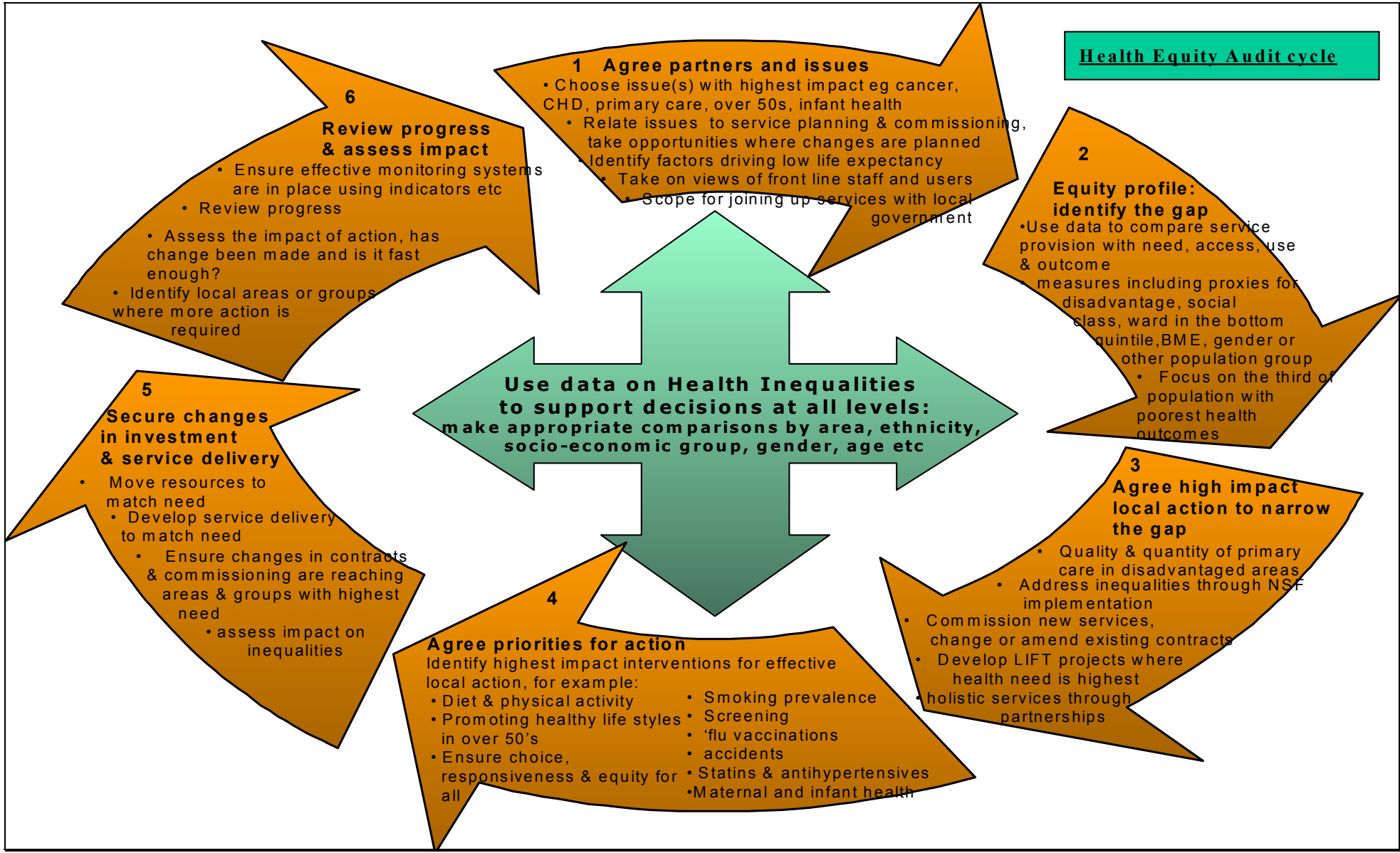


Health Equity Audit

A Guide for the NHS

Health Equity Audit cycle



Health Equity Audit (HEA) – briefing note

1. This guidance is principally aimed at PCT Chief Executives, Professional Executive Committees and Directors of Finance, Planning, Commissioning and Public Health, SHA Directors of Public Health and Performance. It provides a briefing note plus good practice guidance to support achievement of the Priorities and Planning Framework (PPF) requirement to conduct Health Equity Audits to inform NHS service planning and commissioning. Health Equity Audit is not mandatory for other Trusts or non-NHS service providers, but those who wish to use this technique to inform service provision may also be interested.

Context

2. *Tackling Health Inequalities: A Programme for Action* identified Health Equity Audit (HEA) as a key tool to embed evidence on inequalities into mainstream NHS activity such as planning, commissioning and service delivery. The **PPF for 2003-06** set out a number of targets which support the Programme for Action including **the requirement for PCT service delivery to be informed by a HEA** and an annual public health report. The technique can also be used by acute and other service providers. As at present only PCTs are required to conduct HEA, **this guidance focuses just on HEA of NHS services.**

3. In order to stop inequalities widening, progress needs to be made fast, especially by the NHS, and **HEA can help identify what will have high and rapid impact.** Focusing HEA on issues which will have the most impact on health inequalities will support the achievement of:

- the national Public Service Agreement target for health inequalities in infant mortality and life expectancy
- PPF/Local Delivery Plan targets across the board, and provide a way to ensure that the LDP as a whole does not widen inequalities
- local inequalities priorities.

What are Health Equity Audits?

4. **Health equity audits** identify how fairly services or other resources are distributed in relation to the health needs of different groups and areas, and the priority action to provide services relative to need. (This may include resources such as services, facilities, and the determinants of health). The overall aim is not to distribute resources equally but, rather, relative to health need, otherwise inequities occur which lead to health inequalities. The **HEA cycle is not complete until something changes which is likely to reduce inequalities demonstrably.** For NHS services, that would probably be resource allocation, commissioning, service provision or care outcomes.

What is HEA for and how is it done?

5. **The diagram is a step by step guide** to the HEA process.
- **The purpose of HEA is to help services narrow health inequalities by using evidence on inequalities to inform decisions on investment, service planning, commissioning and delivery and to review the impact of action on inequalities.** It is a way of getting health inequalities into the mainstream of NHS activity. High level HEA may inform

overall strategy development. More focussed HEA may aid or drive action in target areas within the strategy. It can be used by performance managers to review the actual and potential effects of service decisions on health outcomes. It can also support the local authority overview and scrutiny function.

- **Partnership working.** As set out in the PPF, PCTs will be leading the process of agreeing a single set of local inequalities priorities with local authorities, other NHS Trusts and other partners, probably through the Local Strategic Partnership (LSP). LSPs may wish to use HEA across the range of the LSP's services or to support Health Impact Assessment. It will be important to have a component on NHS services, and this guidance focuses on that. Some local authorities are using or testing out a similar process to HEA to address inequalities in their services. HEA can provide opportunities for joined up problem solving and long-term action on complex and stubborn issues.

Getting maximum impact from HEA – what issues should be addressed?

6. HEA should **focus action on issues with the highest impact** on health inequalities, remembering that the socio-economic dimension of health inequality has a social gradient. So addressing inequities is about the breadth of the whole distribution, not just the extreme end, ie this is not just about vulnerable groups.

- The issues which will have **rapid impact**, and support achievement of the 2010 health inequalities target, are **cancer, circulatory disease, respiratory disease, maternal health and infant mortality**. To support the life expectancy part of the target, a key focus in areas of low life expectancy will be on **improving the health of the over 50s**. At the same time, **improving the health of children** will help to prevent inequalities in the future. **Prevention** (especially smoking, diet and physical activity) and services can be addressed by HEA. **The quality and quantity of primary care services relative to need** underpin all these.
- In addition, **local issues** may be important, for example: accidents and unnatural deaths, as these are not evenly distributed across the country; and groups in the local population with specific health needs, such as Black and minority ethnic groups with high prevalence of particular conditions. HEA can be used by PCTs to compare themselves with others with similar characteristics (eg former mining community, similar level of deprivation etc) to identify where there is scope for improvement.
- HEA should be **pragmatic**, using opportunities (for example, a major service development or NSF implementation) to ensure that inequalities issues are addressed.
- Looking at issues across the whole local health community along **the care pathway** may highlight where the inequities are occurring and reveal cumulative effects of unequal access to services along the patient's journey through primary prevention, secondary prevention, acute and chronic care.
- HEA can also be used to ensure that **new initiatives and existing priorities**, such as access, waiting, booking and choice, patient and public involvement or the implementation of NSFs, are narrowing and not inadvertently widening inequalities.

- A HEA programme should address **the dimensions of health inequalities**, aiming to narrow the gap in health outcomes between:
 - social classes (focussing on all manual groups, not just the most deprived)
 - geographical areas (within the PCT or comparing the PCT with the national average or with PCTs with similar characteristics)
 - men and women
 - different Black and minority ethnic groups and the population as a whole
 - age groups, particularly by improving the health of infants and children and prolonging active healthy lifestyles in the over 50s
 - between the majority of the population and vulnerable groups and those with special needs. These might include: rough sleepers and homeless people, including homeless families with children in temporary accommodation; prisoners and their families; refugees and asylum seekers; travellers; Looked After children and care leavers; vulnerable people with mental health problems, chronic conditions, physical or learning disabilities.
- Providing services relative to need should also **support achievement of a range of targets across the whole LDP**, including access targets in primary and secondary care, and targets for cancer and circulatory diseases. For example, addressing the quality and quantity of primary care in disadvantaged areas can impact on A&E attendances, promoting prevention can support **demand management** and the timing of presentation with disease and therefore mortality rates.
- Focusing on disadvantaged areas and groups provides the opportunity for **high health gain for investment** as well as narrowing health inequalities, as this is where the burden of morbidity and mortality lies. So improving equity should support efficient service delivery.

What would be the outcome of HEA?

7. Identifying what can be changed is for local decision. Examples include:
- **changing acute contracts** to promote equitable access or outcomes, especially for high impact services such as angiographies or CABGs.
 - **joined up thinking** across contracts and projects eg assessing individuals for fuel poverty, benefits, smoking cessation and falls initiatives as part of the single assessment of the elderly.
 - establishing **innovative ways of reaching groups** sometimes considered hard to reach or time-consuming. For example using community development workers, peer educators and community groups or community venues such as schools, Working Mens Clubs, day centres, gay and lesbian venues etc to reach needy populations. Once a population is reached for one service, this can provide a way in for efficient delivery of other services too. Some of these groups may be contributing to the under-achievement of LDP targets, for example screening, 'flu vaccination, smoking in pregnancy.
 - identifying the **win/win opportunities**, such as using prevention to support demand management. For example supporting accident prevention can reduce admissions and

A&E attendances. It may be that some of the access targets are eased if the needs of disadvantaged populations are specifically addressed.

