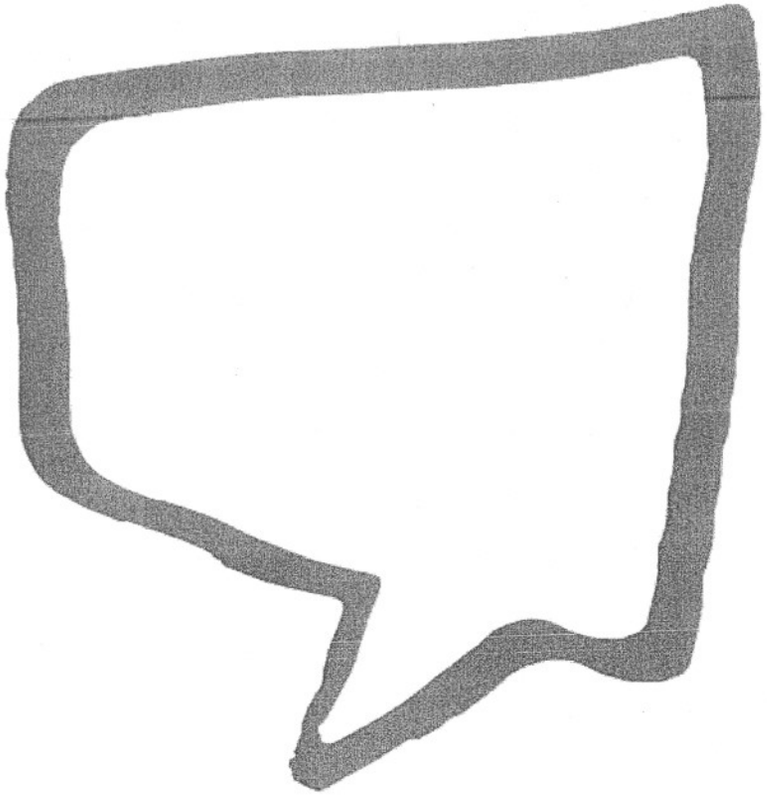
Health Inequalities

Brent London Borough Council and
Brent Teaching Primary Care Trust
Audit 2008/09
May 2009



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Contents

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Summary report

Introduction

1 Health inequalities are a key issue for both the Department of Health and the Department for Communities and Local Government. The gap in life expectancy between those at the top and bottom of the social scale is wide and has grown since the 1970s.

2 The Local Government Act 2000 places a duty on local authorities to promote the social, economic and environmental well being of their area. The NHS operating framework for 2007/08 requires Primary Care Trusts (PCTs) and local authorities to work together in partnership for the benefit of tax payers and patients.

3 While some action is being taken nationally, the main contribution is made locally. Local authorities and PCTs know that they must act together if they are to address this issue and use their resources effectively. In many areas joint plans to address health inequalities will form part of the Local Area Agreement (LAA). The introduction of local data on all age all cause mortality provides the incentives for effective partnership working between PCTs, local authorities and other partners that need to deliver the life expectancy aspects of the health inequalities target. It will also give flexibility for organisations to focus on the interventions that are most important to their local population.

Background

4 The London Borough of Brent (the Council) is one of only two local authorities serving a population where the majority of people are from ethnic minorities, and these groups are growing faster than any other. Up to 8 per cent of residents are classed as refugees or asylum-seekers. The population is growing and dynamic with recent figures indicating significant numbers of people moving into the borough creating new emerging communities, as well as significant numbers of transient people within the borough. Brent's official ONS population forecast in 2006 was approximately 270,000, although Council-commissioned research suggests that this figure could be at least 10,000 higher and is growing strongly. Almost a quarter of residents are under 19 years old and, within the five renewal neighbourhoods, a third of residents are under 16 years old, compared with a fifth in London more generally.

