Tackling Health Inequalities in the North East

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Deloitte.

audit commission

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Section 1 - Introduction, summary and way forward

Introduction

1 The North East has areas of the poorest health in the country. This means that people suffer from significantly greater ill-health and die younger than in other parts of the country. Of the 70 areas identified by the Government as having the worst health and deprivation indicators - the Spearhead Group - 16 are in the North East. Understanding which groups of the population are most affected and doing something about it is the focus of tackling health inequalities.

2 Health and well-being is a priority for national improvement. The promotion of healthier communities has an effect on the well-being and prosperity of the population and investment is likely to bring significant long-term benefit. Addressing such a large issue is not the preserve of any one organisation but must be addressed through co-operation and a shared commitment to action. Tackling health inequalities absorbs huge amounts of public money in both local government and health sectors. Securing optimum value for money from these combined resources requires effective joint working among public sector bodies and with the third sector.

3 The regional health and well-being strategy 'Better Health, Fairer Health', launched in February 2008, sets a clear ambition:

> **'The North East will have the best and fairest health and well-being, and will be recognised for its outstanding and sustainable quality of life'**

4 There have been improvements in health. Most notably, for example premature death rates from heart disease and stroke are rapidly reducing across the region and life expectancy continues to rise. However, despite this progress, significant inequalities still exist. Many areas in the North East are not on track to meet the national target to reduce by at least 10 per cent the gap in life expectancy between the areas with the worst health and deprivation indicators and the population as a whole by 2010.

5 Increasing life expectancy can mask widening gaps in health inequalities. Local Strategic Partnerships (LSPs) may be doing well on the life expectancy target but this may just be a local reflection of the national trend of increasing life expectancy. Also, a primary care trust (PCT) could meet its overall target for improvement, for example in smoking cessation, focusing only on the more affluent areas of its patch, but the effect would be to widen health inequality.

'It is often supposed that action on the determinants of health automatically tackles the determinants of health inequalities. In fact, positive trends in health determinants can go hand in hand with widening inequalities in their distribution among the population – for example, rising levels of overall educational attainment could mask a growing gap in attainment between the highest and lowest social groups (Graham and Kelly, 2004). This underlines the importance of understanding the relationship between health inequities and health inequalities. It also explains why local strategies concerned with the underlying determinants of health need to be assessed for their health impact.'

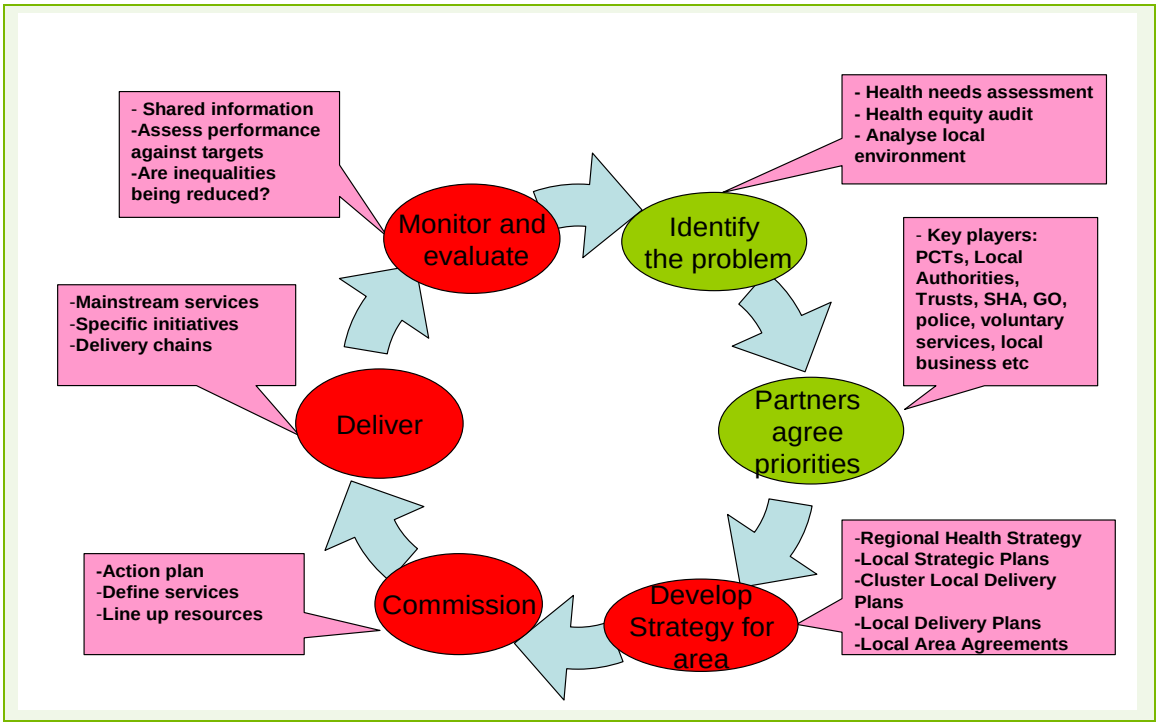
Source: Health Development Agency Promoting Healthier Communities 2004

6 Improving people's chances in life relies on action in many areas, through for instance education and employment opportunities, and access to good housing, as well as cultural change. These issues cannot be tackled by one agency but need a concerted effort from public and private sector as well as the voluntary sector and individuals across the North East.

7 The Audit Commission and Deloitte have been reviewing how organisations across the North East work together to address health inequalities and what the challenges are, focusing on the key elements in this process as outlined in Figure 1.

Figure 1 Health inequalities circle

Partners need to address all the areas illustrated in the circle to achieve impact



Source: Audit Commission

8 This project has involved, at different stages, approximately 50 public sector bodies across the North East covering local government, NHS, police, fire and probation sectors, plus associated partners. The outcomes of a survey and workshop (phases 1 and 2 of our work), with representatives from councils, police, PCTs, trusts and other public sector bodies and the community and voluntary sector who are responsible for addressing health inequalities, reported in 2008 that in general, areas were:

- good at identifying the problem and agreeing priorities; but
- less good at developing targeted strategies, commissioning and delivery of services and monitoring and evaluating.

9 They identified seven key challenges for North East organisations and individuals working to improve health outcomes (Table 1).

Table 1 Seven key challenges

Phases one and two of the project identified seven key challenges for organisations responsible for addressing health inequalities in the North East

Challenge 1 - Funding based on effectiveness To ensure effective evaluation of projects and the continued funding of those that deliver tangible improvements. To use this learning in financial and project planning and performance management systems.
Challenge 2 - Targeting services To gather intelligence on where gaps in services exist and a profile of those accessing services. To use this to target services at those areas and individuals where there is unmet need and bring about improvements in health.
Challenge 3 - Accountability for performance To ensure health and well-being strategies are translated into local plans (for example Local Area Agreement) that contain sufficient detail and relevant targets to monitor progress on improved health and reduced inequalities.
Challenge 4 - Joint working, networking and awareness To spread awareness of priorities and services on offer and provide networking opportunities and information sharing systems to improve the links between service planners and service providers. Cascade messages and targets down to front-line workers like teachers, health professionals, social workers.
Challenge 5 - Leadership from regional agencies To transform the North East into the healthiest region in the country within a generation. To use the Regional health and well-being strategy to provide direction for the North East and link national, regional and local policies. Develop networking opportunities and support to share good practice to achieve this aim.

Challenge 6 - Getting the best from the third sector To give community and voluntary sector organisations increased certainty over funding with agreed targets and simplify commissioning arrangements to make it easier for them to bid for the provision of services.
Challenge 7 - Using community views To ensure community views influence how and where services are provided.

10 We have focused our work on tackling health inequalities in the North East on these challenges in order to get the greatest effect in this important area for improvement. The final phase of our work has looked at the arrangements and action being taken in relation to two issues which have an impact on health inequalities in the North East in four selected geographic areas, to identify enablers and barriers to tackling the seven key challenges (see Table 1). Following discussion with other regulators and support organisations, the review focused on alcohol misuse and teenage pregnancy as two issues which are major contributors to health inequalities, both nationally and in the North East.

11 We examined arrangements and outcomes in four Local Strategic Partnership (LSP) areas, but with links to county-wide or regional arrangements where appropriate. We have undertaken detailed reviews which enable us to compare and contrast approaches and to identify key messages that can be shared more widely across the North East. We focused on the following.

Table 2 Local health inequalities probes

Teenage pregnancy	North Tyneside Stockton-on-Tees
Alcohol	Durham Sunderland

12 The choice of geographic area was made to align with ongoing review work by organisations that regulate, audit, inspect or review and with recent or planned visits by the Department of Health National Support Teams. In particular, we worked closely with the Teenage Pregnancy National Support Team and carried out our visit at Stockton alongside them. This approach was agreed with the Directors of Public Health at the Strategic Health Authority and at each of the PCTs and councils.

Summary and way forward

Key messages

13 The health of people in the North East is generally worse than for England as a whole but good progress is being made on improving this situation with life expectancy increasing and, in most areas, the mortality rate is reducing a faster rate in the North East than nationally with the gap between the North East and the rest of the country narrowing.

14 Life expectancy is affected by a wide range of factors including individual lifestyle, living and working conditions and general socio-economic, cultural and environmental conditions as well as the quality and availability of health services. The relationships between these factors are complex so the progress made in increasing life expectancy represents a real achievement.

15 Reducing smoking prevalence is a success story for the North East. Prevalence has been reduced by over 20 per cent and the North East no longer has the highest prevalence of smokers in England. The regional tobacco control office (called FRESH) was awarded the Chief Medical Officer's national gold award for public health in 2009.

16 This progress in addressing health inequalities has been achieved through leadership from regional agencies, partnership working between NHS and local government, together with partners in other organisations such as police and fire, and the voluntary sector at the local level and by increasing or prioritising funding.

