Scrutiny Report

Report of the Healthier Communities & Older People Scrutiny Panel

The Strategic Response to Health Inequalities in North Lincolnshire

March 2011

NORTH LINCOLNSHIRE COUNCIL

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FOREWORD FROM THE CHAIRMAN

Councillor Trevor Barker
Chairman of the Healthier Communities and Older People Scrutiny Panel.

I have pleasure in presenting this report, detailing the Healthier Communities and Older People Scrutiny Panel's review into the Strategic Response to Health Inequalities in North Lincolnshire.

Unfortunately, we live in an area, and a country, that is notable for the inequality between people. There are profound, and often widening, inequalities between how long people will live, their levels of education, their life chances, how much money they earn, how likely they are to contract a serious disease, and how likely they are to become a victim of crime.

In turn, this is damaging to social cohesion and to society in general.

I believe that this review is timely, as it coincides with a renewed focus at a local level to tackle these inequalities. There are also new opportunities to put measures in place to tackle inequality as health services and local democracy change and develop across North Lincolnshire. We sense a real thirst to address the inequity we see locally, although there are challenging times ahead that will require leadership and real action in our communities. We hope our recommendations go some way to achieving the necessary improvements.

I would like to thank the Vice-Chair and the other members of the panel for their hard work and dedication throughout this review. This is a complex area with many considerations, but we were greatly assisted by our discussions with the key witnesses that the panel spoke to. Again, we wish to pass on our appreciation.

I commend the report and look forward to monitoring progress.

BACKGROUND TO THE REVIEW

The panel has long held aspirations to undertake a piece of work on inequality in North Lincolnshire. As with every other community, North Lincolnshire has inequality throughout many areas of people's lives. However, this is not inevitable. Some societies such as Japan, Sweden, Finland and Norway have far greater levels of equity, and this tends to co-exist with greater community cohesion, lower levels of mental illness, higher levels of literacy, lower levels of teenage pregnancy and a host of other positive outcomes.

Clearly, the Red Flag we received in 2009 was of particular concern to the scrutiny panel, and the follow-up visit by Local Government Improvement & Development raised the issue higher on the panel's priorities. As such, members decided to conduct a review into how the various organisations under the umbrella of the North Lincolnshire Partnership responded to the concerns around our rates of inequality.

The panel has spoken to a number of key witnesses, and sought evidence from a wide range of sources.

RECOMMENDATIONS

The final recommendations of the panel are summarised below:

Recommendation 1
The panel reiterates the recommendations within the Director of Public Health's (DPH) 2010 Annual Report, and requests a formal response from the council's executive and NHS partners in line with the requirements of the council's constitution and the Health and Social Care Act (2001). Namely, these are:

- Embed public health outcomes into mainstream services,
- Develop shared understanding of 'what works' to reduce inequalities in health across local agencies
- Deliver an area based approach to health improvement which recognises differences in local assets, needs and priorities

Recommendation 2
The panel also reiterates recommendations 2, 8 and 9 within their 2010 scrutiny report "The Inverse Care Law in North Lincolnshire", and requests a formal response from the council's executive and NHS partners in line with the requirements of the council's constitution and the Health and Social Care Act (2001).

Namely, these are:

- ...that the DPH, through the Wellbeing and Health Improvement Partnership (WHIP) and wider Local Strategic Partnership (LSP), should lead on the formulation of a comprehensive, multi-agency targeted action plan on Improving Health in Priority Neighbourhoods. This should address the vision and priorities within the North Lincolnshire Health and Wellbeing Strategy and other key documents, in order to respond to the concerns about health inequality. Furthermore, the panel recommends that a co-ordinated response to the health inequalities Red Flag contained within the Oneplace survey be prepared by the Director of Public Health, and shared with the LSP, the WHIP, clinicians and the public.
- ...that every effort be made by NHS North Lincolnshire and North Lincolnshire Council to protect public health and preventative budgets where there is evidence of cost-effectiveness and beneficial health and social outcomes, particularly where public health measures are linked to tackling health inequalities.
- ...that the Chair of the LSP ensures that all key agencies represented on the LSP, including the private and Voluntary and Community Sector, recognise the opportunities to work together in a concerted effort to reduce inequality (including health inequality) across North Lincolnshire.