5 Whilst large sections of Brent are relatively affluent, many residents experience high levels of deprivation and low incomes. The 2007 Index of Multiple Deprivation places Brent within the 15 per cent of most deprived local authorities in the country. The neighbourhoods experiencing the highest deprivation are largely located in the south of the borough, although this situation is changing with high levels of deprivation now seen in pockets to the north of the borough. The most deprived residents also have the lowest income levels, highest unemployment levels, poor and overcrowded housing and the worst health outcomes across the borough. Men from the least deprived areas can expect to live over nine years longer than those in the most deprived areas and this gap has remained constant in recent years.

Audit approach

6 The audit review is being undertaken in two stages. This interim report relates to the first stage, a high level review to identify key risks. This has comprised:

- interviews with key staff and partners; and
- document reviews.

7 The findings of this high level review will inform the scope and audit approach of stage two of the audit.

8 The fieldwork for the first stage of our audit was undertaken during November and December 2008.

Main conclusions

9 There is clear strategic commitment from the Council and NHS Brent to tackle health inequalities. There is broad and shared understanding amongst government and NHS partners that addressing health inequalities is a key issue for Brent. The Health and Well Being Strategy 2008 to 2018 represents a broad based approach capturing the ambitions and priorities for the Local Strategic Partnership (LSP) for improving the health and well-being of Brent's residents and their families. Tackling health inequalities is not consistently embedded in other key strategies with the focus on outcomes variable. The overarching strategic approach enables partners to work together to address health inequalities through agreed priorities and actions. However, the lack of specific outcomes means that partners cannot measure the impact of their activities against their ambitions and priorities.

10 Leadership for the health inequalities approach is supported with good examples particularly from the Council of individuals championing health inequality issues. The effective governance of all actions relating to health inequalities is constrained with the strong individual ambitions to champion the health inequalities agenda vulnerable to changes in key personnel. Clear leadership embracing key partners and workstreams in a systematic and embedded manner will assist with engagement of all parties working to address health inequalities.

11 Key partnerships are identified through the Health and Well Being Strategy. Partnership working to tackle health inequalities between the Council and the PCT has strengthened but partnership arrangements with wider bodies such as research and academic institutions, the voluntary sector and provider trusts are limited. The engagement of the public and communities of interest as partners is not yet embedded and there is limited challenge from Overview and Scrutiny (OSC) on progress in tackling health inequalities. The effective engagement of key partners increases the capacity within Brent to tackle health inequalities

12 The Joint Strategic Needs assessment developed jointly between the Council and NHS Brent is a comprehensive needs analysis which is the prime evidence base for the Health and Well Being Strategy and the NHS Brent Commissioning Strategy Plan. This identifies key issues for Brent and specifically the role of cardiovascular disease as having the most significant impact on life expectancy. Currently capacity issues restrict sufficient data analysis but this is being addressed through the current NHS Brent Organisational Development Plan. At a strategic level there is strong commitment from all partners to understand diverse communities. Further refining is now required to ensure that this understanding is truly comprehensive.

13 The existing workforce is not being used effectively to tackle health inequalities. There are some good examples of local initiatives but there is no overall strategic approach. Public health capacity is developing and Non Executive Directors (NEDs) and Councillors are making good progress in developing the skills and abilities to challenge plans on health inequalities. An integrated approach to using the wider workforces of all the partners increases the capacity to deliver health inequality priorities through using extensive contact with the public.

14 There is commitment at the highest level to the effective performance management of health inequalities. There is no overarching performance management framework for tackling health inequalities and the performance management of current activities linked to health inequalities is not yet systematic and embedded. The Commissioning Strategy Plan has the most developed performance management but the Health and Well Being Strategy and associated action plan lack SMART quantified targets. The absence of performance management of all actions relating to health inequalities limits the ability of partners to measure progress, take appropriate action and demonstrate the link between inputs and outcomes.

