**Derby Health Inequalities Partnership**

**Terms of Reference v0.7 October 2023**

1. **Purpose**
	1. The Derby Health Inequalities Partnership exists to co-ordinate activity across local partners to reduce health inequalities in Derby.
	2. The partnership was established by Derby City Council and Community Action Derby in response to the COVID-19 Pandemic which highlighted significant inequalities in health risk factors and outcomes as disproportionately experienced by Black, Asian and Minority Ethnic communities, people living in areas of deprivation and disabled people. The partnership provides a shared space for discussion, decision making and actions to improve health outcomes and reduce inequalities primarily for these groups.
	3. DHIP is an important point of contact for community groups and leaders, acting as a bridge between system and community (both ways) and as a trusted source of accurate and evidence-based information.
	4. The partnership brings a community development, strengths-based approach to addressing health inequalities. Our work is grown from the bottom-up. To achieve this we work with existing community assets to build capacity, engage and plan activity with the wider community.
2. **Objectives**
	1. Facilitate community-led planning and action to improve health outcomes and reduce health inequalities through:
		1. Community consultation and engagement to understand what health issues are most important within our communities.
		2. Health promotion/education: supporting the development of knowledge, skills and confidence in health issues.
		3. An advisory function to health services and providers to improve their offer for our communities and holding to account for actions following that advice.
	2. To bring together communities, community organisations, health providers and commissioners to promote effective engagement and co-production of health-related activity.
	3. To develop and promote a shared understanding of the breadth of lived experience of health and wellbeing in Derby, so that plans, strategies and commissioned services make a difference to people’s lives.
	4. To work towards achieving secure and sustainable funding for Partnership activity.
	5. To develop an annual workplan which outlines strategic and operational delivery to achieve objectives.
3. **Membership**
	1. The core membership of the Derby Health Inequalities Partnership comprises local community organisations with an interest in improving health and wellbeing and reduce health inequalities in Derby. The core members are set out in Appendix 3.
	2. Membership and membership structures to the Partnership may evolve during the partnership’s initial development stages.
	3. Once fully established a review of the core membership will be conducted on at least a bi-annual basis.
	4. Additional attendees may be invited upon the discretion of the Chairs
	5. Further statutory and public sector partners will be invited in as the partnership requires or the opportunity arises.
	6. The Partnership may establish task and finish sub-groups to focus on specific work.
4. **Meetings**
	1. The Derby Health Inequalities Partnership will meet at least quarterly.
	2. The Chair of the Derby Health Inequalities Partnership will be shared between Community Action Derby and Derby City Council, Public Health.
	3. Derby City Council, Public Health and Community Action will share the provision of administrative support to the Partnership and will be responsible for arranging meetings, compiling minutes and for disseminating information amongst members.
	4. Decisions will be arrived at by consensus, as outlined in the Partnership’s *Decision-making and Prioritisation Framework*, provided in Appendix 4.
5. **Governance and Reporting**
	1. Reporting and accountability arrangements and relationships are set in Appendix 1.
	2. The Partnership has a strategic steering group. The core membership of the steering group will be drawn from Derby City Council Public Health, Community Action Derby, Derby Homes, and the NHS Integrated Care Board. Terms of reference for the strategic steering group can be found in Appendix 5.
	3. The Partnership will report to organisational boards/cabinets regarding the use of funds and delivery of outcomes.
	4. Operational working groups are established according to need in order to deliver on activity outlined in the workplan. These groups report into the steering group.

