ITEM No …5(b)…….

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 31 OCTOBER 2017**

REPORT ON: **TACKLING HEALTH INEQUALITIES IN DUNDEE: AN INTEGRATED APPROACH**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB36-2017**

1.0 PURPOSE OF REPORT

To inform the Integration Joint Board of dedicated work taking place at a community and city-wide level to help tackle health inequalities, and the improved focus and opportunities that are arising from bringing together the different health inequalities strands.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Notes the content of this report including the positive health inequalities activity taking place in the city as detailed in section 4.2;

2.2 Notes the purpose of the dedicated service redesign/expansion and the opportunities arising from this as detailed in section 4.3;

2.3 Notes the potential impact on service delivery and strategic reporting requirements during the change process as detailed in section 4.4.

3.0 FINANCIAL IMPLICATIONS

None.

4.0 MAIN TEXT

4.1 Health inequalities

4.1.1 Health inequalities are defined as *preventable and unjust differences in health status experienced by certain population groups.* The fundamental causes of health inequalities, such as poverty, are recognised as being rooted in the socio-political forces which drive decisions and priorities and which can result in the unequal distribution of power, money and resources. Lifestyle behaviours and access to healthcare impact on health inequalities but do not fully explain the differences.

4.1.2 Health inequalities in Scotland are persistent and widening and have been identified as a top priority for the Scottish Government. Inequalities exist not only in the gap between the poorest and most affluent sections of society but across the whole socio-economic spectrum and within specific population groups. In Scotland, despite average life expectancy increasing, people living in the most deprived areas can expect to live 13 years less than those in the most affluent areas and will also experience 23 years less good health.

4.1.3 There is limited evidence on what works to tackle health inequalities; however the consensus across academics and policy makers is that solutions must be multi-factorial, attempt to level up not down, and incorporate both upstream and downstream approaches. Research has

indicated that important principles for reducing health inequalities in terms of healthcare include removing barriers to services, providing more intensive support for disadvantaged groups, targeting deprived people and places, and effective partnership working across agencies. Characteristics of interventions that are less likely to reduce health inequalities include information based campaigns, written materials, whole population approaches and those that involve significant price or other barriers.

4.1.4 Dundee Health and Social Care Partnership (HSCP) identified health inequalities as a priority theme in its strategic and commissioning plan. The strategic needs assessment showed that Dundee City has an increasing population with a high proportion of deprived areas and people, and a changing demographic that will see an increase in numbers of older people and a decrease in the working aged population. Dundee has the second lowest life expectancy in Scotland with variation in gender and deprivation; the life expectancy of a female living in the most affluent part of Dundee is 10 years higher than a male living in the most deprived area.

4.1.5 Dundee has marked differences in lifestyle behaviours and resultant poor health across socio-economic groups. The patterns of some behaviours are not straightforward but the harm caused is disproportionate within disadvantaged populations. Drug misuse is concentrated within socio-deprived communities and is associated with other health and social problems. People with long-term conditions and co-morbid mental health problems live disproportionately in Dundee's disadvantaged communities. Alcohol related emergency admissions, drug and alcohol deaths, and suicides are high in the city and are closely related to deprivation.

4.2 Tackling health inequalities in Dundee

4.2.1 Dundee has a long tradition of community activity with a focus on tackling inequalities within deprived areas and populations. These include:

- Dundee Healthy Living Initiative (DHLI) provides a wide range of health promoting activities in disadvantaged areas. It supports volunteers to help run the programme and works in partnership with organisations in the statutory and third sector
- Keep Well targets specific vulnerable groups such as the homeless, offenders and carers, offering health checks, advice and support. Staff signpost clients to services and activities and Associate Practitioners support people to access these
- Equally Well supports a change process at a local and city wide level through provision of multi-agency health and wellbeing networks, tests of change, and a training programme to foster new ways of working particularly for frontline staff
- Sources of Support (SOS) link workers provide a social prescribing service within identified GP Practices taking referrals for people with poor mental health and wellbeing affected by their social circumstances and helping them access a wide range of services and activities
- The Health and Homeless Outreach Team (HHOT) provides clinics, assessments, advice and healthcare to homeless people in various locations and has recently transferred to the health inequalities bundle. Work is underway to identify how exactly the work of this targeted team will enhance and complement the new model for health inequalities.

4.2.2 The teams, which include clinical, link worker and community development practitioners employed through NHS Tayside and Dundee City Council (DCC) Housing and Communities section, were managed separately and now have a developing interim management structure. Individual data collection systems exist alongside a variety of strategic and service reporting responsibilities that differ across teams. Changes have been made incrementally in recent years to develop better collaborative working, collective planning and reporting, and to look creatively at the overall budget. This preliminary work was useful in paving the way for a more concerted service redesign to move towards a sustainable, efficient and effective model for the future.

