Health inequalities in Scotland

Impact report

Prepared by Audit Scotland
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Audit Scotland is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. It provides services to the Auditor General for Scotland and the Accounts Commission. Together they ensure that the Scottish Government and public sector bodies in Scotland are held to account for the proper, efficient and effective use of public funds.

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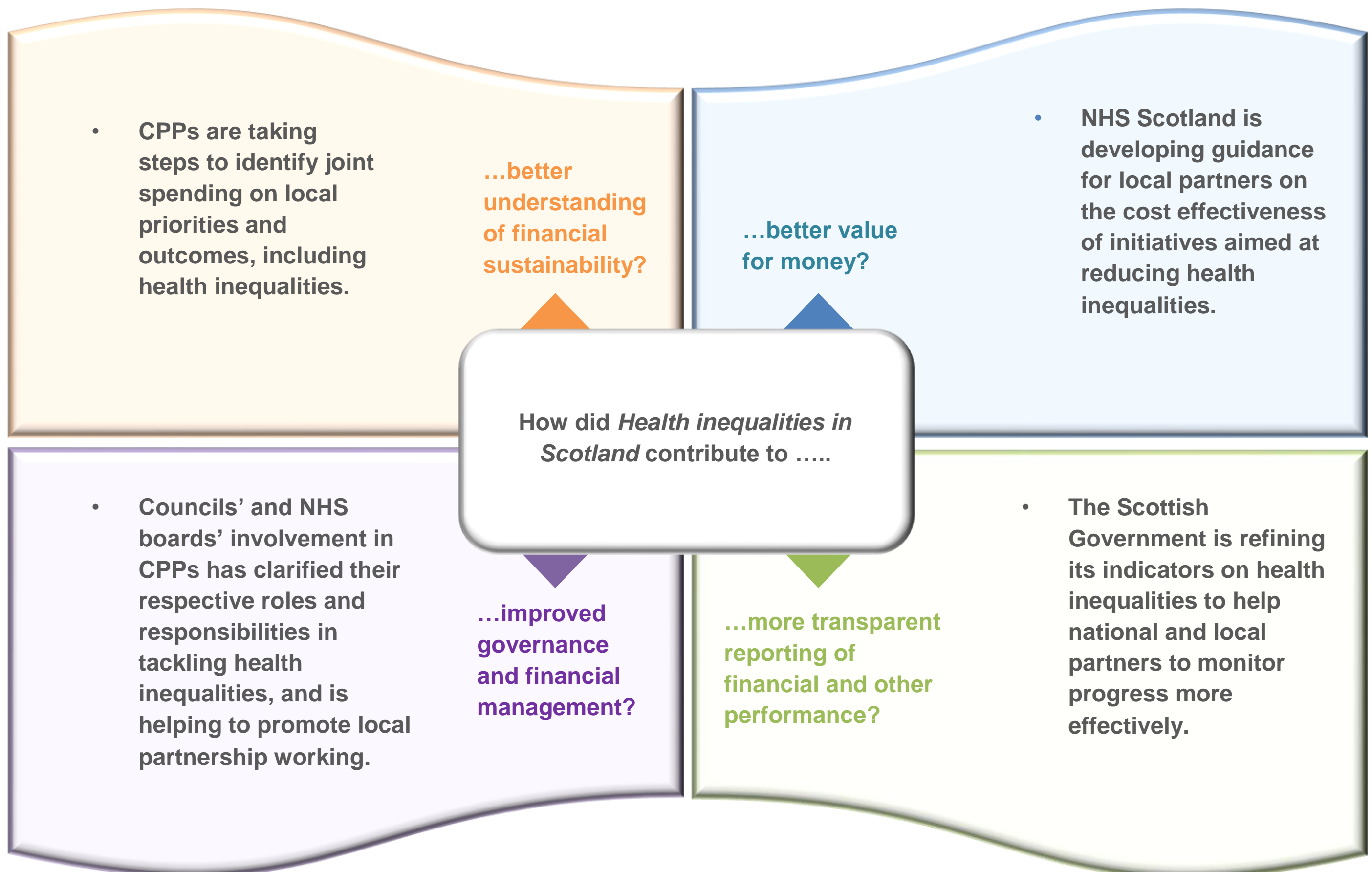
Summary of overall progress

Contribution to key aspects of public sector audit



Introduction

1. This report summarises the impact made by the joint Accounts Commission / Auditor General for Scotland performance audit *Health inequalities in Scotland* published on 13 December 2012.

