

External Reference Group Report

February 2007



Greater Manchester Health Inequalities Review

Greater Manchester Health Leadership Network

Audit 2005/2006 and 2006/2007

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Organisations involved

*denotes the organisation has a representative on the External Reference Group.

5 Boroughs Partnership
Ashton, Leigh and Wigan PCT*
Bolton Hospitals NHS Trust
Bolton MBC
Bolton PCT*
Bolton, Salford and Trafford Mental Health NHS Trust
Bury MBC*
Bury PCT
Central Manchester and Manchester Children's NHS Trust*
Central Manchester PCT (Now Manchester PCT)
Christie Hospital NHS Trust
Government Office North West
Greater Manchester Ambulance Service (Now NWAS)
Greater Manchester Centre for Voluntary Organisation*
Greater Manchester SHA* (Now part of NHS North West)
Heywood and Middleton PCT(Now part of Rochdale PCT)
Manchester City Council *
Manchester Mental Health and Social Care NHS Trust
North Manchester PCT (Now Manchester PCT)
North Trafford PCT * (Now Trafford PCT)
North West Public Health Observatory
Oldham MBC
Oldham PCT*
Pennine Care NHS Trust*
Pennine Hospitals NHS Trust
Rochdale MBC
Rochdale PCT
Salford City Council
Salford PCT

South Manchester PCT(Now Manchester PCT)
South Manchester University Hospitals NHS Trust (now University Hospital of South Manchester NHS Foundation Trust)
South Trafford PCT(Now Trafford PCT)
Stockport NHS Foundation Trust
Stockport MBC*
Stockport PCT
Tameside Acute Hospitals NHS Trust
Tameside and Glossop PCT
Tameside MBC
Trafford Healthcare
Trafford MBC
Wigan MBC
Wrightington, Wigan and Leigh NHS Trust*

Introduction

- 1 'Health and well being' and the health inequalities that exist across the country are key national priority areas with investment in improving health likely to yield significant long-term benefit. Promoting healthier communities and reducing the gap between the least and most healthy groups of the population have a significant effect on well-being and prosperity. Addressing such a large issue is not the preserve of any organisational sector alone. There is much that individual organisations can do, but to tackle health inequalities across Greater Manchester, many issues require greater co-operation and shared vision.
- 2 Recent government policy reform proposals and new initiatives reflect recognition at a national level that improving the health of the population is imperative. Different government departments have some part to play in the development and implementation of these policies.
- 3 The NHS Operating Framework for 2007/08 emphasises the importance given to this agenda. Alongside this are opportunities through local area agreements (LAAs) to tackle local health inequalities, with a move towards more challenging agreements in the LAA health block which reflect the importance now placed on this agenda.
- 4 Reducing health inequalities and delivering improved health outcomes will depend on robust implementation at local level. Local government and health organisations often have different and competing priorities and targets to address. Having a common set of priorities is an essential pre-requisite for successful delivery of improved outcomes.
- 5 Increasingly this is reflected in local strategic partnerships, associated health partnerships and LAAs. Wigan, Manchester, Salford, Bolton, Oldham and Rochdale are all neighbourhood renewal fund (NRF) areas. They have neighbourhood renewal strategies and floor target action plans (FTPs) in place (developed by the LSP) to reduce health inequalities as one of the six domains of deprivation. However, the national evaluation of neighbourhood renewal commissioned by the ODPM (now DCLG) identified health as the one aspect of deprivation where the gap between the most deprived and the rest is widening.
- 6 The success and effectiveness of health partnerships varies across the country because joint working is complex and presents unique challenges. The challenges to develop healthier communities and close the health inequalities gap are closely linked to other initiatives and shared priorities facing statutory organisations. Sustainable communities, safer and stronger communities, neighbourhood renewal and regeneration, environmental targets and economic development aspirations are all heavily inter-related.

- 7 In Greater Manchester, a complex conurbation adds to the challenge for statutory organisations. There are 10 PCTs, 10 local authorities and local strategic partnerships, 4 mental health NHS Trusts, an ambulance NHS Trust, a Strategic Health Authority, 7 acute and specialist NHS Trusts and 3 NHS Foundation Trusts. There are also many other agencies outside the statutory field which will play an increasingly important part, including private, community and voluntary agencies.

Background

- 8 Greater Manchester has one of the lowest life expectancies in the country. Despite progress in recent years, Greater Manchester as a whole is not projected to achieve the key public service agreement (PSA) targets (although some parts of the conurbation will meet some aspects). This includes:
 - by 2010 reduce inequalities in health outcomes by 10 per cent as measured by infant mortality and life expectancy at birth.
- 9 Having identified major challenges facing Greater Manchester in addressing health inequalities, audit teams worked closely with lead officers from local government and NHS bodies to agree and design an approach to reviewing arrangements to tackle health inequalities at a pan-Greater Manchester level. The work involves Audit Commission auditors and colleagues from the private audit firms (KPMG and PWC). The work was agreed by all audit suppliers because the risks that current arrangements do not secure value for money and will not deliver improved outcomes are relevant to all the audited bodies.
- 10 The unique audit approach took a whole system view and focused on how organisations work collaboratively to make a real difference. The final specification was agreed in January 2006.

