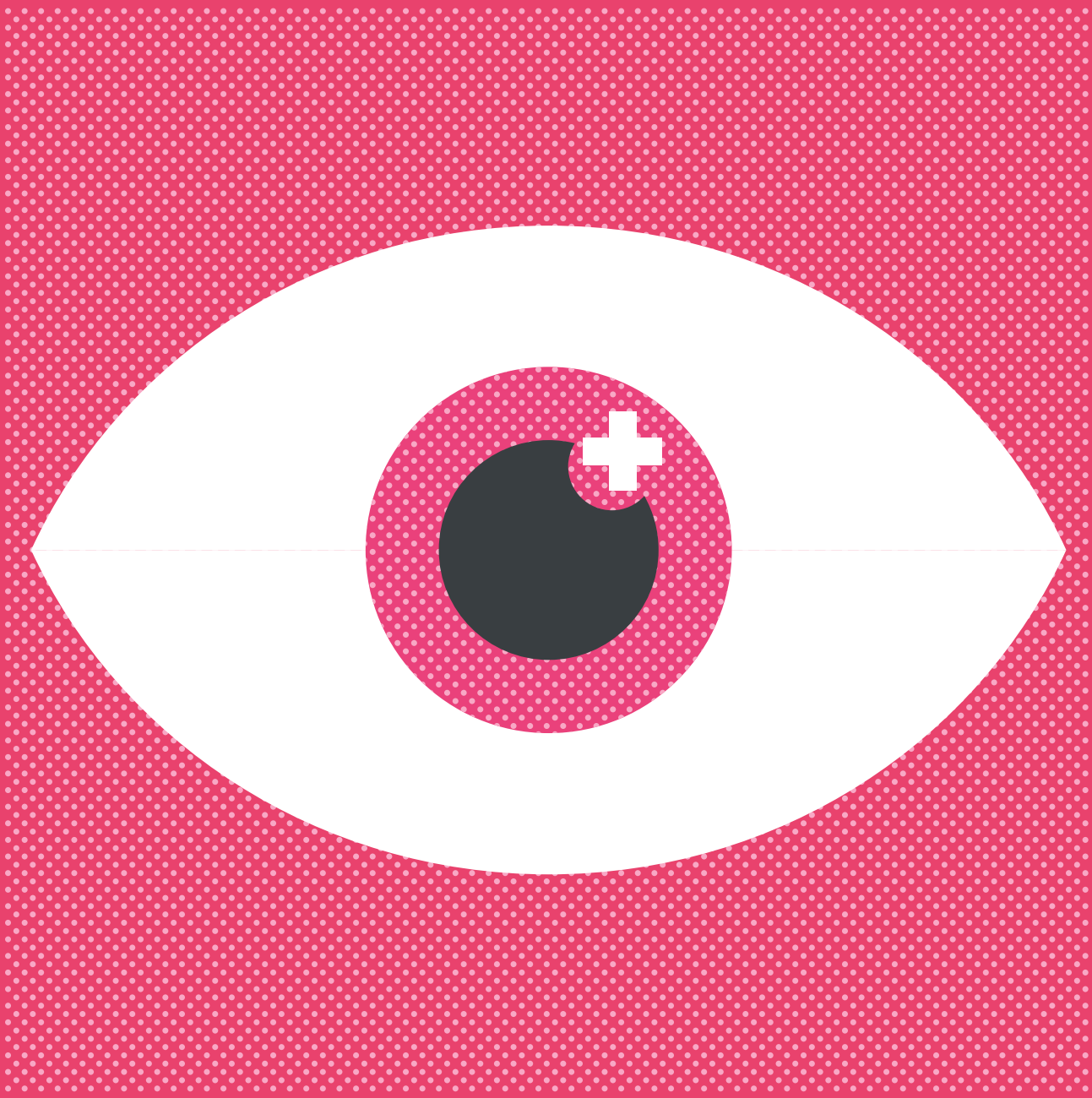
MAYOR OF LONDON

Tackling Health Inequalities

An overview of health inequalities and the role of scrutiny



CfGS Centre for Governance and Scrutiny

Cavill Associates public health consultancy

Progress HEALTH PARTNERSHIPS

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An overview of health inequalities and the role of scrutiny

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This document provides detailed background information on key principles underpinning policy on health inequalities, and the way in which councillors with scrutiny responsibilities can support the development and refinement of those policies.

It was produced in consultation with members of scrutiny committees, and the officers who support them, across London. They requested a briefing document on health inequalities to help in their work.

It should be read in conjunction with the accompanying 'Tackling health inequalities: questions for London scrutiny committees' to ask when they are considering health inequalities.

