Public Audit Committee

1st Report, 2013 (Session 4)

Report on Health Inequalities

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Public Audit Committee
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CONTENTS

Remit and membership

Report 1
Introduction 1
Background 2
Primary Care
Whole time equivalent data 4
Methods of moving GPs into deprived areas 5
The extended primary care team 6
Acknowledging multimorbidity in adopting effective approaches to treatment 7
Health inequalities initiatives
Measuring the success of initiatives 8
The Keep Well programme – follow-up care 9
Long-term funding and support for initiatives 10
Tracking health board spend 11
Community Planning Partnerships 13

Annexe A: Extract from the minutes 15
Annexe B: Oral evidence and associated written evidence 17
Public Audit Committee

Remit and membership

Remit:

The remit of the Public Audit Committee is to consider and report on—

(a) any accounts laid before the Parliament;

(b) any report laid before or made to the Parliament by the Auditor General for Scotland; and

(c) any other document laid before the Parliament, or referred to it by the Parliamentary Bureau or by the Auditor General for Scotland, concerning financial control, accounting and auditing in relation to public expenditure.

(Standing Orders of the Scottish Parliament, Rule 6.7)

Membership:

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Willie Coffey
James Dornan
Iain Gray (Convener)
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Public Audit Committee
1st Report, 2013 (Session 4)

Report on Health Inequalities

The Committee reports to the Health and Sport Committee as follows—

INTRODUCTION

1. Tackling health inequalities has been a significant and complex problem in Scotland for over 50 years. The Public Audit Committee has taken a strong interest in the challenges faced in tackling inequalities, undertaking scrutiny in the past year of two reports from the Auditor General for Scotland (AGS) in and around this subject area. These were entitled Cardiology Services¹ and Health Inequalities in Scotland.² Having taken formal evidence from key stakeholders and undertaken fact-finding visits in deprived areas, the Committee considered that issues arising from this work would provide valuable context for the Health and Sport Committee inquiry into health inequalities. As this report is seeking to inform the Health and Sport Committee’s inquiry, without pre-empting its findings, the report takes the form of a summary of evidence which the Health and Sport Committee may wish to explore further.

2. The publication of the report on Health Inequalities in Scotland provided the Committee with the opportunity to pursue further some of the concerns highlighted in its cardiology services inquiry. The Committee received a briefing from the AGS on 19 December 2012 on the report, followed by a session with Scottish Government officials, including the Chief Medical Officer. It then held an evidence session on 30 January 2013 which looked at the provision of primary care services and the level of funding targeted at deprived areas to help reduce inequalities. The session used the Greater Glasgow area as a case study, given the high levels of deprivation that exists in this area. The Committee would like to thank all those who gave evidence.

¹ The recommendations of the Cardiology Services inquiry are available on the PAC website along with the Scottish Government’s response - www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/54692.aspx
² Details of those who gave evidence to the Committee and their written and oral evidence are available on the PAC’s website - Official Report of Meeting 30 January 2013 (606KB pdf) / www.scottish.parliament.uk/parliamentarybusiness/28862.aspx?r=7628&mode=pdf
3. Given this Committee’s remit, its work has focused on how effectively and efficiently resources have been used to reduce health inequalities. This report does not comment on every issue raised in the AGS reports or raised in evidence. Instead, it highlights what it considers to be key issues, from an audit perspective, that the Health and Sport Committee may wish to pursue.

BACKGROUND

4. The key determinant of health inequalities is deprivation. The AGS report on health inequalities opens with some stark figures on the extent of health inequalities including—

- average life expectancy of men in the most deprived areas is 70.1 years, in the least deprived areas it is 81 years;
- for women it is 76.8 years in the most deprived areas, in the least deprived areas it is 84.2 years;
- exclusive breastfeeding rate at 6-8 weeks is 15% in the most deprived areas, in the least deprived areas it is 40%;
- GP consultations for anxiety per 1,000 patients is 62 in the most deprived areas, in the least deprived areas it is 28; and
- alcohol-related hospital admissions per 100,000 population in the most deprived areas is 1,621, in the least deprived areas it is 214.

