	Agenda Item: 10
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**24 September 2019**
TITLE:	**HEALTH AND WELLBEING BOARD PRIORITIES UPDATE: HEALTH INEQUALITIES DASHBOARD**
Organisation	**Birmingham City Council**
Presenting Officer	**Justin Varney, Director of Public Health**

Report Type:	**Presentation**

1. Purpose:	
1.1	This report sets out the current measures for the Health and Wellbeing Board's agreed Health Inequalities matrix. It includes a description of each measure, its strengths and limitations and the desired direction of travel.
1.2	The Board is asked to delegate action against these measures to the Board's sub-forums.

2. Implications:		
BHWB Strategy Priorities	Childhood Obesity	
	Health Inequalities	Y
Joint Strategic Needs Assessment		
Creating a Healthy Food City		Y
Creating a Mentally Healthy City		Y
Creating an Active City		Y
Creating a City without Inequality		Y
Health Protection		Y

3. Recommendation

It is recommended that the Board:

- NOTE the contents of the report.
- DELEGATE action against each of the indicators to the Board's sub-forums as detailed in Table 3.

4. Report Body

Background

4.1 The Birmingham Health and Wellbeing Board has set Health Inequalities as one of its strategic priorities. On 30 July 2019 the Board agreed a Health Inequalities Dashboard (Table 1) following detailed discussions at its 15 May 2019 Development Session and its informal Board meeting on 18 June 2019.

Table 1: Birmingham Health and Wellbeing Board Health Inequalities Dashboard

	Physical health	*Mental health*	*Wellbeing*
Micro level	Chronic disease: Type 2 Diabetes and CHD (recorded prevalence)	Chronic disease: Depression (gap between recorded and modelled prevalence)	Immunisation rates (various)
Macro level	Physical activity and inactivity	Healthy life expectancy	Economic inactivity for health reason.
Special interest	Smoking in pregnancy	Gap in employment rates for mental health and learning disabilities	Gap in school readiness for those with free school meal status

4.2 The Board agreed the Health Inequalities Dashboard would brake down health inequality according to physical health, mental health and wellbeing and at a city level (macro), ward/GP practice level (micro) and special focus level i.e. community of interest such as those with free school meal status.

4.3 Birmingham Public Health Division was tasked to provide further information on each of the chosen indicators on the health inequalities dashboard to show the strengths, limitations and desired direction of travel.

4.4 On 30 July 2019 the Board approved the development of four Health and Wellbeing Board Sub-Forums to support the delivery of the Heath and Wellbeing Board's objectives:

- Creating a Mentally Healthy City Forum
- Creating a Healthy Food City Forum
- Creating an Active City Forum
- Creating a City Without Inequality Forum

4.5 These Sub-Forums sit alongside the already established Health Protection Forum.

Local context

4.6 There are many different things that drive health inequalities in a city like Birmingham. For this reason, the Board has chosen a series of indicators that span physical health, mental health and wellbeing and those that have a strong connection to other inequalities in the city such as employment and school readiness.

4.7 The Health Inequalities Dashboard will be presented as an information update at each formal Board meeting; as the indicators have different release periods each update will present the latest published figures on the Dashboard. In addition, each of these indicators will be grouped according to theme and discussed in depth on a rotational basis as part of the Board's programme of formal meetings.

4.8 A snapshot of each of the chosen indicators is discussed in turn below. Further information on the indicators including definitions, sources, methodology and caveats are available in **Appendix 1**.

Health Inequalities dashboard indicators

Micro level indicators: Diabetes, recorded prevalence

4.9 Around 7% of people in the UK have a diabetes diagnosis. A large proportion of cases can be attributable to increasing levels of obesity and other lifestyle risk factors that are considered modifiable with public health intervention.

4.10 Diabetic complications may result in considerable morbidity and have a detrimental impact on quality of life. Prompt diagnosis, effective treatment and monitoring are crucial to prevent significant damage to the body or even death..

