Reducing health inequalities and improving health

What councillors can do to make a difference

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NHS Health Scotland Foreword

NHS Health Scotland is the lead national agency for reducing health inequalities in Scotland. Our five-year strategy, *A Fairer Healthier Scotland*, outlines our commitment to working across the whole of the public sector and with other partners to address inequalities in health for those who are most vulnerable and disadvantaged. Our unique contribution is our expertise in improving the evidence to strengthen the case for action across the public sector. This evidence increases a collective understanding of the causes and effects of health inequalities and the policies, planning, and most importantly, the action that will make the greatest impact.

The Christie Commission on Public Service Reform clearly sets out the need for a much stronger focus on prevention and early intervention within public services. A commitment to this vision for change will lead to improved outcomes for all of our communities, especially those who are currently experiencing poorer health and wellbeing as a direct consequence of the unfair circumstances they live in.

This is a shared ambition for all of us, but we shouldn't underestimate the challenges we will need to overcome to realise it. Understanding each of our unique roles and how we can work together will be central to our success.

NHS Health Scotland recognises the crucial role elected members have in improving the circumstances that lead to inequalities in health and ensuring a fairer share of improvement in health within the communities they serve.

This resource is the first in a series of learning opportunities that NHS Health Scotland is committed to offering in partnership with other key agencies such as the Convention of Scottish Local Authorities (COSLA) and the local government Improvement Service (IS).

We recognise the importance of listening to what the people who use our services say about what information and resources work best. The resources we produce will therefore draw from the findings of a recent review with elected members.

I commend this resource to all elected members to help strengthen your council and local partnerships' roles, action and impact.

Margaret Burns CBE,
NHS Health Scotland Chair

COSLA Foreword

Having spent more than twenty years as an elected member, I can think of no greater challenge than tackling health inequalities. The fact that people in our most disadvantaged communities can expect to live ten years less than those who are better off is a profound injustice. And unfortunately, the problem has endured over the course of my time in office.

Elected members have sometimes felt frustrated that despite wanting to change these outcomes, they have not had the tools or support to do so. This publication from NHS Health Scotland goes some way to change that. It recognises the multiple roles that councillors hold: as community leaders who interface directly with the most urgent local challenges; as political leaders who have their hands on the levers of change; and as the democratic representatives of people who are often marginalised or disempowered.

This publication also seeks to inform. It allows us to share the best work that councils and their partners are taking forward in different localities. It lets us know where to go to find the emerging evidence or profiles of our communities. In short, it will be a vital tool in helping us tackle the health inequalities agenda head-on.

It is clear that there is no single intervention or strategy that will overcome health inequalities in our society. But through the patient examination of the evidence, councillors can be a vital agent for change. That is why I am pleased to say that COSLA endorses this publication.

Cllr Peter Johnston,
COSLA Health and Wellbeing Spokesperson

The aim of this resource

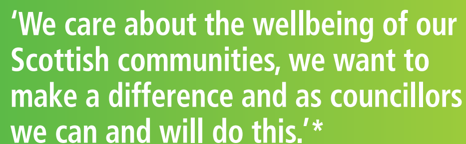
This resource is for all councillors and aims to highlight your crucial role in the following three main themes which are woven throughout the resource:

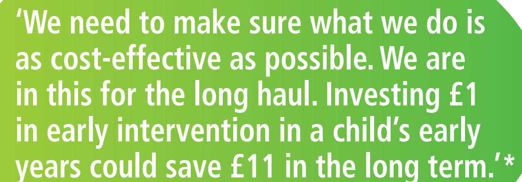
- Reducing health inequalities
- Improving health in a fairer way
- Protecting health

Prompts for your thoughts and questions are offered throughout the resource to help you apply some of these themes to your own local council and partnership context. You will also notice the use of practical example illustrations and quotes from fellow councillors as further food for thought.

The resource is structured around what the evidence tells us about the action needed to reduce health inequalities and improve and protect health. It makes specific connections between this and your different roles in community leadership; partnership working; your constituency/representational role; policymaking, scrutiny role and your responsibilities for the council as a large and complex corporate body.

The comments below from two councillors illustrate the powerful motivation to make a difference for their communities.





Success in reducing health inequalities and improving and protecting health and wellbeing relies on policy, planning, practice and review that reflects the approaches the evidence tells us are more likely to be effective. These include robust policies for reducing income inequalities and improving employment and education, as well as multi-agency efforts to improve access to, and the quality of, local services.

The financial pressures on public services and the need to ensure the most efficient use of all resources are at the forefront of your role. You are also responsible for setting policy and scrutinising progress based on the needs and involvement of local communities. Your role provides a unique opportunity to drive change within council and partnership services and improve community outcomes.

Further publications and resources

An e-learning resource is presently under development and will be available in due course. This will allow for website links to be created and the use of videos and other media. It will also include additional material such as:

- a closer examination of the impact of the integration of adult health and social care and addressing health inequalities
- other NHS and council interfaces such as the role of public health, community planning and the integration of children's services
- developing the preventative spending agenda.

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* Elected members' views from NHS Health Scotland review of elected member health inequalities and health and wellbeing skills, knowledge and experiences.

