Tackling Health Inequalities in Haringey

Final report

June 2008

Contents

Appendices

1 Executive summary

1.1 Context

Health inequalities are differences in health experience and health outcomes between different population groups for example, by socio-economic status, geographical area, age, disability, gender, or ethnic group.

This review assesses the extent to which public sector organisations in Haringey understand their local health inequalities; direct resources appropriately to address the gap; have arrangements in place to challenge and review their actions, and know how well they are doing.

1.2 Main conclusions

Overall we have found that, compared to other reviews we have carried out in the South East of England, that Haringey is advanced in its health inequalities agenda and it is important that this momentum is continued and further enhanced. Although some areas for improvement have been identified, it should be noted that outcomes for local people are generally moving in the right direction.

Referred to within this document are the results of a 'SNAP' survey - this survey was sent to officers and staff of both the Borough and the PCT and additionally members of the voluntary sector. We received 18 responses to the survey and hence the results cannot be taken as being statistically significant, however we have included some reference to these results to generate discussion. We have included the replies from this survey in Appendix B for reference.

Our main conclusions are summarised below and our recommendations are detailed in Appendix A;

- Review of the various agencies' strategies demonstrates that there are good structural links in place across the partnership to promote health and wellbeing. Each strategy document has its own focus but it is clear to see how the various documents relate to each other with the clearly stated aims of improving well being and reducing HI.

  A key challenge for the partners going forward will be to look at developing further the Joint Strategic Needs Assessment (JSNA). The development of the JSNA at Haringey is potentially more challenging than other areas given the inherent high mobility of the population in this early part of the 21st century, especially since the admission of the accession states to the EU.

- There are examples of strong joint work on specific areas and issues. There is the joint appointment of the Director of Public Health, which is a funded via a 50/ 50 split between the Council and the PCT. There is a clear agreement that there is a shared process with partners for identifying local health inequalities, and Haringey has been recognised within the community for its partnership work.

- We took the view that although there has been engagement with provider trusts for the Health Inequalities agenda their focus did not yet reflect their crucial role in taking HI forward. They have crucial information on people who regularly present to A&E who suffer from health inequalities and such data could be used to enhance understanding of HI issues within the Borough.

- There is a strong relationship with the voluntary sector, in particular with HAVCO, which has provided access to information to feed into the health inequalities agenda. There is

an opportunity for the partnership to become more involved with research institutions and to potentially identify a university with an interest in HI to join the partnership board.

- The LAA has recently been updated with significant commitment to 35 challenging targets, some of which focus on health and wellbeing. Once these have been finally agreed it will be important to update the well being scorecard and monitor these targets. There is a strong flavour of improving health and well being within the 35 targets.

- The last public health report was in 2006, however the Director of Public Health, since appointment in January 2008, has been working on the JSNA which will in effect become the next public health report. The report will develop in a more interactive fashion than the current public health report, which is a more traditional public sector organisation driven model. It is clear that there will need to be an appropriate IT platform in place to support the functionality that is envisaged for the JSNA.

- There is currently a shortage of analyst skills within the public health team there is scope to work more closely with the Council in terms of providing more capacity in this area.

- Joint training in public health needs to be enhanced at all levels, we see particular benefit for joint member/ NED training in this area to embed partnership working further.

- The WBPB agenda needs to be more clearly focused on Well Being Strategic Framework outcomes. Each agenda item should be clearly linked to either a HI target or future strategic development.

- The Well Being Scorecard has been developed which represents a realistic measurement tool, however at this stage it does not have the level of attention/focus at the Well Being Partnership Board that we believe it merits. We a regular report from the Well Being Chair Executive that highlights challenging areas.

- There have been several examples identified of good practice in relation to wellbeing programmes run for staff at partner organisations. Examples include staff concessions at leisure centres, tips on staying stress free, and programmes at both the Council and the PCT focussing on cycling and walking to work. There is also a scheme in place at the Council known as the Haringey guarantee which is a scheme for tackling worklessness through working with employers and local communities to provide work and skills for local people.

- Although the programmes identified above are all positive, we have not found evidence of corporate responsibility policies in place at partner organisations, these would enhance the development of well being programmes across the Borough and provide an example to other organisations which Haringey works in conjunction with.

Our detailed findings are highlighted in Section 3 of the report.

2 Background and context

2.1 Background

At present, there are significant levels of health inequality in some parts of the country. The basis of the issue is that some groups of the population suffer from significantly greater ill-health (morbidity) and earlier death (mortality) than the average and other groups of the population. Understanding which groups of the population these are and doing something about it is the underlying principle of this review.

The existence of health inequalities in their own right presents risks to public sector organisations. Deprived communities and their populations suffering from ill-health and increased morbidity will reduce access to work opportunities and contribute to levels of poverty and economic decline. People suffering from increased ill-health required increased support in terms of incapacity benefit and income support.

Premature death causes economic impacts in a wide variety of ways. The direct costs to health services alone of dealing with death through accidents, coronary heart disease, cancer, stroke and mental illness, as well as other issues, are well documented.

2.2 National context

Health and wellbeing is a key national focus for improvement. Narrowing the health gap between the most disadvantaged groups and the rest of the country is a top government priority. This is reflected in a single nationwide Public Services Agreement (PSA) target to reduce inequalities in health outcomes by 10% by 2010, as measured by infant mortality and life expectancy at birth. Reducing health inequalities is also one of the four top-level priorities in the 2007/ 08 NHS operating framework.

Tackling health inequalities is a new formal requirement on both local authorities and Primary Care Trusts (PCTs). The principal role is set out for PCTs in the Department of Health's 'Roles and Functions' statement in May 2006 as follows;

'Improving the health status of its population and reducing health inequalities, in partnership with local authorities'.

