Nottinghamshire County Council

Report to Health and Wellbeing Board

02 September 2015

Agenda Item: 7

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

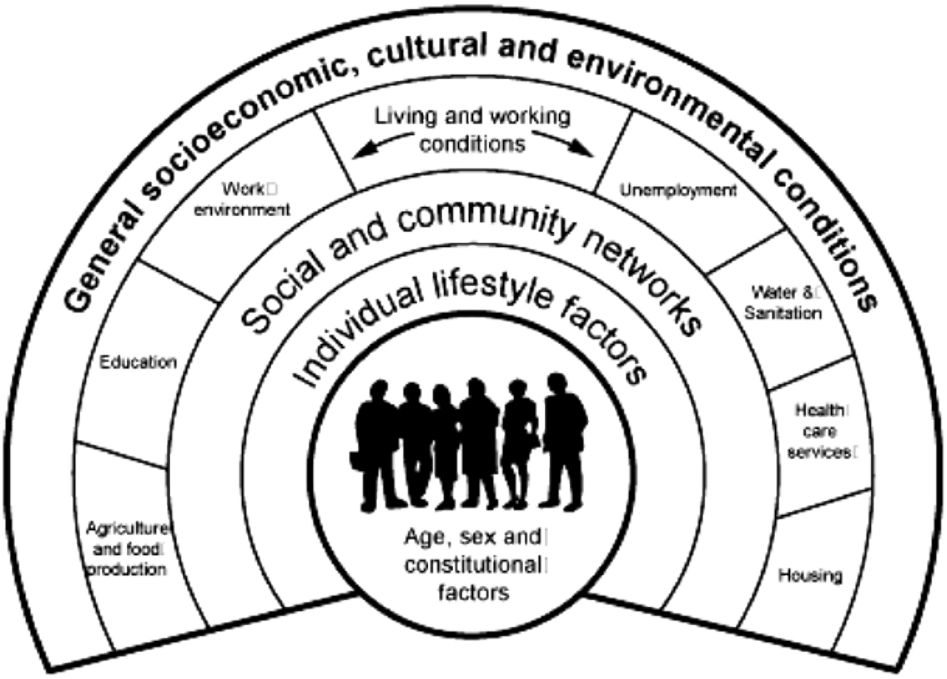
HEALTH INEQUALITIES

Purpose of the Report

1. This report sets out the current state of health inequalities in Nottinghamshire, to update the Board on Life Expectancy, and to set a baseline for Healthy Life Expectancy. It shows trends and provides benchmarks against the national averages. It describes the main underlying factors that contribute to health inequalities in Nottinghamshire County and actions being taken to address these, and it proposes areas where more effort is required. The Health and Wellbeing Board is requested:
   a. To continue support for programmes and initiatives which are already addressing the main contributors to inequalities in life expectancy and in healthy life expectancy. It is especially important to sustain these in times of austerity.
   b. To commit to driving up the quality of primary care through co-commissioning and for each Board member representing a CCG to endorse the development of a CCG strategy for improving the quality of primary care with Key Performance Indicators to demonstrate progress.
   c. To work in partnership to address hotspots where contributing factors to health inequalities intersect, geographically or within population cohorts.
   d. To embed consideration of impact on health equality within service commissioning, transformation and redesign, using the local Health Inequalities Framework.
   e. To hold a Health and Wellbeing Board workshop to agree priorities for improving Health Inequalities and develop multiagency action plans to address the leading causes of Health Inequalities, as an integral part of the Nottinghamshire Health & Wellbeing Strategy..

Information and Advice

2. Health Inequalities is a huge and complex topic within the area of population health and wellbeing. There are multiple determinants of health and wellbeing, all of which can contribute to health inequalities. One way of looking at Health Inequalities might be to review equality of access to the services that support health and wellbeing. However, this risks being overly simplistic, as many of the determinants and causes of inequalities overlap and interact. The diagram below represents the main groups of factors that determine health and wellbeing for individuals and populations.



3. This report will focus on the factors that have the greatest overall impact on health inequalities. It will summarise the authoritative evidence of what causes health inequalities and what needs to be done to address them at national and local levels, and it will provide a picture of Health Inequalities within Nottinghamshire, comparing the local picture with national data, where available, using two overarching indicators: Life Expectancy and Health Life Expectancy.

4. In November 2008, Professor Sir Michael Marmot was asked to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England. His report "Fair Society, Healthy Lives" centred on the themes of: social justice, the social gradient in health and health inequalities, fairness, economic context, social inequalities and climate change. The costs of inequalities were explained in terms of years of life lost, years of healthy life lost and economic costs.

5. Marmot concluded that reducing health inequalities would require action on six policy objectives (see table below) and that delivering these policy objectives would require action by central and local government, the NHS, the third and private sectors and community groups. The Marmot review identified that strategies to address health inequalities needed to tackle health risks (smoking, alcohol, obesity and drug use) and social determinants (early years, education, work, income and communities).

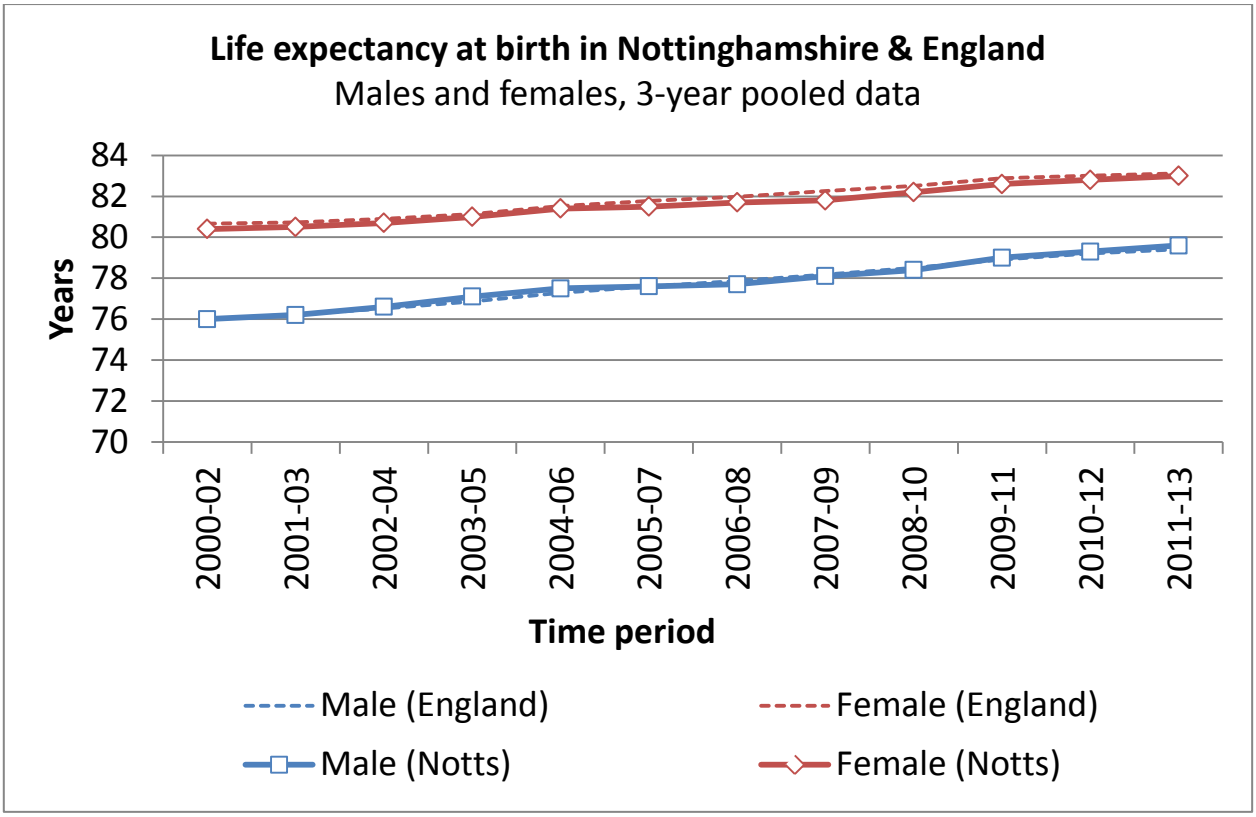
6. The Health and Wellbeing Board is therefore well placed to engage in participatory decision-making at local level to ensure that there are effective local delivery systems focused on health equity in all policies.

Marmot objective	Determinants	Local lead
i. Give every child the best start in life	Smoking in pregnancy Breastfeeding	Nottinghamshire County Council Nottinghamshire County Council
ii. Enable all children, young people and adults to maximise their capabilities and have control over their lives	Education	Nottinghamshire County Council
iii. Create fair employment and good work for all	Employment Living wage	Local Enterprise Partnership All members as employers and as advocates at national level
iv. Ensure healthy standard of living for all	Employment Living wage Housing, Planning	Local Enterprise Partnership HWB members as employers and as advocates at national level District & Borough Councils
v. Create and develop healthy and sustainable places and communities	Community Engagement Access to leisure facilities and green spaces	District & Borough Councils
vi. Strengthen the role and impact of ill health prevention	Access to and quality of primary care Healthy Lifestyles	Clinical Commissioning Groups Local Enterprise Partnership

Life Expectancy

7. Life Expectancy (LE) is the length of time that, on average, a new-born baby can expect to live. It has a slight bias towards earlier/younger deaths. Many factors determine LE, and significant variations are found based on sex, ethnicity and socio-economic status.

8. There is a 3.4 year difference in LE in Nottinghamshire between males (79.6 years) and females (83 years). Over time the LE gap between the sexes is decreasing, as male LE is improving faster than female LE, from a 4.4 year gap in 2000-02 to a 3.4 year gap in 2011-13.



Source: Public Health Outcomes Framework Data tool, Public Health England. Accessed April 2015

The table below summarises the main LE indicators, and these are shown in detailed charts in Appendix 1.

