Health Inequalities
National Support Team
Strategic Feedback

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Worcestershire 16th – 20th November 2009
The 1 to 1 discussions concentrated on strategic aspects of addressing health inequalities, the results of which are reported in this presentation, while the workshops looked at 6 contributors to the life expectancy gap i.e. Cardio Vascular Disease (CVD) Secondary Prevention, Low Income, Debt and Health, Tobacco Control, Cancer, Preventing Seasonal Excess Deaths and Alcohol Harm Reduction.
Achieving percentage change at population level can be pursued in three main ways

**Population Health Level**
Direct input at population level through legislation, regulation, taxation, mass media etc. (e.g. preventing smoking in enclosed public spaces)

**Personal Health Level (Frontline Services)**
Applying effective personal health interventions (e.g., cholesterol management with statins, affordable warmth) so systematically, and at a scale that improvements add up to population level change

**Community Health Level (community engagement)**
Engaging, developing and empowering communities effectively and systematically enough that resulting health improving and health seeking behaviours result in percentage change at population level.

Achieving improvement in health inequalities through a combination of these factors will depend on ‘the organised efforts of society’ at four points in the population health triangle as shown above. The whole must be driven by committed leadership fostering engagement, effective local strategic partnership, and locally owned, coherent vision and strategy. Interventions must be provided effectively with system and scale by frontline services pro-actively pursuing health outcomes.

Community development should be addressed in a systematic, rather than ad-hoc approach, targeting engagement and support to the weakest, and least capable of responding alone. A range of processes should connect frontline services into the heart of communities, reaching out to ‘seldom seen, seldom heard’ groups and individuals.
Strengths
Leadership and Engagement

- A strong visionary leadership for health improvement has been demonstrated by the joint Director of Public Health.

- In 2008/09, the third year of its existence, NHS Worcestershire has achieved each of its statutory financial duties by delivering overall financial balance, operating within its annual cash limit and managing capital expenditure within its capital resource limit.

- The World Class Commissioning Panel developed an overall impression of the organisation, which is that through strong leadership it has stabilised the financial position and the local healthcare system, established strong partnerships and is building confidence with the local population.

- The appointment of a cabinet member lead for Health Improvement together with investment in time and training in developing the community leadership role of elected members is to be commended.
Leadership and Engagement

- Under Comprehensive Performance Assessment (CPA) Worcestershire County Council (WCC) is improving strongly and demonstrating a 4 star overall performance.
- In March 2008, WCC were awarded the prestigious Beacon Authority Status for their work on Tackling Climate Change.
- Worcestershire Acute Hospitals NHS Trust represented the NHS as a winner of the Top 100 Employers for Working Families in 2009, and was also listed amongst the Top 100 Healthcare Employers in 2009 by HSJ and Nursing Times.
- The Acute Trust offers apprenticeship schemes for administration grade staff and is working with Worcestershire University to develop further opportunities for training and development and placements as part of its role as a ‘corporate citizen’.
- Strong leadership is demonstrated in terms of the single equality scheme and a robust process for Equality Impact Assessment is in place across the partnership.
Partnerships: Structures and Processes

- NHS Worcestershire has established a £1,000,000 Health Improvement Fund and a Community Leadership for Health fund. These will help facilitate local ownership of action to address health inequalities.

- The PCT has strengthened its partnership arrangements with WCC, with the PCT Trust Board and County Council Cabinet signing a joint concordat outlining their commitment to joint working.

- The Worcestershire Hub, launched in 2002, is a partnership between the County Council and the six district councils. Its primary aim is to improve access to council services for the people of Worcestershire and establish more efficient and effective ways of working for the partners through a range of access points.

- The Joint Director of Public Health together with the Public Health Consultant leads for each district LSP and the Health Improvement Coordinators based in each district council, provides a good model for coordination of activity to improve health across, and between, the county and districts. This also provides an opportunity to raise the profile of health inequalities and public health interventions.

- Communication leads from different partner organisations meet on a quarterly basis and have an email network.
Partnerships: Structures and Processes

- There is a Joint Commissioning Unit for adult services, which includes a manager lead for Health and Well Being. This is governed by health and social care board with senior representatives across both WCC and NHS Worcestershire. This model is being considered for Children's Services.
- The Pooled Reward Grant from the first round Local Area Agreement (LAA) provides opportunities for joint delivery of health improvement and health inequalities targets.
- Plans have been developed in areas of greatest needs/Health Hotspot areas to take forward these LAA targets. This will further strengthened by the participation of Worcestershire as one of the 13 Total Place Pilots nationally.
- There is a defined partnership structure which is working well but has also recognised the need to address four major challenges arising from the complexity of Worcestershire's administrative layers in order to further improve partnership working.
- As part of the partnership structure, the ‘Shenstone group’ is in a good position to drive forward the health inequalities agenda.
Vision and Strategy

• The Sustainable Community Strategy and NHS Worcestershire’s Strategic and Annual Operating Plans recognise Health Improvement as an important issue.

• A new Health Improvement Strategy has been developed that describes how health will be improved by Worcestershire County Council and NHS Worcestershire, in concert with the wider Partnership, and under the leadership of the DPH.

• The Health Improvement Strategy identifies 14 ‘Health Hotspots’ across Worcestershire which better describe the relationship between social deprivation and health outcomes. Activity identified in the action plan accompanying the strategy is prioritised within these areas.

• The Public Health Directorate Annual Report forms part of a wider Public Health Intelligence Strategy to provide partners in Worcestershire with comprehensive information about health and care services, and also identifies those groups most likely to experience Health Inequalities in Worcestershire.
There is a well-resourced Public Health Intelligence Team with excellent analytical expertise, good access to relevant datasets and consultant level leadership ensuring appropriate input into strategic decision-making.

