Performance Detailed Report

February 2008

audit commission

PKF

Accountants & business advisers

Health Inequalities

Essex Public Services

Audit 2007/08

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Introduction

1 Health inequalities are differences in health experience and health outcomes between different population groups. These groups can be determined by socio-economic status, geographical area, age, disability, gender or ethnic group.

2 Improving health and wellbeing and narrowing the health gap between disadvantaged groups and the rest of the population is one of the Government's top priorities. The single overarching target to reduce health inequalities is a national Public Sector Agreement (PSA) target.

By 2010, reduce inequalities in health outcomes by 10 per cent as measured by infant mortality and life expectancy at birth.

3 Public sector organisations should therefore determine whether resources are appropriately targeted at health inequalities, whilst also sustaining efforts to improve the overall health of the population.

4 The health inequalities gap in the East of England, as for England as a whole, is increasing[1] [2]. The difference in life expectancy between Essex authorities is over four years; below district level the difference is 18 years (see Appendix 1).

5 Addressing such a complex issue is not the preserve of any one organisational sector, but must be addressed through co-operation and shared vision. There is a significant risk that the governance arrangements put in place to reduce health inequalities may not be robust enough to deliver all partners' priorities and also achieve value for money. This increases the importance of establishing effective arrangements for delivering the health inequalities agenda, including performance and risk management as well as scrutiny and effective challenge.

6 The purpose of this audit was to:

- assess current arrangements across Essex to reduce health inequalities; and
- examine future plans to improve life chances and reduce health inequalities.

7 Essex in this context includes the whole county, ie Thurrock and Southend as well as the area covered by Essex County Council. In this report, all references to Essex use this definition.

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[1] 'Our NHS, our future', NHS next stage review interim report, Lord Darzi, October 2007

[2] Tackling Health Inequalities: 2004-2006 data and policy update for the 2010 National Target, Department of Health, December 2007

8 The audit was undertaken in three stages.

- **Diagnostic**: This involved a document review, interviews with a small number of key people and a survey.
- **Action planning workshops**: involving representatives of Essex health and local government bodies and the Fire & Rescue service.
- **Chief Executives' Forum**: This final stage was to share the main conclusions with Essex public services Chief Executives and agree a way forward.

Main conclusions

Strategic approach

9 There is a strong commitment to tackling health inequalities amongst partners. There is clear agreement that health inequalities are everybody's business and that councils have a community leadership role to play in this agenda. This commitment is demonstrated through Local Area Agreement (LAA) and Local Strategic Partnership (LSP) plans, although not all councils have yet engaged their members in the health inequality debate.

10 Despite this level of strategic intent, there is no agreement on the best strategic approach to take to addressing health inequalities. Given the already complex nature of the organisational structure and boundaries across Essex, it is important that a common strategic approach is agreed by all Essex bodies on how to tackle health inequalities, although the solutions and specific approaches may well vary according to local need and circumstances.

11 There is insufficient strategic focus given to health inequalities within most existing strategies and policies. Where they do refer explicitly to health inequalities, they often concentrate primarily on inequalities between different geographical areas. More commonly, they are often aimed at more general health improvement as opposed to reducing health inequalities.

Targets

12 Targets set are not appropriately focused or balanced, which hampers proper measurement of the impact of health inequalities initiatives. In many cases, specific health inequalities targets have not been set, or where set, are too broad. In addition, not all partners recognise that this is a long term agenda that requires longer term targets, with appropriate milestones, to be agreed and monitored.

13 Organisations understand that targets need to be set at a local level, and be designed to tackle local needs, but within the overall framework of the LAAs. However, local understanding is needed of which national or county targets apply or are important locally; and how this should be balanced against the need for corporacy. Each organisation needs to understand what it contributes to each target.

Information

14 Whilst there is some good information available which is being well used in some areas, it is not always shared effectively or with maximum impact. Lack of baseline information and other barriers to obtaining appropriate data have not yet been overcome and the quality of some data is variable. This undermines organisations' ability to successfully target resources and performance manage activities in respect of health inequalities, and also impedes decision making processes.

15 The Joint Strategic Needs Assessment provides a useful and comprehensive analysis of needs and health inequalities of the different populations in Essex. Its joint development is widely supported and it has the potential to significantly improve future action planning and decision making across the county and encompassing all three LAA areas.

Performance management

16 There is no clear vision of how health inequalities are to be performance managed and limited information available on which to base performance management. Without clearly formulated outcomes and measures, performance management will be weak.

17 Involvement of Non Executive Directors, elected members and Overview and Scrutiny Committees is very varied. Without strong involvement, understanding and interest from non executives, there will be insufficient challenge and direction.

Public Health

18 Public health is developing its influence and relationships but these vary in maturity. Where they exist, joint Director of Public Health posts are seen as a benefit but despite extensive recruitment efforts, Essex County Council does not yet have a Director of Public Health. This has delayed progress.

19 Public Health resource in Essex is dispersed and it is felt by participants that best use is not being made of this resource. Without developing more sophisticated arrangements that match the complexity of the county, public health expertise and influence will not be used to its full potential.

Collaboration

20 Partnerships and relationships between organisations are developing but are not yet fully effective. There is an increasing recognition that health inequalities can only be tackled by working together, yet our survey revealed feelings that partners are not always inclusive or collaborative when developing strategies that impact on lifestyle issues. The role of the voluntary and community sector in partnership approaches to tackling health inequalities is not well defined and their contribution is therefore not maximised.

