Health Inequalities

Croydon London Borough Council and Croydon Primary Care Trust (NHS Croydon)
Audit 2008/09
December 2009
Status of our reports

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- any third party.

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Introduction

1 Health inequalities are a key issue for both the Departments of Health and Communities and Local Government. The gap in life expectancy between those at the top and bottom of the social scale is wide and has grown since the 1970s.

2 Significant health inequalities currently exist across England and are reflected in large differences in life expectancy. At present some groups of the population suffer from significantly greater ill-health (morbidity) and earlier death (mortality) than other population groups. The results of high levels of morbidity and mortality are risks to well-being for individuals and to the wider locality. These include:
   - higher levels of unemployment;
   - higher levels of disaffection which can lead to higher levels of crime;
   - reduced economic well-being; and
   - increased costs of managing ill-health and chronic disease.

3 While some action is being taken nationally to address health inequalities, the main contribution is made locally. Primary Care Trusts (PCTs), now known as NHS organisations and Local Authorities are required to work together in partnership to address health inequalities and have an aim to reduce the gap in life expectancy by 10 per cent by 2010. This will require effective use of resources. In many areas joint plans to address health inequalities will form part of the Local Area Agreement (LAA). The introduction of local data on all age all cause mortality provides the incentives for effective partnership working between PCTs, local authorities and other partners that need to deliver the life expectancy aspects of the health inequalities target. It will also give flexibility for organisations to focus on the interventions that are most important to their local population.

Background

4 Croydon is a relatively wealthy and healthy London borough, but with pockets of deprivation and poorer health. It has the largest population of the London boroughs (339,500 people), of which 40 per cent can be described as Black or Minority Ethnic (consistent with the regional average of 42 per cent). There are a large number of refugees and asylum seekers, mainly concentrated in the north of the borough. Croydon is ranked 125 out of 354 local authorities in England in terms of average deprivation (where 1 is most deprived). Waddon, New Addington, Broad Green and Fieldway are the most deprived wards within the borough; however no wards have areas that are among the 10 per cent most deprived in the country.
5 Over the last ten years, early death rates from heart disease, stroke and cancer have fallen. However, there are health inequalities within Croydon by location, gender, and ethnicity. For males living in the most deprived areas of Croydon, life expectancy is almost nine years less than for those living in the least deprived areas. For females the difference is just over five years. (2009 APHO Health Profile). The Council's Corporate Assessment report in 2008 stated that the health of communities in Croydon is improving, although the Council and its partners still have work to do to achieve consistent results and reduce health inequalities.

6 The Audit and Inspection Plans 2008/09 for both the Council and the PCT identified the reduction of health inequalities as a risk and it was therefore agreed with the respective chief executives, and audit committees, that a review of health inequalities would take place.

Scope and objectives

7 Focusing on joint working between the PCT and the Council, this audit has:
   • assessed the strategic approach to tackling health inequalities;
   • assessed whether resources are being effectively deployed in the pursuit of reducing health inequalities and narrowing the gap;
   • assessed if there is an environment for improvement; and
   • assessed the mainstreaming of health inequalities interventions.

8 The work is being undertaken in two stages. This report (the first stage) is a high level review to identify key risks, using the questions in Table 1 below. The second stage will be tailored to address any of the key issues identified in stage 1, or if preferred by the Council and PCT, to focus on particular local issues. It will most likely take the form of a workshop.

Table 1 Key questions used for the review

<table>
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<th>Question</th>
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<tr>
<td>Do strategies to address health inequalities exist and are they effective?</td>
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<td>Do partnerships charged with addressing health inequalities function effectively?</td>
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<tr>
<td>Does the available data and intelligence support organisational and shared strategic and operational decision making to address health inequalities?</td>
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<td>Do performance management systems support the monitoring and evaluation of activities necessary to address health inequalities?</td>
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<td>How is the workforce being engaged to address health inequalities?</td>
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<td>Are corporate responsibility principles adequately reflected throughout organisational strategies?</td>
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Summary report

Audit approach

9 The audit included:
   - interviews with 18 key staff and partners; and
   - document reviews.

10 This report will be discussed and agreed with the Chief Executive Officer of NHS Croydon and the Executive Director of Adult Services and Housing.

