Agenda item: **[No.]**

Overview and Scrutiny Committee **On [Date]**

Report Title: **Scrutiny Review – Men's Health: Getting to the heart of the matter**
Forward Plan reference number (if applicable): **[add reference]**
Report of: **Councillor David Winskill, Chair of the Review Panel**
Wards(s) affected: **All**
1. Purpose (That is, the decision required) 1.1 To approve the scope and terms of reference for the Scrutiny Review.
2. Recommendations 2.1 That the scope be approved. 2.2 That the terms of reference be approved.
Report Authorised by: **[Designation of Chief Officer (Include signature here)]**
Contact Officer: **Melanie Ponomarenko, Senior Policy Officer** **Tel: 0208 489 2933** **Melanie.Ponomarenko@Haringey.gov.uk**
3. Local Government (Access to Information) Act 1985 3.1 Background papers relating to this report:

4. Reason for the review

4.1 The Centre for Public Scrutiny (CfPS) is currently running phase two of a health inequalities development programme providing support to successful Overview and Scrutiny Committees to undertake a review into health inequalities.

4.2 Haringey Overview and Scrutiny Committee submitted a successful bid in June (Appendix A).

4.3 Haringey is therefore one of a number of areas which will help the CfPS to pilot a new 'Return on Investment' model of scrutiny. This new model aims to make scrutiny more outcome focused with clear links to the Marmot objectives and the wider determinants of health. It also aims to assist the panel in forecasting the impact of their recommendations.

4.4 To assist in this process each development area has been appointed an expert adviser and is expected to use the CfPS toolkit developed in phase one - 'Peeling the onion'.

5. Key National Policy

5.1 **Healthy Lives, Healthy People** - Public Health White Paper

5.1.1 The White Paper sets out the Government's long-term vision for the future of public health in England. The aim is to create a 'wellness' service (Public Health England) and to strengthen both national and local leadership.

5.1.2 The paper aims to strengthen both national and local leadership by having directors of public health, employed by local authorities and jointly appointed with Public Health England. Their role will be to lead on driving health improvement locally.

5.1.3 Responding to the challenges set out in Professor Sir Michael Marmot's powerful 'Fair Society, Healthy Lives' report, the White Paper includes a proposal for a new, health premium that will reward progress on specific public health outcomes.

5.1.4 The premium is intending to fight health inequalities thus formally recognising disadvantaged areas which face the greatest challenges, and will therefore receive a greater premium for progress made.

5.1.5 Local authorities will deploy resources to improve health and well-being in their communities using ring-fenced health improvement budgets allocated by the Department of Health and based on a formula grant for each area.

5.2 **Marmot review- 'Fair Society, Healthy Lives'**

5.2.1 The government has expressed its commitment to reducing health inequalities. In 2010 The Marmot review; *'Fair Society, Healthy Lives'* was published in response to the request made by the former Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. The strategy

includes policies and interventions that address the social determinants of health inequalities. Key messages delivered and relevant to this scrutiny review:

1. Evidence suggests that there is a social gradient in health – the lower a person's social position, the worse his or her health. Therefore our effort should also be focused on reducing the gradient in health.
2. The review also reaffirms the point that health inequalities result from social inequalities. Therefore tackling health inequalities requires action across all the social determinants of health.
3. There is also an emphasis on the fact that action taken to reduce health inequalities will benefit society in many ways. Benefits like economic benefits in reducing losses from illness associated with health inequalities, which account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.
4. Reducing health inequalities will require action on six policy objectives (See below)
5. Delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors and community groups. National policies will not work without effective local delivery systems focused on health equity in all policies.
6. Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.

5.2.2 The review also identified 6 evidenced based policy objectives for action most likely to have the greatest impact on reducing the gap in health inequalities long-term:

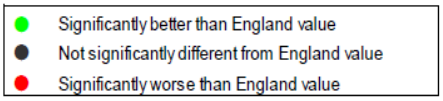
1. Give every child the best start in life
2. Enable all children young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention

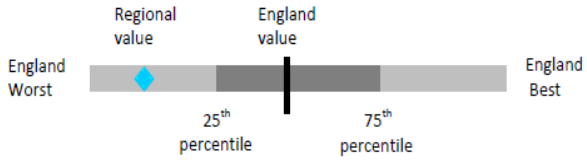
5.3 Marmot indicators for Local Authorities in England

5.3.1 To mark the one year anniversary since the publication of 'Fair Society, Healthy Lives' the London Health Observatory and Marmot Review Team produced baseline figures for some key indicators of the social determinants of health, health outcomes and social inequality that correspond, as closely as is currently possible, to the indicators proposed in Fair Society, Healthy Lives*:*

