Health inequalities

Brent London Borough Council and Brent Teaching Primary Care Trust

Audit 2009/10

September 2010

audit commission

Contents

Summary report

Audit approach

1 The audit review was undertaken in two stages. Our initial work comprised:

- interviews with key staff and partners; and
- document reviews.

2 The first stage of the review was undertaken in late 2008 and reported in the early part of 2009 in a written report highlighting key strengths and potential risks. In July 2009, major partners held a stakeholder engagement event which reviewed actions on health inequalities. The Audit Commission's report findings were shared at this event. Our findings were subsequently presented to the Audit Committee of NHS Brent (the PCT) and the Health Overview and Scrutiny Committee of the London Borough of Brent (the Council).

3 The Corporate Area Assessment (CAA) undertaken in 2009 noted some specific aspects of health in Brent. This included high levels of Diabetes and Tuberculosis.

4 The second stage of our review (agreed in a separate project brief in late 2009) assessed how key stakeholders were addressing the risks identified in the first stage of the review. It also reviewed the arrangements in place to ensure delivery of the health inequalities programme. We extended our review to include how partners in Brent were working to address Diabetes and Tuberculosis - issues noted in the 2009 CAA review.

5 The fieldwork for the second phase of our review was undertaken in early 2010 and our emerging findings reported as a presentation to key stakeholders in April 2010. The agreed presentation is attached as appendix 1.

6 This final report brings together an updated summary of the stage one review, the presentation from phase 2 and the action plan and progress to date.

Acknowledgement

7 The PCT and the Council have both worked with us to gain some objective insight into its arrangements for addressing health inequalities, and we are grateful to staff and partners for their cooperation.

Introduction

8 Health inequalities are a key issue for both the Department of Health and the Department for Communities and Local Government. The gap in life expectancy between those at the top and bottom of the social scale is wide and has grown since the 1970s.

9 The Local Government Act 2000 places a duty on local authorities to promote the social, economic and environmental wellbeing of their area. The NHS operating framework for 2007/08 required Primary Care Trusts (PCTs) and local authorities to work together in partnership for the benefit of taxpayers and patients.

10 While some action is being taken nationally, the main contribution is made locally. Local authorities and PCTs know that they must act together if they are to address this issue and use their resources effectively. In many areas joint plans to address health inequalities will form part of the Local Area Agreement (LAA). Introducing local data on all age all cause mortality provides the incentives for effective partnership working between PCTs, local authorities and other partners that need to deliver the life expectancy aspects of the health inequalities target. It will also give flexibility for organisations to focus on the interventions that are most important to their local population.

Background

11 The London Borough of Brent is one of only two local authorities serving a population where most people are from ethnic minorities. Up to 8 per cent of residents are classed as refugees or asylum-seekers. The population is growing and dynamic with recent figures showing significant numbers of people moving into the borough creating new emerging communities, as well as significant numbers of transient people within the borough. Brent's official ONS population forecast in 2006 was around 270,000, although Council commissioned research suggests that this figure could be at least 10,000 higher and is growing strongly. Almost a quarter of residents are under 19 years old and, within the five renewal neighbourhoods, a third of residents are under 16 years old, compared with a fifth in London.

12 While some sections of Brent are relatively well-off, many residents experience high levels of deprivation and low incomes. The 2007 Index of Multiple Deprivation places Brent within the 15 per cent of most deprived local authorities in the country. The neighbourhoods experiencing the highest deprivation are largely found in the south of the borough, although this is changing with high levels of deprivation now seen in some pockets in the north of the borough. The most deprived residents also have the lowest income levels, highest unemployment levels, poor and overcrowded housing and the worst health outcomes across the borough. Men from the least deprived areas can expect to live over nine years longer than those in the most deprived areas and this gap has remained constant in recent years.

13 The first review identified the following key strengths.

- Clear strategic commitment from key partners to tackle health inequalities.
- Key individuals are strongly supportive of actions to lessen health inequalities for Brent.
- Key partnerships have been identified to tackle health inequalities.
- The Joint Strategic Needs Assessment (JSNA) provides a sound and shared foundation for work on reducing health inequalities.
- High-level commitment to performance managing health inequalities actions.