Indicator		Value (years)	Time period	Local trend	Benchmark to England
Gender gap in LE, Notts average		3.4, Female – Male	2011-13	Decreasing	Below (better)
LE gap by district	Females	2.7, Rushcliffe – Mansfield	2011-13	Increasing	0.1yrs below (better)
	Males	3.2, Rushcliffe – Ashfield			
LE change over time by district, greatest / least improved	Females	3.0, Ashfield / 2.2, Mansfield ie female LE has improved least over time in Ashfield and most in Mansfield	2000-13	Increasing	0.2yrs above (better)
	Males	4.4, Broxtowe / 2.9, Gedling ie male LE has improved least over time in Ashfield and most in Mansfield			
LE gap by MSOA	Females	12.4, Rushcliffe – Bassetlaw	2008-12	Not available	Local area indicator – national benchmark not applicable
	Males	11.2, Ashfield – Rushcliffe			
LE gap by deprivation	Females	7.8, Notts least – most deprived	2006-10	Not available	Local area indicator –
	Males	8.8, Notts least – most deprived			

quintile					national benchmark not applicable

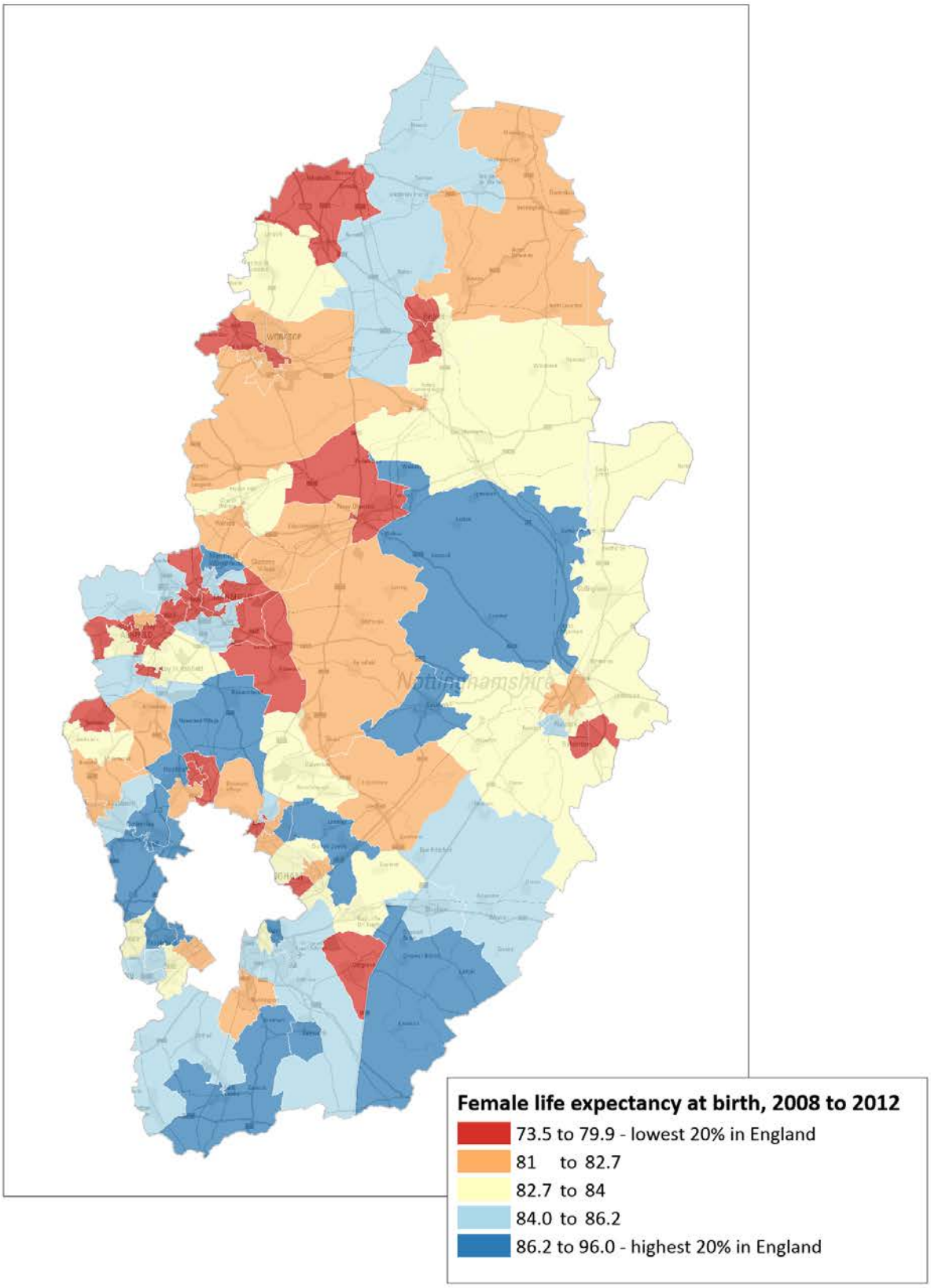
9. The gap in LE between males and females has remained consistently below and better than the national average. This gender gap was 4.7 years in England and 4.4 years in Nottinghamshire in 2000-2002 and by 2011-2013 it had decreased to 3.7 years in England and 3.4 years in Nottinghamshire.

10. LE is increasing over time in all districts. The geographical variation in LE across Nottinghamshire is shown in Appendix 1. LE is greatest in Rushcliffe (84.1 years for females and 80.8 for males), and least in Mansfield (81.3 years for females) and Ashfield (77.6 years for males). The gap in LE between the best and worst districts is staying the same for females and reducing slightly for males.

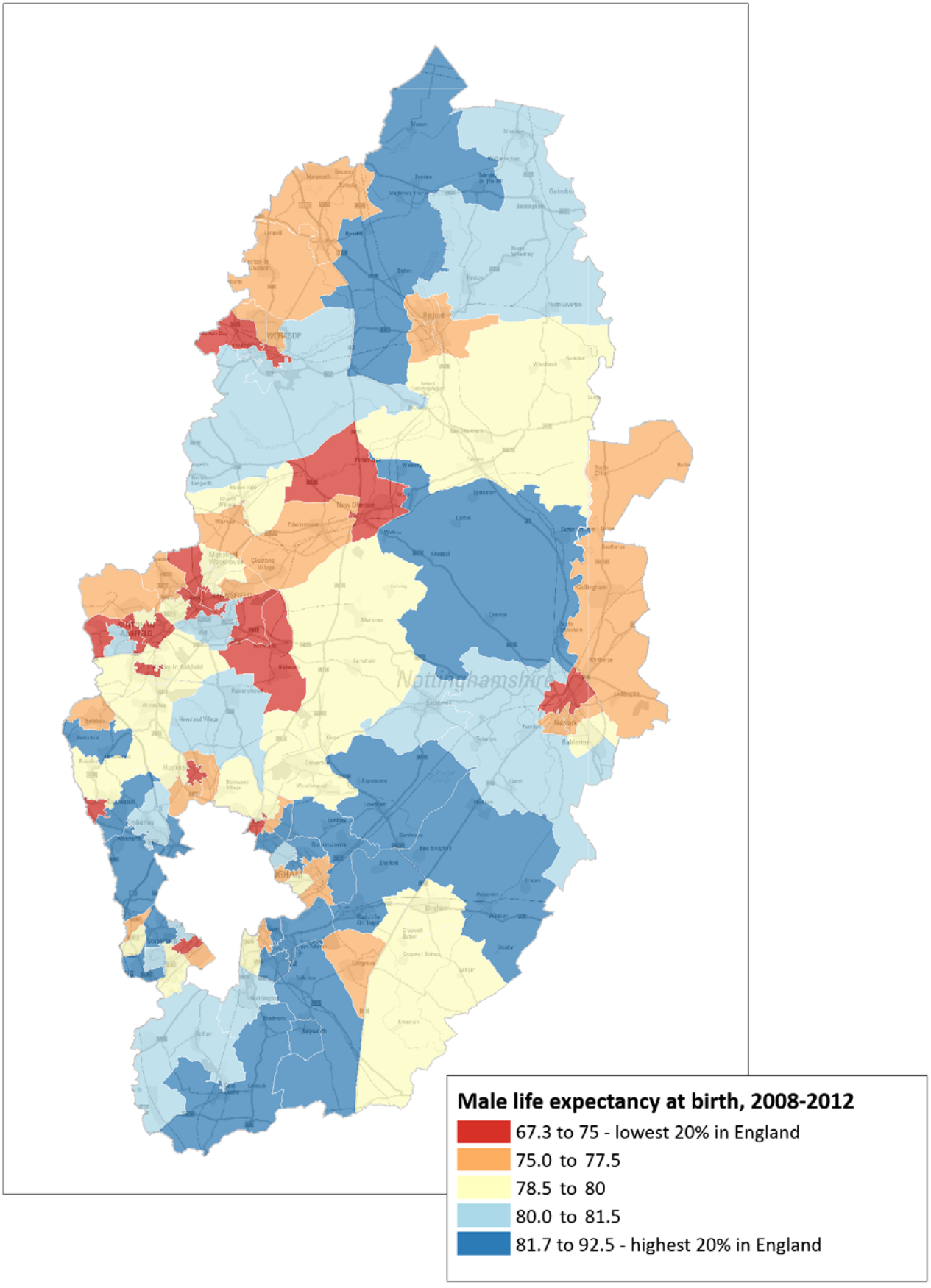
11. Bigger geographical differences in LE are seen at the level of Middle Super Output Areas (MSOAs, areas of between 5,000 and 15,000 people or 2,000and 6,000 households). For the period 2008-12, the difference in female LE between the best and worst MSOAs was 11.2 years, and in male LE the difference was 12.4 years.

12. Some of the differences in LE between groups of different ethnicities are due to genetic predisposition but this only accounts for a small fraction. Where variation is seen, this is therefore for the most part unwarranted. However, data are not available on the differences in LE between people of different ethnicities in Nottinghamshire because ethnicity is not recorded on death certificates.

13. The difference in LE between the most and least deprived deciles is 7.8 years for females and 8.8 years for males. The maps on the next two pages show where the “hotspots” are, with the areas with the lowest LE showing as dark red and the areas with the highest LE showing as dark blue. The boundaries show MSOAs. This closely follows patterns of deprivation and is unwarranted variation.

