NHS

Dudley Strategy for Tackling Health Inequalities:

2010-2015 Summary Strategy

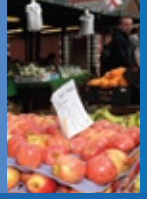
Dudley Public Health

Dudley Metropolitan Borough Council

The Dudley Group of Hospitals NHS NHS Trust

Dudley CVS

Dudley Community Partnership achieving together


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.

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Dudley's Vision

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".

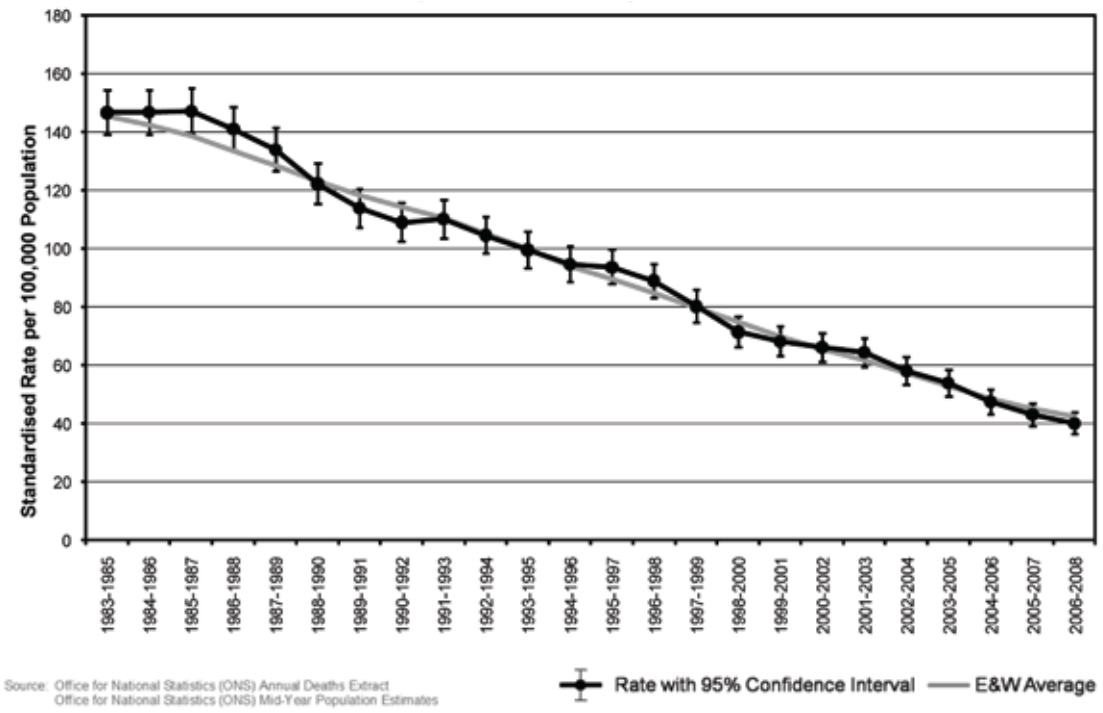
Our vision for our services as a Dudley Health and Well-being Partnership is that we will:

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.

Introduction

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/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.

Directly Standardised Mortality Rates from All Causes by Year 3-Year Rates, Dudley, Both Sexes All Ages, 1983-1985 to 2006-2008



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.