Recommendation 3
That the council work with the emerging GP consortium and the local Healthwatch organisation (when in place), as well as non-statutory representatives, during the establishment of the Health and Wellbeing Board to ensure that tackling inequalities is a key priority in its work. We further recommend that the council should help support the Health and Wellbeing Board in

the following key areas:

- Drawing up a strategic action plan, agreed by all partners, based on the inequalities mapping exercise described on page 11 (see recommendation 2, first bulletpoint also). This should include key actions based on the contents of the 2010 Public Health White Paper, Professor Sir Michael Marmot's report Fair Society, Healthy Lives (2010), NICE guidance and other evidence-based best practice. There should also be clear, accountable ownership of the actions and challenging timescales for completion.
- Outside of this plan, there should be a particular focus on working with GPs and others to tackle key areas where the greatest impact on inequality can be achieved. These areas are described on page 11,14 and 15.
- Thought needs to be given into how area based working feeds into the work of the Health and Wellbeing Board,
- The Board should contain at least one member who acts as an Inequalities Champion,
- To prevent duplication, and if legislation allows, the Board should work alongside Safer Neighbourhoods and others to produce a combined Joint Strategic Needs Assessment / Joint Strategic Intelligence Assessment and economic assessment,
- To act as a sounding board for national or local public health campaigns,
- The Board should be the main mechanism to ensure that the recommendations within the Marmot Report are implemented locally where this is appropriate. Links to the council's Management Team and other key individuals and groups will need to be established,
- In line with this, the Board should work with the Chief Executive of the council and others to reduce duplication and ensure that tackling health inequalities is considered by all Directorates in the council and across the public sector.

Recommendation 4

The panel recommends that the Health and Wellbeing Board agree a small number of specific priorities to tackle in their first year, agreeing a joint and targeted approach, monitoring progress as required. One strong contender might be to enhance and extend Stop Smoking services, targeted at our most deprived communities, as identified within the DPH's annual report and the Joint Strategic Needs Assessment.

Recommendation 5

The panel recommends that discussions begin at a senior, strategic level at North Lincolnshire Council regarding how Marmot's related concept of proportionate universalism (as described on page 12) could be applied locally, particularly as we move towards an area-based working model of local democracy, with associated place-based budgets. Clearly, there will always be a need for some universal services. However, the panel believes that maximum flexibility should be given to a targeted approach of delivering services and combining resources to meet the challenge of reducing the inequalities across North Lincolnshire.

Recommendation 6
To coincide with recommendation 5, the panel recommends that the council and health partners employ a greater use of equality impact assessments when considering key decisions (for local government) or substantial developments or variations (for NHS bodies), based on the proportionate universalism principles Localism Bill 2010-11 and the forthcoming requirements of the Equalities Act 2010, both outlined on page 12.

Recommendation 7
To counter the problem described on page 10 about a lack of corporate leadership in taking the health and inequality agenda forward at a strategic level, the panel recommends that the Director of Public Health, fully supported by the Chief Executive of the council and the relevant Cabinet Member take ultimate responsibility for progress post-2013 (subject to future statutory requirements/ responsibilities). The Director of Public Health is the key figure for health improvement, tackling inequality and addressing the wider determinants of health, but to achieve this role they need to be granted the freedom and means to work across the full range of functions in the council, advising on their impact on the health of the local population and working with key strategic partners to identify inequalities and develop and implement strategies to reduce them. This will require support from the Chief Executive and Cabinet Member, and also the Directors of Adult Social Services, Children's Services and other Directors and senior officers to ensure the agenda is intrinsically ingrained in the work of each Directorate across the council and the wider partnership. In the shorter term, NHS North Lincolnshire will, of course, continue to work alongside the council, with the Health and Wellbeing Board and GP Consortium also playing key roles in the future.

Recommendation 8
The panel recommends that a task and finish group is established to agree the future ownership of the Sustainable Communities Strategy, and to ensure its aims and priorities are suitably understood, embedded and monitored across the area.

