

# Health inequalities in Scotland

Views of community planning and  
health professionals



 AUDIT SCOTLAND

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## 1. Introduction and Method

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### Introduction

- 1.1 Audit Scotland is undertaking a national performance audit to assess how well Scotland is addressing health inequalities. As part of this, they appointed us - ODS Consulting - to undertake a series of focus groups with community planning and health professionals on how effectively health inequalities are being tackled in their local areas. The research took place in June 2012. This report sets out our findings from these focus groups.
- 1.2 Audit Scotland has defined health inequalities as '*Differences in life expectancy and health problems that people in different groups experience*'. The audit includes behaviours (such as substance misuse, smoking or lack of physical activity); conditions (such as mental health or cancer); and early years issues (such as healthy birthweight and breastfeeding).

### Method

- 1.3 Twelve local authorities and eight NHS boards were identified by Audit Scotland and invited to take part in the research<sup>1 2</sup>. Audit Scotland wrote to the Chief Executive of each council and each NHS board to inform them of the research and the wider national audit. In all 12 local authority areas, we invited the Community Planning Partnership (CPP) manager and the manager from the corresponding Community Health Partnership (CHP) to attend a focus group. Two groups were held - one in Glasgow and one in Edinburgh.
- 1.4 In six of these local authority areas<sup>3</sup> we also invited frontline health professionals to focus groups in their local area. Focus group discussions took place in four of these authorities, and a series of telephone interviews were undertaken in two authorities, where the short timescales did not allow a group to be arranged. Two discussions took

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<sup>1</sup> The local authorities identified were Aberdeenshire; Argyll and Bute; City of Edinburgh; Falkirk; Fife; Glasgow City; Orkney; Renfrewshire; South Ayrshire; Stirling; West Dunbartonshire; West Lothian.

<sup>2</sup> The NHS boards were Ayrshire and Arran, Fife, Forth Valley, Grampian, Greater Glasgow and Clyde, Highland, Lothian and Orkney.

<sup>3</sup> These local authorities were Aberdeenshire; Argyll and Bute; Fife; Glasgow; Orkney; and Renfrewshire.

place with CPP and CHP managers (one in the East and one in the West).

- 1.5 The main aim of the focus groups with CPP and CHP managers was to hear their views on how well organisations were tackling health inequalities in their area through partnership working and, in particular, whether there was clarity about roles and responsibilities; how they targeted resources; performance management; accountability; and the impact of national policies.
- 1.6 Eight managers from Aberdeenshire, City of Edinburgh, Falkirk, Fife, Stirling and West Lothian met in Edinburgh, and nine managers from Argyll and Bute, Renfrewshire, South Ayrshire and West Dunbartonshire met in Glasgow. A representative from Orkney CPP was also interviewed by telephone.
- 1.7 Of the 17 managers who took part in these discussions, eight were from CHPs and nine from CPPs.
- 1.8 The main aim of the focus groups with frontline staff was to examine the enablers and barriers to reducing health inequalities. We also discussed partnership working; measuring progress; and awareness and engagement of those with the most significant health problems.
- 1.9 In total, 46 frontline staff were involved in discussions. They came from a wide range of backgrounds:
  - 11 staff working in addictions services (including alcohol and drugs misuse and smoking);
  - 11 staff working in health improvement and health promotion;
  - 7 staff from community projects or voluntary organisations;
  - 6 staff working in early years or youth health (including dental health and family centres);
  - 5 hospital based nurses (including a cardiac rehab nurse; a midwife and an occupational therapist);
  - 4 community based nurses (including health visitors and breastfeeding coordinators); and
  - 2 other staff (a speech therapist and a staff member from a day centre for older people).

- 1.10 Focus groups were selected for this research as they are particularly useful for in depth exploration of perceptions, attitudes, feelings and opinions. Focus groups also allow peers to come together and share ideas and experiences.
- 1.11 A discussion guide for each group was designed by us in conjunction with Audit Scotland. The guides were designed to ensure that the two hour discussion was participative. The discussion guides are included - for CPP and CHP Managers (Annex 1) and for frontline staff (Annex 2).

### **Notes on the findings**

- 1.12 The following chapters present the findings from the two focus groups with CPP and CHP managers and the discussions with frontline staff. Verbatim quotes are included to illustrate key points. We agreed with participants in advance that their comments would not be attributed to them directly.

## 2. Focus groups with CPP and CHP managers

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2.1 This chapter explores the views of CPP and CHP managers, drawn from the views expressed during two focus group discussions and one telephone interview.

### The definition of health inequalities

2.2 Initially, a number of CHP managers expressed concern about the language of health inequalities and that the term could mean different things in different places. For example there was 'equality of access' where everyone had equal access to services and 'equality of outcomes' where, for example, everyone had the same life expectancy. These were quite different.

2.3 For the purposes of the focus group discussions, the participants agreed to use the definition provided by Audit Scotland.

### Roles and Responsibilities

2.4 A discussion on roles and responsibilities was an important element of the focus groups with CPP and CHP managers. This covered the role of:

- CPPs and their Single Outcome Agreements;
- CHPs;
- General Practitioners (GPs); and
- the Scottish Government.

### *The Role of CPPs and the SOA*

2.5 In some cases, the CPP was seen as having been a driving force bringing partners together effectively. For example:

- a thematic group in one CPP brings together a wide range of organisations to focus on tackling health inequalities, with a particular focus on alcohol misuse;
- one CPP was seen to have taken a particularly strong role in targeting action on health inequalities on particular groups of people within the area based on identified need;
- more generally, CPPs had helped to engage a wider range of partners in tackling health inequalities than had previously been the case;
- there had been some shift in resources (for example towards work with children and families); and
- in one area, it was felt that the CPP was making the CHP more accountable and providing a greater political and community overview of health issues.