Scope and objectives

- 11 The original objectives of the review were as follows.
 - To assess the effectiveness of the partnership arrangements for addressing current and future health inequalities and health needs across Greater Manchester, including through local strategic partnerships (Health). This included whether neighbourhood renewal funded sites and LAAs have complementary measures of success to those outside these initiatives and whether any wider lessons can be drawn.
 - To support the joint work programme of PCTs and local authorities in identifying specific actions required in addressing health inequalities. This included facilitating joint working and shared solutions in key priority areas.
 - To support improvement from activities within and between organisations in Greater Manchester by making recommendations for specific actions.

- To facilitate the development and use of tools to aid improvement.
 - To inform the auditors' requirement to provide a value for money (VFM) conclusion at each individual audited body. The findings fed into 2006 Use of Resources in local government and Auditors Local Evaluations in health bodies.
- 12 It is important to state that this was not a review of Public Health and its effectiveness but drew on the experience and contribution of these departments across Greater Manchester and more widely.

Audit approach

- 13 The approach took place in three phases. The first phase was broad in scope and sought to identify overall strengths and weaknesses across the conurbation to inform subsequent phases.
- 14 Phase two was constructed to examine the key points arising from the findings in phase one in more detail. A workshop approach to phase two focused on the issues that required joint or collaborative attention. Phase three drew together the action plans arising from the workshops and the main actions formed a presentation at a 'Greater Manchester Health for All – Everybody's Business' launch event on the 7 December 2006.
- 15 Two further Audit Commission cross-cutting reviews have taken place across Greater Manchester. These were on Out of Area Placements for Children, and on Integrated Social Needs Transport. Where appropriate, these reviews drew from each others' findings.

Management of the review

- 16 To ensure efficient management of the review each organisation agreed to nominate a colleague to represent their sector at an external reference group. The External Reference Group (ERG) was mandated to agree the specification of the review, provide a conduit to other organisations and agree any reports. This approach, which departs from the more usual reporting lines to individual organisations, was crucial to ensuring that the review remained dynamic and was carried out efficiently. We are grateful to those who provided their time to this valuable arrangement.
- 17 The draft report was presented to the Health Leadership Network (HLN) (which has incorporated the ERG) on the 23 November 2006 and it is anticipated that any follow up work in 2008 will work through the HLN or any successor arrangement.

Current position

- 18 The review of health inequalities arrangements across Greater Manchester is now complete. Initial findings from phase one were presented during early to mid 2006.
- 19 Phase two picked up on the key issues through a series of workshops during the summer of 2006. These workshops raised the profile of health inequalities, enabled the sharing of some good and excellent practice and facilitated robust debate about how to address the issues raised in the initial review. Individual briefings were produced following each of these workshops. The detail of the attendance at the workshops and the proposals that emerged are outlined in the appendices of this report.
- 20 As a result of the momentum created by this review and the recognition by all audited bodies of the need to create a greater profile for the challenge, a conference was convened to share current thinking and action plans.
- 21 The 'Greater Manchester Health Inequalities – Everybody's Business' event was held on the 7 December 2006 and shared the main findings from the review alongside a number of other informative and powerful presentations. Included in this conference was a public pledge signed on behalf of all organisations taking part in this review. This pledge set a marker for all organisations to work individually and collectively together to address health inequalities as a priority.
- 22 This report pulls together the main findings from the review and actions that have been agreed. We have summarised these to form a set of main recommendations and have provided all the proposed areas for development in more detailed form in the appendices.
- 23 The main recommendations have been agreed through the External Reference Group (Health Leadership Network) and will form the basis of a follow up review which will take place in 2008.

Main findings

- 24 Whilst there remains a great deal to do, Greater Manchester is positioned better now to work together on tackling health inequalities for the wider population than at the start of our review. The speed with which findings have been shared and have informed current strategic thinking is testament to the commitment of all parties involved. There is a marked difference now from when we originally reported in early 2006.
- 25 The public pledge made on behalf of all the NHS Trusts, PCTs and local authorities in Greater Manchester alongside other key partners was a clear sign that organisations are taking this challenge very seriously and that the findings from the review are accepted. It also demonstrates that each and every organisation recognises that they have a role to play in this arena. From this position of strength Greater Manchester is well placed to improve collaborative effort amongst all partners.
- 26 Collaboration through joint working is moving in the right direction at a borough/city level and in some areas at a Greater Manchester level. This is demonstrated in some LSPs and health partnerships where many examples of good initiatives were available.
- 27 There is a wealth of information available and clear demonstration by many that Greater Manchester knows what the health inequalities are and where they are most prevalent.
- 28 At the start of our review, the Greater Manchester conurbation had neither a shared vision of health inequalities nor any shared actions to narrow the gap. There was a lack of ownership in recognising the Greater Manchester picture and the value of collaborative effort. The lack of progress in reducing the health inequalities gap points to the need for radical action to achieve significant change. Areas that need most attention are:
 - engagement with the voluntary sector;
 - improving the knowledge of the barriers facing diverse groups in accessing public services;
 - using the advice of public health directors more strategically and collaboratively;
 - the links between public health and commissioning decisions;
 - the limited attention given to mental health and the inequalities that exist in this field;
 - the uncoordinated use of data analysts to provide public health intelligence;
 - the limited challenge to this agenda provided by non-executive directors (NEDs), and members in their roles in cabinet, at board level and in scrutiny;
 - the limited progress in adopting corporate responsibility principles; and
 - sharing of good practice more widely.

Main recommendations – creating an Environment for Change

Recommendation – Health leadership

R1 Define the role of the health leadership network and its terms of reference.

