DRAFT Strategy to tackle health inequalities.

South Local Care Partnership

"In England, health is getting worse for people living in more deprived districts and regions, health inequalities are increasing and, for the population as a whole, health is declining. In particular, lives for people towards the bottom of the social hierarchy have been made more difficult."

Professor Sir Michael Marmot, "Health equity in England: The Marmot Review 10 years on", 2021

"Prevention, population health management and tackling health inequalities are not a distraction from the immediate priorities: indeed, they are the key to sustainable solutions to those immediate performance challenges".

"There will never be a perfect time to shift the dial toward focusing more on preventative services and interventions. It is easy to argue - especially in the current climate of financial constraints and performance issues - that addressing these issues should be something we consider when the current pressures have died down. But that has always been the case."

"The truth is, unless we make the change, the continual focus on improving flow through acute hospitals will simply channel more and more of an older and increasingly unhealthy population into acute hospitals, which will never be large or efficient enough to cope."

The Hewitt Review: an independent review of integrated care systems, 2022

"Everybody knows that prevention is better than cure. Interventions that protect health tend to be far less costly than dealing with the consequences of illness".

Lord Darzi's report on the state of the National Health Service in England, 2024

"The nature of the problem has changed – our health systems are modelled on the idea of the cure. The cure is produced in vertical systems of command and control – but you can no longer cure – you need to prevent, care and support – and this needs a completely different way of working."

Hilary Cottam: radical health[1]

[1] https://www.hilarycottam.com/radical-health/

South LCP strategy to tackle health inequalities

Contents

Contents

1. Introduction 3
   1.1 Why/how this strategy has come about. 3
   1.2 Who has been involved in developing it. 3
   1.3 Our shared ambition 3
   1.4 Our goals together 3
   1.5 Our respective roles in making this happen 3
2. What are health inequalities? 4
   2.1 Health inequalities 4
   2.2 Healthcare inequalities 4
3. Strategic context and evidence base 5
   3.1 Global context 5
   3.2 Policy context 6
   3.3 Data on health inequalities and impact on NHS demand 9
   3.4 Financial case for prevention and health inequalities 11
   3.5 Plans and health and wellbeing strategies in Devon ICS 12
4. Measuring impact 13
5. The role of South Local Care Partnership in tackling health inequalities 14
6. Conclusion 15

Appendices 16
   Appendix 1 16
   APPENDIX 2 18

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1. Introduction

1.1 Why/how this strategy has come about.

The South Local Care Partnership (LCP) of Devon Integrated Care System brings together public sector and community organisations to have a strategic view and prioritise work across its area. Its area spans the unitary authority area of Torbay and part of the Devon County Council area that includes most of Teignbridge District Council and half of South Hams District Council areas. The rationale for this is based on the footprint of the services provided by Torbay and South Devon NHS Foundation Trust which provides community and acute physical health and social care.

The objectives of the Population Health subgroup include developing a prevention and inequalities strategy that addresses key areas of inequality identified in the population health profile. To date, the work has involved reviewing the locality health profile and identifying priority areas of focus. Creating this strategy helps the LCP to look further ahead, developing a longer-term approach to tackling deep-seated issues that reactive responses to short-term funding do not allow for.

1.2 Who has been involved in developing it.

Members of the Population Health subgroup include public health consultants from Torbay and Devon local authorities, leaders from voluntary, community, charity and social enterprise sector infrastructure organisations, Torbay and South Devon NHS Foundation Trust, Devon Partnership NHS Trust and NHS Devon.

1.3 Our shared ambition

To tackle inequalities in outcomes, experience and access within the South Local Care Partnership.

1.4 Our goals together

- Develop and identify a shared vision for population health.
- Provide clarity on inequalities within the South LCP, recognising the difference between health inequalities and healthcare inequalities and how these link to ambitions of the One Devon Partnership Integrated Care Strategy and 5 Year Joint Forward Plan and the 10 year NHS Plan.
- To use the intelligence generated to ensure that population health, heath and healthcare inequalities, prevention, and early intervention, are centre stage in thinking, planning and actions across the South LCP.

1.5 Our respective roles in making this happen

All organisations and sectors to focus on their strengths, amplifying the connections between us to make more of a difference. For example, since the COVID pandemic the VCSE has been drawn into supporting crisis management (such as supporting

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people to be discharged more quickly from hospital), rather than its core strength and purpose of prevention and supporting the core determinants of health.

By working together in this way, all organisations will be able to identify where their inequalities are and be better equipped to address them.

2. What are health inequalities?

2.1 Health inequalities

These are differences in the status of people's health where poor health is caused or increased by avoidable, external factors. These can be grouped in four categories:

a. **Socio-economic factors** (for example, income)
b. **Geography** (for example, coastal or rural)
c. **Specific characteristics** (for example, ethnicity or sexuality)
d. **Socially excluded groups** (for example, people who are seeking asylum or experiencing homelessness).

