2010

Dudley Strategy for Tackling Health Inequalities: 2010-15 Full strategy including Evidence Review and Detailed Action Plans

Dudley Metropolitan Borough Council

DUDLEY COMMUNITY PARTNERSHIP achieving together

Dudley CVS DUDLEY COUNCIL FOR VOLUNTARY SERVICE

The Dudley Group of Hospitals NHS Trust NHS

NHS Dudley

FOREWORD

Since our last Health Inequalities Strategy was produced in 2005, Dudley has seen reductions in mortality for all of the main causes of ill health, including cancer, heart disease and respiratory disease. Life expectancy for all sections of society has improved, but the gap between the richest and poorest has increased slightly.

Tackling health inequalities is as much about tackling the social determinants of ill health as it is about changing our own behaviour to live healthier lives. The current economic climate will see some jobs disappear and unemployment is set to rise. Everyone in the borough will be impacted on by the reduction in public spending. A robust strategy and a collective determination from all our partners will be necessary to implement some of the tough choices that lie ahead if we are to ensure that everyone in Dudley is able to live out their lives in the best possible health.

I welcome this new strategy with its strong focus on social determinants and on identifying the priority actions that will have the greatest impact on reducing health inequalities in Dudley.

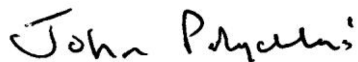
Andy Gray
Chair of Dudley Community Partnership
September 2010

ENDORSEMENT OF THE 2010 – 2015

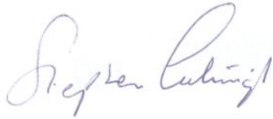
HEALTH INEQUALITIES STRATEGY

This revised Health Inequalities Strategy has been produced in the light of new national policy to reduce health inequalities. It has been informed by feedback from the Department of Health's National Support Team (NST) for Health Inequalities who visited us in 2009.

The Local Authority, Health and Voluntary sector jointly endorse the plans.



John Polychronakis
Chief Executive, Dudley Metropolitan Borough Council



Dr Stephen Cartwright
Managing Director, NHS Dudley

Paula Clark
Chief Executive, Dudley Group of Hospitals NHS Foundation Trust

Dennis Hodson
Director, Dudley Community Partnership

Andy Gray
Chief Officer, Dudley Council for Voluntary Services

ACKNOWLEDGEMENTS

The production of this strategy has involved a large number of contributors and authors. The editorial team would like to thank everyone who has given their time to read, write and amend the drafts.

EDITORIAL TEAM

Valerie Little	Director of Public Health, NHS Dudley
Tony Collins	Deputy Director of Public Health, NHS Dudley
Brendan Clifford	Assistant Director Policy, Performance and Resources, Directorate of Adult, Community and Housing Service, Dudley MBC
Sue Holmyard	Assistant Director of Planning and Environmental Health, Dudley MBC
Diane McNulty	Public Health Manager – Health Improvement, NHS Dudley
Ian McGuff	Assistant Director for Quality & Partnership, Childrens Services, Dudley MBC

CONTRIBUTING AUTHORS

Karen Jackson	Consultant in Public Health, NHS Dudley
Angela Moss	Public Health Information Analyst Manager, NHS Dudley
Ruth Olding	Programme Manager for Tobacco Control, NHS Dudley
Jody Pritchard	Programme Manager for Community Health Improvement, NHS Dudley
Amarjot Birdi	Health Improvement Programme Manager Health Inclusion/Public Mental Health Promotion, NHS Dudley
Andrew Hindle	Strategic Commissioning Lead - Older People and Long Term Conditions, NHS Dudley
Sue Cooper	Associate Director, Primary Care Commissioning, NHS Dudley
Tessa Norris	Director of Community Services & Integrated Care, Community Services, Dudley Group of Hospitals NHS Foundation Trust
Steve Corton	Head of Community Engagement, NHS Dudley

CONTENTS

FOREWORD……………………………………………………………………………..…..…
ACKNOWLEDGEMENTS……………………………………………………………….…..
CONTENTS………………………………………………………………………….…..
1. EXECUTIVE SUMMARY………………………………………………..…....6
2. VISION STATEMENT…………………………………………………......18
3. INTRODUCTION……………………………………………………….....19
4. HEALTH INEQUALITIES AND THE SOCIAL DETERMINANTS OF HEALTH…………………………………………………………………….23
5. LEADERSHIP AND PARTNERSHIP…………………………………………52
6. COMMUNITY ENGAGEMENT……………………………………………...56
7. PRIORITY ACTIONS TO IMPACT ON HEALTH INEQUALITIES……………61
   7.1 Secondary Prevention Cardiovascular Disease……………………… 61
   7.2 Acute Cardiovascular Disease (CVD), Transient Ischaemic Attack (TIA) and Stroke………………………………………………………………..74
   7.3 Tobacco Control ..….……..……......………………………………..... 92
   7.4 Alcohol Harm Reduction ………………………………………………104
   7.5 Cancer…………………………………………………………….…..…118
   7.6 Chronic Obstructive Pulmonary Disease (COPD)……………………136
   7.7 Seasonal Excess Deaths (SED)………………………………..……143
   7.8 Other Contributory Causes……………………………………..….…154
8. DELIVERING THE SERVICES THAT WILL MAKE A DIFFERENCE……...178
   8.1 Primary Care……………………………………………………..….178
   8.2 Social Care……………………………………………………….…183
   8.3 Transforming Community Services………………………………….185
   8.4 Developing the Role of the Voluntary and Community Sector………189
   8.5 Volunteers, Health Champions and Health Trainers…………………192
   8.6 The Prevention Role of the Acute Sector……………………………196
9. KEY RECOMMENDATIONS…………………………………………...198
   9.1 Dudley Health Inequalities High Level Action Plan 10/11 – 14/15….201
REFERENCES……………………………………………………………..........208

.

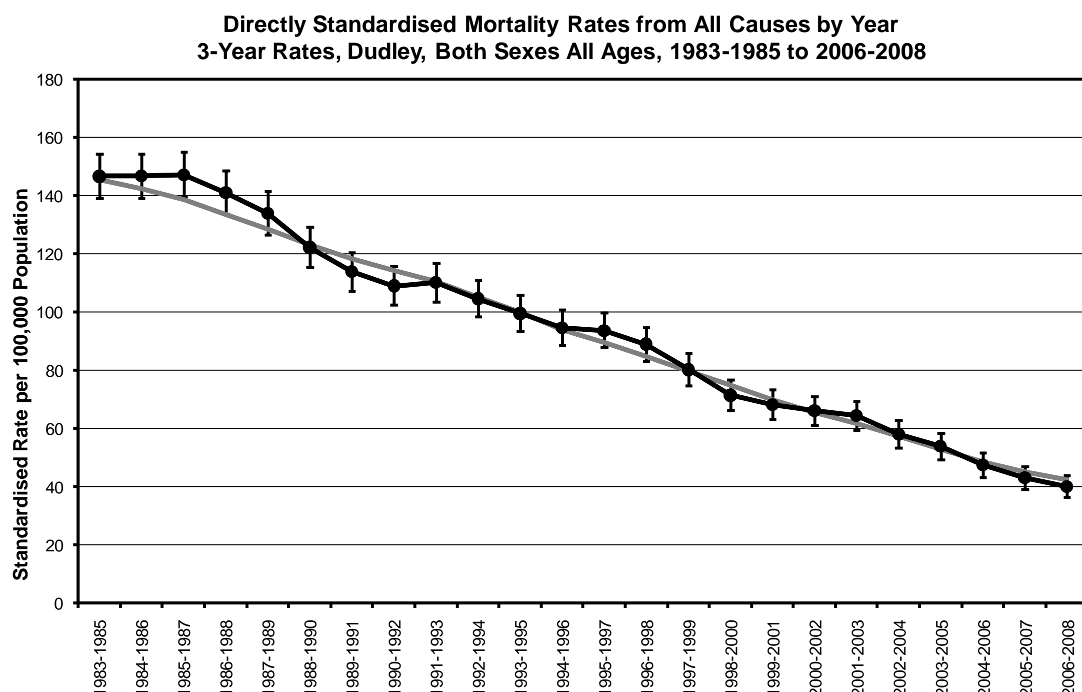
Appendix 1 Performance Indicators ………………………………………………….....215
Appendix 2 Delivery Plans for Priority Actions……………………………………219
Appendix 3 Health Inequalities Checklists…………………………………….…235

1. EXECUTIVE SUMMARY

BACKGROUND

This strategy replaces and builds on the previous strategy to tackle health inequalities in Dudley, *Closing the Gap – Tackling Health Inequalities in Dudley* (Dudley MBC and PCT, 2005). In the five years since the strategy was written we have seen mortality rates from the main contributory diseases all reduce slowly and life expectancy for Dudley residents has increased from 75.7 years for men and 80.3 years for women in 2003 to 80.3 years for men and 81.9 for women by 2008.

.



Source: Office for National Statistics (ONS) Annual Deaths Extract
Office for National Statistics (ONS) Mid-Year Population Estimates

Rate with 95% Confidence Interval — E&W Average

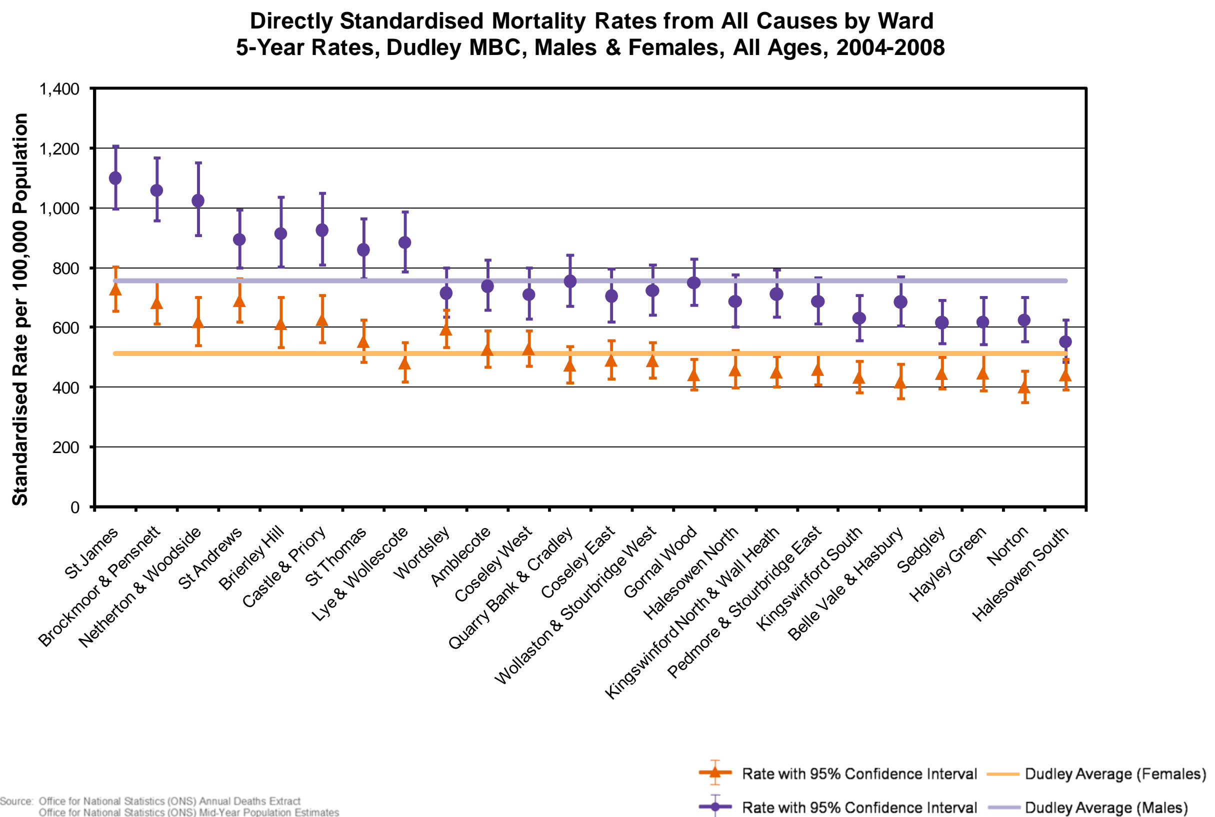
However the gap in life expectancy for the most affluent residents in the borough compared with those living in the poorest areas still persists. There are also gender differences associated with health inequalities and males bear the bigger burden of morbidity from disease and premature death.

The previous strategy from 2005 set a target based on a national Public Service Agreement to;

''Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth.''

It is not possible to say whether we have achieved this target yet, since 2010 data is not available. However the gap is no longer widening at the same rate.

Life expectancy for the whole population has improved, but the gap between the national average and the spearhead authorities (the most deprived Local Authorities) has widened by 7% for men and 14% for women since 1995-97. Life expectancy for the whole population in England is now 77.9 years for men and 82.0 years for women. Life expectancy in Dudley is improving, but there are still significant differences across the borough



Whilst it is pleasing to see the reduction in premature mortality the inequalities gap is still very evident and it is for this very powerful reason that this strategy seeks to address the social determinants of health as well as focusing on improving the health of the most deprived populations within the borough.

STRATEGIC PRIORITIES

The 2005 strategy identified three key priorities:

- Reduce poverty
- Tobacco control
- Increase educational attainment

There were three principles that underpinned the delivery of the strategy:

- A systematic approach to planning
- Strengthened partnerships to maximise planning
- Providing equitable services:

Significant progress has been made against the three key priorities with some actions achieved and some progress made against others. The notable successes have been in tobacco control with the introduction of the smoking ban in public places and the effectiveness of the local quit smoking services. Educational attainment has also improved over the last five years with 76% of pupils achieving grades A to C in 2010, compared with 56% in 2006. Improvements have also been seen in housing, reducing fuel poverty and the regeneration of deprived neighbourhoods, all of which have contributed to the reduction in health inequalities.

The challenge for the refreshed strategy is to build on this foundation in a very different economic environment and ensure that we continue to implement plans that support the health and economic well being of the most vulnerable groups in the borough.

In July 2009 the Department of Health's Health Inequalities National Support Team visited Dudley to assess our performance in reducing health inequalities. Their report was very favourable in a number of areas, particularly partnership, strategic vision and community engagement. However they did identify five key priority actions for Dudley.

- Strengthening leadership for health and health inequalities across the partnership and particularly within the Local Authority and Acute Trust
- Improving the quality and capacity of primary care
- Refreshing the Health Inequalities Strategy, developing detailed delivery plans and agreeing a common frame of reference for monitoring progress on addressing health inequalities.
- The continued market development of the voluntary, community and faith sector.
- The simplification of neighbourhood community engagement structures.

These recommendations, and other specific recommendations relating to priority actions known to have a significant impact on reducing health inequalities, have been taken into account in the development of the refreshed strategy. They have been summarised as high level actions in the delivery plan, together with the outcomes and indicators that will be used to monitor progress.

Whilst this strategy has been in development a key report was released and a number of important policy changes have taken place that will impact on how health inequalities will be addressed in the future. Firstly, The Marmot Review, 2010 was released in February 2010. This review emphasised the persistent nature of health inequalities in England and suggested that efforts should be made to tackle the social gradient in health, but 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 proportionate to the level of deprivation. He identifies a number of policy areas that will have the greatest impact on reducing health inequalities and these have been adapted to become the key strategic aims of this strategy.

STRATEGIC AIMS

❖ **Give every child the best start in life**
❖ **Create fair employment and good work for all**
❖ **Ensure a healthy standard of living for all**
❖ **Create and develop healthy and sustainable places and communities**
❖ **Strengthen the role and impact of ill health prevention**

The first policy change that impacts on health inequalities is the role of the 'Big Society', which encourages people to take more control over their own lives, rely less on the state 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.

The other major policy shift has been reflected in the White Paper, *Liberating the NHS* (Great Britain. Department of Health, 2010), which sets out radical change for the way in which NHS services will be commissioned and delivered in the future. 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 by 2013.

LEADERSHIP AND PARTNERSHIP

In the midst of these changes we need to safeguard the strong partnerships developed with people living in local communities in Dudley. Long before statutory requirements like the 'Duty to Involve' came into being, public and voluntary sector agencies in Dudley have been working alongside local communities to ensure that people can affect decision making, influence change in the delivery of health and social services, gain experience and skills which may lead to a better quality of life for them and their families, and take ownership of their own health improvement.

This work has been built on trusting relationships, which takes time to develop. An increasing focus on market-driven, cost-efficient models of service delivery brings an inevitable tension in keeping local people at the forefront of our thoughts and our plans. In this climate we need to work particularly hard at valuing and sustaining these relationships and ensuring they continue to be based on trust, respect, empathy and reciprocity.

GIVE EVERY CHILD THE BEST START IN LIFE

While data systems exist to look at progress, at a population level, on immunisation, breast feeding, and attainment at reception year of primary school, there are no systems which enable the full picture to be obtained of the developmental progress of our children in the vital early years. Equally, the systems for tracking fidelity to the Healthy Child Programme and fidelity to important formal manual-based parenting programmes are not well developed. Undoubtedly, each individual child's progress is recorded in a health, education, children's centre record or parenting programme database but the systems to extract this and examine progress across the child population as a whole or for disadvantaged sub-groups of the population is not always there. This is a priority for development. It is not a small job and will require time to implement. Nevertheless, we will not be able to assess whether our interventions in early years are producing the outcomes we desire if we do not have systems to allow us to view progress.

It has not been possible in the timescale for production of this strategy to amass data on the relative spend on children in the early years versus spend on the school years and the adolescent years in Dudley. Marmot (2010) acknowledged that this is not wholly possible at national level either. However, it should be possible to at least reproduce for Dudley an analysis of the type presented in the national data in the Marmot Review. It is recommended that investment in school and adolescent years should be examined to see if there is any way in which efficiency can be improved to release resource to be invested in the vital early years.

Dudley has no structured intensive home visiting service, such as that delivered within a Family Nurse Partnership Programme, though intensive family support is being delivered through children's social care, children's centres and the Family Intervention Programme to some of the Borough's most disadvantaged families. A further nurse based programme is essential for some families. Any investment released from other areas for early years should be channelled into the commissioning of a Family Nurse Partnership Programme for families on a defined set of eligibility criteria, with a clear means of auditing outcomes.

The structured approach to implementation of formal parenting programmes set out in *Dudley's Parenting Support and Family Learning Strategy* (Dudley Children's Trust, 2009) should continue but with full tracking of adherence to eligibility criteria which ensure that those who need them most get them. Impact in terms of outcome measures must be tracked.

Undoubtedly, productivity would be improved and potentially some resource released, if there was more formal integrated working between the Health Visiting

service the midwifery service and the Children's Centres, particularly between the outreach workers and Health Visitors.

Ensuring that paid parental leave is available for workers within Dudley may not be within the compass of the statutory agencies to deliver, but all statutory agencies should ensure that their own policies embrace this and economic regeneration initiatives should promote this.

Pre and immediately post-natal periods are crucial for a child's development and the improvements required in the antenatal care service are highlighted in Dudley's complementary Infant Mortality Reduction Action Plan. The action plan must be implemented in full.

Child care for working mothers with children aged 2 – 5 years can be extremely beneficial but may not be benign if the child care is of a poor quality. Children who experience high quality early years childcare provision are well placed to achieve better outcomes in school and beyond and develop better social emotional and cognitive abilities necessary for lifelong learning. Independent inspection data identifies that 81% of childcare providers in Dudley have achieved good or outstanding grade. Quality assurance of the child care provision in Dudley remains a high priority

CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL

Maximising fair employment for all in Dudley has the potential for making a major contribution to a reduction in inequality of health outcomes. Dudley is currently developing a local economic strategy, designed to develop the local economy and maximize employment. It will be important for this strategy to focus not only on total jobs gained but also on attracting high quality jobs for Dudley people to access. The full set of measures to achieve this is being set out in the Dudley Local Economic Strategy and is not repeated here. For maximum impact on reducing health inequalities Dudley needs to:

- Ensure that data systems for tracking the impact of economic strategy initiatives use a consistent approach to assessment across the social gradient.

- Ensure that public and private sector employers adhere to equality guidance and legislation.

- Develop means of implementing guidance on stress management and the effective promotion of wellbeing and physical and mental health at work, both for public sector and private sector employees.

- Consider the potential for incentivising employers to adapt jobs to provide suitable employment for lone parents, carers and people with physical mental health problems.

- Ensure that Dudley participates to the maximum in any available well evidenced active labour market programmes

ENSURE A HEALTHY STANDARD OF LIVING FOR ALL

As things stand, the extent to which all people in Dudley will have disposable income which provides sufficient for them to have a standard of living for a healthy life is very dependent on national policies adopted by central governments. In particular, the extent to which central governments are prepared to shift the taxation system towards being more progressive; the extent to which welfare policy initiatives are designed to remove the 'cliff edge' and the extent to which measures are implemented to ensure full take up of entitlement to state benefits.

In the meantime, all public service agencies in Dudley should be ensuring that those eligible and entitled to benefit are receiving it.

It is a legal requirement for the Dudley MBC to produce a strategy to reduce child and family poverty and the key actions for poverty reduction in Dudley are contained in that document and are not reproduced within the strategy. The Child and Family Poverty Reduction Strategy must be implemented in full.

CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

The creation of healthy, sustainable places and communities combined with the mitigation of climate change can have an impact in reducing health inequalities. Good policies will include plans to increase opportunities for walking and recreation in green spaces, sporting and cultural facilities complementing strategies to reduce obesity and increase physical activity which contribute to improved mental and physical health.

The priorities for Dudley are:

- Increase opportunities for active travel across the social gradient
- Maintain access and quality of open and green spaces across the social gradient
- Continue to improve the energy efficiency of housing and reducing fuel poverty
- Support locally developed and evidence based community regeneration programmes that reduce barriers to community participation and reduce social isolation

STRENGTHEN THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

Most of the NHS budget is spent on treating illnesses which in many cases are preventable. It is estimated that approximately 4% of the national NHS budget is spent on prevention and in times of economic pressure it is often the health improvement programmes that suffer because of the more immediate need to treat people who are ill. The evidence base for prevention is better developed in some areas than others; indeed the public health benefits for immunisation programmes and screening programmes are well established and there is strong evidence to

support the prescribing of statins for lowering cholesterol and for the use for blood pressure lowering medication in the treatment of heart disease.

Interventions that rely on changing the behaviour of populations are also known to work, but they take a long time to become established and their impact may not be able to be measured for many years. The action plans for reducing mortality from cardio-vascular disease, cancer, chronic obstructive pulmonary disease, which are the three biggest causes of mortality in Dudley, are supported by actions that include primary and secondary prevention measures. Separate plans to reduce alcohol and tobacco consumption are included because of their known impact on mortality rates.

Actions for Secondary Prevention Cardiovascular Disease

- Reduction in the gaps between actual and expected prevalence for the key vascular diseases via
  - The implementation of NHS health checks, to ensure a high uptake from those who are most at risk and more unlikely to take up a health check e.g. men, minority ethnic communities and low income groups. Targeted promotions, out-reach services and case-finding especially in relation to hypertension should be part of this response.
  - Investigate practice outliers with low levels of prevalence for the Coronary Heart Disease (CHD) and stroke registers

- Variation in performance across practices for treatment outcomes: Investigate performance for practice outliers starting with blood pressure and cholesterol management.

- Develop an on-going programme of health equity audits supported by the incorporation of a health equity element into all planned primary care/service audits. E.g. medicines management audits, service reviews, improved ethnicity monitoring across primary care/ community services.

- Put strategies in place to increase referrals to Lifestyle Risk Management Service (LRMS) for those on practice registers and improve outcomes for patients from deprived areas.

- Develop and implement a self care strategy as part of the long term conditions strategy so there is a menu of quality assured options for all newly diagnosed vascular patients.

Actions for Acute CHD

The National Support Team (NST) identifies a number of priority areas for action and this section draws on those in conjunction with the main findings from the Health Needs Assessment:

- Introduce public awareness campaigns with a targeted approach to groups with higher needs; over 65s, minority ethnic groups, women and deprived areas. Health care professionals should take every opportunity to advise all patients

with, or at high risk of vascular disease to call 999 should they experience unexplained chest pain.
- Continue to embed delivery of expanded services for acute myocardial infarction (MI) diagnostics and revascularisation and review the equity of provision in a further 5 years time.
- Repeat the cardiac rehabilitation equity audit with larger numbers to establish a fuller picture and implement recommendations made from this. This should include a review of Did Not Attends (DNAs) and Do Not Responds (DNRs) for cardiac rehabilitation and the establishment of routine procedure to follow-up these groups.

Actions for Acute Stroke/Transient Ischaemic Attacks(TIA)

The NST identified a number of priority areas for action:

- Continue **F**acial weakness, **A**rm weakness, **S**peech problems, **T**ime to call 999 (FAST) awareness programmes with an emphasis on segmentation and use of social marketing to ensure the message reaches all communities, to include the development of targeted campaigns for minority ethnic groups and the over 65s
- Continue implementation of current stroke/TIA workstreams to increase speed of access to diagnostics and treatment to meet the national targets set out in the accelerating stroke improvement programme in all cases, specifically:
- If any metrics remain significantly below target, consider equity auditing to compare demographics of patients receiving optimum versus not optimum care.
- Audit GP TIA referrals data for consistency
- Review GP practice performance for outlying practices in relation to admissions data

Actions for Chronic Obstructive Pulmonary Disease(COPD)

Although the HINST did not hold a specific workshop on COPD when they visited us, they have since produced a series of recommendations on delivering better management of COPD based on the experiences of the Spearhead PCTs. These recommendations have been reviewed and concur with the COPD pathway that is implemented in Dudley.

The local priorities for development are:-

- As part of the National COPD Strategy and to increase prevalence numbers in Dudley a ‘Missing Millions’ (previously undiagnosed COPD) pilot that has commenced: Audit of 800 patients via GP surgeries, community pharmacists, Dudley Stop Smoking
- Implement the new NICE guidelines for COPD Mild, Moderate, Severe and Very Severe
- There is an application via Strategic Health Authority (SHA) End of life workforce projects for an end of life care lead/nurse for COPD
- There is a concerted focus to improve under diagnosis and increase prevalence of asthma in Dudley via an education and training programme. There will also be actions to reduce the numbers of recurrent admissions with asthma

Actions for tobacco control

The NST identified a number of priority areas for action and an action plan has been developed to be included ensure that they will form part of the tobacco control programme. The recommendations have been outlined in conjunction with current local action and priorities:

- Strategic approach to Tobacco Control is best co-ordinated by an effective multi-agency partnership:
    - Continued strong senior level support and leadership for Tobacco Control agenda
    - Review role of Tobacco Action Group (TAG)
    - TAG continued accountability to Dudley Community Partnership via the Health and Wellbeing Partnership
    - Refresh the Tobacco Strategy and action plan in line with new National Strategy
    - Development of advocacy role of the Alliance around Second Hand Smoke and Illicit tobacco
- Further develop an evidenced based and proactive approach to illicit tobacco
    - Plan local priorities
- The PCT, Acute Trust, Local Authority and other partners should explore ways in which data can be collected and shared to improve local intelligence on key areas e.g. smoking in pregnancy, illicit tobacco, under age sales
- Intention to commission Environmental Health to carry out additional smokefree compliance checks in routine and manual workplaces to include illicit tobacco and stop smoking information
- There would be a benefit in developing a programme of ongoing test purchasing to explore the issue of supply of tobacco to young people
- The early adoption of Department of Health Stop Smoking in Secondary Care toolkit provides an opportunity to ensure effective care pathways are in place for smokers – this will impact on the key contributors to tackling health inequalities.
    - This would also provide an opportunity to ensure a formally agreed care pathway for smoking in pregnancy to be used by all staff.
- The Department of Health Stop Smoking Interventions in Primary Care toolkit is rolled out to ensure strengthened infrastructure for quality brief interventions.
- All tobacco control initiatives will require senior level support and agreement between Primary and Secondary Care organisations to ensure a seamless quality service for clients.
- It will be beneficial to have Varenicline as a first line smoking cessation medication.

Actions for alcohol harm reduction

The national health inequalities team have identified four key actions that will impact on health inequalities and result in both short term and longer term health gains through:

- Tackling underage/illegal alcohol consumption and encouraging the industry to promote responsible drinking
- Combating crime related disorder
- Raising awareness of, and educating about, safe and sensible drinking
- Facilitating identification of at risk individuals and enabling access to alcohol treatment services which are consistent with national standards
- In addition there is a commitment to implement the high impact changes that are known to impact on reducing premature mortality

Actions to reduce cancer inequalities:

The key priorities for impacting on cancer inequalities are:

- Promote healthier lifestyles
- Raise awareness of cancer signs and symptoms and increase the uptake of screening programmes
- Reduce cancer waits for all patients
- Enhance quality and timeliness of information
- Provide financial and psychological support

IMPLEMENTING THE HEALTH INEQUALITIES STRATEGY

Such a broad ranging strategy can only be achieved by a whole range of partners working together in a co-ordinated and planned way. The strategy brings together many individual action plans that are already being delivered through existing multi-agency partnerships.

The progress on reducing health inequalities is currently overseen by the Health Improvement Modernisation Management Team (HIMMT) which reports to the Health and Wellbeing Board, which in turn reports to Dudley Community Partnership. Independent scrutiny of the strategy is done by the Health Overview and Scrutiny Committee. It is likely that these structures will change in the future and a newly structured Health and Wellbeing Board will take responsibility for monitoring health improvement plans and reducing health inequalities.

There are important roles for all statutory agencies. Local Authority directorates, including Adult Social Care, Children's Services, Environmental Health and Housing will take a lead role in delivery of the strategic aims and the Local Authority will ensure the involvement of the new GP Commissioning Cluster in implementing the strategy when its new public health role becomes functional. The prevention role of the Foundation Trust needs to be developed as they become the providers of some community health services and the work on developing the role of the third sector needs to be advanced. As part of the Big Society vision the role of Community Health Champions, Public Health Volunteers and Health Trainers will become more prominent over time.

The role for Community Engagement and consultation will remain an important feature in delivering this strategy and will influence the priorities and future direction

of the work. The development of the strategy has been informed by a comprehensive joint strategic needs assessment.

2. VISION STATEMENT

The mission statement of Dudley Health and Well-being Partnership:

> *''We will work together to improve the health and well-being of the population of Dudley and reduce the gap in health inequalities to improve life expectancy and health outcomes for all by 2015''.*

Our vision for our services as a Dudley Health and Well-being Partnership is that we will:

1. Listen to the needs of our local population and promote good health and well-being for all through effective commissioning for health improvement.

2. Meet the health and social care needs of our most vulnerable residents.

3. Recognise the diversity of local needs and empower individuals and communities to take responsibility for their health and well-being by targeting resources effectively.

4. Ensure that the citizens of Dudley receive quality local services that will protect and care for the vulnerable and those at risk from harm.

5. Improve the health of all children and the life chances of looked after children and care-leavers as a result of stronger partnership working.

6. Promote enhanced citizenship and improve the ordinary life experiences of older people.

7. Improve mental health and well-being and actively promote independence and social inclusion.

8. Encourage and support innovation in developing better services for Dudley people through developing and supporting our workforce.

3. INTRODUCTION

Background

Differences in health status and life expectancy between the wealthiest and the poorest in society are not a new phenomenon. Identifying differences in life expectancy according to social status has been done for at least two hundred years. The real concern is that these differences have persisted despite the dramatic fall in mortality rates over the last decade, brought about by improvements in medicines and treatment and an improvement in living standards.

Although life expectancy has increased, healthy life expectancy, described as the measure of average length of life free from ill health and disability, has not increased. The number of years gained have been years living with a chronic disease or disability. So not only do poorer people have a shorter life expectancy they can also expect to spend more of their shorter lives with a disability.

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). Reducing health inequalities requires national action on social, economic and health policy and local action by local government, the NHS, the voluntary sector, the private sector and local communities.

The policy context

In 1998 Sir Donald Acheson published the *Independent Inquiry into Inequalities in Health* (Acheson, 1998) which emphasised the importance of social conditions throughout the course of life and its impacts on health outcomes. He identified three important priorities:

- ❖ To assess the impact on health inequality of all health policies
- ❖ To give priority to women of child bearing age, expectant mothers and young children
- ❖ To reduce the gap in living standards between the worst off and the average

The government's response to the Acheson report was a national health inequalities strategy, *Tackling Health Inequalities: A programme for action* (Great Britain. Department of Health, 2003). The national strategy had twin aims: to deliver a national health inequalities target by 2010 (reducing inequalities in infant mortality and life expectancy at birth) and to support a long term sustainable reduction in health inequalities. In 2003, following a review, a new funding formula was approved which included a specific allocation for health inequalities.

2004 saw the release of *Choosing Health: Making healthy choices easier.* (Great Britain. Department of Health, 2004) which set out the national strategy for improving health. Reducing health inequalities was included in the 2004 NHS planning guidance. The following year 'Spearhead' authorities were established in order to

tackle health inequalities in the twenty most deprived PCTs. These PCTs received additional funding in addition to the Choosing Health allocations. Dudley was not a Spearhead authority.

Dudley's response was to produce its own strategy, *Closing the gap – Tackling Health Inequalities in Dudley* (Dudley MBC and Dudley PCT, 2005). This strategy reflected the current policy and thinking at the time and reflected the national targets:

- Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between manual groups and the population as a whole
- Staring with local authorities, by 2010, to reduce by at least 10% the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole

At the time of writing it seems that we are unlikely to have achieved these targets. 2010 data is not yet available but the gap in life expectancy has not narrowed over the last ten years and may in fact be increasing slightly.

Three local priorities were chosen based on national evidence for what works, local needs and views expressed by the community.
The priorities were:

Reduce poverty

Develop a joint anti-poverty action plan that maximises the potential for all agencies to reduce poverty
Outcomes

- An anti-poverty strategy was produced in 2006/07 and has been implemented in part

Tobacco control

Support and implement a 'smoke free generation' programme in Dudley with a focus on deprived areas

Outcomes
The smoke free generation programme has been very successful and has made substantial progress in:

- Reducing exposure to second hand smoke
- Reducing tobacco promotion by enforcing legislation
- Ensuring compliance with relevant tobacco regulation legislation
- Reducing availability and supply of illegal tobacco products
- Stop smoking services have increased and have focused on deprived areas, vulnerable groups, pregnancy and the early years
- Successful media campaigns have been implemented and evaluated positively

Improve educational attainment

Action to increase the educational attainment, aspirations, life skills of adults, children and young people in deprived areas and of key vulnerable groups through the implementation of Every Child Matters

Good progress has been made in:

- Implementing the Children's Centres programme
- Implementing the Extended Schools programme
- Further develop the Healthy Schools programme (100% achieved accreditation)
- Focusing on parenting skills and family support networks
- Greater focus on vulnerable children e.g. looked after children, teenage mothers

Tackling health inequalities beyond 2010

The previous strategy was due to be refreshed in 2010. In July 2009 the Health Inequalities National Support Team (HINST) visited Dudley to assess how we were progressing in reducing health inequalities. They had amassed a wealth of experience in assessing the Spearhead PCTs and the evidence base for interventions known to impact on reducing health inequalities had been developed as a result of the Spearheads' work.

The team assessed our performance in a number of areas and made recommendations for us to consider and implement. This strategy refresh focuses on those recommendations and brings together a number of different strategies and plans from across organisations that impact on health inequalities. There was also a performance review by the Strategic Health Authority late in 2009, followed by a desk top review undertaken by the Audit Commission earlier in 2010. The findings of all the reviews were generally very positive with some helpful suggestions on where the focus of our efforts for greatest impact over the next five years should be.

HINST recommendations for five key priority actions for Dudley

- Strengthening leadership for health and health inequalities across the partnership and particularly within the Local Authority and Acute Trust.

- Improving the quality and capacity of primary care.

- Refreshing the Health Inequalities Strategy, developing detailed delivery plans and agreeing a common frame of reference for monitoring progress on addressing health inequalities.

- The continued market development of the voluntary, community and faith sector.

- The simplification of neighbourhood community engagement structures.

These recommendations are addressed throughout the document and the production of this refreshed strategy is the result of one of their recommendations.

STRATEGIC AIMS

The main policy driver for this strategy is the Marmot Review, *Fair Society, Healthy Lives* (Marmot, 2010) which is the biggest review of Health Inequalities since the Acheson report in 1998. As well as focusing on the causes of mortality; heart disease, cancer, chronic obstructive pulmonary disease, and the causes of the diseases, smoking, alcohol, physical activity and nutrition, Marmot also draws attention to the 'causes of the causes' of disease which are the social determinants of ill health. He has identified a number of policy areas that directly impact on health inequalities and we have adapted these to become the strategic aims of this refreshed strategy.

❖ **Give every child the best start in life**
❖ **Create fair employment and good work for all**
❖ **Ensure a healthy standard of living for all**
❖ **Create and develop healthy and sustainable places and communities**
❖ **Strengthen the role and impact of ill health prevention**

The following chapters address all of these key issues and there are a series of recommendations and delivery plans that show how we intend to address these problems over the next five years.

4. HEALTH INEQUALITIES AND THE SOCIAL DETERMINANTS OF HEALTH

SOCIAL DETERMINANTS OF HEALTH

'Social determinants' are those economic and social conditions which shape the health of individuals and communities as a whole. Often referred to as 'the causes of the causes' of ill health, they have an important and substantial influence on the existence and distribution of inequalities in health. The most recent and definitive review to date of social determinants of ill health in England is that undertaken by Sir Michael Marmot (2010) in his review *Fair Society, Healthy Lives* whose report to Government was published in February 2010. Marmot sets out some key principles:

- *'Serious health inequalities do not arise by chance and cannot be attributed simply to genetic make up, 'bad', unhealthy behaviour or difficulties in access to medical care, though these factors remain important. Social and economic differences in health status reflect and are caused by social and economic inequalities in society.'*

- *'Health inequalities that are preventable by reasonable means are unfair and correcting them is a matter of social justice'.*

- *'Action should be taken across the social gradient and should not be aimed at the most worst off (proportionate universalism).'*

- *'Tackling health inequalities means tackling climate change. Actions to create a sustainable future will have health benefits across society.'*

Addressing Inequalities

Inequalities exist in many contexts for individuals, groups and communities whether related to broad socio-economic factors such as poverty and unemployment, or with regard to age, culture, disability, ethnicity, gender, race, religion, sexual orientation, spirituality or any other status. The socio economic position of individuals and families shapes their access to material resources, to every aspect of experience in the home, neighbourhood, and workplace and is a major determinant of health inequalities.

If wellbeing can be defined as, *'a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment'* (Great Britain. Department of Health, 2009c), then poor physical health is a significant risk factor for poor mental health. Conversely, mental well-being protects physical health and improves health outcomes and recovery rates, particularly for coronary heart disease and stroke. Evidence shows that poor mental health results in poor self-management of chronic illness and is also linked to a range of health damaging behaviours, such as smoking, drug and alcohol abuse, poor diet and unwanted pregnancy (NMHDU, 2010). High levels of inequality, social

injustice and deprivation impact negatively on mental health and wellbeing, thus reducing individual and community resilience to cope positively with life's changes, challenges, and adversities (Friedli 2009, Foresight Project Report, 2008). Certain groups often referred to as marginal, vulnerable or socially excluded groups and communities, are therefore more at risk of experiencing inequalities in health.

Equality is about creating a fairer society where everyone can participate and has the opportunity to fulfil their potential, and social inclusion is the process by which efforts are made to ensure that everyone, regardless of their experiences and circumstances, can achieve their potential in life. Under the new Equality Act 2010 which became law in October 2010 and covers the same groups that were protected by previous equality legislation (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation), public bodies are accountable in terms of the equality and diversity agenda with clear duties to work towards eliminating discrimination and promoting equality of opportunity.

A social gradient in health exists in that, better social and economic position results in better health (Marmot, 2010). Marmot advocates a universal approach which also recognises the need for 'a greater intensity of action' for those at 'greater social and economic disadvantage'. Some groups and communities experience limited or no access to a wide range of support, for example, older people, children and young people, homeless people, people from minority ethnic communities, asylum seekers/refugees, economic migrants, prisoners, single parents, carers, looked after children, mental health service users, people with physical/learning disabilities, gay, lesbian, bisexual and transgender peoples, and many others who are vulnerable and at risk. This is not a definitive list by any means and may vary depending on the particular strategy, policy or service, but it gives an idea of which communities may need to be targeted to make a real difference to health inequalities.

Key issues that have been identified in relation to work with all vulnerable groups include, improving data collection and analysis, scoping of services to identify gaps, improving access, developing culturally relevant services, and working to eliminate stigma and discrimination. Strategies for health and wellbeing need to consider these issues from the outset, and services need to address them in planning, development, delivery and review, in order to mainstream and integrate the diverse needs of a local community.

In this section of the strategy, the evidence from the Marmot Review is summarised; selected data available on the position in Dudley is presented; and finally recommendations are made on what needs to happen in Dudley.

Based on Marmot's assessment of key policy areas to impact on the social determinants of health, 4 areas are examined here for Dudley;

- Early years; giving *every* child the best start in life.
- Fair employment and good work for all.
- A healthy Standard of Living
- Dudley as a healthy and sustainable place.

THE EARLY YEARS: GIVING *EVERY* CHILD THE BEST START IN LIFE

Early Years: What does the evidence tell us?

A child's physical, social and cognitive development during the early years strongly influences their school readiness and educational attainment, economic participation and health. It is demonstrated in the literature that in-utero environments affect adult health and that these programmed changes may be the origins of a number of diseases in later life. Low birth weight in particular is associated with poorer long term health outcomes and disadvantaged mothers are more likely to have babies of low birth weight. Maternal health including stress, diet, drug, alcohol and tobacco use during pregnancy influences foetal and early brain development. The biological effects of birth weight on brain development interact with other social position influences to impact on cognitive development.

The first year of life is crucial. Neuro-development during this time provides the foundation for children's cognitive capacities and if they fall behind at this stage they are more likely to fall further behind at subsequent educational stages. Poor development of cognitive ability has been shown to be a powerful determinant not only of earnings but of propensity to get involved in crime. It is likely that a levelling up of cognitive function across the social gradient will lead to narrower social inequalities in health.

Similarly, the early years are important for the development of non-cognitive skills (application, self regulation and empathy). If these skills are not developed, children fail to develop the capabilities that enable them to make and sustain positive relationships as they grow up into the school years and in later life. Pre-school influences remain evident even after 5 years spent in full time primary school. Children who do not develop fully in the early years are not 'school ready' and this impacts on their subsequent educational attainment and hence economic participation and health. Children of educated or wealthy parents may score poorly in tests but will still catch up, whereas children with worse off parents are very unlikely to do so and there is no evidence that early entry into schooling reverses this pattern.

The key set of interacting factors which impact on educational outcomes are:-

- birth weight
- post-natal depression
- being read to every day
- having a regular bed time at age 3

Reviewing the evidence of effectiveness of interventions, Marmot (2010) concludes that the following are the key requirements for England:

- Increasing the proportion of overall expenditure allocated to the early years and ensuring that it is focused progressively across the social gradient.

- Giving priority to pre and post-natal interventions such as intensive home visiting programmes (eg. family nurse partnership) that reduce adverse outcomes of pregnancy in infancy).

- Providing paid parental leave in the first year of life with a minimum income for healthy living.

- Providing support to families through evidence based parenting programmes.

- Developing programmes for the transition to school.

Early Years; What Do We Know About Dudley?

Maternal health and antenatal care:

There is an apparently high rate of late booking for antenatal care in Dudley especially among women from minority ethnic communities. Data from Dudley Group of Hospitals Foundation Trust and Royal Wolverhampton NHS Trust indicates that in 2009-10 only 64% of pregnant women had had an assessment of their health and social care risks and needs by 13 weeks.

Dudley's smoking in pregnancy rate at the time of birth is not different from the West Midlands average and is declining, but in 2009/10 there were almost a fifth of mothers (18.3%) smoking at delivery.

Under 18 conception rate for Dudley is declining but remains above the England rate. The under 18 years conception rate for the three years 2004-2006 was 47.7 per 1.000. There were 819 conceptions over the three years, 53% of which were births (435). So there are an average of 145 births to teenage mothers in Dudley each year.

Low birthweight:

Figure 1

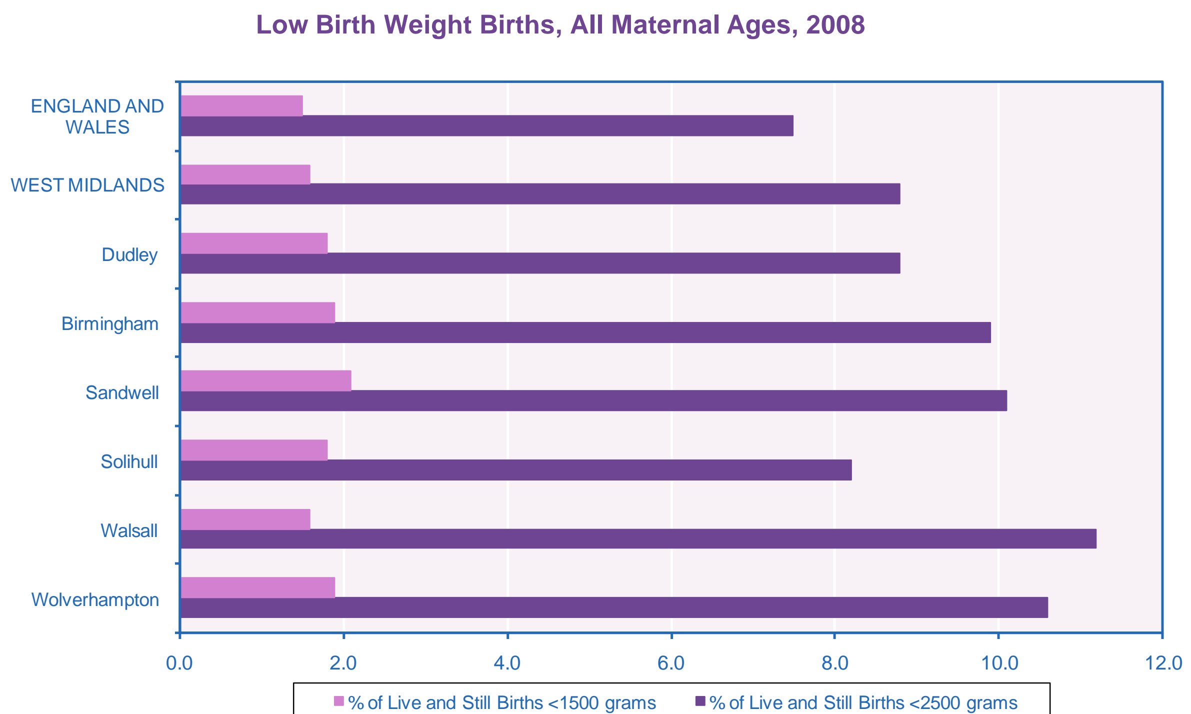


Figure 2

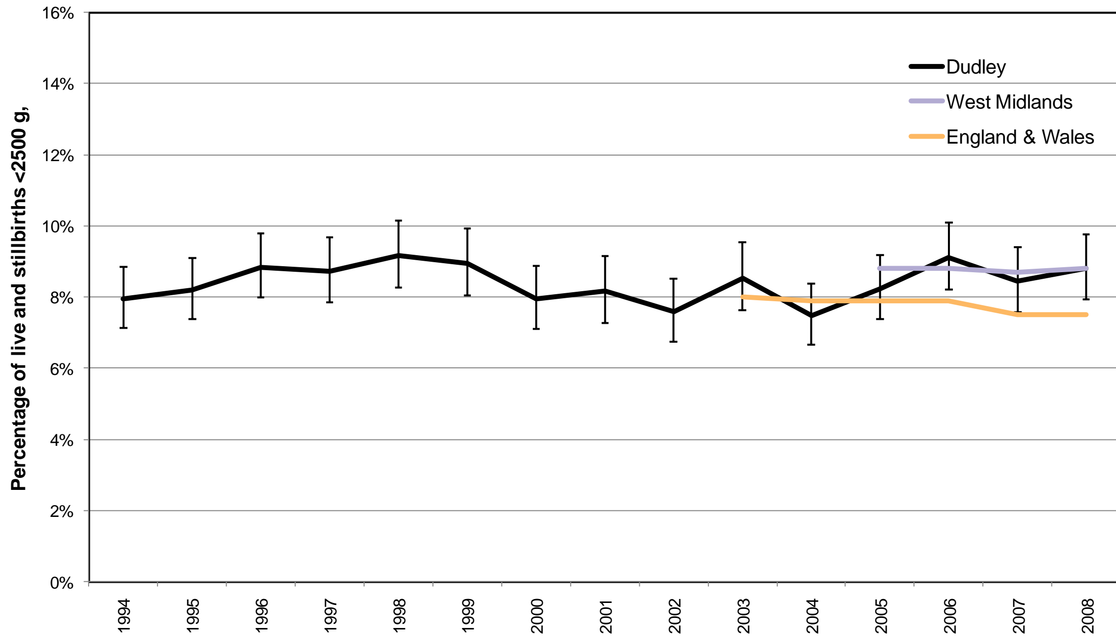
LOW BIRTHWEIGHT BIRTHS, 2008
PERCENT OF LIVE AND STILL BIRTHS <1500 AND <2500 GRAMS, ALL MATERNAL AGES

AREA	% of Live and Still Births <2500 grams	% of Live and Still Births <1500 grams
ENGLAND AND WALES	7.5	1.5
WEST MIDLANDS	8.8	1.6
Dudley	8.8	1.8
Birmingham	9.9	1.9
Sandwell	10.1	2.1
Solihull	8.2	1.8
Walsall	11.2	1.6
Wolverhampton	10.6	1.9

Source: NCHOD

At 8.8% the proportion of low birthweight babies in Dudley is significantly higher than England and Wales (Figure 1&2). 1.6% are of very low weight (<1500g).

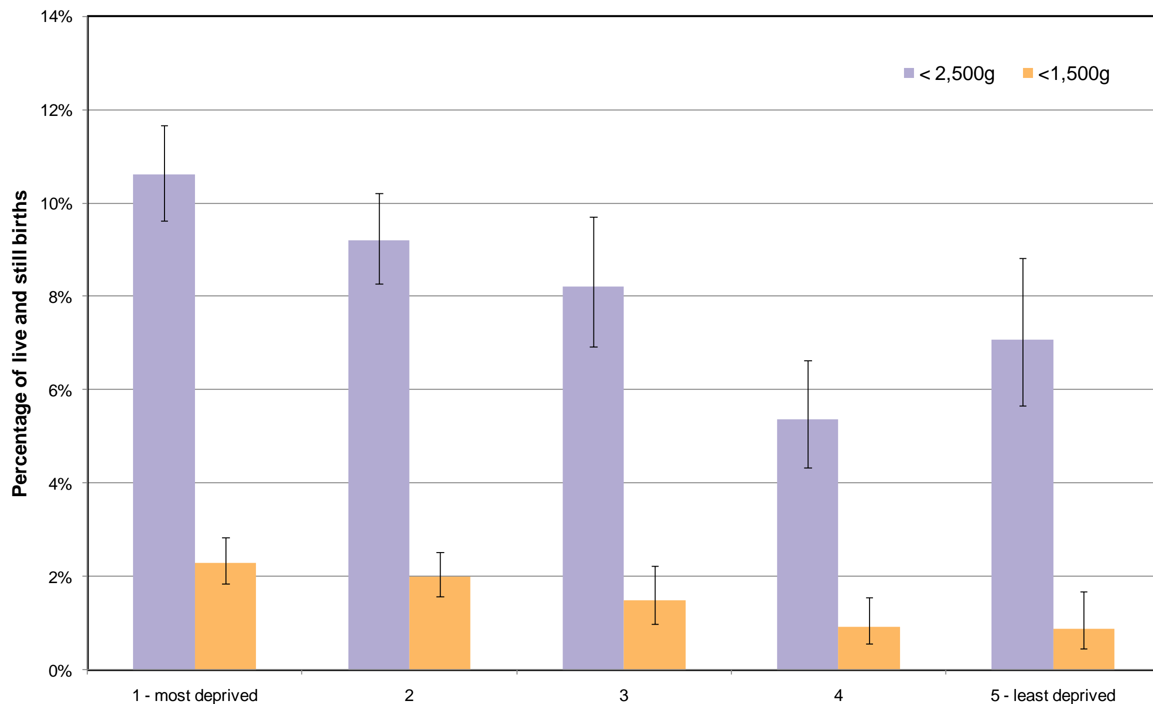
Figure 3



Source: ONS birth registrations, NCHOD

There was a small rising trend from 2004-06 but this has levelled off over the following two years (Figure 3). There is evidence of a social gradient in low birthweight in Dudley (Figure 4)

Figure 4



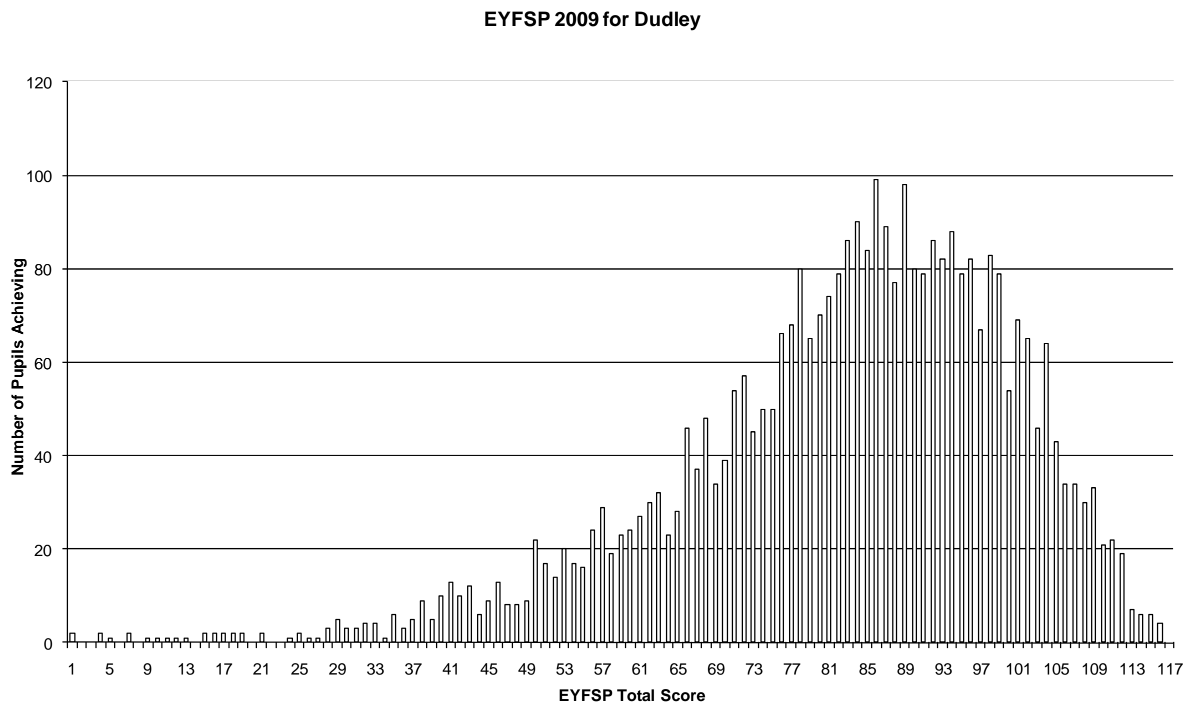
Source: Office of National Statistics, Annual Birth Extracts

Early cognitive development:

Although the Healthy Child Programme forms the basis for the Dudley Antenatal, Neonatal and Child Health Surveillance Protocol, (implemented across Dudley with the Health Visitor as the lead professional), there are no audits currently available which give an indication of the level and distribution of cognitive development across the early years child population in Dudley. Indeed, to date, the computerised record systems available have not even allowed fidelity to the protocol to be audited, as the requisite patient based system with appropriate coding has not been in place.

Data on children's attainment at the Early Years Foundation Stage (EYFS), which is assessed at reception year in primary school, is available. The data for Dudley children for 2009 show a skewed distribution (Figure 5)

Figure 5



However, if the distributions are looked at by IMD quintile there is evidence of a social gradient in median scores

EYFS Median Scores by National Deprivation Quintile Dudley 2009				
Q1	Q2	Q3	Q4	Q5
80	82	89	89	90
Source DMBC				

There is a difference of 10 in the median score between quintile 1, the most deprived and quintile 5, the least deprived.

Whilst there is an assessment for EYFS undertaken pre-school, there is no central collection of data on this so it is not possible to assess the profile for Dudley children at this pre-school stage.

Parenting:

Dudley has developed a multi-agency P*arenting Support and Family Learning Strategy* (Dudley Children's Trust, 2009) and in the development of this undertook an audit of formal manual-based parenting support within the Borough.

The audit of parenting support was carried out and sought to find out the extent to which practitioners had been trained in and implemented programmes at 4 levels of support need:

> Tier 1 Universal need: prevention focused on whole population where problems are not obvious (67,196 dependent children)
>
> Tier 2 Need for support: problems may be beginning to show and action is needed to prevent them worsening (24,245 children in 2008)
>
> Tier 3 Child Welfare Concern: prevention strategies required to focus on multiple, complex and longstanding difficulties requiring individually tailored services (2055 children in need in June 2008)
>
> Tier 4 Protection need: prevention at this level requires clear interagency focus which seeks to safeguard the child/young person

The audit of parenting support offered by providers was carried out and its key findings were:

Tier 1 - All Children's Centres offer a universally available parenting programme, most commonly the *NCH Handling Children's Behaviour* (Finch, 1995). Some schools also offer this programme but coverage is patchy. Dudley PCT Children's services staff are trained in the Solihull Approach, as are teachers in the Specialist Early years Service and many Children's Centre staff. Some Children's Centres use the Family Links Nurturing Programme. All schools were planning to offer Family SEAL (Social and Emotional Aspects of Learning) by 2011.

Tier 2 - There is a gap in availability of Tier 2 formal parenting programmes. Where Children's Centres or schools identify that parents have Tier 2 needs the practice is to encourage parents to attend Tier 1 programmes and provide some additional support during and after the programme.

At Tiers 3 and 4 - the DMBC Senior Parenting Practitioner delivers the Triple P parenting programme, working in close co-operation with a range of multi-agency services. The Senior Parenting Practitioner is also trained in Webster Stratton and Strengthening Families and Communities, so is able to select from a menu of programmes.

There is no readily available data on the numbers of families in receipt of these programmes, the numbers of sessions delivered or outcome of intervention.

All parenting programmes should include the key components recommended by NICE (National Institute for Health and Clinical Excellence, 2006) and there should be clear eligibility criteria, fidelity to the programme and delivery at the correct intensity. There are currently no systems in place which allow a regular audit/assessment of these items. Ensuring that the investment in parenting programmes is effective will require these.

Surestart Children's Centres:

These centres are intended to be service hubs where children under 5 and their families receive integrated services and information. Children's Centres across the Borough provide access to a range of services.

While the Health Visiting Service now has a named Health Visitor relating to each of the Children's Centres, fully integrated working remains underdeveloped. The early years' workforce may not be being used to maximum effect.

There is no intensive home visiting support service (such as the evidence –based Family Nurse Partnership recommended by Marmot).

Dudley provides a web-based Children and Young People's Service Directory and gives access to information on support the parents can access for their families. There are 50 information champions based in children's centres and neighbourhood learning facilities and contributing to the Dudley Families Information Services.

Paid Parent Leave During the First Year:

For 1- 5 year olds there are no adverse effects of maternal employment on cognitive development, but if children are in poor quality child care for long hours there may be some negative effects on behaviour. Changes in parental employment patterns are not inevitably benign and there is some work linking maternal employment to lower levels of breast feeding, increased levels of obesity at 3 years and poorer indicators of diet and physical activity at 5 years. Paid parental leave is associated with lower rates of maternal depression, lower rates of infant mortality, fewer lower birth rate babies, more breast feeding and more use of preventive healthcare. There is no

data which shows us locally what access parents across the social gradient have to paid parental leave during the first years of their children's life.

Early Years: What Needs to be Done in Dudley?

While data systems exist to look at progress, at a population level, on immunisation, breast feeding, and attainment at reception year of primary school, there are no systems which enable the full picture to be obtained of the developmental progress of our children in the vital early years. Equally, the systems for tracking fidelity to the Healthy Child Programme and fidelity to important formal manual-based parenting programmes does not exist. Undoubtedly, each individual child's progress is recorded in a health, education or children's centre record but the systems to extract this and examine progress across the child population as a whole or for disadvantaged sub-groups of the population is not there. This is a priority for development. It is not a small job and will require time to implement. Nevertheless, we will not be able to assess whether our interventions in early years are producing the outcomes we desire if we do not have systems to allow us to view progress.

It has not been possible in the timescale for production of this strategy to amass data on the relative spend on children in the early years versus spend on the school years and the adolescent years in Dudley. Marmot (2010) acknowledged that this is not wholly possible at national level either. However, it should be possible to at least reproduce for Dudley an analysis of the type presented in the national data in the *Marmot Review.* It is recommended that investment in school and adolescent years should be examined to see if there is any way in which efficiency can be improved to release resource to be invested in the vital early years.

Dudley has no structured intensive home visiting service, such as that delivered within a Family Nurse Partnership Programme. This is essential for some families. Any investment released from other areas for early years should be channelled into the commissioning of a Family Nurse Partnership Programme for families on a defined set of eligibility criteria, with a clear means of auditing outcomes.

The structured approach to implementation of formal parenting programmes set out in *Dudley's Parenting Support and Family Learning Strategy* (Dudley Children's Trust, 2009) should continue but with full tracking of adherence to eligibility criteria which ensure that those who need them most get them Impact in terms of outcome measures must be tracked.

Undoubtedly, productivity would be improved and potentially some resource released, if there was more formal integrated working between the Health Visiting service and the Children's Centres, particularly between the outreach workers and Health Visitors.

Ensuring that paid parental leave is available for workers within Dudley may not be within the compass of the statutory agencies to deliver, but all statutory agencies should ensure that their own policies embrace this and economic regeneration initiatives should promote this.

Pre and immediately post-natal periods are crucial for a child's development and the improvements required in the antenatal care service are highlighted in Dudley's complementary Infant Mortality Reduction Action Plan. The action plan must be implemented in full.

Child care for working mothers with children aged 2 – 5 years can be extremely beneficial but may not be benign if the child care is of a poor quality. Quality assurance of the child care provision in Dudley remains a high priority.

FAIR EMPLOYMENT AND GOOD WORK FOR ALL

Fair Employment and Good Work for All: What Does the Evidence Tell Us?

The evidence presented in the Marmot (2010) report shows clearly that patterns of employment reflect and reinforce the social gradient. Unemployment is unequally distributed across socio-economic groups, with those in the lower groups at higher risk. Unemployment has both short term and long term impact on health. While there are immediate adverse health consequences of being made redundant, studies have shown steady negative effects proportional to the duration of unemployment which damage health progressively. Long term unemployment has the greatest adverse effect on health. Unemployment has been consistently associated with an increase in overall mortality and, in particular, suicide. The unemployed have much higher use of medication and much worse prognosis and recovery rates.

Marmot (2010) suggests 3 ways in which unemployment affects levels of morbidity and mortality.

- Loss of employment leads to lower living standards which may reduce social integration and lower self esteem.
- Unemployment as a trigger for distress, anxiety and depression.
- Negative impact on health behaviour which is associated with increased smoking and alcohol consumption and decreased physical exercise.

Conversely limiting illness and disability can lead to a higher risk of unemployment, though the extent to which these act as a barrier to work is dependent on educational qualifications.

The evidence reviewed by Marmot leaves little doubt that recent rises in unemployment, and particularly youth unemployment, are likely to significantly worsen health inequalities. This makes getting people into employment an important strategy for improving health and reducing inequalities.

However, it is only an effective strategy if working conditions are good. Exposure to physical hazards, physically demanding or dangerous work, long or irregular working hours or health adverse posture at work can all adversely affect health. Poor working conditions are most prevalent amongst those in 'precarious jobs' that are defined by a lack of safety at work, by exposure to multiple stresses including strenuous tasks which the worker has little control over, low wages and high job

instability. Factors such as job security, job satisfaction, supervisor and peer support, are related to both psychological and physical health impacts including depression, cardiovascular disease, coronary heart disease and musculo-skeletal disorders.

Psycho-social hazards of low worker control, having a large number of demands and little support at work combine these factors into 'isostrain'. Work stresses measured by isostrain have been shown to increase the risk of the metabolic syndrome (a combination of risk factors for diabetes and heart disease).

On the basis of the evidence reviewed, Marmot (2010) concludes that getting people into work is of critical importance for reducing health inequalities but these jobs need to be sustainable and offer a minimum level of quality including not only a decent living wage but opportunities for in-work development and flexibility to balance work and family life with protection from adverse working conditions that can damage health.

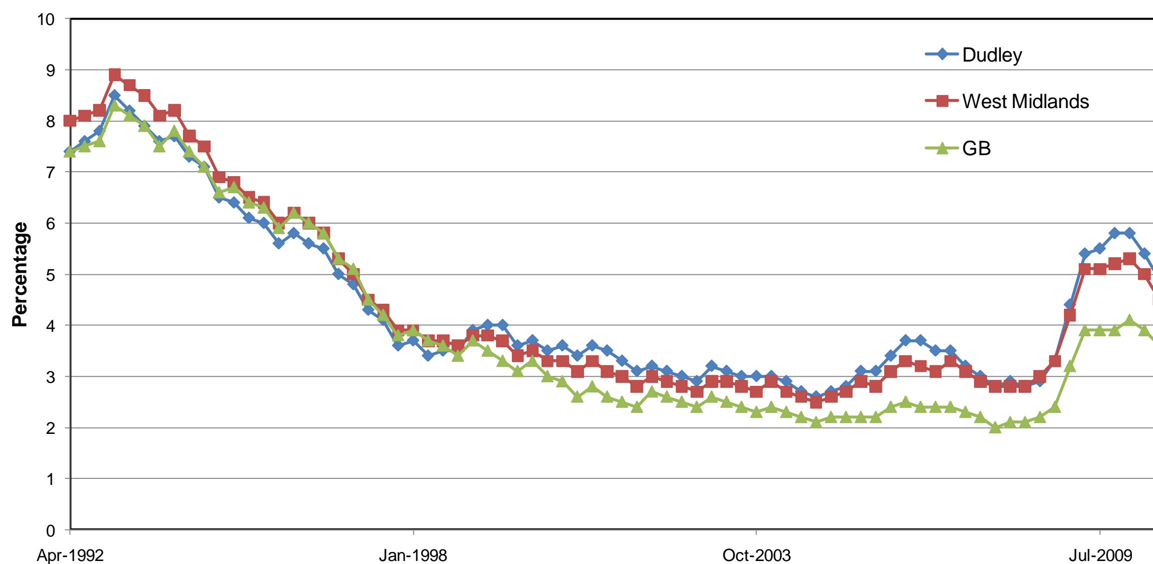
The importance of getting people into work has been recognised for almost two decades now by policy makers and a variety of schemes referred to as 'active labour market programmes' have been implemented to integrate the unemployed into work, rather than simply providing passive income support when people are out of work. The Marmot Review (2010) of effectiveness shows that active labour market programmes implemented since the middle 1990s have had some success in terms of labour market outcomes. It is of particular note that the groups for whom no programme of assistance was available over this period, young people aged 16 and 17, saw unemployment rise steadily even through a period of economic growth. 1 in 4 of the economically active in this age group was unemployed in 2007. The current recession obviously poses a major threat for progress made up until 2007.

There is some evidence that active labour market programmes have contributed to increasing income amongst recipients, though they are most effective when combined with other fiscal and benefit measures to 'make work pay'. There has been little research on the subsequent effect of those improved labour market outcomes on health outcomes. There is some limited evidence that participation in government training programmes can have positive effect on the psychological health and subjective wellbeing of the participants compared with unemployed people not involved in such programmes. The effects of active labour market programmes seem to vary in relation to a range of individual factors including the initial attitude of participants to work ('job readiness') and the effectiveness of their allocated advisors. The evidence for a positive impact of active labour market programmes for people with mental health difficulties is much stronger. Vocational rehabilitation services, particularly individual placement and support services (IPS) can significantly increase rates of employment for those with mental illness.

Fair Employment and Good Work for All: What do we know for Dudley?

As elsewhere, unemployment levels in Dudley reflect the prevailing economic conditions. Figure 1 shows unemployment levels from 1992 - 2010 as measured by Job Seekers Allowance (JSA) claimants. (Note from August 10th 2010 all rates downloaded are as % of age 16-64 for males and females previously age 16-64 for men and 16-59 for women thus the percentage shows a reduction from previous levels).

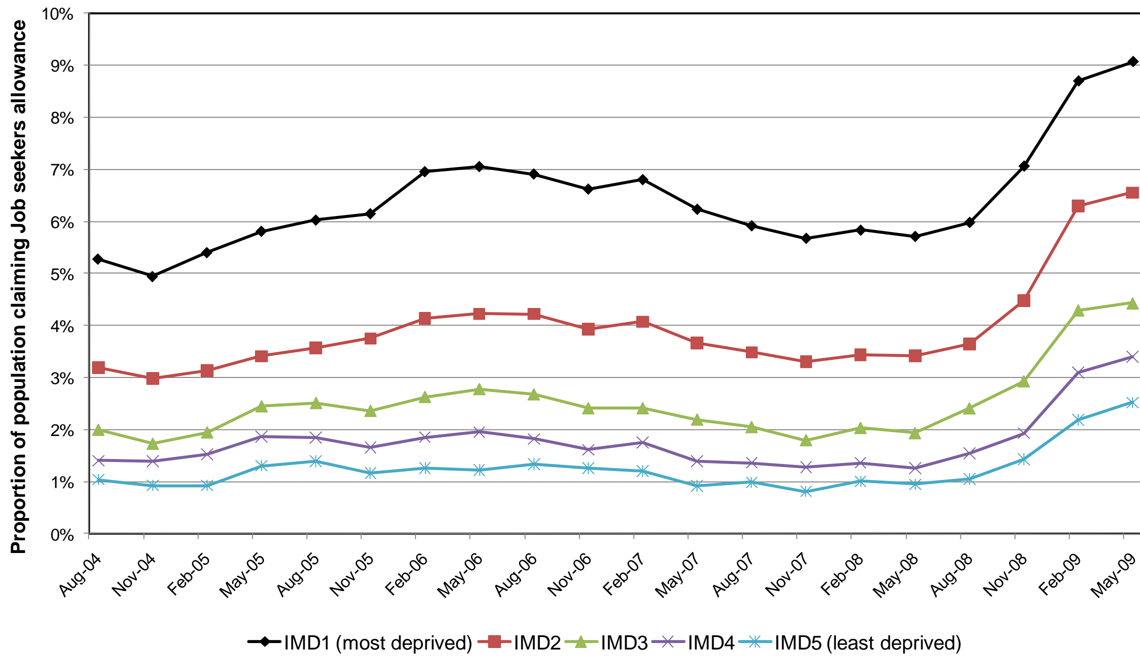
Figure 1



The impact of the most recent recession has been sharper in Dudley than in the West Midlands and Great Britain.

If this is analysed by deprivation quintile (Figure 2) it can be seen that since May 2008, there has been an increasing trend in the proportion of people claiming JSA across all deprivation quintiles, but this trend increased at a faster rate in the more deprived areas. There has been an increase of over 3% in the most deprived quintile, compared with an increase of 1.5% in the least deprived quintile over the same time period from May 2008 to May 2009.

Figure 2

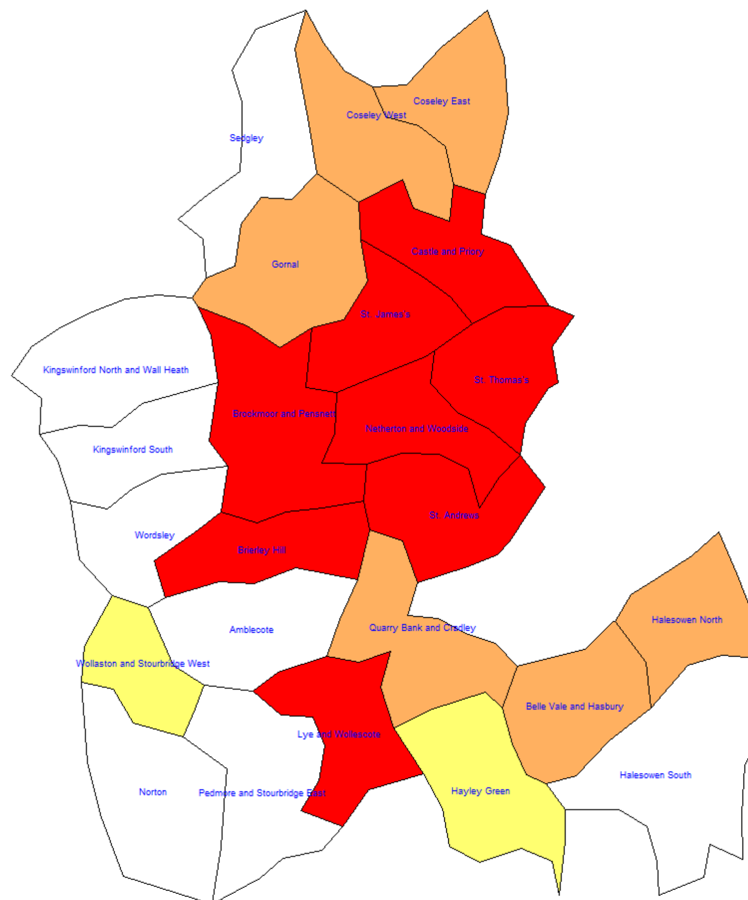


The spatial distribution of unemployment, as measured by key out of work benefits, is shown in Figure 3.

Figure 3

Proportion of the working-age population who are in receipt of key out-of-work benefits for Dudley (Feb 2009)

Colour	Category
Red	In the highest 1,677 wards for Great Britain as a whole (i.e. highest sixth of wards)
Orange	In the next 1,677 wards (i.e. second sixth)
Yellow	In the next 1,677 wards (i.e. third sixth)
White	below the Great Britain average - remaining 5,033 wards



Source: Poverty.org.uk (accessed 02/08/2010)

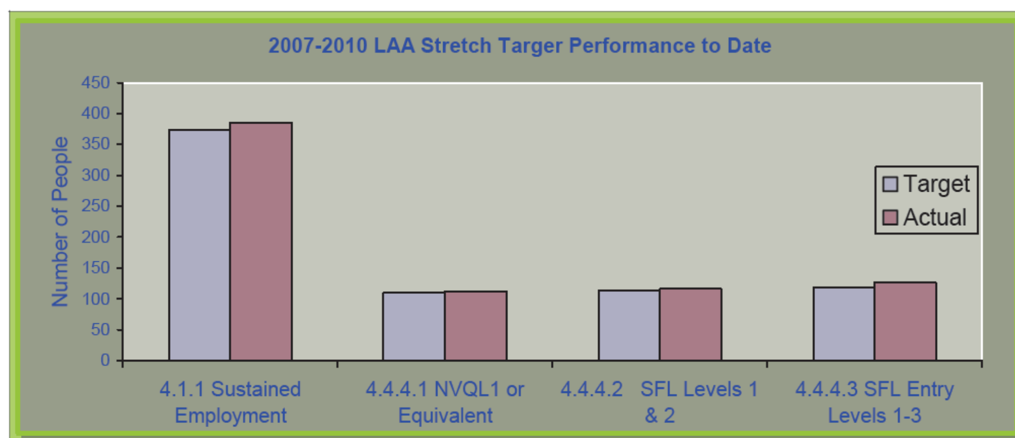
Data on the impact of all of the most recent Active Labour Market Policy (ALMPs) on labour market outcomes for residents of Dudley is not readily available and it has not been possible to assess their success or otherwise at a working population level.

Data is available for those ALMPs for which Dudley MBC is the provider and for the recently completed *Local Area Agreement* (LAA). (Dudley Community Partnership, 2008). The results for the LAA undertaken over the 3 years 2007-08 to 2009-10 are shown in Table 1 below.

Table 1

The 2007-2010 LAA contains stretch targets that directly support local people from priority wards in the borough and key priority groups to achieve qualifications and sustained employment (i.e. in employment for more than 13 weeks). These stretch targets are delivered by Future Skills Dudley and Adult & Community Learning Team (DMBC).

LAA Outcome EDE 4.4 – Increase Skills Level	2009/10 Target	Performance as at Qtr 4		3 Year Performance	
		Target	Actual	Target 07-10	Actual To date
EDE 4.1.1. Employment Stretch Target To increase the numbers of people aged 18-64 moving into sustained employment from within either Priority Wards or from Key Priority Groups, through key delivery agencies.	153	153	165	374	386
EDE 4.4 – Increase Skills Levels					
4.4.4.1 – Skills Stretch Target Clients achieving NVQ Level 1 or equivalent	53	53	55	110	112
4.4.4.2 - Skills Stretch Target Clients achieving Skills for Life (SFL) – Levels 1 & 2	41	41	44	113	116
4.4.4.3 - Skills Stretch Target Clients achieving Skills for Life (SFL) – Entry Levels 1-3	48	48	60	118	126



- *Performance at the end of the LAA period shows that 386 clients have moved into sustained employment from within priority wards or from key priority groups against a target of 374*
- *112 people achieved NVQ L1 or equivalent against a target of 110, 116 clients achieved Skills for Life Levels 1 and 2 against a target of 113 and 126 clients achieved Skills For Life Entry Level against a target of 118.*

At the time of writing 2 ALMP schemes are being delivered through Dudley MBC – the Future Jobs Fund and the Flexible New Deal. It aims to create 150,000 jobs.