INTRODUCTION

What's this resource all about?

This resource provides a high-level overview of some of the key principles underpinning policy on health inequalities, and the way in which councillors with scrutiny responsibilities can support the development and refinement of those policies. It focuses particularly on the unique context to this issue in London – where population shifts and deprivation, as well as the uncertain impact of the COVID-19 pandemic make action in this area especially important.

It describes the health inequalities prevalent in the UK and London today; discusses their multiple causes; explains the importance of tackling health inequalities; and gives guidance to scrutiny committees on sources of information and lines of enquiry. This resource sets out the issues that elected council members may wish to consider in relation to how health inequalities are being addressed within their own council areas and aims to help elected members pose questions they may want to ask to seek assurance about local activities and progress. It contains lots of references and signposts to additional information.

Health inequalities, along with their causes and consequences, are an element of wider inequalities brought about by structural and systemic injustices in society. This needs to be the foundation for any action on scrutiny of health inequalities. It is also important to understand that the culture, background and experiences of local people, local communities, professional policymakers and elected councillors can influence how the associated economic, social and cultural factors of health inequalities can be tackled. This engages closely with how we interpret our collective responsibilities under the Equality Act to support, protect and empower those with protected characteristics. It also has broader implications around the work that elected councillors can do to challenge their own perspectives, and the perspectives of professionals, by empowering the voices of their communities and those who might otherwise be ignored or side-lined.

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This resource focuses on health, but it is relevant to all scrutiny committees

The Mayor of London published his pan-London Health Inequalities Strategy[1] in September 2018 – one of his statutory responsibilities. The strategy highlights the stark inequalities that exist across the capital, and the importance of ensuring that London is a healthier, fairer city, where nobody's health suffers because of who they are, or where they live. It outlines a series of evidence-based aims and objectives, that we can all work towards together to make a difference. This is built upon in a series of stakeholder guides[2].

1. https://www.london.gov.uk/sites/default/files/health_strategy_2018_low_res_fa1.pdf
2. https://www.london.gov.uk/what-we-do/health/london-health-inequalities-strategy/stakeholder-guides

Mayor's London Health Inequalities Strategy: Aims for London and key areas for mayoral action

Aim 1

Healthy Children: Every London child as a healthy start in life

Ensuring the widespread adoption of The Healthy Early Years Programme London, particularly in the most deprived communities.

Aim 2

Healthy Minds: All Londoners share in a city with the best mental health in the world

More Londoners to be trained in mental health first aid informed approaches, starting with young Londoners.

Aim 3

Healthy Places: All Londoners benefit from an environment and economy that promotes good mental and physical health

For London to have the best air quality of any major global city.

Aim 4

Healthy communities: London's diverse communities are healthy and thriving

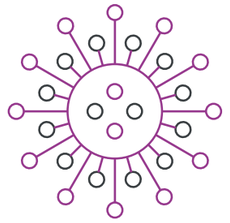
Support more Londoners in vulnerable or deprived communities to benefit from social prescribing.

Aim 5

Healthy living: the healthy choice is the easy choice for all Londoners

Londoners are doing the physical activity they need on a daily basis to stay healthy, with efforts focused on supporting the most inactive.

Why should you care? Inequalities, and the importance for local authorities



COVID-19

During 2020/21, the COVID-19 pandemic highlighted the stark health inequalities in the UK. Data from Public Health England showed that the impact of COVID-19 has replicated and deepened existing health inequalities. The risk of dying among those diagnosed with COVID-19 is higher in people living in the more deprived areas than those living in the least deprived; and higher in those in Black, Asian and Minority Ethnic (BAME) groups than in White ethnic groups[3]. This is an indicator of the inequalities that have existed for many years across all aspects of health, brought into focus by the global pandemic.

London has been hard hit by the COVID-19 pandemic. Evidence is constantly being updated, but a number of important data sources are shown here:

How coronavirus has had an impact across London

- A May 2020 study from King's College London on the initial phases of the pandemic: > **Click to view**
- A May 2020 publication from the Health Foundation on wider health inequalities relating to the pandemic: > **Click to view**
- Health Foundation inquiry into the pandemic: > **Click to view**
- A July 2020 summary of a study from City University and others on the mental health impacts of the pandemic: > **Click to view**
- A June 2020 study on unequal impacts of the pandemic from the Institute for Fiscal Studies: > **Click to view**
- An August 2020 study by Camden Council on local inequalities and how they have been exacerbated by the pandemic: > **Click to view**

3. Public Health England. 2020. Disparities in the risk and outcomes of COVID-19. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment data/file/892085/disparities_review.pdf