17 However, significant issues remain.

- Life expectancy is improving but people in the North East are still likely to die younger than the national average.
- Death rates in the North East have been falling for the last ten years but remain above the average for England. While in most areas in the North East, rates are falling faster than the national average there are some areas where the gap with the rest of the country is increasing and the fall has been less than the national average. Additionally, there can be significant differences in life expectancy between wards within in the same local area.
- Male life expectancy is improving but men in the North East are still likely to die younger than the national average. In some parts of the North East men living in the most deprived areas can expect to die more than ten years earlier than their counterparts in less deprived areas.
- Female life expectancy in the North East is below the national average. In some parts of the North East women living in the most deprived areas can expect to die more than seven years earlier than their counterparts in the least deprived areas.

18 There are also significant issues in the North East around unhealthy lifestyles.

- The percentage of women smoking in pregnancy in the North East is the worst in the country and is around one and a half times the national average. All areas in the North East are above the 2010 target of 15 per cent.
- The North East breastfeeding initiation rates are the worst in the country and all areas in the North East have breastfeeding rates that are below the national average.
- Year 6 children in the North East have higher obesity rates than the national average.
- The North East has the highest teenage pregnancy rates in the country and all areas in the North East are unlikely to hit the Government target to reduce teenage pregnancies by 50 per cent by 2010.
- Hospital admission rates related to alcohol in the North East are the highest in the country and are growing faster than in England as a whole. All areas in the North East are worse than the England average.

19 Organisations in the North East need to build on the notable progress that has been made to date and ensure that they move further and faster in addressing health inequalities. Our report highlights a number of key areas that partnerships need to focus on to improve action to address health inequalities.

20 **Strategic priorities and funding should be aligned**. Additional funding is being made available in some areas to tackle health inequalities. Positively, much of this funding is from recurring rather than short-term budgets, which is important because secure funding facilitates building up of expertise and experience. Partnerships need to ensure that value for money is obtained from this investment.

21 There are significant economic and financial costs associated with health inequalities that can be reduced through successful funding in action to address health inequalities. As an example, the North East Public Health Observatory estimates that the cost of alcohol consumption and misuse within the North East could be approximately £1 billion per year. As financial pressures on public services increase in the current economic climate, it will become even more important for public sector bodies to obtain and **demonstrate value for money and improved outcomes** from expenditure. Organisations must ensure that resources are directed appropriately to narrow the health inequalities gap.

22 The current economic climate could lead to further pressure on both finances and services and increasing health inequalities so it is important to ensue that resources are targeted effectively. **Successful targeting** of services on those who most need them must be based on good data. Likewise demonstrating that services are reaching target groups needs **good data**. We found that this data is often not available. Service providers cannot always demonstrate that those who most need services are receiving them and that the best value for money and outcomes are being achieved. It is important that commissioners have robust data on which to **evaluate projects and action plans.**

23 We found that **accountability and performance management** arrangements are often weak or not in place. Consequently, those delivering services may not be adequately held to account and value for money and improved outcomes cannot be demonstrated.

24 **Joint working** is variable. We found some good examples, but also other instances where lack of partnership working reduces effectiveness. **Joint data collection** needs to improve and a lack of shared information systems can also cause problems. One common theme was the need to more fully engage GPs.

25 Agencies need to look for ways to better support and use the resources available in the community and voluntary sector. They should strengthen and **expand community and voluntary sector input** to increase capacity and diversity of provision and also support third sector organisations to bid for work.

26 We found mixed practice in terms of **taking community views into account** in developing high level strategies and service development plans.

Way forward

27 We have discussed our findings with Government Office North East, North East SHA and Directors of Public Health from across the North East to agree how our work can contribute to furthering their vision for the North East. We will also share this report with all of the public sector bodies in the North East covered by the review. Auditors will consider the implications of this report for their local areas. Our work was co-ordinated with the Comprehensive Area Assessments.

28 Local organisations should use this report to self-assess whether the recommendations made under each of the seven key challenges (section 3 of the report) are applicable to them and identify and implement actions as appropriate. Organisations should also assess their own arrangements for tackling the key challenges in addressing health inequalities against the questions set out in Section 3.

Section 2 - Health Inequalities in the North East

29 This section uses comparative data to identify and illustrate some of the major health inequalities issues in the North East. The data is organised around:

- life expectancy and causes of death;
- children and young peoples health; and
- adult health and lifestyle.

Life expectancy and causes of death

Life expectancy

30 There is a big difference between the life expectancy of some groups of the population and others, and this varies from area to area.

31 There is considerable pressure to increase life expectancy and reduce the gap between the worst and best groups of the population. The national target is a ten per cent reduction in the relative gap by 2010, and most organisations will have to take concerted action to achieve the target. The 2008 Department of Health report 'Health Inequalities: Progress and Next Steps' states that:

> **'…..nationally, life expectancy is increasing for both men and women, including in the Spearhead areas. But it is increasing more slowly there, so the gap continues to widen, and it is widening more for women than men.'**

32 For many areas the actions needed to meet the target are specific health interventions. This is because to achieve the 2010 target, action is needed to prevent people who are already suffering from ill-health from dying.

33 Organisations must also ensure that preventative healthcare and actions are taken to prevent people becoming ill in the first place, through stopping smoking, reducing excess alcohol consumption, providing open spaces, work life balance, employment, transport and environmental changes. These are often more difficult to do and in particular more difficult to demonstrate a positive impact. These are the longer-term actions that all organisations should be taking action on.

34 Both male and female mortality rates are declining nationally (Table 3) and in the North East. In most areas in the North East rates are falling faster than the national average, which represents significant progress. However, in some areas the fall has been less than the national average meaning that the gap between those LSP areas and the rest of the country is increasing. The female mortality rate in Hartlepool is virtually the same as it was in 1998.

Table 3 Closing the gap - difference between North East and national mortality rates 1998 and 2007

	Fall in female mortality rate 1998 - 2007 (%)	Fall in male mortality rate 1998 - 2007 (%)
Gateshead	27	30
Northumberland	20	30
Durham	19	28
Redcar and Cleveland	18	27
Darlington	17	27
North East	**19**	**26**
Sunderland	22	25
South Tyneside	20	25
North Tyneside	15	25
England	**17**	**23**
Newcastle	24	22
Middlesbrough	9	20
Hartlepool	0	20
Stockton on Tees	25	19

Source: National Centre for Health Outcomes Development

Male life expectancy

35 Male life expectancy is improving but men in the North East are still likely to die younger than the national average. In Hartlepool and Middlesbrough the difference is three years. In some parts of the North East (Darlington, Gateshead, Newcastle, Redcar and Cleveland and Stockton) men living in the most deprived areas can expect to die more than ten years earlier than their counterparts in the least deprived areas.

36 Average male life expectancy in England has now risen to 77.7 years but the gap between the least deprived and the most deprived areas is widening. While life expectancy rates are increasing overall, they appear to be rising faster for the more affluent.

Table 4 Male life expectancy 2005-2007

Northumberland	77.7
England	**77.7**
North Tyneside	76.7
Redcar and Cleveland	76.7
Durham	76.5
Stockton on Tees	76.5
North East	**76.3**
Darlington	76.3
Gateshead	75.8
Newcastle	75.7
South Tyneside	75.6
Sunderland	75.6
Middlesbrough	75.0
Hartlepool	75.0

Source: Association of Public Health Observatories

Table 5 Male life expectancy in the most and least deprived areas (2003-2007)

	Most deprived areas	Least deprived areas	Difference
Durham	73.9	80.0	6.1
Sunderland	72.6	80.1	7.5
South Tyneside	72.9	80.5	7.6
Hartlepool	71.8	79.8	8.0
Northumberland	72.4	80.5	8.1
Middlesbrough	71.3	80.5	9.2
North Tyneside	71.6	81.1	9.5
Newcastle	71.2	81.3	10.1
Darlington	70.3	80.8	10.5
Gateshead	72.1	83.2	11.1
Redcar and Cleveland	72.3	83.3	11.1
Stockton on Tees	70.4	81.9	11.5

Source: Association of Public Health Observatories

37 Table 4 shows the life expectancy for males (2003-2007) in the 20 per cent most and least deprived areas in each LSP area in the North East. The health inequalities gap ranges from 6.1 years in Durham to more than 11 years in Gateshead, Stockton and Redcar and Cleveland. The table reflects the differences between the 20 per cent most deprived and 20 per cent least deprived parts of each area. Even larger differences can be found at ward level. For example, in Durham the difference between the ward

with the highest life expectancy and the ward with the lowest life expectancy is 12 years.

Female life expectancy

38 Female life expectancy in all North East LSP areas is below the national average. In Hartlepool the gap is three and a half years. In some parts of the North East (Darlington and Sunderland) women living in the most deprived areas can expect to die more than seven years earlier than their counterparts in the least deprived areas.

Table 6 Female life expectancy (2005-2007)

England	**81.8**
Northumberland	81.3
North Tyneside	80.9
Redcar and Cleveland	80.8
Stockton on Tees	80.8
Newcastle	80.6
South Tyneside	80.5
North East	**80.4**
Darlington	80.4
Gateshead	80.4
Durham	80.2
Sunderland	79.8
Middlesbrough	79.6
Hartlepool	78.2

Source: Association of Public Health Observatories

39 The life expectancy for females (2003-2007) in the 20 per cent most and least deprived areas in each LSP area in the North East show the health inequalities gap ranges from 4.6 years in Durham to 8.1 years in South Tyneside. Even larger differences can be found at ward level. For example, in Durham the difference between the ward with the highest life expectancy and the ward with the lowest life expectancy is 16 years.

