Health & Social Services Committee HSS-13-01(p.5)

Date: **18 October 2001**
Venue: **Committee Room 1, National Assembly for Wales**
Title: **Local Government Partnership Council:**
Task and Finish Group on Health and Well Being

Purpose

1. To report the completion of the work of the Local Government Partnership Council's Task and Finish Group on Health and Well Being and to provide the Committee with the final report, which is attached as Annexe A.

Summary

2. Overall, while much progress has been achieved in the advancement of work to promote public health and well being in Wales, there is still much to do. The evidence suggests that:

- Partnerships are developing at the local level, but that they need time to mature, to become more inclusive and to become a mainstream way of working.
- Some sectors and professional groups require more support and encouragement before they can play a full part.
- There is a general dearth of involvement by the private sector, particularly commerce and industry, in partnership working to improve public health.
- There are some particular issues to be addressed concerning the participation and understanding of health professionals.
- The needs of some groups in society are not addressed as fully as they might be and some issues, particularly those concerning health at work, require greater attention and emphasis.
- There is further scope for the development and 'joining up' of policies and strategies, for more emphasis on research and evaluation, for developing capacity and infrastructure and for action more generally to promote health and well being.

Background

3. The Task and Finish Group on Health and Well Being was established in March 2000 and completed its work just over a year later. The membership, the terms of reference, the work programme, the findings and recommendations are all set out in the report attached.

4. The Local Government Partnership Council received the report on 9th July and noted that events had to some extent overtaken it: developments were being taken forward in the context of the new NHS plan. It was requested that the report be passed on to the Task Groups now working on that plan.

Consideration

5. The implementation of the NHS plan provides an opportunity for the NHS and its partners to address the findings and recommendations contained in the report.

Compliance

6. There are no issues of regularity or compliance.

Financial implications

7. Not relevant to this paper.

Cross-cutting themes

8. The National Assembly's action plan for implementing the national health promotion strategy, *Promoting Health and Well Being*, provides a platform for co-ordinated action to promote public health and provides opportunities for the Assembly to take forward

recommendations in the report.

Action for Subject Committee

9. The Committee is asked to note the final report of the Local Government Partnership Council Task and Finish Group on Health and Well Being.

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Annexe A

Local Government Partnership Council

Task and Finish Group

on

Health and Well Being

Final Report

June 2001

INTRODUCTION

1. The Health and Well Being Task and Finish Group was established by the National Assembly's Local Government Partnership Council with the remit:

'To identify the current roles of existing and potential community alliance partners in addressing the Assembly's new public health and well being agenda, and to pin point ways in which their contributions can be better facilitated and enhanced.'

2. The Group was chaired by the Minister for Health and Social Services. Its membership (see Appendix 1), was drawn from a wide range of organisations including local government, the NHS, Community Health Councils, the trade unions, the voluntary sector and the National Assembly.

3. The Group's tasks included:

- An examination of the current role of local government, the NHS and other community alliance partners or potential partner organisations in addressing the new public health and well being agenda;
- Consideration as to whether the policies/ strategies being followed and actions being taken by each organisation with regard to health and well-being were adequately focused;
- Identification of ways in which the contribution made by each organisation to the achievement of the public health and well being agenda through alliances at community level could be enhanced; and
- The provision of advice on the need for further work.

4. During the course of the work of the Task and Finish Group, *Improving Health in Wales – A Plan for the NHS with its partners* was published. The work of the Group was shared with the Plan's Editorial Team and has influenced the direction and range of action that the Plan proposes.

Programme of work

5. The work programme comprised four key elements:

5.1 A public opinion survey that set out to:

- Identify the major health and well being issues that the public feel should be tackled;
- Obtain public perceptions of the relative contribution of various organisations and of the public themselves to improving health and well being; and,
- Find out which age groups the public felt were priorities for action to promote health and well being.

Details of the research and the evidence found are provided in Appendix 2.

5.2 A survey of organisations that set out to:

- Establish current activities, roles and relationships played by organisations working in community alliances to improve the health and well being of the Welsh population.

A sample of some 1300 organisations was selected from health, local government, education, and the voluntary and community groups sector. The study methods and the findings are described in Appendix 3**.**

5.3 Qualitative research with professionals in the primary care sector that set out to address three key themes:

- The current role of primary care professionals in addressing the Assembly's public health agenda;
- The contribution of primary care professionals to local alliance working; and
- Facilitating and enhancing the contribution of primary care professionals.

The research involved a combination of focus groups and telephone depth interviews with a range of people working in primary care including GPs, health visitors, practice nurses, community midwives, dentists and pharmacists. Further details of the work and its outcomes are given in Appendix 4.

5.4 Participatory regional workshops were held to:

- Gather evidence from health alliance members across Wales;
- Provide an opportunity for participants to share their experience of progress to date; and
- Share their views on how this may be strengthened in the future.

Representatives from all sectors were invited to attend and the participants were drawn mainly from local government, the NHS, trade unions and the voluntary sector. Members of the Task and Finish Group were also present at all three events. Details of the events and the evidence found are provided in Appendix 5.

Reports and Studies

6. To help it scope its work and to gain an understanding of the policy and planning framework, the Group undertook an overview of the main policies and initiatives supporting health and well being in Wales, including *Communities First* and Health Impact Assessment. The Group also considered evidence that summarised the main factors causing health inequalities in Wales, as shown in Appendix 6.