Recommendation 9
The panel recommends that the council's executive ensure that, following the passage of the Localism Bill 2010-11 and the Health and Social Care Bill through Parliament, robust arrangements are put in place to ensure that progress on this important issue is open to scrutiny and is monitored by elected members.

FINDINGS

1. Health Inequalities - an introduction

Health inequalities exist where there are differences in people's health, and the causes of ill-health, in different communities. There are many things that affect how healthy people are, and how long they can expect to live. These include where people live, their income levels, whether they are employed, and how they live their lives. There is a complex relationship between determinants of ill health, such as whether people smoke, how much they drink, the standard of their accommodation, and how likely they are to become ill or to die prematurely.

We know that people's health has improved markedly over the past 150 years. However, large differences between the health of different groups remain. This is evident when comparing the life expectancy of the most affluent people in society with those with the lowest incomes. However, it can also be seen in many other aspects of health. Poorer people tend to develop certain illnesses more frequently and with worse outcomes. They are more likely to have more years of poor health and disability and also poorer access to services. This phenomenon exists in all developed countries across the world.
In a similar trend to the national picture, every community's health in North Lincolnshire is getting better. However, the health and life expectancy of those in the most deprived areas is improving at a much slower rate than elsewhere. Since 2001, the number of premature deaths amongst our most affluent residents has reduced by 21%. For the most deprived residents, the number has only improved by 5%. This is leading to a stark and worsening health inequalities gap. A male living in our most deprived areas can expect to live 11.6 years less than a man living in our most affluent areas. For females, the figure is 8.1 years. This figure has also widened since 2001.

Premature death is only one result of the inequalities within North Lincolnshire. When compared to the most affluent 20%, our poorest residents are:

- Nine times more likely to die prematurely from lung disease,
- For females, six times more likely to become pregnant as a teenager, four times less likely to be breastfeeding at 6-8 weeks, and three times more likely to smoke during pregnancy,
- Three times more likely to die prematurely from heart disease and lung cancer, or to be admitted to hospital for alcohol problems.
- Twice as likely to smoke, be admitted to hospital via Accident and Emergency and to suffer poor health in older age.

Of course, health is not the only area where there are significant inequalities across North Lincolnshire. As might be expected, there is a general, inter-related trend that, as income increases it correlates with improvements in educational attainment, opportunities for children and young people, housing and air quality and the provision of green spaces away from traffic. The risk of becoming a victim of crime is also lowest in our least deprived areas. Recent figures released by

the London Public Health Observatory state that North Lincolnshire is performing significantly worse than the national average for young people not in education, employment or training.

Health inequalities are often compared to income levels, as seen above. However, inequalities also exist between different groups of people with similar incomes. For example, men are more likely than women to die prematurely from cardio-vascular disease, cancer and stroke. Inequalities can also be linked to ethnic origin, poor mental health, physical or learning disability, and sexual orientation. For example, black and minority ethnic (BME) groups and those for whom English is not a first language are far less likely to access existing services, and BME groups are up to three times more likely to suffer from early onset dementia. This illustrates the complexity of the issue.

2. Concerns Raised About Health Inequalities in North Lincolnshire.

It is important to note that health inequalities exist throughout the whole country, and have existed for many years; certainly longer than the establishment of local government and the NHS.

However, considering the current organisational structures, action to tackle health inequalities was urged almost ten years ago in 2002. The Director of Public Health's (DPH) annual report from that year recommended the development of "schemes to tackle inequalities. Within the Local Strategic Partnership and partner organisations, all new developments and plans that affect health must show how they aim to reduce inequalities".

The Improvement and Development Agency (IDeA) were invited to undertake a 'Healthy Communities' peer review in 2008. Whilst this review found many areas of good practice, it recommended the need for an over-arching strategy to tackle health inequalities. The review acknowledged that there was widespread recognition that geographic health inequalities was a major issue locally, although concern was expressed about the pace of addressing the issue.

