Health inequalities

Essex public services

Audit 2009/10

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Accountants &
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audit commission

Contents

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.

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).

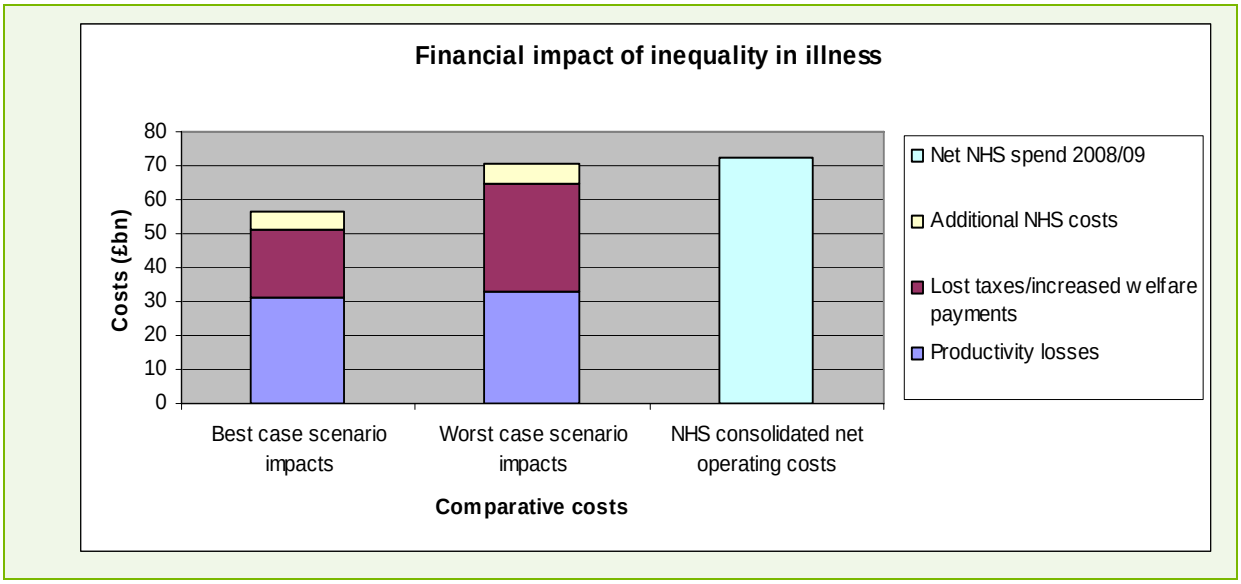
Fair Society, Healthy Lives

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.

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.

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 increasing[i] (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 3[ii]).

[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.

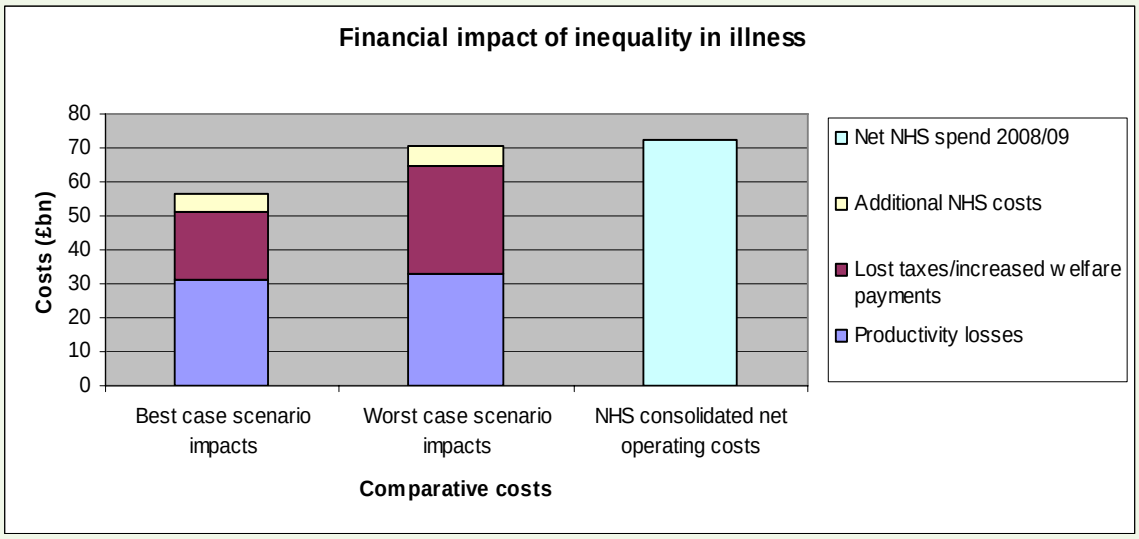
[i] Spearhead Group: the fifth of areas with the worse health and deprivation indicators in England (none of these is in Essex)

"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.