The 2004 White Paper 'Choosing health: making healthy choices easier' resulted in health inequalities targets being included in PSAs for all government departments. 'Health Challenge England - next steps for Choosing Health 2007' sets out a new approach that aims to enable everybody to make a contribution to the nation's health. Further investment is expected to help achieve sustained improvement in health with a specific focus on inequalities, smoking, obesity, alcohol and substance misuse, sexual health including teenage pregnancy and mental wellbeing.

The 2007 White Paper 'Strong and prosperous communities - Health and Wellbeing' builds on this, placing the challenge of addressing health inequalities at the heart of changes. In particular, there is a focus on strengthening partnership working on the health agenda and the quality of scrutiny and overview arrangements.

The Department of Health's 'commissioning framework for health and wellbeing' sets out a reform agenda for the health service. It emphasises the need for joint strategic needs assessment by Councils, PCTs and other relevant partners; and the effective sharing and use of information.

2.3 Local context

Haringey is a Borough of major contrasts with significant differences in affluence and deprivation between the east and the west of the Borough. This is reflected in the indicators of health where the worst indicators are seen for those living in the east of the Borough.

There are two indicators of health within Haringey that are of particular concern. Firstly, Haringey has more deaths in babies under 1 year old than most other parts of London and the UK. Secondly, although life expectancy in men is improving, there are significant differences for men born in the east of the Borough compared with men born in the west of the Borough.

Deprivation is a key issue for Haringey. Haringey is the 13th most deprived borough in England and the 5th most deprived in London. Socio economic deprivation has a key impact upon people's health and this is reflected in the fact that overall, people have a higher life expectancy in the affluent west compared to the east of the borough.

2.4 Health inequalities in Haringey

Overall, people in Haringey live longer than they did a decade ago, but on average die younger when compared to the population of England and Wales. There has been a slight rise in life expectancy for women since the last Public Health report in 2006 and females born between 2002-2004 are expected to live 5.5 years longer than males born in the same period. Male life expectancy in Haringey at birth during this period was lower than the national average of 76.5 years by 1.8 years, and this gap has widened since the last equivalent period in 1996-1998.

However, progress is being made in improving the health of local people and reducing health inequalities. The Standardised Mortality Ratio for all causes and all age groups is improving compared with the national average, and the life expectancy plan outlines priorities to reduce premature mortality within the Borough.

2.5 Audit approach

This review assesses the extent to which public sector organisations in Haringey understand their local health inequalities; direct resources appropriately to address the gap; have arrangements in place to challenge and review their actions; and know how well they are doing. This review has focused on six key areas as follows;

The work involved:

- surveying partner organisations;
- document review;
- interviews; and
- focus groups.

The review was designed to examine six main issues:

- how partners set and deliver strategic and operational objectives in relation to health inequalities;
- how partners work together to tackle health inequalities;
- how partners use information and intelligence to drive decisions;
- how partners have engaged their workforce in the health inequalities agenda;
- how partners manage performance; and

- how partners are approaching the issue of corporate social responsibility.

The outcome of the review is a joint performance report across local government and the health economy in Haringey. It identifies risk areas, makes high-level recommendations, and shares notable practice to help improvement planning. An action plan is included in Appendix 1 to help partners move forward on reducing the health inequalities gap and address recommendations for improvement.

We would like to take this opportunity to record our appreciation for the efforts and assistance of Eugenia Cronin, joint director of public health, Helena Pugh from Haringey Council, Vicky Hobart from Haringey PCT, and all other staff who have taken part in this review.

2.6 Status of this report

This report was finalised and approved at the Well Being Partnership Board on the 2nd October 2008.

This report has been prepared for the members of London Borough of Haringey and the directors of Haringey Primary Care Trust, and should not be relied upon by any third parties.

3 Delivering strategic and operational objectives

3.1 Context

The health inequalities agenda is complex. In order to tackle this effectively, it is essential that organisations have a strategy to tackle inequalities that is based on health need.

It is difficult for a range of separate organisations to make a difference unless they work collaboratively. Organisations across the economy should therefore have a shared vision, identify common priorities and develop a strategy to improve health, which is jointly owned by all parties. This requires strong leadership, and management arrangements that are "fit for purpose". It also requires individual organisations to develop a clear link between the shared, economy-wide priorities and their own commissioning / procurement plans.

3.2 Is there a strategy for tackling the health inequalities agenda that is based on health need?

There are a number of strategies for tackling health inequalities within Haringey. Overall responsibility for addressing health inequalities rests with the Haringey Strategic Partnership (HSP). The HSP has developed a Community Strategy, and there are 6 agreed outcomes from this strategy with one being 'Healthier people with a better quality of life'. This sets out ambitions to reduce Health Inequalities and looks at why reduction is important, what the objectives and targets are and also how success will be measured.

The Community Strategy is supported by the Council Plan and links into the Plan's key priority of 'encouraging lifetime wellbeing at home, work, play and learning'. There are also strong links into the key strategic priorities of the Haringey PCT Commissioning Strategy Plan, such as 'promoting a healthier Haringey by improving health and well-being and tackling Health Inequalities'.

One of the four fundamental building blocks in the LAA is 'Healthier Communities and Older People' and there are a number of mandatory and optional indicators for measuring progress within the Healthier Communities and Older People block..

The Wellbeing Strategic Framework (WBSF) is the key strategic framework for reducing health inequalities and improving wellbeing in adults. This has been approved by the Wellbeing Partnership Board (WBPB) and represents an action plan to improve life expectancy and reduce health inequalities.

Review of the strategies that are in operation demonstrates that there are good structural links in place to promote health and wellbeing. Each strategy document is different but it is clear to see how they relate to each other with the ultimate aim of reducing health inequalities.

