National Audit Office

Department of Health

Tackling inequalities in life expectancy in areas with the worst health and deprivation

Results of a survey of spearhead primary care trusts and local authorities

JULY 2010

Contents

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Part One

Introduction and methodology

1 As part of the methodology for our study on tackling inequalities in life expectancy in areas with the worst health and deprivation, the National Audit Office (NAO) conducted a survey of primary care trusts and local authorities in spearhead areas, in July and August 2009. A total of 61 spearhead primary care trusts and 42 spearhead local authorities responded, representing response rates of 98 per cent and 60 per cent respectively.

2 This report presents our analyses of these two surveys and is published separately on our website alongside the published NAO report on tackling inequalities in life expectancy in areas with the worst health and deprivation (publication date 2 July 2010).

3 The survey's principal objectives were to obtain evidence on actions to address health inequalities, the support received to tackle health inequalities in spearhead areas and partnership working between the primary care trusts and local authorities. Both primary care trusts and local authorities were asked about the support received to tackle health inequalities and about partnership working and community engagement. In addition primary care trusts were asked about their organisational structure and the actions taken to address health inequalities whilst local authorities were asked about the work of the Overview and Scrutiny Committee, responsible for health scrutiny.

4 The surveys were developed in consultation with the Health Inequalities Unit at the Department of Health, the Information Centre for Health and Social Care and the Association of Directors of Adult Social Services.

5 The results of the survey are presented in anonymised form. All percentages are shown as "valid percentages" i.e. they exclude blank and not applicable responses.

Part Two

Tackling health inequalities locally

Health inequalities strategies and targets

6 Over a third (36 per cent) of spearhead primary care trusts had their own documented health inequalities strategy whilst almost half (49 per cent) had a joint health inequalities strategy with the local authority and 58 per cent had a health inequalities strategy owned by the local strategic partnership (**Figure 1**).

7 Most spearhead primary care trusts (80 per cent) and a majority of spearhead local authorities (58 per cent) had set a target, or targets, to reduce health inequalities between the least and most deprived geographical areas within their catchment area (**Figure 2**). Of the primary care trusts that had set targets, at least 50 per cent had set a target to reduce the life expectancy gap or overall mortality gap. The other targets category in Figure 2 covers targets relating to world class commissioning, vital signs, annual health checks and Local Areas Agreements and therefore is likely to include some of the other categories.

Figure 1
Spearhead primary care trusts with a documented health inequalities strategy

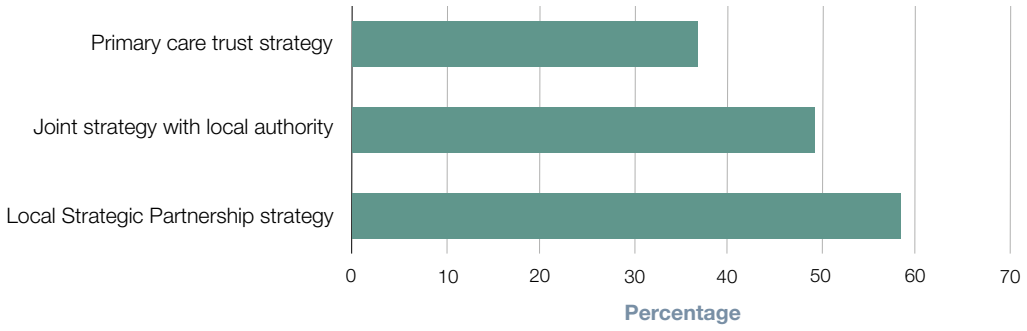
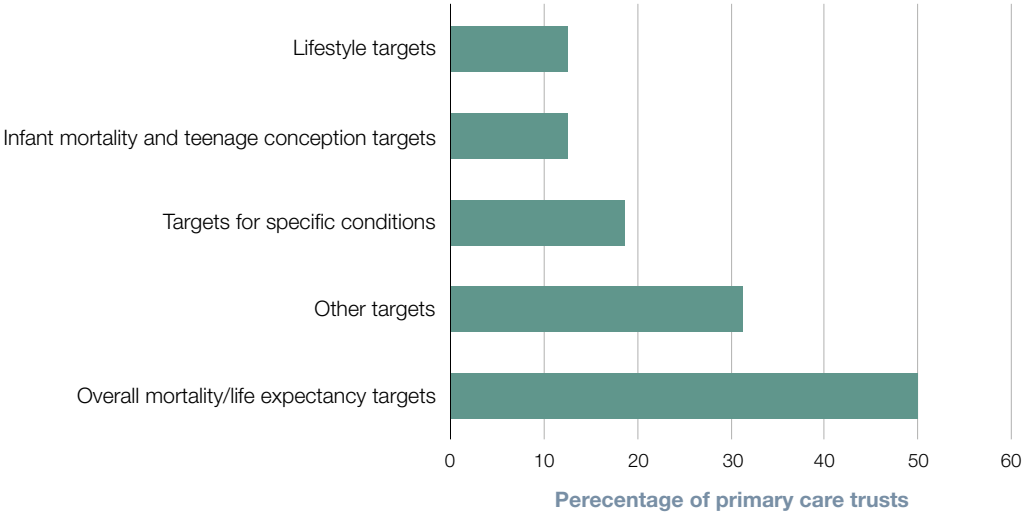


Figure 2
Spearhead primary care trusts with a documented health inequalities strategy

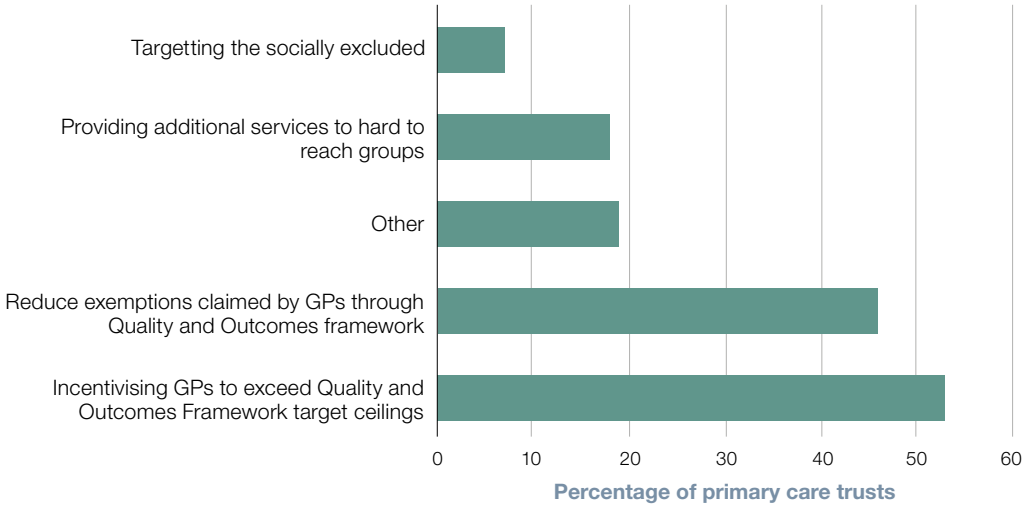


Specific initiatives to tackle health inequalities

8 Spearhead primary care trusts were asked if they were implementing any specific initiatives to increase access to services for those at risk of suffering from health inequalities, and in particular whether they were incentivising GPs to exceed Quality and Outcomes Framework[1] target ceilings and whether they were reducing the levels of exemptions claimed by GPs through the Quality and Outcomes Framework system. More than half (52 per cent) were incentivising GPs to perform better than Quality and Outcomes Framework target ceilings and 45 per cent were trying to reduce the levels of exemptions claimed by GPs through Quality and Outcomes Framework payments (**Figure 3**). Some were targeting the socially excluded whist other were providing additional services to hard to reach groups. The other category in Figure 3 covers wider initiatives such as whole systems approaches and extending GP opening times.

1 The Quality and Outcomes Framework is a system for the performance management and payment of GPs in the NHS in England, Wales, and Scotland. It was introduced as part of the new general medical services contract in April 2004, replacing various other fee arrangements.

Figure 3
Initiatives implemented by spearhead primary care trusts to increase access to services



9 Between 2007-08 and 2009-10, spearhead primary care trusts expect to increase spending on smoking cessation services by 45 per cent (**Figure 4**). In terms of smoking cessation services on offer, 96 per cent of primary care trusts offered individual behavioural counselling whilst 86 per cent offered group behavioural therapy.

10 All spearhead primary care trusts reported that clearly defined success measures were always or usually in place for each project or initiative aimed at tackling health inequalities and 98 per cent reported there were always or usually clearly defined timeframes within which those success measures were to be assessed (**Figure 5**).

