Glasgow Caledonian University

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# CommonHealth Catalyst: Understanding, contextualising, and addressing health disparities in Lanarkshire

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# Our findings and Key Recommendations

**PROJECT OVERVIEW:** This project is focused on Lanarkshire in west-central Scotland. Here, health inequalities are some of the widest and deaths from 'diseases of despair' are some of the highest in Europe. Designed to address these inequalities at a local level, this research concentrated on equipping partners with the tools and knowledge to do so through improved approaches to integrated care.

First, epidemiological analysis was used to highlight existing data around health outcomes and inequalities in Lanarkshire. Oral histories were then used to gather experiences of coping strategies used by local people to help contextualise this health data.

Then, with a specific focus on Lanarkshire's integrated care system (ICS), community asset mapping and programme budgeting from health economics were supplemented with in-depth interviews with policymakers and local activities to enhance understanding of local ICS operations and impacts. Through collaborative approaches including patient and public involvement (PPI) built on trust and deliberative engagement, the research began to explore different collaborative models for integrating co-production into health systems. At this stage, the main aim was to identify potential mechanisms for improving Lanarkshire's ICS to address localised health inequalities more effectively.

**KEY STUDY COMPONENTS & FINDINGS:**

| *Theme 1: Learning from the past to shape solutions for the future* | *Theme 2: Mapping the health and wellbeing ecosystem* |
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| *1a: Looking at historical and present epidemiological data and the health profile of Lanarkshire over time*<br>• Deindustrialisation in Lanarkshire and the associated higher levels of poverty in the region means it has been particularly adversely affected by austerity policies, lower life expectancies, wider inequalities, and stagnating population health.<br>• There are significant data sources which can help measure and monitor health, health inequalities, and their determinants in Lanarkshire, but more investment in better data at hyper-local (i.e., the community and neighbourhood) levels is necessary. | *2a: Programme budgeting (PB) and (marginal) analysis*<br>• PB helped assess the current allocation of financial resources to understand the range of health and social care services available in Lanarkshire and the extent of provision across the health and social care partnerships in North and South Lanarkshire<br>• Those involved in the PB exercises demonstrated a willingness to use their data on cost and activity (and on a granular level) to ensure available resources are being utilised in a manner that maximises quality and outcomes. |
| *1b: Exploring the industrial heritage of Lanarkshire and legacy of deindustrialisation on health*<br>• When exploring the long-term economic and social impacts that the declining importance of industrial activities had on employment and production in Lanarkshire, four key themes emerged: use of public and community resources, managing household budgets, caring responsibilities, and negotiating ageing and retirement.<br>• Historically, relationships between families and the state have been framed in terms of dependency culture in an unhelpful way; the area is instead characterised by an interdependence between individuals, families, local communities, evolving economic structures, and the state. | *2b: Asset-based approaches and the identification of community assets through asset mapping approaches*<br>• The community asset mapping approach brought together members of the public alongside those within the voluntary, community, and social enterprise (VCSE) sectors to create physical maps of assets in their local areas they considered to be health enhancing. Commonly identified assets included relationships (i.e., social networks, community anchor organisations, community spaces and activities, natural greenspace, education establishments, transport, and local shops and retail outlets.<br>• While there were common assets identified across Lanarkshire, locally there are isolated issues and challenges that require targeted approaches to address. Some of these challenges include transport infrastructure, approaches to development and community input into those projects, and health board communication. |

**WHAT THIS MEANS FOR POLICY ACTION GENERALLY:**
While we have focused attention on Lanarkshire, we have developed a number of tentative policy actions and recommendations that are likely to resonate with other former industrialised areas, particularly in the context of the role of VCSE organisations and health and social care integration:

- **Context, history, and connection to place all matter when making policy that will have local relevance and impact.** People are not passive in the face of the structural economic forces related to deindustrialisation in so called 'deprived' or 'left behind' areas; they have agency and operationalise a variety of 'formal' and 'informal' assets to manage changing circumstances. The VCSE sector frequently occupies a crucial role between formal public services and informal familial and neighbourhood networks and resources. Thus, **there is a need to understand the wider system of actors and relationships and the macro-level enablers and constraints impacting health, wellbeing, and inequality**, while also focusing on the needs, resources, and connections within local communities.
- **The VCSE sector is involved with ICSs in different ways.** The sector's relationship with ICSs can be complementary (via formal contractual relationships with the ICS such as provision of social prescribing); supplementary (working to address the social determinants of health through focusing upon local social vulnerabilities); or adversarial (e.g., deliberately eschewing close working with the state). **These heterogeneous relationships are context specific (both geographically and temporally) and must be managed appropriately to maximise existing resources and relationships while delivering better health and social care outcomes**.
- Many people are excluded from the VCSE sector so **only engaging with VCSE organisations an attempt to build on patient and public involvement that integrates co-production practices into health systems may miss key perspectives** (especially regarding the impact of integrated care on service users, patients, and communities). It should not be assumed that VCSE organisations represent their communities adequately, or even at all, but they are still essential partners in integrated health and social care delivery.

**RECOMMENDATIONS:**

- Relationships between different sectors and organisations need to be further established, developed, and embedded at both decision-making and service-delivery levels to truly support joint working and integration in practice and goals around person-centred care and efficiency.
- Leaders need to insist on and create an environment that enables transformative change that connects disjointed parts of ICSs and challenges persistent structural barriers. There are four potential components to this transformation:

1. Ensure the needs of an individual as a whole person and the community with broad capacity co-exist at the centre of an integration agenda.
2. Create rules and systems that are more flexible and effective at facilitating knowledge, resource, and skill sharing across organisations and sectors.
3. Re-allocate budgets to address localised needs and early-intervention/ prevention services.
4. More effectively embed the role of VCSE organisations in local decision-making and day-to-day service provision.

**CONCLUSIONS:** It is possible to bring together resource use data across health and social care as well as local VCSEs — disaggregated by relevant decision-making factors, such as population characteristics or locality — to support work focused on addressing health disparities at a local level. This research has also demonstrated the utility of a multidisciplinary and cross-sector collaborative approach to research which helps contextualise new understanding and knowledge generation in a manner that accelerates action to, in this case, improve health outcomes for individuals and communities.

The CommonHealth Catalyst project aimed to develop a community research consortium that would support Lanarkshire in its work to address health disparities in a collaborative and integrated way. Ongoing investment in this partnership, and funding for further projects that extend the baseline investigations piloted through this research, will ensure these important models of investigation and working can be sustained and have ongoing positive impacts in communities and on health.

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