Public Health and Prevention Sub Group

Health Inequalities Work Stream

1.0 Introduction

In July 2020, the Health Inequalities Task and Finish Group was formed to take forward work for the Public Health and Prevention LRF Recovery Sub-Group. This Sub-Group is part of the system wide Recovery work. The Recovery sub group is identifying the impacts of COVID 19 in several prevention and public health areas. Health inequalities is one of these areas and the Task and Finish Group has been formed to report back on COVID-19 related impacts and opportunities.

Inequalities covers a broad range of themes and it should be noted that the following areas are covered within other sub groups:

- Climate emergency – Environment LRF sub group
- Walking and Cycling – Health Behaviours and Environment sub groups
- Housing related issues – Housing sub group
- Loneliness and isolation – Mental Health and Vulnerable People sub groups
- Looked after Children – Vulnerable People sub group

2.0 Health Inequalities Task and Finish Group members

Adrian Chapman (PCC/CCC)

Matt Oliver (PCC/CCC)

Tony Jewell (Public Health)

Val Thomas (Public Health)

John Ford - Norfolk and Norwich University Hospital NHS Foundation Trust

Clare Gibbons South Cambs DC

Phil Hughes – Fenland DC

3.0 Initial Discussions and Findings from Task and Finish Group

Health inequalities are systematic, avoidable and unfair differences in health (and wider quality of life) outcomes between populations, between social groups within the same population or as a gradient across a population ranked by social position. Inequalities in health outcomes arise from inequalities in social determinants of health, risk factors and health care access and provision.

Health inequalities is a core component of the draft Cambridgeshire and Peterborough Health and Wellbeing Strategy 2019-24. The strategy, which has been informed by a Joint Strategic Needs Assessment (JSNA), sets out clear priorities and outcomes to address the wider determinants of health and healthy lifestyles inequalities. These are:

Priority 1: **Places that support health and wellbeing**

- New housing developments and transport infrastructure which support residents' health and address climate change
- Preventing homelessness and improving pathways into housing for vulnerable people.
- Reducing inequalities in skills and economic outcomes across our area.

Priority 2: **Helping children achieve the best start in life**

- Delivering the Best Start in Life from pre-birth to age five
- Developing an integrated approach for older children and adolescents

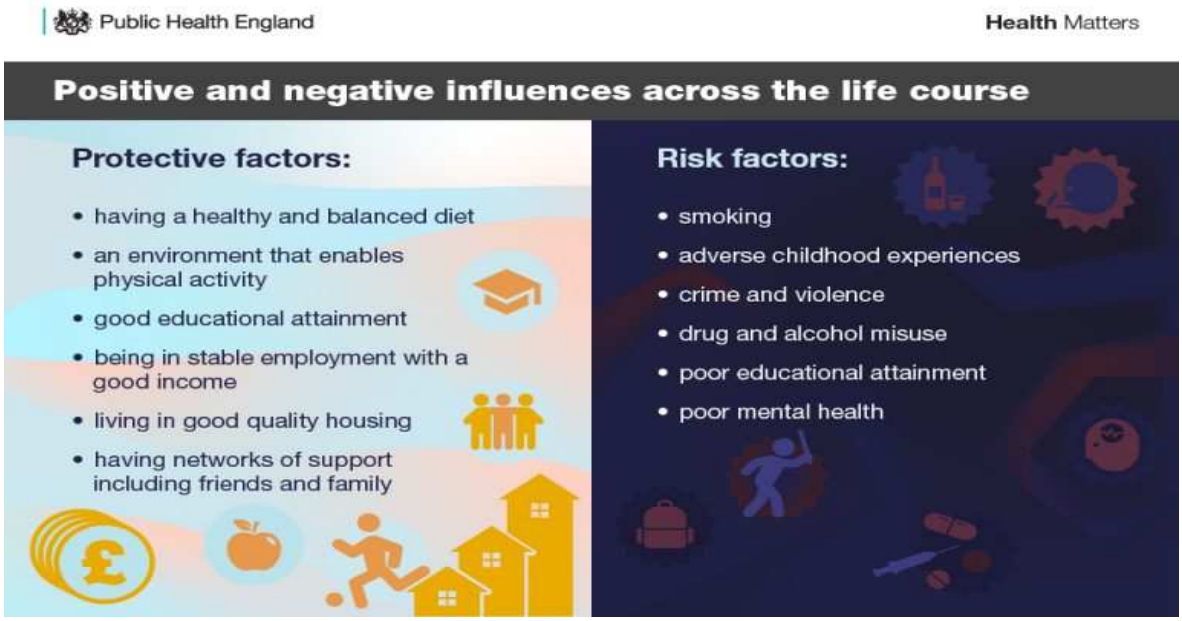
Priority 3: **Staying healthy throughout life**

- A joined up approach to healthy weight, obesity and diabetes
- Reducing inequalities in heart disease and smoking
- Improving mental health and access to services
- Ageing Well – meeting the needs of a growing older population

Priority 4: **Good Quality health and social care**

- Embedding the 'Think Communities' approach to place based working
- A joint approach to population growth
- Addressing financial challenges together
- Acting as a system to reduce health inequalities

A person's physical and mental health are significantly influenced by a range social, economic and environmental factors. These can be categorised as follows:



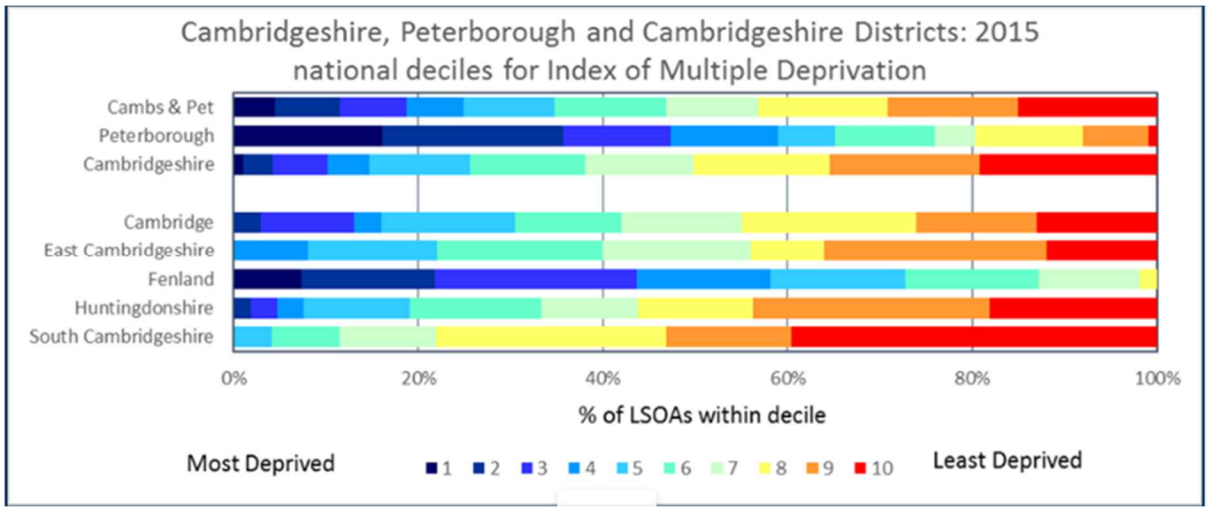
Addressing the wider determinants of health will help improve overall health by optimising the conditions into which people are born, live and work.

