NHS
National Institute for Health Research

Equal North: Communities and Neighbourhoods

St Mary's Conference Centre
Monday 20th November 2017

School for Public Health Research

NHS
National Institute for Health Research

Equal North Research and Practice Network

Professor Clare Bambra

Funded by SPHR NIHR

fuse

LiLaC

The University Of Sheffield.

Equal North Network

NHS
National Institute for Health Research

- A Northern Research Network of academics, policy and practice members
- Mapping the skills and interests of members related to health and social inequalities research and practice
- 4 network meetings across the North – in NE, NW, Y&H and London
- Research Exercise identifying the priorities for future research
- N=450+ members across NE, NW, and Y&H

House-keeping

NHS
National Institute for
Health Research

Programme for the day

NHS
National Institute for Health Research

11.00	**Introductions**
11.15	Greg Fell, Director of Public Health, Sheffield City Council *Ten steps to reframing inequalities in health*
11.45	Jane South, Professor of Healthy Communities, Leeds Beckett University *Community engagement, equity and empowerment: what do we know – what can we do?*
12.15	Panel responses and open discussion
12.50	**Lunch and networking**
13.45	WORKSHOP SESSIONS (3 rooms) • *How can housing providers help tackle health inequalities*? • *What is the relationship between community empowerment and health inequalities?* • *How can we ensure good health in diverse communities*?
14.45	**Tea/coffee and networking**
15.00	Feedback on the workshops and messages for the public health system: Julia Burrows, Director of Public Health, Barnsley Metropolitan Borough Council Corinne Harvey, Public Health Consultant, Public Health England, Yorkshire & Humber
15.30	**Thanks and close**

Reframing health inequalities in 10 steps

Greg Fell
Director of Public Health
Sheffield
Greg.fell@sheffield.gov.uk
@felly500

1 Language and location

- Health ≠ NHS
- Determinants ≠ Inequalities and vice versa
- HI ≠ “a health” thing, or a “public health” thing
- DH is wrong sponsor agency.
- Social v medical model
- Assets vs risks to health & burden of disease type of approach.

2 Public Health

- health protection, health care, health improvement.
- SCC has a PH strategy . 5 pages
- Being “done”. No glitz and glamour
- Budgets slashed, repeatedly.
- Services, function, responsibility

3 HI Strategy - 2014

- “writing plans” wont solve
- much broader context across the city – fairness, poverty, financial inclusion, inclusive growth…..
- Proportionate universalism matters. Why don't we succeed in the aspiration
- No single pithy “answers”. Marmot’s recipe
- Complex interplay of - Health / Wealth / Education / Poverty / Family aspiration

4) wider context - exceptionally challenging

- Most challenging outlook for public services since 70s.
- Austerity will continue
- Brexit - Pre Brexit signals were that austerity will continue into 2020s. Post Brexit - no econ textbook
- Local governance is messy. Mayors, no mayors. Devo, no devo
- Deep trouble spending wise - ASC / children's social care, NHS, prisons at breaking point
- we need stable long term government
- History (1970s) says minority govt will last – deal-making, think in days and weeks, not decades.

5) LA in difficulties

- Makes it risk adverse
- Strong gradient in Correlation between LA cuts and deprivation.
- Resource allocation formula create inequality. Worse in North
- Cumulative impact of welfare reform – directly on people, indirectly through large cuts to service delivery.

5) What's the currency - £ vs outcomes

- If £ we will do the wrong things
- don't have a conversation about £ till we've had a conversation about outcomes
- Don't have a conversation about outcomes till we've had a conversation about inequality
- the Stigltz argument

6) Localities – we over obsess on it

- Different definitions re geography and boundary
- Democratic renewal, efficiency public service deliver, efficient service delivery, other
- NHS / LA / Police / Housing / real
- Don’t sweat it. It will never be right
- Takes our mind away from non geographical – excluded pops, mental illness, LD

7) Third sector will not, by itself, solve the HI problem

- Though it is critically important. Glasgow Social Context work
- tough times continue - More demand / Core funding vs activity based funding
- relationship between stat and VCS. Level playing field. Expose the asymmetrical nature openly and debate it.
  - ROI vs cashable savings vs cost effective. Kidney transplant vs well being programme
  - Monitoring requirements – which vary widely between different funders.
  - Contract length
- Believers and non believers

8) Social prescribing

- Ideological issues – medicalises something not medical?
- VCS ≠ SP etc
- Commissioned activity – tends not to pick up core funding. Activity funders tend to not want to pay high management cost (which mostly used for core funding)
- Activity at end of prescription rather than process
- Mostly likely to be delivered by small orgs, with local footprint. At risk. Weaker financial position.
- Infrastructure orgs also at risk
- Takes years to build neighbourhood level relationships.

9) Different models of growth. Interplay with “health inequalities”

- Need econ growth.
- Needs to be inclusive. Nobody left behind.
- Focus on the whole resource envelope and bending it to doing the right thing. No new £
- Two way relationship between growth and economic and well being.
- Building in the externalities most often excluded from conversations about “the economy”
- Intergenerational aspects of externalities – from birth to career to old age
- Services seen as investments rather than cost drains

10) summary – 7 issues to attend to

- “evidence”. Different paradigms. Over focus on individual level interventions. Much less focus on structural interventions.
- Don’t need to measure with fine grain detail.
- No burning platform that speaks on the currency all aligns
- not seen as mission critical. cross cutting thus not “owned”
- The word “health” in HI – outcome vs causation
- What and who do you want to influence – proposition. Money, Power, Permission
- Frame in 5 ways to well being….. multiple levels

Thank you for your attention
What is your view?