A key challenge for the partners going forward will be to look at developing further the structure of the Joint Strategic Needs Assessment (JSNA). This will describe the means by which partners will describe the current and future healthcare needs of the Borough and what the strategic direction of service delivery will be to ensure these needs are met. The development of the JSNA at Haringey is potentially more challenging than other areas given the high mobility of the population. Haringey is ambitious in going beyond the minimum data set required for the JSNA and seeking to enhance the quality of the data set further to ensure that a robust JSNA will result in more effective commissioning to improve well-being and to reduce Health Inequalities.

Recommendation 1 - to continue the development of the JSNA

Haringey has decided to go beyond the minimum data set in developing the JSNA and it is likely there will be considerable planning required to obtain detail for secondary analysis. There are also potential difficulties in developing a JSNA given the high mobility of the population, therefore partners will need to ensure that proper arrangements are in place to ensure development of the JSNA is successful. If this is the case, it is highly likely that benefits will arise in the form of more effective commissioning aimed at improving health and well-being and reducing health inequalities.

3.3 Is the leadership of this strategy clearly defined and operating effectively?

Leadership of the health inequalities appears to be sound. There are clear structures in place that sit underneath the Haringey Strategic Partnership, in the form of Well-Being Partnership Board and the Wellbeing Chairs Executive - both of which have the aim of promoting and delivering a healthier Borough. Each supporting programme and initiative is assigned a lead agency which is responsible for its delivery.

3.4 Is wider public health expertise influential in developing strategies?

The public health teams at the PCT and key officers within the Council have been instrumental in setting health priorities that, in turn, have informed strategy development at an organisational and partnership level. The Haringey Strategic Partnership (HSP) has also consulted with other stakeholders through a consultation event attended by over 130 people in February 2006 which focussed on 7 key issues identified to help Haringey people live healthier and longer lives. As detailed in Section 3.3 the recent appointment of the Joint Director of Public Health also brings a fresh perspective, as experiences and best practice identified from other areas can be used to assist Haringey in further development of its strategies.

3.5 Are strategic priorities being implemented with clear accountability and delivery mechanisms?

High level progress against the relevant LAA targets is monitored by the HSP. The Well Being Strategic Framework Implementation Plan is the key delivery vehicle for accountability and achievement of strategic outcomes.

A well-being scorecard has been developed and this incorporates all targets and these are monitored at the Well-being partnership board. The scorecard is updated on a quarterly basis. The WBPB has 5 sub groups, organised around the 7 outcomes of the WBSF. The chairs of these sub-groups have been identified as lead contacts for each of the outcomes.

We see the well being scorecard as a crucial initiative in helping to monitor outcomes and challenge performance.

3.6 Are Health inequalities strategies and commissioning plans reflected in financial plans and budgets?

Our survey identified that when respondents were asked the question as to what extent to they would agree with the statement 'that my organisation's financial plans identify resources for achieving the health inequalities plan' nearly 90% agreed. This has also been evident from examples identified such as Recreation services and Libraries at the Council whereby funding for promotions in respect of healthy eating, recreation and smoking cessation has occurred and therefore incorporated into budgets and financial plans.

However, when respondents were asked the question 'indicate the extent to which a cost benefit analysis of options for action *to reduce HI* has been undertaken in the last 2 years, 57% either disagreed or disagreed strongly. It would appear therefore from this survey and also feedback from meetings with staff that there could be some additional investment put into this area to ensure there is a clear understanding of what the costs and benefits are when options are being assessed.

Recommendation 2 - to improve cost/benefit analysis of options to reduce HI.
We recommend that partners further promote a wider understanding of and focus upon the costs and benefits of options of specific courses of action to reduce Health Inequalities.

4 Delivering in partnership

4.1 Context

The causes of health inequalities are complex. Individual organisations can help to address health inequalities by introducing local solutions. However, they are more likely to have a significant impact if they work in partnership with other bodies to identify the root causes of health inequalities and provide joint solutions. In order to deliver systematic and sustainable change, it is essential for health and local government organisations to work together to tackle health inequalities. This requires the engagement of service providers as well as commissioners. Working with universities and the voluntary sector can also be hugely beneficial in identifying issues and delivering solutions to specific groups - especially hard to reach communities.

4.2 Have appropriate partnerships been identified and are they engaged? Are Local Strategic Partnerships (LSPs) and Local Area Agreements (LAAs) being used effectively to deliver change?

A wide range of partners contribute to the health inequalities agenda. The Haringey Strategic Partnership (HSP) has developed a Community Strategy which sets out broad and general ambitions for the Borough to achieve by 2016. Haringey has evidenced its commitment to reducing health inequalities through its recent update in the Local Area Agreement (LAA) where 35 improvement targets have been set. The HSP has set up 5 theme boards for each of the 5 themes in the LAA, one of which is the Well Being Partnership Board, which has overall responsibility for implementation of the Well Being Strategic Framework (WBSF). The Wellbeing Partnership Board (WBPB) is comprised of representatives from the PCT and Borough Council, voluntary sector and provider Trusts. The Well Being Chairs Executive oversees this partnership board and considers its agenda.

Partnership arrangements have historically been very good within the Borough and this has been extended towards the commitment to tackling health inequalities across all organisations. Additionally, good working relationships are in place at top management level. Our survey results indicated a good level of commitment to the health inequalities agenda, with strong agreement that top management are committed to tackling health inequalities and general agreement that joint decision-making in this area is effective.

The Local Area Agreement (LAA) has a strong focus on the health inequalities agenda; there has been recent update which has identified 35 improvement targets. The Well Being Partnership have devised a Scorecard that monitors the achievement of these targets and it is important that this scorecard is updated once the LAA has final ministerial sign off in June 2008.

