

GO-NW Health Support Package: Final Report September 2006

Tim Blackman, Neighbourhood Renewal Advisor

1 Summary and recommendations

- 1.1 This report identifies factors associated with whether the 21 Local Strategic Partnerships in the North West funded by the Neighbourhood Renewal Fund have been closing their relative gaps in teenage conceptions and premature deaths from circulatory diseases and cancers. It describes how LSPs can learn from each other in the light of these findings and sets out a reporting framework for performance assessment of the NRF health targets. The report is a revised version of the earlier draft report, which it replaces.
- 1.2 There is a mixed picture of LSP performance against these targets. In six of the 21 LSP areas there has been a narrowing of the gap in circulatory diseases mortality, in eleven there has been a narrowing of the gap in cancers mortality, and in ten there has been a narrowing of the gap in teenage conceptions. Most of the LSPs have experienced widening gaps since the inception of the Neighbourhood Renewal Strategy but the picture is not consistent. In only one LSP have all three gaps been narrowing and similarly there is only one LSP where all three gaps have been widening.
- 1.3 A survey of the LSPs was undertaken to gather data about ways of working and contextual factors that may be linked with their relative gaps, looking back three years as well as assessing the current situation. The questionnaire data were supplemented by a range of secondary data on each LSP area.
- 1.4 Relatively few factors from among the many included in the analysis showed systematic associations with change in relative gaps for each health target. However, those that did showed quite strong relationships. These factors were often different for each target.

Circulatory diseases

- 1.5 For circulatory diseases, the local context appears to make a significant difference as to whether the relative gap has been closing. Few LSP areas among those with higher deprivation or higher population turnover than the others had seen their gaps narrow. There is a case for focusing anti-poverty, employment, housing and neighbourhood sustainability programmes more strongly on this sub-set of NRF areas to tackle the wider determinants of their health inequalities. This could create a context more conducive to these LSPs achieving the narrowing of their gaps that most of the other LSP areas have achieved.

- 1.6 Subject to this qualification about context, two types of intervention were associated with the circulatory diseases gap closing. These were giving the same priority to intervening to change the environment as to individual interventions, and good targeting and delivery of secondary prevention.
- 1.7 There has been a marked shift over the last three years to ways of working that appear to be more successful in tackling the circulatory diseases gap. However, a small minority of LSPs have not made this shift, a significant group are still relying predominantly on individual commitment and champions, and most still report that there are not good plans and systems in place.
- 1.8 Given that secondary prevention of premature deaths from circulatory diseases is within the frame of NHS performance management, there is an important role for NR performance management to ensure that primary prevention continues to have a high priority across the local NHS, local government and partner organisations.

Cancers

- 1.9 The local context also appears to make an important difference to the cancers gap. No LSP areas with lower liveability, only one with higher deprivation and only two with higher population turnover have seen their gaps narrow. Where these contextual factors are not favourable it is still possible for the gap to be narrowing but in a particular combination of circumstances. This was when joint meetings with partners were described as about finding win-wins *and* there were proactive and effective smoking cessation services in place.
- 1.10 Joint meetings between partners that were about finding win-wins were associated with a distinctive mix of activities in those areas that stated this description fitted their locality. This often took the form of delivering health initiatives and messages through non-health care settings and activities, and improving cross-referral and joint training between agencies.
- 1.11 The working practices associated with successful outcomes for the cancers gap are more common now than three years ago. This is especially the case for smoking cessation services. However, an appreciable minority of LSP areas reported that joint meetings between partners are not about finding win-wins and that their understanding and targeting of inequalities in cancer mortality are less than good.

Teenage conceptions

- 1.12 A wider range of factors than for circulatory diseases and cancers were associated with closing the teenage conceptions gap, but a cluster of attributes were important. These all related to the quality of partnership working and the high priority given to tackling teenage conceptions.
- 1.13 In addition, two approaches to intervention were associated with a narrowing gap: a major focus on lifestyle interventions and many smaller initiatives rather than – or alongside – a few major interventions.

- 1.14 LSP areas where the teenage conceptions gap has been narrowing were much more likely to review their progress at least quarterly rather than over longer periods.
- 1.15 Relatively low population mobility appeared to be a favourable context making closing the teenage conceptions gap more likely.
- 1.16 Working practices associated with a narrowing of the teenage conceptions gap are more common now than three years ago. However, some LSP areas have not adopted these practices and some have shifted to focusing only on a few major interventions.

System factors

- 1.17 System factors are attributes of the wider working environment such as the quality of partnership working and relationships with Government Office. They were most significant for teenage conceptions. Only one system factor appeared to affect progress with the circulatory diseases gap: initiatives relying on individual commitment and champions for success. Similarly, only one system factor was associated with the cancers gap: whether joint meetings between partners were described as about finding win-wins.
- 1.18 Relationships with Government Office varied according to the issue and have generally improved over time in terms of assessments of their value. GO-NW is regarded as providing most support for tackling teenage conceptions.
- 1.19 Over three years, the role of LSPs has shifted from being seen as largely passive to having a stronger role in setting directions and holding partners to account. However, it is still only a minority of LSPs where this is happening, and there is clearly progress to be made with establishing this role.

Performance assessment

- 1.20 A pro forma for collecting data to support LSP performance assessment is set out at the end of this report. This is designed to facilitate a process of identifying the floor target, the drivers that contribute to change in the floor target, and the 'theory of change' that links intervention programmes to these drivers.

Recommendations

- a) The sub-set of LSPs that have so far failed to narrow their relative gaps in circulatory diseases or cancers mortality should receive more support for interventions in the wider determinants of their health inequalities, such as anti-poverty, employment, housing and neighbourhood improvement and sustainability programmes.
- b) Interventions that improve the environment in ways that impact on risk factors for circulatory diseases, and good targeting and delivery of secondary prevention, should receive a high profile in LSP plans to tackle inequalities in premature deaths from circulatory diseases.
- c) LSPs should demonstrate the win-wins planned and achieved by joint meetings between partners to tackle inequalities in early deaths from cancers. They should also demonstrate how local smoking cessation services are both effective and proactive in tackling inequalities.
- d) LSPs should give particular attention to the quality of partnership working to tackle teenage conceptions, give the issue a high priority, undertake regular (at least quarterly) monitoring, focus on lifestyle interventions, and run many small initiatives rather than, or alongside, a few major interventions. Performance assessment should focus on these aspects.
- e) Most LSPs need to devote more attention to setting directions and holding partners to account.
- f) NR performance management should ensure that NHS performance management of health care services and their outcomes is complemented by a strong focus on performance assessing the contribution of primary prevention and tackling the wider determinants of health inequalities.
- g) LSP plans should be regularly updated to capture the dynamic nature of the health floor targets.
- h) LSP plans should demonstrate plausible modelling of how interventions will put in place the resources and reasons for change to occur. Option appraisal should support the choice of intervention.
- i) Monitoring should include both progress to date and monitoring of the contextual factors likely to affect progress.
- j) NR, LAA and NHS performance assessment for health inequalities should be aligned across the GO-NW region and this should be mirrored in local performance management systems for tracking shared targets.
- k) Local performance management systems should be designed to link targets, drivers and programmes in a causal chain that supports regular monitoring and assessment of risk. There should be policies in place for how different levels of risk will be addressed.