1. **Review of the Terms of Reference**
	1. The Terms of Reference will be reviewed at least annually and will be led by the DHIP Strategic Steering group.
2. **Appendices**
	1. Reporting and accountability arrangements and relationships
	2. Priorities
	3. Core Membership
	4. Decision-making Framework
	5. Steering Group Terms of Reference

**A.1 Appendix 1 - Reporting and accountability arrangements and framework**

**A.2 Appendix 2 - Priorities**

**Derby Health Inequalities Partnership Priority Setting 2023-24**

The priorities of the group will be shaped by input from the community and will reflect:

* Themes from consultation work and local insights
* Derby City Joint Strategic Needs Assessment
* Derby City Health and Wellbeing Strategy
* Funded programmes of work, such as NHS Core20Plus5, DLUHC Vaccine Champions
* Key reports and public health evidence-based practice

The key priority of this group in the immediate timeframe is to influence, advise and facilitate health and wellbeing service planning and interventions to make sure that they effectively address health inequalities in Derby.

Areas of concern that were highlighted in the PHE disparities report and reflected in local data are as follows:

* Infant Mortality (Maternal and Infant Health)
* Maternity
* Vaccination coverage
* Under 75 mortality rates from cancer
* Under 75 mortality rates from cardiovascular disease
* Obesity (including childhood obesity)
* Diabetes, heart disease and cancer
* Mental health and emotional wellbeing
* Healthy Life Expectancy

The NHS Core20Plus programme will also be used to guide targeting of priority groups. Core20PLUS is a national NHS England approach to support the reduction of health inequalities at both national and system level:

Core20 - The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD).

PLUS population groups are ethnic minority communities; \*inclusion health groups; people with a learning disability and autistic people; people with multi- morbidities; and protected characteristic groups; amongst others.

\*Inclusion health groups include: people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

The DHIP Consultation report highlighted key themes, recommendations and actions:

|  |  |
| --- | --- |
| *Consultation Recommendations* | *DHIP Actions* |
| Bridge the knowledge gap between healthcare professionals and communities, ensuring that information is widely accessible and that individuals can make informed decisions about their health. Part of this should involve the provision of translated resources and improved interpretation services. Acknowledgement of variation in digital literacy among populations and where it is not possible to avoid digital use, support to be provided. | Identify current position and policy - does Integrated care System have a framework/policy or minimum standards to support interpretation and translation across the system. Is there a digital literacy policy?  |
| Religious and cultural considerations to underpin all care, health promotion and information provided to individuals and communities. | Continue to scope good quality, effective Cultural Competence training provision (discussions started with Joined Up Care Derbyshire Quality Conversations Programme) – scope and develop core training to offer and deliver throughout system (content, costs, possible provider(s), what exists already, etc.)   |
| Community-based and co-produced health promotion and information events are required to address social norms and engage communities in culturally sensitive discussions regarding health behaviours. Consider hosting events in faith centres/places of worship. | Continue to support Core20Plus5 Connector activities, continue with DLUHC roll-out, continue to support other organisations delivering health events (but focus on providing advice and scrutiny to improve quality).  |
| Aim to develop Community of Practice and coordination role in relation to health events – to include comms, cultural competence and promotion of good practice.  |
| Support Black, Asian and Minority Ethnic families to talk openly about health issues including addiction, sexual and mental health. | Continue to support localised activity through Connectors but prioritise additional work – mapping and action planning, including scrutiny of data, locally commissioned services and identifying gaps and issues. Aim for normalisation as a long-term objective. |
| Increase number of community events which aim to tackle loneliness and mental health. | Continue to address through other actions, including cultural competence training (target local orgs like MIND). Connect and use informal opportunities/events taking place to promote DHIP and engage with additional groups, e.g. Black community event at Sinfin Park.  |
| Create publicity materials (Banner, flyer, impact report) with DHIP branding to support proactive activity.  |
| Healthcare professionals are to be trained to be culturally sensitive. Improvements should be made to the provision of culturally specific services, including those focused on drugs, alcohol, sexual health and preventive behaviours such as diet and physical activity. | Continue to scope good quality, effective Cultural Competence training provision (discussions started with Quality Conversations) – scope and develop core training to offer and deliver throughout system (content, costs, possible provider(s), what exists already, etc.)  |
| Healthcare professionals to be given further training on the use of medical tools on darker skin including phlebotomy and the use of pulse oximeters. | Continue to scope good quality, effective Cultural Competence training provision |
| Continued engagement with communities to improve understanding of the gaps in services currently provided. | Prioritise mapping of local services and start to create a simple directory/infographic for signposting to local services – possible action for *Health Without Borders* group to support as work has already started. |
| Health services commissioned locally by the government and NHS – such as Livewell, Phoenix Futures and sexual health services should measure and report on how effective they are at meeting the needs of Black, Asian and Minority ethnic communities. | Consider submitting a request oI to locally commissioned PH services to show how well they are currently meeting the needs of black and Asian minority groups in Derby – discuss initially at DHIP Strategy Group Submit formal requests for response to consultation recommendations to key local Providers |
| Transition away from top-down initiatives which do not consider the opinions and experiences of the communities being engaged with, instead NHS and Local Authority to build in the role of community participation. | Continue to support ICB Hypertension project, HWB Strategy refresh, Core20Plus Connector activities as all are examples of good practice in relation to community participation. Continue to raise profile of DHIP and its role in advising and promoting good practice with other organisations, events and activities. |
| The NHS should pro-actively and continuously work to build relationships with communities, particularly among the younger generations, providing support and gain their trust. | Explore work with Derby Youth Alliance and others to co-produce actions and next steps. Make funding available if required. |
| A health in all policies approach should be prioritised across Derby City Council for the purpose of building and sustaining an environment which promotes healthy behaviours. | To be explored as part of HWB Strategy development. |
| Further piece of work to be conducted into questions 5 and 6 ‘What would you like there to be more of to support you or your family’s health?’ and ‘What can we do to stop the unfair differences in health?’ as it was apparent that communities were not yet equipped to answer these questions. | Continue to support HWB Strategy work and explore further actions. |
| Specific actions should be agreed and prioritised as soon as possible to support the dissemination of this report across the system. | Formal request for response to consultation recommendations from all local Providers, plus dissemination of Impact Report.  |