- Male life expectancy
- Female life expectancy
- Slope index of inequality (SII) for male life expectancy
- Slope index of inequality (SII) for female life expectancy
- Slope index of inequality (SII) for male disability-free life expectancy
- Slope index of inequality (SII) for female disability-free life expectancy
- Children achieving a good level of development at age 5
- Young people who are not in education, employment or training (NEET)
- People in households in receipt of means-tested benefits
- Slope index of inequality for people in households in receipt of means-tested benefits

Extract from the Haringey Indictor set in relation to men's health:





Haringey

	Indicator	Local Authority Value	Regional Value	England Value	England Worst	Range	England Best
	Health outcomes						
	Males						
1	Male life expectancy at birth (years)	76.6	78.6	78.3	73.7		84.4
2	Inequality in male life expectancy (years)	6.8	7.1	8.8	16.6		2.7
3	Inequality in male disability-free life expectancy (years)	11.5	9.1	10.9	20.0		1.8

Source: London Health Observatory, Marmot Indicators for Local Authorities in England

5.4 London Health Inequalities Strategy

5.4.1 The first London Health Inequalities Strategy was published in March 2010 and provides the framework for action. The strategy is due to be refreshed every four years. The London Health Inequalities Strategy recognises there is a social gradient in health – the lower a person's social position, the worse his or her health. The strategy aims to diminish the steepness of the social gradient so that the health gaps between all Londoners are lessened.

5.4.2 The Mayor's strategic objectives for reducing health inequalities in London are to:

1. Empower individual Londoners and their communities to improve health and well being

2. Improve access to London's health and social care services, particularly for Londoners who have poorer health outcomes.
3. Reduce income inequalities and minimise the negative health consequences of relative poverty.
4. Increase opportunities for people to access the potential benefits of work and other forms of activity.
5. Develop and promote London as a healthy place for all – from homes to neighbourhoods and the city as a whole.

5.5 The London Health Inequalities Strategy – First Steps to Delivery to 2012

5.5.1 Sets out agreed actions to prioritise to 2012 against the thirty high-level commitments which form the bedrock of the strategy. It summarises the first steps already identified with partners to be further built upon over the coming months.

5.5.2 This includes first steps such as:

- Encouraging regional and local organisations to review the extent of their current focus on health inequalities in strategy development, investment and programme planning and in prioritisation – key partners mentions include Overview and Scrutiny Committees.
- Engaging regional and local scrutiny leads in joint work to increase their focus on reducing health inequalities throughout their scrutiny plans and investigations.
- Tackle street trading of illicit tobacco, and the illegal sale of tobacco and alcohol, through use of existing effective interventions, and encourage widespread adoption.
- Work with NHS to scale up approaches to building capacity in Voluntary and Community Sector to deliver physical activity services.

6. Local Policy

6.1 Health Inequalities National Support Team (HINST)

6.1.1 The Department of Health Inequalities National Support Team (HINST) visited Haringey in late 2009. The National Support Team (NST) held several stakeholder events to understand the local context and assess barriers to and opportunities for making progress at a population level. A number of high level recommendations were made, and following the visit an action plan was developed an approved by the Cabinet member of Adult and Social Care and by the Department of Health. Key recommendations from the visit included:

1. Undertake further analysis quantifying the number of lives that need to be saved and assessment of the necessary scale and reach of interventions required to reduce mortality rates to sustain progress towards the 2010 mortality targets and address inequalities within Haringey.
2. Develop detailed delivery plans informed by the above analysis, equity audit and social marketing.
3. Develop a culture of data and analysis underpinning all strategic and commissioning decisions, as part of a whole systems approach to addressing health inequalities.
4. Establish clear local clinical and practitioner leadership in Cardiovascular Disease (CVD), Stroke, and Cancer.
5. Continue to focus intensively on improving the quality of primary care across the 3 levels of support, and build a partnership approach to case-finding.
6. Take a partnership approach to the development of commissioning groups relating to the contributing factors to health inequalities and the development of improved patient pathways.
7. NHS Haringey should fully integrate its strategic and operational community engagement work internally and with other partners.
8. Continue the development of the Well-Being Partnership Board and the Haringey Strategic Partnership structures in relation to locality working, engagement of the Voluntary Community Services (VCS) and the broader healthy communities' agenda.
9. Ensure specific initiatives are developed and implemented to embed

6.2 Haringey

6.2.1 Haringey has a significant history in tackling health inequalities and continues to address these at every level across the borough. Tackling health inequalities has been integral to the production of several key strategies and plans in Haringey over several years. The Sustainable Community Strategy is the overarching strategy of the Haringey Strategic Partnership, examples of other key strategies and plans include: Sustainable Community Strategy[i], Well-being Strategic Framework, Children and Young People's Plan, Community Safety Strategy, Housing Strategies, Greenest Borough Strategy and Regeneration Strategy, Safer for all, NHS Strategic Plan, Life Expectancy Action Plan, Infant Mortality Action Plan, Report of the visit of the National Support Team of the Department of Health. These existing plans will form components that will shape the future health inequalities strategy. Haringey needs assessments and local information for example Haringey Our Place and Joint Strategic Needs Assessment should inform local strategies.

