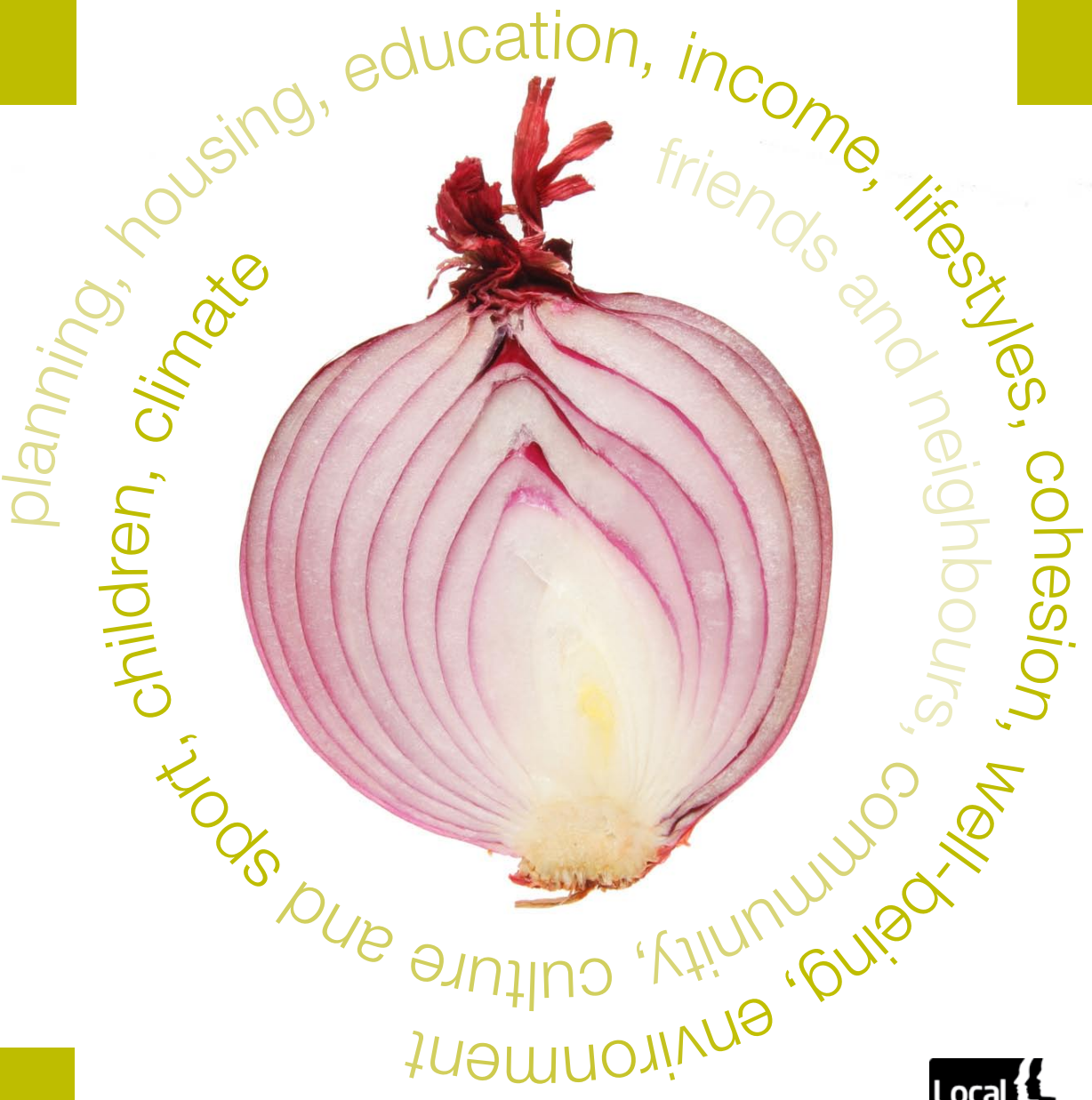
Peeling the onion

Learning, tips and tools from the Health Inequalities Scrutiny Programme



cfps Centre for Public Scrutiny
accountability, transparency, involvement

HEALTH INEQUALITIES cfps

Local Government Improvement and Development

Contents

The Centre for Public Scrutiny

The Centre for Public Scrutiny promotes the value of scrutiny in modern and effective government, not only to hold executives to account but also to create a constructive dialogue between the public and its elected representatives to improve the quality of public services.

In recognition of the value that scrutiny can bring, in 2009, the Centre received funding from the Healthy Communities Programme at Local Government Improvement and Development, via the Department of Health, to deliver a programme that examined in more detail the benefit that scrutiny can bring to tackling health inequalities. This publication is the learning so far from the programme, the views expressed in this publication are those of the contributors to this programme and not necessarily those of the Department of Health.

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Ministerial foreword

Local authorities are crucial for the success of our proposals to tackle the many lifestyle and society-driven health problems we face, and reduce inequalities. We need councils to continue to provide strategic leadership for public health and to work in partnership with the new local NHS structures and across the public, private and voluntary sectors. Adopting the new role through Health & Well-being Boards as system leader to encourage coherent commissioning strategies, promoting the development of integrated and joined up commissioning plans across the NHS, social care, public health and other local partners.

Our new approach will place local communities at the heart of public health. Local government will have the freedom, responsibility and funding to innovate and develop their own ways of improving public health in their area. There will be real financial incentives to reward progress on improving health and reducing health inequalities, and greater transparency so people can see the results they achieve.

Local overview and scrutiny committees have a key role to play here. The Centre for Public Scrutiny (CfPS) recognises the expert role locally elected councillors have in helping public services to understand the issues that their communities face; and set out to demonstrate the active and vital role that 'scrutiny' can have in helping its partners understand issues so that gaps in inequalities can be narrowed.

This CfPS publication is the product of two years work and includes the insight from 47 local councils in 10 Scrutiny Development Areas recruited from across the country to develop innovative solutions to long-standing problems. The scope of their work is very impressive, with innovation threaded through each review, as they have developed new or refined ways to use the scrutiny function.

This publication highlights the key attributes that make reviews successful and includes learning and case studies to help other scrutiny committees to carry out similar reviews.

I hope you will find this publication interesting and a source of ideas to inform the contribution of local overview and scrutiny to improving the health of people in your communities.

Paul Burstow MP
Minister of State for Care Services

Editor's introduction

'Finding many layers - like peeling an onion'

This quote from a programme participant captures the complexity of understanding and tackling health inequalities.

Scrutiny and health inequalities

'Health inequalities' is the generic term used to describe differences in the health and well-being of individuals and groups. A person's well-being, how long they live and how well they are, is strongly influenced by where they live, and factors such as their social and economic background, income, employment and education.

The link between health inequalities and the wider determinants of health can be better understood using the diagram below. It shows the widening circles of influence on people's health. Of course these circles are not independent of each other, for example levels of income have a strong effect on lifestyle, and people themselves influence the circles by the choices they make.

Local Government has a significant role in improving health; the services that are provided by local authorities can affect a persons' health. Scrutiny provides a platform for members, officers, the community and professionals to come together to focus on and unpick the complexities of health inequalities.

Ref

Campbell, F. (Ed)(2010) The social determinants of health and the role of local government. London:IDeA adapted from Barton, H. and Grant, M. (2006) 'A health map for the local human habitat' in Journal of the Royal Society for the Promotion of Health Vol 126, No 6

Health Inequalities Scrutiny Programme

Just under two years ago, the Centre for Public Scrutiny recognised the potential of scrutiny in better understanding local health concerns and set out to demonstrate the active and vital role that it can have in helping councils and their partners narrow gaps in health inequalities. With funding from the Department of Health, through the Local Government Improvment and Development Healthy Communities Programme, the Health Inequalities Scrutiny Programme worked with 10 Scrutiny Development Areas (SDAs) around England to help develop innovative solutions to long-standing inequalities. See page nine for full details of the 10 areas.

This programme wanted to show the role that scrutiny can have in helping places better understand health inequalities and the actions that they can take to tackle these issues.

The 10 SDAs started and concluded their scrutiny reviews in 2010. Their journeys have been followed closely so that the learning from what they did could be published more widely to the sector in this publication. 13.5% of councils (47 in total) in England took part in the programme; either on their own or in partnerships of scrutiny committees.

Each of the SDAs received a small pot of funding to develop and test new ways of carrying out scrutiny or collecting evidence. In addition to this, participants were supported by a CfPS Expert Adviser who helped them to work through their reviews.

Strategic advice and guidance was provided by a National Reference Group – including a Senior Fellow from the Marmot review team, a Director of Public Health, Scrutiny Councillors and Officers, and officials from the Department of Health and Local Government Improvement and Development.

Learning from the SDAs

Action Learning has been a key feature of each of the reviews within the programme – it has helped to keep reviews on track and to maximise the learning across the programme. In November 2010, a national learning event was held for all the SDAs.

With all the SDAs together for the first time, a recurrent theme from each of their reviews emerged - innovation! These authorities had used a number of creative ways to gather their evidence to understand health inequalities and their communities.

Participants took part in action learning workshops based on themes identified as key attributes of successful scrutiny reviews (described below). What was special about the event is that all of the workshops were different. Expert Advisers that have been working with each of the SDAs brought variety to the day by facilitating using techniques not usually associated or used by scrutiny committees.

Despite the variety in project structures; and the huge span of topics being tackled some important common learning has emerged; such as the six “attributes” of an effective scrutiny review, which are captured in this publication in Section Two and summarised on the following page.

Vision, leadership and drive

Following the SDAs on their journeys and detailing experiences of starting the review, keeping momentum going and how not to lose sight of the vision.

Community and stakeholder engagement

Seven seeds to successful engagement in scrutiny are identified, detailing innovative methods to engage local people and stakeholders.

Partnership working

From single councils working with their local partners, to whole region scrutiny - what made them successful and what were the benefits?

Local understanding

How to identify the inequalities in your area, who needs to work with you, and how you might begin to understand the data that is and isn't there.

Being systematic

Detailing what steps there are in a successful scrutiny review and how they can be translated in to a model for councils.

Monitoring and evaluation

Details how to build action learning in to the process at the middle and end of the review – exploring how this made a difference.

Scrutiny – an effective resource for public health

What is clear is that their work has demonstrated that 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.

Using scrutiny in this way has brought new challenges to existing mechanisms – councillors and officers have acquired new skills, adopted new ways of working, and can see things from a different perspective. This publication enables them to share these challenges in more detail with you.

The learning from this programme is more important than ever in the light of the Government's decision to return responsibility for public health to local authorities and to task them with co-ordinating healthcare, social care and health improvement activities in their areas.

Using this publication

This publication has been constructed from the insight gained by the SDAs in their reviews. It:

- ☑ Looks at what health inequalities are, and why scrutiny is believed to be an effective tool for tackling them.
- ☑ Describes what participants feel are the key attributes for a successful scrutiny review of health inequalities and gives some practical tips from each of them.

- ☑ Spotlights the work of the 10 areas in individual case studies pulling out elements such as: the reasons for the review, the journey, the key learning points, innovative practice, and early signs of review impact.
- ☑ Highlights ways to carry out scrutiny reviews, and provides tools and techniques developed or refined during the programme.

The aim of this publication is to reach beyond those members and officers within the scrutiny function. All of the reviews have been developed in partnership with the NHS, the Local Strategic Partnership, and in some cases the community. The methods explored by the SDAs are transferrable to activities other than scrutiny.

This resource is evolving – and will be updated on a regular basis. It will be supplemented by a series of fact sheets launched throughout the year – highlighting new and emerging insight. Currently this will include:

- ☑ Scrutiny Development Areas and community engagement.
- ☑ Member and officer skills needed in reviewing health inequalities.

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The 10 scrutiny development areas

Scrutiny Development Area	Review topic	Participating councils
Blackpool	Minimum pricing of alcohol	Blackburn with Darwen Borough Council, Blackpool Borough Council, Cumbria County Council, Lancashire County Council
Cheshire	Health inequalities in rural areas	Cheshire East Council,Cheshire West and Chester Council
Chesterfield	Geographical health inequalities	Chesterfield Borough Council
Dorset	Cardio-vascular disease	Bournemouth Borough Council Dorset County Council
NW London Councils	Housing, health and the environment	London Boroughs of: Brent, Ealing, Hammersmith and Fulham, Houslow, Royal Borough of Kensington and Chelsea, City of Westminster
NE Region	Ex-service community review	Darlington Borough Council, Durham County Council, Gateshead Metropolitan Borough Council, Hartlepool Borough Council, Middlesbrough Council, Newcastle City Council, North Tyneside Metropolitan Borough Council, Northumberland County Council, Redcar and Cleveland Borough Council, Stockton-on-Tees Borough Council, South Tyneside Borough Council, Sunderland City Council
Portsmouth	Alcohol admissions to hospital	East Hampshire District Council,Fareham Borough Council, Gosport Borough Council, Hampshire County Council, Havant Borough Council, Portsmouth City Council, Winchester City Council
Sefton	Geographical health inequalities	Sefton Metropolitan Borough Council
Staffordshire	Mental health services	Cannock Chase District Council, East Staffordshire Borough Council, Lichfield District Council, Newcastle-under-Lyme Borough Council, Stafford Borough Council, Staffordshire Moorlands District Council, South Staffordshire Council, Tamworth Borough Council
Warwickshire	Ante and post natal services for teenage parents	Nuneaton and Bedworth Borough Council, Rugby Borough Council, Warwickshire County Council

Section 1

Scrutiny and health inequalities

The health inequalities challenge - and scrutiny

Fair Society, Healthy Lives, a strategic view of health inequalities in England post 2010 (Marmot Review) gathered together the best global evidence to guide policy and practice in addressing a fairer distribution of health and narrowing the gap between the health of the richest and poorest in England.[1] The evidence is clear and highlights that health inequalities arise out of social inequalities in the circumstances in which people are born, grow, live, work and age. The recent report from the Equality and Human Rights Commission concurs. Geography matters and so too does socio-economic status.[2] The incidence of ill-health is closely associated with area deprivation especially amongst those under 65 years old.

'These persistent inequalities of socio-economic status are overlaid and intertwined with disadvantage of gender, ethnicity, sexual orientation, disability, age, religion and belief.'

These persistent inequalities of socio-economic status are overlaid and intertwined with disadvantage of gender, ethnicity, sexual orientation, disability, age, religion and belief.

There is a clear social gradient in health in England. The poorest on the gradient die seven years sooner than the richest and they can be expected to become disabled or suffer a limiting illness up to 17 years earlier. This does not happen by chance. Around the country Joint Strategic Needs Assessments are showing deprivation is generating poor social, economic, and environmental conditions in specific communities which lead to poor behaviours and poor health outcomes. The abrasive nature of inequality leads to an accumulation of disadvantage and health hazard throughout life and early childhood experiences have the most profound effect on life chances and health. Low level stress and the lack of control that are a consequence of disadvantage and adverse conditions results in poor mental well-being and physical health as well as lifestyles and behaviours.

The economic and human case for taking action is also clear. The costs involved are enormous. It is estimated that inequalities in illness accounts for productivity losses of £31 -33 billion per year: lost taxes and higher welfare payments in the range of £20-32[3]. Additionally, NHS healthcare costs associated with inequality are well in excess of £5.5 billion each year.[4]

The Marmot strategic review recommends action is taken on the social determinants of health through six policy objectives:

- **Give every child the best start in life**

  Early childhood experience has a profound effect on health and development throughout life with the foundations of key aspects of development (physical, intellectual and emotional) laid at this stage.

- **Enable all children, young people and adults to maximise their capabilities and have control over their lives**

  Educational attainment is one of the key predictors of physical health and mental well-being as well as income, employment and quality of life.

- **Create fair employment and good work for all**

  Being in good employment is protective of health and well-being. Getting people into work is of critical importance. Work needs to be able to offer a decent wage, opportunities to develop and offer protection from adverse conditions which can damage health.

1 Marmot M (2010) Fair Society, Healthy Lives.

2 Equality and Human Rights Commission (2011) How fair is Britain

3 Frontier Economics (2009) Overall costs of health inequalities. Submission to the Marmot Review. www.ucl.ac.uk/gheg/marmotreview/Documents.

4 Morris S. (2009) Private communication.

- **Ensure healthy standard of living for all**

  Income levels from wages and social protection systems should support healthy living including nutrition, physical activity, social interaction, transport etc.

- **Create and develop healthy and sustainable places and communities**

  Places and communities are important for physical and mental well-being. Social capital within communities promotes resilience and well-being.

- **Strengthen the role and impact of ill health prevention**

  Ill health prevention and early detection should be scaled up across the social gradient.

'Concerted effort, of sufficient scale and intensity, will be required across the whole range of interacting factors that shape health and well-being...'

Action consistent with these policy recommendations is essential if the social determinants of health inequalities are to be tackled across the social gradient and if greater fairness and social justice are to be developed. It is unlikely that any single strategy or action which relies on intervention in one part of the system will be effective or create the synergy necessary to reduce overall health inequalities. Concerted effort, of sufficient scale and intensity, will be required across the whole range of interacting factors that shape health and well-being - in particular, early child development and education, employment and working conditions, housing, urban planning and neighbourhoods, transport and an adequate standard of living to participate fully in society.

The social gradient is important. Social policy on health inequalities has for the most part been focused on the most disadvantaged in our society. It is right to focus special efforts on the poorest but if the focus is only on the poorest everyone above the bottom, bar the richest, lose out. The social gradient in health demonstrates that health is progressively worse as the socio-economic hierarchy is descended.

It is possible to have a much shallower gradient than is currently the case in England. Action to achieve this should be universal but with a scale and intensity that is proportionate to the scale of disadvantage. Greater intensity of effort and investment is likely to be required to address the greater social and economic disadvantage; but focusing only on the bottom of the gradient means tackling only a part of the problem.

The white paper on public health *"Healthy Lives, Healthy People"* recognises that health is determined by wider social influences throughout life right from the beginning.[5] Action is proposed across the policy objectives set out above with the exception of the policy objective relating to a healthy standard of living for all. The white paper also emphasises the key role of local government in leading the partnership to address health inequalities locally.

The Marmot Review identified the role of local government as pivotal with a crucial role to play in renewal of local democracy and giving citizen's voice in developing the prospects for their local area.[6] Local councils hold the power to secure the economic, environmental and health and well-being of their population. This calls for the effective exercise of community leadership in drawing together citizens, communities and key partners to build health, well-being and resilience through transformational leadership of sustainable community strategies, local enterprise partnerships and health and well-being boards. These roles become even more important as understanding of the social determinants of health has developed. If inequalities in early child development and education, housing, employment and working conditions,

5 H.M. Government (2010) Healthy Lives, Healthy People: Our strategy for public health in England. www.official-documents.gov.uk

6 Sen A. (2010) The idea of justice. Peguin Books, London.

place and the built environment, and sustainability are driven by the same causes it requires a concerted effort across the whole system. Any single sector response will be insufficient to reduce the social gradient in health.

A focus on promoting greater civic and political participation and empowerment of communities is essential in creating the conditions where people and communities thrive and well-being is extended. Local Government is at the heart of promoting economic and environmental well-being through regeneration and place making. Recent evidence stresses the importance too of nurturing the psycho-social well-being of local populations where people and place come together.[7] This is particularly relevant at a time of major recession with significant reductions in public sector spend and where many feel alienated from formal political and civic structures. The approach would address the total population focusing across the social gradient but with a scale and intensity proportionate to disadvantage. The role of Local Government lies in orchestrating action to address health and well-being in collaborative action between local communities and partner agencies focused on the social determinants of health extending opportunities for co-production of strategies and services which promote whole system activity.

'...scrutiny challenges the existing professional and political structures and creates new opportunities for engagement and self-reliance...'

The role of overview and scrutiny

The role of overview and scrutiny was introduced in local government in 2001. Scrutiny has developed as an important element of democratically elected councils in exercising strategic community leadership in delivering local health improvements and holding the executive and other partners to account in delivering services responsive to the needs of the local population. Increasingly the scope of scrutiny has been extended to take a wider view of health improvement and closing the health gap. This emphasis begins to reshape the role of individual councillors and local councils to focus on creating health, well-being and resilience of local communities in a partnership which maximises knowledge, capability and self-confidence. In this way, scrutiny challenges the existing professional and political structures and creates new opportunities for engagement and self-reliance.

As a member of the National Reference Group which has overseen the 10 Scrutiny Development Areas (SDAs). It has been clear that addressing the complexities of the social determinants of health has been challenging. As the Marmot review stressed there is a need to address the complex, multicausal and multifactorial causes of inequality and marshal whole system action to address the social determinant of health. The learning from the 10 SDAs will be beneficial as responsibility for public health transfers to local government from 2013 to ensure the scrutiny function is effective in holding the key stakeholders to account in delivering health improvement and increasing the well-being of the local population.

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7 Aked J. Michaelson J. and Steuer N. (NEF) (2010) The role of Local Government in promoting well-being. LGID and NMHDU.

Scrutiny and health inequalities – a public health perspective

Public health has its primary focus on the health of populations rather than, as is the case for a GP say, on the health of an individual patient. So Directors of Public Health look at how measures of health and well-being, disability and disease are distributed in the population they have responsibility for. In England this is usually the population of an upper tier local authority. Knowing the distribution patterns of health and well-being, public health next looks at what are the likely causes of those patterns. Of course, it is individuals who become ill and among the causes of ill health are matters of genetic inheritance and of individual choice and behaviour. But research over the past 30 years has built up an impressive evidence base, brought together in The Marmot Review *Fair Society, Healthy Lives*. There is a social gradient in health – the lower a person's social position, the worse his or her health – social inequalities. Directors of Public Health are mandated to improve the health of their whole population; and this cannot be achieved without effectively tackling and reducing health inequalities. In the language of The Marmot review, "creating a fairer society is fundamental to improving the health of the whole population and ensuring a fairer distribution of good health". Clearly, creating a fairer society is a matter for everyone, but public health knowledge and skills have a distinctive contribution to make, which is recognised in the public health white paper *Healthy Lives, Healthy People*.

A new public health system

Healthy Lives, Healthy People argues that local government and local communities need to be at the heart of improving health and well-being for their populations and tackling health inequalities. Local government is central to this endeavour because:

- The full range of local authority functions have an impact on the health of the local population.
- Many of the necessary interventions to address health inequalities require various statutory and voluntary sector organisations to work in partnership, and it is to the local authority that the various partners look for leadership.
- It is the local authority that is most rooted in and has most direct accountability to the local population.

Healthy Lives, Healthy People also sees a public health service integrated into local government as an essential means through which local government can, working with its neighbourhoods and communities, deliver on reducing health inequalities and improving the health and well-being of those communities.

Over three decades ago elements of public health moved out of local government and into the NHS, while other elements of public health remained an integral part of local government services. In the intervening years the diversity of public health has multiplied and in many ways the term 'public health' is an overarching one for a whole variety of related but fairly distinct areas of knowledge, practice and services. *Healthy Lives, Healthy People* heralds what can be seen as the prodigal return of an evolved public health to its historic home in a transformed local government. Consequently, contemporary public health has much to learn about modern local government, including how public health can best enable local government discharge its mission of

Building good relationships with public health professionals:

- ☑ Enable public health professionals to see scrutiny as an opportunity not an opponent.
- ☑ Identify the added value to be gained by working across complementary functions in public health and the council.
- ☑ Hold get-to-know-you sessions so that public health professionals, council officers and members learn more about each other.
- ☑ Make better use of public health data and intelligence.
- ☑ Create opportunities for the Director of Public Health and scrutiny members to jointly plan and set priorities for the year ahead.

reducing the health inequalities that are being experienced by its constituent communities and neighbourhoods.

The vision that *Healthy Lives, Healthy People* sets out for the role of the Director of Public Health in local government includes identifying health inequalities and developing and implementing local strategies to reduce them. This is an extraordinarily complex and difficult assignment the success of which will require ownership and active engagement by the whole of local government, and most importantly of members. Ideally all members will have a concern to see health inequalities being effectively tackled by the Director of Public Health but health scrutiny members will have a particular interest and opportunity to help ensure health inequalities remain (or become) a central concern rather than a marginal interest of the council. In achieving this, health scrutiny can also make a unique contribution to helping shape how the local authority and the Director of Public Health in particular develops and implements the council's strategy for tackling health inequalities.

Scrutiny – an effective public health tool

Scrutiny can make a unique contribution to a council's strategic approach to health inequalities. In many places, health scrutiny members and Directors of Public Health work well together on a range of specific health inequalities issues and in future this should become normal good practice everywhere. The respective perspectives that the public health professionals and members bring to health inequalities are complementary – each has much to learn from the other, with members bringing a different but equally valuable perspective. An inquiry by health scrutiny into a particular health inequality issue can be initiated from a member, prompted by a request from the Director of Public Health or an issue highlighted in the Joint Strategic Needs Assessment. Contrasting and comparing professional perspectives with that of lay members who know their communities well can enrich the inquiry, yielding insights and identifying possible ways of proceeding that either alone would possibly not have identified.

Public health has been criticised for focusing on the 'deficits' – problems, needs and deficiencies - that characterise communities experiencing marked health inequalities. But local members are also aware, usually from first-hand experience,

Scrutiny can:

- ☑ Help public health professionals to engage with the council and other agencies to tackle health inequalities.
- ☑ Make a contribution to a council's strategic approach to health inequalities.
- ☑ Bring together different professions and perspectives – enriching the outcome.
- ☑ Make effective use of local elected members with their knowledge and insight in to communities.
- ☑ Strike the balance by involving professionals and lay people.
- ☑ Be a very effective means of focusing the attention of outside agencies on health inequalities – strengthening the case for investment.
- ☑ Use its investigative mode to really dig under the surface and gain a greater understanding of the issues that communities face – and the assets that they have.
- ☑ Provide an independent arena to focus on issues that are sensitive or contentious.
- ☑ Confer authority and status in engaging and influencing decisionmakers.

of the community resources and resilience that frequently exist in excluded groups and disadvantaged communities. So, in a scrutiny inquiry members are well placed to draw attention to the assets that are to be found within a community, those assets which communities can use to build their future, a building that public health action can then support.

It is frequently not easy to get the attention of decision makers when the concern is health inequalities and persuading them to invest in tacking health inequalities can be even more fraught. The process of a scrutiny inquiry and the advocacy of well-informed health scrutiny members can be a surprisingly effective means of focusing wider attention on the issue and strengthening the case for investment. I have certainly found this to be the case in Bristol where over the past few years a case has successfully been made with the support of the Health Scrutiny Commission for new investment to deal with some of the worst effects of alcohol misuse in the context of tackling health inequalities. This is but one example of several where inquiry and support by health scrutiny has been an important policy lever for both getting attention and resources.

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Director of Public Health

Bristol City Council and NHS Bristol

A benchmark for effective scrutiny of health inequalities

All councils need to work in ways that meet the needs of their communities, but alongside this flexibility it is important that they understand and embed good practice. A benchmark for effective scrutiny of health inequalities includes the following core attributes:

1 Visionary leadership

Leadership is vital to establishing a vision for scrutiny of health inequalities and for ensuring objectivity and effectiveness of scrutiny reviews, especially as data and evidence can be complex and sometimes contradictory. Sometimes the issues considered or stories heard are sensitive and emotive. Establishing a clear vision and delivering this through good chairing skills can help maintain objectivity and keep reviews on track with the agreed vision and scope. A lack of leadership can result in 'mission creep' in to unfocused or subjective debate. Scrutiny support officers can help support chairs by providing advice, guidance and briefings.

Good leadership is not always 'forceful' leadership - a dominant chair may stifle a review. Good chairing skills will ensure that all councillors and others can participate fully in reviews, drawing on their knowledge and skills to achieve a fair hearing of a range of evidence and views. This allows recommendations to be evidence-based.

Following a scrutiny review, it should be possible to reflect on the key leadership qualities that contributed to outcomes that influence future services and impact health inequalities.

Indicators of good chairing are:	Test by:
☑ Ability to take account of all perspectives.	☑ Good attendance at meetings and a concise agenda.
☑ Clear understanding of issues and scope.	☑ Good reaction by third parties when the review is explained to them.
☑ Think creatively but realistically.	☑ The willingness and openness of participants in the review.
☑ Inclusive approach to gathering evidence.	☑ Smooth running of the meeting – with good levels of interaction.
☑ Respecting the opinions of others.	☑ Involves others in setting the agenda.
☑ Open-minded, willingness to learn.	
☑ Flexibility to put others at ease.	
☑ Knowing what needs to be produced at the end and what happens on the way.	
☑ Looks beyond the immediate future.	

2 Scoping

Being clear about the scope of health inequalities reviews will help to keep reviews focused. Without a clear scope it is easy for reviews to become too broad, making it difficult to focus on the real issues.

Good data and professional evidence can help councillors establish a scope for their work. But it is also important to hear from individuals and communities about how inequalities impact on them. By balancing professional judgement and public opinion, scrutiny reviews can provide a forum for 'co-producing' solutions to problems.

A clear scope is likely to have more impact and influence than one that is too broad and becomes unfocused.

Indicators of good scoping are:	Test by:
☑ Involves external specialists and experts in scoping – true collaboration. ☑ Clearly sets out aims and objectives – intended outcome / key objectives and key lines of enquiry. ☑ Identifies information known and needed. ☑ Identifies who needs to be involved. ☑ Identifies sources and witnesses. ☑ Is realistic. ☑ Sets timescales – and milestones. ☑ Clearly identifies how the review will be measured. ☑ Details resource requirements. ☑ Highlights risks (positive and negative). ☑ Makes provision for learning review pit stops and end evaluation.	☑ Mutual understanding by all parties of the reasons for the review. ☑ How closely the final report matches the initial scoping brief. ☑ Ability to measure the effectiveness of the review and likely impacts. ☑ The review keeps to time and objectives. ☑ Risks are mitigated. ☑ Partners fully engaged in the process.

3 Timescales

Establishing a vision and a clear scope will enable councillors to set a timeframe for their work. In setting the timeframe for a review, they will need to consider:

- How to make best use of time and resources.
- How to decide the best type of review to hold i.e. full review or mini-scrutiny.
- How to best influence strategic planning, commissioning and business cycles.
- How to best hear from local people (for example, the best times to hear from young families, older people or full-time workers).

Health inequalities can be complex and challenging. A review of them can be daunting for councillors who may have pressures on their time and few resources to support their work. But a number of ways have been developed for councillors to consider these issues over one or two days. They enable limited councillor capacity to make a difference. They can also have a positive impact on communities or individuals by demonstrating an efficient approach leading to recommendations for change. Of course, speed is not everything and councillors may want to spend longer on some issues.

Indicators of good time planning are:	Test by:
☑ Having a staged approach and project timeline. ☑ Sets an achievable programme. ☑ Genuine barriers are recognised – such as holidays and committee cycle. ☑ Builds in allowances for the unknown.	☑ Delivering the review on time as laid out at initial scoping. ☑ Stages of the review not being rushed. ☑ Fits with corporate timeline.

4 Efficiency and effectiveness

It is helpful to identify the resources available for reviewing health inequalities, for example the Joint Strategic Needs Assessment, time, officer support, people who can provide information, advice and evidence. This will help to work out the best ways of working.

Working in different ways is appropriate in different settings and with different groups of people. An effective scrutiny review will make good use of the strengths of the resources available, amongst councillors, professionals and the community. Councillors need to be confident that the methods used are effective and efficient in gathering evidence and testing its validity.

Indicators of efficient and effective working are:	Test by:
☑ Work with other councils to tackle common issues. ☑ Get out in the community with people who provide and experience services. ☑ Councillors working in small teams and reporting the outcomes. ☑ Using positive approaches like 'Appreciative Inquiry'.	☑ The value felt by partners and stakeholder involved. ☑ Can you use a previous review as a benchmark? ☑ Better informed councillors and officers by gaining information first hand.

5 Speaking to the right people

Working out who are the best people to speak to about health inequalities goes hand in hand with ways of working. How you work can determine who you hear from; who you want to hear from can determine how you work.

Some general principles to consider are:

- Who holds data we need look at?
- Who has experience we need to hear?
- Who plans services?
- Who provides services?
- Who receives services?
- Who cares for those who receive services?
- Who else might have an interest that might be insightful?

Councillors should ask ,'how can each group or individual be best engaged in our work?'. For some this may be through formal meetings and presentations but some communities or groups may be more likely to want to take part in their own environment, for example by councillors going in to the community. Information collected in formal or informal ways is equally valid.

Indicators of good engagement are:	Test by:
☑ Reaching more than the usual participants. ☑ Good timing to allow genuine influence. ☑ Willing participation and interest in continuing the dialogue.	☑ The responsiveness to follow-up requests or their willingness to participate in future reviews. ☑ Satisfaction by participants / contributors to the process. ☑ Evidence that useful information has been sourced through the engagement process.

6 Understanding data

One of the values of scrutiny is its capacity for unpicking different types of data or information. Historically, more value has been placed on quantative data, such as the numbers of users of a particular service. The benefit of scrutiny is that it can combine quantative and qualitative data, e.g. individual and group stories and experiences. A mix of both types can provide a rich and clear picture of the impact of health inequalities and can help to demonstrate the value of change on broad aspects of health and well-being. It is therefore important for best practice scrutiny to clearly identify the types of data and information used, drawing attention to the sources and validity of quantative data and clarifying the use of information provided by representatives, who represent a group experience, as opposed to individuals who represent a view. Each may be equally valid, but each should be identified for what they are.

Indicators of good information are:	Test by:
☑ Involving the right stakeholder – will help you access the information that you will need. ☑ Getting more than data – find out what works and what doesn't work. ☑ Combining the information should tell the story of the community or issue.	☑ A good mix of qualitative and quantitative. ☑ Speaking to local people – is the information telling the right story?

Your Joint Strategic Needs Assessment (JSNA) is an important component in understanding data and health concerns locally. See the chapter on Local Understanding within Section Two for more information on using your JSNA, and its role in scrutiny.

