Item 3a

Report of the Executive Director Core Services
and the Executive Director of Public Health & Communities
to the Overview and Scrutiny Committee (OSC)
on 28th November 2023

Healthy Life Expectancy and Health Inequalities

1.0 Purpose

1.1 The purpose of this report is to provide the Overview and Scrutiny Committee with an update on healthy life expectancy (HLE). This includes a summary of Barnsley's current position, and a discussion of the factors that affect the number of years people in Barnsley spend in good health.

1.2 HLE is a key measure of health inequalities. To demonstrate the approach the Barnsley Place Based Partnership is taking to address health inequalities, this report and Item 3b - Barnsley Place Based Partnership: Tackling health inequalities in Barnsley outlines the place-based health inequalities strategy and aligned Barnsley Council inequalities plan.

2.0 Introduction and Background

What is Healthy Life Expectancy (HLE)?

2.1 HLE is the average number of years a person would expect to live in good health in a particular area. The measure is based on current mortality rates and the prevalence of self-assessed 'good' or 'very good' health in the population.

2.2 As we continue to both work and live longer, how long we will spend in good health becomes increasingly important. According to the Health in 2040 report, 9.1 million people in England are estimated to be living with major illness by 2040, 2.5 million more than in 2019. This is an increase from almost 1 in 6 to nearly 1 in 5 of the adult population.[1] Most of this increase is the result of an ageing population. The impact of this is a growing and costly demand for health and social care services.

2.3 Where a person lives has a significant impact on their healthy life expectancy. Boys born in England's wealthiest areas can expect twenty-one extra healthy years compared with boys in the country's poorest areas. For girls, the figure is 17 years.

2.4 There are also inequalities in life expectancy that impact how long a person might experience poor health. For example, two populations may both spend on average of 15 years in poor health. However, this might be a quarter of life for a group with life expectancy of 60 years, but only a sixth for a group with life expectancy of 90 years.

What are Health Inequalities?

2.5 Health inequalities are unfair, avoidable, and systematic differences in health and related needs, outcomes and services between different people and groups of people.

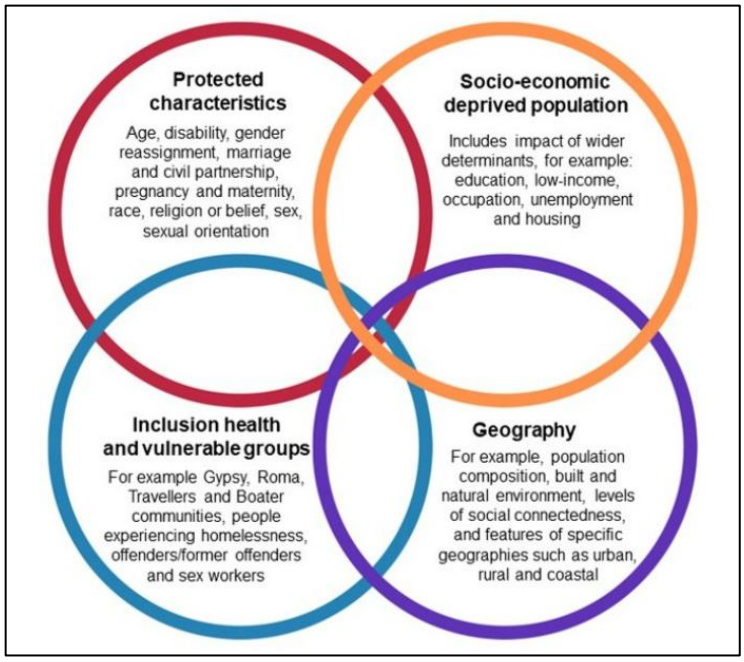
2.6 Health inequalities affect all of us in one way or another. It is not a concept that is unique to a handful of "hard-to-reach" groups but has a scale of impact across the entire population.

2.7 There are overlapping factors (Figure 1) that affect where we feature on this scale. These relate to 'who we are' (demographic), our 'general circumstances' (social, economic, and environmental) and other

[1] Watt T., Raymond A., Rachet-Jacquet L., Head A., Kypridemos C., Kelly E., Charlesworth A. 'Health in 2040: projected patterns of illness in England.' The Health Foundation; 2023 (https://doi.org/10.37829/HF-2023-RC03).