2. The audit provided an overall assessment of how well Scotland is addressing health inequalities. Given the scale and complexity of the problem, we did not examine in detail the impact of wider policies such as education, employment and housing on reducing health inequalities. We outlined the scale of health inequalities in Scotland and the effects on specific groups of people. We estimated how much the public sector spends on reducing health inequalities, although information on this was limited. We assessed whether access to health services is equitable for all groups within the population, particularly people living in deprived areas. Finally, we reviewed the available evidence around the effectiveness of approaches to reducing health inequalities.

3. The key messages from the report were:
   - Overall health has improved over the last 50 years but health inequalities remain a significant and long-standing problem in Scotland. Deprivation is a major factor in health inequalities, with people in more affluent areas living longer and having significantly better health. Health inequalities are highly localised and vary widely within individual NHS board and council areas. Children in deprived areas have significantly worse health than those in more affluent areas.
   - The Scottish Government takes account of deprivation, rurality and remoteness, and other local needs in allocating funding to NHS boards and councils. However, it is not clear how NHS boards and councils allocate resources to target local areas with the greatest needs.
   - The distribution of 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 healthcare. Patterns of access to hospital services also vary among different groups within the population, with people from more deprived areas tending to have poorer access and outcomes.
   - Reducing health inequalities requires effective partnership working across a range of organisations. However, there may be a lack of shared understanding among local organisations about what is meant by ‘health inequalities’ and greater clarity is needed about organisations’ roles and responsibilities.
   - National policies and strategies which aim to improve health and reduce health inequalities have so far shown limited evidence of impact. Changes will only be apparent in the long term but measures of short-term impact are important to demonstrate progress towards policy goals. Many initiatives to reduce health inequalities have lacked a clear focus from the outset on cost effectiveness and outcome measures. This means that assessing value for money is difficult.

- Current performance measures do not provide a clear picture of progress. Community Planning Partnerships' (CPPs') reports on delivering their Single Outcome Agreements (SOAs) are weak in the quality and range of evidence used to track progress in reducing health inequalities, and differences among SOAs means that a Scotland-wide picture is hard to identify.

4. The report made a number of recommendations for the Scottish Government, CPPs, NHS boards and councils. We recommended that there should be improvements in how resources are targeted at those with the greatest need, and how progress in tackling health inequalities is measured. We also recommended that there should be improvements in how health services are distributed to ensure that different groups, particularly those from deprived areas, have adequate access to services. The recommendations, along with an update of progress against each one, are detailed in the Appendix. The recommendations for CPPs reflected several of the Accounts Commission's strategic priorities, including: providing strong leadership and governance; improving partnership working; and ensuring transparent performance reporting.

5. A number of reports have been published over the years on health inequalities in Scotland. Our audit aimed to add value by providing an independent national assessment of how well health inequalities are being addressed. The audit built on previous Audit Scotland work on CPPs, Community Health Partnerships, mental health services, and drug and alcohol services. It also linked with our audits of CPPs which started in 2012.

Raising awareness and communication of key messages

Media coverage

6. The report had extensive media coverage, including front page leads in both *The Scotsman* and *The Herald*. The Director of Performance Audit did broadcast interviews with the BBC and STV and was also interviewed on the Radio Scotland *Good Morning Scotland* show. The Senior Manager gave an interview with *The Herald*.

7. Most media coverage focused on the following key messages:
    - The large differences between more affluent and more deprived areas in health and life expectancy, and the overall lack of progress in narrowing these health inequalities gaps
    - The mismatch between the distribution of GPs across Scotland and the higher levels of ill health in more deprived areas.