7 Regular reflection and evaluation

It is commonplace for scrutiny committees to complete a review, make recommendations and then move directly on to the next priority issue for review. Where this happens, there is a high risk that lessons learnt about what went well and what could have been done differently may be ignored. As a result the quality of scrutiny does not improve. Evaluation of the process should look at all aspects of the review and identify how effective the activities have been in achieving both outputs, such as developing relationships with commissioners and users of services, and outcomes, such as improving access for disadvantaged groups.

The SDAs have demonstrated the importance of regular reflective discussions between the

councillors undertaking scrutiny of health inequalities – not just leaving it to the end. By reflecting on the process and outputs and points during the process, members are able to stay focused on the task and priority identified and not become distracted by secondary issues. This also enables collective learning between members, especially where tasks have been shared between the group. Regular reflection enables review groups to ask:

- Are the methods being used the most effective in collecting evidence and information?
- Are findings beginning to indicate issues that need to be probed further?
- Are all members effectively involved in the review or are one or two dominating?
- Are there groups or information providers who need to be involved that were not identified at the beginning?
- Is there learning from the process that can be used to inform future reviews?

Indicators of effective continuous learning are:	Test by:
☑ Review stays on track and any adjustments needed can be reacted to. ☑ Builds in the views of all participants. ☑ Shared understanding of the review outputs.	☑ Learning is carried in to other reviews. ☑ Processes and systems adjusted as a consequence of the learning. ☑ Better informed participants – and therefore more able to contribute.

8 Recommendations

All reviews must reach a point where recommendations can be made that aim to improve the outcomes of services for local people. In some circumstances it may be tempting to make recommendations that are idealistic but, unless it is possible for recommendations to be achieved, there is no value in this. A compromise may be to make recommendations that are short, medium and long term. Effective recommendations are likely to be:

- Realistic.
- Measurable, in so far as it can be identified when they have been achieved.
- Appropriate within the current economic and political climate.

Indicators of good recommendations are:	Test by:
☑ Original objectives of the review are met. ☑ Clear and concise format. ☑ That the implementation is able to be measured.	☑ Stakeholders response to the recommendations. ☑ The number of recommendations that are implemented.

Section 2

Key attributes

Vision, leadership and drive

Introduction

These three words are easy to say and very hard to do! They can also be difficult to pin down in practical terms - and yet were critical to success in the SDA programme. The 10 SDAs all had different experiences of leading the process from the start, of ensuring the vision and drive kept going through thick and thin – and crucially not losing sight of it all in the final stages. Some projects involved a single authority suggesting a focused leadership task compared to those involving two, three or more authorities, often from different tiers of local government, where leadership was more dispersed.

However despite the variety in project structures and the huge span of topics being tackled, some important common learning emerged. The top issues for achieving vision, leadership and drive were:

Developing an understanding of the task

Member commitment and enthusiasm for the review topic itself

Officers keeping things going

Dorset - Cardio-vascular disease review - click here

These three issues are also complex and hide layers of learning. Health inequalities and their complexities were new for most people and there was a real learning curve that people needed to travel to achieve a vision of what they could aim for, and to keep up their momentum when things got difficult. Member enthusiasm was widely reported as critical to the projects and where this was interrupted e.g. by elections, the role of officers to keep things moving was equally critical.

NE Region - Ex-Service community review - click here

Project participants also emphasised cross generational leadership: '*you don't have to be a certain age to have the ability to lead'; and how 'leadership doesn't always have to be too dogmatic but can be about creating a situation where you can listen, watch and learn from others'.* Their discussions about their learning also produced consistent comments about passing down knowledge between generations and having a long term vision and learning over time. They felt leadership and drive came from *'people turning themselves upside down to get something done'* and those not afraid to stand out from the crowd.

'you don't have to be a certain age to have the ability to lead'

In considering their experiences of vision, leadership and drive, the 10 SDAs explored what were the key issues at the start, what was involved in keeping things going in the middle, and what mattered in the final stages. This three stage approach structures the next section, logging the comments and learning from the projects as a whole and signposting to specific projects that highlight the points made.

Warwickshire - Services for teenage parents review - click here

At the start vision, leadership and drive are about...

Paying attention to all the people involved – this helps keep them on track and owning the work: members, officers, the public, other stakeholders: *'member enthusiasm is crucial plus getting partners on board and good officer support and ideas'*. Projects had different challenges here. In Dorset one authority took its review in to all council departments and in to its partner agencies, while the North East involved 12 authorities in one regional review. For Warwickshire this involved *'bringing together members from Districts and County and overcoming the usual animosities between the organisations'*; others found multi-authority work straightforward with

Blackpool Minimum pricing of alcohol review - click here

Staffordshire - Mental health services review - click here

Cheshire - Rural health inequalities review - click here

London - Housing, health & environment review - click here

NE Region - Ex-Service community review - click here

much goodwill. However it was important to recognise panel members did not all know each other and making time to form relationships, as well as to clarify scrutiny for people like the local Director of Public Health.

What practical steps helped?

- ☑ Early launch event to involve people (e.g. London).
- ☑ Rotating meeting chairs from different authorities (e.g. Blackpool).
- ☑ A briefing note to all partners (e.g. Staffordshire).
- ☑ Having a group that included other professions/interests, the Local Strategic Partnership, Director of Public Health, community development to bring a good mix of skills, actively avoiding parochialism.

Developing an understanding of the task – this was about open exploration early on to generate ideas and open up the topic but also being focused on vision and objectives for the work. In some areas starting off was hampered: '*difficulty in getting initial information/data on the issue e.g. on ex service personnel'* or was able to start from personal experience: '*review panel members giving valuable testimony themselves at the outset'*.

'clear terms of reference avoided problems later on'

What practical steps helped?

- ☑ Having a relevant and important issue that everyone wanted to get to grips with and not just stereotypical 'health' issues.
- ☑ Being clear on scope: *'clear terms of reference avoided problems later on'*.
- ☑ Open atmosphere in working groups for all participants to contribute.
- ☑ *'Not pre-judging the outcome of the study'; 'being honest about what the review will involve'.*
- ☑ Having a clear plan to start with, noting resources and time required; not only relying on formal data to focus the work (e.g. Cheshire).

Keeping things going in the middle involves...

Keeping a focus on the aims of the review but also staying open to changing views, context and information that require a different approach: *'do not hesitate to change direction or review your plan if necessary*'. Participants emphasised the need to do proper planning but at the same time to keep an open mind: what else could we do that would help us? could we try this method/approach out before committing to it?

What practical steps helped?

- ☑ Keep reviewing the plan en route.
- ☑ Trying innovative methods, even in a small way (e.g. Hounslow's small estate based event in London).
- ☑ Deliberately inviting people with different views from the group's (e.g. Blackpool).

London - Housing, health & environment review - click here

Expect a journey with ups and downs – that is energised by the material you collect and the people you bring on board: *'a good topic develops a life of its own, it maintains its own momentum'.* People found they got momentum through evidence *'or rather intelligence'* gathering. This *'kept the good questions coming' and enabled 'leapfrogging of ideas'* and new information from people, places visited and to be investigated*. 'Getting actual evidence from the veterans and support groups, charities showed what was available, knowing how many veterans knew about the services and how to access them'*: all this was very motivating.

What practical steps helped?

☑ Huge amount of commitment and enthusiasm from officers.

☑ Involving members in interviewing people; persisting!

Keep doing your planning even if it all changes! And try to avoid tricky times of the year – like the May elections or *'the August slump'*... Participants got through these but wished they hadn't been there! Capacity was a major issue and required much resilience, passion and belief from officers.

What practical steps helped?

☑ Persistence again!

☑ Keeping it on the agenda and reviewing what was possible at each stage.

☑ Officers stepping into the breach when member capacity limited post-election (e.g. London).

Having face-to-face discussion – projects found this was key to keeping people informed and keeping people on track: *'getting panel and all stakeholders together informally'*. This helped build *'friendships, common goals and wanting to benefit the community'* which was crucial to maintaining commitment. Events also helped involve a range of stakeholders and gain many perspectives on complex issues. (See *Community & stakeholder engagement* section).

What practical steps helped?

☑ Keeping it on the agenda.

☑ Allowing enough time for review on the agenda.

☑ Mid-term action learning session.

☑ Building on the learning – seeking clarification when necessary.

☑ Doing all this with a mix of people there.

Vision, leadership and drive at the end requires...

Ensuring focus is kept and recommendations are worthwhile: participants wanted to make a difference by what they were doing and needed to keep clear focus on the topic and to frame proposals for action that they and other partners could genuinely follow through.

What practical steps helped?

- A summary of the evidence gathered to keep discussion focused and recommendations linked to evidence.
- *'A can-do attitude with sound reasons for the recommendations'*.

Blackpool Minimum pricing of alcohol review - click here

Cheshire - Rural health inequalities review - click here

Chesterfield - Geographical health inequalities review - click here

- ☑ Recommendations between the different authority reviews being brought together to find common issues.
- ☑ Agreeing achievable but challenging recommendations.
- ☑ Media support.

Keeping space for full debate and to maintain ownership of the outcomes – despite the rush and pressure that all projects experienced to complete their work, participants underlined the importance of really making sure people felt happy with the conclusions and that people were not disappointed in the outcomes proposed. This included *'making joint work relevant to all authorities', 'cycling [several times round issues] to get meaningful recommendations'* and recognising that in many cases people had changed their views from the start of the review once they reached the end.

What practical steps helped?

- ☑ Quality criteria for recommendations.
- ☑ *'Professionally listening and discussing the needs of [the people concerned]'.*
- ☑ *'Recognising that not reaching the original goal does not necessarily mean failure!'*
- ☑ Enthusiasm of final witnesses meant interest in the project revived.

Thinking about follow-through & next steps – many participants commented that their review would not really end at all! *'Does it end?', 'hope to continue in the same way'* are typical reactions. People were clear that monitoring progress & follow-up were crucial among next steps. Also that some recommendations may lead to the need for further scrutiny work. Implications for their own authority and how it works were also key to recognise at this stage, requiring continuing leadership and drive from members e.g. Blackpool recommending action by licensing committees.

What practical steps helped?

- ☑ *'CfPS advisers kept our focus in meetings'* and enabled all panel members to take part in final stage discussions.
- ☑ Listing next steps.
- ☑ Explicitly acknowledge 'I've learnt a lot' and views may have changed.
- ☑ Recognising that just because the project hadn't reached its original goals, it didn't necessarily mean it had failed, just that the vision and focus of the project had adapted as it progressed (e.g. Cheshire).

Finally the paradox of partnership required in leadership and yet the need nonetheless for individual vision and drive was highlighted. The Chesterfield SDA commented:

[The work] highlighted the benefits of many people/communities being mobilised to achieve a goal who may have agreed vision and drive – but also that leadership and direction, often from one individual or organisation, is a necessary catalyst to make the change happen. In our case, it highlights the important community leadership role for councils and their scrutiny councillors / function.

Top tips
for creating and keeping vision, leadership and drive

- ☑ Involve all partners early on to create ownership.
- ☑ Choose a focus that people are enthusiastic about for the area.
- ☑ Ensure you prioritise face-to-face discussions during the project.
- ☑ Create a good mix of people in the review group/panel.
- ☑ Actively seek differing views in gathering information and start early on.
- ☑ Work out scope and plan; stick to the scope but expect the plan to change!
- ☑ Involve people in innovative ways, start on a small scale.
- ☑ Enable members and officers to take part in evidence gathering.
- ☑ Take time to conclude and frame your recommendations.
- ☑ Tenacity and persistence are crucial!

Community & stakeholder engagement

Introduction

When addressing complex issues, such as health inequalities, overview and scrutiny committees (OSCs) depend on making excellent connections with stakeholders including disadvantaged communities. The government agenda on localism and the Big Society gives added impetus to community and stakeholder engagement. OSC's are trying an exciting range of approaches.

Sefton - Geographical health inequalities review - click here

Some of the 10 Scrutiny Development Areas (SDAs) used a more traditional committee and witness approach while others used more informal and innovative approaches. Informal approaches included going out to meet individual residents, service users and/or staff and groups to get stories; through surveys and interviews; using a community artist in schools; and a video booth in the city centre. Events took place which involved specific groups, as well as events that enabled conversations between representatives of all relevant stakeholders including the community in relation to the review.

While most SDA's focused on a topic, Sefton and Chesterfield engaged with a community and wanted to discover and make recommendations concerning the issues that mattered to that community. Despite the diversity of approaches and focus of inquiries, all had rich experiences of successful engagement to share. For some this was from large engagement projects as part of a review; for others it was doing things well in small and important ways, for example, having the right person co-opted on the panel who could reach people they wanted to reach or address those people in ways that encouraged openness and trust.

Chesterfield - Geographical health inequalities review - click here

This chapter describes the seeds of success or core of good engagement which the SDA's discovered from their own practice some of which was unique to the specific health equity reviews they undertook and some related to wider experience. Examples from Salford's recent review on smoking are also referred to.

Seven seeds of success for community and stakeholder engagement

Good facilitation, management and leadership are key elements of effective engagement of the community and other stakeholders. Clarity about the focus of the review, setting boundaries and keeping within the project scope are important; but there are times when a review needs to modify and change direction to ensure a better review.

Warwickshire - Services for teenage parents review - click here

What practical steps helped?

☑ Background work and a common understanding of the key issues are vital before deciding on the lines of a review; and can begin to uncover useful networks and secure mutually trusting relationships.

☑ Develop this in to a stakeholder analysis – who should you be engaging in the review.

☑ Good chairing and an enthusiastic panel made a big difference. The role of panel members can differ, traditionally the scrutiny officer may have arranged all the involvement and consultation and write up the notes, this is not always the case. A more pro-active committee will be able to do more. In Warwickshire:

"The members of the panel were very good and fired up. They arranged their own meetings with young people and came back and reported."

Giving time to the process of relationships

Many people welcome involvement and consultation as an opportunity to be heard, however some have been disappointed by previous experience.

- People have felt they have given their time, expertise and information and not seen the results. It can feel as if something is extracted from you, taken away in a briefcase and if it comes back, it comes back in a form which is unrecognisable; for example a report.
- Sometimes a focus on problems, deficits and needs has resulted in officers and communities feeling defensive.

There are many ways that OSC's and other organisations have made consultation a better experience. Through their initial approach; the consultation itself; how they feedback afterwards but probably the most important – giving time to developing relationships.

The more relationships with partners and the community are open and mutually trusting; the more scrutiny is likely to benefit.

Chesterfield - Geographical health inequalities review - click here

What practical steps helped?

☑ Chesterfield used an appreciative or strength based approach. This focused on building open and trusting relationships between all stakeholders. By starting with capturing what is working, it enabled people to start with what they are proud of in their area or concerning what they do. Because it is a no blame approach participants felt less defensive. Participants raised what needs to be changed themselves and shared their solutions which were practical. As they identified what needed to change, they took responsibility for their role in the solution.

Warwickshire - Services for teenage parents review - click here

☑ It helped when panel members put themselves in the shoes of the people that they want information from. People wanted to know what would change for them as a result of their involvement. Warwickshire found it helped when getting people on board to explain to potential participants why their contribution was both unique and invaluable. The hard thing may be getting people there in the first place.

☑ In London, information about the review was sent out to all stakeholders along with an invitation to an event. The flyer was particularly useful at highlighting the issues and how stakeholders could get involved.

'The panel worked hard to involve the midwives who were very busy. They explained their terms of reference on the phone and then sent them. They came to an event for half a day but stayed for the whole day.' (Warwickshire)

London - Housing, health & environment review - click here

Value Involvement and feedback results

Showing participants that you value and respect their contributions sets a solid foundation for their commitment and future involvement. There are many ways that OSC's can value involvement:

☑ Giving community members £5 vouchers for attending meetings or helping with consultation.

☑ Covering the travel, refreshments and costs of care for dependants help people who might not otherwise have done get involved.

☑ Organising meetings to fit in with school times enabled people who pick up children from school to fully participate.

Sefton - Geographical health inequalities review - click here

Chesterfield - Geographical health inequalities review - click here

London - Housing, health & environment review - click here

If you want people to do something for you, the trust and connection can be enhanced by first asking what you might do for them. For example if a group are looking for funding for a project and are unaware of funding sources, directing them to sources of funding they have a chance of securing may make them enthusiastic to help the OSC.

The way you feedback to stakeholders both about what you did with their contribution and what happened as a result is crucial. Just sending a report is not enough.

A verbal report or film which enables people to hear and see their contribution can be transformational because people can begin to believe that what they say is important, the confidence this brings may lead to taking on much more active roles. The importance of this cannot be overemphasised, especially if you are likely to want to consult this group again in the future.

What practical steps helped?

☑ Chesterfield produced a film of their event which can be used with people who took part in the event and other stakeholders including the local community.

☑ Sefton had a celebration event which not only brought the young people together but also their parents.

The power of personal stories

'The intransigence and complexity of heath inequity can feel overwhelming. The individual stories enabled OSC's to understand the reality of disadvantage and connect with people who wanted their lives to be different.'

Understanding local people and their lives will enhance the findings of any study or review. Some of the SDAs captured personal stories from their participants – these stories were enormously powerful. They were both an excellent way of getting direct information from service users 'face to face contact' and individuals experiences are a powerful evidence base. The way that a story became a metaphor for an inquiry is detailed in the Chesterfield case study, this may have been true of the London inquiry too, where a young man had cycled four miles to tell his story of overcrowded housing, school exclusion, youth offending and his passion to have the opportunity to change.

The intransigence and complexity of heath inequity can feel overwhelming. The individual stories enabled OSC's to understand the reality of disadvantage and connect with people who wanted their lives to be different. For some this transformed how they saw their role:

Previous role	New role
What does the expert evidence tell us about the necessary strategic changes?	What can we learn from individuals whose lives are leading to the worst of the gap in health experience and who are eager to transform their lives? How do we make sure they can transform their lives?

The power of the stories also illustrated how good engagement with a few people at little extra cost can be powerful.

The right approach – is not the always the same for everywhere or everyone

Communities, stakeholders and inequalities are complex and different. OSCs should value this diversity and create an environment where participants feel at ease to contribute. This includes considering the right place or venue, getting the communication right, and showing a willingness to listen.

Chesterfield - Geographical health inequalities review - click here

What practical steps helped?

☑ Focus on the way that you ask questions. This included the importance of open questions and appropriate questions for different stakeholders.

Members of the Chesterfield SDA discovered a new way of connecting:

'We were not a committee going to a meeting to be addressed, but our role was to watch, look and listen, not question. People told us things; we did not have pre-set ideas. Our 'informants' had the 'freedom to do what they wanted. We allowed people to do it their way, we did not manage. There was no pressure in the discussion, the ideas came out. No-one was negative; there were no put downs. We got diverse views which focused on the wider picture, everyone participated.'

Portsmouth - Alcohol admissions to hospital review - click here

☑ Choosing the right settings- places where people felt comfortable to share. There was particular diversity about the right place and to some extent this depended on who the OSC wanted to reach. Most of the SDAs went out to where service users and providers were.

- Portsmouth SDA successfully used a video booth in the city centre to get residents views – reaching as many people as possible in a random way.
- Sefton SDA successfully used a community artist in a school to include children and young people.
- Blackpool SDA used open space methodology to enable everyone to contribute and have their views listened to.

Sefton - Geographical health inequalities review - click here

Right people – focused approaches!

Getting the right people with the right influence to the table during the review enriches the outcome. Many of the SDAs have been successful in bringing together a range of individuals and organisations who haven't worked together in the past.

A key stakeholder is the public – effective community involvement is more than community engagement.

Engagement is all of what is described above – facilitating their interaction or seeking their views. Involvement is a step further. It's about a mutual partnership – setting the direction together. This has been seen in many of the SDAs however notably within the Chesterfield SDA. The community have been involved to the extent that the residents that were involved in the review have started a new community group – a sustainable way to implement the recommendations from their review.

Blackpool Minimum pricing of alcohol review - click here

Make sure you use it

The importance of using stakeholders contribution was the final seed to success, in particular, the role of the OSC in supporting action and facilitating what is needed.

Contributions were used specifically in the recommendations and in the report, which took many forms, including a film, oral or written report.

What practical steps helped?

☑ All of the SDAs are making their reports available to the community, whether this be available on the internet, producing DVDs or direct feedback to groups.

☑ Planning the review effectively – ensured that the right people were engaged and that a plan was in place to report back.

The Chesterfield SDA draws attention to the need to ensure that the panel or planning group cover the implementation stage as well as the inquiry or review stage. The way that the review is set up; who is involved; how ownership of the issues are encouraged; and the "SMARTness" of recommendations will be crucial to maintaining trust, relationships and readiness to engage another time.

Chesterfield - Geographical health inequalities review - click here

Conclusion

Overall, the SDA's suggest that many OSC's are successfully evolving new ways of engaging their communities and other stakeholders and that working out the most appropriate way to connect with the people the OSC need to hear from is vital. Once that is clear, giving time and value to these essential relationships pays great dividends.

Between them, the 10 SDAs used over 50 ways to engage with their communities and stakeholders. Some of these are highlighted in Section Three.

Top tips Seven seeds of successful engagement:

☑ Good facilitation, management and leadership.

☑ Giving time to the process of relationships.

☑ Value involvement and feedback results.

☑ The power of personal stories.

☑ The right approach – is not always the same for everywhere or everyone.

☑ Right people – focused approaches.

☑ Make sure you use it.

Guides to stakeholder and community engagement

IPPR North and Social regeneration consultants for the North East - Good conversations, successful communities, better services – Positioning Paper (October 2010).
http://www.ippr.org.uk/ipprnorth/publicationsandreports/publication.asp?id=786

The Joseph Rowntree Foundation have a wide range of publications on involvement and engagement specifically related to different groups, see http://www.jrf.org.uk/publications and go to involvement and engagement link at the bottom of the page, under browse by link.

Practical ways to engage with your community.
http://www.idea.gov.uk/idk/core/page.do?pageId=16639575

Partnership working

Effective topic-based scrutiny, such as reducing health inequalities, rather than service-based reviews can be greatly enhanced through working in partnership with other councils, health or third sector organisations.

There is much evidence in the accounts of the Scrutiny Development Areas (SDAs) of the advantages of partnership working in a scrutiny environment. It is also important to note that there is no 'one size fits all' approach to partnership. Many, but by no means all, of the scrutiny members and officers have previous experience of working with colleagues in neighbouring authorities, and others in health and third sector organisations. Values of trust, openness and honesty, and a sense of collaboration are common attributes to successful partnerships.

This section considers the following key aspects as identified by the experiences of the SDAs:

- **What is meant by partnership working?**
- **Managing relationships, valuing each other**
- **Working with other local authorities**
- **Working alongside community groups**
- **Top tips for scrutiny in partnership**

What is meant by 'partnership working?'

An examination of each of the SDA projects identifies that there is no universal understanding of the term 'partnership', but that a common feature of effective partnerships is that they have *"shared visions, shared working arrangements and shared goals".*

NE Region - Ex-Service community review - click here

Shared vision – a clear picture in hearts and minds of members, officers and others involved in a scrutiny review.

- Members and officers across the North-East region of England were concerned that there appeared to be little information on health, social care and welfare services for the ex-service community on discharge from the Armed Forces. A shared vision, of trying to achieve better access to services for a vulnerable and unrecognised but sizable community, provided the basis for all twelve unitary councils to come together.
- Taking a different approach to partnership working, seven councils in North-West London came together with an overall shared vision to examine how housing impacts upon health inequalities. However, each council had its own priority areas, opportunities and experiences. Recognising that a single joint scrutiny review exploring diverse issues such as spatial planning, overcrowded housing and fuel poverty, might be complex, councils paired up to investigate topics.

London - Housing, health & environment review - click here

Shared working arrangements – councils involved in partnership working may need to be innovative when exploring how they will work together. At times, officers from one council may be providing direct support to members from another council, and project work may be allocated and carried out by other groups, such as NHS or third sector organisations. Trust will be an important quality in such relationships, and it may be necessary to hold regular meetings or learning sessions so that people can keep up to date.

NE Region - Ex-Service community review - click here

Warwickshire - Services for teenage parents review - click here

Dorset - Cardio-vascular disease review - click here

London - Housing, health & environment review - click here

Sefton - Geographical health inequalities review - click here

- Councillor Ann Cains, Chair of the North-East Joint Committee commented,

  "Working together was hard, requiring trust and co-operation between members and officers across different councils, but we've got there and it's working. While working on a previous regionwide project, witnesses such as NHS managers and front-line staff had commented that it was much simpler to attend one set of meetings, than meetings all over the North-East".

- Meanwhile, Warwickshire County Council, Nuneaton and Bedworth Borough Council and Rugby Borough Council came together to investigate antenatal and post-natal services for teenage parents. Initially, three other borough councils expressed an interest in joining the review, but did not have the necessary available resources, at that time, and so the review was limited to two borough council areas. Paul Williams, of Warwickshire County Council, reflected that,

  "Health inequalities exist across our whole County area. With the experience of a health inequalities review behind us, next time, if a borough is unable to provide resources to support such a review, we will aim to invite members from that borough, and see how we can best support them. We feel it is better to be inclusive".

Shared goals – it is important to focus on what might reasonably emerge from partnership working. Compromises may need to be made in order to bring partners on board, and offer them something useful as an outcome of working together. This may mean that a 'vision' needs to be reined in, or even expanded.

- Dorset County Council led a project involving Bournemouth Borough Council initially aimed at lifestyle and the need for cardio-vascular disease (CVD) services. Working in partnership with local health services, it became clear that there would be a limited contribution to improvements in CVD services through a scrutiny review. However, the review was repositioned to explore the impact of the social determinants of poor health, in relation to CVD, such as education, housing and planning services. This examination using a new 'lens' provided an insight into CVD that had not been considered before.

Managing relationships, valuing each other

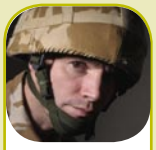
Each of the SDAs took a different approach as to when to involve other organisations, groups and individuals as partners. Some SDAs, such as the North-East region councils, the North-West London Boroughs and Sefton Metropolitan Borough Council identified that partnerships were important as part of the initial bidding and scoping process. Others SDAs, such as Blackpool and Chesterfield identified key partners after the projects started.

Listen to your partners. Let them direct the flow of the project as necessary. In the North-East, early meetings with key partners, the Army and the Royal British Legion, identified three workstream groups - physical health, mental health needs and access to welfare and wrap-around services. Each group was led by a specific member and supported by his or her scrutiny officer. However, members were invited to join a workstream group that interested them, rather than be appointed to one, which meant that some members did not have dedicated officer support on the review from within their own council. Steven Flanagan, Newcastle, noted:

Sefton
- Geographical health inequalities review - click here

Chesterfield
- Geographical health inequalities review - click here

Staffordshire
- Mental health services review - click here



NE Region
- Ex-Service community review - click here

Blackpool
Minimum pricing of alcohol review - click here

"It was very heartening to see how well members and officers from different authorities worked with each other. This is an approach that we would definitely use again."

Find out what your partner can do that you can't do by yourself. Debbie Campbell, of Sefton Council, involved the local primary care trust in the project design,

"We have good relations with NHS Sefton, it made sense to work with them on this project. We jointly produced a consultation programme, and met health professionals, patient representatives and parents, children and carers."

Let partnerships emerge; get the 'right people' on board. Chesterfield Borough Council took a 'ground level' view. It became clear that key partners were Derbyshire County Council; though at a front-line service delivery level rather than with senior managers. Getting local community groups interested was also important if project outcomes were to be sustainable. Anita Cunningham commented,

"A large number of partners were already working in the locality. They were mobilised to take part due to their existing interest and work there. It enabled a 'whole system' approach to service improvement."

Working with other local authorities

Across the SDAs there was no particular model for partnership working which should be a prescribed template for others to follow. Partnership arrangements need to be shaped locally. However, it is important to have structure and shape, and a framework for managing the review, identifying where partners 'fit in', how evidence will be gathered and considered and how decisions will be made.

Modifying standing arrangements for committees. In Staffordshire, the scrutiny model involves district councils' members sitting on committees with county councillors. Also, the health inequalities issue 'crossed' the terms of reference of at least two standing committees. Councillor Geoff Morrison commented,

"An advantage of involving district councillors at the outset is that we can examine a wider set of determinants of health influenced by both county and district services, than if we were to start with the county council alone."

Agreeing a shared protocol for joint working. The North-East region built on existing informal arrangements and established a formal joint committee to commission the ex-service community review. All twelve councils signed up to a protocol which set out ways of working, support arrangements and the decision-making process.

Bringing other councils on board during the review process. Blackpool Borough Council's review into minimum pricing of alcohol expanded to include a wider geographical area of the North-West of England than originally planned. Sensing that neighbours faced similar issues, the Blackpool team invited members from Lancashire, Cumbria and Blackburn with Darwen to take part. The review covered more ground that might be possible by a single authority, and regular meetings led to sustained participation. Councillor Sue Fowler said:

"Working with members from other councils broadened our perspective, and we were able to listen to independent and small retailers about what was happening in different parts of the North-West in relation to alcohol pricing. Our next challenge is to gather the views of large chains such as Tescos and Sainsburys, both of which decided not to take part in our review."

Portsmouth - Alcohol admissions to hospital review - click here

Working alongside community groups

The value of working with community groups and individuals in a community cannot be understated. Rather than involving them as consultees, you may wish to go a step further and involve local people in the design of a review, and commission them to carry out work on behalf of the partnership.

Chesterfield - Geographical health inequalities review - click here

Working with local people. Jane Di Dino, Portsmouth City Council, noted,

"We worked closely with NHS services and Portsmouth's street pastors, and bringing groups with a common interest together was very helpful in reducing alcohol-related admissions to hospital. Given the large student population and that Portsmouth is a naval port, we agreed that services for these vulnerable and 'at risk' groups could be further improved with the support of local universities and the Royal Navy".

Letting community partnerships emerge and grow during the review process – beyond consultation. Councillor Jane Collins, Chesterfield Borough Council reflected,

"Our partnership approach embraced local community groups. You don't realise fully the range and depth of resources you have available until you start to look around. Knowledge of our network snowballed as the project moved forward. We found that significant drivers for working together are enthusiasm and momentum."

Councillor Collins added,

"Some of the outcomes encompass things public service organisations talk about all the time - such as co-production, empowering communities to help and do for themselves and taking a bottom up not top down approach to service delivery. The recommended actions will be the beginning of these three things – and could be the start of a community based and driven Action Group where resources will (hopefully, if everyone stays committed) be directly targeted to the community to help address needs and concerns."

Top tips for partnership working

In conclusion, the SDAs point to the following as their top tips of scrutiny working in partnership

- ☑ **Invest time and energy in identifying potential partners who may add value to the scrutiny review.**
- ☑ **Refine the scope of the review if necessary, a new partner can bring something to the table that cannot be achieved by other means, and that the 'something' will be of use in the project.**
- ☑ **Listen to your partner. Be flexible, and agree a shared vision, shared working arrangements and shared goals.**
- ☑ **Review the shared vision, shared working arrangements and shared goals regularly, and agree a commentary on how the review process continues to meet these aims.**
- ☑ **Let your partner have the opportunity to shape the review. The reason that they are working with you is that they can bring something to the review that you cannot achieve by yourself. Be clear with them about the way you work, the way you make decisions, and let them feel part of the process. Share successes and disappointments.**
- ☑ **Agree a framework for the review, and be clear how decisions will be made – using or building on existing arrangements, working with a formal or informal protocol?**
- ☑ **If opportunities arise during a review to bring in new partners, let that happen if it is in the interests of the project. Refocus the shared vision if necessary.**
- ☑ **Work with local people and embrace their ideas.**

Local understanding

A key element of a successful scrutiny review of health inequalities is local understanding – developing an understanding of the local context and what is known about the locality, and the issue or aspect being scrutinised, in terms of local information. The key aspects of this theme covered below are:

- Using and exploring your Joint Strategic Needs Assessment.
- Understanding health inequalities.
- The importance of a stakeholder analysis.
- Data and information:
  - o What's missing,
  - o Categories of information.
- Confidentiality.
- How Cheshire's review of health inequalities in rural areas used the three types of information.

Using and exploring your Joint Strategic Needs Assessment

Joint Strategic Needs Assessments (JSNAs) have developed over time and now with the drive from the Coalition Government will play an even more important role in developing local strategic direction and commissioning of health and well-being services.

At the start of the Health Inequalities Scrutiny Programme, it was a surprising fact that only 50% of councils attending Regional CfPS' Health Scrutiny Events had received a presentation on their JSNA at a scrutiny committee. However this programme has shown the benefit of having a definitive guide to understanding health needs – it is vital in ensuring that services are effectively delivered and based on actual health needs.

Using the JSNA is one of the best ways and a good starting point to understand your local community, and its inequalities.As a minimum, a good JSNA should be the definitive local guide that:

☑ Shows a comprehensive local picture of health and well-being needs.

☑ Partners undertake jointly – gathering intelligence and analysis on the 'big picture', e.g. what's working, what's not, and what could work better? Or, where should we invest or disinvest resources for best value?

☑ Partners use to negotiate and agree overarching priorities on health and well-being.

☑ Influences public commissioning and decision-making behaviours.

☑ Summarises information on the strategic picture for health and well-being for wider audiences (e.g. the public, NHS Commissioning Board, providers, local media, or any audience the Health and Well-being Board considers appropriate).

A guide to developing a good JSNA has been produced by Local Government Improvement and Development. This guide is due to be launched in May 2011 and can be found by using the link in the *links and references section* at the end of this publication.

Warwickshire - Services for teenage parents review - click here

Blackpool Minimum pricing of alcohol review - click here

Chesterfield - Geographical health inequalities review - click here

Cheshire - Rural health inequalities review - click here

NE Region - Ex-Service community review - click here

Portsmouth - Alcohol admissions to hospital review - click here

This programme has highlighted and demonstrated the valuable role that the scrutiny process can have in:

☑ Developing the content of the JSNA.