- l) The results of this assignment should be used to inform the development of a range of learning initiatives designed to exchange knowledge between LSPs about effective practices.

- m) This exercise should be repeated in three years time so that the relationship between ways of working and health outcomes can be investigated over a longer time span, providing firmer evidence about the contribution of these ways of working and contextual factors to floor target performance.

2 Aims and tasks

2.1 In December 2005, Government Office for the North West commissioned Tim Blackman, a Neighbourhood Renewal Advisor based at Durham University, to undertake a package of work with the following aims:

- To identify from across the 21 Local Strategic Partnerships in the North West receiving support from the Neighbourhood Renewal Fund those activities/initiatives most consistently linked with success in meeting health floor targets, taking into account local contexts and wider evidence about 'what works'.
- To identify opportunities for the 21 LSPs to support each other by facilitating cross-LSP learning and the exchange of best practice.
- To develop a reporting template for performance management of the NRF LSPs.

2.2 The main tasks undertaken over the 20 days of the assignment were:

- Reviewing a range of background documentation, including performance management reports from the region's PCTs; reviews and self-assessments by the LSPs and GO-NW comments on them; and LSP NRF improvement plans.
- A statistical analysis of progress being made by each of the 21 NRF LSPs with circulatory diseases, cancers and teenage conceptions.
- Collation of a range of contextual data on each LSP area.
- Delivery of a workshop in Wigan on 20 January 2006 to consult with LSPs on design of a survey to gather data on their ways of working and how contextual factors affect their work.
- Design of a questionnaire for the LSP survey, incorporating feedback from the Wigan workshop.
- Execution of the survey and data input for analysis.
- Analysis of survey results and preparation of findings as a Powerpoint presentation.
- Presentation of the findings and facilitation of a workshop to discuss the results at the North West health inequalities conference held in Wigan on 10 March 2006.
- Follow-up of survey non-responders.
- Further analysis of survey data, including written comments and examples submitted with the questionnaires.
- Development of proposals for a performance management reporting system and template.
- Attendance at three LAA health block meetings in Manchester to discuss methods, questionnaire design and the draft report.
- Attendance at three meetings with GO-NW in Manchester to discuss planning and progress.
- Submission of a draft report in May 2006.
- Review of comments, addition of some late questionnaire returns, further data analysis, revision of draft report and submission of final report in September 2006.

- 2.2 In addition, a presentation on the assignment was made at a Neighbourhood Renewal Unit seminar on 11 July 2006.

3 Floor target performance

- 3.1 NRF is intended to enhance the design and delivery of mainstream programmes and services for disadvantaged neighbourhoods and groups. Its importance is in helping to identify new ways of working that are more effective at improving outcomes for disadvantaged people and the neighbourhoods in which they live. The national NR strategy sets neighbourhood renewal for the first time within a national framework of accountability. LSPs receiving NRF are expected to provide leadership, and Government Offices are responsible for ensuring that they account for their progress and for supporting them to improve performance.
- 3.2 LSP performance is assessed mainly in relation to NR floor targets, which form part of PSAs and LAAs and are 'inequality targets'. The main health targets are by 2010 to reduce by at least 10% the relative gap in life expectancy between the England average and the fifth of local authority areas with the worst health and deprivation, and to reduce by at least 10% the relative gap in infant mortality between routine and manual social classes and the average for England and Wales.
- 3.3 The main contributors to the life expectancy gap are circulatory diseases and cancers. There are therefore specific targets to reduce premature mortality from heart disease and stroke to achieve a 40% reduction in the gap between the national average and the worst areas, and from cancer so that there is a 6% reduction. There are also two targets to tackle the underlying problems of ill health by reducing adult smoking to 21% or less, with a reduction to 26% or less for routine or manual groups, and reducing the under-18 conception rate by 50%, with faster progress in the most deprived wards. A further target added by the 2004 Spending Review is to halt the year-on-year rise in obesity among children under 11 by 2010. These are national targets and NR areas are expected to formulate local targets to meet them and to establish similar targets for closing gaps *within* their areas.
- 3.4 An analysis was undertaken for this assignment to establish the recent trends for each LSP regarding inequalities in premature mortality due to circulatory diseases and cancers and in teenage conceptions. It was agreed with GO-NW to measure these gaps in terms of trends over recent years in relative differences between the NRF and non-NRF local authority areas in the North West region. Thus, the analysis looks at inequalities within the North West and the extent to which the NRF areas are closing the gap with their non-NRF neighbours.
- 3.5 Table 1 shows the results of this analysis. Overall, in six LSP areas there has been a narrowing of the gap in circulatory diseases mortality, in eleven there has been a narrowing of the gap in cancers mortality, and in ten there has been a narrowing of the gap in teenage conceptions.

Table 1: Change in relative gaps between NRF areas and the non-NRF average in the North West

A value of '1' in the columns for 1998-00 and 2002-04 would indicate no difference compared to the non-NRF average. The higher the number, the greater the gap. The shaded cells identify a widening relative gap.

