



Health Development Agency

Health equity audit: a baseline survey of primary care trusts in England

Annexes 1–4

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Copies of this publication are available to download from the HDA website (www.hda.nhs.uk).

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ISBN 1-84279-422-1

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About the Health Development Agency

The Health Development Agency (www.hda.nhs.uk) is the national authority and information resource on what works to improve people's health and reduce health inequalities in England. It gathers evidence and produces advice for policy makers, professionals and practitioners, working alongside them to get evidence into practice.

Annex 1 All PCTs in England

(*n* = 303; survey respondents in bold)

Adur, Arun and Worthing PCT

Airedale PCT

Amber Valley PCT

Ashfield PCT

Ashford PCT

Ashton, Leigh and Wigan PCT

Barking and Dagenham PCT

Barnet PCT

Barnsley PCT

Basildon PCT

Bassetlaw PCT

Bath and North East Somerset PCT

Bebington and West Wirral PCT

Bedford PCT

Bedfordshire Heartlands PCT

Bexhill and Rother PCT

Bexley Care Trust

Billericay, Brentwood and Wickford PCT

Birkenhead and Wallasey PCT

Blackburn With Darwen PCT

Blackpool PCT

Blackwater Valley and Hart PCT

Bolton PCT

Bournemouth Teaching PCT

Bracknell Forest PCT

Bradford City Teaching PCT

Bradford South and West PCT

Brent Teaching PCT

Brighton and Hove City PCT

Bristol North PCT

Bristol South and West PCT

Broadland PCT

Bromley PCT

Broxtowe and Hucknall PCT

Burnley, Pendle and Rossendale PCT

Burntwood, Lichfield and Tamworth PCT

Bury PCT

Calderdale PCT

Cambridge City PCT

Camden PCT

Cannock Chase PCT

Canterbury and Coastal PCT

Carlisle and District PCT¹

Castle Point and Rochford PCT

Central Cheshire PCT

Central Cornwall PCT

Central Derby PCT

Central Liverpool PCT

Central Manchester PCT

Central Suffolk PCT

Charnwood and North West Leicestershire PCT

Chelmsford PCT

Cheltenham and Tewkesbury PCT

Cherwell Vale PCT

Cheshire West PCT

Chesterfield PCT

Chiltern and South Bucks PCT

Chorley and South Ribble PCT

City and Hackney Teaching PCT

Colchester PCT⁶

Cotswold and Vale PCT

Coventry Teaching PCT

Craven, Harrogate and Rural District PCT

Crawley PCT

Croydon PCT

Dacorum PCT

Darlington PCT

Dartford, Gravesham and Swanley PCT

Daventry and South Northamptonshire PCT

Derbyshire Dales and South Derbyshire PCT

Derwentside PCT

Doncaster Central PCT

Doncaster East PCT

Doncaster West PCT

Dudley Beacon and Castle PCT

Dudley South PCT

Durham and Chester-le-Street PCT

Durham Dales PCT

Ealing PCT

Easington PCT

East Cambridgeshire and Fenland PCT

East Devon PCT

East Elmbridge and Mid Surrey PCT

East Hampshire PCT

East Kent Coastal PCT

East Leeds PCT

East Lincolnshire PCT

East Staffordshire PCT

East Surrey PCT

East Yorkshire PCT²

Eastbourne Downs PCT

Eastern Birmingham PCT

Eastern Cheshire PCT

Eastern Hull PCT

Eastern Leicester PCT

Eastern Wakefield PCT

Eastleigh and Test Valley South PCT

Eden Valley PCT¹