The scrutiny process can help councils and their partners to really get to understand the community and the health outcomes of its residents. Scrutiny uses an intensive magnifying glass on an issue – taking that important step back – to look at the community / issue holistically. In Chesterfield for example, Appreciative Inquiry and the local community helped to explore what was good about the area and how these good things could be replicated. It is therefore a good idea for JSNA to look at the assets of a community as well as the needs.

☑ Exploring if the JSNA is fit for purpose.

Sometimes the JSNA falls short of providing the information that you need to effectively commission services based on need. Scrutinising the effectiveness of the JSNA is therefore another vital and effective role that a scrutiny committee can have. Using examples of good practice highlighted in the above publication and the benchmark within it – members will be able to carry out a 'fit for purpose' test on their JSNA.

Understanding health inequalities in your area

What is the issue?

It is understood that health inequalities are complex, as they have a number of contributory factors. All of the Scrutiny Development Areas (SDAs) had identified the health inequality that they wanted to review before applying to become an SDA – but how did they know which health inequality to focus on?

For some areas it is a well known inequality, and a public health priority:

☑ Warwickshire's review for teenage parents had grown out of work that they had been doing on this theme.

☑ Blackpool and Portsmouth's review in to different aspects of alcohol and its affect on health – was as a result of alcohol being a high health priority.

For others they knew that they had a community that suffered worse health outcomes and they wanted to understand why – the underlying determinants:

☑ Chesterfield used Appreciative Inquiry to get to understand a community better – so that it could address the wider determinants alongside well-being.

☑ Cheshire has a large rural population and some very isolated villages; they wanted to understand rural isolation and its affect on health.

☑ The North East knew that they had a large population of ex-service personnel – however little was known about their well-being if they did not access services when leaving the forces – this review has helped to plug that information gap.

Information on health inequalities was in some cases hard to find, knowing what impacts on health and well-being and how that in turn affects a persons health outcomes is a difficult one to quantify. Many of the SDAs had to use new ways to collect information.

What practical steps can help?

Quotes from SDA participants:

☑ *"Involving relevant stakeholders at the start of the review –allowed for a better understanding of the issue and information on the topic."*

☑ *"Work-shadowing partners was good – e.g. police and ambulance – enabled councillors to speak to staff and users of services about what could be improved."*

☑*"Think beyond traditional methods - use story telling techniques, video diaries, video booths or voting i-pads."*

☑ *"Be open to new and unusual sources."*

☑ *"A mapping exercise showing where resources are (on a map) - and getting local councillors, officers and representatives from local groups to validate the map was helpful."*

☑*"Transcend pre-conceived ideas – councillors had pre-conceived ideas about young people's views but the direct involvement of young people helped show the councillors that they were wrong and that the young people's views were different."*

☑ *"Use Appreciative Inquiry approach to look at what works and makes people happy – for us, this created the information."*

☑ *"We moved away from the need to have information and numbers of patients to the need to gather evidence about what works and what doesn't."*

The Marmot review helped to focus the mind on health inequalities – and provide a sound evidence base for what works in reducing health inequalities. In February 2011 they published a useful tool – a basket of indicators that can be used to understand health inequalities in more detail. This can be found in Section Three.

Stakeholder analysis

Scrutiny officers will typically turn to colleagues in their council's research/information department for help and advice in sourcing information. However a key common theme arising from sharing experiences across the 10 SDAs, was the need to do a "stakeholder analysis". This is about identifying who are the people who are or should be interested, or who can help.

It is useful to recognise that there are different kinds of stakeholder such as:

- People and organisations who should be interested in our findings and recommendations – and whom we will want to influence.
- People, organisations and networks who can present evidence to us – witnesses:

  "One individual can sometimes provide a lot of information (e.g. Director of Public Health) - if you can identify the right witness you can get the right data."

- People and organisations who may hold information that would be useful to us.

What practical steps can help?

☑ Do an analysis of stakeholders at the start of your review – this should also be kept under review as focus and knowledge may change during the review.

☑ Produce a short information "flyer" – a half-page or so that tells potentially interested parties about what the review is trying to achieve.

☑ Involve stakeholders in discussions about the information that they hold – don't just guess that they hold it.

☑ Challenge stakeholders to help the review achieve its goals by offering useful information that the committee didn't think of.

Some good ideas suggested by the SDA participants were:

- *"You need to think past the challenges and make good use of intermediaries, e.g. the British Legion helped us to reach ex-service people."*
- *"Faith groups played a key role in collecting data as they are respected in the community."*
- *"There is no substitute for talking to users, even if the evidence from organisations is inconsistent."*
- *"Focus groups are good ways to get views".*
- *"We made clear we would deal with personal information sensitively highlighting issues not individuals – you can get a personal case study that is anonymous."*
- *"It was hard to find data about veterans – no one asks people if they are veterans, although this is improving and GPs are now able to ask and it goes on their record. For some people, their service background was so long ago that they don't think it relevant."*

Data and Information

It is helpful to consider the type of information that you need at the start of your review:

- What is the information that we want?
- What is the information that is available?

What practical steps can help?

☑ Consider the information at the same time as doing a stakeholder analysis.

☑ Recognise that, in practice, this is an iterative (repeating) process. That is, until you identify who are the stakeholders, and talk with them about what they have - you can't fully know what is available.

☑ Adjust your sense of what is the information that you want, in the light of emerging knowledge and a better sense of what can be obtained.

The SDAs suggested some good ideas:

- *"We developed key lines of inquiry: first we decided the areas/issues to explore; then we identified the lines of inquiry. This helps someone coming to a meeting to be prepared for the conversation, and provided structure for our review."*
- *"We made a judgement not to repeat work done previously in engaging with local people and were able to make use of information previously collected by another agency."*
- *"Being clear about the framework for scrutiny, what information we are looking for and how we will use it was really valued by NHS and other stakeholders."*

Confidentiality

During the process of defining information requirements and contacting stakeholders, a third dimension arises:

- What is the information that third parties are willing to let us have – or may be persuaded to extract?

This is where developing local understanding gets more difficult. Third parties may have legitimate concerns about the confidentiality of the information they hold – and that it may in practice enable individuals to be identified.

What practical steps can help?

☑ Recognise that information holders may also be falling back on traditional concerns that are open to challenge.

☑ There may be data available that has never been extracted or used. For example, GPs may be collecting data on smoking prevalence or other aspects of lifestyle - that are not routinely extracted and summarised. If this is the case see if the GP or the local Primary Care Trust were willing to resource this piece of work.

☑ Negotiate – over access to data, this is something that scrutiny officers must be prepared to do.

What's missing?

After all of the preparation work; it maybe that you find that the information simply doesn't exist. In which case, there is a fourth aspect to think about in relation to information.

For example, some of the reviews found:

"It was easy to get information, but there are often gaps and information is not 'joined up."

"We had no trouble establishing facts, but in trying to find out about the nature of services, we realised that service providers couldn't provide information on the effectiveness of services."

"The problem is the data that's NOT collected."

"A lot of primary information that we thought would be available wasn't."

"We have had to gather evidence and move away from our expectations."

"Information you thought would be held either doesn't exist or it does but we can't access it."

"Information provided was often too broad and/or in the wrong format."

"Data is frequently collected in systems that are incompatible across agencies, so you can't link or match data. We even came across voluntary organisations that were working in silos."

"The challenge is how to deal with feast or famine of information, and how we can be proactive."

What practical steps can help?

Some examples from the SDAs were:

☑ *"There was a lack of information to establish whether there were inequalities - so we went out and collected our own data through focus groups."*

☑ *"Some information is readily available whereas others we recognised that we had to go and get."*

☑ *"We thought about how to get information from the harder to reach."*

☑ *"Simply identifying what's missing can itself stimulate other agencies to ask questions, collect information, or link up information in new ways."*

☑ *"Finding the right information often needs luck (to find where it is or who holds it) – so the challenge is, how can we plan to be lucky."*

Categories of information

Information can be categorised as **quantitative** (numbers of things) or **qualitative** (or "soft" - information in narrative or visual formats that can often provide a rich picture but may not be "statistically robust"). Focus groups, opinions, interview notes and "anecdotal" information fall into the latter category.

What practical steps can help?

Some reviews specifically noted the need to have a balance between quantitative and qualitative information:

☑ "*Bringing quantitative and qualitative data together is a big challenge.*"

How Cheshire's review of health inequalities in rural areas used three types of information

This review grappled with the challenge of defining and acquiring the appropriate information for its Joint Health Overview & Scrutiny Committee.

What practical steps can help?

This review looked at how to get information on health inequalities for "small pockets" – and while this was for rural areas, the concept and methodology would be equally as applicable to urban areas.

In recognition of the three categories of stakeholder outlined above, they identified three types of information that would give local understanding:

☑ Type One – information held by other organisations such as the council and Primary Care Trust (PCT), or that ought to be available from them.

continues

Cheshire - Rural health inequalities review - click here

- ☑ Type Two – "anecdotal" information – information which is not currently available but which the review decided to create. It did this by (a) asking councillors their views and (b) local councillors and officers going out and talking with local residents in the two pilot rural areas about their experience of health inequalities.
- ☑ Type Three – information derived from a "**mini-review**"* of one aspect of the experience of health inequalities in rural areas – for which a focus on mental health was chosen. *Mini-scrutiny review is explained further in Section Three.

Top tips for developing local understanding

- ☑ Use your Joint Strategic Needs Assessment as a starting point for understanding health inequalities.
- ☑ Consider how your review could help to provide information to include within the Joint Strategic Needs Assessment.
- ☑ Use national and local resources to understand health inequalities.
- ☑ Work with stakeholders to define the inequality and information needed.
- ☑ Carry out a stakeholder analysis – ensuring the right people are involved and contribute, can improve the effectiveness of the review.
- ☑ Use experts to help you understand the data that is available – and the data that isn't. Trying to work this out on your own is a daunting task.
- ☑ Data confidentiality can cause problems when you are trying to source relevant information that can help with the review – be mindful of the type of data that you want and why – work again with experts to understand protocols that may exist.
- ☑ Think creatively about how you can gather information that is missing – members conducting surveys, students helping etc.
- ☑ When scoping your review – have an awareness of the different types of data (above) and how you can gather these in the review.

Being systematic

Whilst each review is different, and the way in which the elements of scrutiny are carried out may differ, this chapter identifies the core processes which together, create a sound and robust system for scrutinising health inequalities. Systematic planning can help to ensure that overview and scrutiny achieves its fullest potential and makes effective recommendations. Much of this is common sense, but it is easy to become caught up in a need to respond to health inequalities without working through the most effective process to achieve maximum influence. Being systematic in planning and process can help.

Planning systematically

There are seven stages to this approach:

1. Identifying why the issue is important

Begin by identifying why the issue is important locally. For example:

- It is an identified issue within the Joint Strategic Needs Assessment.
- Identifying health inequalities from data held locally, regionally or nationally.
- An existing concern from a previous scrutiny review.
- An issue raised by another committee or department within the local authority.
- The result of issues raised with the committee by external organisations, groups, or individuals.
- Identification of a group or issue that is often neglected by councillors or officers.
- A national priority.
- The result of identifying a change in service usage.

Each different trigger point will be helpful in identifying the potential stakeholders and scope of the review, but before a review is launched, it is important to verify whether it is an issue for local people. You may already have information about what local people consider to be important issues from existing involvement activities such as neighbourhood forums, citizens' panels, surveys or public meetings. If the information doesn't exist, members of the review group might consider holding a focus group with representatives of a neighbourhood or community or attending one or more existing groups and discussing the proposed review topic and how it has been identified with local people. Other chapters in this guide consider methods of *Community and Stakeholder Engagement* in more detail.

By involving local people in determining the topics for and methods of scrutiny, councillors may be able to probe into the causes of inequalities and the issues of importance to local people resulting in robust and influential reviews.

2. Identifying what is already known – scoping the review

Before starting to scrutinise it is important to clarify what is already known about the issue, where information is held and whether anyone else has reviewed a similar issue either locally or elsewhere. By the end of this process the committee or group should be able to agree the aims, objectives and terms of reference of the review.

Key areas to consider are:

- What do we already know?
- Where is the evidence for these views?
- What do we hope to achieve?
- What has been done that is similar and is still relevant?
- Who else might have information?

Learning from the Scrutiny Development Areas (SDAs) indicates that it is important to be flexible at this stage and to focus on the information that is and isn't available, rather than making assumptions about what should be. The sections in this document on a *Benchmark for effective scrutiny* and *Local understanding* may be helpful in scoping the review.

When information has been identified, good practice shows benefits from producing a pack of national and local information about the topic for each councillor to use as reference. Also, by involving external specialists in scoping the topic and familiarising councillors with the language and concepts, robust questioning and investigation can take place as the review develops.

3. Identifying who should be involved

The role of all participants influences the whole scrutiny process. This includes the role that officers and councillors take.

Feedback from the SDA's shows it is important to choose a chair for a review with the right skills to provide leadership, vision, drive and focus. This will enable the review to effectively challenge and become *"a shepherd more than sheepdog"* (SDA area feedback). The section in this document on *Leadership, vision and drive* will help in planning for this.

Councillors need to be clear about who is best placed to scrutinise an issue. Learning from the SDAs indicates that councillors with an interest both for and against an issue helps to reflect the different community views. In two-tier authorities, and where health inequalities exist between localities within a local authority area, it may be important to involve councillors from district and borough councils or representing different types of wards. It may also be helpful to involve councillors representing different scrutiny committees, e.g. health and adult social care or health and planning. A diversity of councillor interests or responsibilities may result in more effective scrutiny. This is especially important when addressing health inequalities themselves as the causes and effects rarely fit into one service area and are likely to span a number of areas of responsibility. Enthusiasm and interest in the issue are also important, although there may be risks if participants have specific knowledge and are not open to challenge themselves.

It may be appropriate to consider involving one or more external stakeholders as co-opted members to the review group. Before doing so, consider how they will add value to the group:

- Do they have direct or indirect experience of the inequalities being considered? If so, will this enable members to focus on the causes or change the emphasis to the effects of health inequalities?
- Do they have specialist expertise that would provide advice to councillors?
- Can they provide a view that councillors would not have?
- Will they be comfortable being involved in scrutiny, or would they be happier observing and providing advice at another stage?

- Do they have specialist information about the issue? If so would they be more effective in providing evidence or information?
- Which stakeholders are best placed to provide evidence and information?

In some cases there may be a number of groups and individuals wanting to participate. 'Having a seat at the table' is sometimes seen by external groups as providing an opportunity to have more influence on scrutiny, when it may be more effective for groups to provide evidence and information to a panel whilst remaining outside the scrutiny process. The review group should consider with officers how best to capture the diversity of voices and how to ensure that none are lost, whilst also maintaining a balance of views. It will then be in a position to identify any gaps. If a review only gathers information from self-nominating groups it is likely that the views of individuals who are uncomfortable participating in formal processes will be lost. It is essential to identify how to ensure that the 'voices' of the target community is heard in all its diversity. The section on *Local understanding*, within this document, may be helpful in identifying who should be involved in a review and what role they should take.

4. Identifying where overview and scrutiny will have most influence – setting priorities

A major challenge for scrutiny is ensuring that review topics have greatest influence. This may not always be the most popular issue, or address the most significant health inequality. Sometimes it may be appropriate to focus on an issue that can be influenced and which enables the review group to build credibility with service providers or other stakeholders, before addressing the 'big one'.

Prioritising issues is key. It requires councillors to objectively consider the list of possible topics and decide what to act on now, what to keep for later, and what to reject outright. A number of techniques can be applied, for example:

- Setting priorities according to deadlines, e.g. where there is an opportunity to influence a commissioning strategy through the recommendations from a review.
- Setting priorities according to true importance of a task, i.e. recognising that the issue cannot be ignored – although to identify recommendations and influence services to address them will be challenging.
- Setting priorities based on what's important to the local authority or partnership, i.e. focusing on issues already identified in the council's broader strategic plan or in the Local Strategic Partnership.
- Using the ABC method. This method asks participants in a group to rank a list of issues as:

  A = vital B = important C = nice

  The rankings are then compared and the topic with the most A's is chosen. This can be developed into ranking a list of priorities from 1 to 10 and then compared.
- Setting priorities by using 'pay off' versus 'time'. This technique considers the level of influence (pay off) versus the time or resources likely to be needed to undertake a review. It may be useful when there is limited capacity or time to undertake a review.

It is useful to always check with commissioners and providers of services whether there are any planned reviews, service changes or developments about to take place that scrutiny can input into.

5. Identifying best methods and approaches

It is often easy to jump into a review using locally tried and tested methods, only to realise part way through that things could have been done differently, and sometimes better. The different sections of this publication may be helpful in avoiding this but in addition there should always be some flexibility built in to deal with the unforeseen, e.g. bad weather can prevent meetings being held, and witnesses at formal hearings can become defensive and provide minimal information. It may be helpful to consider:

Timing – is there a limited timeframe to undertake the review? If so, a one day hearing may be the best approach. If not, how long is needed?

What practical steps can help?

☑ Provide participants with short briefings about the aims and objectives of the review and likely areas for questioning.

☑ Don't repeat consultations and engagement activities that have already been done by others – make use of their data instead.

Resources – what capacity do councillors and officers have to undertake background research, to brief participants providing information, to travel to different venues?

What practical steps can help?

☑ Work with service users to collect their stories on a one to one basis.

☑ Stay focused on the topic despite distractions.

Confidence – how confident are councillors and officers to try different approaches to collecting information during a review? For example, how confident are they to go to a job centre to talk and listen to unemployed people and staff?

What practical steps can help?

☑ Use observation as well as routinely analysed data and interviews.

☑ Go out to gather evidence rather than inviting people to come to a meeting. Examples include, councillors 'shadowing' ambulance staff and going out to visit community groups.

☑ Reflect with the review group at points during the process helps to stay on track and to improve scrutiny skills.

Risks – what are the risks associated with different approaches? For example, if the committee is challenged in its recommendations, how robust does it believe its methodology has been ?

What practical steps can help?

☑ Encourage full participation of councillors, sharing tasks to gain shared ownership.

☑ Have sound but flexible systems in place to be clear with participants, whatever their background, about why their information or story is important.

☑ Plan the end of the review, this may be an exit strategy or a 'next steps' strategy.

The approach that is used should pay attention to the qualitative or experiential data from people excluded from or unable to access the services as well as the more formal data held

by organisations. It shows the broader impact of health inequalities. This may result in a combination of methods of scrutiny being applied to one review, enabling councillors and officers to work separately and together in order to gain an in-depth view both about the issues and about ways in which they might be addressed, in order to make robust recommendations.

6. Identifying when the review should take place –the best time to have the greatest influence

Timing can be important for a review to be successful. Not solely when the review takes place, but also timing of meetings, of engagement activities, and for making recommendations.

The best time to undertake a review should be identified in partnership with the key stakeholders.

Times to avoid, in addition to local authority timing constraints,

- Statutory organisations are unlikely to have the capacity to participate actively in reviews during budget setting period (usually January to March).
- Voluntary organisations receiving public funding are less likely to have the capacity to participate towards the end of the financial year if they are unsure of their funding.
- Members of the public may struggle to participate during summer holidays (parents and carers of children), during winter weather (anyone but especially older people, carers, parents and carers of children).
- People who work are unlikely to be able to participate during the working week.
- Many people are unlikely to participate in the evening during the winter.
- Young people are unlikely to participate during the week, at evenings, and in formal environments.
- Most people are unlikely to participate in the preparation period for main holidays such as Christmas and Easter or other religious festivals.
- People belonging to different cultural and religious groups will have days and times when they are unable to participate.

...Many people are unlikely to participate in the evening during the winter...

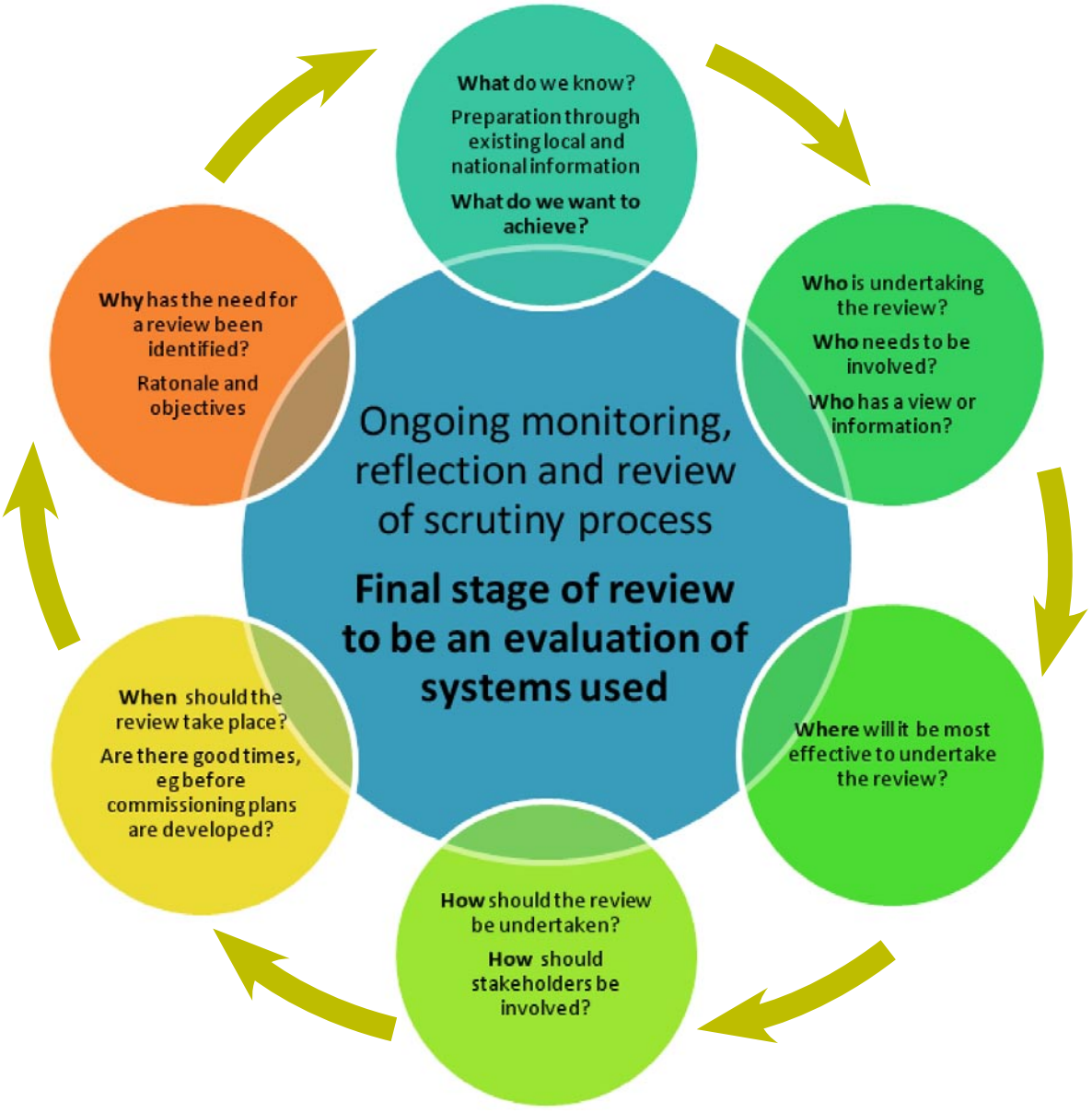
A central activity for a forward thinking and inclusive scrutiny review is to check with stakeholders about both the timing of the review and the timing of the activities within the review. For example:

- By checking with commissioners of services to find out whether there are opportunities to influence services and timing a review to capitalise on this.
- To talk to interested groups before the review starts, or their representatives, to identify the best time and location to engage with them.
- To ascertain the best time for making recommendations, e.g. two weeks before a Board meeting.
- To clarify the most effective method for presenting recommendations to all main stakeholders.

...One of the benefits has been the regular pauses for reflection during the reviews...

7. Monitor and review

After an intense scrutiny review, often focusing on challenging and difficult issues and requiring a variety of skills and approaches, there is often a temptation to make recommendations, breathe a sigh of relief and move onto the next pressing priority for scrutiny. The drawback with this approach is that learning about what has worked well and what could be improved, where there is good data, and where information is lacking, or where influence has been achieved and where it has not been, may be lost. One of the benefits identified by both councillors and officers of the health inequalities project has been the regular pauses for reflection during the reviews, and how the reflective learning has benefited the scrutiny process. At the end of all reviews this should be drawn together into an opportunity to identify how recommendations or influence will be monitored and how the scrutiny process can be improved in the future. The outcomes of a monitoring and review or evaluation meeting may have a large influence on the effective scrutiny of health inequalities and other issues in the future. This publiation includes a chapter on *Monitoring and evaluation*.



Monitoring and evaluation

Monitoring and evaluation are crucial ingredients for a successful review. In this section we examine how they have been used at two distinct phases of the Scrutiny Development Area (SDA) reviews:

1. **Project managing a review.** We look at how action learning has helped to keep reviews on course to achieve their original objectives or to inform decisions on whether and how to change course when emerging evidence points to a different approach.
2. **Post review monitoring and evaluation.** We look at how the SDA reviews have framed their recommendations and planned further action to ensure that recommendations are implemented and that their impact is evaluated.

Project managing a review

The key lessons from the SDAs about project managing reviews were as follows:

Make sure you understand the subject under review

Many reviews will be exploring subjects that involve complex issues and processes. Whilst the panel should not get bogged down in technical detail, it is really helpful to have at least one panel member who is independent from the council, but has the relevant technical knowledge. This will help the panel to focus its attention on the most fruitful areas and set realistic targets for its work.

Use action learning as an integral part of your review

As one of the conditions for CfPS support, each SDA was asked to undertake two or more action learning sessions during the course of the review, one in the middle and one near the end to reflect on what had been learnt. The SDAs reported that this approach had many benefits for the review process. The kind of questions that are used in this approach include the following:

- What is going well and not so well?
- Are we on course to achieve our objectives?
- Does the emerging evidence indicate that we need to change/modify our objectives or our approach?
- Are we collecting the right evidence?
- Are we consulting/involving the right people (and using the best approaches)?
- Do we have the right vision, leadership, skills and drive available in the team?
- Are we communicating effectively with partners?
- What should we be doing (or should we have done) differently?

Portsmouth - Alcohol admissions to hospital review - click here

"The action learning process was the catalyst for bringing everyone involved in the review together for the first time. Without the requirement to conduct an action learning session we may have missed that opportunity."

Jane Di Dino, Portsmouth

"We had a good approach to monitoring our progress as we project managed the review. The action learning process allowed us to reflect on what we learnt at different stages of the review and to adjust our course accordingly. We responded well to new evidence and emerging ideas."

Lucy Johns, Dorset.

Chesterfield - Geographical health inequalities review - click here

The Chesterfield SDA used the original bid to CFPS as the basis of their project plan. At each steering group meeting they looked at progress against the milestones set in the project plan and decided on what action was needed in response to emerging issues. They described this as an informal approach to action learning.

Involve key stakeholders in some part of the action learning process

Some of the SDAs conducted their action learning sessions as a closed discussion within the review panel without the involvement of wider stakeholders. They found this to be the most efficient way of making management decisions about the course of the review and the deployment of resources. However, others like Portsmouth invited a wide range of stakeholders and used the sessions as part of the engagement process in their review of alcohol related hospital admissions. This approach had the advantage of making the wider group feel more involved in the review but it is not the best environment for making executive decisions. Review panels should consider which aspects of reflective learning need to be done in closed discussions and which aspects would benefit from wider discussion.

The Sefton SDA was managed by a group of members and officers from the Local Authority and the NHS but they also held an action learning session that included ward councillors, heads of departments, service users and community members.

Sefton - Geographical health inequalities review - click here

"The action learning session was valuable in bringing together a wide range of views. It supplemented the informal reflection and learning that took place in the management group as our project progressed."

Debbie Campbell, Sefton

Portsmouth - Alcohol admissions to hospital review - click here

Use an independent facilitator and/or chair for action learning

Many of the SDAs used their expert adviser to facilitate the action learning sessions and found that they benefited from the adviser's independence, experience and facilitating skills. It enabled them to stand back and reflect on learning points in a more detached way. However, you don't always need an external facilitator.

In their review of issues around minimum pricing of alcohol, Blackpool decided to use a different chair for the action learning sessions as they felt this would allow a more detached assessment of learning. They had not done that on previous reviews but reported that they may adopt the same approach in future.

Blackpool Minimum pricing of alcohol review - click here

Set realistic indicators of success when scoping your review

The process of scoping your review should include decisions about what you expect to achieve by particular milestone dates. You should identify indicators of success and set targets that are challenging but achievable. They should be measurable so that you will be able to monitor how well you are doing as the review progresses. Some of the indicators will be about outcomes:

- **How can this review make a difference to people's lives?**
- **What inequalities do you want to reduce?**
- **How will you know whether they are reducing?**

Other indicators will be about the processes you use in the review;

" What inequalities do you want to reduce?"

- **Are we finding the evidence we need?**
- **Are we consulting and involving the right people?**
- **Is our project plan realistic in relation to the resources we have available?**

In scoping the Warwickshire SDA members chose to focus on a narrow range of key issues where they could have a significant impact rather than try to cover a wide range of issues. The main issues were about the effectiveness of care pathways so the panel wanted to design an approach that would enable them to explore how pathways could be improved. The approach adopted was to bring the managers of the appropriate care pathways together in a select committee setting. They then used the action learning sessions to reflect on how well their designed approach fitted their purpose.

" How will you know whether they are reducing?"

The Authorities involved in the North East SDA developed their project plan at an "Evidence Day" and then used an officer group to monitor adherence to the plan, to assess risks and to manage stakeholder engagement. Newcastle City Council provided the leadership and support for the review and used their own project management model to provide the support that members needed. This included a traffic light system to show how actions were shaping up against the plan. The officer group provided regular monitoring reports to the member's panel to help them assess what was going well and what needed to be improved. With twelve Local Authorities involved it was essential to have this sort of disciplined governance arrangement.

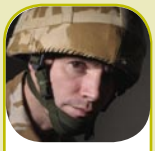
The London SDA adopted a more decentralised approach for their review of housing issues as a wider determinant of health. They broke the review down into four key themes and different boroughs led on a particular theme. Co-ordination was achieved by using a common approach to action learning and by the production of a shared learning report.

Have the courage to change course if you're on the wrong track

Once you have scoped your review and produced your project plan there may be a temptation to focus on compliance. Have we done all the things we set out to do by the deadlines we set? Whilst this is part of the project management process, it is not the whole story. As the review progresses and evidence starts to emerge, you need to evaluate what it is telling you about the issues that you want to investigate. Are you addressing the most important issues? Have you adopted the most appropriate approach?

Warwickshire - Services for teenage parents review - click here

London - Housing, health & environment review - click here



NE Region - Ex-Service community review - click here

In their review of health inequalities in relation to cardio-vascular disease (CVD) Dorset and Bournemouth set out to examine risk factors, looking at problems and assets in four of their most deprived communities because there was some evidence that rates of CVD were greatest in these areas. Their focus was on the effectiveness of healthy living initiatives to influence behaviours around diet, exercise and smoking. However as the review progressed it became clear that the scope for improvement through such initiatives is limited compared with the development of partnership strategies to address the wider determinants of health such as housing, education, employment and environment. In reaching this view, the panel was influenced by local evidence from public health reports and consultations in the four areas as well as evidence from the Marmot report about gradients of health inequalities. They decided to make a major change to their project plan which meant abandoning plans to gather further evidence in the four deprived areas in favour of addressing a series of challenging questions to leaders of the Local Strategic Partnerships and managers of key services. They found that many managers were not focused on the impact that their services have on health outcomes and recognised that a whole systems approach was needed to improve outcomes. This would not have happened if the review team had a tick-box mentality.

Dorset - Cardio-vascular disease review - click here

Post review monitoring and evaluation

The work done by the SDAs has highlighted the importance of post review monitoring and evaluation. The key learning points are as follows:

Set realistic targets in your recommendations to measure implementation and impact

In the section above on project management we referred to the value of having a panel member who has good experience and knowledge of the subject under review. This is also important in helping you to set realistic targets for post-review implementation.

Most of the SDAs have framed (or intend to frame) their recommendations in a way that makes it clear who should do what by when. In some cases this simply sets target dates by which the Executive is expected to respond to the review's recommendations but some SDAs go further than that. The Warwickshire report is a good example of this. It contains an action plan in the form of a table that specifies, for each recommendation, the responsible officer or agency, an implementation date and comments that explain the proposed action in more detail.

Most of the reviews include targets for the review teams themselves about when they will revisit the issue (usually after six and/or twelve months) and what they will be looking for when they do. They often specify an early date by which those responsible for implementation are asked to respond to the recommendations as well as dates for reports on progress. Some reviews also specify how and when impact will be evaluated in the longer term.

Warwickshire - Services for teenage parents review - click here

Make use of any available data from performance management systems used by managers of relevant services

Where reviews are looking at services that use well-developed performance management systems, there should be data available to evaluate their efficiency and effectiveness in relation to their stated objectives. This is really helpful to the review process but remember that services usually design their performance targets to focus on their core business and may not have targets that relate to more crosscutting issues.

The Warwickshire review of services for teenage parents found that some of the services that they were looking at did not have strong performance management arrangements with quantified data. This meant that evaluation of effectiveness had to rely on rich but subjective data from user feedback. The review recommends some improvements to process design including recommendations about how processes and outcomes are measured.

Staffordshire - Mental health services review - click here

Have a dialogue with the people who you expect to implement your recommendations

Staffordshire have a protocol by which scrutiny reports go to the cabinet who are required to respond stating what they will do by what dates, what will change as a result and who will be responsible. The scrutiny committee will monitor and evaluate change after twelve months.