5. The AGS in evidence to the Committee added some more detail on the nature of inequalities in deprived areas—

“People in more deprived areas have higher rates of coronary heart disease, mental health problems, obesity, alcohol and drug misuse problems, diabetes and some types of cancer, and children in deprived areas have significantly worse health than those in more affluent areas. For example, they have lower average birth weights and breastfeeding rates, have poorer dental health and are more likely to be obese.”

6. In terms of the economic cost of inequalities, the report states—

“…if the death rate in the most deprived groups in Scotland improved then the estimated average economic gains would be around £10 billion (at 2002 prices); and if the death rates across the whole population fell to the level in the least deprived areas, the estimated economic benefit…could exceed £20 billion”

7. The report also makes clear from the outset the complexities involved in addressing such inequalities, stating—

“Tackling health inequalities is challenging. Health inequalities are influenced by a wide range of factors including access to education,

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3 Scottish Parliament Public Audit Committee Official Report, 19 December 2012, Col 1044
4 Scottish Parliament Public Audit Committee Official Report, 19 December 2012, Col 1046
employment and good housing; equitable access to healthcare; individuals’ circumstances and behaviours, such as their diet and how much they drink, smoke or exercise; and income levels.”

8. The Committee has focused its most recent work on money targeted through health boards to primary health care services and on Scottish Government health care initiatives. However the Committee wishes to highlight, as useful context for the Health and Sport Committee in embarking on a broader inquiry, the observation of Sir Harry Burns, Chief Medical Officer, that the drivers of health inequalities ultimately lie outside the healthcare system.5

KEY ISSUES

Primary care

Distribution of General Practitioners

9. The Committee heard during its inquiry into cardiology services that although Scotland has a higher ratio of General Practitioners (GPs) to people compared with every other UK country, the distribution of GPs did not necessarily reflect the respective needs of people according to the level of deprivation in their area. The Committee’s report invited the Scottish Government to review whether GP numbers are adequate to meet the needs of patients in deprived communities and ethnic minority communities.

10. The Scottish Government response highlights existing mechanisms for allocating GPs according to need. It highlights that health boards are required to put in place—

“…those arrangements they consider necessary to meet all reasonable requirements for their area. Funding allocations to Health Boards are calculated based on a number of criteria, including the additional costs associated with morbidity and life circumstances. Weighting towards these factors increases the level of funds allocated to Health Boards in deprived areas. This funding enables boards to fund, amongst other things, GP services for their area.”6

11. The Scottish Government response also highlights the work of GPs at the “Deep End” (commonly known as the Deep End project). These are GPs that work in 100 general practices serving the most socio-economically deprived populations in Scotland (86 of which are in Glasgow).

12. The AGS report on health inequalities elaborates on the issue of GP distribution, with one of the key messages being—

“Appropriate access to health services is an essential part of reducing health inequalities. GPs have a critical role to play in helping to reduce inequalities and in facilitating access to the whole range of NHS services including hospital care. But the distribution of

5 Scottish Parliament Public Audit Committee Official Report, 19 December 2012, Col 1072
6 Scottish Government response to the Cardiology Services inquiry
primary care services across Scotland does not fully reflect the higher levels of ill health and wider needs found in deprived areas, or the need for more preventative health care. The distribution of other primary health care services, such as pharmacies, is more closely matched to need.”7

Whole time equivalent data
13. The AGS report (Exhibit 13) suggests that deprivation is reflected to a limited extent in the distribution of GPs, however those figures are based on overall headcount of GPs as opposed to whole time equivalent numbers. Audit Scotland notes that “the availability of GPs is more accurately measured by whole time equivalent (WTE) rather than headcount8”. The Scottish Government responded to a request for WTE GP figures broken down by deprivation by stating—

“It has not been possible to construct an estimate of whole time equivalent GPs across Scotland. Calculating WTE figures for GPs is not straightforward since GP practices are virtually all independent contractors and are not employed by Health Boards. However, we will be carrying out a survey of GPs this year which will indicate WTE figures for GPs and other practice-based health professionals. This will not be broken down by deprivation. Most GP practices serve populations living in a mixture areas, some more deprived than others.”9

14. The witnesses on 30 January 2013 included GPs from the Deep End project and the co-ordinator of the project, Professor Graham Watt (University of Glasgow). The Committee explored the distribution of GPs across Scotland with these witnesses, having received written evidence from the Deep End project that suggested that maintaining what it perceived to be a flat distribution of GPs “is a recipe for widening health inequality”10. Professor Watt responded—

