Developing the new Joint Health and Wellbeing Strategy with a focus on Tackling Inequalities

Wendy Burke

Director of Public Health

Progress to date

- An Officer Working Group has been established
- Impact analysis of the direct and indirect impacts of the COVID-19 pandemic is complete
- Report providing a summary of the evidence base for tackling inequalities has been compiled
- Work to profile current activity and approaches in the borough to tackle inequalities in underway
- Using Marmot principles as a framework to shape the strategy policy priorities will be agreed
- Consultation and engagement plan is in place
- The annual State of the Area Event which takes place in October will exclusively focus on the developing strategy engaging a range of partners and organisation
- The event comprises three workshops each focussing on two of the Marmot principles with an additional overall plenary session (8th 12th 13th and 14th October)
- On track to bring the draft strategy to the next meeting of the Health and Wellbeing Board in November

What are inequalities and what drives them?

Chris Woodcock

What are inequalities?

- Inequalities are unfair and avoidable differences in socioeconomic circumstances across the population, and between different groups within society
- Inequalities arise because of the conditions in which we are born, grow, live, work and age
- These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing
- There are many kinds of inequality, and many ways in which the term is used
- This means that when we talk about ‘inequality’, it is useful to be clear on which measure is unequally distributed, and between which people

Inequalities of what?

- Health inequalities are ultimately about differences in the status of people's health. But the term is also commonly used to refer to differences in the care that people receive and the opportunities that they have to lead healthy lives, both of which can contribute to their health status.

- Health inequalities can therefore involve differences in:
  - **health status**, for example, life expectancy and prevalence of health conditions (time spent without conditions or illnesses that limit people's ability to carry out day-to-day activities).
  - **behavioural risks**, for example, smoking rates (more deprived, more likely to smoke). Leading cause of preventable illness and premature death in England, *Costs adult social care £1.4 billion. £8.6 billion from lost productivity*
  - **wider determinants of health**, employment. *On average, for every 10 percentage points higher the employment rate, healthy life expectancy is around 5.1 years higher for men and 3.7 years higher for women.*
  - **access to care**, for example, availability of treatments/vaccinations (homeless)
  - **quality and experience of care**, for example, levels of patient satisfaction

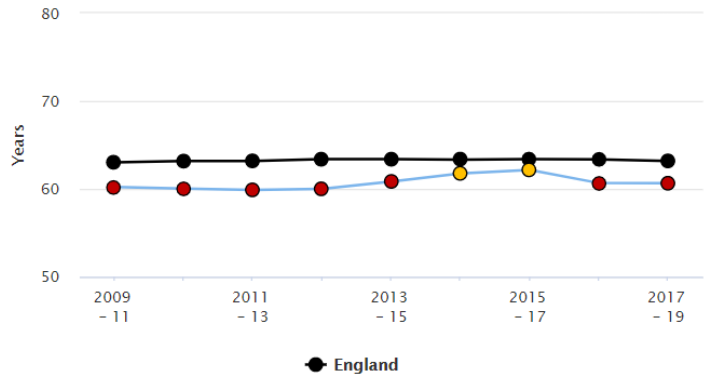
Indicator	Period	England	North Tyneside	Battle Hill	Benton	Camperdown	Chirton	Collingwood	Cullercoats	Howdon	Killingworth	Longbenton	Monkseaton North	Monkseaton South	Northumberland	Preston	Riverside	St Mary's	Tynemouth	Valley	Wallsend	Weetslade	Whitley Bay
Life Expectancy																							
Life expectancy at birth, (upper age band 90+) (Male)	2015 - 19	79.7	78.1	79.1	79.5	78.8	74.5	79.2	81.2	75.2	79.7	78.0	82.0	79.5	77.5	79.2	72.2	83.7	77.6	78.5	75.7	80.9	74.6

Gap of 9.2 years within North Tyneside

Healthy life expectancy at birth (Male)

Life expectancy - Years

Export chart as image | Show confidence intervals | Show 99.8% CI values | Export table as CSV file