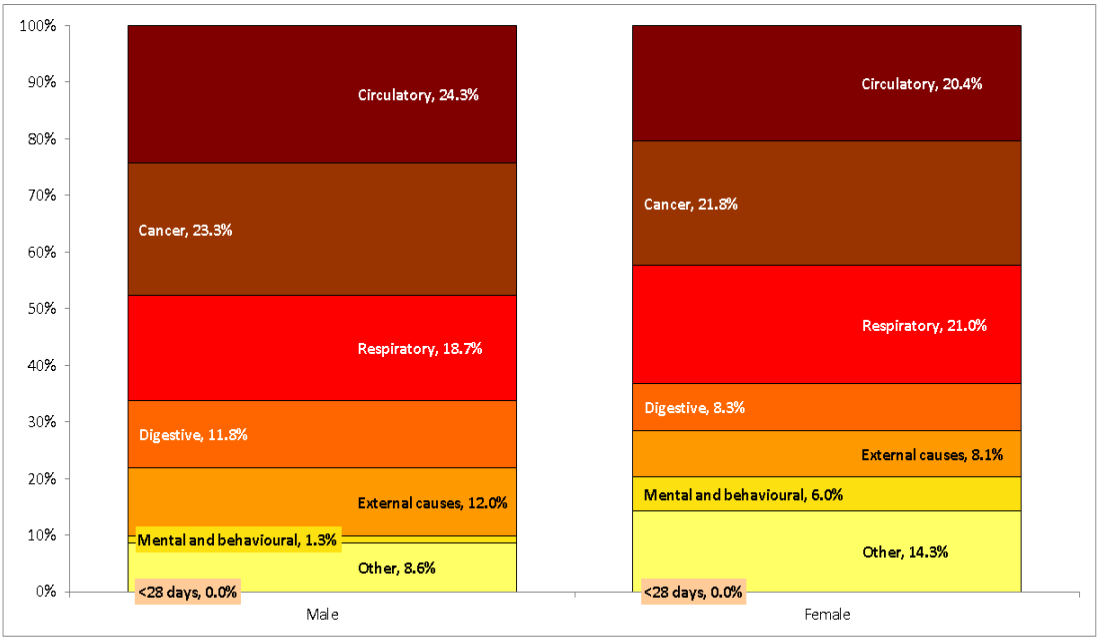

Female life expectancy at birth, 2008 to 2012
73.5 to 79.9 - lowest 20% in England
81 to 82.7
82.7 to 84
84.0 to 86.2
86.2 to 96.0 - highest 20% in England

14.


Male life expectancy at birth, 2008-2012
67.3 to 75 - lowest 20% in England
75.0 to 77.5
78.5 to 80
80.0 to 81.5
81.7 to 92.5 - highest 20% in England

15. The main contributors to the LE gap between males and females in Nottinghamshire are cardiovascular disease (CVD), cancer and respiratory disease. These three disease groups together account for 3.77 years of LE lost in males and 3.07 years lost in females, between the most and least deprived quintiles in Nottinghamshire i.e. between approx. 60-65% of the total difference.

Breakdown of the life expectancy gap between most and least deprived quintiles in Nottinghamshire, by broad cause of death, 2010-2012

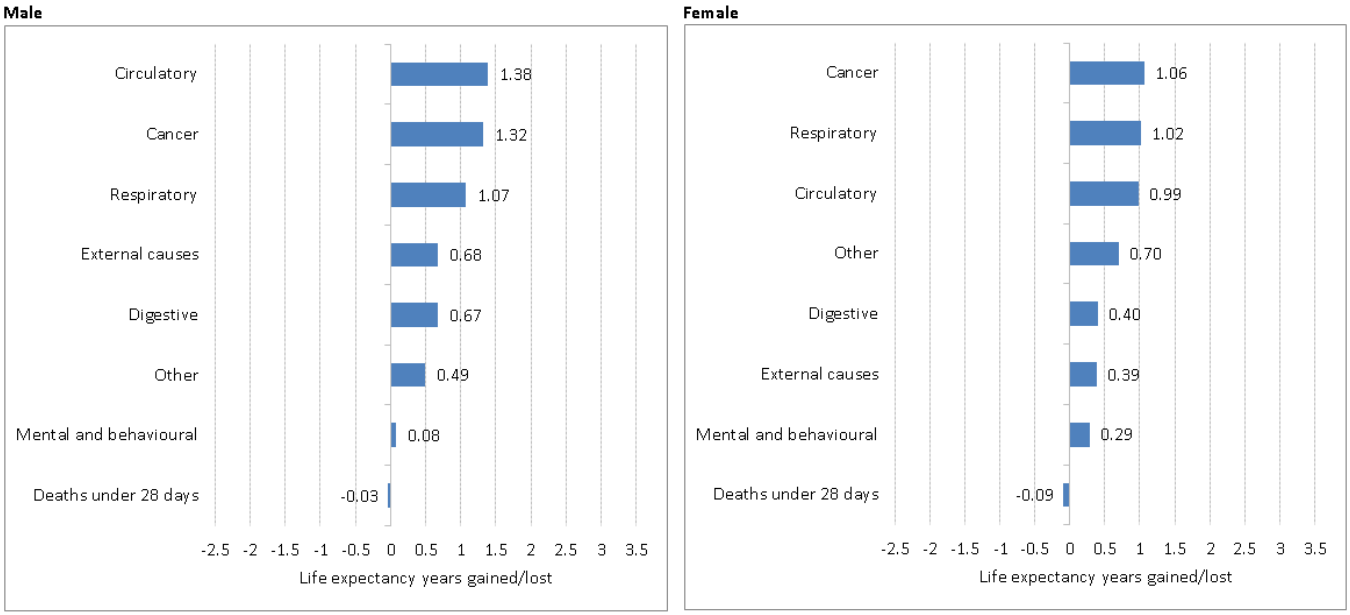


Footnote: Circulatory diseases includes coronary heart disease and stroke. Digestive diseases includes alcohol-related conditions such as chronic liver disease and cirrhosis. External causes include deaths from injury, poisoning and suicide.

Table showing the breakdown of the life expectancy gap between Nottinghamshire most deprived quintile and Nottinghamshire least deprived quintile, by broad cause of death, 2010-2012

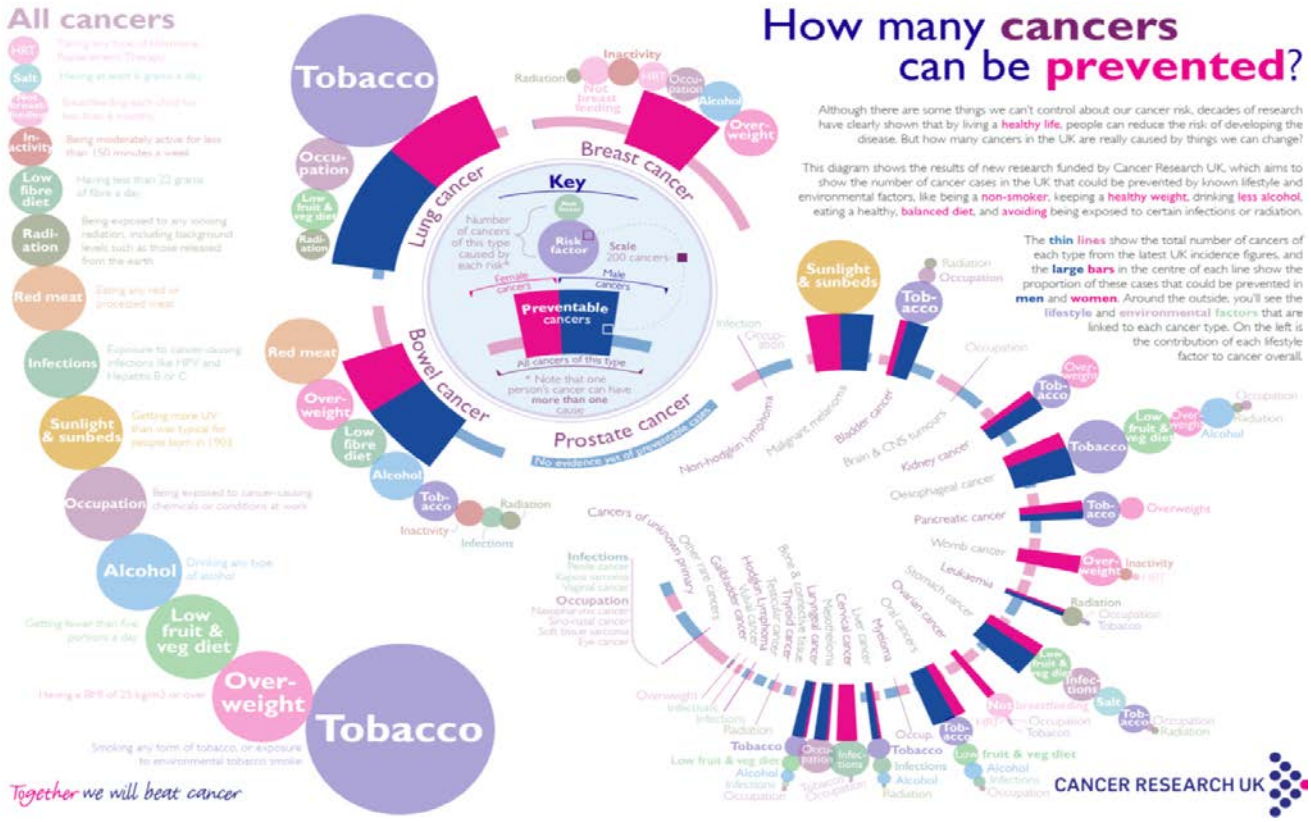
16. The charts below show how many years of life would be gained if the most deprived quintile in Nottinghamshire had the same mortality rates as the least deprived, for each of these contributors.

Life expectancy years gained or lost, by broad cause of death, 2010-2012



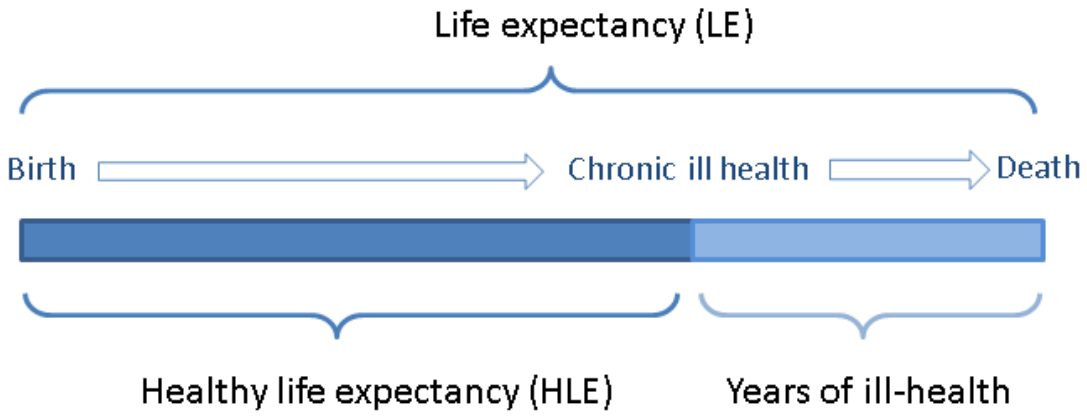
Footnote: Circulatory diseases includes coronary heart disease and stroke. Digestive diseases includes alcohol-related conditions such as chronic liver disease and cirrhosis. External causes include deaths from injury, poisoning and suicide

17. The main modifiable risk factor underpinning CVD, cancer and respiratory disease is tobacco use. This is illustrated in the cancer prevention chart below, in which tobacco is seen to be the single greatest contributor to cancer overall. Indeed research suggests tobacco explains half the difference in the LE gap. Alcohol and obesity can also be seen to feature prominently in many types of cancer, as they do for CVD.



