



HAZ

BRENT HEALTH ACTION ZONE CONFERENCE 2005 REPORT

MIND THE GAP:
PARTNERSHIPS IN ACTION TO
TACKLE HEALTH INEQUALITIES



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The Brent Health Action Zone Conference 2005, Mind the Gap: Partnerships in Action to Tackle Health Inequalities was held in the Crown Moran Hotel, Cricklewood, on Wednesday 29 June 2005.

Attracting over 105 delegates, the conference reflected a wide range of stakeholders from the community, voluntary and statutory sectors, with an interest in sustaining effective partnership working, to narrow health inequalities in Brent.

The conference was co-chaired by Jean Gaffin OBE, Chair of Brent tPCT and Cllr Ralph Fox, lead Member for Adults, Health & Social Care at Brent Council.



Welcome from Co-Chair Jean Gaffin

Jean Gaffin opened the Conference by welcoming everyone, remarking on the importance of the occasion to celebrate the achievements of Brent HAZ. Jean mentioned that Brent was fortunate to have been able to draw funds into Brent through the Health Action Zone but government would not be continuing this particular funding stream past march of next year. She introduced Steve Maingot, Non-executive Director at the tPCT and Chair of the HAZ Committee. Steve spoke of the success of the HAZ in bringing together communities with a common interest, allowing all voices to be heard and facilitating frank discussion.



The programme began with a presentation by Jackie Collins - HAZ Manager who provided an overview of the work of Brent HAZ over the past year and considered future issues.

Jackie praised the huge amount of activity in HAZ funded projects over the past 12 months, from which many had benefited. A total of 18 projects had been funded under the Tuberculosis (TB), cancer and diabetes priority areas, in addition to eight pre-existing projects which had been running prior to 2004. As such, £965,000 had been invested in health inequalities work in the current year. Jackie reiterated Jean Gaffin's opening comments that Brent had been fortunate to have received HAZ funding over the last six years – funding that would end in March of 2006.

Jackie acknowledged that it had been a controversial decision to focus on three medical conditions (TB, cancer and diabetes), rather than on the broader determinants of health - areas such as housing, employment and education. However, she said that the resultant close working relationship with staff in the tPCT and the opportunity to work across professional and organisational boundaries has proved this is a model worth continuing.

“In selecting TB, Cancer and Diabetes, we were able to work on three conditions where inequalities play a significant factor and address these through the cross cutting theme of community engagement and targeted interventions.”



Jackie stated that the key question for the conference was whether HAZ investment in multi-sectorial partnerships translated into a reduction in health inequalities and an increase uptake of services from communities

traditionally 'hardest to reach?' The extent of health inequalities in Brent and across Britain in general indicates a structural failure of the health service to tackle these inequalities on its own. This was highlighted in the Acheson report in 1997 which advocated building partnerships across a broader range of organisations and sectors. Health Action Zones were the forerunner to Local Strategic Partnerships, bringing together all the public sector agencies, including health and the local authority, with the voluntary, community and private sector.

Reference was made to 1999, when Brent became a Health Action Zone and the HAZ team was first tasked to: work across different agencies to tackle health inequalities, deliver better services and to act as trail blazers for new ways of working locally.

Health inequalities exist in two ways. (i) as social constructs – barriers that exist in accessing health services, (ii) where their health is negatively impacted by environmental and economic factors.

An example of the first, is how disabled people are denied a proper and equal health service because of the way the structure is set up. In the case of the second kind of health inequalities, they can not be addressed by the process of inclusion or a social model. People who live in poor housing; in areas with high crime rates; where pollution is high; have limited employment opportunities are negatively affected in terms of the impact of these factors. A multi-sectorial approach, is the effective solution to tackling these problems.

There are of course situations where inequalities of access to services play a factor. We can address this using a cross cutting theme of community engagement and targeted interventions to specific communities.

Delegates were shown a slide which illustrated the part of the Bakerloo line running 3.5 miles from South Kenton to Harlesden in Brent. The life expectancy of a man living in Harlesden is 78 years, however, living a few miles further north in South Kenton would add an additional eight years to his life expectancy. This unacceptable inequality was best addressed through a partnership approach.