The effects of inequality are multiplied for those who experience more than one of these factors. These factors impact on the opportunities people have to lead healthy lives which can results in differences in:

- **Health status** (for example, life expectancy or likelihood of developing long term health conditions)
- **Access to care** (for example, availability of given services)
- **Quality and experience of care** (for example, levels of patient satisfaction)
- **Behavioural risks to health** (for example, smoking rates, reliance on more accessible unhealthy food)
- **Wider determinants of health** (for example, quality of housing).

Core determinants of health are often experienced together and over a long time which increase the range of inequality.[2]

2.2 Healthcare inequalities

This refers to differences in the care that people receive and the opportunities that they have to lead healthy lives. Reasons for people receiving a difference in care might be due to the factors above, unconscious bias or prejudice in the way our services are structured which makes them inaccessible for some, or the way they are delivered.

Further definitions can be found in **APPENDIX 1**

[2] https://www.kingsfund.org.uk/insight-and-analysis/long-reads/what-are-health-inequalities

3. Strategic context and evidence base

3.1 Global context

Health inequalities do not exist in isolation of global or national issues. Reaching the root causes to address them is more than individual services or sectors can manage on their own, so must be done collaboratively.

3.1.1 Kate Raworth's Doughnut Economics model illustrates what is essential for people to thrive in a way that meets the needs of everyone on the planet, within the means of the planet. (Figure 1)

The two rings are the foundation of life's essentials (social), and the ceiling of the planetary boundaries that protect Earth's life-supporting systems (ecological). Between these two boundaries is a doughnut-shaped space that is ecologically safe and socially just, where all can thrive.

If there is shortfall in any of the social foundation areas or the ecological ceiling is overshot, inequalities exist, and the planet is at further risk. This has two implications for working strategically to address health inequalities:

1. Health inequalities and resulting problems that relate to people's health and demand on services cannot be solved by looking through a health service lens alone. If people are in poorly paid work, living in unstable housing, and can't access or prioritise recommended diets, their health will suffer as a result.
2. We can no longer plan, structure and deliver health and care services without regard to their effect on our local and global environment.

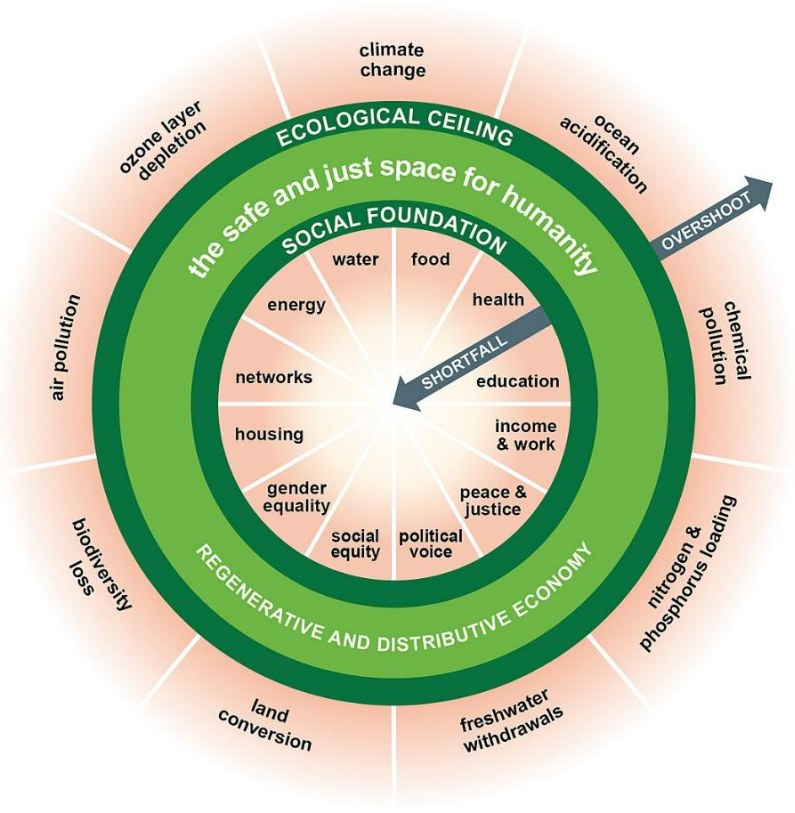


Figure 1- the Doughnut of social and planetary boundaries

3.1.2 Public Health traditionally uses the Dahlgren and Whitehead model (1991) to illustrate the social determinants of health, which includes similar social components.