Table 7 Female life expectancy in the most and least deprived areas (2003-2007)

	Most deprived areas	Least deprived areas	Difference
Durham	78.1	82.7	4.6
Middlesbrough	76.6	81.4	4.8
Hartlepool	76	81.8	5.8
Gateshead	77.5	83.7	6.2
Northumberland	77.1	83.5	6.4
Redcar and Cleveland	78.5	84.9	6.4
Stockton on Tees	77.1	83.8	6.7
Newcastle	77.5	84.4	6.9
North Tyneside	77.2	84.1	6.9
Darlington	76.5	83.7	7.2
Sunderland	78.4	85.7	7.3
South Tyneside	78.2	86.3	8.1

Source: Association of Public Health Observatories

All age, all cause mortality

40 More people die each year in the North East than the national average. Death rates in the North East have been falling for the last ten years and in most areas in the North East are falling at a faster rate than in the rest of the country. However, mortality rates remain about 12 per cent above the average for England.

41 Female mortality rates in Hartlepool have not fallen. In 1998 the Hartlepool rate was 667 per 100,000 population, in 2007 it was 666. Male mortality rates in Hartlepool fell by 20 per cent in the same period.

42 Table 8 shows all age, all cause mortality rates in the North East. These are measures of the total number of deaths each year for every 100,000 people. The most recent information is for 2007. The table shows that mortality rates in all LSP areas in the North East are worse than the England average. The highest female mortality rates are in Hartlepool and Middlesbrough and the highest male mortality rates are in Hartlepool, Middlesbrough, Newcastle and Sunderland.

Table 8 The directly aged standardised mortality rate per 100,000 population from all causes at all ages

	Female	Male
England	**488.7**	**688.8**
Northumberland	525.4	711.4
Darlington	561.6	737.4
Durham	557.3	742.5
Redcar and Cleveland	499.9	743.7
North East	**552.4**	**774.1**
Gateshead	538.5	776.2
Stockton on Tees	538.0	777.8
North Tyneside	551.8	781.0
South Tyneside	562.1	795.4
Newcastle	539.6	811.9
Middlesbrough	628.1	837.8
Sunderland	565.5	842.2
Hartlepool	665.8	877.6

Source: National Centre for Health Outcomes Development (NI 120a and NI 120b 2007)

Mortality rate from all circulatory diseases at ages under 75

43 The mortality rate from circulatory diseases is falling quickly in the North East but is still 18 per cent higher than the average for the rest of the country. Middlesbrough has the highest rate in the North East and is 47 per cent higher than the national average.

44 Circulatory disease is one of the main causes of premature death under 75 years of age in England for both men and women, accounting for just over a quarter of all such deaths in this age group. Reducing mortality rates from circulatory diseases will therefore make a significant contribution to increasing life expectancy.

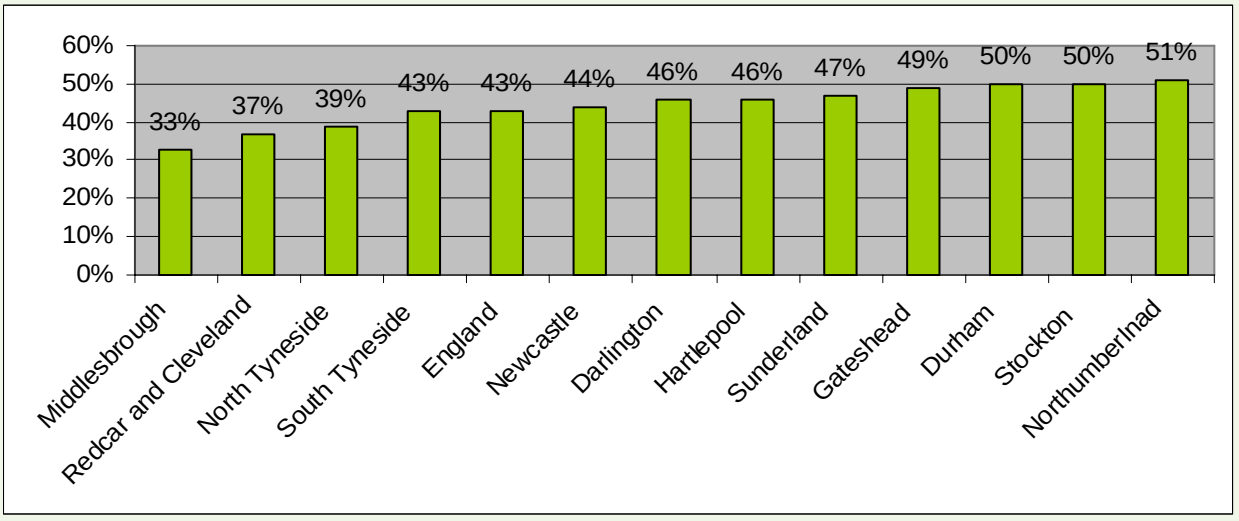
Table 9 The directly age-standardised mortality rate from all circulatory diseases per 100,000 population aged under 75 years - 2007/08 (NI 121)

England	**74.4**
Northumberland	74.9
Stockton on Tees	82.4
Durham	83.4
Sunderland	85.6
North East	**87.6**
Darlington	88.1
Hartlepool	90.6
Redcar and Cleveland	90.9
North Tyneside	93.0
Newcastle	93.3
Gateshead	93.5
South Tyneside	94.1
Middlesbrough	109.6

Source: National Centre for Health Outcomes Development

45 The Department of Health target is a 40 per cent reduction by the year 2010 from the baseline rate in 1995-1997. Figure 2 shows that since 1998 most LSP areas in the North East have reduced mortality from circulatory diseases by more than 40 per cent and by more than the national average. Rates have reduced by fifty per cent or more in Durham. Stockton and Northumberland. Mortality rates are falling more slowly in Middlesbrough, Redcar and Cleveland and North Tyneside.

Figure 2 Reduction in mortality rates from all circulatory diseases at ages under 75 1998 - 2007



National Centre for Health Outcomes Development

46 The Northern Region health services have introduced a cardio-vascular risk assessment system that pulls together and standardises a range of existing practices. It involves the following.

- GP practice registers in which an online risk assessment produces a score for each patient.
- This score can be from known health history or from predictive data for people who have not visited their GP for some time.
- People with the top 20 per cent risk scores in each practice are called in for an assessment. This will cover prescribing (medicines and exercise where relevant) and agreement of a personal health plan, which will be monitored periodically.
- Associated benefits are the triggering of specific care pathways for people with significant heart disease or diabetes, who will be picked up by the screening.

47 Local targeting of populations that do not use GP services so much (which will cover a lot of deprived areas) is similarly structured but implementation may vary.

- The risk assessment screening service is to be offered in local pharmacies in areas with low GP attendance rates.
- Workplace events involving screening are organised in some areas.
- Social marketing is being researched to find out what kind of messages and media are most likely to get the attention of certain groups such as BME, gypsies, travellers and women likely to smoke during pregnancy.

Mortality rate from all cancers at ages under 75

48 All North East LSP areas except Darlington have a higher cancer mortality rate than the national average. The highest rate is in Hartlepool which is 47 per cent higher than the national average. Mortality rates are falling nationally and in the North East but the average for the North East is still 17 per cent higher than the average for England.

49 Most LSP areas in the North East are on track to meet the target to reduce cancer mortality rates by 20 per cent by 2010. The cancer mortality rate in Hartlepool is the same as it was ten years ago.

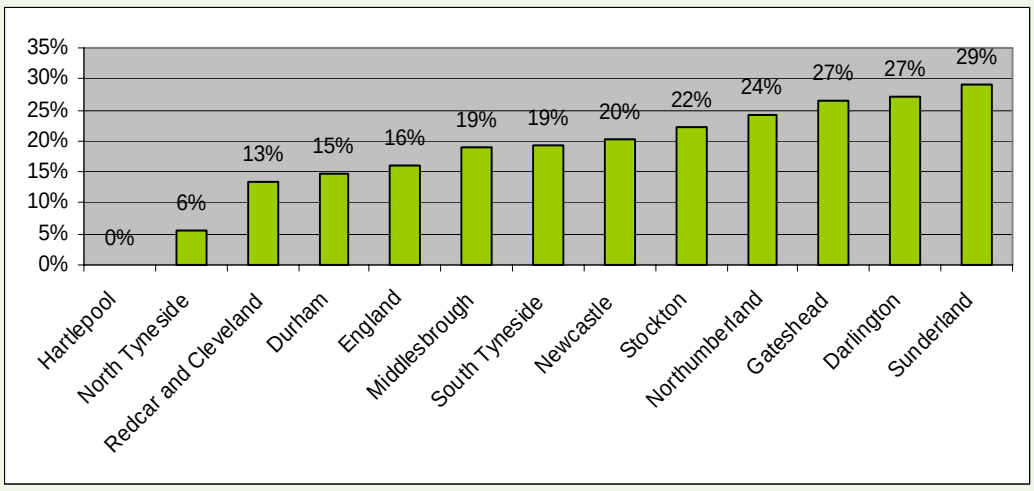
Table 10 The directly age-standardised mortality rate from all cancers per 100,000 population aged under 75 years - 2007/08.

Darlington	113.1
England	**114.1**
Northumberland	115.0
Gateshead	121.1
Stockton on Tees	122.9
Redcar and Cleveland	129.2
Durham	131.4
North East	**133.3**
Sunderland	134.2
Newcastle	140.6
South Tyneside	151.2
North Tyneside	153.3
Middlesbrough	154.2
Hartlepool	168.1

National Centre for Health Outcomes Development (NI 122)

50 The Department of Health target is to reduce mortality rates by 2010 from cancer by at least 20 per cent in people under 75. Figure 3 shows that since 1998 most LSP areas in the North East have reduced mortality from cancers by around 20 per cent (or more) and by more than the national average. Rates have reduced by 29 per cent or more in Sunderland. Mortality rates are falling more slowly in North Tyneside, Redcar and Cleveland and Durham and have not reduced in Hartlepool in the last ten years.

Figure 3 Reduction in mortality rates from all cancers at ages under 75 1998 - 2007



National Centre for Health Outcomes Development

Children and young peoples' health

Smoking in pregnancy

51 The percentage of women smoking in pregnancy in the North East is the worst in the country and is around one and a half times the national average. All LSP areas in the North East are above the national average and Middlesbrough and Redcar and Cleveland are more than twice the national average. All LSP areas in the North East are above the 2010 target of 15 per cent.