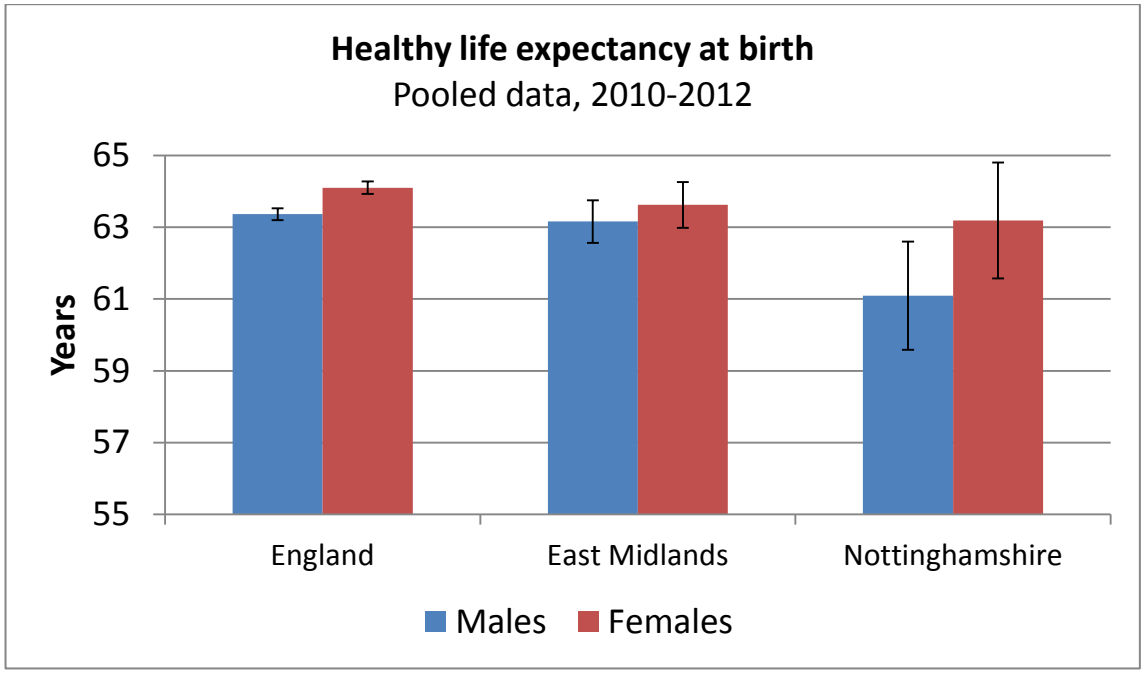
Healthy Life Expectancy

18. Healthy Life Expectancy (HLE) is an indicator that has not been reported in Nottinghamshire before. This report therefore sets a baseline for this measure. HLE is a measure of the average number of years a person would expect to live in good health based on current mortality rates and prevalence of self-reported good health. (Health-Adjusted Life Expectancy, Disability-Adjusted and Disability-Free Life Expectancy are similar measures but the methodology differs for each).



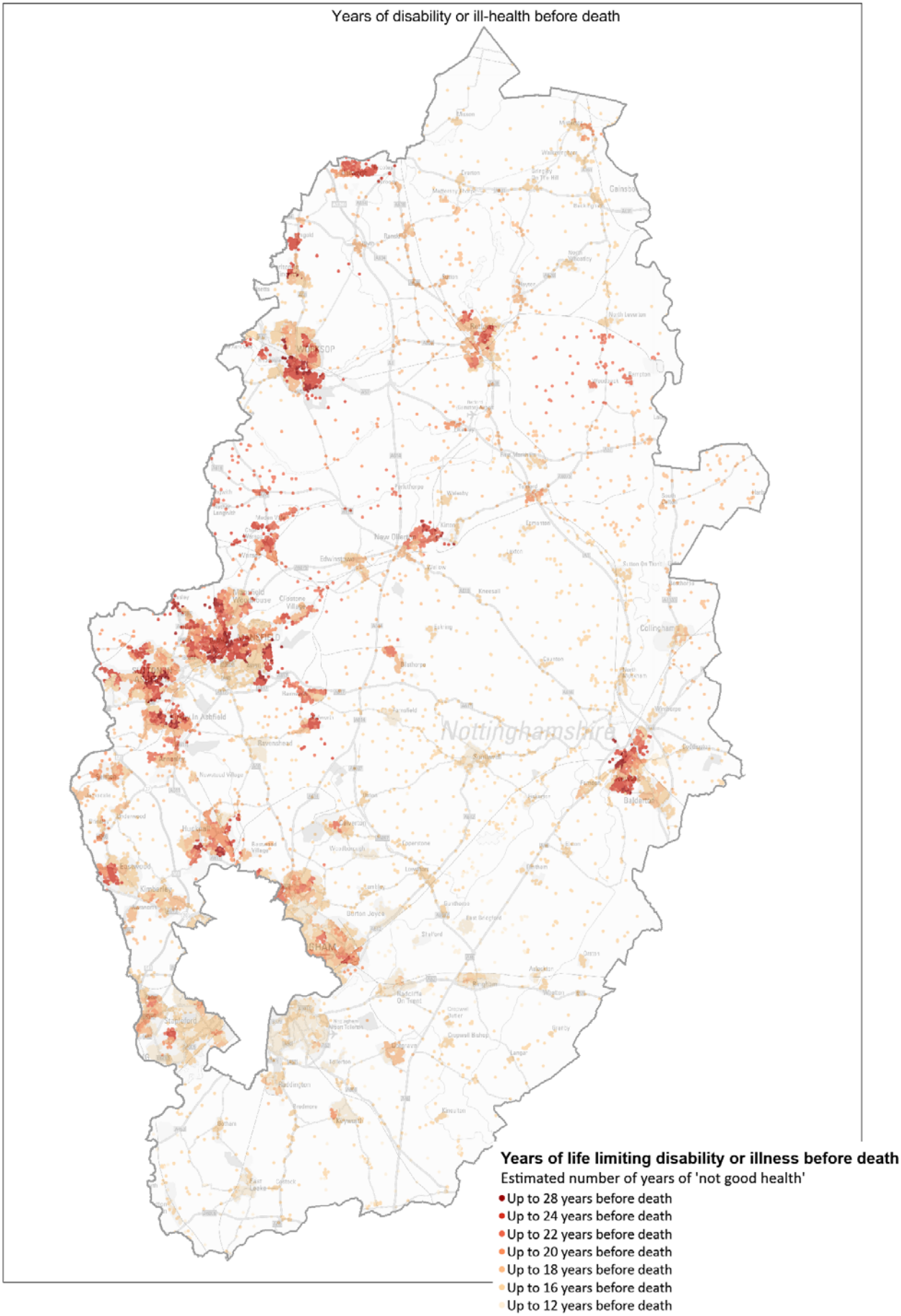
19. Many of the underlying factors and actions being taken to address HLE are the same as for LE, but some are different. For example Macmillan recently reported that for the first time as many people survive cancer as die from it, and so cancer survivorship has a greater impact on HLE than ever before due to the long term consequences of treatment such as lymphoedema, chronic fatigue, anxiety, pain, incontinence (National Cancer Survivorship Initiative).

20. It can be seen from the chart below that Nottinghamshire has a statistically significant worse HLE than the national average for males and, notwithstanding the wide confidence intervals, may have a worse HLE than the regional and national averages for both males and females.



Source: Marmot Indicators 2014, PHE London Knowledge & Intelligence Team

21. The map below shows the geographical variation in HLE, clearly demonstrating the "hotspots" where people are living longer with ill health. This closely resembles the LE maps presented in section 12, but this HLE map has greater granularity and identifies "hotspots" at the level of discrete estates, which could inform a multi-agency workshop to plan very targeted and specific action. See Appendix 1 for street level example.


Years of disability or ill-health before death
Nottinghamshire
Years of life limiting disability or illness before death
Estimated number of years of 'not good health'
Up to 28 years before death
Up to 24 years before death
Up to 22 years before death
Up to 20 years before death
Up to 18 years before death
Up to 16 years before death
Up to 12 years before death

22. The main contributors to poor HLE overlap with those for poor LE, however there are some conditions that do not significantly affect overall length of life but that contribute significantly to chronic ill-health, such as mental health disorders, injuries and musculoskeletal diseases. Local data are not available, however the Global Burden of Disease lists the greatest number of years lost to disability in the Western European Region as resulting from:

Years of healthy life lost due to disability (YLDs), 2010

Cause, by main group	Proportion of YLDs	Largest subset(s)
Musculoskeletal disorders	30.6%	22.5% low back / neck pain
Mental and behavioural disorders	14.1%	7.8% major depressive 3.6% anxiety disorders
Respiratory	5.6%	2.7% chronic obstructive pulmonary disease 2.2% asthma
Cardiovascular disease	5.6%	1.8% ischaemic heart disease 1.1% stroke
Falls	5.4%	N/A
Substance misuse	3.9%	1.7% alcohol 1.1% opioids
Injuries	3.4%	2.3% pedestrian / transport
Diabetes	2.9%	N/A
Migraine	2.9%	N/A
Cancers	2.7%	1.7% benign prostatic hyperplasia 0.3% breast cancer
Alzheimer's	2.5%	N/A
Neurological conditions	1.4%	0.6% epilepsy
Digestive diseases	1.1%	0.4% inflammatory bowel disease

Source: WHO Global Burden of Disease, accessed July 2015

ACTION

23. For any geographical area or population group there is no simple root cause of health inequalities but where underlying factors and causes intersect, this leads to "hotspots" and creates sharp gradients of health inequality that merit concerted action at a locality level by individual partners, multi-agency partnerships and / or by the Health and Wellbeing Board as a whole. There is always more that could be done. Areas of work that have the greatest potential to yield results would aim to:
    - Eliminate unwarranted variation in medical and clinical outcomes between primary care practices
    - Embed action to address health inequalities across all areas of the Health and Wellbeing Strategy
    - Ensure that area-based initiatives include actions to address the main underlying causes of health inequalities.