The Steering Group will review priorities annually (using the decision-making and prioritisation tool) and will develop a detailed Workplan to outline priority actions. Note this is not about leading programmes of activity but influencing, advising, and connecting amongst the membership of the group and with health services (initially) to better enable community needs to be met.

The work of the group is likely to consist of:

* Advisory/reference group function
* Co-ordination of health promotion and community development activity
* Co-ordination and/or influence on service development around health for example cultural competence
* Co-ordination of focus groups around health focussed work
* Making sure of shared learning and application of best practice

Longer-term vision: we recognise that health services have a limited impact on health outcomes, so in the future we wish to include in scope wider determinants, cohesion, and integration etc.

**A.3 Appendix 3 - Core Membership (***not final and may evolve see point 3.2***)**

|  |  |
| --- | --- |
| **Organisation** | **Representative** |
| Active Derbyshire | Stuart Batchelor |
| Artcore | Ruchita Shaikh |
| BCM | Sonya Robotham |
| Black Lives Matter | Cecile Wright |
| Black Lives Matter | Val Watson |
| Children First | Irshad Baqui |
| Community Action Derby | Jonathan Dwerryhouse |
| Community Action Derby | Ejaz Sarwar |
| Community Action Derby | Amjad Ashraf |
| Community Action Derby | Natasha Cover |
| Community Action Derby | Ailya Habib |
| Community Imam | Ustad Burhaan |
| Community One | Ansar Hussain |
| Community Representative (previously Derby City Council) | Pamela Thompson |
| Council of Gurdwaras | Ranjit Seehra |
| DASP | Kuljit Tambur |
| DAWN | Sidra Rasool |
| Derby City Council, Locality Working | Neil Woodhead |
| Derby City Council, Public Health | Marie Cowie |
| Derby City Council, Public Health | Celia Edwards-Grant |
| Derby City Council, Public Health | Siobhan Horsley |
| Derby City Council, Public Health | Sajda Kausar |
| Derby City Council, Public Health | Simran Sanghera |
| Derby Homes | Kara Joskowski |
| Derby Homes | Carl Tring-Willis |
| Derby Women’s Centre | Yasmin Nazir |
| Disability Direct | Amo Raju |
| Evergreen | Misba Khan |
| Golden Generation | Riasat Hussain |
| Ikhlas Education Centre | Ghulaam Murtaza |
| Multi-Faith Centre | Geoff Sweeney |
| Pakistan Community Centre | Asaf Afzal |
| Reflection Path | Aftab Rehman |
| Reflections | Amer Salaam |
| Retired doctor / community voice | Dr Mussadaq Iqbal |
| Roma Alliance Derby | Shameem Malooq |
| Sahara Project | Jangir Khan |
| United Sisters of Derby | Tazim Fazal |
| West Indian Community Centre | Nezrine Hudson |