	Circulatory diseases mortality < 75 years			Cancers mortality < 75			Teenage conceptions (15-17 years)		
	1998-00	2002-04	Change	1998-00	2002-04	Change	1998-00	2002-04	Change
Allerdale	1.17	1.01	-16.16	1.07	0.99	-7.62	1.02	1.04	2.14
Barrow-in-Furness	1.12	1.27	14.69	1.16	1.22	5.53	1.42	1.26	-16.04
Blackburn with Darwen	1.29	1.35	5.47	1.17	1.25	7.98	1.45	1.37	-7.39
Blackpool	1.29	1.39	10.84	1.20	1.20	0.76	1.79	2.15	35.76
Bolton	1.19	1.31	12.08	1.12	1.09	-3.48	1.36	1.46	9.99
Burnley	1.31	1.39	7.79	1.27	1.27	0.48	1.71	1.68	-3.08
Halton	1.22	1.28	6.23	1.29	1.26	-2.56	1.32	1.26	-5.81
Hyndburn	1.24	1.19	-5.35	1.10	1.15	5.53	1.69	1.63	-5.85
Knowsley	1.35	1.39	3.76	1.28	1.41	12.94	1.28	1.28	-0.08
Liverpool	1.39	1.44	5.47	1.39	1.34	-4.87	1.39	1.22	-16.95
Manchester	1.51	1.65	13.57	1.45	1.39	-6.42	1.59	1.78	19.50
Oldham	1.43	1.41	-1.87	1.21	1.21	0.76	1.49	1.60	10.45
Pendle	1.18	1.27	9.25	0.93	0.90	-2.74	1.42	1.33	-9.29
Preston	1.21	1.19	-1.66	1.00	1.05	5.07	1.26	1.44	17.98
Rochdale	1.32	1.53	20.69	1.15	1.20	4.70	1.47	1.44	-2.99
Salford	1.31	1.45	13.72	1.29	1.33	3.29	1.51	1.57	6.07
Sefton	1.02	1.06	3.09	1.15	1.10	-4.58	0.94	0.95	0.80
St Helens	1.22	1.18	-4.66	1.12	1.10	-2.16	1.44	1.38	-6.57
Tameside	1.34	1.35	0.54	1.19	1.17	-2.29	1.34	1.52	18.45
Wigan	1.33	1.33	-0.73	1.18	1.12	-6.51	1.43	1.47	4.46
Wirral	1.02	1.09	6.76	1.17	1.16	-0.92	1.21	1.24	2.36
Non-NRF averages (rates per 10,000)	12.65	9.70		13.13	12.05		392	357	

3.6 Table 1 indicates that half or more of the LSPs have experienced widening gaps since the inception of the Neighbourhood Renewal Strategy but the picture is not consistent. Some LSPs where the circulatory diseases gap has been narrowing have been experiencing a widening of their cancers or teenage conceptions gap. In only one LSP have all three gaps been narrowing (St Helens) and similarly there is only one LSP where all three gaps have been widening (Blackpool). Given these different performances there is likely to be an opportunity for LSPs to learn from each other about what is working best in the North West to narrow these gaps. Most LSPs have something to contribute, given that in 20 of the 21 LSPs at least one of the gaps is narrowing.

4 Finding out what's working

4.1 A recent report commissioned by the Neighbourhood Renewal Unit identifies a number of success factors associated with successfully meeting floor targets (GFA Consulting, 2005). This study was concerned with the targets for crime, education and worklessness, but the results are likely to be of general relevance. They helped inform design of the survey of NRF LSPs undertaken for this assignment.

4.2 The GFA study found that success was associated with:

- A concerted focus on the issue.
- The cumulative impact of a variety of actions rather than a single 'big bang'.
- Targeting, concentrating on some types of problem and some areas more than others.
- Breaking down issues to be managed by working groups.
- Regular meetings to review progress.
- Clarity about what needs to be done.
- Questions asked of those not meeting targets.
- Partnership working with shared goals and budgets.
- User-centred projects with a personalised approach.

4.3 The GFA methodology was based on selecting four LSP areas with contrasting performance and, by reading their strategies and interviewing local informants, identifying factors that were associated with successful progress against the floor targets. Given the time constraints for this assignment, the most efficient way to gather similar information about local factors was to undertake a self-completion survey of key informants in each LSP. This enabled all 21 NRF LSPs to be surveyed and had the advantage compared with the GFA methodology of administering a standard set of questions about the ways of working and contextual conditions prevailing in each LSP area. The answers could then be compared with the data in table 1 to explore whether there are any relationships between these attributes and health outcomes.

4.4 In order to make these comparisons, LSP respondents were asked to report on ways of working and contextual conditions prevailing three years ago so that comparisons of these with the health trend data would be more valid. The health trend data are not totally up-to-date and it takes time for interventions to

have an impact. An attempt was made to take these lags into account by looking back a few years. This meant that some LSPs could not be included in the analysis because informants were not in a position to assess what was happening three years ago. Informants were also asked about ways of working and contextual conditions now, enabling changes in these attributes over the last three years to be compared.

- 4.5 There is potentially a very large number of attributes that could be surveyed to capture these different ways of working and contextual factors. The questionnaire was designed to be comprehensive but to include only those attributes that evidence points to as likely to be relevant to outcomes or that participants in the Wigan workshop considered important. It was based on self-assessment with an invitation for responses to be evidenced by examples and case studies. The survey was administered by Durham University and respondents were guaranteed confidentiality, with no LSPs being individually identified in the analysis.
- 4.6 Three questionnaires were developed for each of circulatory diseases, cancers and teenage conceptions. GO-NW provided the names and addresses of the local informants who would be appropriate to answer each questionnaire, generally in the local PCT. Many of the questionnaires were completed following wider consultation with colleagues by these local contacts.
- 4.7 The achieved responses, after several reminders and follow-ups, are shown in table 2.

Table 2: LSP response rates

	Circulatory diseases	Cancers	Teenage conceptions
Complete return	15	12	14
Partially complete return*	5	7	3
No return	1	2	4

* Generally because respondents were unable to make assessments for 3 years ago

- 4.8 The three questionnaires can be found at the following web links:

Cancers:

<http://www.dur.ac.uk/resources/sass/Cancers%20questionnaire.pdf>

Circulatory diseases:

<http://www.dur.ac.uk/resources/sass/CD%20questionnaire.pdf>

Teenage conceptions:

<http://www.dur.ac.uk/resources/sass/Teen%20conceptions%20questionnaire.pdf>

- 4.9 The structure of the questionnaires for all three floor targets was as follows:
 - Introduction and instructions.
 - Respondent contact details and details of who contributed to the responses.

- Section 1: A series of self-assessment questions on 'ways of working' with scales from exemplary to less than basic, scale descriptors and space for written examples to evidence the assessment for:
 - Identification, understanding and targeting of health inequalities.
 - Partnership working at a strategic level.
 - Partnership working on the ground.
 - Reaching vulnerable groups.
 - Awareness of health dividends.
- Section 2: A series of diagnostic questions on:
 - Prioritisation of health issues.
 - Types of intervention strategy.
 - Timing of progress reviews.
 - Organisation of the health partnership.
 - Nature of joint meetings.
 - Working culture in the locality.
 - Relations with Government Office.
- Section 3. Typical interventions:
 - Schools, colleges and workplaces compared with community settings.
 - Environmental measures compared with individual interventions.
 - Conformity with a good practice example.
- Section 4. Local context:
 - Organisational leadership.
 - Organisational culture.
 - Extent of focus on primary care, acute care, lifestyles, and environmental and social conditions.
 - Role of the LSP.