Key risks

14 The first review identified the following areas of risk.

- How can the sponsorship of health inequalities projects be made more explicit rather than implicit?
- How can the effectiveness and impact on health inequalities of the Overview and Scrutiny Committee be maintained?
- What actions are available to support engagement of the provider trusts in tackling health inequalities?
- How can partnership arrangements be further developed with the voluntary sector and service users and carers?
- What further refinement might be required to ensure the needs of all diverse communities are effectively captured?
- What possibilities exist to use of all the wider workforces to contribute effectively to reductions in health inequalities?
- Is extra Public Health capacity required to support the overall work programme?
- Where could further performance management framework support actions relating to heath inequalities?
- What further data is required to monitor performance and demonstrate impact?
- How can a clear plan or cross-cutting approach towards corporate responsibility help the wider determinants of health across all departments and organisations?

15 The key risks identified in the first phase of the review were adopted by the PCT and the Council. An action plan to address these risks has been developed internally and is being monitored by the Health and Wellbeing Steering Group. The action plan capturing progress made to date is attached as appendix 2.

Main conclusions

16 Our second stage review confirmed the clear strategic commitment from the Council and NHS Brent to tackle health inequalities. There is broad and shared understanding between local government and NHS partners that addressing health inequalities is a key issue for Brent. The Health and Wellbeing Strategy 2008 to 2018 represents a broad based approach capturing the ambitions and priorities for the Local Strategic Partnership (LSP) for improving the health and wellbeing of Brent's residents and their families. Previously, tackling health inequalities was not consistently embedded in other key strategies and the focus on outcomes was variable. The overarching strategic approach enables partners to work together to address health inequalities through agreed priorities and actions.

17 There is strong leadership for tackling health inequalities from both key stakeholders. The effective governance of all actions relating to health inequalities has been strengthened to ensure a continued approach to key actions.

18 Key partnerships are identified through the Health and Wellbeing Strategy. Partnership working to tackle health inequalities between the Council and the PCT has strengthened but partnership arrangements with wider bodies such as research and academic institutions, the voluntary sector and provider trusts are limited. The engagement of the public and communities of interest as partners is not yet embedded and there is limited challenge from Overview and Scrutiny (OSC) on progress in tackling health inequalities.

19 The JSNA developed jointly between the Council and the PCT is a comprehensive needs analysis and is the prime evidence base for the Health and Wellbeing Strategy and the NHS Brent Commissioning Strategy Plan. This identifies key issues for Brent and specifically the role of cardiovascular disease as having the most significant impact on life expectancy. Additional capacity is helping to support further data analysis. At a strategic level there is strong commitment from all partners to understand diverse communities. The JSNA is being refreshed to ensure that this understanding remains current and comprehensive.

20 Further use of the existing workforce to tackle health inequalities is possible. There are some good examples of local initiatives and evidence of an emerging wider approach. Public health capacity is developing and Non-Executive Directors (NEDs) and Councillors are making good progress in developing the skills and abilities to challenge plans on health inequalities.

21 The Council and the PCT are working more closely together on health inequalities and there is good commitment to the effective performance management of this issue. At the time of our initial review the Commissioning Strategy Plan had the most developed performance management. This has been extended to include the Health and Wellbeing Strategy and associated actions. The impact on health inequalities is constrained by a lack of clearly defined outcomes in some areas.

22 A corporate responsibility policy in relation to the wider determinants of health has not been developed. However the principles of corporate responsibility, that is how the organisation behaves for example, as an employer, a buyer of goods and services, as a landholder and commissioner of building work, are starting to be reflected in activities. Both the Council and NHS Brent have started to consider formally the financial implications of corporate responsibility. Further work will help ensure the principles of corporate responsibility are more explicitly reflected in future organisational strategies.

Diabetes and Tuberculosis

23 In Brent, the prevalence of diabetes is expected to rise by 20 per cent over the coming years and in July 2008 Healthcare for London reported poor scores for diabetic care. Subsequently improved outcomes became a specified objective in the Health and Wellbeing Strategy and the PCTs Commissioning Strategy Plan. A diabetic priority action group is in place with diabetic care pathway and guidelines and as part of the vascular risk assessment programme specific interventions for pre-diabetics are being offered.