How coronavirus has had an impact across London

- Build Back Fairer: The COVID-19 Marmot Review. › **Click to view**
- GLA Rapid Evidence Review - Inequalities in relation to COVID-19 and their effects on London. › **Click to view**
- Wider impacts of the COVID-19 pandemic and recovery of population health outcomes for London › **Click to view**
- New Policy Institute. People and places in London most vulnerable to COVID-19 and its social and economic consequences. › **Click to view**

Covid-19 will continue to frame public policy for many years, even after the immediate threat of infection or to life recedes, and many parts of our lives return to some sense of normality. Treatment delays owing to pressures on the NHS, long-term physical and mental health implications caused by COVID-19, and the social and economic impacts of many months of isolation, inconsistent childcare, reduced access to education, housing and lost and precarious employment and other challenges will cast long shadows, each with significant implications for health and inequalities.

> **"As the UK emerges from the COVID-19 pandemic 'Build Back Better' has become the mantra. Important, but we need to Build Back Fairer. The levels of social, environmental and economic inequality in society are damaging health and wellbeing."**
>
> **Build Back Fairer:** the COVID-19 Marmot Review

Demographic shifts

Understanding the impacts of inequality requires understanding of local demographics. At the point in the census cycle at which this report has been written, this can be a challenge. Confirmed census data is nearly a decade out of date, with new data from the 2021 Census (due to take place on March 21, 2021) only coming on-stream in 2022 or 2023.

Demographic information is available from the GLA's London Datastore: › **Click to view**. Individual councils have their own local data sources.

A useful overview of general demographic change can be found on the Centre for London website: › **Click to view** (from 2018).

London's public health structures

Public health is led by the Directors of Public Health in the 32 London boroughs. Coordination on London-wide activity is carried out via London Councils and the Association of Directors of Public Health London.

Boroughs individually and collectively commission a range of community and secondary health services following a range of footprints (for example, mental health services follow a different footprint to that occupied by Clinical Commissioning Groups (CCGs) or Primary Care Networks PCNs). This includes joint commissioning activity with local NHS bodies.

Five STP areas exist in London, and plans are proceeding for the development of integrated care systems (ICS) across these areas.

The London Health Board, chaired by the Mayor of London, is currently leading on cross-capital collaboration (on health inequalities, amongst other things) and has a sub-group focused on equity.

The political nature of inequality

Inequality is a political issue. It is about structures and systems established over many decades which explicitly and implicitly disadvantage some over others because of biases (often unconscious) held by policymakers. Tackling these issues is complex and requires reflection and insight, especially among elected members. Elected councillors have a unique perspective on the needs of local people, whilst bringing their own political and personal viewpoints on these issues into the discussion. Meaningful member discussion will need to start with an exploration of these structural characteristics and how councillors' personal understanding of communities, their needs and the barriers that they face may need to be considered in order for holistic plans to be developed.

Some of the characteristics of structural inequality include:

- Pay gaps based on gender and race. This can be as a result of structural racism or sex discrimination. But more subtly it can be due to organisations tending to appoint and promote people to senior positions with few or no childcare responsibilities and with mastery of professional behaviours which are more likely to reflect white people's education and life experiences;
- A lack of understanding among decision-makers about the value of time – i.e. in the ability of service providers and commissioners to engage with service users in a certain way, in certain places, and at times which might be convenient for professionals, but not for their communities;
- Services or ways of working which discriminate against people with specific access needs – not just physical access, although even that is a challenge in some places, but also access for disabled people with other complex needs;

- The precarious nature of many people's lives and an inability for service designers to think about how this influences how people engage with services. People with unstable accommodation or employment, or other complexity in their lives, will be unable to engage with traditional engagement activities. People experiencing such precarious conditions are disproportionately likely to come from a group, or groups, with a protected characteristic.

Through awareness of these characteristics, members can also challenge the presence of institutional barriers in councils, health bodies and other organisations – which inadvertently bolster the inequality which they aim to attempt to resolve.

While scrutiny cannot itself bring about a sea change, it can surface unspoken assumptions amongst policymakers.

These issues can be difficult for officers to address. In some places, policymaking and "management" of health inequalities fails to take account of these broader political factors, with traditional policy levers and interventions being used to tackle some of the most obvious consequences of health inequalities without tackling their root cause.

While scrutiny cannot itself bring about a sea change in the way that the causes of health inequalities are understood, it can surface unspoken assumptions amongst policymakers and others about what those causes are and how we can shift our approach from tackling consequences to building a society where the causes are addressed.

Without this political direction, and broader organisational commitment to a structural and cultural shift in how this issue is tackled, it is likely that health inequalities will continue to rise notwithstanding increased attention and resources – as the last decade has shown[4].