4.10 To supplement the self-reported data on local context, some key variables from secondary data sources were added for each LSP as follows:

- *Index of Deprivation (IMD) 2004: Average score for local authority area.* For the analysis, the LSP areas were divided between those with lower deprivation scores (less than 30) and those with higher deprivation scores. This was based on inspecting how the scores cross-tabulated with the changes in the relative gaps in health outcomes.
- *Liveability score.* This has been calculated by MORI for every local authority area in England (Collinge, Duffy and Page, 2005). The score is based on a combination of resident survey responses about the visual quality of their neighbourhood and the proportion of the housing stock that is terraced or high rise housing. For the analysis, the LSP areas were divided between those with higher liveability (a score greater than 70) and those with lower liveability. As with the IMD, this was based on how the scores cross-tabulated with the changes in the relative gaps in health outcomes.
- *16-19 year-olds as a proportion of the total local population (2001 census).* This showed no relationship with the health outcomes and was not included in the analysis.

- *65 plus year-olds as a proportion of the total local population* (2001 census). This also showed no relationship with the health outcomes and was not included in the analysis.
- *Proportion of the local population in black and minority ethnic groups* (2001 census). This initially showed a relationship with the circulatory diseases outcomes but did not do so when other factors were included in the analysis.
- *Persons who moved address in the previous year* (2001 census). This is a measure of population turnover. For the analysis, the LSP areas were divided between those with lower population turnover (less than 12.5%) and those with higher turnover on the same basis as deprivation and liveability.

4.10 The data were coded for analysis using SPSS (the Statistical Package for the Social Sciences) and fsQCA. The latter is an analytical software package developed by the American sociologist Charles Ragin (Ragin, 2000). It works out causal combinations associated with given outcomes: in this case whether or not relative gaps in the floor target indicators have been narrowing. What causal factors are included in the model is a matter of judgement based on the wider evidence base, theory and empirical analysis. In this exercise, all the factors included in the questionnaire and from the secondary data sources had some justification for being regarded as possible causal factors from either the published evidence or from practitioners' theories about what was important, and which were shared at the Wigan workshop (such as the importance of individual commitment and champions). However, relatively few factors were found to show any pattern with whether or not the health target gaps were narrowing. This was explored by running crosstabulations in SPSS. Those factors that did appear to show a pattern were selected for inclusion in the QCA model. Running this model then enabled how these factors operate in combination to be investigated, particularly how these combinations relate in any systematic way to whether the gaps are narrowing. While the following commentary treats these factors as causal in relation to the gap outcomes, it is important to keep in mind that these are associations and so we cannot be definite about causation. The results, nevertheless, demonstrate some strong associations where causal links seem plausible.

5 Results for circulatory diseases

- 5.1 Table 3 shows the results of the QCA analysis for the circulatory diseases outcome. This outcome is shown in the final column of the table, with the darker-shaded 'Y' cells indicating a narrowing gap and the lighter-shaded 'N' cells indicating a widening gap. The table is split into two halves horizontally to distinguish these two groups of LSP areas. The rows in the table are the 17 LSPs included in the analysis.
- 5.2 Six factors demonstrated a relationship with the outcome when cross-tabulated with it. The presence of one of these in an LSP area is indicated by a darker-shaded 'Y' cell. The LSPs all have different combinations of these factors, except for two pairs of LSPs where the gap has not been narrowing.

- 5.3 Two features of the local context appear to have an important effect on whether the circulatory diseases gap has been closing: lower population turnover compared to other LSPs and, to a lesser extent, higher deprivation. These factors appear to be *necessary* conditions for the gap to have been closing but are not *sufficient*. In addition, it appears that there needs to be a distinctive approach to intervention, particularly promoting change in the environment with as much priority as individual interventions. Examples of this kind of environmental intervention are encouraging walking and improving the local food and retail environments of shops and catering outlets. However, this is not sufficient on its own. It needs to be combined with the more favourable contextual factors of lower population turnover or lower deprivation.
- 5.4 The influence of higher population turnover is difficult to interpret from this analysis alone. It may have an effect via poorer access to services and may be associated with lower 'social capital' in neighbourhoods with significant proportions of transient households.
- 5.5 Best practice in secondary prevention also appears important to narrowing the gap. LSPs reported whether they complied or not with the following practice: 'The large majority of people with symptomatic CHD in the locality are thought to be identified and a comprehensive programme of secondary prevention is being delivered in primary care practices with above average prevalence and high-risk groups'. Three out of five of the successful LSP areas stated that they conformed with this description. There were also three LSPs among the widening gap group that conformed, indicating again that a single attribute is not sufficient for success.
- 5.6 Prioritising tackling inequalities in circulatory diseases and initiatives predominantly relying on individual commitment and champions also appear to be important among the successful LSPs. However, these attributes are shared by a high proportion of the LSPs where the gap has not been narrowing. They only appear to be important when combined with effective approaches to intervention and favourable contexts.
- 5.7 Most of the LSPs where the gap has not been narrowing reported that initiatives relied predominantly on individual commitment and champions. The sustainability and effectiveness of this working culture may be an issue and was contrasted in the questionnaire with a statement that 'initiatives rely on good plans and systems largely independently of who is involved'. Table 4 shows the results of analysing what shifts in working practices have occurred over the three-year period, including whether there has been a shift from this apparent dependency on individual commitment and champions to relying on good plans and systems. Overall, there is a marked shift to ways of working that are associated with those LSP areas where the gap has been closing. However, a small minority of LSPs have not made this shift, a significant group are still relying predominantly on individual commitment and champions, and most still report that their area is not characterised as having good plans and systems working independently of who is involved.

Table 3: Factors associated with a narrowing gap in premature mortality from circulatory diseases

Initiatives rely on individual commitment and champions	Issue is prioritised over and above other inequalities	Best practice in targeting secondary prevention	Relatively low IMD	Promoting change in the environment has same priority as individual interventions	Relatively low population turnover	Gap closing?
Y	Y	Y	Y	Y	Y	Y
N	Y	Y	Y	Y	N	Y
Y	Y	N	Y	Y	Y	Y
Y	N	Y	N	Y	Y	Y
Y	N	N	N	N	Y	Y
Y	Y	N	Y	N	Y	N
Y	Y	Y	N	N	Y	N
N	N	Y	Y	Y	N	N
N	N	Y	N	Y	N	N
Y	Y	N	N	Y	N	N
N	Y	N	N	N	Y	N
Y	N	N	Y	N	N	N
Y	Y	N	N	N	N	N
Y	Y	N	N	N	N	N
Y	N	N	N	N	N	N
N	N	N	N	N	N	N
N	N	N	N	N	N	N