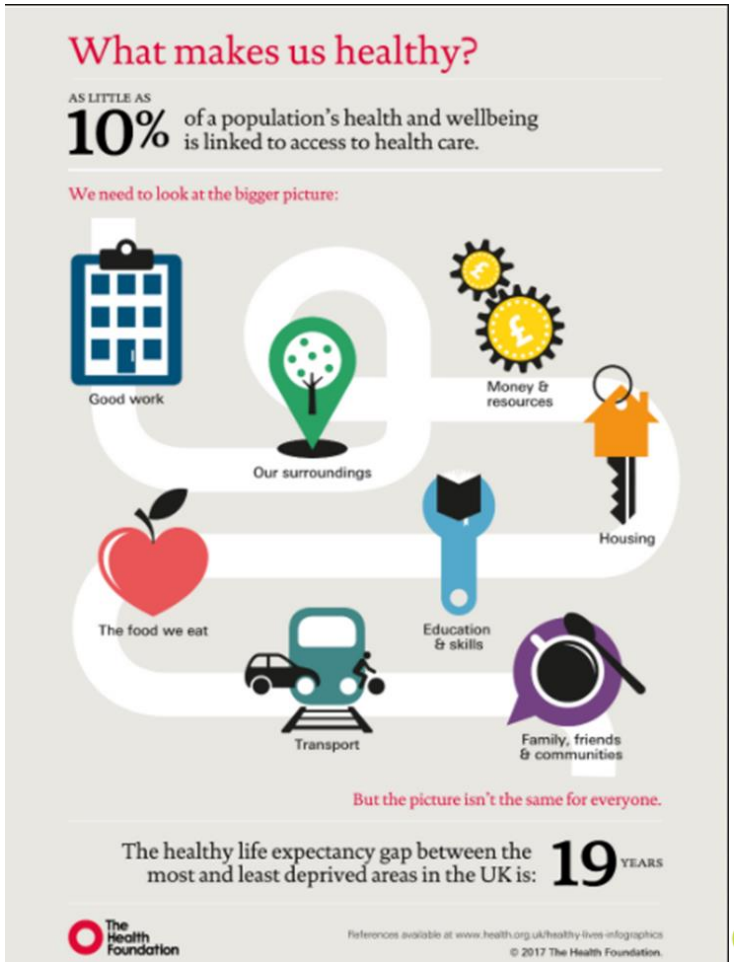


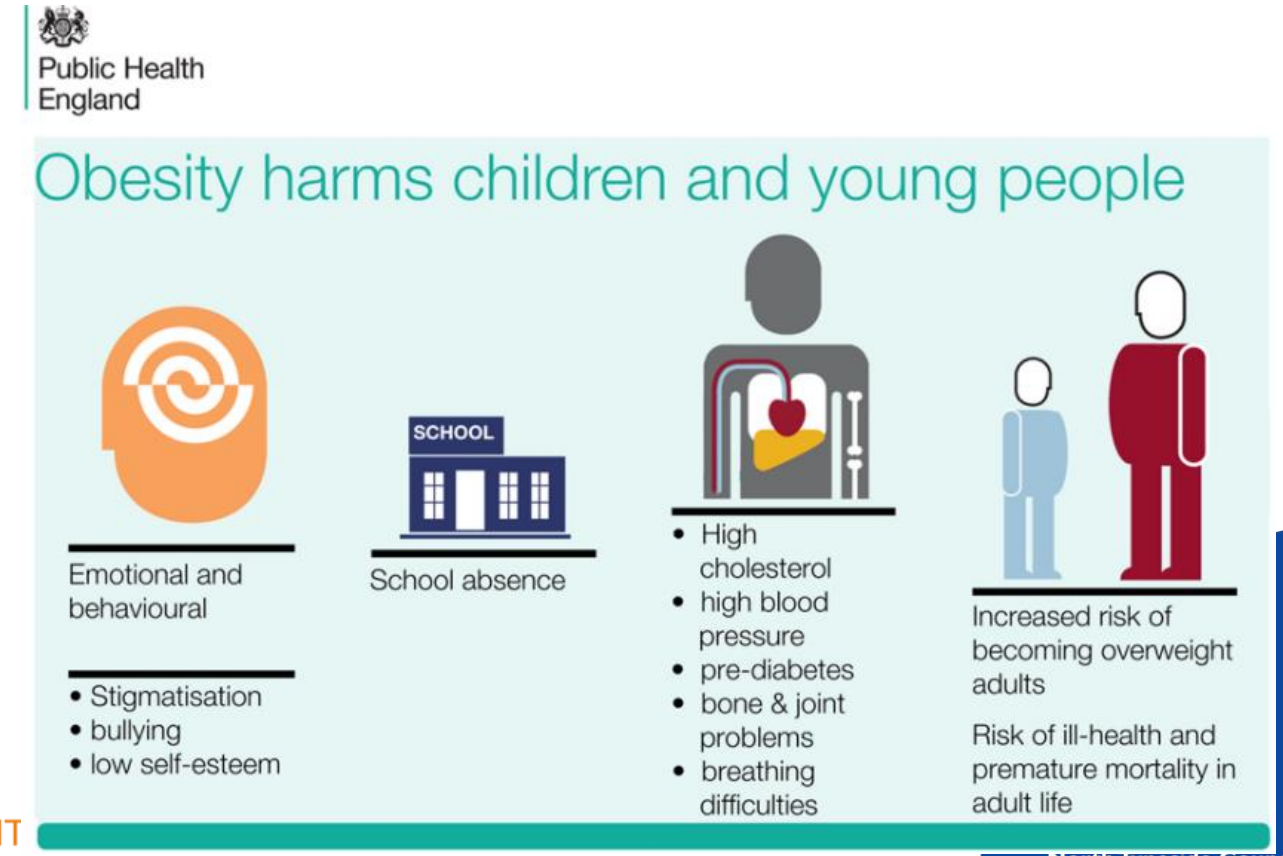
Recent trend: Could not be calculated

Period		North Tyneside Count	North Tyneside Value	North Tyneside 95% Lower CI	North Tyneside 95% Upper CI	North East	England
2009 - 11		-	60.2	58.6	61.8	59.7	63.0
2010 - 12		-	60.0	58.3	61.7	59.6	63.2
2011 - 13		-	59.9	58.2	61.6	59.3	63.2
2012 - 14		-	60.0	58.2	61.8	59.6	63.4
2013 - 15		-	60.8	59.1	62.6	59.6	63.4
2014 - 16		-	61.8	60.0	63.5	59.6	63.3
2015 - 17		-	62.2	60.5	63.8	59.5	63.4
2016 - 18		-	[illegible]	58.9	62.4	59.4	[illegible]
2017 - 19		-	60.6	58.7	62.5	59.4	63.2

Gap of 2.6 years with national

Indicator	Period	England	North Tyneside	Battle Hill	Benton	Camperdown	Chirton	Collingwood	Cullercoats	Howdon	Killingworth	Longbenton	Monkseaton North	Monkseaton South	Northumberland	Preston	Riverside	St Mary's	Tynemouth	Valley	Wallsend	Weetslade	Whitley Bay
Year 6: Prevalence of overweight (including obesity), 3-years data combined	2017/18 - 19/20	34.6	35.1	40.3	34.6	40.8	39.2	43.4	28.3	44.9	30.9	40.3	19.4	31.1	34.1	28.9	43.2	24.1	26.8	34.7	37.7	42.6	26.6





Inequalities between who?

- Differences in health status and the things that determine it can be experienced by people grouped by a range of factors. In England, health inequalities are often analysed and addressed by policy across four factors:
  - socio-economic factors, for example, income (+£1000 = +0.7 years)
  - geography, for example, region or whether urban or rural
  - specific characteristics including those protected in law, such as sex, ethnicity or disability
  - socially excluded groups, for example, people experiencing homelessness.
- And these factors are all interrelated

