

Reducing Health Inequalities

Gloucestershire County Council, Gloucestershire PCT

Audit 2008/09

Date **18 May 2009**

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Introduction

- 1 Tackling health inequalities and dealing with their impact absorbs huge amounts of public money in both local government and health sectors, as well as on central government. Securing optimum value for money from these combined resources requires effective joint working among public sector bodies.
- 2 Reducing health inequalities has been central to government policy since the NHS Plan (2000) set a national target to reduce inequalities in health outcomes by 10% by 2010 as measured by infant mortality and life expectancy. However health inequalities has only become a targeted priority within the NHS operating framework within the last three years. Health inequalities is a strategic priority within the World Class Commissioning Framework.
- 3 Local strategic partnerships (LSPs) and Local Area Agreements (LAAs) will be critical to the success of future efforts to improve health and tackle health inequalities. There is a specific duty for PCTs to work with local authorities to produce a joint strategic needs assessment (JSNA).
- 4 Through Comprehensive Area Assessment (CAA), the Audit Commission, Care Quality Commission and other regulators will be working closely with councils, primary care trusts and other public bodies from April 2009 to assess progress on improving the quality of life for local people. CAA assesses how well local quality of life is being improved, how well improvements reflect local needs and priorities, and what the prospects for the future are. This review of health inequalities in Gloucestershire will help inspectorates understand what is happening locally and will be part of the shared evidence file for CAA. This evidence file will also be used to inform local organisational assessments in autumn 2009. Findings will also be used to inform our use of resources assessment and value for money conclusion at NHS Gloucestershire and Gloucestershire County Council.



Background

- 5 Gloucestershire residents are generally healthier than those in many other parts of the country. Within the county, however, there are areas and communities which experience deprivation and significant health inequalities. For instance, in the most deprived communities the rate of prevalence of coronary heart disease is twice that of rates in the least deprived; young children and infants are twice as likely to be admitted to hospital in an emergency.
- 6 Partner organisations in Gloucestershire have made a strong commitment to reducing health inequalities. The Gloucestershire Health and Community Wellbeing Partnership (GHCWP) sets out in the Gloucestershire Health and Community Wellbeing Strategy 2008 that its aim is:

“To improve the overall health and wellbeing of people living in Gloucestershire and to narrow the gap in health outcomes between communities and groups living in our disadvantaged and more affluent areas”
- 7 Partnership working in Gloucestershire is coordinated within the overall framework of the Gloucestershire Conference which includes the Gloucestershire Strategic Partnership (GSP), the Accountable Bodies Group and Community Strategy Executive Board. Through the Gloucestershire Conference there is a framework for ensuring that the different bodies and partnerships are working together to deliver local priorities. District LSP representatives sit on the GSP and districts contribute to the thematic partnerships including the GHCWP.
- 8 The introduction to the Gloucestershire LAA 2008 states that its vision is based on "narrowing the gap". The two main priorities for improving health and wellbeing are:
 - **"reducing health inequalities by focusing on the main causes of premature mortality. Priority has been given to lifestyle factors that can reduce the risk of cancer and cardiovascular disease such as, reducing smoking, raising breastfeeding prevalence, increasing physical activity and encouraging sensible alcohol consumption. Activity is focussed in the 20% most deprived Super Output Areas as identified by the Index of Multiple Deprivation and Gloucestershire's most disadvantaged and vulnerable communities; and,**
 - **supporting independence, health and wellbeing for older and vulnerable people."**
- 9 Gloucestershire LAA indicators include:
 - NI 120 All age, all cause mortality rate
 - NI 53 Prevalence of breastfeeding at 6-8 weeks from birth
 - NI 39 Rate of hospital admissions per 100,000 for alcohol related harm

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- NI 8 Adult participation in sport and active recreation
- NI 57 Children & young people's participation in high-quality PE & sport
- NI 51 Effectiveness of child and adolescent mental health services
- NI 54 Services for disabled children
- NI 58 Emotional and behavioural health of children in care

10 The ten priority areas for action set out below have been identified by the Gloucestershire Health and Community Wellbeing Partnership for the next ten years in the Gloucestershire Health and Community Wellbeing Strategy. Reducing health inequalities is seen as a cross cutting theme that underpins the work of the partnership in each area.