'protected characteristics' that might make us susceptible to discrimination (e.g., inclusion groups).

Figure 1: Domains of health inequality



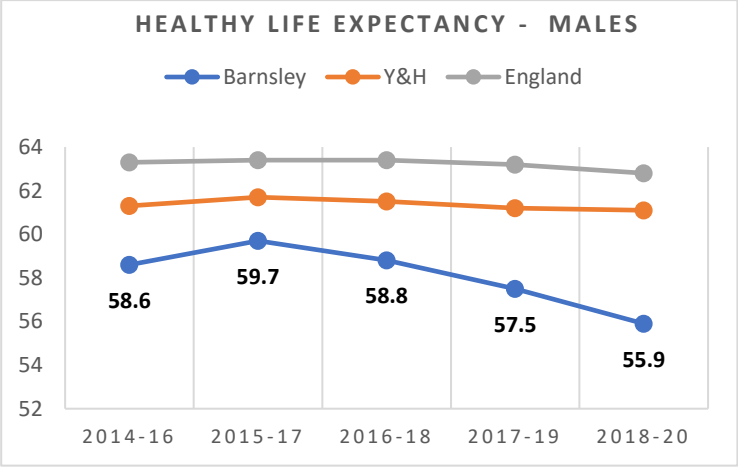
Source: Public Health England (PHE) Place-based approaches to reducing health inequalities

2.8 Due to such social, economic, and environmental circumstances and other characteristics outside of their control, people living in Barnsley are likely to spend more of their day-to-day lives in poor-health than people in other areas of the UK and are more likely to die younger.

3.0 Current Position

3.1 HLE at birth in the UK showed no significant change between 2015 to 2017 and 2018 to 2020. At the same time, HLE in Barnsley has been falling. The most recent published data for the period 2018-2020 shows that HLE for Barnsley males is 55.9 years, and for Barnsley females the figure is 60.1 years (as shown in Figure 2 and 3).

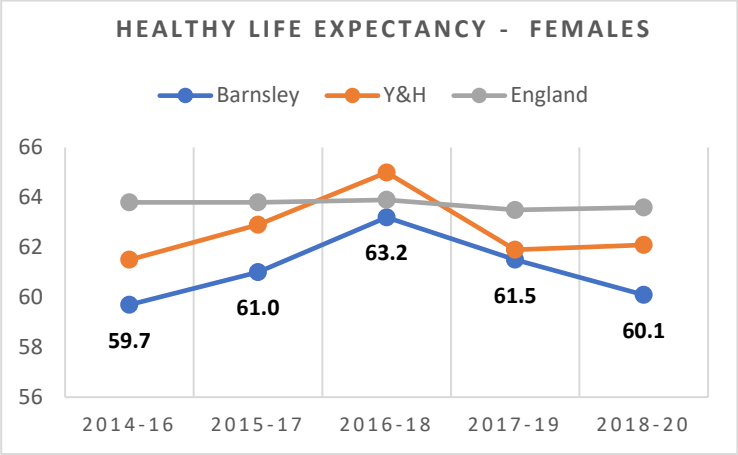
Figure 2: Healthy life expectancy of males in Barnsley 2018-20



Source: OHID, Public Health Outcomes Framework

3.2. For males in Barnsley, HLE is 6.9 years lower than the national average, and for females the figure is 3.5 years lower. There has been a greater fall in HLE for men in Barnsley of 3.5 years since 2015-17 (compared to 0.9 years for women) and this is a particular cause for concern.

Figure 3: Healthy life expectancy of females in Barnsley 2018-20



Source: OHID, Public Health Outcomes Framework

3.3 It is not possible to provide a ward breakdown for HLE as the source data for health status – the Annual Population Survey - is only available at Local Authority level. However, life expectancy data shows an inequality gap between our most and least deprived wards. For example, men living in Penistone East Ward can expect to live up to 8.4 years longer than men living in Worsborough Ward.