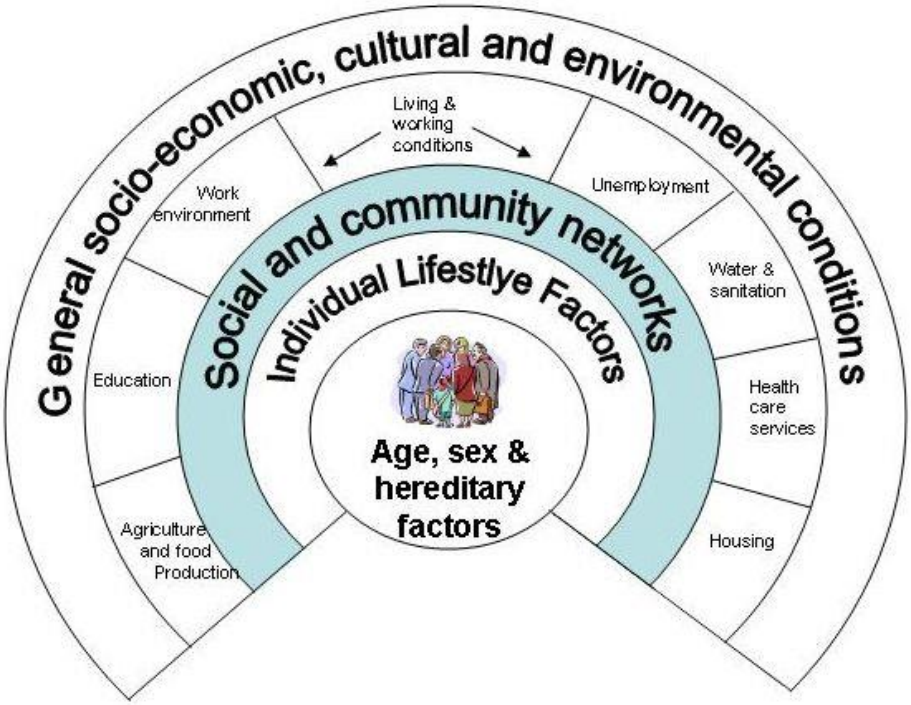


Figure 2 Model of health determinants.

3.2 Policy context

3.2.1 Marmot region

"There is a social gradient in the proportion of life spent in ill health, with those in poorer areas spending more of their shorter lives in ill health." – Marmot review 10 years on.

In April 2023 the South West became the first 'Marmot Region'. Marmot Places (originally cities) recognise that health and health inequalities are shaped by the social determinants of health and take collaborative action to improve health and reduce health inequalities. There is no specific funding attached to the initiative but there is support from the UCL Institute of Health Equity, and a focus on innovation and sharing of practice between partners. One objective is 'strengthening the health equity system at place' which fits well with the aspirations of this strategy. Torbay's Director of Public Health is a member of the South West Marmot Region steering group. Marmot Places - IHE (instituteofhealthequity.org) Work undertaken to tackle inequalities through the South LCP could go under the banner of the Marmot Region, using this as an opportunity to showcase local innovation as well as to learn from other sites.

A Marmot Place recognises that health and health inequalities are mostly shaped by the social determinants of health (SDH): the conditions in which people are born, grow, live, work and age, and takes action to improve health and reduce health inequalities.

The UCL Institute of Health Equity works with places to reduce inequalities in health by:

1. Assessing the extent of inequalities in health and the social determinants of health locally, reviewing actions already happening and scoping the local context.
2. Identifying where places can go further to reduce inequalities and spot where there are gaps in existing actions.
3. Evaluating how partners within a place can work together more effectively to achieve greater impact and make the needed changes; even in the challenging financial and resource context.
4. Strengthening the health equity system in a place.
5. Implementing new approaches and interventions to tackle health inequalities and inequalities in the social determinants of health.

3.2.2 The Chief Medical Officer's report in 2021[3] highlights the substantially higher burden of physical and mental health conditions in coastal communities. The report highlights four main points, which resonate with local leaders and communities in Devon:

1. "older, retired citizens – who have more and increasing health problems – often settle in coastal regions but without the same access to healthcare as urban inland areas. In smaller seaside towns, 31% of the resident population was aged 65 years or over in 2019, compared to just 22% in smaller non-coastal towns

2. difficulties in attracting NHS and social care staff to peripheral areas is a common issue. The report found coastal communities have 14.6% fewer postgraduate medical trainees, 15% fewer consultants and 7.4% fewer nurses per patient than the national average, despite higher healthcare needs

3. an oversupply of guest housing has led to houses in multiple occupation (HMOs) which lead to concentrations of deprivation and ill health. Directors of public health and local government leaders raise concerns about the challenges of poor quality but cheap HMOs, encouraging the migration of vulnerable people from elsewhere in the UK, often with multiple and complex health needs, into coastal towns

4. the sea is a benefit but also a barrier: attracting NHS and social care staff to peripheral areas is harder, catchment areas for health services are artificially foreshortened and transport is often limited, in turn limiting job opportunities. The least wealthy often have the worst health outcomes."

Coastal and rural related deprivation is one of Devon ICS's 'PLUS' priority groups.

3.2.3 The Chief Medical Officer annual report 2023[4] focussing on health in an ageing society highlights the social and economic environments in which people live and work directly affects the amount of disease people have and therefore the rate that they age, their life expectancy and their healthy life expectancy. The prevalence of frailty is higher and starts at a younger age in areas of deprivation.

[3] Chief Medical Officer's Annual Report 2021 - Health in Coastal Communities – Summary and recommendations (publishing.service.gov.uk)
[4] Chief Medical Officer's annual report 2023: health in an ageing society - GOV.UK (www.gov.uk)

3.2.4 Joint Strategic Needs Assessments for Devon and Torbay
These highlight a 10-15 year difference in life expectancy between those in most and least deprived areas, and an even wider gap in healthy life expectancy. They highlight a 15 year difference in life expectancy between different areas of Devon. People in Devon at risk of inequalities, including older people, are less physically active than the national average, and more likely to need an emergency hospital admission following a fall, contributing factors to poorer healthy life expectancy.