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 JNSA 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 Well Being 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.

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 and 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.

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 though 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 – Essex Local Strategic Partnership

1 The Essex Partnership, which is the Local Strategic Partnership (LSP) for Essex County Council area, has significantly strengthened its arrangements for tackling health inequalities. Further improvements are needed, but it already has a much stronger base for delivery and having an impact on health inequalities in the future. This progress is the more impressive given the complexity of public service organisational arrangements in Essex.

2 This appendix 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.

3 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 Essex 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.	G	Essex LSP has made strong progress in developing a common strategic approach specifically addressing health inequalities.
R2 Develop and agree health inequalities targets locally and at LSP level based on the identified needs.	G	Good progress is being made in developing health inequalities targets. These targets have been selected on the basis of available evidence on the short term interventions that will improve health inequalities in the longer term.
R3 Exploit the full potential of the Joint Strategic Needs Assessment (JSNA) to identify health inequalities.	G	The JSNA is being used well and continues to improve decision making and action planning in Essex.
R4 Improve arrangements for sharing, managing and using information across all partner agencies.	A	Essex LSP has made good progress in sharing, managing and using information between partners, although challenges remain.

Recommendations	RAG rating	Conclusion
R5 Consider production of a public health report for Essex as a whole to underpin the common strategic approach.	G	The DPH for Essex County Council produced his first public health report in 2008. There is good synergy between this report and those of the five PCTs. However, it has had limited impact in some parts of Essex. The annual reports of individual DPHs are influential.
R6 Strengthen joint planning for tackling health inequalities through the local strategic partnerships and local area agreements and clarify accountability for delivery.	G	Essex LSP has strengthened its joint planning arrangements for health inequalities. Accountability is clearly ascribed. The joint public health team role has been influential.
R7 Ensure action is co-ordinated, strategically led and designed to meet overall objectives and priorities as well as local needs.	A	Action is well coordinated and strategically led by the LSP, with the County Council providing a strong lead. However, coordination is made harder because of the variable priority being given to health inequalities by district LSPs.
R8 Develop a clear performance management framework for health inequalities, with strong Member and Non Executive involvement.	A	The LSP has a clear overall LAA performance management framework, within which it manages performance on reducing health inequalities. There is good Member involvement. However, more could be done to present the overall picture on health inequalities.
R9 Improve awareness and knowledge of health inequalities and their implications amongst elected members and all service areas within Essex public services.	G	Awareness and knowledge of health inequalities and their implications amongst elected members have improved markedly. There is strong Member involvement and political drive to tackle health inequalities.
What outcomes have been achieved by the local strategic partnerships and how have they impacted since our 2007/08 review?	G	The LSP and its partners have achieved a number of positive outcomes, with a number of notable projects. Health inequalities, as measured by differences in life expectancy, are decreasing in some, but not all parts of the county.

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

4 The Essex Partnership has made strong progress in developing awareness and a common strategic approach specifically addressing health inequalities. The partnership has made health inequalities a strategic priority, with an agreed focus on the priorities of obesity, mental health and alcohol. Progress has been particularly strong in north east Essex, tackling some of the most acute inequalities in the county. There is good collaboration with the adjacent LSPs for Southend and Thurrock with a number of shared projects.

5 The partnership has a clear strategic commitment to tackling health inequalities across all its themes; community safety, transport and children as well as health and well being. It has agreed that the Essex Strategy will be updated to include a stronger emphasis on tackling health inequalities. It organised a well attended and successful health inequalities summit in November 2009, which demonstrated the level of commitment across the wider partnership.

6 Increasingly, other services, such as drug and alcohol services, and other organisations, such as the Fire and Rescue Service, are seeing the role they can play in tackling health inequalities and becoming more engaged in the partnership approach.

7 The County Council has adopted a health inequalities strategy, focussing on the contribution every part of the Council can make but also recognising the importance of a partnership approach. Although this is primarily intended as an inward facing strategy, it has wider influence. Partners around the county are aware of it, and to varying degree take account of it in developing their own strategic approaches.

