Public Health England

Enclosure PHE/14/39

PHE Board Paper

Title of meeting	PHE Board
Date	Wednesday 26 November 2014
Sponsor	Paul Johnstone
Title of paper	***Due North: Report of the Inquiry into Health Equity for the North* – Developing PHE's Final Response**

1. Purpose of the paper

1.1 Due North was an independent inquiry commissioned by PHE to take a fresh look at the evidence in the light of the changes in public health responsibilities, the current economic context, and, from a northern perspective, to consider what could be done differently to impact on health inequalities.

1.2 This paper provides an update on engagement activity since the Due North report was published on 15 September, discusses the recommendations for PHE (see Appendix 1) and for Government (see Appendix 2), and poses a number of questions to the PHE Board to help shape PHE's response.

1.3 The supporting schedules are:

Appendix 1 Due North recommendations for PHE
Appendix 2 Recommendations for Central Government

2. Recommendation

2.1 The Board is asked to:

a) **COMMENT** on the extent to which PHE should develop its role in supporting government and other partners in assessing the impact of policy change on health and health inequalities.

b) **NOTE** and **COMMENT** on the proposed PHE responses to the Due North recommended actions contained in Appendix 1, particularly the options set out for action 1.

c) **COMMENT** on PHE's position on the report's recommendations for Government, grouped into four themes and considering individual recommendations in this context, and the further opportunities available to PHE to raise the debate nationally on health inequalities in the North of England.

3. Introduction and background

3.1 This paper is an update to the papers considered by National Executive on 25 June and 2 September that provided background to the inquiry and an interim response to the report from PHE.

3.2 Due North was an independent inquiry commissioned by PHE to take a fresh look at the evidence in the light of the changes in public health responsibilities, the current economic context, and, from a northern perspective, to consider what could be done differently to impact on health inequalities.

3.3 The Inquiry panel supported by a wide range of experts made 4 high level recommendations with 56 supporting actions. Focused around the wider determinants of health, rather than individual lifestyle and behaviour change, the Inquiry's recommendations result from an analysis of the root causes of health inequalities such as poverty, education and the differences in opportunities available to individuals. The focus of their recommendations therefore relate to the roles played by national and local government, the NHS and other agencies in making a difference to communities and individuals in the North of England.

3.4 PHE has a key role in supporting work on health inequalities and the wider determinants of health, such as those measured through Domain 1 of the Public Health Outcomes Framework. Our role is also to support the Secretary of State in his legal Duty to address health inequalities as outlined in the Remit Letter. We do this through advocacy, partnerships, world-class science, knowledge and intelligence, and the delivery of specialist public health services. It is within this context that our response to Due North is made.

3.5 A further paper may be submitted to the National Executive and Board in the New Year offering a proposed final response to the Due North report, following further debate and comments received from partners locally and nationally.

4. Supporting debate in the north

4.1 Of the 56 suggested actions in the report, many are aimed at agencies working together across the north of England and publication of the report has generated considerable interest across Local Government, the Voluntary and Community Sector (VCS) and the NHS. In Local Government, officers and elected members have been leading discussions at Local Enterprise Partnerships, Health and Wellbeing Boards, Cabinet meetings and Corporate Leadership Teams on how they can respond locally to the recommendations. One Local Authority is also using Due North to inform discussion on the restructuring of their children's services, and the three DPH networks in the north are preparing formal collective responses setting out their perspectives on the recommendations and how they see PHE as being able to best support their implementation.

4.2 Centre directors and their teams have also been encouraging debate amongst stakeholders locally supported by a toolkit of resources and other resources commissioned by PHE such as the evidence reviews on local action to address health inequalities published by the Institute of Health Equity. This material has also been made available to inquiry panel members and other stakeholders to

support discussions they may wish to lead themselves. Some highlights of our engagement include:

a) A constructive breakfast meeting at the PHE conference to explore initial steps including actions for engaging the VCS and Local Government
b) Presenting at the annual meeting of the North West Voluntary and Community Sector organisations and further plans now being developed to provide a webinar to further engage the VCS across the North.
c) Presenting at a workshop at the North East Health Summit organised by the Association of North East Councils and attended by PHE CEO and the shadow health secretary.
d) Speaking at the North tripartite meeting of NHSE, Monitor and the Trust Development Agency to all NHS Chief Executives of NHS Trusts, Foundation Trusts and CCGs and the 50 Local Authorities on the links between Due North, 'Well North' and the NHS 5 Year Forward View.