24. There is a role for all members of the Health and Wellbeing Board within these broad areas of work, but some are clearly better placed to lead on particular strands of work, and some areas of existing work warrant greater effort (see table below, showing areas where there is robust evidence to support improvements in LE – these will also have an impact on HLE).

Pregnancy / Early Years	**Role: Local Authority**	**Role: Primary Care**	**More effort needed**
Good antenatal / Obstetric care	Less	More	
Smoking and Obesity in Pregnancy	Equal	Equal	✓
Reduce Teenage Pregnancy	More	Less	
Family Planning	Less	More	
Breast Feeding	Less	More	✓
Vaccination	Less	More	
Children and Young People	**Role: Local Authority**	**Role: Primary Care**	**More effort needed**
Educational Attainment	More	Less	✓
Prevent uptake of smoking	More	Less	✓
Childhood Obesity	More	Less	✓
Adults and Older People	**Role: Local Authority**	**Role: Primary Care**	**More effort needed**
NHS Health Checks	Less	More	✓
Lifestyle – Smoking	Equal	Equal	✓
Lifestyle – Exercise	More	Less	✓
Lifestyle – Diet	More	Less	✓
Lifestyle – Alcohol	More	Less	✓
Road Traffic Accidents	More	Less	
LTC Management / Pathways / Self Management	**Role: Local Authority**	**Role: Primary Care**	**More effort needed**
Cardiovascular Disease & Diabetes (inc reducing BP, HbAIc, Cholesterol, detect AF)	Less	More	✓
Respiratory Disease / COPD (inc detect, diagnosis, manage)	Less	More	✓
Employment /Environment	**Role: Local Authorities**	**Role: Primary Care**	**More effort needed**
Wellbeing at Work scheme	More	Less	✓
LA and NHS as good employers (Living Wage)	Equal	Equal	✓
Living Wage advocacy	More	Less	✓
Cancer Prevention	**Role: Local Authorities**	**Role: Primary Care**	**More effort needed**
Lifestyle – Smoking *	As above for Adults & Older People * 30% of cancer is due to smoking, and 30% is due to diet		
Lifestyle – Diet *			
Lifestyle - Alcohol			
Cancer Early Detection & Treatment	**Role: Local Authorities**	**Role: Primary Care**	**More effort needed**
Screening	Less	More	
Education	Less	More	ongoing; national

			campaigns
Early Referral	Less	More	?
Effective Treatment	Less	More, + secondary care	?

25. Areas of work can also be identified to address inequalities in HLE, but there is less known about the evidence base. There is evidence to support the following:
    - Musculoskeletal health – workplace ergonomic assessment and training, NICE guidance for the management of low back pain (equal roles for local authorities and primary care)
    - Mental Health - building resilience and social inclusion, access to treatment/talking therapies and parity of esteem in primary care identification and early intervention (equal roles for local authorities and primary care)
    - Housing and Planning – links between health and housing are well established but less known about what works best, other than fuel poverty and winter deaths.

26. Clearly there are too many areas of work where more effort is needed, to be able to do justice to them all at the same time, so it would be advisable for the Health and Wellbeing Board to agree its priorities. The Health Inequalities Framework (Appendix 2) and the accompanying toolkit currently under development would be useful to facilitate this, using a workshop format. Although this framework was developed to support health service commissioning, it takes a systematic approach that is transferable to Health and Wellbeing Board strategic action planning.

27. Two key publications argue that healthcare professionals have a role in addressing the social determinants of health as well as individual lifestyle behaviours. A British Medical Association (BMA) publication sets out, very briefly, some of the evidence and examples of actions that doctors can take to affect the social determinants of health and reduce the social gradient. A report from the Institute of Health Equity at University College London (UCL) draws on examples of excellent practice and describes areas where greater action is necessary, making some practical suggestions about how to take forward action on the social determinants of health. Best practice identifies that the gap in health outcomes can be reduced through strengthening quality and capacity of primary care, and more targeted and systematic use of approaches to prevention, early diagnosis, medical drug treatment and condition management. Some areas to consider are:
    - fit for purpose premises
    - accessibility (location, opening hours)
    - quality of care (case finding, pathway management, prescribing, exception reporting, reduction of clinical variation)
    - practice management, staffing and capacity
    - workforce education and training.

28. Examples of existing services and initiatives to address the main factors that contribute to LE and HLE variations in Nottinghamshire include:
    - Combined – Tobacco Declaration; Lifestyle services; Change 4 Life; Healthy Options Takeaway Scheme; Wellbeing at Work Scheme; Daybrook Connecting Communities Programme, Nottinghamshire Obesity Strategy

- CVD – NHS Health Check Programme; Abdominal Aortic Aneurysm Screening, Stroke awareness campaign (Act F.A.S.T.)
- Cancer – Cancer Screening, Be Clear on Cancer national media campaigns
- Respiratory disease – Air quality management areas, Flu and pneumococcal immunisation, COPD pathways
- Early years – Sure Start services located in areas of deprivation, Child immunisation, Healthy Schools, Educational psychology service / Inclusion support, Nottinghamshire Child Poverty Strategy
- Long term conditions – Multidisciplinary locality teams and integrated services; Patient education programmes; Diabetic Eye Screening; Rushcliffe Primary Care Best Practice Specification
- Mental Health – Nottinghamshire Mental Health Strategy.

Other Options Considered

29. Not applicable.

Reason for Recommendation

30. It has been shown that there are already robust programmes, strategies and actions in place to deal with the main contributing factors to health inequalities between groups within the Nottinghamshire population. However, there are areas of potential concern such as areas where more effort is required to make a real impact on inequalities; “hotspots” where contributing factors intersect, and potential gaps that may merit more detailed consideration by the Board in future, especially for the contributors to HLE.

Statutory and Policy Implications

31. This report has been compiled after consideration of implications in respect of crime and disorder, finance, human resources, human rights, the NHS Constitution (Public Health only), the public sector equality duty, safeguarding of children and vulnerable adults, service users, sustainability and the environment and ways of working and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

RECOMMENDATIONS

1) To continue support for programmes and initiatives which are already addressing the main contributors to inequalities in life expectancy and in healthy life expectancy. It is especially important to sustain these in times of austerity.
2) To commit to driving up the quality of primary care through co-commissioning and for each Board member representing a CCG to endorse the development of a CCG strategy for improving the quality of primary care with Key Performance Indicators to demonstrate progress.
3) To work in partnership to address hotspots where contributing factors to health inequalities intersect, geographically or within population cohorts.
4) To embed consideration of impact on health equality within service commissioning, transformation and redesign, using the local Health Inequalities framework.

5) To hold a HWB workshop to agree priorities for improving Health Inequalities and develop multiagency action plans to address the leading causes of Health Inequalities, as an integral part of the Nottinghamshire Health & Wellbeing Strategy.

Chris Kenny, Director of Public Health

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Constitutional Comments (SLB 31/07/2015)

32. The Health and Wellbeing Board is the appropriate body to consider the content of this report.

Financial Comments (DG 05/08/2015)

33. There are no financial implications in this report.

Background Papers and Published Documents

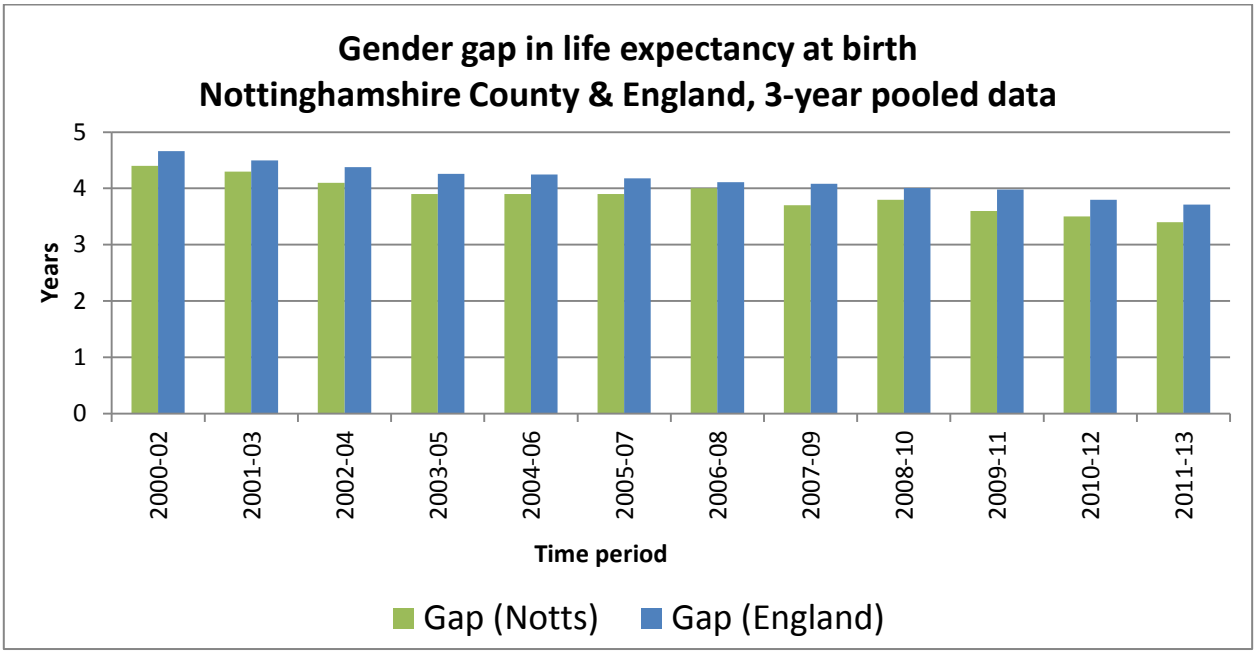
Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- None