3.4 Life expectancy is a measure of the mortality rates that occur in any given population at a point in time. Life expectancy changes more with an increase or decrease in deaths at younger ages than with the same number of deaths at older ages. In Barnsley, our child mortality rate 1-17 years for the same period (2018-20) increased to 16.7 per 100,000 population (a total of 24 deaths). This is currently the highest rate in the Yorkshire and Humber region. As the rate is calculated from a small sample size, an increase or decrease of 1-2 deaths can cause variation across annual time periods, and so figures should be interpreted with caution. However, it is important that we closely monitor this trend as child mortality rates are seen as an important indicator of the effect of wider economic and social conditions on child health.

3.5 In line with the government's statutory guidance Working Together to Safeguard Children 2018, the Barnsley CDOP (Child Death Overview Panel) reviews the circumstances surrounding the death of each child on an individual basis in order that any modifiable factors identified can form the basis of key recommendations. Consideration is given to changes in local service provision which may prevent future harm and what action could be taken at a regional or national level.

<u>Drivers of Healthy Life Expectancy</u>

3.6 Analysis by the Office for Health Improvement and Disparities (OHID) suggests that changes in self-reported good health would have a larger impact on HLE than changes in mortality rates. That is, if prevalence of self-reported good health were to improve by 2% in all age groups, and mortality rates were to remain constant, the increase in HLE would be 1.3 years.

3.7 Having a chronic condition significantly increases the odds of self-reported poor health, with strong evidence that having multiple chronic conditions, known as ‘multimorbidity,’ increases these odds even further.

- Conditions of the musculoskeletal system (muscles, bones, joints) have the strongest association with self-reported health and have a large prevalence among the population.
- Cardiovascular disease also has a significant association and is a key driver of years of life lost.

3.8 In addition to chronic health conditions, poor recent wellbeing and mental ill-health are identified in numerous studies as being associated with self-reported poor health.

3.9 The relationship between behavioural risks and wider determinants is also important – with income, employment, education, physical activity, smoking and other factors all showing associations with self-reported poor health.

3.10 These individual factors can reinforce each other to increase the health risks and challenges that groups face. Unemployment, for example, as well as being associated with a direct negative impact on health, can harm future earning potential, thereby affecting other determinants of health such as income and the ability to afford decent housing– which in turn can impact on health behaviours and decision-making processes.

3.11 Research shows that these 'social determinants' can be more important than health care or lifestyle choices in influencing health, with studies suggesting that they account for between 30-55% of health outcomes.

3.12 The Global Burden of Disease (GBD)[2] study quantifies health loss from hundreds of diseases, injuries, and risk factors. The GBD tool shows that the conditions discussed above are prevalent in the top ten conditions causing the greatest disease burden in Barnsley (Figure 4). These conditions account for around 40% of total Disability Adjusted Life Years (DALYs). DALYs for a disease or health condition are the sum of the years of life lost (YLL) due to premature mortality and the years lived with disability (YLD). One DALY represents the loss of the equivalent of one year of full health.

Figure 4: Global Burden of Disease data for Barnsley

Top ten conditions causing greatest disease burden (Disability-Adjusted Life Years): Barnsley

Cause Name	Percentage of total DALYs in selected area (%)
Ischemic heart disease	8.61
Chronic obstructive pulmonary disease	5.20
Tracheal, bronchus, and lung cancer	4.91
Low back pain	4.66
Stroke	3.63
Diabetes mellitus	3.29
Depressive disorders	2.59
Lower respiratory infections	2.54
Headache disorders	2.26
Colon and rectum cancer	2.23