4.3 We are also exploring opportunities and linkages on cross-North working, such as the 'Northern Futures' project established by the Deputy Prime Minister to create an economic hub in the north of England, and linking more closely with the Well North programme which is focused on targeted work with communities to develop preventative interventions to support health and social care.

4.4 These discussions, supported by PHE, are both enabling local agencies to discuss and debate their response to the recommendations of the report as well as helping us to consider our own response including any resources that might be required to support local actions.

5. Response to PHE's recommended actions

5.1 The report recommends eight actions for PHE [listed at Appendix 1]. In general terms, the actions are resonant with PHE's mandate to shape the debate on the underlying determinants of health. However, in deciding our response we need to consider carefully where best to focus our resources so that we can have the most impact. There are two key issues to consider.

5.2 Firstly, many of the recommendations propose a supporting role for PHE to work with local partners (actions 2, 4, 6, 7 and 8 at Appendix 1). Through our engagement activity we need to understand whether local partners would want to take these actions forward and if so, what support they would want from PHE. We are aware that in the case of two recommendations, some colleagues in local government are already progressing these and PHE centre colleagues are determining how best they can support these actions: (action 4) to support the involvement of health and wellbeing boards and public health teams in the governance of Local Enterprise partnerships and Combined Authorities and (action 6) to support the development of a network of Health and Wellbeing Boards across the North of England with a special focus on health equity.

5.3 Secondly, three recommendations relate to the role that PHE could play in assessing the impact on health and health inequalities of Government policy (actions 1, 3 and 5 at Appendix 1). Our remit letter does indicate the potential for

PHE to play a greater role in this area: *'[PHE] make recommendations to central government, local government, the NHS and others on the basis of the evidence and its professional and scientific judgment. Its advice should be focused on areas where PHE can make a unique contribution and add most value. This can include recommendations based on an assessment of the impact of improving health on the economy and society'.* Should we wish to play a greater role in this, there are two main options:

a) A model for health impact assessment has been developed but is little used. At a minimum, our role could therefore be to encourage and promote its use more widely. This would build on the work already being undertaken by PHE's Health Equity team to develop a health equity impact assessment approach (the Health and Health Equity in all Policies project). Existing work with the Department of Energy and Climate Change on fuel poverty and with the Child Poverty Unit and the Child Poverty and Social Mobility Commission on child poverty, health inequalities and educational attainment are potential examples of such approaches.

b) Alternatively, PHE could play a more major and proactive role, in which case we would need to assess both the capability and capacity we would need to build internally to be able to respond promptly and comprehensively to support government and other partners to assess the impact of their policies on health and health inequalities.

5.4 The Board is asked to **COMMENT** on the extent to which PHE should develop its role in supporting government and other partners in assessing the impact of policy change on health and health inequalities.

5.5 Should the Board favour option (ii) above, we would then need to consider our response to Due North's first recommended action for PHE (to conduct a cumulative assessment of the impact of welfare reform and reduction in funding on national and local public services) which could be regarded as a retrospective health impact assessment. This would be a methodologically very complex and resource intensive piece of work to take forward due to challenges of attribution of causation to different dimensions of policies, as well as the issue of understanding local decisions about priorities for spending at a time of wider economic downturn. Options for our response are posed in Appendix 1.

5.6 The Board is asked to **NOTE** and **COMMENT** on the proposed PHE responses to the Due North recommended actions contained in Appendix 1, particularly the options set out for action 1.