- 2.6 However, there were also concerns expressed that in some cases the CPP focused on small dedicated budgets (for example, the resources that had previously been allocated by the Scottish Government through the Fairer Scotland Fund) rather than mainstream budgets. It was acknowledged that generally there had been little or no progress in redirecting mainstream budgets.
- 2.7 Also, there was some frustration that although tackling health inequalities is being promoted within CPPs and through their strategic frameworks, other 'non-health' agencies need to take more ownership of this issue. However the need for clear roles and responsibilities is highlighted in the following quote.

“When health inequalities is described as ‘everyone’s business’, there’s a danger that it can become ‘nobody’s business’.”

CPP Manager

- 2.8 There was considerable discussion about the impact of the Single Outcome Agreement (SOA) and the different ways in which health inequalities are reflected in this document. It was evident that there was a wide variety of approaches taken. These included:
- an area where the focus of the SOA was on the determinants of health (such as employability; safety; and parenting) rather than on health inequalities themselves;
  - an area where a clear and explicit outcome in relation to health inequalities was contained in the community plan, as well as the SOA;
  - a number of areas where the SOA contains particular measures drawn from the national ‘basket of indicators’ – although many of the indicators used are related to the universal health of the population rather than health inequalities (or ‘closing the gap’); and
  - an increasing trend for SOAs to focus on a much narrower range of key priorities than in the past – where health inequalities are not named among the key priorities, this can impact adversely on the focus placed on health inequalities.

### *The Role of CHPs*

- 2.9 Generally, managers thought that the CHP was seen as delivering ‘health services’ – while the CPP was seen as tackling a number of the determinants of health. The CHPs were seen to have significant budgets which were substantially focused on acute and clinical services, rather than tackling health inequalities.

“In my area the CHP is seen as being clinically dominated – their way of working in partnership is diminished by that.”

CPP Manager

2.10 Participants in the focus groups identified a clear tension for the CHPs in terms of the outcomes that they were expected to deliver. On the one hand, CHPs were driven by the HEAT targets<sup>4</sup> for which the NHS was accountable to the Scottish Government. The HEAT targets were seen, in the main, to be universal or whole population objectives, rather than objectives which would reduce health inequalities. On the other hand, CHPs had some local accountability for successful delivery of the SOA. However, it was generally felt that the accountability to the Scottish Government had to be (and was) given priority over the looser accountability for delivery of the SOA. This was compounded by the fact that the CPP was not a corporate body.

### ***Role of GPs***

2.11 Although some individual GPs were seen as committed to tackling inequality (usually because of ‘social conscience’ and personal experience), generally they were seen as not interested or engaged, nor, in many cases, did they recognise that health inequalities were part of their role.

2.12 Where GPs have been successfully engaged this has tended to be dependent on the interest of the individual. For example, in one area, they have been working to take diagnostic services out into community settings. This has been developed based on the level of support from local GPs rather than the level of need. Similarly, early decisions about Keep Well had been developed ‘opportunistically’, based on where support from GPs could be gathered and that this had led both to a ‘patchy’ take up and a lack of service in some areas with the greatest health inequalities.

“GPs are only switched on to the inequalities they get paid directly for.”  
CHP manager

2.13 It was generally agreed that GPs were not engaged strategically. And it was felt that there was no vehicle for engagement with GPs at a local level. Some managers felt that it would be useful if joint planning of the location of GPs surgeries could be developed so that access in the areas with the greatest health inequalities could be improved. But, at present, GPs made decisions about where surgeries would be.

2.14 The participants in the focus groups had some good experience of ‘social prescribing’. Put simply, this involved GPs giving ‘prescriptions’ for physical exercise or healthy eating courses rather than for drugs. However, the early good experience tended not to be sustainable and to

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<sup>4</sup> These are the NHS in Scotland’s annual national performance targets which reflect Scottish Ministers’ priorities for the health portfolio.

last only as long as GPs were incentivised and mainstream resources were available to support access to services following prescription.

- 2.15 Some managers felt that even when GPs do see health inequalities as part of their everyday work, they generally have a limited understanding of how to tackle health inequalities in their local areas. For example, GPs may have limited understanding of groups that do not attend their practice and are least likely to use health services.
- 2.16 The general view was that GPs had not 'bought in' to a preventative approach. However, the point was also made that given that health inequality was not the sole responsibility of the health service, it would be true to say that other groups of professionals (such as teachers) had not bought in to prevention either. And it was a pity that the current review of health and social care did not encompass leisure and other aspects of the wider determinants of health.
- 2.17 There was a strong sense from the managers that GPs should have a greater role in the health inequalities agenda. It was suggested that this could be supported at a national level by incorporating tackling health inequalities in GP contracts and performance measurement.

### ***Role of Scottish Government***

- 2.18 The Scottish Government had played an important role in legislation – for example the ban on smoking in public places and the proposed minimum pricing of alcohol. Managers felt that it would be useful if the Government also provided more incentives for eating healthy food (for example through a tax on 'junk food').
- 2.19 But the HEAT targets are seen to have created a problem in relation to partnership work. The HEAT targets are (understandably) the main focus for CHPs – as their direct line of accountability is to the Scottish Government. There was a view that these targets were unhelpful in relation to health inequalities. A large proportion of the HEAT targets relate to universal services, with a very limited number of more recent targets containing a health inequality aspect. It was felt that they did not include the important issues – because they are hard to measure. There was also a sense that a lot of energy is 'diverted' to focus on achieving HEAT targets.
- 2.20 Managers felt that there may be a role for the Scottish Government to bring the HEAT and National Performance targets closer together. As part of this it might also be possible to align GP targets with the health inequalities agenda.
- 2.21 Managers commented that since the 1970s the gap in health equality had widened substantially. Equally Well was seen as being 'unobjectionable' but unlikely to have a major impact on health

inequalities on the ground. Managers noted that they most often used Equally Well as a reference document – for example when they were making applications for funds.

