



05 Review of progress:

undertaken by the University of East London

063

In this section . . .

Progress by LHC partner organisations against the 'implications for action' recommended in previous *Health in London* reports is reviewed, including:

Background to and methods used in the review by UEL are described

Findings from the review are presented:

- Improving health intelligence
- From evidence to policy to action

Findings are discussed and conclusions are presented:

- Success and future role of the London Health Commission partnership
- Progress made in 'improving health intelligence'
- Progress made in moving from 'evidence to policy to action'
- Improving partnerships
- Which interventions work?
- 'Broader awareness' and the need for continued co-ordinated and coherent action on the wider determinants of health

Background and methods

The Institute for Health and Human Development (IHHD) at the University of East London was commissioned to review progress made by LHC partner organisations against the ‘implications for action’ recommended in the *Health in London* report series 2002–2005. All LHC partners (see Appendix Annexe II: Status review) were sent a detailed questionnaire requesting information and documentation relating to progress within the themes, and the picture obtained from these was further developed through interviews with partners’ key personnel. IHHD used the ‘implications for action’ identified in previous reports to provide the thematic framework (Box 1) for a structured review of activities and progress among partners, and collated and analysed all information as described below before preparing a summary for this report.

The review took place over eight weeks in September and November 2006. Data were collected through a multi-methods approach that combined written

information from LHC partners using a standard questionnaire with a desk review of websites, publications, reports and other documents submitted by partners. In addition, qualitative in-depth interviews were conducted with key informants within the partner organisations. Seventeen organisations completed the questionnaires and 13 interviews were conducted. The different data sources and methods were triangulated by the review team to strengthen the validity and reliability of the process, and corroborate the findings. The questionnaire was structured under three main themes, looking at how information on health is produced and used, how it influences policy, strategy and action, and what specific research on health inequalities and wider determinants has been undertaken.

The ‘looking back review’ concentrates on LHC partner organisations, and gives a flavour of the huge variety of work being carried out across London. LHC partners reflect the diversity of stakeholders in the London health economy, and also have a diversity of roles. These include: policy

Box 1 Thematic framework for review

Theme	<i>Health in London</i> recommendations
(a) Improving health intelligence	Enhance monitoring, sharing and comparability of measures Enhance ethnicity profiling Enhance community involvement in generating information
(b) From evidence to policy to action	Enhance evidence-based policy and action Enhance sharing of information on health inequalities Enhance community involvement in disseminating information Enhance integration of wider determinants of health into work routines Enhance alignment with regional and national programmes Enhance partnership working and targeting Explore use of new levers and tools
(c) Increasing understanding	Commission research Conduct specific research

making; service commissioning and delivery; funding; scrutiny and monitoring; advising; provision of evidence and advocacy. A brief description of the remit of LHC partner organisations is included in the diagram *'London and Londoners – Making the Links for Health'* (LHC, 2006) (see inside front cover). We have sought to highlight how different partners are using their different roles to achieve progress, the barriers they have had to overcome, and the factors that have contributed to success. By ensuring that experiences are shared, London's partners for health will learn from each other, and increase the effectiveness and coherence of their work on health inequalities and their wider determinants.

Findings from the review

London's population is the most diverse and mobile in the UK, and experiences marked variation in health and its wider determinants. The excitement generated by work to deliver the 2012 Olympic and Paralympic Games, and their legacy, is providing new opportunities for, and new commitment to, action on health inequalities.

The LHC, as London's strategic partnership for health, links regional and local agencies with primary responsibility not only for health, but also for economic, social and cultural development. It is, therefore, in a unique position to co-ordinate actions that address the determinants of health in a holistic fashion. The proposed new powers for the Mayor in relation to health inequalities signal a new era for the LHC partnership, in which it will work to further strengthen its role in driving forward regional action to address health inequalities and build new streams of work to deliver effective policy and intervention. This approach to promoting

broad engagement in health and wellbeing initiatives in London is consistent with the 'fully engaged' scenario described by Wanless (2004).

Key building blocks for success are already in place. Legislation, including the Race Relations (Amendment) Act 2000, the Children Act 2004, and the Disability Discrimination Act 1995, is providing the legal framework and shaping statutory duties. National government is putting in place an overarching policy framework intended to allow sound strategies to be developed by all partners.

At regional level, the LHC partnership has worked to ensure that information describing the demographic and geographic distribution of health inequality and some of its determinants is increasingly available and used in planning and decision-making, and that evidence is more widely used to define priority interventions. The LHC continues to succeed in increasing understanding among statutory and non-statutory sectors' stakeholders of how they can impact on health inequalities and promote information sharing. It works to ensure that actions on inequalities and their determinants are mainstreamed into stakeholders' work programmes. At the same time 'bottom-up' drivers of change are strengthening both demand and capacity for action on health inequalities – through the increasing influence of local community and rights-based agendas – and the growing role of the third sector.

Improving health intelligence

Health intelligence requires not only that information and evidence on health is collected, processed and presented, but also that it is used effectively in decision-making, and shared among partners and

stakeholders. In this section we consider progress made by partners in these areas, giving particular attention to work on improving understanding of the importance of actively focusing on ethnicity and the promotion of the use of toolkits that support the mainstreaming of health inequalities work in partners' activities.

