DUNDEE OUTCOME 4:

"Our people will experience fewer health inequalities".

National Outcome 6:

We live longer, healthier lives.

Introduction

During 2010/11, Healthy Dundee, the strategic lead for the Health and Wellbeing theme, has continued to explore and develop new ways of working with Dundee's communities to improve the health of the population.

Further information on these indicators can be accessed from the Dundee Partnership website: **http://www.dundeepartnership.co.uk/sites/default/files/Indicator%20Metadata%20Report.pdf**

Indicators

The five indicators for Dundee Outcome 4 are:

4.1 Male Life Expectancy at Birth.

4.2 Female Life Expectancy at Birth.

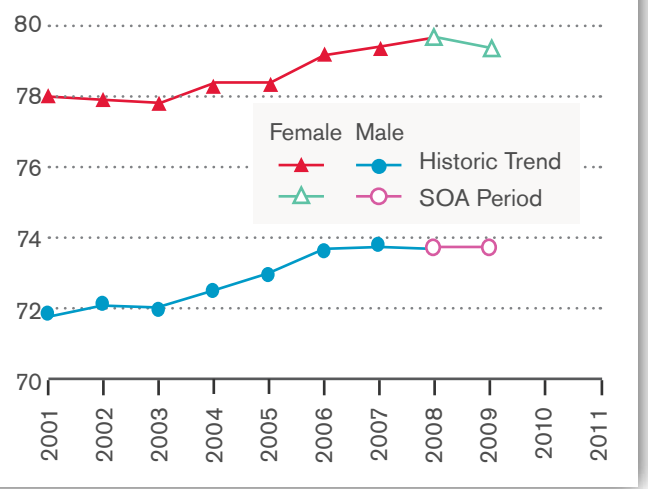
4.3 Gap in all cause mortality in those aged under 75 between the most deprived areas and the Dundee average (deaths per 100,000).

4.4 % adults who would say drug misuse or dealing is common in their neighbourhood.

4.5 Deaths per 100,000 population from alcohol related diseases.

Trend over SOA period	Status
Indicator moving in desired direction	✓
Indicator showing no significant change	~
Indicator moving against desired direction	X

4.1, 4.2 Life expectancy at birth

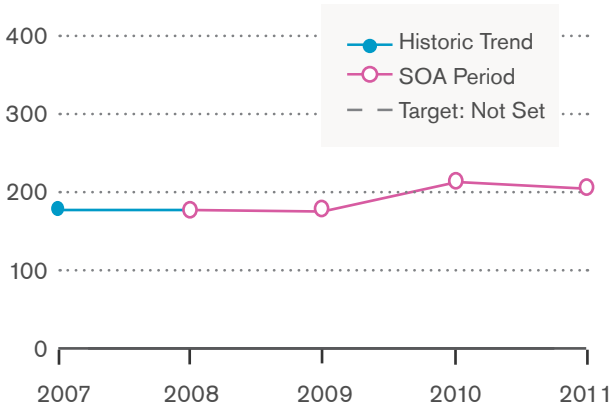


Life expectancy at birth	Male	Female
2008	73.7	79.7
2009	73.7	79.4
2010	-	
2011	-	
Target	-	
Trend over SOA period	Not available	

Commentary

This indicator has changed from the 'gap in healthy life expectancy' to just 'life expectancy' following advice from the Scottish Government Statistics branch. This is the latest data available. Data for the years 2008-2010 will be available in October 2011. The information here is based on life expectancy at birth which is the average number of years a newborn infant can expect to live if current mortality rates continue to apply. Overall life expectancy for males and females has shown an increasing trend although the latest period showed a slight reduction in female life expectancy. Inequality between males and females is common across the developed world and the reasons are not clearly understood. This indicator allows the monitoring of the trend in life expectancy over time for Dundee City as a whole. However, data at this level does not allow us to discern inequalities in life expectancy in areas within the city.

