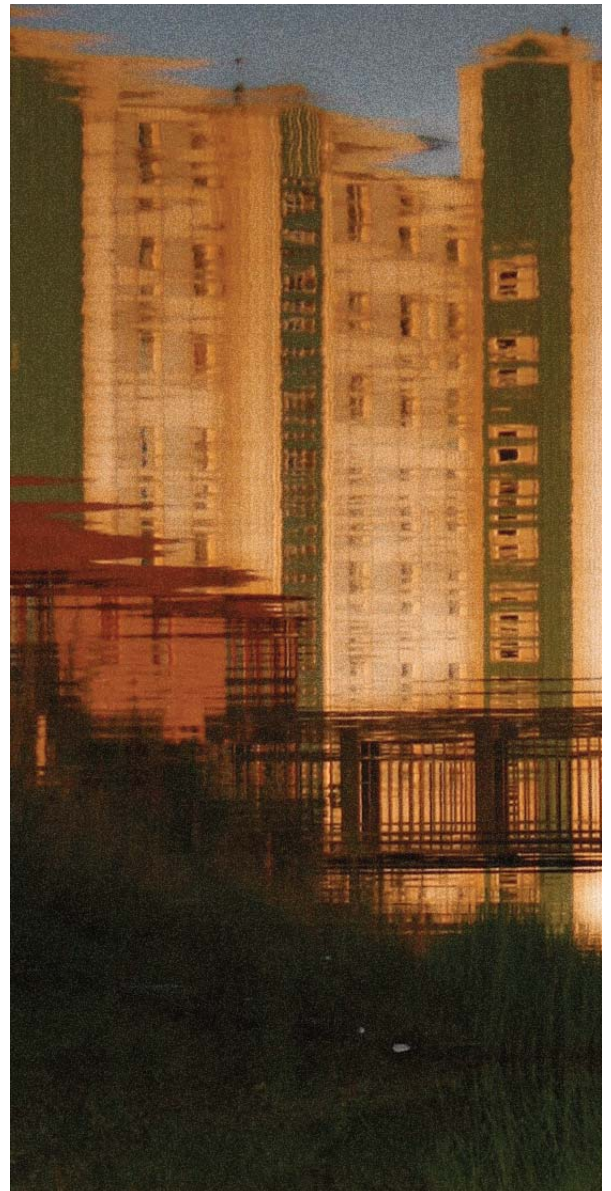


Tackling Health Inequalities and Poverty: a consultation with Scotland's Third Sector

*carried out by
Voluntary Health Scotland
for the Scottish Government
Public Health and
Wellbeing Directorate*

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Tackling Health Inequalities and Poverty - Consultation with Scotland's Third Sector

Introduction

Living longer healthier lives and combating the significant inequalities in society are key Government objectives for a better Scotland. Reducing inequalities in health is therefore crucial to this purpose. The Ministerial Task Force on Health Inequalities was set up in October 2007, with the aim of:

- Agreeing priorities for cross-cutting government activity that will achieve measurable outcomes in reducing health inequalities
- Identifying practical measures to reduce the most significant and widening health inequalities
- Ensuring key sectors and organisations that are involved in delivering action on health inequalities work alongside the Task Force in order to build commitment and support

The specific objectives of the Task Force are:

- To reduce factors in the physical and social environments in Scotland that perpetuate health inequalities;
- To build the resilience and capacity of individuals, families and communities to improve their health; and
- To enhance the contribution that public services make to reducing health inequalities

And its priorities are:

- Maintaining an emphasis on supporting families and children in the very early years;
- Enhancing mental health, wellbeing and resilience;
- Strengthening the importance of education and skills, income and employment status as factors which can combat inequalities in health; and
- Taking a multi-agency approach in which public, private and third sectors work together, with strong Government leadership.

The Task Force is due to report in June 2008.

The Task Force priorities are made explicit in the *Better Health, Better Care: Action Plan* (December 2007), in which there is commitment to:

- Increase healthy life expectancy in Scotland
- Break the link between early life adversity and adult disease
- Reduce health inequalities, particularly in the most deprived communities
- Reduce smoking, excessive alcohol consumption and other risk factors which compromise a healthier life

The Ministerial Task Force has also been informed by the Government's approach to tackling poverty through the development of a new delivery framework for reducing income inequality - *Taking forward the Government Economic Strategy: a discussion paper on tackling poverty, inequality and deprivation in Scotland* (January 2008). In this, the Government sets out its fresh approach for delivering sustainable economic growth through adherence to the Government's three 'golden rules' of Solidarity, Cohesion and Sustainability. Within the Purpose Targets, the objective of ensuring that greater equity underpins the delivery of sustainable economic growth is reflected in the Solidarity Target:

- To increase overall income and the proportion of income earned by the lowest three income deciles as a group by 2017

- this is predicted to have a positive effect on tackling poverty and contribute to the achievement of the UK-wide target to eradicate child poverty by 2020.

