



HEALTH EQUITY STRATEGY 2010

Communities in Control

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1. Executive Summary

NHS Tayside's 2003 Health Inequalities Strategy laid out that health inequalities are the differences found in various aspects of health between different groups, especially between those who are best off and those who are worst off in society. The 2003 strategy resulted in progress in many areas, however, this strategy suggests a far more radical approach. It describes the devastating effect that health inequalities caused by relative poverty have on the communities we serve. That effect is the enormous scale of poor mental health and wellbeing, long term physical ill health and early death in the poorest communities. It sets out the aim of closing the inequalities gap by aiming for health equity in a generation. That does not mean aiming to completely remove all unfair variation in health, but it does mean reducing the avoidable differences dramatically, to the point where they do not represent the appalling and systemic unfairness we now face. For example, it means reducing the years of life lost annually to poverty in Tayside from being measured in thousands to being measured in hundreds. This goal requires fundamentally different approaches to health from NHS Tayside, not just working harder at our current efforts.

Comprehensive evidence suggests that the one of the main ways relative poverty causes harm is the chronic stress it causes when people experience society's unfairness. Unhealthy lifestyles such as substance misuse which help people cope with this stress are passed on at very early ages. Teenage pregnancy is both a product of this cycle and an accelerant. Teenage mothers from deprived areas are most at risk of lacking skills to raise children with normal development. Breaking the cycle of deprivation leading to ill health early is therefore vital for future generations. Having a sense of worth, aspiration and confidence can protect people from such harm – it can give them resilience. We can help to build on existing confidence and resilience, and rebuild aspiration where it is harmed by supporting communities to take control of their environment and the services that surround them. This is a very different goal than just aiming for faster or closer services.

This is primarily a strategy for investing in community resilience, investing time and effort in promoting social capital and community enablement. We will primarily do this by offering social responses to social problems. In particular we will support co-production: helping people to plan services and to take back elements of services which do not need to be delivered by health professionals so that in total, services are co-produced by communities and the NHS. This promotes social capital - the importance of a connected and caring society - over institutions. In short we will ensure that our services promote more patient and community enablement, not more dependency on the NHS.

Our range of effort will need to look different in every area of Tayside because people's needs are different, and the community networks which can support them are different. The key is to see people as the start of the solution, not the start of the problem – to recognise that people know what will make a difference and can tackle problems themselves with our help. This is much healthier, in every sense of the word, than the NHS setting out to do things to people and fix things for them.

This is therefore a strategy for NHS Tayside to promote health as much as it cares for ill health. It is about making a cultural change that is already starting to happen consistent throughout NHS Tayside and its partners, so that through joined up effort we can help communities become stronger and healthier. This needs to happen jointly with our traditional partners such as local authorities but also with the parts of the voluntary sector that we tend to have less contact with, such as small charities, self help groups and informal community groups that are in touch with people who are not in touch with us.

We need to see all these actions as related despite some being for shorter term results and some for longer term.

For example, actions to make services easier to access or to promote healthier behaviours are needed in the short to medium term, but they must never be conducted in a way that harms resilience or promotes dependency on our services. Ideally such efforts should inherently promote social capital and empowerment, whether by using co-production, by supporting community networks, by sharing services with the voluntary sector, by offering social prescribing or by increasing empathy of our staff and our organisation.

Throughout the strategy we commit to specific actions, but more importantly we describe the sort of actions that will help and declare our intention to support our staff and communities develop other ideas jointly as we go. In particular we want to focus all these ideas, culture change and actions on breaking the vicious cycle of poverty and ill health early by prioritising the improvement of children's early years.

What is not included in this strategy is a list of all the actions NHS Tayside and its partners will take in the five years that it covers. Strategies need to give direction without being directive. This strategy lays out the culture change and outcomes required in five years, and gives illustrative examples but does not prescribe detail. Specific and detailed actions are laid out in NHS Tayside's annual commissioning plan, in Single Outcome Agreements, in the plans of its Community Health Partnerships and in the plans of partner organisations such as Local Authorities, Colleges, etc. Each year these plans will detail the specific changes (and the associated costs and timescales) that will be undertaken in the coming year. Those plans will include actions for the coming year which will achieve outcomes during that year such as improved access to services, as well as those which will take longer than one year to show benefit. For convenience, a summary list of all commitments which are included in this strategy is in section 2. The rest of the strategy goes on to explain why they are needed and explain them in more detail.

As health equity is such an important topic, NHS Tayside will enhance its already rigorous performance management and scrutiny mechanisms to ensure that this strategy is fully implemented: that the scale of actions are appropriate to the scale of the problem and to the ambition of achieving health equity within a generation.

2. Summary of Commitments

Throughout this strategy a range of commitments are made. To make it easier to see them all they are listed here, broadly grouped by the parts of NHS Tayside which will lead actions. Many actions will affect all areas so this should be treated as a grouping for convenience of reading rather than a strict allocation of tasks. This is also represented as a driver diagram in Figure 1 below.

Board Policy

- Make "Contributing to achieving health equity within a generation" our most important aim, integrating the ideas in this strategy in all work.
- Only approve strategies/plans that are responsive to very local needs and the variations in such health and social needs across our communities, including those in rural areas.
- See all these actions as necessary and inter-related despite them covering short, medium and long term actions.
- Systematically redesign mainstream services within resources instead of using projects based on non-recurring funding.
- Manage performance so that the whole strategy is implemented fully, and in a co-ordinated way across NHS Tayside and our partners.
- Target new resources and those freed up by redesign at these priorities.
- Take progressively bolder actions to re-allocate resources if these approaches fail to achieve the required changes within three years.

Commissioning Early Years Improvements

- Prioritise the improvement of “Early Years”, supporting parents to help themselves, and creating communities which are positive places to grow:
 - identify vulnerable young families and provide preventative interventions
 - tailor ante-natal programmes to meet health and social care needs
 - develop evidence-based young parenting programmes
 - promote mutual support networks for parental collaboration
 - work with young people to help them improve their environment and create opportunities for active recreation and fostering aspiration
 - support young people’s mentoring and befriending programmes
 - develop measures of childhood development as proxies for long term success in reducing inequalities

Organisational Development

- Promote community networks, resilience and social capital for example by:
 - involving people more in the design of services, especially where they can also take back the delivery of services (co-production)
 - developing time-banks
 - building a community development programme with our partners
 - supporting mainstream services to promote social capital
- Develop reporting mechanisms covering current positions, trends and trajectories for services and committees.

Workforce

- Develop training and development so that all staff see health inequalities as the most important issue, and understand how they can help.

Public Health and Health Strategy

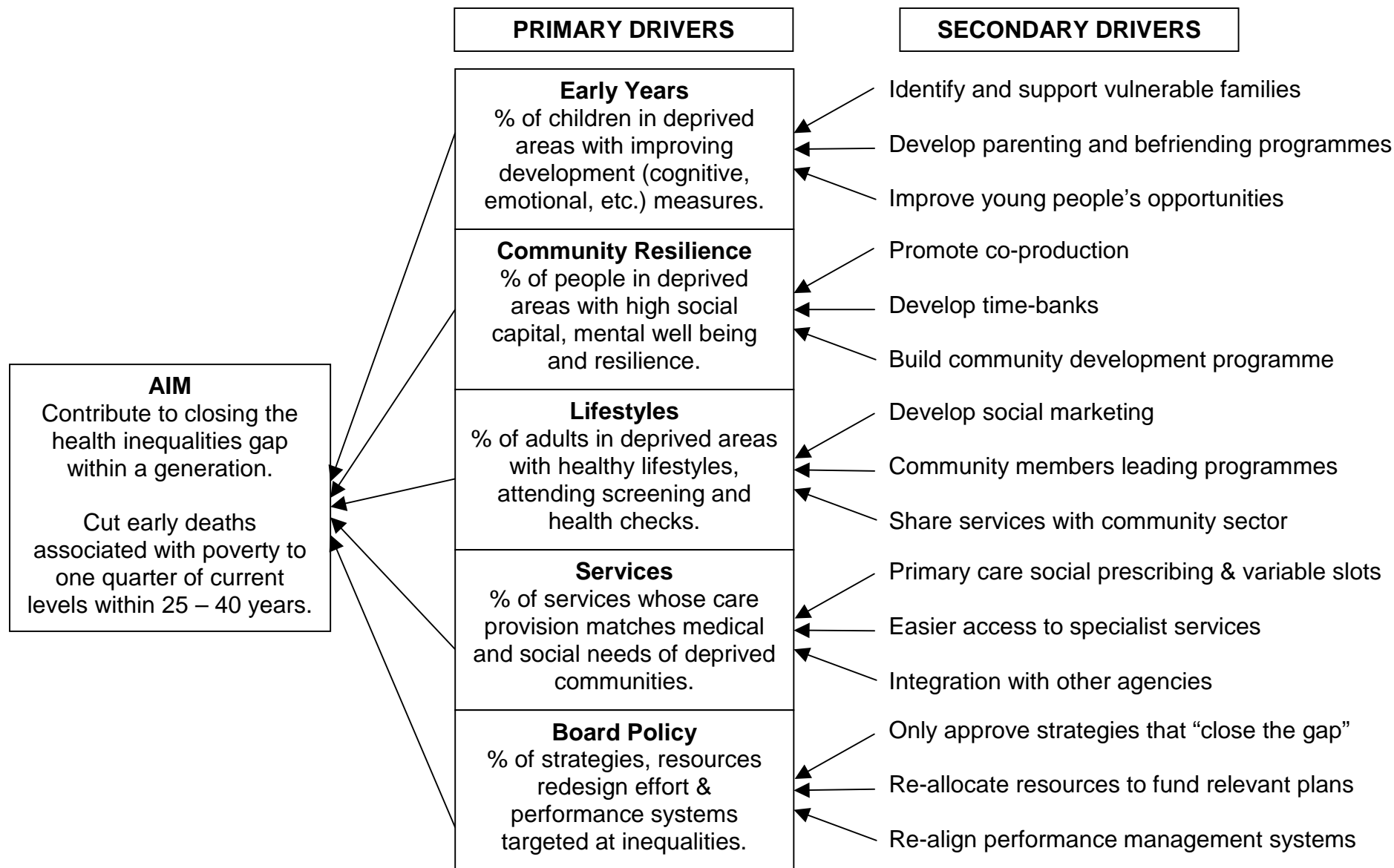
- Support behaviour change more effectively for example by:
 - using social marketing techniques
 - asking people who have already changed to healthier behaviours to help us lead the continued effort
 - asking employers, charities, voluntary groups etc. to carry out health checks and support people with desired changes
- Increase screening uptake in deprived areas using social marketing and community development techniques.
- Continue to refine ideas and build evidence on effective means of tackling health inequalities.
- Develop and agree measures of progress with our communities and partners including:
 - progress on integrated measures of improved mental health and well being, less long term ill health and less early death
 - social capital and childhood development
 - replacing targets that seek average improvements with targets on closing the inequalities gap
 - improving our evaluation capacity
- Develop understanding of differential sources of mental well being, ill health and early death.
- Expand capacity on inequalities health intelligence. For example, to link monitoring systems and expand them to include other useful measures.
- Alignment of staff and strategies in line with the topics in this strategy