4. Michael Marmot, Jessica Allen, Tammy Boyce, Peter Goldblatt, Joana Morrison (2020) Health equity in England: The Marmot Review 10 years on. London: Institute of Health Equity.

Definition of health inequalities

Health inequalities are defined as 'avoidable, unfair and systematic differences in health between different groups of people'[5] The Marmot review of Health Equity in England said that putting health inequalities right is a matter of social justice[6].

What causes health inequalities?

Health inequalities are caused by a complex mix of societal; environmental and individual influences. These are known as wider determinants of health[7].

THE CAUSES OF HEALTH INEQUALITIES

London has stark health inequalities. Health inequalities are caused by a complex mix of societal, environmental and individual influences.

Fundamental causes

Macro-level influences include:

- Economic forces
- Socio-political environment
- Political priorities and decisions
- Societal values to equity and fairness

These in turn influence key aspects of society:

- Income
- Wealth
- Power
- Poverty
- Marginalisation and discrimination

Wider environmental influences

The fundamental causes influence the distribution of wider environmental influences on health and access to services and wider society.

- Access to employment
- Access to green space and the natural environment
- Air quality
- Housing quality
- Fuel Poverty
- Transport
- Access to learning (quality of early years education, schools, further education and lifelong learning)
- Spatial and community planning
- Access to services and commodities
- Social and cultural capital

Individual experience

- The wider environmental influences impact on individual experiences at multiple lvels. This is where health inequalities are exposed:
- Employment status, quality and security of employment, access to a living wage, receipt of benefits
- Living conditions, housing tenure, quality and location of housing, fuel poverty
- Community conditions, safe communities, access to green space, access to transport, community cohesion / connectedness
- Educational attainment: starting with access to quality early education, school readiness, literacy and numeracy, qualifications and access to training
- Access to services: healthcare, social care, voluntary and public sector services
- Exposure to lifestyle risk factors, diet, tobacco, physical activity, drugs and alcohol

Effects

Living in an unequal society in turn leads to inqualities in

- Wellbeing
- Healthy life expectancy
- Morbidity
- Mortality

Inequalities | **Health Inequalities**

Upstream → **Downstream**

Adapted from a diagram from Health Scotland

It is not simply about improving access to health and other services; it is about tackling the fundamental inequalities that exist in society.

Tackling both the causes and consequences of health inequalities therefore requires a complex mix of approaches and interventions. It is not simply about improving access to health and other services; it is about tackling the fundamental inequalities that exist in society. In local authorities this needs strong and effective leadership, ideally with a designated leader for inequalities; elected member champion and an executive management team lead for inequalities who will provide focus and leadership. It requires mainstreaming an understanding of inequalities into day-to-day work and an understanding by politicians and others about what levers they have at their disposal to tackle the issue. As we noted above, these levers are as much about bringing about cultural change in how organisations (especially councils) consider these issues, as structural, operational interventions on things such as obesity, sexual health and so on.

What can be done? What works to reduce health inequalities?

Many of the causes of health inequality lie outside the control of the individual. Poorly-designed public health campaigns designed to tackle the consequences of health inequalities can be oppressive, because they push responsibility for tackling these systemic problems onto individuals (and communities) – increasing stigma and perpetuating inequalities and injustice. Addressing health inequalities requires local authorities and their partners to understand the fundamental and wider causes of health inequality, compelling them to take responsibility for their role in perpetuating such inequalities and altering and removing the power structures which support them[5].

An understanding of the impact of a variety of public sector activities on health inequalities will already exist within councils but scrutiny can use its powers to go deeper. It can look at power structures, who decision-makers and policy-makers are, and how information is used to support policy-making. It can look at the extent to which policy-makers hold the questionable view that they are able to interpret evidence "objectively" in the interests of developing policy.

5. The Kings Fund. 2020. What are health inequalities? https://www.kingsfund.org.uk/topics/health-inequalities

6. Michael Marmot, Jessica Allen, Tammy Boyce, Peter Goldblatt, Joana Morrison (2020) Health equity in England: The Marmot Review 10 years on. London: Institute of Health Equity.