“You asked for whole-time equivalent data, so we have given it to you. It is the most recent data—it is from 2003, after which the Government stopped collecting it. That was not a deliberate decision, it just happened as a result of the new contract, which engages with practices rather than with individual doctors. The result is that that crucial information—which previously was not valued—has not been collected.”11

15. The Committee recognises that GPs are independent contractors which is a complicating factor in seeking to collate WTE headcount data. In addition, GPs working in practices that cover areas that include both affluent and deprived communities, will be challenging to categorise. However, this information is an

7 AGS report Health Inequalities in Scotland – page 22
8 AGS report Health Inequalities in Scotland – paragraph 41
9 Supplementary evidence from the Scottish Government on the AGS report Health Inequalities in Scotland
10 Evidence from the Deep End project on the AGS report Health Inequalities in Scotland
11 Scottish Parliament Public Audit Committee Official Report, 30 January 2013, Col 1168
extremely useful starting point for effectively assessing whether there is a sufficient allocation of GPs in deprived areas.

16. The Health and Sport Committee may wish to pursue the possibility of the Scottish Government overcoming the practical barriers to collating WTE headcount figures for GPs, and providing this information broken down according to the level of deprivation.

Methods of moving GPs into deprived areas
17. A number of suggestions were made in evidence as to how GP numbers in deprived areas could be increased, if necessary.

Fellowships
18. Professor Graham Watt suggested that more fellowships could be based in deprived areas—

“The most valuable clinical time in practices is that of the experienced GPs, although training can be an attractive option—there is an argument for that—as can fellowships. If there were as many fellowships for working in deprived areas as there are for working in rural areas, that would be a good step in the right direction.”

“…Let us just say that the 2003 data is flat—if we add in the training posts, it becomes slightly biased towards affluent areas.”

19. An increase in the number of fellowships in deprived areas could increase the number of GPs trained in the specific challenges of these areas such as the high number of patients with psychological conditions and/or comorbidity. This issue was highlighted in the Committee’s cardiology services report (paragraphs 46 to 48).

Incentives
20. The AGS acknowledged the restrictions of the GP contract, but suggested that there was scope for incentives to be used to encourage GPs to move to deprived areas—

“The challenge for the Government is that GPs are independent contractors so they cannot be directed to particular places in Scotland. However, we have seen that incentives can work. For example, specific incentives were introduced to encourage dentists and pharmacists to set up in more deprived areas...the association between the distribution of dentists or pharmacies and deprivation is much clearer than that for the distribution of GPs. That is why we think there is room to go further...to put incentives into the GP contract to encourage the same sort of pattern.”

12 Scottish Parliament Public Audit Committee Official Report 30 January 2013, Col 1167
13 Scottish Parliament Public Audit Committee Official Report 30 January 2013, Col 1168
14 Scottish Parliament Public Audit Committee Official Report, 19 December 2012, Col 1057 — the evidence referred to in the quote is on page 23 of the AGS report on Health Inequalities in Scotland
21. As background to the AGS’s comments on dentistry, the AGS report shows that the deprivation allowance for dentists that was introduced in 2007 has had a positive effect. More recent additional initiatives that specifically target children living in deprived areas are also beginning to reap rewards. The Childsmile Practice Programme was rolled-out from October 2011, supported by £2m of funding per annum. Dental practices receive payments that are skewed towards patients from the lowest three deprivation categories. The Scottish Government evidence states that “preliminary data from the programme is encouraging with 84 per cent of independent contractor GDS practices delivering Childsmile interventions”. In addition, the National Dental Inspection Programme has demonstrated that inequality, in terms of tooth decay, in the P1 age group has fallen quite significantly between 2008 and 2012.

22. The Scottish Government acknowledged in evidence that there is more scope to include some form of tailored contractual measures in a Scottish GP contract—

“...our priority to date has not been so much to dictate where practices should be located, but to work with GPs to ensure that the allocation formula and the contractual measures give sufficient priority to deprivation. We are very willing to do more on that...I accept that the contract could offer more, which is one reason why we have recently worked hard with the BMA to try to agree with it a more Scottish contract.”

