TOWER HAMLETS

People access joined-up services when they need them and feel healthier and independent

Executive Summary

This equalities assessment reviews the underlying health and wider social determinant inequalities that contribute to the low healthy life expectancies that Tower Hamlets residents face and the contributing factors.

Healthy Life Expectancy (HLE) is used as a measure of quality of life and is based on life expectancy and the time spent in good health Men in Tower Hamlets have the lowest healthy life expectancy in the country whilst Women have the fifth lowest levels.

Tower Hamlets is culturally rich borough with a very diverse population. However, there are also high levels of deprivation. The borough was ranked as the 7th most deprived borough in 2015's Indices of Multiple Deprivation. There is a clear correlation between deprivation and health inequalities which partly explains the low healthy life expectancies that our residents experience.

Addressing the wider social determinants of health, such as housing, the environment, education and employment will have the greatest impact on the health inequalities that exist in the borough. This was highlighted through the Marmot Review; which noted that integrated and preventative based solutions for tackling health inequalities had the greatest reach and effect.

Key headline findings include:

- 53.6 years is the average healthy life expectancy (HLE) for males in Tower Hamlets and 63.3 years is the average HLE for males in England. Tower Hamlets females have the 5th lowest HLE in the country (57.1 years compared to national average of 63.9 years)
- Tower Hamlets older residents are amongst the loneliest in England
- In the period 2016 to 2026 the number of residents aged 65+ is projected to grow by 38 per cent, compared with a 22 per cent increase of the total borough population. The population of residents aged 90+ is projected to double over this time period, rising from 700 in 2016 to 1,400 in 2026
- High levels of White British pregnant women are smoking – 16 per cent compared to London figure of 4.9 per cent
- High levels of Vitamin D deficiency (over 80 per cent) compared to national levels of half the population
- An estimated 10-12 per cent of pregnancies in Tower Hamlets are complicated by gestational diabetes; this is substantially higher than the England average of 2-5 per cent. (81.7 per cent of women with gestational diabetes are from a Bangladeshi background
- In 2013/14 there were 746 people with a learning disability registered with a GP in Tower Hamlets. Of which 46.5 per cent received a health check for which funding is provided for
- The prevalence of HIV is around 5.9 per 1000 in the 15-59 population in Tower Hamlets. Higher than the England prevalence of 1.8 per 1000
- 7.6 per cent of Tower Hamlets provide unpaid care. This is lower than the percentage of those providing care in London (8.4 per cent) and England (10.3 per cent). However, Tower Hamlets has a higher of proportion of carers who are providing more than 50 hours of care per week than London (21.6 per cent) and England (23.1 per cent) average.

What is the purpose of the Strategic Plan Outcome Area?

This strategic priority is linked to the council's public health duty as defined by the Health and Social Care Act 2012; which moved public health functions from the former Primary Care Trusts to local authorities.

This priority is focused on promoting healthy lifestyles and addresses the wider causes of ill health, through a refreshed health and wellbeing plan that focuses on

transformation and partnership whilst committing all sections of the council to actively promote the health and wellbeing of all our communities.

It's about improving the care and support for vulnerable adults and their carers, integrating with health and promoting independence and keeping people safe from all forms of abuse. As well as keeping vulnerable adults safer, minimising harm and neglect. Delivering the council commitment to the Mental Health challenge and working with local employers to tackle mental health stigma and improving participation in sport, and other health promoting activities, at a community level.

What is the national picture in terms of inequality for this topic?

Age

Based on body mass index (BMI) nearly a third of children aged between 2 to 15 are overweight or obese. Furthermore, children aged 5 and from the lowest income backgrounds are twice as likely to be obese compared to more well off counterparts and by age 11 they are three times as likely.[1] Being obese doubles the risks of dying prematurely furthermore obese adults are seven times more like to become a type 2 diabetic which can lead to other complications such as the amputation of limbs and blindness.

Between 6 -13 per cent of older people in the UK are lonely and isolated. As a result, in 2001 the National Services Framework for Older People was published. It highlighted the relationship between isolation to falls and depression in older people.[2] This relationship was reinforced further by the Marmot Review into the wider social determinants of health.[3] The government in response to national findings on loneliness and isolation has included specific sections on tackling said issues in the Care Act 2014[4] as well as the introduction of new Adult Social Care Outcomes framework (ASCOF) measures aimed at monitoring levels of social isolation at the local authority level.