Preparing and presenting information and evidence

The **London Health Commission's** *Health in London* report series has consistently presented information on health inequalities to stakeholders in a user-friendly format. The LHC has also generated a considerable amount of new 'evidence' through consultation with stakeholders, as well as strengthening the evidence base through HIA literature reviews. Importantly, it has ensured that the outputs of this work are available through its website.

The **London Health Observatory** is the national lead observatory on health inequalities and ethnicity. It has produced a range of valuable reports on the variation in health and its wider determinants in London. The data analyses presented in the *Health in London* reports for the last four years have been carried out by the LHO in partnership with the GLA's Data Management and Analysis Group (DMAG).

The **London Development Agency** now requires all projects it supports to break down numbers of beneficiaries by ethnicity, gender and disability status. This is an example of an organisation working to implement the Commission for Racial Equality's (CRE) non-statutory guidance *Ethnic Monitoring. A guide for public authorities* (CRE, 2002), which supports

public authorities to meet their duties under the Race Relations (Amendment) Act 2000. Over time, the impact of this LDA initiative should be considerable, as the LDA directly or indirectly supports over 18,000 charities and over 40,000 voluntary and community groups whose work impacts on health and its wider determinants. Along with other regional development agencies, the LDA will, in future, be working more closely with the

Box 2 Improving health information through partnerships at regional level: London Development Agency and Office for National Statistics

Community and voluntary sector organisations hold a wealth of important information about health inequalities (including detailed local-level information), which needs to be properly fed back to inform the policies of the LHC, central government departments and agencies, and the health service. This is not currently happening as well as it should, for several reasons, including: lack of resources; widely differing reporting requirements; lack of skilled workers; and limited interest in, or requests for, such information by Londonwide agencies. LHC partners feel that some Londonwide agencies are not sufficiently equipped to receive, process and analyse qualitative information. Driven by these concerns, and in response to the Allsopp report *Review of Statistics for Economic Policymaking* (2004), the LDA is working with the ONS to jointly produce more reliable data. It sees this step as an important development that will give it better access to good-quality, timely, London-specific data. The LDA is currently working with the ONS to ensure that the government commitment to a London regional statistical presence is implemented.

Office for National Statistics to develop better-quality and more relevant regional information (Box 2).

Health Link is carrying out work to identify groups suffering from health inequalities, and to understand how 'information disadvantage', and misdirected policies and service designs can place already disadvantaged groups in 'double jeopardy' because targeted services, although available, are either not known to these groups, or inaccessible or unacceptable to them.

Trade unions are also working to capture and record information about ethnic origin and disability, and to operate effective equality policies. For example, the **South East Region Trades Union Congress (SERTUC)** has published research on market labour inequality in relation to ethnic origin, with a focus on Asian workers.

The **London School of Hygiene and Tropical Medicine** is carrying out a number of research projects looking into health inequalities at national level, and is undertaking work to examine Londonwide issues, such as health inequalities among Asian communities.

The **International Centre for Health and Society at University College London**, led by Professor Sir Michael Marmot, is involved in a wide range of national and international research projects focused on health inequalities. He advised on *Tackling Health Inequalities: a programme for action, commissioned by the UK Department of Health* (2003), laid down to achieve the national target for 2010 to reduce the gap in infant mortality across social groups, and raise life expectancy in the most disadvantaged areas faster than

elsewhere. Professor Marmot also chairs the WHO Commission on Social Determinants of Health which, allows the work of the LHC to be placed into the international context.

Improving use and sharing of information

LHC partners with a commissioning and delivery role have put in place mechanisms to integrate information on inequalities (in determinants, access to services and health status) into planning. PCTs are, for example, signing up to neighbourhood renewal 'floor targets' for health inequalities. A head-on approach to tackling health inequalities is to build consideration of these into practice-based commissioning as has been done in **Southwark PCT**, and through the **South East London Public Health Network (SELPHNet)** Health Inequalities Group work plan.

London NHS, the London strategic health authority (SHA), PCTs, and the Regional Public Health Group are increasingly contributing their understanding of health and health inequalities to the work of local authorities, for example, through providing support for the development of local area agreements (LAAs).

Public health leads in SHAs also partnered with the LHO to mainstream health inequalities work into PCT local delivery plans. SHAs are increasingly directing PCTs to use information about health inequalities systematically in developing and prioritising their work plans. The former North West London SHA, for example, featured health status and health inequality in a detailed supplement to its annual report 2003/04. A stocktake of the delivery of activity to address health inequalities was commissioned in 2004 by

the North East London SHA.

An important approach to improving data sharing has been the establishment of networks, such as the Southwark Analytical Hub, which allows data on

wider determinants and small area analyses to be shared between the police, local authority (housing, environmental services, education, social care, and employment) and health services (Box 3).

Box 3 Improving data sharing through partnerships at local level: Southwark Analytical Hub

068

As one of the boroughs experiencing greater deprivation, Southwark has been at the forefront of initiatives to improve information on health and its wider determinants. The Southwark Analytical Hub was established in April 2005 as a partnership between Southwark PCT, Southwark Council and other key partners, to provide analytical capacity and support to the whole system at local level. It works through a network of data and policy analysts from across all partners, and adds value by providing cross-cutting analyses that complement the more focused analysis done by partner organisations.

