Recommendations

1 **Develop, support and resource structures to reduce health inequalities in Harrow**

2 **Involve and consult communities**

3 **Involve Local Authority members in the Tackling Health Inequalities agenda**

4 **Agree joint priorities and targets on health inequalities**

5 **Develop local well-being pathways for priority issues**

6 **Utilise flexibilities such as pooled budgets and joint appointments**

7 **Monitor progress on tackling health inequalities (by PCT Board and Local Authority Health and Social Care Scrutiny Sub-committee)**

8 **Ensure that the NHS delivers on its role as a corporate citizen (aligning regeneration priorities with the massive expenditure of the NHS)**

9 **Target NHS investment at those individuals and communities that have been traditionally under-served**

10 **Ensure that NHS investments are informed by equity audits**

11 **Improve life expectancy throughout Harrow, focusing on the seven wards with the lowest life expectancy**

12 **Tackle the major killers (circulatory disease and cancer), and reduce inequalities for these killers**

13 **Reduce infant mortality**

14 **Reduce the low birthweight rate, focusing on the seven wards with the highest rates**

15 **Report progress on these 14 recommendations in next years' Annual Public Health Report**

Appendices and references

Appx 1 Key NHS interventions to support the achievement of the National Health Inequalities Target

Appx 2 Key issues for integrated planning, types of local action with examples

Appx 3 *Closing the Gap*: setting local targets to reduce health inequalities

Appx 4 *Tackling Health Inequalities: a programme for action*

Appx 5 Setting priorities

Appx 6 Commentary about calculations based on small sample sizes

Appx 7 Populations of Harrow, London and England, by age and sex, 2001

Appx 8 Ethnic origin of Harrow population, percentages, 2001

References

Appendix 1 Key NHS interventions to support the achievement of the National Health Inequalities Target

Reproduced from the Department of Health website

Background

The Health Inequalities targets in the areas of life expectancy and infant mortality were announced by the Secretary of State, Alan Milburn, in February 2001 aimed at narrowing the health gap in childhood and throughout life between socio-economic groups and between the most deprived areas and the rest of the country.

Key NHS interventions to deliver the targets

For the first time ever, health inequalities were made a key priority for the NHS in the Priorities and Planning Framework (PPF) for 2003-06 *Improvement, Expansion and reform: the next three years.* The PPF set out the need to identify a single set of local priorities with partners, supported by tools such as equity audits, and an approach that is responsive to community needs.

Primary Care Trusts (PCTs) will take the lead locally in driving forward health inequalities work in the NHS, and will work closely with NHS Trusts, Local Authorities and other partners to take concerted action on public health and prevention, health services and the wider determinants of health such as housing, transport, education. But the work of the NHS itself that will have enormous impact on health inequalities.

The key interventions for the NHS are listed below, focusing on disadvantaged groups and areas:

Life expectancy

- Ensuring that prevention and treatment services for cancer and Coronary Heart Disease (CHD) reach those in greatest need or with poorest health outcomes, including disadvantaged groups and ethnic groups with high prevalence. For CHD in particular reducing hypertension and increasing prescription of statins.
- Increasing smoking cessation
- Reducing excess winter deaths, including by increasing influenza immunisation

Infant Mortality

- Reducing smoking in pregnancy
- Improving nutrition in women of childbearing age
- Reducing teenage pregnancy
- Increasing breast-feeding initiation and duration rates
- Providing effective ante-natal care (including screening and immunisation) and promoting early ante-natal booking
- Improving the quality of midwifery, obstetric and neonatal services
- Effective education about ways to promote health, e.g. immunisation
- Provision of high quality family support (e.g. through health visitors) including particular efforts to address risk factors for Sudden Infant Death

All of these interventions need to be underpinned by the following principles:

- Improving access to, and quality of, services for currently under-served areas and groups, particularly primary care services
- Targeting service provision to ensure high quality services are delivered relevant to need

- Ensuring workforce are targeted more intensively at deprived areas and groups
- Ensuring services are culturally sensitive
- Improving translation, advocacy and interpretation services
- Ensuring availability of appropriately skilled public health practitioner workforce to undertake preventive work with disadvantaged groups