Main conclusions

Delivering strategic and operational objectives

11 There is a comprehensive strategy for tackling the health inequalities agenda, through the joint health improvement plan (‘Improving Health and Wellbeing. Our Plan for a Healthy Croydon 2008-2011’) (HIMP). The HIMP takes forward the health priorities in the Community Strategy and provides effective focus for tackling individual issues.

12 A strong and effective leadership model is in place. Leadership of the Community Strategy and HIMP are clearly defined and there is high level representation from partner organisations. The shared development of these strategies facilitates ownership and understanding of priorities by partners. This is further enhanced by clear lines of accountability for strategic priorities, which enables individual organisations and departments to understand their roles and responsibilities in tackling health inequalities.

13 The Public Health department is relatively well resourced and expertise is used effectively to inform and understand health inequalities across Croydon, feeding into strategies and plans. Strategies are reflected in the financial plans and budgets of the Council and the PCT. This approach enables resources to be targeted at areas of greatest need.

Delivering in partnership

14 The Local Strategic Partnership (LSP) and Healthy Croydon Partnership (HCP) have broad-based membership that is effectively engaged, supporting the reduction in health inequalities. There is scope to build on this sound base through increasing from the involvement of the business sector; further developing links with research and academic institutions; and making greater use of voluntary sector data.

15 The LSP’s Community Strategy and Local Area Agreement (LAA) are used with some effect to deliver change. They demonstrate a good understanding of the wider determinants of health, providing a more integrated approach to tackling local health inequalities. This has had some success in improving health outcomes and scrutiny committees effectively challenge progress and plans. However, significant issues remain for smoking quit rates, teenage conceptions, childhood obesity and infant mortality.
There is strong partnership work with the voluntary sector enabling more effective outreach into the community. However, the sector’s involvement in decision making by the various LSP themed partnerships were perceived at times as inconsistent, potentially limiting the valuable contribution they might make to decisions. In addition, there is no systematic approach for communication between the LSP’s Themed Partnerships about their work relating to the health inequalities agenda. This means partnerships are likely to be working more in isolation.

Partnership arrangements with research and academic institutions are underdeveloped locally, with links tending to be ad hoc. Consequently the full range of opportunities is not being realised.

Using information and intelligence to drive decisions

The Joint Strategic Needs Assessment provides a good understanding of local health need and its likely impact on demand for services both in the short and medium term. This and a wide range of other public health data informs key organisational strategies and plans, supporting operational decision making by partners. Its use in the commissioning process enables resources to be targeted at areas of greatest need.

Securing engagement from the workforce

The existing workforce is being used to tackle health inequalities through a range of initiatives, such as signposting services and staff being trained to advise on specific issues. Training has not yet been provided across all areas in both organisations, leaving some areas that could contribute to health improvement being underutilised at present. Non-Executive Directors and Councillors have the skills to challenge plans to tackle health inequalities. Their involvement in the health and wellbeing agenda will increase the level of corporate buy-in to tackling issues.

Performance management of health inequalities

There is high level commitment to the effective performance management of health inequalities. Both the Council and the PCT have clear performance management frameworks in place and monitor a wide range of targets. However, at an operational level, it is not clear whether the impact of initiatives is tracked, to identify whether actions have succeeded or failed. This makes it harder to gauge the effectiveness of initiatives.

Strategies and plans relating to HIMP priorities do not always set measurable timebound targets and the targets do not always flow clearly into action plans. This makes it difficult to effectively monitor performance against plans, inform future action and set realistic trajectories.
Corporate responsibility

An overarching corporate responsibility policy has not been developed across the partnership or by individual organisations. The principles of corporate responsibility consider how an organisation behaves as, for example, an employer, a purchaser of goods and services, a landholder, a commissioner of building work to improve staff health. There has been some progress with discrete initiatives by the Council and PCT individually, but no evidence of either organisation considering the financial implications of corporate responsibility. As such there is limited strategic focus in this area and a gap in the local approach to tackling health inequalities.

Recommendations

The following recommendations have been identified as part of this initial review. The Council and the PCT should ensure these recommendations are implemented to support the continued improvement of arrangements to minimise local health inequalities.