'Health inequalities are systematic differences in health between different groups within a society. As they are socially produced, they are potentially avoidable and deemed unacceptable to civilised society. Often economic factors are the primary determinants, but these can also underpin or exacerbate other dimensions of social inequality, such as, differences in power and opportunities as well as discrimination on the basis of gender, race, disability, age, sexuality or religion.'
(*A Fairer Healthier Scotland*, 2012)

Billy's story

Billy Reid is ten years old and lives in a two-bedroom council flat. The flat is damp and the walls are covered in mould. The flat is located in one of the most income-deprived areas in Scotland where deaths related to alcohol, drugs and suicides are high and school-based educational attainment is low.

Billy has spent an increasing amount of time at his aunt's house (Marion McKay). This is because his mother has to work in the evening and his father (Brian) is frequently absent. When his father does come home he is often, as Billy puts it, 'out of it'. Billy speaks openly about his father's drug-taking and that he doesn't like the way it makes him behave.

The relationship between Janice Reid (Billy's mother) and Marion McKay became strained when Marion began to criticise Brian's behaviour and in particular the way it affects Billy. Janice Reid stated she wanted Billy to stay at home and not to spend so much time with his aunt, who Janice claims was telling him lies.

On 16 February 2012 the council out of hours team was called and attended with a police officer. Billy was found alone in a distressed state and his appearance was unkempt. Mrs Reid was contacted by police officers at her work and Billy's father was found some streets away, incoherent under the influence of drugs and alcohol.

Janice Reid has struggled to find flexible employment that allows her to care for her children. The local school does not provide after-school care or a breakfast club. Janice struggles to make ends meet and the flat is 'impossible to heat'. Billy's father has been known to spend extended periods away from home without explanation. These absences can last as long as three months.

Billy's story is based on a real situation. When Billy was born his life expectancy was 62. If he had been born in a less deprived area it would have been 76.

The story highlights the impact of life circumstances such as poverty, unhealthy environments, difficulty in accessing services (e.g. breakfast and after-school clubs) and the impact of substance misuse. So many of the things that cause health inequalities are linked and as the definition on page 6 highlights, are connected to poor economic circumstances.

In terms of direct impact on the individual, it is income, employment and education which offer the greatest potential for reducing health inequalities.

What are the implications for the council and its partner organisations for improving things in the short term for families like Billy's?

How is the council and its partners working together to intervene much earlier to eradicate fuel poverty, increase employment opportunities, improve neighbourhood environments and access to services for the benefit of this family and others in similar circumstances?

Billy is from one family. We need to recognise that health inequalities extend right across Scotland and they are getting worse. When healthy life expectancy† is considered, health inequalities are even wider.

Our population is ageing and it is anticipated that there will be greater demand placed on services in the future. The prevalence of long-term conditions such as dementia, heart and lung disease and diabetes (to name a few) will rise. The likelihood that someone suffers from more than one long-term condition is higher in more deprived areas and as such a greater burden will be placed on scarce resources unless inequality is addressed.

Reducing inequalities will contribute to your communities living longer and healthier lives.

Inequalities in health status are increasing within Scotland and this is a major cause for concern (life expectancy in more affluent parts of Scotland is increasing faster than in the least affluent areas).

The graph on the next page shows life expectancy for men and women in Scotland since 1971 and compares this to other countries. Life expectancy is one of the best overall indicators of health and wellbeing.

† Whereas life expectancy is an estimate of how many years a person might be expected to live, healthy life expectancy is an estimate of how many years they might live in a 'healthy' state.

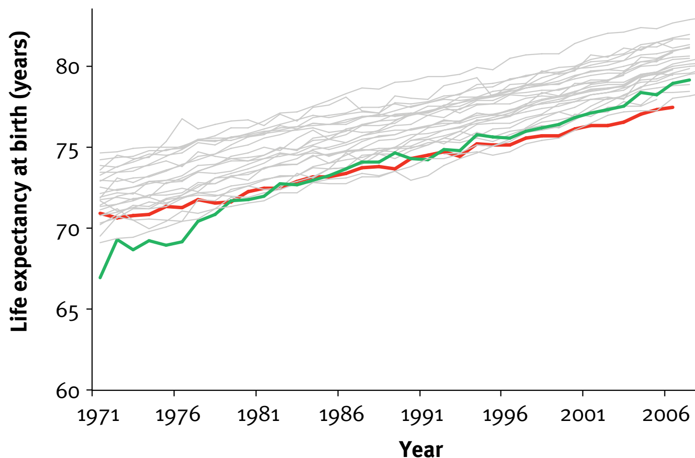


Figure 1 – Life expectancy in Scotland compared to other countries from 1971 (Source: Human Mortality Database)

[Data extracted from the Human Mortality Database for: Australia, Austria, Belgium, Canada, Chile, Denmark, England and Wales, Finland, France, Germany, Ireland, Iceland, Israel, Italy, Japan, Luxembourg, Netherlands, New Zealand, Northern Ireland, Norway, Portugal, Scotland, Spain, Sweden, Switzerland, Taiwan and West Germany]

Figure 1 shows that although life expectancy in Scotland (represented by the red line) has improved since 1971, other countries have improved more quickly (e.g. Portugal, shown by the green line), leaving Scotland with the lowest life expectancy of this group.

Even in those parts of Scotland where the population enjoys better health and longer life expectancy, there remain wide inequalities within those more affluent council areas. Scotland does not simply have a problem in its most deprived areas: affluent areas in Scotland have lower life expectancy than affluent areas elsewhere.

Health inequalities exist in varying population groups as well. For example, data shows that Gypsy Travellers have much poorer health than other UK resident English-speaking ethnic minorities and economically disadvantaged white UK residents.