The Future Jobs Fund is a fund of around £1 billion nationally to support the creation of jobs for long term unemployed young people and others who face significant disadvantage in the labour market.

The Fund was announced in Budget 2009. As the Future Jobs Fund is a challenge fund, not all organisations that submitted bids were successful. The fund is run by the Department for Work and Pensions (DWP) in partnership with the Department for Communities and Local Government (CLG) and with input from Jobcentre Plus and Regional Government Offices in England.

Future Jobs Fund forms part of the Young Person's Guarantee. From early 2010, everyone between the ages of 18 and 24 who has been looking for work for a year will get an offer of a job, work experience, or training lasting at least 6 months.

Future Skills Dudley (FSD) project manage the Future Jobs Fund programme.

	Phase 1
	October 2009 to June 2010
Starts	203
Job Outcomes	15

Phase 2 runs from April 2010 to March 2011.

The previous Government introduced the Flexible New Deal in January 2008.

It was a fundamental part of the Government's wider welfare reform and underpinned the principles of working towards eradicating child poverty by 2020. The Flexible New Deal replaced New Deal 18 – 24 and 25+ and Employment Zone programmes. It provides opportunities for Prime Contractor organisations (of which Future Skills Dudley MBC is one) from the private, public and third sectors to work together to deliver this new programme across all Jobcentre Plus districts from autumn 2009.

The Coalition Government has announced that Flexible New Deal will be replaced by a Single Work Programme. All Prime Contractors have been informed that Flexible New Deal will stop by June 2011. Future Skills Dudley will continue to be one of two Prime Contractors delivering the Flexible New Deal programme for the Black Country up to June 2011.

Labour market outcomes to date are shown in table 2 below.

Table 2

Flexible New Deal Oct 2009 – Aug 2010	Dudley Borough
Referrals from Jobcentre Plus	2385
Starts on programme	1695
Job starts	324
13 weeks sustained employment	99
26 weeks sustained employment	21

Source: Dudley MBC Econ Regeneration Dept.

For people with mental health problems the data is sparse. The current National Indicator set tracks employment in those aged 18-69 years who are in receipt of secondary care mental health services and receiving the Care Programme Approach. There is some indication of recent improvement in this indicator for Dudley (Table 3)

Table 3

Dudley Borough	
% 18-69 yrs receiving Care Programme Approach from secondary care services in employment at last review	
2008-09	2009-10 Apr-Dec
1.0	4.3

Source: NHS and Social Care Information centre

Across England the percentage for Local Authorities for Apr-Dec 2009 ranged from 1.4% (Newcastle upon Tyne) to 22.7% (Windsor and Maidenhead), reflecting not only the success at keeping/moving mental health clients into employment but also local labour market conditions.

Fair Employment and Good Work for All: What Needs to be Done in Dudley?

Maximising fair employment for all in Dudley has the potential for making a major contribution to a reduction in inequality of health outcomes. Dudley is currently developing a local strategy, designed to develop the local economy and maximize employment. It will be important for this strategy to focus not only on total jobs gained but also on attracting high quality jobs for Dudley people to access. The full set of measures to achieve this are being set out in the Dudley Local Economic Strategy and are not repeated here. For maximum impact on reducing health inequalities Dudley needs to:

- Ensure that data systems for tracking the impact of economic strategy initiatives use a consistent approach to assessment across the social gradient.

- Ensure that public and private sector employers adhere to equality guidance and legislation.

- Develop means of implementing guidance on stress management and the effective promotion of wellbeing and physical and mental health at work, both for public sector and private sector employees.

- Consider the potential for incentivising employers to adapt jobs to provide suitable employment for lone parents, carers and people with physical /mental health problems.

- Ensure that Dudley participates to the maximum in any available well evidenced active labour market programmes.

A HEALTHY STANDARD OF LIVING FOR ALL

A Healthy Standard of Living for All: What does the Evidence Tell Us?

Marmot's review shows that both income and wealth have an effect on health inequalities. People on low income do not buy goods and services that maintain and improve their health and often have to purchase cheaper goods and services that may increase their risk of ill health. Low income can also mean that people do not participate in ordinary social and community life, leaving them with low self esteem or feelings of being less worthy. There is also a psycho-social adverse effect deriving from perceived position in the social hierarchy. Further evidence shows that the degree of inequality in income in society affects not only the poor, but society as a whole. Countries with marked income inequality have worse health and higher rates of crime and other adverse social outcomes. In high income countries, the evidence suggests that more generous social protection (benefit) systems lead to better population health outcomes and increased life expectancy.

In the UK income inequality rose rapidly between 1984 and 1990. Since then inequality in equivalised disposable income remained constant till approximately 2001, when it began to fall. The fall halted in 2004/05 and inequality in equivalised disposable income remained at a steady level from then until 2007/08.

Data from ONS presented in the Marmot Report (2010) shows that In 2007/08 the top fifth of all households earned 16 times more than the bottom fifth. Transfer payments (cash benefits paid through the welfare system) mitigated this considerably so that once these are taken into account; the top fifth of all households earned 7 times the lowest fifth. However, the UK tax system is overall regressive (given the high proportion of taxation taken as indirect taxes), which means that for final disposable income the top fifth of all households have 6 times the bottom fifth. It can be seen from these figures that the mitigation of income inequality is mainly

achieved through transfer payments, rather than the taxation system. It is therefore particularly important to ensure that those entitled to benefits take them up.

Marmot (2010) concludes that, in the current UK system, benefits are inadequate to provide a healthy standard of living or have failed to reach those in need. They tend to be based on a black and white distinction between being reliant and non-reliant on various components of support, creating the so called ‘cliff edge’ which discourages people from seeking work or staying in work.

First time pregnant mothers in receipt of benefit remain vulnerable particularly if they are under 25 and only receive lower age benefit rates, making it difficult to maintain a healthy standard of living.

The introduction of the minimum wage has had some effect on the distribution of original income and the introduction of tax credits has increased support for working people on low incomes. The working family tax credit introduction has been shown to be associated with reduction in single parent anxiety and improvement in a family’s income has been shown to have a particular impact on adolescent children; the gaps between them and other teenager’s behaviour narrowed. (Rates of poor self esteem, unhappiness, truancy, smoking and the desire to leave school at 16 all halved).

However the initiatives have not succeeded in reaching all those who are entitled and there remain many citizens who do not have a sufficient income to live a healthy life. Marmot (2010) commends the concept of a minimum income standard (MIS) as a basis for assessing the adequacy of the benefits system. MIS includes sufficient income for consuming a healthy diet; some allowance for expenses related to exercise costs; and costs related to social integration and support networks; in addition to the items customarily included in the calculation of minimum income. The MIS is different for people in different circumstances. For some groups the MIS is higher than the currently defined poverty line (60% median income). Using the MIS, only 2/5ths of those with no children in receipt of income support meet MIS. For couples and single parents with children income support levels are approximately 2/3rd of MIS.

A Healthy Standard of Living for All: What do we know for Dudley?

Table 4 below shows the average weekly household income for Dudley and England, by national quintile. (Using national quintiles, it should be noted that there are no households in Dudley which fall into the top quintile for England).

Table 4

TABLE 4: Summary of the effects of taxes and benefits by quintile groups on ALL households, 2007-08									
		Quintile groups of ALL households[1]							
		Bottom	2nd	3rd	4th	Top	All households	Ratio Top/Bottom quintile
Income per household (£ per week) [2]								
Ave Total household weekly income (unequivalised) [3]	England	480	569	639	737	946	674	2.0
	Dudley	504	595	676	790	N/A	575	1.6
Ave Net household weekly income (unequivalised) [4]	England	407	470	523	588	709	539	1.7
	Dudley	423	484	554	615	N/A	473	1.5

1 Households are ranked by Ave Weekly Household Net Income equivalised before housing costs

2 This table shows unequivalised income. Equivalised income has only been used in the ranking process to produce the quintile groups

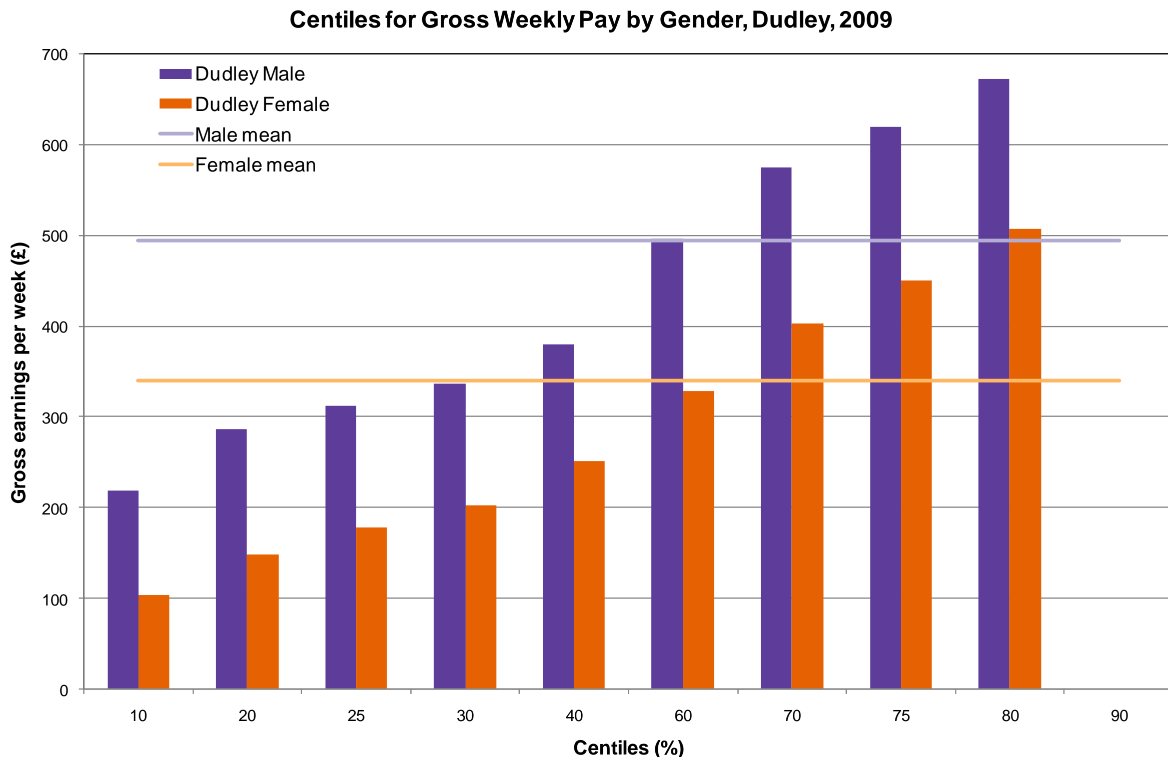
3 Total household weekly income (unequivalised) - is the sum of the gross income of every member of the household plus any income from benefits such as Working Families Tax Credit.

4 Net household weekly income (unequivalised) - is the sum of the net income of every member of the household. It is calculated using the same components as gross income but income is net of direct taxes such as income tax, national insurance and council tax

Data source: Income: Model-Based Estimates at MSOA Level, 2007/08, ONS

The income gradient for Dudley is further illustrated by looking at gross weekly pay (Figure 4) where both male and female pay show a gradient, with a slightly steeper gradient for men. The gender gap in pay is immediately apparent.

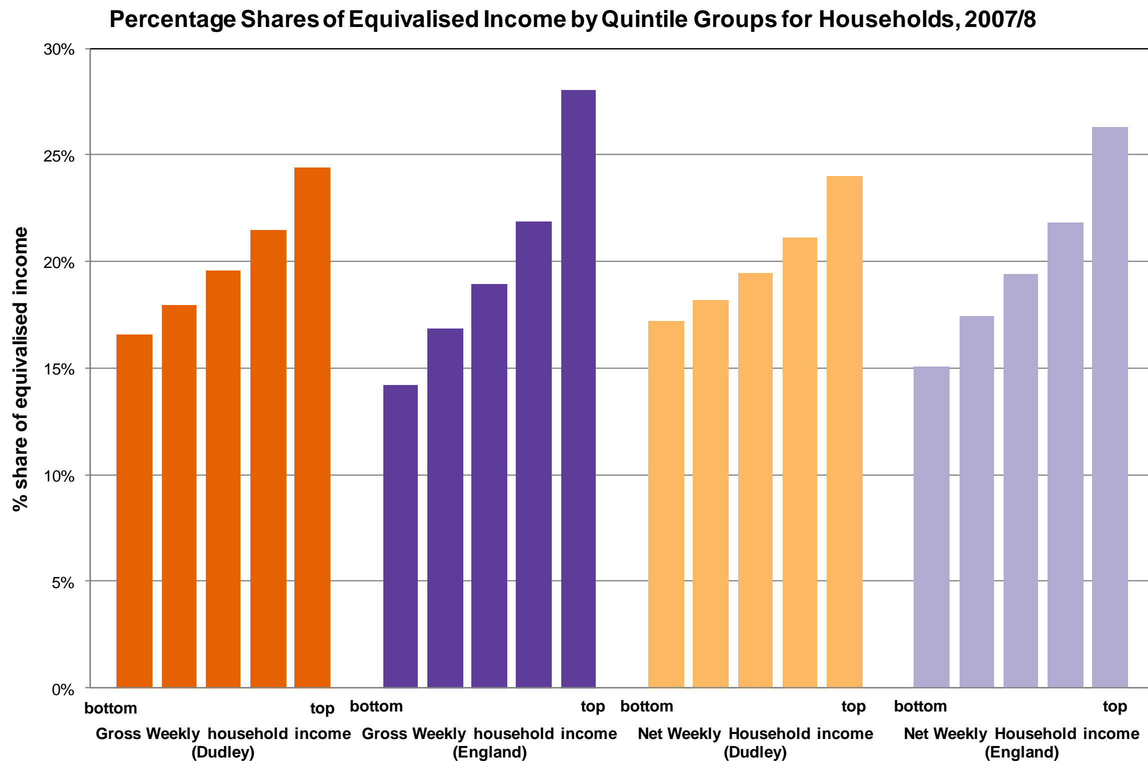
Figure 4



Data source: www.nomisweb.co.uk, Annual Survey of Hours and Earnings, 2009

A comparison of the household income gradient in Dudley with that in England is shown in Figure 5.

Figure 5



Data source: Income: Model-Based Estimates at MSOA Level, 2007/08, ONS

Households are ranked by net equivalised income before housing costs and grouped into quintiles. In this chart, the data for Dudley has been grouped into quintiles for Dudley only, whereas the England level data is grouped into quintiles for the whole of England.

The income received by households is affected by direct taxation such as income tax, national insurance and council tax. The ratio of the top/bottom quintile for gross income is 1.5 for Dudley and 2.0 for England, whereas this ratio is slightly reduced for net income, when taking account of direct taxes, to 1.4 and 1.7 respectively. A steeper gradient is seen between the bottom and top quintiles for England than for Dudley.

The spatial distribution of income deprivation in Dudley is shown in Figure 6. This map shows income deprivation in Dudley, based on information from the Index of Multiple Deprivation (IMD) 2007. The income deprivation index is the proportion of people who are income deprived in an area, ranked nationally.

Figure 6

Income Deprivation Index by Lower Super Output Area

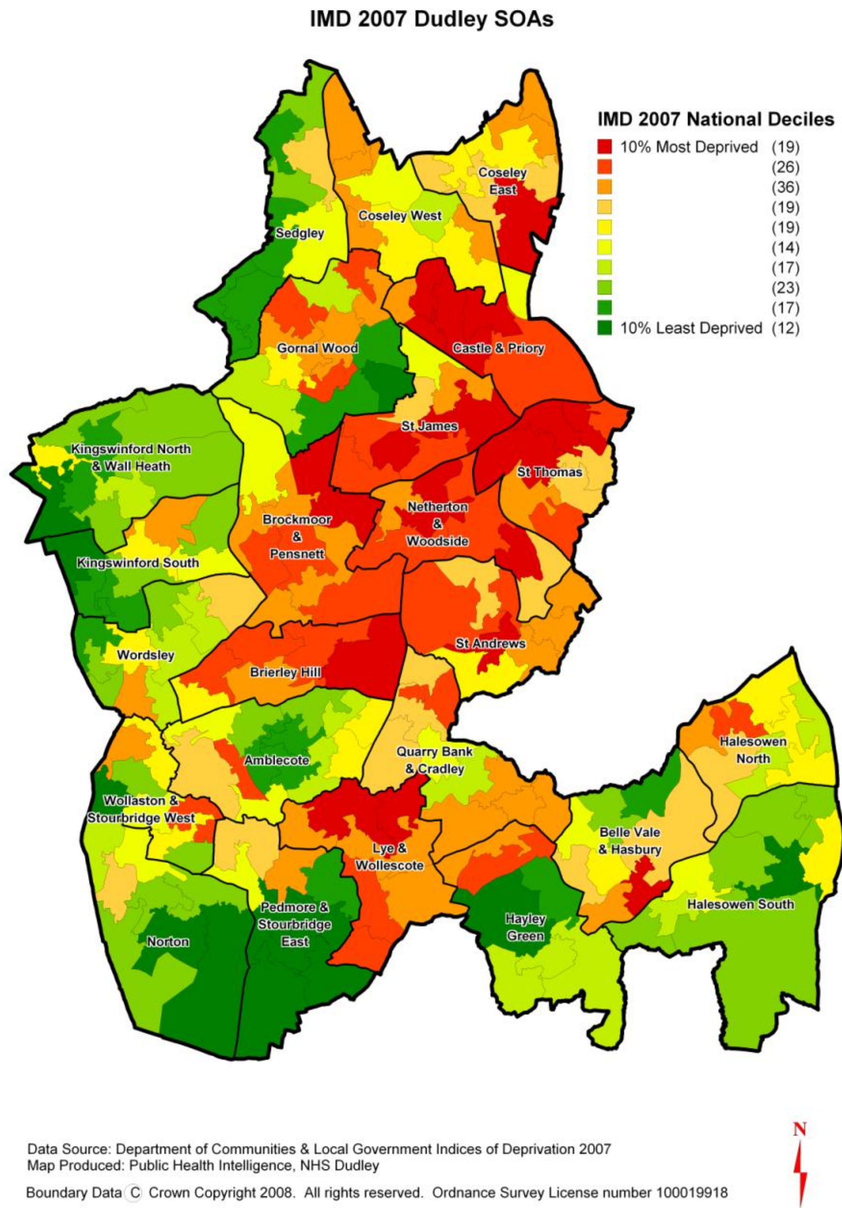
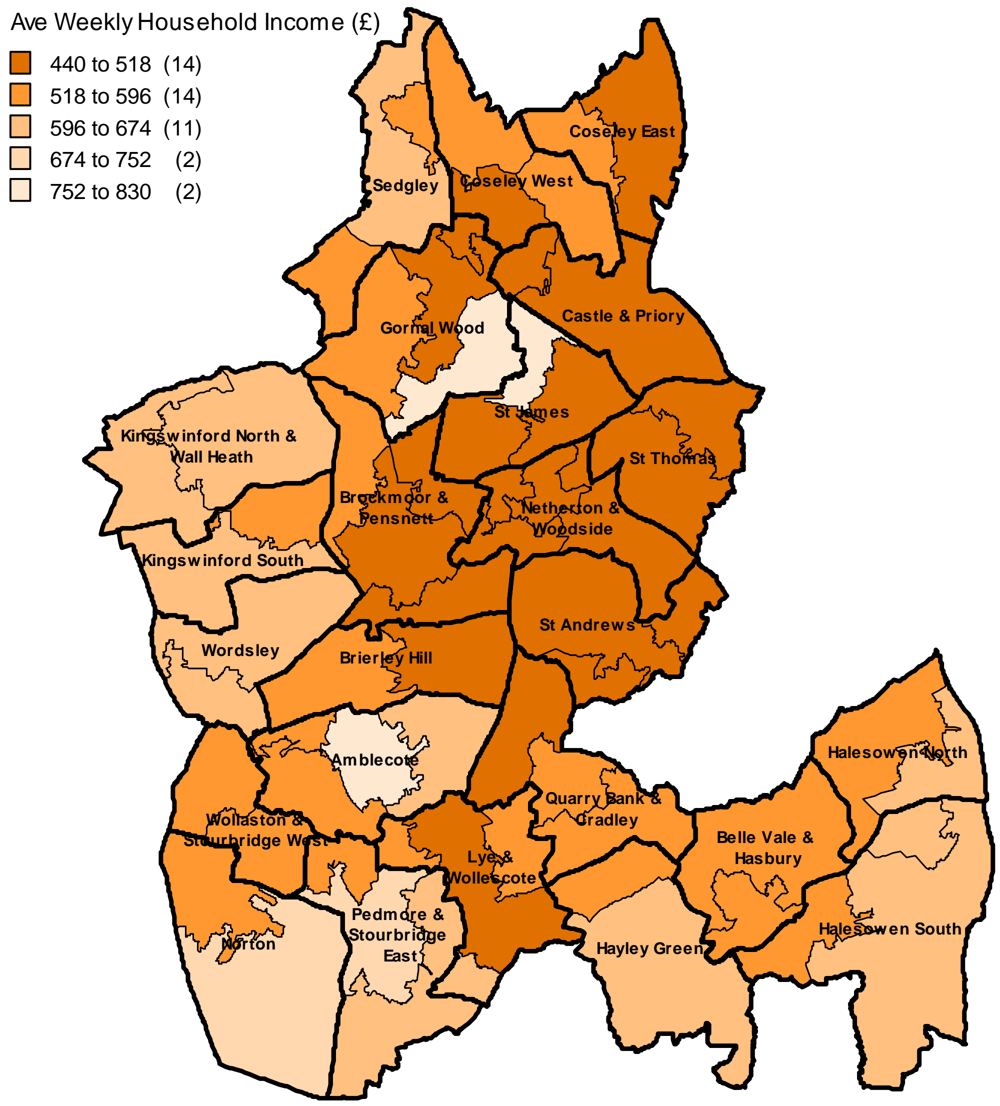


Figure 7 shows the income distribution across Dudley at MSOA level, based on modelled estimates for 2007-8.

Figure 7

Modelled Estimates of Average Weekly Household Income by Middle Super Output Area

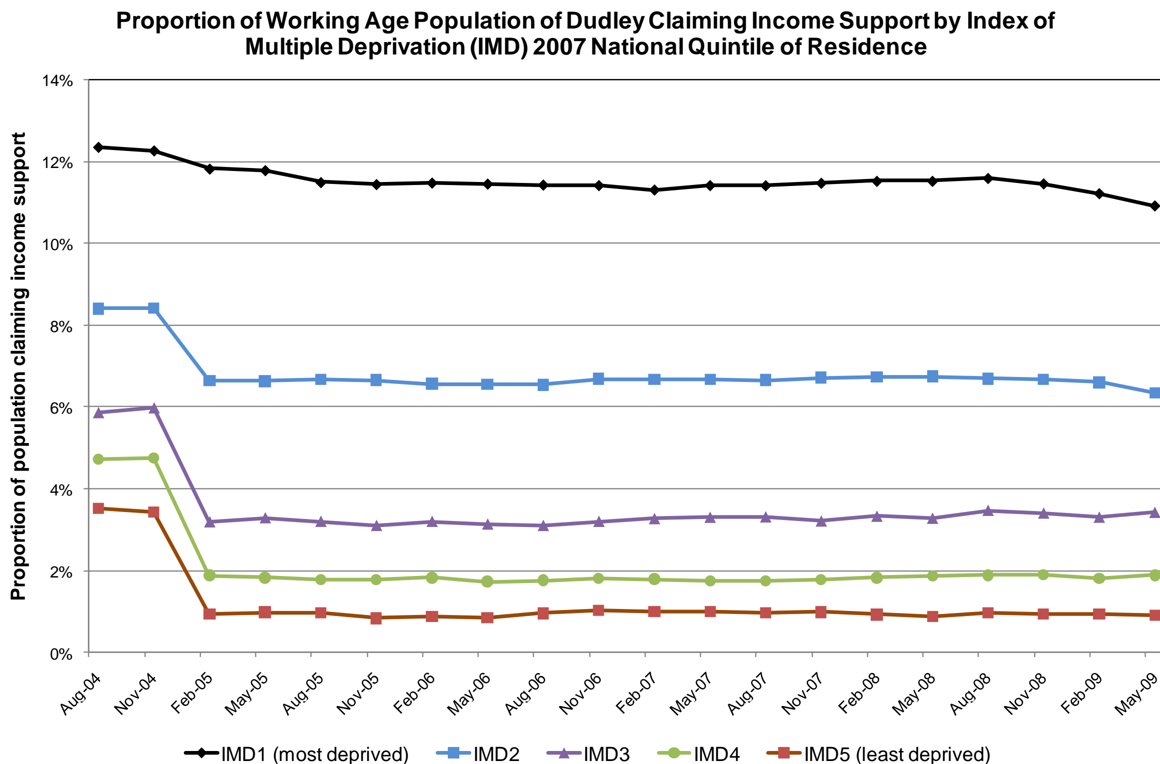


Source: Income: Model-Based Estimates at MSOA Level, 2007/08, ONS

The proportion of income support claimants in the working age population varies by IMD quintile, showing a gradient from most deprived (highest proportion of claimants) to the least deprived (Figure 8). IMD is a general measure of deprivation

in the round and may be seen as a proxy for social position, although it should be borne in mind that there is a small degree of autocorrelation in that levels of income support form part of one component of the index. Nevertheless the trend lines suggest that the inequality gap appears to be narrowing slightly, with the proportion of claimants of income support in the 2 most deprived quintiles showing a decreasing trend from August 2008. In the 3 least deprived quintiles, the proportion of claimants has stayed fairly constant from February 2005 to May 2009.

Figure 8

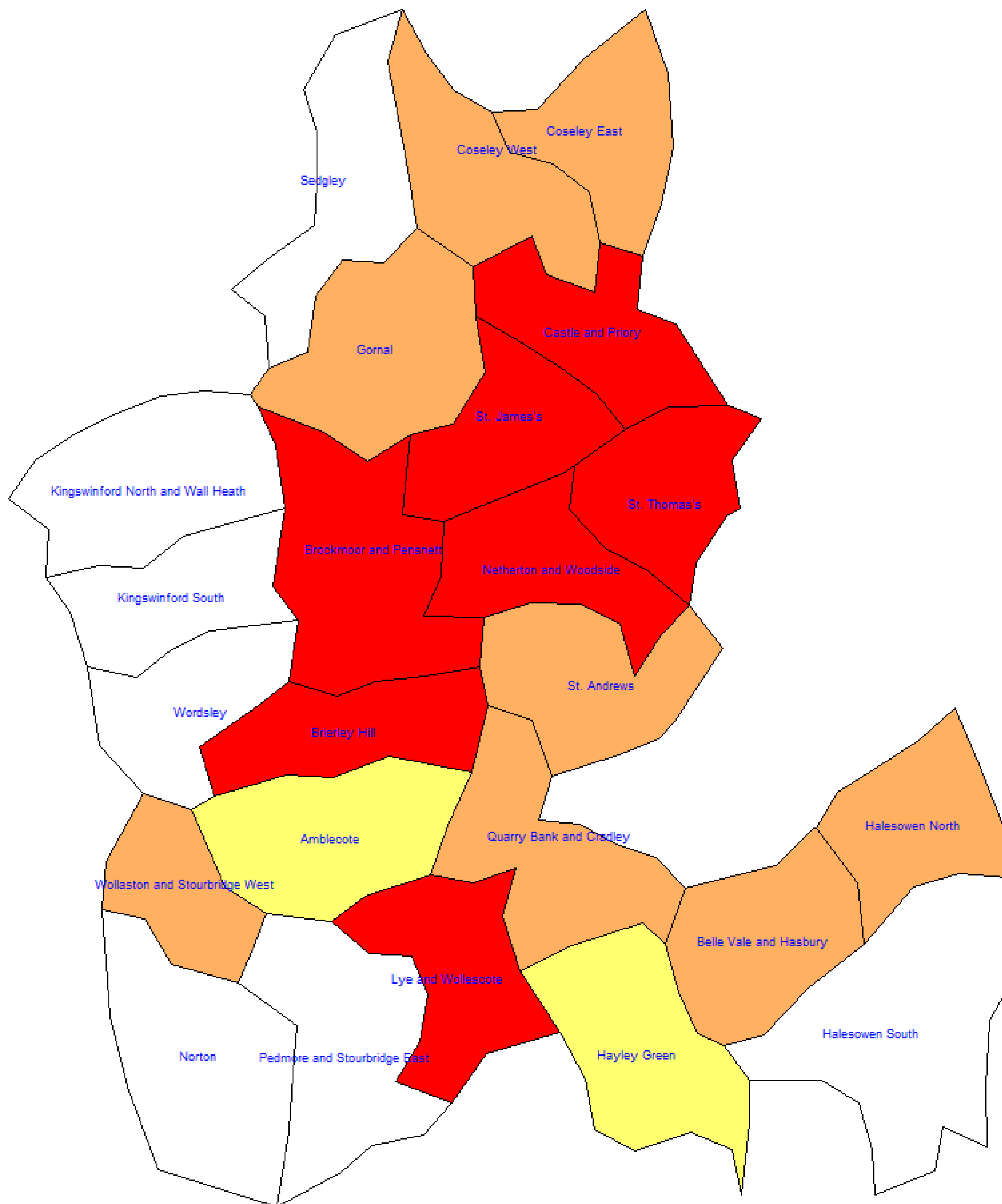


Note: the steep decline in the number of claimants between November 2004 and February 2005 is due to changes in the benefits system which resulted in some claimants having income support replaced by tax credits.

An indication of pensioner poverty may be gained from examination of the guaranteed part of pension credit. Figure 9 shows the spatial distribution for Dudley.

Figure 9

Proportion of the population aged 60+ who are in receipt of the Guaranteed part of Pension Credit for Dudley (Feb 2009)



(red)	In the highest 1,677 wards for Great Britain as a whole (i.e. highest sixth of wards)
(orange)	In the next 1,677 wards (i.e. second sixth)
(yellow)	In the next 1,677 wards (i.e. third sixth)
(white)	below the Great Britain average - remaining 5,033 wards

Source: Poverty.org.uk (accessed 02/08/2010)

The Marmot report showcases examples of CAB in GP practices projects throughout England. The Marmot (2010) report comments that *'many of these programmes are offered on a project by project basis and receive short term funding. Few financial support interventions are mainstreamed into PCT or local authority budgets, yet many are consistently effective in improving incomes and reducing debt'.* The GP commissioners in Dudley have mainstreamed the funding of Citizen Advice Bureaus in GP surgeries into a 3 year agreement. With a service provided from 12 of the Borough's 53 practices. The siting of the CAB centres is in centres serving deprived communities. The service sees between 500 and 600 clients per year (although clients will have multiple appointments), gaining in the region of £0.5m per year additional income for poor people in the Borough.

A Healthy Standard of Living for All: What Needs to be Done in Dudley?

As things stand, the extent to which all people in Dudley will have disposable income which provides sufficient for them to have a standard of living for a healthy life is very dependent on national policies adopted by central governments. In particular, the extent to which central governments are prepared to shift the taxation system towards being more progressive; the extent to which welfare policy initiatives are designed to remove the 'cliff edge' and the extent to which measures are implemented to ensure full take up of entitlement to state benefits.

In the meantime, all public service agencies in Dudley should be ensuring that those eligible and entitled to benefit are receiving it.

It is a legal requirement for the Dudley MBC to produce a strategy to reduce child and family poverty and the key actions for poverty reduction in Dudley are contained in that document and are not reproduced here. The Child and Family Poverty Reduction Strategy must be implemented in full.

Dudley as a healthy and sustainable place: what does the evidence tell us?

One of the major features of *The Marmot Review* (2010) is the alignment of climate change and health inequalities.

The Marmot Review stated that climate change will have the greatest impact on the urban poor, elderly and children – "*lowest level of income, quality homes and health".*

The recently published report *Health Effects of Climate Change in the West Midlands* (May, 2010) also explains the need to actively reduce health inequalities thereby reducing those at most risk as a result of climate change.

Within the West Midlands, coronary heart disease, strokes and infant mortality together with respiratory disease are all linked to extremes of temperature.

Although temperature variations during the life of this strategy are minimal, effective adaptation measures should be identified to reduce the impact of increased summer temperatures of (0.5°c – 2.5°c) by 2010. In urban areas the 'Urban Heat Island Effect' will exacerbate the increase in temperatures.

Research has demonstrated that the fewest deaths occur in summer with a temperature range of 17°c – 20°c (Fisher, 2009).

In the next decade, summer temperatures will increase and those within the winter months, this may lead to reduced winter mortality but an increased summer mortality rate. With temperatures in excess of 20°C increasing coronary heart disease and respiratory incidents are likely to increase.

Other issues of health will relate to an increase in food borne and water borne diseases in warmer weather

Flooding will impact on both physical and mental wellbeing, although summer rainfall is set to reduce, intensity of showers is set to increase. Drier summers will also increase ozone pollution which will have a negative impact on respiratory disease.

Within this context, reducing health inequalities, together with recognition of the need for adaptation strategies to address the impact of climate change at a service delivery level are a priority.

There are numerous policies derived from government that have aimed to improve the quality of community environments e.g. New Deal for Communities, Bikeability, The Housing and Regeneration Act, Green Flag Awards and World Class Places. Few of these have examined their impact on reducing health inequalities or reducing the social gradient. All policies seeking to promote active travel or improve the quality of the environment should also assess their impact on reducing the social gradient.

Dudley as a healthy and sustainable place: what do we know for Dudley?

The Climate Change group has been in existence since 2008. The three main areas of work for this group are:

- Carbon management
- Resource efficiency
- Climate change

The National Indicator that the group seeks to address is the per capita reduction in CO_2 emissions in the local authority area. Dudley is the lowest in the Black Country region and second lowest in the Black Country region. Table 5 shows the targets for reducing carbon emissions in the borough.

Table 5

NI 86	National rating	Direction of travel	Baseline and year	2008/09	2009/10	2010/11
Per capita reduction in CO_2 emissions in the LA area (source: DEFRA)	Lowest in BC region 2nd lowest in WM region 42nd lowest nationally	CO_2 levels improving	6.1 tonnes per capita (2005)	-3.2%	-6.4%	-9.7%

(Source: Dudley Community Partnership Strategic Plan)

Dudley as a healthy and sustainable place: what needs to be done in Dudley?

The key actions from the climate change delivery plan are:

- Gaining strategic buy-in and partner collaboration in the fields of resource efficiency and carbon management
- Building knowledge and capacity to take action within a ready community of interest
- Building knowledge within a geographical community of energy and climate change issues and raising capacity to take action
- Banish the inefficient community building
- Implementing Dudley Heroes awards
- Raising awareness of climate change and its impacts

In addition Marmot (2010) recommends a number of policy areas for local action:

- Increase opportunities for active travel across the social gradient
- Maintain access and quality of open and green spaces across the social gradient
- Continue to improve the energy efficiency of housing and reducing fuel poverty
- Support locally developed and evidence based community regeneration programmes that reduce barriers to community participation and reduce social isolation

5. LEADERSHIP AND PARTNERSHIP

Dudley Community Partnership

Reducing health inequalities requires action by all services and agencies that have an impact on the economic, environmental and social determinants of health. The Dudley Community Partnership (DCP) provides cross agency leadership by bringing together key partners from the public, voluntary, community and business sectors, and is currently chaired by the Chief Executive of NHS Dudley.

The DCP has a key role to play in reducing health inequalities, as one of its main aims is to ensure that all of the partners can work together effectively to improve the quality of life of everyone in Dudley Borough. The Community Strategy provides the main vehicle for doing this.

The *Dudley Community Strategy* (Dudley Community Partnership, 2005) outlines a set of key partnership priorities based on a 15 year vision. This vision is based on the expressed concerns of local people and agencies' own awareness of specific issues affecting the borough. It was shaped by over 5000 local people and more than 40 community groups. The vision for 2020 is one of sustainable, inclusive and connected communities across the Dudley Borough.

The Community Strategy is revisited every three years. The most recent version outlines the aspirations for improvements under six themes, many of which impact on health inequalities, and one of which specifically focuses on health and wellbeing.

The Community Strategy provides the overarching plan for all partners to work to. It highlights where inequalities exist for certain sections of the population and where additional action is required to promote equality. It is based on 5 principles which shape the way that partners work together. They are:

- Promoting equality – tackling inequality
- Safeguarding the future
- Reflecting priorities through physical change
- Delivery in partnership
- Involving people

Dudley Community Partnership is supported by a sub structure of borough wide thematic strategic partnerships, which are responsible for developing action plans for, and overseeing delivery of the priorities within the Community Strategy. The Health and Wellbeing Partnership takes a strategic overview of health inequalities, including performance monitoring and regular review of the metrics. It also manages and monitors joint working arrangements between the NHS and the Local Authority. This work is underpinned by the *Dudley Health & Social Care Commissioning Framework and Strategy 2008-13,* (NHS Dudley and Dudley MBC, 2008) and a strong track record of commissioning older people's, learning disability and mental health services.

Next Generation Local Area Agreement

'Dudley's *Next Generation Local Area Agreement 2008/11* (Dudley Community Partnership, 2008) focuses on creating a vibrant and sustainable economy and reducing inequalities. This vision is intended to support the much broader vision of the Community Strategy by recognising that a strong economy is key to delivering stronger communities. The commitment to tackling inequality, vulnerability and differences in opportunities is viewed as a cross cutting theme across all four priorities – wealthy communities; healthy communities; environmentally-aware communities and safe and cohesive communities.

Key partners were involved throughout the process of identifying these priorities, and the partnership agreed a range of criteria to assist in the process, which included an assessment of whether or not the priority in question would contribute to narrowing the gap.

A structural review of the partnership has resulted in Task and Finish Groups being 'charged' with the responsibility of delivering agreed outcomes and taking ownership of agreed indicators. This approach will ensure that the expertise and knowledge of a core group of partners, who are already involved in the Thematic Partnerships, remains central to the work, but will also enable broader involvement of other partners.' *(*Next Generation LAA 2008 -11, 4th Submission, Dudley Community Partnership May 2008)

Strong leadership and a strategic partnership with agreed priorities and responsibilities needs to be underpinned by partnerships which are effective for middle management and frontline staff.

In Dudley, work to address health inequalities is further supported by:

- A strong and well organised voluntary, community and faith sector.
- A Director of Public Health (DPH), who has been jointly appointed by NHS Dudley and the Local Authority. The DPH is a member of the Council Corporate Board and has access to the council cabinet. Regular board-to-board meetings take place between NHS Dudley and the Local Authority and the DPH provides a strong lead on health inequalities.
- Strong relationships between commissioners in NHS Dudley and the Local Authority, and also with providers.
- A number of joint appointments and secondments between NHS Dudley and the Local Authority.
- Strong commitment within the Council Plan and NHS Dudley's strategic plan to address health inequalities.

- A Community Renewal team which coordinates agency and community activity in identified neighbourhoods, with a focus on deprivation. This has resulted in considerable joint working between all partners at a neighbourhood level, and has led to improvements in basic 'place' based issues such as crime, the environment and housing. Local communities are now, in general, ready to move on to addressing 'people' based issues such as health, education, skills and jobs.

- NHS Dudley's Public Health teams and the Council's Community Renewal team are in the early stages of developing Neighbourhood Health Plans. These will provide a very focussed and coordinated approach to addressing health inequalities in localised areas and will help to maximise the capacity of partner agencies to deliver against the priorities identified.

In addition:

- Health inequalities will now feature on the Overview and Scrutiny agenda and performance against health inequalities targets will be reported to this group when a new performance framework has been agreed.
- Consideration is being given to appointing a lead member for health inequalities. Dudley PCT has identified a post for a GP Champion for 'staying healthy'.
- The new Chief Executive of the Dudley Group of Hospitals Foundation Trust will take forward the health promoting role of the hospital and take a positive role in reducing health inequalities.

Dudley has a strong tradition of partnership working and is well placed to tackle the health inequalities that exist within the borough. However, recent changes introduced by the new coalition government and substantial budget cuts will present future challenges, and changing circumstances may impact on agencies priorities and activities. This comes at a time when strengthening partnership arrangements even further is necessary to maximise the potential for tackling health inequalities.

The Health Inequalities National Support Team that visited in July 2009 recognised the strength of partnership working in the borough, but identified a need to strengthen leadership across the partnership, including the engagement of elected members and non-executive directors.

The Transforming Community Services agenda and the transfer of public health functions to the Local Authority also present key challenges in relation to redefining and clarifying responsibilities and accountabilities and (re)building trusting relationships.

GPs have always had a role to play in addressing health inequalities as practitioners, community leaders and commissioners. With new responsibilities for commissioning, close partnership working arrangements between GP consortia and local authorities

will need to be developed to ensure an improvement in public health and a reduction in health inequalities.

In the midst of these changes we need to safeguard the strong partnerships developed with people living in local communities in Dudley. Long before statutory requirements like the Duty to Involve came into being, public and voluntary sector agencies in Dudley have been working alongside local communities to ensure that people can affect decision making, influence change in the delivery of health and social services, gain experience and skills which may lead to a better quality of life for them and their families, and take ownership of their own health improvement. This work has been built on trusting relationships, which takes time to develop. An increasing focus on market-driven, cost-efficient models of service delivery brings an inevitable tension in keeping local people at the forefront of our thoughts and our plans. In this climate we need to work particularly hard at valuing and sustaining these relationships and ensuring they continue to be based on trust, respect, empathy and reciprocity.

6. COMMUNITY ENGAGEMENT

Community Engagement

The very process of community engagement, when done well and appropriately, can contribute beneficially to people’s health and well-being. In short, community engagement is a healthy activity.

Background

Engaging and empowering local people and groups has been a requirement of local public sector bodies and councils for some time now. Recently the *Strong and Prosperous Communities, The Local Government White Paper* (Great Britain. Department of Health, 2006) has called for a ‘more comprehensive approach to engagement’ and *Communities in control. Real people, real power* (Communities and Local Government, 2008) continued this theme calling on Local Strategic Partnerships to ‘streamline consultation and engagement’.

The Marmot Review (2010) *puts empowerment of individuals and communities at the centre of action to reduce health inequalities.’* It goes on to say that *‘there needs to be a more systematic approach to engaging communities for Local Strategic Partnerships at both district and neighbourhood levels, moving beyond often routine, brief consultations to effective participation in which individuals and communities define the problems and develop community solutions.*

An empowering approach to engaging communities

In Dudley, a multi-agency programme of work called *‘In it together’* (Dudley Community Partnership, 2010) was initiated in 2007, led by Dosti, Dudley’s Community Empowerment Network. Over 250 local people, primarily drawn from Dudley’s voluntary, community and faith sector networks contributed to an initial discussion and consultation document which explored the issues at the heart of community engagement. Following this, 92 professionals participated in workshops to help shape a local community engagement training and support package.

‘In it together’ is a partnership approach to empowering community engagement. It encourages and supports organisations and people to bring together their community engagement work and plans, to enable them to move beyond consultation and jointly deliver/facilitate meaningful and empowering community engagement activity. An empowering community engagement approach facilitates participation and promotes inclusion, and thus acts as a protective factor for mental well-being (NMHDU, 2010)

Dudley Community Partnership agency leads, including the Health and Wellbeing Partnership, have signed up to and fully endorsed the *‘In it together’* work programme which encompasses the following:

- A *Comprehensive Community Engagement Strategy* (Pendry, Prescot and Pritchard, 2009) – written as an interactive document and tailored into four

different versions to support practitioners, managers, elected members and representatives;

- A *Community Engagement guide and toolkit* (Pendry, Roberts and Walker, 2009) which takes people through each step in undertaking an engagement activity. This work has been led by DMBC.
- A consultation database which seeks to coordinate community engagement activity, avoid duplication and share learning. This has been developed by DMBC and is now being rolled out to partners.
- Three levels of training –
    - **Level 1: Understanding Engagement** is core training which supports people to understand Dudley's empowering approach to engaging communities.
    - **Level 2: Practising Engagement** offers a range of modules including facilitation skills, cultural awareness and community consultation tools.
    - **Level 3: Supporting others to engage** will be developed over time to offer support for people to develop their own and others community engagement practice, through for example, mentoring, buddying or Action Learning Sets.
- A Community Engagement Network which supports people to understand, practice and develop their engagement practice.

The strong partnership approach which underpins *'In it together'* has enabled the sharing of key information and resources across agencies, including corporate training, previously only available to staff from the employing organisation.

The *'In it together'* work programme is coordinated and progressed by a multi-agency Community Engagement Working Group, which reports into the Stronger Communities Thematic Partnership group of the Local Strategic Partnership - Dudley Community Partnership.

Further information on the *'In it together' work programme and supporting documents are available to download from the dosti website www.dosti.org.uk/downloads.*

Shared principles and values

To achieve an empowering approach to engaging communities, agencies need to work in line with shared principles and values. *'In it together'* (Dudley Community Partnership, 2010) promotes a common language and understanding in relation to community engagement, which links the principles in the Community Strategy, the values in the Local Compact and is reflected in the PCT's *Communications and Engagement Strategy* (NHS Dudley, 2009) and DMBC's *Corporate Engagement Principles* (Dudley MBC, 2009)

Shared principles and values will support closer collaborative work between organisations, of which there are already several existing and emerging examples, such as:

- DMBC sharing their community engagement database with the NHS economy in Dudley to facilitate learning and sharing of practice, improve the effectiveness of community engagement activity and reduce duplication. This is a prelude to extending access to other statutory and voluntary sector organisations.

- NHS Dudley and DMBC *Dudley Health & Social Care Commissioning Framework and Strategy 2008-13* was underpinned by a wide-ranging engagement through a nationally recognised 'Think Tank' process and health inequalities was established as a theme to guide commissioning activity.

- Follow-on work from the 'Think Tank' activities through a two phase engagement exercise – phase one utilised a mobile film unit to elicit views about health and social care, and phase two will utilise the film from this to stimulate further discussion and comment from a diverse range of audiences across the borough.

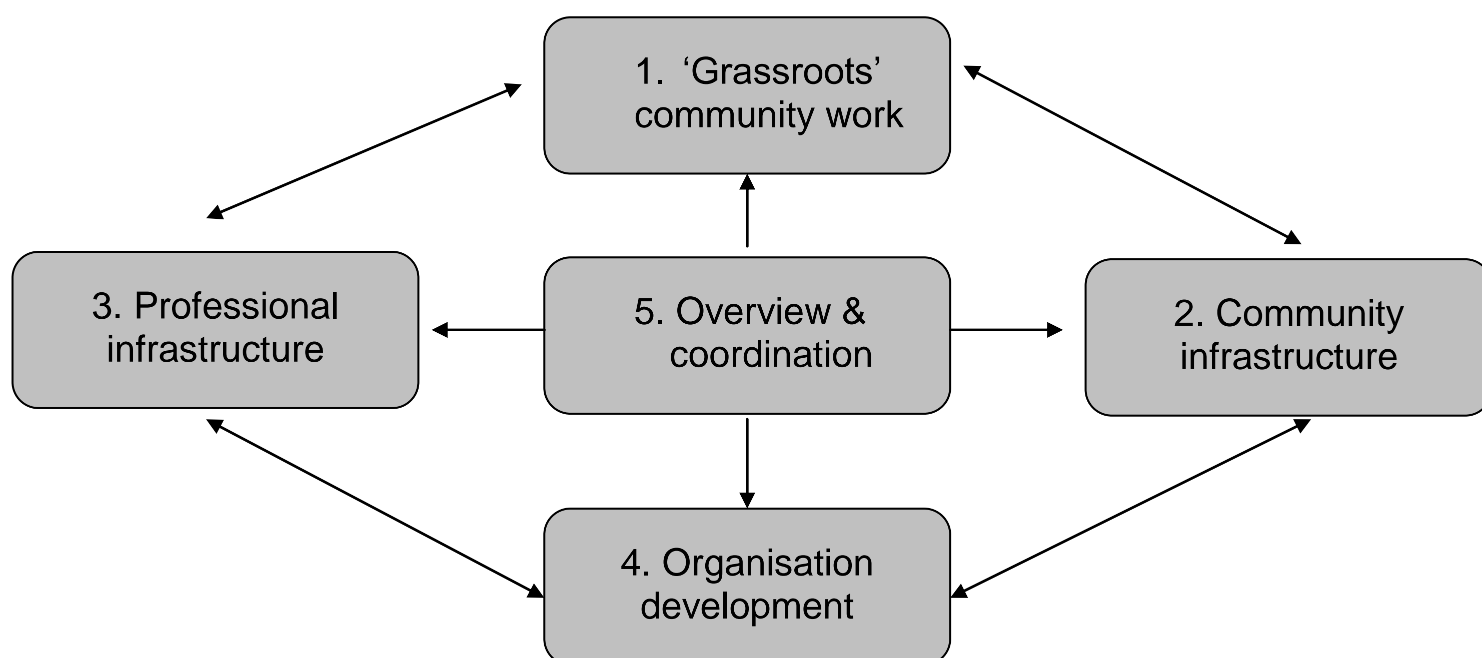
A planned and systematic approach

'To effectively tackle health inequalities and avoid the vast amount of waste and / or additional costs incurred from under-used services, poor self-management of long term conditions and commissioned activity and services which fail to move beyond pilot / short term funding, a planned and systematic approach (to community engagement) is crucial,' (Smithies, 2010).

In Dudley, the strategic approach taken through *'In it together'* (Dudley Community Partnership, 2010) is helping to ensure that community engagement activity impacts on change at all levels. The National Support Team also recognised that we have extensive, regular and secure arrangements for community engagement on health and social care issues.

The *Five Elements* model proposed by the Health Inequalities National Support Team (Smithies, 2010) provides a framework to plan, deliver, monitor and evaluate community engagement work (Figure 1). Applying this model to both cross-agency strategic approaches and individually commissioned initiatives and services will help to ensure that the sustainability, reach and impact of community engagement work is maximised.

Figure 1 – The Five Elements Model (Smithies, J., 2010)



In Dudley we have extensive, regular and secure arrangements for community engagement. *'In it together'* is paving the way to connect much of the community engagement work at a cross-agency strategic level. The challenge now is to ensure that all community engagement activity considers each stage of the model in its planning and delivery. This will require better access to decision making structures, and strategic leadership roles being built into community engagement work to ensure that work directly with local communities informs areas such as workforce development, commissioning and service redesign.

Public Health and the Local Authority (Community Health Improvement and Community Renewal respectively) are using the Five Element Model to review current activity, identify gaps and plan for a more coordinated and strategic approach to community health improvement in the most deprived neighbourhoods in the borough through the development of Neighbourhood Health Plans.

The Health Inequalities National Support Team recommended that local communities are made more aware of health inequalities and are engaged more effectively in setting local priorities, and that neighbourhood engagement structures are simplified. Collaborative working between the Local Authority and NHS Dudley is ongoing to ensure that community engagement structures and activity is simplified and streamlined to avoid duplication and gain maximum benefit from the processes already in place. The development of Neighbourhood Health Plans will also help to ensure that grassroots community work is better coordinated and that it informs local priorities within each element of the model.

Transferring power to communities

NICE guidance on community engagement recognises that different levels of community engagement can directly and indirectly affect health in both the intermediate and longer term. '*Community engagement approaches which enable communities to work as equal partners, or delegate some power to them – or, indeed provide them with total control – may lead to more positive health outcomes.'* (NICE, 2008a.)

During the Health Inequalities National Support Team visit in July 2009, it was identified that very few mechanisms exist locally for empowering communities through democratic means (e.g. town / community Councils), community investment (e.g. Community Land Trusts), or through service provision (e.g. through a Healthcare social enterprise).

'In it together' supports people to identify the most appropriate level / method of community engagement according to the purpose of their engagement activity and will help to ensure that whichever method (mechanism) is used, people undertaking, managing and resourcing engagement activities in Dudley do so in the most empowering way possible.

However, without a shift of power towards individuals and communities it will be difficult to achieve the penetration of interventions needed to impact effectively on health inequalities. (Marmot, 2010)

The coalition Government has set out their driving ambition to put more power and opportunity into people's hands by 'Building the Big Society.' This agenda presents many opportunities and supports existing work in Dudley which is aiming to increase the number of people who participate in meaningful engagement and are able to make a difference. If this agenda is to support progress in reducing the health inequalities gap we must not underestimate the scale of the challenge ahead.

Those experiencing the greatest inequalities are likely to be the least able to solve problems and improve life for themselves and their communities. While inequalities persist, people who have the least will benefit the least from the transfer of power and responsibility.

Energy and commitment to social action underpinned by strong partnership working and a move towards co-production, whereby providers and users work together in equal and reciprocal partnerships will be required to make sure that everyone can participate in a way which will improve their health and wellbeing, and help them to help themselves and each other.

7. PRIORITY ACTIONS TO IMPACT ON HEALTH INEQUALITIES

Building on its experience of supporting the spearhead areas to reduce health inequalities, the Health Inequalities National Support Team has been able to develop a number of priority actions that have been shown to have the greatest impact on mortality targets. Their recommendations for Dudley included a number of important actions for us to implement in order to address our inequality gap. This section focuses on the key disease areas that contribute to the biggest gaps locally.

7.1 SECONDARY PREVENTION CARDIO-VASCULAR DISEASE

Introduction:

Cardiovascular Disease (CVD) is a collective term for a group of related conditions affecting the heart, arteries or blood vessels. It includes Coronary Heart Disease (CHD) (about 50%) and stroke (about 25%).

Nationally there has been a steady and marked decline in death rates from CVD. In fact the overall reduction has surpassed the government target:

'substantially reduce mortality rates by 2010 from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole from a 1996/7 baseline'.

The health inequalities gap in relation to CVD mortality and prevalence is well documented with higher levels for men than women, lower income levels than higher and for specific ethnic groups. Deaths from CHD are three times higher among unskilled men than professionals and around 50% higher in South Asian communities than the general population and early onset of the disease two to three times higher (CQC, 2009).

Nationally the CVD inequalities gap is reducing, with latest data (2007) showing a reduction of 36% in the absolute gap between the Spearhead PCTs and the England average. The national gap in 2007 was 23.5 deaths/100,000. (CQC, 2009, p. 12).

Dudley reflects the national picture overall but our inequalities gap is widening for men. CVD levels have declined steadily, but remain the biggest single cause of premature death in Dudley accounting for around 150 deaths in the under 75s each year. There is some evidence that for men the rate of decline is beginning to slow. CVD continues to be a major factor in overall health inequalities, with rates in some wards being more than 3 times those in other wards. The gap between the wards with the highest and lowest rates has widened for men but not for women. The deprivation gradient in premature mortality from circulatory diseases is much steeper in men than in women. (Little and Moss, 2009)

Figure 1

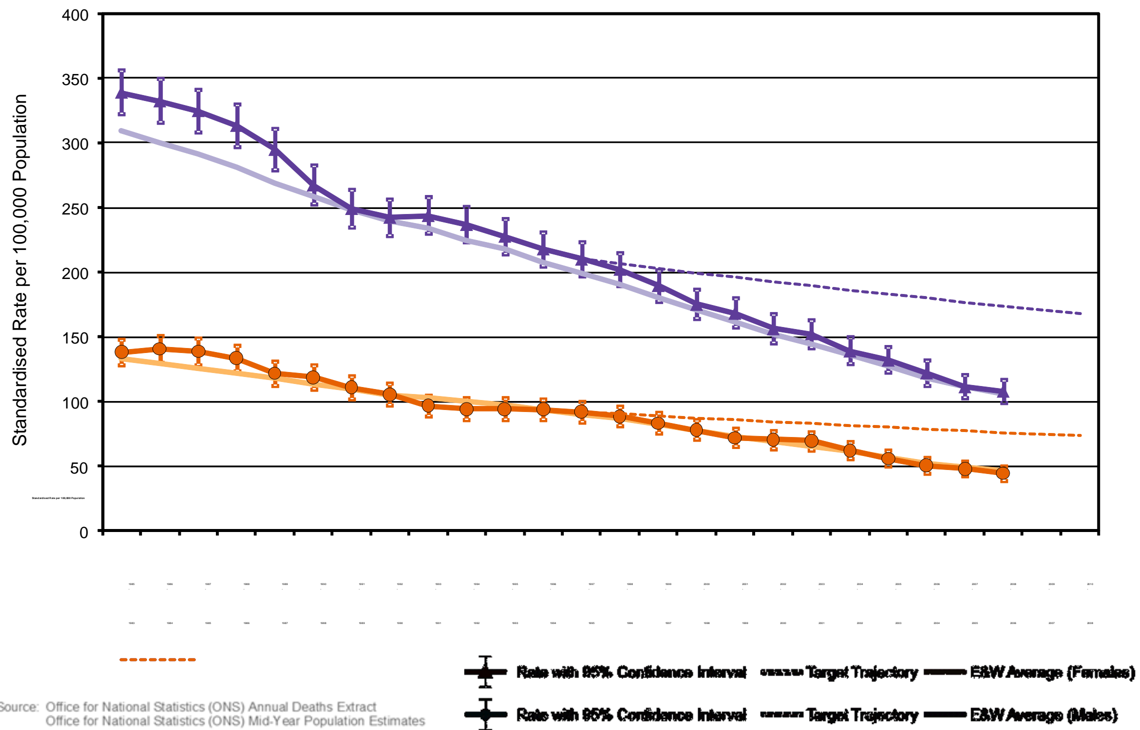
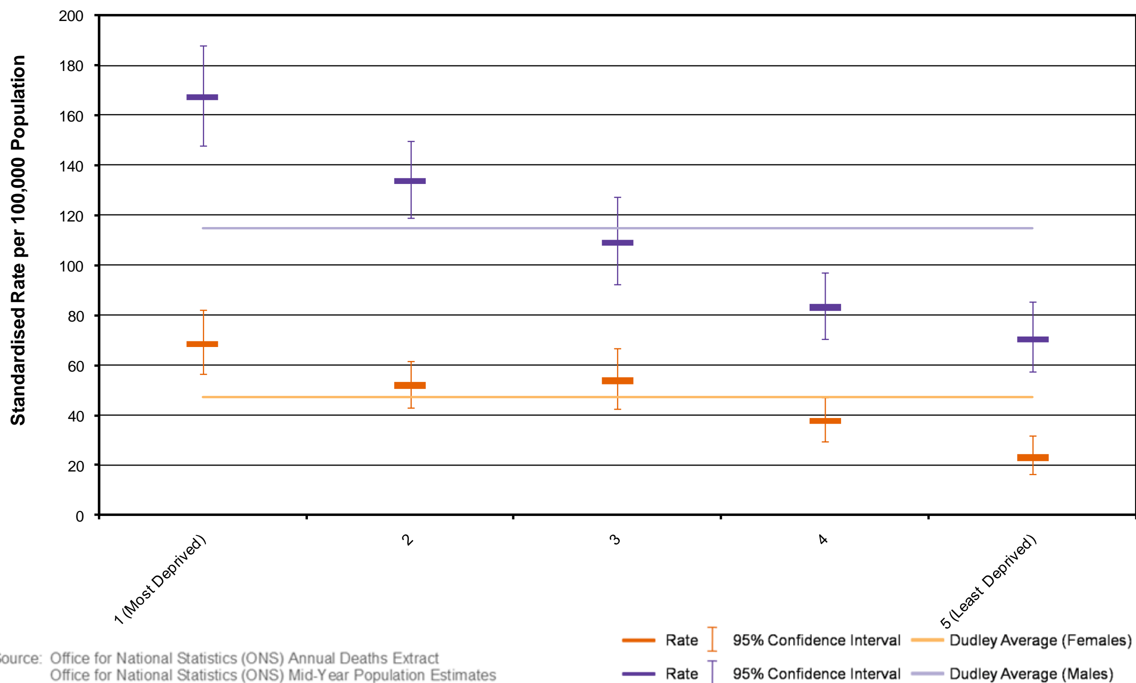


Figure 2



There has been a slow-down in the rate of decline in mortality for stroke, particularly for men in the last few years. The rate of premature mortality for stroke in men is now significantly higher than the England and Wales average (Figure 3).

Figure 3

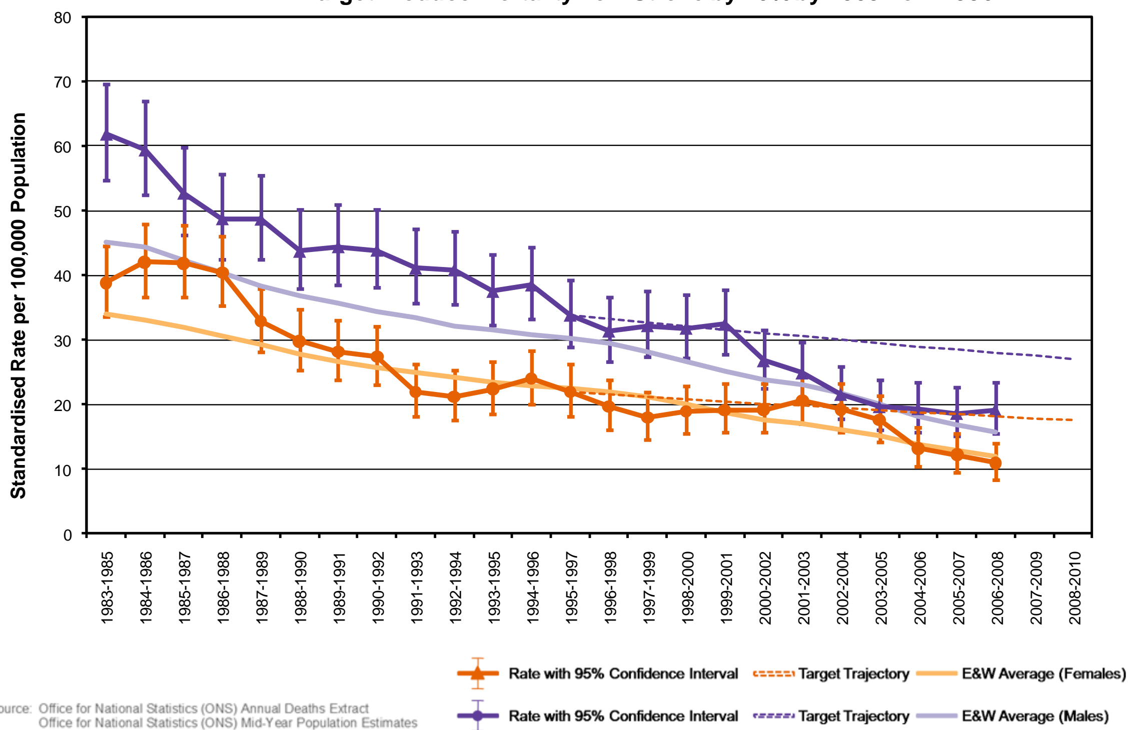
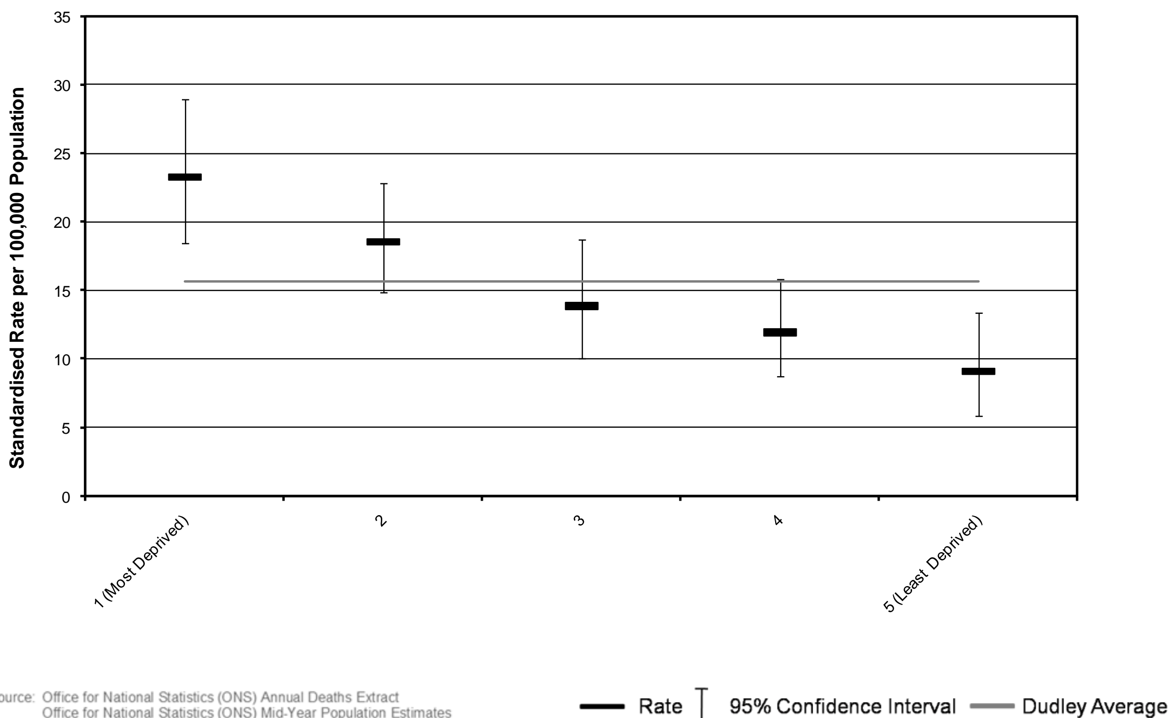


Figure 4



Secondary Prevention of CVD

Optimum management of the vascular long term conditions within primary care is a key strategy in the reduction of CVD health inequalities. The numbers of people living with a chronic disease are set to rise substantially because our population is growing, ageing and lifestyle risk factors such as obesity are becoming more common.

Health inequalities may result due to deprivation, ethnicity, age, sex and occupation. This section focuses on deprivation as the information is available and deprivation has been found to be linked with occupation and ethnicity.

Health inequalities in relation to the secondary prevention of CVD can occur at different points:

- Are people coming forward in the first place? The gap in expected to actual prevalence for the key disease registers gives an indication
- Once identified are people accessing treatment?
    - Are exclusions from the register justifiable? Exception reporting for the disease registers gives an indication
    - Are patients reviewed regularly and their risk factors measured and recorded? QOF clinical indicators on recording gives an indication
    - Are drugs prescribed where indicated? QOF clinical indicators on prescribing gives an indication
    - Is there access to supportive services? Referrals to Lifestyle Risk Management Services (LRMS) gives an indication
- Are outcomes from treatment equitable?
    - Are risk factors controlled to target levels? QOF clinical indicators on control gives an indication
    - Are prescribed drugs titrated to optimum levels? Bespoke medicine management audits can give an indication
    - Are LRMS outcomes equitable? Outcomes monitoring data from LRMS gives an indication

Prevalence recording of vascular diseases and precursor conditions

The quality and outcomes framework (QOF) of GP contracts requires GPs to report the number of people on the various special disease registers. The actual disease prevalence reported from QOF can be compared to expected disease prevalence estimated from national disease prevalence models. Expected and actual prevalence for the key vascular diseases/conditions for Dudley as a whole is shown in Table 1.

Table 1: Expected and Actual Prevalence. Dudley Average.

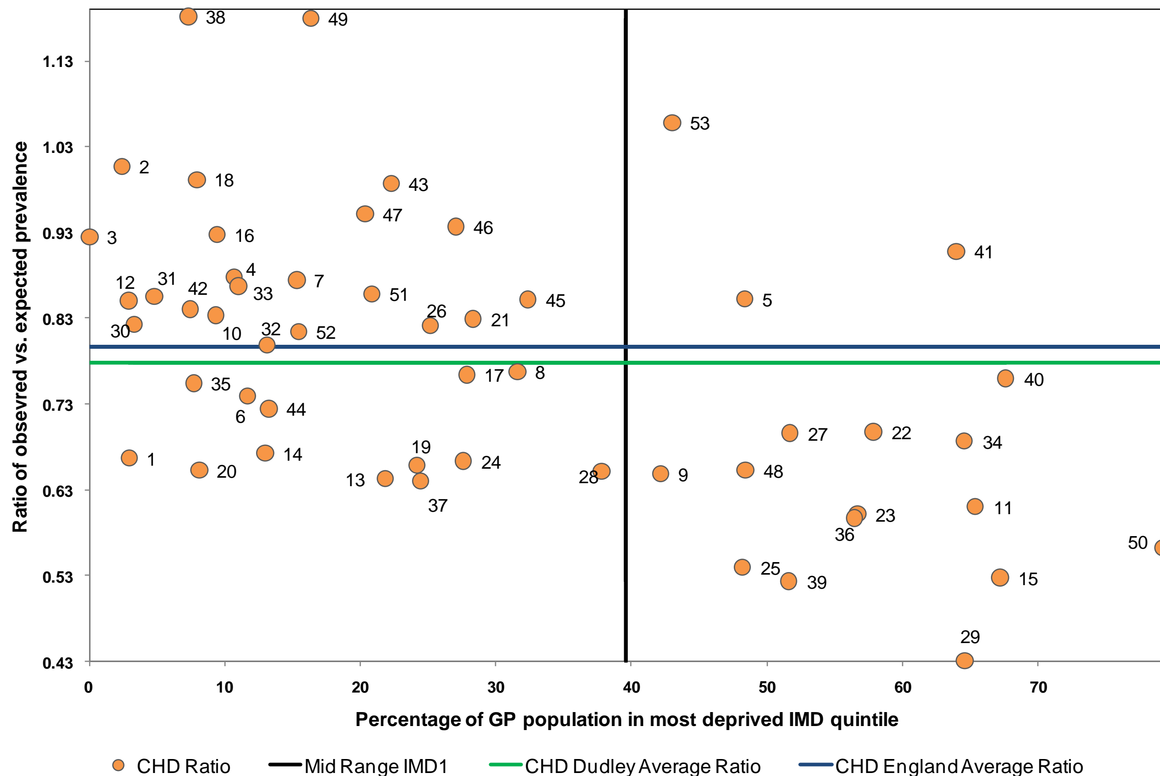
Disease/condition	Expected Prevalence	Actual Prevalence
CHD	5%	4%
Stroke	2%	2%
Hypertension	25%	16%
Diabetes	6%	5%

Source: Doncaster PHIU April 2009 QOF Benchmarking tool

There is an under-reporting of prevalence, especially for hypertension (Table 1). Looking at practice level data, there is an association between deprivation and practice performance in the recording of prevalence for some of the vascular diseases. Practices in more deprived areas tended to have higher levels of unrecorded prevalence for CHD and stroke (Figure 5 & 6) resulting in poorer access to treatment. An opposite association was seen for diabetes (Figure 7) with practices in the least deprived areas more likely to have higher levels of unrecorded prevalence.

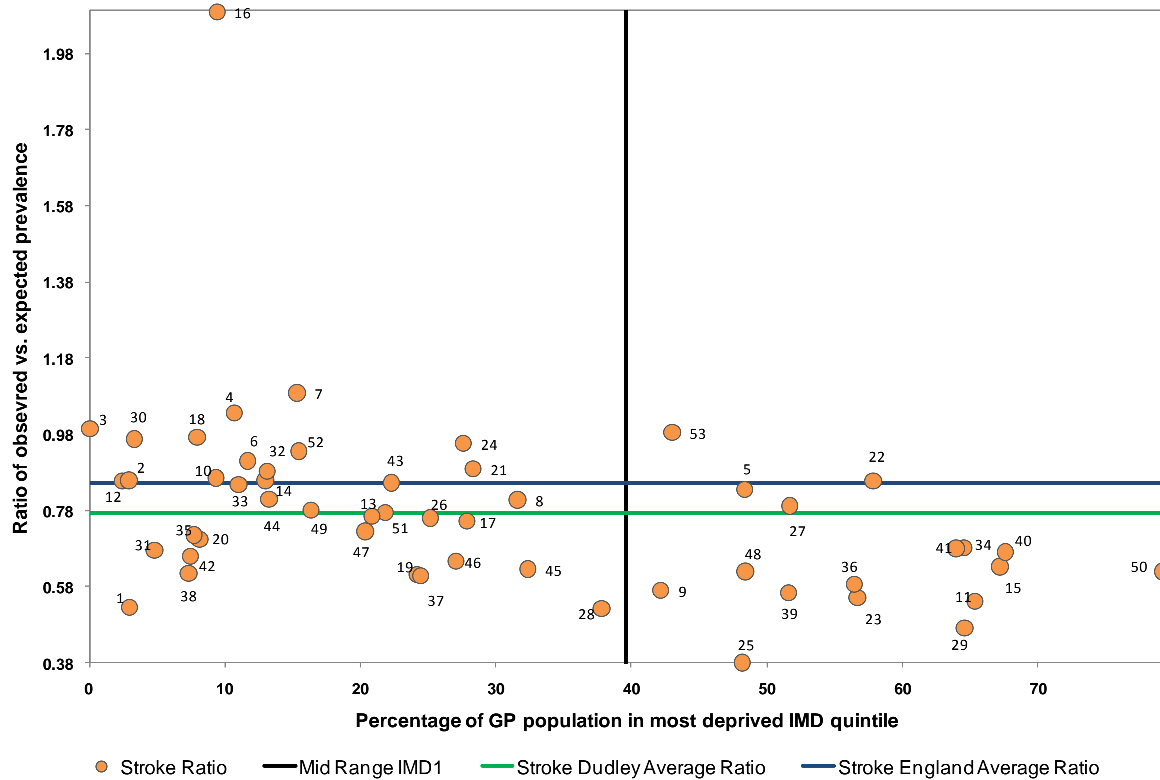
Figure 5:

Prevalence Recording Ratios for CHD (r=0.537,r^2 = 28%)



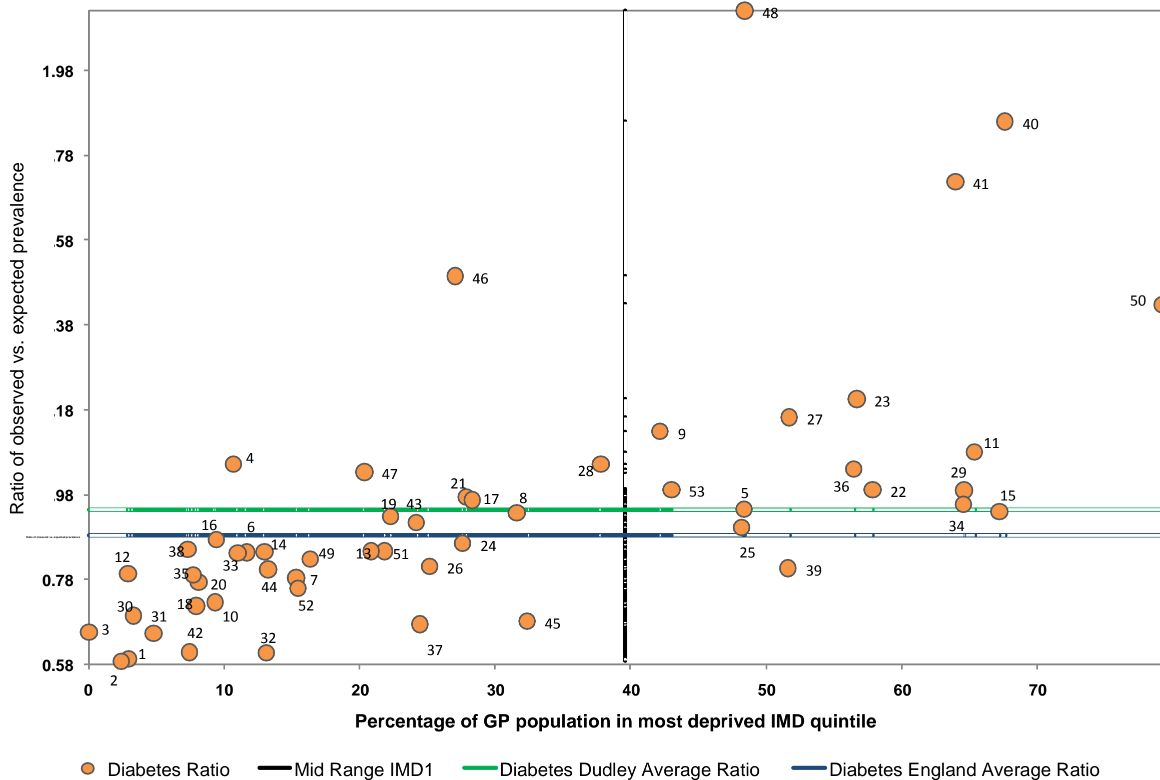
Source: Quality Outcomes Framework disease register 2008/09
Primary Care Mortality Data GP Registered Population
Department of Communities & Local Government Indices of Deprivation 2007

Figure 6: Prevalence Recording Ratios for Stroke/TIA (r=0.413, r^2 =17%)



Source: Quality Outcomes Framework disease register 2008/09
Primary Care Mortality Data GP Registered Population
Department of Communities & Local Government Indices of Deprivation 2007

Figure 7: Prevalence Recording Ratios for Diabetes (r=0.6, r^2 = 40%)



Source: Quality Outcomes Framework disease register 2008/09
Primary Care Mortality Data GP Registered Population
Department of Communities & Local Government Indices of Deprivation 2007

There is great variation in performance between practices, with a number of practices consistent poor performers. Where practices differ significantly, this could be due to poor data recording, a need to improve case finding, higher exception reporting which would need investigating or alternatively a higher or lower actual prevalence in that GP practice population. These are important areas to concentrate on in order for the PCT to have an impact on reducing health inequalities in the borough.

