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An Outcomes Approach to Health Inequalities:
What is the Contribution of Community Regeneration?

A SURF Open Forum in partnership with Health Scotland
Thursday 31st May 2007, Radisson SAS Glasgow

Background reading paper

Improving Scotland's health and reducing health inequalities requires action across a range of sectors and agencies, each contributing different services and accessing different groups in the population. The contribution to health improvement from community planning partners involved in community regeneration is widely recognised, but as yet remains poorly specified.

The Scottish Urban Regeneration Forum (SURF) have agreed to facilitate an engagement event with their membership to clarify a) what are the main ways in which local community regeneration contributes to achieving health improvement outcomes and b) what health improvement outcomes are most relevant. This forms part of a wider engagement process Health Scotland is taking forward with a range of different partners and settings between April – July 2007. As part of this process we wish to recognise the contribution of actions and services in influencing individual lifestyles as well as those concerned with addressing the wider determinants of health (e.g. income, employability, physical environment)

The purpose of this paper is to provide the background context to Health Scotland's work in this area and to stimulate thinking and prior to discussion at the engagement event.

Community Planning Partnerships

Community Planning Partnerships (CPPs) are an important local cross-cutting mechanism for delivering health improvement in Scotland. Local authorities have a duty to initiate, maintain and facilitate the joint planning process for local public services, the core partners being NHS Boards, Scottish Enterprise, Highlands and Islands Enterprise, Joint Police Board, Joint Fire Services, Chief Constable Police and Strathclyde Passenger Transport.
From the perspective of CPPs, improving population health and well-being is a common priority area. Local partnership commitments are set out in several plans, primarily the Joint Health Improvement Plans (JHIP). The JHIP sets out plans for improving population health in a local authority area, defining priorities and actions for each partner organisation, while the Regeneration outcome Agreement (ROA) sets the planning framework for service delivery to achieve better and additional outcomes for the most deprived 15% of the local population. Other examples of CPP plans that contribute to health improvement include those of the Alcohol and Drug Action Teams and Children's Services.

In these plans, activities/services that impact on health include work that is 'badged' as health improvement work and focused on individual behaviour change (e.g. alcohol, tobacco, food/diet, physical activity and mental health and well-being) as well as "unbadged" work on the wider determinants of health, such as building strong, safe and attractive communities through housing provision, town planning, community regeneration, getting people back into work, raising educational achievement.

Analytical work commissioned by national bodies has helped to highlight some of the issues and challenges of integrated approaches to planning for health improvement[1], [2]

- the need for better integration of the health improvement agenda across government departments and improved links across ministerial portfolios;
- the need to align health improvement activities with other CPP work (mainstream service programmes), and cross cutting agendas;
- the need to acknowledge and clarify the contribution of mainstream local services and work on health determinants and community regeneration to improving population health and well-being
- the need to foster an outcomes approach to community planning to illustrate the logical links between identified need, proposed activities and outputs and the short to long-term outcomes
- greater evidence for, and focus on, strategies and actions that will help reduce health inequalities
- a rationalisation of plans and the streamlining of planning processes;
- more flexible planning and delivery guidance combined with supportive scrutiny processes
- integrated approaches to guidance and support at national level from the Scottish Executive and agencies such as Health Scotland and Communities Scotland.

The community planning process is still developing in many areas due to in part the complex and challenging processes and agendas it faces. An Audit Scotland report[3] found it to be highly variable in its maturity across local areas and progress is impeded by problems such as the different geographic boundaries, different accountability and financial regulations across partner organizations, the lack of integration and prioritisation of a large number of national policy initiatives, and the separate funding streams to support these. To achieve the potential envisaged for community planning a fundamental change in the way of working at national level is required to allow more effective coordination across SEHD, with other Scottish Executive departments and with partner organisations[4]. It may also be necessary to agree at national level the shared

[1] *Health Improvement and Health Inequalities: a local authority perspective.* CCL Associates and Hexagon. Edinburgh, CoSLA, 2005.

[2] *Health Improvement Planning in Scotland: An analysis of JHIPS and Regeneration Outcomes Agreements".* University of Glasgow and Bishop's Consulting. Edinburgh, Health Scotland and Communities Scotland, 2005.