Delivery Unit

- Improve service access in areas of greatest need for example by:
 - extending the reach of services that are known to be effective specifically to increase uptake by people in poorer areas
 - adapting principles from the Unmet Needs Pilots to services caring for poor mental health, long term ill health and early death

- Ensure that increased access to care does not promote dependency, but ideally promotes resilience and social capital as well as addressing needs.
- Improve primary care's ability through for example:
 - increasing social prescribing
 - longer consultation times for people with socially complex problems
 - increasing GP empathy and patient enablement
- Integrate services with partner agencies so they are easier to access, and provide more holistic services for people's social and health needs.
- Engage fully with the voluntary sector as part of all these efforts.
- Systematically support volunteering in a much wider range of settings.
- Improve wealth of poorer communities by, for example:
 - expanding the HealthCare Academy so that we routinely employ significant numbers of people from deprived areas
 - expanding work like Discover Opportunities
- Use Improvement Methodology and Triple Aim as methods of co-producing further ideas and implementing this strategy.
- Ensure that work to implement the Scottish Government's "*Towards a Mentally Flourishing Scotland*" and "*Equally Well*" is integrated with this work.

Figure 1: Driver Diagram of NHS Actions



3. Aiming for Health Equity

Contributing to achieving health equity in a generation is NHS Tayside's single most important aim. This is because in the people, families and communities we work with relative poverty is the largest single cause of:

- poor mental health and wellbeing,
- long term physical ill health, and
- early death.

Poor health associated with relative poverty is the most severe form of inequality in society. Our population profile shows that at the worst extreme the poorest people in Tayside have around 10 years more ill health and live 23 years less than the richest people. Whilst NHS Tayside should continue to consider links between the different 'strands' of equality and poor health no other disadvantage systematically cuts healthy life expectancy by over 30 years from around 80 to around 50. This is not just a problem for a few people: over 84,000 people in Tayside live in some of the most deprived areas in Scotland. A snapshot analysis by David Shaw, a GP in Dundee, suggests that over 180 deprived people die early every year. If they had the same life expectancy as people from richer areas they would together live about 3,700 years longer.

***Poverty kills.
It kills life, it kills health and it kills spirit.
It kills on a devastating scale.***

One of the most surprising facts, explained in section 4, is that relative poverty does not just harm poorer people, it harms richer people too, so it is in everybody's interest to tackle the problem. Society must act not just for these moral reasons, but for economic reasons too. All those extra decades of ill health that kill hundreds of people early every year are also a massive drain on the NHS, and on taxpayers.

This is not a strategy about reacting to these health inequalities, or about reducing them a little. As the World Health Organisation's (WHO) radical report "*Closing the Gap in a Generation*" urges, this is a strategy for **dramatically reducing** them. It is unrealistic to aim to completely remove all variation in health, but we need to abolish its systemic unfairness: to aim for health equity within a generation. If Tayside's early deaths were reduced to a quarter of their current level within 25 to 40 years (to less than a thousand years lost annually), we would be close to Health Equity. That needs all measures of the health gap which are currently widening to stop within five years, and all measures which are currently stable to narrow.

This is such a large scale and long term problem, especially in Tayside, that it will only be solved by wholesale adoption of new and radical approaches to improving health and wellbeing. Promoting community control as a health solution is not new or radical in itself. Many of our partner agencies already understand and adopt it in many aspects of work, but for an NHS Board to adopt it throughout all its work, and for all partners to work systematically together in the same vein to achieve a critical mass of effort **would** be new and radical.

Charles Leadbeater of the Public Service Design Agency describes this shift well:

“Radical public services innovation will only come from a markedly different starting point. The key will be to redesign services to enable more mutual self-help, so that people can create and sustain their own solutions. The best way to do more with less is to enable people to do more for themselves and not need an expensive professionalised public service... Services do a better job when they leave behind stronger supportive relationships for people to draw on and so not need a service... For most of the last decade, we have seen public services as systems and standards, to be managed and rationalised. Instead, we should re-imagine public services as feeding relationships that sustain us in everyday life”.

NHS Tayside cannot achieve such a far reaching ambition of handing control back to people easily or alone, we must work with the people we serve in a completely different way and that will be challenging for everyone. All of the public sector must work in the same way, and the local authorities are ready to lead this change with us. However, we must realise that in setting out to do things differently for ever we will not be able to prescribe in detail how we will do it. Instead, as Harry Burns, the Chief Medical Officer has said, we must describe the culture change we are aiming for and then learn as we go, being nimble to adopt the tactics which work and abandon those that do not. However, to understand why such wholesale changes are needed we need to understand the detail of why and how poverty kills.

4. Understanding Why Poverty Kills

Systematically worse health does not just affect the poorest people. Health worsens with lower salary and social status at every level. This is related to not being able to afford healthy food, pleasant environments to exercise in, transport to health services, etc. However, it is not a problem that can be solved just by increasing salaries: evidence from around the world compiled in Richard Wilkinson and Kate Pickett's book *“The Spirit Level”* shows that health is significantly better when the wealth gap between the rich and the poor is smaller. Rich people in unequal countries like the UK, where that gap is large, are far less healthy than rich people in more equal countries like Sweden where the gap is narrow.

***What other people earn affects your health
as much as what you earn.***

People throughout unequal societies see that they are much worse off than the very rich. We feel conscious of low status and the more relatively deprived we are, in terms of poverty, but also job insecurity, debt, education, housing etc., the more chronic stress and poor mental wellbeing we suffer and the less able to take positive action we become. Whether our behaviours are healthy or not becomes irrelevant when poor mental wellbeing in the form of stress, anxiety and depression dominates, and when the community support networks which protect from harm do not function. The Scottish Government's plan *“Towards a Mentally Flourishing Scotland”* says mental wellbeing includes both *how people feel*: their emotions and life satisfaction, and *how people function*: their self-acceptance, positive relations with others, personal control over their environment, purpose in life and autonomy.

Without positive mental wellbeing we naturally concentrate on individual coping and stress relief rather than healthy behaviours and supporting each other. Income is more likely to be spent responding to peer pressure and expectations instead of on health, and on children's health.

Stress relief in these circumstances often comes from physically and socially harmful habits such as smoking, drinking and taking drugs. These behaviours lead to more poverty and crime and to a dysfunctional and distrustful society generally.

Poor parenting and early childhood experiences affect development and behaviour throughout life, perpetuating the cycle of ill health from one generation to the next. Social pressure is intense: when people all around you indulge in harmful habits, the likelihood of joining in is high. This vicious cycle is social in nature, depending on unfair income distribution, peer pressure and social expectations to sustain it. However, whilst this fact lies at the heart of the problem, it also points to the solution to breaking the cycle and creating a virtuous cycle instead of a vicious one. A virtuous cycle that helps tackle not just health problems but many other problems communities face.

5. Understanding Community Resilience

Social support is as powerful as peer pressure and when people, families and communities come together to support each other, they can improve health as well as addressing many other problems. Studies in the WHO report “*Mental Health, Resilience and Inequalities*” by Lynne Friedli show that whilst narrowing the relative poverty gap improves health, improving mental wellbeing also protects from harm – it gives resilience. Richer communities are naturally more resilient than poorer ones, but poorer communities can boost resilience and hence health by increasing social capital. So when people know, help and trust each other, when one good turns deserves another and when a community feels like a community, not just a place where individuals live, people are able to be healthier, happier and safer.

***Community networks are the very
immune system of society.***

This does not mean that stronger community networks, targeted employment practices or better mental wellbeing, social capital, aspirations and enablement that flow from them will stop people from indulging in health harming behaviour, eliminate teenage pregnancy or remove all inequalities in health. Many other factors influence health and need to be tackled by all public sector agencies together. But they do represent the background against which other problems should be viewed. They represent some of the most effective ways to improve life circumstances and despite being more social problems than medical ones, the whole NHS has a large and significant role to play - a very different role to the one it is currently playing. This role is about how the NHS and other agencies can help communities take more control of their own affairs including health, rather than what the NHS or other agencies can do to, or for, communities to improve their health.