8. The main report was downloaded around 12,400 times in the 12 months after publication – the highest of any Audit Scotland report since monitoring began in 2007, and around five times higher than the Audit Scotland average. The key messages document was only downloaded just over half as much as the average. A breakdown of media items and downloads is provided in the table below:

Media items/downloads	Number of items: Twelve months after publication
National press	27
Local press	9
Television	11
National radio	16
Local radio	18
Specialist press	0
Web	17
TOTAL MEDIA ITEMS	**98**
Main report downloads	12,437
Key Messages downloads	295
Podcast downloads	360
TOTAL DOWNLOADS	**13,092**

Presentations by the audit team

9. The team gave a number of presentations following publication, including to:
   - Scottish Parliament Health and Sport Committee (private briefing)
   - Glasgow City Council Health and Social Care Policy Development Committee
   - Scottish Parliament Cross-Party Group on Health Inequalities
   - Minority Ethnic Carers Of People Project
   - Midlothian Council.

10. In May 2013, Claire Sweeney (Senior Manager) presented our findings at national conference *Reducing Health Inequalities: Creating a Healthier and Fairer Scotland*. Phil Grigor (Project Manager) was invited to present our findings at a Holyrood conference on health inequalities in June 2013 but the event was cancelled.

Parliamentary consideration

11. The Auditor General briefed the Scottish Parliament's Public Audit Committee (PAC) on 19 December 2012. At the same session, the Committee also took evidence on the report from Derek Feeley (Director-General, Health and Social Care, Scottish Government) and Sir Harry Burns (Chief Medical Officer). Discussions focused on the complexity of health inequalities, the targeting of funding and distribution of health services to help tackle the problem, and initiatives aimed at reducing health inequalities. The Scottish Government

subsequently provided written evidence to the committee to follow up some of the issues raised at the meeting.

12. PAC held a follow-up session on our report in January 2013 with representatives from the *General Practitioners at the Deep End* project (which involves the 100 general practices serving the most deprived areas in Scotland) and public health officials from NHS Greater Glasgow and Clyde. Discussions again centred on the apparent mismatch between the distribution of primary care services and the higher levels of ill health in more deprived areas, and the role of the wider NHS in helping to reduce health inequalities. Witnesses also discussed funding allocations to NHS boards and the importance of local partnership working.

13. PAC published its report on our findings and the above discussions in April 2013. The report focused on four main issues: primary care, including the distribution of GPs; initiatives to tackle health inequalities; tracking health board funding aimed at tackling health inequalities; and role of CPPs. In October 2012, the Scottish Parliament's Health and Sport Committee agreed that health inequalities was its top priority for an inquiry. PAC intended that its report would inform the Health and Sport Committee's inquiry.

14. In December 2012, the Audit Scotland project team provided a private briefing to the Health and Sport Committee to help inform the remit of its inquiry. In January 2013, the committee took evidence from Derek Feeley and Sir Harry Burns as part of its inquiry, and the following month it held a follow-up session with representatives from Glasgow University, Glasgow Centre for Population Health, NHS Health Scotland and Poverty Alliance. Discussions focused on various issues in our report, including: links between deprivation and health inequalities; lack of progress in tackling health inequalities; spending on health inequalities; early years initiatives; and access to health services.

15. The Health and Sport Committee held a stakeholder conference in February 2013 to inform the scope of its planned inquiry. Representatives from NHS Health Scotland led a session on the role of the National Performance Framework, Single Outcome Agreements and wider community planning in tackling health inequalities. The presenters included a number of our recommendations for CPPs to help generate discussion among the delegates.

16. As part of its work on health inequalities, the Health and Sport Committee is holding a short inquiry on early years. Audit Scotland submitted a written response on behalf of the Accounts Commission and the Auditor General for Scotland, based on our *Health Inequalities* report and initial scoping work on early years.