52 Babies born to mothers who smoke:

- are more likely to be born prematurely and with a low birth weight;
- have organs that are smaller on average than babies born to non-smokers;
- have poorer lung function;
- are twice as likely to die from cot death;
- are ill more frequently;
- get painful diseases such as inflammation of the middle ear and asthmatic bronchitis more frequently in early childhood; and
- are more likely to become smokers themselves in later years.

In addition, pregnant women who smoke increase their risk of early miscarriage.

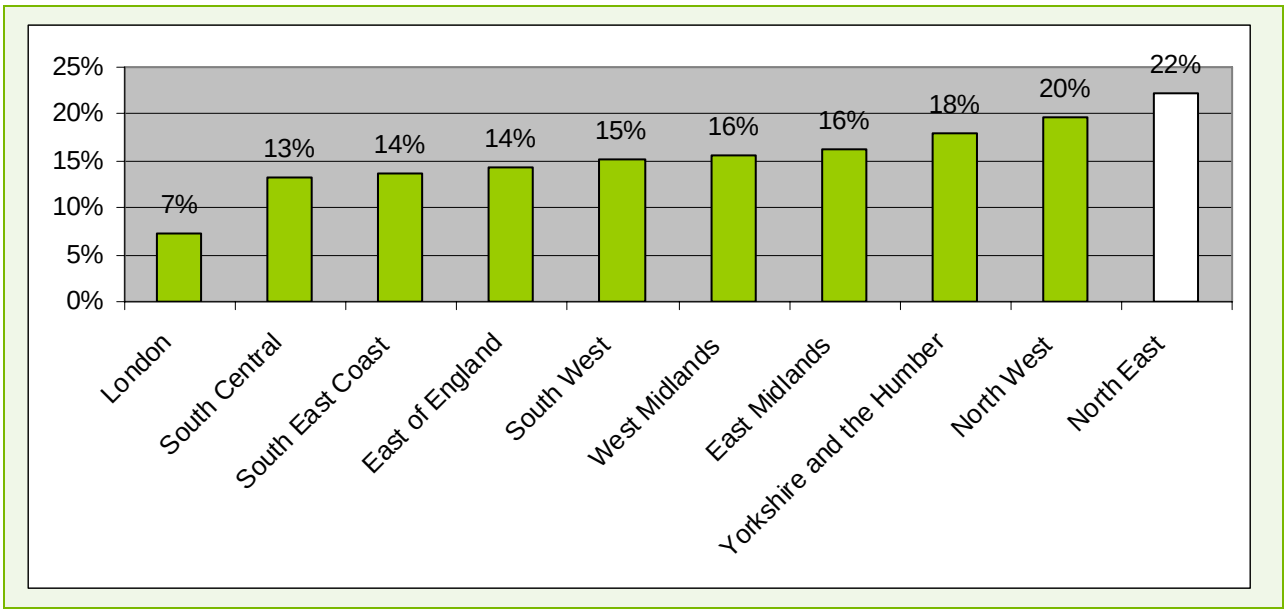
53 The Smoking Kills white paper sets a target to reduce smoking among pregnant women to 15 per cent by 2010. It seems unlikely that that target will be achieved for the North East as a whole, although some LSP areas are close to achieving it.

Table 11 Percentage of women giving birth in 2007/08 with smoking in pregnancy status recorded

	Per cent
England	**14.7**
Newcastle	17.6
North Tyneside	17.8
Gateshead	18.5
Northumberland	18.5
Stockton on Tees	19.8
Darlington	21.3
North East	**22.2**
Durham	22.5
Sunderland	24.0
Hartlepool	27.7
South Tyneside	28.8
Middlesbrough	29.6
Redcar and Cleveland	31.2

Source: Association of Public Health Observatories

Figure 4 Smoking in pregnancy rates by Region 2007/08



Association of Public Health Observatories

54 Better Health, Fairer Health, the Regional health and well-being strategy , says:

> **'We will undertake a broader marketing campaign to highlight the dangers to babies of smoking during and after pregnancy.'**

55 Fresh Smoke Free North East is a partnership funded by PCTs and local authorities in the North East. Fresh aims to tackle death, disease and disability caused by smoking. It has supported national campaigns encouraging women to stop smoking during pregnancy.

56 The National Institution for Health and Clinical Excellence plans to publish guidance on smoking cessation in pregnancy and childbirth in May 2010. This will give guidance on which interventions are effective and cost effective in helping women to quit smoking immediately before or during pregnancy and after childbirth.

Breastfeeding initiation

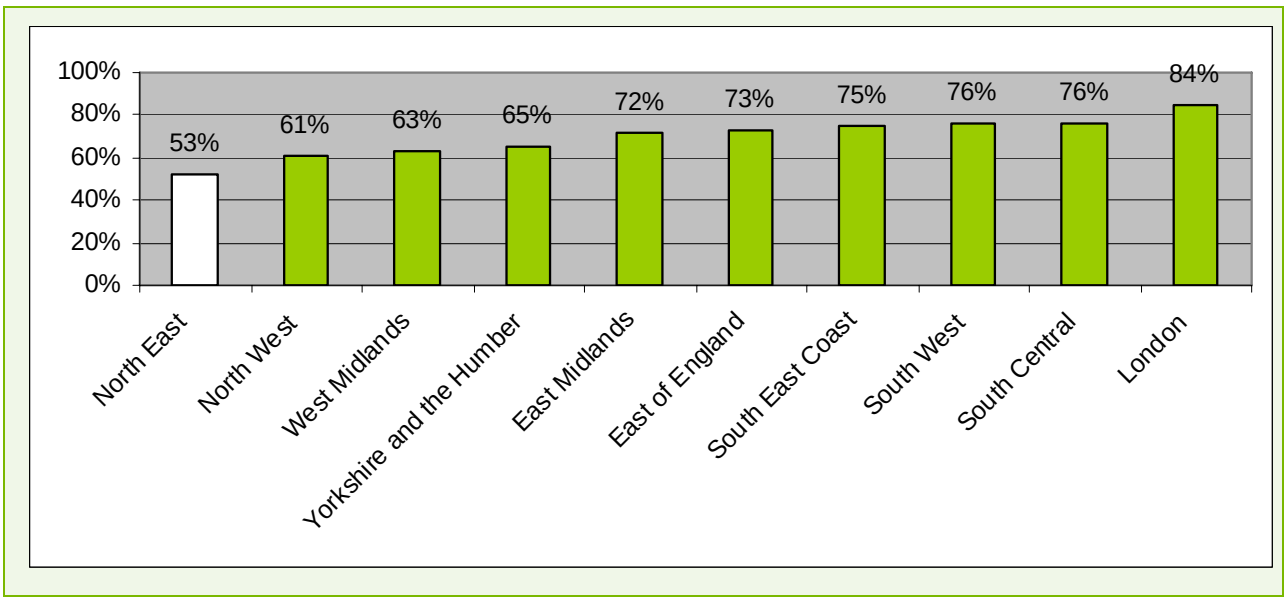
57 The North East breastfeeding initiation rates are the worst in the country and all LSP areas in the North East have breastfeeding rates that are below the national average. Rates are not improving in Middlesbrough and Redcar and Cleveland.

Table 12 Percentage of women who gave birth where breastfeeding status is recorded

	2006/07	2007/08	2008/09	Change 2006/07 to 2008/09
England		**69.9**		
Darlington	57.3	57.9	60.0	⇑
Newcastle	55.4	56.2	59.0	⇑
Gateshead	51.3	59.6	58.5	⇑
Northumberland	49.5	59.1	57.6	⇑
North Tyneside	53.3	55.5	57.4	⇑
Stockton on Tees	51.7	53.1	56.8	⇑
North East		**52.4**	**54.4**	
Durham	51.9	52.8	54.2	⇑
Sunderland	38.9	40.3	52.2	⇑
Redcar and Cleveland	53.0	52.5	51.2	⇓
South Tyneside	46.3	50.8	48.5	⇑
Middlesbrough	46.8	46.5	44.1	⇓
Hartlepool	35.7	35.9	42.2	⇑

Source: Association of Public Health Observatories

Figure 5 Breastfeeding initiation rates by Region (2007/08)



Association of Public Health Observatories

58 Breastfeeding helps protect the baby against infections, diabetes, eczema, obesity and asthma and helps protect mothers against ovarian cancer, breast cancer and weak bones later in life.

59 The Government has committed to increase support for breastfeeding. This is part of its strategy to reduce health inequalities. It has set a target in the priority and planning framework to increase breastfeeding initiation rates by two percent each year, focusing particularly on women from disadvantaged groups.

60 As a region, the North East achieved a two per cent improvement in rates between 2007/08 and 2008/09. However, there are two areas where rates are actually lower than they were two years ago (Middlesbrough, Redcar and Cleveland).

61 The Early Life Regional Advisory Group has recently set out its priorities including the following.

- Develop the North East Breastfeeding framework.
- Ensure robust breastfeeding data collection.
- Conduct mapping of all breastfeeding services in the North East.
- Disseminate North East Infant Feeding, Weaning and Nutrition Guidelines.
- Develop a breastfeeding social marketing campaign.

62 As the uptake of breastfeeding is believed to be affected by cultural and social influences the SHA is taking a regional approach to trying to change attitudes through social marketing.

Obese children

63 Year 6 children in the North East have higher obesity rates than the national average. Northumberland is the only area in the North East with childhood obesity levels below the national average.

64 Obesity is linked to higher rates of myocardial infarction, coronary heart disease, stroke and atrial fibrillation, stress incontinence, diabetes, dyslipidaemia, back pain and arthritis.

65 The national target is to halt the year-on-year rise in obesity among children by 2010/11.

66 The highest rates of childhood obesity are in Hartlepool and the fastest rising are in North Tyneside and these are the only North East LSPs that did not choose childhood obesity as a LSP target. Northumberland has below average rates.

