The Highland Council

Community Safety, Public Engagement and Equalities Committee – 3 December 2014

Agenda Item	**12**
Report No	**CPE 43/12**

Health Inequalities and Physical Activity in Highland

Report by Head of Health Improvement, NHS Highland

Summary
This report provides an overview of the main areas of work that have been progressed across the Highland Community Planning Partnership to help reduce health inequalities and promote physical activity.

1. Background

1.1 The Highland Community Planning Partnership Health Inequalities and Physical Activity Theme Group is tasked with overseeing progress on the health inequalities and physical activity priorities outlined in the Highland Single Outcome Agreement and overseeing the development and implementation of partnership work to support a reduction in health inequalities and an increase in levels of physical activity.

1.2 Health inequalities is recognised as a cross-cutting theme within the Community Planning Partnership and work has been undertaken to reflect this in all of the theme groups and delivery plans. The appended report by the then outgoing Director of Public Health and Health Policy, submitted to the Community Planning Board at its meeting on 13 October 2014, provided a comprehensive update to that Board on this theme and related issues.

2. Health Inequalities

2.1 Whilst the overall health of our population continues to improve, Highland, like the rest of Scotland, continues to have a widening gap in life expectancy between the richest and poorest members of our society. The underlying causes of these inequalities in health are increasingly recognised as inequalities in the distribution of wealth and power.

2.2 Tackling health inequalities therefore requires upstream work to address the underlying socio-economic inequalities as well as focussing on more downstream lifestyle factors.

2.3 The Ministerial Task Force Review of health inequalities in 2013 concluded that action to tackle health inequalities were required at national and local level. It recommended a life course approach, particularly focussing on the early years as the most cost effective method of reducing health and social problems later in life.

2.4 There has been considerable focus in recent years on investing more resources in services and interventions that prevent use of costly interventions later in life or at a later stage when interventions are not only more costly but often less effective. Investment in prevention must continue to be a high priority if we are to be successful in improving the health of our population and reducing future demand on our services, but there is also a need to maintain a balance between universal services and targeting efforts at specific hard to reach groups. This approach is needed in all services where those most in need are least likely to access universal services, and is called 'proportionate universalism'.

3. Physical Activity

3.1 Research has shown that physical inactivity is the largest attributable factor of all-cause mortality. That means that it causes more deaths than obesity, diabetes and smoking combined, making physical inactivity the fourth leading cause of preventable death.

3.2 Establishing patterns of physical activity from the early stages of development and maintaining these throughout our lives into older age contributes significantly to increasing the proportion of life spent in good health.

4. Local Activity

4.1 Local activity in Highland includes:

- Close working between Community Planning Partnerships on the wider determinants of health.
- Community development work in our most socio-economically deprived and fragile rural areas.
- Work to build community empowerment and resilience.
- The Early Years Collaborative.
- The Keep Well programme.
- Primary care pilot work.
- Mitigating the impact of welfare reform.
- Targeted and universal health improvement services aimed at promoting healthy lifestyles.
- Housing and homelessness.
- Preventative services: immunisation, screening, 'Detect Cancer Early'.
- Primary care dentistry.
- Support for workplace health and employability initiatives.
- Work on poverty, including fuel poverty.
- Work on Equality and Diversity.
- Promoting the outdoors for physical activity.
- A broad range of leisure and sporting opportunities provided by Highlife

Highland.

- Pilot work with Scottish Government to determine what would motivate local communities in Highland to become more active.
- A wide range of formal and informal opportunities for physical activity and sport offered by community groups, local sports clubs and Third Sector organisations.

5. Implications

5.1 This is an update on activity across the Community Planning Partnership on health inequalities and physical activity. There are therefore no Resource; Legal; Equalities; Climate Change/Carbon Clever; Risk; Gaelic; or Rural implications as a result of this paper.

Recommendation

Committee Members are asked to note the content of the appended report.

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Date: 24 November 2014

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Attachment: Health Inequalities and Physical Activity in Highland – Report for the Community Planning Board, October 2014

Health Inequalities and Physical Activity in Highland

Report for the Community Planning Board
October 2014

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1. Executive Summary and Recommendations

1.1 Health Inequalities

Inequalities in health continue to widen in NHS Highland. There is now much greater clarity over the fundamental causes of these inequalities and the actions required to reduce them at national and local level. Local activity in Highland includes:

- Close working between Community Planning Partnerships on the wider determinants of health.
- Community development work in our most socio-economically deprived and fragile rural areas.
- Work to build community empowerment and resilience.
- The Early Years Collaborative.
- The Keep Well programme.
- Primary care pilot work.
- Mitigating the impact of welfare reform.
- Targeted and universal health improvement services aimed at promoting healthy lifestyles.
- Housing and homelessness
- Preventative services: immunisation, screening, 'Detect Cancer Early'.
- Primary care dentistry.
- Support for workplace health.
- Work on poverty, including fuel poverty.
- Work on Equality and Diversity

Monitoring progress in reducing health inequalities as a result of these initiatives is difficult and national work is underway to develop a national system. Specific projects and programmes have their own internal evaluation and monitoring. A challenge for all public sector organisations lies in acknowledging that preventive upstream work in one agency prevents later problems occurring in another agency's area and working together to understand their inter-dependency.

It has been recognised that further progress must also be made in understanding the significant contribution that the third sector makes in the promoting health and wellbeing, and the reduction and mitigation of health inequality. Part of this includes identifying and measuring the impact of work already commissioned by the statutory sector which contributes towards this but which is not currently recognised, measured or valued in this way.

The good foundations established over the last 2 years should continue, as a reduction in longstanding health inequalities will not occur without sustained long-term effort and resource directed effectively. Short-term projects and initiatives have not delivered the sustainable improvements intended and have often not been easily evaluated. Routine services need to have an awareness and ability to respond proportionately to health need

embedded in their routine activity. Community development work also needs long-term sustainability

1.2 Physical Activity

Despite great efforts, there has been no real increase in levels of physical activity since the National Physical Activity Strategy (Let's Make Scotland More Active) was launched 11 years ago. Local activity in Highland to encourage and promote people to be more active includes:

- Promoting the outdoors for physical activity
- A broad range of leisure and sporting opportunities provided by Highlife Highland
- Pilot work with Scottish Government to determine what would motivate local communities in Highland to become more active
- A wide range of formal and informal opportunities for physical activity and sport offered by community groups, local sports clubs and Third Sector organisations

1.3 Recommendations

1. The assets-based and co-production approaches to empower communities and individuals should be developed through continuing commitment to community development work in the long-term.
2. Community planning partners should seek to work more closely to tackle wider determinants of health, particularly employability and employment, and recognise the fundamental determinants of social and economic inequality that lead to inequalities in health outcomes.
3. Mitigating the impacts of welfare reform will remain a priority for several years.
4. An explicit commitment to reducing the gap between the health of the worst off and the population average should be routinely included in all relevant strategic plans and intentions and reflected in resource use; information on variation in service provision (through the health profiles) should be regularly reviewed to ensure that services are targeted appropriately at the areas and population groups in greatest need.
5. Inequalities impact assessment should be built into all partners processes for major policy and service changes.
6. All partners should ensure they actively seek to obtain and record the required data on Equalities and Diversity to permit analysis and monitoring of activity and outcome for vulnerable groups.
7. Interventions and services that prevent illness or reduce its impact tend to be more effective and cost-effective than treatment services. There should be a continuing emphasis on improving and extending such preventive services, such as immunisation, screening, and the work of the Early Years Collaborative, particularly the promotion of breastfeeding.
8. Smoking cessation services and smoking prevention activity should be actively promoted and targeted at the areas and groups with the highest prevalence of smoking.
9. Community planning partners should ensure that its procurement and contracting practice includes social clauses such as the promotion of the living wage, employability and community benefit schemes.