[3] Audit Scotland (2006) *Community Planning: an initial review*. Edinburgh, Audit Scotland, June 2006

4 Scottish Parliament Audit Committee report, Community Planning: an initial review. SP Paper 770 AU/S2/07/R2 2nd Report March 2007 (Session 2)

priority areas for health improvement. It is also necessary to develop the capacity and capabilities for integrated approaches to funding, planning and accountability.

An outcomes approach to performance management

The Scottish Executive *High Level Action Plan* (Dec 2006) commits government to adopting a more outcome-focused approach with a stronger emphasis on managing performance, on local accountability and on quality assurance. There is now work underway to develop stronger, simpler performance management frameworks for public service delivery with the emphasis on framing local accountability in terms of delivering outcomes. The new performance framework for local government is currently out for consultation.

In addition, *"Transforming Public Services: The Next Phase of Reform"* (2006) also emphasises an outcome focused approach, the need to streamline funding and planning processes. The challenge of strengthening leadership and the confidence to prioritise activity based on local need and national priority outcomes is also highlighted. A response to the Public Service Reform agenda from a health improvement perspective is available at www.healthscotland.com/localgovernment

To support the development of integrated, outcome focused approaches to health improvement planning by CPPs, Health Scotland, Communities Scotland, Scottish Executive Health Improvement Strategy Division and the Improvement Service have commissioned consultancy support for the 3 CPP areas of Aberdeenshire, Fife and North Ayrshire. The work reports in the summer 2007, but it is clear that the development of outcome focused plans that can be monitored is very challenging. Progress up dates from this work in the form of E.Bulletins can be found at www.healthscotland.com/localgovernment

Health Scotland's new work programme

This exploration with CPPs of how best to support effective integrated and outcome-focused community planning has helped to direct the development of a much wider programme of national level work with the Scottish Executive in 2007/08. The new programme of work has been developed by Health Scotland to create greater coherence and synergy across the depts./sectors that contribute to delivering health improvement outcomes and to further develop integrated planning and performance management for this work. To do this, we are in the process of engaging with national and local partners across a range of settings and sectors – the health service, local government, CPPs, community and voluntary sector – in order to develop a 'whole system' approach to:

- Identifying and agreeing **national level priorities for health improvement**, expressed as high level population outcomes; are the current targets appropriate?
- Given that national agencies and local community planning partners will be accountable for delivering these, to what extent **is the current delivery system fit for purpose?** Who contributes what to delivering health improvement outcomes? What can we do to improve the effectiveness and efficiency of delivery?

- Developing **leadership** for health improvement across the whole system, focusing on planning in partnership to improve the reach and results of delivery in terms of population health and reducing inequalities

The new work stream is reporting to a cross-departmental Scottish Executive Steering Group being convened by the Health Improvement Strategy Division.

Engagement process

Engaging across the full range of community planning partners (especially the health service, local authorities and the community and voluntary sector) is a critical part of the process so as to generate an understanding of priority outcomes for health improvement for different partners and an appreciation of what each sector contributes to achieving these outcomes, through both the delivery of their own services and in partnership with others.

In 2007/08 Health Scotland has been asked by the Scottish Executive to lead a review of the NHS performance management framework for health improvement. Within the health service, performance management of NHS Boards is the role of Scottish Executive Health Dept and the current framework is based on targets is known as "HEAT" (Health, Efficiency, Access and Treatment). The current outcomes and targets for "Health" improvement are set out as Appendix 1. Using an outcomes approach, we are suggesting the NHS Boards focus performance management on those areas of health service delivery that already (or have the potential to) contribute most to improving population health and reducing inequalities. As part of the initial scoping stage of this work, a full day seminar was held with NHS Boards on 17 April and a Working Group has been established to work with the Health Scotland team to take this work forward.

Beyond the NHS Boards, we wish to engage with other community planning partners to assess the relevance of the current health improvement outcomes and targets. As these targets were not set with the wider range of Community Planning Partners in mind, the potential for their contribution may not be fully realised.