Table 13 Percentage of children in year 6 who are obese (NI 56)

	2006/07	2007/08	
Northumberland	18.3	17.9 per cent	⇓
England	**17.5**	**18.3 per cent**	⇑
Redcar and Cleveland	17.0	18.7 per cent	⇑
Darlington	21.0	20.4 per cent	⇓
Stockton on Tees	19.6	20.4 per cent	⇑
North Tyneside	17.5	20.5 per cent	⇑
North East	**19.9**	**20.8**	⇑
Newcastle	21.3	20.8	⇓
Durham	19.7	20.9	⇑
Sunderland	21.4	21.2	⇓
South Tyneside	20.2	21.5	⇑
Gateshead	20.2	21.6	⇑
Middlesbrough	20.6	22.7	⇑
Hartlepool	24.2	25.6	⇑

Source: Information Centre for Health and Social Care

67 Obesity, diet and physical activity is one of the key themes in the Regional health and well-being strategy . The Obesity, Diet and Physical Activity Regional Advisory Group met for the first time in November 2008 and aims to establish an infrastructure across the region to support family interventions for seriously obese children and families.

Under 18 conception rate

68 The North East has the highest teenage pregnancy rates in the country and all LSP areas in the North East are unlikely to hit the target to reduce teenage pregnancies by 50 per cent by 2010.

69 The DH/DCSF PSA target is to reduce the under 18 conceptions rate by 50 per cent by 2010 from the 1998 baseline rate. Table 14 shows that while all LSP areas in the North East, except Middlesbrough, have reduced the teenage pregnancy rate since 1998 they are a long way short of the 2010 target and are unlikely to achieve it.

Table 14 Rate of conception per 1000 girls aged 15-17 (NI 112).

	2007	Change on 1998 baseline (%)
Northumberland	37.5	-10.3
England	**41.7**	**-10.5**
Gateshead	49.2	-13.8
Redcar and Cleveland	49.6	-14.2
Durham	49.9	-8.3
North Tyneside	52.8	-9.5
North East	**52.9**	**-6.4**
Darlington	55.2	-13.7
Stockton on Tees	55.3	-14.2
South Tyneside	55.7	-0.2
Newcastle	58.0	-9.8
Sunderland	59.3	-6.0
Middlesbrough	66.7	+0.3
Hartlepool	66.8	-11.7

Source: Office for National Statistics and Teenage Pregnancy Unit

70 The consequences of teenage pregnancy are to increase the risk of a number of poor outcomes, such as low educational attainment, poverty and worklessness, poor health and infant mortality. The facts are stark[1].

- At age 30, teenage mothers are 22 per cent more likely to be living in poverty than mothers giving birth aged 24 or over, and are much less likely to be employed or living with a partner.
- Teenage mothers are 20 per cent more likely to have no qualification at age 30 than mothers giving birth aged 24 or over.
- Teenage mothers are more likely to partner with men who are poorly qualified and more likely to experience unemployment.
- Teenage mothers have three times the rate of post-natal depression of older mothers and a higher risk of poor mental health for three years after the birth.
- The infant mortality rate for babies born to teenage mothers is 60 per cent higher than for babies born to older mothers.
- Teenage mothers are three times more likely to smoke throughout their pregnancy, and 50 per cent less likely to breastfeed, than older mothers – both of which have negative health consequences for the child.
- Children of teenage mothers have a 63 per cent increased risk of being born into poverty compared to babies born to mothers in their twenties, have higher mortality rates under 8 and are more likely to have accidents and behavioural problems.
- Among the most vulnerable girls, the risk of becoming a teenage mother before the age of 20 is nearly one in three.

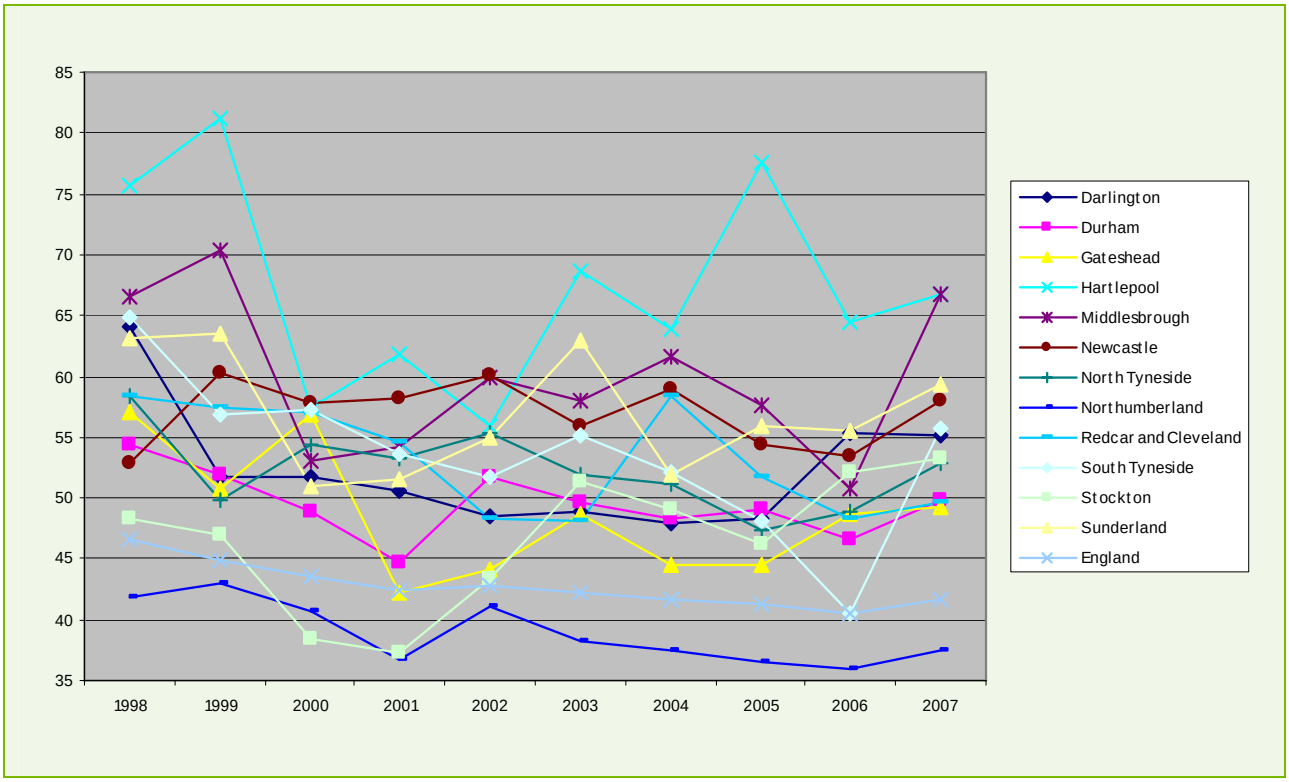
[1] Teenage Pregnancy: Accelerating the Strategy to 2010, DfES (2006)

71 The North East teenage pregnancy rate in 2007 was 27 per cent higher than the national average. The rates in Hartlepool and Middlesbrough were about 60 per cent higher than the national average.

72 Conception rates are volatile and can vary markedly from year to year. There is an inconsistent picture across the region in relation to closing the gap compared with the national average with some LSP areas experiencing a significant increase in the gap. Teenage pregnancy is not mentioned in the Regional health and well-being strategy .

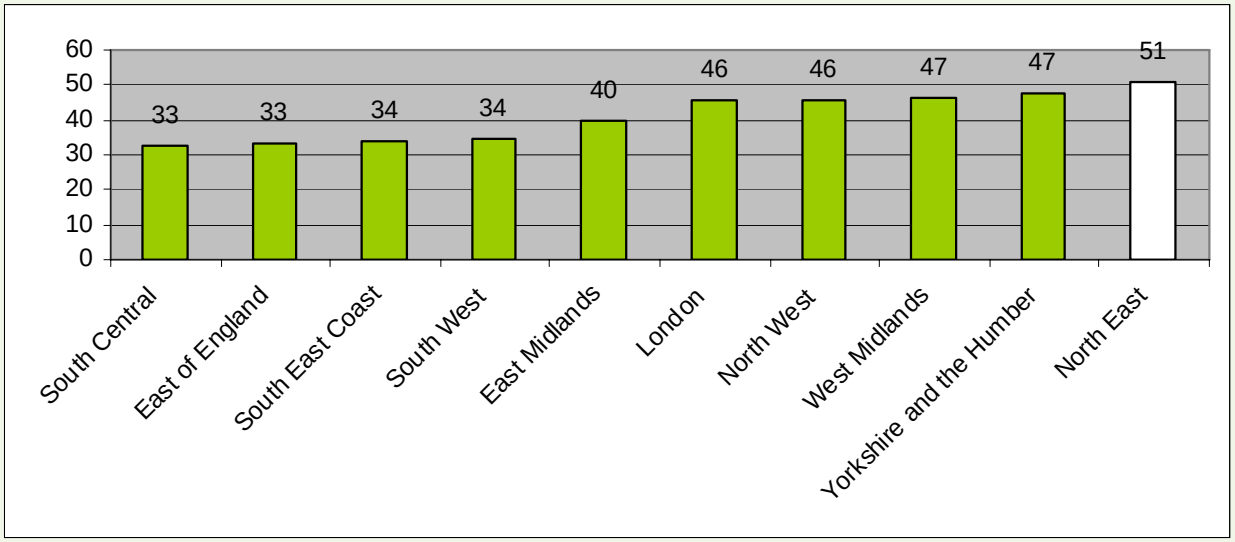
73 Figure 6 below charts the teenage pregnancy rates for each North East LSP area in the ten years from 1998 to 2007. It shows that rates can fluctuate markedly from year to year.

