ANNEX A: PUBLIC HEALTH REFERENCE GROUP PAPER

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1 PURPOSE

1. This report is presented to the Public Health Reference Group (PHRG) as a summary and recommendations of next steps following the productive discussion held on Health Inequalities at July PHRG where the group were asked to consider the following questions:

1. What do you understand by health inequalities -and how should we choose to frame the issue in Cambridgeshire and Peterborough?
2. What are the drivers for focusing on health inequalities e.g. outcomes for individuals, demand on services, economic productivity –and what outcomes do you think we should focus on?
3. Are there any quick wins we could start work on now?
4. How should we take forward medium term strategic work?

Members of the reference group provided answers to the questions before the meeting and built on them as part of a wider discussion.

There was a commitment from PH to take away notes and identify themes in order to inform next steps.

2 KEY POINTS

Themes from discussion

The July discussion was very informative and wide ranging. This has made it difficult to identify any strong themes or preferences for future direction. Two themes which came through were:

1) The need for a place based approach, whilst also recognising that inequalities are experienced by different groups which are not spatially patterned. Groups discussed included LGBT, incoming communities, offenders etc.
2) The group did not have sight of current actions happening on the ground in relation to health inequalities in order to identify quick wins and medium term actions.

In order to progress is was suggested that a mapping exercise could be undertaken to identify major gaps, this would also support another recommendation related to sharing and championing what was already going on.

Further, it was suggested case illustrations and examples of issues for different groups e.g. Pregnancy, Older adults, Place based housing, Employment, Integration of generations and LGBT etc would also be of benefit.

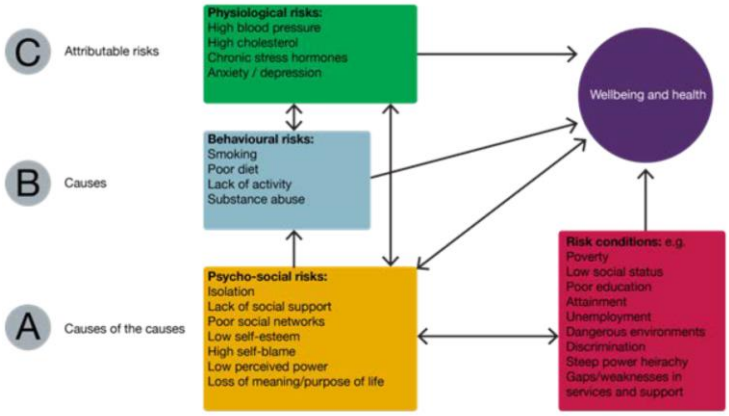
Evidence based framework to support reducing of health inequalities

To support the ongoing discussion and the need to focus going forward the following summarises core principles on reducing health inequalities based on Public health England's 'Guidance on reducing health inequalities: system, scale and sustainability[1]'.

Key principles included:

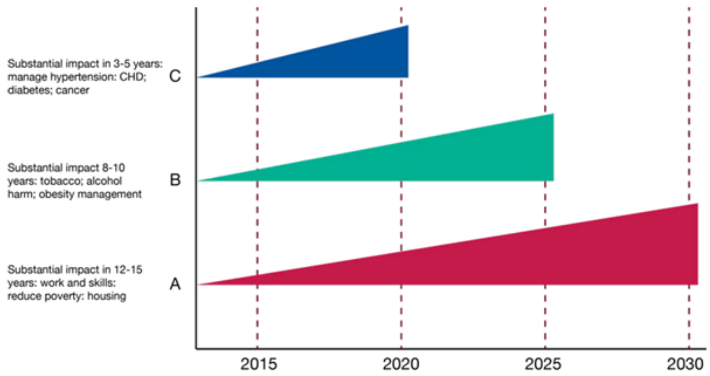
1) To have real impact at population level, interventions need to be **sustainable and systematically delivered at a scale** in order to reach large sections of the population**.**

2) Intervention need to be made at **different levels of risk** – physiological (BP, cholesterol), behavioural (smoking, exercise), psychosocial (Social Isolation, Low perceived power) recognising that all are interconnected and are determined by risk conditions or determinants of health.



3) Intervene for impact over time – Different types of intervention will have different impacts over different time periods. For example, interventions at levels to improve the community infrastructure to encourage people to walk and exercise could take many years to impact on health. While stopping smoking will have an immediate impact as well as longer term improvements.