- Active and healthy ageing
- Reduce obesity
- Reduce alcohol harm
- Reduce smoking prevalence
- Improved sexual health
- Better access to services for all
- Healthier workplaces
- Improved emotional health and wellbeing
- Putting people first – transforming social care
- Accessible, healthy and safe housing

11 The Gloucestershire Health and Community Wellbeing Strategy was developed through consultation with a wide range of stakeholders including Local Health & Wellbeing Partnerships; District Councils; Local Patient and Public Involvement (PPI) / Local Involvement Networks (LINKs) interim forums; and partners in the Gloucestershire Conference to ensure that it reflected the health and wellbeing needs of Gloucestershire residents.

12 The South West Strategic Health Authority (SWSHA) has set out targets for reducing health inequalities in the Strategic Framework for Improving Health in the South West 2008/11 which are more ambitious than the national targets for the same time period. These reflect the overall better health of the South West, but, as the SWSHA framework acknowledges, within a generally healthy region there are areas of deprivation. This is the case in Gloucestershire, and achieving these targets will be challenging.

Purpose of work

- 13 This review is a high level assessment of current arrangements and their capacity to reduce health inequalities in Gloucestershire. We focused on joint working between local partners to:
- assess the strategic approach taken in Gloucestershire to tackle health inequalities;
 - assess whether resources are being effectively used to reduce health inequalities and narrow the gap; and,
 - identify areas for improvement.
- 14 We used the following high level questions to inform the work:
- *Do strategies to address health inequalities exist and are they effective?*
 - *Do partnerships charged with addressing health inequalities function effectively?*
 - *Does the available data and intelligence support organisational and shared strategic and operational decision making to address health inequalities?*
 - *Do performance management systems support the monitoring and evaluation of activities necessary to address health inequalities?*
 - *Are joint workforce planning arrangements adequate to address the skills, competencies and capacity needed to address health inequalities?*
 - *Are corporate responsibility and sustainability principles adequately reflected throughout organisational strategies?*

Audit approach

- 15 We have carried the review out through:
- interviews with staff from the PCT and County Council, non executive directors and councillors;
 - a half day discussion group held with members of the Gloucestershire Health and Community Wellbeing Partnership and colleagues; and,
 - document review.

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Main conclusions - summary

- 16 The Gloucestershire Health and Community Wellbeing Partnership (GHCWP) has established a sound basis for partnership working to reduce health inequalities. This should enable the Partnership to make good progress in future. Health outcomes for Gloucestershire are improving. Life expectancy is increasing; rates of infant mortality are reducing; teenage pregnancy rates have reduced significantly.
- 17 However the GHCWP has not yet fully developed its role in directing, coordinating and managing work and resources across the county to maximise the impact of local activities. This is partly an effect of working within the complexities of a two tier system. Its underdeveloped role limits its ability to achieve significant reductions in health inequalities.

What works well

- 18 County wide work on reducing health inequalities is strongly supported by a clear and well targeted Gloucestershire Health and Community Wellbeing Strategy. The strategy is based on good intelligence, including the views of local people. The PCT, County Council, districts and the two provider trusts have a strong commitment to reducing health inequalities.
- 19 Partnership working is generally strong. The GHCWP includes all seven councils, NHS Gloucestershire, the Gloucester Hospitals Trust and the 2gether Trust. The voluntary and community sector is also well represented. All sectors are working well together.
- 20 The GHCWP and its Strategy is clearly based within the Gloucestershire Strategic Partnership (GSP), the LAA and wider Gloucestershire Conference. There are good links between the Health and Wellbeing Partnership and the other thematic partnerships so that work in each supports achievement of local targets across all themes. There are also strategic links made between themes through the Community Strategy Executive Board (CSEB).
- 21 Information on health inequalities is well presented and designed to be used in delivering improvements in health at county and district level. The Action Cards for each of the Gloucestershire ten priorities for improving health provide a clear and accessible approach to setting out plans, measures and progress. The DPH annual report is equally clear and accessible, and includes district profiles.

What needs to be developed

- 22 The strategic leadership role of the GHCWP is not fully developed. The GHCWP provides strategic direction but has not yet moved to the stage of providing oversight for work related to health inequalities in the county. It plans to do this through the Gloucestershire Conference and the planned performance framework for the Gloucestershire Health and Wellbeing Strategy.