Social care is facing a national funding crisis due to cuts to local government grants from the Department from Communities and Local Government (DCLG). It's forecasted that by 2020 councils will be facing an estimated £1.3 billion social care funding gap. Older people are living for longer and with multiple long term conditions and demand for adult social care will rise. Local authorities have highlighted the growing impact on service users, particularly older people. Issues such as appointment times that are too short; provider failure and unmet needs will leave the older people at a significant advantage if the funding crisis continues.[5]

Pregnancy/maternity

Breastfeeding reduces illness in young children and a reduction in hospital admissions. In the longer term being breastfed as child has been linked to a reduction in obesity and type 2 diabetes in adults and children as well as a

reduction in high blood pressure and blood cholesterol levels.[6] The World Health Organisation (WHO) has set a target of 50 per cent of all children breastfed at six months by 2025.[7] In the UK just over a third of mothers are still breastfeeding as 6 months compared to 81 per cent are birth. In response the government has included breastfeeding measures in the Public Health Outcomes Framework (PHOF) with local authorities charged with monitoring and improving breastfeeding rates.

In 2015/16, 10.6 per cent of mothers in England were recorded as smoker at the time delivery. There are some geographical differences amongst all NHS England Regions, with smoking prevalence varying from 16 per cent in Cumbria and North East to 4.9 per cent in London.[8] Smoking during pregnancy has been linked to increases in stillbirths, premature delivery and low birth weight.

Postnatal depression (PND) affects between 10-15 per cent of women who give birth. The symptoms are similar to those who suffer from depression are other times. The onset of PND varies but usual starts one or town months after birth.[9]

Every year approximately 650,000 women give birth in England and Wales, of which 2-5 per cent of these pregnancies involve women with diabetes. An 87.5 per cent of pregnancies complicated by diabetes are due to diabetes in pregnancy (gestational diabetes). Diabetes in pregnancy is associated with numerous conditions including higher rates of miscarriage, preterm labour, birth injury and pre-eclampsia. Gestational diabetes is a type diabetes that usually arises during the second or third trimester. Women who are overweight, advanced maternal age, have a family history of diabetes, smoker or are from BME background are more likely to suffer from gestational diabetes.[10]

Race and religion/belief

Three million people in the UK have diabetes of which 10 per cent are type 1 and 90 per cent type 2. Type 2 is largely preventable and 80 per cent of the cases in the UK have been attributed obesity. Type 2 diabetes is up to 6 times more likely in people in of South Asian descent and three times more likely in people African and Africa-Caribbean people.[11] Type 2 diabetes has been linked to higher levels of cardiovascular, kidney and eye disease as well as increased risk of needing an amputation of the lower limbs.[12]

In general, people from Black, Asian and minority ethnic groups living in the UK are more likely to be diagnosed with mental health problems; are more likely to be admitted to hospital for a mental health problem; are more likely to experience poor outcomes from treatment and are more likely to disengage from mainstream mental health services. The trends could be explained by a number of factors including access, cultural influences and poverty.[13]

Gender

Healthy Life Expectancy (HLE) is used as a measure of quality of life. It is measure based on life expectancy and the time spent in good health. The average HLE at bitch in England for males was 63.4 years and 64.1 for females. This average does mask stark differences between regions. The Highest HLE for males was in Richmond upon Thames (70.0 years) and Wokingham for females (71.0 years). The lowest HLE was in Tower Hamlets for males at 52.5 years and Manchester for females at 55.5 years.[14] There is a link between HLE and deprivation; with people in the poorest regions spending the least amount of time in good health.

18.8million adults play sport at least once a week in England. More men play than women. 40.7 per cent of men play sport at least once a week compared to 31.7 per cent of women. The difference is larger at younger ages; however, it does become narrow as people age.[15] A lower level of female participation in sports is a health, social and economic development issue. The WHO recommends 30 minutes of moderate daily activity for good physical and mental health; however the WHO estimates that 60 per cent of the world's population do not meet this level of activity with the majority being women. Barriers include the hyper masculinisation of sport and the perception that male sport is the elite; socio economic barriers such as poverty; lack of safe infrastructure and clothing and equipment and knowledge barriers including a lack of awareness of the benefits of physical activity.[16]