FINDINGS

7. Overall, while much progress has been achieved in the advancement of work to promote public health and well being in Wales, there is still much to do. The evidence obtained suggests that partnerships are developing at the local level, but that they need time to mature, to become more inclusive and to become a mainstream way of working. Some sectors and professional groups require more support and encouragement before they can play a full part. There is a general dearth of involvement by the private sector, particularly commerce and industry, in partnership working to improve public health. There are some particular issues to be addressed concerning the participation and understanding of health professionals. The needs of some groups in society are not addressed as fully as they might be and some issues, particularly those concerning health at work, require greater attention and emphasis. There is further scope for the development and ‘joining up’ of policies and strategies, for more emphasis on research and evaluation, for developing capacity and infrastructure and for action more generally to promote health and well being.

Health and well being issues

8. There are differences of understanding between the general public, organisations and professionals on matters of public health and well being, as well as differences between organisations and professionals in their priorities and emphases. In particular the evidence showed:

- A lack of emphasis on the health and well being of ethnic minorities and travellers by all types of organisations;
- A lack of engagement by commercial and industrial organisations in addressing the health and well being needs of disadvantaged groups;
- A greater emphasis in Unitary Authorities than elsewhere on addressing environmental and economic determinants of health;
- Greater attention in the NHS than elsewhere to addressing the key causes of morbidity and mortality;
- A lack of involvement of Town and Community Councils in addressing health and well being issues;
- Widespread opportunities for more investment in workplace health promotion;

- More engagement by secondary than by primary schools and Further and Higher Education in lifestyle issues;
- The need for more commitment to addressing inequalities in health by NHS Trusts, the education sector and commerce and industry;
- A lack of public understanding of their own and other contributions to improving health and well being.

Partnership working

10. There is scope for strengthening and further developing partnerships based on mutual understanding and flexibility and for a greater emphasis on partnership working for health and well being:

- By the education sector, commerce and industry and Town and Community Councils;
- With the private sector;
- By NHS Trusts and Local Health Groups (LHGs), to bring them in line with efforts made by Health Authorities;
- By understanding of the practice of partnerships, and the skills needed to make them work, especially in working with the voluntary sector;
- By the use of networks to share experiences and learning from examples of best practice.

Strategies and policies

11. There is scope for many organisations to develop policies and strategies to enhance their contribution to promoting health and well being, in particular for:

- Town and Community Councils to develop strategies for improving the health and well being of people within their areas;
- Extending health and well being strategy development throughout CHCs, CVCs and primary schools;
- The further development of workplace health policies including the promotion of exercise ;
- Encouraging the uptake of stress management policies particularly outside Unitary Authorities and NHS Trusts and of healthy eating policies particularly outside schools;
- Schools to consider their position on VDU policies.

Links to national and local policy

12. There is scope for:

- Greater efforts to ensure that organisations and professionals are more aware of the national and local policies that should guide their work;
- Improved links to national and local policy in the health and well being work of the educational, voluntary, commercial and industrial sectors and Town and Community Councils;
- Extending the use of Health Impact Assessments;
- Reinforcing the work of health professionals and others through economic and cultural change and vice versa.

Research and evaluation

13. There is scope for research and evaluation to become a more integral feature and to underpin work to improve health and well being by:

- Greater use of the evidence base in health and well being action in the educational and commercial and industrial sectors;
- Greater use of evaluation and/or audit of health and well being action across all sectors;
- Further development of progress and outcome measurement in NHS Trusts drawing on the wider methodology used in Health Authorities and LHGs;
- Broadening the use of needs assessment for, and progress and outcome measurement of, health and well being action in the educational, voluntary and commercial and industrial sectors;
- Developing more appropriate targets and indicators.

Capacity and infrastructure

14. There is scope to strengthen and enhance the work of organisations and individuals on health and well being by:

- Education and training for professionals, managers and practitioners across and between organisations, particularly to improve planning and management skills for community health development;
- Guidance and support to encourage the involvement of elected members.
- Support for planning and development, through tools, guidance and other resources to help translate policy into action;
- Clarifying the roles, functions and relationships among health professionals, in particular for members of primary care teams;
- Encouraging the development of new and/or extended roles for health professionals, for example health visitors, dentists and pharmacists;
- Increasing the capacity of the voluntary sector to enable it to respond to community health needs, joint funding bids, and community participation and consultation;
- A new public health infrastructure combining medical, social, environmental, economic and cultural approaches to health and well being through partnership, multi-professional and multi-agency working.

RECOMMENDATIONS

15. All organisations have a part to play in improving health and well being in Wales. The National Assembly is uniquely placed to provide national leadership and to enable and encourage all social partners and sectors to play their full part. Unitary Authorities are well placed to provide local leadership and to address the determinants of health and health inequalities in partnership with all sectors including the NHS, the voluntary sector, commerce, industry and Town and Community Councils. All organisations can work to improve health for those who work for them, through the services they provide to the wider community and through partnership with others.

16. **The National Assembly should consider:**

- Encouraging all organisations to place a greater emphasis on the health and well being of ethnic minorities and travellers;
- Sponsoring a public education programme to promote a better understanding of health and well being issues and responsibilities;
- Identifying ways of increasing the capacity of the voluntary sector locally and nationally to participate fully in the health and well being agenda;
- The development of a new infrastructure for public health in Wales;

- Developing new and more appropriate targets and indicators for health and well being;
- Developing and providing new tools, guidance and other resources to help local partners translate policy into action;
- Requiring that the education and training it funds for health professionals and others should reflect its policies for health and well being and provide the skills needed to deliver it;
- Ways to engage commerce and industry, including the trades unions, in the promotion of health and well being;
- Improving the communication of policies and strategies to all sectors.