- 2.22 Interestingly, some managers equated the Equally Well strategy with the Equally Well Test Sites and expressed some concern that any lessons from the Test Sites may not have been learned. Some felt that the Test Sites had helped re-design services with organisations working together better than before. Others were unimpressed by the progress made in their local Test Site.

“The Test Site was not doing anything special or different – expectations are widely out of synch with what could actually be delivered.”

CHP Manager

- 2.23 Concerns were expressed that good practice from pilot or one-off projects seldom transferred to the mainstream. For example, a ‘social prescribing’ pilot, through which GPs referred patients to physical activities seemed to have had positive results. But the project ceased once the agreed funding ended and was not replicated.

- 2.24 Some CPP managers felt that the Scottish Government has done a lot of positive work to drive the health inequalities agenda, but that they now need to leave CPPs to ‘get on with it’. In other areas there was support for the National Performance Framework and the arms-length support that has been available from the Scottish Government. This has helped with the process of effectively focusing on local needs.

- 2.25 There was some concern among managers that different parts of the Scottish Government sends “conflicting messages” and that there needs to be more joining up at the national level.

“There is a real push for integration at the local level but at the national level there are still silos.”

CPP Manager

- 2.26 There was also concern that the Government was looking for change within the three year SOA cycle, and that health inequalities need a long term approach and that it may take generations to make substantial progress.

“The Government need to be able to say that ‘there are some things that we are not able to fix quickly – so we will concentrate on things that will make a difference, like job readiness, education and early years’.”

CHP Manager

- 2.27 It was noted that tackling health improvement locally was not helped by the Government’s decisions to maintain more accident and emergency

hospitals than planned. This significantly reduced the resources available for tackling health inequality.

## Partnership working

2.28 Although health inequality was seen as an area for joint work, it was often noted that:

- joint work focused on individual projects, rather than 'mainstream expenditure';
- health services were sometimes expected by other partners to deliver all health outcomes (although this was felt to be becoming less common);
- joint work was often better in rhetoric than in bringing about real change on the ground; and
- joint work can lead to duplication rather than synergy.

2.29 Generally the CHP was felt to be well integrated within the CPP – and in one case was described as 'the health delivery arm of the CPP'. CPPs were felt to have brought a focus to link strategies and work through agreed outcomes. It was felt that there had been reasonably strong 'buy in' from the organisations involved in community planning.

2.30 However, there were examples of the CPP and the CHP not working in partnership and ultimately duplicating services. For example, in one area, it was felt that the CPP and the CHP tended to run on parallel – but not connected tracks – and this led to frustration. There is relatively good integration at local level. But this is seen to fall down at a local authority wide and NHS board level. Lines of accountability for the CPP and CHP are different, with the CHP reporting to the Scottish Government. This has led to poor co-ordination.

2.31 Local leadership and 'champions' in each partnership for tackling health inequality were seen as important. One CPP is currently working to establish local health champions across all partners. They are also working on creating a better system of priority based budgeting and will be able to track spending. Ultimately they are looking to bring about a shift in mainstream resources.

## Priorities and Targeting

2.32 In one area, local public health networks considered local priorities, which were fed in to the decision making process so that there was a balance between local and strategic priorities.

2.33 The managers discussed the benefits of targeting particular groups to reduce inequalities. While there was support for national initiatives, they believed that there were a range of specific local services that should be targeted to those in greatest need. Part of this would be to increase

awareness and access. It was generally agreed that those least likely to access services were the group with the greatest need for services.

- 2.34 However, there was disagreement. One CHP manager had a strong view that there was no evidence that targeting reduced inequalities and asserted that universal approaches (such as the ban on smoking in public places and minimum pricing on alcohol) had a more beneficial impact on those with the poorest health.
- 2.35 Generally targeting was informed by needs assessments undertaken by CHPs. This information was often supplemented with data from Keep Well (or Well North) using low income and poor health outcome domains from the Scottish Index of Multiple Deprivation (SIMD) to target resources. It was felt that the CHP profiles provided useful information - although it was noted that given the small numbers in some cases, care should be taken with small area statistics (for example the figures provided at ward level).
- 2.36 Rural areas found the datazones used in SIMD (which have an average population of 800 people) too blunt an instrument to assist with targeting, because deprivation is dispersed throughout small areas. Although there are some 'traditional' pockets of deprivation that are picked up in the SIMD, most of the rural areas have deprived households dispersed among them. Here, attempts to map (over time) those households suffering from health inequality were being undertaken. And here, as elsewhere, community development and community capacity building was seen as being an important way to engage people and communities that were least likely to use health services.

“Deprivation is found in households – not across whole communities. We need to work with individual households.”

CHP Manager

### Monitoring and measuring progress

- 2.37 Managers had mixed views on the measurement of progress. There was a general concern that there were multiple levels of accountability with partners reporting through their organisation's processes as well as to the CPP. It was felt that this often led to duplication and multiple reporting.
- 2.38 The managers told us that there is now a growing use of local research, forecasting and logic modelling. But managers questioned whether staff working in the area of health inequalities would have the skills to conduct a robust evaluation of their projects and programmes.