The extended primary care team

23. The Committee also received evidence that the number of GPs is by no means the only factor that contributes to targeted care in deprived areas. The make up of a primary care team and the level of collaborative working between the constituent members of a team was increasingly important in tackling health inequalities, where once the role of the GP alone was paramount. Sir Harry Burns commented—

“The effectiveness of the intervention is not necessarily driven by the number of GPs; it is driven by the number of people in the extended primary care team. The evidence from things such as the keep well and equally well programmes suggests that the signposting of individuals is important.”

24. Dr Peter Cawston, Deep End project, also spoke of the transformation of the relationship between GPs and pharmacists in the past 10 years and added that “the key issue is what the primary healthcare team can contribute to the reduction of health inequalities”.

15 Scottish Parliament Public Audit Committee Official Report, 19 December 2012, Col 1057
16 Supplementary evidence from the Scottish Government
17 Scottish Parliament Public Audit Committee Official Report, 19 December 2012, Col 1067
19 Scottish Parliament Public Audit Committee Official Report, 30 January 2013, Col 1172
25. In considering what constitutes an ideal distribution of GPs, the Health and Sport Committee may wish to acknowledge the increasing importance of the primary care team as a whole in tackling health inequalities in deprived areas.

26. Taking this into account, should the Health and Sport Committee consider that there is merit in increasing the proportion of GPs based in deprived areas, it may wish to explore the potential to:

- increase the number of fellowships in deprived areas; and
- incorporate incentivising measures into the GP contract or the Qualities and Outcomes Framework (QOF).

Acknowledging multimorbidity in adopting effective approaches to treatment

27. The AGS report reiterates a message from recent findings from the Deep End project, that GPs in deprived areas treat more patients with multiple health problems than GPs working in less deprived areas.\(^\text{20}\) GPs in deprived areas are constrained by a shortage of consultation time with patients that present with multiple conditions. This limits the opportunity to provide appropriate treatment, advice and referral to suitable services.\(^\text{21}\) The support required to improve the long-term health of individuals can be multi-faceted and access to sufficient consultation time with GPs is a vital element of this.

28. In evidence, Professor Graham Watt elaborated on the challenges treating patients with multimorbidity presents—

“Recent data from ISD Scotland...show that only 12 per cent of consultations in general practices involve one Qualities and Outcomes Framework condition...The commonest comorbidity involves psychological problems...Although multimorbidity is commonest in old people...most people with multimorbidity in Scotland are under 65 because of the demography.”\(^\text{22}\)

“The health service needs to gear up in order to provide a more integrated experience for patients with multiple morbidity. That work can be done only by generalists, not by an army of specialists, and clearly has to be done in general practice. Moreover, if it is not done best in deprived areas, the net effect will be a widening of inequality.”\(^\text{23}\)

29. Professor Watt suggested that the Qualities and Outcomes Framework\(^\text{24}\) is based on a linear approach to diagnosis and treatment—

\(^{20}\) AGS report *Health Inequalities in Scotland* – Paragraph 42
\(^{21}\) AGS report *Health Inequalities in Scotland* – page 22
\(^{22}\) Scottish Parliament Public Audit Committee *Official Report*, 30 January 2013, Col 1162-3
\(^{23}\) Scottish Parliament Public Audit Committee *Official Report*, 30 January 2013, Col 1163
\(^{24}\) ISD Scotland website - the Quality & Outcomes Framework (QOF) represents one of the main sources of potential income for general practices (GP surgeries) across the UK. Participation by general practices in the QOF is voluntary. For those that do participate, the QOF measures
“It is only very recently that research has turned its attention to multiple morbidity. Almost the entire research establishment and the literature, guidelines and policy are based on the vertical approach to cancer, heart disease and mental health issues, and not on the individual who has all three.”

30. The Committee was encouraged to hear from Scottish Government officials that more focus had been given in negotiations on the GP contract to treating patients in a way that reflects multiple morbidity. The ability to treat patients for multiple conditions, and also to be able to assess the effectiveness of health care services based on this approach, would seem to be an important shift in focus.

31. The Health and Sport Committee may wish to look further at how the NHS is shifting towards treating patients based on multimorbidity, and how the effectiveness of any such shift will be measured.

