ISLINGTON

Public Health
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Report of: Director of Public Health

Health and Wellbeing Board	**Date: 24/09/2020**	**Ward(s): ALL**

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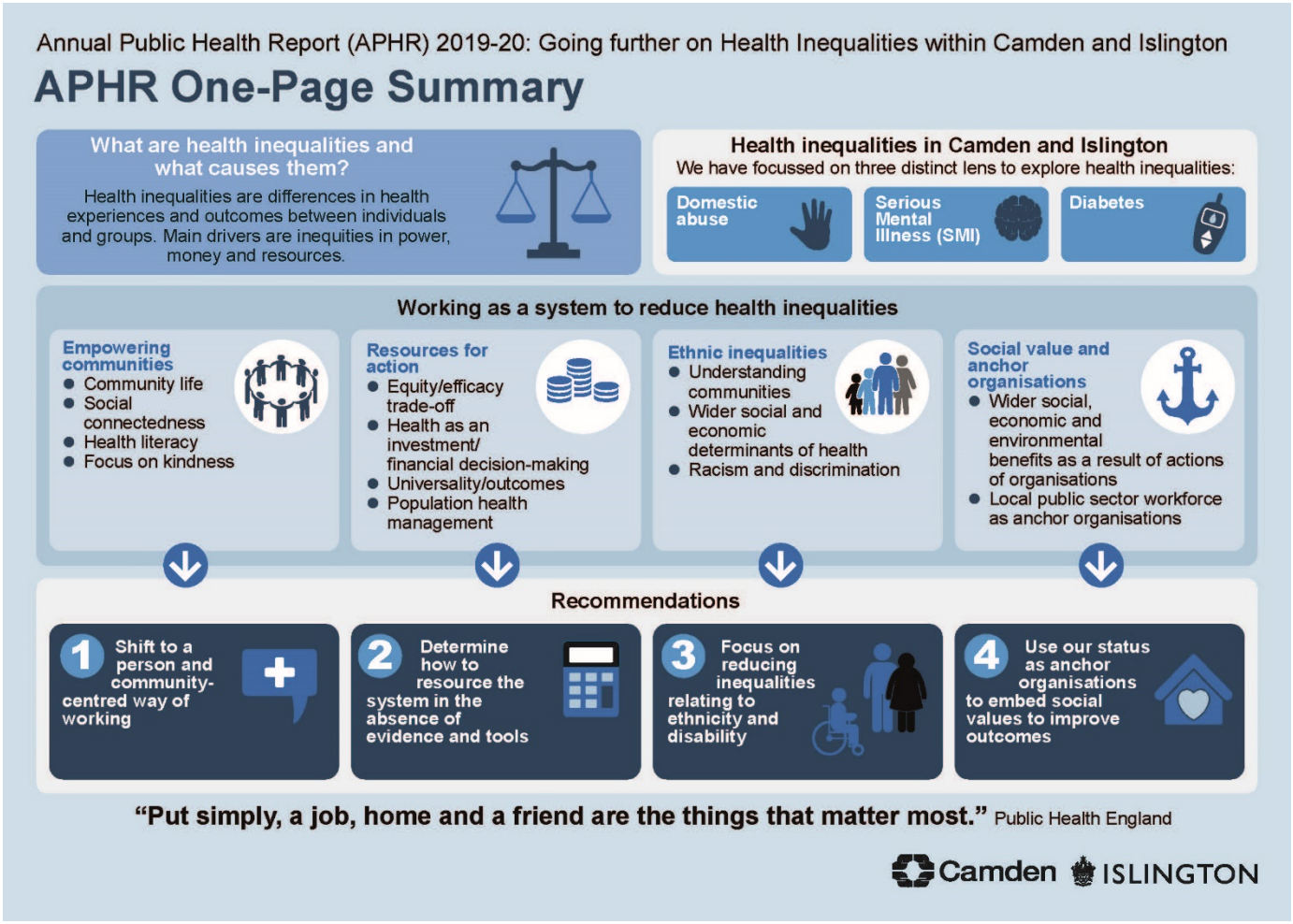
SUBJECT: Annual Public Health Report 2019-20
Going further on Health Inequalities within Camden and Islington

1. Synopsis

1.1 Directors of Public Health in England have a statutory duty to write an Annual Public Health Report (APHR) to consider the state of health within their communities and provide evidence-based recommendations for improving health and wellbeing. The content and the structure of the report is decided locally. In 2013-14, Camden and Islington's APHR focused on tackling health inequalities. In this year's APHR, we revisit this focus on health inequalities in the two boroughs to understand what progress has been made, to consider what else we need to do and how we might need to work differently in future to reduce health inequalities. This APHR was published in February 2020, and was due to come to the March meeting of the Health and Wellbeing Board, which was postponed due to the COVID-19 pandemic.

