

**Strategy
to reduce health inequalities
within Southwark 2009-2020**

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Lead Officer	Dr Ann Marie Connolly, Director Public Health
Lead Author	Jeffrey Lake, Specialist Public Health Trainee
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GLOSSARY

BME	Black and Minority Ethnic Group
C2DE	Skilled working class, working class, casual and lowest paid workers, pensioners and those in receipt of benefits
CHD	Coronary Heart Disease
CVD	Cardio Vascular Disease
DALY	Disability Adjusted Life Years
DH	Department of Health
DES	Clinical Directed Enhanced Services
DLA/AA	Disability Living Allowance and Attendance Allowance
DWP	Department of Health Department of Work and Pensions
ESA	Employment and Support Allowance
ECM	Every Child Matters
GMS	General Medical Services
GP	General Practitioner
ICD10	International Statistical Classification of Diseases and Related Health Problems
HR	Human Resources
IMD	Index of Multiple Deprivation
LAA	Local Area Agreement
LHO	London Health Observatory
LDQ	Least Deprivation Quintile
MEND	Childhood Obesity Programme
MSOAs	Middle Level Super Output Areas
MDQ	Most Deprivation Quintiles
MSM	Men who have sex with men
NHS	National Health Service
NEPHO	North East Public Health Observatory
NVQ4	National Vocational Qualifications Level 4
NICE	National institute of Clinical Excellence
ONS	Office of National Statistics
PBC	Practice Based Commissioning
PCT	Primary care Trust
PPI	Patient and Public Involvement
PSA	Public Service Agreement
QALY	Quality Adjusted Life Years
QoF	Quality and Outcomes Framework

RCN	Royal College of Nursing
SBIs	Screening and brief interventions
SOAs	Super Output Areas
SRE	Sex and Relationships Education
WCC	World Class Commissioning
WHO	World Health Organisation

Introduction

Health inequalities are defined as the differences in health status or in the distribution of health determinants between different population groups (WHO 2008).

Clear socio-economic gradients exist in relation to health determinants and health outcomes. There is a complex array of factors and causes of inequalities in health outcomes and they operate at many different levels. However there are three main domains that into which these factors can be classified and which are amenable to intervention:

- Socio-economic environment
- Lifestyles and behaviours
- Access to effective health, social care and other services

Southwark has a young, mobile and ethnically diverse population compared to England as a whole. Despite very high levels of social deprivation there has been considerable progress in narrowing the health gap between Southwark and England. Female life expectancy in Southwark is now slightly higher than the national average and male life expectancy in the borough is 0.73 years below the England figure. Progress has also been made in reducing mortality rates, including those for cancer, circulatory disease and infant mortality.

Despite this overall progress there are still stark inequalities within Southwark. The gap in average life expectancy between the most deprived fifth and the least deprived fifth of our population is 3.4 years for women and 5.2 years for men. The gap between local authority wards in the borough is much bigger at about 10 years for females and 17 years for males. Our target in this strategy is to narrow the life expectancy gap between the most deprived and the least deprived parts of Southwark by 20% by 2020.

While Southwark has many activities in place to address these health inequalities, it has lacked an explicit strategy. This document fills that gap. It provides an overview of health inequalities, describes the current situation, sets out our goals and identifies priorities for action.

In order to build on recent success in improving overall health, more effort must be made to address those in greatest need in the borough. This requires the collaboration of the public, private and third sectors in taking action at different levels including for individuals, communities and the whole population. These actions need to address the many factors that affect our health including socio-economic determinants, lifestyles and access to services.

Tackling health inequalities must therefore be seen as everyone's business and should become 'hard-wired' into the way we work. This should include working jointly on clear priorities, targeting those in greatest need, engaging the community and ensuring that key policies and activities are geared towards narrowing the health gap.

1 Overview

1.1 Overall aim and approach

1.1.1 This strategy sets out our intentions to address health inequalities in Southwark. It has the following overall aim:

Our aim is to reduce inequalities in health in Southwark by narrowing the gap between those at greatest risk of poor health outcomes and those who have the best health.

1.2. Purpose of the Strategy

1.2.1. The purpose of this strategy is to support Healthy Southwark to deliver its target of the reduction All Age All Cause Mortality (AAACM) and deliver the NHS targets to improve Life Expectancy and narrow the health gap between the least deprived most deprived.

1.2.2. It will support the delivery of these targets by bringing together a series of focussed actions by the health services with individuals to improve their healthcare and lifestyles, and by other organisations that can impact on people's life chances.

1.2.3. It is focussed on people living in the most deprived quintiles of the borough

1.3. Delivery of the Strategy

The strategy will be delivered by:

1.3.1. Doctors and Nurses - through improving detection and treatment of heart disease, diabetes and cancers for those living in the most deprived areas. They will also work to improve the outcomes for women and their babies with the most high risk pregnancies.

1.3.2. Health improvement practitioners - will work to reduce smoking, improve physical activity, improve healthy eating, and reduce harmful alcohol consumption for those living in deprived communities and those with mental health problems.

1.3.3. Staff working with schoolchildren, young people who are NEET, those living in social housing and the unemployed - to improve the life chances of people who may be at long term risk of health problems due to low income and poor life chances. (Delivery plans are on pp 45-60 indicating a lead coordinator for each of the five theme areas)

1.4. Other strategies and their contribution to reducing health inequalities

1.4.1 This strategy complements other major strategies and their delivery of improvements that will impact on health. It does not seek to replicate their work which will have significant impact on health, but to provide a complementary strategy and framework.

Table 1.1 Current major strategies and their role in reducing health inequalities

Children's and Young Peoples Plan (in draft form)	Narrowing the Gap and Improving education attainment will have long term benefits for health of young people as they grow older
Employment and Enterprise Strategy (Under review)	Improving access to employment and income has significant impact on health of the poorest
Sports and Physical Activity Strategy	Will improve the uptake of physical activity for those who do not traditionally participate in physical activity and use a wider range of non traditional settings
Healthy Weight Strategy	Targeted approach to reducing obesity and a population approach to lowering the average weight
NHS Southwark Strategic Plan	Commissioning plan for the NHS in Southwark to improve health and health services for local community
Southwark Alcohol Strategy	Reduce the numbers of those engaged in harmful drinking
Regeneration and Major Projects work	Significant long term impact on the health and quality of lives through improved housing and better social environment for the deprived areas that will undergo major regeneration programmes
Housing Strategy	Long term impact through improving the quality of social housing for the most deprived

1.5 Monitoring the Strategy

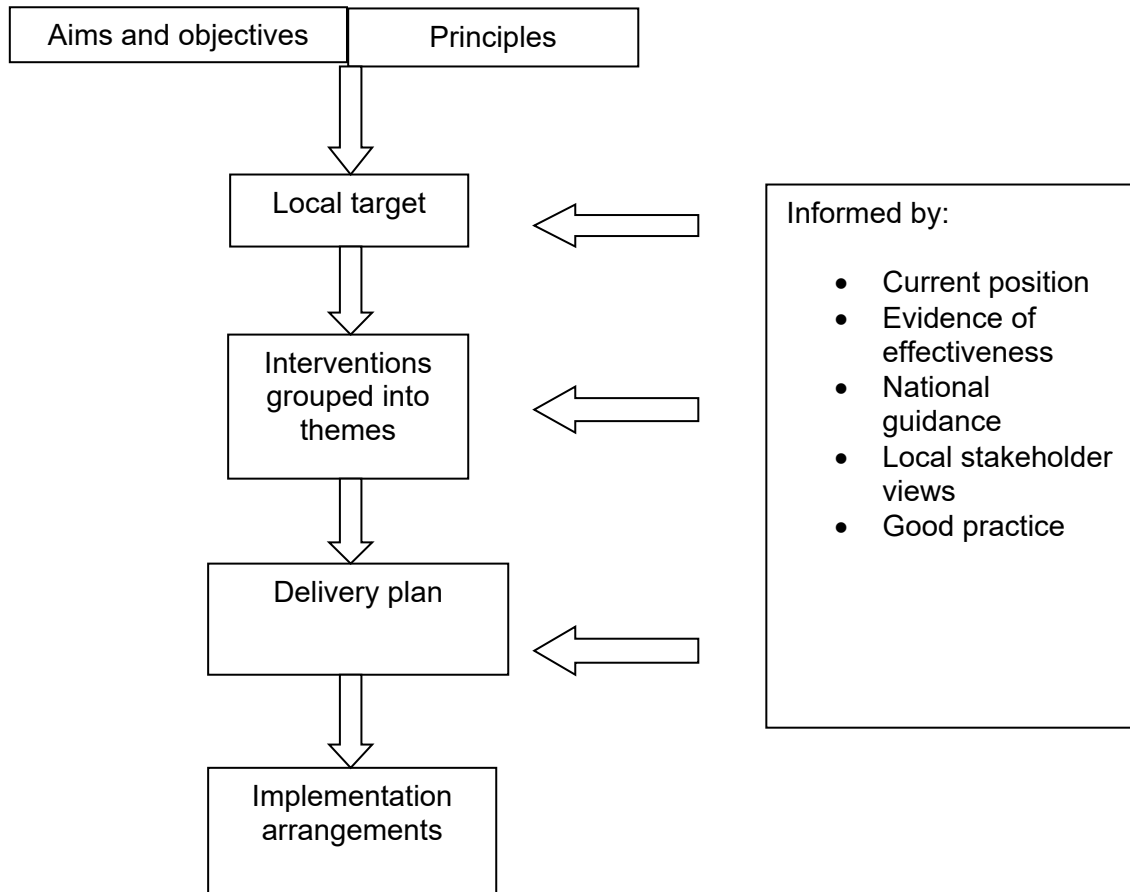
The strategy and its implementation will be monitored by the revised Healthy Southwark Partnership Board. It will be monitored by the high level target AAACM and also through the use of intermediate metrics or progress against delivery plans.

Table 1.2
 What can local organisations do to narrow the health gap

Organisation	
Southwark Council	<p>Ensure that major strategies help to narrow the gap.</p> <p>For children narrowing the gap on poverty, increasing uptake of school meals, continuing to improve educational attainment , reducing the proportion of children who are obese.</p> <p>For adults narrowing the gap by improving the employment opportunities, improving quality of housing and environment in the worst off areas and make it easier for adults with worst health to take regular physical activity</p>
Police	<p>For the most deprived areas reduce fear of crime, manage the damaging impact of substance misuse and alcohol, support the improved liveability of neighbourhoods,</p>
Universities, Third level and Further Education (FE) colleges	<p>Assess the impact of the admissions criteria on entry by those from deprived communities</p> <p>Promote a healthy staff across all sections of the organisation</p> <p>Facilitate more people entering into further qualifications that will assist entry into employment</p>
Businesses	<p>Facilitate employment of local people into local businesses</p> <p>Support local Apprenticeship Scheme and work placements for young and longer term unemployed people</p> <p>Promote opportunities for staff to improve their health e.g. smoking , physical activity</p>
NHS	<p>Deliver programmes of care that ensure improvement in health, enhance programmes for those in the most deprived communities and monitor impact of care service on improving outcomes for those in the most deprived areas.</p> <p>Support opportunities to assist local residents into employment in the NHS</p>
Voluntary sector	<p>Support local communities to find local and appropriate solutions</p> <p>Support local communities in the most deprived areas to make best use of health and other services that will help keep a healthy life</p>
Faith Groups	<p>Support local communities to find local and appropriate solutions</p> <p>Support local communities in the most deprived areas to make best use of health and other services that will help keep a healthy life</p>

For all agencies monitor impact of strategies and programmes to ensure that they do not have unintended consequences of widening the gap

Figure 1.1 Overall approach to reducing health inequalities in Southwark



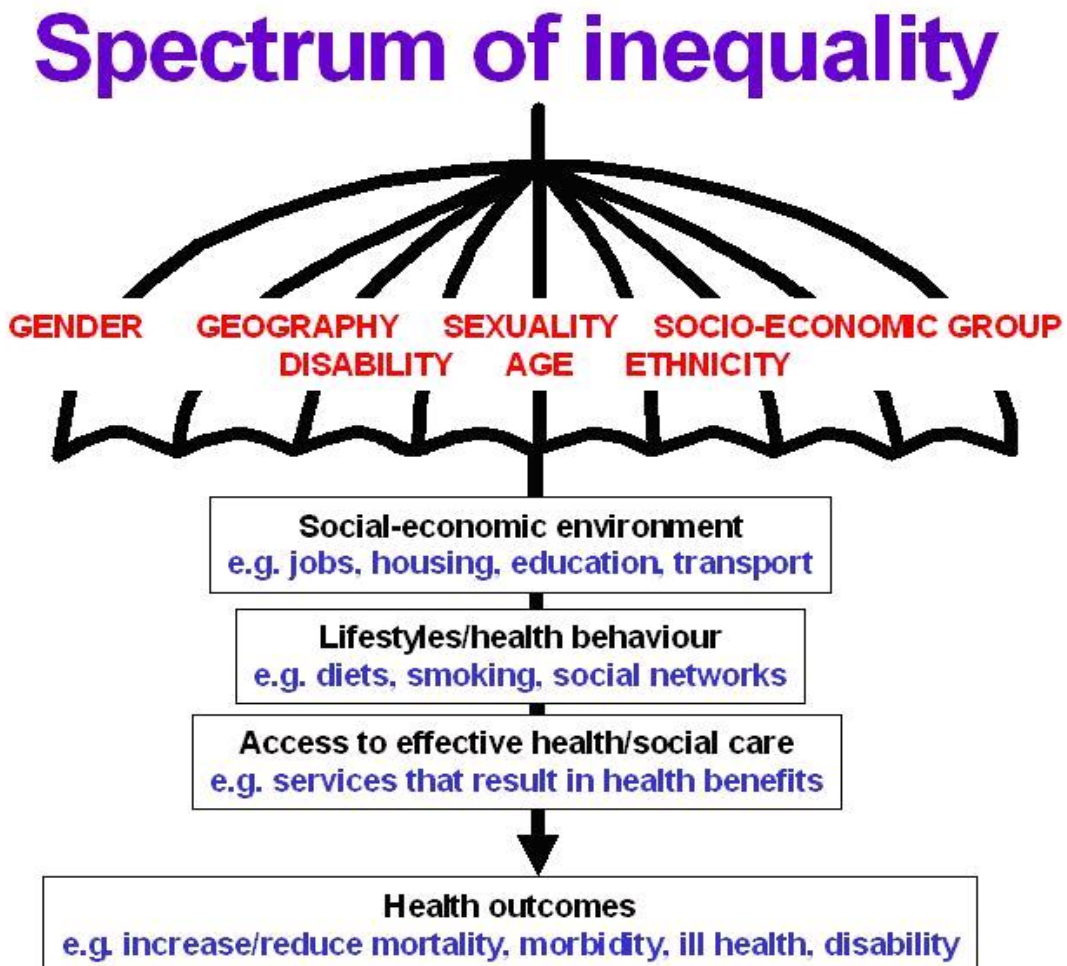
1.6 Defining health inequalities

1.6.1 'The relationships between inequality and poor health and social problems are too strong to be attributable to chance' (Wilkinson et al 2009). Figure 1.2 below presents some of the main determinants of health and the pathways by which these lead to different health outcomes.

