



Chapter 5

Making it happen: A framework for delivering and monitoring reductions in health inequalities along the social gradient

5.1 Delivery systems

This chapter considers specific roles and responsibilities in the delivery of reductions in health inequalities across the social gradient. Central and local government, the NHS, the third sector, the education system, the private sector, individuals, families and communities all have significant roles and responsibilities for reducing health inequalities and delivering the interventions and proposals outlined in Chapter 4.

Throughout this chapter key delivery and implementation proposals are highlighted in bold. The proposals were shaped by feedback from a number of sources. These include the reports of the Review task groups, responses to the Review consultation and feedback from a range of conference, seminars and workshops across the country attended by the Review team. The outcome of these formal and informal consultations suggested greater flexibility is desirable across the delivery system. This includes government providing coherent, consistent strategic direction and aspirational targets, while facilitating local partners to engage with the public and communities in finding local community-driven solutions to health inequalities. Local indicators and targets used for monitoring should be nationally comparable.

Details are provided about two major regional partnerships, between the Review team and the North West region and London. The aim of these partnerships has been to work with regional partners as exemplars in implementation and for the Review to learn from their work.

This chapter also sets out the framework needed to set targets and establish indicators of outcome, output and process to underpin the recommendations of the Review and address the issues of research and evaluation.

5.1.1 Taking a whole-system approach

Chapter 3 explored the lessons learned so far from recent strategies to reduce health inequalities. Strategies that rely only on intervention in one part of the system will be insufficient to make the necessary difference to patterns of inequality. A whole-system approach is needed in which organisations and people work together with activity at national, regional, local and individual levels. The national and regional levels are concerned with:

- The imperative of greater social justice and sustainability and the implications for policies to redistribute power and resources, and improve financial systems
- Policies to maintain and improve universal health and welfare systems
- Strategy and policy to enable public services to create and promote the conditions within which individuals, communities and the public take control of their own lives and have a voice.

Locally, the focus should be on:

- Creating opportunities for individuals and communities to set the agenda for change to define local problems and search out local solutions
- Developing, commissioning and improving good-quality, integrated local services co-produced with the public to achieve better outcomes for communities and individuals.
- Appropriate links between these levels and organisations will be necessary to create partnerships to address health inequalities and there needs to be a shift in power and resources towards local communities.

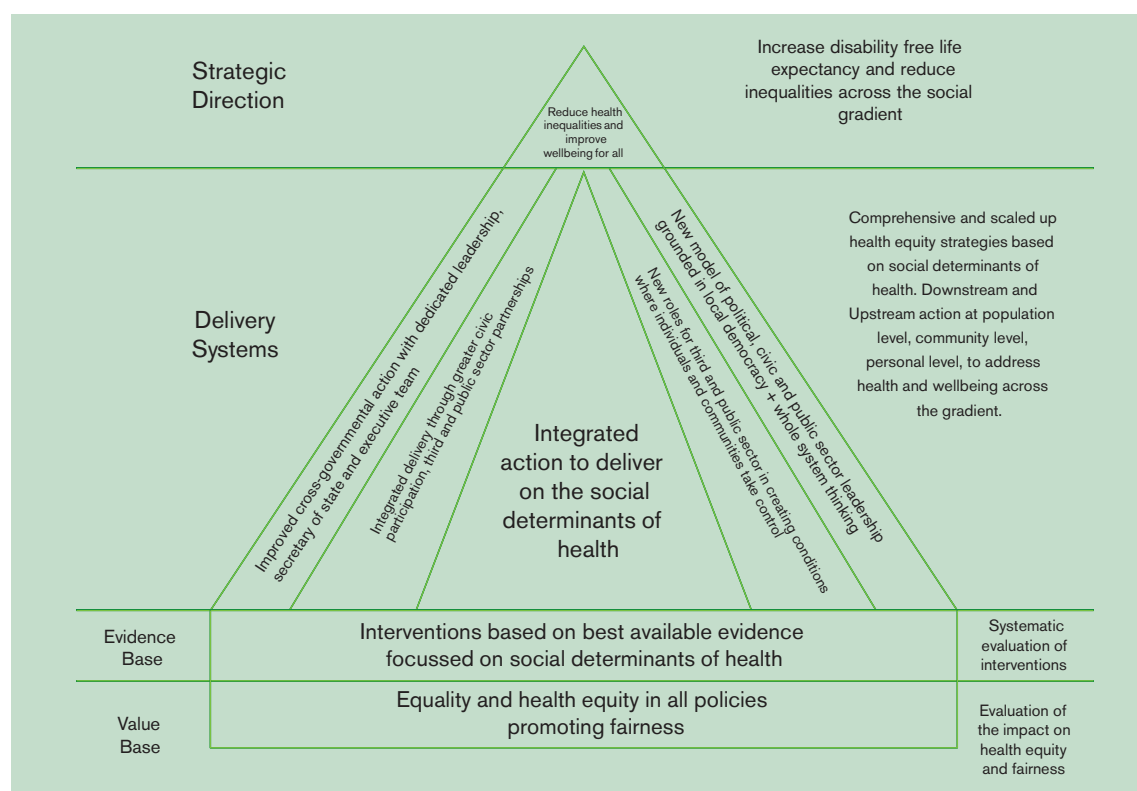
5.1.2 Empowering people: securing community solutions

Without citizen participation and community engagement fostered by public service organisations, it will be difficult to improve penetration of interventions and to impact on health inequalities.⁵⁴⁰ The private sector also has a key role to play (see, for example, Section 5.1.7). To achieve this goal community engagement practices need to move beyond what are often routine, brief consultations, to involving individuals in partnerships to define problems and develop local solutions to address those problems. Community interventions should be about:

- Building active and sustainable communities based on principles of social justice. This is about changing power structures to remove barriers that prevent people from participating in the issues that affect their lives.⁵⁴¹

Promoting this approach sets a new task for political, civic and public service leadership in creating the conditions which enable individuals and communities to take control of their own lives, and in developing and sustaining a wider range of capabilities across the life course.⁵⁴² This is set out in Figure 5.1 and the subsequent proposals.

Figure 5.1 Future delivery scenario



Source: Adapted from a model in Bernstein et al⁵⁴³

— **Political, civic and managerial leadership in public services should focus on creating the conditions in which people and communities take control, to lead flourishing lives, increase health expectancy and reduce disparities in health expectancy across the social gradient.**

5.1.3 The role of national government

Political leadership

In Chapter 3 we described how a lack of coordination across government departments presents a significant challenge for addressing health inequalities. Responsibility for the social determinants of health lies across government. The scale and complexity of the task of reducing health inequalities cannot be underestimated. This Review recommends in this context that robust political leadership should be provided through the Secretary of State for Health with an explicit cross-government remit to deliver on health inequalities. This political leadership should be supported by the appointment of joint, multi-skilled teams working across all relevant government departments to facilitate integrated cross-government policy under the direction of a single lead director with overall authority and responsibility.

— **Cross-cutting political leadership on health inequalities should be vested at Cabinet level with the Secretary of State for Health having lead responsibility, working**

with other ministers across government, to deliver this cross-departmental agenda.

— **A joint multi-skilled cross-cutting team with a single director should support the political leadership.**

Departmental leadership

In considering the issue of key departmental leadership, a more dispersed model could be beneficial in gaining wider ownership across government but might risk dissipating responsibility. The Review therefore proposes that the Department of Health should retain a lead role with all other relevant government departments explicitly specifying their particular role and contribution in delivering on health inequalities based on the social determinants of health. There should also be an explicit requirement that all government policies and strategies be subject to a health equity impact assessment. This would provide a robust platform for concerted action.

— **The Department of Health should retain the lead for health inequalities. Other Government departments should set out explicitly their strategic contribution to reducing health inequalities based on the social determinants of health.**

— **All national and local policies and strategies should be routinely scrutinised through a health equity impact assessment.**

The outcome of consultations undertaken by the Review emphasised the role of government in providing strong, inspirational and consistent leadership based on influence. Direction through nationally set targets should be limited to carefully considered measures that harness and support intended strategic direction. There is also an argument for more dispersed leadership, with national and regional government focusing on broad strategic plans around the social determinants of health. This framework would support a move to a more facilitative approach to local delivery systems and a shift away from nationally imposed targets. It would free up local partnerships to find locally appropriate solutions to locally identified problems and would foster accountability.⁵⁴⁴

Developing awareness among delivery organisations about the centrality of the social determinants in shaping health inequalities should be a central task for the Department of Health, Regional Offices and Strategic Health Authorities. This would help relevant delivery organisations shape more effective intervention and prevent a drift into projects solely focused on individual behaviours and lifestyle (discussed in Chapter 3).

The policy emphasis should address how mainstream spending can best be utilised to reduce health inequalities, rather than relying on new project funding. Interventions should be implemented with an evidence-based evaluation framework, incorporating a health impact assessment. Such action would inform public debate on the effectiveness of policies and disinvestment and investment for future delivery.

The principles set out seek to create new roles and national action to support local delivery based

on co-production and the encouragement of public participation and engagement that shifts power away from the centre towards people and communities and facilitates local action and delivery.