6. Government recommendations

6.1 Due North poses 22 recommendations for central government (see Appendix 2) to take forward across departmental boundaries and which cover the interests of HM Treasury and the departments of Business, Industry and Skills; Communities and Local Government; Education and Health. These recommendations are far reaching and would require significant policy change and development. Others require significant investment which is challenging in the current fiscal context and

would need to be considered as part of Spending Review decisions. We have identified four broad themes under which the recommendations can be grouped to enable us to consider what our own response might be. To an extent, all four themes align to PHE's priorities or ways of working and there is merit in considering in more detail how our current work supports the aims of the report's recommendations, as well as what more we could do:

a) the **devolution of powers** to local authorities: this builds on placed-based approaches to public health, and locally led solutions that draw on all the assets and resources of an area so that they take control and rely less on external support. Assessing and reflecting local needs within national policy, such as through Health and Wellbeing Boards and Joint Strategic Needs Assessments, is essential to improving health outcomes. This theme also responds to current national and local political interest such as the Deputy Prime Minister's 'Northern Futures' project. Recommendations within this theme include granting local government a greater role in deciding how public resources are used to improve the health and wellbeing of the communities they serve or giving local government greater flexibility to raise funds for investment or use assets to improve the health and wellbeing of their communities.

b) **early years**: ensuring every child has the best start to life is one of our priorities. We recognise that more needs to be done to lessen the variation for children across the country, by making more progress and doing so faster than we have done to date. A number of these recommendations call for additional investment so we need to be mindful that in the current fiscal context, this would require disinvestment elsewhere. For example reducing child poverty through the measures advocated by the Child Poverty Commission or increasing the proportion of overall expenditure, allocated to the early years and ensuring expenditure on early years development is focused according to need.

c) **tackling poverty**: poverty is one of the causes of health inequalities and action directed at tackling poverty is an integral part of our statutory duty to reduce inequalities. Specifically, employment, one of our 'game changers', is critical to breaking the cycle of inequality as we know that good quality work promotes better health. Recommendations include ending in-work poverty by implementing and regulating a Living Wage or ensuring that welfare systems provide a Minimum Income for Healthy Living.

d) **monitoring progress and impact**: as an organisation we are driven by evidence and data, and the intelligence they provide. We fully support the monitoring and evaluation of health interventions to ensure they are appropriate, targeted and effective. We need to determine how far we want to develop the capacity and capability to support proactively partners nationally and locally to monitor progress and impact. Recommendations include assessing the changes in national policies on health inequalities in general and regional inequalities in particular or carrying out a cumulative impact assessment of any future welfare changes to ensure a better

understanding of their impacts on poverty and to allow their negative impacts to be more effectively mitigated.

6.2 At this stage in considering our response to Due North, it would be helpful to understand PHE's position on these broad themes before considering the detail of any recommendations and PHE's role in supporting these. Notwithstanding this, the general themes from Due North could offer an opportunity to engage others in a wider debate on the importance of addressing health inequalities between the North and South of England and could support the development of engagement activities at a national level for example through Westminster events, possibly lead by councils or universities from the North of England.

6.3 The Board is asked to **COMMENT** on PHE's position on the report's recommendations for Government, grouped into four themes and considering individual recommendations in this context, and also the further opportunities available to PHE to raise the debate nationally on health inequalities in the North of England.

7. Links to other PHE programmes on health inequalities

7.1 PHE is committed to working with national and local government as well as a wide range of interested partners to identify ways to achieve better life chances and level up the gradient of ill health. We are taking forward a breadth of activity on health inequalities which we can also highlight in our full response, including:

a) Well North: We are developing the Well North programme with Manchester University, local authority and academic partners across the North, to build on hotspot analysis to identify communities that use lots of hospital services and propose targeted preventative interventions to both improve health and reduce the reliance on hospital-based services. This is led by Aiden Halligan and will be jointly funded (50-50) between councils stepping forward to pilot, and PHE.

b) Translating the Marmot review recommendations into action: PHE commissioned Prof Sir Michael Marmot's team at the Institute of Health Equity to build on the review findings and produce evidence and briefings about practical actions that could be taken at local level.

c) Best start in life: through work with health visiting and school nursing, family nurse partnerships and the Troubled Families programme, one of PHE's seven strategic priorities is to give children the best start in life. PHE has commissioned the Early Intervention Foundation to provide evidence to support action on early years.

d) Asset Based Community Development: PHE has recently agreed to support a programme of work across Directorates facilitating shared learning to support emerging practice, and providing system leadership and the development of knowledge products on the use of community empowerment approaches that be used to address health inequalities.

e) National Conversation on Health Inequalities: a programme of work involving the public, professionals and elected councillors, in a dialogue about health inequalities to improve understanding of the public's perceptions and experiences of health inequalities.