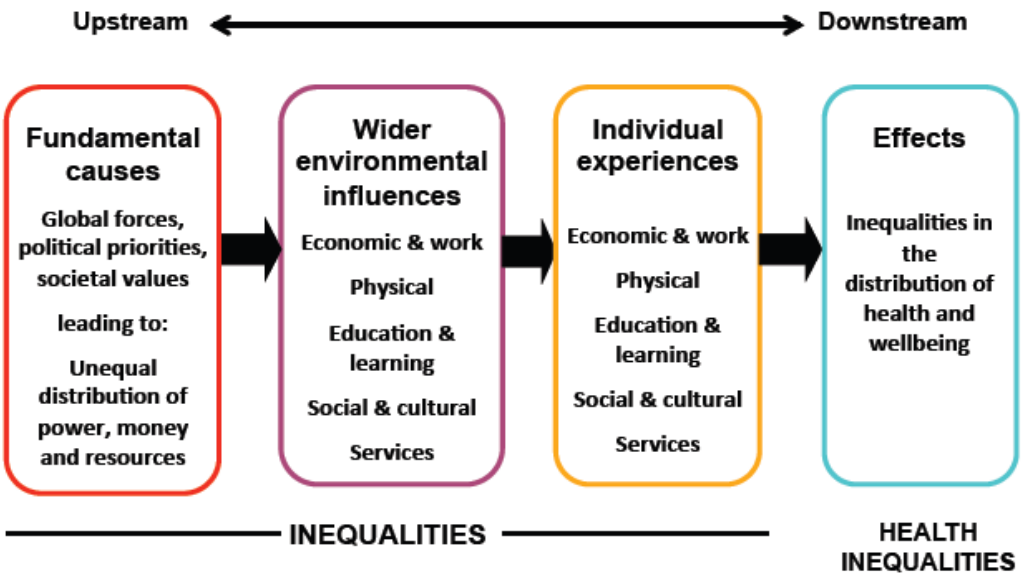
10. Community planning partners should build on existing employability work to become the exemplar.
11. Community planning partners should support staff to be aware of/recognise inequalities issues and develop inequalities sensitive practice.
12. Social and wellbeing outcomes should be built into community planning partners' service plans alongside other service outcomes.
13. Community planning partners should build on existing work to reduce poverty, particularly fuel poverty.
14. The contribution of the third sector in the promotion of health and wellbeing and the reduction and mitigation of health inequality should be better understood, measured and valued. The health inequality sub-group should play a leading role in taking forward this work, but with a significant emphasis on supporting progress right across community planning.
15. Community Planning Partners should ensure coordinated, targeted intervention with people who are at risk of homelessness due to underlying addiction or mental health issues in order to help them maintain settled accommodation.
16. Transport policies that support walking, cycling and public transport should be prioritised.
17. The current Highland Physical Activity and Sport Strategy should be reviewed and refreshed.

2. Overview of Health Inequalities

2.1 Health Inequalities in Scotland

Scotland, in common with the rest of the UK, continues to have a widening gap in life expectancy between the richest and the poorest members of society[1], although overall health in the population continues to improve. The underlying causes of these inequalities are increasingly recognised as inequalities in the distribution of wealth and power (Figure 1)[2].

Figure 1: Health inequalities: theory of causation (summary version)



The health conditions which contribute to the life expectancy gap (primarily cancer, smoking and alcohol-related diseases and injuries) have changed over time; fifty years ago, communicable diseases were prominent contributors. Tackling health inequalities therefore requires more upstream work to address the underlying socio-economic inequalities in society as well as focussing on more downstream lifestyle factors.

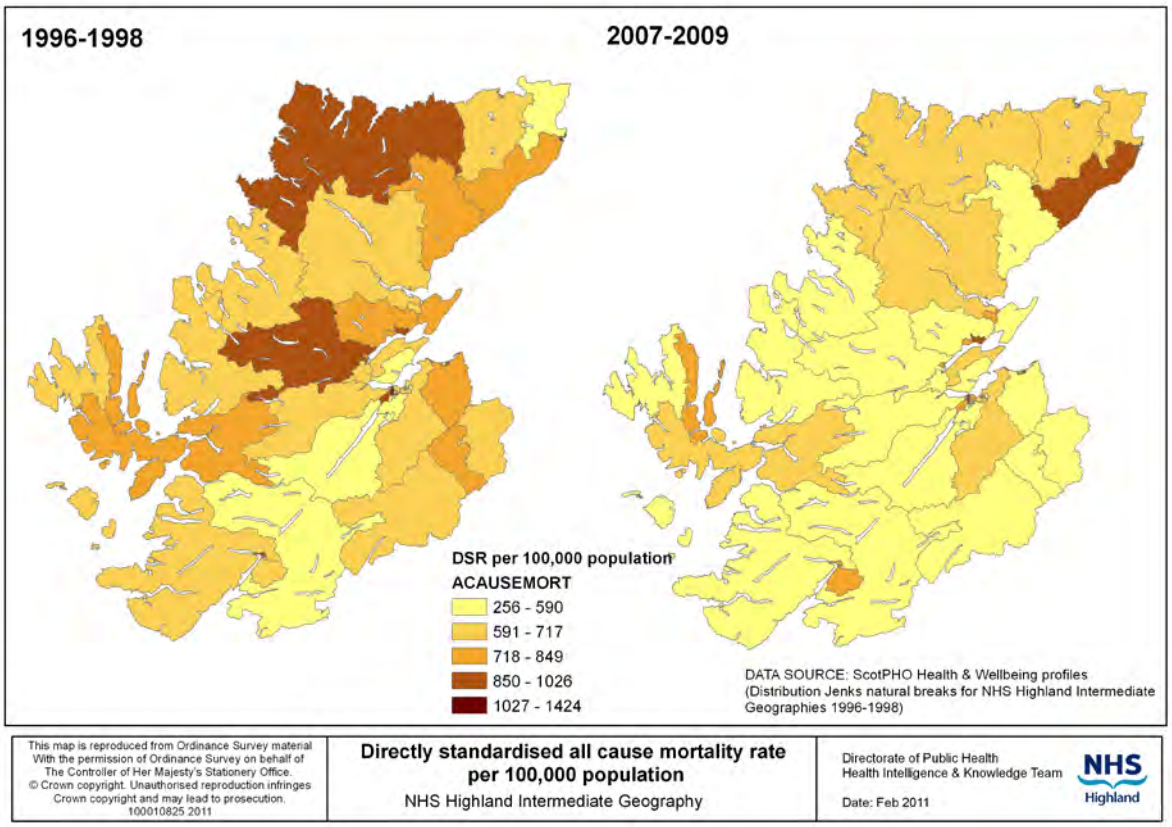
The Ministerial Taskforce Review in 2013 concluded that actions were required across all three levels of the determinants shown in Figure 1 and a balance was needed between improving the overall health of the population and reducing inequalities in health. It recommended that national and local action was needed, focussing on those interventions shown to be effective and discontinuing those that are ineffective. A life course approach was also recommended, particularly focussing on the early years as the most cost-effective method of reducing health and social problems in later life.

2.2 Health Inequalities in Highland

Inequalities in Highland are similar to those described for Scotland. Population health has improved on most measures between the 1990's and the late 2000's, but health is still improving more slowly for some of our communities (Figure 2). Inequalities in morbidity and

mortality outcomes associated with income deprivation have increased or remained very similar over recent periods despite work on health improvement. Across Highland not all deprived people live in areas that would be recognised as deprived, but there are a number of areas with higher numbers of income deprived people that consistently have poor population health outcomes. The same geographic areas tend to be found at the poorer performing end of the range on most measures and in all time periods.

Figure 2



This data was initially presented in the 2011 Public Health Annual Report[3] and updated for the Inequalities Conference held in Inverness in 2013[4]. Since then, detailed health profiles for adults and children have been produced at district and area level[5]. These profiles are being widely presented and discussed district partnership meetings and used to inform commissioning decisions. They contain information on the wider determinants of health, the potential for health improvement, health protection and the need for health and social care.

The 2011 Public Health Annual report made recommendations for action by Community Planning Partnerships, integrated health and social care services, other service providers, including the voluntary sector, and public health professionals. This report updates the work that is in progress with all these agencies and makes further recommendations on continuing and extending the work.

2.3 Tackling Health Inequalities and Investing in Prevention

There has been considerable focus on investing more resource in services and interventions that prevent use of costly interventions later in life or at a later stage when interventions are not only more costly but also less effective[6].

Depending on the focus of specific initiatives, preventative spend has the potential to contribute to reducing inequalities.

Examples include:

- Action in the early years, to improve child development, parenting and education, is well recognised to reduce health and behavioural problems in later life and is a major national focus for work through the Early Years Collaborative[7].
- Action to improve road safety, reducing injuries and consequent health and other service use.
- Health services and interventions such as smoking cessation, screening and immunisation aimed preventing disease occurring in the first place or reducing its impact by early detection and treatment.
- Anticipatory care planning to reduce risk of hospital admission.
- Community development and asset based approaches.
- The Change Fund and services to keep older people healthy and engaged in meaningful activity.

These examples illustrate the need to maintain a balance between universal services and targeting specific hard to reach groups. For example a target of 70% coverage for a universal service such as screening, if met, will improve overall population health, but the inequalities gap may widen if there are not also specific efforts made to encourage uptake among those least likely to take up the routine invitation to participate. Such an approach is termed “proportionate universalism”.

This approach is needed in all services, where those most in need of them are least likely to be able to access the universal services. Specific services are sometimes available to support particular hard to reach groups, such as the homeless and gypsy travellers, but these are not necessarily joined up across organisations.

The contribution that the third sector in Highland makes towards the promoting health and wellbeing, and the reduction and mitigation of health inequality, is becoming increasingly clear. The diverse range of services, initiatives and activities that the sector delivers often address many of the fundamental ‘upstream’ social and economic causes of health inequality as described above. Much of the third sector’s work is preventative by its very nature. It is often community-led groups and initiatives responding to local needs and gaps in public service provision, particularly in our most isolated and remote communities, that lead to innovative approaches that offer essential support to some of the hardest to reach, most vulnerable and disadvantaged people in Highland.