— **National government and policy should focus on the provision of clear, broad strategic plans for health inequalities, setting out short, medium and long-term objectives and should facilitate and support local action to define and deliver on local issues.**

Supporting delivery

The creation of support systems based on a model similar to the Health Inequalities National Support Team would enable speedy dissemination of good practice and extend support to local areas where awareness or expertise was lacking or where performance is falling short of the national framework and local expectations.

5.1.4 The NHS

This section will consider the contribution of Primary Care Trusts as commissioners of health services, the roles of NHS Trusts, Primary and Community Health services and Mental Health services.

NHS Primary Care Trusts

The NHS has a significant role to play in policy and programmes involving health promotion, disease prevention and health care. Even though most of the observed social inequalities in health status are not *caused* by what goes on in health care services,

Case Study Working in partnerships across communities

In the last 10 years Merseyside Fire & Rescue Service in Liverpool has expanded its role to one of ‘promoting healthier, safer communities’. This aim is pursued through a vast range of programmes and services, both targeted and universal, and an extensive network of over 120 formal and 80 informal partnerships.

The expanded service includes a universal service of home fire safety checks, installing free smoke alarms, discussing evacuation plans, and checking for potential fire hazards. The visits led establishing the community fire safety team, who visit homes flagged up as vulnerable by home fire safety checks. This team often refer to partners such as social services or housing associations. MFRS have visited over 400,000 homes. A further targeted provision is the team of advocates who have specific knowledge in certain areas and offer a personal service for people most in need of help, including drug and alcohol dependency advocates, disability and older persons’ advocates.

Ten youth programmes are available. The focus of these programmes includes promoting

healthy lifestyle and fitness, sex education, drugs and alcohol awareness and road safety awareness. One programme is FSN (fire support network) cage football, that aims to improve the fitness of the local youth and reduce anti-social behaviour. Just under 6,000 young people attended the sessions.

Lastly, the MFRS have implemented programmes to create community fire stations. These include on site free gyms, gardens and gardening projects, and community rooms.

MFRS received a Healthy Workplace Award for the extended services offered to their staff and families. They offer an Employee Assistance Programme, focusing on proactive health messages and signposting staff to healthy living. Sickness rates have decreased from 19 days/year in 1994/95 to 5.5 days in 2008/09

This exemplary work has been recognised in the recent receipt of a beacon award in reducing health inequalities and have received previous Beacon awards for “Services to Older People” and for “Early Intervention: Children at Risk”.

this does not mean that there is no role for the health care system in *reducing* inequalities in health status. Indeed, the health system has a potentially pivotal contribution to make to tackling social inequalities in health in a number of ways:

- Engaging people and communities in the co-production of world-class commissioning for patient-focused, integrated health services in partnership with local councils, third and private sector organisations.
- Putting its own house in order by commissioning an equitable NHS and addressing those inequalities in health *care* that are contributing to the observed inequalities in *health status*.
- Prioritising the commissioning of services that prevent or ameliorate the health damage caused by living and growing up in disadvantaged circumstances (that is, the health damage caused by wider social determinants of health) by responding systematically to individual and collective health conditions
- Shifting progressively the balance of spend from acute care into primary and preventive care and upstream interventions
- Acting as a champion and facilitator to influence other sectors to take informed action to reduce inequalities in health
- Promoting a culture of evaluation and research involving the public in identifying the most effective interventions to improve health
- Directly influencing other social determinants of health, such as local employment and economies, through effective commissioning and acting as a good ‘corporate citizen’ in everything from staffing to catering.⁵⁴⁵

NHS Trusts

There are other ways in which the health system can directly influence wider social determinants of health, improving local employment opportunities and proactively seeking to influence the local economy of disadvantaged areas. There is evidence of promising initiatives from around the English regions on all these issues. These include:

- *Tackling poverty by boosting the incomes of patients.* As part of wider anti-poverty strategies, several health sector agencies, in particular primary care organisations, have been experimenting with offering advice about claiming welfare benefits, a service delivered in health care settings. This directly tries to address the links between mental and physical health and income inequality, debt and material deprivation (described in Chapter 2).⁵⁴⁶
- *Improving working conditions.* Creating an organisational culture within NHS Trusts that maximises the participation of staff and reduces stress while supporting staff with effective and timely occupational health services. Such initiatives would not only be cost effective but would also provide a model for all employers. The recommendations of the final report of the NHS Health and Well-being Review (Boorman Review) are particularly relevant.⁵⁴⁷ The Boorman Review should be enhanced to ensure that inequalities in staff health are addressed through action on primary prevention for NHS staff in addition to reductions in incidence and duration of sickness absence.
- *Tackling unemployment.* The potentially significant contribution of health services in relation

Case Study Patrick, Healthwise Hull

Healthwise Hull is a community development programme focused on improving local health and well-being, targeting 3,000 people and seeking to train 300 local health champions to empower individuals within communities to adopt a healthy lifestyle. Its two accredited courses had a positive impact on ex-paratrooper Patrick, who completed both successfully. The training provided the opportunity for Patrick and his family to reflect on their health behaviours and consider how to improve their well-being. While the courses focused on healthy eating, smoking cessation, exercise and emotional well-being, it also encouraged participants to lead the way in voluntarily encouraging members of their community to engage with its messages. Patrick is testimony to this and has helped 545 people from his community work towards a healthy lifestyle.

Through his work as a Community Health Champion, Patrick has established firm links with members of his community by providing training

and support in healthy eating, exercise and smoking cessation. Patrick explains, ‘I speak to people in my own way... [I] pass on what I’ve learned personally. I tell them how it can be, if they change.’ Patrick uses a variety of means to communicate including booklets and leaflets but his preferred way is to provide a tailor-made programme. He states, ‘I get them to keep a diary. Then I sit down with them and say: could you change this or that? I then keep in contact with them to provide support when it’s needed.’

The initial Community Health Champion training, combined with Patrick’s work experience as a Community Health Champion, enabled him to access further education and paid work. Patrick now works as a health trainer and believes that accessing the course through Healthwise Hull helped him to positively change his career direction and health behaviours. He states, ‘It’s changed our family. We were in the right place at the right time. Those two courses have changed our lives.’

to work has been recently reiterated by the Government. There is particular emphasis on the value of intensifying medical rehabilitation services to help people recover from or manage their health condition to enable a return to employment.

- *Boosting the local economy.* The health sector can directly reduce poverty and unemployment by harnessing the NHS's purchasing power and position as a major employer. The premise on which this initiative is built is the recognition that the NHS and the public sector have tremendous economic weight. If this purchasing power were harnessed to support local businesses in the most hard-pressed communities, then the benefits might extend to greater social inclusion and equity, as well as improving the health of the community served.⁵⁴⁸

Primary care and community health services

Currently, GPs, like most primary care services – community health services, dentists, pharmacists and opticians, do not see tackling the social determinants of health inequalities as core business.⁵⁴⁹ However, it is possible to prioritise health inequalities as a routine part of primary health care and this could be reflected in existing GP contracts and contracting arrangements with other independent contractors and community health services.

Empowering patients

A number of policy initiatives have sought to put patients at the heart of the NHS and primary care and these could be focused on reducing health inequalities. Expert patients' programmes have extended health literacy programmes and support patients in exercising greater levels of expertise in managing long-term conditions. Evaluation of these programmes demonstrates the benefits to patients, their families and the NHS by improving self-management and health literacy.⁵⁵⁰

'Social prescribing' has also been used as a mechanism for linking patients with non-medical sources of support within the community.⁵⁵¹

Initiatives using local health trainers, community health champions and community development work also show encouraging signs of empowering individuals to participate and take control of their health and well-being. The impact of such innovations on health inequalities has yet to be determined. However, the approach facilitates greater participation of patients and citizens and support in developing health literacy and improving health and well-being.

There are also some individuals and groups who become marginalised as a consequence of stigmatised attitudes and who either access services but fail to receive a consistent service or who fail to access primary and community health services at all.⁵⁵² This poses a particular challenge to services in meeting health needs where patient mobility, chaotic lives,

Case Study Working with South Asian taxi drivers to create coronary heart disease champions for achieving better health in Sheffield (CABS)

One Medicare and Sheffield NHS looked at innovative ways to reduce health inequalities by screening, promoting access to services and empowering patients. They targeted South Asian Taxi drivers who had been identified as a high risk for coronary heart disease (CHD) and diabetes and who were known from the local health equity audit to struggle with accessing health care.

Engagement with community leaders took the form of a half-day consultation attended by a number of drivers who were identified and invited through existing contacts. Following this, a two-day training course on CHD was offered to a core group of drivers who would then become 'health champions' for the project.

Meetings were held with the Sheffield Taxi Trade Association to publicise the screening to drivers. The 'champions' were also involved in leafleting other drivers and the screening opportunity was advertised through the local taxi radio system.

Eighty taxi drivers attended the Sheffield City GP Health Centre for cardiovascular screening. As part of the health checks their height, weight, body mass index (BMI) and blood pressure were tested. In addition they were provided with onsite testing for blood glucose, cholesterol, liver and kidney

functions in order to provide a 'one stop' check and were given advice to improve their health.