**Responsibility of Core Members**

* Members are expected to take responsibility to influence their own organisation to deliver actions agreed by the Partnership and to feedback on the issues raised.
* Be prepared to participate effectively in and contribute to partnership meetings.
* Encourage partners/colleagues to attend Task and Finish Groups where appropriate.
* Members should look for opportunities to identify, share and help secure resources to support the work on improving health and wellbeing and reducing health inequalities.
* If the capacity to attend every meeting is an issue, core members should share this with a deputy who will report and make representations on their behalf.
* Members are expected to primarily represent their organisations/community groups; however, it is understood that individuals may areas whereby they have secondary representation due to their personal own characteristics, ethnicity, direct experiences etc and this will be valued.

**A.4 Appendix 4 – Decision-making and Prioritisation Framework**

1. **Our Principles and Values**

The purpose of this framework is to support and underpin the decision-making processes of

Derby Health Inequalities Partnership, because insecure funding and limited capacity

of partners and members means that difficult choices sometimes have to be made.

The framework draws from community development practice and the Principles of Public Life (the Nolan principles).

Community Development recognises that some people, some groups and some communities are excluded and oppressed by the way society and structures are organised. It is fundamentally based on the values of human rights, social justice, equality and respect for diversity. The principles which underpin its practice, and therefore DHIP’s practice are:

* Self-determination - people and communities have the right to make their own choices and decisions.
* Empowerment - people should be able to control and use their own assets and means to influence.
* Collective action - coming together in groups or organisations strengthens peoples’ voices.
* Working and learning together - collaboration and sharing experiences is vital to good community activity.

<https://www.scdc.org.uk/who/what-is-community-development>

The Seven Principles of Public Life, which should also underpin DHIP practice and decisions are are:

* + 1. Selflessness - act solely in terms of the public interest;
		2. Integrity - do not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. Declare and resolve any interests and relationships;
		3. Objectivity - act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias;
		4. Accountability - be accountable to the public for decisions and actions and must submit themselves to the scrutiny necessary to ensure this;
		5. Openness - act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing;
		6. Honesty - be truthful;
		7. Leadership - follow and demonstrate these principles in own behaviour and treat others with respect.

These principles should be applied and followed at all times and DHIP members should feel

safe to challenge behaviour when principles are not followed.

1. Our approach to decision making (*based on ICB approach*)

DHIP will make significant decisions by ‘consensus’ and, where needed, in consideration of the criteria and scoring from the prioritisation tool. We expect reasonable disagreement about how we allocate resources. The consensus of decisions made will be mindful of DHIP’s aims and objectives (*link to these*). This framework will help us to treat disagreements respectfully so that those affected can sign up to decisions made by:

1. finding solutions that everyone actively supports, or at least can live with. This is done by ensuring that all opinions, ideas and concerns are taken into account. The assumption is that every member of the group or committee has a voice worth hearing and that all concerns are reasonable, and this is crucial to making good decisions. If a proposal is deeply troubling to even one person, that concern is respected; if it is ignored, the group is likely to make a mistake;
2. ensuring everyone in the group is committed to common goals that are clearly understood, and to be able to tell the difference between their personal preferences and what will help the group achieve its goals;
3. ensuring decisions are reached by consensus and reflect the thoughts and feelings of the group as a whole, rather than just the majority. Effective consensus building results in decisions that have been thoughtfully considered and take into account diverse experience and views.