It is important you look at the equality aspects that can cause health inequalities. If attention to individual, family and community need isn't properly considered in relation to the protected characteristics set out in the Equality Act 2010,‡ there is a danger that health inequalities in your area will worsen.

What does this mean in terms of what we need to do? We have to focus on improving the health of people who are most in need – the aim is to help them catch up with the better-off. This will mean improving some people's health more than others.

‡ The protected characterisitics set out in the Act are: age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity. www.legislation.gov.uk/ukpga/2010/15

Suggestions for evidence-based action to address health inequalities

- Prioritise disadvantaged groups (e.g. multiply deprived families and communities, unemployed people, those living in fuel poverty, rough sleepers, homeless people).
- Provide services universally, but with a scale and intensity that are proportionate to the level of disadvantage.
- Provide accessible services (e.g. easily accessible locations, services that are affordable with good transport links).
- Offer intensive support (e.g. systematic and tailored approaches involving face-to-face or group work, home visiting, good quality pre-school day care).
- Do not only target geographical areas defined as deprived. Targeting only these areas will not include vulnerable people living elsewhere. Neighbourhoods that are considered as being well-off overall with good health outcomes can still include individuals and families that are experiencing health inequalities.
- People in rural areas can also be experiencing inequalities that may not be as easy to identify (see Paul's story on page 23). Policy action should be considerate of this.
- Local policy should not be discriminatory. Discrimination can lead to and perpetuate health inequalities.
- Ensure local agencies work together with common aims and measures to reduce health inequalities.

Interventions less likely to be effective in addressing health inequalities[1]

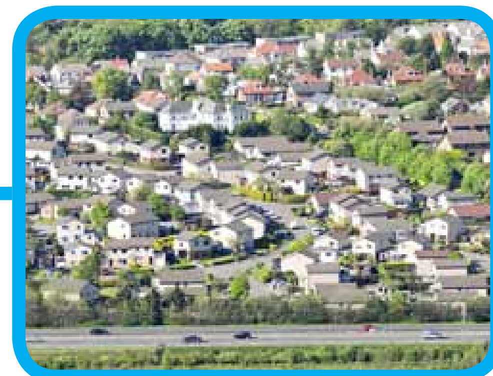
- Information-based campaigns (mass-media information campaigns).
- Written materials (pamphlets, food labelling).
- Campaigns reliant on people taking the initiative to opt in.
- Campaigns/messages designed for the whole population.
- Whole-school health education approaches (e.g. school-based anti-smoking and alcohol programmes).
- Approaches which involve significant price or other barriers (i.e. if it costs the individual a significant amount to take part in the intervention).
- Housing or regeneration programmes that raise housing costs.

The above interventions can be helpful in improving general population health and could have some effect on addressing health inequalities too, but there is a risk that these actions may widen health inequalities. This is because well-intended interventions could have unintended detrimental consequences. This could occur within your council area; for example, through a whole-school-based intervention aimed at encouraging all children to increase their physical activity or eat more healthily. Activities like these have been shown to widen health inequalities. This is because they require individuals to opt in, or to respond to the provision of information. Those living in more affluent situations and areas are more likely to take up these messages because there are greater opportunities for them to do so.

These interventions are also less likely to be effective at reducing health inequalities, if done in isolation from actions focused on tailored intensive support and improving the social circumstances of people's lives (e.g. income, poverty, housing). In contrast, action to reduce economic inequalities and policies which use legislation or taxation are more likely to be effective.

Although Scotland has become a world leader in devising public health legislation (e.g. the ban on smoking in public places and minimum unit pricing for alcohol) there has been much less progress in reducing economic and social inequalities. Given that income, wealth and power inequalities are the key determinants of health inequalities, it is unlikely that health inequalities will decline unless substantial progress is made in these areas.

Your community leadership role



Arguably one of the first steps in a community leadership role for addressing health inequalities and improving health and wellbeing is to gain an understanding of the needs of that community.

The Scottish Public Health Observatory[2] has produced 'Health and Wellbeing Profiles'[3] for each council area in Scotland.

The profiles summarise each Scottish council area/down to ward level using 59 indicators that cover a range of health outcomes, health-related behaviours and the wider determinants of health (including life expectancy, households in extreme fuel poverty, primary school attendance, crime rate and people receiving free personal care at home).

'It shouldn't be about the NHS, the council or other services going in and saying what they are doing, it should be about the community itself saying what they want.'*

However, information and data on community wellbeing is only one way of understanding community need. The insights you gain from talking with communities, individually in your surgeries and through working with community groups, are invaluable and help to strengthen the sense of need and priority.

You will also hear the views of council officers, police, NHS staff and voluntary workers on their experiences of the needs of that community.

Once you have this understanding and picture, you can mobilise and lead community action and involvement.

You can work across partnerships and council services to influence and lead change.

You also have the authority to make decisions about funding that will help redress some of the inequalities that exist. Often decisions involve the cooperation and involvement of other partners, harnessing commitment to resource long-term prevention.

This illustration shows how a community is using different approaches to become involved, take ownership and ultimately be responsible for improvements in their health and wellbeing. It suggests the role of the councillor in this process.

Practical example

The staff and management committee of a local community centre in Clackmannanshire are working with people from the council, NHS, police, fire service, college and third sector to make the area a better place to live for everyone.

The approach they are using encourages communities to believe in and change their lives and situation for the better. It is moving from representative democracy to participative democracy. As such, councillors have a pivotal leadership and enabling role.