- Consider how engagement with local businesses could be further increased, identifying the benefits for both parties in reducing health inequalities, and involving them in any action planning.
- Engage with Croydon Voluntary Action regarding the use of existing databases, to ensure the best stakeholder coverage in the Third Sector.
- Develop and maintain a framework for regular communication between the LSP’s themed partnerships about their work relating to the health inequalities agenda, to strengthen the approach to tackling health inequalities.
- Ensure that decision making processes in LSP themed partnership groups are clear to all contributors.
- Consider how partnership arrangements with research and academic institutions could be developed, to inform work on health inequalities and make better use of resources.
- Ensure that all frontline staff are trained to identify health inequalities issues and to signpost local people to advice and support services accordingly.
- Ensure that all targets identified in strategies and plans clearly follow through to action plans, are measurable and timebound.
- Further develop the approach to Corporate Responsibility, supporting local commitment to tackling health inequalities.

The way forward

We have agreed to present this report to the Chief Executive of NHS Croydon and the Executive Director of Adult Services and Housing. We will revisit the agreed actions during 2009/10 to assess the improvements achieved by the Council and PCT.
This review is aligned to the Comprehensive Area Assessment (CAA), which we have publicised to both the PCT Board and Council Members. CAA covers many important priorities including tackling the causes of ill-health, where public bodies are required to work effectively together and with their communities.

The first CAA assessments will be reported in December 2009.
Delivering strategic and operational objectives

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

There is a comprehensive strategy for tackling the health inequalities agenda, through the joint health improvement plan (‘Improving Health and Wellbeing. Our Plan for a Healthy Croydon 2008-2011’) (HIMP). The Community Strategy 2008-2011 for Croydon effectively explores the health and wellbeing issues facing its local community, such as life expectancy (particularly smoking, physical inactivity and obesity), infant mortality rates and teenage conception rates. The health issues in the Community Strategy are taken forward through the HIMP, which is supported by the Council’s Corporate Strategy (including its Children and Young People’s Plan) and by the PCT’s Commissioning Strategy Plan (CSP) and Operating Plan. This approach provides a clear overview of progress against health inequalities and demonstrates effective focus for tackling individual health inequalities issues.

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

Leadership of the Community Strategy and HIMP are clearly defined, with high level representation from partner organisations, enabling commitments to be made on their behalf. The Community Strategy was developed and collectively agreed by the LSP which has an overarching Board, supported by the CEO group and Themed partnerships (Healthy Croydon, Equalities and Cohesion, Children and Young People, Safer Croydon, Economic Development, Cultural, Climate Change and Environment and Strengthening Communities). The HIMP is taken forward by the Healthy Croydon Partnership (HCP) which is co-chaired by the Cabinet Member for Health & Adult Social Care and the Chair of the PCT. The partnership meets quarterly and reviews progress against Health and Wellbeing indicators in the LAA. The HCP Executive Group is made up of senior executive officers from the PCT, the Council, Mayday Healthcare NHS Trust, South London and Maudsley NHS Foundation Trust and Croydon Voluntary Action. It is chaired by the Chief Executive of Croydon Primary Care Trust and is responsible for taking forward the business of the HCP, agreeing work plans for, and receiving reports from, the twelve HCP subgroups. It reports to the LSP on progress against key outcomes. Cabinet members for Children and Young People and Housing also attend HCP meetings, with other councillors attending where appropriate. They bring useful knowledge about their wards which helps to inform the approach to health inequalities. The HCP has a Partnership Manager who works across the Council and the PCT, liaising with other partners. This framework provides a strong and effective leadership model to tackle health inequalities across the borough.
Is wider public health expertise influential in developing strategies?

29 Wider public health expertise is used effectively to inform and understand health inequalities across Croydon. The Annual Public Health Reports have been used to inform planning and strategy, and are superseded by the annual Joint Strategic Needs Assessment (JSNA). Development of the JSNA in 2008 was led by the PCT's Director of Public Health, along with the Council's Executive Directors for Adult Services & Housing and for Children, Young People & Learners. This has strengthened its ownership across both organisations. The Public Health department also undertakes predictive modelling for health inequalities issues and uses a single equalities impact assessment template, covering ethnicity, disability, gender, sexual orientation, religion, and age. Strategies such as the Community Strategy, the HIMP and the CSP have clearly drawn on Public Health data, as have strategies on specific issues such as smoking and teenage conceptions. The widespread use of Public Health data enables resources to be targeted at areas of greatest need.

30 The Public Health department is relatively well resourced, being one of the largest in London. The PCT and the Council are in the process of appointing a Joint Director of Public Health, which will further strengthen the influence of Public Health in Croydon.

