

Health

inequalities

Essex public services

Audit 2009/10

September 2010



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Status of our reports

The Statement of Responsibilities of Auditors and Audited Bodies issued by the Audit Commission explains the respective responsibilities of auditors and of the audited body. Reports prepared by appointed auditors are addressed to non-executive directors/ members or officers. They are prepared for the sole use of the audited body. Auditors accept no responsibility to:

- any director/member or officer in their individual capacity; or
 - any third party.
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Summary report

Introduction

- 1 This summary report (pages 3 to 8) is designed to be read as a stand alone report. The detailed report (page 9 onwards) includes the same material, expanded to give more detail and specific examples. The report summarises progress in Essex as a whole (ie including Southend-on-Sea and Thurrock), with appendices providing an assessment for the relevant Local Strategic Partnership(s).
- 2 This report is not a commentary on individual organisations but looks at how partnership and public services are working together to tackle health inequalities, an issue that no one organisation can tackle alone.

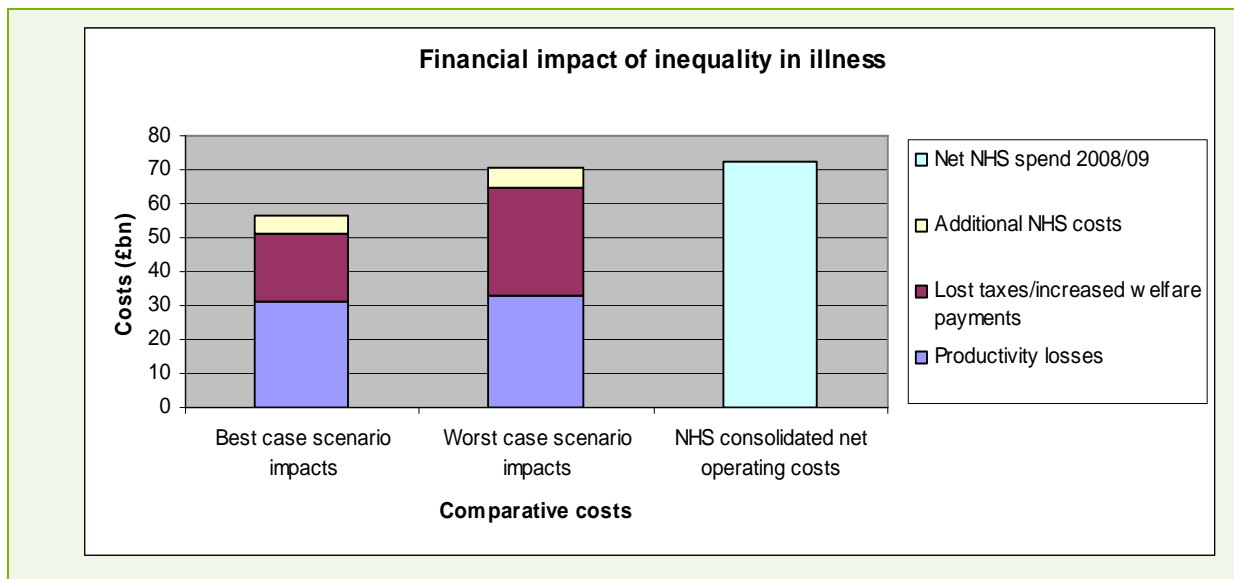
Health inequalities

- 3 Health inequalities are differences in health experience and outcomes between different population groups. These groups can be determined by socio-economic status, geographical area, age, disability, gender or ethnic group. Many factors contribute to health inequalities, including poverty, employment, education, housing and lifestyle.
- 4 In 2004, the then Labour Government set a single overarching target to reduce inequalities in health outcomes by 10 per cent as measured by infant mortality and life expectancy at birth by 2010. This target has almost certainly been missed. The health inequalities gap in the East of England, as for England as a whole, is increasing.ⁱ There have been achievements, for example, proportionally more people who have quit smoking in Essex come from the more deprived areas. However, the difference in life expectancy between Essex districts is over four years; within districts, the difference is as much as 18 years (see Appendices 2 and 3).

Fair Society, Healthy Lives

- 5 In February 2010, the Department of Health published 'Fair Society, Healthy Lives', a strategic review of health inequalities chaired by Professor Sir Michael Marmot. The review stresses that tackling health inequalities is a matter of social justice, with real economic benefits and savings. It also demonstrates that current patterns of health and health inequalities will undermine the policy of raising the retirement age. The review makes wide ranging recommendations which will require a joint approach across all central government departments, local government, the NHS, the third and private sectors and community groups.
- 6 The report estimates the adverse impacts of inequalities on government finances. In the worst case scenario, at over £70 billion a year, this is almost as much as the entire NHS consolidated net operating costs for 2008/09, as shown in Figure 1.

ⁱ Tackling Health Inequalities: 2006-08 Policy and Data Update for the 2010 National Target, Department of Health, December 2009

Figure 1 Financial impact of health inequalities

Sources: 'Fair Society, Health Lives' Department of Health (February 2010) and Department of Health Resource Accounts 2008/09

- 7 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.

White Paper 'Equity and Excellence: Liberating the NHS'

- 8 On 12 July 2010, the Government published its White Paper 'Equity and Excellence: Liberating the NHS'. It signals far-reaching changes in the way the NHS is organised, which will have a major impact on arrangements to tackle health inequalities.
- 9 A national Public Health Service is to be established. Local authorities will become responsible for assessing local strategic health needs and local delivery of health improvement. There will be a ring-fenced budget, allocated to reflect relative population health outcomes, with a health premium to promote action to reduce health inequalities.
- 10 Local authorities are to have a greater role in planning health services, promoting the joining up of local NHS services, social care and health improvement.
- 11 One proposal is that local authorities establish Health and Wellbeing Boards that will bring together locally elected representatives, social care and those responsible for commissioning care. The Boards are intended to bring democratic legitimacy, ensure consistency of commissioning and integration between health and social care.

Summary report

- 12 PCTs are to be abolished from 2013, with GP consortia taking over the commissioning of most health care to meet the assessed needs of the population they serve. These consortia are to come into being in shadow form in 2011/12, becoming fully operational in April 2013. There will also be an NHS Commissioning Board that will amongst other things commission primary care. Despite responsibility for public health moving to local authorities, it is likely that the GP consortia and the NHS commissioning board will be responsible for commissioning many of the health services that contribute to tackling health inequalities. The locality structure of the latter remains unclear.
- 13 Public sector organisations will need to review existing arrangements for tackling health inequalities in the light of the White Paper as further detail emerges. Partnership arrangements will need to be reviewed to ensure they reflect the changed responsibilities for commissioning services, in particular, engaging with the emerging GP consortia.

Background

- 14 The complex issue of health inequalities can only be addressed through co-operation and shared vision. This is particularly challenging in Essex due to the complexity of public service organisational arrangements, with three upper tier authorities, twelve district councils and five PCTs, two of which have boundaries that overlap those of the unitary authorities and County Council. There is a significant risk that arrangements may not be robust enough to deliver all partners' priorities and achieve value for money.
- 15 We therefore undertook an audit in 2007/08 across all Essex local authorities, PCTs and the Fire & Rescue Service to assess arrangements to reduce health inequalities; and examine future plans to improve life chances and reduce health inequalities.
- 16 Essex in this context includes the whole county, ie Southend-on-Sea and Thurrock as well as the area covered by Essex County Council.

Audit approach

- 17 The purpose of this follow up review was to assess the arrangements now in place across Essex to reduce health inequalities, to assess progress against our original recommendations and to identify what outcomes have been achieved.
- 18 Our original recommendations (which are set out in full in Appendix 1) were made under four headings:
 - strategic approach;
 - information and joint planning;
 - delivery and monitoring performance; and
 - political involvement.