The community is taking a positive approach and rather then focusing on what they don't have, the starting point is to identify what they do have. So they are aiming to make the best use of their assets; i.e. their community centre, green space and woods and their tangible community spirit.

Councillors reach out through their surgeries and through the management committee of the community centre as well as via informal local meetings, periodic community newsletters delivered to each household, an invitation to every resident to come to a 'community listening event', community walkabout with residents and partners, and litter pick-ups.

The 'throughcare and aftercare service' team works with young people leaving care who are often experiencing poverty, disadvantage and exclusion. The service has moved from meeting with young people in the local supermarket café to the improved environment of the local community centre, where food and the use of the gym hall for activities like badminton is also available.

The partnership approach is new for this area but there have been several small-scale improvements and improved relationships between partners and residents as trust has begun to build. Priority areas have now been identified by residents of all ages.

Continued on the next page

Some residents' views:

'Before this work started, we felt like we were a forgotten community but partners are listening to us now, whereas in the past they didn't. We think this is a good way to work together now.'

'This has helped us to bring the community together again and brought in members of the community who haven't used the centre for a long time. We are trying our hardest to meet the needs of our neighbours and fellow residents and do what needs to be done to make our environment, health and lives better.'

Voluntary sector agencies also make important contributions, as this example from Angus council illustrates:

Practical example

We have a life skills centre that has been developed by Voluntary Action Angus, our third-sector partner. This centre is about people coming together to share skills which enhance a sense of achievement. It helps people to develop their skills through volunteering.

The unintended consequences of this project, through creating the opportunity for people to come together within a community, are many and varied. For example, people have recovered from heroin addiction, stopped taking anti-depressants and improved their ability to cope with stress. It has also helped people move on from homeless situations to better family integration; cope with the diagnosis of cancer and helped them to give something back into the community before it is no longer possible for them to do so, again assisting with their life journey in respect of their own health.

These are all very positive stories from people who have been given an opportunity to participate. Councillors have an important role to play in supporting this kind of community empowerment.

Which community and voluntary sector organisations in your ward and/or council area contribute to reducing inequalities and improving health? Is their contribution recognised?

What can you do as a community leader to address some of the barriers that communities face and help them take more control over matters that are important to them?

How are your council and local partnerships, for example the integrated health and social care partnership, using local data and intelligence to involve communities in changing service delivery and so reduce inequalities?

Your partnership role

People in Scotland are living longer, but not necessarily in good health. This has an impact on health and social care services, and the available resources at their disposal to respond to the demand. COSLA estimates the gap between resources and demand for local government will be £3.8 billion by 2016–17.§

Scottish Government,[4] councils and many other organisations increasingly recognise the importance of partnership to achieving better outcomes for and with people and communities. Improving integrated working at a local level is one of the main pillars for public sector reform as outlined in the Christie Commission's report on the future delivery of public services.[5]

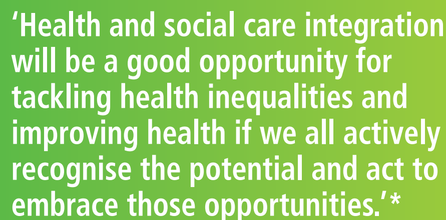
'The only way is through partnership, and councillors have an important role to play, particularly in light of the services that the council is involved in. It is important to ensure all councillors get away form the misconception that health equals an NHS problem'*

The community planning process and the creation of the Single Outcome Agreements have been strengthened. Further changes are on the way to ensure that responsibilities and accountabilities are jointly shared between partners.

Integrated adult health and social care partnerships with shared governance and accountability between the NHS and the council have the potential to come together to plan services and make budget decisions based on public health needs assessments. Similarly, processes to jointly plan and deliver services and report outcomes collaboratively for children are evident.

§ In preparation for Spending Review 2010 and the 2011 Christie Review, COSLA in conjunction with Scottish Government, developed a funding model to identify the financial pressures and potential funding gap up until 2016–17 based on anticipated reduction in resources.

These joint services will also address the issues of early intervention, prevention, reducing health inequalities and improving overall population health.



The proposed Integration of Adult Health and Social Care Bill sets out two main organisational models for integration:

- The 'Lead Agency Model', which involves one partner delegating some of its functions and a corresponding amount of its resources to the other, which then hosts the services and integrated budget on behalf of the health and social care partnership. A partnership agreement between the Health Board and the local authority establishes the functions and resources to be delegated between the partners.
- The second model would see the creation of a health and social care partnership as a body corporate of the Health Board and local authority. The Health Board and local authority would agree the amount of resources to be committed by each to the integrated budget for delivery of services, to support the functions delegated to the partnership. The integrated budget would be managed on behalf of the partnership by a jointly accountable officer, whose authority and accountability in relation to delivery of the partnership's delegated functions would be determined by his or her statutory functions.

While these proposals are unlikely to achieve parliamentary endorsement until 2014 at the earliest, it is clear that many councils and Health Boards are already giving thought to future partnership arrangements. It is vitally important that in doing so, partnerships consider how public health responsibilities are discharged, along with shared strategic priorities in tackling health inequalities. This work should be based on robust public health needs assessments and be consistent with the overall strategic direction set by the community planning partnership and Single Outcome Agreement.