The hub's work programme derives from priorities identified by Southwark Alliance, which is the local strategic partnership for the borough. It has provided research and intelligence input to support the review of the Southwark Community Strategy and Neighbourhood Renewal Strategy, including long-term population projections, and assessment of the economic and social implications and scenario-planning exercises. It has also produced a range of themed and cross-cutting analyses, for example, understanding the relationship between ethnicity, unemployment and other deprivation factors. This network has provided a valuable mechanism for data sharing, and is beginning to achieve better co-ordination of data and intelligence across the public sector locally.

In the third sector the 'umbrella' organisation **London Voluntary Service Council (LVSC)** maintains a database of information on voluntary and community sector organisations in London. It currently collects information on the geographical area served and the characteristics of their service users, including whether they come from specified ethnic, faith, sexuality, disability or age groups, or are refugees. LVSC can also provide analyses of local variation in the wider determinants of health and health inequalities through the networks it hosts, such as the Third Sector Alliance, Voluntary Sector Forum, London CVS Network, Second Tier Advisors' Network – CASCADE (see Resources).

The importance of focusing on ethnicity

The LHO and LHC jointly led a campaign to have ethnicity coding included in birth and death notifications and statistics, as part of the LHO's Ethnic Health Intelligence Programme, 'Diversity Counts' (Aspinall *et al.*, 2003). Ethnic coding of births and deaths data is probably the single action that could most improve the evidence base for identifying ethnic and racial inequalities in health and health care. Ethnicity recording is particularly important for London, given its ethnic diversity and local variations, and the changing profile of its population over time.

Londonwide improvement of collection and application of ethnic monitoring is a core element of the **London Development Centre's** Care Services Improvement Partnership (CSIP) five-year

action plan, which draws from the Department of Health's *Delivering Race Equality in Mental Health Care (DRE)* (DH, 2005b) action plan. Achieving significant progress with ethnic monitoring has been chosen by CSIP as one of three key indicators of its success in taking the DRE agenda forward. In addition, the **King's Fund** has initiated work to improve ethnic profiling in hospital episode statistics in the NHS, to ensure that valid codes are used to identify patients.

Toolkits

Carefully developed generic resources are now available that can support any agency from any sector in achieving a detailed understanding of health inequalities and their wider determinants. Toolkits for HIA, health equity audit, and race equality impact assessments are being used more and more widely as a way to target activity. Good practice guidance such as that issued to local authorities on ethnic monitoring is helping to spotlight and mainstream health inequalities in agencies' core business (CRE, 2002).

The **London Health Commission** has developed and promoted the Londonwide application of HIAs. The LHC's HIA programme has considered the health implications of all the Mayor's statutory strategies, including those for spatial development, transport, economic development, and environmental strategies, as well as some non-statutory strategies, in particular those for young people and older people. HIA was also carried out on the bid documentation for the Olympic and Paralympic Games. This work has been internationally recognised by the WHO and others. The LHC is now actively developing integrated approaches to impact assessments with key partners, such as the London Sustainable

Development Commission.

From evidence to policy to action

In this section we review how partners and stakeholders have taken concrete action to influence the health inequalities revealed by the health intelligence system. Success in tackling health inequalities and their wider determinants requires each agency both to work in partnership with others and to understand and use the leverage of its individual role. We first consider how partnership working is adding value, and then move on to consider how individual partners are making a difference, grouping them by their primary role in the health economy.

Evidence to policy to action – through partnerships for health

Partnerships are the main delivery vehicles for implementing national policies, such as *Choosing Health* (Department of Health, 2004), *Every Child Matters* (HM Government, 2004) and *Our Health, Our Care, Our Say* (Department of Health, 2006), which have the potential to provide a focus to bring the work of LHC partners together into a more coherent effort to address health inequalities. Across London, part of the LHC's added value is ensuring partners see themselves as part of a bigger picture, facilitating joint processes and closing gaps in knowledge, and providing advocacy, advice or action on health without interfering with individual agencies' mandates.

More locally, LAAs are forming an important focus for such partnerships. These three-year agreements between central government, local authorities, PCTs, local strategic partnerships (LSPs) and other key partners set out the priorities for local areas and the means to deliver these (see Office of the Deputy Prime Minister (ODPM), 2005, *Local Area Agreements*

Box 4 LAAs and health inequalities

Target performance reward grants (PRG) for meeting specific targets have been agreed. In London, LAA health and social care targets specifically include tackling health inequalities in Barking & Dagenham, Brent, Camden, Enfield, Hounslow, Islington, Kensington and Chelsea, Lewisham, Tower Hamlets and Waltham Forest, as specified. This corresponds to over £2 million earmarked for physical activity and childhood obesity, over £2 million earmarked for teenage pregnancy, over £3 million earmarked for older people, vulnerable adults and carers, close to £1 million for breastfeeding, over £2 million earmarked for disease management, over £2 million earmarked for National Healthy Schools Standard, and close to £6 million earmarked for smoking cessation, smoke-free policy and tobacco control, which brings the total close to £20 million. The important aspect of this is that responsibility and expenditure for health outcomes moves from the health sector to include all local partners, which substantially increases the public health capacity at local level.

Guidance). Both the mandatory and voluntary aspects of LAAs provide a range of opportunities to develop local initiatives to improve health and reduce health inequalities. Although the organisations involved each have quite specific roles – such as service commissioning and delivery, funding, scrutiny, monitoring and advising, or delivery of evidence and advocacy – all organisations can be brought into a shared process as far as health inequalities are concerned (Box 4).