@felly500

greg.fell@sheffield.gov.uk

Community engagement, equity and empowerment: what do we know – what can we do?

Jane South, Professor of Healthy Communities,
School of Health and Community Studies
National Adviser – Communities, Public Health England

Presentation at Equal North Network Meeting:
Communities and Neighbourhoods, 20th November 2017

LEEDS BECKETT UNIVERSITY

The public's health - where should we start?

- What do we know about working with communities?
- What are the challenges around evidence into action?
- Do we need a different model of evidence? What needs to be measured?

LEEDS BECKETT UNIVERSITY

Public Health England

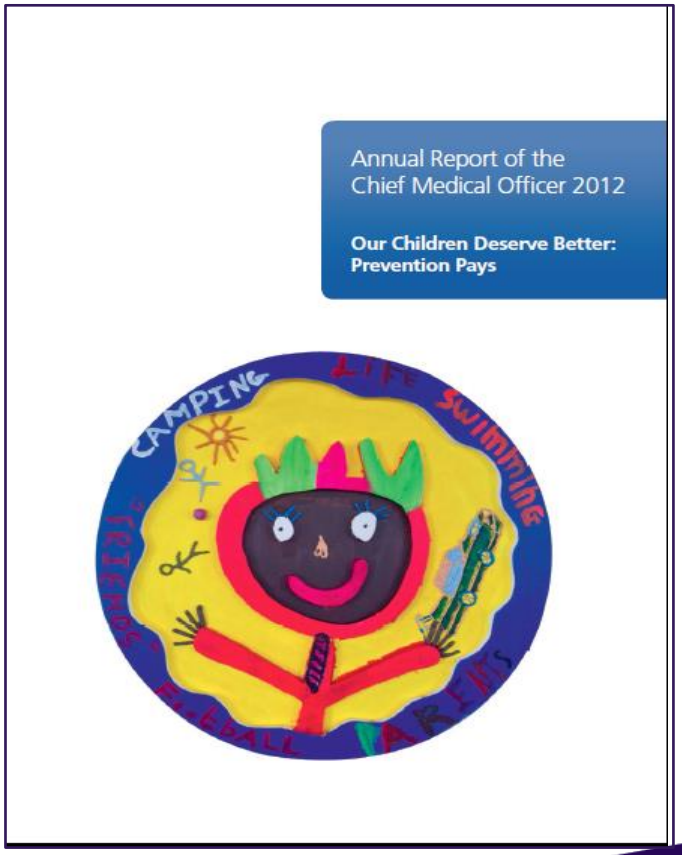
WHO Europe (2013) Review of social determinants and the health divide

"How people experience social relationships influences health inequities. Critical factors include how much control people have over resources and decision-making and how much access people have to social resources, including social networks, and communal capabilities and resilience."(p.13)

Our children deserve better (2012)

Risk and resilience factors affecting health outcomes **at a community level**:

- Socio-economic disadvantage
- Poor housing conditions
- Positive social networks eg neighbours, peers, teachers
- Access to positive opportunities
- Participation in community activities eg church