Main conclusions

- 19** Essex public sector organisations have made good overall progress against our recommendations, particularly in consolidating strategic approaches to deal with health inequalities, working together to develop operational arrangements to deliver the strategies and improving member awareness. Some issues require further attention, particularly in delivery, target setting and local performance monitoring. Progress in each of these areas is summarised below.

Strategic approach

- 20** Most Local Strategic Partnerships (LSPs) now have an agreed and effective strategic approach to tackling health inequalities. Synergy between individual organisations' strategies and those of their partners is generally good.
- 21** Some LSPs have not made health inequalities a strategic priority. These are generally areas where overall health is good. This is a matter for local judgement, but these LSPs need to be sure that needs assessment supports their decision.

Information and joint planning

- 22** Essex partners continue to take an effective approach to developing the Joint Strategic Needs Assessment (JSNA). The JSNA is used well and continues to inform and improve decision making and action planning across Essex.
- 23** Arrangements for sharing, managing and using information across partner agencies have improved markedly, with plans in place for further improvement, although challenges remain.
- 24** There are varying levels of confidence amongst partners in the robustness and reliability of available data. There are also some concerns about data complexity, timeliness, comparability and consistency issues. This undermines partners' ability to plan and prioritise work on health inequalities effectively and challenges their ability to set meaningful and robust performance targets.
- 25** The appointment of a Director of Public Health (DPH) for Essex County Council has led to the production of a report for the Essex County Council area. Public health reports at both PCT and county level provide consistent and authoritative advice and information. Wider distribution and increasing awareness of these reports will support the development of a common strategic approach.
- 26** The appointment of the DPH for Essex County Council and PCT secondments into the county public health team have strengthened public health capacity and helped the five DPHs in Essex to work together more effectively, making an influential input into the Essex wide theme groups.
- 27** Joint public health appointments between PCTs and councils have had a major impact on joint planning and commissioning, as well as information sharing and developing awareness of health inequalities and their impact.

Summary report

- 28 Joint planning for tackling health inequalities through LSPs has been strengthened and accountability for delivery clarified. However, some LSPs are less clear on the distinction between their work to improve health overall and their approach to reducing inequalities.

Delivery and monitoring performance

- 29 Mechanisms for measuring, reporting and managing progress in reducing health inequalities are under-developed. All LSPs have clear overall performance management frameworks, with strong Member and Non Executive involvement. These arrangements are becoming increasingly robust. However, a lack of specific health inequality targets and reports means that most LSPs are limited in their ability to measure progress. Consequently, they do not have systematic ways of reporting key messages back to the individual partner organisations. These issues would benefit from further consideration.
- 30 LSPs and individual organisations have set themselves targets. However, it is not always obvious which targets relate to health inequalities rather than to general health improvement. Targets do not always have associated milestones and timescales. It is difficult to set targets for health inequalities, but without clearer success measures and milestones, it will be hard for LSPs, PCT Boards and Councils to assess the impact of the spending decisions that will be necessary in the current economic climate.
- 31 Action taken to date has not been sufficiently well designed or co-ordinated to reduce overall health inequality in Essex. There have been some successes, for example, proportionally more people who have quit smoking come from the more deprived areas, and there has been success in tackling childhood obesity in many districts. However, the overall picture has worsened, with the life expectancy gap widening overall. Relevant targets and success measures are not clear enough. For example, little has been done to document the contribution to reducing health inequalities that other non health-specific targets make, such as educational attainment or provision of decent homes. This makes it difficult for LSPs to articulate a sufficiently comprehensive picture of what is being done to tackle health inequalities, or to be able to demonstrate that action is designed to meet priorities.

Political involvement

- 32 Elected members' awareness and knowledge of health inequalities and their implications has significantly improved. Generally, organisations have worked hard to provide information and opportunities for both elected members (and non executive directors) to explore the complex issues and political dimensions of health inequalities. However, there is more to do to ensure all members have the same high level of understanding. This is particularly important for portfolio holders, such as for transport and housing in order to explore the links between their portfolio and health inequalities.

Outcomes

- 33 Work on health inequalities in Essex has led to mixed outcomes. However, there are many examples of innovative, targeted action to reduce health inequalities, some of which have received national recognition. Some notable examples are listed below. There is more detail and more examples given in the detailed report and appendices.

- All five PCTs five have had success in targeting smokers from the most deprived areas.
- Teenage conception rates have reduced across Essex.
- Partners have had some success in reducing the gap between the schools with the highest rates of obesity and all schools.
- A 'Village Agents' scheme in rural areas of the county is improving access to services to address health inequalities caused by rurality.
- The Fire & Rescue service run Firebreak courses across the county, helping disaffected young people (who are likely to experience health inequalities) get their lives back on the right track.
- The Fire service and Police work with the Princes Trust to deliver a personal development programme for young people in Basildon, Colchester, Southend and Thurrock.
- 'Reach Out' is a project in Tendring which has received national recognition and is quoted in the Marmot review. It helps people living in areas with high levels of deprivation receive advice and assistance to tackle poverty and improve health. The project is tackling the wider determinants of inequality and has been welcomed by local people.
- Another project in north east Essex which has received national recognition is health trainers, including youth trainers, who work in the areas of greatest inequality to provide health checks and advice and interventions to improve people's health.
- Family intervention projects in Basildon, Harlow, Southend, Tendring and Thurrock bring services together to work with families to change behaviours. These projects are having some notable successes, which should reduce the extent to which those families experience health inequality.
- A Vitality Bus goes into more deprived areas of Basildon and Thurrock and is soon to start operating in Brentwood as well. It offers stop smoking, cooking and health checks. Similarly, a Spotty Bus has been used to increase child immunisation rates in areas with low take up.
- As part of a drive to make services more personalised, Thurrock has worked with people with learning disabilities on outcome focussed health action plans. It has also set up a Community Interest Company, run by people with learning disabilities to put them in control of their own services. Both these initiatives have been recognised nationally
- Another effective and innovatively targeted pilot initiative in Colchester offered Job Seekers Allowance claimants and homeless people living in temporary accommodation health checks. Feedback has been positive and plans are in place to roll out both schemes.

Detailed report

Introduction

- 34** 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. Many factors contribute to health inequalities, including poverty, employment, education, housing and lifestyle.
- 35** Tackling health inequalities was a top priority for the previous Labour Government and continues to be a priority for the current Conservative and Liberal Democrat coalition Government. To date the focus has been on narrowing the health gap between disadvantaged groups and communities and the rest of the country, as well as improving health overall. A single overarching target to reduce health inequalities was set in 2004 as a national Public Sector Agreement target:

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

- 36** The health inequalities gap in England, as a whole is increasingⁱ (see Tables 1 and 2), suggesting that inequalities are worse today than 10 years ago. In Essex as a whole the gap is also increasing. Only in north east Essex and mid Essex has the gap narrowed since the end of 2006 and, in the case of mid Essex, this is at least in part due to a reduction in life expectancy in the less deprived areas. The difference in life expectancy between Essex districts is over four years; within districts, the difference is as much as 18 years (see Appendices 2 and 3ⁱⁱ).

ⁱ Tackling Health Inequalities: 2006-2008 data and policy update for the 2010 National Target, Department of Health, December 2009

ⁱⁱ The maps in appendices 2 and 3 serve to illustrate the scale of the issue. Although the data is relatively old (2003), local intelligence suggests the picture has not changed radically since.