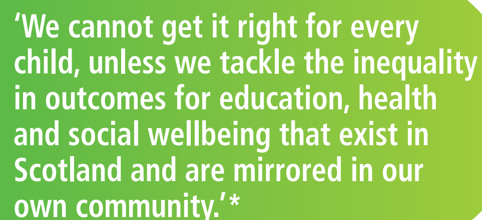
As part of the Local Government in Scotland Act 2003,[6] a duty of community planning was introduced along with a power of community wellbeing. Community planning is continually evolving, but what is constant is the role that councillors have in this partnership agenda and the connections they can make with improving health inequalities and improving health.

There are various other partnerships that work towards improving health and wellbeing, and councillors have key influencing roles within these, such as licensing committees and alcohol and drug partnerships.[7]

Early years partnerships

We know that there are many challenges that single agencies alone cannot successfully tackle. An important time to intervene to improve health and tackle health inequalities is in the very early years. Getting it right for every child (GIRFEC)[8] is an important framework to base partnership activity on and as this councillor says below, there is a need to tackle the causes of inequality so we can get it right.

Nationally work is underway on an 'early years collaborative' themed around a child's life stages.[9] This work has a major opportunity to address health inequalities and bring together the contribution of a range of different agencies to make a difference.



Partnership and early intervention is essential and the project overleaf addressing child poverty in East & West Dunbartonshire, Glasgow City, Inverclyde, East Renfrewshire and Renfrewshire councils is an example of how partnership working and collaboration have been a success locally even in the short term.

Practical example

'Healthier Wealthier Children' was launched in Glasgow in 2010. It seeks to address child poverty in Glasgow and its surrounding area. It has grown from a need to increase the uptake of a voucher scheme that enables pregnant women and families in receipt of certain benefits to access healthy food and vitamins.

The collaboration between NHS Greater Glasgow & Clyde, Glasgow City Council, East Renfrewshire Council, Inverclyde Council, Renfrewshire Council, West Dunbartonshire Council, the voluntary sector and the Glasgow Centre for Population Health aimed to:

1. test partnership models of providing local Healthier Wealthier Children advice services for pregnant women and families with young children at risk of, or experiencing, child poverty
2. build action on child poverty into mainstream services for children and families, and financial inclusion services, beyond the life of the project.

By creating information and referral pathways between NHS early years workforce and money/welfare advice services, midwifes and health visitors could strengthen the identification of need for advice among pregnant women and families, thereby reducing the impact of child poverty.

The project generated impressive financial gains (over £2 million) for pregnant women and families over a short timescale (less than two years). Of the 2,516 referrals, 1,347 (54%) accessed some type of service. Almost one in two (663) people receiving advice were entitled to some type of financial gain, with an average annual client gain of £3,404. Many of these gains may not have been accessed through traditional money/welfare advice service delivery.

The support of councillors would facilitate the sharing of lessons more widely from this partnership approach to commissioning advice services in the future.

Link to website: **www.nhsgg.org.uk/content/default.asp?page=home_hwc**
Link to Summary report: **www.gcph.co.uk/assets/0000/3404/HWC_final_report_EXEC_SUMMARY.pdf**

Health protection partnerships

Councils have a vital role to play in protecting the health of the people who visit, work and live within the area. You take measures to prevent infectious diseases (e.g. food poisoning, flu), reduce the risks from environmental hazards (e.g. air pollution, contaminated land) and control outbreaks of disease (e.g. E. coli, legionnaires' disease).

Protecting the health of your communities also involves councils progressing environmental sustainability and reducing the impact of climate change.

Your council, working with your local Health Board,[10] helps protect vulnerable people from serious infections through cleanliness and hygiene in care establishments and supporting vaccinating schoolchildren against cancer. To guide the delivery of these services and the other activities referred to above, a joint health protection plan sets out how the health of the people within your area is protected from many of the health hazards that may arise locally.

A good example of health protection in action is the routine assessment of air quality by councils, taking action when levels of certain pollutants present a risk to health.

Practical example

Aberdeen Council's active travel plan includes an action to reduce transport-related pollution by requesting drivers to switch off their engines, in particular when parking outside schools. This makes their town cleaner, more environmentally friendly and helps reduce diseases such as asthma. The active travel plan also aims to encourage more sustainable modes of transport, e.g. walking and cycling to/from schools, so promoting associated health benefits.

Some questions

Are you confident that the partnerships your council is involved in to improve inequalities and health outcomes have clear shared objectives, consistent with addressing health inequalities and improving health and wellbeing, particularly for the early years?

What support does the council provide for councillors engaged in partnerships?

How is the GIRFEC framework being implemented in your council and partnership area? Are the actions taken as a result considerate of the impact on health inequalities?

Is your council giving thought to the opportunities that public service reform will present in developing partnership arrangements with the NHS as a means of tackling health inequalities?

Your constituency/ representational role

All councillors have a representational role. Councils provide the only direct public services where executive decisions are taken by elected (as opposed to appointed) decision-makers. If there are health inequalities and health and wellbeing concerns that are specific to people whom you represent, you have the opportunity to take those directly to the appropriate decision-makers in the area.

As a local representative, you have a unique perspective on how the council and its community planning partners are achieving the outcomes they have agreed in their Single Outcome Agreement. This links with the section on community leadership and the different ways you engage with communities to establish their views and feed back how their priorities are being met – how things are changing for the better.

Many of the issues Paul experiences (see below) have now been addressed by the council but his story (based on a real case study) highlights the particular needs of older people living in remote rural areas. It aims to stimulate thought on how you might represent the needs of vulnerable people.

Paul's story

Paul moved back to a remote rural area from a central area in Shetland to look after his elderly mother who is housebound. Paul is unable to drive and he can't leave the house for long periods because of his caring responsibilities.