Twenty patients were assessed as being at elevated risk above 20 per cent and therefore needing follow-up. One in four patients was found to have a BMI greater than 30 (above the safe range). A quarter of the patients present on the screening day was a smoker and smoking cessation advice was provided.

Thirty follow-up appointments were made, and 20 taxi drivers attended. Those drivers who were assessed to be requiring further intervention were offered the opportunity to see the GPs in the Sheffield City GP Health Centre or their own family doctor. All patients were satisfied with the service.

A further cohort of 17 drivers was recruited to the project largely through the engagement work of the first group of 'champions'. A subsequent screening was attended by 98 drivers.

One of the most important outcomes of the project has been the impact on the lives of the drivers who participated, and the informal work they are doing with others in the South Asian community to promote awareness and action around the causes of vascular disease.

stigma or patient capability pose significant barriers. There appears to be a lack of overarching strategy to respond to these socially excluded groups. This could be addressed through use of practice improvement models aimed at developing more inclusive working practices in primary care and community health services.⁵⁵³

Taking a population perspective in general practice

Since 2004, GP practices in primary care have implemented a quality outcome framework (QOF). This forms part of the General Medical Services (GMS) contract and links financial incentives to the quality of care offered for a range of chronic conditions. In 2007/8, the average general practice earned over £120,000 from QOF at a cost of £1.1 billion

to the NHS. The objective of QOF is to improve the quality of care patients are given by rewarding practices for the quality of care the practice provided. However, as currently constructed, full achievement of available points is possible without covering the entirety of any particular practice population. There is no incentive to achieve across the clinical, patient experience or additional service domain for all registered patients. This potentially means that those hardest to reach and most in need are not engaged through QOF. QOF does hold the potential to be a powerful tool which, linked with other data sources, would allow for systematic monitoring of registered patients and enable a practice-based population perspective to be taken and encourage a greater focus on prevention.⁵⁵⁴

Case Study Bromley by Bow Centre

The Bromley by Bow Centre (BBBC) is a large established charity in Tower Hamlets, East London, started 25 years ago as a Church community group offering rent-free space to local artists, and later becoming a nursery. It now hosts the local GP surgery, social enterprises, a children's centre, a healthy living centre, and provides adult education courses, care and health services for vulnerable adults, as well as outreach programmes and a range of advice services. The centre has one, main, four-acre site where many services are provided, and where it has restored a local park as an asset for the local community. It has two satellite sites and also delivers services offsite in GPs' surgeries and community locations. Several artists still have their studios onsite and act as tutors for projects.

The range of services offered at BBBC include:

- Health, well-being, and exercise advice and classes, from smoking cessation and walking groups to swimming and yoga classes
- Care services and personal development courses for adults and people with physical and learning difficulties
- ESOL (English for Speakers of Other Languages) and vocational courses, as well as family learning courses. In 2007/8, 80 per cent of learners gained a qualification, above the national average, while 79 learners found either employment or a long-term voluntary position after taking part on a vocational training course in childcare, health and social care or customer service. BBBC is the third largest provider of adult education in Tower Hamlets.
- Welfare, employment, housing and debt advice and practical support to claim benefits, deal with debt and overcome housing problems; advice and practical support with job searching and job applications; and housing help provided by the local registered social landlord, Poplar HARCA, partnering with BBBC.

- A children's centre, which also provides health services, parenting advice, and family learning sessions.
- Social enterprise start-up support. The Beyond the Barn programme has helped to set up 27 social enterprises since its inception in 2005. Twenty-one are trading successfully and have created over 100 new jobs.

All services are delivered within the centre, where staff from across different services, such as GPs, advisers, tutors and childcare staff, work together to ensure clients access the services they need. GP referral to other advice and support services is common as well as referral to health and exercise classes within the centre.

The charity's turnover is more than £4 million, and it has in excess of 100 full- and part-time staff, 3,000 users and a wide range of partnerships with key local stakeholders. BBBC has a number of core partners based within and near the centre, including the GP partners, Bromley by Bow Church in Community, and Poplar HARCA. Other partners include the local authority, the local PCT, higher and further education colleges, other registered social landlords, and a variety of smaller community and third sector groups.

BBBC is internationally renowned as an exemplary model for its social entrepreneurial approach to community regeneration and in particular, for its effective delivery of integrated services. A number of process evaluation studies carried out on the centre's programme have recognised its distinctiveness, and praised its innovative work. These included a study of evaluation practice in regeneration, a study seeking to quantify the centre's impact on the local economy, and an assessment of its work with older people.

For more information see www.bbbc.org.uk/

Focusing on prevention to address health inequalities

As set out above, primary care could contribute to a range of preventive services, including population screening at a practice level. Evidence suggests that people from lower socioeconomic groups have their cancer diagnosed at a later stage, which subsequently affects treatment options and prognosis. Socioeconomic deprivation is a strong predictor of screening participation; colorectal screening and attendance for relevant tests are lower in deprived groups and similar findings are reported for breast and cervical screening.⁵⁵⁵ This means more bespoke initiatives are necessary and if conducted well and targeted to engage disadvantaged people and groups as a preventive and early intervention delivery mechanism, they could contribute to health improvement. An example is the NHS Sheffield CABS Project – see case study on page 155.

Primary care, occupational health and work

Primary care also has a central role in patients' employment, as highlighted in Dame Carol Black's review of health and work.⁵⁵⁶ Traditionally, GPs and primary care staff have only basic training in occupational health but there is potential to extend support to patients, especially where this leads to employment. A national education programme is currently being rolled out throughout the UK to increase GPs' competence and confidence in dealing with the clinical issues relating to work and health. Sustaining support to facilitate participation in employment is critical, as set out in Policy Objective C.

Engaging communities

Community engagement can serve as an important lever to reduce health inequalities by influencing service provision. This often operates best in small localities and the involvement of primary care services is critical. Benefits to the community extend beyond the initial intervention and through increased participation lead to greater confidence and competence among individual citizens and can bring many positive real-life changes.⁵⁵⁷

Other models of community engagement include the healthy living centre initiatives, which provide opportunities to engage local people, increase social capital and have financial benefits associated with co-location of services.⁵⁵⁸ However, such initiatives need to be embedded in local communities and not be a consequence of large, centrally driven roll-outs. Creating a local focal point with inclusive programmes and activities was identified as a key initiative in focus group work undertaken in 2009 in communities in Hackney, Manchester and Birmingham for the Review.⁵⁵⁹ Primary and social care services could develop such centres to address the social determinants of health inequality and promote the provision of integrated neighbourhood-focused services.

- **The Quality Outcome Framework should be revised to ensure that general practices are incentivised to provide 100 per cent coverage of the quality of care for all patients.**

- **Primary care services should develop and adopt inclusive practice that seeks to empower patients and develop their health literacy. Inclusive practice would also emphasise the facilitation of registration of disadvantaged groups who have difficulty in accessing health care.**
- **General Practices should be revitalised to take a more systematic practice-based perspective, informed by QOF and other relevant data, to promote targeted prevention services.**
- **General Practices should scale up responses to occupational health in line with the national initiative.**
- **Primary Care is well placed to act as a focus hub within local communities and should be encouraged and incentivised to adopt this role as a contribution to integrating services and promoting healthier communities.**

Mental health services

The evidence set out in Chapter 2 emphasises the close relationships between physical health and mental well-being. Mental health and well-being has a significant influence in all spheres – achievement, life style, physical health, resilience and recovery, employment, relationships, and civic participation and engagement.⁵⁶⁰ Mental Health Services for children and adults within the NHS, and the Local Authority and the third sector, have vital roles to play in promoting positive mental health and well-being and ensuring effective partnership working and fully integrated commissioning and service provision.

The Review places significant emphasis on early years development and behaviours. Access to support services when needed is important, especially when there are mental health issues. Early interventions have an important contribution to the promotion of good parenting and building resilience. High quality pre-school programmes are also effective in improving children's self esteem and behaviours.

Responses to the Department of Health consultation on *New Horizons* continue to highlight the difficulties in accessing Child and Adolescent Mental Health Services and action is needed to address this issue. Early intervention and access to psychological therapies is crucial in addressing early onset mental illness and stress. This suggests that the system across Children's Services, including schools, needs greater integration. Schools promoting positive mental health and early identification and referral are gateways into services for at-risk children and their families. Key workers can provide both input and signposting into wider support services.

Access to Adult Mental Health Services has been subject of a National Service Framework (NSF) since 1999 and much has been achieved as a consequence. Continuation of reform of mental health provision was explored in the *New Horizons* report.⁵⁶¹ That emphasised a need to build on the National Service Framework with an emphasis on preventing ill health and on early intervention, tackling stigma,

strengthening transition and personalised care through a care programme approach.

Ease of access to a range of integrated social and health care services focused on recovery, psychological therapy and outreach is critical. Out of hours support is important in supporting recovery and enabling people receiving secondary care services to continue in employment or re-enter the labour market. Work contributes to maintaining and recovering self confidence and self esteem and reduces social exclusion by extending social networks and support, as described in Policy Objective C.