8. Next steps

8.1 We have made a commitment to provide a fuller response to Due North in the Spring following widespread discussion with stakeholders. In our interim response, we outlined that this would focus on the report's recommendations for PHE in spring 2015, setting out how it will feed into our programme of action on health inequalities. We will continue to support local debate and invite formal responses from sectors on their response to the Due North actions both to encourage local agencies to consider their own response and to help us decide how best to support them.

8.2 These engagement activities will be completed by the close of the calendar year to enable us to prepare our fuller response for endorsement (including any resource implications) by the National Executive in the spring. Proposals for an event in Spring 2015 are also being developed bringing together panel members, people and organisations engaged in this debate and determined to achieve a step change in the health and wellbeing of communities across the north of England.

8.3 It is proposed that we retain the original governance 'structure' adopted for the period leading up to the publication of the Due North report and the drafting of our interim response. This included an editorial/project team drawn from the directorates of operations, strategy and health and wellbeing, reporting to an executive group comprising the Directors of Strategy (Jonathan Marron), Health and Wellbeing (Kevin Fenton), and the North Region (Paul Johnstone).

9. Conclusions

9.1 Due North has been a significant catalyst for the debate on health inequalities in the north of England. The request for PHE colleagues to attend organised discussions and workshops has been gathering momentum and adding support to discussions being lead across local Government in responding to their duty to improve the health of their local population.

9.2 The report is also timely because Government and all main political parties are looking to support further economic investment in infrastructure, jobs and in the north and councils particularly through Combined Authorities are also seeking more devolved responsibility.

9.3 Our response to Due North builds on considerable work already undertaken to address health inequalities across the country and will be vital for PHE in playing its role in addressing what is known as the 'North-South divide'.

9.4 Our engagement activities will continue over the next two months and the debate at National Executive and Board will be key to informing our final response to Due North in the Spring and our future work in this area.

Tracey Sharp
Deputy regional director – north region
November 2014

APPENDIX 1 – DUE NORTH RECOMMENDATIONS FOR PHE

Recommended Action	PHE proposed response
1. Conduct a cumulative assessment of the impact of welfare reform and cuts to local and national public services.	This is **subject to the Board's discussion** about PHE's role in health impact assessments. In that context, there are two initial options for developing our response to this recommendation. Proposal 1: Reject completely As a retrospective impact assessment this would pose challenges in the attribution of causation to different dimensions of policies, as well as the issue of understanding local decisions about priorities for spending at a time of wider economic downturn. The recommendation could be rejected on the basis of the methodological complexity, the wide range of confounding variables and the resource intensive work that it would entail. Proposal 2: Accept with Caveats If we were to accept the recommendation we would need to undertake further scoping to determine the required resources and the most appropriate approach. For example, we could look to commission this work externally or undertake work in-house to identify readily available indicators which could then enable us to determine the impact of future policy on health outcomes. Should this be the preferred option, we would then submit a further paper to NE/Board once the resource implications were known.
2. Support local authorities to produce a Health Inequalities Risk Mitigation Strategy for the financial years 2015/16-2017/18	Subject to local discussion, it is proposed that this recommendation is **accepted with caveats**. Before proceeding with this recommendation PHE would wish to consult with local government stakeholders, including the LGA and ADPH, on the acceptability of Health Inequalities Risk Mitigation Strategies and on content and scope of guidance/tools that might support their production if required.
3. Help to establish a cross departmental system of health impact assessment.	This is **subject to the Board's discussion** about PHE's role in health impact assessments. There are differing views as to whether it is more effective to introduce a free-standing process focusing specifically on health and health inequalities – or to use a form of integrated impact assessment that looks at health and health inequalities alongside other impacts. Subject to scoping work about our capability and capacity, a selective approach to prioritising policies that have greater relevance to health and health inequalities may be an appropriate approach to achieve maximum benefits from this approach.
4. Support the involvement of health and wellbeing boards	It is proposed that this recommendation is **accepted with caveats**.