The annual report would be produced later in the year and this would demonstrate the efficacy of HAZ funded projects – the majority of which had exceeded their indicators set. Where some projects had struggled, they were supported to get back on track.

Examples were provided of partnership working in the steering groups of the three priority areas of TB, cancer and diabetes. Organisations involved on the TB steering group included the North West London TB network; North West London Hospitals, Willesden chest clinic and TB Alert – a national charity. These partners did not receive funding, but were willing to get involved which has resulted in a more comprehensive package of projects for those with TB and at risk of infection.

The Cancer steering group had involvement from the tPCT, St Luke's Hospice and from the smoking cessation project all of whom have added value to HAZ funding. Additionally a play on cervical screening, has been brought to Brent three times in the past year, improving access particularly for those who have not traditionally taken up screening.

For Diabetes, teams of health professionals and community organisations have been brought together to run diabetes awareness programmes. The diabetes newsletter has been translated into community languages with the support of community organisations

It is these benefits of working across organisational boundaries that has brought all these things into evidence.

The HAZ manager has been working on the top level to look at opportunities to effect positive change either through influencing processes or structures. Change can be effected through future work with the Local Strategic Partnership (Partners for Brent) and the forthcoming Local Area Agreement. The real challenge for the tPCT and its partners is how to change that life expectancy gradient in the coming years. A cautionary note from a London Health Observatory report shows that if a scatter gun approach is taken to tackling health inequalities without targeting those most disadvantaged, the people who most benefit will be those least disadvantaged, thus further widening the health gap. "We need to be much wiser about targeting interventions, which means we need to have data to understand community profiles and to monitor the interventions that work and those that don't."

In the remaining nine months, there is still much work for the HAZ to do. The legacy the HAZ leaves will be an evidence based approach - one that supports as well as monitors; a model of partnership working, that values all partners and their expertise and lastly, an understanding of how to engage with hard to reach communities and use this to effect change.

Jackie Collins then introduced three short presentations designed to showcase examples of HAZ funded partnership work, across the voluntary and statutory sectors.

Narrowing the Gap through Effective Partnerships

Dr Shuja Shafi of North West London Hospitals Trust was the first of the three speakers and focussed his presentation of the HAZ priority area of TB.



Dr Shafi talked about how he had been struck by the question on how best to tackle health inequalities in a recent Health Care Commission Consultation document sent to the Trust. He cautioned against inadvertently widening the health gap, by not incorporating the community perspective within such processes. Dr Shafi emphasised the importance of the Trust engaging and working in partnership with the community in order to understand their particular needs and to prevent hospital admission; the number of people who had been kept out of hospital could form a measure of success in providing health services. This would assist in making the NHS a genuine National Health Service.

He gave TB as a good example of rising health inequality which has earned Brent the title of TB capital of Europe. He went on to highlight the scale of the problem and to look at the approach taken locally to address the issue.

While expected TB cases in England were nine per 100,000 of the population and 45 per 100,000 in London, in Brent the figure is over 90 and much greater in particular communities where the figure is as high as 210. The Government has encouraged joint efforts across diverse agencies including local authority, voluntary sector and health sector as the way forward to tackle the difficult task of reducing the incidence of TB.

When TB was agreed as one of the HAZ priority areas, there was a huge volume of expression of interests to undertake TB related projects making the task of allocating funds difficult. The best compromise was to group similar project ideas and fund them together. There were some wonderful ideas: finding

out what people understood by TB; what the obstacles were to providing services, de-stigmatising TB; bringing back skilled retired health professions to contribute to the programme and developing a TB patient pathway map. This resulted in the development of outreach activity; a resource and teaching group; TB awareness training and a research project to find out the communities experiences, views and attitudes to TB.

If the HAZ philosophy is to breakdown barriers and for organisation and people to work together, I believe we have achieved that.

Dr Shafi ended by saying that in his experience there are people out there who are victims of health inequality. They are perceived to be hard to reach and regarded as difficult individuals. The Health providers have a desire, a willingness and indeed a central directive to improve their plight. There are sections of the community, mainly the voluntary organisations, that exist to provide support and achieve this objective. Health care professionals must work in partnership with such organisations. When this happens, all will appreciate, as Dr Shafi himself has done – the wealth of experience and expertise of voluntary sector organisations.