Table 1 Life expectancy at birth - males

Life expectancy at birth - males	England	Spearhead group ⁱ	Absolute gap	Relative gap (target measure = minus 10%)
1995-97 (baseline)	74.6 years	72.7 years	1.9 years	2.57%
2006-08	77.9 years	75.8 years	2.1 years	2.75%
Change	+ 3.3 years	+ 3.1 years	+ 0.2 years	Plus 7%

Source: 'Tackling health inequalities: 2006-2008 policy and data update for the 2010 national target' - Department of Health, December 2009.

Table 2 Life expectancy at birth - females

Life expectancy at birth - females	England	Spearhead group	Absolute gap	Relative gap (target measure = minus 10%)
1995-97 (baseline)	79.7 years	78.3 years	1.4 years	1.77%
2006-08	82.0 years	80.4 years	1.7 years	2.02%
Change	+ 2.3 years	+ 2.1 years	+ 0.2 years	Plus 14%

Source: 'Tackling health inequalities: 2006-2008 policy and data update for the 2010 national target' - Department of Health, December 2009.

Fair Society, Healthy Lives

- 37** In February 2010, the Department of Health published 'Fair Society, Healthy Lives', a strategic review of health inequalities chaired by Professor Sir Michael Marmot, Chair of the World Health Organisation's Commission for Social Determinants. This review makes wide ranging recommendations which will require a joint approach across all central government departments, local government, the NHS, the third and private sectors and community groups.
- 38** Marmot points out that focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. Actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These include productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs. The fair distribution of health, wellbeing and sustainability are important social goals.

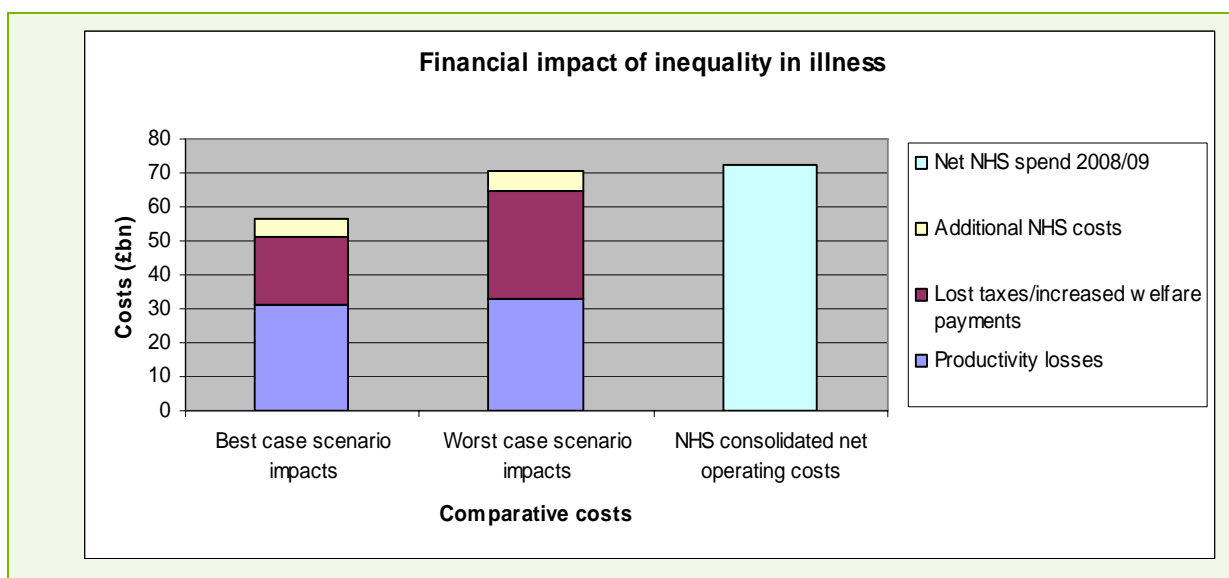
ⁱ Spearhead Group: the fifth of areas with the worse health and deprivation indicators in England (none of these is in Essex)

"It is estimated that inequality in illness accounts for productivity losses of £31-33 billion per year, lost taxes and higher welfare payments in the range of £20-32 billion per year, and additional NHS healthcare costs associated with inequality are well in excess of £5.5 billion per year. If no action is taken, the cost of treating the various illnesses that result from inequalities in the level of obesity alone will rise from £2 billion per year to nearly £5 billion per year in 2025."

("Fair Society, Healthy Lives")

- 39 This statement can be presented graphically (see Figure 2) to show the adverse impacts of inequalities on government finances. In the worst case scenario, this is almost as much as the entire NHS consolidated net operating costs for 2008/09.

Figure 2 Financial impact of health inequalities



Sources: 'Fair Society, Health Lives' Department of Health (February 2010) and Department of Health Resource Accounts 2008/09

- 40 Marmot also demonstrates that current patterns of health and health inequalities will undermine the policy of raising the retirement age. He shows the gap between life expectancy and disability-free life expectancy at birth, by neighbourhood income level. With the levels of disability shown, more than three-quarters of the population do not have disability-free life expectancy as far as the age of 68 – the pensionable age to which England is moving. Those living in the most deprived areas can expect only some 52 years of disability-free life. If society wishes to have a healthy population, working until 68 years, he suggests it is essential to take action both to raise the general level of health and to flatten the social gradient.

- 41 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.

White Paper 'Equity and Excellence: Liberating the NHS'

- 42 On 12 July 2010, the Government published its White Paper 'Equity and Excellence: Liberating the NHS'. It signals far-reaching changes in the way the NHS is organised, which will have a major impact on arrangements to tackle health inequalities.
- 43 A national Public Health Service is to be established. Local authorities will become responsible for assessing local strategic health needs and local delivery of health improvement. There will be a ring-fenced budget, allocated to reflect relative population health outcomes, with a health premium to promote action to reduce health inequalities.
- 44 Local authorities are to have a greater role in planning health services, promoting the joining up of local NHS services, social care and health improvement.
- 45 One proposal is that local authorities establish Health and Wellbeing Boards that will bring together locally elected representatives, social care and those responsible for commissioning care. The Boards are intended to bring democratic legitimacy, ensure consistency of commissioning and integration between health and social care.
- 46 PCTs are to be abolished from 2013, with GP consortia taking over the commissioning of most health care to meet the assessed needs of the population they serve. These consortia are to come into being in shadow form in 2011/12, becoming fully operational in April 2013. There will also be an NHS Commissioning Board that will amongst other things commission primary care. Despite responsibility for public health moving to local authorities, it is likely that the GP consortia and the NHS commissioning board will be responsible for commissioning many of the health services that contribute to tackling health inequalities. The locality structure of the latter remains unclear.
- 47 Public sector organisations will need to review existing arrangements for tackling health inequalities in the light of the White Paper as further detail emerges. Partnership arrangements will need to be reviewed to ensure they reflect the changed responsibilities for commissioning services, in particular, engaging with the emerging GP consortia.

Background

- 48 Such a complex issue is not the preserve of any one organisation and can only be addressed through co-operation and shared vision. This is particularly challenging in Essex due to the complexity of public service organisational arrangements, with three upper tier authorities, twelve district councils and five PCTs, two of which have boundaries that overlap those of the unitary authorities and County Council. There is a significant risk that arrangements may not be robust enough to deliver all partners' priorities and achieve value for money.

Detailed report

- 49 We therefore undertook an audit in 2007/08 across all Essex local authorities, PCTs and the Fire & Rescue Service to assess arrangements to reduce health inequalities; and examine future plans to improve life chances and reduce health inequalities.
- 50 Essex in this context includes the whole county, ie Southend-on-Sea and Thurrock as well as the area covered by Essex County Council.