Ellesmere Port and Neston PCT

Enfield PCT

Epping Forest PCT

Erewash PCT

Exeter PCT

Fareham and Gosport PCT

Fylde PCT

Gateshead PCT

Gedling PCT

Great Yarmouth PCT

Greater Derby PCT

Greenwich Teaching PCT

Guildford and Waverley PCT

Halton PCT

Hambleton and Richmondshire PCT

Hammersmith and Fulham PCT

Haringey Teaching PCT

Harlow PCT

Harrow PCT

Hartlepool PCT

Hastings and St Leonards PCT

Havering PCT

Heart of Birmingham Teaching PCT

Herefordshire PCT

Hertsmere PCT

Heywood and Middleton PCT

High Peak and Dales PCT

Hillingdon PCT

Hinckley and Bosworth PCT

Horsham and Chanctonbury PCT

Hounslow PCT

Huddersfield Central PCT

Huntingdonshire PCT

Hyndburn and Ribble Valley PCT

Ipswich PCT

Isle of Wight PCT

Islington PCT

Kennet and North Wiltshire PCT

Kensington and Chelsea PCT

Kingston PCT

Knowsley PCT

Lambeth PCT

Langbaugh PCT

Leeds North East PCT

Leeds North West PCT
Leeds West PCT
Leicester City West PCT
Lewisham PCT
Lincolnshire South West Teaching PCT
Luton PCT
Maidstone Weald PCT
Maldon and South Chelmsford PCT
Mansfield District PCT
Medway PCT
Melton, Rutland and Harborough PCT
Mendip PCT
Mid Devon PCT
Middlesbrough PCT
Mid-Hampshire PCT
Mid-Sussex PCT
Milton Keynes PCT
Morecambe Bay PCT
New Forest PCT
Newark and Sherwood PCT
Newbury and Community PCT
Newcastle PCT
Newcastle-under-Lyme PCT
Newham PCT
North and East Cornwall PCT
North Birmingham PCT
North Bradford PCT
North Devon PCT
North Dorset PCT
North East Lincolnshire PCT ⁴
North East Oxfordshire PCT
North Eastern Derbyshire PCT
North Hampshire PCT
North Hertfordshire and Stevenage PCT
North Kirklees PCT
North Lincolnshire PCT ⁴
North Liverpool PCT
North Manchester PCT
North Norfolk PCT
North Peterborough PCT ³
North Sheffield PCT

North Somerset PCT
North Stoke PCT
North Surrey PCT
North Tees PCT
North Tyneside PCT
North Warwickshire PCT
Northampton PCT
Northamptonshire Heartlands PCT
Northumberland Care Trust
Norwich PCT
Nottingham City PCT
Oldbury and Smethwick PCT
Oldham PCT
Oxford City PCT
Plymouth Teaching PCT
Poole PCT
Portsmouth City Teaching PCT
Preston PCT
Reading PCT
Redbridge PCT
Redditch and Bromsgrove PCT
Richmond and Twickenham PCT
Rochdale PCT
Rotherham PCT
Rowley Regis and Tipton PCT
Royston, Buntingford and Bishop's Stortford PCT
Rugby PCT
Rushcliffe PCT
Salford PCT
Scarborough, Whitby and Ryedale PCT
Sedgefield PCT
Selby and York PCT
Sheffield South West PCT
Sheffield West PCT
Shepway PCT
Shropshire County PCT
Slough PCT
Solihull PCT
Somerset Coast PCT
South and East Dorset PCT
South Birmingham PCT

South Cambridgeshire PCT

South East Hertfordshire PCT

South East Oxfordshire PCT⁵**South East Sheffield PCT**

South Gloucestershire PCT

South Hams and West Devon PCT

South Huddersfield PCT

South Leeds PCT

South Leicestershire PCT

South Liverpool PCT

South Manchester PCT

South Peterborough PCT³**South Sefton PCT**

South Somerset PCT

South Stoke PCT

South Tyneside PCT**South Warwickshire PCT****South West Dorset PCT**

South West Kent PCT

South West Oxfordshire PCT⁵**South Western Staffordshire PCT****South Wiltshire PCT**