Evidence suggests that the incidence of mental health problems is very high for transgender people. For example, one survey found that 88 per cent of respondents had suffered from depression, 80 per cent from stress and 75 per cent from anxiety at some time and rates of self-harm (EHRC Transgender Research Review) and of attempted suicide were high Isolation, discrimination and transphobia were thought to contribute to this.[17]

Disability

People with learning disabilities have poorer physical and mental health outcomes compared to the general population. However, this can largely be prevented by addressing the health inequalities that underlie this.[18] The main contributing factor the poorer outcomes for people with a learning disability is they often face difficulty in recognition illness or communicating their needs to health care professionals.[19] GPs are given extra money to perform annual health checks for people with a learning disability as a way to narrow the difference in health outcomes. However in 2013/14 only 44 per cent of eligible adults with a learning disability received a GP health check.

Many People with long term physical health conditions commonly experience mental health problems. Common mental health conditions include depression, anxiety or dementia in the case of older people. People with co-morbid problems tend to have a poorer prognosis for their long term condition and as a result a poorer quality of life. If you have a mental health condition and a physical health condition your life expectancy can be shorted considerably. This exasperated by

the current structure of health and social care services in England; which are not organised to treat both mental and physical health conditions in an integrated way.[20]

Approximately 100,000 people were living with HIV in the UK at the end of 2014. Of these just over 15 per cent don't know they have HIV because they have not had an HIV test or they have contracted HIV since their last test. Approximately 6,000 people test positive for HIV a year, of which more than half are men who have sex with men (MSM). Approximately 50 per cent of people with HIV are MSM. In the heterosexual half, 55 per cent are from a Black African background.[21]

The 2011 Census found that 5.4 million people were providing unpaid care, a third of were providing 20 or more hours per week. 166,000 of these were young carers aged between 5-17 years old. The Census showed that the health of carers deteriorated as the number of hours of care provided increased. 5.2 per cent of carers reported their own health as 'not good' overall, this rose to almost 16 per cent among those caring for more than 50 hours a week.[22] In general, the demands of being a carer can affect a person's quality of life, affecting the wider social determinants of health and ultimately their health. People who provide high levels of care are twice as likely to be permanently sick or disabled and 625,000 people have health problems due to their caring responsibilities.

Sexual orientation

Research over the past 2 decades has indicated that the gay men in the UK use drugs more than the general population; with particular use of 'club drugs' such as ketamine, cocaine and LSD. However, recently evidence has suggested that there has been a shift in drug use amongst gay men towards chemsex. Chemsex is when sex occurs between men under the influence of drugs. The rise in the use of drugs during sex has promoted a public health concern about the possibility of high risk sexual behaviour, which could result in the transmission of sexually transmitted infections (STIs) or even HIV.[23]

Lesbian, gay and bisexual (LGB) people are more likely to suffer from poor mental health. Being LGB is not in itself the trigger but the social impact of being LGB is thought to trigger the onset of mental health problems.[24] LGB people deal with things such as verbal abuse, discrimination, rejection, prejudice; abandonment and physical abuse which are believe to trigger poor mental health. Within the LGB group, lesbian and bisexual people are even more likely to experience poor mental health.

LGB individuals and carers often experience discrimination and marginalisation when receiving social care that often impacts on their ability to access services and receive the most appropriate support.[25] Additionally, the Majority of care received by older people is provided informally by spouses and/or adult children. However, older LGB people are less likely to have children than heterosexual

people and tend to have differing social support networks with the notion of family going beyond the traditional biological family. Fully understanding the issues faced by older LGB people is hindered by the poor service user data available.[26] This can be attributed to older LGB people being less likely to come out due to experiences in earlier life as well as social care practioners not asking questions about sexual orientation.

Gender reassignment

For transgender people, health care specific to transitioning is a major issue. GPs' resistance, delays in accessing gender identity clinics, problems in the clinics and the medical approach taken to transgender treatment could all be problematic.

In a large, but unrepresentative survey, around a third of GPs were identified as resistant to assisting patients to transition (Whittle, 2007, referred to in the EHRC Transgender Research Review). However, this was a substantial improvement compared with 15 years previously. The 2007 survey also found that about half of transgender respondents thought their GPs did a good job, although awareness raising for GPs both on gender reassignment (including long-term medical care and updating of records) and general health care for transgender people was needed (Scottish Evidence Review).