Commissioning activity

11 We asked spearhead primary care trusts whether a number of statements applied to their commissioning activity (**Figure 6**). Reports on commissioning performance covered key population health and inequality issues in 93 per cent of primary care trusts. Around two-thirds of primary care trusts (69 per cent) reported that analysis was undertaken of the impact of commissioning decisions upon key inequalities, that social marketing was seen as a product of commissioning decisions (69 per cent), not a separate activity, and that public health staff were integrated into the commissioning team (64 per cent).

Figure 4

Mean spend per spearhead primary care trust on smoking cessation services

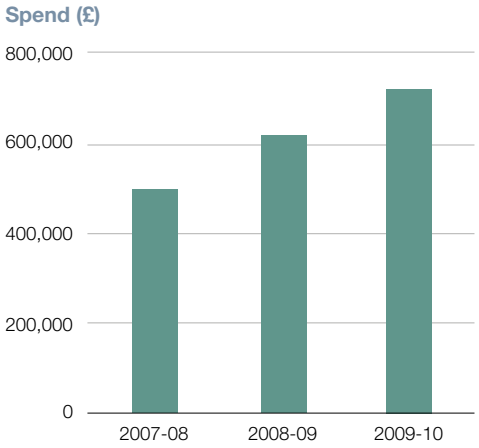


Figure 5

Spearhead primary care trusts defining success measures and timeframes for health inequalities initiatives

	Always (%)	Usually (%)	Occasionally (%)	Never (%)
Success measures defined	36	64	0	0
Timeframe defined	45	53	2	0

Figure 6

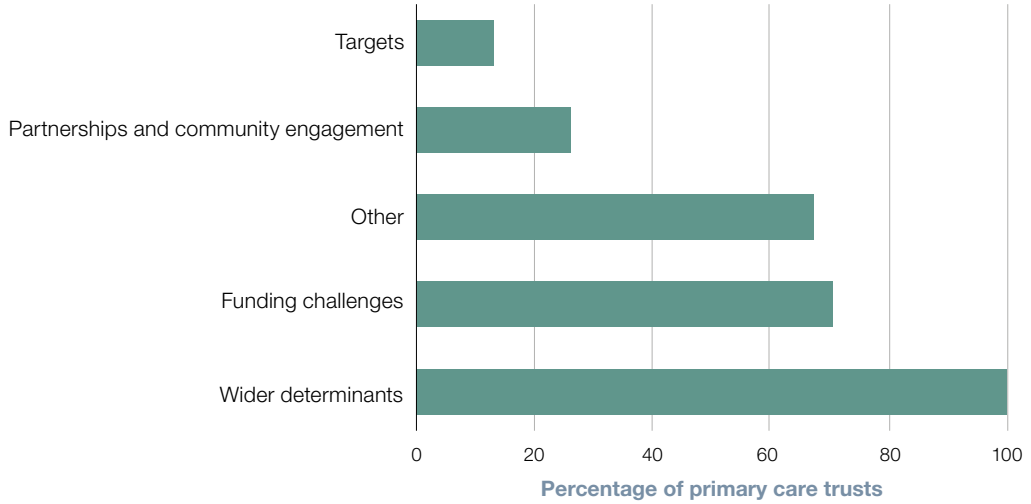
Spearhead primary care trusts' commissioning activities

Statement	Responses – level of agreement (%)
Reports on commissioning performance cover key population health and inequalities issues	93
Analysis is undertaken of the impact of commissioning decisions on key inequalities	69
Social marketing is seen as a product of commissioning decisions, not a separate activity	69
Public health staff are integrated into the commissioning team structure	64

Challenges in tackling health inequalities

12 We asked spearhead primary care trusts to name the three key challenges that they faced in tackling health inequalities. All primary care trusts named the wider determinants of health in their three key challenges whilst 70 per cent named funding challenges (**Figure 7**). The other category in Figure 7 includes the quality of primary care, the need for an increased focus on and prioritisation of public health and health inequalities, and the scale of the health inequalities and deprivation faced by primary care trusts.

Figure 7
Key challenges faced by spearhead primary care trusts in tackling health inequalities



Part Three

Support to tackle health inequalities

The role of strategic health authorities

13 Strategic health authorities are responsible for performance managing primary care trusts in their area and are also responsible for developing plans for improving health services in their local area. We asked primary care trusts whether their strategic health authority had undertaken a number of actions in relation to addressing health inequalities and how helpful these actions were (**Figure 8**).

Figure 8
Strategic health authority support for spearhead primary care trusts in tackling health inequalities

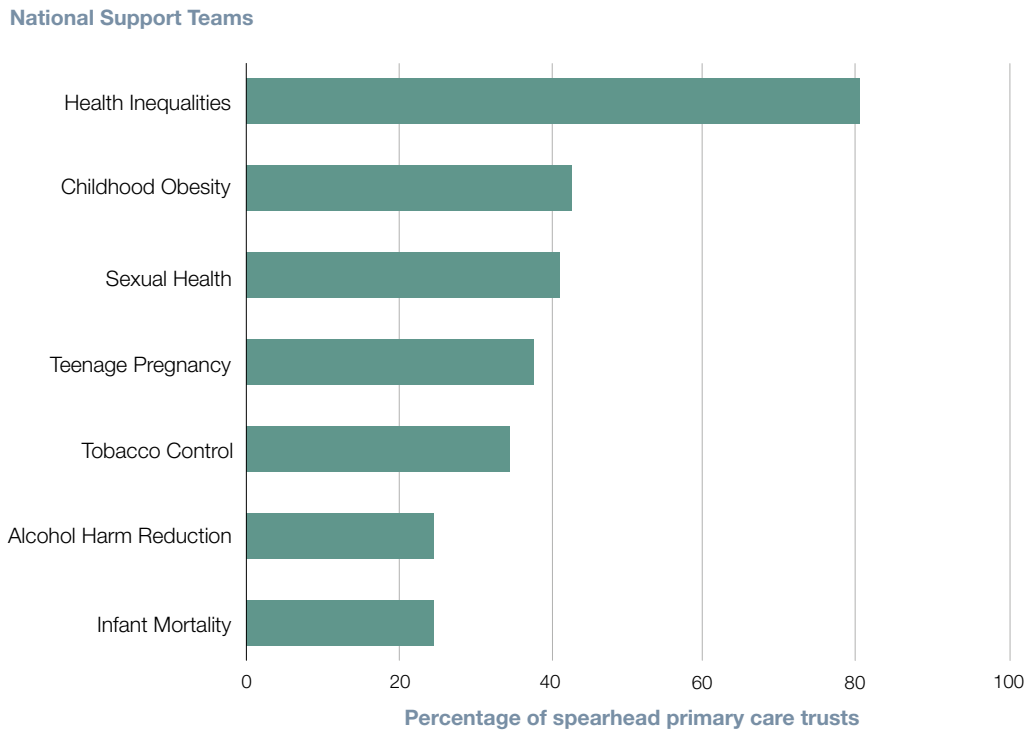
Action	Percentage of primary care trusts where action was taken by the strategic health authority	Primary care trust assessment of helpfulness of strategic health authority actions (%)			
		Not at all helpful	Not very helpful	Fairly helpful	Very helpful
Laid down a clear way forward in strategic health authorities' strategic documents	85	0	13	71	15
Focused on health inequalities through their performance management regime	80	12	10	63	15
Issued guidance	70	4	15	77	4
Developed interventions to increase the geographical scope of impact and provide economies of scale	64	5	23	55	18
Been a source of practical advice to address problems	43	6	30	52	12
Provided advice to help implement recommendations of the National Support Teams	41	3	20	70	7
Provided financial support to implement recommendations of the National Support Teams	11	19	56	19	6

14 Spearhead primary care trusts reported that the majority of strategic health authorities had laid down a clear way forward for primary care trusts in strategic documents (85 per cent), had focused on health inequalities through their performance management regime (80 per cent), had issued guidance (70 per cent) and had developed interventions to increase the geographical scope of impact and provide economies of scale (64 per cent). Most primary care trusts felt this support was fairly or very helpful. Strategic health authorities were rarely a source of financial support for primary care trusts in implementing National Support Team recommendations (11 per cent) and less than half of the primary care trusts felt that their strategic health authority had been a source of advice in problem solving or implementing recommendations (43 per cent).

National Support Teams

15 The Department of Health has established National Support Teams which aim to help primary care trusts and local authorities tackle a number of issues, including health inequalities. Spearhead primary care trusts and local authorities had been visited by a number of these teams (**Figure 9**).

Figure 9
Spearhead primary care trusts with a documented health inequalities strategy



16 On the whole both primary care trusts and local authorities found National Support Team visits very useful, for example 47 per cent of primary care trusts found the visit of the Health Inequalities National Support Team very useful and an additional 47 per cent said it would lead to a step change in performance (**Figure 10**). However, 43 per cent of primary care trusts found the Tobacco Control National Support Team visit of limited use or of no use.