South Worcestershire PCT

Southampton City PCT

Southend on Sea PCT

Southern Norfolk PCT

Southport and Formby PCT**Southwark PCT****St Albans and Harpenden PCT**

St Helens PCT

Staffordshire Moorlands PCT

Stockport PCT

Suffolk Coastal PCT

Suffolk West PCT

Sunderland Teaching PCT

Surrey Heath and Woking PCT

Sussex Downs and Weald PCT**Sutton and Merton PCT**

Swale PCT

Swindon PCT**Tameside and Glossop PCT**

Taunton Deane PCT

Teignbridge PCT

Telford and Wrekin PCT**Tendring PCT**⁶**Thurrock PCT****Torbay PCT**

Tower Hamlets PCT

Trafford North PCT

Trafford South PCT

Uttlesford PCT**Vale of Aylesbury PCT**

Wakefield West PCT

Walsall Teaching PCT

Waltham Forest PCT

Wandsworth PCT

Warrington PCT

Watford and Three Rivers PCT

Waveney PCT

Wednesbury and West Bromwich PCT

Welwyn Hatfield PCT

West Cumbria PCT¹

West Gloucestershire PCT

West Hull PCT

West Lancashire PCT

West Lincolnshire PCT

West Norfolk PCT

West of Cornwall PCT

West Wiltshire PCT

Western Sussex PCT

Westminster PCT

Windsor, Ascot and Maidenhead PCT

Witham, Braintree and Halstead Care Trust

Wokingham PCT

Wolverhampton City PCT

Wycombe PCT

Wyre Forest PCT

Wyre PCT

Yorkshire Wolds and Coast PCT²**Notes: Joint returns**

1 Carlisle & District PCT; West Cumbria PCT; Eden Valley PCT

2 East Yorkshire PCT; Yorkshire Wolds & Coastal PCT

3 North Peterborough PCT; South Peterborough PCT

4 North Lincolnshire PCT; North East Lincolnshire PCT

5 South East Oxfordshire PCT; South West Oxfordshire PCT

6 Tendring PCT; Colchester PCT

Annex 2 Audit topics

Coronary heart disease (CHD) (50)
CHD (12)
CHD (under discussion)
Cardiac rehabilitation (2)
CHD – focusing on equity of distribution in Norfolk of tertiary care; revascularisations for patients with CHD
Uptake of aspirin in CHD patients
Equity provision for cardiac revascularisation services
CHD carried out
CHD – access to treatment
Likely topics include CHD
CHD highly likely but also support for wider multi-dimension of approach
CHD revascularisation
At an SHA – access to CHD
Major themes are being discussed – CHD is likely
Probably CHD
Contributed to Shropshire & Staffs Cardiac Network CHD Audit
Access to lipid-lowering drug therapies
Likely CHD
CHD HEA – agreed and to start in May 2004
Statins to be agreed by board
CHD treatments
Some aspect affecting CHD
Heart failure (probably across the sector)
We are also addressing CHD on a PH network basis for Staffs & Shropshire
Access to coronary artery bypass grafting and percutaneous transluminal coronary angioplasty
Cardiac revascularisation services
CHD services
CHD (access to primary care); prevalence of CHD within PCT; treatment modalities by ward; management of CHD in primary, secondary and tertiary care; distribution of risk factors for heart disease; unequal management of risk factors
Work is well under way on an HEA of the patient journey in CHD
Revascularisation – does need equal supply between residents living in most deprived and least deprived wards?
CHD mortality (2)
CHD (equitable distribution of preventive measures and response to need)

CHD, particularly focusing on obesity and CHD risk factors
CHD bypass procedures
CHD – access to primary and secondary care
Myocardial infarction
CHD quality marker, eg prescribing
Smoking cessation rates (25)
Smoking cessation services
Use of smoking cessation services
Likely to be smoking cessation – using HEA to assess where greatest prevalence of smokers are using in line with socio-economic data, undertaking baseline assessment of service provision at both specialist service and primary care level, and using this information to plan and commission future smoking cessation service provision
Smoking cessation referrals – relationship between smoking and socio-economic groups and deprivation has been well documented
If our system was equitable we would expect to have more referrals from areas within borough with the highest levels of deprivation
Access to smoking cessation services for young people
Smoking cessation (6)
Smoking cessation service is the first priority area to be audited
Smoking cessation specialist service
Smoking cessation services
HEA of smoking cessation
At a PCT level – smoking cessation services
Smoking cessation
Smoking – different impact of quitters by social class
Smoking
Smoking cessation (at Lambeth PCT level)
HEA of smoking in pregnancy
Smoking cessation at six or 12 months by each of our 12 practices
Smoking cessation utilisation and deprivation
Delivery of smoking cessation services, advancing from practice-based to community-based
Access issues (22)
Access and quality in general practice
Access to primary care, breast and cancer screening, selected selective surgery procedures (eg hip replacement, cataract, revascularisation by people with learning difficulties) (joint HEA with LA)
The fall in uptake of cervical screening in Great Yarmouth PCT
Access to services with respect to inequalities in health
Access to local health services – aims to understand how people from black and minority ethnic communities are using our local primary/secondary care services
Access to primary care (3)
Deployment of primary care
Equity review of access to primary care sites as part of PCTs' estates strategies
Likely hospital utilisation
Cervical screening update (4)
Breast screening uptake (3)
Retinopathy screening (at LSL level)
Equity of core primary care services

Access to services with respect to inequalities in health
Access to oral health services
Health visiting and children's services (19)
Health visiting (uptake/engagement)
Health visiting services for children <5 across PCT area
A review of health visiting services
The approach is embedded in the PCT's commissioning/planning process. One example would be the 'allocation of health visitor resource'
Children's services (2)
School nursing service
Health visiting/child health services
Health visiting service
Health visitor services for children in need
Some aspects affecting children; these may be related to: school nurse provision, dietician advice and availability, incontinence services
Children's services – possible priority
School nursing time allocation in relation to need measured by educational attainment/free school meals
School nurses and health visitor caseloads in relation to local deprivation scores
Oral health in <14 year olds
Access to child oral health
Health visiting
Reallocation of provision – community nurses across children centre/Sure Start boundaries
Improving life chances for children and young people
Area-based (12)
Identification of an area of deprivation (part of Dacorum Health Plan 2003–06). Identification of key stakeholders and discussion under way to understand details of 'inequity' and possible solutions identified
Neighbourhood management – equity of health and service provision in one part of the borough to inform development of a neighbourhood management pilot
Geographical inequalities in health practice profiles
Ward-based comparisons
Health status profiles
Profile of relative deprivation using DETR index of multiple deprivation (IMD)
Health inequalities in two most deprived wards plus pockets of deprivation
Practice-based profile linking activity and deprivation data
Central PCT geographically based public health profiles have been produced and circulated to key managers and nursing staff
IMD – local community developments – four broad areas – yet to be fully agreed by PCT and partners
Interactive mapping of inequalities in North Tyneside
Diabetes (15)
Inequity of access for people with diabetes (more)
Diabetes (7)
Some aspect affecting diabetes
Diabetes management in primary care – application of diabetes prevalence models to give estimates for diagnoses and undiagnosed prevalence at practice level. Use of quality and outcome framework/diabetes register data to identify variation in management in primary care
Access to diabetes care