- 29 The terms of reference for the Health Leadership Network should be defined and the role of the group more widely understood in the context of existing structures. The group should have mandated representation from all sectors and provide easy access to decisions on key health issues facing Greater Manchester as a whole. It should agree and provide monitoring of the high level health inequalities indicators and provide a cross-cutting link between all sectors to facilitate joint action and sanction. Individual members should be drawn from the key chief executive groups and sector partnerships. It is recognised that this group might be transitional but its key functions should be retained in any future structural changes so that a vision for a healthier Greater Manchester is retained.

Recommendation – Non-Executives and Members

R2 Ensure non-executive directors (NEDs) and members are equipped to challenge in a robust manner.

- 30 The key role of NEDs and members is to challenge organisation policy and decisions in order to maximise impact. The importance of this agenda is such that they should be afforded opportunities to understand health inequalities issues both within their local context and the Greater Manchester picture. These new opportunities and existing or revised induction programmes should be undertaken across sectors and include mental health dimensions, public health and diversity, as they relate to the gap in health outcomes.
- 31 In the light of the Local Government White Paper (Strong and Prosperous Communities), and its strengthening of the role of scrutiny, council members working in this field should be part of any training programmes.
- 32 All boards and, in particular, the boards of commissioning organisations should better equip NEDs and members with information to enable more robust challenge. This should include regular and meaningful information about successes and challenges of closing the health inequalities gap.

Recommendation – Policy decisions

R3 Policy decisions should be considered in light of their impact on health inequalities.

- 33 All policy decisions should consider their potential impact on health improvement and health inequalities. Papers to boards and decision making groups should assess any impact on health for local communities and/or staff groups (for example, by adding a standard section to prompt impact assessment). Undertaking this regularly will result in raised awareness and enable changes to be made at an appropriate point.

Recommendation – Public health and public health intelligence

R4 Use a well organised Directors of Public Health (DPH) group informed by public health intelligence at a Greater Manchester level to ensure strong public health principles are used in policy and commissioning decisions.

- 34 DPHs must work together to address Greater Manchester challenges and be a source of leadership and direction. Organisations should support the collaborative effort of DPHs. Impact across Greater Manchester will be greater if common issues are addressed jointly.
- 35 Ensuring that common issues are discussed at a Greater Manchester-wide level will help to ensure buy-in and action from senior policy makers. This should include the development of a Greater Manchester-wide public health reporting process and the identification of key groups and partnerships at sub-regional and regional levels through which to engage.
- 36 DPHs should share and make smarter use of public health intelligence. This should be through a more effective use of the existing analytical capacity. Organisations should support the development of a structured Public Health Intelligence network which is able to provide relevant information on the key issues affecting Greater Manchester. This resource must be focussed on the information needed to take decisions, especially commissioning decisions, and form the basis of performance management arrangements for monitoring success across Greater Manchester in delivering improved life expectancy and closing the health inequalities gap. Links to the Health Leadership group should be clear.
- 37 DPHs must be equipped to reinforce Greater Manchester delivered messages locally to ensure that agreements for action are reached more efficiently.

Recommendation - Commissioning

R5 Ensure capacity is available to engage in a wider range of commissioning activities.

- 38 Find a productive way for commissioning agencies to engage with providers to ensure that the learning, research and knowledge encapsulated within acute, specialist and mental health trusts are used to inform commissioning decisions.
- 39 Commissioning activities should extend to engaging both the research and university community and the voluntary and community sector. In the medium term, this will need financial investment in, and committed engagement with, the existing voluntary sector services infrastructure and consortium to facilitate improved engagement. Improvements in sharing of information between statutory and voluntary services will be crucial to helping both parties understand each others' needs better.
- 40 Ensure that commissioned activities to address health inequalities will work effectively in diverse communities by engaging with those communities. This should include working with the voluntary sector to connect with hard to reach groups and in designing and delivering services in imaginative and innovative ways.
- 41 Ensure that tendering arrangements that exist and are to be developed (with the advent of contestability in procurement) are streamlined in order to be more accessible to the local voluntary, community and small business sectors.

Recommendation – Corporate responsibility

R6 Embrace corporate responsibility to harness the power of the statutory sector through local procurement and employment in particular.

- 42 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.
- 43 All organisations should better understand and embrace the role of the corporate responsibility agenda and the impact successful delivery has on the well-being of the local community.
- 44 Support the set up and organisation of a virtual network to provide organisation leads in this area with support and advice in achieving the implementation of corporate responsibility principles.

Detailed findings

- 45 Across Greater Manchester we found a lot of good practice, and some excellent practice, at individual organisation level, and considerable skill and enthusiasm among all levels of staff. Awareness of health inequalities issues is becoming clearer and getting greater attention both nationally and locally. Developmental work has taken place in some areas across the conurbation and within individual organisations, and we wish to acknowledge this. There is too much to mention in detail in this report, but we recognise that all organisations have developed in some area of this agenda.
- 46 We included all organisations regardless of Neighbourhood Renewal Funding (NRF) or Spearhead¹ status in the review. Whilst it is clear that organisations that have NRF/Spearhead funding benefit from this added stream, many, though not all, of the initiatives appear to be short term. We would need to do further work to establish whether these initiatives are likely to be mainstreamed or complement a health inequalities strategy sufficiently. This status did confer a higher priority in these areas and possibly a greater recognition of the issue. However, inequalities exist in all areas of the conurbation, and some of the greatest and widening inequalities exist in non-NRF/Spearhead areas.
- 47 The associations that exist within the conurbation are also of considerable benefit and whilst at differing levels of development AGMA, the Association of GM PCTs, the Acute Chief Executive Forum, the Mental Health Network and Greater Manchester Centre for Voluntary Organisation (GMCVO), in particular, provide a strong basis for sector collaboration and the opportunities of intra-sector working at Chief Executive level. These groups are in a very strong position to provide joint influence and collaborative effort.
- 48 We concentrate in this report on issues that affect every organisation and where value will be added by working collaboratively.

