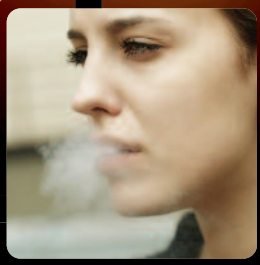

Scrutiny Report

The Strategic Response to Health Inequalities in North Lincolnshire

Report of the Health Scrutiny Panel

December 2012

NORTH LINCOLNSHIRE COUNCIL

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FOREWORD FROM THE CHAIRMAN

Councillor Jean Bromby
Chairman of the Health Scrutiny Panel

Like virtually all other areas of the country, in North Lincolnshire we have marked differences between the health and wellbeing of our various communities. For many years, we have known that this gap is too large, and that, in many cases, it is getting larger. This is not solely caused by differences in incomes, as there are also noticeable gaps between:

- **Men and women,**
- **Different age groups,**
- **Different ethnic groups,**
- **Those with disabilities or long term mental health problems.**

Historically, there have been concerns expressed that not enough was being done locally to address these gaps. This culminated in a report by a previous scrutiny panel some 18 months ago. Given the recent and ongoing changes to the health and social care structures, we felt it appropriate to revisit this report, and to explore where we may be able to take steps to improve the situation further.

Two key issues relevant to this are the transfer of responsibilities for public health to the local authority, and the establishment of the Health and wellbeing Board. We welcome the public health transfer. Recent guidance states that 'when we focus on the social determinants of health, rather than the medical cause of some specific disease, we see that local government services are health services. It is no exaggeration to say that without local government, adults and children would die sooner, would live in worse conditions, would lead lives that made them ill more often and would experience less emotional, mental and physical well-being than they do now'.

My view is that the Health and Wellbeing Board is the key driver to addressing health inequalities. It is the only body locally with the necessary influence, expertise and membership to tackle this complex issue. However, it will be important to embed a public health ethos in everything that the council, the health services, and our partner agencies do.

Tackling inequalities is not merely extending people's lives; it is about 'adding life to years, rather than years to life'. We must endeavour to make sure that everyone has the opportunity to progress in life, can access the services that they require, and can take control of their own health and wellbeing. Inequalities should not be seen as something difficult to solve or inevitable, and therefore easily avoidable. We need to have clear plans in place that result in co-ordinated and genuine action in communities. This is where we will see inequality being tackled, and not in a meeting room at the Civic Centre.

Finally, I would like to thank the Vice-Chair and all of the panel members for their unfailing interest, commitment and hard work throughout this complex review. I commend this report and look forward to receiving a detailed, timetabled response to our recommendations.

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.

This culminated in a 2011 report from the former Healthier Communities and Older People Scrutiny Panel. In July 2012, the Health Scrutiny Panel took a decision to update this report to incorporate recent developments across local government and the NHS, and incorporating the coalition government's stated aim to 'improve the health of the poorest, fastest', before re-submitting this to Cabinet for action.

The panel spoke to a number of key witnesses, and sought evidence from a wide range of sources. The updated report included the most up-to-date data.

GLOSSARY

Clinical Commissioning Group or CCG	A group of clinicians — mainly GPs — who will design and commission local health services throughout England. These will replace Primary Care Trusts from April 2013.
DPH	Director of Public Health
Health and Wellbeing Board	A council committee responsible for encouraging integrated working and developing Joint Strategic Needs Assessments and joint Health and Wellbeing Strategies.
Joint Strategic Needs Assessment (JSNA)	A local analysis of the health needs of populations to inform and guide commissioning of health, well-being and social care services within local authority areas.
Joint Health and Wellbeing Strategy (JHWS)	A strategy unique to the local area, agreed by the Health and Wellbeing Board, to agree local priorities and to set out how to respond to the needs identified in the Joint Strategic Needs Assessment.

RECOMMENDATIONS

The final recommendations of the panel are summarised below:

Recommendation 1:
The panel 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 cabinet and NHS partners in line with the requirements of the council's constitution and the Health and Social Care Act (2001). These have been slightly updated to take into account of the new structures, and are listed below:

- that the Director of Public Health (DPH), through the shadow Health and Wellbeing Board and in co-operation with other partners, should lead on the formulation of a chapter in the forthcoming Joint Health and Wellbeing Strategy setting out a comprehensive, multi-agency targeted strategy and action plan on tackling inequalities in health and the wider social determinants, including improving health in priority neighbourhoods. This should address the vision and priorities identified in the Joint Health and Wellbeing Strategy and other key documents, in order to respond to the continued concerns about health inequality. This should also include key actions based on the Public Health Outcome Framework, Professor Sir Michael Marmot's report Fair Society, Healthy Lives (2010), NICE guidance and other evidence-based best practice. There should be clear, accountable ownership of the actions, details of the evidence base, and challenging timescales for completion. (This echoes recommendations 4 in the Director of Public Health's 2011-12 annual report)