17. **Local Government should consider:**

- Greater partnership working with the private sector in the promotion of health and well being;
- Investment in workplace health for schools;
- Encouraging schools to become more involved in the promotion of healthy lifestyles;
- Greater involvement for Town and Community Councils in addressing health and well being issues in their communities and for their staff;
- Guidance and support for elected members to help them become more involved and engaged in health and well being;

18. **The NHS should consider:**

- Greater engagement by Trusts in partnership working for health and well being and in the new public health agenda of addressing the social and economic determinants of health and inequalities in health;
- Greater use of evaluation and audit of health and well being action;
- Further development of progress and outcome measurement;
- Clarifying the roles, relationships and functions of the members of primary care teams for the promotion of health and well being;
- Enhancing the education and training of professionals, managers and other practitioners to improve planning and management skills for community health development;
- Extending CHC participation in local health and well being issues.

19. **The voluntary sector should consider:**

- The ways in which its capacity to engage in partnerships for health and well being can best be strengthened;
- How to help other organisations to understand the principles of partnership working with it.

20. **All organisations should consider:**

- Increasing investment in health and well being action;
- Increasing their efforts to improve health at work through employment policies and practices and health promotion;
- How to strengthen partnerships and share experience;

- Their understanding of the practice of partnerships and the skills needed to make them work;
- Improving communication between organisations, professionals and the public;
- Greater use of evaluation, audits and evidence in their work to promote health and well being;
- How to make and use Health Impact Assessments.

Appendix 1

Members of the Task and Finish Group on Health and Well Being

Welsh Local Government Association Nominations

1. Cllr. Mike Hedges, WLGA Social Affairs Spokesperson, City & County of Swansea,

2. Mr. David Seal, Director of Housing & Regulatory Services, Pembrokeshire County Council.

3. Mr. Hugh Gardner, Director of Social Services, City & County of Swansea.

4. Mr. Colin Jones, Secretary, WLGA.

5. Dr. Clive Grace, Chief Executive, Torfaen County Borough Council.

National Assembly Nominations

6. Dr. Ruth Hall, Chief Medical Officer.

7. Mrs. Julie Gregory, Director of Health Service Strategy.

8. Ms. Helen Thomas, Director of Social Policy Group.

NHS Nominations

9. Mr. Simon Jones, Chairman, Bro Taf Health Authority.

10. Mr. Graham Coomber, Mr David Hands (shared), Chief Executives,
Gwent and North Wales Health Authorities.

11. Mr. Keith Thompson, Chief Executive. North West Wales NHS Trust.

12. Dr. Sharon Hopkins, Director of Public Health and Policy.
Bro Taf Health Authority.

Local Health Group Representatives

13. Dr. Doug Paton, Chair, Powys LHG.

14. Dr. Peter Thomas, Chair, Torfaen LHG.

Wales TUC Nomination

15. Mr. Derek Gregory, Regional Secretary, UNISON.

CBI

16. To be confirmed

Voluntary Sector

17. Mr. Rob Taylor, Director, Age Concern Cymru.

Town and Community Council Nomination

18. Councillor Emrys Williams, NALC.

Assembly Member

19. Dr. Brian Gibbons, AM.

Appendix 2

PUBLIC OPINION SURVEY

1. The aims of the survey were to: identify the major health and well being issues that the public feel should be tackled; obtain public perceptions of the relative contribution of various organisations and of the public themselves to improving health and well being; and, find out which age groups the public felt were priorities for action to promote health and well being.

2. A small number of questions were included in an omnibus survey, which was designed to be representative of the adult population resident in Wales aged 16 and over. The unit of sampling was the electoral ward and 68 interviewing points throughout Wales were selected with probability proportional to resident population, after stratification within unitary authority.

3. Within each sampling point, interlocking quota controls of age and social class were employed for the selection of respondents. Quotas were set to reflect the demographic profile of Welsh residents and no more than one person per household was interviewed. Interviews were conducted face-to-face in the homes of respondents.

4. Experienced fieldworkers were used with postal and telephone back-checking on part of each interviewer's work. Fieldwork was conducted over the period 1 - 5 June 2000 and a total of 1,008 interviews were completed and analysed.

Health and well-being

5. When asked *'What in your opinion are the most important issues that need to be tackled to improve the health and well being of the people of Wales?'* at least one in ten respondents to the public opinion survey mentioned reductions in waiting lists (14%), better or retained local NHS services (14%) and increased investment or general improvements in health care (13%). The next most frequently mentioned issues were improved employment opportunities (9%), more NHS staff (7%), more hospitals and beds (6%), better education (6%) and a cleaner environment in general (6%).

6. When asked about the contribution that organisations and individuals such as themselves could make to improving the health and well being of people in Wales, four out of five respondents (79%), identified important things for the NHS to do and 59% did so for local government. The proportions for the National Assembly, individual people and voluntary and community groups were 54%, 41% and 32% respectively. Further analysis showed that the above proportions varied with social class, being higher for non-manual than manual social groups.

Groups, settings and communities

7. When asked to say which age groups they considered a priority for action to improve health and well being in Wales, respondents to the public opinion survey most frequently mentioned school children, the elderly and pre-school children. Adults aged 25 – 29 were the least prioritised age group.