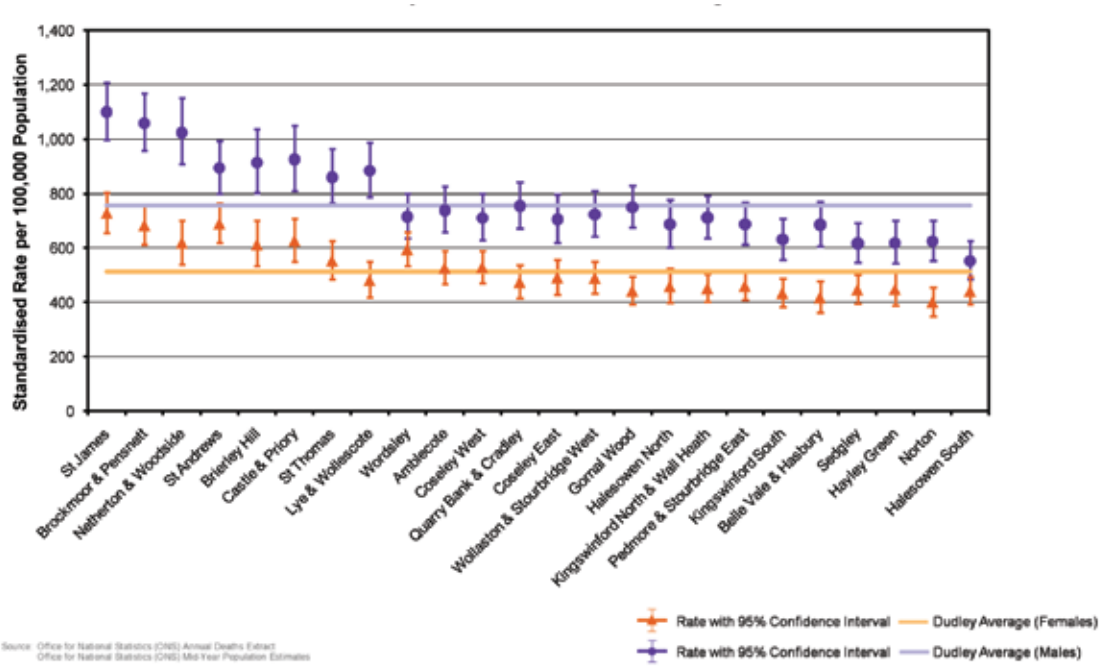
The previous strategy set a target based on a national Public Service Agreement to;

''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 are 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

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



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.

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 in Dudley has also improved over the last five years with 76% of pupils achieving GCSE 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.

Strategic Context

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.

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. The integration of Public Health into Local Authorities presents a real opportunity to tackle social determinants of health and provide a greater focus on improving the health and well being of everyone in Dudley.

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.

Health Inequalities And The 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 makeup, '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, 2009), 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 fulfill 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.

Developing the Strategy

The production of the Health Inequalities strategy has been the result of many months of collaborative working between many departments and multi-agency working groups, each tasked with describing the current position with regard to a specific aspect of health inequalities; identifying gaps and deciding on priority actions that will have the greatest impact on reducing the inequalities gap.

There has been an in depth needs analysis of health inequalities in Dudley which has formed the basis of the Director of Public Health's annual report for 2010. There is also a full strategy document with evidence reviews and detailed action plans reflecting the vast breadth of work that has been undertaken in order to give us a very clear understanding of the nature and scale of health inequalities in Dudley. This summary document attempts to capture some of the key points and challenges and summarises the priorities for future action.

Marmot (Department of Health 2010) described five actions that would have the biggest impact on reducing health inequalities. These have been adopted as the strategic aims of the new strategy.

Give Every Child the Best Start in Life

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

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.


Priority actions to give very child the best start in life

- 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.

- Reproduce an analysis of the money currently spent on early years as presented in the national data in the Marmot Review, Fair Society, Healthy Lives (Department of Health, 2010). 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.
- 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.
- Develop 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.
- 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

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 (Department of Health, 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.