- that, following the transfer of public health to the council in April 2013, every effort be made 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 council's Chief Executive ensure that all key local and regional agencies, 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 2:
That the council work with the Clinical Commissioning Group, providers and other stakeholders 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:

- That it be acknowledged that the Health and Wellbeing Board should be the key strategic to body to lead and co-ordinate on tackling inequalities.

- That, as a priority, there should be a particular focus on working with the Clinical

Commissioning Group, locality integrated health and social care teams and others to tackle key issues where the greatest impact on inequality can be achieved. These issues are described in more detail on page 14.

- The Board should contain at least one individual who acts as an Inequalities Champion,

- The Board should work alongside the Safer Neighbourhoods Strategy Board, the Children's Trust Board and others to produce the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy,

- To act as a 'sounding board' or co-ordinator for national or local public health or health and wellbeing improvement campaigns,

- The Board should be the main mechanism to ensure that the recommendations within the Marmot Report are implemented locally where this is appropriate. Strong 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 the Director of Public Health to reduce duplication and ensure that tackling health inequalities is considered by all Directorates in the council and widely across all sectors.

Recommendation 3:
The panel recommends that the Health and Wellbeing Board, in consultation with others, be asked to consider agreeing a small number of specific priorities to tackle in their first year, agreeing a joint and targeted approach, and monitoring progress as required. One strong contender might be to seek an integrated approach to tackling multiple lifestyle risks such as alcohol misuse, smoking, poor diet and low levels of physical activity in priority areas where many risk factors often co-exist. The Clinical Commissioning Group has identified their own priorities and it will be important that the Health and Wellbeing Board's priorities complement these.

Recommendation 4:
The panel recommends that the council's Director of People, the Director of Public Health, and the Clinical Commissioning Group hold discussions with providers to consider how Marmot's related concept of proportionate universalism (as described on page 15) could be applied within the locality based teams. This should include consideration of 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. This echoes recommendations 2 and 3 in the Director of Public Health's 2012 Annual Report.

Recommendation 5:
The panel recommends that the council and health partners routinely employ equality impact assessments when considering all key

RECOMMENDATIONS

decisions (for local government) or substantial developments or variations (for NHS bodies), based on the proportionate universalism principles as described on page 15.

Recommendation 6:
To counter the problem described on page 12-13 about a lack of corporate leadership in taking the health inequalities agenda forward at a strategic level, the panel recommends that the Health and Wellbeing Board take ultimate responsibility for progress post April 2013 (subject to future statutory requirements/responsibilities). The Health and Wellbeing Board are the only co-ordinating body locally that has the wide knowledge, clinical input and political leadership required to seek holistic improvements to people's health and wellbeing, to tackle inequality, and to address the wider determinants of health.

Recommendation 7:
The panel recommends that, following the transfer of the public health function to the council in April 2013, the Director of Public Health is 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 council's Cabinet, its Chief Executive, and also the council's three Directors and other senior officers to ensure the agenda is intrinsically ingrained in the work of each Directorate across the council.