A range of reports provide a comprehensive picture of health needs across the County, including summary district health briefings and analysis identifying ‘health hotspots’/‘areas of greatest need’ for targeted interventions. The 2008 Practice Based Commissioning Needs Assessment gives a detailed description of PBC registered populations.

The HINST endorses the recent production of ‘balanced scorecards’ for primary care, which clearly present a detailed set of indicators for each practice, including traffic-light ratings to compare performance against the Worcestershire average. The proposed school health profiles also demonstrate an innovative use of pupil level education and health data.

An analysis has been undertaken to look at actual Vs expected expenditure on health services. There is also a strong focus on anticipating future health needs based on forecasting demographic change and disease prevalence rates and modelling the potential impact of evidence-based interventions on future demand for health services.

There is a strong research and intelligence unit in the WCC, 50% of its activity is paid for by partners to provide them with information support. There are also good linkages across PCT and LA information teams through the ‘Joint Information Group’, which is well placed to take forward the JSNA including plans around developing a web based tool.
Frontline Services

There are a range of new primary care facilities up and running or in development.

- A new £17.7 million community hospital is being built in Malvern Hills District and is on target to open in Autumn 2010.
- Droitwich Spa's new medical centre opened for business in September 2008 providing care for 19,000 patients.
- A walk-in centre in central Worcester.

- Worcestershire is set to get its own radiotherapy unit following plans by the Three Counties Network Board to open new units in both Worcester and Hereford.
- The PCT is developing a new Primary Care Strategy through a process of clinical and stakeholder engagement.
- NHS Worcestershire have a ‘quality prescribing scheme’ which together with spot audits are improving the prescribing practice of primary care. There are also a range of enhanced services provided through community pharmacy including smoking cessation, emergency hormonal contraception, methadone etc.
- HINST noted an number of examples where service resources have been redefined or differently commissioned based on assessment of need (e.g. areas, times of year, new roles).
Frontline Services

- Health trainers have been piloted in 3 areas and there is a tender process in progress to roll these out to other areas.
- Work has been undertaken to develop health improvement and mental health services within prisons.
- The Acute Trust has adopted the ‘Think Glucose’ national programme.
- The Acute Trust has a major ‘health at work’ programme which includes the development of a new facility which is due to opened soon by Dame Carol Black. The Partnership, through the Health Improvement Strategy, also have a focus on workplace health.
- The Worcestershire Mental Health Partnership Trust has a very well recognised early intervention for psychosis service and plans to develop a similar programme on early intervention for dementia.
- NHS Worcestershire are looking at an innovative programme to roll out a tariff system for stop smoking provision which will result in a wider pool of providers. This is being rolled out in advance of the region wide proposal.
Frontline Services

- A primary care performance framework is being developed using the Primary Care Commissioning Support Tool (disseminated by Department of Health). This includes:
  - A balanced score card is being piloted with the 11 practices who have lost finance under the new QOF payment criteria
  - Modelling of high performance vs. funding/earnings has been undertaken
  - Annual reviews have been initiated in order to get the ‘basics right’
- Primary Medical Services (PMS) and General Medical Services (GMS) contracts have been reviewed. New contracts are planned to focus practices on areas of improvement with remedial actions identified if performance is not improved. A review of the financial impact of moving more practices from GMS contracts to PMS is also being undertaken.
- A GMS and PMS strategy is being developed through building a culture of ownership and understanding of outcomes. This is being driven through a GMS and PMS strategy group (sub group of the Commissioning Executive) who are currently agreeing the following outcomes: improved health; increased quality; increased access; increased performance and ensuring value for money.
- The 100+ Local Enhanced Services (LESs) are being reviewed against take up and strategic fit which should ensure that only those which are effective are re-commissioned.
- Practices have moved to Fair Share allocation which has helped to match resources to need in deprived communities
Community Engagement

The HINST has developed a community engagement good practice framework which identifies those elements that are necessary to achieve a systematic, comprehensive and effective strategic approach to community engagement. This includes the following elements:

- **Structures and Profiling**:
  - Structures (for communities of place)
  - Neighbourhood Management
  - Communities of Identity and Interest
  - Community and Neighbourhood Profiling
  - Stock-take of Community and Neighbourhood and Infrastructure
  - Community and Neighbourhood Action Planning

- **Engagement and Capital Building**:
  - Community consultation
  - Community partnership
  - Community empowerment
  - Development of Human Capital
  - Development of Social Capital

- **Organising for delivery**:
  - Public sector staffing for community and neighbourhood engagement
  - Procurement/commissioning of community and neighbourhood engagement
  - Service delivery to enhance/respond to community and neighbourhood engagement
  - Neighbourhood/Community of Identity and Interest Service Centres
  - Community and neighbourhood engagement services support and organisation

- **Organising for change**:
  - Social Marketing and service targeting
  - Organisation development and change management
  - Partnership integration
Community Consultation

1. Minimal consultation; little feedback.
2. Large meetings / 'usual suspects'
3. Menu of methods - citizens panels, patient liaison/user groups, household surveys; evidence of impacting on action/service change.
4. Reaching seldom seen and heard groups; coordination between partners with communities, using a consultation schedule to avoid over consultation; evidence of impacting on action/service change.
5. Stakeholder engagement involving front line staff, with clear feedback - "we asked, you said, we did, this is the difference you made"; evidence of extensive use of trained community volunteers/commissioned VCS orgs in consultation work with peers.