Exception Reporting
Exception reporting is the process by which patients are excluded from chronic disease registers for reasons such as failing to attend an appointment after 3 reminders, or refusing treatment. Nationally GPs working in more deprived areas tend to show higher exception reporting (CQC, 2009, p.17), but this was not the case in Dudley for any of the vascular disease registers.

Exception reporting for all vascular disease registers was extremely varied across the practices. Although the overall Dudley average was lower than the England average for all registers, there were a number of practices with very high exception levels compared to other practices. It is important to review performance in this area, especially with the practice outliers to ensure that exclusion criteria are fair and are not inadvertently contributing to health inequity.

Management of Hypertension for Vascular Diseases in Primary Care
There is high variation in performance between practices for both the recording and control of blood pressure across all vascular disease/ condition registers: CHD, stroke, diabetes, hypertension and Chronic Kidney Disease (CKD). The range of performance gaps are detailed in Table 2. The percentage gap represents the numbers of patients that are not being treated at optimum level.

Table 2: Range of performance gap

Disease/condition register QOF Clinical Indicator	Percentage gap range	Dudley average	England average
CHD 5 (Bp record <15mnth)	0% to 10%	2.2%	2.2%
Stroke 5 (Bp record <15mnth)	0% to 12.6%	3.1%	3.1%
Diabetes 11 (Bp record <15mnth)	0% to 10.5%	1.7%	1.6%
CKD2 (Bp record <15mnth)	0% to 7.4%	1.8%	2.6%
CHD 6 (Bp control ≤150/90)	1.3% to 21.3%	9.9%	10.5%
Stroke 6 (Bp control ≤150/90)	0% to 27.3%	11.3%	12.1%
Hypertension 5 (Bp control ≤150/90)	10.2% to 43.2%	20.9%	21.7%
Diabetes 12 (Bp control ≤145/85)	8.9% to 52.3%	22.0%	20.2%
CKD3 (Bp control ≤140/85)	3.8% to 52%	27.3%	26.9%

Higher performance gaps for blood pressure control are evident particularly for the hypertension, diabetes and CKD registers. Dudley's average performance is similar to the England averages for all registers, - slightly better for all except diabetes and CKD.

Performance variation cannot be explained by deprivation for Dudley, as there was no association found between practice deprivation level and either blood pressure recording or control for any of the vascular disease/ condition registers, which reflects the national picture. (Craig.and Mindell, 2008).

There are a number of practices that consistently appear below average in performance. Differences may be due to poor data recording, a need to improve disease register management i.e. patients not invited for annual reviews or high non-attendance rates, poor prescribing regimens and low levels of lifestyle referrals, or they may be due to poor patient compliance with drug or lifestyle therapies. These are important areas to concentrate on in order for the PCT to have an impact on reducing health inequalities in the borough.

Cholesterol Management for Vascular Diseases in Primary Care
There is high variation in performance between practices for both the recording and control of cholesterol across the vascular disease/ condition registers - CHD, stroke, and diabetes. The range of performance gaps are detailed in Table 3.

Table 3: Range of performance gap

Disease/condition register QOF Clinical Indicator	Performance gap range	Dudley average	England average
CHD7 cholesterol record <15mnth	0% to 16%	6.3%	6.0%
Stroke 7 cholesterol record <15mnth	0% to 38.5%	9.4%	8.6%
Diabetes 16 cholesterol record <15mnth	0% to 12.1%	4.2%	4.0%
CHD 8 Cholesterol control ≤ 5mmol/l	5.6% to 30.6%	16.2%	17.9%
Stroke 8 Cholesterol control ≤ 5mmol/l	5.3% to 47.9%	21.7%	23.1%
Diabetes 17 Cholesterol control ≤ 5mmol/l	3.8% to 27.0%	15.8%	17.4%

Performance gaps for cholesterol recording are particularly evident for the stroke register. Dudley's average performance is similar to the England averages for all registers; slightly better for all in relation to control but poorer for recording especially for stroke.

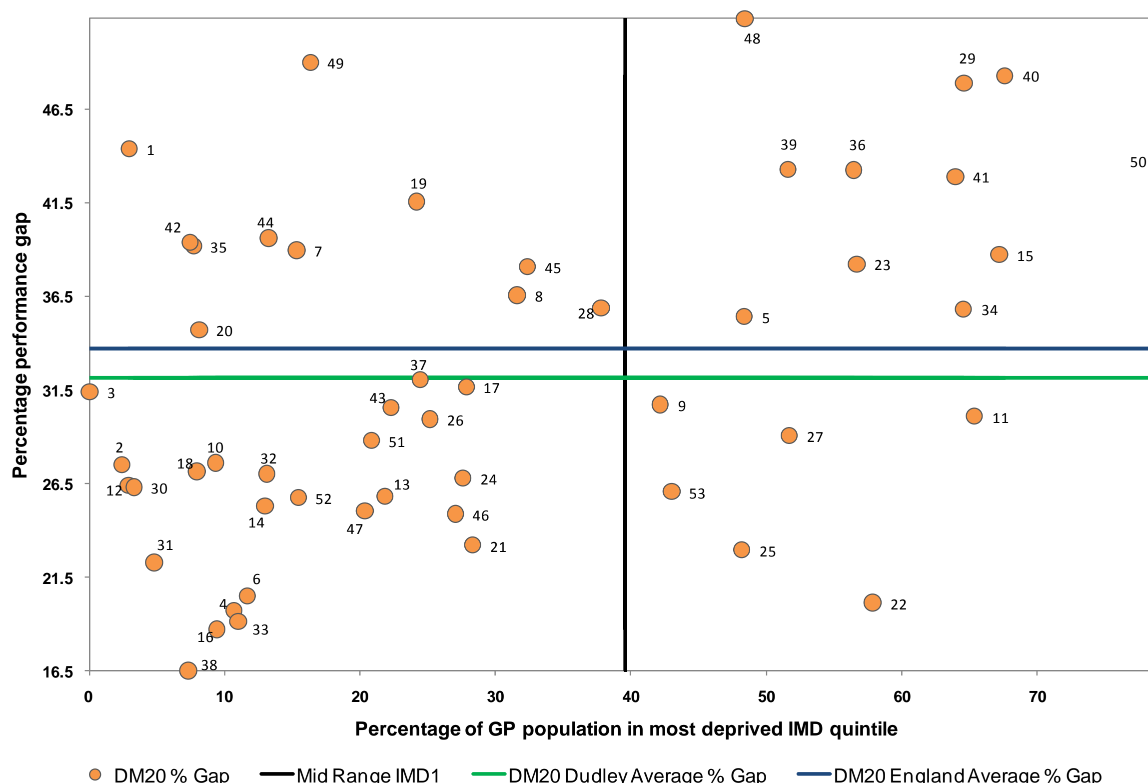
Performance variation cannot be explained by deprivation for Dudley as there was no association found between practice deprivation level and cholesterol control for any of the vascular disease/ condition registers. This is different to the national picture for cholesterol control for CHD (CHD8) where poorer control is still associated with more deprived areas. (CQC, 2009, p.17).

Blood Sugar Control in Diabetes

Performance gaps for optimum blood sugar control in diabetes are high and ranged from 16.5% to 51.3% against a Dudley average of 32% and an England average of 33.5%. (Figure 8)

There is a weak association between deprivation and practice performance with poorer control being evident for practices in more deprived areas.

Figure 8: Blood sugar control (HbA1c≤ 7.5) (r=0.43,r^2 =19%)



Source: Quality Outcomes Framework disease register 2008/09
Primary Care Mortality Data GP Registered Population
Department of Communities & Local Government Indices of Deprivation 2007

Cardio-protective Prescribing

Practice QOF performance for the prescribing of cardio-protective drugs is also extremely varied for all vascular disease/condition registers and was not associated with deprivation. QOF performance data does not give detail on whether drugs are titrated to the optimum levels, only that they are prescribed so giving an insight into access to treatment not equity of treatment outcomes. Dudley's average performance is similar to the England average - slightly better for all indicators. Performance gaps were much lower for the prescribing of the clot preventing drugs (antiplatelet/anticoagulant).

Table 4: Range of performance gap

Disease/condition register QOF clinical indicator	Percentage gap range	Dudley average	England average
CHD 11 (ACE-I/A2 Antagonist)	0% to 23.1%	10.0%	10.7%
Diabetes 15(ACE-I/A2 Antagonist)	0% to 100%	8.3%	10.3%
CKD5(ACE-I/ARB)	0% to 100%	13.3%	13.3%
Heart Failure 3(ACE-I/ARB)	0% to 20%	7.1%	10.0%
CHD10 (Beta blocker)	0% to 46.1%	22.8%	27.5%
CHD 9 (aspirin/anti-platelet or anti-coagulate)	0% to 14.5%	5.3%	5.8%
Stroke12 (aspirin/anti-platelet or anti-coagulate)	0% to 13.5%	4.9%	5.9%
AF3 (aspirin/anti-platelet or anti-coagulate)	0% to 10.6%	5.2%	6.3%

Lifestyle Risk Management Service Referrals (LRMS)

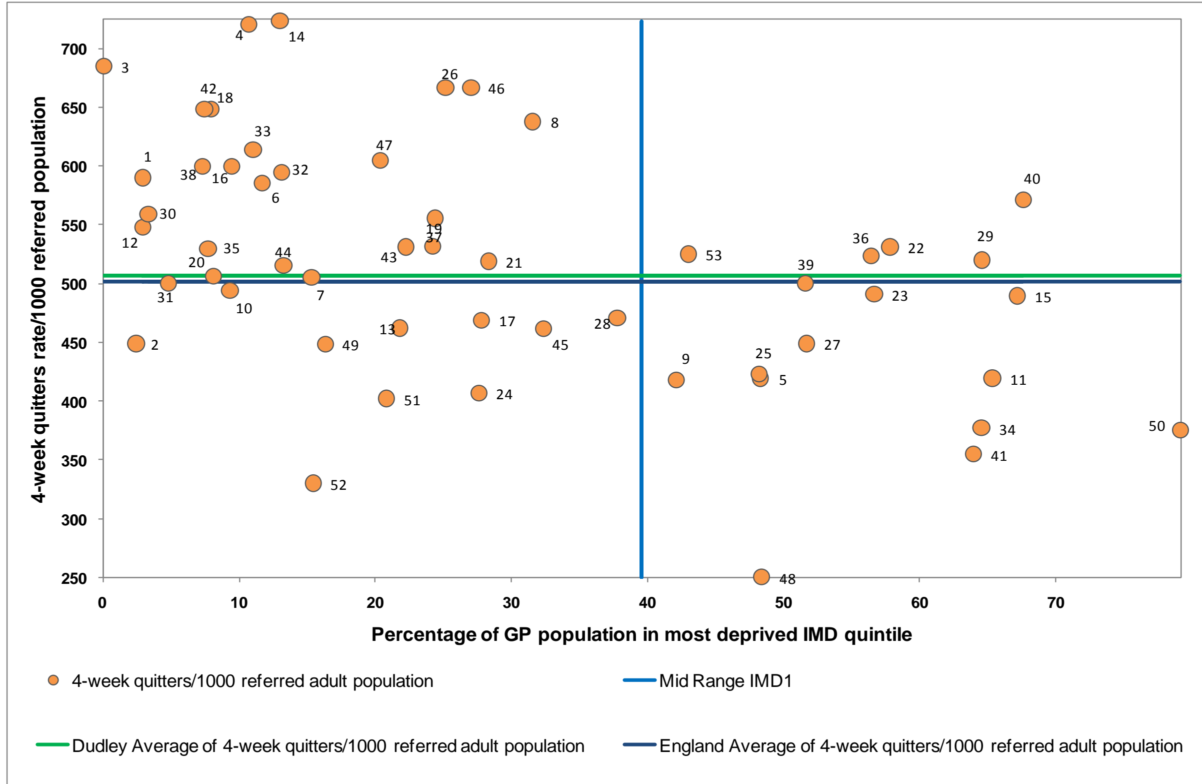
An important element of chronic disease management and secondary prevention is assessment of the patient's lifestyle and referral to LRMS where appropriate. Referral rates/practice were reviewed for physical activity referrals and 4 week smoking quitter rates. It was not possible to separate out primary and secondary prevention referrals.

Outcomes for stop smoking services in relation to 4-week quit rates were also reviewed to give an indication of the equity of treatment outcomes. Outcomes from physical activity referrals are not routinely available.

Practice referral rates for physical activity were extremely varied and not related to deprivation. They were also very low across practices ranging from 0 to 16/1,000 adult population with a Dudley average of 2.7/1,000. Overall 4 week quit outcomes for stop smoking were high, ranging from 250 to 721/1,000 referred adult population with a Dudley average of 500/1,000. (Figure 9)

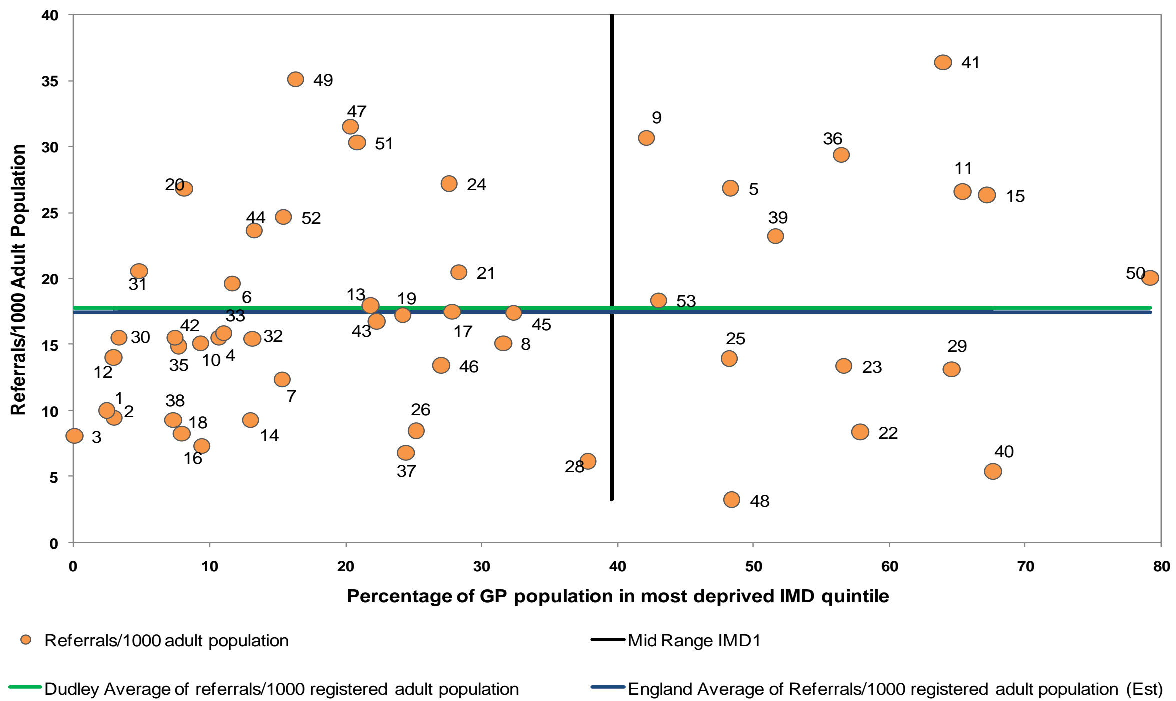
Practice referral rates for smoking showed a medium positive relationship to deprivation, with practices in deprived areas having higher referral rates. This matches need and suggests equitable provision as prevalence of smoking is greater in areas of higher deprivation. However outcomes across practices were very varied with practices in deprived areas having lower 4 week quit rates. So although people in deprived areas are more likely to be referred, they are less likely to stop smoking. (Figure 10)

Figure 9 : 4-week quit rates per practice IMD (r=0.3)



Source: Dudley Stop Smoking Service
Primary Care Mortality Data GP Registered Population
Department of Communities & Local Government Indices of Deprivation 2007

Figure 10: Stop Smoking Service Referrals per Practice IMD (2008/9 data)(r=0.49)



Source: Dudley Stop Smoking Service
Primary Care Mortality Data GP Registered Population
Department of Communities & Local Government Indices of Deprivation 2007

Conclusions:

The general conclusions from the analysis of QOF outcomes is that practice performance variance is very high and is not explained to a great extent by deprivation factors. In summary:

- There is a high level of under-reporting of prevalence, for all key vascular diseases/conditions, particularly for hypertension
- Deprivation factors are associated with lower prevalence recording for stroke and CHD
- There is a great variation in practice performance for all vascular disease registers for all indicators - prevalence recording, exception reporting, clinical treatment and control
- There are a number of practices that are consistent poor performers.
- There are high numbers of patients that are not being treated to optimum levels for blood pressure, cholesterol or blood sugar across the CHD, hypertension, stroke, diabetes and CKD registers
- Differences in access due to deprivation was not evident in the access to treatment once a patient is on a disease register. This was highlighted by the QOF indicators on exception reporting, blood pressure and lipid measurement, drug prescribing and referral to LRMS.
- Deprivation was a factor in relation to differences in outcome of treatment for some risk factors specifically the control of blood sugar and success at stopping smoking. It did not have an impact for the control of blood pressure or lipids.
- Low access rates were noted for exercise referral programmes, but access to stop smoking services was high.

Recommendations

The *Tackling Inequalities in life expectancy in areas with the worst health and deprivation* (Great Britain. Department of Health, 2010) recommends 3 key interventions to provide a cost-effective way of reducing the gap in life expectancy in relation to CVD:

- Increase the prescribing of drugs to control blood pressure by 40%
- Increase the prescribing of drugs to reduce cholesterol by 40%
- Double the capacity of stop smoking services

These have been taken into consideration in the following recommendations which focus in 3 areas:

- Ensuring strategies are in place for risk factor reduction, case-finding and early detection of the key vascular diseases
- Ensuring that high risk groups can access and use services and achieve equitable treatment outcomes
- Tackling the variation in practice performance and raising the level of overall performance to ensure more patients are treated to optimum levels. This priority will be covered in Section 8.1 on primary care.

The key priorities for action include:

1. Reduction in the gaps between actual and expected prevalence for the key vascular diseases via:

    - The implementation of NHS health checks, to ensure a high uptake from those who are most at risk and more unlikely to take up a health check e.g. men, BME communities and low income groups. Targeted promotions, out-reach services and case-finding especially in relation to hypertension should be part of this response.
    - Investigate practice outliers with low levels of prevalence for the CHD and stroke registers

2. Variation in performance across practices for treatment outcomes:

    - Investigate performance for practice outliers starting with blood pressure and cholesterol management

3. Develop an on-going programme of health equity audits supported by the incorporation of a health equity element into all planned primary care/service audits. E.g. medicines management audits, service reviews, improved ethnicity monitoring across primary care/ community services.

4. Put strategies in place to increase referrals to LRMS for those on practice registers and improve outcomes for patients from deprived areas.

5. Develop and implement a self care strategy as part of the long term conditions strategy so there is a menu of quality assured options for all newly diagnosed vascular patients.

7.2 ACUTE CARDIO-VASCULAR DISEASE (CVD), TRANSIENT ISCHAEMIC ATTACK (TIA) AND STROKE

This section focuses on the priority areas of acute care for CHD, specifically acute myocardial infarction (AMI) or heart attack, TIA and stroke.

Coronary Heart Disease (CHD)

A heart attack is said to have occurred when the myocardium (heart muscle) is damaged as a result of impaired blood supply. This is known as a myocardial infarction. The amount of damage is greatest when the blood supply to part of the heart is cut off altogether as a result of a thrombus (blood clot formation) within one of the coronary arteries (blood vessels) supplying that area of the heart. Under these circumstances, the electrocardiogram (ECG) recorded after the onset of occlusion will usually show an abnormality termed 'ST elevation'. Patients suffering from this condition are said to have sustained 'ST elevation myocardial infarction', abbreviated to STEMI and require emergency reperfusion treatment with either thrombolytic drugs or, the preferred option, primary percutaneous coronary intervention (PCI) by angioplasty and stenting, aiming to treat within 1 hour of the onset of symptoms. Non-ST elevation myocardial infarction or NSTEMI does not require very rapid emergency reperfusion treatment, but does require specialist cardiology involvement, access to angiography and coronary intervention in the form of drugs or revascularisation. STEMI accounts for approximately 40% and NSTEMI 60% of all MIs, although the number of STEMI is falling and NSTEMI remaining static (MINAP, 2009).

Establishing the level of health equity involves investigating if differences exist in access and treatment/ treatment outcomes based on deprivation, ethnicity, age, sex and occupation. The extent to which this can be achieved easily depends on the level of data available especially within routine data sets and also the coverage/reach of a service or programme. Routine hospital activity data has been used to examine equity of access, treatment/treatment outcomes. Areas reviewed include:

- Total admissions for CVD
- Admissions, and access to diagnostics and interventional treatment for acute myocardial infarction(AMI)
- Secondary Prevention Prescribing for AMI
- Cardiac rehabilitation

Admissions

Total admissions for all CVD increased by a small but statistically significant amount for the 3 year rate (2006/7-2008/9) This increase was due to an increase in elective admissions, particularly for women. (Figure 1). Emergency admissions remained constant. (Figure 2). All increases relate to hypertension admissions both elective and emergency particularly for men and also to elective diabetes admissions particularly for women. The admissions data for CVD and AMI shows that at the macro level, admissions generally reflected the higher risk and needs of specific

population groups including men, BME and deprived groups but that other factors other than actual need, strongly influenced access to treatment once deprivation, sex and age were accounted for.

Figure 1:

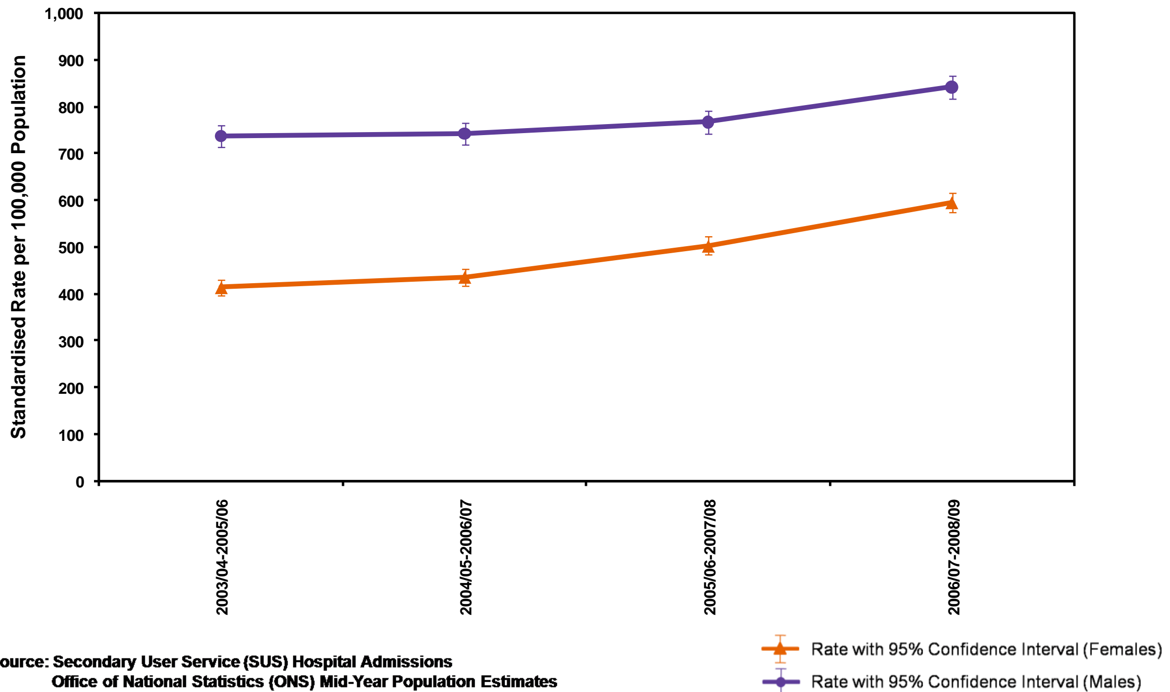


Figure 2:

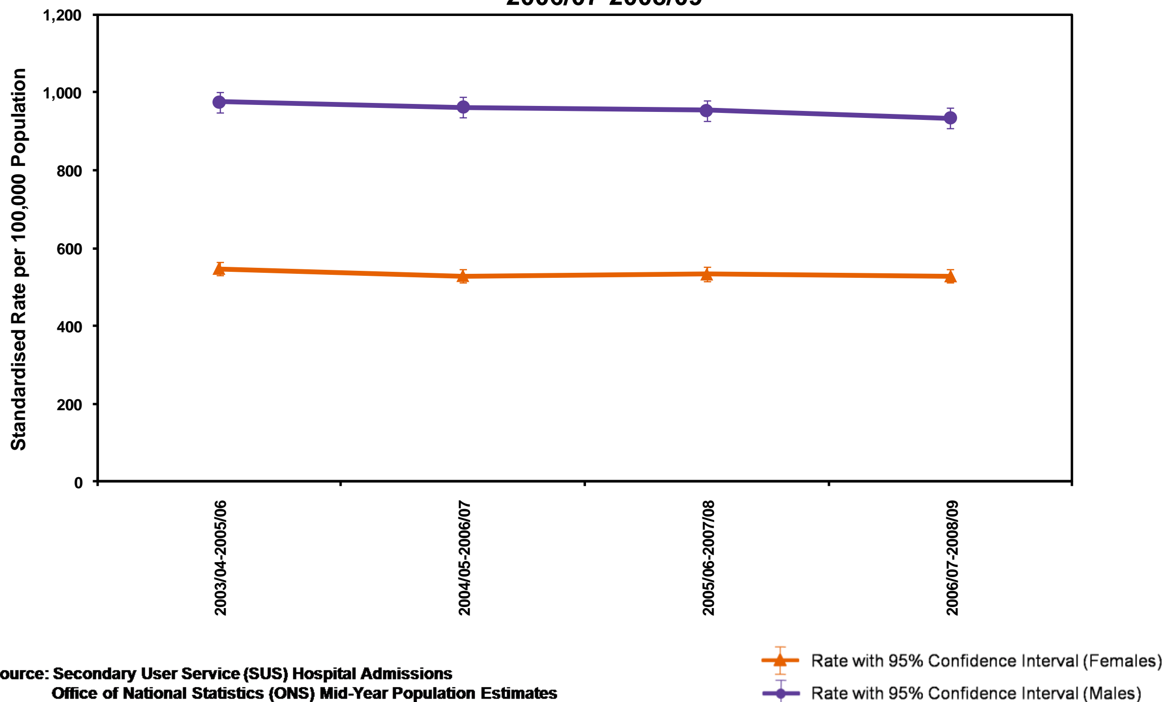


Figure 3:

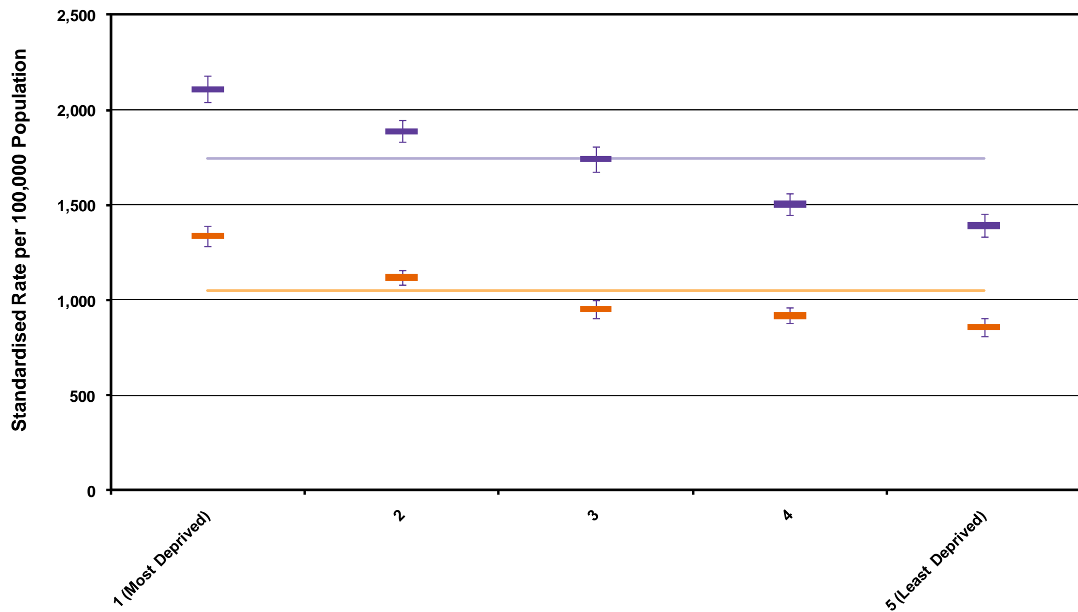


Figure 4:

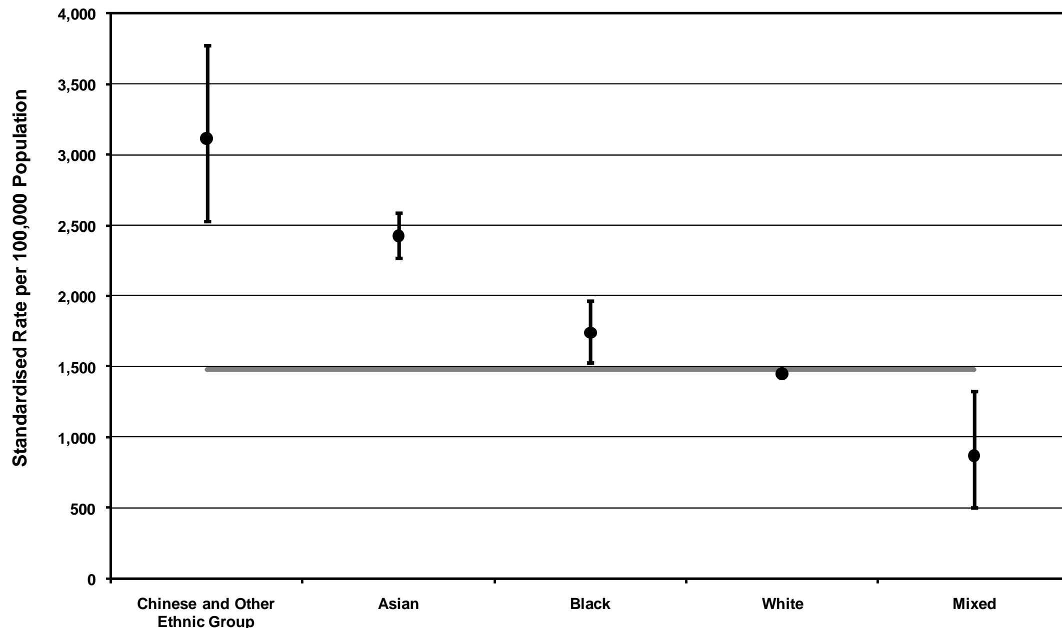


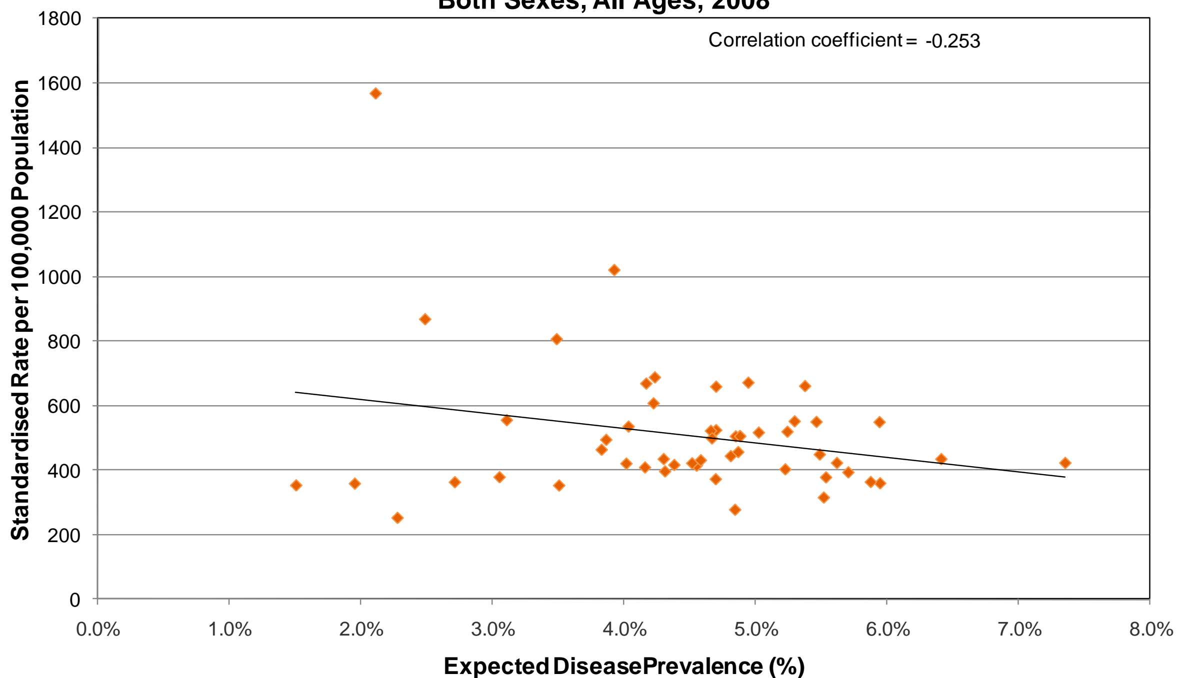
Figure 5

Directly Standardised Admission Rates from All admissions All CVD by Percentage of GP population in the Most Deprived IMD 2007 Quintile Both Sexes, All Ages, 2008

Source: Secondary Users Service (SUS) Hospital Admissions
Primary Care Mortality Data GP Registered Population
Department of Communities & Local Government Indices of Deprivation 2007

Figure 6:

Relationship between Directly Standardised Admission Rates from All admissions CHD and Expected Disease Prevelance by GP Practice Both Sexes, All Ages, 2008



Source: Secondary Users Service (SUS) Hospital Admissions
Primary Care Mortality Data GP Registered Population
Quality and Outcomes Framework 2008/09

Timely Response

Approximately 30% of patients who die of MI do so before reaching hospital. For the remainder, their prognosis is dependent on the time it takes to restore blood flow to the ischaemic myocardium. The earlier reperfusion is achieved, the greater the benefit. Mortality is twice as high in patients treated 4-6 hours after the onset of symptoms as it is in patients treated within 1-2 hours. Therefore, it is imperative that patients suffering an MI should receive medical attention as quickly as possible (BHF, 2006).

Timely access to treatment for AMI is dependent on:

- Public knowledge and awareness of signs, symptoms and speed of response
- Emergency response times
- Access to timely diagnostics and treatment - reperfusion

Public knowledge and awareness of the symptoms and need to call 999 is low in the general population and pre-hospital delays are greater in older people, women, deprived, ethnic groups and patients with pre-existing conditions. Currently there are no national or local awareness campaigns running.

Emergency reperfusion for Dudley patients is delivered by a tertiary level Primary PCI service for STEMI MI at the Heart and Lung Centre at New Cross Hospital (NCH) Wolverhampton. The Black Country is one of the first to roll out this service, with coverage across England currently at only 25% (MINAP, 2009). National good practice standards for PPCI have been set of 90 minutes between arrival at interventional centre and reopening of artery (door to balloon) and 150 minutes from call for help to reopening of the artery (call to balloon). Door to balloon times are dependant on speed of access to diagnostics and treatment within the hospital and call to balloon time incorporates ambulance response times and triage via other admission routes as well as hospital efficiency. Performance at NCH for 2008/9 was close to the average for England (Table 1).

Table 1: Speed of Access Measures for PPCI (Source MINAP data 2009)

PPCI measures	(door to balloon)	(call to balloon)
New cross hospital	82%	77%
England average	84%	79%

Source MINAP data 2009

Door to balloon times are specifically influenced by the method of admission. Routine data analysis at New Cross shows a mean average door to needle time for 999 ambulance admissions directly to the heart and lung centre as 67.8 minutes compared to 83.1 minutes for other admission methods e.g. via self presentation at New Cross A&E. 28% of patients entered the pathway by the self presentation route. This reiterates the need for public awareness campaigns.

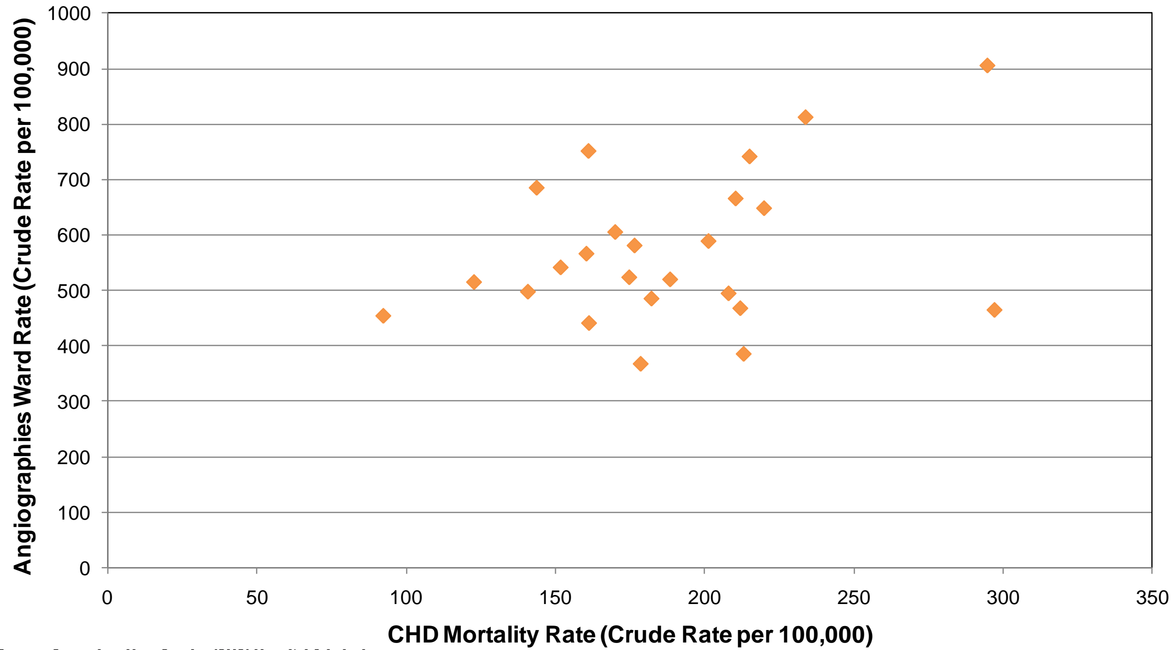
Acute MI is dealt with as a Category A call with a target response time of 8 minutes. Weekly Category A response times for the WMAS during 09/10 ranged from between 55% to 85% with an average of 72.3%.

For NSTEMI patients, a major influence on speed of access to diagnostic and appropriate treatment is whether they are admitted to a coronary care facility and seen by a cardiologist. MINAP have begun collecting data in this area and results for 2009 showed that for Dudley Group of Hospitals, 100% of NSTEMI patients were admitted to a cardiac ward/unit and 99% of them were seen by a cardiologist or member of the team.

Revascularisation – Access to Diagnostics and Interventions
Revascularisation includes primary percutaneous intervention (PPCI), PCI and coronary artery bypass grafts (CABG) and is the key intervention type for AMI both STEMI and NSTEMI. Angiography is the main diagnostic procedure. A health equity audit on access to angiography and revascularisation was carried out in Dudley for financial year 2004/5 (Atri, 2006) using 2003/4 data which showed the presence of health inequities for both diagnostics and treatment. Since this report, there have been increases in diagnostic and interventional capacity at the local hospital and the introduction of a new tertiary level PPCI service at New Cross.

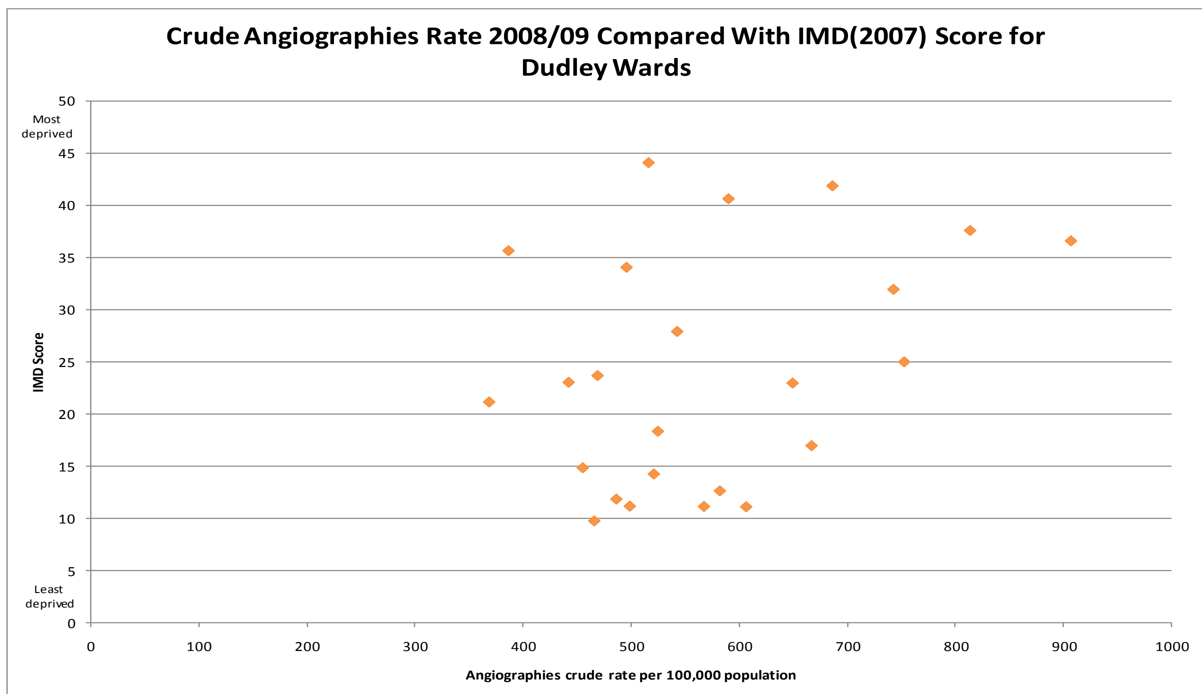
A review of the access to angiography and revascularization for 2008/9 data has identified an increase in access to diagnostics and revascularization. Dudley moved from having the lowest access rate to the highest rate across the Black Country with an SMR adjusted rate of 3609 per million population (pmp) for angiograms and 1757pmp for revascularisations. Increased access has improved the equity of access and narrowed inequalities as illustrated by Figures 7, 8, 9 and 10 which show moderate positive relationships between access rates and CHD mortality (as a proxy for need) and access rates and ward deprivation for angiograms and revascularisations. The latter was a stronger relationship than demonstrated in the 2004/5 audit, but is not as strong as the relationship between deprivation and CHD death rates which represents the full indication of need. Other factors besides actual need are still an influence, as these relationships were found to be weaker at the practice level.

Figure 7: Angiogram Access Source: Dudley PCT (r=0.35)



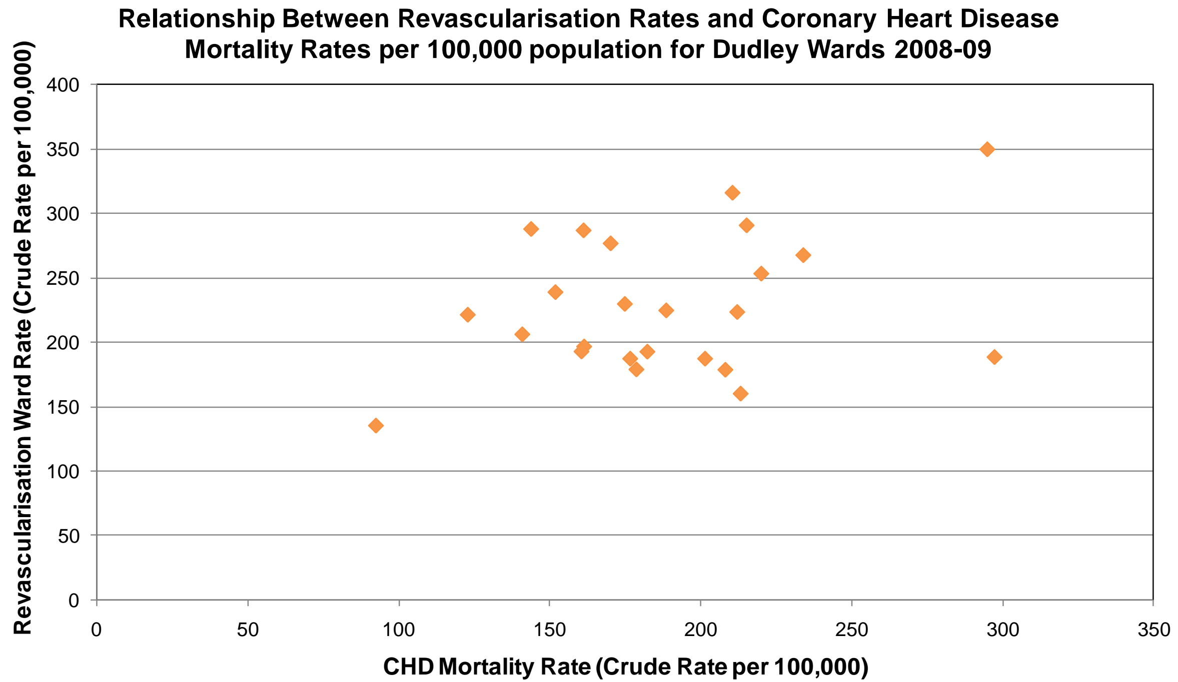
Source: Secondary User Service (SUS) Hospital Admissions
Office of National Statistics (ONS) Mid-Year Population Estimates
Office of National Statistics (ONS) Annual Deaths Extract

Figure 8: Angiogram Access (r=0.34)



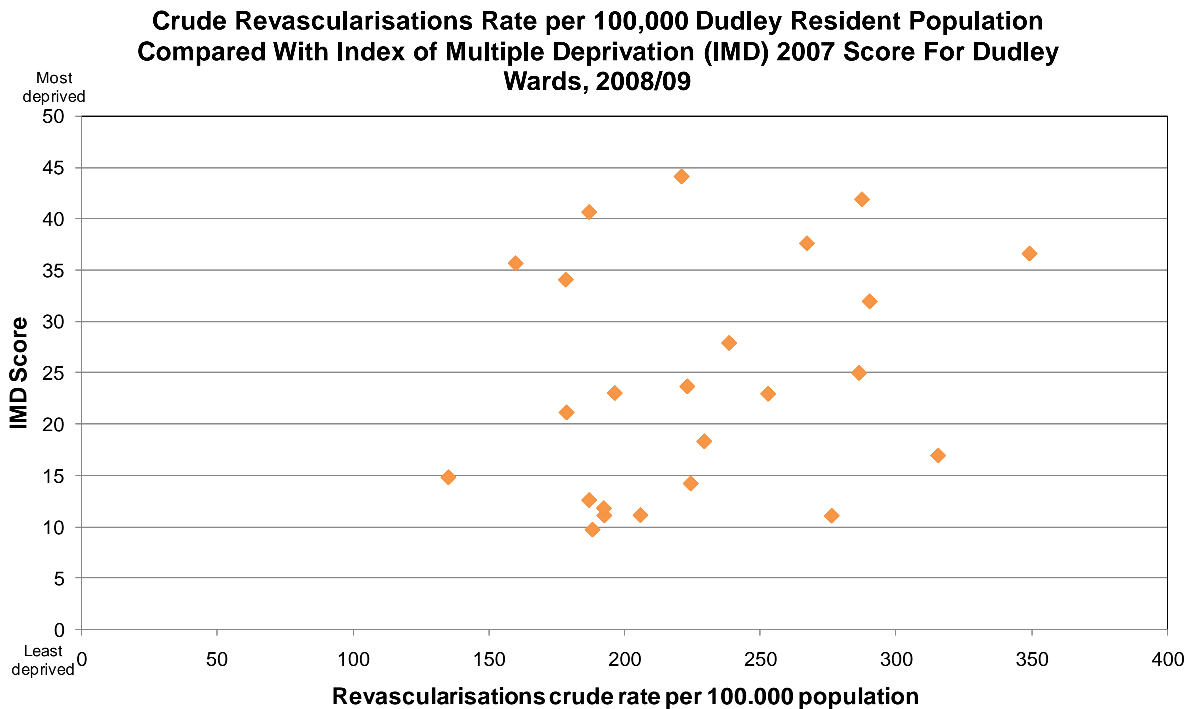
Source: Office of National Statistics (ONS) Annual Deaths Extract
Office of National Statistics (ONS) Mid-Year Population Estimates
Department of Communities & Local Government Indices of Deprivation 2007

Figure 9: Revascularisation Access (r=0.34)



Source: Secondary Users Service (SUS) Hospital Admissions
Office of National Statistics (ONS) Annual Deaths Extract
Office of National Statistics (ONS) Mid-Year Population Estimates

Figure10: Revascularisation Access (r=0.26)



Source: Office of National Statistics (ONS) Mid-Year Population Estimates
Department of Communities & Local Government Indices of Deprivation 2007

Cardiac Rehabilitation

Dudley has a gold star cardiac exercise rehabilitation service providing a 26 week structured exercise programme at phase 3 followed by a further 26 weeks maintenance programme at phase 4. All patients are offered cardiac exercise rehabilitation post MI, and post MI revascularization, PCI, PPCI and CABG, and for stable and unstable angina. Table 2 shows uptakes across the conditions were variable for 2008/9 in Dudley reflecting the national picture.

Table 2

Cardiac Rehabilitation Uptake Rates (2008/9)	Total patients discharged with primary diagnosis	Estimated No of patients eligible/referred for cardiac rehab*	Number starting cardiac rehab	% of those eligible starting cardiac rehab
Acute MI	362	304	131	43.1%
Coronary revascularisation CABG/PCI	388	326	156	47.8%
ACS unstable angina	147	124	30	24.2%
Stable Angina	145	122	42	34.4%
PPCI	114	95	68	71.6%
Other (HF, arrhythmias)	144	121	52	42.9%

*This data was not routinely available for 08/09, hence this is an estimation based on the Black Country Cardiac Network uptake of cardiac rehabilitation study which identified an 84% uptake rate for Action Heart. This data will be routinely available from 09/10.

An uptake study was conducted across the Black Country during 2008/9 which identified that 16% of patients were not referred for Cardiac Rehabilitation in Dudley and showed significant differences in referral by age, diagnostic group, ethnicity, gender and employment status. The audit was repeated during 09/10 with larger numbers so that a more detailed analysis could be carried out at each health economy level but this is not yet available.

Conclusions

The general conclusions from this acute CHD Health Needs Assessment are:

- The admissions data for CVD and AMI shows that at the macro level, admissions generally reflect the higher risk and needs of specific population groups including men, BME and deprived groups but that other factors other than actual need, strongly influence access to treatment once deprivation, sex and age are accounted for.
- Public knowledge and awareness of the symptoms and need to call 999 is low in the general population and pre hospital delays are greater in older people, women and patients with pre-existing conditions. There are also health seeking behaviour differences for ethnic and deprived groups

- That an increase in access to diagnostics and revascularisation for acute MI resulting from the opening of the tertiary PPCI service and general capacity improvements within secondary care has improved the equity of access and narrowed inequalities over the last five years. Some factors besides actual need are still an influence.
- That there are significant differences in referral to cardiac rehabilitation by age, diagnostic group, ethnicity, gender and employment status that needs to be investigated

Recommendations for Acute CHD

The NST identifies a number of priority areas for action and this section draws on those in conjunction with the main findings from this health needs assessment:

- Introduce public awareness campaigns with a targeted approach to groups with higher needs; over 65s, BME, women and deprived areas. Health care professionals should take every opportunity to advise all patients with, or at high risk of, vascular disease to call 999 should they experience unexplained chest pain.
- Continue to embed delivery of expanded services for acute MI diagnostics and revascularisation and review the equity of provision in a further 5 years time.
- Investigate reasons for 'no procedures' being undertaken with the PPCI service
- Repeat the cardiac rehabilitation equity audit with larger numbers to establish a fuller picture and implement recommendations made from this. This should include a review of DNAs and DNRs for cardiac rehabilitation and the establishment of routine procedure to follow-up these groups.

Transient Ischemic Attack (TIA) and Stroke

Until fairly recently society has been fatalistic about stroke seeing it as an inevitability of aging. However medical and technological advances have transformed our understanding of the brain and the treatments available for restoring blood flow and improving brain function when areas of the brain get damaged. It is now recognized that time is critical – the faster someone reaches expert help, the greater their chances of making a full recovery.

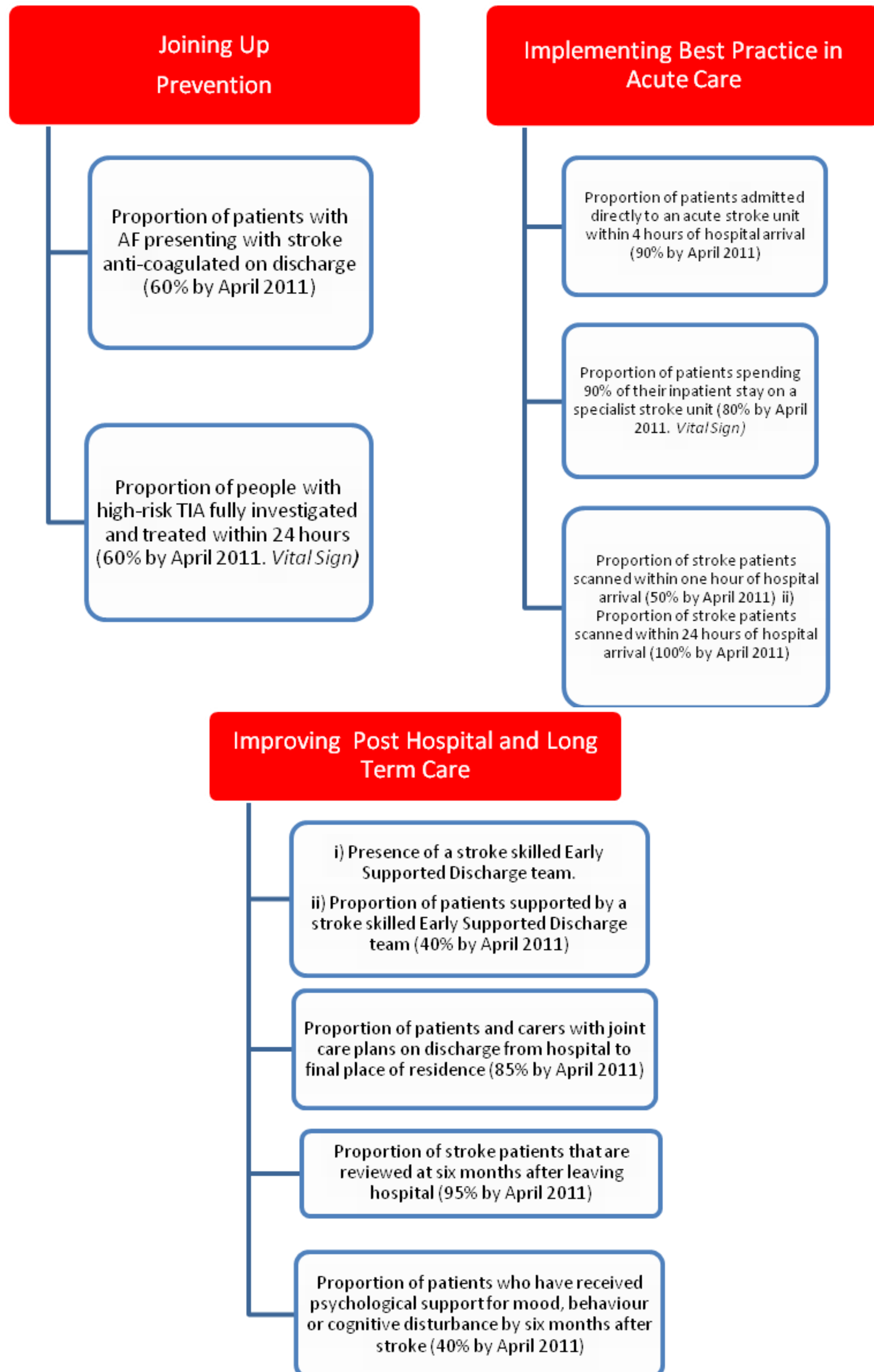
The *National Stroke Strategy* (Great Britain. Department of Health, 2007a) was published with a view to introduce a comprehensive revolution of stroke services with the implementation of rapid response systems that get people to centres of expertise quickly, directly to the scan they need and onwards to appropriate treatment and care. Key priorities within the stroke strategy include:

- the need to speed up access to diagnostic scanning/imaging for TIA
- the need to ensure stroke is treated as a medical emergency (hyper acute stroke) with access to diagnostics and thrombolysis within an appropriate timeframe. 'Time means brain'.
- improving rehabilitation and long term care

The stroke strategy was followed by the Accelerating Progress in Stroke Care Improvement Programme in March 2010 which set a number of national indicators for stroke and TIA care with targets for achievement by April 2011 (Figure 11) to

speed up delivery of the National Stroke Strategy within the worsening financial climate. NICE have also produced a set of quality standards that dovetail into the national indicators. Best practice tariffs have also been introduced from April 2010 incentivising hospitals to achieve targets and quality standards in relation to care provided on an acute stroke unit and timely delivery of initial brain imaging.

Figure 11



Establishing the level of health equity involves investigating if differences exist in access and treatment/ treatment outcomes based on deprivation, ethnicity, age, sex and occupation. The extent to which this can be achieved easily depends on the level of data available especially within routine data sets and also the coverage/reach of a service or programme. Developments within stroke/TIA are relatively new - coverage of new service developments are low and data systems are in development or very recently implemented. As a result this section has gaps in its analysis and makes recommendations for future audits. Areas reviewed include:

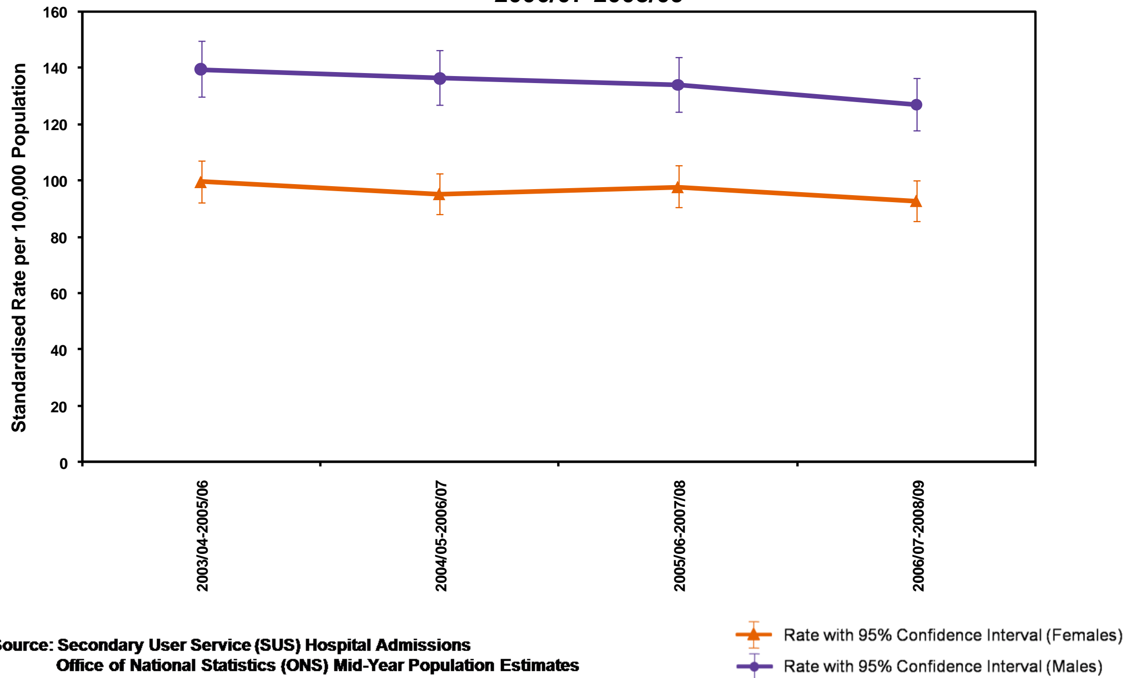
- admissions for stroke and TIA,
- timely access to treatment for emergency stroke and TIA,
- access to timely diagnostics and treatment for urgent and non-urgent stroke and TIA.

The pathways for stroke and TIA can be categorised into urgent and non urgent. For urgent (hyper acute) patients should be admitted to a stroke ward, given the appropriate scans within 1 hour and thrombolysed within 3 hours. Dudley Group of Hospitals introduced a 24/7 thrombolysis service in 2007 to meet this requirement. For non urgent stroke, patients should be admitted to a stroke ward and scanned within 24 hours. TIA patients identified as urgent - at high risk of stroke, may or may not be admitted, but should be scanned and treated within 24 hours. Those at low risk should be treated and managed within 7 days. In Dudley, a fast track referral system operates within the hospital and throughout primary care to ensure urgent and non urgent cases are treated at the TIA clinic within the necessary time frames.

Admissions

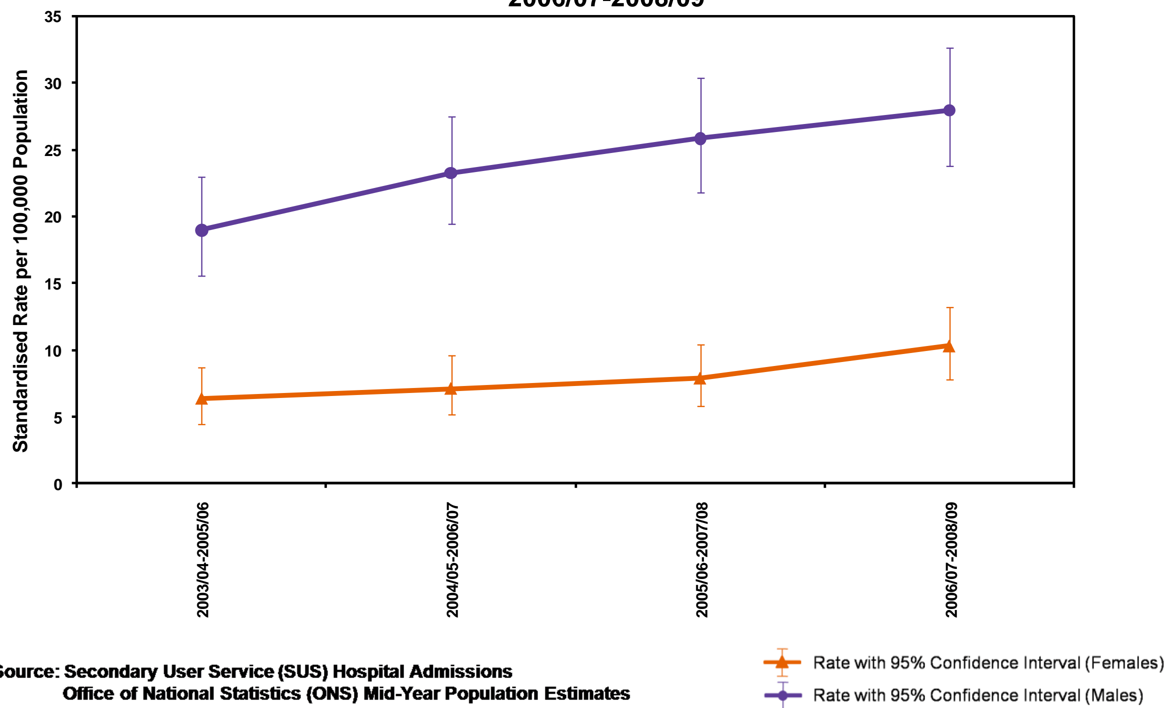
Emergency admissions have been relatively static over the last 5 years for both men and women, while elective admissions have risen, especially for men, although this is not a statistically significant rise. Men have higher rates of admissions than women overall, which reflects their higher risk of CVD. The admissions data for stroke and TIA shows that at the macro level, admissions generally reflected the higher risk and needs of specific population groups including men, BME and deprived groups but that factors other than actual need, strongly influenced access to treatment once deprivation, sex and age were accounted for.

Figure 12



Source: Secondary User Service (SUS) Hospital Admissions
Office of National Statistics (ONS) Mid-Year Population Estimates

Figure 13



Source: Secondary User Service (SUS) Hospital Admissions
Office of National Statistics (ONS) Mid-Year Population Estimates

Figure 14

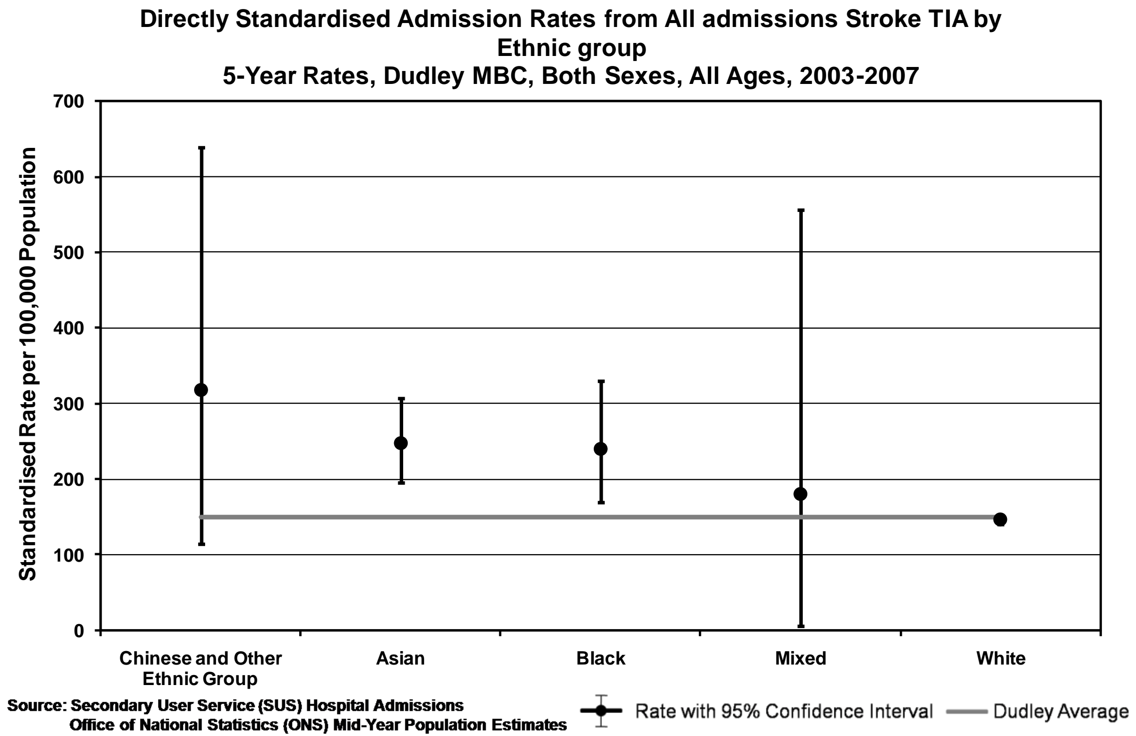


Figure 15

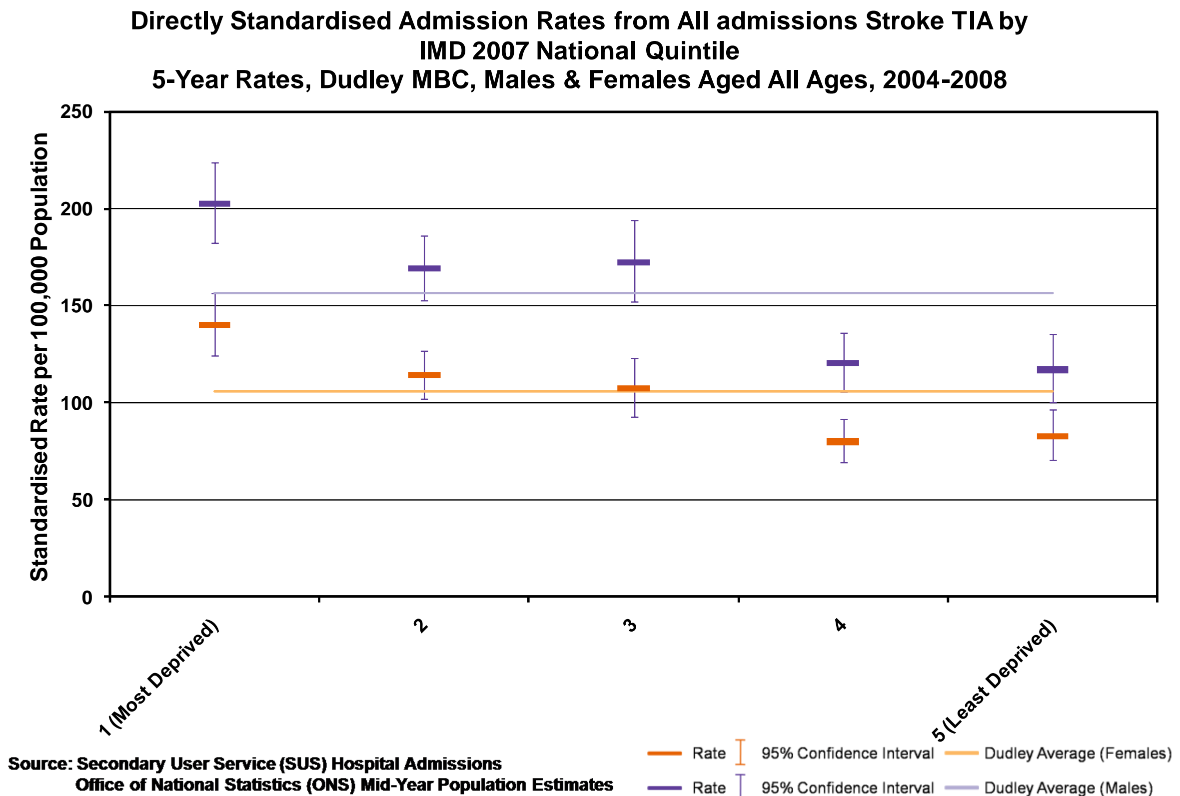
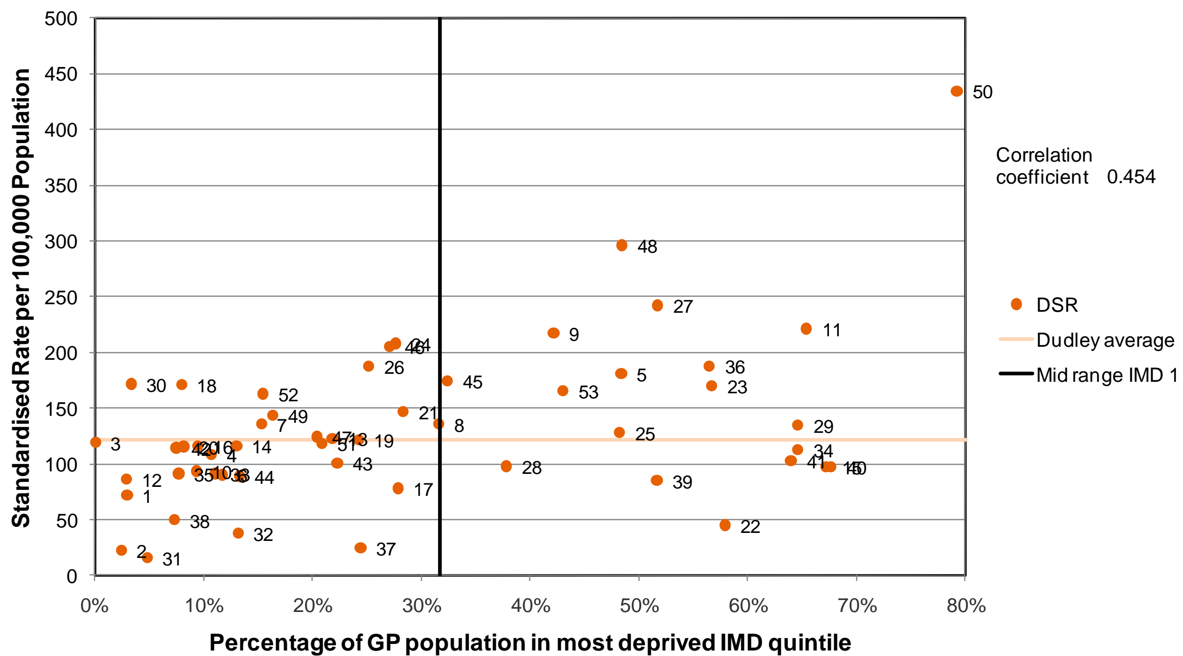


Figure 16:

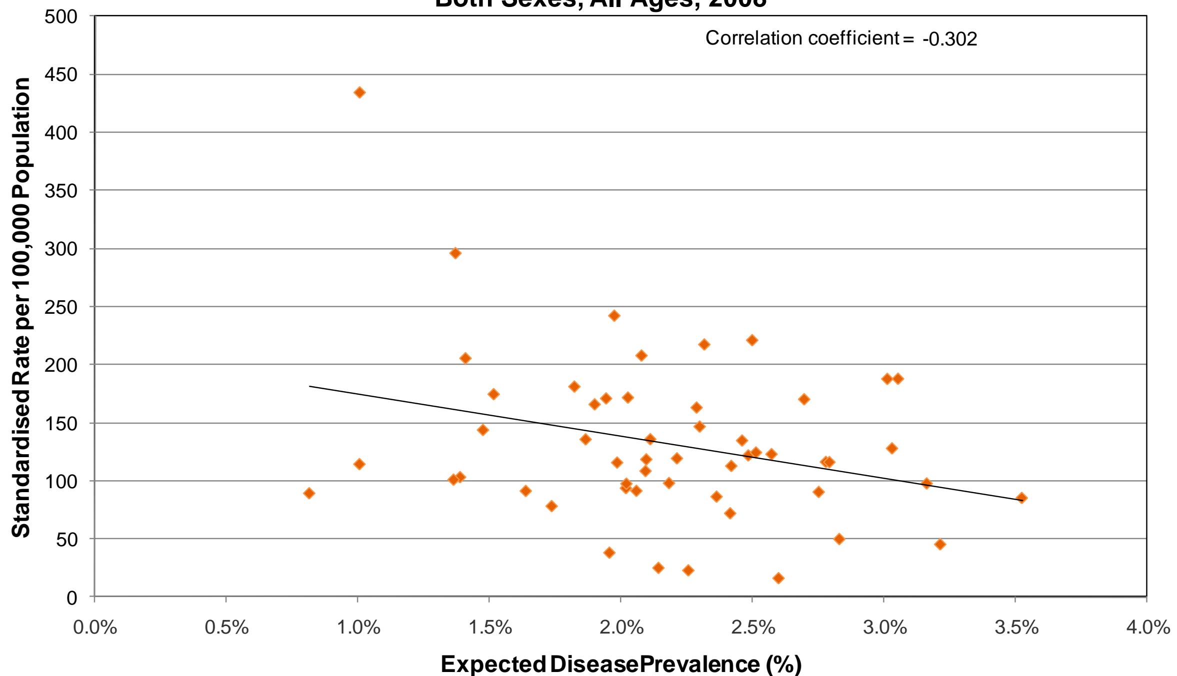
Directly Standardised Admission Rates from All admissions Stroke TIA by Percentage of GP population in the Most Deprived IMD 2007 Quintile Both Sexes, All Ages, 2008



Source: Secondary Users Service (SUS) Hospital Admissions
Primary Care Mortality Data GP Registered Population
Department of Communities & Local Government Indices of Deprivation 2007

Figure 17

Relationship between Directly Standardised Admission Rates from All admissions Stroke TIA and Expected Disease Prevelance by GP Practice Both Sexes, All Ages, 2008



Source: Secondary Users Service (SUS) Hospital Admissions
Primary Care Mortality Data GP Registered Population
Quality and Outcomes Framework 2008/09

Timely Response

Timely access to treatment for stroke/TIA is dependent on:

- Public knowledge and awareness of signs, symptoms and speed of response
- Ambulance response times and use of validated tools to diagnose stroke/TIA
- Access to timely diagnostics and treatment

Public knowledge and awareness of the symptoms and need to call 999 for stroke is low. The national F.A.S.T campaign was introduced in 2009 and evaluation of this was carried out in May 2009 by Central Office of Information on behalf of the Department of Health (Central Office of Information, 2009), and has shown some positive results. Pre and post awareness levels were measured and showed increases in the need to call 999 from 58% to 70% amongst the general population (52% to 62% amongst the black Caribbean and South Asian populations), awareness of early detection being beneficial from 53% to 66% in the general population (42% to 51% for black Caribbeans and South Asians) and in recognition of symptoms from 79% to 89% in the general population (67% to 83% for black Caribbeans and South Asians). The lower levels of awareness within key Black and Minority Ethnic communities needs to be addressed since they are at higher risk of stroke. Lower levels of awareness has also been found for the over 65s (The Stroke Association, 2007). Local data for awareness in Dudley is not available; however one can assume a similar pattern of awareness. There have been a number of FAST campaigns in Dudley which have been aimed at the general population, particularly in lower income areas. There are currently no targeted campaigns for older people or BME communities.