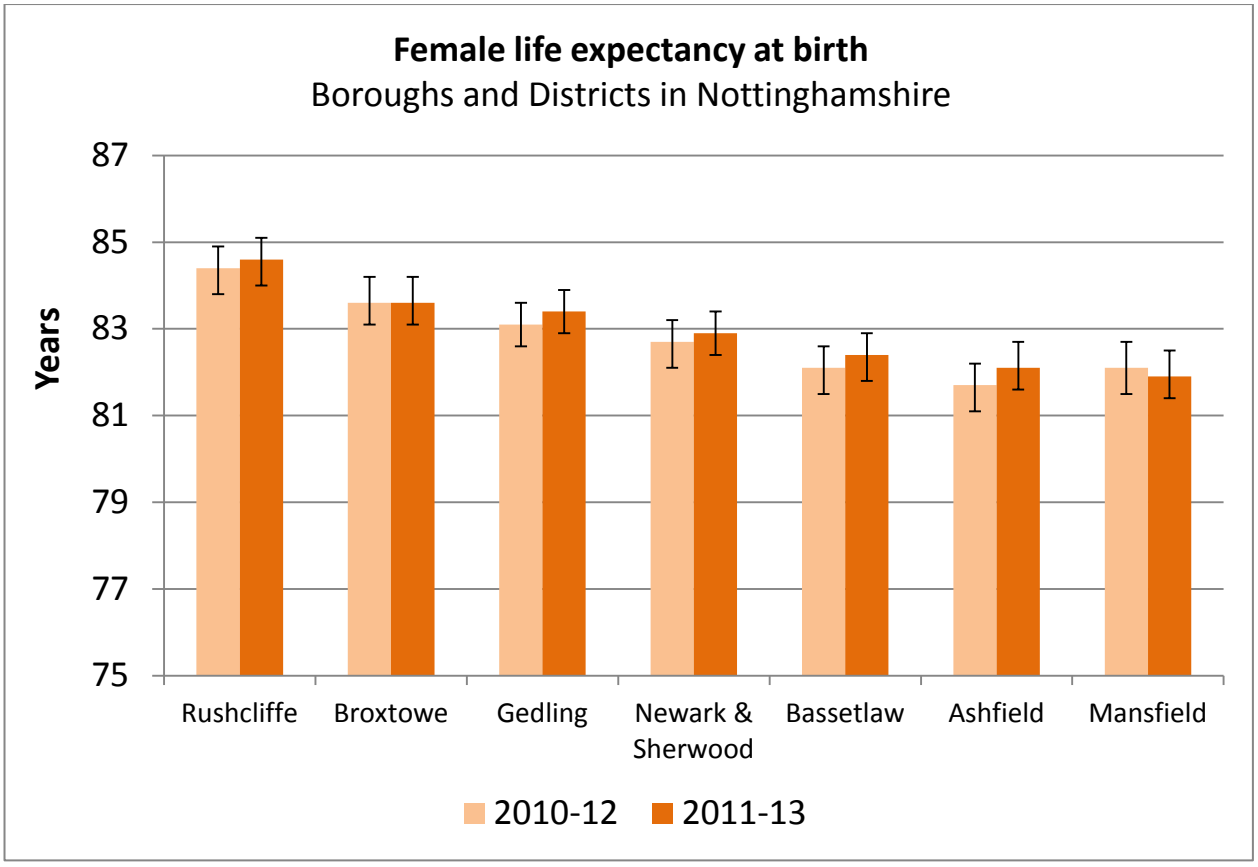
Electoral Divisions and Members Affected

- All

Appendix 1



Source: Public Health Outcomes Framework Data tool, Public Health England. Accessed April 2015



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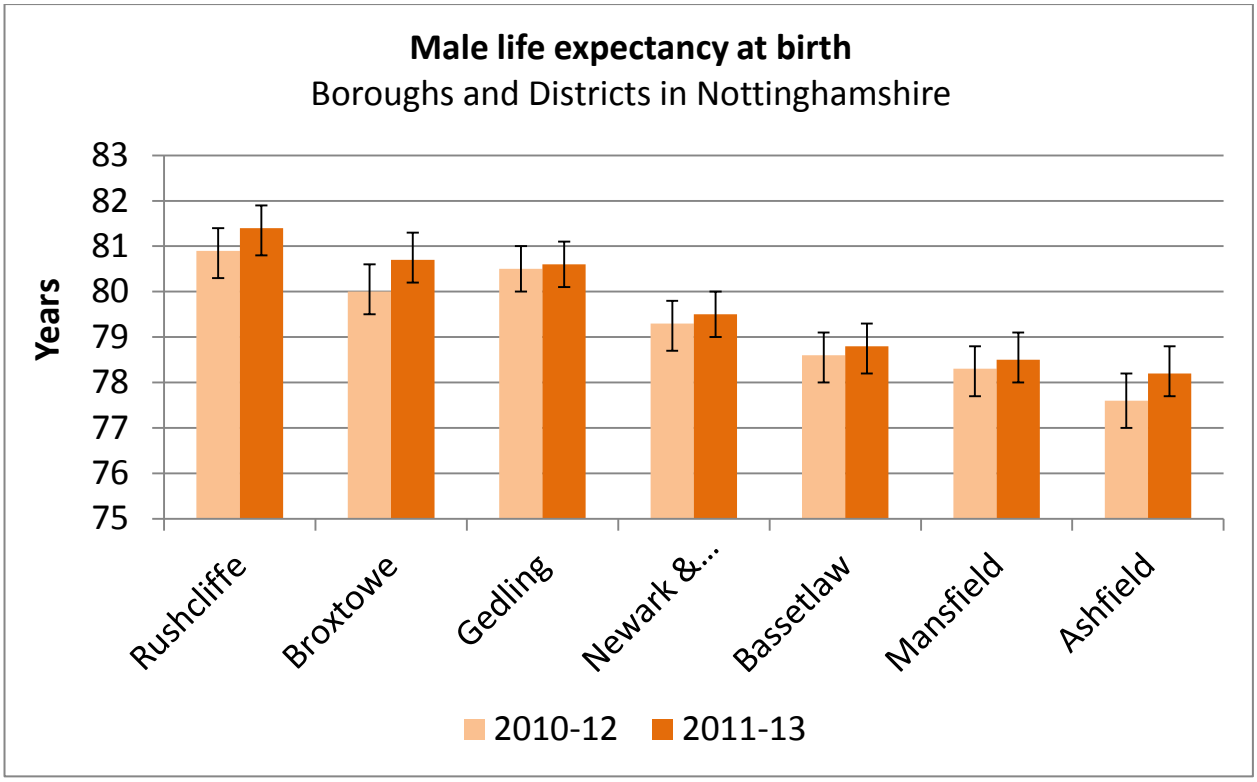

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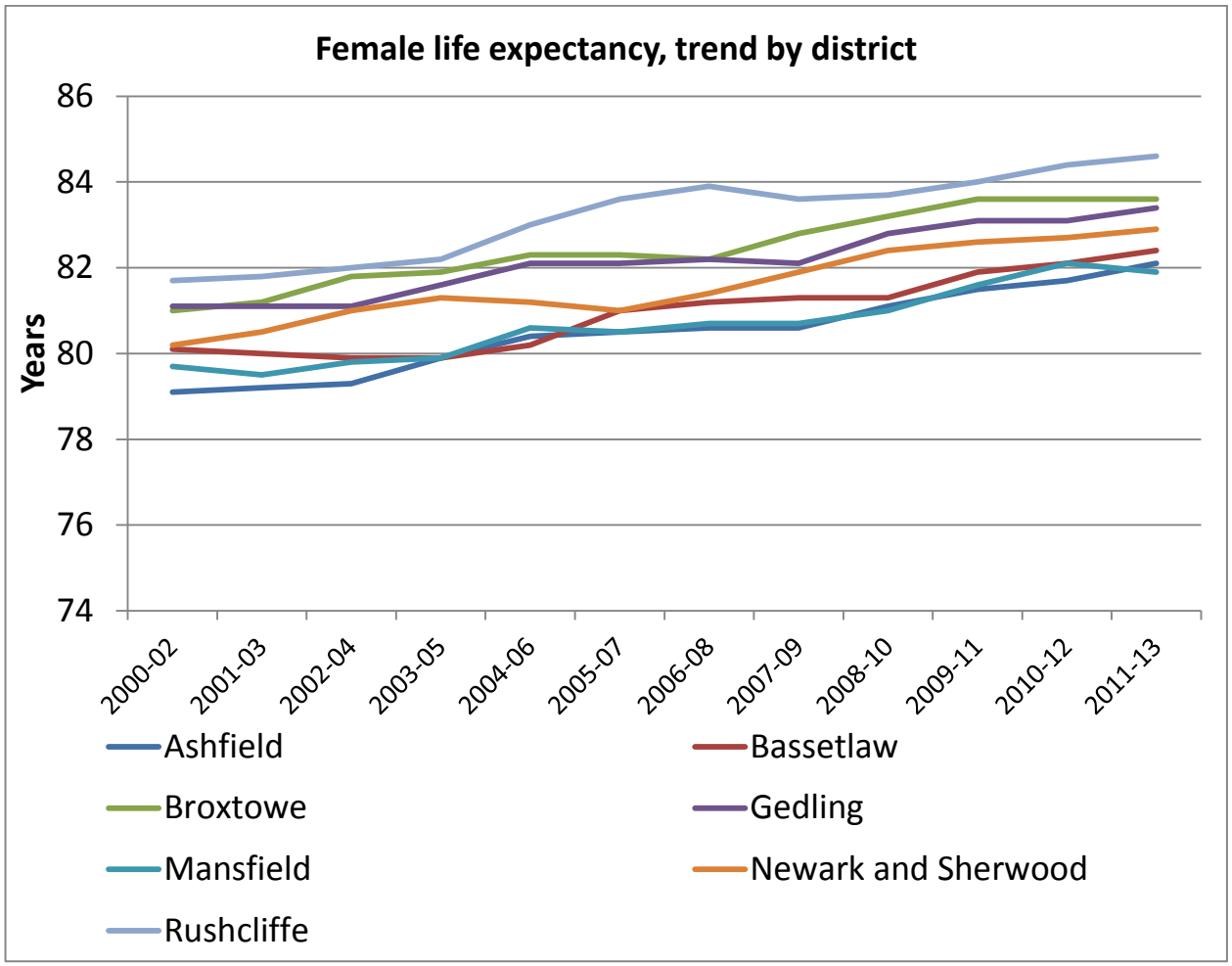