The impact of COVID-19 on Inequalities in North Tyneside

Pam Colby

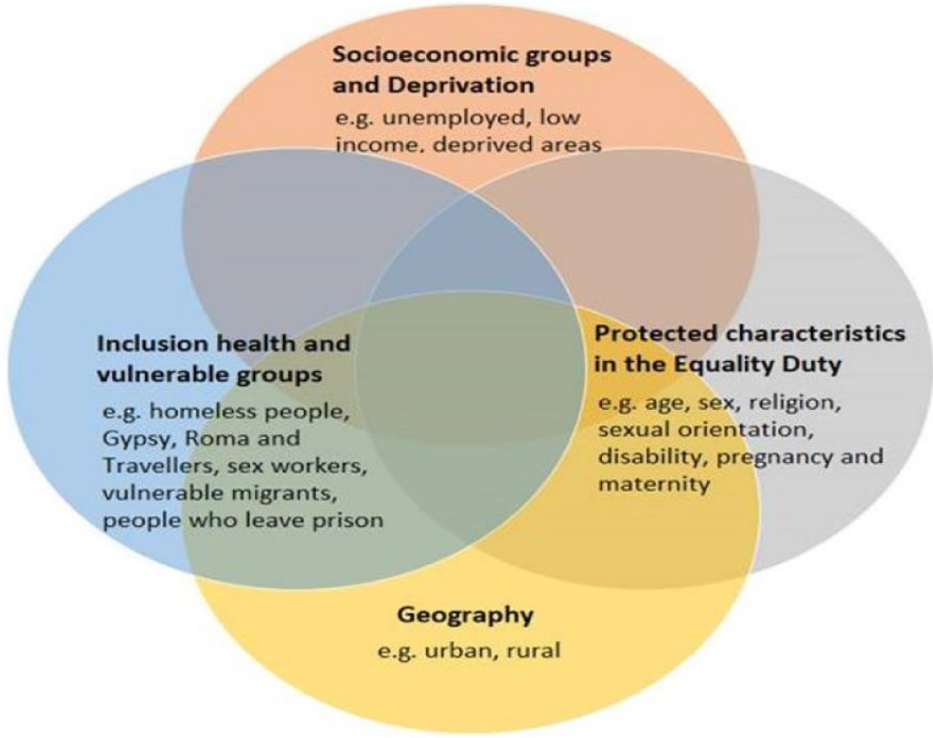
Introduction

- The COVID-19 pandemic has had a huge impact and has affected the daily lives of everyone. Many families have suffered significant loss and there has been widespread disruption to services and our economy.

- There have been multiple impacts on our communities both direct from the burden of disease and mortality and the indirect effects of the response to the pandemic and the control measures that have been put in place.

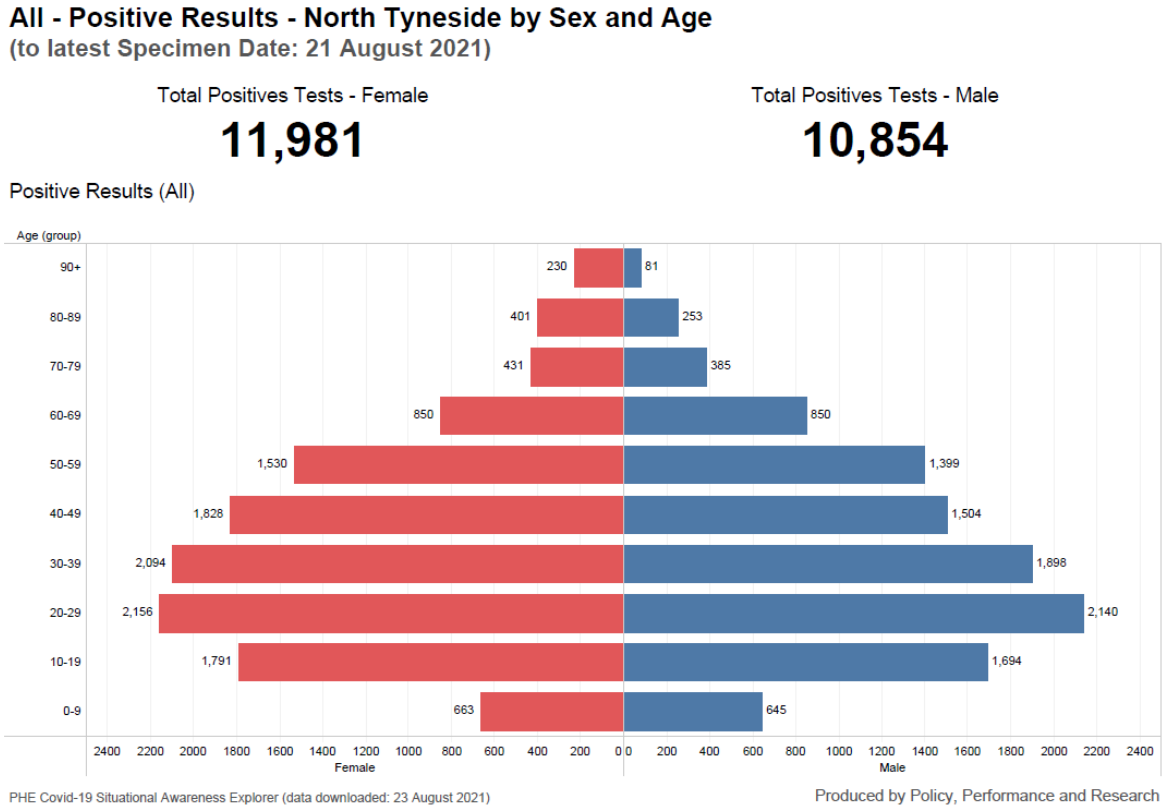
- The COVID-19 pandemic and wider governmental and societal response has exacerbated some of health and wider inequalities already in existence at a national and local level. Due to their nature, these inequalities can often overlap, and becomes more pronounced.

- Evidence suggests that those people who are least able to deal with the impact of the pandemic have been hit the hardest.