Other NHS interventions

Other key NHS interventions to support narrowing of health inequalities more broadly than the target areas include:

- Identification of local health inequalities, including improving data quality and collections to identify groups or areas with high health need/poor health outcomes
- Providing local leadership by developing and sustaining close partnership working, identifying a single set of local priorities and taking concerted action with partners to tackle health inequalities, including influencing community strategies. Contributing to the development of the Local Strategic Partnership to realise its potential for health improvement and tackling inequalities.
- Supporting Sure Start, contributing to regeneration and leading the development and delivery of the health domain of Local Neighbourhood Renewal Strategies in the most deprived areas.
- Making the NHS a power for regeneration to stimulate local economies and enhance the employability of disadvantaged groups, through its local employment and purchasing procedures and capital programmes.

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Appendix 2 Key issues for integrated planning, types of local action with examples

Adapted from:

Hamer, L. (HDA), and Smithies, J. (Labyrinth Consultancy and Training) *et al* *Planning across the local strategic partnership (LSP) Case studies of integrating community strategies and health improvement*, HDA, London, 2002

Working across boundaries

Use the flexibilities of the Health and Local Government Acts to work across boundaries where possible

Identify priority issues to be planned across boundaries and focus initial partnership working on these

Identify geographical areas that are meaningful to all partners – from priority neighbourhoods upwards

Include representatives from the NHS at all levels of partnership so as to help maintain continuity

Identify lead planners in PCTs and local authorities for different cross-boundary issues and allocate responsibility to a relevant partnership to co-ordinate action

Partnership arrangements & accountability (structures)

Map existing partnerships and their resources and current activities to help identify common links

Simplify partnership arrangements and structures wherever possible around key themes

Set out accountability arrangements alongside a map of partnership structures

Create partnership support units to provide co-ordination and champion joint activity

Develop joint education and training programmes across sectors

Use the concept of 'wellbeing' to bring together work across partners

Ensure that the PCT is represented on the LSP and establish close working relations between PCTs and district councils

Clarify where health partnerships sit within the LSP family of partnerships, and identify the health improvement roles of the other partnerships (linked to social inclusion, community safety, wellbeing and so on)

Planning arrangements (strategies)

Simplify and co-ordinate local planning timetables and combine plans as far as possible

Identify cross-cutting strategic themes for the community strategy and agree priorities based on these, rather than on individual targets

Map priorities on a neighbourhood basis and identify which partnerships can take forward action on these through the appropriate plans

Clarify the relationship between area-based initiatives and how these will become part of mainstream LSP planning processes

Link priority setting and financial planning, so that each partnership has delegated responsibilities to cost plans

Move beyond joint working across health and social services and identify joint planning for health across the range of other community strategy priorities

Community involvement & consultation

Map the communities covered by the LSP and the range of existing voluntary and community groups and networks

Review the results of existing consultation exercises for use by all partners

Prepare a community development strategy across all partners and identify priority areas, issues and groups for consultation, and pool resources for these activities

Co-ordinate all community consultations and involvement work across the LSP and pool resources for consultation activities

Identify the range of joint mechanisms that the LSP can use for different types of consultation and involvement (e.g. joint citizens' panels, joint area-based participatory needs assessment in deprived areas)

Clarify where consultation activities or responses need to be led by one organisation for particular issues

Focus new consultation exercises on community solutions not simply needs, and concentrate efforts on small neighbourhood areas

Use the nationally agreed compact with the voluntary sector and create common agreements across LSP members and key voluntary sector organisations (small voluntary organisations as well as the umbrella groups)

Identify ongoing funding for community development workers through the voluntary sector to support community representatives on LSP

Fund regular events and provide grants through the voluntary and community sectors as part of consultation and development work

Encourage secondments and joint posts across the statutory and voluntary sectors

Set up and resource a voluntary sector forum to share learning and experiences in community development

Use the community empowerment fund (or other funding) for local outreach work, disseminating community information, providing training and education and linking excluded groups in different areas through networks

Link patient advice and liaison services (PALS) to broader community involvement work