Health inequalities initiatives

Measuring the success of initiatives

32. The AGS report has some disheartening observations on the lack of evidence to demonstrate the impact of long-term initiatives. For example it suggests that there is no evidence that Equally Well test sites have helped to reduce inequalities and that “NHS Scotland has not yet determined how to evaluate the long-term impact and cost effectiveness of Keep Well.”

33. The AGS added in evidence that—

“Successive Governments have introduced a range of strategies that aim to improve health and reduce inequalities. It is clear that measuring the success of those strategies is difficult, because many interventions are long term and it often takes a generation or longer before significant improvements can be seen. Measurements for short-term and medium-term improvements are needed in order to demonstrate progress and ensure that the actions that are being taken are having the desired effect.”

34. The Scottish Government published its latest annual Long-term monitoring of health inequalities in October 2012. This includes a range of indicators to monitor progress on reducing health inequalities. The Scottish Government highlighted in evidence that Health Improvement, Efficiency, Access and Treatment (HEAT) targets are focused on making a proportional investment in areas of deprivation achievement against a range of evidence-based indicators, with points and payments awarded according to the level of achievement.

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25 Scottish Parliament Public Audit Committee Official Report, 30 January 2013, Col 1169
26 Scottish Parliament Public Audit Committee Official Report, 19 December 2012, Col 1083
27 AGS report Health Inequalities in Scotland - Exhibits 10 and 11 show spending on special initiatives
28 AGS report Health Inequalities in Scotland
and that “as a result, you would expect benefits to flow through in the longer-term indicators”.  

35. Professor Watt highlighted the merits of a central unit to produce research that could include assessing what approaches to reducing health inequalities were proving effective—

“...I note that the evidence to inform a lot of the suggestions is missing. That is why our position is heavily steeped in experience, rather than evidence...The English school for primary care research gets £17 million a year from Government, and the Wales school for primary care research gets £2.7 million, but the Scottish Government has withdrawn its funding from the Scottish school of primary care for such research so we will not produce the evidence to inform the policy. We will therefore continue to depend on experience and rhetoric.”

36. The Committee considers that progress needs to be made in the effective performance assessment of specific initiatives. The Health and Sport Committee may wish to give this further consideration, including considering the potential merits of a centrally funded research function.

The Keep Well programme – follow-up care

37. The Committee’s cardiology services report highlighted that “it is essential to ensure the patient’s journey includes timely and good links maintained with other departments such as social work and secondary care”. The report recommended that NHS boards work with local authorities and GPs to identify all the community support services available in each medical practice area so that patients may be more quickly supported to make lifestyle changes following Keep Well health checks. It also highlighted the need for families to “encourage and support family members who require to change their lifestyle following a health check”.

38. Professor Watt made clear in evidence the importance of ensuring that a positive initiative such as Keep Well, that was proving successful in increasing the number of people screened for conditions, was built upon through effective follow-up care—

“...the question is: what now? Each of those patients needs continuity of personalised care that does not fragment into lots of different directions. The cardiovascular risks that have been ascertained will be part of the patient’s agenda, but not the whole of it.”

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32. Public Audit Committee report on Cardiology Services - Paragraph 48
33. Public Audit Committee report on Cardiology Services - Paragraph 50
34. Public Audit Committee report on Cardiology Services - Paragraph 87
35. Scottish Parliament Public Audit Committee Official Report, 30 January 2013, Col 1182
39. The Health and Sport Committee may wish to request evidence on the extent to which the success of the Keep Well programme is being capitalised on with resources targeted at follow-up care.

**Long-term funding and support for initiatives**

40. A theme in the evidence heard from primary care service providers, NHS Greater Glasgow and Clyde and the Chief Medical Officer was the need to provide sustained long-term funding and support for initiatives.

41. The Committee heard encouraging evidence about the Keep Well programme taking the positives from older initiatives and working them into the programme to aid a more long term, established, approach to targeting health checks at those in deprived areas. A health board representative stated—

“In the keep well programme, we are keen that we should learn from the very long history of short-term projects through which we have sought to address health inequalities, including have a heart Paisley...it has been woven into what the keep well programme is continuing to develop. We want the keep well programme to become much more embedded.”