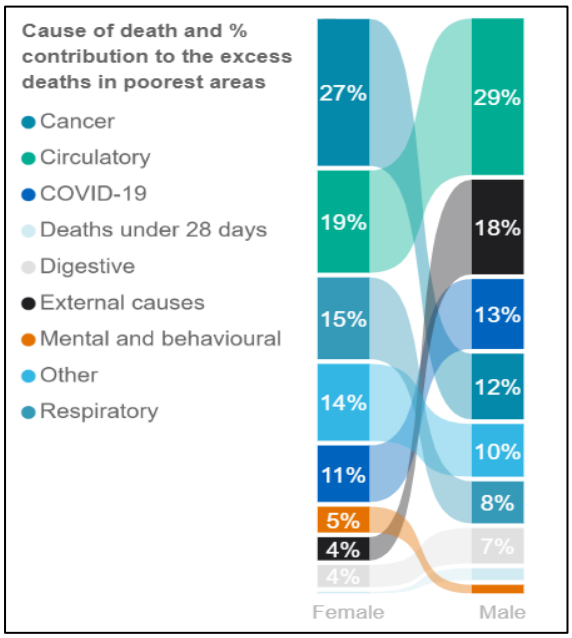
Source: Global Burden of Disease 2019. Institute for Health Metrics and Evaluation (IHME). **GBD Compare Data**

3.13 Around 40% of adults in Barnsley are living with some form of chronic illness or disability. Nearly 1 in 4 of these residents live in the most deprived 10% of communities in England. This compares to less than 1 in 100 residents who live in the least deprived areas. This means in Barnsley there is a clear correlation between deprivation and multimorbidity.

3.14 The link between chronic illness and deprivation in Barnsley is also clear when we view the leading causes of death and their contribution to excess deaths in our most deprived areas (Figure 5).

[2] Global Burden of Disease 2019. Institute of health Metrics and Evaluation (IHME), University of Washington. Available from: https://vizhub.healthdata.org/gbd-compare/

Figure 5: Diseases that contribute to the gap in life expectancy between the most and least deprived areas of Barnsley (2020-21)



Note: "External causes" refers to deaths caused by environmental events and circumstances that are external to the body (sometimes called deaths from accidents and injury).

Source: OHID, Picture of Health tool[3]

Risk Factors

3.15 Some of the association with deprivation described above is linked to the leading risk factors for health. Smoking, physical inactivity, and obesity are all strongly associated with poor health and have higher rates of prevalence in more deprived groups of the population.

3.16 People's ability to adopt healthy behaviours is shaped by the circumstances in which they live. That includes the education and support they receive in their early years, income, access to green space and healthy food, the work people do and the homes they live in.

3.17 There are also strong commercial factors at play, including the relative expense and availability of healthy and unhealthy foods, alcohol, and tobacco, and how they are advertised and promoted (known as the commercial determinants of health).

3.18 Deprivation is also a direct risk factor. Good health deteriorates faster for people living in the most deprived areas. By age 55–59, more than half of people living in the most deprived areas report having less than good health. For those living in the least deprived areas, this occurs 20–25 years later, at age 75–79 for women and 80–84 for men.[4]

4.0 The Approach to Improve Outcomes

4.1 In Barnsley we are working together to do more to improve health and reduce health inequalities in the local population. This requires action across all the determinants of health and, where action is beyond the reach of the health and care sector, working across sectors and with wider partners to make progress.

4.2 Item 3b - Barnsley Place Based Partnership: Tackling health inequalities in Barnsley outlines the plan for tackling health inequalities at a local level.

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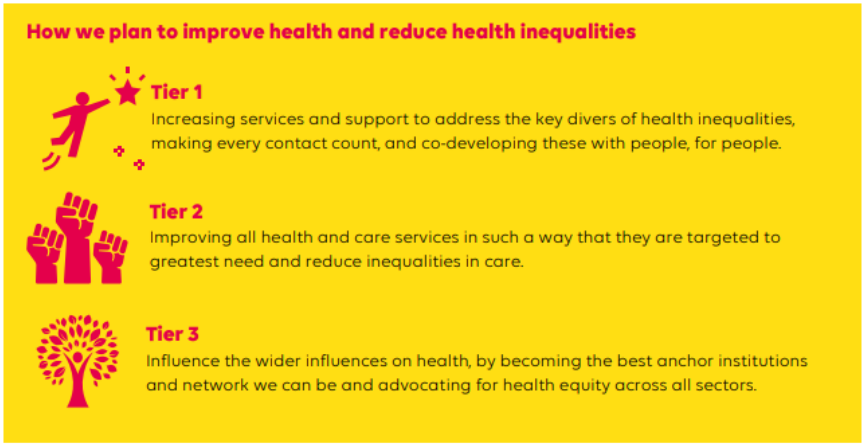
4 The Health Foundation. 2022. 'Proportion of population reporting good health by age and deprivation'. Available here: https://www.health.org.uk/evidence-hub/health-inequalities/proportion-of-population-reporting-good-health-by-age-and-deprivation