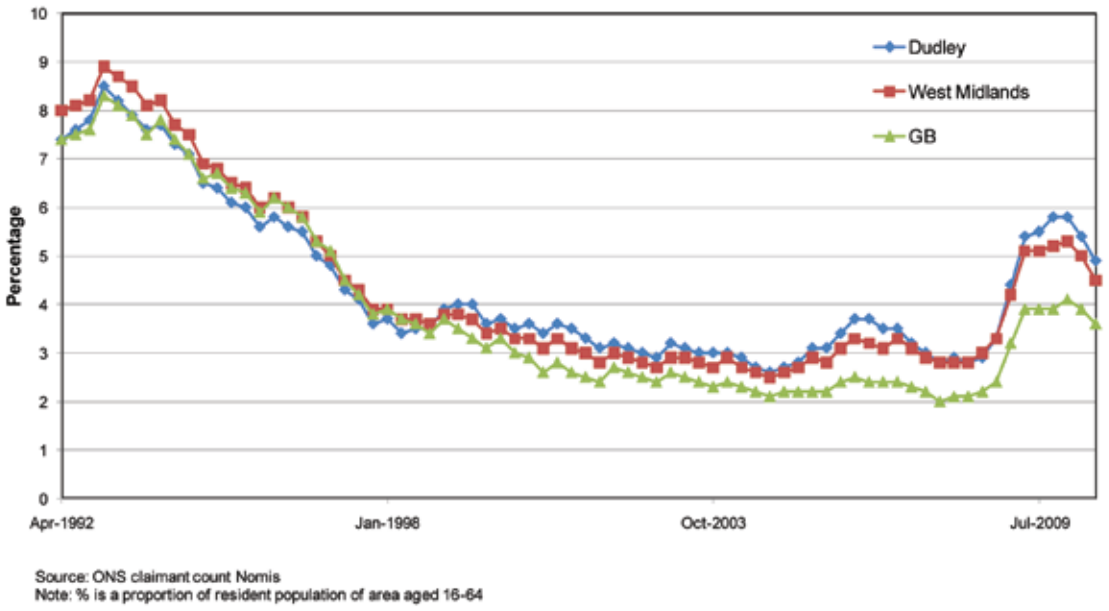
The evidence reviewed by Marmot leaves little doubt that recent rises in unemployment, and particularly youth unemployment, are likely to significantly worsen health inequalities. This makes getting people into employment an important strategy for improving health and reducing inequalities.

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.

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 below 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).

People claiming Job Seekers Allowance as a percentage of the working-age population (aged 16-64), 1992-2010



Source: ONS claimant count Nomis
Note: % is a proportion of resident population of area aged 16-64

Priority actions to provide fair employment and good work for all

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 programme

Ensure a Healthy Standard of Living for All

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.

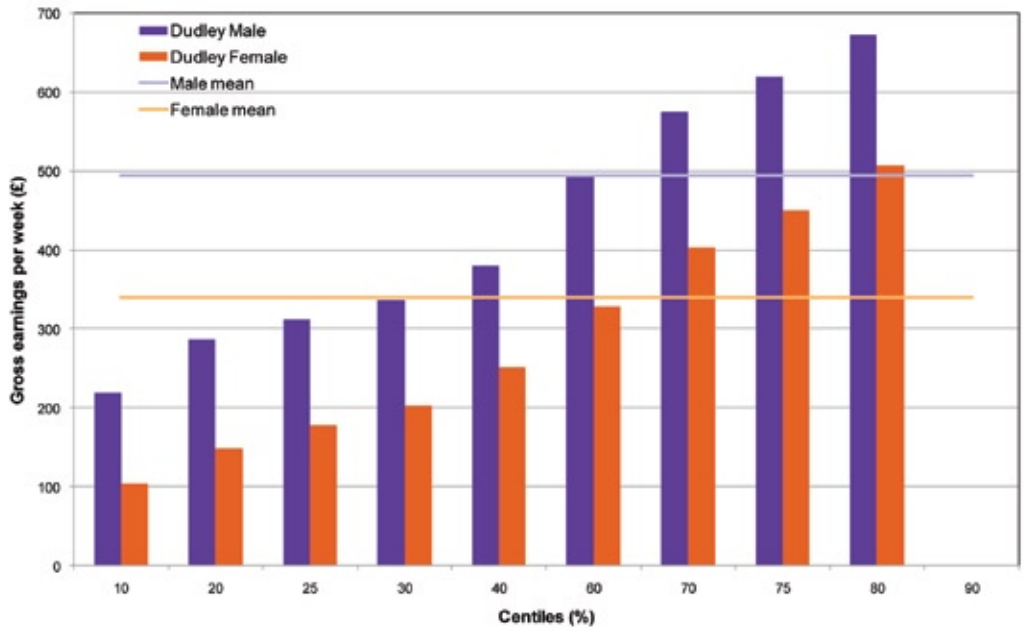
Marmot (2010) concludes that, in the current UK system, benefits are inadequate to provide a healthy standard of living or have failed to reach those in need. They tend to be based on a black and white distinction between being reliant and non-reliant on various components of support, creating the so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