42. Elaine Egglestone, a health visitor at Govanhill Health Centre, commented on targeted funding provided in 2008 in south-east Glasgow for an infant feeding team—

“We feel that just as we were getting up and running and what we were doing was beginning to work, the [Chief Executive Letter 36] money was removed and our team went.”

43. Dr Cawston, from the Deep End project, also highlighted his frustration with initiatives that are carried out in a short term fashion and “come and go”.

44. Sir Harry Burns made clear to the Committee that it will take political “stickability” of 5 to 10 years to see a difference through initiatives—

“...the history of the effort to narrow health inequalities is full of three-year projects and projects that are done piecemeal in different parts of Scotland. At the end of the three years the projects are evaluated, people say “Oh, there is no difference,” and we take the money away.”

45. The Committee wishes to highlight this evidence on the importance of long-term sustained funding and political support for initiatives.

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37 Scottish Parliament Public Audit Committee *Official Report*, 30 January 2013, Col 1165
38 Scottish Parliament Public Audit Committee *Official Report*, 30 January 2013, Col 1173
An early years approach was widely supported in evidence, featuring in the AGS’s report and in evidence from the Deep End project\(^{40}\), the health visitor and NHS Greater Glasgow and Clyde\(^{41}\). The Scottish Government made clear the importance in tackling inequalities of “starting young”\(^{42}\). A relatively new long term initiative in this area is the Early Years Collaborative which is aimed at reducing infant mortality and improving attachment and readiness to learn\(^{43}\). The Collaborative was launched in October 2012.

As it is at an early stage in its implementation, the Committee considers this to be an opportune time for the Scottish Government to ensure that measures are in place to evaluate the impact and cost effectiveness of the initiative over time.

The Health and Sport Committee may wish to consider looking at the Early Years Collaborative as a case study, including whether there is long term funding and short, medium and long term performance assessment measures in place.

Tracking health board spend

Budget allocations are made to health boards with weighting given to, amongst other things, the level of deprivation in a health board area. Once this budget is delegated it is for health boards to allocate it according to need. The Scottish Government provides ring-fenced funding for particular initiatives which aim to tackle health problems commonly associated with health inequalities (around £170m in 2011/12).

The AGS report makes clear that tracking funding through to core service provision level is very challenging. For example, it states in relation to health board funding that “there is no national or local information about how NHS boards allocate these resources locally...there is no information about specific spending on health inequalities”\(^{44}\).

The AGS elaborated on this when briefing the Committee—

“One of the challenges is that we do not know to what extent the £11.7 billion that was spent on the NHS last year and social care spending by councils is targeted on the people who have the most significant needs and biggest health problems.”\(^{45}\)

When this was raised with NHS Greater Glasgow and Clyde, witnesses challenged whether the NHSScotland Resource Allocation Committee (NRAC) formula, which determines funding allocations to health boards, adequately takes account of deprivation—

\(^{40}\) Scottish Parliament Public Audit Committee Official Report, 30 January 2013, Col 1162

\(^{41}\) Scottish Parliament Public Audit Committee Official Report, 30 January 2013, Col 1191

\(^{42}\) Scottish Parliament Public Audit Committee Official Report, 19 December 2012, Col 1072

\(^{43}\) www.scotland.gov.uk/Topics/People/Young-People/Early-Years-and-Family/early-years-collaborative

\(^{44}\) AGS report Health Inequalities in Scotland – page 16

\(^{45}\) Scottish Parliament Public Audit Committee Official Report, 19 December 2012, Col 1050
“the inadequacy of our community data...means that deprivation is not properly reflected in the assessment of need and therefore the morbidity and life circumstances measure...The technical advisory group on resource allocation, of which I am a member, is trying to make the MLC component of NRAC more sensitive to deprivation.”

53. NHS Greater Glasgow and Clyde went on to suggest that the level of funding allocated by the health board in its area to deprived communities was well in excess of the amount of funding allocated by NRAC based on the deprivation criteria. The basis for higher funding allocated at a local level than provided for by NRAC was the health board’s own resource allocation model, “which gives more resource per head of population to our most deprived areas and less to our more affluent areas”. Examples of targeted funding included preventative spending on health improvement teams.