4.11 The prevalence of Diabetes is reported at a GP Practice level as part of the QOF (Quality Outcomes Framework). The Board's chosen indicator will report the gap between the highest and lowest recorded Diabetes prevalence in GP practices across the City. This will allow the Board to identify possible under recording and underdiagnoses and measures the gap between the highest and lowest diagnosis rates in Birmingham. It will allow monitoring of progress toward meeting previously unmet need as well as understanding the population need for identification and prevention programmes.

4.12 Future in depth reporting of this indicator will allow the Board to investigate inequalities observed at a GP Practice level across the City.

Micro level indicators: Coronary Heart Disease (CHD) recorded prevalence

4.13 Coronary heart disease (CHD) is the single most common cause of premature death in the UK. The research evidence relating to the management of CHD is well established and if implemented can reduce the risk of death from CHD and improve the quality of life for patients. CHD can be managed effectively with a combination of lifestyle changes, medicine and, in some cases, surgery. With the right treatment, the symptoms of CHD can be reduced, the functioning of the heart improved and further episodes prevented.

4.14 The prevalence of CHD is reported at a GP Practice level as part of the QOF (Quality Outcomes Framework). As with the Diabetes indicator above, the Board's chosen CHD indicator reports the gap between the highest and lowest recorded prevalence in GP practices across the City.

4.15 Future in depth reporting of this indicator will allow the Board to investigate inequalities observed at a GP practice level across the City.

Micro level indicators: Depression (gap between recorded and modelled prevalence)

4.16 Depression is responsible for 12% of the global burden of non-fatal disease and is expected to be the world's second most disabling disease by 2020 (after cardiovascular disease). Depression is responsible for 109 million lost working days every year in England at a cost to the economy of £9 billion.

4.17 This measure allows the Board to assess whether depression is being accurately diagnosed and recorded in an equitable manner across Birmingham. It will show the difference between the expected levels of depression and the levels of those diagnosed. Both under and over diagnosis of depression can be indicative of issues within the individual GP or at a system level and would require in-depth exploration.

Micro level indicators: Immunisation rates (various)

4.18 Health protection is an essential part of achieving and maintaining good public health in Birmingham. Communicable diseases, also known as infectious, transmissible or contagious diseases, are illnesses that can spread between people and result from the infection, presence and growth of pathogenic (capable of causing disease) biological agents in individual human hosts. Programmes such as national immunisation and screening programmes and the provision of services to diagnose and treat communicable diseases are important parts of the system to protect the health of the Birmingham population.

4.19 Measles, mumps and rubella are highly infectious conditions that can have serious, potentially fatal complications, including meningitis, swelling of the brain (encephalitis) and deafness. They can also lead to complications in pregnancy that affect the unborn baby and can lead to miscarriage.

4.20 The measles, mumps and rubella (MMR) vaccine is a safe and effective combined vaccine that protects against 3 serious infections—measles, mumps and rubella (German measles)—in a single injection. The full course of MMR vaccination requires 2 doses. Although measles is rare in the UK, outbreaks do still occur when not enough of the population are vaccinated. There is considerable variation in uptake of MMR vaccines across the GP practices in Birmingham; some Practices have vaccinated only 1 in 5 children, others have achieved 100% coverage.

4.21 Seasonal Influenza (flu) can have significant health impacts, particularly on people with existing health conditions and weaker immune systems due to age. Flu is a largely preventable disease with an effective vaccination for those at risk. The uptake of flu vaccinations of the target groups varies significantly. None of the programmes in Birmingham achieve the targets or recommended

levels of uptake. Variation in uptake at GP Practice level is also significant.

4.22 All of the immunisation and screening programmes delivered in Birmingham are nationally specified, co-ordinated and commissioned locally by a PHE team embedded in the NHS England West Midlands Team.

4.23 Whilst city level immunisation and vaccination data is publicly available, data on GP practice level immunisation rates is only available for health protection assurance and contract management purposes and is therefore not currently available in the public domain. The Public Health Division is exploring opportunities to make this micro-information available on the health inequalities dashboard and will report back progress to a future meeting of the Board.