8 The County Council and three of the PCTs have created a joint public health team. This has created a pool of expertise and helped the partners agree shared priorities and objectives.

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

9 The LSP is making good progress in developing health inequalities targets. The Essex Local Area Agreement (LAA) contains a number of targets that relate to health inequalities. In particular, it contains a stretch target for all age all cause mortality rate for the 20 per cent most deprived districts. The Partnership has disaggregated district level targets from the overall LAA targets and made them more challenging in the districts with the greatest inequalities.

10 The Partnership takes a holistic view, recognising that targets for sustainability, regeneration, housing and homelessness, employment and educational attainment are highly relevant to tackling health inequalities.

11 A number of targets are explicitly expressed and set to deliver reductions in health inequalities. These targets have been selected on the basis of available evidence on the short-term interventions that will improve health inequalities in the longer-term. Examples include helping people with mental health problems into employment, reducing the number of young people not in employment, education or training, tackling temporary homelessness, improving educational attainment and a target to reduce unemployment, focussed initially on Tendring as one of the areas with the greatest inequalities.

12 Targets need to have associated milestones and timescales with success criteria and a clear understanding of how they combine towards the overall objective. It is important that the Essex Partnership ensures its approach, and that of its individual partners, to target setting deals with these issues

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 Essex. Partners feel they have ownership of the JSNA and that it drives the health inequalities agenda. They have used it as the base document for their strategies, thus ensuring that not only are their approaches based on robust needs assessment, but also that they are consistent and properly aligned.

14 The JSNA is being updated and improved on a rolling basis so that it remains relevant. It is being developed to cover area such as mental health and learning disability in more detail as well as new chapters on demography and public opinion. The Partnership is evaluating the JSNA through a survey of stakeholders to assess what has worked well, what needs to be improved and what impact the JSNA has had on commissioning. This is good practice which should lead to the JSNA becoming increasingly relevant and responsive to partners' needs.

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

15 Essex LSP has made good progress in sharing, managing and using information between partners, although challenges remain. There are a number of examples of the progress made. The JSNA has brought high level needs information together. It is supported by very clear and informative matrices of health inequality issues at district level. The creation of a County Council public health team and the key roles played by the County Council and PCT Directors of Public Health have helped develop trust and facilitate information sharing.

16 There are particular challenges in sharing personal information, but good progress is being made. The Multi-Agency Risk Assessment Conference (MARAC) approach, which is a coordinated community response to domestic abuse, has shown how sensitive information can be shared appropriately and to good effect. Other examples include the Village Agents scheme which has a shared information point so that partners can track what they each do in response to referrals received.

17 There are a number of systems in place or in development for sharing information. The Essex Partnership Portal, hosted by County Council, is a website containing a wide range of information and documents which aid communication across Essex partnerships. It also serves as a source of local information for the public and service users. There are plans to bring all information useful for planning together through the Essex Neighbourhood Information Management System project. It will be important to ensure these systems are coordinated and do not overlap or duplicate effort.

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

18 The DPH for Essex County Council produced his first public health report for the County Council in 2008. The next report is due to be published this year, with the main theme as obesity. It will include a review of progress since the 2008 report.

19 There is good synergy between the County Council public health report and those of the five PCTs. PCT Directors of Public Health were all involved in the development of the County Council public health report.

20 However, the report has had limited impact in some parts of Essex, partly because, as a County Council report it is not able to cover Thurrock as well. Some local partners are not clear what is its intended audience and how is it meant to be used.

21 The annual reports of individual DPHs are influential documents. In response to these reports, local partners are focussed on the main public health challenges facing each district. The reports have informed the development of PCT and district council strategies and LSPs' Sustainable Community Strategies.

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

22 Essex LSP has strengthened its joint planning arrangements for health inequalities and clarified accountabilities. The Community Wellbeing and Older Peoples' Partnership leads joint planning for health inequalities. It has wide representation, is well attended and able to provide robust and challenging debate and discussion on health inequality issues. It has ascribed overall accountably to the County Council portfolio holder and the County Council DPH, with named individuals responsible for each specific action or project.

23 The LSP is increasingly tackling health inequalities through its whole joint planning structure. For example, a Be Healthy group, which reports to the Children's Trust Board, has a specific health inequalities action plan that includes work to reduce teenage pregnancy, tackle obesity, substance misuse and poverty and improve child & adolescent mental health services.