and public health teams in the governance of Local Enterprise partnerships and Combined Authorities	There are many potential benefits to this recommendation in terms of the possibility to impact on economic growth and access to employment as well as influencing issues of transport and sustainability. PHE would wish to consult with local government stakeholders, including the LGA and ADPH, on the content and scope of the support for the involvement of health and wellbeing boards and public health teams in the governance of local enterprise partnerships. Some Local Authorities are beginning to progress this already and PHE Centres are looking at what support is required.
5. Contribute to a review of current systems for the central allocation of public resources to local areas	It is proposed that this recommendation is **accepted with caveats**. Any decision to review current systems for the central allocation of public resources to local areas is not within the remit or control of PHE. However should such a review be established by another organisation, it would be relevant for PHE to contribute to that review on issues relating to improving health and reducing health inequalities relating to the use of devolved budgets.
6. Support the development a network of Health and Wellbeing Boards across the North of England with a special focus on health equity.	It is proposed that this recommendation is **accepted with caveats**. The combined learning of the northern Health and Wellbeing Boards (HWBs) is potentially a valuable asset and benefits could be gained from sharing the learning through a recognised structure. The LGA have a lead role in supporting HWBs and their network development and we will explore with them how we can best offer our support to this work, whilst determining the wishes of HWBs to progress this action. This recommendation would be taken forward by the North Region and Centres and debate on this subject is already being supported by PHE Centre staff.
7. Collaborate on the development of a charter to protect the rights of children.	Subject to local discussion, it is proposed that this recommendation is **accepted with caveats**. The success of this will rely on having agencies agreed on commitments to children and young people, that the commitment is made in public and that it is focussed on rights to early intervention and prevention and to access to best health care. This recommendation would be taken forward by the North Region and Centres, with PHE's supporting role to be determined.
8. Work with Healthwatch and health and wellbeing boards across the North of England to develop community-led systems for health equity monitoring and accountability	Subject to local discussion, it is proposed that this recommendation is **accepted with caveats**. Healthwatch is a relatively recent organisation and is undergoing development. However, the network recommended in 6 could be a mechanism through which this was agreed and implemented. This recommendation would be taken forward by the North Region and Centres.

APPENDIX 2 – RECOMMENDATIONS FOR CENTRAL GOVERNMENT

Recommendations relating to devolution of powers	
1.10	**Develop a national industrial strategy that reduces inequalities between the regions.** At present the government has invested £2 billion5 in an industrial strategy that is focused on supporting growth in particular sectors such as emerging technologies. Whilst this is important, there also needs to also be a clear objective to use industrial strategy to help spatially rebalance the economy and promote sustainable and quality employment that is good for health. For example the Regional Growth Fund has centralised decisions previously taken at regional level. A national industrial strategy should support decentralisation of decision-making to more effectively target resources to where they will make the greatest difference.
1.13	**Develop policy to enable local authorities to tackle the issue of poor condition of the housing stock at the bottom end of the private rental market.** Local authorities already have some powers to regulate the private rented sector where housing conditions are poor. Central government needs to work with local government to strengthen their ability to improve the quality of housing in the private rented sector. Greater flexibility for local government to housing investment including local borrowing and enabling local government to 'earn back' savings made to the housing benefit bill through investment in affordable housing, could support the greater investment needed.
1.16	**Grant City and County regions greater control over the commissioning and use of the skills budget and the Work Programme to make them more equitable and responsive to differing local labour markets.** Greater control over the use of the skills budget would allow City and Country regions to address local skills gaps, improve school to work transitions, and develop integrated approaches that move those out of work into employment. At present, funding for adult further education (16-19+) and skills training, including apprenticeships, is mainly controlled centrally. Commissioning, accountability and planning of the Work Programme has been centrally managed by the DWP and this has not led to effective models of provision. A number of organisations and reviews have already called for some type of localisation of the Work Programme. Local partners including Local employers, local authorities and community and voluntary organisations are best placed to set local priorities and budgets and develop integrated approaches that support transitions into employment and progression within the workplace whilst delivering what is needed to achieve local economic priorities. This would, include establishing integrated support across the public sector to improve the employment prospects of those out of work, shaping further education and training provision and apprenticeships, Joining up schools, vocational training apprenticeships and employment support and better integrating skills and training into the Work Programme.

