Tackling Slough's health inequalities and wider determinants of health: Considerations for Slough Wellbeing Board and Frimley Integrated Care System

Author: Dr Liz Brutus, Consultant in Public Health, Public Health, Slough Borough Council
Date: 31 Jul 2018

Purpose of paper

1. This paper discusses how Slough's Wellbeing Board and Frimley Health and Care Integrated Care System (Frimley ICS) can contribute to tackling health inequalities and targeting the wider determinants of health. Learnings from Slough are likely to have implications for other areas of deprivation and health inequality across the Frimley ICS footprint. The paper attempts to outline the balance of where work is best done – trying to tease out what lends itself to the ICS level in a "do once and share" approach versus the local level.

Background

2. The recent work of PHE South East (PHE SE) presented by Don Sinclair, has highlighted some of the stark differences in the distribution of both life expectancy and certain health conditions, depending on where you live in the ICS footprint (and by proxy, your socioeconomic status). In short, as seen nationally, across the ICS, the better off you are, the better your health and the longer you live. In contrast, the less money you earn, the worse off you are with earlier and more frequent ill health and a shorter life overall.

3. Most health inequalities[1], both across Slough and between Slough and other Frimley ICS areas, have not improved and for many issues, have worsened. As a result we need to refocus our priorities and actions.

4. At present, ward-level health data is not yet routinely presented for the Frimley ICS footprint. However, based on the PHE SE analysis, in this paper, where available, Slough's Britwell & Northborough (B&N) and Bracknell Forest's Warfield Harvest Ride (WFR) wards have been used to illustrate the differences in health outcomes between deprived and affluent areas across the ICS. Frimley ICS consists of some 110 wards, with Slough wards consistently over-represented for being in the lowest quintile of health outcomes – whatever the health condition.

Describing health inequalities in Slough

5. The health inequalities described by PHE SE predominantly demonstrate the differences in health experience by socio-economic deprivation. However, in general, health inequalities can also be seen between ethnic minorities, those living with disability (particularly where there is mental illness or learning disability), people whose sexuality is other than heterosexual and in short, amongst any group where stigma or discrimination is more common. In addition, there may be complex interactions amongst people with more than one such characteristic and/or poor socioeconomic status, whose health outcomes can be particularly poor.

[1] Health inequalities are differences between people or groups due to social, geographical, biological or other factors. These differences have a huge impact because they result in people who are worst off experiencing poorer health and shorter lives. (NICE)

6. There is a social gradient in pretty much any health measure but in Slough, we see these health inequalities across the life course, particularly in:
   - Children's poor early start with persistently high levels of childhood overweight and obesity, low physical activity, poor oral health, low immunisation rates and maternal mental health problems. (This is especially significant as a good start in life can positively disrupt a cumulative cycle of disadvantage and poorer health outcomes over a person's whole life.)
   - Working age adults with:
     - High rates of overweight , obesity and inactivity which, in Slough's population with a large population of people with South Asian heritage, is associated with high rates of diabetes;
     - Higher smoking rates (16.6% in Slough vs eg 11.2% in Windsor and Maidenhead / 10.9% in Surrey). Knock-on effects include the higher rates of smoking-related hospital admissions – 1,847/100,000 in Slough vs 1,051/100,000 in Windsor and Maidenhead, worsening over winter.
     - High rates of un-diagnosed hypertension and chronic obstructive pulmonary disease (COPD) (and to a lesser extent, undiagnosed diabetes and atrial fibrillation) which all contribute to the high rates of emergency adult admissions overall;
     - In particular, we see a 7-fold difference between e.g. B&N and WHR in premature deaths (i.e. under 75s) due to coronary heart disease (CHD). Slough has more than twice the death rate than the England average and this is strongly related to high rates of historically undiagnosed or poorly managed diabetes, hypertension and smoking.
     - In addition, a smaller number of working age people in Slough experience high rates of TB (almost unseen outside of London), late diagnosed HIV, substance misuse and mental health problems which are also important markers of social disadvantage and stigma.
   - Older people in Slough have higher rates of social isolation with more pensioners living alone (42.5% vs 26.3% in WHR and 31.5% in England). Social isolation is associated with both poorer mental and physical health.