24 The joint public health team created between the PCTs and County Council has strengthened joint planning. It provides expert advice and has improved mutual understanding and trust across the partner organisations.

25 Not all partners are fully engaged in joint planning. For example, there is more to do to involve the Fire & Rescue service and to explore the contribution it could make. Joint planning in district LSPs is variable, with some having less well developed arrangements than does the county partnership. This can inhibit the effective delivery of county LSP objectives at local level.

26 There will be a significant impact from the changes to the NHS that will be implemented as a result of the White Paper 'Equity and Excellence: Liberating the NHS'. The LSP will need to review existing arrangements for tackling health inequalities considering 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.

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

27 Action is well coordinated and strategically led by the LSP, with the County Council providing a strong lead. The LSP's robust joint planning arrangements provide the framework within which action can be coordinated. Initiatives such as the 2009 county conference have given opportunities to agree coordinated approaches across a wide range of partners. However, coordination is made harder because of the variable priority being given to health inequalities by district LSPs.

28 The LSP has allocated funding to support action to tackle health inequalities. The County Council has also allocated additional resources. All these resources are being targeted on the priority issues and the districts facing the greatest challenges.

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

29 The LSP has a clear overall LAA performance management framework, within which it manages performance on reducing health inequalities. There is good Member involvement. Each Board is responsible for reviewing its own performance and overall monthly progress reports are reviewed by a performance management sub group. A performance scorecard is posted on the Essex Partnership Portal to provide an accessible and regular performance update to all partners.

30 There is no stand alone performance report on health inequalities. To do so would run the risk of it being seen as a special interest area rather than core business. However, more could be done to present the overall picture on health inequalities, for example by flagging in reports the targets that relate to health inequalities and link to the overarching NI 120 target (all age all cause mortality rate for the 20 per cent most deprived districts).

31 Partners have robust internal performance management frameworks which report on and manage performance on all targets, including those that relate to health inequalities. County Council Members review and scrutinise progress against their health inequalities strategy through the Health overview and scrutiny committee. All officers have an individual objective set through the performance appraisal system with health inequality targets relevant to their particular role.

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

32 Awareness and knowledge of health inequalities and their implications amongst elected members has improved markedly. Health inequalities are within the portfolio of a member of the County Council Cabinet. This is also the case in most district councils.

33 There is now strong Member involvement and political drive, led by portfolio holders. This is demonstrated by County Councillors' adoption of a health inequalities strategy. Members are now able and prepared to make the case for differential allocation of resources to the areas of the county with the greatest needs, based on the vastly improved information that is now available.

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

34 The LSP and its partners have achieved a number of positive outcomes. Specific examples include four of the five PCTs exceeding their smoking quit targets with 29 per cent of the quitters overall coming from the 20 per cent most deprived areas. There are a number of notable projects which are showing positive outcomes. Some outstanding examples are described below.