7. Health Scotland. Reducing Health Inequalities. 2015. (page 26) http://www.healthscotland.scot/media/1182/reducing-health-inequalities-aug-2015.pdf

A wide range of local authority policies and practices affect health, for example:

- **transport and active travel policies.** For example, a scrutiny committee might look at how active travel policies (in particular those put in place as a result of the pandemic) might be designed in a way that does not engage with people with complex health needs;
- **availability of good quality green spaces** (and the design of public spaces and infrastructure more generally). For example, scrutiny might look at how an understanding of health needs and outcomes are built into local standards, and into planning documents to guide developers in the design of public spaces;
- **wider leisure policy.** For example, scrutiny might look at how certain concessionary services for certain groups of individuals might be set out in leisure contracts;
- **healthy local food environments.** For example, scrutiny investigations looking at local development, licensing or strategic planning (or education) might engage with the issue of how the council understands the availability and pricing of healthy food in different parts of the borough;
- **the housing market.** For example, oversight of the private sector market or energy efficiency. Review of things such as private sector landlord licensing – or of renewal of social housing stock – could look at how housing can impact on inequalities;
- **social housing access and affordability.** For example, scrutiny might look at how local people's circumstances might make it more difficult for them to access the housing options service, and how housing options generally might be constrained by individual experiences of inequality or inequality across an area – as well as looking at how such issues impact on people's use of more informal housing swaps;

- **reduction of fuel poverty.** For example, scrutiny might look at how people living in conditions of deprivation might be disproportionately more likely to have prepay meters, or how low income arising from long-term conditions and only partially alleviated by PIP and DLA heightens existing risks;
- **planning policy.** For example, scrutiny can look at the extent to which health inequalities are mainstreamed in development plan documents; scrutiny can also look at the assumptions and issues underpinning master planning, and the extent to which wholesale redevelopment might disadvantage existing residents whose specific needs may not be met by that activity.

An overriding policy issue is the extent to which local people (and particularly those who may be pejoratively identified as "vulnerable", "marginalised" or "hard to reach") are directly involved in policy-making through participative or deliberative methods such as co-production. The logic should lie in shifting professionals' understanding of local people from passive or pliant "clients" who should be "consulted" on changes, to being partners in the exercise of power.

"Health in all policies": an international approach to centring health equity in the policymaking process

Health in All Policies (HiAP) is an approach which takes a broad-spectrum view on the health implications of a range of decisions. It draws on and reflects Marmot principles in identifying and capitalising on the links between health and prevention, and policy on connected matters.

The Local Government Association produced a HiAP resource pack in 2016: **> Click to view**

Scrutiny can seek to understand the extent to which health considerations are – or should be – treated as critical to policymaking more generally.

A key concept championed in the Marmot report is 'Proportionate Universalism'. This is an approach that balances targeted and universal population health perspectives through action proportionate to needs and levels of disadvantage in a population. It requires tough decisions about allocating resources in all areas in proportion to need, but it can address the burden of disease across a number of determinants of health to narrow the gap in health inequality.

Key resources from the Marmot review

- The Health Foundation and Institute of Health Equity commissioned a "10 years on" review of the Marmot Report from Michael Marmot himself. It was published in February 2020: > **Click to view**
- Slide deck summarising "10 years on" findings: > **Click to view**
- Presentations from an LGA webinar in June 2020 on the Marmot principles, health inequalities and the impact of the pandemic: > **Click to view**
- LGA councillor workbook published in August 2020 on "health in all policies", focusing on health equity and the pandemic response: > **Click to view**
- Other resources produced by the LGA on social determinants of health: > **Click to view**
- In December 2020 'Build back fairer: The COVID-19 Marmot review' was published. Produced by the Institute of Health Equity and commissioned by the Health Foundation as part of its COVID-19 impact inquiry to investigate how the pandemic has affected health inequalities in England > **Click to view**

The role of scrutiny committees in addressing health inequalities

The reduction of health inequalities has been an important component of public service policy and delivery for over a decade and yet nationally they have continued to increase[6]. Making change requires a concerted effort and for action to be taken nationally, regionally and locally.

The impact of policies on reducing health inequalities should be considered by all scrutiny committees (not just health and social care) as a standard part of the work planning process.

The structural complexity of health inequalities make scrutiny an ideal space for its investigation. Scrutiny is uniquely able to investigate complicated cross-cutting issues and has the powers to do so.

More information on scrutiny's statutory powers can be found in:

- "Pulling it together" (CfGS, 2018): › **Click to view**
- "The good scrutiny guide" (CfGS, 2019): › **Click to view**
- Statutory guidance on overview and scrutiny (HMG, 2019): › **Click to view**

The impact of policies on reducing health inequalities should be considered by all scrutiny committees not just health as a standard part of the work planning process. Other steps should also be taken to mainstream an understanding of equality in all committees' work more generally.