“We’re working towards a more evaluative approach – but there’s an issue of ensuring that we have a body of staff that have the skills for that type of work.”  
CHP Manager

2.39 In many cases it was felt there was still a focus on outputs, rather than on real change over time.

2.40 Some CPP and CHP managers commented that as they were not asked specifically for evidence of progress, then health inequalities were not being given sufficient priority.

“I’m not sure we’re being asked for meaningful evidence on health inequalities by the Scottish Government. And it doesn’t feel like it’s being given specific priority in my area.”  
CPP Manager

### Examples of good practice

2.41 We asked managers for examples of good practice in their areas. The main examples raised were:

- a rural health project that had successfully narrowed the health inequality gap through a community development approach;
- joint work on, and impact of, a health and homelessness project that had involved effective joint work and had made an impact for homeless people;
- the work that local public health networks had done to engage and work with local communities;
- a tele-health project which has allowed older people to live independently for longer in their own homes;
- a Tobacco Alliance which brought together a number of partners and had good results – especially in the most deprived areas;
- the engagement of local communities in the design and delivery of services;
- the ‘de-cluttering’ of the partnership landscape – focusing on community planning as a way of thinking rather than a structure; and
- the bringing together of community learning; employability and welfare advice into a one-stop shop, which has had good early results.

### 3. Focus groups with frontline staff

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- 3.1 This chapter explores the views of frontline staff, drawn from the views of 46 staff members expressed through four focus groups and nine separate telephone interviews.

#### Main health inequalities

- 3.2 We discussed the main health inequalities that staff were dealing with in each area. A wide range of inequalities were identified by frontline staff. Some were behavioural such as smoking; drug and alcohol misuse and lack of physical activity. Others were conditions, such as mental health, high blood pressure and cancer. There were also issues relating to early years, such as childhood obesity and breastfeeding.
- 3.3 Staff identified a strong link between deprivation and poorer health outcomes. There was concern about unemployment, particularly about cross-generational unemployment leading to a cycle of poor health outcomes for families and communities.
- 3.4 Staff also mentioned inequalities among different groups of people, such as minority ethnic people (including refugees), LGBT people and older people.
- 3.5 Staff from rural areas indicated that accessibility was also a key issue in terms of health inequalities. The time and distance involved in travelling to appointments or to access services in rural areas was seen to be a real barrier.

#### Priority given to tackling health inequalities

- 3.6 There were different views about whether tackling health inequalities were given priority in local areas. Some staff indicated that health inequalities were a high priority in their area. This was determined both by the number of initiatives set up to tackle inequalities and the attention given to the issue at managerial and strategic level. Tackling health inequalities was felt to have become an increasing priority for one local authority area where it was suggested that HEAT targets had helped to give inequalities a focus<sup>5</sup>.
- 3.7 Staff in one area suggested that tackling health inequalities was a low priority for the NHS and was also not a priority locally. It was seen as an 'add on'. This low priority was based on the perception that NHS

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<sup>5</sup> This was a different view from that expressed by managers. It leads us to wonder whether there was some confusion between focusing on particular health issues (such as healthy birth weight) through a universal approach and the tackling of health inequalities (such as closing the gap in birth rates between the most deprived communities and the overall population).

budgets were ‘highly skewed’ towards reactive care, rather than health promotion and anticipatory care.

- 3.8 It was suggested by staff in more than one authority that health improvement was often an area of budget cuts and efficiency savings. This suggested that tackling health inequalities was not a high priority for the NHS.

“We do what we can afford to do.”

Frontline staff member

### Influence of local and national strategies

- 3.9 Staff in most areas felt that documents such as the Single Outcome Agreement helped to put health inequalities ‘on the agenda’ and had helped to identify the issues to tackle. However, others felt that the community plan in their area included tackling inequalities as an overarching theme. Although this covered health inequalities, health was not always identified as a priority. They felt that while the rhetoric was fine, the practical steps for tackling health inequalities were not made clear.
- 3.10 Equally Well and Keep Well were identified as important national strategies. Staff with experience of one of the eight Equally Well Test Sites in Scotland felt that the Test Sites had allowed the development of new approaches. This had led to some good examples of how to tackle health inequalities. In one area, a lot of the work took place with children and young people using an asset based approach. This approach was felt by staff to have been successful.

#### Example

In one Test Site, a Mobile Alcohol Intervention Team (MAIT) came about as a response to underage drinking. A mobile unit could engage groups of young people to raise awareness of drinking alcohol and provide interventions that helped people understand the dangers of drinking. The MAIT project operates on a Friday night and targets young people under 25 years. Young people are referred to the service and this can be through the police, youth workers or community wardens. Staff from MAIT were able to have discussions with the young person about their alcohol consumption and to identify things that could make them safer.

- 3.11 Staff involved in the work of Equally Well which sought to ‘do things differently’ by establishing community based initiatives indicated that it would be unlikely for a health board to focus all of its work in this way – despite its successes.

“It will take a courageous health board to say ‘let’s abandon performance management targets and apply an Equally Well approach of letting people do what they think is best for the patient.’”

Frontline staff

3.12 Keep Well was also seen as a successful national strategy. In one area, it was suggested that Keep Well had become embedded into working practices – but there were concerns that it had not made a huge impact in terms of tackling health inequalities. This was because those that would benefit from the service lived in the most rural areas, making accessibility issues a consideration. In another area, although the staff commented on the ‘extra burden’ that Keep Well placed on staff workloads, it was felt to have made a difference in identifying new patients who could then benefit from services.