4.3 The Barnsley Health Equity Group (BHEG) is the delivery partnership for this strategy. Under the guidance and coordination of BHEG, organisations across Barnsley's Integrated Care Partnership are aligning their approach using a three-tier framework (Figure 6).

Figure 6: Three-tier framework for reducing health inequalities



4.4 This framework strikes a balance between "the whole" – acknowledging what determines our health and wellbeing (and, therefore, the need for health and care services) covering almost all aspects of society, economy, and the environment – and that which is within the immediate grasp of an integrated care system.

4.5 Whilst many of the causes of health inequalities are more readily addressed through shifts in national policy, investment, and infrastructural changes (e.g., industry), there are things we are doing locally, and we can do a lot more. The three-tier framework is already being used to strengthen the approach to reducing health inequalities across Barnsley, within Barnsley Hospital, Barnsley Council, South West Yorkshire Foundation Trust, and across Barnsley's Primary Care Network. Examples of work currently underway across the three-tier framework are provided on page 7.

4.6 Social prescribing is gaining momentum as a way of addressing the wider social determinants of people's health. Social prescribing link workers, based as part of the multi-disciplinary team in primary care networks, can spend more time with an individual, focusing on what matters to them, and take a holistic approach to their health and wellbeing. They can also connect people to the most appropriate and helpful community groups and statutory services providing practical and emotional support.

4.7 Barnsley residents can be referred to Link Workers from a wide range of local agencies, including GPs, pharmacies, hospital discharge teams, allied health professionals, the fire service, the police, job centres, social care services, housing associations and voluntary, community and social enterprise (VCSE) organisations.

Tackling health inequalities in Barnsley – action across the three tiers

Tier 1: *Increasing services and support to address the key drivers of health inequalities, making every contact count, and co-developing these with people, for people.*

How's Thi ticker? – Community Blood Pressure Checks

"How's Thi Ticker?" (HTT) is a local campaign and partnership initiative working across primary care, local authority, charities, and businesses to increase blood pressure checks and treatment. The aim is to improve cardiovascular health outcomes for target population groups.

The initiative supports our place-based plan to reduce health inequalities by taking the service out into our communities encouraging those most at risk to get tested in convenient locations. HTT also adopts a Making Every Contact Count (MECC) approach to health promotion. The team discuss and signpost to appropriate support for a whole range of health and social care issues.

A Population Health Management (PHM) approach was undertaken to identify high risk target groups. The team looked at primary care data on patients missing a blood pressure check over a 5-year period alongside GP registered population data, and ward population data. Through this analysis it was identified that men in their 50's living in the top two most deprived areas of Barnsley were more likely to have not had a recent blood pressure check.

As HTT has grown, we have been able to tailor the scheme based on participant feedback around their health needs, for instance providing information on services such as weight management and smoking cessation. The mobile nature of the service means that the team continue to speak to residents and businesses to gather feedback on locations and support services required. How's Thi Ticker has been highlighted as an example of good practice in an NHS England population health management toolkit. The video can be viewed here.

Tier 2: *Improving all health and care services in such a way that they are targeted to the greatest need and reduce inequalities in care*

Barnsley Community Diagnostic Centre

Barnsley has opened the Community Diagnostic Centre (CDC) in the town centre, increasing accessibility of care, and integrating services with people's daily lives. The CDC has already received positive feedback from users and staff and has been recognised nationally, including a recent visit from the Chief Executive of the NHS.

Analysis of which local communities are benefiting most from this initiative is underway and will be used to inform planning for phase two of the CDC's development which will include expanding the diagnostic services available. Learning from the CDC will inform development of other community health and wellbeing offers funded by the place partnership, including consideration of integrating a health offer into libraries and other existing facilities that reach further into communities.