The current health improvement performance targets for community regeneration are oriented around the same topic approach (i.e. disease risk factors and behaviours) to health improvement as adopted for the current "HEAT" targets for NHS Boards. The regeneration related outcome indicators for health are set out in Appendix 2. If health improvement outcomes were to include the wider health determinants or life circumstances, the whole set of regeneration outcome indicators could be seen as relevant to improving population health and reducing health inequalities. The wider set of regeneration outcome indicators are set out as Appendix 3.

A **key issue** is defining a set of relevant and meaningful national **level priority outcomes for health improvement** that acknowledge the different perspectives and contributions of community planning partners. The different perspectives might include:

- A topic based approach (e.g. decreasing obesity, improving mental and sexual health, reducing alcohol intake & reducing tobacco use)

- A life stage approach (e.g. Early Years and Childhood, Teenage Transitions, Adult Life and Workplace, Older People)
- A health determinants perspective (e.g. education, training, income, employment and housing)
- A whole system approach - outcomes are defined against a set of cross cutting priorities shared across the whole CPP (e.g. Developing a strong, sustainable and competitive economy; encouraging lifelong learning and developing community capacity; Improving health and well-being; Investing in housing and its infrastructure; Improving transport; Enhancing cultures and the natural environment and Developing, safe, strong and attractive communities)

The approach taken in North Ayrshire CPP (as part of some consultancy work that has been commissioned by Health Scotland, Communities Scotland, Scottish Executive Health Improvement Strategy Division and the Improvement Service) has been to agree at Chief Executive level what the priorities for health improvement are for the CPP area.

A "life stage" approach has been adopted rather than a health "topic" approach. The life stage selected as a priority is 'teenage transitions' and the outcome defined is reducing the number of teenagers within a specified age group entering NEET (Not in Education, Employment or Training). The thinking behind this relates to the strong link between health status and levels of deprivation, income, educational attainment and employment (a "health is wealth" perspective). In terms of the ROA, this approach also helps to connect health improvement across to sections on "Raising Educational Attainment" and "Getting People into Work".

Appendix 4 gives an example of a logic model for a community safety plan using the wider determinants of health as a starting point.

Alternatively a health topic perspective could be the staring point making links to achieving health outcomes. Appendix 5 gives an example of a logic model for a plan using alcohol as a starting point.

While the associations between socio-economic status and health are well established, there is little evidence of effective interventions aimed at the social-economic or other wider determinants of health to help guide the development of plans that will be evidence-based and monitorable to demonstrate a contribution to health gain.

The paper by Hilary Thomson et al (2005), *"Do regeneration programme improve public health and reduce health inequalities? A synthesis of the evidence from UK policy and practice (1980 – 2004)* recognises that there is little formal research evidence to establish the impact of national regeneration investments on socioeconomic or health outcomes.

It is suggested that this does not mean that this is a reason not to investigate these links and contribute to building the evidence base in the process. The evaluation of the *Go Well* initiaitive in Glasgow is a good example of this. Regeneration initiatives are in a good position to address health inequalities because they have the responsibility for responding to the wider determinants that have impact on people's physical and mental health.

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The paper by Thomson et al offers some potentially useful ways to think about health outcomes and socio-economic outcomes, identifying both direct and indirect measures that are available:

Health Outcomes
Direct Measures: Morbidity, mortality, quality of life, well-being
Indirect measures: Registration of use, satisfaction with the level of health services
Socio economic outcomes relevant to determinants of health
Including – housing, education, training, income and employment
Direct Measures: Household income, housing quality
Indirect measures: Receipt of welfare, satisfaction with housing, impacts on crime and neighbourhood outcomes

Health Scotland engagement event hosted by SURF

This event is part of a process in which Health Scotland will engage with different partners and aims to explore:

a) What are the main ways in which local community regeneration contributes to achieving health improvement outcomes and

b) What health improvement outcomes are most relevant.

The Programme will include workshops to discuss the advantages and disadvantages of the two approaches to health improvement, life circumstances as a starting point or health topics and move on to explore the implications of these different starting points for health improvement outcome planning.