Direct Impacts

- 1st confirmed positive case in North Tyneside was 5th March.
- 22,869 total positive cases up to 21st August 2021
- 483 deaths registered
- 330 outbreaks; 114 schools, 93 workplaces, 53 care homes
- 4,820 admissions to Northumbria and Newcastle NHS Foundation Trusts*
- Potentially 3,100 residents could have long covid based on 1.5% national estimates



*Northumbria and Newcastle Hospitals serve North Tyneside residents, as well as residents in Northumberland and Newcastle and the wider North East region

North Tyneside Council

Indirect Impacts

Social factors

- Loneliness increased during the pandemic, largely due to lockdowns. Disproportionately affected older people, clinically extremely vulnerable residents and care home residents.
- Additionally, 77% of people avoided contact with someone who old or vulnerable, exacerbating social isolation and loneliness of people they care for.
- Increase in working from home, together with lockdowns reduced access to support. Domestic abuse reporting increased each time lockdown eased. Almost half (46%) of all domestic abuse cases involved households with children.
- Significant increase in volunteering. VODA's Good Neighbours Scheme had 430 volunteers supporting 3,200+ residents with access to food and medication.

Disruption to school-based learning

- Schools closed to pupils between March and September 2020, with the exception of vulnerable pupils and children of keyworkers.
- In 2020/21, pupils experienced frequent periods of self-isolation leading to missed education and social contact with peers.
- Learning loss in the North East was 2.8 months for primary aged pupils and 3.3 months for secondary school pupils. Nationally, pupils in schools with high take up of free school meals experienced the largest losses, likely widening the attainment gap.

Indirect Impacts

NHS, waiting times and health screening

- Health care services were reprioritised to manage increased demand from COVID-19, increasing waiting time and decreasing treatment activity in some specialities.
- Nationally treatment decreased more in the most deprived areas (9,162 per 100,000 compared to 6,765 per 100,000 in the least deprived areas).
- In February 2021, 1,138 North Tyneside CCG patients waited more than 52 weeks for treatment. The main specialities awaiting treatment were Ophthalmology and Dermatology.
- Northumbria CCG reported many patients chose to delay their surgery during the pandemic.
- Health screening was impacted, except for Antenatal and New-born screening. Cancer screening shows variation at a GP level which indicates more deprived areas have lower coverage rates.

Disability and Long-term health conditions

- Residents with long term or pre-existing conditions had longer wait times for hospital appointments and less than a third received their usual treatment.
- Disabled people reported higher levels of loneliness, worsening mental health and isolation.
- 15,000 residents (7.2%) were identified as clinically extremely vulnerable and advised to “shield”

Unpaid carers

- Access to social care services decreased during lockdowns, increasing dependence on unpaid carers.
- 7% of carers reduced their working hours during the pandemic, for caring reasons, with this rate doubling in the 30-49 year old age group. Most carers are female.

Indirect Impacts

Excess deaths

- Deaths due to other medical conditions, including cancer and heart disease increased.
- In England, 5,800 excess deaths from heart disease and stroke occurred in the first year of the pandemic with 130,000 fewer heart procedures taking place in the first 13 months of the pandemic, a 26% drop.

Obesity levels

- Being overweight or obese is associated with an increased risk from COVID-19.
- 65.7% adults in North Tyneside were reported to be either overweight or obese.

Health related behaviour

- Smoking rates decreased to 12.8% during 2020, mirroring the national rate.
- 27% adults drink more often than before the pandemic and 23% drink more units of alcohol. 32% consume 6-8+ units on a weekly basis, 3% daily.
- In 2020, nationally there was a 20% increase in alcohol specific deaths due to alcoholic liver disease, mental and behavioural disorders due to alcohol and alcohol poisoning.
- North East has the highest rate in the country at approximately 22 per 100,000 population. The UK rate was 14 per 100,000.

Life Course

Pregnancy/Maternity

- Access to pregnancy and maternity services and support reduced during lockdowns.
- Women attended maternity appointments alone and partners had to leave after the birth of the child. This guidance changed in December 2020.
- New parents were unable to access practical support from family adding to mental strain and social isolation during lockdowns. Mother and baby groups were unable to take place physically.
- Nationally, in pregnancy, Black women were eight times and Asian women four times more likely to be admitted to hospital with Covid.

Children and Young People

- Children and young people were disproportionately impacted in terms of lost education and social interaction.
- The attainment gap is likely to have widened further between children living in deprived areas and their peers. Pre-pandemic, 39% disadvantaged pupils in North Tyneside achieved standard 9-4 passes in GCSE English and Maths compared to 72.4% of non-disadvantaged peers.
- The volume of contacts and referrals to Children's Social Care has increased. As well as Children in Need and the number of children on Child Protection Plans.