1.6.2 While a wide range of factors will influence health, it can be helpful to look at three main domains that are potentially amenable to intervention:

- at the broadest level the socio-economic environment sets constraints and opportunities that affect people's lives and ability to remain healthy and to withstand risks to health
- Individuals' lifestyles and behaviours such as smoking and drinking alcohol directly impact on health and individual well-being.
- at the local level, access to effective health, social care and other services can directly affect the health outcomes of individuals.

Figure 1.2. The spectrum of inequality



Source: www.lho.org.uk/HEALTH_INEQUALITIES/HealthInequalities.aspx

1.6.3 Relative poverty is a key component of the socio-economic environment that underpins health inequalities. However, as Figure 1.2 above suggests, there are

some other important dimensions of inequality that can be separate from peoples' locality or socio-economic circumstances. Examples of these include:

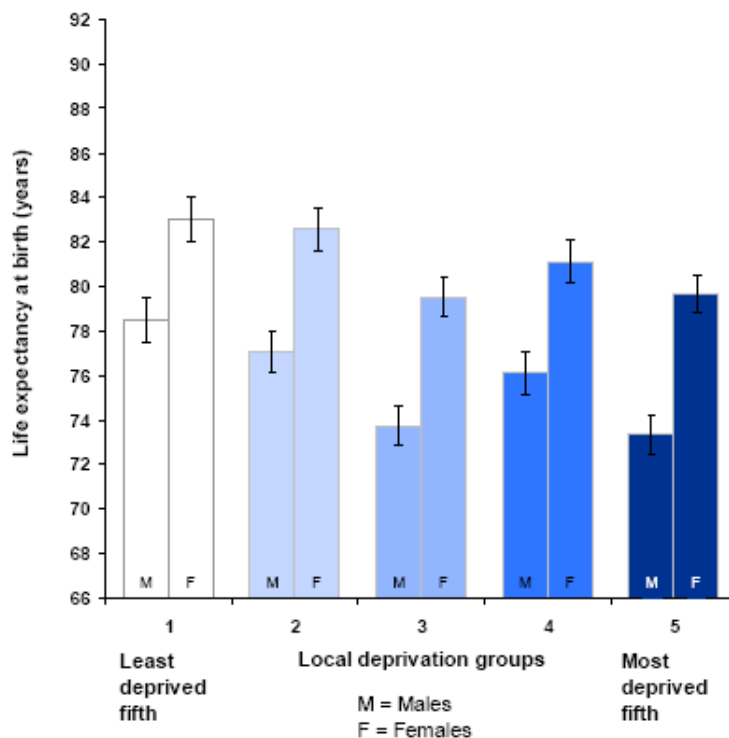
- ethnicity
- gender
- sexuality
- disability
- age

1.6.4 Generally Southwark has high levels of deprivation. This strategy focuses mainly on geographical areas as a means of tackling socio-economic and other inequalities in Southwark. This will help the Healthy Southwark Partnership to agree action plans and to measure progress. The focus on localities will, however, need to be complemented by a flexible and sensitive approach to ensure that all groups facing inequalities have their needs addressed. There is a need to engage people in the most deprived areas of the borough to enable discussions with local communities about barriers to health and well-being and to help identify appropriate solutions and interventions

1.7 The inequality gradient

1.7.1 Figure 1.3 shows a clear gradient in life expectancy between the most and least deprived areas in the borough.

Figure 1.3. Male and female life expectancy by deprivation quintile in Southwark



I 95% confidence interval. These indicate the level of uncertainty about each value on the graph. Longer/wider intervals mean more uncertainty. When two intervals do not overlap it is reasonably certain that the two groups are truly different.

Source: www.healthprofiles.info

1.7.2 Social Gradients

Social gradients may be explained by having control over life opportunities and to be able to participate fully in society. (Marmot 2002) The social gradient for mortality rises with decreasing socio-economic status. Similar social gradients can be observed for many different diseases, disabilities, health behaviours and access to services. As Asthana et al. (2004) note, there is a consistent social gradient across many specific conditions as well as a gradient in self-reported overall health. The Joseph Rowntree Foundation (2003) found that people in the poorest fifth of the income distribution are two-and-a-half times more likely to become disabled during a year than those in the top fifth. The Office of National Statistics (2002) showed that 17% of men and 16% of women in managerial and professional occupations smoked, compared with 34% of men and 30% of women in routine and manual occupations.

1.7.3 Tudor Hart (1971) proposed 'the inverse care law' to describe the tendency for the availability of health services to vary inversely to the need for those services in the population served. Whilst there have been increasing efforts to locate services in areas of greatest need since then, a social gradient in the use of services often persists. For example, Belsky et al (2006) observed that whilst Sure Start programmes have been located in the most deprived communities, they have disproportionately benefited relatively less socially deprived parents in those areas.

Summary

Health inequalities result from differences between people's socio-economic and other circumstances, health behaviours and access to services

Clear socio-economic gradients exist in relation to health determinants and health outcomes.

There is a complex array of causes of inequalities in health outcomes and these operate at many different levels

This strategy clarifies and supports the action needed to reduce health inequalities in Southwark.

2 Policy and evidence context

2.1 Background

2.1.1 Although health inequalities research has had a long history in this country, it was not until relatively recently that the issue received significant policy attention. A key influence was the Acheson Report (1998), formally the 'Independent Inquiry into Inequalities in Health', which found widespread evidence of health inequalities and set out a variety of recommendations to address them with particular focus on the wider social determinants of health.

2.1.2 The NHS Plan (2000) committed the NHS to addressing health inequalities by requiring Primary Care Trusts to:

- decide which health inequalities are most evident in their area;
- decide which health inequalities are most feasibly tackled within budgetary constraints; and
- devise a scheme for deciding which specific health inequalities reduction programmes should receive funding.

2.1.3 In early 2001 a number of targets were introduced to focus attention and to measure progress. These included the following:

- starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between manual groups and the population as a whole.
- starting with Health Authorities, by 2010 to reduce by at least 10 per cent the gap between the quintile of areas with the lowest life expectancy at birth (i.e. lowest 10%) and the population as a whole.

Department of Health, 2001.

2.1.4 The means of addressing inequalities were identified in policy in 2003.

'Tackling Health Inequalities: A Programme for Action' (DH, 2003) set out plans around four themes:

- supporting families, mothers and children – to ensure the best possible start in life and break the inter-generational cycle of health inequalities
- engaging communities and individuals – to ensure relevance, responsiveness and sustainability
- preventing illness and providing effective treatment and care – making certain that the NHS provides leadership and makes the contribution to reducing inequalities that is expected of it
- addressing the underlying determinants of health – dealing with the long-term underlying causes of health inequalities.

2.1.5 These themes were underpinned by five principles:

- preventing health inequalities getting worse by reducing exposure to risks and addressing the underlying causes of ill health
- working through the mainstream by making services more responsive to the needs of disadvantaged populations
- targeting specific interventions through new ways of meeting need, particularly in areas resistant to change
- supporting action from the centre by clear policies effectively managed

- delivering at a local level and meeting national standards through diversity of provision

2.2 Public service agreement targets

2.2.1 The commitment to address health inequalities was further strengthened in 2004 with the introduction of public service agreement (PSA) targets (Deputy Prime Minister's Office, 2004). These included:

- in deprived areas, to substantially reduce mortality rates from heart disease and stroke and related diseases so that the absolute gap between the national rate and the average rate for deprived areas is reduced by 40 % by 2010.
- to tackle the underlying determinants of ill health and health inequalities by:
 - reducing adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less;
 - reducing the under-18 conception rate by 50% by 2010 as part of a broader

2.3 Progress

Southwark has already made substantial improvements to the health of the population in a great many areas

- Life Expectancy in females has increased
- Breastfeeding rates at 6-8 weeks well above the national trajectory
- Major diseases e.g. coronary heart disease and cancers rates have improved
- More people participating in healthy activities
- Neighbourhood Renewal Funds/Working Neighbourhood Funds for Health Improvement programmes and campaigns involving GPs and SureStart
- Educational attainment has increased
- Environment improved with cleaner air and greener places
- Road Safety is much improved
- Employment opportunities increased
- Major regeneration schemes completed e.g. Surrey Docks and Bankside

2.3.1 A number of progress review and guidance policy documents have been published in recent years. In 2007, the Department of Health reviewed progress in delivering the programme of action and identified high-impact recommendations to achieve the life expectancy target by 2010 (DH,2007). 'Systematically addressing health inequalities' (DH, 2008) identified the major lessons learnt to date in addressing health inequalities, and 'Health Inequalities – progress and next steps' (DH, 2008) set out with the greatest potential for addressing the leading causes of health inequalities in the long term.

These are:

- investing in early years and parenting;
- using work to improve health and wellbeing;

- promoting equality;
- developing mental health services further
- coordinating action – both nationally and locally.

2.3.2 The major themes of these publications include the need to clearly understand the areas that make the greatest contribution to health inequalities and to ensure that intervention is of an appropriate scale and quality to deliver progress. The scale of the challenge requires leadership and engagement across partnerships and communities.

2.4 Local review of health inequalities

2.4.1 An Audit Commission report on health inequalities in Southwark (Audit Commission, 2008) found that health inequalities have been identified as a key improvement priority within key primary care trust, council, and partnership documents. Nevertheless, it concluded that a more explicit approach to addressing health inequalities is required, supported by systematic mechanisms to ensure delivery. A number of recommendations were made:

- develop a joint overarching health inequalities strategy that coordinates and provides a focus for initiatives to tackle inequalities
- develop robust outcome measures that can help effectively evaluate the impact of initiatives
- ensure the overview and scrutiny committee provides effective challenge on a wide range of health inequality issues
- make better use of available health intelligence and data to influence commissioning
- work with local communities to identify appropriate solutions and interventions
- develop a structured training programme for staff, non executive directors and members to address the skills and competencies needed to effectively address health inequalities. This should include community engagement component to the training.
- develop a clear and explicit plan towards corporate responsibility in respect of the wider determinants of health across departments and organisations.

2.5 Reducing health inequalities – the evidence base

2.5.1 There is a growing amount of evidence on the effectiveness of interventions to improve population health and address health inequalities. The quality of this evidence varies between different topics and interventions and reflects both the amount of research carried out and the complexity of the problem. For example single interventions that aim to deliver effects on specific health outcomes in a short period of time are relatively easy to investigate. However as interventions become more complex, their effects more wide ranging, or the timescale extends, it becomes progressively more difficult to establish their precise impact. Nevertheless, it is clear that health inequalities cannot be addressed simply by short term measures alone and although the magnitude of the impacts might be unpredictable, coordinated investment in both the short, medium and long term are essential.

2.5.2 Some of those actions where the impact on health inequality is clearest are included in the health inequalities toolkit (LHO, 2008). This identifies high impact interventions that can be expected to reduce mortality rates in the short term. These include action to tackle smoking, high blood pressure, high cholesterol and infant death. In all of these areas identifying those people at particular risk of negative

outcomes (often with existing disease) allows intervention at the individual level and, when scaled up in numbers, can lead to a population level decrease in mortality.

2.5.3 Looking to the longer term, health inequalities are ultimately the result of the circumstances of people's lives as well as their personal lifestyles. Consequently, action to address them must extend far beyond the health services (DH, 2008). As NICE (2004) recognises "health inequalities are so deeply entrenched that providing disadvantaged groups or areas with better services – and better access to those services – can only be one element of a broader strategy to address the distribution of the wider determinants of health".

2.5.4 The benefits of early years education and childcare on a wide range of outcomes are well established (Zoritch, 2000). The soon to be published Healthy Child Programme will set out the framework for the health and well-being of children and young people from 0 – 19 years and the five Every Child Matters outcomes are focused on reducing health inequalities and to improve the health and well being of children and young people.

These are:

- Being healthy
 - Staying safe
 - Enjoying and achieving
 - Making a positive contribution
 - Achieving economic wellbeing
- (<http://www.dcsf.gov.uk/everychildmatters/>)

'Narrowing the gap' (DCSF 2007) sets out to reduce the attainment gaps between advantaged and disadvantaged young people is a top priority so that so that all have an opportunity to succeed, irrespective of gender, race, disability or background.

2.5.5 Housing has a key role in local strategies to reduce health inequalities. Two key priorities on a health agenda focus on reducing health inequalities and improving health. There is good evidence of the significance of housing quality for health but far more limited research on the impact of specific housing improvement intervention (Thompson et al, 2002). This is also the case in other areas but the absence of evidence should not be equated with evidence of the absence of any effect.

2.5.6 An important driver for the development of evidence based practice is the provision of evidence reviews and recommendations from NICE. A variety of public health reviews and recommendations have already been produced and many more are under development. This forms an important tool in efforts to reduce inequalities at the local level and will help to make the best use of limited resources.

2.5.7 The Sustainable Community Strategy identifies priorities for the decade to 2016. The vision for the future includes Improving Life Chances: High levels of unemployment and benefit dependency should be tackled through strengthening vocational skills and supporting business growth. Life chances should also be improved through increasing educational attainment and reducing health inequalities.

Summary

Addressing health inequalities has become a significant policy aim

This has been supported by national targets relating to the life expectancy of people in different geographic areas and across different social groups.

Government has provided an increasing amount of guidance as to how health inequalities should be addressed.

Tackling health inequalities requires coordinated action across different sectors and willingness amongst partners to support and add value to the activities of others.

While evidence for some interventions is robust, other approaches (especially complex socio-economic interventions) have longer term outcomes and the evidence base is more complex

Activity to address health inequalities should disproportionately benefit those in greatest need.

3 Where are we now?

This section provides a brief overview of some key inequalities within Southwark. It focuses initially on some important determinants of health and then provides some key data on inequalities in health status within the borough. Further information is available in other more detailed documents including the Joint Strategic Needs Assessment and the Annual Public Health Report.

3.1 Southwark's Population

3.1.1 There were 274,000 residents in Southwark in 2007. Compared to the rest of the country, the borough has a younger age structure and is more ethnically diverse, with a higher proportion born overseas. It is estimated that the population will increase annually by approximately 1,300 to 4,000 per year depending on the population projection used.

3.1.2 Compared to both England & Wales and London, a lower percentage of the population is White, with just over half of the population (52. %) describing themselves as White British. A higher percentage of Southwark's population is Black (25.9%) compared to England & Wales (2.3%) and London (10.9%). The largest minority ethnic groups in Southwark are Black-African (16.1%) and Black-Caribbean (8%). The Asian population in Southwark is two thirds lower than the London average of 12.1%.

3.1.3 There are particularly high proportions of black and minority ethnic (BME) populations in the centre and northwest of the borough (Peckham ward 68%, Livesey and Camberwell Green 50%, Faraday 48%, Chaucer 47% and Brunswick Park 46%).