For those who call 999, thrombolysis can be an effective treatment for stroke if delivered within 3 hours of the on-set of symptoms, thus the patient needs to be diagnosed using FAST, receive a category A ambulance response (8 minute response) with rapid referral to hospital for imaging within one hour and subsequent drug administration. TIA patients that are of a high risk of stroke are also required to be identified using the ABCD2 score and imaged within 24hours. The NICE quality standard measures the proportion of total stroke and TIA screened by ambulance staff and transferred to a stroke unit within one hour. This is a new metric, and the 4 months data for 2010 shows a slow increase to 25% in May 2010 against a target of 100%.

TIA and Stroke Diagnostics and Services

The accelerating stroke programme and associated targets was only recently launched in March 2010 hence the metrics, and data collection processes and service developments are relatively new. Table 3 gives a snapshot of Dudley's position against April 2011 targets. Data available in most cases is just 4 months. The table indicates the month 4 position (May).

Table 3

	Metric for May 2010 (unless stated)	April 2011 target
High risk TIA treated within 24hours	64% (09/10 yr data)	60%
Stroke patients scanned within 1 hour of hospital arrival	14%	50%
Confirmed ischemic stroke thrombolysed	3%	10%
Stroke patients scanned within 24 hrs of hospital arrival	55%	100%
Patients spending 90% of time on stroke unit	71%	80%
Eligible patients receiving first dose of aspirin (or alt) within 24 hours	71%	100%
Stroke patients with AF anti-coagulated on discharge	35%	60%

Generally, service and pathway developments are in the early stages of advancement and it is too early for a realistic focus on equity auditing. The priority is to continue to increase general capacity and speed of access to diagnostics and treatment and achieve the April 2011 targets for the metrics above. If any metrics remain significantly below target, equity auditing can be considered to compare demographics of patients receiving optimum versus non optimum care.

Conclusions:
The general conclusions from this acute stroke/TIA health inequalities health needs assessment are:

- The admissions data for stroke/TIA shows that at the macro level, admissions reflect the higher risk and needs of specific population groups including men, BME and deprived groups
- Public knowledge and awareness of the symptoms and need to call 999 is lower in certain high risk groups - particularly BME groups and over 65s
- Service and pathway developments for acute stroke/TIA are in the early stages of advancement following the publication of the *National Stroke Strategy* (Great Britain. Department of Health, 2007) in December 2007 and the accelerating Stroke Improvement Programme in March 2010 and it is too early for a realistic focus on equity auditing. The priority is to continue to increase general capacity and speed of access to diagnostics and treatment as identified within the PCT's/health economy's current priorities and work-streams and driven by continual review of vital signs, national targets and sentinel audit data.

Recommendations for Acute Stroke/TIA

The NST identifies a number of priority areas for action and this section draws on those in conjunction with the main findings from the HNA:

- Continue FAST awareness programmes with an emphasis on segmentation and use of social marketing to ensure the message reaches all communities, to include the development of targeted campaigns for BME and the over 65s

- Continue implementation of current stroke/TIA workstreams to increase speed of access to diagnostics and treatment to meet the national targets set out in the accelerating stroke improvement programme in all cases, specifically:

  - If any metrics remain significantly below target, consider equity auditing to compare demographics of patients receiving optimum versus non optimum care.
  - Audit GP TIA referrals data for consistency
  - Review GP practice performance for outlying practices in relation to admissions data

7.3 TOBACCO CONTROL

Introduction
Tobacco control is collective action taken to reduce smoking prevalence; as research shows that no single approach to tackling smoking will be successful in isolation. The Government has implemented a comprehensive range of measures over the last decade based on the World Health Bank recommendations known as the 'six strand' approach. The six strands are:

1. Reducing exposure to secondhand smoke (SHS)
2. Communication and education
3. Reducing the availability and supply of cheap tobacco
4. Support for stop smoking services
5. Reducing tobacco promotion
6. Tobacco regulation

This approach has been shown to be highly effective in England with some of the measures being largely self sustaining, for example the health warnings on tobacco packs and smokefree public places. Key areas that require continued funding and intervention at local level are the provision of stop smoking services, tackling illicit tobacco and communications and education campaigns (APPG, 2010).

Cigarette smoking is closely and pervasively linked to a wide range of markers of socioeconomic and personal disadvantage resulting in increased well known health risks. Smoking also directly exacerbates poverty, by taking up a substantial proportion of disposable income and pre-empting expenditure on basic necessities such as food and clothing (RCP, 2000).

Nationally, around 35% (22,000) of all deaths due to respiratory diseases and 29% (37,500) of all cancer deaths were attributable to smoking. In addition, 14% (20,600) of deaths due to circulatory diseases and 6% (1,300) of deaths due to diseases of the digestive system were attributable to smoking (ONS, 2010). **In Dudley, it is estimated that between 2006-8, there were 1,497 deaths that were attributable to smoking** (Dudley PCT, 2009a).

Smoking in pregnancy can increase infant mortality by approximately 40% (Great Britain. Department of Health, 2009b). Babies born into poorer households are significantly more heavily exposed to passive smoking throughout infancy and childhood, and non-smokers living in more deprived circumstances remain more heavily exposed to other people's smoke throughout life. Being born into an environment where smoking is modelled as the norm inevitably leads to higher rates of smoking uptake in adolescents from poor backgrounds (RCP, 2000), therefore perpetuating smoking and health inequalities.

Smoking prevalence in pregnant women nationally was 14% in 2008 as measured by women's self-reporting at the time of delivery (this is widely thought to be an underestimate since there is evidence of significant underreporting. (Great Britain. Department of Health, 2009b)· The PSA (2010) target was to:

“reduce smoking during pregnancy to 11% by 2015

In Dudley smoking prevalence at time of delivery reduced from 17% in 2005 to 15% in 2009 then rose again in 2010 to 17%. (DGH, 2010). However data from the Perinatal and Infant Mortality programme, shows Dudley to have a prevalence of 9.5% at delivery for 2009 and 5.7% for 2010 (Q1&Q2), with Dudley achieving the highest smoking cessation rates across the West Midlands. This data collection was funded by the NHS West Midlands ‘Investing for Health’ programme and collects routine data from maternity handheld records, including smoking status at booking, delivery and smoking cessation rates, on a case by case basis. The aim is to understand the key reasons why perinatal and infant mortalities occur, and develop early interventions which will reduce their incidence. This data is audited regularly and shows good quality case ascertainment and data collection. Work is ongoing in partnership with Midwifery Services to understand the reasons for the data variations between the two methods and improve data quality and reporting.

Overall smoking prevalence in England has decreased from 28% in 1998 to 21% in 2008, with 21% of men and 20% of women reporting smoking (NICE, 2008b). However, prevalence of smoking amongst people in the routine and manual socio-economic group continues to be greater than amongst those in the managerial and professional group 26% and 15% respectively in 2007. In 2008 the prevalence in the routine and manual group rose slightly to 28% (ONS, 2010) highlighting there is still more to be done to achieve the 2010 Public Service Agreement on smoking to:

“reduce adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less”

The overall smoking prevalence for Dudley as determined by the Dudley Health Survey 2009 is 18.5% (Dudley PCT, 2009b). Whilst the overall smoking prevalence is lower than the national average, and has fallen from 21% in 2004 it varies significantly with ward area, social deprivation, age, and gender.

Smoking Prevalence by Ward Area

Table 1 shows smoking prevalence by ward in Dudley. The wards with smoking prevalence higher than both the national and local average in bold type are Brierley Hill (26%) closely followed by Castle and Priory, St Andrews, Quarry Bank and Cradley (25%), Coseley West (24%), St Thomas (23%), Lye and Wollescote, Brockmoor and Pensnett and Gornal Wood (22%). Wall Heath and Kingswinford North has the lowest prevalence at 9%.

Table 1

Ranking of Dudley Wards of Indices of Multiple Deprivation (IMD 2007) comparable to smoking prevalence 2009

Ward Names	IMD 2007 National Rank 1 = Most Deprived 7928 = Least Deprived	Smoking Prevalence 2009
Castle & Priory	504	**25%**
St. Thomas	644	**23%**
Netherton & Woodside	696	19%
Brierley Hill	807	**26%**
Lye & Wollescote	1008	**22%**
St. James	1066	18%
Brockmoor & Pensnett	1138	**22%**
St. Andrews	1264	**25%**
Coseley East	1655	20%
Quarry Bank & Cradley	2106	**25%**
Belle Vale & Hasbury	2150	18%
Coseley West	2249	**24%**
Gornal Wood	2360	**22%**
Halesowen North	2487	16%
Wollaston & Stourbridge West	2994	18%
Hayley Green	3775	14%

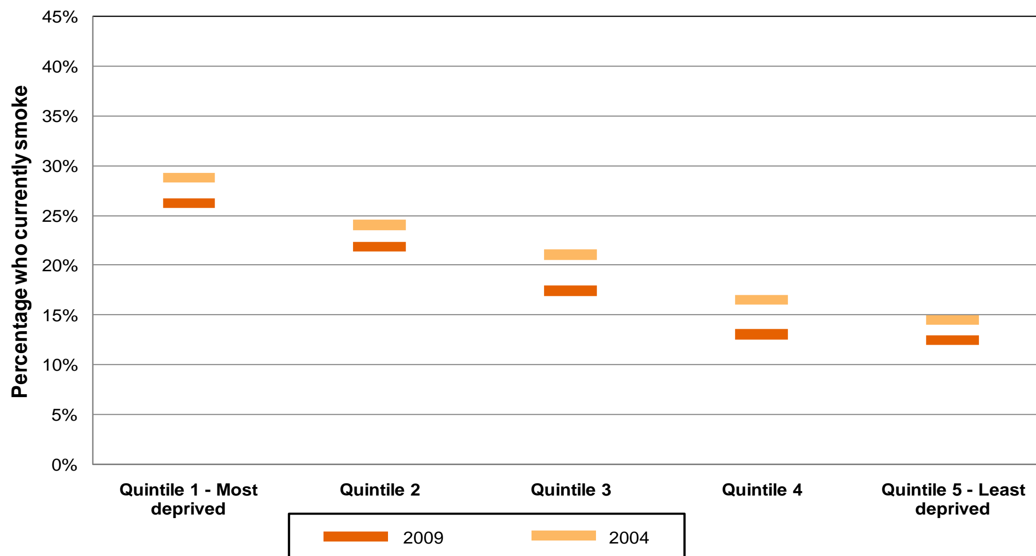
Ward Names	IMD 2004 National Rank 1 = Most Deprived 7932 = Least Deprived	Smoking Prevalence 2009
Wordsley	4153	18%
Amblecote	4252	14%
Kingswinford South	4804	18%
Pedmore & Stourbridge East	4806	20%
Norton	5065	12%
Halesowen South	5457	18%
Sedgley	5704	14%
Wall Heath & Kingswinford North	5954	9%

Key
Among the 10% most deprived wards nationally
Among the 10 – 50% most deprived wards nationally
Among the 50% least deprived wards nationally

Smoking Prevalence by Deprivation

Figure 1 shows the smoking prevalence by IMD quintile in Dudley which highlights in 2009 the proportion of smokers in the most deprived areas was 26% compared to 12.5% in the least deprived area. This compares to the national picture indicating further targeting of services for smokers in these groups is needed.

Figure 1

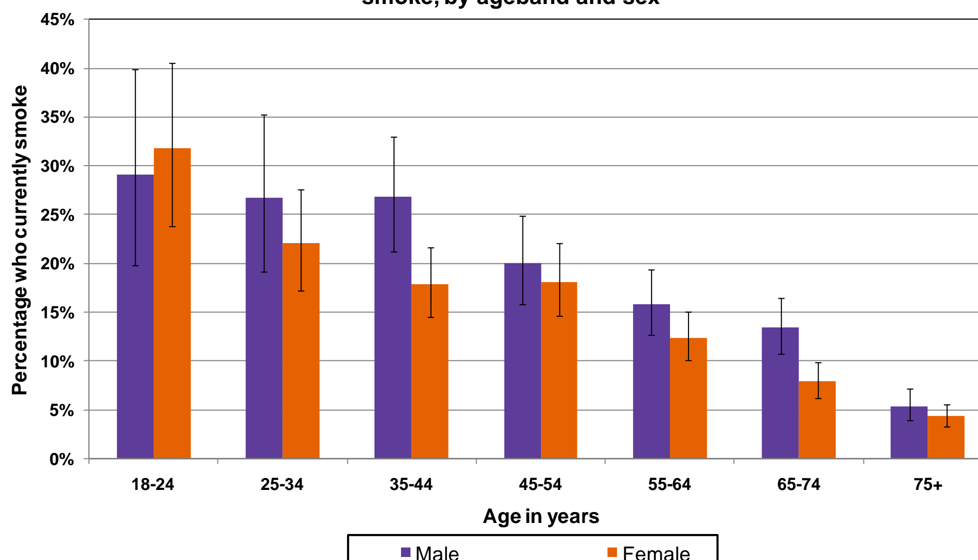


Source: Dudley Health Survey 2004 and 2009

Smoking by Age and Gender

Figure 2 shows the smoking prevalence by age band and gender in Dudley. In both sexes the proportion of respondents who smoke is highest in 18-24 year olds and falls with increasing age. In 18-24 year olds the proportion of females who smoke is higher than the proportion of males, but in all other age bands the proportion is higher in males than females. Overall more men report as being smokers (20.5% compared with 16.6% women).

Figure 2



Source: Dudley Health Survey 2009

Smoking Prevalence Targets

A new Tobacco Control Strategy for England – A Smokefree Future was released in February 2010 (Great Britain. Department of Health, 2010a), by the then government, which outlined challenging aspirations to further reduce smoking rates.

The Smoke Free Futures vision contained three overarching objectives:

1. To stop the inflow of young people recruited as smokers.
   - ***Aspiring to reduce the 11–15-year-old smoking rate to 1% or less, and the rate among 16 and 17-year-olds to 8% by 2020.***
2. To motivate and assist every smoker to quit.
   - ***Aspiring to reduce adult smoking rates to 10% or less, and halve smoking rates for routine and manual workers, among pregnant women and within the most disadvantaged areas by 2020.***
3. To protect our families and communities from tobacco-related harm.
   - ***Aspiring to increase to two-thirds the proportion of homes where parents smoke but that are entirely smokefree indoors by 2020.***

It is unclear at this stage whether the new coalition government will continue with these aspirations and we await confirmation in the Public Health White Paper due to be released in December 2010.

Tobacco Control in Dudley

A considerable amount of action on tobacco control has been underway in Dudley for many years. A Tobacco Control Strategy for Dudley was developed in 2007 – Creating a 'Smokefree Generation' - which outlines a local partnership approach and key priorities to provide children and young people in Dudley a fair chance to grow up in a smokefree environment where smoking is not seen as the norm.

The strategy was developed by the Tobacco Action Group (TAG) in line with the Department of Health's six strand approach. It set out a clear three year action plan and monitoring framework from 2007-10. The group reports regularly to the Dudley Health and Wellbeing Partnership. The strategy will be reviewed and updated in view of the new national Tobacco Strategy and Public Health White Paper due out in December 2010.

Dudley also takes the lead in co-ordinating the Black Country Tobacco Control Alliance (BCTCA), which facilitates a more strategic approach to tobacco control activities across the four Black Country boroughs through partnership working, sharing of resources and good practice and joint project and campaign work. The BCTCA is focussing joint action on tackling illicit tobacco.

Dudley PCT identified the Tobacco Control programme as one of its key World Class Commissioning (WCC) priorities in 2010 supported by additional recurrent investment within the PCTs strategic plan to bring the target of 4 week quitters to 3554/year and rate /1000 population to 14.22 by 2015 and to achieve a reduction in the demand for healthcare further upstream. This programme of work will be delivered through a comprehensive tobacco control approach.

1. Stop Smoking Service Provision

Dudley Stop Smoking Service (DSSS) delivers an NHS quality, evidence based stop smoking service, targeting smokers from deprived communities and hard to reach groups. DSSS commissions stop smoking services and acts as a provider as a last resort for a small number of service areas where no other provider is available. The service network comprises:

- One-to-one support in GP practices and community pharmacies. Currently 88% of GPs and 77% of pharmacies in Dudley provide this service.
- One-to-one and group support in workplace settings
- One-to-one support for Dudley Group of Hospital 'in and out' patients.
- Group support on a rolling programme basis in community venues across the borough. Groups are co-delivered by trained volunteers.
- Drop-in clinics and groups in schools and clinics provided by trained Stop Smoking Specialists (School Health Advisors, Children's Centre staff)
- Intensive one-to-one support for pregnant women and their family in the home setting.

Health Equity Audit

DSSS carries out a health equity audit (HEA) every 2 years to provide a detailed profile of clients attending the service to establish if service provision and developments are delivering equitable services in proportion to smoking prevalence rates from social class groups across Dudley. The most recent HEA was completed in 2010 and identified that the number of people accessing the service has been increasing year on year with over 25,000 smokers having accessed the service in the period April 2002 to March 2009.

Figure 3 shows the proportion of clients accessing DSSS by the Index of Multiple Deprivation 2007 (IMD, 2007) by national quintile. There is a significant negative trend in the proportion accessing DSSS from the most deprived to the least deprived people in Dudley. The proportion accessing DSSS in the 20% most deprived areas of Dudley is four times that of people in the 20% least deprived areas. This highlights that the service is responding to the increased need identified earlier by the high smoking prevalence in this group. There has been a significant increase in the proportion of people accessing DSSS from the 20% most deprived areas in the last seven years and a corresponding decline for clients from the 20% least deprived areas.

Figure 3:

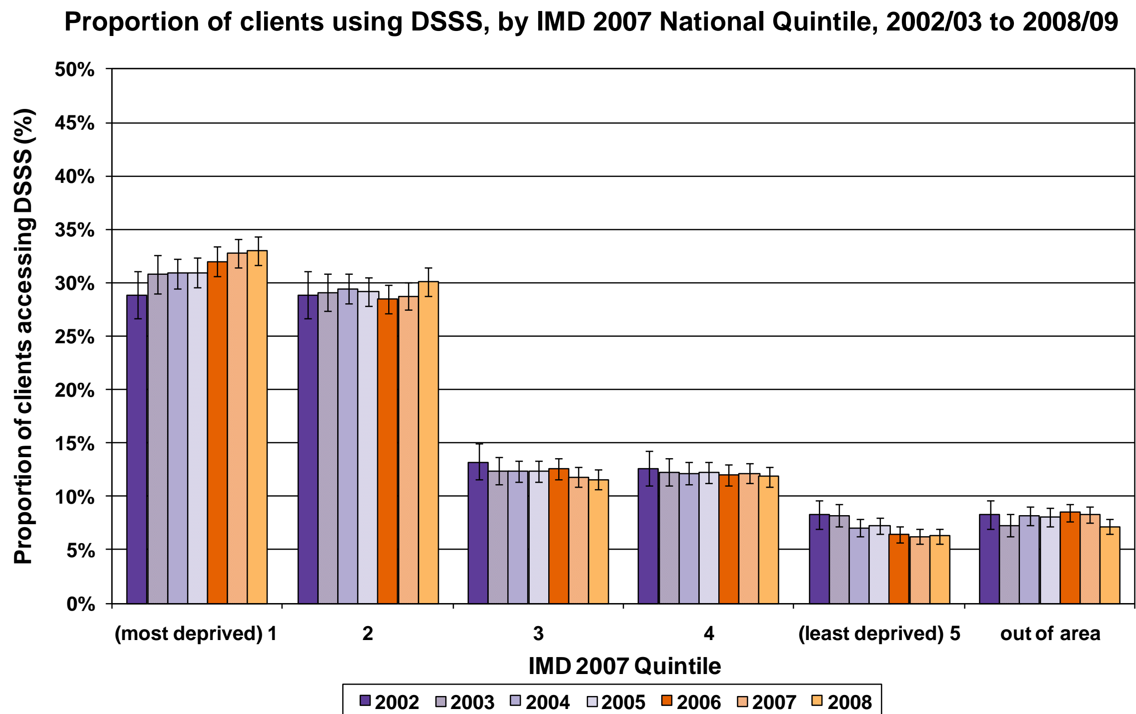
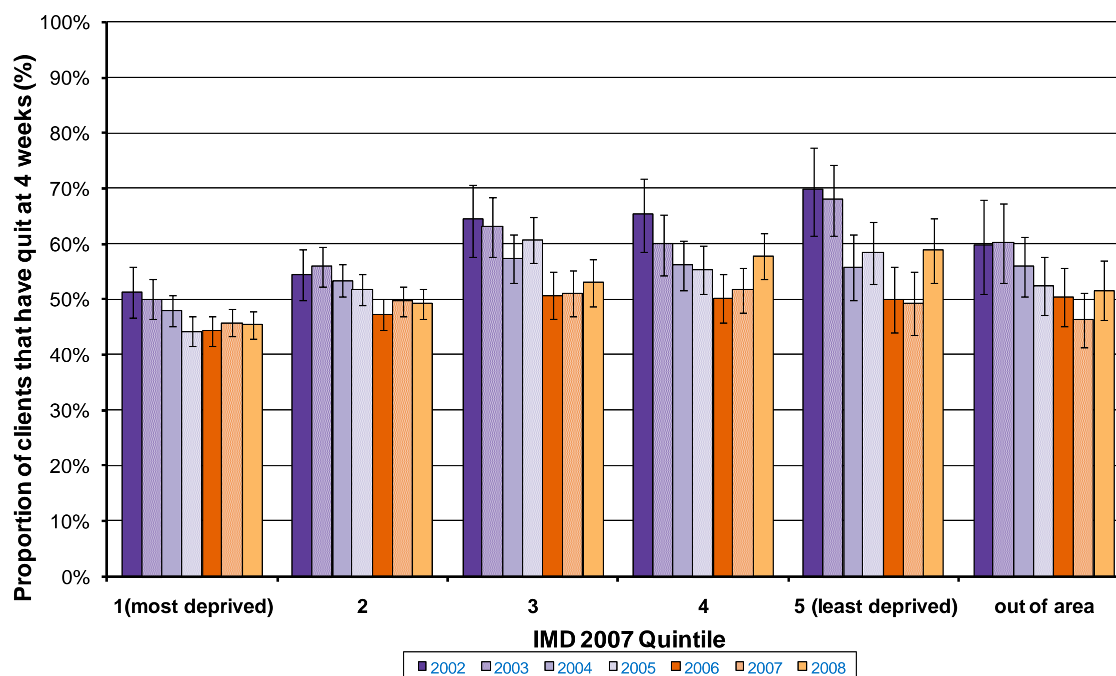


Figure 4 shows the proportion of clients accessing the DSSS who have a successful 4-week quit status by IMD 2007. Clients accessing the service from the 20% most deprived areas are significantly less likely to quit at 4 weeks than those clients accessing the service from the 20% least deprived areas. Over the last 7 years the gap between these two groups is closing in terms of quit rate with the clients from the 20% least deprived areas reducing their 4-week quit success at a greater rate than the 20% most deprived areas which have not significantly declined with time. However, 2008-9 has seen a quit rise in the least deprived quintile.

Figure 4:

Proportion of clients using DSSS that have quit at 4 weeks, by IMD 2007 National Quintile, 2002/03 to 2008/09



Source: Dudley Stop Smoking Service
Department of Communities & Local Government Indices of Deprivation 2007

DSSS have updated their Pharmacotherapy Guidelines in 2009 to include combination therapy and Varenicline as a first line treatment. This will provide the most evidenced based treatments for heavily dependent smokers who are generally in the most deprived areas. It is anticipated that this will contribute to improving quit outcomes for the most needy smokers.

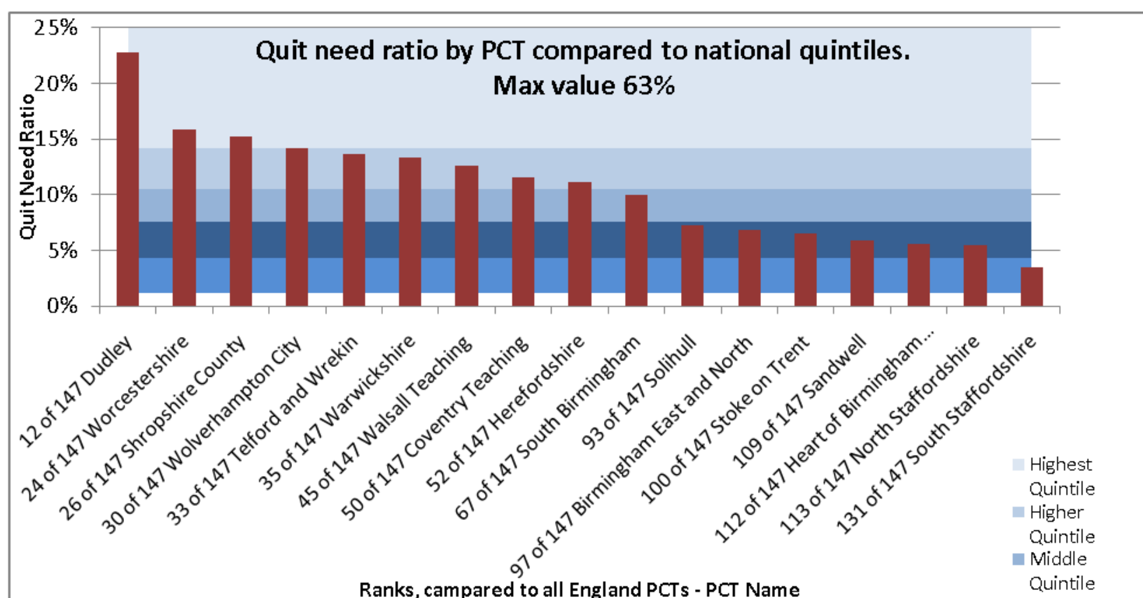
Smoking and Pregnancy Services

DSSS has provided a specialist service to help pregnant smokers and their families stop smoking since 2000. The service aims to reduce the percentage of pregnant smokers in Dudley and consequently have a positive impact on perinatal and infant morbidity and mortality. There has been a steady increase in women accessing the service since 2002. Dudley Stop Smoking and Pregnancy (DSS&P) service has been used nationally as an example of good practice through Infant Mortality and Tobacco Control National Support Team visits and provides leadership for the West Midlands Regional Smoking and Pregnancy network.

A recent national audit of smoking and pregnancy services was commissioned by the West Midlands Government Office to determine the performance and effectiveness of the West Midlands Smoking and Pregnancy Services, compared to other England PCT services. The analysis has placed Dudley in the top 10% (12th of 147) of smoking and pregnancy services nationally for women quitting on a 'quit need' basis, and top performing for the West Midlands Region (Figure 5). This information reassures us that Dudley is providing a good service for those who are most at need.

Figure 5:

Smoking and Pregnancy Services in West Midlands quit need ratio compared with services across England



2. Tackling illicit tobacco

The geographical positioning of Dudley, close to the M6 and M5 corridor, unfortunately provides organised criminal operators an ideal location for processing cut-price illicit tobacco. It remains widely available, particularly within the poorest communities. Through the BCTCA, Dudley Trading Standards Service and DSSS work in partnership with HM Revenue and Customs on joint activities to reduce the illegal selling of smuggled and illicit tobacco products. This has involved the sharing of intelligence, promotion of a national complaints hotline and a workplace information campaign highlighting fines for selling in workplaces.

This programme of work was reviewed at a recent local Illicit Tobacco Summit which has identified the key areas for future action which include better intelligence sharing templates and protocols, local education and awareness campaigns and better monitoring processes.

Dudley PCT has commissioned a programme of education and enforcement with regards to the sale of tobacco and alcohol products from Dudley Trading Standards Service. This joint programme of work will significantly contribute to the Council Plan objective of reducing harm to children by limiting access to alcohol and also effectively assist in the implementation of the Tobacco Strategy for Dudley and Social Responsibility Scheme through targeted inspection and enforcement of underage sales legislation. It will also contribute to the incidence of sales currently at 6% (2009/2010) to be reduced and to provide effective education and training to traders. This area of work will be monitored through the Tobacco Action Group.

3. Communication and Education

DSSS work in partnership with many local organisations to provide public and workplace education and media campaigns. These are planned to link to national campaigns such as No Smoking Day and Smokefree England to maximise local impact. All local stop smoking service education materials are branded in line with Smokefree England, again to maximise the impact of national advertising and media campaigns. DSSS have won several national awards in the last three years for its No Smoking Day education and media campaigns. This year there is no national advertising due to Government cuts so there will be a need to maintain a high presence locally.

DSSS commissions Environmental Health Services to carry out workplace smokefree inspections, educate employers on selling illicit tobacco and promote stop smoking service provision in the workplace. It is anticipated that this partnership approach will increase the number of routine and manual smokers accessing stop smoking services.

Smoke free Homes

Exposure to secondhand smoke (SHS) is harmful to health, particularly for children. The home is where children are exposed to SHS the most with the main source of exposure being from their parents and in particular maternal smoking. Exposing new born babies and children to SHS is a major risk factor for bronchitis, pneumonia, coughing and wheezing, asthma attacks, middle ear infection, cot death and possibly cardiovascular and neurobiological impairment.

DSSS has been working with a wide range of organisations on promoting Smokefree Homes focussing interventions initially in pregnancy and pre-school years where children may not have a voice. This area of work is being reviewed through social marketing activities both with health professionals and parents. It is planned to expand and develop this area of work to include early years and primary schools aiming to educate parents and children to champion the smokefree message in their own homes. Work is already underway on recording exposure to SHS in the homes through a more structured approach to data collection from Personal Child Health Records (PCHR) and also through the Dudley Schools Health Related Behaviour Questionnaire.

Schools and Youth Education

This workstream has been integral to Dudley's tobacco programme working in partnership with Dudley Health Promoting Schools Service. It aims to deliver a developmental tobacco education programme in primary and secondary schools.

This year has seen young people involved in the redevelopment of this programme with more of a youth advocacy approach. This has given us more insight to what young people want and need. A smoking toolkit has been developed and is due to be launched in March 2011. We are also looking at new ways to provide tobacco education through a match funded arts and health project that will see 10 new projects being delivered by youth groups across Dudley. These will be robustly evaluated and reported on through Dudley's Youth Council and the TAG.

Conclusions
The Dudley tobacco control programme has been shown to be effective in contributing to reducing overall smoking prevalence through delivering an evidenced based multi strand approach. However it could go further to reduce smoking prevalence in the most deprived areas and amongst pregnant women.

In summary:
- Smoking prevalence is declining nationally and locally. However there still remains approximately double the number of smokers in the more deprived areas than the least deprived nationally and in Dudley
- Smoking in pregnancy prevalence is declining nationally, although the data is thought to be an underestimate. In Dudley prevalence has risen in the last year and concerns have been raised about the data collection process.
- DSSS is successfully targeting smokers from deprived areas to access services but fewer remain stopped than in the least deprived areas.
- The Dudley smoking and pregnancy service is highly recognised for delivering an excellent service but local prevalence data does not correlate with this.
- Dudley has a range of wider tobacco control programme areas that are essential in providing a comprehensive approach to raising the issue of tobacco in a variety of settings and to drive smokers to stop smoking services.
- Dudley plays a key role in the Black Country Tobacco Control Alliance (BCTCA). Joint project work is focussing on dealing with illicit tobacco. Scoping work has been carried out with workplaces and retailer visits were carried out across all four boroughs.
- Dudley's Smokefree Homes programme is developing to include early years and primary school workstreams.
- The schools and youth tobacco education programme will focus on using arts for health as a medium to get key messages across to young people. Young people are at the centre of how this work will develop.

Recommendations
The NST identified a number of priority areas for action an action plan has been developed to be included ensure that they will form part of the tobacco control programme. The recommendations have been outlined in conjunction with current local action and priorities:

Strategic approach to Tobacco Control is best co-ordinated by an effective multi-agency partnership:
- Continued strong senior level support and leadership for the tobacco control agenda
- Review role of Tobacco Action Group (TAG)
- TAG continued accountability to Dudley Community Partnership via the Health and Wellbeing Partnership Board
- Refresh the Tobacco Strategy and action plan in line with the new National Strategy
- Development of advocacy role of the Alliance around SHS and illicit tobacco

Further develop an evidenced based and proactive approach to illicit tobacco
- Plan local priorities

The PCT, Acute Trust, Local Authority and other partners should explore ways in which data can be collected and shared to improve local intelligence on key areas e.g. smoking in pregnancy, illicit tobacco, under age sales.

Intention to commission Environmental Health to carry out additional smokefree compliance checks in routine and manual workplaces to include illicit tobacco and stop smoking information.
There would be a benefit in developing a programme of ongoing test purchasing to explore the issue of supply of tobacco to young people.

The early adoption of DH Stop Smoking in Secondary Care toolkit provides an opportunity to ensure effective care pathways are in place for smokers – this will impact on the key contributors to tackling health inequalities.

- This would also provide an opportunity to ensure a formally agreed care pathway for smoking in pregnancy to be used by all staff.

The DH Stop Smoking Interventions in Primary Care toolkit is rolled out to ensure strengthened infrastructure for quality brief interventions.

All tobacco control initiatives will require senior level support and agreement between Primary and Secondary Care organisations to ensure a seamless quality service for clients.

It will be beneficial to have Varenicline as a first line smoking cessation medication.

7.4 ALCOHOL HARM REDUCTION

There are numerous measures that highlight the relationship between alcohol consumption and health inequalities in Dudley. Some of these differences relate to geographic areas, whilst others relate to differences in population groups. There are correlations between local measures of social deprivation and measures of alcohol-related burden across the area for:

- The contribution of alcohol to life expectancy
- Mortality from causes directly related to alcohol
- Hospital episodes attributable to alcohol
- The rate of crimes estimated to be attributable to alcohol

These relationships suggest that the more deprived areas of the borough have a disproportionately high burden on the NHS, have a disproportionately high level of alcohol related mortality and have a disproportionate contribution to reduced life expectancy due to alcohol.

The contribution of alcohol to life expectancy

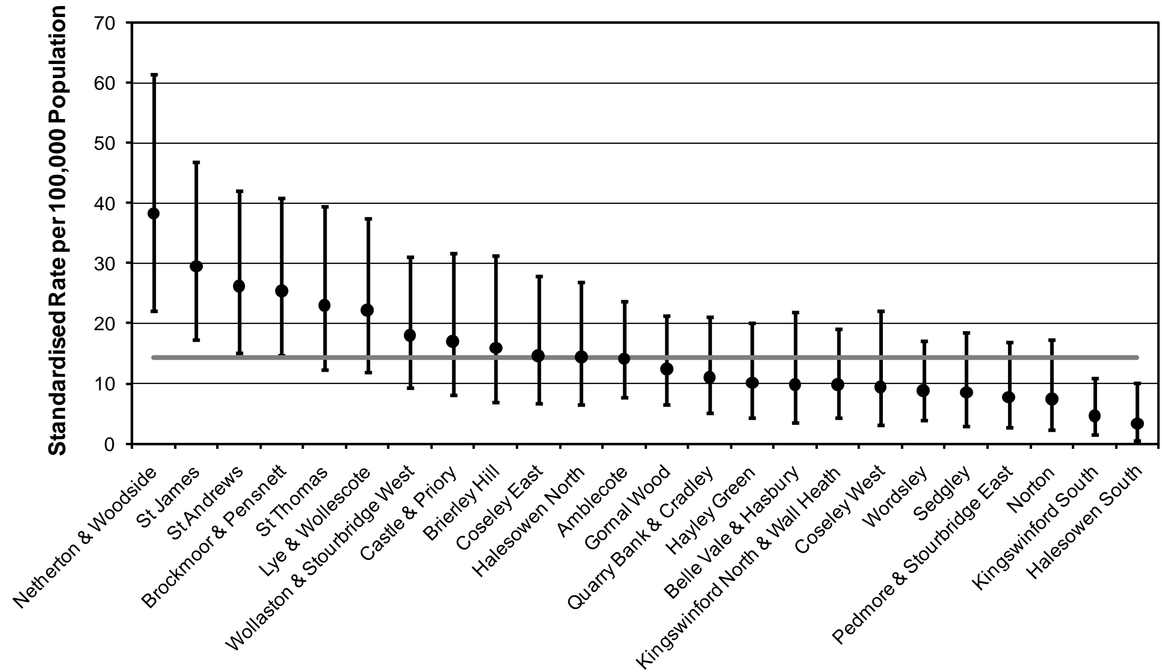
The enjoyment of alcohol has been part of our culture for thousands of years. It is part of the way we enjoy our leisure time and celebrations with friends and family. There is some evidence that small quantities of alcohol may have a beneficial effect and prevent against cardiovascular disease, however drinking alcohol above safe recommended levels can cause a variety of health harms. High levels of alcohol consumption are associated with obesity, cancer, cardiovascular disease and haemorrhagic stroke.

The harm that alcohol does is across all ages, gender and race but there are inequalities in the way that this impacts on life expectancy across the borough. The ward level data shows some variation in different parts of the borough, but the significant differences can be seen between mortality in Netherton and Woodside, St James, St Andrews and Brockmoor and Pensnett compared with Kingswinford South and Halesowen South (Figure 1). The gender inequalities are also evident when ward level data for males and females is compared. (Figure 2)

Mortality rates from alcohol related causes are lower for women anyway, but even in wards where male mortality is high, women generally are less likely to die from an alcohol related disease than their male counterparts. Estimates show that a man living in Netherton and Woodside is more than 5 times likely to die earlier from an alcohol related cause than in the more affluent wards of Halesowen or Kingswinford.

Figure 1

Directly Standardised Mortality Rates from Alcohol-Related Diseases by Ward
5-Year Rates, Dudley MBC, Both Sexes, All Ages, 2004-2008

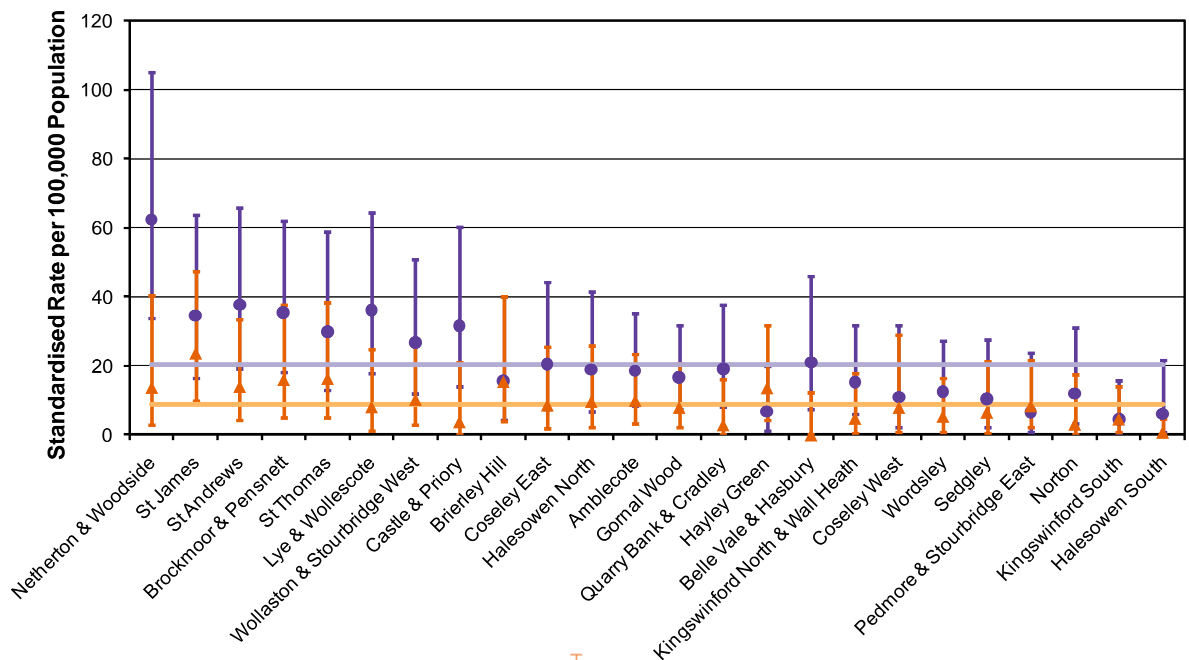


Source: Office for National Statistics (ONS) Annual Deaths Extract
Office for National Statistics (ONS) Mid-Year Population Estimates

Rate with 95% Confidence Interval — Dudley Average

Figure 2

Directly Standardised Mortality Rates from Alcohol-Related Diseases by Ward
5-Year Rates, Dudley MBC, Males & Females, All Ages, 2004-2008



Rate with 95% Confidence Interval — Dudley Average (Females)
Rate with 95% Confidence Interval — Dudley Average (Males)

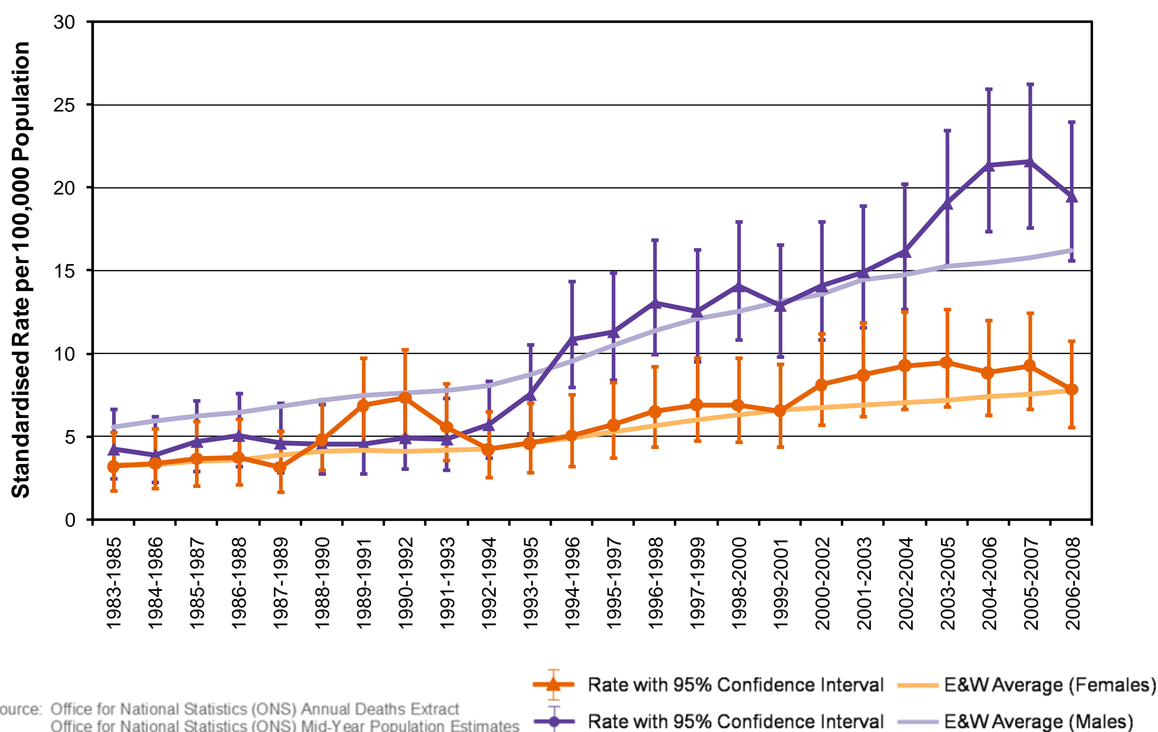
Source: Office for National Statistics (ONS) Annual Deaths Extract
Office for National Statistics (ONS) Mid-Year Population Estimates

Mortality from causes directly related to alcohol

Mortality from alcohol can be accounted for by a number of different causes. The alcohol specific diseases of alcoholic liver disease (cirrhosis), ethanol poisoning, chronic pancreatitis and alcoholic gastritis are the main contributors to chronic ill health and premature mortality. The highest numbers of admissions to hospital are due to mental and behavioural disorders associated with high levels of alcohol consumption and in some cases combined with illegal substance misuse. Mortality due to suicides is also more common in this group.

Between 1983 and 1993 Dudley's alcohol premature mortality rate was below the England average for both males and females. Since 1993 the premature mortality rate for males has steadily increased. The mortality for males has been consistently higher than females apart from 1990 to 1993 when female mortality exceeded that of males. From 2002 to 2007 the premature mortality rate was significantly higher than the England average, but for the last two years this rapid rate of increase seems to be slowing, but the inequality gap between males and females has widened.

Figure 3



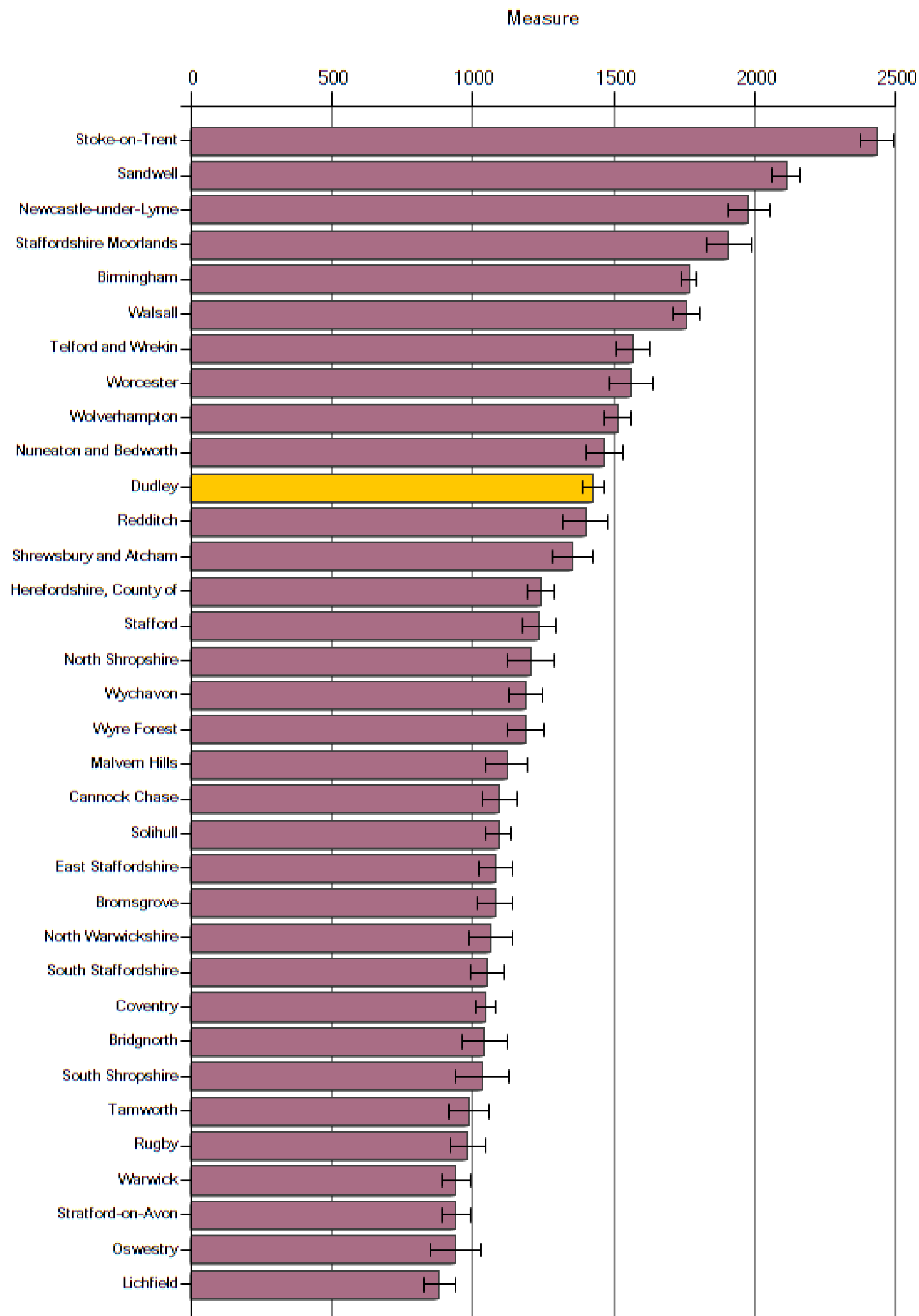
Alcohol related hospital admissions

The rate of alcohol related admissions to hospital is used as a proxy indicator for the amount of alcohol related harm there is in the community. The indicator is made up of alcohol specific causes and around twenty conditions where alcohol is an 'attributable fraction' of those admissions. In 2002/03 Dudley was below the England and West Midlands average, but by 2005/06 the rate of admissions began to climb steeply, placing Dudley as the 11th highest in the region for alcohol related

admissions. The following year Dudley was 5th highest, but the rate of increase now seems to be slowing down. This correlates with the reduction in alcohol related mortality over the last two years seen in previous graphs.

Figure 4:

Alcohol-related harm hospital admissions in the West Midlands by Local Authority 2007/08

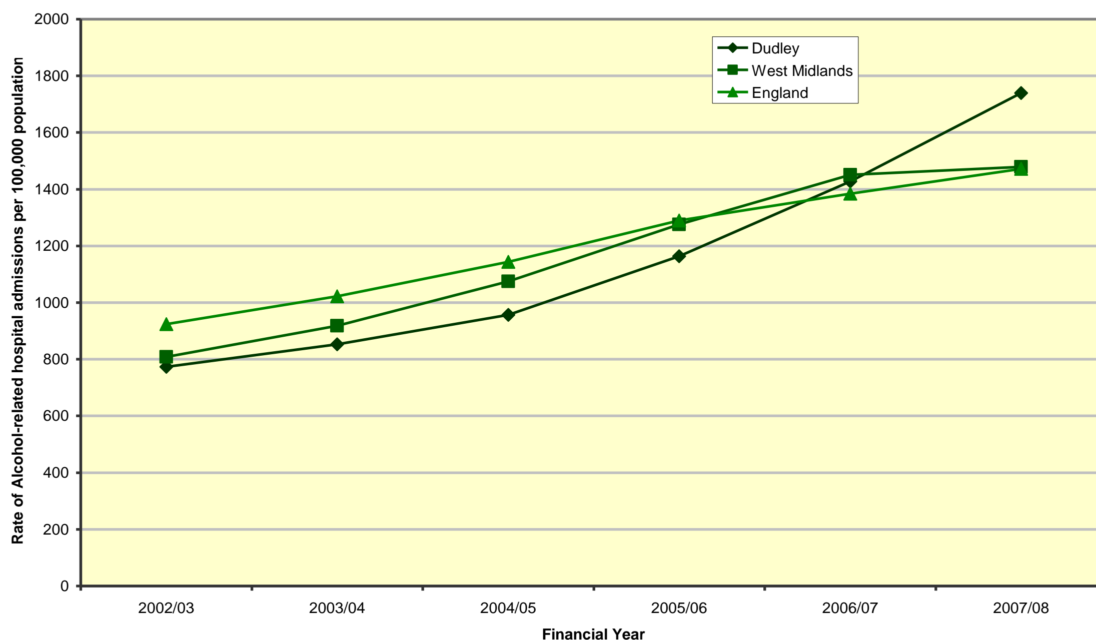


Source: LAPE, NWPHO

In 2008/09 there were 4919 alcohol related harm hospital admissions to Dudley hospital, of which 4543 were resident in Dudley and the remainder were non-residents. An analysis of the Dudley residents by age and sex is given in Figure 6. Of the alcohol related harm hospital admissions for Dudley residents 2831 were male and 1712 were female (62 and 38% respectively), and the proportion of all admissions increased with increasing age for both men and women. The gap between men and women in terms of admissions was lowest in the under 35 age group.

Figure 5

Rate of alcohol-related admissions per 100,000 population (EASR), Dudley, West Midlands region and England



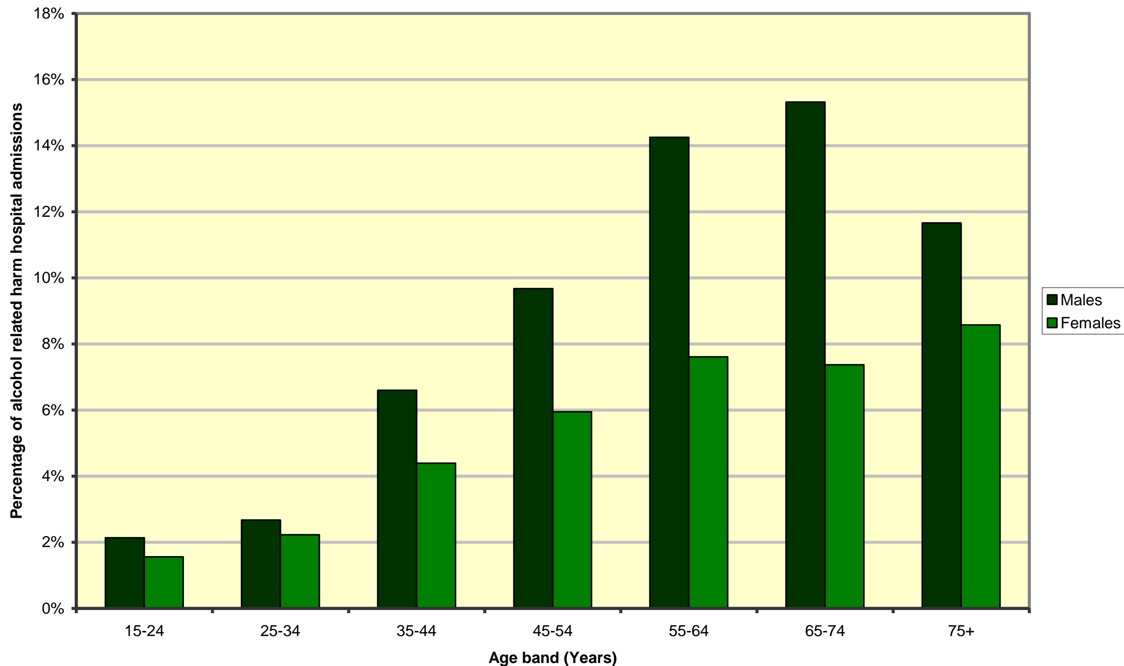
Source: UNIFY

The rate at which hospital admissions has increased in Dudley was the main reason for it being chosen as a partnership target to try and reduce the numbers of people being admitted to hospital and ultimately impact on reducing premature mortality from alcohol consumption.

By far the biggest burden of alcohol morbidity in Dudley is in white males in the 35 to 54 year old age group. This is the group that has been identified for targeted interventions to reduce their alcohol consumption, which in turn would reduce the number of hospital admissions and also impact on premature mortality. Only 6% of the total admissions were from ethnic minority groups, reflecting the percentage of these groups in the total population, but does not take account of the fact that some ethnic groups are more vulnerable to the effects of alcohol so this figure may be masking an inequality in access to services

Figure 6:

Percentage of Alcohol related harm hospital admissions by age and sex for Dudley residents 2008/09

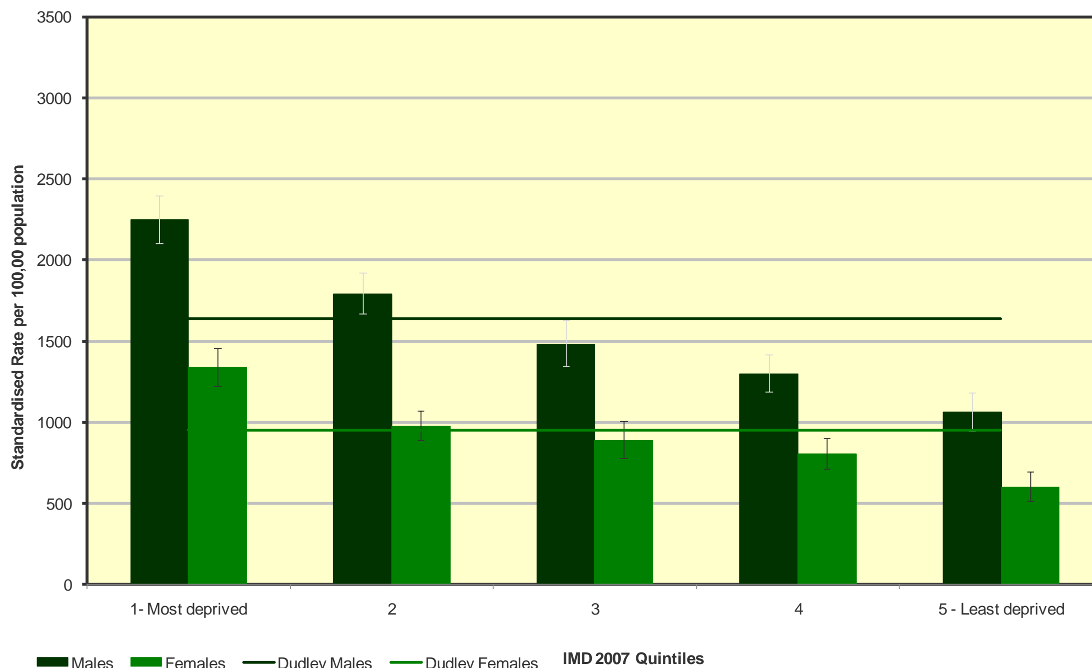


Source: Secondary User Service (SUS) Hospital Admissions

Admissions to hospital increase steadily across the age ranges up to the age of 65-74. The 75+ shows a decline, indicating that a number of people will have died by this age from alcohol related causes, or other diseases.

Figure 7:

Directly standardised alcohol related harm hospital admissions for Dudley 2008/09 by index of multiple deprivation (2007) national quintiles.

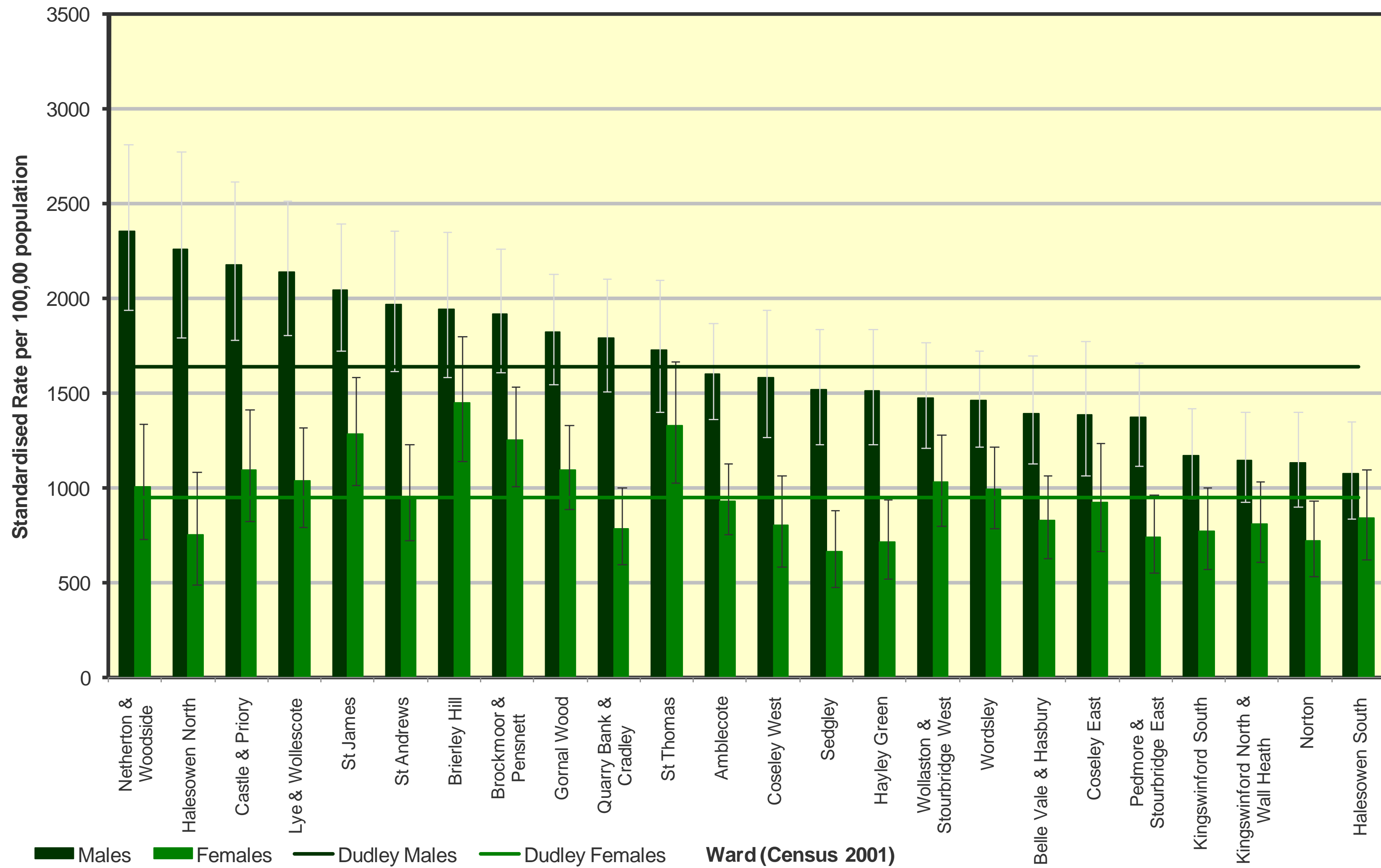


Source: Secondary User Service (SUS) Hospital Admissions.
Department of Communities and Local Government Indices of Deprivation 2007

The directly age sex standardised alcohol related harm hospital admission rate (per 100,000 people) for Dudley residents in 2008/09 was 1281.5, and was significantly higher for men than women (1636.8, 948.7 for men and women respectively).

Figure 7 shows the directly age sex standardised alcohol related harm hospital admission rate (per 100,000 people) for Dudley residents in 2008/09 by IMD 2007 quintiles. In terms of alcohol related harm hospital admissions there is a strong positive relationship with increasing deprivation for both men and women. This relationship was not observed for the prevalence of heavy and binge drinking.

Figure 8: Directly standardised alcohol related harm hospital admissions for Dudley 2008/09 by Ward (Census 2001).

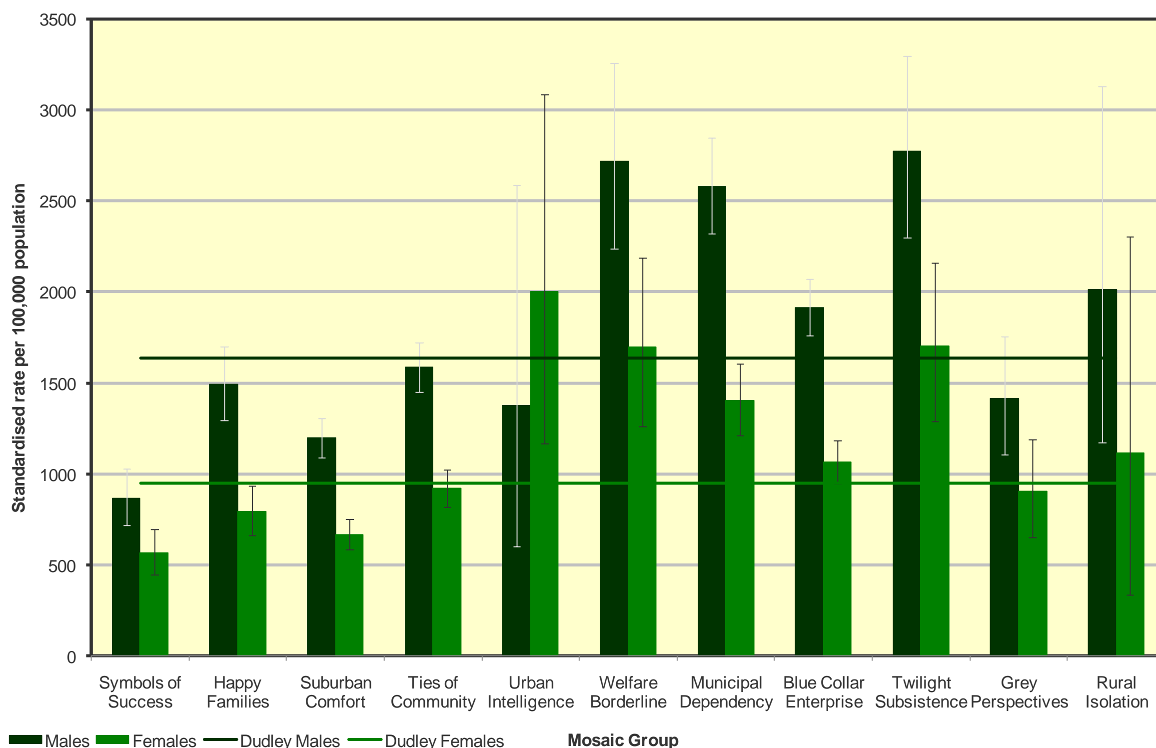


Source: Secondary User Service (SUS) Hospital Admissions.

Figure 8 shows the directly age sex standardised alcohol related harm hospital admission rate (per 100,000 people) for Dudley residents in 2008/09 by ward according to the 2001 national Census. For men there were five wards where the admission rate was significantly higher than the Dudley average for men. Netherton and Woodside had the highest rate of admission and was nearly 45% higher than the Dudley average for males. The other wards were Halesowen North, Castle & Priory, Lye & Wollescote and St. James. For women there were four wards where the admission rate was significantly higher than the Dudley average for women. Brierley Hill had the highest rate of admission and was nearly 55% higher than the Dudley average for females. The other wards were St. James, Brockmoor & Pensnett and St. Thomas

Figure 9:

Directly standardised alcohol related harm hospital admissions for Dudley residents in 2008/09 by sex and Mosaic group.



Source: Secondary User Service (SUS) Hospital Admissions.
Experian Public Sector

Figure 9 shows the directly age sex standardised alcohol related harm hospital admission rate (per 100,000 people) for Dudley residents in 2008/09 by Mosaic group. Mosaic identifies populations according to socio-economic factors and gives a picture of the local population in terms of employment, life-stage and relative affluence.

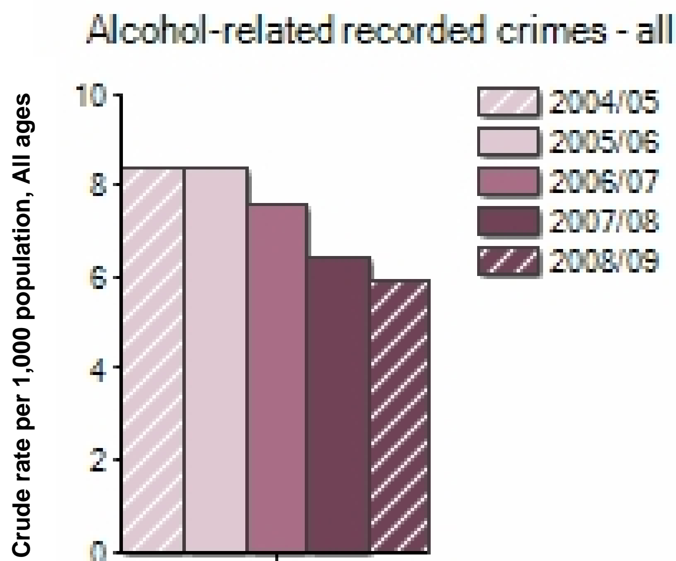
The Mosaic groups with significantly higher admission rates for men were Twilight subsistence (older people living on pensions with little additional income), Welfare borderline (people in low paid jobs supported by some benefits) and Municipal dependency (the most deprived groups with no employment living on benefits). For

women the Mosaic groups with significantly higher admission rates were the same groups as for the men with the addition of Urban Intelligence which showed the highest level of hospital admissions for women showing twice the level of the Dudley average for women. The Urban Intelligence group are largely younger people in higher paid jobs. This suggests that prevention programmes should be aimed at both sexes in the Mosaic groups Welfare borderline, Twilight subsistence and Municipal dependency and then additional programmes should be targeted at women in the Urban intelligence Mosaic group.

Alcohol Related Crimes

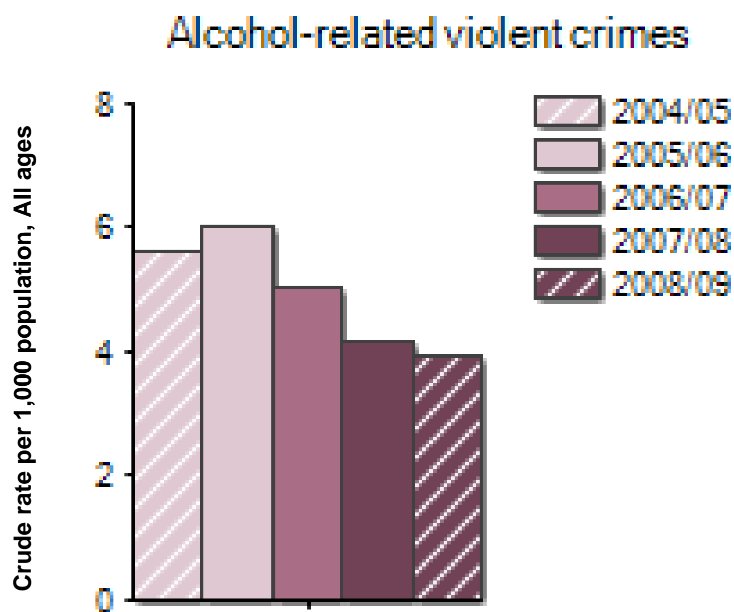
Alcohol related crime has been steadily falling in Dudley over the last five years. There is a perception amongst the public that alcohol related crime is still a problem, probably because public drunkenness is very visible in some parts of the borough.

Figure 10



Source: LAPE, NWPHO

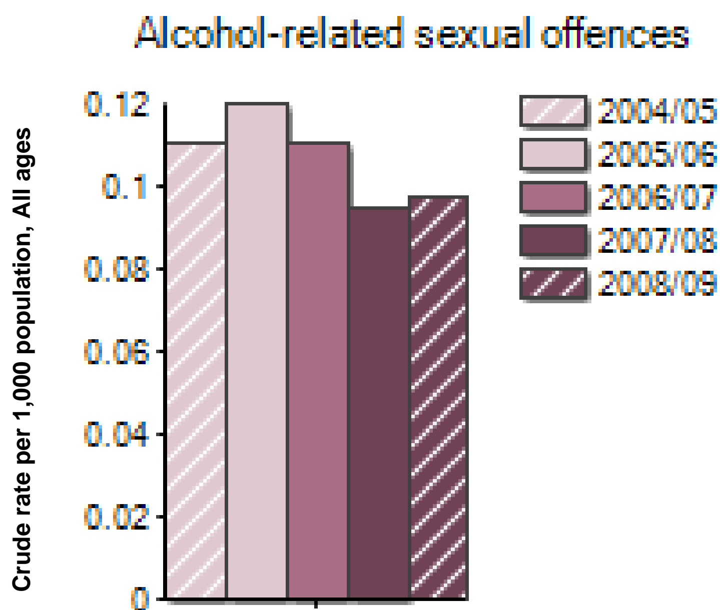
Figure 11



Source: LAPE, NWPHO

There has also been a decline in alcohol related violent crime over the last four years and although there was an increase in 2005/06, the overall trend is downwards

Figure 12



Source: LAPE, NWPHO

There are well established links between alcohol and risky sexual behaviour and alcohol plays a part in the numbers of unplanned teenage conceptions, but the

numbers of alcohol related sexual offences remains low and the overall trend is downwards even though there was a small increase in recorded offences in 2008/09.

Local Patterns of alcohol consumption

There are a number of accepted categories of alcohol consumption and the North West Public Health Observatory has produced synthetic estimates of the number of hazardous, harmful and binge drinkers for every local authority in England. The estimates probably understate the extent of problematic drinking because they rely on self reporting through surveys e.g. the Health Survey for England and Dudley's Adult Lifestyle Survey

Definitions of drinking levels

- ***Sensible drinking****:* no more than 3-4 units a day for men, and no more than 2-3 units a day for women.
- ***Binge drinking****:* 8 or more units of alcohol for men, and 6 or more units of alcohol for women on their heaviest drinking day in the past week.
- ***Hazardous drinking*****:** drinking above recognised 'sensible' levels but not yet experiencing harm. Defined as drinking between 22 and 50 units of alcohol per week for males, and between 15 and 35 units of alcohol per week for females.
- ***Harmful drinking***: drinking above 'sensible' levels and experiencing harm. Can be defined as drinking more than 50 units of alcohol per week for males, and more than 35 units of alcohol per week for females.
- ***Alcohol dependence***: drinking above 'sensible' levels and experiencing harm and symptoms of dependence.

Table 1:
NWPHO synthetic estimates of hazardous, harmful and binge drinking in adults (aged 16+, HSE 2005)

	Binge drinking		**Hazardous drinking**		**Harmful drinking**	
	%	number	%	number	%	number
Dudley PCT	17.7 (15.7, 20.0)	43,465	18.4 (16.9, 19.9)	45,253	5.2 (4.7, 5.8)	12,840
West Midlands Region	17.3 (16.3, 19.6)	763,430	16.5 (16.8, 19.8)	770,333	5.2 (4.4, 5.4)	206,962
England	18.0 (17.4, 18.6)	7,278,674	20.1 (18.4, 21.8)	8,027,474	5.0 (4.5, 5.6)	2,010,856

Key findings from the most recent *Dudley Health Survey 2009* (Dudley PCT, 2009b) show:

- The proportion of respondents who are binge drinkers has fallen significantly since 2004, from 22% to 17%. The proportion of respondents that are heavy drinkers has also fallen significantly, from 34 to 27%.

- There are significantly more male binge and heavy drinkers than female.
- In both sexes the proportion of respondents who are binge drinkers falls with increasing age. The proportion of males who are binge drinkers is higher than females in all age bands, although in 18-24 year olds this difference is not significant. The same pattern is seen in heavy drinkers.
- The proportion of respondents who are binge or heavy drinkers is much higher in white respondents than BME in both males and females.
- There is no gradient between least and worst deprived areas for either heavy or binge drinking.
- The prevalence of both heavy and binge drinking is lowest in those who have never worked/long term unemployed. The prevalence of binge drinking is highest in lower supervisory and technical occupations and heavy drinking is highest in higher managerial and professional occupations.

Evidenced based interventions for hazardous, harmful and moderately dependent drinkers

Dudley's *Alcohol Strategy* (Dudley Community Safety Partnership, 2010) key aim is, 'To reduce the harm caused by alcohol to individuals, families and the community.'

The national health inequalities team have identified four key actions that will impact on health inequalities and result in both short term and longer term health gains through:

1. Tackling underage/illegal alcohol consumption and encourage the industry to promote responsible drinking
2. Combating crime related disorder
3. Raising awareness of, and educating about, safe and sensible drinking
4. Facilitate identification of at risk individuals and enabling access to alcohol treatment services which are consistent with national standards

Optimal outcomes at a population level require a population focus to facilitate local communities' optimal use of the services as well as providing the most effective evidence based interventions. Central to the success of this approach is effective multi-agency partnership working as well as effective planning and commissioning of the services and activities that are necessary to achieve maximum health gain.

RECOMMENDATIONS

The local alcohol strategy has identified actions that address all these points and has been written in line with the key government documents as well as ensuring implementation of the high impact changes that are known to make the greatest impact on reducing alcohol related admissions to hospital. The key recommendations recommended by HINST are now incorporated into the delivery plan.

These include:

- Securing additional investment to reach the reduction in alcohol related admissions target identified in the local strategic plan. The additional investment allows the introduction of a locally enhanced service (LES) in Primary Care and to increase the capacity of the Tier Two specialist alcohol treatment service to deal with increased referrals from Primary Care. Together with the additional A&E alcohol liaison nurse these should begin to impact on CHD, hypertension, stroke, cancer and liver disease, thereby releasing resources to be invested in other health services. The increased investment will reduce health inequalities in relation to differences in life expectancy and infant mortality across Dudley and contribute to reducing obesity levels, teenage pregnancy and domestic abuse.

- Undertaking training needs analysis to allow planning for the introduction of Identification and Brief Advice (IBA) across the health economy and partner organisations. IBA has a strong evidence base and has been shown to be effective in reducing alcohol consumption in harmful and hazardous drinkers. Frontline staff will be offered training in identification and brief advice (IBA) to enable more people who are drinking at harmful or hazardous levels to be identified earlier and referred into community services rather than into hospital.

- Work has already begun on a service review of the Tier Two provision and to put in place improved referral pathways as a start to achieving integrated alcohol service provision. An equality impact assessment of services will identify access issues and ensure that service provision is equitable for all groups.