DHIP: August 2023

1. **DHIP Prioritisation Tool**

**Criteria for Consideration**

1. Public Health and DHIP Impact – which DHIP consultation recommendations and actions, public health outcome Indicators (or causes), Core20Plus areas, DLUHC recommendations, does it aim to address?
2. Accessibility (who will access, how?)
3. Meeting needs of vulnerable groups and underserved communities (are these needs met elsewhere?)
4. Evidence of effectiveness (does it work/meet DHIP objectives?)
5. Efficient use of resources (does it represent value for money?)
6. Acceptability and sustainability (what would happen if funding/support was not provided?)
7. Monitoring and evaluation (Can/how will success be measured or demonstrated?

**Scoring**

**1-4 for each Criterion:**

1: Low = 5 points

2: Moderate = 10 points

3: High = 15 points

4: Very High = 20 points

**Prioritisation Scoring Template**

|  |  |
| --- | --- |
| **Intervention Name/Lead Organisation:**  |  |
| **Intervention Cost:** |  |
| 1. | Brief Description of service (including area/s the intervention is being delivered) |
|  |  |
| 2. | **DHIP Impact**: Does the intervention directly impact on DHIP recommendations and actions, Public Health Outcomes (causes), Core20Plus areas, DLUHC recommendations?If so, which outcomes/recommendations and how will your service impact on these. |
|  | Score =  |
| 3. | **Access**: Who is expected to directly benefit from this intervention? Can this be quantified?  |
| Score = |  |
| 4. | **Vulnerable Communities**: How does this address the direct needs of vulnerable communities/population groups in Derby City? |
| Score = |  |
| 5. | **Evidence of Effectiveness**: Is there evidence that this will work? Will it meet DHIP objectives and actions?  |
| Score = |  |
| 6. | **Efficiency/Monitoring and Evaluation**: Does this intervention provide value for money and how will success be measured/demonstrated? |
| Score = |  |
| 8. | Additional Comments |
|  |  |
| **Total Score:** |  |

**A.5 Appendix 5 - DHIP Strategic Steering group Terms of Reference**

**1. Purpose**

* 1. To provide strategic direction for DHIP activity, reflecting agreed aims, objectives, needs and priorities.
	2. Ensure effective joint working to achieve maximum impact from resources available, at both strategic and operational level.

**2. Objectives**

* 1. Oversight of Partnership meetings and the work of task and finish groups.
	2. Responsible for decision making and governance including records of decision making.
	3. Develop links with strategic partnerships within the city and co-ordinate input.
	4. Receive intelligence from communities and strategic partners and enable a co-ordinated response.
	5. Lead the learning and reflection process on DHIP ways of working to ensure improvement.
	6. Support leadership and skills development for the steering group and strategic connectors.

**3. Membership**

Derby City Council (Public Health, Locality Working)

Community Action Derby

Derby Homes Limited

Integrated Care Board/NHS

Strategic connectors: These members are from local communities, with a variety of roles (voluntary, community, paid) and are recognised as a credible voice by local communities. They have potential to highlight health inequalities within the system and act as champions for local change.

**4. Meetings**

Monthly

**5. Governance and Reporting**

Accountable to the Partnership and the organisations that members represent, through their usual reporting channels.

Terms of Reference to be reviewed annually (or sooner if this becomes necessary), along with the DHIP Terms of Reference.

1. Limitations

DHIP acknowledges that individual partners and members are bound by the roles, responsibilities and operating procedures of their respective organisations and this may limit the ability of DHIP to act independently. Where required, DHIP will use its agreed decision-making framework and prioritisation tool to navigate difficult and contentious decisions.