Danny Maher, the next speaker, summarised the work of Cricklewood Homeless Concern (CHC) – a local voluntary sector organisation as being about two things: regenerating and revitalising the lives of single homeless people.



CHC was established 20 years ago by local people because of the emergence of homelessness in the 1980's particularly amongst the Irish community. It started off as a soup kitchen in a local church and become an important resource for homeless people. In the past five years the number of Irish homeless being catered for has fallen from 80% to about 75 %. This is because the world has changed rapidly. Fewer people are coming from Ireland, conversely there has been a growth in other communities, in particular those from east Africa,

together with a general increase in the numbers of refugees and asylum seekers, now making up 25% of CHC clients. One thousand people are seen per year, so this is a significant new dimension in the work at CHC.

That new dimension has brought new challenges, particularly mental and physical health problems associated with this group. This has forced CHC as stakeholders, to look at how best to respond to the health inequalities of this group. CHC had an opportunity to talk with Brent Housing Services - who were aware of what the HAZ was trying to do - and decided that it would be an opportunity for all to come on board. The was a smart move for a number of reasons, including: good value for money, economies of scale and a more sustainable outcome.

A health and homeless project has been set up in the last year. The Brent HAZ aspect focuses on all the three priority areas of cancer, TB and diabetes. So far three people have been identified and diagnosed with cancer. The essence behind the cancer element is trying to inform this very disadvantaged client group of what is available for them in terms of mainstream services; inform them in an accessible format, language that they speak and on a one-to-one basis. There are barriers for this client group which relate to the prejudice surrounding cancer and not wanting other people to know they have the condition.

Another element of the cancer project is smoking cessation. The centre caters for 50-60 people a day, plus 16 staff and 20 volunteers and everyone apart from two members of staff, smokes . A by-product of this, is that staff and volunteers have been encouraged to be part of the smoking cessation element. If the centre is trying to encourage its client group to stop smoking, there is no point in doing that if the staff and volunteers are continuing their own smoking habits.

The next element – TB: a very good relationship has been developed with the TB clinic. People are sent there directly which is proving very successful in terms of breaking down organisational barriers. An excellent service - the London X-ray Mobile Service - which CHC have been liaising with to bring to the day centre, is coming on board probably in July. This will be promoted to encourage people to access it.

In relation to diabetes most people diagnosed are at the level that require both medication and a change in their diets. The benefit of having a centre is that there is a focus on holistic issues like nutritional intake in the meals provided and the use of Brent Community Physical Activity project. In addition, services are brought to the centre, such as GP services and other primary care staff. Excellent working relationships have been develop with GPs offering Personal Medical Services (PMS) for homeless people.

The key success factor is to work in partnership. Problems can not be cured working in isolation, but resources can be pooled to make a real impact on health.

Aaysha Shah of Brent Council Housing department introduced her role of ensuring that health issues are reflected in housing strategy and policy, to have an impact on improving health in Brent's population. Working with the HAZ has been very important in linking the issues of homelessness and poor housing with health inequalities.



One research source has indicated that, TB is 200 times higher in Brent than it is in the general population and it is known that Brent has a disproportionate demand for housing as compared to other London Boroughs because of

the high levels of homelessness. This is to do with general inequalities, but particularly in terms of economics and accessibility.

How do partners tackle the problems identified? The best way is to have a targeted approach. If partners look at the disadvantaged especially homeless people and people in poor housing, the aim is to improve their health at a faster rate than the general Brent population. There is an urgent need to improve the accessibility to services especially for 'hard to reach' groups – that is well recognised in Brent and Housing has worked with the HAZ to jointly fund a post to work with the homeless. Housing is working with local partners in the both the community and statutory sectors with continuing commitments from Council Members and officers to reduce health in equalities and improve the quality of life for Brent residents.

What Housing aims to do is to look holistically at people's needs by working with health partners and social services to have a single assessment process so that partners can tackle the range of problems the person may be experiencing in terms of housing, social care and health. It is recognised that working in partnership can have a meaningful impact and is key to addressing health inequality priorities.