- 23 The performance management framework for the Gloucestershire Health and Community Wellbeing Strategy is not yet complete. Some health inequality priority areas do not have clear targets. Links between the county strategy and district strategies do not in all cases provide a clear delivery chain. There is no systematic reporting of progress to the GHCWP. The Health Overview and Scrutiny Committee reviews some health inequalities issues and the annual report of the Director of Public Health, but does not routinely review the impact of the GHCWP.
- 24 There is no joint workforce planning strategy to develop the public health capacity within the county. The partners have taken opportunities to train frontline staff in early interventions and advice. However these good examples are not identified and implemented consistently across the wider workforce. Without a strategic approach, partners are missing the opportunity to use staff from all sectors to contribute to reducing health inequalities in the county.
- 25 No organisation was able to demonstrate clearly that they have an agreed corporate responsibility approach to health inequalities within local social and economic developments. Some organisations had some policies in place but they did not assess outcomes in relation to health inequalities. This means organisations are not taking full advantage of opportunities to address health inequalities as local employers, service commissioners and providers.

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Recommendations

Recommendation	
R1	Complete the review of the strategic leadership role of the GHCWP to <ul style="list-style-type: none">• Clarify its leadership and accountability for the work of different organisations in the partnership including district health and wellbeing strategies.
R2	Complete the review of the performance management framework for health and community well being strategy to <ul style="list-style-type: none">• Agree clear measures and targets for the ten priority areas• Agree a process and schedule for reporting progress on the work of the partnership in contributing to reducing health inequalities• Review the role of the HOSC in reviewing the overall contribution of the GHCWP to reducing health inequalities in Gloucestershire and its impact.
R3	Develop a joint workforce planning strategy across the county to increase skills in public health competencies for those staff who are able to use them to reduce health inequalities.
R4	Review organisational corporate responsibility strategies for reducing health inequalities as employers and within local social and economic developments.



Detailed report

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

- 26 The Gloucestershire Health and Community Wellbeing Strategy (GHCWS) sets out a clear and strong approach to reducing health inequality as an integral part of improving health and wellbeing in the county. It is based on a good understanding of health needs, and of the importance of partnership working and the wider determinants of health to deliver its aims. The Strategy commits partners to targeting areas and groups with poor health outcomes to close the gap with more affluent areas.
- 27 Leadership for the GHCWS is clearly located in the Gloucestershire Health and Community Wellbeing Partnership (GHCWP). This represents all the local statutory bodies, including the district councils, as well as community and voluntary organisations. The PCT and County Council rotate the chair between them which provides a strong message of joint ownership and commitment. The vice chair is from the voluntary sector which again sends a clear message about the importance of the voluntary sector as partners. A joint Director of Public Health provides county leadership for reducing health inequalities and supports coordination between the plans and actions of the County Council, the PCT and districts. The framework for leadership is clear.
- 28 Both the PCT and the County Council have demonstrated their commitment to reducing health inequalities through the Local Area Agreement (LAA), which includes a number of indicators related to health inequalities. This commitment is supported by PCT and County Council operational plan objectives and policies. However, these links are not apparent in all the district sustainable community strategies. The GHCWP does not as yet appear to be driving fully the strategy across the different member organisations. Achieving the full engagement of all partners would enable the Partnership to have a stronger strategic leadership and accountability role. The Partnership plans to review its remit and terms of reference in 2009 /10 in order to strengthen its leadership and management of the Gloucestershire Health and Wellbeing Strategy.

Do partnerships charged with addressing health inequalities function effectively?

- 29 The Gloucestershire Health and Community Wellbeing Partnership has clear links and relationships with the other thematic partnerships, sectoral partnerships and district LSPs. There are good links with the six health and wellbeing partnerships, community safety partnerships, as well as the community and voluntary sector. The GHCWP has mapped the different thematic partnerships in the Gloucestershire Conference to ensure that it has effective links with each. This is managed through the structure of

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the Gloucestershire Conference, which provides the overall framework for partnership working in Gloucestershire. There is sufficient overlap of membership with other partnerships such as the children and young people strategic partnership, and the economy and environment partnership, to make sure that they work together to achieve LAA priority targets. The GHCWP members who are members of other partnerships influence these to address health inequalities (for instance the DPH is a member of the Children and Young People Partnership). Their influence is also beginning to have an impact on the Community Strategy Executive Board. The GHCWS clearly refers to the wider range of LAA indicators to which it will contribute including those not within the health and wellbeing block.