Support tools

17 There are a range of support tools and data sets available for use by primary care trusts and local authorities to tackle health inequalities. We asked spearhead primary care trusts and local authorities whether they used a number of these tools and how useful they found them (**Figure 11**). The survey results indicate that support tools are widely used and are generally considered to be helpful.

Figure 10
How useful were the National Support Team visits?

	Spearhead primary care trusts				Spearhead local authorities			
	Usefulness (%)				Usefulness (%)			
	Of no use	Of limited use	Quite useful	Very useful	Of no use	Of limited use	Quite useful	Very useful
Sexual Health	0	0	48	52	11	22	45	22
Health Inequalities	0	6	47	47	0	22	50	28
Alcohol Harm Reduction	0	14	57	29	0	13	50	35
Teenage Pregnancy	0	18	45	37	0	27	18	55
Childhood Obesity	0	24	44	32	0	29	57	14
Tobacco Control	5	38	48	9	0	20	53	27

Figure 11

Usefulness of tools/data sets to tackle health inequalities

Tool/data set (source)	Spearhead primary care trusts					Spearhead local authority				
		Helpfulness (%)					Helpfulness (%)			
	Used the tool (%)	Of no use	Of limited use	Quite useful	Very useful	Used the tool (%)	Of no use	Of limited use	Quite useful	Very useful
NICE guidance	95	0	11	47	42	81	0	13	50	38
Data and policy updates from the Department of Health or strategic health authority	95	0	8	75	17	69	4	21	61	14
Health profiles (Public Health Observatories)	93	0	33	35	31	95	0	26	34	39
Neighbourhood Statistics (Office for National Statistics)	93	0	2	42	56	86	0	9	46	46
Health Survey of England	93	0	25	58	16	74	0	38	28	34
Health inequalities intervention tool (London Health Observatory/Health Inequalities Unit, Department of Health)	90	0	19	57	24	57	0	29	46	25
Prevalence models (Public Health Observatories)	87	0	12	60	29	50	0	5	63	32
Clinical and Health Outcomes website (National Centre for Health Outcomes Development)	85	0	0	32	68	45	0	0	33	67
Programme budgeting data (Department of Health)	82	0	33	44	23	43	0	35	35	29
Health inequalities status reports on the Programme for Action (Department of Health)	77	0	20	61	20	52	5	19	48	29
Health inequalities – local basket of indicators data retrieval tool (London Health Observatory/ Department of Health's Health Inequalities Unit)	69	3	28	50	20	48	0	11	56	33
Healthy Communities Collaborative (Improvement Foundation)	66	0	18	61	21	48	5	25	55	15
NHS Comparators website (NHS Information Centre for Health and Social Care)	66	3	16	39	42	31	0	14	50	36
Infant Mortality Implementation Plan (Department of Health)	62	0	14	65	22	38	0	27	40	33
Forward projection of performance against health inequality PSA targets (Association of Public Health Observatories)	54	3	12	62	24	40	0	7	67	27
Health Poverty Index visualisation tool (NHS Information Centre for Health and Social Care)	49	3	53	40	3	31	0	33	67	0

18 We asked spearhead primary care trusts and local authorities to rate the effectiveness of how support to tackle health inequalities was communicated to them (**Figures 12** below and **Figure 13**). The communication of support was felt to be most effective from the Public Health Observatories (for primary care trusts) and from the Department of Health (for local authorities).

19 The majority of spearhead primary care trusts (64 per cent) and local authorities (67 per cent) reported that the support offered to help tackle health inequalities in its entirety met most of their requirements (**Figure 14** on page 15). However, a significant minority, 36 per cent of primary care trusts and 33 per cent of local authorities reported that the support offered did not meet many or any of their requirements.

Figure 12
Effectiveness of the communication of support

	Spearhead primary care trusts Effectiveness (%)				Spearhead local authorities Effectiveness (%)			
	Not at all	Not very	Quite	Very	Not at all	Not very	Quite	Very
Public Health Observatories	2	12	56	30	22	32	35	11
Health Inequalities Unit, Department of Health	2	22	58	18	5	15	37	43
Strategic health authority	0	26	64	10	7	15	49	29
NHS Information Centre for Health and Social Care	10	33	41	16	7	26	67	0
More general health and well-being support from the Department of Health	3	41	54	2	10	23	46	21
Improvement Foundation	7	42	44	7	16	42	29	13

Figure 13
Spearhead primary care trusts and local authorities reporting fairly effective or very effective communication

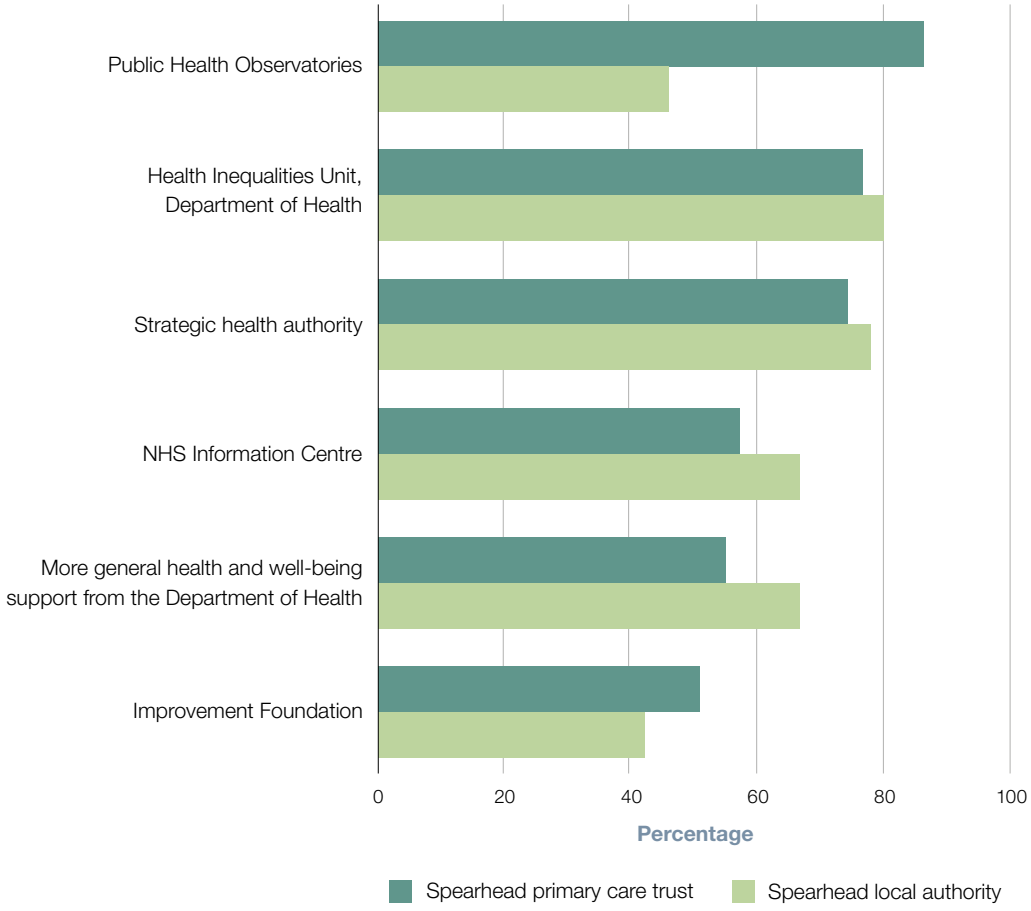
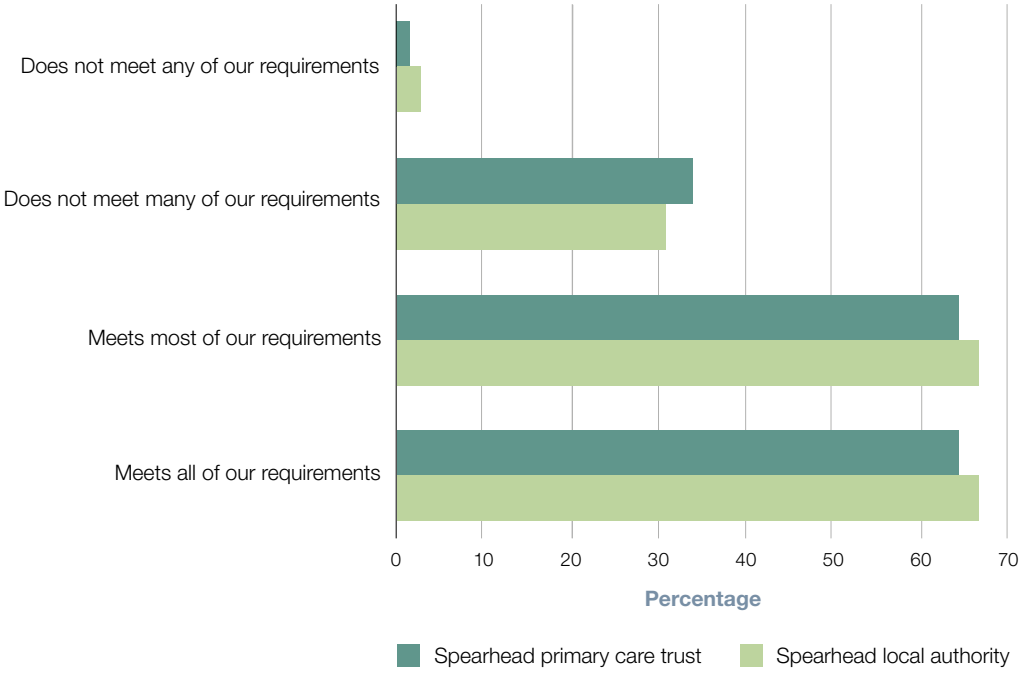
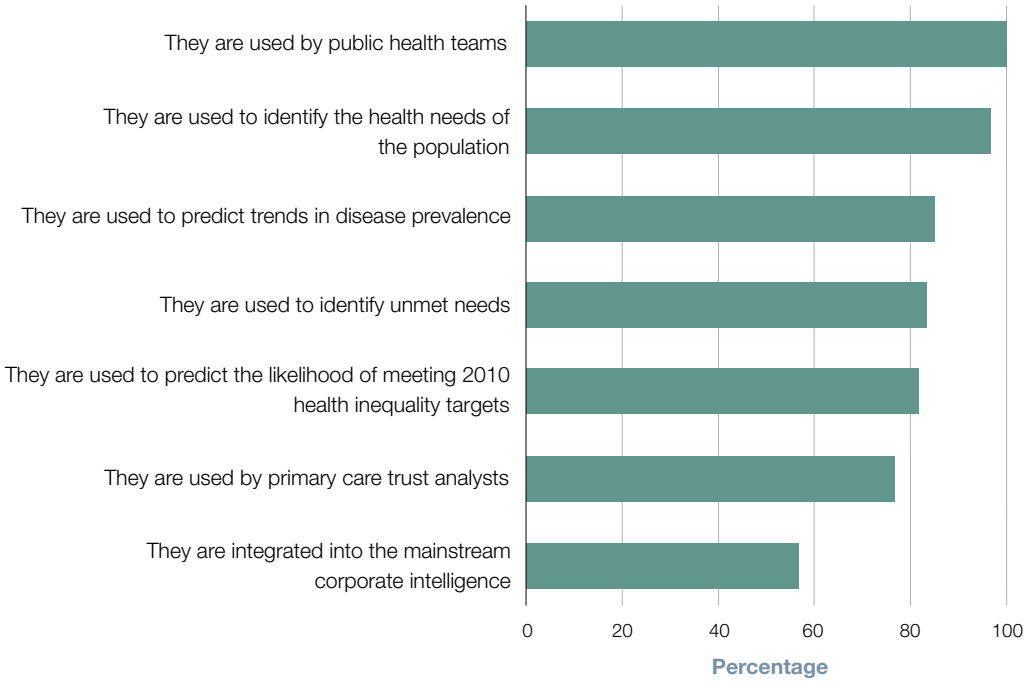