What lessons have been learnt? It has been identified that supporting community involvement in planning, delivery and decisions about health is essential and tackling the root causes of poor health and health inequalities should be done through mainstream services and by collaborating in joint working at a local level.

GETTING RESULTS

BRIDGING THE HEALTH GAP

GAIL FINDLAY, COORDINATOR FOR THE LONDON HEALTH COMMISSION



Gail Findlay conveyed her pleasure at being present at the Conference, particularly as a former Director of the HAZ in Camden and

Islington. The key message was that “communities lie at the heart of health improvement... and of course partnerships.” - a message clearly echoed in the Choosing Health White paper. Partnership is not easy, but it is essential if progress is to be made in tackling the health gap.

Making a difference in health has to be long-term and one of the weaknesses of current efforts is the continual investment in short-term projects without building-in mainstreaming from the outset. Gail expressed her personal view that short-term projects should not be funded at all, only long term developments that can be mainstreamed, whole-system and broad fronted. It could be seen as a contradiction to advocate the need for targeting, which Brent has done over the past years – focussing on a small number of areas where significant impact could be made. However, this needs to be part of a broader fronted strategy that all partners are working to, linking with neighbourhood renewal and the forthcoming Local Area Agreement.

Gail's current role as Coordinator for the London Health Commission is linked to the work of the Health Development Agency (HDA) which is looking at evidence on what works in terms of improving health and tackling health inequalities. The recent merger of the HDA with the National Institute for Clinical Excellence (NICE) will further the mission to improve the evidence base and to develop clear guidelines on what works in public health – a key issue for the future. In wholeheartedly embracing public health; developing guidelines on what works and providing pointers to good ways of investing in health, NICE has a role to play in stemming the activity that makes no difference to improving health and increasing activity on what does.

The London Health Commission is a high level partnership which has the aim of reducing health inequalities in the Capital and improving the life of Londoners. All the major players in London sit around the table and there are a series of forums of stakeholders with good links and networks across London. The Commission was launched by the Mayor in 2000 and builds on the London Health Strategy. The focus is on the underlying determinants and wider determinants of health, less on health services. Health impact assessments are undertaken on all Mayoral strategies. The Commission reports annually and publishes updates and briefings.

It works at three levels: influencing policy makers, supporting local action and driving specific things through programmes of work. The Commission works to key priorities linked to respective forums.

Gail pointed out that the policy context for addressing the health gap has existed for some time, going back to the World Health Organisation (WHO) 'Health for All 2000, The Black Report, Health of the Nation and so on, yet this has not been achieved. The theme has been on-going and is now a familiar one. The key question is “Are we actually closing the gap? Are we finding ways of bridging that gap or are we actually investing a lot of time effort and moneys but making no progress. That is the question”

On a personal note, Gail felt that the latest white paper Choosing Health had been disappointing because of the emphasis on the individual. It has some good elements on providing a greater emphasis on tackling inequalities in health to close the gap; ensuring marginalised and excluded communities benefit from faster improvements and a strong focus on building partnerships.

Gail said that the amazing view from the assembly chamber, of the spiral ramp that goes up through the middle of her base at City Hall, is reminiscent of efforts in tackling health inequalities. It sometimes felt like going round and round in circles “but you will see the glimpse of progress and that is what keeps us going. We are going round in circles, but we are making progress and building slowly on the learning that we all experience in our efforts to bridge the gap”

London's profile in terms of health inequalities, major causes of ill health and the complex determinants of health, were summarised. On the map of London's local authorities, male life expectancy in Brent, was selected as one of the more deprived profiles. Gail felt that as a wealthy city, the extent of inequality, with many living in poverty in London, was a disgrace. The solution to addressing these issues lay in working in partnership to arrest the current trends and set targets locally, concentrating on the most deprived wards. Timely information would be needed to enable measurement of progress in the short to medium term. to assess the reduction in the health divide.

HAZ Debate

'This House believes that Partnership Working is the Most Effective Way to Tackle Health Inequalities'.