Involve staff in identifying the links between frontline work and the LSPs' strategic plans and how the roles of key staff groups can develop to support cross-sectoral working and community development

Member involvement

Use health overview and scrutiny committees to track partnership working on health and wellbeing issues and health inequalities

Create lead members for health and wellbeing or health and social exclusion and provide officer support

Use the experience and networks of members in community needs assessment work

Reducing inequalities/tackling deprivation

Use health and social impact assessment tools in planning across sectors to identify the likely impacts on inequalities

Map local inequalities and service use by different groups and pool information at neighbourhood level

Identify how the neighbourhood renewal strategy (or equivalent social inclusion strategy) will be reflected in the HIMP and *vice versa* – to highlight the NHS role as an employer and local regenerator in deprived areas

Identify how service modernisation can address work to reduce inequalities and help local regeneration and vice versa rather than allocating funding separately

Using the flexibilities – pooled budgets, joint posts & integrated services

Clarify the LSP's role in making decisions about pooled resources and integrated services

Make use of the Health Act flexibilities and the Local Government Act to pool resources and develop new services which have been identified through partnership working

Set up a system of joint bidding from external sources of funding

Align mainstream budgets linked in to shared long term outcomes

Set up joint commissioning teams who link directly to LSP structures and joint priorities

Create LSP-funded posts from an LSP pooled budget

Create joint posts across the local authority and the PCT to help raise awareness of the links between health and wellbeing

Create new posts in PCTs to work with frontline health staff to help develop new ideas for integrated services

Use the good practice guide on joint appointments

Joint priorities, targets & performance management

Set up joint information units to create common data sets for integrated planning

Develop LSP-level indicators to judge its performance and reflect these in partners' performance management systems where possible

Track how the funding and action of different LSP members is contributing to achieving national targets and the local indicators that can demonstrate this

Agree which plans will be approved through the LSP and what the accountability arrangements will be for monitoring targets

Appendix 3 *Closing the Gap* : setting local targets to reduce health inequalities

The Health Development Agency[1] describe how to set local targets to reduce health inequalities in *Closing the Gap: setting local targets to reduce health inequalities*. Key points from the document are summarised here.

The importance of systematic planning

Targets can be set in any domain or layer of influence. They become **inequality targets** *if they clearly state the improvement to be attained in a way which is differentiated by socio-economic group or relate to actions directed at particular socio-economic groups*. (1: 10–11)

Norfolk HimP used a checklist of different measures of inequality when developing strategies and policies:

- Inequality of the wider determinants of health (housing, education, transport, employment, nutrition)
- Financial and geographical inequality (some areas may receive a disproportionate amount of financial resources which are not based on need)
- Inequality of service provision (services vary unfairly between populations)
- Inequality of access to services (unequal opportunity to use services, inaccessibility to some members of the community)
- Inequality of service use (poor uptake of benefits advice, lack of awareness of services or the right to use them)
- Inequality of health and illness between individuals and groups (different illness and death rates for people from different social, ethnic groups and for men and women)

Successful targets need to meet five criteria

1	**Credibility**	Targets must find a balance between being realistic – capable of being achieved within a proposed timescale – and being sufficiently ambitious.
2	**Relevance**	Targets should relate to an overall strategy and relate to clearly identified health problems which are demonstrably amenable to action.
3	**Evidence based**	Sufficient data should be available about the effectiveness of interventions required to tackle the problem to which the target relates. Targets should relate to actions/interventions based on evidence of what works.
4	**Ownership**	Targets should be meaningful and acceptable to all those who are to be responsible for their delivery. Best achieved by involving all key players in actually setting the targets.
5	**Monitoring & evaluation**	Organisations responsible for achieving the target should be clearly identified and lead responsibility assigned.