However, despite this significant contribution, there is much more work to be done, both within the third sector and across the statutory sector, to identify, understand, measure and value the contribution the third sector makes in the prevention of poor health and wellbeing and the reduction and mitigation of health inequality.

3. Highland CPP Health Inequalities Theme Group

The Highland Community Planning Partnership Health Inequalities Theme Group is tasked with overseeing progress on the health inequalities priorities outlined in the Highland Single Outcome Agreement and overseeing the development and implementation of partnership work to support a reduction in health inequalities in Highland.

Health inequalities is recognised as a cross cutting theme within the CPP and in recent months discussions have taken place with the lead officers of each of the CPP theme groups to look at how inequalities is reflected in all of the theme group outcomes and work plans. The culmination of this work was a workshop with the Chief Officers group of the Highland CPP to examine the fit between the actions and outcomes across all the CPP theme groups and the Health Scotland inequalities framework. This work highlighted that the mix of outcomes and actions within the various theme group plans was difficult to assess for impact on inequalities, particularly where universal statements were made that did not make explicit reference to engaging hard to reach, vulnerable or deprived groups.

As a result of this work, the CPP agreed that each theme group should review its action plan to make explicit reference to reducing inequalities. In the meantime, the health inequalities theme group has developed a work plan[8] which sets out a small number of priorities to progress over 2014/15. These include:

- Preventative spend.
- Welfare reform.
- Housing and homelessness.
- Fuel poverty.
- Employability.
- Older people.
- Physical activity.
- Community Learning and Development.
- Developing monitoring/surveillance.

A number of other emerging issues are also being discussed and considered for partnership action including:

- Transport.
- Promoting use of local community assets.

3.1 Preventative Spend

The Highland Council have provided £1 million through their preventative spend funding to support people in deprived communities: £450,000 of this is supporting 7 community based posts in NHS Highland.

Four Community Health Co-ordinators, who started in early 2014, are working with specific geographical areas of deprivation; Wick, Alness, Merkinch and Fort William. Their role is to:

- Get to know the community through meeting with key people and mapping out existing community facilities and activities including what community development resource are available in the area from other agencies.
- Develop and/or work with an existing group that can represent the views of those with an interest in reducing health inequalities, in the community. This may include for example existing community projects, community council representatives, statutory and voluntary sector organisations and will vary from area to area.
- Work to build connections between existing community development workers with the aim of getting everyone to better understand each other's role and where they can best work together for the benefit of the community.
- Undertake work with the community to identify their priorities for action to reduce health inequalities and develop ways to communicate this through appropriate channels/organisations.
- Support the community to develop networks between projects, groups and organisations where it would be helpful to work together.
- Support communities to develop skills for taking action to reduce health inequalities through delivering appropriate training to individuals and groups. For example Health issues in the Community training, Group work skills etc.
- Support communities to develop skills to take part in decision making events/meetings etc and to campaign for change.
- Support communities to understand and access opportunities for funding to support work to reduce health inequalities.
- Measure progress using a range of suitable methodologies and frameworks and share this with appropriate organisations, groups and community members as required.

Three community food and health practitioners are working with the geographical areas identified by the Keep Well programme (Wick, Thurso, Easter Ross area, Fort William and Kinlochleven as well as the Merkinch, Raigmore, Kinmylies, Dalneigh and Hilton areas of Inverness). Their role is to develop group interventions to support healthy weight and work with communities to improve the access and availability of healthy food and opportunities for physical activity.

3.2 Community Development

National strategic guidance on Community Learning and Development was produced in 2012. The national performance framework defines the purpose of CLD as 'to empower people, individually and collectively, to make positive change in their lives and in their communities, through learning', and that CLD should focus on:

- Improving life chances for people of all ages, through learning, personal development and active citizenship.
- Developing stronger, more resilient, supportive, influential and inclusive communities.

New legislative regulations, designed to strengthen the position of CLD places a duty on Local Authority education services to develop a CLD plan by September 2015. Although the

legislative duty falls on the Local Authority, it is clear that partners are expected to work together to develop and implement this plan and that a CPP CLD partnership will be the vehicle to do this.

In 2012 the CPP established a Community Development Task Group to develop a strategic framework and action plan[9] to make best use of the public pound by improving approaches to investment in CD, strengthening co-ordination, collaboration and reducing duplication and sharing of resources where possible. The approach for this work was to identify four urban and four rural areas in which to test approaches to alignment of partnership resource. The CPP has agreed that a CLD strategic partnership should be formed to develop a CLD plan for Highland and ensure that the new legislative requirements are met. The work of the CPP CD task group will be subsumed into this partnership group.

An event to bring together all Community Development and related post holders in Highland took place on 22 May. The event provided an opportunity to begin to shape a more coherent and cohesive partnership approach to Community Development in Highland by:

- Developing an understanding of each other's role.
- Promoting and sharing good practice.
- Sharing experiences of delivering with communities.
- Developing a network of professionals with an interest in community development and health inequalities.
- Considering how to support a more joined up approach to this work including how we evidence impact.

3.3 Fuel Poverty

Fuel poverty is a determinant of health, and marker for poverty in general, for which Highland has much higher rates than the rest of Scotland[10]. These data were highlighted in the 2011 Public Health annual report; the proportion of the households in fuel poverty across Highland has not changed according to the most recent data (2012). In Highland 39% of households spend 10% or more of their income on fuel, compared to 27% in Scotland as a whole.

Pensioners form the majority of the population in fuel poverty: 61% in Highland.
Fuel poverty is exacerbated by aspects of rural living, with higher costs of fuel and increased fuel usage due to a lack of local activities and transport enabling people to get out and socialise[11]. The health impacts of cold housing and fuel poverty are well recognised[12].

Healthy Homes for Highland (HHH) is a multi-agency referral scheme for vulnerable households at risk of fuel poverty in Highland Council area[13]. The referral scheme reaches vulnerable and hard-to reach householders by working with agencies that have face to face contact with people. Frontline staff can quickly and easily refer people for advice by using the simple referral card or helping the householder to call: 0808 808 2282. Each card and call referral is co-ordinated by Home Energy Scotland.

Anyone referred to HHH can get free advice and assistance with:

- Making their home warmer and ways to reduce their fuel bills which may lead to the installation of grant funded insulation, heating and other energy efficiency measures.
- Making their home safer through a Home Fire Safety Check.
- Getting more income from tax credits and benefits and access to other entitlements.
- Debt counselling.

There were 300 successful contacts made by staff between January 2012 and 31 March 2014, out of 395 referrals to HHH.

3.4 Welfare Reform

Over the past few years significant changes have been made to the welfare system. The overall effect of these changes has been to reduce the numbers of people who are entitled to receive benefits, reduce the value of the benefits themselves, increase the conditions associated with claiming benefits/tax credits and increase the sanctions which are applied to people who have not, for whatever reason, complied with such requirements.

In June 2012, the Director of Public Health for NHS Highland presented information on the potential health effects of Welfare Reform (and, specifically, the financial uncertainties for NHS Highland contained therein) to the Scottish Parliament Finance Committee. Subsequently, the Scottish Public Health Network issued guidance on mitigating the impacts of reform[14]. Over the past year partners have been working to develop and implement plans to mitigate against the impact of welfare reform.

Practitioners have continued to monitor the impacts of welfare reform in Highland as it has been implemented. To date they have identified several key impacts:

1. Increased demand for welfare rights advice and money advice, with people seeking advice presenting with more complex cases and asking for help later (making support more urgent);
2. Highland Council Work Clubs footfall has increased dramatically with a strong focus on supporting individuals with benefit claims/appeals, their compliance and commitment regarding benefit claims as well as assisting individuals to access, training, education or work.
3. Benefit sanctions do not appear to be applied consistently across the Highlands, this causes considerable hardship and people need more help to be safe from sanctions and supported better to comply with their conditions of benefit.
4. Particular groups are suffering hardship and there are concerns about a lack of transitional assistance for them. Groups in need of more support include:
    a. People with mental ill health regarded as fit for work. They are struggling to cope with the welfare system demands, not coping with the job search and applications process and are being sanctioned with benefits stopped. They can present in a state of distress and anger and their behaviour can be challenging for some staff to deal with.
    b. People with poorer literacy and numeracy skills.

c. People without access to the internet or skills in using it to claim benefits or search for employment.
d. Long term unemployed people, as they are less ready to enter the workforce and require more intense one to one support.
e. People applying for the Personal Independence Payment (PIP). Although roll out is limited at this time, there have there been lengthy delays in processing applications (6 months is the norm). As the UK Government expects the budget for this group to reduce by 20%, it is likely that this group will need support to appeal decisions.
f. Although we are unable to quantify numbers at this time, carers are affected by PIP processing delays because the Carer's Allowance cannot be claimed until PIP is awarded. This means carers either care in poverty or stop caring.
g. People living in rented accommodation, particularly Council and Housing Association tenants lacking in confidence about their arrangements for paying rent (this is reported separately to this meeting).
h. Some people with sensory impairment have struggled to receive the information they need in appropriate formats.
i. Younger people appear to have to rely more on their parents for financial help.