The conference moved on to one of the highlights of the day, the HAZ Debate. This was a lively, energetic and entertaining stage-managed event, in which each candidate presented a forceful argument for why their case should be supported. The motion were presented in dramatic style for the purpose of illustrating extreme 'for' and 'against' positions to the motion.

Speaking for the motion - Patrick Lewis, of Harlesden and Stonebridge Neighbourhood Renewal Team. Speaking against the motion – Jackie Collins, Brent HAZ. This was followed by discussion in groups on the issues raised in the debate and by the registering of group votes. The motion was carried.

Key points against the motion

- Partnerships do not work because partners have their own priorities, lines of accountability and legal constraints
- There is no level playing field. There is a system of 'first amongst equals' for those who have money and why should they share their money with the have-nots ?
- The '3' problem: active partners; inactive partners; lame ducks
- Partnerships worry about how they going to run partnerships and get caught up in "we need to negotiate the approach" rather than getting on with what needs to be done.

Key Points for the motion

- Partnerships a tool for the 21st Century. Not one agency can solve societies problems, resulting from the wider determinant of health, on its own. While silo mentality has helped to exacerbate problems partnerships are the best way to achieve a successful and sustainable outcome
- Rather than splitting resources, partnerships offer the possibility of pooling resources and getting added value on investments
- Good partnerships have to be worked at, ensuring clear objectives, clear expectations of responsibilities and shared objectives which motivates and leads to results for stakeholders
- The beauty of partnerships lies in its diversity and the recognition of the value of the different strengths and attributes that each part partner brings to the table. That is why it is not and should not be, a level playing field

Debate Discussion Groups

There were 7 debate discussion groups in which the issues raised within the debate were discussed. The groups were facilitated by: Brigitte Dingle, Cath Kane, Chris Baguma, Danny Maher, Flora Baafuo-Awuah, Marco Inzani and Vigi Rajagopalan

Group 1 Facilitator Chris Baguma

Key points for the motion

- Sharing information / experience / networks / awareness
- Sharing of resources to achieve common goals
- Expertise specialising
- Equality of opportunity
- Avoid repetition & re-inventing the wheel
- Holistic problem solving
- Shared vision
- Better service provision – set to grassroots / needs
- Capacity building – clear direction
- Effective communication
- clarity & direction of terms, aims & objectives, code of conduct – monitoring & evaluation
- Inclusiveness / equality of opportunity, statutory, public, private, voluntary
- sharing of resources – information, expertise, experience, common goals, capacity

Against the motion

- partnerships don't translate into practice
- dominance in partnerships – money, power – use resources to achieve own goals
- left out issues in meetings – points not taken on board
- different agendas in partnerships – forming cliques
- absence of trust in partnerships – better said than done – talk shop
- unfairness / inequality / distrust / lack of recognition
- lack of co-ordination
- defined objectives – common realistic purpose
- compromise / accommodation is lacking
- not translated into practice – domination by cliques leading to guarded sharing of power, resources
- differing agendas – targets – lack of trust – power bases
- lack of co-ordination, mistrust, compromise, accommodation, unfairness, inequality

IN FAVOUR 11 AGAINST 0

DEBATE/DISCUSSION

Group 2 Facilitator Cath Kane

This group was unanimously in favour of the principle of partnership working. Discussion arose in relation to the reality of partnership working, particularly experiences of inequality.

Key points

- Idea is good. The reality is different.
- Inequality rather than equality is inherent in the process
- Lack of adequate funding and resources hinders effective implementation of partnership working and actions.
- Different individuals give different inputs, this has a direct effect on outcomes – partnership working is a process of managing many different variables. If there is no commitment to taking inequality into account, the process of partnership won't work.
- Lack of committed resources can act as a barrier. All sectors operate within a constantly changing environment. Priorities change all the time.
- There must be clarity about the rules of engagement in the partnership process so that partners know how they are expected to contribute
- Strong Chair is important; someone with an understanding of group dynamics & processes as well as having an understanding of inequalities in power & how these can be redressed.
- There needs to be a willingness to change by all partners /contributors otherwise the process won't work.
- There needs to be an understanding of different languages & cultures on all sides, including organizational differences as well as ethnicity & race; this is a lot about building the capacity of partners to be able to communicate effectively with each other.
- Theory without practice is sterile'
- Representation is an issue; the voluntary sector is vast, no single organization can represent all interests.
- Time & resources need to be allocated to support networking & develop understanding.
- Closure on partnership projects is important when objectives have been achieved.