- **Early intervention is needed across the social gradient to support children and their families with mental health and behavioural issues, via integrated provision across Children’s Services and schools.**
- **Adult Mental Health Services should focus on integrated and jointly commissioned services that seek to address prevention, early intervention, tackle stigma, strengthen transition arrangements and provide personalised and innovative care focused on recovery.**

5.1.5 The role of Local Government

Local Government plays a crucial role in the lives of citizens’ and in the prospects of the areas for which they are responsible. Local Councils are directly responsible for a broad range of services: both directly delivering some, and commissioning organisations to deliver others. They also have an important role in shaping and monitoring services in their area, for example in relation to local environmental standards. And they are a major player in local strategic partnerships and other groupings which bring service providers together.

The Local Performance Framework is intended to strengthen their role in promoting partnership working between local delivery agents and enabling local areas to tackle cross-cutting issues collectively. The key elements are:

- **Local Strategic Partnerships (LSPs)**
Multi-agency partnerships bringing together the different parts of the public, private, community and voluntary sectors locally.
- **Sustainable Communities Strategy (SCS)**
The overarching plan for promoting and improving the economic, social and environmental well-being of an area
- **Local Area Agreements (LAAs)**
These establish priorities for a local area, as agreed between central government and the Local Authority and its partners in the LSP.
- **Comprehensive Area Assessments (CAA)**
An independent system for measuring local performance.
- A duty on PCTs and Local Authorities to undertake a **Joint Strategic Needs Assessment (JSNA)** of the future health, care and wellbeing needs of the local population

Councils are therefore well placed to bring all agencies – public, private, third sector – to tackle cross-cutting issues which affect their residents and their community. Local Government has a key role as a:

- Major employer within local areas
- Commissioner of services
- Community leadership and democratic renewal
- Exercise of powers in health and well-being as part of the local sustainable community strategy
- Community safety and place shaping
- Provider of children’s services, including education, and adult social care, leisure services, planning and so on.

These roles emphasise the influence and contribution that Local Authorities can make to the social determinants of health and to reducing health inequalities. As set out earlier, Councils have sometimes been reticent in leading on health inequalities either because the NHS was seen as the lead agency or there has been a lack of understanding of the key drivers.⁵⁶²

Local Councils have the power to secure the economic, environmental and social well-being of the local population. They are therefore in a key position to mobilise action to tackle health inequalities and improve well-being. Evidence from the Reducing Health Inequalities Beacon Councils 2008/9 provides examples of excellent work, although there are concerns about scaling up both partnerships and interventions if intransigent health inequalities are to be addressed and the gaps narrowed. In some areas new arrangements for more integrated health and social care provision have emerged, with joint commissioning and integrated provision. ‘Total place’ pilots are also underway, exploring the scope for achieving better outcomes and greater efficiency from closer joint working.

Action to address health inequalities will mean raising the awareness of the social determinants of health among Local Government, including elected members. There is a real challenge to increase political and workforce capacity and confidence in addressing the social determinants and a need to disseminate successful initiatives while also understanding the limitations of lifestyle interventions. There is also a need to scale up interventions to achieve better outcomes.

Critical to any success is the issue of collaborative partnership working. Health inequalities cannot be addressed by any single organisation or indeed any one sector. Any approach needs to be forged in strong partnership working across disciplines and sectors. This requires a positive exercise of community leadership alongside commissioning.

- **Greater emphasis should be given to the pivotal role of Local Councils in delivering health improvement and reducing health inequalities in leading local partnerships, supported by Primary Care Trusts who lead the local NHS.**

Adult social care

The evidence set out in Chapters 1 and 2 describes how life expectancy is rapidly increasing (although unequally). The population has aged significantly over the past 25 years. In 2008, 16 per cent of the population was over 65 years old. If the current trend continues, 23 per cent will be over 65 years old by 2033, which represents 3.2 million people. The over-fifties are the largest users of health and social care services.⁵⁶³ The impacts of the ageing population and levels of long-term illness and disability hold enormous implications for these services. Tight eligibility criteria have been introduced as a way of managing demand. Recipients of social care services are likely to be the most socially disadvantaged and most will have a long-term debilitating illness or disability.

According to Age Concern, approximately one in five older people lives in poverty.⁵⁶⁴ Data from the Health Survey for England 2005 show that disparities exist between low and high socioeconomic groups in a number of health indicators for older people, with people in the lowest quintile of income reporting poorer general health, lower levels of fruit and vegetable consumption and higher degrees of mobility problems and lower-limb impairment.⁵⁶⁵ Similarly, the prevalence of ischemic heart disease among older people is higher in the most deprived areas. Diabetes prevalence and uncontrolled hypertension are also inversely related to income.⁵⁶⁶ Chandola *et al* illustrated, using longitudinal data from the Whitehall II study, that people from lower occupational grades showed a steeper decline in physical health than those in higher grades.⁵⁶⁷ Differences in self-reported health were also found between occupational grades, and a widening of relative inequality was demonstrated with increasing age.

Adult social care therefore makes a significant contribution to health and health inequalities. The recent emphasis on personalisation of services has had a positive impact but the current lack of coherence in the overall policy framework is a cause for concern. Promotion of the active engagement of service users can serve as a springboard for enhancing the lives of users who might be marginalised or stigmatised, enabling them to exercise greater degrees of control and responsibility. The current drive within the NHS to improve the quality of health care in 'Transforming Community Health Services' also holds potential for the greater integration of health and social care and joint action on health inequalities.

Future action to address these issues should include continued efforts to identify those disadvantaged individuals and groups who are not currently in receipt of services.

- **The impact of health inequalities on an ageing population with increased incidence of disability and life-long illness holds significance for future strategies and policies. Such strategies require adequate funding.**
- **Long-term strategies should be debated and developed alongside effective mechanisms for adequate and sustainable investment to address health inequalities.**

Children's Services

The framework for Children's Services was set out in 2003 in the seminal Green Paper *Every Child Matters*. This created a strategy underpinned by the Children Act 2004, in which vulnerable children and young people would be protected within a framework of universal services to improve the well-being of every child. The *Children's Plan, National Service Framework for Children, Young People and Maternity Services* and the child health strategy, *Healthy Lives Brighter Futures*, built on these foundations. The focus has been on developing better partnership working, joint commissioning and integrated services. Children's Trusts have developed in different localities at different speeds and in different ways, reflecting diverse needs and local contexts. The Apprentices, Skills, Children and Learning Act 2009 strengthens Children's Trust cooperation arrangements more generally by standardising what has been shown to be effective practice. The Act establishes Children's Trust Boards on a statutory basis and adds new statutory partners – schools, colleges and Jobcentre Plus.

The Children and Young People's Plan (CYPP), prepared by the Children's Trust Board, becomes a joint strategy agreed by partners with the aim of promoting cooperation at each organisational level across agencies. The Plan will show how partners on the Children's Trust Board will work together to commission and deliver services that are child and family centred, improve local outcomes for children integrate, services better and focus on closing the gaps in outcomes for disadvantaged groups against a background of improved outcomes for all children.

A key task of the Children's Trust Board is to ensure that the interests of children, young people and families are understood throughout the LSP so that the social determinants of health can be addressed. This includes embedding the CYPP in the Sustainable Community Strategy (SCS) and articulating the impact of wider cross-cutting issues which do not have a specific child focus, such as local housing, regeneration and transport plans, and embedding actions on these issues in the preparation of the Local Development Framework. New draft guidance on Children's Trusts will be published in March 2010.

The new Children's Trust Board and CYPP represent an important change which provides a unique opportunity to drive forward better partnership working, including the opportunity to pool or align budgets around agreed cross cutting outcomes. This will enable the health sector to draw on support from its partners to deliver its priorities, while contributing to the priorities of other partners.

It is important that recommendations from this review in respect of early years services and the child care workforce are considered within any revised guidance and in subsequent strategic developments.

- **Any revised guidance for children's services must take into account the evidence and recommendations of this Review, with**

particular reference to early years, education and workforce development set out in Policy Objective A.

- **Furthermore, future plans for children and young people's services should specifically address the social determinants of health and the impact on health inequalities. The Children's Trust Board, in preparing the CYPP, should help PCTs address local health inequalities and deliver improved health outcomes for children and young people by developing a shared local vision between the Local Authority, PCT and others on the Children's Trust Board which will agree partners' contributions and drive progress through the CYPP.**

5.1.6 The role of the third sector

The third sector includes 140,000 general charities, 55,000 social enterprises, 4,500 cooperatives, 1,830 Housing Associations with £55 billion of assets, mutuals and faith communities.⁵⁶⁸ The third sector has a major role to play in developing local engagement and partnerships through establishing and drawing on links with local people, families and communities. The third sector is well placed to access communities and identify assets that would extend community networks, engaging and supporting individuals and developing community infrastructure through self-help, unpaid work and voluntary endeavour. The sector is diverse, which can be both its strength and weakness.⁵⁶⁹

While the real and potential contribution of the third sector to reducing health inequalities is recognised, there remain concerns about how well the sector is supported, both to deliver its services and to effectively engage as a strategic partner. The funding of many third sector organisations is precarious and increasingly dependent on statutory sources. Trends in charitable giving combined with other economic conditions, for example, lower returns from investments and higher costs to charities as employers, have led to limited availability of voluntary funds for even large, national charities.