15 A corporate responsibility approach in respect of the wider determinants of health has not been formally developed. The Council and NHS Brent have not begun to consider formally the financial implications of corporate responsibility. However, the principles of corporate responsibility are reflected in organisational strategies with a view to making this more explicit in the future. A formally agreed and consistent approach to the principles of corporate responsibility will facilitate the embedding of a commitment to tackling health inequalities across all departments and service areas.

Key Strengths

16 The following key strengths are identified.

- There is clear strategic commitment from key partners to tackle health inequalities.
- Key individuals are strongly supportive of actions to reduce health inequalities for Brent.
- Key partnerships have been identified to tackle health inequalities.
- The Joint Strategic Needs Assessment provides a sound and shared foundation for work on reducing health inequalities.
- There is high level commitment to performance managing health inequalities actions.

Key Risks

17 The following key risks are identified.

- How can the sponsorship of health inequalities projects be made more explicit rather than implicit?
- How can the effectiveness and impact on health inequalities of the Overview and Scrutiny Committee be maintained?
- What actions are available to support engagement of the provider trusts in tackling health inequalities?
- How can partnership arrangements be further developed with the voluntary sector and service users and carers?
- What further refinement might be required to ensure that the needs of all diverse communities are effectively captured?
- What possibilities exist to use of all the wider workforces to contribute effectively to reductions in health inequalities?
- Is additional Public Health capacity required to support the overall work programme?
- Where could further performance management framework support actions relating to heath inequalities?
- What further data is required to monitor performance and demonstrate impact?
- How can a clear plan or cross cutting approach towards corporate responsibility assist in respect of the wider determinants of health across all departments and organisations?

The way forward

18 This is the interim report summarising our findings and key risks from our high level review. The report will be further updated following the completion of our second stage of fieldwork when an action plan will also be added to address our recommendations. The scope for stage two of the work will be set out in a separate specification.

19 From 1 April 2009, Comprehensive Area Assessment (CAA) will be introduced. This replaces comprehensive Performance Assessment (CPA) and will transform the way the performance of local public services is assessed.

20 CAA is the new framework through which the major public service inspectorates will together make independent assessments of how well people are being served by their local public services. Its focus is primarily on the prospects for better outcomes locally rather than the internal workings of individual organisations.

21 Many important priorities, such as tackling the causes of ill-health, improving the local economy and reducing carbon emissions, require public bodies to work effectively together and with their communities. This in turn requires a joined-up assessment framework.

22 CAA will recognise the importance of effective partnership working and the role of councils in leading and shaping the communities they serve. This means CAA will look at services developed in partnership including health and well-being, community safety and cohesion, sustainable communities, economic development, housing, children's and older people s services.

23 It will address issues such as:

- improving access to healthcare;
- increasing the availability of affordable housing;
- reducing the fear of crime, improving educational achievement; attracting investment; and
- reducing the areas carbon footprint.

24 Local audit work, such as this review of Health Inequalities, will inform CAA assessments and in particular will provide evidence of local health outcomes. The first CAA assessments will be reported in Autumn 2009

Acknowledgement

25 The Council and NHS Brent have both worked proactively with us in order to gain some objective insight into its arrangements for addressing health inequalities, and we are grateful to staff and partners for their cooperation.

Detailed report

Do strategies to address health inequalities exist and are they effective?

26 There is clear strategic commitment from both the Council and NHS Brent to tackle health inequalities. There is broad and shared understanding amongst local government and NHS partners that addressing health inequalities is a key issue for Brent. The Health and Well Being Strategy 2008 to 2018 represents a broad based approach capturing the ambitions and priorities for the Local Strategic Partnership (LSP) for improving the health and well-being of Brent's residents and their families. This complements NHS Brent's recently agreed Commissioning Strategy Plan 2008 to 2013 which has at its core a strategic approach to reducing health inequalities. This informs all major initiatives and specifically has targeted, evidence based bio-medical interventions which are focused around the vascular intervention programme. This aims to reduce the gap in life expectancy by six months over five years and raise life expectancy in all Brent residents. The overall approach ensures that a strong focus on health inequalities is present and embedded within the PCT.

