Taking on inequalities in Health and Wellbeing locally
How Health and Wellbeing Boards can lead the way

Hilton Hotel, Neville Street, Leeds
Thursday, 17th January 2013

I attended the above conference and was one of a handful of Councillors from across the region who attended. The majority of attendees were those that worked in or with health. I sat on a table with members of Public Health England, Sheffield Voluntary Sector, members and support for the Sheffield Health and Wellbeing Board.

The speaker for the day was Professor Chris Bentley (www.hinstassociates.com). Yes - just one man - all day! I was sceptical but the day was very informative and Chris Bentley's knowledge of examples all over the country was fascinating. His background is interesting and you can read it here: http://www.hinstassociates.co.uk/associate/associate-6

Too Pink and Fluffy

Chris started off by referring to a recent article where he was described as Health and Wellbeing Boards as being 'too pink and fluffy'. The rest of the day expanded on that point and drawing key lessons about what needs to happen to make a difference to health inequalities. It's not easy; you've got to be hard-nosed about it; but the alternative is the new health and wellbeing boards could just become a talking shop.

Social injustice is killing on a grand scale

We were taken through the Bridging the Gap in a Generation report and then the Marmot Review. As a newcomer to health inequalities these were useful cornerstones to the issue. Some sobering points from the report were

- Life expectancy has shot up since 1970s to 2000s. 5 years has been added, the fastest improvement in human existence.

- However though it has improved for all socio-economic classes, the gap between non-manual and manual workers has not narrowed. Social class still matters more than where you live.

- When you look at the number of years people expect to live in good life, the difference in class is more stark. The most deprived are a long way behind and will require more resources to make a difference.

- The best start in life is important. It is too late to tackle inequalities at school, resources must focus on the first few years of life. Marmot gave a list of interventions which have been developed further.

- Skills development has an effect on health. Employment is positive for health outcomes, but the quality of the employment matters just as much.

- Indirect taxes hit the poorest hardest. Increased tax on fags and booze compound the problem, as people end up spending more of their disposable income on tax. The VAT rise increases inequality.

- The role of government is important in tackling health and social problem. Those that are more redistributive can address inequalities. Scandinavian countries do this post-earnings, Japan does this pre-earnings. This theory is developed further in The Spirit Level.

Miles on the Clock

There was a useful analogy when looking at what you could do about health inequalities. Health inequalities were described to us as miles on the clock; some things like poverty or smoking mean you clock up the miles a lot quicker.

Local authorities have a lot of levers to try and prevent us clocking up those miles. Licensing (the smoking ban has had a positive influence on health outcomes), by-laws, welfare benefits, trading standards and environmental health are examples.

The example of Warrington and the alcohol harm reduction strategy was given. Details in their Joint Strategic Needs Assessment (JSNA) can be found here.

Be bold

Key factors in successful interventions were they were large scale, consistent and long term. Be consistent and bold. There was a danger that commissioning could follow fads and fashions and have a project piecemeal approach.

The most successful programmes delivered to the whole of the population but changed their scale according to the different needs of certain groups. We explored the dangers of Commission Group approaches in leaving gaps which in turn would not deliver the bigger population outcomes needed.

It is complex

Chris Bentley described the new structures and we had an interesting discussion on our table about the different approaches of boards and clinical commissioning groups across Yorkshire. Budgets and power were interesting factors that may upset the proposed balance of the new structures.

Health and Wellbeing boards were diverse; some had brought in policing, housing, leisure and environmental representatives.

Are you driving change or just a talking shop?

There was a real danger that Health and Wellbeing Boards would become a talking shop. An example was given of a board that just meets four times a year. That wouldn't work unless there was a substructure for change.

Boards needed to have sufficient challenge and be asked the questions:

- How are you going to demonstrate the change you've made?
- Who is accountable for that change?

There was a discussion about the buzzwords 'integration' and 'partnership working'. The evidence showed that you still had to have a programme manager accountable, as diffused responsibility did not bring about change.