The framework for reducing income inequality will be focused on delivery of the Solidarity target, but to achieve this it will also be important to attain the Cohesion target:

- To narrow the gap in participation between Scotland's best and worst performing regions by 2017

- narrowing the gap in economic activity between Scotland's best and worst performing regions is key to promoting equity and tackling the challenges of multiple deprivation.

These objectives are considered to be the conditions of economic and therefore societal sustainability in Scotland.

Against this background, the Government is developing its strategic approach to improving health, combating health inequalities and tackling poverty through the involvement of all sectors, identifying effective approaches and initiatives that will shape ongoing action. The role of the voluntary or third sector is seen as increasingly important in strategic approaches to addressing these issues and in identifying through its stakeholders the approaches which work best.

The consultation

As part of the strategic approach to tackling poverty and its impact on health inequalities, Voluntary Health Scotland was asked by the Government Public Health and Wellbeing Directorate to ascertain the views of a selected range of stakeholders in third sector networks on current Government approaches to combating poverty and health inequalities and what kind of additional efforts which should be made by the different sectors. Respondents were also asked to provide examples of effective initiatives from within the third sector.

The consultation consisted of two phases. The first phase took the form of an on-line enquiry, which was carried out in February 2008 through the use of an on-line enquiry tool, Survey Monkey. The link to the enquiry is:
http://www.surveymonkey.com/s.aspx?sm=4tXdngZ8o_2fztPlpxLRiRdg_3d_3d

The enquiry yielded 123 responses in just over two weeks. The resultant material was analysed by Rock Solid Social Research and used as the basis for the second phase, a roundtable discussion event for an invited third sector audience held on 17th March, at which the Minister for Public Health, the Director for Public Health and Wellbeing and the Deputy Director for Social Inclusion were present.

Phase One – on-line enquiry

Analysis of the on-line phase of the consultation is presented below.

Findings

1 Supporting government priorities for tackling poverty and health inequalities

Government priorities for tackling poverty and addressing health inequalities identified thus far are: protecting and supporting the early years; improving mental health and wellbeing; maximising income; improving employment opportunities; creating opportunities for and take-up of education, learning and skills development

When asked if they agreed with these priorities as key areas for action on poverty and health inequalities, respondents were almost unanimously in support. However, they added a number of other areas for action which were felt to be crucial. Most salient of these were fuel poverty, homelessness and environmental conditions affecting elderly people. Respondents also prioritised working with marginalised groups which included young people and young adults in transition – those leaving care and leaving home, those becoming unemployed or affected by family break up - as directly meriting policies and action.

One respondent said: *“Fuel poverty has clear links to health inequalities. While the Scottish Government recognises the impact of damp homes on health, the promotion of affordable warmth must be prioritised and supported by Health Boards”* (environmental charity); and another added: *“I would like to see work supporting the elderly population as many of them live in poverty and isolation, this contributing to poor quality of life and ill-health”* (community food project).

And: *“Young people leaving school and leaving care having to manage their lives as they try to get into the job market are among the most vulnerable.”* (youth support agency)

Specific approaches were highlighted: improving access to existing services; supporting the acquisition of financial skills and eating well on a low income;

structural action on the benefits and taxation system (although this is a reserved issue, it was felt that the Scottish Government was in a good position to influence Westminster on this); and increasing learning and recreational opportunities for young people.

2 Prioritising prevention and early intervention

Respondents were asked to rank three preventive measures and early interventions according to their effectiveness in breaking the cycle of disadvantage and its effects on health inequalities. The measures and interventions were: a) increasing educational opportunities; b) enhancing skills development; and c) improving employability. All were considered important, although there was a slight weighting towards improving early learning opportunities – seen as a prerequisite for improving skills and employability.

Additional themes which featured strongly were providing as much support as possible to families and interventions to improve mental health, wellbeing and self-confidence. While most of these preventive measures and early interventions focused on working directly with individuals, families and communities, there was still strong support for addressing what were seen as the real root causes of poverty – structural inequalities – *“These [above] interventions address the effects of the structural organisation of institutions, systems and decision-making – we would include better provision of good standard housing, affordable good quality food, more opportunities for leisure and recreation and participation in local decision making.”* (community health projects network)

3 Alleviating the impact of poverty on health

Turning to the impact which poverty has on ill-health, respondents were asked which of a number of measures for lessening the impact of poverty on health they most favoured. The measures were: a) targeting support for young mothers prior to the birth of their baby; b) targeting direct support towards lone parents; c) increasing childcare opportunities for lone parents; and d) providing general support for families with very young children.