- Undertaking a review of alcohol workplace policies, initially for the Local Authority, PCT and the NHS Trust and then offering support to all other employers in the Borough. This will help to tackle the sickness absence caused by alcohol and its impact on productivity. Alcohol awareness training has been identified as a priority for all staff and contractors who deal with the public across all partner organisations, including the voluntary sector.

7.5 CANCER

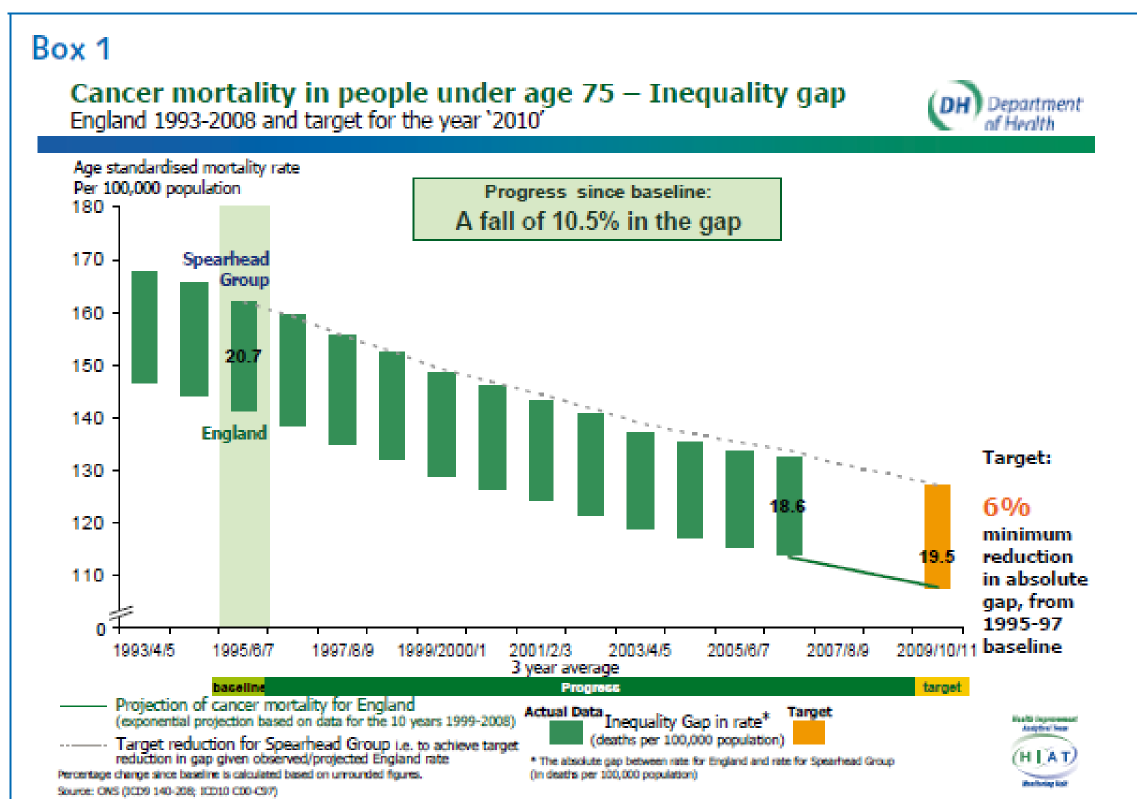
Tackling Cancer Inequalities

Much needed progress has been made in cancer treatment and care over the last few decades leading to improvements in survival rates across the population as a whole. However despite these improvements it is still the case in England that if you are from certain social, ethnic, or age groups you are more likely to develop cancer and less likely to survive it.

The aim of the *Cancer Reform Strategy* (Great Britain. Department of Health, 2007b) is to reduce inequalities in cancer incidence, increase access to high quality cancer treatment and care and improve cancer outcomes for all.

The Department of Health's Public Service Agreement (PSA) for cancer mortality (ages under 75) included a commitment to reduce the absolute gap in mortality rates between the England average and the areas with the worst health and deprivation (Spearhead PCTs) by at least 6% by 2010, compared to a baseline from 1995-97, as well as to deliver an overall reduction in mortality of at least 20%.

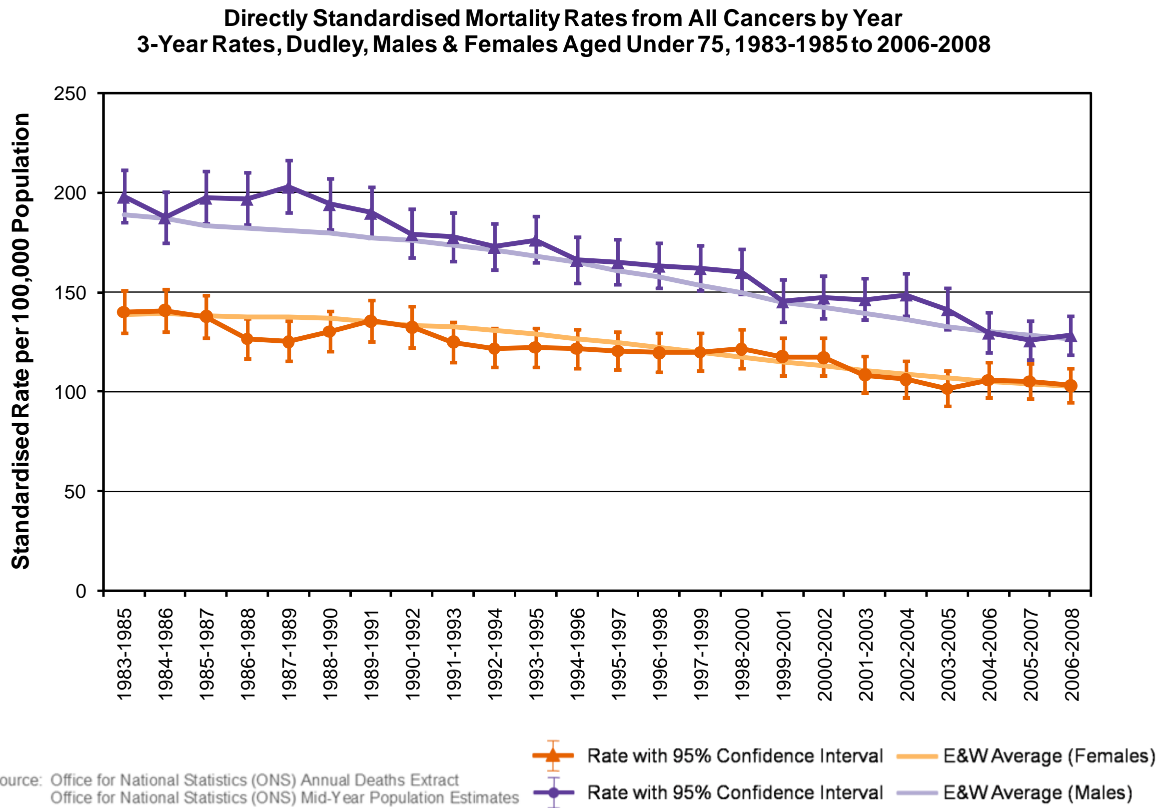
Progress on the PSA has been encouraging. Three-year average mortality rates for cancer (ages under 75) in England have fallen for each period since 1995-97 (the baseline) and are now 18.2% below this rate. If this trend continues, the target will be met. Progress on reducing the gap between England and the Spearhead Group of PCTs has also been significant. The gap has reduced by 10.5% since the baseline, compared to the targeted reduction of at least 6% by 2009-11.



Where are we in Dudley?

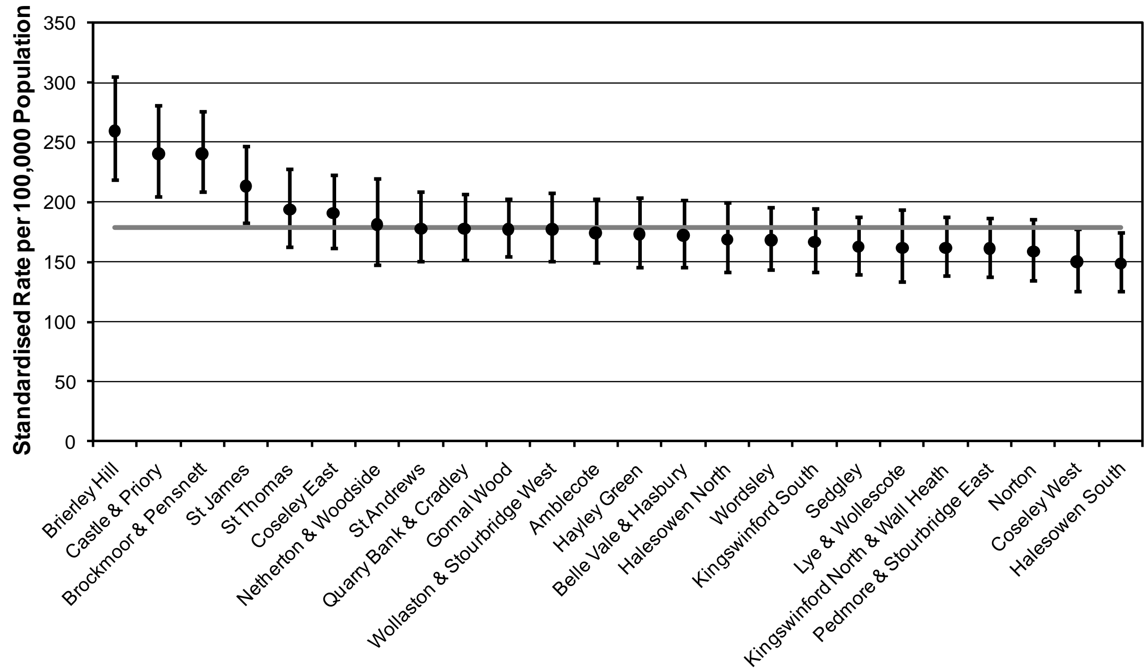
Cancer remains the second largest cause of premature death in Dudley accounting for around 800 deaths in the under 75s each year.

Figure 1



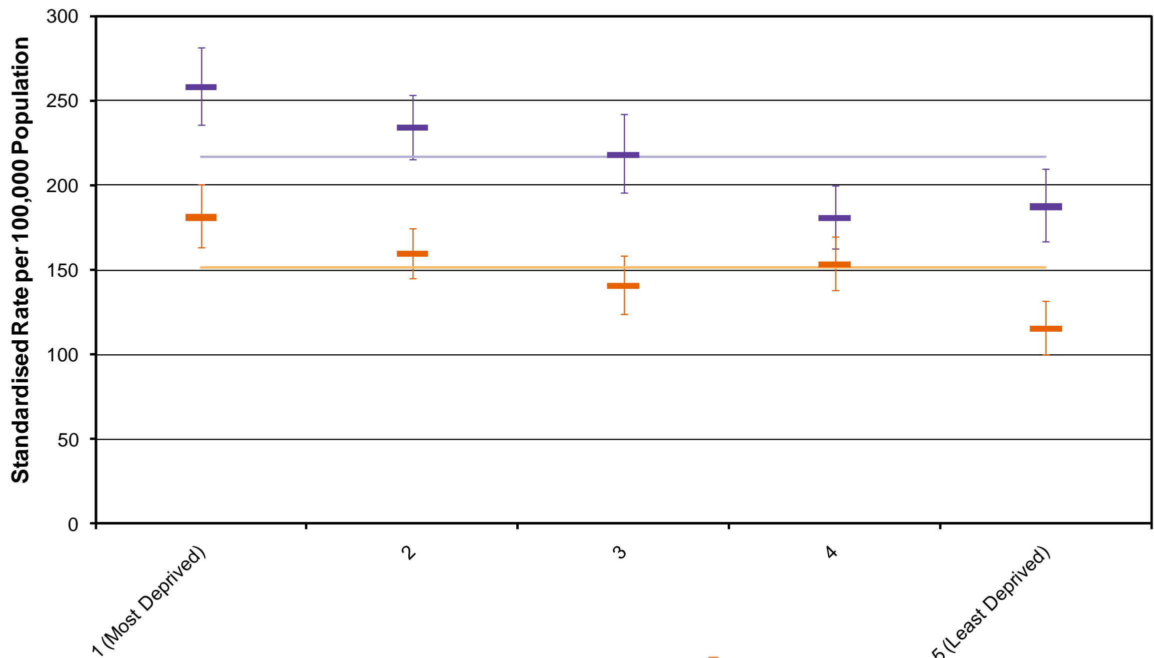
Dudley has similarly shown a significant fall in cancer mortality but the inequalities gap remains stubbornly wide with rates in some wards being 50% higher than those in other wards.

Figure 2



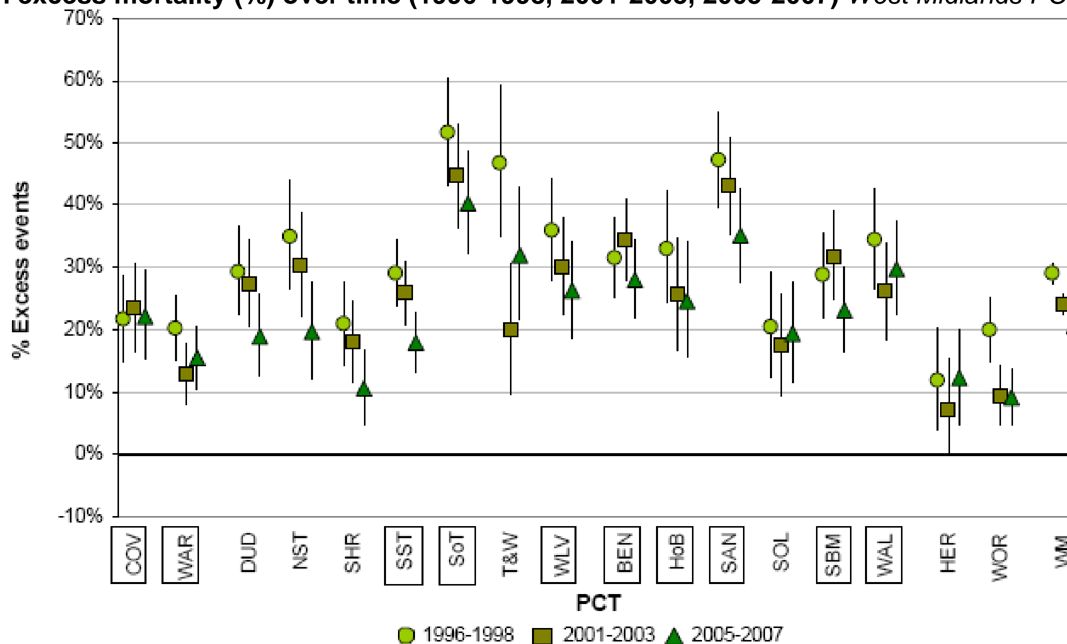
The inequality gap is greater for men than women.

Figure 3



The deprivation gap in invasive cancer mortality in males has fallen significantly over time in the West Midlands. In the period 2005-2007, 3,777 extra deaths (21%) were registered than would be expected when compared to the most affluent population, down from 4,916 (29%) in 1996-1998. This suggests the deprivation gap between all West Midlands residents and the most affluent population is closing. This trend is also seen in Dudley.

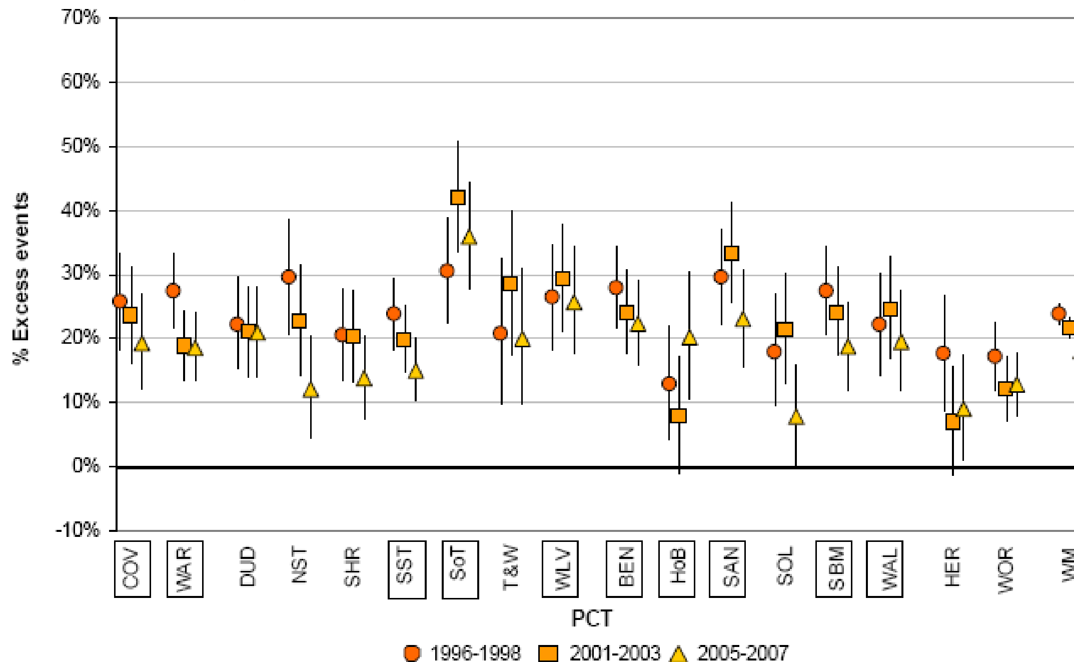
Figure 4
All invasive cancers, excluding non-melanoma skin cancer (ICD10 C00-C97 excl. C44): Trends in excess mortality (%) over time (1996-1998, 2001-2003, 2005-2007) *West Midlands PCTs, males*



Source: West Midlands Cancer Intelligence Unit, Excess Cancer Incidence and Mortality 1997-2007

The deprivation gap in invasive cancer mortality in females has also fallen significantly over time in the West Midlands. In the period 2005-2007, 2,942 more deaths (18%) were registered than would be expected compared to the most affluent population, down from 3,721 (24%) in 1996-1998. This suggests that the deprivation gap between all West Midlands residents and the most affluent population is closing. This trend is also seen in Dudley.

Figure 5
All invasive cancers, excluding non-melanoma skin cancer (ICD10 C00-C97 excl. C44): Trends in excess mortality (%) over time (1996-1998, 2001-2003, 2005-2007)
West Midlands PCTs, females



Source: West Midlands Cancer Intelligence Unit, Excess Cancer Incidence and Mortality 1997-2007

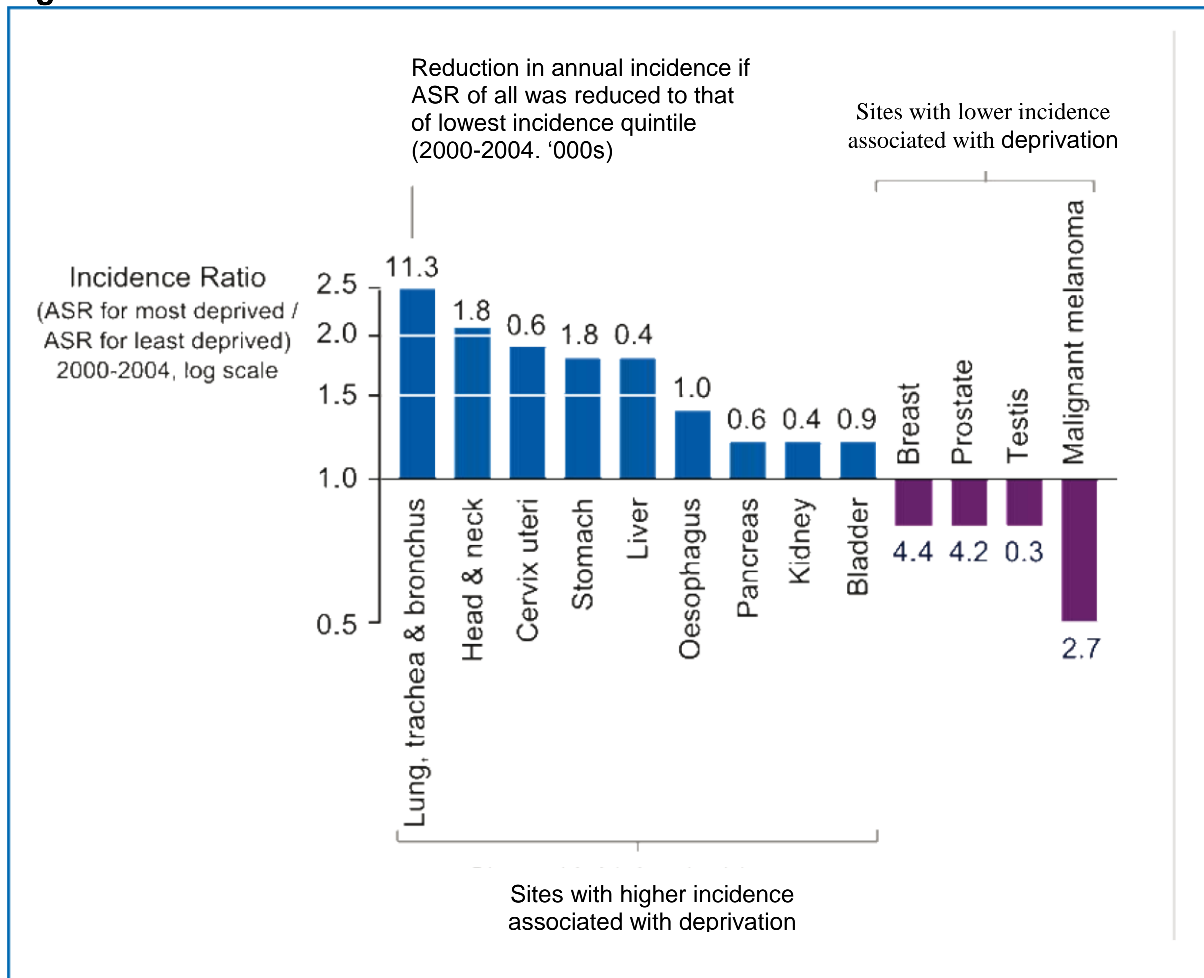
Cancer incidence

For the 2000-04 time period all malignancies group and 11 of 23 site groups showed a statistically significant association between cancer incidence and socio-economic deprivation. (National Cancer Intelligence Network, 2009). Head and neck, stomach, liver, lung and cervical cancers were particularly strongly associated with social deprivation, for these groups rates in the most deprived quintile approached twice that in the most affluent quintile. While those of breast, skin and prostate are found at increased rates among higher socioeconomic groups. Even among those cancers where incidence is higher among wealthier socioeconomic groups death rates are higher among deprived communities.

The picture for ethnic minority groups varies according to cancer type and ethnic group. In general, incidence is lower amongst ethnic minority groups, although there are some important exceptions (incidence of prostate cancer is greater amongst Black African and Black African-Caribbean men, liver cancer in South Asians, and mouth cancer in Bangladeshis)

Age standardised incidence rate ratios (most deprived/least deprived) for selected sites. England 2000-04

Figure 6

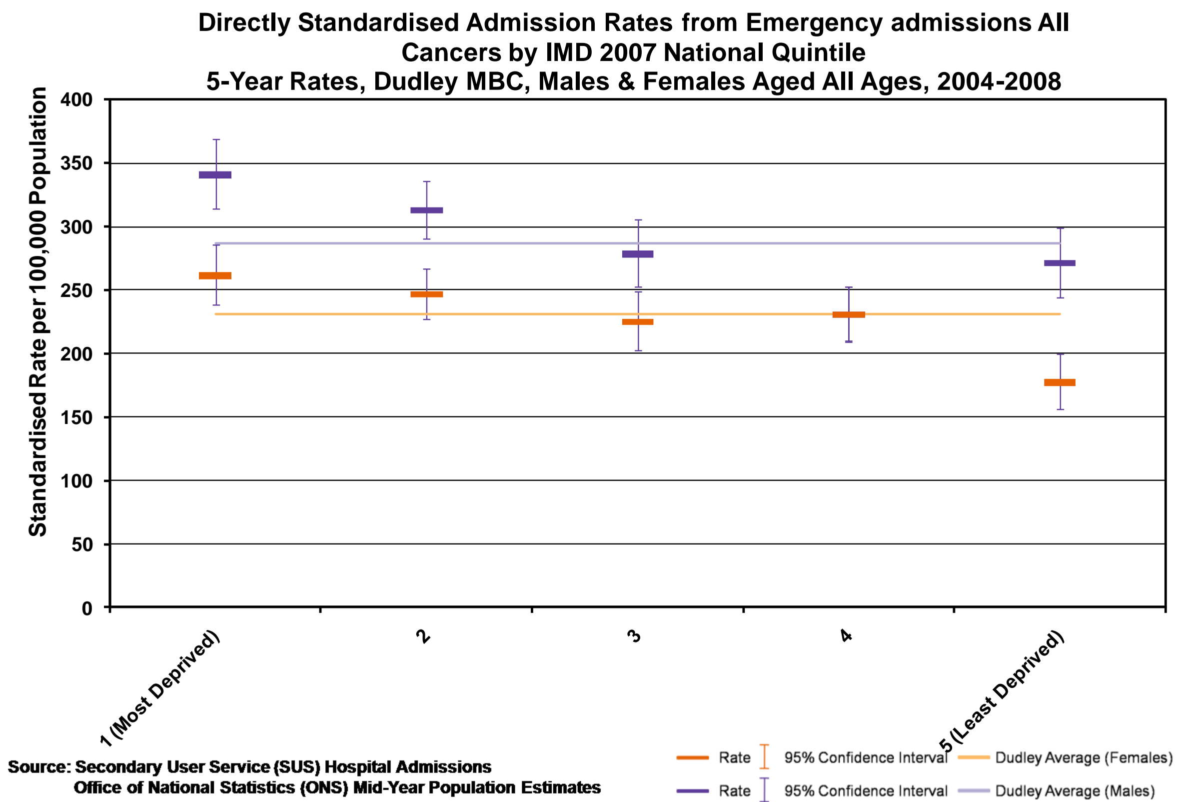


Based on ratios published in the NCIN report on 'Cancer Incidence by Deprivation'

Cancer admissions

Admissions data for cancer shows that admissions generally reflect the higher risk and needs of specific population groups including BME and deprived groups.

Figure 7



Levels of emergency admissions for cancer reflect that patients may not be being diagnosed or treated at an early stage of their cancer. Thus it may be an indicator of late presentation, late diagnosis and entry to care not through primary care. Patients from deprived areas, older people and women are more likely to be admitted as emergencies.

Figure 8

Directly Standardised Admission Rates from Emergency admissions All Cancers by Percentage of GP population in the Most Deprived IMD 2007 Quintile
Both Sexes, All Ages, 2008

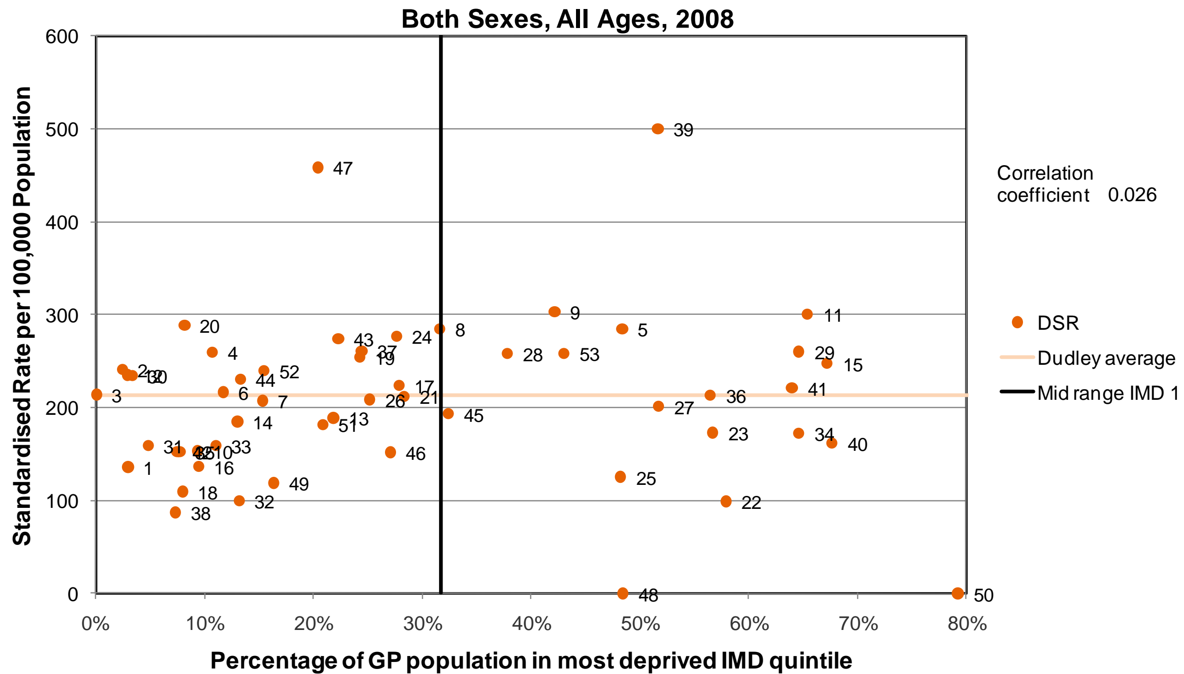
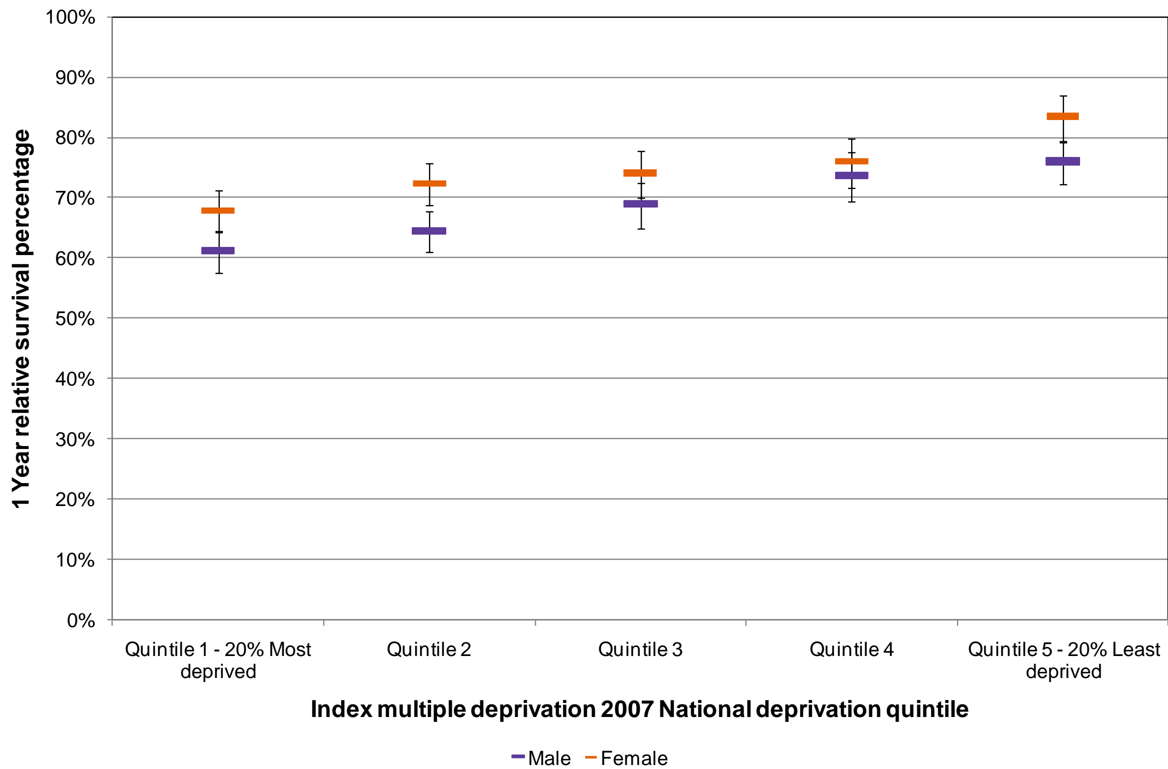


Figure 8 reveals a weak association between emergency admissions and levels of deprivation in general practice suggesting that quality of primary care may have a large over-riding effect.

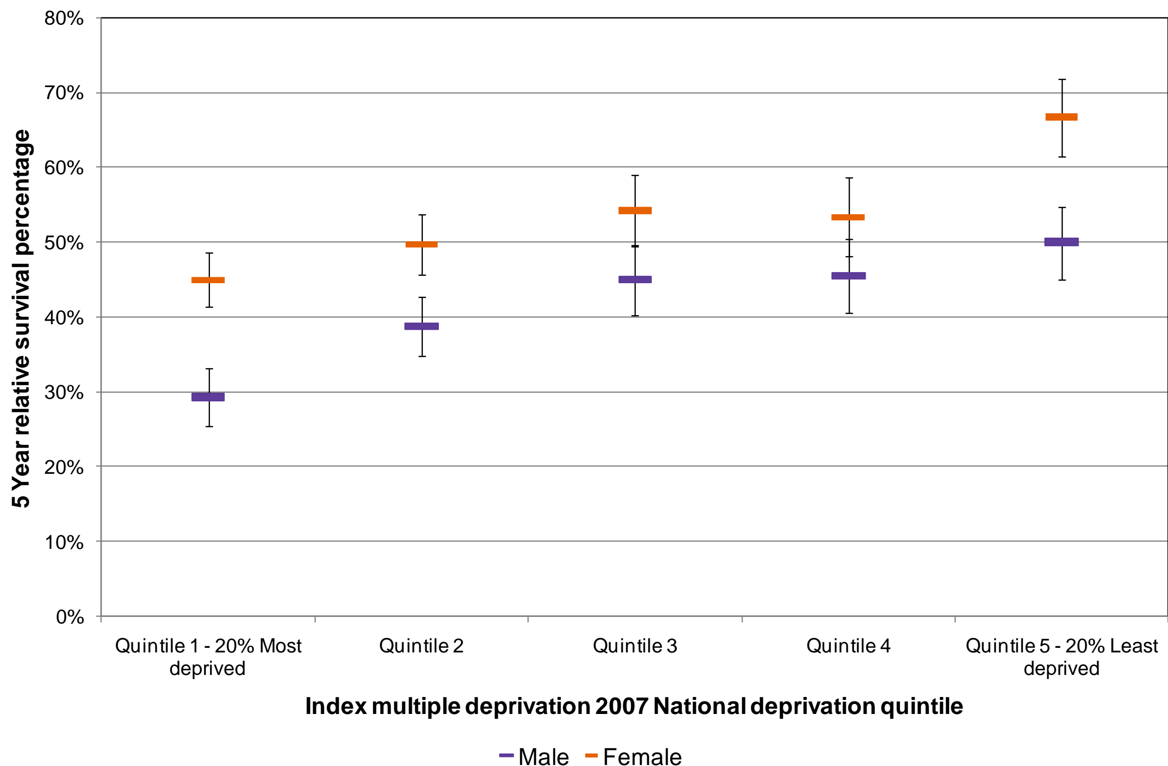
Between 1986-90 and 96-99 the gap in survival rates between the most and the least deprived groups in England and Wales increased for 19 out of 33 cancer types and stayed the same or decreased for the remaining 14 cancer types. Figures 9 & 10 show a similar social gradient in 1 year and 5 year survival for all cancers in Dudley 2007.

Figure 9
Social Gradient in 1 year Survival for all cancers, excluding non melanoma skin cancer (ICD10 C00-C97 ex C44)



Source: WMCIU
Department of Communities & Local Government Indices of Deprivation 2007

Figure 10 Social gradient in 5 year survival for all cancers, excluding non melanoma skin cancer (ICD10 C00-C97 ex C44)



Source: WMCIU; Department of Communities & Local Government Indices of Deprivation 2007

One of the priorities of the *Cancer Reform Strategy* (Great Britain. Department of Health, 2007) is to diagnose more cancers early. The most suitable indicator to demonstrate early presentation with signs and symptoms of cancer is the stage of cancer at diagnosis, but this important information is not universally available at present.

1 year cancer survival rates can be used as a surrogate measure for stage of spread of cancer at presentation, poor survival rates associated with advanced stage at presentation. Advanced stage presentation can be related to delayed attendance or delayed diagnosis. 5 year survival is an indicator of outcome including stage at presentation and the quality of care provided. Factors known to impact upon 5 year survival rates are socio-economic status and uptake and compliance with appropriate high quality treatment.

At PCT level the number of cases for many cancers can be small leading to sensitive results that require careful interpretation. Therefore it was agreed nationally that only the four tumour sites of breast, lung, colorectal and prostate were sufficiently large enough at PCT level to provide robust analyses.

As a comparator the Eurocare4 1 year survival rate has been incorporated into the tables as a consensus target for the four main tumour sites. The Eurocare4 project is based on a collaboration established in 1989 between the Istituto Nazionale Tumori (Milan, Italy), the Istituto Superiore di Sanità (Rome, Italy) and a large number of population-based cancer registries, from12 European countries, with incidence and survival data available. However care should be taken when comparing these data as the methodologies for collecting this information does differ across the countries included.

Figure 11: One year survival by PCT & Network. 2006. Source West Midlands Cancer Intelligence Unit. RAG rating from Cancer Commissioning Toolkit - National Cancer Intelligence Network. (Consensus target – Eurocare 4)

Breast cancer

PCT	Rate %	CCT RAG status
Dudley	95.6	
North Staffs	93.6	
Shropshire	96.1	
South Staffs	95.6	
Stoke	95.1	
Telford & Wrekin	95.8	
Wolverhampton	95.4	
Worcestershire	97.0	
GMCN	95.6	
UK rate	95.1	
Consensus target*	97.0	

Lung cancer

PCT	Rate %	CCT RAG status
Dudley	24.5	
North Staffs	26.2	
Shropshire	27.4	
South Staffs	28.3	
Stoke	27.1	
Telford & Wrekin	23.7	
Wolverhampton	30.6	
Worcestershire	28.4	
GMCN	27.2	
UK rate	28.2	
Consensus target*	37.0	

Colorectal cancer

PCT	Rate %	CCT RAG status
Dudley	76.2	Green
North Staffs	70.6	Amber
Shropshire	77.0	Green
South Staffs	74.9	Green
Stoke	66.1	Red
Telford & Wrekin	80.0	Green
Wolverhampton	70.8	Amber
Worcestershire	71.4	Amber
GMCN	73.7	Green
UK rate	71.1	Amber
Consensus target*	79.0	Green

Prostate cancer

PCT	Rate %	CCT RAG status
Dudley	96.8	Green
North Staffs	93.4	Amber
Shropshire	98.7	Green
South Staffs	98.0	Green
Stoke	90.0	Amber
Telford & Wrekin	94.0	Amber
Wolverhampton	96.8	Green
Worcestershire	97.0	Green
GMCN	96.1	Green
UK rate	94.1	Amber
Consensus target*	96	Green

There are also a range of survivorship issues which have an impact on equality including provision of financial advice, access to follow up assistance in returning to employment and access to psychological support.

Research (Davey, Austoker and Macleod, 1999) focused on women with breast cancer found that those living in deprived areas were:

- More likely to be diagnosed with advanced cancer
- More likely to have a mastectomy, rather than breast conserving surgery
- Less likely to receive radiotherapy
- Less likely to have surgical treatment
- Less likely to have survived five years

Lifestyle factors account for most of the variance in cancer incidence between the most and least deprived groups. Higher smoking prevalence among lower socioeconomic groups is the single most important contributing factor to inequalities in cancer incidence and mortality but different exposures to other risky health behaviours that contribute to inequalities in cancer rates such as: poor diet, obesity,

alcohol consumption, sun exposure also contribute. Smoking causes 9 out of 10 cases of lung cancer. Examination of local smoking cessation services reveals people from deprived areas are more likely to be referred but are less likely to stop smoking. (See Section 7.1)

Diet is linked to around a third of all cancer deaths particularly from bowel, stomach, mouth, larynx, oesophagus, breast and prostate cancer. Sun and UV exposure is the most important preventable cause of skin cancer. Incidence is expected to triple over the next 30 years if people continue to sunbathe and over-use sun-beds. Historically skin cancer has been linked to affluent groups however the overall pattern is changing as increasing numbers of people can afford to holiday abroad or use sun-beds. Disadvantaged groups practice less protective behaviour and are less likely to check their skin and therefore have poorer survival outcomes.

Table 1: Selected cancers, estimated percentages preventable through lifestyle change.

	Estimated % preventable
Lung	33%
Breast	42%
Colo-rectal	43%
Total all cancers	26%

Source: World Cancer Research Fund and American Institute for Cancer Research (2009). Policy and action for Cancer Prevention - Food, Nutrition and Physical Activity: A Global Perspective.

Modelling of primary prevention uptake based on the future health scenarios described in *Securing our Future Health: Taking a Long Term View* (Wanless, 2002) predicts substantial health gains in terms of cancer incidence, mortality and years of potential life lost.

Part of the rest of the difference is attributable to lack of awareness, delayed diagnosis and inequalities in uptake of screening. Levels of public awareness of cancer signs and symptoms are generally low, but even lower in some groups, such as deprived communities, some minority ethnic groups and men. This may contribute to lower uptake of screening and later presentation when symptoms arise. Among disadvantaged groups there is evidence of misunderstanding and fear about cancer. People from deprived groups are the most likely to present at health services (and be diagnosed) when their cancer is at a more advanced stage. (Gordon-Dseagu, 2009). Health literacy is a particular problem for some socioeconomically deprived patients.

Inequalities exist for other population groups including: black and ethnic minority groups, older people – (demographically the biggest risk factor for cancer is increasing age), men and women, vulnerable groups with learning disabilities or mental health problems and individual sexual orientation.

For the vast majority of cancers, incidence increases with age. Just over half of all cases of cancer occur in people over 70 years old and a fifth in people over 80 years. The improvement in cancer mortality achieved over the last decade has been much less marked for the over 75s. Older people with cancer receive less intensive

and less radical treatment than younger people. It is true that some older people will present later, have co-morbidities or are too frail for treatment but age should never be the sole reason for treatment decisions. NCIN estimated that around 15,000 people aged 75 and over die prematurely from cancer in the UK each year.

Men are diagnosed with more cancers (excess incidence 16%) and have a higher mortality from cancer (38% excess mortality) although this varies by cancer type. This means that there are more women than men living with or beyond a diagnosis of cancer. Cancer accounts for 25% of the life expectancy gap for men and 16% of the gap for women. The cancers which would deliver the greatest increase in life expectancy in Dudley if mortality rates were equivalent to the UK average are: oesophago-gastric cancers, colorectal cancer, lung cancer and breast cancer.

Men have a lower awareness of the signs and symptoms of cancer but although it has been assumed that men delay seeking help there is no evidence that this is the case. Some men find GP services to be inaccessible and further work is needed to develop “male friendly” primary care services.

People with mental health problems have higher smoking rates and higher rates of overweight and obesity. People with schizophrenia have been found to be twice as likely to have bowel cancer and sufferers with depression have higher rates of breast cancer. Evidence suggests people with mental health problems are more likely to postpone presentation when they have cancer symptoms, delay the diagnosis process and present with more advanced cancer. They also have poorer uptake of screening programmes. Mental health professionals may have little training in cancer signs and symptoms while primary care staff may not always have the communication skills required to assess the needs of individuals with mental health problems.

Similarly people with learning difficulties may struggle to express changes to their health potentially complicating and delaying diagnosis and also have lower uptake of screening programmes.

Variations in cancer incidence between ethnic groups, is likely to be the result of a mixture of lifestyle and genetic factors. As well as cultural factors variation may also be related to deprivation. Women from minority ethnic groups are more likely to present with more advanced breast cancers and have poorer survival than white women. Breast cancer occurs at a younger age and as a more aggressive tumour type among black women of African or Caribbean descent. However breast cancer rates are lower among South Asian women. Smoking rates and tobacco consumption are higher among males from some minority ethnic communities including Bangladeshi, Caribbean and Chinese. Prostate cancer rates are higher among black African and Caribbean men.

Cancer awareness is generally lower in minority ethnic groups as is screening uptake. These vulnerable groups have unmet needs relating to health information, awareness of cancer risk factors, signs and symptoms and cancer services. There is a need for access to culturally relevant information about cancer and its signs and symptoms.

What are the gaps/where are we going

Sources of inequality in cancer survival and mortality in Dudley include:

- Awareness and attitude to lifestyle risk factors for cancer
- Awareness of the early signs and symptoms of cancer
- Uptake of prevention, screening and primary care services
- Access to diagnostic and treatment services from primary care
- Access to diagnostic and treatment services in secondary care
- Provision of information and support
- Access to high quality end of life care for all people approaching end of life

Cancer awareness measures show that awareness of cancer symptoms is lower in men, younger people, lower socio-economic groups and ethnic minority groups (University College London, 2009).

Screening uptake for bowel cancer is lower for men and uptake for breast and cervical cancer screening is very close to the national targets of 80%.

Primary care audit (Eden and Davies, 2010) reveals late presentation with symptoms to primary care and delays in diagnosis and referral in primary care.

Tackling inequalities requires a real commitment to reducing inequalities in cancer by focusing on 1 year survival rates for all ages. A 1 year indicator would shift attention to the vital first year after cancer is suspected, provide impetus to raise awareness of early symptoms of cancer, promote early presentation and diagnosis and speed up the referral system.

Key actions to reduce cancer inequalities:

- Promote healthier lifestyles
- Raise awareness of cancer signs symptoms and increase the uptake of screening programmes
- Reduce cancer waits for all patients
- Enhance quality and timeliness of information
- Provide financial and psychological support

The majority of health information is text based. Letters, leaflets, and websites are sometimes produced in small print and written in complex language that people can find difficult to understand. Research suggests that one in six patient information leaflets produced by hospices and palliative care units can only be read by 40 per cent of the population, and that only 30 per cent of GPs surgeries have accessible information for people with learning disabilities. A key factor in the low take up of financial benefits is a lack of information. Research indicates that around three quarters of cancer patients report not being given benefits information by anyone. A third of cancer patients – likely to be those most in need and least able to get information themselves – stated that they would have liked such advice.

As more people than ever are surviving after a diagnosis of cancer and the number diagnosed with the illness is rising it is estimated that one in ten people over the age of 65 are living with a diagnosis of cancer. There is therefore much to do to plan and organise services to help and support cancer survivors.

Extended age limits for screening – breast cancer to 73 and bowel cancer to 75 to gain benefits and achieve uptake rates need to ensure communication and promotion to target groups.

The Health Inequalities National Support Team found that in Dudley there was:

- Good primary care participation in national audit of primary care of newly diagnosed cancer.
- Excellent public/user engagement in planning services e.g. head and neck.
- A dedicated cancer patient information lead in the cancer network.
- A strong community focus, including education and awareness raising by clinical nurse specialists.
- Nationally recognised work on promoting HPV vaccination by the HPV vaccination co-ordinator.
- A commendable level of psychological support for cancer sufferers and charitable cancer drop in centre support for patients eg. 'Light House'.
- An innovative cancer health improvement coordinator post in the PCT, who utilises social marketing and community engagement to increase awareness of cancer and uptake of cancer screening, eg. 'Blossoms and Mangos'- a series of plays aimed at minority groups to address barriers to screening uptake.

How do we get there?

The aim is three-pronged; to reduce the number of people who develop cancer through effective prevention messages, to reduce cancer deaths through earlier diagnosis and optimum treatment and reduce inequalities through effective social marketing techniques.

Whilst a similar proportion of people in Dudley as elsewhere have cancer more people die from the condition. The largest cause is the number of people in deprived areas developing lung cancer (particularly men) and the most effective intervention is to reduce smoking rates in these areas.

Promote healthy behaviours, including nutrition and physical activity, to reduce obesity.

To improve health outcomes for people with cancer there is a need to encourage earlier presentation and detection and increased access to evidence based treatments.

Analyse the results of the 2010 National Cancer Patient Experience survey which will provide a comprehensive view of experience by age, gender, deprivation and ethnicity.

Multi Disciplinary Teams should monitor new patients by ethnicity, age, gender, postcode and primary treatment, also stage at presentation. Use of this data through annual equality audits should enable inequalities to be addressed at the service level. This will help to identify indicators of late presentation that emerge, outcomes following treatment etc. Without staging data, it is not possible to compare like for like outcomes locally and between local services and national/international comparators.

To tackle the rising incidence of skin cancer the need is to reduce access to sun beds by under 18yr olds and promote the safe sun message.

Organise comprehensive social marketing/community engagement campaigns focused on 6 key cancers lung, breast, bowel, cervical, prostate and skin; including a focus on inequalities in uptake of screening programmes. Co-ordinate activity between the Cancer Network and the PCT to avoid duplication and enable collaboration and resource sharing with PCT neighbours in awareness raising and in tackling barriers to screening.

Ensure expansion of the breast screening programme to 47-50 and 70-73 and expansion of bowel cancer screening programme to 75.

Increased focus on cancer survivorship, for example, providing better cancer health information in partnership with the voluntary sector such as supporting the Macmillan Citizens Advice Bureau service

Ensure access to high quality end of life care and extend choice for dying cancer patients.

Review primary care urgent 2 week referrals and conversion rates (to cancer diagnosis) to ensure best use of urgent referral route.

Examine variation in primary care referral rates which may indicate population groups or geographic areas where there is low public awareness and/or negative beliefs or lack of good quality primary care services.

Systematically employ the Cancer Commissioning Toolkit to ensure implementation of National Improving Outcomes Guidance for all cancer sites, in particular for upper gastrointestinal cancers and specialist supportive and palliative care to ensure best outcomes for cancer patients in Dudley.

Strengthen the role of GPs in early awareness/diagnosis of cancer and improving screening uptake.

Address capacity issues at the local cancer unit to ensure equality of access to high quality to chemotherapy, for example, by considering community treatments.

Develop sustainable mechanisms to routinely and systematically capture and use cancer data including:

- Staging data
- 1- and 5- year survival data with benchmarking for PCT, provider trust

- Benchmarking of surgery aspiring to be curative e.g. lung, stomach, colorectal
- Data to help identify late presentation by locality/ethnicity/ tumour type

7.6 CHRONIC OBSTRUCTIVE PULMONARY DISEASE

BACKGROUND

It is estimated that there are more than three million people in England living with chronic obstructive pulmonary disease (COPD), although only 835,000 have been diagnosed. It causes more than 25,000 deaths a year. It is the second most common cause of emergency admissions to hospital and the fifth largest cause of readmissions to hospital.

The direct cost to the healthcare system is estimated to be between £810 million and £930 million a year. The economic cost is assessed as being even higher, with lost productivity to employers and the economy estimated at £3.8 billion. COPD causes at least 20.5 million lost working days amongst men and 3.5 million days among women every year. The social cost of COPD is related to quality of life because sufferers are unable to participate in everyday activities such as gardening or housework and 66% of sufferers were unable to take a holiday because of limited mobility or disabling breathlessness.

COPD is a term used to describe a group of conditions, mostly chronic bronchitis or emphysema. Asthma is usually included in this heading because of the similarities in symptoms and the burden on the healthcare system, but it is not a principal contributor to premature mortality. The main symptoms are shortness of breath and reduced exercise ability. There is usually a cough and production of phlegm and patients often have repeated chest infections. The lung damage is gradual in onset and eventually irreversible, leading to disability and eventually death.

INEQUALITIES AND COPD

There are established links between deprivation and lifestyle factors, but smoking is the single most important, preventable risk associated with COPD. Giving up smoking is one of the key things to achieve to reduce risk. Unfortunately, where lung disease is severe it cannot be reversed, so early identification is essential to improve the prognosis.

Maternal smoking during pregnancy is associated with reduced lung function in school aged children and it also affects foetal development of the respiratory system. There is strong evidence to suggest that exposure in pregnancy may predict the development of asthma and reduced lung function later in life. Taking up smoking at a young age (before 16) is also a predictor of increased risk of COPD at a later age.

Inequalities due to COPD arise from the fact that smoking is more prevalent in lower socioeconomic groups. 26% of routine and manual workers smoke compared with 15% of those in managerial and professional occupations. Department of Health estimates suggest that routine and manual workers represent approximately 50% of the people with COPD in England. Men aged between 20 and 64 who are employed in unskilled manual occupations in England and Wales are around 14 times more likely to die from COPD than men in professional roles and are around seven times more likely than those in managerial and technical operations (Great Britain. Department of Health, 2010).

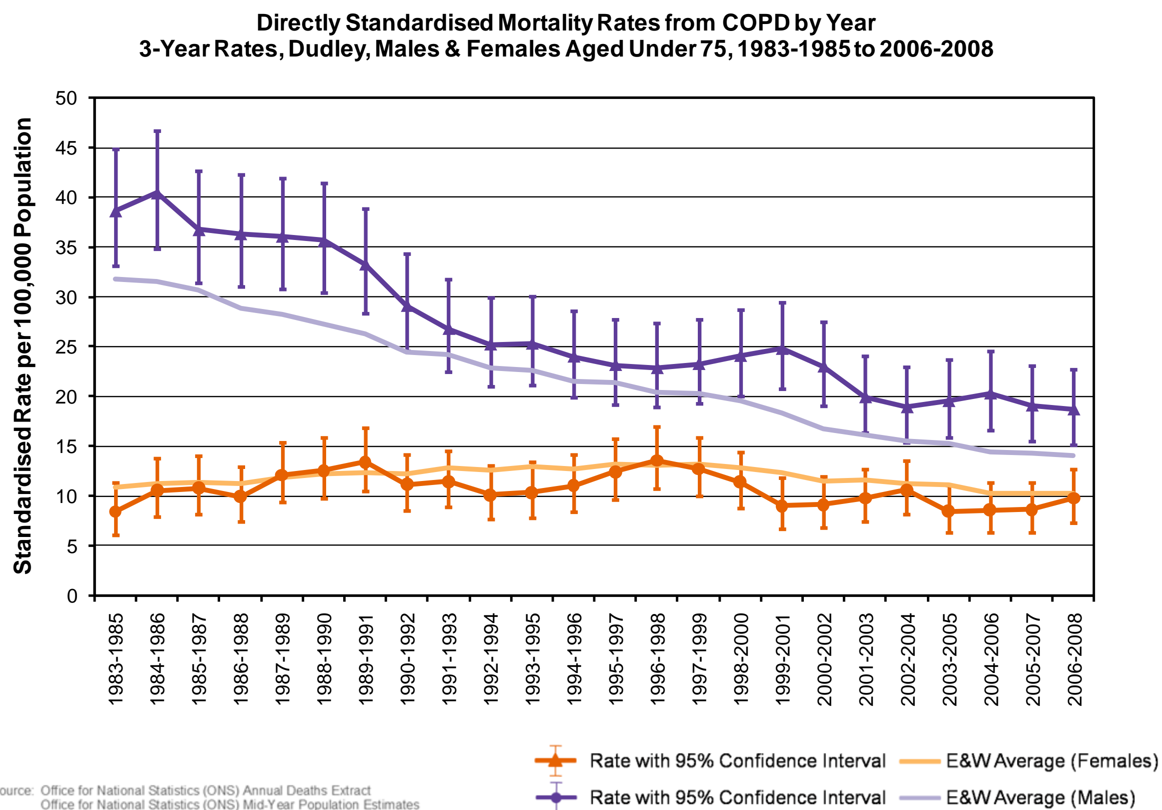
The inequalities gap is even bigger for those from the most disadvantaged sections of the community where in some cases smoking prevalence can reach 74% (e.g. people with schizophrenia) (Great Britain, Department of Health, 2010)

CHRONIC OBSTRUCTIVE PULMONARY DISEASE IN DUDLEY

There has been a general decline in premature mortality from COPD in Dudley over the last twenty-five years, but the rate of decline has now slowed and the gap between Dudley and England and Wales has widened slightly in the last six years.

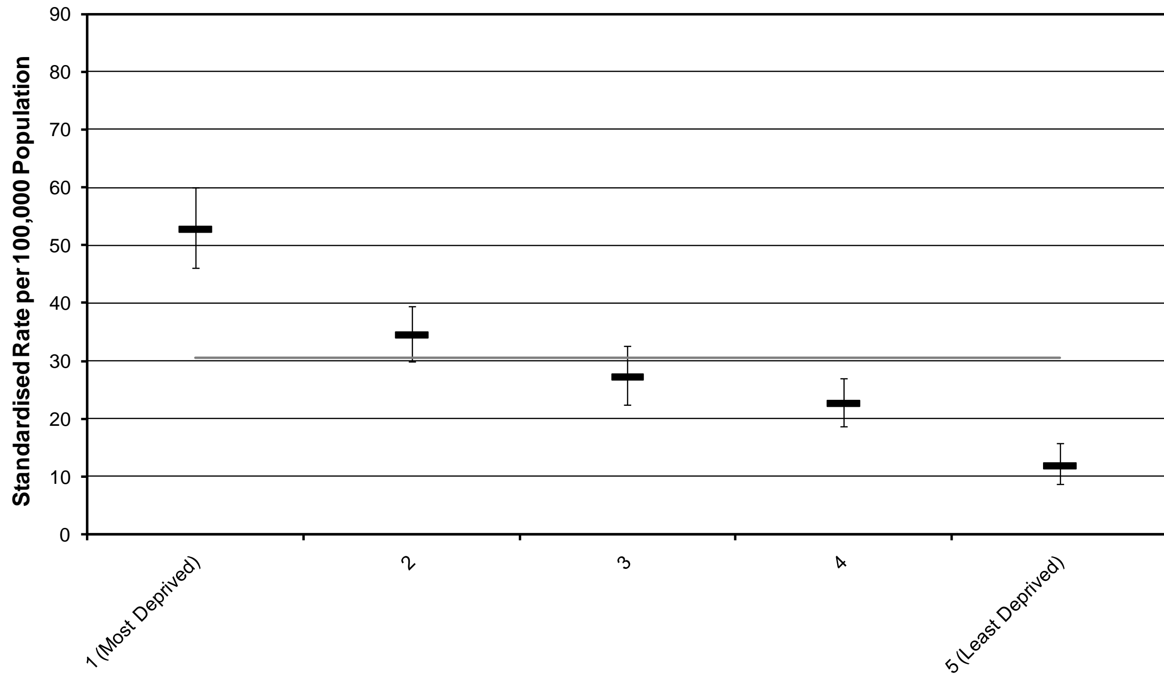
When differences in gender are analysed it can be seen that premature mortality in males is significantly higher than the national average, and although female rates are still below the national average the gap is getting much narrower than it was twenty-five years ago. (Figure 1)

Figure 1



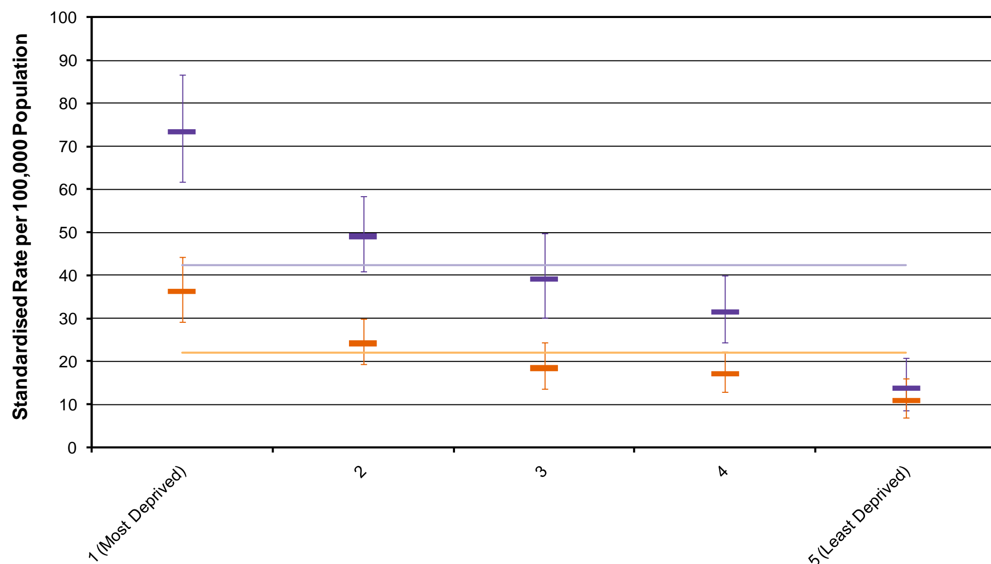
When we look at mortality using the deprivation indices it is noticeable that premature mortality from COPD is significantly higher in the most deprived quintile compared with the least deprived. (Figure 2)

Figure 2



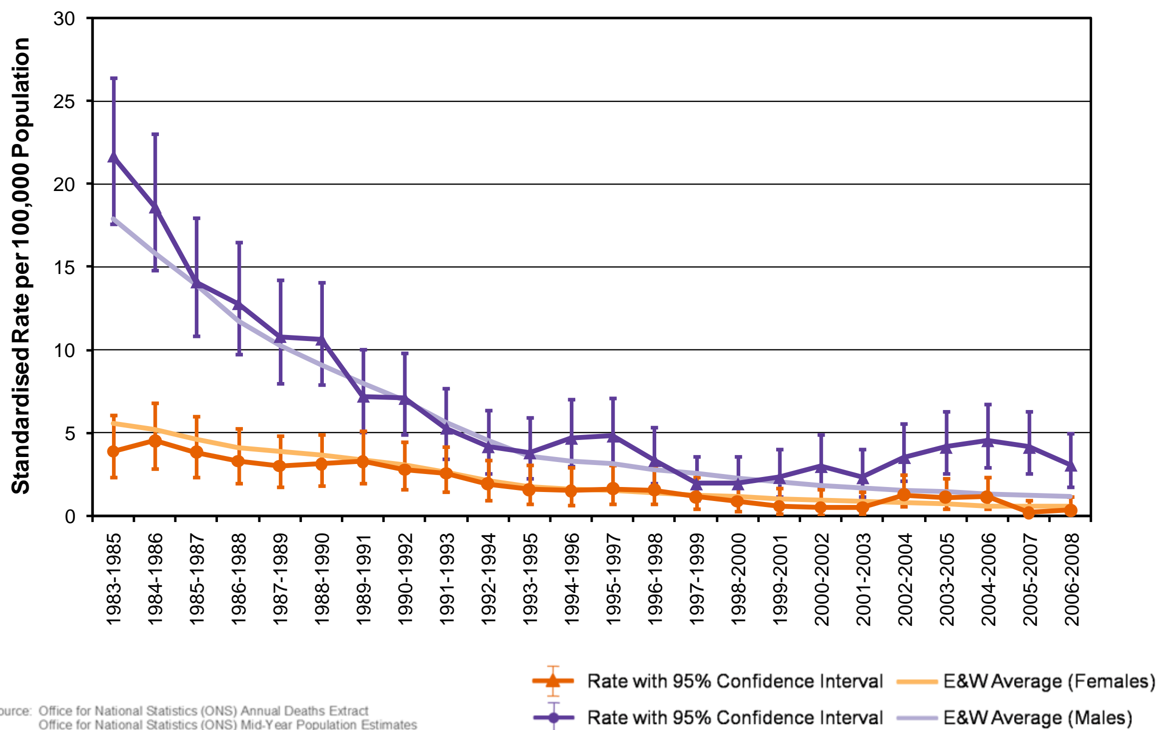
Males in the bottom quintile of deprivation have higher mortality rates than females and the gap between the most deprived quintile and the least deprived quintile is much bigger for males than females (Figure 3)

Figure 3



If the mortality associated with the two biggest disease contributors to COPD, bronchitis and emphysema, are compared a similar pattern can be seen. The decline in premature mortality is the greatest in males, but this decline has slowed and is now higher than the national downward trend. (Figure 4)

Figure 4



Admissions to hospital associated with COPD

The three year rates for admissions to hospital caused by COPD have reduced slightly for males but increased very slightly since 2003 for females .(Figure 5). Emergency admissions show the same patterns

Figure 5

.

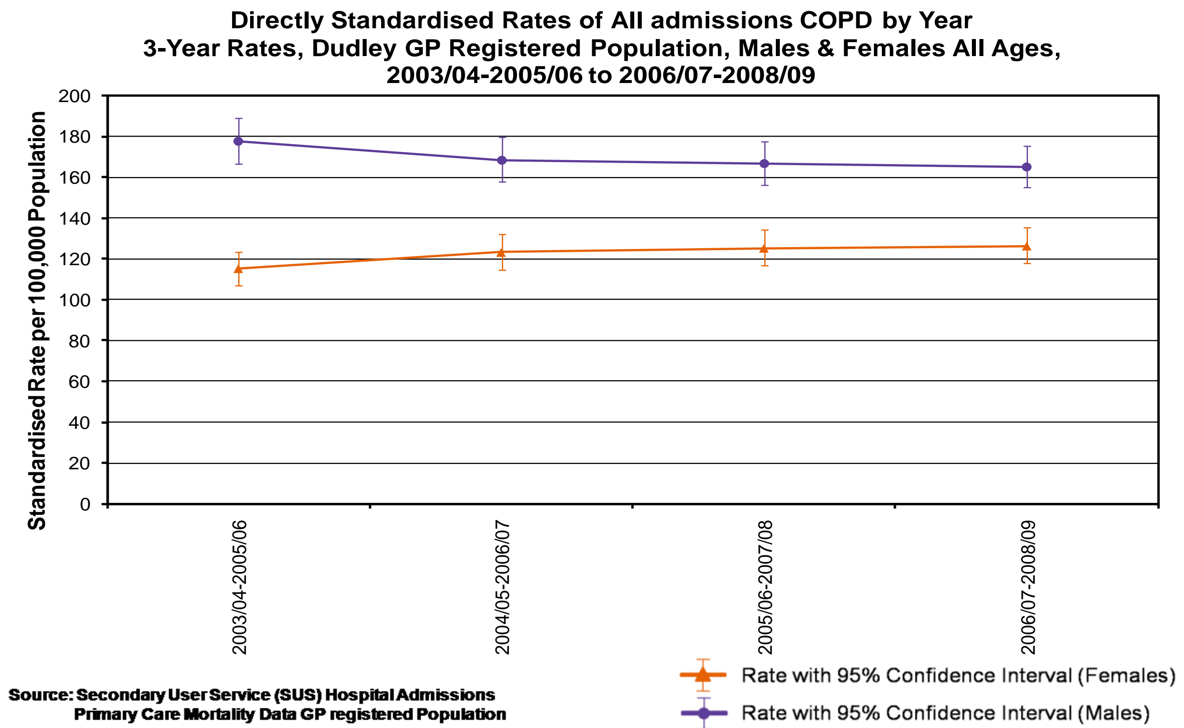
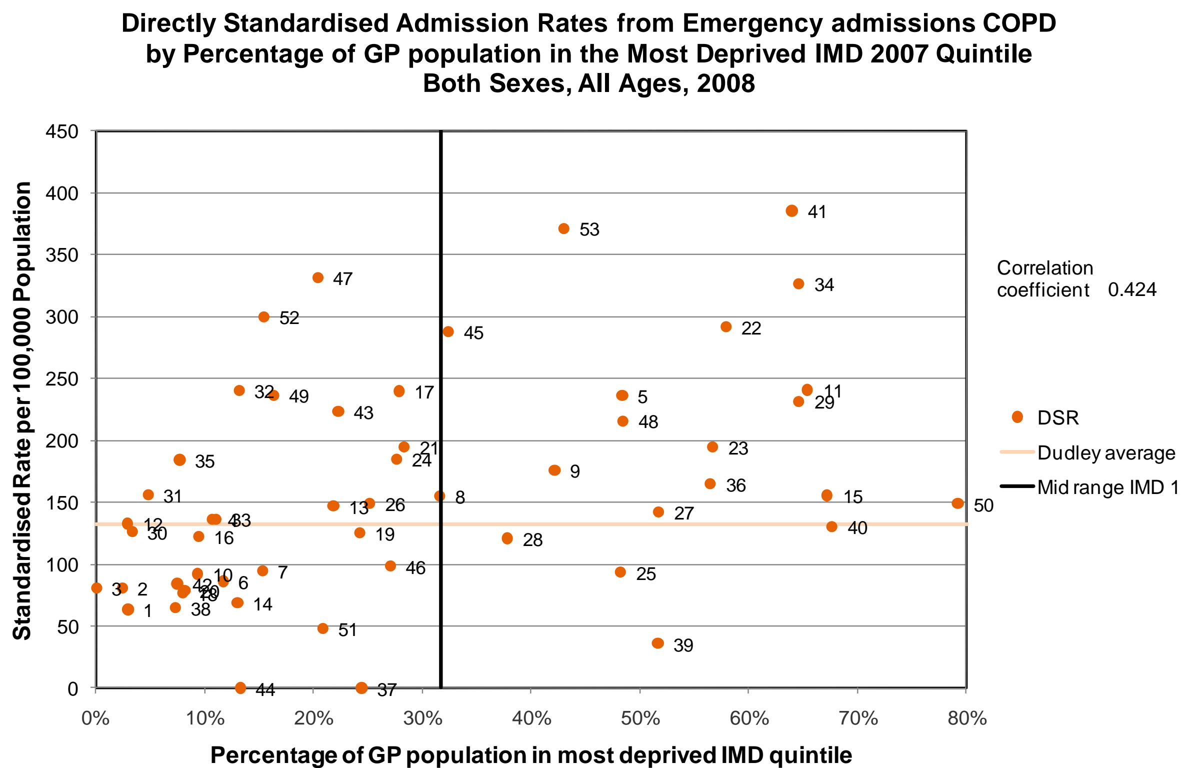


Figure 6

.



There is a weak correlation between deprivation and emergency admissions for COPD, with GP practices with a higher percentage of their population in the most deprived quintile showing slightly more tendency to have higher rates of emergency admissions for COPD. (Figure 6)

COPD SERVICES IN DUDLEY

COPD LES

- A COPD Local Enhanced Service (LES) is in place that provides proactive management of patients with COPD to reduce hospital admissions by reducing and minimising duration of exacerbations.
- Each practice has developed a 'high risk of admission' register so that these patients can be easily identified.
- The initiative has seen the introduction of a self management plan for every patient as well as the provision of standby antibiotics/steroids for patients. Additionally a web based intranet site has been developed detailing guidelines for the treatment and management of COPD patients which is accessible to all health professionals across the borough.
- Current data is indicating that there are positive outcomes from this service and a reduction in admissions to hospital for COPD.
- The COPD LES is closely monitored and the numbers of reviews and patient admissions to hospitals are brought to the attention of the practices and discussed.

Other initiatives

- A lead Respiratory Nurse for community nursing linking in with the Dudley Respiratory Assessment Service. The role includes support to generic staff including primary care practitioners, community case managers and other community staff.
- COPD personal management plans (part of LES)
- All the practices to have at least one member of staff to have undertaken training and have the COPD Diploma.
- Pulmonary rehabilitation services are available at a range of community venues
- Oxygen therapy assessment service with full patient support provision.
- Smoking cessation services
- Local clinical guidelines agreed between primary and secondary care

The National Strategy for COPD consultation document was issued this year and scrutinized via the Respiratory LIT. In Dudley COPD has had a concerted focus driven by the LES. There are further areas that Dudley needs to take forward e.g. end of life care and identifying people with COPD not known to practices.

The performance of COPD services and review of the pathway is reviewed by the Respiratory Local Implementation Team that meets quarterly and includes both primary and secondary care clinicians, pharmacists, public health, nurses and commissioners,

HINST and COPD

Although the HINST did not hold a specific workshop on COPD when they visited, they have since produced a series of recommendations on delivering better management of COPD based on the experiences of the Spearhead PCTs. These recommendations have been reviewed and concur with the COPD pathway that is implemented in Dudley.

The local priorities for development are:-

- As part of the National COPD Strategy and to increase ascertainment numbers in Dudley a 'Missing Millions' (previously undiagnosed COPD) pilot has commenced: Audit of 800 patients via GP surgeries, community pharmacists, Dudley Stop Smoking Service
- Implement the new NICE guidelines for COPD Mild, Moderate, Severe and Very Severe
- There is an application via SHA for End of Life workforce projects for an end of life care lead/nurse for COPD
- There is a concerted focus to improve under diagnosis and increase ascertainment of asthma in Dudley via an education and training programme. There will also be actions to reduce the numbers of recurrent admissions with asthma

7.7 SEASONAL EXCESS DEATHS

REDUCING SEASONAL EXCESS DEATHS

Excess winter deaths (EWD) are widely attributed to the effects of cold. They occur mainly in the elderly and more particularly in the over 85 year age group. The majority of deaths are linked to circulatory and respiratory diseases and there is a smaller, but relevant, number linked to falls. There are also increased numbers of deaths linked to seasonal influenza, which can increase greatly in a flu pandemic.

Older people living in older or large properties who cannot afford to keep their house warm are most at risk, and fuel poverty (spending more than 10% of annual income on energy bills to keep the house heated to adequate levels) affects the elderly and vulnerable groups the most.

Initiatives designed to improve insulation and heating of properties are known to impact on excess winter deaths. Other high impact initiatives are those designed to reduce falls in the elderly and to promote the uptake of influenza vaccinations. Whilst most of the effective initiatives focus on reducing deaths from cold, it must be borne in mind that excess summer temperatures, also cause an increase in deaths among the very young, the vulnerable and the elderly. This is likely to become more of a problem if the predicted effects of climate change come about.

EXCESS WINTER DEATHS IN DUDLEY

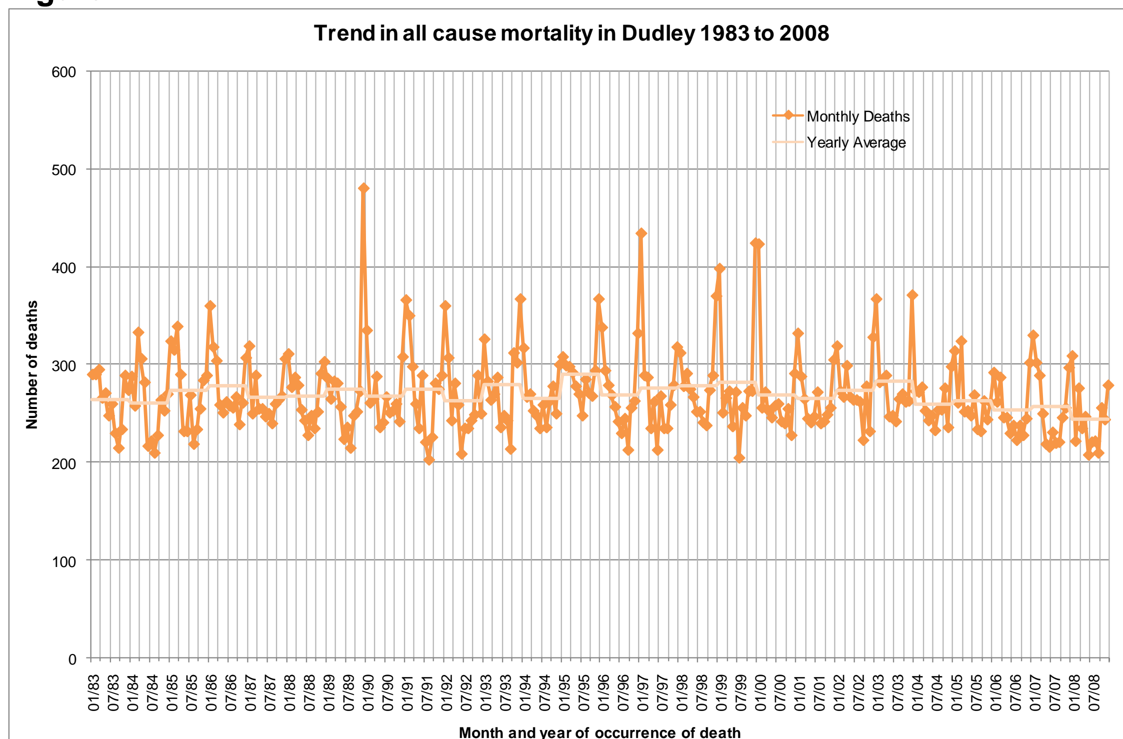
Excess winter deaths are defined as:

The number of deaths in the four winter months (December to March) minus the average number of deaths in the preceding four months (August to November) and the subsequent four months (April to July).

This means the year used for calculations runs from August to July, compared with other data which is usually based on a calendar year (January to December) or a financial year (April to March). The calculation of EWD is expressed as a percentage of the average number of deaths in the preceding four months and this provides the excess winter deaths index (EWDI).