6.3 Health Inequalities Cross Party Working Group

6.3.1 A Health Inequalities Cross Party Working Group has been set up in order to determine the priority areas to be addressed in the health and wellbeing strategy in order to reduce health inequalities in Haringey.

6.3.2 This group has been focusing on a number of areas e.g. life expectancy, mental health and wellbeing.

6.3.3 The draft Haringey Health and Well Being Strategy consultation is due to begin in mid to late September 2011.

7. Local Context

7.1 **Key facts**

- Circulatory diseases are one of the major causes of death and illness locally, accounting for 33% off all deaths in 2006/08.
- Deaths from circulatory disease are not evenly distributed across Haringey, with significantly higher rates observed in the East of the borough.
- Male life expectancy in Haringey is lower than the England and London average and within Haringey there are significant inequalities (of up to 9 years between the more affluent West and the more deprived East).
- People in lower socio-economic groups are less active than those in the higher socio-economic groups, at levels of 14.4% and 24.6% respectively.
- 23.2% of the adult population took part in moderate sport and physical activity three times a week for at least 30 minutes in 2008/09; the participation rate is lower in the East of the borough.
- Obesity varies considerably across the borough with an estimated 25% of residents in the East of the borough obese.
- There is an over representation of hospital admissions for circulatory diseases in ethnic minorities in the borough.
- Following a decrease in the male life expectancy gap between England and Haringey 2002/04, the gap has again increased over the recent few years. Therefore this remains a key challenge for the borough.

7.2 The following has been extracted from the **Cross Party Working Group** paper on Life Expectancy (the full paper can be found in Appendix B):

- The gap in life expectancy across Haringey mirrors the Index of Multiple Deprivation across the borough.

- The contributors to the gap in male life expectancy between Haringey and England are circulatory disease (28%) and cancers (25%).
    - Relating to age: 8% is due to men aged 40-49 years, 30% of the gap is due to men aged 50-59 years, 35% is due to men 60-69 years.
    - In total 73% of the gap in male life expectancy is due to men aged 40-69 years.

- Reducing inequalities in cardiovascular and cancer mortality in adults (particularly men over 40) will have the greatest impact on reducing inequalities in life expectancy in Haringey.

- The Health inequalities National Support Team (HINST) iiidentified evidence based actions that would have an effect within a short timescale. This includes early diagnosis and management of disease (early intervention) and effective prevention of further illness (secondary prevention) in people who have already ill e.g. had a heart attack or stroke. Though much of this is within the realm of the NHS, the Council has a key role in supporting secondary prevention and raising awareness about key diseases within communities.

7.2.1 **Prevention**

- Smoking, physical inactivity, obesity, poor nutrition and alcohol are important risk factors[iii] for Cardiovascular disease and cancers, demonstrate a social gradient across socio-economic groups and are more common in certain Black and Minority Ethnic (BME) groups.

7.2.2 **Smoking**

- There is a strong link between smoking rates and deprivation.

- Certain groups have high rates of tobacco use and higher nicotine dependence e.g. lone parents, specific ethnic groups e.g. Turkish, Bangladeshi, Irish men and people with mental health problems, about half of whom smokeiv. National rates of smoking are reducing. vIf this continues it should reduce the incidence of CVD and later on Cancer incidence.

- The “London Boost” (2006) for the Health Survey For England modelled smoking prevalence as 28.6% males and 24.2% females in Haringey compared to 25.3% for males and 18.8% for females in London.