Again, these measures were seen as of almost equal importance, re-emphasising the principle of acting early to prevent children from growing up with the damaging effects of living in poverty. It was also felt that there must be continuity of support, which invariably requires co-ordinated interventions at different times – it was of little use putting in extra resources to support lone parents with under fives if that support did not continue in the school context. Providing parenting programmes and engaging absent fathers in the lives of their children were given priority, too.

Respondents came out strongly in support of intervening to reduce the impact of poverty on the lives of other vulnerable groups, in particular young people requiring more chances and more choices in life, homeless people, carers and those with addiction to drugs – *“While working with families with young*

children is very important, we must remember that there are many other vulnerable groups of individuals with multiple needs”, one respondent said.

4 Determining the best policy avenue for poverty reduction

The Task Force is interested in hearing where the emphasis should be put in relation to poverty reduction – enhancing the internal capacity of individuals to lift themselves out of poverty, or removing external barriers to income enhancement, such as improving access to education and employment. This is a long debated issue, and the superficial impression was that respondents leaned towards enhancing internal capacity (58%) over removing external barriers (41%). However, within these categories, very few favoured a one-line approach and most respondents qualified their position by saying clearly that both approaches were necessary and mutually reinforcing. One respondent quoted evidence from the Poverty Alliance and studies by the Joseph Rowntree Foundation which suggested that: *People’s capacity and resourcefulness are automatically increased when barriers to income enhancement are removed*. And a housing charity added: *People need to feel they can succeed and then they will be able to work through the barriers.*”

Respondents listed a number of ways in which internal capacity could be enhanced and external barriers removed. These included increasing self-confidence and self-esteem, raising aspirations, pursuing educational and learning opportunities (seen as enhancing internal capacity), as well as removing benefits disincentives, providing affordable child care and improving educational opportunities, transport and housing (seen as removing external barriers).

Encouraging the building of self-confidence and self-esteem, raising aspirations and helping people to overcome barriers to services are considered as areas in which the third sector excels.

5 Closing the gap or lifting the poorest out of poverty?

Research shows that unequal societies, where the gap is greatest between rich and poor, experience the worst health inequalities¹. We also know that improving overall economic performance does not necessarily make the poor less poor and for some years, Scottish government policy has put more emphasis on closing the gap than on lessening absolute poverty. Respondents to this enquiry, however, appeared to be marginally more in favour of lifting the poorest sections of the community out of poverty (54%) than of closing the gap (46%). As before, however, the two approaches were not seen as mutually exclusive.

Those who preferred closing the gap as the primary approach adhered to ethical principles of solidarity, egalitarianism and fairness in support of this approach – *“The wealth of rich people is as much the issue as the poverty of poor people – inequalities are unhealthy in themselves”* (national support group); and *“Inequality and the perception of inequality is corrosive to good communities*

¹ R. Wilkinson (1996) *Unhealthy Societies: the Affliction of Inequality*. London: Routledge

and the commitment of individuals to the social good" (local community health initiative).

A number of those in favour of lifting the poorest out of poverty cited the evidence for the perceived ineffectiveness of many "closing the gap" initiatives. One national support group for older people said: *"Closing the gap means there is potential for more people to enter into poverty"*; and another respondent said: *"Closing the gap might just uplift the central section and leave the top and bottom sections in very much the same position as they are now."* (local community health project).

Respondents mentioned specific groups of vulnerable people on whom targeted efforts to reduce poverty should be concentrated – groups who are potentially at risk as well as those already living in or on the margins of poverty. These included lone parents, BME groups, refugees and asylum seekers, homeless people and, increasingly, low-paid workers and low-income home owners.

6 Prioritising Government action on tackling the root causes of poverty and alleviating its effects on health

Respondents were asked to rank those actions already identified as top priorities for action by the Task Force. The actions are: a) concentrating on support for the early years; b) enhancing opportunities for increasing education and learning; c) increasing employment opportunities; and d) providing interventions to improve mental health and wellbeing.

All four priorities were seen as of more or less equal importance, and interlinked. One national support group for lone parents pointed out: *"Contradictions in government policy should be addressed: lone parents are to be pressurised into employment; part-time work leaves them vulnerable to low pay and consequent poverty, but full-time work leaves their children with little parental time"*.

Some respondents felt that it was insufficient to promote educational, learning and employment opportunities without ensuring that people had suitable conditions in which to pursue these opportunities – cramped space in a damp unheated house was a deterrent to learning, as was lack of affordable child care facilities at a training centre, or an unwelcoming reception by front-line public sector workers for clients living in poverty. Others felt that there was an over-emphasis on the early years and on getting lone parents back to work and stressed the importance of maximising benefits take-up by vulnerable groups – including young people, those with special needs or who were homeless, those with mental health needs and older people. Many implied that without approaches to improving mental health and wellbeing – approaches in which the third sector has long experience – promoting learning and employment take-up was likely to be of limited value.