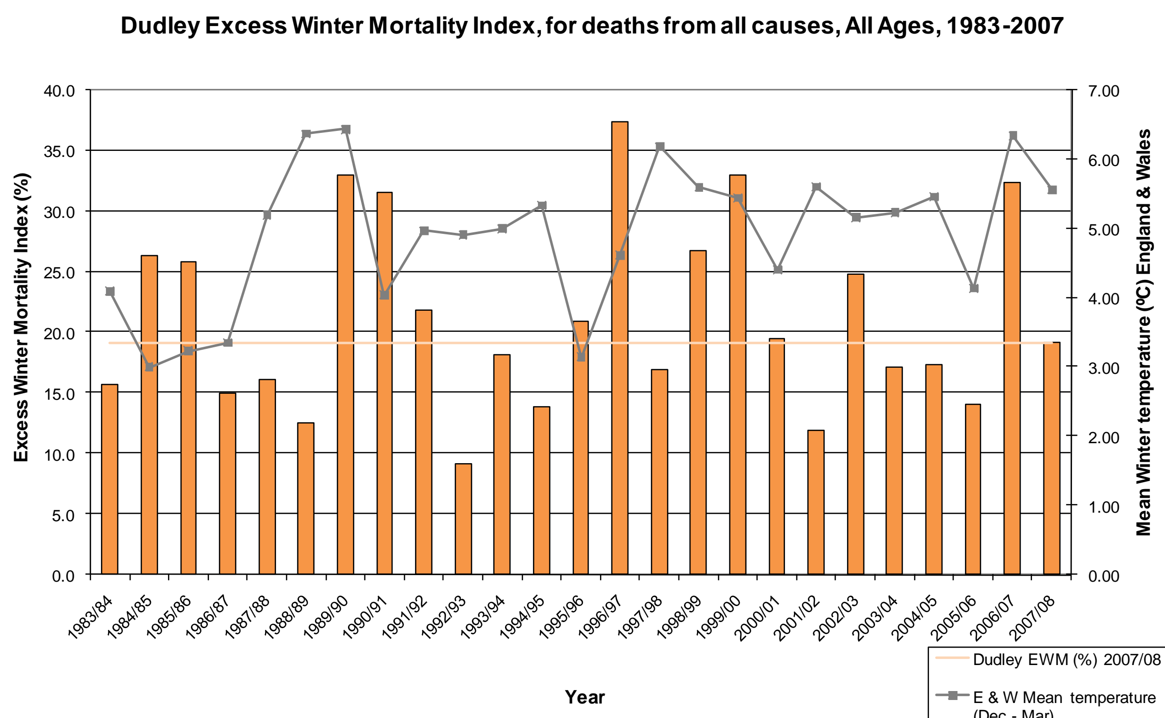
Seasonal mortality patterns

Figure 1



The graph (Figure 1) shows the seasonal variation in deaths from all causes from 1983 to 2008 with winter spikes in January 1990, 1996, 1997 and 1999. Since 2000 the increase in numbers of winter deaths has fallen slightly in line with regional and national trends.

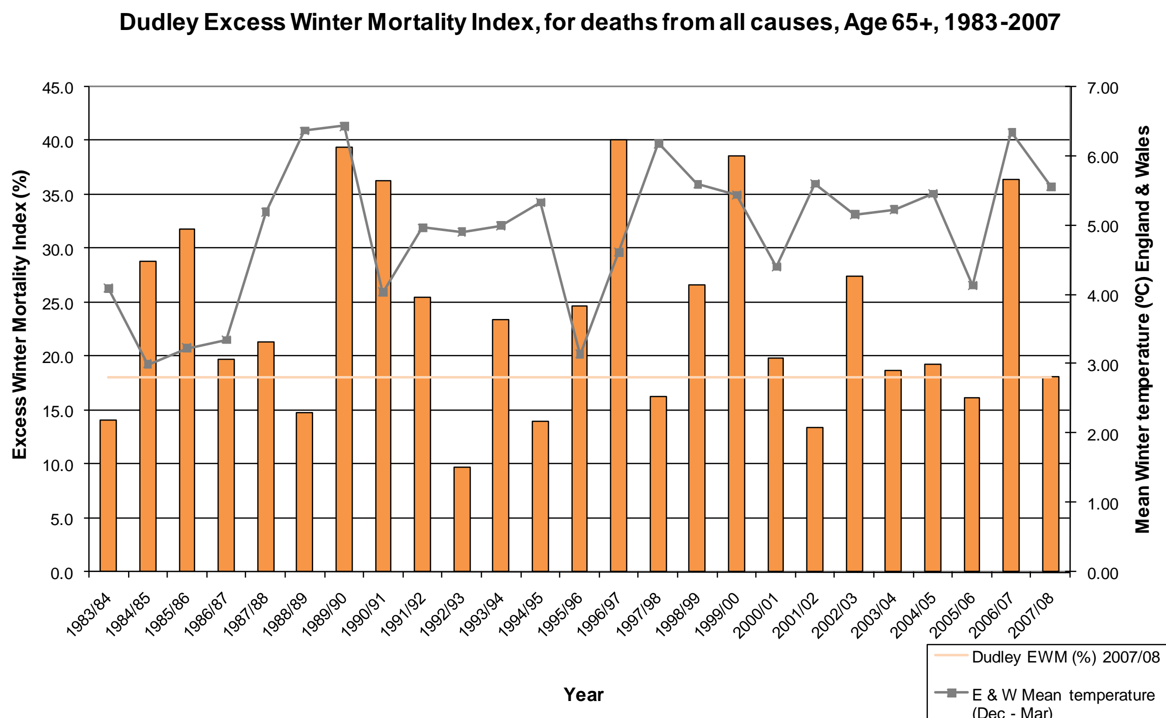
Figure 2



The excess winter mortality index (Figure 2) does not show a close correlation with low mean winter temperatures, which suggests factors other than cold have played a part in those winters with higher than normal deaths. Seasonal influenza, for instance, may also affect the EWDI.

Figure 3

Age



Excess winter deaths can affect all age groups but the 65+ group has the biggest susceptibility. Figure 3 shows that the profile for 65+ is similar to that for all ages. The increase in mortality for the 85+ age group is more pronounced, but the correlation between increased mortality and mean winter temperatures is not strong, suggesting that factors other than external temperature also play a part in this older age group.

Figure 4

Gender

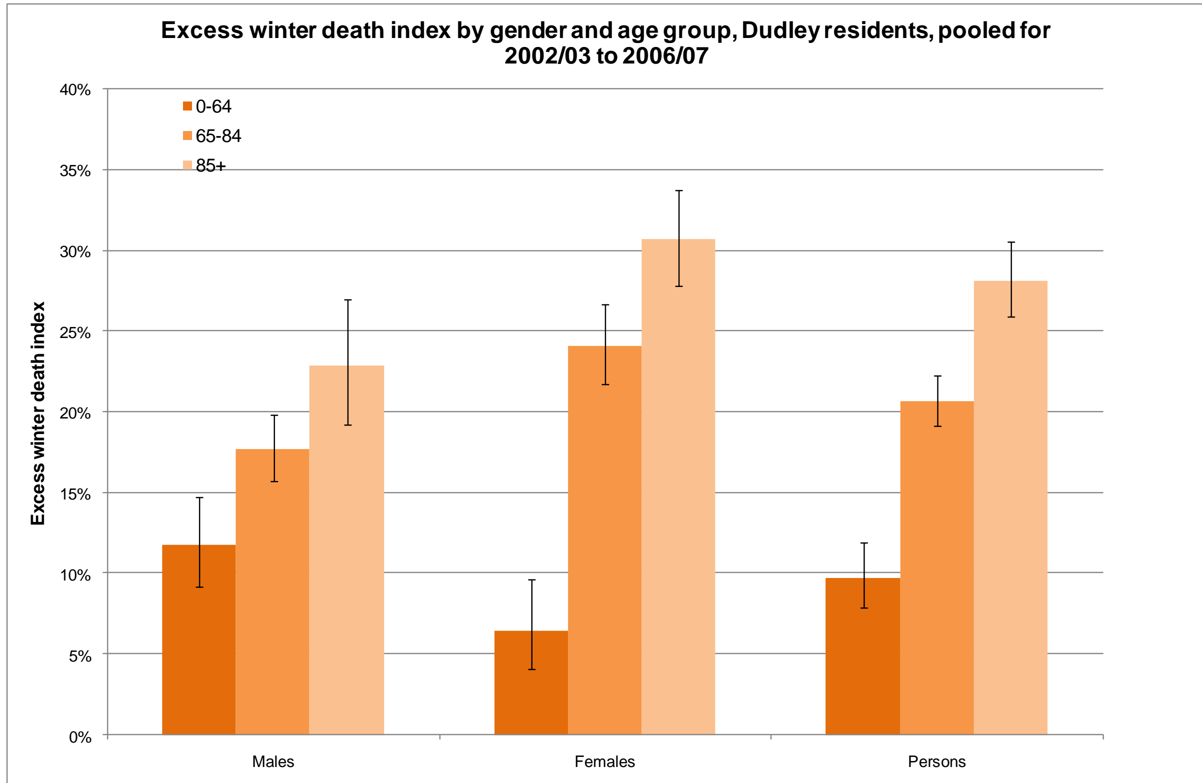
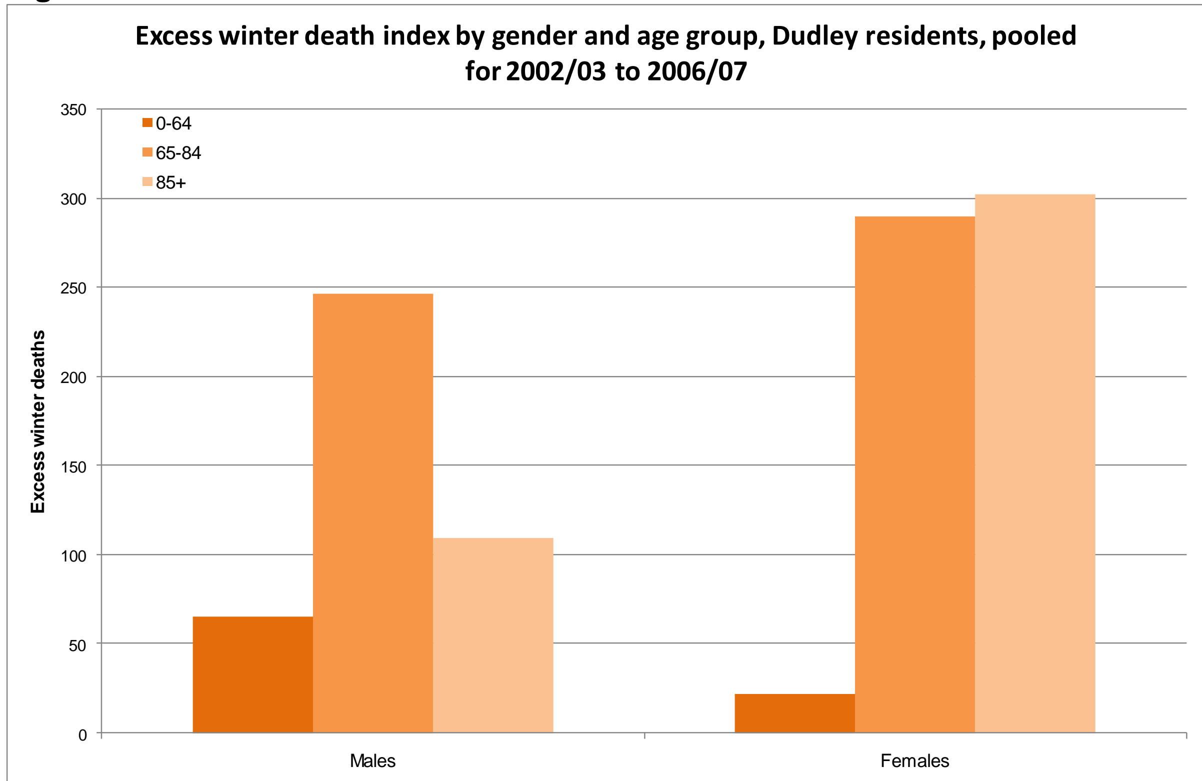


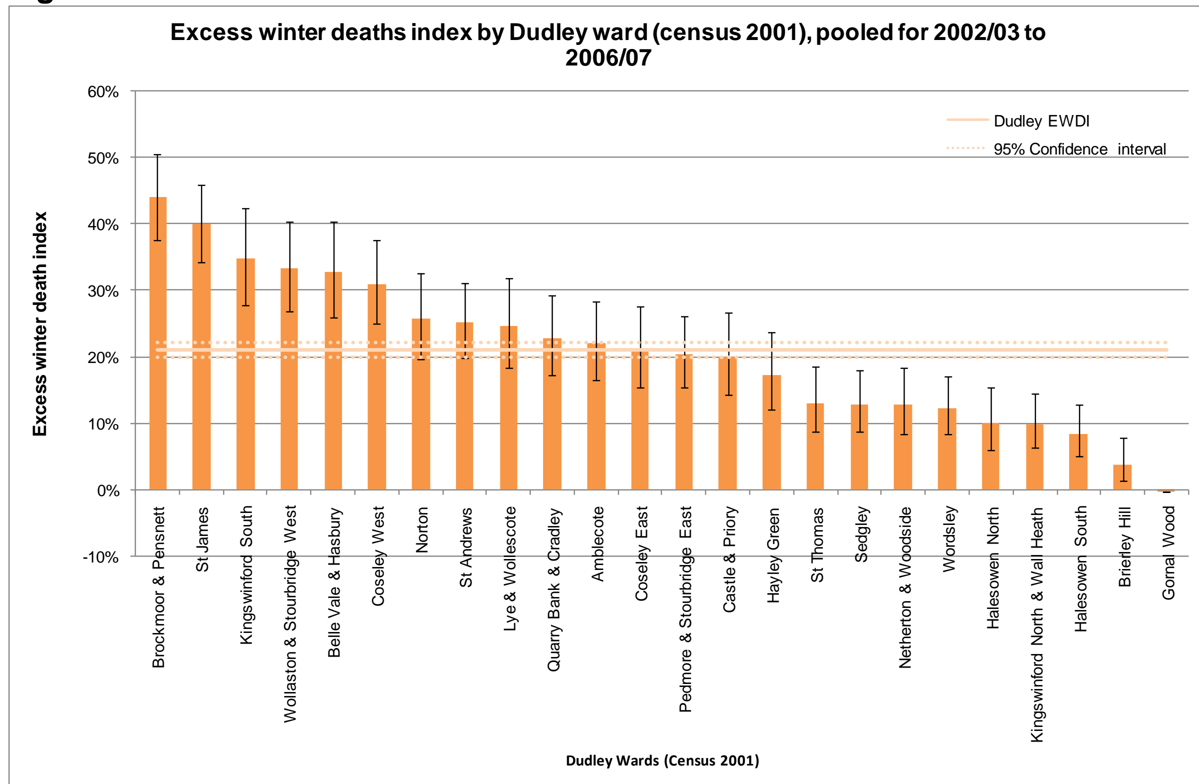
Figure 5



When gender inequalities are compared, (Figures 4 & 5) it can be seen that more men than women die before the age of 64, but for both the 65-84 year age group and the 85+ it is females that have increased mortality. The biggest cause of deaths for females aged 65+ is for respiratory diseases and these medical conditions are worsened by cold and damp.

Local variations across Dudley

Figure 6

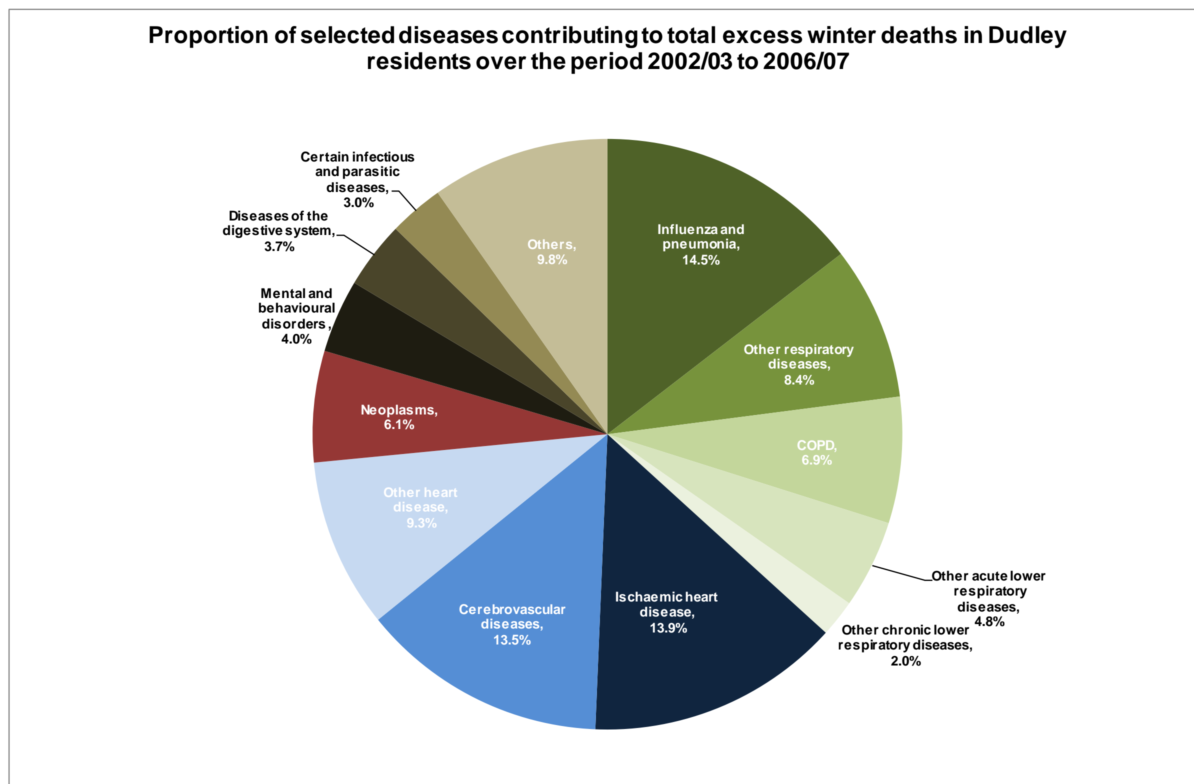


Inequalities in excess winter deaths (Figure 6) are also evident across the wards in Dudley, although they do not follow the usual patterns for other health inequalities. Brockmoor and Pensnett and St James' ward have the highest numbers of winter deaths whereas Gornal Wood, Brierley Hill and Halesowen South have very small numbers.

If Dudley PCT is compared with other PCTs in the West Midlands region there were 989 excess winter deaths between 2002/03 and 2006/07, giving Dudley the 5th highest percentage of the regional total of winter deaths in the region.

Figure 7

Causes contributing to total excess winter deaths



Almost all the major causes of death can contribute to winter mortality, (Figure 7) but the most common causes are respiratory and circulatory diseases which account for 70.3% of all deaths.

Influenza and pneumonia account for 14.6% of the total; the largest single contributor of all the major causes. An increase in the uptake of the influenza vaccine would make a real difference to premature deaths in this category, particularly amongst vulnerable groups and the elderly. The Department of Health target for uptake of flu vaccine is 70% and Dudley has reached or exceeded this target from 2006 to 2009 in the over 65s (Figure 8). Uptake amongst the under 65s has been less successful and although there has been a year on year increase since 2006 it only just reached 50% uptake against a Department of Health target of 60% by 2009/10 (Figure 9).

Figure 8

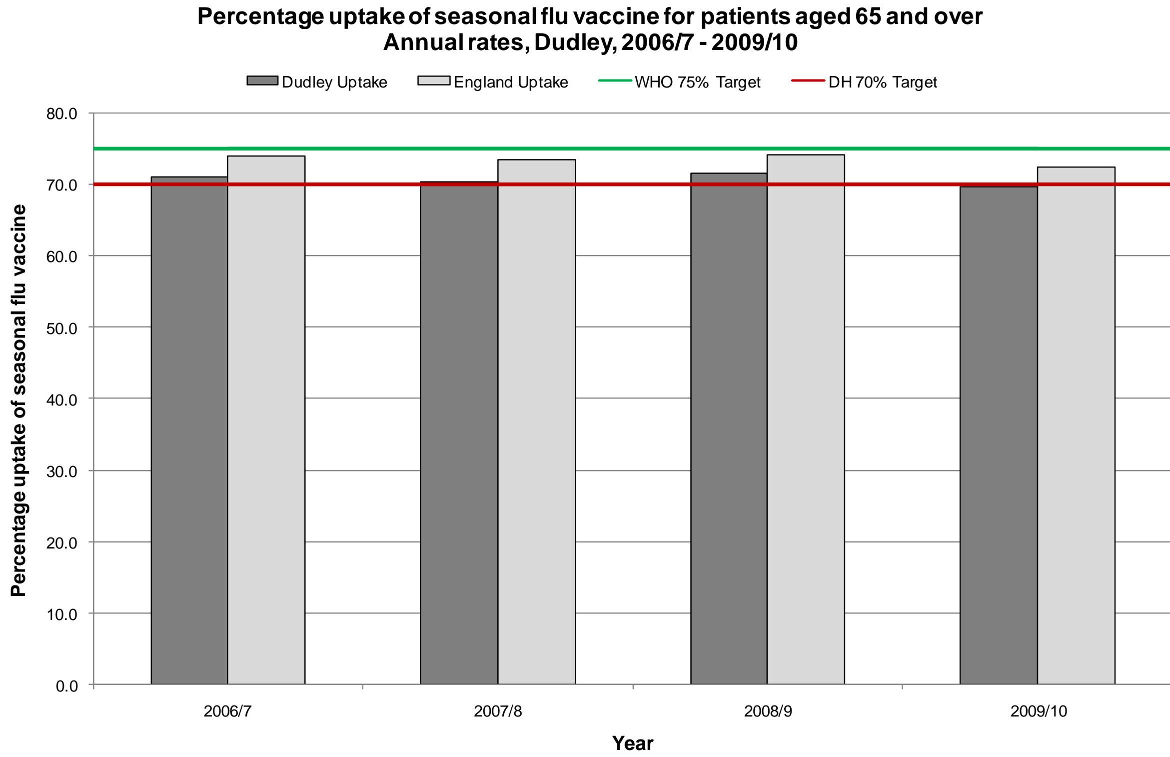
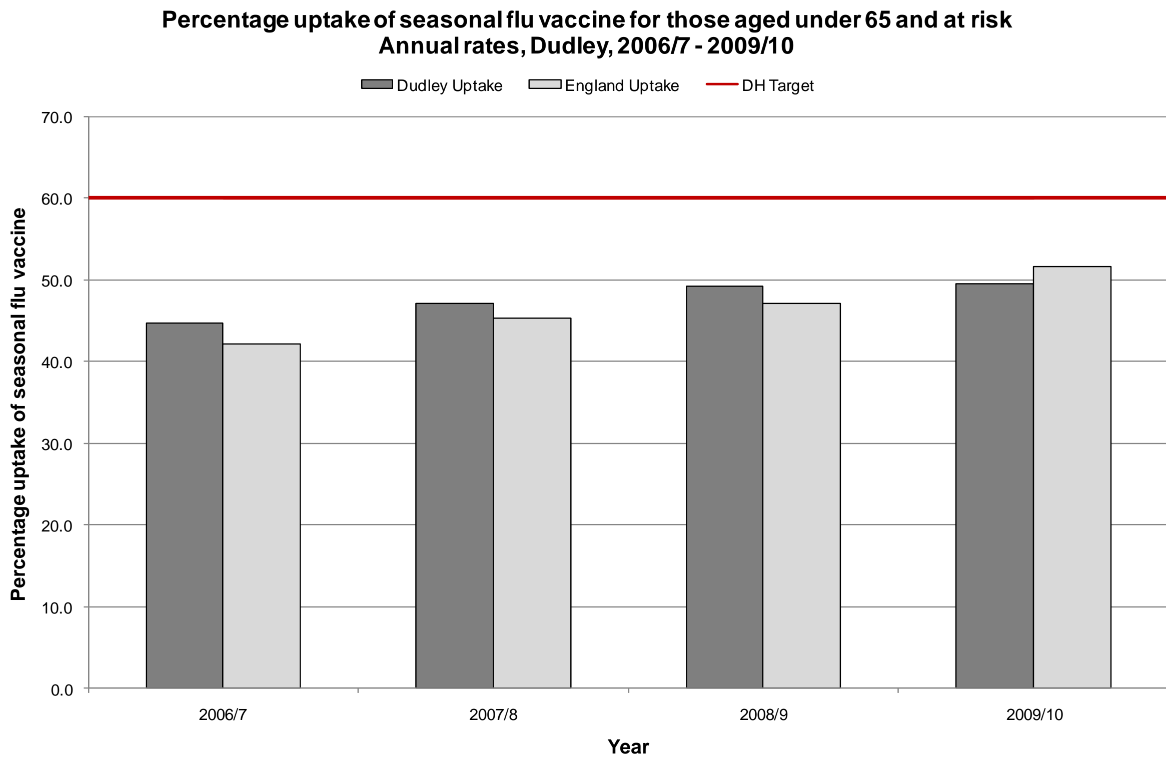


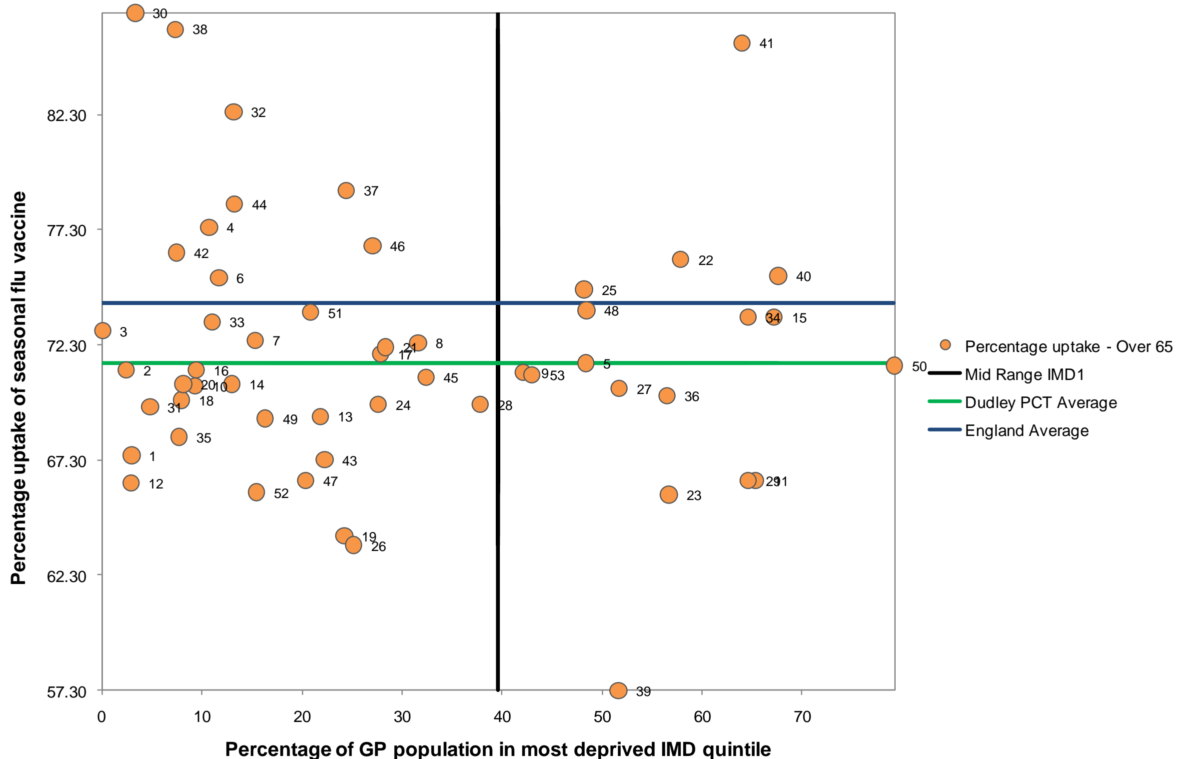
Figure 9



When percentage uptake by GP practice is plotted against the most deprived quintile for the over 65 GP population the correlation is quite weak (r =0.098) (Figure 10). Dudley's uptake is below the England average. There are many practices with less than 30% of their population who are most deprived not achieving 70% uptake.

Figure 10

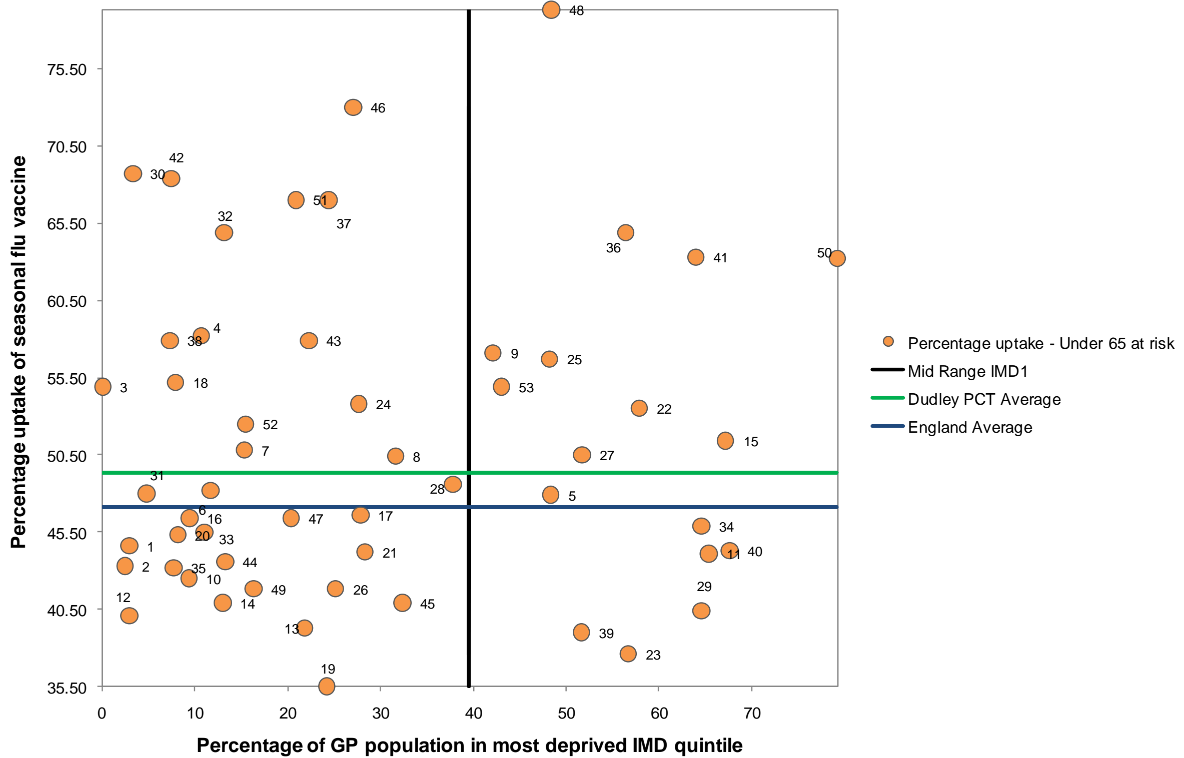
Uptake of seasonal flu vaccine in those aged 65 and over by GP against percentage of GP population in most deprived IMD quintile, Dudley 2008/9 (R=0.0984, R^2=0.97%)



When uptake of the 'at risk' groups in the most deprived quintile are compared the correlation is more positive (r = 0.58) (Figure 11). Dudley is also slightly higher than the England average in influenza uptake for these vulnerable groups, but at less than 50% there is more that could be done in primary care to reduce the inequality gap for influenza uptake rates.

Figure 11

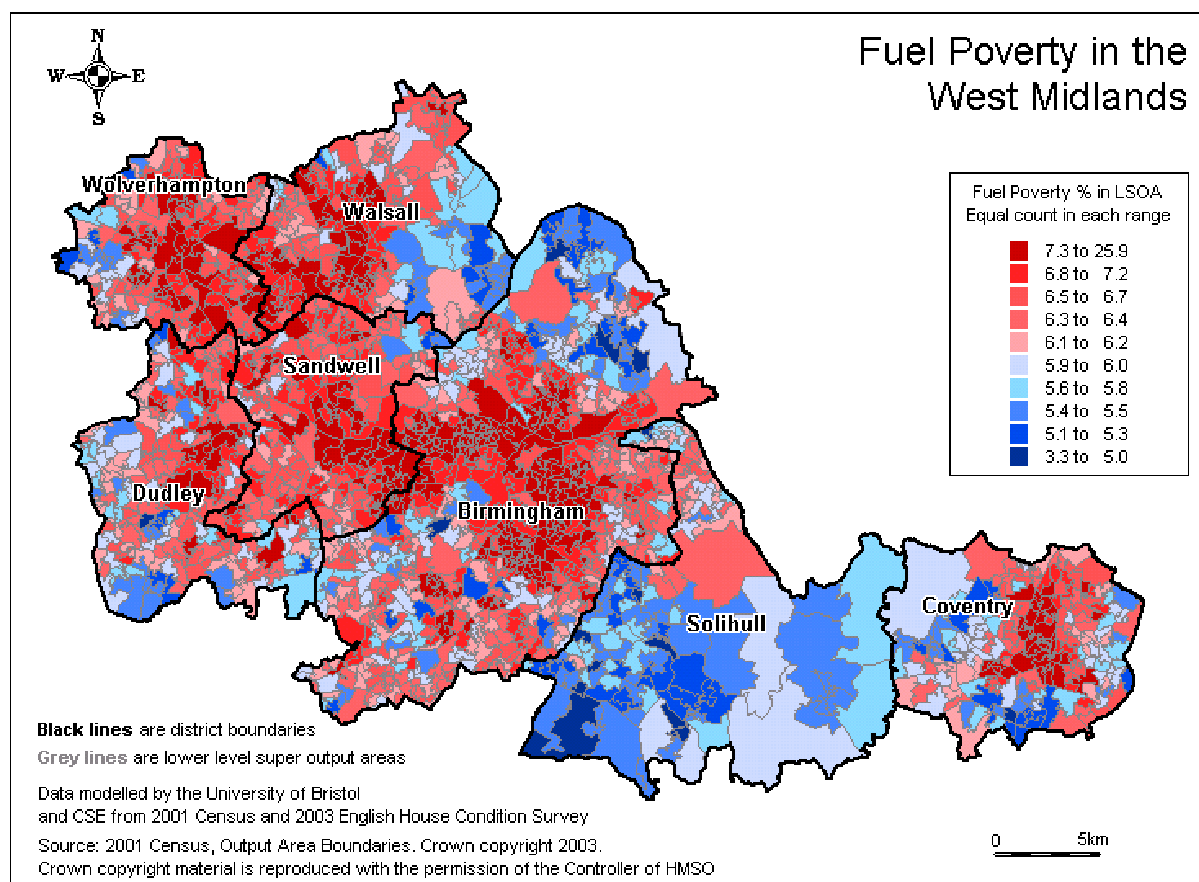
Uptake of seasonal flu vaccine in those at risk by GP against the percentage of GP population in most deprived IMD quintile, Dudley 2008/9 (R=0.58, R^2=3.4%)



Fuel Poverty

There is an established link between poor housing and health and typically it is older people that are living in older properties that are poorly insulated and difficult to heat. Fuel poverty affects rural and urban areas alike, but Dudley has small pockets of fuel poverty where anything between 7.3% and 25.9% of the population are spending more than 10% of their income on energy (Figure 12). In general these pockets are to be found in the parts of the borough where there are old properties. The Decent Homes standard was brought in to ensure that all homes are insulated and have central heating; Dudley is set to meet the Decent Homes standard for its council owned properties by 2011.

Figure 12



Seasonal Excess Winter Deaths

Current services in Dudley

Health through Warmth
Initiatives that are in place and have developed since 06/07 include the Health Through Warmth initiative that has received national recognition for the work in Dudley at the NHF Neighbourhood Awards.

Excess Winter Deaths Impact Group
A group has been established in Dudley to take forward and collaborate on initiatives that can help reduce winter deaths. This has representation from the following people.

Membership includes:-
Public health, Health through Warmth lead, case managers, commissioning lead for older people, local authority managers, specialist nurses for COPD and Heart Failure, Age Concern, older people specialist pharmacist and the falls coordinator.

The group will establish terms of reference and reporting mechanisms such as the Older People's Board

Tackling Seasonal Excess Deaths at a population level

The HINST has identified a number of priority actions that are known to impact on reducing seasonal excess deaths and these actions are forming the basis for a specific delivery plan developed by the winter deaths impact group.

Next stages and action plan

- Establish data on the numbers of excess winter deaths (coding by diagnosis) to enable targeted interventions
- To address any inequalities for example the most vulnerable and deprived and develop an action plan
- To develop a Communication strategy (ensure awareness of public health messages)
- To address the recommended actions plans from the Health Inequalities National Support Team
- Establish links with health and housing
- To develop better public awareness on the dangers, prevention and interventions.
- This will include working with public health, the PCT and DACHS communications, Dudley Community Voluntary Services, libraries and local websites including the Dudley Older People's website www.ageingwelldudley.org

7.8 OTHER CONTRIBUTORY CAUSES

External causes of death
Where are we and what are the gaps?
The external causes of death are defined as those from injury and poisoning and they account for less than 5 per cent of all deaths in England and Wales (3.5% in 2008, Vital Statistics). In Dudley for the same period 1.5% of deaths were due to injury and poisoning. Deaths from injury and poisoning account for nearly half of all deaths in the 15-34 age group for England and Wales (48.4% in 2008) and 21.4% in the same age group in Dudley. This proportion is significantly higher in men than women. Therefore deaths from injury and poisoning have a large impact in terms of premature deaths and potential years of life lost. In addition to this there is considerable research in the literature confirming that the risks of both unintentional and intentional injury are related to deprivation status, with those at the greatest risk living in the most deprived areas (Laflamme, Burrows and Hasselberg, 2009).

Deaths from injury and poisoning make a significant contribution to the gap seen in life expectancy between the most and least deprived quintiles in Dudley (LHO, 2010). The estimated life expectancy years gained (2001-2005) if the Most Deprived Quintile (MDQ) of Dudley MCD had the same mortality rate as the least deprived quintile in the local authority for external causes are 1.09 years (16.6%) for men and 0.03 years (0.8%) for women.

Figures 1-2 show the trend in mortality from accidents and suicides and undetermined injuries for Dudley and England and Wales. Five year rates are shown due to the relatively low numbers. For accidents the directly standardised mortality rates in Dudley over the last 20 years have been below those for England and Wales, but in the last five years Dudley has seen a rise in the rate of deaths from accidents and now has mortality rates equivalent to England and Wales. Dudley is no longer on target to meet “Our Healthier Nation” target of a 20% reduction on the 1996 baseline by 2010. Directly standardised mortality rates for suicides and undetermined injury have declined over the last 20 years and have continued to track levels for England and Wales. The target reduction has been met for women but is unlikely to be achieved for men. Mortality rates both from accidents and suicide and undetermined injury are higher in men than women.

There is a strong gradient of deprivation for mortality from both accidents and suicide and undetermined injuries particularly for men as shown in Figures 3-4 respectively.

To further understand the data it has been further analysed using the International Collaborative Effort (ICE) on injury statistics matrix which classifies injury and poisoning deaths according to both mechanism and intent using standard groups of the ICD codes (ONS, 2006).

Figure 1

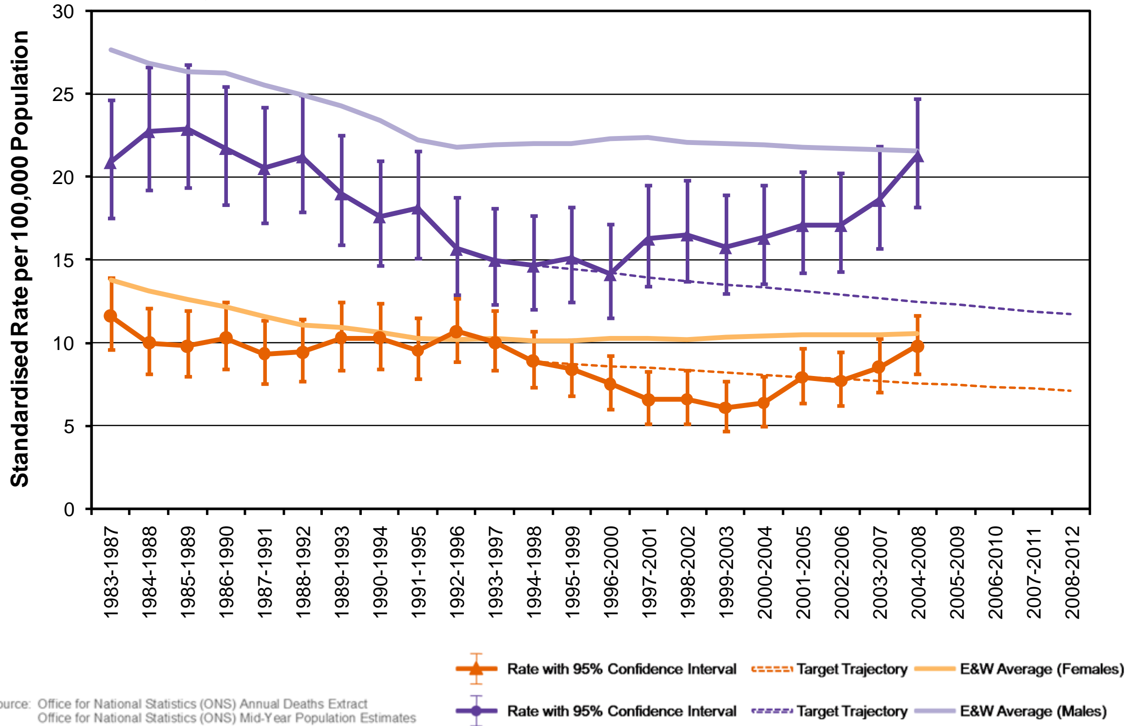


Figure 2

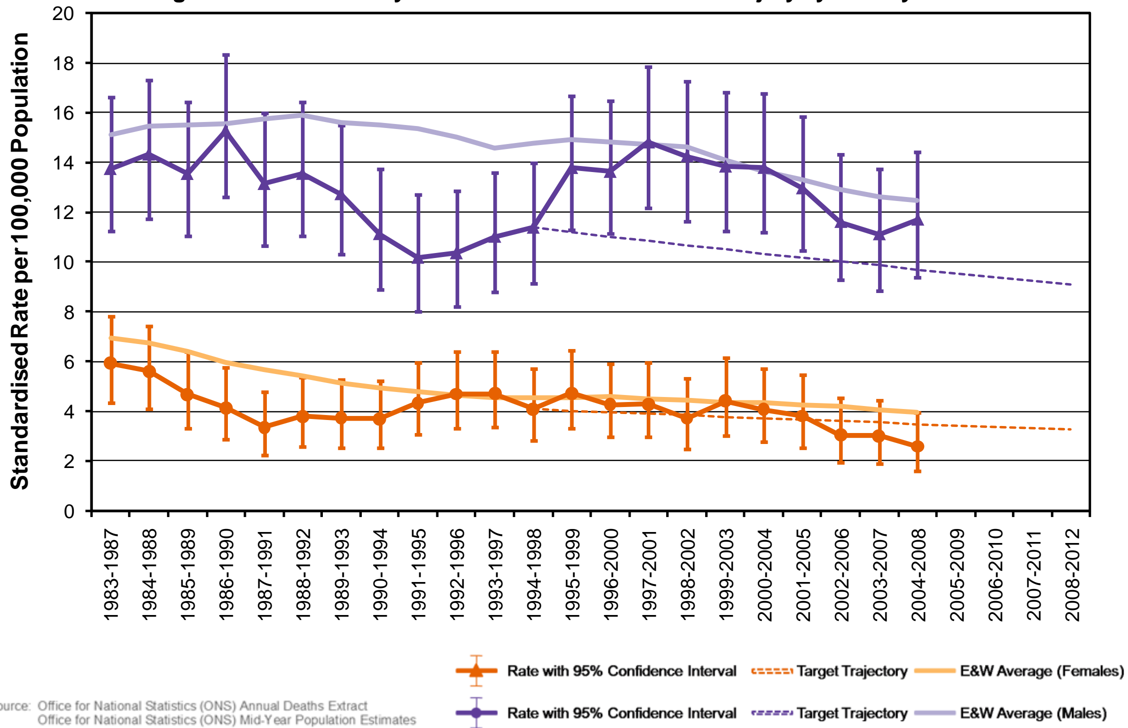


Figure 3

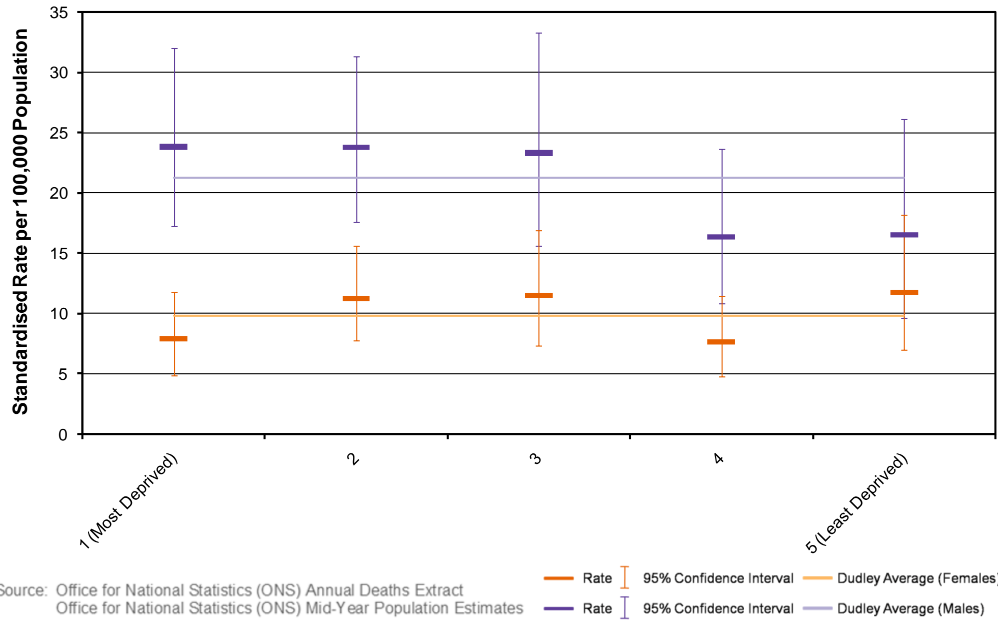


Figure 4

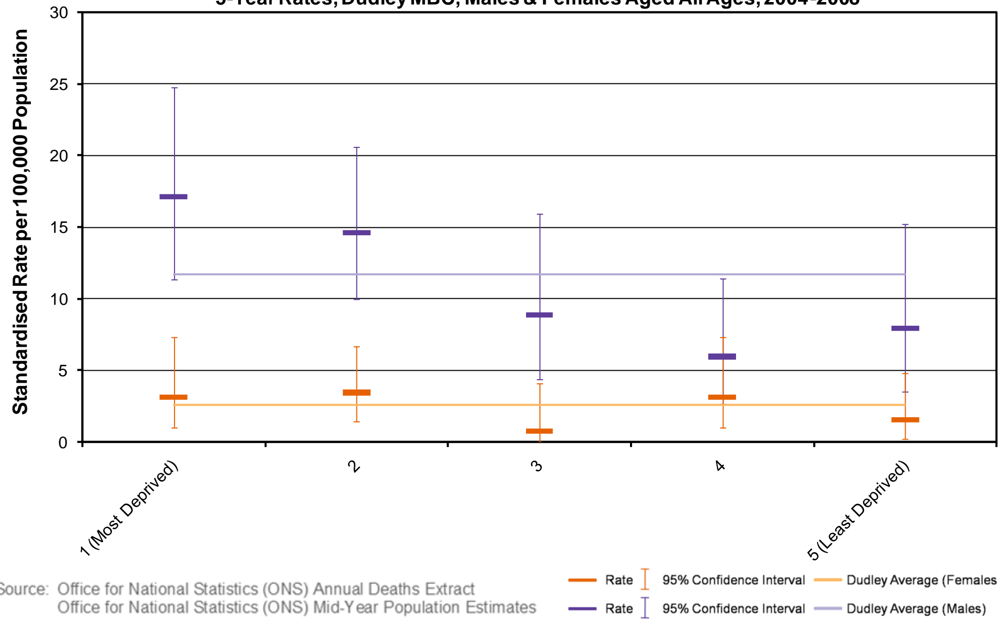


Figure 5a & b shows the trend in mortality rates for accidents and suicides and undetermined injuries by sex and broad age band. The highest rates are in the oldest age group for accidents and this is the only age group where rates are equivalent for females and males. Rates are generally higher for males than females between ages 15 and 64, with this gap beginning to narrow for ages 50-54 and older. At ages up to 15, rates are also more similar between males and females, but again tend to be higher in the males. Rates begin to rise after age 9 through to age 20-24. In males rates tend to decline from age 20-24 to 65-69 and then start to increase to the oldest age group. For women the pattern is slightly different with a tendency for rates to gradually increase from age 20-24 through to age 50-54, where the rate declines until 65-69 after which the rate increases rapidly.

The pattern is different for mortality from suicide and undetermined injury but is similar for males and females with the rate increasing from age 10-14 to age 50-54 when it declines to age 65-69 when it levels off. The rate overall is considerably higher for males at all age bands between 10-14 and 60-64.

Trends of mortality for accidents by broad age band (Figures 6a,b,c & d) show rates in the 75 and over age band for both males and females were far higher than in any other age group throughout the period 1983-1987 to 2004-2008. Rates in this age band declined to the late 1990s before beginning to rise again. For females in all age bands the trend has been for the rates to decline across the whole period but they reached a minimum in the late 1990s. For males, only the under 15 and the 55-74 age band have followed the pattern described for females. The other age bands have shown no overall change.

Figure 5a

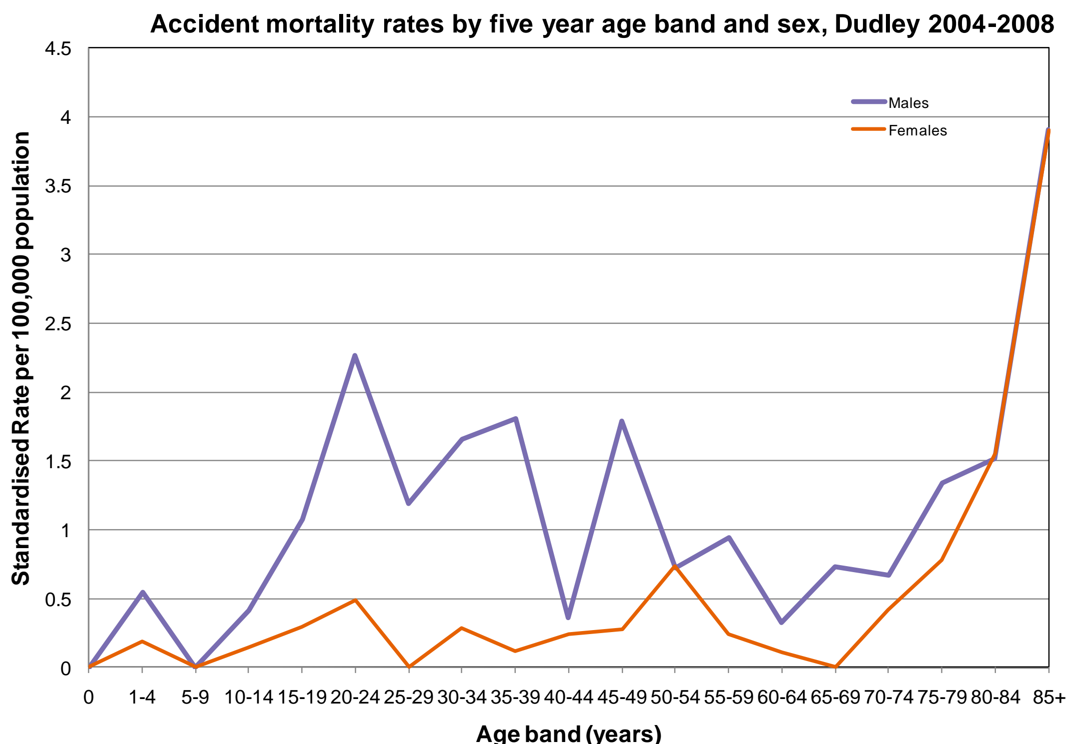
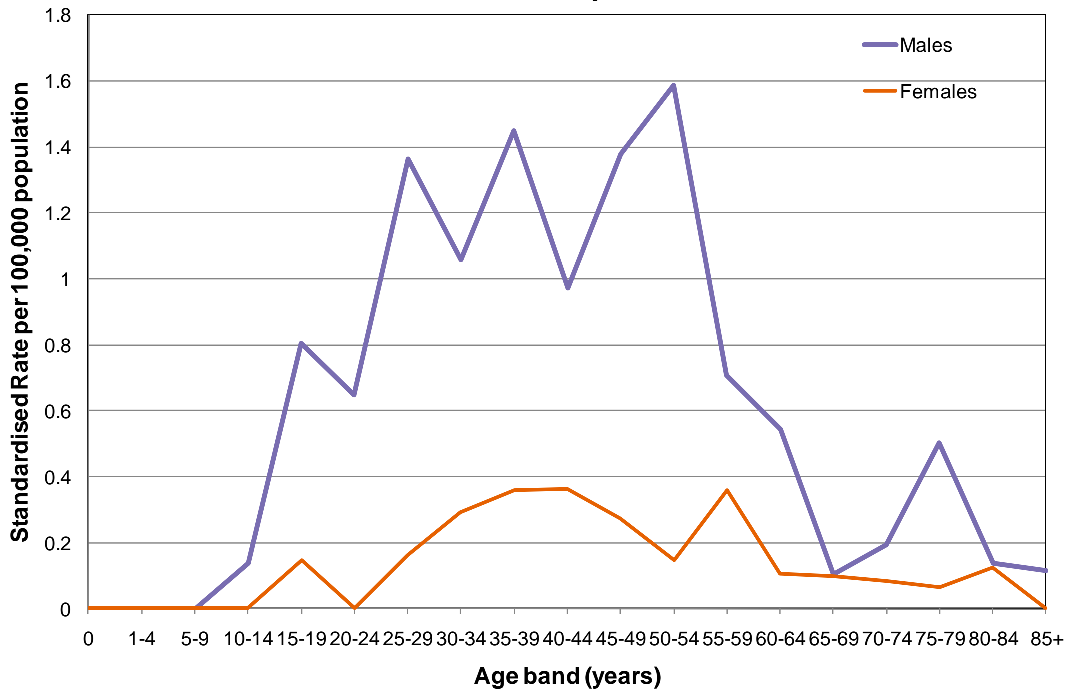


Figure 5b



Source: Office of National Statistics (ONS) Annual Deaths Extract
Office of National Statistics (ONS) mid-year population estimates

Figure 6a

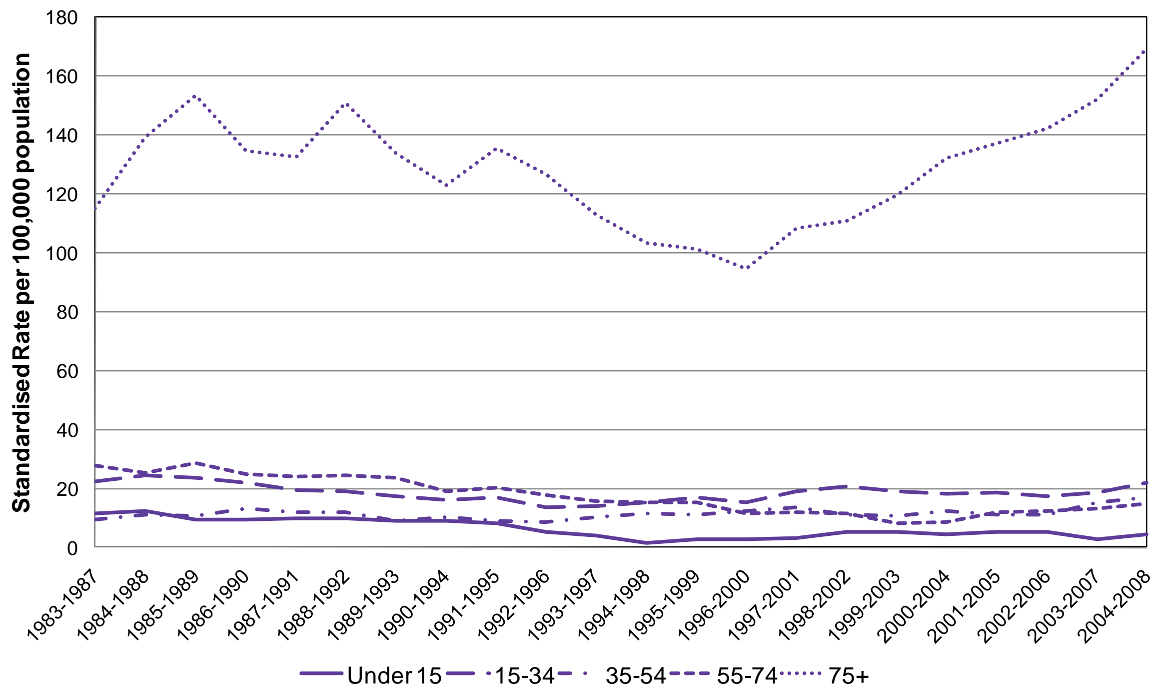


Figure 6b

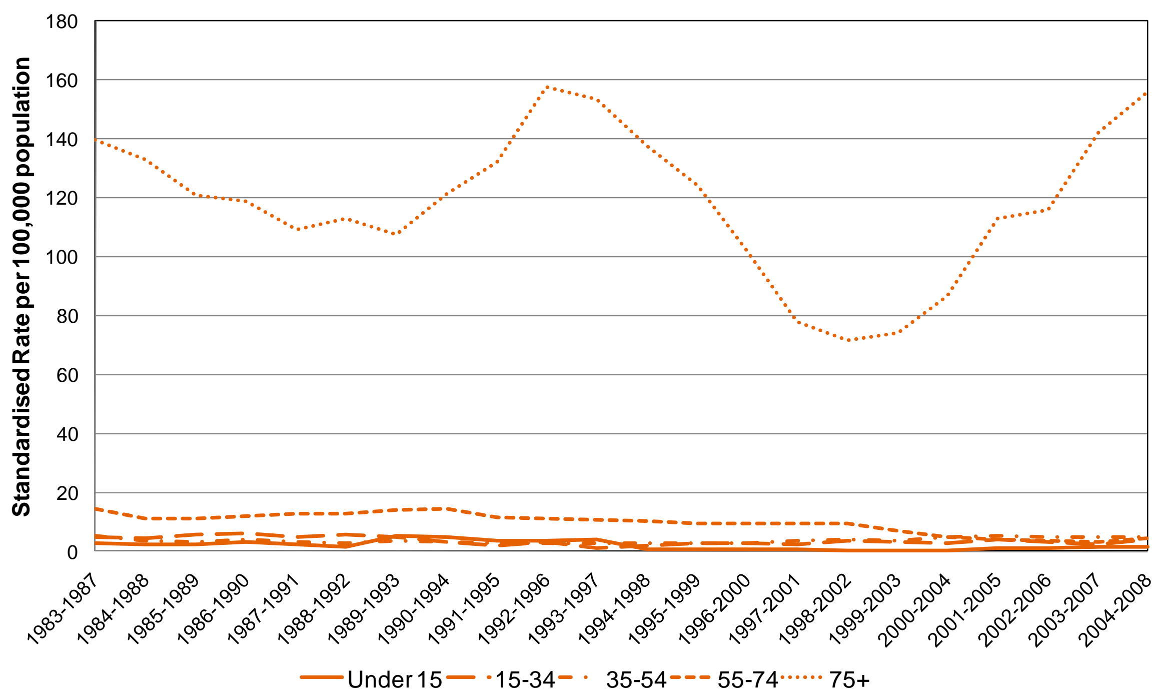


Figure 6c

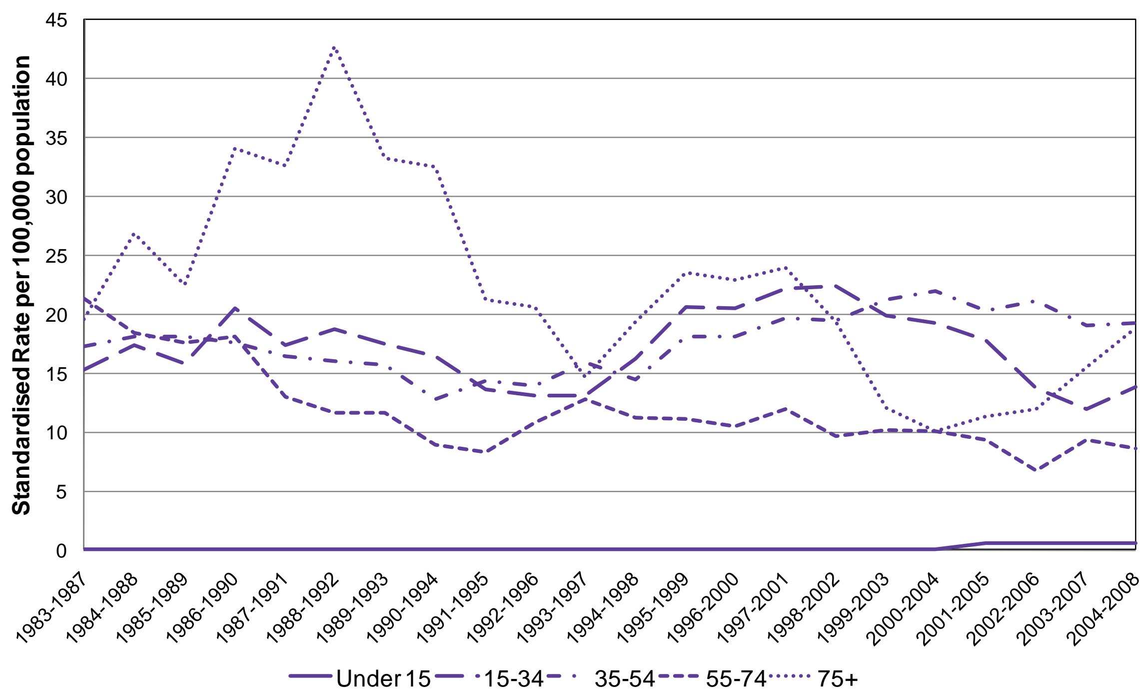
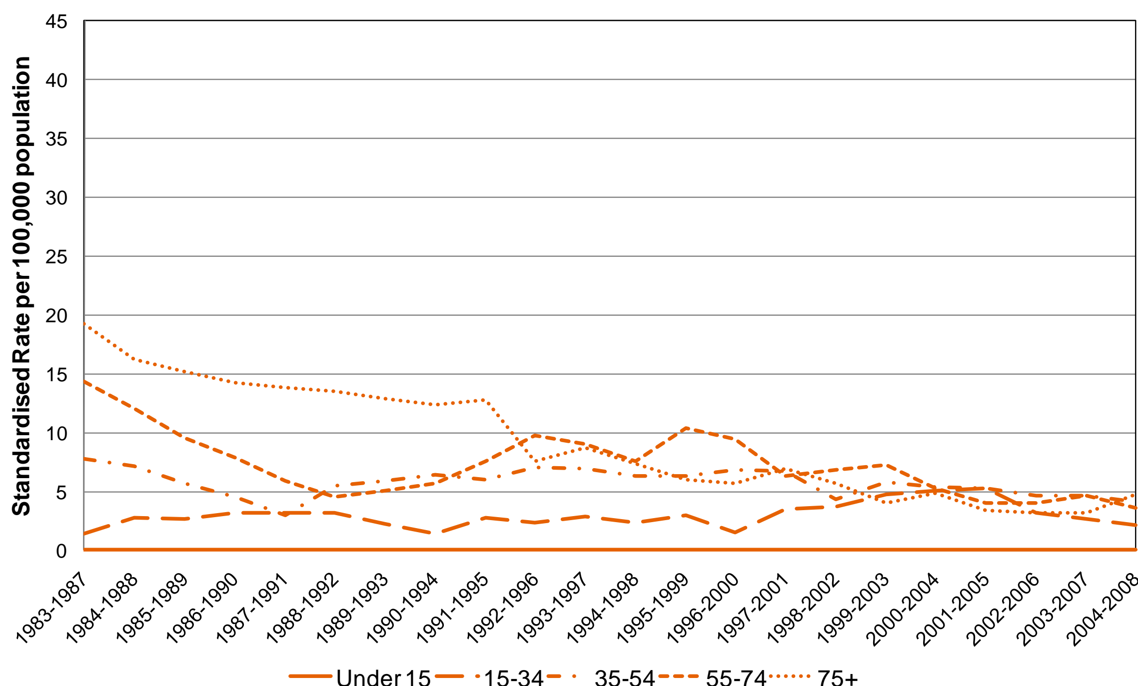


Figure 6d



Source: Office of National Statistics (ONS) Annual Deaths Extract
Office of National Statistics (ONS) mid-year population estimates

Patterns of mortality by intent, within mechanism

In 2004-2008, the majority of falls and fractures were unintentional (91% for males and 89% for females) (Figure 7a and 8a). If it is assumed that the deaths from osteoporosis were also unintentional, then all fall and fractures for males would be unintentional and 99% for females. The majority of deaths from suffocation were suicides of undetermined intent, though 5% and 25% for males and females respectively were unintentional. Poisoning was split across four main intents – drug abuse/dependence (52% for males and 25% for females), unintentional (23% and 29%), suicide (15% and 4%) and undetermined intent (11% and 42%). When compared to the period 10 years earlier there has been a shift for mortality from poisoning for females away from drug abuse/dependence (from 41% in 1994-1998 to 25% in 2004-2008), with the opposite true for males (increasing from 27% in 1994-1998 to 52% in 2004-2008). All deaths due to transport incidents were unintentional. This is directly a result of the ICD coding guidelines (ONS, 2006).

Figure 7a

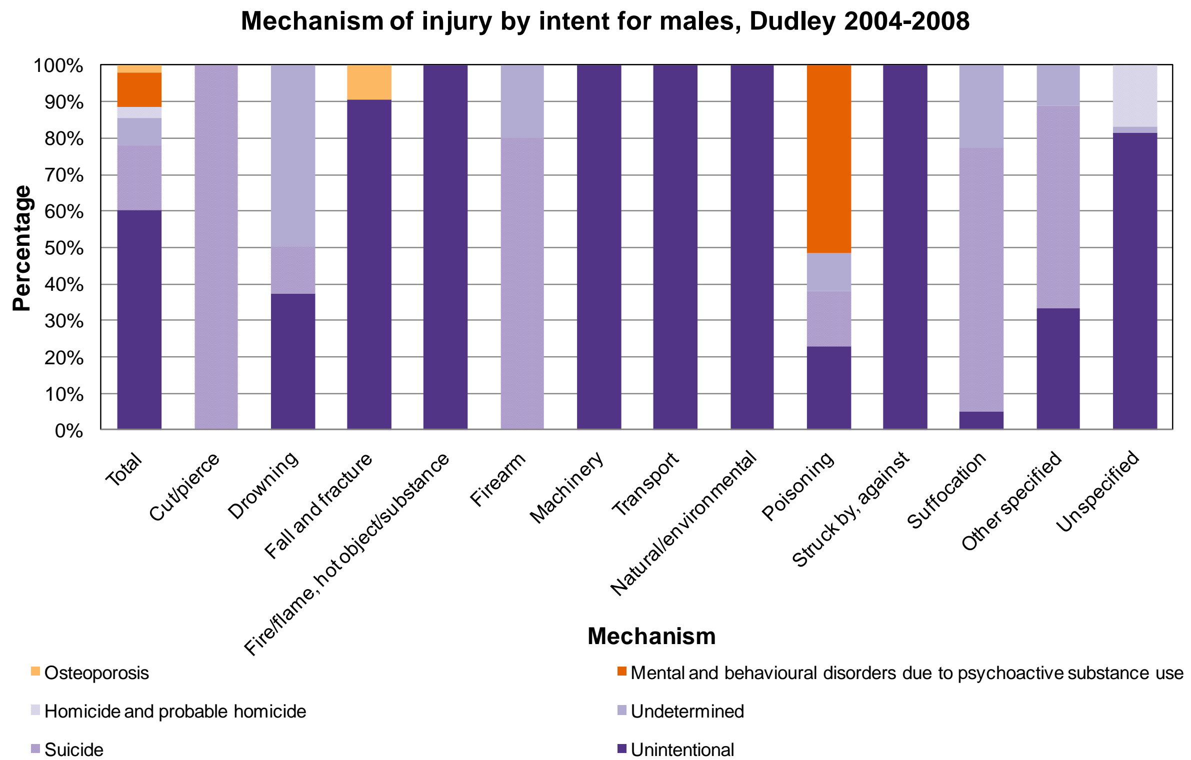
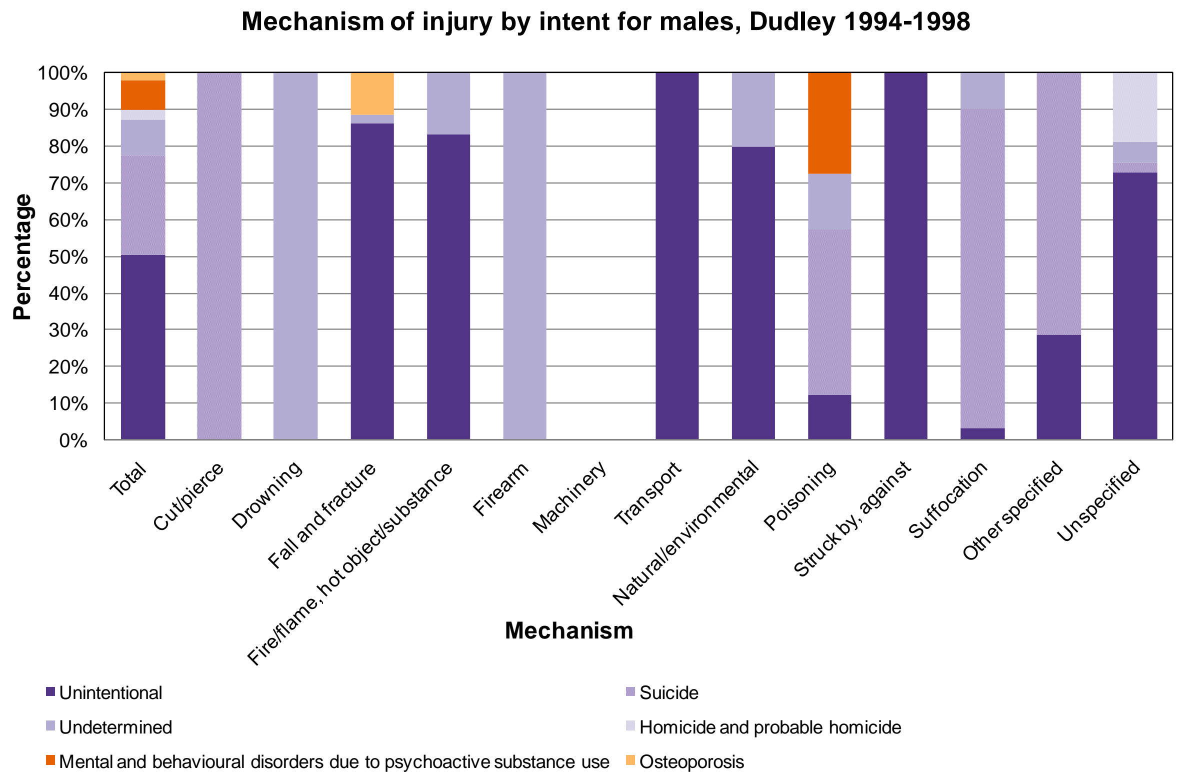


Figure 7b



Source: Office of National Statistics (ONS) Annual Deaths Extract
Office of National Statistics (ONS) mid-year population estimates

Patterns of mortality by mechanism, within intent

During 2004-2008 the most common mechanisms for unintentional injuries among males were falls and fracture and transport (32% and 30% respectively). The pattern of mechanisms for mortality from unintentional accidents was very similar. In 1994-1998 with the exception of 4% of deaths from fire/flame which was absent in 2004-2008. For females the majority of unintentional deaths in 2004-2008 and 1994-1998 were due to falls and fractures (46% and 62% respectively), followed by unspecified (42% and 5%). In 2004-2008, for suicides, suffocation was the most common mechanism for males (67%), compared with poisoning (49%) in 1994-1998. In 1994-1998, 63% of female suicides were due to poisoning with the remainder split between suffocation, cut/pierce, firearm and drowning. Whereas in 2004-2008, the main mechanism, was suffocation (71%) with only 14% due to poisoning.

Deaths from undetermined intent had a wider range of mechanisms associated with it, but the major shift has been an increase in the proportion of deaths from suffocation and a decrease in the proportion of deaths from poisoning in males. Despite this shift these remain the major mechanisms. For females poisoning remains the main mechanism, but suffocation is now the second mechanism. There has been a reduction in the percentage of drownings in females Figure 8a-b.

Figure 8a

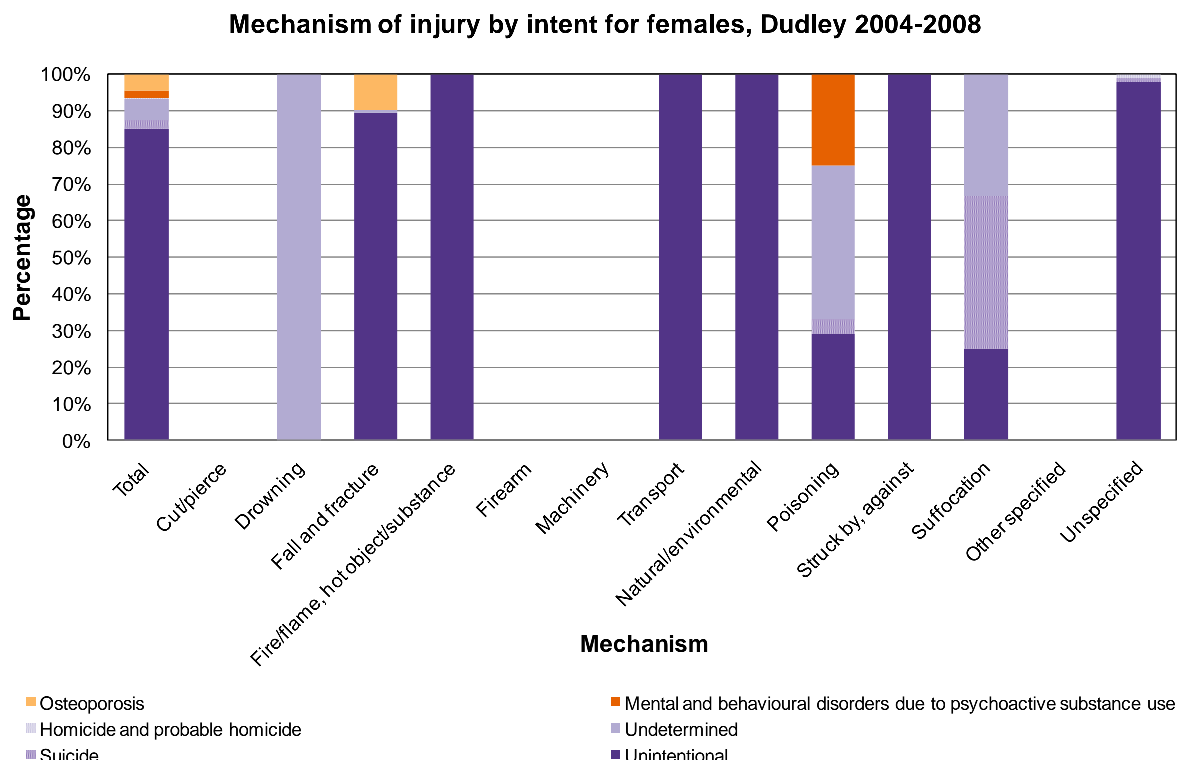
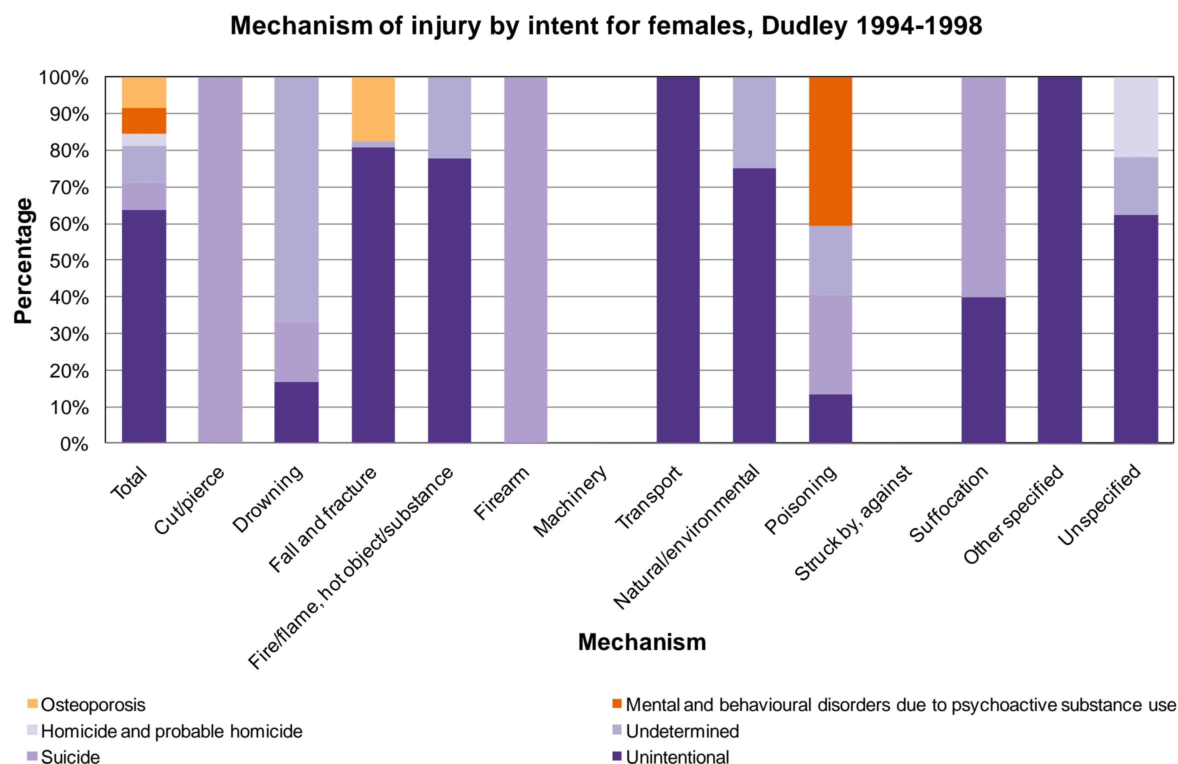


Figure 8b



Source: Office of National Statistics (ONS) Annual Deaths Extract
Office of National Statistics (ONS) mid-year population estimates

Patterns of injury and poisoning mortality for the top four mechanisms by age

Mortality varies by five-year age band according to the mechanism of death. For falls and fractures in both males and females there is a strong relationship with age, with rates increasing across the age bands with a rapid rise in rates from age 65 to 85+. In this age band falls and fractures are by far the highest mechanism of death (Figure 9a & b). For males the other mechanisms show a similar pattern across age bands, with rates lowest in the 5 to 9 age band and rates rise to a maximum in early adulthood. The age band of the peak varies by mechanism – for transport it is age 20-24, whereby it then declines gradually across the older age bands, whereas for poisoning and suffocation it is in men aged 20-24 and 25-29 respectively. For both poisoning and suffocation these higher rates are maintained until age 45-49 when they begin to decline.