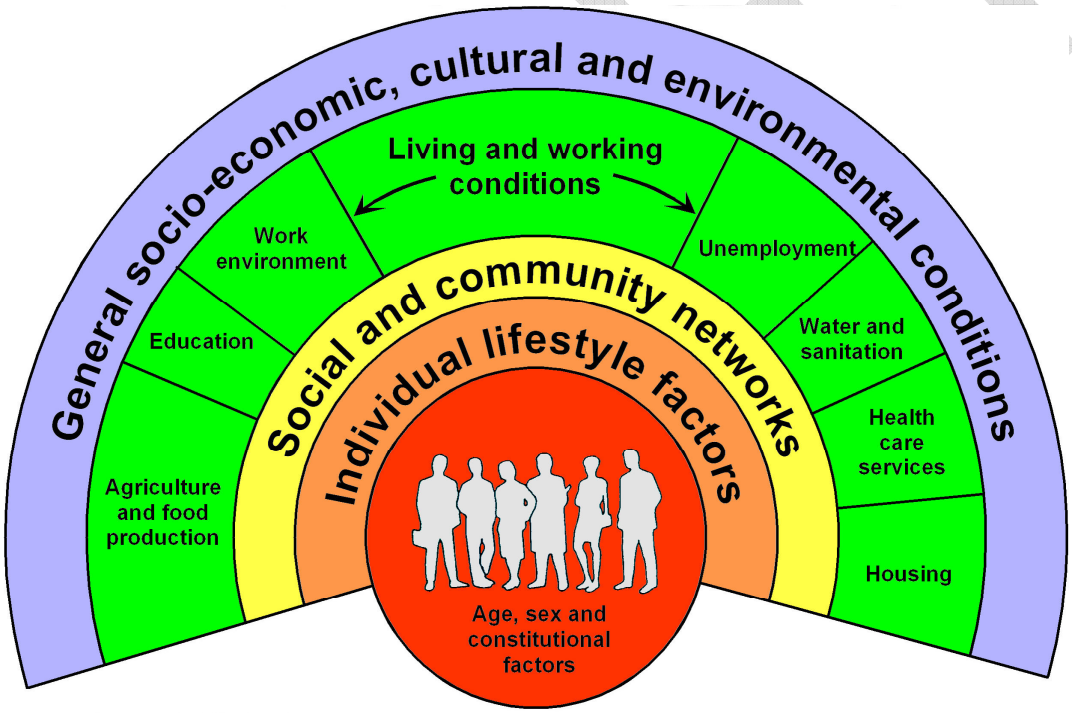
- 26106 males and 24108 females smoke in Haringey

8. The review terms of reference

Using the Dahlgren and Whitehead model (as per diagram below) the review intends to build on previous work done to tackle the life expectancy gap. The review will aim to develop recommendations to increase male life expectancy in the ethnically diverse east of the borough – *the corridor of deprivation*. More specifically the review intends to focus on cardiovascular disease and how we engage the local population in:

- **Prevention:** smoking, physical activity, alcohol, obesity
- **Early intervention** (adults over 40):cardiovascular disease

The review will not duplicate work already being undertaken, for example by the Health Inequalities Cross Party Working group, but intends to dove-tail and make recommendations to inform this work.



Source: Dahlgren and Whitehead, 1991

9. Members of the Review Panel

- Councillor Winskill Chair
- Councillor Waters
- Councillor Rice
- Councillor Hare

Stakeholders

- Public Health
- General Practitioner(s)
- Pharmacies
- Leisure Services
- Private Leisure providers
- Local men
- Health Trainers
- Smoking cessation representative
- Local Involvement Network rep
- Acute Trusts
- Haringey Association of Voluntary and Community Organisations
- Haringey Advisory Group on Alcohol
- Faith groups

10. External Advisor

10.1 The Centre for Public Scrutiny has appointed Sally Brearley as the adviser for this review. Sally has a background in patient and public involvement and is also the Chair of Health Link, a member of the NHS Future Forum, a Visiting Senior Research Fellow in Public and Patient Involvement National Nursing Research Unit at Kings College London.

11. Scrutiny Process

Meeting 1 – Overview and context

Meeting 2 – Prevention/Not getting ill

Meeting 3 – Early Intervention/seeing someone quick enough

Meeting 4 – Secondary prevention/staying well

Meeting 5 – Draft report and recommendations

In addition it is proposed that a survey is undertaken and a consultation event is held to engage local men in the target groups and ensure that their views are fully incorporated in the review.

The review is being officially launched at the Haringey PCT AGM on 20th September, a number of local men have also been invited to this event.

The review timeline will also need to incorporate two learning events as part of the Centre for Public Scrutiny Pilot process.

[i] Sustainable Community Strategy

[ii] Redoubling Efforts to achieve the 2010 National Health Inequalities Life Expectancy Target. Resource Pack. Department of Health. March 2010.

[iii] Five Year Strategy 2009-2013. NHS Nottingham City.

[iv] Meltzer, H. OPCS Surveys of Psychiatric Morbidity in Great Britain Report 1 the prevalence of psychiatric morbidity amongst adults living in private households. London : HMSO , 1995)

[v] Health Survey for England 2006-8