3.8	**Grant local government a greater role in deciding how public resources are used to improve the health and wellbeing of the communities they serve.** This could include: • A specific aim to incrementally increase the proportion of total public expenditure controlled locally. This can help to rebalance the economy, bring national and local government closer to people, and curb inequality, but only if resources are allocated fairly and used to develop local economic policy that addresses health inequalities. • Agreements between national and local government that ensure devolved funds address health equity. Any new devolution agreement or deal needs to have specific objectives to improve outcomes for disadvantaged residents - and therefore address economic and health inequalities (focusing on for example stronger communities, good quality employment, and focused help for those experiencing social and economic exclusion).
3.9	**Revise national policy to give greater flexibility to local government to raise funds for investment and use assets to improve the health and wellbeing of their communities,** this could include, for example: • Granting councils greater freedom within prudential financial guidelines, to borrow to make investments that provide social and economic returns and improve health and wellbeing. • Reviewing restrictions on investments by local authority pension schemes so that they can be used to make investments that promote economic development in the North that improves health and wellbeing, as well as providing a return on investment. • Exploring the possibilities of giving local authorities in England a greater share of the existing tax base to make investments that provide social and economic returns and improve health and wellbeing. This would strengthen local democracy, allowing local people to see more clearly what their taxes pay for locally and enable local government to shape spending priorities. This must however be done in a way that does not increase inequalities between more prosperous and less economic successful places.
3.11	**Invite local government to co-design and co-invest in national programmes, including the Work Programme, to tailor them more effectively to the needs of the local population.**

Recommendations relating to early years	
2.6	**Embed a rights based approach to children's health across government.** This would mean a high level commitment to children's rights with the aim of improving child health and reducing health inequalities. The arguments are not just about the evidence but also that investing in children is morally and legally the right thing to do. The benefits of investing in the early years are well demonstrated, and large numbers of children stand to benefit.
2.7	**Reduce child poverty through the measures advocated by the Child Poverty Commission** which includes investment in action on the social determinants of all parents' ability to properly care for children, such as paid parental leave, flexible work schedules, living wages, secure and promising educational futures for young

	women, and affordable high quality child care;
2.10	**Invest in raising the qualifications of staff working in early years childcare and education.** The priority should be to raise the qualifications for all existing staff to level 3 and at least 30 per cent of staff trained to level 6. 8 The evidence clearly shows that it is essential that early years education and childcare is of high quality if children are to benefit. Extending access to childcare must therefore be supported by improvements in the quality and standards of childcare provision. The Nutbrown review commissioned by the coalition government has recommended that level 3 qualifications should become the baseline standard for all staff working with children.
2.11	**Increase the proportion of overall expenditure, allocated to the early years and ensure expenditure on early years development is focused according to need.** The Government should gradually move funding to the early years and this funding should be weighted toward the most disadvantaged children. The government should assess and monitor the level of public expenditure on the early years by all government departments and how this funding is distributed within the country, reporting progress on shifting resources to the early years annually. The government appointed Frank Field to conduct a review of 'Poverty and Life Chances'. That review has recommended that resources are shifted to the early years. At present, however, it is not possible to assess the proportion of public resources from across government departments, that is being invested in the early years or to fully understand the impact on this of cuts in public expenditure.
2.12	**Increase investment in universal support to families through parenting programmes, children's centres and key workers, delivered to meet social needs.** The Government needs to re-affirm its commitment to providing key services through children's centres. Rather than reducing their capacity, children's centres should be the community hubs providing a range of support services for parents and children under one roof, including health services. Linked to health visiting and outreach work, children's centres should reach all families.
2.13	**Make provision for universal, good quality early years education and childcare proportionately according to need across the country**. Providing any education is not enough, since it is the quality of pre-school learning that appears to be critical for longer-term beneficial effects. The evidence indicates that current universal entitlement to child care is making the most difference to children from disadvantaged backgrounds and that expanding this would increase maternal employment and improve child development. 8 The Government should extend universal free entitlement of early years child care and education to 15 hours a week of early years child care and education for 48 weeks per year, for all children from the age of two until they enter school, and guarantee an additional 20 hours of subsidised childcare a week for families in which all parents are in work. This recommendation would greatly expand the current free entitlement, reflecting the evidence base that this would benefit all families, with the benefits most pronounced for those on low incomes.

