

Health Inequalities Commissioning Framework



Use your NHS **well**

Contents

Foreword

from the Director of Public Health
Dr Melanie Smith

Foreword from the Director of Public Health	03
Introduction	04
What are Health inequalities?	05
What causes Health inequality?	07
The wider determinants of health in Kensington and Chelsea	08
The importance of addressing the whole social gradient	09
The role of the NHS in reducing health inequalities	10
The role of NHS Kensington and Chelsea in reducing health inequalities	10
1 Put our Own House in order	11
1.1. Leadership from the top to make our vision and strategy clear	13
1.2. Strengthen the role of ill-health prevention	14
1.3. Directly affect the wider determinants of health	16
1.4. Increase commissioner confidence in commissioning to reduce inequality	17
1.5. Strengthen the role of the Equality Impact Assessment	24
1.6. Strengthen engagement with people and communities	27
2 Act as a Local Champion	28
2.1. Position NHS Kensington and Chelsea as a leader in tackling health inequality	28
2.2. Maximise PCT impact on the wider determinants of health	28
2.3. Make partnerships more effective	30
2.4. Increase the confidence of our residents in the PCT	32
3 Collect, Use and Share the Evidence	33
3.1. Build all commissioning decisions on a comprehensive evidence base	33
3.2. Improve evaluation of service outcomes	34
3.3. Share knowledge with all stakeholders and partners	35
References	36

Authors

Dr Helen Asquith
Steve Shaffelburg
Akin Adepoju
Patricia Griffiths

The evidence is overwhelming that inequalities in health will continue to exist until we tackle the inequalities in society. We know that many of the wider determinants of health are beyond the traditional reach of the NHS. However, this is not an argument against action. This Framework makes the case that in order to be an effective local champion for reducing inequalities across and with other sectors, NHS Kensington and Chelsea must set an example and get our own house in order. This is an integral part of our vision to be a health advocate.

Part of getting our house in order involves ensuring that PCT services are not inadvertently increasing health inequality. No NHS employee intends to widen the gap but this is what can happen if we do not ask the right questions at every step of the commissioning cycle. Before commissioning any new projects to tackle health inequality, we must examine what we commission already and make sure that services are accessible to all residents who need them.

The concept of Proportionate Universalism, championed by the Marmot Review, provides an appropriate response to those who argue that, because Kensington and Chelsea is at the top of most health 'league tables', resources to tackle health inequalities should be directed elsewhere. However, we know the social gradient in Kensington and Chelsea is steep. We must tackle local inequalities with local action.

Proportionate Universalism also provides a useful lens for Commissioners to consider their work. To reduce health inequalities, action should be universal but proportionate to the level of disadvantage. This does not necessarily mean that we shift our attention away from the more deprived wards in the borough, where premature mortality rates are double those in the rest of the borough. Rather, Commissioners must consider an appropriate mix of universal and targeted interventions.

We have called this report a framework because it provides a structured approach for Commissioners to tackle health inequalities. But it could equally be called a 'scaffold' because, in a real sense, we want to provide a temporary platform upon which Commissioners can build sustainable action. Eventually, the scaffolding is taken down to leave a stable and self-sustaining commissioning approach.

So the challenge to the PCT is to make this framework unnecessary in the long term. First, we must embed action to tackle health inequalities into everyday practice. Second, we must champion action on health inequalities throughout the borough. And third, we must collect and share the evidence.

Headline Messages

1. Put Our Own House In Order
2. Act as a Local Champion
3. Collect, Use and Share the Evidence



Introduction

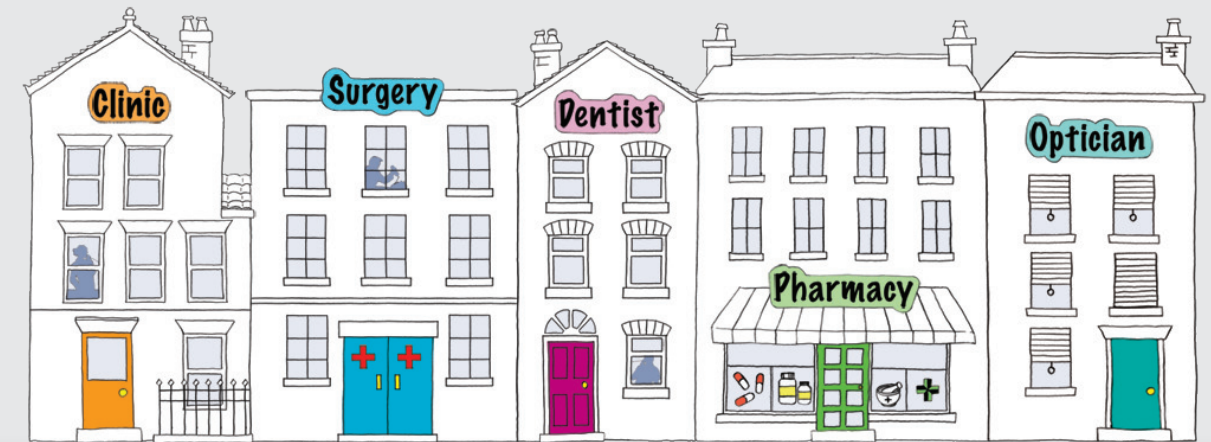
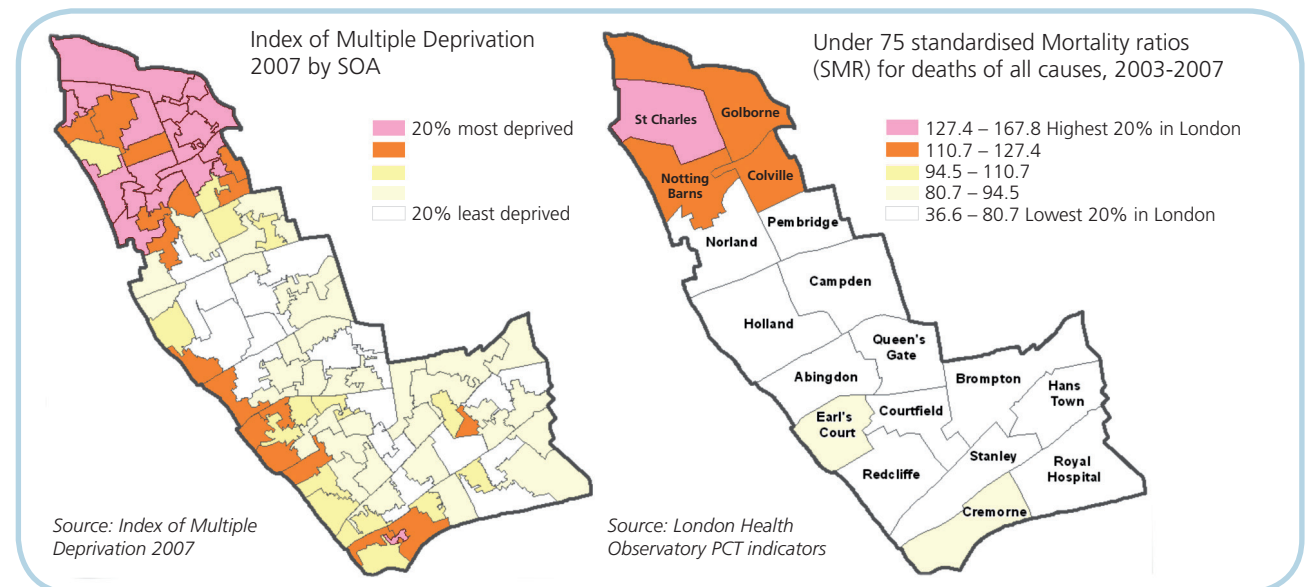


Figure 1

Deprivation and premature (<75) mortality in Kensington and Chelsea



What are health inequalities?

Health inequalities arise from a range of social and demographic inequalities. Since 1986, a succession of high level reports^{5,6,7} have highlighted the resulting social gradient in health: health outcomes are progressively worse in proportion to disadvantage. Most commonly, low socioeconomic status is identified as the principal cause of poorer health outcomes. However, other factors such as ethnicity, mental health, disability, gender, and age make a significant contribution.

The gap in life expectancy – A striking example of health inequality can be seen in the gap in life expectancy between the richest and poorest neighbourhoods in England. On average, people in the poorest neighbourhoods will die seven years earlier than people in the richest neighbourhoods (Figure 2). A seven-year gap in male life expectancy also exists in Kensington and Chelsea⁸.

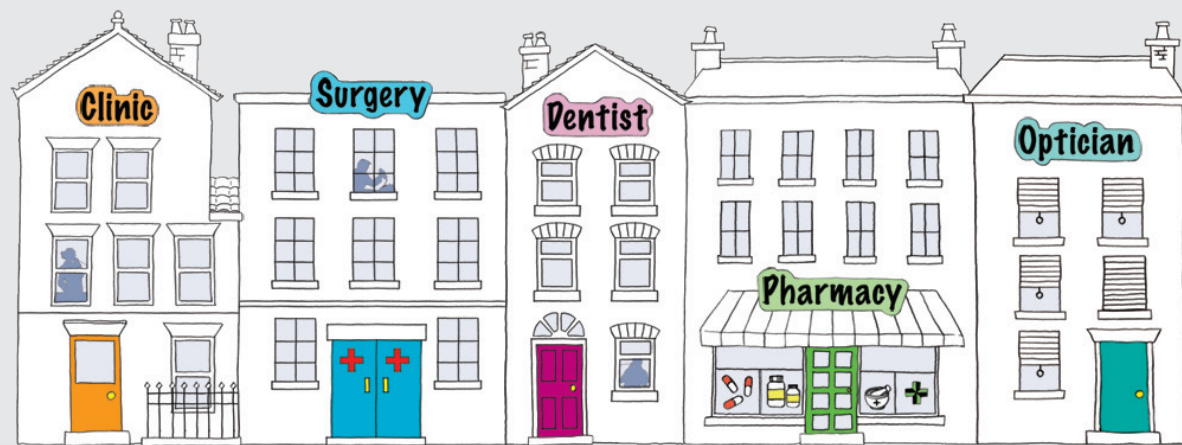
‘People with higher socioeconomic position in society have a greater array of life chances and more opportunities to lead a flourishing life¹.’

Kensington and Chelsea is often seen as an exemplar of good health in the UK. The ward with the highest life expectancy in the country, Queen’s Gate, is located in the borough. However, this excellence masks the fact that considerable inequalities exist between groups within our borders². Residents in the most northerly wards are twice as likely to die prematurely (before age 75) as the residents in the south².