Leadership

- 49 Individual organisations play different parts in developing the health inequalities agenda, and the extent to which leaders of organisations led this agenda varied. 'Health inequalities' was not a real priority for many organisations even though most were doing something to address it. This situation has changed dramatically over the last 18 months. All organisations now recognise that every one has a part to play in addressing health inequalities.

¹ The Government have set Public Service Agreement targets to address geographical inequalities in life expectancy, cancer, heart disease, stroke and related diseases. The targets aim to see faster progress compared to the average in the "fifth of areas with the worst health and deprivation indicators". Achievement of the targets will be assessed on the outcomes for this group in 2010. The local authorities and PCTs which make up these areas are the Health Inequalities Spearhead Group. The Spearhead group is defined on local authority data and consist of 70 local authorities that are then mapped onto PCT boundaries.

- 50 There was no Greater Manchester wide ‘vision’ for a healthier conurbation which set out the key priorities for the population into which all organisations had played a part. There was, however, a recently developed Public Health delivery programme which outlined a number of priorities. This was developed within the confines of the Association of Greater Manchester PCTs and the Directors of Public Health. It was not shared with other audited bodies at the time but has since become more widely owned as a framework on which to build.
- 51 The Health Leadership Network (HLN) now exists and its terms of reference are being developed to ensure that health continues to have prominence on the Greater Manchester scene. These arrangements are likely to change and adapt as plans for City Region structures develop.
- 52 It is imperative that health is represented in future conurbation arrangements as a key strand to provide continued impetus and focus.

Scrutiny and challenge

- 53 The role of non-executive directors (NEDs) and members was examined during the course of the review. Whilst, individually, many people in this role were keen to address health inequalities they were largely unsupported in this. Very little information on health outcomes, needs and analysis of inequalities was made available to the majority of NEDs and members to enable them to offer effective scrutiny and challenge. Information provided to many boards and cabinet meetings was scant and not designed to enable informed questioning.
- 54 A workshop held during Phase two highlighted that training of NEDs and members in the area of health inequalities does not take place routinely. The complexity of such an agenda requires ongoing and regular updating and this was not available.
- 55 NEDs and members are well placed to understand the issues facing their own neighbourhoods but were not facilitated to provide greater insight into the challenges facing their own organisations.
- 56 Health inequalities is a cross-sector agenda but opportunities do not naturally exist for health and local authority NEDs and members to meet jointly to discuss issues facing common areas.
- 57 Health overview and scrutiny committees (HO&S) clearly have a key role to play in the scrutiny of this agenda. But many HO&S committees find their time consumed in dealing with health service re-configuration and less on the major health issues affecting the population. Whilst health service reconfiguration is clearly a major value for money issue and requires scrutiny, much greater benefit could be derived by a consistent approach to using health outcomes as a way of driving this agenda. Wider public health issues are not regularly on the agendas of these committees.
- 58 Enabling members and NEDs to challenge effectively will ultimately lead to better use of resources and more sensitive decision making processes. An environment that welcomes challenge is stronger for it.

Policy decisions

- 59 Many policy decisions are taken on a regular basis throughout the public sector organisations that work for the population of Greater Manchester. We found limited evidence that these decisions are routinely taken in light of the impact they can have on the health of the population and the inequalities that exist. Many seemingly tangential decisions can often be amended to some extent to deliver some increased health benefit.
- 60 Good practice that could affect the health impact of policy decisions and facilitate shared solutions was rarely shared between organisations.
- 61 Building up a culture where decisions are not taken in isolation of their effect on other policies will ensure corporate processes invite constructive challenge, are open to scrutiny and are made within the context of a wider range of intelligence. Decisions made in this way will be more robust and are more likely to contribute to a wider range of corporate objectives, for example, regeneration, capital planning decisions, local recruitment policies, transport, cultural and environmental decisions.

Public health

- 62 The public health infrastructure in Greater Manchester is significant. There is a highly skilled and specialised workforce comprising ten directors of public health (DPHs). These posts are most often held between the PCTs and local authorities with a direct remit to address public health issues in their own borough. The size of individual departments that support the DPHs varies.
- 63 A public health network was in existence at the beginning of our review but this had had limited impact within the public sector at large and was not having the impact that such a network could potentially have. The lack of impact of the network meant that the opportunity for Greater Manchester-wide influence was being missed. For example, there was limited contact with the Association of Greater Manchester Authorities (AGMA) and Acute NHS Trust colleagues.
- 64 Each DPH produces a statutory annual report for their borough area. These documents are informative but are variable in style, content and emphasis. These valuable reports are not widely read in practice and do not noticeably influence commissioning decisions as a matter of routine.
- 65 By continuing to take a borough based perspective the DPHs miss opportunities to influence GM-wide strategy and become more widely influential. The limited resource of the public health arena was not being optimised.
- 66 DPHs take lead roles across GM for specific policy areas but this was not recognised by the wider community. The acute hospital sector in particular had little direct contact with DPHs.
- 67 The continued development and integration of the public health function across all sectors and the recognition of a unique set of skills and approaches will benefit Greater Manchester. A more inclusive and collaborative approach will facilitate better decision making and ultimately better use of limited resources.