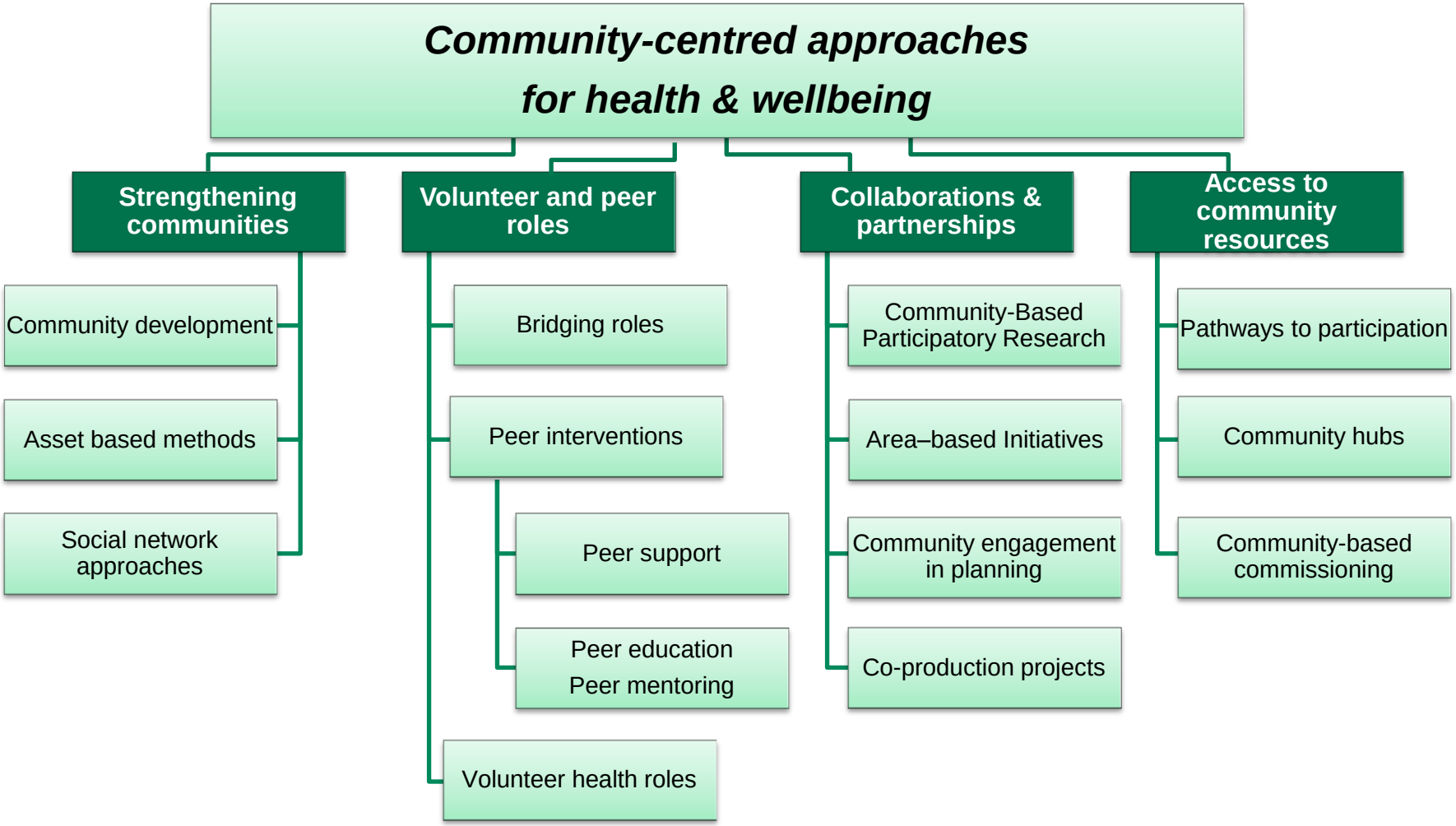


LEEDS BECKETT UNIVERSITY

Public Health England

NHS England

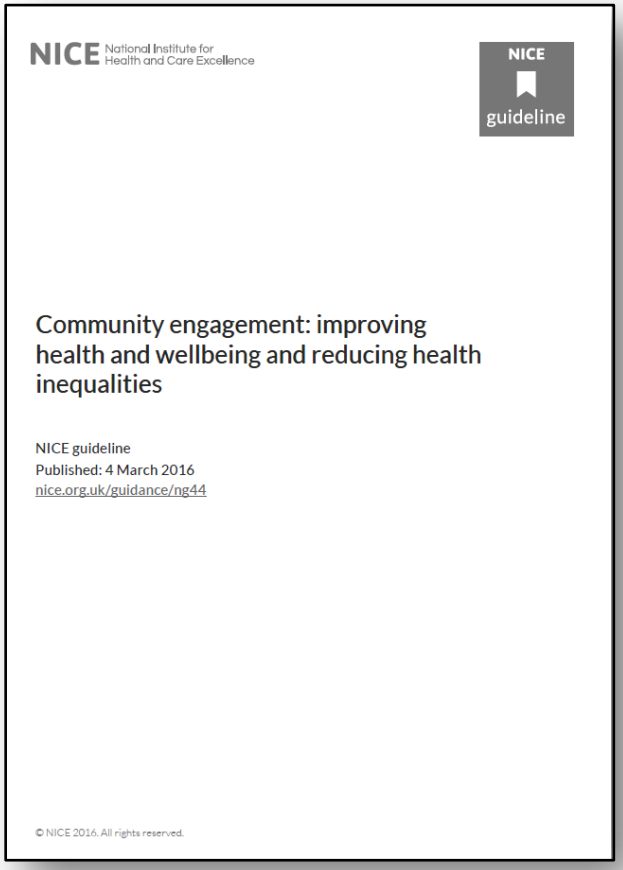
The family of community-centred approaches



PHE & NHS England (2015) A guide to community-centred approaches for health and wellbeing: https://www.gov.uk/government/publications/health-and-wellbeing-a-guide-to-community-centred-approaches

Public Health England

NICE Guidelines Community engagement (2016) NG44



"Over recent years, there has been a significant increase in published evidence on community engagement. There is also a growing informal evidence base about how initiatives work in practice. But the latter is difficult to capture and formally evaluate." (p. 20)

The community contribution

- Skills, knowledge and experience
- Bridging and connecting to address inequalities
- Pathways for individuals can build capacity in communities

South, J., White, J. Gamsu, M. (2013) People-Centred Public Health. Bristol: The Policy Press.

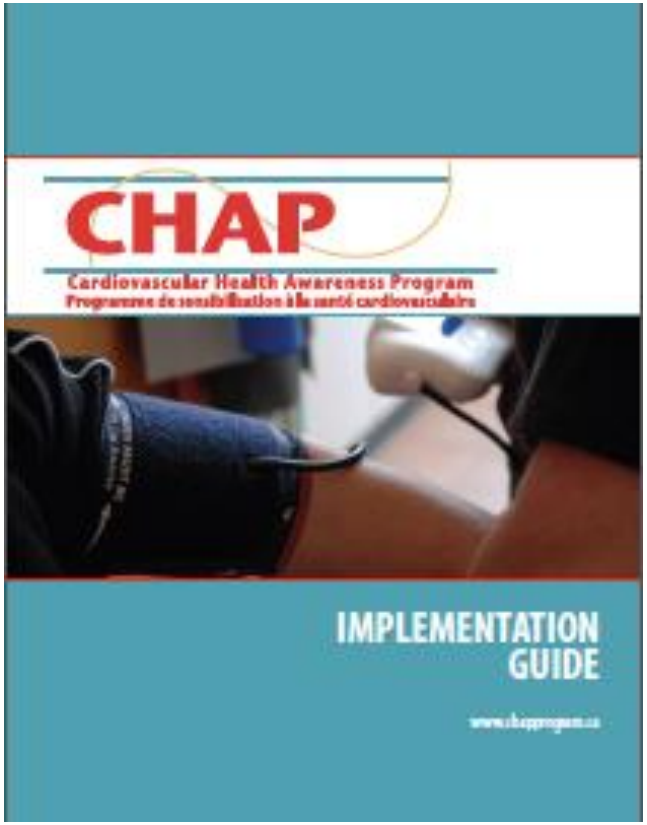
LEEDS BECKETT UNIVERSITY

What are the challenges around evidence into action?