Table 4: Shifting working practices – circulatory diseases

Attribute	LSPs with the attribute:			
	3 years ago	Now*	Not now*	3 years ago but not now
Promoting change in the environment same priority as individual interventions	7	16	4	0
Best practice in targeting secondary prevention	6	16	4	0
Circulatory disease inequalities prioritised	9	18	2	0
Initiatives rely on individual commitment and champions	11	8	11	5
Initiatives rely on good plans and systems	2	7	12	0

* includes LSPs that were unable to assess the situation three years ago

- 5.8 These results can be considered against the wider evidence base. In England and Wales, mortality from coronary heart disease fell by 54% between 1981 and 2000 (Unal, Critchley and Capewell, 2005). It is estimated that about half of this large fall was due to primary prevention, a fourfold larger reduction in deaths than those estimated as attributable to secondary prevention. This emphasises the importance of achieving change in the environment, especially facilitating moderate exercise and healthier food retailing, catering and consumption. At a more general level, measures that reduce demand-control and effort-reward imbalances in working and neighbourhood environments are also likely to have significant effects (Blackman, 2006).
- 5.9 There is currently a substantial emphasis on primary care initiatives such as risk registers, statins and hypertensives to reduce circulatory diseases. This is often argued as a way of making faster progress towards the 2010 targets. There is some evidence from this analysis of the effectiveness of these interventions (the best practice example was modelled on them) but this should not mean losing sight of the strong influence of high deprivation, high population turnover and effective environmental interventions on inequalities in premature deaths from circulatory diseases. Given that secondary prevention is within the frame of NHS performance management, there is an important role for NR performance management to ensure that primary prevention has a high priority across the local NHS, local government and partner organisations.

6 Results for cancers

- 6.1 Table 5 shows results from the same type of analysis as for circulatory diseases. Three of the six factors that differentiate to a substantial degree between LSP areas where the gap has been narrowing and those where it has not are contextual: liveability, deprivation and population turnover. In one LSP area with relatively high liveability and relatively low population turnover, the gap has been narrowing despite sharing none of the ways of working of the other LSP areas with narrowing gaps.
- 6.2 Liveability has a strong contextual effect, with all but three of the LSP areas where the gap has been closing having relatively high scores. This is not the case for any of the LSP areas where the gap has been widening, suggesting that the visible quality of the physical environment has a role to play in premature cancers deaths. One way this might be working is through the effect of low liveability environments on increasing the likelihood of smoking. A link between living in poor quality environments and a higher prevalence of smoking in the population has been suggested by several studies, and better quality environments may be conducive to smoking cessation services having a greater impact (Parkes and Kearns, 2006).
- 6.3 Local practices also make a difference but appear more likely to do so in combination with these contextual conditions being favourable. Where contextual conditions are not favourable, a single combination seems to be particularly important to the chances of success: joint meetings with partners that are about finding win-wins combined with proactive and effective smoking cessation services. The latter was self-assessed against the following

statement: ‘The cessation support needs of smokers in high prevalence groups and areas are well-understood and smoking interventions work to overcome cultural and environmental barriers to quitting as well as providing NRT and Zyban largely reactively to people who want to quit (in other words, you are confident that a substantial number of smokers are quitting *who would have been unlikely to have quitted without the work going on in your area*).’

6.4 With unfavourable contextual factors and this combination being absent, one LSP still has a narrowing gap. In this case success is associated with its combination of proactive and effective smoking cessation services and good/exemplary understanding and targeting of inequalities. Another LSP area, however, has a similar profile but a widening gap, suggesting that outcomes are unpredictable with so few favourable factors in place.

Table 5: Factors associated with a narrowing gap in premature mortality from cancers

Good/exemplary understanding and targeting of inequalities	Relatively low population mobility	Relatively low IMD	Proactive and effective smoking cessation services	Joint meetings with partners about win wins	Relatively high liveability	Gap closing?
Y	Y	Y	Y	Y	Y	Y
Y	Y	Y	Y	Y	N	Y
Y	N	Y	Y	Y	Y	Y
N	Y	N	Y	Y	Y	Y
N	Y	Y	Y	N	Y	Y
N	N	Y	N	Y	Y	Y
N	N	N	Y	Y	N	Y
N	Y	N	N	N	Y	Y
Y	N	N	Y	N	N	Y
Y	N	N	Y	Y	N	N
Y	N	Y	N	N	N	N
N	N	N	Y	N	N	N
N	N	N	Y	N	N	N
N	Y	N	N	N	N	N
N	Y	N	N	N	N	N
N	N	N	N	N	N	N
N	N	N	N	N	N	N

6.5 Table 6 shows how the working practices associated with successful outcomes are more common now than three years ago. This is especially the case for smoking cessation services. However, an appreciable minority of LSPs are reporting that joint meetings between partners are not about finding

win-wins and that their understanding and targeting of inequalities in cancer mortality are less than good.

Table 6: Shifting working practices - cancers

Attribute	LSPs with the attribute:			
	3 years ago	Now	Not now	3 years ago but not now
Joint meetings between partners are about finding win-wins	7	10	8	2
Best practice smoking cessation	9	18	1	0
Good/exemplary targeting of inequalities	6	11	8	0

* includes LSPs that were unable to assess the situation three years ago

6.6 The survey collected information on the interventions being undertaken in the LSP areas. Those doing well with the cancers target tended to be where smoking prevalence was surveyed at ward level; there was a focus on increasing the number of quitters in the most deprived areas; smoking cessation services had been integrated with neighbourhood management; there were extensive smoke free initiatives; there was focused work to improve awareness of breast and cervical cancer symptoms among target groups and to target inequalities in screening rates; there were health partnership sub-groups on topics such as physical activity and food with pooled funding; there were box schemes and playground markets to improve access to fruit and vegetables; vulnerable groups such as people with learning disabilities, travellers and asylum seekers were targeted to improve rates of screening and physical exercise; and there was cross-referring between dietetics, smoking cessation and exercise schemes and services. This range of activity seems to be captured by the attribute 'joint meetings between partners are about finding win-wins'.

7 Results for teenage conceptions

7.1 A larger number of attributes differentiated between LSP areas with narrowing or with widening relative gaps in teenage conceptions than with circulatory diseases or cancers. However, table 7 suggests that just by health partnerships prioritising teenage conceptions over and above other issues the relative gap can narrow. Ten of the 17 LSPs included in the analysis reported that they had prioritised teenage conceptions in this way. Eight of these had seen their gap narrow.