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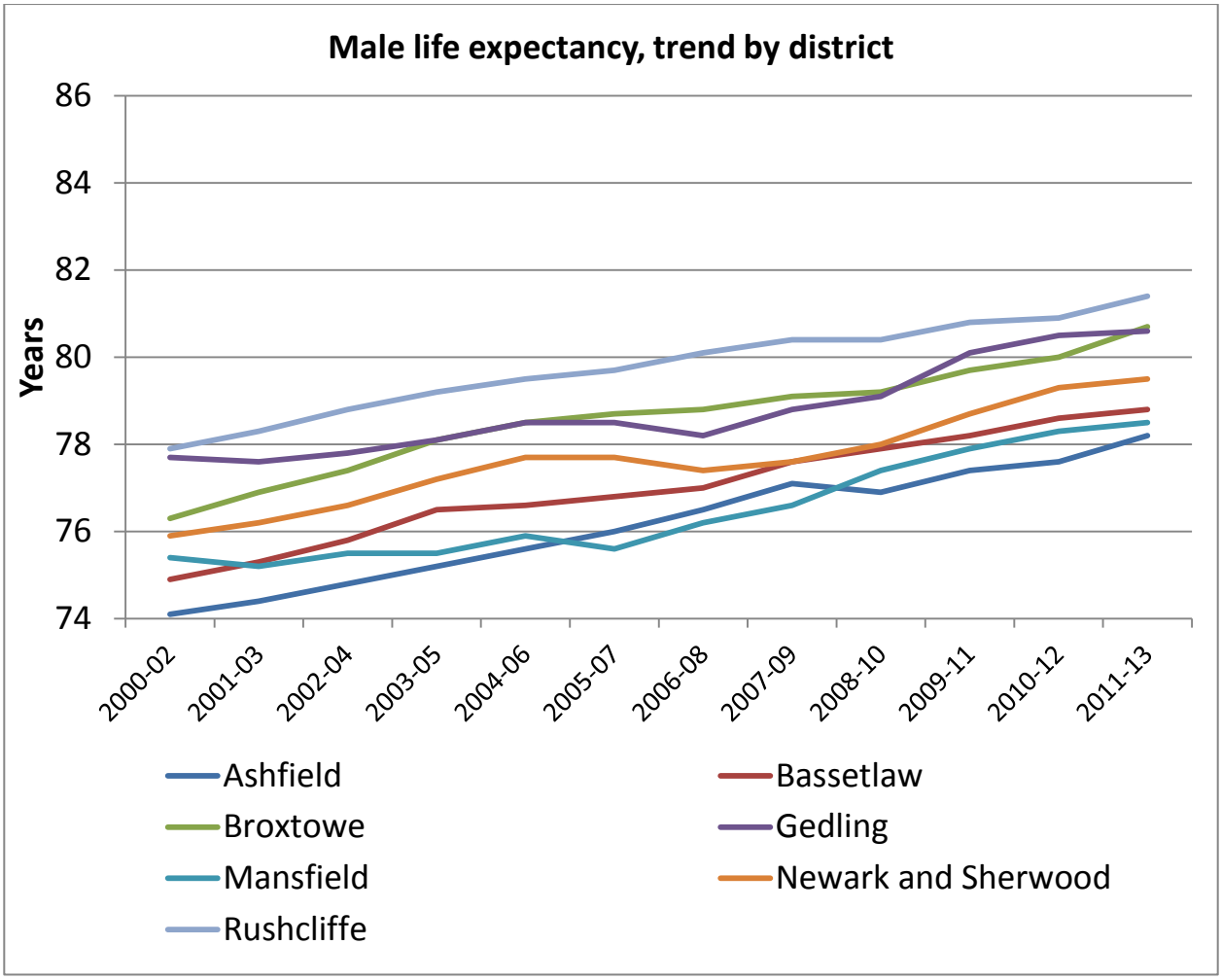

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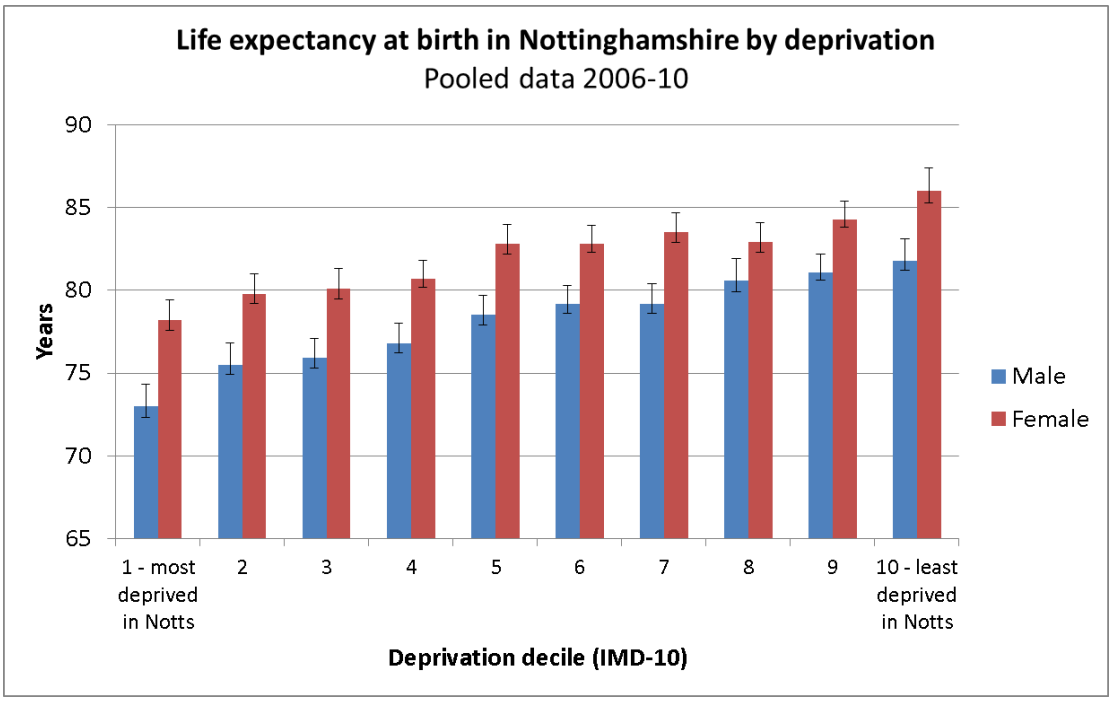
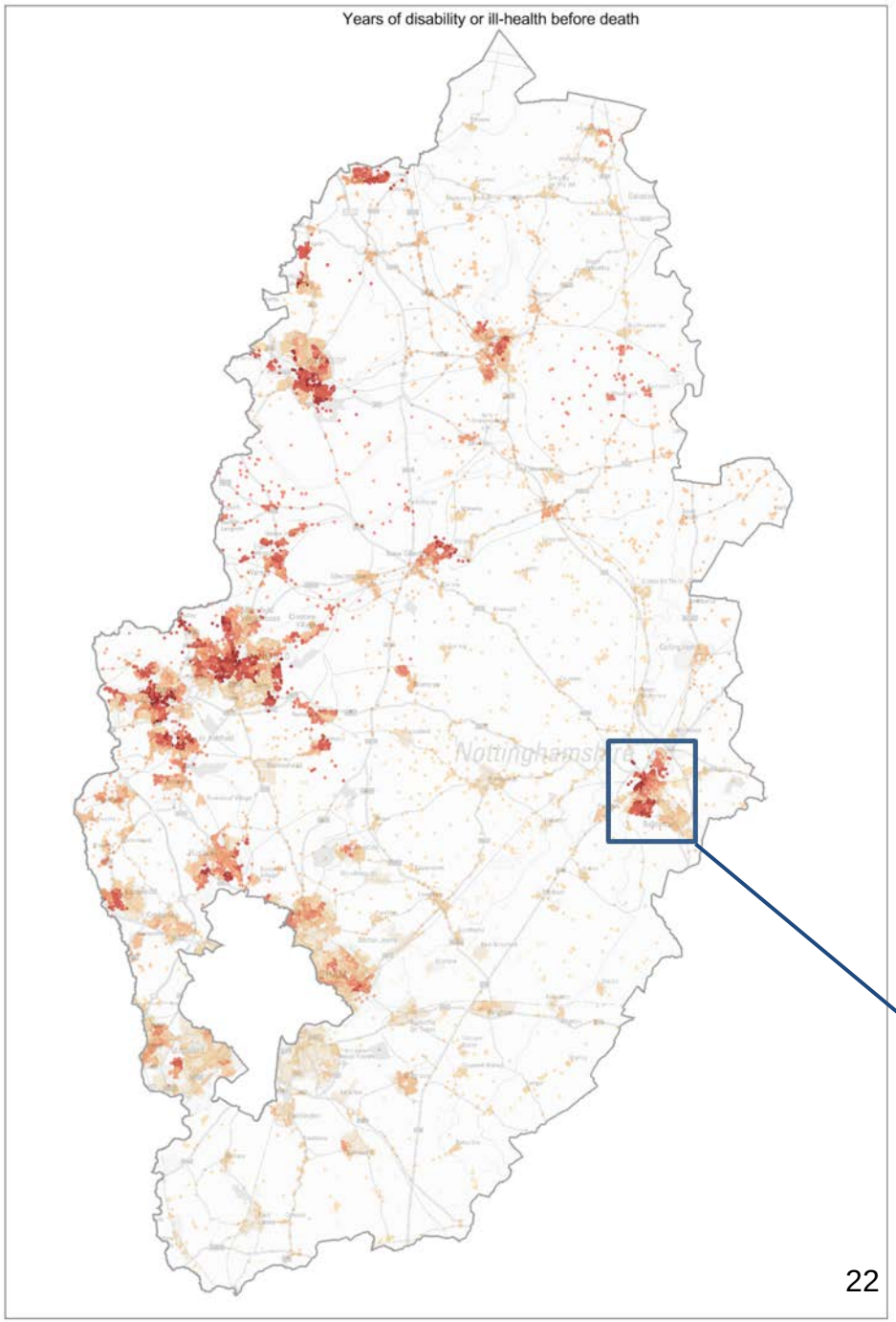


Source: The Public Health Observatories in England, based on analysis of ONS mortality data and population estimates