The role of Health and Wellbeing Boards in addressing health inequalities

Health and Wellbeing Boards (HWBs) are a statutory forum where political, clinical, professional and community leaders from across the local health and care system come together to improve the health and wellbeing of their local population and reduce health inequalities[8]. All 32 London Boroughs have their own HWB[9]. Examples of good practice by HWBs to address health inequalities include[10]:

- working with Directors of Public Health to undertake analysis of the main drivers of inequalities in health outcomes and access in an area
- developing integrated plans to reduce health inequalities
- developing plans which incorporate the principles of system, scale and sustainability – and specific actions from all partners to address the wider determinants of health

8. https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/health-and-wellbeing-systems

9. https://www.londoncouncils.gov.uk/our-key-themes/health-and-social-care/health-and-wellbeing-boards

10. NHS England. Place based approach to work on health inequalities https://www.england.nhs.uk/wp-content/uploads/2019/11/EDC03-Place-Based-Approach-Health-Inequalities.pdf

- ensuring plans include locally agreed short, medium and longer-term targets to reduce health inequalities
- engaging with Voluntary, Community and Social Enterprise (VCSE) sector and local residents to ensure actions build connected and empowered communities
- ensuring local communities, community and voluntary sector organisations and statutory services work together to plan, design, develop, deliver and evaluate health and wellbeing initiatives

Each borough's Director of Public Health (DPH) is obliged to produce an annual report summarising their priorities and progress for the year (See Appendix One). These can be used as a springboard for further study of any issues arising from that report which relate to health inequalities. For example: following the publication of the annual report, the DPH could have an informal meeting with the relevant scrutiny chair to talk through the report and seek to agree on any areas of concern which councillors could pick up to discuss in more detail in committee. After deciding on an issue, the DPH and chair could agree on further information to circulate to members to help plan for a public session to explore key pressures around health inequalities, potentially with a range of external witnesses and stakeholders. Such a session might benefit from a preparation meeting with committee members. Scrutiny functions can also proactively contact their DPH as part of their annual work programme planning process, to understand which areas of local health outcomes are especially affected by inequality.

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Health inequalities: place-based approaches to reduce inequalities – Guidelines to support local action on health inequalities.
› Click to view

Examples of scrutiny on health inequalities in London

- Brent Breathes: air quality scrutiny inquiry, 2019: **› Click to view**
- Southwark Council: reducing health inequalities inquiry: 2019: **› Click to view**
- Camden Council – Learning from Camden's Bangladeshi community to drive improvements in their health and wellbeing **› Click to view**

The mindset that policymakers in these different fields use to interpret their duties and responsibilities, and how they personally engage with the concept of structural inequality in their work, will be a particular focus for scrutiny. Do professionals in highways infrastructure, for example, understand the public health and equalities implications of their work? How would such an understanding influence how they direct and prioritise their work?

It is important to ensure that the local authority workforce know and understand the causes of health inequalities and are motivated to see it as part of everyone's role to address them. This includes not only staff who directly deliver services, but also – perhaps especially – those who have strategic leadership, planning and governance roles.

For example, a scrutiny committee or panel reviewing the following year's budget could press the chief finance officer, Chief Executive or Leader on how health inequalities have been considered in understanding the impacts of certain savings proposals, and how certain savings might have disproportionate impacts on those who suffer from deprivation in particular areas. Members could consider the ward-by-ward impact of those decisions based on indices of deprivation[11].

11. https://data.london.gov.uk/dataset/indices-of-deprivation

Training should also cover how to use tools such as health needs assessment, health equity audit and health impact assessment appropriately in strategic planning and operational delivery. This should consider how the local authority is conducting statutory Equality Impact Assessments (EqIAs). Do they consider an appropriate range of policies and services? Is health adequately covered?

For example, a scrutiny committee could use equalities impact assessments to decide what forthcoming decisions or other issues could be escalated for detailed discussion in committee. Looking at the Forward Plan and having advance access to EqIAs, members might decide to focus their efforts on those matters where the equalities impact is thought to be negative – or where members feel that an EqIA is of poor quality and hence requires further investigation.

It is also important to consider the extent to which effective engagement systems are in place to listen, understand and respond to issues highlighted by the voluntary sector and local communities and that barriers to community participation are removed. Good scrutiny is based on strong local knowledge, rooted in effective community consultation.

> **"Using scrutiny can bring an added dimension when trying to understand the complexities of health inequalities – something that can enhance what professionals are already trying to do."**
>
> **Centre for Public Scrutiny:** Peeling the Onion

Further resources on co-production and deliberation

Summary of co-production in the context of social care (but relevant to co-production and co-design of services in relation to health inequalities): **Click to view**

Some examples of co-production in the field of social care can be found at **Click to view**

Planned poorly, co-production can cement inequality. It can privilege the articulate, and those with the time and ability to engage with professionals. It can also privilege gatekeepers – people seen to "represent" those otherwise without a voice. Design therefore needs to be inclusive.