The London Voluntary Service Council and GLA jointly developed a *Compact on Relations between the Mayor of London, Transport for London, the London*

Development Agency and London's Voluntary and Community Sector in April 2003. (GLA, 2003) This document is a statement of principle concerning relations between the statutory agencies and London's voluntary and community organisations. It provides a framework by which voluntary and community organisations can be involved in policy development and service delivery for all Londoners. Through this process, for example, the voluntary and community sector has been involved in the *Every Child Matters* (HM Government, 2004) agenda and in responding to the government's Third Sector Review.

Evidence to policy to action – through commissioning and service delivery

Primary care trusts are playing a crucial role in tackling health inequalities (see Box 5), and LAAs are reinforcing their leadership role and supporting this by identifying additional funding. LAAs are increasingly streamlining with PCTs' local delivery plans, which themselves contain work to narrow health inequalities as an integral component, providing valuable opportunities to bring health inequalities and public health into local community planning.

There is a variety of ways in which PCTs have started tackling health inequalities in their work streams, including those summarised below.

- Information on inequalities is being combined with information on health trends, access to services, and health outcomes in routine reporting.
- Equity and access to services for specific health conditions, for specific services and for specific geographical areas such as deprived neighbourhoods are being assessed through health equity audits which all PCTs are expected to carry out.

- Multi-agency health improvement and public health partnerships are increasingly being developed at borough level, promoting and engaging work to address health inequalities across the system; health improvement initiatives have been developed with local BAME community groups, and work is ongoing with borough race equality leads and partners to set up BAME involvement mechanisms.
- Practice-based commissioning presents new opportunities to address health inequalities. Some PCTs have carried out additional analyses of Quality and Outcomes Framework (QOF) data to identify and support practices in most deprived neighbourhoods which are under-achieving on QOF indicators, thereby embedding both action against health inequalities and ethnic profiling into the commissioning and financing of services.
- Joint appointments, where directors of public health are shared between PCTs and their local authorities, are becoming increasingly common and the new Local Government Bill will formalise these arrangements and encourage other senior joint appointments to be made. Shared posts have huge potential to ensure that health inequalities become a cross-cutting issue in planning at borough level, and that local authorities can act on the wider determinants in a co-ordinated way. Likewise, PCT chairs also sit on or chair other local government boards and partnerships, such as drug and alcohol action teams (DAATs).
- A final, important tool is to allow a comprehensive view through the establishment of networks, which allows data on wider determinants and

small-area analyses to be shared between the police, local authority (housing, environmental services, education, social care, employment) and health services (see Box 3).

Box 5 PCTs and health inequalities

Southwark's Men's Health Programme is a holistic programme providing well men's nurse-led outreach 'MOTs'; nutrition and dietetics support (one-to-one, waist watchers, healthy eating talks, cook and eat sessions); physical activity promotion; tobacco control (underage and contraband sales); smoke-free spaces; smoking cessation; mental health (suicide prevention, stress management, anger management) and health promotion for gay men. The programme targets the most deprived neighbourhoods and men who are least likely to access services. It reflects a multi-agency partnership: trading standards; health and safety; leisure services; park and sports; PCTs dietetics and nutrition service; smoking cessation service; mental health NHS trust; voluntary sector and community groups. It is funded under the Neighbourhood Renewal scheme and is thus linked to the monitoring of high-level floor targets and outputs. Key to success is the commitment from LSP and partners to addressing health inequalities.

Breast Feeding Cafes is another Neighbourhood Renewal-funded scheme. It involves peer-led breast feeding promotion and training for professionals. Breast feeding 'cafes' were set up across the boroughs, where mothers can meet to provide peer-led support. UNICEF UK and Le Leche League training was provided to health professionals and peer counsellors by health visitors, midwives, voluntary sector and Sure Start staff. Volunteer mothers were enrolled and the scheme was successfully evaluated.

Road traffic casualty rates are higher in deprived communities and are higher among the minority ethnic population compared with the white population. **Transport for London** is preparing borough profiles and will encourage the borough practitioners to use best practice guidelines, including those on community engagement (see Box 6). In 2005 ‘The Scott Smith Campaign’ promoted in cinemas was aimed at the BAME community. Research has shown that in the age group from birth to 15 years, African-Caribbeans are the highest-risk group per 1,000 population in road traffic casualty rates (where ethnicity was recorded).

The **Metropolitan Police Authority** (MPA) is another specialised agency which is taking inequalities seriously. Through its positive action policy it has achieved an increase from 4% to 7% of BAME and women police officers over the last three to four years. Among police community support officers this proportion is above 30%. The MPA contributes to regional

Box 6 Transport for London and inequalities

The Transport Operational Command Unit (TOCU) is dedicated to fighting crime on buses, bus routes including red-route enforcement, tackling illegal taxi-touts and assisting in the control of traffic congestion. The service is intended to be of particular benefit to: women, who are targeted for specific crimes such as sexual harassment or assault; people who are vulnerable and targeted for hate crimes, such as gay men, lesbians, bisexual and transgendered people, BAME groups and faith groups; and older people (who proportionately do not go out at night due to fear of attack).