Community Partnership

1. Engagement tokenistic/ unequal power relationships.
2. Engagement with support to consult/feedback to wider community/ies.
3. Community representatives feel that they have some influence over priorities, decisions and resource allocation.
4. Respect and trust between all partners & shared learning; formal p'ship agreement in place; community reps feel fully engaged, conflict resolution possible.
5. Community led operational partnerships with statutory sector involvement with access to resources to deliver improvements; community representatives contributing to and impacting at, strategic levels as well as local/area/own community levels.

Community Empowerment

1. Few community organisations; exclusive and inward looking, with limited lifespan.
2. Wide range of community organisations, income mainly from commissioned activities, grant aid. Community organisations actively seeking to ensure they are open and representative.
3. Range of community organisations – resourced predominantly through voluntary effort but some long standing and established.
4. Some devolution of assets / participatory budgets; social enterprise and trading focus across a range of established community orgs. Orgs have a strong voice, can lobby for change; well supported by Infrastructure Support Organisations.
5. Community organisations well established, visibly representative of own communities & delivering local/CoI services from a sustainable & stable asset base and/or ensuring strong community voice which is impacting on mainstream change.
NB shaded boxes imply there is already some good work at this level but perhaps only in patches or perhaps strongly led by one of the main statutory bodies only, rather than systematically. It can also indicate that plans are in place but are yet to be fully implemented in relation to that level of the model and thus the impact cannot yet be fully assessed.
Community Engagement

- In developing Strategic Plan, the PCT engaged the public and key stakeholders in a number of ways and recognises that involving local communities in the development of health services in Worcestershire and building confidence in the NHS are two of the most significant challenges facing the PCT in the next few years.
- There is a Community Engagement and Communication Strategy which proposes six strategic communications objectives that form the basis for communications and engagement work in the future.
- There is also a newly created Communications and Community Engagement team that has been established to lead work in this area.
- There is a Community Leadership and Engagement Framework produced by the County Council, which has been formally adopted by the six District Councils and offers the opportunity for a joined up approach to Community Engagement across Worcestershire (Strategic Plan).
Community Engagement

- There are pockets of innovative and excellent community engagement work across the County, being undertaken by skilled and committed staff from a range of partner organisations.
- NHS Worcestershire has gradually expanded its community engagement team over the last couple of years.
- NHS Worcestershire’s community engagement team are training facilitators to work alongside lay people to train a wider range of PCT commissioning and provider staff to effectively capture patient experience.
- The Worcestershire County Council Community Engagement Team are active members of all 6 District LSPs as well as the County LSP.
- Work is underway to strengthen the community leadership roles, skills and commitment of elected members.
- A post has been established within the Voluntary, Community and Faith sectors (VCFS) to support the market development of the VCS.
- There is clear evidence that the investment in young people’s participation and engagement is paying dividends in terms of expanding the range of forums and initiatives where young people play and active role/have a strong voice.
Community Engagement

- There is a Non-Executive lead for community engagement on NHS Worcestershire Board.
- The 6 relatively new Health Improvement Coordinators are valued by a range of professionals and VCSF organisations and are actively playing a positive role in connecting communities, VCFS groups and organisations and service providers, and in making links into commissioning.
- Health Trainers have been recruited from within the communities they are working and there are plans for expansion.
- A joint consultation website has just been set up where partners can share what consultations they are planning/have undertaken, which is also accessible to the public.
- NHS Worcestershire has an equality and Human rights Committee and a working group for commissioners (a provider arm group is also being set up).
- A joint Single Health Equalities Partnership has been set up across the three main NHS bodies (PCT, Acute, Mental Health) and outreach research has been undertaken to identify barriers the main equalities communities face in accessing services. A report is due which should feed in to commissioning.
- The County Council has established a Corporate Equality Board with outward as well as inward facing Task Groups established for each of the equalities communities, including reps from PCT and from the relevant equalities communities. Staff networks also link into these structures.
Community Engagement

- A range of services are delivered by mobile units or in community buildings (e.g. services for young people in youth centres; Age Concern Mobile Day Centre).
- There is a good infrastructure of Parish Councils and a range of Infrastructure Support Organisations (ISOs) who are linked together through the Worcestershire Infrastructure Consortium (WIC).
- Partnerships and Communities Together (PACTs) have been widened beyond their initial crime/police primary focus and offer potential for cross partner locality focused community engagement.
- Area Forums have been established in Hot Spot areas.
- There has been extensive community engagement (including with young people) in the development of the new Malvern Community Hospital. There are other examples of engagement in new build/reoriented facilities such as schools, leisure centres, hubs.
- NHS Worcestershire has recently established a new post to lead social marketing.
- The Acute Trust has 6,000 shadow members which provides an opportunity for engagement with local patients and communities in service developments.
- NHS Worcestershire has recently developed a ‘Patient Insight Panel’ which provides patient into service redesign.
Recommendations
Context

There is a danger that as the overall health outcomes at a County level are better than the England average there may be some loss of focus on health inequalities despite the fact that there is:

- A significant gap in life expectancy between the most deprived ‘hot spot’ and the most affluent area of the County (circa 12 years). This gap is larger than HINST see in many areas with more challenging health problems.
- The Director of Public Health noted that if the most deprived area of the County had the life expectancy of the best around 450 premature deaths could be saved each year.
- National and international research has shown conclusively that inequalities impact on all the local population* and bring down the health potential of all citizens.
- Long term poor health means that those in the worst health spend many more years in pain, with limited mobility, and with poorer mental health as well as dying prematurely. This impacts on health and care budgets as well as on families and communities.