Finally, a number of people pointed out that while reform of the fiscal and benefits systems was an issue reserved to the Westminster Parliament, the Scottish Government was in a good position to advise Westminster of the

directions which needed to be taken, from experience of the current Scottish situation.

7 Determining the best contributions of other bodies and sectors to the alleviation of poverty

Respondents were asked to identify ways in which other bodies and other sectors could best make a difference to addressing the root causes of poverty and alleviating its effects on health. There was consensus here that long-term strategic planning across all sectors was absolutely essential. Moreover, strategic planning without some measure of joint budgeting and development action was of limited value – in short, the focus must be on *“agreeing cross-sector priorities and budgets being allocated to actions rather than organisations”* (anonymous).

Additionally, partnership working on the ground could reduce red tape and thereby improve access to benefits and services for vulnerable groups by signposting people to services, providing co-ordinated information and creating single assessments of need.

The private sector was seen as having a major contribution to make on the ground, both as employers and investors in local communities and the public sector should be making more use of these opportunities. Private sector employers were considered to have a responsibility for providing living wages, training and career development, flexible working conditions, fair recruitment practices and maintenance of equality and diversity in the workplace, as well as support for vulnerable workers, including those affected by mental ill-health.

As investors, private sector companies had many means at their disposal for alleviating community poverty – providing socially-just bank lending, social housing, fair pricing of healthy foods, leisure opportunities, employee volunteering openings and sponsorship of health-promoting services.

As a national lobbying group put it, *“long-term commitment to economic activity in deprived areas, rather than focusing on profit and shareholder values over a short time; involving members of local communities in meaningful way...is key to making a difference”*.

8 Determining the best partnership opportunities for the third sector

The added value brought by the third sector to anti-poverty work and tackling health inequalities is already well known. Across Scotland, many hundreds of voluntary organisations, support groups and community development projects are working effectively in close partnership with the statutory sector.

Identifying the most positive opportunities for third sector partnerships with other sectors, the majority of respondents focused mainly on the need to open up the field at strategic planning levels. Participation in community planning and in relation to health, the Joint Health Improvement Plan, as well as in high-level working groups and in joint funding bids were all seen as key opportunities. The

new Concordat and with it, requirement for local authorities to establish Single Outcome Agreements was seen as an additional route to strategic partnership working with the third sector.

At operational level, many pointed out that the third sector was uniquely placed to address the root causes of poverty in communities, in partnership with statutory agencies, and to respond sensitively to the immediate needs of the most vulnerable – *“the third sector is able to engage individuals labelled as ‘hard to reach’ and this should be taken up and harnessed by other sectors. Joined up approaches to service users would avoid a multitude of access points....”* (environmental charity).

But respondents acknowledged the weaknesses of their own sector and the current difficulties it was facing, which were detracting from its effectiveness: *“The third sector is very disparate; it needs improved knowledge and understanding of the issues generally and of the opportunities that can open up via social enterprise, improved co-ordination and effective impact at strategic and delivery levels. The danger of large scale procurement is that instead of closeness to the community it relies on efficiency via scale...”* (local network body).

And: *“More mechanisms are needed to bring about greater understanding between the sectors in identifying what’s better for sectors to take forward individually and what’s better for sectors to collaborate on, clarifying the actual benefits which are brought about for people experiencing poverty when sectors collaborate.”* (community health network).

Respondents did acknowledge the responsibilities which the third sector itself needed to take on for pointing out the value of its own approaches: *“Third sector organisations could do more to present better their ideas and ways of working. The focus on engaging with other sectors should be on the benefits to their business rather than preaching about their responsibilities”* (national lobby group)

9 Bringing third sector skills to the alleviation of poverty and its effects on health

Respondents were asked to rank key areas to which third sector skills could make most difference. The areas for intervention were: a) measures to support children’s early years; b) enhancing opportunities for increasing learning and skills development; c) increasing employment opportunities; and d) providing interventions to enhance mental health and wellbeing. Increasing employment opportunities through informal learning and formal training support to individuals, combined with enhancing mental health and wellbeing, were the most highly ranked of these areas, and again, respondents felt that the third sector was well placed in terms of the skills of its workforce to work in this context.

Many respondents emphasised that it was by means of providing extensive support for improving mental health and wellbeing that the third sector supported individuals in increasing their self-confidence and therefore their employability. The third sector was extensively seen as excelling in crisis intervention, helping people to get back on their feet and become better at taking charge of their own lives, which led eventually and in many cases, to their being able to enter or re-enter the job market.

Throughout this enquiry generally, it seemed that respondents saw Government as already providing a great deal of support for the early years and believed that third sector skills were best deployed in working with communities and with particular groups of vulnerable young people and adults in building self-worth and confidence. People said: *“Reaching out and involving the most excluded members of our communities, feeding back experiences of those most disadvantaged to influence strategy and services...”* (campaign group), and *“Supporting the participation of people experiencing poverty in engaging with public sector bodies”* (community health network).