Diabetes – topic identified for future HEA
Access to diabetes care
Diabetes care in relation to nursing homes
Access to diabetes services in residential care settings
Maternity and infant health (10)
Infant health
HEA of breastfeeding prevalence
Low birth weight rates
Access to antenatal care
Breastfeeding
Maternity services – possible priority
Family planning and contraceptive services
Oral health in <5 year olds
Access to antenatal care
Perinatal mortality services review
Sexual health (10)
Sexual health (5)
Sexual health – topic identified for future HEA
Access to sexual health services
HIV
Do sexual health services meet the needs of those whose needs are greatest?
Sexual health services
Cancer (10)
Lung cancer and equity audit (2)
Possibly cancer (2)
Cancer (4)
Cancer care access
Cancer, eg lung cancer admissions
Older people (8)
Older people (2)
Older age access to services
Post-discharge district nursing services for older people
Older people (chronic disease management) possible priority
Hip fractures
Stroke in older people
Older/vulnerable people
Mental health (5)
Mental health HEA commissioned
Mental health
Mental health in older people
Mental health services – possible priority
Deliberate self-harm
Teenage pregnancy (7)
Have looked at teenage pregnancy and prison health in terms of profiling inequalities, and looking at subsequent commissioning effects
List of priorities has been identified – still under discussion but likely to include teenage pregnancy

Teenage pregnancy – progress and geographic issues
Teenage pregnancy – possible priority
Teenage pregnancy (3)
Surgical procedures (4)
Cataract surgery
Joint replacements
Hip replacements
Hip and knee operations
Learning difficulties (5)
Learning difficulties
2004/05 we intend to use HEA to focus on the health needs of people with learning disabilities
Potentially HEAs on learning disabilities and disabilities
Do services meet the needs of people with learning difficulties?
Learning disability equity profile
Black and minority ethnic groups (9)
Assessment of need/provision for black and minority ethnic residents. Three main action items identified – ethnic monitoring; workforce composition; cultural competency
Access to breast cancer screening by women from black and minority ethnic groups
Patient profiling being rolled out to all 62 GP practices within PCT. This identifies the ethnic/cultural and broad health status of patients
The data are currently being used to conduct an HEA in two pilot practices, with a view to rolling out to nine further practices in 2004
Uptake of smoking cessation services by ethnic group
Access to rapid-access chest pain clinics by ethnic group
Uptake of other directly provided services by ethnic group (in collaboration with race equality steering group)
Access to diabetes services (diabetes centre, dietetics podiatry for South Asian communities)
Need for improved data on ethnicity
Do services meet the needs of ethnic minority groups?
Contraceptive services (2)
Contraceptive services
Access to contraceptive services
Accidents and falls (5)
Accident prevention
Falls
Childhood accidents (2)
Childhood accident prevention equity audit
Stroke (2)
Stroke
An HEA for stroke to link in with wider piece of work on changing models for delivery of healthcare services across the local health economy
Prescribing and deprivation (2)
Prescribing and deprivation
Fair shares prescribing budgets
Life expectancy (1)
Infant mortality (1)