An illustration is that people believe that fixing the obvious causes of ill health such as poor housing will help solve people's problems. Yet studies in an evidence review commissioned for this strategy show this will only help if done in the right way. Some initiatives to improve community housing actually harm physical health. One reason suggested was that in a particular improvement programme, subsequent rents doubled, worsening people's poverty, and reducing their chance of affording a healthy diet. In contrast the Hunter Crescent estate of Perth (now known as Fairfield) was well known for its social and health problems. In the early part of this decade the council, crucially, gave control of the estate redevelopment to the residents. Those residents worked with developers to decide the policies and changes for the area. Not only is housing improvement sustained, but people report that the area is a happier place, and is viewed by others as a desirable place to live. The people in Fairfield say they feel more enabled than they used to.

Another example is in Malcolm Gladwell's book "*Outliers*". Gladwell describes the "mystery" of the good health of people in a small town called Roseto in America (studied in the American Journal of Public Health). Most people had moved there from Italy and experienced much better health than neighbouring towns and much better than most of America. When the reasons for this were analysed it turned out that superficially the people had similar lifestyles and genetics to others. They ate as badly as others in America (worse than in Italy), took similar amounts of exercise; and people with similar ancestors elsewhere had worse health. The only aspect that differed significantly was the sense of community and subsequent resilience. People talked on doorsteps, spent time in each others houses, socialised together and had strong community networks – they had social capital.

In "*The Wee Yellow Butterfly*" Cathy McCormack writes that for those trapped in a toxic mixture of economic circumstance life can be hard but a strong spirit and a refusal to accept what is given can release energy and creativity for individuals and their communities. In the Clifftown and Hayshead areas of Arbroath, residents' Association Chairman, Margo Reilly "encourages volunteers to better their community by looking at what the community wants to achieve" she then "helps that to happen by encouraging partnership action which uses the time and talents of the local residents in community planning".

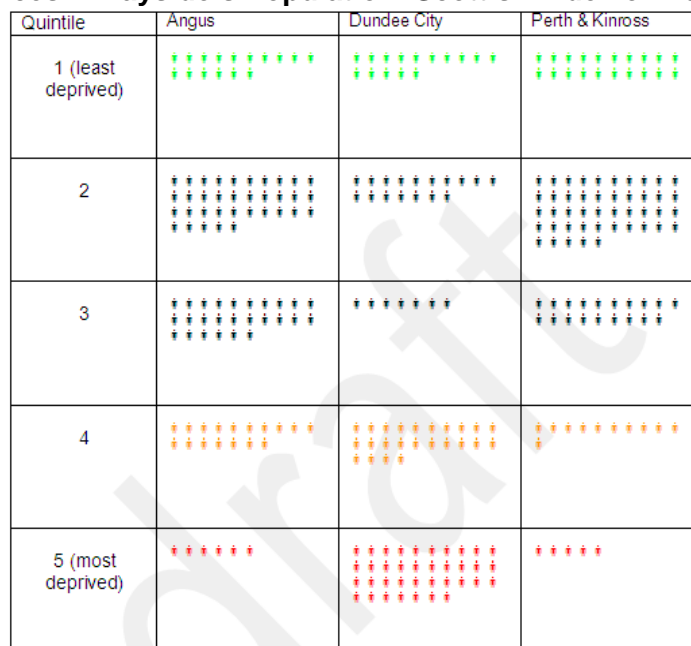
The significance of these lessons to the NHS is huge. Most of us accept that the NHS should improve access to its services in deprived areas, and should enable poorer people to make better lifestyle choices. But if we "do things to" people, without thinking through the consequences on the social and community aspects of health – whether people feel in control of their environment (enabled), and whether they support each other (social capital) - we will be unlikely to help, and more importantly, despite our best intentions, we may even harm inadvertently.

Increased access to traditional NHS services can harm health even more than poor housing action. Not just because imposing solutions on people undermines their own control in the short term, but because people can become dependent on the NHS in the long term. If people seek, and the NHS provides, medical solutions to social problems, people become less able to protect themselves from things that harm health, and less able to cope with all forms of harm. The NHS therefore needs to help people find alternatives to seeking healthcare as a solution to social problems as well as providing appropriate services for medical needs. It might be as simple as letting people know what is going on in their community that they could be part of, or it might be as complex as whole new programmes of community development. The point is that our current style and scale of effort on these types of problems will not come close to solving the problems, no matter how hard we try, which is the main reason this strategy is needed. However such work is supported by the Government's "*Meeting the Shared Challenge*" programme which aims to support a shared understanding of, and a strategic commitment to, a community led approach to health improvement and addressing health inequalities.

6. Understanding Communities in Tayside

Problems of poor health, poverty, teenage pregnancy, crime and addiction are not spread evenly throughout Tayside. In developing this strategy we thoroughly updated our population profile and published it with this strategy. It shows that the majority of severe poverty, ill health and early death is concentrated in Dundee where almost two thirds of the population live in some of the most deprived areas of Scotland (see Figure 2 below). However the concentration of deprivation is not evenly spread: walk through small neighbourhoods in Dundee and see affluence and people with good health; walk to the next street and see the absolute opposite.

Figure 2: Differences in Tayside's Population: Scottish Index of Multiple Deprivation



Data Source: SIMD 2006 & GRO(S) SAPE populations 2007

Similarly, towns of Angus and Perth and Kinross with far less overall poverty and deprivation, still have discrete pockets of severe deprivation where health needs are very different to the rest of the town. Outside towns, rural areas have poverty which is less easy to spot. This poverty is characterised by a combination of low income and isolation from services and communities which are important to health. When taking these aspects into account, almost a quarter of people in Angus, and one sixth in Perth and Kinross, live in some of the most deprived areas in Scotland.

Think about the important points covered already:

- extreme relative poverty destroying wellbeing
- poor wellbeing leading to unhealthy coping behaviours and chronic stress
- individual coping behaviours harming health
- poor parenting harming child development
- family behaviours and peer pressure reinforcing and repeating the cycle
- local communities needing to be resilient and powerful
- community networks being the immune system of society
- agencies taking well intentioned but actually harmful actions

Add to this the differences in poverty, community and health needs comparing one small area with another. It becomes clear that centrally re-allocating resources to push more, say, secondary care services at all poor communities, irrespective of whether they want or appear to need them, and without considering what their whole (especially social) needs are would be inappropriate. The challenge is to work with communities, not to find out what they want and then provide it, but to enable them to take control and provide their own solutions. Communities need to be involved in the delivery of services, behaviour change initiatives and solutions, as well as in their design. This enablement and related ideas are called co-production.

7. Promoting Co-production

On a simple level co-production is about involving people in the delivery of public services. This helps people change the relationship with services from dependency to genuinely taking control. It helps improve public ownership and helps services improve by increasing their relevance. The new economics foundation (nef) pamphlet “*Co-production*” describes deeper and more important reasons for promoting co-production. The skills and values involved are also those that communities need to improve the social capital which is so critical to wellbeing. Co-production on this level is about valuing and rewarding fairly people’s everyday contributions to society. One tool which does just this is timebanking. Timebanking is in use in Tayside. For example, Dundee Association for Mental Health’s Orbit Approach rewards users for time they commit with complementary therapies.

nef describes other examples of timebanking, both generally and in relation to changing public services. It also describes other examples of co-production. A powerful example is from Lehigh Hospital, Philadelphia. On discharge you are told that someone will visit you at home to make sure you are OK; see if you have enough heating, food etc. That person will be a former patient, not a health professional, and when you are well, you will be asked if you will do the same for someone else. The result is more than a significant cut in re-admission rates: more than people in communities taking back over-professionalised services. It promotes communities looking out for each other, and reduces the dependency that convinces many patients they have nothing worthwhile to offer. It promotes enablement and social capital.

***People are at the heart of the solution,
not the heart of the problem.***

Co-production as supported by the public sector in general and the NHS in particular should always:

- view people as assets who have skills vital to improving our services
- break down barriers between service provider and user
- promote people supporting each other
- include an element of reciprocity
- build community
- support resilience

The nef pamphlet suggests 10 measures which NHS Tayside and partners could use to gauge our collective success in promoting co-production working with our staff and partners, as well as with communities – these are listed at Appendix 1. We are working with nef to help us develop these ideas and work which will support them. An important note is that the heart of this strategy was created using co-production by many relevant agencies in a dedicated event in Perth.

8. Developing a New NHS Culture

The new NHS culture is therefore not to assume that a policy designed for the average person with a particular health need or demographic label will suit everyone with that need. It is not to lay out precise actions that NHS Tayside has decided to do to, or for, people, even if it has listened carefully. Instead, the new culture is to acknowledge that despite many of the wider determinants of health such as housing lying outside traditional health care, we can act with partners and communities to directly improve wealth, community resilience and social capital.

We can do this as well as supporting behaviour changes and improving access to services. If done to genuinely help communities take control, these actions will improve health just as directly as the wider determinants.

They will not just improve health through the direct observable outputs such as better services; they will lay the foundations for communities mentally flourishing and becoming “*Equally Well*”.

***The NHS can be more of a health service - improving health
Less of a sickness service - delivering care***

NHS Tayside will tailor those efforts to be truly responsive to very local needs - not just responsive to obvious health needs, but by working with partners and communities, responsive to all individual, family and community needs. It will promote co-production so that local communities can not only be involved in delivering care and other services, but also in creating or developing community networks that take control of environments and do what is needed for their children to grow up in aspirational families that live in caring, supportive environments.

This approach forms the fundamental context or philosophy that all service improvement effort must adhere to. It forms the essence of the cultural change needed consistently in all services, not just in those departments with staff working on community development. In particular this creates a different perspective from which to evaluate our current efforts. In the old culture where local access and increased uptake were part of the ultimate goal, putting specialist services into communities despite extra cost and decreased efficiency was a good thing, as was offering more local access to screening. In the new culture of empowering people, promoting social capital through co-production and community networks which look after each other in the widest sense, and in particular in decreasing unnecessary and unhealthy dependency on services, these efforts need to be thoroughly re-evaluated to check that access is not at the expense of dependency.