Information and intelligence

- 68 The links between the Government Office (North West) (GONW), Public Health Observatory (PHO) and PCT level public health departments were also found to be variable. Some public health departments made greater use of the information available from the GONW and PHO than others. Very valuable information is available at many levels but limited use is made of such data.
- 69 Public health intelligence is also available from within a variety of other organisations across Greater Manchester. This information is also not widely shared between organisations or across sectors. Databases that hold information relevant to the health inequalities agenda exist but there is no common approach or consistency to making the most of what is available. Some organisations are re-inventing the wheel in developing their own systems of analysis.
- 70 Data analysis skills exist right across the conurbation but their capacity and output are often kept purely within individual organisations. A public health intelligence network does exist but this is in isolation from existing structures. It tends to form a support network which, whilst valuable for its members, has little direction or obvious link to performance against the priorities for Greater Manchester. There was no evidence of planning for, and developing, the data analyst workforce.
- 71 As part of phase two of the study, the public health intelligence community came together to discuss the issues facing them. The richness of discussion, proposals put forward and the extent of the information available to the organisations across Greater Manchester illustrated the powerful opportunity and potential for better collaborative use of such data.
- 72 Improved management and use of the specialist and skilled capacity in all sectors from the public health intelligence community will enable those leading the health inequalities agenda to monitor progress better, understand where any important information gaps lie, and direct resources, using robust information.

Commissioning

- 73 Commissioning decisions are not influenced to any significant degree by the public health agenda, especially in the health sector. Health needs assessments are undertaken in a variable manner and there is little evidence that the assessments lead to robust commissioning decisions. There was some liaison between individual DPHs and commissioning teams. But this was at individual organisation level and no links existed between the Greater Manchester DPHs and Greater Manchester Directors of Commissioning to consider GM-wide public health issues and the health inequalities agenda. Consequently, opportunities are missed to consider commissioning decisions in the light of the GM wide picture.
- 74 Relationships between commissioners and the voluntary sector are patchy. The voluntary sector has infrastructures at borough level which enable two-way communication in these areas but little use is made of this consortium approach by PCT commissioners.

- 75 The recent establishment of the VSS infrastructure consortium provides a mechanism for realistic engagement although the capacity and resources do not exist to undertake the level of engagement required.
- 76 The VSS infrastructure is capable of reaching the entire voluntary sector, filtering the sector to identify issues by soliciting views from a variety of organisations and seeking the views of minority groups. The VSS structure can also support action to facilitate engagement between public sector and voluntary providers, yet insufficient use is made of these valuable attributes.
- 77 The voluntary sector across Greater Manchester is varied and diverse and it is this very diversity which could provide public bodies with a rich stream of intelligence and access to 'hard to reach' populations – many of whom are the very populations with the greatest health inequalities. Relationships at borough level vary considerably and are developing, but the voluntary sector is not used on a GM wide basis to inform service design or delivery.
- 78 During the review it became clear that engagement between voluntary sector bodies and the health service is generally not well developed. Accessing the right people in PCTs is difficult for the voluntary and community sector as structures vary across all PCTs, commissioning priorities are sometimes unclear and tendering arrangements are complex. Some voluntary and community sector groups cannot hope to bid for services or be involved in their design as their entire resource could be used up in doing so. As a result insufficient use is made of the expertise available in the voluntary sector.
- 79 There were many examples where there was a lack of dialogue in practice between commissioners and other bodies. There is no forum for PCT commissioners to engage with acute and mental health providers outside the tensions of the contracting framework. As a result the expertise that exists in these organisations does not contribute systematically to strategic service development or service review. Equally the commissioning of services is not well informed by research available locally. Universities are not routinely commissioned to undertake local research to inform decisions. This was disappointing given the availability of research skills so close by.
- 80 A wider range of activities for commissioners may prove challenging but the benefits will be significant. There is clear scope for more robust dialogue with providers, improved access to smaller community and voluntary groups, the use of a wider range of research skills through better use of university capacity, public health expertise and data analysis. Together these will help to deliver services that are more sensitive to need and that will ultimately improve health and life expectancy in Greater Manchester.

Corporate responsibility

- 81** Corporate responsibility should be a very important part of all public sector agendas. However, we found that on the whole this concept was poorly developed and was not widely understood. Where it was well understood, organisations could demonstrate the impact that their decisions were having on the community they serve. For example, the use of London based firms was questioned by one organisation. The support to a local business to enable them to meet NHS supplies standards and the provision of subsidised travel for hospital staff and local recruitment policies were other examples of activities that affect the local community by using the power available to the NHS in particular, as large employers and procurers of goods and services.
- 82** The 'corporate citizen' workshop highlighted the range of skilled and enthusiastic people who are keen to support the development of this important agenda. Maintaining a support network for those with a lead responsibility in this area in their organisations is crucial in promoting effective practices from within and outside Greater Manchester. Lead people need to have the 'headroom' to enable them to co-ordinate the wide range of activities such an agenda encompasses, rather than just being a role attached to their day-job.
- 83** The Sustainable Development Commission was delighted to be invited to speak at the 'corporate citizen' event, along with a range of other speakers. It was the first time that they had been asked to address a group of health service staff. The workshop highlighted that there is a wide range of activity being undertaken on this agenda, but more can be done to embed this in the way that organisations behave.
- 84** The health service and local authority sectors account for over £10 billions of spend across the conurbation. Even small changes in the way that money is used and channelled can potentially have a considerable impact on the lives of the people living in Greater Manchester. The development of a culture of corporate responsibility will lead to those resources being used more sensitively to help save energy, reduce waste, provide local employment and facilitate local organisations to be fully engaged with their communities.
- 85** The Greater Manchester Health Inequalities launch event: 'Everybody's Business' held on the 7 December 2006 and the signing of the public pledge were clear signals to the population of Greater Manchester that change is required across Greater Manchester. The pledge showed not only the organisations' commitment to act, but also the willingness to be judged against it in the course of time. Speakers from organisations across Greater Manchester demonstrated their determination to ensure that this issue will remain a high priority.