“Although I was critical of Keep Well at the start, it has been great. We are getting access to people who don’t usually come near us, but they get an invitation to Keep Well and through the lifestyle questions, you discover new patients.”

Frontline staff member

3.13 Generally staff felt that national initiatives had resulted in positive projects and approaches. However there were concerns that interventions were short-term with time limited resources. This made it very difficult to continue the activities and to build them into mainstream activities. In one area, there was some concern from staff that when the Keep Well programme had been rolled-out the initiative had been watered-down and would not achieve the same outcomes as had been achieved in the pilot.

3.14 There was some concern that when national programmes are ‘top-down’, local practitioners design projects to fit the particular initiative (and the funding available) rather than the identified local need.

### Partnership working

3.15 Staff had both good and bad experiences of partnership working. In general, partnership working was not seen to be consistent. In some cases, some partners were good at supporting and taking action, while others were not. An example was given of where a council was able to find money and resources and encouraged staff to get involved in a pilot for a major national programme to tackle health inequalities - but the NHS was unable to match these resources.

**Example**

In order to deliver the HEAT target on child healthy weight, a lot of work had to be carried out in schools. The NHS were able to work in partnership with Education Services to deliver sessions in schools, and in some cases, teachers delivered some of the work on behalf of the NHS. Education Services were able to offer free venues for undertaking these training sessions which made a huge difference to the health improvement team. A similar project was to be undertaken with support from Leisure Services – but did not get off the ground because free venues could not be sourced.

- 3.16 In one area, a refocusing of health and social care was felt to have brought about a change towards more positive partnership working.

“The integrated health and care board has helped create good partnership working, but even before (this board) clinicians and frontline staff worked well together.”

Frontline staff

- 3.17 Frontline staff from the voluntary sector suggested that the introduction of the Change Fund had required partnership working between the third sector, the NHS and the local authorities.

“The Change Fund has led to good partnership working. It has meant that the voluntary sector have had to work with the Council and the NHS.”

Frontline staff

- 3.18 However, overall the frontline staff from voluntary organisations felt that they were the ‘poor neighbour’ and that there was still a reluctance from statutory services to include them in information sharing.

“From a voluntary sector perspective, much of the work into tackling health inequalities goes by without being heard about – we often feel removed from partnership working.”

Frontline staff

- 3.19 Staff from statutory agencies in one area were clear about the importance of partnership working which involves voluntary sector organisations as they are more community based. They also stressed that third sector organisations can overcome the structural barriers that health partners face and can establish an initiative more quickly.

- 3.20 Some frontline staff from voluntary organisations felt that the emphasis on contracting and moving towards social enterprise was creating competition between third sector organisations that might inhibit partnership working.

3.21 Staff suggested that successful partnership working comes down to ‘who you know’ and that a lot of partnership working is based on personal relationships, local networking and word of mouth. This was viewed, in some cases, as a positive way of working, and an acknowledgement that often ‘partnership working works better when personalities get along’.

“Working together makes things easier. Local networking is very important.”  
Frontline staff

3.22 Yet, it could be frustrating for staff to have to rely on personal relationships to get work off the ground – and it could create problems when individuals who had built strong networks moved on from a job.

3.23 There were a number of suggestions as to how partnership working could be improved. These included:

- sharing information;
- GP referrals;
- improved communication; and
- avoiding duplicating services.

### *Sharing information*

3.24 Staff suggested that partnership working could be made much easier if there were systems in place to improve the sharing of information between partners. In one area it was noted that there are times when the NHS and local authority need to share information on clients, but the current IT system does not allow this to happen – creating additional workloads.

“Staff should be able to email a client’s assessment form, but the system is not confidential enough to be able to do it.”  
Frontline staff

#### **Example**

A pharmacist who is undertaking health checks as part of a community health based intervention is not able to email any information to the client’s GP. The information has to be physically printed off and taken to the GP surgery because there is no secure email. This creates more work for the pharmacist and gives them no incentive to continue to carry out health checks in the community.

### *GP referrals*

3.25 GPs were mentioned by frontline staff as ‘gatekeepers’ to patient information. Staff found that GPs did not often refer clients to their community based services. One participant suggested that GPs are driven by their business and costs which are ‘at odds with the rest of the health service’. Staff commented that it was time consuming and difficult

to have to then inform the GPs about local services to which they should refer patients.

### ***Improved communication***

3.26 Communication was thought to be a major issue in terms of improving partnership working. Staff indicated that they were frustrated at not having the time to find out what other work is going on, and the voluntary sector specifically mentioned being 'left out' of communication about new services. Staff believed that this resulted in 'missed opportunities' for partnership working.

3.27 It was agreed by staff that there needs to be more clarity and accountability around partnership working. Some staff suggested that it is not clear who is responsible for particular service delivery, what it is that is being delivered and the timescales involved. There was a need for more clarity over roles.

"Partnership working could be improved by having more time to find out about what others are doing, time to attend meetings and just knowing who else is out there and what they are responsible for."

Frontline staff

### ***Avoiding duplicating services***

3.28 It was suggested that there were 'overlapping agendas' between some local authorities and the NHS board operating in the area. Staff spoke of council staff taking on roles that were traditionally undertaken by the NHS. One example was a new ante-natal group that was set up by community education workers from a local authority. The focus of this group was educating mothers on breastfeeding. However, this is a job that is still being undertaken by nurses, creating duplication. Nurses also found that they were being asked to refer their patients to this council service.