9. Integrating Agency Efforts

A theme of this paper is that health is about more than health care but that the NHS needs to be fully engaged with that wider agenda. That helping people to take control of virtually any aspect of their environment or improve social capital is just as important to improving health as helping them take control of services. In other words, as Derek Wanless described in his series of public health reports, a fully engaged population is part of a public health agenda. The key point here is that this is an agenda every public service needs to be part of. We need to build on existing partnership work particularly in Community Planning Partnerships and evidenced in Single Outcome Agreements. We need to work in a thoroughly co-ordinated way so that communities are not faced with the NHS talking about community networks for health, and police talking about different ones for safety, and the council promoting different ones for climate change solutions. It is also about agencies sharing learning with each other and acting to deliver services in a thoroughly joined up way.

10. Engaging Community and Voluntary Sectors & Promoting Volunteering

The community and voluntary sectors have many vital roles in aiming for health equity. They are often in the best position to promote social capital and develop community engagement. The NHS needs to support such organisations to share community information, support parents, promote healthy choices, spot health problems, deliver aspects of care and develop links with health workers.

We will engage fully with these sectors so that they have a more equitable and esteemed relationship with NHS Tayside and with the public sector generally, so that they are part of the joined up approach across agencies. One aspect where such organisations are well placed to recognise, develop and support opportunities is in the promotion of volunteering, including the volunteering of our staff. Volunteering can range from informal arrangements to 'help out' through to more formal arrangements, such as Befriending, Buddying, joining Patient Partnership Groups, being a Community Activist, becoming an Expert Patient, training Lay Workers, joining a Peer Supporter network etc.

Volunteering benefits the person receiving support, but it also enhances self-worth and self-esteem, increases wellbeing in the volunteer and can be a strong part of a virtuous cycle of support and development within communities. Often those receiving support go on to help others in similar situations. This encourages continued benefits and improved wellbeing and capitalises on their unique position to understand and support others facing similar issues to their own.

Examples of volunteering abound in Tayside but we need to support them more systematically, including rewarding our staff for volunteering. The Angus Community Health Partnership and Volunteer Centre recently published "*Beyond the Trolley Service*" discussing the benefits of volunteering and how the NHS can support it. An example is Kirriemuir's Friday Night Project, which organised for a sports centre to be available at night. Up to 120 young people attend and it wouldn't happen if it wasn't for the efforts of young people who volunteer to raise young people's awareness about drugs, alcohol and health issues and as befrienders to ensure that young people with learning disabilities and other challenges were able to participate.

11. Towards a Mutual NHS

"*Better Health, Better Care*" stated that we need a more inclusive relationship with the Scottish people; a relationship where patients and the public are affirmed as partners rather than recipients of care. We need an NHS that is truly publicly owned and accountability is shared with the Scottish people and with the staff of the NHS. These concepts are fundamental building blocks on which ideas in this strategy like co-production and community resilience rest. When we consulted with people in the most deprived areas of Tayside about this strategy they told us about the things they felt would help, and that are perhaps obvious:

- that unhealthy behaviours start with children learning them from their parents and friends so that is where we should focus most of our efforts
- that the reason some neighbourhoods feel unsafe is young people hang around because they have nothing to do and nowhere to go

They told us they could see these things for themselves and could tackle them if they were not prevented by laws, or hindered by distant bureaucracies and were instead helped by local services using a little local discretion, effort and flexibility. This is consistent with the Scottish Government's drive to 'shift the balance of care'.

12. Seeing Long Term Connections

This strategy covers some of the big causes of poor mental health and wellbeing, ill health and early death. It highlights that these problems are far worse in the most deprived areas, where people suffer most poverty and have less enablement and social capital. Individual solutions might appear to be isolated but if we follow their impact we see that they are not. Again paraphrasing Harry Burns, Scotland's Chief Medical Officer, it might look like we can pick and choose aspects that we will work on, but we cannot if we truly want to improve a whole system, as opposed to being seen to do something.

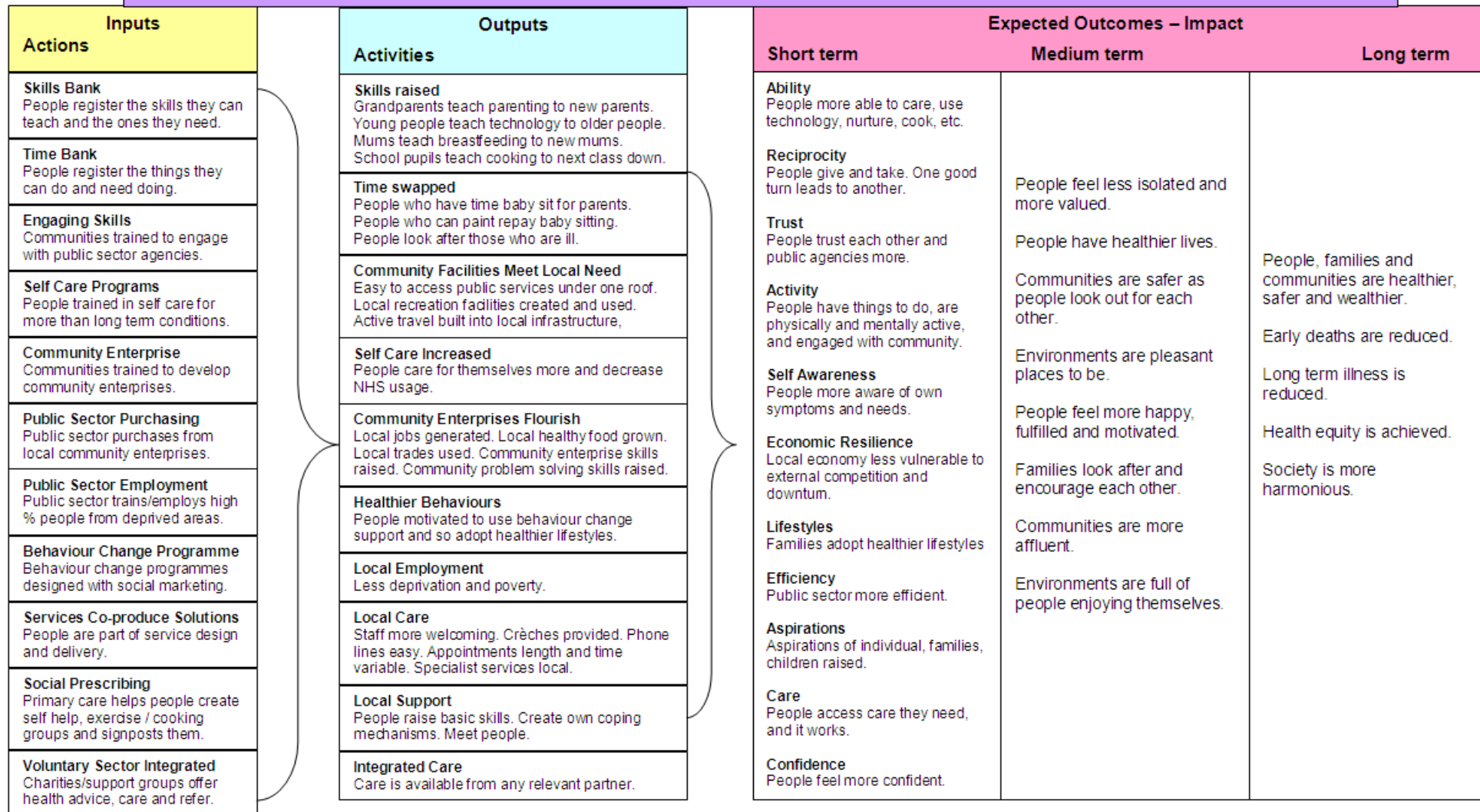
The approach of pilots that target single issues and rely on ring fenced funding but then stop might seem attractive, but they are not.

The real issue is that, as with all “wicked” problems, the various factors are not simple or isolated from each other but are complex, entrenched and inter-related. They will not go away if we find some time or money to do extra things in addition to the usual services and ways of doing things. This is why it is difficult to measure the success of individual actions and why it is dangerous to try to list all the actions we will take. It would be impossible, and would imply that they were exhaustive.

Instead this strategy describes the cultural change needed and lists the sorts of actions that ought to help. It is particularly important to say that some actions may have a relatively quick impact, whereas others may take years to make a difference. This does not mean we can delay actions which will take a while to bear fruit, nor can we treat the actions with quicker impact as independent of them.

A good analogy is that of planting a garden. When planting you need to plant the acorns that will take twenty years to grow to oaks, at the same time as taking cuttings for medium sized bushes in a few years, at the same time as planting this year’s annuals. In particular you need to see the various actions as related because it is important to plant things where they won’t harm each other, and to think about how it will all look in the end. The diagram in figure 3 shows the various types of action in this strategy relating to each other. It shows that we should see some results in the short term, but will have to wait longer for the more systemic changes. Whilst all these actions and benefits are probably needed, and need all agencies to work together, they are not exhaustive. Work must continue to develop the actions that will sustain the culture change at the heart of this strategy.

Figure 3: Relationship between wide range of actions (logic model) to aim for Health Equity



13. Enacting the New Culture

The new NHS culture of acting on the wider determinants of health through empowerment and enablement at all levels needs to permeate our thinking and our actions. The aim is to improve mental health and wellbeing so that people are more able and likely to choose healthy lifestyles, more likely to tolerate and control existing illness, and less likely to need care in the future. In the meantime, people who still have much greater health problems still cannot or do not access the sort of health care they need, and should be supported to choose healthier behaviours. The more traditional NHS aims of improving access and supporting behaviour change are still therefore relevant, but they need to be done in a different way with different end goals in mind. That means the three main types of specific action are:

- supporting communities, especially the poorest ones, to improve enabling community networks and so improve their own mental health and wellbeing;
- enabling poorer people and families to choose and maintain behaviours which lead to good health, and reject behaviours which damage health;
- ensure health care and other services are designed to integrate and match people's overall needs (not just obvious health needs) much more closely.