Tier 3: *Influence the wider influences on health, by becoming the best anchor institutions and network we can be and advocating for health equity across all sectors*

Supporting the apprenticeship levy

The apprenticeship levy that our collective organisations receive from central government is often under used and results in funds being returned instead of going into the local economy. Barnsley Council has committed in its Apprenticeship Strategy to transfer up to 25% of its annual levy contribution to other organisations (equivalent to approximately £145,250 per year). The council began in 2022 to support the Yorkshire Ambulance Service (YAS) in this way. YAS tend to spend all its levy and Barnsley Metropolitan Borough Council has committed £70,000 to support it with a further 10 Level 3 Apprenticeships.

Using wider sources of funding to build employment opportunities and respond to health needs is a win across all tiers. Sheffield Council has recently done so by transferring its levy to increase the domiciliary care workforce and improve the lives of frail and elderly. Barnsley is looking at how it can take a similar approach.

4.8 There are further ambitions outlined in the Place Based Plan relating to 'who' in the Barnsley population we might aim to engage, in 'what' ways we might support them and 'how' we proceed. These ambitions are incorporated in Barnsley's Place Based Partnership's Health and Care plan 2023-25 to ensure this becomes embedded into everything we do.

4.9 The 'How' ambition contains important underlying principles and values to ensure that as a place we strengthen our approach to reducing health inequalities. We need to take everyone along with us, so the local population, the workforce and any key stakeholders participate and share an understanding of why we are making these changes.

4.10 We need to effectively communicate the evidence on the social determinants of health to our workforce, partners, and residents to address the mismatch between public perceptions of what influences health, explaining how and why health is influenced by wider determinants and why experiences are unequal. Presenting information in a way that involves stories about people in context of these wider determinants may be a powerful way to communicate these messages.

4.11 Barnsley Council is a key partner of BHEG. We are developing a health inequalities plan, aligned to the place-based strategy with an overall aim to "*Make Health Inequalities Everyone's Business*." Using the three-tier approach, we have considered desired outcomes for key stakeholders – residents (tier 1), customers (tier 2) and partners & workforce (tier 3). The proposed plan will feature the wealth of existing work already underway and explore new ways of working.

5.0 Future Plans and Challenges

5.1 As the Health Foundation notes[5], there are significant obstacles for improving healthy life expectancy. These may affect both the 'health' and 'life expectancy' parts of the measure. Before the COVID-19 pandemic there were pressures from slow growth in household living standards, stubbornly high poverty rates, and an ageing population. The pandemic created further pressures, including a health care backlog, as well as the wider impact on socioeconomic factors such as education, employment, and household income.

5.2 The government's Levelling Up White Paper includes an ambition to improve HLE by 5 years by 2035, with analysis by the Health Foundation suggesting that this improvement would take 192 years based on trends up to 2017-19 (excluding the effects of the pandemic). Turning around this deteriorating situation requires considerable investment in improving general economic and social conditions as well as in public health, health care and social care.

5.3 There are limitations to using the HLE metric as a measure of poor health. Although it is considered a reasonable measure of morbidity, it is a subjective measure and can mask variation of what counts as 'good health' between groups and places. There is also a considerable time lag in the data. We are currently looking at key lines of enquiry in relation other sources of data to allow further analysis of more up to date and comparable data. This will hopefully provide a more detailed and timelier picture of ill health at a local level which is not self-reported.

5.4 We encourage Elected Members to continue supporting our ambitions to tackle health inequalities; to have conversations in your communities, share experiences of residents, and challenge us in the work that we do. In your roles within the Area Governance arrangements and through Area Councils you are already ambassadors for reducing health inequalities (understanding local data, bringing in your local community knowledge and undertaking priority setting), and ensuring you commission the right services in your communities to meet their needs. Within your roles at the Ward Alliance meetings, you also support the facilitation of many projects in your local communities that may contribute towards the reduction of health inequalities (e.g., How's Thi Ticker?). Understanding the needs of communities is key to addressing health inequalities and improving health and these community roles are invaluable.