24 Currently much of the Tuberculosis in Brent is imported and the current treatment approach has good completion rates. This is being supported with improved commissioning arrangements and a strengthened control approach. The Tuberculosis steering group and Tuberculosis clinical group have been reinvigorated with a timetable for action which includes a strengthened strategic approach later in 2010.

Appendix 1 – Presentation

NHS Brent & LB Brent
Tackling Health Inequalities – part 2

Part 2 – progress to date

Neil Sandys & Gary McLeod
26th April 2010

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Health Inequalities – scope of presentation

- Outline of the review & key lines of enquiry for part 1
- Identified key issues from part 1
- Key lines of enquiry for part 2 review
- Part 2 emerging findings
- Draft recommendations

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Health Inequalities – key metrics

- 2009 Annual Public Health Report indicates that for 2004-06:
  - life expectancy for Brent women is 83.4 years (London average is 80.9)
  - life expectancy for Brent men is 78.2 years (London average is 77.4)
  - Since 1991 life expectancy for men has increased by 4.6 years & 3.4 years for women
- The 9.3 year gap in life expectancy has persisted over a number of years - a recent reduction in the gap is linked to a reduction in life expectancy in Northwick Park rather than improvement in Harlesden

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Health Inequalities – narrowing the gap

Initial high - level review considered 6 key themes:

1. Delivering Strategic and Operational Objectives
2. Delivering in partnership
3. Using Information and Intelligence to Drive Decisions
4. Securing Engagement from the Workforce
5. Performance Management
6. Corporate Responsibility

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Health Inequalities – narrowing the gap

Key strengths

- Strategic commitment amongst key partners and key individuals are strongly supportive of actions to reduce health inequalities
- Key partnerships have been identified
- JSNA is a sound and shared foundation across the partnership for work on reducing health inequalities
- There is high level commitment to performance managing heath inequalities
- Risks from part one review actively addressed

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Progress on part one risks (1)

Key risk	Progress
• How can the sponsorship of HI projects be made more explicit?	• H&WB day /one of 6 key areas for stronger joint working and joint action plan to address previously identified risks
• How can the effectiveness of the HOSC be maintained ?	• Focused on NWL hospitals issues
• What initiatives are available to support engagement of provider Trusts in tackling Health Inequalities?	• Captured in commissioning intentions/ standards for better health
• How can partnership arrangements be further developed with – the voluntary sector; and – service users and carers ?	• Supported through appointment of Head of Partnerships – developing public and patient involvement
• What further refinement might be required to ensure the needs of all diverse communities are effectively captured?	• Further use of JSNA & work and primary care work

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Progress on part one risks (2)

Key risk	findings
• What possibilities exist to use all of the wider workforces to contribute effectively to reductions in health inequalities?	• Physical activity and green travel for LB Brent staff
• Is additional public health capacity required to support the overall work programme?	• Additional staff appointed/ new DPH appointment expected
• Where could further performance management framework support actions relating to health inequalities ?	• Captured in Health and Well-Being
• What further data is required to monitor performance and demonstrate impact?	• Captured in Health and Well-Being
• How can a clear plan or cross-cutting approach towards corporate responsibility assist in respect of the wider determinants of health?	• All plans contribute but not explicitly.

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Summary findings and key lines of enquiry for part 2

Progress in some areas, less in others. Second stage of review focused on:

➡ Are governance and arrangements for working together effective ?

➡ Are suitable arrangements in place to ensure delivery of the health inequalities agenda ?

➡ CAA follow-up - are suitable arrangements in place to address high levels of diabetes and TB in Brent ?

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Planning and monitoring to manage the gap (1)

Are governance and arrangements for working together effective ?

- Current position:
  - One of 6 key priorities as part of improved joint working between LA and PCT and prior risks being actively addressed.
  - Considering more explicit approach e.g. possible PMO approach
  - HI indicators to be included in Health & Well Being performance dashboard
  - Developing public and patient involvement.
- Arrangements could be improved by:
  - Clarifying roles and responsibilities
  - Having an agreed focus on Health Inequalities
  - HOSC could develop wider focus on longer-term strategy to narrow the health inequalities gap
  - Scope for stronger engagement with provider Trusts & voluntary sector

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Planning and monitoring to manage the gap (2)

Are suitable arrangements in place to deliver the health inequalities agenda ?