These approaches of supporting mental health, enabling behaviour change and improving access must be integrated so that care becomes more holistic, with staff and services thinking about people's social needs, not just their medical needs. The staff of 'Discover Opportunities in Dundee' already strive for this ideal. They provide help for people to develop their skills for work, helping them with social confidence as well as helping them with health problems and many other issues, recognising that these needs are inter-related. They also recognise that work and socialising are good for health and that confidence and skills help people want to work as well as making it more likely that they will find work.

If this integration is not done there is a real danger that we will make inequalities worse. This is because just giving people with poor mental health extra care for physical illness, without supporting them to improve their wellbeing, and take control of their own health can de-skill them further, creating an unhealthy dependency on the NHS and on medicine in general.

Giving anti-depressants to people with minor depression who do not need them happens regularly. These drugs are no use unless people have major depression, so the NHS wastes money and creates a dependency beyond unwarranted repeat prescriptions. We need to recognise that many problems of low wellbeing are inherently social and lead the way in actively seeking non-medical solutions. This is the essence of why these proposals are radical. The NHS puts most of its effort into faster, more cost effective access to the newest treatments for physical health, but if it forgets that mental health and its social sources are as important as physical health, it can harm health.

This approach makes lifestyle interventions such as well designed smoking cessation programmes more likely to work because people have the strength, will and support to use them. Similarly, training on eating healthily and cheaply is not enough if people do not have access to fresh affordable fruit and vegetables. Exhorting people to exercise without helping them ensure their environments are safe and pleasant is futile. We need to ensure our efforts are truly joined up and thought through, without thinking for people. When we consulted about this strategy it was striking that people could describe the solutions more clearly than many policies. Young people for instance described that they need places to enjoy sports and activities together.

Where they do not, and where they lack social support to make better choices, they hang about street corners which scares people, they turn to drugs, alcohol and smoking for lack of anything else to do, leave school with no ambitions and are more likely to become teenage parents as a result. In this context helping young people get what they need, whether it is a pool table or a father figure, is a bigger priority than more traditional approaches to public health.

A final important point about the new culture is that we are learning all the time about what helps to tackle health inequalities. Current evidence points to social capital, mental health and employment practice as solutions, but it is constantly evolving. We therefore need to constantly monitor ideas and assess our efforts to improve.

14. Improving Early Years

All of the points in this strategy apply especially to children. Reports in the past two years have put the UK bottom of the league of industrialised nations for child wellbeing. 1 in 3 children across Tayside, and more than half of children in Dundee, are from families with low income. Children living in the most deprived areas experience much poorer health, wellbeing and life chances than their more affluent counterparts. Less able richer children overtake more able poorer children by the age of six. The UK has the highest rates of substance misuse and teenage pregnancy in Europe, both of which are symptoms as well as causes of ongoing inequalities.

Our deeply unequal society damages children most of all.

Child Poverty Action Group in Scotland

All too often agencies respond to crisis situations and the consequences of failure when it is too late to alter established behaviour. We also tend to treat social problems such as substance misuse, young offending, teenage pregnancy and poor educational attainment as if they were separate from one another, instead of addressing their root causes.

The family is the biggest single influence on young people's lives. Families work with what they know and experience and children copy what they see and hear. The experiences of very early childhood affect the creation of the adult brain and influence behaviour and personality for life. A child brought up in a stable and loving environment is better placed to succeed in life, than a child from a less secure background. It is in the first years of life that inequalities in health, education and employment opportunities are passed from one to generation to the next.

Improving the early years experiences of such children is key to breaking the repeated cycle of poor outcomes. What makes the most difference is a nurturing and secure home environment, and in particular where there is interaction and communication between a parent and child from birth, as well as opportunities for play, learning and developing aspirations.

There is a need to transform the way public services interact with families and young people and the community. We need to shift the focus from crisis management to prevention, early identification and early intervention.

The biggest gains will come from supporting parents – to help themselves - and creating communities which are positive places for children to grow up.
“The Early Years Framework”, Scottish Government

14.1 *Identifying and Providing the Best Start for Vulnerable Families*

Identifying, engaging with, and supporting more vulnerable parents and families to provide a stimulating and supportive early years environment, as well as making sure that there is good access to high quality pre-school and school education, is central to improving the life chances of young people and the overall efforts to combat inequality. Yet we know that those parents most in need are often the least likely to access services.

The NHS comes into contact with almost all women during their pregnancy. It is well placed to identify where women and families need additional support and to work with others, including the voluntary sector, to tailor more holistic ante-natal programmes that meet health and social needs and offer children the best start in life. Newborn babies respond to positive interaction from parents and carers. The importance of communication in the first years of life should be included in the advice that expectant and new parents are given.

Services such as those treating adults with addiction problems, mental illness, learning or physical disability or chronic disease, many of whom have children, should also play a key role in identifying families at risk and referring them for support where appropriate.

Whilst identifying parents at an early stage and providing preventative intervention needs to be a greater priority, we also need to make sure that there is effective access to intensive family support for those who need it.

14.2 *Positive Parenting*

There is now considerable evidence on the importance of good parenting and the benefits of evidence-based parenting programmes. Parenting programmes have been shown to:

- Improve communication and family cohesion
- Improve academic attainment
- Reduce behavioural problems
- Reduce risk taking behaviours
- Reduce levels of anxiety and depression (amongst parents and children)
- Improve aspiration and wellbeing
- Improved long-term life chances for the children

A Cochrane Review investigating ways to prevent alcohol misuse also identified a parenting programme as the most promising of all interventions in preventing substance misuse and other risky behaviours among young people. “*Pathways to Problems*” noted that the most important factors which influence whether young people will use tobacco, alcohol or other drugs hazardously are family relationships, circumstances and parental attitudes to substance misuse. It concluded that good parenting and stable family life can reduce these risks. This is particularly important as problem drug use is both a symptom of, and one of the most significant contributors to, health inequalities and is a significant factor in child abuse and neglect.

There is also emerging evidence to suggest that parenting programmes have wider protective benefits for communities through breaking the negative cycle. Older children who have been through the programme act as positive peer models for younger children and parents on the programme also spread their learning to families and friends and many go on to develop support networks.

14.3 Positive Economic Return

The argument for investing most effort and resources in early years and parenting is backed up by a strong economic case. The Government's "*Early Years Framework*" highlights the costs of current systems failure and cites the example of providing intensive secure care for a teenager at a cost in excess of £200,000 each year and the costs of impaired health, lack of employment and criminality throughout life at many times that. By contrast, parenting programmes typically involve a modest outlay. Similarly the cost of caring for children looked after by the state is around £170,000 per year and could be avoided.

Economic evaluations of parenting and pre-school programmes have shown a return of up to 27-fold on investment through decreased health, social care and criminal justice costs and higher earnings potential. In the US one parenting programme, the Strengthening Families Programme, was adopted in a number of US States mainly on the grounds of its economic benefits.

Both "*Towards a Mentally Flourishing Scotland*" and a recent economic evaluation by Lynne Friedli and Michael Parsonage "*Mental Health Promotion: Building an Economic Case*" also cited supporting parents and early years and parenting skills training/pre-school education as the "**best buys**" to improve mental health and wellbeing.

14.4 Parental Collaboration

Relying on professionals and professionally delivered programmes will not be enough to tackle the scale of the problem and will not by itself provide the stable and loving families and communities that children need to thrive and aspire. We need to harness the skills, knowledge and commitment of parents, grandparents and communities themselves to provide the positive and safe environment for all our children to grow up healthy, happy and resilient.

In her book "*Detoxing Childhood*" Sue Palmer stresses the importance of parents taking back control of the business of raising their children, and finding their own ways of overcoming the damaging aspects of 21st century life. She gives the example of a father in inner city London who got together with parents living in the adjacent streets to talk about how children didn't play outside any more. They agreed to keep an eye on them so they could play out and agreed boundaries that would ensure that they were safe. Another example is a group of parents in the north-east of England that raised money to turn an unused allotment into a wilderness play area where children make dens and explore the outdoors. In Tayside, we've seen the positive results of mums living in the most deprived areas supporting one another to breastfeed.

As well as directly benefiting from participating in parenting programmes and sharing their experiences, parents can also gain accreditation and help to deliver support to other parents. Parents can form *mutual support networks* for parents to meet up, chat and swap ideas.

14.5 *Engaging Young People*

Encouraging young people to become actively involved in mutual support networks is vital to increasing the capacity and resilience of individuals, families and communities and in tackling the underlying causes of inequality and some of the more serious social problems facing our community. Just as with their parents, we need to listen to the experience of children and young people and encourage them to use their own resources to be part of the solution.

The new economic foundation (nef) highlights the example of engaging disaffected 16 year olds in the most deprived schools in Chicago to act as tutors for 14 year olds, and the positive impact this has had on academic achievement and on the incidence of bullying.

Many young people are already actively involved as peer educators or in befriending schemes as mentors. Befriending is a supportive and supported relationship offered to vulnerable people finding community living difficult. Mentoring and befriending have benefits for community-led development. As well as improving the young person's experiences of social interaction with a positive role model, it encourages participation in new activities or situations and develops more trusting relationships which can build confidence, self-esteem and recovery and lead to wider community participation as volunteers. A nationwide survey by *Big Brothers Big Sisters* (www.bbbs.org) found that participants in mentoring and befriending services were 52% less likely to skip school, 46% less likely to begin using illegal drugs and more likely to get along with their families and peers.

This type of community development is an example of readily achievable, inexpensive ways of engaging and supporting more vulnerable young people without the need to resort to more traditional medical or other professionally-led interventions. By encouraging young people who have benefited from interventions of this type to themselves volunteer as friends, supporters and mentors to other people, we can begin to create a 'virtuous cycle'.