5. More information is needed to understand the impact for some groups in the community; this includes carers and homeless people living in temporary accommodation.

NHS Highland and NHS Tayside are working with the Scottish Government to develop a series of NHS-led Welfare Reform Mitigation Projects. While NHS Tayside is developing urban-based pilot projects, NHS Highland will concentrate on Welfare Reform mitigation in rural areas. The target group for the pilot projects are people with mental health problems and people who misuse substances as it is felt that these two groups may have particular difficulties in complying with conditional criteria set out in the new benefits and may, therefore, be disproportionately likely to be subject to sanctions. The associated funding is only available in the 2014-15 financial year and projects require, therefore, to be cost-neutral or cost-saving in the longer term. This work is directed by a partnership board which involves many of the community planning partners and progress is reported to the health inequalities theme group though the multi agency Welfare Reform Working Group.

In recognition of the likely impact of welfare reform, Highland Council has allocated an additional £250,000 to the 8 Citizen Advice Bureau and the Council's in-house income maximisation and money advice teams to help support people who may be affected by the changes. This will be a significant part of the overall package of mitigation. Bureaux and the Council's in-house teams report continuing high demand for welfare benefits advice, particularly in relation to Employment Support Allowance, Personal Independence Payments and issues associated with the changes implemented through welfare reform. Demand continues for representation and reconsideration work associated with appeals. In 2013/14 the total financial gain to customers from CAB and in-house services amounted to £13.2m[15].

The Council's Member led Welfare Reform Working Group has identified 6 key priorities going forward, based on feedback from practitioners. These are:

Priority 1: Welfare reform actions need to continue to involve every service in the Council and be co-ordinated in a way that helps people most.

Priority 2: Vulnerable clients need enhanced support and hand holding to navigate the system, including appealing welfare decisions.

Priority 3: Employability support needs to accommodate a diverse range of needs and include people furthest from the labour market and with challenging behaviour.

Priority 4: Digital inclusion/participation/literacy needs to be led as a corporate policy, co-ordinated across the Council, linked to the customer services strategy and agreed and delivered in collaboration with community planning partners, notably HIE given its lead in rolling out Next Generation Broadband.

Priority 5: Financial capability /budgeting skills should be supported.

Priority 6: Continue to lobby with UK Government.

3.5 Housing and Homelessness

People are more vulnerable to homelessness if they are affected by drug / alcohol addictions or suffer have poor mental health. These conditions can often affect people's ability to maintain settled accommodation. Delivering well focussed services that help people to address long term addictions or improve mental health will have a positive impact on preventing homelessness.

Community Planning Partners should ensure coordinated, targeted intervention with people who are at risk of homelessness due to underlying addiction or mental health issues in order to help them maintain settled accommodation.

Where people do become homeless it is important that they have proper access to health services and that they obtain the support they need to enable them to move back into mainstream housing. In order to do this community planning partners need to be able to target appropriate services to support people in order to help them move back into mainstream housing and prevent repeat homelessness.

Currently there are two separate strategic planning / partnership groups in relation to homelessness: the Council's "Homelessness Partnership Group" and the NHS "Health and Homelessness Partnership Group". Work has taken place to develop a single remit for a highland Homelessness Partnership Group and a launch event, bringing both groups together, is planned for early December 2014.

3.6 Employability

A separate Report on the development of Employability Services in Highland is included in the Agenda for this meeting. However, in the context of this Report it should be noted that

Employability (assisting people with barriers to access employment) is a standing item on the Health and Inequalities agenda. In particular there are areas of strong collaboration in the actions on Preventative Spend; Community Development and Welfare Reform. The Employability Services are about to enter into a new European Programme which will provide opportunities for further collaborative work in tackling poverty and associated inequalities.

3.7 A Minimum Income Standard for Remote and Rural Scotland and Local Incomes and Poverty in Scotland

In 2013, the two pieces of published research which had a focus on rural poverty were; *A Minimum Income Standard for Remote Rural Scotland* and *Local Incomes and Poverty in Scotland.* The former considered the increased costs of living in rural areas and the latter the difficulties in measuring poverty and deprivation in these areas.

In 2012 HIE, in partnership with a range of public agencies, commissioned the Centre for Research in Social Policy (CRSP) at Loughborough University to establish a Minimum Income Standard (MIS) for remote and rural Scotland. MIS is an ongoing programme of research to define what level of income is needed to allow a minimum acceptable standard of living in the UK today. The research provides an evidence base that can be used by public sector partners to develop policy and target resources at the types of investment that will mitigate the increased cost burden of living in such areas, raise income levels and contribute to improved prosperity and quality of life across the region.

It has long been recognised (at least by the region's residents) that the cost of living in the Highlands and Islands is higher than the cost of living in other parts of the country. However, such comparisons have historically relied on anecdotes or isolated examples, and no comprehensive research has previously been undertaken to look systematically at the issue.

Extending the MIS research to the region provided the opportunity to identify (and quantify) the components of household expenditure that account for any differences in the cost of living in remote and rural Scotland compared to the baseline MIS UK research (which was originally undertaken in 2008 and is updated annually). The MIS programme of research has international credibility and is the basis for calculating the Living Wage, the concept of which has been adopted by both Scottish and UK Governments.

Using the tried and tested Minimum Income Standards (MIS) methodology the research undertook to:

- Identify the additional or different costs faced by households living in the remote and rural areas of Scotland in order to achieve the same living standards as households living in other areas of Scotland and the UK.
- Distinguish how these costs vary for different household types and in terms of location.
- Provide findings which inform the social policy debate and are accessible to the general public.

In most respects, the range of goods and services that people in remote rural Scotland consider necessary for a minimum standard of living are similar or equivalent to those living elsewhere in the UK. However, the costs of achieving this minimum standard are different. No single factor raises the overall costs of living but the combination of many of these factors leads to a higher minimum income requirement than other parts of the UK.

The research found that the minimum cost of living in remote rural Scotland ranges between 10-40% more than the equivalent in urban UK and by up to 25% more than a rural town in England. This varies across the different household groups.

MIS is relevant to the discussion on poverty, but does not claim to be a poverty threshold. However, it is pertinent to the poverty debate in that almost all households officially defined as being in income poverty (having below 60% of median income) are below MIS. Ongoing work with partners is planned to identify the types of interventions the public sector can make (or facilitate) to narrow the gap identified by the research.

In 2012, the Improvement Service, acting on behalf of four Scottish Local Authorities[i] and the Scottish Government carried out a research project to improve measures of local incomes and poverty in Scotland. Although the Scottish Index of Multiple Deprivation (SIMD) has provided valuable information, the way in which SIMD is measured – by area and at times very large rural areas – means there has been a lack of local level data on income and poverty.

The study used existing national survey information to estimate income patterns in the four study local authority areas. Three national datasets[16]were used as well as other sources. There were three steps to estimating income and poverty:

- Statistical modelling to predict individual household incomes in sample surveys
- Use these relationships to predict values for small area populations, given their characteristics
- Control for consistency at the level of groups of similar areas

The income measures used included the proportion of households at risk of poverty through earning less than 60% of the national median income before and after housing costs and the proportion of households with significant material deprivations.

The study found that there were differences between the SIMD measure of low income and the survey-based measures, particularly in rural areas. Groups who receive income related benefits were found to be concentrated in the most deprived SIMD areas. However individuals on low incomes but *not* receiving income related benefits are found across all SIMD datazones. Particularly in rural areas, people were more likely to be on low incomes but not receiving low income benefits. This would confirm the thinking locally that individuals in rural areas are less likely to claim benefits despite entitlement. The study also showed that different measures of income and poverty produce different levels of 'poor' households in an area.

Given that the SIMD income domain is based largely on benefit uptake, these survey-based measures are more useful in highlighting poverty in rural areas

Both of these studies are important as they assist our understanding of the needs of our population and for developing policies and plans, e.g. the fuel poverty strategy, concessionary pricing and charging policies. Local level data on income and poverty is important also for Community Planning partners and for the targeted action to reduce health inequalities as set out in the Single Outcome Agreement.

Following the publication of these studies, Highland Council has developed a rural impact assessment tool for Highland. A rural impact assessment tool operates in a similar way to an Equalities Impact Assessment in providing key questions to policy makers on areas to think about when developing a new policy or service. These questions prompt the officer to consider the potential impacts of the new policy or service on rural areas.