- 30 Partnerships with Gloucestershire Hospitals and the 2gether NHS Foundation Trusts are well developed. Both trusts are strongly engaged with the health inequality agenda. The Gloucestershire Hospitals Trust representative sponsors the work on reducing smoking. The 2gether Trust sponsors the work to improve emotional health and wellbeing, which is addressed as a social inclusion issue closely connected to inequalities.
- 31 Partnership between the PCT and the County Council is strong at a senior level, but below this level of staff it is weaker. Council and PCT staff do not fully understand each others' roles and that of each others' organisations, nor the contribution that each makes to reducing health inequalities. There are inevitable cultural differences between local government and health, which can sometimes be obstacles to working well together. Some staff do not understand the different processes each organisation uses; the council cabinet system can in particular seem slow to NHS staff. Where the organisations appear to be moving at different paces misunderstanding and frustration can develop. Without good mutual understanding it will be difficult for the County Council and PCT to maximise joint use of their resources.
- 32 Partnerships between the statutory and the community and voluntary sector (CVS) are strong. As well as having a structured engagement through the Gloucestershire Conference and through membership of the GHCWP, voluntary sector representatives and organisations are sponsors or champions of some of the ten GHCWS priority areas. PCT Board members have personal links to the voluntary sector, and a good understanding of it. The strength of partnership working was spoken highly of by focus group participants. Strong partnership working is seen as the base on which much of the health inequalities work is built. Longstanding inter-organisational relationships, with a good level of trust, and local knowledge enable "two plus two to equal five"¹ in Gloucestershire.
- 33 There are effective partnerships between the PCT and the districts. The districts are seen to be very important in delivering the health and well being strategy. A PCT public health manager works with each district. Each PCT Non Executive Director is linked to a particular district area, in which they take a special interest. The PCT also jointly funds health improvement facilitator posts with each district, most of whom have bases in both the local authority and the PCT. These posts help strengthen PCT engagement with the districts through closer involvement with local issues. However, district health and wellbeing plans are still not fully integrated with the Gloucestershire HWB Strategy, reflecting the complexity of working within a two tier system.

¹ Comment made by a voluntary sector representative in the discussion group.

- 34 There is wide engagement through the LSPs with users and local residents. The GHCWS was developed in consultation with the community and voluntary sector. "Village agents" are employed to work with local communities and act as support agents and advocates. The GCHWB draws on their intelligence on local community and individual views for feedback. There are now also "community agents", who work with specific communities such as black and ethnic minority communities. Health trainers are being introduced in 2009/10. There is active representation of the older people's network and carers' group and other community groups on the GHCWP board. The Children and Young People's Strategic Partnership (CYPSP) also has effective engagement with children and young people.
- 35 The focus group participants however noted the need to take this engagement work further to address health inequalities more effectively. Those deprived groups and communities to whom most work is targeted will not necessarily be part of a formal engagement and consultation process; the words used to describe health inequalities are unlikely to be heard and understood by groups who are disadvantaged or marginalised. Examples were given of community development work which had successfully engaged a wider range of people. A variety of different ways of getting messages across to different communities were cited by the focus group as being more effective than traditional approaches. It was seen as very important to increase the accessibility of the GHCW Strategy and to disseminate it more widely. The PCT is currently commissioning a social marketing firm to test out new ways of reaching different groups with health improvement messages. There is therefore good evidence that the partners are taking steps to ensure wider engagement. It will be important to evaluate the impact of this work.

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

- 36 There is extensive data and intelligence available in Gloucestershire to support partnership work on reducing health inequalities. The data is shared through MAIDeN, a local database, which enables all partners to access information and analyse it to meet their needs. MAIDeN has been used to support the JSNA, and informs the children and young people's plan as well as the health and community wellbeing strategy. Detailed needs assessments have been undertaken by the PCT in partnership with the County Council and the GHCWP to inform priority areas to address. The annual Director of Public Health report clearly identifies county public health priorities. Some external partners however note that MAIDeN can be difficult to access.
- 37 The County Council and the PCT are now bringing together their work on intelligence and research into closer joint working arrangements. There is a joint post, which leads on the Joint Strategic Needs Assessment (JSNA). A joint strategic intelligence board, chaired by the joint Director of Public Health, has been set up which supports the LAA

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and the thematic partnerships. This provides a base for more effective future joint use of intelligence.