Recommendations to help address inequalities include implementing the World Health Organisation's Age Friendly Communities framework (Torbay signed up to this in 2021), using the Core20PLUS5 approach, development of a Cardiovascular Disease Inequalities dashboard.

3.2.5 The NHS England Health Inequality statement, published in 2023 sets out the responsibilities of NHS providers. To fulfil duties of service provision in ways which comply with the NHS Act 2022, Integrated Care Boards and NHS Trusts are required to:

- Understand healthcare needs including by adopting population health management approaches, underpinned by working with people and communities.
- Understand health access, experience and outcomes including by collecting, analysing and publishing information on health inequalities set out in the Statement.
- Publish information on health inequalities within or alongside annual reports in an accessible format.
- Use data to inform action including as outlined in the Statement.

NHS organisations are expected to use health inequality data to inform strategy development, policy options review, resource allocation, service redesign, service delivery decisions and service evaluations.

3.2.6 NHS Long-Term Plan
Reducing health inequalities is one of the main priorities of the NHS Long-Term Plan, refreshed in the NHS at 75 update in 2023. The Health and Care Act 2022 enshrines this priority in legislation by stating that addressing health inequalities in outcomes, experience and access, improving outcomes in health and healthcare and supporting social and economic development are integral to the four core aims of an integrated care board (ICB):

1. Improve outcomes in population health and healthcare
2. Tackle inequalities in outcomes, experience and access
3. Enhance productivity and value for money
4. Help the NHS support broader social and economic development

An updated 10 year NHS Plan is being prepared following Lord Darzi's assessment of the NHS and a change in government in the summer of 2024. The government will focus on 3 strategic shifts, moving care from:

- hospital to community
- sickness to prevention

- analogue to digital

These shifts will help to:

- cut waiting times for care
- reduce the amount of time spent in ill health
- tackle health inequalities
- reduce the lives lost to the biggest killers - cancer, cardiovascular disease and suicide
- make the NHS sustainable in the long term[5]

3.3 Data on health inequalities and impact on NHS demand

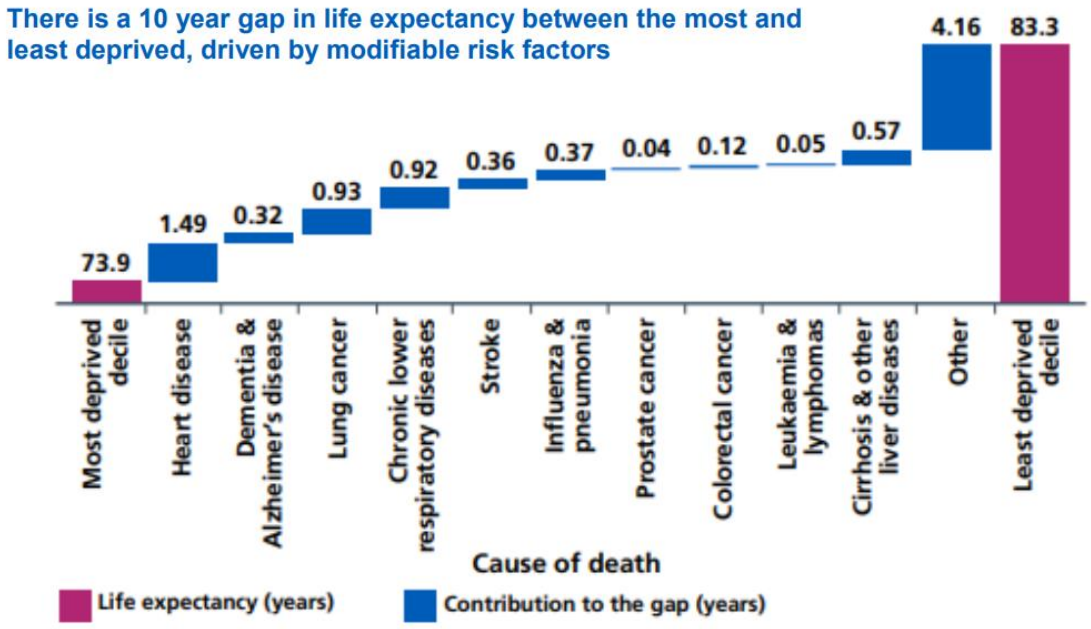
3.3.1 Health inequalities have always existed but the evidence from multiple sources indicates they are worsening. In both the 2020 Health Equity Study by Sir Michael Marmot, and the evidence base to the NHS England major conditions strategy (2023), there is confirmation that improvement in life expectancy has stalled and the deprivation gap in life expectancy is widening, driven by preventable and manageable disease. 42% of the burden of poor health is attributable to modifiable risk factors (see figure 4).

