APPENDIX A

Health Inequalities in North Lincolnshire – response to Health Scrutiny Panel recommendations report

	Scrutiny 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:**			
1.1	**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)**			
1.2	**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.**			
1.3	**That the council's Chief Executive ensures 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.**			
1.1	**Action:** The JHWS is built on the premise of Sir Michael Marmots 'Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England' 2010 (See supporting Priority Actions within the JHWS). The developing JHWS has a key focus within a range of six priority outcomes and five priority actions, and all underlying delivery plans require a multi agency approach to deliver targeted actions. The health inequalities agenda is intrinsically threaded through the JHWS and its priority areas. In particular it has specific precedence within the Closing the Gap priority outcome. All key actions are to fit within a framework of PH outcomes, Sir Michael Marmot and NICE in order to work towards meeting health inequalities based on sound evidence for 'practice' and service development in line with NHS mandate, Health and Social Care Act – all of which are linked to Sir Michael Marmots 'Fair Society, Health Lives' (2010). The meeting of this framework will be evidenced within the developing and mandatory Joint Strategic Needs Assessment (JSNA) which provides detailed health and social care needs information and the Joint Strategic Assessment (JSA) which provides a single story approach regarding the whole of North Lincolnshire on the wider determinants such as population, economy, housing, transport, leisure etc.	**Timescales:** July 2013 October 2013 July 2013 July 2013 Ongoing	**Progress:** JHWS now developed, ratified June 2013. Progress will be informed via the delivery plans, HWB, and developing JSNA and JSA. 5 JHWS Priority area Strategic leads/Champions and Vice Champions identified.	**Responsible Officer:** DPH Priority Action Lead Offices and HWB Champions
1.2	**Action:** HWB partners are committed to working together to ensure there is appropriate system leadership to ensure resources and investment are focussed on improving health and wellbeing and tackling inequalities. HWB partners will work together to ensure that resources are deployed appropriately and investment is made where it will address the priorities and deliver	Ongoing		