Box 7 The MPA and health inequalities

The MPA has published a joint MPA/NHS review on mental health and policing – working with key partners in the NHS – which contains a series of recommendations to ensure the police response to Londoners experiencing mental illness is appropriate. Each year, up to 10,000 people with mental health support needs come into contact with the police. There are many reasons for this: people may be detained for their own safety or the safety of other people; police may accompany social workers to a person’s home for a mental health assessment; or it may become clear that somebody who has been arrested for a criminal offence is suffering from mental distress. Among the many issues addressed, the review has identified areas in which changes in process or policy would benefit service users and eliminate discrimination, particularly for key groups such as young black men, who may be experiencing more problems accessing mental health services.

work on a range of issues requiring joined-up approaches, including on young people and education ‘drop-out’, mental health, housing, domestic violence, drugs and alcohol. There are formal links with PCTs as statutory partners, through crime disorder reduction partnerships and community safety partnerships, and these links are reinforced where the directorships of public health are held jointly between PCTs and local authority (Box 7).

The **London Development Centre** is the regional Care Services Improvement Partnership (CSIP), which brings together a number of care improvement programmes with the shared goal of improving people’s lives through better services, and promoting the independence, wellbeing,

Box 8 Mental health inequalities

Capital Volunteering is a pan-London programme which aims to tackle issues of mental health and social inclusion through volunteering. The lead partners are Community Service Volunteers (CSV) and the London Development Centre, and the programme is funded by the Treasury through its Invest to Save Budget (ISB). Other key partners include a wide range of local voluntary and community organisations, employers, local authorities and NHS trusts. Capital Volunteering projects are located across London, and cover a wide range of interests and activities. These include: supported volunteering opportunities with a wide range of local community and voluntary organisations; befriending, mentoring and advocacy; arts, music, dance, photography, film, environment, sport and exercise; self-help groups, peer support and social clubs. To date, over 600 mental health service users are changing the quality of their lives through volunteering. The key indicator of success is measurable changes in the social inclusion aspects of mental health service users' lives, and the Institute of Psychiatry (IoP) is evaluating the effects that participating in Capital Volunteering is having. In spite of some initial apprehension, most people (85%) said they had already gained from taking part in the project, by developing new knowledge and skills, building greater confidence, meeting new people, and supporting others, and having a sense of achievement and satisfaction from taking part in a new activity.

inclusion and equality of people who use services, and their carers (Box 8). CSIP aims to support and promote organisations to work in effective partnership across statutory, voluntary and independent sectors and by involving people in contact with services and carers.

A joint initiative funded by the GLA, London Development Centre (LDC) and London Councils (formerly Association of London Government), and set up and managed by the LHC, is the Language Support Services (LSS) project. The project aims to reduce inequalities in health by improving access to quality language support services across public sectors in London (Box 9).

Evidence to policy to action – through funding agencies

Some funding agencies are also being proactive in driving forwards work to understand and address health inequalities and their wider determinants. Monitoring by ethnicity has been a statutory duty for the [London Development Agency](#) since 2002, and the LDA has passed this duty on to all agencies and projects it supports

Box 9 Improving access to information: LHC Language Support Services (LSS) Project

The LSS project was set up in 2003 as a pan-London participatory programme of research and development on language support services for London. It aims to reduce inequalities in health by improving access to quality language support services across public sectors in London. The LSS consists of three linked work components: a needs assessment across all sectors; research into engaging service users; and research on quality and capacity building. The work, which involves stakeholders at all levels, will result in the creation of common minimum standards for language services across London, improved communication support, and increased users' access to such services. The LSS is an important tool for the LHC, to build on good practice to meet the communication needs of London's multi-ethnic communities.

through contractual obligation since April 2003. Since 2004/05, the LDA has been monitoring all project beneficiaries by ethnicity, gender and disability. Equality targets are agreed with the Mayor on an annual basis, and form a key part of the LDA's budget approval and performance-monitoring processes. Each funded project gets assessed initially for each of the cross-cutting themes of equalities, health and environmental sustainability. (Box 10)

The LDA's health and sustainability team works to ensure that sustainability and health cross-cutting themes are

Box 10 Learning for Work: Hammersmith Hospitals NHS Trust

The LDA is funding the Hammersmith Hospitals NHS trust to run a Community Recruitment Apprenticeship Programme (Learning for Work). The approx. £1 million, three-year, community-driven project aims to recruit 200 local people onto an intensive training and work experience package with Hammersmith hospitals and primary care trust. Recruited clients are long-term unemployed residents from the local community who have undergone an initial job assessment. They remain on benefits while they undertake a training programme, which includes an introduction to the NHS and key skills training. People successfully completing this course can then move onto a 42-week paid and mentored job with the trust. The project has already delivered 88 learning opportunities, and moved 20 people into employment. The Learning for Work project is also supporting the development of a multi-disciplinary skills centre based at Charing Cross Hospital. The project will use these facilities to provide further training to existing staff and bring both staff and trainers together in the same work space.

mainstreamed into the agency's work programme, with support from partners including the LHC. In addition to project-level appraisal, the LDA also carries out impact assessments of draft strategies, such as the cross-cutting impact assessment of the London Food Strategy and the draft London Tourism Vision and Action Plan, as well as the LDA Corporate Plan.

Evidence to policy to action – through policy, monitoring and advisory agencies

Agencies whose roles are primarily monitoring, advisory and instrumental in policy development and implementation have introduced guidance into their work plans to support implementing and service delivery organisations to prioritise health inequalities. **Strategic health authorities** share information on ways to address health inequalities among PCTs, and try to promote work to address these in PCTs' commissioning processes. At the same time SHAs have worked with local authorities on LAAs and local development plans, while also supporting the regional public health group in its work to influence LAA development and contribute to decisions about their sign-off.

