

Performance Project Brief

Last saved:

Health Inequalities

Cambridgeshire County Council

Cambridgeshire PCT

Cambridge City Council

East Cambridgeshire DC

Fenland DC

South Cambridgeshire DC

Audit 2007/2008

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Introduction

- 1 Health and wellbeing is a key national focus for improvement. Narrowing the health gap between disadvantaged groups and the rest of the country is a top priority. The single overarching target to reduce health inequalities is a national Public Sector Agreement (PSA) target. The target is based on *Tackling Health Inequalities: A Programme for Action* (2003).

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

- 2 This target has since been underlined in subsequent policy documents, including two White Papers; *Choosing Health* (2004) and *Strong & Prosperous Communities* (2006). It is now one of the four top level priorities in the 2007/08 NHS Operating Framework.
- 3 The latest data shows that there has been a widening of these inequalities. In fact, positive trends in health determinants can go hand-in-hand with widening, not diminishing, inequalities in the population. For example rising levels of educational attainment could mask a growing gap in attainment between the highest and lowest social groups.

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

Health inequities are the differences in **opportunity** for different population groups that result in unequal life chances and unequal access to health services, nutritious food, adequate housing and so on. These can lead to health inequalities.

- 4 Public sector organisations must therefore determine whether resources are appropriately targeted in relation to the health needs of different groups. Without this, people can experience inequality of provision, access and take-up of services.
- 5 A sample of the many targets which reflect this broad range of issues and underpin the overarching 2010 PSA target are outlined in Appendix 1.

Background

- 6 The promotion of healthier communities has an effect on the well-being and prosperity of the population and investment is likely to yield significant long term benefit. Addressing such a large issue is not the preserve of any organisational sector alone, but must be addressed through co-operation and shared vision.
- 7 Healthier Communities is one of the five Local Area Agreement (LAA) blocks and provides a focus for joint work to reduce health inequalities. However, it is acknowledged that joint working across different organisations has been facilitated by various previous developments including Local Strategic Partnerships (LSPs), joint commissioning and, earlier still, Health Action Zones (HAZ). The introduction of LAAs provides a further mechanism for building on and improving that joint working, and strengthening the role of the LSPs.
- 8 The development of the local LAA demonstrates the active involvement of senior representatives from a broad spectrum of partners. There are not only the mechanisms in place but also an ongoing commitment to joint working.
- 9 There are many different partners involved in the health inequalities agenda. These often have competing priorities and all have many other demands on scarce resources. Some partners involved, particularly in the health sector, have also been subject to recent large scale reorganisation. 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. Across the country, early partnership action on LAAs has been initiated but the pace of change is often limited by the capacity of individual organisations and staff to deliver and implement the changes. Universally, there is a need to establish a number of key arrangements, often including performance and risk management, as well as scrutiny and effective challenge.

Agreement to sharing information

- 10 So that we can deliver an effective cross-cutting piece of work across a large number of audited bodies, we aim to pool both information and audit staff. In practice this means:
 - audit staff carrying out work at your authority/trust may be employed by the Audit Commission, KPMG, PKF, PwC or Robson Rhodes;
 - auditors involved in the project will share information about individual audited bodies with other members of our project team; and
 - the final reports/presentational material produced as part of the project may include summarised information about individual organisations. These reports will be shared with all audited bodies participating in this project.

- 11 Notwithstanding the Commission's statutory rights of access to information, and the statutory powers of the Commission and its auditors for the purposes of their functions, the Commission will always exercise care when obtaining, keeping or disclosing information. To that end it is Commission policy to notify any organisation that it is obtaining, keeping or disclosing information that relates to it. In addition (but without prejudice to the statutory rights referred to above) the Commission seeks to obtain the consent of that body or individual before sharing this information.
- 12 On that basis we would be grateful if each organisation involved would confirm by signing and returning the letter in Appendix 2 that they have understood and, on behalf of their organisation, agreed to this approach. The letter can be sent in e-mail format to Colin Rockall as Team Leader (see Paragraph 17 below).

Objectives

- 13 To identify key local health inequalities in addition to arrangements in place and future plans for their reduction, including:
 - establishing strategic and operational objectives;
 - determining policy and making decisions;
 - ensuring that services designed to address health inequalities meet the needs of the local population;
 - identifying and managing governance and financial risks, including those arising from partnerships;
 - managing financial and other resources, demonstrating value for money is being managed and achieved; and
 - monitoring and reviewing progress.