[5] The Health Foundation. 2022. 'Healthy life expectancy target: the scale of the challenge'. Available from: https://www.health.org.uk/news-and-comment/charts-and-infographics/healthy-life-expectancy-target-the-scale-of-the-challenge

6.0 Invited Witnesses

The following witnesses have been invited to answer questions from the Overview & Scrutiny Committee regarding their role in this area of work: -

Rebecca Clarke, Head of Health Protection & Healthcare, Public Health & Communities, Barnsley Council
Emma Robinson, Senior Public Health Officer, Public Health & Communities, Barnsley Council
Cheryl Devine, Senior Practitioner, Public Health & Communities, Barnsley Council
Andy Snell, Public Health Consultant, Barnsley Hospital NHS Foundation Trust/Barnsley Council
Carrie Abbott, Service Director, Public Health & Regulation, Public Health & Communities, Barnsley Council
Anna Hartley, Executive Director Public Health & Communities, Barnsley Council
Joe Minton, Associate Director – Strategy, PHM & Partnerships, South Yorkshire Integrated Care Board
Jamie Wike, Deputy Place Director – Barnsley Integrated Care Place Based Partnership
Cllr Wendy Cain, Cabinet Spokesperson, Public Health & Communities

7.0 Possible Areas for Investigation:

Members of the committee may wish to ask questions around the following areas:-

- Given that the Health Foundation has suggested it will take 192 years to increase HLE by 5 years, where do you think you can make the biggest impact in the short, medium, and long-term?

- Which of the priorities within Barnsley 2030 and the Health & Wellbeing Strategy will have the greatest impact on healthy life expectancy? Are there any quick wins?

- What intelligence did you use to determine the priorities for tackling health inequalities?

- What local factors are currently hindering progress? What plans are in place to tackle these?

- How much influence do you have over wider council plans and policies to ensure that they do not negatively impact on communities and create inequalities, particularly when there are conflicting priorities?

- What evidence do you have that the work outlined in the report is improving outcomes for residents?

- What more needs to be done to ensure that interventions are based on more accurate and timely intelligence and data – where are the gaps and when do you expect them to be addressed?

- What analysis has been done to understand the differences between men and women when it comes to smoking prevalence, being overweight etc and what is the gender breakdown of those attending interventions, NHS Health-checks etc?

- Can you give recent tangible examples of how you have increased services and support to address the key drivers of health inequalities, because of working with, and listening to, residents?

- What has happened to our communities since 2015 that has caused such a sharp decline in healthy life expectancy when compared to the rest of Yorkshire and the Humber?

- What factors, in addition to income deprivation, help to explain differences in life expectancy between areas? Are they as important as income, or even more important?

- What can you do to encourage behaviour change?

- What work is being done with young people to improve future healthy life expectancy?

- How can you guarantee that Barnsley residents will benefit from transferring the Apprenticeship Levy to other organisations?

- Regarding child mortality in Barnsley, what are the trends indicating, were any due to service failure or a gap in services? What has been put in place following CDOP investigations?

- What can elected members do to support this area of work?

8.0 Background Papers and Useful Links

- Item 3b - Barnsley Place Based Partnership: Tackling health inequalities in Barnsley
- Barnsley Health and Care Plan 2023-25
- Health Foundation: How to talk about the building blocks of health

9.0 Glossary

Health inequalities – the unfair and avoidable differences in people's health across the population and between specific population groups.

Social determinants of health – non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life.

Local Authority - an organization that is officially responsible for all the public services and facilities in a particular area.

BHEG	Barnsley Health Equity Group
CDC	Community Diagnostic Centre
CDOP	Child Death Overview Panel
DALYs	Disability Adjusted Life Years
GBD	Global Burden of Disease
HLE	Healthy Life Expectancy
HTT	How's Thi Ticker!
MECC	Making Every Contact Count
OHID	Office for Health Improvement & Disparities
OSC	Overview & Scrutiny Committee
YAS	Yorkshire Ambulance Service
YLL	Years of Life Lost

10.0 Officer Contact

Jane Murphy/Anna Marshall, Scrutiny Officers, Scrutiny@barnsley.gov.uk