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

Centiles for Gross Weekly Pay by Gender, Dudley 2009

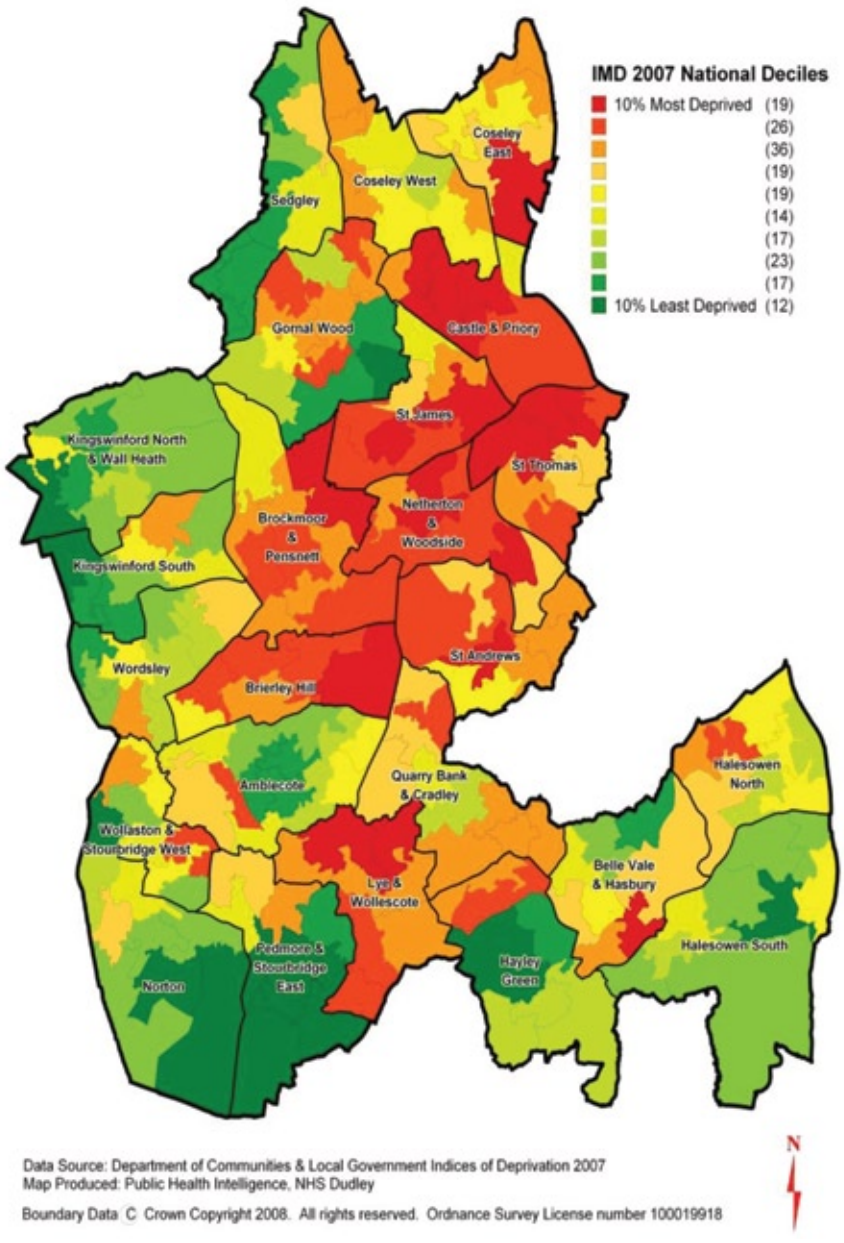




The income gradient is very clear across the centiles of deprivation. The gender gap in earnings is immediately apparent with males earning considerably more than females at every level.

The map shows income deprivation in England 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. The map shows clearly that the most income deprived households are in the central and eastern parts of the borough.

Income Deprivation Index by Lower Super Output Area



Data Source: Department of Communities & Local Government Indices of Deprivation 2007
Map Produced: Public Health Intelligence, NHS Dudley

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.

Priority actions to ensure a healthy standard of living for all

- 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

One of the major features of The Marmot Review (Department of Health, 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 as will 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 occur.

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.

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.

Priority actions for healthy and sustainable communities

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

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.

Priority 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.