3.1.4 A continuing challenge is to plan and provide for people in Southwark who are excluded from official counts. These include short-term residents who live and work in the borough for less than 12 months. There is also a need to ensure that official population estimates are sensitive to population changes such as migration patterns. Local administrative datasets can be combined with official population statistics to help understand patterns at the local level.

3.1.5 Socio-economic factors are a key influence on inequalities and Southwark has high levels of social deprivation compared to most local authorities. The following table shows the borough's index of multiple deprivation (IMD) ranking for 2007. This combines a number of different factors and local authorities are ranked from 1 (most deprived) to 354 (least deprived). Southwark scores particularly poorly on the income and employment scales as compared with other boroughs.

Table 3.1. Southwark indices of deprivation 2007

Indicator	Southwark's position in England (out of 354 local authorities)*	Southwark's position in London (out of 33 local authorities)*
Index of Multiple Deprivation 2007	26	9
IMD income scale	18	7
IMD employment scale	22	2

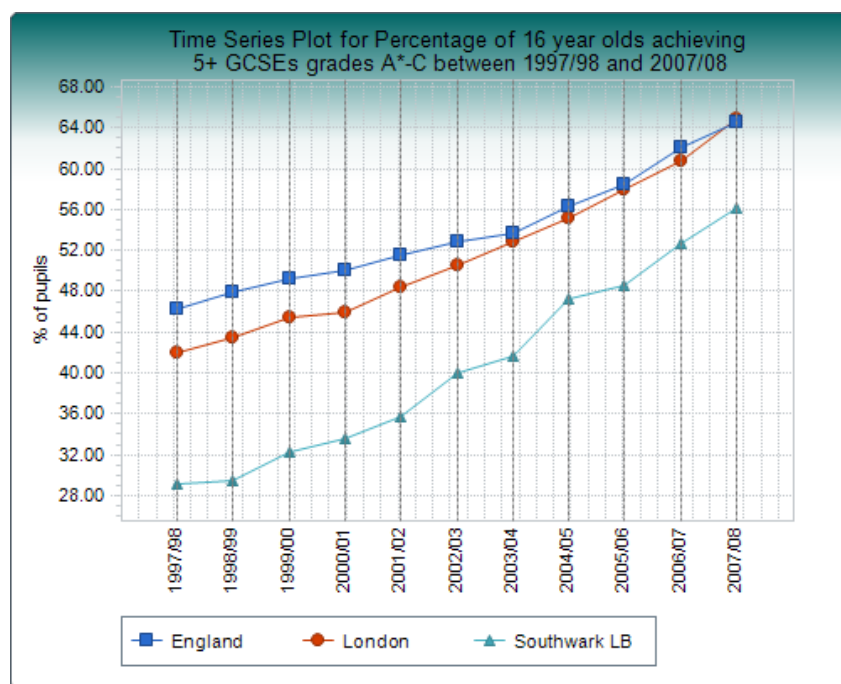
Note: 1 = most deprived

Source: London Health Observatory 2009

3.1.6 The 2007 scores represent a slight improvement from the previous (2004) index, when Southwark was identified as the 17th most deprived local authority nationally. However the extent of the deprivation experienced in Southwark remains considerable and the borough is still within the 7% most deprived areas in the country. Overall, 58% of the Southwark population is within the bottom quintile of deprivation nationally (i.e. the bottom 20%). This deprivation is concentrated in the Lane, Nunhead, Peckham, Camberwell Green, East Walworth, South Bermondsey and Rotherhithe (see map in Appendix 1).

3.1.7 One aspect of the deprivation index is education and Figure 3.1 shows that there has been some narrowing of the gap between Southwark and London/England on one indicator of educational achievement, although the difference remains considerable.

Figure 3.1 Percentage of 16 year olds achieving 5+ GCSEs, 97/98 – 07/08



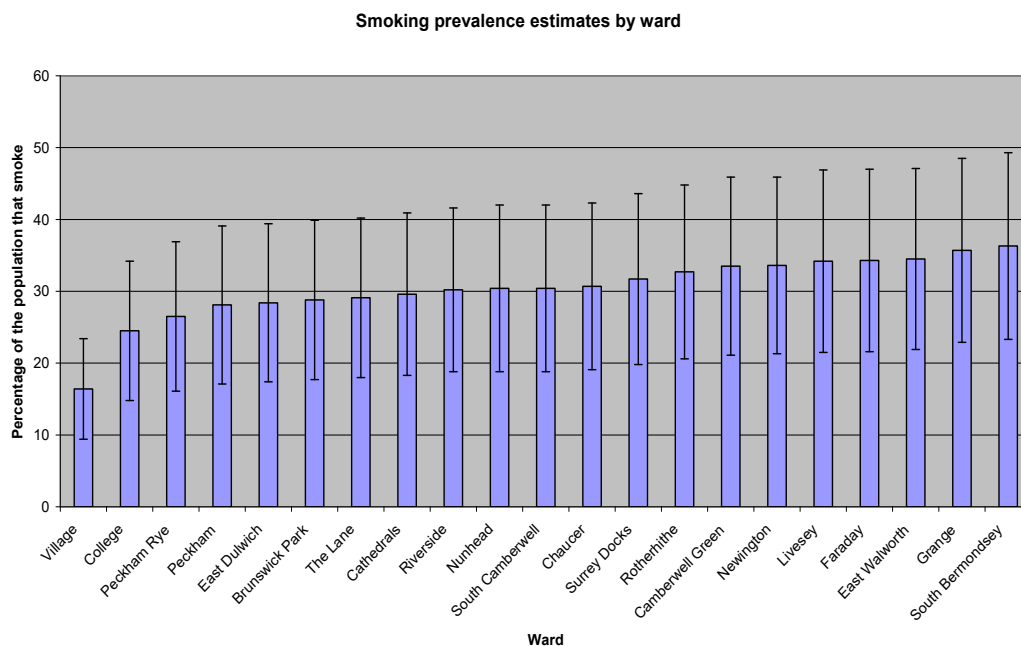
Source: Floor targets interactive 2008

3.1.8 Whilst Southwark had a larger proportion of people with qualifications equivalent to NVQ4 or higher than London (42.6% compared to 37.4%) it also has a higher proportion with no qualifications (16.2% compared to 12.8% in London) (Source: ONS population survey 2007). The borough is therefore more highly polarised than London as a whole.

3.1.9 Being unemployed does have an effect on life chances. It increases the chances of becoming ill and possibly becoming depressed. This is so for young people if they have never worked. (BMJ 2009) The proportion of working age population claiming benefits is above average at 15% compared with 13% for London and the rates for lone parents remains above average at 3.2% as against 2.9% for London. Ethnic minorities are disproportionately represented. There are 6.9% of people claiming ESA and Incapacity Benefits compared to London's rate of 6%. Source: (Shared Intelligence Southwark Economy 2009) The effects of the recession may mean that these figures will be on the increase.

3.1.10 Lifestyles are another key determinant of health and these can vary widely with PCT populations. One important example is the prevalence of smoking and Figure 3.2 indicates that there is an estimated two-fold difference in smoking levels across the borough. This gives an indication of the areas that should be targeted if inequalities are to be reduced.

Figure 3.2 Estimated smoking by ward in Southwark 2000-2



Source: Health and Social Care information Centre
(thin lines indicate 95% confidence interval)

3.1.11 One of the important strands in preventing ill health is to detect health problems at an early stage and to give people access to appropriate services. Access can be unequal across localities, GP practices and across particular population groups. Across the whole of Southwark the PCT estimates that:

- approximately 6,030 people with CHD are not yet diagnosed and on GP disease registers to help ensure systematic care (2007)

- about 1,950 people with diabetes are not yet diagnosed and on GP disease registers (2005)
- about 29,200 people with hypertension are not yet diagnosed and on GP disease registers (2007)

3.1.12 For people who are diagnosed and on registers there are also inequalities across GP practices in Southwark in relation to the health outcomes that they achieve. For example:

- the proportion of people on Southwark GP diabetes registers that have their blood sugar controlled at target levels ranges from 35% to 78%
- the proportion of people on Southwark GP hypertension registers that have their blood pressure controlled below 150/90 ranges from 55% to 96%

3.2 Mortality rates

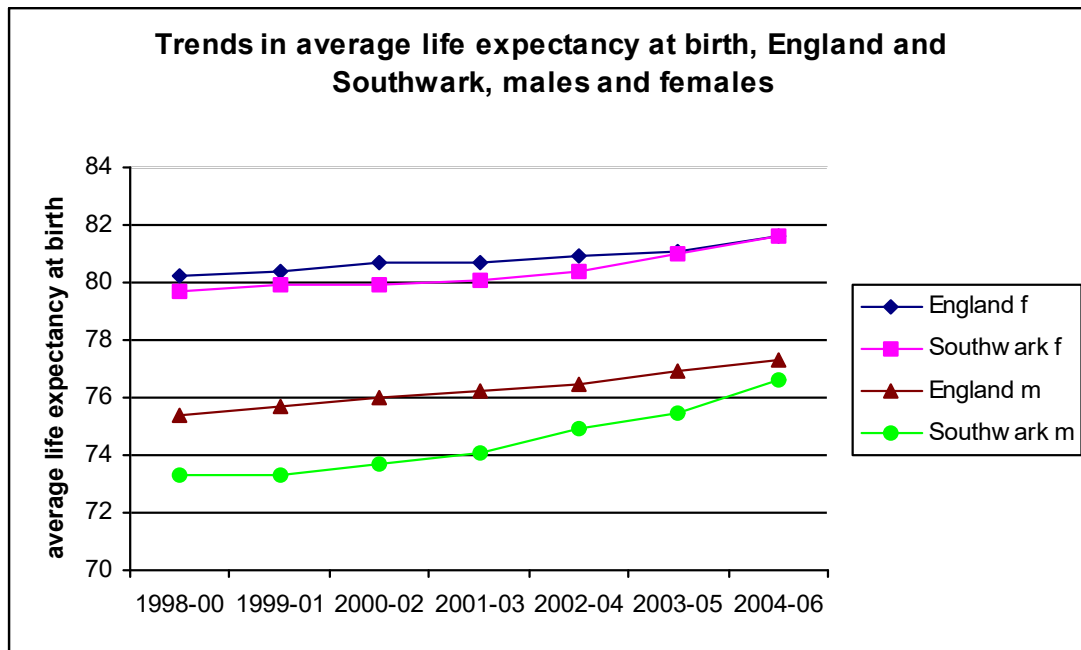
3.2.1 There has been considerable progress in reducing mortality rates in Southwark since 1993. Experience nationally would suggest that this is both a result of improved health equity for local people and of imported health improvements due to gentrification of some areas of the borough. Despite overall progress there are wide inequalities between localities in Southwark. Appendix 2 gives two examples of this in relation to the two biggest causes of death - cancer and for circulatory diseases.

3.2.2 The standardised mortality ratios in the Appendix indicate the death rate in a population after adjusting for age and sex, with the national figure being expressed as 100. For example they show that the circulatory disease mortality rate in Surrey Docks is about half the national average whereas that for The Lane ward is 70% above the national figure. There is therefore a three-fold difference in death rates across Southwark.

3.3 Life expectancy

3.3.1 Figure 3.3 shows that there has been a slightly greater increase in local life expectancy than that seen nationally and consequently the gap between Southwark and England has narrowed. The most recent data (2006-2008) indicates that female life expectancy is slightly higher in Southwark at 82.4 years compared with 82.02 years for England as a whole, and for men life expectancy is 77.2 years compared with 77.93 years for England. (GLA/DMAG 2009)

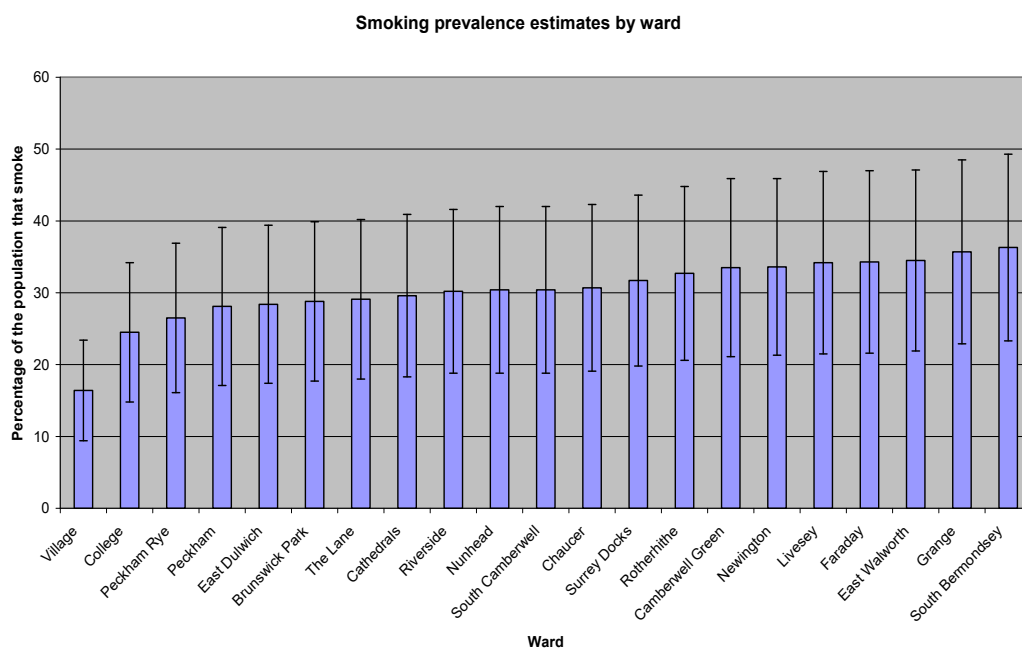
Figure 3.3 Male and female life expectancy at birth, Southwark and England, 1998-2000 to 2004-06.



Source: Floor targets interactive 2008

3.3.2. Lifestyles are another key determinant of health and these can vary widely with PCT populations. One important example is the prevalence of smoking and Figure 3.2 indicates that there is an estimated two-fold difference in smoking levels across the borough. This gives an indication of the areas that should be targeted if inequalities are to be reduced.