- *Complex systems*
- *Scale*
- *Social action*

LEEDS BECKETT UNIVERSITY

Cardiovascular Health Awareness Program CHAP - Canada



BMJ

RESEARCH

Improving cardiovascular health at population level: 39 community cluster randomised trial of Cardiovascular Health Awareness Program (CHAP)

Janusz Kaczorowski, professor,[1,2,3] Larry W Chambers, president and chief scientist,[4] Lisa Dolovich, associate professor,[2,5,6] J Michael Paterson, scientist,[7] Tina Karwalajtys, assistant professor,[2] Tracy Gierman, director,[8] Barbara Farrell, scientist,[4,9] Beatrice McDonough, public health nurse,[10] Lehana Thabane, associate professor,[5] Karen Tu, scientist,[7] Brandon Zagorski, analyst,[7] Ron Goeree, associate professor,[5] Cheryl A Levitt, professor,[2] William Hogg, professor,[4,9,11] Stephanie Laryea, research assistant,[2] Megan Ann Carter, research associate,[11] Dana Cross, acting director,[8] Rolf J Sabaldt, associate clinical professor[6]

[1]Department of Family Practice, University of British Columbia, 910-5950 University Boulevard, Vancouver, BC, Canada V6T 1Z3
[2]Department of Family Medicine, McMaster University, Hamilton, ON, Canada
[3]Child & Family Research Institute, Vancouver
[4]Institut de recherche Élisabeth-Bruyère Research Institute, Bruyère Continuing Care and University of Ottawa, Ottawa, ON, Canada
[5]Department of Clinical Epidemiology and Biostatistics, McMaster University, Hamilton
[6]Department of Medicine, McMaster University, Hamilton
[7]Institute for Clinical Evaluative Sciences, Toronto, ON, Canada
[8]Academic Health Council, University of Ottawa, Ottawa
[9]Department of Family Medicine, University of Ottawa
[10]Public Health Services, City of Hamilton, Hamilton
[11]Institute of Population Health, University of Ottawa
Correspondence to: J Kaczorowski januszkaczorowski@familymed.ubc.ca

Cite this as: BMJ 2011;342:d442
doi:10.1136/bmj.d442

ABSTRACT

Objective To evaluate the effectiveness of the community based Cardiovascular Health Awareness Program (CHAP) on morbidity from cardiovascular disease.

Design Community cluster randomised trial.

Setting 39 mid-sized communities in Ontario, Canada, stratified by location and population size.

Participants Community dwelling residents aged 65 years or over, family physicians, pharmacists, volunteers, community nurses, and local lead organisations.

Intervention Communities were randomised to receive CHAP (n=20) or no intervention (n=19). In CHAP communities, residents aged 65 or over were invited to attend volunteer run cardiovascular risk assessment and education sessions held in community based pharmacies over a 10 week period; automated blood pressure readings and self reported risk factor data were collected and shared with participants and their family physicians and pharmacists.

Main outcome measure Composite of hospital admissions for acute myocardial infarction, stroke, and congestive heart failure among all community residents aged 65 and over in the year before compared with the year after implementation of CHAP.

Results All 20 intervention communities successfully implemented CHAP. A total of 1265 three hour long sessions were held in 129/145 (89%) pharmacies during the 10 week programme. 15 889 unique participants had a total of 27 358 cardiovascular assessments with the assistance of 577 peer volunteers. After adjustment for hospital admission rates in the year before the intervention, CHAP was associated with a 9% relative reduction in the composite end point (rate ratio 0.91, 95% confidence interval 0.86 to 0.97; P=0.002) or 3.02 fewer annual hospital admissions for cardiovascular disease per 1000 people aged 65 and over. Statistically significant reductions favouring the intervention communities were seen in hospital admissions for acute myocardial infarction (rate ratio 0.87, 0.79 to 0.97; P=0.008) and congestive heart failure (0.90, 0.81 to 0.99; P=0.029) but not for stroke (0.99, 0.88 to 1.12; P=0.89).

Conclusions A collaborative, multi-pronged, community based health promotion and prevention programme targeted at older adults can reduce cardiovascular morbidity at the population level.

Trial registration Current controlled trials ISRCTN50550004.