	improved outcomes. Budget setting processes across agencies are crucial to ensure the appropriate allocation of funding, with requirement for a realistic approach to investment in some areas and potential reductions in others. Within the process to commission and deliver preventative work locally focus will include review and allocation of preventative budgets and savings. Which is key when considering the evidence nationally that preventative measures in terms of cost effectiveness to services do work and create savings. For example (but not exhaustive): Alcohol related harm is estimated to cost society between 17.7 and 25.1 billion per year (DoH 2008). It costs the NHS (in England) up to 2.7 billion a year to treat chronic acute effects of drinking (DoH 2008). Estimates suggest 35% of A&E attendances and ambulance costs are alcohol related. Although there is there is limited evidence base, some alcohol intervention review work suggests that minimum pricing: £100m saved over 10 years (public sector) at NO COST; reducing the number of outlets: could save the NHS 3.5 million in year 1; introducing licensing restrictions: save the NHS up to £45 million in year 1; total advertising bans could reduce health costs by up to £316 million in year 1; and educational programmes incorporated into the school curriculum require no significant extra costs unless delivered by external agencies. In addition, Brief Advice provision in primary care and A&E saves between £3.81 to £10.00 for every £1.00 spent (in A&E, savings to NHS of £67,000 per year). An evaluation report by the Personal Social Services Research Unit on the evidence of effectiveness of the 'Partnerships for Older People Projects' nationally (2009/10) found that of 146 separate schemes run across 29 English local authority areas from 2006 to 2009, two-thirds of the schemes were aimed at reducing social isolation and exclusion or promoting healthy living among older people, with the remainder directed specifically at avoiding hospital admission or facilitating early discharge. Activities included fitting a simple grab rail in bathrooms to establishing active living centers. The schemes helped support 246,000 people, average age 75, and reduced overnight hospital stays by as much as 47%, attendance at A&E departments by 29%, and out-patient appointments by 11%. Following the inclusion of Community Public Health Facilitators (CPHF) within the integrated teams there is an ever growing presence of PH within the localities, in addition to the ongoing generic and Health Improvement work via the PH team and partners to reduce inequalities.	2013/2014	PH contract arrangements to be reviewed/transformed. In addition, further PH measures will be extended / introduced as part of the JHWS delivery plans. CPHFs working alongside integrated teams. PH core staff integrated within Council Peoples/Places directorates. CPHF team under review.	DPH
1.3	**Action:** The HWB now has an appropriate membership to fulfil shared leadership and commissioning commitments and meet all priorities and opportunities being identified through the JSNA, JHWS and delivery plans. Consideration is given to how the HWB engages with the private sector.	October 2013	Key priority actions being outlined within JHWS.	LA Chief Executive
	Scrutiny 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:**			
2.1	**That it be acknowledged that the Health and Wellbeing Board should be the key strategic body to lead and co-ordinate on tackling inequalities.**			
2.2	**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			
2.3	**The Board should contain at least one individual who acts as an Inequalities Champion,**			
2.4	**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,**			
2.5	**To act as a 'sounding board' or co-ordinator for national or local public health or health and wellbeing improvement campaigns,**			
2.6	**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**			
2.7	**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.**			
2.1	**Action:** Commitment of Council demonstrated during Shadow HWB development, part of MOU. The HWB is defined within the MOU as the key strategic body to lead and co-ordinate on tackling inequalities and will be clear within the developing JSNA and JSA evidence base and JHWS.	**Timescales:** April 2014 Ongoing	**Progress:** Now established HWB as formal committee of the Council HWB MOU JHWS now in draft.	**Resp Officer:** LA Chief Executive / HWB Chair of HWB
2.2	**Action:** Development areas will be prioritised via the HWB and JSNA evidence base and priorities tackled in line with JHWS, underlying strategic developments and delivery plans and commissioning plans. Formal structure exists to ensure work with CCG through ICB and reporting to HWB. Vice Chair of HWB is CCG chief officer.	July 2013 April 2013	Work through HWB steering group to develop the JHWS, and link to CCG commissioning plans.	HWB, CCG Chair, ICB
2.3	**Action:** Chief Executive identified as Inequalities Champion, however it is the responsibility of all HWB members to advocate reducing and work to reduce inequalities. As well as the embedding of tackling inequalities across the council work and objectives.	April 2013	Chief Executive - Inequalities Champion JHWS Priority Action Champions and Vice Champions identified.	HWB / LA Chief Executive
2.4	**Action:**Safer Neighbourhoods Strategy Board, the Children's Trust Board and others are all represented on the JSNA working group, the JHWS steering group and the HWB as recommended by national guidance for JSNAs/JHWS'.	April 2013	Embedded	HWB
2.5	**Action:** The HWB will act as a 'sounding board' or co-ordinator for national or local public health or health and wellbeing improvement campaigns as per recommended guidance and MOU.	Ongoing	Embedded as part of MOU?	Mel Holmes
2.6	**Action:** Marmot policy objectives are embedded within the JHWS infrastructure. In addition key CMT members are involved within the JHWS development and HWB membership, and HWB partnerships and sub groups.	Ongoing	DPH functions now incorporated within LA senior team.	HWB

			Public Health Transformation Board operational. HWB – sub groups in development. Embedded in JHWS Structure.	
2.7	**Action:** Elements of which are already being implemented via the integration of the DPH within LA senior team and the embedding of some PH staff in directorates across the council. JHWS Priority Action Champions now identified to act as advocates for reducing inequalities through action.	April 2013 July 2013	Incorporation of PH staff within People and Places directorates. JHWS Priority Action Champions.	HWB
3	**Scrutiny Recommendation** **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.**			
	Action: Six priority outcomes and five priority actions have been set within the draft JHWS by the HWB. These will be supported and underpinned by wider strategies and action plans incorporating multiple lifestyle risks. The priorities chosen are interlinked and require partners to work together with the CCG and HWB to ensure a 'golden thread' approach throughout all plans and reflect identified JHWS priorities. There is also significant health improvement activity within localities to target service input including: Effective commissioning and robust provision will contribute to the successful delivery of the JHWS. Under the auspices of the HWB, and to ensure it fulfils its statutory responsibility to increase the use of joint commissioning and pooled budgets, the Integrated Commissioning Board (ICB) will develop existing joint commissioning arrangements (where they remain fit for purpose) and identify further opportunities for joint commissioning, where they will deliver added value.	**Timescales:** July 2013 2013/2014	**Progress:** Priorities agreed. CPHFs, HTs, health check/screening programmes. MOU	**Resp Officer:** HWB HWB
4	**Scrutiny Recommendation:** **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 inequalities across North Lincolnshire. This echoes recommendations 2 and 3 in the Director of Public Health's 2012 Annual Report.**			
	Action: The JHWS six priority outcomes and five priority actions of: Focusing on 'best start' from conception to age 2; improving literacy and numeracy (including health literacy); addressing poverty; improving town centres; and modelling behaviour change (healthy workplaces) will contribute to the targeted approach towards reducing inequalities overall. In addition there is commitment to deliver identified work programmes to address priorities and deliver improved outcomes. The Integrated Working Partnership (IWP) will identify changes to the workforce and identify opportunities for integration,	**Timescales:** July 2013 2013/2014	**Progress:** Priority actions identified. CPHF team focus is area based. Discussions ongoing with	**Resp Officer:**