Sources [2] Kendall, 1998; [3] Whitehead, Scott-Samuel and Dahlgren, 1998; [4] Water and Herten, 1998

Three additional principles/issues are specific for inequalities targets

1	**Levelling up**	Inequalities targets need to specify a levelling up of the health of the worst-off in society, not a levelling down of the rest. Narrowing of the health gap should not be achieved by any deterioration in the health of other groups.
2	**Differential targeting**	Related to the points about realism and ambition in the target-setting process. There is a risk targets could focus on groups where health improvement might be quicker or easier to achieve. One approach is to set targets that take account of the causes/effects of ill health in different sections of society. For example, higher targets can be set for deprived areas/particular ethnic groups, or gender-specific targets can be set where socio-economic inequalities impact on health differently between the sexes.
3	**Focusing 'upstream'**	Given the established evidence base about the social determinants of ill health, targets to address inequalities need to move beyond disease-based or service-specific outcomes. Inequalities targets also need to direct action towards wider determinants of health – closer to the point of causation. For instance looking at risk factors, such as smoking, or on tackling improvements in wider living and working conditions.

Sources [3] Kendall, 1998; [2] Whitehead, Scott-Samuel and Dahlgren, 1998

There are four stages in the process of setting health inequalities targets

1 Establishing a starting position

Articulating a shared vision, a set of principles or values about how health inequalities are understood locally and why they are important for local policies.

2 Building a picture of local needs

The process of target setting requires an understanding of the population so that we know where to focus our efforts.

Norfolk's public health report 2000 described local health inequalities. HimP strategic objectives (published subsequently) were backed with evidence of inequalities and action to address such. Norfolk drew up a charter for reducing inequalities and developed a checklist for assessing strategies and actions. Partner agencies committed to:

Ensure that new strategies, policies and plans specifically address inequalities

Consult partners on achieving change

Allocate resources according to need and to the inequalities identified

Produce an annual statement describing the contribution to the strategy, policy or plan to reducing health inequalities.

3 Developing strategy

When devising a strategy for setting inequality targets, there needs to be a clear focus. Six possible focus points are suggested.

- **Focus on areas**

  We can look at differences between geographical areas (electoral wards or neighbourhoods). Health problems tend to cluster so this approach enables an area to be targeted for greater/faster improvement. A potential drawback is that it may exclude the significant number of disadvantaged people who do not live in areas defined as 'deprived'.

  Many HimPs used this approach.

- **Focus on populations**

  We know that some populations are particularly susceptible to certain conditions. This makes the targeting of such populations another 'way in' to formulating local strategy. Possible 'populations' include – specific minority ethnic populations; teenage mothers; lone parents; young people leaving care; or an age group where specific inequalities are prevalent or where particular risk factors are high.

  Interventions aimed at the young are often chosen to prevent ill-health/health inequalities in the next generation.

- **Focus on the wider determinants of health**

  Some of the most important determinants of health inequalities lie outside the health sector. Improvements in housing, education, low income or unemployment are very powerful levers in reducing health inequality.

  Strategies with this focus needs to involve a range of partners.

  Suffolk County Council HimP indicators included developing local bus services in under-served areas and reducing the number of long-term unemployed

  Stockport agreed a target to ensure that over a 10-year period all residents have access to affordable, good quality food, supporting food co-operatives in areas of deprivation

- **Focus on risk factors**

  Exposure to health risk is often unevenly distributed throughout the population.

  Targets to reduce smoking prevalence or increase vegetable consumption in deprived population group would be examples of risk-based inequalities targets.

- **Focus on health outcomes**

  Certain diseases or health outcomes (CHD, accidents, some cancers, and infant mortality) are significantly influenced by social gradients.

  Inequalities targets can focus on narrowing this gap setting differential rates for improvement across the socio-economic spectrum.

  North Nottinghamshire HimP set a general 10 % reduction in all-cause SMRs for people aged 65 to 74, with a higher 20 % target for 15 to 64 year-olds in 10 (deprived) wards (2005).

  Lambeth, Southwark and Lewisham 20 % reduction in home accidents by 2008 in targeted areas.

- **Focus on access to services**

  Nationally there has been much evidence of inequity in service use by poorer people. If we believe there is evidence of this locally we can set targets to bring about improvement.

  A strategy with this focus needs to be linked to increased service capacity, proper monitoring and be complemented with targets relating to prevention.