The way forward

- 86** The actions and recommendations outlined in this report need to be addressed by individual organisations across Greater Manchester. It is expected that where actions warrant joint work, existing structures will ensure that action is taken. AGMA, Association of GM PCTs, the Mental Health Network, GMCVO and the Acute Chief Executives Forum should ensure that joint actions are carried forward. The Health Leadership Network will make sure that all public sector bodies are made aware of the recommendations, and it will establish arrangements to monitor implementation of them.
- 87** The nature of this audit report is unusual in that it is relevant to, and addressed to, a large number of organisations across Greater Manchester. The actions are equally relevant to all organisations, although some may consider some actions to be more of a priority than others. This is realistic, but each organisation should be responsible and accountable for making progress in each of the areas outlined. Failure to put in place arrangements to implement the actions will result in a hugely missed opportunity from the momentum and commitment built up. It would also fail the people of Greater Manchester.
- 88** The actions outlined here will go a considerable way in creating an environment to bring about change. Organisations will also have other plans and agreed actions to tackle health inequalities. In recognition of that, how the actions required are effected is left for organisations to address as appropriate to their circumstances and their wider business plans. However, the actions outlined in this report are designed to support already existing priorities, and need to be dovetailed with them.
- 89** We have agreed to follow up the review in 2008, and auditors will look for evidence from key individuals and organisations across Greater Manchester with a responsibility for ensuring that recommendations are acted upon. At the December conference we described what our report might look like in 2008. The key points are outlined below:
- big issues monitored by a joint lead health group;
 - well informed and equipped NEDs and members;
 - Health Overview and Scrutiny fundamental part of keeping on track;
 - fully functioning and integrated public health network;
 - well focused data and intelligence informing commissioning decisions;
 - a robust structure for engaging with the voluntary sector;
 - some radical changes in use of existing resources; and
 - corporate responsibility well progressed.

Appendix 1 – Phase 2 workshops

Table 1 Final plan for workshops

The following areas made up the series of activities and workshops in Phase 2.

Workshop/event subject	Who attended?	Purpose and outcome
Voluntary sector engagement 12 September 2006	Cross-sector – 50 +	To develop practical ways in which organisations can better engage with the voluntary and community sector. Attended by 50+ people this has resulted in a number of important actions aimed at make this difficult area of collaboration more effective.
Mental Health 17 October 2006	Cross-sector representation – 60+	To understand and develop solutions to practically make mental health more prominent in service delivery. 60 people interested in and involved with mental health attended a lively and wide ranging series of discussions.
Health Inequalities for non-executive directors, and councillors 31 October 2006	A range of non-executive directors and council members 70+	To explore Health Inequalities issues and the practical ways in which the group can influence organisational actions necessary. Attended by 70 NEDs and Members and others involved in scrutiny.

Workshop/event subject	Who attended?	Purpose and outcome
Information and Intelligence 31 October 2006	Data analysts from across Greater Manchester 25+	To explore the capacity issues facing data analysts across Greater Manchester and understand what needs to happen to develop and make better use of the skills available. Attended by major players in the world of Public Health analysis in Greater Manchester and beyond.
Role of Directors of Public Health 3 November 2006	Directors of Public Health 11	Explore the collective role of the DPHs across Greater Manchester. A very positive day attended by DPHs from all areas which culminated in actions designed to work collaboratively across Greater Manchester.
Corporate citizen 9 November 2006	Corporate citizen leads from the NHS and beyond 25+	To develop actions which ensure that organisations are able to incorporate Corporate Citizen principles within business plans. A series of very informative presentations about the importance of embracing corporate responsibility and its effect on health inequalities and more. Agreement that regular sharing of experience will help those tasked with ensuring this is embedded.

Workshop/event subject	Who attended?	Purpose and outcome
Autumn event Greater Manchester Health Inequalities - Everybody's Business 7 December 2006	Cross-sector 250+	A 'visioning' event for Greater Manchester. To 'launch' and advertise the work that individual organisations/partnerships are doing. A series of presentations sharing the Greater Manchester picture and strategy launches. Culminated in a public pledge by organisations to work together to make a difference.