The broad social and economic circumstances that together influence health throughout the life course are known as the 'social determinants of health'. There is a social gradient across many of these determinants that contribute to health with poorer individuals experiencing worse health outcomes than people who are better off.

PHE, https://www.gov.uk/government/publications/health-profile-for-england/chapter-6-social-determinants-of-health, 2017

On average, men who live in areas with the worst social and economic deprivation have significant health problems by their early fifties – while in the least deprived areas they stay healthy until over age seventy. The picture for women shows a similar gradient.

In Cambridgeshire and Peterborough we see these same inequalities. Many communities are prosperous and healthy with good outcomes compared to the national picture. But some communities experience poverty, low education and skills, and poor health outcomes. There are more communities with these issues (shown as blue-black on the chart below) in Peterborough and Fenland, and a smaller number in Cambridge and Huntingdon.



The CCG's Cambridgeshire and Peterborough Health Inequalities Strategy sets out the stark inequalities that exist in the social determinants of health, risk factors, health care provision and clinical outcomes across socio-economic, disadvantaged and inclusion health groups. A 10 year life expectancy gap exists between men living in the poorest areas of Peterborough compared to the richest areas of Cambridge. The gap in life expectancy is driven by early deaths in cardiovascular disease, cancer and respiratory conditions – many of these are caused by the socioeconomic factors within our communities. Low income, poor quality housing, and poor education are all key factors which contribute to health inequalities. The strategy sets out the following objectives:

- Preventing homelessness and improving pathways into housing for vulnerable people.
- Reducing inequalities in skills and economic outcomes across our area.
- Reducing inequalities in heart disease and smoking
- Acting as a system to reduce health inequalities

The cost to the NHS alone of health inequalities was estimated in 2011/12 to be at least £12.5 billion/year. This was calculated by estimating the difference in NHS spend between the most and least disadvantaged fifth of the population. In Cambridgeshire and Peterborough CCG this would be equivalent to approximately £106 million/year, at 2011/12 costs.

COVID-19 has significantly changed the health inequalities context. However, this is just the tip of the iceberg with health inequalities likely to worsen even more due to the impact on health care services, mental wellbeing and economic impact on employment, debt, housing, benefit payments and education. These social influences are key determinants of what makes people healthy or unwell and have been significant factors in peoples' exposure to and outcomes from COVID-19.

COVID-19 has disproportionally affected poor areas with a 1,000 extra people dying in the most deprived decile in England due to COVID-19 during March to May 2020, compared with the least deprived areas and 2,500 extra people from any cause of death during this period. There is a clear socio-economic trend in COVID deaths.

COVID has particularly highlighted just how significant the health impact is on marginalised and vulnerable groups. Public Health England's report (*Disparities in the risk and outcomes of Covid 19*, June 2020) set out the key risk factors include age, sex, occupation, living in a deprived area and coming from a Black, Asian and Minority Ethnic (BAME) group.

Some of the risk factors are:

Age

There is a sharp gradient in COVID risk with ageing so that more older people get a severe illness, often requiring hospitalisation and sadly die as a result of Covid 19.

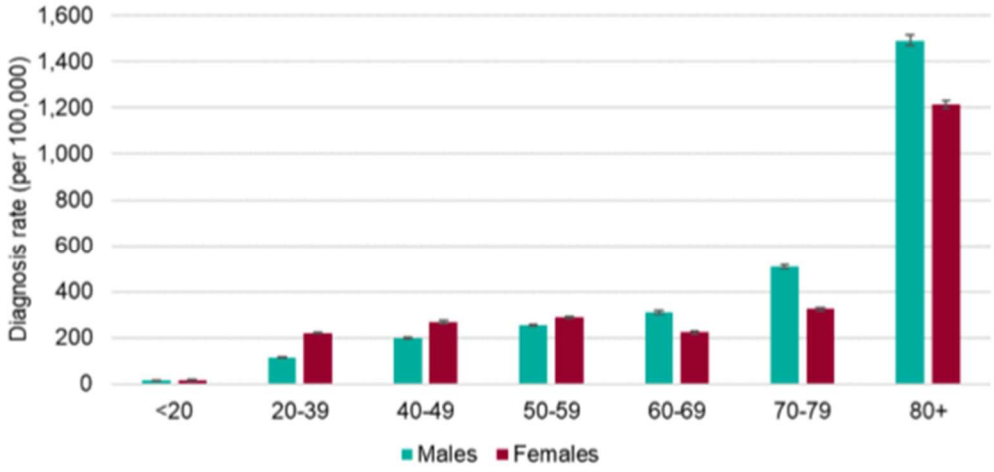


Figure 1.2. Diagnosis rates by sex and age as of 13 May 2020, England. Source: Public Health England Second Generation Surveillance System.