Wider determinants of health and their impact on health inequalities

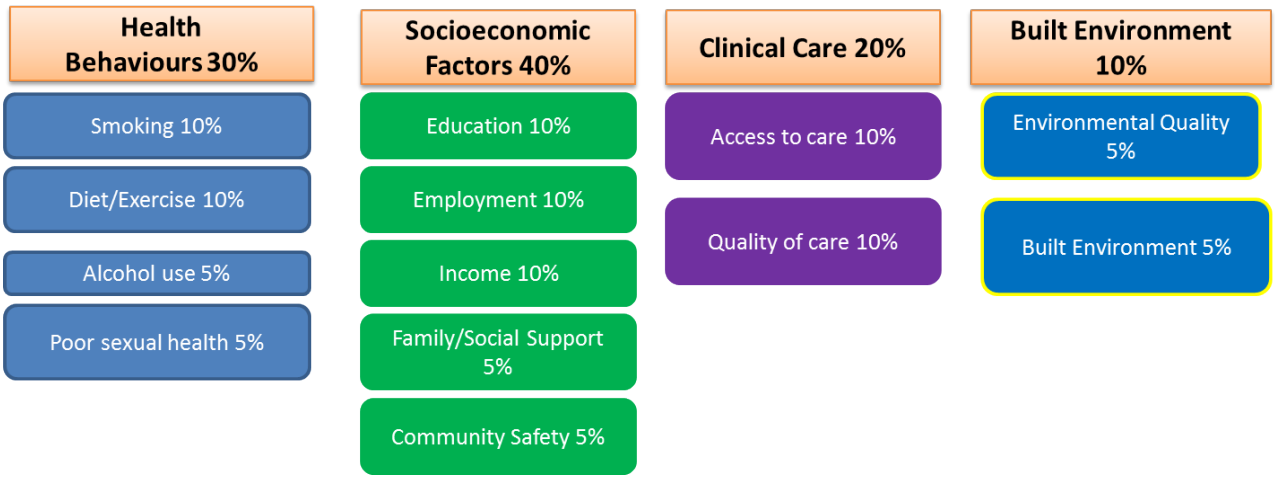
7. Individuals are at the centre of their health and bear responsibility for it and the health behaviour choices they make but this is not the whole story. As can be seen in Figure 1 below, factors outside an individual's control also affect their health – for example, including their access to health care, employment status, their working or educational environment (from whether physical safety is protected through to whether their line manager or head teacher pays attention to employee or student mental wellbeing) and air quality. For example, Slough has considerably higher rates of air pollution than other areas in the Frimley ICS footprint and this has an impact on conditions and associated hospital admissions due to childhood asthma, COPD and CVD.

8. In comparison to most localities in the ICS footprint and despite the number of successful business start-ups, being the most productive town in the UK[2] and attracting new businesses at a faster rate than anywhere else in the UK, Slough's resident population is disproportionately over-represented by low to low-middle-income households. Many of

[2] Centre for Cities, 2017

Slough's population experience high levels of in-work poverty - a barrier for people wanting to take action towards their goals. Around a million workers in England claim benefits each year because their income is so low. The jobs tend to have short-term prospects and few, if any, benefits such as sickness or maternity cover. This can create a cycle where workers move between work and worklessness (known to some as the 'lobster pot'), in which it is hard for people to find the time, energy or money to build their confidence or skills to break out of this cycle.[3]

Figure 1: Factors contributing to overall health outcomes



Source: Robert Wood Johnson Foundation

9. Income deprivation affects 21.3% of B&N's population in comparison to an England average of 14.6% and WHR's 3.0%. Overall income levels also affect basic decisions which affect health. These range from decisions about food (we have seen the rise in foodbank use in Slough and other less affluent areas), quality of housing, home heating, transport and homelessness (both of single people and families). Income also affects more subtle issues such as social engagement and a person's sense of personal control in being able to improve any part of their lives - contributing to a negative cycle of limiting life circumstances.[4] Slough GP data show that patients don't feel confident in managing their own condition which suggests various factors including low sense of personal agency and poor health literacy consistent with a more deprived population.[5]

Why do health inequalities matter to Slough and to the Frimley ICS?

10. Health inequalities matter for a variety of reasons; at a moral level, for their unfairness to the individual and the kind of society we want. However, inequality impacts not just health but crime, educational achievement and social cohesiveness.[6] At an economic level, there is

[3] H Khan et al. Good and Bad Help: How purpose and confidence transform lives. NESTA. 2018. Available at: https://www.nesta.org.uk/report/good-and-bad-help-how-purpose-and-confidence-transform-lives/
[4] R Wilson, C Cornwell et al. Good and Bad Help: How purpose and confidence transforms lives. NESTA. Feb 2018. Available at: https://www.nesta.org.uk/report/good-and-bad-help-how-purpose-and-confidence-transform-lives/
[5] Slough CCG Profile. 2017. Berkshire PH Shared Team Informatics. Available at: http://www.slough.gov.uk/council/joint-strategic-needs-assessment/slough-ccg-profile.aspx
[6] K Pickett, R Wilkinson. The Spirit Level: Why equality is better for everyone. (Allen Lane 2009)

the 'double whammy' of premature ill health and death resulting in lost productivity (and tax revenues) while associated with additional social care, health and welfare costs.