- Current position
  - Vascular health programme identified as a key intervention in CSP
  - Plan to develop a LES and & monitoring arrangements
  - Public health skills and capacity has been improved
  - Cardiovascular programme to be implemented from June 2010
- Arrangements could be improved by:
  - Developing a performance management framework to monitor actions which are intended to reduce the health inequalities gap
  - Consider an explicit corporate responsibility approach

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Planning and monitoring the gap (3)

Are suitable arrangements in place to address Diabetes ?

- Forecast 20% rise in diabetes over coming years
- July 2008 Healthcare for London report indicated poor scores
- Improving outcomes is a specified objective in H&WB strategy and the CSP
- Have diabetic priority action group & care pathway /guidelines:
- Have refreshed physical activity strategy and draft obesity strategy and specific focus in CSP
- Intervention for pre-diabetics

- No specific strategy
- Scope for further patient education.

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Planning and monitoring the gap (4)

Are suitable arrangements in place to address Tuberculosis ?

- Strong treatment approach with good completion rates:
- Current treatment approach to be complimented by strengthened control approach and improved commissioning arrangements.
- Have TB Steering Group and reinvigorated clinical group:
- No current strategy but do have timetable and plan for strategy in October 2010.

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Brent Health Inequalities – progress to date

Key messages:

- Risks identified in part 1 review adopted and monitored through Health and Well-Being steering group
- Despite prior finance pressures vascular risk programme is being implemented.
- Focus on monitoring actions to reduce the health inequalities gap actions through Health and Well-Being Steering group.
- Increased pressures on NHS funding will place ALL activities under scrutiny for effectiveness.

Improving the strategic approach

- How will things be different in
  - 10 years?
  - 5 years?
  - 1 year?
- How will Brent know if the right actions are being undertaken and if progress is being made?
- How does Brent ensure sustained collective and high level responsibility for this?

Improving the strategic approach

Recommendation 1

– **Ensure the Health and Well-Being Steering Group effectively monitors those actions intended to narrow the health inequalities gap.**

Tackling Diabetes and Tuberculosis

Is there a clear focus on the disease area ?

Can this be supported with effective project and performance management arrangements ?

Which interventions will provide sustained impact ?

Tackling Diabetes and Tuberculosis

Recommendation 2

– **Support task groups on Diabetes and Tuberculosis to identify interventions which will have measurable impact in the short, medium and longer-term.**

Summary

- Progress to date
  - Clear understanding of the issues.
  - Strong partner commitment.
  - High level approach to driving improvement.
  - Focused approach to addressing identified risks from part 1 review

- Key actions
  - Embed actions to address risk from part 1 review
  - Complete identified outstanding actions.
  - Monitor on-going progress of all HI actions in the light of reduced public sector funding.
- The way forward
  - Finalise summary report with recommendations.
  - Findings to inform the UoR assessment.

Appendix 2 – Action plan

Appendix 2 – Audit Commission Review of Health Inequalities in Brent

Risk	Action to address risk	Actions needed	Officer responsible	Timescale
1. How can the sponsorship of health inequalities projects be made more explicit rather than implicit?	The role and remit of the Health and Wellbeing Steering Group is being reviewed. This group will take the lead in ensuring actions to address health inequalities are embedded in the delivery plans of partners, including service areas in the council. Terms of reference and membership are also being reviewed so that group has the right people on it and it is addressing the right issues. This is in recognition that its function has changed since the Health and Wellbeing Strategy was developed. The chair of the Health and Wellbeing Steering Group will rotate between NHS Brent and the council and the work programme is to be developed jointly by the two organisations. This is to reflect the work streams that are being taken forward by each organisation.	The Health and Wellbeing Steering Group needs to: • confirm its terms of reference; • confirm group membership; • agree a work programme and meeting schedule for the coming year. The work programme will be updated at each meeting; • agree reporting lines for the Group and its position within local authority, PCT and LSP structure; and • identify other groups working to deliver Health and Wellbeing Strategy work streams through a mapping exercise.	Simon Bowen and Cathy Tyson	To be completed by May 2010