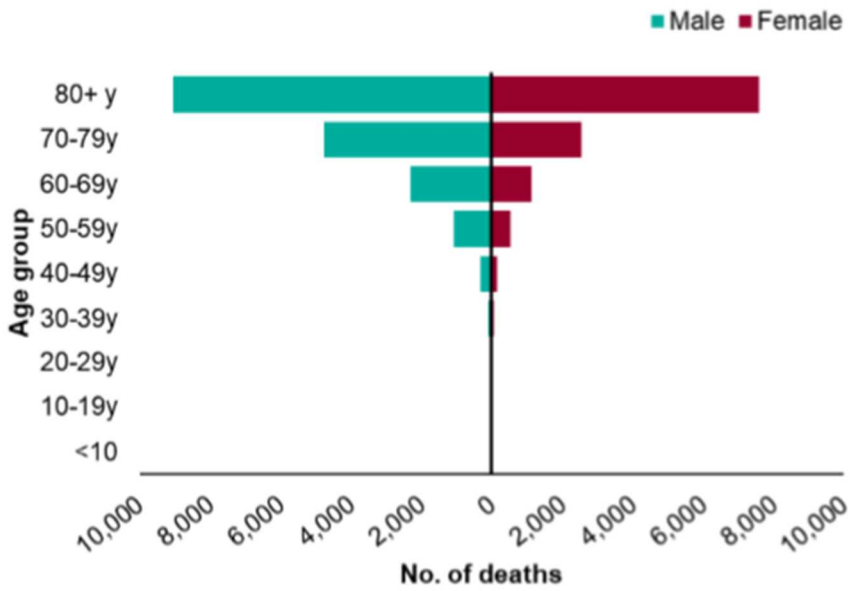


Figure 1.4. Age sex pyramid of laboratory confirmed COVID-19 deaths as of 13 May 2020, England. Source: Public Health England COVID-19 Specific Mortality Surveillance System.

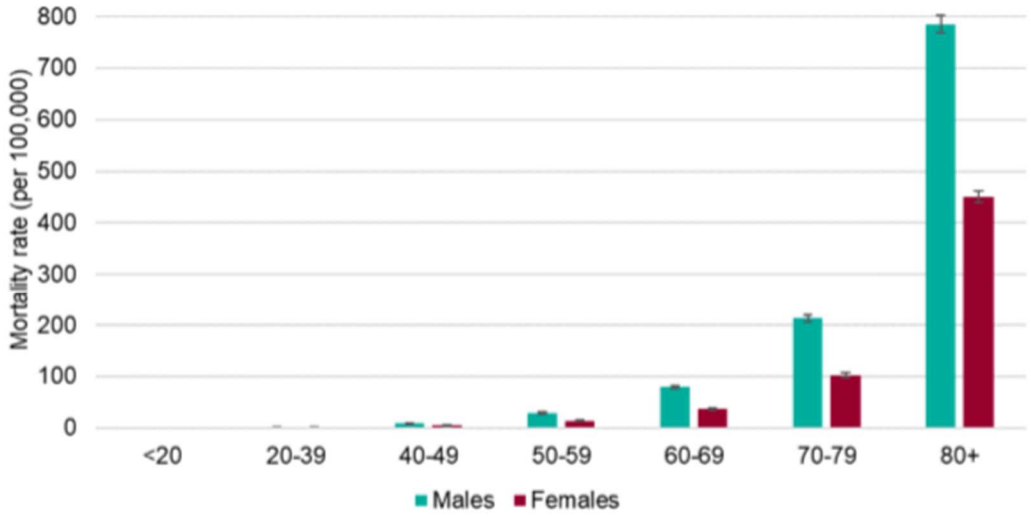
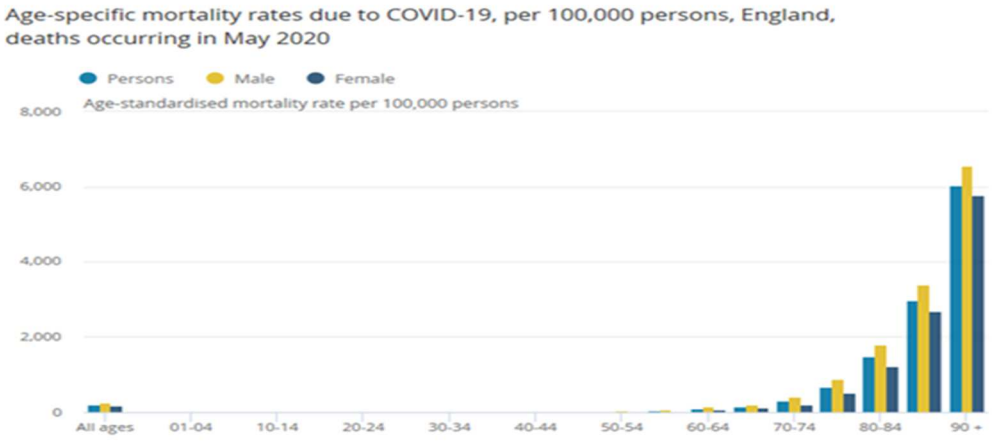


Figure 1.5. Crude mortality rates of laboratory confirmed COVID-19 deaths per 100,000 population by age group and sex, as of 13 May 2020, England. Source: Public Health England COVID-19 Specific Mortality Surveillance System.

Sex

Taking into account the age structure of the population, more men than women die of COVID-19. The age-standardised mortality rate (ASMR) in England in May for all ages combined was significantly higher in males (250.2 deaths per 100,000 males) than females (178.5 deaths per 100,000 females).

Looking at the mortality rates by age and sex, the difference between males and females increased with age. In all age groups below 50 years, the age-specific mortality rates were similar in males and females However, analysing April's data, the PHE *Disparities* report finds that among working age men as a group (which includes men from 50-64 as well), those diagnosed with a positive test are twice as likely to die as females. In the oldest age groups (starting from 80 to 84 years), males had a significantly higher COVID-19 mortality rate than females (see figure below).



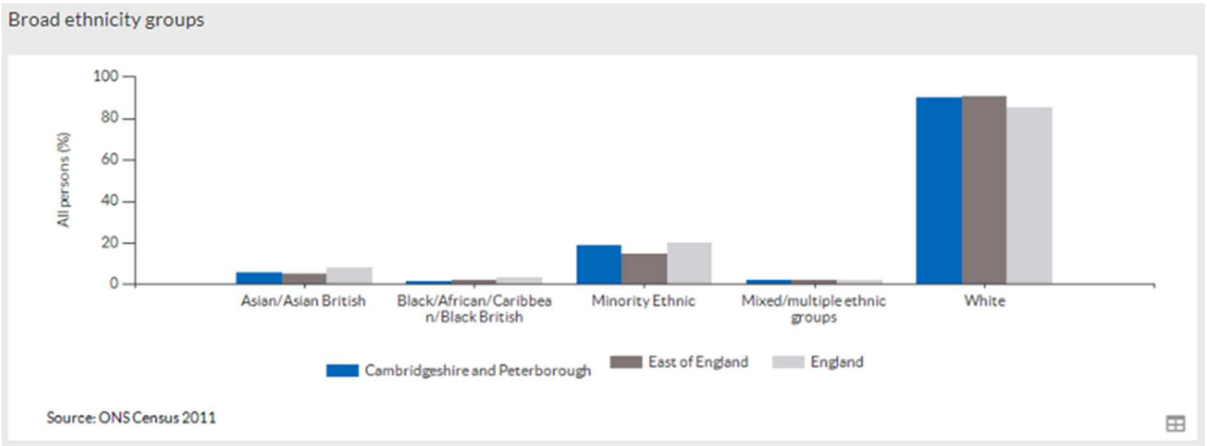
Source: Office for National Statistics – Deaths involving COVID-19

Ethnicity and BAME risk

One of the next biggest risk factors in getting severe illness and dying from Coronavirus is ethnicity. Black people make up only 3% of the population, but they account for six out of every 100 coronavirus deaths. The PHE *Disparities* study stated that once age standardised the highest diagnosis rates of COVID-19 per 100,000 were in people of Black Ethnic Groups and the lowest in White ethnic groups.