11. Given the proposed financial connectedness of all the organisations and areas within the ICS footprint i.e. 'we're all in it together', we need to look for opportunities to reduce or delay the additional health and social care costs associated with health inequalities above and beyond the well-described challenges associated with an ageing population.

12. Fortunately, ill health and rising care demands are not inevitable results of either age or income. For example, in B&N, healthy life expectancy is 59.1yr whereas in WFR, it's 77.2yr[7] - a huge gap of 18.1yr. It's not age itself that drives ill health but cumulative social and health circumstances - many of which can be prevented or at least delayed through supporting everyone to live and age better. There is an established and growing evidence-base on what can be done. The NHS's Five Year Forward View recognised this and called for a 'radical upgrade in prevention'. (However, recognising the difficulties in delivering prevention more consistently across the NHS, the All Our Health Framework[8] for frontline staff was published in 2018.)

13. One particularly knotty issue which will likely present a political challenge to ICS partners is how these health inequalities are addressed and the level of investment distributed. Marmot[9], whose seminal review of health inequalities for Government in 2010, recommended that action should be taken for all but for those with the most need, more must be done – so-called 'proportionate universalism'. In reality, in order to address the inequalities across the footprint, this will mean that areas of deprivation and greater health inequality including but not limited to wards in Slough, will need higher levels of investment than their wealthier and healthier areas and resident populations.

What's being done in Slough already to tackle health inequalities?

14. Much of the work of Slough Borough Council implicitly addresses the wider determinants of health within the constraints of its central government funding which has been halved over the period 2010/11 to 2017/18.[10]

15. There are ambitious plans for the town's future which include regeneration of the town centre, the arrival of Crossrail and a potential third runway at Heathrow. Alongside investment in transport, housing, schools, community buildings and leisure facilities these developments will bring benefits and opportunities to residents and communities.[11]

16. For example, Slough schools rate highly in working to close the gap in educational attainment between children receiving free school meals (a marker of income deprivation)

---

[7] ONS life expectancy tool. Available at: https://www.ons.gov.uk/visualisations/dvc479/map/index.html

[8] All Our Health. Available at: https://www.gov.uk/government/publications/all-our-health-about-the-framework/all-our-health-about-the-framework

[9] M Marmot et al. Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010. Available at: http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

[10] https://www.local.gov.uk/parliament/briefings-and-responses/debate-reductions-local-government-funding-house-common

[11] Slough Borough Council. Slough Story. 2017.

and those without FSM and have increasingly high overall attainment for all. There are low levels of NEETs (young people not in employment, education or training).

17. Work on housing, adult education, parks and green space, leisure facilities, support to community groups and community development all contribute to close the gap and in particular, have significant benefits to mental health and wellbeing which, in turn, beget better outcomes in employment, education and other elements of health.

18. Recognising the relationship between non-health factors on improving health, especially in tackling issues such as loneliness and social isolation's damaging effects, the work of Slough's voluntary and community sector is vital. The move towards more social prescribing[12],[13] (largely delivered by the SPACE Consortia[14] (Slough Prevention Alliance Community Engagement)) is promising.

19. Within the limits of the reducing Public Health ring-fenced grant for Slough, there remains a fairly broad programme of preventive work aimed at the individual across the life course and which largely correspond to the health needs identified in Slough within the Joint Strategic Needs Assessment[15]. However, with a shrunken and activity-driven budget, the PH offer probably lacks the required scale for radical change.

20. The Public Health services range from the provision of the 0-19 Service (of health visitors and school nurses), lifestyle behaviour change services across the lifecourse, promoting, for example, healthy eating, greater physical activity, better mental health, smoking cessation, safer reproductive and sexual health and the provision of a substance misuse service.

21. The CCG have been working to 'close the prevalence gap' with earlier diagnosis and tighter management of diseases which both drive unplanned emergency admissions and reflect the strong social gradient of health inequalities. In particular, these include coronary heart disease, diabetes, asthma and COPD – all diseases that are more common (or have worse impact) in less affluent populations.

22. In addition to various East Berkshire CCG programmes of work (including NHSE Right Care) which have looked to reduce the clinical variation across specific health pathways, the Frimley ICS includes the 'Reducing Clinical Variation' workstream with various sub-streams of that including maternity, diabetes and cardiovascular pathways which have particular relevance for Slough residents.