27 Tackling health inequalities is not consistently embedded in other key strategies and the focus on outcomes is variable. The Health and Well Being Strategy Action Plan lacks specific outcomes using measures such as improved, reduced or decreased while the Commissioning Strategy Plan has targets which are specific, measurable, achievable, and realistic and time bound (SMART). There is no clear 'golden thread' embedding the reduction of inequalities in all key documents. Good examples include the Sport and Physical Activity Strategy which targets improved access and promoting health benefits to those groups most at risk and the Regeneration Strategy which is focused on key areas for intervention. The overall strategies enable partners to work together to address heath inequalities through agreed priorities and actions. However the absence of a fully embedded approach and lack of specific outcomes in places means that partners could do more to increase the impact of their activities against their ambitions and priorities.

28 Leadership for the health inequalities approach sits with the Director of Public Health, a joint appointment between the Council and NHS Brent. There is a strong level of commitment to tackling health inequalities across key service areas with good examples particularly from the Council of individuals championing health inequality issues. The effective governance of all actions relating to health inequalities is constrained with the strong individual ambitions to champion the health inequalities agenda vulnerable to changes in key personnel. Clear leadership embracing key partners and workstreams in a systematic and embedded manner will assist the engagement of all parties working to address health inequalities.

29 The use of wider public health expertise in developing strategies is good with links to wider areas such as transport, housing and leisure. The Joint Strategic Needs Assessment (JSNA) provides an evidence base which is used in the development of further strategies, for example, strategies for linking with gypsy and traveller communities. The effective use of public health expertise widens the impact and understanding of health inequalities and supports the effective direction of resources.

30 Strategies and health inequality commissioning plans are being embedded in Council activities and are increasing reflected in the plans of NHS Brent. For the Council the planning framework mirrors budget planning and the majority of targets in Health and Well Being Strategy are already budgeted in other plans. For NHS Brent key actions from the Health and Well Being Strategy are reflected in financial plans and budgets. A number of initiatives are at an early stage and for each initiative there is a timeline for when each business case will come forward to be assessed by the PCT. This effective approach ensures that health inequality issues are identified, and have planned outcomes.

Key risks

- How can the sponsorship of health inequalities projects be made more explicit rather than implicit?

Do partnerships addressed with addressing health inequalities function effectively?

31 The Health and Well Being Strategy outlines the ambitions and priorities of Brent's Local Strategic Partnership for improving the Health and Well Being of residents and families. Key partners are involved in the Health and Well Being Strategy and have made reducing the gap in life expectancy at birth between the top five and bottom five neighbourhoods in Brent a key strategic target. Some stakeholders reported variable engagement in the different partnerships with particular strengths in the Drug and Alcohol and Children and Young Peoples Strategic Boards which are well engaged in the Health Inequalities agenda. The effective engagement of all partners will strengthen the wider impact when addressing health inequalities.

32 There is limited challenge from overview and scrutiny (OSC) on progress in tackling health inequalities. The function is being developed having previously had an agenda focused on issues in the acute sector and with NHS Brent. Health inequality areas which have been reviewed include progress on teenage pregnancy and smoking cessation targets. OSC receive updates on all LAA targets paying particular attention to health targets. Insufficient scrutiny of health inequality issues significantly limits the challenge on progress made.

33 The role of provider trusts on health inequality issues is limited and concepts of provider trust involvement differ across different agencies. Key aspects of delivery are captured in the Commissioning Strategy Plan and there is emerging involvement in the Health and Well Being Strategy and developing links with NHS Brent through the Director of Strategic Commissioning. The use of Dr Foster data by NHS Brent enables identification of acute service users if required. Currently there is no plan for brief interventions, for example, support to stop drinking for regular binge drinkers who are treated in Accident and Emergency. Reduced provider trust involvement limits the ability of all partners to deliver priorities and develop whole system solutions to health inequality.