4.3 Gap in all cause mortality in those aged under 75 between the most deprived areas and the Dundee average (deaths per 100,000)

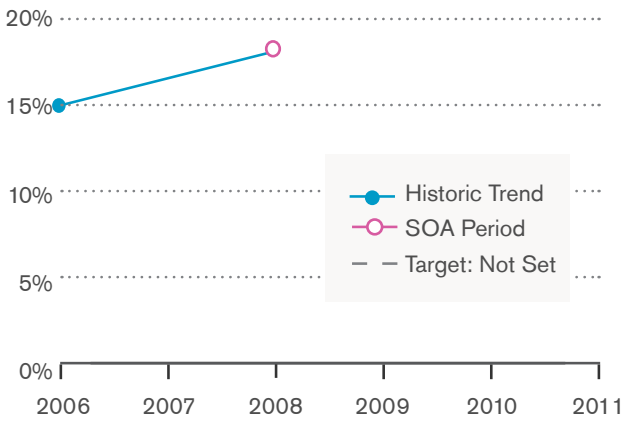


Gap in all cause mortality in those aged under 75 between the most deprived areas and the Dundee average (deaths per 100,000)	
2008	177.2
2009	177.2
2010	214.2
2011	202.4
Target	-
Trend over SOA period	X

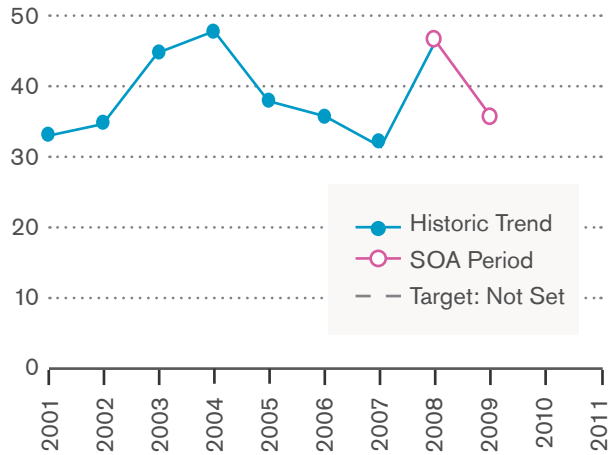
Commentary

This indicator has been used since the start of the SOA 2008 process. Mortality rates are measured as deaths per 100,000 population. This indicator compares the figure for Dundee as a whole with that for Dundee's most deprived areas (areas within Scotland's 15% most deprived data zones). It shows the inequality that mortality rates within Dundee's deprived areas are greater than those for Dundee as a whole. The gap in all cause mortality in those aged under 75 is affected by changes in mortality associated with a number of causes and with multiple, complex health experiences in the population. A numeric target for this indicator is still being considered and in the meantime we will monitor the overall trend over time. The data showed a considerable increase in 2010, but the rate has reduced since then. Overall the trend has shown an increase over the SOA period to date although it is hoped that the recent decrease will contribute to a continuing downward trend.

4.4 % adults who would say drug misuse or dealing is common in their neighbourhood



4.5 Deaths per 100,000 population from alcohol related diseases



% adults who would say drug misuse or dealing is common in their neighbourhood	
2008	18
2009	-
2010	-
2011	-
Target	Not available
Trend over SOA period	-

Commentary

This is a new indicator that aims to monitor perception of drug misuse. Data for 2005/06 has been taken from Scottish Neighbourhood Statistics. Data shown above for 2007/08 comes from the Scottish Household Survey. While this is a potentially useful indicator to gauge public perception of drug misuse activity, it is reliant on survey data that is not routinely available on an annual basis.

Deaths per 100,000 population from alcohol related diseases	
2008	46.3
2009	35.6
2010	-
2011	-
Target	Not available
Trend over SOA period	-

Commentary

This is a new indicator that aims to monitor alcohol abuse. The sharp increase shown by the 2008 data went against the overall decreasing trend. The rate has decreased over the SOA period shown above. This indicator was not originally in the indicator set, so there is no target attached to it at present. There is potential to agree a target for the future with appropriate partner organisations.

i) What have we achieved?

Health Equity Strategy

In 2010 NHS Tayside, on a partnership basis, developed a Health Equity Strategy for Tayside. The aim of the strategy is to address health inequalities and bring about health equity in a generation. Dundee Community Health Partnership (CHP) is responsible for developing a partnership Health Equity Action plan for the city.