Most of the review teams held discussions during the course of their reviews with the agencies that they would expect to implement changes. This ensures that there are no surprises and that recommendations are realistic. It is also a way of ensuring that those responsible take ownership of the proposed changes.

Ann Cains, a member of the North East SDA said that in Stockton this kind of dialogue continues after the report has been produced. She will attend meetings of the council's executive and the board of the Primary Care Trust to discuss the review's recommendations. This will ensure that those organisations have a clear understanding of the issues and can make informed decisions about how they will implement the recommendations.

NE Region - Ex-Service community review - click here

Top tips

Monitoring and evaluation may not be the most glamorous part of the review process but it can make or break a review! Here are some top tips to help you:

- ☑ Make sure you have someone on the panel with good knowledge and experience of the subject under review. This will help you to home in on key issues and set realistic targets.
- ☑ Use action learning as an integral part of the review process and involve key stakeholders in part of the action learning. Also use an independent facilitator.
- ☑ Be realistic about what you can achieve through the review and focus on things you can influence. If you discover issues of real concern that are beyond your scope draw them to the attention of others who may be in a better position to explore them further.
- ☑ Don't be afraid to change course if you find surprising evidence.
- ☑ Have a dialogue with the people who you expect to implement your recommendations, and set realistic targets to measure implementation and impact.

Section 3

Scrutiny tools and techniques

Understanding health inequalities

Understanding the definition of health inequalities; the wider social and economic determinants that effect health; and how to find out what your local health inequalities are - were challenges faced by the Scrutiny Development Areas (SDAs).

Understanding health inequalities and the wider determinants

In order to work through these challenges and help members and officers to understand issues in more depth, SDAs adopted different approaches, these included:

Sefton – held a training and capacity building event for members, officers and stakeholders. Facilitated by a CfPS Expert Adviser, the event helped all participants to understand what health inequalities were like in Sefton. It helped to bring new insights in to local assets and health needs.

London – held a launch event for their review on the impact that housing has on health. They brought together around 60 people from housing, planning and other professions to explore together the impact that poor housing and planning decisions can have on health. The event was very successful in helping people to see that health was everyone's business.

In **Staffordshire** – officers compiled briefing packs for members, highlighting the issues and bringing all of the facts together in one place.

Local councils, and the services that they deliver have a huge impact on the health of the community, this is one of the main reasons for the recent decision to move public health from Primary Care Trusts to councils. Members and officers will have the opportunity to make a real impact in the health improvement agenda – by looking at health from a whole system point of view.

There are several training packages that can help you to understand what health inequalities are. However one that was funded by the Department of Health is *Health Everyone's Business*. The training modules within it introduce those working in local councils to the public health skills that are central to ensuring that council core services have positive impacts on health and well-being. The modules aim to provide participants with the knowledge, skills and language to promote health within key council roles. Use the link below to explore this resource in more detail.

http://www.healthknowledge.org.uk/teaching/health-everyones-business

How to do you get to understand what your local health inequalities are?

In the chapter on Local understanding we help you to explore the types of information that you will need to gain a better understanding of your communities, but understanding the inequalities in health is a major part of this. This fact sheet explores and points you to two ways of understanding health inequalities:

☑ Marmot review recommendations

☑ Living well across local communities

Marmot review recommendations

It is not enough just to focus on health outcomes and illnesses – the government commissioned the Marmot review of health inequalities in England post 2010 *Fair Society, Healthy Lives*, which was published on 12th February 2010.[1] This review recommended action that emphasised the importance of tackling social inequalities in reducing health inequalities – a so-called 'social determinants' approach to preventing ill health.

1) http://www.marmot-review.org.uk/

In order to help local councils and their partners the Marmot review team has been working with the London Health Observatory and partners in the development of indicators to reflect the aspirational targets proposed in *Fair Society, Healthy Lives*. This basket of indicators will be used to monitor health inequalities and the social determinants of health for all 'upper tier' local authorities in England. It is the upper tier that will take over the responsibility for public health from 2013.

The Association of Public Health Observatories [2] website also contains results for lower tier local authorities, and a guide to interpretation.

The indicators at upper local authority level are:

☑ Life expectancy at birth.

☑ Children reaching a good level of development at age five.

☑ Young people not in employment, education or training (NEET).

☑ % of people in households receiving means tested benefits.

In addition there is an index showing the level of social inequalities within each local authority area for:

☑ Life expectancy at birth.

☑ Disability free life expectancy at birth.

☑ % of people in households receiving means tested benefits.

"Living Well" across local communities

Within the North West - the Living Well[3] framework has been developed. It is a long-term approach that describes a way of working locally to remove entrenched inequalities; it makes clear the link between the well-being of an individual and that of the community and the place.

Their way of focusing on well-being provides an opportunity to take a new and different approach to improving health and reducing health inequalities:

☑ It provides a greater focus on the wider, social determinants of health as well-being is largely socially determined.

☑ It recognises the social nature of health and the value of collective action for improving health, rather than reliance on individual change.

☑ It focuses on health as a positive outcome of wellness, not just the absence of mortality, disease or health-damaging behaviour.

☑ It recognises the causal factors of why individuals make certain lifestyle choices & changes - shifting the focus from what people are doing (e.g. drinking, smoking) to why they are doing it (e.g. lack of control, self esteem, optimism, self determination, contentment and fulfilment).

☑ Therefore, it allows intervening more effectively to tackle the root causes and conditions of health. This necessitates a holistic approach, as the presence or absence of good mental well-being underpins all lifestyle change.

To measure the cumulative and combined impact of the Living Well work at individual, group, neighbourhood and community levels, indicators are needed that can easily be collected regularly and reported to the public and to partner agencies.

2) http://www.lho.org.uk/LHO_Topics/national_lead_areas/marmot/marmotindicators.aspx

3) http://www.northwest.nhs.uk/document_uploads/Publications/Living%20Well.pdf

The desire to look at outcome measures has driven the development of this framework. It includes a number of key dimensions, and includes a top ten set of indicators for the Living Well approach:

Deficit indicators:

1 Disability free life expectancy in men (or healthy life expectancy).
2 Disability free life expectancy in women (or healthy life expectancy).
3 Adult smoking prevalence.
4 Child obesity in year six.

Asset indicators:

5 % Redundant in past year who found a new job.
6 % Reporting coping on current income/confident in ability to receive financial help in a crisis.
7 % Reporting recommended levels of recreational exercise.
8 % Reporting participation in local groups and/or frequency of meeting people outside own household.
9 % Reporting positive mental well-being (WEMWBS or equivalent measure of life satisfaction).
10 % Reporting positive evaluation of functioning in local area (i.e. ability to influence local decisions, sense of belonging in local area, feeling safe at home at night).

Health scrutiny partnership protocol

The following partnership protocol has been devised using the protocol developed by the North East Region Joint Scrutiny Committee.

They have agreed for this to be used by other areas interested in carrying out joint scrutiny arrangements and reviews.

Joint Health Overview and Scrutiny Committee of:
[*insert named authorities***]**

TERMS OF REFERENCE AND PROTOCOLS

Establishment of the Joint Committee

1. The Committee is established in accordance with section 244 and 245 of the National Health Service Act 2006 ("NHS Act 2006") and regulations and guidance with the health overview and scrutiny committees of **[*** insert named authorities***]** ("the constituent authorities") to scrutinise issues around the planning, provision and operation of health services in and across the **[*** insert sub region / region***]**, comprising for these purposes the areas covered by all the constituent authorities.
2. The Committee will hold two full committee meetings per year. The Committee's work may include activity in support of carrying out:

   (a) Discretionary health scrutiny reviews, on occasions where health issues may have a regional or cross boundary focus, or

   (b) Statutory health scrutiny reviews to consider and respond to proposals for developments or variations in health services that affect more than one health authority area, and that are considered "substantial" by the health overview and scrutiny committees for the areas affected by the proposals.

   (c) Monitoring of recommendations previously agreed by the Joint Committee.

For each separate review the Joint Committee will prepare and make available specific terms of reference, and agree arrangements and support, for the enquiry it will be considering.

Aims and objectives

3. The **[*** insert name of scrutiny committee***]** Joint Health Overview and Scrutiny Committee aims to scrutinise:

   (a) NHS organisations that cover, commission or provide services across the **[*** insert sub region / region***],** including and not limited to, for example, the NHS, local primary care trusts, foundation trusts, acute trusts, mental health trusts and specialised commissioning groups.

   (b) Services commissioned and / or provided to patients living and working across the **[*** insert sub region / region***].**

   (c) Specific health issues that span across the **[*** insert sub region / region***].**

Note: Individual authorities will reserve the right to undertake scrutiny of any relevant NHS organisations with regard to matters relating specifically to their local population.

4. The **[*** insert name of scrutiny committee***]** Joint Health Overview and Scrutiny Committee will:

   (a) Seek to develop an understanding of the health of the **[***insert sub region / region***]** population and contribute to the development of policy to improve health and reduce health inequalities.

   (b) Ensure, wherever possible, the needs of local people are considered as an integral part of the commissioning and delivery of health services.

   (c) Undertake all the necessary functions of health scrutiny in accordance with the NHS Act 2006, regulations and guidance relating to reviewing and scrutinising health service matters.

   (d) Review proposals for consideration or items relating to substantial developments / substantial variations to services provided across the **[*** insert sub region / region***]** by NHS organisations, including:

      (i) Changes in accessibility of services.

      (ii) Impact of proposals on the wider community.

      (iii) Patients affected.

   (e) Examine the social, environmental and economic well-being responsibilities of local authorities and other organisations and agencies within the remit of the health scrutiny role.

Membership

5. The Joint Committee shall be made up of **[*** insert number of members***]** Health Overview and Scrutiny Committee members comprising 1 member from each of the constituent authorities. In accordance with section 21(9) of the Local Government Act 2000, Executive members may not be members of an overview and scrutiny committee. Members of the constituent local authorities who are Non-Executive Directors of the NHS cannot be members of the Joint Committee.
6. The appointment of such representatives shall be solely at the discretion of each of the constituent authorities.
7. The quorum for meetings of the Joint Committee is one-third of the total membership, in this case four members, irrespective of which local authority has nominated them.

Substitutes

8. A constituent authority may appoint a substitute to attend in the place of the named member on the Joint Committee. The substitute shall have voting rights in place of the absent member.

Co-optees

9. The Joint Committee shall be entitled to co-opt any non-voting person as it thinks fit to assist in its debate on any relevant topic. The power to co-opt shall also be available to any Task and Finish / Working Groups formed by the Joint Committee. Co-option would be determined through a case being presented to the Joint Committee or Task and Finish Group / Working Group, as appropriate. Any supporting information regarding co-option should be made available for consideration by Joint Committee members at least 5 working days before a decision is made.

Formation of Task and Finish/Working Groups

10. The Joint Committee may form such Task and Finish/Working Groups of its membership as it may think fit to consider any aspect or aspects within the scope of its work. The role of any such Group will be to consider the matters referred to it in detail with a view to formulating recommendations on them for consideration by the Joint Committee. The precise terms of reference and procedural rules of operation of any such Group (including number of members, chairmanship, frequency of meetings, quorum etc.) will be considered by the Joint Committee at the time of the establishment of each such Group. The Chair of a specific Task and Finish Group will act in the manner of a Host Authority for the purposes of the work of that Task and Finish Group, and arrange and provide officer support for that Task and Finish Group. These arrangements may differ if the Joint Committee considers it appropriate. The meetings of such Groups should be held in public except to the extent that the Group is considering any item of business that involves the likely disclosure of exempt information from which the press and public could legitimately be excluded as defined in Part 1 of Schedule 12A of the Local Government Act 1972 as amended by the Local Government (Access to Information) (Variation) Order 2006.
11. The Chair of the Joint Health Overview and Scrutiny Committee may not be the Chair of a Task and Finish Group.

Chair and Vice-Chairs

12. The chair of the Joint Committee will be drawn from the membership of the Joint Committee, and serve for a period of 12 months, from a starting date to be agreed. A Chair may not serve for two consecutive twelve-month periods. The Chair will be agreed through a consensual process, and a nominated Chair may decline the invitation. Where no consensus can be reached then the Chair will be nominated through a ballot system of one Member vote per Authority only for those Members present at the meeting where the Chair of the Joint Health Overview and Scrutiny Committee is chosen.
13. The Joint Committee may choose up to two Vice-Chairs from among any of its members, as far as possible providing a geographic spread across the region. A Vice-Chair may or may not be appointed to the position of Chair or Vice-Chair in the following year.
14. If the Chair and Vice-Chairs are not present, the remaining members of the Joint Committee shall elect a Chair for that meeting.
15. Other than any pre-existing arrangements within their own local authority, no Special Responsibility Allowances, or other similar payments, will be drawn by the Chair, Vice Chairs, or Tasking and Finish Group Chairs in connection with the business of the Joint Committee.

Host Authority

16. The local authority from which the Chair of the Joint Committee is drawn shall be the Host Authority for the purposes of this protocol.
17. Except as provided for in paragraph 10 above in relation to Task and Finish Groups, the Host Authority will service and administer the scrutiny support role and liaise proactively with the other **[*** insert sub region / region***]** local authorities and the regional health scrutiny officer network. The Host Authority will be responsible for the production of reports for the Joint Committee as set out below, unless otherwise agreed by the Joint Committee. An

authority acting in the manner of a Host Authority in support of the work of a Task and Finish Group will be responsible for collecting the work of that Group and preparing a report for consideration by the Joint Committee.

18. Meetings of the Joint Committee may take place in different authorities, depending on the nature of the inquiry and the potential involvement of local communities. The decision to rotate meetings will be made by members of the Joint Committee.

19. Documentation for the Joint Committee, including any final reports, will be attributed to all the participating member authorities jointly, and not solely to the Host Authority. Arrangements will be made to include the Council logos of all participating authorities.

Work planning and agenda items

20. The Joint Committee may determine, in consultation with health overview and scrutiny committees in constituent authorities, NHS organisations and partners, an annual work programme. Activity in the work programme may be carried out by the Joint Committee or by a Task and Finish / Working Group under the direction of the Joint Committee. A work programme may be informed by:

    (a) Research and information gathered by health scrutiny officers supplemented by presentations and communications.

    (b) Proposals associated with substantial developments / substantial variations.

21. Individual meeting agendas will be determined by the Chair, in consultation with the Vice-Chairs where practicable. The Chair and Vice-Chairs may meet or conduct their discussions by email or letter.

22. Any member of the Joint Committee shall be entitled to give notice, with the agreement of the Chair, in consultation with the Vice-Chairs, where practicable, of the Joint Committee, to the relevant officer of the Host Authority that he/she wishes an item relevant to the functions of the Joint Committee to be included on the agenda for the next available meeting. The member will also provide detailed background information concerning the agenda item. On receipt of such a request (which shall be made not less than five clear working days before the date for despatch of the agenda) the relevant officer will ensure that it is included on the next available agenda.

Notice and summons to meetings

23. The relevant officer in the Host Authority will give notice of meetings to all Joint Committee members, in line with access to information rules of at least five clear working days before a meeting. The relevant officer will send an agenda to every member specifying the date, time and place of each meeting and the business to be transacted, and this will be accompanied by such reports as are available.

Attendance by others

24. The Joint Committee and any Task and Finish / Working Group formed by the Joint Committee may invite other people (including expert witnesses) to address it, to discuss issues of local concern and/or to answer questions. It may for example wish to hear from residents, stakeholders and members and officers in other parts of the public sector and shall invite such people to attend.

Procedure at Joint Committee meetings

25. The Joint Committee shall consider the following business:

(a) Minutes of the last meeting (including matters arising).

(b) Declarations of interest.

(c) Any urgent item of business which is not included on an agenda but the Chair agrees should be raised.

(d) The business otherwise set out on the agenda for the meeting.

26. Where the Joint Committee wishes to conduct any investigation or review to facilitate its consideration of the health issues under review, the Joint Committee may also ask people to attend to give evidence at Joint Committee meetings which are to be conducted in accordance with the following principles:

(a) That the investigation is conducted fairly and all members of the Joint Committee be given the opportunity to ask questions of attendees, and to contribute and speak.

(b) That those assisting the Joint Committee by giving evidence be treated with respect and courtesy.

(c) That the investigation be conducted so as to maximise the efficiency of the investigation or analysis.

Voting

27. Any matter will be decided by a simple majority of those Joint Committee members voting and present in the room at the time the motion is put. This will be by a show of hands or if no dissent, by the affirmation of the meeting. If there are equal votes for and against, the Chair or other person chairing the meeting will have a second or casting vote. There will be no restriction on how the Chair chooses to exercise a casting vote.

Urgent action

28. In the event of the need arising, because of there not being a meeting of the Joint Committee convened in time to authorise this, officers administering the Joint Committee from the Host Authority are generally authorised to take such action, in consultation with the Chair, and Vice-Chairs where practicable, to facilitate the role and function of the Joint Committee as they consider appropriate, having regard to any Terms of Reference or other specific relevant courses of action agreed by the Joint Committee, and subject to any such actions being reported to the next available meeting of the Joint Committee for ratification.

Final reports and recommendations

29. The Joint Committee will aim to produce an agreed report reflecting a consensus of its members, but if consensus is not reached the Joint Committee may issue a majority report and a minority report.

(a) If there is a consensus, the Host Authority will provide a draft of both the conclusions and discursive text for the Joint Committee to consider.

(b) If there is no consensus, and the Host Authority is in the majority, the Host Authority will provide the draft of both the conclusions and discursive text for a majority report and

arrangements for a minority report will be agreed by the Joint Committee at that time.

(c) If there is no consensus, and the Host Authority is not in the majority, arrangements for both a majority and a minority report will be agreed by the Joint Committee at that time.

(d) In any case, the Host Authority is responsible for the circulation and publication of Joint Committee reports. Where there is no consensus for a final report the Host Authority should not delay or curtail the publication unreasonably.

The rights of the health overview and scrutiny committees of each local authority to make reports of their own are not affected.

30. A majority report may be produced by a majority of members present from any of the local authorities forming the Joint Committee. A minority report may be agreed by any *[number derived by subtracting smallest possible majority from quorum: e.g. if quorum is 4, lowest possible majority is 3, so minority report requires 1 members' agreement]* or more other members.

31. For the purposes of votes, a "report" shall include discursive text and a list of conclusions and recommendations. In the context of paragraph 29 above, the Host Authority will incorporate these into a "final report" which may also include any other text necessary to make the report easily understandable. All members of the Joint Committee will be given the opportunity to comment on the draft of the final report. The Chair in consultation with the Vice-Chairs, where practicable, will be asked to agree to definitive wording of the final report in the light of comments received. However, if the Chair and Vice-Chairs cannot agree, the Chair shall determine the final text.

32. The report will be sent to *[name of the NHS organisations involved]* and to any other organisation to which comments or recommendations are directed, and will be copied to NHS **[*** insert sub-region/region***],** and to any other recipients Joint Committee members may choose.

33. The *[name of the NHS organisations involved]* will be asked to respond within 28 days from their formal consideration of the Final Report, in writing, to the Joint Committee, via the nominated officer of the Host Authority. The Host Authority will circulate the response to members of the Joint Committee. The Joint Committee may (but need not) choose to reconvene to consider this response.

34. The report should include:

(a) The aim of the review – with a detailed explanation of the matter under scrutiny.

(b) The scope of the review – with a detailed description of the extent of the review and it planned to include.

(c) A summary of the evidence received.

(d) An evaluation of the evidence and how the evidence informs conclusions.

(e) A set of conclusions and how the conclusions inform the recommendations.

(f) A list of recommendations – applying SMART thinking (Specific, Measurable, Achievable, Realistic, Timely), and how these recommendation, if implemented in accordance with the review outcomes, may benefit local people.

(g) A list of sources of information and evidence and all participants involved.

Timescale

35. The Joint Committee will hold two full committee meetings per year, and at other times when the Chair and Vice-Chairs wish to convene a meeting. Any three members of the joint committee may require a special meeting to be held by making a request in writing to the Chair.

36. Subject to conditions in foregoing paragraphs 29 and 31, if the Joint Committee agrees a report, then:

    (a) The Host Authority will circulate a draft final report to all members of the Joint Committee.
    (b) Members will be asked to comment on the draft within a period of two weeks, or any other longer period of time as determined by the Chair, and silence will be taken as assent.
    (c) The Chair and Vice-Chairs will agree the definitive wording of the final report in time for it to be sent to *[name of the NHS organisations involved].*

37. If it believed that further consideration is necessary, the Joint Committee may vary this timetable and hold further meetings as necessary. The *[name of the NHS organisations involved]* will be informed of such variations in writing by the Host Authority.

Guiding principles for the undertaking of [*** Insert sub region / region***] joint health scrutiny

38. The health of the people of **[*** Insert sub region / region***]** is dependent on a number of factors including the quality of services provided by the NHS, the local authorities and local partnerships. The success of joint health scrutiny is dependent on the members of the Joint Committee as well as the NHS and others.

39. Local authorities and NHS organisations will be willing to share knowledge, respond to requests for information and carry out their duties in an atmosphere of courtesy and respect in accordance with their codes of conduct. Personal and prejudicial interests will be declared in all cases in accordance with the Members' Code of Conduct of each constituent authority.

40. The scrutiny process will be open and transparent in accordance with the Local Government Act 1972 and the Freedom of Information Act 2000 and meetings will be held in public. Only information that is expressly defined in regulations to be confidential or exempt from publication will be considered in private. The Host Authority will manage requests and co-ordinate responses for information considered to be confidential or exempt from publication in accordance with the Host Authority's legal advice and guidance. Joint Committee papers and information not being of a confidential nature or exempt from publication may be posted on the websites of the constituent authorities as determined by each of those authorities.

41. Different approaches to scrutiny reviews may be taken in each case. The Joint Committee will seek to act as inclusively as possible and will take evidence from a wide range of opinion including patients, carers, the voluntary sector, NHS regulatory bodies and staff associations, as necessary and relevant to the terms of reference of a scrutiny review. Attempts will be made to ascertain the views of hard to reach groups, young people and the general public.

42. The Joint Committee will work to continually strengthen links with the other public and patient involvement bodies such as PCT patient groups and Local Involvement Networks, where appropriate.

43. The regulations covering health scrutiny allow an overview and scrutiny committee to require an officer of a local NHS body to attend before the committee. This power may be exercised by the Joint Committee. The Joint Committee recognises that Chief Executives and Chairs of NHS bodies may wish to attend with other appropriate officers, depending on the matter under review. Reasonable time will be given for the provision of information by those asked to provide evidence.

Select committee top tips

Warwickshire - Services for teenage parents review - click here

Warwickshire Scrutiny Development Area chose to use a traditional scrutiny review method for their chosen review. Below are their top tips to using the select committee approach for reviews where there are issues about care pathways.

- ☑ Make a list of all the organisations, departments etc that commission or provide services for the client group concerned and make a map of the various processes or care pathways involved.
- ☑ Identify the people responsible for managing the services you have listed and tell them about the review. Explain what you want to explore and why. Invite them to the select committee day and explain how it will work.
- ☑ Before the select committee meeting date, send delegates a questionnaire with general questions about services, opportunities and barriers to delivery. The returned questionnaires will give members an idea of areas they might want to explore.
- ☑ As well as inviting managers, secure the assistance of frontline workers who deliver services on the ground.
- ☑ Use your process map to help you prepare a schedule for the day so that you have contributions from people in the order in which they should be interacting in the way they provide the services. This allows you to explore the boundaries, gaps and barriers between services. How effectively do people communicate and refer clients to ensure a seamless pathway? How does this compare with the experiences of service users? What improvements do participants suggest?
- ☑ Ask participants to stay for the whole session so that they can learn how they fit into a much wider framework.
- ☑ Record the findings of the select committee session and report back to the participants. Ask them to verify accuracy and for any further thoughts.
- ☑ Use an action learning session mid way through the review and at the end to reflect on what you have learnt and feed this into your conclusions and recommendations.

Prioritising review topics

A process for topic selection and prioritisation

Choosing which topic to scrutinise is a difficult task. However the complexities of health inequalities and the need to focus on the root issue or the causes of the causes instead of the apparent health concerns makes this even more complicated.

☑ How do you know what to focus on?

☑ Which actions will have a greater impact?

Many of the Scrutiny Development Areas had chosen the topic of their health inequalities review. They had drawn their priorities from such things as the Joint Strategic Needs Assessment and local knowledge.

However there are a number of external factors that influence our health – how therefore do you choose which one is going to be the focus of the review?

Over the next few pages you will be presented with two models for prioritising topics for scrutiny reviews.

Staffordshire - Mental health services review - click here

Prioritisation tool - one

Choosing a topic to review

A model based on a process developed during a health inequalities scrutiny review in Calderdale (not a Scrutiny Development Area).

It follows a three-stage process to prioritise a topic from a wide range of themes:

☑ Generating ideas for topics.

☑ Using criteria to select a priority.

☑ Planning a work programme of priority topics.

Prioritisation tool - two

Prioritising the focus within a chosen topic

A model used by Staffordshire Scrutiny Development Area as part of their review.

This systematic process helped to narrow the number of areas to focus on within the chosen topic, by using a simple staged process.

Prioritisation tool one

Choosing a topic to review

The model below has been adapted and updated from a process developed by Calderdale Health Scrutiny in 2009 in conjunction with Linda Phipps, Expert Adviser at CfPS. It has been agreed that this can be used within this publication to give an example of how to prioritise topics for a scrutiny review of health inequalities.

How is the process used?

The process has three stages:

- Generating ideas for topics.
- Using criteria to select a priority list of potential topics.
- Planning a work programme of priority topics.

Stage one – generating ideas for potential topics

- Thinking about breadth of scope – should the topic be "cross-cutting"?
- Look at partnership priorities and the Joint Strategic Needs Assessment.
- Consider relevant stakeholder priorities.
- Look at a particular area / community - not just a service.
- Consider relevant data – that can give an indication of need – Index of Multiple Deprivation, Health Profiles etc.
- Looking at aspects e.g. a quality of a service rather that all aspects of a service.
- Consider focusing on specific groups of users/carers, or on provider groups e.g. the independent sector.
- Use the insight and knowledge of elected members and officers.

Stage two – using practical criteria to select a priority list of potential topics

The matrix that Calderdale developed is below.

- Apply the questions in table one to all those priorities identified in stage one above.
- Some criteria may be more significant than others, so a process of "weighting" them will be needed by your review team – consider which are the most important questions and weight accordingly.

Stage three – planning a work programme of priority topics

The possible topics for scrutiny, which fit well with the proposed criteria, become the priority list of potential topics. The overview and scrutiny committee now needs to decide how these topics might best be dealt with by scrutiny – how to fit them into its work programme in a way that is realistic and deliverable. Calderdale developed a process of allocating their priority topics to one of three categories:

P Priority topic for full or possible "mini-scrutiny" in current municipal year.

O On the current work programme.

A Aspirational topic to be reviewed when the work programme permits or to be dealt with by other means.

Table two - shows how Calderdale allocated their priority topics to these three categories.

Table one: Calderdale criteria for selecting a priority list of potential topics

Suggested criteria	YES	NO
Would scrutiny make a difference? • Could it add value? • How big an impact could it make?		
Is the issue of significant concern to the public (how do we know)?		
Is it an issue of common concern shared with health services and other local partners?		
Is there evidence of poor performance (compared with other areas / targets set)?		
Is there a lot of variability in the quality of the service?		
How significant is the strength of concern?		
Is there evidence of significant variations in service between areas of the authority (or groups of service users)?		
Could scrutiny help to 'narrow the gap' and reduce inequalities in provision or outcomes?		
Is there an opportunity to learn from, celebrate and spread examples of good practice?		
Is it important in relation to the Council's Corporate Priorities / the Community Strategy / the Joint Strategic Needs Assessment?		
Is it a cross–cutting issue, involving services across the Council and beyond to other partners / providers?		
Are there any reasons not to choose the topic at this time? • Is there a better / more appropriate way to look at this than scrutiny? Is it already being tackled by some other means? • Is the situation unclear due to forthcoming legislation or changes currently taking place?		
What are the resource implications of choosing this topic?		

Table two: Calderdale: example of categorisation matrix for priority topics for the scrutiny work programme

Suggested topic	Category
Health improvement	
• Obesity	O
• Smoking	O
• Alcohol	A
• Back to work	P
Implementation of partnership priorities	A
Access to services	
• Oral health	P
• GP services	A
• Mental health	A
• Social care	A
• Sexual health	A
Preventative measures ('is prevention working?')	A
Service quality/customer care including choice agenda	A

Important notes:

Learning from the Scrutiny Development Areas has shown that it is vital that any prioritisation process includes as wide a partnership as possible, this helps to:

☑ Provide balance - all perspectives are brought to deciding the long list of topics.

☑ Broaden the subjects involved in the long list – such as education, health, crime, unemployment, housing, lifestyles etc – don't just stick to traditional health services.

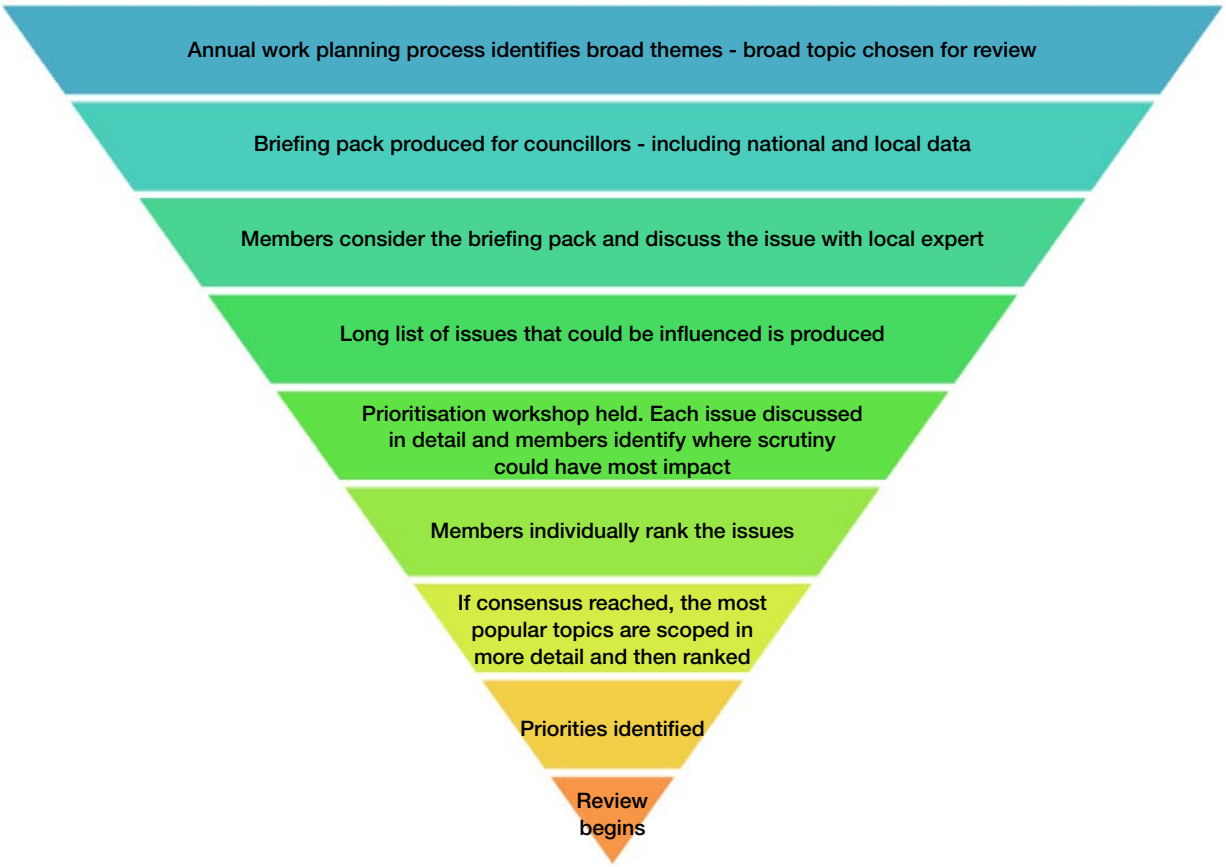
☑ Ensure that all or most of the facts are known about the issue.

☑ Ensure buy in from those stakeholders involved – as they feel part of the process. The more partners understand the reasons for the review the better the partnership.

Prioritisation tool two

It is always challenging to identify the primary priority issues where overview and scrutiny can make most impact and influence improvement. This is especially so in relation to health inequalities. Each participating councillor will initially focus on the needs of their own ward, constituents and network of contacts and want to make a difference for them. Using a prioritisation tool can help to focus on the wider issues and issues where there can be greatest influence. It can also provide support in explaining to external stakeholders why an issue is, or is not, the priority for scrutiny at this point in time.

A number of prioritisation tools are referred to in the chapter on Being Systematic. The following simple staged process is recommended.



Staffordshire - Mental health services review - click here

The tool was applied in Staffordshire as follows:

1. The committee identified the key issues to be scrutinised during the year as part of a health scrutiny work programme planning process. The identified issues were based on evidence, suggestions and member concerns.
2. The members were concerned about whether lower level/preventative mental health services in Staffordshire were given appropriate priority by stakeholder organisations. This became the topic for the health inequalities review.
3. The committee was aware that the subject was very broad so decided to select three areas of focus to look at in-depth.
4. A briefing pack of information was provided to each of the members involved in the review. This contained relevant national policy documents, Joint Strategic Needs Assessment and strategy, financial information and service mapping data. The pack was produced by the officers supporting the review with input from the relevant NHS commissioning officer.