> **Coalfield** HAZ information systems to monitor inequalities in access/uptake of preventive treatment and rehabilitation services for heart disease, e.g. use/need ratio, patients' views, referral patterns.
>
> **Wigan** provided equitable provision of practice-based and community services – particularly counselling and physiotherapy which have been identified as areas currently offering inequitable service access.

4 Agreeing targets

The choice and success of targets will be influenced by pragmatic and political considerations. A balance has to be struck that takes account of a range of factors. These could include: types and sources of data available, requirements for performance management, the overall vision and framework being adopted in local strategic planning, the views of partners and communities, the profile and context of the local area.

Success in reaching targets will depend on how effectively a focus on inequalities in health is embedded within each programme, influences the choice of priorities, the flow of resources and sets the overall strategic direction.

It will involve matching information on deprivation to plans and priorities; synergy between different projects targeted towards reducing inequalities; developing the role of PCTs; ensuring that a focus on inequalities is maintained within health and health-related programmes; and reorienting policies in order to narrow the health gap.

Types of target identified in *Closing the gap*

Aspirational — to motivate and inspire, and may not be specific (quantifiable improvements, timescales or method).

> **North Tyneside** community plan, HimP, Sure Start programme and HAZ all jointly *agreed to reduce health inequalities and give specific consideration to the health of children and families*

Process — generally an intermediate stage in a service or activity.

> **Cotswold** council commissioned research on health inequalities through the community strategy

Activity directed at reducing inequality, measures of such activity will act as a proxy for the intended health benefits.

Portsmouth: all accepted homeless applicants to receive an offer of permanent accommodation within 28 days

Outcome specify a desired improvement in specific health outcomes or risk factors**.**

Sandwell HAZ set outcome targets for 2005 for instance a target for 8 per cent low birth weight babies – from a 10 per cent baseline

Norfolk adopted an approach which adjusted national targets to local variation. They sought to improve their overall figures, but focussed most on areas of highest need. For circulatory disease they sought a 40 per cent reduction in the average mortality rate and a 50 per cent reduction in each areas variance from the average.

Exposure to risk factors directed specifically at the social, economic or environmental determinants of health rather than disease-based outcomes.

North Nottinghamshire set education targets including: 10 per cent more GCSE A to C grades in the 10 most deprived wards

Coalfield HAZ targeted increasing by 80 per cent children cycling or walking to school.

Coventry aimed to increase the take-up of *Passport to Leisure and Learning Scheme* by 20 per cent of those eligible by 2001.

Bringing it all together

Closing the Gap suggests a number of steps in setting local targets. [1: 22-25]

- Set inequalities targets firmly within the mainstream strategic planning cycle
- Decide a process and structure for setting the targets – who should be involved, when and how?
- Identify relevant regional targets, performance frameworks and learning networks
- Map inequalities and deprivation, undertake an equity audit
- Review existing local targets and action being taken to achieve them
- Identify and establish links with local communities to support the mapping and development of targets
- Agree priorities for action and set a number of targets around these
- Relate targets to action across key strategic and local plans
- Agree a 'basket' of local indicators to monitor progress
- Establish funding arrangements
- Monitor and evaluate targets linked to performance management systems

Appendix 4 Tackling Health Inequalities: a programme for action

Some examples of local action from the Department of Health's 2003 document are summarised here.

What local bodies can do

Supporting families, mothers and children – maternity and child health and child development, improving life chances for children and young people, reducing teenage pregnancy and supporting teenage mothers.

The local response:

- PCTs can encourage low-income mums to initiate and continue breastfeeding by targeting support at low-income and black and minority ethnic groups, using link workers and community mothers schemes
- schools can participate in the Food in Schools programme, improving the diet and nutrition of children
- PCTs and local authorities can work together to reduce smoking, providing tobacco education programmes and smoking cessation clinics
- local authorities can work to reduce injury and deaths from accidents, particularly road accidents among children from disadvantaged areas
- local authorities can encourage exercise among young children by increasing the use of abandoned or low-grade green spaces and promoting sports centres and leisure facilities
- all local bodies can involve young people in designing and evaluating the impact of public sector services
- school nurses can work with Connexions personal advisers to ensure that the appropriate support is in place to help a young person with mental health needs
- specialist health care staff can work from outreach centres including schools and neighbourhood nurseries
- local housing authorities can prevent homelessness through effective homelessness strategies working with local partners from the statutory and voluntary sectors. [THI: p28]