The HINST would urge the PCT, Local Authorities and Partners to be ambitious in relation to their own contribution and their added value by working together to addressing health inequalities within the County

•See for example Richard Wilkinson’s work:
Vision and Strategy

HINST has seen evidence of organised planning and delivery of interventions in Worcestershire that will improve health in the medium term i.e. the extensive lifestyle programme. However HINST feel that this is not the case for those interventions whose impact will be seen in the short term e.g. cancer and CVD. There is also scope to develop further partnership approaches in those areas where actions will have a more longer term impact e.g. transport, income and debt.
Vision and Strategy

- The HINST feels there is scope for impact on the major killers in the short-term, which if appropriately focussed and systematically applied could reduce Worcestershire’s internal mortality gap.
- The Health Improvement Strategy, 2008-2013 establishes the need for joint action to increase life expectancy and address health inequalities. The HINST would recommend that partners work together and build upon this approach to establish a clear vision and a strategic approach to reducing health inequalities within Worcestershire. This could lead to the development of a supplement to the strategy which details actions to reduce health inequalities in the short, medium and longer term and provide a framework to embed priority actions by locality. It will also be important that robust governance arrangements are in place to enable progress to be monitored.
- This action plan should be informed by the outcomes from the Health Inequalities HINST workshops feedback report. For areas not covered by the workshops, priority programmes could be checked against the ‘Diagnostic’ model to ensure that in addition to service outcomes, the right conditions for achieving target population outcomes are considered as part of the planning process.

HINST could work with NHS West Midlands to offer support around this.
Vision and Strategy

• In order to develop the approach to tackling health inequalities as outlined in the previous slides NHS Worcestershire and partners should agree to a common frame of reference for comparing and monitoring health inequalities in Worcestershire, this may be by
  – Further refining the ‘Health Hotspots’ concept and aggregating the population in these areas to permit comparison and monitoring. This combined population would equate to around 10% of the total population in Worcestershire.
  – Communities of interest (e.g. Gypsies and Travellers, Minority Ethnic Groups) compared with local averages
  – Diffusely spread families and individuals of interest (e.g. people with learning disability; enduring mental illness; low IQ; chaotic families)
• This would form the basis of a performance management framework for the refreshed Health Improvement Strategy, which recognises the short, medium and long term outcomes. This will give clarification to the partnerships about the scale of the challenge and a focus for industrially scaled and appropriately targeted interventions.
• There may also be a need for the LAA targets to be broken down where possible in accordance with the refreshed Health Improvement Strategy in order to quantify intervention outcomes and give focus to addressing intra-district inequalities.
Vision and Strategy

- There are clearly acknowledged housing issues in Worcestershire (e.g. limited affordable housing; under served by bungalow accommodation) and the recognition of the certain impact this is and will have on short, medium and long-term health. The HINST would recommend partnership working on this issue including the consideration on the development of a specific and pragmatic Housing and Health Strategy. Joint working might include an exploratory workshop on Housing and Health.

  The HNST and NHS West Midlands can offer support

- A joint communication strategy needs to be developed which should include an information plan to support the refreshed Health Improvement Strategy and action plan. Information should be made available in user friendly, ‘marketing’ formats for a wide range of audiences including seldom heard groups and to staff.
Vision and Strategy

- The HINST recommends that the partners systematically and routinely consider the impact on health and health inequalities when reviewing capital plans and services development proposals. Greater use of Health Impact and Health Inequality Impact Assessments would help with this and in relation to any financial uncertainty, would ensure that health inequalities are not exacerbated.

- The HINST has seen examples of the use of programme budgeting and marginal analysis to assess the best fit between needs and resources to achieve the best health outcomes.

The HINST can signpost to these examples

- The Overview and Scrutiny process could be a useful mechanism for examining progress and driving forward action on health inequalities, and further enhance the community leadership roles of local elected members.
Leadership

Health inequalities are crosscutting and therefore everybody's business. It appears that at the moment there is not an explicit, shared vision to enable the partnership to address the health inequalities challenge in the short, medium and long term. Continued strong commitment at senior level and leadership will be needed to drive this agenda through all levels of agencies and partnerships.

To achieve this will require:

- A clear working definition of health inequalities and the importance of tackling this issue in Worcestershire, which is clearly communicated across all partners to raise the profile of the issue and to highlight this as a priority area.
- Ownership of and responsibility for action to deliver health inequalities targets needs to be shared appropriately between partners and across all Directorates of the PCT mirroring the ‘One Council’ process undertaken earlier in the year.
- A consideration of the development of health inequalities champions across the partnership supported by a programme of leadership development. This may be particularly important for primary care clinicians.
- Public health being seen as ‘everybody's business’ across the leadership of the partnerships and through the tiers of management. There is an opportunity for joint development programme across all levels of partner organisations. The HINST would recommend adopting an organisational development approach of which there are good examples of intra and inter organisational programmes, producing cultural change at senior/middle management levels. HINST can signpost to good practice in this area.
Leadership

- The HINST would recommend the development of a structured learning framework designed initially for Elected Members and Non-Executives of the PCT to raise levels of knowledge and understanding of the determinants of inequalities in general, and health inequalities in particular and actions to alleviate them. This could be a joint initiative between the Councils and the PCT.

- This will ensure a better understanding of health inequalities and allow partners to recognise the specific part they can play, and to embed this within existing work streams.

- Partners will need to agree how far they are committed to reducing health inequalities within the County by adopting local targets. This will necessitate recognition that some areas will require disproportionate resource to achieve equitable outcomes.

- The existing data and intelligence functions will have an important part to play in communicating the evidence of health inequalities across partnerships in a user friendly way, and in establishing baselines against which progress of initiatives can be measured.