1.2 While the APHR has traditionally been in the format of a published paper-based report, this year the APHR adopts a new, more interactive online format. **Below is a brief summary of the report, however to access the full online content, please visit the link here (full online address: https://sway.office.com/ekoBb0CN5VesgU38).**



2. Recommendations

2.1 **NOTE** the content of the report.

2.2 **CONSIDER** and **DISCUSS** the report's major themes and recommendations, and the role of the Board in helping take forward the work on improving outcomes related to health inequalities in Islington.

3. Background and Summary

3.1 Camden and Islington have some of the starkest inequalities in health in the country. Health inequalities are deeply entrenched within different communities and notoriously difficult to reduce. Nationally and locally, the COVID-19 pandemic has both highlighted and exacerbated these long standing structural inequalities, and has disproportionately impacted on certain population groups, in particular older people, people from Black, Asian and minority ethnic (BAME) backgrounds and more deprived populations[1]. Despite a long-standing focus on health inequalities in both boroughs over many years, and a more focussed effort, in response to COVID-19, to protect these population groups, and prevent and mitigate any further

[1] Public Health England (PHE). Disparities in the risk and outcomes from COVID-19 [Online]. June 2020. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892085/disparities_review.pdf

disproportionate impacts, there has been relatively little progress in reducing the stark differences in health experience and outcomes that exist within our communities.

3.2 Whilst recognising the structural and complex causes of health inequality, and that change requires a commitment to concerted long-term action, this report also calls for a shift in approach and a shift of gear if we are really to effect change, which, in light of the COVID-19 pandemic, is more pertinent now than ever. An approach that empowers individuals and communities to improve their health and wellbeing is crucial, as is a different whole system approach across the public sector system, working with partners and communities. Borough health and wellbeing partnerships in both Camden and Islington, as well as the developing integrated care system across North Central London, present an opportunity for us to work differently and capitalise on the acceleration in partnership working that has occurred as a result of COVID-19, to really reduce health inequalities and support all our residents to live fulfilling lives.

3.3 Within this report we have explored health inequalities through three different lenses (community empowerment, resource allocation decisions, a targeted approach to ethnic inequalities, and anchor institutions and social value) that impact different people and different parts of the public sector system, as well as looking at the essential components and levers that are important if we are to reduce health inequalities (community empowerment, resourcing, ethnicity, and anchor organisations and social value). There is no single action to reduce health inequalities. Many of the factors that influence health and wellbeing, for example kindness in communities, are influenced by many other things than local public sector policy and action. However, what is clear is that, as public sector bodies and as major employers, we can all make a difference.

3.4 While austerity has led to dramatic reductions in local government funding, and the local NHS is under significant financial pressure, in each borough the council, the NHS and the wider public sector is still a significant economic force. There are no easy answers on how to distribute resourcing across an organisation or system to reduce health inequalities. There is also a lack of evidence-based tools to help prioritise and assess the impact of actions. However, with the move towards population health and integrated care we need to be proactively exploring whether we can do things differently within current levels of resource – this includes looking at how we use and deploy our workforce differently, as well as our money.

- The developing local borough partnerships in each borough, and the emerging integrated care system, provides an opportunity for a discussion with our communities about how we should allocate resources to tackle health inequalities in order to prioritise investment based on community priorities. This would include for example, a deliberative discussion on the trade-off between equity and efficiency, as well as investing for future health versus short term gains in efficiency.

- Within existing services, there needs to be specific consideration of whether resources are being appropriately distributed based on differing levels of need or use of services based on local demographic or socio-economic factors and/or if further weighting is needed to tackle inequalities. Examples of this could include explicitly incentivising for the delivery of services to particular ethnic groups and/or for those with severe mental health illness so that outcomes can be 'levelled up'. With the emergence of primary care networks (PCNs), and neighbourhood and locality working in our respective boroughs, there may be new opportunities to proactively address this.