Priority 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.
- Investigate reasons for 'no procedures' being undertaken with the Primary Percutaneous Coronary Intervention (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 Did Not Attends (DNAs) and Do Not Resuscitates (DNRs) for cardiac rehabilitation and the establishment of routine procedure to follow-up these groups.

Priority 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

Priority 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

Priority 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.

Reducing alcohol health inequalities

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 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. The gender inequalities are also evident when ward level data for males and females is compared.

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.

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.

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

Priority 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

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.

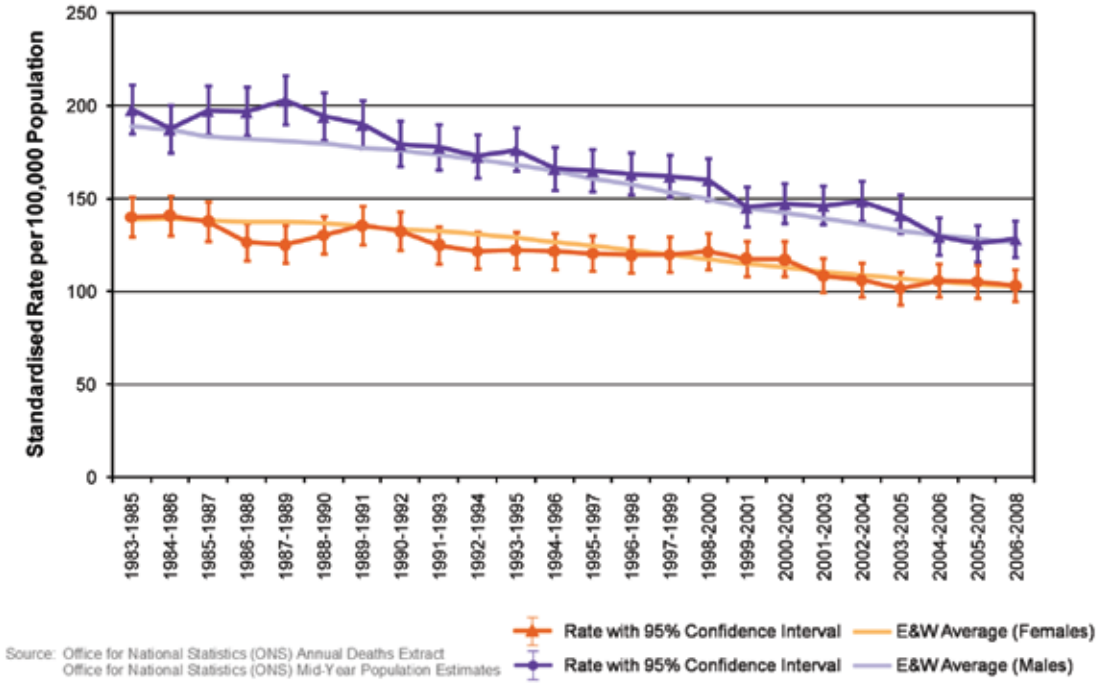
The Department of Health's Public Service Agreement (PSA) for cancer mortality (ages under 75) included a commitment to reduce the absolute gap in mortality rates between the England average and the areas with the worst health and deprivation (Spearhead PCTs) by at least 6% by 2010, compared to a baseline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

Directly Standardised Mortality Rates from All Cancers by Year 3-Year Rates, Dudley, Males & Females Aged Under 75, 1983-1985 to 2006-2008



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

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.

Priority 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

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.