Macro level indicators: Physical activity and inactivity

4.24 Physical inactivity is the 4th leading risk factor for global mortality accounting for 6% of deaths globally. People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle. Regular physical activity is also associated with a reduced risk of diabetes, obesity, osteoporosis and colon/breast cancer and with improved mental health.

4.25 Physical activity and physical inactivity measures are reported by Public Health England on an annual basis, these are based upon a sample of the population who responded to the Active Lives self-reported survey. Currently Birmingham has 61.0% self-reported physically active adults compared to an average of 63.2% in the West Midlands region 66.3% average in England. Matching the regional average would equate to approximately 60,000 more people in Birmingham having a physically active lifestyle.

Macro level indicators: Healthy life expectancy

4.26 This indicator is an important summary measure of mortality and morbidity. Healthy life expectancy shows the years a person can expect to live in good health rather than with a disability or in poor health.

4.27 Birmingham males have a healthy life expectancy of 59.9 years, compared to 62.1 years and 63.4 years for the West Midlands and England respectively. Birmingham females have a healthy life expectancy of 58.9, compared to 62.9 and 63.8 for the West Midlands and England respectively.

Macro level indicators: Economic inactivity for health reason

4.28 This indicator is a measure of people of working age who due to having ill health or a disability are claiming Employment and Support Allowance (ESA) benefit, Incapacity Benefit (IB) or Severe Disablement Allowance (SDA). IB and SDA have been replaced by ESA. ESA provides financial support for people unable to work to their full capacity due to ill health or disability along with personalised support and can be applied for from employment, self-employment or unemployment.

4.29 Names, definitions and eligibility of benefits within the welfare system change over time. Changes in this indicator should be understood in this context as they do not necessarily reflect change in the health of the working age population or

change in the capacity of the labour market to employ people with varying health conditions. Universal Credit is gradually replacing Employment and Support Allowance (ESA). This will affect the rate of ESA claimants.

4.30 Whilst not working will be the right option for some of these people, staying out of work longer term may contribute to a worsening of health outcomes for others. This is because a person's employment status has both an associative and a causal relationship with a range of health outcomes.

4.31 Helping people back to work where appropriate can improve health outcomes by connecting people to the health promoting aspects of work.

Special interest indicators: Smoking in pregnancy

4.32 Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. On average, smokers have more complications during pregnancy and labour including bleeding during pregnancy; placental abruption and premature rupture of membranes; increased risk of miscarriage; premature birth, stillbirth; low birth-weight; and, sudden unexpected death in infancy.

4.33 Currently the proportion of Birmingham's mothers who are known to be smoking at time of delivery is 8.2%, compared to 11.9% and 10.8% for West Midlands and England respectively. Birmingham is currently the best performing Local Authority in the region. Birmingham is already compliant with the Birmingham and Solihull United Maternity & Newborn Partnership (BUMP) target of 10%.

4.34 The Tobacco Control Plan contains a national ambition to reduce the rate of smoking throughout pregnancy to 6% or less by the end of 2022. Given the relatively low prevalence of smoking at time of delivery already present in Birmingham this should be viewed as a minimum target. This would equate to approximately 400 less smokers at time of delivery per year in the City.

Special interest indicators: Gap in employment rates for those in contact with secondary mental health services; employment rates for those with learning disabilities

4.35 There is robust and consistent evidence that work is good for wellbeing, physical health and mental health. It is especially important that those in contact with secondary mental health services and learning disabilities—and who therefore are already at a probable disadvantage in terms of mental health and wellbeing compared to the general population—are able to benefit from the positive health outcomes associated with being in employment.

4.36 The preferred direction of travel is to reduce the gap in employment rates between those in contact with secondary mental health services and those with learning disabilities versus the employment rate in the general population.