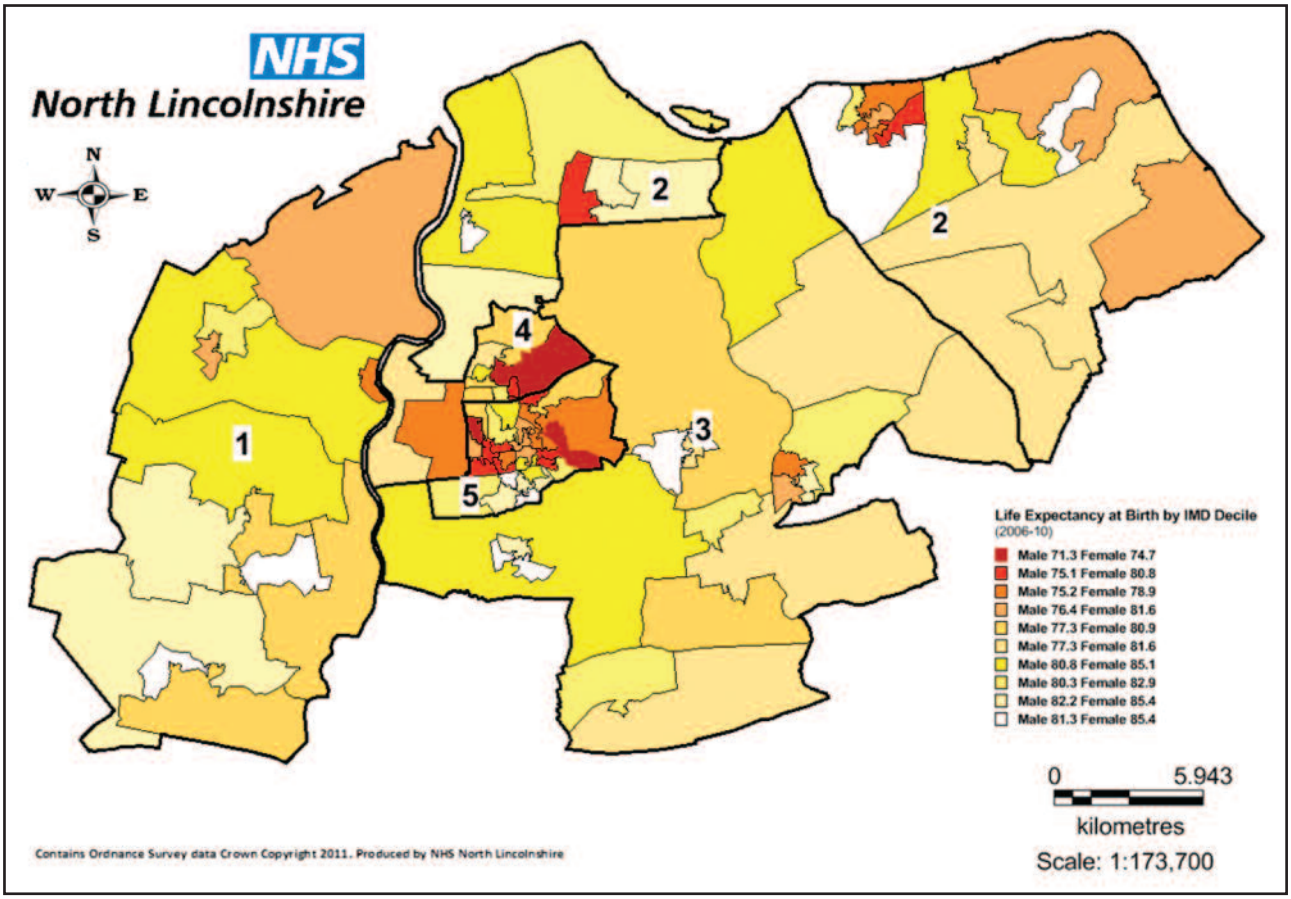
Recommendation 8:
The panel acknowledges that the health and social care field, and public sector organisations generally, are likely to be in a period of transition for a number of years. The panel therefore recommends that key organisations, structures and priorities are kept under review, at a minimum of 6-monthly intervals. In particular, the panel recommends that the move to community-based models of care be kept under close review. The panel believes that, to ensure future sustainability of services across North Lincolnshire, a fundamental shift of services into the community will be required in order to let the Acute Trust focus on those who need to be in hospital. Locality based integrated teams may well need to increase in size and specialism.

FINDINGS

1. Health Inequalities – an introduction

Health inequalities exist where there are differences in people's health, and the causes and prognosis 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.



FINDINGS

In a similar trend to the national picture, every community's health in North Lincolnshire is getting better and there have been some notable successes in recent years, not least around reducing young offenders' recidivism, improving services for looked after children and reducing the number of young people engaging in risky behaviours. 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 health inequalities gap that has widened in recent years. A male living in our most deprived areas can expect to live 10.7 years less than a man living in our most affluent areas. For females, the figure is 9.5 years. This figure has also widened since 2001. The latest figures suggest that our local figures for inequality by life expectancy are worse than both national and regional averages, significantly so in the case of men. The diagram on the previous page shows life expectancy for males and females across North Lincolnshire.

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

- 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, stroke 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 and opportunities for children and young people. There is a clear link between relative deprivation and weaker education outcomes at all ages. Similarly, the risk of becoming a victim of crime, living in poor housing or in areas without green spaces, is also lowest in our least deprived areas.

Health inequalities are often compared to income levels. However, inequalities also exist between different groups of people with similar incomes. For example, men are more likely than women in the same communities 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 first urged 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." The report recommended that "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".