However, it is not just Black ethnic groups that are at further risk when compared to White ethnic groups. After accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death when compared to people of White British ethnicity. People of Indian, Pakistani, other Asian, Caribbean, and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British. These analyses did not account for the effect of occupation, comorbidities or obesity. These are important factors because they are associated with the risk of acquiring COVID-19, the risk of dying, or both. Other evidence has shown that when comorbidities are included, the difference in risk of death among hospitalised patients is greatly reduced.

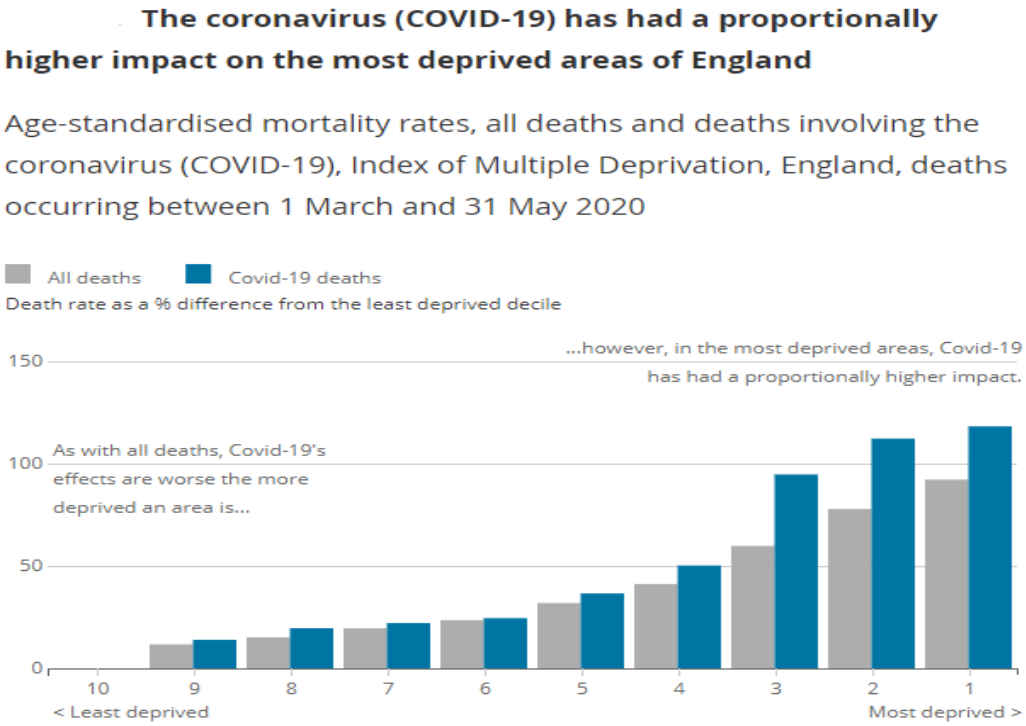
In Cambridgeshire and Peterborough the overall percentage of BAME groups are low in comparison with England, however the rates differ significantly across the different district and city local authority areas. For example, the White population account for 96.2% of the population in East Cambridgeshire, whereas in Peterborough the White population accounts for 82.5% of the population.



	Cambridgeshire and Peterborough		East of England		England	
	Count	%	Count	%	Count	%
Asian/Asian British	47,130	5.9	278,372	4.8	4,143,403	7.8
Black/African/Caribbean/Black British	10,174	1.3	117,442	2	1,846,614	3.5
Minority Ethnic - Total	149,992	18.6	860,795	14.7	10,733,220	20.2
Mixed/multiple ethnic groups	16,029	2	112,116	1.9	1,192,879	2.3
Other ethnic group	4,977	0.6	28,841	0.5	548,418	1
White	726,531	90.3	5,310,194	90.8	45,281,142	85.4

Deprivation

The government has observed that people living in the poorest areas of England and Wales have been twice as likely to die from COVID-19 as those in less deprived areas. The analysis done by the ONS highlights the disparity in deaths per 100,000 people from those areas with high levels of socio-economic deprivation compared with areas with low levels. The graph below shows this.



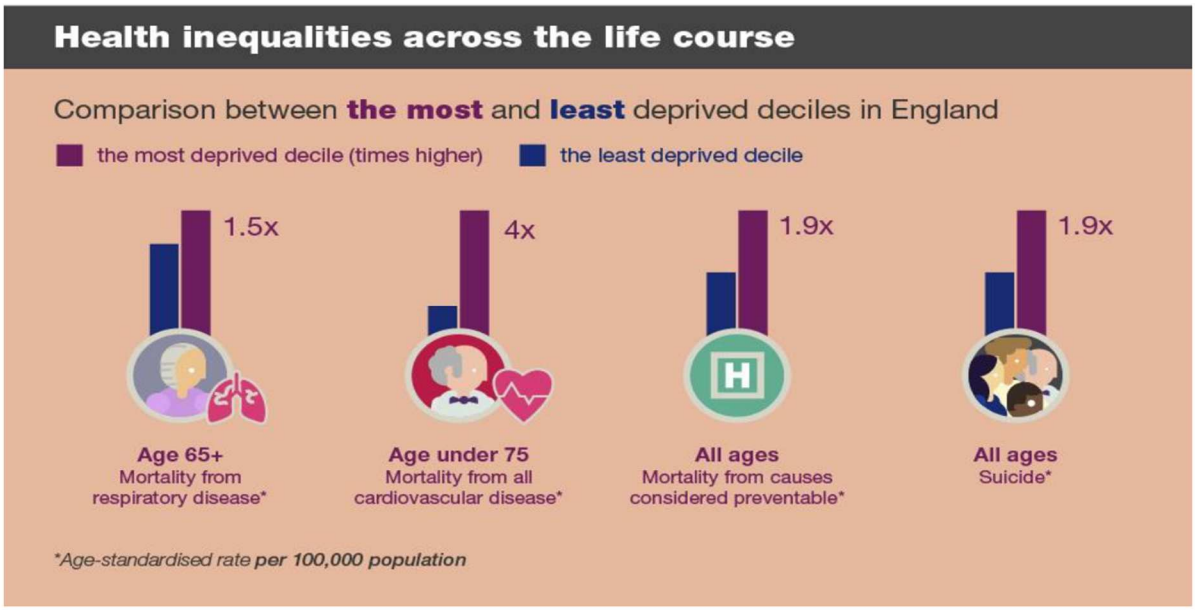
Source: Office for National Statistics – Deaths involving COVID-19