Figure 14
The extent to which the support offered met the requirements of spearhead primary care trusts and local authorities in tackling health inequalities



20 We asked spearhead primary care trusts how the support tools were being used across their organisation (**Figure 15**). Primary care trusts reported that the support tools and data sets available were used widely but are least likely to be incorporated into mainstream corporate intelligence.

Figure 15
Use of support tools and data sets across spearhead primary care trusts



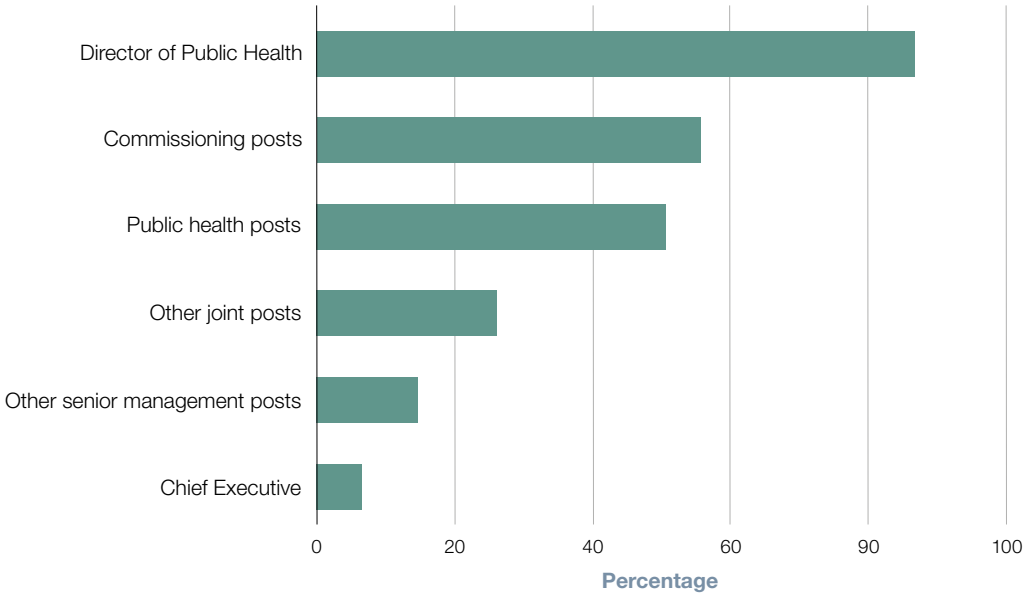
Part Four

Partnership working

Partnership between spearhead primary care trusts and local authorities

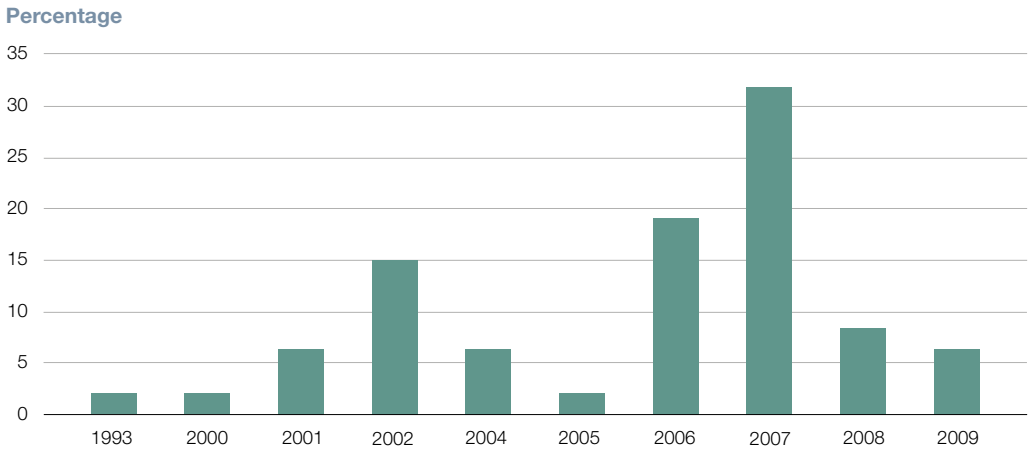
21 The post of Director of Public Health was a joint appointment between the primary care trusts and the local authority (or authorities) in 86 per cent of the spearhead primary care trusts who responded to the survey (**Figure 16**). More than 50 per cent of spearhead primary care trusts also had joint appointments with their local authority (or authorities) for other public health positions and for commissioning posts.

Figure 16
Spearhead primary care trusts with jointly held posts with local authorities



22 Joint appointments are a recent trend – almost two thirds of joint Directors of Public Health have been appointed since the beginning of 2006 (**Figure 17**).