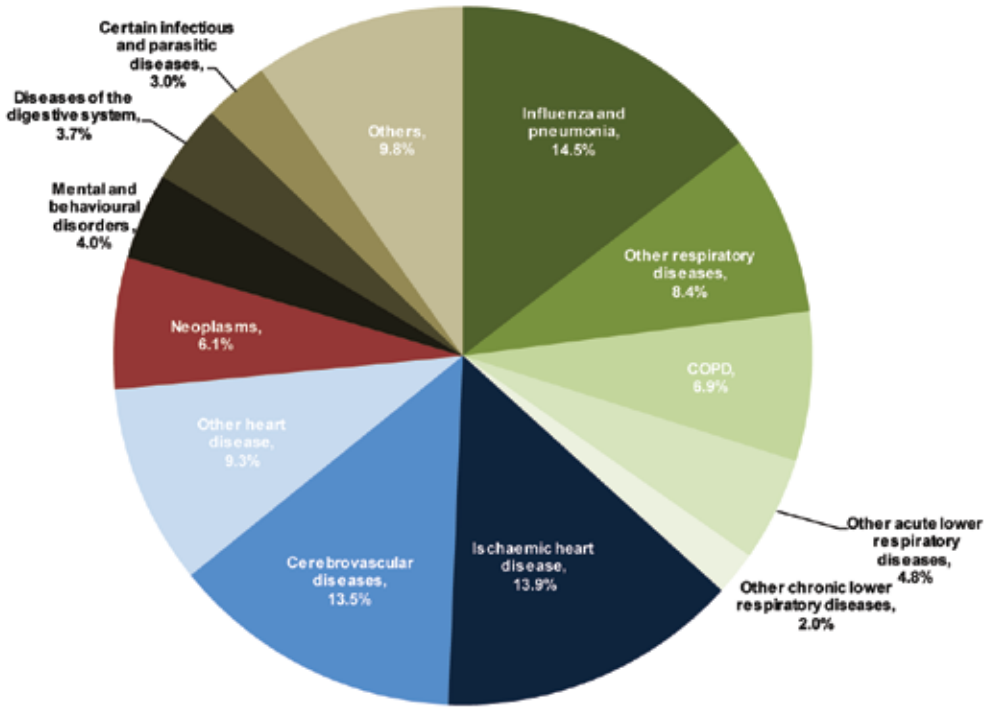
Older people living in older or large properties who cannot afford to keep their house warm are most at risk, and fuel poverty (spending more than 10% of annual income on energy bills to keep the house heated to adequate levels) affects the elderly and vulnerable groups the most.

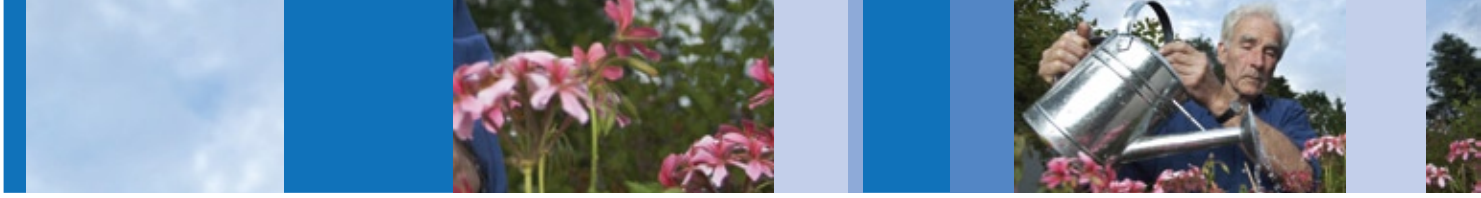
Initiatives designed to improve insulation and heating of properties are known to impact on excess winter deaths. Other high impact initiatives are those designed to reduce falls in the elderly and to promote the uptake of influenza vaccinations. Whilst most of the effective initiatives focus on reducing 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.

Almost all the major causes of death can contribute to winter mortality, but the most

Where are we in Dudley?
Causes contributing to total excess winter deaths

Proportion of selected diseases contributing to total excess winter deaths in Dudley residents over the period 2002/03 to 2006/07





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 with co-mobilisation (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.

The Health Inequalities National Support Team 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.

Priority actions to reduce seasonal deaths

- 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

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 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. The newly structured Health and Wellbeing Board will take responsibility for monitoring health improvement plans and reducing health inequalities during 2011/12.

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 Clinical Commissioning Group in implementing the strategy when its new public health role becomes functional.

Primary care is a key deliverer of services and early identification and treatment of disease is essential to reduce premature mortality. The prevention role of the Foundation Trust needs to be developed as they have become the providers of some community health services and the work on developing the role of the third sector needs to be advanced.

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. Dudley has a strong record in community engagement and this was recognised by the National Support Team, but there needs to be a more systematic approach to engaging communities, moving beyond consultation to effective participation in which individuals and communities define the problems and develop community solutions. When community engagement is done well it can contribute to people's health and wellbeing. 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 exist, people who have the least will benefit the least from the transfer of power and responsibility.

