Community Development and Health Network

Programme for Government

December 2016

Community Development and Health Network (CDHN) is a regional network organisation, consisting of over 1800 organisations. We support and engage our network to advance their knowledge and skills in community development, to influence policy and to reduce health inequalities.

Health inequalities are the unfair and avoidable differences in the health status of people in our society. They exist because of the conditions in which people are born, grow, live, work and age, the wider determinants of health.

We welcome the move to an outcomes approach and CDHN are delighted to see outcomes such as; we have a more equal society, we enjoy long, healthy, active lives, we have high quality public services and we connect people and opportunities through our infrastructure. Many of the outcomes and action plans seek to influence the wider determinants of health and therefore CDHN are hopeful that this Programme for Government will generate long term change and a reduction in social and health inequalities.

Partners

A whole systems approach has been long advocated for by public health and those seeking to address the wider determinants of health and CDHN are pleased to see this approach in the PfG. The Programme for Government and the delivery plans make many references to co-design and co-delivery. Working in partnership is central to whole systems approach, co-design and co-delivery it is also a key component to successfully and faithfully implementing OBA. "Inclusion is a process not an end point" (Friedman, 2015). The success of OBA and therefore the PfG is reliant on inclusion and partnerships, CDHN are calling for a minimum requirement to engage to be developed. Each SRO should be required to hold at least quarterly stakeholder engagements.

Outcomes and indicators

Outcome 11 – indicator – usage of online channels to access public services. This indictor is very much focused on output data, it could be strengthened if it examined satisfaction levels or resolution of issues through the use of online access to public services. Evidence should be required to show the relationship between usage and satisfaction and/or resolution. Simply relying on usage data could be misleading, for example, there could be high usage with high levels of dissatisfaction.

Two of the indicators look at specific services, health and social care and schools. There are no indicators on many of our key public services; housing, police, fire, library and environment services. Without data on a range of public services CDHN would argue that it would be difficult to the outcome of public services are of a high quality.

Community Development and Health Network

Programme for Government

December 2016

Turing the curve and the story behind the base line

Data can be used to assess if the curve is being turned at indicator and population level. Aggregate data at both population and indicator level provide important insights. It is vital that this does not lead to the sidelining of other disaggregate, qualitative and quantitative data. We must keep going back to the story behind the baseline and using a range of data to ensure that there are no sub-populations or communities being left behind and that potentially conflicting data and outcome trends are understood.

The health inequalities monitoring reports from the Department of Health are an excellent example of how the interrogation of data can deepen understanding of what is happening and uncover different impacts. For example, there have been improvements in the standardised death rate due to circulatory disease for under 75s. The interrogation of the data shows that the least deprived have improved at a greater rate than the least deprived. Overall the same data shows that there have been improvements in health outcomes but that there is a widening in the health inequalities gap. The curve is turning in relation to health improvement but causing a widening of inequality.

CDHN are keen that all data in the PfG is interrogated in this way, not only within but also across outcomes. To be able to do this data will need to be collected at sub-population/community level for several of the indicators. Performance indicators may offer a vehicle through which this data is collected and analysed but if not, the data should be collected as part of the indicator.

These indicators include:

- % of the population with GHQ12 scores ≥4. Knowing which sections of the population are more vulnerable to poor mental health will help target resources to the right area.
- % of people who are satisfied with health and social care. The delivery plan mentions 10,000 voices and how this was able to capture the views of different user groups. This needs to be a core element of data collection moving forward. User groups who could be included are: mental health, learning disability, physical disability, elderly, oncology, paediatrics. The performance indicators should seek to examine the experience and satisfaction of the different groups in relation to the different fields within health and social care: primary care, acute (emergency and non-emergency), social care and social work
- Gap between % of non FSME school leavers and % FSME leavers achieving at level 2 or above. Data which captures how specific demographic within FSME, such as BME, new entrants or carers, are faring would be welcomed.

Turning the curve at population level is an important driver but the analysis needs to be more nuanced, to understand potentially conflicting data and to ensure there are no communities being left behind.

CDHN would be happy to discuss our response in more depth.

Contact: Meabh Poacher, Policy officer, meabhpoacher@cdhn.org or 028 30264606