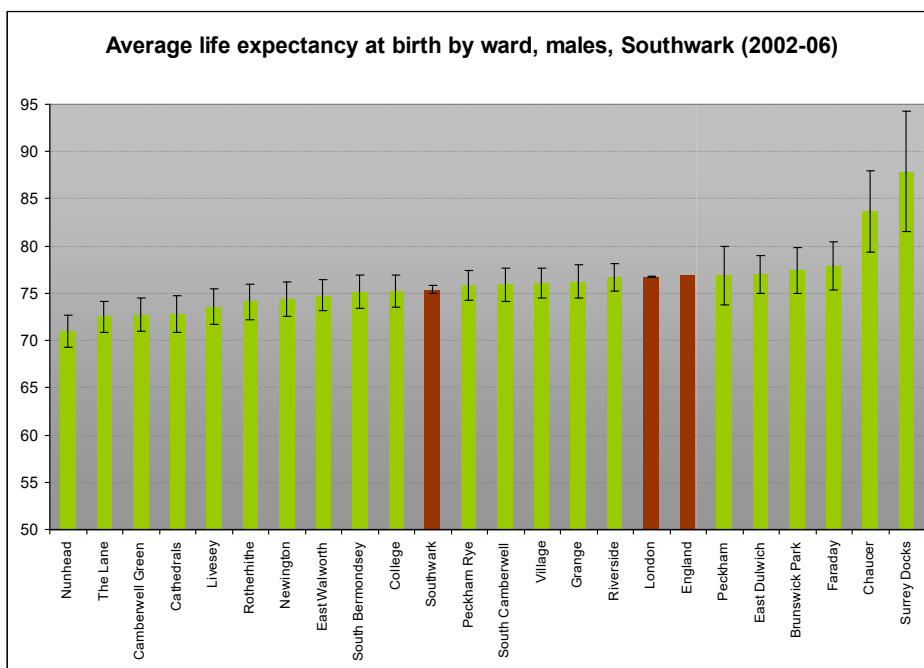
Figure 3.2 Estimated smoking prevalence by ward in Southwark 2000-2



Source: Health and Social Care information Centre
(thin lines indicate 95% confidence interval)

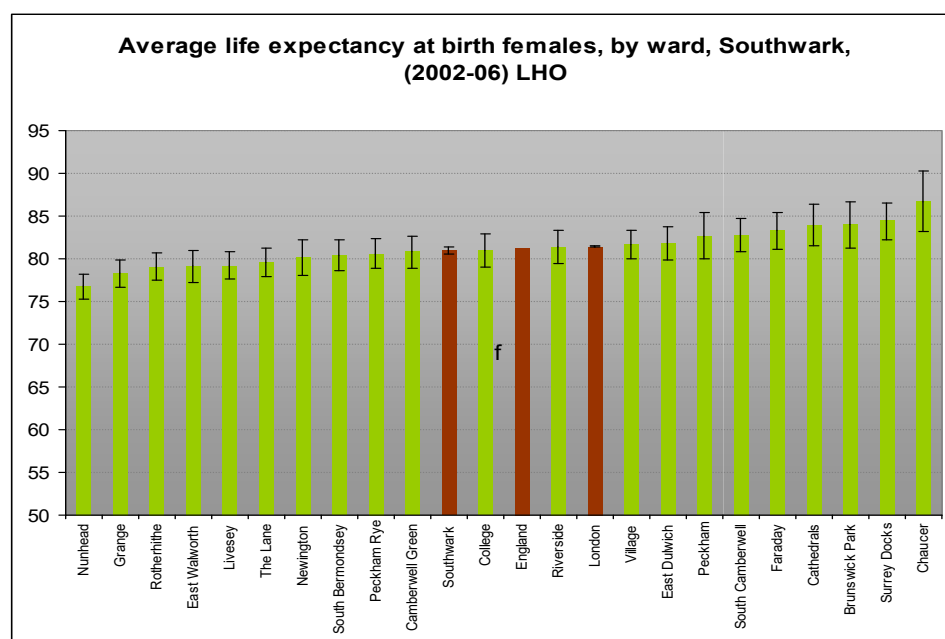
3.3.3 The major focus of this strategy is to reduce inequalities within the borough. Figures 3.4 and 3.5 show the most recent life expectancy data for male and female life expectancy at ward level.

Figure 3.4. Average male life expectancy at birth by ward 2002-6.



Source: LHO 2008.
(thin lines indicate 95% confidence interval)

Figure 3.5 Average female life expectancy at birth by wards 2002-6.



Source: LHO, 2008.

3.3.4 The above figures show the scale of the task in hand. There are very substantial inequalities across the borough and these have grown bigger in recent years:

- The gap in male life expectancy between wards has grown from 7.2 years in 1999-2003 to 16.9 years in 2002-2006
- The gap in female life expectancy between wards has grown from 6.0 years in 1999-2003 to 9.9 years in 2002-2006.

Reducing this gap will not only be beneficial in itself but will help to further improve the overall health status of the borough's population.

3.3.5 The over-riding target of this strategy is to reduce the inequality in life expectancy between the most deprived fifth and least deprived fifth of Southwark's population (see section 5). The baseline position is shown in Tables 3.2 and 3.3, and indicates that there is a clear and statistically significant life expectancy gap between the most deprived and least deprived quintiles of Southwark's population. For both females and males however there is a dip in life expectancy in the middle quintile which would merit further investigation.

Table 3.2 Average female life expectancy in Southwark by deprivation quintile, 2002-2006.

Deprivation quintile	Average life expectancy (years)	95% confidence intervals
Quintile 1 (most deprived)	79.6	78.8 - 80.5
Quintile 2	81.1	80.3 - 82.1
Quintile 3	79.5	78.6 - 80.4
Quintile 4	82.6	81.6 - 83.5
Quintile 5 (least deprived)	83.0	82.0 - 84.0

Source: LHO 2009

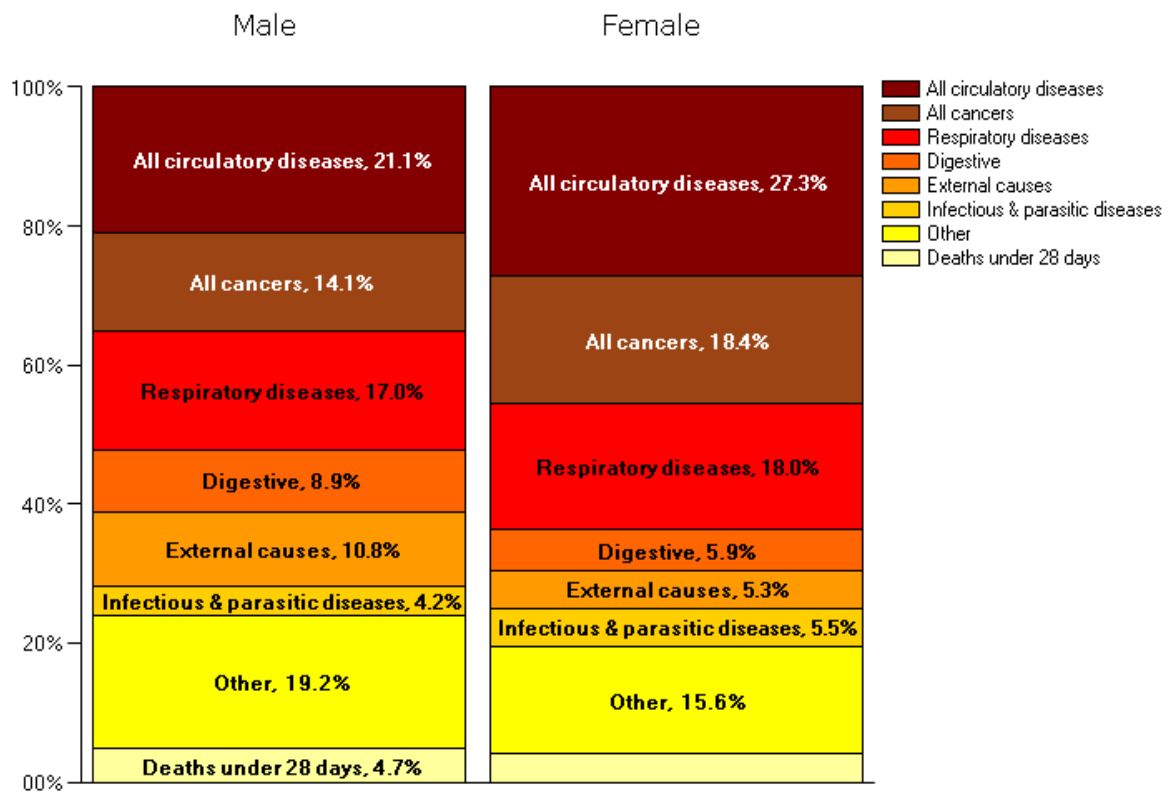
Table 3.3 Average male life expectancy in Southwark by deprivation quintile, 2002-2006

Deprivation quintile	Average life expectancy (years)	95% confidence intervals
Quintile 1 (most deprived)	73.3	72.5 – 74.2
Quintile 2	76.1	75.2 – 77.1
Quintile 3	73.8	72.9 – 74.6
Quintile 4	77.1	76.1 – 78.0
Quintile 5 (least deprived)	78.5	77.5 – 79.5

Source: LHO 2009

3.3.6 Another breakdown of the health gap in Southwark is shown in Figure 3.6. This shows the relative contribution of different causes of death to the inequalities gap in Southwark and illustrates the importance of some key health problems. Tackling these will be vital if the inequalities gap is to be reduced. More details of the gap by cause of death are provided in Appendix 3.

Figure 3.6. Breakdown of the life expectancy gap between the most deprived and least deprived quintiles of Southwark LB by cause of death



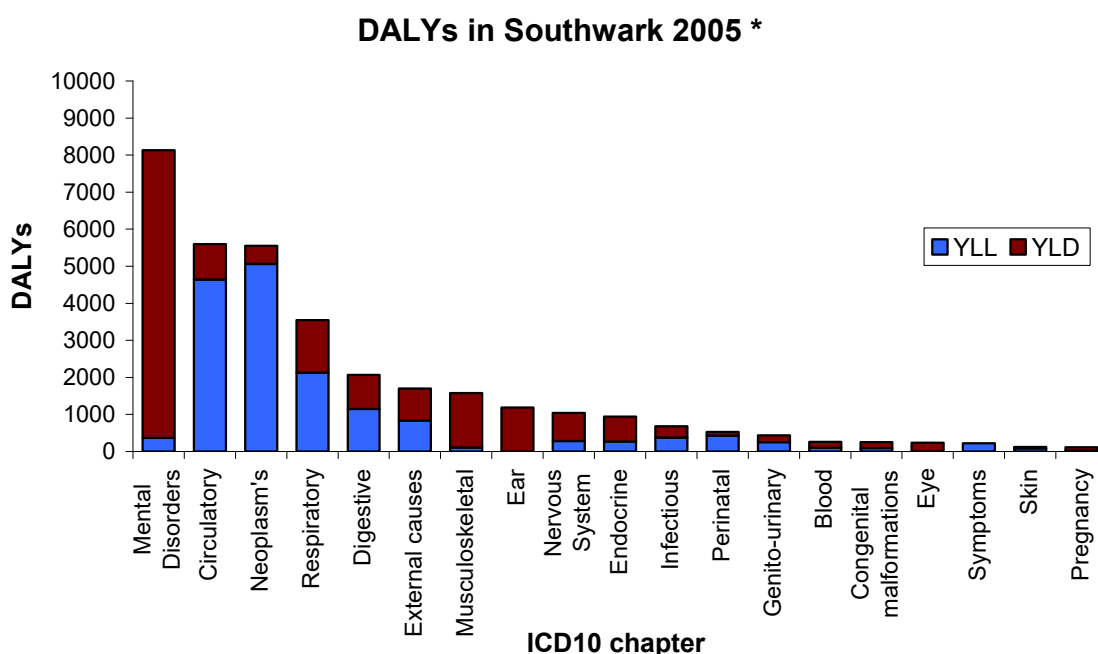
Source: LHO Health inequalities intervention tool

3.4 Overall health burden

3.4.1 Health is a broad concept and mortality rates provide only part of the picture. Figure 3.7 below combines both years of life lost (mortality) and years of life lived in disability (morbidity) into a concept known as disability adjusted life years (DALYs). By this measure, a disability which compromises quality of life by 50% leads to the loss of one DALY every two years

The figure below shows this for different disease groups (shown as ICD10 chapters) and highlights the very substantial impact of mental health problems in the population.

Figure 3.7 Disability adjusted life years lost in Southwark 2005



* using standard LE & 3% discounting

Source: Dodia and Phillips, 2008

3.4.2 Although there is limited local data available, national research has found a social gradient in diagnosis of depression and mental disorders (Lorant et al, 2003). The scale of local need is considerable: amongst people aged 16-74 in Southwark there are estimated to be:

- 12,222 people with generalised anxiety disorder
- 19,411 with mixed anxiety and depression
- 41,929 with a neurotic disorder
- 8,111 with depressive episode.

Source: NEPHO 2008

3.4.3 The association between mental health and other problems should not be overlooked. For example, those with mental health problems tend to have poorer physical health, to suffer more disability and have more damaging health behaviours, as do people with learning difficulties. Equally children and adults with disabilities and complex needs require help and support in the community since they are more likely to be socially isolated and unable to participate in activities that can help maintain health.

3.4.4 The mental health of children and young people can be helped through the Targeted Mental Health in Schools project. 'There is clear evidence that children who are emotionally or mentally healthy achieve more at school and are able to participate more fully with their peers and in school and community life. Research also shows that mental health in childhood has important implications for health and social outcomes in adult life.' (DH/DSCF 2007)

3.4.5 People with mental health problems are more likely to be stigmatised and less likely to engage fully in society. For example people who are disabled because of mental health problems have lower employment rates than all other disabled groups.

The Social Exclusion Unit found that 55 per cent of people with a mental health problem found that stigma was a barrier to employment. (MIND 2009) There are also an increasing number of people with medically unexplained symptoms and, over a patient's lifetime, correlates with a number of anxiety and depressive disorders. (Katon et al 1998)

3.4.6 The growing numbers of older people and people experiencing long term limiting illnessness and disability must not be overlooked. They need to be able to access services so they can be maintained in their own homes. For example dementia is particularly isolating for many families and as the condition progresses, the costs of care to the families and services are huge and access to memory services for example, can delay some of these effects and help maintain a quality of life.

3.5 Current arrangements for tackling inequalities

3.5.1 There is a wide range of action in place to help reduce health inequalities in Southwark, but as the Audit Commission (2008) has noted there has been no overarching strategy or action plan to address the issue. Some action to tackle health inequalities may be implicit and may have been overlooked. The impact of that action may also be diminished by failing to identify, and make use of, opportunities for collaboration between local agencies.

3.5.2 Current action takes place at many levels and is delivered by all agencies within the Healthy Southwark Partnership as well as by other bodies. The following sets out just a few examples of action that will help to narrow the health gap in the borough

Figure 3.8 Examples of local action to reduce health inequalities in Southwark

Factor affecting health inequalities	Examples of local action
Socio-economic determinants	Regeneration projects Employment support
Lifestyle	Smoking cessation provision Weight management programmes Healthy walks programme
Access to services	CVD risk assessment Improving access to psychological therapies

Source: NHS Southwark.

3.5.3 Work to address inequalities is co-ordinated within some key local frameworks that help to co-ordinate and galvanise local action. These are described in the remainder of this section and include:

- Community strategy
- Local area agreement targets
- World class commissioning
- Other local targets and plans

3.5.4 The Sustainable Community Strategy, Southwark 2016, sets out a clear commitment to client centred and integrated service provision and identifies key actions including:

- Tackling poverty, worklessness, poor environment, inadequate housing and crime.
- Reducing infant mortality.
- Reducing obesity and teenage pregnancy.
- Improving accessibility to sexual health services for young people.
- Targeted intervention for those at risk of diabetes and heart disease.
- Improved outreach to communities.