- **reviewing** whether **progress** can be speeded up on programmes specifically addressing inequalities eg smoking in pregnancy, breastfeeding, teenage pregnancy, substance misuse, services for homeless people etc.

8. Data issues

- **Routinely available data and information** can be used to support HEA, also data gathered through local audit and research, and existing data such as in DPH reports. “Data paralysis” is to be avoided, where possible using information that is already there.
- **Providing data in time** for the decision is vital.
- Imperfect data and creative use of postcodes, indices of deprivation and proxies should be used if they are “**fit for purpose**” for the decision being made. Where necessary, PCTs should seek expert advice, for example from the Public Health Observatory.
- The **local basket of indicators** (available at http://www.lho.org.uk/HIL/Inequalities_In_Health/Basket_Of_Indicators/Basket.htm) provides a menu of indicators which PCTs may find useful for HEA.
- HEA may reveal local **data development needs** or data quality issues which need to be addressed to ensure sound evidence supports decisions. For example, the quality of ethnicity data in the NHS is generally poor, but this is a key dimension of inequality. Any data problems with Local Delivery Plan inequalities targets would also highlight the need for action.
- It is good practice for HEAs to be made **publicly available**.

9. Capacity issues

- The scope of the HEA and the range of issues addressed are for PCTs to decide based on the services with the potential to have the highest impact on inequalities and opportunities presented by forthcoming service developments and plans. PCTs may wish to schedule a programme of HEAs to address the highest impact issues systematically.
- PCTs which have analytic resource constraints may wish to join forces with neighbouring PCTs or their public health network to conduct HEA, but the HEA should lead to a demonstrable change in all PCTs involved.

10. Developing HEA

- PCTs are at different stages of development with HEA. PCTs should review their capacity to carry out HEA and address any weaknesses identified, with a view to embedding HEA to become a mainstream performance improvement tool as part of every planning cycle. This is not a one-off exercise.
- SHAs have a performance management role in ensuring that all PCTs are developing and using HEA effectively as a driver for change to narrow health inequalities.

Local examples of HEA

11. Some local examples of HEAs are attached, and a paper providing a fuller example from Liverpool is being made available on the health inequalities website www.doh.gov.uk/healthinequalities. Many thanks to the originators

Acknowledgements

12. This briefing note has drawn on earlier work and benefited from input by a wide range of people to whom thanks are due:

- Lucy Hamer (Health Development Agency), Bobbie Jacobsen (London Health Observatory), Julian Flowers (Eastern Region Public Health Observatory) and Fiona Johnstone (St Helens PCT) who produced *Health Equity Audit Made Simple* (January 2003).
- Gillian Schiller (Gateway Consulting Group) who ran a consultation exercise on that document.
- A wide range of HEA champions and critical friends who have contributed their time and energy. In particular those who provided the examples in the pack: Ruth Hussey, Fiona Johnstone, Margaret Eames, Tom Hennell, Iain Buchan, Julian Flowers, Tony Jewell, Neil Riley, Chris Bentley, Ann Richardson and the Health Poverty Index team.

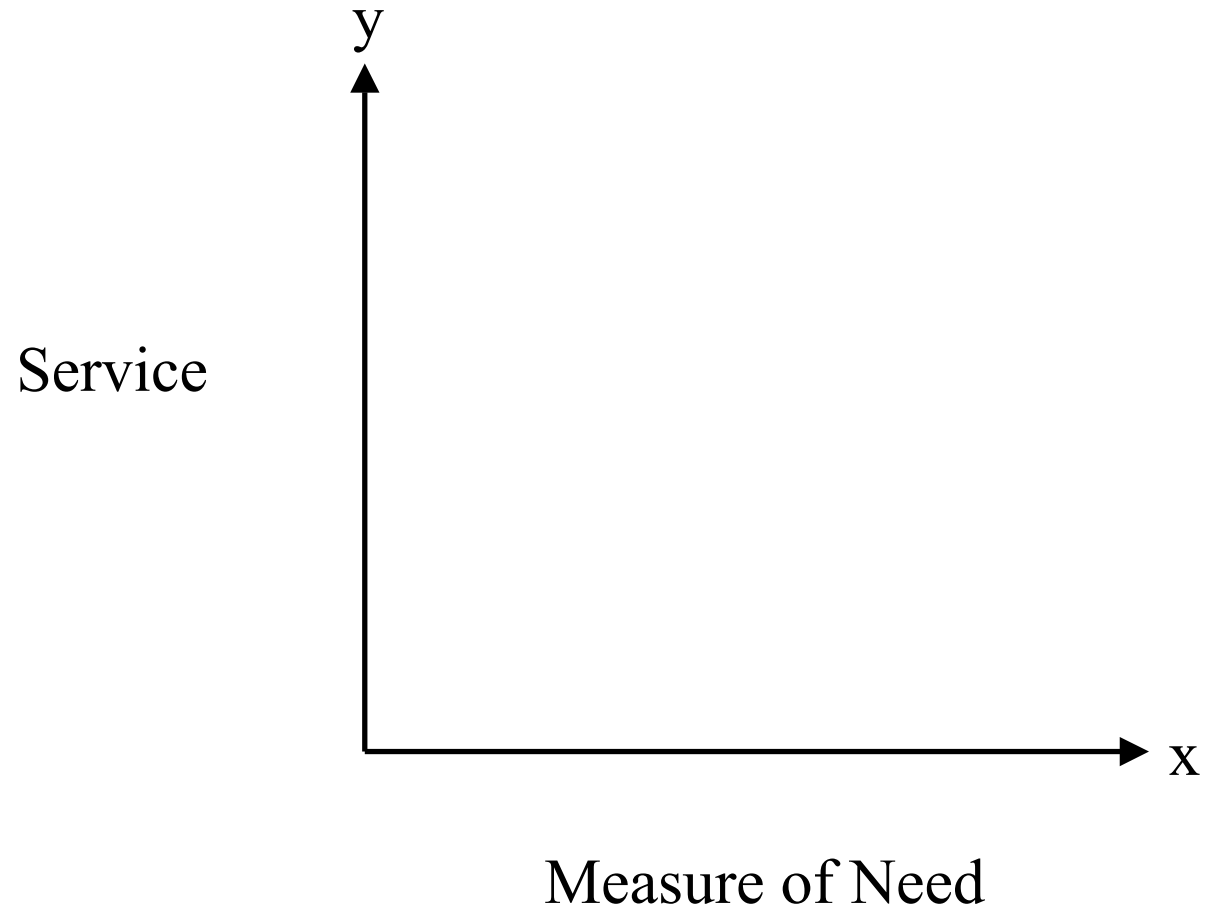
Health Equity Audit: local examples

Presented with thanks to Margaret Eames, Tom Hennell, Iain Buchan, Julian Flowers, Tony Jewell, Neil Riley, Chris Bentley, Ann Richardson and the Health Poverty Index team

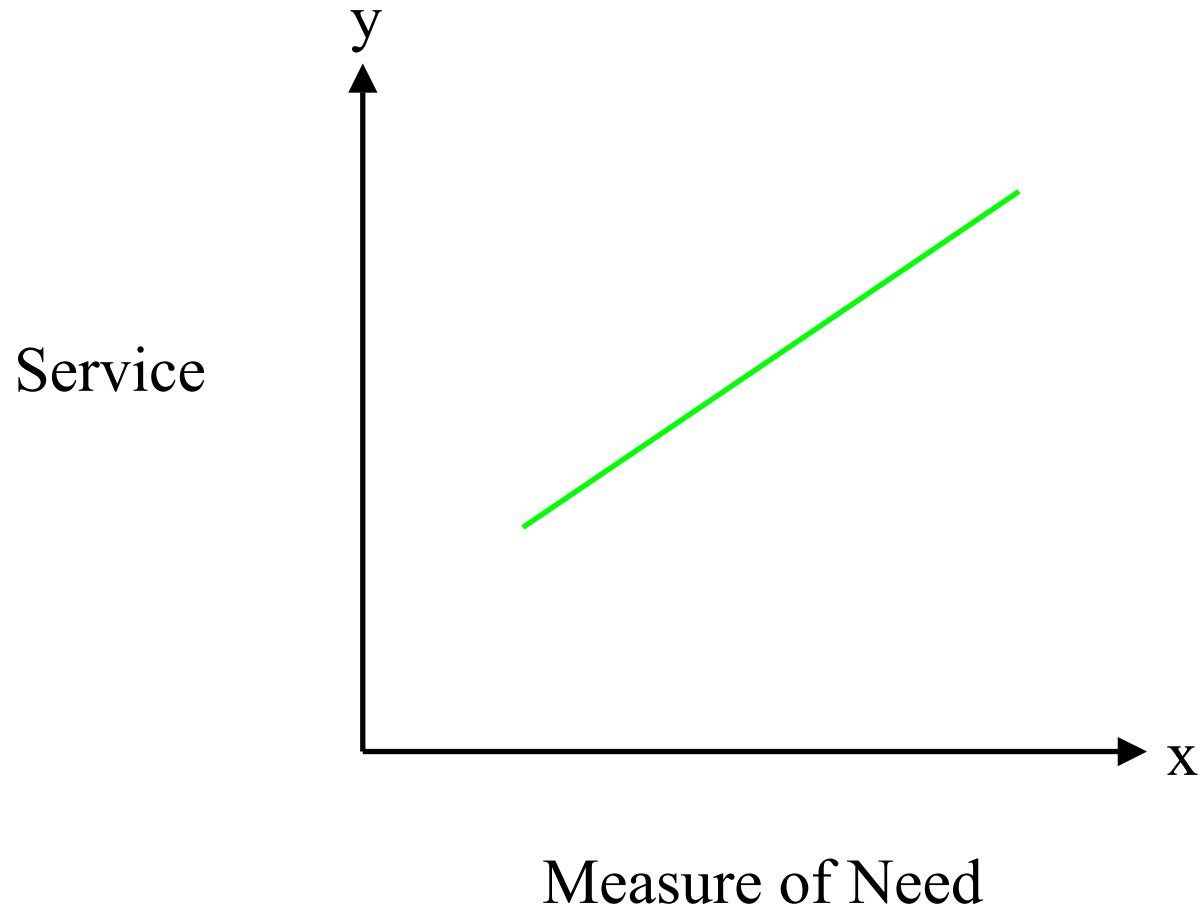
Example 1: the basics

With thanks to Margaret Eames, head of Public Health
Intelligence, Bedfordshire and Hertfordshire SHA