---

[12] Social prescribing, sometimes referred to as community referral, is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services. Kings Fund

[13] What is social prescribing? Kings Fund. 2017. Available at: https://www.kingsfund.org.uk/publications/social-prescribing

[14] SPACE. Available at: https://spaceslough.org.uk/

[15] JSNA – Slough 2018. Available at: https://www.slough.gov.uk/council/joint-strategic-needs-assessment/jsna-summary-and-why-we-need-it.aspx

23. Furthermore, the Frimley ICS 'Prevention and Self Care' workstream is working to explore and develop opportunities which help tackle health inequalities such as community asset development.

What is best practice to address health inequalities?

24. There is a bank of evidence and commentary on 'best practice' available about how best to tackle health inequalities (including tackling the wider or social determinants of health). However, it is also recognised that each local system will have its own unique interplay of complex factors and that given this complexity, different interventions have different time scales at which they operate over the short, medium and longer term.

25. This short paper does not intend to cover the detailed evidence but instead highlights PHE's *Reducing health inequalities: system, scale and sustainability*[16] which provides an extensive review of the evidence and tools available.

Conclusion

26. Overall, while there has been fairly good investment in Slough to tackle the deeply entrenched issue of health inequalities and there has been some improvement in health outcomes, the health inequality gap between most wards in the borough and their more affluent neighbours in the ICS has barely changed, and perhaps, even slightly worsened.[17]

27. This suggests that we cannot continue to do things the same way if we want to see a step-change in closing the gap in health outcomes across both Slough and the ICS. Some of this step-change will require a change in culture and explicit decisions about how we work with residents.

28. However, in addition, there are very tangible actions that will need to be driven at pace and scale. This includes relatively greater investment in health and care spending in the more deprived wards in Slough and other areas or population groups with greater need – Marmot's 'proportionate universalism'.

Recommendations

29. Based on key elements of PHE's *Reducing health inequalities: system, scale and sustainability,* Slough Wellbeing Board in collaboration with its Frimley ICS partners, should consider the following:

A. Building understanding and planning change

1) Request access to population health data that matches the ICS footprint from PHE

A huge amount of data exists which provides information across the service user's journey, including for example, information on health and social care service usage and health and wellbeing outcomes. At present, the IT system *Connected Care* is still gathering momentum across the patch and in addition, access to data remains fragmented over different geographical

[16] Reducing health inequalities: system, scale and sustainability . PHE. 2017. Available at: https://www.gov.uk/government/publications/reducing-health-inequalities-in-local-areas

[17] PHE SE (Don Sinclair's slide set) 2018. (Awaiting publication)

levels, analytical teams and limited by various information governance issues. To support a better understanding and monitoring of health inequalities, an early recommendation/request to PHE would be to start presenting data wherever available at the ICS footprint geographical level while still maintaining sufficient granularity to at least ward level.

2) Improve understanding of residents and empower them

a. **Improve understanding of residents and the opportunities and challenges for better health and wellbeing**

In addition to service-related resident engagement, it would be valuable to conduct qualitative work to better understand how residents, particularly those experiencing health inequalities, consider their health and wellbeing and the factors (including use of health services) that affect it. Given the changing demographic in many areas of socioeconomic deprivation, both in Slough and other areas within the Frimley ICS, this should take into consideration important pyscho-social and cultural issues such as health beliefs, health literacy[18,19] and 'superdiversity'[20].

Any qualitative work should be solution-focused with a very practical view on how findings can be rapidly used to improve health and wellbeing eg using behavioural insights such as social marketing to increase uptake of preventive or selfcare-related health care and public health services.

b. Further develop co-production of services

Work more consistently with residents to design and produce services – both to improve the quality and effectiveness of services but also, because it helps empower residents and tackle health inequalities[21].

3) Develop strategy for tackling health inequalities at the appropriate level of action

The initial priority for both Slough Wellbeing Board and Frimley ICS should be on coming to a shared understanding of local health inequalities and in particular, the impact of the wider determinants of health.

Working with residents, we should develop strategy to tackle health inequalities in Slough and the other deprived areas of the ICS, addressing the wider determinants of health, and agreeing the level at which is most effective to act. Through stakeholder engagement, we will need to tease out what issues lend themselves to being dealt with at the ICS level in a "do once and share" approach vs what is best dealt with locally.

---

[18] 'Health literacy' refers to people having the appropriate skills, knowledge, understanding and confidence to access, understand, evaluate, use and navigate health and social care information and services. (PHE 2015)

[19] Improving health literacy to improve health inequalities. PHE. 2015. Available at: https://www.gov.uk/government/publications/local-action-on-health-inequalities-improving-health-literacy

[20] 'Superdiversity' encompasses the varied patterns of transnational migration, legal statuses, countries of origin, socio-economic statuses, linguistic abilities, cultural and ethnic factors that amalgamate to influence the health and health behaviours of people. (Vertovec 2006).