If NHS Kensington and Chelsea is to fulfil its ambition to become the recognised health advocate for all residents³, we must tackle these inequalities. The NHS Constitution makes it clear that the NHS has an explicit duty to promote equality⁴.

Building on successes already achieved and drawing heavily on the evidence base, this framework will give Commissioners the tools and confidence to achieve reductions in health inequality. The Framework seeks to:

1. Secure Board and Executive support
2. Inspire Commissioners to put consideration of health inequalities at the heart of commissioning
3. Provide the knowledge and skills for Commissioners to reduce inequalities
4. Support Commissioners through training and ongoing collaboration
5. Strengthen the use of existing tools to address health inequalities – e.g. Community Engagement and the Equality Impact Assessment
6. Position NHS Kensington and Chelsea as a leader in tackling health inequality



However, it is important to note that life expectancy works best as an indicator for large populations. Within smaller populations, such as in Kensington and Chelsea, gaps in life expectancy are more sensitive to inaccuracies in population denominators and are harder to demonstrate with statistical significance. For example, they are also often skewed by the location of care homes. Locally, the monitoring of premature mortality (deaths under the age of 75) is more robust for measuring inequality.

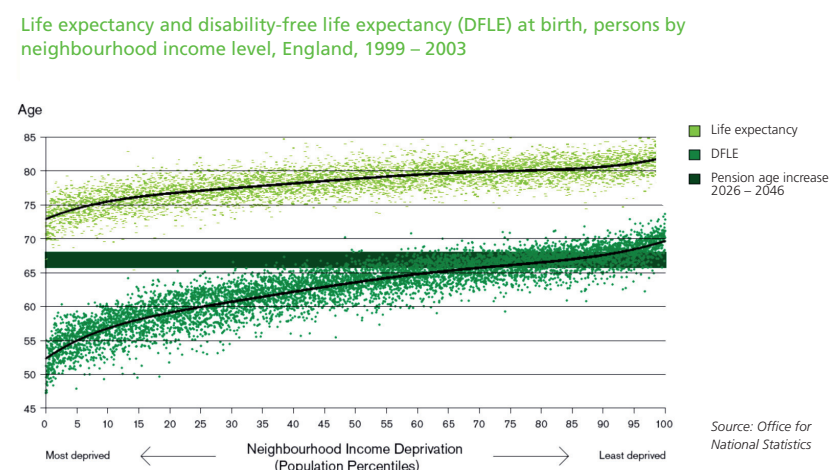
The gap in health expectancy and well-being – The Marmot Review puts strong emphasis on the quality of years lived and identifies large inequalities in well-being across the social gradient. Perhaps more disturbing than the gap in life expectancy is the even bigger inequality in wellbeing. Marmot used *disability-free life expectancy* (DFLE) as an indicator to quantify the years lived free of limiting long term illness. The social gradient of DFLE is even steeper than for life expectancy. More affluent groups live on average 17 years longer without disability than the poorest groups⁹.

This has significant implications, especially for the future of the workforce within an ageing population. The thick green line on Figure 2 indicates the pensionable age to which England is moving. With the disability levels shown, nearly three quarters of the population do not have a disability-free life expectancy as long as 68 years. This will be a problem, even allowing for the fact that a significant number of people living with disabilities also view themselves as healthy and expect to be working until 68 or longer.

Figure 2

Taken from the Marmot Review 2010

Life Expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England 1999-2003



What causes health inequality?

The causes of health inequality are fairly well understood:

The wider determinants of health are a major influence on health inequality (Figure 3). Within Kensington and Chelsea, there is considerable variation in income, employment, education, housing and standards of living. These are all related to health outcomes.

High risk lifestyle choices are strongly correlated to deprivation, most notably seen in increasing smoking levels with increasing deprivation¹⁰.

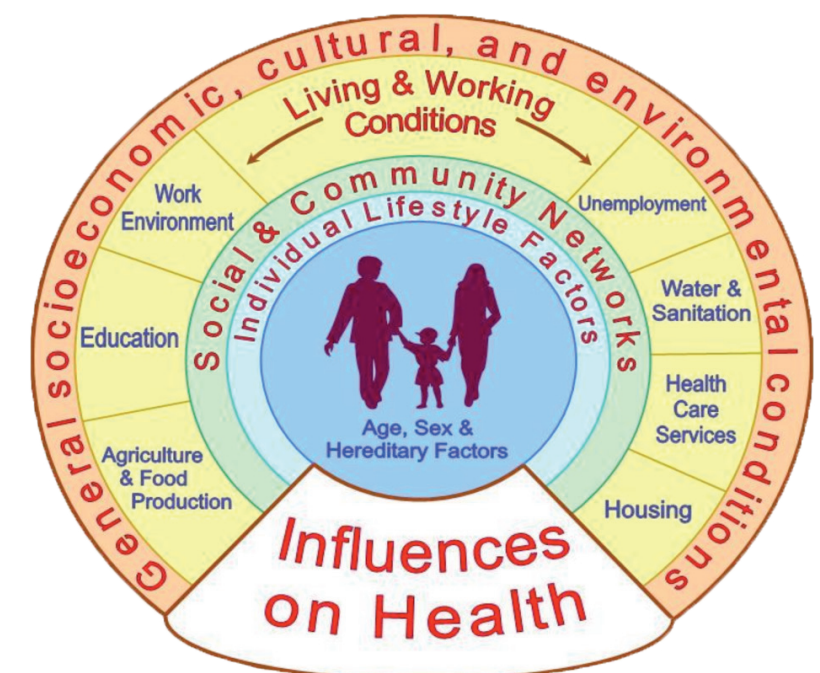
Being a member of certain groups (e.g. those with a physical disability or a mental illness, BME groups and the homeless) also plays a part due to social marginalisation, poor access to services and likelihood of income deprivation.

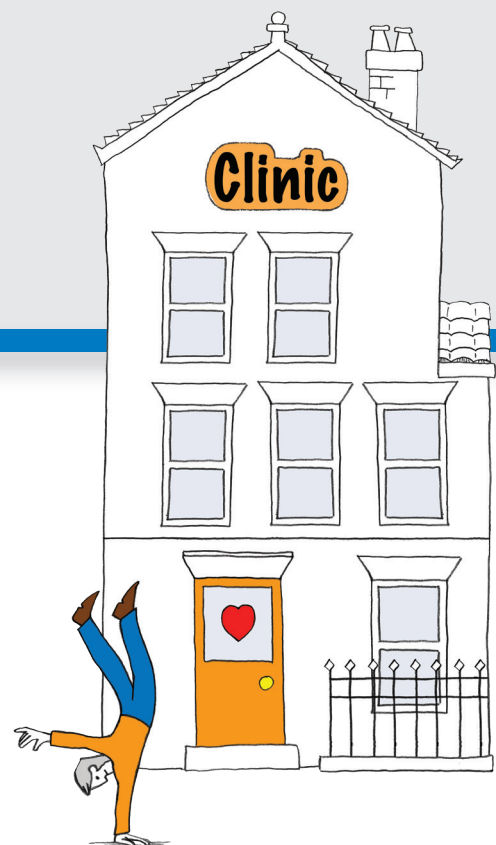
Poorer access to local services is associated with economic disadvantage. The Inverse Care Law describes the fact that poorer areas are often served by the poorest quality services¹¹. However, there may also be issues of decreased demand from poorer populations, particularly for preventative services.

Figure 3

Dahlgren and Whitehead
Diagram of Influences on Health

1991





The wider determinants of health in Kensington and Chelsea

Figure 1 demonstrates how socioeconomic deprivation is linked to a higher risk of premature mortality across the Borough. Poor health outcomes are also linked to other determinants such as ethnicity and whether people live in social housing, as seen in **Figures 4 and 5**. This pattern in Kensington and Chelsea can also be demonstrated for a number of the wider determinants.

Figure 6 maps risk of readmission to hospital across the borough. One might expect that readmission rates would be highest in the South where there are greater numbers of older people, traditionally the group at highest risk of readmission. In fact, the highest rates of readmission are found in the North. This highlights the point that health outcomes depend on a very complex interaction of wider determinants. It also demonstrates the powerful impact socioeconomic deprivation has on health outcomes.

Figure 4

Map of Social Housing in K&C.

Social housing is concentrated in the north of the borough. However there are pockets of social housing in the south.

2001 Census

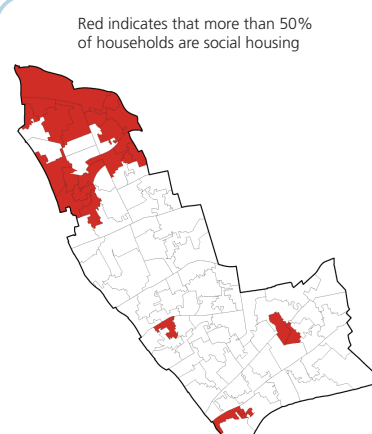


Figure 5

Proportion of the Kensington & Chelsea population belonging to a Black & Minority Ethnic (BME) group.

BME groups tend to be more focussed in areas of deprivation and social housing. 2001 Census

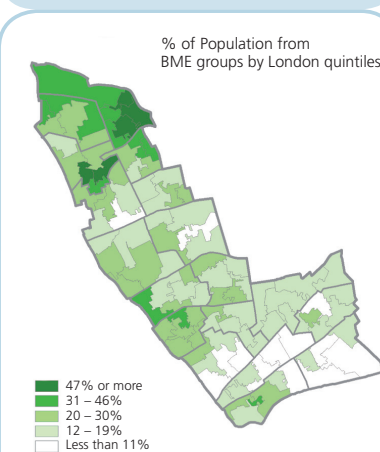
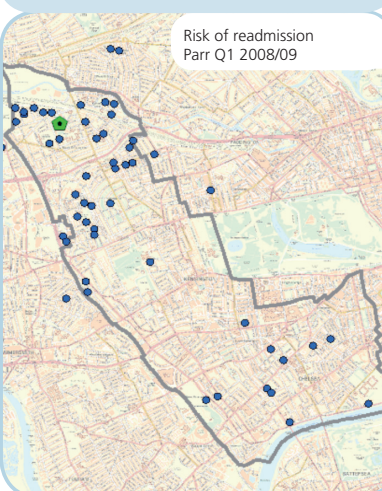


Figure 6

Risk of Readmission

People in the north are more likely to be at risk of readmission to hospital despite the fact that the residents here are, on average, younger than in the south.