21 Joint planning for health inequalities is at different stages across the county, but is generally under-developed.

Accountability

22 Leadership and accountability arrangements are unclear within individual organisations and particularly within partnerships, where there are tensions between corporate and partnership responsibilities. Without clear accountability, strong leadership and defined roles, progress in tackling health inequalities is likely to be patchy and targets are less likely to be met.

Awareness and knowledge

23 There are variable levels of understanding within different service areas and between different professional groups. For those most directly involved, such as public health professionals, the issues are clear. However, other services and groups do not see the connection between their role and health inequalities so clearly. Training, reporting and sharing knowledge are under-developed, lessening the potential power of knowledge and increasing the risk that innovation opportunities will be missed.

24 Elected Members have not always been informed of health inequalities issues, or involved in developing or monitoring the agenda and approach. With good information, members will need to make difficult political decisions on the focus and allocation of resources.

Delivery and resources

25 Action is insufficiently co-ordinated, strategically led or designed to meet overall objectives and priorities. The good things that are happening are not being systematically identified, harnessed, shared, replicated and built upon.

26 It is unclear how great the commitment is to the health inequalities agenda when it comes to resource allocation. Resources are generally being allocated to universal services rather than specifically targeted at health inequalities.

27 The fact that the health inequalities gap continues to increase suggests that what is being done is either not sufficient or not effective.

Next steps

28 There are four main areas to be addressed:

- strategic approach;
- information and joint planning;
- delivery and monitoring performance; and
- political involvement.

29 Partners recognise that a single Essex wide approach to health inequalities is unlikely to be effective. Many health inequalities issues are local issues, needing local solutions. However, without a common overall strategic approach, with agreed local and Essex-wide priorities and a shared view of the importance of the agenda, joint planning will remain problematic, accountability unclear, action is likely to be uncoordinated, and difficult to performance manage.

30 Information, including the Joint Strategic Needs Assessment, needs to be exploited to its full potential. Information needs to be better shared, managed and used across all partner organisations.

31 Action needs to be co-ordinated, strategically led and designed to meet overall objectives and priorities as well as local needs, backed up with a clear performance management framework.

32 Elected members and non executive directors need to have information and an understanding of the issues involved in health inequalities in order to provide the necessary political or Board level leadership. Elected members will need to make difficult political decisions on the focus and allocation of resources.

33 In the detailed report (paragraph 104), we make specific recommendations addressed to all the Essex public services which took part in this audit. These are brought together in an action plan at Appendix 3 which is for each organisation to complete with its partners.

Detailed report

National context

Health inequalities are differences in health experience and health outcomes between different population groups. These groups can be determined by socio-economic status, geographical area, age, disability, gender or ethnic group.

34 Health inequalities are a major threat to public health and present an ethical challenge. Some geographical areas and population groups experience significantly lower life expectancy and poorer quality of life than others.

35 Deprived communities or population groups suffering greater ill-health and increased morbidity will have less access to work opportunities and contribute to levels of poverty and economic decline. People suffering from greater ill-health require increased support from a range of public services, including benefits, health, social care and other local services.

36 The latest national data shows that there has been a widening of the inequality gap. Whilst there have been improvements in life expectancy in the most deprived areas, the gap between the most deprived and least deprived areas has actually widened[3] [4].

37 Consequently, health and wellbeing is a key national focus for improvement and narrowing the health gap between disadvantaged groups and the rest of the country is one of the Government's top priorities. The single overarching target to reduce health inequalities is a national Public Sector Agreement (PSA) target.

By 2010, reduce inequalities in health outcomes by 10 per cent as measured by infant mortality and life expectancy at birth.

38 This target has been underlined in successive policy documents, including two White Papers; 'Choosing Health' (2004) and 'Strong & Prosperous Communities' (2006). It is one of the four top level priorities in the 2007/08 NHS Operating Framework, restated in the 2008/09 Framework as: 'Keeping adults and children well, improving their health and reducing health inequalities'. The Secretary of State announced in the autumn of 2007 that the Government will publish a comprehensive strategy for reducing health inequalities.

[3] 'Our NHS, our future', NHS next stage review interim report, Lord Darzi, October 2007
[4] Tackling Health Inequalities: 2004-2006 data and policy update for the 2010 National Target, Department of Health, December 2007

39 Public sector organisations should therefore determine whether resources are appropriately targeted at health inequalities, whilst also sustaining efforts to improve the overall health of the people of Essex. Without this, people can experience inequality of provision, access and take-up of services, and quality of life.

40 The promotion of healthier communities with improved health equality has an effect on the wellbeing and prosperity of the whole population. Investment in this area has the potential to yield significant long term benefit.

41 Addressing such large and complex issues is not the preserve of any one organisational sector alone, but must be addressed through co-operation and shared vision. Joint working across different organisations has been facilitated by a number of previous developments including joint commissioning and Local Strategic Partnerships (LSPs). Local Area Agreements (LAAs) provide a further mechanism for building on and improving joint work to reduce health inequalities and strengthen the role of the LSPs.

42 Large amounts of public service resource are used to provide services that could have a beneficial impact on health inequalities. Maximising value for money from these combined resources requires effective joint working between public sector organisations.

Background

43 The health inequalities gap in the East of England, as for England as a whole, is increasing. The difference in life expectancy between Essex authorities is four years, with men in Harlow living on average four years less than their counterparts in neighbouring Uttlesford. Below district level the difference is much greater: up to 18 years (see Appendix 1).