4.2.3 Individual budgets for the above interventions have been pooled to ring-fence health inequalities funding and foster better integration and partnership working. This development was guided by the now disbanded Dundee Health Inequalities Group, which produced a commissioning statement and led a number of successful applications for Integrated Care Funds (ICF) to build on and sustain this work. The DCC financial contribution sits within the mainstream Neighbourhood Services budget with a commitment to build on health inequalities activity in a local authority setting.

4.2.4 The service redesign proposal was developed by a small working group and approved by the HSCP Chief Officer in June 2017. The group looked at the changing nature of inequalities, demographics and deprivation, scrutinised service data and information, gathered the views of staff, managers and strategic officers, and identified areas of expertise, overlaps and duplication. It took into account the potential scale-up of social prescribing, funding availability and savings requirements, and the internal restructure within the HSCP. It strove to retain the best and most appropriate aspects of the teams' activities whilst responding to the need to modernise and future proof the service.

4.2.5 In June 2017, the Scottish Government confirmed almost £500k funding per annum from the national Community Link Worker Programme to expand the SOS service across Dundee. At the same time, the HHOT was transferred to the health inequalities bundle and is now managed by the Keep Well Team Leader. Restructure at a strategic level within the HSCP is ongoing and has resulted in some changes in senior personnel and responsibilities, including for health inequalities.

4.3 The redesigned health inequalities service

4.3.1 Much of the redesign is focused on improved targeting, better working relationships between the different teams and other health and social care services, and appropriate movement of individuals between work-streams. All teams focus on supporting those at higher risk of health inequalities, be it very vulnerable population groups or through a more preventative approach in areas of deprivation. The criteria for targeting in the round were agreed as follows:

1. Adults living in the Scottish Index of Multiple Deprivation (SIMD) 20% most deprived areas, and who fulfil one of the following additional criteria:
2. Offenders
3. Homeless
4. Substance misuse
5. Carers
6. Low income: unemployed/unfit to work/in-work poor
7. Poor mental health and wellbeing
8. Other population groups at higher risk of poor health and health inequalities, as required

Those who fit into criteria 1 only can participate in open access community health activities but will not be provided with dedicated staff support, which will be targeted at those in more need. Data collection systems will be developed to demonstrate the shift towards a more equitable programme across communities which engages the harder to reach. The Keep Well Team will add a locality focus to their role, providing an enhanced nursing resource in local communities and comprehensive health checks in venues such as community cafes and local hubs. The number of SOS link workers will increase through additional Scottish Government funding; patients accessing link worker support fit into many of the criteria above.

4.3.2 Three aspects to health inequalities activity were agreed:

1. Working at an individual level
2. Working at community level
3. Influencing wider system change

1. Working at an individual level

This is the primary role of the Keep Well, SOS and HHO teams which engage clients through a variety of routes including general practice, homeless hostels, community settings, or via partner organisations. Individuals have access to a comprehensive assessment including physical, psychological and social elements, and are supported to identify and meet their own goals by drawing on personal assets and, where required, service support. A focus on physical health is led by a nurse whilst issues around mental health and social circumstances can be led by a nurse, mental health nurse or link worker. This may involve a one-off appointment with referral/ signposting to other services, longer term support on a 1 to 1 basis, or referral to group support through linking to the community component of the team. Complex needs which require a high level of support and intervention can be addressed by the practitioner offering the initial assessment, or through an Associate Practitioner or volunteer, depending on the level of support required.

The intention is not for the team to provide ongoing care and support to individuals but to engage people on their health, support change, and link the person to other services or activities for longer term support if necessary.

2. Working at a community level

There are two key aspects to the work in communities; the provision of supportive networks and groups, and access to professionals who have an understanding of and skills to address the prevention and health inequalities agenda. Offering non-threatening, positive opportunities for individuals to come together is critical, whether on a geographical or special interest basis, as is building the capacity of groups to sustain and run their own health and wellbeing activities. This requires expertise and support from the community health inequalities team to respond to need and develop participants' skills, knowledge and confidence.

The community team promotes integrated working through a range of local collaborations including multi-agency health and wellbeing networks, which act as a forum for sharing skills and knowledge across sectors. The networks will evolve as the HSCP develops its approach to locality working, and agrees how this sits alongside existing community structures such as Local Community Planning Partnerships.

The community team also provides support to a wide range of local staff to develop inequalities sensitive practice; this overlaps with and is reported in the section below.

3. Influencing wider system change

Supporting change across the system is vital to ensure that service providers and planners take cognisance of the health inequalities and prevention agendas and that resources are targeted towards those at higher risk. The community team plays an important role in the provision of training opportunities that help develop inequalities sensitive practice across a range of agencies and partner organisations. The training supports frontline staff to have an understanding of the impact of poverty and health inequalities and to change practice appropriately, be that through engagement/targeting, assessment processes, or provision of longer term support. Local people are also supported by the community team to gain an understanding of health inequalities and their determinants, ensuring that more vulnerable and marginalised individuals are welcomed into community groups without fear of stigma.