IN FAVOUR 10 AGAINST 0

Group 3 Facilitator Danny Maher

Key points

- Lots of experiences of good partnerships and bad partnerships.
- Good partnerships help maximise outcomes, understand community needs, ensure appropriate people are on board and delivery, tolerate peoples pressures, and work to a common goal.
- Some people did have experiences that it was better to go it alone to implement a lot quicker, but the majority agreed that we need partnerships to implement a lot better. Quote "you need two hands to clap"

IN FAVOUR 9 AGAINST 1

Group 4 Facilitator Brigitte Dingle

Key points

- There was no contest as far as this group was concerned between going it alone and partnership working.
- Everyone immediately agreed that partnership working was the only way forward and mainly debated the positive aspects. There were some caveats however – when forming partnerships the agenda must be very clearly set out with the expectations and constraints of each organisation being detailed. Voluntary and community organisations often felt "small" and unsure of their worth in partnership situations when faced with the power of large statutory organisations.
- Partnership working helps maximise efforts and helps the statutory organisations to reach targets.
- Without the help of voluntary organisations it would be difficult to reach people in certain communities.

IN FAVOUR 8 AGAINST 0



Group 5 Facilitator Marco Inzani

- Lots of experiences of good partnerships and bad partnerships.
- Good partnerships help maximise outcomes, understand community needs, ensure appropriate people are on board and delivery, tolerate peoples pressures, and work to a common goal.
- Some people did have experiences that it was better to go it alone to implement a lot quicker, but the majority agreed that we need partnerships to implement a lot better. Quote “you need two hands to clap”.

IN FAVOUR 9 AGAINST 1

Group 6 Facilitator Flora Baafuo - Awuah

The overall outcome of the group of 10 was a unanimous vote in favour of the motion as the multiple benefits of partnership working made it the preferred option. It was agreed that partnership work is a new concept and will take some hard work to implement it effectively. However, the following were some of the challenges perceived to hamper its success and progress:

Key points

- The need to clearly define what partnership is.
- Some partnership have unequal partners, statutory organizations tend to dominate and voluntary sector organizations, because of the need for funds, have had to sometimes compromise or go along with discussions.
- The need to have clear definition of roles and responsibilities.
- The need to share risks.
- The need to empower voluntary organizations in responding to the needs of the ‘hard to reach’.
- The need for realistic targets and goals to be set for voluntary sector groups.
- The need for statutory organizations to actively involve voluntary and community based groups in their planning and decision making process.
- The need for clear communication lines between partners (both top bottom and bottom up).
- The necessity to prevent situations where partnership working has delayed work, due to protocols and bureaucracy.

IN FAVOUR 10 AGAINST 0

**Group 7** Facilitator Viji Rajagopalan

Key discussion points on the pros and cons of partnership working. All group members voted in favour of partnership working.

Why partnerships don't work

- members of the partnership may have different constraints, differing priorities because agendas differ.
- Health sector attitude of “knowing it all”.
- There is no equal playing field between voluntary and statutory agencies.
- People can't influence change. The success of a partnership depends on the process of negotiating.

Why partnerships do work

- because no one service has a total understanding of health issues, government requirements, legal imperatives.
- Sharing resources in partnership avoids replication, risk is shared and brokered.
- Partnerships bring different assets to the work.

IN FAVOUR 11 AGAINST 0

Of the seven groups - all voted overwhelmingly in favour of the motion. Therefore the motion was carried.

Welcome back from Cllr Ralph Fox

The second part of the conference was opened by co-conference Chair, Cllr Ralph Fox, responsible for adults health and social care on Brent Council. Cllr Fox stated that this remit meant that he was firmly at the centre of partnership working with health partners and the community & voluntary sector. He welcomed the next speaker Ann O'Neill from Brent MENCAP

Tackling Health Inequalities: Learning Disabilities in Brent



Ann O'Neill introduced Mencap as a leading voluntary sector organisation representing and working on behalf of people with learning disabilities. Mencap works in partnership with a variety of partners including Social Services and Education. It

is affiliated to the national charity, Royal Mencap but operates separately and sometimes holds divergent views from the national body.