The main benefits of this review to the partnership as well as to at least some of the individual organisations involved are the facilitated joint assessment between partners of:

- arrangements in place for achieving effective value for money outcomes in the key local health inequality areas identified;
- key weaknesses in partnership and governance arrangements; and
- key strengths in the notable practice area identified.

The outcomes from this review will include a joint summary report of the above as well as:

- joint action plans to address the key weaknesses identified, developed in facilitation between partners;
- a small number of joint high level recommendations distilled from these action plans; and

- sharing of the strengths of the notable practice to aid wider learning and improvement.

Audit approach

- 14 We propose to undertake the work in three distinct phases – focus, evidence, improvement. The approach to be firmed up in discussion.

Table 1 Key questions

What evidence is there of local partners reducing health inequalities?

- 1 What targets have been agreed between partners?
- 2 Are targets being met and actions followed through by partners?
- 3 What is the local pattern of health inequalities and where are the gaps?
- 4 What is already going on locally and is it working?
- 5 How is access to services being increased for disadvantaged groups?

How are partners progressing action to achieve/improve on targets and longer term actions?

- 6 What is the level of understanding about health inequalities and local partners' roles in tackling them?
- 7 Are governance arrangements robust?
- 8 What is the current capacity and capability for delivering on health inequalities?
- 9 How effectively is performance managed? Do current arrangements provide value for money?
- 10 How effective is decision-making and resource allocation?

Table 2 Proposed approach

<p>Phase 1</p> <p>July to September</p>	<p>Focus</p>	<p>Objective: to clarify and agree the focus (including the topic to be reviewed under the theme of health inequalities) and arrangements for the fieldwork:</p> <ul style="list-style-type: none"> • in discussion with key partner representatives; and • including one or two examples where things are working well. <p>Identify a small group of key partners with whom the report and proposed action plans will be progressed.</p> <p>A small group of named contacts within the key partner organisations is being identified, with whom we will liaise on behalf of all partners. Arrangements will include gaining the written agreement to sharing of information (see Appendix 2), arranging single and cross-agency interviews, issuing the self-assessment snap survey, assisting with the circulation of the brief, timetable, feedback and reports to all parties involved and co-ordinating responses.</p> <p>Contacts are asked initially to:</p> <ul style="list-style-type: none"> • consider relevant partners for participation in the survey and cross-agency interviews and action planning to follow; and • Assist in issuing the self-assessment snap survey to an agreed address list. This could include wider partners, for example, community groups/voluntary sector, where relevant to the specific topics selected. <p>Data and documents (see Appendix 3) will be requested from partner organisations where these are not available on the internet or already held by the Audit Commission.</p>
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Phase 2 September/ October	Evidence gathering	Objective: to prepare for cross-agency interviews and action planning. Analysis of data and documents pertaining to target areas selected. Analysis of self-assessment snap survey responses. Interviews – a small number of individual interviews to be held to inform data collection on the topic to be reviewed The application of any notable practice will be explored. Interviews may include partners beyond those being audited such as voluntary organisations.
Phase 3 October to December	Improvement planning	The survey responses will help inform discussions at a multi-agency workshop (possibly in November): <ul style="list-style-type: none">• to facilitate understanding amongst partners of key barriers and levers to action in the selected target areas;• to facilitate joint action planning to combat these;
Report by Spring		Purpose of the Report: <ul style="list-style-type: none">• to report to key partners these findings and action plans plus a summary of related recommendations. These to be monitored in subsequent work.• To include key themes in a brief summary East of England report to the SHA

Reporting and timescales

- 15 Initial contact will be made during July/August in order to prepare for the cross-agency interviews and action planning to be held in the Autumn 2007. Subject to the review progressing to the timescale described, we would aim to issue a single, joint report in Spring 2008 to the audited bodies involved. This could be circulated by audited bodies to additional partners if deemed appropriate. A summary report for the SHA will also be produced.

- 16 Notwithstanding the Commission’s statutory rights of access to information, and the statutory powers of the Commission and its auditors for the purposes of their functions, the Commission will always exercise care when obtaining, keeping or disclosing information. To that end it is Commission policy to notify any organisation that it is obtaining, keeping or disclosing information that relates to it. In addition (but without prejudice to the statutory rights referred to above) the Commission seeks to obtain the consent of that body or individual before sharing this information.

Audit personnel and key contacts

- 17 Key personnel who will carry out this work are as follows.

