RESPONSE TO THE DRAFT REGULATIONS RELATING TO PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014 – SET 1

OUR CONTEXT

NHS Health Scotland is the national NHS Board for reducing health inequalities and improving health in Scotland. Our vision is a Scotland where all people and communities have a fair share of the opportunities, resources and confidence to live longer healthier lives.

Whist average population health has improved in Scotland health inequalities have continued to grow. Health inequalities are largely the result of social inequalities; they can be prevented and are not inevitable.

Our primary aim is to work with and through the public, private and third sector in order to translate the knowledge of what works to reduce health inequalities and improve health into effective action.

Action to reduce health inequalities and improve health needs to be taken concurrently at three levels:

1. Action to undo inequalities in power, money and resources
2. Action to prevent the factors in the environment that harm health- for example-low income, poor quality work, poor quality housing, inequitable access to public services and local assets
3. Action to mitigate the impact of inequality at the level of individual experience- equitable **access (access in proportion to need) to and experience of high quality health and social care services is important at this level.**

The planning and delivery of integrated health and social care services that are proportionate to need is therefore crucial to both mitigating and preventing further harm to health from inequality.

We have completed the consultation proformas and in addition offer this more detailed response.

OUR RESPONSE

We welcome the proposed regulations and orders for Public Bodies as described in the Draft Regulations Relating to Public Bodies (Joint Working) (Scotland) Act 2014 – Set 1. The policy aims are clear and well defined.

We recognise in particular the opportunity for integrated Health and Social Care Partnerships (HSCP) to contribute to a reformed public service agenda as defined by The Scottish Government, following the recommendations of

the Christie commission[1]. The Christie Commission recognised that future public spending is unsustainable if no action is taken to reduce demands relating to the ageing population (where the population lives an ever-increasing length of time in ill-health). Christie highlighted that there is an opportunity available now to invest in public health measures that will reduce the need for public spending in the future (sometimes called 'failure demand').

'Preventive spend' is often characterised in the context of prevention as spending in the current period that is expected to reduce public spending demands in the future by reducing avoidable health and social problems. This definition contrasts with public health definitions of 'prevention', where the aim is to either:

- reduce the incidence of health problems (primary prevention)
- reduce the progression of health problems (secondary prevention)
- reduce the impacts of disease (tertiary prevention)
- reduce unnecessary health interventions (quaternary prevention)

We see that HSCP have potentially a role to play in contributing to all levels of preventative activity.

For preventive spend to achieve its primary aim of reducing future demands on public spending, there are at a least three important conditions that must be met:

1. The spending must reduce the length of time spent in ill-health, not just increase life expectancy – that is, longer healthy life expectancy and less time spent in ill-health toward the end of life.
2. Where reduced demands for public services are achieved these savings must be realised by reducing spending in those areas (e.g. if demand for a hospital clinic reduces by 25%, excess spending on that clinic could be reduced). This is very difficult task as there are frequently fixed costs to running services; reducing demand can often result in a higher quality service being provided rather than a reduced capacity service of the same quality.
3. Spending cannot be diverted to meet other unmet needs (it is therefore important that evidence-informed decisions are made around competing demands for spending using bodies such as the Scottish Medicines Consortium).

If prevention is to be effective it must be about decreasing and/or eliminating poor outcomes for people; waste & duplication; ineffective interventions and widening inequalities

Preventative activities that are cost effective **and** reduce inequalities are:

- those which have a wide reach;
- are low in cost per person

[1] Commission on the future delivery of public services. Edinburgh, Scottish government, 2011.

NHS Health Scotland- reducing health inequalities for a fairer healthier Scotland

- those for which effectiveness not reliant on the individual's ability or capacity to access the intervention or change their behaviour.

These include such things as structural changes in the environment; legislative and regulatory controls; income support; reducing price barriers; improving accessibility of services; prioritising disadvantaged groups and offering intensive support

THE NATIONAL HEALTH AND WELLBEING OUTCOMES

We welcome the national health and wellbeing outcomes identified for Health & Social Care Partnerships, (HSCP) but we suggest that it would be helpful to state explicitly how these outcomes are related both to the personal outcomes (Talking Points) and the strategic outcomes identified in the Older People's Outcomes Framework (OPOF) developed by Health Scotland, Joint Improvement Team (JIT) and Scottish Government (SG)[2],[3] The purposes of these three sets of outcomes needs to be clearly articulated to avoid potential confusion. For example:

- Personal Outcomes (Talking Points) – for use by those working directly with older people and others in receipt/need of health and social care services
- Service-related Outcomes (HSCP Health and Wellbeing Outcomes) – for those delivering health and social care services
- Strategic outcomes – (OPOF) for those planning and commissioning health and social care services for a population