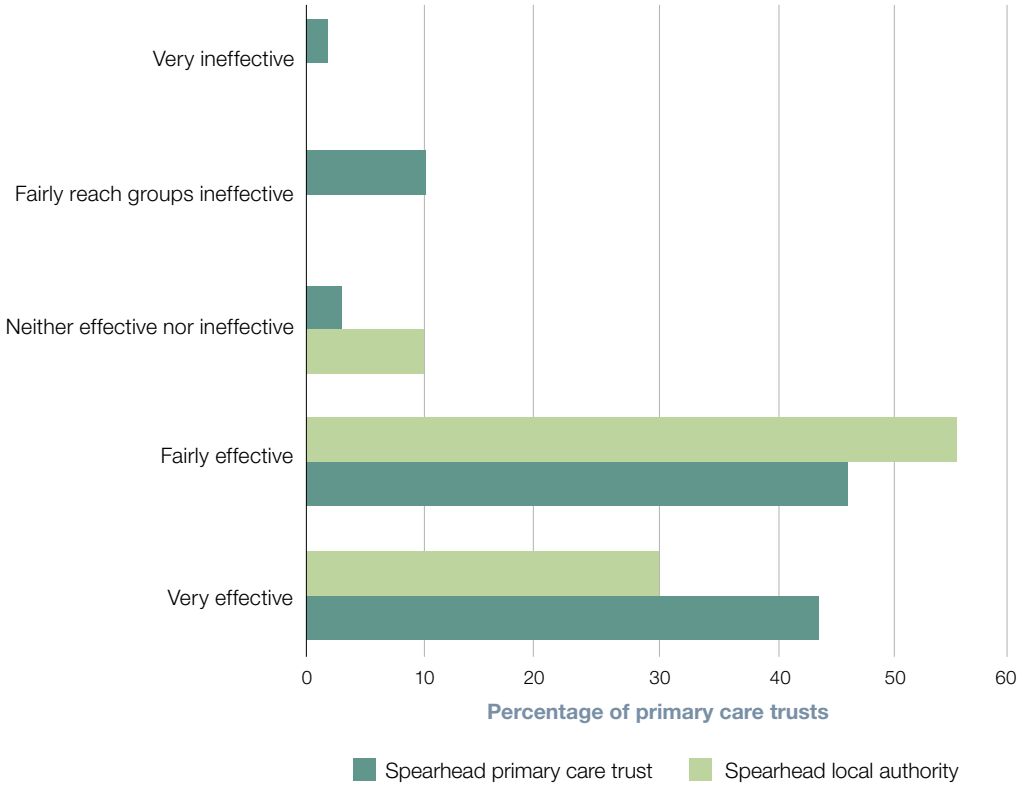
Figure 17
Year in which the post of Director of Public Health became a joint appointment



23 Most spearhead primary care trusts and local authorities reported that they worked well together with 85 per cent of primary care trusts and 90 per cent of local authorities rating the effectiveness of their partnership working as fairly effective or very effective (**Figure 18**).

Figure 18

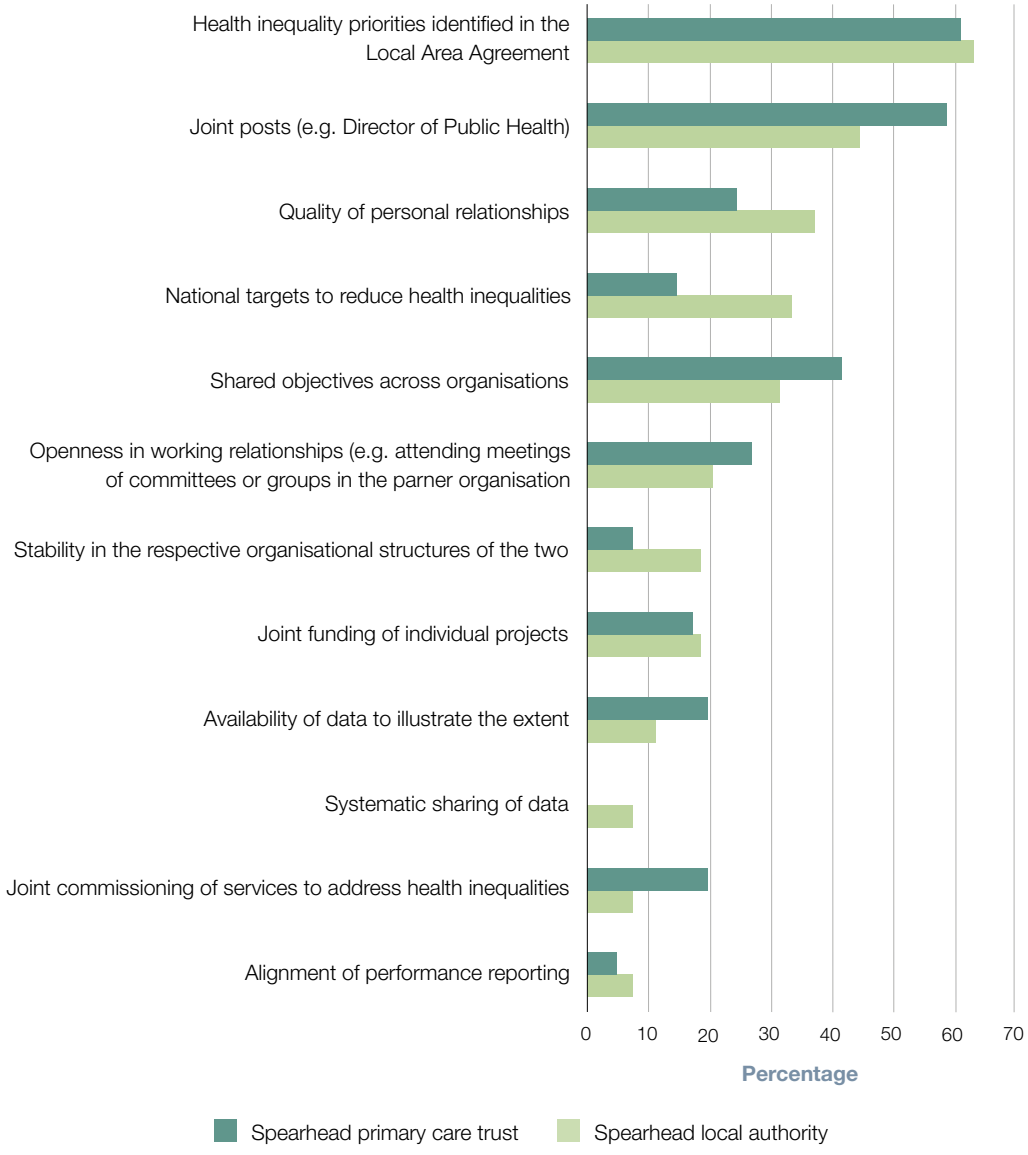
Effectiveness of partnership working between spearhead primary care trusts and local authorities



24 The two biggest factors for both spearhead primary care trusts and local authorities in making partnership working more effective in tackling health inequalities over the last five years were the identification of health inequality priorities in Local Area Agreements and the creation of joint posts, such as Directors of Public Health (**Figure 19**). Other important factors were shared objectives, national targets to reduce health inequalities and the quality of personal relationships.

Figure 19

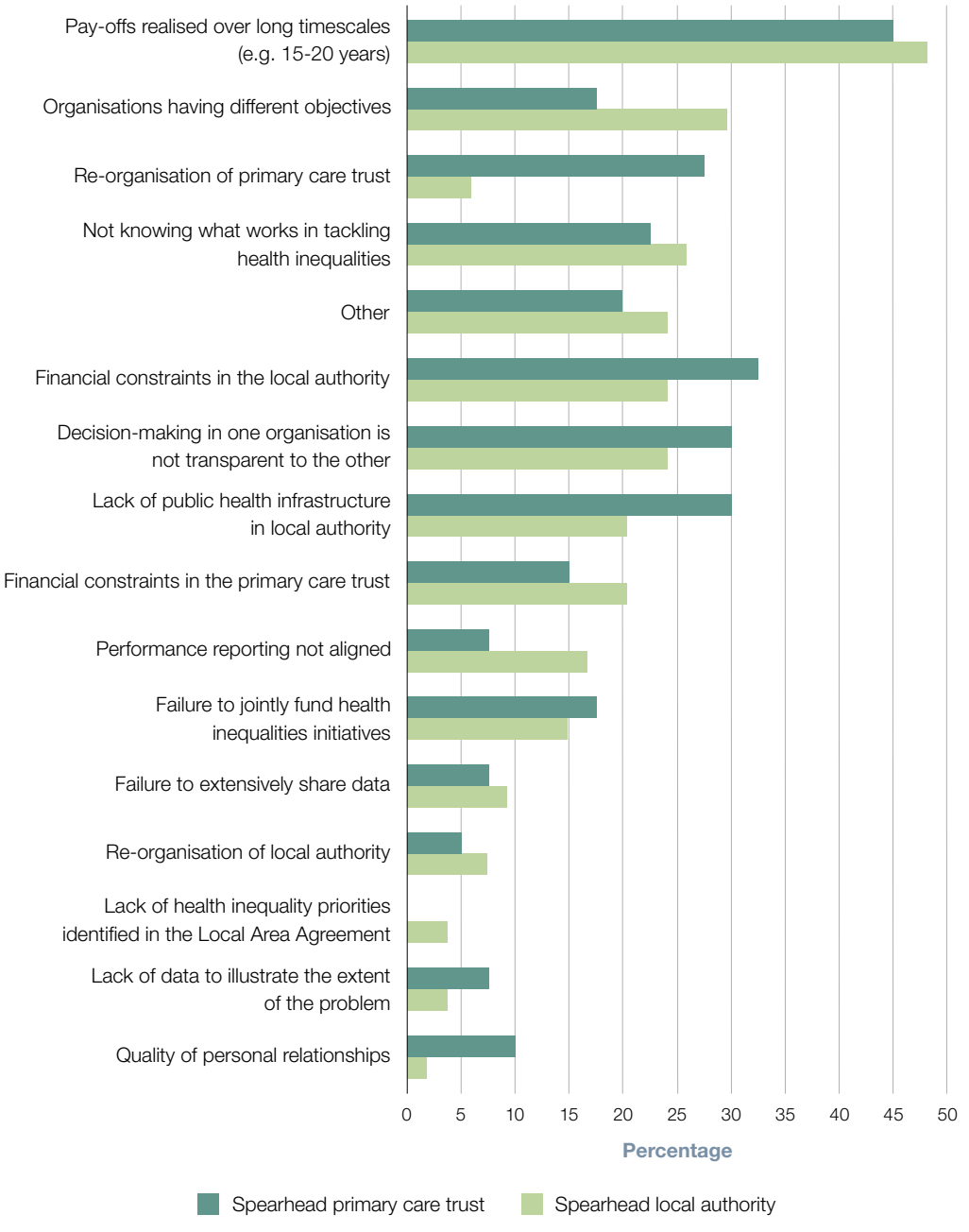
The most important factors in making partnership working more effective at tackling health inequalities