"A lot of so called 'partnership' is just duplication."

Frontline staff

### **The impact of CPP and CHPs on partnership working**

3.29 Staff had mixed views on whether the CPPs and CHPs had made an impact on tackling health inequalities. For example, staff suggested that the CPP and CHP were too strategic and had responsibility for too many other issues for health inequalities to be a priority.

"The concept of the CPP is a good one, but the reality is that they are responsible for too much and therefore can't do anything efficiently. We are just one of 100 things they need to focus on."

Frontline staff

- 3.30 Some staff felt that the CPP is too distant from frontline staff and there needs to be better dissemination of CPP priorities and strategic approaches.

“Some practitioners and even managers don’t know what the CPP is – it’s too distant. What’s happening at the CPP needs to be filtered down more effectively, in whatever format.”

Frontline staff

- 3.31 In spite of CPPs generally having sub-groups or thematic groups dedicated to the topics of health and wellbeing, there were mixed views on how effective they could be. Staff said that by only meeting four times a year, they were not able to have a real impact.
- 3.32 There were examples however of where a number of partners came together as part of the CPP to highlight and tackle issues effectively.

**Example**

The Health and Communities sub-group of the CPP in one area has representatives from Social Work, Health, Education, the Voluntary sector, Fire and Rescue services, as well as older people, young people and carers from the community. This group were made aware that there had been a drop in the numbers of young people attending afterschool activities. Working together, they discovered that a change in the local bus timetable had meant that school children were not able to get home if they attended any afterschool activities. The sub-group were able to work with the local transport department to change the timetables so children could attend activities after school.

- 3.33 Where positive impacts had been made through joint working, it was suggested that this was down to the ‘right people in the right jobs’. There were examples of partners ‘coming to the table, but not doing anything’ as well as those who were notable in their absence from any joint working. In one area it was suggested that social work ‘were not at the table when they should have been’ and staff found that it came down to personal relationships and asking people ‘favours’ if social work input was required.

**Identifying need**

- 3.34 Often tackling health inequalities involves targeting resources at a particular group of people or geographic location. Identifying these individuals or areas can be challenging.
- 3.35 Staff acknowledged that statistical data on particular health issues can help decide where to target specific projects and outreach work. However, staff commented that often the data (specifically the NHS

Health Scotland Health and Wellbeing profiles) they receive are out of date and that they need to ‘pull in favours’ if they want to get any relevant statistics. Some staff have tried to ask GPs for information, without success.

- 3.36 Staff felt that client-facing staff – often people working in the community – had a better idea of what the issues were. For example – a local pharmacy that runs a needle exchange would see people every day and have a good idea who could benefit from additional services. The key is to establish projects in areas where people will use them.

**Example**

Accident and Emergency services in one area have been introducing alcohol brief interventions. These have also been taking place in GP clinics and antenatal classes. This includes a conversation between the health professional and the patient about the amount of alcohol they consume to establish whether this is hazardous or harmful. Then appropriate advice or a referral is undertaken.

- 3.37 Staff suggested that there needs to be more capacity building in the local community. This could be by training local community activists who know the local area. For example, staff from the voluntary sector had experience of training former heroin users to go out and speak to current users to discuss with them joining a methadone exchange programme.

**Enablers for tackling health inequalities**

- 3.38 The discussion focused on the factors that enable frontline staff to tackle health inequalities. The main enablers identified were:
- organisational leadership that allows staff to take risks and to try things;
  - staff with a ‘can do’ attitude and a will to make things work;
  - having the right type of people in the right jobs;
  - effective partnership working among public and voluntary sector partners;
  - effective engagement with the community and an understanding of needs from the community perspective;
  - flexibility in ways of engaging service users – for example taking services to people (rather than people coming to services); extending opening hours; use of telecare and video conferencing.

“We create more barriers for ourselves by making it difficult for people to access services, for example, you can have a GP appointment but you have to call between 8am and 8.30am.”

Frontline staff

- a robust legislative framework that promotes health - examples given were the ban on smoking in public places and minimum pricing of alcohol.

### Barriers to tackling health inequalities

3.39 The discussion then focused on the barriers for frontline staff in tackling health inequalities. The main barriers identified were:

- lack of funding – with a feeling that this had impacted particularly on health improvement and had also restricted trying innovative approaches;
- the lack of priority given to prevention and early intervention – the largest part of health expenditure is in the last months of a person’s life and if some of this could be used earlier in life, it would lead to a longer active and independent life for many people;
- a perception that roles were changed and that staff were required to take on more responsibility.

“You do get additional training, but now you find that once you would refer a client to another service, but now you’re the expert. Your responsibility grows.”

Frontline staff

- the reactive nature of the work – dealing with issues as they arise, rather than tackling the root cause of the problem.

“We do what we can afford to do; we have finite resources, that means we have to do short, sharp work.”

Frontline staff

- a target-driven culture – which staff felt impacted on the amount of time they can spend with patients, and one person commented that they felt ‘stifled’ by targets.

“A lot of the measuring, monitoring and paperwork that nurses are expected to undertake is a real barrier to spending time with patients.”

Frontline staff

- the lack of opportunity to record intermediate outputs or anecdotal feedback from service users;
- too much ‘short-termism’ and too much re-structuring and re-branding of approaches;
- a lack of understanding of the timescales for bringing about change.

“There are a lot of good things happening on the ground to tackle health inequalities but often people are looking for results too soon.”

Frontline staff

- particularly in rural areas, there were geographic barriers to accessing services.

“A trip to the islands where there are only two patients eligible to receive an intervention is hard to justify when there is a town on the mainland where there are 500 people who could benefit.”