17. Two MSPs asked Parliamentary Questions which referred specifically to the recommendations in our report. Mary Scanlon (Con) asked why SOAs do not provide robust evidence of progress in reducing health inequalities. In his response, the Minister for Public Health referred to the Scottish Government's and COSLA's 2012 review of community planning. This review identified the need to improve SOAs, and the Scottish Government and COSLA 2012 published guidance for CPPs which included health inequalities as one of six key priorities.

18. Duncan McNeil (Lab) asked a range of questions about the extent to which:

- information about the number of whole-time equivalent GPs and practice nurses was collected across different levels of deprivation
- the distribution of primary care services fully reflects levels of deprivation
- NHS boards monitor the use of primary care, preventative and early detection services by people from more deprived areas
- the GP contract includes measurable outcomes to monitor progress towards tackling health inequalities
- national indicators had been introduced which specifically monitor progress in reducing health inequalities.

The Cabinet Secretary for Health and Wellbeing's responses largely reflected the Scottish Government's reported progress on implementing our recommendations (see Appendix). The Cabinet Secretary also indicated that this year, NHS boards are required (for the first time) to complete a 'strategic assessment of primary care' as part of the annual local delivery plan process. He stated that these assessments will inform boards' shift in resources to strengthen and expand the role of primary care.

Local consideration of the report

19. Responses from councils and NHS boards indicated that over two-thirds of these bodies formally considered our report in the 12 months after publication. Some organisations which did not formally consider the report indicated that our findings and recommendations were more applicable for CPPs and were already being taken forward through Single Outcome Agreements. Just over ten per cent of councils and NHS boards carried out a self-assessment following publication of our report.

20. Several councils and NHS boards indicated that our report was of limited value because we did not examine in detail the impact on health inequalities of factors such as housing, employment and education. However, most councils and NHS boards reported a range of responses to the findings and recommendations. These included:

- Using the report's findings as a position statement to support existing plans and actions (for example, the need for strong local partnership working)
- Organising local events to identify actions to help tackle health inequalities, for example, through newly integrated health and social care arrangements, or targeting resources at areas with the greatest need (Case study 1)
- Establishing local working groups and workstreams to implement our recommendations, for example, through clarifying partners' roles and responsibilities, reviewing the distribution of GPs, and identifying spending on reducing health inequalities (Case study 2).

Case study 1

NHS Shetland response to recommendations

NHS Shetland's Consultant in Public Health Medicine gave a presentation to the Community Planning Board in December 2013 on *Health Inequalities in Shetland* which drew on Audit Scotland's report and the self-assessment checklist. The presentation, which was well received by partners, placed particular emphasis on the need for a preventative approach, joined up working and targeting resources at the most vulnerable and those in need. This is especially important when resources are tight and council services in particular are being reduced.

Source: NHS Shetland

Case study 2

NHS Grampian response to recommendations

Tackling health Inequalities is a key priority for NHS Grampian, and the Board welcomed Audit Scotland's report as it provided additional leverage to address the problem locally. The report will also help to inform and support the new arrangements for health and social care.

Following the publication of the report and discussions with the Chair, the Board identified one of its non-executive members as its 'champion' for health inequalities, and held a seminar on how to tackle the problem. NHS Grampian is responding to the reports findings through various workstreams, including:

- The Director of Public Health's (DPH) annual report, which is a key planning document to support local and national health agendas. Health inequalities is a theme which runs through the report, and the DPH used our findings to support and influence local partners' roles and responsibilities in addressing the issue.
- As part of the Board's modernisation agenda, ensuring that its primary care premises are fit for purpose is taking account of the location and distribution of GPs.
- Establishing equity as one of five top-level decision objectives within the Board's *Decision Making Process* pilot initiative. The board will identify and quantify defined sub-groups with the population with higher level of needs when considering options for change.
- Increasing the use of deprivation level in datasets to improve understanding of the health of the population, including differences in outcomes between specific groups. This will help to inform the Board's actions and use of resources.
- Using current local initiatives, including the Children and Young People's strategic framework, Early Years improvement work, and the recently-agreed Older People's strategy to increase the prominence of health inequalities. NHS Grampian will also use these initiatives to develop a process for capturing preventative spending.