25 Both primary care trusts and local authorities in spearhead areas reported that the factor having the biggest impact in holding back partnership working to address health inequalities over the last five years was that the pay offs from tackling health inequalities were realised over long timescales (e.g. 15-20 years) (**Figure 20**). Primary care trusts reported that organisations having different objectives and not knowing what works

Figure 20

The factors having the biggest impact in holding back partnership working to tackle health inequalities



in tackling health inequalities were also important factors holding back work to tackle health inequalities whilst local authorities reported that financial constraints and a lack of public health infrastructure in their organisations were important factors.

26 The majority of both primary care trusts and local authorities in spearhead areas reported that the number of Local Area Agreement indicators reflecting health inequalities was likely to stay the same in the future (**Figure 21**). None reported that the number was likely to decrease.

27 Most spearhead primary care trusts have data sharing protocols in place with local authorities and other agencies to allow the sharing of administrative data, survey data and other qualitative data (**Figure 22**). However, 57 per cent of primary care trusts reported that there was only limited integration between primary care trust and local authority data systems (**Figure 23**).

Figure 21
Likely change in the number of Local Area Agreement indicators reflecting health inequalities

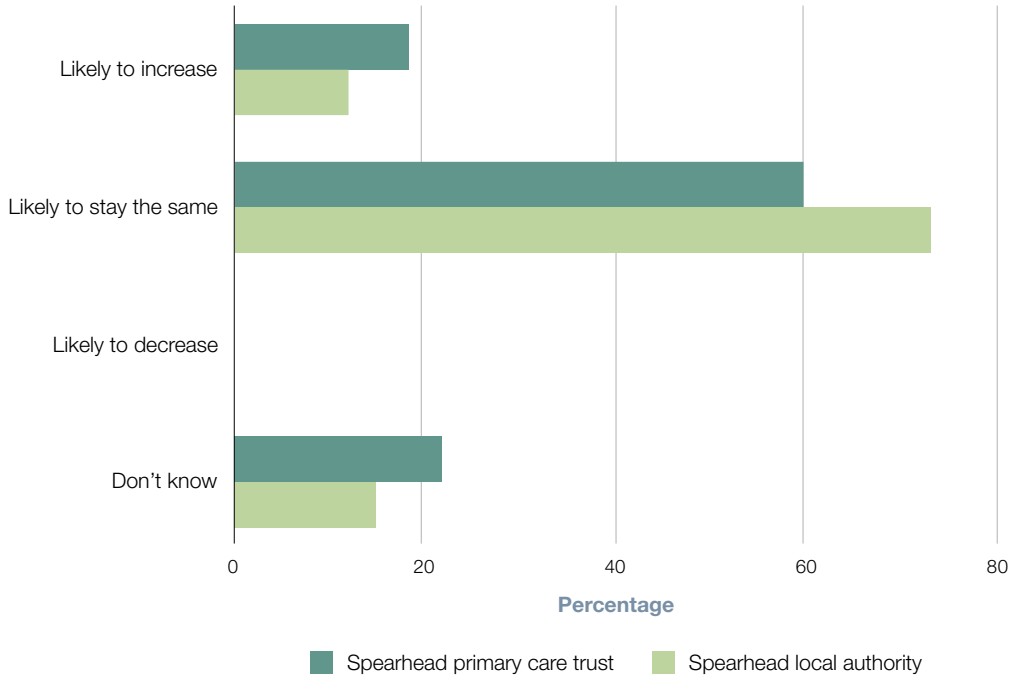


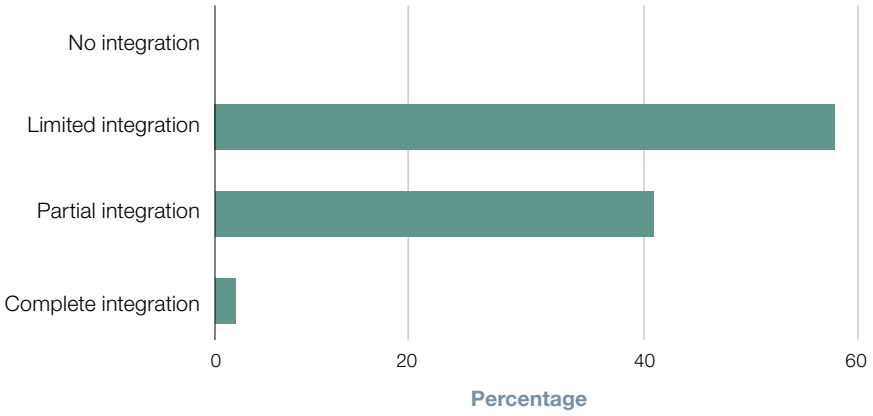
Figure 22

Percentage of spearhead primary care trusts with data sharing protocols in place for different data types

Administrative data (%)	Surveys (%)	Other qualitative data (%)
83	83	76

Figure 23

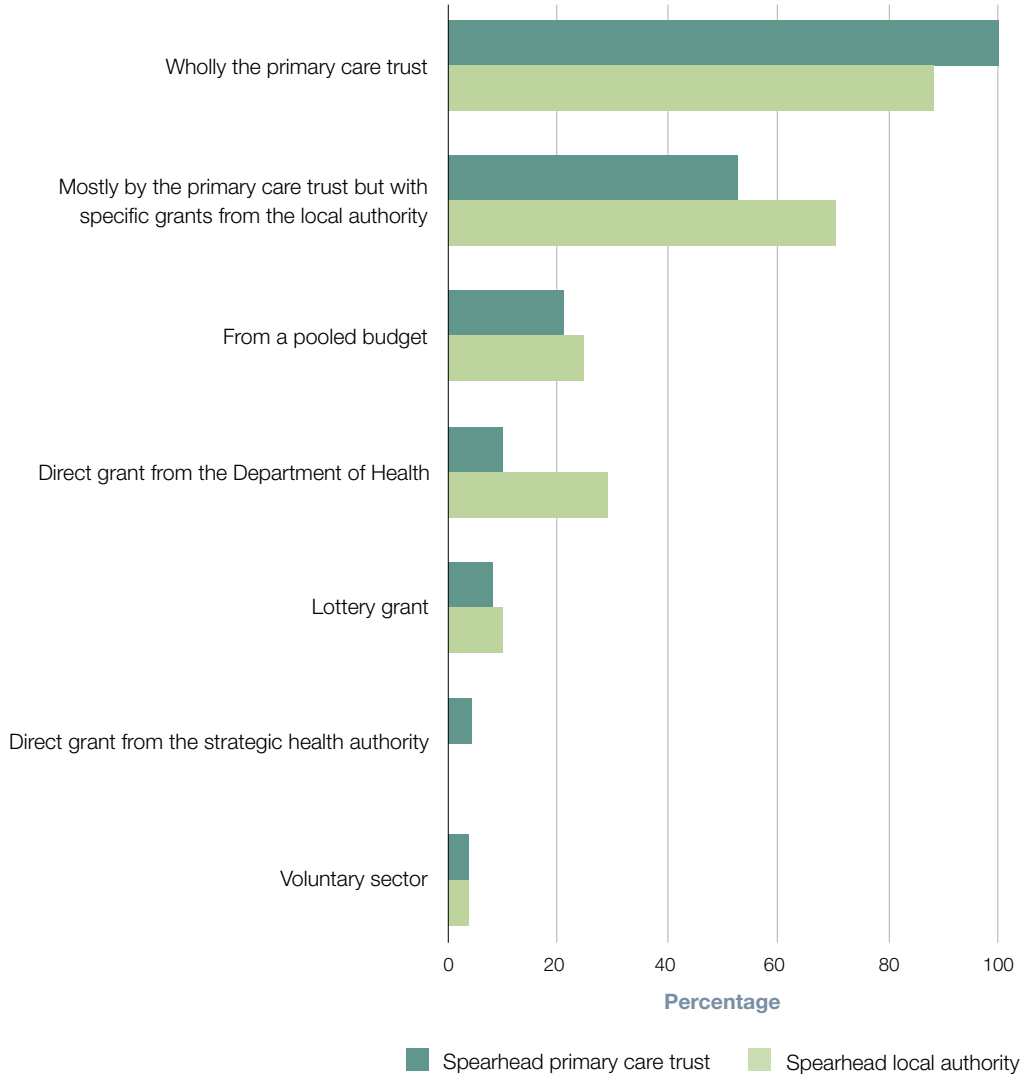
Integration of spearhead primary care trust and local authority data systems