Looking at deaths involving the coronavirus (COVID-19), in England, the rate for the least deprived area (Decile 10) was 58.8 deaths per 100,000 population and the rate in the most deprived area (Decile 1) was 128.3 deaths per 100,000 population; this is 118% higher than the least deprived area. In the least deprived area, the age-standardised mortality rate for all deaths was 242.6 deaths per 100,000 population. In the most deprived area, the age-standardised mortality rate for all deaths was 92.2% higher than that of the least deprived, at 466.2 deaths per 100,000 population."

High diagnosis rates may be due to geographic proximity to infections or a high proportion of workers in occupations that are more likely to be exposed. Poor outcomes from COVID-19 infection in deprived areas remain after adjusting for age, sex, region and ethnicity, but the role of comorbidities requires further investigation.

In Cambridgeshire and Peterborough there are approximately 97,000 people living in areas that are deemed to be within the 20% most deprived areas in England (or decile 1 and 2 of 10).These areas are most concentrated in Peterborough, Cambridge and Fenland.

Deprivation is a significant factor in health inequality across the life course with social and economic factors remain relevant in adulthood, with big differences in health between the most and least deprived communities, locally and nationally.



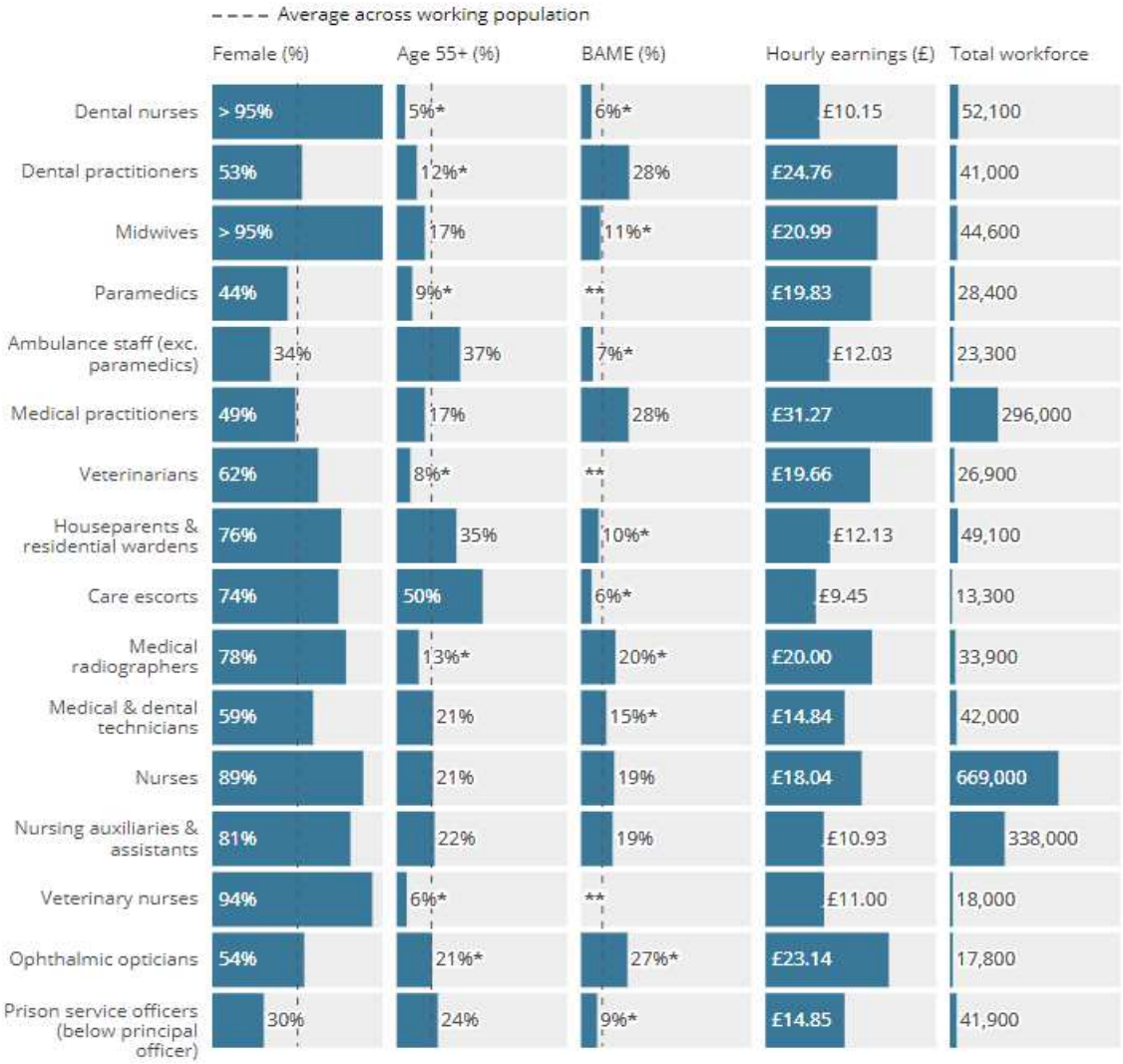
High risk occupations

There are numerous occupations that have greater exposure to individuals with COVID-19 and therefore increase the risk of contracting it themselves. For example, healthcare professionals are more exposed to individuals that have contracted the virus. Other occupations include bus drivers, store assistants, teachers, security guards and any other occupation that requires the individual to be present in an environment where there is physical proximity to other individuals. This may make them more likely to come into contact with someone that has COVID-19. However much of this risk could be mitigated with adequate PPE.