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

31 There are clear lines of accountability for strategic priorities. The LSP monitors progress against the Community Strategy, with each themed partnership being responsible for developing and implementing the long term vision, aims and actions for their respective priorities, reporting on progress to the LSP. Each LAA target aligned with the Community Strategy has a Lead Partner Organisation, Lead Executive Officer, and Lead Cabinet Member, with responsibility for the targets fed down into divisional, team service and individual's plans. The HIMP has both Council and PCT named leads for each priority, providing a strong joint approach. The clear lines of accountability enable the individual organisations and departments to understand their roles and responsibilities in tackling health inequalities.

32 Joint plans are in place to tackle cross cutting health issues, such as obesity, alcohol and drug misuse, smoking, teenage conceptions and mental health. For example, the HIMP priority of improving sexual health is supported by the PCT’s Teenage Pregnancy Action Plan and the Council's Children and Young People’s Plan, and will be further strengthened with the development of a Sexual Health Strategy for Croydon. Developing joint strategies in cross cutting areas enables a more holistic approach to reducing specific health inequalities.
Are strategies and health inequalities commissioning plans reflected in financial plans and budgets?

Strategies for health inequalities are reflected in financial plans and budgets. The Council's medium term financial strategy ensures that budgets are directed towards corporate priorities (which reflect Community Strategy priorities) through the integrated service and financial planning processes. The Council has a joint timetable for developing budgets, service plans and workforce plans, which ensures that budgets are aligned to these priorities. The CSP sets out the PCT's spending intentions for the next five years, based on the health needs of the population, with health inequalities as a key theme. The CSP is reflected in the PCT's financial plans and budgets, including the Operating Plan. Reflecting health inequalities commissioning plans in financial plans and budgets will ensure that resources are targeted at areas of greatest need.

Delivering in partnership

Have appropriate partnerships been identified and are they engaged?

Croydon has a long history of partnership working, and was the only London borough to win beacon status for its LSP and LAA in 2008. Elements recognised within this included a strong embedded partnership ethos, and mature, trusting relationships. Both the LSP and the HCP have broad-based membership that is effectively engaged. For HCP this includes: the Council; the PCT; Mayday Healthcare NHS Trust; South London and Maudsley NHS Foundation Trust; Croydon Voluntary Action (including representation of ethnic minorities and faith groups); Croydon Health and Care Forum; Croydon Disability Forum; Croydon Refugee Forum; Croydon Children and Young People's Network; Metropolitan Police; London Probation; and the business sector. The effective use of partnerships increases the capacity of the Council and its partners to deliver its priorities.

Businesses are actively engaged in the LSP and the HCP and there is high level representation from Croydon's Economic Development Company (EDC) - an independent private sector-led company, established as the lead delivery body for the borough's Economic Development Strategy. Businesses are involved in the smoking cessation agenda and with the Council's regulatory arm for alcohol (though less so in the development of action plans) and in small scale projects that will positively impact on health inequalities. For example, the Opportunities-funded work experience and employment for disabled people and those with learning disabilities or mental health issues. The HCP recognises the scope to further increase this buy in, particularly through the major local employers. The active engagement of businesses, particularly the major local employers, will help to support the reduction of health inequalities.

Croydon has a strong and active voluntary sector, providing valuable input to HCP from the groups it represents. Croydon Voluntary Action (CVA) indicated its willingness to share information from the 1,500 people mapped onto its contacts database. However, it has insufficient capacity to develop this information into a useful format for partners. This means that a potentially rich source of information to tackle health inequalities is largely untapped at present.
### Recommendations

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<tr>
<th>R1</th>
<th>Consider how engagement with local businesses could be further increased, identifying the benefits for both parties in reducing health inequalities, and involving them in any action planning.</th>
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<tr>
<td>R2</td>
<td>Engage with Croydon Voluntary Action regarding the use of existing databases, to ensure the best stakeholder coverage in the Third Sector.</td>
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### Are local strategic partnerships and local area agreements being used effectively to deliver change?

37 The LSP and LAA are being used as a focus to deliver change and the approach for addressing health inequalities has had some success in improving health outcomes. For example, women are getting early access to maternity services, breastfeeding initiation rates are increasing and smoking rates during pregnancy are falling. The Community Strategy demonstrates a good understanding of the wider determinants of health and of local inequality, linking to other strategies and plans such as housing, homelessness, education, crime disorder reduction and the economic strategy. It sets LAA targets across its priorities on areas that impact on health inequality, such as reducing worklessness; increasing the supply of affordable housing and improving the condition of existing homes; increasing the number of young people from low income backgrounds progressing to higher education; and reducing CO2 emissions. The Community Strategy and HIMP set out where rates are high across Croydon for issues such as teenage pregnancy and smoking and target initiatives accordingly. This provides an integrated and focused approach to tackling local health inequalities. However, significant issues remain with outcomes for infant mortality, teenage conceptions, childhood obesity and rates of smoking quitters.