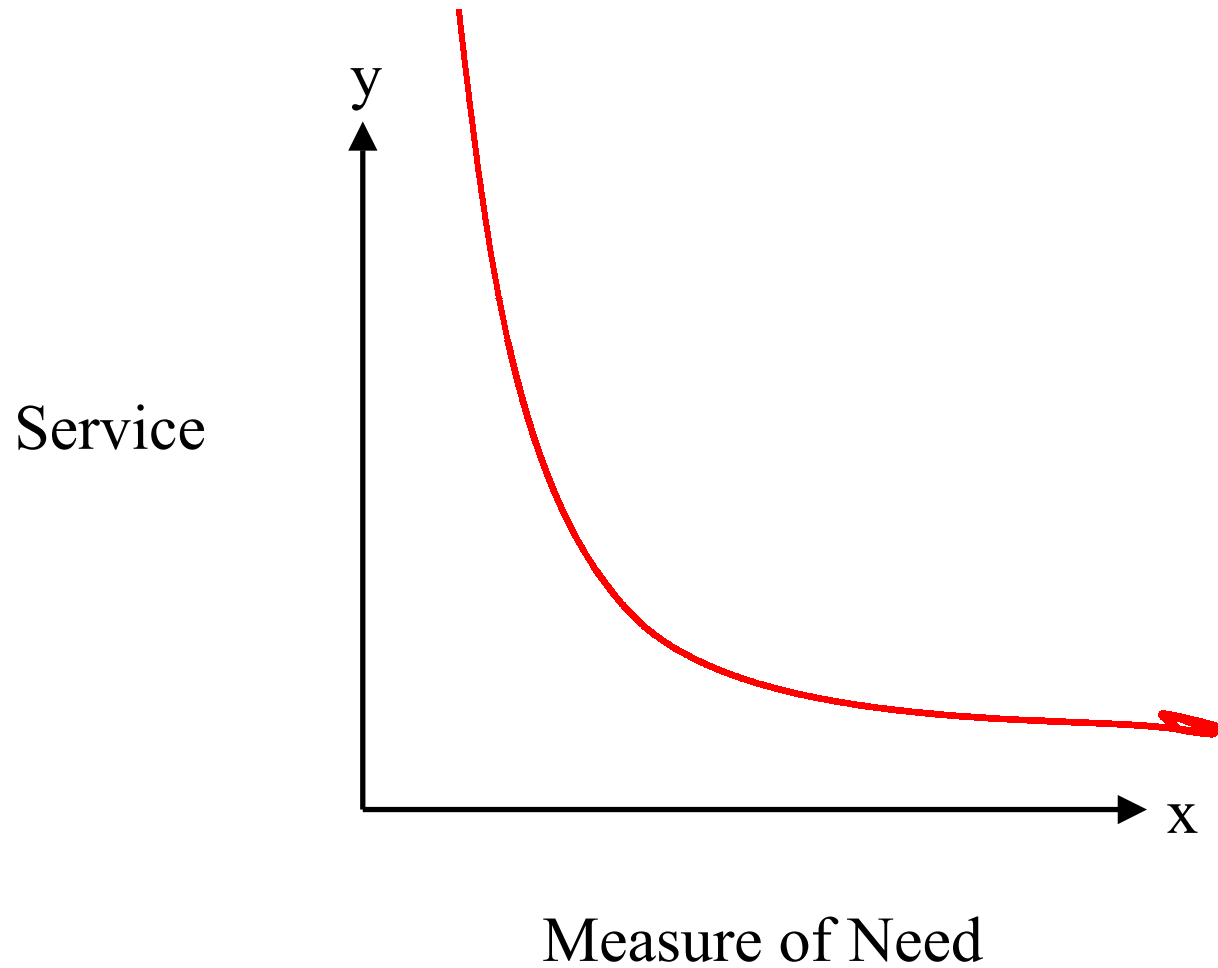
At its core, Health Equity Audit
compares the provision of a service with
a measure of the need for it



In this simplified example, high need is matched by high service provision: the desirable situation



In this simplified example, those with most need get the lowest level of service: the undesirable “inverse care law”



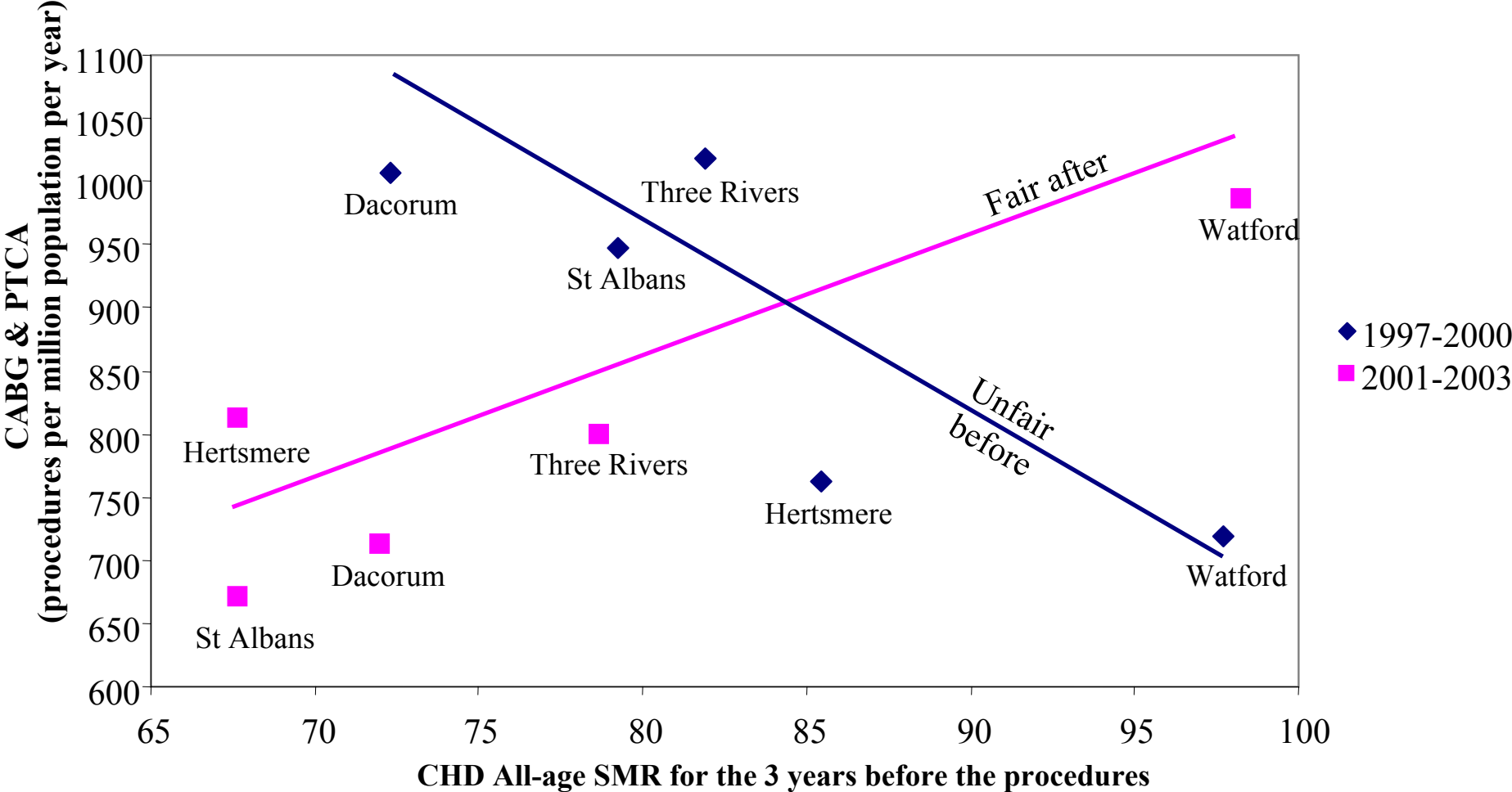
Example 2: CHD services in West Hertfordshire

With thanks to Iain Buchan, University of Manchester
(formerly of West Hertfordshire HA)

CHD NSF Linked Equity Improvement in West Hertfordshire

- The introduction of the NSF in West Hertfordshire focused upon equitable development of cardiology services.
- This included a £300,000 shift in recurrent resources towards areas of highest need.
- The next chart shows an improvement in the fairness of the distribution of coronary revascularisation procedures before and after the introduction of the CHD NSF in West Hertfordshire.