Life Course

Working Age Adults

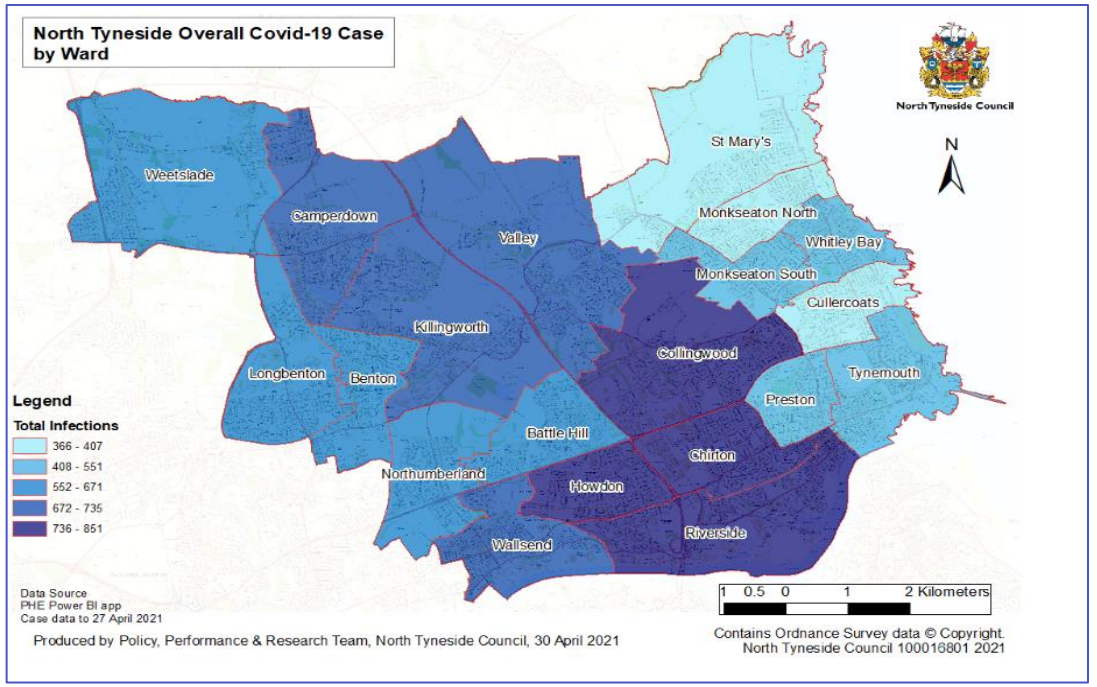
- Mortality from Covid-19 has been higher among certain job types, specifically jobs in process plants and, caring and personal services.
- People with Black, Asian and other ethnic minority backgrounds are also disproportionately more likely to have died from the virus; working in jobs with a high exposure risk and higher use of public transport is thought to have contributed to this.
- Nationally there are 3.2 million workers in high risk roles (e.g. health and social care, education, childcare, etc.) and 78% are female, increasing the risk of exposure to the virus and mental stress.
- Young people, aged 16-24 years old, have seen the highest increase in unemployment in North Tyneside.
- Working class females are more likely to have been furloughed than males, whilst home schooling and caring roles have also had a disproportionate effect on working females.

Older People

- Older people have suffered more in terms of mortality risk, especially care home residents. Nationally 75-year-olds account for three-quarters of COVID-19 deaths
- Social isolation and loneliness amongst older people has been exacerbated by national lockdowns and increased vulnerability to COVID-19.
- Physical activity levels in adults decreased, potentially increasing frailty in older age. in older age

Our communities

- A fifth of residents live in the most deprived areas in England. 11 year gap in average life expectancy between most and least deprived areas.
- Covid-19 infection and mortality higher in ‘deprived’ areas. Vaccination take up has been lower.
- Universal Credit claimants increased by 90%.
- Unemployment benefits claimants increased to 6.3%, from 3.8% the previous year. Higher proportion of claimants in the Southern Area of the borough.



- Furloughed employments peaked at 28,000 in July 2020, mostly in hospitality, construction, arts, entertainment and recreation.
- Under 30s and those with household incomes under £10,000 more likely to be furloughed
- Food poverty has continue to worsen. Pre-pandemic, 8% of residents were unable to afford food, increasing to 14% of people in the southern area of North Tyneside.
- Pupils accessing free school meals increased to over 7,000.
- Child poverty in the borough is highly likely to increased further. 22% children live in low income families.