5. At the introductory meeting of the review group the pack was discussed and the main issues relating to the subject identified. The meeting included a presentation by the county Commissioning Officer for Mental Health. At the end of the meeting a long list of 10 possible areas of focus was produced. Each related to lower level/preventative mental health services in Staffordshire.
6. A workshop was held to consider each of the areas on the long list and to prioritise them. Each issue was considered against a set of criteria:
   - What was understood by the topic?
   - What was the relationship between the topic and health inequalities in Staffordshire?
   - How did the topic relate to mental health promotion, prevention or early intervention?
   - What influence might a review have and what scrutiny outcomes might be achieved?
   - Where there were any areas missing?
7. Following the discussion, individual members ranked the area from 1 to 10, with one the lowest priority and 10 the highest. The combined results showed that whilst there was not complete agreement on the highest ranking three topics, there were five priority areas. Officers were asked to prepare a mini scope for each of the issues, setting out more detail of the potential focus for review.
8. The mini scopes were provided to members by email and they were asked to prioritise the five issues based on the criteria used in the workshop. This ranking process identified three priority areas. It was agreed that the two topics that were not chosen would be revisited at the end of the review, when members would consider whether they wanted to recommend them in their final report as areas for further or future work.

By using a clear process for prioritisation all members are able to understand why the final topic or topics have been chosen for review. This enabled them to explain the process confidently to local people as well as to commissioners and providers of services. By 'holding' issues that were identified as being important but not being reviewed at this time, there is an opportunity for members to consider them in the future. Regular reflection during the review enables members to remain mindful about how they identified the priorities and the additional topics that may be considered in the future.

Mini scrutiny - two models

These two models for mini scrutiny were created to provide quick, simple, cost effective, "do-able" and transferrable ways of carrying out effective scrutiny reviews in half a day.

Scrutiny is recognised as a valuable tool, but sometimes reviews can take several months to conclude. This method of scrutiny was developed so that a review could effectively be done in a short space of time – half a day – and yet add value and improve health outcomes.

How it works

There are two-stages to the review:

1. Prioritising the topics of concern.
2. Holding a half day mini-review (a health condition or a small geographical area).

Prioritisation

Using one of the two models within the publication, identify and prioritise the topics that you are wanting to review – during this process you will have the chance to review one – or if you prefer, two – topic(s): a health condition, and/or a geographical area.

The prioritisation process is ideally done by the supporting officer group and presented to the Chair and/or the panel for endorsement, e.g. using email, so as to speed up the process, but this can also be done as the first part of the mini review(s).

Half day mini-review(s) (model template appendix one)

☑ Three-layered 'Health condition model'.

o Consider your local health inequalities – are there any significant health concerns that would benefit from a half-day focus?

☑ 'Small geographical area' model.

o Do you have communities with worse health outcomes than others? This model works best where it focuses on a small area (that is, smaller than ward level) and where good amounts of data and information are available.

The following are key stages in developing this approach to mini scrutiny reviews – and they are detailed further below:

☑ Develop an officer group to support the review.

☑ Establish a wide-ranging scrutiny review panel to carry out the review.

☑ Arrange one or two half day workshops.

☑ Research and analysis.

Developing an officer working group

Purpose

There is quite a lot of preparation involved to enable mini-reviews to be carried out by members in the half day as outlined above. Therefore an officer group is essential to ensure that the review is scoped correctly, that the right partners are involved and that appropriate research and information is sourced.

Suggested membership:

☑ The Council (officers).

☑ The PCT – or their successors (GP Consortia) in the future NHS.

☑ Community / health development worker.

☑ Officer from the Local Strategic Partnership.

Key tasks:

☑ Support members during the review.

☑ Manage the process.

☑ Research and provide information to carry out the review effectively.

☑ Stakeholder analysis.

☑ Determine who can contribute context and ideas - witnesses.

☑ Develop a briefing pack for members on the issues that have been identified so that they are prepared and they are able to prioritise appropriately.

☑ Develop a set of questions that can be circulated to the members for consideration in advance of the workshops – these questions will help members to bring their own knowledge to the review – sample questions are outlined below.

☑ Organise one or two half day workshops – of the two types above.

☑ Create methods to generate ideas (e.g. discussion tables rather than whole-group committee –style).

☑ Service the review.

☑ Review councillor questionnaires to extract ideas.

☑ Use a simple “project plan” to ensure delivery.

☑ Refine ideas into solutions and test out among partners.

☑ Consider external facilitation.

Establishing a wide-ranging scrutiny review panel

Purpose

To bring together scrutiny members or chairs from across the organisation so that a whole council approach can be taken to understanding health inequalities with external partners to ensure that the review is effective.

Suggested membership

☑ Chair/member from each OSC.

☑ Ward councillors where a small area is chosen.

☑ PCT colleagues – or their successors (GP Consortia) in the future NHS.

☑ Community / health development workers.

☑ Officers of the Local Strategic Partnership.

☑ Local Partners relevant to the topic – e.g. Central Government Department (Department for Work and Pensions etc), agencies, schools etc.

Tasks

☑ Use the pre-circulated questions issued to councillors to find out about health concerns in your area.

☑ Attend the half-day mini review meeting(s).

☑ Contribute your anecdotal knowledge.

☑ Propose examples, case studies, and people who can be contacted and involved and give evidence.

☑ Ensure recommendations are drawn up and that they flow from the conclusions.

Arrange half day workshop(s)

Practical arrangements need to be made for the half-day workshops. This section is not intended to tell you how to organise the events, but some considerations that you should use to inform their planning.

☑ Consider using community venues in the geographical area that you have chosen.

☑ Prioritise topics.

☑ Use simple project planning tools to share the workload and manage the tasks and delivery – on top of your “day job”.

☑ Be realistic about timescales and specify who is doing what when.

☑ Be very clear on communications – converting interest – to commitment – to action.

☑ Focus on a small number of key and deliverable recommendations.

☑ Consider external facilitation.

Research and analysis

The reason that this type of review can be done quickly is down to the planning and research that is undertaken by officers prior to the review. Therefore getting an understanding of the health condition and the geographical area that you have chosen is key.

See section on *Local understanding* – this will help you to work through what information you need and how and who you can get this from.

Top tips

- ☑ Encourage health partners to contribute anecdotal information i.e. more than "statistical information".
- ☑ Check statistics are sufficiently recent.
- ☑ Consider trends as well as history.
- ☑ Include and value anecdotal as well as "hard" quantitative information.
- ☑ Go beyond data gathering to achieve impact.

Benefits of the methods

- ☑ Support and enable effective joint working between the Council, the Health & Overview Scrutiny Committee and the NHS body (currently the PCT).
- ☑ Inviting all Scrutiny Panel Chairs encourages a focus on health, well-being and health inequalities in all areas including planning, transport and housing - embedding the need for leadership on health inequalities across the Council.
- ☑ Quick, focused and highly deliverable.
- ☑ A focus on real issues in health inequalities and on outcomes.
- ☑ Generates short and "to-the-point" case studies.
- ☑ Generates an impetus for action underpinned by joint Health & Overview Scrutiny Committee.
- ☑ Relevant action plan on which people want to follow through.
- ☑ Practical – Councillors can relate to the issues and use their own anecdotal evidence, experience and knowledge.
- ☑ Pre-circulated questions enable members to collate ideas from themselves, family, friends and local residents.
- ☑ Both condition and area models add value in different ways.
- ☑ Highly transferrable models of scrutiny.
- ☑ Councillor feedback from where it has been used suggests that this process has worked very well, with high levels of satisfaction with process and outputs.

Pre-circulated questions for Councillors

In order to get the most out of the workshops, the following questions were sent to participants – this meant that they were better prepared and able to participate.

- What do you know about health in your Ward e.g. life expectancy, major diseases?
- What do you think are the main determinants of good health?
- In your Ward do you think people have good access to information about health?
- Are there any particular factors in your Ward that you feel contribute to poor health or good health e.g. housing, education?
- What do you think needs to change in terms of health?
- How do you think our Council area compares nationally in health terms?
- What is your view on the different types of (condition chosen e.g. cancer) and who is experiencing these?
- What issues need to change in relation to the experience of (condition chosen e.g. cancer)?
- What role do you think the Council should play in narrowing health inequalities?

Cheshire - Rural health inequalities review - click here

Note: these models were developed by Associate Consultant Linda Phipps with funding support from the CfPS and LGID, in working with a number of Councils to develop improved models for scrutiny. It was most recently used within the Cheshire SDA, who applied the mini-scrutiny model to the review of mental health in rural areas.

Appendix one

The mini-scrutiny model

The template on the following page outlines the mini-scrutiny approach in action, as applied by the Cheshire SDA to a mini-scrutiny of mental health in rural areas.

The mini-review used the following stages, in each case:

A. **Defining the issue** - Is there plenty of information or little information, and who has the information?

B. When **actions or interventions** would help (e.g. ideas for self-management, early diagnosis, treatments)?

C. **Gap analysis** - What gaps are there in actions or provision or in our knowledge?

D. **Conclusions and Action Planning** - What needs to happen next and by whom?

Stages:

1. **Relevant area/ groups:** defining what are the geographical areas/who are the groups that we need to focus on – e.g. in Cheshire, who are the groups that are experiencing health inequalities and what do we mean by “rural”?
2. **Experience of health inequalities:** Identify ways in which health inequalities are experienced.
3. **What could help?** Self-management and prevention.
4. **What could help?** Early diagnosis.
5. **What could help?** Treatments.
6. **Outcomes** – what are the impacts and changes we want to see?

Appendix one: Methodology for reviewing health inequalities - panel review session structure experience of health inequalities

Stage	(A) Defining the issue	(B) Actions/ interventions	(C) Gap analysis	(D) Conclusions & action planning
1) RELEVANT AREA/ GROUPS	Info / No Info			
2) EXPERIENCE OF HEALTH INEQUALITIES	Info / No Info			
3) SELF MANAGEMENT/ PREVENTION	Info / No Info			
4) EARLY DIAGNOSIS	Info / No Info			
5) TREATMENT	Info / No Info			
6) OUTCOMES	Info / No Info	Not applicable	Not applicable	

Areas for pre-review questions for members based on the chosen issue/condition.

Not applicable.

Areas for generic review questions.

Areas for exploration, discussion and agreement at Scrutiny Panel.

Scrutiny and Appreciative Inquiry

Chesterfield Scrutiny Development Area wanted to involve partnerships, local people and organisations in the review. They used whole system Appreciative Inquiry.

Chesterfield - Geographical health inequalities review - click here

What is Appeciative Inquiry?

Appreciative Inquiry is a process for engaging stakeholders in conversations. It uses a solution focused mindset which will inform the whole piece of work. A solution focus starts from the perspective that we are problem focused because problems get attention and resources. We might be more successful if we focus on solutions. There is an underlying belief that the solution exists within all systems; we do not need experts from outside to tell us what to do. An inquiry can last anything from a day to several months and involve anything from a dozen to millions of people. Designed initially for use by private businesses in the US, it has been used in schools, for whole cities, refugee camps and on topics including smoking and alcohol.

☑ The first task is to set up a planning and implementation group. The group will include people who can engage the participants who need to be involved and ensure the outcomes are implemented.

☑ Identify the focus of the inquiry, which will be positive and indicate what the review is trying to achieve; not what they are trying to get rid of, for example improving health equity not reducing health inequalities.

☑ Participants are carefully selected and personally invited. The aim is to get a balance of representatives from the whole system that impacts on the subject of the inquiry, including people in authority e.g. politicians and senior managers, others with resources e.g. delivery managers, experts on the issue, people with information and needs which might include frontline workers and residents. They will also come from the full range of agencies and organisations in an area or working on an issue, for example local authority, health, fire, police, voluntary, community, faith, local businesses etc.

☑ Participants are facilitated through a process where they:

- jointly discover what is already working by sharing stories of their best experiences and developing an understanding of the qualities that are leading to success;
- agree a vision of what their world will look like if they are successful;
- identify the principles which will underpin change in order to get from the best of the present to the future they want to create;
- identify priorities for change and how to make things happen that will be sustainable.

There are no speakers, and timings are loose, methods such as open space and world cafe can be used as part of Appreciative Inquiry. Appreciative Inquiry brings people with different perspectives to an issue together in conversation. It enables people to draw attention to what is already working and what needs to be preserved and nurtured to build a better future. It is very energising.

The benefits to Chesterfield

Appreciative Inquiry provided a new way of using overview and scrutiny which may be particularly appropriate for addressing complex problems such as health equity. It had been especially successful in engaging people and bringing them together. It involved the scrutiny committee in working alongside stakeholders and the community. The participative methods

drew out the assets and issues, identified a shared and desired future and commitment to work together to get there. It has offered new ways of communicating in depth. As a result the scrutiny committee is more aware of what was going on in the area.

Conventional thinking	Vs	Appreciative thinking:
Focus on problems, deficits and needs.		Focus on strengths, assets and solutions.
Stakeholders, especially residents are subjects.		Stakeholders are participants.
External consultant as expert; uses their tools, extracts the data, analyses it and makes recommendations to senior people who make decisions about and for others.		External consultant as facilitator: enables participants to inquire and create the future they want together.
Review is followed by implementation.		Inquiry and implementation are part of the same process and can be simultaneous.
Ownership and relationships mediated through hierarchy which can be authoritarian.		Fosters ownership and relationships strengthening resilience in the system.
Can be dis-empowering.		Empowering.
Searches for 'objective truth'.		Underpinned by a belief that there is no-one truth, what you see depends on where you are looking from and on your mindset.
Often concerned with 'numerical' measurement of impact at the expense of understanding qualitative impacts.		Focused on a deep understanding of qualitative impacts e.g. learning from human stories.
Judges, often leading to blame.		Reflects, usually leading to learning.

The key outcomes included the establishment of new relationships, energy, commitment and confidence.

Further resources

There are a number of publications and advice / guidance on Appreciative Inquiry.

A useful publication that provides more detail on Appreciative Inquiry is:

A glass half full: how an asset approach can improve community health and well-being (IDeA 2010) http://www.idea.gov.uk/idk/aio/18410498

Scrutiny and Open Space

Blackpool Minimum pricing of alcohol review - click here

Blackpool Scrutiny Development Area wanted to involve local people and organisations in the review – but members were keen not to set the agenda. It was important to keep an open mind and avoid pre-conceived ideas, and they wanted an engagement process that allowed this. The event therefore used the open space technique.

What is Open Space?

Open Space is a method for holding meetings that means people self-organise. There are no speakers; no set agenda and timings are loose. The people who come create the event on the day. They suggest the agenda and they organise their own discussion groups. They then set their priorities for continuing action at the end using 'dot democracy' via coloured stickers. Often a follow-up group is formed.

Open Space works best when: 'a major issue must be resolved, characterised by significant complexity and diversity, the pressure of potential or actual conflict and a decision time of yesterday' (Harrison Owen, designer of Open Space method).

So an Open Space event focuses on a key question that matters for the groups or communities involved. The people who come suggest topics for discussion around this question that matter to them – their passions – and they take responsibility for the discussions and for the resulting action. They do not create a 'wish-list' for other people to do.

Both passion and responsibility are key to the success of open space. This means that each participant needs to make sure they are contributing and/or learning at all times – if not the 'law of two feet', or law of mobility, means you move on to another discussion which you can contribute to or learn from. Being self-organised means you organise your own time so that you get the most out of the event.

Harrison Owen developed and popularised Open Space from 1985. He felt the best bits of conferences or meetings were always the breaks and aimed to create those kinds of conversations all the time. He drew on ways of holding meetings he saw in West Africa and in other traditional communities. So aspects of open space may feel familiar to you. To find out more visit: openspaceworld.org .

The benefits to Blackpool

Their event was flexible enough for a great range of people to connect their ideas and hold useful discussions despite their real differences in age and background i.e. young people and school students, older people, private sector shop managers, pub managers, health staff, and councillors. It meant they were able to talk about tricky issues like stereotyping of young people in a non-threatening way. It especially helped young people suggest agenda topics. In the end the event also enabled the councillors to identify practical action they could take in their own authorities and strengthened their commitment to working in a broad partnership in future.

Scrutiny and GPs

General Practitioners are the lynch pins of the NHS Primary Care system but, to date, their engagement with overview and scrutiny committees (OSCs) has been quite limited in most parts of the country as, in the main, OSCs have worked more closely with Primary Care Trusts and Acute Trusts. However, proposals in the Health and Social Care Bill make it essential that GPs and Local Authority scrutiny bodies build a much stronger working relationship. This section of the publication explores some recent examples (one Scrutiny Development Area, and two others) of where GPs have been involved in scrutiny, and examines how the landscape affecting GPs and scrutiny is changing and offers some top tips on how to build stronger relationships.

Some experiences of GPs' involvement in scrutiny

Staffordshire - Mental health services review - click here

Discussions with officers who have supported recent reviews involving GPs have revealed some common factors that the officers feel contributed to successful outcomes. We talked to Sarah Garner, who supported Staffordshire County Council's review of lower level preventative mental health services, Anne Mitchell at Leicestershire County Council who supported a review of practice based commissioning and Kim Pocock who supported Nottingham City Council's review of how earlier diagnosis can improve the treatment of people with dementia. The key messages were as follows:

- The routes used to invite participation by GPs included contact through the PCT, the Local Medical Committee, the Professional Executive Committee or through local practice managers. Whichever route was used it worked best where links were already well established and there were good working relations between scrutiny officers and members and NHS personnel. One officer commented that trust and good relations take time to build and require some level of continuity.
- Some GPs had little previous knowledge of how scrutiny works so, where this was the case, it was helpful to provide a simple briefing on how the review would work and to emphasise the critical friend style of scrutiny.
- GPs were keen to be involved in scrutiny where they saw it as an opportunity to work with key stakeholders and to explore ways of making services more responsive to people's needs. This was particularly the case where they could see that elected members were passionate about the subject and in tune with the needs of their communities. Some GPs found that involvement in scrutiny enabled them to link up with partners who contributed to the same patient pathways. Some GPs had reflected that there were benefits in terms of their own professional development and the opportunity to discuss wider public health issues with fellow professionals.

Warwickshire - Services for teenage parents review - click here

- Good scrutiny support was important in each review. This included simple explanations about process, limiting the amount of paperwork and good time management.

Angela Warner is both a GP and a Warwickshire County Councillor who has chaired health scrutiny reviews. She believes that scrutiny works best when there is a common commitment to bring about real service improvement. She feels that health colleagues respond best to scrutiny when they see it as a positive and creative process rather than negative, slow and bureaucratic. Elected members have to be in tune with their community's needs and should be in a great position to use their local knowledge and their involvement in wider public policy issues to inform the development of improvements in health and well-being. If GP consortia take over responsibility for the majority of commissioning, Angela believes it will be vital for council scrutiny

members to work with consortia representatives to build new relationships based on mutual respect and a clear understanding of each other's motivation.

How is the landscape changing?

If the current proposals in the Health and Social Care Bill are implemented, GP consortia will have responsibility to commission a wide range of care and treatment services from April 2013. Alongside this enhanced commissioning role for GPs the Bill contains provisions to ensure public accountability. Each consortium will have a duty to prepare commissioning plans setting out how they will use their budgets and how outcomes will be improved. They will need to demonstrate that they have reflected the Joint Strategic Needs Assessment and the Joint Health and Well-being Strategies that will be prepared by the new Health and Well-being Boards (of which they will be core members). They will be required to publish information on their arrangements for remuneration and prepare an annual report in which they must reflect the public and patient consultations that they have conducted.

The Bill's proposals for health overview and scrutiny confer these powers on the Local Authority as a whole and allow flexibility about how the function is discharged within its governance arrangements. The scrutiny powers will be strengthened to cover any commissioner or provider of NHS funded services including, of course, GP consortia.

These proposals represent a major change in the formal relationships between GPs and scrutiny bodies. It will be crucial that both sides work closely together in the transition period, sharing and consulting each other on their plans including arrangements for public and patient involvement.

continues

Top tips on building relationships between GPs and scrutiny bodies

- ☑ Representatives of scrutiny and shadow GP commissioning consortia will need to agree local protocols about how they will work together. CfPS has developed a framework called "Accountability Works For You", that could provide a basis for developing such protocols.[1]
- ☑ Build on existing good relationships where they exist and value continuity of support. In many places those relationships will not exist because the people involved will be new to the scene. In these cases it is even more important for scrutiny members and representatives of GP consortia to work together to identify issues that need to be addressed in developing positive and creative approaches to scrutiny (as suggested above by Cllr Angela Warner).
- ☑ Keep things simple. Value people's time and don't overload them with paperwork.
- ☑ Use common briefings to make sure we all share a common understanding of the new legislation and the ground rules for engagement.
- ☑ Focus on key issues where scrutiny can make a real difference to outcomes for people.
- ☑ Encourage health colleagues (and particularly the new GP consortia) to involve scrutiny members and local involvement networks (or Health Watch when it is established) at an early stage in the commissioning cycle. This will enable you to make a constructive contribution to needs assessment and strategy development rather than simply react critically to proposals at a later stage.
- ☑ When GPs are involved in a review keep them informed about how the review progresses and give them an opportunity to comment on conclusions and recommendations.

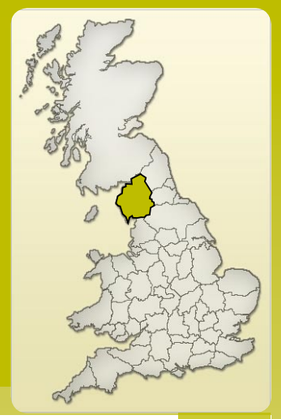
1) http://www.cfps.org.uk/what-we-do/accountability-works/accountability-works-for-you/

Section 4

Scrutiny Development Area case studies

Blackpool
Minimum pricing of alcohol

Blackpool Council led this review into Minimum Pricing for Alcohol (MPA) that involved Lancashire and Cumbria County Councils, and Blackburn with Darwen Council. This review was triggered by the severe problems faced in Blackpool and other authorities as a result of harmful drinking. The councils involved formed a joint review group of members and officers that met regularly between March and November 2010 to consider the wide range of issues involved. The project culminated in a large multi-stakeholder event in October 2010.



Reason for choosing topic

Blackpool has among the highest levels of alcohol related harm in the country, both direct health effects such as premature death and chronic liver disease, and other consequences such as disorder and violence. An estimated 40,000 Blackpool residents drink at hazardous or harmful levels or 28% of the adult population. Alcohol is a factor in many domestic violence incidents and is a major contributing factor in violent crime. There is also a high number of alcohol related admission to A and E. Blackpool has over 1,900 on-licensed premises that support the visitor economy and approximately 180 off-licences, mostly concentrated in the poorest wards. The partner authorities face, similar issues of harmful drinking. It was felt that MPA would provide a strong focus, somewhat different from previous approaches to overview and scrutiny, and offer opportunities to feed into and relate to the current national debate about alcohol pricing.

Project journey

For details on the project journey, follow this link.

Early impact

This was an excellent opportunity to bring together elected members from across the region to contribute to the national debate around the minimum pricing of alcohol. Of particular importance to Blackpool, was the question as to whether minimum pricing would do anything to improve alcohol related health inequalities in the town.

At the start of the review, a number of members on the scrutiny working group had already formed their own opinions on whether or not they were in favour of minimum pricing. It was interesting to see how those opinions were influenced and in some cases changed, during the course of the review when more evidence was considered and discussed.

This model of scrutiny proved particularly valuable and will be used again where appropriate – such as a strategic issue that affected at least all of the region or a national issue.

Quote from the lead member, Cllr Mrs Fowler:

"As well as showing how well joint scrutiny can work across councils within the region, the review highlighted the value of gaining such a wide cross section of public opinion and the particularly valid contribution that young people can bring to a debate such as this."

Key learning points

The stakeholder event was an invaluable way of pooling ideas/comments/experience/fears on alcohol issues from all sections/ages in the community. Meeting young people and getting their views first hand was crucial. The number of young people who attended was sufficiently high (around two dozen out of 80 people) to ensure their input affected all the discussions and they themselves proposed a number of the discussion topics.

The importance of avoiding pre-conceived ideas and keeping an open mind was vital throughout. The working group had to put a lot of effort into drawing in the views of people and groups opposed to pricing controls for alcohol - these views added to the debate.

A commitment to partnership in the group was also sustained throughout and proved very important for members to work together on a tricky topic and for each authority to feel at the end that their area had gained benefits from involvement. The authorities involved agreed that it had been a positive experience and they wanted to work together on future studies.

Recommendations

At the outset of the review, the aim of the Working Group was to explore if the introduction of a minimum price for alcohol would be an effective tool to reduce harmful drinking and its effects within the local area. After careful consideration of the wealth of evidence and opinions presented throughout the review, members agreed that a number of actions would be required to fully address the issue rather than a single solution. They agreed seven recommendations – these are detailed in the project journey.

Innovation

This review looked at a topic that is essentially a national issue, requiring national legislation for full impact. Members were nonetheless able to engage a wide range of people in thinking through the topic "how best to reduce harmful drinking through pricing".

The stakeholder event was especially innovative, using Open Space methodology to enable all participants to contribute to setting the agenda for the morning and to run their own discussion groups. This ensured everyone got the issues they felt mattered onto the agenda and dealt with. The event used the latest technology to capture views and discussions; including networked I-Pads, and the use of interactive voting to capture the views of participants before and after the event. A number of issues and priorities emerged from the event that were fed in to the review.

The review is a good example of how when you explore health inequalities you may not always achieve what you set out to do, but the journey and eventual destination really add value and produce helpful results.

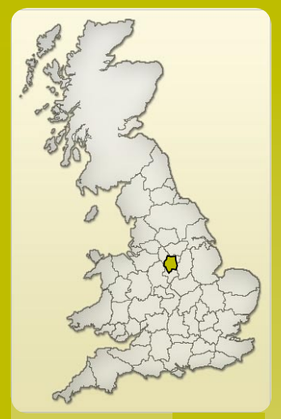
Models of scrutiny developed

This review showed how a local partnership of authorities can tackle what is a national issue yet gain genuine local benefits. It was motivating for the members to be working on something so current in the headlines and for government policy in England and Scotland. It was also a regional issue in the North West with Greater Manchester authorities publishing policy at around the same time. The regular working group meetings, well attended by both officers and members from all participating authorities, developed a solid approach that fostered trust and open review of issues. They produced recommendations that they felt could be implemented locally, helped greatly by a thorough summary of the (often conflicting) evidence on minimum pricing of alcohol that officers prepared.

The stakeholder event demonstrated the importance of using methods that fit the topic: Open Space allows a totally open agenda at the start that suited the potentially highly polarised debate on alcohol pricing very well. It also offered maximum flexibility that suited both young people and older people. The electronic voting also helped people see where they started and where they ended up. Use of this tool could be further refined to distinguish which stakeholders thought what, if used in future.

Cheshire
Health inequalities in rural areas

A review of health inequalities in rural areas was undertaken February – November 2010 by two "new" unitary Councils in Cheshire – Cheshire East and Cheshire West & Chester. A Joint Health Overview and Scrutiny Committee was set up for this purpose. The review focused on identifying and addressing persistent "pockets" of health inequalities believed to exist in rural areas but which are masked by overall and average levels of greater affluence and well-being in those areas. The review also set out to ask about what we mean by rural health inequalities as this may not be the same as for urban areas.



Project journey

For details on the project journey, follow this link.

Reason for choosing topic

Initially the councils were interested in improving a very wide range of aspects of health inequalities in rural areas including how health promotion/improvement schemes could best focus on areas of greatest need, and using mapping activities to tackle health inequalities, and a series of mini-reviews of areas such as pregnancy and early years, education, accessing services and advice, and older people. At an initial scoping meeting, the review lead officers recognised that this would not be deliverable in the timescales, and the aspects were reviewed in terms of what would both be of local interest and create new knowledge.

Early impact

This review demonstrated just how complex health inequalities are and how rural areas are viewed differently by different people. For example, where country life can be peaceful and idyllic to one person, it can be isolated and lonely for another.

The review highlighted to members this difference of opinion and challenged them to look beyond this and really understand the communities the review was focusing on.

Whilst it is still early days, the review highlighted a "data" gap. The review wanted to look at data at a very small population level (lower than super output area) - and this was not readily available. They developed ways of deciding what information they needed, and a model for filling this gap.

Data sharing or lack of it was another issue that the review encountered. Therefore work is now underway to produce data sharing protocols to achieve better outcomes for local people.

However perhaps one of the most exciting emerging areas of work is with the new GP Consortia for West Cheshire and its relationship to scrutiny. The consortia has expressed an interest in the review and its findings and wants to work with members to produce better ways of working together to tackle rural health inequalities. It is hoped that similar progress can be made with the GP consortia in Cheshire East as well as the findings being a useful reference document for the emerging Health and Well-being Boards in their role in tackling health inequalities.

accountability, transparency, involvement

Innovation

The review set out to do something very innovative – to see what information could be found out about hidden "pockets" of health inequalities. The particular challenge was finding the "pockets" within areas generally assumed to be "wealthier".

The review found it very difficult to obtain data that could help members to understand rural inequalities at a sufficiently low level.

Therefore the review created a methodology for addressing low level data. This included the definition of three types of information sources, and an information grid which lists possible sources of information, both "traditional" and "creative", and their degree of usefulness. As an example of the creative use of information, animal neglect can be indicative of poor health of the owner, or a fire services risk assessment can indicate someone in need of support for smoking cessation.

Recommendations

At the conclusion of the review, the following recommendations were formed:

- That the gathering of Type one and Type two information be further developed, so that those rural areas and sub-areas where there may be the greatest experience or risk of health inequalities can be identified. This will focus on refining information from the four to six most productive organisational sources.
- Local knowledge is vital for identifying where inequalities may exist in rural areas, therefore the review recommended that the Council and local health commissioners/ providers of service should develop formal links with local councils and local organisations, especially third sector organisations, to help identify where such inequalities are.
- Public sector partners encouraged to develop protocols for sharing information to identify the small pockets of health inequalities in rural areas.
- Transport was a major factor affecting people's health outcomes. It is recommended that integrated and varied public transport options be pursued within rural areas where more imaginative solutions may be required, including encouraging healthcare providers to consider transport when developing new facilities.
- That the model for Type one information be put forward as our key contribution as an SDA, to developing the national publication for scrutiny of health inequalities.

"Traditionally, health inequalities have been seen as an issue affecting urban areas; when this review started I did not expect to find health inequalities in a rural areas but I soon changed my view!" Councillor Arthur Moran, Chair Joint Health Inequalities Scrutiny Panel.

Key learning points

Do a stakeholder analysis right at the start - getting the right partners involved in the review at an early stage is key.

Research your topic thoroughly and choose something that will be interesting/innovative and add to knowledge rather than the topics that have all been looked at before.

Use simple one-page project planning techniques to help to define and break down the review's stages, and sequence and schedule the work of the review.

Consider at the beginning all the types of information that may be useful and try to gather this information in parallel. Think carefully about how you are going to communicate (eg questionnaire, flyer); the actual questions to be asked; who you are going to ask; and where you are going to ask them - we found some people less forthcoming on their own doorsteps than when "out and about."

Models of scrutiny developed

This review developed a methodology for using data in different ways. This included:

Type one information grid - setting out the stakeholders that could hold useful information for the review. The grid also comments on the usefulness and accessibility of the data as it relates to health inequalities. The grid also categorised the information - traditional vs innovative/creative sources.

Type two information questionnaires - two questionnaires were developed to get the views of members and rural dwellers.

Type three information A mini-scrutiny review to look at mental health services in rural areas, and the health inequalities experienced.

Chesterfield
Geographical health inequalities

Chesterfield Borough Council led a multi agency scrutiny review on what works in Rother and what may improve health outcomes. As well as local elected members, the panel consisted of community representatives, officers from the Local Strategic Partnership and NHS Derbyshire County. The review ran from February to November 2010 with the main focus being on a stakeholder event in September 2010. A film is available of the 'Big Conversation' a key inquiry event.

Reason for choosing topic

Rother is the most deprived area in Chesterfield. It includes areas which fall within the top 10% of the most deprived areas in England. The inquiry planning group were determined to discover what was working in Rother and build from there. They felt that they needed to understand Rother better, and gain an appreciation of the positives of the community and how they could support the community to reduce their inequalities.

Early impact

The Appreciative Inquiry method enabled the panel to understand how the community wants to be. The 'whole system' approach used has already had a positive affect on the delivery of front line services – by facilitating better connections and commitment, e.g. a resident who had a central role in the review, now runs a group at the new GP practice.

With the support of key services, and democratic leadership, the recommendations empower the Rother community to better help itself achieve its aspirations, enabling bottom up, community driven change to influence improved health for the future – a more sustainable approach.

Rother Action Group has been formed made up of residents, and stakeholders. Although early days, it is envisaged that this work will be the beginning of a change process; where support and information available to the Rother Action Group will help stimulate behavioural and lifestyle changes in Rother. Behaviour change such as increased regular exercise, stopping smoking, improved carers support through buddying support, talking to neighbours, helping with garden chores and making people feel part of the community and not alone, could help to change lives and in turn improve health.

Project journey

For details on the project journey, follow this link.

Cllr David Stone, Lead Member for Safe, Healthy and Active Communities at Chesterfield Borough Council said:

"We've worked with partners, residents and stakeholders to form a Rother Action Group, which will be the driving force in taking forward our recommendations. We're very encouraged by the positive response to the project from all concerned, especially the local community. The Council and NHS Derbyshire County will continue to provide a key leadership role for the Group."

Innovation

The review panel adopted the Appreciative Inquiry technique to help them to engage in solution focused conversations with local people rather than conversations about problems and deficits. It was clear that the way you ask questions affects the information that you obtain. By focusing on what is working the panel learnt a lot about where people go for useful support.

The panel worked alongside all stakeholders including experts and residents rather than calling them as witnesses.

This facilitated new connections, relationships and shared ownership. The processes of gathering evidence, analysis and implementation were simultaneous as they evolved as all participants talked to one another. The methods used were fun and the stories were powerful.

The review approach ensured a strong, working together culture, which focused on joint service improvements and policy developments, rather than a formal holding to account role where witnesses are individually called to local authority scrutiny meetings to give evidence.

Key learning points

Appreciative Inquiry provided a new way of using overview and scrutiny which may be particularly appropriate for addressing complex problems such as health inequalities. It was especially successful in bringing people together, learning what was going on in the area and providing new ways of communicating. The key outcomes had been the establishment of new relationships, energy, commitment and confidence.