Engaging communities and individuals

The local response:

- communities and neighbourhood wardens can introduce walking buses for school children, and provide escorts for elderly people afraid of walking alone
- get local people involved in identifying local needs, influencing decision making and evaluating their local services
- health and local authority community development teams working in areas of greatest need can be jointly funded
- provision of health and social care services by the community and voluntary sector within the principles of social enterprise
- local authorities can work in partnership with local communities to improve green spaces so that they can be used for exercise and provide children's play areas
- PCTs and local authorities can sign up to and implement a common local Compact

- develop new or reshape existing services to meet the needs of vulnerable groups
- PCT staff can work with transport planners to improve access to health services for those in disadvantaged groups and areas
- set up integrated neighbourhood teams including health staff, police and education in disadvantaged areas. [THI: p30]

Preventing illness and providing effective treatment and care

The local response:

- PCTs can work with communities and charities to introduce more comprehensive smoking prevention and cessation strategies targeted at low-income groups, black and minority ethnic groups, young people, pregnant smokers and prisoners
- trading standards officers and police can tackle tobacco sales to minors and smuggling
- primary health care professionals and local authorities can collaborate to promote exercise on referral schemes for individuals whose health is being seriously put at risk by physical inactivity
- local planners can map food deserts so local 5 A DAY programmes can improve food access
- PCTs can support the expert patients programme which provides self management training for people with long-term conditions
- PCTs with poor rates of dental health can consider fluoridating their water supply as part of their overall health strategy and invite the SHA to carry out the necessary consultation
- local authorities can integrate health care issues into wider regeneration initiatives, such as Supporting People strategies and LSP community plans
- PCTs can work closely with local authorities on the delivery of Sure Start local programmes and other local strategies in their areas
- PCTs can match staffing to levels of health need. [THI: p30]

Addressing the underlying determinants of health

The local response:

- PCTs can work with partners to promote access to welfare advice and support in health and outreach facilities
- local authorities can ensure that staff regularly visiting the over 60s know what energy efficiency measures are available in their area
- PCTs can work with local people and agencies to set up home safety, energy efficiency and repairs scheme for vulnerable families and older people
- health professionals can make referrals to energy efficiency programmes to address fuel poverty
- local authorities can buy goods and services from deprived areas in the locality
- neighbourhood wardens can mobilise communities to create clean and safe environments for local people
- transport planners can carry out child safety audits
- GPs and health professionals can take account of the wider determinants of health in their consultations. [THI: p36]

The local authority role

Action – local authorities:

- promoting healthier communities and narrowing health inequalities is one of seven Shared Priorities agreed between central and local government
- local authority transport planners will conduct accessibility planning in partnership with PCTs and other local bodies to improve access to jobs and services for disadvantaged groups and areas in Local Transport Plan areas
- local authorities can assess LSPs and ensure that their continuous performance improvement incorporates a health perspective and the need to address health inequalities
- local authorities can prioritise reducing health inequalities in their statutory community strategies and plans
- local authorities and PCTs will work together more closely on the delivery of Sure Start local programmes and Children's Centres
- regional policies, including regional economic and housing strategies can also be assessed for their impact on health and health inequalities. [THI: p40]

Appendix 5 Setting priorities

We need to set priorities because we have a responsibility to use our resources wisely, maximise health gain and reduce inequalities in health outcome.

Types of decisions faced – we may be asked to prioritise between:

1. Different conditions
2. Different client groups
3. Different parts of the well-being pathway – for instance the proportion of spending on lay care, self care, prevention, primary care, secondary care, tertiary care, social care, etc.
4. Different geographical areas.

Search for an explicit system for a priority setting

There have been a number of attempts at developing an explicit system for a priority setting but none has become a universally accepted model; one reason for this being a lack of information. However, what was learnt from these attempts was that process is more important than the product and it is vital to ensure procedural rights. People must have fair access to decision makers and the chairing must be unbiased.