Figure 6 Teenage pregnancy rates 1998 - 2007



Office for National Statistics and Teenage Pregnancy Unit

Figure 7 Teenage pregnancy rates 2005-2007 by Region



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74 Local complexities include the following.

- High standards of contraception advice and services are being developed but only address certain needs, albeit that association with drugs and alcohol is a factor.
- School based education is in place but many teenagers who get pregnant are not at school.
- Long Acting Reversible Contraception (LARC) is not popular despite availability.
- Numerous reasons why teenagers actively seek, or ignore the known risk of, pregnancy are emerging. They include lack of educational or job prospects, lack of ambition generally, family support for teenage mothers and even family encouragement.
- It is not possible to prevent all teenage pregnancies. Care of teenage mothers and their children is therefore part of the approach to reducing health inequality, including smoking and alcohol advice, breast feeding initiation and social support.

75 There is evidence across North East LSP areas of revision to teenage pregnancy strategies going on now. Proposals include:

- social marketing to find out how to get messages across;
- risk assessment by school nurses leading to planned intervention with families;
- collecting more detailed information about individual circumstances to differentiate approaches; and.
- generic support services for pregnant teenagers and teenage mothers integrated with the pregnancy prevention services.

76 Regional agencies provide support on teenage pregnancy which is valued. However teenage pregnancy is not identified as a priority in the Regional health and well-being strategy which reduces its profile and accountability. The support of the Teenage Pregnancy Co-ordinator is valued although post holders are on secondment and expertise is lost when the secondment ends.

Adult health and lifestyle

Hospital admissions related to alcohol

77 Hospital admission rates related to alcohol in the North East are the highest in the country and are growing faster than in England as a whole. All LSP areas in the North East are worse than the England average.

78 Table 15 shows that the average rate for the North East for alcohol related hospital admissions is around 40 per cent higher than the average for England. The rate for Newcastle is almost 80 per cent higher than the national average.

Table 15 The rate of alcohol related admissions per 100,000 population (NI 39) 2007/08

England	**1472**
Northumberland	1767
Durham	1801
Stockton on Tees	1825
Darlington	1886
Hartlepool	1951
Redcar and Cleveland	2043
North East	**2046**
Sunderland	2049
South Tyneside	2083
North Tyneside	2273
Gateshead	2322
Middlesbrough	2517
Newcastle	2615

Source: Hospital Episode Statistics and North West Public Health Observatory

79 The North East Public Health Observatory (NEPHO) published a report in 2006 setting out the main trends and patterns around alcohol consumption in the region. The key findings are as follows.

- Adults in the North East are more likely to drink heavily than adults in the rest of England.
- There is a higher prevalence of ‘hazardous’ or ‘dependent’ alcohol consumption in the North East than in other English regions.

- There are higher rates of alcohol related morbidity in the North East among men and women than in the rest of England.
- The overall cost of alcohol misuse in the North East is approximately £1billion per year.

80 Alcohol related admission rates in the North East are the highest nationally (Figure 8). They have increased significantly over the last few years and are increasing particularly quickly in Darlington, Hartlepool and Stockton (Figure 9).

Figure 8 Alcohol related admissions 2007/08 by Region

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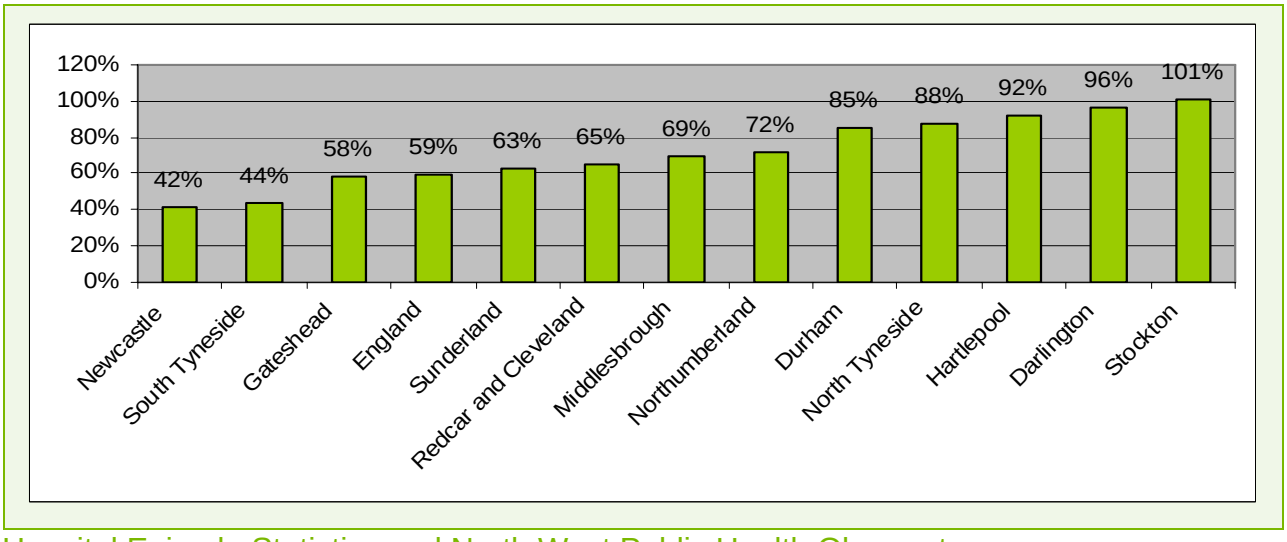
Figure 9 Increase in alcohol related admissions from 2002/03 - 2007/08



Hospital Episode Statistics and North West Public Health Observatory

81 We found that regional and national leadership on alcohol issues has successfully influenced the development of services. Alcohol is one of the ten key themes in the Regional health and well-being strategy .

82 The UK's first regional alcohol office was set up in Darlington in February 2009. The office, known as Balance, has the remit to:

- raise the profile of alcohol-related issues across the region through media campaigns;
- share best practice in prevention and treatment services; and
- push for responsible practice in the pricing, sale and promotion of alcohol.

Smoking quitters

83 NHS Stop Smoking Services in the North East have been highly successful and all LSP areas in North East have higher smoking quitter rates than the England average.

84 The Department of Health report Health Inequalities: Progress and Next Steps says of smoking:

> **Smoking is responsible for one sixth of deaths in the UK. It kills half of all people who smoke. It is the area where behaviour change would make the greatest impact on health inequalities.**

85 Table 16 relates to national indicator 123. This indicator measures the number of people each year in every 100,000 people in the area who report that they have given up smoking for at least four weeks. The most recent information is for April 2008 to March 2009.

Table 16 The rate of self-reported smoking quitters per 100,000 population aged 16 or over receiving support through NHS Stop Smoking Services 2008/09. (NI 123)

Hartlepool	1561
Durham	1204
North Tyneside	1190
Sunderland	1134
South Tyneside	1086
Middlesbrough	1083
North East	**1063**
Darlington	1056
Redcar and Cleveland	1017
Stockton on Tees	956
Newcastle	951
Northumberland	859
Gateshead	829
England	**813**

Source: Information Centre for Health and Social Care and Department of Health

86 The North East has the highest rate of smoking quitters of any of the regions in the country. The cost per quitter is also the lowest in the country at £156.34 compared to a national average of £218.59. The University of Oxford Department of Public Health estimates that smoking costs the NHS in excess of £5 billion a year.

87 The Tobacco Regional Advisory Group has established a number of priorities including:

- denormalising tobacco use and continuing to change attitudes to smoking in the Region;
- influencing national and local decision making and policy around tobacco control so it challenges the health inequalities in the North East; and
- developing a common understanding of the tobacco control agenda across all partners.

88 The North East Stop Smoking Office (called FRESH) won the Chief Medical Officer's national gold award in 2009 for reducing the percentage of North East people who smoke by more than anywhere else in England.

Section 3 - Seven key challenges in addressing health inequalities in the North East

89 This section is based on the findings from our four local reviews and sets out messages for each of the seven key challenges identified in phases one and two of our work. It identifies issues that have wider application and includes questions for organisations to consider in addressing health inequalities in their own area. While we have presented these as seven separate challenges, there are clearly interconnections between them.

Challenge 1 - Funding arrangements

90 Funding arrangements can be complex. Many initiatives that target health inequalities are based on short term funding and valuable experience and expertise can be lost when initiatives cease. The challenge is:

- to ensure effective evaluation of projects and the continued funding of those that deliver tangible improvements; and
- to use this learning in financial and project planning and performance management systems.

91 Our alcohol and teenage pregnancy probes found that additional funding is being made available - alcohol treatment services in particular are being prioritised. Alcohol services are being strengthened in line with national recommendations and significant funding is being provided to support prevention and treatment services. Much of this funding is from recurring rather than short-term budgets, this is important because secure funding facilitates building up of expertise and experience. The North East Alcohol Misuse Statement of Priorities estimates that for every £1 spent on alcohol treatment services £5 is saved on criminal justice and social costs - an investment with a significant financial payback in itself.

92 We also found that good progress was being made to introduce effective services to reduce teenage pregnancies in line with recommendations for interventions made by the national teenage pregnancy unit. Additional PCT and council funding was being made to help support work on improving progress towards the 2010 target but much of this funding was non-recurrent short-term funding which carries the risk of initiatives being discontinued when the funding runs out. It can be difficult to identify exactly how much is being spent on reducing teenage pregnancies because many of the staff involved address multiple issues.

93 From our work on the probes we consider that organisations should:

- ensure that strategic priorities and funding are aligned;
- identify gaps in services and prepare business cases for funding;
- carry out scenario modelling on the possible impact on services arising from increased demand due to increased awareness of service availability;
- refine and redirect funding streams as evidence becomes available as to the effectiveness of treatments provided.