The majority of voluntary organisations in the health and social care sector are now heavily dependent on grants and contracts from national and local government and, increasingly, the NHS. The growth of commissioning, and the corresponding reduction in grant funding for the voluntary sector; has led to increased competition for contracts both between different third sector organisations and between the third sector and the private and statutory sectors.

There is increasing concern that the current commissioning environment disadvantages the third sector generally and may even threaten the survival of smaller voluntary organisations. The range of factors includes:

- The inability of smaller organisations to marshal the resources, including the time, skills and knowledge, to effectively compete for tenders
- Commissioning practices favouring larger organisations and the statutory sector, for example, clustering services to be put out to tender in

a single contract can lead to smaller and niche providers being squeezed out

- Short-term contracts with insufficient time for development and consequences for staff recruitment and retention
- The growing requirement for contracts to be delivered on tighter funding, leaving little scope for developmental work and innovation.

There is also concern about the inconsistency of engagement of the third sector as a key partner in national, regional and local strategic planning. Although there are good examples of third sector involvement, for example in some LSPs, there are still challenges in ensuring that the diversity of the sector is adequately represented. The support for voluntary sector infrastructure varies between local authorities and there is continuing concern that representational structures tend to exclude smaller and volunteer-led organisations.⁵⁷⁰

- **LSPs should engage the third sector in a systematic way to maximise the potential in engaging local communities, tapping into local communities and supporting and fostering individual and collective empowerment and capacity-building to contribute to the development of civic participation.**
- **The diversity of the sector needs to be fostered and supported, acknowledging the contribution it can make in engagement, participation and community services in addressing health inequalities.**
- **Issues of sustainable funding need to be addressed as part of the compact between statutory partners and the third sector.**

5.1.7 Role of private sector employers

Employers have a central role to play in preventing ill health and in promoting health and well-being. In Chapter 2 and Chapter 4, Policy Objective C, we outlined the importance of good work in reducing workplace stress and health inequalities. There has been some reluctance on the part of employers to actively address such issues, despite clear evidence that the costs of not addressing stress and other work-related causes of ill health are significant.

LSPs could provide guidance and incentivise employers to offer advice and funding for initiatives in health in the workplace. This could include the provision of vocational training and return to work schemes, as well as supporting the employment of those suffering from disabilities or ill health.

Occupational health has traditionally been detached from mainstream health care and access to it varies greatly between sectors and according to size of the industry or employer. Occupational health and vocational rehabilitation should be fully integrated into the NHS, providing a *Fit for Work* model for the unemployed and those on incapacity benefits. Occupational health services for small employers, as well as support services for large employers' health teams should be developed. Such a model could provide guidelines, resources and security to employers,

improving the health of the workforce, and for hiring and retaining people that have experienced long-term unemployment or ill health or disability.

The Department for Business, Innovation and Skills has a key role in encouraging exemplary practice. It could encourage employers to input into addressing other determinants of health, for example through voluntary uptake of the 'healthy living wage', along with previous initiatives such as *Investor in People* and *Living Wage* awards. There is also a need to recognise organisations with smaller resources that provide advice and support to their employees on lower incomes to access benefits and health services.

Unpaid work is often a step into paid employment for those who need more skills, work experience and an unthreatening and flexible environment to gain confidence to enter the labour market.

— **Issues concerning prevention, early intervention, improvements to health and safety, the impact of good leadership and management have a critical impact on workforce health and development. The Department for Business, Innovation and Skills and Department for Work and Pensions have key roles in overseeing effective implementation of best practice in promoting physical and mental well-being of the workforce. This is detailed in Annex 2, sections C2, C3 and C4.**

5.1.8 Enhancing partnerships

The WHO Commission on Social Determinants of Health global report *Closing the Gap in a Generation* highlighted that the problems of health inequalities are complex, multi-causal, cross sector and multidimensional.

Partnership working has played a key role in policymaking to address health inequalities. While there are examples of vibrant joint working, in many instances it has fallen short of expectations. Robust leadership is required for partnership working at local and regional levels through:

- Developing awareness of the underlying causes of health inequalities, freeing up people and agencies to take risks, building intensity and scale in strategic and systematic interventions supported by mainstream funding rather than focusing on short-term projects and initiatives.
- Creating new kinds of partnerships in a delivery model based on co-production that encourages genuine public engagement in decision-making, shifting the balance of power towards local people and away from professionals and formal institutions.

Leading partnerships

Evidence from spearhead areas suggests that the current LSP framework requires considerable development and enhancement.⁵⁷¹ Improvements would include greater clarity and articulation of strategic direction between agencies, underpinned by an explicit agreement of priorities. A move away

from national target-driven implementation, which often reinforces silo working, and a shift to limiting targets to those essential to driving strategy may facilitate a whole-system approach. This would allow local policy-makers, service providers and citizens to assess and respond to specific local problems with more explicit local accountability for delivery on health inequalities.

Within such a framework, local leadership is important in championing partnership working on health. Political leaders and Chief Executives of Local Councils, as well as Chief Executives and Boards of PCTs and Directors of Public Health, have critical but not exclusive roles to play.

The Review has argued earlier (section 5.1) that what is required is robust political, civic and executive leadership based on a whole-system approach. This should be supported by organisational development programmes across the public services and the creation of visible and measurable outcomes for citizens and communities.⁵⁷²

LSPs are tasked with developing and publishing a sustainable community strategy for their areas, setting out plans and action to be taken to promote social, economic and environmental well-being. Each partnership has a sub-partnership with a remit for local health and well-being. LSPs do not have legal powers or resources of their own. They seek to ensure that different organisations work together to identify local needs, develop a long-term sustainable community strategy for an area and deliver services more effectively. Resource decisions must be taken by constituent statutory organisations. This raises major questions on the status of the LSP, especially in the light of the change in status of Children's Trust Boards. Ownership, commitment and accountability may be enhanced by similarly establishing LSPs on a statutory basis and being explicit about the responsibility and accountability of statutory members to deliver agreed local commitments.

This strengthening of accountability would enhance the prospect of Sustainable Local Community Strategies being integrated with the range of individual agency strategies such as LAAs, CAAs, Local Authority Corporate Plans, PCT World Class Commissioning Strategic Plans and NHS Operating Plans, creating a golden thread through which local policies establish coherence and explicit strategic direction.

- **LSPs should be established on a statutory basis and the accountability of statutory partners should be explicitly stated in order to facilitate partnership working on the social determinants of health.**
- **National and local leadership should demonstrate the importance and priority of addressing health inequalities explicitly as part of all local sustainable community strategies.**
- **Leadership skills require enhancement at all levels and should be supported by a national Organisational Development and Leadership Programme, sponsored**

jointly by the Departments of Health and Communities and Local Government, and the Cabinet Office.

Systematic engagement of communities in partnership

Community engagement on a systematic basis is an essential element in partnership working for addressing health inequalities. Without this, reducing health inequalities will not be possible. This represents the fully engaged community scenario of the Wanless Report.⁵⁷³

Systematic engagement is necessary at a number of levels:

- City/district-wide, drawing meaningful input into strategy, service planning and performance management from a wide range of voluntary, community and faith organisations
- Locality level, drawing on third sector organisations and community groups at smaller ward level, including engagement in locality commissioning of health and council services
- Neighbourhood level, connecting into neighbourhood management.⁵⁷⁴

This approach requires mapping community assets, identifying barriers to participation and influencing and building community capacity through systematic and sustained community development.

- **All LSPs should implement effective participation strategies aimed at empowering individuals and promoting community development to enhance community assets and facilitate community solutions to health inequalities.**

Joint appointments and joint teams

The development of LSPs has further potential for joint appointments across partner agencies, especially between PCTs and Local Authorities. This is particularly so in relation to jointly appointed and funded Directors of Public Health, initiated to facilitate a cross-cutting strategic approach to tackling public health issues. Currently 80 per cent of Directors of Public Health are appointed between PCTs and Local Authorities. Directors of Public Health occupy a key position in delivering on health inequalities. The role in advising LSPs and the partner agencies on the local impact of health inequalities and making progress in addressing these through the local sustainable community strategy should be strengthened. This independent advisory role could be linked with the Overview and Scrutiny Panel role and Local Involvement Networks (LINks), to develop more explicit local accountability and monitor progress.

There is considerable variation in the adoption of other joint appointments. Some areas have fully integrated teams focused on health and health inequalities; others have taken more limited action with marked differences in staffing levels. Benefits of such appointments lie in increased understanding about roles and responsibilities, reduction in organisational

boundaries and improved engagement and leadership across organisations. These appointments could be supported by joint commissioning and sustainable finance arrangements consistent with best practice.⁵⁷⁵

Extension of joint appointments would facilitate greater integration of public sector services. The current 'Total Place' pilots have yet to be evaluated but hold the potential to facilitate partnership. Alternative models include extension of cross agency commissioning for health equity and more integrated provision. The creation of community hub facilities was identified as a high priority in focus group work with excluded groups in Birmingham, Hackney and Manchester.⁵⁷⁶

The workforce implications of taking concerted action on health inequalities must be taken into account. Responding effectively requires action by a broad range of professions and sectors including housing, planning, transport, education, social care, and health care as well as public health. Each has a different training and culture, which creates major difficulties. The Egan Report identified the shortage of generic skills for those care professions involved in developing sustainable communities.⁵⁷⁷ The task is greater given the breadth of the health inequalities agenda. National action is essential to skill up the relevant professions to meet the demands of the new agenda.