- The development/implementation of a joint communications strategy to recognise real progress in reducing inequalities, and engage communities in addressing outstanding challenges would be beneficial.
Leadership

- Worklessness is significant in Worcestershire within some communities e.g. people with mental health problems. Whilst there are a number of examples of initiatives in this area, HINST believes that the public sector is in an excellent position as one of the major employers within the area to lead an effective ‘Good Citizen’ local employment strategy focusing on bringing workless people into employment. Building upon the individual schemes already in place a more comprehensive, systematic and scaled up joint strategy across the public sector could be established.

- There is an acknowledgement that transport across Worcestershire, particularly in the more rural areas, is an important issue in terms of people’s ability to easily access services, employment, leisure etc and the wider impacts on peoples physical and mental health. Strong senior leadership, building upon the Transport Plan and Accessibility work already underway, is required to develop a more coordinated joint approach to promoting pedestrian, cycling and alternative transport with health in mind.
Partnership

- Building on the development of the Joint Commissioning Unit the HINST would endorse the proposal by the Director of Finance at NHS Worcestershire and the Joint Commissioning Unit Manager to host a conference to scope further opportunities to develop a more integrated approach for joint commissioning and provision of services. The agenda for this event should include a consideration of a holistic partnership approach to delivering health, care and wellbeing outcomes learning from examples of innovative local practice. (Identified in the feedback from the seasonal excess deaths workshop)

- Whilst recognising the strength of the district focused public health structure the HINST recommends that the Partnership focuses specifically on the contributions and roles that Districts can play within the County partnership e.g. in connecting together local communities and Parishes. This approach would be strengthened by clearly identifying roles and responsibilities.

  HINST could assist with this

- Practice Based Commissioning (PBC) needs to be involved in wider partnership working, structures and processes.
  - PBC needs to be actively represented within the LSP structures
  - Public Health, LA and voluntary/community sector representatives could be invited to join PBC Boards
  - PBC groups need to be involved in the development of service specifications, including those for Health Gain
The full engagement of the VCFS in health improvement and addressing health inequalities is vital. HINST recommend that the Worcestershire Strategic Partnership reviews how to most effectively engage and strengthen the VCFS. Such a review should consider:

- The value and effectiveness of Infrastructure Support Organisations (ISOs) and coordinating bodies/forums in relation to their role in supporting and enabling partnership working across the VCFS and between the VCFS and the Worcestershire LSPs.
- NHS and Council financial investment in VCFS ISOs (currently this is relatively low). Consideration should be given to reviewing the cost/benefits of such investment in helping maximise the coordination, networking and sector development impact of such bodies which all LSP partners and communities can benefit from.
- The adequacy and appropriateness of networks/infrastructures to enable 'representation' of the VCFS within partnership structures and joint working.
- The unique contribution of the VCFS and how this can be best harnessed.
- The effectiveness of the existing COMPACT and the structures for monitoring and review of its implementation.
- Identification of the best way to support and strengthen smaller and BME VCFS organisations.
- ‘Market Development’ (World Class Commissioning Competency 7) of the VCFS so that the sector can be sustained/expanded and be able to compete in a ‘contract’ culture. As well as looking at ways of strengthening the capacity of individual VCFS bodies, the review should also look at how to support brokerage arrangements to enable a range of opportunities by which the local VCFS can be supported to ‘grow into’ commissioning, e.g. through subcontracting, consortium bidding, & statutory/voluntary sector partnerships.

*** The HINST can signpost to areas that have undertaken such reviews.
There is good evidence of health needs assessments describing the overall health needs of populations at different geographical levels - from county-wide to ‘health hotspots’. However, there is potential for a better understanding of the health needs of specific population groups including, for example, BME communities, travellers or those with mental health problems.

There is potential for further use of population segmentation analysis making use of for example MOSAIC or ACORN data, across the partnership.

Health Impact Assessments and Health Equity Audits need to form a routine element of work around service reviews and planning, new urban developments, strategies and plans across the partnership. In particular, the geography and significant rurality of Worcestershire places an onus on considering equity of access and the potential health impacts for communities resulting from changes in service provision.

To ensure that programmes, projects and campaigns can be industrially scaled appropriately it will be necessary to carry out systematic evaluation and impact assessment of all pilots. This is of particular relevance to projects funded through the Health Improvement Fund.
Targets, Trends and Needs Assessments

- The HINST endorses the Public Health Intelligence Team’s efforts to obtain more detailed primary care data at individual patient level, and improved child health data. Access to these datasets would greatly increase the range, and level of detail, of future analyses.
- The HINST perceived public health analysis would benefit from both improved marketing across the partnership and on interpreting key messages for a wide range of stakeholders.
- There is potential for further work on linking prescribing data with health outcomes and programme budgeting to assess cost against outcomes at GP practice level. The HINST note the use of the ‘Primary Care Commissioning’ tool disseminated by DH, which provides further options of analysing practice level data and peer comparisons across the Country.
- Progress has been made in the use public health analysis to inform commissioning, but it needs to be developed further to make public health intelligence fully embedded in all commissioning processes across the partnership.
Frontline Health Services

Achievement of sustained improvements in life expectancy in Worcestershire is dependent on good quality primary care. The HINST would regard the further develop of this sector as critical and endorse the commitment of NHS Worcestershire to support this work.