Source: NHS Grampian

21. Around a half of councils and NHS boards reported that our report and recommendations are contributing to improvements in governance or financial management. Some organisations indicated that our findings had endorsed current approaches or had helped to improve CPPs' working arrangements aimed at addressing health inequalities. Several councils and NHS boards reported that our report had led to improved financial or performance reporting. For example, NHS Highland reported that our findings had contributed to the development of inequalities-targeted work within the board and through the Highland, and Argyll and Bute CPPs. This included the development of an inequalities monitoring framework which these CPPs will use to report on local performance to their partnerships boards.

Contribution to national policy developments

22. The Scottish Government reported various national developments which reflected some of our findings and recommendations, for example:
    - The Scottish Government is refining its existing indicators on health inequalities to help national and local partners to monitor progress more effectively.
    - NHS Health Scotland is supporting local partners to evaluate the impact and cost effectiveness of local initiatives to reduce health inequalities.
    - The Scottish Government established the Inequalities Action Group to support the Health and Community Care Delivery Group to identify how best to take forward priority areas to tackle health inequalities.

23. The *General Practitioners at the Deep End* project welcomed our report as it highlighted that the distribution of GPs across Scotland does not fully reflect levels of deprivation. Representatives from the project referred to our report in evidence to the Scottish Parliament Public Audit Committee and Health and Sport Committee, and in their March 2013 publication *What can NHS Scotland do to prevent and reduce health inequalities? Proposals from General Practitioners at the Deep End.*

Progress on implementing recommendations

24. The Scottish Government, NHS boards and councils reported varying degrees of progress on implementing our recommendations (see Appendix). The Scottish Government recognised the advantages of some of our recommendations – for example, identifying collective spending on health inequalities, and improving the evaluation of initiatives which aim to help tackle the problem. However, it also highlighted difficulties in implementing some recommendations, such as collecting and publishing information on the number of whole-time equivalent GPs and practice nurses across the various levels of deprivation, due to a lack of data.

25. NHS boards and councils reported a range of actions they are taking, or plan to take, in relation to our recommendations. For example, around a half of NHS boards indicated that they had identified systematic under-representation of particular groups' use of primary care, preventative and early detection services, and had taken targeted action to improve uptake of these services by these groups. However, most improvements reported by NHS boards and

councils were related to their community planning roles, and followed recent guidance to CPPs from the Scottish Government and COSLA rather than in response to the recommendations. This guidance covered a range of issues including partnership working, community engagement, performance reporting and joint resourcing, and it applied to CPPs' activities in general rather than specifically to heath inequalities.

Appendix. Progress on implementing the recommendations in *Health inequalities in Scotland*

Part 2: Spending

Recommendation	Progress
1 The Scottish Government and NHS boards should: include measurable outcomes in the GP contract to monitor progress towards tackling health inequalities, and ensure that the Quality and Outcomes Framework is specifically designed to help reduce health inequalities.	• The Scottish Government agreed that more could be done with the GP contract to help tackle health inequalities. It reported that it had agreed a number of measures with the BMA for 2013/14 which would be important for deprived areas, including anticipatory care for those most at risk of hospital admission. The government indicated that these measures aim to minimise the bureaucracy associated with the GP contract and allow GPs to exercise their clinical judgment in caring for patients. • The Scottish Government also reported that it is investing in leadership in general practice to help implement health and social care integration, particularly in deprived areas. This includes the Links Project which explores how GP practices can work better with local communities and use all available assets to improve health.
2 NHS boards and councils should: identify what they collectively spend on reducing health inequalities locally, and work together to ensure that resources are targeted at those with the greatest need.	• The Scottish Government, NHS boards and councils acknowledged the benefits of identifying collective spend on health inequalities but highlighted the difficulties in identifying specific resources which are assigned to tackle the problem. However, some local organisations are taking steps to identify relevant spend, and reported a variety of local approaches they have taken (or plan to take) in conjunction with their community planning partners to identify local areas with the greatest need, and to target resources at these areas. For example, North Ayrshire Council and its community planning partners are creating a logic model and a set of indicators to allow members to measure their financial commitments in relation to particular health inequalities programmes. • The Scottish Government and COSLA's Agreement on *Joint Working on Community Planning and Resourcing*, published in September 2013, places clear expectations on community planning partners to: - share resource planning information and budget assumptions with each other at an early stage - work together through CPPs to deploy resources to achieve the jointly agreed priorities set out in the SOA (including tackling health inequalities).