10 Identifying the strengths of individual third sector organisations

Respondents were asked to describe the particular strengths of their own organisation in tackling the effects of poverty on ill-health. By and large, the strengths of respondent organisations mirrored those of the third sector in general.

Third sector added value attributes identified within respondents’ accounts of the key strengths of their own organisation included skills in partnership working, crisis intervention and rapid response ability and providing sustained support for individuals and groups – in other words, being there for the long term.

The third sector is uniquely placed to respond rapidly and sensitively to individual need. It quickly gains trust with those who can be wary of statutory services, provides early intervention, can alleviate crisis and signposts people to statutory services. Often it is third sector organisations which provide the links between individuals or groups and a range of services in different sectors. They support and work with the most excluded and vulnerable people whom statutory services often find hard to reach and address individual and community deficit in self-esteem and confidence, encouraging positive mental health and wellbeing and making people more able to take charge of their own lives.

The sector offers volunteering opportunities and work placements, thereby increasing chances of employment, and promotes participation by individuals and communities in civic society.

All these attributes can bring much to partnership working with the statutory sector, can ease the pressure on public services and have the power to address and alleviate poverty and its effects on health.

11 Highlighting third sector work in alleviating poverty and addressing health inequalities

Many respondents to this enquiry provided vivid accounts of ways in which their work was responding directly to poverty in this unique “third sector way”. Snapshots of some of these are featured here.

“We work closely with primary care staff, encouraging them to refer people who might benefit from learning. In this way we have been able to meet some very socially isolated people who spend most of their day simply coping with the challenges of poverty and deprivation. Getting involved in learning starts to reduce social isolation, improve self-worth and open up alternative futures” (health and literacy project).

“Our energy professionals work with the public, private and third sectors. We help them to develop policies and programmes for identifying and tackling the effects of cold damp homes on service users. We use a range of approaches suitable for the group involved – giving affordable warmth advice by telephone, offering support in people’s homes, running group work sessions. Referrals to and from associated organisations enable amore holistic service, helping people get out of fuel debt and create warmer healthier homes....” (third sector energy advice agency).

“We run a fruit and veg co-op in the nursery where mums can pre-order, pay and pick up their order when they pick up their children. We have also a breakfast club for mums – mums rarely eat in the morning and this does not provide a good role model for their children” (food co-operative).

“Our volunteering towards employment project supports people volunteering in the NHS and with other partners. Our volunteers may have had mental health problems, addictions etc., and they are now better equipped for re-employment because of he skills they have developed as volunteers” (volunteer centre).

12 Aligning resources across sectors to alleviate poverty and its effects on health

Respondents were asked for their views on and experience of ways in which resource-alignment can best be achieved in the interests of preventing and alleviating poverty and its effects on health.

Respondents put the strongest emphasis on effective partnerships. They listed key ‘quality’ features of good partnership working at both planning and operational levels. Essential to the process is mutual respect and a shared vision of what needs to be achieved, jointly developed strategies and service planning, equitable allocation of resources, effective communication between all partners, shared intelligence (including the vital dimension of engaging constantly with service users and local communities), joint workforce learning and skills development and mechanisms for signposting users to services across all sectors.

In effect, respondents were identifying the key principles of *The Scottish Compact* and where these exist, of local *compact* agreements for joint working.

In relation to the relief of poverty and its effects on health, early intervention was seen as “spending money now to save money later”. If needs are anticipated at an early stage and jointly managed resources put in, the need for expensive single-agency intervention can be avoided at a later stage. Examples of this include working with vulnerable older people to minimise fuel poverty and maximise household warmth, thus saving crisis-driven hospital admissions; encouraging young mothers to feed their families on a low budget, thus minimising the damaging development of poverty-related poor nutritional status and its effects on their children’s learning and wellbeing.

Resource sharing was another valued strategy. One respondent said: “*Where resources are tight, there should be scope for a group of organisations to employ staff on a shared basis to carry out targeted work. In our experience service users are initially reluctant to go outwith the [third] sector because of fears of discrimination but a single specialist post can be shared between three or four agencies*” (addiction support service).

Better use of “social prescribing” was seen as another means of effective resource-sharing – “*If cross-referral between from healthcare services and the many local third sector organisations were better organised, people could be supported in the community, often preventing illness arising from poverty and deprivation and avoiding the need for more costly health care...*” (volunteer centre).

Financial incentives for partnership working were highlighted – a condition of funding being granted should be that there must be cross-sectoral working: “*Working partnerships between the statutory services and voluntary organisations need to be backed by government with financial incentives, otherwise the inclusion of the sector in partnerships is not meaningful.*” (mental health campaign group).