Appendix 2 – Detailed issues arising from workshops

Directors of Public Health workshop

Proposed areas for improvement	Lead responsibility
Develop a streamlined structure for the production of a public health report for Greater Manchester to reinforce local reports and improve the monitoring of the public health programme objectives.	Directors of Public Health
Ensure that greater efficiency and effectiveness is achieved by co-ordinating and collating Health Equity Audits.	Directors of Public Health
Identify key partnerships at neighbourhood, borough, sub-regional and regional levels engage with improving health, regeneration and improving quality of life at which DPHs must ensure that health inequalities inform decision making.	Directors of Public Health
Convene a date for Directors of Adults and Children’s social services and DPHs to meet to discuss together the Local Government White Paper (Strong and Prosperous Communities) which will ensure a rapid, co-ordinated and effective response to the implications.	Directors of Public Health
Clarify lead responsibilities across the whole range of projects and initiatives (not just the 16 projects) and ensure clear and mandated representation by one PCT DPH on behalf of the others.	Directors of Public Health
Produce a template for service developments/briefings so that DPHs have a consistent way of knowing exactly what is happening across the DPH network. Distribute using the new DPH website.	Directors of Public Health
When receiving updates regarding the Public Health Delivery Programme briefings should cover barriers and outcomes in addition to process issues. This will facilitate a more informed way of managing difficulties on individual programmes and DPHs being better informed about each of the work streams.	Directors of Public Health

Proposed areas for improvement	Lead responsibility
Develop mechanisms to identify issues on agenda of Greater Manchester-wide meetings coming up and ensure stakeholders are briefed. This will ensure that health inequalities issues inform decisions at policy and strategy level.	Directors of Public Health
Ensure that DPHs share and make smarter use of public health intelligence. This should be through a more effective use of the existing analytical capacity and information available to all organisations across Greater Manchester and wider (not just health).	Directors of Public Health
It is recognised that the challenge that alcohol consumption presents to the region is a key priority. It was thus agreed that a workshop on alcohol must be arranged. This presents an ideal opportunity to put many of the above issues into action, ensuring that stakeholders are identified, the public health intelligence community is used and communications issues are addressed as part of understanding the key issues and in preparation for a Greater Manchester Alcohol plan. A key outcome should be an agreed way forward in identifying what commissioning changes need to be made.	Directors of Public Health
Ensure DPHs are able to respond to the inception of Multi-Area Agreements to influence the agreements made appropriately and add a collective influence for Greater Manchester.	Directors of Public Health
Ensure that ‘impact on the health of the population’ is routinely part of cover sheets for any briefings to Association of Greater Manchester PCT meetings and influence Association of Greater Manchester Authorities (AGMA) and other policy/decision making meetings to do the same. This will ensure that Health Inequalities and public health implications of policy decisions are routinely considered and challenge on a wide range of issues.	Directors of Public Health
Prepare a communications strategy to improve links with SHA and influential external groups. This will help the DPHs to identify and prioritise their Greater Manchester-level work and be more effective in targeting their resources.	Directors of Public Health
Ensure DPHs are equipped to reinforce Greater Manchester delivered messages locally to ensure that agreements for action are reached more efficiently and that actions can then follow more rapidly.	Directors of Public Health

Voluntary sector workshop

Proposed areas for improvement	Responsibility
Better voluntary sector representation on local strategic partnerships.	LSPs
Stronger leadership on cross-sector engagement through improved relationships between the public sector and the voluntary sector infrastructure.	All
Improved voluntary sector infrastructure networking at Greater Manchester level to facilitate realistic engagement. The voluntary sector is set up to represent individual groups and this makes understanding and communicating with the sector very difficult. An infrastructure exists through the Voluntary Sector Services consortium where some organisations represent the whole or advise on voluntary sector input and this should be made use of to facilitate realistic engagement.	All
Investment in voluntary sector infrastructure for health inequalities at borough and sub-regional levels to enable improved engagement and communication with local organisations.	PCTs and LAs
Improved sharing of information on the commissioning cycle.	Directors of Commissioning
Ensure public sector staff have access to a directory of local voluntary sector services.	Voluntary Sector (GMCVO) with PCTs and LAs
Developing a shared set of standards on the required evidence base for commissioning services.	Directors of Commissioning
Production of a template for service specifications – so that voluntary sector providers know exactly what commissioners are looking for, streamlining and simplifying the tendering process to make it more accessible to the voluntary sector.	Directors of Commissioning
Producing a schematic of the planning and commissioning processes which will provide easy understanding of who to/how to contact in primary care and local authorities.	Directors of Commissioning

Proposed areas for improvement	Responsibility
Publishing and sharing plans, strategies and priorities.	PCTs and LAs
Publishing directories of contact information within statutory organisations.	PCTs and LAs
Holding a regular panel/workshop.	All

Mental Health workshop

Proposed areas for improvement	Lead responsibility
Commissioners and providers need to find ways to work together better to share joint skills and knowledge of mental health, to reflect the needs of local communities and understand better what needs to be commissioned.	Mental Health Network PCTs and MH Trusts
The voluntary sector can contribute to understanding the needs of local communities and to meeting these in imaginative and innovative ways. Commissioners need to work more creatively with the voluntary sector, particularly small providers, develop strong partnerships with robust communication frameworks, and, ensure a diversity of providers and commission from the most effective.	Mental Health Network Commissioners and Voluntary Sector
Commissioners should work more closely with universities to develop the evidence base for new ways of working. Universities need to work more closely with service users to ensure that their needs are central to developing improved preventative, primary, secondary and tertiary care.	Commissioners and Universities
Improve the impact of non-executive directors and members by providing a training programme across organisational boundaries covering health inequalities and public health, mental health and diversity.	All Trusts and LAs
Enable Health Overview and Scrutiny Committees to challenge more effectively through a similar training programme. This would enable Committees to take a more holistic and strategic approach and move towards scrutinising longer term health improvement.	Mental Health Network HO and S committees with LAs
Develop the link role with the Directors of Public Health to consider mental health in any work on long-term conditions, advise and support commissioners, demonstrate the impact of mental health on other outcomes and targets, show commissioners where they can add value, and identify how savings can be re-invested in better services.	Mental Health Network and lead DPH with Commissioners