The Dundee Partnership has agreed that, in terms of implementation of the Health Equity Strategy, priorities should focus on 3 main actions which could achieve the transformational change as set out in the Strategy. These are,

- The development of social prescribing across the city based on the findings of the local pilot.
- Roll out and implementation of lessons learned from the Dundee Equally Well Test site.
- Enhancement and further roll out of the Dundee Healthy Living Initiative.

Improving information

A series of local partnership profiles have been developed to support the ongoing work of the LCPPs. These profiles have given the LCPPs valuable information across a number of key health indicators to inform the development of local community plans and will also support the Health and Care theme to identify where resources and activity should be more effectively targeted.

The development of Local Care Centres

Dundee's first Local Care Centre (LCC) is to be established in Whitfield, one of the more disadvantaged areas of the city. The Whitfield LCC is a collaborative project between NHS Tayside and Dundee City Council as part of the local authority's urban regeneration and school replacement programme. The aim of LCCs is to progress joint working, co-location and targeted service delivery in the heart of local communities. It will reflect the needs, experiences and choices of all service users in the community, whether patients or carers, as well as the specialist needs of social work, clinical and non-clinical staff in Dundee.

Keep Well

Keep Well is aimed at delivering anticipatory care through primary care, including General Practice and a range of other teams. NHS Tayside had initially developed a model specifically targeting those aged 45-64 living in more disadvantaged communities, offering Keep Well health checks in General Practice, and providing advice and interventions in relation to health-related behaviours. Treatment is initiated where indicated and ongoing support is provided in general practices and the community dependent on the patients' needs. A range of additional new developments has widened the programme to include a number of other 'at risk' groups.

Providing a Keep Well health check, targeted at those who are more likely to have cardiovascular disease and are less likely to attend services, supports the agenda of improving healthy life expectancy and closing the inequalities gap. The data suggests that a range of medical interventions, ongoing support and lifestyle changes such as weight loss are having an impact. To date, 34% of the target population, around 6000 people, have had at least one new chronic disease or risk factor identified, including 568 new hypertension diagnoses and 178 new diagnoses of diabetes. These risk factors are linked to a significant risk of heart disease and stroke in the future and early diagnosis and treatment is important. Data is currently being analysed to assess the impact Keep Well has had on the health of those who have received a health check. Early indications show a statistically significant decrease in blood pressure, HDL Cholesterol and a reduction in rate of weight gain.

Keep Well may be contributing to the considerable reductions being seen in admissions to hospital where Coronary Heart Disease is identified as the main diagnosis. There has been a similar decrease in the number of occupied bed days where Coronary Heart Disease is the main diagnosis.

The Dundee CHP profiles published by Scottish Public Health Observatory report a decrease in the rate of early deaths from Coronary Heart Disease from 87.5 per 100,000 population in 2008 to 64.4 per 100,000 population in 2010.

CASE STUDY 10:

Hearty Lives

Dundee Community Health Partnership was successful in securing £1.3 million from the British Heart Foundation (BHF) to build on current exemplar good work through Keep Well and Community Heart to continue tackling health inequality across Dundee. The funding period was from April 2009 until March 2012 for the clinically based projects and March 2013 for the social inclusion projects.

The partnership with BHF has developed and strengthened during this time and will continue to be in place through resources, services and products after the grant award has come to an end.

The Hearty Lives Dundee Programme comprises a number of project strands delivering a mixture of clinical and social inclusion type services - all to people who are at risk and live in areas of within the city which face the challenges of inequalities in the broadest sense.

The Clinical Projects are as follows:

- Extension of the Keep Well age range for health checks to 40-44 years.
- Provision of a specialist community based cardiovascular nursing team providing opportunistic heart health checks across the city in targeted locations - all aimed at improving access and providing knowledge of health improvement to those people living with a range of inequalities. Almost 900 people have received opportunistic checks.
- Provision of specialist clinics within the community to support patients with a high cardiovascular disease risk. Fourteen clinics have been run to date.
- Provision of Cardiology clinics in community settings, in partnership with a Consultant Cardiologist, providing specialist services closer to peoples' homes. Eleven cardiology clinics have been run.

The Social Inclusion projects are as follows:

- Active Families Dundee - a partnership with Sports Development and Dundee City Council which delivers a tailored and supportive programme of intervention with families who face challenges but who want to become more physically active as a family. Further partners in this project are Dundee Healthy Living Initiative and NHS Paediatric Obesity Service – all aimed at reducing the trend in childhood obesity.
- Workplace Health Coaching Service - a partnership with the Working Health Services team to provide a health coaching service in targeted workplaces across the city. The service will target employees who fall into low paid categories in the main and who require support to lead healthier lifestyles.