54. The approach taken by this health board demonstrates why it is challenging to ‘track the pound’ from allocation by the Scottish Government to the provision of care at primary and secondary care level aimed at reducing inequalities. With the exception of funding ring-fenced for particular initiatives, health board funding is allocated according to the NRAC formula and then re-allocated again according to a local funding model. This funding is not necessarily tracked based on the amount specifically allocated towards tackling health inequalities within different areas of primary and secondary care in an area.

55. The Committee appreciates that health boards require to retain the independence to allocate according to need and therefore funding for tackling inequalities will be allocated in different ways, using different funding models, in different health board areas. However these tailored approaches may make it challenging to track spending.

56. Being able to track funding is the first step in assessing whether this targeted funding is having an impact on health inequalities. Accurately targeted funding is fundamental in seeking to tackle a complex problem which requires sustained funding for long term initiatives. Knowledge of how funding is being targeted, twinned with a means to collate evidence that demonstrates which elements of this targeting funding is proving most effective is vital to inform decisions on budget allocations at a national level. Over time, more informed funding decisions should improve the collective impact of health inequalities initiatives.

57. The Committee would encourage the Health and Sport Committee to pursue in its inquiry the need to improve the ability to track funding aimed at tackling health inequalities.

58. It may also wish to consider further the issue raised by NHS Greater Glasgow and Clyde on the inadequacy of community level information leading to a less than adequate weighting for deprivation in health board budget allocations.

46 Scottish Parliament Public Audit Committee Official Report, 30 January 2013, Col 1191
47 Scottish Parliament Public Audit Committee Official Report, 30 January 2013, Col 1191
Community Planning Partnerships

59. The AGS report highlights some very good examples of local working. However it also shows, in exhibit 21, a number of issues with CPPs struggling “to provide consistent or robust evidence about how well health inequalities are being tackled”. Audit Scotland suggested in evidence that there was a “lack of clear focus” at a local level on tackling inequalities. A lack of information sharing that would improve partnership working is also highlighted in the report along with issues about the profile of CPPs. For example it states that “some practitioners and managers do not know what a CPP is”.

60. Audit Scotland were very clear about how important the CPP role is in tackling inequalities—

“They have a lead role in the agenda, and it is important that they have a clear idea of priorities in developing their approach to health inequalities collectively, and that they have clear measures in place to check that they are making a difference and that the investments that they make in an area lead to improvements for local people. That came through strongly from our local work.”

61. There are a number of pieces of work either led or overseen by the Scottish Government aimed at ensuring that health inequalities are prioritised at a national and local level, including measures to encourage CPPs to establish a leading role:

- the Scottish Government has identified health inequalities as one of the priorities for the community planning review;
- CoSLA has issued guidance (4 December 2012) which identifies health inequalities as a clear key priority for single outcome agreements; and
- the Ministerial Taskforce which seeks to ensure a coordinated approach across Scottish Government portfolios has been reconvened.

62. The Committee notes the number of organisations involved at a national and local level in tackling inequalities and the key role that needs to be played by Community Planning Partnerships in bringing all of these efforts together and taking a lead in this area. It is therefore extremely important that CPPs work collaboratively and that there are strong lines of accountability that ensure that the organisations involved in the Partnerships are sufficiently motivated to co-operate. The Committee notes that the recent joint report Improving community planning in Scotland from the AGS and Accounts Commission makes recommendations for improving collaborative working and accountability.

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48 Scottish Parliament Public Audit Committee Official Report, 19 December 2012, Col 1051
49 Scottish Parliament Public Audit Committee Official Report, 19 December 2012, Col 1058
50 AGS report Health Inequalities in Scotland – page 29
51 Scottish Parliament Public Audit Committee Official Report, 19 December 2012, Col 1052
52 Scottish Parliament Public Audit Committee Official Report, 19 December 2012, Col 1067
54 AGS and Accounts Commission report Improving community planning in Scotland
63. The Committee highlights to the Health and Sport Committee the key role expected of CPPs, and the concerns relating to inconsistent performance of CPPs across Scotland detailed in the AGS's report.
ANNEXE A: EXTRACTS FROM THE MINUTES OF THE PUBLIC AUDIT COMMITTEE

19th Meeting, 2012 (Session 4), Wednesday 19 December 2012

Section 23 report – Health inequalities in Scotland: The Committee took evidence on the Auditor General for Scotland's report entitled "Cardiology services" from—

Caroline Gardner, Auditor General for Scotland;
Claire Sweeney, Portfolio Manager, and Phil Grigor, Project Manager, Performance Audit Group, Audit Scotland;
Derek Feeley, Director General Health and Social Care and Chief Executive NHS, Sir Harry Burns, Chief Medical Officer for Scotland, and Donald Henderson, Head of Public Health Division, Scottish Government.