- 38 The JSNA provides a sound basis for the partnership's work, but is still developing. It is now being developed into an eJSNA. Partners oversee the development of the eJSNA through a county wide group chaired by the DPH. That the eJSNA needs to develop further is understood; for instance a new workstream has been set up to look at how to include information on patients' and users' views.
- 39 The County Council and PCT have very good information on children and young people's health and wellbeing from the Gloucestershire On Line Pupil survey (OPS) which it runs biennially. This obtains a high response rate and provides a wealth of information about school students' lifestyles, wellbeing and health. The data are used to help target health improvement work within schools and localities. Public health needs assessments for children and young people have been carried out. The Children's and Young People's Partnership have used this data to help the Children and Young People's Plan to target priorities to close the inequalities gap.
- 40 There is evidence that health inequality data are used to inform commissioning, and have contributed to improved outcomes. Two examples are the reduction in teenage conception rate in Gloucestershire, which was achieved through concerted action based on local information, and commissioning services for people with learning disability. Health Equity Audits have been carried out on cancer and on heart disease.
- 41 There are some gaps in the data. Some of these are where Government has not yet set baselines for data. Other gaps are where local data e.g. on breastfeeding prevalence, are not available through standard data collection. The PCT has established a new system to collect this data on a routine basis on breastfeeding as it has been identified by partners as a high priority. County analysis of children and young people's health needs identified information gaps and gaps in some services e.g. their need for mental health services. The public health team are aware of these gaps and plan to address them.
- 42 The partners also use feedback from local communities to inform the GHCWS. Feedback includes the input of village and community agents, as well as the contributions from the voluntary sector to consultations. The councils have been able to use their existing surveys and citizens' panel tools to inform their work. The PCT is aware of the need to improve its models for community engagement and is currently auditing its engagement with users and carers to assess its effectiveness.
- 43 There is well presented information on health inequalities which can be used at county, district, and in some cases, ward level to inform activity to improve health. The annual DPH report and the district profiles provide accessible and well focussed information which related to the wider county priorities. The Action Cards for each priority area also present information in a clear and accessible way which sets out the issues, planned actions and measures of success. Each card is written in plain English and will be made available in different languages and formats (e.g. video clips) so that they are accessible to every one in Gloucestershire.

Do performance management systems support the monitoring and evaluation of activities necessary to address health inequalities?

- 44 Delivery of the strategy is in its early days, and progress has not yet been clearly demonstrated. The strategy is delivered through action on the ten priority areas, e.g. on access to services, alcohol, housing, emotional health and wellbeing, each of which is sponsored by a GHCWP member, and championed by a lead officer. There are "action cards" for each of these, which set out the aims of the work plans, outcome measures and links to the LAA. These are a potentially strong tool, but are widely acknowledged by GHCWP members to need more development. Some have less well developed performance measures than others. To date there has been no systematic report of the action cards to the GHCWP, although there has been reporting on the LAA targets to the Gloucestershire LSP. There has been little consistent evaluation of health inequalities projects. The GCHWP has recognised the need to improve performance management and is reviewing the current arrangements. A more rigorous performance framework will be needed to ensure the strategy's progress is being monitored and demonstrate that the GHCWP is driving it forward.
- 45 The Gloucestershire Conference structure ensures that health inequalities are increasingly addressed and challenged across different partnerships. This provides a strategic level of challenge and scrutiny
- 46 The contribution of different organisations to delivering the priorities is variable. While the districts make an important contribution to reducing health inequalities through their work in leisure, housing, community support and through specific projects, it is not always clear how these support county wide priorities. Districts also have different levels of resources to support the health and wellbeing agenda which affects their abilities to contribute equally. Although at least one district has a very well structured health and wellbeing plan which links local to county wide objectives, showing a clear delivery chain, others do not have such a link between local and county priorities. There is scope for the GHCWP to build work with districts to ensure that all organisations are clear on their role and responsibility for delivery. The GCHWP has already begun this work through collating information on each district's priorities which will be assessed against the GCHWS priorities to identify links and gaps.
- 47 The Health Overview and Scrutiny Committee (HOSC) is effective in requesting info and challenging health issues. Information is regularly provided to non executive directors and members. In the last year the HOSC has reviewed county wide performance on smoking cessation, access to sexual health services and NHS service targets. There has been a report to the HOSC on equitable access to primary care and on variations in life expectancy by area. The HOSC has also joined forces with other local councils to create a Joint Great Western Ambulance Service Overview and Scrutiny Committee to monitor ambulance services on behalf of local residents following the merger of Avon, Gloucestershire, and Wiltshire ambulance services. This was in response to the concern of local residents that their service was adversely affected by the merger and is linked to the wider issue of access in rural areas. The