38 Both the LSP and the HCP were reviewed in 2008, with the outcomes reported to the Croydon Strategic Partnership Board and the HCP Executive Group respectively. This was to ensure their arrangements remained fit for purpose. Whilst there is some communication between partnerships such as the HCP and the Equalities and Cohesion Partnership, this does not happen systematically across the LSP’s eight themed partnerships. This means that partnerships may miss opportunities to share valuable information and insights that could sharpen and refine approaches to tackling health inequalities.

### Recommendation

| R3  | Develop and maintain a framework for regular communication between the LSP’s themed partnerships about their work relating to the health inequalities agenda, to strengthen the approach to tackling health inequalities. |
Do overview and scrutiny committees challenge progress on tackling health inequalities?

39 The Health and Adult Social Care subcommittee of the Overview and Scrutiny Committee effectively challenges progress on tackling health inequalities. The subcommittee consists of councillors across the whole borough - covering both affluent and deprived areas. The Cabinet Member for Health and Adult Social Care has recently been requested to provide a briefing note for the subcommittee on improving outcomes in health inequalities and on LAA targets. NHS Croydon, Mayday Hospital NHS Trust and South London and Maudsley NHSFT are also required to report to scrutiny on progress and responding to challenge. In September 2008, all three trusts attended a scrutiny meeting which considered their plans for the future of Purley War Memorial Hospital, how these had been affected by the economic downturn. Subjects to undergo review in the 2009/10 scrutiny work programme include teenage pregnancy and men’s mental health. Teenage pregnancy has been included given the high rates, in spite of having a comprehensive strategy and multi agency approach in place. It will be the focus of a joint review with the Children, Learning and Leisure Scrutiny subcommittee, reflecting the importance placed on it. The subcommittee also reviews the HCP Annual Report and the Annual Health Check declarations to which it adds comments. Challenging progress with health inequalities issues should contribute to the successful implementation of local initiatives.

40 Challenge on health inequalities is cross-cutting, with a number of the Scrutiny reviews by other subcommittees including research into health-related issues. Examples include: an investigation of health services and advice provided to asylum seekers living in Croydon; and school sports, given concerns about decreasing physical activity among young people in Britain and growing obesity in children. There have also been a number of joint health scrutiny consultation exercises, regarding substantial variation to existing services, such as the 'Better Services - Closer to Home' consultation which proposed a radical reorganisation of Wandsworth, Sutton, Merton and north-east Surrey hospital provision. Challenging progress and actions in this way strengthens the approach to tackling health inequalities.

Are provider trusts engaged in the health inequalities agenda?

41 Provider trusts are effectively engaged in the health inequalities agenda. Mayday Healthcare NHS Trust (the main local provider of acute services) and South London and Maudsley NHS Foundation Trust are both represented on the HCP and as such were involved in developing the HIMP. Mayday has also been involved in initiatives to reduce health inequalities, such as changing the opening hours of the Genito Urinary Medicine (GUM) clinic to make it more accessible and working with the trust to identify and support people with alcohol-related problems (with which the London Ambulance Service has also been involved). This facilitates the development of whole system solutions to health inequalities issues.
Have partnership arrangements been developed with research or academic institutions and the voluntary sector? Are the public and communities of interest effectively engaged as partners?

42 There is strong engagement with the voluntary sector and communities of interest. Croydon Council was awarded Beacon status in 2007 for increasing voluntary and community sector service delivery, demonstrating a mature working relationship and active involvement in all aspects of work. This included planning and delivery of services, commissioning arrangements and focus on developing capacity in the voluntary sector and integrating the LAA into the LSP structures. There are numerous examples of joint work with the voluntary sector, including the Health Champions programme and the Partnership for Older People (POP) bus. The Health Champions programme recruits and trains local people to lead local health work in the community, researching their community’s needs, delivering projects accordingly. It is run by CVA, with input from community development experts, Public Health staff, Health Inequalities Policy Officer (LBC) and librarians (accessing health advisors and information). The programme was in the final five for the NHS Centre for Involvement Awards. The POP bus is also run by CVA (with funding from the PCT and Council). It is a mobile service that brings a range of specialist advisors to various venues across the borough as part of a planned advertised programme. Integrated services are also delivered through joint facilities such as the Peppermint Healthy Living Centre, in Valley Park, which is engaging with some deprived and hard to reach residents. Strong partnership work with the voluntary sector enables more effective outreach into the community, so helping to improve health and reduce health inequality.