Good sideways communications between organisations and close working relationships between operational staff have also had a positive impact on the health of local people. There is the joint appointment of the Director of Public Health, which is a funded via a 50/ 50 split between the Council and the PCT, which is unusual as health inequalities has been mostly seen as a PCT issue in other areas.

4.3 Do overview and scrutiny committees challenge progress on tackling health inequalities?

Overview and scrutiny committees should be an effective resource for challenging the progress being made in tackling the health inequalities agenda. In reality, however, these committees may lack the knowledge of the health inequalities agenda to provide that challenge. Within Haringey the Overview and Scrutiny Committee has shown interest in getting involved in the health inequalities agenda. We consider that the challenge role of scrutiny will best be exercised when:

- The WBPB have fully embedded their strategies for delivering improved health and well being
- Robust data on outcomes is available for challenge and review

We attended the Well Being Partnership Board and assessed how well it addressed strategy and performance issues within the Well Being Strategic Framework Implementation Plan. The WBPB had an extremely full agenda and at this particular meeting the discussion mainly centred around strategy documents, a process which is seen as completely necessary, however this focus on strategy meant that review of performance (through the Wellbeing Scorecard) was neglected. We recommend that consideration be paid to the structure of the agenda of these meetings and that it is better linked to the Well Being Strategic Framework. Operational issues should only form part of this agenda if they are linked to the outcomes of this framework.

Recommendation 3 - improve structure of WBPB
Consider the agenda of Haringey's Well Being Partnership Board to have a balance between strategy and performance issues with specific linkages to the Well Being Strategic Framework. Following embedding of the Implementation Plans consideration should be given to involving Overview and Scrutiny to challenge the progress made against the Health Inequalities agenda.

4.4 Are provider trusts engaged in the health inequalities agenda?

The terms of reference for the HSP include membership of the provider trusts, there is also representation on the WBPB. The PCT and Borough have engaged provider trusts however their presence and focus did not yet reflect their crucial role in taking the HI agenda forward. We noted that there had been non-attendance at the last two meetings of the WBPB by provider Trusts. Health inequalities are having a significant impact on emergency admissions and activity in A&E and secondary care provision, which can lead to pressure on achieving national targets. As such we consider that, given that the population of Haringey are highly mobile and there is a tendency of that population to attend A&E rather than a GP, that provider Trusts have access to significant amounts of information to aid in the health inequalities agenda and greater input is required.

Recommendation 4 - effective involvement of provider trusts
There are opportunities to improve the effectiveness of provider trusts within the health inequalities agenda. In particular, they could provide further information on A&E attendance levels.

4.5 Are the public and communities of interest effectively engaged as partners?

Haringey has a strong relationship with the voluntary sector, notably with its involvement with Haringey Association of Voluntary and Community Organisations (HAVCO). This is further evidenced by the Community and Voluntary Sector having 6 members on the 33 member HSP. There are also community and voluntary sector representatives on each of the thematic boards reporting to the HSP.

Whilst engagement with the voluntary sector has been positive it is recognised that there exists opportunities to engage further with research institutions and to potentially identify a university with an interest in HI to join the partnership board. It is understood that universities undertake a lot of research into health inequalities and their causes. However, their relationships with the organisations that are responsible for tackling the health inequalities agenda are not always well developed.

There has been evidence in the past of engagement with members of the public in developing health strategies and the Public Health team expect to hold similar community meetings prior to the completion of the Joint Strategic Needs Assessment (JSNA). Our survey results found however that there was a lack of clarity on what the mechanisms were for members of the community to get involved in developing action on HI.

Recommendation 5 - improve engagement with the public and communities of interest
Opportunity exists to engage with research institutions to understand what their role could be in the health inequalities agenda. Once engaged that resource could be used to commission further studies on areas where gaps currently exist.

5 Using information and intelligence to drive decisions

5.1 Context

The basis of all good policy decision-making often comes down to effective use of data and / or intelligence. Turning data into decisions is crucial to targeting resources and no more so than when tackling health inequalities.

5.2 Does a comprehensive health needs analysis exist which is shared with appropriate bodies and addresses health inequalities?

The last public health report for Haringey was completed in 2006, this report was well received and there was clear appetite for this information within the community. The Director of Public Health (joint appointment) has been in post since January 2008 and has been working on the production of the joint strategic needs assessment (JSNA). It is envisaged that this JSNA is going to be far more interactive with an IT platform that allows interrogation of the data. This will enable users to gain insight into the areas for which they are responsible and/ or interested in.

The key challenge in this area is to maintain momentum with the exercise to ensure that the output has an appropriate feed into other key developments such as the Commissioning strategy. The JSNA is making innovative use of geographical information systems to map health information, which will increase the accessibility and impact of data

Recommendation 6 - move forward the JSNA
The Public Health Team should continue with the development of the JSNA, specifically the IT platform that is envisaged should be further explored to ensure that users can interrogate the data set for their needs.

5.3 Is there effective and efficient use of data analyst skills and capacity in identifying health inequalities issues?

The new model JSNA that the public health team are developing will require increased analyst skills as a high degree of effort is required for extraction and interpretation of data and then applying this to Commissioning. Currently there is a capacity issue within the Public Health team as there are three vacant consultant posts, but when these posts are filled the challenges in place should be addressed. However, in areas that we have reviewed within the South East of England we have found that there is a national shortage of skilled data analysts, and that there has been difficulty in recruiting to the vacant posts. Going forward, there may be need to consider using some analyst capacity at the Borough Council if these posts remain unfilled.

Recommendation 7 - address capacity issues
To ensure that the data set can be developed on a timely basis it is imperative that the public health team is at full capacity. Consideration should be paid to use any capacity within the Borough Council for analyst skills.