- For some of our most vulnerable residents and families, such as victims of domestic abuse, we should consider as a system whether we are investing sufficient resources, given the long lasting and significant impacts on both resident outcomes, as well as the impacts on the public purse, and we should also consider the balance in our investment between "response" versus "prevention or early intervention". In the case of domestic abuse, preventing a child from experiencing violence, and the negative impact on their health and wellbeing, could result in long term savings for the public sector. There is a role for all agencies to tackle these kinds of complex social issues through a public health approach.

- In recognition that community empowerment is vital for reducing health inequalities (and particularly ethnic inequalities) there should be consideration of how as public sector organisations, we are proactively supporting the community, through the voluntary and community sector and faith-based groups, for example, to ensure that the needs of communities are heard and acted upon.

3.5 Some of the largest opportunities to make a difference quickly, as we have more direct control and levers over the policies and outcomes, is in our roles as anchor institutions and through the delivery of social value. Across organisations there are opportunities to share learning and potentially the delivery of some initiatives, particularly for more vulnerable groups.

3.6 A sizeable proportion of both NHS and local government staff on lower wages live locally.

- Directly supporting their health and wellbeing in the workplace, for example, promoting healthy eating, active travel, stopping smoking, and positive mental health which are designed to be accessible and promoted to those on lower wages, will have a direct impact on health and wellbeing outcomes, including conditions like diabetes.

- We also need to ensure that there is support for staff in relation to the wider determinants of health, such as support for staff who may be experiencing issues such as domestic abuse and debt.

- Wider workforce initiatives (e.g. unconscious bias training to tackle racial discrimination) that seek to address the equality gaps that persist for those from BAME groups, women, and people with disabilities, will also make a difference. Ensuring our workforce, particularly senior managers, are more representative of local communities is important.

3.7 As major employers, and through our supply chains, we have the opportunity to proactively support people getting into work.

- As a system and building upon existing programmes, we have an opportunity to support those with severe mental health illness to gain meaningful employment – a key driver of inequalities for this group.

- On average, people living with a disability in Camden and Islington report that their lives are less meaningful. Providing more opportunities for people with disabilities (as well as supporting our existing workforce with disabilities) to get a job within local public sector organisations or participate in volunteering is important for wellbeing.
- Apprenticeships provide an opportunity to get local people into employment, including those living with disability but also those from different local communities. Both

councils have well developed apprenticeship schemes and all organisations have a financial incentive to utilise their apprenticeship levy.

3.8 Through delivery of our own services as well as commissioning and procurement there are opportunities to ensure that we are enabling community empowerment, resourcing to support a reduction in health inequalities and reducing ethnic inequalities including tackling racial discrimination.

- We can ensure that robust equalities impact assessments are being undertaken that highlight where there are inequalities that need to be addressed, and that subsequent monitoring is undertaken to assess the impact of measures or mitigations taken to tackle these inequalities.

- Our measures to secure and maximise social value should also seek to reduce health inequalities between different groups. There also needs to be value placed on empowering our local communities to improve their health and wellbeing, including through the commissioning of voluntary and community sector organisations who have a unique role in supporting local communities.

- As an example of how we can better embed kindness in public sector policy to improve wellbeing, emerging work from Scotland is looking at how kindness could be delivered through contracting and procurement. It focuses on the importance of building relationships with communities (again, a key role of the voluntary and community sector) rather than the traditional, rational side of service delivery.

3.9 The recommendations from this APHR include:

3.9.1 We need a systematic shift to more person and community centred ways of working across the public sector system to improve health and wellbeing. To do this, we need to:

- Consider how community-centred approaches that build on individual and community assets can become an essential part of mainstream strategies and local plans to improve health and wellbeing.

- Work with a wide range of statutory and community partners to develop an asset-based community development approach, which involves mapping local community assets as well as needs as part of the joint strategic needs assessment (JSNA) process.

- Value, harness and support the role of people and communities in their health and wellbeing, including through co-production, volunteering and social movements for health.

- Ensure that accessible, inclusive and meaningful resident and service user engagement and involvement is embedded at all levels across the system.