- **The current practice in setting up joint appointments holds the potential to enhance partnership working.**
- **Joint commissioning units and integrated provision should become a requirement for local government and PCTs using sustainable joint financing in accord with Audit Commission Guidance.**
- **National action is required to skill up the workforce involved in addressing health inequalities across the wide range of disciplines and agencies involved in delivery, based on the social determinants of health.**

Local Area Agreements

Each LSP publishes a sustainable community strategy, which is underpinned by a local performance framework called a Local Area Agreement (LAA). These have extended the role of LSPs and increasingly given them greater focus, although there are some significant differences in the reported impact of LAAs between Unitary, County LSPs and District LSPs, with less impact reported in the latter.⁵⁷⁸

LAAs have proved effective in providing a platform for local agreement about priorities and developing a joint vision for future action with common strategies and targets. However, there has been limited progress in joint activity on commissioning and pooling budgets. There is also mixed evidence from LSPs that the duty to cooperate has been effective or made a positive difference to the quality of partnership or delivery. Subsequent sections on monitoring will address issues of local accountability on progress.

Joint Strategic Needs Assessment

The Local Government and Public Involvement in Health Act 2007 required local authorities and PCTs to produce a Joint Strategic Needs Assessment (JSNA) of the health and well-being of their local communities. The majority of LSPs in the 2008 survey identified the development of the JSNA as improving the focus on health outcomes and inequalities.⁵⁷⁹ This, linked to the World Class Commissioning Programme being implemented through PCTs, has potential for improving the focus on better quality care, improved health and well-being and a reduction in health inequalities across local communities through joint working and partnership.

To be effective, a JSNA must be informed by accurate and shared national, regional, district and local intelligence, with local community issues identified through active engagement. Consultation undertaken during this Review highlighted some difficulties and reticence in agencies sharing information.⁵⁸⁰ This requires review and clarity of guidance to agencies involved in LSPs.

- **Guidance should be issued to clarify information exchange between key partners to inform and enhance joint protocols concerning information and intelligence exchange to enhance joint planning.**
- **All local joint planning should be grounded in local communities and informed by national, regional, district and local neighbourhood intelligence and set within common agreed and transparent priorities.**

5.1.9 Partnerships for implementation

Two partnerships have been developed: between the Review team and the North West region and London. Brief details are set out below:

North West partnership

Closing the health gap between all citizens continues to be a major focus for the North West. This is not only a matter of social justice but is crucial for building a sustainable economy with a healthy workforce and functioning, capable, self-reliant communities.

Forming a partnership with the Review team has created an enhanced momentum and interest in the region to tackle health inequalities. Professor Sir Michael Marmot visited the region several times during 2009, and those opportunities were used to inform and involve a wide range of people. The region was able to use the latest evidence from the Review to bring people together to identify priorities for the North West. At one event they used the forum of ‘open space’, where over 200 people including councillors, police, local government, third sector, housing sector, academia, representatives from Local Involvement Networks, as well as the health sector came together to identify realistic yet creative approaches to current and future challenges in narrowing the health gaps.

The approach has started to create solutions to people’s questions, such as:

- How do we involve people, organisations and communities to enjoy life and live longer?
- How can we give every child born in the North West the best possible start?
- How can we support public demand for social justice?
- How can we best beat the impact of the recession?
- How do we move from theory and evidence about the gap to realistic organisational, local and individual action?

Over the coming months the region will be working with a wide range of stakeholders to produce a plan for action over the next 10 years. This will underpin the objectives in the forthcoming Regional Strategy 2010. The aim is to build on the immense assets of the region to secure the best health and well-being for all.

The London Partnership

A partnership has been established between the Mayoral Office and the Review team to support the implementation of the London Health Inequalities Strategy. Professor Sir Michael Marmot presented at two major conferences to inform the debate and to galvanise key stakeholders for action.

The Greater London Authority Act gives the London Mayor unique responsibilities to produce a health inequalities strategy for the capital. The draft strategy was launched for public consultation in August 2009 and due for completion on 10 January 2010.

The draft strategy proposes action for London to be a city where all people can live fit, flourishing and involved lives. Its aims are to:

- Empower individual Londoners and communities to improve health and well-being.
- Improve access to London’s health and social care services, particularly for Londoners who have poorer health outcomes.
- Reduce income inequalities and minimise the negative health consequences of relative poverty.
- Increase opportunities for people to access the potential benefits of work and other forms of meaningful activity.
- Develop and promote London as a healthy place for all – from homes to neighbourhoods and the city as a whole.

A joint working group has been established to consider the action plan for implementation following the closure of consultation in order to make the strategy a reality for London.

5.2 Framework for targets and indicators to assess performance improvement

5.2.1 The framework

On the basis of the conceptual approach and the recommendations identified in Chapter 4, Annex 2 lists the types of indicators appropriate for monitoring process, outputs and outcomes in each of the areas of action (see Figure 5.2). It is envisaged that where these are to be used to set objectives and hold delivery organisations to account, they will need to be SMART (Specific, Measurable, Achievable, Relevant and Time-bound). This has a number of implications:

- Different indicators may be required to support and measure performance improvement in the short (2012–15), medium (2016–19) and long term (2020 and beyond).
- Some indicators may not currently be measurable. But there needs to be a realistic prospect that measurement tools would be put in place to fit with the relevant timescales.
- Performance indicators need to be defined in a way that would make it possible for the agencies concerned to achieve the improvements being sought by the strategy.
- To ensure relevance and specificity, as the strategy develops over time, the detailed indicators may change.

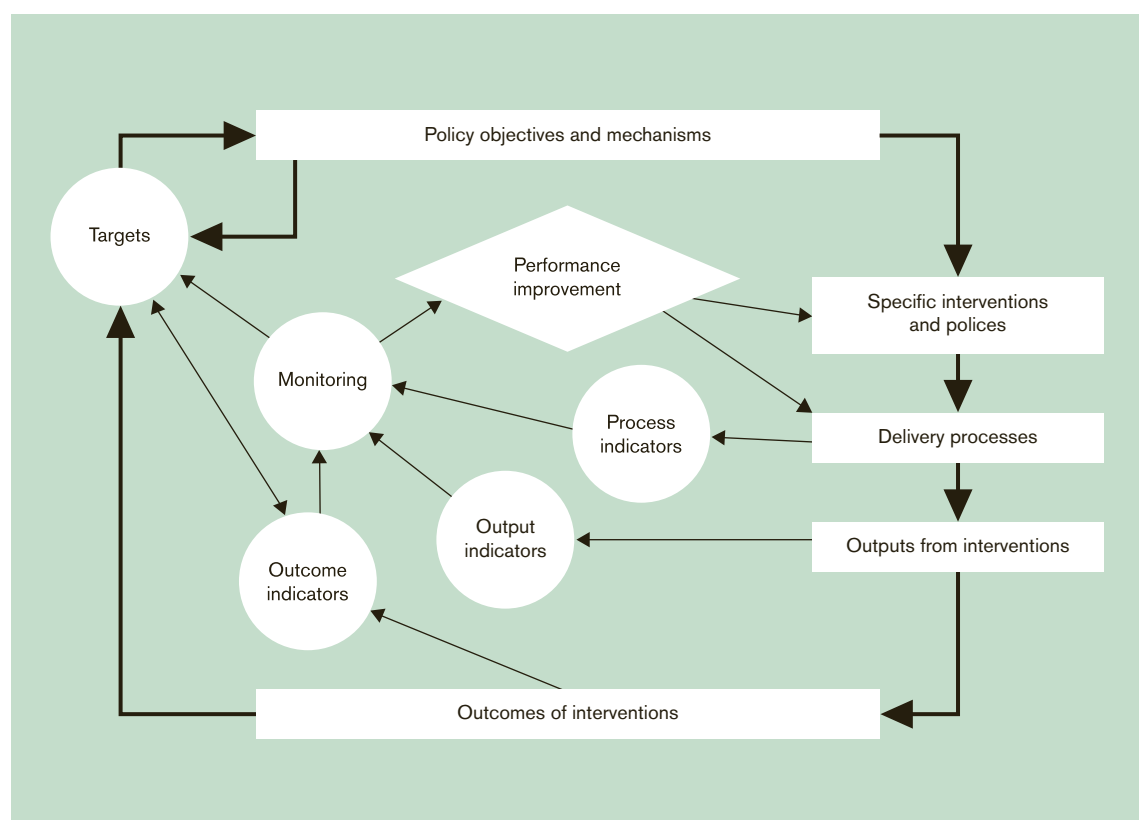
As indicated in Sections 5.2 and 5.3, aspirational targets should be set at a national level and supported by a framework of locally measurable indicators. As part of accountability arrangements for local partnerships such as CAAs and LAAs, local agencies should select targets from this framework that match local needs and provide a basis for performance improvement to be assessed. Implicit in this use of indicators is the need for comparability across areas on a national basis, to ensure that fair and valid assessments of performance improvements can be made.