SHAs have a performance management role with PCTs, and have used this to push for improved ethnic profiling, and to ensure *Choosing Health* (Department of Health, 2004) and health inequalities targets are included. In London, the Public Health Performance Management Framework has been developed by the **Regional Public Health Group** together with the **London Health Observatory** and the former North West London SHA Public Health Group.

The LHO quantified the likely impact on health inequalities of interventions earmarked for inclusion in local delivery

plans work. Interventions on wider determinants of health and health inequalities need to be delivered through partnerships, and SHAs are working with PCTs to shape commissioning of services, bringing in public health understanding to advise other parties on how to develop interventions.

In July 2006 a new pan-London SHA replaced the former five London SHAs. It is expected that this move should allow a closer alignment with the Government Office for London and other regional partners, increasing the focus on a Londonwide view on issues where regional harmonisation matters.

The role of the **Government Office for London** (GOL) is to represent central government across the capital, delivering policies and programmes in the London region on behalf of ten central government departments. Crucial for tackling health inequalities, it administers Neighbourhood Renewal and New Deal for Communities funds. Its five key priority areas for 2006/07 reflect the five areas of the LAA process: making London more healthy, more safe, more sustainable; investing in London's children; and developing London's economy.

The importance of the GOL for health inequalities is two-fold. First, the GOL has acted as an advocate for the inclusion of work to address health inequalities and their wider determinants (such as housing, employment, and transport,) into wider local government priorities. Second, the GOL assists boroughs by providing additional capacity through, for example, Neighbourhood Renewal Fund advisers and regional drugs advisers and pump-priming monies.

A head of division is the GOL-appointed champion of health inequalities at GOL board level, ensuring wider determinants of health are taken into account when delivering policies and programmes in the London region, on behalf of ten central government departments.

The **Regional Public Health Group (RPHG)**, co-located with the GOL, leads negotiations on the health component, or 'block', of the LAA, ensuring evidence-based approaches to address health inequalities and the wider determinants of health are embedded in these agreements. The RPHG is the Department of Health's regional presence and the regional director of public health is the Mayor's Health Adviser. Its workstreams are largely based on the priorities outlined in the public health white paper *Choosing Health* (Department of Health, 2004). In London, the RPHG works within a 'wider public health group' including the Health Protection Agency, the London Deanery, the LHC, the LHO, London NHS, and the Thames Cancer Registry, on behalf of both the GOL and Department of Health. It works opportunistically with a wide range of partners across London to promote, improve and protect the health of Londoners.

The **Greater London Authority** – the Mayor, the London Assembly and the GLA group functional bodies (Transport for London, MPA, LDA, London Fire Brigade) has a range of responsibilities in relation to the wider determinants of health and a cross-cutting duty on health, alongside equalities and sustainability. The GLA has limited direct powers on health, yet it has been successful in achieving influence through the development and implementation of its strategies and through its involvement in key regional

partnerships. Where the Mayor has a statutory role in appointment of key staff or approving budgets and corporate plans, the profile of health issues has been raised (for example, in Transport for London, MPA, LDA, London Fire Brigade), facilitated by the LHC's HIAs of relevant strategies. In addition, this year each organisation within the GLA group has to report more explicitly on what it does in relation to health and wider determinants of health, and reflect this in their forthcoming corporate plans and budgets.

The Mayor has also promoted partnership and the involvement of service users by developing a number of relevant partnerships, including the Greater London Alcohol and Drug Alliance, the African Caribbean Mental Health Commission, and more recently, the Board for Refugee Integration in London (Mayor of London, 2004b). The GLA has influenced action by local government, other service delivery agencies and voluntary sector organisations on a range of issues related to health, through a range of initiatives, including the London Assembly's programme of health scrutinies. The Mayor's equalities team has led development of a range of equalities schemes (on race, gender, faith, disability, sexuality), and has developed and applied equalities impact assessment methodologies to support both the GLA and other organisations to refine their approaches to equalities in mainstream work.

London Councils (LC – formerly the Association of London Government) is responsible for policy development on behalf of London's 32 boroughs and the City of London Corporation. It makes the case for local government across London, and inequalities, diversity,

mobility of London's population are high on its agenda. LC has a substantial programme on urban regeneration and economic development. It co-ordinates issues like accessible transport across London boroughs and receives information from all boroughs. Its grant programme (£23 million) comprises funding to voluntary sector organisations, and some regional programmes, including the London Child Poverty Commission, and the LHC.

LC has been involved in the negotiations on the latest round of LAAs. The new white paper on the future of local government *Strong and Prosperous Communities* (DCLG, 2006a) gives a greater role to local government to lead administratively and politically. Local partnership working, including with the NHS on tackling health inequalities and health promotion, is an important part of this agenda. Likewise, the *Our Health, Our Care, Our Say* (Department of Health, 2006) policy stresses the importance of local authorities and their distinctive role in public health. LC is developing tools for joint commissioning and for the integration of health inequalities into commissioning, to support the expanding role of local government in these areas.