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Appendix 1

HEAT targets for NHS Boards

Reduce health inequalities by increasing the rate of improvement for the most deprived communities by 15% across a range of indicators including; CHD, cancer, adult smoking, smoking during pregnancy, teenage pregnancy and suicides in young people: target date 2008

To reduce adult (16+) smoking rates from 26.5% (2004) to 22.0% (2010)

Reduce incidence of exceeding the weekly alcohol limit of 21 units to 29% for men and of 14 units to 11% of women: target date 2010.

50% of all adults (aged 16+) accumulating a minimum of 30 minutes per day of physical activity on 5 or more days per week.

95% uptake target for all childhood vaccinations (ongoing)

Reduce suicide rate between 2002 and 2013 by 20%

Reduce by 20% the pregnancy rate (per 10000 population) in 13 – 15 year olds form 8.5 in 1995 to 6.8 by 2010

60% of 5 year old children (primary 1) will have no signs of dental disease by 2010

Appendix 2

National Priority Regeneration Outcomes for Health Improvement

Deaths per 10,000 population from coronary heart disease, all cancers and all other causes
SIP CCI 8
The same indicator is included in Inequalities in Health (with a split by age of under 75 and 75 and over)

Total number and rate of self-reported smoking pregnant women when booking their first antenatal appointment averaged over a three-year rolling basis

SIP CCI 4/Inequalities in Health

Total number and rate of women breastfeeding at six to eight weeks after the birth of their child averaged over a three-year rolling basis

SIP CCI 3/Inequalities in Health

Proportion of live singleton births of low birth weight

Emergency admissions

Proportion of population being prescribed drugs for anxiety of depression or psychosis

Diet – consumption of fresh fruit/green vegetables
Inequalities in Health

Increasing the proportion of those aged 17 to 24 taking part in sport more than twice a week:
Sport21 Target 5

Appendix 3

Regeneration Outcome Agreements
Beyond Health Improvement

National priority : Building strong safe and attractive communities

Percentage of adult residents reporting fear of crime

Percentage of adult residents stating fear of crime is having a moderate or great effect on the quality of life

SIP CCI 9

Total volume and rate of crimes against property, broken down by burglary and all other property-related crimes

SIP CCI 10
Number and percentage of
residents stating they are satisfied with their neighbourhood
SIP CCI 11

(Please note that there are likely to be changes to these questions in SHS and Scottish Crime and Victimisation Survey from 2005)

Geographic access to services
SIMD2004

Drive time in minutes to GP, petrol station, post office, primary school, supermarket

Percentage of low demand social rented housing, as indicated by

- Small or non-existent waiting list
- High tenant turnover
- High void level

High refusal rate

National priority: Getting people into work

Total number of claimants in receipt of unemployment related benefits
SIP CCI 7

Overall SIMD 2004 Employment domain, comprising
unemployment claimant count,
incapacity benefit recipients,
severe disablement allowance recipients,
compulsory New Deal participants (New Deal for under 25s and New Deal for 25 plus) not included in the claimant count

Total number of children living in a household where the adult is of working age and receives key benefits
SIP CCI 1

Number and percentage of working age adults with no qualifications

National priority: Raising educational attainment

Total number and percentage of children attending publicly-funded schools and attaining Level A in maths, reading and writing by the end of Primary 3
SIP CCI 2

Total number and proportion of half-days of unauthorised absence (including truancy, temporary exclusions and unauthorised absence) reported separately for primary and secondary schools
SIP CCI 6
Average tariff score both for each quintile (the bottom 20% etc), and all S4 pupils
SIP CCI 5

Indicators from National Priorities in Education,
Achievement and Education
National Priority 1
To raise standards of educational attainment for all in schools, especially in the core skills of literacy and numeracy, and to achieve better levels in national measures of achievement including examination results
http://www.nationalpriorities.org.uk/guidance.html

Indicators from National Priorities in Education, National Priority 5
To equip pupils with the foundation skills, attitudes and expectations necessary to prosper in a changing society and to encourage creativity and ambition
http://www.nationalpriorities.org.uk/guidance.html

Number and percentage of working age adults with no qualifications
(see also Getting people into work)