3.5.5 Within the Local Area Agreement (LAA) specific local targets have been set which establish where we aim to be in future years. These include items explicitly identified as health inequality targets as well as many others that concern the broader determinants of health:

- 4-week smoking quitters per 100,000 population 16+
- Obesity in Yr 6 children, school data
- All age all cause mortality rate

- Early access to maternity services
- Social care clients receiving self directed support
- Vulnerable people achieving independent living

3.5.6 Targets agreed through NHS Southwark in support of its World Class Commissioning (WCC) plan have a clear relevance to health inequalities:

- average IMD (deprivation index) score
- life expectancy at time of birth
- infant mortality
- cancer mortality rate premature mortality (under 75 years)
- substance misuse
- CVD mortality – Premature mortality (under 75 years)
- diabetes controlled blood sugar – the % of patients with HbA1c <7.7%
- Decrease in obesity rates among primary school children in year 6
- Patient experience (primary and community services)

3.5.7 Finally, there are a number of other local plans that will impact on health inequalities in one form or another. Examples of these include:

- Housing strategy
- Primary and Community Care strategy
- NHS vital signs

Summary

Southwark is the 26th most deprived local authority area nationally (out of 354) and has relatively low employment and income. It also has a young, ethnically diverse population.

Considerable progress has been made in recent years in reducing the life expectancy gap between Southwark and the rest of England. However, inequalities within the borough remain considerable and a polarisation can be observed in a

variety of health outcomes.

The gap between the most deprived and the least deprived fifths of Southwark's population is 3.4 years for women and 5.2 years for men.

Whilst there is a considerable range of local action underway to address health inequalities, the specific contributions of different activities must be made explicit and where possible, quantified so that effective monitoring of programmes is possible.

Mental illness is a considerable cause of long term disability.

4 Where do we want to be?

4.1 Aims and objectives

Our aim is to reduce inequalities in health in Southwark by narrowing the gap between those at greatest risk of poor health outcomes and those who have the best health.

- ensure collaboration across sectors in reducing health inequalities with coordinated action in the short, medium and long term
- ensure that addressing inequalities runs as a thread through all major PCT and Council strategies and plans
- ensure that services benefit those in greatest need
- ensure that prioritisation and investment to address health inequalities is based on a clear and realistic understanding of the scale and effectiveness needed to deliver change at the population level

4.2 Principles

4.2.1 The key principles underpinning our approach are:

- to ensure that addressing health inequalities is everyone's business across the partnership
- to build on and complement existing strategies, plans and targets
- to employ systematic methods of needs assessment, evaluation, and equity impact assessment to support decision making and commissioning.
- to ensure that community engagement a central component in local planning, building active and sustainable communities
- to ensure that there is appropriate balance between achievement of short, medium and long term objectives
- to ensure that actions are focussed on measurable achievement and outcomes
- need for robust community engagement to be central component to addressing health inequalities

4.3 Southwark's inequalities target

4.3.1 Local targets are a way of setting a clear direction, galvanising action and enabling measurement of success. It is important that a local target is:

- quantifiable
- challenging
- meaningful
- consistent with good practice
- achievable
- statistically robust

4.3.2 Data on health inequalities are available at different geographical levels and in the past the local authority ward has often been used in the past as a basis for measurement. This has the advantage of being locally identifiable but is prone to fluctuations simply as a result of small numbers. Wards can also contain different populations within them and thus the average can mask some substantial inequalities.

4.3.3 More recently the concept of the deprivation quintile has been used. This is based on a collection of very small areas (MSOAs) that together form into fifths (quintiles) of the total population. As they are based on deprivation they directly address inequalities issues and because they are combined into quite large populations (fifths of the whole borough) they are statistically more robust refer Appendix 1

4.3.4 We have decided to use deprivation quintiles as the basis of our target and for it to be expressed in terms of life expectancy. The target is set out below and in short hand can be expressed as ‘20% by 2020’.

To reduce the life expectancy gap between the most deprived quintile and the least deprived quintile of the population of Southwark by 20% by the year 2020

Indicator	Females	Males
Average life expectancy – most deprived quintile	79.6	73.3
Average life expectancy – least deprived quintile	83.0	78.5
Difference (the life expectancy gap)	3.4 years	5.2 years
Improvement target (20% of the gap)*	0.7 years	1.0 years

*note: This is the minimum improvement in life expectancy required for the most deprived quintile over the next ten years. In reality it is likely that life expectancy of the least deprived people in Southwark will also have improved by 2020, so it will be therefore be necessary to adjust the improvement target accordingly.

4.3.6 Some initial work has been carried out to model the implications of this target and some of the key interventions required. This is described further in section 5 of the strategy.

Summary

Southwark is committed to tackling inequalities both within Southwark, and between Southwark and England. It has clear strategic aims and targets to be achieved.

Our local target is to reduce the life expectancy gap between the most deprived quintile and the least deprived quintile of the population of Southwark by 20% by the year 2020.

This means an increase in average life expectancy for females in the poorest areas of 0.7 years and for males of 1.0 years.

5 How will we get there?

5.1 Priorities for action

5.1.1 There are many initiatives to improve overall population health and well being in Southwark. These are set out in various documents including the Commissioning Strategy and the Community Strategy. The focus here is on narrowing the gap in life expectancy – a specific but very complex and long standing problem.

5.1.2 Tackling health inequalities requires coordinated action across different sectors and willingness amongst partners to support and add value to the activities of others. Action needs to address a wide spectrum of issues including socio-economic factors, lifestyles and access to services. Some actions will have short term effects, while others aimed at tackling deep rooted problems may take many years to achieve results. Action will need to involve many different people and agencies across all sectors of Southwark’s community.

5.1.3 While there needs to be action on many fronts we have chosen five themes for special attention. These have been chosen on the basis of their impact on health inequalities and the potential to make improvements. Figure 5.1 lists the five themes and illustrates their importance to inequalities in Southwark.

Figure 5.1 The five priority themes in tackling health inequalities in Southwark

The interventions supporting each of these themes are set out in the following table, alongside the rationale for their inclusion.

Theme	Intervention	Rationale	Delivery by
Cardiovascular disease and diabetes	<p>For people living in the most deprived quintile (MDQ)</p> <ul style="list-style-type: none"> • Implement the NHS health checks in high risk communities • Improve CVD and diabetes case finding • Improve Blood pressure control • Achieve good cholesterol control 	<p>These are the biggest causes of early mortality in Southwark and there are strong inequalities between socio-economic groups and between some ethnic groups. Improving the prevention, detection and treatment of these conditions is known to be one the most effective ways of reducing inequalities.</p>	<p>NHS</p> <p>Theme coordinator - NHS officer</p>
Infant mortality/ early years	<ul style="list-style-type: none"> • Early referral and access to maternity care • Reduction in teenage pregnancy rate 	<p>Infant mortality rates are very high in more deprived areas and are a key contributor to reduced life expectancy. Health in early years is vital in setting the pattern for</p>	<p>NHS</p> <p>Theme coordinator - NHS officer</p>

		later life and early intervention can pay dividends for the future.	
Cancer	<ul style="list-style-type: none"> • Improve coverage of Cervical screening through working with primary care • Improve bowel screening through health promotion activities in specific areas 	Cancer is the second biggest cause of inequalities in Southwark. Early detection and treatment of cancers is crucial to improving people's health outcomes and can prevent avoidable deaths.	NHS Theme coordinator - NHS officer
Lifestyles	<p>For those in the MDQs</p> <ul style="list-style-type: none"> • Increase numbers of smoking quitters • Train GP practices in brief interventions for alcohol problems • Develop local walking initiatives • Healthy eating as part of a family approach weight management programme • Improve access to HIV testing for MSM and African communities • Healthy living package for people with enduring mental health problems 	Smoking, alcohol use and physical activity levels are key determinants of health. Rates vary between different population groups and there is increasingly good evidence of interventions to tackle unhealthy lifestyles	NHS Theme coordinator - NHS officer
Life chances	<ul style="list-style-type: none"> • Increase free school meal uptake 	Many health problems have their origins in wider social	Southwark Council

	<ul style="list-style-type: none"> • Improve employment through: • Access into employment for school leavers • NEETs increase employment • Increase employment through recruitment into local NHS • Benefits advice • Improve access to (IAPT) psychological therapies for those from BME communities • Improve energy efficiency of homes in all tenures 	<p>and economic conditions. Reducing inequalities in the longer term will depend on action to improve the life chances of people in greatest need. Mental health problems substantially affect life chances as well as being a source of health inequalities in themselves.</p>	<p>Theme coordinator - Council officer</p>
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5.1.4 The inclusion of these themes in the core of our inequalities strategy should help to:

- increase their profile in the borough
- co-ordinate interventions
- step up the scale of the interventions
- target them into the most deprived areas

5.2 The delivery plan

5.2.1 The delivery plan includes action for each of the five themes together with outcome measures, targets and other data needed to support effective implementation. It will be updated and reviewed as more information becomes available (for example when baseline data are completed) and in the light of changing circumstances. Where relevant this would be carried out in consultation with the Healthy Southwark Partnership

5.2.2 Each of the five themes has a small number of specific interventions. Again these are designed to focus attention on particularly important interventions but they are not meant to be exhaustive. The purpose is to maintain a high level of focus on

key priorities for special attention in the most deprived areas. The interventions are based on key guidance and evidence, including:

- National Support Team feedback
- Department of Health Inequalities guidance
- Local plans and strategies
- Quantitative and qualitative research data
- Best practice and other evidence.

5.2.3 Some interventions may have the potential to deliver very profound effects for relatively small numbers of people whereas others may deliver more modest benefits but to larger numbers of people. Southwark's strategic approach is to identify those actions that ensure best outcomes for the largest number of people and which can be scaled up as far as possible in order to effectively meet our goals.

5.2.4 Local health outcomes in some parts of the borough remain worse than those nationally and benefits have not reached all parts of the population. Considerable inequalities exist between Southwark residents in different parts of the borough. Appropriate and consistent targeting of resources will be required to ensure that the people in the more deprived areas of the borough benefit most and their life expectancy is raised more quickly than average. This will require special efforts and measures to target resources in the populations that need them most. This may mean disinvesting in the least deprived areas so that the more deprived areas can benefit.

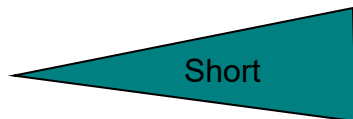
5.2.5 Actions will therefore be focussed where they can have maximum impact and can help reduce the inequality gap. This will be flexible according to the particular intervention and will often mean a geographical focus on the most deprived areas. Other ways of targeting resources may include a focus on GP practices, housing estates, income or employment groups, people from specific BME communities, schools, and workplaces.

5.2.6 The reason for targeting in different ways is two-fold. One is that a particular population group may be exposed to a higher risk of ill-health than others. An example of this is that black African men are at higher risk of hypertension, stroke and HIV than the overall population and action to address these will be an effective way of reducing overall inequalities. The other reason is that the delivery of an intervention needs to be tailored to local circumstances – for example it may be more effective to provide some services to particular schools or GP surgeries rather than to post-code areas.

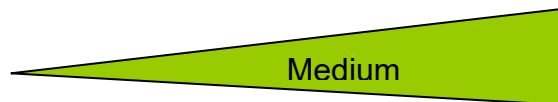
5.2.7 The delivery plan is intended to improve health over the whole strategy period. While implementation will start from the beginning of the strategy period, the health impacts will vary according to the problems being tackled. The timescales for anticipated outcomes of the inequalities delivery plan are illustrated in Figure 5.2. In this context the meaning of the timescales is as follows:

- short term: 2010 and 2011
- medium term: up to 2015
- long term: up to 2020

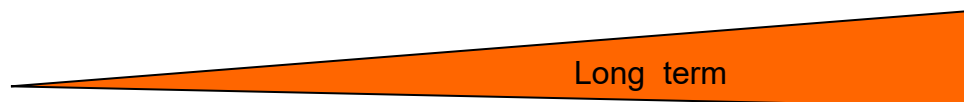
Figure 5.2. Key actions to reduce health inequalities within Southwark, by timescale of health impact



- Cardiovascular disease prevention (delivery plan parts 1.1, 1.3 & 1.4)
- Teenage pregnancy (2.1)
- Early access to maternity care (2.2)
- Cancer screening (3.1 & 3.2)
- Sexual health (4.5)



- CVD and diabetes case finding (1.2)
- Smoking cessation (4.1)
- Brief intervention for alcohol (4.2)
- Increasing physical activity (4.3)
- Healthy eating support (4.4)
- Healthy living - mental health (4.6)
- Benefits advice (5.3)
- Access to psychological therapies (5.4)



Education & skills (5.1)
Employment (5.2)
Building neighbourhoods to sustain long term well being
Education

5.3 Intervening on the right scale

5.3.1 The target to reduce the life expectancy gap by 20% in Southwark is ambitious (the most recent national target was a 10% reduction over 6 years). It is important to assess the implications of the target in terms of the numbers of people in the borough who would be affected. This is partly to provide a 'reality check' but also to help local partners to consider what scale of interventions are needed to make a meaningful contribution.

5.3.2 To help with this, the PCT has carried out some modelling of life expectancy and of some of the interventions. This should be seen as the start of a process and will be developed further as more evidence becomes available.

5.3.3 Table 5.1 shows the effects of saving lives on life expectancy in Southwark's most deprived quintile. There are many alternative scenarios that could be modelled but the ones below are designed to illustrate some possibilities. They should be seen as examples rather than specific predictions.

Table 5.1 Examples of the effects of reducing mortality in the most deprived quintile in Southwark.

Health improvement in Southwark's most deprived quintile (annual)	Average number of deaths reduced per annum	Modelled effect on average life expectancy in the most deprived quintile
One quarter reduction in all infant deaths	2.3	Increase by 0.18 years
One quarter reduction in all deaths from CVD in people aged under 75 years	12.3	Increase by 0.52 years
One quarter reduction in all deaths from cancers in people aged under 75 years	13.1	Increase by 0.57 years
Prevent all excess infant deaths in the MDQ compared to the LDQ	5.8	Increase by 0.47 years
Prevent all excess CVD deaths in the MDQ compared to the LDQ	33.0	Increase by 1.2 years
Prevent all excess cancer deaths in the MDQ compared to the LDQ	17.0	Increase by 0.71 years

Source: ONS population and mortality data modelled with an ONS life expectancy calculator. Notes: Five years worth of data have been used in this model to help ensure statistical reliability, but the above figures are illustrations of annual reductions in mortality. For deaths in the under 75 group it has been assumed that the reduction in deaths would be proportionate in every specific age group from 1 to 74 years.

5.3.4 The first three rows show the effects of an absolute reduction in infant deaths and in cardiovascular diseases and cancer deaths in the under 75-age group. To put those figures in context the total average number of deaths under 75 in the MDQ is 177 per annum, the large majority of which are caused by infant deaths, cancers or CVD. The last three rows show the effect of a relative reduction of deaths in any age group in the MDQ down to the level found in the least deprived quintile. The overall improvement needed to meet Southwark's 2020 target is to improve average life expectancy in the MDQ by 0.7 years for females and 1.0 years for males, so the achievement of just some of the above illustrations would be a major step towards this.