The Improvement in W Hertfordshire Coronary Revascularisation Equity Before and After Introducing the CHD NSF



Source: Local finance information system and ONS; all denominators are based on Census 2001 projection:

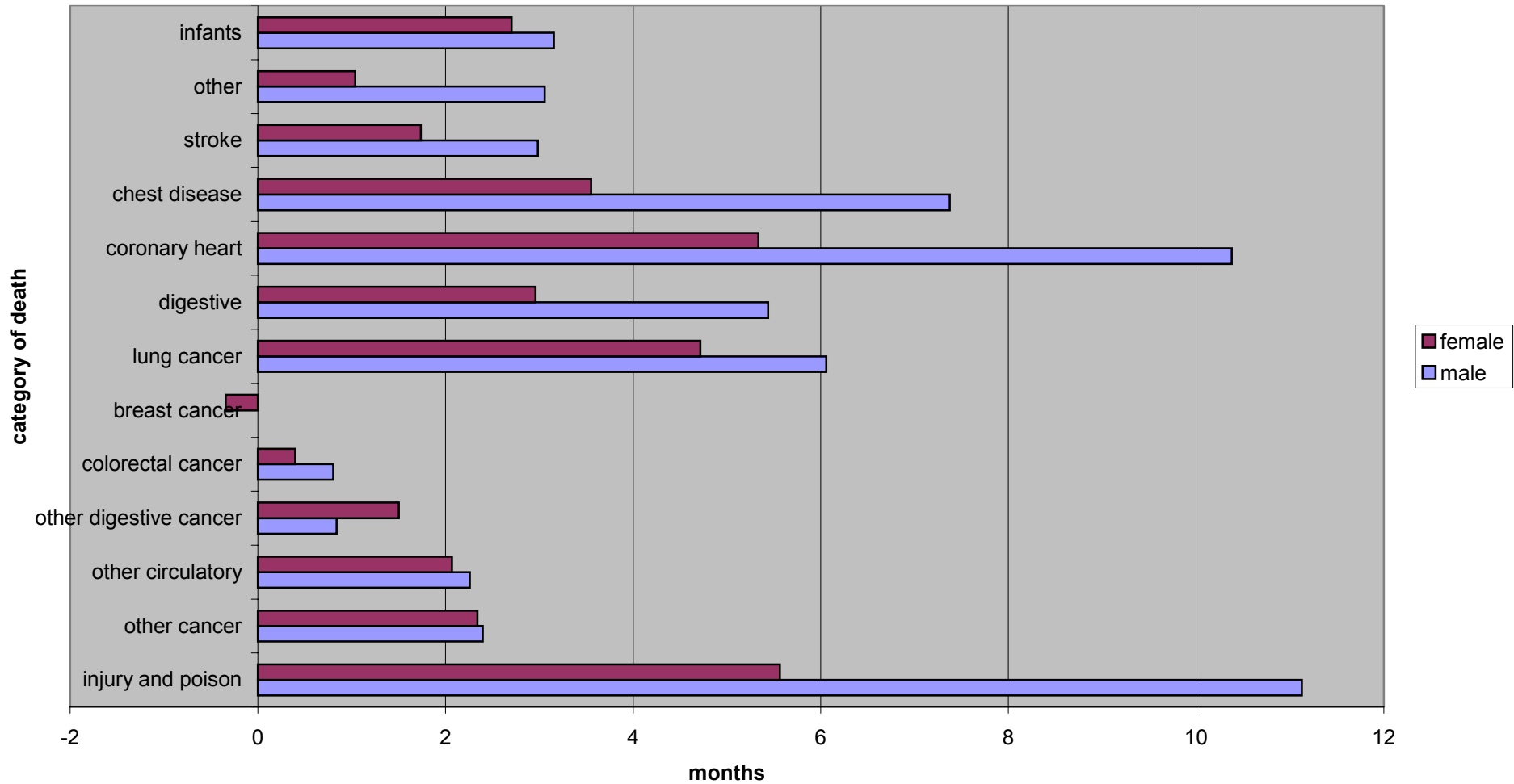
Example 3: Identifying the causes of low life expectancy in Manchester

- This analysis helps identify the high impact issues in a locality

With thanks to Tom Hennell, North West Public Health Observatory/ North West Public Health Team

Commentary: This example shows the drivers of low life expectancy in Manchester, showing up the importance locally of injury and poison - different to the national pattern

**Reduced Life Expectancy - compared to E&W average
Persons under 75 dying in Manchester 1996-2000**

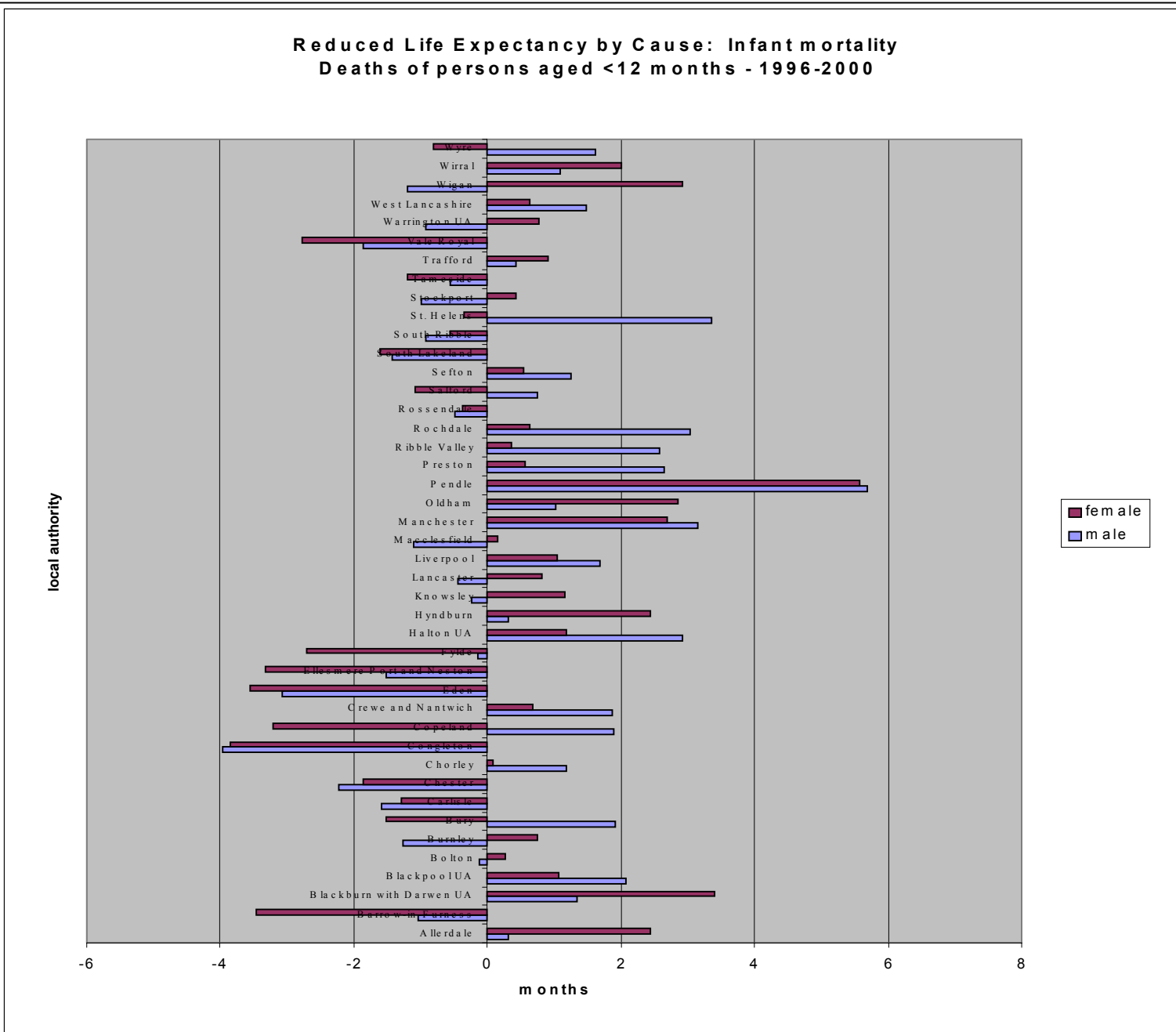


Mortality in the North West: infant mortality and lung cancer analyses

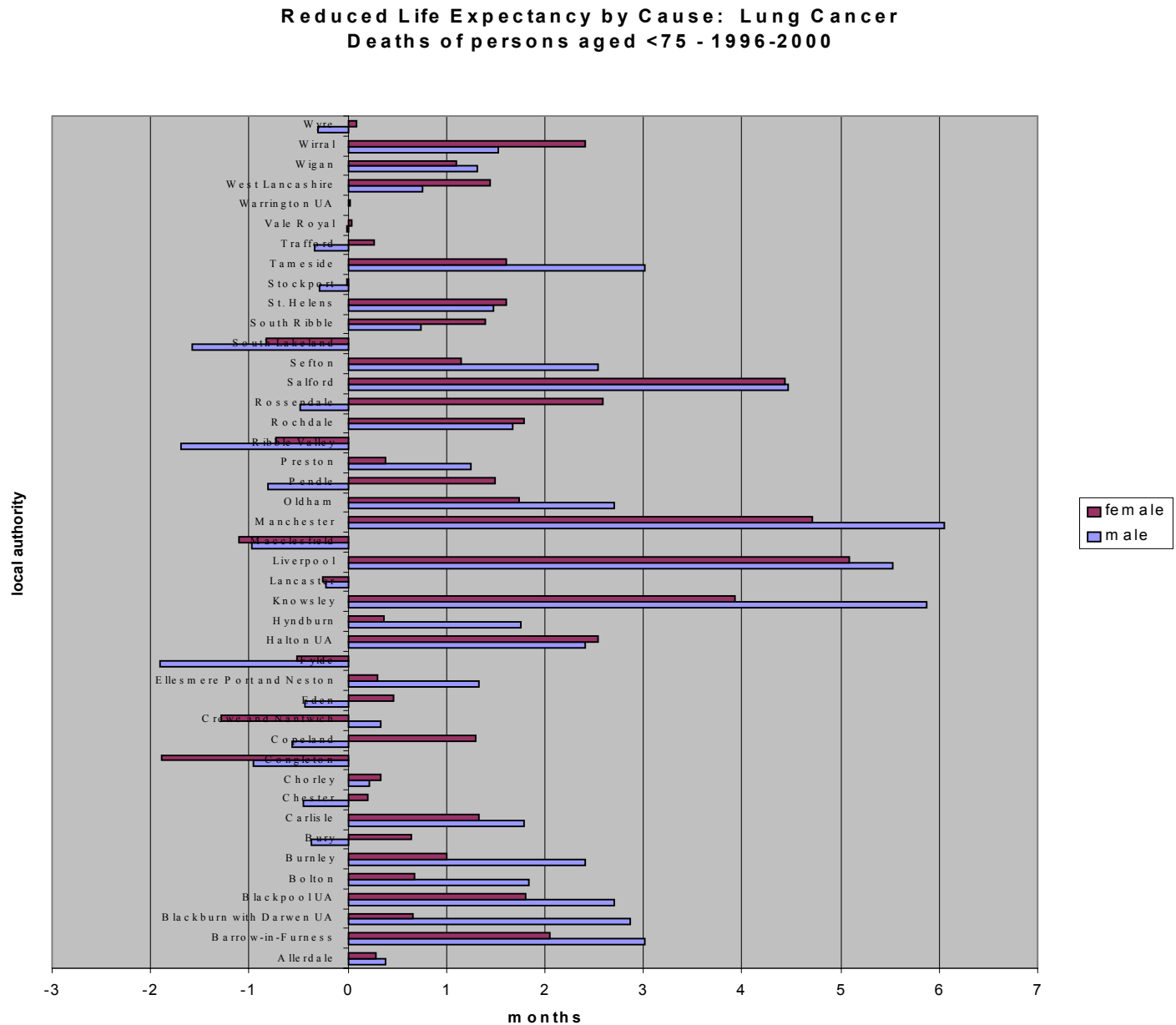
- These presentations allow an assessment of how many months of life expectancy might be gained, were local mortality rates – for specific causes - to be reduced to the national average for England and Wales.
- These graphs have been used this year by the national Neighbourhood Renewal Unit to inform Implementation Seminars with selected Local Strategic partnerships in the North West – in order to discuss local progress towards floor targets.