Audit approach

- 51 The purpose of this follow up review was to assess the arrangements now in place across Essex to reduce health inequalities, to assess progress against our original recommendations and to identify what outcomes have been achieved. The findings have informed the Value for Money conclusion at each audited body.
- 52 Our original recommendations (which are set out in full in Appendix 1) were made under four headings:
 - strategic approach;
 - information and joint planning;
 - delivery and monitoring performance; and
 - political involvement.
- 53 The audit was undertaken by a review of our existing knowledge, followed by a request to each organisation to provide specific additional information. We then presented our initial findings at a series of six workshops (one in each PCT area and one for the Essex Partnership) at which the issues were explored, our findings challenged and further information provided, especially on outcomes.
- 54 This report summarises progress in Essex as a whole, with an appendix for each Local Strategic Partnership (LSP) at Appendix 1. Each council and PCT will receive the appendix for its LSP(s). The Police and Fire & Rescue Services will receive the appendices for the three upper tier LSPs, ie Essex county, Southend and Thurrock.
- 55 Appendix 2 shows the variation in life expectancy across Essex at ward level. Appendix 3 has a map, used in the workshop sessions, which shows how much life expectancy can vary for people living only a short distance away from each other. It does this by plotting life expectancy along the railway lines for each ward with a station within it.ⁱ

Main conclusions

- 56 Essex public sector organisations have made good overall progress against our recommendations, particularly in consolidating strategic approaches to dealing with health inequalities, working jointly to develop operational arrangements to deliver the strategies and improving member awareness. Some issues require further attention, particularly delivery, target setting and performance monitoring. Progress in each of these areas is summarised below.

ⁱ The maps in appendices 2 and 3 serve to illustrate the scale of the issue. Although the data is relatively old (2003), local intelligence suggests the picture has not changed radically since.

Strategic approach

- 57 At the time of our original audit, there was clear intent to tackle health inequalities but no agreement on the best strategic approach to take. Most LSPs now have an agreed and effective strategic approach. This is generally articulated in the strategy for health and wellbeing within sustainable community strategies. Some LSPs, for example Southend, have also adopted a specific health inequalities strategy. Chelmsford has taken a particularly holistic view. It has a plan for addressing inequalities targeted on a range of inequality issues rather than solely on health inequalities. Braintree LSP is developing an approach across all areas of all services, including Education, Housing, Environment and the Citizens Advice Bureau, recognising the impact that these services can have on reducing health inequalities. Colchester has a well established Life Opportunities Plan tackling inequalities across the borough.
- 58 Some LSPs have not made health inequalities a strategic priority. These are generally areas where overall health is good. This is a matter for local judgement, but these LSPs need to be sure that their decision is based on sound information and analysis. Even where there are not wide variations in health, there may still be pockets of deprivation and sections of the population, such as people with learning disabilities, who are experiencing inequality.
- 59 Most individual organisations have given health inequalities some strategic priority, including it as a strand within their plans. Some, such as Epping Forest, Harlow and Tendring Councils, have adopted health inequalities as a corporate priority. Some organisations, including the County Council, have developed specific health inequalities strategies to focus their whole organisation on the issue and to help individual service areas understand the contribution they can make. Tendring has developed a notable approach in which all services and all staff can recognise the contribution they can make. All the PCT strategies, in particular North East Essex PCT, include health inequalities as a central theme.
- 60 The strategic contribution that the Police and the Fire & Rescue Service can make is being increasingly recognised. The correlation between health inequalities, crime and community safety is becoming better understood. Areas experiencing health inequalities are often also areas of higher crime, drugs and alcohol abuse (which of course can lead to increased crime and anti social behaviour) and therefore tend to suffer the effects of crime disproportionately. Fires and accidents are also more common in these areas. Targeted preventative work by the Fire & Rescue Service can have a major impact.
- 61 Our original review identified widespread inconsistency across Essex in approaches to dealing with health inequalities. The synergy between individual organisations' strategic approach to tackling health inequalities and that of their partners is now generally good. However, this needs to be kept under review to ensure a common strategic approach continues to develop, particularly when there are so many other competing priorities.

Information and joint planning

- 62 Essex partners continue to take an effective approach to developing the Joint Strategic Needs Assessment (JSNA). It is being updated on a rolling basis. Some partners are concerned that the move to a more thematic JSNA could weaken its local focus and so make it less useful to them. They would value local updates to inform local planning and commissioning decisions. However, the partners are demonstrating their commitment to ensuring that the JSNA remains relevant and continues to be improved through an evaluation of its impact and usefulness.
- 63 The JSNA is used well and continues to inform and improve decision making and action planning across Essex. As Sustainable Community Strategies are refreshed, they are being revised to take account of the information provided by the JSNA. For example, Epping Forest is using 'Shaping the Future' district and ward level profiles to support the production of the new Sustainable Community Strategy and to raise Member awareness of particular issues within their wards.
- 64 The JSNA increasingly influences commissioning. It is recognised and valued as an improvement over any previous information source, although it does not attempt to be comprehensive. Other, more detailed data, for example on carers needs has to be used alongside its higher level information. This has not been made sufficiently clear to all partners. Some organisations, such as the Fire & Rescue Service, have made less use of the JSNA to date, but as awareness of its potential increases, this differential is reducing.
- 65 Arrangements for sharing, managing and using information across partner agencies have improved markedly, although challenges remain. The JSNA has brought high level needs information together. Partners were planning to bring all information useful for planning together into one warehouse through the Essex Neighbourhood Information Management System project. Funding for this initiative has recently been withdrawn, but an effective mechanism for collecting, validating and collating information across all partners is still required.
- 66 There are an increasing number of information sharing protocols in place. A noteworthy example is Basildon LSP's adoption of a data sharing protocol developed by the Community Safety Partnership. This is supported in practice by a Council data analyst being based in the police station.
- 67 Some problems still remain in terms of sharing sensitive information, for example from Accident & Emergency departments in hospitals, but these problems are being tackled and progress is being made. Experience with the Multi-Agency Risk Assessment Conference (MARAC), which is a coordinated community response to domestic abuse, has shown how sensitive information can be shared appropriately and to good effect.
- 68 The creation of joint public health posts between PCTs and councils, with good governance arrangements, has had a number of benefits, including facilitating information sharing and maximising resources.

- 69 There is varying confidence in the reliability and robustness of the data available to LSPs to support their decision making processes. Additionally, the data complexity and wide variety of data sources, coupled with the relatively old age of even the most recent data available on some topics, can result in seemingly contradictory conclusions being reported. This makes the determination of priorities more challenging, increasing the risk of resources being inappropriately targeted, and makes it difficult to set meaningful and robust performance targets.
- 70 In our original report, we recommended partners considered producing a public health report for Essex as a whole to underpin the common strategic approach. This has not been possible as there are five PCTs, each with a Director of Public Health (DPH) who has a statutory responsibility to produce a report for their PCT area. However, the appointment of a DPH for Essex County Council has led to the production of a public health report for Essex County Council area. Individual DPHs have been involved in the production of this report. The value of having a high level report giving clear and consistent messages is well understood. However, it is not widely publicised or known about by all organisations. Wider distribution and increasing awareness of public health reports at both PCT and county level will support the development of a common strategic approach.
- 71 The appointment of a DPH for Essex County Council and PCT secondments into the county public health team have strengthened public health capacity and helped the five DPHs in Essex to work together more effectively, contributing to the Essex wide theme groups.
- 72 Joint planning for tackling health inequalities through LSPs has been strengthened and accountability for delivery clarified. All LSPs have a theme group with responsibility for health inequalities which coordinates action. In most cases this is the Health and Wellbeing group. However, some LSPs are less clear on the distinction between their work to improve health overall and their approach to reducing inequalities.
- 73 There are examples of good collaboration between LSPs. For example, Castle Point and Rochford LSPs have established a joint Health & Wellbeing Partnership. The three LSPs in West Essex are undertaking some effective joint planning. For example, 'Fit as a Fiddle' is a jointly run scheme across West Essex for older people. The three LSPs, working together on Future Jobs Fund, were successful in obtaining funding for 80 posts for getting young people into work.