44 The joint working required effectively to tackle health inequalities is made more challenging in Essex by the complexity of public sector organisation configuration. There are 15 local authorities with one county, two unitary and 12 district or borough councils plus countywide Fire & Rescue and Police services. Complexity is exacerbated by the fact that, unlike many other counties where there is one PCT for the county area, there are five PCTs in Essex, with two of these covering both County and unitary authority areas.

45 As a result, not all boundaries are coterminous and there are many different partnership configurations involved in the health inequalities agenda. These often have competing priorities and all have many other demands on their resources. In addition, some partners, particularly in the health sector, have also been subject to recent large scale reorganisation.

46 In this environment, there is a significant risk that the governance arrangements put in place to reduce health inequalities may not be robust enough to deliver all partners' priorities and also achieve value for money. This increases the importance of establishing effective arrangements for delivering the health inequalities agenda, including performance and risk management as well as scrutiny and effective challenge.

Audit objective and approach

47 The purpose of this audit was to:

- assess current arrangements across Essex to reduce health inequalities; and
- examine future plans to improve life chances and reduce health inequalities.

48 The organisations participating in this audit were the County Council, the two unitary authorities of Thurrock and Southend, the twelve district or borough councils, the five PCTs, the two Essex mental health partnership trusts, and the Essex Fire & Rescue Service

49 Essex in the context of this audit includes the whole county, ie Thurrock and Southend as well as the area covered by Essex County Council. In this report, all references to Essex use this definition.

50 This report is structured around nine themes:

- Strategic approach;
- Targets;
- Information;
- Performance management;
- Public health;
- Collaboration;
- Accountability;
- Awareness and knowledge; and
- Delivery and resources.

51 The audit was undertaken in three stages.

- **Diagnostic**: This involved a document review, interviews with a small number of key people and a survey (to which 212 responses were received - see Appendix 2 for detailed results).
- **Action planning workshops**: The initial findings from the diagnostic stage were shared at a series of three action planning workshops in November 2007, which were attended by 44 representatives of the Essex Fire service, health and local government bodies. At their request, a separate report summarising the workshop discussions and proposed actions was circulated to all workshop participants for their use.
- **Chief Executives' Forum**: This final stage was to share the main conclusions with Essex public services Chief Executives in January 2008 and agree a way forward.

Conclusions

Strategic approach

52 There is recognition within the public service organisations in Essex that health inequalities are everybody's business and that councils have a community leadership role to play in this agenda. Survey results, interviews and the workshops all indicated that the vast majority of people recognise the health inequalities agenda.

53 A high level commitment to tackling health inequalities is demonstrated by a number of organisations, either individually or through LAAs and LSPs. Commitments to tackling health inequalities are made in a number of strategies and plans. For example, the Essex County Community Strategy sets a specific aim to reduce inequalities and health inequalities, and recognises the impact on health and, implicitly, on inequalities, of the other parts of the strategy. This is reflected in individual sections on community cohesion, community safety, transport, and leisure.

54 In essence, there is good strategic intent within Essex but still work to be done to convert that intent into workable strategies with clear objectives, priorities, targets and expected outcomes. A clear strategic approach and focus enables effective target setting, performance management and scrutiny.

55 There is insufficient strategic focus given to health inequalities within most existing strategies and policies. Many strategies either make no mention of health inequalities or the statements are too broad and generalised to have impact. Not all LSPs include specific reference to health inequalities in their terms of reference. If action is to be effective, coordinated and holistic, health inequalities must be part of how the whole of each organisation thinks.

56 Where strategies and planned actions do refer explicitly to health inequalities, they often concentrate primarily on inequalities between different geographical areas. There is a risk that insufficient attention is given to the inequality experienced by dispersed groups within the population, such as people with disabilities or mental health problems.

57 Strategies and planned action are often aimed at more general health improvement as opposed to health inequalities. Health improvement and health inequalities are often seen as interchangeable agendas. General action to improve health is essential but does not automatically reduce health inequalities. In fact, health improvement initiatives can sometimes increase the inequalities gap as take up is usually lower among those groups suffering inequality.

58 There is an emerging consensus that health inequalities should be a theme embedded within, and mapped between all other key strategies and policies, rather than a specific badged joint strategy. This needs to be explicit in overall objectives about regeneration, prosperous communities, educational attainment, work, skills, etc. In the few cases where this approach has been taken, it has helped to integrate health inequalities into other agendas and create greater corporate ownership. Examples include Mid Essex PCT within the Healthy Living Strategy and Southend Borough Council within its older people's and children's services strategies. The County Council intends taking this approach with its community well-being and later life strategies. However, South East and South West Essex PCTs are working on specific health inequalities strategies.

59 There are advantages and disadvantages to both approaches. However, given the already complex nature of the organisational structure and boundaries across Essex, it is important that a common strategic approach is agreed by all Essex bodies on how to reflect health inequalities at a strategic level and that each organisation makes a clear public statement on how it is tackling health inequalities. The risks of failing to agree a common approach are:

- action will not be sufficiently co-ordinated to generate real impact;
- failure to make best use of resources through economies of scale;
- increased resources will be required to monitor and deliver against mismatched policy initiatives through duplicate or overlapping systems; and
- lack of clarity for service users.