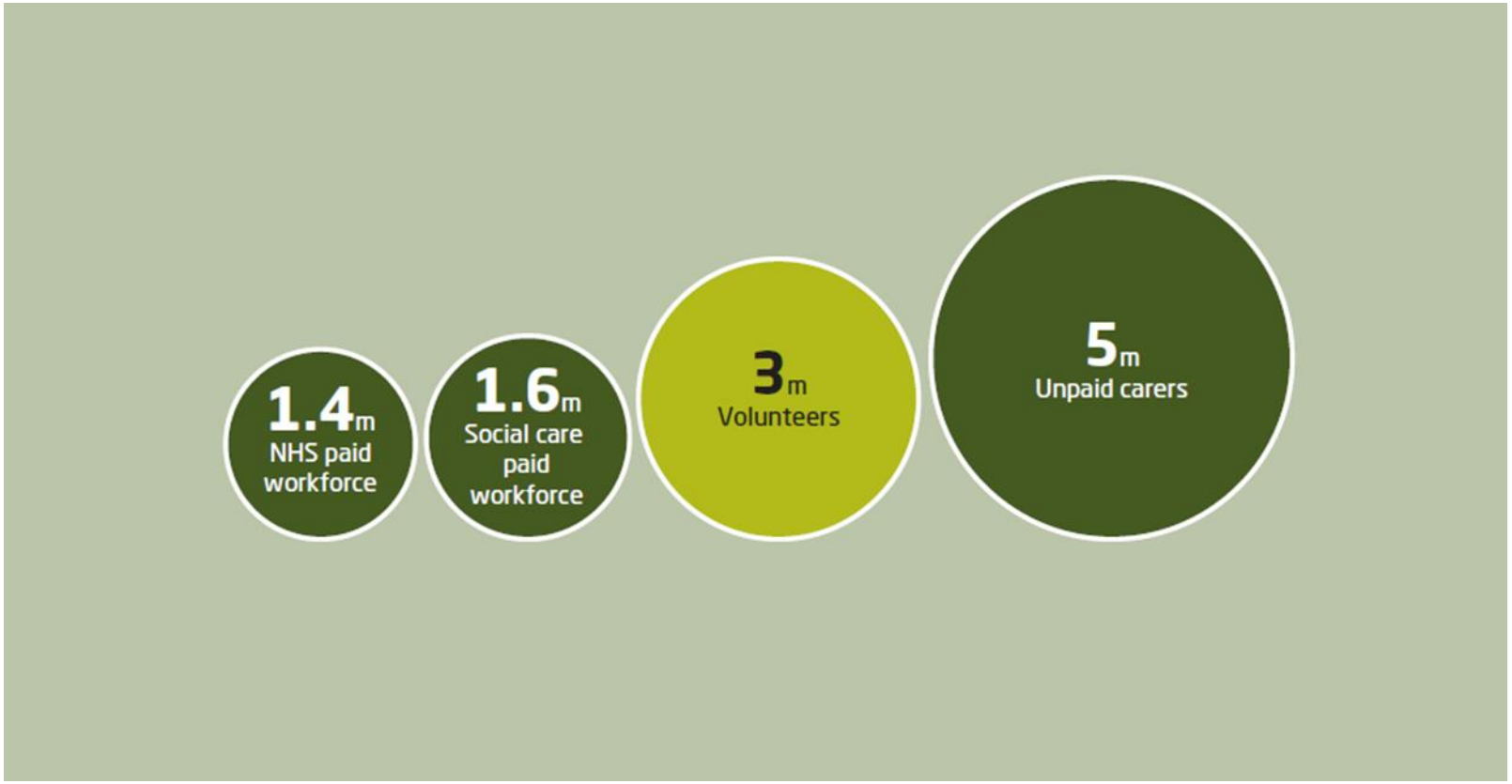
INTRODUCTION

In 2002 the World Health Organization identified high blood pressure as the leading risk factor for death, forecasting an epidemic of hypertension and identifying community programmes to prevent cardiovascular disease as a priority.[1] Worldwide, 30% of all deaths are due to cardiovascular disease, and more than 54% of deaths from stroke, 47% of those from ischaemic heart disease, and 14% of all deaths are attributable to high blood pressure.[2,3] Effective population based strategies for health promotion and disease prevention, both for people with established cardiovascular disease and for those at risk of developing it, are seen as critical to countering widespread and growing epidemics of obesity, hypertension, diabetes, heart disease, and stroke.[4-6] Both the incidence and the prevalence of hypertension increase with age, and the lifetime residual risk of developing hypertension for a middle aged person with normal blood pressure is 90%.[7]

A recent review of community programmes for prevention of cardiovascular disease included 36 community programmes that took place between 1970 and 2008 and concluded that although generally favourable changes in overall cardiovascular risk have been shown, considerable uncertainties about their effectiveness remain.[8] The review further concluded that studies of programmes better adapted to current circumstances need to be implemented and rigorously evaluated before widespread implementation of such programmes can be recommended. Specific

DS
KETT
VERSITY

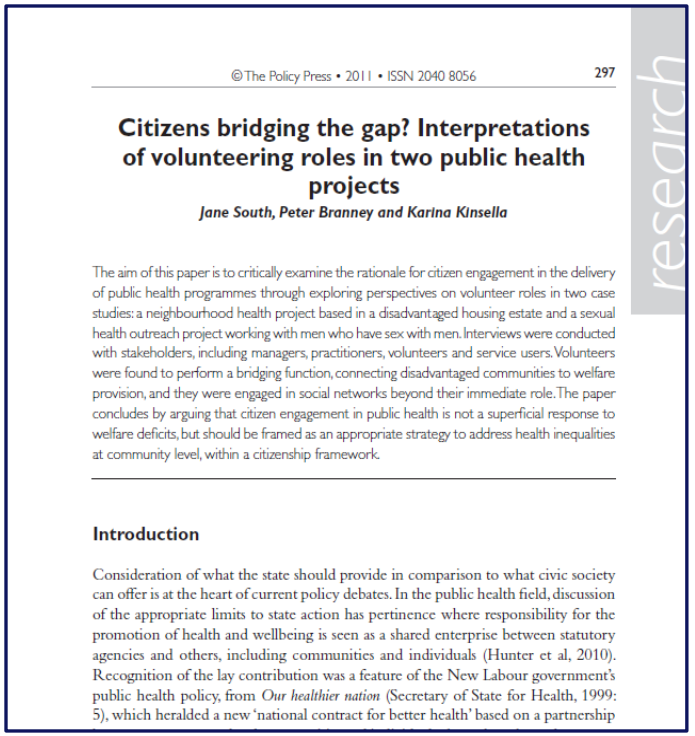
Number of health and social care employees, volunteers and carers in England



Source: The King's Fund (2013) Volunteering in health a care. Securing a sustainable future.