The Covid-19 pandemic exacerbated inequality and highlighted the unequal impact of the disease on different population groups, some of whom were not previously thought to be an at-risk group. The success of specific strategies to target homeless people and ethnic minorities with vaccination support are examples where adapting the service delivery model makes a positive difference to people's health and wellbeing and creates healthcare equity.

The UK 'cost-of-living crisis' has further worsened the socio-economic inequalities that drive many health disparities. The disease groups in figure 4 contain many of the areas where this strategy and the community services element of the clinical strategy (see section 3.4) overlap and where joint prevention strategies and targeting approaches will be effective.

Figure 4: life expectancy gap

[5] Road to recovery: the government's 2025 mandate to NHS England - GOV.UK



Devon and Torbay Joint Strategic Needs Assessments (JSNAs) highlight the difference in overall life expectancy and in healthy life expectancy between the most and least deprived areas in Devon and Torbay.

3.3.2 The demand presenting to the NHS has led policy leaders to examine the impact of health inequality and deprivation on admissions to hospital. Figure 5 shows the correlation between emergency admissions for hypertension, respiratory and mental health. These three conditions are three of the five identified in Core20PLUS5 as being more prevalent in deprived communities.

This data indicates an evidence base for prioritising the areas to target based on the known impact on demand from certain disease groups.

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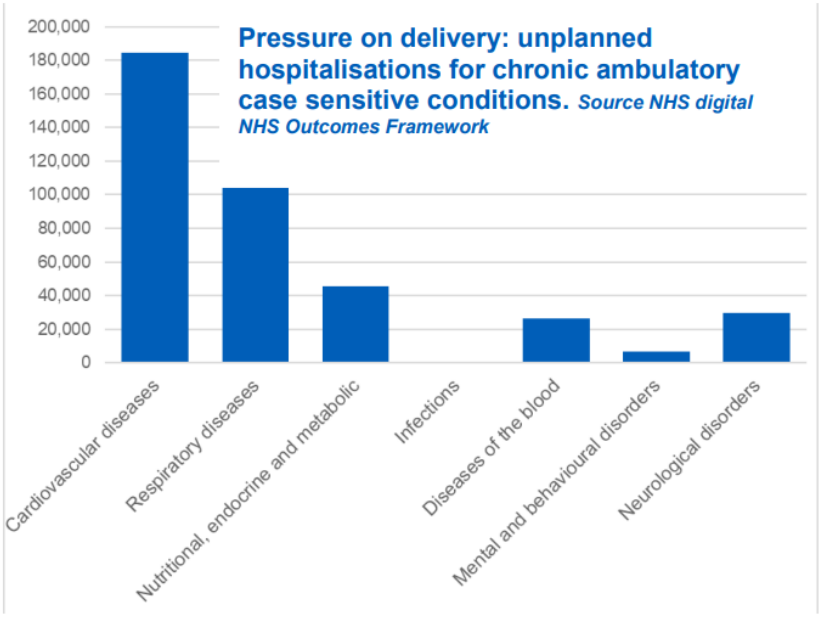

Figure 5: national emergency admissions for hypertension, respiratory and mental health.

3.4 Financial case for prevention and health inequalities

3.4.1 The Healthcare Financial Management Association report 'Health Inequalities: establishing the case for change' from May 2023 draws together the evidence indicating that inequalities in health can drive demand for NHS services. Avoidable differences between population groups can impact the prevalence of conditions, and the ability and willingness of people to seek treatment prior to crisis and care costs increase the less planned the care.

At a time of intense demand on the NHS, significant financial pressure, and critical workforce shortages often means providers favouring a response to the immediate presenting problem rather than thinking about the long-term repeat presentations.

It is therefore an explicit medium-term aim of this strategy to have developed a business case for investing in targeting health inequality as a way of reducing demand on our NHS services (see section 5). It is a longer-term ambition to build on this and move to shared budgets between different organisations and sectors for longer-term work.

3.4.2 Serving a population which has more healthy years in retirement age will reduce the complexity and volume of healthcare need, providing the return on investment of interventions. Marmot links poor health to loss of economic productivity and higher welfare spend which creates the alignment to wider health and wealth policies across national and inter-governmental policy. Levelling Up and Local Government policies increasingly recognise the link between health, housing, skills, employment, crime, environment and the need for commitment from all partners to

tackle these root causes of deprivation to ensure the health and wealth of a local area.

Making the case for longer term change to tackle health inequalities during a period of extreme pressure for the NHS, with short term recovery targets, is challenging. For this reason this strategy recognises the need to target areas using the available evidence base; approached in ways with proven benefit and in partnership with the communities impacted. Evaluation and learning from a range of impacts is crucial evidence to develop effective partnerships, maintain stakeholder buy-in and make the business case for sustainable funding.

3.5 Plans and health and wellbeing strategies in Devon ICS

3.5.1 The Devon Integrated Care System's Joint Forward Plan includes a commitment to population health and prevention as everybody's responsibility and inform everything we do.