Appendix 3

ORGANISATIONAL SURVEY

1. Research was commissioned to help establish current activities, roles and relationships played by organisations working in community alliances to improve the health and well being of the Welsh population. A sample of some 1300 organisations was selected from the health, local government, education, and voluntary and community group sectors.

2. Self-completion questionnaires were distributed to appropriate senior individuals in each organisation (e.g. Health Authority Chief Executives, Local Health Group General Managers, *Better Health Better Wales* contacts in Unitary Authorities and head teachers in schools). Those not responding within three weeks were contacted through a combination of reminder letters and/or telephone reminders. The response rate was very respectable for a postal self-completion survey, exceeding 80% in six categories of organisation.

Health and well-being

3. The survey showed that:

- Addressing heart disease and cancer prevention was most frequently reported by the NHS, though nearly a third of Unitary Authorities and secondary schools reported regularly addressing heart disease prevention;
- In addition to the NHS, a majority of Unitary Authorities reported regularly addressing the prevention of mental illness;
- Smoking, sexual health, nutrition, physical activity and drugs and alcohol were reported as being regularly addressed across NHS organisations, secondary schools and Higher and Further Education (not nutrition). In addition, the majority of Unitary Authorities reported regularly addressing exercise and drugs and alcohol. Similarly the majority of respondents from commerce and industry and primary schools mentioned regularly addressing smoking and physical activity, respectively;
- Unitary Authorities were the most likely to report regularly working on the determinants of health such as housing regeneration, ‘green’ transport, crime and disorder, community health development and economic regeneration. Additionally, the majority of Health Authorities and Local Health Groups reported regularly addressing crime and disorder and community health development. The latter also had majority involvement from NHS Trusts, CHCs and CVCs. Three-quarters of CVCs also reported regularly addressing economic regeneration;
- Workplace health promotion was most frequently reported by NHS Trusts, Unitary Authorities and commerce and industry, and least frequently reported by Town and Community Councils and voluntary organisations;
- A majority of respondents from Local Health Groups, Unitary Authorities, CHCs and CVCs reported that reducing health inequalities was regularly addressed by their organisation. At the other end of the spectrum this was reported by less than one in ten Town and Community Councils, schools and commercial and industrial businesses;
- Regularly advocating/lobbying for policy development or policy change was most frequently reported by CHCs, the voluntary sector and LHGs;
- The majority of NHS organisations, CHCs and Unitary Authorities reported that they regularly provided education or information for health to the public and health and other professionals (not CHCs).

Groups, settings and communities

4. The survey showed that: the majority of LHGs, NHS Trusts and Unitary Authorities reported working regularly across all age groups. For Health Authorities working with the 5-44 and 60-74 age groups was reported most frequently. Among CVCs and CHCs reporting focused on the over 25's, while for voluntary organisations it was the working age population and, as expected, for schools and Further and Higher Education organisations it was children and young adults, respectively.

5. As far as particular groups of the population were concerned, the majority of Unitary Authorities reported that they regularly worked with the unemployed, homeless, single parent families, children in care, carers, low income groups and people with specific illnesses or disabilities. The majority of NHS Trusts also reported that they regularly worked with these groups, apart from the unemployed. Among Health Authorities, LHGs, CVCs and voluntary organisations, the majority reported that they regularly worked with people with specific illnesses or disabilities. Carers also appeared to be reported frequently by LHGs and CVCs and low-income groups by CVCs. For none of the organisational groups did a majority of respondents report regularly working with ethnic minorities or travellers.

Partnership working

6. Health and Unitary Authorities were the most likely to report regular partnership working with a range of other organisations. As well as regularly working with each other, the majority of both groups reported regular partnership working with LHGs, NHS Trusts, primary care providers (GP, dentist, pharmacist etc), CHCs, schools, CVCs, voluntary organisations, community groups and the National Assembly for Wales. The data also showed that CVCs reported the next most extensive network of regular partners from other organisational types, followed by LHGs, NHS Trusts and CHCs. The educational sector, voluntary organisations, commerce and industry and Town and Community Councils all provided less evidence of regular partnership working.

7. To ascertain the strength of partnership working, organisations were asked about 4 possible levels of joint activity – from consultation through to planning, commissioning and delivery. Analysis of the data showed that the majority of health authorities reported joint delivery of health and well-being work with local government, the voluntary sector, and community groups. Similarly, the majority of LHGs reported joint delivery with local government, while the main delivery partnerships for the majority of unitary authorities appeared to be with the NHS and the voluntary sector. At the other end of the scale, few Town and Community Councils, schools and commercial and industrial organisations reported being engaged even at the consultation level of partnership working.

8. When asked specifically about Local Health Alliances, all Health and Unitary Authorities reported that they made a contribution, as did the vast majority of NHS Trusts, LHGs, CHCs and CVCs. A quarter of voluntary and further and higher education organisations also reported making a contribution to Local Health Alliances, but there was little engagement by Town and Community Councils, commerce and industry and schools.

Organisational strategies and policies

9. As might be expected all Health Authorities, LHGs and NHS Trusts reported that improving people's health and well being was a key objective of their organisation. All Unitary Authorities, along with the vast majority of CHCs and voluntary organisations, and two-thirds of educational and commercial and industrial establishments also reported this. Less than one in four Town and Community Councils thought that improving people's health and well being was a key organisational objective.