5.2.2 Existing sets of indicators

In selecting indicators and targets, we do not start with a blank canvas. Within the Department of Health's current Strategic Framework, there is an increasing emphasis on local accountability⁵⁸¹. The NHS is held to account through a set of indicators, referred to as 'vital signs'⁵⁸². Not all of these are set as targets. Instead, there is a stepped, three tier approach, with PCTs required to deliver plans to the Department only on tier 1 indicators. For tier 2 indicators, PCTs agree plans with Strategic Health Authorities (SHAs), while for tier 3 indicators, PCTs, with local partners, agree which indicators to prioritise based on local benchmarking and the outcomes of the JSNA undertaken by PCTs and local authorities.

A considerable amount of work has been undertaken previously in the UK to develop indicators of health inequalities, social inequality, area inequality and for equality and human rights purposes. There is

Figure 5.2 Framework for indicators and targets



merit in using or further developing existing indicators, where these are appropriate for this purpose.

In 2008 the Department for Communities and Local Government issued a set of 185 national indicators (NIS) for English Local Authorities and Local Authority partnerships. In 2009 an updated set of 188 indicators was issued.⁵⁸³ That set is intended to underpin the performance framework for local government and provide national outcomes and a single basis for measuring performance. The NIS covers four dimensions: stronger and safer communities; children and young people; adult health and well-being and tackling exclusion and promoting equality; local economy and environmental sustainability.

Examples of other relevant indicator sets include:

- The ‘basket of indicators’ developed by the London Health Observatory, monitoring the existing health inequality targets
- The indicators (and potential disaggregation of these) identified in Table 5 of ‘Ten Years On’⁵⁸⁴
- The range of equality characteristics identified in the equality monitoring framework developed by the Equality and Human Rights Commission. While the Equality Measurement Framework (EMF) is not a performance measurement framework, it does provide a baseline of evidence for evaluating progress and deciding priorities
- The health poverty index, which makes it possible to contrast groups, differentiated by geography and cultural identity, in terms of their ‘health poverty’ (a combination of both their present state of health and future health potential or lack of it)
- Health Profiles, which provide a snapshot of health for each local council in England using key health indicators, enabling comparison locally, regionally and over time. They are designed to help local councils and the NHS decide where to target resources and tackle health inequalities in the local area
- The Index of Multiple Deprivation 2007, which

combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for each small area in England

- The Neighbourhood Statistics website, which provides access to nationally available data about small geographic areas (www.neighbourhood.statistics.gov.uk).

5.2.3 Components of the framework

The indicators must capture the following dimensions on which interventions can impact:

- Life course
- Social determinants
- Health outcomes (morbidity, mortality, well-being).

Life course approach

The life course approach underpins monitoring of how action on social determinants impacts on outcomes. It recognises that the most powerful outcomes that result from interventions at each stage in the life course are to be found later in life. In general, the earlier the intervention, the greater are these subsequent outcomes. This has significant implications for the timeframe for anticipating that outcomes will be observed. Outcome indicators within the framework must include some that adequately capture the health and other social consequences of interventions both in early years and subsequently.

Social determinants

The dimensions of social determinants, for which indicators must be included in the framework (some of which will need to be developed as part of the strategy) are listed in Box 5.1.

Two key issues that must be addressed in measuring each of these dimensions of social determinants are:

- Does the availability of data on a particular topic limit attention to national indicators that can be applied locally, but will generally not have

Box 5.1 Dimensions of social determinants

- Adequate standards of living
- Decent work
- Fair employment
- Good start
- Education
- Appropriate skills
- Opportunities
- Physical environment
- Capability
- Social support and social capital:
 - Family
 - Community
 - Networks
- Service provision
- Relative income inequality
- Financial capability

Box 5.2 Issues affecting selection of indicators

- Importance
- Feasibility and cost
- Availability
- Clear relevance to interventions
- Technical Issues
- Criteria/guidance:
 - Breadth
 - Balance
- Smallest population for which indicator is reliable
- Information governance
- Impact
- Indicator sets
- Data sources

relevance to local circumstances, or does it enable a wider choice – topics that can be underpinned by locally relevant indicators that, nonetheless, contribute to achieving the outcomes being measured at national level?

- Each of the social determinants does not act individually, so indicators will be strongly inter-related. For this reason, caution will be required in the use of proxy indicators of determinants.

Health and well-being indicators

The measurement of health outcomes is central to assessing the success of the strategy. These need to relate to the major conditions associated with health inequalities – those on which the recommendations and associated interventions are intended to have a significant effect (in terms of scale and impact). The outcomes need to reflect improvement in both the quality and length of life across the social gradient.

A key aim of the proposed strategy is to improve both health and well-being across the social gradient. For this reason, there is a need to capture health status, measured through subjective perceptions, such as general health, limiting long-term illness and disability, as well as through diagnosed morbidity indicators obtained through surveys or routine clinical practice in the NHS, such as the growing amount of information becoming available through the Secondary Uses Service (SUS).

It will be equally important to develop outcome indicators based on some of the different cultural aspects of what constitutes well-being – looking at measures beyond health, such as positive attitudes. Several indicators of well-being are currently collected across different data sources:

- Early Child Development Index
- SF-36
- EQ-5D
- SF-6D
- GHQ-12
- Quality of life (participation, esteem)
- Life satisfaction
- Mental state

However, none is currently collected at a scale that would enable routine monitoring below national level. Field trials are needed to establish the feasibility of large-scale routine collection on a nationally consistent basis.

As important as measures of individual well-being are indicators of community and societal well-being. These can be developed to measure the impact on the social gradient. At community level, this can be achieved by focusing on a range of desirable issues that are currently socially graded (for example, sustainable housing, safer roads, community empowerment). The National Indicator Set provides a basis for selecting some of the indicators needed by local partnerships. Similarly, at national level, macro-level indicators can be used that correlate with social division (for example, income inequality, environmental harm). This follows from proposals from the Sarkozy Commission⁵⁸⁵ internationally and the development of UK indicators of societal well-being.⁵⁸⁶

5.2.4 Selection of indicators

Based on the previous discussion, the issues that need to guide the selection of indicators are summarised in Box 5.2.

An indicative framework, covering all the recommendations listed in Chapter 4, is given in Annex 2.

5.3 National targets

Aspirational national targets are required to ensure a strategic focus on reducing inequality and achievement of the intended health gain. The implication of the conceptual framework that has underpinned this Review is that these targets need to relate to long-term improvements in health outcomes and in the more immediate outputs from our highest priority recommendations, those relating to development in childhood, which most strongly influence the subsequent life course.

National health outcome targets across the social gradient

It is proposed that national targets in the immediate future should cover:

- **Life expectancy (to capture years of life)**
- **Health expectancy (to capture the quality of those years).**

Once an indicator of well-being is developed that is suitable for large-scale implementation, this should be included as a third national target on health inequality.

National targets for child development across the social gradient

It is proposed that national targets should cover:

- **Readiness for school (to capture early years development)**
- **Young people not in education, employment or training (to capture skill development during the school years and the control that school leavers have over their lives).**

National target for social inclusion

It is proposed that there be a national target that progressively increases the proportion of households that have an income, after tax and benefits, that is sufficient for healthy living.

The types of indicators needed to monitor processes, outputs and outcomes in the full range of recommendations in this report are outlined in Annex 2. Examples of the detailed indicators that are currently available are given on the Marmot Review website, www.ucl.ac.uk/ghg/marmotreview.

This wider set of indicators is intended to be for discretionary use by local partnerships.

5.4 Issues in implementing the framework

On the basis of the lessons learned from the current health inequality strategy, a number of key questions were identified in Section 3.6, concerning implementation of a framework for indicators and monitoring.

5.4.1 What dimensions of inequality should be covered?

Ethnicity and individual socioeconomic status have many alternative definitions. Decisions must be made about which measures to use, and then these measures must be built into routine information systems. Very different methods are required in measuring and monitoring the size of inequalities and changes over time if the objective is to focus solely on the most disadvantaged, reduce the gap between the poor and the affluent, or level the social gradient.

- **Indicators should be comparable nationally, across the UK and, where international standards are well developed, to other countries**

5.4.2 To what timescale should targets relate?

The report of the Commission on Social Determinants of Health set as a goal ‘closing the gap in a generation’. Some of the recommendations in this report will take even longer to feed through, as they affect experience of a new generation through their life course, for example, the impact of early years education and later schooling on subsequent labour market participation and accumulation of pension wealth. In contrast, the relatively short time horizons for the current inequality targets in England militate against life course approaches. In terms of what can be achieved in making progress towards the Review’s recommendations, in the short term this argues for giving greater emphasis to objectives that focus on initiating social and organisational processes and obtaining a range of outputs, and for giving greater emphasis to the health outcomes in the long term.

Targets can be aspirational, setting out improvements we would like to see in indicators of health outcomes (or health actions, behaviours, and so on). However, as indicated in Section 5.10, targets set for organisations (including strategic partnerships) should ideally be SMART. In particular, they must be capable of being affected by those organisations, through direct action or influence, in the specified time scale. For example, current targets are based on mortality data. While these can be affected by health policy, changes that the NHS or other public bodies can achieve in a short time tend to be negligible compared with the underlying long-term behavioural, socioeconomic and societal factors that they and others need to influence.