Underpinning the programme is the required Programme Management, fully funded as part of Hearty Lives Dundee and driving the above projects forward in tandem with a rigorous national and local evaluation process.

Smoking

The NHS Tayside Best Value Review of Smoking Cessation and Prevention (2006), identified that investment in tobacco-related behaviour change should be targeted at areas of highest need, i.e. those areas of social deprivation. Recognising that Dundee had a particular issue with women who smoke during pregnancy, the first smoking cessation incentive scheme in the UK, 'Give it Up for Baby', was implemented. This scheme has significantly changed the numbers of pregnant women engaging with smoking cessation services and proved more successful than previous interventions with around 6% of smoking mothers in Dundee recruited.

In March 2009, a wider incentive scheme, Quit4U was launched targeted at adults aged over 16 years living in the most deprived areas of Dundee. Interim evaluation reports from Quit4U indicate take up and cessation rates significantly higher than those achieved in other smoking cessation interventions. A full evaluation of the programme is expected during 2011.

Quit4U was able to recruit 1,200 additional smokers against a predicted uptake of 900 smokers for its first year of operation. Quit4U retains 45% of smokers at one month against a Tayside average of 28% at one month. These innovations have been recognised by the Scottish Government and other NHS Boards.

Smoking prevalence in Dundee has dropped from 30.5% in 2008 to 26% in 2010 and is now no longer statistically significantly different from the Scottish average of 25%. Smoking rates vary widely across the city and there are still areas where smoking prevalence is higher than the Scottish or Dundee average. The percentage of women smoking in pregnancy has decreased from over 35% to below 30% but remains significantly higher than the Scottish average.

Conception rates of teenagers in Community Regeneration Areas

The Health Buddies in Schools pilot programme has completed its first phase. The aim of this programme was to develop and deliver agreed time-limited programmes for peer led approaches to sexual health, relationships and well-being within Morgan Academy and Menzieshill High School. Twenty-five S3 pupils from both secondary schools were recruited and trained as health buddies. The programme received a Diana award and continues to develop. Funding has been secured to extend the programme for a further 2 year pilot, enabling the approach to be delivered in 4 secondary schools and a model of sustainability to be developed.

All secondary schools have a generic health drop-in supported by a school nurse and a health promotion officer operating weekly. Community pharmacies offer sexual health services within local communities. Young people's sexual health services are also available at Ninewells Hospital and The Corner.

All schools are developing and implementing the Curriculum for Excellence. This includes outcomes and experiences in relationships, sexual health and parenthood. The Web project delivers programmes to offsite centres across the city. Staff development opportunities are available and work is currently ongoing to offer training on risk-taking behaviour through a multi-agency approach.

The Speakeasy parenting programme has been introduced to school and community groups. This 8 week programme provides practical support and advice on positive parenting and aims to encourage and enable parents to talk to their children about relationships, sexual health and other risk-taking behaviours.

Statistical evidence is being gathered to show comparative trends in conception rates in areas of high and low disadvantage.

Dundee Family Nurse Partnership

The Dundee Family Nurse Partnership (FNP) was launched in January 2011. The FNP is an intensive preventive programme through pregnancy for all first time mothers under the age of 20 until the child is 2 years of age, which benefits children and families who have the poorest outcomes. The family nurse will work intensively with the family (25 case loads per nurse) and support families throughout the city.

The Dundee FNP is the second test site in Scotland, chosen as one of the largest groups, with an investment of £3.2 million over 3 years. The FNP team will comprise family nurses, supervisors, administration staff, and will be managed by the Dundee Community Health Partnership.

ii) What challenges are we facing?

Although progress is being made to improve the health of the population of Dundee and to reduce the identified health inequalities, it is recognised that a number of challenges need to be faced and overcome by the Partnership if significant improvements are to be made in the future.

Improving population health versus reducing inequalities

Interventions which improve the health of the overall population do not necessarily reduce inequalities and may in fact serve to increase the inequalities gap if they are taken up disproportionately by the less deprived. In order to meet population health improvement targets there is a temptation to target interventions at those who are most likely to take them up and make behaviour changes as a result.