Joint planning case study

In the south east Essex area, Rochford and Castle Point LSPs have a joint Health and Wellbeing Partnership thematic group. This group is undertaking some innovative work to tackle health inequalities, and improve service effectiveness and value for money, using a Total Place approach. This has involved workshops with attendees from a wide range of partners brought together to map out a typical interventions timeline for engagement with a live case study of a 'frequent flyer' service user. This was then critically reviewed and remodelled at a task and finish style workshop in order to produce a better practice model of intervention that could be applied to a wider range of actual families.

Detailed report

- 74 All LSPs keep their arrangements under constant review. This should enable joint planning for tackling health inequalities to continue to improve.
- 75 The joint public health appointments between PCTs and councils have had a major impact on joint planning and commissioning, as well as information sharing and developing awareness of health inequalities and their consequences. The post holders have been able to improve trust and mutual understanding between PCTs and their partner councils, which has facilitated information sharing and joint planning. Their expertise and specific focus on health inequalities has helped raise Member and officer awareness, a fact readily acknowledged by both. This has supported a stronger strategic focus on health inequalities, backed up by action planning with specific targeted interventions.

Delivery and monitoring performance

- 76 All LSPs have clear overall performance management frameworks, with strong Member and Non Executive involvement. These arrangements are becoming increasingly robust. Notable approaches include Chelmsford LSP agreeing to enhance its performance management reporting arrangements with the use of case studies to improve their understanding of issues, outcomes and achievements.
- 77 Mechanisms for measuring, reporting and managing progress in reducing health inequalities are underdeveloped. Performance management frameworks cover health improvement activity well but it is not clear how performance specifically on reducing health inequalities is reported and managed. Most LSPs do not have systematic ways of reporting key messages back to the individual partner organisations. Some LSPs, such as Southend, have developed a basket of indicators to measure their progress against this priority. Other LSPs and organisations do not think it is helpful to report separately against cross cutting issues such as reducing health inequalities, as it runs the risk of them being seen as special interest areas rather than core business. These issues would benefit from further consideration.
- 78 LSPs and individual organisations have set targets for their objectives and associated actions. Some are locally based targets based on identified needs. It is difficult to demonstrate causality as there are so many factors affecting health experience, some of which are beyond the control of LSPs and their constituent organisations. However, targets are not being expressed and set to deliver explicit reductions in health inequalities. It is not always obvious which targets relate to health inequalities as opposed to general health improvement. There is more to be done to develop long term targets with milestones and timescales, showing how individual projects contribute to the reduction of health inequalities, whether by geography or population groups.
- 79 Because targets and success measures are not clear enough, it is difficult for LSPs to demonstrate that action is designed to meet priorities. It will be hard for LSPs, PCT Boards and Councils to assess the impact of future spending decisions, especially in a time of financial stringency, unless clearer success measures and milestones have been agreed.

- 80 Action taken to date may not have been sufficiently well designed to meet local needs or effectively co-ordinated. Health improvement activity is only relevant to health inequalities if it is targeted. An example is the smoking cessation service, which is universally available, but targeted at areas and population groups with the highest need. Although there have been some successes, including smoking quit rates, the overall picture has worsened, with the life expectancy gap widening.

Political involvement

- 81 Elected members' awareness and knowledge of health inequalities and their implications has significantly improved. Organisations have worked hard to provide information and opportunities for both elected members and non executive directors to explore the complex issues and political dimensions of health inequalities. Examples include DPH presentations to Overview & Scrutiny Committees. There is more to do to ensure all members have the same high level of understanding. In particular, there is more work to do with other portfolio holders, for example for transport or housing, to explore the links between their portfolio and health inequalities. Nevertheless, very good progress has been made, which is leading to a more informed, committed and strategically driven approach to tackling health inequalities in Essex.

Outcomes

- 82 Work on health inequalities in Essex has led to mixed outcomes. Improvements have been made but there are some areas where outcomes are deteriorating. There are many examples of innovative, targeted action to reduce health inequalities, some of which are described in the following paragraphs.
- 83 All five PCTs are exceeding their smoking quit rates and have had success in targeting smokers from the most deprived areas, with four of the five exceeding the targets they set themselves.
- 84 Teenage conception rates have reduced across Essex. In Brentwood, the reduction since 1998 has been 33 per cent, which is the best performance in Essex.
- 85 The partners are tackling childhood obesity effectively. Epping Forest has the lowest prevalence amongst Essex districts at 7.3 per cent. More importantly, partners have had some success in reducing the gap between the schools with the highest rates of obesity and all schools. They have targeted their interventions, including an extension of the MEND scheme (nutrition and exercise) in south west Essex which has had a success rate of between 70 and 80 per cent in terms of stabilising or reducing the BMI measurements of participating children.
- 86 A Village Agents scheme in rural areas of the county is improving access to services to address health inequalities caused by rurality.
- 87 Braintree runs health & wellbeing days targeted at older people from isolated rural locations, providing transport to get them involved in the activities.
- 88 The Maldon hospital link worker project works with carers to ensure that when patients are coming out of hospital, both the carer and the person they care for are having their needs met. The project has surpassed expectations in the number of referrals generated so far and will be continuing to take referrals from health and social care workers, increasing awareness of carers' issues.

Detailed report

- 89 The Fire & Rescue Service and Police work with the Princes Trust to deliver a team programme in Basildon, Colchester, Southend and Thurrock. This is a 12-week personal development course for young people, offering work experience, qualifications, practical skills, community projects and a residential week.
- 90 The Fire & Rescue service run Firebreak courses across the county. These are a very effective way of engaging disaffected young people (who are likely to experience health inequalities) and helping them get their lives back on the right track.
- 91 Councils have acted to reduce poverty. Several, such as Colchester, are working in effective partnership with Citizens Advice Bureaux and Children's Centres. Revenues and Benefits departments across Essex are proactive in trying to ensure vulnerable people claim the benefits to which they are entitled. For example, benefits surgeries are held at a hostel for homeless young people in Brentwood, with trained staff to help young people with benefit applications. All these young people are also now offered a specialist health assessment on arrival.
- 92 'Reach Out' is a project in Tendring which has received national recognition and is quoted in the Marmot review. It helps people receive advice and assistance to tackle poverty and improve health. The project was developed through a partnership between the PCT, County Council and the Interaction Partnership and is run by the local Citizens Advice Bureau (CAB). CAB members knock on doors in areas with high levels of deprivation, offering to provide information and advice to people with a wide range of issues. The project is tackling the wider determinants of inequality and has been welcomed and is valued by local people.
- 93 Another project in north east Essex which has received national recognition is health trainers, including youth trainers, who work in the areas of greatest inequality to provide health checks and advice and interventions to improve people's health.
- 94 Family intervention projects in Basildon, Harlow, Southend, Tendring and Thurrock bring services together to work with families that are causing problems for their communities, but also themselves, to change behaviours. These projects are having some notable successes, which should reduce the extent to which those families experience health inequality.
- 95 Although still at the planning stage, St Luke's Healthy Living Centre in Southend is being developed to provide seamless services in an area of high inequality. It is to include health provision funded by the PCT, a base for children's services staff funded by the Council; and a community facility.
- 96 An exercise programme called Gym Express, aimed at weight management, has been developed in some of the more deprived areas of Basildon and Thurrock. It provides three months' free gym attendance followed by subsidised membership. There have been 2,000 attendees of whom two thirds lost more than five per cent of their weight and 60 per cent continued their membership. Weight management programmes for men have offered martial arts, which is more acceptable to many men than traditional gym membership.