The support networks for Health and Wellbeing Boards are patchy across the country. In our region there was little support for boards but the Clinical Commissioning Groups did have a support network.

Use your intelligence

We were taken through some worked examples of how Boards had come to their priorities, using statistics coupled with grassroots information. They had used the Slope Index to see where they were an outlier (worse than average). For example, Kent has focused a section of their strategy on a deprived area that had worst outcomes then there should be, as they felt they could make the biggest difference there.

Characteristics of successful boards

Eight points were given to achieve outcomes that need to be addressed by boards.

1. Governance: who is running the show? (a strategic forum or performance driver)
2. Programme Planning : who is accountable (responsible and empowered)
3. Information Governance :sharing intelligence (data flows; communications strategy)
4. Joint Strategic Needs Assessment (bottom-up and top-down)
5. Priority setting: how does it really work? (evidence, ethics, politics)
6. Setting targets : locally relevant and meaningful (measurable, ambitious, do-able)
7. Select interventions : strongly evidence based (offer major contribution to change required)
8. Develop business plan : economic case for change (cost benefit; cost utility; return on investment;)

Christmas Trees

Chris Bentley spent a while explaining where we can intervene to be successful. This is based on his Christmas Tree model. A video explanation can be found here : http://vimeo.com/21023658

A key learning is that the board has to have Partnership, Vision and Strategy, Leadership and Engagement to be successful in the three sides of the Christmas tree - systematic and scaled intervention through services, systematic community engagement and service engagement with the community.

That's the theory what does it look like in practice

This is where the day got exciting, real life of examples of the theory working in practice. The first example was from Doncaster regarding lung cancer. There was problem with people with lung cancer not presenting early enough and therefore there was a higher than normal mortality rate (the data). Through talking to local people (the intelligence) it appeared that people didn't know anyone who had lung cancer, unlike other forms such as breast cancer and didn't know what the symptoms were. There were myths such as only smokers get it, and you've got to be seriously ill probably on oxygen to have lung cancer – an image gleaned from anti-smoking adverts. They therefore undertook a programme systematically and on a large scale to engage with the community about the symptoms and dispelling some of the myths. They also encouraged GPs to do more chest x-rays when people did present, as again the data and intelligence showed Doncaster GPs used them less than average.

They also highlighted the importance of making every contact count. Whoever was dealing with that individual they would raise the issue and refer them if needed. This happened not just in the NHS, but with people outside in social care or housing.

Another key point was that they started with staff first, as they were part of the population.

Partners on Health and Wellbeing Boards – I'll scratch your back if you scratch mine

The benefits to the members of the boards should be clear. An example was between a Housing provider and a Clinical Commissioning Group where an agreement could be sought if the housing provide helped find people they engaged with who had coronary heart disease this year, next year the Clinical Commissioning Group would help the housing provide find people with cold, damp homes next.

Improving consistency and quality of services can have an impact on outcomes

Particularly long terms conditions, looking at the consistency and quality of them can improve outcomes quickly. An example from Wakefield and Bolton was given where there were inconsistencies in the number of patients with diabetes where the blood sugar was under control. Specialists / nurses and GPs sat down together with the the worst patients to look at how they could control the patients blood sugar levels. This up-skilled the GPs and nurses in the management of these conditions and had a big impact on outcomes.

What can you do if you give a pensioner new central heating but they don't use it?

There are four points in the chain where intervention can break down. You could be delivering fantastic interventions giving pensioners new heating systems but if they don't get to the right pensioners, or they are worried about turning them on due to heating costs you are not solving the problem of cold damp housing, even though you make think you are.

The example of Coronary Heart Disease in the UK were given, a disease where 10.2 million people are at risk

5.7 million people have it

↓ **A**

2.6 million people are aware they have it

↓ **B**

2.3 million people are eligible for treatment

↓ **C**

1.3 million people are on treatment

↓ **D**

1 million people are compliant with their treatment

Between each point (A, B, C and D) there is drop off people being successfully treated, and it is at these points that interventions can make a difference and increase on only 1 million people who are getting successful treatment.