Funding for health inequalities interventions

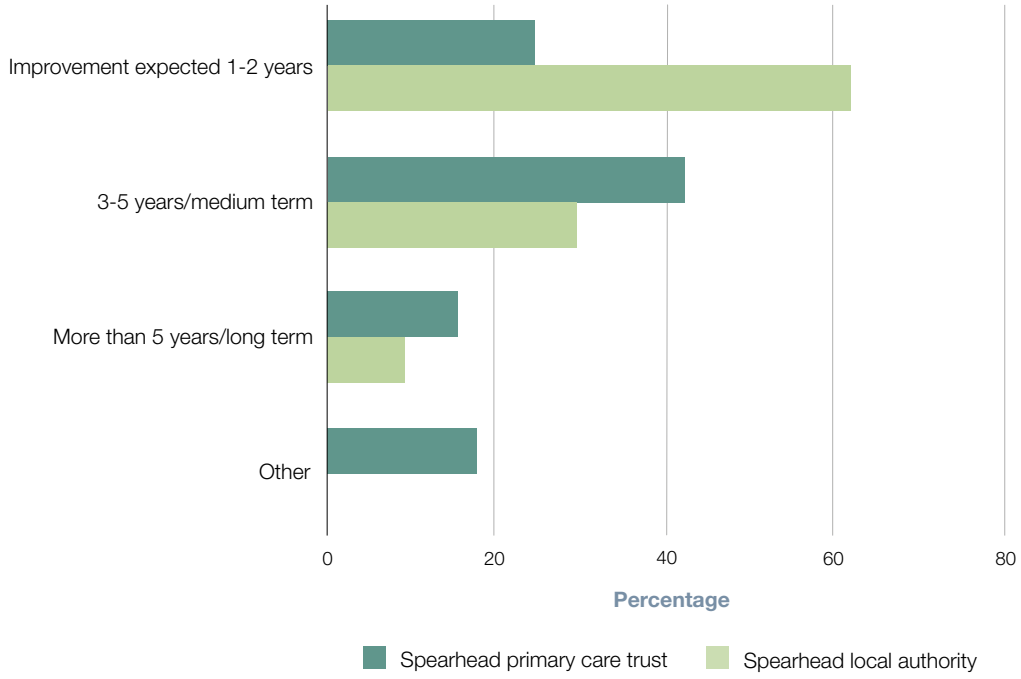
28 Health specific interventions tend to be funded either wholly by the spearhead primary care trusts or mostly by the primary care trusts but with specific grants from the local authority (**Figure 24**).

Figure 24
Funding mechanisms used 'usually' or 'always' for health specific interventions



29 More than three quarters of spearhead primary care trusts (78 per cent) and more than half of local authorities (64 per cent) felt that Joint Strategic Needs Assessments had led to an increase in investment to tackle health inequalities. However local authorities tended to expect a quicker improvement in local outcomes as a result of that investment than that expected by primary care trusts (**Figure 25**).

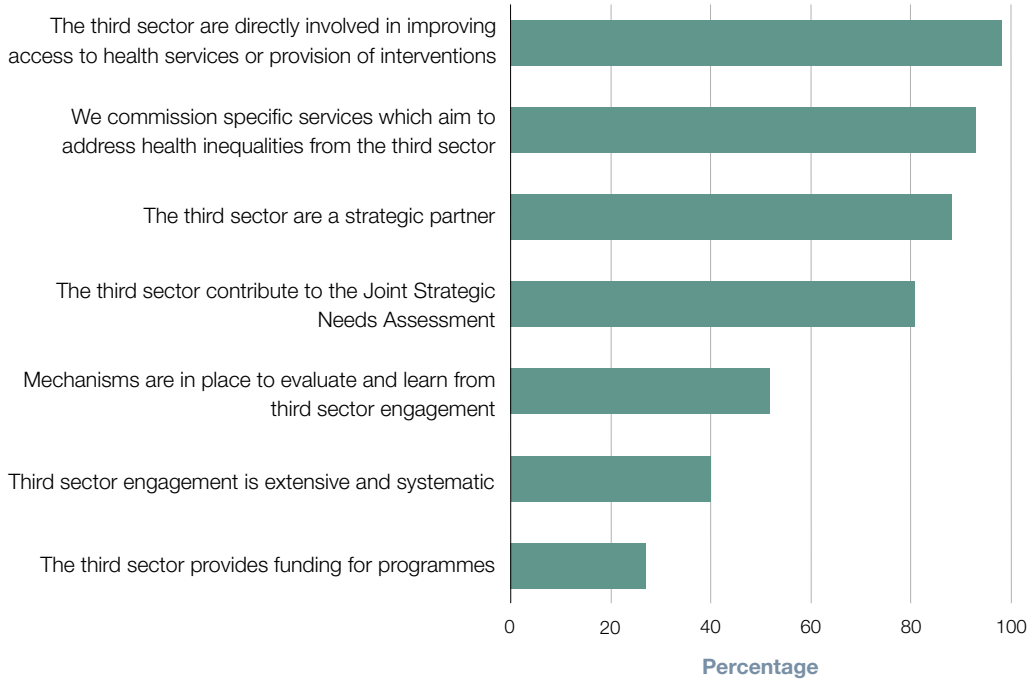
Figure 25
Expected timescale of improvements in local outcomes as a result of increased investment



Third sector and community involvement

30 We asked spearhead primary care trusts about the involvement of the third sector in addressing health inequalities (**Figure 26**). Primary care trusts reported that the third sector were directly involved in improving access to health services or the provision of interventions in 98 per cent of primary care trusts whilst 93 per cent of primary care trusts commission specific services which aim to address health inequalities from the third sector and 88 per cent consider the third sector to be a strategic partner. However, only 40 per cent of primary care trusts reported that third sector engagement was extensive and systematic and only 27 per cent noted that the third sector provided funding for programmes.