We also learned that:

- The methods resulted in participants feeling valued. It brought everyone that could make an impact in the area together.
- Starting from within the community and what is working was energising and developed a 'can do' atmosphere; we successfully focused on a wider picture.
- The novel way of doing the review required a sensitive balance between councillors on the panel providing leadership whilst having the wider involvement and ownership of the group.
- The geographical approach of addressing health inequalities in a specific community has helped us understand that there are many social factors that can influence health at any one time. Trying to resolve all these influences may be the most effective way in the longer term to address health equity.
- If using a whole system approach, the planning team needs to be wider than scrutiny councillors and involve appropriate senior officers and executive councillors. Planning teams should be involved in implementation as well as the inquiry.

Models of scrutiny developed

Appreciative Inquiry is founded on powerful, underlying assumptions:

- In every situation something works… find it and let it flourish.
- What we focus on becomes our reality… if we focus on possibilities we find possibilities – if we focus on problems we find problems.
- There are always multiple realities – different ways of seeing.
- The way we ask questions either creates or denies possibilities. So be mindful in how we do this.
- The language we use creates our reality.
- When we carry forward to the future some of our old ways - then they should be the very best of our old ways.
- Value differences – diversity nourishes creativity and resilience – seek it out and welcome it.

The scrutiny review applied this thinking to conducting its review – and has seen its potential as a powerful tool for scrutiny.

Recommendations

Below is a summary of the recommendations coming out of the review:

- Map, index and publicise the services and projects being delivered in Rother.
- Set up and promote 'Pride of Rother' awards to recognise and celebrate what's working in Rother, to acknowledge and reward those who deserve recognition, working with Rother's Community Forum and community groups.
- Set up and support a Community Buddies Service.
- To produce a newsletter to residents of Rother informing them of the detail and outcomes of the scrutiny project and of next steps commitments.
- Subject to agreed additional support, the Health Inequalities Scrutiny Panel will use the experience gained, alongside the CfPS publication, to redeliver the scrutiny project for other Chesterfield areas as needs require.
- The Council to take the report and its recommendations into consideration when developing and delivering the Council's "Tackling Health Inequalities Plan".

Dorset
Cardio-vascular disease

Dorset County Council and Bournemouth Borough Council conducted a joint review of health inequalities with a focus on cardiovascular disease. The Review Panel consisted of elected members from the two Local Authorities plus colleagues from public health, community development and the Local Involvement Networks (LINks).

Project journey

For details on the project journey, follow this link.

Reasons for choosing topic

The two Authorities had identified that cardiovascular disease is a major cause of early preventable death. Despite an overall picture of generally good health among the wider populations of Dorset and Bournemouth, there are some pockets of severe deprivation with high early mortality rates associated with relatively high rates of cardiovascular disease. Taking the opportunity presented by the CfPS Scrutiny Development Areas project, the two authorities formed a Panel to investigate this issue in more depth. They recognised that both lifestyle factors and the wider determinants of health have an important impact on the risk of cardiovascular disease so they decided to look at both.

Early impact

None of the findings in the review answered why real change had not been achieved in health inequalities across Dorset and Bournemouth. The Panel concluded that this is the result of two things:

- Targeted interventions have been insufficient in scale (or too short term) to effect a change.
- targeted interventions being delivered through public health are not sufficiently linked or synchronised to local authority work that is trying to improve the socio-economic determinants of health.

The Panel believe that change in health inequalities will not happen until both of these issues are addressed.

The timing of this review has been perfect. It has allowed the local authorities involved to understand the complexity of health inequalities and the role they have to play in owning health improvement and it has paved the way for the structural health changes that are to come.

"The danger with work around health inequalities is expecting quick wins – if this review has identified anything it is that this is not about the short term – this is about the long haul. Real change means a long-term sustained, co-ordinated programme across many spheres at both a local and at a national level. This review is a small contributory part at the beginning of a long process of change."

Debbie Ward, Director for Adult and Community Services, Dorset County Council.

Recommendations

The panel made eight recommendations which they felt would go some way to improving the situation:

1 That Health Impact Assessments be completed as part of any new or revised strategy, policy or service development.

2 That the Local Authorities support targeted interventions commissioned by the local Public Health teams that focus on the most disadvantaged, but also work in parallel to tackle the wider determinants of health in the area.

3 That the scrutiny committees of the Local Authorities jointly lobby central government to make health impact a material consideration in planning policies. Also that health impacts form part of any central government change to taxation and welfare benefits.

4 That Local Strategic Partnerships are supported to raise awareness of the impact that all partners have on health and well-being; move away from rigid organisational structures to task focused, time limited cross authority groupings; and a performance management framework that puts health inequalities at the heart of partnership working.

5 That the "Place" philosophy is supported so that resources are pooled where possible to provide sustainable long term funding for interventions to reduce health inequalities and build community resilience.

6 That Local Authorities become custodians of best practice in supporting health and well-being in relation to their procurement and contracting activity and their workplaces.

7 That support is given to community development initiatives that build personal self-esteem and community empowerment.

8 That the review's impact is monitored and evaluated in twelve months time.

Innovation

One key feature of this review is the process by which the Panel modified its focus in light of emerging evidence. This refinement prompted a major piece of work to find out whether service managers appreciate the impact that their actions can have and the extent to which they work in partnership to address public health issues. They identified all those service areas that appear to have a potential impact on health and contacted the managers of these services. This included town planning, transport, economic development, housing, trading standards, children's services, catering (including procurement) and facilities management.

As well as raising the awareness of health across the council; it showed how managers focus on their core business and this means the organisation as a whole misses the opportunity to address wider "wicked" issues. Strong leadership to make health a more significant driver for local authority strategies is needed; and the potential to achieve better results through health impact assessments and better co-ordinated policies and strategies.

Another important ingredient in the review approach was the composition of the Panel. Local elected members, public health professionals and a community development worker brought a wealth of professional knowledge that was crucial to the review.

Key learning points

Some of the most significant learning points from the review were:

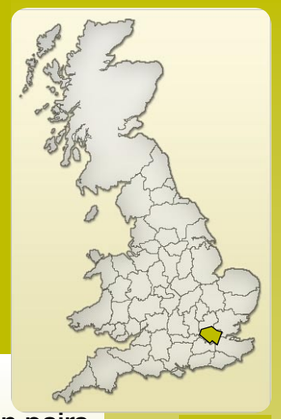
- The Panel had the courage to change direction mid-review. The key ingredients were good leadership, a strong mixture of skills and expertise, and a willingness to reflect and learn as the review progressed.
- The process of gathering responses from managers across both Authorities proved challenging. On reflection it would have been valuable to have an officer from both authorities on the Panel rather than do everything through one officer, as it was difficult to receive responses when you do not work for the authority.
- Tackling health inequalities is complex and difficult. There is a strong case for developing a balanced strategy of targeted interventions on lifestyle factors linked with broader policies to address the wider determinants of health affecting the whole population.

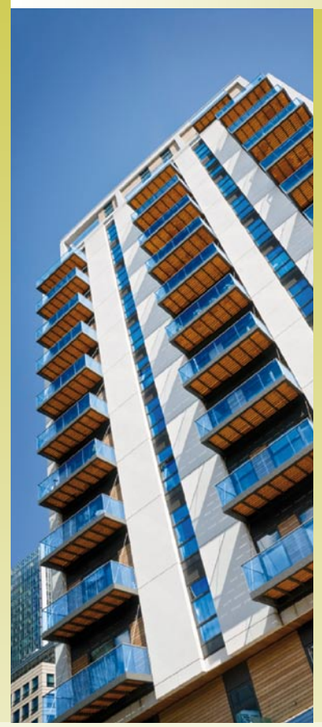
Models of scrutiny developed

This review was about constructive enquiry and a process of adapting to emerging evidence. It used the three main strands of work described in the project journey. The main area of development was on the first of those strands of work as it involved the design of a set of questions for service managers about their understanding about the impact of their work on health inequalities.

London
Housing, health and the environment

Although housing is a key determinant of long term health it has traditionally operated in isolation, focusing on housing markets, new supply, improvements to housing stock, design and management of rented homes. This review involved the London Boroughs of Brent, Ealing, Hammersmith & Fulham, Hillingdon, Hounslow, RB Kensington & Chelsea and City of Westminster. They felt their review was a significant opportunity to establish and strengthen the connection housing has on the quality of life of residents and on inequalities in their areas.





The review ran from June until December 2010. Councils agreed to work in pairs on the following four 'liveability' strands:

- **The effects of overcrowding on physical and mental health.**
- **The effects of overcrowding on educational attainment, and children's development.**
- **The effects of the overall built environment including new housing developments (i.e. good spatial planning including transport links, access to 'real' open and play spaces, controlling noise pollution, ensuring community safety).**
- **Fuel poverty (the inability to keep a house warm at acceptable cost).**

Reason for choosing topic

Members wanted to better understand how housing as a determinant of health was actually affecting their residents, and what potential solutions could be formulated and put forward from their findings. NW London and its housing position offered a number of dimensions that could illustrate the issues for other areas. This included the difficulties for low income families in securing decent housing in an expensive city and evident health inequalities, for example TB rates across north west sector authorities are significantly higher than the England and national average.

Cllr Sheila D'Souza, lead member for the Westminster task group:

"Our investigation has shown that there is valuable work going on, but that in today's financial climate it is vital for the worth of that work to be clearly evidenced. The future is uncertain and we must ensure that what we are doing is adequately monitored and evaluated so that when tough choices have to be made, we make the right ones."

Early impact

Some of the impacts being felt already include:

- Better awareness of housing and health as an issue – this is due to holding a stakeholder event very early on in the review and the individual work stream investigations.
- Gaining a better understanding from local people about how housing is affecting their lives – valuable engagement techniques have been utilized – and will continue to be beyond the life of the review. Also an appreciation of using schools as community hubs and for information dissemination.
- Better partnership working and joined up services.
- In Hounslow - the project will continue for longer than first envisaged as the local school based on the estate is keen to allow children to voice their views as they see this as a valuable tool.
- In Westminster - As a result of conducting the investigation, the PCT found funding for a health visitor to receive referrals to address the health issues of overcrowded families. The investigation also revealed that more work needed to be conducted to effectively evaluate the impact of the programme to help overcrowded families. This review is due to be carried out over the coming months.

Project journey

For details on the project journey, follow this link.

Key learning points

Members learnt that while they may have limited influence e.g. over private sector housing/ development, they must use what they have cohesively and work across council departments to achieve this. Officers in this project discovered others whose work was relevant but about which they previously knew nothing.

Another key insight was the positive response of local residents to talk to their councils about these issues and how they saw them: 'it's about the public in their environment, their happiness'. It also became clear that creating events or conversations that really added insights did not mean having large numbers necessarily: one in-depth case study or a few willing residents reflect the 'whole system' in what they say and offer many ideas for following up problems or opportunities with other departments.

There was as much learning in what was difficult or showed deficits in the system e.g. finding out a local tenant participation officer did not really know anyone on the estate in question raised concerns for the housing department. The work reinforced to all involved the importance of housing to health and the trickiness of evaluating its actual impact. Equally the importance of scoping and of member leadership were emphasised.

Innovation

The paired work shows an interesting way to conduct joint work, as it allowed for a greater spread of involvement and partnership working. The span of issues in the review around housing and the built environment opened up the discussion on links with health at the right time, given the imminent shift of public health to local authorities and their responsibilities for housing and the built environment through planning and development, transport etc.

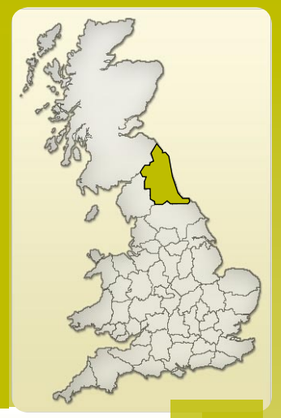
A variety of ways to engage people were used in the review. Partners used a range of methods with success: Hillingdon used in-depth case studies of families in overcrowded conditions; Hounslow focused on a particular estate and involved residents in thinking about their environment's impact on their well-being; Brent investigated the evidence for fuel poverty affecting health, working with NHS partners; Westminster undertook shadowing of an overcrowding caseworker – these are described further in the partners' summaries, within the project journey.

Models of scrutiny developed

The use of paired councils to create a review and help each other was valued and helped make this large project more manageable. The sectoral reach of this review is also an interesting model for exploring a commonly held issue but nuanced differently in the different authority areas or according to their members' interests. The importance of scrutiny work that reaches into all the sections of the council itself is also highlighted by the review, since staff in planning, environmental health and housing were not focused on health outcomes, despite overall community development policy or well-being aims of councils.

North East Region
Ex-service community review

All twelve local authorities of the North East of England undertook a regionwide scrutiny review of the health inequalities facing the ex-service community, during the period February 2010 to January 2011. The lead authority was Newcastle City Council and the other participants were Darlington, Durham, Gateshead, Hartlepool, Middlesbrough, North Tyneside, Northumberland, Redcar and Cleveland, South Tyneside, Stockton-on-Tees and Sunderland. A wide range of organisations took part, and the British Army and the Royal British Legion in particular contributed to the planning of the review.



Project journey

For details on the project journey, follow this link.

Reason for choosing topic

The ex-service community is considered to be people who have served in the Armed Forces, together with their relatives, dependants and carers. They make up a large group of the population whose wellbeing and health needs have been affected by a significant common experience.

Most people leave the Armed Forces healthy, and make a successful transition to civilian life. However a report by the Kings College in 2009 found that there were common mental health diagnoses of alcohol problems, depression and anxiety disorders. In particular, those who leave the Services early were up to three times more likely to commit suicide than the general population.

Few hard facts are available nationally, and detailed information on the ex-services community population in the North East is scant. It is estimated that there may be up to one million veterans, family members and dependants across the region.

Innovation

Choosing the right topic - The scope of the scrutiny review captured the imagination of members and officers because it was timely in terms of the target group, an ex-services community which, through preliminary scrutiny research, did not appear to be visible to public services – both in local government and health.

Partnership working – The main innovation was the partnership working between twelve unitary councils. The North East region encompasses Northumberland, Tyne and Wear, Durham and the Tees Valley, and covers urban and rural communities, from Berwick upon Tweed to Middlesbrough, a distance of just over 100 miles. Members and officers put any political or local differences aside and adopted a flexible approach and adapted their ways of working in response to this challenge, building upon existing networks.

Paul Baldasera, South Tyneside, commented,

"The officer support felt a lot different, and required a good deal of goodwill and understanding between officers who had varying levels of capacity to offer the project."

In relation to working collaboratively with members and officers from other councils, *Feisal Jassat, Durham, added,*

"Partnership working can be difficult. Trust, openness and honesty are important. Shared struggles and shared celebrations are important."

Recommendations

The report contains 47 separate recommendations, on the following themes:

- Promoting effective communication and co-ordination across agencies, providers and the third sector.
- Improving awareness of the needs of the ex-service community among service providers.
- Improving awareness of available services among the ex-service community.
- Improving responsiveness within organisations.
- Improving co-ordination across organisations.
- The transition of Armed Forces personnel to civilian services following discharge.
- Ensuring equality of access for Armed Forces families.
- Veterans' mental health services.

Examples:

Recommendation 3: that all organisations providing (or potentially providing), services for the ex-service community should be required to encourage veterans to voluntarily identify themselves by asking 'have you served in the UK Armed forces?'

Recommendation 17: that the North East National Housing Federation is requested on behalf of local authorities across the region to carry out work with Registered Social Landlords to raise awareness of the housing needs of the ex-service community.

Recommendation 36: that the new Health and Wellbeing Boards prioritise veterans' mental health issues, taking a lead in ensuring that on day one of discharge into civilian life that services are in place to meet the needs of the ex-service community in relation to both NHS and social care provision.

Early impact

There are two major early impacts identified:

1 The review has already made a valuable impact in successfully bringing together a wide range of individuals and organisations to focus on the needs of the NE ex-service community. The Regional Joint Health Scrutiny Committee wanted to sustain involvement and enthusiasm, and has therefore arranged a further major event should be arranged for all relevant organisations at the end of March 2011. This event will allow organisations to provide an initial response to the recommendations relevant to them and to provide an opportunity for them to work together with others to identify issues such as feasibility, priorities, timescales and costs with the aim of agreeing the most effective way of achieving the review objectives.

2 Partnership working across 12 local councils was also an important aspect of the review. The Joint Health Scrutiny Committee is now well established with a clear understanding of its role and the contribution it can make to health scrutiny in the region.

Key learning points

1 Joint reviews need agreement on structures and processes. This review began with a joint memorandum of understanding and a project board, but these were later absorbed into a standing joint committee with a detailed protocol, which required consultation with legal officers and securing full council approval across all twelve authorities. This took several months, but all concerned felt that it was worth it to achieve a robust framework. Both the project memorandum and the committee protocol are available from the project team.

2 Good project planning and 'matrix' planning between the workstream groups is difficult but important. Members and officers noted that there was a lack of information in relation to public and third sector services available to the ex-services community. Though there were three separate and distinct workstream groups, each with their own terms of reference, it became evident that, at times, they were 'calling' the same witnesses. One of the areas of learning for the North East scrutiny network is the need to ensure that this is managed in future reviews.

"Regional scrutiny of services for the ex-service community has distanced itself from party political prejudices and biases, as the scrutiny review has been focused on a social phenomenon common to all areas across the region."

Councillors Veronica Dunn (Newcastle), Margaret Finlay (South Tyneside), Stuart Green (Gateshead) and Graham Hall (Sunderland)

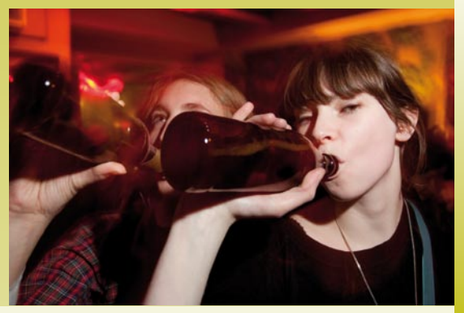
Model of scrutiny developed

This review demonstrated that integrated scrutiny on a region-wide basis, covering urban and rural areas, is possible (see Protocol Section Three). The key features are:

- Clearly allocated support officers.
- Free interaction of members.
- Shared understanding of overall objectives.

Portsmouth
Alcohol admissions to hospital

Portsmouth City Council's Health Overview and Scrutiny Panel conducted a review of alcohol-related hospital admissions at Queen Alexandra Hospital, from January to December 2010. The review also included representatives from the surrounding local authorities of Gosport, Fareham, Havant, East Hampshire, Winchester and Hampshire; the Director of Public Health and Primary Care Trust, the City Council's Substance Misuse Co-ordinator plus others from the NHS, local government and the voluntary and community sectors.



Reason for choosing topic

The Portsmouth Alcohol Strategy 2009-13 estimated that "over 40,000 people in Portsmouth drink at levels that may harm their health". Portsmouth's rate of alcohol-related hospital admissions is higher than the national average, and is the highest rate in the South East. Alcohol misuse also affects significant numbers indirectly, including family, friends and colleagues. Queen Alexandra Hospital serves residents from Portsmouth and its surrounding areas. The Panel felt that a review of alcohol-related admissions at this hospital would give members an overview of alcohol misuse in the whole area, and enable them to produce recommendations across multiple agencies to benefit the whole community.

"Facilitating this review has been a "challenging pleasure". It has brought fresh insight to a subject that has a very high public health profile, and captured the imagination of so many stakeholders. The process and the final report have been very well received by all those involved in the review, the Cabinet member at Portsmouth City Council and nationally within the Department of Health."

Tony Quinn, Senior Local Democracy Officer, Portsmouth City Council.

Innovation

The review is especially notable for the innovative engagement and outreach work undertaken by members. This included visits to service providers such as the Medical Assessment Unit and the Intensive Care Unit at Queen Alexandra Hospital; to stakeholder groups such as Portsmouth Users Self-Help (PUSH) Group; work-shadowing the police and ambulance service; observing in the City Council CCTV Control Room and the Emergency Operations Centre of the South Central Ambulance Service; and going out and about with Portsmouth Street Pastors. All work shadowing took place between the hours of 22:00 and 03:00 on Friday or Saturday nights. A successful public participation event was held; an online survey attracted close to 1,000 responses; and a video booth diary recorded the views of people participating in the local night-time economy.

Early impact

Helping to understand an issue - A key success of the review has been the way that it has gathered evidence, as it moved away from the traditional means of inviting witnesses into a committee room to be questioned and towards members gaining firsthand experience of the complexities of dealing with alcohol related hospital admissions. This added real value to the process and will be an approach adopted for further reviews.

Partnership working - one notable impact to date has been an understanding of the number of agencies that are involved in Alcohol Services in the Portsmouth area - and how better co-ordination of these services could improve health outcomes for local people. Plans are already a foot to streamline practices.

Engaging communities - With a little forethought and creativity, engaging the community in this contentious issue proved to be a key cog. For example, the night-time work shadowing allowed the panel to see the transformation within the city at night and better understand some of the issues affecting local people, council staff and the impact on inter-agency working.

Project journey

For details on the project journey, follow this link.

Key learning points

Getting the right partners working together is vital, even those that have never met or worked together before. The review established relationships that should pay dividends for years to come, in terms of greater mutual understanding, improvements to productivity and higher quality services.

Whilst some of the methods proposed for the review did not happen due to time constraints or because they proved impractical; many innovative scrutiny tools were developed and implemented, demonstrating that it pays to be ambitious and creative at the start, whilst maintaining flexibility to change and adapt as a review progresses.

Accessing specific information from other agencies proved challenging because of the differing systems used. A learning point could be to start a review with this awareness and be more flexible in what is requested. Alternatively, a review could "test the system" by asking for highly specific and relevant information, to uncover issues in information collection and retrieval. These could be usefully addressed as an outcome of the review.

Recommendations

The final report and recommendations were approved by the Panel in January 2011. Implementation of these recommendations will make the following difference:

- Increased awareness of the real cost of alcohol misuse.
- Education of future generations of the dangers of alcohol misuse.
- Improved communication between partner agencies.
- More effective inter-agency working.
- More robust collection of data on assaults and licensing infringements.
- Closer working between licensing and planning.
- Reduced alcohol-related hospital admissions, including a reduction in "frequent flyers".

Models of scrutiny developed

The review identified a well-defined, health-related topic which nevertheless had broad-ranging implications for all areas of public service and community life, and a distinct connection to commercial interests. It demonstrates the potential for health scrutiny to tackle issues that fall outside the remit of any other single body. The high-profile role of the Director of Public Health, as a joint appointment between the NHS and local government, is of note. This may be a model of scrutiny that will come to greater prominence, with Public Health situated more firmly within local government.

Sefton
Geographical health inequalities

The 2009 Annual Public Health Report, *Invest for the Future*, made the connection between health and well-being, with other areas, such as employment, education, housing and environments. Responding to this, the council established a cross-cutting, cross-party Overview & Scrutiny Working Group, involving members who were involved in health, education, environment and safer/stronger communities to try to understand health inequalities in Sefton. The review held between June and December 2010 also involved NHS Sefton, local schools, parents and children and other stakeholders.

Reason for choosing topic

In Sefton, as in the rest of England, people living in the poorest neighbourhoods die earlier than those in the richest neighbourhoods. In Sefton the gap in life expectancy is nine years for males and eight years for females. The priorities emerging from Sefton's Joint Strategic Needs Assessment highlighted the requirement to:

- Reduce health inequalities within Sefton, and between Sefton and other areas.
- Focus on prevention and early detection of both physical and mental illness.
- Reduce the levels of behaviours that carry risk for future health.
- Tackle the main diseases from which people die.

In recognition that disadvantage starts before birth and accumulates throughout life, local partners gave the highest priority to exploring ways of giving every child the best start in life. This determined the key focus for the review.

Project journey

For details on the project journey, follow this link.

Innovation

The social determinants of health and well-being are a complex area for research. Members were attempting to understand the impact on local people of factors and forces that are, to a large extent, determined by national and sometimes international conditions and government policies. This review:

- Used innovative forms of direct engagement with local people, including groups who are not viewed as key partners to the council including teachers and members of faith communities. The use of the community artist to engage very young children was a particularly unique feature of this review.
- Highlighted a 'relational 'process which emerged as a consequence of the school visits and member walkabouts. These visits linked theory and data to the reality of people's lives, this generated deep commitment to finding a way forward, even in difficult times.
- Demonstrated the importance of seeing assets as well as needs and challenges. It used these assets and issues to map and to support strategic direction on reducing health inequalities.

Recommendations

Nine recommendations were presented to decision makers in the Council and NHS Sefton. These can be found in more detail in the project journey, however they can be summarised under two main areas:

Schools and teachers can be effective influencers in promoting healthy eating and lifestyles. Schools are also valuable community assets that tend to be under used. The review recommended that the Council and schools should work together in making sure that these assets are used for the benefit of the community.

Community Assets – in terms of the physical assets available and the range of knowledge within communities could be utilised more effectively by:

- More effective planning of the use of facilities and information provided to communities.
- Council partners and community leaders working together on service design to tackle inequalities.

Key learning points

1. The critical and unexplored role of schools as community assets in supporting health and well-being for all children - and their almost invisible but vital contribution made to families and the broader community.
2. Children have very strong opinions about health and well being and understand what supports it and what gets in the way for them and their families. Children are often active protagonists in persuading adults to change detrimental health behaviours including smoking and drinking too much.
3. Many children and families in Sefton are burdened by poverty, family breakdown and domestic violence. This was hard for members to hear, particularly when hearing about these issues directly from children themselves.
4. The perceptions of local people may be at odds with 'the facts' about an area and its assumed assets. This has been a challenge to current norms around strategy development for all partners.
5. The issue is larger and more complex than either members or officers first thought! There is a need to use the information that emerges from the review to identify a small number of high impact issues to take forward.

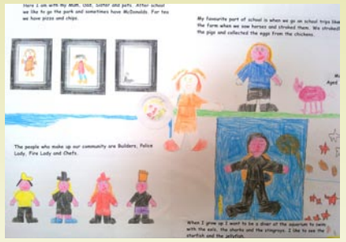
Early impact

Although the report and recommendations from the review have only recently been published – there are some early signs of impact. These include:

- The review developed and built on innovative methods, by using examples from previous working groups. This facilitated better information sharing and the availability of data for the project but also beyond.
- Members found that visiting community venues to meet with key stakeholders and services users, and walking around the community were invaluable ways of getting to the heart of an issue. Scrutiny reviews in the future will be much more exploratory.
- A legacy of collaborative working has been left by the review – as it was very effective at building partnerships – both across organisations and with seldom heard groups (such as children).
- Local democracy in the community - awareness of the services that Sefton Council and its partners provide has increased with the schools and the children knowing more about their local area, who their councillors are and what keeps them healthy.

"The involvement of five and six year old children, through a community artist, enabled us to put the thoughts, experiences and aspirations of the generation who will be most affected at the heart of our review."

Cllr A Hill, Chair, Overview and Scrutiny Working Group



Models of scrutiny developed

This review has demonstrated the power of a scrutiny process and has developed three transferable features:

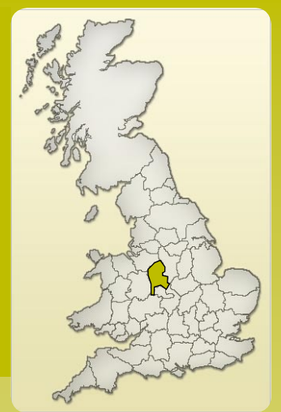
Moving scrutiny out of the town hall to a more direct encounter with local people as a means of gathering information to inform strategy.

Developing an effective model for engaging children and their families in the scrutiny process allowing for a better understanding of a community.

The establishment of a cross-party alliance of politicians and the use of formal and informal models of partnership working provided a richer picture of local needs and assets.

Staffordshire
Mental health promotion, prevention and early intervention

Staffordshire County Council, working with its district and borough councils, undertook a review of the effectiveness of lower level and preventative mental health services in Staffordshire between July 2010 and April 2011. The review was undertaken by a working group made up of councillors from across the councils and from the Health Scrutiny Committee and Social Care Scrutiny Committee. The review also involved other partners including the voluntary sector and Job Centre Plus.



Reason for choosing topic

The topic was chosen through the health scrutiny work programming planning process and by identifying that improving the mental well-being of the population and the related services are a priority both nationally and in Staffordshire. There is concern that mental health promotion, prevention and early intervention services are lacking, under developed and inequitable (in access and outcomes) across Staffordshire. Differences exist between services in the north and south of the county.

Quote from the working group Chair, Councillor Geoff Morrison:

"... we have been struck by the scale of unmet need (and) are convinced that the more emphasis and consideration given to mental health issues, the earlier we can intervene to prevent people going on to develop more serious problems... Our work has been aimed at making sure the local health economy is investing and doing what it can to, where possible, save people from long term mental illness with all its personal, social and economic consequences."

Innovation

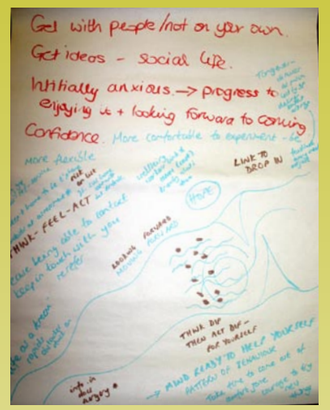
The review has enabled new ways of working for councillors. The use of different tools for setting priorities, building relationships and for collecting information has challenged all members to take an active role in the review. More in-depth information collection has been possible as a result of the use of methods such as visits, telephone conferences and specialist focus groups. Consistency was provided by the Chair and regularly meeting and sharing experiences the Group has continued to work as a team and have ownership of their work.

Regular reflection on how the processes are working has also helped councillors to recognise that, for example, they need to prioritise issues and sometimes let go of issues of particular interest if a greater impact can be achieved by considering something else.

Early impact

This review took place at a time of change in mental health policy and provision; shifting from a range of services intended to reduce demand on hospital care, towards promotion, prevention and early intervention with the aim of reducing demand for treatment and the impact of mental illness and poor mental health. The way the review was carried out, focusing on particular areas and places, allowed members to look at this issue both strategically and locally, shedding light on what this shift means for service delivery in Staffordshire. Involving a range of people allowed members to draw out various issues and identify opportunities for action to improve services and emotional well-being in Staffordshire.

At the time of writing it is too soon to pinpoint early impact on the implementation of the commissioning strategy – but the new techniques developed and used during the review were invaluable and will be utilised in future reviews.



Focus group activity

Recommendations

At the time of printing this publication, the Staffordshire review has not concluded. This case study will be updated as this happens.

Project journey

For details on the project journey, follow this link.

Key learning points

Prepare well - take time to understand the issues and what the language actually means, i.e. understanding the concepts of mental health and mental illness, helped to generate lines of enquiry and keep the review focused.

Focus on opportunities to make a difference, e.g. the updating of the commissioning strategy.

Prioritisation was an important element - helped to keep the focus on a manageable number of areas.

Producing mini scope documents for each issue was useful. These could be easily adapted and provided to brief stakeholders. This meant that there were no surprises and that stakeholders had an opportunity to prepare information in advance.

Previous reviews have been 'whole group' activities, requiring all members of the review group to participate at all times. This was resource intensive and resulted in a fewer number of members being actively involved. By sharing the work between pairs or small groups, with regular full group meetings, capacity was increased and more in-depth information and evidence gathering could take place.

Models of scrutiny developed

A model for stepped action approach was developed including regular reflection.

- Using a clear framework for information gathering and preparation, allowed the review group to clarify its areas for questioning and lines of inquiry early on.
- Using a prioritisation tool to individually rank issues ensured that the workload was manageable.

Engaging with service users using three different approaches enabled the members to learn new approaches to engagement and to understand the need for different methods with different groups of people. These approaches were:

1. Visual discussion group using a number of interactive methods to engage users in discussion.
2. Interrupted story method looking at critical points during the users' journey through services.
3. Using discussion through a focus group.

Warwickshire
Ante and post natal services for teenagers

Nuneaton and Bedworth Borough Council, Rugby Borough Council and Warwickshire County Council conducted a joint review of services for pregnant teenagers and teenage parents. The panel consisted of elected members and scrutiny support officers from the three authorities plus a co-ordinator from the County Council's "Respect Yourself Campaign."

Reasons for choosing the topic

The topic was chosen because there was evidence that whilst a considerable amount of work is being done to meet the particular needs of teenage parents it is inconsistent in terms of its quality and distribution across the county. Members were concerned that national evidence shows that a lack of support for teenage parents can result in long -term health and well-being problems for them and their children.

Early impact

Unlike many areas of health inequality, services for teenage parents have a constantly and rapidly changing client base. This review has focused principally on teenage parents from 16 years of age to their 20th birthday. This means that at most a teenage parent will be considered just that for four years. How then can we measure the impact of the services being provided to teenage parents? This can be done by looking at the life outcomes of children born to teenage parents (a long-term project), by monitoring the take up of services and the reaction of teenage parents to those services (a short-term project) and by questioning those people who deliver the services about their perception of them.

Some of the early impacts identified relate to the processes followed by health and other agencies.

1) The rigour of the review helped to gain a better picture of the needs of teenage parents.

2) Service providers responding to the gaps identified by the review, in particular the way that services are measured and data is captured.

Project journey

For details on the project journey, follow this link.

Quote from Councillor Angela Warner – Chair of the Task and Finish Group

"In 21st century Britain any inequality of opportunity is unacceptable. It is good to think that we have done our bit to reduce health inequalities for at least a part of our community. Health and social care providers now have a clearer idea of the needs of teenage parents and for some practitioners this has been the first opportunity they have had to see the whole picture and to consider working collectively on it."