In a 2012 large, but unrepresentative, survey long delays were found in accessing gender identity clinics (with only 60 per cent of respondents seen within a year) (Scottish Transgender Alliance's 2012 survey of transgender people's mental health reported in the Scottish Evidence Review). The EHRC Transgender Research Review suggested that waiting times (and access to treatment) had varied with general (rather than trans-specific) changes in health care policies.

Once seen in a clinic, many transgender people encountered difficulties (ranging from administrative errors to problematic attitudes towards transitioning) (EHRC Transgender Research Review). Qualitative research pointed to the need for improved knowledge amongst psychiatrists involved in assessment for gender transition treatment (EHRC Transgender Research Review).

In contrast with the previous reviews, only one study was identified on transitioning and health. This examined patient satisfaction with gender identity clinics (GICs) and with related local service provision (i.e. GP services, local psychiatric services and speech therapy) (Davies et al., 2013). Based on a representative survey of users of GICs, this research examined satisfaction with a number of aspects of treatment and the administration of treatment. Twenty per cent were dissatisfied with the level of support for others close to the patient. Thirty-one per cent were dissatisfied with local psychiatric services. Twenty-seven per cent were dissatisfied with the wait for the first appointment. Nevertheless, 94 per cent said they would recommend the services if a friend or relative had a gender-related problem. The most notable area for improvement was the interface between GICs and local psychiatric services.

A further problem, identified in qualitative research, was in the reported commonly standardised medical approach and a lack of recognition of the diversity of experience of transgender people (EHRC Transgender Research Review). This was reported to force transgender people to adopt the prevailing medical treatment discourse to gain treatment, whether or not it matched their lived experience and needs. Moreover, as with mental health medical professionals involved in transitioning were seen as tending to pathologise the transgender experience. The EHRC Sexual Orientation Research Review identified different health care needs of male to female and female to male people.

What is the local picture in terms of inequality for this topic?

Age

Based on Public Health England's model, which estimate subjective loneliness for older people at the local authority level, Tower Hamlets is ranked as 1 out of 33 for London and 1 out of 326 for England.[27] It is believed that poor health, deprivation, widowhood and living alone all contribute towards the high levels of loneliness.

A reduction in adult social care funding remains a challenge for the council, yet demand is projected to increase as the number of older people who live in the borough increases. Over the next decade, the older population is expected to grow faster than the borough population as a whole. In the period 2016 to 2026 the number of residents aged 65+ is projected to grow by 38 per cent, compared with a 22 per cent increase of the total borough population. The population of residents aged 90+ is projected to double over this time period, rising from 700 in 2016 to 1,400 in 2026. Year on year there has been a reduction in adult social care expenditure as a result of reductions in central government funding. Meeting growing demand and fulfilling the council's legal duty to offer care where there is need will remain a challenge.[28]

Nearly 1 in 7 children (4-5 year olds) in reception and over a quarter of children in year 6 (10 -11year olds) are overweight or obese in Tower Hamlets. The borough has the fifth highest proportion of overweight 10-11 year olds in London and the sixth highest in the country. BAME children (particularly boys) are more likely to overweight. Poor diet and low levels of physical activity are contributing factors.

In 2012 45.9 per cent of 5 year old children experienced tooth decay, the second highest in London (32.9 per cent) and considerably higher the England average of (27.9 per cent). There are variances in ethnicity, Eastern European, Pakistani and Bangladeshi children more likely to experience tooth decay in comparison to White British children. Dental extraction remains one of the highest causes of hospital admissions for children in Tower Hamlets[29].

Pregnancy/maternity

The percentage of mothers smoking at time of delivery in Tower Hamlets is relatively low (3.4 per cent) when compared to London (4.9 per cent) and England (11.4 per cent).[30] There is some disparity between ethnic groups. There is a lower smoking prevalence in Bangladeshi mothers. However, the percentage is 16 per cent when amongst white mothers.

The Tower Hamlets population has a higher risk of vitamin D deficiency due to a high proportion of people with darker skin, people who cover their skin for cultural reasons and people with largely sedentary lifestyles. Vitamin D is particular important for growth and especially important for pregnant mothers and babies.[31] Between 80-97 per cent of Tower Hamlets residents are thought to have vitamin D deficiency in Tower Hamlets, significantly higher than the national population at 50 per cent.