Targets

60 There is a clear recognition that targets need to be set at a local level, designed to tackle local needs, but within the overall framework of the LAAs. However, local understanding is needed of which national or county targets apply or are important locally; and how this should be balanced against the need for corporacy. Areas already doing well on a particular measure may need to set themselves stretch targets in order to help achieve the overall county target.

Table 1 Examples of target setting

Some targets for tackling health inequalities have been set and agreed with partners in some areas.

Castle Point's Community Strategy is an example of setting targets for improving life expectancy and reducing inequalities between wards

Maldon's Community Strategy is a good example of connecting health targets to other targets, for example, for the built environment

Colchester Borough Council has selected four targets to reduce gaps between the borough average and the worst affected areas for smoking, childhood obesity, life expectancy and teenage conceptions

Harlow Council has set local targets that are more ambitious than the countywide LAA targets for issues where it faces greater challenges than other parts of Essex; for example, obesity reduction and increasing overall life expectancy.

61 Overall, however, there is a lack of specific health inequality targets within the action plans of organisations. In many cases targets have not been set or, where set, they are too broad. For example, targets often focus on health improvement rather than health inequalities and are not always targeted on specific areas or population groups.

62 It is possible that these more generic health improvement targets may assist in reducing health inequalities but often there is little information available on the outcomes desired or achieved against those targets, making it difficult to determine their likely or actual impact.

63 It is not clear whether this is because performance management processes are not in place, information on outcomes is not being measured or reported, actions have not yet produced tangible or measurable outcomes, or a combination of all of these.

64 In addition, the need for longer term targets is not recognised by all partners. The national PSA targets are set for 2010, which focuses attention on the next two years. Important as this is, not all partners have recognised that this is a long term agenda, and it takes time to see results. Longer term targets, with appropriate milestones, are therefore also necessary.

Information

65 There is some good information available that is being well used in some areas. Public health data is being increasingly shared and used. Health Impact Assessments are a powerful planning tool and have been used to target certain services, such a smoking cessation and primary care development on the areas of greatest need and inequality. Several organisations, notably West Essex PCT, are exploring the potential of social marketing (see Table 2).

Table 2 Notable practice

Social marketing in West Essex

Health related social marketing is: "the systematic application of marketing concepts and techniques, to achieve specific behavioural goals, to improve health and reduce inequalities". A social marketing strategy and commissioning framework is being developed by West Essex PCT and partner agencies. Two main strands are proposed. One is a specific project to improve uptake and outcomes from smoking cessation in men in socio-economic groups four and five. The other is to use social marketing as a corporate process, underwriting all public health and wider PCT activities to promote user engagement with services or campaigns which have poor uptake, retention or outcomes. The PCT is engaging commercial sector advertising expertise to support this. The project draws on data sources and methodology also being used or explored by Essex Fire & Rescue Services and by the County Council.

66 The Joint Strategic Needs Assessment that is being developed in Essex provides a useful and comprehensive analysis of needs and health inequalities of the different populations in Essex. The approach taken is widely supported and there is confidence it will provide an increasingly good evidence base to support future decision making and action planning. A single, authoritative source of information such as this will underpin an effective overall strategic approach and reduce the risk of inappropriately targeted resource.

67 Information is not always shared effectively or with maximum impact. There are also shortcomings in arrangements for managing and using information. Lack of baseline information or mechanisms to collect data going forward could be a barrier to success if not addressed. This includes identification and understanding of hard to reach groups. Barriers to obtaining data and information exist for a number of reasons, including professional attitudes, technical difficulties and data protection. An understanding of the importance of obtaining and sharing good quality data is essential to an effective approach to tackling health inequalities. There are examples of good practice and collaborative approaches to tackling these difficulties, such as those used in greater Manchester, from which Essex partners can learn.

Table 3 Managing information

The Greater Manchester approach to managing information

Partner agencies in greater Manchester have employed a Data Intelligence Manager whose role is to work on public health data, focus it and use it to inform targets. This was in recognition of audit findings that collectively, the partners had a very extensive data resource but were not focusing it.

Source: Audit Commission 2007

68 Failure to identify and collect relevant data for all targets being measured will undermine organisations' ability to successfully target their resources and performance manage their activities in respect of reducing health inequalities, as well as impede decision making processes.

Performance management

69 There is no clear vision of how health inequalities are to be performance managed. Most organisations and LSPs have general monitoring arrangements in place, but it is not possible within these arrangements to identify progress in respect of health inequalities.

70 Whilst tackling health inequalities should not necessarily be performance managed through a separate process, it is imperative that comprehensive and detailed joint arrangements, perhaps through LSPs, are implemented to reduce the risks associated with poor performance or inappropriately directed resources.

71 The lack of focused health inequalities performance measures, desired outcomes and milestones discussed in the Targets section above will undermine organisations' ability to monitor performance effectively. This will need to be addressed to ensure the success of any performance management arrangements developed and implemented.

72 This is a complex area to performance manage, partly because it is difficult to demonstrate causal links; for example, educational achievement has increased in Harlow but it is difficult to evidence whether, or to what degree, the Healthy Schools initiative has contributed to this. Consequently, although the principles of setting and monitoring SMART (specific, measurable, achievable, realistic and timely) targets are relevant, performance may also need to be measured qualitatively, not just quantitatively.