7.2 Other practices are in fact likely to follow from this commitment to prioritising teenage conceptions and this is also suggested by table 7. Giving high priority to teenage conceptions is indicative of a related set of characteristics that are common to most of the successful LSPs. These are excellent or good organisational leadership in the locality, an aspirational organisational culture, joint meetings where needs and responsibilities are clarified between partners,

and good or exemplary partnership working at a strategic level. These ways of working appear to make an important contribution to closing the gap. They also tend to be associated with distinctive approaches to intervention: a major focus on lifestyle interventions and, to a lesser degree, many smaller initiatives rather than – or alongside - a few major interventions.

- 7.3 In the three LSP areas where the gap is narrowing but leadership, aspirations and partnership working are not reported as being strong, these distinctive approaches to intervention are still in evidence. They appear to contribute to the success of these LSPs although, fortunately for them, in combination with one important favourable contextual factor, relatively low population mobility. Where this contextual condition is absent, strong prioritisation, leadership, aspirations and partnership working appear to be critical to success.
- 7.4 Table 8 shows that the apparently successful working practices for closing the teenage conceptions gap are all more common now than three years ago. However, some LSP areas have not adopted these practices. Some have also shifted away from taking many small initiatives instead of - or alongside - a few major interventions and projects towards just major interventions and projects.
- 7.5 A brief case study of Liverpool illustrates more tangibly the features of an LSP area where the teenage conceptions gap has been closing. The Liverpool Teenage Pregnancy Partnership Board has senior representation from partner agencies and meets quarterly to review progress and actions. It has three Implementation Groups: 'Better Prevention' working on sex and relationships education, 'Better Support' working on support for pregnant teenagers and parents, and 'Media and Communication'. The meetings are a means of holding partners to account for their contribution to reducing teenage conceptions. There is partnership delivery of multi-professional training in sex and relationships education (that includes foster carers) and sexual health networks in high-rate conception wards. Consultation with young people about service planning and evaluation takes place, and there is an outreach team targeting organisations working with groups known to be most at risk of teenage pregnancy.
- 7.6 Strong prioritisation and leadership, effective joint meetings that establish responsibilities, and good partnership working at a strategic level are necessary to achieve the range of initiatives and the focus on lifestyle interventions that can have an impact on teenage conception rates. Teenage conceptions are a marker of the wider issue of well-being among young people and need to be addressed by tackling its wider determinants. While deprivation is often cited as an important factor in this respect, this analysis has identified population turnover as an issue in making progress with narrowing the relative gap in teenage conceptions. Instability in young people's lives is likely to affect their behaviour, health and educational achievement. Young people who have been abused or neglected are more at risk of becoming teenage parents and more likely to live in less stable neighbourhoods. There is also evidence that depressing and disadvantaged neighbourhoods create contexts for high risk behaviours such as unprotected sex (Cohen *et al.*, 2000).

Table 7: Factors associated with a narrowing gap in teenage conceptions

Relatively low population mobility	Major focus on lifestyle interventions	Progress against targets reviewed at least quarterly	Many smaller initiatives	Good/exemplary partnership working at a strategic level	Joint meetings between partners clarify needs and responsibilities	Aspirational organisational culture locally	Excellent/good organisational leadership locally	Teenage conceptions prioritised by health partnership compared to other inequalities	Gap closing?
N	Y	Y	Y	N	Y	Y	Y	Y	Y
N	Y	Y	N	Y	Y	Y	Y	Y	Y
N	N	Y	Y	Y	Y	Y	Y	Y	Y
N	Y	Y	Y	N	Y	Y	Y	Y	Y
N	Y	N	Y	Y	N	Y	Y	Y	Y
Y	N	N	Y	Y	N	Y	Y	Y	Y
N	N	N	N	Y	Y	Y	Y	Y	Y
Y	N	N	Y	Y	N	N	N	Y	Y
Y	Y	N	Y	N	Y	N	N	N	Y
Y	Y	Y	Y	N	N	N	N	N	N
N	Y	Y	Y	N	Y	Y	Y	N	N
N	Y	N	Y	Y	N	Y	Y	N	N
Y	N	N	N	Y	N	Y	N	Y	N
N	N	N	Y	N	N	N	Y	N	N
N	N	N	N	N	N	Y	N	Y	N
N	N	N	Y	N	N	N	N	N	N
Y	N	N	N	N	N	N	N	N	N

Table 6: Shifting working practices – teenage conceptions

Attribute	LSPs with the attribute:			
	3 years ago	Now	Not now	3 years ago but not now
Teenage conceptions prioritised above other issues	10	14	3	1
Excellent/good organisational leadership	10	13	4	0
Aspirational organisational culture	11	14	3	0
Joint meetings between partners that clarify needs and responsibilities	7	12	5	0
Good/exemplary partnership working at strategic level	8	15	2	0
Many smaller initiatives rather than – or alongside – a few major interventions	12	10	7	5
Major focus on lifestyle interventions	8	14	3	1

- 7.7 Tackling the impact of deprivation and instability on children and young people’s lives means reducing poverty and improving housing and neighbourhood conditions. National policies are critically important but local practices make a substantial difference. They are likely to be most effective where they raise the aspirations of young people. This means putting in place the resources and reasons for finding identity and esteem in other ways than early parenthood, with achieving qualifications and employment being key aspirations in this respect (Graham and McDermott, 2006).
- 7.8 Targeting teenage conceptions and monitoring performance are handicapped by the delay of two years or more in the availability of ward-level data from the Office of National Statistics. Regular reviewing of actions and progress cannot be achieved by just using ONS data and requires developing local systems that can be updated regularly by drawing on local births data. These data can also be used to explore relationships between teenage birth rates and school catchments, deprivation, ethnicity, neighbourhood type and educational achievement. It is worth noting that the LSPs where the teenage conceptions gap has been narrowing were much more likely to review their progress at least quarterly rather than over longer periods.

8 System factors

8.1 System factors included in the survey were:

- Functioning of the local health partnership, including progress reviews and whether there are separate working groups.