3.8 Older People

Discussions have taken place with the lead for the Older People's theme group to ensure that health inequalities is recognised and reflected in the work of that group. Current joint working on inequalities and older people is particularly focused on the work being undertaken by the RCOP Community Networker posts, the Community Health Co-ordinators and community development activity that is specifically aimed at older people. The health inequalities group will continue to maintain close contact with the older people's theme group and develop appropriate action where any gaps are identified.

3.9 Training and Awareness Raising

A number of training and awareness raising events have been held or are planned for 2014-15. The Third Sector Interface are organising a series of workshops on the themes within the Highland SOA, including one on health inequalities. The Theme of Health Inequalities will also feature on the agenda of other SOA themed seminars as part of the recognition of the cross-cutting nature of health inequalities. SCVO have already hosted a public debate on health inequalities at Eden Court theatre and plan to run a series of seminars on health inequalities jointly with NHS Highland later in 2014. SCVO have also set up a health inequalities forum through the Highlands and Islands Equality Forum (HIEF) project and have had two meetings so far to bring together members of the third sector in Highland with an interest in health inequalities to increase knowledge and develop awareness of action on inequalities within the sector. The Highland Public Health Network offers regular training on improving health and health inequalities to all statutory, voluntary and third sector staff.

A Community Development event organised by NHS Highland and the Third Sector Interface in May of this year brought together staff from across organisations in Highland that are involved in community development work. The aim of the event was to allow delegates to:

- Develop an understanding of each other's role.
- Promote and share good practice.
- Share experiences of delivering with communities.

- Develop a network of professionals with an interest in community development and health inequalities.
- Consider how to support a more joined up approach to this work including how we evidence impact across Highland.

The outputs of this event will be considered and further work built into the action plan for the health inequalities theme group.

3.10 Third Sector Health Inequality Forum

Through its Highlands and Islands Equality Forum (HIEF) project, and in partnership with the HTSI, SCVO has established a Highland Third Sector Health Inequality Forum. Exactly how the forum develops will be continually guided by its membership as it develops, but the overarching objectives are to:

- Increase awareness and understanding of the social and economic causes of poor health and health inequality.
- Develop a strong and effective voice to promote the third sector's important contribution in preventing poor health and reducing health inequality.
- Strengthen the great work already happening by sharing ideas and experiences and exploring new opportunities together.
- Further develop the third sector's contribution in the design and delivery of public services related to health inequality through community planning and public sector partnership working.

In recognition and support of the development of this initiative the forum is now officially represented on the CPP health inequality sub-group.

3.11 Monitoring and Evaluation

Reducing the gap in life expectancy will take a long time and monitoring changes in it, while essential in the long term, is not particularly helpful for evaluating the short term success of individual programmes. Each major programme, such as the Early Years Collaborative, welfare reform mitigation plans and local community development work, has or is developing driver diagrams or logic models to show how evidence-based activity and interventions will contribute to short and intermediate outcomes that in turn contribute to reducing health inequalities in the longer term.

Evaluation of programmes such as Keep Well is occurring at both national and local level. Work to develop a national monitoring framework is underway. Such a framework is needed as the benefits of activity and resource use in one sector or organisation is frequently seen in another: improving road safety reduces injuries that need NHS treatment; improving parenting and educational achievement reduce behavioural problems seen in the criminal justice system.

Considering the levels of determinants in Figure 1, key short term indicators of progress in reducing health inequalities are those which measure income disparities and poverty rather than health status.

Nevertheless, the CPP must be able to demonstrate that its services are available to all those who need them and that no individual or population group has more difficulty then others in effectively accessing services, thus inadvertently widening inequalities. Information systems are not currently adequate to demonstrate access to services by specific groups on a routine basis across the partnership or within individual organisations. Variation in service provision across Highland is available for some services in some organisations, but it is not necessarily clear to what extent this variation reflects underlying population need or differences in practice.

4. Preventative Services

Although many preventative health services are provided by NHS Highland and Highland Council, the Third Sector contribute significantly to preventative services through commissioned work such as mental health support, alcohol and drug counselling and mitigation of welfare reform. Organisations such as New Start Highland and Calman Trust are examples of the important role of the third sector in providing services which are intended to prevent or reduce health problems either developing or worsening.

There are some preventive services that have had a particular focus throughout 2013 and 2014 with some new service developments. Of note are the new immunisations introduced in 2013 and programmes for screening and early detection of disease.

4.1 Immunisation

Immunisation is a universal service and is one of the most effective and cost-effective ways of preventing specific communicable diseases. Maintaining high coverage of the population (usually around 95%) ensures that not only those who have been immunised are protected but those who are unable or too young to be immunised are also protected through herd immunity.

Uptake of the routine childhood immunisation programme varies according to socio-economic status and Highland has greater variation than the rest of Scotland[17], with those in the most deprived quintiles falling below the threshold for maintaining herd immunity for all vaccines, particularly for MMR. There have been outbreaks in measles and mumps in recent years, which reflects this low uptake, which has improved following campaigns to raise awareness and offer boosters. While uptake by GP practice is monitored routinely, there is no clear pattern to low uptake, which varies from quarter to quarter. Improvement has focussed more on Highland-wide campaigns as a result. The delivery method is also under review in Caithness where it is hoped that delivery by school nurses will improve uptake of school leaving boosters.

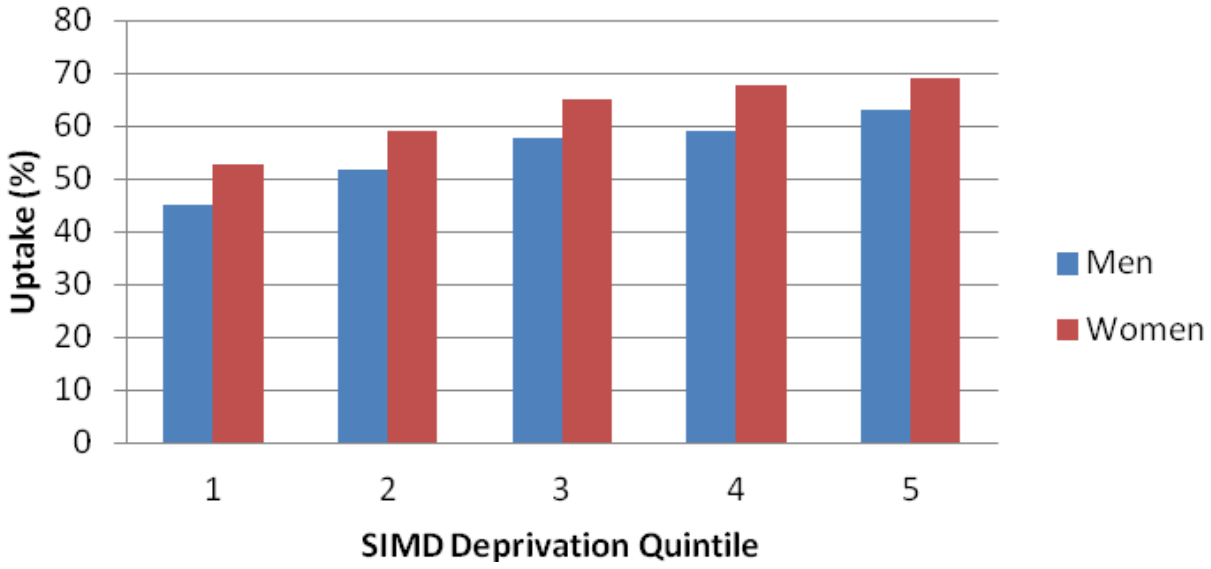
Rotavirus immunisation started in January 2013 and has demonstrated a huge reduction nationally in lab confirmed rotavirus[18]. It is expected that this reduction will be reflected in reduced admissions, but the data are not yet available.

4.2 Screening

Screening has been defined as '…*a process of identifying apparently healthy people who may be at increased risk of a disease or condition*.[19]' It aims to reduce the risk of developing a condition or to detect conditions before they give rise to symptoms, enabling treatment to be offered early with the aim of reducing morbidity and mortality. Screening programmes are only introduced nationally when there is robust evidence that they provide more benefit than harm at acceptable cost. Individuals across Scotland are invited to take part in programmes for which they are eligible[20].

Uptake of screening varies across the population, with some groups being less likely to take part than others. Figures 1 and 2 below show the uptake of bowel and breast screening within Highland and across Scotland respectively by deprivation. Scottish Indices of Multiple Deprivation (SIMD) quintile 1 is the most deprived and quintile 5 is the least deprived.