For females, rates for all mechanisms were lowest in the 5-9 age band. Rates then rise for age, but there is only a clear peak for transport in young adults (15-24 years). Suffocation peaks at two age bands 30-34 and 50-54, whereas poisonings gradually rise to age 40-49, decline and have a second rise at 55-59 and then again at age 70-74.

Figure 9a

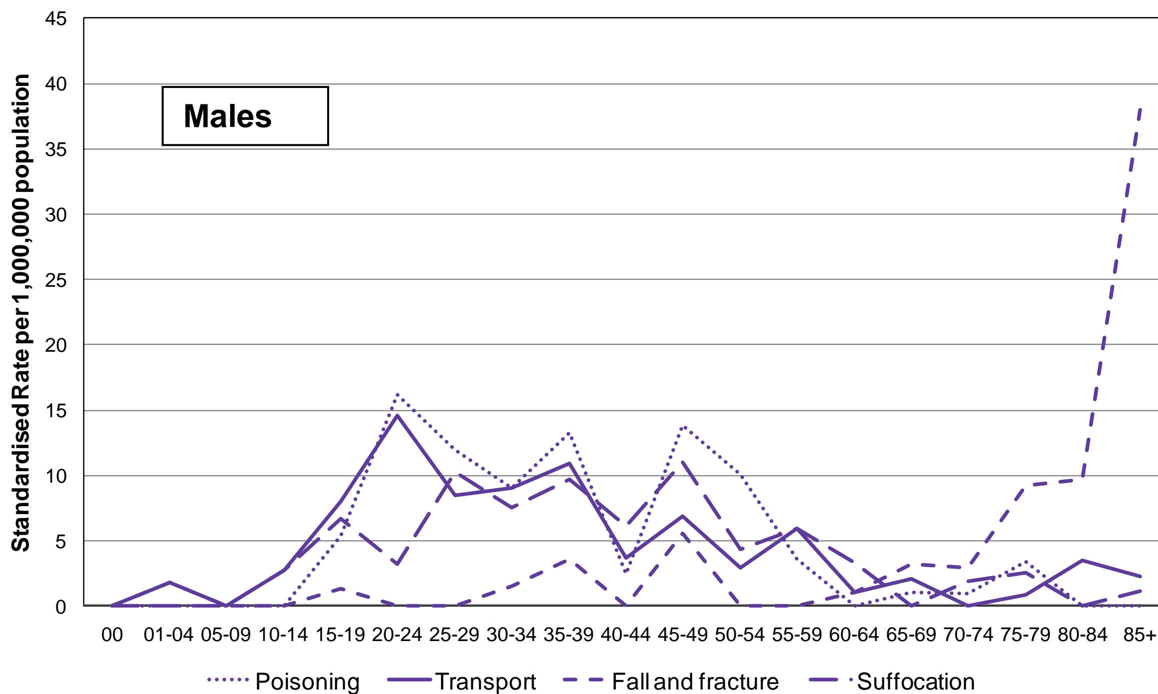
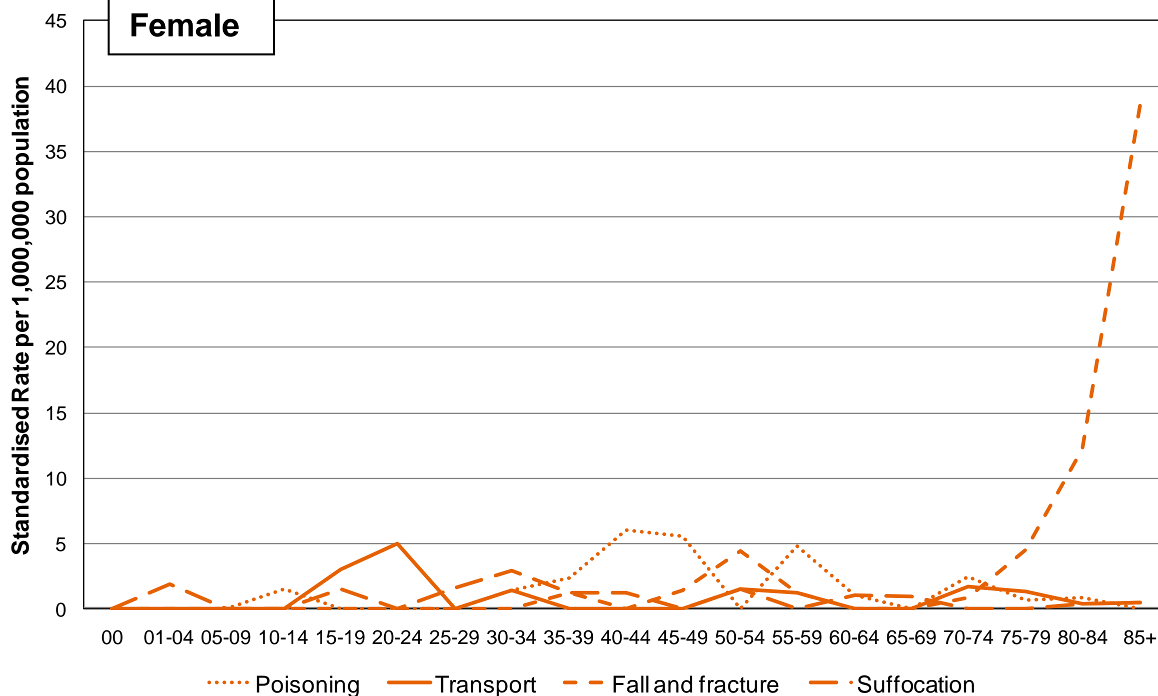


Figure 9b



Source: Office of National Statistics (ONS) Annual Deaths Extract
Office of National Statistics (ONS) mid-year population estimates

Key findings from analysis of mortality data using the ICE matrix

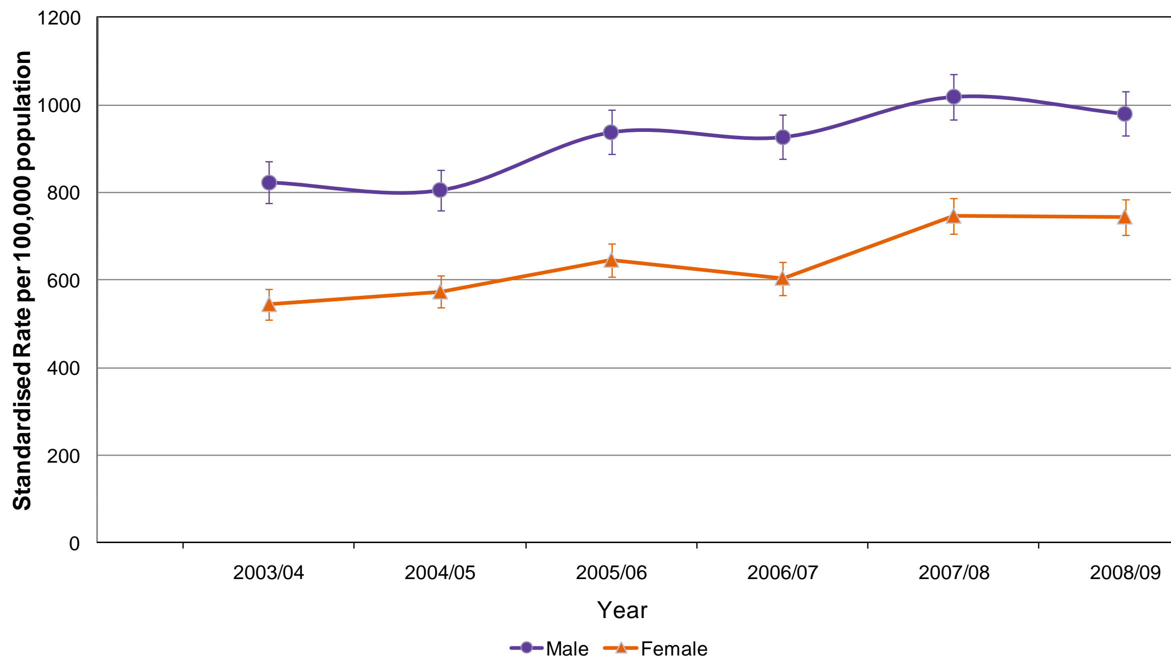
- Overall mortality rates due to accidents, suicides and undetermined injury are higher in males than females. Mortality rates have declined over time and continue to do so for suicides and undetermined injury, whereas for accidents there has been an upturn since 2000 and rates for Dudley are again similar to those for England and Wales.
- There is a health inequalities gradient for mortality from external causes (higher rates in the most deprived areas) and this is worse for males.
- The rise in mortality rates for accidents over the last 10 years is most apparent in the over 75 age band with the main mechanism being falls and fractures. In males there has been little change over time in mortality rates from accidents for the 15-54 age band, whereas it has declined for females. This is true also for this age band with mortality rates from suicide and undetermined injury.
- In 2004-2008 falls and fractures were the most common mechanism of injury mortality, followed by poisoning and transport. The move in emphasis away from transport as the main mechanism is due to a real decline in traffic accidents and to the inclusion of deaths from drug abuse/dependence with deaths from poisoning and deaths from osteoporosis and fracture with external cause unspecified with deaths from falls.
- There has been an increase in the death rates for drug abuse/dependence and homicide rates in males since 1994-1998.
- In terms of deprivation the main mechanisms which show a negative social gradient are poisoning (particularly ages 15-54 and 75+ for males and age 35-74 for females), transport for males where the negative gradient is prominent in the 15-34 age band, suffocation which shows a negative gradient overall for males and females and this is emphasised in the under 75 age for males and the under 35 age band for females. Falls and fractures showed no overall social gradient for males and showed a positive gradient for females over 75, but a negative gradient for the younger age bands.

Hospital Admissions from external causes

Figures 10-11 show the trend in hospital admissions from accidents and suicides and unintentional injuries for Dudley. For accidents the directly standardised emergency hospital admission rates in Dudley over the last 6 years have been rising and are significantly higher for men than women. Directly standardised emergency hospital admission rates for suicides and undetermined injury have increased over the last 6 years and this has been at a faster rate for females and hence admission rates are higher for females than males. There is a strong gradient of deprivation for emergency hospital admissions from both accidents and suicide and undetermined injuries particularly for men for accidents and for both sexes for suicide and undetermined injury as shown in Figures 12 and 13 respectively. To further understand the data it has been analysed using the International Collaborative Effort (ICE) on injury statistics matrix.

Figure 10

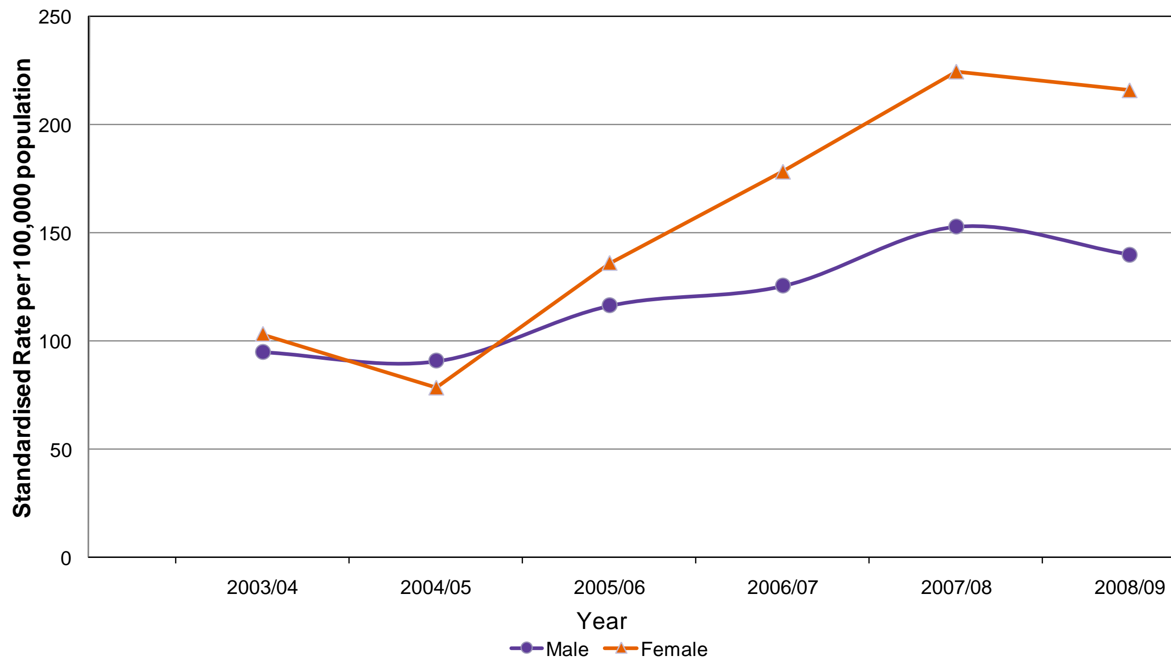
Directly standardised emergency hospital admissions from accidents by year single year rates, males and females, 2003 to 2008, Dudley



Source: Secondary Users Service (SUS) Hospital Admissions
Office of National Statistics (ONS) mid-year population estimate

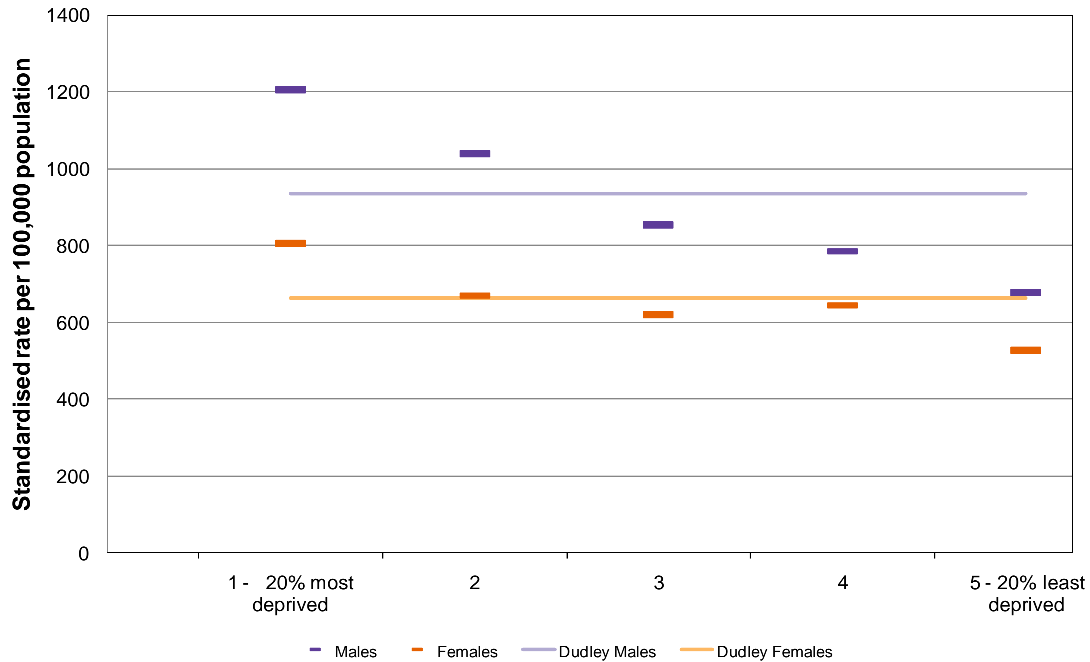
Figure 11

Directly standardised emergency hospital admissions from suicides and undetermined injuries by year single year rates, males and females, 2003 to 2008, Dudley



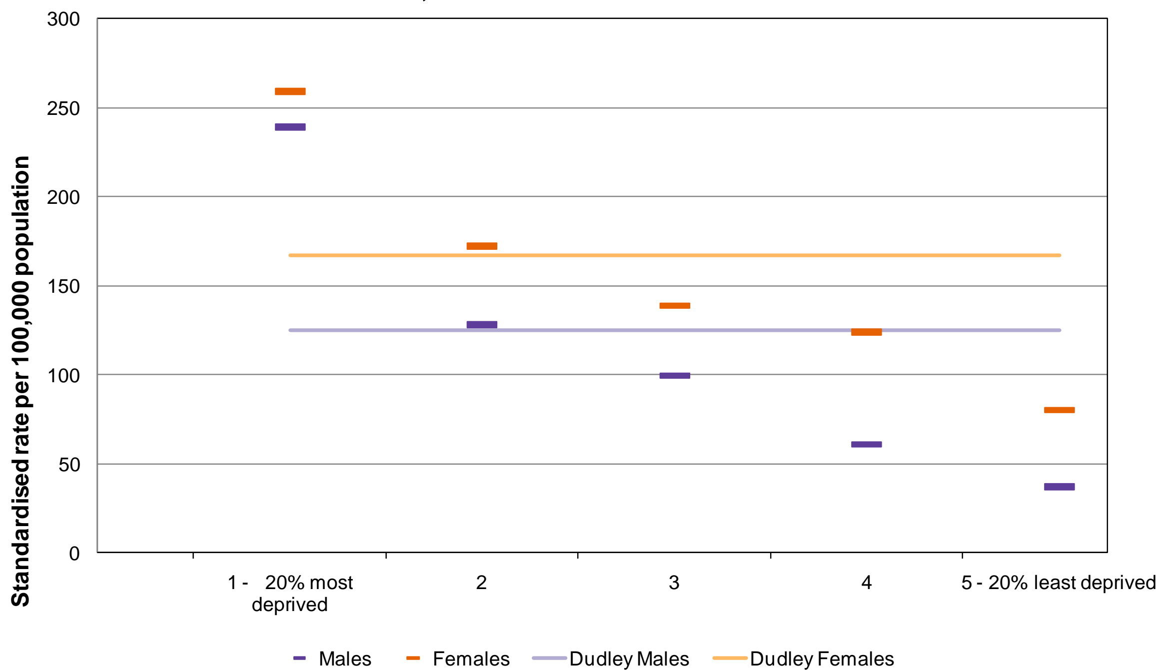
Source: Secondary Users Service (SUS) Hospital Admissions
Office of National Statistics (ONS) mid-year population estimate

Figure 12



Source: Secondary Users Service (SUS) Hospital Admissions
Office of National Statistics (ONS) mid-year population estimate
Department of Communities & Local Government Indices of Deprivation 2007

Figure 13



Source: Secondary Users Service (SUS) Hospital Admissions
Office of National Statistics (ONS) mid-year population estimate
Department of Communities & Local Government Indices of Deprivation 2007

Figures 14a & b shows the trend in emergency hospital admission rates for accidents and suicides and undetermined injuries by sex and broad age band. For accidents the highest rates are recorded for the under 15 age group for males and females and these then decline across the age bands to a minimum at age 65-69, after this rates increase again to a maximum at age 85+. Up to age 65-69 admission rates for accidents are higher in males than females and after this age group the opposite is true.

The pattern is different for emergency hospital admissions from suicide and undetermined injury but is similar for males and females with the rate increasing from age 10-14 to age 20-24 for males and age 15-19 for females. The peak admission rate was considerably higher for females, but after the initial peak the rates of admissions were similar between the sexes.

Trends of emergency hospital admissions for accidents by broad age band (Figures 15a & b) show rates in the 75 and over age band for both males and females were far higher than in any other age group throughout the period 2003 to 2008. Rates in this and all other age bands have risen over this time period. Trends of emergency hospital admissions for suicide and undetermined injury by broad age band (Figures 16a & b) show rates in the 15-34 and 35-54 age bands for both males and females were far higher than in any other age group throughout the period 2003 to 2008. Rates in these age bands have risen the most across this time period for both sexes but the increase has been greatest for females, with admission rates for these age bands being higher for females. Admission rates for suicide and undetermined injury have also increased for the under 15 age band and are higher for females. .

Figure 14a

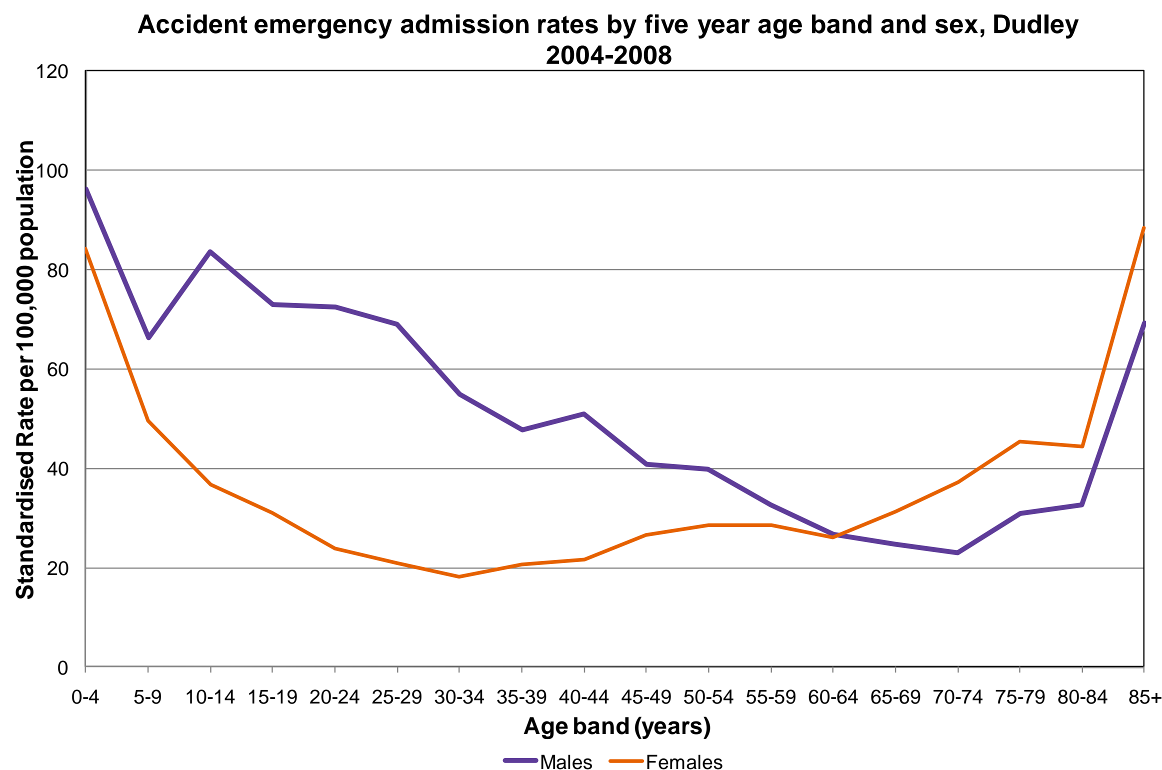
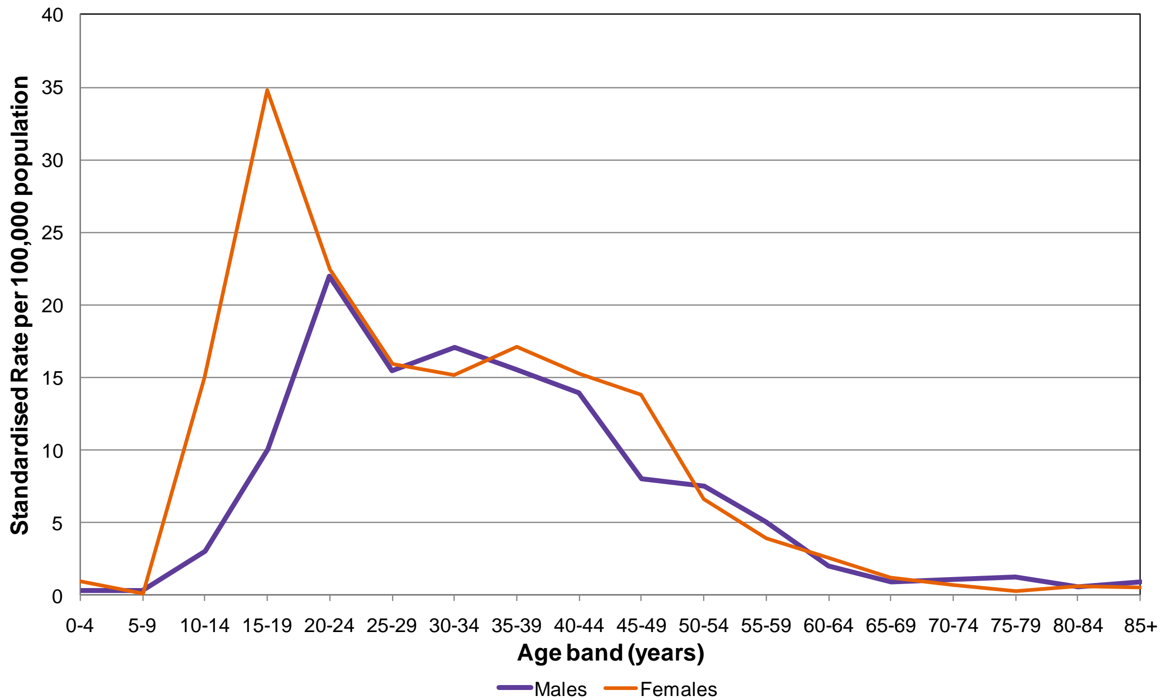


Figure 14b



Source: Secondary Users Service (SUS) Hospital Admissions
Office of National Statistics (ONS) mid-year population estimate

Figure 15a

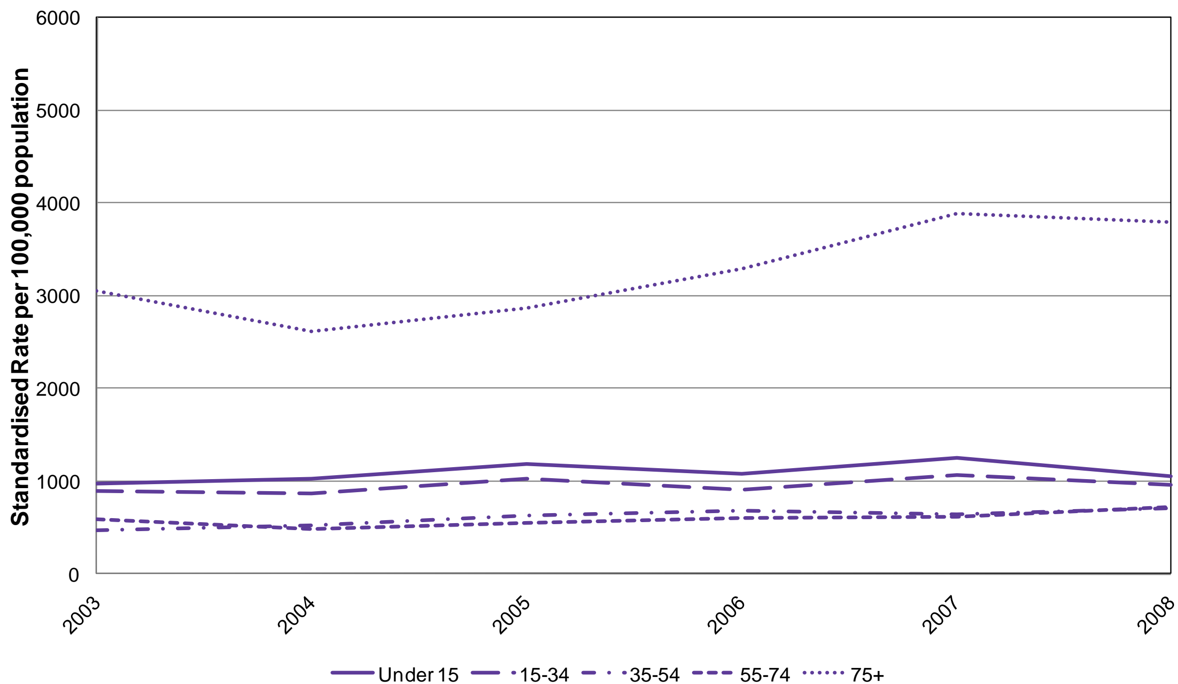
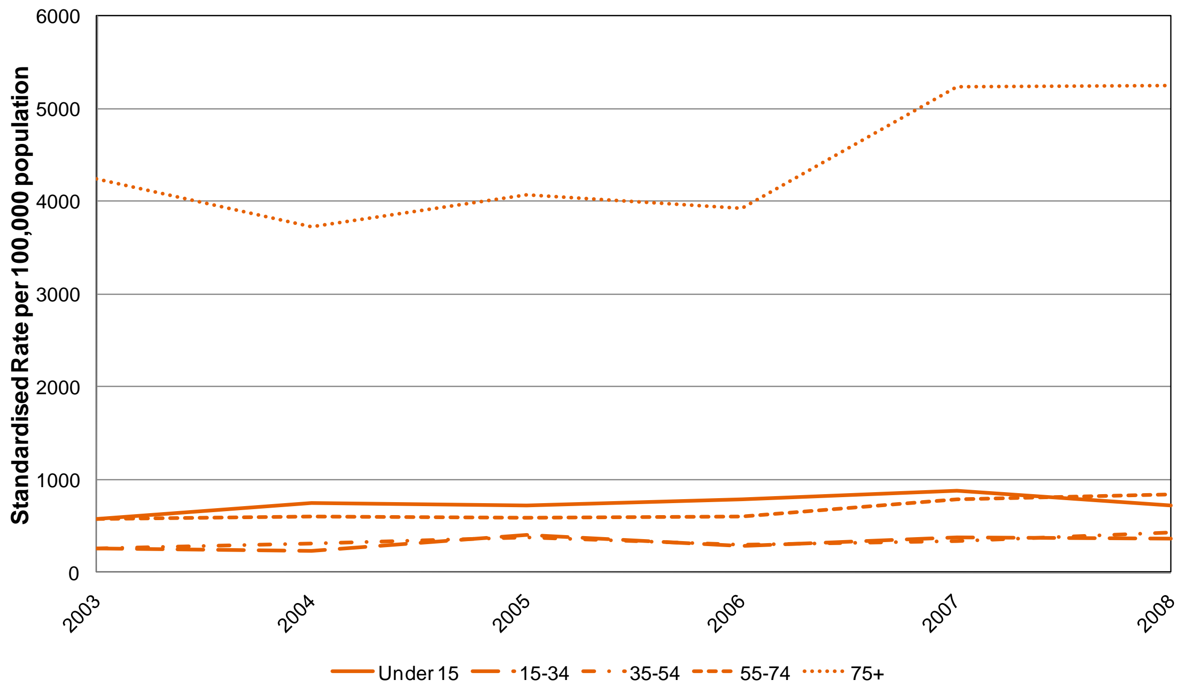


Figure 15b



Source: Secondary Users Service (SUS) Hospital Admissions
Office of National Statistics (ONS) mid-year population estimate

Figure 16a

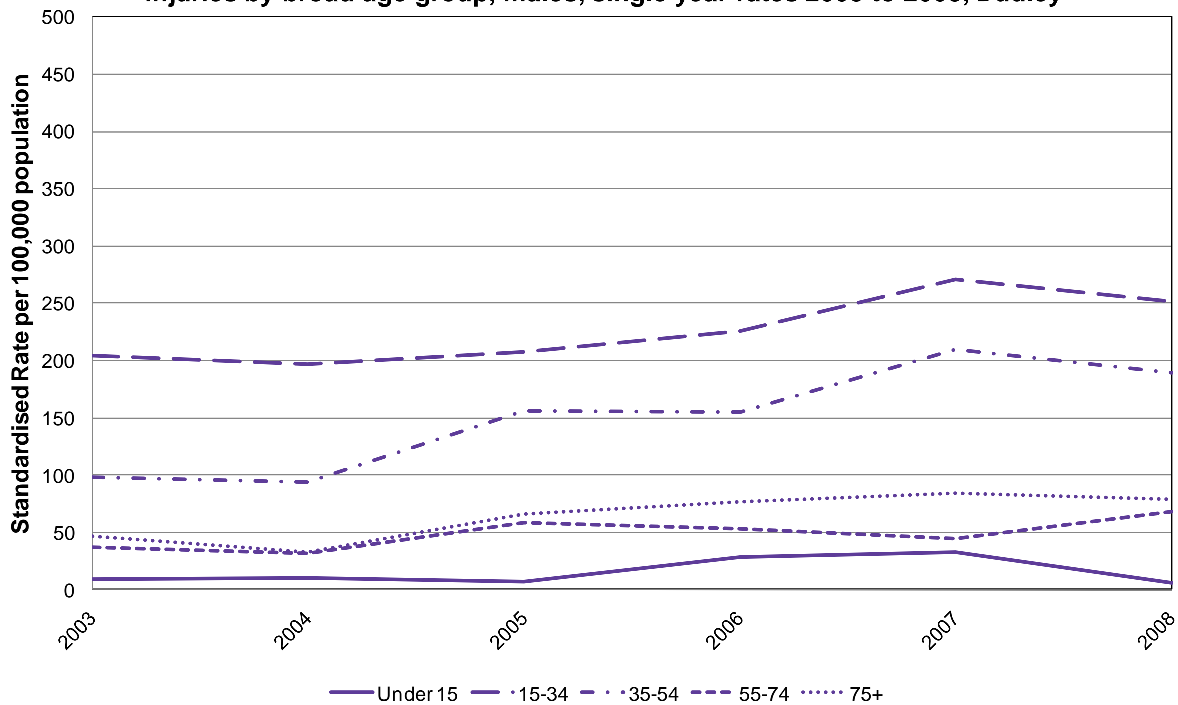
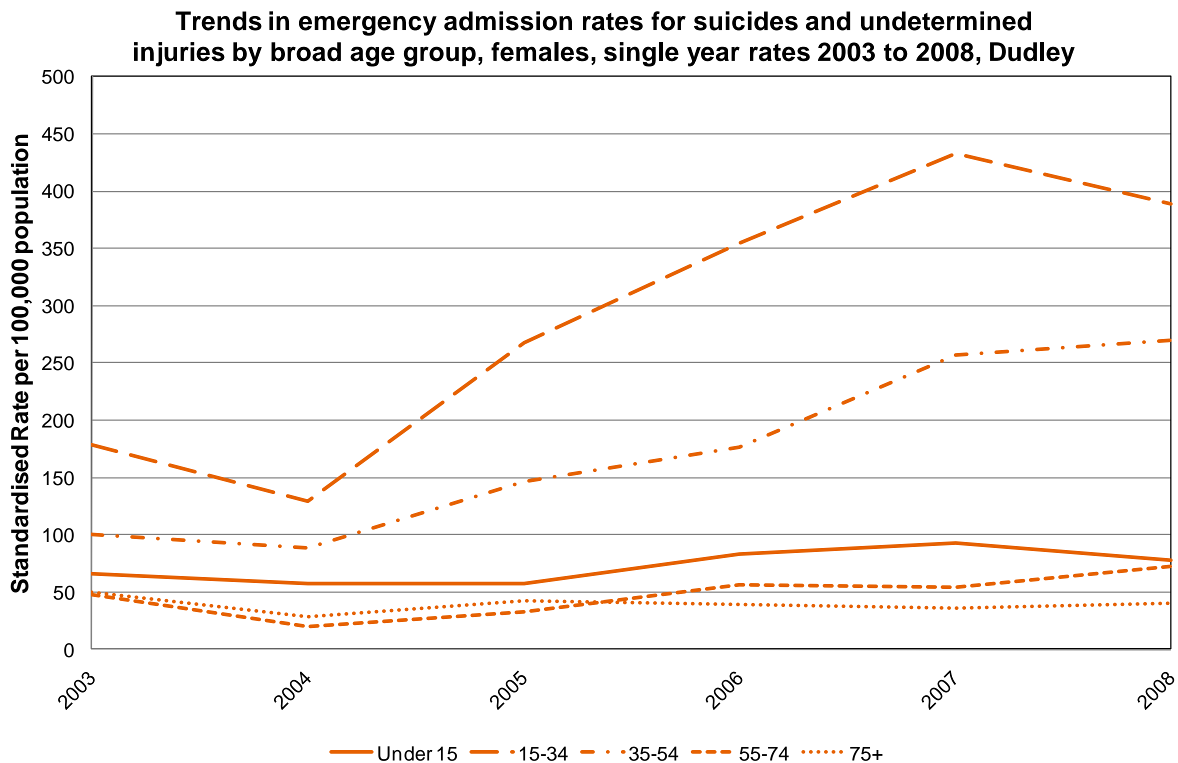


Figure 16b



Source: Secondary Users Service (SUS) Hospital Admissions
Office of National Statistics (ONS) mid-year population estimate

Patterns of emergency hospital admissions by intent, within mechanism

In 2004-2008, the majority of falls and fractures were unintentional (99% for males and females) (Figure 17a &b). If it is assumed that the admissions for osteoporosis were also unintentional, then all fall and fractures would be unintentional. The majority of emergency admissions from suffocation were unintentional, though 29% and 13% for males and females respectively were attempted suicide or undetermined injury. For females only 8% of admissions due to suffocation were attributed to homicide/attempted homicide. Poisoning was split across four main intents – drug abuse/dependence (47% for males and 22% for females), unintentional (15% and 16%), suicide (34% and 56%) and undetermined intent (3% and 6%).

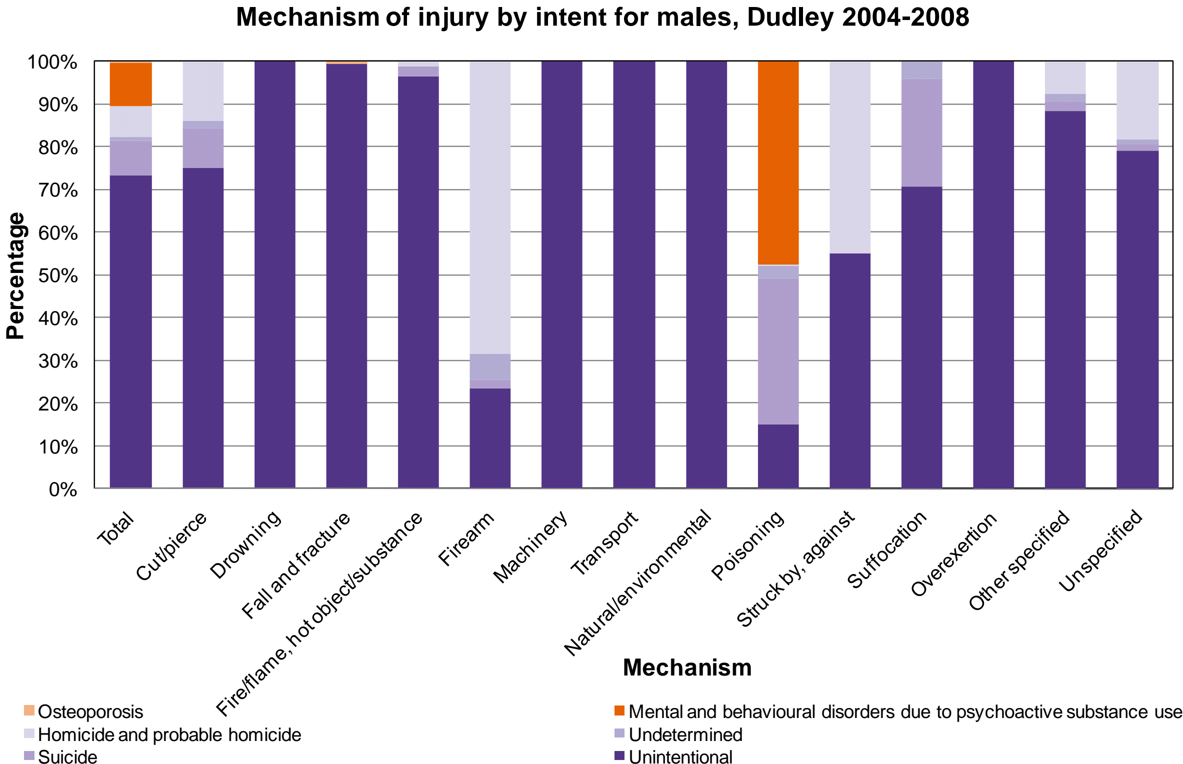
All hospital admissions due to transport incidents were unintentional. This is directly a result of the ICD coding guidelines (ONS, 2006).

Patterns of emergency hospital admissions by mechanism, with intent

During 2004-2008 the most common mechanisms for unintentional injuries among emergency hospital admissions for males were falls and fracture and transport (51% and 15% respectively). For females the majority of unintentional emergency hospital admissions in 2004-2008 were due to falls and fractures (76%), followed by transport (6%). In 2004-2008, for attempted suicides, poisoning was the most common mechanism for males and females (89% and 93% respectively).

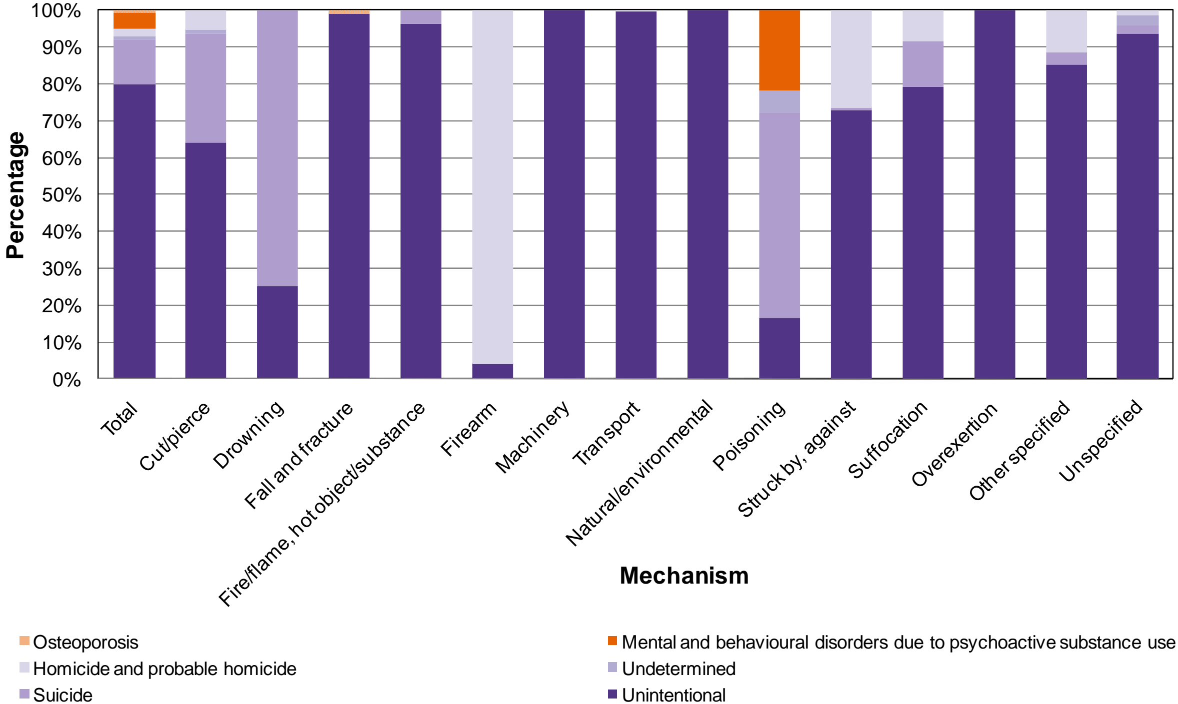
Admissions from undetermined intent had a wider range of mechanisms associated with it, with poisoning accounting for the largest proportion (68% and 92% for males and females respectively). For males cut/pierce and firearms are the other common mechanisms (12% and 6% respectively).

Figure 17a



Source: Secondary Users Service (SUS) Hospital Admissions
Office of National Statistics (ONS) mid-year population estimate

Figure 17b



Source: Secondary Users Service (SUS) Hospital Admissions
Office of National Statistics (ONS) mid-year population estimate

Patterns of injury and poisoning emergency hospital admissions for the top five mechanisms by age

Emergency hospital admission rates vary by five-year age band according to the mechanism of external cause. For falls and fractures in both males and females there is a strong relationship with age, with rates high in the under 15 age band, gradually declining across the age bands to 35-39, when rates begin to increase with increasing age, with a rapid rise after age 65. In the under 15 age band and the 65+ age band falls and fractures are by far the highest mechanism of emergency hospital admissions from external causes (Figure 18a & b). For males the other mechanisms show a similar pattern across age bands, with rates lowest in the 5 to 9 age band and rates rise to a maximum in early adulthood. The age band of the peak varies by mechanism – for transport and it is age 15-24, whereby it then declines gradually across the older age bands, whereas for poisoning the peak is in men aged 20-39. Struck by/against admission rates peak for the 15-19 age band and then gradually decline with increasing age. Cut/pierce gradually increases to a maximum rate at age 20-24 and again gradually declines with increasing age.

For females, rates for all mechanisms with the exception of falls and fracture were lowest in the 5-9 age band. Rates then rise for age, but there is only a clear peak for poisoning at 15-19 years and transport in young adults (15-24 years). Poisonings decline rapidly by age 25 but remain at this elevated level through to age 49, when it gradually declines to very low levels.

Figure 18a

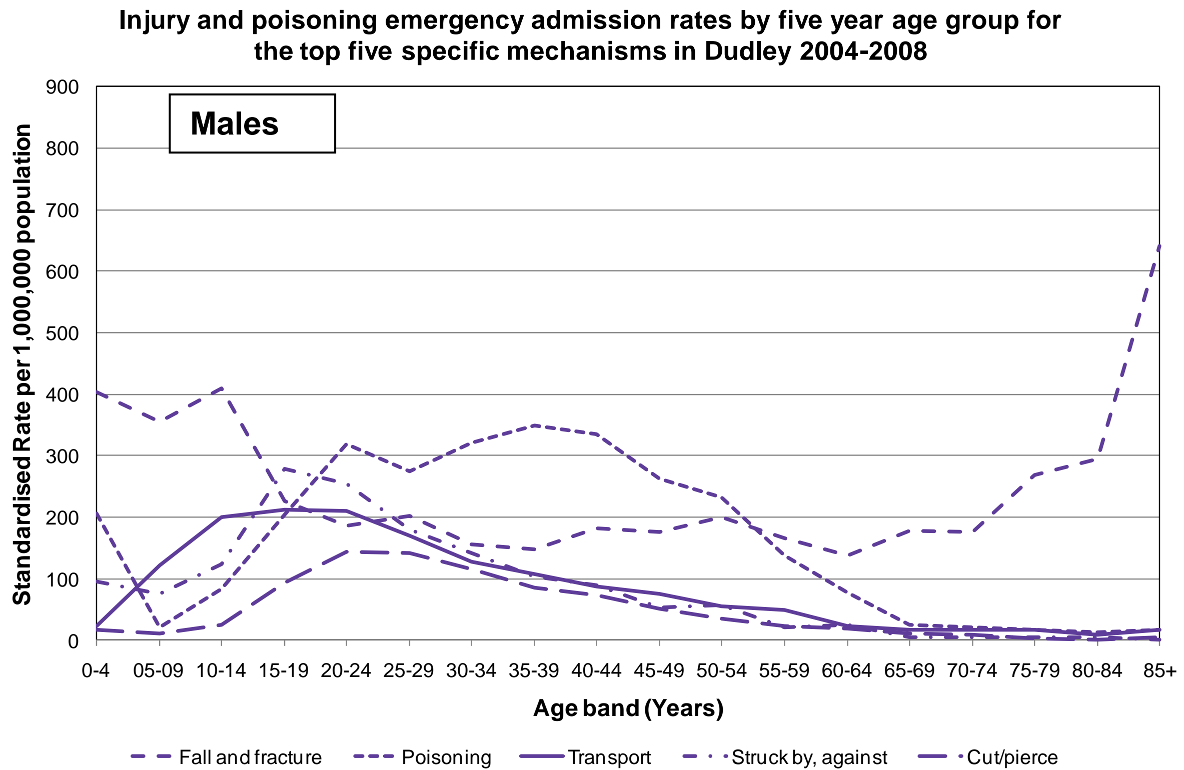
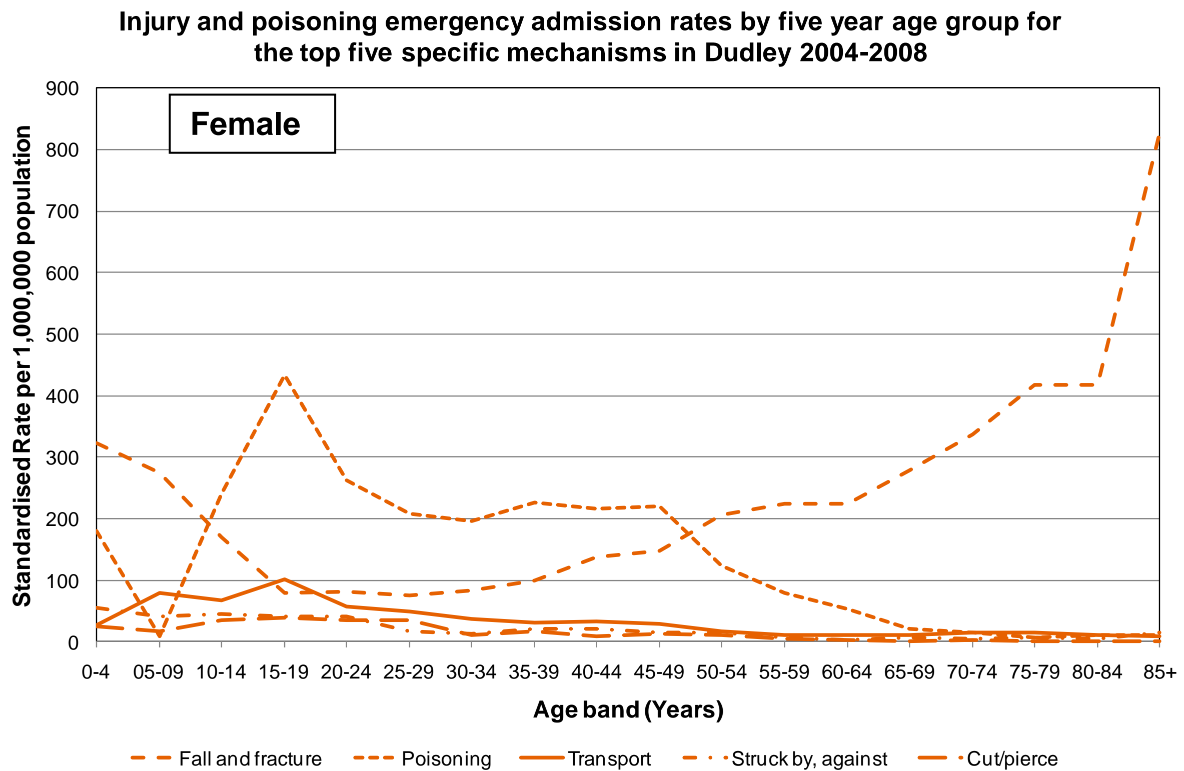


Figure 18b



Source: Secondary Users Service (SUS) Hospital Admissions
Office of National Statistics (ONS) mid-year population estimate

Key findings from analysis of emergency hospital admissions data using the ICE matrix

- Overall emergency hospital admission rates due to accidents, suicides and undetermined injury are higher in males than females. Emergency hospital admission rates have increased over time and continue to do so particularly for suicides and undetermined injury in females.
- There is a health inequalities gradient for emergency hospital admissions from external causes (higher rates in the most deprived areas) and this is more pronounced for males.
- The rise in emergency hospital admissions rates for accidents over the last 6 years is most apparent in the over 75 age band with the main mechanism being falls and fractures. There has been an increase in admissions rates across all age bands and mechanisms.
- In 2004-2008 falls and fractures were the most common mechanism of injury admission, followed by poisoning and transport.
- In terms of deprivation the main mechanisms which show a negative social gradient are poisoning (particularly ages 15-54 for males and age 0-54 for females), transport for males where the negative gradient is prominent in the 0-54 age band. Falls and fractures showed a smaller social gradient for males and showed a no gradient for females over 75, but a negative gradient for the younger age bands. Although the rate of admissions for drowning overall are low they do all arise from the most deprived quintile mainly in the 0-4 age band.

How do we get there?

In 1999, the Government White Paper *Saving Lives: Our Healthier Nation* (Great Britain. Department of Health, 1999) set out the first comprehensive Government plan focused on the main killers: cancer, coronary heart disease and stroke, accidents, mental illness. It set out to establish tough but attainable targets in priority areas. These were that by 2010 death rates accidents would be reduced by at least a fifth and serious injury by at least a tenth and for mental health to reduce the death rate from suicide and undetermined injury by at least a fifth. As seen earlier these targets are unlikely to be achieved both nationally and in Dudley. Additionally these targets are even more unrealistic in the lower socioeconomic groups.

Dudley has had a Joint Accident Prevention Strategy Partnership since the year 2000, and the current *Joint Accident Prevention Strategy* runs from 2009-2012 with annual action plans (Dudley MBC and Dudley PCT, 2009). The strategy to date recognised the impact of health inequalities on accident and unintentional injuries, and the current action plan has key programmes that work across Dudley and addresses the key areas highlighted in this needs assessment (Moss, 2010).

In terms of suicide and undetermined injury, these are covered in the *National Service Framework for Mental Health* (Great Britain. Department of Health, 1999) which had seven standards of which Suicide Prevention was Standard Seven and Mental Health Promotion was Standard One.

Several factors determine whether a person is likely to take their own life and these include physically disabling or painful illnesses, mental illness, alcohol and drug misuse and level of support. Stressful life events such as death, loss of a job, relationship breakdown or imprisonment can also contribute and for many people it is a combination of factors rather than a single cause (Great Britain. Department of Health, 2002). Suicide is the most common cause of death in men under the age of 35 and the main cause of death in people who have a mental illness. We know that 75% of individuals who commit suicide are not in touch with mental health services, nor do they have a mental disorder (Great Britain. Department of Health, 2001), hence a broad strategic approach is required involving a wide range of health and social care agencies, voluntary organisations, Government departments, and the private sector so that suicide prevention is everyone's business.

The current *National Suicide Prevention Strategy for England* (Great Britain. Department of Health, 2002) set out targets for 2009–11 for reductions in the suicide rate via actions to reduce risk in key high-risk groups, and to promote mental wellbeing in the wider population. This has been followed up by the Department of Health new Mental Health Strategy *New Horizons: Towards a Shared Vision of Mental Health* in 2009 (Great Britain. Department of Health, 2009c). This reported good progress in the reduction of suicide rates in the general population and in the prevention of suicide among young men, on mental health wards and in prisons. It identifies the need for the development of a refreshed strategy by the National Suicide Prevention Strategy Advisory Group, covering the changing demography of our society and the current economic climate. This will consider the risks of different groups; for example, young men leaving the forces, older men and rural communities.

Dudley developed two strategic documents following the NSF namely:

- A Joint Mental Health Strategy for Dudley Health and Social Care Economy 2004-2010
- The Dudley Adult Mental Health Joint Commissioning Strategy 2010-2013

The latter of these two documents gives a comprehensive account of the services commissioned and an action plan to develop the services further and these consider the major associated health inequalities.

Taking Positive Steps in Dudley (Thompson and Gaddu, 2004) was developed as a local suicide prevention strategy and delivered the following key actions:

- A Suicide Audit and Prevention Group was established to collate data and develop local actions.
- PCT carried out an analysis of the Significant Event Audits collated and identified areas for action/setting of local standards.
- Suicide Prevention Awareness Packs were developed and disseminated via training to 62 GP practices.
- Mental health services recorded progress against *Preventing Suicide: A toolkit for mental health services* (NIMHE, 2003).
- Developed and disseminated Dudley's Good Mental Health Guide across all sectors to enable signposting to relevant agencies.

- Action plan updated in 2008 to reinforce the 'combined approach' (CSIP, 2007, Pg 16) which focused on both primary prevention and secondary prevention to support individuals/groups at risk of suicide.

From the needs assessment in the last six years there has been a notable increase in the rate of hospital admissions from suicide/self-harm, particularly in young women and there is a strong social gradient associated with this for both sexes. The Royal College of Psychiatrists produced a position statement *No health without public mental health the case for action* (RCP, 2010). The paper urges the Government to prioritise public mental health as part of their public health policy on the basis that mental illness is the largest single source of burden of disease in the UK with physical health being inextricably linked to mental health. The statement recommends that: 'In order to address health inequalities it is essential that interventions are targeted at those people who are less likely to benefit from universal approaches and are at higher risk' and 'A suicide prevention strategy should remain a government priority and should include strategies to address and reduce the incidence of self-harm'.

Dudley's *Mental Health Promotion Plan for 2006-2009* (Birdi et al, 2006) included suicide prevention as one of the 8 priority areas identified for local action and supported working links across both agendas. Currently a new mental health promotion plan is being developed in line with the new national mental health strategy *New Horizons* (Great Britain. Department of Health, 2009c) and will continue to reflect work on this important health issue and address inequalities.

A collaborative and multidisciplinary approach to promoting mental health and preventing suicide is advocated and will contribute significantly to progress this agenda, by reducing the potential for suicide in key risk groups such as: young men, offenders, victims and survivors of abuse, looked after children, new mothers, Asian women, asylum seekers, older people, people who are bereaved by suicide and people from lesbian, gay, bisexual and transsexual (LGBT) communities.

Next Steps for Dudley will be to set up a multi-disciplinary Strategic Suicide Prevention Group in line with the refreshed *National Suicide Prevention Strategy for England* (Great Britain. Department of Health, 2002) to carry this work forward. Key recommendations from the NHS West Midlands Regional Development Centre (O'Hara, 2009) identify a need to focus on:

- Collaborative and joined up working
- Profiling the mental health and wellbeing needs of the local populations
- Data and information support
- Workforce development

8. DELIVERING THE SERVICES THAT WILL MAKE A DIFFERENCE

8.1 PRIMARY CARE

1. Background

This chapter should be read in conjunction with the *Reaching Excellence – A Primary Care Strategy for Dudley 2009- 2014* (NHS Dudley and Dudley MBC, 2009) which highlights a number of key actions to target services to reduce health inequalities. The needs assessment undertaken to underpin the strategy raised a number of concerns including

- Too much variation in GP practice performance
- Variable standards of practice management
- The need to scale-up prevention and health promotion
- Managing long term conditions
- Access to Primary Care

2. Proposed Actions To Address Health Inequalities In Primary Care

2.1. Too much variation in GP practice performance

The PCT is currently reviewing its performance management arrangements for all GP, dental, opticians and pharmacy contractors. Scorecards are being developed for all contractor services to enable both poor and excellent performance to be identified. This approach also enables contractors to benchmark their own performance at both a local and national level.

Where examples of good practice are identified these will be shared and where underperformance is an issue support programmes will be established.

To support the process of identifying poor performance and dealing with it appropriately the current policy for dealing with performer list issues is being reviewed and will be adapted to include contract management issues so that there is a dispute policy with a transparent and open process to be followed when areas of concern are identified.

In some instances, the consequences may mean re-commissioning an entire practice. Opportunities to provide a re-commissioned service will be subject to the PCT's procurement policies and will therefore be open to all potential providers.

This approach is being adopted for all contractors but is more developed for GP practices as a consequence of reviewing Personal Medical Services Contracts (PMS) this year. Traditionally PMS practices have enjoyed a higher level of funding and therefore the review aims to achieve value for money. We have agreed a key set of performance indicators that have been categorised into silver, gold and platinum standards. Over the coming months negotiations will take place with individual practices around achieving at least silver standards and an agreed level of gold and platinum over the next 3 years depending on the level of funding that is being received. The outcome of this piece of work will be that all practices will be achieving

the minimum standards set out by the PCT, agreed with the Local Medical Committee and explicitly stated in the PMS contracts. General Medical Services Contracts (GMS) will also be expected to achieve the minimum standards required by this approach.

Where practices fall below these standards, timeframes for improvement will be agreed, and time limited support for improvement will be provided in certain circumstances. Following this, if a practice fails to improve to the required standard, the PCT will:

- limit the practice's opportunities to deliver extended services, until acceptable standards are achieved for universal services
- re-commission the service or services where performance continues to be below the agreed standard beyond the agreed timescale for improvement.

2.2 Variable standards of practice management

Practices require good management skills to ensure robust business and clinical systems are in place; for instance, in order to target services at particular groups of patients, practices must have highly effective call and recall systems which are supported by good data recording. There are currently 15 of our 54 GP practices who score less than 90% of the possible achievement points in the organisational domain in QOF.

Looking ahead, general practice is likely to need an increasingly high standard of practice and business management. In recognition of existing variability and the future potential requirements, the PCT will work with local practice managers to create an advanced practice manager development programme which is accredited with a local University. This will help Dudley to grow its own cadre of the next generation practice managers, who will have the top-level skills likely to be required for general practice in the coming decade.

The PCT will also work jointly with local practice managers to develop a mentoring scheme. This will provide sessional support from a highly experienced practice manager to work alongside staff in a practice, which wishes to develop its systems and staff skills further.

2.3 Primary Care Continuing Professional Development (CPD)

General Practice within Dudley has historically had access to a comprehensive education programme provided by the PCT. Traditionally a large number of practices have made best use of the training available but there are still practices who do not participate in training. A training needs analysis is underway to inform how we can better commission training to meet the needs of all practices within Dudley. This will result in more innovative ways of delivering training supporting practices who already engage but also reaching those who currently do not.

A local primary care Continuing Professional Development (CPD) scheme will be developed which provides opportunities for multi-disciplinary groups of staff to learn together on priorities arising from this strategy, including:

- primary healthcare teams coming together within a practice or on a locality basis, involving GP practice staff, PCT community staff, pharmacists and social care staff – this will support local integration and coordination of services
- joint CPD between consultants, GPs, nurses, therapists, pharmacists, support workers and managers working in both secondary and primary care, initially to support better management of long term conditions, improving care pathways and personalised services.

The PCT will also explore opportunities to provide training to all primary care contractors including dentists, pharmacists and opticians.

Good practice management enables practices to have robust business and clinical systems in place. Practice management is the bedrock of good clinical outcomes

2.4 Access To Primary Care

Research into the access to primary care by Black and Minority Ethnic (BME) communities has been shown that certain communities do not access primary care. The PCT has commissioned a new GP practice in the Kates Hill ward that will provide an outreach facility to engage with groups offering health promotion advice and encourage them to use all primary care services appropriately. Patients will also be able to register with this new practice so long as they live within a reasonable distance.

3. Systematic and targeted prevention and early detection of disease

The needs assessment found that the prevalence rates of some major diseases are much lower than expected. This suggests that there are significant numbers of people who are in the early stages of diseases, which if treated, could improve their life expectancy.

Based upon GP practice disease registers an estimate of prevalence can be made taking account of age, gender, ethnicity and deprivation. An analysis of the 2008/9 data shows that there may be quite large numbers of people missing from disease registers:

Table 1: GP Disease Registers

Diseases	Estimated number of people 'missing' from GP registers
Hypertension	28,700
Asthma	10,300
Dementia	3,000
Diabetes	1,800
Coronary heart disease (CHD)	1,990
Strokes/TIA	800

Further analysis shows that for hypertension, asthma and dementia, the 'missing' patients are spread out across most GP practices. This suggests that Dudley-wide initiatives will be needed in order to improve the detection of these diseases. In contrast, for diabetes, CHD and strokes, there are 'missing' patients in only a small number of practices. This suggests that action needs to be targeted in these practices in order to improve detection.

There is also variation across practices in respect of MMR, childhood immunisation and flu vaccinations.

Prevalence and vaccination Indicators have been agreed as part of the revised performance management arrangements described above to ensure that all practices achieve the PCT's minimum standards in these areas.

4. Managing Long Term Conditions

The Quality and Outcomes Framework (QOF) provides a useful way of assessing how well primary care manages people with a long-term condition. In Dudley, GP practices as a whole are in line with the national and regional averages for most aspects of chronic disease management. Again, this masks some very high levels of performance as well as some practices where performance is below average. Although the QOF was originally set up to incentivise best clinical practice, and is not a contractual requirement, the clinical standards do support high quality chronic disease management.

Through improved performance management arrangements, GP practices who are not achieving targets will be supported to improve their existing performance and where they consistently fail measures will be put in place to address underperformance (see section 1). Good practice will be identified and shared to improve outcomes for patients in poorer performing practices.

Table 2 gives examples of the numbers of people in Dudley with long-term conditions that are missing out on specific treatments or interventions, which are known to improve health. For these patients, health outcomes are likely to be poorer than for patients receiving the treatments. Treating these patients to QOF standards would make a significant contribution to reducing health inequalities in Dudley.

The number of people with hypertension, whose blood pressure is not managed to the standard, is of particular note, since poor blood pressure control for this group is a risk factor for a number of other serious long-term conditions.

Table 2 – Numbers of patients with long-term conditions who are not receiving clinical treatments, which improve health based on 2008/9 QOF Data

Clinical indicators (from QOF)	**Dudley achievement in 2007/08**	**No. eligible patients**	**No. of patients not treated to the QoF standard (excludes exception reports)**
Blood pressure management of patients with coronary heart disease (150/90 or less). CHD6	89.46%	12,172	**1,283**
Patients with coronary heart disease who have been prescribed a beta blocker in the last 6 months CHD10	75.20%	9,886	**2,452**
Cholesterol management of patients with TIA or stroke (5mmol/l or less). STR8	78.5%	5,153	**1,090**
Blood pressure management of patients with hypertension (150/90 or less). BP5	77.82%	49,873	**11,061**
Patients with diabetes whose blood sugar level is under control (HbA1c is 7.5 or less (or equivalent test). DM20	69.52%	12,626	**3,848**
Blood pressure management of patients with diabetes (145/85 or less). DM12	76.8%	12,881	**2,988**
Patients with asthma who have had a review in the last 15 months. AST6	79.99%	17,995	**3,600**

8.2 SOCIAL CARE

Adult Social Care

Social Care in Dudley is delivered across two Council Directorates, the Directorate of Adult, Community and Housing Services and the Directorate of Children's Services as well as through the Dudley Walsall Mental Health Trust.

The Directorate of Adult, Community and Housing Services commission services to meet the assessed need of adults in Dudley who require social care services. This is provided to service user groups such as

- Older people
- Adults with physical disabilities
- Adults with learning disabilities
- Adults with sensory impairments

Services are commissioned by the Directorate of Adult, Community and Housing Services to meet these needs. These services are provided by either the private and independent sector or the Council's in-house provision. Strategic arrangement of provision across these sectors is focussed on key activities such as hospital discharge, intermediate care and promoting independence or 're-ablement.' The *Dudley Health and Social Care Commissioning Framework and Strategy 2008*-13 (NHS Dudley and Dudley MBC, 2008) is the over-arching statement of our commissioning intention which include focus on health inequalities and specific joint commissioning activity such as in mental health, learning disabilities or specific parts of older people's services e.g. equipment services.

Through a grant-funding programme, the Directorate of Adult, Community and Housing also supports numerous small providers of services in the Borough who are supporting specific communities such as black and minority ethnic communities in Dudley.

Assessment of individuals is largely undertaken in a locality basis across the five districts of the Borough. This means that locality teams are closely linked to all the areas that they serve and as such are close to the concerns of local communities. Specialist services for people with learning disabilities are also arranged geographically but on a North-South basis. Community Care Development Workers for the teams support work to engage even more closely with people from black and minority ethnic groups across the Borough. People with complex disabilities are supported through an Independent Living Team with a focus on promoting independence. Occupational Therapy services play a key role in the overall assessment and support process e.g. in the assessment for the provision of equipment where use of such equipment will allow people to be more independent. Social Work staff also work in the hospital setting to ensure a whole-system approach to hospital discharge, ensuring safe transition across a pathway from hospital to community settings.

The Local Authority has lead responsibility for ensuring that adults are safeguarded in Dudley and this is done under the auspices of a Dudley Safeguarding Adults Board. All agencies contribute to this but the Council ensures co-ordination of effort.

Mental Health Services are delivered through the Dudley Walsall Mental Health Trust. This provides the full range of mental health interventions for adults in Dudley across the social care and health spectrum. It includes the role of the Social Work and social care staff working in mental health to support the delivery of these services. The services cover in-patient hospital treatment to community support including assertive outreach.

These services, therefore, support people in meeting their care needs through advice, information and guidance, assessment, brokerage and direct service provision. The aim of the services is to "Put People First," promote independence of service users and support to informal Carers. This effort requires partnership working and through this people have opportunity to engage with the services and meet their desired outcomes. Structures such as the Older People's Board or the Learning Disability Board promote this approach whereby people who use services, their carers and the wider public can engage as needed.

In this way, Health Inequalities are addressed through promoting equitable access to and engagement with services to promote the independence of users and carers.

8.3 TRANSFORMING COMMUNITY SERVICES

Introduction

Dudley Community Services provide a wide range of adult and children's services to the population of Dudley. The core service specifications have been developed over many years and are regularly reviewed to ensure they are able to respond to demographic changes identified within the *Joint Strategic Needs Assessment* (Little and Moss, 2009) and other commissioning strategies. In 2009/10 the Community Contract was agreed with commissioners and has been used by them to monitor the performance of Dudley Community Services on activity and quality indicators. This report endeavours to outline the key changes we have made to the way our services are managed and demonstrate how we believe we have positioned ourselves to respond to the agenda for Transforming Community Services and to support the commissioners in addressing the priority needs of the resident population of Dudley Borough and reduce Health Inequalities.

Vision and Values within Dudley Community Services.

In 2009/10 we developed our own set of vision and value statements which built of those of Dudley PCT but reflected the "provider" function more clearly so that they had added relevance to our service areas. These have been updated for 2010/11 to reflect the Transforming Community Services agenda and have been distilled into 5 mission statements;

Box 1 Mission Statements

1. To lead the safe transfer of DCS into one or more alternative organisations under the TCS agenda
2. To work in partnership to develop integrated services which deliver a positive patient experience, promote independence and improve health outcomes
3. To deliver prevention and early intervention services that meet the needs of our communities
4. To provide first class community health services that people trust, in the right setting and at the right time
5. To attract and retain an effective, diverse and flexible workforce enabling them to develop their skills and expertise

These mission statements and supported by the nine strategic objectives shown in Box 2 and will be linked to the DCS business plans and those of the clinical business units. This helps us to ensure that prevention and early intervention are seen as everybody's business and enables us to focus on this as we continue to transform community services.

Box 2 Strategic Objectives

1. We will effectively lead DCS through an organisational change management programme
2. We will achieve clinical excellence
3. We will contribute to the achievement of public health targets
4. We will design and deliver patient centred care, develop new and existing services to meet changing needs
5. We will ensure the health and safety of our patients, staff and visitors

6. We will manage our resources effectively
7. We will attract and retain an effective, flexible workforce
8. We will use technology to improve performance
9. We will develop strong and effective partnership working

What have we done so far?

In 2009/10 DCS responded to the Transforming Community Services agenda and undertook a full management restructure. This enabled us to develop 3 Clinical Business units which focus on Children, Young People and their Families; Long Term Conditions and End of Life Care; Acute Care and Rehabilitation. We believe this will help us support the commissioners in addressing their key priorities on Public Health targets, Unplanned Care and Long Term Conditions.

We have focused the Health Visiting service on the pre-school children and are developing effective transition from them to the School Health Advisor services. This includes shared records which will improve continuity of care for children with additional needs. Both Health Visitors and School Health Advisors have a significant public health role around prevention and early intervention for the registered GP populations, school populations and also for wider public health initiatives.

The Community Health Nurses who provide services for the elderly have been realigned to the community nursing services which will enable them to further develop their role in addressing the needs of some of our most vulnerable patients and this should support care closer to home, admission avoidance and effective discharge after a period in hospital. The community nursing teams have also been reviewed and are working more effectively within their clusters.

Dudley Community Services also played a key role in responding effectively to the Pandemic in 2009. We provided immunisation services for patients and staff and also made significant contributions to the establishment and running of the Anti-Viral Collection Point.

Actions to support the reduction of Health Inequalities.

A virtual ward pilot is being run in a Practice in one of the most deprived areas of the Borough and if effective will be rolled out in the north of the Borough which will address a significant level of health needs for some of our most deprived populations

Our Nurse Consultant for Long Term Conditions undertook a review of frequent attendees at Emergency Departments. This showed a significant number who had drug or alcohol issues and this work is being taken forward within the urgent care work streams to identify how the needs of these clients can be met. We are training all our Health Visitors in Breast Feeding to establish best practice.

We will be training all staff to undertake Brief Interventions with clients. We have developed an award winning service for children and adults from ethnic minority groups affected by Haemoglobinopathies.

DCS has some key performance targets relating to public health and health inequalities in our community contract and CQUIN targets which we will be delivering in 2010/11 these include; Breast Feeding, Smoking Cessation, Obesity,

Our Learning Disability Specialist Health Service continues to address the health inequalities of clients/patients with a learning disability with the provision of over 1700 specialist training places this year for staff working within learning disability services and generic health and social care providers. In addition training is provided to GPs and their surgery staff in support of the DES health screening.

We have redesigned the Community Team for Learning Disabilities to ensure that the nursing resource are able to target patients health needs and link with the delivery of care continued with the individual 'Health Action Plans'

Our LD Health Access Service continues to support clients to access cancer screening programmes, e.g. Breast, Cervical and Bowel screening and making information as accessible as possible to help mainstream stream services make reasonable adjustment. Within the Acute Hospital this service has had influence to ensure a new system to identify LD patients who need additional support and consideration is implemented, together with the introduction of a Champion within their ED services. This year has also seen the further development of our older people's dementia service and continued developments within mental health with the progress of the Green Light and equality of access.

Timely access to a musculoskeletal service is important to the return of an individual to everyday activities including work. Our physiotherapy musculoskeletal service has introduced a centralised booking system for patients some from areas of high deprivation. This system has enabled these patients to access the service faster by offering the next available appointment rather than the next appointment at a nearby clinic.

Our Community Diabetes Specialist Service is able to provide a service for patients that is culturally sensitive. The service is able to encourage the education of not only the patients but also their families. In doing this the service is able to educate a wider group of people in the risks associated with diabetes and the strategies needed to reduce the incidence.

The podiatry service is receiving targeted service improvement to improve access to the service especially for the 'housebound' patients requiring care at home.

DCS are working with the Strategic Health Authority (Project 9) and our Wolverhampton University partners to develop the workforce in the delivery of specified pathways. The selected projects are:

- Diabetes
- Stroke
- COPD
- End of Life care

DCS have been commissioned to provide tissue viability services and we look forward to developing this new service within Dudley.

A Health Visitor is seconded to the Zone for four hours a week to look at the health needs of young people who are substance misusers. All young people seen will have a health plan developed for them.

The Youth Offending Nurse is working some additional hours to support the Family Intervention Project. The project offers intense support packages to children and families where there are particular issues related to offending behaviour and is managed within the Youth Offending Service.

Recruitment has taken place for a Specialist Speech and Language Therapist to work one day a week in the Youth Offending Team, this is a new initiative.

The Paediatric Asthma and Allergy Clinic has just commenced funded by the Queen's Nursing Institute and the NHS West Midlands Fund for Innovation. This will offer an accessible service closer to home.

The Speech and Language Team (SALT) service employs a bilingual co- worker, and we also use Language Line (as well as Applied Language Solutions (ALS)). This means that clients can have the service explained to them and appointments made in a language they understand, which means they can consent and commit to treatment. They then come along and have an interpreter via ALS when they come to their appointments.

SALT also prioritise looked after children, and has targeted services for hard to reach children.