Generally people with learning disabilities have poorer health than the general population. Recent research shows that people with learning disabilities die younger, get a relatively poorer service from GPs and when they go into hospital. They suffer an additional range of health problems such as heart problems and have a much bigger chance of getting certain health conditions. With those that have thyroid problems or hearing and sight problems. The attitude is quite often "We won't do any thing because it is their learning disability" Brent MENCAP works with partners at the tPCT and hospitals to overcome this attitude.

The government issued a White paper 'Valuing People', in 2002 on people with learning disabilities. There was a recognition that people with learning disabilities were among the most marginalised groups and that national action was required. Councils and the tPCT then went about setting targets for people with learning disabilities in areas such as employment and home ownership. Big issues remain on social inclusion .

On the whole things have begun to change in Brent and other boroughs but evaluation of the programme three years on, has shown that little progress has been made and many boroughs are not hitting the targets.

Valuing people funding had been used to improve access to

housing - working closely with the housing department - for people with a learning disability and for a range of projects to reduce social isolation .

Royal Mencap have campaigned for the Department of Health (DoH) to undertake a study into why so many people with a learning disability die younger than the rest of the population. In the last year, the tPCT ran a programme on learning disability awareness for NHS staff. Out of about 1000 staff in Brent, eight turned up. From this it can be concluded that services to people with a learning disability is not high on the agenda.

The Brent Mencap website illustrates some the work being undertaken with partners in the tPCT to improve health with some Welren (West London Research Network) funding. One of the Valuing People targets around health is that everyone with a learning disability should have a health action plan and talk with a health professional or an advocate. In order to check whether action plans were working and made a difference, Mencap has set up a research project employing researcher with learning disabilities to find out from people if the action plan has made a difference. Mencap is also looking at the poor uptake of services by people from Black & minority ethnic communities with reference to Somali communities. A Somali worker has been employed to carry out this work with one of the Somali groups and carers. This partnership research will be used to influence policy and make a difference in improving the health of people with learning disabilities

Anne O'Neill concluded "Partnership working involves taking risks but is worth it, if it means an improvement in people's life chances."

Facilitated Panel Discussion: The Future for Brent: Getting Results on Shared Health Inequality Priorities

The conference ended with a Panel Discussion facilitated by freelance consultant, Clementine Femiola. The Panellists were: Sarbjit Ganger – Asian Women's Resource Centre, Jenny Goodall- Brent Social Services, Jacky Peacock – Housing Representative, Brent Community Network and Judith Stanton- Brent tPCT.

The aim of the discussion was to focus on looking to the future and addressing the following questions: how can effective partnership working on shared health inequality priorities be sustained over time in the future? What are the key drivers from the sectors represented around the table (community; voluntary; local authority; health), that would ensure that this would happen?

Each of the panellists talked about the policy drivers within their sectors which made working in partnership to reduce the health gap an essential requirement.



Sarbjit Ganger talked about about the Treasury cross-cutting review which highlighted the importance of the role and the need for capacity building of the voluntary / community sector (VCS) to enable a meaningful contribution to the delivery of shared local

priorities. The review lead to a document published by the Home Office entitled Capacity Building and Infrastructure Framework, which emphasised the valuable role of the VSC in delivering effective public services.

Sarbit emphasised the special role of the VSC in working closely with some of the most deprived communities that are at risk of social exclusion. It is crucial that this dimension of work is valued and brought to partnership working in order to address health inequalities effectively. This is a central drive from government – based on the recognition that effective involvement of multi-sectoral stakeholders in effective partnerships is more likely to deliver inclusive services.

Reference was also made to effective partnership working in the Domestic Violence Forum - Chaired by Sarbjit. The forum demonstrated that agencies such as the metropolitan Police, community and voluntary sector, council and health partners could work in partnership to achieve shared outcomes.