10. Nearly all Health Authorities, LHGs, Unitary Authorities, voluntary organisations and secondary schools reported that they had a strategy for their work on improving people's health and well being. This was also the case for around three-fifths of CHCs, half of CVCs, primary schools, universities and colleges and two-fifths of commercial and industrial organisations. For Health Authorities and LHGs this was mainly a separate strategy focussing specifically on health and well-being issues, but for Unitary Authorities, CVCs and universities and colleges this was mainly an element of broader or non health specific strategies such as on poverty and economic and community development. By way of contrast, the vast majority of Town and Community Councils reported that they did not have and were not planning to have a health and well being strategy, as did around two-fifths of CHCs, a third of CVCs and a quarter of primary schools.

11. The majority of Health Authorities, NHS Trusts, Unitary Authorities, educational establishments and commercial and industrial organisations reported to have policies in place to promote the health and well being of their employees, whereas the majority of CHCs, CVCs and Town and Community Councils appeared to neither have such policies nor to be developing them. Among those with policies the majority reported that they covered health and safety, equal opportunities, harassment and bullying, VDU use (apart from schools), smoking and alcohol and drugs (apart from the voluntary sector and LHGs for drugs). Stress management policies were more frequently reported by NHS Trusts and Unitary Authorities and healthy eating policies by schools.

Links to national and local policy

12. The survey showed that the majority of Health Authorities, LHGs, NHS Trusts, CHCs, Unitary Authorities and CVCs, took *Better Wales, Better Health, Better Wales* and Health Improvement Programmes into account when deciding on action to improve people's health and well-being. Community Plans were also taken into account by the majority of Health Authorities, LHGs, Unitary Authorities and CVCs, as was the health promotion consultation document, *Promoting Health and Well-being*, by the majority of Health Authorities, CHCs and Unitary Authorities, and Health Impact Assessments by the majority of NHS organisations. On the other hand, only a minority of Town and Community Councils, educational establishments, voluntary organisations and commerce and industry appeared to be grounding their health and well being work in appropriate national and local policy.

Research and evaluation

13. In deciding on action to improve people's health and well being the majority of NHS and voluntary organisations reported taking research evidence into account. The majority of NHS organisations also reported taking needs assessments with local communities into account, as did CHCs, Unitary Authorities and CVCs.

14. In terms of monitoring progress and the outcomes of action to improve people's health, the majority of Health Authorities, LHGs, CHCs, and Unitary Authorities reported using a variety of methods: assessing progress towards identified targets and performance indicators, assessing changes in service use patterns, use of professional judgement, surveys of users and informed feedback and discussion. All but two of these, the use of targets and informed feedback and discussion, were also mentioned by the majority of NHS Trusts, while it appeared that the other organisational groups used a more limited range of assessment procedures. The use of specific evaluation and audit tools to measure progress and outcomes was a minority pursuit across all sectors.

Capacity and infrastructure

15. In the survey, the majority of Health Authorities, LHGs, NHS Trusts, Unitary Authorities, and further and higher education and commercial and industrial organisations reported helping their staff to develop their skills for health and well being work. They provided opportunities for gaining professional or academic qualifications and/or undertaking short (less than a week) externally ran courses or in house training. It also appeared that CHCs, the voluntary sector and schools focussed on short courses and in house training.

16. As might have been expected, there was widespread agreement across organisational groups, apart from Town and Community Councils, that more resources (e.g. time, money and staff) were very important in helping them to become more involved in work which improves people's health and well being. The majority of Health Authorities, LHGs and Unitary Authorities also thought that help in finding out what works best was very important for enhancing further action, while support for staff training and professional development was a priority for NHS Trusts and secondary schools. Other types of assistance which were highly rated included the provision of financial incentives by Unitary Authorities and CVCs, more networks to share information and ideas by NHS Trusts and more information and education materials by secondary schools.

Future action

17. When asked about their intentions over the next three years, the majority of Health Authorities, LHGs and Unitary Authorities indicated greater involvement with creating healthier environments, addressing social and economic determinants, disease prevention, promoting healthy lifestyles, reducing health inequalities, advocating/lobbying for policy (not LHGs) and providing education/information for health. The majority of NHS Trusts, CHCs, the voluntary sector, Further and Higher Education and commerce and industry reported intentions to expand their work. With all seven areas of work asked about, only a minority of Town and Community Councils and primary schools indicated intentions for enhanced activity.

Appendix 4

HEALTH PROFESSIONALS SURVEY

1. The primary care sector was covered through qualitative research involving a combination of focus groups and telephone depth interviews with a range of professionals working in primary care including GP's, health visitors, practice nurses, community midwives, dentists and pharmacists. The study addressed three key themes:

- The current role of primary care professionals in addressing the Assembly's public health agenda;
- The contribution of primary care professionals to local alliance working;
- Facilitating and enhancing the contribution of primary care professionals.

2. In total, 124 health care professionals from all parts of Wales took part in this study. All three main regions of Wales were sampled as well as remoter areas of West and South - West Wales. Respondents were given the option of being interviewed in Welsh if they wished to do so.

3. The fieldwork started on December 4 2000, following a period of development of topic guides and stimulus materials between November 21 and December 1 2000. Focus groups and depth interviews were completed by 24 January 2001.