94 Organisations working to reduce health inequalities should also consider the following questions.

1.1	Are priorities backed by funding?
1.2	Are there examples of where funding has been moved due to priorities? Or examples of successful schemes that have stopped due to lack of funding?
1.3	Sustainability - is there a good mix of short term and permanent initiatives? When short term funding runs out are successful schemes funded from mainstream?
1.4	Is innovation encouraged? Are there examples of innovative schemes?
1.5	Is local research and piloting used? Are pilots evaluated for cost effectiveness? Is it clear what success looks like?
1.6	Are strategies unduly influenced by funding opportunities rather than effectiveness?
1.7	Are there coherent implementation plans? Are they based on evidence of what works?

Challenge 2 - Targeting services

95 Services are not always targeted at those who need them most. This is caused by a combination of factors, including the availability of ring fenced funds for some initiatives but not others. The people that ask for help and access services are not always those who need them most. The challenge is:

- to gather intelligence on where gaps in services exist and a profile of those accessing services; and
- to use this to target services at those areas and individuals where there is unmet need and bring about improvements in health.

96 Successful targeting of services on those who most need them must be based on good data. Likewise demonstrating that services are reaching target groups needs good data. This data is often not available. Services cannot demonstrate that those who most need services are receiving them and that the best value for money and outcomes are being achieved. Better information is needed on gaps in services and profiles of those using services.

97 We found that considerable effort is being made to target services on areas identified through joint needs assessment but that much of the information is based on estimates. Generally, there is not enough robust data to ensure that services are targeted at those who most need them or may need them in the future.

98 Recommendations made that could have wider application include:

- ensure the effective collection of data with the objective of ensuring that services are targeted at those who need them most;
- ensure services are in place to identify and meet the needs of all vulnerable groups;
- ensure targets for services are more specific about whether services are delivered to target/high risk areas, groups and individuals and service reviews report performance against these targets; and
- investigate any failure to reach target groups.

99 Organisations should consider the following questions.

2.1	Has there been a needs assessment or equity audit? Does it highlight action required? What action has been taken as a result?
2.2	Have you identified areas/groups of people to target?
2.3	Are priorities targeted on the areas/people identified by needs assessment?
2.4	Are there examples of services targeted at priority groups or hard to reach groups? Are there examples of services that should be better targeted?
2.5	Is there information on the numbers of people accessing services who are from target groups?
2.6	Are there incentives to reach target groups or are performance systems focused on overall numbers?
2.7	Have inequalities been reduced for target groups?
2.8	Are the most disadvantaged people in communities being helped? Have any been missed?
2.9	Are there examples of social marketing being used to achieve behavioural goals?
2.10	Are mainstream initiatives/services tailored to meet the needs of diverse communities?
2.11	Do strategies differentiate between improving health/overall performance and reducing inequalities?

Challenge 3 - Accountability for performance

100 LSPs are not always successful in holding to account those responsible for delivery. The challenge is:

- to ensure health and well-being strategies are translated into local plans (for example the Local Area Agreement) that contain sufficient detail and relevant targets to monitor progress on improved health and reduced inequalities.

101 We found that accountability and performance management arrangements are often weak or not in place. Partners may not be able to monitor and drive progress and divert or bid for additional resources to meet priorities. This can be due to:

- lack of SMART targets;
- little benchmarking;
- lack of performance data;
- front line staff not trained in IT data systems;
- lack of IT support or expertise; and
- inadequate performance reporting.

102 Consequently, those delivering services may not be adequately held to account and value for money and improved outcomes in those areas targeted cannot be demonstrated.

103 We found that high level targets may be in place and be included in all key strategic documents but more detailed performance targets are needed to enable progress to be demonstrated. There is little benchmarking of service levels locally or nationally.

104 Recommendations made that could have wider application include:

- develop effective performance management including clear outcome measures for providers;
- develop arrangements to evaluate initiatives and ensure continued funding of those that deliver tangible outcomes;
- strengthen information systems, data quality and data sharing arrangements to support the effective collection of data which will enable better monitoring, targeting of services and co-ordination between agencies;
- produce a set of priority performance indicators, milestones and targets to allow in-year monitoring of performance below the high level targets recognising that there can be a time-lag in seeing high level change; and
- consider ways of working with other services to benchmark service provision.

105 Additionally, organisations should consider the following questions.

3.1	Are action plans being delivered successfully? Are forecast outcomes being achieved? Which initiatives are achieving good outcomes/which are failing?
3.2	Are partners held accountable for delivery? Are there service level agreements for partnerships? Are there partnership agreements?
3.3	Are there sound arrangements for reviewing performance? Is monitoring information shared? Is there an information sharing policy? Are outcomes monitored for all strategies/action plans? Are service level agreements used to monitor achievements? What action is taken with those partnerships or schemes not delivering targets? Do members and non-execs challenge partnership performance? Are partnership objectives translated into staff performance objectives?
3.4	Is capacity/knowledge on public health across partners adequate? Is public health expertise used to best effect? Are public health staff involved in developing targets and holding services to account for performance?
3.5	Do information systems support performance monitoring? Is there an information strategy for partnerships? Is reliable baseline information available? Are there problems collecting information for any strands of work? Are there plans to improve data or collect data to fill gaps? Is all data of good quality?

Challenge 4 - Joint working, networking and awareness

106 Sometimes the delivery of services in isolation reduces effectiveness - the same people have a range of problems which can only be addressed by the joined-up delivery of a variety of services. The challenge is:

- to spread awareness of priorities and services on offer and provide networking opportunities and information sharing systems to improve the links between service planners and service providers; and
- to cascade messages and targets down to front-line workers like teachers, health professionals, social workers.

107 Joint working is variable. We found some good examples but also other instances where lack of effective partnership working reduces effectiveness. Data collection needs to improve and lack of shared information systems can also be an issue.

108 We found that partnership working at the strategic level was good and that partner organisations had shared priorities and that there were often shared posts.

109 One common theme was the need to more fully engage GPs. This is being attempted through the incentive of Quality Outcomes Framework points and payments for providing additional services.

110 Recommendations made that could have wider application include:

- implement data collection mechanisms that support commissioning; and
- ensure that GPs receive adequate training to deliver brief interventions and to engage with alcohol treatment services.

111 Organisations should assess their arrangements against the following questions.

4.1	Is it clear how individual partnerships contribute to the overall vision?
4.2	Are there clear links between strategic and operational partnerships and a good mix of national and local aims and targets?
4.3	Are links made between health inequalities strategies and other strategies?
4.4	Are strategies linked on a regional, sub-regional area and local basis?
4.5	Do strategies include suggestions for tackling the wider problems –social, environmental or occupational problems as well as health problems?
4.6	Are there sound delivery chains or pathways which ensure the service is user focused rather than service centred?
4.7	Are the right people or organisations delivering services? Are responsibilities clear? Is it clear who has to deliver what and by when? Are there any disputes?
4.8	Are there pooled budgets?
4.9	Are front line staff adequately engaged and briefed e.g. teachers, youth workers, and doctors?
4.10	Are there joint staff? Are lines of accountability clear?
4.11	Is there joint training?
4.12	Is there agreement to share information about clients where appropriate?
4.13	Is there a common agreed dataset?

Challenge 5 - Leadership from regional agencies

112 Our 2007 survey reflected a perception amongst respondents that leadership from the Strategic Health Authority and Government Office North East had not been particularly visible and that local agencies would welcome more support to develop strategies. Our initial report coincided with the launch of the regional health and well-being strategy. The challenge now is:

- to transform the North East into the healthiest region in the country within a generation;
- to use the Regional health and well-being strategy to provide direction for the North East and link national, regional and local policies; and
- to develop networking opportunities and support to share good practice to achieve this aim.

113 'Better Health, Fairer Health', the region's first health and well-being strategy was launched in February 2008. It consists of ten key themes and aims to make people living in the region the healthiest in the country within a generation.

114 The SHA has taken significant and effective steps to ensure that strategic health priorities are reflected in the choice of national indicators in Local Area Agreements (LAAs). It did so in collaboration with Government Office North East and through PCT locality directors of public health, who are key figures in LSPs.

115 The major causes of premature death in the North East (cardio vascular disease and cancers) are largely reflected in choice of LAA indicators, as are indicators for associated lifestyle choices such as smoking, obesity and alcohol. This is broadly confirmed by comparison with LSP priorities, although direct comparisons are not always possible.

Figure 10 SHA regional health priorities and LSP indicators

'Better Health Fairer Health' aims	LSP indicators chosen (of 12 LSPs)
Reducing smoking prevalence	Smoking cessation (11)
Obesity.....	Child obesity (10)
Preventing early deaths.....	Mortality rates - all or specific (10)
Physically active environment	Physical activity adults and/or children (8)
Safe consumption of alcohol.....	Alcohol related admissions (8)
Mental health.....	Emotional health of children (5)

116 Regional advisory groups have been set up for each of the ten themes in the regional strategy. The groups have progressed their agendas to varying degrees to date. The SHA needs to monitor progress and hold these advisory groups to account.

117 The SHA monitors progress against the NHS 'Vital Signs' performance framework and WCC delivery agreements, which is a good proxy for monitoring health and well-being LAA indicators. The SHA public health team also has regular performance meetings with PCT locality directors of public health.

118 We found that regional and national leadership on alcohol issues has successfully influenced the development of services. Alcohol is one of the ten key themes in the Regional health and well-being strategy .

119 The UK's first regional alcohol office was set up in Darlington in February 2009. The office, known as Balance, has the remit to:

- raise the profile of alcohol-related issues across the region through media campaigns;
- share best practice in prevention and treatment services; and
- push for responsible practice in the pricing, sale and promotion of alcohol.

120 Regional agencies provide support on teenage pregnancy which is valued. However, teenage pregnancy is not identified as a priority in the Regional health and well-being strategy which reduces its profile and accountability. The support of the Teenage Pregnancy Co-ordinator is valued although post holders are on secondment and expertise is lost when the secondment ends.

121 Organisations should assess their arrangements against the following question.

5.1	Do you understand how you can be better aligned with *Better Heath, Fairer Health* and how you can engage effectively with the SHA, Government Office and other regional bodies?

