

Improving Health and Wellbeing: Developing an Integrated Approach Through Community Planning

Summary Report: September 2007

Planning

Health
Improvement

Community

Integration

Partnerships

Outcomes

Prepared by

**Gleny Watts, Norma Hurley and
Jennifer Lambert**
Blake Stevenson Ltd

1 Melville Park
Edinburgh EH28 8PJ

Tel: 44 (0) 131 335 3700
Fax: 44 (0) 131 333 1033

admin@blakestevenson.co.uk
www.blakestevenson.co.uk

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Introduction

Health Scotland, in partnership with the Scottish Government Health Improvement Strategy Division, Communities Scotland, and the Improvement Service, commissioned Blake Stevenson Ltd to undertake a consultancy process on the development of integrated planning and delivery for health improvement, improving life circumstances and tackling health inequalities in Scotland across Community Planning Partnerships (CPPs), including Community Health Partnerships and Councils.

Aims

The aims of the consultancy were to:

- identify any factors and processes that facilitate and hinder planning and delivery for health improvement and improving life circumstances and wellbeing at the Community Partnership Planning level
- test out and develop mechanisms and tools to support the integration and alignment of health improvement and improving life circumstances work with mainstream services and crosscutting agendas
- establish ways to improve the planning of the health improvement agenda and its delivery and in particular activity aimed at reducing inequalities and improving life circumstances.

The process covered a nine month period and included work in three selected areas: Aberdeenshire, Fife and North Ayrshire. Each of these areas has different geographies, levels of deprivation and needs, structures and contexts in terms of health improvement.

Background Context

There have been a number of key policy documents over the recent past that stress health improvement and the reduction of health inequalities as two of the key cornerstones of government policy. There has also been desk-based research that questions whether existing Joint Health Improvement Plans (JHIPs) and Regeneration Outcome Agreements (ROAs) provide any certainty that planned health improvement outcomes will be achieved.

This lack of certainty, linked to the importance attached to this policy area, led to this current consultancy process.

Definitions

The report provides some of the key definitions and meanings used during the consultancy process and these are summarised below.

Health Improvement

By 'health improvement' we include both 'badged' lifestyle determinants of health, that focus on behaviours such as smoking, substance misuse, eating, and physical exercise together with the 'unbadged' health, social and economic determinants such as having a job and a good income (see *Social Determinants of Health: The Solid Facts* (WHO, 2003) for further information on the latter).

Integrated Health Improvement

Different agencies have different understandings of what is meant by 'integrated', but for this consultancy the definitions used were taken from 'Integrated Health Policy: Examples from the UK' (Sewel, Bauld and Judge, University of Glasgow, 2002):

- Integrated approaches that tackle several lifestyle-related determinants at the same time (versus single-topic based approaches)

Behavioural health determinants, such as tobacco use, drugs, alcohol, nutrition, sexual health, physical activity, and mental health determinants such as coping with stress, family structure, and social support.

- Integrated approaches across policy sectors that deal with 'structural' health determinants

'Structural' health determinants include social, economic, environmental and culture related health determinants such as living and working conditions, education, employment, access to health care and other public services, housing conditions, air and water pollution, noise, transport, and cultural diversity.

- Integrated approaches that deal with lifestyle-related health determinants and 'structural' health determinants

This is a combination of the first and second definition.

In addition, integrated health improvement planning should include the community or 'collective' dimension to health, valuing the role of communities acting in their own right to improve the health status of their neighbourhood or community, however defined. The combined skills, expertise and knowledge, together with social networks, community organisations and the traditions and values that bind people together (called 'social capital'), are increasingly recognised as assets in helping bring about improvements in people's quality of life and wellbeing as much as the efforts of the agencies charged with delivering services to them.

Evidence

There are two broad types of evidence in relation to health improvement: the evidence to identify the problem and the evidence of interventions that work.

Evidence to support the identification of the health problem is an assessment of need based on health, social and economic data combined with qualitative evidence (e.g. community needs assessment/engagement processes) to support identified

need where this is available. An analysis of this evidence should enable each planning area to begin to prioritise between the competing demands for resources and action. Each area in Scotland has a community health and wellbeing profile that provides the basic health statistics for the area. This evidence has to draw on a wide range of quantitative and qualitative information including both evidence relating to lifestyle factors and 'unbadged' evidence that refers to life circumstances.