Certain demographics are disproportionately represented in the most at-risk occupations relative to the general population. For example, midwives are almost exclusively female as shown in the table below. BAME groups are disproportionately represented among medical practitioners, dental practitioners and ophthalmic opticians relative to the population of BAME groups. People with lower earnings are more likely to live in deprived areas and are less likely to have the option to work from home due to the nature of the work. This further increases their risk to contracting COVID-19.

An analysis of occupations therefore will cross-reference the key risk factors discussed in the preceding parts of Category A above as in the case of BAME workers. To understand the occupational risk, it is necessary to assess each occupation by the demographics of its workforce, as suggested by the following diagram which looks at characteristics of occupations nationally:

Characteristics of workers in highest exposure occupations

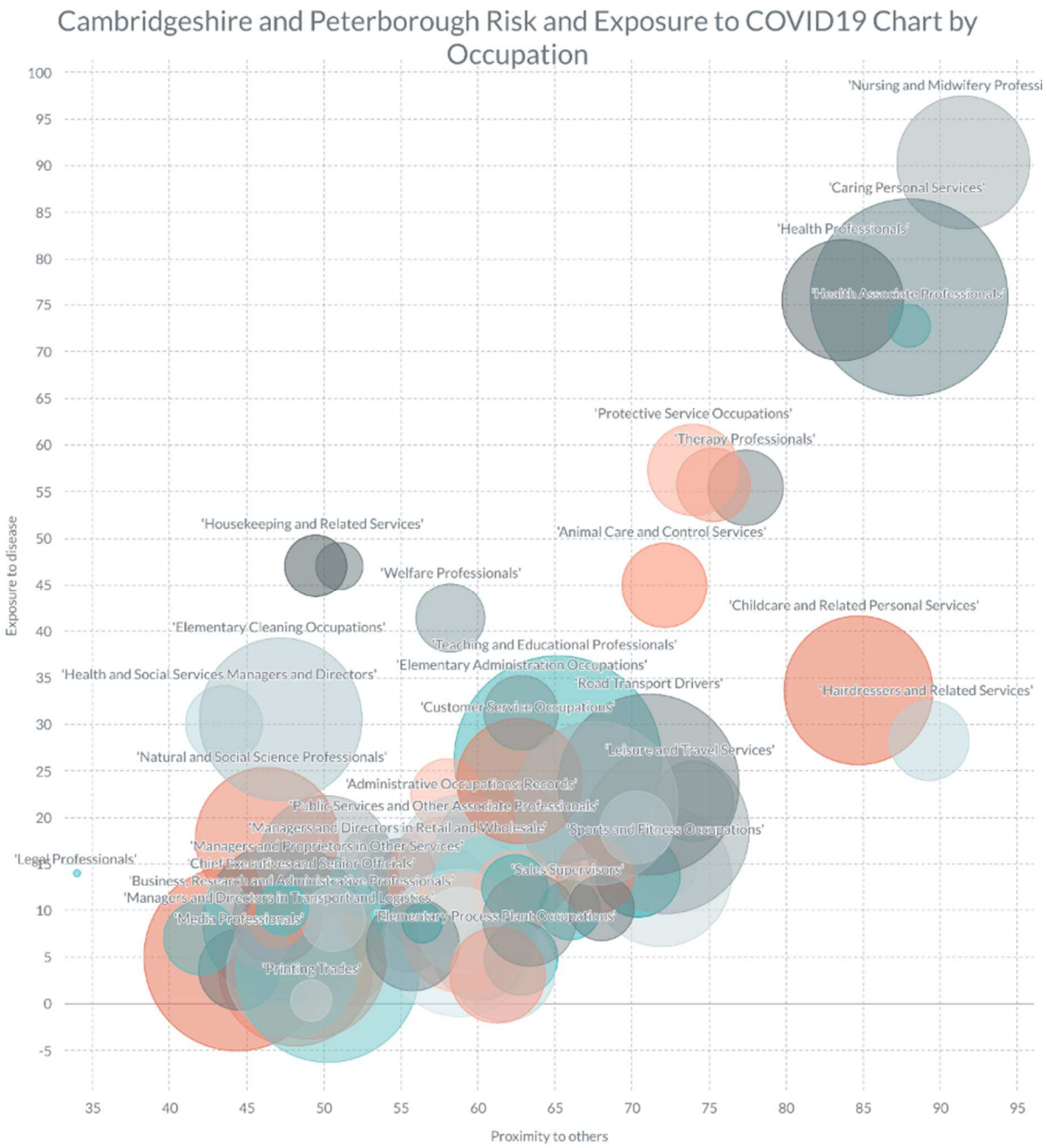


* Data is based on low sample sizes and should be used with caution

** The sample size is too small to produce a reliable estimate

Source: Annual Population Survey and Annual Survey of Hours and Earnings - Office for National Statistics

The graph below provides an indicative view of what proportion of people are working in high risk occupations across Cambridgeshire and Peterborough. The chart shows that there are significant numbers of people with jobs working in high risk occupations, primarily in a healthcare setting. The full data table used to populate this chart can be found in the references section