There is currently variability of outcomes achieved by practices indicating potential for the improvement of minimal standards. There are a number of strands of activity developing across NHS Worcestershire aimed at improving the quality of primary care and in order to have a more comprehensive and robust approach to this area HINST suggest that the proposed development of a PMS and GMS strategy is developed into a comprehensive Primary Care Quality Improvement Strategy/Action Plan, which includes a focus on improving primary care estate where necessary (the opportunities provided by the accommodation strand in the Total Place Pilot should be exploited). This work needs to be accelerated with accountability for progress through regular reports to the NHS Worcestershire Board.
Practice Performance QOF Data in Worcestershire

Worcestershire QOF 2008/9 showing the levels of clinical points achieved by practices which provides an indicator for the general level of quality of primary care. This graph demonstrates a reasonable consistent level of quality across the practices.
QOF 2008/9 showing the levels of non clinical points achieved by practices in Worcestershire, which is a proxy indicator for organisation capability in the practices. Without good organisation skills the practice would not be able to organise its registers, reviews etc.
This graph provides Worcestershire an opportunity to compares its position with another spearhead PCTs position on achievement of non clinical points earned - demonstrating it is possible to better its position.
Analysis of CHD Outcome indicators in Worcestershire

Worcestershire QOF 2008/9 showing achievement of % patients whose last BP reading was less than or equal to 150/90. The orange bar being % of patients for whom the target was missed and the yellow the % exception coded – the patients in both these are not therefore receiving the effective treatment/support they require – these are often those most likely to be experiencing health inequalities.
Worcestershire QOF 2008/9 – This graph of achievement of % patients with COPD with FeV1 recorded in last 15 months indicates an inconsistent review process for people with COPD with particularly poor performance in 1 practices who only just reached 40% of their registered COPD patients.
This graph illustrates the expected distribution of GP practices within any PCT area (this does not illustrate Worcestershire’s position). There will be GPs within each of the groups 1 – 3 and the recommended action is outlined on the next slides.

**Distribution of GP Performance**

- **Action required:**
  1. Remove handful of practices that are incompetent and irremediable
  2. Target underperforming practices for ‘high challenge, high support’ from PCT
  3. ‘Raise the bar’ with higher expectation of all practices through ‘integrated governance’ and incremental incentives

Where no progress, consider partial or complete competitive commissioning.
Frontline Services

1. Consistently poorly performing practitioners. A robust approach which seeks to manage the small handful of persistent poor performers with methods including periods of clinical supervision, retraining sabbaticals, and in some cases suspension and referral to GMC.

2. Practitioners performing below average. This could involve substantial hands-on audit of records, action plans which could be included in new individual contracts for improvement, and where necessary provision of targeted wraparound services (e.g. inputs from medicines management, IM&T Services and clinical speciality areas such as COPD). It is important to ensure that any remedial action proposed does not adversely impact on the availability of services for vulnerable communities. Another example of improving performance may be through a gateway process would ensure practices achieve basic standards before being considered for any enhanced services.

The HINST can signpost to good practice.
Frontline Services

3. Raising the bar for everybody.

It should be recognised also that 70% achievement also means 30% failure. It is likely that a large proportion of vulnerable and complex patients will be concentrated in this final 30%. This will include for example people from minority cultures and vulnerable groups such as those with low IQ, learning disability, enduring mental health problems and those from ‘chaotic families.’ For such groups it will require disproportionate effort and resource to achieve the same outcomes.

– Continue to systematise the production of good quality, well presented information at practice level on important delivery areas – e.g. CVD, diabetes. Build on the concept to improve poorer performers to levels of effectiveness and cost effectiveness of the best, whose performance should be celebrated.

– Develop an exemptions strategy in practices with higher levels of exceptions through a study of patient characteristics in current excepted groups.

– Explore the use of local incentives schemes to raise the ceiling of achievement on targets e.g. ‘exponential’ scale of extra payments to reduce exemptions and lack of progress beyond national incentive ceilings; development of a QOF Plus contract for raised standards.

The HINST can signpost to examples of good practice in these areas of developing primary care quality and will work with NHS West Midlands and GOWM to explore options for specialised support for this area.
Frontline Health Services

- There is an opportunity to mobilise partnerships further to promote healthier living – e.g. by training workers in the partnership and those organisations they commission services from so that every contact becomes a potential health contact – all staff health promoters.

- The HINST recommends systematising and scaling the application of interventions through the development of a Health Gain Schedule for all provider services, making at least tobacco, alcohol and weight management everybody’s business. This should involve:
  - key screening questions for frontline staff to use
  - brief intervention training and updates
  - referral pathways
  - an activity monitoring system

- A similar Health and Wellbeing Schedule could also be used by Local Authority commissioners with respect to their providers in relation to the contribution that can be made by front line staff.

- A further schedule could be developed for use with Worcestershire Mental Health Partnership Trust, building on their existing good practice, securing physical health and health improvement for clients with enduring mental health problems, and learning disabilities.
Frontline Services

- HINST perceives a need to develop a more systematic and shared approach to the development of care pathways covering the span from prevention through to end of life.

- HINST endorse the proposed programme of training for Community Pharmacists around Medicines Utilisation Reviews. These have the potential to have a significant impact on outcomes if targeted and appropriately resourced.

- The outcomes from the annual QOF visits could be enhanced by the inclusion of prescribing input as part of the visiting team. Further improvements in practice performance can be gained by better use of QOF outcome and prescribing costs data to identify those practices where further support could be of benefit.
By plotting the QOF outcomes, by practice, for diabetes indicators against the prescribing cost for that practice for diabetes medication, it is possible to identify practices which can be supported to improve. This is not a graph illustrating Worcestershire’s position.
Addressing Diabetes Inequalities through Community Engagement

This model was developed as part of strategic work to tackle inequalities in health, with a specific focus on diabetes, by the Community Development service of NHS Bradford & Airedale.