Figure 1: Uptake of bowel screening among men and women 50-70 years resident in Highland offered screening during the period November 2010 – October 2012 by SIMD quintile, Scotland



Source: NHS Scotland Information Services Division22

Figure 2: Uptake of breast screening (3 years combined) among Scottish women aged 50-70 years by SIMD quintile, Scotland, 2009/10 – 2011/12

Source: NHS Scotland Information Services Division23

As can be seen, uptake of screening may vary by gender (e.g. uptake of bowel screening among men is lower than that among women) and deprivation (uptake falls with increasing deprivation). Participation may also vary by age (e.g. uptake of cervical screening is lower among younger compared to relatively older women). Communication plans are being developed to raise public awareness of screening with the aim of encouraging people to think about taking part in programmes for which they are eligible. Consideration will be given to how best to reach those groups among whom participation in screening is relatively low.

4.3 Detect Cancer Early (DCE)

DCE is a national programme[21] aimed at improving the overall five year survival rate from cancer in Scotland, to among the best in Europe. The programme started in 2012 and has focussed on raising awareness of the benefits of early detection of breast, bowel and lung cancer with the general public. There has been a parallel focus on improving access to diagnostic services for these three cancer sites.

Relative to other mainland Boards, NHS Highland already has high uptake rates of breast[22] and bowel screening,[23] the main route for early detection of these cancers. Plans to raise awareness of both these and the abdominal aortic aneurysm & cervical screening programmes are being developed which will consider how to reach individuals within groups who are less likely to take up offers of screening. For lung cancer, work that will contribute towards increasing the proportion of patients diagnosed at the earliest stage is underway.

5. Health Improvement Services

Health Improvement services aimed at supporting people to adopt healthier lifestyles (such as reducing smoking and alcohol intake, increasing physical activity and improving dietary choices) are available across the population of Highland, but there is a particular need to focus on encouraging hard to reach and vulnerable groups to engage with these services. The community development and Keep Well programmes now established in NHS Highland's most socio-economically deprived areas and with vulnerable groups are encouraging this engagement as part of their work. Smoking cessation is the only health improvement service with a specific target around inequalities, but locally, delivering alcohol brief interventions, improving physical activity and healthy weight interventions also have a focus on inequalities.

5.1 Smoking Cessation

Smoking-related diseases continue to contribute substantially to the health inequalities gap and preventing children starting to smoke and helping existing smokers to stop remain very cost effective interventions in terms of preventing illness at a later date.

The 2012 Scottish Household Survey showed that smoking prevalence across Scotland continues to decline (23% of adults in 2012 reflecting 7.8% reduction since 1999). However, adults in the 15% most deprived areas of Scotland are considerably more likely than those in the rest of Scotland to say that they are current smokers (37% and 20% respectively). The adults who most commonly smoke are those unable to work due to short-term ill-health (60%), those unemployed and seeking work (51%) and those who are permanently sick or disabled (51%).

NHS Highland's smoking cessation service continues to support around 2000 people to quit every year (based on remaining quit at 1 month). In 2011 Scottish Government asked Boards to target their efforts at the most deprived areas and set an inequalities target that required NHS Highland to deliver 4288 quits at one month by March 2014, including 2358 (54.9%) in the 40% most deprived within Board SIMD areas. We were able to exceed this target, delivering 6217 quits, including 3046 (49%) from our 40% most deprived areas. The target for 2014-15 requires us to maintain the focus on inequalities and sustain our efforts to support people to quit by setting a target of 682 successful quits at 12 weeks rather than one month in the 40% most deprived within Board SIMD areas.

5.2 Oral Health

Despite an overall improvement in recent years in the oral health of the people of Scotland inequalities persist, with the burden of disease concentrated in more deprived and vulnerable populations. A key priority for Scottish Government is to reduce oral health inequalities whilst promoting oral health improvement for all[24].

With recent improvements in the availability of NHS dentistry in Highland waiting lists for dental registration have all but disappeared. However, just 70% of the population are

currently registered with a NHS dentist. Registration rates are lowest amongst the youngest (0-2 yrs) and oldest (75 yrs +) age groups – 47.7% and 56.5% respectively[25] (ISD 2013).

Good oral health should be established in the child's earliest years. Early dental registration (by 6 months) and regular contact with the dental team will provide essential support to ensure good oral health for all children.

In Highland in 2012 approximately 1 in 10 of the adult population was over 75 yrs old; it is estimated that by 2035 this will have doubled to almost 1 in 530. In addition older people are keeping their teeth longer, in Scotland in 2003 only 42% of adults aged over 75 yrs had some natural teeth in 2011 this had risen to 58%[26]. Therefore the result is an increasing proportion of the older population being susceptible to gum disease and tooth decay. These diseases are preventable, but when they are allowed to progress, older people may require increasingly complex dental treatment[27].

In 2005 the Dental Action Plan provided a national commitment to develop and deliver oral health preventive support programmes for children and adults in most need. In May 2012 the Scottish Government published the National oral health improvement strategy for priority groups which acknowledged that people living with a disability or who are older and frail, and those who are experiencing homelessness, should have the same opportunities as others to enjoy good oral health and that for these priority groups using dental services in traditional ways may not be easy[28]. In addition, the Public Dental Service (PDS) was formed in 2013 from the merger of the Salaried General Dental Service (SGDS) and the Community Dental Service (CDS) with a key role of ensuring that Boards continue to reduce oral health inequalities and make NHS dental services available for all those who wish to access them in their area. This requirement includes vulnerable groups of people who may be unable to access general dental services.

National Programmes

In order to reduce oral health inequalities actions must be universal but with additional resources targeted at those who experience the highest levels of disadvantage.
The following national programmes are being delivered in Highland:

Childsmile *- a national programme designed to improve the oral health of children in Scotland and reduce inequalities both in dental health and access to dental services.*
The programme was established in Highland in 2008 and implemented following a staged approach.
At 2013/14:

- 95% of nurseries were participating in the supervised tooth brushing programme.
- 59% of primary schools were participating in supervised tooth brushing including all those where children are at greatest risk of poor oral health.
- 46% of 3 and 4 yr olds were targeted to receive fluoride varnish application in nursery.
- 47% of P1 to P4 pupils were targeted to receive fluoride varnish application in school.

Caring for Smiles *– Scotland's national oral health promotion, training and support programme, which aims to improve the oral health of older people, particularly those living in care homes.*
Caring for Smiles is offered to all Highland care homes for dependant older people and other priority groups at least yearly. All care homes are linked to a Public Dental Service clinic and dedicated Oral Health Educator to facilitate access to dental care and oral health advice. Oral health training and awareness raising is also being rolled out to care at home providers and non-paid carers via their supporting organisations. Work is underway to extend training in to community and general hospitals wards.

Smile4life *– a training guide for all health and social care professionals to deliver oral health training to staff working directly with homeless people.*
From October 2013 in conjunction with three other Health Boards NHS Highland has delivered Smile4life training to homeless support agencies as part of HoPSCOTCH (**Ho**meless **P**eople in **SCOT**land: a feasibility trial of a **C**ommunity–based oral healt**H** intervention). The trial is to run for a maximum of 12 months with 41 clients receiving the intervention in each Health Board.

Mouth Matters *- a national training guide for an oral health improvement programme to be implemented in Scottish prisons*.
The national launch of the training guide will take place in August 2014 at which NHS Highland's Public Dental Service will be represented. The guide will support the PDS to further develop the dental and oral health improvement service currently in place at Inverness Prison.

Early Years Collaborative
Dental registrations for 0-2 yr olds are the lowest of any age group. The oral health improvement team are engaging with a range of stakeholders: parents, public, midwives, health visitors and dentists to increase dental registrations amongst this youngest age group.

NHS Highland Target - *At least 60% of 3 and 4 year old children in each SIMD quintile to receive at least two applications of fluoride varnish per year by March 2014.*
The dental target was set for the end of 2013/14. Final reporting will not be available until November 2014 and while progress nationally has been disappointing (Highland 14.9% - year to 31/12/2013) significant headway has been made with the most vulnerable children – 53.4% of Highland's 4 yr olds in SIMD 1 received the recommended 2 applications of fluoride varnish in the year to 31/12/2013.

5.3 Primary Care Health Inequalities Pilot Project
In 2012 Scottish Government set out to test innovative interventions in GP practices which could help patients improve their health utilising an 'asset' approach to health inequalities. GP Practices with populations from deprived areas according to SIMD were asked to identify interventions that could be delivered efficiently and effectively to vulnerable families and patients with complex health and social needs.

Fairfield Medical Practice in Inverness became involved in this project and over the past two years has been trying new ways of working to improve health and reduce health inequalities. Identification of patients to take part in the project has been undertaken by the multidisciplinary practice team. Activity has included:

- Provision of an extended 'health review' with the GP which consisted of a 30 minute appointment.
- Patients supported to attend a bespoke 'health empowerment' course that the practice negotiated with local life coaches.
- Use of wellbeing assessment tools including the Warwick Edinburgh Mental Wellbeing Scale.
- The Patient Enablement Instrument and the WHO –Five Wellbeing Index.
- Development of connections with wider community resources including local employability initiatives.
- Development of 'social prescribing' activity, including a cycle prescription with 'Velocity', a local organisation that aims to inspire more people to cycle.