[21] Co-production catalogue. NESTA. 2013. Available at: https://www.nesta.org.uk/report/co-production-catalogue/

B. Interventions: Individual, Community and Locality levels of action

4) Further develop interventions at an individual level that tackle health inequalities

a. **Scale up provision of individual interventions** (such as developing through the 'Reducing Clinical Variation' workstreams).
For example:

i. **Close the prevalence gap of conditions** with a significant social gradient that drive the burden of ill health in more deprived geographical areas and 'at risk' groups including people with severe mental illness, learning disability and travellers. In particular, these include earlier identification of conditions such as undiagnosed hypertension, depression, COPD or diabetes. Poorly diagnosed conditions with a significant social gradient include learning and behavioural conditions and childhood asthma.

ii. **Scale up provision of healthy behaviour change** amongst the most socially deprived across Slough and the ICS – both in the 'well' population (primary prevention) and those already being treated by health and social care (secondary prevention). Residents at particular risk include people with mental health conditions and learning disability but each locality may have additional groups. Smoking, physical inactivity and obesity remain the most significant of these unhealthy behaviours.

iii. **Scale up provision of social prescribing** as a means of action at the individual 'patient level' to tackle the wider determinants of health.

b. **Scale up Making Every Contact Count (MECC)** (Already part of the Frimley ICS Prevention Workstream)
This supports professionals (including healthcare, social care and voluntary sector) to identify residents most in need of support to improve health and wellbeing and empowers the professional to have those 'healthy conversations'.

5) **Boost Asset-based Community Development** (already part of the ICS Prevention workstream)
Supported by PHE recommendations, this would empower communities from the 'inside out' and support the shift towards greater self-management and in line with Adult Social Care 'strengths-based conversations'.

6) Tackle prioritised wider determinants of health based on the JSNA
It would be helpful to map current work to address wider determinants (recognising that a good deal of this sort of activity is already done by SBC and other local authorities) to identify and prioritise specific gaps and opportunities for joint action with Wellbeing Board and/or ICS partners. Other key players in tackling wider determinants of health include the voluntary and community sector (VCS) as recognised by the Institute for Health Equity and summarised in their related review[22].) Potential and current areas of action for members of the Slough Wellbeing Board are outlined in Table 1 below.

[22] Voluntary sector action on the social determinants of health: evidence review. IHE. 2017. Available at: http://www.instituteofhealthequity.org/resources-reports/voluntary-sector-action-on-the-social-determinants-of-health

Table 1: Key areas of wider determinants of health and how Slough Wellbeing Board members could or already act

Wider determinants of health: **Key areas**	**Potential areas where Slough Wellbeing Board partners could or already act to tackle wider determinants**		
	SBC	**NHS**	**Other Board Partners including VCS, Local Business and other Public Sector**
Sustainable ecosystem	Climate change strategies, recycling, planning and development	Climate change strategies (eg transport and travel policies, procurement), recycling	Climate change strategies, recycling,
Natural environment	Green spaces, parks, air quality and sustainable development	Air quality and sustainable development	Green space volunteering
Built environment	Cycle routes, speed limits, housing, building controls	NHS Estates (planning and development)	Housing (private landlords)
Activities	Benefits advice, homelessness support, play provision, school programmes,	In-house advice on benefits and housing	Youth work provision, play provision
Local economy	Regeneration, business grants, social enterprise, JobCentre Plus collaboration, geographically-appropriate 'living wage' (including supply-chain)	NHS job provision, in-job training and apprenticeships, geographically-appropriate 'living wage' (including supply-chain)	Private sector job provision, work readiness schemes, social enterprise, geographically-appropriate 'living wage' (including supply-chain)
Community	Community development, youth groups, volunteering,	Co-production of services, social prescribing, patient participation groups	Community and voluntary sector groups, volunteering
Lifestyle	Leisure, libraries, licencing, workplace health, other Healthy settings[23] (including Healthy Early Years and Healthy Schools)	Workplace health (which includes 'Healthy Hospital')	Workplace health

Source: Adapted from Wider Determinants of Health: Local Authority Framework. 2017 (Dr Rachel Gill, Consultant in Public Health, Surrey County Council)

[23] 'Healthy Settings' involve a holistic and multi-disciplinary method which integrates action across risk factors. The goal is to maximize disease prevention via a "whole system" approach. (World Health Organisation – Ottawa Charter 1986).