- The nature of joint meetings between partners in the locality: whether they are about obtaining more funding, shared goals and budgets, finding win-wins, clarifying needs and responsibilities or holding partners to account for meeting targets.
 - Working culture of the locality: whether initiatives rely on committed individuals and champions, team players or good plans and systems.
 - The health partnership's relationship with Government Office, ranging from adding value and assisting progress to being an obstacle to progress.
 - The quality of organisational leadership experienced through the health partnership, from excellent to poor.
 - Whether or not the local organisational culture experienced through the health partnership is aspirational, comfortable or complacent and inward-looking.
 - The quality of leadership from the LSP: setting clear directions and holding partners to account, a useful but not especially directive forum, largely passive receiving and sharing information, or a mixed picture.
- 8.2 System factors were most significant for teenage conceptions, accounting for the majority of attributes associated with whether or not the gap had been closing. These include good partnership working at a strategic level, the health partnership giving teenage conceptions high priority, good organisational leadership, an aspirational organisational culture, joint meetings between partners that clarify what needs to be done and by whom, and regular reviewing of progress against targets.
- 8.3 Only one system factor appeared to affect progress with the circulatory diseases gap: it was more likely to have been closing where the working culture was one of initiatives relying on individual commitment and champions. Unlike the favourable system factors for teenage conceptions, which are more common now than three years ago, this factor is less common now. This is a result of the shift towards relying on good plans and systems (although this is still not the case for most of the LSPs).
- 8.4 It was also the case that only one system factor appeared to affect progress with the cancers gap: it was more likely to have been closing where joint meetings between partners were about finding win-wins. From the evidence provided in the questionnaire returns, this often took the form of delivering health initiatives and messages through non-health care settings and activities - with a mutual benefit - and improving cross-referral and joint training between agencies.
- 8.5 Relationships with Government Office varied according to the issue and have generally improved over time in terms of assessments of their value (see table 7). GO-NW is regarded as providing most support for tackling teenage conceptions. One LSP assessed GO-NW as an obstacle to progress for circulatory diseases and cancers but as adding value for teenage conceptions.

Table 7: Health Partnerships’ relationships with Government Office

		<i>Adds value and assists progress</i>	<i>Helpful, but occasionally</i>	<i>Makes little difference</i>	<i>Obstacle to progress</i>
Circulatory diseases	<i>Now</i>	1	7	6	1
	<i>3 years ago</i>	1	4	10	0
Cancers	<i>Now</i>	3	6	4	1
	<i>3 years ago</i>	2	5	7	0
Teenage conceptions	<i>Now</i>	7	6	3	1
	<i>3 years ago</i>	5	6	5	1

8.6 Table 8 shows how the role of the LSP has shifted from being seen as largely passive to having a stronger role in setting directions and holding partners to account. However, it is still only a minority of LSPs where this is happening, and there is clearly progress to be made with establishing this role.

Table 8 Role of the LSP

		<i>Sets clear directions and holds partners to account</i>	<i>Useful forum but not especially directive</i>	<i>Largely passive, receiving and sharing information</i>	<i>Mixed picture</i>
Circulatory diseases	<i>Now</i>	6	8	1	1
	<i>3 years ago</i>	1	5	6	4
Cancers	<i>Now</i>	6	8	0	2
	<i>3 years ago</i>	1	7	4	4
Teenage conceptions	<i>Now</i>	7	6	0	3
	<i>3 years ago</i>	2	7	3	4

9 Learning opportunities

9.1 This exercise has identified a series of factors associated with closing relative gaps in circulatory diseases, cancers and teenage conceptions. These factors are the attributes of LSP areas where the gap has been closing, and these areas are likely to have positive lessons to share with LSPs where the gap has not been closing. Most LSPs have something to offer in this respect.

9.2 For circulatory diseases there are between four and eleven LSPs, depending on the attribute, that have not adopted practices that have been adopted by areas making better progress. This number is between one and eight for cancers and between two and seven for teenage conceptions. Table 9 shows the current situation across all the LSPs as to whether or not the most successful attributes have been adopted.

Table 9: Attributes associated with closing relative gaps in health outcomes: situation ‘now’ by LSP area

LSP area	Circulatory diseases					Cancers			Teenage conceptions							
	Promoting change in environment	Secondary prevention best practice	Prioritising	Individual champions	Good systems and plans	Joint meetings find win wins	Best practice smoking cessation	Good targeting of inequalities	Prioritising	Leadership	Aspirations	Joint meetings clarify needs/ responsibilities	Strategic partnership working	Many small initiatives	Regular reviews	Lifestyle interventions
1	Y	Y	Y	N	N	Y	Y	N	N	N	N	N	Y	Y	Y	N
2	Y	N	N	N	N	Y	Y	N	N	Y	Y	Y	Y	Y	N	Y
3	Y	Y	Y	No data	No data	No data	No data	No data	Y	Y	Y	Y	Y	Y	Y	Y
4	Y	Y	Y	N	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y
5	Y	Y	Y	N	N	N	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
6	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y
7	Y	N	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	N	Y	Y
8	N	Y	Y	N	N	Y	N	N	No data	No data	No data	No data	No data	No data	No data	No data
9	N	Y	Y	N	Y	N	Y	Y	Y	Y	Y	Y	Y	N	Y	Y
10	N	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	N	Y	N	N	Y
11	Y	N	Y	Y	N	N	Y	Y	Y	Y	Y	Y	N	Y	N	N
12	N	Y	N	Y	N	N	Y	N	Y	Y	Y	N	Y	Y	N	N
13	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
14	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	N	Y	N	N	Y
15	Y	N	Y	N	Y	N	Y	Y	Y	Y	Y	Y	Y	N	Y	Y
16	Y	Y	Y	Y	Y	N	Y	N	Y	Y	Y	Y	Y	Y	N	Y
17	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N	Y
18	Y	Y	Y	Y	N	N	Y	N	No data	No data	No data	No data	No data	No data	No data	No data
19	No data	No data	No data	No data	No data	Y	Y	Y	No data	No data	No data	No data	No data	No data	No data	No data
20	Y	Y	Y	Y	N	No data	Y	N	N	N	No data	N	N	No data	N	Y
21	Y	Y	Y	N	N	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data

- 9.3 There are four methods that could be used to exchange learning based on these findings:
- The 'non-adopters' could be paired in knowledge transfer partnerships with the 'adopters' as a type of organisational mentoring.
 - The 'adopters' could contribute workshops on how they have developed and implement their successful practices.
 - The 'non-adopters' could be given their profile from table 9 and requested to develop their own plans for how they might improve their profile.
 - Complementing any of the above approaches, the more detailed information from the questionnaire could be organised as a good practice guide, with case studies illustrating how a particular way of working is delivered in practice.
- 9.4 It is important not to neglect the contextual factors that appear to make a difference to floor target performance: deprivation, liveability and population turnover. These factors can be influenced by local action, such as welfare rights work, employment and training projects, and neighbourhood renewal. Additional resources and good practice guidance could be targeted on those LSPs facing particular challenges in these respects.