A prioritisation process needs to be:

1. Legitimate and fair
2. Transparent
3. Recorded
4. Free from conflicts of interest.

The priority setting process needs:

1. An ethical framework
2. An open process
3. To involve clinicians and other key stakeholders.

An ethical framework requires:

1. Agreement of what equity means
2. Evidence of effectiveness
3. Patient choice.

Defining equity

There is no agreed definition of equity in the context of health and health services. Arguably, equity is not the same as equality, which means that everyone should get exactly the same services regardless of their need. By attempting to achieve health equity, we may be aiming to achieve equal health, or equal use for equal need, equal access for equal need, or equal quality of care for equal need. To achieve any of these, however, interventions, whether preventive, primary or secondary care, would need to be directed towards the people with worse health and greater needs.

Evidence of effectiveness

It is generally agreed that we should not fund any interventions when we have good evidence that they are ineffective. In general, we would only fund treatments that we knew to be effective. There are, however, certain circumstances when it is difficult to test an intervention using randomised controlled trials.

Table 5.1 Levels of evidence of effectiveness

Evidence obtained from:	
I a	systematic review of meta-analysis of randomised controlled trials
I b	at least one randomised controlled trial
II a	at least one well-designed controlled study without randomisation
II b	at least one other type of well-designed quasi-experimental study
III	well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies
IV	expert committee reports or opinions and/or clinical experience of respected authorities

Source *The Guideline Development Process – Information for National Collaborative Centres and Guideline Development Groups.* National Institute for Clinical Excellence, London, 2001

Cost effectiveness

Often reliable, accurate data about cost effectiveness do not exist. However, it is hard to justify the allocation of major resources to interventions which are very expensive and which offer minimal benefit.

Harrow PCT will be developing an ethical prioritisation framework.

Appendix 6 Commentary about calculations based on small sample sizes

There are 21 electoral wards in Harrow, each with about 10,000 people living in them. Potentially, a useful way to build a more detailed picture of health and the factors that influence health is to analyse data at electoral ward level. However, this approach has two main problems.

Small numbers – for some events (such as death from injury) the numbers that occur in an electoral ward in any one year will be quite small – fewer than five as the result of injury. This makes it difficult to interpret variations. For example, an 'extra' death in Greenhill ward would increase by 20% 'accident deaths' for the year. All the percentage increase would be the direct result of one case of accidental death. However if we saw the same percentage increase across the whole borough – say 20 more accident deaths – we would be much more concerned, because the increase would be less likely to be due to chance variation.

Use of averages – people with poorer health may live in areas where people enjoy better than average health. This needs to be remembered when considering the average rate for an electoral ward.

Appendix 7 Populations of Harrow, London and England, by age and sex, 2001

males	*<5*	*5 to 14*	*15 to 44*	*45 to 64*	*65 to 74*	*75 to 84*	*85 +*	*all*
England	1498073	3252834	10115344	5773137	1921450	1096284	265022	23922144
%	6.26	13.60	42.28	24.13	8.03	4.58	1.11	–
London	243740	452821	1702588	696050	218901	122864	31829	3468793
%	7.03	13.05	49.08	20.07	6.31	3.54	0.92	–
Harrow	6213	13903	44539	22854	7111	3992	1341	99953
%	6.22	13.91	44.56	22.86	7.11	3.99	1.34	–

females	*<5*	*5 to 14*	*15 to 44*	*45 to 64*	*65 to 74*	*75 to 84*	*85 +*	*all*
England	1428165	3098742	10266150	5898386	2181391	1654851	689002	25216687
%	5.66	12.29	40.71	23.39	8.65	6.56	2.73	–
London	234447	434369	1778311	738175	249166	187689	81141	3703298
%	6.33	11.73	48.02	19.93	6.73	5.07	2.19	–
Harrow	5806	12879	46076	24615	8209	6184	3092	106861
%	5.43	12.05	43.12	23.03	7.69	5.79	2.89	–

all persons	*<5*	*5 to 14*	*15 to 44*	*45 to 64*	*65 to 74*	*75 to 84*	*85 +*	*all*
England	2926238	6351576	20381494	11671523	4102841	2751135	954024	49138831
%	5.96	12.93	41.48	23.75	8.35	5.6	1.94	–
London	478187	887190	3480899	1434225	468067	310553	112970	7172091
%	6.67	12.37	48.53	20	6.53	4.33	1.58	–
Harrow	12019	26782	90615	47469	15320	10176	4433	206814
%	5.81	12.95	43.81	22.95	7.41	4.92	2.14	–