- 97** A Vitality Bus goes into more deprived areas of Basildon and Thurrock and is soon to start operating in Brentwood as well. It offers stop smoking, cooking and health checks. Similarly, a Spotty Bus has been used to increase child immunisation rates in areas with low take up.
- 98** Basildon and Thurrock LSPs have encouraged cycling through a scheme called Bike It. This is targeted on the most deprived areas, which often have the most dangerous roads. It involves road safety and cycle maintenance and has led to a significant increase in the number of bikes parked at local schools.
- 99** As part of a drive to make services more personalised, Thurrock has worked with people with learning disabilities on outcome focussed health action plans. It has also set up a Community Interest Company, run by people with learning disabilities to put them in control of their own services. Both these initiatives have been recognised nationally.
- 100** SOS buses in Colchester and Southend have led to significant reductions in violence related to alcohol in the two town centres, reduced A&E attendances and ambulance call outs and given exciting opportunities to deliver health messages to vulnerable young people.
- 101** NE Essex PCT has set up a local enhanced scheme (LES) with GPs which is tackling health inequalities. Participating practices look after over 16,000 patients in low life expectancy wards. The aim is to increase take up of screening for certain long term conditions. So far, practices have improved hypertension management control from 68 per cent of patients to 79 per cent and for diabetes management from 65 per cent to 82 per cent. The PCT has also begun a LES to improve access for patients with learning disabilities to primary care with a focus on screening for heart disease and cancer.
- 102** A GP Care Advisor service has been successful in keeping people in their homes in Colchester and Tendring. The advisors help people access social care and self-help support to help them maintain their independence at home. Over 2000 patients are helped each year. The scheme is not unique, but it is more holistic than most in the way it covers health, social care and welfare support. In Harlow, targeted nurse led clinics are helping vulnerable older people remain in the community.
- 103** Another effective and innovatively targeted initiative saw Job Seekers Allowance claimants offered health checks at Colchester Job Centre for a two week pilot during February 2010. Over 200 were carried out, identifying a significant number of health issues. Feedback from all concerned has been positive and further checks are planned in Colchester and Tendring Job Centres during the summer of 2010. Outcomes include 43 people referred to their GP as a result of their cholesterol tests and 40 people who took up membership at a local gym. Similarly, homeless people living in temporary accommodation were offered health checks at their accommodation over two days in March 2010. Nineteen were carried out, identifying a significant number of potentially serious health issues. Feedback has been positive and further checks are planned in June 2010, covering children as well as adults.

Appendix 1 – Southend Local Strategic Partnership

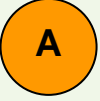
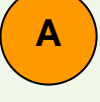

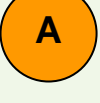


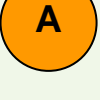
Context

- 1 The Southend Joint Strategic Needs Assessment (2008) highlights significant geographical variations by Medium Super Output Area for life expectancy and mortality rates from a variety of causes. For example, there is a gap of more than eight years in life expectancy between the electoral wards with the highest and lowest life expectancies.
- 2 Deprivation is strongly associated with poor health, and Southend is one of Essex's most deprived areas. It has pockets of high affluence and wards which suffer notable deprivation. Five Super Output Areas fall within the 10 per cent most deprived areas in England, and an estimated 45 per cent of the borough's population lives within the 20 per cent most deprived areas in the East of England. At the other end of the spectrum, Super Output Areas within West Leigh rank among the 20 per cent least deprived wards in East of England.



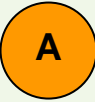
Overall summary of progress

- 3 Southend LSP (Southend Together) has significantly strengthened its arrangements for tackling health inequalities since we undertook our first stage review. Further improvements are needed, but it already has a much stronger base for delivery and for having an impact on health inequalities in the future.
- 4 Progress against our original recommendations and the outcomes achieved are described in this appendix and summarised in the table below. A green rating indicates strong progress with the LSP on track to fulfil the recommendation. Amber indicates reasonable progress but with more to do. Red indicates limited progress with significant issues to address.

Table 3 Southend LSP - summary of progress

Recommendations	RAG rating	Conclusion
R1 Agree a common strategic approach to addressing health inequalities, with agreed local and Essex-wide priorities.		Southend Together has made good progress in developing a common strategic approach, but this is still at an early stage of implementation. Specifically, tackling health inequalities is increasingly integral to the LSP's overall approach, and this will be further enhanced through the new Health Inequalities Strategy.
R2 Develop and agreed health inequalities targets locally and at LSP level based on the identified needs.		Some progress has been made in developing health inequalities targets, although further clarification of explicit targets is required. Clearer identification of how targets impact on health inequalities and what success looks like would improve understanding and decision making.
R3 Exploit the full potential of the Joint Strategic Needs Assessment (JSNA) to identify health inequalities.		The JSNA is being used well and continues to improve decision making and action planning in Southend. Local partners are contributing to the continued development of the JSNA.
R4 Improve arrangements for sharing, managing and using information across all partner agencies.		Southend Together has made good progress in sharing, managing and using information between partners, although challenges remain and developments are still in progress.
R5 Consider production of a public health report for Essex as a whole to underpin the common strategic approach.		The DPH for Essex County Council produced his first public health report in 2008. The South East Essex report is well understood, but the county report is less well known or used.
R6 Strengthen joint planning for tackling health inequalities through the local strategic partnerships and local area agreements and clarify accountability for delivery.		Southend Together has strengthened its joint planning arrangements for health inequalities, using the local strategic partnerships and local area agreement to clarify accountability for delivery.
R7 Ensure action is co-ordinated, strategically led and designed to meet overall objectives and priorities as well as local needs.		Action is coordinated through the LSP. Work to tackle health inequalities is becoming more embedded in the core programme delivery.

Appendix 1 – Southend Local Strategic Partnership

Recommendations	RAG rating	Conclusion
R8 Develop a clear performance management framework for health inequalities, with strong Member and Non Executive involvement.		The LSP has a clear and robust overall LAA performance management framework but mechanisms for measuring, reporting and managing progress in reducing health inequalities specifically, are under-developed.
R9 Improve awareness and knowledge of health inequalities and their implications amongst elected members and all service areas within Essex public services		Partners have worked hard to improve awareness and knowledge of health inequalities and their implications among elected members. Briefings have raised awareness among staff and partners.
What outcomes have been achieved by the local strategic partnerships and how have they impacted since our 2007/08 review.		The LSP and its partners have achieved a number of positive outcomes. However, despite these successes, action has not been targeted effectively enough to have the impact required. Inequalities persist and are increasing, when measured by the differences in life expectancy.

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

- 5 Southend Together has made good progress in developing a common strategic approach, but this is still at an early stage of implementation. The LSP has recently approved a Southend-on-Sea Health Inequalities Strategy which will become the focus of the LSP's work to reduce health inequalities. The Strategy is a powerful document, drawing on evidence from a number of sources to demonstrate the case for proposed changes and actions.
- 6 The LSP recognises that there is much to do to tackle health inequalities and further partnership activity is required to agree the priorities for action and how this will be resourced. Health inequalities is one of the significant challenges facing the Council and partner agencies, particularly as most partner agencies are facing a future with limited additional resources and significant efficiency savings required. New ways of working to tackle health inequalities will need to see a reallocation of resources to tackle the areas of greatest need.
- 7 An officer working group has been established between Southend-on-Sea Borough Council and NHS South East Essex, with a view to implementing the Health Inequalities Strategy. This should provide the necessary commitment to achieve the changes required to deliver the Strategy.