14.6 *Measuring Impact*

Waiting a generation to see the impact of action we take today to improve life expectancy or reduce the rate of cancer among the poorest communities can hamper innovative interventions and lessen individual and organisational commitment to tackling inequalities. Measuring the improvement of child development in early years may provide an answer to the difficulty in being able to demonstrate shorter-term impact. Professor John Franks, Director of the Scottish Collaboration for Public Health Research and Policy, advocates that Scotland should adopt sensitive indicators, such as childhood cognitive and educational outcomes (physical health, social and emotional maturity and language and communication skills) which are quicker to show change and have a strong predictive power for lifelong health and wellbeing.

Intervention in the early years of life is the best way to encourage healthy lifestyle habits, build emotional resilience, support aspiration and ultimately break the cycle of deprivation and inequality. It needs to be an overriding priority for NHS Tayside and the work we do with partners and the community.

15. Committing to Specific Actions

The previous sections of this strategy have explained:

- the scale and nature of the problem (that poverty kills)
- the long term ways in which these problems can be lessened (equality of wealth and resilience)
- how these will help in the long term (less chronic stress, better mental health and wellbeing)
- the sorts of actions that will help (co-production and community networks)
- the understanding that is needed (of different needs in different communities)
- the culture change that is needed (seeing wider determinants of health as relevant to NHS work as much as to its partners)
- the style of integrated working that is needed (working with communities, statutory partners, the voluntary sector and volunteers)
- the need to focus on early years (to break the cycle early)

All these elements are necessary to lay out the direction, without listing the specific actions individual services need to take. However, we do need to identify the concrete actions which apply to all of NHS Tayside, and examples of things that will be done differently by specific services. This section lays out concrete actions and examples. Some of them need to be done as described, while others are just illustrations. The people that manage and deliver our services need to take them and work with communities and partners to develop them and related ideas.

Specific service by service actions will be created within annual commissioning plans. They must of course demonstrate adherence to all the principles in this strategy, and demonstrate that they will deliver the sort of progress required. There is a risk in listing examples in this way that they will be deemed as correct and should be imposed on communities, whereas the whole point is that they should be developed **with communities**. In addition the examples are not exhaustive. In other words, services cannot rest if these examples are implemented. They are the start of a process of developing new ways of doing things.

15.1 *Building a Community Development Programme*

To help communities develop strengths and skills we need to help empower them. This is about helping people, families and communities develop skills and confidence to solve the problems they prioritise. Our communities tell us that this can be about developing fundamental skills that are lost such as cooking healthy foods cheaply. It can be about bringing up children positively to play their full role in society, or caring for each other with less dependency on the NHS. We might help communities create employment, exchange skills and services, or influence public agencies. These and others skills and values are at the heart of healthy, strong communities. They are what communities need most for health equity.

These skills and the values behind them are often called social capital, and helping communities build social capital is one of the most important things the public sector can do. We will systematically co-produce, ideally with our partners, a Community Development Programme which communities want. It will focus on supporting and developing the social capital of communities with most needs, and ensure a scale of ambition and progress adequate to achieve their agendas.

An example is the Perth and Kinross Healthy Communities Collaborative. This project is led by older people and professionals. Community members make improvements for themselves and their communities based on their local knowledge. This enhances relationships and networking between organisations and helps sustainability. In year one they raised awareness about falls through looking at footwear, vision, environment, medication and exercise. Falls reduced in a number of areas by 30% and social capital increased by 10%. In year two indoor curling was introduced to sheltered housing units, lunch clubs, care homes and public events. Eleven curling groups are now established with 110 people taking part. Professionals and community members also qualified as chair based exercise instructors and 16 groups are now running. Year three focuses on mental health and well-being in later life.

However, it is not just such dedicated staff that affect social capital. The way mainstream services work can either help or hinder, so we will work with them to develop ways to help. For example if we can help develop community enterprises, our Supplies Department will purchase all supplies and services legally possible from such enterprises. This will re-invest money in local communities, create local jobs and, importantly, jobs that develop wider skills not just those of the task at hand.

We will look to our community development partners such as Dundee Healthy Living Initiative (DHLI) to help us develop services in ways that our communities need. This helps our services improve and helps communities increase their social capital and enablement. Staff at these organisations too often have to re-apply for funding. We acknowledge the importance of these organisations in delivering this strategy and whenever possible will work with others to transfer funds to recurring sources. In return such organisations will need to ensure that communities build such skills themselves, and do not become reliant on ongoing support from them.

15.2 Improving Service Access for Poorer People

All services need to be easier for people with more health needs to access, and to be more integrated and holistic in their approach. However, increasing access generally can widen health inequalities because people with less health needs often respond more. We therefore need to take services that are known to be effective and extend their reach specifically to increase uptake by people in poorer areas. We will continue offering initiatives disproportionately or exclusively to people from poorer areas, and will adapt the principles from our Unmet Needs Pilots. Those principles were that three key issues facilitated service uptake:

- Perceived and actual ease of access
- Feeling welcome and valued
- Perceived importance and effectiveness

Services that met these criteria appeared more likely to facilitate uptake and longer term engagement. These three issues appeared to be achieved through five potential service characteristics: **proximity, responsiveness, convenience, timing and continuity.**

We will roll out these ideas across services, starting with those whose needs are the greatest, such as those with poor mental health and long term ill health. This will be done on a long term sustainable basis, not with more pilots. This does not mean deciding a final pattern of service delivery from the outset, it means continuing to learn and adopt better ways to improve prevention and access, but as part of the usual way of delivering services, not as projects with fixed term funding.

Such efforts should reduce unnecessary dependency on the NHS and promote social capital. Every opportunity must be taken to work with deprived communities to promote self care and deliver care in an integrated way with other services through partner agencies, community development organisations, community enterprises, the voluntary sector, volunteering and other relevant approaches. To improve basic access by removing the need to visit multiple venues, and to promote this more integrated and holistic approach, services from various agencies will be co-located whenever possible. The joint aims of such efforts are to:

- improve mental health and wellbeing through social capital and community networks;
- motivate people to adopt healthy lifestyles using co-production, social marketing and other techniques;
- ensure that levels of care match need but distribute care appropriately between self care, social network support, community care and NHS care.

There are a number of specific tools and approaches already in use in small areas which will help services to develop in the ways described. We will help priority services adopt these approaches more systematically, and in the process of learning from this, develop toolkits or learning packages which other services can use to roll out the approach more widely. The NHS Scotland Quality Strategy currently in development will also be relevant when developing services.

15.3 Improving Primary Care in Deprived Areas

People and GPs alike tell us that sometimes GPs do not have options available to respond to people with mental health and wellbeing problems. As described above, people in deprived areas have far more mental health and wellbeing problems than those in affluent areas. The response in some cases is to prescribe medicines which provide symptomatic short term relief without addressing the root cause. Different responses such as social prescribing **are** available but we need to work with practices to develop them.

One example is already being trialled in Erskine Practice in Dundee, where patients who need time to talk through their issues but do not need a GP can discuss them with a chaplain. Patients and GPs alike describe the difference that this approach makes. *“When I go to see a GP he does things to me like referring or prescribing. You don’t even give me advice; you listen, say things differently and help me make sense of them”*. This is about helping people take back ownership of solutions which in the past social support networks would have done.

Because practices with a high proportion of patients from deprived areas face such a high volume of mental health and wellbeing problems and have too few effective means of responding, they are often overwhelmed. The time for consultations is often too short to get into meaningful discussion about the root cause of the problems, and the types of social prescribing or self help that could be useful. Stewart Mercer and colleagues in the West of Scotland have shown that if GPs have a couple more minutes to discuss problems they can get to the root cause, and instead of prescribing medicines can increase the patient’s power to take control of the situation. They have also shown that patients who have consulted with GPs with higher empathy levels also have higher enablement. Higher enablement seems to lead to patients being more likely to do what they intended to do at the consultation one month later.

These are just three things that we will support in practices serving the most deprived communities: social prescribing, longer consultations and ways of increasing empathy and patient enablement, such as training and support for GPs.

15.4 Supporting Behaviour Change

Most specific behaviours which continue the cycle of ill health are worse in deprived areas. More smoking, worse diets, less exercise, more problem drinking and drug taking, more teenage pregnancy and less breastfeeding are all significant problems. As described throughout this strategy we need to understand the causes of these problems and address them at source. That is the reason the thrust of the strategy is about promoting enablement through social capital and helping communities take control. We must also do more to help people choose healthier behaviours by helping motivate them to change, and making it easier to change. This work includes a range of tools including social marketing which help staff understand what is important to people. Examples of using social marketing in Tayside include the “Give It Up For Baby” and “Quit 4U” programmes. These pay people from deprived areas in grocery vouchers for quitting smoking in a bid to motivate them through the difficult cravings period.

We will roll out these approaches to other areas including the development of a social marketing toolkit for services, but the culture running through this strategy will be applied. That means that wherever possible such programmes will be tailored to the very specific needs of communities. They will take account of a range of related needs, not just a narrow behaviour, and they will involve those communities in delivering the help. Such help will ideally promote social networks and self help rather than more NHS or state services.

Similarly where we know that it is difficult, despite motivation and support, to choose healthy behaviours we will work with partners to address this. For example, people tell us that they need cooking skills but they also need to be able to buy fresh fruit and vegetables in local communities. We will address these problems, ideally through community enterprises or similar approaches mentioned above.