Prioritising the reduction of health inequalities will mean targeting interventions at those least likely to make behaviour changes which may in turn mean that population health does not improve as quickly as it otherwise would.

Targeting of resources in this way can be difficult when statutory bodies are required by law to provide a universal service to all those who are eligible. Much of the targeted work being taken forward is funded on a project basis through short term external funding and thus has had little impact on how mainstream services are provided. Reducing health inequalities will require support at a planning and political level to allow us to make the transformative service changes which may be required.

Funding

A number of the key projects identified above have only been possible because the Partnership has been able to attract external short-term funding. Whilst this funding has been very welcome and has allowed us to develop innovative approaches within our communities, the shifting of resources from "mainstream" services and the redesign of these services is taking place over a much longer timeframe. For the majority of projects it has not proven possible to achieve definite assurances regarding long term funding. This uncertainty has led to a high staff turnover in some instances and reluctance to raise expectations of our communities given that work may be unsustainable. The uncertainty regarding funding does not help to build and sustain trusting relationships with our communities.

Identifying communities and individuals to be targeted

Targeting of communities to date has depended on the use of postcode and SIMD data to identify those people living in the most deprived areas. Whilst this certainly assists us in targeting those most at risk, limitations to this approach have been identified. There are many people in low incomes living within areas of relative affluence. For these individuals the impact of deprivation may be felt acutely and yet services may not be targeted at them. Conversely, relatively affluent people living in areas of deprivation may be targeted by services inappropriately. In some cases this can lead to feelings of unfairness within the community.

In addition, there are a number of groups who are vulnerable or at risk because of risk characteristics other than income, for example older people, those with learning disabilities, people from particular ethnic backgrounds. Whilst it is recognised that within Dundee the majority of inequalities are due to inequalities in socio-economic status, different targeting methodologies are required to identify and target these communities.

Developing new approaches within a diminishing budget

If statutory organisations and partners are to meet the needs of future generations, it is accepted that we need a shift in the way public services are delivered. Implementing this shift will require significant investment, at least in the short to medium term. At the same time we are delivering services to meet the needs of the current population and at a time when public finances are stretched. The Partnership is working closely together to address some of these issues (e.g. through the Reshaping Care for Older People agenda) and must ensure that this close partnership working continues across all work streams.

Impact of joblessness / recession

The current financial crisis and resulting joblessness and decrease in spending power across our communities will undoubtedly have a knock-on effect on people's health and well being. Already some evidence is emerging which shows an increase in the rate of suicide across the UK. The Partnership is required to meet targets which were extrapolated from baselines at a time of relative affluence and we will therefore be required to work even harder to ensure that targets are met.

iii) How will we achieve more?

Fit for purpose review

In common with the other Strategic Theme groups, Healthy Dundee is undergoing a review of its fit for purpose. Identifying the three priorities for implementation of the Health Equity Strategy and aligning these with the SOA has given the Theme group a basis for review of remit, membership, reporting and governance arrangements. The fit for purpose review will include exploring how the theme group links with operational management groups such as the Health and Local Authority Management Group (which has operational accountability for SOA Outcome 6). The review will allow the theme group to explore the implications of and opportunities provided by current key pieces of work such as the implementation of the Change Fund and the associated support being given locally by Scottish Government to improve data analysis at a local level.

The multi-faceted nature of health inequalities

Healthy Dundee recognises that the causes and manifestations of health inequalities are multi-factorial and emerge across all the Partnership's Strategic Theme groups and Cross Cutting Themes. In order to meaningfully address these inequalities, there is a need to explore further the potential for localisation and integration of public services.

Community Engagement

The need for culture change, from focussing on the negative aspects of our communities that need addressing towards an asset based approach which makes use of positive feedback mechanisms to enable communities to flourish, is well described in the Health Equity Strategy. Healthy Dundee is keen to take forward innovative means of engaging communities, building on existing engagement methodologies where appropriate. In particular we wish to explore how health inequalities can be addressed in conjunction with local community planning processes. Learning from local programmes such as StobsWellbeing and Keep Well will be central to these developments, as will learning from other programmes such as the Beacon Project in Cornwall.

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