PARR Q1 2008/09



The importance of addressing the whole social gradient

The gradient in health is across the whole of society and not a dichotomy between rich and poor. In other words, socio-economic advantage is linked to better health across all social economic groups. This does not simply mean that the wealthiest groups in society have better health than the poorest. Rather, people in the highest socio-economic bracket are likely to be healthier relative to people in the next socio-economic bracket, who in turn are likely to be healthier relative to people in the bracket below, and so on.

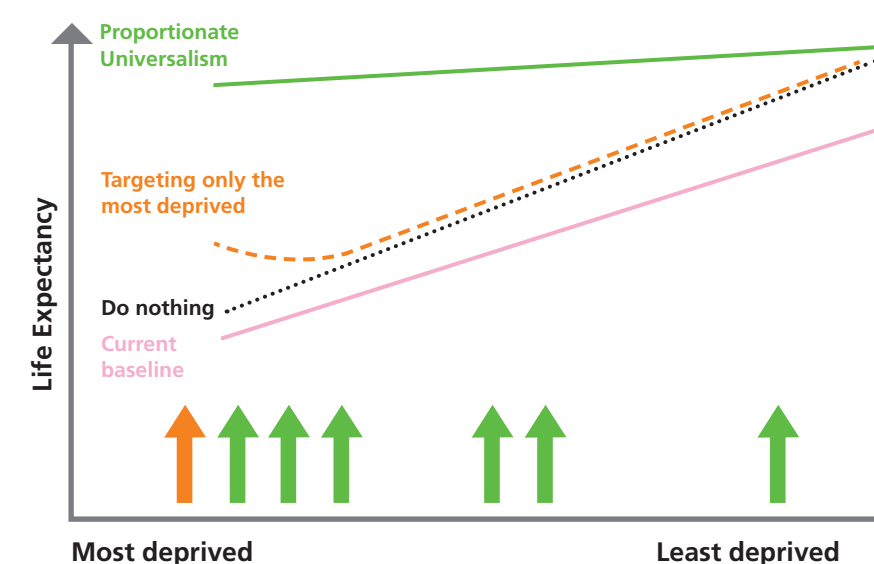
Many initiatives target only the most disadvantaged groups, for example the National Support Team's work with Spearhead PCTs. However, Marmot argues that the evidence shows that targeted approaches do not provide the whole solution. Not only does this approach risk neglecting pockets of deprivation within affluent areas and populations just above the poverty threshold, but it also ignores the nature of the social gradient. In order to reduce the steepness of the social gradient in health, actions must be universal but 'proportionate to the level of disadvantage'¹². A fairer society will be better and healthier for all. This approach is called **Proportionate Universalism**. **Figure 7** compares this approach to doing nothing and to strategies that target only the most disadvantaged.

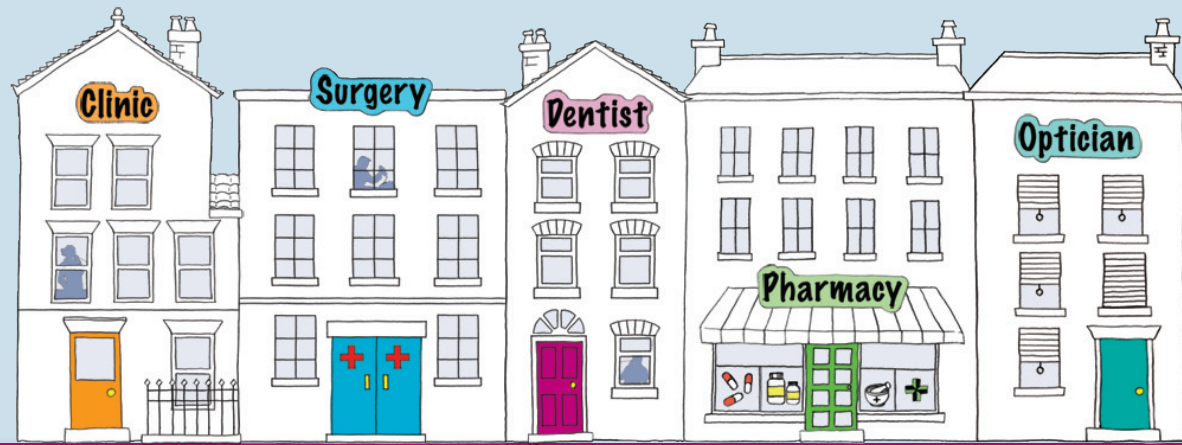
Figure 7

Diagram representing the theoretical effect of different strategies to tackle health inequalities.

The yellow arrow indicates actions targeting only the most deprived, resulting in the yellow dashed line.

The green arrows represent actions commissioned with an approach of Proportionate Universalism, resulting in the solid green line. This approach is most effective at reducing the gradient in health inequalities across society.





1. Put Our Own House In Order



'Even though most of the observed social inequalities in health status are not caused by what goes on in health care services, this does not mean that there is no role for the health care system in reducing inequalities in health status.'¹³

The challenge for the PCT is to lead on reducing health inequalities, while building up the willingness and ability of its partners to act on the wider determinants in their control.

There is a strong economic argument for action. Direct NHS healthcare costs in England associated with treating the consequences of inequality amount to £5.5 billion per year⁷.

The role of NHS Kensington and Chelsea in reducing health inequalities

The PCT must be a leader in tackling health inequality in the borough. If we get it right for tackling health inequalities, we will be getting it right as the recognised health advocate for all residents¹⁴. Our role is summarised in these themes which will be explored in the rest of this document:

1. Put Our Own House In Order

2. Act As A Local Champion

3. Collect, Use and Share the Evidence



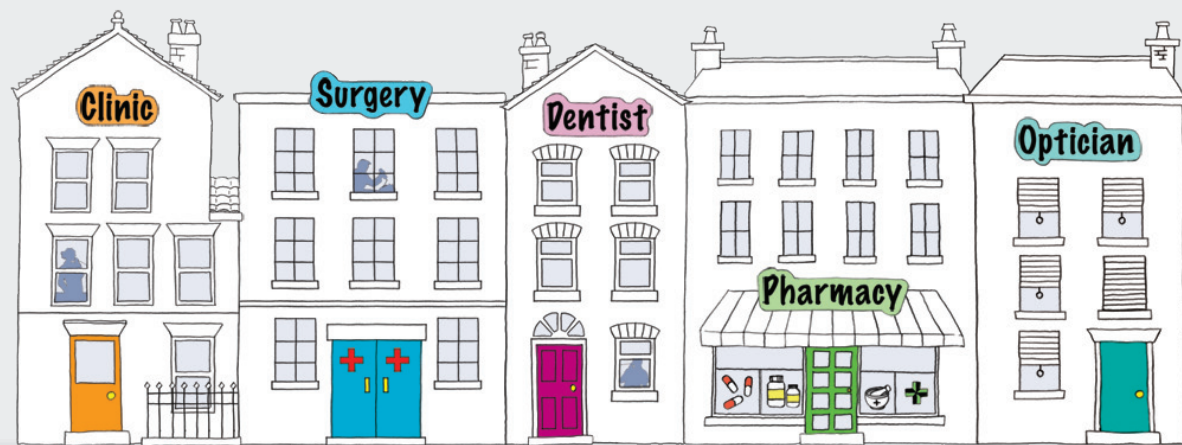
'The Health System has a potentially pivotal contribution to make to tackling social inequalities in health in a number of ways [including] putting its own house in order by commissioning an equitable NHS'¹⁵

While most inequalities are not caused by the healthcare system directly, the way that health services are structured can contribute to inequalities in health outcomes. Despite the best intentions, some services are inadvertently increasing inequality¹⁶. This is unacceptable. We must ensure that all Commissioners, with leadership from the Board and Trust Management Team (TMT), have the knowledge and confidence to reduce health inequalities.



For example, Patient choice inadvertently can widen health inequalities Patient choice is widely promoted as a means to drive up quality. However, if information to support choice is only available to those who read English via the internet, then the higher quality choices can only be chosen by those who may need them least.

This involves a change in ethos. We need a clear vision and strategy, as described in this framework, to be championed by high-level advocates within the PCT¹⁷. Service planning and design must begin with awareness of our population and their needs. Before devising any changes, we must examine what we already commission. In order to ensure that services do not inadvertently widen health inequalities, an Equality Impact Assessment (EqIA) will explore the potential impact of the service on population subgroups¹⁸. Effective engagement with the community will enrich both the service design and EqIA¹⁹.



1.0 Aims

- 1.1 Leadership from the top to make our vision and strategy clear
- 1.2 Strengthen the role of ill-health prevention
- 1.3 Directly affect the wider determinants of health
- 1.4 Increase commissioner confidence in commissioning to reduce inequality
- 1.5 Strengthen the role of the Equality Impact Assessment
- 1.6 Strengthen engagement with people and communities

In addition to the above, two major aspects of *Putting Our Own House in Order* have been considered within their own section:

Act as a Local Champion: Expands on the need to strengthen existing partnerships and develop new relationships with non-NHS organisations to address the wider determinants of health.

Collect, Use and Share the Evidence: Expands on the need to look for and use evidence of best practice to support commissioning.

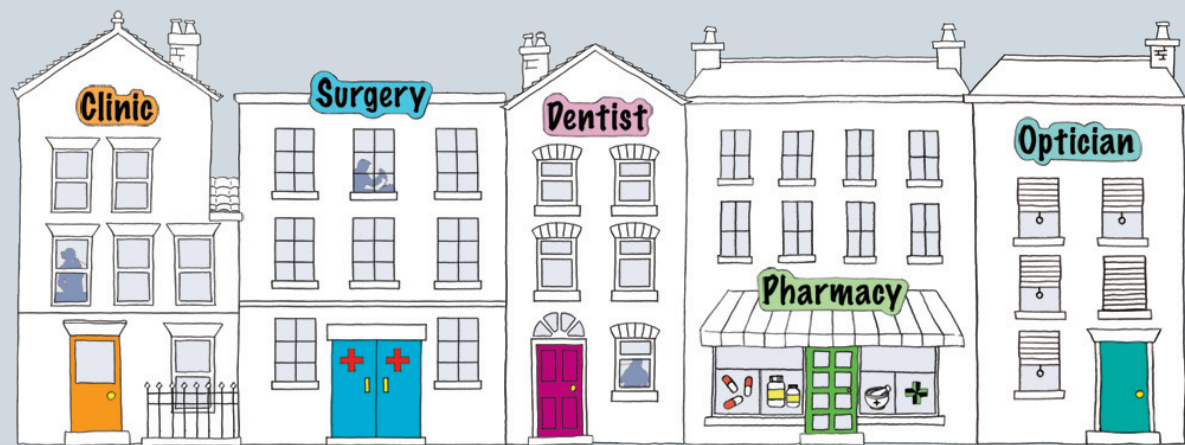


1.1 Leadership from the top to make our vision and strategy clear

'Lead from the top with chief executives, directors of finance, commissioning and primary care, and clinical leadership playing their part. Public health can play a leading role, but cannot deliver this alone²⁰.