5.4 Does public health data and intelligence inform commissioning strategies?

As recognised previously, the Public Health report of 2006 is the most up to date data set that Haringey has. In the period from 2006 to present there has been an Equalities Impact Assessment undertaken in relation to the Primary Care Strategy which has been used to assess access to

Primary Care by all groups within the Community. Our survey results showed strong agreement that Public health information is used to help understand local health inequality priorities and that public health information is used to help understand the impact of any service development on the health of the local population. It is recognised the JSNA will play a critical role in understanding the community needs further and will directly feed into commissioning plans.

5.5 Have organisations identified knowledge gaps and are they working towards filling them?

The public health team are quite open in their approach to the data set they are collating, they have been clear in what they do and do not know. Once the gaps are known they will devise plans to address the gaps and involve community where necessary. Sufficient resources need to be devoted to this area to ensure that data doesn't become out of date and inaccessible.

5.6 Do partners have a robust understanding of the issues facing diverse communities?

The Council and its partners have a good understanding of their local communities. Our survey results showed overall agreement that there is a shared process with partners for identifying key local hard to reach groups. An up to date data set will provide further information on hard to reach groups that will affect the strategy in this area. Feedback in the area of disagreement of this area outlined that they would like to see more work done to raise awareness in this area such as ensuring that newsletters and promotions actually reach hard to reach groups.

There have been some examples of partners being effective at implementing action to provide access to hard to reach groups, such as:

- there is a choose and book scheme in place at Wood Green library where outpatient appointments can be booked through the internet. Libraries are now opened on weekends and evenings to increase access.
- there is also a lot of information on health matters available in many different languages with the aim of targeting hard to reach groups.
- there is the vision to re-orientate health groups on a geographical basis, the Primary Care Strategy has been revised on this basis. Additionally the Prinmary Care Strategy with its hub and spoke model is hoping to address some of the access issues within the community, however it is noted that there has been some concerns over the transport situation in Haringey that may hinder access to these sites.

5.7 Does a wide range of stakeholder intelligence inform decision making?

There is evidence that stakeholders have been engaged in developing health strategies, for example one of the four fundamental building blocks in the LAA is "Healthier Communities and Older People", which was developed through consultation, including an event attended by over 70 people. An event was also held in February 2006 to provide a forum for staff to discuss health and well-being issues in Haringey and to identify local priorities for improving health and reducing inequalities over the next 5 years. The event was organised jointly by Haringey Council, Haringey Teaching Primary Care Trust, and Haringey Association of Voluntary and Community Organisations.

Going forward these community stakeholder meetings have been seen as an instrumental process in developing the JSNA. It is important that Haringey continues to use this forum to ensure community buy-in to the health inequality agenda.

6 Securing engagement from the workforce

6.1 Context

The public sector has a substantial workforce. This workforce needs to be used effectively to tackle health inequalities. The whole workforce, and especially those who engage directly with the public, should have an understanding of the key health inequalities that need to be tackled in their local area and how they can help to address them. Specialist public health teams need to be used effectively to enable action to tackle health inequalities to be properly targeted at the areas of need. Non-Executive Directors (NEDs) in health, and local government council members, need to understand the health inequalities agenda and how it affects their decisions on all areas.

6.2 Is the existing workforce being used effectively to tackle the health inequalities agenda?

The Community Strategy is in place and all partners are signed up to the Wellbeing Strategic Framework. The Director of Public Health role is already beginning to enhance further the positive working relationships that exist between the Council and the PCT.

There is evidence that efforts have been made to ensure that front-line staff are equipped with the skills and understanding to help address health inequalities. For example there has been investment in education and training to ensure that staff are equipped to handle potential health issues, such as a training session that was attended by over 500 people in respect of detecting abuse. Also, smoking cessation programmes are in place and classes are well attended with reasonable rates of success.

6.3 Is specialist public health skill and capacity available to organisations to tackle the health inequalities agenda?

Haringey's public health team is structured in a way that aims to maximise the impact on all public services within the area. The director of public health post is a joint appointment with accountability to both the PCT and the Council. There is also specialised input from the Adults, Culture and Community Services directorate at the Council and also specialised assistance from the inequalities and partnerships division within the PCT.

6.4 Do NEDs and members have the skills required to provide challenge in relation to plans to tackle health inequalities?

There is evidence that Members and NED's are supportive of the issues of Health Inequalities and how these can be reduced in the Borough, such as discussions on health issues at the Overview and Scrutiny Committee.

However, we understand that there has been little specific joint training for Members or NED's on this issue, and this clearly represents an opportunity particularly as the joint DPH is now in post and able to participate in training events. This could also be extended further down the organisation, as our survey indicated that 75% of recipients had not had joint training with partners on health inequalities.

Recommendation 8 - more training on HI issues
There is potentially an opportunity to enhance joint training in HI at both Non Executive Director and Member level as well as further down the organisation.

7 Performance Management

7.1 Context

The health inequalities agenda requires strong performance management to ensure that strategic plans are delivering the required impact. Performance management systems need to cover performance at both an organisational and partnership level. An effective performance management system will enable organisations to identify the actions taken against plans and the extent to which these are delivering the required results.

7.2 Is there a commitment at the highest level to effective performance management of health inequalities?

The update of the LAA in September 2007 (to be finalised in June 2008) identified 35 improvement targets which represent the priorities for improvement agreed between central government and all members of the Haringey Strategic Partnership from 2008. The Haringey Well-being Strategic Framework (WBSF) outlines the priority actions to improve life expectancy and reduce health inequalities. In terms of monitoring progress, the WBPB is responsible for the implementation plan of the WBSF, it is not solely responsible for its delivery. There is joint ownership for the delivery of the framework. Each supporting programme and initiative in the WBSF is assigned a lead agency that is responsible for its delivery, and a lead thematic partnership, which is responsible for monitoring performance.