Our communities

- Visits to parks and green spaces increased significantly across the Tyne and Wear region during the pandemic as more people took up exercise outdoors.
- Cycling in North Tyneside increased by 59% in the last year.
- Coronavirus Act 2020 gave social and private tenants more protection from eviction, however this ended in May and evictions resumed in June 2021. Mortgage possessions also recommenced in June 2021.
- Rough sleepers were placed in emergency accommodation and provided welfare packs and support as part of the government's 'Everyone in' initiative.
- Crime in North Tyneside decreased significantly during 2020/21, with particular reductions in theft offences, criminal damage, violence against the person and public order offences.
- Anti-social behaviour increased, partly due to suspected breaches of Covid legislation reported to the police, but there were increases in noise complaints and neighbour disputes.

A summary of the evidence to effectively tackle inequalities

Louise Gray

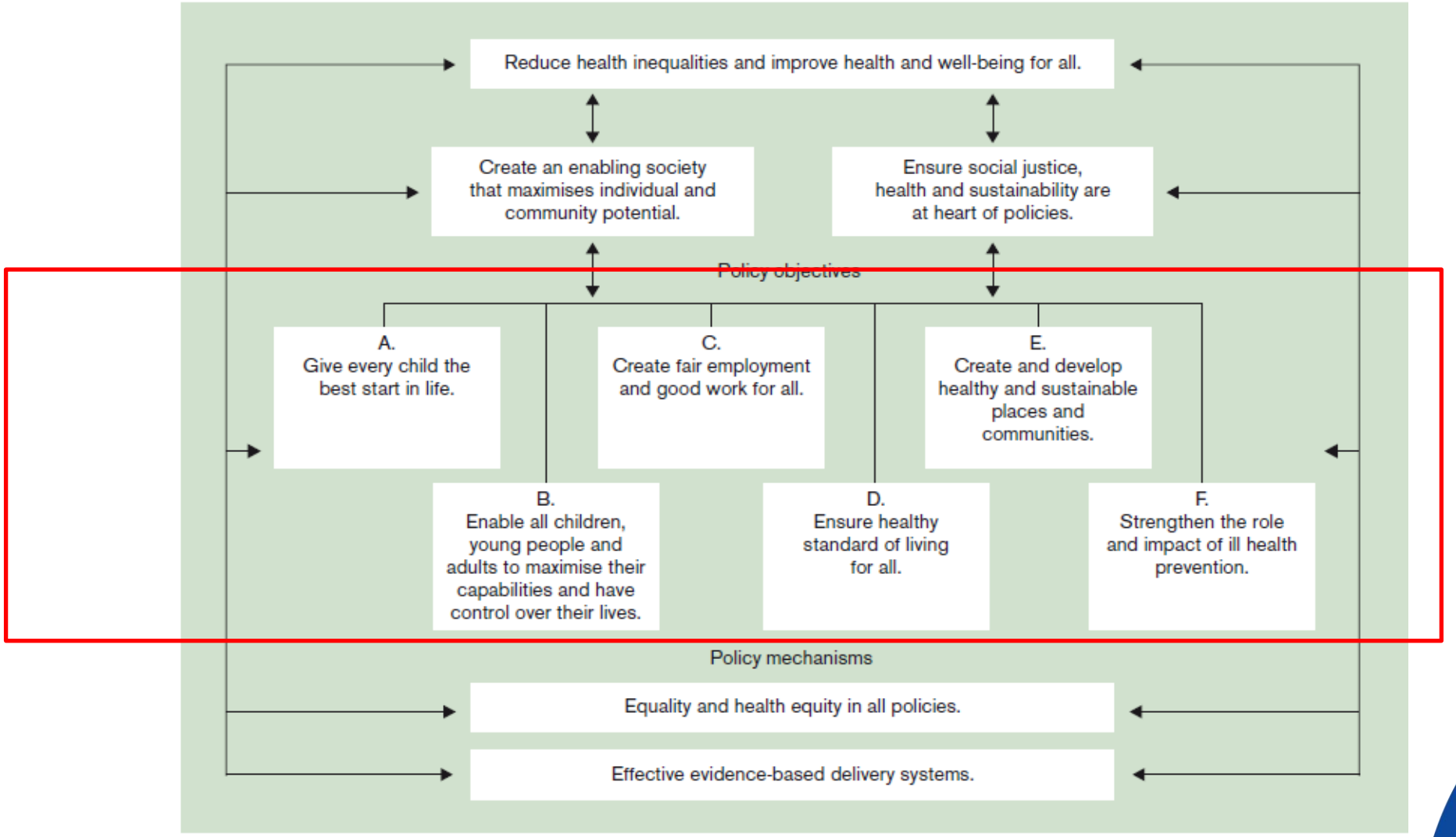
Inequalities and health

- These slides can be read alongside a more detailed report on the evidence base for tackling inequalities
- A lot of the evidence focuses on *health* inequalities, as they are often the visible part of structural inequalities driven by, economic and political factors
- This notion that health is not distributed equally was described in the Black Report in 1980 and reinforced by subsequent pieces of work in the 1990s and early 2000s
- The socio-economic gradient in health
- Two key reports have been produced by Institute of Health Equity, led by Sir Michael Marmot, (2010 and 2020) considered to be the most current, comprehensive and robust evidence base

The “Marmot Approach”

- Evidence shows that disadvantage starts before birth and accumulates across the life course
- To address health inequalities, there is a need to create the conditions for people to take control of their own lives – with action across the social determinants
- This approach requires coordination and collaboration - health inequalities reach beyond the NHS, emphasis on the role of LAs and VCS
- “**Proportionate universalism**” – it is not enough to just focus on the 10% most deprived etc. as there are poorer outcomes from the top down. Universal action is needed to reduce inequalities, but with a scale that is proportionate to the level of disadvantage
- Marmot proposed two key principles and several policy objectives (six in 2010 and five in 2020) and provided practical examples for each, underpinned by evidence

Marmot approach [2]



The evidence base – effective interventions

- There is a lot of evidence to show the impact of inequalities but a smaller evidence base of proven interventions
- There is not yet a national inequalities strategy, but NHS England, Public Health England and Public Health Scotland are developing evidence-based resources to support areas/organisations to utilise a whole system approach to tackle inequalities
- Several resources are underpinned by evidence and examples of place-based interventions to support a ‘Marmot approach.