With thanks to Tom Hennell, North West Public Health Observatory /North West Public Health Team

Comment: The chart shows infant mortality by area in the North West for boys and girls



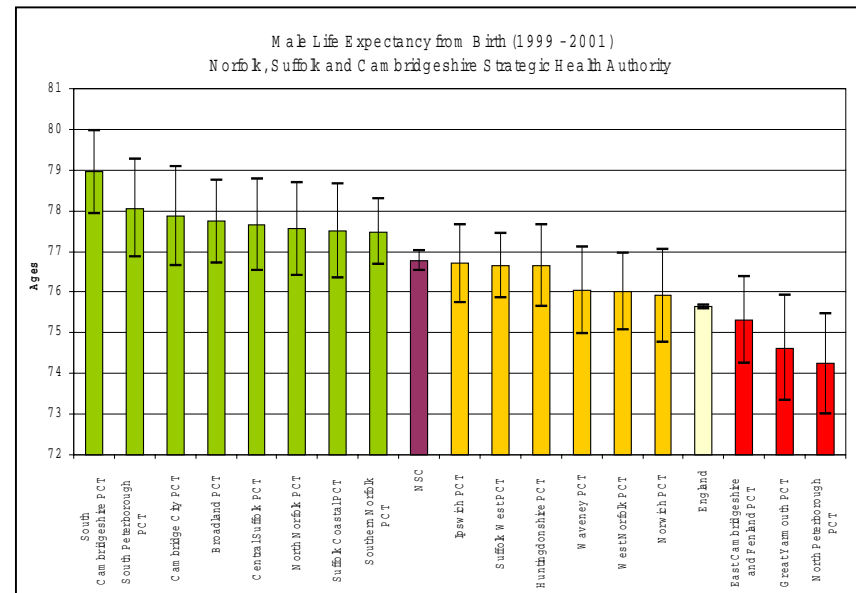
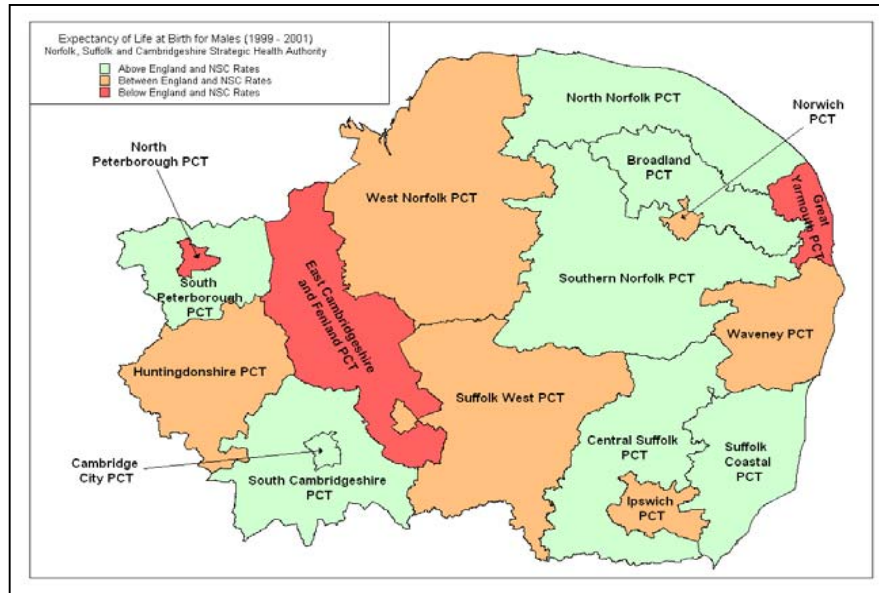
Comment: The chart shows lung cancer by area in the North West for males and females



Example 4: Life expectancy, mortality rates and service provision in Norfolk, Suffolk and Cambridgeshire

With thanks to Tony Jewell and Neil Riley,
Norfolk, Suffolk and Cambridgeshire SHA

Life Expectancy at Birth for Males (1999–2001) by PCT



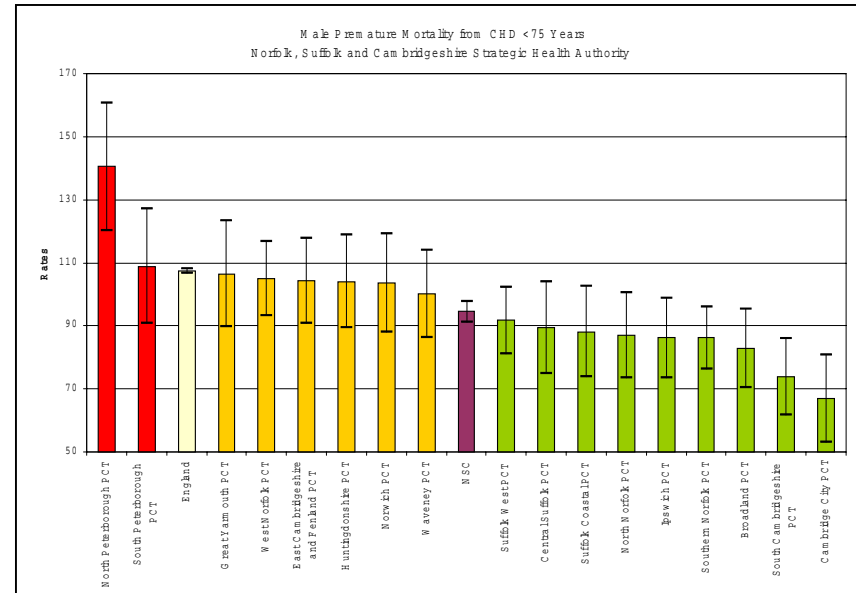
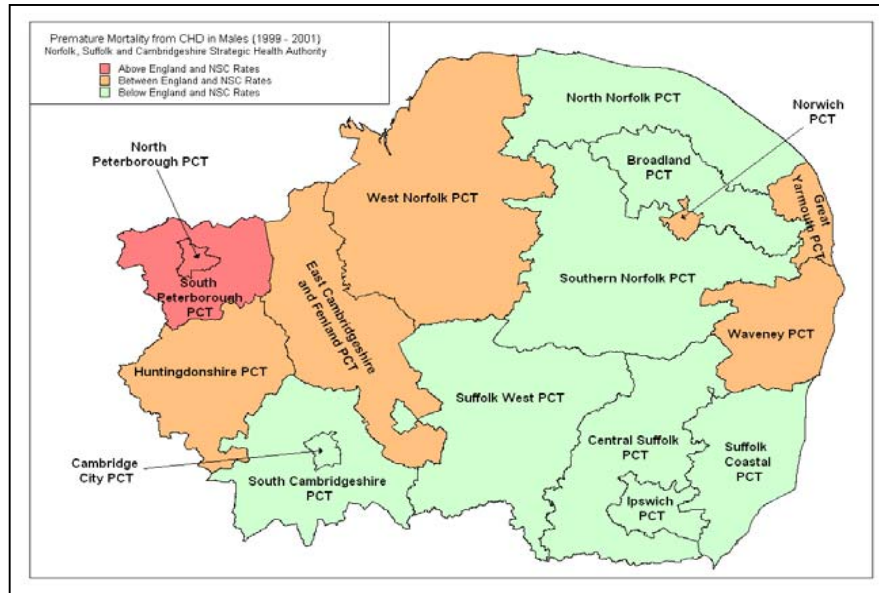
Central Suffolk PCT	77.7	Broadland PCT	77.7
Ipswich PCT	76.7	Great Yarmouth PCT	74.6
Suffolk Coastal PCT	77.5	North Norfolk PCT	77.6
Suffolk West PCT	76.6	Norwich PCT	75.9
Waveney PCT	76.0	Southern Norfolk PCT	77.5
		West Norfolk PCT	76.0
Cambridge City PCT	77.9		
East Cambridgeshire and Fenland PCT	75.3		
Huntingdonshire PCT	76.6	North Peterborough PCT	74.2
South Cambridgeshire PCT	79.0	South Peterborough PCT	78.1
NSC	76.8	England	75.6

Commentary

- There is a direct correlation between expectancy of life and deprivation score.
- There is a gap of almost five years between the lowest and highest life expectancies.
- Males born in Cambridge City and in areas of affluent rurality have the highest expectancy of life.
- Males in Fenland and deprived urban areas of Great Yarmouth and North Peterborough have the lowest life expectancy.
- There is a national target to reduce the gap in life expectancy.