15.5 Increasing Screening Uptake in Deprived Areas

Some ill health prevention work, such as supporting behaviour change described above, is about avoiding the behaviours that lead to diseases. However we can also reduce the incidence, prevalence and burden of disease by catching diseases early. For example, people in deprived areas develop far more cancers at far younger ages and die from them far more than people in more affluent areas. Cancer screening programmes can detect cancers very early and either prevent them altogether or significantly reduce their harm, extending life by many years but uptake is low in deprived areas. We must therefore work to increase uptake in these areas. However we must not do it by simply sending more screening units or invitation letters to deprived areas. We must work with small communities in the ways described throughout this paper: within the context of a community development programme; to involve people in the understanding of why these are helpful; to find out what would motivate them to attend screening; and to involve them in the programmes we might then develop, both in their design and their delivery. Similarly, health checks can be carried out at people’s place of work or training, and they do not need to be done by NHS staff. We will work to increase the number of people who can do this such as small employers, charities, voluntary groups etc. These are prime examples of opportunities to promote co-production, to build communities and to build social capital as well as opportunities to increase uptake of screening and reduce ill health and early death.

15.6 Increasing Employment in Deprived Areas

As in most areas, the public sector is a large employer in Tayside. We are leading the way in helping people from deprived backgrounds get employment with our Healthcare Academy.

The academy gives people work experience in a supportive environment, and guarantees them a job interview. People who have been through the programme tell us about the difference it has made to their lives, not just to themselves by becoming motivated and confident to go out and earn, but to their children who then see working and taking holidays as a normal way of life. These changes have a dramatic effect in helping to break the cycle of deprivation, but only help relatively small numbers. We will expand these efforts to the point where we routinely employ large numbers of people from deprived areas. This will be in line with expanding the Discover Opportunities approach mentioned above.

16. Delivering

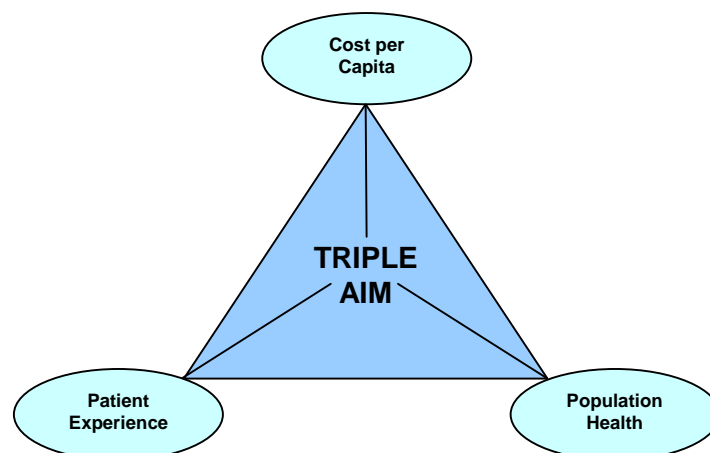
In planning to deliver the improvements this strategy promises we acknowledge that, as illustrated by the examples throughout, we are already using a number of very helpful initiatives, and have many others to draw on from elsewhere. Much of the challenge is about moving from using ring fenced temporary pilots as the way of doing things, to working differently in mainstream services. Much is about the cultural change that's needed for these efforts to gain a critical mass, or perhaps the critical mass of effort which will indicate a change of culture.

Most of the ideas are not new or additional to other strategies and initiatives. It is the systematic adoption and integration of aims that this strategy, crucially, aims to promote. For example, many staff in NHS Tayside already thoroughly understand the concept of testing changes, learning from them and developing them to become more systematic and lead to bigger changes. This "Improvement Methodology" is appropriate for delivering this strategy so long as it continues to adapt to working with communities to promote enablement and social capital. Similarly, the concepts of understanding detailed needs of communities, looking at more than health needs and working together with partners and communities is embodied in the Institute of Healthcare Improvement's Triple Aim programme. Growing numbers of staff have been trained and supported in developing these approaches already, and these efforts are being integrated.

16.1 Triple Aim

The Triple Aim Framework is the simultaneous pursuit of:

1. The health of a defined population
2. The experience of care by the people in this population
3. The cost per capita for providing care of this population



These three dimensions pull on the health care system from different directions. Changing any one of the three has consequences for the other two.

With the goal of optimising performance on all three dimensions we recognise the dynamics of each dimension while seeking the intersection of best performance on all three. Over emphasis on any one aspect will distort the system.

Through Triple Aim there is a focus on quality, innovation and productivity, addressing unwarranted variation, procedures and technological usage. It enables discussion between primary and secondary care, uses data to drive decisions, spreads best practice, and prompts the termination of low value interventions.

The WHO has issued a report by Thomson, Foubister & Mossialos on health financing schemes in all of the EU countries. One of the recommendations is to avoid confusing efficiency with expenditure control. Spending on healthcare should not be conditional, rather it should always demonstrate value for money. System level metrics are required which include healthcare, social care and public health.

In Bolton they are using Triple Aim in relation to health equity through community health and wellbeing partnerships. Bolton has developed five themes with the community that guide the work of all the partners within Bolton: Healthy; Achieving; Prosperous; Safe; Cleaner and Greener; Strong and Confident. Measures to monitor progress on each of these themes have also been developed with the community. Through the 'Healthy' theme there will be a balance between individuals receiving what they need alongside wider health gain for the community within a specific healthcare resource.

Our Community Planning Partnership's Single Outcome Agreements are key to integrating effort so we will work with them to maximise the opportunities for joint working. We commit to co-producing the next phases of agreeing this strategy and implementing it with those partners and with the communities we jointly serve.

Many staff across different agencies have recently welcomed the creation of the Scottish Government's report and action plan "*Towards a Mentally Flourishing Scotland*". Again the concepts there have synergy with this strategy and the key will be ensuring effective joint working towards common goals. Similarly the Scottish Government's report and implementation plan "*Equally Well*" helped trigger the creation of this strategy so the concepts are thoroughly aligned. There are however some elements of the "*Equally Well Implementation Plan*" which are too detailed for this strategy but still need to be delivered and monitored. To act on and deliver these strategies NHS Tayside will use its recently agreed framework for Strategic Effectiveness. The commitments in this strategy will be reflected in the annual commissioning plan. Each year they will list the actions that our services will take to deliver these strategies. These will be specific actions and will detail the sections of this strategy to which they relate, the timescales within which they will be achieved and the expected outcomes.

17. Managing Performance

NHS Tayside's Director of Public Health (DPH) is responsible for liaising and agreeing with managers throughout the organisation to ensure the range of actions being taken each year comprehensively cover this strategy over time. In other words the DPH will ensure that the next five annual commissioning plans between them include enough actions to fully implement the five years that this strategy covers. The DPH will also ensure that these actions are coordinated within the NHS and with our community planning partners, and then delivered in a co-ordinated way.

Once those actions are clearly identified and co-ordinated in the relevant commissioning plan and the Delivery Unit's Delivery Plan, it will be the responsibility of each relevant manager throughout NHS Tayside to ensure they are implemented.

Performance management of these actions is carried out by senior management and co-ordinated by the DPH. In any of the above cases the senior manager must take remedial action if the actions being taken are not adequate, and refer persistent irresolvable problems to the Chief Executive.

This range of performance management activity is aggregated at the Chief Executive's TayStat meeting, and the Chief Executive has overall accountability for monitoring that the strategy is being delivered. As this is such an important part of the work of NHS Tayside, we will ensure that the aggregation forms part of a Strategic Review which ensures that individual strategies are being implemented, and that the right strategies are in place. NHS Tayside's Board will annually dedicate meetings of it and its committees to such Strategic Reviews.

18. Developing Our Workforce

As mentioned, the culture of NHS Tayside needs to change so that ALL staff see health inequalities as the most important health issue. In particular we all need to see it as an issue which we can affect, whatever our role. We recognise that this will be extremely challenging as many of the ideas are unfamiliar to many staff focused on treating ill health rather than incorporating ways to prevent it. We will develop our existing training and development for all trainees, new staff and existing staff to incorporate these topics. This will cover a range of issues including understanding:

- the size and nature of health inequalities in Tayside;
- that poor mental health affects lifestyles and leads to ill health and early death;
- that mental health and wellbeing are affected by social and community networks as well as wider sources such as housing, employment, etc.;
- that all services need to be more accessible and responsive to need;
- that attitudes of public sector bodies and employees can help or hinder.

The last issue addresses the "softer side" of attitudes and culture including:

- Wanting people to take responsibility for their own health, but the NHS still tending to tell them what to do.
- Wanting people from deprived populations to use our services but people reporting that some staff are still abrupt, off-putting and make them feel inferior. Some of those services are in the wrong place or delivered at the wrong time to be accessible.
- Wanting people to act on our advice but we are still using leaflets which are photocopied several times making it hard for highly literate people to read them, as well as those with reading difficulties.

19. Measuring Progress

Many of the actions described here can be started immediately but as described, most will need to be developed and will take time to show results. We will therefore agree a range of measures to assure our communities and partners that together we are taking enough actions, committing the right sort of effort and adopting the right approaches. These actions will be priorities for our communities and will be based on as sound health economics as possible to ensure that cost effectiveness is built in. Every action committed to in this strategy will be monitored systematically to ensure it is carried out across the whole of NHS Tayside, promoted in every service development or strategy and reflected in agreements with our partners.

We will also measure medium term objectives such as stabilising the measures of the health gap which are currently widening, and narrowing those measures which are currently stable.

Another critical medium term objective is measuring child development.

As mentioned in section 14.6, because life outcomes are predicted by the developmental progress of children as early as three years old, they represent good markers of whether we are making progress on life expectancy without having to wait thirty to fifty years to find out. Finally we need to measure long term progress towards health equity through the ultimate health objectives for the poorest communities of:

- improved mental health and positive wellbeing
- less long term ill health and
- less early death

It is most important that we do not view these objectives or the actions that lead to them as separate issues. We now understand more clearly than ever before the role that poor mental health and wellbeing plays in causing preventable ill health and early death in the most disadvantaged communities. Without good mental health and positive wellbeing, people do not feel motivated or able to take the lifestyle choices which lead to good health. However, our current indicators measure years of life with or without illness separately to years of life with or without mental wellbeing and so inhibit integrated decision making. This is such a fundamental issue that we wish to create new measures of health that combine the three views. This effort will be linked to national Mental Health indicators work and the development of a HEAT target on mental wellbeing. For example, we need to be able to measure wellbeing and social capital. However current measures are contentious so this will need developmental work. We are currently building the level of health economics expertise needed to ensure all this.