73 It is important that any performance management framework developed acknowledges this complexity. In some cases, input and process outcomes, as well as the ultimate health improvement outcomes, may be valid performance measurements. In particular, if there is good research evidence that a given intervention is effective, it may be appropriate to rely on this evidence and only monitor the operation of the intervention itself.

74 Commitment and involvement of non executive directors, elected members and overview and scrutiny committees is very varied. Without strong involvement, understanding and interest from non executives, there will be insufficient challenge and direction.

Public Health

75 Public health is developing its relationships and influence. This is particularly important in LSPs, so that public health issues, including health inequalities, become central to their thinking. Where public health is well integrated with commissioning in PCTs and local authorities, the focus on health inequalities tends to be stronger. There are different models across Essex from which partners could adopt what works best.

76 Joint Director of Public Health posts are seen as a benefit in Southend and Thurrock, helping keep public health and health inequalities as everybody's business. This is an issue for Essex county where, as yet, no joint appointment has been made, leaving the County Council without direct access to public health advice. However, the situation is complicated, as expectations vary about the extent to which one Director of Public Health can speak for others - or for PCTs other than their own.

77 Best use may not be being made of the total public health resource available across Essex. Essex's public health resource it is dispersed and not working together as well as it could be. There is an informal network, with different Directors of Public Health leading on different issues but without developing more sophisticated arrangements, public health expertise and influence will not be used to its full potential.

78 There is no public health report for Essex as a county area. Public Health reports can provide authoritative information and advice on patterns of health inequalities and evidence based approaches to tackling them. Without a high level report, aimed at decision makers, giving them clear and consistent messages, it will be difficult to develop a shared strategic approach.

Table 4 Public Health impact

Examples of the advice and impact of public health reports

South West Essex PCT has produced a comprehensive health status summary report which proposes an approach to tackle health inequalities faced by young people through a targeted school-based approach aimed at schools serving the most deprived wards.

West Essex PCT has used annual public health reports to support the adoption of health inequalities as a priority in the PCT's strategy.

North East Essex PCT has reviewed data which identifies significant variations in health. It highlights the link between deprivation and poor health. It shows that areas of greatest need are poorly served by health services and recommends that the PCT needs to consider where to invest in service development in primary care.

Collaboration

79 Partnership working and relationships between organisations are developing. For example, several LSPs have led stakeholder forums which have been useful in agreeing priorities and objectives between partner organisations as a basis for the formulation of strategies and targets.

80 There is an increasing recognition that health inequalities can only be tackled by working together, using every opportunity at the partners' disposal. This is having a positive impact on the potential for effective joint working. However, our survey revealed feelings that partners are not always as inclusive or collaborative as they could be when developing strategies that impact on lifestyle issues. Respondents would like to see greater communication and involvement, especially with and between the voluntary sector and with NHS trusts. Suggested improvements included commitment to the same agenda and better attendance at each others' meetings. Mature partnership working, based on mutual understanding of different perspectives and imperatives, is a prerequisite to effective joint planning.

Table 5 Notable practice

Life Opportunities in Colchester

Colchester's Local Strategic Partnership has adopted a priority to improve life opportunities in the borough. Members representing some of the borough's key public sector organisations have set targets to reduce the gap between the borough average and the worst affected areas for problems with 6 themes: crime, education, health, housing, skills and worklessness. These targets are chosen at the local level rather than imposed from above, and are designed to be specific and measurable. The health targets aim to reduce the gap between the borough average and the worst affected areas for smoking rates, childhood obesity and teenage pregnancy. Staff from North East Essex PCT and Colchester Borough Council have identified the worst affected areas and are currently agreeing actions plans to direct resources towards them.

81 Joint planning for health inequalities is at different stages across the county, but is generally under-developed. The complexities of boundary issues, especially in the two tier area, and lack of coterminosity in Essex make joint planning difficult, so require better communication and smarter working. Until a clear strategic view has been established, joint planning cannot be effective.

82 Joint planning is largely being managed through the LSPs and the LAA process, which clearly have the potential to drive the agenda. However, in most cases, they have not given any specific focus to health inequalities, as opposed to health improvement. Workshop participants suggested that health inequalities need to be embedded within LSPs and LAAs by identifying a champion on each LSP, whose role would be to ensure health inequalities are considered in all the LSP does, particularly in regeneration plans and strategies. Other suggestions were to produce good practice guidelines for LSPs and to audit LSPs' approach to tackling health inequalities.

83 There is no systematic engagement of the full range of services and relevant agencies in meeting the health inequalities agenda. Each individual service within each council, PCT, the Fire & Rescue service and other partners has a role in relation to tackling health inequalities. For example, many fires have a smoking, drugs or alcohol related cause. Fire authorities have valuable insight into areas that need targeting and undertake valuable prevention work in schools and the wider community.

84 In recognition of this, the County Council is developing a well-being strategy which is intended to make the connections for its services such as planning and the built environment; air quality monitoring; parks and open spaces and their impact on mental health; Trading Standards and their enforcement role with cigarettes, alcohol and food labelling; Education and the impact of educational attainment.

85 The role of the voluntary and community sector in partnership approaches to tackling health inequalities is not well defined. Survey respondents from the sector described services that could impact on health inequalities but felt they were not full partners. Voluntary sector capacity is variable although they are often the best placed to address health inequalities issues and can be innovative in their approaches. There is significant local knowledge within the voluntary and community sector that is not being utilised.