Partnership performance management arrangements have been well developed, in particular the Well Being Scorecard which is seen as a realistic measurement tool. This scorecard is based on the LAA targets. However, when we attended the Well Being Partnership Board the Scorecard was included with a very full agenda and covered only briefly. We suggest that consideration is given to how the agenda might give greater opportunity to discuss challenges in the outturns relating to the Well Being Strategic Framework. It may be that this is done via a regular report from the Well Being Chair Executive that highlights challenging areas. It may also be assisted by agenda items being clearly labelled with the relevant Well Being Strategic Framework outcomes.

Recommendation 9- Well Being Scorecard
We recommend that the Well Being Scorecard is reviewed on an exception basis and that appropriate consideration is given to the performance agenda, this may require review by the Well Being Chair Executive prior to the WBPB meeting.

7.3 Is past and current performance used to plan future action to tackle health inequalities?

Partners in Haringey are taking an increasingly robust approach to target setting. HSP members negotiated targets for the next round of Local Area Agreements, which showed high commitment to 35 targets that have a heavy emphasis on health and social care indicators. There is awareness and commitment to the HI agenda and the acknowledgement that the gap is not reducing at a quick enough rate. However, the problems within the borough are quite significant as high mobility rates mean that the population changes at a rapid rate and effectiveness of action cannot easily be determined or measured.

The most recent London Health Report (January 2008) indicates that Haringey has one of the worst health and deprivation indicators, with the borough mentioned as:

- unlikely to meet life expectancy targets for both males and females,
- highest rates of infant mortality, and

- unlikely to meet 2010 target for cancers or heart disease and stroke

This indicates that the Borough faces significant challenges in meeting future targets and this in turn creates the requirement to have a robust performance management system that is reviewed and acted upon.

7.4 Is there an appropriate performance management framework in place which is regularly reviewed?

The Well Being Scorecard will need to be revised once the final set of LAA targets have been agreed. Our survey results indicate that there may be some scope to improve the information that has been provided to partners or better understand their requirements, when asked 'we can show that HI have narrowed in the last two years in the area my organisation covers' 45% disagreed with this statement. It is recognised however that there are difficulties linking what the impact has been as a result of an action – for e.g. giving up smoking and how many more years you will live as a result.

Recommendation 10 - Revise Scorecard for the LAA targets
Once agreed the Well Being Scorecard should be updated for the new LAA targets.

8 Corporate responsibility

8.1 Context

Public services generally employ a significant proportion of their resident populations, and therefore have an opportunity to directly tackle health inequalities through their day-to-day activities. This means using corporate powers and resources in ways that benefit rather than damage the social, economic and environmental conditions in which we live. How public services behave as employers, purchasers of goods and services, managers of transport, energy waste and water, as landholders and commissioners of building work and as an influential neighbour in many communities can make a big difference to people's health and to the wellbeing of society, the economy and the environment.

There are considerable benefits to public sector bodies of taking a corporate responsibility perspective to business and private industry recognises its impact on the bottom line.

8.2 Has a corporate responsibility policy / approach been developed?

There are several programmes in place amongst partners identified in section 8.3 below. However, although these are all positive, we have not found evidence of formal corporate responsibility policies in place at partner organisations. If policies were developed, this could assist in promoting corporate responsibility principles more widely and also minimise potential risk (financial and reputational) to organisations from not having clear policies and guidelines in place.

8.3 Is there progress on taking action with corporate responsibility principles?

Although corporate approaches to social responsibility are not yet in place, in practice there has been a significant amount of ad-hoc activity aimed at improving the health and wellbeing of staff. For example;

- a scheme in place at the Council known as the Haringey guarantee which is a scheme for tackling worklessness through working with employers and local communities to provide work and skills for local people;
- staff concessions at leisure centres to encourage use and improve overall wellbeing;
- focus at both the Council and the PCT in developing the cycling scheme whereby bicycles have been purchased to encourage use. There are also walk to work programmes;
- programmes and tips on how to stay stress free such as the introduction of flexitime to improve work/life balance and improve general wellbeing.

8.4 Have organisations begun to consider the financial implications of corporate responsibility?

This is an area where we have requested additional information to further our understanding, but as yet we are awaiting information in this area.

Recommendation 11 - develop an approach to corporate social responsibility
Partner organisations should develop formal corporate social responsibility plans or policies, which recognise their significant influence as local employers, commissioners, property owners and developers, and neighbours to the local community. These plans should identify how partners can use their full range of services to stimulate health improvement and address health inequalities, and consider the financial implications of doing so.

A Action Plan

Page no.	Recommendation	Priority 1 = high 2 = medium 3 = low	Responsibility	Agreed	Comments	Date
8	**Recommendation 1 - to continue the development of the JSNA** Haringey has decided to go beyond the minimum data set in developing the JSNA and it is likely there will be considerable planning required to obtain detail for secondary analysis. There are also potential difficulties in developing a JSNA given the high mobility of the population, therefore partners will need to ensure that proper arrangements are in place to ensure development of the JSNA is successful. If this is the case, it is highly likely that benefits will arise in the form of more effective commissioning aimed at improving health and well-being and reducing health inequalities.	1	JSNA Steering Group Eugenia Cronin		Phase 1: Core data set to be discussed at: • Council CEMB • PCT Board Core data set available on the website Phase 2: • Project Brief to be finalised • Consultation Plan to be agreed and undertaken • Area(s) focus to be decided by (Links to recommendation 6 and 7)	29 July 6 July August August from Sept. March 2009
9	**Recommendation 2 - to improve cost/ benefit analysis of options to reduce HI.** We recommend that partners further promote a wider understanding of and focus upon the costs and benefits of options of specific courses of action to reduce Health	2	Joint Commissioning Group Helen Brown/ Margaret		Cost-benefit analysis is not currently undertaken, however, under World Class Commissioning, the PCT is planning a major piece of work to understand how expenditure is related to health outcomes, which will necessarily include impact on health inequalities. This will be started during Autumn 2008.	From October 2008