Source ONS Census 2001 ©Crown copyright

Appendix 8 Ethnic origin of Harrow population, percentages, 2001

	White %	*Black %*	*Asian %*	*Mixed %*	*Other %*
Pinner	78.26	3.17	14.32	2.30	1.94
Pinner South	77.36	1.85	16.44	1.99	2.38
Harrow Weald	72.81	5.96	16.69	2.83	1.71
Stanmore Park	74.77	3.90	17.52	1.88	1.91
Hatch End	74.03	3.12	18.95	2.15	1.75
Canons	71.54	3.46	19.65	1.94	3.42
Headstone North	65.49	3.30	25.75	2.32	3.13
Wealdstone	58.74	9.63	25.95	2.73	2.95
Harrow on the Hill	60.33	6.75	25.98	3.40	3.55
Greenhill	58.48	7.70	26.08	4.01	3.72
Headstone South	59.11	6.64	28.72	3.30	2.22
Marlborough	56.07	8.93	29.44	3.24	2.34
Roxbourne	51.93	11.48	29.58	4.20	2.81
Belmont	62.58	3.41	29.86	1.92	2.23
West Harrow	57.24	5.87	30.71	3.51	2.68
Roxeth	51.25	9.63	31.92	4.02	3.19
Rayners Lane	54.33	5.24	34.17	3.38	2.89
Edgware	40.15	8.20	45.11	2.49	4.05
Kenton West	40.69	6.71	48.00	2.80	1.80
Queensbury	36.56	6.58	51.93	2.28	2.60
Kenton East	35.62	6.80	53.64	2.37	1.58

Source ONS, Census 2001 ©Crown copyright
Notes Classifications are –
White: white British, white Irish, white other
Asian: Asian or Asian British, Asian Indian, Asian Bangladeshi, Asian Pakistani, Asian other
Black: black or black British, black Caribbean, black African, black other
Mixed: white/black African, white/black Caribbean, mixed other
Other: Chinese, other

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Acknowledgements and thanks

A large number of people have contributed directly or indirectly to the process of making this report, including: Kingsley Akuffo, Andrew Appleby, Bindu Arjoon-Matthews, Michael Bannon, Mitch Blair, David Cohen, Debbie Craig, Suzanne Elgohari, Riaz Esmail, Janet Farrant, Stephen Farrow, Jane Fernley, Lindsay Forbes, Ellen Goodchild, Kirsty Green, Cindy Halley, Michael Hart, Efe Ibitomisin, Mohamoud Ibrahim, Poonam Jain, Amol Kelshiker, David Kerrigan, Peter Lachman, Tony Lear, Gareth Llewellyn-Roberts, Joyce Markham, Mahendra Mashru, Sue McLellen, Howard Myers, Chaand Nagpaul, Gareth Noble, Paul Osburn, Mark Patchett, Vijay Patel, Ian Pearce, Leonard Peter, John Pope, Nalini Prasad, Margaret Price, Janet Riddell-Heaney, Gill Roberts, Nicholas Robinson, Gillian Schiller, Claude Seng, Shikha Sharma, Yousouf Soogun, Rachel Stephen, David Summers, Philip Sutcliffe, Kashmir Takhar, Jane Thomas, Ken Walton, Pauline Warner, Mary Whitehead and Mick Wright.

I would like to thank the authors of the independent articles about Harrow partnership work in Section **4**: *Working together to tackle health inequalities*; and the work of The North West London Health Protection Unit in Section **5**: *Communicable disease control.*

Finally I would particularly thank Charlotte Ashton, Hugo Crombie, Paul Ellis, Tania Misra, Oliver Morgan and Cath Roper for their work, much of it at unsocial hours.

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