Roles – bridging and connecting

We can talk to people here in their own language that they can understand, because we're just normal people. And I think they trust us because we are normal people…And I think we get through to quite a few people, don't we? Because they trust us. I think it's trust."



© The Policy Press • 2011 • ISSN 2040 8056

research

Citizens bridging the gap? Interpretations of volunteering roles in two public health projects

Jane South, Peter Branney and Karina Kinsella

The aim of this paper is to critically examine the rationale for citizen engagement in the delivery of public health programmes through exploring perspectives on volunteer roles in two case studies: a neighbourhood health project based in a disadvantaged housing estate and a sexual health outreach project working with men who have sex with men. Interviews were conducted with stakeholders, including managers, practitioners, volunteers and service users. Volunteers were found to perform a bridging function, connecting disadvantaged communities to welfare provision, and they were engaged in social networks beyond their immediate role. The paper concludes by arguing that citizen engagement in public health is not a superficial response to welfare deficits, but should be framed as an appropriate strategy to address health inequalities at community level, within a citizenship framework.

Introduction

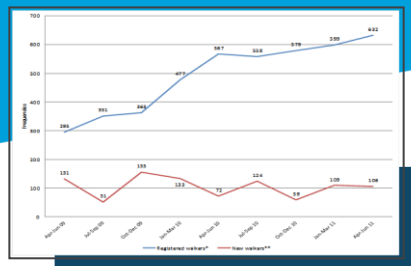
Consideration of what the state should provide in comparison to what civic society can offer is at the heart of current policy debates. In the public health field, discussion of the appropriate limits to state action has pertinence where responsibility for the promotion of health and wellbeing is seen as a shared enterprise between statutory agencies and others, including communities and individuals (Hunter et al, 2010). Recognition of the lay contribution was a feature of the New Labour government's public health policy, from *Our healthier nation* (Secretary of State for Health, 1999: 5), which heralded a new 'national contract for better health' based on a partnership

South, J., Branney, P., Kinsella, K. (2011) Citizens bridging the gap? Interpretations of volunteering roles in two public health projects. *Voluntary Sector Review*, 2, 3, 297-315.