Proposed areas for improvement	Lead responsibility
Deliver fair, accessible services to all communities by equipping staff with the ability to do so, and, monitoring the delivery of services to the communities served. Legislation requires monitoring of race, gender and disability as a minimum.	All
Using corporate powers and resources in ways that benefit social, economic and environmental conditions.	All

Corporate Citizen workshop

Proposed areas for improvement	Responsibility
Share the slides from the event widely.	Director of Health Improvement
Maintain the ‘virtual community’ that has met on this occasion as a communication mechanism.	Corporate Citizen Leads
Share sources of advice and support available and experience of utilising them.	Corporate Citizen Leads
Highlight Regional (ie North West) structures available to support the GM effort (eg NWRDA).	Director of Health Improvement
Provide a focal point for key stakeholders to develop their response.	Corporate Citizen Leads
Maintain focus in areas where there is already collective commitment (eg collaborative procurement hub).	Corporate Citizen Leads
Support and promote the Sustainable Development Commission in further developing their systems to operate as a portal for accessing support and advice.	Corporate Citizen Leads and Director of Health Improvement

Public Health Intelligence workshop

Proposed areas for improvement	Lead Responsibility
To ensure collaborative public health work across Greater Manchester has a strong public health intelligence component.	Director of Health Improvement
To support public health intelligence analysts in PCTs and local authorities by effecting links between them and supporting the sharing of skills and best practice.	Director of Health Improvement
To develop a training and development programme for health intelligence analysts.	Director of Health Improvement
To describe and support the relationship between existing sources of collaborative based information, and to ensure these develop in such a way as to be rooted to local health intelligence structures.	Director of Health Improvement
To provide a forum for developing a collective opinion on the requirements and specification for North West-based work, thus ensuring work undertaken at regional level is rooted to local priorities.	Director of Health Improvement
To describe and support the future joint working relationships between health and local authorities at individual LSP and collective (AGMA) level in Greater Manchester.	Director of Health Improvement
The public health intelligence network co-ordinator should be formally accountable to the Director for Health Improvement for the Association of GM PCTs, hosted by Ashton, Leigh and Wigan PCT but would work between the Association of PCTs and the AGMA Research officers' network to support the achievement of more integrated working at local and regional level.	Director of Health Improvement

Appendix 3 – Action plan

Page No.	Recommendation	Priority	Link to evidence	Link to relevant standards	Positive outcome expected (savings, reduced risks, better value for money)	Consequences of failing to implement recommendation	Cost of recommendation (where significant)	Date reported to the Board	Officer responsible	Implement by when
11	R1 Define the role of the health leadership network and its terms of reference.	High	Interview and documentary evidence confirmed a lack of 'vision'.	C8 C22a,c D4	Improved decision making in light of health outcomes and better use of resources.	Lack of strategic direction and health focus.		To External Reference Group on 23 November 2006	All	Early 2007
11	R2 Ensure non-executive directors (NEDs) and members are equipped to challenge in a robust manner.	High	Interview and workshop evidence confirmed a lack of confidence to challenge this issue.	C8 C22a,c	Improved decision making in light of health outcomes and better use of resources.	Poor use of challenge and scrutiny; decisions go unchallenged.		To External Reference Group on 23 November 2006	All	Summer 2007
12	R3 Policy decisions should be considered in light of their impact on health inequalities.	High	Documentary evidence confirmed a lack of regular consideration of the impact of decisions on health inequalities.	C8 C19 C22	Improved decision making in light of health outcomes and better use of resources.	Policies are implemented without regard to effect on health inequalities gap.		To External Reference Group on 23 November 2006	All	Ongoing.

Page No.	Recommendation	Priority	Link to evidence	Link to relevant standards	Positive outcome expected (savings, reduced risks, better value for money)	Consequences of failing to implement recommendation	Cost of recommendation (where significant)	Date reported to the Board	Officer responsible	Implement by when
12	R4 Use a well organised Directors of Public Health (DPH) group informed by public health intelligence at a Greater Manchester level to ensure strong public health principles are used in commissioning decisions.	High	Interview evidence and workshop confirmed the value added of working collaboratively.	C22b D5 D8a D10a,b	Improved decision making in light of health outcomes and better use of resources.	Poor use of skilled expertise and duplication of knowledge which fails to direct decisions in use of resources.		To External Reference Group on 23 November 2006	All	Ongoing.
12	R5 Ensure commissioning capacity is available to engage in a wider range of activities to inform commissioning decisions.	High	Interview and document evidence confirmed the continued weak link between a number of parties and the commissioning function.	C19 C22 D8a D10a,b	Improved decision making in light of health outcomes and better use of resources.	Weak commissioning decisions made with little regard to impact on health inequalities.		To External Reference Group on 23 November 2006	All	Ongoing.

Page No.	Recommendation	Priority	Link to evidence	Link to relevant standards	Positive outcome expected (savings, reduced risks, better value for money)	Consequences of failing to implement recommendation	Cost of recommendation (where significant)	Date reported to the Board	Officer responsible	Implement by when
13	R6 Embrace corporate responsibility to harness the power of the statutory sector in local procurement and recruitment in particular.	Medium	Interview evidence and workshop activity highlighted variable progress.	C8 C22	Improved decision making and better use of resources.	Lack of progress in using public sector resources for the benefit of the community. Poor use of resources.		To External Reference Group on 23 November 2006	All	Ongoing.