Challenge 6 - Getting the best from the third sector

122 Agencies need to look for ways to better support and use the resources available in the community and voluntary sector. The challenge is:

- to make effective use of the capacity available recognising the specific focus, access and expertise of these organisations; and
- to give community and voluntary sector organisations increased certainty over funding with agreed targets and simplify commissioning arrangements to make it easier for them to bid for the provision of services.

123 We found variation in the extent of third sector involvement. Where the third sector is involved there are concerns about whether they have the capacity to cope with the increased demands being placed on them (in particular for alcohol treatment services).

124 In our alcohol probes we found effective engagement with the voluntary sector in the development of services. The increasing involvement of the third sector should increase the diversity of services delivered. However, providers will need support to deliver new or increased services.

125 In our teenage pregnancy reviews we found differences in the extent of third sector involvement and scope to increase the capacity and diversity of provision.

126 Recommendations made that could have wider application include:

- strengthen and expand community and voluntary sector input to increase diversity of provision; and.
- support third sector organisations to bid for work.

127 Organisations should consider the following questions.

6.1	Has there been an analysis of third sector provision? What third sector provision exists and is it more or less than other areas? Are there gaps in provision?
6.2	Are local voluntary organisations engaged in service planning with public bodies?
6.3	Do commissioning processes ensure that the third sector have the opportunity and incentive to deliver services?
6.4	Do third sector organisations submit high quality costed bids to provide services?
6.5	Do third sector organisations evaluate their own services to make the case for funding/ continued funding?

Challenge 7 - Using community views

128 Community views are important in developing strategies and services. The challenge is:

- to ensure community views influence how and where services are provided.

129 We found mixed practice in terms of taking community views into account in developing high level strategies and service development plans. User and carer involvement needs to be increased.

130 In our alcohol probes we found that community views were taken into account in setting the overall strategic direction and objectives. The picture was more variable on teenage pregnancy. In one area we found good involvement of young people in service development and feedback on services, in another community involvement in developing the strategy was limited.

131 In general we found that carer and user involvement needs to be strengthened.

132 Recommendations made that may have wider application include:

- improve user and carer consultation and increase services for carers; and
- ensure all services seek user views and report on them as part of service evaluations.

133 Organisations should also consider the following questions.

7.1	Are users involved in developing and evaluating health inequalities strategies or individual services? What user feedback has been received on services, plans and strategies? What changes have been made as a result?
7.2	Have hard to reach groups been identified and involved?
7.3	Is sufficient publicity given to partnership performance?
7.4	Are strategies publicised to local people?

Appendix 1 - Recommendations and key questions

The recommendations and key questions have been summarised below for easy reference. These can be used by organisations or partnerships to review the effectiveness of their own arrangements for tackling the key challenges in addressing health inequalities.

Challenge 1 - Funding based on effectiveness

To ensure effective evaluation of projects and the continued funding of those that deliver tangible improvements. To use this learning in financial and project planning and performance management systems.

Recommendations	
R1	Ensure that strategic priorities and funding are aligned.
R2	Identify gaps in services and prepare business cases for funding.
R3	Carry out scenario modelling on the possible impact on services arising from increased demand due to increased awareness of service availability.
R4	Refine and redirect funding streams as evidence becomes available as to the effectiveness of treatments provided.

Questions	Response
1. Are priorities backed by funding?	
2. Are there examples of where funding has been moved due to priorities? Or examples of successful schemes that have stopped due to lack of funding?	
3. Sustainability: - is there a good mix of short term and permanent initiatives? When short term funding runs out are successful schemes funded from mainstream?	
4. Is innovation encouraged? Are there examples of innovative schemes?	
5. Is local research and piloting used? Are pilots evaluated for cost effectiveness? Is it clear what success looks like?	

Questions	Response
6. Are strategies unduly influenced by funding opportunities rather than effectiveness?	
7. Are there coherent implementation plans? Are they based on evidence of what works?	

Challenge 2 – Targeting services

To gather intelligence on where gaps in services exist and a profile of those accessing services. To use this to target services at those areas and individuals where there is unmet need and bring about improvements in health.

Recommendations
R1 Ensure the effective collection of data with the objective of ensuring that services are targeted at those who need them most.
R2 Ensure services are in place to identify and meet the needs of all vulnerable groups.
R3 Ensure targets for services are more specific about whether services are delivered to target /high risk areas, groups and individuals and service reviews report performance against these targets.
R4 Investigate any failure to reach target groups.

Questions	Response
1. Has there been a needs assessment or equity audit? Does it highlight action required? What action has been taken as a result?	
2. Have we identified areas/groups of people to target?	
3. Are priorities targeted on the areas/people identified by needs assessment?	
4. Are there examples of services targeted at priority groups or hard to reach groups? Are there examples of services that should be better targeted?	
5. Is there information on the numbers of people accessing services who are from target groups?	
6. Are there incentives to reach target groups or are performance systems focused on overall numbers?	
7. Have inequalities been reduced for target groups?	

Questions	Response
8. Are the most disadvantaged people in communities being helped? Have any been missed?	
9. Are there examples of social marketing being used to achieve behavioural goals?	
10. Are mainstream initiatives/services tailored to meet the needs of diverse communities?	
11. Do strategies differentiate between improving health/overall performance and reducing inequalities?	

Challenge 3 – Accountability for performance

To ensure health and well-being strategies are translated into local plans (for example Local Area Agreement) that contain sufficient detail and relevant targets to monitor progress on improved health and reduced inequalities.

Recommendations
R1 Develop effective performance management including clear outcome measures for providers.
R2 Develop arrangements to evaluate initiatives and ensure continued funding of those that deliver tangible outcomes.
R3 Strengthen information systems, data quality and data sharing arrangements to support the effective collection of data which will enable better monitoring, targeting of services and co-ordination between agencies.
R4 Produce a set of priority performance indicators, milestones and targets to allow in-year monitoring of performance below the high level targets recognising that there can be a time-lag in seeing high level change.
R5 Consider ways of working with other services to benchmark service provision.

Questions	Response
1. Are action plans being delivered successfully? Are forecast outcomes being achieved? Which initiatives are achieving good outcomes/which are failing?	
2. Are partners held accountable for delivery? Are there service level agreements for partnerships? Are there partnership agreements?	
3. Are there sound arrangements for reviewing performance? Is monitoring information shared? Is there an information sharing policy? Are outcomes monitored for all strategies/action plans? Are service level agreements used to monitor achievements? What action is taken with those partnerships or schemes not delivering targets? Do members and non-execs challenge partnership performance? Are partnership objectives translated into staff performance objectives?	
4. Is capacity/ knowledge on public health across partners adequate? Is public health expertise used to best effect? Are public health staff involved in developing targets and holding services to account for performance?	
5. Do information systems support performance monitoring? Is there an information strategy for partnerships? Is reliable baseline information available? Are there problems collecting information for any strands of work? Are there plans to improve data or collect data to fill gaps? Is all data of good quality?	

Challenge 4 – Joint working, networking and awareness

To spread awareness of priorities and services on offer and provide networking opportunities and information sharing systems to improve the links between service planners and service providers. Cascade messages and targets down to front-line workers like teachers, health professionals, social workers.

Recommendations
R1 implement data collection mechanisms that support commissioning;
R2 ensure that GPs receive adequate training to deliver brief interventions and to engage with alcohol treatment services.

Questions	Response
1. Is it clear how individual partnerships contribute to the overall vision?	
2. Are there clear links between strategic and operational partnerships and a good mix of national and local aims and targets?	
3. Are links made between health inequalities strategies and other strategies?	
4. Are strategies linked on a regional, sub-regional area and local basis?	
5. Do strategies include suggestions for tackling the wider problems –social, environmental or occupational problems as well as health problems?	
6. Are there sound delivery chains or pathways which ensure the service is user focused rather than service centred?	
7. Are the right people or organisations delivering services? Are responsibilities clear? Is it clear who has to deliver what and by when? Are there any disputes?	
8. Are there pooled budgets?	
9. Are front line staff adequately engaged and briefed e.g. teachers, youth workers, and doctors?	
10. Are there joint staff? Are lines of accountability clear?	

Questions	Response
11. Is there joint training?	
12. Is there agreement to share information about clients where appropriate?	
13. Is there a common agreed dataset?	

Challenge 5 – Leadership from regional agencies

To transform the North East into the healthiest region in the country within a generation. To use the Regional health and well-being strategy to provide direction for the North East and link national, regional and local policies. Develop networking opportunities and support to share good practice to achieve this aim.

Questions	Response
1. Do we understand how we can be better aligned with *Better Health, Fairer Health* and how we can engage effectively with the SHA, Government Office and other regional bodies?	

Challenge 6 – Getting the best from the third sector

To give community and voluntary sector organisations increased certainty over funding with agreed targets and simplify commissioning arrangements to make it easier for them to bid for the provision of services.

Recommendations
R1 Strengthen and expand community and voluntary sector input to increase diversity of provision.
R2 Support third sector organisations to bid for work.

Questions	Response
1. Has there been an analysis of third sector provision? What third sector provision exists and is it more or less than other areas? Are there gaps in provision?	
2. Are local voluntary organisations engaged in service	

Questions	Response
planning with public bodies?	
3. Do commissioning processes ensure that the third sector have the opportunity and incentive to deliver services?	
4. Do third sector organisations submit high quality costed bids to provide services?	
5. Do third sector organisations evaluate their own services to make the case for funding/ continued funding?	

Challenge 7 – Using community views

To ensure community views influence how and where services are provided.

Recommendations
R1 Improve user and carer consultation and increase services for carers.
R2 Ensure all services seek user views and report on them as part of service evaluations.

Questions	Response
1. Are users involved in developing and evaluating health inequalities strategies or individual services? What user feedback has been received on services, plans and strategies? What changes have been made as a result?	
2. Have hard to reach groups been identified and involved?	
3. Is sufficient publicity given to partnership performance?	
4. Are strategies publicised to local people?	

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