Colin Rockall c-rockall@audit-commission.gov.uk 07901513873	Team Leader. Performance Specialist, Audit commission
Tanya Simpson t-simpson@audit-commission.gov.uk 07813038597	Performance Specialist, Audit Commission
Howard Burton howard.burton@uk.pwc.com	Performance Specialist, PWC
Nigel Smith	Relationship Manager, Audit Commission

Appendix 1 – Example targets

The single overarching target to reduce health inequalities is the national PSA requirement:

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

Source: Department of Health PSA target

- 1 A sample of the kind of specific targets to direct local action to achieve this overarching target is included below. These would be adapted for local circumstances.
 - Reduce mortality rates from heart disease, strokes and related diseases by 34.3 per cent in people under 75 by 2008.
 - Reduce mortality rates from cancer by 17.1 per cent in people under 75.
 - By the end of March 2008, to accumulate to a total of 2,000 people each achieving a loss of at least 5 per cent body weight upon completion of a 12 week 'Slimming on Referral' course.
 - Increase by 3 per cent the proportion of adults taking part in sport and recreational physical activity for at least 30 minutes at least three days a week.
 - Increase the number of people who quit smoking, measured after four weeks from 1,853 (2003/04) to 4,746 (2007/08).
 - All public sector organisations to be smoke free by end of 2006.
 - All enclosed public places and work places to be smoke free by the end of 2007.
 - Increase the number of patients completing treatment for Chlamydia infection from 2,341 (2003) to 3,801 (2008).
 - Increase the number of community psychiatric nurses acting as link workers in GP surgeries from 0 to 12.
 - Reduce the number of days spent in acute hospital beds by people aged 75 and over as a result of emergency admissions by 17.8 per cent.
 - Reduce under 18 conception rates as part of a broader strategy to improve sexual health from 32.8 (2003) to 34.4 in 2008 per 1,000 young women aged 15-17.
 - Aggregate net change in Disability Adjusted life Years (DALYs) expected from the changes in BMI (Target an additional 173 DALYs).
 - Reduce the number of low birth rates from 6.8 per cent (2003) to 5.9 per cent by 2008.

12 Health Inequalities | Appendix 1 – Example targets

- Increase number of mothers in Sure Start programmes breastfeeding at birth from 60 to 66 per cent by 2008.
- Increase number of mothers in Sure Start programmes breastfeeding at six weeks from 42 per cent to 48 per cent by 2008.
- Increase the number of school based drop-in centres from 9 to 12.
- Increase the number of adult drug users in treatment.
- Increase drug and alcohol education and awareness events.
- Increase the area of green space managed in whole or in part for its ecological interest.

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Appendix 2 – Sharing information

We would be grateful if each organisation involved would confirm by signing and returning this letter, with the adjustments where indicated, that they have understood and, on behalf of their organisation, agreed to the sharing of information, as outlined in paragraphs 10-12.

Sample letter from Chief Executive of the council/PCT etc

Dear Team Leader

Health inequalities: Disclosure of information relating to [Council/PCT etc]

I consent to you sharing information that you have obtained when carrying out the Health inequalities project with other auditors from the Audit Commission, PKF, PwC and Robson Rhodes.

I also consent to you sharing summarised information you have obtained when carrying out the Health inequalities project with other participating audited bodies including the Strategic Health Authority (SHA).

Yours sincerely

XXXXXXXXXX

Chief Executive

Appendix 3 – Data and document request

We will request documents in the first instance from within the Audit Commission.

No	Document	What we are looking for	Key questions
1	Community Strategy	contextual population data joint work to reduce inequalities	1, 2, 5, 6
2	Local Area Agreement	as above specific targets joint health inequalities strategy	1, 2, 3, 5, 8, 10
3	Latest Public Health annual report	contextual population data joint work to reduce inequalities	1, 2, 3, 4, 5, 6
4	High level planning and delivery documents for health inequalities	joint and single health inequality strategies specific health inequalities projects specific targets	1, 2, 5, 6, 7, 8, 9
5	LSP plans	as above	1, 2, 3
6	Local Strategic Partnership(s) remit and terms of reference	joint decision-making and governance arrangements	3, 7, 10
7	Commissioning plans for health inequalities	specific initiatives commissioned match of local and joint work	7
8	Overview and scrutiny committee(s): <ul style="list-style-type: none"> • remit; • terms of reference; and • recent relevant work. 	joint decision-making and governance arrangements	7, 10
9	Performance monitoring	impact of any changes made	4, 5, 9
10	Health equity audits or similar	assessment of impact of interventions joint working	3, 4, 9
11	Resourcing plans	allocated resources	10
12	Evaluations, eg cost-benefit analysis	re specific health inequalities projects	9