86 Practice Based Commissioning could have a significant impact on health inequalities. Organisations are recognising the need to work with GPs using the Practice Based Commissioning and Quality Outcomes Frameworks to ensure good information and the right incentives are in place for GPs to play their part in tackling health inequalities.

Accountability

87 Leadership and accountability for health inequalities is not clear, either within organisations or to partnerships. Despite widespread recognition that organisations from all sectors have a role to play, there is an overwhelming lack of clarity over who is accountable for work on health inequalities, and achievement of targets. Without strong leadership, clear accountability and defined roles, progress in tackling health inequalities is likely to be patchy and targets are less likely to be met.

88 Only 40 per cent of respondents to our survey were clear on who is accountable for work on health inequalities within their own organisation. Of the 58 people who named who they thought was accountable, 22 said public health, or more specifically the Director of Public Health; 19 named a specific post or individual; eight named specific people or departments; nine either didn't know, said it was various people or that 'we should all be accountable".

89 Accountability is particularly unclear within partnership arrangements. It is problematic because the partnerships concerned do not have a statutory basis and ultimate accountability is always going to be to the partners' employing body, not the partnership. There is recognition that the best approach may be to develop joint ownership of targets, especially where more than one agency has a contribution to make in the target's achievement.

90 Only a quarter of survey respondents felt clear who is accountable for work on health inequalities within relevant partnerships. Of those who did, most said the Director of Public Health or the PCT generally; only a few said the Council or the LSP. More listed a number of organisations, suggesting they saw accountability as diffuse: "It can be clear, but often accountability is in dispute in partnerships".

Awareness and knowledge

91 There are variable levels of understanding within different service areas and between different professional groups. For those most directly involved, such as public health professionals, the issues are clear. However, as identified in the Collaboration section above, other services and groups often do not see the connection between their role and health inequalities so clearly. This weakens the potential power of knowledge gathering and sharing and increases the risk that innovation opportunities will be missed.

92 Training, reporting and sharing knowledge are under-developed. Workshop participants suggested general training will be needed on the Joint Strategic Needs Assessment and health inequalities more widely to allow people to understand the bigger picture, the connections and the impact of their services on health inequalities. Systematic training, reporting and sharing knowledge will lead to improved awareness.

93 Elected Members have not always been informed of health inequalities issues, or involved in developing or monitoring the agenda and approach. Our survey identified some doubts about the level of local political understanding or support for this agenda. Comments from Members themselves included the following.

"I had never even heard of the subject. I am on our council's Overview and Scrutiny Committee that would deal with this issue and we never have!"

"My position on the Council does not involve me in this area at present; a specific health overview and scrutiny panel was set up but never met."

"This has been a very useful exercise and has made me think about the issues."

"Health inequalities do not appear to be a big issue for my council."

Members and Non Executive Directors need to have information and an understanding of the issues involved in health inequalities in order to provide the necessary political or Board level leadership.

94 Based on good information and an understanding of the issues, elected members will need to make difficult political decisions on the focus and allocation of resources. There is a political difficulty for members in making locally unpopular decisions, such as decommissioning and redistributing resources, in support of the health inequalities agenda as a whole. The case will need to be made as to why differential investment can benefit the whole of the community. Identifying the priority health inequality issues in each ward and appraising individual elected members of those issues, so that they can champion those causes and assist with the management of public perception and expectation, may ease this tension.

95 There is a strong link between educational attainment and deprivation and an equally strong link between deprivation and health inequalities. However, the impact of educational attainment on health inequalities, and vice versa, has not been sufficiently explored with education authorities and establishments.

96 Workshop participants asserted that education services have a large part to play in tackling health inequalities but that potential barriers to success are:

- lack of space in the curriculum;
- lack of consistency of approach within schools; and
- over dependence on school leadership.

97 There are also associated risks, for example, the risk of stigmatising children within the school setting in the attempt to tackle inequalities, which may be mitigated by an approach that concentrates on issues and geographic areas rather than individual children.

Delivery and resources

98 Action is insufficiently co-ordinated, strategically led or designed to meet overall objectives and priorities. There are good but isolated examples of local action being taken to target and reduce health inequalities. One of several examples of notable local action is the healthy living centre in Temple Sutton school in Southend (see Table 6). There are a number of examples of access to services being improved for disadvantaged groups and services being targeted at areas of greatest need. PCTs are increasingly investing differentially in smoking cessation, sexual health and primary care services in order to target health inequalities. However, all these initiatives need to manage the risk that too much focus on a particular group of people could result in stigmatism.

Table 6 Notable practice

Temple Sutton School, Southend

Temple Sutton School is located in a ward with a significant proportion of public sector housing and households with low income and other disadvantages. It has developed an ethos of support and development for both its pupils and their families and uses the facilities for wider purposes through extended school days. It hosts Southend's Locality Co-ordinator (Central) and therefore serves as a hub for the multi-agency integrated working arrangements organised there. The school is also the site for one of Southend's eleven children's centres, making provision for children from birth to age eleven. Building on this success, the school has led a community initiative to develop a healthy living centre utilising excess open space on the campus. This initiative is supported by a local company, South East Essex PCT and Southend Borough Council. The concept is to provide a hub for social enterprise, acting as a community and activity centre and a base for local businesses, as well as a health centre managed on behalf of the PCT.

99 There is also a lot of action already underway, particularly regeneration projects, that is not specifically badged as tackling health inequality but which is likely to be having an impact. Nevertheless, unless the strategic and performance management links are made to this work, it is not possible to assess or measure its true impact on health inequalities. Additionally, the fact that the health inequalities gap continues to increase suggests that whatever is being done is either not sufficient or not effective.