Figure 3: Time needed to deliver outcomes from different intervention types



[1] https://www.gov.uk/government/publications/reducing-health-inequalities-in-local-areas

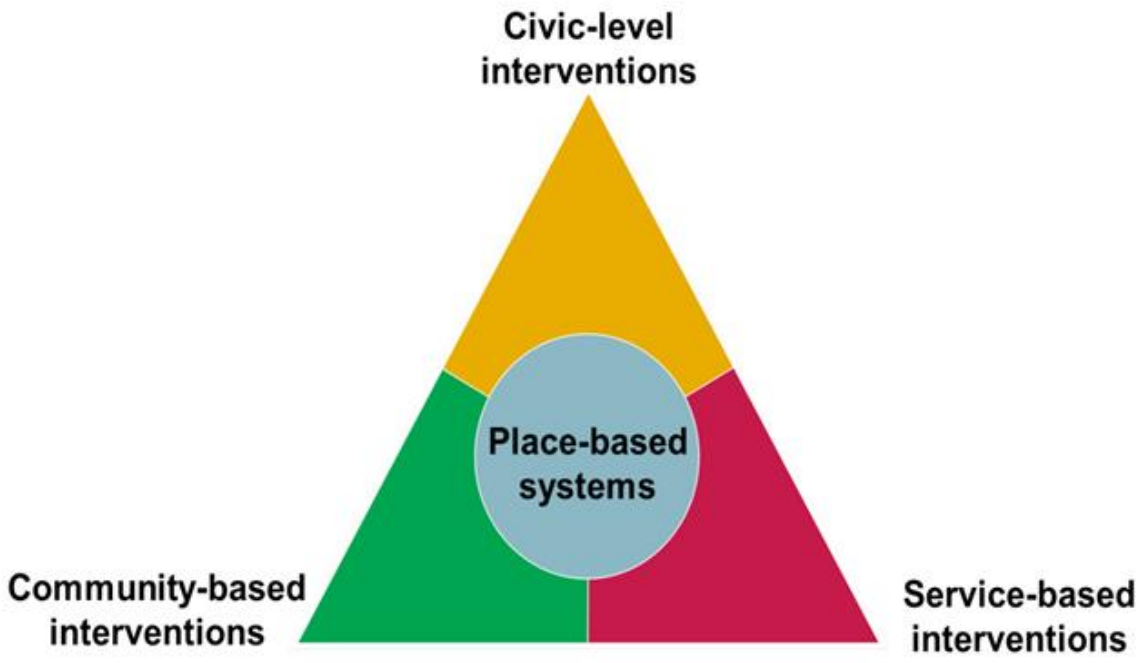
4) Intervene **across the life course** – start well, live well, age well (direct link to Marmot themes).

5) **Making an impact at population level** - Intervening at civic, community and service levels can separately impact on population health. In combination, the impact will be greater.

- **Civic interventions** – through healthy public policy, including legislation, taxation, welfare and campaigns can mitigate against the structural obstacles to good health. Adopting a Health in All Policies approach can support local authorities to embed action on health inequalities across their wide ranging functions.

- **Community level**, encouraging communities to be more self-managing and to take control of factors affecting their health and wellbeing is beneficial. It is useful to build capacity by involving people as community champions, peer support or similar. This can develop strong collaborative/partnership relationships that in turn support good health.

- **Service level** – Effective service based interventions work better with the combined input of civic and community interventions, eg a tobacco control strategy will include civic regulation on smoking in public spaces, and contraband sales; support to community campaigns and smoking policies in workplaces; as well as smoking cessation services.