Page no.	Recommendation	Priority 1 = high 2 = medium 3 = low	Responsibility	Agreed	Comments	Date
	Inequalities.		Allen			
11	**Recommendation 3 - improve structure of WBPB** Consider the agenda of Haringey's Well Being Partnership Board to have a balance between strategy and performance issues with specific linkages to the Well Being Strategic Framework. Following embedding of the Implementation Plans consideration should be given to involving Overview and Scrutiny to challenge the progress made against the Health Inequalities agenda.	1	WBCE Eugenia Cronin ?		Restructured WBPB and WBCE agendas to link items to 7 WBSF outcomes beginning • WBCE • WBPB Discuss performance using well-being scorecard exception reporting beginning • WBPB • WBCE (Links to recommendation 9 and 10) Timetable an Overview and Scrutiny review of health inequalities for 2009-10 , following visit by National Support Team for health inequalities (July 2009).	July October June July Need to schedule this.
11	**Recommendation 4 - effective involvement of provider trusts** There are opportunities to improve the effectiveness of provider trusts within the health inequalities agenda. In particular, they could provide further information on A&E attendance levels.	2	Joint Commissioning Group Helen Brown		• Major acute provider Trusts already members. • Clarify how to engage more effectively with provider trusts, including in sub-groups. • Joint Commissioning Group to review which other providers should be represented and how.	Autumn
12	**Recommendation 5 - improve engagement with the public and communities of**	2			• Making a Positive Contribution group set up • Building on relationship with Institute of Child Health	May 2008

Page no.	Recommendation	Priority 1 = high 2 = medium 3 = low	Responsibility	Agreed	Comments	Date
	interest Opportunity exists to engage with research institutions to understand what their role could be in the health inequalities agenda. Once engaged that resource could be used to commission further studies on areas where gaps currently exist.		Joint Commissioning Group Helen Brown		re: obesity • Director of Public Health to explore possibilities with Middlesex University, School of Health and Social Care	Ongoing Autumn 2008
13	**Recommendation 6 - move forward the JSNA** The Public Health Team should continue with the development of the JSNA, specifically the IT platform that is envisaged should be further explored to ensure that users can interrogate the data set for their needs.	2	WBCE Eugenia Cronin		• Considering IT platform options such as: o the Newham model developed by Geowise using a product called Instant Atlas o Expanding the GIS internet solution developed by spatial to encompass the partnership	March 2009
13	**Recommendation 7 - address capacity issues** To ensure that the data set can be developed on a timely basis it is imperative that the public health team is at full capacity. Consideration should be given to use any capacity within the Borough Council for analyst skills.	2	Director of Public Health Eugenia Cronin		• JSNA Technical Group established and shares data • HTPCT has increased its capacity by successfully recruiting to 4 consultant posts • The PCT and LA have identified further resources to support the JSNA (PCT via Investment Strategy and LA via dedicated time within Information Officers' posts).	May July August

Page no.	Recommendation	Priority 1 = high 2 = medium 3 = low	Responsibility	Agreed	Comments	Date
15	**Recommendation 8 - more training on HI issues** There is potentially an opportunity to enhance joint training in HI at both Non Executive Director and Member level as well as further down the organisation.	2	Director of Public Health Eugenia Cronin		• DPH has established LBH corporate public health group, with aim of cascading training through LBH. • DPH with Assistant Chief Executive PPP&C is convening an event for elected members. • DPH in discussion with NEDs on training needs through world class commissioning assurance framework.	May 2008 October/ November Autumn 2008
16	**Recommendation 9- Well Being Scorecard** We recommend that the Well Being Scorecard is reviewed on an exception basis and that appropriate consideration is given to the performance agenda, this may require review by the Well Being Chair Executive prior to the WBPB meeting.	2	WBCE Sarah Barter		• At WBCE on 20 June agreed to discuss performance using well-being scorecard exception reporting as standing item on WBCE and WBPB	WBPB June WBCE July
17	**Recommendation 10 - Revise Scorecard for the LAA targets** Once agreed the Well Being Scorecard should be updated for the new LAA targets.	2	WBCE Sarah Barter		Completed	June 2008
19	**Recommendation 11 - develop formal plans and procedures for corporate social responsibility**	2	PMG Mun Thong		• Both the Council and PCT are seeking to develop plans for integrating corporate social responsibility. • The Council is developing a People Strategy to cover	March 2009 September

Page no.	Recommendation	Priority 1 = high 2 = medium 3 = low	Responsibility	Agreed	Comments	Date
	Partner organisations should develop formal corporate social responsibility plans or policies, which recognise their significant influence as local employers, commissioners, property owners and developers, and neighbours to the local community. These plans should identify how partners can use their full range of services to stimulate health improvement and address health inequalities, and consider the financial implications of doing so.		Phung/ Eugenia Cronin		all aspects of employment including corporate social responsibility. The Strategy will be considered at Management Board and committee stage in September 2008; it contains a series of actions that will co-ordinate corporate social responsibility activities • An overarching policy of Corporate Social Responsibility can be developed between Haringey TPCT, Haringey Council and local voluntary and community groups, this needs discussion and agreement, initially through the PMG, Performance Management Group LBH. Agreement to develop a joint policy would need to be raised through the Haringey Strategic Partnership and agreed at that forum. • It should be noted that there are key workstreams, initiatives, projects and strategies that correlate with CSR not least the Greenest Borough Strategy, the Haringey Guarantee, well being and SCEB workstreams amongst many others. There is a need to pull this work together with overarching principles for working as ethical and socially responsible public services and employers, with a commitment and tangible evidence of creating and investing in a culture of CSR.	2008