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HOSC reviews the Director of Public Health report annually. However the HOSC agenda does not review the impact of the GHCWP on reducing health inequalities regularly.

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

- 48 There are examples of good practice in joining up the workforce such as the joint children and young people's health and wellbeing team. This has been recently appointed to and is managed and funded by the PCT and County Council. It brings together a cross disciplinary group of staff to support the healthy schools and healthy schools plus programmes.
- 49 It is not clear that there is a joint approach to managing and developing the capacity of staff employed by the GHCWB partnership to address health inequalities. There is specific training available for some staff e.g. health visitors to enable them to deliver the health and wellbeing agenda better. This includes equality and diversity training, training in public health for health visitors and community nurses. There are some joint workforce development events, but these are not systematic. There are good examples of training frontline staff such as home care assistants to provide warm and well advice, police community support officers signpost people to stop smoking services, as do health care assistants in the hospitals, but these also are not systematically identified and introduced. Housing staff inform local residents about how they can improve the energy efficiency of their homes as part of the Warm and Well programme. There appears, however, to be no consistent approach to ensure a wide range of appropriate staff have the skills to deliver health promotion or understand how their work could reduce health inequalities. For instance, social care staff could be trained in early interventions for smoking cessation; housing staff on falls prevention. Without consistent provision of public health training in the wider workforce partners are missing the opportunity to use staff to contribute to reducing health inequalities in the county.
- 50 Most councillors now have a much clearer understanding of the health inequalities agenda, and of its importance. Links are made to other areas of council work. However, there still are some councillors who are sceptical of the need to reduce health inequalities and do not consistently see it as a priority, particularly at district level.
- 51 Non-executive directors on the PCT Board are well informed about health inequalities. A high proportion of non executive directors have a background of working in relevant fields e.g. in the voluntary sector, with carers, with children, with people with mental health problems, and bring this knowledge and understanding with them to inform and challenge the Board discussions

Are corporate responsibility and sustainability principles adequately reflected throughout organisational strategies?

- 52 All sectors use a different term for this agenda - 'corporate citizen', 'social responsibility' and 'corporate responsibility' among them. We will refer to 'corporate

responsibility' when referring to this issue. The statutory sector is in a position of great influence as major employers and large-scale procurers of goods and services. They can consequently have a significant impact on promoting better health among their workforce, among the people with whom they interact, and who are affected by their activities.

- 53 One of the ten Gloucestershire priorities for improving health is to have a healthy workforce. The action card for this priority demonstrates a wider understanding of the role of employers helping reduce health inequalities, but this is not consistently linked to what the partner public and voluntary sector organisations can do. The Gloucestershire Public Sector Employment Partnership has a health and wellbeing sub group, but it does not have a clear performance framework which links its work to the GCHWB strategy.
- 54 Corporate responsibility is supported by both the PCT and the County Council but is not systematically built in to their work. Both organisations have dedicated sustainability officers, both have a programme of work to reduce carbon emissions. The County Council is introducing initiatives to improve the health and wellbeing of its staff. It is also looking at ways of ensuring that it is an inclusive employer, for instance it has signed up to becoming a Mindful Employer. The PCT is also a Mindful Employer. The PCT regularly reviews its workforce profile in terms of gender, age and ethnicity to review how this compares to the population. Both the County Council and the PCT ensure that equality training is provided to staff. Policies in both organisations, including the GCHWB Strategy, are assessed for their impact on equality in both organisations.
- 55 No organisation was able to clearly demonstrate that they have an agreed corporate responsibility approach to health inequalities within local social and economic developments. Some organisations had policies in place but they did not assess the financial impact, or outcomes in relation to health inequalities. This means organisations are not taking full advantage of opportunities to address health inequalities as local employers, service commissioners and providers.

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