We also suggest that the set of Health and Wellbeing Outcomes are clustered to differentiate clearly between:

a) Service user outcomes (Outcomes 1, 2, 3 ,7) the improvements that are expected to result from the use of health and social care services for particular population groups
b) Quality standards for service delivery (Outcomes 4, 5) reduced variations across Scotland, improved equity of access
c) Quality standards for the people/resources necessary to provide these (Outcomes 6, 8, 9) – the support to be provided for those who provide health and social care (whether paid or unpaid) and the efficient use of resources in service delivery

On Outcome 5 - 'health and care services contribute to reducing health inequalities' - We believe that a focus on achieving this outcome should help HSCP take health and social care services towards a decisive shift to prevention through the planning and operational mechanisms that they have.

[2] http://www.healthscotland.com/scotlands-health/evaluation/planning/hi-performancemanagement-nhs/OutcomesOlderPeople.aspx
[3] http://www.jitscotland.org.uk/

Preventative activities that are cost-effective and reduce health inequalities are listed above. HSCPs need to identify effective preventive priorities that can be very closely aligned to the actions required of them to reduce health inequalities and improve health.

A close planning relationship between Health and Social Care Partnerships and other planning structures within their Community Planning Partnership architecture will be important in order to maximise effective action to reduce health inequalities as many of these are outwith the functions delegated to integrated HSCP as described in set 1 of the consultation papers. Coherence between the development of local HSCP performance indicators and CPP SOA development plan and NHS Board Local Delivery Plan guidance is therefore important.

For example, a closer relationship with local housing providers that goes beyond the current requirements in the regulations such as those relating to housing adaptations to address fuel poverty and support for maintenance of tenancy for vulnerable people is vital. HSCPs also have potential to use their employment and procurement role, potentially linking this activity with the quality ambitions.

A focus on these areas as joint indicators of working towards achieving the national health and wellbeing outcomes would be welcome.

We suggest that Outcome 5 needs to more clearly articulate what are the most effective contributions of HSCP to reducing health inequalities. We propose these contributions lie across three key areas:

1. **Planning for local population need**

Planning health and social care services using whole population approaches is vital to achieving a shift to prevention. The new HSCP offer an opportunity to strengthen prevention through partnership action on anticipating need and acting to mitigate the impact of social inequalities on health.

Applying the principles of public service provision in proportion to the needs of users has been demonstrated as important in addressing inequalities - these would include services included in the delegation of functions from NHS Boards- for example general medical services. Within these services, more intensive support is sometimes required to be able to meet the health and social care needs of population groups and individuals who are furthest away from benefiting from health and social care services.

We know that particular groups in the Scottish population disproportionately experience long term conditions and have multiple and complex health and social care needs when compared with the general population– for example people living in poverty, in poor housing, with poor social networks. Poverty and deprivation can further interact with the legally protected characteristics, and so increase the risk of discrimination and powerlessness.

NHS Health Scotland- reducing health inequalities for a fairer healthier Scotland

We feel that HSCP need to have the necessary expertise within their strategic planning groups to identify and anticipate need in their population groups and then to plan health and social care services in proportion to that need. They should do so with due reference to equalities legislation and human rights - using these as levers to plan and develop services that are in proportion to and sensitive to the range of needs in their population.

2. Access to services

Reductions in population health inequalities depend on addressing a wide range of social factors, with service access and local interventions playing a small but crucial role that has to date not been well defined. There is a growing body of evidence that some groups experience difficulties with access and use of health and social care services- these are often the group who are in most need of these services- the so called 'Inverse Care Law'. The Better Together surveys[4] and the reports from the Deep End Practices[5] all demonstrate that equity of access and quality and continuity of care to meet often complex needs remain key issues that will need to be addressed if the integrated partnerships are to demonstrate that they are contributing to reducing health inequalities.

3. Workforce Development

Achieving an integrated local system, with clear expectations that the workforce will focus on inequality and on achieving equitable service provision at all levels of planning and practice will require leadership and workforce development. That development must be planned and delivered in a partnership context with the principles of co-production and community (including service user) engagement in evidence.

There are specific skills needed across the health and social care workforce at planning and practice levels. Knowledge and skills within the workforce should include: planning the budgeting and delivery of equitable service provision; understanding the impact of social inequalities on health; approaches to reduce the impact of inequalities on health and social care service use; commissioning of and working with interpreting services; sensitive enquiry skills and the ability and leadership qualities to work in partnership.

[4] http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/InpatientSurvey
[5] http://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/