See also:

- Lwembe S, Green SA, Chigwende J, Ojwang T, Dennis R. Co-production as an approach to developing stakeholder partnerships to reduce mental health inequalities: an evaluation of a pilot service. Prim Health Care Res Dev. 2017;18(1):14-23 **Click to view**
- Rocco Palumbo & Rosalba Manna (2018) What if things go wrong in co-producing health services? Exploring the implementation problems of health care co-production, Policy and Society, 37:3, 368-385 **Click to view**
- Schlappa, H., Yasmin, I. & Tatsuya, N. (2020). Relational leadership: An analytical lens for the exploration of co-production. in: Loeffler, E. and T. Bovaird (Eds.). The Palgrave Handbook on Co-Production of Public Services and Outcomes. London: Palgrave Macmillan (forthcoming).

Centre for Governance and Scrutiny

In the aftermath of the results of the initial 2010 Marmot inquiry, the Centre for Governance and Scrutiny (then Centre for Public Scrutiny) carried out significant practical research on health inequalities, culminating in the delivery of a national support programme. This activity ran between 2011 and 2014. This work programme recognised the key role scrutiny can play and led to a range of useful resources shown below:

- "Peeling the onion" (2011). 13.5% of councils in England were involved in this comprehensive support exercise for local scrutiny of health inequalities, funded by the NHS; **Click to view**
- "Tipping the scales" (2012). This work looked at the return on investment of scrutiny work with a particular focus on scrutiny work engaging with the Marmot outcomes; **Click to view**
- "Getting wiser about growing older" (2012). This work drew on the experience of a large number of English councils carrying out scrutiny of older people's wellbeing; **Click to view**
- "Valuing inclusion" (2013). Further practical research with six council areas on scrutiny and health inequalities; **Click to view**
- "Men behaving badly: 10 questions council scrutiny can ask about men's health" (2015) **Click to view**

Blueprint for scoping reviews

The word 'scoping' is used to describe the planning or designing of a scrutiny review. The process of scoping involves councillors working together to establish what matters in a scrutiny review, what the review will look at and what methods will be used.

1. Listening to local people

Scoping begins with listening. What are the experiences of local people, as articulated by local people themselves? These experiences may be different to those expected by professionals. Insights can be gleaned from:

- Councillor door-knocking, and councillor surgeries;
- Campaigns and activism from local groups;
- Reference panels established by local NHS bodies, and local Healthwatch.

Experiences can be about:

- Equity in access to the health system and social support;
- Equity in treatment, and the ability to lead in treatment decision; Equity in the way that services are, overall, designed and delivered to meet local people's needs.

The terms 'equity' and 'equality' are sometimes confused but are not interchangeable. Global Health Europe says 'inequity refers to unfair, avoidable differences arising from poor governance, corruption or cultural exclusion while inequality simply refers to the uneven distribution of health or health resources as a result of genetic or other factors or the lack of resources'.[7]

2. Working with local people to establish a scope and a way of working

Will your review be a traditional task and finish review – or will you seek to involve local people as active participants? What might this mean for the way that you decide to work?

All sorts of methods and mechanisms exist to carry out scrutiny reviews in ways that empower local people – but councillors and others within the authority might be wary of approaches that could be seen as taking power away from elected representatives. While co-opting people on to a committee might be one option, other approaches include those where councillors support local people to co-produce (see co-production box above) solutions to complex problems, or take part as equals in a deliberative process to reach a consensus view on a contentious matter.

Tackling this issue means addressing the unconscious biases which may drive how councillors and officers work. Councillors usually live in-borough, but officers (including scrutiny and democratic services officers) may not. How can those officers help to design a process which is inclusive, and which requires acute local knowledge? When and where should power be ceded to local people, to drive the scrutiny process?

3. Understanding the challenge: hearing stories and reviewing data

Once a general scope has been set, scrutiny (and local people) can begin to dig into the issues in more detail. This could start with an exploration of the local authorities Joint Strategic Needs Assessment (JSNA) that looks at the current and future health and care needs of local populations. The JSNA is concerned with wider social factors that have an impact on people's health and wellbeing, such as housing, poverty and employment. It looks at the health of the population, with a focus on behaviours which affect health such as smoking, diet and exercise, provides a common view of health and care needs for the local community and importantly identifies health inequalities

Some of these issues may include:

- Transience: the experience of people who move frequently, between boroughs;
- Language, community and ethnicity: whether the NHS, councils and other professionals truly understand how local people exist as part of communities, which may reflect ethnic or religious background, and how those communities may aid, or hinder, access to healthcare and the adoption of healthy lifestyles;
- Vulnerability: the experiences of those whose characteristics – disability (mental or physical), sexuality, gender – might make them especially isolated, and it particularly difficult for their needs to be met;
- Pathways between professionals and through care: understanding the journeys that people take to get support for themselves.