Recommendations

The panel's recommendations focused largely on ways of improving outcomes by redesigning processes and systems. Each recommendation was associated with a particular conclusion from the evidence and was presented in an action plan that identified the officer or agency responsible for implementation, a target date and comments to explain the recommendation in more detail.

They included the following:

- Encouraging organisations providing services to teenage parents to adopt systems for performance management and customer feedback.
- Encouraging all hospitals to identify a member of the community midwifery team to specialise in the needs of teenage parents, provide continuity of care and support teenage parents living in more remote locations using outreach workers.
- Promoting greater involvement by the Child and Adolescent Mental Health Services in CAF Family Support meetings.
- Promoting discussions on how to fill a gap left by the withdrawal of the Connexions post of adviser to teenage parents.
- Monitoring the new Family Nurse Partnership and how it links with other services.
- Reducing the administrative burden on front line staff.
- Developing measures to encourage teenage parents to use children's centres.
- Finding ways to effect a smooth transition from midwifery care to health visitor care.
- Promoting discussions about an enhanced role for the voluntary and community sector.
- Reminding schools about guidelines on the education of school age parents.
- Examining the implications for teenage parents of raising the education participation age.
- Finding ways of enhancing the midwifery referral system and support from outreach workers to ensure teenage parents attend appointments when referred.
- Investigating ways of strengthening the voice of teenage parents.
- Promoting access to the Family Information service.
- Sharing good practice amongst practitioners.

Key learning points

- The panel was keen to make recommendations that would directly improve outcomes for teenage parents. However the shortage of hard quantitative evidence and performance management systems for some of the services prevented this. Therefore recommendations were made about how performance is measured so that future monitoring will be able to focus on outcomes.
- A previous consultation "Big Mouth" showed that teenage parents do not usually have a strong and influential voice. Therefore an important by-product of the review was a recommendation to strengthen their voice.
- The review presented a great opportunity for partnership working between the county and two district councils on an issue that is of concern to all three councils. Members found this to be a rewarding experience. Not all districts were able to take part in the review due to limited capacity. This was disappointing, and on reflection members felt that they could have found a way to work around this by sharing support arrangements.
- Early desktop research was key to the success of the review. National and local information brought together at the start provided a good platform for members and prevented the need for further research.

Innovation

One very important aspect of this review was the use of a select committee approach to explore some of the strengths and weaknesses of existing processes and systems affecting care pathways for teenage parents (see project journey). Whilst the select committee approach is not a new model of scrutiny, panel members wanted to use it to explore its use in understanding health inequalities and to demonstrate its effectiveness.

The panel examined national evidence, collected a lot of information from service users and practitioners and identified a number of issues that they wanted to explore in greater depth. They held an evidence gathering day involving a number of stakeholders. This provided the opportunity to gather a huge amount of information very quickly; members were able to develop their thinking as the day progressed and the invited witnesses learnt a lot from each other.

Models of scrutiny developed

The review used the select committee model in a very effective way. They have produced their top tips for an effective select committee hearing – this can be found in Section Three of this publication. On reflection members agreed that the key success factors of the review were:

- Choosing the right topic.
- Engaging the right members with the right skills and motivation.
- Obtaining good officer support.
- Scrutinising, not criticising.
- Good desk-top research.
- Gathering evidence from the right people in the right way.
- Sticking to a tight timetable but giving the subject the time it deserves.
- Developing recommendations that are realistic and measurable.

Section 5

Appendices

Blackpool - the project journey

In November 2009, Blackpool's Director of Public Health presented Blackpool Council's Health Overview and Scrutiny Committee with an update on the Joint Strategic Needs Assessment. The report highlighted that alcohol related issues continued to be a major determinant in people's health in Blackpool and suggested that the introduction of a minimum pricing scheme would lead to dramatic long term improvements. He considered that a scrutiny review would be of great benefit in providing democratic input into the debate. The Committee agreed to formulate a Working Group with members from Blackpool Council, Cumbria and Lancashire County Councils and Blackburn with Darwen Council to investigate.

During the initial scoping meeting it was agreed that the purpose of the review would be as follows:

- To gain a better understanding of the advantages and disadvantages of minimum pricing of alcohol as a tool to reduce harmful drinking.
- To explore whether and how minimum pricing might be applied at local level and with what effect.
- To use the results of the review to provide information to the public and to increase the debate on harmful drinking locally.
- To feed into national and regional strategy on alcohol minimum pricing from a local perspective.

From the outset, it was intended that the review would be in the format of an evaluation and consultation exercise on the feasibility and impact of introducing minimum pricing as an effective tool to reduce harmful drinking. The conclusions from the review would then be fed into Central Government.

However, during the course of the review, the Working Group recognised that there was no single solution to resolving the escalating problem of harmful drinking and its effects, and agreed to widen the scope to include other areas in addition to pricing. The specific areas covered within the review were taxation, licensing legislation and the licensing role, education and advertising.

The review working group began by inviting local and regional health professionals to discuss their concerns in more detail and found they entirely endorsed the notion of minimum pricing of alcohol as crucial to reduce harmful drinking. Members of the group themselves had widely differing views about the topic and found the health input from research and local data compelling.

The Association of Greater Manchester Authorities (AGMA) had now supported minimum pricing of alcohol but had not approved a By-Law. Working Group members agreed to discuss minimum pricing of alcohol with their respective Chief Executive's and feedback views. The group agreed to hold a large stakeholder event in the autumn 2010 to raise the level of debate, and meanwhile to continue to explore the issues themselves in order to produce a short summary of evidence for the stakeholder event.

Meetings through the summer involved contributions from the police, from trading standards and from the on-trade through a regional manager from Town and City Pub Co. A community group working with people recovering from alcoholism also gave evidence. Then the working group recognised the lack of input from people or organisations anti minimum pricing of alcohol. Efforts were made to contact these and written material from the British Retail Consortium and the Wine and Spirit Trade Association was considered. A Wine and Spirit Trade Association

Blackpool - the project journey *continued*

representative came to the September meeting and created interesting debate about minimum pricing of alcohol impact on producers as well as the on- and off-trade, and about the complexities of defining sales 'below cost price' - an emerging position of government.

The Portman Group and Professor Tonge, of Liverpool University also gave input in writing. Officers at Blackpool summed up the arguments for and against minimum pricing of alcohol in a short report sent to people signing up for the stakeholder event held at Blackpool Football Club on 11th October. Over 90 people, including a large number of young people, people working in off-licences, supermarkets and community groups, came to the event, held a wide range of discussions and prioritised their views. Blackpool 6th Form Students Council also sent a written piece with their views. Officers then summarised the often conflicting evidence from the whole review.

The final meeting of the working group drew on all these sources to agree their conclusions and recommendations for action:

- To support minimum price as a national policy.
- Lobby Central Government to implement and publicise this.
- Further develop and strengthen licensing and publicise this.
- To develop licensing practice in their areas.
- To develop education for post 16s and their parents especially.

Cheshire - the project journey

In 2009, Cheshire West and Chester partnered with Cheshire East Council in a bid to become a Scrutiny Development Area. The two councils were new Unitary Councils formed earlier that year, with a large rural population, and the scrutiny committee wanted to understand health inequalities in their rural communities.

Whilst officers were keen to look at around 10 rural areas, it was agreed that, to manage the workload, the process would be piloted in two rural areas – one in each council – and rolled out around the autumn to a further tranche of rural areas. Some time was spent on the methodology of how to select the pilot areas, with a review of data in the component parts of the Index of Multiple Deprivation. Ultimately it was agreed that this was not crucial and that two areas from a list of the 10% of areas scoring highest in the Index of Multiple Deprivation would be chosen. One community had the characteristics of "urban edge" rural and the other "deep rural".

An initial literature search suggested that there were few academic sources on the review topic. The review identified and examined three types of information sequentially:

- **Type one** – information held by other organisations such as the Council and Primary Care Trust (PCT), or that ought to be available from them.
- **Type two** – "anecdotal" information – information which is not currently available but which the review created by (a) asking local councillors their views and (b) local councillors and officers going out and talking with local residents in the two pilot rural areas about their experience of health inequalities.
- **Type three** – information derived from a "mini-review" of one aspect of the experience of health inequalities in rural areas - in this case mental health.

Four meetings of the Joint Health Overview and Scrutiny Committee were held, along with an intermediate and an end-point Action Learning Review meeting.

Members also made a visit to each of the two pilot rural areas chosen, and toured the areas, visiting facilities to get a "feel" for the areas. Members commented at the final Action Learning Review meeting on how helpful this had been:

> *"I didn't think there were any Health Inequalities in the rural areas – my views have changed... "* Panel Member.

What was the experience of seeking the three types of information?

Type One information was sought from an enormous range of stakeholder organisations, and a "flyer" was created to let external organisations know about the review and seek their input/co-operation. However, some were either unable to share/ process this information or unwilling to do so; for example, because small patient numbers might make individuals identifiable. This raised the question; do agencies really know who are the people who are experiencing or most at risk of health inequalities? (For example agencies may target a group of people known to live in sheltered housing, but be failing to meet the needs of the scattered elderly or young mothers living individually in small hamlets).

The key conclusion, in relation to type one information (e.g. people on benefits) is that it can identify a RISK of experiencing health inequalities.

Although frustrated with the lack of progress with collecting type one information, the review moved on to an alternative source – going directly to the experience of local people themselves. Councillors and officers felt that, looking back, they had spent too long on trying to get the type one information, and could have moved on sooner.

Cheshire - the project journey *continued*

Type two information was gathered via a questionnaire to local members to elicit their views; and a questionnaire for members/officers to use 1:1 with rural dwellers, to seek their view on the health inequalities experienced. This produced useful "anecdotal" information and gave us a much clearer view of the key role that access to facilities – and transport to facilities – plays in rural dwellers' access to healthcare, quality food, leisure activities and other aspects that contribute to health and well-being. The opportunity to make greater use of Parish Councils – who to talk to - was highlighted.

Type Three information was gained by a focus on one aspect of rural health inequalities – mental health. This used a model of **"mini-scrutiny"** to hold a two-hour mini-review on this topic, with witness presentations, and proved a rich source of information.

At the time of writing, the final scrutiny report and its recommendations are being taken through the committee system for endorsement. The councils recognise that they chose a difficult topic, but are proud of their willingness to take a risk and be innovative, and of creating a methodology that can be used by other councils.

Chesterfield - the project journey

Geographical health inequalities

Chesterfield Borough Council wanted to understand why people in one of their communities suffered worse health outcomes than other areas. The inquiry planning group were determined to discover what was working in Rother and build from there. The panel did not go in with preconceived ideas about what they might 'fix'. The panel worked with local people and workers in Rother and people who make decisions that affect Rother, in other words a slice of the whole system. They used Appreciative Inquiry to engage in solution focused conversations rather than conversations about problems and deficits.

The key aims of the review were:

☑ To gather information about behaviour and lifestyles in Rother to enable better targeted and prioritised service provision to improve health and well-being that is needs based.

☑ To enable Rother residents alongside the organisations which support them to influence appropriate service redesign to improve health and well-being by:

- gathering information about existing strengths or assets in the area – the building blocks for health and well-being, alongside information about behaviour and lifestyles.
- identifying a shared vision for health and well-being.

The Health Inequalities Scrutiny Panel worked closely with a small group of key public service and community representatives to plan the review. Training workshops enabled the project group to develop their awareness and understanding of Appreciative Inquiry. To discover Rother's assets, they asked residents for positive stories concerning their health or well-being. Many of the stories were very powerful.

"Being able to read and write changed my life."

A man went into the local adult education centre with a form he could not complete. He got the help he needed and signed up for literacy classes. This led on to voluntary work and eventually getting a job.

The story became our metaphor, because our aspiration was that the inquiry would lead to change which would enable more people who want and are ready to transform their lives, to be successful.

Residents and people from a range of agencies at all levels were then invited to the Rother Matters Big Conversation event held in September 2010. Participants included community activists, workers delivering services in Rother, politicians and senior officers. Agencies represented included the police, the PCT, voluntary and community organisations and the borough and county council.

Pre-selected residents told their stories of success. From the seeds of success they heard in the stories; event participants identified what was working in Rother:

- Sense of community, community identity and cohesion.
- Vision, aspiration and goals.
- Good networks, friends and family power, people power.
- Determination to make a difference.
- Positive experiences.
- Leadership and communication.

Chesterfield - the project journey *continued*

- Professional support and services, community agencies.
- Informal networking and good neighbours.

This provided the system with an understanding of what needs maintaining, nurturing and developing to ensure future success in developing Rother as a sustainable community with better health and well-being.

Working in groups, participants agreed their vision for Rother.

> *"It is 2013 and people want to be in Rother which is a good place to work, rest and play with health, happiness and togetherness from the cradle to the grave."*

Participants agreed actions that would build from the best of what is already working to their agreed vision.

- Pride of Rother Awards.
- A Community Buddies volunteers service.
- A map and catalogue of available services in the area.
- Better communications and access to information.

A Rother Action Group is being created following the review, made up of residents and stakeholders. This Group will be the driving force in taking forward the review recommendations including the above actions.

It is hoped that with the support of key services, residents, and democratic leadership, the recommendations empower the community to better help itself achieve its aspirations, enabling bottom up, community driven change to influence improved health for the future – a more sustainable approach.

To ensure the vision is realised, it has been essential to maintain momentum and involvement by keeping participants informed and making them feel valued. The panel plan to invite all participants to the full council where the report will be discussed and the DVD shown. The DVD can be used at the community forum and other places in Rother and Chesterfield to publicise the inquiry and its outcomes.

Dorset - the project journey

In the original bid to become a Scrutiny Development Area Dorset County Council and Bournemouth Borough Council had envisaged that the Panel would take a staged approach to the review by setting the national scene, inviting written evidence, holding a series of select committee style question and answer sessions, engaging with communities and then drawing conclusions. It would focus mainly on lifestyle risks like smoking, poor diet and lack of exercise and on four of the most deprived areas within the two Local Authority areas (West Howe and Boscombe in Bournemouth, Melcombe Regis and Bridport in Dorset). However it soon became clear to the Panel that this approach needed to be revised for the following reasons:

- Public Health colleagues felt that a focus on small areas already known to be areas of multiple deprivation would not reveal anything new and would overlook the fact that poor health is not just limited to people living in those areas but is connected to how the majority of people live right across Dorset and Bournemouth. The publication of the Marmot report at an early stage in the review, with evidence of a social gradient of deprivation, lent support to this view. *"Actions must be universal, but at a scale and intensity that is proportionate to the level of disadvantage". Marmot 2010.*
- Work had already been done on what influences lifestyle and behaviour. NHS Bournemouth and Poole had commissioned Ipsos MORI Social Research Institute in 2009 to undertake research to explore the scope for incentives to encourage target groups to quit smoking or lose weight. There was a danger of duplicating community engagement work that had already been done.
- The Panel realised that the challenge of how to address health inequalities was much more complex than originally anticipated. The work that had already been done to look at lifestyle factors had told part of the story but very little work had been done on how to address wider determinants of health. It was agreed that this is where the review needed to focus its attention.

This shift of emphasis towards a more population wide consideration of social, economic and environmental determinants of health was delivered through three main streams of work:

1. Information was sought from a wide range of managers responsible for service strategy and design within Local Authority Departments to assess the extent to which they appreciated the impact their services have on health and particularly cardiovascular disease, either directly or indirectly; and whether that impact was immediate or affecting future generations. Questions were asked about how health impact is built into plans and policies and how managers contribute to partnership working and on health impact assessments.

2. The Panel retained its original plan to conduct some small area socio-economic profiling of deprived areas but the purpose was now different. It was designed to see what profiling might reveal about the wider determinants of health in West Howe, Boscombe, Melcombe Regis and Bridport and to consider what assets such as leisure and cultural facilities and places of worship exist within those areas that might mitigate some of the risk factors.

3. The original idea of using a select committee style question and answer session was retained but in a different form from that originally planned. Towards the end of the review one such session was held to tease out some of the challenges in delivering change that would have a positive impact on the wider determinants of health through Local Strategic Partnership work and specific practical actions. This session helped the Panel to formulate some of its conclusions and to reach broad agreement on its key recommendations.

Dorset - the project journey *continued*

Based on these three main strands of work the Panel concluded that real change in health inequalities had not been achieved for two main reasons:

- Targeted interventions on lifestyle risks had not been sufficient in size relative to the scale of the issue.
- The targeted health interventions that are being delivered alongside work within local authorities to improve the socio-economic determinants of health across the whole population are not sufficiently linked or synchronised with one another.

The Panel made eight recommendations which they felt would go some way to improving the situation (see Case Study).

Cardio-vascular disease

London - the project journey

This review involved the London Boroughs of Brent, Ealing, Hammersmith & Fulham, Hillingdon, Hounslow, RB Kensington & Chelsea and City of Westminster. The review was a significant opportunity to establish and strengthen the connections housing has on the quality of life of residents and on inequalities in their areas.

Their work ran from June till December 2010 and focused on four 'liveability strands:

- The effects of overcrowding on physical and mental health (Westminster and Kensington & Chelsea).
- The effects of overcrowding on educational attainment, and children's development (Hillingdon).
- The effects of the overall built environment including new housing developments (i.e. good spatial planning including transport links, access to 'real' open and play spaces, controlling noise pollution, ensuring community safety) (Hammersmith & Fulham and Hounslow).
- Fuel poverty (the inability to keep a house warm at acceptable cost) (Brent and Ealing).

Early on in the review the partner authorities identified their focus in relation to the issues in their area. This created three pairings, where two neighbouring authorities were working on the same issues. Each pairing developed jointly a scoping document for their work as did Hillingdon who was working solo.

This helped clarify specific action that would explore the issue and to find complementary activities within pairs that could strengthen their evidence base jointly. The group set up a Communities of Practice[1] to enable continuous sharing of ideas and information on this very broad area of the built environment.

The London elections in May 2010 produced a delay for the partners in getting going as in several authorities there was a change of control or changes in leading members. However the officer group (well established since 2003) continued the momentum through organising a launch event in July for a wide range of stakeholders from all the boroughs and 'make a splash' at the outset to gain interest.

This event produced helpful input to each strand of work involving approximately 60 people from housing and planning with health people, using a 'world cafe' approach. Some non-health people started by wondering why they were there but were soon able to make connections between their work and health issues.

Following this event partners began their own reviews and investigations as detailed above.

These reviews produced a wealth of material which has been analysed for local relevance as well as shared across the partnership. For example,

- Hillingdon are proposing amendments regarding overcrowding to their Local Development Frameworks and also investigating the coverage of school breakfast and after-school clubs.
- Hounslow is following up estate-based work with the local school.
- Brent is setting up a local referral network on fuel poverty and ensuring property used by the council is up to standard.

The London Scrutiny Development Area faced two kinds of difficulties: structural problems and the inherent complexities of health inequalities. For London, the elections had a major destabilising effect compounded by very different scrutiny structures between authorities. These problems manifested in different ways:

- Ealing were unable to carry out their plans although officer reports were taken to relevant committees and officer links are moving the fuel poverty issue forward.

1) http://www.communities.idea.gov.uk/welcome.do

London - the project journey *continued*

- Hammersmith & Fulham as lead partner experienced a change in leading members which took key leadership away from the overall project. As the review ended opportunities were therefore missed to capitalise across the NW sector in terms of action on overall conclusions.
- However the complexities of evaluation and measurement of the issues were also challenging: how hard it was to show a direct link between fuel poverty and ill health, whereas the link with poverty as a whole can be tracked; similarly assessing the impact on children's educational attainment is extremely hard. Interestingly in several cases local residents made it clear they saw priorities in their lives differently than the councils may expect e.g. preferring an overcrowded flat in a known and friendly area, to a suitably sized house in a strange area.

Mini case studies have been produced below for each of the livability strands:

- The effects of overcrowding on physical and mental health.
- The effects of overcrowding on educational attainment, and children's development.
- The effects of the overall built environment including new housing developments.
- Fuel poverty.

Overcrowding and health

Lead – Westminster City Council and Royal Borough of Kensington and Chelsea

Why was the topic chosen?

Overcrowding is a particularly acute problem in Westminster and Kensington & Chelsea, due to a high demand for housing, limited supply and a mismatch between housing stock and demand. Tackling overcrowding is therefore a key priority.

Kensington and Chelsea

How was the review carried out?

Over autumn 2010, information on current practices and issues facing overcrowded households was gathered, predominantly through front line officer experience. This involved:

- Meeting with front line staff from the Housing Needs Department, and in particular the Housing Opportunities Team, considering their views and experiences with those households living in overcrowded conditions.
- Meeting with the Head of Environmental Health.
- Interviewing two officers within the Housing Opportunities Team, who focus on overcrowding, visiting overcrowded households who have applied for assistance.
- Considering comments and opinions of those registered on the Common Housing Register made to staff.
- Identifying other health related initiatives and further opportunities for partnership working in the future through discussions with officers across Housing and Environmental Health.
- Assessing Overcrowding priority as a determinant in the development of a new Allocation Policy through the Allocation Policy Review Working Group.

What are the main findings?

The Royal Borough is ranked fourth out of all local authorities in England and Wales, with 5.5 per cent of households in the borough (in both private and social sectors) being overcrowded. In 2009/10, there were only 556 lettings and yet over 7,200 people are currently waiting on the Common Housing Register. The table below highlights how acute the issue of overcrowding is in the Royal Borough, with 1,569 overcrowded households.

Table 1: Number of over-crowded and severely over-crowded households (Nov 2010)

	Number of households	Total of household members
Lacking 2 bedrooms or more	418	1639
Lacking at least one bedroom	1151	3844
Total	**1569**	**5483**

Key points arising from the review (and in particular interviews with the officers in the Housing Opportunities Team) were:

Overcrowding and health *continued*

- Recommendations are being made to mitigate current problems including: limited redecoration assistance to improve the property's desirability under mutual exchange, signposting to homework clubs for children, advising on more appropriate use of rooms/ space saving ideas (bunk beds are sometimes offered), revised internal layout (making two rooms from one), extensions to property (including loft extensions), referrals to Environmental Health in cases of serious disrepair and offers of assistance into private rented accommodation for severely overcrowded families.
- Officers are picking up on health issues that may have not have been previously highlighted by applicants and may advise them to complete a medical self assessment form in the first instance.
- Special forms are being used to record this key information from household visits. These are similar to the toolkit example for officers visiting households given in the Mayor of London's 'Overcrowding in social housing – a London action plan'.
- Many households already make best use of limited space. Caseworkers feel that many households who have not already adopted a 'common sense' approach to make the best use of their home, do not tend to act upon recommendations made.
- Take up of free adult courses and the use of after school homework clubs, is low (despite the homework club facility being available on many estates).
- Where opportunities for de-conversion/ extensions are identified (for example loft extensions), landlords do not always readily engage in pursuing these, despite funding being available. Budgets for this type of work are time limited and opportunities are sometimes missed.
- Despite offers of appropriate sized accommodation in the private rented sector for severely overcrowded households, most stay put. Applicants have a strong desire to remain in The Royal Borough and do not want to give up a secure tenancy. However, some families with children with behavioural/ mental health issues do take up offers out of borough in order to move to properties with gardens.
- The Housing Department's Health Assessment Team is inundated with medical information submitted for assessment in respect of applicants' hopes for increased priority for housing on medical grounds. The team is dealing with an increased amount of applications for medical priority on overcrowding and health grounds and is currently considering ways of tightening its review procedure, such as how GP reports are dealt with which request a higher priority for housing.

Key learning points and challenges

Key learning points:

Allocations Policy

At the time of carrying out the review, we were also re-writing our Allocations Policy, which has since been finalised. Some of the learning from the review has been used to inform our new Allocations Policy. In regards to the issue of overcrowding and health, the new Allocations Policy:

- Presents a clear and realistic message to applicants in respect of health assessments and the likelihood of being awarded priority for re-housing.
- Gives priority to under occupying households wanting to move, to free up larger units of which we have fewer in the borough compared to smaller properties.
- Provides higher priority to those who are severely over-crowded (lacking two bedrooms or more).

Overcrowding and health *continued*

- Defines household to mean the applicant, partner, children aged 20 years or less and anyone else with an exceptional need to live with the applicant. Whilst this does not dictate who may live in a property, it gives a strong message to households to prevent them making the household intentionally overcrowded whilst recognising the impact (both health and social) on children in severely overcrowded conditions.
- Introduces new Health and Independence (medical) points, which assess the impact housing has on independence and health and not the health issue or illness itself.

Working with health services

Potentially, a number of opportunities exist for increased joint working with the PCT as a result of the review. These may include developing a referral service to the PCT to work with specific households and signposting to specific services such as smoking cessation and other health related advice. However, given the major changes to the PCT in respect of structure, commissioning and geographical boundaries, these opportunities will be investigated at a later date.

Key challenges:

Supply and demand issues

Moving households into appropriately sized accommodation has the most significant effect on a household's well-being. However, in reality, only a small number of households are assisted in this way due to the lack of supply of larger units. Whilst the Royal Borough aims to make best use of limited resources, it is also responsible for delivering a clear message to overcrowded households about their chances of being re-housed; in order to give them the opportunity to pursue alternative options to remaining overcrowded that may improve their well-being and health. In the short-term, measures such as changing the use and layout of rooms may be helpful but will only have limited effect.

Table 2: Numbers waiting compared to lettings on bedroom size (Feb 2011)

Bedroom size needed	Studio	1	2	3	4	5	6	7	8	Total
Total on waiting list	3483	647	1850	941	287	65	11	5	2	**7291**
Total letting 2009/10	151	169	157	67	12	0	0	0	0	**556**

The importance of location to tenants

Given the very nature of 'overcrowding and health' and the sensitivities associated with it, the topic is fairly subjective. What many households hold dear, may not necessarily be what is best for their health and well-being. For example, sacrificing increased living space for location. An extremely limited supply of housing (particularly family sized units) means that most families will remain overcrowded and whilst other housing options and short-term improvement suggestions in respect of improving health can be made, they are not always taken up. Nevertheless, we will continue to:

- Investigate and recommend home based practical solutions towards alleviating the problems associated with overcrowding.
- Promote social mobility to provide support in increasing opportunities for overcrowded families.

Overcrowding and health *continued*

- Assess consultation feedback in respect of overcrowding as a determinant in the development of a new Allocations Policy.
- Give future consideration to opportunities for partnership working with landlords and health services towards an improved health and housing approach to alleviating the effects of overcrowding.

Westminster

Westminster's investigation aimed to address an identified need to assess the impact of interventions to mitigate the negative effects of overcrowding – work that fell under the Local Area Agreement-funded Health and Overcrowding Project. As part this project an overcrowding casework team – consisting of three caseworkers – has been visiting overcrowded families to discuss the potential impacts on their health, manage their expectations in terms of re-housing, make assessments for space saving solutions and sign-post to wider health improvement services.

How was the review carried out?

During September and October 2010 the Task Group organised and attended the following sessions to gather evidence:

- Meetings with representatives from Housing and Housing Needs;
- Site visit to view properties that had been modified to house larger families and discussion with prospective tenants regarding their views about moving into the properties;
- Accompanied an overcrowding caseworker in carrying out their work and talking to tenants;
- Guided visit with environmental health to properties being renovated to bring them up to standard;
- Attended a quarterly performance monitoring meeting of the Health and Overcrowding Project Steering Group where quarterly targets and case studies were presented by caseworkers.

What are the main findings?

The investigations findings can be grouped into five key areas:

(i) The role of caseworkers

It was notable from the site visits and case studies that caseworkers were greatly valued by the families they visited. Once initial scepticism of the involvement of the council was overcome and the purpose of the visit realised, tenants tended to engage proactively. Whilst it is difficult to demonstrate the impact on a household's well-being, there seems to be a significant demand for positive, personal interventions by skilled advisers to help resolve housing and work/life problems.

(ii) The priority given to overcrowding by tenants

It was apparent from the findings of the review that overcrowded families often have different priorities to those of the council and NHS. Simply put, cramped conditions and associated health issues were not always the top priorities for those households experiencing them – priorities sometimes included needing to hear street noise and a sense of belonging.

(iii) The importance of ensuring health issues are addressed

Following delays, the project is now supported by a health practitioner whose role it is to provide specific support on improving the health of those living in overcrowded homes. Monitoring

Overcrowding and health *continued*

arrangements have been put in place to review the effectiveness of this resource.

(iv) The need for rigorous evaluation

The best evidence to date of beneficial impacts from the project derives from the anecdotal feedback received from the tenants and quarterly case studies reported by the caseworkers.

The original toolkit included a mechanism for evaluating health benefits from the number of health action plans developed by the health practitioners and the follow up assessments of the health goals attained after four months. Together with the feedback received from satisfaction surveys, this could still be a useful tool to illustrate health improvement or decline.

(v) The challenge of reduced resources

The current financial climate has already led to the withdrawal of funding which means the three caseworkers are only due to be in post until the end of March 2011.

Although the council's primary commitment is on re-housing the most severely overcrowded families by 2013-14, the long waiting lists, especially for those households that do not fall into the severe category, means there is a place for intervention particularly where health could be improved.

Key learning points and challenges

- The investigation recognised the challenge of adequately measuring the health impacts of interventions particularly in circumstances in which families might be experiencing many problems and receiving a variety of support services.
- A particular challenge for the council was that, whilst programmes could be put in place to alleviate health implications of overcrowded households, the choices of individual families had the potential to undermine positive interventions.
- Joining up funding streams and partnership working was a challenge but where it was successful, as in this case, there were very clear rewards.
- In deciding on the future funding of such projects it would be important to consider whether there may be something that would contribute to reducing health inequality and thereby potentially attract funding in terms of the proposed health premium.
- The investigation has shown that there is valuable work going on but that in today's financial climate it is vital for the worth of that work to be clearly evidenced. The future is uncertain and we must ensure that what we are doing is adequately monitored and evaluated so that when tough choices have to be made, we make the right ones.
- The investigation was successful partly because lead members were able to develop proactive working relationships with senior officers. Via e-mail, members could ask for quick updates and press for action on key points. Before the final report was even signed off the investigation had already led to a successful outcome as the PCT was persuaded to reallocate resources to fund a health visitor to receive referrals to overcrowded families.
- From the start the investigation focused on a particular programme which meant the research stayed on track and was always considered to be achievable.

The effects of overcrowding on educational attainment, and children's development

Lead – London Borough of Hillingdon

Why the topic was chosen?

Overcrowding is just one of the many socio-economic factors that can affect children's development and educational attainment. 2009 survey data for the Borough shows that overcrowding across the whole of Hillingdon is 5.6%; the national average is 2.5%; overcrowding in the Hayes and Harlington constituency is 10.4%, i.e., more than 4 times the national average and 85% higher than the Hillingdon Borough average. Analysis of the 2001 census data also shows that, in London, nearly a third of all children are living in overcrowded accommodation; the figure for England as a whole is 12%.

Living in overcrowded accommodation can have a negative effect on families by affecting health and educational attainment and can impact negatively on life chances. Under-achievement at school can be caused by lack of space for children to do their homework. Absence rates may be higher because of illness associated, at least in part, with poor living conditions. Older children may spend more time outside the home, on the streets or at friends' homes to find privacy and space.

One of the main aims of this Working Group was to review the Council's arrangements for addressing the effect that overcrowding has on educational attainment and children's development in the Borough. It is hoped that this work will act as a catalyst to the work that must be undertaken to tackle the effects of overcrowding in Hillingdon.

How the review was carried out?

The main method for collecting evidence for this review was through a series of witness sessions held in August and September 2010. These three witness sessions involved representatives from various departments from within the Council as well representatives from outside organisations.

In addition to these sessions, the Chairman of the Working Group met with a young person who had grown up in an overcrowded home and who believed that his development and educational attainment had suffered as a result. This meeting was held on 30 September 2010 and looked at what help had been received and what further help would be useful to young people in this situation.

The Working Group also set up a consultation event at Barra Hall Children's Centre which took place on Friday 10 September 2010. This Children's Centre is situated in an area with a high overcrowding rate and enabled members to speak to a parent that was currently living with her family in an overcrowded home (the three bedroom house was occupied by three families, each comprising two adults and two children – 12 individuals in total).

What were the main findings?

One of the main findings of the review was that, whilst excellent work is being undertaken to improve children's development and educational attainment at some schools with the introduction of measures such as breakfast and homework clubs, this is not being done in a joined up way with other agencies.

Residents are often subconsciously aware of the impact that overcrowding has on the family but will not necessarily associate this with the behaviour or development of their children. There also seemed to be a lack of awareness of where to get help.

The effects of overcrowding on educational attainment, and children's development *continued*

Key learning points and challenges

Key challenges included:

- Ensure that the review is scoped to a manageable size. Really think through how much the review will cover and how long it would take to complete.
- Keep focused and try not to make the subject too complicated. Trying to comprehend and focus on the effect of overcrowding on educational attainment and children's development rather than concentrate on overcrowding was quite challenging. It was really important to ensure that members were kept on track.
- Trying to find out what work was currently being undertaken was also a challenge. Little thought seemed to be given to coordinating work with other departments so there were little pockets of action all over the place.
- Frustration that many overcrowded homes were not deemed 'statutorily overcrowded', as specified by Government.

Key learning points included:

- A lot of really good information can be gleaned from doing semi-informal interviews with service users. Getting one member and one officer to meet up with a service user in an informal environment is incredibly useful.
- Don't be afraid to get members to do some of the leg work. We asked members to write up instances that their residents had raised with them where overcrowding was impacting on their children's education and development. We also asked members to attend the Children's Centre event and make notes about the conversations that they had.
- We didn't have to reinvent the wheel. The housing team was already producing information about overcrowding – the review recommended that this information be distributed to Children's Centres in the areas of the Borough that are most overcrowded and that the officers also hold regular drop in sessions there to answer any queries.
- We established current best practice in schools and looked at how that could be rolled out to all schools.

The effects of the built environment including new housing developments on health

Lead – Hammersmith & Fulham and Hounslow

Why was the topic chosen?