The review suggested a range of other actions to improve local people's health and wellbeing. These included the use of Health Impact Assessments and Health Equity Assessments, greater targeting of resources on a geographic, community and service basis and ensuring that "health is everyone's business."

This review was followed in December 2009 by a joint "oneplace" independent assessment of all local public services within North Lincolnshire. Again, this highlighted several areas of strength locally, including housing, waste management, reductions in serious road traffic accidents and promoting independent living.

Despite these strengths, the assessment raised significant concerns around health inequalities in North Lincolnshire. This was highlighted further through identifying health inequalities as the only "red flag" issue within the assessment, describing "significant concerns about results and future prospects

that are not being tackled adequately".

The oneplace assessment found that "In North Lincolnshire, the better off live up to ten years longer than those from poorer areas. The gap is getting worse, and not enough is being done to change it. Too many people in North Lincolnshire are smokers. The number of teenage girls getting pregnant is too high. Too many women smoke in pregnancy and not enough mothers breast feed their babies. All of these contribute significantly to ill health in North Lincolnshire. There are also high levels of obese adults and many older people not in good health in North Lincolnshire".

"The Local Strategic Partnership is taking action to address all these problems, but progress is too slow. Initiatives aimed at the main causes of ill health, such as smoking, obesity, exercise, diet and healthy lifestyles have yet to have a significant impact on health inequalities in North Lincolnshire. The partnership needs to do more if the health of North Lincolnshire residents, and especially those from the poorer areas, is to improve".

"Achievement is rising for children up to seven years old, but getting worse for seven to eleven year olds. This is especially so for those young people from the poorest backgrounds."

Following the 2008 review by IDeA, a follow-up visit by their successor body (the Local Government Improvement & Development (LGID)) was undertaken in the spring of 2010. Again, they noted some areas of good practice and progress. However, the LGID presentation expressed frustration with the pace of change, the lack of strategic planning and leadership and a perceived gap between planning and action 'on the ground'. The LGID findings will be discussed in more depth within the conclusions section of this report.

3. The Local Response to These Concerns.
In recent years, several pieces of work have been completed, aiming to tackle inequalities and to respond to the concerns raised in previous paragraphs.

The issue of health inequalities, as might be expected, has repeatedly been highlighted as a key issue in documents issued by NHS North Lincolnshire. The organisation's Strategic Plan stated in 2008/09 that they would endeavour to "...eliminate the health gap between the most affluent and most deprived. We will start by reducing by 10% the health gap by 2012".

A joint Health and Wellbeing Strategy was launched in April 2009. This set out a local vision "That everyone in North Lincolnshire enjoys improved wellbeing and health and that health inequalities are significantly reduced and ultimately eliminated." This strategy agreed twelve relevant priorities, largely based on improving people's health. Some of these were around 'lifestyle' issues, such as "reducing alcohol harm", "reducing smoking", and "reducing sexual ill health". Other priorities were more general. The strategy set out the two key aims as:

- Reducing inequality — to ensure our wards are not below the UK average for deprivation in any area, including health.
- Improving sustainability — to ensure that the actions taken deliver a better quality of life now and for future generations in North Lincolnshire.

The strategy sets out some actions that could have the most rapid impact on inequalities in life expectancy in North Lincolnshire. These are:

- Reducing the number of smokers in our poorest communities,
- Identifying and managing cases of high blood pressure and high cholesterol in our poorest communities,
- Earlier detection of lung cancer,
- Better management of chronic lung disease, heart failure and diabetes in our poorest communities,
- Increasing levels of physical activity.

A North Lincolnshire-wide Joint Strategic Needs Assessment (JSNA) was published in 2008, and refreshed in 2010. This document provides an overview of North Lincolnshire, and an analysis of the needs of our local residents, in order to help improve health and wellbeing and to tackle inequalities. This document also makes a number of references to health inequalities and the need to adopt new ways of working in order to target those most at risk. It also highlights, again, the widening gap in many areas.

The North Lincolnshire Partnership has a Programme of Action for tackling inequality in North Lincolnshire. This document includes a range of pieces of work to build capacity, tackle the determinants of inequality, target programmes and improve links to local and regional strategy and guidance. Around half of these actions have now been completed. A mapping exercise has also been undertaken with the theme leads for the six thematic partnership boards that sit under the Strategic Partnership.