Figure 6: overview of the Devon ICS Joint Forward Plan

3.5.2 Devon and Torbay Health and Wellbeing Boards have two core statutory documents, the *Joint Strategic Needs Assessment (JSNA)* and the *Joint Health and Wellbeing Strategy.* The JSNAs describe the current and future health needs of the area, highlighting inequalities:

- www.devonhealthandwellbeing.org.uk/jsna/jsna-headline-tool
- Provisional TORBAY JOINT STRATEGIC NEEDS ASSESSMENT 2024/25 (southdevonandtorbay.info)
- Torbay JSNA by ward - 2024/25

Devon's health and wellbeing strategy respond's to the vision of:
Health outcomes and health equality in Devon will be amongst the best in the world and will be achieved by Devon's communities, businesses and organisations working in partnership.
The vision of Torbay's health and wellbeing strategy is:
To create a healthy, happy Torbay where individuals and communities can thrive.

Both strategies have a central, underpinning strand on inequalities.

3.5.3 The South Population Health Profile, developed for the LCP includes some high-level data from the Joint Strategic Needs Assessment information. This has been used to identify priority areas that the South LCP wants to focus on. All health, social and environmental indicators show an inequality gradient, so it is important that every LCP member organisation has regard for inherent inequalities in every work programme, as well as putting in place specific projects to tackle these.

In June 2024 the LCP reviewed its health profile and prioritised its PLUS groups as:

1. Rural/coastal communities
2. Ageing & isolated, frailty
3. Mental health
4. Unpaid carers
5. Young people & adults with SEND

All to be enabled by digital transformation

4. Measuring impact

4.1 In recent years the depth of data and analytical capabilities have significantly increased in response to this being essential to narrowing the inequality gap. However, despite the advances in knowledge and understanding, inequalities can still be hidden from immediate view. It's important to use data to help ask deeper questions, gain more insight from different sources, including from people experiencing inequality, and not make assumptions.

4.1.1 There are four main categories of data which will be accessed to support delivery of this strategy, working with our local care partnerships.

i. **Population Health** data joins up information across local health and care partners and enables population segmentation and risk stratification. This gives insight into the holistic needs of different population groups and the drivers of health inequalities. Partners can identify a local 'at risk' cohort and create the evidence base for the targeted action needed. Population health management means using data, evidence and knowledge in all forms to create local intelligence that aids decision-making.

ii. **National data platforms**. NHS England has invested in several data platforms to support the use of data in guiding local decisions to reduce the health inequality gap. The health inequalities improvement dashboard focuses on Core20PLUS5 data and is contained within NHS National Data Platform (the Foundry) which identifies significant health inequalities statistical analysis and suggests actionable insights.

iii. **Local data capabilities**. Devon ICB hosts the One Devon Dataset that combines our local public health data with NHS and social care services. Primary Care Networks can also connect to this to provide a health profile for their patient area and help them target support. There are clear opportunities to use data in this way to inform and prioritise our health inequalities work as well as to collaborate on further research with partners.

iv. Our **police, council and charity partners** also collect data for example on anti-social behaviour, place of safety; housing supply, fuel poverty, evictions and housing standards; and gaps in community resilience respectively. Data sharing agreement to enable the overlay with health data will guide and target the interventions to reduce health inequalities and enable effective partnership working.

v. **Neighbourhood qualitative data**. We will take concerted steps to understand the lived experience of people who are impacted by health inequalities. It is only by listening to the lived experience that services can understand how they must adapt their provision models to mitigate disadvantage and deprivation.

5. The role of South Local Care Partnership in tackling health inequalities

5.1 The Local Care Partnership has an opportunity to work towards a longer-term view for collective action across sectors and organisations, many of which are anchor organisations. Traditionally, funding, effort and time has been channelled through topic silos that reduces overall impact. The Local Care Partnership has an opportunity to look across all these aspects to connect the dots and make more of the work.

5.2 The partnership actively involves most, but not all health and care organisations/departments. A connection with the Health and Wellbeing Boards that do have representation from other sectors that are working to reduce inequalities across determinants of health, such as police, housing and economy is essential.

5.3 The preferred approach for the LCP is to support organisations, departments, groups and teams to identify the health inequalities in all their work so they can be addressed.

Collecting insights from this process together will enable us to develop a more collaborative longer-term plan.

5.4 This strategic, universal approach provides the opportunity to draft and test tools and approaches to 'finding the inequality', making it easy for all to routinely identify and address health inequalities in all work.

5.5 The anticipated outcomes of this work are:

a. Increased knowledge and understanding in population health management tools, cultivating a shared approach to this work across the LCP area.

b. Nurture of and learning from innovative projects which have potential to tackle health inequalities.

c. Identification and agreement of shared key areas where there are levers for change, that can be worked on together.

d. Clarification of individual organisation or sector roles and what is needed to do this work.

e. Being better placed to respond quickly to and get best use of the frequent short-term funding opportunities that this kind of work is currently based on.

f. Plan for longer-term funding, designing opportunities to pool and share funds.

6. Conclusion

6.1 There are significant policy and data drivers to tackle inequality in our locality.

6.2 There is evidence of a clear need and an opportunity to come together and explore new ways to make a difference to inequalities that, despite effort by many, are becoming more sustained.