Prison health (1)
Have looked at teenage pregnancy and prison health in terms of profiling inequalities, and looking at subsequent commissioning effects
Fuel poverty (1)
Fuel poverty to be agreed by board
Environmental health (1)
City-wide environmental health
Undecided (5)
Other (45)
Need to improve use of health information within the commissioning process
See attached inequalities action plan [<i>not attached</i>]
Variety of topics – some as part of mainstream Public Health Annual Report work, eg mortality issues, others including health action zone work to target inequalities spend, work on diabetes, etc
Undecided – will identify 10–12 topics. Consultation under way
The 2002/03 Annual Public Health Report included chapters on smoking, refugees and asylum seekers, teenage pregnancy, and a review of think-tank projects which were instigated from 1994 onwards
One other primary care-based or a secondary care-focused audit
A number of audits are planned around aspects of the following priorities: reduced mortality from avoidable deaths; premature mortality from CHD in <75s; reduced premature mortality from cancer in <75s; reduced teenage conceptions; reduced mortality from accidents; reduced admissions to hospital for serious accidents; reduced excess winter deaths
Reprovision of services across Fareham & Gosport in response to closure of MOD hospital site in 2007 – includes outpatients across a wide range of specialities, diagnostics, therapy services, day surgery, minor injuries unit, services for older people
Allocation of community staff
Have assessed process. Awaiting publication of director of public health (DPH) annual report to identify specific topics – developing profiles for CHD, cancers, diabetes, children, older people and falls
Major borough-based equity reports pending – previous data showed appropriate relationship at ward level between CHD standardised mortality ratio and revascularisation rate
Other possibilities: child dental health, smoking cessation – but no prevalence data; breastfeeding
Flu vaccination rates: overall PCT met 70% target but local concern that this includes significant variation between practices – particularly an issue affecting practices with high black and minority ethnic registered population
A health improvement and inequalities strategy ... overall analysis of inequalities within PCT area
Selected primary care services
A more general focus on health inequalities and performance versus targets has been produced
We are now considering audits on breast screening uptake, immunisation (MMR) uptake and critical incident reporting
Improved mapping of partnership to ensure all partners are involved
Outpatient referrals by deprivation and geographical area
We are also looking at how HEA can be built into developments around the new General Medical Services contract and with multi-agency work
Repeat healthy lifestyle survey
Opportunities for physical activity resources
Community nursing
Chronic obstructive pulmonary disease
Work on ensuring health promotion messages are delivered in many different ways to improve delivery
HEA as part of Community Plan, looking at rural access issues

Gender differences
Burden of disease as part of the Lambeth PCT business planning process
Chronic diseases (2)
Special groups (eg homeless)
Corporate caseload working
IMD scores
Possibly transport
Lifestyle issues (smoking, physical activity, obesity) (2)
Immunisation and vaccination
We haven't thought about it
Health improvement as a whole
Evaluation of work of the nurse-led clinic
Using the HEA framework to examine community nursing services
Need for improved data collection – have identified particular priorities of practice-level data
Have used the census, and mortality, morbidity, prescribing, revascularisation, crime, drugs, patient advice and liaison services
Do services meet the needs of people living in neighbourhood renewal areas?
Drug misuse
Exercise/physical exercise

Annex 3 Responses to question: 'How was the audit topic agreed?'

Agreement within PCT (*n* = 60)

- Agreed by PCT board and PEC which receive regular updates on equity audits
- By director of public health (DPH)
- Response and feedback to gaps in our current annual report; further information to support the new General Medical Services contract; enhanced services
- Priority for manager of PCT community services and PCT children's programme area
- By DPH
- Discussion with PLD service managers in health and social care; proposal from black and minority ethnic subgroup of inequalities partnership board following focus group work with women from black and minority ethnic groups
- See attached inequalities action plan – developed at away day of Health Improvement Directorate and later approved by the PCT board
- Agreed between DPH and myself (Specialist Registrar in Public Health)
- We are using topics that were already in play – generally were previously discussed with stakeholders and board
- By public health team
- Topic was chosen by the DPH as an illustration of the use of HEA; we are currently working on a process to agree future topics
- Via health plan process – multi-agency, presented at board level
- Proposals developed at Public Health Directorate Seminar
- DPH following prioritisation of geographical inequalities by the multi-agency Joint Commissioning Board for Health Inequalities
- Discussion within the public health directorate and between public health and clinical governance
- Key areas for PCT; access to information
- Discussion with managers, executive team, clinicians, partnership groups, PEC and other colleagues
- PH identified access problems; services need review and redesign
- The need to complete an equity profile in coronary heart disease was identified in the PCT's recent Commission for Health Improvement review. In any case this had been agreed by members of the cardiac strategy group and others as a priority. The final choice of topic for the Annual Public Health Report rests with the DPH
- Identified through PEC and Trust Board
- Discussion at the professional executive committee; organisation development event including board, PEC and senior managers; final agreement by board
- Following a joint workshop for the board and clinical executive on health inequalities, priorities for HEA were discussed with the clinical executive and then agreed by the board
- Board and partners workshop
- After the Annual Public Health Report was published, the DPH made recommendations to the board and they were accepted
- Board and PEC workshop using workshop group technique to identify and prioritise topics
- Meeting of board/PEC with input from PH and Health Informatics
- After discussion with PEC and board, but following recommendation by DPH
- Through board self-assessment
- PEC and PCT board
- At joint board/PEC meeting
- At PEC/board informal meeting and endorsed at formal meetings
- Board subgroup
- Via PEC/board, PEC subgroups
- Local strategic partnership theme group
- PCT subgroup
- Informed by findings of the initial strategic HEA
- Not yet agreed, but likely to be through the equality and