As well as agreeing new actions and measures, we will review our current measures of progress. Too many targets require average improvements in service or health. Such targets allow for large improvements in the health or care of affluent communities and small improvements or even worsening in deprived populations, hence widening inequalities whilst appearing to succeed. We will ensure every target and objective possible focuses on closing the inequalities gap instead of requiring average improvements in health or service delivery.

In developing this strategy we commissioned a review of evidence from around the world which is published with this strategy. It was conducted jointly by the Social Dimensions for Health Institute (SDHI) and NHS Tayside. The review showed that very few initiatives properly evaluate their effect on health inequalities. As we deliver the actions we commit to, we will build in evaluation so as to expand the evidence base. We do not have, and are never likely to have, the research skills and capacity for one central team to assess all these efforts throughout NHS Tayside. Instead we aim to work with SDHI to create capacity to help services redesign and evaluate themselves.

20. Developing Information Systems

We will improve our systems for gathering and reporting up to date information regarding health equity. This is because we currently do not systematically gather or report enough indicators of inequalities in health and wellbeing, or service usage and quality. We will develop reporting mechanisms covering current positions, trends and trajectories so that:

- all services report comprehensively on their inequality efforts;
- all services, performance management and scrutiny receives specific relevant reports on the degree of success in closing the inequalities gap in their area;

- NHS Tayside, its partners and communities understand which factors are the major contributors and determinants of poor mental health and wellbeing, long term ill health, and early death in poorer communities by local area.

All this work on information systems and the progress reporting requirements described above will be detailed specifically for monitoring purposes. We will need to develop our capacity to do this, in particular the linking of financial information, performance information, and public health intelligence. For example, there are specific helpful reports, showing how causes of early death vary with place and age of death, but we cannot currently create them systematically and hence target effort accordingly. Similarly we can show how much spend is dedicated to people from each GP practice but do not currently link that to deprivation or health need. Other technical measures of deprivation such as the GINI co-efficient are also useful but are not currently used and will be developed.

21. Aligning Strategic Aims

NHS Tayside has already agreed that its four strategic aims are:

To improve healthy life expectancy by supporting people to look after themselves

To contribute to closing the health inequalities gap within a generation

To ensure services meet minimum quality standards, especially patient experience

To be cost effective in all decisions, actions and services

Whilst this strategy primarily addresses the second aim (health inequalities), it says as much about supporting people to look after themselves albeit from a community empowerment perspective. Whilst that effort is to be targeted at deprived communities the principles are applicable to all communities. Similarly, whilst the point of promoting community engagement, empowerment, social capital and co-production are the mental wellbeing and physical health benefits that they confer, these also address quality and cost effectiveness. Services which focus more on providing the things that are so specialist that they need to be delivered by the NHS, and to deliver them in a way that communities want are inherently both more cost effective and high quality. In particular, services that deliver help which communities, the voluntary sector etc. could provide better and cheaper waste money. Services which foster unhealthy dependency on the NHS harm health.

22. Working within Financial Constraints

The cost of failing to support disadvantaged communities in tackling health inequality would be continued increases in caring for more and more long term ill health. As stated at the beginning of this strategy, poverty kills early but it also causes decades of ill health before it kills. It is caring for this ill health that costs the NHS, and the taxpayers who fund it, so much money.

NHS Tayside will not be able afford to care for the predicted future burden of ill health and even if it could, it could not recruit enough staff to achieve it. Removing health inequalities and helping the people of Tayside to choose lifestyles which are naturally healthy by supporting them in mental health and wellbeing is therefore needed not just morally, but for NHS Tayside to survive in the long term, and to care for people's remaining ill health which will always be present.

NHS Tayside currently spends around £4.2m on efforts which are knowingly and deliberately targeted at deprived communities.

That figure is not exact because methodologies vary when calculating such figures. Specifically it does not include services which are global but which also therefore support people in the poorest communities.

For example the funding for the Scottish Government's "Keep well" programme is included in the £4.2m but funding which pays for health visitors who support anyone including the poorest people is not. The figure represents less than 1% of the 2008/09 revenue available to NHS Tayside.

Severe financial constraints mean that there is likely to be little or no additional money with which to fund the actions to which we commit here. However most of them cost little or no new money, and will generate large savings in the medium to long term. They will mostly be carried out by changing the way we use our current effort and resources in the ways described throughout this strategy. The Directorate of Public Health for example probably used to target less than 10% of its resources at health inequalities, but this has risen to over 30% in the last five years despite its budget having shrunk by around 10% in that time. The directorate plans to continue this rise despite continuing financial challenges. We will go further than this and ensure our staff and strategies are aligned to the key topics in this strategy such as improving Early Years.

Some changes will cost money and NHS Tayside must optimise the use of all available resources in order to significantly reduce this inequity. We must remember though, that without the changes signalled in this strategy, financial balance in the future will be even more difficult than the apparently unprecedented financial challenges we face today.

If, as we monitor the delivery of the strategy, this approach (of advocating that everyone in NHS Tayside changes the way they work) appears to be insufficient within three years we will take progressively bolder action to centrally re-allocate resources. Some people will be disappointed at the implied delay in this stance as they feel that being radical is about, for example, taking health visitors from affluent areas and targeting them at working for deprived areas. However we firmly believe the correct approach is to work differently by us all helping communities to tackle the root causes of ill health, not to throw more traditional resources at ill health. That is why this strategy is called Communities in Control.

Appendix 1 - nef Measures of Co-production

1. Reward reciprocity in funding regimes. Assess the extent to which the ultimate beneficiaries of funded services have been enabled to play a role – and reserve part of the grant to reward this involvement.

2. Reward people for their efforts in the local neighbourhood, and review the benefits system so that it stops discriminating against voluntary engagement to support services by people outside paid employment.

3. Shift the way professionals are trained so that frontline staff are able to learn about the values and skills of co-production and are recognised for putting these skills into practice.

4. Develop ways of capturing the real benefits of co-production and the loss when it is absent so that public service commissioning and measurement recognise and record what is important about mutual support.

5. Set a duty to collaborate not just between services, but bringing together services, their clients and the public, and require all public bodies to involve clients in the design and production of services.

6. Embed networks of exchange, such as timebanking, within public service institutions, including surgeries, hospitals, schools and housing estates.

7. Swap targets for broad measures of well-being that enable practitioners to demonstrate the value of co-production approaches in terms of individual and social well-being.

8. Review current health and safety measures to ensure that unnecessary regulation and a culture of risk aversion doesn't present a barrier to the involvement of service users and the communities based around public services.

9. Launch a co-production award scheme and a co-production fund to encourage innovation in the public and voluntary sectors.

10. Acknowledge the importance of size and innovation rather than looking to roll-out 'scaled up' blue print models of co-production. Recognise instead the importance of human-scale interaction and the ongoing innovation of this approach that leads to the development of appropriate local responses.

Appendix 2 Glossary

Community	Community most often describes a group of people living in the same area. It can also describe a group of people with common attitudes or interests or who work or study in the same place.
Community Resilience	Resilience is the capability to anticipate risk, limit impact, and recover quickly. When a community is resilient it is the network within the community that provides this strength.
Co-production	Active input in the development and delivery of services by the people who need services, as well as – or instead of – those who have traditionally provided them.
Cost Per Capita	The cost of a service divided by the number of people in a defined population.
Discover Opportunities	An organisation in Dundee which provides help for people to develop their skills for work, helping them with social confidence as well as helping them with health problems and many other issues, recognising that these needs are inter-related.
Driver Diagram	A tool used to conceptualise an issue and to determine the components of a system which will then create a pathway to achieve a goal.
Empowerment	Gaining greater influence and control over health and quality of life.
Enablement	Optimising independence and wellbeing at home (or in a homely setting) through self management and rehabilitation.
Healthcare Academy	Part of NHS Tayside which gives people work experience in a supportive environment, and guarantees them a job interview.
Improvement Methodology	The concept of testing changes, learning from them and developing them to become more systematic and lead to bigger changes.
Partner Agencies	All of the organisations that work along with the NHS. This includes other public sector organisations as well as those in the voluntary sector.
Relative poverty	A standard of poverty that compares what an individual or group has compared to most people in that society. This is in contrast to absolute poverty where people are said to be in poverty at a particular

level regardless of the society around them.

Social Capital

The collective value of all [social](#) interactions and networks and the motivation that comes from these networks to do things for each other.

Social Marketing

The systematic application of marketing, alongside other concepts and techniques, to achieve specific behavioural goals, to improve health and reduce inequalities.

Social Prescribing

Signposting that seeks to link patients up with non-medical facilities and services available in the wider community that they can access to address factors that influence their wellbeing.

Time banks

A way for people to come together to help others and help themselves at the same time. Participants 'deposit' their time/skills in the 'bank' by giving practical help and support to others and are able to 'withdraw' time/skills when they need something done themselves.

Triple Aim

A framework, developed by Institute of Healthcare Improvement, for the simultaneous pursuit of:

1. The health of a defined population
2. The experience of care by the people in this population
3. The cost per capita for providing care of this population

Unmet Needs Pilots

Pilot studies in Tayside funded by the Scottish Government that were focussed on the issue of inequalities in access to and use of both primary and secondary healthcare services.

Voluntary Sector

Also known as the third or not-for-profit sector. This is different from volunteering.

Wellbeing

A contented state of being happy and healthy.

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