London First, representing the business community, brings expertise in modern business practices to the health inequalities agenda and facilitates involvement of the business sector in relevant regional initiatives. It has acted to bring together the public, the voluntary and the private sector around issues such as the GLA's Diversity Works programme, as well as contributing to the development of the bid for the 2012 Olympic Games, with its focus on education and health.

As a national body, the **Commission for Racial Equality** enhances the alignment of regional and national programmes through tools such as the *Race Equality Guide 2004 – a performance framework* (CRE, 2004). The guide addresses the areas where NHS organisations are to make

progress with the implementation of the Race Relations (Amendment) Act 2000, assisting them to fulfil their leadership role.

Evidence to policy to action – the role of the London Health Commission

We have reviewed the complex but increasingly coherent structures and processes that are in place to tackle health inequalities in London, and some of the progress which is being made. The London Health Commission is at the hub of this. First, it is the only regional partnership mandated to maintain an overall picture of progress, highlighting gaps, providing evidence, influencing policy development, and, more generally, raising awareness of, and promoting co-ordinated action around the wider determinants of health (see Box 11). Second, its unique position within the GLA provides the political support necessary for it to work effectively in providing strategic leadership across London and to promote and develop effective partnerships. The strength of the LHC lies in its ability to be strategic, freed as it is from implementation or performance management, and its ability to forge real partnerships among agencies and organisations whose work can have a strong impact on the wider determinants of health.

The LHC is further influencing policy and action by providing and disseminating evidence on health inequalities and their wider determinants. It is working at the cutting edge to develop tools to support health action (such as HIA and integrated impact assessments), and tools which integrate health and sustainability considerations into a single, comprehensive, strategic planning framework (Sustainable Local Economies

Box 11 London Works for Better Health

The LHC launched the London Works for Better Health programme in August 2003 (initially sponsored by the King's Fund). Working in partnership with health, employment and regeneration stakeholders across the capital, it aims to develop and implement strategies that will improve health and reduce health inequalities through employment and enterprise, as well as promote healthy and sustainable employment practices.

One of the London Works programmes is, Making Health Work for Business – London Workforce Futures Partnership. With funding from the European Social Fund, under the Equal Community Initiative, and together with the Learning and Skills Council London South and others, advisory services and other resources are made available to support SME (small and medium-sized enterprise) managers and their employees, raising awareness of the implications of the Disability Discrimination Act for SMEs. It has introduced innovative ways to focus on health and job retention, establishing Healthy Workplace Advisers, providing training in a (NVQ-accredited) Healthy Workplace Management and Leadership Programme, and offering tools such as help to develop Business Cases for a Healthy Workplace.

The London Works programme now directly supports the LDA in its role as lead research and development agency (RDA) for health and in the development of its own programme.

for Health Project), it works with partners to support practical work to tackle health inequalities in the workplace, and in society. It allows public concern to be expressed, such as in the Big Smoke Debate, when the LHC gathered the opinion of 40,000 Londoners, identifying large support for restrictions on smoking in public places ahead of government's decision to tackle this issue through legislation.

Discussion of findings and conclusions

London is a cultural and economic magnet for the world, with enormous diversity and mobility among its people. Many of the determinants of health inequality in the city lie in the corresponding social and economic inequality, cultural variation, and differential access to opportunities and health-related services that are found here. If we are effectively to meet the challenge of reducing health inequalities, we must understand their nature and distribution, and act effectively not only within the health service, but across the whole social and economic fabric of the city. Together, the LHC's partners in all sectors have precisely the remit and responsibility to influence this whole fabric.

Success and future role of the London Health Commission partnership

Over the last four years the LHC has succeeded in using its unique position to lay the foundations for, and to start to build real coherence and co-ordination into, strategic action on health inequalities. It has focused both on health intelligence and the concrete actions partners need to take in addressing health inequalities, grounding action in real engagement with London's diverse communities. And in doing so it has shown that such a partnership is effective in bringing public, private, and civil society organisations and agencies onto the same page, sharing resources, information and commitment, and gearing their individual efforts towards this shared purpose.

Discussions held with partners during the course of the review revealed different perceptions of the future role of the LHC and varying expectations. This review should be used to promote a renewed dialogue among LHC members as to the

commission's identity, agreeing on its future mandate and means of achieving it.

Progress made in 'improving health intelligence'

Our review has demonstrated the progress made in improving health intelligence. This has included:

- focused preparation and presentation of data and information describing the distribution of health inequalities and their wider determinants through reports and accessible datasets
- extension of monitoring of the social, economic and demographic characteristics of beneficiaries of projects and activities, especially in relation to ethnicity, better analysis of inequalities in service access
- better data sharing through local partnerships.
- In addition, the development and delivery of carefully developed toolkits and health impact assessments, which embody state of the art understanding of the pathways between health and its wider determinants, are making it possible for non-health agencies to understand the health consequences of different policy and intervention choices.

There is, of course, much still to be done. There is a widespread commitment to continuing to work to deliver more nuanced ethnic categories. There is a commitment to overcome the enduring difficulties in integrating information that are generated by multiple organisations, operating at multiple levels of the system and collected on different reporting cycles. There is a need to consider how better to tap into the rich seam of data that exist at lower levels, especially among local third sector organisations, but that are not captured in a standardised form or in a

way that can readily be fed back to the centre. Here, detailed information about health, health inequalities and wider determinants remains untapped including examples of good and promising practice that would be valuable to LHC partners.