The practice continues to review its activity and is keen to continue to try new and innovative ways of working to improve the health of some of their most vulnerable patients.

5.4 Healthy Working Lives

Although available to all *organisations*, services are particularly aimed at organisations that employ low paid, unskilled workers. Free and confidential Workplace Visits are carried out by our team of specialist Healthy Working Lives Advisers, providing practical, face to face advice on any issues related to occupational health, safety and wellbeing. Advisers give information and advice on all aspects of health and safety, and in promoting health in the workplace. Where appropriate, they can recommend other organisations that can help with specific areas of expertise. Advisers can also help with the development of policies and practices, such as those on drugs and alcohol, risk management, attendance management, employability, smoking cessation, and health and the environment. Free Workplace Visits for small- and medium-sized organisations are also offered in order to help those workplaces become safer and healthier. Training is offered and designed to develop employers' understanding, knowledge and skills, the suite of interactive training and awareness sessions cover a range of health topics such as Health and Safety and Mental Health.

There are currently 90 organisations signed up to the Healthy Working Lives Award programme in Highland which involves 48,873 employees.

Working Health Services

The Working Health Service is targeted at Small to Medium Enterprises that have no access to Occupational Health or Employment Assistance Programmes and aims to improve health and support individuals to remain in work or return to work. The service provides individuals in eligible organisations with an initial assessment to identify any health issues or barriers to work. It offers a case management approach with individually tailored

interventions and prompt access to locally delivered treatments such as physiotherapy, occupational therapy and counselling.

Health and Work Service

The main purpose of this new service is to establish an independent state funded Health & Work Service (HWS) to make occupational assessments and advice more readily available to employees, employers and General Practitioners (GPs) to enable them to better manage sickness absence. It will provide occupational health advice and support for employees, employers and GPs to help individuals with a health condition to stay in or return to work. There are two elements to the service which is due to start in late 2014:

- *Assessment***:** Once the employee has reached, or is expected to reach, four weeks of sickness absence they will normally be referred by their GP for an assessment by an occupational health professional, who will look at all the issues preventing the employee from returning to work.
- *Advice*: Employers, employees and GPs will be able to access advice via a phone line and website. The primary referral route for an assessment will be via the GP. Guidance will make clear that referral should be the default option, unless individuals meet the criteria for when referral maybe inappropriate. Following an assessment, employees will receive a return to work plan containing recommendations to help them to return to work more quickly and information on how to access appropriate interventions. The new service will complement, rather than replace, existing occupational health provision and will fill the gap in support where that currently exists.

5.5 Keep Well

Keep Well is a national programme aimed at reducing inequalities in health. It started in 2012, following a year of transition from the earlier Well North programme, and is now in its third year of operation. Funding is expected to reduce over the next two years and the programme is developing a sustainable future delivery structure based on this expectation. The national programme has emphasised the delivery of cardiovascular health checks to specified hard to reach and vulnerable population groups.

Highland has taken an assets-based and community development approach to delivering health checks in the main areas of socio-economic deprivation in Highland in order to engage with these and other disadvantaged groups16. The annual report for 2013-1417 is due for submission to Scottish Government in August. Key results for the year are:

- 1817 out of a target number of 2140 health checks were delivered in 2013-14, signifying that approximately 41% of our total eligible target population for the year received a health check.
- 33.6% of those who attended a health check were referred to follow-on services; in the main to encourage and/or support lifestyle changes. The majority of referrals were made to a GP (12.2%) and dental services (6.4%). In terms of the latter, this provides a good indicator that we are reaching and engaging the right people in view of recent evidence implying that those who report poor oral hygiene have an increased risk of developing cardiovascular disease. It is understood that 56.3% of

these referrals were attended on at least one occasion, but it has proved difficult to track patient journeys across all referral systems.

- 12.7% of those who had a health check, and whose risk was assessed, were identified as having a high risk of cardiovascular disease, with 15.5% of all carers being at high risk increasing to 20.6% of carers aged 50-64 years.
- Local evaluation of the NHS Highland Keep Well programme is in progress and expected to report towards the end of 2014. Some national evaluation has been reported but more detailed work is expected at a later date.

6. Equalities and Diversity

The Equality Act 2010 includes a public sector duty that requires all public bodies to give due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct that is prohibited by the Equality Act 2010.
- Advance equality of opportunity between people who share a relevant protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The protected characteristics in the Equality Act are: age, disability, gender, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief and sexual orientation.

The guidance is explicit that consideration of the three needs of the general equality duty must form an integral part of the organisations decision-making process. This process must be carried out with rigour and with an open mind in such a way that influences, and can be seen to influence, final decisions.

The Guidance that accompanies the Act is fairly prescriptive in describing some of the ways that public sector bodies require to demonstrate that they are fulfilling their public sector duties. For example, to demonstrate that we assess and review policies, we are required to undertake and make public, equality impact assessments. To demonstrate that we are mainstreaming equality, we are required to ensure that our staff are well trained on aspects of the Equalities Act and the implications for their day to day work.

The Act helps support public sector organisations to recognise that different individuals, groups and communities can face particular barriers and difficulties that can result in inequalities in access to and experience of services, and in inequalities of outcome. Areas that people and research tell us contribute to the inequalities in health experienced by many people with protected characteristics are:

- Access to Health Improvement Resources.
- Access to Health Services.
- Experience of Health Services.
- Participation & Involvement.
- A safe, inclusive and fairer community.
- A skilled and motivated workforce that reflects the communities it serves.

Equality Impact Assessments help to embed considerations of equality throughout organisational functions but need to be more systematically used. Ethnicity recording is important in enabling services and organisations to analyse routine activity by ethnicity and access to services.

7. Early Years Collaborative (EYC)

There is now a solid evidence base for the impact on the well being of children and young people from adverse early years experiences and strong evidence as to how early disadvantage can be offset by supporting the role of parents to achieve the best outcomes for their children: from infant and parental mental health to healthy weight, injury avoidance and income maximisation35.

The Collaborative have set the following stretch aims:

- Reduce by 15% the rate of stillbirth and infant mortality by 2015 (work stream 1).
- 85% of children to reach all of the expected developmental milestones by the time of the child's 27-30 month health review by December 2016 (work stream 2).
- 90% of children to reach all of the expected developmental milestones by the time the child starts primary school, by December 2017. (work stream 3).
- 90% of children to reach all of the expected developmental milestones by the time the child starts primary 4, by December 2021.(work stream 4).

The EYC is focusing on two key overarching themes: getting the right help at the right time; and building & promoting positive relationships. These themes cover the work across the age range from 0-8 and the key change areas identified by the National EYC. Highland has two "pioneer sites": 'from milk to first foods: healthy weaning in Highland' and 'Nursery Development Overviews'.

Alongside work to develop the skills of front line practitioners to use improvement methodology as part of their everyday work, emphasis has been placed on developing a strategic approach to improvement through the existing For Highland's Children 4 Improvement Groups. This approach aims to mainstream improvement activity and ensure that work is targeted at tackling inequalities in health.

7.1 For Highland's Children 4

There are a range of performance measures in For Highland's Children 4 (The Highland Council's integrated children's services plan) that are intended to bring more scrutiny on potential areas of health inequalities in the early years. These include for the first time measures seeking to reduce any gap between the most and least affluent areas of Highland for some immunisations and core surveillance contacts. This approach will be tested out over the next few months and if differences are identified this will prompt improvement activity to seek to address these.[29]

7.2 Infant Feeding

Ensuring that babies are breastfed is one of the key interventions that give children the best start in life. The WHO recommends that all babies should be exclusively breastfed for at least the first 6 months of life and the Early Years Collaborative is also focussing on the promotion of breastfeeding.

In addition, the NHS in Scotland had a HEAT target which was that 33.3% of babies were exclusively breastfed for the first 6-8 weeks. In NHS Highland, has set a more challenging target of 36%, which is a local standard allowing for monitoring and improvement. Despite this focus, breastfeeding rates in Scotland and Highland remain below these target levels38 with a strong socioeconomic gradient in the proportion of babies who are breast fed with babies from more affluent areas are more likely to be breast-fed than those from poorer areas.

An extensive programme of work to encourage breastfeeding, including peer support workers to support new mothers from our most socio-economically deprived areas to breast feed and obtaining UNICEF accreditation for hospital and community services. More recently, Highland CPP partners have committed to making all their facilities supportive of breast feeding by participating in the NHS Highland welcome sticker scheme.

7.3 Healthy Start

Healthy Start is a UK-wide government scheme to improve the health of low-income pregnant women and families on benefits and tax credits. The scheme provides eligible women and families, with vouchers that can be exchanged for milk, infant formula milk, fresh and frozen fruit and vegetables with registered retailers. The scheme also provides coupons to exchange for maternal vitamin tablets and children's vitamin drops[30].