Paul is unable to work, access social opportunities and take part in community life. He and his mother have to rely heavily on a family member to bring shopping once a week.

The bus service is generally thought to be good, but it is not always easy for Paul to find buses to fit in with his and his mother's needs. Paul finds it 'impossible' to get to the main town.

This means he is unable to access the optician, dentist, hospital, library and other services. Paul has great difficulty in getting to the hospital in Aberdeen when his mother is admitted in emergencies. He feels a journey to the doctors is 'easy' for those with a car or those living within walking distance. Paul's journey to the doctors involves a 24-mile round trip. This means he relies on lifts, or trying to book appointments to fit in with the bus feeder service. This also limits the opportunities Paul has to visit his mother.

Access to support and activities for older people is limited, access to elderly lunch clubs and day-care is, as Paul puts it, 'impossible' and he experiences significant problems in getting a home help or other forms of care.

Paul feels cut off and misses his friends from where he used to live. He would like to be able to get out, to work (even part-time) and learn new things. However, he receives no help or support with caring for his mother and because local connections in the area have been lost, he no longer has local networks to assist.

So what can you do as a councillor?

- Ensure that the life experiences from your constituents are fed into community, corporate and service planning, including the community planning partnership and the integrated adult health and social care partnership.
- Ensure all service providers explore inequalities within their service area or geographic community and implement changes to service delivery in order to reduce inequalities.
- Recognise that intervention at an early stage of an individual's or household's journey into deprivation and social exclusion is less costly in the long term.
- Increase targeting of mainstream funding to those who need it, and reviewing the role the provision of telecare[¶] has in supporting frail and vulnerable people to remain in their own homes and communities.

Do you use individual cases that are brought to your attention by your constituents as a means of reviewing the policies and decisions of the council and its partners?

In what other ways can you act as an advocate for people you represent in order to improve the lives for those most vulnerable and disadvantaged?

How can you further encourage your constituents to bring their concerns to you?

¶ Telecare (sometimes also referred to as telehealth) services use technology to help people live more independently at home. This includes things like personal alarms and health-monitoring devices. Telecare services are especially helpful for people with long-term conditions, as they can give individuals and their families peace of mind that they're safe in their own home and that their health is stable without having to make regular visits to a doctor's surgery. This telecare project in Fife won the Chair's Award at the 2011 COSLA Excellence Awards: **http://awards.cosla.gov.uk/2011/03/cosla-chairs-award-fife-council-safer-walking-for-people-with-dementia/**

Your policymaking and scrutiny role

This is a challenging element of your role, partly because health inequalities is a complex policy area requiring complex solutions. But you can look for small changes in the right direction over the short, medium and ultimately long term. To do this, you need to know you have the right policy in place to start with, as well as a shared vision across partner agencies with ways of measuring impact, or as this councillor below calls it, 'a tracking process'.

Creating robust policy

The sources for developing 'policy' are found in many places. Manifesto proposals, whether from a party or personal commitment; ideas and challenges generated by the local community; proposals from officials and other workers; ideas and interests that councillors bring into the council; academic evidence; data and information. Bearing these sources in mind it is also important to embrace the areas for evidence-based action referred to on page 10 of this resource. It is income, employment and education which offer the greatest potential for reducing inequalities.

'We need to consider targeting resources at the major causes of health inequalities. We know the problems, and we need to make sure a tracking process is in place for people we know will have poor life and health outcomes.'*

As mentioned in section one of this resource, the impact of well-intended interventions on a complex society is not always immediately apparent and may actually have detrimental unintended consequences. It is for this reason that evidence-based and impact-assessed policies and actions are needed.

To try and help assess the possibilities of such unpredicted and unintended consequences, an increasing number of councils use processes that enable officers and councillors to make judgements and decisions on policy proposals in relation to the impact to the population of the area. Crucial to this process is recognition that policies have different impacts on different groups of the population.

The use of environmental impact assessments is now a well-established part of physical planning processes. Increasing numbers of councils are working with partner organisations to carry out health impact assessments[11] or health inequalities impact assessments,[12] which address equality and diversity, health inequalities and evaluate policy changes for impact.

An example is the assessment of the City Centre Southern Arc Area Development Framework in Edinburgh.[13] Officials from the City of Edinburgh Council and a team from NHS Lothian's Public Health directorate worked together on an assessment of the potential health impacts of proposals to improve the physical environment of an area stretching from Haymarket in the west of Edinburgh across the city centre as far as Holyrood and the Scottish Parliament.

Practical example

Health impact assessments provide a set of tools for looking at how a project or plan affects health. They are recognised by the World Health Organization as a robust and effective way of helping agencies and communities to think about health. This enabled partners to identify how the Southern Arc Framework might have potential positive and negative impacts on health. Recommendations have then been developed so that:

- the positive impacts can be maximised
- the negative ones can be kept to a minimum.

The health impact assessment was carried out by City of Edinburgh and NHS Lothian and involved discussions and stakeholder engagement over 12 months. It addressed multiple aspects of the potential impact on the city of the area development framework (ADF), including the physical environment; transport; community safety; alcohol licensing; greenspace; health and wellbeing.