- **Targets for LSPs must be achievable through their direct action or influence in the timescale specified when they are set.**

5.4.3 On what type of areas or individual characteristics should indicators and targets be based?

A key issue in defining indicators and setting targets is whether the focus of attention is on administrative units, individuals grouped by geographic area (residence or catchment area) or by social determinants or individuals’ personal characteristics based on their life course.

The current national health inequalities targets provide examples of two approaches: the life expectancy target is to narrow the gap in average life expectancy defined at local authority level, and the infant mortality target defines the gap as between groups based on individuals’ socioeconomic status. Other high-level inequality targets have used geographically grouped data in a variety of ways – spearhead targets and teenage pregnancy targets define different targets for different local authorities, the LAA ‘within-area targets’ define geographical target areas within local authorities.

Using individual characteristics has the advantage of avoiding the problems of drawing inappropriate conclusions from changes at an area level (discussed in Chapter 3), but relies on the availability of data at individual level for analysis. Where reliable individual data are not available at local level, this makes it impossible to analyse or monitor the indicator or target locally and a proxy or synthetic estimate needs to be used. This is particularly an issue for rare events (for example, infant mortality) or population groups that form only a small minority of an area (for example, ethnic groups in many areas).

If target areas were to be defined in terms of outliers converging to the average, then the targets would, at least to some extent, be achieved, misleadingly, through well-recognised statistical processes associated with random variation. This will be less of an issue when the variable is sufficiently robust at the area level being used, not changing or fluctuating rapidly over time. This can be avoided if a distributional target is chosen, for example by focusing on the gradient or aspects of the range of variation. However, for area-based strategies the constant change in the position of a local area on the distribution can make it very difficult to set a coherent local strategy and to monitor the effects of interventions. This needs to be reflected in the way in which local targets and indicators are set and relate to those at national level.

By setting targets based on a target subgroup within local areas (for example, the most deprived fifth), undue emphasis is given to relatively unstable local indicators of outcome. Where there are few enough outcome events within a whole district, limiting local monitoring to changes among a small fraction of the people in the area makes this issue much worse. By focusing on reducing differences across the social gradient, this can, to some degree, be avoided.

- **Targets and indicators should, wherever possible, be focused on the reduction of differences across the social gradient.**

5.4.4 Measuring the social gradient in health

Since the development of the 2004 inequalities targets, various studies have investigated alternative methods of analysing and monitoring inequalities over time. The methods investigated include:

- Absolute range (absolute difference between rates in the most and least deprived groups)
- Relative range (ratio of rate in the most deprived areas to rate in the least deprived areas – *currently used for the existing targets*)
- Slope index of inequality (SII) and relative index of inequality (RII) (which are sensitive to the mean health status of the population and can be interpreted as the absolute effect on health of moving from the lowest socioeconomic group through to the highest)
- Concentration index (which allows analysis of the extent to which poor health is concentrated among those in the most disadvantaged groups)
- Population attributable risk (PAR) (which measures the proportion of disease in the study population that is attributable to exposure to a particular factor and thus could be eliminated if that exposure were eliminated).

These different methods have pros and cons. For example: ratios in themselves do not give information about absolute improvement and will not inform about performance across the intermediate groups of population; the SII and RII only work well if there is a reasonably linear relationship between deprivation and the health indicator of interest. This frequently requires transforming the available data (for example, using logarithmic scales), which can detract from the ease with which it can be understood. It is also important to note that measures of inequality will not necessarily work locally, when gradients that exist at a national level might not apply in particular areas.

In Scotland, the task force that produced the Equally Well approach to health inequalities in 2008 was set up and had advice from a group of government and external experts on appropriate high level population measures of health inequalities. This group proposed a set of headline indicators of health outcomes. For each of these headline indicators, the expert group proposed the use of three measurement approaches in order to give a comprehensive picture of inequalities across the whole population. This addresses the problem with previous area-based health inequalities targets that only sought to improve the health of people living in the most deprived areas.

Relative Index of Inequality (RII)

How steep is the inequalities gradient? This measure describes the gradient of health observed across the deprivation scale, relative to the mean health of the whole population.

Absolute range

How big is the gap? This measure describes the absolute difference between the extremes of deprivation – the rate in the most deprived minus the rate in least deprived group.

Scale

How big is the problem? This measure describes the underlying scale of the problem and past trends.

These different measures give insight into different aspects of inequalities. The most fundamental of these differences is between absolute and relative measures of inequality.

- **To avoid misleading conclusions and creating perverse incentives, indicators need to reflect both absolute and relative reductions made to inequalities, based on the measures described in this report.**

5.5 Data availability

The current data set for monitoring health inequalities in England comprises the two health inequalities targets, targets for reducing inequalities in smoking prevalence and cancer and CVD under age 75, as well as 12 headline indicators, and the local basket of health inequalities indicators. These were necessarily designed around the limitations of data systems and the demands of monitoring progress (they needed to be regularly updateable, robust enough to detect changes over time, compatible with broader policy objectives and so on). They do not necessarily provide an integrated, comprehensive and transparent approach to tracking progress in tackling health inequalities through action on the social determinants.

5.5.1 Limitations of the data infrastructure, both nationally and at local level

In considering how to address the shortcomings of available data, consideration will need to be given to the feasibility of making improvements in the timescale required, inconsistencies that may be created in existing time series, the lack of any previous data to measure ‘before and after’ effects when new collections are introduced, the cost of new systems and collections and the burden on the public and organisations responsible for collection and processing.

Concern has been expressed that the task of addressing limitations in local data systems is imposing a significant burden of additional data collection (for example, with the need to develop new systems to measure, and process data on, the health of local populations). It also raises issues about confidentiality and safe data storage and what is feasible within current information governance constraints.

5.5.2 Improving timeliness

For targets set on health outcomes, it is common for the data to become available only after a considerable time-lag. For example, mortality data that depend on death registrations and considerable data processing tend to be at least nine months behind at the time of their publication. Especially in cases where rates are changing rapidly, such as with premature coronary heart disease mortality, this means that monitoring

is never sufficiently timely to support management action.

Furthermore, in order to overcome year-on-year variations, the custom is to group multiple years of data, for example the most recent three years or the most recent five years. While this introduces stability to the process, it also means that monitoring is that much less timely.

Timeliness issues can be addressed through forecasting methods that maximise use of information that is available. More consideration could be given to the use of such methods to ensure timeliness in monitoring health indicators and progress against targets.

5.6 Addressing the problems with area-based measures

As discussed in Chapter 3, by measuring changes only at broad area levels (for example, administrative area level), we cannot tell whether or not any improvements being made are confined to the more affluent living in an otherwise generally deprived area. The introduction of within-area inequalities targets attempted to address this problem, but these targets were independent of the national targets and were still focused on areas where socioeconomic circumstances varied greatly from household to household.

These issues would pose less of a problem if small area data were used to define indicators and targets (for example, Super Output Areas), as long as the numbers being measured in the small areas were sufficient to enable analysis. Other advantages of using small area data are:

- All areas would have had a stake in the target
- Measures of inequality would be more sensitive to change
- The target could be scaled from national to regional to local level
- There could be a greater focus on gradients across an area.

5.7 Evaluating the impact of interventions

5.7.1 The need for evaluation

The Health Select Committee has identified the need for interventions on health inequalities to be more adequately evaluated.⁵⁸⁷ In Chapters 3 and 4 we noted the limitations to the evidence on effectiveness that is available from past interventions. While there is often evidence of the general health effects of interventions, there is a dearth of evidence in respect to the impacts and cost-effectiveness of interventions on health inequalities. As a recent Public Health Research Consortium report shows,⁵⁸⁸ this is the case in terms of both primary studies and systematic reviews. Similarly, more research has been conducted on the effects on health inequalities of downstream interventions, than for upstream interventions.

All too frequently, interventions and policies are implemented without building into their design the

capacity to undertake a thorough evaluation of the outcomes. This is inherently difficult in a social context where the link between the intervention and outcomes of interest may be separated by a number of intermediate stages and a long time lag. There is also a tendency to roll out small-scale interventions before there has been adequate time to assess effectiveness – making sound comparisons extremely difficult. Nonetheless, as highlighted in the 2009 Health Select Committee Report into health inequalities,⁵⁸⁹ there are a number of basic steps that can be taken to ensure that novel interventions are implemented in a way that significantly reduces the challenges involved in evaluating social interventions.

5.7.2 Evaluating an impact on the social gradient

There are a number of issues that require attention in assessing whether new policies and interventions are having an impact in bringing about a change in the social gradient in health. While we focus here on this specific issue, the points are derived from some of the basic rules for testing any relationship between an intervention and its presumed effects.

Factors for consideration include:

- The scale used for the outcome variable
- The relation between the outcome and the explanatory variable
- The nature of the intervention
- The size of the effect.

Evaluation

- **Where new interventions are implemented as part of the health inequalities strategy, they should initially be designed as time-limited pilot studies with an integral evaluation strategy built in. Scaling up should only be undertaken once sufficient time has elapsed to observe that the intervention has had a positive effect and to record its impact.**