5.3.5 Some specific interventions have also been modelled. The body of evidence is greater for cardiovascular interventions and smoking, and some key results are shown in the following paragraphs.

5.3.6 A national health inequalities toolkit has been used to examine the effects of improving blood pressure control in Southwark. The results suggest that:

- supporting 75% of the estimated 3329 males with hypertension in the most deprived quintile to bring their blood pressure down to target levels would add

0.1 years to average male life expectancy in the most deprived quintile (source: Health inequalities interventions toolkit).

- The same intervention for 85% of the estimated 3449 females with hypertension in the MDQ to bring their blood pressure down to target levels would add 0.1 years to average female life expectancy in the most deprived quintile (Source: Health inequalities interventions toolkit).

5.3.7 One of the most recent policy initiatives has been to introduce vascular health checks for people aged 40 to 74. The following data show the results of modelling a targeted high uptake of this programme in Southwark’s most deprived quintile (90% compared to 80% nationally). The modelling suggests that in the MDQ each year:

- There would be 2491 invitations to of 40-74 years olds to attend for a check
 - 2242 people in the MDQ would attend
 - 98 people would use stop smoking services
 - 829 would have a brief exercise discussion
 - 362 people having an obesity intervention
 - 94 would have a chronic kidney disease diagnosis
 - 248 people put on anti-hypertensive drugs
 - 181 people put on statins to control their cholesterol
- (Source: NHS Vascular checks toolkit)

5.3.8 The above figures use national assumptions about the health needs of the population screened and may therefore underestimate the service requirement in a more deprived and less healthy population.

5.3.9 Evidence relating to the costs and benefits of some interventions has been gathered by the Department of Health (2008a) and are set out in Table 5.2. This looks at the average health gain that would be experienced by people in a specific age group who undergo a specific treatment. These health gains are expressed as ‘quality adjusted life years’ (QALYs). One whole year in a state of completely good health would be expressed as 1.0 QALY gained. A figure of less than 1.0 QALY suggests that there would be a gain of less than one extra year in full health, or alternatively could mean gaining a year or more but in a relatively poor health state.

Table 5.2. Health benefit in QALYs of selected interventions

Intervention	Relevant population group	Average QALYs gained per person as a result of the intervention.
Statins	Male 40-49	0.47
	Male 50-59	0.30
	Male 60-69	0.18
	Male 70-79	0.08
	Female 40-49	0.35
	Female 50-59	0.27
	Female 60-69	0.17
	Female 70-70	0.08
Anti-hypertensive drugs	Male 40-49	0.79
	Male 50-59	0.71
	Male 60-69	0.60
	Male 70-79	0.57
	Female 40-49	0.88
	Female 50-59	0.74
	Female 60-69	0.60

	Female 70-70	0.45
Smoking cessation	All	0.39

Source: Department of Health 2008a.

5.3.10 We estimate that there are very approximately 10,000 smokers amongst the 53,400 people who live in Southwark's most deprived quintile. This would include the most hard to reach groups in this quintile. A targeted effort to support 20% of them (2000 people) to stop smoking would add 0.1 years to the average life expectancy of the most deprived quintile. This measure would reduce the relative gap between the MDQ and the Southwark average by 6.3% for males and 4.6% for females (Source: Health inequalities intervention tool)

5.3.11 Research on alcohol services has found that there is an average gain of between 0.026 and 0.042 years of life each person who has a brief intervention in primary care (Matrix Bazian 2008). Applying this intervention to an illustrative 5,000 hazardous drinkers in Southwark's most deprived quintile would thus achieve an increase of between 130 and 210 years of life. This would include people who do not readily access services for whatever reason.

5.4 The wider context

5.4.1 Because health inequalities have many different causes there are many organisations and individuals in the borough that can play a role in narrowing the gap. Agencies responsible for issues such as education, housing, employment, community safety and environmental health can improve health through their primary roles but can also influence lifestyles (such as smoking and alcohol use) and can even improve access to health services. Conversely while the NHS provides health services and health improvement projects, it also has a key role as an employer and educator of local people. The many businesses and voluntary sector organisations in Southwark have a substantial influence on socio-economic factors, lifestyles and service access, and can also reach people who are not involved in mainstream health and social care services.

5.4.2 While the focus of this strategy is on improving life expectancy (in line with national and local targets) this should be seen as part of a more holistic approach to improving health and well being. Improving people's lifestyles and life chances will have a wider effect on local communities and will bring a range of improvements in the longer term. There is also increasing recognition of the interplay between mental health and physical health and of the crucial role of the early years of life. The Family Nurse Partnership programme, which is being piloted in Southwark, is helping to improve the life chances of vulnerable babies, young children and their families. The first year evaluation report shows that changes take place in health behaviour, relationships, parental role and maternal well-being. (DH/DCSF 2008) People who have adverse childhood experiences (such as parental substance abuse or who experience abuse and neglect themselves) are more likely to have mental health problems, and people with mental health problems have higher rates of physical illnesses such as heart disease or cancer (Source: J Nurse, Dept of Health). Action to improve living conditions and the resilience of individuals and communities can thus have a knock-on effect on a number of health outcomes.

5.4.3 Finally, we need to recognise that targets and actions in this strategy may need to be reviewed in the light of changing national and local circumstances. For example it may need to be adapted because of changes in national policy or targets – the current Marmot review being particularly pertinent. Local factors include the impact of

Southwark's changing economy and mobile population – the pattern of deprivation across the borough may be different in future and the strategy would need to adapt to reflect this. This will require an intelligent and flexible approach to commissioning that is based on high quality local intelligence and is responsive to changing needs.

5.4.4 It is therefore important that the strategy remains a living document and that new evidence from e.g. NICE can be integrated into the services as part of the commissioning agenda. Whilst the outcomes of the targets are mainly quantitative with the performance framework, more qualitative research calls for the involvement of local people as to their ideas and information about what might benefit their health. Evaluation of the strategy itself needs to be included and research workshops to identify what research questions could be considered. Opportunities for research on health inequalities locally could be considered in collaboration with Kings Health Partners

Summary

Cooperation is required between public, private and third sectors to ensure coordinated investment to address health inequalities in the short, medium and long term.

Interventions will be focussed on groups in greatest need and where there is greatest scope for benefit

Interventions will be scaled appropriately to achieve the planned outcomes. The

6. Delivering the strategy

6.1 Implementation arrangements

The key to reducing inequalities in health is to work towards equality by a sustained sense of direction. This needs a multiagency approach with collaboration and cooperation to achieve necessary change.

Therefore:

- The plan includes interventions that are already in place but need more action to improve outcomes. It is about increasing access to health information and advice, health services, social care, education and employment opportunities for the most deprived sections of the population in Southwark.
- The interventions on the delivery plan were identified because they were the services and programmes that were less successful in creating change and therefore needed more consideration. It is about improving the access and giving more attention to 'hard to reach' populations and support their engagement in the services

6.1.1 This strategy does not stand alone but is integrated with a number of other initiatives and plans to improve the lives of people in Southwark. Some examples of these are shown in Figure 6.1, but it is important to note that these are only some of the plans that will have an impact on health in the borough.

Figure 6.1. Examples of key initiatives and plans that will help to narrow inequalities within Southwark.

Initiative/ plan	Links to inequalities strategy
Sports and Physical Activity Strategy	To ensure that all relevant age groups, high risk groups and people who could most benefit are enabled to participate in physical activity. Has a particular focus on addressing the needs of children and their families.
Regeneration and Major Projects Programme	To ensure that planning of new space takes into account to need to design in safe and enjoyable places to walk, cycle, play and exercise
Healthy Weight Strategy	Particularly in relation to the focus on early years, on actions in schools and on improving active living for children and their families
Think Family	Particularly in relation to vulnerable families and families with multiple difficulties through Early Intervention Parenting Programmes and increased emotional health and wellbeing support
NHS Southwark Strategic Plan	Focuses action on key NHS priorities including improving health and access to services.
Alcohol Strategy	The focus will be within Primary Care for screening and brief interventions programme for alcohol intake
Mental Health Strategy	In progress
Employment and Enterprise Strategy	(Under Review) Focus will on enabling access to education and training opportunities plus assessment of people with disabilities to be able to

	access support and opportunities for work
Children and Young Peoples' Plan	(In Development) The agenda for Every Child Matters includes the statutory responsibility to redress inequities in the most deprived pupils
Sustainable Community Strategy 2016	Improving Life Chances: Reducing High levels of unemployment and benefit dependency strengthening vocational skills and increasing educational attainment. A better place for people: Greener, cleaner and more pleasant place to live, work and visit.

6.1.2 Implementation will be overseen by Healthy Southwark (part of the local strategic partnership) which will agree action plans and review progress on a regular basis. This review will include both process and outcome reports. Each themed action plan will be the responsibility of specific individuals from one of the partnership bodies as appropriate. They will also support other strategies in place or in development.

6.2 Supporting arrangements

6.2.1 The success of the strategy will rely on robust supporting arrangements being in place. The rest of this section highlights some of those but the list is not exhaustive.

Impact assessment

6.2.2 When contemplating a new project, or significant changes to existing policies or services, the planning process should take health determinants (and their effect on inequalities) into account. Services and amenities should be targeted according to need. This means that those who are most disadvantaged should be prioritised and protected from negative health impacts.

6.2.3 A health inequality impact assessment checklist can focus attention on the needs of vulnerable groups. Completing this at an early stage of the planning process can assist planners in ensuring that the needs of those groups are met.

6.2.4 Equality and diversity impact assessment (EqIA) is a tool for identifying the potential impact of an organisation's policies, services and functions on its residents and staff. It can help staff provide and deliver excellent services to residents by making sure that these reflect the needs of the community.

Information and monitoring

6.2.5 It is vital that all members of the Healthy Southwark Partnership are able to assess progress in meeting our goals. Involvement plans and community engagement are critical at the planning stages of the interventions. Appropriate measures of health inequalities are needed to help monitor progress and inform future service development, and these should be routinely available to facilitate regular review and reporting. The Audit Commission report (2008) noted the need for the development of more robust outcome measures within Southwark's health inequalities plans. Some progress has been made in the attached delivery plan but further work is needed in some areas.

6.2.6 Health equity audits are one useful tool to help identify how fairly services or other resources are distributed in relation to the health needs of different groups and areas, and to the priority action needed to ensure that services are provided relative

to need. Some health equity audits have already been carried out in Southwark and future audits will be based on some of the priority areas for action in this strategy.

6.2.7 Joint strategic needs assessment is a process that identifies current and future health and wellbeing needs in light of existing services, and informs future service planning taking into account evidence of effectiveness. It is carried out jointly between agencies and provides vital evidence for use in commissioning local services. Future JSNAs provide an opportunity to look at specific inequalities issues in more depth.

Community engagement and scrutiny

6.2.8 Southwark has a wide range of active community and voluntary sector organisations including faith organisations. We will work through Community Action Southwark, the Community Engagement Division of the Council and the Public Involvement team in NHS Southwark to identify local groups and develop our community engagement approach to enable local people in the most deprived areas to become involved in these areas of work. Community engagement is essential to inform prioritisation and decision-making, to establish public support and ownership over interventions and as a process which itself facilitates access to, and control over local service provision.

6.2.9 As the Audit Commission (2008) report noted, effective scrutiny arrangements which includes LINKs, are required to ensure that there is appropriate challenge of proposed policy developments so that efforts to address health inequalities are not compromised by incompatible policies elsewhere.

Training

6.2.10 A comprehensive programme of training for staff at all levels is required so that everyone recognises, and can take action to support ways in which their roles contribute to addressing health inequalities. This needs to include the engagement of local communities and the role that community outreach plays supporting and educating local people

Summary

Robust processes are required to ensure an effective strategic approach to health inequalities.

These will cut across local agencies and will include consideration of the impact of local policies on inequalities

Performance will need to be monitored closely if targets are to be met.

Tools such as joint strategic needs assessment and equity audit can provide valuable evidence to support service planning.

Community engagement is key so that local people are able to co-produce solutions to health inequalities

It is important that the process is subject to local scrutiny

Training will be required to allow more staff to make an effective contribution to reducing inequalities

Delivery Plan.

Theme 1: Cardiovascular disease and diabetes						
Lead agency & individual	Geraldine O'Dea and Sian Davies, NHS Southwark					
Links to other strategies/partnerships	Commissioning Strategy Plan 2009/10 to 2012/13 – Initiatives 6 (CVD) and 7 (Diabetes) South East London Cardiac and Stroke Network.					
Timescale for health outcomes to be seen	Short to medium term					
Monitoring arrangements	PCT Primary Care - PEC and PBC					
Intervention	Segmentation and targeting	Outcome measure	Target & milestones	Timescale for action	Resource implications	Risks & Challenges
1.1 Implementation of NHS health checks in high risk communities	<p>Start PCT roll out in GP practices in the MDQ. Incentives to achieve above average uptake rate in practices in MDQ.</p> <p>Pilot community pharmacy approach in MDQ and results to patient's GP</p>	<p>Number and % of eligible people in MDQ practices offered a check by age-group, sex, ethnicity</p> <p>Number having check identified</p> <p>% high, med, low risk</p> <p>% high, med risk referred for risk lowering interventions</p>	<p>2009/10 Pilot</p> <p>2010/11 10%</p> <p>2011/12 15%</p> <p>100% of eligible people offered check by 2013</p> <p>70% accepting or having had a check by 2013</p>	<p>Start November 2009</p> <p>Pilot on 8 GP practices with higher percentage of patients from the MDQ</p> <p>Total population 73,043 patients</p>	<p>QoF Plus</p> <p>Public health offering extra support for monitoring practices</p> <p>Support offered from PPI plus need for communications support</p>	<p>Uptake in hard to reach groups is likely to require special action.</p> <p>GP patient lists may be out of date – list cleaning exercise could help</p>

1.2 Improve CVD and diabetes case finding in MDQ.	Improve registration for CHD, stroke, hypertension and diabetes by piloting use of practice focus in practices in MDQ	Recorded prevalence of CHD, stroke and diabetes in MDQ as % of expected prevalence Revised threshold	March 2010 70-85%	Health checks see above Practice Focus to find what the gap is.	QoF Plus Training and additional support to all community staff in MDQ. Improve publicity/ awareness in MDQ.	Prevalence of CVD and diabetes is higher in some ethnic groups. May require alternative/ additional ways of case finding.
1.3 Improve blood pressure control by maximising achievement of QoF target for BP control (<150/90 in hypertensives, more challenging for diabetics and those with chronic kidney disease) in MDQ, e.g. using Anti-hypertensives	Focus on practices in MDQ to enable achievement on highest PCT QoF thresholds without exceptions initially and stretch targets in subsequent years	Uptake of local hypertension QoF Revised threshold	March 2010 70-85%	Start October 2009 (tie in with practice performance visits)	Qof Plus	
1.4 Achieve good cholesterol (<5mmol/L) control in a higher proportion of those with CHD, stroke, and diabetes in MDQ, e.g. statins	Priority support for practices in MDQ to achieve PCT QoF target Links to primary care performance management Promotion of local QoF for cholesterol control in CHD to practices in MDQ.	Revised threshold	March 2010 70-85%	Start October 2009	QoF Plus	