6.3 The recommendation is that LCP partners work collaboratively as outlined in section 5 above.

6.4 It is essential that collaboration and partnership includes those from, and representing communities in the South LCP area, to ensure actions have positive impact.

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Appendices

Appendix 1
Further definitions

Inclusion health is an umbrella term used to describe people who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. The NHS England Inclusion Health framework aims to redress the extreme health and social inequities among the most vulnerable and marginalised in a community.[6]

Equality means treating everyone the same or providing everyone with the same resource.

Equity means providing services relative to need, recognising inequalities that are deemed to be unfair or stemming from some form of injustice and which are avoidable, unnecessary, or controllable.
Most health inequality strategies recognise that reducing the steepness of the social gradient in health involves actions which are universal, but with a scale and intensity matched to the level of disadvantage: this is known as proportionate universalism.

Wider determinants are a diverse range of social, economic and environmental factors which impact on people's health. Such factors are influenced by the local, national and international distribution of power and resources which shape the conditions of daily life. They determine the extent to which different individuals have the physical, social and personal resources to identify and achieve goals, meet their needs and deal with changes to their circumstances.

The wider determinants of health are interlinked: for example, someone who is unemployed may be more likely to live in poorer quality housing with less access to green space and less access to fresh, healthy food. This means some groups and communities are more likely to experience poorer health than the general population. These groups are also more likely to experience challenges in accessing care.

Core 20+5 is an approach designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement. There are versions for both adults and children. **Core20** is the most deprived 20% of the population as measured by the index of multiple deprivation; **Plus** are those ICS-chosen groups experiencing poorer than average health access and/or outcomes particular to its area, who may not be captured within the Core20 and who would benefit from tailored healthcare approaches i.e. inclusion health groups; **5** refer to the key clinical areas of health inequalities.

[6] https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/what-are-healthcare-inequalities/inclusion-health-groups/

For adults they are **maternity**, **severe mental illness**, **chronic respiratory disease**, **early cancer diagnosis** and **hypertension** with smoking cessation recognised as a common positive intervention for all. For children the 5 are **asthma**, **diabetes**, **epilepsy**, **oral health** and **mental health**. Devon is using Core20+5 to segment the population to prioritise attention and resources.
(See appendix A for more about Core20+5).

South Local Care Partnership (LCP)
The area of 'South' refers to Torbay and South Devon; i.e. the local authority areas of Torbay, Teignbridge and South Hams. The area includes Dawlish, Teignmouth, Newton Abbot, Ashburton, Buckfastleigh, Totnes, Dartmouth, Brixham, Paignton and Torquay and the surrounding villages.

The Local Care Partnership is a range of people working together, regardless of the employing organisation, to deliver joined-up collaborative care that meets the local population's needs. It includes statutory organisations, third sector (community groups) and elected members, alongside local people, to develop services that support people to access the right support when they need it and thrive using their individual and community assets.

Devon Integrated Care System is a partnership of health and care organisations working to improve the lives of people in Devon, Torbay and Plymouth.

Anchor organisations are large, local organisations that can influence the health and wellbeing of a place through how they use their resources. They can influence local social, economic and environmental priorities to reduce health inequalities. Anchor organisations are large employers such as the NHS, local authorities and colleges.

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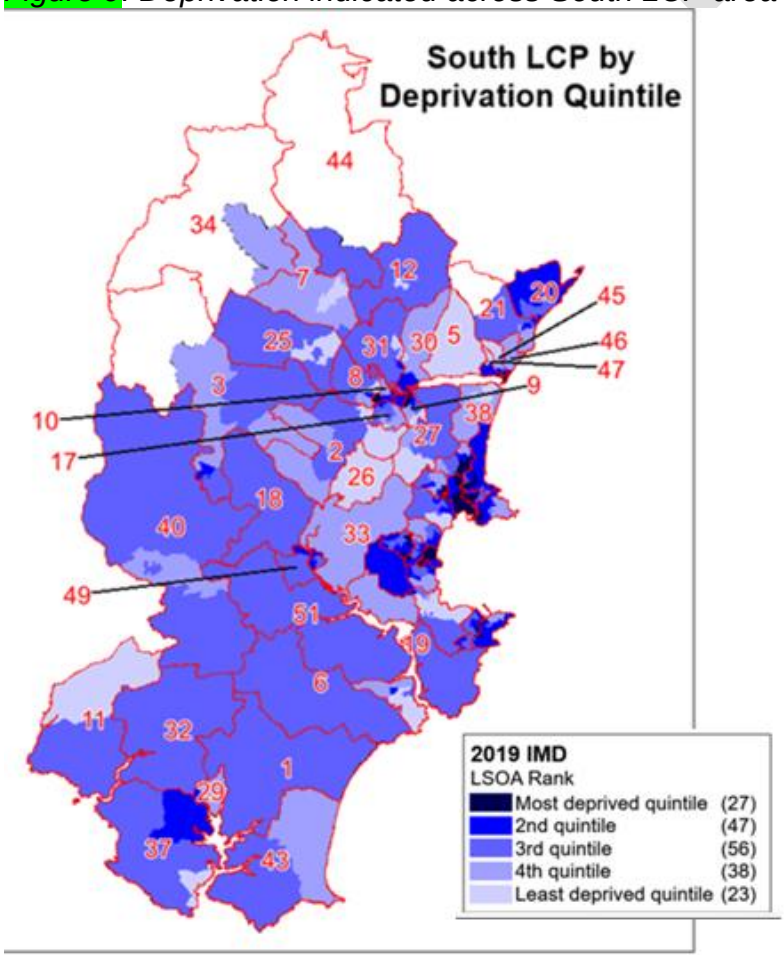
APPENDIX 2