- diversity committee (a subcommittee of the board)
- DPH suggestions, agreed by board
- Smoking cessation (along with several other key areas of service delivery) was identified by the board, PEC and key PCT personnel during the self-assessment consultation (questionnaire and workshop event); secondly, the PCT board discussed, following consultation, the possible priorities for HEA and agreed that smoking cessation service would be taken forward
- Completed HEA – following a request from the race equality steering group in PCT; current HEA – agreed in liaison with coronary heart disease commissioning lead in PCT; planned HEA – agreed in liaison with race equality steering group
- By executive directors
- Improving life chances for children and young people gained neighbourhood renewal funding on an agreement that Interactive Mapping of Inequality in North Tyneside (iMINT) mapped the data for assessment of need; links to Health Plan; discussed at PEC/agreed at board; potential list compiled by PH consultant
- After the Annual Public Health Report was published, DPH made recommendations to board and they were accepted
- Agreed to look at these areas as key areas of concern highlighted by PEC
- Public health information analysts and commissioning team
- Process involved one discussion session with the board and two with the PEC ... it has been agreed that the joint Directorate of PH should put the topics in to a prioritised programme of HEA for 2004–06, taking into account a number of criteria (impact on morbidity and mortality, impact on health inequalities, amenability to potentially earlier improvement, availability of data and evidence, and resources to lead the HEA process)
- Agreed by the board and PEC
- PEC asked for service review with needs assessment and recommendations for changes and investment
- Agreed due to the current mapping work already under way in both areas. The HEA will be used to give a framework to the work and will help inform developments in both areas, eg outreach sessions from the diabetes centre will now be based in underserved areas
- PEC defined
- Discussion among senior managers
- Through the PH team. The topics were agreed as pilots to test the process before wider implementation in the organisation. Our PEC/board are also aware of and support this work
- Agreed by DPH and health development health

improvement group

- Priorities identified through consultation with PEC members
- At board/PEC seminar
- Following team discussion and inclusion in Annual Report
- Discuss at PEC and referred to board
- Discussion among PH team and with wider PCT team, partners
- With individual clinicians involved; with directors/executive meeting across health community

Agreement by PCT within a wider context (n = 19)

- Both agreed after discussion at local authority overview and scrutiny committee
- By PH team along with a colleague from the local authority, a local health visitor, a district nurse and a PH information analyst
- PH profiles are produced by health intelligence managers dedicated to provide information to support audit and service planning/commissioning. The health intelligence managers are employed within the Health Inequalities Resource Centre, which is a ring-fenced PCT resource supporting health improvement and health equity. Patient profiling is included in the local delivery plan from 2003–04, and is resourced to roll out to all practices in a phased programme. Further topics to be agreed through self-assessment
- Board self-assessment; agreement via PH network to work across PCTs on heart disease; do-ability given limited PH analyst capacity
- DPHs of the East Kent health economy
- A working group involving four local PCTs
- A multi-agency health inequalities group covering the borough of Sefton chose it
- An iterative process. Coronary heart disease – through discussion between DPHs across 10 PCTs. Health profiles – headlines to the board, practical action through LSP structures
- To date, topics identified through development of health profile, update of local health inequalities strategy, city council inequalities strategy, community strategy, public health directorate, local and city-wide (health improvement) planning groups (part of wider health and social care partnership within the city), and local community-based initiatives/developments and alliances
- Agreed by inequalities group (PCT, social services, voluntary sector, borough council, Healthy Living Centre), PEC and board

- These are PCT priorities. Also through discussions with the West Yorkshire SHA
- Request from non-executive, from SHA
- Agreement to focus on people with learning disabilities in 2004/05 was reached after discussions with the Health of Coventry Group (PEC/LSP) and the Learning Disabilities Commissioner
- Initial identification of topic areas during PEC/board self-assessment; involvement of PCT health improvement group in developing HEA programme. Used multi-agency working groups within the PCT to discuss priority options (eg older people's working group). Discussed identified priorities with SHA
- Formal consultation with PCT board and PEC; clinical audit forum (includes lay representation)
- Board/PEC seminar session; public health network discussion
- Discussion within PH network
- Pan-Birmingham PCTs' (four) DPHs; response to star ratings; public health team/commissioning directorate

Local health improvement priorities, service needs and epidemiology (*n* = 10)

- These are not formally agreed. They are the areas which reflect local health improvement priorities
- Teenage pregnancy/prison from health inequalities profile ... in first Annual Report; coronary heart disease/cancer from lead causes of death therefore potential impact – all covered in DPH Annual Report. Child health – being discussed
- Based on a wide range of prevalence data between practices from clinical audits. The entitlement for patients with similar conditions to access an equitable service of optimal quality. We have to adapt our plans in the light of the new General Medical Services contract
- Young people have growing smoking rates and our local service did not cater for this age group particularly
- Coronary heart disease equity because of death rates; discussion with colleagues re remaining topics
- Coronary heart disease a major cause of death within PCT population. PH epidemiology data showed inequalities in coronary heart disease prevalence within the population, therefore the PCT board agreed that further investment was appropriate. The NSF local implementation team agreed this and work was taken forward by PH
- Coronary heart disease and diabetes are lead services for the PCT – high morbidity and high mortality; children's