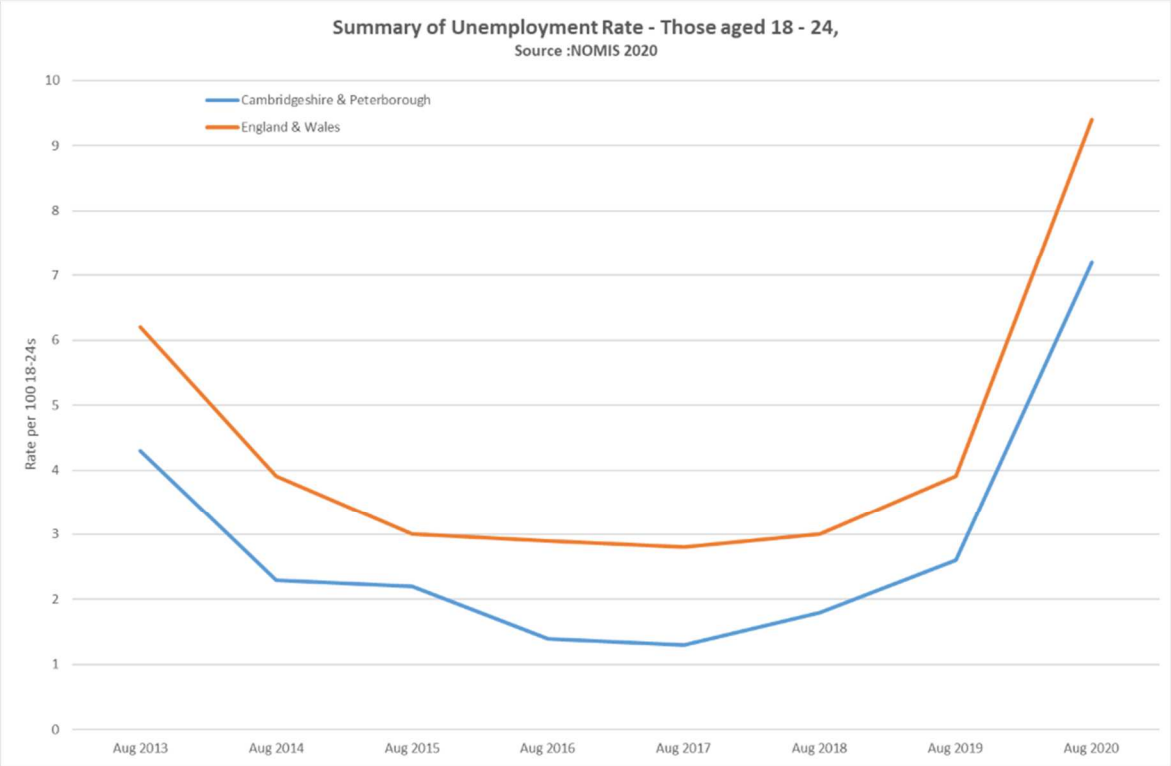


The Economy sub group are leading on these issues and are developing plans for inclusive growth across the economy

Young People

The long term impacts of the pandemic are likely to be felt by young people both now and for decades to come. Prior to lockdown, youth unemployment had already been rising with over 700,000 people aged 16-24 not in education, employment or training nationally, compared to the same three month period last year. A report by a panel of experts and led by the Learning and Working Institute estimates that a further 500,000 young people will enter long term claimant unemployment (without a job for 6 months) over the next 18 months.

Locally, we have seen an increase of 3,100 young people aged 18-24 claiming Universal Credit comparing August 2020 to March 2020 pre-pandemic. The unemployment rate amongst this group has increased from 2.6% of 18-24 year olds to 7.2% over the year to August 2020.



COVID 19 has caused impacts on many different groups of people, some clear and obvious, some known to public services, and others more hidden and affecting people who would not normally be involved with public services.

We know that some people are at higher risk of severe and lasting harm or death from COVID-19. These people were the focus of the 'shielding' elements of the pandemic management regime. Other high risk areas include:

- People at risk of poor mental health due to anxiety about COVID-19 or the increased social isolation caused by the lockdown measures. This would also include people experiencing bereavement due to COVID-19 infection
- People at risk from economic impacts caused by lock down and the supressed economic operating conditions that outbreak management has caused. The economic impacts arise from the restrictions on movement imposed by the Government to manage the pandemic, and affect economic sectors differently. However, despite the significant investment Government has provided on job retention schemes, unemployment is rising rapidly and will likely continue to rise over the coming months. People at risk from harm in this category may not have been known to public services before. There will also be people who are already in deprived circumstances who face further issues as a result of the economic impacts they experience.

Think Communities and placed based working

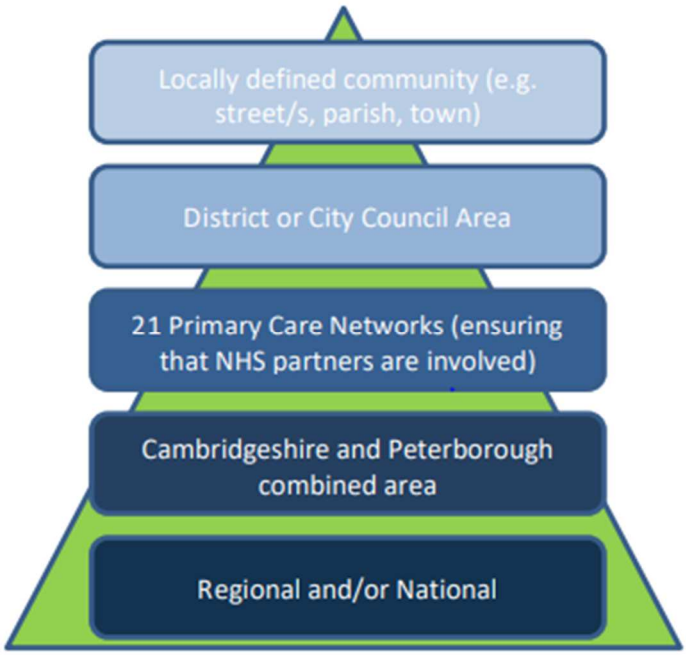
Since the beginning of the pandemic, the coordinated Hub response developed across Cambridgeshire has proven the concept of the Think Communities approach in real time supporting tens of thousands of residents to protect themselves from COVID-19, and as such not overload the NHS or other statutory services. This way of working together across all local councils, services and communities has resulted in positive outcomes for our residents, communities, the council and our partners. It hasn't relied on public sector reform, but instead a common-sense approach to working smarter together. This unified approach is something we want to build on, taking Thinking Communities as a concept into delivery across Peterborough and the county.

It is important that we now capitalise on the relationships, working arrangements and processes that have been shown to work well, as well as review where necessary, as we evolve our services into a new normal of outbreak management and coping with the social, health and economic challenges which our citizens will face in the future. We have a unique opportunity to work differently to support residents and communities in need, to provide opportunities for everyone, and to ensure our communities truly are at the centre of our organisation.