Finally, the Director of Public Health has recently released her annual report, which focused specifically on the Marmot agenda and inequalities. The report emphasises the need for action on health inequalities, and makes three specific recommendations that are described on page 5, and have been reiterated by the panel.

4. The National Context

Many attempts have been made to tackle health inequalities through legislation and guidance from government over the past ten years. However, inequalities have continued to widen.

In February 2010, Professor Sir Michael Marmot released his wide-ranging Strategic Review of Health Inequalities in England Post-2010. This document built on previous work by Black (1980) and Acheson (1998) around action to tackle health inequalities. Each report shared common conclusions and recommendations. In very general terms, these are that the gap between the richest and poorest should be reduced, that services should be prioritised to those most in need, and to ensure that all policies assess the

impact on health inequalities.
Marmot also goes further, advocating the integration of planning, transport, housing, environmental and health systems, and also re-focussing much more on evidence-based preventative work. Marmot is clear that, whilst actions should be targeted at those most at need, that there needs to be an element of proportionality and a realisation that some services will always need to be universal. Marmot termed this approach 'proportionate universalism'.

Since mid-2010, the coalition government has consulted on, and began implementing, a series of proposals to radically reform how health and (to a lesser extent) social care services will be planned, commissioned and provided in the future. In short, if the legislation is agreed by Parliament and receives Royal Assent, this will see the abolition of Primary Care Trusts and Strategic Health Authorities. The majority of health commissioning will be undertaken by GP consortia. Local Health and Wellbeing Boards will help support and co-ordinate healthcare, in partnership with the GP consortia. It is anticipated that responsibilities for public health will transfer to local authorities.

The Government has also released a Public Health White Paper highlighting their intentions for the future. The proposals include a national body (Public Health England), a local DPH based in upper-tier and unitary authorities, and a local ring-fenced budget with an additional 'health premium' for deprived areas. Tackling inequality is also a key element across much of the NHS Outcomes Framework published around the same time.

The current financial situation has been well documented. There are concerns that this could have a detrimental effect on health inequalities. Historically, recessions tend to lead to greater fuel poverty, unemployment, and an increase in a variety of health complaints. The Joint Strategic Needs Assessment states that "The recession has impacted most heavily on those areas and communities with the least resources, and threatens to widen the health inequalities gap. Of particular concern is the rise in unemployment, and long term unemployment amongst the under 25s, which has risen faster than nationally".

"As the number of families at risk of poverty increases, the gap in opportunities and outcomes, including health outcomes, between relatively advantaged and disadvantaged children could widen".

The revised Equality Act 2010 will include a requirement to embed equality considerations within the day to day work of public bodies from April 2011. As some groups access services less and receive differing outcomes, this duty could become increasingly important in future years.

The partnership continues to receive support from LGID on improving health and addressing inequality.

CONCLUSION

Whilst the panel is heartened by recent progress in mapping the work across North Lincolnshire that can have an element of tackling inequality, members do have concerns on three separate but related issues.

Firstly, North Lincolnshire Partnership's Delivery Board agreed to this mapping exercise and a resultant action plan in September 2010. The mapping is now being finalised. However, the panel is concerned that almost a year passed between the Red Flag on health inequalities and meaningful action to begin. Indeed, it has been known for many years prior to 2009 that inequality is a particular issue locally, but for a range of legitimate but unhelpful reasons, there was limited co-ordinated, concerted effort to tackle this.

Secondly, as the Delivery Board and Strategic Partnership are currently under review, the panel is concerned that the required action plan will either be passed to the fledgling Health and Wellbeing Board, postponed or even abandoned altogether. Clearly, the first option is the most favourable outcome but will be working with a newly established body, whereas the latter two of these options will damage efforts to tackle the enduring problem. If, as expected, the Delivery Board is disbanded, the best outcome could result in a significant gap in time until the move towards area based working is agreed and embedded across North Lincolnshire. At worst, the agenda could be lost altogether.