At a strategic level, there are links with key groups such as HSCP Strategic Planning Groups (SPG) and Dundee Partnership to support changed thinking and harness potential on the breadth of issues that impact on health inequalities. A fixed term co-ordinator post funded through ICF and sited within the health inequalities team has been providing additional support for service managers and practitioners to develop their thinking and practice based on the recommendations of the Dundee Partnership report on prevention.

4.4 Summary of the shift, opportunities and challenges

4.4.1 In summary, the service improvements outlined in this report are shown below:

Previous model	New model	Benefits and opportunities
Health Inequalities (HI) teams operate separately	HI teams are integrated	Increased collective planning, reporting, working and focus
Budgets sit and are managed separately	Budgets are integrated and managed collectively	Better and more creative use of resources
Senior management dispersed	One senior manager for all components	Integrated strategic reporting and influence
Community groups and activities are open access	Community programme is open access ***and*** targeted at vulnerable individuals	More equitable service on a city wide and community basis
Health checks are targeted at vulnerable populations in non-local settings	Health checks are also offered on a locality basis	Improved targeting and more equitable access to clinical support
Minimal pathways/transfer of vulnerable individuals across HI workstreams	Increased pathways/ transfer of individuals between different components of the HI team	Strengthened referral pathways across different work-streams
Social prescribing available in	City wide social prescribing service in	Enhanced, more equitable service

small number of GP practices	qualifying GP practices	
Limited bridging support for SOS/ Keep Well clients to access services/ activities	Increased bridging support through Associate Practitioners	Improved uptake of activities and services from vulnerable people
No multi-disciplinary locality HI teams	Locality teams are established and formulating collective plans and initiatives	Better understanding of roles and responsibilities, thus avoiding duplication
Limited skill mix and relatively flat structure	Increased skill mix and layered structure	Better use of resources and more efficient line management structure
Separate development worker job descriptions for Equally Well/ DHLI staff	Single development worker job description	More flexibility within roles and less duplication of effort

4.4.2 A service cannot continue to deliver its programme to the same level and change to meet future need concurrently. The redesign will see the community team recalibrate activities locally to include a focus on more vulnerable groups and individuals, and the Keep Well team develop an additional locality focus.

4.4.3 An increased focus on capacity building for local people and practitioners will mean that, over time, local service delivery is increased as service providers and community representatives sustain existing health inequalities activities and develop their own programmes that contribute to this agenda. This will allow dedicated health inequalities staff to focus less on delivering activities or offering support on an ongoing basis, and more on engagement, progression, and bridging support to allow vulnerable individuals to participate in generic community provision.

4.4.4 The dedicated health inequalities team are not the only staff who can engage people around health or adopt social prescribing approaches. It is part of their role to support a wider service shift by working closely with others to pioneer ways of working that ensure that preventative and recovery approaches, and everything in-between, are offered proportionate to need. Equally, other local staff can support community development initiatives and groups that promote health and wellbeing. Partnership working is key to ensure that the dedicated health inequalities team continues to offer a programme that is innovative, fills gaps in provision, and builds capacity for others to sustain new developments over the longer term.

4.4.5 The challenges of implementing the redesign and action being taken to address these are summarised below:

Challenges	**Action taken**
Lack of individual and collective data systems and associated support	Future streamlining of indicators across strategic plans and identification of potential support mechanisms
Dispersed and different service and strategic reporting arrangements	Integration of systems in the future where possible
Impact on frontline HI services whilst redesign/ shift is underway	Maximising role of volunteers in the interim and building capacity of services/ local people to support activities
Supporting staff through the redesign process	Line managers offer ongoing support. Development session are scheduled at regular intervals
Ensuring that agreed priority groups and individuals are targeted effectively and engage	Effective partnership working across workstreams, creative engagement processes, liaison with services that support at-risk groups
Agreeing role and involvement of the HHOT	Ongoing discussions with HHOT and creative thinking about the way forward
Large scale recruitment for SOS scale up at same time as redesign of HI service	Delegation of duties where possible and effective time management at senior level
Change of personnel at senior level and HI lead to be identified	Regular updates scheduled with Chief Officers and revisiting role of Community Health Inequalities Manager once redesign is in place
Availability of staff across the wider system to participate in service development/ training opportunities with HI focus	Effective targeting of priority staff and flexible delivery of training/ development opportunities
Maintaining and building on HI activity whilst meeting	Creative and best use of resources through

future savings targets and budget shortfalls	development of skill mix across workstreams. Effective forward planning

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues.

6.0 RISK ASSESSMENT

This report has not been subject to a formal risk assessment as it is a status update and does not require any policy or financial decisions at this time; however, the working group that produced the service redesign proposal looked closely at, and consulted on, the potential impacts on staff and communities of integrating the teams.

7.0 CONSULTATIONS

The Chief Finance Officer and the Clerk were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

None.

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DATE: 6 October 2017

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