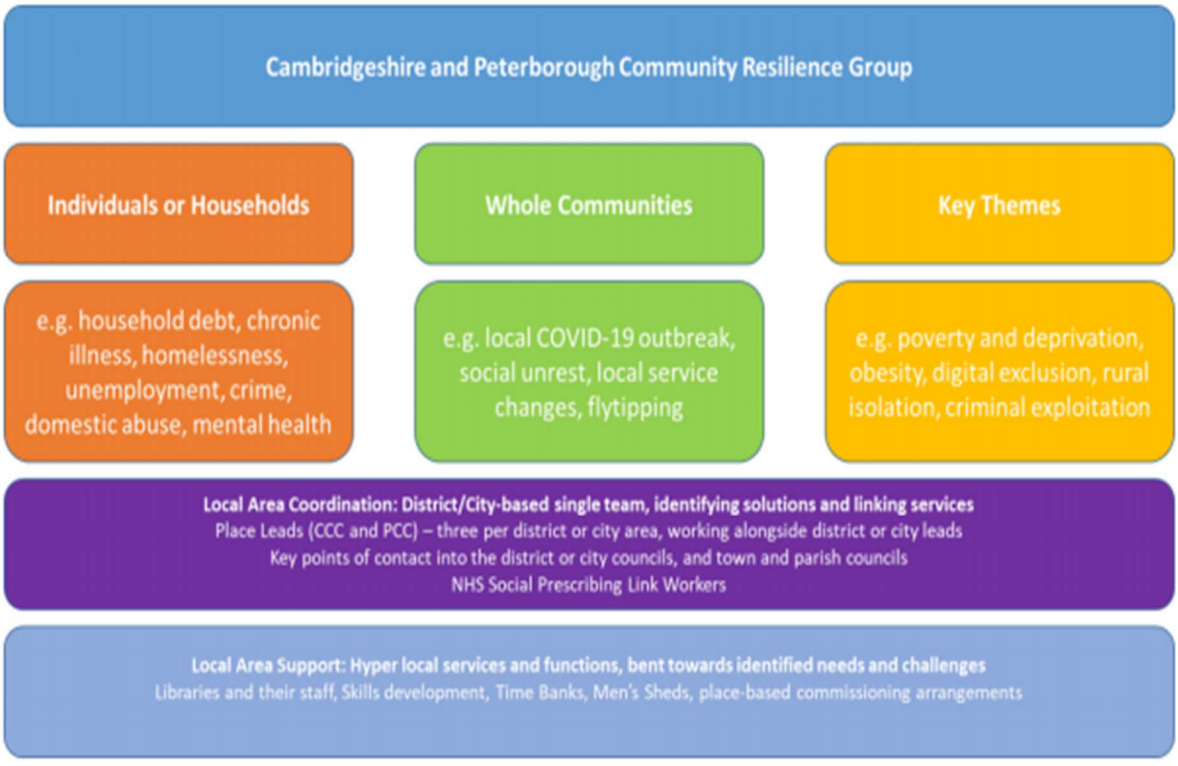
This step-change is perhaps best described as seeking to create a unified approach across our public sector system, using the now well-developed principles of Think Communities. Our aim is to ensure that communities are given the opportunities and access to information and support where necessary at the most local level, in ways that make most sense to them. Our residents shouldn't be concerned about who delivers which service or provides what opportunity; instead, they should experience a unified public sector response that feels and is accessible, proportionate, timely and effective.

To ensure focussed leadership, the Communities and Partnerships Service Directorate in PCC/CCC will align its whole focus to the Think Communities Unified Approach – for example, libraries will lead or directly contribute to much of the place-based work (including place-based commissioning, community responses, befriending), our skills service will support the social mobility agenda, and our regulatory services functions will support economic and community recovery.

The Service Directorate will work with our partners to fully establish place-based approaches to collaborative public service delivery, in support of the council's strategic priorities. Our work during the pandemic has shown that, in fact, the unified approach we are seeking to take needs to work at a number of different geographical levels, as required and defined by our communities – see the diagram below.



The experience of delivering a Think Communities approach in real time over the past few months has enabled a sharper focus to be determined for the things we should focus on, as illustrated in the diagram below:



Other key points

- Income, environment and education are all significant factors which impact health and whilst the links between deprivation and poor health outcomes are not new, they have been further highlighted during the pandemic. The

councils and its partners recognise the need to jointly tackle inequalities which has formed the basis of the Health and Wellbeing strategy. The strategy is underpinned by the Joint Strategic Needs Assessment which provides a 2019 baseline of health needs.

- The environment where people live can play a critical role in shaping long term health. CCC are working with partners to develop innovative ways of building new housing and communities that can adopt new planning principles to improve health and quality of life. Northstowe in South Cambridgeshire, is one of ten Healthy New Towns nationally and has received funding to create a healthy environment. Learning from these towns has led to agreement of ten national 'Healthy New Town' planning principles ("Putting Health into Place"), which have been adopted by several large housing developers. Locally we're developing a toolkit to implement the 'Healthy New Town' principles.

  District Council planning officers from Cambridgeshire and Peterborough have met with representatives of the local NHS 'Estates' group, to work out how to plan better together for health and care services in new housing developments.

- In 2014, the Equality Trust published its findings on inequality. They noted that the overall cost of inequality in the UK was £39 billion per year and resulted not only in a financial impact, but reduced physical and mental health, lower life expectancy and higher crime and imprisonment. The report argues that even small improvements to equality would result in lower levels of crime and imprisonment, better mental health, higher healthy life expectancy, and would lead to a socially and financially richer society.

- When we consider Health Inequalities across the system, it is helpful to view them through the lens of the four grand challenges. The evidence demonstrated in this report highlights that the impact of the pandemic, will widen the gaps that already exist. It could be suggested that this shared vision helps frame our focus, in conjunction with other Subgroups.

  The Four Grand Challenges

  - **Give people a good start in life**
  - **Ensure people have good work**
  - **Create a place where people want to live**
  - **Ensuring people are healthy throughout their lives.**

4.0 Links to existing strategies and the system wide landscape

Draft Cambridgeshire and Peterborough Health and Wellbeing Strategy

PCC Draft Healthy Weight Strategy

Tobacco Control Alliance

Priorities for local Integrated Neighbourhoods

CCG Diabetes and Obesity Clinical Community (including the BMI Can Do It campaign)

New Government Obesity strategy

PHE Better Health Campaign

Other STP clinical communities

PCC Active Lifestyles and Sport Strategy

National Sport England Strategy ‘Towards an Active Nation’

PHE COVID-19 review of disparities in risks and outcomes

NHS Long Term Plan

Cambridgeshire and Peterborough Health Inequalities Strategy

Think Communities

Joint Strategic Needs Assessments

Better Start in Life

Adults Positive Challenge

Better Care Funding

Impacts of Covid 19 in Cambridgeshire and Peterborough Needs Assessment

5.0 Key Partners

District Councils (including their partners and stakeholders)

Cambridgeshire and Peterborough Clinical Commissioning Group (including Primary and Secondary Care)

All LRF partners should act as champions and consider workplace interventions to ensure a healthy happy workforce (Police, Fire, Ambulance service etc.)

Voluntary and community sector who deliver at community level

Disability/inclusive agencies

Everyone Health (including their partners and stakeholders)

Living Sport (including their partners and stakeholders)

Sport England

Early years and education sector

Workplaces

Social Prescribers

Primary Care Networks

PCVS

Hunts Forum

Adrian Chapman

Chair of Inequalities work-stream.

October 2020

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