Figure 26
Involvement of the third sector in addressing health inequalities

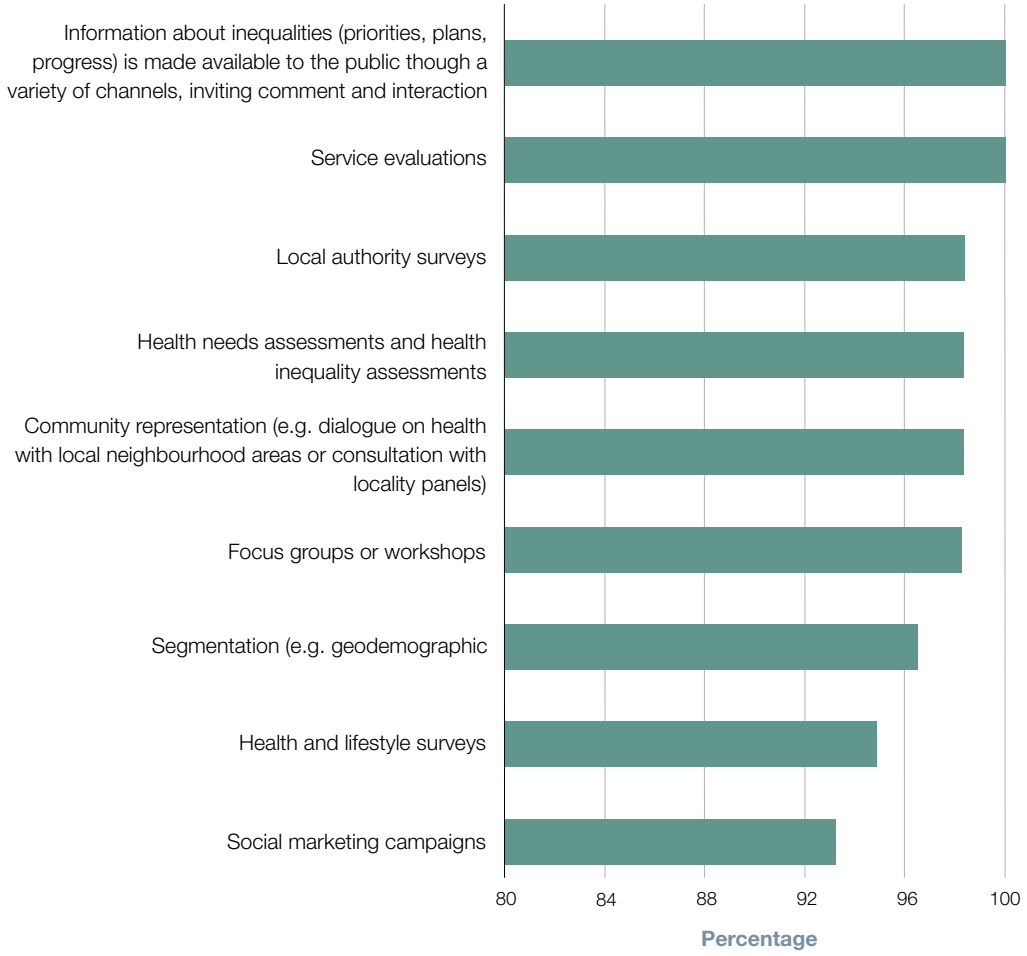


31 We asked spearhead primary care trusts about the involvement of the community in addressing health inequalities (**Figure 27**). All primary care trusts reported that there was a range of community projects and awareness campaigns aimed at reducing health inequalities among communities with the greatest need and 93 per cent reported that communities were directly involved in improving access to health services or provision of interventions.

Figure 27
Involvement of the community in addressing health inequalities

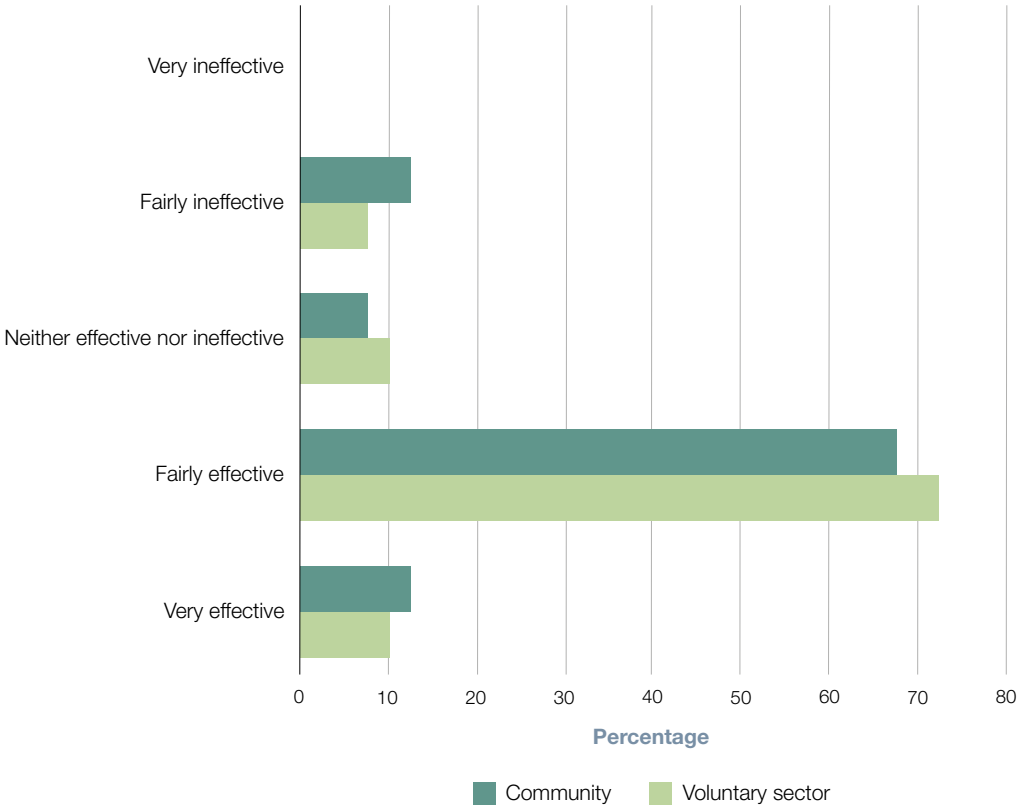
32 All spearhead primary care trusts reported that information about inequalities (priorities, plans, progress) was made available to the public though a variety of channels, inviting comment and interaction and that they used service evaluation to engage local populations (**Figure 28**).

Figure 28
Methods used by spearhead primary care trusts to engage local populations



33 We asked spearhead local authorities to comment on the effectiveness of spearhead primary care trust engagement with the local community and voluntary sector. Most local authorities reported that their local primary care trust was fairly effective at engaging with the local community and the voluntary sector (**Figure 29**).

Figure 29
Effectiveness of spearhead primary care trusts at engaging with the local community and voluntary sector



34 Most spearhead local authorities (90 per cent) either agreed or strongly agreed that there were a range of community projects and awareness campaigns aimed at reducing health inequalities among communities with the greatest need and 77 per cent either agreed or strongly agreed that communities are directly involved in improving access to health services or provision of interventions (**Figure 30**). However, 53 per cent either disagreed or strongly disagreed that community engagement was extensive and systematic.

Figure 30
Local community engagement on health related issues

Statement	Responses – Level of agreement (%)				
	Strongly agree	Agree	Don't know	Disagree	Strongly disagree
There are a range of community projects and awareness campaigns aimed at reducing health inequalities among communities with the greatest need	35	55	0	8	3
Community engagement is extensive and systematic	13	33	3	48	5
Communities are directly involved in improving access to health services or provision of interventions	10	67	10	10	3
Mechanisms are in place for primary care trusts to evaluate and learn from community engagement	8	55	23	15	0
Primary care trusts are using the Local Involvement Network effectively to consult with the community on a range of health-related issues	8	55	10	23	5
The community contribute to the Joint Strategic Needs Assessment	8	49	5	33	5
One off consultation, such as a workshop, is currently more common than longer-term community engagement	3	33	3	53	10

Part Five

The work of local authority Overview and Scrutiny Committees responsible for health

35 Since January 2003, every local authority with social services responsibilities has had the power to scrutinise local health services. Overview and Scrutiny Committee take on the role of scrutiny of the NHS – they aim to bring democratic accountability into healthcare decisions and make the NHS more publicly accountable and responsive to local communities.

36 We asked Overview and Scrutiny Committees in spearhead areas about their work in relation to tackling health inequalities (**Figure 31**). Most scrutiny committees were aware of health inequalities issues and these broadly informed their activity, but few were engaged with groups and communities with the poorest health or undertook scrutiny on the health impacts of programmes based in the most deprived areas.

37 We asked the committees to name the three factors posing the biggest challenges to their committees in ensuring health inequalities are tackled (**Figure 32** on page 33). They reported that these were 'gaining effective community involvement in the work of the Committee,' 'difficulties in separating health inequalities from other issues,' and 'scrutiny across a number of organisations (NHS and non-NHS)'.

Figure 31

The work of overview and scrutiny committees to tackle health inequalities

Statements	Applies to Scrutiny Committees (%)
The committee consider inequities in service provision, access and outcomes as part of scrutiny reviews of NHS or local authority services	79
Members of the health scrutiny committee receive profiles of the health inequalities of the local population to inform scrutiny work	79
The committee maintain an overall balance in the scrutiny work programme between service issues and broader health inequalities issues	76
The committee has made recommendations for tackling health inequalities and equity issues in its work	74
When identifying and selecting topics for scrutiny health inequalities is one of the criteria used	69
The committee make connections with other scrutiny committees on the wider determinants of health inequalities	67
Tackling health inequalities is in the terms of reference of the overview and scrutiny committee responsible for health scrutiny	50
Groups and communities with the poorest health are engaged in the work of the committee	33
The committee undertake scrutiny on the health impacts of programmes based in the most deprived areas	29
The Committee has a lead member for health inequalities	17

Figure 32

The three biggest challenges facing scrutiny committees in ensuring health inequalities are tackled

Statement	Responses – local authorities placing the statement in their three biggest challenges (%)
Gaining effective community involvement in the work of the Committee	64
Difficulties in separating health inequalities from other issues	49
Scrutiny across a number of organisations (NHS and non-NHS)	44
Scrutiny across local authorities and boundaries	36
Agenda is driven by NHS reorganisation/reconfiguration	28
Monitoring recommendations and any changes made	18
Ensuring support for the Committee's work from the wider authority or authorities	15
Other	15
Lack of evidence base for tackling health inequalities	8
Lack of supporting data and evidence on health inequality issues	5
Local Strategic Partnership does not focus on health inequalities	5
Little opportunity to address primary care issues	3