Premature Mortality

from Coronary Heart Disease in Males <75 Years (1999 - 2001) by PCT

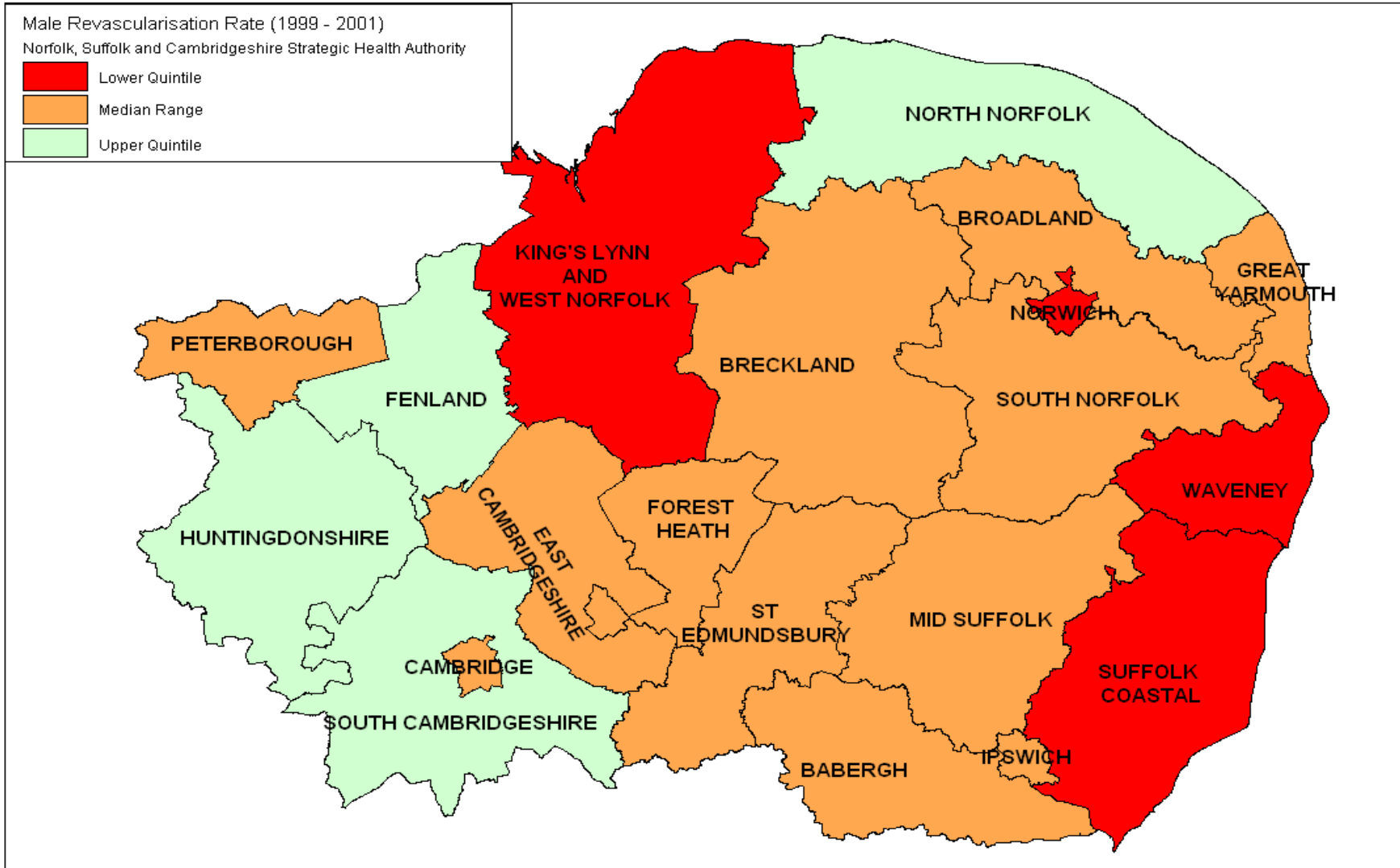


Central Suffolk PCT	89.4	Broadland PCT	82.8
Ipswich PCT	86.2	Great Yarmouth PCT	106.5
Suffolk Coastal PCT	88.1	North Norfolk PCT	86.9
Suffolk West PCT	91.7	Norwich PCT	103.5
Waveney PCT	100.0	Southern Norfolk PCT	86.2
		West Norfolk PCT	104.9
Cambridge City PCT	67.0		
East Cambridgeshire and Fenland PCT	104.2		
Huntingdonshire PCT	104.0	North Peterborough PCT	140.5
South Cambridgeshire PCT	74.0	South Peterborough PCT	108.9
NSC	94.6	England	107.4

Commentary - Rates per 100,000 men <75 years.

- Coronary heart disease is the biggest killer of males across NSC. There were 3259 deaths between 1999 and 2001 in those under 75.
- Smoking, obesity and family history are risk factors.
- Males in deprived areas have the highest mortality rates, with the North Peterborough PCT rate almost double the Cambridge PCT rate.
- Peterborough rates are higher than the England rate.
- The CHD NSF sets standards for prevention, treatment and rehabilitation.

Commentary: This map shows revascularisation rates are low in the areas of highest CHD mortality, Peterborough and Great Yarmouth, and high in areas of low mortality: the inverse care law



Action taken following the analysis of CHD services in Norfolk, Suffolk and Cambridgeshire

- This analysis is part of an *Atlas* being used to accompany the Strategic Health Authority's *Health Delivery Plan*.
- It is presented in a way to contrast local performance with regional and national levels
- It focuses attention on geographical disparity of health and health services

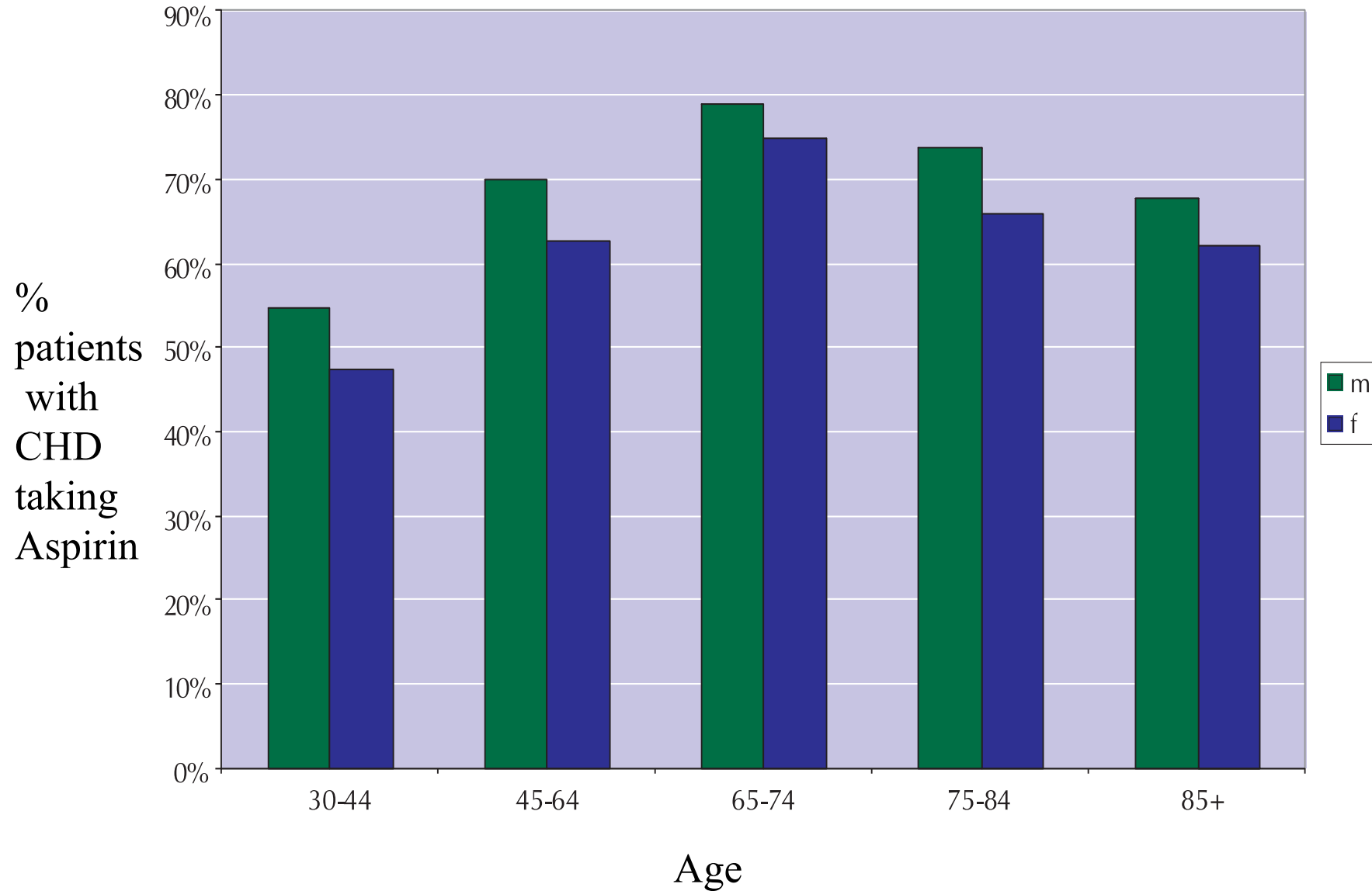
Example 5: More CHD services in East Anglia

With thanks to Margaret Eames, head of Public Health
Intelligence, Bedfordshire and Hertfordshire SHA, and
Julian Flowers, Eastern Region Public Health Observatory

Uptake of aspirin by CHD patients

- The following chart shows age and gender inequalities in the uptake of aspirin by CHD patients