- 8 The Southend Sustainable Community Strategy 2007-2017 (SCS) gives a commitment to improving health outcomes generally, but is not focussed on reducing health inequalities (although reference is made to the linked outcome in the LAA). However, the SCS is currently being refreshed and the LSP anticipates that the update will ensure the SCS contains a clear, cross-cutting theme of the continued reduction of inequalities across Southend. The health ambition is expected to focus on reducing health inequalities and the clear objectives and actions that will be undertaken to achieve this.

R2 Develop and agreed health inequalities targets locally and at LSP level based on the identified needs.

- 9 NHS South East Essex's 5 Year Strategy includes, as a local priority, a commitment to reducing health inequalities by 2014 and related targets.
- 10 The Southend JNSA has been used to refresh the Southend Local Area Agreement (LAA), which includes a section on reducing health inequalities and a basket of health inequalities indicators. However, targets to be achieved have not yet been set against these indicators.
- 11 Health inequalities targets for children have been reflected in the Children and Young People Plan Action Plan. These were based on the JNSA and a needs assessment that was undertaken for the Children and Young People Plan. This document provides more explicit targets about what should be delivered by each of the actions, although exactly how this links to addressing health inequalities is not clear.
- 12 The Southend-on-Sea Health Inequalities Strategy Action Plan needs to be populated in a similar way, to provide a clear expression of what is intended to be delivered by each of the actions taken and what the health inequalities outcomes achieved will be.

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

- 13 The JSNA is being used well and continues to improve decision making and action planning in Southend, as elsewhere in the county.
- 14 The Southend JSNA highlighted significant geographical variations by Medium Super Output Area for life expectancy and mortality rates from a variety of causes. The key issues for Southend are detailed within each of the chapters of the JSNA, increasing their profile and wider awareness of the issues.
- 15 The Southend JNSA has also been used to refresh the Southend LAA which includes a section on reducing health inequalities and a basket of health inequalities-related indicators, although the articulation of the local targets and success measures, to be achieved against those indicators, needs to be improved. Specifically, long-term targets are needed, but with milestones over the medium-term to measure progress towards the ultimate target.

Appendix 1 – Southend Local Strategic Partnership

- 16 Local partners are contributing to the continued development of the JSNA. Ideas for possible development include using the Place Survey and tracker survey results to ensure reported needs are included and describing the expected outcomes from interventions and activities to help measure success. However, there is a concern that the move to a more thematic JNSA could weaken its local focus and so make it less useful.

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

- 17 The quality of arrangements amongst Essex partners for sharing data is variable and there have been some difficulties in sharing data relating to personal information. Reasons for this include partners not providing information on the grounds of confidentiality or because there are concerns over partners' data quality arrangements.
- 18 There are a range of information sharing arrangements, including:
- LSP Lead Officers' Information Group.
 - South East Essex Data Sharing Group.
 - Essex Information Management Group.
- 19 Southend-on-Sea Borough Council has developed a data observatory that includes information from a variety of sources, in partnership with the East of England Data Observatory. The data observatory group, which comprises representatives from across the Council, with links to partner agencies, updates the borough profile on a six-monthly basis (including use of consultation and perception data). This information is shared throughout the LSP to identify trends and issues. The group have identified a number of areas where the data indicates that further investigation is warranted to enable the LSP to understand the nature of the issue and develop a co-ordinated partnership response.
- 20 The data analysts from NHS South East Essex, Southend-on-Sea Borough Council and the Police work closely together, enabling a greater understanding of the data sources available and of opportunities for sharing information to be developed further.
- 21 Southend Together endorsed a Partnership Information Sharing Protocol in January 2010. This is being taken to each individual partner's decision making board for formal endorsement, to ensure that all of the partners are committed to working together in an agreed way.
- 22 Partners are working to tackle the challenges in data sharing due to limitations in information systems. Southend Together have implemented the Cardiff Model (involving the Police, CDRP, PCT, Hospital and the DAAT). The PCT has ensured that the sharing of the data through the model is included in their contract with Southend University Hospital. The anonymous data will be passed to the CDRP analyst who will produce a summary report that will be distributed to all key agencies. The data provided by the Cardiff Model will enable partners to identify overall trends in violence and violence hotspots. This will enable work to be undertaken on preventative interventions at the source, reducing the resource required to deal with the results of incidences of violence and violence hotspots.

- 23 The Director of Public Health (DPH) and her team play an effective role in facilitating information sharing and have been assisted in this through the Southend data observatory. However, this may become duplicated through the county-wide plans to bring all useful planning information together through the Essex Neighbourhood Information Management System (ENIMS) project. Partners have not yet clarified the relationship between this project, the Southend data observatory and the Eastern region public health observatory.

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

- 24 The DPH for Essex County Council produced an Annual Report for Essex based on the key health inequalities issues identified through the Joint Strategic Needs Assessments. However, the report has not been widely publicised and most LSP partners are unaware of its content.
- 25 The DPH for South East Essex produced a similar report, highlighting the differences in health across the area and making recommendations to tackle health inequalities. The South East Essex report is well understood, but if the county report is not also used, there is a risk that high level issues affecting the whole county may not be adequately considered.

R6 Strengthen joint planning for tackling health inequalities through the local strategic partnerships and local area agreements and clarify accountability for delivery.

- 26 Southend Together includes the Health & Wellbeing Partnership. This is a collaborative group including representatives from the relevant statutory and non-statutory organisations, working together to deliver the aims of the partnership.
- 27 The LSP has produced a Governance Framework and Performance Management arrangements that seek to clarify roles, responsibilities, accountability, reporting lines and performance management arrangements.
- 28 Southend Together's vision for 2017 includes that:
- the quality of life for local people is good; and
 - health inequalities within Southend are minimal.
- 29 This focus is reinforced in the latest LAA where 'Tackling Health Inequalities' is one of the seven key priorities.
- 30 The Southend LAA 2008-2011 was developed through a top-down and bottom-up approach to ensure agreement and wide ownership of the areas chosen for tackling health inequalities. Much work is done in the four key strategic partnerships on work that could impact on health inequalities, but is not explicitly recognised as such.
- 31 The new Southend Health Inequalities Strategy confirms partners' commitment to this agenda and sets out the actions currently being taken to tackle and reduce health inequalities.

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

- 32** Embedding national and local health inequalities measures in the Southend LAA has helped to ensure that there is strategic leadership for key health inequalities issues.
- 33** The adoption of the Southend Health Inequalities Strategy will provide the partnership with an opportunity to streamline activity and coordinate resources to meet local needs.
- 34** Partners are currently refreshing the SCS, which will explore the potential to start including shared strategic priorities across LSP partners and include these in the SCS.
- 35** Examples of action that is co-ordinated are in place, such as the work to develop the new St Luke's Healthy Living Centre, which aims to secure one centre consisting of three key service elements, working in partnership to deliver seamless services of:
- a health provision funded by the PCT through a Service level agreement;
 - a base for children's services staff funded by the Council; and
 - a community facility, funded through the Community Interest Company (CIC).
- 36** Although there have been some successes, for example smoking quit rates, the overall picture has worsened with the life expectancy gap widening. This suggests that action taken to date may not have been sufficiently well designed to meet local needs, or effectively co-ordinated to have the desired impact.