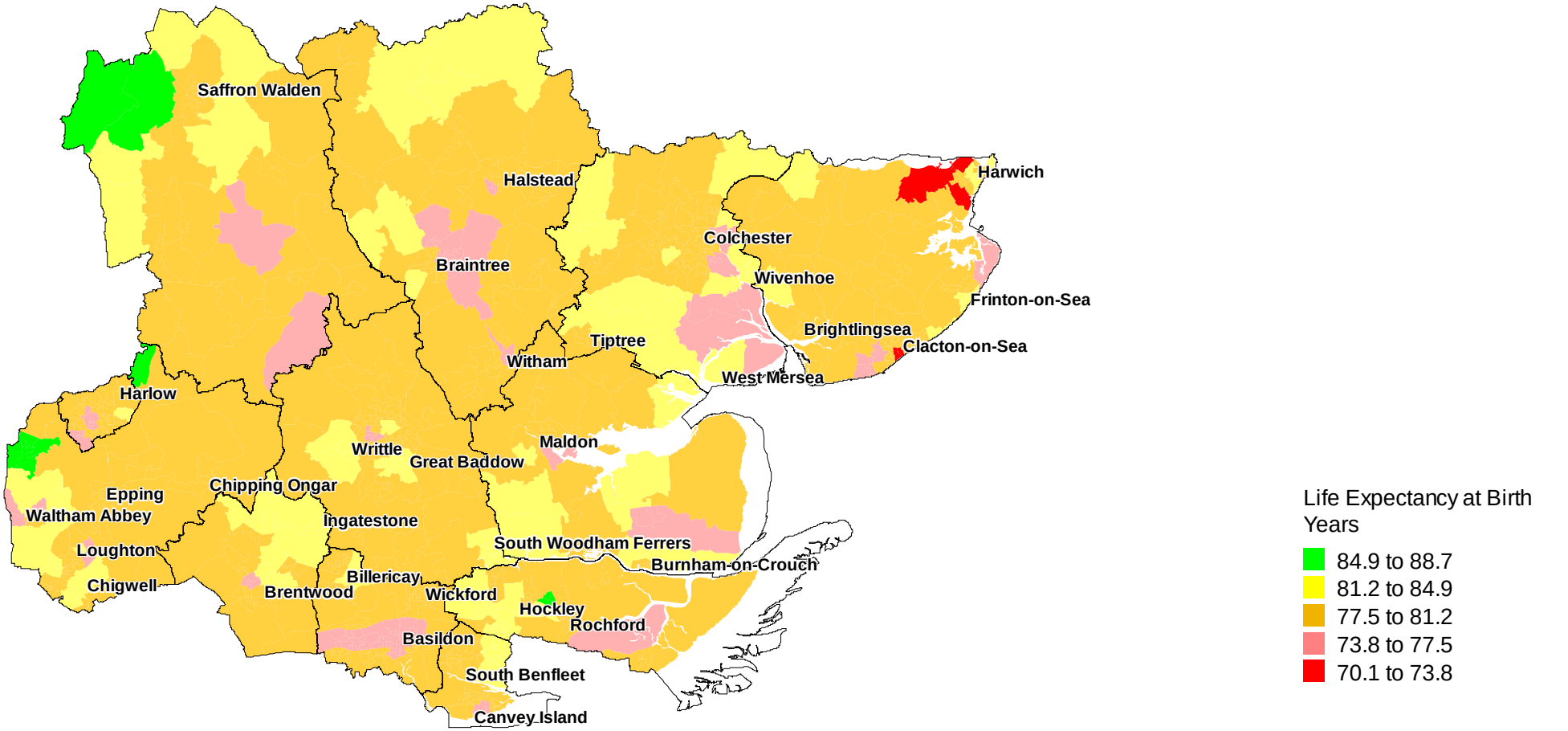
- ‘ReachOut’ is a project which has received national recognition and is quoted in the Marmot review. It helps people receive advice and assistance to tackle poverty and improve health. The project was developed through a partnership between the County Council, NE Essex PCT and the local Interaction Partnership. It 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.
- Another project 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.

- A Village Agents scheme in rural areas of the county is improving access to services to address health inequalities caused by rurality.
- A GP Care Advisor service has been successful in keeping people in their homes in north east Essex. 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.
- An effective and innovatively targeted initiative saw homeless people living in temporary accommodation in Colchester offered health checks at their accommodation. Nineteen were carried out, identifying a significant number of potentially serious health issues. Feedback has been positive and plans are in place to roll out this scheme more widely. A similar scheme offers Job Seekers Allowance claimants health checks at the Job Centre.
- The 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) which is stabilising or reducing the BMI measurements of participating children.
- North East 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.
- 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. The Fire service and the Police work with the Princes Trust to deliver a team programme in Basildon & Colchester. This is a 12-week personal development course for young people, offering work experience, qualifications, practical skills, community projects and a residential week.
- Family intervention projects in Harlow, Tendring and Basildon 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.
- Essex has made good progress with some of the population groups at high risk of experiencing health inequalities. For example it has done well in helping people with mental health problems or learning disabilities into work.

35 These achievements should have an impact on health inequalities. However, there is more to do in terms of sharing learning and best practice. District LSPs are at very different stages in their approach to tackling health inequalities. This is reflected in the varied trend for the life expectancy gap at a local level. For example, in north east Essex, the gap between the 20 per cent most deprived areas and the other 80 per cent reduced from 3.54 years in December 2006 to 2.88 years by June 2009. At the other extreme, in West Essex, the gap has increased from 2.29 to four years.