Funding should be allocated to specific objectives but restrictions on the eligibility for support of particular groups affected by poverty were seen to put unnecessary restrictions on what could be achieved at a community level through cross-sectoral local initiatives. In other words, the desired outcome – an overall increase in take-up of local employment opportunities, for example - should allow for the third sector to partner statutory services at all stages of the process, bringing its own unique strengths to the outcome.

13 Identifying other factors which can lessen the impact of poverty on health

Respondents were asked for their views on what other factors could make a significant difference in alleviating the impact of poverty on health. By far the greatest emphasis was put on a reiteration of the necessity for cross-sectoral working – by sharing resources, developing skills jointly and increasing employer input. A respondent described this in more detail: *“Definitely encouraging more willingness to work across sectoral boundaries. Staff in our project all have a background in adult education but are based in NHS premises. Primary care staff who work according to a psycho-social model of health value our input and value having our project as an additional resource for people who are their patients”* (health and literacy project).

The second main focus was put on building evidence of what works and feeding this into government policy and staff training, ensuring that funding is sufficiently stable to promote and embed best practice.

Workable approaches included *“Having a ‘skills bank’ of tools, approaches and strategies which can successfully be used in tackling inequalities; having local ‘champions’ to promote services* (smoking cessation organisation); and:

“Ensuring that successful local anti-poverty initiatives are sustained with long-term funding; ensuring that evidence is collected from these initiatives and shared across all sectors; building capacity in ‘poverty awareness raising with managers and staff of public sector organisations” (community health network).

In the performance management of health improvement systems and interventions, there must be a joint determining of what outcomes translate into improvement and what intermediate stages must be gone through to achieve this improvement. The third sector need to articulate more clearly exactly what it can contribute to this process and partnerships encouraged to let third sector skills shine through where these are best positioned to make a difference. As one community food initiative said: *“Not everyone needing to make dietary changes is able to aspire to full-time employment – what is needed are indicators of the increase in self-confidence and self-esteem which clients can achieve with third sector support”*.

National intermediary bodies Voluntary Health Scotland and CHEX are currently working with NHS Health Scotland to build third sector capacity for building evidence of its own effectiveness.

Phase Two – Roundtable Discussion

The material derived from the on-line enquiry was used as basis for the roundtable discussion held on 17th March. The Minister for Public Health, the Director of Health Improvement and the Deputy Director for Social Inclusion took part in the discussion.

The Minister for Public Health, Ms Shona Robison MSP, opened the discussion with an overview of the Government's position on tackling health inequalities and the key issues that had emerged thus far from the deliberations of the Task Force.

Ms Robison emphasised that the strength of the Task Force on Health Inequalities lay in bringing together ministers from across all government directorates and key external partners, including CoSLA, to address the extent of health inequalities and identify the scope for action. In the course of its work, The Task Force had agreed key concepts and ways of working. These state that:

- Action must be cross-governmental
- Work is needed to raise awareness across all sections of society of the implications of poverty and inequalities for Scotland's health and future
- Priority must be given to moving forward practical action rather than on further analysis of the problem
- Community Planning Partnerships (CPPs) could be the best context for action, but their capacity and ability to reach those most excluded requires to be strengthened
- Actions must be evidenced-based and applied in creative ways
- The key starting point for action must be families, engaging with their needs even before the birth of children
- Clear service pathways must be developed to meet anticipatory need, obviating inappropriate crisis intervention
- To make best use of the substantial investment in local government and health, service re-design must be prioritised
- Better use must be made of the skills of people on the ground, in particular frontline workers
- The measurable achievements of third sector work in partnership with other sectors must be built into models for action, using third sector skills in building trust with people most affected by health inequalities
- There must be recognition that action must be sustained over a time period much longer than four years, requiring cross-party support by the body politic for long-term success

Following reflections by Ms Robison on the progress achieved by the Task Force, input was provided by the Deputy Director for Social Inclusion, Mike Palmer, on the current Government Economic Strategy's approach to tackling poverty, inequality and deprivation in Scotland.

Participants were reminded of the clear role laid out for the third sector in tackling health inequalities in both *Better Health, Better Care* and the *Government Economic Strategy*, as follows:

- *We will improve the capacity of the third sector to reduce health inequalities by:*
 - *Supporting commissioners, funders and community-led services to achieve shared outcomes; and*
 - *Reviewing the way in which NHS Scotland supports third sector organisations to explore ways of enhancing the sustainability of programmes that demonstrate a clear benefit for patients and carers*

And:

- *The third sector should be regarded as a full partner in the [economic strategy] process....*

The roundtable discussion was framed around identification of the characteristics of interventions most likely to be effective in reducing health inequalities. These characteristics emerged from the analysis of the data yielded by the on-line enquiry.