Risk	Action to address risk	Actions needed	Officer responsible	Timescale
	Reporting lines for the group and other existing groups that are working to address health inequalities (such as the Strategic Obesity Group) will be clarified. At present many of these groups are working in isolation and need to be part of a coherent structure with clear reporting lines so that outcomes can be monitored and evaluated.			
2. How can the effectiveness and impact on health inequalities of the Overview and Scrutiny Committee be maintained?	More effort is being made to work with the Health Select Committee so that health inequalities are a bigger part of their work. In the last three meetings, the committee has considered reports on: • Local Area Agreement Performance Indicators; • Smoking Cessation; • Obesity (at two separate meetings); • Public satisfaction with access to GP services; and • Childhood immunisation. Efforts are also being put into the development of a performance report to monitor the work being done in the borough to address health inequalities.	Agree Health Select Committee work programme, including health inequalities issues and reporting of performance information.	Cathy Tyson	Work programme to be agreed in June 2010

Appendix 2 – Action plan

Risk	Action to address risk	Actions needed	Officer responsible	Timescale
	As well as being monitored by the Health and Wellbeing Steering Group, this will be reported to the Health Select Committee on a regular basis so that members are aware of the major challenges in addressing health inequalities.			
3. What actions are available to support engagement of the provider trusts in tackling health inequalities?	The engagement with provider organisations on tackling health inequalities is limited at present. They do have a role to play in this regard, promoting healthy lifestyles to patients, addressing issues such as smoking and referring patients to smoking cessation services. Tackling health inequalities is one of the Care Quality Commissions standards for better health and so the work they do to address health inequalities should be reflected in their submissions. There may be opportunities to influence provider organisations through the commissioning cycle and include a health inequalities element within contracts. This needs to be explored by NHS Brent commissioners to see what scope there is for this.	Contact NWL Hospitals and CNWL to seek a nomination to the Health and Wellbeing Steering Group. Work with NHS Brent commissioners to see what scope there is to include a health inequalities element into contracts with providers, and consider how this can be monitored. Current contracts include quality schedules and CQUIN (Commissioning for Quality and Innovation) payments. These elements need to be clarified – agreed to invite an officer from commissioning to attend the group to identify how this issue can be taken forward through contracts.	Simon Bowen	September 2010

Risk	Action to address risk	Actions needed	Officer responsible	Timescale
	The revised membership of the Health and Wellbeing Steering Group includes a place for a representative from North West London NHS Hospitals Trust and Central and North West London NHS Foundation Trust. Both organisations will be approached seeking a nominee for the group.	Monitoring of Standards for Better Health declarations from NWL Hospitals on tackling health inequalities. The Trust will be invited to attend the group to discuss this issue.		
4. How can partnership arrangements be further developed with the voluntary sector and service users and carers?	Both the council and NHS Brent are moving away from a grants based funding regime to setting up contracts with voluntary sector organisations to deliver its priorities and aims, including tackling health inequalities. This needs to be further developed and there maybe issues within the voluntary sector that need to be addressed so that are able to prepare bids for such contracts. A conference has taken place with the voluntary sector to inform them of health and adult social care commissioning. There will be a voluntary sector representative on the Health and Wellbeing Steering Group which should help relationships with the sector and hopefully flag up any issues that voluntary organisations have in helping to address health inequalities.	Invite a Local Involvement Network representative to be on the Health and Wellbeing Steering Group. Annual stakeholder event to be held to consider ways to consider the major health inequalities in Brent and how they are being addressed by organisations in the borough.	Cathy Tyson/ Kostakis Christodoulou	Ongoing

Appendix 2 – Action plan

Risk	Action to address risk	Actions needed	Officer responsible	Timescale
5. What further refinement might be required to ensure that the needs of all diverse communities are effectively captured?	The council has a well developed evidence base which provides comprehensive information on Brent's different communities. This is publically available and is used by NHS Brent. Whilst the evidence base is one useful source of information, greater use needs to be made of qualitative information that is robust and reported widely so that individuals can inform and influence services in the borough. The council and PCT are working on the development of a partnership consultation strategy and action plan. Within this there is a commitment to share resources and information so that better informed decisions can be made on services in the borough. The strategy will be completed by May 2010.	Continue to update and refresh evidence base, ensuring information is provided from within the council and PCT to improve its content. Implement Partnership Consultation Strategy from May 2010 and engage with Community Engagement Team at NHS Brent to consider the information they are picking up in engagement work. Refresh JSNA.	Cathy Tyson	Ongoing
6. What possibilities exist to use of all the wider workforces to contribute effectively to reductions in health inequalities?	There are numerous opportunities to use the wider workforce of both the council and PCT to contribute to addressing health inequalities. The Health and Wellbeing Steering Group have held discussions with Housing Services on the possibility of housing officers contributing to this agenda, by providing information on healthy lifestyles to tenants, or signposting them to different services (smoking cessation, for example).	Add workforce issues to the Health and Wellbeing Strategy Group work programme for further consideration.	Simon Bowen and Cathy Tyson	September 2010