Actions

1. Obtain Corporate approval of the Framework as the means to put reducing health inequalities at the heart of our commissioning strategy
2. Increase the accountability for tackling health inequality by requiring formal agreement of Equality Impact Assessment (EqIAs) by the *Investment Approval Group*, *Clinical Executive Committee* and/or *Finance, Investment & Performance Board SubCommittee* as appropriate
3. Establish a sustainable and well-resourced Health Inequalities Working Group. Membership would include representation from Equality and Diversity as well as Public Health. Its function would be to:
 - a. Support commissioners in tackling health inequality
 - b. Ensure good quality EqIA



1.2 Strengthen the role of ill-health prevention

'Promoting good health and preventing ill health saves money... A small shift in resource towards public health prevention activity would offer significant short, medium and long term savings to the service and to the taxpayer ²¹.'

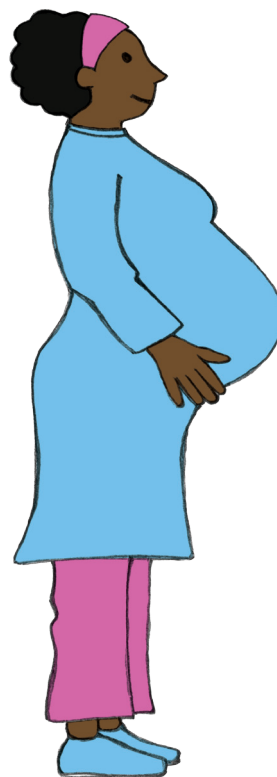
Preventable diseases are major players in health inequalities

Preventable diseases are responsible for much of the gap in health outcomes. For example, smoking is responsible for approximately half of the difference in life expectancy between the lowest and highest income groups²². Smoking-related death rates are two to three times higher in low-income groups than in wealthier social groups²³. In Kensington and Chelsea, over 70% of deaths are caused by diseases whose major risk factor is smoking²⁴, and around 17% of deaths are directly caused by smoking²⁵.

The co-benefits of prevention on equality and economics

Currently only 4% of NHS funding is spent on prevention²⁶, despite the strong economic case for increasing investment in it. It is well established that preventing disease results in long term cost saving for the NHS²⁷.

Given the prevalence of preventable disease and its disproportionate burden on disadvantaged populations, it makes sense for the PCT to capitalise on the co-benefits of prevention²⁸. The fact that we can achieve long-term savings by the same means that we use to tackle health inequality is a very convincing argument to support greater investment in prevention.



Invest in prevention to save in the short, medium and long term

The PCT demonstrated its commitment to prevention in our 2010 Commissioning Strategic Plan (CSP). Importantly, this document recognised the change of mindset required: 'the nature of public health interventions means that most of these savings to the NHS will not appear for years, even decades. The reality is that most public health interventions – including many of those that are being implemented in Kensington and Chelsea – will cost money in the short-term. Nonetheless, there is compelling evidence that some prevention initiatives will reduce short-term demand on primary, secondary and/or tertiary services'³.

Effective health promotion requires innovative approaches and partnership with non-health sectors

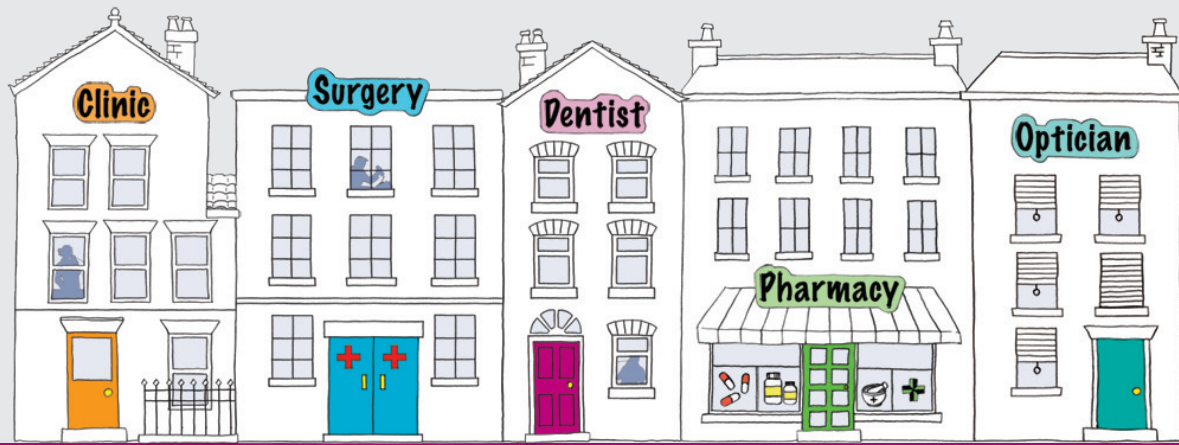
Changing behaviours requires action on the wider determinants that shape behaviour in the first place. Effective health promotion often benefits from partnership with non-health sectors to develop innovative approaches. Residents are also more likely to engage if services are efficient and integrated with the services they receive from other statutory sectors.

For example, Innovative use of midwives

Developing the role of midwives to take advantage of their access into people's homes to give opportunistic health promotion on topics outside their traditional remit, such as accident prevention, nutrition and physical exercise.

Actions

1. Commission or undertake a piece of work to develop a methodology to assess PCT spend on prevention
2. Once the benchmark is established, the PCT should set a target to shift the balance of spend upstream from acute services into ill-health prevention and primary care
3. All commissioners should make use of the NICE public health guidance relevant to the services they commission (go to nice.org.uk, click 'NICE guidance by topic', select 'public health')
4. For all spending, commissioners should analyse the health benefits & cost savings in the short, medium & long term
5. All departments need to consider how non-health sector partners can be commissioned to deliver innovative prevention strategies integrated with PCT services
6. Service Level Agreements should make it clear that the PCT expects clinicians to identify issues outside of their clinical expertise that impact on their patient's outcomes. Once identified, clinicians should signpost appropriately



1.3 Directly affect the wider determinants of health

Although local government and other public sector agencies hold many of the levers that shape inequalities²⁹, the PCT is not without influence. In fact, our vision to become the recognised health advocate for Kensington and Chelsea commits us to action.

The PCT is well positioned to coordinate and influence the wider determinants of health. We must lead by example, tackling the wider determinants that we can directly affect through equitable employment practices and the commissioning of specific programmes. From this platform we can influence local policy with greater force.



For example, *Fit For Work* programme

Dame Carol Black's review³⁰ of the health of Britain's working age population highlights the health and social impact of being out of work.

Kensington and Chelsea's Fit for Work Programme is part of a national pilot that supports people in the early stages of sickness to get back to work. Our model strengthens partnerships at both strategic and operational levels. Our two partners, CLCH Occupational Health and RBKC Environmental Health, will work with local GPs and employment support and debt counselling services to integrate services.

The PCT also have a legal obligation to ensure that all our policies and practice meet the needs of all our staff and those who use our services regardless of their age, disability, ethnicity, gender, religion or belief or sexual orientation. Our **Single Equality Scheme** sets out how we will meet our obligations under equality legislation during the period 2008 to 2011³¹.

This section discusses ways that the PCT can *directly* impact on wider determinants. The next theme, *Act as a Local Champion*, expands on ways to influence local policy on wider determinants.

Actions

1. Every department should examine whether it could benefit from greater attention to the wider determinants
2. Support local employment and economies
 - a. Increase supported staffing opportunities for people with disabilities
 - b. Continuously monitor whether the workforce reflects the local population
 - c. Use the existing Single Equalities Scheme to move towards a PCT workforce that better reflects the local community



1.4 Increase commissioner confidence in commissioning to reduce inequality

Commission with Proportionate Universalism

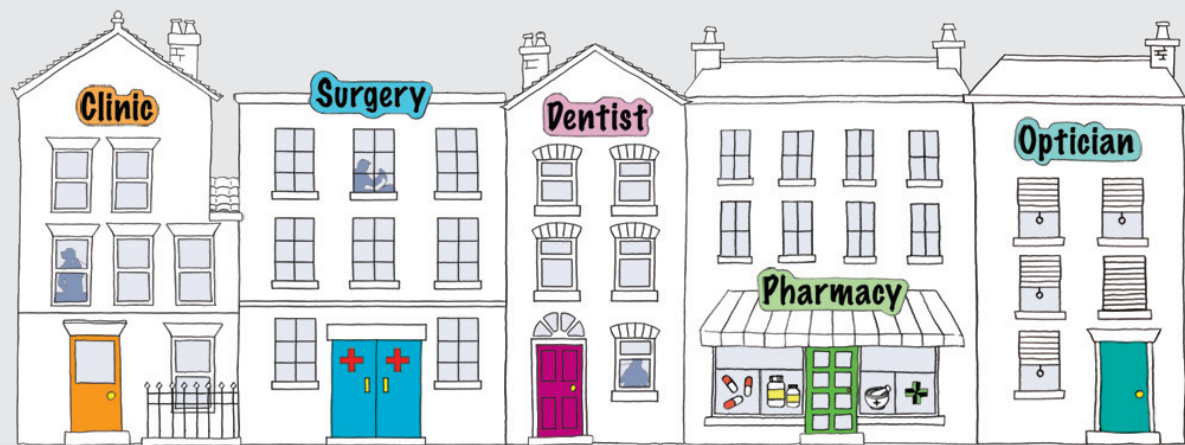
Pursuing a strategy of Proportionate Universalism would see us commissioning services that are 'universal, but with a scale and intensity that is proportionate to the level of disadvantage'³². It is reasonable to expect that the more disadvantaged groups require a greater share of the overall budget to maintain or improve health compared to more affluent groups.

Proportionate Universalism also involves commissioning a combination of universal and targeted services.

Universal services are offered to all residents and address the whole social gradient. Commissioners must ensure that universal services do not inadvertently widen health inequalities. Physical access, staffing and budgets should be allocated in proportion to levels of need across the borough.

For example,

Integrated health care systems are designed for all residents but we can ensure they do not widen inequalities by physically locating the hubs in areas of greatest need.