Consideration of approach - Health inequalities in Scotland (in private):
The Committee considered its approach to the joint Auditor General for Scotland and Accounts Commission report entitled "Health inequalities in Scotland" and took oral evidence from—

Caroline Gardner, Auditor General for Scotland;
Angela Canning, Assistant Director, Claire Sweeney, Portfolio Manager, and Phil Grigor, Project Manager, Performance Audit Group, Audit Scotland.

The Committee agreed to take oral evidence from primary care service providers and NHS Health Board. The Committee also agreed to seek further written evidence from the Scottish Government.

2nd Meeting, 2013 (Session 4), Wednesday 30 January 2013

Section 23 report - Health inequalities in Scotland: The Committee took evidence on the joint Auditor General for Scotland and Accounts Commission report entitled "Health inequalities in Scotland" from—

Professor Graham Watt, Norie-Miller Professor (General Practice and Primary Care), University of Glasgow, and Coordinator of GPs at the Deep End; Dr Susan Langridge, GP, Possilpark Health Centre; Dr Peter Cawston, GP, Drumchapel Health Centre; Elaine Egglestone, Health Visitor, Govanhill Health Centre; Dr Linda de Caestecker, Director of Public Health, and Dr Anne Scoular, Consultant in Public Health, NHS Greater Glasgow and Clyde Health.

Consideration of evidence - Health inequalities in Scotland (in private):
The Committee considered the evidence received at agenda item 3, and took evidence from—

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The Committee agreed to provide a report to the Health and Sport Committee highlighting issues raised during evidence. The Committee will consider a draft of this report at a future meeting.

5th Meeting 2013, (Session 4), Wednesday 27 March 2013

Section 23 report - Health inequalities in Scotland (in private): The Committee considered and agreed a report on the joint Auditor General for Scotland and Accounts Commission report entitled "Health inequalities in Scotland", subject to a change to be agreed by correspondence, and agreed arrangements for its publication.
ANNEXE B: ORAL EVIDENCE AND ASSOCIATED WRITTEN EVIDENCE

Please note that all oral evidence and associated written evidence is published electronically only, and can be accessed via the Public Audit Committee’s webpages, at: http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/29860.aspx

19th Meeting, 2012 (Session 4), Wednesday 19 December 2012

ORAL EVIDENCE
Caroline Gardner, Auditor General for Scotland; Claire Sweeney, Portfolio Manager, Angela Canning, Assistant Director and Phil Grigor, Project Manager, Performance Audit Group, Audit Scotland; Derek Feeley, Director General Health and Social Care and Chief Executive NHS, Sir Harry Burns, Chief Medical Officer for Scotland, and Donald Henderson, Head of Public Health Division, Scottish Government.

2nd Meeting, 2012 (Session 4), Wednesday 30 January 2013

ORAL EVIDENCE
Professor Graham Watt, Norie-Miller Professor (General Practice and Primary Care), University of Glasgow, and Coordinator of GPs at the Deep End; Dr Susan Langridge, GP, Possilpark Health Centre; Dr Peter Cawston, GP, Drumchapel Health Centre; Elaine Egglestone, Health Visitor, Govanhill Health Centre; Dr Linda de Caestecker, Director of Public Health, and Dr Anne Scoular, Consultant in Public Health, NHS Greater Glasgow and Clyde Health.

WRITTEN EVIDENCE
- Scottish Government (231KB pdf)
- The GPs at the Deep End (497KB pdf)

SUPPLEMENTARY WRITTEN EVIDENCE
- NHS Greater Glasgow and Clyde (142KB pdf)
- The GPs at the Deep End Group proposals (290KB pdf)
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