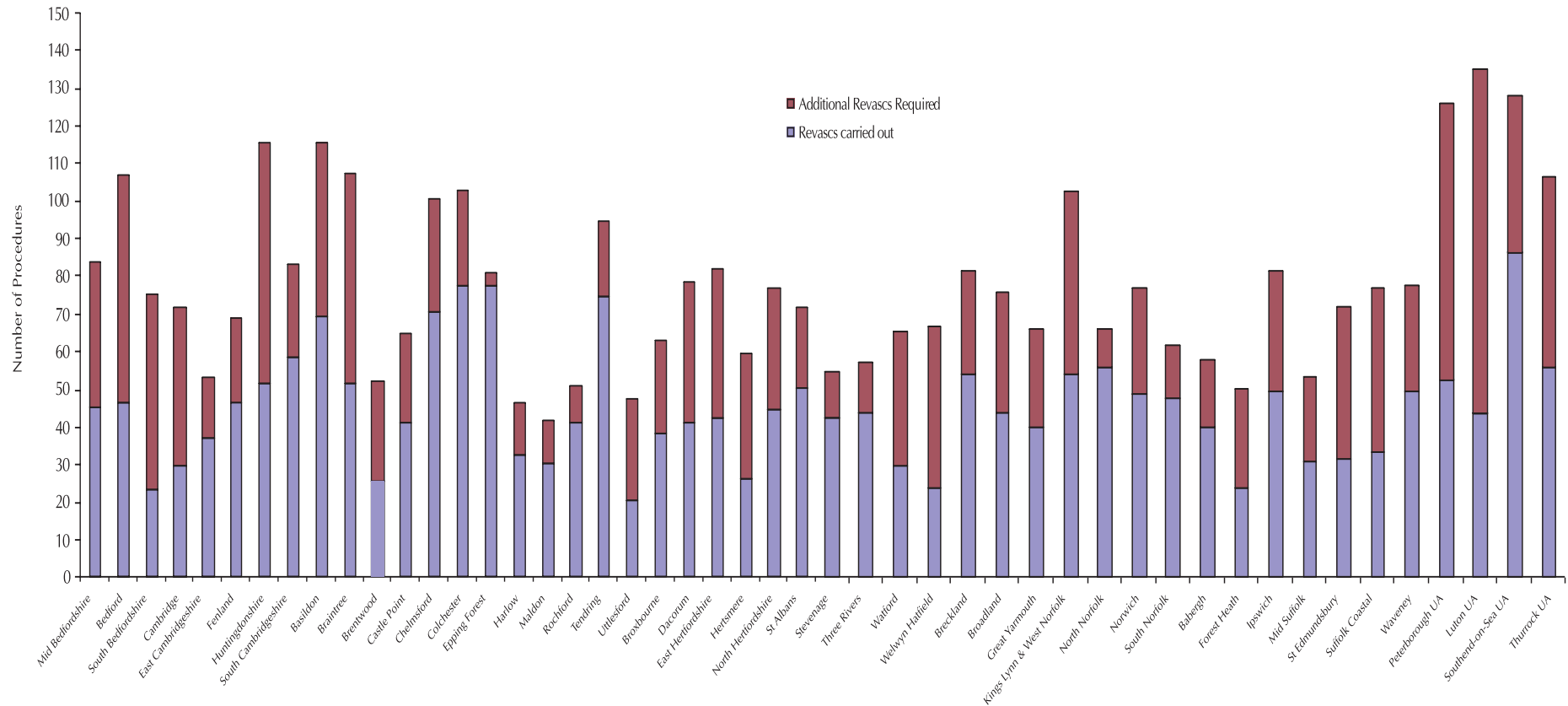
Uptake of Aspirin by patients with CHD in Cambridge & Peterborough PH network



Provision of Revascularisations compared to NSF standards

- The following graph shows an example of variable provision compared to an NSF standard, indicating geographical inequalities

The Gap between current provision of revascularisations (1999-2000), and the number needed to meet NSF targets



How are these findings being used locally?

- Each CHD network is using these findings to inform commissioning of appropriate cardiological capacity to address inequity.

Example 6: Breast cancer

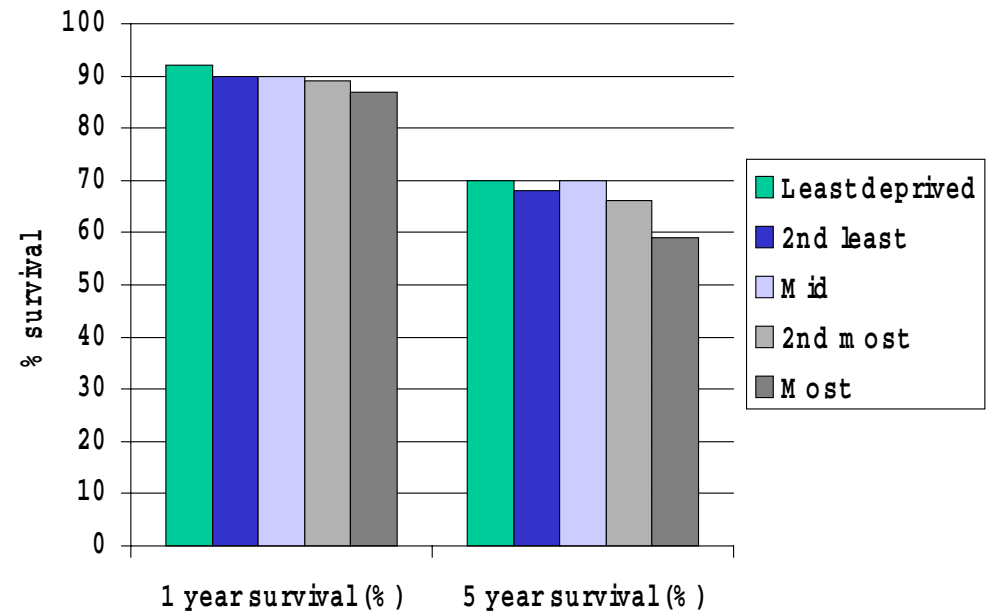
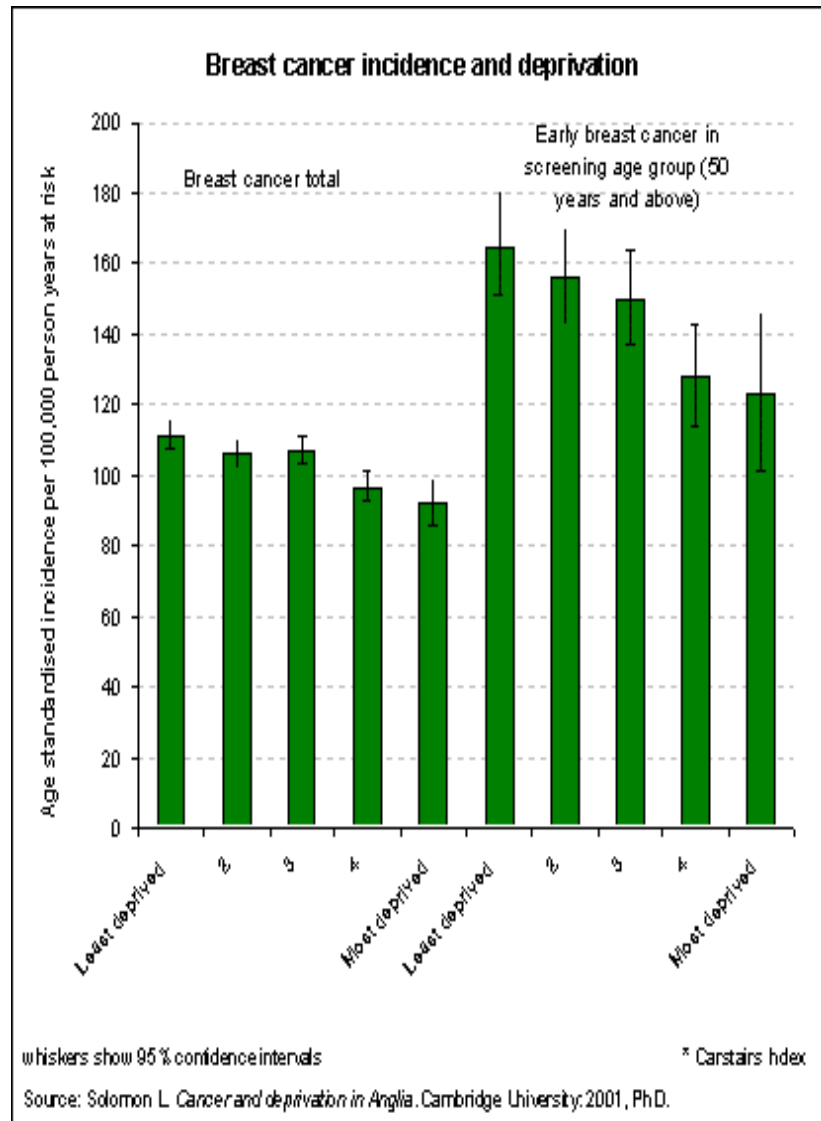
- The following slide shows that although disadvantaged women are less likely to get breast cancer, those that do have lower survival rates than more affluent women.

With thanks to Margaret Eames, head of Public Health Intelligence, Bedfordshire and Hertfordshire SHA

Breast Cancer by Deprivation

a) Incidence

b) Survival



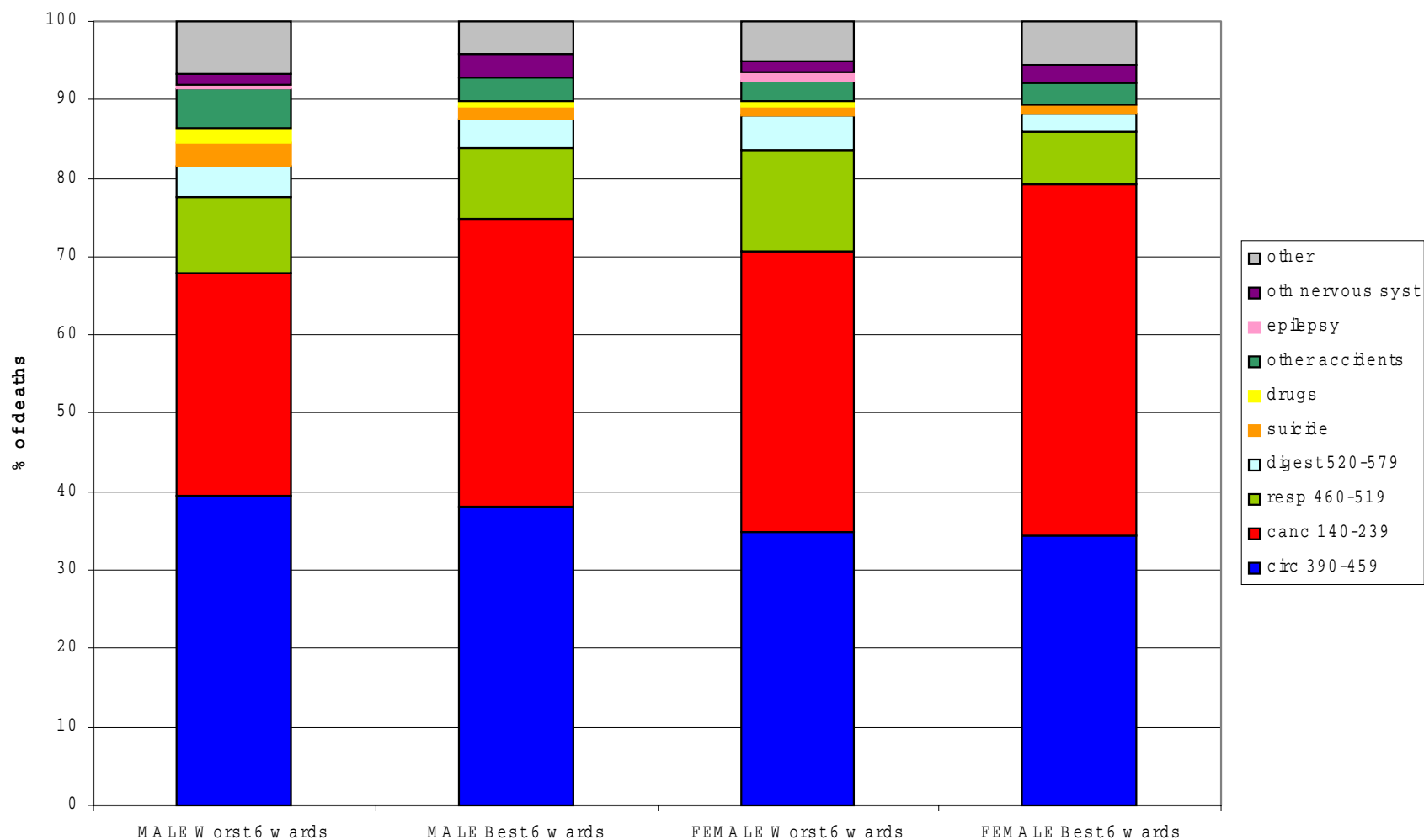
Source: Cancer survival trends in England & Wales 1971-95. ONS

Example 7: Inequalities in the causes of death between men and women and between deprived and affluent areas in Sheffield

With thanks to Chris Bentley, S Yorkshire SHA and
Ann Richardson, Sheffield Health Informatics Service

Commentary: This analysis can help support local action by showing different patterns of cause of death. Men die more often as a result of risk taking behaviour from such causes as drug taking and accidents, and death from epilepsy is more common in deprived wards for both men and women in Sheffield.