Targeted services are offered to specific disadvantaged groups when they are unable to take full advantage of the universal service or have specific needs. The Social Exclusion Task Force makes this clear in their recent document *Inclusion Health*²³ which proposes a national framework to drive improvements in health outcomes for socially excluded groups. Crucial outcomes of this report will be the development of Joint Strategic Needs Assessment (JSNA) and commissioning guidance to reflect the specific challenges of assessing and addressing the needs of disadvantaged groups.

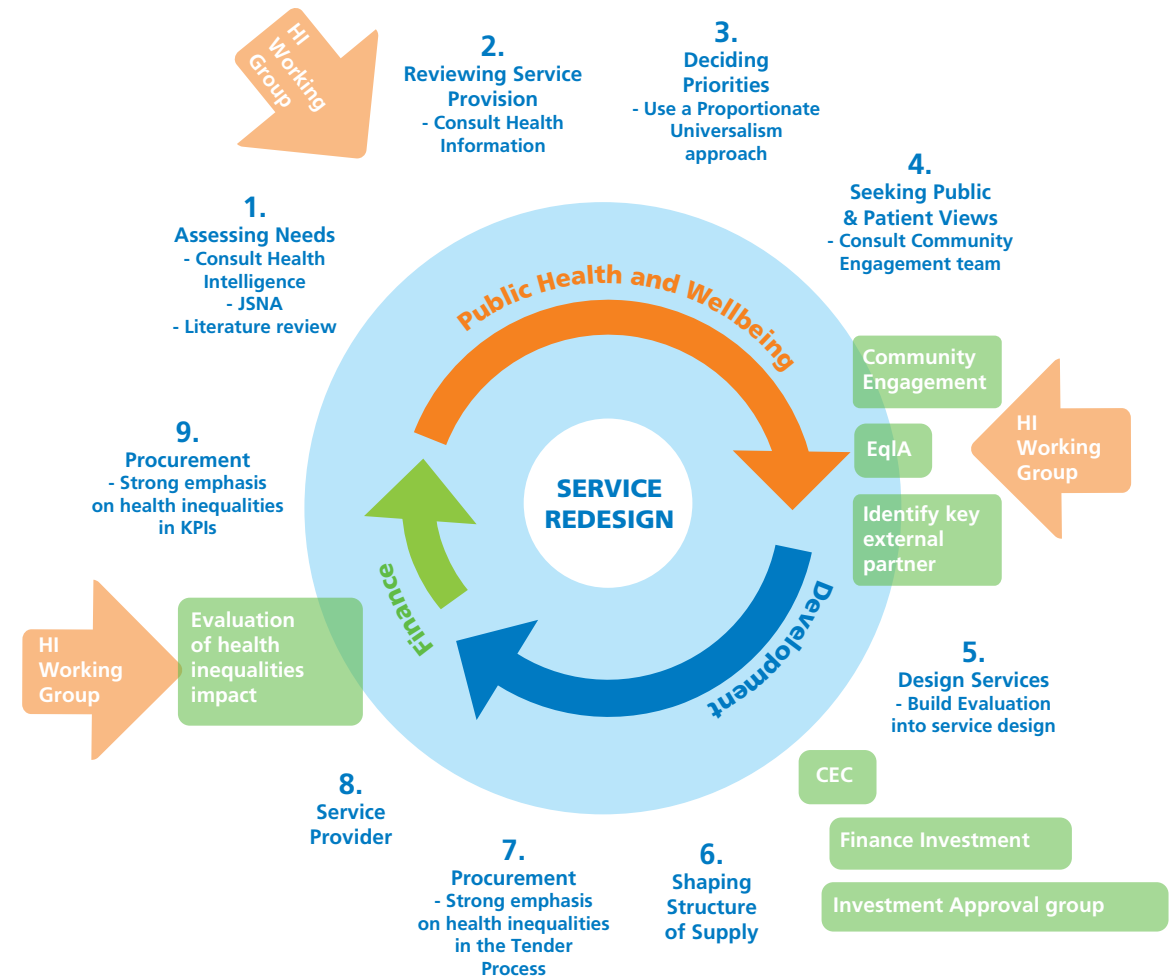
For example,

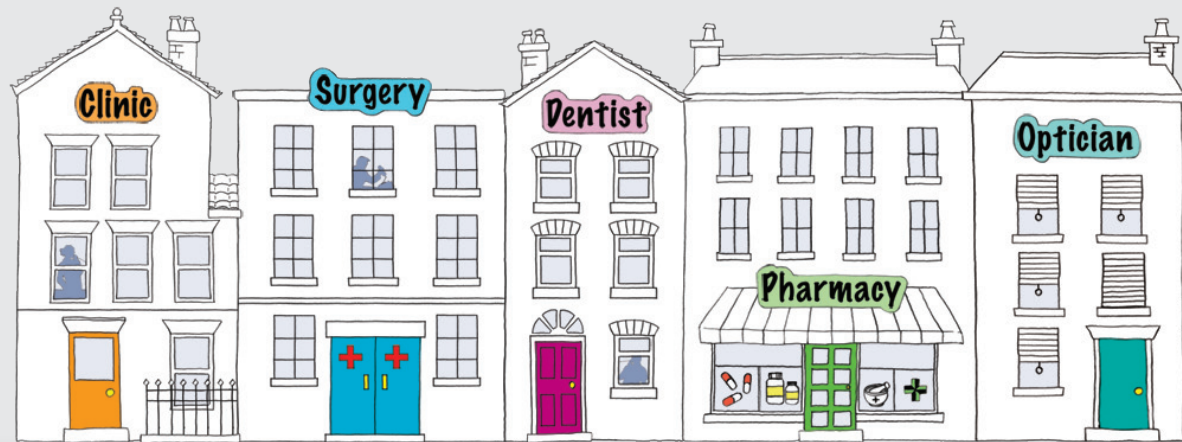
Universal cardiac rehab programmes are often underused by BME groups, women and people with disabilities due to cultural, physical or other social barriers²⁴. The addition of specially designed cardiac rehab programmes targeting these groups increases uptake and retention.

Actions

1. Allocate resources in proportion to need, following an approach of Proportionate Universalism
2. Health Intelligence should consider the upcoming JSNA guidance that is being produced by the National Inclusion Health Board
3. Commissioners should use the JSNA as a basis for understanding need across the borough and between different groups within the local population
4. Commissioners should develop action plans or pledges based on the actions listed in this document
5. NHS Kensington and Chelsea should incorporate the upcoming Inclusion Health commissioning guidance in our approach to reach the needs of more disadvantaged groups

The Commissioning cycle Adapted from the DH Commissioning Framework 2006





Consider Health Inequalities throughout the commissioning cycle

Using the PCT map of the commissioning cycle, we have highlighted the stages where a consideration of health inequalities should occur. In reality, not all commissioning follows such a formal course. However, the diagram demonstrates the importance of considering health inequalities throughout. Similarly, community engagement is a useful tool at several stages in order to both plan and evaluate services.

The Health Inequalities (HI) Working Group will be formalised to provide advice at any point of the cycle. It is particularly important to consult them at the stages highlighted in the map on page 19.

Universal services can inadvertently widen health inequality

National evidence has shown that current attempts to improve health have often inadvertently increased health inequality, despite the best intentions³⁵. Advantaged groups often take up and benefit from universal services more than disadvantaged groups.

For example,

Cervical screening programmes present significant barriers to women with learning disabilities, resulting in lower uptake rates³⁶

Actions

1. Undertake a piece of work assessing DNA (Did Not Attend) rates for all services in order to evaluate engagement of service users. Undertake this work on a priority basis, starting with higher impact services
2. Respond to the results of this work, using community engagement strategies to identify barriers to attendance

Equitable commissioning may cost more

Funding should be based on need. This will involve accepting that it may cost more to provide the same service to a certain groups due to increased cost of delivery and support. We must also move away from historical funding, where budgets are allocated simply according to what services cost in previous years.

For example,

National data shows it is three times more costly to support someone quitting smoking who is from an ethnic minority than a white Caucasian³⁷

Actions

1. Commissioners should work towards knowing the cost per head of interventions, comparing disadvantaged groups and the general population
2. Commissioners should work towards being able to analyse whether these costs per head reflect need, and act on the results by adapting Service Level Agreements (SLA) where possible

Hitting the target but missing the point

The easiest to reach are often the more affluent. Targets may introduce an 'incentive ceiling' where, in order to reach the target, we deliver to groups that are easiest to engage. This approach fails disengaged populations that are likely already to be disadvantaged³⁸.

An important example can be seen in QOF (Quality and Outcomes Framework) threshold targets and exception reporting which can lead to GP registers sub-optimally diagnosing and treating deprived populations³⁹. They do well on the easier to reach in order to achieve the target. However, several PCTs have made progress in compensating for this effect, using Local Enhanced Services (LESs) to add additional incentives to GPs to deliver on health inequalities.

Actions

1. Commissioners should consider adapting all contractual tools to ensure that GPs provide more equitable quality of care to all patients
 - a. Compensate for QOF by incentivising GPs with LES
 - b. Contractual penalties if GPs perform badly
2. For all targeted services, commissioners should analyse the impact of the target on health inequalities:
 - a. Use the EqIA if planning a new service
 - b. For existing services, analyse activity data to determine which patient groups are under-engaging. Under-engagement should be addressed through social marketing



Quick wins can be short-sighted

Short term target-driven projects are often commissioned over more complex programmes. However, NICE recommends 'spending to save' in the future⁴⁰. Success is more likely to come from the cumulative impact of a range of complementary programmes over time⁴¹.

Build on current activity and infrastructure

There is no need to re-invent the wheel. Scale-up or modify successful current programmes. Think how mainstream spending can be best used, rather than relying on new project funding⁴². Proper evaluation can showcase successful local programmes. This will avoid unnecessary set-up costs, double running and awareness building.

Actions

1. All business cases should include an evaluation of whether any existing services could potentially play a part in or deliver the proposed new service. This should include cost analysis

The co-benefits of sustainability and equality

The sustainability agenda is closely aligned with strategies to tackle health inequality. First, the environmental benefits of a sustainable lifestyle also improve health. Second, changes in society that foster sustainability can also reduce health inequalities. This is because interventions to promote sustainability often impact more on deprived populations. For example, areas with greatest need of green spaces are often the most deprived. Policies to improve access to green spaces will put parks in these areas. This will improve health by encouraging physical activity and increasing community well-being.

NHS Kensington and Chelsea's Carbon Reduction Strategy seeks to reduce our carbon emissions by 10% by 2015. This reduction will not be possible without the active engagement of Commissioners.