Health and well-being

4. In the qualitative study, health professionals described the health and well being issues in Wales as they saw them. These were:

- The rise in poverty, lack of employment and decent jobs and the rise of an underclass have led to a subsequent deterioration in health;
- Many people live in poor housing in Wales and there are too many sink estates and out of town shopping and leisure facilities;
- There is a culture of poor sexual health including family planning;
- Pregnancy has become an illness and breast-feeding is still not considered normal in public in our society;
- Many young people lead high-risk lives in terms of health – smoking, drinking, sex, drugs, crime. They are under increasing pressure from society while the school system does not adequately equip them with practical and job skills to cope with their adult lives;
- Migration and the changing shape of the family have left many people with inadequate support networks. The elderly and single and young mothers are particularly vulnerable groups. There is a growing elderly population placing demands on the NHS;
- Men’s health is often neglected, partly because of their reluctance to seek help;
- A lack of materials and trained interpreters deprives Welsh speakers and ethnic minorities of access to the NHS;
- Parenting is not valued. Negative lifestyles and bad parenting get passed on from one generation to the next. Domestic violence and child abuse are on the increase;
- Many people, particularly the most deprived, live unhealthy lifestyles – smoking, drinking, poor and "convenient" diets, over eating, lack of exercise, drugs;
- On the one hand there is a lack of knowledge and confusion about what is healthy both in terms of lifestyle, particularly food, and medicine. Conversely, greater access to the media, particularly the internet, has given some sectors of the population greater knowledge and expectations;
- The public are more anxious about their own and their children’s health and less able to cope with minor ailments;
- People have greater expectations with regards to material possessions. This has led to a debt culture and feelings of relative deprivation;
- These greater expectations have extended to the NHS and the general public has become more demanding. They want instant access, instant cures for lifestyle problems and health tests;

- One positive side of a more demanding population is greater opportunity for early diagnosis and treatment;
- People are less inclined to take responsibility for the care of their own family members and for supporting their neighbours;
- It has become a more complaining and litigious society and that has extended to the NHS.

5. Health professionals saw their contribution to health promotion as being on an individual basis with Health Visitors and Community Midwives defining it as part of their core role whereas GPs tackle it on a more ad hoc basis. GPs felt that they promoted health through chronic disease management, but not beyond that. Health Visitors felt they were in a good position to be involved in health promotion because of their unique position of visiting healthy families in their own homes over many years. Community Midwives felt that the respect they have among mothers makes them well placed to be involved in health promotion through influencing lifestyles and encouraging breast-feeding.

Inequalities

6. Health professionals' perceptions of health inequalities and how to tackle them emerge from the qualitative study:

- There are great inequalities in poverty, the health and health provision of Wales. Rural areas are a particular concern;
- The cause and the solutions to inequalities are mainly socio-economic and should be tackled from outside the NHS;
- Most health care professionals deal with inequalities on an individual basis;
- Sure Start, Healthy Living Centres and increased vaccinations are initiatives that have addressed inequalities;
- There are barriers in the NHS to addressing inequalities including a reluctance and inability to favour sectors of the population;
- Most barriers come from the people of Wales themselves – a lack of sense of personal responsibility, a reluctance to change, a lack of knowledge and assertiveness and poor mental health;
- Many of the areas of deterioration in health are lifestyle issues and therefore require socio-economic solutions.

Partnership working

7. The qualitative study showed the health professionals' view of partnership working:

- Team working and alliances have improved, although they often exist better in theory than in practice, often relying on the co-operation of the individuals concerned;
- Barriers to team working are lack of time, the right structures, clarity of roles, physical access, different employers and cultures in the NHS;
- The relationships that cause the most difficulties seem to be with the Trust employed nurses and the GPs, the NHS with Social Services and the different nursing groups with each other. All the professional groups have problems with Health Service administration, particularly pharmacists and dentists;
- Possible solutions include using the same building, cross over roles, practice-based social workers and collaborative initiatives like Sure Start;
- There was not a lot of awareness of Health Alliances.

Capacity and infrastructure

8. In the qualitative study all the participants felt they had many barriers to doing more in health promotion. All the professionals focus on a limited range of people – GPs usually only see the sick, Health Visitors and Community Midwives are confined to young mothers,

District nurses tend to visit the elderly and terminally ill and so on.

9. Other issues for the professionals related to their role and possible conflicts with health promotion. For example:

- GPs do not see themselves as ideal role models and feel wider health promotion may be in conflict with their role as patient advocate;
- The Health Visitor role is not very clearly defined and there is a lot of dispute in their profession as to exactly how medical it should be;
- Both Health Visitors and the Community Midwives are increasingly involved in Child Protection;
- Community Midwives only see mothers for a short period of time. Pregnancy is often an emotional period and not an ideal time for further change;
- Dentists are in short supply in the NHS, and claim that not enough of them have been trained in prevention. They feel that the NHS system of payment does not encourage any preventative dental care;
- Practice Nurses, like other health care professionals, feel over stretched, lack time to devote to health promotion, and need their own assistants.

10. All health professionals in the study felt that the causes of ill health are primarily socio-economic and therefore macro-economic avenues provide the best solutions.