On the basis of this very granular understanding of local needs, councillors can reflect on structural inequality itself – and consider how the council and other bodies can work differently to dismantle barriers that might exist relating to this inequality.

4. Developing findings, and recommendations

Co-production, supported by deliberation, can be a powerful way for scrutiny to develop high quality findings. Councillors and local people can work together, to talk through and agree a set of recommendations which make sense for them. This may be more resource intensive but is more likely to lead to results which will make an impact.

This is likely to highlight opportunities that go beyond the committing of additional resources, to the redesign of services.

Some of the practical solutions set out in “Peeling the onion” and associated CfGS publications are likely to remain relevant.

Conclusions

In outlining the importance of addressing health inequalities within your local communities, highlighted by the current COVID-19 pandemic, it is clear that local authority scrutiny committees need to consider the impact of local policy and action on widening or narrowing the inequalities gap.

This work can not be carried out in isolation and must engage local communities and the voluntary sector alongside public sector specialists. There is a wealth of resources and case studies, highlighted with this document, that can be used to inform the actions of members and scrutiny officers. The accompanying document 'Tackling health inequalities: questions for scrutiny committees' can be used by committees when considering health inequalities.

Appendix one: sources of evidence and data

There is lots of information out there and the situation is complex; try not to get overwhelmed. Speak to your Director of Public Health to get a full sense of the information available, to request a data briefing, or to refine your approach.

The content of a "model" briefing paper on health inequalities will vary from council to council. Councillors may want a strategic, overarching view on the issue – or how the issue affects a particular group of people or geographical area. Whichever is the case, it should:

- Embrace proactive consultation with the communities affected and utilise this consultation to inform every step of the scrutiny response
- Reflect a clear sense from councillors about exactly what they are looking for and why;

- Reflects an understanding of the nature of health inequalities and applies that understanding to the specific demographic circumstances of the borough;
- Draw on both general local data (see below) and specific user experiences to set out a narrative of inequalities and their impacts;
- Sets out the practical measures that the DPH, and other partners, are seeking to take to address the issues – including timescales and where responsibilities lie;
- Invites discussion and commentary from councillors about the unique perspective and insight which they, as elected representatives, can bring to the issue.

Local data on issues influencing health inequalities may be available from:

- **Local public health reports, including ad hoc subject reports**
- **The Joint Strategic Needs Assessment (JSNA) for your area**
- **Locality profiles[12]**
- **Data from the Office of National Statistics, including census data[13]**
- **Public Health England - Public Health Profiles, aka Fingertips[14]**
- **Data from Primary Care Networks[15]**
- **The local Clinical Commissioning Group[16]**
- **NHS Right Care data packs[17]**

12. https://data.gov.uk/
13. https://www.ons.gov.uk/census
14. https://fingertips.phe.org.uk/
15. https://www.kingsfund.org.uk/publications/primary-care-networks-explained
16. https://digital.nhs.uk/data-and-information/publications/ci-hub/ccg-outcomes-indicator-set
17. https://www.england.nhs.uk/rightcare/products/ccg-data-packs/

Appendix two – case study

Below is an example of a simple tool devised and used by Camden Council in their scrutiny implementation of the Healthy Streets Approach[18]. For each of the criteria for Healthy Streets (rows labelled 1–10) they asked themselves some key questions, focusing on the views of local people. This approach can be applied directly to scrutiny on health inequalities.

Panel findings and judgements (from Cllr Alison Kelly, Camden)

Topic / key lines of enquiry:	Local people and organisations told us	Our interim findings and judgements are:	Camden cabinet members and officers told us:	Our findings and judgements are:	Our recommendations are:
1. People choose to walk, cycle and use public transport					
2. People feel safe					
3. Pedestrians from all walks of life					
4. People feel relaxed					
5. Places to stop and rest					
6. Not too noisy					
7. Shade and shelter					
8. Things to see and do					
9. Easy to cross					
10. Clean air					

18. https://www.london-councils.gov.uk/our-key-themes/transport/healthy-streets

Appendix three – glossary of terms

Inequality
Uneven distribution of health or health resources as a result of genetic or other factors or the lack of resources

Health inequality
Avoidable, unfair and systematic differences in health between different groups of people

Inequity
Unfair, avoidable differences arising from poor governance, corruption or cultural exclusion

Wider determinants of health
A diverse range of social, economic and environmental factors which impact on people's health.

Proportionate Universalism
An approach that balances targeted and universal population health perspectives through action proportionate to needs and levels of disadvantage in a population

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