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The recommendations included both council and NHS priorities. The area development framework should:

- ensure that walking and cycling infrastructure in the area is both protected and prioritised for investment. This is likely to bring benefits for both public health and for the city's economy
- seek to ensure that connectivity across the area is improved and that this gives priority to active travel modes and public transport. It is important to ensure an appropriate balance that meets the needs of different forms of transport and both reduces and mitigates the adverse effects of high traffic volumes such as poor air quality and congestion
- ensure that some specific sites which provide a poor walking environment and poor connectivity have been identified. Further detailed work would identify opportunities to improve these areas
- ensure that the existing greenspace provided by the Meadows, Princes Street Gardens and Holyrood Park are maintained. There may be opportunities for further small-scale improvements to greenspace
- support measures to improve energy efficiency of both new and existing housing
- acknowledge the Licensing Board's restriction on alcohol overprovision in the parts of the area development famework area and ensure that future economic development supports a balanced mix of sectors.

Since the area development framework was ratified by the City of Edinburgh Council, a series of projects have been developed by the council, NHS Lothian and other partners. These include a dedicated post in City of Edinburgh Council Transport to focus on walkability and street design guidance and a post looking to further increase opportunities for physical activity. Work on licensing and environmental improvements is ongoing.

[City Centre Southern Arc Area Development Framework: Key Health Issues, 2011]

Another illustration is the health impact assessments (HIAs) that were carried out in Glasgow as part of the planning process for the 2014 Commonwealth Games.[14]

Practical example

A health impact assessment allowed partners to identify how the Commonwealth Games might have potential positive and negative impacts on health.

The health impact assessment was carried out by Glasgow and its partner organisations and involved discussions and engagement with more than 3000 people. It addressed multiple aspects of the potential impact on the city and surrounding areas including the physical environment; transport; the image of Glasgow; community safety; health and wellbeing – and the opportunities for individual behaviour change.

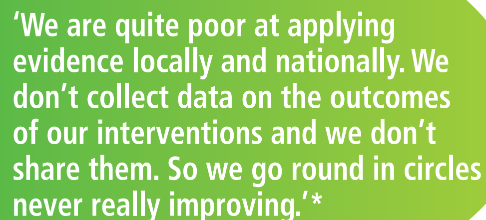
[Health Impact Assessment of the 2014 Commonwealth Games, Glasgow City Council, 2009]

Some questions

Does your council currently use health impact assessments (HIAs) or health inequalities impact assessments (HIIAs) in the development of policy?

Do you know where to go to get extra support on HIAs and HIIAs if you require it?

Scrutiny



Councils strive to ensure the best possible service delivery to their communities as well as continually improving these services.

An essential part of this is to ensure the best use of public money to reach those who are most vulnerable. It is necessary to scrutinise existing budgets and judge how spending should shift towards the prevention of health inequalities. This is an important element of 'preventative spending'. Preventive spending is about focusing budgets on those things that stop progression towards unwanted health or social consequences, for example preventing alcohol misuse in communities. For this to be effective in reducing health inequalities, this preventive spending needs to be focused on those who are most vulnerable and disadvantaged.

'Local authorities that carry out robust and reliable self-evaluation to improve their corporate processes, service performance and outcomes for citizens and users are likely to have detailed, accurate, up-to-date and verifiable information that will allow scrutiny bodies to effectively assess risk and target scrutiny activity to where it is most necessary.' (Audit Scotland, 2012)

Understanding and scrutinising progress on health inequalities and health outcomes is a challenging area for councillors and officers alike as the changes take place over a long period of time. That said, it is important to look for a short-term positive direction of travel. Systems to monitor progress have been developed such as this one used in Angus.

Practical example

Angus Community Planning Partnership uses an approach called 'getting it right' which is measuring outcomes for children and young people and their parent/carers over time.[15] The tool, 'WellbeingWeb' was initially developed through a Children Affected by Parental Substance Misuse project and is now been rolled out for all children with additional support needs. The 'WellbeingWeb' measures progress in respect of SHANARRI (Safe; Healthy; Active; Nurtured; Achieving; Respected; Responsible and Included) principles[8] with 'getting it right' and is an example of children and carers can measure perceptions of their own progress.

Some questions

Does your council or partnership currently use self-evaluation to scrutinise work in tackling health inequalities, improving and protecting health?

Does your council or partnership currently work with council officers and/or external agencies to support in the delivery/evaluation of services in these areas?

How are you scrutinising budgets to ensure not only preventative spending but preventive spending that addresses health inequalities?

Your corporate council role

The council is often the largest employer within an area (in the second quarter of 2012, total employment in Scottish local government was well over a quarter of a million people).

Premature deaths from both accidents and disease are declining and the workplace has played an important role in this reduction. However, no downward trend for workplace illness has been identified yet. 77,000 people suffered from work-related illness, a rate of 2,900 per 100,000 people working in 2010/11 (Labour Force Survey).[16] The most commonly reported types of illness responsible for employee absence were musculoskeletal disorders and stress, depression or anxiety.

Mental health issues at work are estimated to cost Scottish employers over £2 billion every year. This is an average of £970 per employee. Four in ten sick days are now taken by staff with a mental health problem and one in six employees is likely to suffer from a condition such as stress, depression or anxiety.

The Scottish Centre for Healthy Working Lives (SCHWL) helps employers to create a safer, healthier and more motivated workforce by offering practical information and advice to improve health and safety and the wellbeing of their staff.

For example, Scottish Centre for Healthy Working Lives resources and training can support managers in helping them understand how to prevent and deal with issues such as stress, anxiety or depression.

The Healthy Working Lives Award Programme provides a step-by-step guide to achieving a healthier workplace.