- These approaches all show that the interdependent relationships between wider inequalities and the wider determinants of health

Evidence to support an approach aligned with Marmot's policy objectives

- **Best start in life** – Inequalities in the early years have a lasting impact, but interventions at this stage can be the most effective and cost effective. Priority areas should be child poverty, early years services, school readiness. Examples include Family Nurse Partnership, Empowering Parents Empowering Communities, Incredible Years, Healthier Wealthier Child Programme and programmes in Greater Manchester and Bradford
- **Maximise capabilities and have control** – Approaches that tackle inequalities in the school years can have lasting impact. Priority areas include reducing the social gradient in skills and qualifications, school exclusions and youth crime. Examples include programmes in Greater Manchester, Coventry and London/Essex

Evidence to support an approach aligned with Marmot's policy objectives [2]

- **Fair employment and good work for all** – There are established links between health and both work and the quality of work and priority areas should be improving access to good quality work and supporting reducing unemployment across the social gradient. Examples include NEET work in Tower Hamlets, Swansea, Surrey and Wakefield and programmes with adults in Birmingham and Redcar
- **Healthy standard of living for all** – Social disadvantage is more than just a lack of money, and poverty has a cumulative effect across the life course. Examples include Salford Living Wage programme, financial advice in GP practices in Glasgow, debt support in Peterborough and the Build Back Fairer' work in Manchester

Evidence to support an approach aligned with Marmot's policy objectives [3]

- **Sustainable places and communities -** The environment in which people live impacts on their health and other outcomes and priorities are around empowering communities, community capital and crime/antisocial behaviour. Examples include Bike Kitchens, Local Conversations in Gateshead and Longbenton, Healthy New Towns, Local Plans/SPDs, Mersey Forest Nature4Health
- **Strengthening the role of ill-health prevention** – The evidence supports an approach which focuses on those conditions most strongly related to health inequalities and interventions related to the social determinants of health and alcohol, smoking and obesity across the social gradient. Examples include work in Glasgow to improve access to screening programmes and specific programmes during the pandemic in Camden and Hertfordshire to mitigate the disproportionate impacts

Conclusions

- Inequalities arise because of the conditions in which we are born, grow, live, work and age
- An Inequalities Strategy needs to take account of all of this, not just the visible consequences
- Action is needed across the whole of society and across the whole of the life course
- A collaborative approach to tackling inequalities should be at the heart of all that we all do
- Framework should be in line with the Marmot approach and the six Marmot policy objectives with universal action that is at a scale and intensity, appropriate to the level of disadvantage and need