10 Performance assessment

- 10.1 This assignment has involved carrying out a special survey to explore the range of factors that contribute to performance against health floor targets. Given the three-year time frame used, it would be informative to repeat the exercise in three years time. This would enable the relationship between ways of working and health outcomes to be investigated over a longer time span, providing firmer evidence about the contribution of these ways of working and contextual factors to floor target performance.
- 10.2 The assessment of performance needs to focus on the factors likely to make most difference to performance. An aim of this assignment has been to help inform this focus. Generally, the performance assessment process needs to collect standardised and comparable data on:
- Targets, which are regularly updated to capture the dynamic nature of the health floor targets, which are to close the gap with England averages that are continuing to improve.
 - Interventions, with plausible modelling of how interventions will put in place the resources and reasons for change to occur. Option appraisal should support the choice of intervention.
 - Monitoring of progress to date.
 - Monitoring of contextual factors likely to affect progress.

- 10.3 Creation of the new regional SHA provides an opportunity to align performance assessment across the GO-NW region so that it jointly serves the requirements of NR, LAAs and the NHS. All these sectors share high-level targets for narrowing the gaps in life expectancy and infant mortality, which are essentially targets for *places* rather than solely for organisations. However, organisations have different contributions to make, with LSPs, local councils and PCTs able to impact on different drivers behind the same high-level target. These drivers are essentially second order targets that nest under the high-level or first-order targets. For example, for life expectancy the LSP could have targets for clarifying needs and responsibilities across the strategic levels of partner organisations, and for narrowing gaps between neighbourhoods; the local authority could have targets for improving housing or reducing accidents among the most disadvantaged sections of the local population; and the PCT could have targets for identifying residents at most risk of serious illness and implementing preventative treatments. The cross-sectoral performance management of these contributions requires drawing on the separate performance assessment systems of the LSP, local government and PCT, pooling these indicators in one overarching system. This would connect the different drivers to the high-level targets and enable them to be tracked using a control chart format so that trends and deviations from target trajectories can be identified.
- 10.4 A major weakness of many performance management systems is that they do not incorporate an ability to use evidence and learn from experimentation. Connecting drivers to targets is a means of doing this, essentially by stating a 'theory of change' regarding the effect of interventions on drivers and in turn the effect of those drivers on the target. For example, more and better targeted smoking cessation services could achieve an increase in smoking quitters that should impact on lung cancer prevalence and in turn impact on premature mortality and life expectancy. By stating these theories of change in a systematic way outcomes can be monitored and evaluated. Questions can then be asked about whether the right thing is being done or whether the right thing is being done in the wrong way.
- 10.5 To support this process a performance assessment framework needs to:
- Identify each target, its indicator(s) and the trajectory planned to meet it.
 - For each target, identify the drivers that impact on it and the indicator(s) for tracking change in the driver.
 - For each driver identify the intervention programmes that are expected to achieve significant change in the driver.
 - Nest the programmes, drivers and targets together as a causal chain.
- 10.6 Completing this process means that there is:
- a theory about what *drives change* to deliver targets.
 - data for monitoring the targets and the drivers.

- a theory about how interventions will provide the resources and reasons for drivers to move in ways that would not otherwise happen.
- A prediction that can be tested that the interventions will deliver the target.

10.7 Performance assessment uses this process to ask regularly:

- Whether the programme is the *right thing to do* compared with alternative options.
- Whether the programme is *being done right* compared with best practice.
- That it is the right thing to do, being done correctly, but external factors are working against the intervention so that the scope of intervention needs to be widened.

10.8 The following pro forma is an example of a template that can collect data for this process.

Performance Assessment Pro Forma

Floor target ¹ :		Lead Agency ²	Report date ³	Report no.
-----------------------------	--	--------------------------	--------------------------	------------

Key driver ⁴	Ref:	Description:	Cross-ref: ⁵
Indicator ⁶	Ref:	Description:	Collected by:

Key driver trajectories (quarterly reporting)⁷

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Target														
Actual														
Risk ⁸	■	■	■											

Relevant programmes⁹

Programme	Risk	Programme	Risk	Programme	Risk	Programme	Risk
	■						
	■						
	■						

¹ Neighbourhood Renewal Strategy floor target, e.g. reduce the gap in life expectancy between Oldham and the England average by 10% by 2010.

² The agency responsible for accounting for progress against the target, e.g. Oldham PCT.

³ For recording each report on progress and numbering cumulatively.

⁴ Each floor target will have one or more drivers, e.g. premature deaths due to circulatory diseases. The target trajectory for this and other drivers should be modelled so as to achieve the overall planned trajectory to meet the floor target. In all cases, narrowing gaps within the district should be identified as a driver for the overall target of narrowing gaps with the England average.

⁵ The cross-reference identifies any other floor targets for which this is also a driver. These shared drivers may receive additional priority and resources.

⁶ The indicator should be defined and the person or agency responsible for collecting and reporting on it identified.

⁷ Include the past trend as well as the projected trend

⁸ Traffic light the assessed degree of risk of not meeting the target given the roll-forward at each quarterly monitoring. There should be a policy for what actions follow an amber or red assessment.

⁹ These are the programmes that your theory of change argues are most relevant to having the desired impacts on the drivers, e.g. your smoking cessation programme. Risks should be highlighted where programmes appear not to be delivering as expected. There should be a policy for the actions that follow an amber or red assessment.

11 References

- Blackman, T. (2006) *Placing Health*, Bristol: Policy Press.
- Cohen, D., Spear, S., Scribner, R., Kissinger, P., Mason, K. and Wildgen, J. (2000) "Broken Windows" and the Risk of Gonorrhoea', *American Journal of Public Health*, 90 (2), pp. 230-236.
- Collinge, A., Duffy, B. and Page, B. (2005) *Physical Capital: Liveability in 2005*, London: MORI.
- GFA Consulting (2005) *Improving floor target performance: What works?* London: ODPM.
- Graham, H. and McDermott, E. (2006) 'Qualitative Research and the Evidence Base of Policy: Insights from Studies of Teenage Mothers in the UK', *Journal of Social Policy*, 35 (1), pp. 21-37.
- Milne, E. (2005). NHS smoking cessation services and smoking prevalence: observational study. *British Medical Journal*, 330, 760.
- Parkes, A. and Kearns, A. (2006) 'The multi-dimensional neighbourhood and health: a cross-sectional analysis of the Scottish Household Survey, 2001', *Health & Place*, 12 (1), pp. 1-18.
- Ragin, C. C. (2000) *Fuzzy-Set Social Science*, Chicago: University of Chicago Press.
- Swann, C., Bowe, K., McCormick, G. and Kosmin, M. (2003) *Teenage pregnancy and parenthood: a review of reviews*, Evidence Briefing, London: NHS Health Development Agency.
- Unal, B., Alison, J. and Capewell, S. (2005) 'Modelling the decline in coronary heart disease deaths in England and Wales, 1981-2000: comparing contributions from primary prevention and secondary prevention', *British Medical Journal*, doi:10.1136/bmj.38561.633345.8F (published 17 August 2005).