36 These figures show there is more to be done but have to be treated with some caution. First, they are at PCT level and the picture will vary between districts. Second, 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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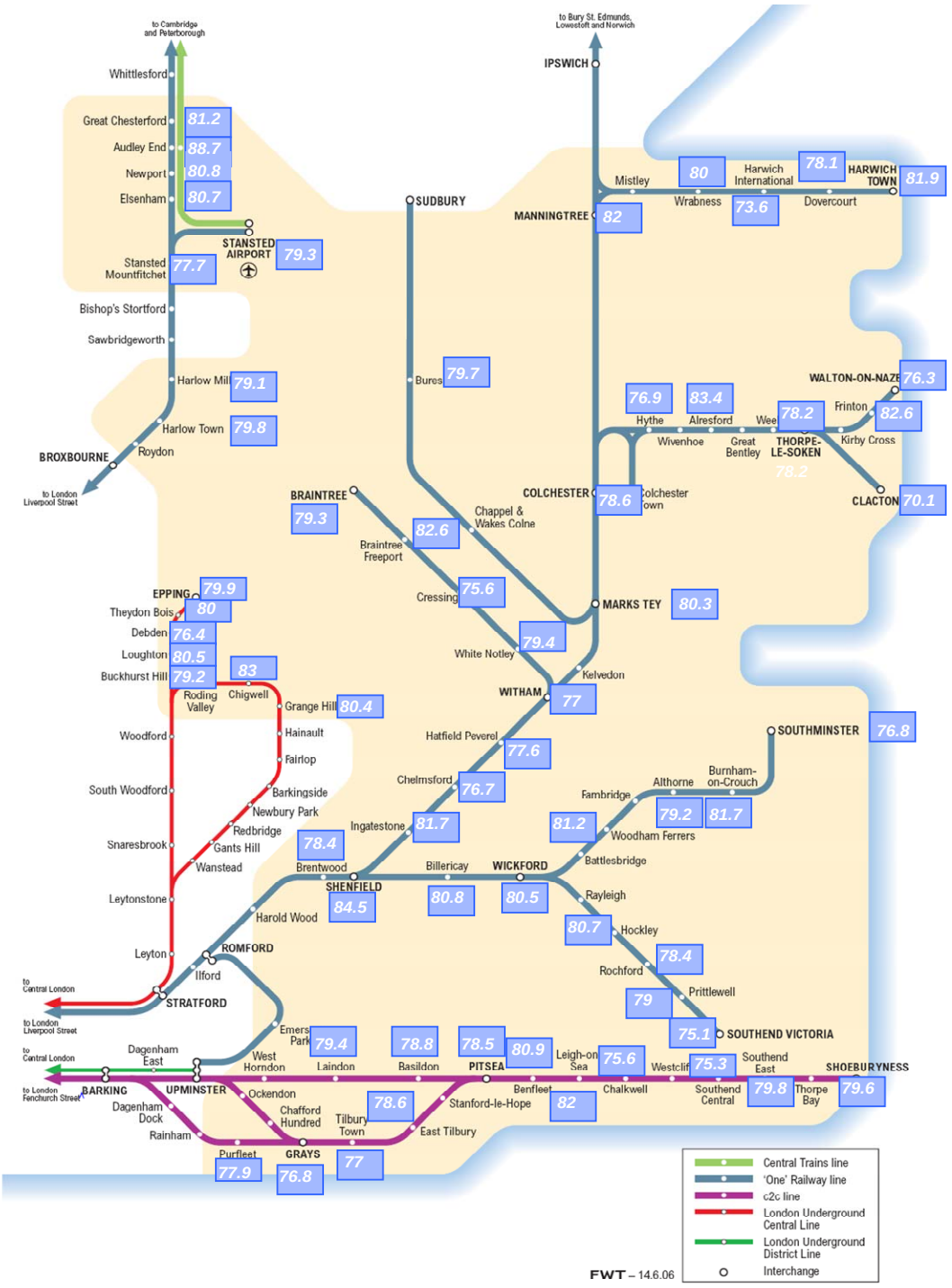
ONS, Super Output Area Boundaries. Crown copyright 2004. Crown copyright material is reproduced with the permission of the Controller of HMSO

Appendix 3 – Variations in life expectancy along the railway line



Source: Life expectancy at birth for wards in England and Wales (Experimental) 1999-2003, ONS
Rail Map Source: http://www.essexcc.gov.uk/vip8/ecc/ECCWebsite/dis/gui.jsp?channelOid=74978&guideOid=71775

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For further information on the work of the Commission please contact:

Audit Commission, 1st Floor, Millbank Tower, Millbank, London SW1P 4HQ

Tel: 0844 798 1212 Fax: 0844 798 2945 Textphone (minicom): 0844 798 2946

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