Link to website: **www.healthyworkinglives.com**

Practical example

Inverclyde Council recognised that the area has some of the worst health problems in Scotland. They have the highest figures for coronary heart disease, strokes, and young male suicides in the West of Scotland.

They also saw that through being one of the largest employers in the area they are ideally placed and have a responsibility to make every effort to play a part in reducing these health problems among employees and their families.

As a result of introducing the Healthy Working Lives Award Programme to Inverclyde Council, a network of ongoing contacts has been set up. This has enabled partnership working between the council and local and national health and wellbeing teams.

Inverclyde Council was the first council in Scotland to achieve Gold Award status in the Healthy Working Lives Award Programme. To achieve this, they needed to work through the Bronze and Silver Awards. Some of the steps the council took are outlined below for each award level:

Bronze Award:

- Raise employee awareness of local support for smoking cessation classes, mental health support groups and walking routes employees can access.
- Introduction of 'check my lifestyle' questionnaire to employees (now a permanent part of the staff induction programme).
- Councillors joined a weight loss clinic and encouraged employees to change their lifestyles. This was as a result of an NHS partnership, demonstrating the salt, sugar and fat content in everyday food.

Silver Award:

- Introduction of a 'family friendly' policy incorporating flexible working opportunities, job share, special leave, maternity/paternity/career break, and fostering leave.
- A new stress, mental health and wellbeing policy backed up with the creation of a council Suicide Prevention Officer to help raise awareness and reduce suicide statistics in the area.

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- The leader of the council signed the 'See Me'[17] pledge in support of the council's efforts to reduce the stigma of mental illness.
- Secured funding for an occupational health drop-in service for physiotherapy and a counselling service.

Gold Award:

The council has now held the Gold Award for three years. In that time they have been involved in the following:

- The introduction of annual health surveys.
- Participation in a physical activity research project with Glasgow University.
- Taking forward a 10-year active living strategy.

Some questions

How does your council consider the impact of its decisions on the health and wellbeing of staff and their families?

What polices and initiatives are in place to support the health and wellbeing of the council's workforce?

Does your council hold a Bronze, Silver or Gold Healthy Working Lives Award?

Economic development

In a time when all public sector resources are under intense scrutiny, there is a need for all services to achieve excellent value for money by delivering high-quality and sustainable outcomes in an efficient and effective manner.

Effective economic development can impact positively on a wide range of priority outcomes that matter to your council, your partners and your communities. Helping your unemployed constituents into local jobs can impact positively not only in overall economic terms, but also potentially in terms of improving health inequality outcomes. There are also links to reducing crime levels and strengthening the wider social fabric of communities.

In a best-case scenario, effective economic development can provide an excellent example of the type of early and preventative intervention that can both lead to more sustainable outcomes and reduce overall costs for the public sector. One aspect of this is in the consideration of public sector procurement.[18]

Public procurement

Over £9 billion per year is spent by the public sector in Scotland on goods and services in areas such as health and education. The Public Procurement Reform Programme[19] aims to increase standards, ensuring value for money for the taxpayer. It aims to improve the ways the public sector buys goods, works and services.

Successful reform of public sector procurement could not only deliver economic benefits but social, health and environmental benefits too. Sustainable and responsible public sector procurement can help towards meeting emission targets in the battle to address climate change, while also ensuring local business can flourish in the current economic landscape. Just a few of the steps and considerations you and your council can take are outlined over the page.

Your council and local partnerships have an important role in the procurement of foods and snacks used in all of its public and staff premises. There's also a role in raising awareness of healthy eating among staff and communities. The Healthy Living Award[20] recognises organisations' efforts to do just this.

The Scottish Government National Food and Drink Policy[21] highlights that food should not be considered as just another commodity to procure by the public sector. By its very nature it has the potential to influence our diet and therefore our health, our environment and our economy.

Does your council/partnership recognise sustainable and responsible procurement as a tool for improving health and tackling inequalities?

Given that people in employment generally enjoy better health outcomes than those who are not in work, what role does your council's economic development function have in contributing to better health outcomes for your local population?

In conclusion

Reducing health inequalities is a priority for both national and local government. As a councillor you are ideally placed to address heath inequalities and improve the health of your communities.

We have illustrated the impact of health inequalities from a national right down to an individual level and demonstrated that there is much you can bring to the table in addressing them. However, you and the council cannot do this alone, as organisations and communities will need to work together to reduce health inequalities and improve and protect health.

As a councillor you can, as part of your community leadership role, work with members of your communities to empower them to take ownership and ultimately be responsible for addressing health inequalities and improving their health and wellbeing.

Partnership working will make success in this area more likely, and with the integration of adult health and social care services, the reduction of health inequalities is placed at the heart of this for all services to address.

You are a representative of your community and can champion their cause among other decision-makers, while also scrutinising policy and evaluating services in their delivery of health outcomes as set out in Single Outcome Agreements.

Overall, as a councillor you are elected by your constituents and are accountable for the decisions you make on their behalf. The most important consideration in any of these decisions must be of their health and wellbeing and changing the inequalities that exist across Scotland.

‘If you really want to make a difference, I mean really make a difference in someone’s life and that’s what I came into politics to do, then you have to really know the issues that are there for that family or that person.

‘Information, data and stats are helpful; they show the extremes of the health inequalities, but you have to speak to the people, see it for yourself, then convince yourself and the others you are working with that we can change this and this change will have benefits that reach beyond that individual and that family.’ *

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