Risk	Action to address risk	Actions needed	Officer responsible	Timescale
	Discussions are to continue on this issue to. Other officers who have significant contact with members of the public (such as environmental health officers) could offer similar advice where appropriate. Health visitors also need to be engaged again on this issue, to make sure they are providing the messages needed to people they are in touch with. Ultimately, this is a training issue that the Health and Wellbeing Steering Group will be working to address.	Consider the training requirements for council and PCT staff to enable effective intervention – focus on frontline staff. Ideas include: • frontline staff to be trained so that they are able to signpost or refer people to help for various health issues – possibilities include fuel poverty, smoking, exercise and diet. The Audit Commission has produced case studies on this type of work to be used as a guide for the group; and • agreement to start on small scale to see how this work progresses – complex and difficult issue, but frontline staff are an excellent resource.		
7. Is additional Public Health capacity required to support the overall work programme?	This recommendation has been made in the context of shrinking PCT budgets and so providing extra resource may not be possible, but it would be helpful. NHS Brent has appointed a Health Improvement Consultant to lead on the health inequalities agenda, but at present there are no plans to commit further resource to the Public Health Team.	NHS Brent intends to make best use of existing staff so they are contributing to tackling health inequalities (see above, training example). But there are no plans to recruit further public health specialists at this current time.	Simon Bowen and Cathy Tyson	On-going

Appendix 2 – Action plan

Risk	Action to address risk	Actions needed	Officer responsible	Timescale
8. Do performance management systems support the monitoring and evaluation of activities necessary to address health inequalities?	The Health and Wellbeing Group is working to put together a performance framework to monitor activity aimed at reducing health inequalities in the borough. This will be agreed at the Health and Wellbeing Group meeting in April 2010. Regular monitoring of the framework will become a key activity for group, which will follow up areas of poor performance during its meetings. Health Select Committee will also provide member input into this process.	Develop and agree performance framework to monitor the impact of work designed to address health inequalities. Agree monitoring regime for Health and Wellbeing Steering Group, LSP Board and Health Select Committee.	Simon Bowen and Cathy Tyson	September 2010
9. Where could further performance management framework support actions relating to heath inequalities?		See above – work is happening to address this.		
10. What further data is required to monitor performance and demonstrate impact?	Work is taking place to identify the relevant performance indicators, but they will relate to actions in the Health and Wellbeing Strategy. One of the issues identified by the Health and Wellbeing Steering Group is that many indicators don't show significant changes over the short term (eg changes in life expectancy) and so monitoring the impact of interventions requires a balance of long and short term indicators.	See above re performance indicators.		

Risk	Action to address risk	Actions needed	Officer responsible	Timescale
	Indicators will be drawn from the LAA, Health and Wellbeing Strategy, National Indicator Set and local set priorities.			
11. How can a clear plan or cross cutting approach towards corporate responsibility assist in respect of the wider determinants of health across all departments and organisations?	The Health and Wellbeing Steering Group will be responsible for taking this forward – its key objective will be to embed tackling health inequalities in the delivery plans of the council and PCT. It will need to ensure that those delivering services are aware of the impact their actions have on addressing health inequalities and that their services compliment this work. The Health and Wellbeing Steering Group work programme will need to look beyond traditional areas of work to see where the connections with health inequalities can be made in other council and PCT developments.	Agreed to present the second stage Audit Commission report to the joint Executive Management Team meeting to see how they want this issue to be taken forward. The group will review the PCTs health and wellbeing programme at a future meeting to see what lessons can be learned for future initiatives. Agreed that tackling health inequalities needs to be explicit in the new Brent Council Corporate Strategy, to be approved by July 2010.	Simon Bowen Cathy Tyson	Joint Executive Group 5th October 2010

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