

## **TACKLING HEALTH INEQUALITIES** **- Feedback from External Reviews**

### **PURPOSE**

The purpose of this paper is to provide information to the board on the high level feedback from the National Support Team (NST) for health inequalities visit to Birmingham (Birmingham City Council, Birmingham East and North, Heart of Birmingham and South Birmingham PCTs) in November 2007. It will also to provide initial feedback from the Audit Commission first stage review of tackling health inequalities in the City.

### **BACKGROUND AND INTRODUCTION**

The NST for health inequalities focuses on the Public Service Agreement (PSA) targets aimed at reducing the gap in life expectancy and mortality from the major causes of death (heart disease and cancers). The NST stresses that it is not part of the performance management arrangements of the department of health. The NST gives immediate feedback on strengths and recommendations for further action.

Following on from the NST review of Birmingham and its inequalities in health, the City has commenced a review lead by the Audit Commission. The theme of the Audit Commission is slightly different and focuses on the delivery of corporate objectives and effective partnerships, performance management and use of information and intelligence, workforce engagement and the statutory organisations corporate responsibilities.

The NST for health inequalities is one of a number of support teams established by the department of health to help PCTs and local authorities designated as spearhead areas to deliver on public health priorities and targets.

#### **Spearhead Local Authorities and the Life Expectancy Target**

The inequalities public service agreement (PSA) target is to reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth.

This target is underpinned by two more detailed objectives, as defined in 2004:

- starting with local authorities, by 2010 to reduce by at least 10% the gap (in life expectancy) between the fifth of areas with the worst health and deprivation indicators (the spearhead group) and the population as a whole;
- starting with children under one year, by 2010 to reduce by at least 10% the gap (in infant mortality) between the 'routine and manual' socio-economic group and the population as a whole.

The target for life expectancy focuses on narrowing the gap between the England average and the local authorities with the worst health and deprivation indicators, known as the spearhead group of local authorities. The spearhead group is made up of 70 local authorities (district and unitary), defined as those that are in the worst fifth of districts nationally for three or more of the following five indicators:

- male life expectancy at birth;
- female life expectancy at birth;
- cancer mortality rate in under-75s;
- cardiovascular disease mortality rate in under-75s; and
- Index of Multiple Deprivation 2004 (local authority summary) average score.

Life expectancy at birth has improved for England as a whole and for the spearhead group of local authorities. However, life expectancy has improved more slowly in the spearhead group than for England as a whole. The relative gap in life expectancy between England and the spearhead group is wider in 2002-04 than at the baseline (1995-97) for both males and females. For males, the relative gap is 1% wider than at the baseline, for females 8% wider.

## **REVIEW PROCESS**

### **Department of Health National Support Team (NST)**

The review took place over a four day period in November 2007. The process involved a series of citywide workshops and interviews of key staff. In total over 200 people were involved in the review directly.

The focus of activity was a broad review of activity to address inequalities at both strategic and operational levels, partnership working and an analysis of work in specific areas which included –

- Cardiovascular disease – secondary prevention
- Cardiovascular disease – acute care
- Cancer
- Infant mortality

- Tobacco control
- Preventing seasonal deaths

The feedback was given in the form of a presentation rather than a report and was structured to highlight findings in relation to two key areas; strategic planning and systematic delivery of population interventions.

Feedback included acknowledgement of strengths and recommendations for future action. A summary of the main findings are included in the appendix.

Generally feedback was very positive and there were many examples highlighted as good practice.

### **AUDIT COMMISSION REVIEW**

The Audit Commission has developed an audit guide aimed at ensuring that audited bodies, and the partnerships in which they work, are taking action to:

- understand their local health inequalities;
- direct resources appropriately to narrow the health inequalities gap;
- have arrangements in place to challenge and review their actions; and
- know how well they are doing.

The audit is carried out in three phases. Phase one, which has just been completed, provides an overview phase in which the key risks for delivering against health inequalities are identified.

The review process to date has included an in depth self assessment, NST feedback, interviews with key stakeholders and partners and analysis of key documents.

The work to date has not taken into account looking in detail at arrangements in place for each organisation to tackle health inequalities

### **RECOMMENDATIONS IDENTIFIED FROM EXTERNAL REVIEWS.**

#### **Priority Action**

- That a strategic framework be developed by the partnership – currently there is a lack of a strategic framework that sets out a clear three year rolling programme.