4.37 Currently Birmingham is performing relatively well on the gap in employment rates for those in contact with secondary mental health services and the general population (60.4%) when compared with the West Midlands (65.7%) and England (68.2%). Birmingham is the 14th highest performing Local Authority nationally.

4.38 Employment rates for those with learning disabilities is 1.37% in Birmingham compared with 5.4% nationally. This places Birmingham in the bottom quarter of all Local Authorities. To progress to the third quarter would require an additional 38 people with learning disabilities to gain employment, to be in the top quarter would require an additional 171 people from the current position.

Special interest indicators: Gap in school readiness for those with free school meal status

4.39 Educational attainment is one of the main markers for wellbeing through the life course and so it is important that no child is left behind at the beginning of their school life. This is a key measure of early-years development across a wide range of developmental areas. Children from more deprived backgrounds are more at risk of poorer development and the evidence shows that differences by social background emerge early in life.

4.40 Free school meal status can be used as a proxy measure for deprivation; this indicator allows the Board to assess the inequalities observed in school readiness between those with free school meal status and the general population.

Baseline dashboard figures and direction of travel

4.41 The baseline Health Inequalities dashboard is available in **Appendix 2.** Please note that the provision of micro (GP Practice level) data on the variation in immunisations and vaccinations in the city is currently under review by the Public Health Division and relevant commissioners.

4.42 The latest available data will be presented to the Board using this dashboard template at each of the Board's formal meetings.

Next Steps / Delivery

4.43 It is proposed that the development and delivery of actions against each of these indicators be delegated to the Health and Wellbeing Board's sub-forums (Table 3).

4.44 Given its wider health inequalities remit, it is suggested that the majority of these indicators will be delegated to the City Without Inequality Forum as this Forum will be well placed to investigate differences observed across the City. It is suggested that the indicators relating to immunisation and vaccination rates be delegated to the Health Protection Forum and that improvements to physical activity rates and reductions in physical inactivity rates be delegated to the Active City Forum.

Table 3: Proposed delegation of development and action against indicators to Health and Wellbeing Board Sub-Forums

Sub-Forum	*Health Inequalities Indicator*
Creating a City Without Inequality Forum	Gap in employment rates for mental health and learning disabilities
	Gap in school readiness for those with free school meal status
	Unemployment Economic inactivity for health reason.
	Healthy life expectancy
	Smoking in pregnancy
	Chronic disease: Type 2 Diabetes and CVD (recorded prevalence)
	Chronic disease: Depression (gap between recorded and modelled
Health Protection Forum	Immunisation rates (various)
Creating an Active City Forum	Physical activity and inactivity

4.45 Information updates from the Sub-Forums will be submitted to each formal board meeting; in addition, each Sub-Forum and will deliver a detailed presentation to the Board on progress on a cyclical basis. It is suggested that where applicable, the Sub-Forum present on progress on action against any indictors delegated by the Board.

5. Compliance Issues

5.1 HWBB Forum Responsibility and Board Update

The Health and Wellbeing Board will monitor changes to the Health Inequalities Dashboard at each of its formal meetings. Progress on the development and delivery of actions to address each of the indicators will be monitored by the Board via annual updates of Sub-Forums to the Board.

5.2	Management Responsibility
	Paul Campbell, Acting Service Lead, Public Health Kyle Stott, Service Lead, Public Health Mo Phillips, Service Lead, Public Health Monika Rozanski, Service Lead, Public Health Elizabeth Griffiths, Acting Assistant Director, Public Health

6.	Risk Analysis		
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
The Public Health Division is unable to secure public facing data on GP practice level immunisation and vaccination rates requiring this indicator to be changed on the dashboard.	Medium	Medium	Public Health Division is exploring opportunities for sharing this data with relevant commissioners.

Appendices
Appendix 1 – Indicator background information Appendix 2 – Baseline Health Inequalities Dashboard

The following people have been involved in the preparation of this board paper:

Elizabeth Griffiths, Acting Assistant Director of Public Health
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