To open the discussion, an overview of the main features and findings of the on-line enquiry was provided by Rock Solid Social Research. The full presentation is contained in Appendix 1 to this Report.

In small groups, participants were then asked to address three issues and tasks.

1 Identifying characteristics of successful interventions

In the on-line enquiry, third sector respondents identified a number of essential characteristics or defining features of interventions that are effective in reducing health inequalities. These are:

- Ensuring cross-sectoral, inter-agency delivery
- Working where people are at
- Ensuring a comprehensive approach
- Ensuring responses that are sensitive to ethnicity and culture
- Tailoring services to meet expressed individual and community need
- Working at the interface between supplier and recipient, using the strengths of both
- Working with (extended) families as a unit
- Investing in people's futures
- Maximising individual and collective participation and empowerment
- Embedding sustainable support for long-lasting outcomes

Participants were asked to comment on these and they added further characteristics of success.

1.1 Considerable work needs to be done in communicating effectively Scottish and UK government policies and strategies for poverty reduction; participants noted that significant numbers of people – often those already disadvantaged - still do not have internet access. The use of a variety of media and communication methods is an ingredient of success.

1.2 At the same time, further work is needed to understand and explain to an audience beyond Government the underlying economic causes of inequalities and how these impact on people's health. For people to perceive that they are part of the solution and not just creators of the problem is likely to be marker of success.

1.3 Working with frontline health professionals and local government workers to change their perceptions of and attitudes to health inequalities can increase solidarity and reduce stigma.

1.4 Success breeds success – maximising the visibility of initiatives and celebrating achievements are likely to be precursors of success.

1.5 Ensuring a careful balance between individual and societal responsibility is likely to ensure sustainable results – focusing on mutuality and co-production.

1.6 Successful interventions are likely to feature ongoing analysis of the changing picture of individual and community need - building in action research can help this process.

1.7 Setting jointly-owned and realistic targets supported by sustainable funding are likely to gain "early wins", in which all parties can have a stake.

1.8 Establishing joint posts or ones that link with other local services can maximise resources and lead to jointly owned improvement.

Participants in the roundtable discussion identified many or most of these defining features of success as ones that had led to successful practice by their own organisations.

2 Taking forward and embedding successful interventions in strategy and practice

Participants were asked to say how the successful features identified could be taken forward in strategy and embedded in practice. They advocated a number of key ways of working.

2.1 Establishing a shared vision of a healthier, fairer Scotland and setting up a strategic and practice-based approach common to all sectors and agencies has real potential for the alleviation of poverty.

2.2 Using social marketing approaches in ongoing strategies to explain absolute and relative poverty and how these impact on health inequalities in Scotland today is key to establishing a shared vision.

2.3 Working with all frontline workers and those who are in face-to-face contact with individuals and communities is likely to de-stigmatise poverty and reduce the blame culture.

2.4 Maximising the partnership approach to strategy and practice at all levels is the main predictor of success.

2.5 Engaging with third sector infrastructure locally eg. local councils of voluntary service (CVSs) and community health projects networks is likely to result in wider, more strategic engagement with the third sector.

2.6 Encouraging people to access under-used services through well-used services eg. benefits take-up advice in health centres, health screening information in post offices can maximise the one-stop shop approach.

2.7 Relating to the above, developing the one-stop shop approach and extending local income maximisation initiatives eg. credit union and food-co-operative provision offers individuals and families greater resources for self-reliance

2.8 Promoting measurement of the effectiveness of interventions through Social Return on Investment and social capital increase is to be advocated.

2.9 Establishing identification of savings made to the NHS and other statutory services must be a part of measuring effectiveness.

Participants in the roundtable discussion believed that embedding these key ways of working in strategy and practice were crucial to the success of interventions.

3 Third sector recommendations to the ministerial Task Force

Finally, participants in the roundtable discussion were asked to identify key recommendations for action at policy and practice levels. Their recommendations were clustered under four main headings.

3.1 Communicating the urgency of poverty and health inequalities

Throughout the whole consultation process, respondents from the third sector expressed the view that the meaning of poverty and its impact on the health of people in Scotland required clear explanation at all levels, using as many different means of communication as possible. Accustomed as they now are to raw depictions of absolute poverty throughout the world, many people in Scotland are unaware of the devastating impact of relative poverty in communities close to where they live.

Key Recommendations for improving communication about poverty and health inequalities in Scotland today are therefore:

3.1.1 To create a greater awareness of the definitions of absolute and relative poverty and what these mean for Scotland's health today

3.1.2 To encourage social marketing methods for information dissemination and to include the general public, communities, the third sector and a broad range of statutory sector workers within the target audiences

3.1.3 To use the above approaches to de-stigmatise poverty and inculcate a philosophy of a fairer sharing of Scotland's resources

3.2 Adopting a partnership approach to tackling poverty and health inequalities

In both the online enquiry and the roundtable discussion, respondents from the third sector repeatedly stated the absolute primacy of working together. This reinforces the concept of the "mutual NHS" laid out in *Better Health, Better Care*.