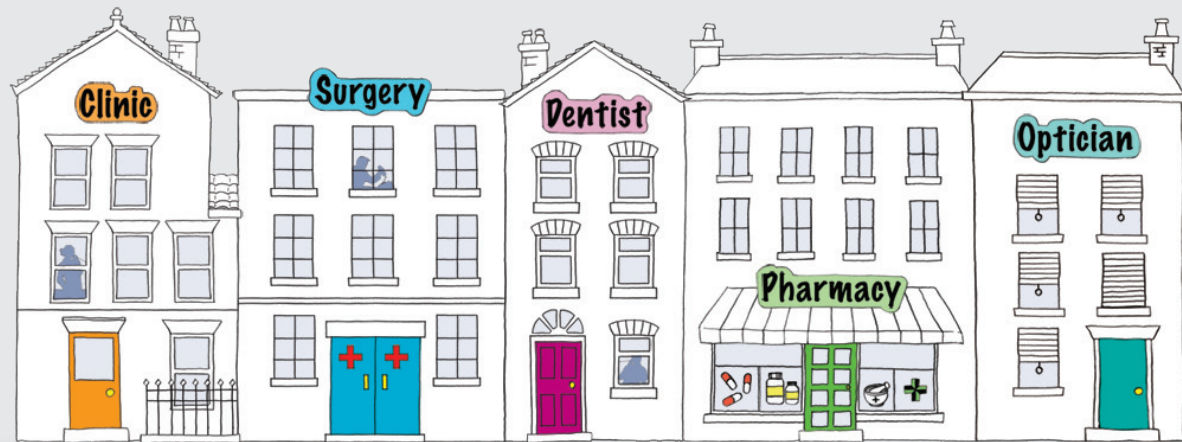
For example,

Increasing active travel will reduce both obesity levels and the number of car journeys.

Encouraging people to eat less meat will help reduce cardiovascular risk as well as reducing the carbon footprint of livestock farming

Actions

1. All Commissioners should be responsible for knowing the carbon footprint of the services they commission and seek to reduce this where possible
2. All tender specifications should include a section requiring potential providers to demonstrate how they will promote sustainability



1.5 Strengthen the role of Equality Impact Assessments (EqIA)

'All national and local policies and strategies should be routinely scrutinised through a Health Equity Impact Assessment.'⁴³

What official documents ask questions about health inequalities?

A variety of documents have been developed by different departments all seeking to examine the impact of services, policies or functions on equality.

- **Equality and Diversity teams** concentrate on compliance with the law and their principle document is the *Equality Impact Assessment*.
- **Public Health** departments focus more specifically on health impacts. Traditionally they have used *Health Impact Assessments* to evaluate the potential impact of new services; and *Health Equity Audits* to look at whether existing services have been allocating resources in proportion to need.

We want to simplify this: NHS Kensington and Chelsea will focus on the EqIA

We believe that all public health functions, as well as compliance with equality and diversity legislation can be served by a robust EqIA. We propose to put the EqIA at the heart of this Framework to provide:

1. **Evidence of compliance** with anti-discrimination and equalities legislation.
2. **A focus for Commissioners to document their analysis** of potential inequalities arising from a service. This should include evidence of community engagement, literature search and a response to needs identified.
3. **An opportunity for quality assurance** of PCT action on health inequalities. Through excellent EqIA, the PCT can ensure that every service it commissions contains thorough consideration of impact on health inequality.

What exactly is an EqIA?

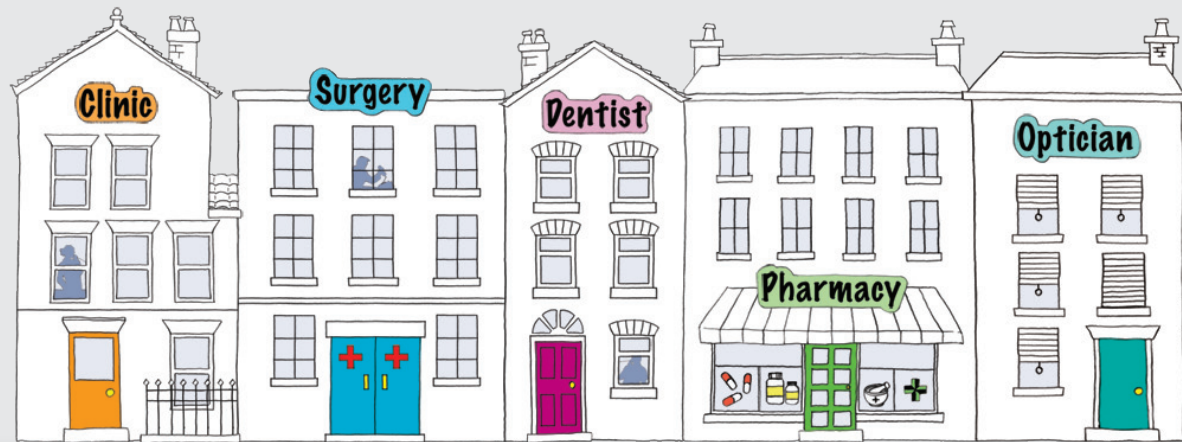
An Equality Impact Assessment (EqIA) is a tool designed for use across all PCTs, local authorities and government bodies to identify the potential impact of policies, services and functions on its staff and residents. Undertaking EqIA both promotes good practice as well as providing evidence of compliance with anti-discrimination and equalities legislation⁴⁴.

Equality and Diversity Managers are responsible for designing the EqIA documents. Typically, the EqIA includes analysis of the impact of services on the local population and PCT staff according to diversity strand. Currently, the diversity strands in NHS Kensington and Chelsea EqIA are: Age, Gender, Ethnicity, Religion, Disability and Sexual orientation.

What will we change about the EqIA?

The EqIA has huge potential as a tool for Commissioners to tackle health inequality. However, currently it is not always used to greatest effect. We propose that for a robust and consistent approach, the EqIA should:

- Contain **Socioeconomic Disadvantage** as an additional diversity strand. This is because socioeconomic disadvantage is a major contributor to health inequalities and has recently been included in the 2010 Single Equalities Bill⁴⁵
- Be compulsory for all new services, policies and functions
- Be performed retrospectively for as many existing services, policies and functions as possible, prioritising those at high risk of impact on inequality
- Involve formal accountability both for quality assurance and sign-off of EqIA.



Actions

1. Make completion of an EqlA an obligatory stage in the commissioning cycle with formal sign off by the Investment Approval Group, Clinical Executive Committee and/or Finance, Investment & Performance Board SubCommittee as appropriate
 - a. An EqlA should be undertaken on all new services
 - b. An EqlA should be completed on all existing services within two years
2. Add Socioeconomic Disadvantage as a diversity strand
3. All EqlA should include evidence of needs assessment, community engagement, literature search and a response to needs identified. An explanation must be supplied if this is not possible.
4. Make it easier for commissioners to complete EqlA
 - a. Revise the EqlA document
 - b. Train commissioners to write EqlA
 - c. Support commissioners while writing EqlA (the Health Inequalities Working Group)
 - d. All completed EqlAs will be posted on the intranet
5. All EqlA to be reviewed by the Health Inequalities Working Group
6. EqlA in tender specifications
 - a. All EqlAs to be included in the invitation to tender documents
 - b. All tender specifications should contain a section requiring potential providers to explain how they will address issues raised in the EqlA
 - c. The scoring should be heavily weighted to ensure that winning providers have addressed issues raised in the EqlA

1.6 Strengthen engagement with people and communities

'Without citizen participation and community engagement fostered by public service organisations, it will be difficult to improve the penetration of interventions and to impact on health inequalities.'⁴⁶

Community engagement should be an essential part of commissioning in order to:

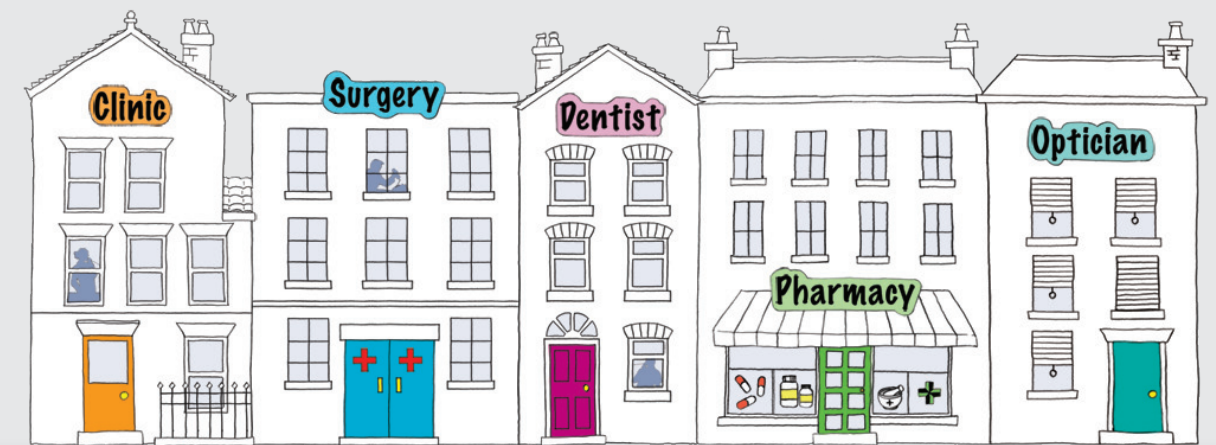
- Give residents greater influence over their own health and local services
- Ensure that commissioning responds to local needs

We must avoid routine, brief consultations but rather involve residents to define local problems and seek solutions together. Ineffective consultations may inadvertently exacerbate inequalities by only engaging with those who are easiest to reach.

Actions

1. Residents should be included on procurement panels, where possible
2. Ensure that all commissioners have read the NICE guidance on community engagement (February 2008) as part of their induction
3. Commissioners should ensure that the results of community engagement are integrated into service design, tender specifications and performance management
4. Assess our progress in strengthening dialogue by collecting feedback from the RBKC Residents Panel

2. Act as a Local Champion



NHS Kensington and Chelsea is uniquely positioned in the borough to influence all the major players required to tackle health inequality. Every PCT has a responsibility to act as a champion and a facilitator to influence other sectors to take informed action to reduce inequalities in health⁴⁷.

2.0 Aims

- 2.1 Position NHS Kensington and Chelsea as a leader in tackling health inequality
- 2.2 Maximise PCT impact on the wider determinants of health
- 2.3 Make partnerships more effective
- 2.4 Increase the confidence of our residents in the PCT

2.1 Position NHS Kensington and Chelsea as a leader in tackling health inequality

If NHS Kensington and Chelsea is to be the recognised leader in tackling local health inequality, we must first lead by example. As well as putting our house in order in terms of commissioning to reduce inequalities, we should be a good corporate citizen in everything from sustainability, staffing and catering⁴⁸. We can achieve this by following the actions in *Put Our Own House in Order*.