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 Community Health Champions, the Health Trainer programme is based on an NHS workforce model. 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).

The Community Health Champion, Public Health Volunteer and Health Trainer Programmes all play an integral role in reducing inequalities 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 wellbeing.

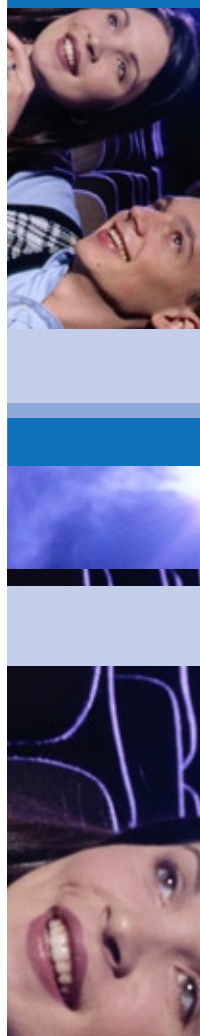
Finally, the strategy was developed as a result of a comprehensive Joint Strategic Needs Assessment, which has now formed the Director of Public Health's Annual Report for 2010. http://www.dudleylsp.org/needs-assessments-data-and-trends/jsna/jsna-documents-section/public-health-reports-2010/

The full Health Inequalities Strategy, evidence review and detailed action plans are available to download from http://www.dudleylsp.org/about-dcp/tps/dhwbb/dudleys-health-inequality-strategy-2010-2015/

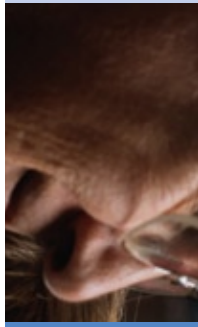
Dudley Health Inequalities Performance Indicators

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%

Indicator	Dudley	England Average	Least Deprived	Most Deprived	External Inequality		Internal Inequality	
					Gradient	Value	Gradient	Value
% Year 6 children very overweight (NCMP, 2008/09)	20.8%	18.3%	14.8%	23.5%	1.14*	2.5%	1.59*	8.7%
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 (%) (Quarter 2 2010/2011)	92.6%	95.0%	97.4%	91.9%	1.03	-2.4%	1.06	-5.5%

Dudley Health Inequalities High Level Action Plan 2010/11-2014/15

Recommendation	Activity	Outcomes	Lead	Timescale
Leadership And Partnership				
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				
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	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
	Consider and agree across agencies a small number of valid measures to assess children's physical, social, emotional and cognitive development at a population level.			February 2012
	Review data item availability in current routine systems and identify means of/ barriers to extraction.			May 2012
	Consider whether any new data collection may be required (bias against instituting collection unless absolutely necessary).			May 2012



Recommendation	Activity	Outcomes	Lead	Timescale
	Develop system reporting outputs required to report on agreed measures.			July 2012
	Implement and test reports on a pilot basis.			Dec 2012
	Review learning from pilots.			July 2013
	Agree continued reports and set up routine surveillance reporting.			November 2013
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.	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
	Produce annual audits for each universal element of the Healthy Child Programme.			Audits for 10-11 by December 2011 and annually thereafter
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	DMBC Children's Directorate	March 2012
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


Recommendation	Activity	Outcomes	Lead	Timescale
Continue implementation of Dudley's Parenting and Family Learning Strategy, with full tracking of adherence to eligibility criteria and outcomes for formal 2. 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.
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
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
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
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

Recommendation	Activity	Outcomes	Lead	Timescale
Create fair employment and good work for all				
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
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
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	March 2013
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
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

Recommendation	Activity	Outcomes	Lead	Timescale
Ensure A healthy living standard for all				
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
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
Create and develop healthy and sustainable places and communities				
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
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
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
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



Recommendation	Activity	Outcomes	Lead	Timescale
Strengthen The Role And Impact Of Ill Health Prevention				
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
Engaging and empowering communities				
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
Use the Five Element Model from (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	Vulnerable groups are positively engaged in decisions that directly affect them	Public Health/MBC	March 2013
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	'In it together' steering group	March 2013

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