NSF implementation needs support, and both children's services and incontinence services are longer-term issues. We have a large population bulge of 50 year olds, so incontinence prevention needs addressing

- Represents a key strategic priority for PCT and local health economy
- Available resources and service need
- As a result of discussions at coronary heart disease LIT and public health meeting, and was in response to low levels of revascularisation in the district

National/regional priority (*n* = 8)

- National priority for PCT ratings
- Neighbourhood management HEA was requested by LSP lead officer (urged by Government Office London as a condition for developing neighbourhood management pilot); coronary heart disease HEA – to meet NSF standard; learning disabilities and disabilities – put forward by respective commissioning partnership boards
- Audit work does not cover one single topic ... the one most developed relates to ethnicity ... this topic emerged as one of the major reasons for inequalities both nationally and within the local authority area. The outbreak of riots in a neighbouring local authority and the lack of an established framework for action were important drivers in the choice of topic
- Related to an NSF; data available
- Recognised national health inequalities/public health priorities, also local priorities emerging from the qualitative multi-agency consultation process on health inequalities
- Poor performance against national targets identified area. Equity dimension prioritised through understanding of local population and wider research
- Chosen for the usual reason that it is a major killer and linked to inequalities
- There is an NSF. It has been recognised as a local priority and is an important public health issue

Public consultation (*n* = 3)

- Consultation under way
- Decided there was a need to have specific evidence and information from black and minority ethnic communities around how our services could become more accessible and sensitive to local need
- Professional consultation with senior and frontline staff followed by public consultation

Data availability and potential to make changes ($n = 1$)

- These topics were agreed as we have data sets that lend themselves to appropriate analysis; they are important inequalities indicators. They are also within our scope to make changes following the HEA if necessary

Other ($n = 6$)

- This is still a proposal to be agreed
- Bit unsure
- The art of the possible
- Still under discussion
- Yet to be finalised
- Ongoing activity

Blank

- Blank 11
- 'Not known' 1

Note: Responses assigned to one category only.

Annex 4 Other comments from PCTs

- Here we have undertaken a population health survey that was planned to coincide with the census (plan to repeat every five years).
- More age-standardised census questions would be useful.
- I think the issue of how each PCT is tackling HEA needs to be looked at. Are we using similar approaches, eg using a 'mainstream' approach to HEA, or is the tendency to focus on one or two key areas, or a combination?
- We have taken a 'bottom-up' rather than 'top-down' approach, carrying out an HEA of a specific service in response to local service issues.
- Would like more data by ethnic category.
- We plan HEAs at a high level – see attached health inequalities action plan. Some of the data you offer we already have. Other bits we'd like to have.
- Although done quite a lot of inequality work through two PH Annual Reports, so far the audit cycle has not been fully completed for any subject area.
- As a single-handed DPH with health promotion support but no public health team, this has been a question of choosing something obvious and straightforward to do. The task and timetable have had to change with the new General Medical Services contract and we are disappointed at the low target set, which serves only to reinforce our observed inequity. We are looking for new ways of encouraging an equitable service, not only for services provided by practices, but for those services we have commissioned on their behalf.
- Data profiling in preparation for HEA is complete. Selection of topics is part of our health inequalities strategy development.
- HEA has to become embedded in local practice and become an annual routine process.
- Information to perform HEA at PCT/practice level not always available; limited support to PCTs for HEA.
- Help with setting 'standards' – specific expertise on methodologies/techniques; expected population data to interpret; methodology especially important for GP practice population to use for comparison.
- It would be useful to have examples of PCTs that have made a difference to services and reduced inequalities as a result of an audit.
- Question 7 difficult to quantify and therefore answer.
- I very much miss the role our former region used to fulfil with the annual production of comprehensive data on mortality, birth weights, etc in ages <16, <65, <75. The information available from the Compendium is a mishmash of a variety of ages, and pulling together a consistent report on mortality other than for all ages is very difficult. A central push to improve the quality and comprehensiveness of ethnicity coding would assist better capacity to identify performance improvements.
- The PCT is building on/revisiting work previously undertaken or planned by primary care groups. New topics are being agreed by involving individuals within the PCT's devolved management structure. The PCT has created a dedicated resource for analysis, profile creation and information sharing to support health improvement and health equity.
- Lots of interest in this, but also a fair measure of confusion. Potentially a good topic for continuing professional development. Also big issues gaining access to PH analyst capacity.
- It has proved to be a very useful awareness-raising exercise in looking at inequalities within our PCT and away from our more deprived neighbouring PCTs within the same borough. The geographical focus is a stage we need to go through, looking at relative deprivation with an asset focus appropriate to the population.
- The star rating indicator focuses on building HEA into mainstream planning, which is why our initial priorities identified by the board focus on pieces of work that the PCT is directly involved in commissioning or delivering. We are fully committed and exploring the potential for

HEA in addressing the wider determinants of health, but have initially focused on more mainstream NHS activity. We have been actively using equity profiling to inform our public health work programme and other strategy work such as NSFs.