Frontline staff

- stigma – particularly in small communities where ‘everyone knows everyone else’.

“If the alcohol counsellor is spotted coming off the boat and going to a particular house, then this can alienate people in the community.”

Frontline staff

- the location of services such as a rehabilitation unit.

“No one wants to have a substance misuse service in their own area, and GP practices don’t want to give accommodation to house a service like that, because it would mean that patients were coming to the surgery.”

Frontline staff

- awareness of services - not just for patients, but for staff knowing of other services which might be suitable.

“We undertook a mapping exercise of local services and I was surprised at the number of services I had never heard of before.”

Frontline staff

- the role of GPs - GPs were seen to have the potential to open gateways to other services for patients, but it was felt that, in fact, they seldom referred patients to other services.

## Measuring progress

3.40 The HEAT targets are the key objectives, targets and measures that the NHS must work towards to meet Government targets. HEAT targets were regularly mentioned as the key target that staff are working towards – although the number of relevant HEAT targets varied depending on the staff role. For example, one participant; a smoking cessation coordinator was working towards the national HEAT target, namely achieving 80,000 successful quits (at one month post quit) including 48,000 in the most deprived SIMD areas, over three years.

3.41 Unlike the views of CPP and CHP managers, staff suggested that HEAT targets were necessary to focus attention on particular issues that would otherwise not be a priority.

“Because of HEAT targets, services are now considering health inequalities.”  
Frontline staff

3.42 Staff indicated that they did collect monitoring data in terms of the **numbers** of people using their service – not least in relation to HEAT targets. Staff were able to talk about the number of interventions they had conducted and how this relates to their own targets and indicators. Many staff said that they collected information on the numbers of clients that attended their services and that ‘numbers are important to collect’ as they show progress has been made.

“We were to deliver alcohol interventions to 206 patients and we got 311.”  
Frontline staff

3.43 However, while there was considerable information about outputs, there was much less of a focus on outcomes – the changes that had been brought about in terms of health and wellbeing as a result of the interventions. Indeed, some staff commented that the requirements to measure progress had detracted from the focus of patient care.

“We are obsessed with measuring. Is it not better to know that there is a good quality programme that is targeted to the people who need it? Do we need to measure the quality of the interaction? We are a culture of over-measurement. It is a no-brainer to have a good quality service.”  
Frontline staff

3.44 Some services do offer their service users feedback forms to find out what they thought of the service provided. Others collected views from service users on any change brought about by the service. But it was felt that the services did not then do anything with the information collected – ‘other than file it.’

3.45 Some staff did question the relevance of collecting statistical data and indicated that the numbers were not very helpful if the difference the project made to the client could not be demonstrated. The problem was that there is no formal way of recording qualitative feedback. In terms of reporting information within the NHS, there is a strict format and it is mostly quantitative. Staff suggested that the NHS is not interested in softer information, even though the staff found that patients often want to tell their stories.

3.46 Staff agreed that there was value in collecting qualitative information from clients, but that this is not always easy, or appropriate to collect. It was thought that this was much easier to do this in the voluntary sector. NHS staff perceived that the voluntary sector had more freedom and experience to use social media, for example, as a way to record client views.

## **Annex One**

### **Discussion guide: Focus Group with CPP/CHP Managers**

# Audit Scotland

## Health inequalities audit

### Focus group discussion guide: CPP and CHP managers

Send 'flyer' and background information to all participants in advance of date of focus group.

#### 1. Background

Audit Scotland would like to find out how well health inequalities are being tackled in Scotland.

Facilitator explains their role and reminds the group of the purpose of the session and set out the ground rules (including that comments will not be attributed).

- Two focus groups with a range of CPP and CHP managers from across Scotland.
- Focused to hear views on partnership working; health outcomes; targeting resources; and what helps and hinders your contributions to tackling health inequalities in Scotland.
- Throughout the discussion, we would be interested to hear about any examples of good practice and ways you have found to overcome any problems. (Possibility of Audit Scotland following up some of these as case studies)
- Audit Scotland has defined health inequalities as
  - *Differences in life expectancy and health problems among different groups of people.*
  - *Including behaviours (such as substance misuse), conditions (such as mental health, cancer), and early years issues (such as healthy birth weight and breastfeeding)*

#### Roles and responsibilities

The first discussion is about the roles and responsibilities of different groups in relation to tackling health inequalities.

1. Thinking first of CPPs, what roles and responsibilities do they have in tackling health inequalities in their areas? To what extent is health inequality reflected in the Single Outcome Agreement (SOA)?
2. To what extent do a range of CPP partners play a role in tackling health inequalities (or is this seen to be the

responsibility of the NHS/ CHP)? And how well is the work of the CHP reflected in the SOA?

3. And are the roles and responsibilities of CHPs in tackling health inequalities clear?
4. How well do you think that GPs make a contribution to activities addressing health inequalities in your area? For example, to what extent is their work targeted at those in greatest need and to what extent is relevant GP activity captured in the SOAs?
5. What would you say is the **role of the Scottish Government** in tackling health inequalities?

### Partnership working

6. Is there a health inequalities thematic group (or similar) operating within your CPP structure? What organisations does this involve – and how effective do you think it is?
7. How well coordinated are the various strategies and activities to tackle health inequalities in your area? Are there any gaps or overlaps?
8. What problems or barriers, if any, do you experience in trying to coordinate the work of CHPs, CPPs and GPs to tackle health inequalities?
9. What successes has partnership working brought about? And what were the main factors behind these successes?
10. How could partnership working be improved?