Theme 2: Infant mortality / early years						
Lead agency & individual	Gillian Holdsworth, NHS Southwark					
Links to other strategies/partnerships	Commissioning Strategy Plan 2009/10 to 20012/13 – Initiative 3 (Infant mortality). Infant mortality sub-group of the LSLMIG. Teenage Pregnancy Strategy. Smoking Cessation Strategy. Obesity Strategy. Breast feeding strategy. Every Child Matters Priorities					
Timescale for health outcomes to be seen	Short to medium term					
Monitoring arrangements	Healthy Southwark Partnership, Young Southwark Partnership, Infant Mortality Steering Group , Children and Young Peoples' Plan Healthy Schools Partnership					
Intervention	Segmentation and targeting	Outcome measure	Targets	Timescale for action	Resource implications	Risks & Challenges
2.1 Reduction in teenage pregnancy rate	Hot spot schools Looked after children Young offenders	Teenage conception rate reduction 100 high risk young people referred and attending services via YOTS, PRU, Connexions	To reduce by 60% the rate of conceptions by 2010 (baseline 1999- rate: 83 per 1000 15-17 female population	Medium Lead – Teenage Pregnancy Coordinator Alex Evans	Consolidation of activity to have full-time coordinator across Lambeth and Southwark - £40,000 Parental SRE plus communications - £15,000 -Coordinator for Health Huts to be based in targeted schools - TP grant: up to £40,000 - Improved sexual health services access: TP grant up to £40,000 -	Ingrained cycle of deprivation New Teenage Pregnancy Strategy to be developed across Lambeth and Southwark
2.2 Early referral and access to maternity care	Women requiring interpreters, Teenage mothers, women with psychiatric illness and substance misuse	% Women completing needs assessment (booking) by 12+6 weeks	Overall target for Southwark: 50% (This reflects the MDQ as	Short	Additional funding in place for Midwifery Group Practices £600,000 over 2 years	Increasing birth rate in Southwark increasing demand on resources

	problems		over 81.5% of GSTT and 86.8% of KCH maternity service users come from the 2 lowest deprivation quintiles)		From 2010/2011 providers will be expected to find capacity growth from activity increase CQUINs incentives for smoking cessation and 12 weeks access to maternity care Centreing model in place for group antenatal care	
2.3 Healthy weight	See lifestyles section					

Theme 3: Cancer						
Lead agency & individual	Gillian Holdsworth, NHS Southwark					
Links to other strategies/partnerships	Commissioning Strategy Plan 2009/10 to 20012/13 – Initiative 4 (Cancer) South East London Cancer Network NHS Southwark					
Timescale for health outcomes to be seen	Short to medium term					
Monitoring arrangements	London Region QA, Cancer Network, Cervical Screening Steering group					
Intervention	Segmentation and targeting	Outcome measure	Target	Timescale for action	Resource implications	Risks & Challenges
3.1 Cervical screening - Addressing low coverage, achieving 14 day TAT: - List cleaning - Supporting primary care to increase coverage - Achieving 14 day TAT	Targeting health promotion activities at geographical areas Map of uptake by deprivation	Coverage by GP practice run quarterly	To reach the target of 75% in December 2010	2009 - 2010	Cervical screening facilitator appointed to support primary care	1) High mobility 2) Low level of literacy 3) Challenge of implementing 14 day Turnaround time (TAT)
3.2 Bowel screening – to increase the uptake	1) Targeting health promotion activities at geographical areas	% uptake rate	To increase the uptake – national target is 60% (current local rate is 38%)	2009 - 2010	1) Health promotion facilitator to be recruited by Screening Centre to develop health promotion work with screening coordinators across SE London	1) Mobile population 2) Test acceptability 3) Engagement with primary care 4) Low levels of literacy locally 5) Ethnic diversity
3.3 Smoking, alcohol and physical activity - see the lifestyles section below.						

Theme 4: Lifestyles						
Lead agency & individual	Rosie Dalton-Lucas, NHS Southwark					
Links to other strategies/partnerships	Commissioning Strategy Plan 2009/10 to 20012/13 – Initiatives 4 (Cancer) and 6 (CVD). Alcohol Harm Reduction Strategy. Alcohol Strategy Group. Healthy Weight Strategy (due Sept 09). Healthy Weight Steering Group. Physical Activity and Sport Strategy (under consultation). Proactive Southwark. Local strategies for mental health and sexual health and an action plan for smoking cessation are in development.					
Timescale for health outcomes to be seen	Medium term					
Monitoring arrangements	Performance will be measured quarterly and reported to Healthy Southwark Partnership Board. Overall progress will be reported to Southwark Alliance annually.					
Intervention	Segmentation and targeting	Outcome measure	Target	Timescale for action	Resource implications	Risks & Challenges
4.1 Smoking cessation in the MDQ practices and population	<p>Targeted activity in MDQ to increase rate of quitters per population to match London's highest</p> <p>Outreach planned for 09/10 includes targeting young people in care, single mums, pregnant smokers, and those with complex needs.</p>	4 week quitters per 100,000 population	<p>Increase smoking cessation <i>interventions</i> in MDQ from 822 to 1032 (in line with London best)</p> <p>Increase <i>quits</i> in MDQ from 274 to 344</p>	Service review and planning to be conducted 2010	<p>210 additional interventions per year = £73,500 / yr</p> <p>Assumptions: Costs associated with delivery of smoking cessation interventions to MDQ are 25% more expensive due to increased intensity of support required. An intervention</p>	<p>Cost and capacity to support practice / incentivise practices</p> <p>Risk of gaming if focus on driving up quality of interventions via practices (i.e. quit rate may improve by providing less interventions to complex need clients)</p>

					<p>for use in MDQ costs on average £350 To match London's highest rate of quitters would mean delivering an extra 210 interventions /yr *</p> <p>* NHS Information Centre</p>	
<p>4.2 Develop usage and effectiveness of Screening and brief interventions (SBIs) for alcohol in primary care</p> <p>(DES) Enhanced Service currently in operation (2008-2010) targeting new patients) in 21 practices. Further details in Clinical directed enhanced services (DES) guidance for GMS contract 2008/09 more detail about intervention at http://www.ncl.ac.uk/lhs/news/item/?brief-interventions-alcohol-and-health-improvement</p>	<p>Training for 100% of practices in MDQ.</p> <p>Draw on assessment of diversity profile of people using alcohol treatment services through contract monitoring information to best target screening interventions</p>	<p>NI39 "Reducing alcohol-harm related hospital admission rates PSA 25" (Hospital Episodes Data)</p>	<p>16 local practices in the national MDQ (5 practices in local MDQ) have not received training on SBIs.</p> <p>6240 add'l patients screened per year (390 practice) = 1120 add'l interventions (70/practice)</p>	<p>By 2010 Develop a strategic plan for the delivery of SBIs. This will need to link to the developing Alcohol Strategy being developed under the aegis of the Community Safety and Enforcement Team</p> <p>By 2011 start roll out of primary care</p>	<p>Train and commission all remaining MDQ practices to offer brief interventions</p> <p>= £1000 (£200/practice for training) plus £9450 / yr</p> <p>Assumptions:</p> <p>Approx £1890* per year per practice for</p>	<p>Need to analyse admissions data by deprivation to establish baseline</p> <p>Is there a case for training practices on brief interventions for a range of issues?</p> <p>DH funding is only available for 2008 and 2010 and not all practices have signed up. At present only new patients benefit from this intervention. Consideration needs to be given meeting the</p>

				alcohol pathway in MDQ practices By 2012 all target practices trained	390 new registrations screened / 70 interventions (x5 practices in MDQ not yet in scheme = £9450) * Based on Alcohol Learning Centre model	needs of existing patients who would benefit from this intervention.
4.3 Physical activity Develop sustainable walking initiatives to increase activity levels in low participation / at risk groups.	Target at risk groups in the MDQ. Groups with lowest participation (3 days x 30 mins moderate activity) are: LT limiting illness / disability (5.5%) Over 55 yrs (8.6%) BME Females (9.9%) Lowest socio-economic group C2DE (11.1%) Could concentrate on 2 audiences within MDQ: ➤ over 55s (inclusive of illness /disability) ➤ BME females	% of pop in MDQ meeting national target (3x30mins moderate intensity) as measured by Active People Survey	Increase participation (at 3x30) by 15% over 3 years in the at risk groups: People with a limiting long term illness/ disability (375 extra) People over 55yrs (650 extra) BME females (750 extra)	2012/13 Short term impact on older people with limiting long term illness/ disability Longer term impact for BME females	Scoping exercise to look at models for expanding walking programmes through primary care, voluntary sector and local authority: £3000 Expand walking programmes/ community activities:	Maternity leave for key post holder. Voluntary sector are a key partner but under increased economic strain Need to address fear of crime for vulnerable groups wanting to take up walking Need to ensure high profile opportunities in Burgess Park and Olympics for 'everyday sport' messages are harnessed to champion walking.

			<p>People from Lowest socioeconomic group C2DE (875 extra)</p>		<p>£150,000 / yr*</p> <p>Assumptions:</p> <p>Only 1 in 5 people on a walking pgm remain active,</p> <p>To achieve a sustained 15% increase in active people in the MDQ (total of 7921 extra people) means getting 39,608 more people engaged in interventions over 3 years.</p> <p>*equivalent of 4 wte staff to train, manage volunteers, promote and</p>	<p>Will recent data for Active People 2 change these figures?</p>
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					lead activities for target groups in each locality 5	
4.4 Healthy eating support as part of a family approach weight management programme	Increase the percentage of healthy weight children from MDQ aged 4--11 to that of the London average Target schools and communities in MDQ	% of children in MDQ of a healthy weight (as indicated by Childhood Measurement Programme data for children in Yr Reception and Yr 6)	Baseline 2008 26% for year 6 children. Deliver 47 programmes over 3 yrs for a cohort of 715 (min est.) obese children aged 4-11 in MDQ in a family approach weight management intervention	2012/13	If scaled up a programme such as MEND (18 sessions) will cost approximately £500 per child/family £119,000/yr	Need to analyse data by MDQ. Consider how delivery might be supported by extended schools / faith communities and make use of new investment in school buildings.
4.5 Improve access to sexual health services and in particular HIV testing for men who have sex with men (MSM) and African communities	Target MSM and African communities	Rate of HIV per 100 000	Increase uptake of HIV testing services by 20%	Refresh of strategy for sexual health by 2010 to decide on further timescales	Provide HIV testing of new patient registrations via GP (target 5 practices in MDQ) : £60,000 / yr* *(based on Lambeth	Sexual Health Strategy expires 2009.

					model currently being piloted).	
4.6 Establish a healthy living package to be referred into from the annual health check for people with mental ill-health including exercise on referral, weight management, smoking cessation	Target people with severe and enduring mental ill-health	% of people receiving annual health check (including option for referral to healthy living activity)	100% of annual health checks to refer to options on pathway	2013/14	Increase exercise referral programme capacity by 50% (200 additional clients / yr) and include broader health support services: £35,000 / yr * *Based on current cost of programme.	Awaiting Mental Health Strategy. Need to model impact on health outcomes.

Theme 5: Life chances						
Lead agency & individual	Alex Trouton and Jeffrey Lake, NHS Southwark					
Links to other strategies/partnerships	Commissioning Strategy Plan 2009/10 to 20012/13 – Initiatives 1 (Index of multiple deprivation) and 10 (Mental health)					
Timescale for health outcomes to be seen	Medium to long term					
Monitoring arrangements	NHS Southwark, Southwark Enterprise and Employment, Children's Trust, Young Southwark Partnership Board, Healthy Southwark Partnership					
Intervention	Segmentation and targeting	Outcome measure	Target	Timescale for action	Resource implications	Risks & Challenges
5.1 Education/ skills Reducing the inequality gap by increasing the uptake of free school meals in schools in MDQ	Primary school children Families receiving benefits	Increase number of school children taking up FSM Baseline (School Census, January 2009): Eligible for FSM 6549 30% primary school children Taking up 5575 25.5% total on Primary roll	Increase in number of FSM	Medium	School inclusion staff	Recession may increase number of families receiving benefits and possible positive impact on take-up of FSM Links with Healthy Weight Strategy 2009 Schools Food Trust
Access into Employment	Care Leavers	Increase % young people leaving care employment education or training	LAA target 2010/11 – 70%	Medium to long term	DWP funding through JCP programmes (Pathways, Flexible New	LAA targets due for review in 2010 Recession decreases job prospects

Not in Education, Employment or Training	16 –18years non- participating in school	Increase levels of employment, training or education			Deal	
	Young people 18 -24 years	increase % in employment, education or training	LAA target NEET 2010/11 - 8%	Medium to long term		
	Young offenders engagement in suitable education, employment or training	Increase in % in employment, education and training	LAA target 2010/11 - 90%		SLAM Mental health and outreach nursing services	Rising numbers of high risk and 'Hard to reach' group incurring social cost being outside education and training systems. NEETS to be reviewed
					DWP funding through JCP programmes	Connexions PCT Outreach Team uncertain funding for the future
					DWP funding through JCP programmes	Southwark Council Employment Strategy being updated
					SLAM Mental health and outreach nursing services	Continuation & development of Southwark Works style interventions such as SLAM/Early Psychosis adviser; Learning

						Disabilities adviser placed with Day Centres/Camden Society); drugs & alcohol interventions (egg Red Kite Learning/Blenheim CDP)
5.2 Employment - local recruitment to the NHS	Schools students work experience Apprenticeships NVQ2	Reduction in unemployment rate in most deprived wards	PCT Apprenticeships Annually, 1-2 per year to NVQ2 for Southwark residents Number accessing post in NHS Number taking up education opportunities NVQ3 or above	2010/11 - 3 Apprenticeships PCT HR Lead Lynn Demeda 1	NHS/Jobs/ Careers on-line and Job Centre Plus Job Fairs locally and RCN Job Fair Successful bid to Future Jobs Fund phase 1	No funding for advertising Local employers being encouraged to accept young people for work placements and apprenticeships Start date dependent on successful bid
Partnership – New Jobs NHS, Southwark Council, Business, & Voluntary Sector	Unemployed Southwark Residents Sub groups Unskilled Partially skilled Skilled	112 jobs to be created	2 posts created in PCT	Start date November 2009 Southwark Council & Southwark College Lead – Southwark Council		