An estimated 10-12 per cent of pregnancies in Tower Hamlets are complicated by gestational diabetes; this is substantially higher than the England average of 2-5 per cent. This can be attributed to the local demography with 81.7 per cent of women with gestational diabetes from a Bangladeshi background.[32]

Race and religion/belief

Type 2 diabetes levels in Tower hamlets are high. Obesity is a key trigger and can be linked to increasing incidences of diabetes in children. However, a significant majority of type 2 diabetes is associated adults.[33] Although obesity in adulthood is lower than both the London and National average in Tower Hamlets, the demography of Tower Hamlets and the large number of BME people is a significant contributing factor. South Asians are up to 6 times more likely to suffer from type 2 diabetes and African and Africa-Caribbean people are three times more likely.

There are specific ethnicity variations in unhealthy lifestyles within the borough. There are high smoking levels in Bangladeshi males, lower levels of fruit and vegetable consumption in Asian and Black population and higher levels of risking dinking in the borough White population.[34] In relation to mental health, there are higher formal admission rates for BME groups, particularly BME men. Issues about cultural attitude and stigmas towards mental health; late access to services and effective advertisement of services to BME communities have all been highlighted as contributing factors. In general health outcomes for Tower Hamlet's Muslim population is poor.[35] There is a correlation between the high numbers of Bangladeshi residents and their predominantly Muslim faith

Gender

Tower Hamlets males have the lowest healthy life expectancy (HLE) in the country, 53.6 years is the average HLE for males in Tower Hamlets and 63.3 years is the average HLE for males in England. Tower Hamlets females have the 5th lowest HLE in the country (57.1 years compared to national average of 63.9 years). This

difference can be attributed to the high levels of deprivation in the borough; Tower Hamlets is the 7th most deprived borough in the country.[36] There are differences in HLE within the borough, with people living in the more affluent areas on spending more time in good health.[37]

Disability

Tower Hamlets has one of the highest proportion of years spent in disability in the country for both males and females (based on Healthy Life expectancy at birth). The 2011 Census data indicated that Tower Hamlets has a slightly higher rate of severe disability (day to day activities limited a lot) in its working age population (4.1 per cent) compared to the average in London (3.4 per cent) and England (3.6 per cent). The Census 2011 results also showed that 13.5 per cent of residents stated that they had a long-term health problem or disability that limited their day to day activities (34,300 residents). This is slightly lower than the regional and national rates (14.1 per cent in London and 17.6 per cent England).

People with learning disabilities have poorer physical and mental health outcomes compared to the general population. GPs are given extra money to perform annual health checks for people with a learning disability as a way to narrow the difference in health outcomes. In 2013/14 there were 746 people with a learning disability registered with a GP in Tower Hamlets. Of which 46.5 per cent received a health check.[38] This is slightly higher than the England average of 44 per cent.

The prevalence of HIV is around 5.9 per 1000 in the 15-59 population in Tower Hamlets. This is higher than the England prevalence of 1.8 per 1000. 70 per cent of HIV cases were accounted for by men who have sex with men (MSM), 20 per cent heterosexual and the remainder were through intravenous drug use or maternal-child transmission.[39] Black Africans are more likely to have HIV, followed by White people< Black Caribbean and Asians.[40]

The 2011 Census identified approximately 19,000 residents in the borough who provided unpaid care; young carers made up 3 per cent of this cohort, slightly higher than the London (2.5 per cent) and England (2.1 per cent) respectively. 57 per cent of carers provide 1-19 hours of unpaid care, 18 per cent provide 20-49 hours and 25 per cent provide 50 hours or more. 7.6 per cent of Tower Hamlets provide unpaid care. This is lower than the percentage of those providing care in London (8.4 per cent) and England (10.3 per cent). However, Tower Hamlets has a higher of proportion of carers who are providing more than 50 hours of care per week than London (21.6 per cent) and England (23.1 per cent) average.

42.9 per cent of people providing unpaid care are Bangladeshi and 32.8 per cent White British. 29 per cent of Bangladeshi and White British residents are providing 50 hours or more of care. 68 per cent of carers reported good health, significantly lower than the borough average of 83 per cent. Additionally 43.5 per cent of carers providing 50 or more hours of care reported bad health, compared to 19.1 per cent

of carers provide 20 to 49 hours and 37.4 per cent providing 1 to 19 hours. Females are more likely to provide care; additionally they are more likely to provide more hours of care and report bad health.