Several partners observed that there has been a preoccupation with analysing and reporting quantitative information. While such information can readily answer questions about 'what', 'where', 'when', 'who', 'how much' and 'how often', it is less useful in resolving queries around 'how' and 'why', where the complex interplay of social and economic factors in impacting health needs to be revealed. Some partners felt that there was a need for partners to develop internal capacity to properly synthesise and apply both quantitative and qualitative forms of evidence.

Progress made in moving 'from evidence to policy to action'.

Our review has also identified progress that has been made in acting on intelligence on health, health inequalities and their wider determinants. We have documented the ways in which LAAs are being used to co-ordinate activities on health inequalities at borough level. PCTs have been supported to develop health equity audits, and multi-agency health improvement partnerships are increasingly being developed at borough level, promoting and engaging work to address health inequalities across the system. Health improvement initiatives have been developed with local BAME community groups, and work is ongoing with borough partners to set up BAME community and other public involvement mechanisms. Appointments of directors of public health jointly between boroughs and PCTs are mainstreaming concerns with

health inequalities across all public sector provision in local areas, and practice, based commissioning is starting to be used to target resources at practices with unhealthy and deprived catchment populations. Londonwide agencies such as the GOL, the GLA, London Councils and the RPHG are actively supporting these local processes with information and advice, tools, money and other resources for joint commissioning and equalities impact assessment and by promoting the involvement of service users.

There are currently many opportunities to secure further progress. Within LAAs there has been a tendency to focus exclusively on the ‘health block’ within LAAs and to ignore the potential for using other blocks, such as employment, to drive forward action on the wider determinants of health and health inequalities. The large regional organisations must continue to support local government and agencies to realise the full potential of performance and commissioning frameworks and targets, Target Reward Grants and Neighbourhood Renewal funding to hardwire action on health inequalities into local provision.

Improving partnerships

Partnerships are the key to effective action, but there is a need for more systematic work to establish how to construct these with clear leadership, efficient structures, adequate shared capacity and resources, and sound evidence-based strategies. Further, there is an urgent need to find ways to build partnerships that are resilient to disruptions in or shifts in statutory functions and responsibilities.

Which interventions work?

Our review hasn’t uncovered any systematic attempt at bringing together

the existing evidence base to ‘increase understanding’ about successful interventions or in generating new evidence. The general assumption, in London and elsewhere, is that improved health services and attention to wider determinants of health, specifically targeted at disadvantaged populations, will tackle health inequalities in London and in the UK. This revolves mostly around reduction in smoking prevalence, prevention and treatment of cardiovascular diseases and access to early antenatal care, alongside improvements in nutritional status, housing, employment and regeneration. There is not only a paucity of scientific evidence for this at population level; little information is available on how to successfully translate it into local action. There is a strong case to call the research funding agencies to account for this and to correct their inappropriate preoccupation with genetic, pharmacological and health service approaches to delivering population health.

Broader awareness and the need for continued co-ordinated and coherent action on the wider determinants of health

We have argued that to succeed in reducing health inequalities we must act effectively, not only within the health service, but across the whole social and economic fabric of the city. We have proposed that, together, the LHC’s partners in all sectors have precisely the remit and responsibility to influence this whole fabric. In considering how to move forwards, the LHC partners are aware of a number of broader issues.

First, the Wanless (2004) report identified that with an ageing population and

increasing costs of high-tech treatments, sustaining the NHS as a service free at the point of delivery will present significant challenges unless major improvements in the effectiveness of disease prevention efforts are achieved – the ‘fully engaged scenario’. This will require both an order-of-magnitude scale-up in effort and resources, and the accelerated mainstreaming of structural interventions into the work of a wide variety of agencies to impact the wider determinants of health, as well as radical innovation in the types of intervention delivered.

Second, the new Commissioning Framework, under development by the Department of Health, is set to revolutionise the way in which health-promotion services are commissioned and delivered, with an extended role for the third sector and the development of new types of delivery organisations, which can provide the types of innovative structural interventions which Wanless’s analysis suggests are needed.

Third, the opportunities presented by the Olympic and Paralympic Games and their proposed legacy for culture, health and regeneration are linking health with broader agendas for economic and social development in a new way, and presenting new challenges for our understanding of how action on the wider determinants of health can have major impact on population health, and for delivering these actions.

Fourth, the proposed new powers for the Mayor in relation to health inequalities will further strengthen the opportunities and demand to deliver policies and interventions that impact the wider determinants across all sectors in London.

All the trends described above point to the need for continued co-ordinated and coherent action on the wider determinants of health. The LHC has demonstrated its capacity to promote such co-ordination among its partners and other stakeholders, and brought increased coherence to their work in this area. In seizing the opportunities provided by the proposed new powers for the Mayor, the LHC intends to work with its partners and national stakeholders to develop a roadmap for delivering Wanless’s ‘fully engaged scenario’ (Wanless, 2004) and a plan to travel rapidly along it. LHC partners are committed to delivering this through support for the development of the Mayor’s health inequalities strategy, and through new streams of activity designed further to engage partners in mainstreaming work on wider determinants. In addition, LHC partners have indicated their intention to continue work to develop links between London’s economic development and structural interventions for health, and to support the development of fit-for-purpose partnerships such as Well London and delivery entities that can put in place the type of multi-faceted interventions that will have real impact in promoting health and reducing health inequalities.