5.3 Benefits advice	Geographical prioritisation under review (provision via GP surgeries)	1. Amount of benefit raised by practices serving MDQ 2. Increase in DLA/AA in SOAS or by practice	Increased rate of take up in MDQs (% increase and timescale under review)	Short term Lead - David Paterson	Staffing currently under review. Resource requirement for delivery in MDQ to be determined.	Services currently adjusting after staff losses Rationalisation of service to some GP Surgeries
5.4 Mental health – improving access to psychological therapies.	Current targeting of BME communities Geographical targeting under development	Numbers and % of clients from BME communities 50 % moving to recovery (WCC target) % retaining employment % returning to work % moving off sick pay and benefits	Currently monitoring only. Service targets for numbers entering therapy, moving to recovery and moving off sick pay and benefits. HI targets to be agreed by Sept 08	PCT Lead Gwen Kennedy Nos entering psychological therapies 09/10 – 4399 Nos moving to recovery 09/10 -2189 Nos moving off sick pay & benefits 09/10 -119	Therapist numbers required 15-18 DWP funding through JCP programmes – Pathways and Flexible New Deal	That access reflects willingness to demand services in more affluent areas Mental Health Strategy currently being updated

<p>5.5 Improve energy efficiency in all homes – council, registered social landlords and private sector (rented and owner occupied)</p>	<p>Geographical</p> <p>Older people and people with disabilities and long term limiting conditions in high risk category for hypothermia</p> <p>BME Elders wishing to remain in their own homes</p>	<ol style="list-style-type: none"> 1. Provision of loft and cavity insulation 2. Reduction in fuel poverty 3. Reduction in seasonal, excess deaths 	<p>Target – Council Homes 14,000 2010 -2012</p> <p>Private Sector category 1 Excess cold Hazards</p>	<p>Southwark Decent Homes standard</p>	<p>Combined Energy savings Programme</p> <p>Seasons Project with Peabody Trust</p> <p>Housing Renewal Services – Step down from hospital</p> <p>Joint Team Home assessment visits to Pensioners re: eligibility for benefits</p> <p>NHS Community Winter Plan awareness requirement to offer support to vulnerable clients</p>	<p>Southwark Core Strategy</p> <p>Southwark Housing Strategy 2009 -2016</p>
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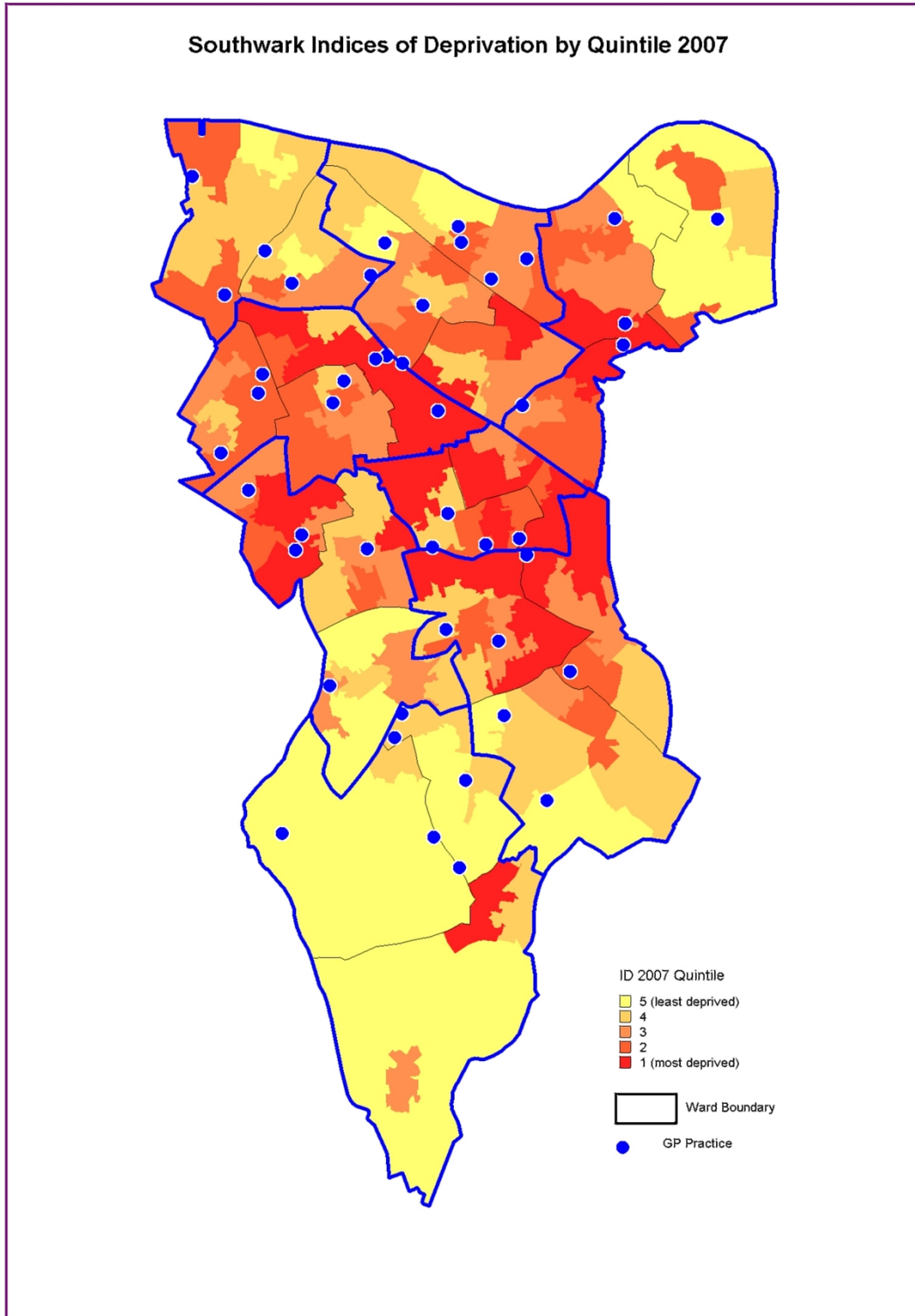
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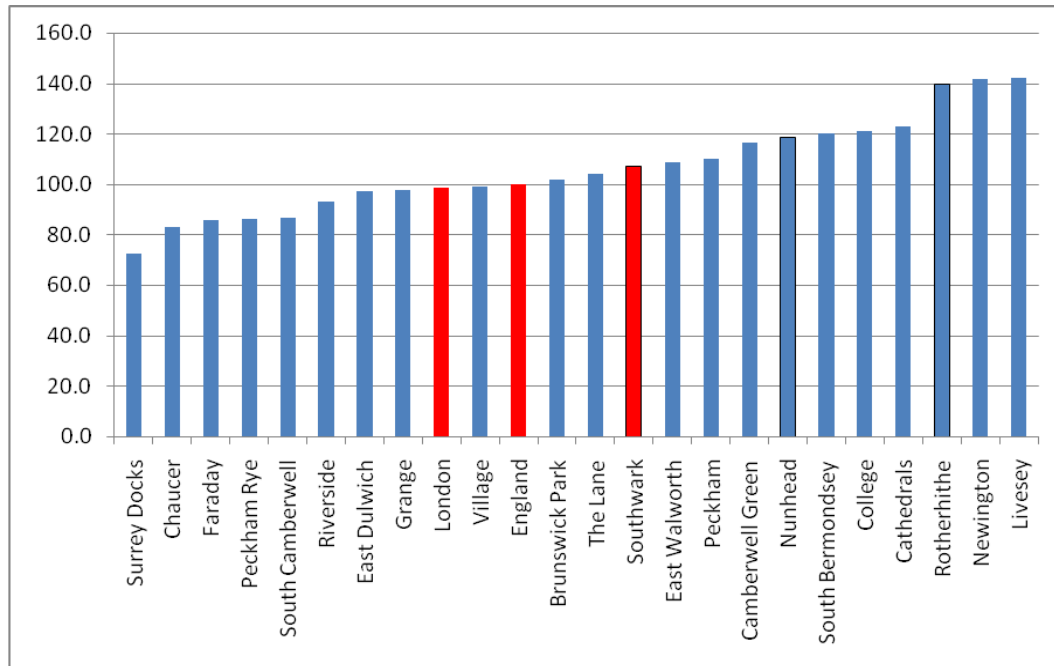
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Appendix 1. Map of Southwark showing deprivation quintiles and location of GP practices.



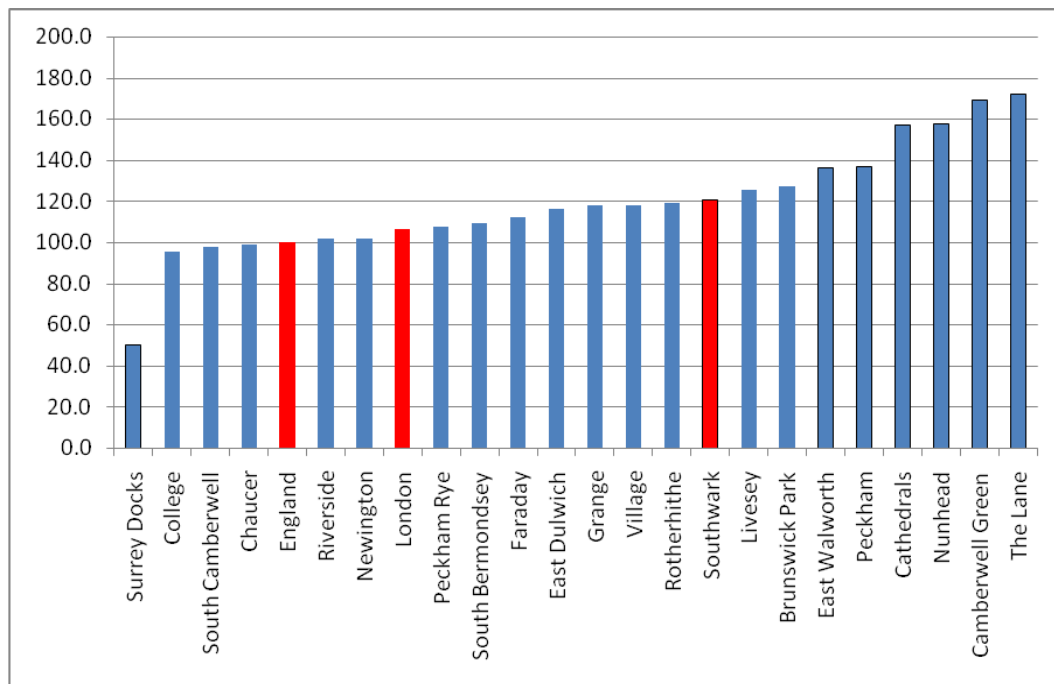
Appendix 2. Cancer and circulatory disease mortality rates in Southwark

a) Standardised mortality ratios for cancers 2002-2006, under 75, ward level



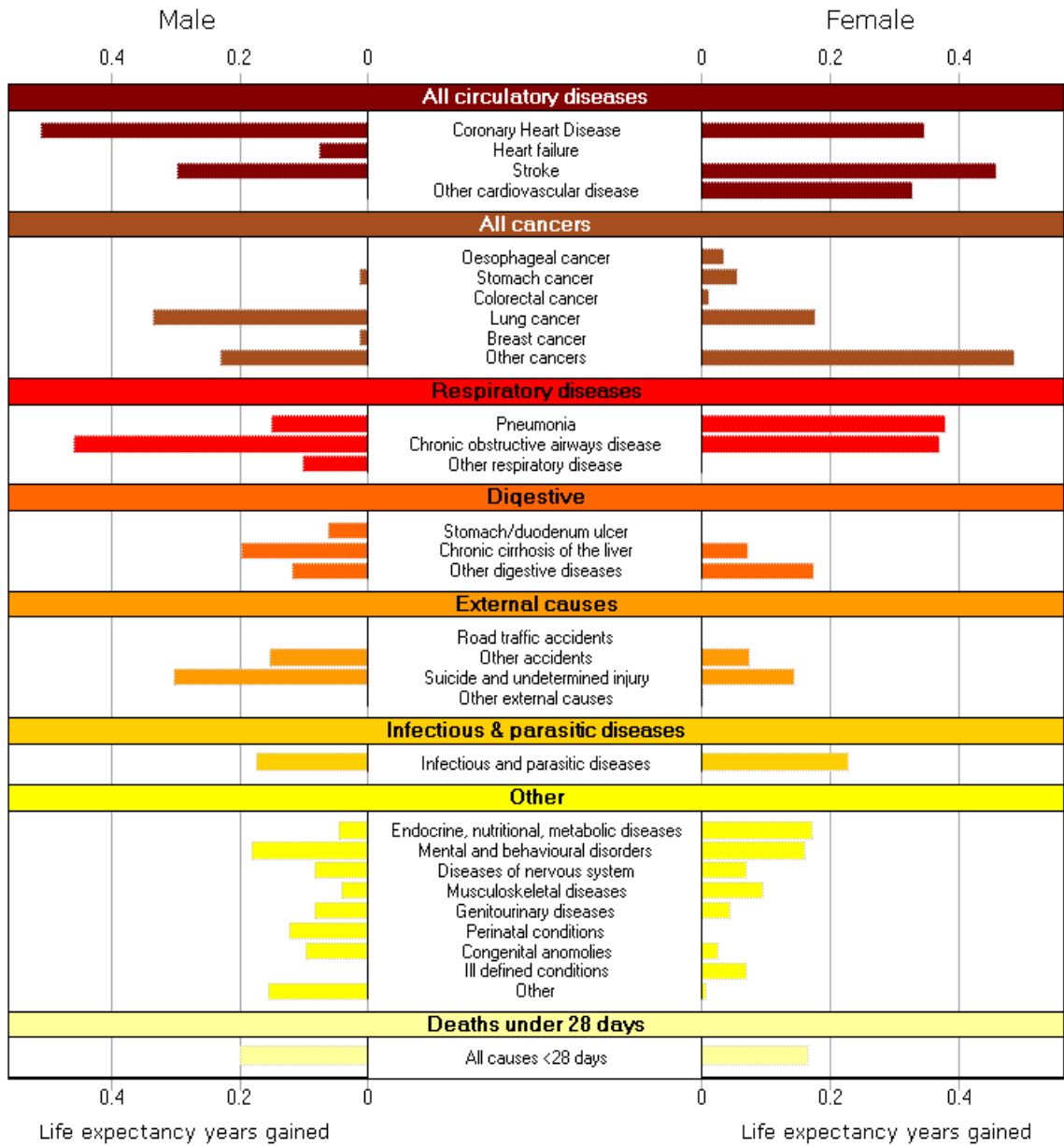
Source: LHO 2008

b) Standardised mortality ratios for circulatory disease 2002-2006, under 75, ward level



Source: LHO 2008

Appendix 3. Relative contribution of specific diseases to the life expectancy gap between the most deprived and least deprived quintiles in Southwark.



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Health Partnership Board members - Core members and wider membership

Young Southwark Executive membership

Boards/Committees

PCT Management Board

Young Southwark Executive

PCT Executive Commissioning

User Involvement and Patient Experience Committee

PCT – Professional Executive Committee

Scrutiny Committee

Visioning Workshop – Employment and Enterprise

Healthy Southwark Partnership Board