8.4 DEVELOPING THE ROLE OF THE VOLUNTARY AND COMMUNITY SECTOR

There have been long-standing positive relationships between public sector health and social care agencies and the voluntary and community sector in Dudley. Many of our services in Dudley could not be delivered without the voluntary and community sector.

Examples have included:

- Grant Funded services by the Dudley MBC's Directorate of Adult, Community and Housing Services to Black and Minority Ethnic groups in Dudley who provide day care and other specialist support within the sector
- Service Level Agreements by the Directorate of Adult, Community and Housing Services with larger providers such as MIND or ReThink
- Health Act (former "Section 28") support by NHS Dudley to local voluntary and community sector activity
- Advocacy roles carried out by organisations on behalf of specific service user groups
- LINk activity undertaken as part of their remit

These examples are underpinned by the Commissioning intentions of both Dudley Council's services in adults and children's social care and those of NHS Dudley. Our Joint Commissioning Framework made health inequalities a key informing principle for our approach to commissioning and the examples of the way we work with the voluntary and community sector referred to above are very much part of that approach.

This context is also strengthened by the broader activity undertaken by the Dudley Community Partnership and its partners in working with the voluntary and community sector to develop a Compact (More information available at http://www.dudleylsp.org/local-compact). Dudley's Local Compact is a partnership agreement between the local public agencies in Dudley Borough, and the voluntary and community sector. Dudley's first Compact was published in June 2002 and has since been revised to include all members of the Dudley Community Partnership. The revised Local Compact was formally signed by representatives of the Partnership in May 2004.

The Local Compact recognises the invaluable contribution made by voluntary and community organisations to the Borough. It sets out a number of principles and undertakings on behalf of local agencies and the voluntary and community sector in order to improve relationships and to work more effectively together in improving the quality of life in the Borough.

This framework aims to give an overall coherence, therefore, to the way in which the sectors work together and this is given practical effect in the delivery of care and health services and the voice which is given to users, carers and patients of our services.

An important addition to this arrangement is the recent development of a Dudley Borough Faith Leaders' Network which was formally launched in November 2009. This strengthens the united voice of all religions that are represented in the Borough in a variety of ways.

The voluntary, community and faith sectors are important to our health inequalities because they often work in areas of deprivation where the issue of health inequalities is at its sharpest in terms of the multiple issues that affect those areas relating to employment, income, housing, skills and experience of health. The work of the sector – particularly in its representative and advocacy roles - often enables the public sector to see more clearly how communities are developing and responding to the many issues that they face in relation to health inequalities.

The Dudley Community Partnership worked with the sector to produce "In It Together" a strategy for engagement. The title indicates the overall shared commitment in the locality and recognition that our work together is how we can best respond to issues of multiple deprivation and sequencing of interventions across all sectors in proactively responding to the challenges we face.

This was something that was noticed by the HINST when they visited us. The recognised the following points:

- There are positive efforts being made to engage the third sector in identifying priorities and opportunities for them to become engaged in the health inequalities agenda. *Valuing People: Moving Forward Together*, (Great Britain. Department of Health, 2004) Compact agreements are some examples of this
- A new document on commissioning with voluntary, community and faith organisations should help to develop this sector further as potential providers of services for the Local Authority and the PCT
- The Faith Leaders Network has already identified work on poverty and homelessness as possible areas for joint working

Next steps

We have a positive context in which to move forward in our engagement with the voluntary, community and faith sectors as it affects health inequalities in Dudley.

Most recently, with the support of the Office for the Third Sector, we have engaged with further dialogue to develop our relationship and any practical changes that might result from that. For example, it is important to us that our local sector is appropriately skilled to participate in tendering exercises to maximise their chances of success within the competitive model. The sector will be addressing that with appropriate support. This will add to the way in which health inequalities can be addressed in the Borough through direct service provision or by strengthening the voice of specific communities in service planning, for instance, which will influence service delivery.

The Coalition Government's approach to the Big Society and a renewed emphasis on localism and civic engagement mean that the voluntary and community sector remain

at the heart of action to address community engagement and address health inequalities.

The Dudley LINk have a developed work programme that is being carried out and will add to the overall awareness of the wider health and social care sector relating to health inequalities. The NHS White Paper, *Liberating the NHS* (Great Britain. Department of Health, 2010) states that a body called HealthWatch will be developed with related aims to LINks and this will take forward this agenda.

The Health Inequalities Action Plan will be the ‘vehicle’ through which these aspirations are made real.

8.5 VOLUNTEERS, HEALTH CHAMPIONS AND HEALTH TRAINERS

The recent Marmot Review (2010) puts empowerment of individuals and communities at the centre of action to reduce health inequalities. In doing so, it sets out a vision of “creating conditions for individuals to take control of their own lives.”

The Community Health Improvement team (Public Health) in collaboration with Dudley Metropolitan Borough Council (DMBC) and the Voluntary and Community Faith Sector (VCFS) are working to address health inequalities through an approach which engages and empowers people from local communities to develop the confidence, knowledge, skills and awareness to improve their own health and well being as well as to influence the health and well being of others within their community.

Communities as geographical areas, or as collectives of people living in the same place or sharing a common identity, can influence an individual’s health in a number of ways, and it is often the negative impacts which are highlighted (e.g. levels of crime and anti-social behaviour resulting in people not feeling safe to go out and exercise). However, the impact of ‘word of mouth’ health information, challenges to commonly held beliefs and misconceptions, ‘support from next door’, and the modelling and normalisation of healthy lifestyle behaviours can also directly impact on and positively influence the health and wellbeing of individuals in a way that health professionals are not able to.

By harnessing this potential, raising health aspirations and supporting local people to make a difference in the heart of their communities, Community Health Champions, Public Health Volunteers and Health Trainers can give individuals the information, support and motivation they need to make healthier choices and sustain healthier lifestyles.

Through the Community Health Champions (CHC) programme local people are engaged and motivated to learn about and change their own health behaviours, and then supported as volunteers to empower and influence their friends, families, neighbours, work colleagues and the wider community.

Community Health Champions can be recruited through workplaces or may be local ‘community activists’ who are identified through well established groups. However, the main focus is on engaging individuals from the most deprived communities or groups experiencing health inequalities. In this case, initial engagement may typically occur through community engagement activities, such as Arts in Health projects, which enable people to get involved in creative and non-threatening activities, and consequently establish and build trusting relationships, build their confidence and self-esteem and raise their health aspirations. In addition to raising their own awareness, these projects enable the community to identify local needs or key issues, which can then inform service redesign and commissioning decisions. By supporting participants to become Community Health Champions, the project becomes sustainable, as key messages and support ripple out into the community beyond the duration of the initial project.

CHC's are trained and supported to 'get good health information into diverse communities'. They are well placed to do so, having local knowledge and credibility, language skills and cultural understanding, and as a result they are able to signpost and support people to access services and activities or pass on health messages to people who otherwise would find themselves isolated from professional services.

CHC programmes have been shown to connect with people living in some of the most isolated and deprived communities and to be successful in improving health outcomes whilst also demonstrating the cost effectiveness of community engagement *Altogether Better Executive Summary* (NHS Yorkshire and the Humber, 2008/09).

Initial outcomes from *People in Public Health* (South, 2009) case studies reviewed by Leeds Metropolitan University identifies a number of potential impacts of the CHC's programme. These include increased knowledge, understanding, confidence and self-esteem; social benefits i.e. reduction of social isolation, community cohesion and less stress; skills development and employability; better access to services and other health resources (especially with groups that are less advantaged); and better information flows between community and public services in addition to the direct benefits of an increase in healthy behaviours (e.g. increased levels of physical activity, fruit and vegetable consumption etc.).

The Community Health Champions model is being introduced in Dudley to engage and support those individuals who may not have the confidence to take up more formal volunteering opportunities. It will provide an important stepping stone into the established and more formal Public Health Volunteering Programme which trains volunteers to deliver key lifestyle services, such as Get Cooking classes, stop smoking groups, weight management classes, expert patient programmes and physical activity programmes such as led walks. Recruitment of volunteers is predominantly targeted within deprived communities and the opportunities available offer many social benefits to both the volunteers and the wider community. For many people voluntary work can also be the first step towards paid employment. Having developed confidence, valuable skills and experience and demonstrated their capabilities, many volunteers become paid as sessional workers to deliver these services, or go on to other education, training or employment opportunities.

Health Trainers (HT) provide one potential route to employment for Public Health volunteers, and other local people who have experience of working in their local community, and a desire to help people achieve a positive lifestyle change.

Health Trainers were identified as an important resource for tackling health inequalities in the '*Choosing Health'* White Paper (Great Britain. Department of Health, 2004), in line with the shift from 'advice on high to support from next door.'

Health Trainers are drawn from local communities and understand the day-to-day concerns and experiences of the people they are supporting. Whilst they share some common characteristics with CHCs, the HT programme is based on an NHS workforce model. Unlike the CHC model, which allows for more local flexibility, HT Services are underpinned by a framework and set of 'core principles.' HTs are also required to demonstrate their competency against two national competencies of

occupational standards, and work within the constraints of a nationally banded job description.

The Health Trainer Service in Dudley will engage with individuals from targeted communities or geographical populations, and supports those who experience the greatest inequalities in health. The service is aimed at people aged 18+ who have existing lifestyle risk factors (e.g. smoking), have a long term condition and would benefit from lifestyle changes (e.g. diabetes) or who have previously been referred to lifestyle services but failed to attend or did not complete the programme. Individuals can be referred through a range of referral routes or self refer if they prefer.

Health Trainers will support, encourage and motivate adults who want to make a change towards a healthier lifestyle but who are unlikely to make and maintain these changes without one to one support. They will promote healthy lifestyle changes in relation to diet, exercise, alcohol consumption, or smoking cessation and support individuals to explore options for health improvement by promoting small changes that will ultimately have a large impact on their overall health. This is achieved by setting goals, creating personal development plans and then supporting them to achieve these goals by providing the appropriate information and support. Health Trainers can help to translate health messages and ensure that clients are able to access the most appropriate services. Finally the clients are regularly followed up to assess their progress and to maintain motivational support.

There is strong evidence to suggest that providing support from the ‘person next door’ in conjunction with psychological skills to alter behaviour can help to reduce inequalities in health (Elliott et al., 2001).

In addition to addressing issues of poor mental and physical health, poor access to services and different lifestyle choices of individuals, the Health Trainer service also focuses on increasing the capacity and capability of people from within local communities to develop a new workforce with the skills to tackle inequalities in health.

HTs undertake training and gain experience and skills which are transferable to other NHS and non-NHS organisations. The recent HT workforce audit indicates that HTs leaving the service typically progress to full-time employment, often within health or social care (Murfin, Mitchell et al., January 2010).

At full capacity Dudley’s Health Trainer Service will have 10 whole time equivalent (wte) Health Trainers, managed by a Health Trainer Service Coordinator and supported by a part-time administrator. Recruitment to Health Trainer posts is being undertaken in two phases, alongside support and capacity building in the Voluntary, Community and Faith Sector to enable services to be commissioned from them in the near future.

The Community Health Champion, Public Health Volunteer and Health Trainer Programmes all play an integral role in World Class Commissioning by ensuring a bottom-up approach to influencing planning and commissioning decisions locally, and strengthening the capacity of the Third Sector. But most fundamentally, they build the

capacity and confidence of individuals and communities to improve their own health and well being.

8.6 THE PREVENTION ROLE OF THE ACUTE SECTOR

BACKGROUND

Hospitals are places where secondary care, either planned or emergency, is delivered. The role of a hospital in prevention is not often considered. There is an international movement of 'health promoting hospitals' around the world that has generated some excellent models of good practice, working with departments inside the hospital and a wide range of partners inside and outside the hospital to improve health and prevent readmissions.

Hospitals and health services may be sources of inequalities themselves if they don't adapt their own functioning and services to the specific needs of different staff, patient and community groups. However they have the potential to mitigate some of the negative health effects caused elsewhere by reducing thresholds to care and by offering health education to improve the health literacy of disadvantaged groups. They also have the potential to act as advocates for their patients and mediate change amongst partner agencies by engaging in partnerships to improve health. Since the health sector is one of the largest employers in the borough they can also contribute to reducing health inequalities through employment opportunities and promoting the health and well being of all their staff.

Many doctors focus on treating the symptoms of ill health they are presented with and are not making the connections necessary to have an impact on reducing the inequalities gap. The immediate causes of the social gradient in ill health, such as smoking, obesity and alcohol misuse are either overlooked by clinicians or left in the belief that they will be picked up by public health professionals. There is good evidence that brief advice delivered by a clinician can have an impact on health behaviour and those patients attending GP surgeries or hospital appointments are particularly receptive to such advice.

CURRENT POSITION

The NST report identified that the NHS Foundation Trust could play a bigger role in reducing health inequalities in Dudley and should take a more proactive role in leadership and partnership in this agenda. Since the visit there has been a change in management at Dudley Group of Hospitals (DGoH) and this has resulted in more involvement in key partnership and strategic groups and of most relevance here, the Health Improvement and Modernisation Management Team (HIMMT) and the Health and Wellbeing Partnership Board.

DGoH is already offering quit smoking support through a 'stop before the op' programme and also support to quit smoking for pregnant women. There are opportunities to take this approach further by offering identification and brief advice for both tobacco and alcohol consumption through CQUIN targets being developed for 2011.

Currently negotiations are taking place to enable the acute trust to become the provider of some community services. This will provide a unique opportunity to develop the public health role of its staff and provide robust links with the community

which it has never done before. There are also opportunities to work more closely with Primary Care since GPs will become the main commissioners of secondary care when 'Liberating the NHS' is implemented. Although responsibility for ensuring reducing health inequalities will fall to the Local Authority, it will also be a commissioning responsibility for the new GP Cluster Boards.

9. KEY RECOMMENDATIONS

The recommendations below have been chosen as the high priority actions that need to be addressed by a range of partners if we are to tackle the gap in health inequalities in Dudley. They reflect the strategic aims of the strategy and provide an indication of the timescale and outcomes that will be achieved. These recommendations are also reflected in a high level action plan which will be implemented and reported against by the nominated lead agency. A high level performance monitoring framework has been developed to show progress against some of the key indicators used to measure health inequalities.

The detailed delivery plans for the key priority disease areas can be found in the appendices. These have been selected for action as having the greatest impact on reducing health inequalities in Dudley and they can be found as action plans in Appendix 2 on page 219.

.

LEADERSHIP AND PARTNERSHIP

1. Strengthen leadership for health improvement and health inequalities across the partnership and particularly within the Local Authority, Dudley and Walsall Mental Health Partnership Trust and Acute Trust and ensure the involvement of GP Commissioning Consortia when they become established. This will be achieved through the establishment of a new Health and Wellbeing Board.

GIVE EVERY CHILD THE BEST START IN LIFE

2. Improve data systems across health and Dudley MBC to allow extraction of population level analyses of developmental progress of children under 5 in Dudley

3. Develop further the existing parenting programme databases to report ethnicity on fidelity to programmes and outcomes of interventions in eligible groups.

4. Consider investment profile in early years, school and adolescent programmes to examine for any scope for disinvestment and re-investment in evidence-based early years programmes.

5. Channel any resources released from other areas of child health investment into the introduction of a Family Health Partnership programme with defined eligibility criteria and clear means of auditing outcomes.

6. Continue implementation of Dudley's Parenting and Family Learning Strategy, with full tracking of adherence to eligibility criteria and outcomes for formal parenting programmes.

7. Develop more formal integrated working between the Dudley Community Services Health Visiting Service, the Dudley Group of Hospitals midwifery service and children's centres in Dudley, particularly between children's

centres' outreach workers and Health Visitors.

8. All statutory agencies to ensure policies for paid parental leave are in place and DMBC/partners economic regeneration initiatives to promote this with employers.

9. Dudley's action Plan to reduce inequality in infant mortality to be implemented in full.

10. Retain the high priority placed on Quality Assurance of childcare provision in Dudley.

CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL

11. Ensure that data systems for tracking the impact of economic strategy initiatives use a consistent approach to assessment across the social gradient.

12. Ensure that public and private sector employers adhere to equality guidance and legislation.

13. Develop means of implementing guidance on stress management and the effective promotion of wellbeing and physical and mental health at work, both for public sector and private sector employees.

14. Consider the potential for incentivising employers to adapt jobs to provide suitable employment for lone parents, carers and people with physical mental health problems.

15. Ensure that Dudley participates to the maximum in any available well evidenced active labour market programmes

ENSURE A HEALTHY STANDARD OF LIVING FOR ALL

16. All public service agencies in Dudley should to encourage those eligible and entitled to benefit to claim it.

17. Implement Dudley's Child and Family Poverty Reduction Strategy.

CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

18. Implement Dudley's Climate Change Action Plans.

19. Increase opportunities for active travel across the social gradient.

20. Maintain access and quality of open and green spaces across the social gradient

21. Continue to improve the energy efficiency of housing and reducing fuel poverty

STRENGTHEN THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

22. Implement the high level interventions that are known to have the greatest impact on reducing premature mortality for those diseases that contribute most to the inequalities gap. (The high level actions from the disease specific areas are to be found in 9.1 page 201)

ENGAGING AND EMPOWERING COMMUNITIES

23. Simplify and streamline neighbourhood engagement structures to avoid duplication and gain maximum benefit from the processes already in place.

24. Use the Five Element Model (Smithies, J. 2010) proposed by the National Support Team to take a more strategic approach to community health improvement in the most deprived areas of the borough.

25. Increase the mechanisms whereby increasing numbers of local people can participate in meaningful engagement and have a greater say and influence over local resources and programmes that impact on health inequalities.

9.1 DUDLEY HEALTH INEQUALITIES HIGH LEVEL ACTION PLAN 2010/11-2014/15

RECOMMENDATION	ACTIVITY	OUTCOMES	LEAD	TIMESCALE
LEADERSHIP AND PARTNERSHIP **1.** Strengthen leadership for health improvement and health inequalities across the partnership and particularly within the Local Authority, Dudley and Walsall Mental Health Partnership Trust and Acute Trust and ensure the involvement of GP Commissioning Consortia when they become established.	Establish a new Health and Wellbeing Board in line with new statutory guidelines	Strong cross-agency leadership for health inequalities which will ensure a high priority for joined up strategy and actions.	Dudley MBC	April 2012
GIVE EVERY CHILD THE BEST START IN LIFE **2.** Improve data systems across health and Dudley MBC to allow extraction of population level analyses of developmental progress of children under 5 in Dudley	Develop scope for review of systems to establish data item availability Consider and agree across agencies a small number of valid measures to assess children's physical, social, emotional and cognitive development at a	Improved intelligence on the developmental progress of the under 5 population in Dudley to confirm JSNA to track outcomes improvement and action specific corrective intervention that may be needed.	Dudley Public Health (PCT)/ DMBC Children's Directorate	September 2011 February 2012

RECOMMENDATION	ACTIVITY	OUTCOMES	LEAD	TIMESCALE
	population level. Review data item availability in current routine systems and identify means of/barriers to extraction. Consider whether any new data collection may be required (bias against instituting collection unless absolutely necessary). Develop system reporting outputs required to report on agreed measures. Implement and test reports on a pilot basis. Review learning from pilots. Agree continued reports and set up routine surveillance reporting.			May 2012 May 2012 July 2012 Dec 2012 July 2013 November 2013
3. Develop further the existing databases to report to formal parenting programmes on fidelity to programmes and outcomes of interventions in eligible groups.	Produce Annual Report on each formal manual-based parenting programme presenting data which gives assurance on fidelity to programme; completion rates; and outcomes achieved. Produce annual audits for each universal element of the Healthy Child Programme.	Improved health outcomes for identified vulnerable groups	Dudley Public Health (PCT/DMBC Children's Directorate)	First report produced for Year 10 by December 2011 and annually thereafter Audits for 10-11 by December 2011 and annually thereafter

RECOMMENDATION	ACTIVITY	OUTCOMES	LEAD	TIMESCALE
4. Consider investment profile in early years, school and adolescent programmes to examine for any scope for disinvestment and re-investment in evidence-based early years programmes.	Undertake a review of current spending across the children's services directorate of the MBC and PCT Consider redirection of any identified savings to early years	Improved health outcomes for all children	MBC lead/PCT/ Children's Services	September 2011
5. Channel any resources released from other areas of child health investment into the introduction of a Family Nurse Partnership programme with defined eligibility criteria and clear means of auditing outcomes.	Resource and introduce a Family Nurse Partnership programme Eligibility criteria to cover the most vulnerable families to receive the additional support	Improves the health outcomes of the most vulnerable children	Dudley PCT	April 2012
6. Continue implementation of Dudley's Parenting and Family Learning Strategy, with full tracking of adherence to eligibility criteria and outcomes for formal parenting programmes.	Ensure the Parenting and Family Learning Strategy is fully implemented, targeted at the families who will benefit most and assess the outcomes. Produce an annual monitoring report on the strategy and outcomes achieved.	Improves the health outcomes of the most vulnerable children	Dudley MBC Children's Directorate	Report on 10-11 by December 2011 at latest. Annually thereafter.
7. Develop more formal integrated working between the Dudley Community Services Health Visiting Service, the Dudley Group of Hospitals midwifery service and children's centres in Dudley, particularly between children's centres' outreach workers and Health Visitors.	Review care pathways and referral mechanisms to ensure seamless service provision across and between all agencies	Improves the health outcomes of the most vulnerable children	DCS/DGH/CC	March 2012

RECOMMENDATION	ACTIVITY	OUTCOMES	LEAD	TIMESCALE
8. All statutory agencies to ensure policies for paid parental leave are in place and DMBC/partners economic regeneration initiatives to promote this with employers.	All agencies to review policies on parental leave are in place and are supported by workplace initiatives	Improves the health outcomes of the most vulnerable children	All statutory agencies	March 2012
9. Dudley's Action Plan to reduce inequality in infant mortality to be implemented in full.	Infant mortality plan progress to be monitored by the Dudley Children's Trust 'Narrowing the Gap' group and successor partnership arrangements. Annual Report on progress.	Reduction in infant mortality	Dudley Children's Trust	March 2013
10. Retain the high priority placed on Quality Assurance of childcare provision in Dudley.	Quality standards to be monitored by the Health and Wellbeing Board	Improved health outcomes for all children	Health and Wellbeing Board	March 2015
CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL				
11. Ensure that data systems for tracking the impact of economic strategy initiatives use a consistent approach to assessment across the social gradient.	Agree a performance framework for assessing the impact of economic initiatives across all socio-economic groups	Economic decisions should not impact unfairly on the most deprived groups	MBC lead/DUE	March 2013
12. Ensure that public and private sector employers adhere to equality guidance and legislation .	Health and Wellbeing Board to receive assurance that all statutory agencies and all contracted providers have processes in place to adhere to equality guidance and legislation	Work practices should not impact unfairly on vulnerable groups	All agencies	March 2012

RECOMMENDATION	ACTIVITY	OUTCOMES	LEAD	TIMESCALE
13. Develop means of implementing guidance on stress management and the effective promotion of wellbeing and physical and mental health at work, both for public sector and private sector employees.	The joint health and wellbeing at work group to take a co-ordinated approach to implementing a pro-active approach to reducing and managing stress in the workplace and providing an expert resource for private sector employees	Work practices should not impact unfairly on vulnerable groups	Joint health and wellbeing at work group	March 2013
14. Consider the potential for incentivising employers to adapt jobs to provide suitable employment for lone parents, carers and people with physical mental health problems.	The health at work group to examine the potential for incentivising employers to adapt jobs for vulnerable groups	Reducing health inequalities by improving economic opportunities for disadvantaged groups	All agencies	March 2013
15. Ensure that Dudley participates to the maximum in any available well evidenced active labour market programmes	The health at work group to actively seek out opportunities to participate in well evidenced labour market opportunities and advise partners of these opportunities	Reducing health inequalities by improving economic opportunities for disadvantaged groups	All agencies	March 2013
ENSURE A HEALTHY STANDARD OF LIVING FOR ALL				
16. All public service agencies in Dudley should endeavour to encourage those eligible and entitled to benefit to claim it.	Provide frontline staff with information on how to signpost their clients to benefits support	An increase in the numbers of people receiving the financial support they are entitled to	MBC lead All agencies	March 2012
17. Implement Dudley's Child and Family Poverty Reduction Strategy.	Health and Wellbeing Board to receive an annual progress report on the implementation of the strategy	Fewer children growing up in poverty	MBC	March 2015

RECOMMENDATION	ACTIVITY	OUTCOMES	LEAD	TIMESCALE
CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PALCES AND COMMUNITIES				
18. Implement Dudley's Climate Change Action Plans.	The Health and Wellbeing Board to receive an annual progress report on the implementation of the strategy	Climate change plans should not impact unfairly on the most vulnerable	MBC lead All agencies	March 2015
19. Increase opportunities for active travel across the social gradient.	Ensure active travel plans include positive access for vulnerable groups	All residents of Dudley should be able to benefit from active travel	MBC	March 2015
20. Maintain access and quality of open and green spaces across the social gradient	New plans should include open and green spaces as an essential consideration	More residents able to enjoy green spaces	MBC	March 2015
21. Continue to improve the energy efficiency of housing and reducing fuel poverty	Review the future of Health Through Warmth/Warm Front programmes to make sure the most vulnerable benefit from energy efficiency improvements	A reduction in the number of people living in fuel poverty and un-insulated homes	MBC	March 2012
STRENGTHEN THE ROLE AND IMPACT OF ILL HEALTH PREVENTION				
22. Implement the high level interventions that are known to have the greatest impact on reducing premature mortality for those diseases that contribute most to the inequalities gap. (The high level actions from the disease specific areas are to be found in 9.1 Page 201)	All the Chairs of the LITs to take responsibility for delivery and monitoring of the relevant Health Inequalities delivery plans and producing an annual report on progress for the Health and Wellbeing Board	A reduction in premature mortality from the biggest contributors to health inequalities	Health services (DGH/DCS/Primary Care/ Independent providers)	March 2015

RECOMMENDATION	ACTIVITY	OUTCOMES	LEAD	TIMESCALE
ENGAGING AND EMPOWERING COMMUNITIES				
23. Simplify and streamline neighbourhood engagement structures to avoid duplication and gain maximum benefit from the processes already in place.	Undertake a review of the neighbourhood engagement structures with a view to simplifying current structures	More people engaged in meaningful consultation	MBC	March 2012
24. Use the Five Element Model (Smithies, J. 2010) proposed by the National Support Team to take a more strategic approach to community health improvement in the most deprived areas of the borough.	Implement the Five Element model from In It Together	Vulnerable groups are positively engaged in decisions that directly affect them	Public Health and partners	March 2013
25. Increase the mechanisms whereby increasing numbers of local people can participate in meaningful engagement and have a greater say and influence over local resources and programmes that impact on health inequalities.	Ensure local decision making procedures are inclusive of all residents	More people engaged in meaningful consultation and empowered to contribute to real change in their communities	MBC	March 2013

REFERENCES

Acheson, D. (1998) *Independent Inquiry into Inequalities in Health.* London: The Stationery Office.

All Party Parliamentary Group (2010) *All Party Parliamentary Group on Smoking and Health Inquiry into the effectiveness and cost-effectiveness of tobacco control.* [online] Available at: http://www.ash.org.uk/files/documents/ASH_743.pdf (Accessed: April 2010)

Atri, J. (2006) *Cardiac Catheterisation and Interventional Procedures for CHD. Investigation of equity of access.* Dudley: Dudley PCT

Birdi, A., Gaddu, U. and Jackson, K. (2006) *Dudley Mental Health Promotion Plan 2006-2009: Priorities for Action in Dudley.* Dudley: Public Health Directorate. Dudley Primary Care Trust.

British Heart Foundation (2006) Factfile: *Delays in Treatment for AMI.* [online] Available at: http://www.bhf.org.uk/idoc.ashx?docid=228971aa-b199-4d5e-8f89-5ae55b5d299b&version=-1 (Accessed: May 2010)

Care Quality Commission (2009) *Closing the gap. Tackling CVD & Health Inequalities by prescribing statins and stop smoking services.* [online] Available at: http://www.cqc.org.uk/_db/_documents/Closing_the_gap.pdf (Accessed: August 2010)

Care Services Improvement Partnership (2007) *National Suicide Prevention Strategy for England: Annual report on progress.* Care Services Improvement Partnership & National Institute for Mental Health in England. London: Department of Health

Central Office of Information (2009) *Stroke Awareness Campaign Tracking*. London: Central Office of Information

Communities and Local Government (2008) *Communities in control. Real people, real power.* [online] Available at: http://www.communities.gov.uk/documents/localgovernment/pdf/1366312.pdf (Accessed: April 2010)

Craig, R. and Mindell, J.(eds.) (2008) *Health Survey for England 2006.* London: National Centre for Social Research

Davey C, Austoker J. and Macleod U. (1999) *Reducing Inequalities in Breast Cancer – A guide for primary care.* London: Cancer Research Campaign

Dudley Children's Trust (2009) *Dudley Parenting Support and Family Learning Strategy*. Dudley: Dudley Children's Trust.

Dudley Community Partnership (2005) *Dudley Community Strategy 2005–2020 – the Dudley Borough Challenge.* [online] Available at: http://www.dudleylsp.org/community-strategy-2010-2013/community-strategy-2005 (Accessed: September 2010)

Dudley Community Partnership (2008) *Next Generation Local Area Agreement 2008/11.* [online] Available at: http://www.dudleylsp.org/local-area-agreements/our-approach-to-the-next-generation-laa (Accessed: September 2010)

Dudley Community Partnership. (2010) *Local compact between the voluntary and community sector agencies in Dudley borough*. [online] Available at: http://www.dudleylsp.org/local-compact (Accessed: September 2010)

Dudley Community Partnership.(2010) *In it together. An empowering approach to community engagement.* [online] Available at: http://www.dosti.org.uk/downloads (Accessed: September 2010)

Dudley Community Safety Partnership (2010) *Alcohol Strategy.* Dudley: Dudley Community Partnership

Dudley Group of Hospitals (2010) *Information Team Smoking & Pregnancy data reports.* Dudley. Dudley Group of Hospitals.

Dudley Metropolitan Borough Council (2009) *Corporate Engagement Principles*. [online] Available at: http://www.dudley.gov.uk/council--democracy/engagement/approach-to-engagement (Accessed: September 2010)

Dudley Metropolitan Borough Council and Dudley Primary Care Trust (2005) *Closing the Gap: Tackling Health Inequalities in Dudley.* Dudley: Dudley Metropolitan Borough Council and Dudley Primary Care Trust.

Dudley Metropolitan Borough Council and Dudley Primary Care Trust (2009) *Joint Accident Prevention Strategy for Dudley 2009-2012.* [online] Available at: http://www.nhsdudley.nhs.uk/sections/publications/documents/FOI26846170759.pdf (Accessed : October 2010)

Dudley Primary Care Trust (2009a) *Mortality Trends Chart Package Spreadsheets.* Public Health Intelligence. Public Health Compendium 2007. [online] Available at: http://www.dudleylsp.org/easysite/public/searchresults.asp?page=1&action=Search&keywords=adult+mental+health&CategoryString=&CategoryList=&SearchItemD=81&strSerchType=All&pgid=57595 (Accessed: April 2010)

Dudley Primary Care Trust (2009b) *Dudley Health Survey, Preliminary Findings.* Public Health Intelligence. [online] Available at: http://www.nhsdudley.nhs.uk/sites/documents/cms/937-2010-8-18-5472652.pdf (Accessed: August 2010)

Eden B. and Davies A. (2010) *Primary Care Cancer Audit*. West Midlands. Greater West Midlands Cancer Network

Elliott, E., Landes, R., Popay, J. and Edmans, T. (2001) *Regeneration and health: a selected review of research*. Nuffield Institute for Health. University of Leeds. Kings Fund, London

Finch, G. (1995) *Handling Children's Behaviour.* London: NCH Action for Children

Fisher, P.A. (2009) *An Examination of the Association between Temperature and Mortality in the West Midlands from 1981 to 2007.* Unpublished MPH Thesis. University of Birmingham.

Foresight Mental Capital and Wellbeing Project (2008). *Final project report*. London: The Government Office for Science

Friedli, L. (2009) *Mental health, resilience and inequalities*. [online] Available at: http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf (Accessed: August 2010)

Gordon-Dseagu, V. (2009) *Cancer and health inequalities: an introduction to the current evidence.* London: Cancer Research Campaign

Great Britain. Department of Health (1999) *National Service Framework for Mental Health: Modern Standards and Service Models*. London: Department of Health

Great Britain. Department of Health (1999) *Saving Lives: Our Healthier Nation*. London: The Stationery Office. (CM4386)

Great Britain. Department of Health (2001) *National Confidential Inquiry: Safety First.* [online] Available at: http://www.doh.gov.uk/mentalhealth/safetyfirst (Accessed: August 2010)

Great Britain. Department of Health (2002) *National Suicide Prevention Strategy for England.* London: Department of Health.

Great Britain. Department of Health (2003) *Tackling Health Inequalities: A programme for action.* London: Department of Health. (CM6374)

Great Britain. Department of Health (2004) *Choosing Health: Making healthy choices easier.* London: The Stationery Office. (CM6374)

Great Britain. Department of Health (2004) *Valuing People: Moving Forward Together - the Government's annual report on Learning Disabilities.* London: The Stationery Office

Great Britain. Department of Health (2006) *Strong and prosperous communities, The Local Government White Paper.* London: Department of Health.

Great Britain. Department of Health (2007a) *National Stroke Strategy*. London: Department of Health. [online] Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081062 (Accessed: August 2010)

Great Britain. Department of Health (2007b) *Cancer Reform Strategy.* London: NHS

Great Britain. Department of Health (2009a) *Health Profile for England 2008.* [online] Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_093465 (Accessed: April 2010)

Great Britain. Department of Health (2009b) *Health of Population Indicator: NHS Feedback as at Q3 2009/10- Smoking At time of delivery*. [online] Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh@en/documents/digitalasset/dh_106797.pdf (Accessed: April 2010)

Great Britain. Department of Health (2009c) *New Horizons: Towards a shared vision for mental health.* Consultation. London: Department of Health

Great Britain. Department of Health (2010) *Liberating the NHS.* London: The Stationery Office. (CM7881)

Great Britain. Department of Health (2010) *Tackling Health Inequalities in life expectancy in areas with the worst health and deprivation.* London: National Audit Office

Great Britain. Department of Health (2010a) *Tobacco Control Strategy for England - A Smokefree Future*. London: Department of Health. [online] Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111749 (Accessed: April 2010)

Great Britain. Department of Health (2010b) *Consultation on a strategy for services for chronic Obstructive Pulmonary Disease (COPD) England.* London: Department of Health

Laflamme, L., Burrows, S. and Hasselberg, M. (2009) *Socioeconomic differences in injury risks. A review of the findings and a discussion of the countermeasures.* Geneva: World Health Organisation. [online] Available at: http://www.euro.who.int/__data/assets/pdf_file/0012/111036/E91823.pdf (Accessed: August 2010)

Little, V. And Moss, A. (2009) *Joint Strategic Needs Assessment of Heath & Wellbeing in Dudley. – an update for 2009.* Dudley: NHS Dudley. [online] Available at: http://www.dudleylsp.org/needs-assessments--data-and-trends/health-jsna/copy-of-copy-of-jsna-documents-for-dudley

London Health Observatory (2010) *Health Inequalities Intervention Tool*. [online] Available at: http://www.lho.org.uk/NHII?LEGap.aspx?la=00CR&comp=3 (Accessed: September 2010)

Marmot, M. (2010) *Fair Society, Healthy Lives: a strategic review of health inequalities in England post-2010 - Executive Summary*. London: The Marmot Review

May, E. (2010) *Health effects of Climate Change in the West Midlands: Summary Report.* Birmingham: Health Protection Agency.

MINAP (2009) *Myocardial Ischaemia National Audit Project - How the NHS manages heart attacks.* London: Royal College of Physicians

Morse, A. (2010) *Tackling inequalities in life expectancy in areas with the worst health and deprivation.* [online] Available at: http://www.nao.org.uk/publications/1011/health_inequalities.aspx (Accessed: August 2010)

Moss, A. (2010) *Health Inequalities Joint Needs Assessment – Dudley.* Dudley: NHS Dudley.

Murfin, Mitchell et. al. (2010) *Health Trainer National Workforce Audit 2009.* London: Department of Health.

National Institute for Health and Clinical Excellence (2006) *Parent-training/education programmes in the management of children with conduct disorders.* TA102. London: National Institute for Health and Clinical Excellence.

National Institute for Health and Clinical Excellence (2008a) *Community engagement to improve health.* CG9. [online] Available at: http://www.nice.org.uk/media/pdf/PH9guidance.pdf (Accessed: August 2010)

National Institute for Health and Clinical Excellence (2008b) *Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach groups*. CG10. [online] Available at: http://www.nice.org.uk/media/pdf/PH10guidance.pdf (Accessed: April 2010)

National Institute for Mental Health in England (2003) *Preventing Suicide: A toolkit for Mental Health Services.* Leeds: National Institute for Mental Health in England.

National Mental Health Development Unit (2010) *Mental well-being checklist*. National Mental Health Development Unit. [online] Available at: http://www.nmhdu.org.uk/silo/files/mental-wellbeing-checklist-a4.pdf (Accessed: April 2010)

NHS Dudley (2009) *Communications and Engagement Strategy 2009-2014.* [online] Available at: http://pctnet.dudley.nhs.uk/documents/cms/601-2010-4-6-4997010.pdf (Accessed: September 2010)

NHS Dudley and Dudley Metropolitan Borough Council (2008) *Dudley Health and Social Care Commissioning Framework and Strategy 2008-13.* Dudley: NHS Dudley and Dudley Metropolitan Borough Council

NHS Dudley and Dudley Metropolitan Borough Council (2009) *Reaching Excellence – A Primary Care Strategy for Dudley 2009-14.* Dudley: NHS Dudley and Dudley Metropolitan Borough Council

NHS Dudley. *Dudley Ageing Well Website.* [online] Available at: http://nhsdudley.nhs/sites/older-people (Accessed: September 2010)

NHS Yorkshire and the Humber (2008-09) *Altogether Better Executive Summary.* Leeds: NHS Yorkshire and the Humber. [online] Available at: http://www.altogetherbetter.org.uk (Accessed: July 2010)

O'Hara, K. (2009) *Approaches to Whole Population Suicide Prevention: Final Report.* West Midlands: NHS West Midlands Regional Development Centre.

Office for National Statistics (2006) 'Trends in injury and poisoning mortality using the ICE on injury statistics matrix, England and Wales, 1979-2004, Health Statistics Quarterly, 32' (winter), pp. 5-18.

Office for National Statistics (2010) *General Lifestyle Survey, Smoking and Drinking among adults, 2008*. [online] Available at: http://www.statistics.gov.uk/ghs/ (Accessed: April 2010)

Pendry, L,. Roberts, D. and Walker, S. (2009) *Corporate Community Engagement Toolkit.* Dudley: Dudley Metropolitan Borough Council.

Pendry, L., Prescott, L. and Pritchard, J. (2010) *The Dudley Community Partnership Interactive Comprehensive Community Engagement Strategy.* Dudley: Dudley Community Partnership.

Royal College of Physicians (2000) *Nicotine Addiction in Britain. A report of the Tobacco Advisory Group of the Royal College of Physicians.* London: Royal College of Physicians.

Royal College of Psychiatrists (2010) *No health without public mental health: the case for action PS24/2010.* [online] Available at: http://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf (Accessed: April 2010)

Smithies, J. (2010) *How to develop and implement a strategic framework for community engagement to support achievement of health and social care goals: the 'Five Elements' model.* London: Department of Health.

South, J. (2009) *People in Public Health.* Leeds: Leeds Metropolitan University.

The Stroke Association (2007) *NOP Survey*. [online] Available at: http://www:stroke.org.uk/media_centre/press_releases/older_people.html (Accessed: August 2010)

Thompson, E. and Gaddu, U. (2004) *Taking Positive Steps In Dudley: Local Suicide Prevention and Reduction Action Plan 2004 – 2010.* Dudley: Dudley South Primary Care Trust, Dudley Beacon and Castle Primary Care Trust and Dudley Metropolitan Borough Council.

University College London. (2009) *Public awareness of cancer in Britain - Report for the National Awareness and Early Diagnosis Initiative.* London: Department of Health.

Wanless, D. (2002) *Securing our Future Health: Taking a Long-Term View.* [online] Available at: http://www.hm-treasury.gov.uk/wanless (Accessed: September 2010)

APPENDIX 1 - PERFORMANCE INDICATORS

Indicator	Dudley	England Average	Least Deprived	Most Deprived	External Inequality		Internal Inequality	
					Gradient	Value	Gradient	Value
Local Economy and Employment								
Income Support claimant rate (total claimants as percent of age 16 – 59/64 (female/male)) (ONS Claimant Count NOMIS, May 2009)	5.3%	4.0%	0.92%	10.92%	1.33*	1.3%	11.9*	10.0%
Job seekers allowance (% of working age population) (ONS Claimant Count NOMIS, May 2009)	5.6%	3.1%	2.5%	9.1%	1.8*	2.5%	3.6*	6.6%
Community Cohesion								
Primary Pupils who feel they are bullied due to colour, race or religion (Dudley Health Behaviour Survey, 2010)	7.7%	NA	4.2%	12.6%	NA	NA	3.00*	-8.4%
Secondary Pupils who feel they are bullied due to colour, race or religion (Dudley Health Behaviour Survey, 2010)	5.9%	NA	4.6%	7.0%	NA	NA	1.52	-3.4%
Personal Wellbeing								
Child wellbeing - % of LSOAs ranked in the bottom 20% nationally (Child wellbeing index 2009)	17.8%	20.0%	0.0%	83.3%	0.89*	2.2%	4.99+*	83.3%
Community Safety								
BCS Comparator crimes per 1,000 population (Dudley Community Safety Partnership, 2010)	34.3	NA	16.5	55.6	NA	NA	3.4*	39.1
Violence against the person offences per 1,000 population (Dudley Community Safety Partnership, 2010)	6.0	NA	1.9	11.3	NA	NA	5.9*	9.4
Skills								
% achieving 5 GCSEs graded A* to C (2008/09) (www.neighbourhood.statistics.gov.uk)	67.1%	69.8%	100.0%	52.6%	1.04	2.7%	1.90*	-47.4%
Smoking								
Secondary school Smoking prevalence – current smoker (Dudley Health Behaviour Survey, 2010)	12.5%	NA	9.1%	12.3%	NA	NA	1.35	3.3%
Diet and Nutrition								
Breastfeeding rate at initiation (Dudley Child Health System, 2009/10)	47.2%	72.7%	60.1%	38.4%	1.54*	-25.5%	1.57*	-21.7%
Breastfeeding rate at 6-8 weeks (Dudley Child Health System, 2009/10)	26.2%	45.2%	40.2%	20.6%	1.73*	-19.0%	1.95*	-19.6%
% Primary pupils eating five portions fruit and vegetables per day (Dudley Health Behaviour Survey, 2010)	24.5%	NA	27.2%	22.9%	NA	NA	1.19	-4.3%
% secondary pupils eating five portions fruit and vegetables per day (Dudley Health Behaviour Survey, 2010)	15.3%	NA	19.1%	14.1%	NA	NA	1.35*	-5.0%
Obesity								
% Reception children very overweight (NCMP, 2008/09)	9.0%	9.6%	3.6%	12.2%	0.94	-0.6%	3.39*	8.6%
% Year 6 children very overweight (NCMP, 2008/09)	20.8%	18.3%	14.8%	23.5%	1.14*	2.5%	1.59*	8.7%

Indicator	Dudley	England Average	Least Deprived	Most Deprived	External Inequality		Internal Inequality	
					Gradient	Value	Gradient	Value
Alcohol								
Alcohol related hospital admissions (standardized rate per 100,000 population) 2004-2008 (SUS))	1390	NA	1107	1707	NA	NA	1.54*	600
Life Expectancy and Mortality								
Male Life Expectancy 2005-2009 (Years)	77.4	77.7	81.4	72.3	1.00	-0.3	1.13*	-9.1
Female Life Expectancy 2005-2009 (Years)	81.9	81.8	85.0	79.0	1.00	0.1	1.08*	-6.0
Mortality from all causes persons (DSR per 100,000 population) (2004-2008)	622	598	450	755	1.04	24	1.68*	305
Premature mortality from all causes persons (DSR per 100,000 population) (2004-2008)	312	303	190	444	1.03	9	2.34*	254
Child (<15 years) mortality from all causes persons (DSR per 100,000 population) (2004-2008)	52.7	49.4	19.1	70.4	1.07	3.3	3.69*	51.3
Circulatory Disease								
Premature mortality from all circulatory diseases persons (DSR per 100,000 population) (2004-2008)	80	80	46	117	1.00	0	2.54*	71
Premature mortality from coronary heart disease persons (DSR per 100,000 population) (2004-2008)	44	46	28	62	0.96	-2	2.21*	34
Premature mortality from stroke persons (DSR per 100,000 population) (2004-2008)	15.7	14.9	9.1	23.3	1.05	1.2	2.56*	14.2
Premature mortality from hypertensive disease persons (DSR per 100,000 population) (2004-2008)	3.3	1.8	1.6	5.4	1.83*	1.5	3.38*	3.8
Cancers								
Incidence of all cancers persons (DSR per 100,000 population) (2004-2008)	394	389	363	436	1.01	5	1.20*	73
Premature mortality from all cancers persons (DSR per 100,000 population) (2004-2008)	116	116	88	151	1.00	0	1.72*	63
Incidence of breast cancer females (DSR per 100,000 population) (2004-2008)	126	124	124	130	1.02	2	1.05	6
Premature mortality from breast cancer females (DSR per 100,000 population) (2004-2008)	22.3	21.0	18.4	21.4	1.06	1.3	1.16*	3.0
Incidence of Lung cancer persons (DSR per 100,000 population) (2004-2008)	42	48	27	65	0.88	-6	2.41*	38
Premature mortality from Lung cancer persons (DSR per 100,000 population) (2004-2008)	21.7	26.5	12.7	41.6	0.82	-4.8	3.28*	28.7
Incidence prostate cancer males (DSR per 100,000 population) (2004-2008)	113	101	134	104	1.12	-12	0.78	-30.0

Indicator	Dudley	England Average	Least Deprived	Most Deprived	External Inequality		Internal Inequality	
					Gradient	Value	Gradient	Value
Premature mortality from prostate cancer males (DSR per 100,000 population) (2004-2008)	10.0	8.8	11.5	8.9	1.14	1.2	0.77	-2.6
Incidence of Colorectal cancer persons (DSR per 100,000 population) (2004-2008)	50	45	43	57	1.11	5	1.33*	14
Premature mortality from Colorectal cancer persons (DSR per 100,000 population) (2004-2008)	10.9	10.6	11.2	14.1	1.03	0.3	1.26*	2.9
Respiratory Disease								
Premature mortality from all respiratory diseases persons (DSR per 100,000 population) (2004-2008)	31.8	25.6	12.3	54.4	1.24*	6.2	4.42*	42.1
Premature mortality from COPD persons (DSR per 100,000 population) (2004-2008)	14.4	12.3	2.5	30.7	1.17*	2.1	12.28*	28.2
Chronic Liver Disease								
Premature mortality from chronic liver disease persons (DSR per 100,000 population) (2004-2008)	13.0	10.1	6.6	28.5	1.29*	2.9	4.32*	21.9
Accidental Injury								
Mortality from accidents persons (DSR per 100,000 population) (2004-2008)	15.5	16.0	14.3	15.8	0.97	-0.5	1.10*	1.5
Premature mortality from accidents persons (DSR per 100,000 population) (2004-2008)	9.4	11.4	6.6	9.9	0.82	-2.0	1.50*	3.3
Hospital admissions from accidents persons (DSR per 100,000 population) (2004-2008)	808	NA	615	1011	NA	NA	1.64*	396
Suicide								
Mortality from suicide and undetermined injury persons (DSR per 100,000 population) (2004-2008)	7.1	8.1	4.8	10.1	0.88	-1.0	2.10*	5.3
Premature mortality from suicide and undetermined injury persons (DSR per 100,000 population) (2004-2008)	6.9	8.1	4.4	10.5	0.85	-1.2	2.39*	6.1
Hospital admissions from suicide and undetermined injury persons (DSR per 100,000 population) (2004-2008)	145	NA	58	248	NA	NA	4.28*	190
Diabetes								
Premature mortality from diabetes persons (DSR per 100,000 population) (2004-2008)	3.4	3.0	1.3	5.1	1.13*	0.4	3.92*	3.8
Alcohol Related Harm								
Premature mortality from alcohol related harm persons (DSR per 100,000 population) (2004-2008)	14.3	11.6	6.6	30.7	1.23*	2.7	4.65*	24.1
Hospital admissions from alcohol related harm persons (DSR per 100,000 population) (2004-2008)	1631	NA	1107	1707	NA	NA	1.54*	600
Excess Winter Deaths								

Indicator	Dudley	England Average	Least Deprived	Most Deprived	External Inequality		Internal Inequality	
					Gradient	Value	Gradient	Value
Excess winter deaths index (2002/03-2006/07)	20.9%	NA	25.2%	19.1%	NA	NA	0.76	-6.1%
Emergency Hospital Admissions								
Emergency hospital admissions from CVD persons (DSR per 100,000 population) (2004/05-2008/09)	732	NA	546	969	NA	NA	1.77*	423
Emergency hospital admissions from Cancer persons (DSR per 100,000 population) (2004/05-2008/09)	255	NA	220	295	NA	NA	1.34*	75
Emergency hospital admissions from COPD persons (DSR per 100,000 population) (2004/05-2008/09)	131	NA	52.3	243.7	NA	NA	4.66*	191.4
Emergency hospital admissions from Asthma persons (DSR per 100,000 population) (2004/05-2008/09)	101.5	NA	47.2	150.0	NA	NA	3.18*	102.8
Emergency hospital admissions from Diabetes mellitus persons (DSR per 100,000 population) (2004/05-2008/09)	53.1	NA	44.3	75.6	NA	NA	1.71*	31.3
Emergency hospital admissions from Depression persons (DSR per 100,000 population) (2004/05-2008/09)	42.2	NA	23.8	63.2	NA	NA	2.66*	39.4
Uptake of Services								
3 Year Breast screening uptake (%) (2008/09)	72.2%	80.0%	77.9%	63.6%	1.11	-7.8%	1.22*	-14.3%
5 Year Cervical screening uptake (%) (2008/09)	80.4%	80.0%	86.2%	73.6%	1.00	0.4%	1.17*	-12.6%
2 Year Bowel screening uptake (%) (2008/09)	55.1%	60.0%	64.6%	43.7%	1.09	-4.9%	1.48*	-20.9%
Childhood vaccinations uptake uptake (%) (Quarter 2 2010/2011)	92.6%	95.0%	97.4%	91.9%	1.03	-2.4%	1.06	-5.5%

APPENDIX 2 – DELIVERY PLANS FOR PRIORITY ACTIONS

PRIORITY AREA: CVD SECONDARY PREVENTION IN THE PRIMARY CARE SETTING DELIVERY PLAN

RECOMMENDATION	ACTIVITY	OUTCOMES	LEAD	TIMESCALE
Improve variation in performance across practices for treatment, access and outcomes- ensuring optimum use of vascular disease registers to manage chronic disease	QOF indicators for blood pressure, cholesterol and blood sugar management, and cardio-protective prescribing to be investigated for practice outliers,– starting with blood pressure	Improved management of vascular long-term conditions	Public Health Shelagh Cleary	March 2011
	Develop and implement a self-care strategy	Improved health outcomes for people with long term conditions	Public Health Diane McNulty	March 2011
Reduce the gaps between actual and expected prevalence for the key vascular diseases	Implementation of NHS health checks programme ensuring high uptake from men, BME communities, deprived areas	Reduction in CVD	Public Health Karen Jackson	March 2013
	Investigate practice outliers with low levels of prevalence for CHD and stroke registers	Reduction in CVD Improved management of vascular long-term conditions	Public Health Shelagh Cleary	March 2011
Primary care services should build health equity assessment into routine audit	Include in primary care and community service contracts	Equity considered as part of service delivery	Primary Care & community Commissioning /Contracting	March 2012
Increase referrals to & outcomes from Lifestyle Risk Management Services	Implementation of IBA (identification, brief advice and referral) for lifestyle issues	Increase in numbers receiving early interventions contributing to a reduction in mortality from smoking and alcohol related causes	Public Health DMcNulty/ KJackson	March 2012
	Improve Stop Smoking Service outcomes for people from deprived areas - via targeted stop smoking clinics	Reduction in smoking prevalence	Public Health Ruth Olding	March 2011

PRIORITY AREA: ACUTE CHD, STROKE AND TIA DELIVERY PLAN

RECOMMENDATION	ACTION	OUTCOMES	LEAD	TIMESCALE
Raise public awareness of the symptoms of heart attack and action to be taken	Introduce public awareness campaigns with a targeted approach to - over 65s, BME, women and deprived areas. Incorporate awareness for health care professionals to advise patients with, or at high risk of, vascular disease to call 999 should they experience unexplained chest pain into existing training programmes	Reduction in CHD mortality Improvement in equity of access for revascularisation	CHD LIT/ BCCN/ patient support groups	March 2012
Consolidation of diagnostics and treatment services for acute MI	Continue to embed delivery of expanded services for acute MI diagnostics and revascularisation and review the equity of provision in a further 5 years time.	Improvement in equity of access for revascularisation	BCCN/PH	March 2015
Investigate demographic differences in referrals to cardiac rehabilitation	Repeat the cardiac rehabilitation equity audit with larger numbers to establish a fuller picture and implement recommendations made from this. This should include a review of DNAs and DNRs for cardiac rehabilitation and the establishment of routine procedures to follow-up these groups.	Increased uptake of cardiac rehabilitation	RT/BCCN	March 2011
Implement Stroke/TIA action plan	Continue implementation of current stroke/TIA workstreams to increase speed of access to diagnostics and treatment to meet the accelerating stroke improvement programme targets Review equity of future provision for any target areas which remain significantly below target	Achievement of accelerated stroke care targets	STIG	March 2012 March 2014
Raise public awareness of F.A.S.T	Continue FAST awareness programmes with an emphasis on segmentation and use of social marketing to ensure the message reaches all communities, to include targeted campaigns for BME & over 65s	Inc in % thrombolysed	STIG/BCCN/ Dudley Stroke Association	March 2012
Review practice variations in patients accessing stroke/TIA pathways	Review GP practice performance for outlying practices in relation to admissions data Audit GP TIA referral data for consistency	Inc in % thrombolysed Improved patient outcomes after Stroke/TIA	STIG/clinical lead for stroke/TIA	March 2012

PRIORITY AREA: TOBACCO CONTROL

RECOMMENDATION	ACTIONS	OUTCOMES	LEAD	TIMESCALE
Strategic approach to Tobacco Control is best co-ordinated by an effective multi-agency partnership:				
- Continued strong senior level support and leadership for TC agenda	TC identified as PCT WCC priority 2010-13	PID developed (copy attached)	KJ &RO	2013
- Review role of Tobacco Action Group (TAG)	Discussed at TAG meeting in JAN10	New terms of reference and new members invited to future meetings	RO	End of Apr 2010
- TAG continued accountability to DCP via the H and WP	Report annually to H&W partnership	Produce report and paper when end of year data available	RO	May 2010
- Refresh the Tobacco Strategy and action plan in line with new National Strategy	National Strategy released in Feb 10 Update local strategy 2010/11	Updated strategy and priorities	KJ & RO	Dec 2010
- Development of advocacy role of the Alliance around SHS and Illicit tobacco	Propose as Alliance priority for 2010/11 workplan at meeting end Apr 2010	Project plan	RO	May 2010
Further develop an evidenced based and proactive approach to illicit tobacco	Identified in PCT Tobacco PID		KJ& RO	
- Plan local priorities	Plans to develop action through the Alliance	25 Workplace visits in conjunction with HMRC	RO	Mar 2011
	Included in role of EH workplace visits	25 workplaces informed of illicit tobacco per month	RO	Mar 2011
The PCT, Acute Trust, LA and other partners should explore ways in which data can be collected and shared to improve local intelligence on key areas e.g. smoking in pregnancy, illicit tobacco, under age sales	Added smoking and Pregnancy data collection as CQUIN Indicator 2009-10	Data still not robust	YH	Mar 2010
		Identify areas for improvement	YH	Mar 2011
	Made improvement to S&P SSS data monitoring to track referrals and develop care plans	Feedback to DGH on referral outcomes	YH	Monthly reports

RECOMMENDATION	ACTIONS	OUTCOMES	LEAD	TIMESCALE
	Include under age sales and illicit data collection in TS enforcement post Looking at ways to improve data sharing between HMRC and TS through the Alliance	Test purchase outcomes Development of protocol for sharing data	RO RO	Mar 2011 Mar 2011
Intention to commission EH to carry out additional smokefree compliance checks in routine and manual workplaces to include illicit tobacco and stop smoking information	0.5 WTE EH Technical Officer post commissioned from Sep 09- Apr 10 Contract renewed Apr 10 – Mar 11	25 workplace visits /contacts per month Total 175 workplace visits 300 workplace visits	RO RO	Mar 2010 Mar 2011
There would be a benefit tin developing a programme of ongoing test purchasing to explore the issue of supply of tobacco to young people	PCT has commissioned a joint alcohol and tobacco trading standards enforcement post from Apr 2010- Mar 2011	400 test purchases per year 20 exercises	RO & JP	Mar 2010 Mar 2011
The early adoption of DH Stop Smoking in Secondary Care toolkit provides an opportunity to ensure effective care pathways are in place for smokers – this will impact on the key contributors to tackling health inequalities. - This would also provide an opportunity to ensure a formally agreed care pathway for smoking in pregnancy to be used by all staff. (Infant Mortality NST recommendations provide further detail on this issue).	Early adopter action in progress Plans to develop a risk assessment tool for pregnant smokers	50 contacts with smokers Reduce IM and problematic pregnancies	JP YH	Mar 2010 Mar 2011
HINST recommend that the DH Stop Smoking Interventions in Primary Care toolkit is rolled out to ensure strengthened infrastructure for quality brief interventions.	5 pilot sites conducting 10 point structures approach BI and referral included in Community CQUIN for 2010-11	Increased access to DSSS BI training for HV and CN Data on BI and referrals to DSSS	JP	Mar 2010 Q1 & Q2- 2010-11

All of these initiatives will require senior level support and agreement between Primary and Secondary Care organisations to ensure a seamless quality service for clients.	Through contractual arrangements as above	Improved SSS service provision	RO	Ongoing
Varenicline has been approved by the MMC Dec 2009		Improved 4 week quit outcomes	JP	May 2010

PRIORITY AREA: ALCOHOL DELIVERY PLAN

Health and Health Improvement

RECOMMENDATION	ACTIVITY	OUTCOMES	LEAD	TIMESCALE
Rise awareness of alcohol harm in the local community	Alcohol awareness campaigns	Three general awareness campaigns to improve knowledge of units and health risks of drinking to excess of the general population Targeted campaign for under 25s on the health risks of binge drinking Partnership Campaign e.g. Christmas Alcohol and Cocaine Campaign	PCT (Public Health) + all partners	March 2011
Ensure information on alcohol is available and accessible to all members of the local population	Information about units and sensible drinking limits are available in the main community languages on the council and PCT websites, and in key healthcare and community settings	Increase in awareness as measured by baseline lifestyle survey Increase in number of places/services where alcohol information is available	PCT (Public Health) + all partners	March 2011
All workplaces should have alcohol policies and provide awareness and support for staff on alcohol	Increase awareness of alcohol in the workplace and ensure businesses are supported to develop alcohol policies Introduce regular alcohol health promotion sessions with employers and community groups	Ensure PCT, NHS Trust and Local Authority have up to date policies on alcohol in the workplace and monitor implementation Establish baseline to reduce alcohol related absenteeism Develop and implement number of sessions held Raised awareness measured by evaluation of sessions	PCT (Public Health) + all partners	March 2013
Identify and target those groups most at risk of alcohol related harm	Targeted interventions to reduce alcohol related admissions to hospital	Awaiting outcome of social marketing study. The interventions may be campaigns or specific interventions e.g. access to brief interventions, etc.	PCT (Public Health) + all partners	March 2012
Provide access to support services for alcohol users and carers	Small grants scheme to support user and carer groups	A minimum of five groups to be supported per annum	PCT (Public Health) + all partners	

Empower community members to raise awareness of alcohol issues in the local community	Implementation of accredited community training course	A minimum of 10 people trained and accredited to deliver alcohol awareness training to community groups	PCT (Public Health) + all partners	March 2011
Make use of the Healthy Towns initiative to promote alcohol awareness and promote safer drinking	Links between the Alcohol Strategy and the Healthy Towns agenda to be developed	Park Rangers to undertake Tier 1 and Tier 2 Drug and Alcohol Awareness Training	DMBC/DAAT	March 2011
Alcohol Misuse and Mental Health	Raise awareness of the links between mental ill health and alcohol misuse	Increase in the number of people receiving appropriate treatment	PCT/DAAT	March 2013

Early intervention and treatment

RECOMMENDATION	ACTIVITY	OUTCOMES	LEAD	TIMESCALE
Implement routine identification in A&E and provide brief advice to those identified	Use the increased capacity of the drug and alcohol liaison team to implement IBA in A&E and follow up patients after leaving ED	Reduction in frequent attendees at ED (baseline to be set) Reduction in alcohol consumption for patients given brief advice measured at 3 month follow-up	PCT	March 2012
Introduce routine identification and brief advice in Primary Care	Develop an alcohol LES to support the existing DES for new registrants Include alcohol IBA in vascular checks	Alcohol register to be set up to establish baseline Alcohol LES to be offered to interested GPs Increase in referrals to alcohol services Reduction in alcohol consumption for patients given brief advice measured at 6 month follow-up	PCT	March 2011
Continue alcohol arrest referral scheme	Offer routine identification and brief advice when people are arrested and in custody	Reduction in alcohol consumption for patients given brief advice measured at 3 month follow-up Reduction in offending rate	DAAT Partnership Manager	March 2011
Roll out alcohol IBA training to health care professionals and a wide range of frontline staff	Training needs assessment to assess number of all staff requiring training and number of programmes to be offered Training of healthcare workforce in early identification and offer brief advice	Increase in number of staff trained in general alcohol awareness. Brief advice and signposting Brief interventions Increase in skills and confidence of staff Increase in numbers of harmful and hazardous drinkers identified and given brief advice	PCT/DAAT	March 2011
Increase capacity of specialist alcohol services to match demand created by increased early identification	Review current specialist alcohol treatment services in light of MoCAM and the Review of the Effectiveness of Treatment for Alcohol Problems	Identify gaps, strengths and weaknesses in current provision Outcome of review to determine future levels of service required to reduce waiting times and address unmet needs	PCT/DAAT	March 2011

Develop an integrated alcohol treatment system across all tiers, including wrap around services	Reconfigure treatment provision where appropriate to ensure that an accessible integrated system of effective interventions is provided across the four tiers to meet local needs Review care pathways and ensure they are fit for purpose	A treatment strategy and action plan is in place and implemented	PCT/DAAT	March 2012
Ensure robust systems are in place for monitoring service provision	Review commissioning and performance management systems for all levels of alcohol intervention	Performance management and reporting systems in place	PCT/DAAT	March 2012
Involve service users and carers in the planning and delivery of alcohol services	Develop a user and carers strategy	Service user and carer involvement strategy developed Service users and carers are demonstrably involved	PCT/DAAT	March 2013
Ensure the needs of vulnerable groups are met, including the homeless and asylum seekers	Improve the identification of alcohol misuse issues in respect of tenancy sustainment referrals and homelessness presentations	Better equipping of staff to respond appropriately	Sian Evans DACHS	March 2013

Reducing crime and disorder, including domestic abuse

RECOMMENDATION	ACTIVITY	OUTCOMES	LEAD	TIMESCALE
Reduce alcohol related harm and reduce crime and disorder through effective advocacy and partnership working	Alcohol Arrest Referral Scheme	Reduce alcohol related offending and improve health outcomes	DAAT	March 2011 subject to funding
	Taxi Marshalling Scheme	Sustain funding for scheme to continue	DMBC Licensing	March 2011
	Pub Watch	Develop effective links with relevant legislation and the "pub trade"	West Midlands Police	March 2015
	Social Responsibility Scheme	Explore further role out of scheme Receive evaluation of scheme	DMBC Trading Standards/ Community Renewal Team	March 2011
	Cumulative Impact Policy	Ensure that cumulative impact is retained in Stourbridge	West Midlands Police	March 2015
	Test Purchasing	Ongoing test purchasing activity informed by intelligence	DMBC – Trading Standards	March 2011
	JAG	Implement activities led by Intelligence	DMBC – Community safety Team	March 2012

Offender Management

RECOMMENDATION	ACTIVITY	OUTCOMES	LEAD	TIMESCALE
Provide a range of interventions to reduce offending and alcohol misuse	Drink Impaired Drivers Programme	Reduce drink drive offences (groupwork)	Probation - Lead Officer - Bronwen Elphick	March 2011
	Low Intensity Alcohol Programme	Reduce Alcohol related offences (groupwork)	Probation -Lead Officer - Bronwen Elphick	March 2011
	Offender Substance Abuse Programme	Work with offenders where alcohol has contributed to their offending. Reduce offending and alcohol misuse (groupwork)	Probation - Lead Officer - Bronwen Elphick	March 2011
	Telford Training Consortium 2000	1 to 1 work with offenders who may disclose problems with alcohol pre or post sentence. Input may be tailored to safer drinking/healthier lifestyles and/drink driving. Training sessions are also arranged for probation staff to acquire expertise in addressing alcohol use with offenders and also to educate them in leading healthier lifestyles themselves	Probation - (Delivered by TTC staff)	Time limited due to funding
	Alcohol Treatment Requirement	1 to 1 work with drink dependent offenders who may require detox or other medical treatment over 4 sessions	Probation - Lead Officer - Bronwen Elphick	March 2011
	Ensuring robust links with Drug Treatment Services	Workforce development – ensure that all Drug Intervention Programme Workers are trained and skilled to be able to deliver a brief intervention or signpost to specialist treatment those drug misusing offenders for whom alcohol is also a "problem Ensure that brief advice and information is delivered to those who receive a DIP Conditional Caution	Cranstoun Drug Services Lead Officer - Dee Russell	March 2012

PRIORITY AREA: CANCER DELIVERY PLAN

RECOMMENDATION	ACTIVITY	OUTCOMES	LEAD	TIMESCALE
Develop effective early awareness social marketing programmes for 6 cancer sites	Develop and deliver social marketing programmes	Increased cancer awareness, earlier stage at diagnosis Increased 1 year survival Increased 5 yr survival	TC/PS	March 2014
Extend screening age and increase uptake of breast screening programme	Increase capacity of breast screening programme Develop social marketing programmes	Increased uptake rates Increased early detection rates Increased breast cancer survival	TC/PS	March 2014
Achieve 14 day turnaround target for results and increase uptake of cervical screening programme	Redesign cervical screening pathway Develop social marketing programmes	Increased uptake rates Increased early detection rates Increased cervical cancer survival	TC/PS	March 2014
Implement Tobacco Control Strategy	See Strategy	Decreased smoking rates Decreased cancer incidence, particularly lung cancer	KJ/RO	March 2014
Implement obesity Strategy	See Strategy	Decreased obesity rates Decreased cancer incidence.	KJ	March 2014
Implement Improving Outcomes Guidance in full	Ensure Peer review compliance Utilise Cancer Commissioning Toolkit	Increased cancer survival rates	TC/CS	March 2014
Analyse the results of the 2010 National Cancer Patient Experience survey	Identify experience by age, gender, deprivation and ethnicity.	Identify areas for improvement in patient experience	TC/CS	March 2012
MDTs should monitor new patients by ethnicity, age, gender, postcode and primary treatment also stage at presentation	Include in Acute Contract (?CQUINS)	Improved understanding of access to treatment in Dudley	TC/CS	March 2012
Provide safe sun message and reduce sunbed usage	Healthy schools sun protection programme Work with LA to limit access to sunbeds	Decreased incidence of skin cancer	JE/TC	March 2014
Focus on cancer survivorship	Develop cancer survivorship strategy Support MacMillan CAB service for cancer survivors	Improved rehabilitation Improved experience	TC/PS	March 2014
Ensure access to high quality end of life care	Implement EOL strategy	Improved rehabilitation Improved experience	PS	March 2014

RECOMMENDATION	ACTIVITY	OUTCOMES	LEAD	TIMESCALE
Review primary care urgent 2 week referrals and conversion rates	Review referrals	Ensure most effective use of urgent referral route	TC	March 2012
Examine Primary Care Cancer Audit and develop cancer update training programme for GPs	Complete Primary care Cancer Audit. Review results. Develop training programme	Increase GP awareness of cancer Earlier diagnosis and referral	TC/PS	March 2012
Address capacity issues at local cancer chemotherapy unit	Redesign chemotherapy service	Increased access to treatment Improved patient experience	TC/DGoHs	March 2014

PRIORITY AREA: COPD DELIVERY PLAN

RECOMMENDATION	ACTIVITY	OUTCOMES	LEAD	TIMESCALE
National COPD Strategy	'Missing Millions' (previously undiagnosed COPD) pilot that has commenced: Audit of 800 patients via GP surgeries, community pharmacists, Dudley Stop Smoking	Increase prevalence numbers in Dudley	Joanne Hamilton and Dr Mark Hopkin	March 2012
NICE Guidance	Implement the new guidelines for COPD Mild, Moderate, Severe and Very Severe as part of the COPD Local Enhanced Service	Increase appropriate reviews of COPD patients and reduce admissions to hospitals.	Joanne Hamilton (Respiratory Nurse) and Dr Mark Hopkin (Respiratory LIT Chair)	March 2012
National COPD Strategy	End of life care lead for COPD	Improve quality of life and choice	Andrew Hindle (commissioner) Joanne Hamilton (Respiratory Nurse)	March 2013

PRIORITY AREA: SEASONAL EXCESS DEATHS DELIVERY PLAN

RECOMMENDATION	ACTION	OUTCOMES	LEAD	TIMESCALE
Develop a SED partnership strategy	Set up a small partnership group as sub-group of the Older Persons LIT to develop a SED strategy	Partnership group set up and strategy developed and action plan implemented	Older Person's commissioner	September 2010
Analysis of local SED data	Data on SED produced as a JSNA for Health Inequalities strategy	HI JSNA produced Data analysed to understand local variations in SED Findings shared across partnership	PH Information	April 2010
SED communication strategy for affordable warmth	Communication strategy to be produced as part of the SED strategy development	Information on SED shared with frontline staff and clear referral pathways being implemented	SED strategy group	September 2010
Scale up the approach to affordable warmth across the partnership	Incorporate an action plan in the strategy to address the scaling up of initiatives in a planned way	Co-ordinated approach to SED is implemented across partnership agencies	SED strategy group	March 2011
Extend the use of the vulnerable adults list and identify key workers to incorporate seasonal protection work with vulnerable adults	Include this as an action in the SED strategy	A co-ordinated scaled-up approach to SED is in place and implemented across the partnership	SED strategy group	March 2011
Ensure people on the vulnerable adults list are assessed for a range of risk factors and they are supported to take up the offers of interventions	Develop a recording system to ensure that vulnerable people on the risk register are assessed and supported to take up interventions Implement a failsafe scheme to ensure that those not assessed or not receiving support are followed up	Fewer vulnerable adults are at risk of SED	SED strategy group	March 2011
Jointly review the community engagement work on affordable warmth, share the findings and inform shared strategic approaches and actions	Incorporate the findings from community engagement into the SED action plan	The new strategy reflects the findings	SED strategy group	March 2011
Develop a training and monitoring programme for frontline staff to support affordable warmth referrals between agencies	Work with the training department to ensure appropriate training is available to all frontline staff	Referral pathways in place and staff trained to refer appropriately	SED strategy group	March 2011

RECOMMENDATION	ACTION	OUTCOMES	LEAD	TIMESCALE
Incorporate questions on cold, damp housing into the SAP for health and social care	Review the questions on cold damp housing and incorporate into the SAP	Housing issues identified by health and social care staff and they are trained to make referrals	SED strategy group	March 2011
Investigate why people who are eligible for influenza and pneumococcal vaccinations and affordable warmth grants do not apply and develop an action plan to address the issues	Use community engagement/PA approaches to identify the reasons for poor uptake of pneumococcal vaccines and affordable warmth grants. Implement an action plan based on the findings	An increase in uptake of pneumococcal vaccines and grants	SED strategy group	March 2011
Health and housing partners to work together to use the HHSRS to inform strategic commissioning plans to reduce SED	To be addressed as an action in the SED strategy	HHSRS used to inform the new SED strategy	SED strategy group	March 2011
Examine the learning from Investing for Health project 2a on developing a robust framework to accelerate the numbers of householders accessing warmth in winter initiatives	Incorporate the learning from Investing for Health into the new SEE strategy	Increase in numbers accessing health through warmth grants	SED strategy group	March 2011
Review the decision on using 'Healthy Outlook' in view of the recent pilot study outcomes	Undertake a local review of the Healthy Outlook findings and its implications for local health inequalities	Make recommendations as a result of the review	Public Health	September 2011

APPENDIX 3 – HEALTH INEQUALITIES CHECKLISTS FOR STRATEGIES AND PLANS

PRIORITY ACTION – STRATEGIES AND PLANS	Does the plan provide adequate assurance? (Tick)	YES	NO
1. Does the strategy or policy make specific reference to reducing health inequalities? 2. Is there evidence to illustrate the inequality? 3. Are all relevant partners engaged in the process? 4. Is there a named person with lead responsibility? 5. Is there a national or local target set? 6. How will progress against the target be measured and reported?			

PRIORITY ACTION – STRATEGY AND GOVERNANCE	Does the plan provide adequate assurance?(Tick)	YES	NO
1. Do the Strategic and Operating Plans address short term (2010), medium term (lifestyle) and longer term (wider determinants)? 2. Spearhead obligations - are there specific strategies to meet AAAC mortality, CVD, Cancer, Infant Mortality PSA targets? 3. Is reference made to the plans that will deliver targets, and who will be responsible for delivery of each? 4. Are other causes COPD, Stroke, Alcohol Seasonal Excess Deaths (SEDs) part of the plans? 5. Is there a reporting process to PCT Board/Partnership Board/ OSC on inequalities targets? 6. Does the Strategic Plan raise any concerns about resources to deliver all the above?			

PRIORITY AREA – COMMUNITY ENGAGEMENT	Does the plan provide adequate assurance? (Tick)	YES	NO
1. Does the LSP have an infrastructure and processes in place to systematically work with **all** vulnerable and deprived communities? 2. Does the PCT have mechanisms to harness LSP community engagement mechanisms: a. to access those seldom seen/heard? b. to improve local healthcare outcomes 3. Does the Plan mention LSP strategy to develop Third Sector input e.g. on access for seldom seen/heard communities? 4. Is a segmented approach being taken to develop customer access strategies?			

HEALTH INEQUALITIES CHECKLIST FOR SERVICES

PRIORITY ACTION – ACCESS TO SERVICES	Does the plan provide adequate assurance? (Tick)	YES	NO
1. Has an assessment been made of evidence of need and a baseline established? 2. Have physical barriers to access been assessed? 3. Have hidden barriers to access been addressed? 4. Is the service friendly to all service users? 5. Is information made available to all users in a variety of different formats? 6. Is there a mechanism for obtaining users' views and is there evidence of how the service changes to take account of these views? 7. Do staff understand the health inequalities agenda and have they received appropriate training? 8. Have the needs of specific users been taken into account?			

PRIORITY ACTION – PRIMARY CARE	Does the plan provide adequate assurance?(Tick)	YES	NO
1. Do all GPs in the PCT achieve 90% or more for total non-clinical QOF points (an indicator of organisational capability/capacity)? 2. Is there a strategy for quality improvement of primary care, which includes: • A 'balanced scorecard'? • A clustering of practices, like-with-like, for benchmarking purposes? • Strong multidisciplinary performance management systems in place (eg challenging QOF exception reporting)? • A range of development resources, for short term deployment, to improve practice performance on outcomes? • Support to practices to support development of business models to expand capacity/capability to achieve outcomes? 3. Does the Plan mention a timely Primary Care strategy/actions to raise the bar for GMS/ PMS contracts, e.g. QOF plus? 4. Is the PCT providing support to practices/PBCs to benchmark and use population health intelligence? 5. Does the PCT use a dashboard of key performance information (QOF, disease registers, admission data, prescribing)?			

PRIORITY ACTION – WORKFORCE AND FRONTLINE ENGAGEMENT	Does the plan provide adequate assurance? (Tick)	YES	NO
Frontline Engagement 1. Is there a systematic workforce development and training plan to harness frontline staff into (at the least) components of SSS, alcohol and obesity management, covering identification of risk and brief interventions? Do these cover: • Acute Trusts and along main patient pathways • Community Health Services • Mental Health • Local Authority Commissioned Services 2. Are there a variety of managed referral pathways to specialist lifestyle risk support services from the main frontline services? 3. Are referral numbers to specialist support services monitored, and actions taken to improve where necessary? 4. Are the above points specified in commissioning schedules?			