What are the good practice examples on tackling inequality in the topic area?

The most effective interventions for tackling health inequalities are programmes that are based on an integrated approach to supporting individuals. Addressing an individual's health and/or care need is important but it's important that the wider social determinants of health are also addressed alongside in order to have the maximum effect.

It's recognised that one of the most effective interventions for minimising health inequalities is ensuring that every child has a healthy start, with a focus on maternal health and the first 2 years. Children's centres (also known as Sure Start Children's Centres) are targeted towards disadvantaged families and provide help and advice on child and family health, parenting, money, training and employment opportunities, as well as early learning and day care for pre-school children. Research has shown that mothers and children who attend children centres exhibit better mental and physical health outcomes when compared to their peers.[41]

Another example of an intervention that focuses on the wider social determinants of health but aims to improve health outcomes is Family Mosaic's 'Health Begins At Home' programme. Family Mosaic, a housing provider in London and South East launched a health and wellbeing programme for their tenants, recognising that as a social housing provider they had a role in helping their tenants improve or maintain their health and wellbeing. An example included offering excursions to an older tenant who wanted to lose weight but suffered from asthma as well as draught proofing his property. Through Family Mosaic's programme local NHS services have reported a drop in planned GP visits, emergency GP visits and nights in hospital.

What evidence is there that we are making a difference?

The past 4 years have been difficult for the local authority and health partners such as the Tower Hamlets Clinical Commissioning Group (CCG) who jointly commission a number of services with the council. The *Health and Social Care Act 2012* brought in a raft of changes which ultimately led to the reorganisation of the NHS. Primary Care Trusts were abolished with the public health function transferred to local authorities. CCGs remain responsible for the commissioning of local NHS services.

Alongside the reorganisation of health and social care services, the council has faced and continues to face large cuts in their central government grants. By 2020 the council's central government grant will have fallen by 50 per cent. Similarly, NHS services have also been facing a funding squeeze whilst trying to manage ever growing demand from a local population that is increasing in size and living longer with 2 or more chronic conditions.

As such, the council and its health and wellbeing related partners have been focusing on mitigating against the impact of the cuts and preventing deprivation and health inequalities from increasing further. Levels of childhood obesity in year 6 pupils (10-11 year olds) have plateaued at just over 25 per cent. Additionally, teenage pregnancy falling to 18.7 per 1000, significantly lower than the national average of 24.3 per 1000. Other achievements include high numbers of children undergoing immunisation.

What more do we need to know?

In general the council intelligence about health inequalities is strong. However, there are weaknesses around the sexual orientation and gender reassignment protected characteristics. Part of the problem is with the Census and the lack of sexual orientation/gender identity questions. This makes it difficult to understand the number of the LGB and T residents in the borough and predict whether some of the national health and wellbeing issues that LGBT face are prevalent in Tower Hamlets.

Additionally, equality monitoring sexual orientation and gender identity in front line services such a social care and mental health services remains quite weak. Practitioners are not asking residents questions about their sexual orientation and gender identity. This makes is challenging to fully understand the profile of residents interacting with council health and wellbeing services and means that emerging local health and wellbeing issues within the Tower Hamlets LGB & T and communities are not brought to the council's attention until it has been picked up as a national trend.

What are the priorities for tackling inequality?

Tackling health inequalities and improving health and wellbeing for local residents is a challenge for public health, health services and social care. To some extent some of the inequalities identified above can be tackled by mitigating against any poor health outcomes through a targeted and direct response. Health authorities (Public Health England, the Department of Health, the Department of Education and NHS England) recognise that tackling the wider social determinants of health; focusing on prevention and giving every child the best start in life are crucial to address health inequalities.

Addressing the wider social-economic determinants that cause deprivation will have the greatest impact on any individual's health outcomes. The Marmot review into health inequalities recognises that there is a social gradient in health, the lower a person's socio-economic positon, the worse his or her health. The Marmot review suggests six areas of actions:

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

The council is currently refreshing its Health and Wellbeing Strategy with a greater focus on transformation, partnership working and addressing the wider social determinants of health. As such over the next 3 years we will be focusing on the following Marmot review related priorities:

- Communities driving change
- Creating a healthier place
- Tackling deprivation
- Children's weight and nutrition
- Developing an integrated system

Services Engaged

- Public Health
- Integrated Health
- Children Social Care

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Endnotes

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