Recommendations related to tackling poverty	
1.8	**Invest in the delivery of locally commissioned and integrated programmes encompassing welfare reform, skills and employment programmes to support people into work;**
1.12	**Expand the role of Credit Unions and take measures to end the poverty premium.** Central government could help to create a regional infrastructure to support and greatly expand the role of local not-for-profit member owned and democratically run institutions that offer affordable credit, such as Credit Unions.6 The government is currently rolling out a credit union expansion project with the Association of British Credit Unions (ABCUL) which involves £38m of funding over 3 years, to help credit unions expand and modernise.7 This now needs to be extended to develop a model that can realistically provide for the expansion of credit unions into disadvantaged communities on a scale that ensures they are an alternative to pay-day lenders. In addition, the central government should be lobbied to end the poverty premium, where the poorest often pay more for goods and services, such as utilities and banking.
1.14	**End in-work poverty by implementing and regulating a Living Wage.** Legislating so that all public sector contractors and government departments pay the living wage. Providing incentives for private sector organisations to pay the living wage such as tapered tax breaks over a limited timeframe.
1.15	**Ensure that welfare systems provide a Minimum Income for Healthy Living (MIHL).** Changes to the benefit system should take place to ensure that they provide a minimum level of income for those out of work and receiving benefits so that they can maintain health and wellbeing. The MIHL provides a benchmark for what is a safe minimum standard of living, which provides equality of opportunity for health and is supported by the World Health Organisation, Age UK and the Marmot Review of Health Inequalities in England. At the same time, current measures that are causing hardship, such as the 'Bedroom Tax', should be stopped.
1.17	**Develop a new deal between local partners and national government that allocates the total public resources for local populations to reduce inequalities in life chances between areas.** There needs to be a review of current systems for the central allocation of public resources to local areas to develop a coordinated approach across government departments that is focused on the objective of reducing the gap in joint public service outcomes (including for example health, wellbeing, education, housing, safety etc) between the most and least deprived areas. This must take into account the differential ability for areas to raise funds through other means such as local taxation and business rates. It must also show an appreciation of poverty in rural areas across the north, which has been underestimated in the past. For example there could be a place based weighting within funding formulas which applies across the public sector, from schools, local authorities, to the NHS, where the objective is to reduce the gap in outcomes between the most affluent and most deprived areas. Just allocating resource based on need will not on its own close the gap – for this to happen resources need to be distributed so that outcomes improve at a faster rate in poorer areas. This may require even greater investment than that solely based on an assessment of need.

2.8	**Reverse recent falls in the living standards of less advantaged families.** Recent economic improvements do not outweigh the damage inflicted during the downturn to the incomes of the poorest people across the country. Poorer members of society (both in and out of work) are under severe pressure. Urgent action is needed to address the cost of living faced especially by low income families, and to ensure all families can afford the 'basics'.

Recommendations relating to monitoring progress and impact	
1.9	**Extend the national measurement of the wellbeing programme to better monitor progress and influence policy on inequalities.** The measuring national wellbeing programme of the ONS develops and publishes a set of National Statistics which are used to monitor national wellbeing across 10 domains. These include health and the main determinants of health. At present this programme just monitors average levels of wellbeing and does not assess socio-economic inequalities in these measures. Indicators should be developed as part of this programme to track inequalities in health and wellbeing across all domains. Government strategy in particular strategies related to economic development should be more closely aligned to these measures of national wellbeing with progress regularly assessed against these indicators.
1.11	**Assess the impact of changes in national policies on health inequalities in general and regional inequalities in particular**
2.9	**Commit to carrying out a cumulative impact assessment of any future welfare changes to ensure a better understanding of their impacts on poverty and to allow negative impacts to be more effectively mitigated.** This would focus on the impact on people living in vulnerable situations, especially children
3.10	**Invest in and expand the role of Healthwatch as an independent community-led advocate that can hold government and public services to account for action and progress on health inequalities**. Healthwatch was established to have "a role in promoting public health, health improvements and in tackling health inequalities". However its focus has primarily been on promoting consumer rights for users of health and social care services. We recommend that local and national Healthwatch organisations are given a clearer remit to monitor progress and advocate for action on health inequalities and to hold local and national government to account for progress.