- The lung cancer audit is being carried out across two PCTs that share a common local authority, LSP and public health team. This enables partnership working in practice by involvement of non-NHS organisations, and a focus on determinants of health. The multi-agency team (question 6) includes PCT, cancer registry, local authority, and the community and voluntary sector.
- We currently have very limited capacity both in terms of epidemiology/information analysis and PH expertise to do this work.
- HEA process is ill-defined. Timescales for completing full audit cycle are likely to vary between subject areas, especially around implementation of actions.
- We are at a very early stage. Health equity will be the focus of the 2004/05 PH annual report. It is hoped it will be published by the end of the year.
- We have only just commenced HEA within the PCT.
- This survey is difficult to interpret in places, so comparison of responses may be difficult.
- There is an urgent need for advice or a national methodology to support priority setting for addressing health inequalities.
- What support is planned by the LHO around HEA?
- There is some confusion on this question regarding self-assessment and HEA *per se*. Question 3 only is answered with the HEA self-assessment held in March 2004. Other questions are in relation to coronary heart disease.
- We are fortunate to have a specialist registrar in public health to do this project, otherwise there would not be the capacity to do it at the current time. I expect that there will be more time available in 2005.
- We have completed the HEA self-assessment, but not yet determined a programme of HEA for the PCT.
- Ongoing support with data analysis, with PHO offering this as core function; it would be valuable if PHO could consider and give comments on the approach/methodology we have used to measure and assess levels of inequalities in health and inequity in service provision in Sunderland.
- Further embedding into PCT agenda, currently public health has been carrying out much of the work in isolation. Greater integration is required in further HEA work, from the top down; identify robust methods for implementation of equity audit findings.
- We are currently planning our corporate approach and programme of HEA.
- We see HEA as being a continuous process where we bite off different chunks, some internal PCT, some local LSP, some cross-SHA area – each has different skill and resource requirements. All are under-resourced at PCT and PH network level.
- It would be good to have some support for information management and technology staff around HEA; some local examples across the patch; what is the link to SHA and the mechanisms of support.
- Having filled in this questionnaire, I think it is a topic I need to revisit.
- I have reluctantly done this having gone through HEA/HEA self-assessment with three PCTs; these data should be pulled from SHA performance reviews.
- Lack of capacity and expertise to undertake HEA in many PCTs.
- HEA has the potential to be a full-time job. HEAs that I have seen vary from just presenting GP practice-level data on two or three topics, to full-scale pieces of work analysing great quantities of work. Both claim to be HEA. Some guidance would be useful. Data at a ward/sub-ward level is proving difficult to find, and these are the data we really need. All help welcome.
- Remember, HEA means many different things to different people.
- Would like the opportunity to share good practice. Appropriate comparative data are difficult to come by – the new census information seems difficult to interpret and to make any useful contribution. It would be helpful to have examples of the audit structure – the HDA documents are helpful but don't give information on the practicalities.
- Small PCTs are already struggling under an impossible workload and PH capacity is derisory. We only do what is unavoidable and I am totally submerged in work. HEA is an unaffordable luxury. Also some guidance on this is rubbish and still don't know what it actually means. HEA hadn't been invented when I was training in public health management. It is a trendy term, but not convinced that it is not just fashionable jargon. So far, not impressed.
- PCTs will be getting support from PH intelligence service, part of the County Durham & Tees Valley Public Health Network.
- PCT has spent time over past couple of months understanding HEAs and completing self-assessment. This has helped to raise the profile among the board and PEC members. However, capacity within the organisation is limited to carry out HEAs.
- Please note some cross-PCT work on this subject is under

way with the PH Intelligence Service.

- Perhaps the trickiest issue to resolve at first was how HEA and Health Impact Assessment fit together. We believe that we have resolved this, with the two techniques interlinking. However, there is scope for more joined-up thinking from the DH and other strategic bodies, as there seem to be different parties pushing work on these two different methods, without guidance on how they work together.
- This questionnaire was confusing to complete, as the questions do not relate well to the self-assessment process as we understood it.
- There is a need to get agreement at regional level on the adoption of a standard way of quantifying the magnitude of health inequalities for health outcomes and services. PHOs should be responsible for obtaining the data needed to generate standard measures of inequalities within PCTs, and for publishing them so that PCTs can compare their health inequality situation with others. This would be a valuable service to PCTs, especially those with limited analytical capacity for conducting equity analyses.
- At this stage of HEA development, those of us working within PCTs need to have good generalisable examples of how HEA has worked at PCT level to reduce inequalities.