The 'evidence of what works' refers to the evidence that identifies the extent to which different interventions work. This may be available through a range of sources such as systematic review processes, national evidence based guidance (e.g. NICE), good quality pilot or demonstration evaluation studies. Evidence of what works is not always readily available or in existence in all areas; where it does exist, for example in relation to smoking cessation, it is important that those planning health improvement make full use of it.

Logic Modelling

Logic modelling is a technique used for planning and evaluation purposes extensively in the USA and elsewhere. The basic logic model is a systematic and visual way to understand and analyse the different relationships between the resources you have, the activities you undertake, and the outcomes or results achieved. The basic model looks like this:

Resources

Activities

Outputs

Outcomes

Long-term
Impact

The theory is that the resources (staff and budgets) available allow for certain activities to take place. If these activities take place (and the activities selected are effective, appropriate and acceptable) they will achieve a set number of services/products (outputs). The outputs will in turn produce benefits for those participating (outcomes). If these benefits to individuals (groups, communities or people in organisations) are achieved, then the sum of these changes may lead to further changes in organisations, communities, and/or systems (impact). Logic modelling is the basis used for the planning framework designed during the course of this consultancy.

Collaborative Gain

One of the key elements in relation to a CPP's effectiveness is to identify the areas where there is added value, or collaborative gain, by working together. In developing an integrated approach it is essential to know where it makes sense to work together and where there is no need to do so because one agency is already fully responsible and effective for an issue or a service.

The Starting Point

The starting point of the process in each of the three selected areas was different; each has different geographies, demographics and structures for health improvement. Each of the three areas was also at a different stage in terms of the development of the JHIP. Because of these variations and differences it has been possible to test out different things in the three areas.

The Consultancy Process

The consultancy was designed to have three main stages; the first a diagnostic stage where the consultants examined all relevant background material and interviewed key stakeholders in each area. The second stage was to provide support on the

issues that had been identified for action in stage one. The third and final stage was to provide feedback, reflect on the process and identify learning from the process itself.

The above process was applied in a similar way for stage one in each of the above areas. From this first stage varying second and third stages evolved as each area identified its own requirements. In Aberdeenshire, the approach led to a focus on one area of deprivation, Buchan and examining how an integrated approach could work there; in Fife it was agreed to take one of the JHIP outcomes and explore fully what an integrated approach with measurable outcomes would look like; in North Ayrshire the emphasis was on a strategic focus linked to implementation in one locality.

Good Practice in the Three Areas

Aberdeenshire

The Traffic Lights data produced by NHS Grampian is an example of good practice in how an area which is overall relatively advantaged economically and socially can nevertheless evidence and focus on the very real pockets of deprivation and health inequalities within its boundaries.

The Traffic Lights are an excellent example of interpreting complex data in a way which makes it clear, accessible, and therefore useful.

One significant outcome from the consultancy process is that the Public Health Lead who has been the key contact working with the consultant has developed an approach which it is hoped will enable a more integrated approach to implementing the JHIP action plan. This is an outcome focused approach.

Fife

Both Fife Council and NHS Fife have signed up to a set of principles for health improvement organisations. These principles commit the organisations to 'viewing improving health and wellbeing as an integral part of day-to-day work and an influence on all aspects of the organisation's activity'. The principles are equally relevant to a range of other agencies, and we know that the voluntary sector in Fife is already in discussion regarding adopting these.

Fife has excellent data available in relation to evidence of need. This includes a Public Health Dataset, data from the Fife Social Justice Analysis System and information gathered through a community budgeting pilot. There is a real partnership approach to gathering this data and ensuring that it is kept up to date.

North Ayrshire

North Ayrshire has demonstrated through this consultancy process its willingness to take on an integrated strategic approach to health improvement. The involvement and discussions with the CPP Board senior members illustrated the commitment and high importance attached to health improvement and reducing health inequalities. The Board agreed that greater strategic focus and prioritisation are needed so that progress in a measured way can be made and that in this sense 'less is better'.

There are already good examples of integrated planning and delivery in North Ayrshire. Among these are Healthy North Ayrshire, the Integrated Children's Services Plan and, at a local level, the Fullarton Community Health House.