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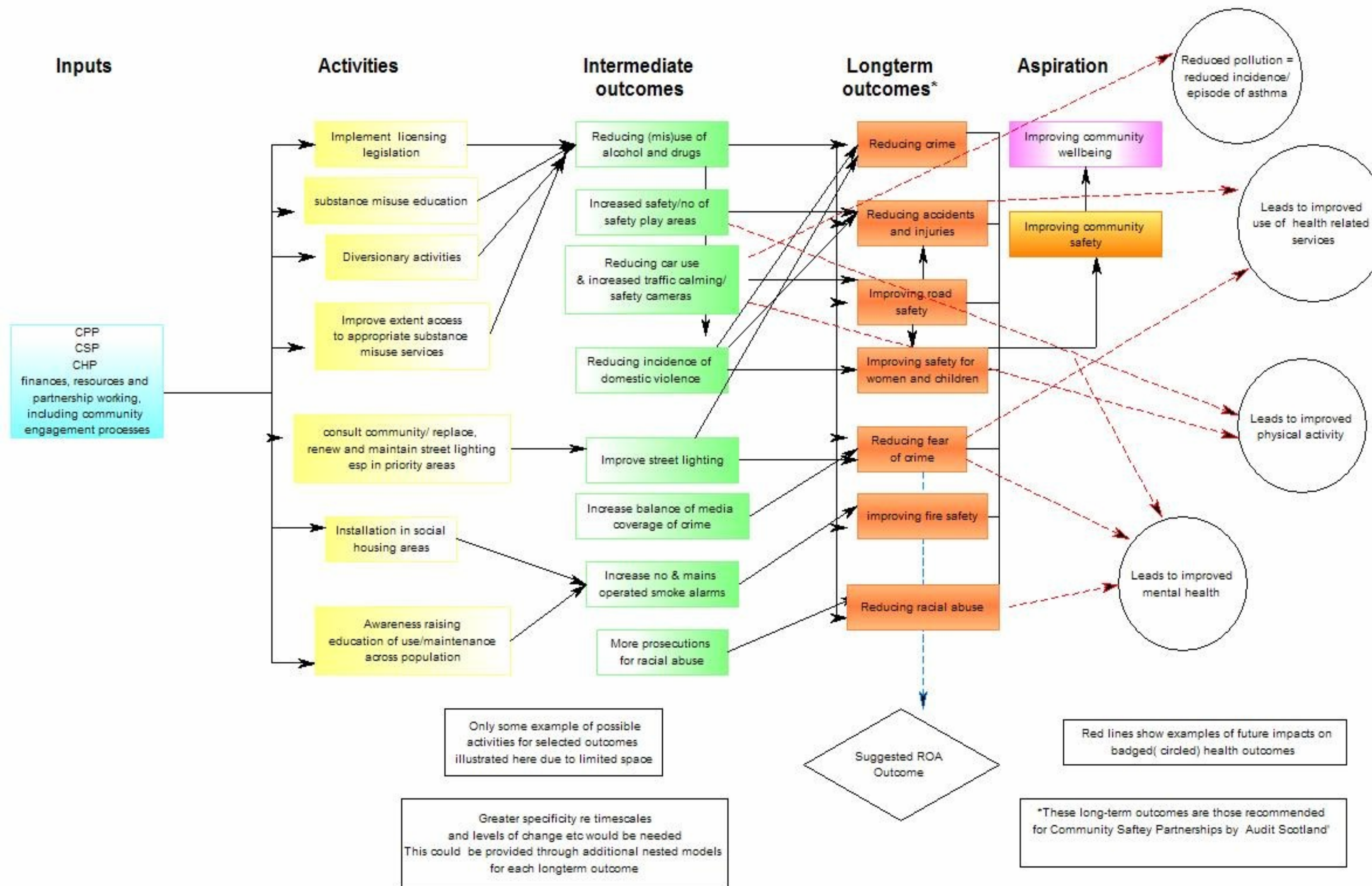
Appendix 4

A logic model showing community safety outcomes (a wider determinant) linking with "badged" health outcomes



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Appendix 5