### Identifying local priorities and those with the greatest need

11. How do you decide which health inequalities (eg drug and alcohol misuse, obesity, mental health and so on) should receive priority in your area?
12. How do you attempt to identify and target those with the greatest need in terms of health inequalities? What are the main barriers to identifying these people?

### Delivering services and monitoring cost effectiveness

13. How do you monitor progress towards addressing national and local health inequality outcomes?
14. To what extent is local funding targeted to take account of deprivation? Is there specific funding for preventative approaches, activities linked to HEAT targets, etc.? And to what extent are NHS and council budgets 'pooled' for activities for tackling health inequalities?

15. And how do you monitor local spending on activities for tackling health inequalities? How do you measure value for money or cost-effectiveness of your activities for tackling health inequalities?
16. Have any activities which were shown to be ineffective (or not cost-effective) been stopped? And are pilots that are shown to be effective built into mainstream activities?

### **National strategies and policies and accountability arrangements**

17. Thinking of the Scottish Government's policies and strategies for tackling health inequalities, what progress do you think is being made in achieving these?
18. How consistent and joined up would you say the various national strategies for tackling health inequalities are? (Eg, *Equally Well*, *The Road to Recovery* and so on.)
19. What impact do you think *Equally Well* has had?
20. How are you held to account for your performance in tackling health inequalities in your areas?
21. How effective are these accountability arrangements in improving the performance of CPPs and CHPs?
22. How well do you think your SOAs align with the national indicators? And does any lack of alignment cause particular problems?

### **Good practice and learning lessons**

23. How effectively do CPPs and CHPs share good practice amongst each other across Scotland?
24. Do you have any examples of good practice examples that have been adopted in other areas?

### **Any other success factors or barriers to success**

25. Are there any other success factors or barriers to tackling health inequalities which you would like to discuss?

Thank participants and close.

## **Annex Two**

### **Discussion guide: Focus Group with Frontline Staff**

# Audit Scotland

## Health inequalities audit

### Focus group discussion guide: Frontline staff

*Send 'flyer' and background information to all participants in advance of date of focus group.*

#### 1. Background

Facilitator explains their role and reminds the group of the purpose of the session and set out the ground rules (including that comments will not be attributed).

- Focus groups with 'frontline' staff involved in tackling health inequalities in six CPP areas – from NHS; CHP; council and voluntary organisations.
- Focused to hear views on partnership working, identifying those with greatest need, access to services and what helps and hinders your contributions to tackling health inequalities in Scotland.
- Throughout the discussion, we would be interested to hear about any examples of good practice or ways you have found to overcome any problems.
- Audit Scotland has defined health inequalities as
  - *Differences in life expectancy and health problems among different groups of people.*
  - *Including behaviours (such as substance misuse), conditions (such as mental health, cancer), and early years issues (such as healthy birth weight and breastfeeding)*

#### 2. Introductions

Each participant introduces themselves and their organisation; explaining briefly their role and the service that they deliver.

#### 3. Health inequalities

- What are the main health inequalities in this local authority area?
- What priority do you think tackling health inequalities is given, compared to other priorities in the area?
- Is health inequality a priority in key local strategies and plans (such as the Single Outcome Agreement)?

- What influence do you think that national strategies like Equally Well and programmes like Keep Well have had?

#### **4. Partnership working**

- How well do councils, health boards and other organisations work together in your area to tackle health inequalities?
- Is there shared agreement on outcomes; plans; identification of resources; sharing skills and resources?
- How could partnership working in your area be improved?
- What impact do you think that community planning partnerships and community health partnerships have had on joint working to tackle health problems and their causes?

#### **5. Delivering services**

- How do you know whether you are making progress through the joint efforts to tackle health inequalities? Probe on targets; indicators; intermediate outcomes; reliability of data.
- Have you examples of successful services being 'rolled out' or 'mainstreamed'? Are lessons learned from successful services and do they inform future service delivery?

#### **6. Enablers and barriers**

*This session would work in small groups – using post-its as an aide to gathering the most important issues.*

Participants are asked to list on separate post-its up to three things that have helped attempts to reduce health inequalities and three things that have got in the way.

The facilitator 'sorts' responses and identifies general agreement (or wide divergences) in the responses. If necessary, use 'dot-voting' to identify the most significant enablers and barriers.

Discuss any issues that might have been expected to be raised that were not – for example:

- Resources- including the impact of reduced resources
- Time/competing demands; facilities
- Workforce/staffing/skill mix/capacity - for example recruitment/retention of staff
- Are there enough local services to tackle conditions and behaviours related to poor health among particular groups
- Are there enough specialist services to help them
- Does your service have sufficient capacity to deal with everyone who needs or wants these services

General discussion about

- the impact that the enablers and barriers (overall) have had on people suffering health inequalities;
- things that the Scottish Government or local organisations could do to improve things; and
- the role of GPs.

## **7. Access to services and targeting those with greatest need**

- How do you identify people with the most significant health problems and therefore the greatest need?
- What are the barriers to engaging people in health improvement?
  - Increasing awareness
  - Identifying and engaging those with greatest needs
  - Take up of services (attendance by those most in need).

## **8. Any other issues?**

Are there any other issues that you think that Audit Scotland should take into account as they consider how well Scotland is tackling health inequalities?

*Thank participants; confirm timescales for publication of Audit Scotland report and close.*

# Health inequalities in Scotland

## Views of community planning and health professionals

If you require this publication in an alternative format and/or language, please contact us to discuss your needs.

You can also download this document in PDF, black and white PDF or RTF at:  
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