43 Decision making processes in LSP themed partnerships were perceived at times as inconsistent and not always transparent to contributors. The different themed partnerships involve CVA to varying degrees in decision making and the impact of its input is not always apparent. As such, the full value of voluntary sector involvement is not always realised.

44 Partnership arrangements with research and academic institutions are underdeveloped locally. Some links are in place through projects with the Institute of Psychiatry and University of East London. There is also some contact with St George’s Hospital NHS Trust through the Public Health Network. However, links with research and academic institutions tend to be ad hoc and consequently the full range of opportunities are not being realised.

Recommendations

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<th>R4</th>
<th>Ensure that decision making processes in LSP themed partnership groups are clear to all contributors.</th>
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<tr>
<td>R5</td>
<td>Consider how partnership arrangements with research and academic institutions could be developed, to inform work on health inequalities and make better use of resources.</td>
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Using information and intelligence to drive decisions

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

The Joint Strategic Needs Assessment 2008 (JSNA) represents a comprehensive health needs analysis that addresses health inequalities, building on Croydon's strong history of annual Public Health reports. It provides an overview of health across the borough, identifying population need across a number of priority areas (including for example, teenage pregnancy, mental health, and disabilities). It demonstrates a good understanding of local health need and its likely impact on demand for services both in the short and medium term. Having a comprehensive needs analysis, will allow resources for health inequalities to be appropriately targeted.

Appropriate bodies were involved in developing the JSNA. It was led by a Project Board, chaired by the Director of Public Health with senior level representation from the Council, PCT and voluntary sector. The JSNA informs key organisational strategies and plans and will be updated annually. Having a comprehensive shared JSNA will support operational decision making to address local health inequalities.

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

Data analyst skills and capacity are used well in identifying health inequalities issues. They have been involved in developing and using a number of sources of information across the Council and the PCT: the JSNA; ward profiles data; Practice Profiles (which provide a portrait of health for a GP practice and enable the PCT to see how well interventions are working); and the Council's Geographical Information System (which allows mapping of data across the borough and overlaying with other maps such as deprivation, identifying hotspots). This approach allows resources to be targeted at areas of greatest need.

Does public health data and intelligence inform commissioning strategies?

Public Health data and intelligence effectively informs commissioning strategies. The JSNA has a strong link to the PCT's CSP and to the Council's Corporate Plan (through the Community Strategy which it mirrors) and the PCT's Informatics and Public Health teams undertake analysis to support performance and commissioning. Predictive modelling undertaken by Public Health has led to shifts in commissioned activity, such as angioplasty services. The PCT has identified this as an area that it wants to improve still further. However, it is not clear the extent to which Practice Based Commissioners are using the JSNA. Use of public health data to inform commissioning strategies effectively targets resources at areas of greatest need.
Securing engagement from the workforce

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

The existing workforce across the Council and PCT is being used to tackle health inequalities through a range of initiatives, although this is not yet fully effective. 'Joining up the frontline' trains frontline staff such as librarians, environmental health officers and health visitors to identify health inequalities issues in their day to day work. They then signpost local people to relevant services, such as loft insulation and pipe lagging for cold homes. A programme of Public Health training is available, with one to two day courses including brief interventions in alcohol, sexual health and increasing physical activity. Some staff have been trained as smoking cessation advisors. For example, crematoria staff (there are often people smoking at funerals), and those in contact with long term users of mental health services and substance misusers, who tend to have high rates of smoking. Staff providing services to children and young people have been trained to be competent and confident in addressing sexual health issues such as avoiding teenage conception. However, training has not yet been provided across all areas, leaving some areas underutilised at present. Use of frontline staff in this way represents good use of existing resources and provides a more integrated approach to reducing health inequalities.