	• NHS boards and councils reported that CPPs are taking steps to implement this agreement, but their work is at an early stage. The planned integration of health and social work services is potentially a model for identifying and analysing collective spend on shared priorities, including health inequalities.

Part 3: Local health services

3 The Scottish Government should: consider introducing incentives for GPs in the most deprived areas to help increase access to GPs in these areas.	• The Scottish Government provided no information about whether it plans to introduce incentives for GPs in the most deprived areas to help increase access to GPs in these areas. It reported that each GP practice will review access on an annual basis to address patients' concerns and to maximise access to all services provided by GP practices.
4 The Scottish Government and NHS boards should: review the distribution of primary care services to ensure that needs associated with higher levels of deprivation are adequately resourced.	• The Scottish Government indicated that most GP practices operate as independent contractors within the NHS. Practice partners decide how best to configure their practices' activities and resources to deliver the primary medical services required under its contract with the local NHS board. • A GP practice's core funding reflects the relative health demands of its patient population. The Scottish Allocation Formula is based on patient numbers and adjusted for local variations in factors such as age, sex and deprivation. The Scottish Government reported that its priority is not to dictate where GP practices should be located, but to ensure the formula and other contractual measures take better account of deprivation. It is working, with a range of practices across Scotland to develop and test interventions which it considers to be the most effective in tackling health inequalities.
5 The Scottish Government and NHS boards should: regularly collect and publish information on the number of whole time equivalent GPs and practice nurses across the various levels of deprivation.	• The Scottish Government reported that most GP practices in Scotland are independent contractors and are not obliged to report whether their individual GPs work full time or part time. • In September 2013, ISD published *The Primary Care Workforce Survey 2013*, which provided information on GP numbers, their designation, gender, age group, and total weekly sessional commitment. However, the survey did not include any details about levels of deprivation.

Recommendation	Progress
6 NHS boards should: monitor the use of primary care, preventative and early detection services by different groups, particularly those from more deprived areas. If this identifies systemic under-representation of particular groups, take a targeted approach to improve uptake.	• Ten of the 11 NHS boards that responded to our follow-up survey reported that they monitored the use of primary care, preventative and early detection services by different groups, particularly those from more deprived areas. Around a half of boards indicated that they had identified systematic underrepresentation of particular groups, and had taken targeted action to improve uptake of these services by these groups.
7 NHS boards should: monitor the use of hospital services by different groups and use this information to identify whether specific action is needed to help particular groups access services.	• Inpatient and outpatient hospital data are available at NHS board and council level by deprivation category, gender and age. • In February 2014, ISD published *Improving ethnic data collection for equality and diversity monitoring* which showed increased completeness in the recording of ethnic group in acute hospital discharge records and new outpatient appointment records. In the last two years, completeness of recording improved 12 percentage points to 78 per cent for inpatient and day case records, and by 20 percentage points to 67 per cent for new outpatient appointment records. However, the level of completeness varied widely across NHS boards.
8 NHS boards should: review patterns of non-attendance for hospital appointments and target action to improve attendance rates of patients living in deprived areas.	• See response to recommendation 7.
9 CHPs should: involve GPs fully in local approaches to reduce health inequalities.	• See response recommendation 21 (roles and responsibilities).