34 Partnership arrangements with wider bodies such as research and academic institutions, and the voluntary sector are limited. The voluntary sector are engaged in the LSP and were involved in consultation on the Health and Well Being strategy. The Health and Social Care Partnership network has wider consultation groups as does the Children and Young Peoples partnership. However further work on comprehensive representation of the voluntary sector is required if it is to be fully representative. This will provide an opportunity to build capacity in the voluntary sector and enable greater co-ordination and mapping of provision to minimise duplication and make the most of resources.

35 The engagement of the public and communities of interest as partners is not yet embedded. Further work on building public and patient engagement is seen by NHS Brent as part of on-going health need assessment. The absence of fully committed and engaged public and communities of interest limits the scope of the Brent partners to improve health inequality issues for all groups.

Key risks

- How can the effectiveness and impact on health inequalities of the Overview and Scrutiny Committee be maintained?
- What actions are available to support engagement of the provider trusts in tackling health inequalities?
- Howe can partnership arrangements be further developed with the voluntary sector and service users and carers?

Does the data and intelligence support organisational and shared strategic and operational decision making to address health inequalities?

36 The JSNA which was developed jointly between the Council and NHS Brent in 2008 is a comprehensive health needs analysis which is shared with appropriate bodies. It reflects health inequalities within the area and is the prime evidence base for the Brent Health and Well-Being Strategy and the NHS Brent Commissioning Strategy Plan. The document identifies circulatory disease as the leading preventable cause of death and that primary and secondary prevention of cardiovascular disease through increasing coverage of antihypertensive and statin treatment has the most significant impact on improving life expectancy. The treatment of cardiovascular disease is also seen as being the most cost effective treatment and will generate long-term efficiencies. Brent also has significant issues with cancer (there is poor local uptake of breast and cervical screening), mental health problems and tuberculosis. Other important areas include smoking as the single greatest cause of preventable illness, obesity where the impact of diet and lack of exercise on future obesity rates is recognised and sexual health. Effectively using information and intelligence to drive and focus decisions will help reduce health inequalities.

37 Both the Council and NHS Brent recognise that lack of capacity issues restricts the data analysis undertaken. The council has a good range of information but there is limited capacity to make full value of the data in areas such as drug and alcohol data. The NHS Brent Organisational Development plan recognises informatics as a key area of development and working with the London Hub the organisation are proposing to develop these skills. This will develop internal capacity and maximise capacity from Hub as they develop. Both Practice based Commissioning and Primary Care are keen to increase the Public Health support at practice level and this will link with the aims of the World Class Commissioning Programme. The absence of sufficient data analysis skills and capacity limits the effectiveness of all parties to use to data collected to maximum effect in targeting health equality actions.

38 Public health data and intelligence (including annual Public Health reports) strongly informs commissioning strategies through the JSNA. This has provided sound foundation to the Health and Well Being Strategy and also the NHS Brent Commissioning Strategy Plan. In both documents the approach for tackling health inequalities is clearly defined and is based on health need. Such sharing of data enables discussion and appropriate challenge within the partnership and supports shared understanding with all key partners.

39 At a strategic level there is strong commitment of all partners to understand the issues facing diverse communities. Further refining is now required to ensure that this is truly comprehensive and universal with all agencies. The Council has a range of mechanisms for engaging communities including black and minority ethnic group forums, area forums and user group forums. NHS bodies have scope for improvement - possibly by linking resources and engaging further with the council. The voluntary sector can also provide information on specific groups that may be overlooked, for example, carers or those with mental health issues. A wide ranging and inclusive approach will ensure that all those with differing health needs are effectively recognised.

Key risks

- What further refinement might be required to ensure that the needs of all diverse communities are effectively captured?

Are workforce planning arrangements adequate to address the skills and competencies needed to address health inequalities?