100 The good things that are happening are not being systematically identified, harnessed, shared, replicated and built upon. There are difficulties to be overcome; for example, sharing good practice can be difficult for provider organisations which are in a competitive market place. Whilst it is necessary to have a strategic level framework to drive the health inequalities agenda, it is also necessary to listen to what is happening on the ground and develop initiatives from a grass roots level.

101 It is unclear how great the commitment is to the health inequalities agenda when it comes to resource allocation, as resources are generally being allocated to universal services rather than specifically targeted at health inequalities.

102 Two PCTs, North East Essex and South East Essex, have allocated small amounts this year specifically to tackle health inequalities and there are encouraging signs of more entrepreneurial commissioning practices in areas where practice based commissioners, PCT commissioners and public health are working closely together. However, funding cannot be targeted effectively unless commissioners have a clear understanding of what they want to achieve and providers can see how they are contributing.

103 There is limited potential for new investment and so the focus needs to be on the use of existing resources and partners working more collaboratively to access alternative sources of funding. However, links with community organisations and voluntary services are under-developed, which limits the statutory partners' ability to identify and join existing initiatives within the community that can be used as a vehicle for tackling health inequalities.

104 Survey respondents expressed some frustration and doubt about how much is actually happening and how far statutory bodies are putting resources into heath inequalities, either directly or via the voluntary sector.

"I think it is easy to identify and discuss health inequalities within partnerships locally, but much harder to jointly fund and put things in place to address them. It may also be difficult to agree and identify what is actually working. Two years is not very long to address inequities which are experienced over a lifetime!"

Next steps and recommendations

105 The following high level recommendations are addressed to all the Essex public services which took part in this audit.

Recommendations

Strategic approach

R1 Agree a common strategic approach to addressing health inequalities, with agreed local and Essex-wide priorities.

R2 Develop and agree health inequality targets locally and at LSP level, based on the identified needs.

Information and joint planning

R3 Exploit the full potential of the Joint Strategic Needs Assessment to identify health inequalities.

R4 Improve arrangements for sharing, managing and using information across all partner agencies.

R5 Consider production of a public health report for Essex as a whole to underpin the common strategic approach.

R6 Strengthen joint planning for tackling health inequalities through the LSPs and LAAs and clarify accountability for delivery.

Delivery and monitoring performance

R7 Ensure action is co-ordinated, strategically led and designed to meet overall objectives and priorities as well as local needs.

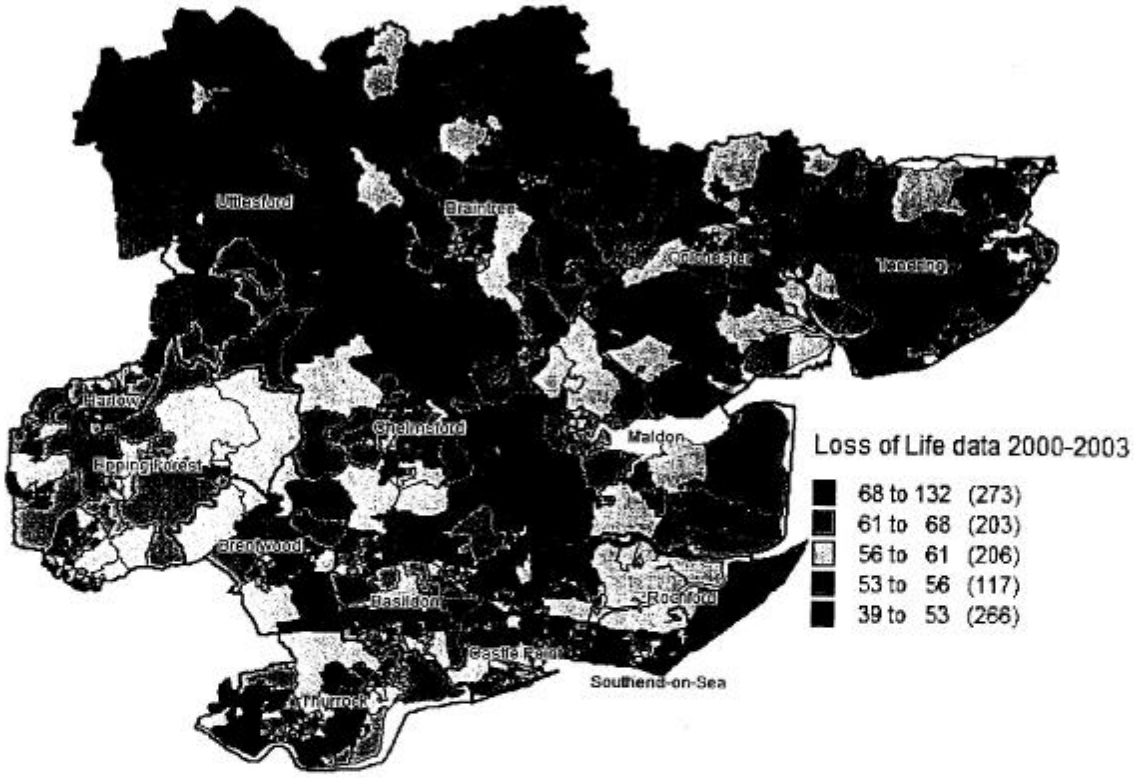
R8 Develop a clear performance management framework for health inequalities, with strong Member and Non Executive involvement.