Other initiatives are in place that make good use of frontline staff, including: London Ambulance Service staff signposting people to local counselling services for drugs and alcohol; the Croydon Health Library and Resources service worked with community pharmacists to run information campaigns about diabetes, healthy heart, safe drinking, safe sexual behaviour and bowel cancer screening; GP and surgery staff training in handling appointments for learning disabilities; and Health Visitors holding drop-in sessions in a café in a deprived area, providing advice on a range of issues such as housing and avoiding conceptions. The targeted approach should help to focus resources and information at areas where peoples’ health is worst.

Recommendation

R6 Ensure that health inequalities' training is rolled out across all frontline staff.

Do Non Executive Directors and councillors have the skills required to provide challenge in relation to plans to tackle health inequalities?

Non Executive Directors (NEDs) and councillors have the skills required to challenge plans to tackle health inequalities. NEDs at the PCT also have the skills and knowledge to provide robust challenge and come from a range of backgrounds relevant to tackling health inequalities. For example housing, health, mental health, BME and business. The involvement of NEDs and councillors in the health inequalities and health and wellbeing agenda will increase the level of corporate buy-in to tackling issues.
Is there commitment at the highest level to effective performance management of health inequalities?

There is clear high level commitment to the effective performance management of health inequalities. The Council was awarded Beacon status in 2008/09 for LSP working and the LAA. Both the Council and PCT have performance management frameworks in place and monitor a wide range of targets at their respective Council and PCT Board meetings. The LAA as a whole is led and monitored by the Council as part of the Croydon Counts reporting schedule. The LSP Themed Partnerships are responsible for taking forward their priority theme in the Community Strategy and named organisations hold responsibility for delivery against individual LAA indicators. The LSP Themed Partnerships report to the LSP Chief Executive's group and to the LSP Board, with the Healthy Croydon Partnership Executive Group reporting on progress against key outcomes for the HIMP. The PCT and the Council also receive service redesign updates, such as adult mental health day care which is jointly commissioned. The high level commitment to performance management of health inequalities issues helps to ensure ownership of progress against key outcomes.

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

The regular performance reports received by the Council's Cabinet and the PCT's Board effectively track progress against targets, identifying variances early on and noting mitigating action. However, at an operational level, it is not clear whether the impact of initiatives is tracked, to identify whether actions have succeeded or failed. This makes it difficult to accurately gauge the effectiveness of initiatives.

The HIMP sets out targets for each priority, which are taken forward through specific strategies and plans. There is a comprehensive strategy and action plan in place for teenage pregnancy, with delivery monitored monthly and fed into the LAA and the PCT's Vital Signs Reporting Systems. However, other targets are not always measurable and timebound and do not always clearly flow into the relevant action plans. For example, the HIMP sets a target of 'Reduce smoking rates in manual workers' but does not say by how much or over what time period. Whilst identifiable as a measurable national target in the Tobacco Control Strategy 2009-2011 (a strategy being taken forward by a subgroup of HCP), it does not clearly follow through to the action plan. Likewise, the HIMP target of 'Offer stop smoking support to five percent of smokers each year' is not easily identifiable in the action plan. This will make it difficult to effectively monitor performance against plans, inform future action and set realistic trajectories.

Recommendation

R7 Ensure that all targets identified in strategies and plans clearly follow through to action plans, are measurable and timebound.
Corporate responsibility

Has a corporate responsibility policy/approach been developed and is there progress on taking action with corporate responsibility principles?

A corporate responsibility policy has not been developed across the partnership or within each organisation, although there has been progress with some of the principles. The principles of corporate responsibility consider how an organisation behaves as, for example, an employer, a purchaser of goods and services, a landholder, a commissioner of building work to improve staff health. It is reflected in a number of different policies held by the Council (which employs 10,500 staff and is the largest local employer) and the PCT. There are discrete initiatives in both organisations, examples of which are:

- flexible working for PCT and Council staff;
- career development opportunities;
- smoking cessation initiatives;
- pedometer challenge (walk to work);
- childcare support;
- gym membership (Council);
- targeted local recruitment for some Council roles (the PCT is required to advertise all jobs on the NHS Jobs website); and
- and a new public sector delivery hub (planned for the Council, the PCT and parts of the Metropolitan Police, with the Council's urban regeneration partner).

The lack of a focused policy for corporate responsibility means there is currently a gap in the local approach to tackling health inequalities.

Recommendation

R8 Further develop the approach to Corporate Responsibility, supporting local commitment to tackling health inequalities.
The Audit Commission

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