South Local Care Partnership health profile

EXERPTS FROM THE FULL PROFILE

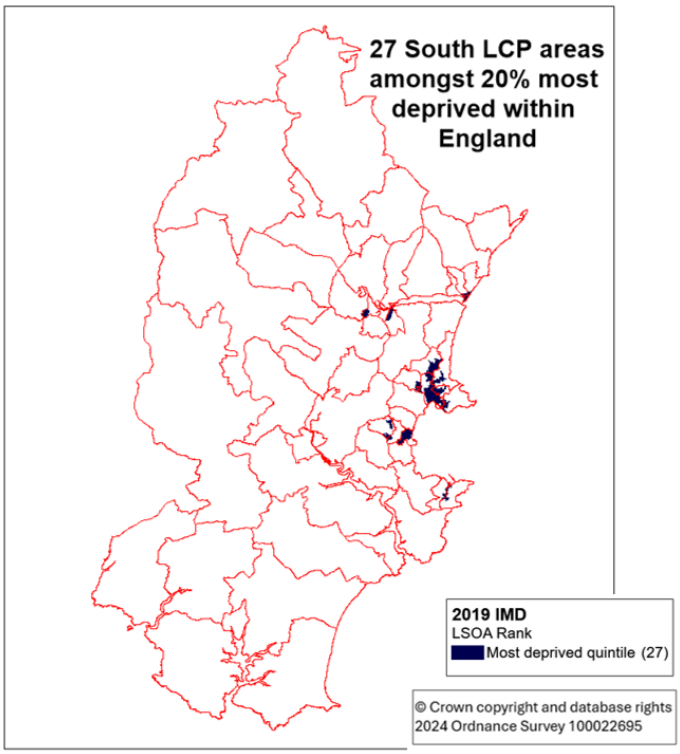
Figure 9 shows Lower Super Output Areas (LSOAs) across South LCP by level of deprivation. LSOAs are similar to electoral wards but proportioned with more even population numbers for ease of data review. It gives us a good indication of where inequalities are more likely to exist in our areas. 27 of the LSOAs in South fall within the 20% most deprived areas in England. 24 of these are in Torbay and 3 in Teignbridge.

Figure 9: Deprivation indicated across South LCP area



Number	Name
1	Allington & Strete
2	Ambrook
3	Ashburton & Buckfastleigh
4	Barton with Watcombe
5	Bishopsteignton
6	Blackawton & Stoke Fleming
7	Bovey
8	Bradley
9	Buckland & Milber
10	Bushell
11	Charterlands
12	Chudleigh
13	Churston with Galmpton
14	Clifton with Maidenway
15	Cockington with Chelston
16	Collaton St Mary
17	College
18	Dartington & Staverton
19	Dartmouth & East Dart
20	Dawlish North East
21	Dawlish South West
22	Ellacombe
23	Furzeham with Summercombe
24	Goodrington with Roselands
25	Haytor
26	Ipplepen
27	Kerswell-with-Combe
28	King's Ash
29	Kingsbridge
30	Kingsteignton East
31	Kingsteignton West
32	Loddiswell & Aveton Gifford
33	Marldon & Littlehempston
34	Moretonhampstead
35	Preston
36	Roundham with Hyde
37	Salcombe & Thurlestone
38	Shaldon & Stokeinteignhead
39	Shiphay
40	South Brent
41	St Marychurch
42	St Peter's with St Mary's
43	Stokenham
44	Teign Valley
45	Teignmouth Central
46	Teignmouth East
47	Teignmouth West
48	Tormohun
49	Totnes
50	Wellswood
51	West Dart

Figure 10 shows just the most deprived areas across South LCP area.



Of the 27 South LCP LSOAs that are amongst the 20% most deprived areas in England, 24 of them are in Torbay.

These are predominantly the central wards of Torquay and Paignton such as Tormohun, Ellacombe and Roundham with Hyde.

Of the 3 LSOAs outside of Torbay, 2 are in Newton Abbot (contained within Buckland and Milber, Bushell wards) and 1 is Teignmouth town centre and seafront (Teignmouth West ward).

Figure 10

Combining data on deprivation with health data helps us identify the ***Core 20***% most deprived areas ***PLUS*** our own inequality priorities to tackle, and ***5*** clinical priority areas – our Core 20PLUS5. This is set out in one image in figure 11.

Figure 11 South Core20PLUS5