Jacky Peacock considered the role of the voluntary sector in dealing with grass roots issues and therefore having direct knowledge of how things really are. Very often Statutory organisation get so involved with achieving targets and can often paint

a rosy picture which bears little relation to what is actually happening on the ground. Jacky referred to a Housing report that recently came to the Local Strategic Partnership which showed glowing statistics of how the needs of vulnerable people were being met – the attitude was very much that there was no need to worry about this issue – where as, the reality on the ground seeing the numbers of harrowing cases was that there very much was a need to worry. This is why it is crucial that the input from the VCS is brought to bear on partnerships.

Judith Stanton discussed the Public Health White Paper Choosing Health and the opportunity that this gives to mainstream the health inequalities agenda. Partnership working

is being promoted top-down and bottom-up and this provides a vehicle for the delivery effective outcomes to improve the health of the population. The tPCT can not do this alone, it can only be done through partnership.



Judith mentioned the three themes of Choosing health: informed choice; personalisation; working in partnerships. Getting feedback from the most disadvantaged groups in terms of accessing services is critical. A small working group in the tPCT is putting

together a draft strategy. It has a patient representative who inputs to this. The strategy will be sent out for consultation and it is very important that a wide range of stakeholders contribute to this in order to ensure effective deliver on tackling health inequalities.

Jenny Goodall talked about the Local Authority's general duty to promote the well-being of its population and the Council tries to do that through a whole range of ways. In thinking about those areas that really contribute to health: housing, regeneration, economic well-being – ensuring that local people are encouraged into employment, public safety.

Jenny referred to the changes that have been brought by the introduction of the Children Act. The government have set a number targets and outcomes for children that the Council has to deliver on, particularly staying safe and healthy. In order to meet those responsibilities, a children's partnership board has been set up. The board represents a whole range of agencies including groups in the voluntary and community sector.

In addition, changes are coming about within the Council and partners in relation to services to older people. The recent joint inspection of older people's services has meant that partners need to look quite closely at the sorts of services being provided to older people, particularly from Black and minority ethnic communities. Reducing health inequalities for older people is a particular challenge because they are often doubly discriminated against in terms of age and very often low income, poor health and housing.

The panel discussion closed with reference to the imperative to maximise opportunities for tackling health inequalities within the Local Strategic Partnership - the borough wide partnership and in the forthcoming Local Area Agreement.

Conference Closure

Jean Gaffin closed the conference by thanking all who had attended, participated and organised the very successful conference and paid tribute to the tremendous work that had gone in to making it run so smoothly.

CONFERENCE EVALUATION FEEDBACK



Presentations

Dr Shafi was engaging and had keen interest in partnership for an important priority group

Great presentation from Gail – very experienced person and speaker with an accessible approach, gave specific examples/case studies and debated real issues

Delighted to see learning Disabilities covered, as L.D. is often excluded/not covered in conferences

The presentations delivered a lot of facts in an accessible and lively way, informed the debate which was useful to understanding issues, a good overview of what is happening in Brent.

Debate

Allowed discussion on both the strengths and the challenges facing partnership working

The debate generated many issues and it would have been useful to have followed up with some practical solutions to achieve partnership working.

The debate was engaging, interesting, very good, lively, and highlighted some key issues.

Facilitated Round Table Discussion

Allowed individual sectors to compare their views on the importance of partnership working now and into the future

This was brilliant

Venue

Room was far too cold, air conditioning was turned up too high which made it hard to concentrate

Venue was not accessible to wheelchair users

Better sound system – some people in the back could not hear very well

Lack of salad/vegetables during lunch, vegetarians not well catered for

Beautiful space, quite clean toilets etc.

How the Programme Could have been Improved

Telling us what difference HAZ has made to health outcomes & what challenges remain

A video clip on Tuberculosis, Cancer, or Diabetes

I would like to see clear exit strategy to HAZ. I would like to see Health inequality body representing all the service providers to replace HAZ.

General Comments

The conference was well presented, well done! I thoroughly enjoy the day and gained a lot of information & knowledge.

The day was excellent and a great turnout. Many Brent faces and contributors who really made the day interesting and a real learning experience. Well done, a great and useful day. Thanks for all your hard work folks!

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