Second, we must position ourselves to influence local policy as far as possible. It is our responsibility to actively seek out innovative ways to align the health inequalities agenda with the activities of local partners. The following section expands on this.

2.2 Maximise PCT impact on the wider determinants of health

The PCT is well placed to influence and coordinate action on the wider determinants of health. Direct commissioning of PCT action on wider determinants, such as *Fit For Work*, has already been discussed. We must continue to work with local government and other public sector agencies that shape the wider determinants.

The PCT can influence local policy

Almost all RBKC activity has public health implications – e.g. transport, housing, education, employment, social care and leisure services. The PCT must position itself and equip its staff to influence RBKC policy so that it maximises health benefits and reduces health inequality.

Innovative partnership work with local statutory agencies

Local statutory agencies provide opportunities to reach our residents in new ways. We can either 'piggyback' onto existing activity or develop new partnership work.

It makes sense to work together. There is considerable overlap between groups that we target to reduce health inequalities and groups of interest to local statutory agencies. For example, criminality is higher in socioeconomically deprived areas⁴⁹ where recreational drug use is common and premature death rates are high⁵⁰. Equally, domestic fires are more common in socioeconomically deprived areas, in council flats and where people smoke or have limiting disabilities⁵¹. It is in the interest of all agencies to work together to tackle the causes.

Furthermore, we will increase residents' confidence in the PCT by delivering efficient services integrated with those they receive from other statutory sectors. This will increase engagement and improve health outcomes.

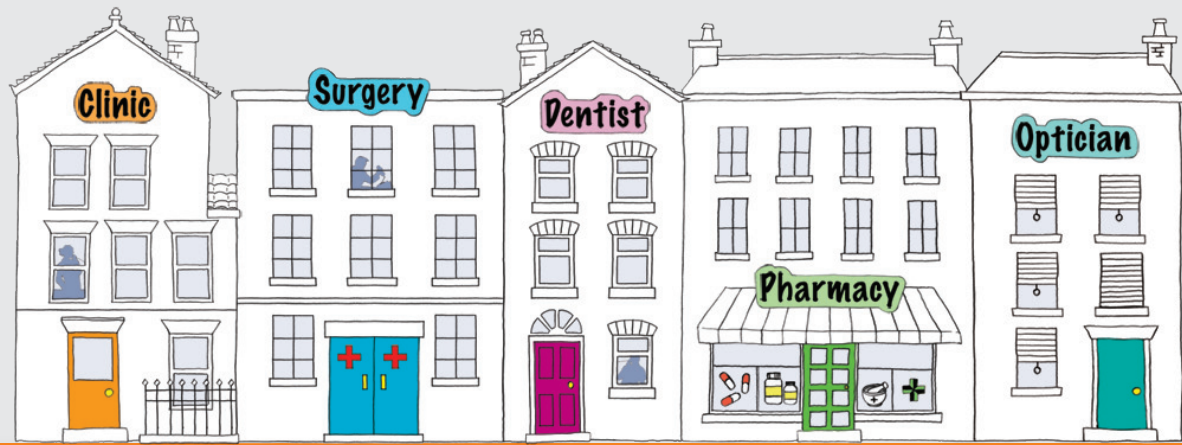
For example, Merseyside Fire and Rescue

In the last 10 years Merseyside Fire & Rescue Service has expanded its role to promote healthier, safer communities by teaming up with PCTs and other local agencies.

While visiting homes for fire safety checks, firefighters deliver opportunistic health promotion on issues such as fitness, sex education, drugs, alcohol and road safety awareness. They also liaise with the housing authority and social services on behalf of residents in need⁵².

Actions

1. The PCT should actively seek to influence the agenda and working of partnership committees and working groups to reflect health inequalities
2. All PCT strategies should contain analysis of whether work with RBKC and other partners can play a part
3. All departments should consider whether their services could benefit from increased involvement with other statutory sectors such as the Police or Fire and Rescue
4. Expand brief advice training (*Nudging People Towards Good Health*) to professionals in other sectors



2.3 Make partnerships more effective

Improving partnership work is a recommendation commonly offered, but easier said than done. The potential gains are clear: by working together partners extend their sphere of influence producing better outcomes and saving money.

Use partnerships that already exist to best effect

Excellent partnerships already exist between the PCT and RBKC with huge potential to affect health inequalities. Indeed, some groups were explicitly established to deliver on these issues such as the Health and Wellbeing Partnership Board. Others have an active issue in health and wellbeing as a cross cutting theme such as the Kensington & Chelsea Partnership (LSP). The Local Involvement Network (K&C LINK), Action Disability K&C and the BME Health Forum are examples of community partners who help us actively engage with communities and shape services to improve health. In our eagerness to innovate, we must not forget to invest in the relationships that we already have.

The third sector is often underused

Some potential partnerships have been underexplored. The third sector is well placed to access communities and identify innovative approaches to reach the 'seldom-seen-seldom-heard'. However, the move to a commissioning relationship with funders has been challenging for some third sector organisations, particularly smaller ones who may be working with particularly marginalised communities.

If the PCT is to stimulate the whole market, it is in our long term interest to support the third sector as a potential provider with training and support throughout the tender process. We currently commission the Kensington and Chelsea Social Council (KCSC) to provide advice and support for local voluntary organisations who are bidding for NHS contracts to provide services. This role will become increasingly important if the potential of third sector providers is to be realised.

Partnerships within the third sector can strengthen bids from that sector but require time to develop. A fair tendering process is clearly essential. However, fairness may involve giving the third sector additional time to bring together the relevant parties. Importantly, consulting early with the third sector and involving them in service design is not against Procurement Law⁵³. It is essential to treat all applicants fairly and maintain transparency. An excellent guide⁵⁴ to involving the third sector has been written by The Compact, a voluntary agreement between the government and the third sector in England.

Actively seek out new ways to work in partnerships

There is considerable potential for novel partnership work between the PCT, the local authority and other statutory sector agencies such as the Fire and Rescue or Police departments. More than just committing to the concept, Commissioners should be encouraged to think imaginatively to devise exciting new opportunities for health promotion and health service delivery.

Align your agendas effectively

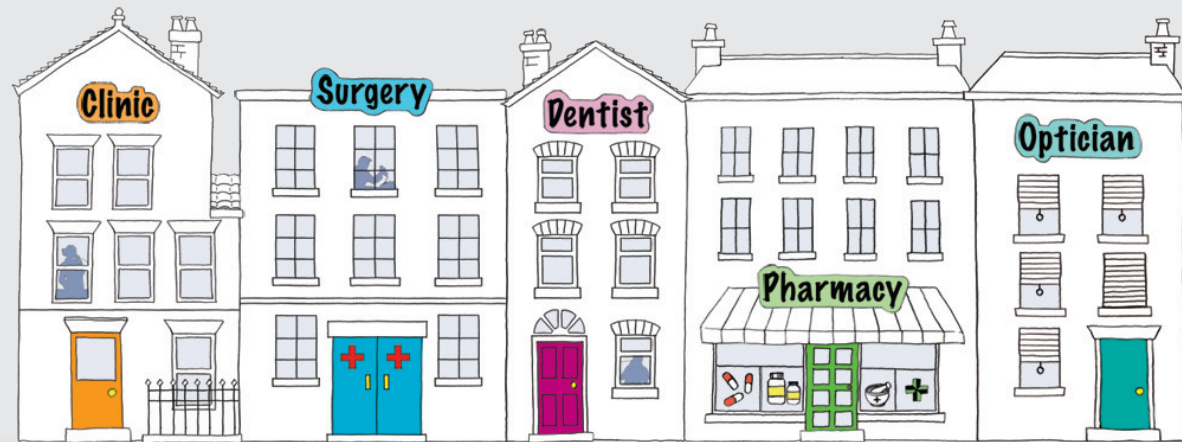
Partnerships work when all parties benefit. It is important to find the co-benefits of your agendas. For example, increasing sustainability and reducing carbon emissions by promoting active travel also helps increase physical activity and reduces cardiovascular risk. We cannot expect others to always support us and must recognise that aligning agendas may involve adapting our own plans or travelling to others' meetings.

Ensure partnerships amount to more than the sum of its parts

We will use meetings as an opportunity to develop innovative *combined* approaches. Otherwise, there is a risk that multi-agency work is nothing more than each partner reporting back to the group on work that they would anyway have done.

Share information effectively

One barrier to efficient partnership work is the lack of data required to support joint interventions. The PCT is signed up to data quality and data sharing agreements with our partners and we will seek to promote both aspects of partnership working.



3. Collect, Use and Share the Evidence

Actions

1. Choosing Good Health Together (CGHT) should frame its Mid-Term Review around health inequalities
2. Use this Framework to stimulate a shared strategic approach to reducing health inequalities with the local authority and other statutory sectors
3. Make greater and more effective use of our existing relationships with community partners including BME Health Forum, K&C Link and Action Disability K&C.
4. Commissioners should actively encourage tender applications from the third sector. This may require:
 - a. Liaison with Kensington and Chelsea Social Council (KCSC) to identify third sector organisations able to deliver programmes addressing local health inequalities
 - b. Contracting
 - i. Commissioners should work with KCSC to develop a more streamlined and joined up contracting process between the PCT and third sector
 - c. Procurement:
 - i. Provision of additional support to applicants inexperienced in tender competition
 - ii. Provision of additional time to third sector applicants when inviting to tender
 - d. Capacity building
 - i. KCSC should be encouraged and resourced to support organisations in contracting applications and tenders
 - ii. Commissioners should encourage the submission of third sector business cases to the PCT outside the contract rounds. This should be coordinated by the KCSC

2.4 Increase the confidence of our residents in the PCT

'Community engagement on a systematic basis is an essential element in partnership working for addressing health inequalities.'⁵⁵

Our residents are an invaluable resource to inform commissioning but they are under used. Partnership with the local community is as important as work with the local authority or third sector. Although it has been discussed earlier in 'Putting Our House in Order', this section on becoming a local champion of health inequalities would be incomplete without ensuring rigorous and effective community engagement throughout the commissioning cycle.