Sources of evidence

LEEDS BECKETT UNIVERSITY

Institute for Health & Wellbeing



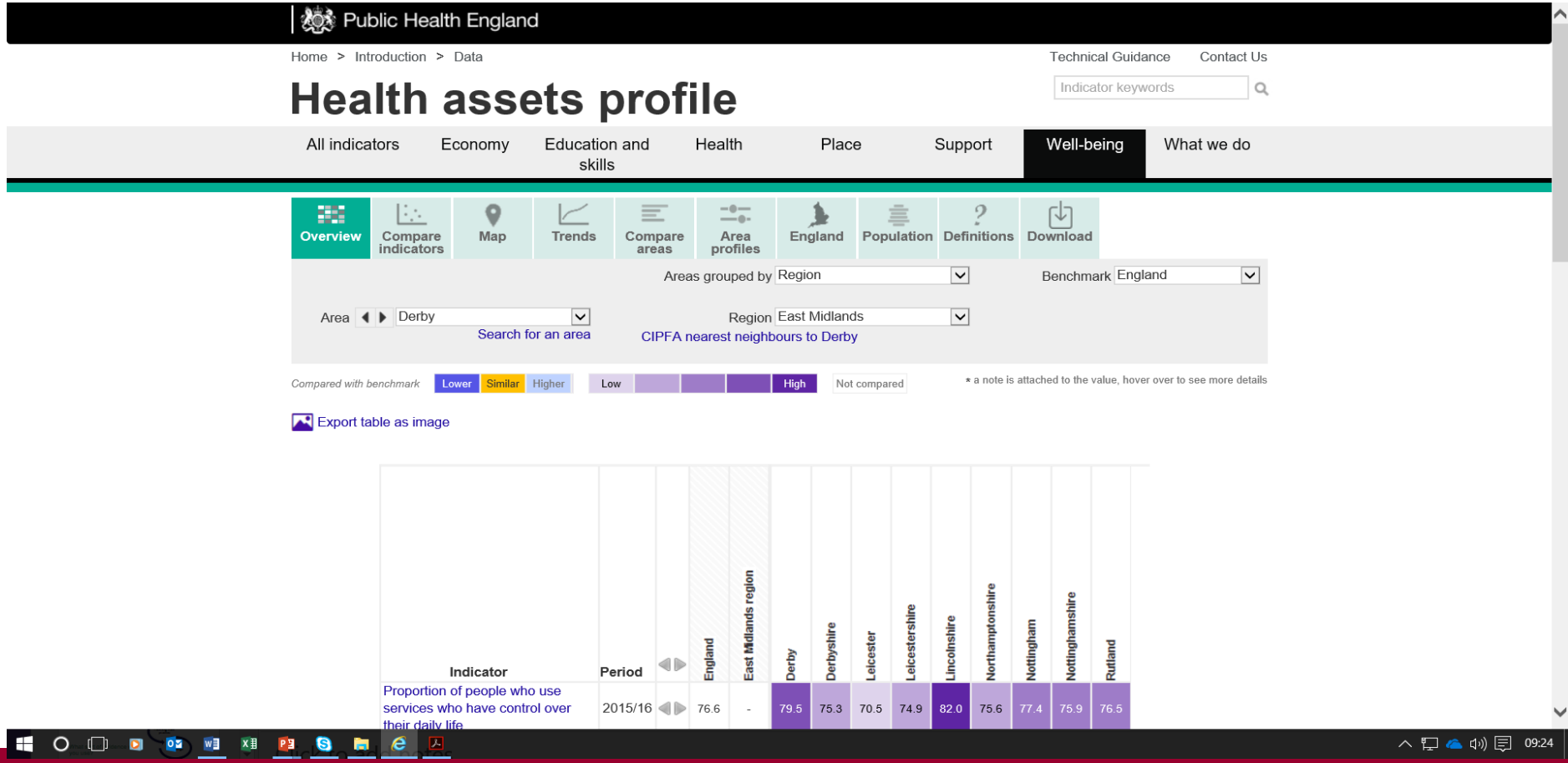
Research-based knowledge

Learning from practice

Community /citizen knowledge

Public Health England

PHE Health Assets Profile



https://fingertips.phe.org.uk/profile/comm-assets

How do participants describe their health walks?

We're a big group of friends, social people who happen to walk on a Monday morning. Again it's like secondary really, the walking.

Helpful as well. If you see somebody struggling we look after each other.

A couple of hours well spent in the morning.

South, J., Giuntoli, G. Kinsella, K., Carless, D., Long, J. McKenna, J. Walking, connecting and befriending: a qualitative study of participation in a lay-led walking group intervention. *Journal of Transport and Healt*h. 2017, 5, 16-26

LEEDS BECKETT UNIVERSITY

Public Health England

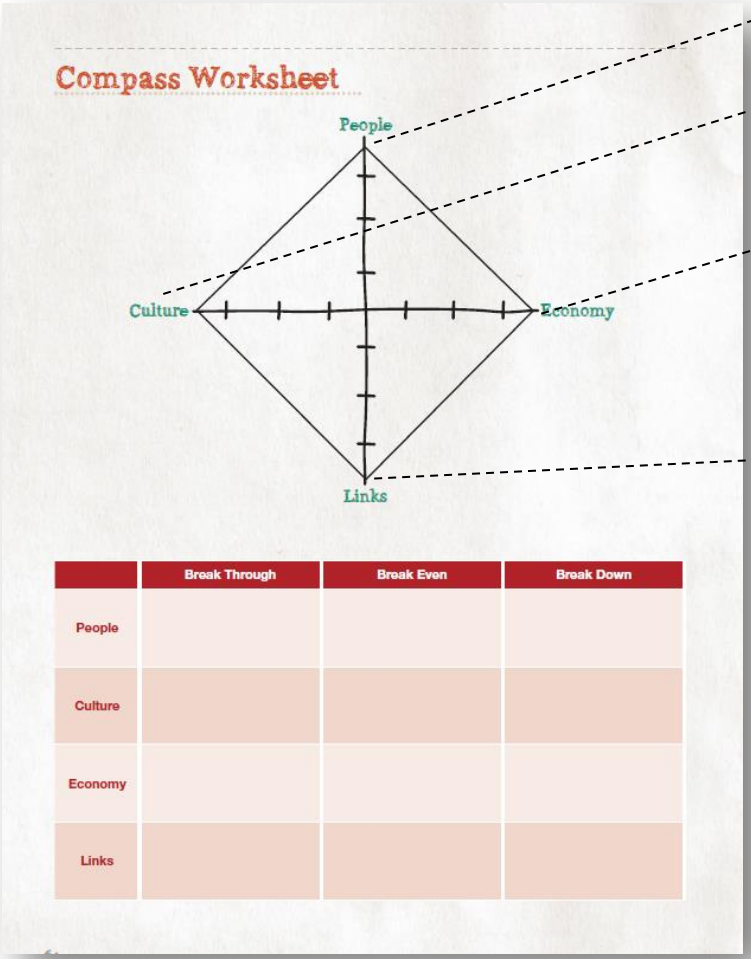
The range of outcomes (PHE 2015)

Summary of potential outcomes reflecting the levels at which change occurs:

Individual	Community	Community Processes	Organisational
• Health literacy • Behaviour change • Self-efficacy, self-esteem, confidence • Self-management • Social relationships, social support • Wellbeing – quality of life • Health status – physical and mental • Personal development, life skills, employment, education	• Social capital – social networks, community cohesion, sense of belonging, trust • Community resilience • Changes in physical, social and economic environment • Increased community resources	• Community leadership – collaborative working, community mobilisation/ coalitions; • representation and advocacy • Civic engagement – volunteering, voting, civic associations, participation of groups at risk of exclusion;	• Public health intelligence • Changes in policy • Re-designed services • Service use- reach, uptake on prevention services • Improved access to health and care services – appropriate use, culturally relevant;

Drawing from Institute of Medicine. An integrated framework for assessing the value of community-based prevention. Washington DC: The National Academies Press, 2012

Community Compass – a participatory tool



Healthy people: supporting individuals' physical and psychological well-being;

Inclusive, creative culture – a positive, welcoming sense of place;

Localised economy – within ecological limits: securing entrepreneurial community stewardship of local assets and institutions;

Cross-community links: fostering supportive connections between inter-dependent communities.