11. Health professionals also cited the impact of developments within the NHS with regard to their capacity for working on health and well being issues:

- The consistent theme throughout was lack of time, despite the fact that many of the participants reported working above their contracted hours;
- Workload and caseloads have increased, limiting the health professionals in the tasks they can do and the time they can spend with their patients/clients;
- More complex medicine, new initiatives like Sure Start, team working, alliance building, auditing, research, bureaucracy, clinical governance, chronic disease management, child protection, vaccinations and screening are all said to be adding to the workload without the necessary increase in staff;
- There is a perceived shortage of healthcare professionals in post, exacerbated by poor recruitment, a rise in retirement, and an increase in part-time workers;
- There have been many new initiatives to improve the health of Wales, most of which have been positively received. There are high hopes for the many projects associated with Sure Start in tackling the health of pre-school children because it is based in the community and has brought many organisations together. The main reservations expressed about Sure Start are insufficient resources and that the projects can be vague and short-term. The schemes are not widespread and do not reach as many women as they should and it is not always easy to access the funds;
- There are many good schemes already in the community and sometimes they are the most effective. These need to be taken into consideration before new schemes are implemented;
- Healthy Living Centres, Health Shops etc are a good way of bringing services together. It saves time, makes access easier and takes away the stigma of going for help;
- Most Community Midwives see the Baby Friendly and Invest in Breast initiatives as very positive contributions towards health.
- There are many initiatives in family planning – drop-in centres, health professionals visiting schools etc.

- LHG Board members talked of good project work, opportunities for alliance building and addressing the inequalities created by fund holding.

12. Some professionals are concerned about the politicisation of health but generally health professionals see the arrival of the National Assembly as a good thing to prioritise the region and provide greater accessibility. However, some feel it slows progress while others feel it is moving too fast without sufficient consultation.

13. Management issues also figure in the professionals' comments. They see the NHS as not well managed because of the calibre of the people and the structures in place. They feel there are too many organisations involved and there is a lack of consistency between them and between regions. The management and lack of leadership for Health Visitors came in for particular criticism.

14. The distribution of money within the NHS is not felt to be very satisfactory. Many health professionals feel that there is too much bureaucracy, pointless statistics and paper distributed. The provision of IT is felt to be inadequate, adding to inefficiency.

15. The health professionals differ in how much they feel they are able to fulfil their roles in community health development. The GPs are more focused on health protection, the Health Visitors on health promotion, the Community Midwives somewhere in-between. Encouraging personal responsibility and changing lifestyles are very difficult on a one-to-one basis.

16. There is some disagreement as to who should be on the Primary Care Team. Should it be practice focused? Should it be medically driven? Should it cover other professions outside health? The Health Visitors and Community Midwives feel that GPs have too much power on the Primary Care Team. There is also some dispute as to how much open access it is reasonable to provide - perhaps it does not encourage patient responsibility.

Appendix 5

REGIONAL WORKSHOPS

1. Three workshops were held in Conwy, Llanelli and Cardiff to gather evidence from health alliance members across Wales. The objective of the workshops was to provide an opportunity for participants to share their experience of progress to date and their views on how this may be strengthened in the future. Participants from all sectors were invited to attend.

2. A similar format and programme was used for each workshop, consisting of a plenary introduction to the purpose of the event in the context of the work of the Task and Finish Group, followed by overviews of health in Wales, the policy background and the purpose and role of local alliances. Plenary and small group discussions were facilitated by using the key features of the World Health Organisation's Investment for Health principles as an agenda for reflection, comment and questions. These were:

- A focus on health
- Full public participation
- Genuine inter-sectoral working
- Equity
- Sustainability
- A broad knowledge - base

A summary of the points raised was subsequently sent to participants for validation and confirmation.

3. 97 participants joined in the workshops, drawn mainly from local government, the NHS, trade unions and the voluntary sector. Members of the Task and Finish Group were present at all three events. The workshops were held during July 2000.

Groups, settings and communities

4. There was a feeling in the Regional Workshops that more work was needed in relating to and understanding the needs of people in communities - their issues and perspectives. This highlighted the need to work with people in their life settings using the same language as the community. The process of consultation and communication needed to be improved. Different jargon appeared to inhibit progress in developing partnerships between departments, and agencies. There was a need to keep selling the message through effective

communication.

5. People in some communities were said by workshop participants to have a generally short-term perspective, to be living on a day to day basis and more interested in where the next meal was coming from. There was a need to inform the public and gain their support and shared responsibility for health and well being.

6. Participants in the workshops reinforced the need for public input and understanding of the issues by all involved. Different communities and people wanted different things and it was important not to be naïve and simplistic about the way in which problems can be solved. Translation into action is difficult and support is needed to ensure this happens.

7. Communities First and the modernising agenda should help strengthen participation and consolidate issues such as funding, sharing expertise and joining up at a community level. There is a need to help communities to help themselves through community education and other opportunities that develop personal skills. The voluntary sector and its networks and structure was felt to be essential in supporting local action for health, but further support was recognised as important as capacity of the sector is a real issue, where demands for representation, consultation and active support in the community are exceeding local resources.

Partnership working

8. It emerged from the views of participants in the regional workshops that equity did not appear to exist between LHGs and LHAs and within - there was a need to identify how an equitable balance of resources and power can be achieved particularly with the voluntary sector. Individuals saw partnership working as an 'addition' to their work and not as an implicit part of it. Some participants felt that there was a need for statutory backing or some other form of reinforcement. There appeared to be a lack of joint vision, purpose or sense of direction.

9. According to workshop participants, LHAs do not always appear to know where they are going. If alliances form and nothing happens in the short term, there is a danger that the members will lose interest. Developing partnerships is a slow process and it can be hard to maintain momentum and motivation. Efforts need to be made to help ensure that the incentives for partnership working are clear to all involved, at all levels.