Access to Services

My ears pricked up this bit, as we have discussed this as health scrutiny. It looks like it will be easier than I thought as there are easy models to use to carry out a Health Equity Audit.

There are a number of reasons why people do not present to services. Professor Angela Tod at Sheffield Hallam University (http://www.shu.ac.uk/research/hsc/about-us/angela-mary-tod) has identified the main factors.

- Geographical e.g. distance from clinic / practice; complex journey
- User unfriendly service access : frosty; bureaucratic reception; cultural / interpreter problems; perceived discrimination; appointment systems; access delays; opening hours; cost barriers
- Community knowledge, understanding, beliefs and expectation: about condition; about service; about life; stigma.
- Personal beliefs and skills: demotivation; low expectations; low self-confidence; poor literacy; low-IQ etc.

Strategies to address these issues need to explore each of these elements systematically.

Community Engagement

The final part of the day focused on intervention through communities. We explored common pitfalls in community engagement, such as :

- There is no such thing as hard to reach groups – there are individuals and families that don't join groups.

- The voluntary / community sector is diverse. There are big national charities working to contract to one person volunteers.

- The voluntary / community sector does not equate to a free option.

- Interventions that involve communities bidding favour those communities that have established infrastructure, which does not necessarily equate to need.

Depending on the structures in communities there is a hierarchy of engagement from Information to Devolved Power. (See Arnstein's Ladder of Engagement : http://www.rkpartnership.co.uk/documents/Arnstein%27s%20Ladder.pdf)

The Sound of Silence

There was brief discussion about Health and Wellbeing Boards and community engagement. For those in local authorities these will sound familiar, that small groups with personal experience are often more vocal than the silent majority. We shouldn't underestimate what that silence tells us, and resources should be spent equally, not just on those who oppose decisions.

It is going to b e be difficult for boards, they will have difficult decisions to make, but it is important to engage people in helping them understand the reasons for those decisions.

Summary
Well, I didn't expect this report back to go onto seven pages, but I think it's testament to the quality and relevance of the day. I have been able to retain a lot of information and it is useful for not just looking at health inequalities but challenges in other council services too.

It is easier to focus on the service, and it's easy to fall in the trap of thinking if we are delivering the service all right, everything is resolved. It is much harder to look at changes in outcomes, and questioning access to the service, how it works, it's quality and consistency, but it is this approach that will deliver the change needed.

This reinforces the need for robust challenge within the Health and Wellbeing Board and brings us back to the opening quote – there is danger that they could become 'too pink and fluffy'.

It also shows the need for good health scrutiny and the committee needs to focus on the impact the new infrastructure is having on health inequality outcomes.

The challenge is huge in Rotherham and interventions will be need to be on an industrial scale across the population to make a difference to outcomes. The responses to the consultation on health inequalities sums up the challenges very well: http://www.rotherham.gov.uk/download/6766/health_inequalities_consultation

Points for Consideration

- The Health Scrutiny Committee should continually scrutinise the impact of the Health and Wellbeing Board on outcomes in the Health and Wellbeing Strategy
- The Health Scrutiny Committee uses the research on access to services by Prof. Angela Todd as a basis for it's spotlight review on access to health services.
- Deprivation plays a major role in health outcomes. Health Scrutiny should be included in reviews that look at poverty and deprivation.
- From April 2013 all commissioners and providers of publicly funded healthcare and social care will be covered by health scrutiny. RMBC needs to make sure it's level of resourcing for health scrutiny can meet this increase in responsibility.
- It is in the council's interest to reduce health inequalities as there are intrinsic links with demand on other services.
- By considering in the gaps in interventions (A,B,C,D), health scrutiny could help find savings for local authority public health spending.
- The relationships between the Heath and Wellbeing Board, Health Scrutiny and Healthwatch will be important.

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