In both **Hammersmith & Fulham** and **Hounslow** there is the recognition that although housing and the built environment are key determinants of long term health they have traditionally operated in silos and partnership working to tackle deep rooted health issues are at early stages. It is felt that there is significant opportunity to use this review to establish and strengthen the connections housing has on the quality of life of residents and inequalities within each Borough.

How was the review carried out?

Both authorities took a different approach to running their review.

Hammersmith and Fulham

In Hammersmith and Fulham - A member led task group carried out a literature review of existing evidence of the relationship between the built environment and health outcomes. This included a review of the Council's Fulham Court Estate Improvement Strategy; a review of national and local policy guidance and regulatory framework around spatial planning and health outcomes. The task group gathered qualitative analysis through front line officer experience and opinion, case studies and site visits.

One of the main ways that the task group gathered useful information was by holding expert witness sessions with housing and planning officers, sheltered housing associations and public health representatives.

Key learning points and challenges

- What can be demonstrated? The association between housing, the built environment and physical and mental health/ill health.
- What can't be demonstrated? The impact of housing and the built environment in isolation from the broad range of elements that can affect health outcomes, for example unemployment and poor education.
- The impact of overcrowding/inadequate supply of larger homes versus spatial planning: a number of interventions are the same for both, for example homework clubs and space saving solutions.

Emerging findings and recommendations

The following recommendations were made:

- **Design:** Spatial Standards to be incorporated in Local Development Framework.
- **Spatial Planning** should include access to facilities, for example open and play spaces.
- **Engagement and empowerment** of tenants and residents in the built environment, for example discussion and advance notification of improvements.
- **Joint working** on health and housing issues to include the Cassidy practice (the nearby surgery) and an enhanced role of housing officers in directing people to health facilities.

The effects of the built environment including new housing developments on health *continued*

Hounslow

In Hounslow - The review involved a half day event on a housing estate, which asked residents how they felt the built environment impacted on their health. The estate chosen was Haverfield in Brentford. The choice was arrived at through seeking advice from colleagues in community cohesion, regeneration, health and housing. A number of data sets were also looked at, including the health profile of the local area and the multiple deprivation indices. The latter in particular was seen as a useful indicator of location in which to carry out the project because it specifically takes into account the wider social determinants of health.

The exercise was set in the context of making clear that there needed to be community ownership for taking action and that this was the only way in which the project would be sustainable.

What were the main findings?

Residents see health and well-being in a holistic way and identified a range of actions they would like to see taken forward to improve health outcomes on the estate. These included things such as, fixing street lighting, maintaining cleanliness on the estate, drugs and alcohol advice, benefits and welfare advice, activities in the community centre and support with mental health issues. There was also the recognition that partners (such as McDonalds on the estate, Watermans, the Council & Hounslow Homes & the Children's Centre) had a role to play and building better relationships with them was key to improving the area and opportunities for people on the estate.

Finally the range of issues discussed emphasised the need for a concerted effort amongst all partners to improve the well-being of residents in the area.

Key learning points and challenges

Key challenges included:

- Getting senior staff in the organisation to take an interest in the project. There is still work that needs to be done across directorates in emphasising the fact that public health is a corporate responsibility.
- Engaging with residents on the estate. Timing was a key issue. As the start of the project was delayed, once things got going there was a need to organise the engagement event on the estate in a short space of time. Whilst a significant amount of time was spent having one to one conversations over the phone in the lead up time to the event with local community organisations and representatives – face to face meetings would have been more beneficial in getting support for the project. Previous engagement activity around the estate had led to the perception by some that "nothing will happen - nothing will change".
- Using Open Space as a method of consultation for the first time! This method of engagement really does mean allowing the participants on the day to take control and own the event. This means you cannot control what happens and can only prepare to a certain extent. It can feel like a risk – but it is one well worth taking. Informal feedback from participants on the day was very positive.
- Getting leadership for the project across the seven boroughs involved. The project started ambitiously with the intention that there would be a joint set of recommendations to come out of the project and be presented to each Council's Executive. This has not happened and is a missed opportunity.

The effects of the built environment including new housing developments on health *continued*

Key learning points include

- Find out for yourself! Prior to the engagement activity on the estate colleagues did share with us that it was difficult to get the community involved and it would be hard getting people there. Conversations with community contacts and their contacts etc are key.
- Schools in hard to engage areas are a valuable resource that can be used to find out how a community feels about an issue. Children are a route into families.
- There is a need to increase awareness across Council directorates about the role all staff have in tackling health inequalities. There is also a need to embed corporate responsibility for this issue. At a time of budget cuts and pressures projects such as these can often be put at risk as management focus on a need to cut costs and meet savings targets.

Fuel poverty and the impact it has on health

Lead – London Borough of Brent (Ealing did not complete their review)

Why the topic was chosen?

Brent Council's Health Partnerships Overview and Scrutiny Committee established this task group to look at the effect that fuel poverty has on peoples' health in Brent. It has been demonstrated in various research projects that fuel poverty and its consequences can have a major impact on physical and mental health and well-being. There are also specific factors in Brent that led members to select this topic, such as the high proportion of housing in the private rented sector (where the proportion of households in fuel poverty is highest), the relative deprivation of the borough, particularly income deprivation and the general health inequalities that exist in Brent – there is a nine year difference in life expectancy between males in Harlesden in the south of Brent and Northwick Park in the north.

How was the review carried out?

In order to carry out their review the fuel poverty and health task group:

- Carried out a review of literature and discussions with housing and health providers on the links between fuel poverty and health.
- Reviewed the means (i.e. grants and income maximisation advice) currently available to both residents and landlords to promote energy efficiency and reduce fuel poverty, of the various agencies involved, and what the take up of these services are.
- Reviewed fuel poverty and affordable warmth strategies currently in place and best practice examples.
- Discussed fuel poverty and health with local energy agencies.
- Held discussions with housing departments and providers on the actions used to promote energy efficiency in social and council housing, and how private sector households in fuel poverty are targeted and reached.
- Discussed with GPs and local health service providers referrals to advice on fuel poverty and affordable warmth. They also considered hospital admissions data for illnesses connected to cold homes and fuel poverty, including the costs to the health service of these admissions.
- Consulted with residents by carrying out a survey to learn more about the effects of fuel poverty on peoples' health and well-being.

What were the task group's main findings?

It has been difficult for the task group to quantify the number of households in Brent in fuel poverty. Data released by government has a significant time lag. Government data released in 2010 shows that the percentage of Brent households in fuel poverty in 2006 was 10.6%.[1] However, the task group was told that 20% was a more realistic figure, although without carrying out a stock condition survey it's not possible to test this.

The task group heard a range of views about the relationship between fuel poverty and ill health. The task group was informed that COPD and other respiratory problems whilst not necessarily caused by the cold; can be exacerbated by the general state of the home, such as the temperature, cleanliness, clutter, living in one room and other social factors such as diet. These are issues associated with poverty, not just fuel poverty. There are knock on effects on general life as people become more confined to their home, or one room.

1 Annual report on fuel poverty statistics 2010 – Department of Energy and Climate Change

Fuel poverty and the impact it has on health *continued*

Hospital data shows that admissions from heart attacks, strokes and respiratory infections peak in October and March and that during the winter months (October to March) admissions for the three illnesses associated with the cold are around 300 a month higher than the average during the summer months. How many of the people admitted are living in fuel poverty is unknown, but it is striking that there is such an increase in admissions during winter months.

The task group's recommendations are split into four main areas:

☑ Advice and information.

☑ Improving energy efficiency of the housing stock and reducing fuel bills.

☑ Working with landlords.

☑ Working with the NHS.

Although there is much good work happening to address fuel poverty in Brent, the task group believes that more could be done, and engaging the NHS on this issue is crucial to make the links between fuel poverty and the impact on health.

In order for this to happen buy-in to fuel poverty work is needed from the top of the local NHS, as well as the council. The task group is recommending that the council works with partners to produce an affordable warmth strategy in order to develop a coherent and focused plan to tackle fuel poverty in the borough.

There are two other areas where the task group particularly hopes action can be taken.

The first is in relation to a comprehensive referral network for people in fuel poverty. The task group was told that many frontline NHS and council staff see people in their homes who are likely to be in fuel poverty. Knowing where to refer those people for help is crucial. The task group is recommending that partners work with a local energy charity to try and put in place this comprehensive referral network.

Secondly, the task group is keen that the council does all it can to encourage landlords to ensure their properties are as fuel efficient as possible. The task group has recommended that the council require landlords to provide properties with at least a D rating under the Energy Performance Certificate system before it is used for temporary accommodation or housing for people placed by the council.

Key learning points and challenges

The key learning points from the review were:

- There is much work happening in Brent to tackle fuel poverty. We are fortunate to have a local charity, Energy Solutions that works on fuel poverty issues in our borough and brings an expertise to this issue.
- Commitment from the health service in Brent to tackle fuel poverty is mixed. There are some very committed individuals who are working extremely hard to give the issue a higher profile. But the local NHS does not regard fuel poverty as a corporate priority.
- As with many issues, especially in the current financial climate, fuel poverty cannot be the responsibility of one organisation – it has to be tackled in a collaborative way by the council, NHS, voluntary sector and private sector. The role of the energy firms could be increasingly important as grant funding (such as Warm Zones) is being cut. Energy firms will be expected to step in and provide funding for carbon reduction and energy efficiency measures in the home, which will help alleviate fuel poverty.
- Income maximisation is key to addressing fuel poverty. Fuel poverty is another facet of general poverty.

Fuel poverty and the impact it has on health *continued*

The key challenges are:

- Replacing the funding for fuel poverty mitigation work, as Warm Zone funding has been significantly reduced following the Comprehensive Spending Review. Will funding be replaced by energy companies, and will it be available for fuel poverty mitigation or to reduce carbon emissions from households, as the two are different?
- Ensuring that frontline staff are aware of fuel poverty and any referral network put in place to help signpost people to advice and guidance where needed.
- Getting organisational buy-in to fuel poverty as an issue to ensure support for initiatives to address it from the council, NHS, voluntary and private sector companies in Brent.

North East Region - the project journey

Ex-service community review

Three distinct factors contributed to a successful health inequalities-driven scrutiny review:

- Member leadership.
- A timely 'evidence gathering' day.
- Effective officer support arrangements.

Scrutiny members and officers in the North-East region of England have nearly three years of collaborative working, often on sub-regional issues. Recognising the scope for carrying out 'place-based' reviews in the future and the potential to further develop joint working across the region, members and officers set up a North-East Joint Health Scrutiny Committee involving all 12 local authorities, and produced a protocol for joint working across the region.

> *"Having twelve local authorities working together on one project has been a bold venture...",*
>
> Councillor Ann Cains, Stockton-on-Tees, and Chair of the Scrutiny Review Project Board.

Councillor Cains went on to reflect that one of the hallmarks of success was the purposeful relationship building between members and officers across the region over the last three years. Over the last twelve months, members and officers devised and piloted a memorandum of understanding for joint working, and a protocol for a standing committee. The experience was invaluable. All twelve councils have now signed up to a single joint health scrutiny protocol, which will continue to be improved through use and subsequent reflection.

As well as leadership, a shared vision was vital. Responding to the world around them in late 2009, members and officers identified that a proportion of their population were from the ex-services community, and they were keen to examine how servicemen, servicewomen, and their families and dependents resettled into the North-East. It became evident that health and social care organisations did not have substantive records relating to the ex-services community – and so members became aware of the potential for health inequalities in a vulnerable group among their communities.

In March 2010, members invited representatives from the Armed Forces and Royal British Legion to help them to 'scope' the review in more detail, identifying what the keys issues were from the perspective of individuals and support groups. The information sharing session was revelatory, and the cornerstone of an effective working relationship and partnership that was to be sustained throughout the review.

The start of the formal review was delayed until June 2010, due to the General Election and local elections. The review hit the ground running with an evidence gathering day, which attracted nearly 60 national, regional and local representatives, including the Ministry of Defence, the Department of Health, the Armed Forces, commissioners and providers of health, social care and wider 'wrap-around' services, such as opportunities for retraining and for further employment. All twelve councils across the North-East region were represented. Time for question-and-answer sessions was built into the event programme, and members felt it was important that they respond to the issues raised on the day.

Three project workstream groups were set up, covering Mental Health, Physical Health and, Social and Economic Well-being, and delegates were invited to join a workstream group in order to start the scoping of their brief. The three groups were co-ordinated by an Officer Project Support Group, which in turn took its lead from, and reported to, a Member Project Board. The Board was later formalised in to a standing Joint Health Scrutiny Committee.

North East Region - the project journey continued

Peter Mennear, Stockton-on-Tees, recalled,

"The Evidence Gathering day worked really well. It was a high profile event, and it was clear that members were passionate about the review. Project management, led by the Newcastle team, was strong – it is important to have a 'lead council' that can drive the regional process."

A particular feature of the review was that project roles were clearly allocated across officers, with one authority leading each work stream and three others in support. Members, however, were free to join whichever work stream most interested them. Steven Flanagan, Newcastle, noted,

"It was very heartening to see how well members and officers from different authorities worked with each other. This is an approach that we would definitely use again."

Angela Frisby, Gateshead, and Jon Ord, Middlesbrough, both workstream group officer leads, reflected,

"We found that co-ordinating the review through a governance structure of the Project Board, a wider officer group and a small Project Support Group of lead officers, of which we were part, was very helpful in ensuring that decisions could be taken quickly at the appropriate level."

June Hunter, Newcastle, said that credit reflects widely.

"The Review benefited from the strong regional member and officer Scrutiny Networks which had been operating effectively in the North East for a number of years. This experience (and camaraderie) made Newcastle's role as lead authority much easier and I have nothing but praise for the hard work, co-operation and good humour shown by our colleagues throughout the year."

At an Action Learning event, Councillors Veronica Dunn (Newcastle), Margaret Finlay (South Tyneside), Stuart Green (Gateshead) and Graham Hall (Sunderland) agreed,

"Regional scrutiny of services for the ex-services community has distanced itself from party political prejudices and biases, as the scrutiny review has been focused on a social phenomenon common to all areas across the region."

At the end of the project, Councillor Cains also reflected that,

"The topic was so huge that it would hardly have been possible without dividing up the task between the three thematic groups".

Councillor Robin Todd, Durham, added,

"Linkages between access to healthcare services 'in-service' and in civilian life are not seamless, and there are issues around the identification of veterans after leaving the Armed Forces."

Ex-service community review

Portsmouth - the project journey

Alcohol-related hospital admissions were identified as a topic for review at the Health Overview and Scrutiny Panel meeting in November 2009. The Panel was made up of members from seven councils, including: East Hampshire District Council, Fareham Borough Council, Gosport Borough Council, Hampshire County Council, Havant Borough Council, Portsmouth City Council and Winchester City Council. The project brief was agreed at its meeting in January 2010. As a result of evidence gathered, the objectives agreed then were slightly amended in August 2010 to the following:

1. To understand the national and local picture for alcohol abuse.
2. To understand the number and categories of alcohol-related admissions at Queen Alexandra Hospital and to evaluate the methods used to record them.
3. To evaluate the impact alcohol abuse has on Portsmouth City Council Services.
4. To understand the causes and impact of alcohol abuse on different sections of society.
5. To understand the treatment services available and the referral system.
6. To understand the work carried out in the following areas: prevention of alcohol abuse; treatment services and enforcement and to gain the views of service users and professionals involved.
7. To learn from examples of good practice elsewhere.
8. To develop recommendations to improve the alcohol abuse misuse services in the city.

Between January and December 2010 the Panel met formally to take evidence on 10 occasions. Witnesses included the Director of Public Health and Primary Care, a medical Consultant and the Emergency Department Operational Manager from the Portsmouth Hospitals Trust, the City Council's Substance Misuse Co-ordinator, the Health Liaison Officer for Hampshire Alcoholics Anonymous, the Development Manager for the Public Health Group South East, Department of Health, the City Council's Licensing Manager and the Assistant Head of Planning Services.

In order to gain a better understanding of the issues involved, and to ensure that as many views as possible were heard, the Panel carried out a number of visits to service providers and stakeholder groups, including detoxification and rehabilitation units and a users' self-help group. Members shadowed the police, ambulance service and Portsmouth Street Pastors and observed in the CCTV control room. They held a public participation event, collected video booth diaries and conducted an online survey.

The Director of Public Health and Primary Care, Dr Paul Edmondson-Jones, and Alan Knobel, Substance Misuse Co-ordinator, were key partners in scoping the review, identifying witnesses and other stakeholders, and in facilitating relationships with them.

Skilled officer support was vital, both in terms of knowledge of the NHS and social care, but also in making connections to the wider local authority remit and other key public services. Officers had to collect, collate, assimilate, interpret and present a vast amount of qualitative and quantitative evidence; and arrange an array of meetings, visits and events, mostly off-premises and at unsocial times.

Members' enthusiasm for the review topic was notably high throughout: it obviously resonated with the concerns of their constituents and their other areas of responsibility as councillors; for example, in regard to licensing and education. Members agreed that recommendations related to alcohol-related hospital admissions had the potential to benefit the community significantly in a variety of ways.

Portsmouth - the project journey continued

The Senior Local Democracy Officer gave a presentation on the review at the Annual Public Health Conference held in Bournemouth in March 2010, generating a lot of interest from other local authorities and health professionals. Two action-learning events were held, towards the middle and end of the review to capture the learning so far and to decide any changes needed to progress the review to best advantage.

One of the problems encountered was the fact that it is not always possible for services to retrieve specific information requested by the Panel because their systems are set up in different ways. Conflicting organisational aims and objectives are also a factor. Whilst these factors may impede the review as planned, uncovering them can be important when it comes to recommendations: not only do these issues cause problems for the Panel, they may also restrict the provision of a seamless service to users and other agencies. Running a review such as this, in parallel with other scrutiny provision, has resourcing implications for a limited scrutiny team and for the workload on members. The commitment of both officers and members to the subject of the review, and a belief in its ultimate value to the community carried it through to a successful conclusion. Some of the factors influencing alcohol-related hospital admissions are out of the control of local government – for example, minimum pricing and some issues surrounding licensing – but members decided they could use the evidence gathered during the review to influence nationally, possibly in conjunction with related reviews conducted by other health overview and scrutiny committees.

The final report and recommendations were approved by the Panel in January 2011. The differences this review will make include the following:

- Increased awareness of the real cost of alcohol misuse.
- Education of future generations of the dangers of alcohol misuse.
- Improved communication between partner agencies.
- More effective inter-agency working.
- More robust collection of data on assaults and licensing infringements.
- Closer working between licensing and planning.
- Reduced alcohol-related hospital admissions, including a reduction in “frequent flyers”.

Sefton - the project journey

In Sefton, as in the rest of England, people living in the poorest neighbourhoods die earlier than those in the richest neighbourhoods. Estimates for wards show that the gap between the highest and lowest life expectancy can be as great as 11 years for males and 10 years for females. Furthermore, even excluding the five percent poorest and richest wards in Sefton, the gap in life expectancy remains at nine years for males and eight years for females. In Sefton as elsewhere, the social gradient in health means that the higher one's social position, the better one's health is likely to be.

This review was informed by the findings and recommendations of *Fair Society, Healthy Lives*, the report of the strategic review in to Health Inequalities in England, published in February 2010. This set out a framework for the Annual Public Health Report and reinforced the fundamental understanding on which the Review process was based, which is that inequalities in health arise because of inequalities in the conditions in which people are born, grow, live, work and age.

The Working Group wanted to develop a clear understanding of how health inequalities impact on the lives of people and their families in the Bootle area and in a comparator area in the Borough where people are considered to be 'better off' and in particular, to target children and their parents/carers/grandparents.

They wanted to explore methods for reviewing the underlying determinants of health inequalities, with the aim of gaining a better understanding of the inequalities in society that affect health and how these play out for children of primary school age in selected areas in Sefton.

Members were clear from the outset that this review would be people-focused and would operate in 'listening mode', staying open to the broader and complex factors that matter to people and affect their ability to 'live well'. In addition they were very keen to avoid negative labeling and to work from people's strengths and capacities rather than assumed and/or measured deficits. This dictated the chosen focus for the detailed work of the Review and influenced the multiple activities chosen to progress it. Sefton has good educational results and it was felt that this would avoid a focus on specific streets or areas where other quantitative data indicated that there is deprivation.

The review was based around three primary schools, two in the south of the Borough and one in the north of the Borough with a particular focus on children aged 5-7 and their families. The Working Group adopted an approach that would explore the broad, complex, and interconnected factors which Marmot and many other sources demonstrate have a major influence in health and well-being. These include employment/income, transport, housing, social networks and activities provided within the Borough by the council and by the third sector and independent organisations. Year one and Year two children and their families were chosen to take part in the review process as it was felt that this cohort would be settled into the routine of school life and would be able to articulate feelings and thoughts about the first five to seven years of their lives. Schools would also have a great deal of information about these children and their families. The work was organised into the following strands of activity including:

1. **Data gathering:** statistical information was drawn from sources such as free school meal uptake and National Child Measurement data.

2. **Member walkabouts:** These took place in the vicinity of the schools during the half term week at the beginning of June 2010 and the main facilities in each area were noted. Relevant ward councillors were also invited to attend. Notes were recorded from these 'walkabouts' but the real value came from members being able to 'get a feel' for the area that they were looking at, particularly during a time when the local school was closed for half term.

Sefton - the project journey continued

3. Visits to Schools: Members visited schools and met with Heads and other school teachers to gather their views at the beginning of the review.

4. Engagement with Children: The Working Group used resources provided by the Centre for Public Scrutiny to employ a *Community Artist* to engage the children within the three schools identified. The engagement programme involved six half day creative work shops in each school entitled *'Me, My Life & My Community'* followed by a celebration event for family and pupils. Using a large 3D dolls house to depict separate scenes for home, school, community and aspirations each child was invited to re-enact their own home and community life.

5. Engagement with Parents / Carers: Parents and carers of Year one and Year two children were invited to complete a short questionnaire which would capture their views and perceptions about local assets and obstacles to their well-being. Parents and carers were approached through the 'Active Kidz' camp held on 26th August as part of the 'Free and Active' programme run by Sefton Council's Leisure Department.

6. Training & Capacity Event: Members also used support from the Centre for Public Scrutiny to facilitate a training and capacity development event. The event was held at the end of July 2010 and attendance was drawn from Working Group Members, Cabinet Members, Sefton PCT Board Members, relevant council officers, headteachers, governors and representatives from the voluntary and community sectors and faith communities. This event was perceived as highly successful in stimulating new kinds of conversations with a very diverse range of stakeholders enabling the new insights into local assets as well as local needs in the target areas.

Staffordshire - the project journey

Background

Mental health promotion, prevention and early intervention services are lacking, under developed and inequitable (in access and outcomes) across Staffordshire.

- Depression is among the highest cost mental health conditions in terms of service cost and loss of earnings.
- People with physical illnesses have higher rates of mental health problems.
- Unemployed people are twice as likely to have depression as people in work.
- Children in the poorest households are three times more likely to have mental health problems than children in well off households.
- People with drug and alcohol problems have higher rates of mental health problems.

In Staffordshire in 2008 it was estimated that: 13,100 people aged 18-64 had symptoms of depression, 84,500 people aged 18-64 had symptoms associated with neurotic disorder, 22,600 people aged 18-64 had a personality disorder and 2,800 people aged 18-64 had a psychotic disorder, with numbers in future years remaining similar.

Given the prevalence/incidence of mental health disorders in the county and the assessed need for lower level mental health interventions they needed to build a better understanding of:

- Variations in local outcomes.
- The extent to which this is related to range and capacity of current provision.
- The extent to which this is related to effectiveness of provision.

Therefore the review has focused on the effectiveness of the current approaches to commissioning services and effectiveness of provision of selected lower level / preventative mental health services in the county.

How the review was conducted

Preparation and selection of areas of focus

Before their first meeting, members of the working group were given a comprehensive pack of information to brief them about current mental health policy and provision.

The group invited an external specialist from the West Midlands Development Centre and the County Commissioner to their first meeting to introduce them to the subject of mental health. This covered:

- Discussion about what being mentally healthy meant to the group.
- A model explaining the distinction between mental illness and mental health - which helped members to understand that a person could have a mental illness but good mental health or no mental illness but poor mental health.
- Discussion about risk factors for mental illness.
- The relationship between mental health and physical health.
- The relationship between mental illness and other inequalities.
- A fictional family case study that highlighted the impact of different interventions on mental health and well-being.
- The national and local context – reinforcing the group's opportunity to influence future mental health commissioning at a time of change.

Staffordshire - the project journey continued

At this meeting, members learned about: the difference between mental health promotion, prevention and early intervention; the nature and purpose of services; and the need for action across organisational boundaries to tackle issues. Inequalities were identified that could be areas of focus for the review, as well as lines of inquiry.

The group did not have the capacity to review everything and so a prioritisation and further scoping exercise was undertaken. This focused members on what was timely and where they could make a difference. As a result, they identified five areas – three of which were included in their review (with the remaining two forming recommendations for further work).

Work on areas of focus

The group always intended to test different approaches to scrutiny of their chosen areas, particularly to involving service users. The approaches were:

1. **Access to psychological therapies** – comparative study of two different places using interviews and visual discussion groups.
2. **Promoting the mental health of the recently unemployed** – study of one place using written evidence and a focus group.
3. **Long-term conditions and mental health** – comparative study of the patient pathways for two prevalent conditions in one place using an inquiry day and "interrupted story" with individual service users.

As Staffordshire joined the Health Inequalities Scrutiny Programme late, the group needed to get through their planned work swiftly. Members divided the tasks between them, collecting evidence in pairs through meetings, telephone conferences, visits and work outside the usual process. Alongside this, regular group meetings were held so that members could share the information collected and what they had learned - as well as check their progress.

Work on access to psychological therapies began first. Members sought a range of views on the two models of provision and the extent to which they formed part of a coherent service that met the needs of the local population. Interviews with service commissioners and providers, as well as GPs, took place. At the same time requests for written information for the next area of work were sent out. In addition, various avenues for identifying service users to participate in the review were tried - these included support groups, user groups and commissioner and provider patient and public involvement groups.

Bad weather and sickness absence over the winter slowed progress with the review and meant that tasks were not completed in the planned order. The group concentrated on getting input from other organisations on promoting the mental health of the recently unemployed. Members gained an employer perspective and heard from the Jobcentre Plus Mental Health Co-ordinator about action and the scope for links to improve the emotional well-being of employees and the unemployed.

Then the group resumed their effort to involve service users in the review and complete the long-term conditions area of work – to make the connections between the patient pathway for the condition and the pathway for mental health. Members held successful focus groups with:

- The Programme Adviser, involving one therapist and seven users at an emotional well-being service. Drawings and text illuminated: what they thought before coming to the service; what was good; what might be improved; and whether they felt confident about what happened next.
- Unemployed people around the opportunities to promote the mental health of the recently unemployed.

Staffordshire - the project journey continued

Concluding work

Checking on progress and writing up their findings as they went through the review, the group identified gaps in their evidence. They filled these through further correspondence, for example writing to the two mental health trusts to seek a view on the boundary between primary and secondary mental health care.

The intended outcome of the review was constructive recommendations that, if implemented, would help ensure that appropriate priority is afforded to lower level/preventative mental health services in Staffordshire in order to:

- Reduce mental health inequalities.
- Prevent mental health problems.
- Intervene early to improve long-term mental health outcomes.
- Deliver cost effective mental health services in a period of recession.

At the time of writing this project journey the review has not concluded. A consultation draft of the group's final report will be shared with stakeholders once the review has concluded, to make sure that the recommendations are constructive. The review will then feed into the contents and implementation of the mental health commissioning strategy for the county.

Warwickshire - the project journey

The review process went through the following six phases:

1. The initial scoping and bid to CfPS to become one of the Scrutiny Development Areas. This was based on evidence of inconsistency of services gathered through consultations with young people conducted by the Respect Yourself Campaign and on national reports identifying issues and examples of good practice.

2. Having succeeded in its bid the panel then looked at the national reports in more depth and received briefings from the Respect Yourself Co-ordinator. This helped the panel to form an understanding of how the services are delivered and about users' responses. They began to identify a number of issues that they wanted to explore further (e.g. how access to services vary across the county, different user responses to the way services are delivered, the extent to which fathers are involved etc.)

3. In order to gain a first hand picture of what services feel like to users some of the members visited children's centres and talked directly with young parents and practitioners. Members on the review panel were keen to undertake field research themselves, and arranged their own visits. Most members did this and found it to be a valuable learning experience. One member said she found that she needed to rephrase questions in a way that the young people could connect with their own experience. Once she had found the connection she received more focused responses. This was an efficient approach as it meant that officers did not have to spend time trying to organise mutually acceptable times. The added benefit of this approach was that it provided members with first hand experience, a rich set of additional information, and more determination to carry out the review.

4. At the end of September 2010 the panel then held a select committee style meeting where they were able to put questions to a wide range of practitioners responsible for delivering services to teenage parents. These included midwives, health visitors, children's centre managers, teachers and co-ordinators delivering education outside school, information service officers, young parents forum leads and Connexions staff. In advance of the meeting all participants were asked to complete a questionnaire about the challenges and opportunities facing the services they provide. This gave the panel a basis for exploring issues further at the meeting. It proved to be really useful to have all the different services represented at the meeting as this enabled the members to explore how the different services fit together. The practitioners themselves also valued the opportunity to discuss issues with each other.

5. After the select committee meeting the panel looked at the full range of evidence that they had collected and started to draw some conclusions. They identified some gaps in the information they required and conducted a "mopping up" exercise to fill any remaining gaps. This included a visit to one of the hospitals to meet with the head of community midwifery.

6. The final stage of the review was to draw conclusions and develop recommendations. This process took over five hours spread over two meetings because of the complexity of the evidence and the panel's determination to add value to the services by making the right recommendations.

Partnership working

Warwickshire has a County Council and five District Councils. This review involved, the County, Nuneaton and Bedworth District Council and Rugby Borough Council. Whilst partnership working across the participating councils was excellent and shows two tier working at its best, not all of the districts could take part due to limited resources. The panel reflected on this and felt that their involvement in the review would have strengthened its outcomes, and further reviews will look to a shared support arrangement.

Warwickshire - the project journey continued

Recommendations

The panel was keen to make recommendations that would directly improve outcomes for teenage parents. However the shortage of hard quantitative evidence and performance management systems for some of the services prevented this. See case study.

The recommendations have been well received. Connexions have already taken action on the recommendation at bullet point 4 in the case study. They have decided to retain their specialist adviser in the north of the county and, in the south, the service will be picked up by general Connexions personnel.

Links and References

The Centre for Public Scrutiny

www.cfps.org.uk

CfPS Tackling health inequalities
http://www.cfps.org.uk/what-we-do/tackling-health-inequalities/

Local Government Improvement and Development
http://www.idea.gov.uk/idk/core/page.do?pageId=1

Department of Health
www.dh.gov.uk

Links to Scrutiny Development Areas reviews

Blackpool

http://www.cfps.org.uk/scrutiny-exchange/library/health-and-social-care/?id=3175

Chesterfield

http://www.cfps.org.uk/scrutiny-exchange/library/health-and-social-care/?id=3174

Cheshire

http://www.cfps.org.uk/scrutiny-exchange/library/health-and-social-care/?id=3171

Dorset

http://www.dorsetforyou.com/media.jsp?mediaid=160515&filetype=pdf

London

Link not currently available

North East

Regional review of the health needs of the ex service community
http://www.cfps.org.uk/scrutiny-exchange/library/health-and-social-care/?id=3122

Mental health services in North Easington (Durham County Council)
http://www.cfps.org.uk/scrutiny-exchange/library/health-and-social-care/?id=2706

Further reviews from Gateshead and Middlesbrough
http://www.newcastle.gov.uk/core.nsf/a/dsscrutreghealth

Portsmouth

http://www.cfps.org.uk/scrutiny-exchange/library/health-and-social-care/?id=3107

Sefton

Link not currently available

Staffordshire

http://www.staffordshire.gov.uk/yourcouncil/decisionmakingcouncil/scrutinylibrary/library.aspx

Warwickshire

http://www.cfps.org.uk/scrutiny-exchange/library/health-and-social-care/?id=3072

Other links and references

LGI&D best practice guide for Joint Strategic Needs Assessments
http://www.idea.gov.uk/idk/core/page.do?pageId=25934589

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(2006) 'A health map for the local human habitat' in Journal of the Royal Society for the Promotion of Health Vol 126, No 6
http://www.idea.gov.uk/idk/core/page.do?pageId=17415112

Marmot M (2010) Fair Society, Healthy Lives.
http://www.marmot-review.org.uk/

Equality and Human Rights Commission (2011) How fair is Britain
http://www.equalityhumanrights.com/

Frontier Economics (2009) Overall costs of health inequalities. Submission to the Marmot Review. www.ucl.ac.uk/gheg/marmotreview/Documents.

H.M. Government (2010) Healthy Lives, Healthy People: Our strategy for public health in England. http://www.official-documents.gov.uk/document/cm79/7985/7985.asp

Aked J. Michaelson J. and Steuer N. (NEF) (2010) The role of Local Government in promoting well-being. LGID and NMHDU
http://www.idea.gov.uk/idk/aio/23693073

IPPR North and Social regeneration consultants for the North East - Good conversations, successful communities, better services – Positioning Paper (October 2010)
http://www.ippr.org.uk/ipprnorth/publicationsandreports/publication.asp?id=786

The Joseph Rowntree Foundation
http://www.jrf.org.uk/publications

Practical ways to engage with your community
http://www.idea.gov.uk/idk/core/page.do?pageId=16639575

The Association of Public Health Observatories website http://www.lho.org.uk/LHO_Topics/national_lead_areas/marmot/marmotindicators.aspx

Link to Living Well
http://www.northwest.nhs.uk/document_uploads/Publications/Living%20Well.pdf

A glass half full: how an asset approach can improve community health and well-being (IDeA 2010) http://www.idea.gov.uk/idk/aio/18410498

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