- Enable health and care professionals and the wider workforce to understand and work in person- and community-centred ways, including a focus on kindness.

3.9.2 We need to determine how we invest and use resources to reduce health inequalities across the system. To do this, we need to:

- Agree how resources are coordinated and used in a systematic way to address strategic goals for reducing health inequalities.

- Think differently about resource decisions which are designed to prevent problems and promote good health and wellbeing, compared with decisions which are primarily about efficiencies in how services are delivered and the delivery of shorter term savings.

- As we increasingly shift to a system focused on outcomes, we need to ensure those people or communities experiencing inequalities are not left further behind by focusing on 'population averages'. Outcomes need to be 'levelled up' across the population.

3.9.3 We need a continued and concerted focus on ethnic inequalities, and given the findings from our kindness survey, on improving experience and outcomes for people living with a disability. To do this, we need to:

- Improve data recording, collection, analysis and reporting across the whole health and care system for ethnicity and disability.

- Meaningful use of detailed Equality Impact Assessments (EIA) that are well thought through, robust, and collaborative before service and system level changes are made.

- Increase health literacy of key community and faith leaders in order to promote health and wellbeing including signposting to key services within the system.

- Engage and involve BAME communities in the planning, development and implementation of interventions and services.

- Education and training for the workforce on diversity, cultural competency, unconscious bias and conscious inclusion.

3.9.4 We need to capitalise on the opportunities we have as anchor organisations and embed social value across the system to achieve our goals for prevention, early intervention and resilience. To do this, we need to:

- Use our social value leavers to address factors that contribute to health inequalities and reach those communities and groups experiencing significant inequalities.

- Capitalise on public sector organisations as employers, to improve health and wellbeing, with a focus on lower paid staff, many of whom live locally.

- Scale and sustain action across 'anchor organisations' locally to deliver change over the medium and longer-term.

The recommendations included in this APHR should be considered in combination with those outlined in a recently published report from Public Health England, which aimed to understand

the extent that ethnicity impacts upon COVID-19 risk and outcomes[2]. Recommendations in the PHE report largely align with, and bolster, those outlined in this APHR, signalling where commitment, focus, and delivery at scale could make a significant difference in improving the lives and experiences of BAME communities.

4. Implications

4.1 Financial Implications:

There are no financial implications arising from this report. The measures and recommendations proposed in this report are not currently quantifiable. Any recommendations from this report, if adopted, will need to be expanded upon and reviewed with the financial implications assessed.

4.2 Legal Implications:

The Health and Social Care Act 2012 (2012 Act) confers duties on Local authorities to improve public health. Local authorities s have a duty to take steps as they consider appropriate for improving the health of people in their area.

The 2012 (s30) added in a new s.73A to the National Health Service Act 2006 requiring the appointment of a Director of Public Health. Under subsection s.73B (5), the Director is required to prepare an annual report on the health of the people in the area of the Local Authority and the Local Authority is required to publish this report.
5.4.2 Under the NHS Act 2006 as amended by the Health and Social Care Act 2012, Local Authorities are required to take particular steps in exercising public heath functions, and the regulations cover commissioning of services.

4.3 Environmental Implications and contribution to achieving a net zero carbon Islington by 2030:

Some of the recommendations made by the report will have an environmental impact as services change. In some cases – particularly those involving integrating existing systems – these impacts are likely to be positive.

4.4 Resident Impact Assessment:

The council must, in the exercise of its functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010). The council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account of disabled persons' disabilities, and encourage people to participate in public life. The council must have due regard to the need to tackle prejudice and promote understanding.

A Resident Impact Assessment has not been completed because this report discusses impact on residents' health and includes input and feedback from local residents throughout.

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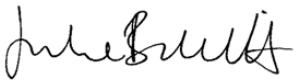
[2] Public Health England (PHE). Beyond the Data: Understanding the Impact of COVID-19 on BAME Communities [Online]. June 2020. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

5. Conclusion and reasons for recommendations

5.1 Based on the report's major themes and recommendations, significant work remains to effectively tackle health inequalities across the borough, particularly in light of the COVID-19 pandemic. By working differently together with our local communities, drawing on support from the Board and the system, there is the opportunity to reduce health inequalities and support all our residents to live fulfilling lives.

Signed by:



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