Part 4: Effectiveness

Recommendation	Response
10 The Scottish Government should: develop measures of short-term impact to demonstrate the effectiveness of its strategies which aim to improve health and reduce health inequalities in the longer term.	• The Scottish Government recognises that focussing on early years is an important aspect of tackling health inequalities in the long term. Establishing appropriate short-term indicators was an integral part of developing the Early Years collaborative. • The government also recognises that it needs to improve evaluation of 'upstream' measures which represent the most effective long-term approach for tackling health inequalities. This presents challenges as it is difficult to assess the effectiveness of such interventions.
11 The Scottish Government should: assess the impact on health inequalities of policies which aim to improve the health of the whole population.	• NHS Health Scotland has developed Health Inequalities Impact Assessments (HIIAs) and a number of these have been carried out. NHS Health Scotland plans to expand this work by developing and distributing new HIIA guidance and training for NHS boards.
12 The Scottish Government should: continue to support shared learning among the Equally Well test sites and encourage the transfer of effective local approaches to other areas.	• NHS Health Scotland is supporting CPPs to tackle health inequalities in their local areas. This includes a range of briefings to help CPPs take appropriate action to reduce or mitigate the impact of wider inequalities on health. NHS Health Scotland will also develop guidance on the cost effectiveness of preventative public health interventions aimed at reducing health inequalities.
13 The Scottish Government should: publish information at a more local level than Scotland-wide, and include factors such as ethnicity, to allow a more detailed analysis of progress in reducing health inequalities.	• Council-level information is published via the Scottish Health and Wellbeing Profiles. These profiles aim to support health improvement in Scotland by providing information about the health of local populations that will help service providers, planners, policy makers and the public make informed decisions to improve health. The council profiles include 59 indicators covering health, social care, housing, economy, education, crime and environment. There are a range of indicators measuring aspects of individual and area deprivation. NHS board level data are expected to be published in spring 2014. • More detailed local profiles covering drugs, alcohol and tobacco use have recently been developed and published by the Scottish Public Health Observatory (ScotPHO), with many of these indicators forming a nationally agreed set of core indicators for Alcohol and Drug Partnerships (ADPs). Progress against the core indicators are included in ADP annual reports shared with the Scottish Government. The alcohol and drug profiles provide data at ADP and NHS board level, and the tobacco profiles are provided at NHS board and Community Health Partnership levels.

14 The Scottish Government should: introduce national indicators to specifically monitor progress in reducing health inequalities and report on progress.	• The Scottish Government does not plan to introduce new national indicators to monitor progress in reducing health inequalities. Instead, it is adding additional details to existing indicators on age, gender, and deprivation to help national and local partners to better understand trends across key groups. The government publishes annual updates on its headline indicators. In its latest report, *Long-term Monitoring of Health Inequalities*, published in October 2013, the low birthweight indicator was supplemented by an additional indicator of appropriate weight for gestational age. The report also presents inequalities information on mortality and incidence of various types of cancer.
15 The Scottish Government and CPPs should: ensure that cost effectiveness is built into evaluations of initiatives for reducing health inequalities from the start.	• NHS Health Scotland is supporting local partners to evaluate the impact and cost effectiveness of local initiatives to reduce health inequalities. For example: - All NHS boards will be circulated with evidence and guidance relating to service access and health inequalities, including information on the cost effectiveness of preventative public health initiatives - NHS Health Scotland plans to develop evidence for CPPs on the cost effectiveness of preventative public health interventions aimed at reducing health inequalities. • The Scottish Government reported that the available evidence indicates that preventative 'upstream' measures (such as employment and taxation policies) are more likely to reduce health inequalities than 'downstream' measures such as treatment of illness or attempts to change behaviours. Preventative measures are also more cost effective but their economic evaluation presents significant challenges due to a lack of reliable data, and the difficulty in isolating the impact of particular initiatives from other compounding factors. There is also potential time-lag between the implementation of policies and expected changes in outcomes.
16 The Scottish Government and CPPs should: ensure that, where appropriate, successful local initiatives for reducing health inequalities are rolled out more widely.	• The Scottish Government plans to use the Health and Community Care Delivery Group to identify how best to take forward priority areas to tackle health inequalities. A newly established Inequalities Action Group will support the Delivery Group by helping to identify priorities, and providing evidence and information on potential delivery.