The uptake of the scheme is reported at postcode sector level. This identifies local areas where improvement in uptake of the scheme needs to be made. The overall position as at March 2014 was an average uptake of 70% across the Highland against a target of 85%. A total of over 700 individuals who are eligible for the scheme have not claimed and work is on going to improve the position through partnership work.

8. Physical Activity

Self-reported data in the Scottish Health Survey (2010) found that only 39% of adults and 72% of children achieved the minimum recommended levels of physical activity (30 minutes per day on five days of the week for adults, and 60 minutes per day for children). Wider research has shown physical inactivity to be the largest 'attributable fraction' of all-cause mortality; and that it causes more deaths than obesity, diabetes and smoking combined, making physical inactivity the fourth leading cause of preventable death.

Establishing patterns of physical activity from the very early stages of development and maintaining these throughout our lives into older age contributes significantly to increasing the proportion of life spent in good health.

There is a social gradient in participation in physical activity, which requires additional focus for areas of deprivation. Lower levels of activity among women, especially teenage girls are of particular concern.

The natural environment in Highland provides an opportunity to capitalise on use of the outdoors for physical activity but recognising that a range of opportunities are needed that can be built into every life. Agencies such as Forestry Commission Scotland, Scottish Natural Heritage, Cairngorms National Park Authority, Community Woodlands Association, and The Conservation Volunteers provide coordination and momentum to maximise the potential of our outdoor spaces.

We also needs to ensure that sustainable and active travel networks in Highland, including Core Paths and Safer Routes networks continue to be improved and expanded. Transport and land use planning that supports use of public transport and active travel wherever possible should be prioritised. This benefits both the resident population and the visiting tourist population.

A strong sense of place allows us to utilise physical activity opportunities to build social and community capacity. Local opportunities in volunteering, grassroots clubs and local groups that join together for enjoyment and/or common purpose are the backbone of community relations. Community participation and diversionary activities reduce crime, and fear of crime; and also provide positive role models for children and young people.

8.1 Promoting the Outdoors for Physical Activity

Within Highland there are many initiatives looking at building up the relationships between physical activity, enjoying the outdoors and health and wellbeing including:

- New Craigs Hospital in Inverness - focus of a partnership project aiming to develop the hospital grounds to provide an attractive and functional setting for patients to enjoy being outdoors in a variety of ways as a contributor to mental health. Detailed plans have been drawn up and the project is currently seeking funding.
- Health walks - a proven and popular way of getting normally inactive people or those with generic health problems to venture out and about and enjoy both the physical

and social aspects of exercise. Step it Up Highland, managed by Partnerships for Wellbeing, operates in 26 communities throughout Highland. Trained volunteers lead walks of varying duration from 20 minutes or so to a couple of hours. A similar scheme is run by the Cairngorms Outdoor Access Trust in Badenoch and Strathspey and across the remainder of the Cairngorms National Park.

- Dunain Community Woodlands Trust in Inverness and the Scottish Waterways Trust entitled 'Woods, Waterway and Wellbeing' – currently under development, this project is investigating the potential for developing links between Dunain Woods and the Caledonian Canal and exploring the use of the therapeutic qualities of woodland and paths to generate and improve feelings of wellbeing. This will also improve general access opportunities in North Inverness and provide longer walks from New Craigs Hospital.
- Abriachan Trust has been working with NHS Highland and others to pilots the national 'Branching Out' initiative. This project trains people to lead forest based activities for people with mental health diagnosis (often severe and enduring). Initial feedback from the pilot has been very positive, and there are plans to provide training and expand the programme to other areas of Highland.

8.2 Highlife Highland

High Life Highland (HLH) is the biggest single provider of culture and leisure services in Highland and as such plays a vital role in improving the health and wellbeing of local communities through promoting healthy lifestyles and engaging communities, families and individuals in managing their health and wellbeing and reducing health inequalities.

Some examples of the work HLH is doing to support reducing health inequalities is detailed below:

- **High Life membership** - Membership offers individuals and families access to a range of health and fitness opportunities in leisure centres throughout the Highlands. In addition to swimming pools and fitness suites, membership enables access to squash courts, swimming lessons and a huge range of group exercise classes for people of all abilities and interests. Budget membership enables access to all facilities: customers pay just 50p per activity if the household is on: Income Support, Pension Guarantee Credit, Job Seekers Allowance or Employment Support Allowance, or individuals on War Disability Pension, Disability Living Allowance, Personal Independence Payment (from 10 June 2013) or Attendance Allowance

- **Cardiac Rehab programmes** - In partnership with NHS Highland, HLH is providing the opportunity for patients in Lochaber and Easter Ross to receive their Cardiac Rehab treatment from AHP's in a non-clinical setting, in the leisure centre, to support them towards their own self-care. Patients are issued High Life cards for the duration of the treatment programme, with the option to retain the cards for up to a 3 month period beyond the end of the programme. Feedback to date has been very positive with many people continuing to use leisure facilities beyond their initial rehabilitation phase. A one year pilot project that commenced in August 2014 involves issuing High Life membership to patients undertaking Cardiac Rehab Phase III programmes

with Allied Health Professionals in all areas of Highland (except Lochaber where there is already a service in place).

- **Otago Exercise Programme** - An evidence based exercise programme aimed at supporting the reduction of falls in older adults. Classes are currently being delivered in 9 leisure centres as well as Care Homes and Day Care Centres in the Caithness, Tain, Inverness and Golspie areas. HLH is currently exploring how to meet the increasing demand from Care Homes to provide a broader outreach service. Feedback from the Otago classes has been very positive.

- **Knowing Me Knowing You** - A partnership between HLH and NHS Highland offering introductory sessions designed to attract and support non participants who do not currently utilise the services and facilities available through HLH to do so. HLH staff show participants round the leisure centre and provide information about the wide range of activities on offer. A free 7 day pass is offered to all participants in the programme.

- **Prostate Cancer and Physical Activity** - HLH in partnership with NHS Highland are planning to implement a programme to engage men who have had a Prostate Cancer diagnosis, in physical activity. The proposal is to identify men with a prostate cancer diagnosis and then invite them to undertake an initial 1 to 1 familiarisation session at a HLH leisure facility. This will be followed by a further two supported sessions and free access to High Life Highland leisure facilities will be made available to the men for a twelve month period. The programme is funded by Prostate Cancer UK and will involve GP practices in Alness, Invergordon, Nairn and Fort William.

8.3 Getting Active – Scottish Government Led Physical Activity Research Project

This project aims to look at how we can radically increase the number of people in Scotland who are physically active. 11 years after the National Physical Activity Strategy (Let's Make Scotland More Active) was launched there has been no real increase in levels of physical activity. Scottish Government and NHS Health Scotland have been working with NHS Highland and HLH to look at what makes people become more physically active.
Staff from the Centre for Institute of Design (Glasgow University Business School and the Institute of Directors) were commissioned to design and facilitate a process of data gathering, analysis and interpretation that would shed light on this question through community discussions. Data gathering has taken place in three localities, Kingussie, Dingwall and Kinlochleven.

Focus groups and some 1 to 1 discussions were undertaken with each community, and included service providers, local clubs and wider community members/interested individuals. This initial work gave the project team an insight into why people are or aren't active in these areas of Highland but also allowed groups and individuals within the communities to make connections with activities already going on in their area. For example:

- Active Schools linking with a local bowling club.
- Community Mental health team linking with Ross County Football Club.
- One participant introducing another to new local leisure facilities.

The 6 key themes were identified from the initial focus groups and interviews:

1. Increase access to excellent value facilities and services.
2. Create connected communities.
3. Motivate those who don't see physical activity as an 'issue'.
4. Reduce barriers to physical activity opportunities in communities, particularly for those contemplating being more active.
5. Develop local opportunities that appeal to whole families and/or provide childcare to allow parents/carers to participate.
6. Create spaces locally which give children a chance to have fun in an outdoor environment.

When asked to prioritise these themes, communities thought that themes 4 and 5 were most important. Communities were then asked to come up with a list of potential actions that could be taken forward in relation to themes 4 and 5. The project continues to be progressed with plans to use improvement methodology to identify small tests of change that can be implemented using the findings from the initial work with the three communities mentioned above.

8.4 Physical Activity and the Third Sector

The third sector plays a significant role in promoting physical activity in Highland through provision of a huge number of clubs and activities that are often run by enthusiastic and well trained volunteers. Activities such as exercise classes, dancing, martial arts, sports clubs and a wide range of other activities takes place every week in sports centres, outdoor pitches and village halls across Highland.

8.5 Physical Activity and Sport Strategy for Highland

The current physical activity and sports strategy was developed in 2009 and is due to expire in 2014. A sub group of the Health Inequalities theme group recently met to review the strategy. There was overwhelming support from across the partnership to develop a new Physical Activity and Sport's Strategy for Highland.

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