Stage one included identifying the four main challenges that were contributing to diabetes related health inequalities. Stage 2 focused on developing action plans to address the four main challenges. Stage 3: focused on identifying which communities to initially target, as part of a planned District wide initiative over 3 years. Delivery of the action plans is still at an early stage (as of October 2009).

Challenge 1. There were still many local people who were unaware of the link between diabetes and lifestyle. There were also significant numbers of people who are unaware of the various identified risk factors that mean certain population groups are at increased risk of developing diabetes. The general level of awareness of the early indications that someone may have developed diabetes was also low – amongst local people and for many health, social care and community service providers (unless specialists in this area). Thus the first challenge was to increase access to information and widen awareness raising through specifically targeted materials, staff with community knowledge and good links to specific communities, and a range of activities and events.

Challenge 2. HINST work had highlighted that there were possibly several thousand people missing from GP Practice Registers in Bradford and Airedale who were likely to be diabetic, based on the population profile. Specific work to raise awareness of the levels of under-diagnosis with local people and health and other professionals was accompanied by the offer of risk assessment sessions in a range of NHS and community venues, planned, promoted and delivered through a range of partnership and joint working initiatives.

Challenge 3: HINST work had highlighted through the relevant QOFs that significant numbers of diabetics on practice registers did not have their blood sugar controlled. Subsequent discussion with specialist community and acute diabetes service providers confirmed that certain communities were less engaged with services, and also that some services (e.g. diabetes education and self management support) were only available to a limited number of newly diagnosed diabetics, and were not easily accessible by many of those who most needed them. The action plan for this part of the work looked at initially outreaching to a range of people who were not using services (e.g. DNAs at specialist clinics) or whose blood sugar and other health management needs (e.g. blood pressure) were often or usually not well controlled. The purpose of the outreach work was to discuss with people their health and well-being from their perspective, their views on the services they were (or were not) receiving, and any other information needs/concerns they had in order to better identify what sort of services and support might need to be commissioned to better meet their needs and tackle the inequalities challenges.

Challenge 4: This focused on upping the skills and awareness of primary care and specialist diabetes services to better meet the needs of their patients and those who were currently not their patients but who needed to be if an equitable, accessible service was to be provided. It also included ensuring GPs and other primary care teams were fully aware of, and had easy routes to link/refer people to lifestyle support change services (e.g. exercise, smoking cessation, Health Trainers, welfare rights) in their locality.

The central box indicates that a coordination is needed to take forward all of this work and feed in the lessons, learning and commissioning/service re-design implications from each of the four inequalities challenge areas of work. In this case the Diabetes Pathway Group was identified as the most relevant coordinating body at a District level. At a locality level local cross sector partnerships are being formed to coordinate the work in relation to all four challenges with specific geographical communities.

Challenge 1 & 2 also include a ‘training the trainers’ approach to ensure staff and volunteers working in services such as children’s centres, home care services, homeless hostels, faith centres and so forth are able to act as advocates and informed message sharers with their own clientele/service users/communities.

For more information on this model or the Bradford work contact Jan Smithies in the HINST Team. jan.smithies@dh.gsi.gov.uk
**Community Engagement**

Although there is some very positive engagement work, much of it is with motivated, vocal communities or reliant on outreach through short term funded projects. Tackling health inequalities will require outreach to and engagement of communities (of place and interest/identity) experiencing the worst health outcomes. A more strategic and systematic approach, building on the pockets of good work underway, and maximising the effectiveness of staff employed by a range of partners/sectors, is needed to widen reach and to pool resources and expertise. A number of initiatives could strengthen strategic and systematic joint working such as:

- Bringing together key community engagement documents from the County Council/Districts, PCT, and other organisations (such as housing associations) to develop a combined LSP Strategic Community Engagement Framework.*
- Agreeing across LSPs who are the key vulnerable groups/communities of interest and identity/often overlooked or unheard communities (e.g. travellers; migrant workers) and developing joint action plans across LSP theme areas/partners to jointly reach out to and engage those communities.

* Haringey Local Strategic Partnership’s framework is worth looking at (on Haringey Council website) as are their documents recording the processes involved in developing a shared strategic approach.
Community Engagement

- Developing an action plan to implement the joint strategic community engagement framework across partners. All partners will need to look at how the framework can be best applied to their role and remit and develop new, or refresh existing, individual organisational action plans.

- The various LSP Boards will need to formally adopt the framework and action plans and to take responsibility corporately for performance managing implementation. This needs corporate leadership and should not just be left to engagement managers/teams.

Other strategic approaches which will strengthen community engagement include:

- Mapping people who have community development and/or engagement as part of their role from all sectors/partners**

- Holding an initial half day event to bring together people with these skills and remits with a view to establishing a Worcestershire community engagement network/working group.

- Making better use of the work that has been put into developing parish plans; this may need to include shaping these to better fit the LSP themes/structures.

The final community engagement slide in this section provides a framework that could be useful for mapping roles and work.
Community Engagement

- There are scattered examples of training staff and community activists/volunteers in a range of community engagement/outreach skills, but very little linked into accreditation routes. A review of training and skill development needs, existing training provision, and gaps, and useful accreditation routes should be undertaken.

- Competitive bidding for local funds will lead to the best bid writing groups/communities getting increased access to funding not necessarily those most in need. A review of whether this is the most equitable way to target funds should be considered.

- There are some examples of commissioning VCFS organisations/groups to lead specific engagement work (e.g. deaf community) but on the whole commissioning is limited to service delivery. This is an area that could be expanded.

