angina, Acute MI, Heart failure, Stroke, Renal failure or Diabetic retinopathy. Also count procedures for lower limb amputation and kidney transplant.

Severe mental illness: smoking rates



Sources: iCAP Central (NHS Medway CCG)
Date range: Snapshot September 2015
Description: Smoking prevalence among registered patients in Medway with diagnosis of severe mental illness (Psychosis, Schizophrenia and Bipolar affective disease). Denominator is those patients with smoking status recorded ever and numerator is those patients who have been recorded as a current smoker in last 15 months. Therefore this indicator may underestimate the true underlying smoking rate among this group.

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