Thirdly, whilst the panel welcomes the mapping exercise as a tool to reduce duplication, we remain concerned about the potential impact of the exercise in fundamentally tackling inequality. By nature, it is a description of work that is already underway, rather than a plan for future action or targeting. As the inequality gap continues to widen, we remain concerned that it will have a significant impact in reducing inequality. The situation is especially challenging given the current financial position across the country, both in terms of the impact on the wellbeing of local people and also the funding that is available to provide services.

Obviously, this is not to say that many genuinely productive and rewarding schemes are not underway. The panel would wish to acknowledge the work of many people, in all sectors of society, who work to support their communities.

The panel acknowledges that the concept of 'inequality' can be nebulous and difficult to pin down to any agency or individual to take responsibility for. This can explain the apparently conflicting problem that arose in the 2008 peer review and 2010 follow-up that 'health should be seen as everyone's business' but at the same time, there is a requirement for a key individual or group to drive and monitor progress.

Despite some recent progress driven by the DPH, the panel shares LGID's concerns around leadership of the agenda and how

ingrained tackling health inequalities are across the partnership. As NHS North Lincolnshire closes its doors in 2013 with the associated loss of key leaders, knowledge and organisational memory, and North Lincolnshire Partnership moves more towards a networking model, the panel's concerns are heightened.

Despite this, the panel is pleased to see that thought is now being given to amalgamate the required financial savings with a move towards new models of local governance and priority towards tackling the determinants of ill health and inequality. The DPH's recent report highlighted the benefits and savings to be made by 'enhancing and coordinating public health interventions across agencies which target inequalities' and promoting a 'joint approach to tackle inequalities in wider determinants of health'.

Many related issues have already been discussed and addressed through recommendations by this scrutiny panel as part of its 2010 review into the Inverse Care Law. We have chosen to reiterate our previous recommendations, as well as restate the recommendations in the DPH's recent annual report.

The panel is also pleased to learn that there is agreement to move towards shaping the revised Sustainable Communities Strategy around the six key outcomes within the Marmot Report. These are:

- Give every child the best start in life,
- Enable all children, young people and adults to maximise their capabilities and 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, and
- Strengthen the role and impact of ill health prevention.

The panel do have some concerns based on a lack of prioritisation. This was highlighted by the various reviews and has been acknowledged by the partnership as an issue. Of course, seeking to provide services to address local issues is a laudable approach. However, prioritising many issues, or a few very general areas, can result in a lack of action or unclear outcomes. For example, when the Wellbeing and Health Improvement Partnership reduced their priorities from 10 to three, this was done by increasing the scope of the priorities. For example, increasing being active, reducing alcohol harm and reducing smoking, which were separate priorities within the Health and Wellbeing Strategy, moved into one wider priority around the wider determinants of health. Again, these are important issues, and work on each must continue. However, genuine prioritisation of effort and resources can lead to far greater results. We have known since 2002 that the fastest and deepest reductions in inequality can be made through smoking cessation and the prescription of drugs to reduce cholesterol and control blood pressure.

However, the House of Commons Committee of Public Accounts has criticised the Department of Health for not pressing for these interventions to be rolled out to the necessary scale to reduce inequality.

Finally, we acknowledge that there may be contributory historical factors to the situation. NHS North Lincolnshire's financial Turnaround process has been well documented, and a series of reorganisations and turnover of key staff has acted against the necessary collective ownership of the issue. The panel welcomes the renewed focus and looks forward to a real but realistic future where the inequalities gap is halted and ultimately reduced, making our society more equitable and fair.

APPENDIX

Membership of the Healthier Communities and Older People Scrutiny Panel

Cllr Trevor Barker - Chairman
Cllr David Wells — Vice-Chair
Cllr Mashook Ali
Cllr John Collinson
Cllr William Eckhardt
Cllr Margaret Sidell
Cllr Margaret Simpson

The following members were also involved in the review:
Cllr Bunyan
Cllr Cawsey
Cllr Davison
Cllr Ellerby
Cllr England
Cllr Jawaid MBE

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