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

- 37** As is the case for most Essex LSPs, mechanisms for measuring, reporting and managing progress in specifically reducing health inequalities are under-developed. The LSP has a clear overall LAA performance management framework, with good Member involvement. Monitoring takes place on a bi-monthly basis by the Southend Together Performance Management Group, with regular call in where there is concern. These arrangements are becoming increasingly robust.
- 38** However, most targets cited as health inequalities targets are related to, but not specifically focussed on, reducing health inequalities. They cover health improvement activity well, but it is not clear how performance specifically on reducing health inequalities is reported or managed.
- 39** The LAA targets are also included in the NHS South East Essex Board Performance Report, which includes NED involvement at Board meetings, ensuring that information is also reaching the individual partner organisations.

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

- 40 The Leader of the Council is also the Chair of the LSP, overseeing all of the ambitions within the SCS, including reducing health inequalities. The Deputy Leader also chairs the Performance Management Group that monitors all LAA targets. The Cabinet Member for Adult Services also sits on the Health & Wellbeing Partnership. These arrangements enable the issues to be understood by those responsible for policy and decision making.
- 41 A Members' working group was formed to oversee the development of the recently approved health inequalities strategy for Southend.
- 42 A paper on the original Audit Commission/PKF Health Inequalities Report was taken through Cabinet and was called into scrutiny, increasing the profile of the health inequalities issues to a wider group of Members.
- 43 'Being Healthy' is one of the priorities of the Children and Young People Plan, which was considered by Cabinet and called in to Scrutiny. Presentations have also been given to Scrutiny Members, most recently on teenage pregnancy.
- 44 Member awareness has been raised through their involvement in the LSP and its developing approach to health inequalities. The PCT has provided briefings and Scrutiny Committee presentations for both the Council and the LSP. Briefings have raised awareness among staff and partners.

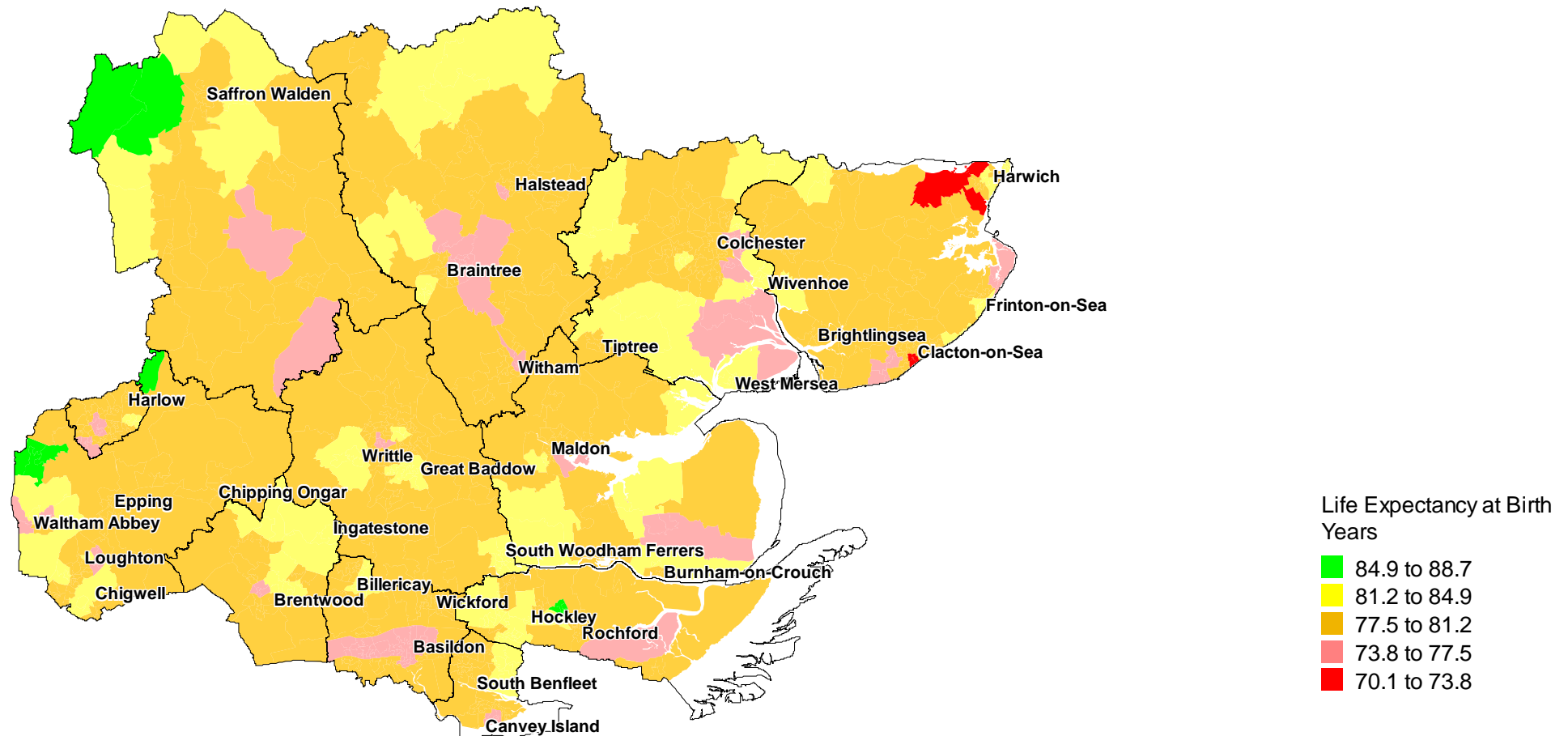
What outcomes have been achieved by the local strategic partnerships and how have they impacted since our 2007/08 review?

- 45 The LSP and its partners have achieved a number of positive outcomes. The PCT and the Council have exceeded their target on smoking quitters, with 1,451 people from Southend giving up smoking in the last year. Nearly a third of quitters are from the more deprived wards. The percentage of smoking quitters from the 20 per cent most deprived Medium Super Output Areas (MSOA) in South East Essex is 32 per cent, which is the second best in Essex.
- 46 The 2009/10 national indicator for Southend on child obesity in reception class indicated that 9.4 per cent of children were considered to be obese, with 18.1 per cent in year 6. These are both better than the national averages of 9.6 per cent and 18.3 per cent respectively.
- 47 The national indicator on participation in sport for 2009/10 indicated a participation rate of 91 per cent, which is significantly better than the national average of 77 per cent.
- 48 The national indicator on Under 18 conceptions showed a 26.1 per cent decrease in the rate compared to the baseline position, which ranks 12th out of 150 areas and is a top quartile improvement in performance. The rate of reduction in teenage pregnancies in the Borough since 1998 was more than twice the national average, and the most recent information shows the level of teenage pregnancy fell to equal the national average for the first time.

Appendix 1 – Southend Local Strategic Partnership

- 49 Advice on sexual health is good and cases of chlamydia in 15-24 year olds are reducing.
- 50 The latest data available to us from Essex County Council shows that, although the PCT did not meet its own ambitious 40 per cent target for smoking quit rates, it achieved performance of 23 per cent of the quitters coming from the 20 per cent most deprived areas, which supports a reduction in health inequality.
- 51 Despite the success of these specific activities, action has not been targeted effectively enough to have the impact required. Inequalities persist and are increasing, as measured by the differences in life expectancy. This may be because the underlying issues are not being adequately recognised, so that the actions are not the right ones in the right areas, and therefore are not achieving the desired outcomes.
- 52 Life expectancy figures, however, have to be treated with some caution. Firstly, they are at PCT level and the picture will vary between the different Council areas. Secondly, although some interventions can have fairly quick results, others are long-term and so will take time to have an impact on the life expectancy gap.

Appendix 2 – Life expectancy at birth in Essex



Source: Life expectancy at birth for wards in England and Wales (Experimental) 1999-2003, Office for National Statistics
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