40 The existing workforce is not being used to effectively tackle heath inequalities. There are some good examples of local initiatives although there is no overall strategic approach. Good local initiatives include park wardens being trained to be park walk leaders to give a wider health understanding, a health walks programme in parks and joint working with leisure centres to deliver specific programmes on exercise on prescription. Within the sports service there is a sports development officer focussing on health and joint working with NHS Brent identifying groups at risk, for example, cardiac rehabilitation courses and weight management courses referred through primary care. The Council has no health and well being programme and no healthy workplace strategy. There are some sessions for staff to improve health and informal staff networks for walking. An integrated approach to using the wider workforce of all the partners increases the capacity to deliver health inequality priorities though using the extensive contact with the public.

41 Public health capacity is developing. There is close working between the Council and NHS Brent and through the jointly appointed Director of Public Health. Public health capacity is being debated within NHS Brent as part of an evolving new structure for 2009/10. Greater capacity would allow better integration of public health with commissioning in order to address health inequalities. The current situation limits the impact public health can have influencing commissioning and actions to reduce health inequalities.

42 Non-Executive Directors (NEDs) and Council Members are making good progress in developing the skills and abilities to challenge plans on health inequalities. Within NHS Brent NEDs are seen as knowledgeable and focussed on health inequalities, for example the recent championing by one NED of the need to improve breast cancer screening where uptake levels were low at 40 per cent. NEDs were widely involved with the Commissioning Strategy Plan. Health inequalities are also a key issue for members because of the health profile of the borough with councillors working hard with NHS Brent to identify key priorities. Suitably equipped NEDs and councillors ensure that plans to address heath inequalities are focused and targeted effectively.

Key risks

- What possibilities exist to use all of the wider workforces to contribute effectively to reductions in health inequalities?
- Is additional Public Health capacity required to support the overall work programme?
- Do performance management systems support the monitoring and evaluation of activities necessary to address health inequalities?

43 There is commitment at the highest level to the effective performance management of health inequalities and targets within the LA performance framework are monitored and managed through the LAA performance framework. There is no overarching performance management for tackling heath inequalities and the performance management of current activities linked to health inequalities is not yet systematic and embedded. The Commissioning Strategy Plan to reduce health inequalities has clear goals, indicators and initiatives with a local measure to narrow the quintiles gap. The Health and Well Being Strategy and associated action plan lacks SMART quantified targets with measures described as 'better' or 'improved' or 'increased'. This limits the partners ability to effectively monitor delivery. The absence of effective performance management of all actions relating to heath inequalities limits the ability of partners to measure progress, take appropriate action and demonstrate the link between inputs and outcomes.

44 Past performance is not yet used explicitly to plan future action. The PCT recognises that some information is weak and this impacts on performance management and so although a trajectory has been set there is not yet the capability and capacity to monitor and manage this. The NHS Brent Organisational Development plan aims to address this gap. Rigorous review of past performance will support all partners in identifying effective and non effective interventions and their linked costs.

Key risks

- Where could further performance management support actions relating to heath inequalities?
- What further data is required to monitor performance and demonstrate impact?

Are corporate responsibility principles in respect to the wider determinants of health adequately reflected throughout organisational strategies?

45 A corporate responsibility approach in respect of the wider determinants of health has not formally been developed and the LB Brent and NHS Brent and have not begun to consider explicitly the financial implications of corporate responsibility. However, progress is being made on taking action with corporate responsibility principles. The principles of corporate responsibility include how the organisation behaves as, for example, an employer, a purchaser of goods and services, as a landholder and commissioner of building work makes a difference to people's health and to the well being of society. Within the Council there is work on green travel plans and walking and highlighting the value of physical activity. There is also work on promoting the Councils range of leisure services within the older people's strategy as a way of developing inclusion. A formally agreed and consistent approach to the principles of corporate responsibility will facilitate the embedding of a commitment to tackling health inequalities across all departments and service areas.

Key risks

- How can a clear plan or cross cutting approach towards corporate responsibility assist in respect of the wider determinants of health across all departments and organisations?

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