The Marmot Review has provided the most comprehensive analysis of the evidence on tackling health inequality to date. For years we have known how to demonstrate the existence of inequality but not what to do about it. The Review illustrates that there is a great deal of published evidence but also that more is required. It is therefore our responsibility as Commissioners to:

- Know how to look for evidence
- Know how to use evidence
- Know how to collect our own evidence
- Share evidence

3.0 Aims

3.1 Build all commissioning decisions on a comprehensive evidence base

3.2 Improve evaluation of service outcomes

3.3 Share knowledge with all stakeholders and partners

3.1 Build all commissioning decisions on a comprehensive evidence base

The ability to collect and use evidence effectively underpins commissioning⁵⁶. Marmot asserts that health inequality can only be tackled if PCTs promote a 'culture of evaluation and research' and by 'involving the public in identifying the most effective interventions to improve health'⁵⁷.

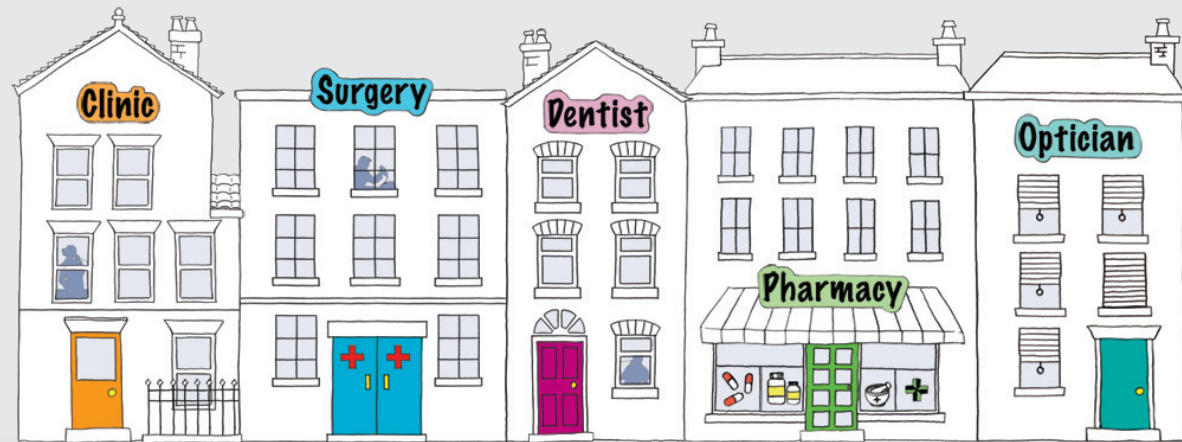
For example, Sources of information to help writing EqIA

Inclusion Health Evidence Pack

A summary of national evidence compiled by the Social Inclusion Task Force at the Cabinet Office. It includes statistics on access to health services and health outcomes for all socially marginalised groups

Health Inequalities Enhanced Support Programme Resources Manual

A Department of Health Enhances online resource containing links to a range of information and tools, including reports of best practice and guides to writing EqIA for specific health issues



Actions

1. Strengthen PCT assessment of health inequalities through a strong JSNA which explicitly explores inequalities
2. Evidence of commissioners developing their skills in tackling health inequality should be included in their ongoing professional development plans:
 - a. Develop skills in literature review by attending training
 - b. Keep abreast of the latest evidence on reducing health inequality in the areas which they commission
 - c. Register as stakeholders during the development of NICE guidance

3.2 Improve evaluation of service outcomes

'All too frequently, interventions and policies are implemented without building into their design the capacity to undertake a thorough evaluation of the outcomes⁵⁸.'

Use appropriate indicators

In order to demonstrate achievement in tackling health inequality, outcomes must be carefully evaluated using well-chosen indicators. In this way we can reproduce successes and learn from mistakes. Indicators should be SMART (specific, measurable, achievable, relevant and time-bound).

Ensure good data collection

Evaluation must be planned early and incorporated into service design from the start. The PCT can ensure that providers collect high quality data if this message is made clear in tender specifications and performance management.

Actions

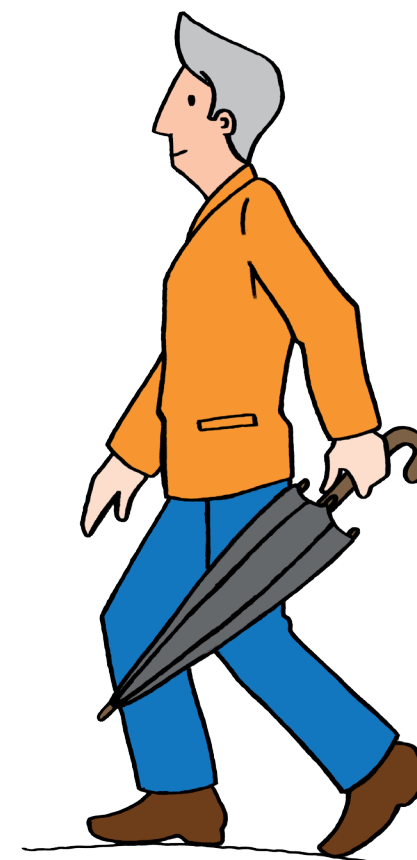
1. All business cases should include criteria for success, including the indicators chosen to measure action on health inequalities
2. All service specifications should ask potential providers to demonstrate how they will ensure robust data collection
3. All services should include KPIs designed to ensure robust data collection by providers
4. All evaluation of service outcomes should include an assessment of the impact on health inequalities

3.3 Share knowledge with all stakeholders and partners

In order to improve our ability to tackle health inequalities, we must share our knowledge and learn from the activity of colleagues and local partners.

Actions

1. Commissioners should share evidence of best practice through the JSNA process
2. Commissioners should be encouraged to document evidence of information sharing in their personal development plans:
 - a. Write up results of success tackling health inequality
 - b. Present both at PCT meetings and conferences



References

- ¹ [The Marmot Review 2010](#) (p. 3)
- ² [Kensington and Chelsea JSNA 2009](#)
- ³ NHS Kensington and Chelsea Commissioning Strategic Plan 2010
- ⁴ The [World Class Commissioning Competencies](#): see appendix 1 for more details
- ⁵ Black Report (1980)
- ⁶ [Acheson Report](#) (1998)
- ⁷ [Marmot Review](#) (2010)
- ⁸ [Kensington and Chelsea JSNA 2009](#)
- ⁹ [The Marmot Review 2010](#) (p.17)
- ¹⁰ Simpson C, Hippisley-Cox J, Sheikh A. Trends in the epidemiology of smoking recorded in UK general practice. British journal of general practice March 2010
- ¹¹ Hart. The Inverse Care Law. Lancet 1971 Feb 27;1(7696):405-12.
- ¹² [The Marmot Review 2010](#) (p.15)
- ¹³ [The Marmot Review 2010](#) (p.153)
- ¹⁴ NHS Kensington and Chelsea Commissioning Strategic Plan 2010
- ¹⁵ [The Marmot Review 2010](#) (p.154)
- ¹⁶ [The Marmot Review 2010](#) (p.86)
- ¹⁷ National Support Team [Systematically Addressing Health inequalities 2008](#)
- ¹⁸ [The Marmot Review 2010](#) (p.152)
- ¹⁹ [The Marmot Review 2010](#) (p.151)
- ²⁰ National Support Team [Systematically Addressing Health inequalities 2008](#)
- ²¹ NICE (2009) Using NICE guidance to cut costs in the down turn
- ²² [The Marmot Review 2010](#) (p.145)
- ²³ Scarborough et al 2008, Jarvis & Wardle 2006 cited in [The Marmot Review 2010](#) (p.144)
- ²⁴ ONS VS 2007 Causes of death in Kensington & Chelsea ([NHS KC Health Information on the PCT intranet](#))
- ²⁵ Kensington & Chelsea Health Profile 2010, APHO and Department of Health 2010
- ²⁶ Health England (2009), [Public Health and Prevention Expenditure in England](#), Report no. 4
- ²⁷ The [Wanless Report](#) 2004
- ²⁸ [The Marmot Review 2010](#) (p.140), [Gilson, Doherty, Loewensen and Francis \(2007\)](#)
- ²⁹ [The Marmot Review 2010](#) (p.88)
- ³⁰ Dame Carol Black Report 2008, [Working for a Healthier Tomorrow](#)
- ³¹ NHS Kensington and Chelsea [Single Equality Scheme](#) 2009
- ³² [The Marmot Review 2010](#) (p.15)
- ³³ Social Exclusion task Force (2010) Inclusion health—improving the way we meet the primary care needs of the socially excluded. HM Government, London.
- ³⁴ [Brodie, Bethel and Breen, 2006](#) Cardiac rehabilitation in England: a detailed national survey. European Journal of Cardiovascular Prevention and Rehabilitation 2006; 13(1): 122-128
- ³⁵ [The Marmot Review 2010](#) (p.86)
- ³⁶ [Watts \(2008\)](#): Access to cervical screening for women with learning disabilities
- ³⁷ National Support Team [Systematically Addressing Health inequalities 2008](#) (p.17)
- ³⁸ White head et al 2009 Task Group Submission to [The Marmot Review 2010](#) (p.88 & 90)
- ³⁹ [Fleetcroft et al 2008](#) “Mind the gap!” Evaluation of the performance gap attributable to exception reporting and target thresholds in the new GMS contract: National database analysis. BMC Health Serv Res. 2008 Jun 17;8:131. and [The Marmot Review 2010](#) (p.157)
- ⁴⁰ [NICE \(2009\)](#) Using NICE guidance to cut costs in the down turn
- ⁴¹ [The Marmot Review 2010](#) (p.86-87)
- ⁴² [The Marmot Review 2010](#) (p.93)
- ⁴³ [The Marmot Review 2010](#) (p.152)
- ⁴⁴ I&DEA, [Ideas and Development Agency](#) website
- ⁴⁵ [Government Equalities Office](#) website
- ⁴⁶ [The Marmot Review 2010](#) (p.151)
- ⁴⁷ [The Marmot Review 2010](#) (p.153)
- ⁴⁸ [The Marmot Review 2010](#) (p.154)
- ⁴⁹ The Home Office 2008/09 [British Crime Survey](#)
- ⁵⁰ [Kensington and Chelsea JSNA 2009](#)
- ⁵¹ Merseyside Fire Department analysis of [The Social Dimension of Fire](#)
- ⁵² The Merseyside Fire and Rescue service [website](#) and [The Marmot Review 2010](#) (p.153)
- ⁵³ [The Compact and Procurement Law](#), A guide to FAQ, July 2009
- ⁵⁴ [www.thecompact.org.uk](#)
- ⁵⁵ [The Marmot Review 2010](#) (p.162)
- ⁵⁶ The [World Class Commissioning Competencies](#): see appendix 1 for more details
- ⁵⁷ [The Marmot Review 2010](#) (p.153)
- ⁵⁸ [The Marmot Review 2010](#) (p.169)