10. Local government’s priorities were felt to be social, economic and environmental regeneration, while the priority of the health service is sickness. Participants asked the question 'How do we get the local authorities engaged on a health agenda when they see their role and legislative requirements as very different?' There appeared to be some confusion between the roles of the LHA and LHG. Some participants felt that there was overlap and the possibility for duplication and that the relationship between them needed to be strengthened, for more effective working and co-operation. Whilst they both have a major focus on health and well being, they appeared to be unclear about their responsibilities for good health. It was felt that further work needed to be undertaken on this.

Links to national and local policy

11. Some delegates at the regional workshops felt that there was a health policy and a social policy, but not an overarching health and social well-being policy based on community health development.

12. There was a general feeling among workshop participants that there were too many initiatives, all of which were felt to be trying to achieve the same basic outcomes. As a result of this people are being spread very thinly, in preparing funding bids, consultations and local action. Many of the initiatives are 3-5 years maximum, which was not long enough to achieve the outcomes of community health development. Health gain may not be evident for up to 20 years. Apart from the number of initiatives, some participants felt that the "breadth of its influence with massively diverse agendas" overwhelmed the LHAs.

13. Participants recognised that it was impossible to fit health into a box, as it is an overall responsibility. The need for a map and tools to help see this in context was recognised. Not all stakeholders or everyone in all organisations can see the big picture, the roles and responsibilities and the links between policies and strategy, purpose and aims. The need for more relevant and appropriate indicators and targets was also recognised. The present ones were causing confusion by only referring to lifestyle and disease trends.

14. The policy documents were seen as a good starting point but there is a need to clarify the meaning of "the new public health" and to develop this concept further, building on community health development approaches. The documents were not seen as being "owned" and needed elected members’ participation, community and political backing to be really effective.

Research and evaluation

15. Regional workshop participants suggested that both macro and micro evaluation were needed to help demonstrate progress. The SHARP initiative will help strengthen the evidence of partnership working with local communities, but it was felt to be still an academically driven exercise. The need for more support for self-evaluation in communities was recognised, as was the need for more relevant and appropriate indicators and targets. Projects in Wales using the WHO Verona Initiative's approach to Investment for Health would also help to strengthen the evidence base in this area and inform the future development of LHAs.

Capacity and infrastructure

16. Regional Workshop participants suggested that Local Authority resources are not set aside for environmental protection or health, even though resources, capacity and commitment were felt to be important in driving this work forward. Participants highlighted that health is largely seen as a product of the treatment of disease through the NHS, attracting substantial resources. However the potential for improving health and well being is through action to prevent illness and to protect health. This can be achieved by redistributing these resources within the NHS and local government. Participants felt that for LHAs to work, the Assembly has to identify resources to support practical projects and mainstream community health action with real, practical outcomes.

17. The 'auditor's view' of investment was felt to be different to the view of investment for health. There are many unevaluated costs of not taking a redistributive approach (drugs, crime, suicide). There was a recognised need for sources of new investment and long-term investment in the whole community process through a commitment to community capacity building and for the complete picture to be recognised by auditors and others.

18. The NHS was felt to be primarily illness focused, pursuing a short term and unsustainable pattern of investment through the medical model, for some time. Although there has been a great deal of new investment, the main emphasis remains on emergency and secondary care. Participants felt that the NHS was very restrictive / prescriptive and hasn't changed with the times with the focus on buildings, services and drugs etc at the expense of health and well being.

19. The remit of Community Health Councils was changing and this was seen to be an opportunity whereby their role in community health development could be strengthened, reflecting local health needs more closely.

20. Cultural changes in health planning and delivery needed to be reinforced through education of officers, members, health and other professionals. Some workshop participants expressed the need to develop a common understanding of a shared agenda across traditional boundaries. There was a need to educate and skill professionals in health development and partnership working and to facilitate communication across professions.

Appendix 6

SUMMARY OF EVIDENCE ON INEQUALITIES

1. A summary of the evidence on inequalities in health in Wales shows that:

- The health of people in Wales is poor compared with that in the majority of European countries and in other parts of the UK. Health in many parts of West Wales and the Valleys is substantially worse than the rest of Wales. Health inequalities are increasing;

- The key factors affecting health and health inequalities are complex. They include poor housing, pollution, social and economic poverty, education and lifestyle. They also include availability and accessibility to health and social care services and biological and genetic determinants;

- Public policies to tackle the environmental determinants of health, both physical and social are the most powerful means of achieving population health gain and the narrowing of health inequalities between social groups;

- Social inclusion and tackling health inequalities are identified as strategic challenges in a number of key strategies including *Better Wales, Better Health Better Wales, Promoting Better Health and Well Being* and *Communities First*;

- Socio-economic determinants are the main explanation for inequalities in health status, and the continuing differences across Wales suggest that the divide will increase unless decisive public policy action is taken;

- While mortality rates have fallen and life expectancy has risen, inequalities have increased. Almost all health indicators confirm the relationship between the prevalence of ill health and poor social and economic circumstances. The complex causes of ill health and the part that economic and social factors have to play are recognised, as is the need for a coherent and co-ordinated approach across agencies to address this;

- The environment is currently seen as the most important determinant of health, and the most relevant area for intervention. Public policies to tackle the environmental determinants of health, both physical and social, are the most powerful means of achieving population health gain and reduction in health inequalities;

- The health inequalities in Wales are likely to result from a combination of economic deprivation, occupational health hazards, high unemployment, poor housing, polluted environment, a high prevalence of unhealthy lifestyles and poor access to healthy choices in foods.