- Male life expectancy. There needs to be attention and resources directed at actual registration, follow through to care planning and effective management.
- Appointment of the new Joint Director Public Health
- Development of a systematic approach to Community engagement. There is a recommendation that this is linked to consultation in the 'Vibrant Urban Villages'
- Improving and developing primary care. The NST suggest a transitional plan to support communities where primary care is sub-optimal.
- Development of the primary care workforce. There is a need to review the primary care workforce in light of programmes such as the MLE.

#### **NEXT STEPS**

- Following feedback from the NST a process of action planning has begun that will feed into the development of the Local Area Agreement process.
- The NST has offered to provide support to Birmingham through the Birmingham Health and Wellbeing Partnership to develop a strategic framework for delivery against a suite of targets, aid effective working with Acute Trusts, support and signpost to good practice in terms of reconfiguration of services and finally to work with PCT's in Birmingham to improve primary care; particularly where care is sub-optimal.
- The audit commission is to undertake the second stage of its assessment. Typically phase two work is about creating an environment for improvement. This phase is largely workshop oriented and brings together partners to examine the key findings in phase one. Proposals for improvements should result from these workshops. Partners in the Birmingham area are already drafting improvement action plans and are keen to use this position statement as a firm basis for those plans

## Appendix 1

### **FEEDBACK FROM THE NATIONAL SUPPORT TEAM FOR HEALTH INEQUALITIES VISIT NOVEMBER 2007 (abridges from the PowerPoint presentation)**

#### **GENERAL STRENGTHS**

##### **Vision and Strategy**

- The LAA has provided an important focal point to bring together a vision and strategy and action plan on a city wide basis.
- Clear analysis of health contributors to the Health Inequalities gap in Birmingham leading to clear aims of Male Life Expectancy (MLE) and Infant Mortality (IM) and clear strategies in place to address MLE and IM
- These strategies (to address MLE and IM) are clearly embedded in the work of each PCT and CC.
- A major reconfiguration exercise for hospital sites has taken place in each PCT area following very extensive and comprehensive programmes of consultation.

##### **Leadership & Engagement**

- All 3 PCTs and the CC are committed to addressing Health Inequalities.
- The Council has placed health at the heart of its strategic planning. Health is one of the five outcomes that starts with the Council's strategic plan and is taken through the directorate business plans and is included in detailed service planning.
- The Leadership through the Health and Well Being Partnership demonstrated commitment to the 2010 Life Expectancy target.
- Some good examples of Public Health facilitation in provider services.
- A plethora of awards and high rated outcomes from inspection demonstrates the strength of the organisations within Birmingham.
- Commissioning processes within Birmingham East and North PCT have been used as standard within DH.
- The Health Community has shown foresight in commissioning McKinseys to develop a model for the whole Birmingham system. This will allow analysis of potential changes resulting from, for example, hospital reconfiguration.

## **Partnerships: Structures and Process**

Good progress has been made to build good joint structures across the PCTs and the CC over a very large and complex health economy

- The Health and Well Being Partnership has been reviewed and an Executive Group established . All three PCT Chief Executives and the Director of Adult Services are members of the Health and Well Being Partnership Executive Group.
- There are, in addition, quarterly summit meetings of the Health and Well Being Partnership involving a wider membership group including the Directors of Public Health .
- There are good communications links and joint working across the PCTs and the CC.
- The joint commissioning structure has been redesigned to involve all three PCTs and Adult and Children's services.
- There appear to be good working relationships between the PCTs and the Acute Trusts.
- There is an intention to appoint a fourth and joint DPH to be located within the CC
- Practice based commissioners seem relatively well engaged including with the Health Inequalities agenda. In each case efforts have been made to link practice based commissioning clusters with the constituency's strategic partnership boundaries.
- The Public Health Information Team is a good example of joint commissioning by the PCTs at a city- wide level

## **Targets, Trends and Needs Assessments**

- Some good examples of primary care indicator sets being used to monitor GP quality and drive up performance.
- Lots of examples of good analytical work.
- There are good levels of profile information on the BSP website, with mapping solutions being introduced next year. Ward profiles and strategies were made available widely on CD and website.
- The Neighbourhood Knowledge Management Programme is potentially a major asset for a range of purposes.