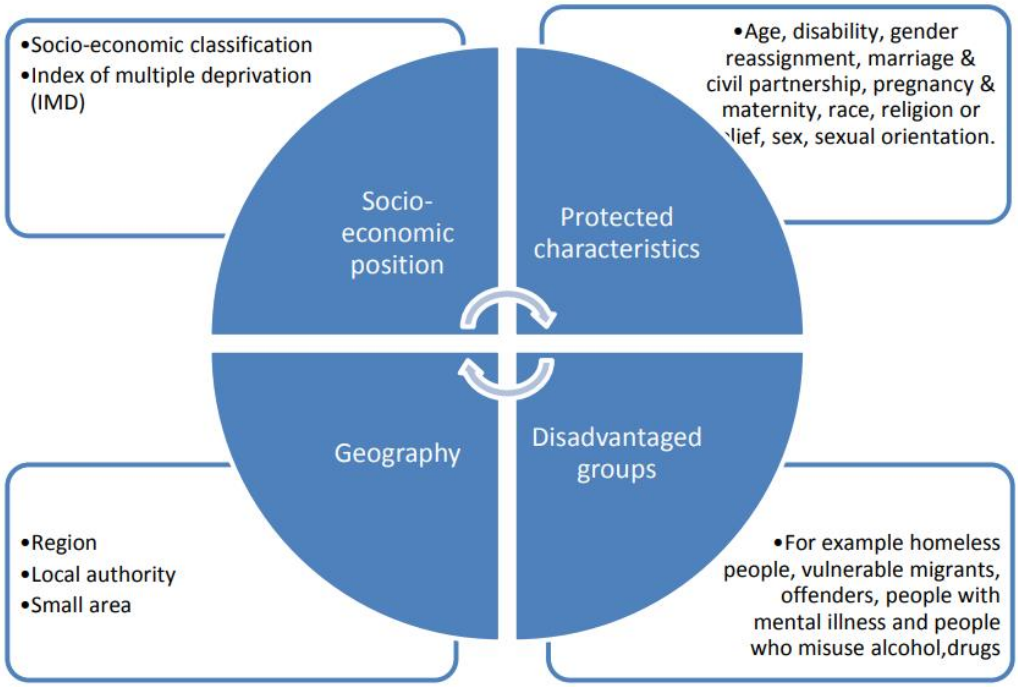


Credit: PHE Public Health Data Science based on the original concept created by Chris Bentley.

Different groups facing inequalities

The PHRG spoke about a number of groups who experience health inequalities. PHE in its report 'Local action on health inequalities - Understanding and reducing ethnic inequalities in health'[2] identified four dimensions for assessing inequalities which include socioeconomic position, protected characteristics, disadvantaged group or population and geography or place. These should be of consideration when choosing next steps.

Figure 1: Four dimensions for assessing inequalities



Mapping exercise

Following the recommendation to undertake a mapping exercise (in order to identify gaps), the table below was produced. This is a 'starter for ten' with a few programmes included, but even with this partial view, shows that there are many programmes of work which either directly (programmes developed specifically to reduce health inequalities) or indirectly (either positively or negatively) impact on health inequalities. A wider piece of work would generate a very large list, which would probably still not be comprehensive - unless focused on specific areas or population group.

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https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/730917/local_action_on_health_inequalities.pdf

Example of ‘starter for ten’ limited mapping exercise

Level of intervention	Specific work focused on health inequalities	Wider programmes of work which will impact on health inequalities	Other opportunities
Civic	• Can Do capital programme – investing in parks, community assets and public realm in Lincoln road area of Peterborough.	• Cumulative alcohol impact zone in Peterborough. • Selective Licensing for HMOs in Peterborough. • Planning – maximising health and wellbeing opportunities from new housing developments • Tobacco control. • PH sign off significant implications in Cambridgeshire Country Council.	• Embedding policies to maximise social value of public sector spend (e.g. local procurement, hiring/providing apprenticeships to local people) • Developing fast food Supplementary planning documents in areas with high fast food proliferation • Routinely undertake health equity impact assessments on all policy areas • ‘Ban the box’ –remove requirement for box on job application forms asking for criminal record where this is not relevant to the job.
Community	• Prevention at scale programme in Wisbech (identifying and developing community assets) • Community Health Champions and Youth Health Champions in Peterborough • Healthy Fenland Fund	• New ‘Think Communities’ strategy – focused on shifting CCC and PCC to a prevention based approach, building community assets • Integrated Communities Strategy in Peterborough	
Services	• Migrant fund programme of work – Supporting E8 migrants who are rough sleeping, developing videos on how to use health services (Eastern European migrants). • Work and health programme – interventions to support those with long term health conditions into work. • Locating healthy lifestyle services in most deprived parts of Peterborough and Cambridgeshire	• AF stroke prevention programme in Peterborough and Wisbech (focused on areas with worst Cardiovascular disease outcomes). • Debt advice, cheap credit & welfare rights	• Increasing identification and treatment of patients with high blood pressure in GP practices • Targeted social prescribing

3 SUMMARY AND RECOMMENDATIONS

Summary

- The group identified the need for both a place based approach, whilst also recognising that inequalities are experienced by different groups which are not spatially patterned.
- The group were unable to identify quick wins and medium term actions due to not being sighted on current actions happening on the ground in relation to health inequalities.
- Health inequalities is a large agenda and consideration needs to be given as to how the group's energy can be focused to make a tangible impact and add value.
- Many different programmes of work are currently being undertaken across Cambridgeshire and Peterborough which either directly focus on health inequalities or impact on health inequalities (both positively and negatively).
- There are limited resources to commission new services although funding may be more accessible for Peterborough and Fenland through bids to external sources. Therefore approaches need to consider how we can influence policy and improve/ tweak current provision to reduce health inequalities.
- Guidance from PHE suggests that to make an impact approaches need to be:
    - Sustainable and systematically delivered at a scale
    - Targeted at different levels of risk
    - Targeted to impact over time
    - Across the life course
    - Targeted at the civic, community and service levels to maximise impact on population health.
- There are a number of different dimensions for considering health inequalities including socioeconomic position, protected characteristics, disadvantaged group or population and geography or place

Recommendations

1) Consider the value of undertaking a wider mapping exercise based on examples contained in this paper.
2) Consider how to prioritise the PHRG's work, given the very wide scope of health