Carnegie UK (2011) Exploring community resilience in times of rapid change. URL: http://www.carnegieuktrust.org.uk/carnegieuktrust/wp-content/uploads/sites/64/2016/02/pub1455011679.pdf

LEEDS BECKETT UNIVERSITY

Prevention Institute, US

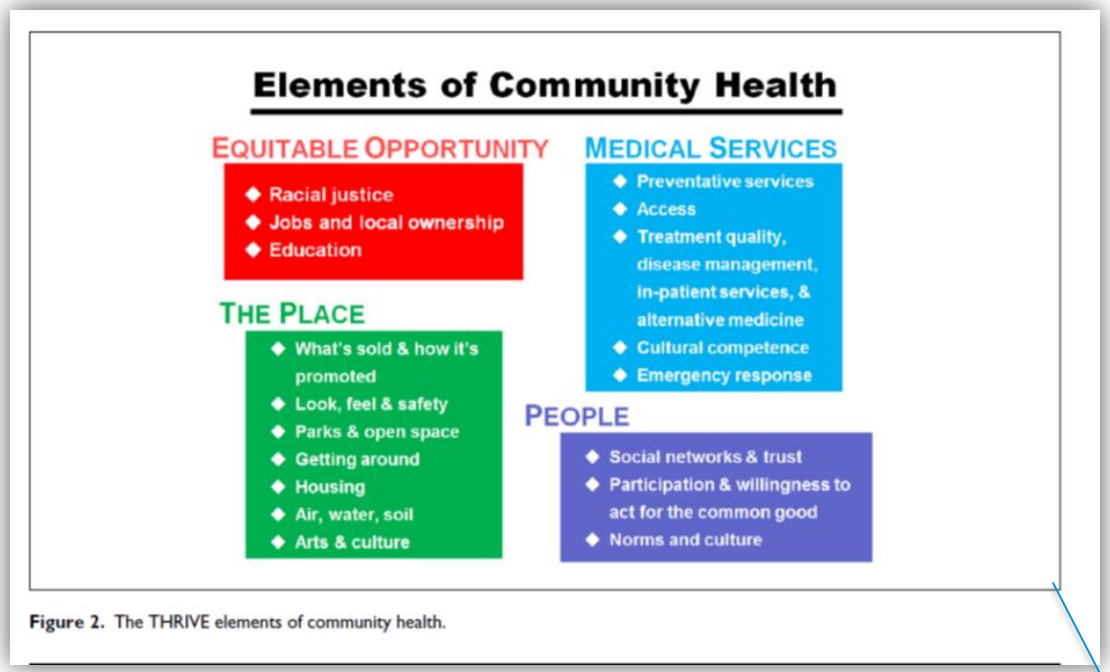


Figure 2. The THRIVE elements of community health.

Cohen, H. (2016) Building a Thriving Nation: 21st-Century Vision and Practice to Advance Health and Equity. Health Education & Behaviour, 43,2: 126

"When we work with organizations and communities to advance prevention, we also learn new strategies and examples that become part of our ever-growing understanding of the best ways to practice prevention."

Concluding remarks

- Inequalities disempower people – it affects individual experiences and community life.
- See communities as building blocks for health & wellbeing and create the conditions that enable people to be involved and have more influence
- We need a new integrative model of evidence to support the development of citizen action on health inequalities

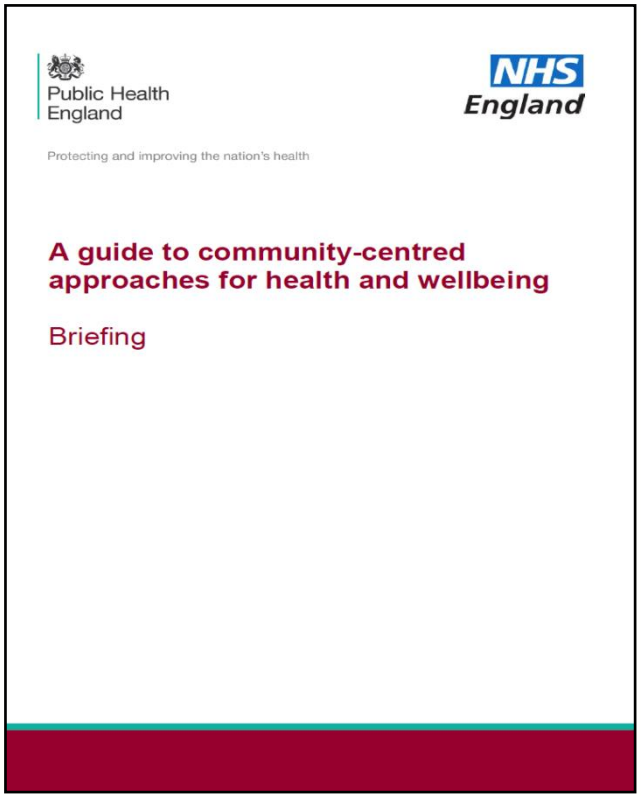
LEEDS BECKETT UNIVERSITY

Thank you

Acknowledgements

My work on community-centred approaches for health and wellbeing is supported by Public Health England.

The views expressed in this presentation are my own and arise from my research and scholarship.



j.south@leedsbeckett.ac.uk

LEEDS BECKETT UNIVERSITY