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'.

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 2009/10 that they would endeavour to reduce the inequalities gap between the richest and poorest fifths of our population by 10%, over the next five years. This was replaced by a national statutory indicator in the World Class Commissioning programme which aimed to reduce inequalities in the richest and poorest tenths; a more challenging target.

A joint Health and Wellbeing Strategy was launched in North Lincolnshire 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. Both the JSNA and the Health and Wellbeing Strategy are being updated at the time of writing this report, but both are likely to highlight continued inequalities.

North Lincolnshire Council is currently working with colleagues in local NHS organisations to establish five locality based integrated teams. These are Scunthorpe North, Scunthorpe South, The Isle of Axholme, Brigg and District, and Barton and Winterton. Each of these localities has a community public health improvement co-ordinator embedded within the integrated teams, in part, to address health inequalities. Each of these localities will have their own particular challenges and needs. For example, smoking and teen conceptions are particular public health concerns in Scunthorpe North, whereas loneliness and isolation are particular concerns in our more rural localities.

The main aim of these integrated teams is to improve the health of local communities and provide health and social care services closer to people's homes and in a non-hospital setting. This is more convenient for people accessing services, enables hospitals to concentrate on those most at need, and provides a less-expensive and more co-ordinated approach. There are often times when people's needs include both health and social care issues, and the teams are better set-up to respond to this. Suitably resourced budgets have been allocated for each locality. It is hoped that the five integrated teams will be fully established by the end of 2013, and the panel has expressed its desire to closely monitor progress.

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Finally, the Director of Public Health published her annual report in 2010, which focused specifically on the need for action on inequalities. The 2011 report also continued this theme with three of the four recommendations including reference to tackling health inequalities. These have been referenced and reiterated by the scrutiny panel in recommendations 1 and 4 (see pages 7-8).

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 reflect need across the social gradient , 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. The Health and Social

Care Act 2012 was agreed by Parliament in the Spring, and has received Royal Assent. Some of the key elements of the Act will see the abolition of Primary Care Trusts and Strategic Health Authorities. The majority of health commissioning will now be undertaken by Clinical Commissioning Groups, supported by a national NHS Commissioning Board, both of which have been given an explicit duty to tackle health inequalities. Local, council-led Health and Wellbeing Boards will help support and co-ordinate healthcare, in partnership with CCGs. Responsibility to improve and protect public health will transfer to local authorities. Each element of this will 'go live' in April 2013, and interim or 'shadow' arrangements are currently in place.

Other changes include the formulation of a national body called Public Health England to co-ordinate public health issues across the country, a local DPH based in upper-tier and unitary authorities, and a local ring-fenced budget with an additional 'health premium' for deprived areas.

The revised Equality Act 2010 includes 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.

CONCLUSION

Whilst the national context has been well documented, there is scope for optimism around health inequalities for the future. The panel is heartened that the NHS Commissioning Board and local CCGs have been given explicit duties to address inequalities. Locally, the role of the Health and Wellbeing Board will be key in bringing together all sides and to help co-ordinate services. There is now a wide, practical realisation that the work of the council, across all of its services, is fundamental to people's health and wellbeing. The Director of Public Health will seek to embed this realisation further.

There are also interesting developments through rolling-out locality based Integrated Health and Social Care Teams. These have the scope to bring together services that have, for too long, been treated as separately planned, commissioned and provided. The panel believes that, in the coming years, these teams will need to be added to and further resourced. For example, there may be scope to include mental health practitioners in the teams, or promote local access to dentistry, community equipment, benefit support, etc. etc. However, the panel is encouraged with the clear roles for the teams, the provision of services closer to people, enabling them to stay in their own homes, and with the obvious enthusiasm of the staff.

Health inequalities is often described as a difficult concept to 'pin down'. The panel agrees that it is certainly a complex issue, but we are clear that this complexity should never be a reason for a lack of action. Some of the differences in health outcomes outlined throughout this report are simply unjustifiable. If we are to shape a fairer North Lincolnshire where all of our residents receive services based on their level of need, there must be genuine leadership, joint working, commitment and planning across all sectors. The panel hopes that this document will go some way to achieving this.

APPENDIX

Membership of the Health Scrutiny Panel

Cllr Mrs Jean Bromby — Chairman
Cllr Trevor Barker — Vice-Chair
Cllr Sandra Bainbridge
Cllr William Eckhardt
Cllr Ralph Ogg

Frances Cunning, North Lincolnshire's Director of Public Health acts as an informal adviser to the panel.

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