General Findings

Some of the key findings from the consultancy process are highlighted here:

- The JHIPs have some strengths but also weaknesses. A key weakness is the lack of prioritisation.
- There is great complexity of structures in all three areas with regard to health improvement planning and delivery. Fife is the only area with coterminosity of boundaries but even in Fife there is a multitude of groups involved in the JHIP and the delivery of health improvement. In Aberdeenshire the lack of coterminosity is extreme.
- It is the consultants view that one of the key issues to emerge from this consultancy process is the lack of strategic leadership from the highest levels within the CPPs. The lack of prioritisation already identified serves to illustrate this lack of strategic leadership: it is the decision-making that sets priorities and makes strategic choices – the hallmark of strategic leadership – which is lacking from the process at present.
- In terms of the planning process it is clear that while there is some evidence of need in each of the three JHIPs, it is insufficiently detailed on specific issues. There is little reference to the evidence of what works in the JHIPs and the consultants' sense is that this is an area that requires significant development and support.
- One of the key aspects that the consultants looked for in relation to outcomes was that they should be measurable and with clear targets set. The outcomes should reflect the results or benefits for people, not what the agencies will do. In general, the outcomes included in the JHIPs were not at this stage.
- One of the barriers to integration at local strategic level is the fact that individual partner bodies are accountable in different ways: the NHS health boards are accountable to the Scottish Government and the local authorities to their elected members and local communities (as well as central government). The priorities and targets set by each of these have to be addressed by the individual organisation and the role of acting as a partner in the CPP tends to come second to this.

- In developing an integrated approach to health improvement we cannot underestimate the cultural barriers that exist; not just in terms of language but also in the whole range of ‘the way things are done’.

Lessons from the Consultancy Process

- The consultancy process has achieved a lot both in terms of how each area has developed its approach to integrated health improvement planning and delivery and in terms of broader learning. However, it is also recognised that the aims were possibly over-ambitious given the time period and the complexity of the structures it dealt with.
- It is recognised that involving the lead contacts from each area in the Steering Group for the consultancy might have helped to ease any tension between local expectations and central requirements. Further clarity about the consultants’ role and status would also have helped to avoid some confusion.
- As part of the consultancy process the consultants have developed an Integrated Health Improvement Planning Framework and a Monitoring and Evaluation Framework to demonstrate how an integrated approach might work in practice. The purpose of these frameworks was as much to assist in the consultancy process and the thinking required to develop an integrated approach as it was to design a definitive tool. The consultants’ view is that no one tool will ever provide all the answers; what is required is a way to engage those responsible for planning health improvement to think clearly about the different elements and to use these to plan future actions. To this end, the frameworks designed have proved useful and are being adapted, or the rationale is being used, in each area.

Overall Conclusions

This consultancy process has confirmed and re-affirmed some of the findings from previous research. The main issues that corroborate the work of the Community-led Supporting and Developing Healthy Communities Task Group relate to the need for involvement of the community in setting the planning agenda, the need for effective partnership working, the importance of leadership for strong partnership work, the need for capacity-building within the community and voluntary sectors (and we would argue throughout partner organisations), and the overall need for greater focus on high quality community engagement.

The use of language and terminology is an awareness raising process that is an essential part of building capacity for all those involved. This requires time so that misunderstandings do not arise.

There is a complexity of structures at a local level and there is a need to address whether this complexity is enhancing the effectiveness and efficiency of community planning or whether it could be simplified.

There is a gap between a theoretical model of health improvement planning and the reality of what actually happens; bridging this gap is a major task.

The consultancy process identified the potential challenges faced by partners in trying to develop and implement health improvement outcomes which they can all

share. Such outcomes may 'compete' with pre-existing outcomes in other plans, both individual partners' plans and also other partnership groups' plans.

There was little evidence of community involvement in setting the agenda for health improvement planning found during the course of the consultancy. There was some evidence of consultation of draft plans, but no evidence of direct community involvement in setting the agenda or of being involved in a prioritisation process. Indeed, there was no evidence of a prioritisation process as such in any of the three areas prior to this work commencing.

The key issues which need to be addressed are building capacity within communities in relation to planning for health improvement and building capacity in public sector bodies as to how to effectively engage with communities.