	where it will deliver added value.		council leadership to develop localities and target resources. Work commenced on transformation programme across health and wellbeing agenda with particular focus on local delivery Champion integration to achieve health and wellbeing priorities Developing, implementing and monitoring the IWP work plan to carry out appropriate integration. Integration Plan developed and linked to HWB.	
5	**Scrutiny Recommendation:** **The panel recommends that the council and health partners routinely employ equality impact assessments when considering all key decisions (for local government) or substantial developments or variations (for NHS bodies), based on the proportionate universalism principles as described on page 15**			
	.**Action:** As defined by the LA IIA process every project, policy, strategy or plan should undergo an integrated impact assessment either in the initial planning stages or at the time of review. Whilst the detail and extent of any IIA should reflect the significance of the policy and the impact in question – there is a gap within the LA IIA process for health although there is an indepth equality section.	**Timescales:** April 2014 April 2014	**Progress:** Cabinet/democratic services to define and authorise amendments to the IIA and the introduction of an EIA.	**Resp Officer:** Cabinet / Democratic Services
6	**Scrutiny Recommendation:** **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 coordinating 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.**			
	Action: As per the Health and Social Care Act 2012 as part of the main functions and duties of the HWBs, NL HWB requires strong engagement across NL communities. It has to maintain and engage the complete but small membership of health and wellbeing service providers included in its membership, in addition to co-opted patient and service user groups, community advocates/groups, and commissioners from other services such as the police/crime commissioners. In tackling health inequalities the HWB needs to be informed by the strength of evidence within its JSA and developing JHWS (a joint responsibility of LA and CCG) through the HWB, so as to inform and drive local commissioning policies and	**Timescales:** Ongoing Ongoing	**Progress:** Appropriate membership established. HWB - MOU	**Resp Officer:** HWB

	practice to address health inequalities. HWB strategic engagement with Healthy Lives, Healthy Futures, in association with the integrational transformational fund. HWB committed to whole system integration with initial focus on three key work strands of frail elderly; conception to age 2; and 13 to 19 year olds.	 Ongoing Ongoing	 DPH member of Clinical Advisory Group. HWB given progress update from HLHF and process for submission of Strategic Plan agreed. Update report to Dec HWB and presentation re frail elderly strand.	
7	**Scrutiny Recommendation:** **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.**			
	Action: An innovative and transformational part hub/part embedded model of Public Health has been established and integrated within LA structures; tying the DPH into a model that functions closely with all council Directors to ensure the health and wellbeing agenda is integral to all LA functions.	**Timescales:** April 2013	**Progress:** Transfer of PH has enabled DPH reporting to CE and embedded PH within directorates; embedding of some PH staff within People and Places is facilitating cross function working. DPH member of PH Transformational Board. PH Transformational Board chaired by leader of the council.	**Resp Officer:** Chief Executive
8	**Scrutiny Recommendation** **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.**			
	Action: Integrated Team priorities include: case management; disease specific care management; supported selfcare; and underpinning health improvement and health promoting activity, which PH can support the development of, to ensure those, particularly in disadvantaged groups and areas are supported to reduce deaths from big killers and support choices about diet, physical activity and lifestyle eg stopping smoking, reducing alcohol use.	**Timescales:** Ongoing	**Progress:** Cabinet approval for review of PH at 6 months. CPHFS locality based. Targeted priority setting within the JHWS.	**Resp Officer:** Chief Executive Director of Public Health