Recommendations

Political involvement

R9 Improve awareness and knowledge of health inequalities and their implications amongst elected members and all service areas within Essex public services

Appendix 1 – Years of potential life lost



This map shows years of potential life lost and so can be used as a proxy for life expectancy, with red areas likely to have the lowest life expectancy, through to dark green areas where life expectancy is likely to be highest.

The Years of Potential Life Lost indicator is an annual, age adjusted, rate of years of potential life lost per 1000 population. So a figure of 200 for a Super Output Area (SOA) indicates that 200 years of potential years of life, after adjustment, have been lost per 1000 members of the population over a year. For example, other things being equal, the death of two one year old children (74.5 times two, years lost) and one 24 year old (51 years lost) in an SOA with a population of 1000 would result in a YPLL figure of 200. The years lost are calculated as 75 minus age at death.

Appendix 2 – Survey results

1 Two hundred and twelve responses were received, with 38 per cent from district and borough councils, 28 per cent from PCTs and the remainder from other partners, including ten per cent from voluntary organisations.

2 The survey consisted of a number of statements, to which respondents were asked to indicate if they strongly agreed, agreed, disagreed, strongly disagreed, or did not know, or the question was not applicable to them. The percentage results are shown in the table below[5].

Statement	Strongly agree or agree	Strongly disagree or disagree	Not applicable / don't know
There is an effective joint health inequalities strategy, based on the health needs of our local population.	46%	28%	25%
The health inequalities strategy is adequately reflected in the Local Area Agreement (LAA) and the Local Strategic Partnership's (LSP) plans, including the sections on community safety, economic development and the environment.	45%	26%	27%
There is enough information about health inequalities for us to identify the needs of the population in the area my organisation covers.	53%	28%	16%
There is an agreed process with partners for identifying local health inequality issues.	40%	30%	27%
There is an agreed process with partners for identifying local hard-to-reach groups.	35%	37%	26%
We can show that health inequalities have narrowed in the last two years in the area my organisation covers.	15%	43%	40%
My organisation regularly uses techniques that help it assess the impact of its approach to tackling health inequalities and to inform service changes.	48%	30%	22%
Partners share and use information on health inequalities well	45%	30%	23%
Acute and mental health trusts have a defined role in tackling health inequalities.	40%	24%	36%
My organisation has developed joint services with partners to tackle health inequalities.	60%	17%	22%
Changes have been made to my organisation's services because inequities in access were identified.	52%	23%	24%

[5] Percentages will not always add up to 100 per cent due to rounding and to no replies not being shown

Statement	Strongly agree or agree	Strongly disagree or disagree	Not applicable / don't know
We can show that access to services has been improved for disadvantaged groups in the area my organisation covers.	54%	25%	20%
We can show that action taken in the last two years has had an impact on issues or services where there was previous under-performance.	45%	25%	29%
Health inequalities are everybody's business and not just a NHS issue.	93%	2%	2%
Councils have a community leadership role which includes promoting a healthier community and narrowing health inequalities.	92%	1%	2%
Public health information is used to help us to understand local health inequality priorities.	75%	9%	16%
We use evidence-based research about what approaches to tackling health inequalities work best.	60%	16%	24%
Public health information is used to help us to understand the impact of any service development on the health of the local population	59%	17%	23%
Joint planning arrangements for health inequalities exist and are effective	39%	28%	32%
It is clear who is accountable for work on health inequalities within relevant partnerships.	30%	37%	30%
It is clear who is accountable for work on health inequalities within my organisation.	42%	24%	28%
My organisation's health inequalities strategy is consistent with the joint health inequalities plan.	30%	13%	54%
My organisation's health inequalities strategy is consistent with its commissioning plan.	31%	12%	55%
The Council's overview and scrutiny committee addresses wider health issues beyond NHS reconfiguration.	37%	14%	49%
The joint health inequalities strategy addresses whole system changes needed.	29%	17%	52%
My organisation has sufficient skills to deliver work on health inequalities.	52%	27%	18%
I fully understand the difference we and our partners intend to make in the most disadvantaged communities.	58%	25%	15%
I have had joint training with partners on health inequalities.	15%	65%	17%

Statement	Strongly agree or agree	Strongly disagree or disagree	Not applicable / don't know
There are effective mechanisms to enable communities to participate in developing action on health inequalities.	29%	36%	33%
Effective joint arrangements are in place for monitoring our progress in tackling health inequalities.	42%	21%	36%
My organisation can produce the information required to monitor performance against the joint health inequalities strategy and plans.	37%	20%	42%
Cost benefit analysis of options for action has been undertaken in the last two years (singly or jointly).	10%	28%	61%
We can show that we have targeted our financial resources on actions which evidence shows have the biggest impact on reducing health inequalities.	30%	28%	41%
Progress is benchmarked against comparable areas.	31%	22%	44%
I know which actions have had a measurable impact on reducing local health inequalities in the last two years.	24%	33%	42%
My organisation's chief officer/members/board members are committed to tackling local health inequalities.	71%	7%	21%
Targets are agreed by partners and are locally relevant.	58%	13%	28%
Joint decision-making for tackling health inequalities is effective.	33%	25%	40%
My organisation's financial plans identify resources for implementing the health inequalities plan(s).	32%	28%	39%