## **NHS Engagement with the Community**

- There are some good examples of Public Health linkage with each constituency strategic partnership and with each Practice Based Commissioning forum .
- PPI services are proactive and working well on consultation. There are some good examples across all three PCTs of engagement with communities, for example, The 'Big Conversation' (BEN)

## **Frontline Services**

Male Life Expectancy – many examples of good projects:

- The Male Screening Programme is an excellent example of a systematic and industrially scaled approach including:
  - Work with GP disease registers using the EHS Programme, followed by clinician telephone, and Healthy Heart across 12 wards.
  - Healthy Heart screening in Football Stadium and mobile facility to encourage screening street by street, with reporting back to GPs to enable building into registers.
- Award winning - Birmingham Own Health telephone outreach service
- The assertive case management programme introduced in BEN. The NST perception is that the level of clinical engagement between primary and secondary care benchmarks quite well against other spearhead communities.
- There is perceived to be a very good standard of Medicines Management across Birmingham

## **RECOMMENDATIONS**

### **Vision and Strategy**

- While there are excellent detailed work plans for the early stages of the work particularly on Male Life Expectancy and Infant Mortality, the NST has not seen a comprehensive delivery plan which tracks through the actions needed in a range of priority areas up to 2010. We recommend the development of a strategic framework which draws together a suite of delivery plans.
- These plans will help to maintain focus, continuing the current focus of industrially scaled interventions and applying them systematically.
- All of the action plans need to be mirrored in the Local Area Agreement (LAA).

- The work to identify unregistered patients might be extended to COPD, where some work has already been started through the Breathe Easy Groups.
- There is already in each PCT the extension of principles underlying the Male Life Expectancy programme to areas other than 12 prioritised wards. There could be a case for more systematically extending programmes into pockets of deprivation which collectively constitute the most deprived 20% of a population regardless of ward.

### **Partnership, Structures and Processes**

- The proposed appointment of a joint Director of Public Health (DPH) post based in the CC will be important in further embedding public health within the partnership. There will be a need to ensure that:
  - There are clear and formalised relationships with the other Directors of Public Health
  - Governance issues are clear from the beginning
  - The joint DPH has access to Cabinet, PCT Boards and BSP Board
  - There are resources to support activity in all organisations
  - The joint DPH is not used as a substitute for wider organisational ownership and engagement of health gain agendas in partnership, by either organisation
- There is a need to map all of the partnership groups to identify free floating groups that impact upon Health Inequalities, and review and link appropriate structures into the Health and Well Being Partnership and the BSP structure in general.
- We understand that a Single Assessment Process has not yet been agreed between all three PCTs and the CC. The NST strongly recommend that this is addressed as soon as possible.
- Through alliances with Finance, Commissioning, Provision and Primary Care, Public Health needs to act as a catalyst introducing a population perspective into the work of each, and helping to identify and delineate mainstream contributions of each to the 2010 health inequalities targets
- The engagement of General Practice is central to many mainstream elements of work including service remodelling and addressing health inequalities. The Local Medical Committee (LMC) can be very influential in 'engaging hearts and minds' of practitioners. The NST would recommend attempting to draw them in as formal partners wherever possible

## **Frontline Health Services**

- Segmentation analysis may help improve 'customer access'
- Give priority to pathway development for major killers, and don't wait for buildings to provide solutions
- Build prevention opportunities systematically into pathways
- Ensure meaningful engagement with wider strategic elements such as Transport, Regeneration and Spatial strategies
- We endorse the expansion of the Birmingham Own Health services to an industrial scale.
- It is recommended that the three PCTs and CC, as commissioners, develop a Health Gain Schedule for 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,
  - Commissioned programmes to develop care pathways to improve efficiency (e.g. Lean methods) and to bring care 'closer to home'. Should build opportunities for prevention and risk reduction into their plans.

## **Improving and Developing Primary Care**

1. Get rid of liabilities: requires persistence, good process and decisive professional leadership with organisational backup.
2. Develop poor performers: PCTs need the capacity to performance develop as well as performance manage practices.
3. 'Raise the bar' for everyone: 70% achievement (eg QOF maximum, breast cancer screen uptake) means 30% failure, often leaving behind the most vulnerable.
4. Commission from the best performers: compensate for persistent poor performance.
  - Partial e.g. shared care contracts with secondary care.
  - Local - Enhanced Service agreements.
  - Complete e.g. re-tender practice.
  - APMS

The performance management of QOF should be 'high challenge and high support', with PCT commissioning having the capacity to do both

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