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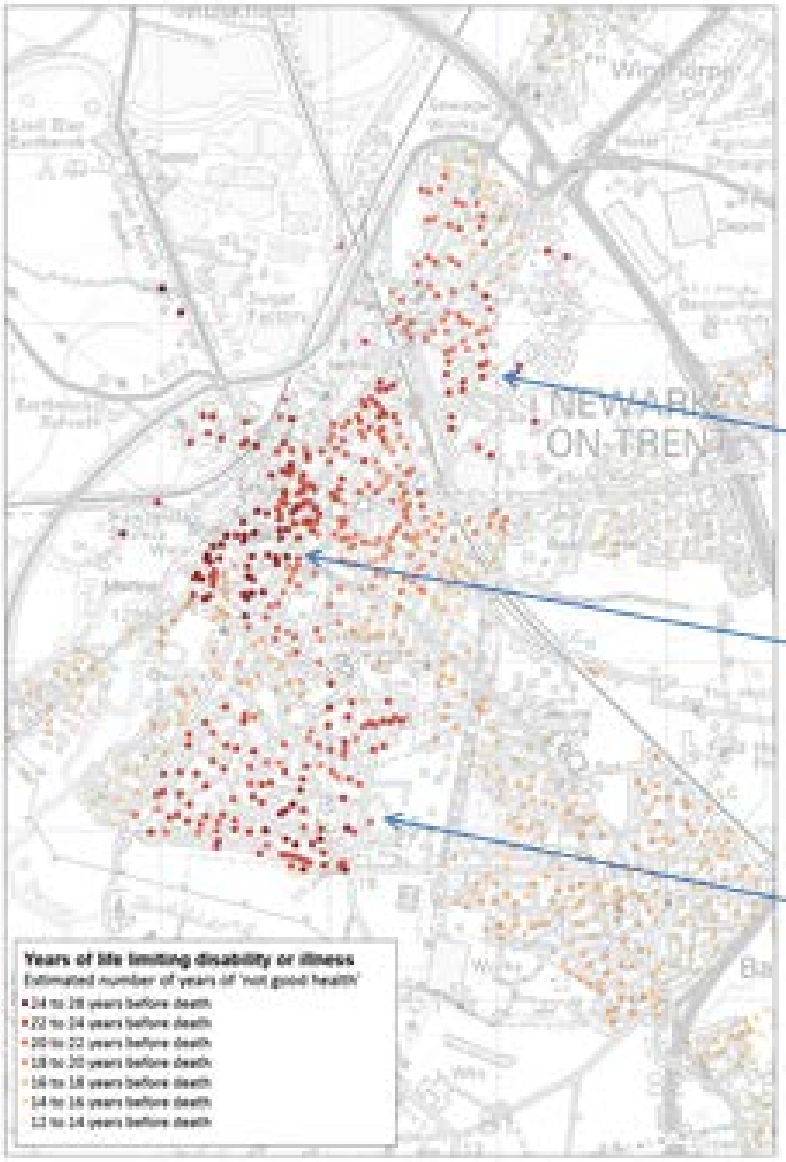
Years of life limiting disability or illness before death
Estimated number of years of 'not good health'
Up to 28 years before death
Up to 24 years before death
Up to 22 years before death
Up to 20 years before death
Up to 18 years before death
Up to 16 years before death
Up to 12 years before death
Bridge
Area with longest time 'not in good health'
Devon / Hawtonville
Years of life limiting disability or illness
Estimated number of years of 'not good health'

Appendix 2

NOTTINGHAMSHIRE FRAMEWORK FOR ACTION ON HEALTH INEQUALITIES

D.Jenkin, Specialty Registrar in Public Health, August 2015

INTRODUCTION

The locally developed health inequalities framework provides a brief, systematic and structured approach to identify focus areas for effective action on health inequalities.

In this context the framework uses a working definition of health inequalities from Public Health England: **"preventable and unjust differences in health status experienced by certain population groups"**

Therefore, whilst inequalities have frequently been expressed in terms of a relationship between health and deprivation, here we broaden our consideration to ensure that resources are aligned to those population groups and geographies in greatest need, with the greatest capacity to benefit from invested resource. This fits well with a consideration of population groups who experience the lowest life expectancy and healthy life expectancy.

The framework concentrates on 3 key areas for exploration:

Section 1: Knowledgebase – what do we know about the individuals and groups experiencing poorer health outcomes in our local area? Do we understand the key underlying causes of inequalities in health outcomes? And can we identify specific evidence based approaches that we could take to reduce these inequalities?

Section 2: Prioritising targeted actions to reduce the gap in health outcomes, to ensure resource is aligned with need.

Section 3: Prioritising systematic approaches to health inequalities which can be embedded within our commissioning and service delivery to ensure that systems and processes have a positive impact on health inequalities.

The framework is intended to provide a useful practical structure to our initial strategic thinking on local health inequalities. As such the framework can and should develop through stakeholder use, where feedback identifies ways to improve its usefulness. It has also been developed from a public health specialist perspective. Therefore its use will likely be most beneficial where it is delivered in a partnership setting, with facilitation by a public health specialist.

Its use will ideally result in the articulation of a short list of focus areas, agreed by stakeholders, for further exploration and development into a health inequalities action plan.

A further toolkit is in development, to accompany the framework, which will provide signposting to available evidence, guidance and best practice. This will support stakeholders to move from identified focus areas for action to credible and effective action plans.

FRAMEWORK SECTION 1: KNOWLEDGEBASE – UNDERSTANDING HEALTH INEQUALITIES IN THE LOCAL POPULATION

LOCAL HEALTH INEQUALITIES – BASE LINE INFORMATION	Have you identified vulnerable groups living in your area, and considered how to ensure they can both access and achieve good outcomes from your services? E.g. protected characteristics, homeless, older people, single parents, people living in isolation, those with English as a second language, travelling communities. Where are the most deprived communities in your area? How many children and older people are considered to be living in poverty in your area? Do you know where the inequality hotspots are in your local area? That is where local health outcomes are much poorer that the local or national averages? Do you have information from service users themselves (e.g. surveys) on their experience of care? Are vulnerable and deprived groups adequately represented in survey responses?
CHARACTERISING THE GAP	How does life expectancy and healthy life expectancy in your area compare with the national average? With other similar areas? How does life expectancy and healthy life expectancy vary within your area? E.g. Slope Index of Inequality. Have you identified the underlying conditions and risk factors are that contribute the most in your area to the gap in life expectancy and other outcomes?
INTERVENTIONS	Have you identified the ways in which your service/organisation can act on those underlying risk factors to improve health inequalities? i.e. specific evidence based interventions which will address the causes of local health inequalities?

DISCUSSION OUTCOME SECTION 1: Identify any critical information gaps which must be addressed in order to prioritise effective action on health inequalities locally.

FRAMEWORK SECTION 2: PRIORITISING TARGETTED ACTION – REDUCING THE GAP

Considering the interventions identified in framework section 1:

IDENTIFY OPPORTUNITIES FOR DEVELOPMENT	How do priorities for action on health inequalities overlap with existing wider priorities of the organisation? What interventions or initiatives are already underway that can be tailored to have a positive impact on health inequalities? Which initiatives provide the best opportunities to work with partners in the local health economy to improve outcomes?
UNDERSTAND THE IMPACT, COST AND SCALE	Which interventions will generate the greatest impact on health inequalities for a given resource investment? I.e. How do the proposed interventions compare in terms of relative cost and cost-effectiveness? How many individuals would you need to reach with these interventions in order to have an appreciable positive impact? Is this scale feasible? Are these interventions associated with a potential for cost savings, through more effective targeted prevention of ill health? Has this cost saving been quantified?
BALANCE INTERVENTIONS	Are these interventions appropriately balanced between: • Primary, secondary and tertiary prevention • Delivering short, medium and long term gains. • Achieving improvements across the life course?
TARGET INTERVENTIONS	How will you demonstrate proportionate universalism? i.e. how will you ensure that the interventions are delivered most effectively in areas of greatest need and taken up by those who are at greatest risk of poor outcomes? Should the intervention be delivered universally ie. Available to all with greater resource invested in those with greatest need? Or should the intervention be commissioned on the basis of need, and only available in areas of greatest need?

DISCUSSION OUTCOME SECTION 2: Identify specific high impact interventions to prioritise for further investigation and development, and accountable stakeholders to lead on each.

FRAMEWORK SECTION 3: SYSTEMATIC APPROACH – EMBEDDING ACTION ON HEALTH INEQUALITIES INTO ALL WORKSTREAMS – P1

(applying action on health inequalities systematically to pathways, processes, programmes, commissioned services)

SYSTEM AREA	DETAIL	This is a GAP
ACCESS AND OUTCOMES	Do you know how access and outcomes vary for your services? Do you routinely evaluate these variations, rather than considering only average performance? Do you routinely review those accessing your service to ensure that vulnerable, deprived and at risk groups are being reached? e.g. health equity audit Where are services located geographically? Do the most deprived communities have local, high quality and accessible services? Do you routinely review referral practices and thresholds for access to services e.g. to ensure that those in greatest need are appropriately engaged and supported? How do you ensure that the most vulnerable or deprived individuals are enabled to participate fully in surveys of service user experience? How do you prioritise improving outcomes for the sub-groups within the population most at risk of poor health (through multiple risk factors or vulnerabilities)? Are there particular care pathways and services that should be prioritised for review of impact on health inequalities?	
COMMISSIONING	Do you use contractual arrangements with providers to ensure that they provide you with evidence of monitoring health inequalities (access and outcomes) and acting to reduce health inequalities through their service provision? Have you set requirements for delivery of quality outcomes which are weighted towards those most in need?	

FRAMEWORK SECTION 3: SYSTEMATIC APPROACH – EMBEDDING ACTION ON HEALTH INEQUALITIES INTO ALL WORKSTREAMS – P2

SYSTEM AREA	DETAIL	This is a GAP
LEADERSHIP	Is there clearly defined system leadership, through designated accountable health inequality leads, inclusion of health inequalities within organisational strategic objectives and individual professional objectives. Is there an expectation of every staff member in the organisation to understand health inequalities and the role they can play to reduce these inequalities?	
POLICY, STRUCTURE & GOVERNANCE	Where a new policy or change to existing service is proposed, is the proposal routinely assessed to identify likely impacts on health inequalities? How is this documented? How are potential negative impacts on at risk groups within the population mitigated? Are there structures within the organisation through which assurance and accountability for action on inequalities is being achieved, including full visibility and priority at governing board?	
CORPORATE RESPONSIBILITY	Does the organisation make full use of its powers as employer and as commissioner to ensure that the way it conducts its business has a positive impact on reducing inequalities? Are all staff employed on at least the living wage? How do you promote vacancies in the organisation to local residents? How have you used procurement as an opportunity to strengthen local businesses and economy? Are corporate and community events routinely held in venues local to more deprived communities?	
PARTNERSHIP & INTEGRATION	Are your goals and initiatives aligned with activity by other organisations in the local health economy to reduce health inequalities? Have you identified opportunities to make use of overlapping priorities to increase effectiveness of the system in tackling health inequalities?	

DISCUSSION OUTCOME SECTION 3: Identify gaps in system and process to prioritise for further investigation and development, and identify accountable stakeholders to lead on each.