17 The Scottish Government and CPPs should: align and rationalise the various performance measures to provide a clear indication of progress.	• The Scottish Government is refining its existing indicators on health inequalities to help national and local partners to monitor progress more effectively. It has revised the current set of National Indicators by adding additional information on age, gender and deprivation.
18 The Scottish Government and CPPs should: establish a shared understanding of what is meant by 'health inequalities'.	• NHS Health Scotland recently produced guidance for councillors to improve their understanding of health inequalities. This is being extended to include guidance for NHS Boards non-executive directors.
19 CPPs should: provide strong and supportive leadership which helps to promote effective partnership working to reduce health inequalities at a local level.	• The Scottish Government and COSLA's *Statement of Ambition* for community planning includes an expectation that CPPs operate as boards to ensure the effective participation of all partners to deliver local plans and improve outcomes. However, NHS boards and councils provided no information about how CPPs plan provide leadership which helps to promote effective partnership working specifically in relation to health inequalities.
20 CPPs should: involve local communities in activities which are aimed at reducing health inequalities.	• The Scottish Government and COSLA's *Statement of Ambition* for community planning includes an expectation that CPPs must: - build a strong understanding of their communities, and provide genuine opportunities to consult, engage and involve them - be able to engage closely with the needs and aspirations of their communities. • However, NHS boards and councils provided no information about how CPPs plan to involve local communities in activities which are aimed at reducing health inequalities.
21 CPPs should: ensure that all partners are clear about their respective roles, responsibilities and resources in tackling health inequalities, and take shared ownership and responsibility for actions aimed at reducing health inequalities.	• Most councils and NHS boards reported that their involvement in CPPs, including the development of shared priorities in their Single Outcome Agreements, had clarified their respective roles and responsibilities in tackling health inequalities. Community planning had also helped to develop shared ownership for addressing the issue. Only one organisation reported that it planned to redesign its Community Health Partnership (to lead the community planning process on health inequalities) specifically in response to our report.
22 CPPs should: clarify with CHPs (and, over time, with the proposed integrated Health and Social Care Partnerships) the respective roles and responsibilities for reducing	• See response to recommendation 21.

health inequalities.	
23 CPPs should: include in SOAs clear outcome measures for reducing health inequalities which demonstrate impact	• All CPPs produced revised SOAs in 2013 following publication of the Scottish Government and COSLA's *Statement of Ambition* for community planning (March 2012) and *Guidance to Community Planning Partnerships* (December 2012). CPPs included a range of indicators in their new SOAs to help monitor progress in delivering the SOA and improving local outcomes. A number of councils and NHS boards reported that their CPPs are further developing and refining their outcome measures. These include specific health inequalities indicators and measures related to wider issues such as employment and education.
24 CPPs should: ensure that all partners take steps to improve the sharing of information to help joint working aimed at reducing health inequalities.	• Several NHS boards and councils provided examples of local information-sharing protocols and initiatives among local community planning partners. However, few of these were specifically linked to health inequalities.
25 CPPs should: improve the transparency of their performance reporting to allow a better understanding of how well they are tackling health inequalities.	• The Scottish Government and COSLA's *Statement of Ambition* for community planning (March 2012) states that transparent and accessible public reporting is key to: - providing assurance about the effectiveness of the CPP - helping CPPs improve how they perform. • However, NHS boards and councils provided no information about how CPPs plan to improve their performance reporting specifically for health inequalities.
26 CPPs should: ensure that robust evaluation, using all available data and including outcome measures and associated costs, are an integral part of local initiatives aimed at reducing health inequalities and that staff have the skills to carry out evaluations.	• NHS Health Scotland is supporting local partners to evaluate the impact and cost effectiveness of local initiatives to reduce health inequalities (see recommendation 15).

27 NHS boards and councils should: carry out health inequalities impact assessments when designing new services or redesigning existing services.	• NHS boards and councils reported mixed progress in this area. Most organisations indicated that they carried out equality impact assessments when designing or redesigning services, and some had used specific health inequalities impact assessments in the past. However, few boards or councils have established processes for assessing the impact of new policies or services on health inequalities although some indicated that this was an area for development.