Deaths <75 years, % by Cause 1995 - 98, Male and Female for the Most and Least Deprived Groups of 6 Wards



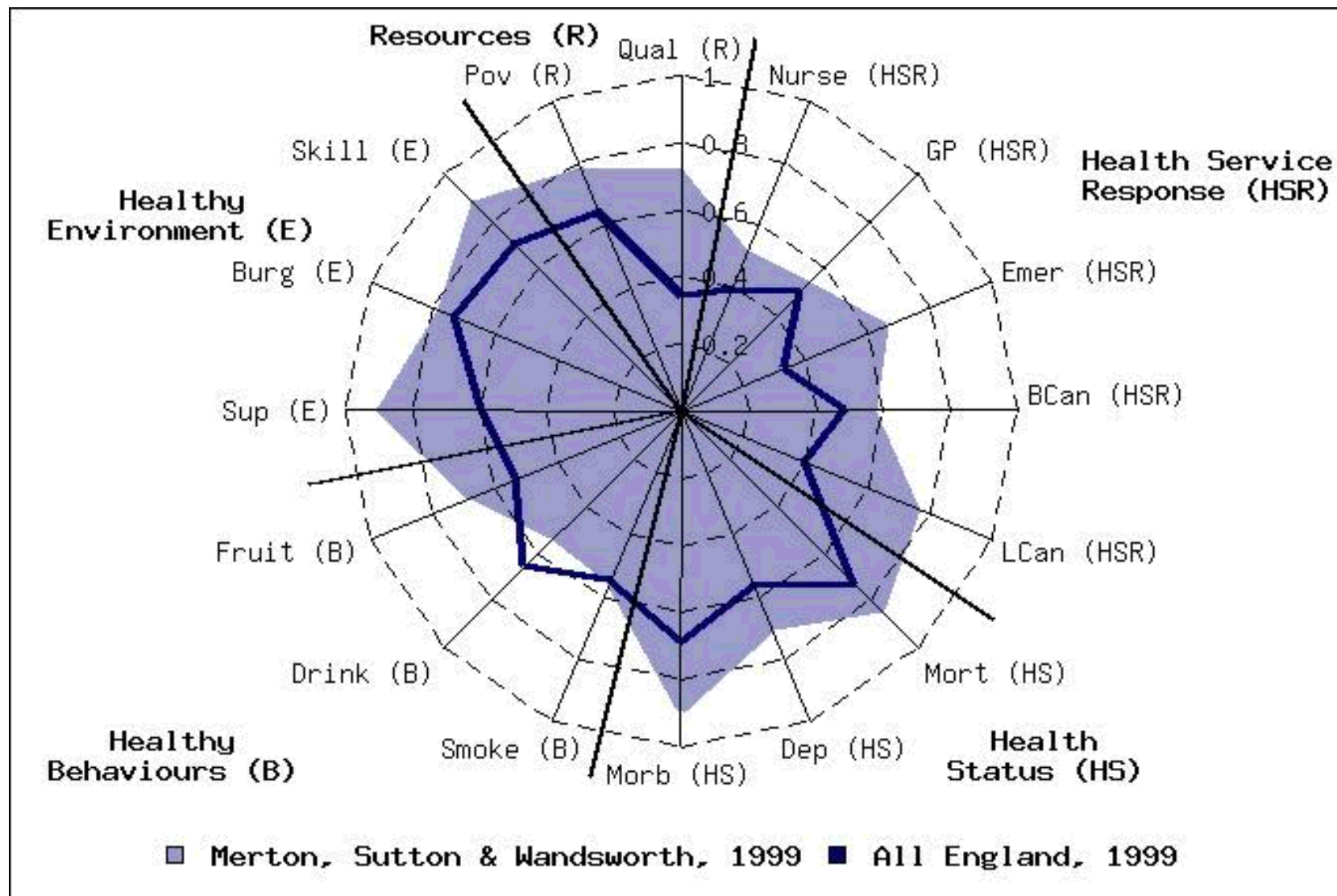
Action taken following the analysis of causes of death in Sheffield

- Work is currently in progress to determine the reasons why death from epilepsy is more predominant in deprived areas than in affluent areas

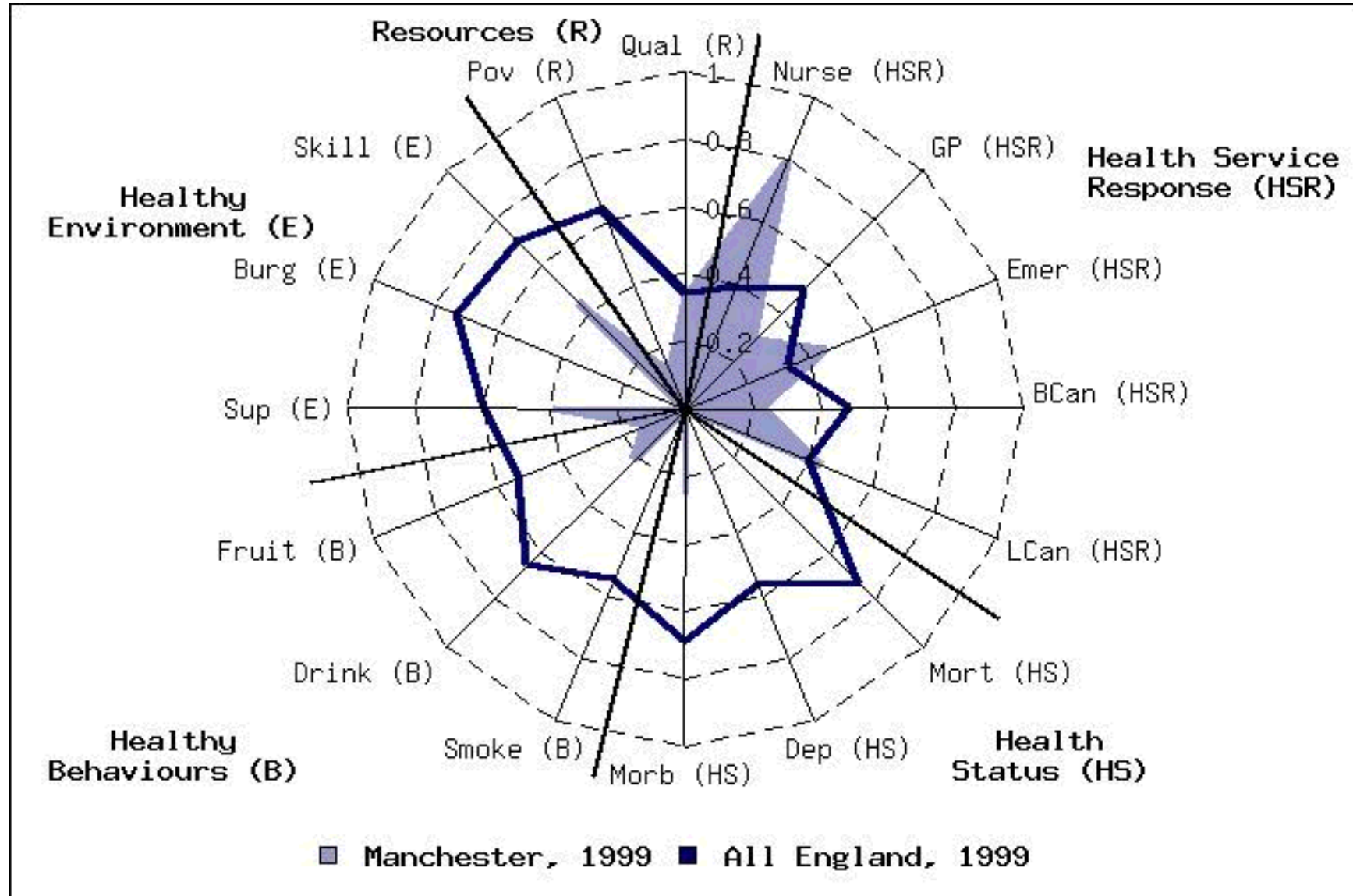
Example 8: The Health Poverty Index

- The health Poverty Index is a visualisation tool for comparing health outcomes in different areas.
- Its development is being funded by the Department of Health and is being carried out by the South East Public Health Observatory (SEPHO) and the Social Disadvantage Research Centre (SDRC) of the Department of Social Policy and Social Work (University of Oxford).
- for all variables, 1.0 corresponds to the best situation and 0.0 to the worst situation.

Merton, Sutton and Wandsworth comparison with rest of England



Manchester comparison with rest of England



Sources of information

- The **Health Poverty Index** can be seen at <http://www.hpi.org.uk/index.php>
- The **Local Basket of Indicators** for health inequalities, which contains measures that can be used for HEA, can be found on the London Health Observatory site at <http://www.lho.org.uk>
- Various documents on HEA can be accessed on PHO sites via <http://www.pho.org.uk>
- *Health Equity Audit Made Simple* is available on the Health Development Agency site at <http://www.hda.nhs.uk>