Key Recommendations for taking a partnership approach to tackling poverty and health inequalities in Scotland today are therefore:

3.2.1 To promote the value of Scotland's people as the greatest resource in the alleviation of poverty and co-production as the means of enhancing personal and societal resources

3.2.2 To maximise returns when planning interventions by using partnership approaches rather than setting up single-sector interventions

3.2.3 To commit meaningful resources to the third sector role in partnership and co-production of health, embedding the principles of the *Scottish Compact* for partnership working

3.3 Maximising returns on investment for health

Third sector respondents to the online enquiry and at the roundtable discussion stressed the importance of establishing a shared vision and desired outcomes from the start and of moving towards these coherently in shared programmes.

Key Recommendations for maximising returns on investment for health are therefore:

3.3.1 To establish from the beginning a shared vision of desired outcomes and use to best advantage the strengths of public sector, private sector and third sector contributions

3.3.2 To ensure that the scale of investment matches the problem and ensure that initiatives are sustainably funded for long enough to make a measurable difference, while still allowing for intermediate indicators of success

3.3.3 To balance resource allocation between addressing general need and targeting the most disadvantaged individuals and communities

3.3.4 To balance approaches which focus on individual income maximisation eg. better benefits take-up with those which improve structural opportunities eg. childcare, learning and skills opportunities

3.4 Establishing evidence of effectiveness in order to replicate successful interventions

Third sector respondents to both the online enquiry and at the roundtable discussion had much to say on evidence and were keen to see established effectiveness measures that allow the strength of third sector working to “shine through”.

They believed that in the performance management of health improvement systems and interventions, there must be a joint determining of end outcomes and an identification of the unique added value brought by the third sector to intermediate outcomes. At the same time, respondents acknowledged that the third sector needs to do more work on establishing measures of added value and translating these into “added health”.

Key Recommendations for establishing evidence of effectiveness to replicate successful interventions are therefore:

3.4.1 To introduce the concept of “public value” in the setting of outcomes

3.4.2 To include in outcome measures an identification of cost savings made eg. where community-based partnership interventions can reduce impact on NHS services

3.4.3 To make better use of social return on investment and social capital as measures of effectiveness

3.4.4 To measure the value of co-production and partnership in the interests of establishing mutuality within the NHS

3.4.5 To promote evidence of success more effectively across Scotland and incentivise replication of workable initiatives

Conclusions to the Consultation

At the end of the two phases of this consultation on the views of third sector organisations in Scotland on current Government approaches to combating poverty and health inequalities and on the additional efforts which require to be

made by all sectors, Voluntary Health Scotland has been able to reach a number of conclusions on the value of the exercise. These are:

1 Third sector organisations across Scotland valued the opportunity to be included in the deliberations of the ministerial Task Force on Health Inequalities. While their experience is diverse, there was considerable consistency in their priorities for strategy and action.

2 The realities of poverty and inequalities in Scotland today and their effects on health need to be better explained to the public and to the workforce across all sectors in order to reduce stigma and increase fairness and solidarity. Imaginative communication methods need to be used.

3 There is room for the Scottish Government to influence Westminster thinking on new approaches to combating the underlying causes of poverty and inequality, based on the Scottish experience.

4 Those participating in the consultation supported and broadly agreed with current Scottish Government priorities for action. However, they identified other additional areas where poverty can be at its most corrosive, areas in which third sector action can make a real difference.

5 It is expected that Government take the main responsibility for supporting families and children in the very early years, making best use of statutory obligations in this area and partnered by the third sector in critical areas.

6 Improving mental health, enhancing self-esteem and confidence in both individuals and communities are pre-requisites for approaches focusing on employment and employability – best use must be made of third sector skills in meeting these needs.

7 Partnership working at all stages is the single best predictor of success. The third sector must be included as strategic thinking partner, as well as partner in delivery. Better use needs to be made of planning and partnership opportunities, including those newly created through changes in local government relationships with national Government with the advent of the Concordat and Single Outcome Agreements.

More creative use needs to be made of the private sector in partnership working.

7 There is an ongoing need for better evidence of “what works best in partnership” and of the value of partnership working itself. Recent thinking on shared outcomes and the value of investment in the public good must be incorporated into evidence. Indicators need to be established which allow the unique added value of the third sector to shine through.

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The on-line enquiry phase of this consultation was organised by Phil McAndrew and Helen Tyrrell of Voluntary Health Scotland

The analysis of the on-line data and the facilitation of the roundtable discussion were carried out by Marion Lacey of Rock Solid Social Research

The report was written by Helen Tyrrell

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