Leadership is essential to health improvement. The Community-led Supporting and Developing Healthy Communities Task Group also identified this issue as critical. In particular, it is the view of the consultants that this consultancy process highlighted the lack of strategic leadership from the CPP Boards (in acting together rather than as individuals) in the health improvement planning process.

The need for national level 'joining up' has been reiterated so often it is something of a cliché. The myriad of different initiatives and funding streams which emanate from national level lead to the plethora of plans and initiatives at local level; the two are inter-related. To require the local level to change without addressing these national level complexities will not work.

Recommendations

The recommendations based on an analysis of the research and its conclusions are as follows:

At National Level

1. The Scottish Government should place the responsibility for planning to reduce health inequalities squarely with Community Planning Partnerships, to emphasise the role that all partners have to play in this important area. This means that there should be a multi-agency approach to health improvement planning involving all community planning partners in order to have health improvement as a cross-cutting theme across the whole CPP.
2. The Scottish Government should issue new guidance to support health improvement planning at community planning partnership level, which endorses the following planning criteria:
 - clarity regarding problem identification and formulation with data and evidence that supports this
 - strategic leadership for the overall planning process, in order to make strategic choices and set priorities within this
 - identification of areas of collaborative gain in relation to health improvement
 - community involvement in the planning process
 - prioritised, well-specified and evaluable outcomes
 - logical links between the selected priority outcomes and the activities chosen to achieve them
 - evidence of what works, from a range of sources, to support the selection of the key activities
 - clarity regarding partners' contributions, roles and responsibilities
 - statements of the principles and values which will inform the services and activities
 - clarity regarding the reach of the interventions and the level of support/exposure to the intervention that is likely to occur
 - anticipated timescales and thresholds for change
 - organisation/workforce change to support the plan as required and the time to allow this to happen.

3. There should be a review of structural boundaries to address the issue of lack of coterminosity – the 32 local authorities, 14 health boards, 22 Alcohol and Drug Action Teams (ADATs) and 40 Community Health Partnerships/Community Health and Care Partnerships (CHPs/CHCPs) make planning for health improvement even more complex than it already is.
4. Those responsible for setting the strategies for workforce learning and development (Health Scotland, COSLA, Improvement Service, Communities Scotland) should build training/capacity building programmes into their workforce strategies to cover topics such as strategic planning, using evidence, outcome-based planning, leadership for health improvement, community engagement and prioritisation.
5. There should be further work to increase the accessibility of the evidence of what works: drawn from both ‘badged’ and ‘unbadged’ sources and establishing an easy route for planners to access this evidence. For example, a website that offers key examples of the evidence of what works by age-band, target groups and topics. (This is a substantial piece of work but at present there is little sense that evidence of what works is used at all in the planning process.)

At Local Level

7. In areas where there is little coterminosity there should be efforts, where possible, to address this by, for example, realigning sub-divisions (of CHPs/police/local authority/Communities Scotland) to match each other.
8. Each CPP should consider undertaking a review of the number of groups meeting to discuss health improvement to assess their role, remit and membership in order to examine whether this number can or should be reduced. This would include identifying better clarity of role between the key players involved in planning for health improvement: the Public Health team; the Community Health Partnership; the CPP’s Board; the CPP’s themed sub-groups and so on.
9. CPPs should be able to access a Leadership for Health Improvement Programme, offered on an action learning set model where counterparts from the different partners involved in the CPP undertake the programme together.
10. The findings from this work coincide with those of the Community-led Supporting and Developing Healthy Communities Task Group. The key issues that need to be addressed are:
 - building capacity within communities and the voluntary sector to engage with health improvement planning as well as to deliver community-led health improvement projects
 - building capacity within partner organisations to know how to engage communities in a meaningful way (the National Standards for Community Engagement and the NHS guidance ‘Informing, Engaging and Consulting the Public’ are a useful starting point for this)
 - building leadership for health improvement at community level
 - recognising the role of intermediary bodies in supporting community-led health improvement (and resourcing this).

Conclusion

This consultancy process has been challenging for all those involved as the debate on how best to integrate health improvement planning has been opened up. The consultancy process has been able to identify the barriers and the complexities that make integrated health improvement planning difficult. It has explored a new approach and developed a framework to support this and identified some existing tools which might be useful. It is hoped that the recommendations contained in this final chapter will help lead to better health improvement planning and from this a reduction in health inequalities.