B Response to electronic survey questions

Q1 **Please tell us the name of the organisation you represent? (optional)**

17

Q2 **Please tick which type of body you represent**

(responses of different partner bodies will be separately identified, individuals will not)

County Council	0
District or Borough Council	6
Unitary Authority	2
PCT	10
Trusts: Foundation, Acute, Mental Health/Learning Disabilities, Ambulance	0
Police Authority	0
Fire Service	0
Other (Please state below)	1

Please specify 'other' 1

Q3 **Position**

Council member / Board member	2
Chief Executive / Director level	6
Other officer	10
Other	1

Please specify 'other' 3

The local pattern of health inequalities

Q4 **Please indicate the extent to which you agree / disagree with the following statements:**

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
There is an effective joint health inequalities strategy based on the health needs of the partner bodies' populations	5	12	1	0
The health inequalities plan is adequately reflected in the LAA and LSP plans, including sections such as housing, crime, environment etc.	6	10	1	1
There is enough information about health inequalities for us to identify the population's needs in the area my organisation covers	3	9	5	1
There is a shared process with partners for identifying key local health inequality issues	5	12	1	1
There is a shared process with partners for identifying key local hard-to-reach groups	2	12	4	1

Local actions

Q5 **Please indicate the extent to which you agree / disagree with the following statement:**

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
We can show that health inequalities have narrowed in the last two years in the area my organisation covers.	1	9	8	0

Please specify 5

Q6 **Please indicate the extent to which you agree / disagree with the following statements:**

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
My organisation regularly uses techniques to assess impact and inform service changes	2	12	3	1
Partners use shared information well	1	13	5	0
Acute and mental health / learning disability trusts have identified roles in tackling health inequalities	1	6	8	0
My organisation has developed joint services with partners	6	12	1	0

Please specify what these are and what makes them joint, e.g. pooled budgets, joint posts 7

Increased access

Q7 **Please indicate the extent to which you agree / disagree with the following statement:**

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
Changes have been made to my organisation's services because inequities in access were identified	4	12	3	0

Please specify 4

Q8 **Please indicate the extent to which you agree / disagree with the following statement:**

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
We can show that access to services has been increased for disadvantaged groups in the area my organisation cover	1	15	3	0
Please specify 5				

Q9 **Please indicate the extent to which you agree / disagree with the following statement:**

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
We can show that action taken in the last 2 years has had an impact on previous under-performance	6	10	3	0
Please specify 4				

Local levels of understanding about roles

Q10 **Please indicate the extent to which you agree / disagree with the following statements:**

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
Health inequalities are everybody's business and not just an NHS issue	17	1	1	0
Councils have a community leadership role which includes promoting a healthier community and narrowing health inequalities	15	3	1	0

Q11 Public health information is used to help us to understand..

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
local health inequality priorities	12	4	3	0
evidence-based research about effective interventions	12	4	2	1
the impact of any service development on the health of the local population	11	2	6	0

Governance arrangements

Q12 Please indicate the extent to which you agree / disagree with the following statements:

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
Joint planning arrangements for health inequalities exist and are effective	3	12	4	0
It is clear who is accountable for work on health inequalities within relevant partnerships	3	14	1	1
It is clear who is accountable for work on health inequalities within my organisation	8	6	3	1
My organisation's health inequalities strategy / plan is consistent with the joint health inequalities plan	5	8	3	0
My organisation's health inequalities strategy / plan is consistent with my organisation's commissioning plan	6	9	1	0

The health overview and scrutiny committee addresses wider health issues beyond NHS reconfiguration	5	13	0	0

Current capacity and capability

Q13 Please indicate the extent to which you agree / disagree with the following statements:

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
The joint health inequalities strategy addresses whole system changes needed	1	9	6	0
My organisation has sufficient skills to deliver work on health inequalities	3	8	5	1
I fully understand the difference we partners intend to make in the most disadvantaged communities	6	11	2	0
I have had joint training with partners on health inequalities	1	4	10	3
There are effective mechanisms for enabling communities to participate in developing action on health inequalities	2	7	9	0

Performance management and value for money

Q14 Please indicate the extent to which you agree / disagree with the following statements:

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
Effective joint monitoring arrangements are in place	2	14	3	0
My organisation can produce the information required to monitor performance against the joint health inequalities strategy and supporting plans	3	12	2	1

Cost benefit analysis of options for action has been undertaken in the last 2 years (singly or jointly)	0	6	7	1

Please specify 1

Q15 Please indicate the extent to which you agree / disagree with the following statements:

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
We can show that we have targeted our financial resources on actions which evidence shows have the biggest impact on reducing health inequalities	2	12	3	0
Progress is benchmarked against comparable areas	2	10	6	0
I know which actions have had a measurable impact on reducing local health inequalities in the last 2 years	3	5	7	2

Decision-making and resource allocation

Q16 Please indicate the extent to which you agree / disagree with the following statements:

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
My organisation's chief officers / members / board members are committed to tackling local health inequalities	9	9	1	0
Targets are agreed by partners and locally relevant	6	12	0	1
Joint decision-making for health inequalities is effective	5	9	3	0

Please describe how it is effective or could be improved 3

Q17 Please indicate the extent to which you agree / disagree with the following statement:

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
My organisation's financial plans identify resources for achieving the health inequalities plan	5	10	2	0

Q18 Please use the space below to make any further comments

2

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