- It is important for credibility and future consultation work that more emphasis is put on feeding back from consultations; a proactive adoption of the 'we asked, you said, we did' quick feedback approach should be considered.

- There are infrastructures and structures for engaging communities of interest and identity in generic equalities work in place but commissioning would be significantly strengthened by more effective linking into these existing wider forums and networks.
Community Engagement

- The NST endorses the appointment of a Social Marketing post within NHS Worcestershire to ensure that Social Marketing is systematically applied to all service planning and commissioning.
- Social marketing principles will be an important tool as World Class Commissioning develops. The NST would recommend a series of orientation training seminars which could best be delivered as a partnership development process. The HINST could signpost to good practice in this area.
- Social marketing is more than undertaking segmentation analysis of population characteristics or communicating messages. The HINST would recommend that training is also offered to frontline staff to enable them to engage with communities to gain and gather market insights to inform commissioning and undertake insight-driven approaches to motivating behaviour change among local people.
- Furthermore the HINST would recommend that partners use the available ACORN/MOSAIC data to allow partners to gain an understanding of segmental preferences in accessing services. This information could then be used to develop a range of tailored ‘customer access strategies’ to change the front end of services. HINST could provide examples.
This Strategic Framework contains 5 key elements that all need to be considered to ensure that either a District or single organisation’s overall approach to community engagement is strategic and impacts on change at all levels. It can be also used in relation to specific community engagement initiatives. Often engagement work is simply focused at grassroots level (small projects with time limited and limited resources) with little use made of existing community or professional infrastructures. Those infrastructures may need creating or strengthening, but will pay dividends in terms of the longer term sustainability of grassroots level initiatives, and in expanding their reach and impact. If change is to be two way (i.e. service better responding and adapting to community need as well as individuals and communities being better supported to make changes and take on challenges) then there has to be routes to, and strategic roles and initiatives built into the overall systematic approach in any given community engagement work or strategy (e.g. workforce development, impact on commissioning, service re-design etc). Making sure work and initiatives in all four of the outer boxes is effective in its own right, but also mutually strengthens, reinforces and expands the impact and any useful learning, is the role of the central ‘overview and coordination’ box. Those who sit in that central box will also be key in making sure the arrows flow – either through opening up communication and information sharing pathways, and/or developing joint working links and partnerships across the different four outer boxes.

The ‘5 Elements’ model works both as a review tool, as a tool to share work across agencies/sectors and/or a locality or community of identity/interest and an to plan initiatives and activities in a strategic rather than ad hoc, short-term project focused way. The arrows – and people whose role includes making sure the arrows work in reality rather than just on paper, are as important as what goes on in each of the boxes. Activity and people/resources to deliver those activities need to be identified for each of the five elements. This will not always mean new resources/roles, but often a better focusing/coordination of those already in place.

A HINST Tool-Kit showing how the ‘5 Elements’ Strategic Framework can be applied in relation to health inequalities challenges will be available from the Department of Health in Spring 2010.

The model was developed by Jan Smithies & Georgina Webster of Labyrinth Consultancy and was published in their book ‘Community Involvement in Health: From Passive Recipients to Active Participants’. Ashgate Publishing:1998. When used it should be referenced accordingly.
Top Take Home Messages

Context
- Overall Health Outcomes across Worcestershire are good when compared with the England average
- Strengthened partnership arrangements and strong public health leadership.
- Wide range of interventions to address lifestyle issues supported by dedicated ‘health improvement’ funds

Priorities for action

Leadership
- There is an need to continue to strengthen leadership for health inequalities across the partnership. Key recommendations include
  - A clear working definition of health inequalities and the importance of tackling this issue in Worcestershire, which is clearly communicated across all partners to raise the profile of the issue and to highlight this as a priority area.
  - Developing health inequalities champions across the partnership supported by a programme of leadership development. This may be particularly important for primary care clinicians.
  - Public Health being seen as ‘everybody’s business’ across the leadership of the partnerships and through the tiers of management.
  - The development of a structured learning framework designed initially for Elected Members and Non-Executives of the PCT to raise levels of knowledge and understanding of the determinants of inequalities in general, and health inequalities in particular.
Top Take Home Messages

Vision and Strategy
• Need to develop a health inequalities supplement to the Health Improvement Strategy building upon the feedback from the HINST report which details actions to reduce health inequalities in the short, medium and longer term and provide a framework to embed priority actions by locality.
• Need to agree to a common frame of reference
  – for comparing and monitoring health inequalities in Worcestershire, and
  – around joint priority areas for action
• Using this to form the basis of a performance management framework which will give clarification to the partnerships about the scale of the challenge and a focus for industrially scaled and appropriately targeted interventions.

Community Engagement
• Need to develop a more strategic and systematic approach to engagement with the community, building on the pockets of good work underway
Top Take Home Messages

Primary Care
• Need to develop a comprehensive Primary Care Quality Improvement Strategy/Action Plan, which includes a focus on
  – removing the variability in performance
  – ‘raising the bar’ on expected minimum standards
  – developing a vigorous exceptions strategy.

Targets and Trends
• Need for Health Impact Assessments and Health Equity Audits forming a routine element of work around service reviews and planning, new urban developments, strategies and plans across the partnership

Social Marketing
Further develop the capacity and capability to undertake social marketing by
• providing a series of orientation training seminars as a partnership development process and training for frontline staff to enable them to engage with communities and gather insights
• using the available ACORN/MOSAIC data to allow partners to gain an understanding of segmental preferences in accessing services and then using this information to develop a range of tailored ‘customer access strategies’ to change the front end of services.